Original Research Paper

Volume - 10 | Issue - 7 | July - 2020 | PRINT ISSN No. 2249 - 555X | DOI : 10.36106/ijar

General Surgery

CLINICO PATHOLOGICAL STUDY OF LOWER GASTROINTESTINAL BLEEDING

Dr. Mubeen Ahmed	Ms General Surgery, Yenepoya Medical College, Mangalore
Dr. M. S Moosabba	M S General Surgery, Yenepoya Medical College, Mangalore
Dr. Abdul Sazeen	M S Junior Resident In General Surgery, Yenepoyamedical College, Mangalore
Dr. Umesh P*	M S General Surgery, Yenepoya Medical College, Mangalore*Corresponding Author

ABSTRACT **Aim:** This is a prospective non randomized observational descriptive study conducted in patients with lower GI bleed. Patients were evaluated for the same and histopathological causes were ascertained along with demographics related to it. **Method:** Total of 90 patients presenting to Yenepoya Medical College with of lower GI bleeding undergone evaluation and management during May 2017 to October 2018 were observed. **Results:** Mean age was 45.19 years standard deviation (14.935 years). 21 cases were in the age group 41-50 years (23.33%). Family history of cancer was seen in 4cases (4.4%) and all were less than 50 years. Predominantly males with 59cases (65.6%). 81 cases (90.0%) were non vegetarians. Hemorrhoids were in 38cases (42.22%). Growth was in 24 cases (26.68 %). Polyps were seen in 8 cases (8.88%). Inflamed mucosa was in 11 cases (12.22%). Hyperemic rectal mucosa in 9 cases (10%).Malignancy was diagnosed in 12 cases (13.3%).

KEYWORDS : Lower Gi, Bleeding Per Rectum

INTRODUCTION

Lower gastrointestinal bleeding refers to blood loss of recent origin originating from a site distal to the ligament of Treitz. It is usually suspected when patients complain of passage of bright red blood or blood clots per rectum.

Lower gastro-intestinal bleeding is a common problem in day to day practice. Though lower GI bleeding is less frequent when compared to upper GI bleeding, the incidence of lower GI bleeding increases with age, and lower GI bleeding may be more common in older patients. [1] Despite the fact that Bleeding per Rectum is a common complaint in day to day practice, every attempt should be made to exclude the underlying pathology at an early stage. Hemodynamic assessment and prompt resuscitation are always the first steps in treating patients with a presumed large-volume blood loss. [2]

Lower GI bleeding typically presents with hematochezia, which can range from bright red blood to old clots. If the bleeding is slower or from a proximal source, lower GI bleeding often presents as melena. In more than 95% of patients with lower GI bleeding, the source of haemorrhage is colon. When compared with upper GI bleeding, no diagnostic modality is as sensitive or specific as endoscopy for making an accurate diagnosis in lower GI bleeding through which biopsy is taken and sent for histopathological examination. [1]

Massive rectal bleeding and malena often presents from upper GI pathology which always should be ruled out by Ryle's tube aspiration and upper GI endoscopy. [3]

When compared to upper GI haemorrhage, lower GI bleeding is a much less frequent reason for hospitalization-it is about 20% as common as bleeding from a location proximal to the ligament of Trietz. However incidence of lower GI bleeding increases with age and may be more common in older patients. [1]

Lower gastrointestinal bleeding (LGIB) can present as an acute and lifethreatening event or as chronic bleeding, which might manifest as irondeficiency anemia, fecal occult blood or intermittent hematochezia.

AIM AND OBJECTIVE

The aim of the study is to do a prospective non randomized observational descriptive study conducted on patients presenting to Yenepoya Medical College, Mangalore with complaints of lower GI bleed. The patients are evaluated for the same and the histopathological cause is ascertained along with the demographics related to it.

MATERIALS AND METHODS

Patients presenting to Yenepoya Medical College with complaints of lower gastrointestinal bleeding willing to undergo its evaluation and management during the period of May 2017 to October 2018 were observed.

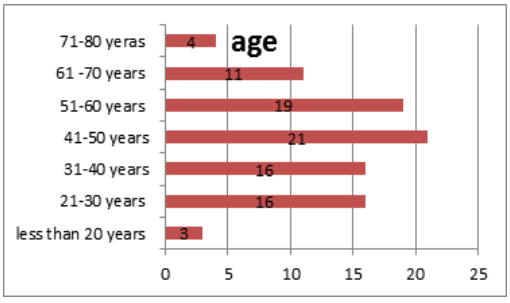
SAMPLING TECHNIQUE

The participants were chosen by the convenient sampling technique. Patients who are not willing/ medically fit for colonoscopy and those with bleeding daithesis are excluded.

RESULTS

The study was a prospective non randomized observational descrprtive study conducted during the study period of May 2017 to October 2018 on patients who attend and patients who were referred from other departments to the Department of General Surgery and the department of gastroenterology of Yenepoya Medical College, Mangalore with complaiints of lower GI bleed who underwent colconoscopy .These were our results.

1 – GRAPH 1 : AGE



MEAN-45.19, STD. DEVIATION

14.935, MINIMUM 18, MAXIMUM 79

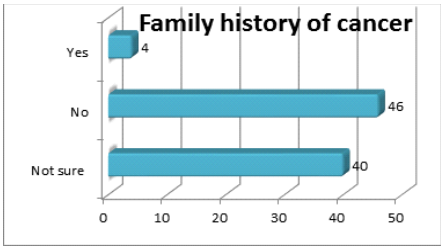
In the present study the mean age was 45.19 years std. deviation 14.935 years. The minimum age was 18 years and the maximum age was 79 years. Most cases were in the age group 41-50 years 21cases (23.33%).

2 – TABLE 1: SEX

SEX	FREQUENCY	%	%	CUMULATIVE PERCENT
FEMALE	31	34.4	34.4	34.4
MALE	59	65.6	65.6	100.0
TOTAL	90	100.0	100.0	

In the present study males predominated the study participants with 59cases (65.6%).

3-GRAPH 2: FAMILY HISTORY OF CANCER



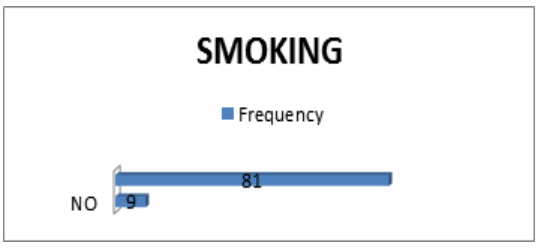
In the present study family history of cancer was seen in 4cases (4.4%)

4 - TABLE 2: DIE

DIET	FREQUENCY	PERCENT
NON VEGETARIAN	81	90.0
VEGETARIAN	4	4.4
EGGEATRIAN	5	5.6
TOTAL	90	100.0

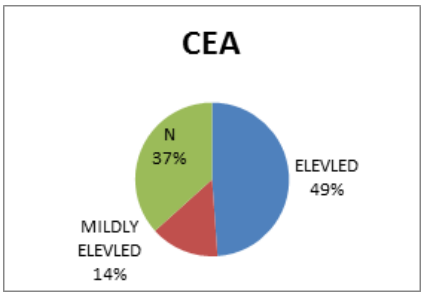
In our study 81 cases with 90% were non vegetarians.

5 - GRAPH 3: SMOKING



In the present study was seen in 81cases (90%).

6 - GRAPH 4: CEA



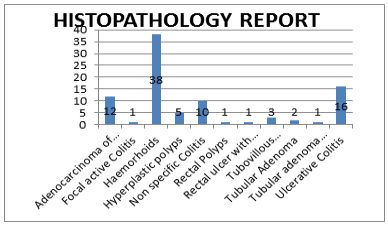
In the present study, CEA was elevated in 58 cases (63.3 %)

7- TABLE 3: COLONOSCOPY FINDINGS

Congested mucosa	Frequency	Percent
Haemorrhoids	38	42.22
Growth	24	26.68
POLPYS	8	8.88
INFLAMMED MUCOSA	11	12.22
Hyperaemic Rectal Rectal mucosa	9	10.0
TOTAL	**90**	**100**

In the present study haemorrhoids, were seen in 38cases (42.22 %), Growth were seen in 24 cases (26.68 %), Polpys were seen in 8 cases (8.88 %), Inflamed mucosa were seen in 11 cases (12.22 %), Hyperaemic rectal mucosa were seen in 9 cases (10.0 %).

9 - GRAPH 5: HISTOPATHOLOGY REPORT



In the present study haemorrhoids were 38 cases 42.2%.

10 - TABLE 4

DIAGNOSIS	FREQUENCY	%
ATYPIA	1	1.1
CARCINOMAS	12	13.3
BENIGN	77	85.6
TOTAL	90	100

In the present study, CARCINOMA was seen in 12 cases (13.3%)

SUMMARY:

The study was a prospective non randomized observational descrprtive study conducted during the study period of May 2016 to December 2018 on patients who attend and patients who were referred from other departments to the Department of General Surgery of Yenepoya Medical College, Mangalore with complaints of lower GI bleed who underwent its evaluation and management.These were our results

- The mean age was 45.19 years std. deviation 14.935 years. The minimum age was 18 years and the maximum age was 79 years. Most cases were in the age group 41-50 years 21cases 23.33%.
- Family history of cancer was seen in 4cases 4.4% and all four cases were less than 50 years
- Males predominated the study participants with 59cases 65.6%.
- 81 cases with 90.0% cases were non vegetarians.
- Haemorrhoids were seen in 38cases 42.22 %, Growth were seen in 24 cases 26.68 %, Polpys were seen in 8 cases 8.88 %, Inflamed mucosa were seen in 11 cases 12.22 %, Hyperaemic rectal mucosa were seen in 9 cases 10.0 %.
- Carcinoma was seen in 12 cases 13.3%.

CONCLUSION:

In our study we had the following conclusions

- In most cases of those who present with gastrointestinal bleed, the diagnosis is usually benign
- Shorter history in those above 35 years, suspicion of malignancy had to be considered
- In those patients who have more than one episode of the symptom, a proper evaluation needs to be done especially if the symptoms last for more than a month.
- ·In those patients who have abdominal distension and altered bowed habits, a diagnosis of colitis needs to be considered.
- In cases of malignancy, patients with a positive family history of colon cancer are significant.

REFERENCES:

1. Sabiston textbook of surgery, 19th EDITION p. no.1173.
2. Davila, r. E. et al. ASGE Guideline: the role of endoscopy in the patient with lower-GI bleeding. Gastrointest. Endosc. 62, 656–660 (2005).
3. Tandon RK, Atmakuri SP, Mehra NK, et al. Is solitary rectal ulcer a
4. Manifestation of a systemic disease?. J Clin Gastroentero l1990; 12:286-90.
5. Barnert, J. & Messmann, H. Nat. Rev. Gastroenterol. Hepatol. 6, 637–646 (2009); doi:10.1038/nrgastro.2009.167
6. Consolo, P. et al. Efficacy, risk factors and complications of endoscopic polypectomy:
7. Ten year experience at a single center. World J. Gastroenterol. 14, 2364–2369 (2008).
8. Prakash, C. & Zuckerman, G. r. Acute small bowel bleeding: a distinct entity with significantly different economic implications compared with GI bleeding from other locations. Gastrointest.
9. Endosc. 58, 330–335 (2003).
10. Hematochezia: The role of urgent colonoscopy after purge. *Gastroenterology* 1988;95:1569-74.
11. Jensen DM, Machicado GA. Colonoscopy for diagnosis and treatment of severe lower gastrointestinal bleeding. Routine outcomes and cost analysis. *Gastrointest Endosc Cl N Amer* 1997;7(3):477-98.
12. Jensen DM. Endoscopic diagnosis and treatment of severe hematochezia. *Tech Gastrointest Endosc* 2001;3(4):178-84.
13. Jensen DM, Machicado DA, Jutabha, Kovacs TOG. Urgent colonoscopy for the diagnosis and treatment of severe diver-ticular hemorrhage. *N Engl J Med* 2000:342:78-82.
14. Jensen DM. Management of patients with severe hematoche-zia – With all current evidence available. *Am J Gastroenterol* 2005; 100:2403-6.
15. Strate LL, Syngal S. Timing of colonoscopy: Impact on length of hospital stay in patients with acute lower intestinal bleeding. *Am J Gastroenterol* 2003;98:317-22.
16. Strate LL, Ayanian JZ, Kotler G, Syngal S. Risk factors for mortality in lower intestinal bleeding. *Clin Gastroenterol Hepa-tol* 2008;6:1004-10.
17. Zuckerman GR, Prakash C. Acute lower intestinal bleeding. Part II: Etiology, therapy, and outcomes. *Gastrointest Endosc* 1999; 49:228-38.
18. Jensen DM. The ins and outs of diverticular bleeding. *Gas-trointest Endosc* 2012;75:388-91.
19. Ishii N, Setoyama T, Deshpande G, et al. Endoscopic band ligation for colonoscopic diverticular hemorrhage. *GastrointestEndosc* 2012;75:382-7.Green BT, Rockey DC, Portwood G, et al. Urgent colonoscopy for evaluation and management of acute lower gastrointestinal hemorrhage: A randomized controlled trial. *Am J Gastroenter-ology* 2005;100:2395-2402.