

SURGICAL MANAGEMENT OF IDIOPATHIC UPPER GASTRO INTESTINAL HAEMORRHAGE

Pages with reference to book, From 31 To 33

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Abstract

Of 776 patients admitted as emergency with acute upper gastro-intestinal haemorrhage, 260 were operated for uncontrollable bleeding. At surgery the cause of bleeding could not be determined in 42 (15%) cases. Vagotomy and drainage was done in 30 and gastric resection in 12 cases. Two patients died after gastrectomy (2/12). Follow up of 38 cases for 5 years showed good results. Two cases were lost to follow up (JPMA 36:31,1986).

INTRODUCTION

Alimentary bleeding with unknown aetiology can be a serious problem for the clinicians, especially when gastroduodenoscopy fails to reveal the source of bleeding or medical management fails to control haemorrhage^{1,2}. The frequency of Idiopathic alimentary bleeding varies from 14.6% to 28.4%³⁻⁶. The aim of this retrospective study is to report 10 years experience in surgical management of idiopathic G.I. bleeding (G. I. B.). Incidence, age, sex distribution and surgical management of patients is presented.

MATERIAL AND METHODS

From January 1973 to 1982, 776 patients with G.I.B. were admitted at King Abdul Aziz University Hospital, National Hospital and Central Hospital, Riyadh, Saudi Arabia. Upper G.I. endoscopy was done in 260 patients prior to gastric surgery for upper G.I.B. Forty-two patients (28 males, 14 females) had idiopathic G.I.B. Their ages ranged between 29-76 years, with a peak at 55-60 years. G.I. bleeding was defined as idiopathic when no lesion or source of bleeding was found on endoscopy, external examination or palpation of stomach and duodenum, as well as internal examination at gastrotomy revealed no pathology.

Endoscopy, per operative angiography, barium meal and laparotomy were utilized to diagnose the bleeding site. Endoscopy and at least one or two of the above mentioned methods were employed. In the patient assessment the important factor is the amount of blood lost and the evidence of continued bleeding. The clinical parameters of continued bleeding were physical signs of shock like hypotension, thin thready pulse, cold clammy skin and invisible jugular venous pressure (J.V.P), blood seen at endoscopy Or in naso-gastric suction. Gross bleeding was indicated if haematocrit was below 25%. Emergency surgery was done in cases of idiopathic upper G.I. bleeding and procedures like truncal vagotomy and gastro-jejuno-stomy with Braun's anastomosis or Bilroth I were employed. The patients were followed up for 5 years.

RESULTS

Out of 260 cases submitted to surgery for acute upper G.I. bleeding, the site of bleeding remained undetermined in 42 (15%) cases. Most of these (6 1.9%) were in 55-60 years age group with a male to female ratio of 2:1. Thirty patients (20 males, 10 females) underwent truncal vagotomy and gastro-

jejunostomy plus Braun's anastomosis (7.3%) and this was successful in controlling haemorrhage with no mortality. Average hospital stay was 15 days. Remaining twelve patients (8 males, 4 females) had Bilroth I partial gastrectomy. There were two male deaths and the average hospital stay was 23 days. Thirty eight patients had regular follow-up for 5 years with no further problem. Two patients were lost to follow up.

The major cause of the death was hypotensive shock, hypoxia and renal insufficiency. Overall result was better in female patients and vagotomy plus drainage was a more successful procedure.

DISCUSSION

Good history and careful physical examination has been the basis of the management of massive upper G.I. bleeding. A team approach has been used, which included attending physician, endoscopist, radiologist and surgeon.

In agreement with previous reports^{4,7} massive idiopathic G.I.B. represents 15% in our study with a peak 55-60 years age incidence and is twice as common in males

Birke and Engstedt³ reviewed 1252 cases of uncontrollable gastro-intestinal bleeding and in 15% cases the site remained unknown. The percentage of idiopathic alimentary bleeding is variable in different studies^{3,6-8} This has been a well known entity for a long time. In the present study also no source of bleeding was found on endoscopy and exploration in 15% of the cases.

Nasogastric tube aspiration^{9,10} and fibre-optic endoscopy^{1,2} in all 42 cases showed presence of blood in the stomach but not the source of bleeding. Double contrast barium meal⁸ study helps with variable accuracy, and angiography¹¹ can locate haemorrhage precisely only during active bleeding, failed to demonstrate the source in this group of patients.

The haematological parameters of dropping Hb and hematocrit (Hct) rising blood urea and signs of hypovolaemia indicate continued bleeding. It takes about 6-10 hours before the effect of haemodilution reflects as diminished Hb and Hct. J.V.P. does not reflect the amount of blood lost, but C.V.P. measurement provides a more accurate means of determining continued bleeding¹² and assessing amount of blood lost.

Patients with recurrent haemorrhage of obscure origin, specially in those over 50 years of age and more than 48 hours from the first haematemesis, are at greater risk, and one should not unnecessarily prolong the operation⁸. Patients over 50 years have poorer prognosis most probably because of the failure of sclerotic vessel to contract and clot².

Many patients may be controlled on medical management, however, if they continue to bleed the choice will be between truncal vagotomy and pyloroplasty or blind partial gastrectomy operation.¹³⁻¹⁵ Results of vagotomy and drainage operations were better than Bilroth I for uncontrollable upper G.I. haemorrhage of unknown cause in Saudi Arabia. Stone et al.¹⁶ had similar experience of superiority of vagotomy and pyloroplasty. Vagotomy and gastrojejunostomy with Braun's anastomosis is recommended as the operation of choice for idiopathic upper G.I. haemorrhage with less morbidity, mortality and shorter operating time in an emergency state with a poor risk patient and the result is superior. Haematocrit below 25% is a good indicator for gross bleeding.

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