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A Year of Gastrointestinal Bleeding: An Epidemiologic Study

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Presenter Information

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Comments

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Title: A year of gastrointestinal bleeding : an epidemiologic study

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Background: For decades the diagnosis and management of gastrointestinal bleeding (GIB) has been based largely on endoscopy. Studying a large cohort of patients presenting to the ED we may find cost-effective alternatives in the management of GIB. We analyzed the epidemiology and initial disposition of all patients who presented to our ED from the perspective of hematemesis versus non-hematemesis, to identify patterns among each cohort's presentations to aid in this.

Methods: Retrospective analysis of medical records for 338 patients presenting to the UMass ED. Two cohorts were identified: those with hematemesis (G1) or non-hematemesis (G2).

Results: 105 patients presented to the ED with hematemesis (G1), 233 patients presented with non-hematemesis GIB (G2). G1 was younger than G2 (54.4 years vs. 65.6 years, $p < 0.001$). There were more males in G1 vs. G2 (61% vs. 53%, $p = 0.154$). Comorbidities in G1 were liver disease (21%), alcohol abuse (20%), and diabetes (11%). Comorbidities in G2 were coronary artery disease (22%), atrial fibrillation (13.7%), and diverticulosis (8%). More patients in G2 than G1 used Coumadin (23% vs. 7%, $p < 0.001$), anti-platelet agents (12% and 3%, $p < 0.004$), and NSAIDs (40% and 32%, $p = 0.203$). Admission hematocrit was greater in G1 compared to G2 (34.1 vs. 30.0, $p < 0.001$). INR was greater in G2 compared to G1 (1.7 vs. 1.3, $p = 0.03$). BUN was greater in G2 compared to G1 (30.2 vs. 23.6, $p = 0.021$). More patients in G2 were admitted compared to G1 (89.6% vs. 78.1%, $p = 0.019$). More were admitted to the ICU in G1 compared to G2 (46% vs. 38%, $p = 0.237$).

Discussion: This study uses a novel approach that elicits different patterns than the traditional delineation of upper versus lower GIB. These results may lead to new decision-making in patients presenting with GIB, allowing for new diagnostic and management paradigms, resulting in cost-effective care.