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Preface – Gastrointestinal bleeding

Acute gastrointestinal (GI) bleeding, whether arising from the upper or lower GI tract, is a medical emergency and a common cause of hospitalization in high, medical and low-income countries. Innovations in pharmacological, endoscopic and radiological care have resulted in reductions in mortality rates. It is rare that patients die from uncontrolled bleeding, but rather from associated co-morbidity, given GI bleeding most commonly affects older patients. Nonetheless, GI bleeding represents a spectrum of severity from trivial, self-limited bleeding to more extreme cases requiring massive transfusion. The ability to accurately risk stratify patients upon first presentation is important so that patients at high risk of adverse outcome receive prompt intervention and monitoring in appropriate clinical areas, whereas those at lower risk of adverse outcome may even be discharged without admission for subsequent outpatient investigation.

Over 30% of presentations with GI bleeding require red blood cell (RBC) transfusion as part of their initial resuscitation. A major paradigm shift has occurred in the use of RBCs after initial presentation with GI bleeding, such that a more restrictive approach has been found to be associated with better clinical outcomes than a more liberal approach to transfusion, akin to findings in other critically unwell populations in medicine and surgery. Acid suppression through use of proton pump inhibition has become a standard prior to performance of endoscopy, since lowering gastric pH is considered to stabilize clots and may reduce the need for endoscopic therapy. After adequate resuscitation, performance and timing of endoscopy becomes critical, although these should not supersede inadequate attempts at resuscitation. Over 97% of cases of GI bleeding can be managed through endotherapy. However in rare cases bleeding cannot be controlled and radiological and/or surgical intervention is needed.

In this issue of Best Practice and Research: Clinical Gastroenterology, up to date reviews are provided on the changing epidemiology of upper and lower GI bleeding, as well as state of the art risk stratification scores. This is then followed by a review summarizing the role of blood transfusion and associated thresholds, acid suppression strategies and then approaches to endoscopic therapy both in the upper and lower GI tracts. Following this, authoritative reviews are provided on the role of radiological and surgical intervention for refractory bleeding. I would like to take this opportunity to thank all of the authors for taking time out of their busy schedules to contribute to these chapters. We have assembled outstanding authors all recognized as leaders in this field, resulting in a state-of-the-art series which I trust will be highly practical and informative to our readers.

Vipul Jairath
Departments of Medicine, Epidemiology and Biostatistics, Division of Gastroenterology, Western University, London, Ontario, Canada
E-mail address: vjairath@uwo.ca.

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