

A 56-year-old man is brought to the emergency department by a friend after vomiting bright red blood several times during the past 2 hours. The patient has no abdominal pain or diarrhea. He has a history of peptic ulcer disease and alcoholic cirrhosis. His friend says that the patient continues to drink alcohol and is not sure whether he is taking his medications regularly. Temperature is 37.6 C (99.7 F), blood pressure is 96/62 mm Hg, and pulse is 112/min. The patient has muscle wasting and scleral icterus. The abdomen is nontender and distended with bulging flanks. Rectal examination shows internal hemorrhoids and maroon stool that is positive for occult blood. He is receiving a normal saline infusion through a peripheral intravenous catheter. Which of the following is the best next step in management of this patient?

- ☐ A. Administer octreotide infusion
- ☐ B. Obtain second intravenous access
- ☐ C. Perform esophagogastroduodenoscopy
- ☐ D. Perform mesenteric arteriography
- ☐ E. Place Sengstaken-Blakemore tube

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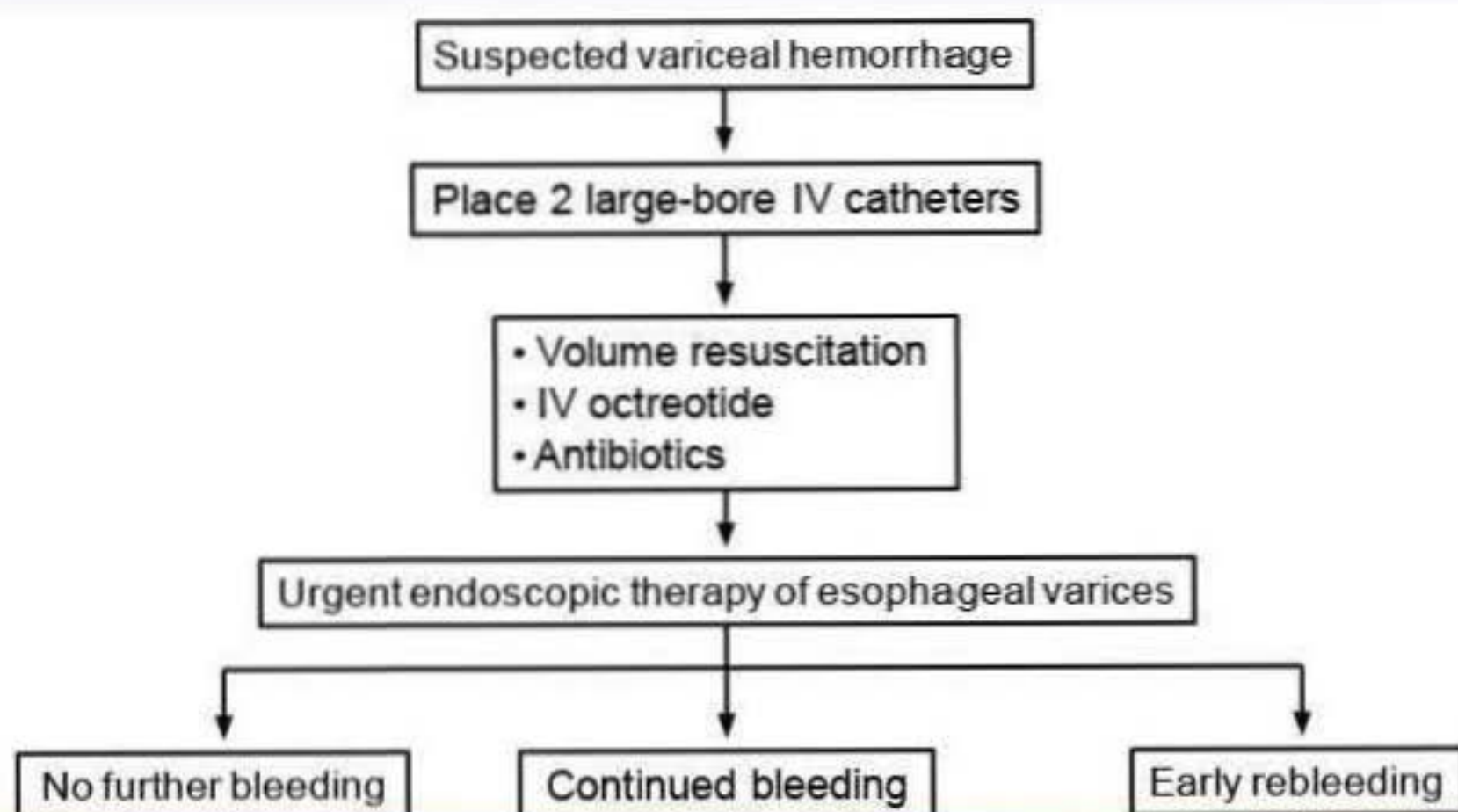
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- ☐ A. Administer octreotide infusion [27%]
- ☒ B. Obtain second intravenous access [44%]
- ☐ C. Perform esophagogastroduodenoscopy [25%]
- ☐ D. Perform mesenteric arteriography [1%]
- ☐ E. Place Sengstaken-Blakemore tube [3%]

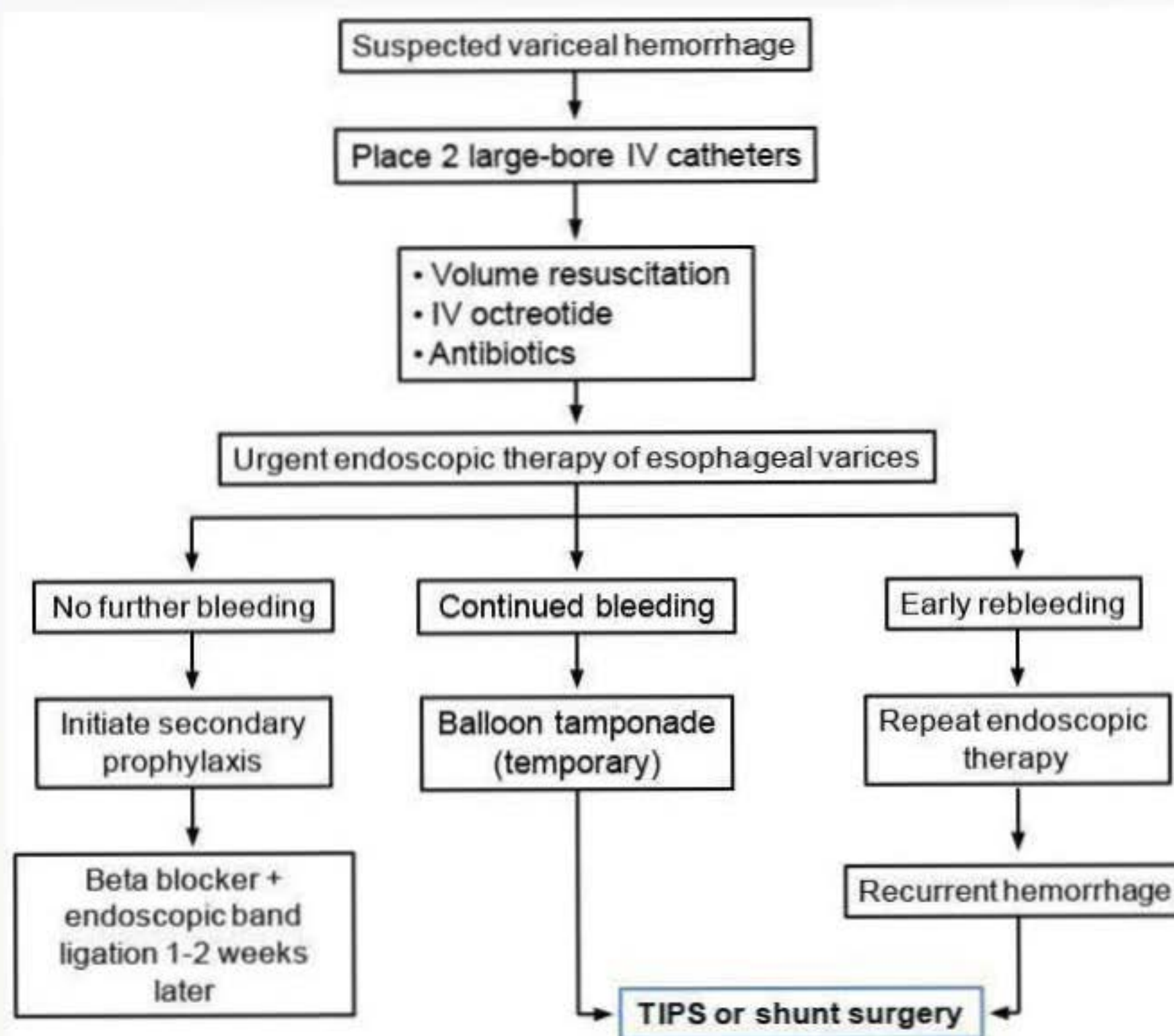
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Explanation:

User Id:



Explanation:

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IV = intravenous; TIPS = transjugular intrahepatic portosystemic shunt.

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This patient has hematemesis in the setting of a history of peptic ulcer disease and alcoholic cirrhosis, which places him at risk for rapid, life-threatening **upper gastrointestinal bleeding (UGIB)**. Therefore, prompt and aggressive fluid resuscitation should be the first step in management. All patients with acute hemorrhage should have vascular access established **immediately** with at least **2 large-bore intravenous lines**.

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Once appropriate vascular access has been established, fluid **resuscitation** with crystalloid should be undertaken while any necessary blood products are prepared for transfusion (eg, packed red blood cell transfusion to maintain hemoglobin at least ≥ 7 g/dL). In addition, patients' airway, vital signs, cardiac rhythm, and urine output should be closely monitored. Patients with UGIB should also receive acid suppression with intravenous proton pump inhibitors and have all oral intake restricted. If variceal bleeding is suspected, as in this case, an octreotide infusion should be considered (**Choice A**). Patients with cirrhosis should also receive prophylactic antibiotics.

Once patients are stabilized, upper endoscopy should be performed to identify and control the source of hemorrhage and to prevent recurrent episodes (**Choice C**). In approximately 50% of cases of variceal bleeding, the hemorrhage ceases on its own without further intervention; this rate is significantly lower than that seen in UGIB due to other causes, which approaches 90%.

(**Choice D**) Contrast angiography should be considered in the small number of patients with UGIB who are not able to be stabilized sufficiently to undergo upper endoscopy or in whom upper endoscopy is unsuccessful in controlling hemorrhage.

(**Choice E**) Balloon tamponade with the Sengstaken-Blakemore, Minnesota, or Linton-Nachlas tubes can be used for the temporary control of bleeding when early endoscopy is unavailable or other modalities are unavailable and medical management is unsuccessful. This method is most often used to control hemorrhage until the patient can be transferred to a tertiary care hospital; it is not considered first-line treatment.

Educational objective:

The first step in the treatment of acute upper gastrointestinal bleeding is to establish vascular access with 2 large-bore intravenous catheters to initiate resuscitation with intravenous fluids.

References:

1. [Management of variceal and nonvariceal upper gastrointestinal bleeding in patients with cirrhosis.](#)
2. [Diagnosis and management of upper gastrointestinal bleeding.](#)

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