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ABOUT DIAGNOSTICS AND TREATMENT OF GASTRO-DUODENAL HEMORRHAGE

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In our days the active waiting tactic of gastroduodenal hemorrhage presents combination of argumented concepts to the owners of conservative and radical treatment. These strategy shows effectiveness in the great part of patients because of hemostatic effects of conservative treatment and because by 7-8 times lower mortality rates after delayed procedures than the emergency ones. After prolonged conservative treatment not rare immunological disorders occur. Lower defence possibility and negative influence over post operative outcomes, by higher coagulability and the aggregation of blood cells and worse rheological parameters.

Through the period ranging 1986-1991 in the Department of Surgery, Dobrich, are urgently accepted 254 patients with bleeding, 64 of them women.Over 2/3 of patients are more than 45 years of age. In 146 of them emergency FGS is performed at 12 hour in the Department of Internal Medicine. The following operative technics were used: T.V., ulcer suturing, pyloroplasty, Billroth I, Billroth II and antrumectomy. After FGS investigation the discovered sources of bleeding are as follows: duodenal ulcer - 100; gastric erosions - 19, stomach cancer - 11, stomach ulcer - 9, and hiatal hernia - 7 patients. Urgently performed endoscopy have got findings divided in three groups: I - with active bleeding (29), II - with stoppage bleeding /thrombi and rests of blood (50), and III - without signs of bleeding. For all 254 patients accepted with a data of bleeding to GIT, conservative hemostatic treatment began but FGS study is done only in 146 of them, and in the other ones x-ray examinations. After immediate custume conservative treatment and stabilized hemodynamic parameters most of patients are discharged with improvement and maintaining therapy with H_2 blockers, antiacids and diet. For 17 patients emergency surgical procedures were performed because of repeated bleeding. The operations emergency done are as follows: suturing and pyloroplasty 3; T.V. with suturing and pyloroplasty 10, Billroth I 4. Under regular conditions still in the end of first stay in the Clinic 34 of them are operated. The kind of operations is: PSV 14, T.V. with pyloroplasty 9, Billroth I 5, Billroth II 1, pyloroplasty 4, Billroth II with antrectomy 1. Emergency identifying of

bleeding sources was helpful for radical decision mainly for duodenal bleeding ulcers. From 100 patients with duodenal ulcers 2 died, one of the pick of the bleeding, no mean immediately performed operation and the second, who was conservatively treated in heavy hemorrhagic shock.

The indications of emergency operative treatment include: hemorrhagic shock induced by bleeding ulcer, continuous bleeding and early recidive bleeding. Performed vagotomy diminished acidity and duodenogastric reflux. Though PSV and TV after 5 years follow-up shows recidive to 15,5% these data are explained without full vagotomy. The regular operations got the possibility of smaller risk and in these groups there are not fatal outcomes. Only one as we noted died after emergency surgery on the top of the bleeding (5,8% mortality). The performed emergency operations: suturing, T.V. and drainage procedure are done in severely ill patients with high operative risk. Emergency FGS got the possibility of correct decision about next therapeutic action. After emergency FGS got the possibility of assessment about rate of bleeding but not inforced it and that made the method convenient in severe status patients. The diagnostic endoscopy would become therapeutic one if vasoconstrictors are injected. Only in 5 patients adrenaline was used with good effect.

Emergency FGS on the pick of the bleeding is a method of choice for exact localization and diagnosis of the bleeding in upper GIT. The most common reasons are ulcer disease, followed by stomach erosions and stomach cancer. The tactic of expectation with the complex of conservative methods is justified at bleeding of ulcer origin and is influenced by the age, coexistent diseases, localization of the sources of bleeding and the rate of hemorrhage in patients. For high risk patients TV and drainage procedure are prefered like short technic.