Case 1

68 yo AAM is admitted to the hospital with chief complaint (CC): emesis of bright red blood. Patient reports that he was shopping when he began throwing up blood at the store. He denies any associated pain, melena, hematochezia, liver disease, or prior episodes. Patient reports some lightheadedness with standing, denies CP, SOB, visual disturbances.

He is taking indomethicin for gout and reports a recent admission 3 months ago for evaluation of occult bleed with colonoscopy and endoscopy which did not show ulcers or active bleeding. Patient denies abdominal pain, chest pain, cough and diarrhea.

PMH:
Gout, HTN, anemia

Review of medical records show that he had a gout flare up while in the hospital 3 months ago and was discharged home with a steroid taper. He was prescribed Indomethacin 50 mg po q 8 hr prn pain but he was taking it daily for the last month.

Stomach biopsy done during the EGD 3 months ago showed acute and chronic inflammation, and a Giemsa stain showed occasional bacteria consistent with Helicobacter. A PAS/Alcian blue stain showed no evidence of intestinal metaplasia. No neoplasm was identified.

Patient missed his follow up appointment and was never treated with antibiotics for Helicobacter pylori.

Medications:
Prevacid, indomethicin

FMH:
Brother died from GI bleed last year

Physical examination:
VS with orthostatic changes
Eyes: conjunctiva pale, no icterus
Chest: CTA (B)

CVS: Clear S1S2
Abdomen: Soft, NT, ND, +BS
Rectal: no stool

What do you think is going on?

Upper GI bleed due to:
- PUD
- NSAIDs-induced gastropathy

What would you do next?

Get IV access
Give IVF - NS bolys and then 250 cc/hr, monitor VS
CBC, CMP, INR/PTT stat

Type and screen 4U PRBC, transfuse if Hgb < 8.

Call GI consult for emergency EGD.

Admit to ICU

What happened?

CBC showed acute anemia with Hgb of 6 (Hgb was 10.9 three months ago).

Intravenous fluids were given, he was placed on oxygen and monitor.
ECG was interpreted as sinus tachycardia.

Risks, benefits and alternatives (RBA) of blood transfusion were explained to the patient and he agreed to transfusion.

Hgb drop in upper GI bleed

BUN increase in upper GI bleed

What happened next?

Patient was admitted to MICU.

EGD showed a bleeding gastric ulcer which was cauterized and bleeding stopped.

Patient required 2 more units of RBC and Hgb increased to 9.0.

Prevacid 60 mg bolus was given and he was placed on Prevacid IV drip at 6 mg/hr for 72 hours. He was transferred to RMF and clear liquids diet was started.

Antibiotic treatment for Helicobacter pylori was started before discharge. $FeSO_4$, vit. C and MVT were also added.

Final diagnosis:

Upper GI bleeding due to gastric ulcer.

Gastric ulcer is secondary to:

- Helicobacter pylori infection
- Indomethacin
- Steroids

What did we learn from this case?

Helicobacter pylori infection needs to be treated aggressively especially in patients with other risk factors for PUD like NSAIDs use.

Three regimens consistently eradicate Helicobacter (90 percent) when treatment duration is 10 to 14 days. The treatment of choice is triple therapy with a proton pump inhibitor, amoxicillin and clarithromycin for two weeks. One example is OAC = Omeprazole, Amoxicillin, Clarithromycin. The first attempt to eradicate H. pylori fails in 5 to 12 percent of patients.