

UPPER GASTROINTESTINAL BLEEDING IN CHRONIC RENAL FAILURE

Pages with reference to book, From 85 To 85

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Gastrointestinal bleeding has been frequently reported as a complication of advanced chronic renal failure¹⁻³ and is the cause of mortality in 3-7% of such patients⁴. However, mortality from gastrointestinal blood loss can be as high as 20% in renal transplant patients. A number of causes of the blood loss from the gastrointestinal tract have been outlined of which duodenal ulcer disease has been proposed as the major cause in one series⁵. However, in yet another series gastritis is the most common cause of gastrointestinal blood loss in renal failure patients⁶. Other lesions responsible for bleeding from the gastrointestinal tract include severe ulcerative esophagitis, gastric ulceration, duodenitis and angiodysplasia. Upper gastrointestinal endoscopy rather than barium series have been used in recent studies to evaluate the causes of blood loss from the gastrointestinal tract and this has resulted in a high yield of mucosal histological lesions rather than peptic ulcer as a cause of blood loss. A number of mechanisms have been proposed for the production of such lesions which cause gastrointestinal blood loss in patients with chronic renal failure. These include disturbances in serum gastrin levels⁷⁻⁹ due to decreased degradation or increased production of the hormone. The gastric acid secretion¹⁰⁻¹⁴ and mucosal barrier in the upper gastrointestinal tract¹⁵⁻¹⁷ are also abnormal. A number of abnormalities have been found in the coagulation process in patients with chronic renal disease¹⁸⁻²⁷ and account for abnormal bleeding from various sites. There is increased factor VIII related Ag, decreased Von Willibrand factor activity and increased prostacyclin production by renal cells in uraemia⁶. Cryoprecipitate and isolated coagulation factor concentrates have been used in the treatment of bleeding in patients with renal failure. It seems that the role of ulcerogenic drugs (such as non-steroidal anti-inflammatory drugs and steroids) is also important in the production of lesions which produce bleeding from the gastrointestinal tract in uraemic patients. The chronic inflammation of the gastrointestinal mucosa with decreased mucosal prostaglandin production has been associated with the use of non-steroidal anti-inflammatory drugs by patients with renal failure²⁸. Other factors which are important include smoking, alcohol and physical stress. Patients with renal failure also have a decreased platelet function¹⁷⁻²⁰. Angiodysplasias of the gastrointestinal tract have recently received importance since the increasing use of upper gastrointestinal endoscopy to diagnose the cause of blood loss and in some series have been found to be the most common lesion causing blood loss. These usually produce small amount of blood loss or recurrent occult bleeding²⁹. It has been observed that patients with renal failure who bleed from the gastrointestinal tract have more severe outcome as compared to those without renal disease. The mean length of hospital stay, the mean number of blood transfusions required, mortality and the chance of having repeated and uncontrolled haemorrhage is manifold increased in these patients. Hence, early endoscopy and diagnosis of cause of bleeding followed by treatment is recommended. Chronic use of antacids and histamine-2 receptor blockers is also advisable to prevent recurrent bleeding.

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