Lower GI Bleeding

↓ Urea or normal / stable H.

Blood below the lig. of Trietz

↳ fibromuscular band originating from the right Diaphragmatic crus and is fixed on the duodeno-jejunal flexure.

Etiology :- * → common in west.

*① Diverticular (MCC). *② Colitis (Ischemic or IBD) 15-20%. ③ Carcinoma, Polyps 10% 1/3%.

④* Angiodysplasia 10% *⑤ Anorectal 10%. ⑥ UGIB 10-15% ⑦ Unknown 2-8%.

rare causes : Radiation, Meckel's diverticulum, Varices.

* Mid GI Bleeding → from lig. of Trietz to Ileocecal valve

Angiodysplasia (MCC) Ulceration (IBDs, NSAIDs) Neoplasia

Clinical presentation :-

① Freash Blood in Stool (unless hemodynamecly unstable and ↑urea → UGIB).
② Melena if proximal lesion (distal to D-J junction)
③ Hypotensive and Shock without overt evidence of Bleeding → always do a rectal exam.

HX or Diagnosis :-

* HX of hemorrhoids, Radiation (radiation colitis, Telangectasias), IBD, Iatrogenic Cause
Bleeding delayed up to 10 days ← polypectomy. ←

Prior episodes, presence of Liver or Renal Diseases

* Drug HX (NSAIDs, Warfarine, Antiplatlet drugs).
* Mixed Blood with Stool or Separate from Stool.
↳ inflammatory process. ↳ anorectal (Benign).
* change in Bowel Hapits.
* amount of Stool.

Investigations :-

LGIB → Continued → urgent Colonoscopy + EGD.
rescure colonoscopy → without preparation.
↓ stops
↓
elective Colonoscopy
±
EGD

Explaining the Causes :-

1. Diverticulosis Large volume, Brisk, painless

Local trauma to the vasa recti within diverticulae can lead to arterial Bleeding that Spontanesly Stops, and rebleeding is common, commonly from the Rt colon diverticuli (larger diverticuli). even though most diverticuli are left colon based.
It's false Diverticuli (only Mucosa and submucosal → Artery penetrates the Muscularis to reach the submucosa & Mucosa → weak point. Rear of the Artery form one side
→ massive Bleeding that's hard to Stop unless hypotension → Vasoconstriction → Stops.

Ischemic Colitis (Low flow State) OR → Embolization OR thrombosis.
More Common than ↗
Duo to hypotension.

So what cause Hypo?
Burns, Hemorrhgic shock, Dehydration. chronic smokers Cathersclerosis) → Low flow
→ Watershed Area → compromized Area that can't handle ischemia (Blood Supply يجي يروح)

Clinicly :- Sudden cramping pain in Left Lower quadrent with bloody stool with Mild to moderate Abdominal tenderness.

Diagnosis : X-Ray : classical thumbprinting (Submucosal hemorrhage / edema)
contrast CT + carfeul endoscopy
CT angiogram

↑ { Single Stribe Sign (Triple S)
↓
Ulcer on one wall of the colon and normal opposite Mucosa.

Bleeding Colonic polyp : ↑ growth rate that exceeds the blood Supply. Ischemia to the top part → erosions → Bleeding

Post polypectomy

Infectious Colitis : Shegella, Ameba, Enteroinvasive E-Coli, Yersenia Enterocoletica

Colonic Tumor Bleeding

UC flare Bleeding

Radiation Colitis

Meckel's Diverticulum
↳ vitelline Duct is NOT absorbed in 7th week
Both Stomach and pancreatic.
DX: Meckel's Scan (IV Technetium) 99m.
acid secreting cells uptake the Technetium 99m
So Stomach + Meckel's will light up.
on the Scan. Small Bowel

Treatment of LGIB:
① Endoscopic [(Adrelarin, Clip, polypectomy (endoloop)] → Arterial Lesion.
[Argon plasma coagulation] ⟶ Angiodysplasia.
② Interventional Radiology : Agiography with Selectin Embolization.
③ Surgery (Must accurtly localize the bleeding source.

Diverticular Bleeding : resuscitation → diagnose + Localize the source of Bleeding → treat the cause
colonoscopy
↓ if unsuccessful + Bleeding is massive.
Hemodynamically Stable → Angiography.
Unstable → Surgery

Radiation Colitis Tx: (Argon plasma coagulation) Telangectasia.

Medical: IBS flare
↳ IV hydration + Steroids + IV Antibiotics.
Infectious Colitis: IV Hydration + Antibiotics.
Ischemic Colitis : ① if there's signs of perforation or infection + increasing tenderness, fever and Dias ⟶ Surgery.
② No signs of perforation or infection → Bowel rest, IV hydration + antibiotics + correction of underlaying condition
more than 50% resolve on conservative management.