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HEMORRAGIES DIGESTIVES HAUTES DANS LE SERVICE DE GASTRO-ENTEROLOGIE ET MEDECINE INTERNE DU CHU DE BRAZZAVILLE

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ABSTRACT

INTRODUCTION: Upper gastrointestinal bleeding (HDH) is the most common emergency in the hepatogastroenterologist. The objective was to study the epidemiological, clinical, endoscopic, etiological, therapeutic and evolutionary profile of upper gastrointestinal haemorrhages in the gastroenterology department of CHUB Brazzaville. PATIENTS AND METHODS: This was a descriptive retrospective study from January 2014 to December 2016, a 2-year period, carried out in the Gastroenterology and Internal Medicine department of the CHUB Brazzaville. The inclusion criteria were patients of 16 and over, admitted for haematemesis and / or melena-type digestive hemorrhage, clinically objectified and / or by acute anemia related to a lesion of the digestive tract. high and having benefited from oeso-gastroduodenal fibroscopy. RESULTS: 84 patients were included either a frequency of 3.59%. Fifty-two were men representing 61.9% of patients. The average age was 37.22 ± 12.96. Non-steroidal anti-inflammatory drugs were found in 57.14%. Esophageal-duodenal fibroscopy (FOGD) was performed beyond the 48th hour in 65.47% of cases. In 50% of cases indication hematemesis. The most common etiologies were peptic ulcer followed in 39.28% followed by rupture of oesophageal varices (OV) in 20.23%. In 90.09% of cases, hemorrhagic ulcers were treated with proton pump inhibitor. No endoscopic or surgical haemostasis was performed. Mortality and haemorrhagic recurrence were noted in respectively 14.28% and 8.33%. Conclusion: upper gastrointestinal bleeding occurs in young patients with male predominance and half of these are hematemesis-positive. Their etiologies are dominated by gastroduodenal ulcers and portal hypertension. The lack of endoscopic plateau makes it difficult to take upper gastrointestinal bleeding in our context.

Keywords : Upper gastrointestinal bleeding • Epidemiology • Aetiologies • Mortality • gastroenterology and internal medicine department University Hospital of Brazzaville

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INTRODUCTION

Upper gastrointestinal bleeding (HDH) is the most common emergency in hepatogastroenterology

and remains an important cause of morbidity and mortality. The mortality rate has remained stable around 3-14% during the last two decades, despite the improvement of resuscitation measures and the advent of new pharmacological and endoscopic therapeutic measures [1,2]. This is mainly due to a change in the epidemiological profile of older and older patients with more comorbidities. In the Congo, epidemiological studies on this subject are rare. J-R Ibara et al reported in 2005 a prevalence of 4.6% of upper gastrointestinal hemorrhages [3]. Our objective was to study the epidemiological, clinical, endoscopic, etiological, therapeutic and evolutionary profile of upper gastrointestinal haemorrhages in the gastroenterology and internal medicine department of the CHUB Brazzaville.

MATERIAL AND METHODS

This was a retrospective descriptive study from January 2014 to December 2016, a 2-year period, performed in the gastroenterology and internal medicine hepatogento-gastroenterology department of the CHUB Brazzaville. Epidemiological, clinical diagnostic and therapeutic data were collected from medical records. Inclusion criteria were patients ≥16, admitted for gastrointestinal hemorrhage with typed hematemesis and / or clinically objectified melena and / or acute facility anemia related to upper gastrointestinal tract injury. having undergone oeso-gastroduodenal fibroscopy (FOGD).

The cause of HDH has been attributed to a given lesion in the presence of active hemorrhage, recent bleeding stigma, or other causes of bleeding (Forrest classification). If there is more than one bleeding lesion, both have been considered etiologic. The endoscopy completion time reflected the time elapsed between the admission date and the completion of the FOGD. Early haemorrhagic recurrence was defined either by a recurrence occurring within 5 days following the completion of the endoscopy, which could be either a haemodynamic instability, a recurrence of haematemesis, an appearance of rectorragies, persistence of melena after three days or appearance of new melena after normal stool staining or a hemoglobin drop of more than 2g / dl within 24 hours.

RESULT AND DISCUSSION

In our study, 84 patients were included in 2338 hospitalized patients, a frequency of 3.59%, among them 32 women (38.09%) and 52 men (61.9%). The average age was 37.22 ± 12.96 years with extremes of 16 to 78 years. Nonsteroidal anti-inflammatory drugs were found in 57.14% (n = 48), a history of digestive haemorrhage was found in 29.76% of cases (n = 25), cirrhotic disease was found in 8.33% of cases (n = 7), 9.24% of cases (n = 11) had no particular history.

All patients had gastrointestinal endoscopy. The indication of FOGD was: hematemesis in 50% of cases (n = 42), haematemesis associated with melena in 25% of cases (n = 21), haematemesis associated with rectorrhagia in 14.2% (n = 12) and rectorrhagia in 10.8% of cases (n = 9). Anemia was found in 77.38% of cases (n = 65) with an average hemoglobin level of 6.17 ± 1.80 g / dl.

FOGD was performed within 24 hours in 13.09% of cases (n = 11), within 36 hours, 20.23% of cases (n = 17), within 48 hours in 1.19% of cases (n = 11). = 1) and beyond the 48th hour in 65.47% of cases (n = 55).

The cause of bleeding was a rupture of oesophageal varices (oV) in 20.23% (n = 25), a bleeding ulcer in 39.28% patients (n = 33). The seat of the ulcer was bulbar in 82% of cases (n = 27) and gastric in 18% of cases (n = 6). The ulcer was classified: Forrest Ia in 6% of cases (n = 2), Forrest IIb in 9% of cases (n = 3), Forrest III in 85% (n = 28). The other lesions found were: gastric cancer in 14.28% of cases (n = 12), caustic oesophagitis in 10.71% of cases (n = 9).

Of the 65 patients with anemia, 64.61% had received a blood transfusion.

The pharmacological treatment of hemorrhagic ulcers was based on proton pump inhibitor (PPI) in 90.09% of cases. No endoscopic or surgical haemostasis was performed. Among patients with haemorrhage related to oesophageal varices rupture, 24% of cases (n = 6) had oesophageal variceal ligation (OLS). No patient had received treatment with a vasoactive substance. The evolution was favorable in 77.38% of the cases (n = 65) with spontaneous cessation of the haemorrhage or after endoscopic treatment. Hemorrhagic recurrence was noted in 8.33% of cases (n = 7). Twelve patients (14.28%) died in relation to cirrhotic pathology.

In our study, 84 patients were included, among them 32 women (38.09%) and 52 men (61.9%). The average age was 37.22 ± 12.96 years with extremes ranging from 16 to 78 years. The clear predominance of men, found in our work, confirms the high incidence of HDH in men compared to women described in the African literature [4]. The average age in our study is younger than that reported in the western environment [5]. In our study, upper gastrointestinal bleeding occurred in young subjects, with male predominance. These could be explained by the high frequency not only of gastrointestinal disorders related to gastrointestinal haemorrhage in men, but also by the high frequency of self-medication of gastrotoxic products (NSAIDs) because in our country the free sale of gastrotoxic products is widespread.

Upper gastrointestinal endoscopy is recommended within 24 hours of the bleeding episode [6,7]. In our series, only 13.09% of patients had performed upper gastrointestinal endoscopy within the recommended time frame. This finding has been described in several African series [8]. This could be explained not only to the delay in consultation for the most part due to lack of financial means and reluctance to perform the endoscopy, but especially by the lack of endoscopic plateau in our department.

Hemorrhages of ulcerative origin were predominant followed by rupture of oesophageal varices. Our results are contrary to those of Diarra et al who reported the rupture of varicose veins as the first cause of HDH [4]. This difference could be explained by the high frequency of NSAID consumption, which is the leading cause of peptic ulcers in Congo, described by Ibara J-R [3]. But because of the increase in viral hepatopathies B and C, there is a rivalry between haemorrhages of ulcerative and varicose origin [9].

All patients with ulcerative gastrointestinal bleeding had been treated with proton pump inhibitors regardless of the Forrest stage, and no endoscopic intervention was performed. In contrast, only six patients had variceal ligation. Our results do not corroborate with Western and Maghreb series [8,10]. This difference is explained by the absence of endoscopy tray in our service.

In our study, the evolution was favorable in 77.38% of the cases (n = 65) with spontaneous cessation of the haemorrhage or after endoscopic treatment. Mortality and recurrence were high in our study and were related to the underlying pathology dominated by cirrhosis. Our results are similar to those of Diarra et al, who found a 22.4% mortality rate due to varicose rupture in cirrhotic patients [4]. On the other hand, Theocharis et al in 2008 reported a low mortality rate related to the early endoscopic management of upper digestive haemorrhages according to the lesion [11].

CONCLUSION

The upper gastrointestinal bleeding occurs in young patients, with predominantly male and are revealed in half of cases by hematemesis. Their etiologies are dominated by gastroduodenal ulcers and portal hypertension; taking gastrointestinal drugs is common. The lack of endoscopic plateau makes it difficult to take upper gastrointestinal bleeding in our context.

Conflict of interest: the authors declare that they have no conflict of interest.

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