Case Report on Upper Gastrointestinal Bleeding with Esophagitis, hiatus hernia and severe Anemia

Nandini Raju Lipate[1], Deepali Ghungrud[2], Aniket Pathade[3], Swapna Morey[4]
1] GNM 3rd yr, Florence Nightingale Training College of Nursing, DattaMeghe Institute of Medical Sciences (DU), Wardha, lipatenandini2002@gmail.com, 7218130496
2] Nursing Tutor, Florence Nightingale Training College of Nursing, Datta Meghe Institute of Medical Sciences (DU), Wardha
3] Research Consultant, Department of Research and Development, Jawaharlal Nehru Medical College, Datta Meghe Institute of Medical Sciences, Wardha, aniketpathade@gmail.com
4] Department of Medical-Surgical Nursing, Smt. RadhikabaiMeghe Memorial College of Nursing, Datta Meghe Institute of Medical Sciences, Sawangi, Wardha, Maharashtra.

ABSTRACT:-
Introduction: Hiatal hernia develops when the belly protrudes past the esophageal gap into the thoracic cavity. In this cases upper gastrointestinal endoscopy's prevalence rate is observed to be 0.8–5.2 percent.
Case presentation: A 65-year-old- male admitted in Tertiary care hospital Wardha,at medicine HDU after RAT negative test.With the complaints of breathlessness, which was sudden in onset and present on excretion since 4 days, complaints of malena which was sudden in onset and since 4 days. No history of hematemesis, abdominal pain, nausea, vomiting. No history of cold, cough, fever, syncope, loss of consciousness. No history of trauma. Previous treatment, no prior hospitalization. There was no associated illness were present like Diabetes mellitus, tuberculosis, and thyroid disorder. No any significant past history. Physical examination and systemic examination was done. In respiratory system: bilateral clear, cardiovascular: heart sound was normal, central nervous system: conscious and oriented, abdominal examination: soft and nontender. No any abnormality detected in musculoskeletal system.
Conservative management: All the routine investigation done. Hemoglobin 5.5gm% was on lower side.ECG and X-ray was done which was normal. Patient was transfused with 2 units of packed red cells (PRC) in view of low HB. Patient was started on PAN infusion and other supportive medications. Ultrasonography was done at bedside which was suggestive of bilateral cortical echotexture of kidney with grade I prostatomegaly. Gastroenterologist opinion was taken and patient was advice for endoscopy. Which was suggestive of large hiatus hernia-hill's grade IV. Patient was advised for repeat CBC, if in lower side then repeat endoscopy, and surgery opinion was taken SOS in emergency (Strangulation, bleeding, obstruction and volvulus).
Surgery opinion was taken and patient was advised for conservative management.
Conclusion: due to conservative management and quality nursing care patient condition was stable and had no active complaints at present hence patient is being discharged.

Keywords: -Upper GI bleed, Esophagitis, a hiatus hernia, and Severe Anemia**.**

INTRODUCTION:

Hiatal hernias can shows clinical manifestations in a variety of ways, both common and unusual. The type and size of the hernia depends on the symptoms. The most common signs are those involving the gastrointestinal tract[1].
Hiatal hernia is a common disease in which abdominal contents protrude over the diaphragm's hiatus and into the mediastinum. In this condition usually involves the gastro esophageal junction, but may include any abdominal organ. The extent of gastric and gastro esophageal junction involvement, as well as herniation of digestive system organs through the hiatus[1].
Hiatal hernia is commonly observed asymptomatically during an upper gastrointestinal endoscopy. The gastro esophageal reflux disease and the Cameron ulcer are the most common causes of this hernia. Cameron ulcer was initially identified in 1986 by Cameron and Higgins[2].
Cameron lesions are linear ulcers or erosions on the gastric mucosal folds at the level of the diaphragm that results from mechanical trauma caused by diaphragmatic contraction caused by respiratory excursions combined with acid injury. Prolonged gastrointestinal bleeding and indigestion are the main causes of iron deficiency anaemia. Mucosal prolapse, imprisonment, volvulus, and esophageal shortening are some of the other problems[2,3].

DOI: 10.9756/INTJECSE/V14I4.303

Cameron erosion and ulcers are two main forms of the same illness spectrum which are minor and serious, respectively. It's impossible to say how common erosions and ulcers are. In all patients undergoing upper gastrointestinal endoscopy, the incidence of hiatal hernia ranges from 0.8 to 5.2 %. There have been no cases of Cameron lesions reported in the African continent[4].

Some research studies are revealed that, the presence of the esophagogastric junction in a retroflexed posture, as well as the assessment of hiatal integrity and axial displacement during an endoscopic examination, can assist diagnose a sliding hiatal hernia. However, author mentioned, did not use retroflexed imaging in this case, and the stomach's position was not altered by the sliding hiatal hernia[5].

Anemia related to iron deficiency with no significant bleeding signs is a common symptom, especially among the elderly. Two possible causes include iron absorption or asymptomatic chronic iron failure due to undetected nutritional deficits or bleeding. Chronic blood loss is the most common cause of iron deficiency in the aging[6].

Case History

A medical case was taken by Tertiary Care Hospital Wardha, Maharashtra, India. This complicated case was taken care of nicely by the hospital because of expert medical team management and excellent nursing care.

Patient information: We report a 65-year-old- male admitted in Tertiary care Hospital Wardha at Medicine HDU after RAT (Rapid antigen test) negative testing with the complaints of breathlessness, which was sudden in onset and present on excretion since 4 days, complaints of malena which was sudden in onset and since 4 days. No history of hematemesis, abdominal pain, nausea, vomiting. No history of cold, cough, fever, syncope, loss of consciousness. No history of trauma. Previous treatment, no prior hospitalization. There was no associated illness were present like Diabetes mellitus, tuberculosis, and thyroid disorder. No any significant past history. Physical examination and systemic examination was done. In respiratory system: bilateral clear, cardiovascular: heart sound was normal, central nervous system: conscious and oriented, abdominal examination: soft and nontender. No any abnormality detected in musculoskeletal system.

Physical examination was done: Pulse: 80 beats per min, Blood pressure: 120/80 mm of Hg, temperature afebrile, general examination was normal.

Medical, family, and Psycho-social history: -There were no history of comorbidities in patient's family. Patient belongs to middle class family. He is living with his wife and 2 son. Patient maintain good interpersonal relation with family members, relatives and neighbours. Patient do not have bad habit like smoking, tobacco chewing and alcoholism.

Relevant past intervention with outcomes: -For above mentioned complaints patient was admitted in private hospital. He was get relief from that hospital. That's why patient referred to tertiary care hospital Wardha.

Diagnostic Assessment: All the routine investigations were done:Hemoglobin: 5.5gm % was on lower side. Red blood cells: 2.74, White blood cells: 8700, MCHC: 31.4, MCV: 64.4, MCH: 20.2, Total platelet count: 3.43, HCT: 17.6. Coagulation profile done-APTT- control-29.5, APTT patient -30.4, Prothombin Time-control l1.9. Prothombin Time-Patient: 13.0, INR: 1.09.Stool for occult blood was negative.TIBC**:** Total iron binding capacity blood test was: 397, Ferritin iron level were: 119. Iron level was: 20. Kidney function and liver function test were done. ECG and X-ray was done which was normal.

Conservative Management:

Patient was transfused with 2 units of packed red cells (PRC) in view of low Hemoglobin. Patient was started on PAN infusion and other supportive medications. Ultrasonography was done at bedside which was suggestive of bilateral cortical echotexture of kidney with grade I prostatomegaly. Gastroenterologist opinion was taken and patient was advice for endoscopy. Which was suggestive of large hiatus hernia-hill's grade IV. Patient was advised for repeat CBC, if in lower side then repeat endoscopy, and surgery opinion was taken SOS in emergency (Strangulation, bleeding, obstruction and volvulus). Surgery opinion was taken and patient was advised for conservative management.

Treatment on admission: Inj. Ceftriaxone 1gm IV BD X 5Days, Inj. Optineuron 1amp in 100 ml NS OD. Inj. Mucomix 600 MG IV TDS,

Treatment on Discharge: Tab. Zifi CV 200mg BDX3days. Tab.Zebineuron ODX 15 Days.

Cap Autrin ODX15 days. Tab Clinidipine 20 mg ODX to continue. Syrup macralfate –O 2TSF 2 hours after lunch and dinner X7 days. Patient was stable and had no active complaints at present. Hence patient is being discharged.

Prognosis: - was good

Follow-up and outcome

DOI: 10.9756/INTJECSE/V14I4.303

Outcomes clinical and patient-reported: Despite the most significant efforts of the Patient, their vibrant health will improve, and her health status will improve even more.Follow-up in case of following signs and symptoms patient are requested to attend the emergency department. Diagnostic and other test findings are critical.

Discussion:

A 65-year-old- male patient came in tertiary care hospital, Wardha with the complaints of breathlessness, which was sudden in onset and present on excretion since 4 days, complaints of malena which was sudden in onset and since 4 days. No history of hematemesis, abdominal pain, nausea, vomiting. No history of cold, cough, fever, syncope, loss of consciousness. No history of trauma. Previous treatment, no prior hospitalization. There was no associated illness were present like Diabetes mellitus, tuberculosis, and thyroid disorder. No any significant past history.

It was manage by the general examination and some routine investigations. Patient was transfused with 2 units of packed red cell in view of lower Hemoglobin. Ultrasonography was done at bedside which was suggestive of bilateral cortical echotexture of kidney with grade I prostatomegaly. Gastroenterologist opinion was taken. Which was suggestive of large hiatus Hernia-Hill's Grade IV. But no surgical management was done. Patient was manage with conservative treatment.

In this case report author mentioned that, patient had anemic clinical manifestations since 1 year while taking an acceptable quantity of therapeutic iron. Patient received three whole blood transfusions for severe anemia caused by congestive heart failure. Patient was also having abdominal pain and blacking of the faeces. By using a chest x-ray (which revealed the hernia), a positive occult blood test, and a barium meal study, the author was able to diagnose a massive hiatal hernia with Cameron ulcer presenting as refractory iron deficiency anemia[7].

The therapy is primarily medical, including acid suppressants and anti-ulcers for the ulcer and iron for the anemia, according to a related type of case report author. If the condition persists, surgery is the only option. On long-term follow-up, there have been no reports of ulcer or bleeding recurrence after surgical therapy[7].

In present case report mentioned that, patient had anemic since1 month and on her laboratory investigation her Hemoglobin was 5.5gm%. After admission patient was transfused with 2 units of packed red cell in view of low Hemoglobin. A number of studies on treatment of hernia and related complications were reported[8-13].

In this case report author mentioned that, patient had clinical manifestation of anemia since one year. For that patient had taken an adequate dose of therapeutic iron. Patient was transfused whole blood three times for severe anemia secondary to congestive heart failure. Additionally, patient had complaints of severe abdominal pain and blacking of stool. On specific investigation it was diagnosed as large hiatal hernia with iron deficiency anemia made by chest x-ray and positive occult blood test and barium meal study[7].

Conclusion:

A 65-year-old- male came in hospital with above mentioned complaints, in critical condition. On admission patient's hemoglobin was 5.5%. On specific investigation Upper GI bleed with Esophagitis wit hiatus hernia with severe Anemia. Patient was transfused with 2 units of packed red cell in view of low Hemoglobin. Conservative treatment was given. After the treatment patient's prognosis was good. Finally patient's hemoglobin raised at 10.5 gm%. Overall Patient had given a positive response to treatment and patient was stable. Hence patient is being discharged.

Ethical approval

Not applicable

Patient Inform consent

While preparing a case report and for publication patient's informed consent has been taken.

Conflict of Interest

The Author declares that there are no conflicts of interest.

Funding

Not applicable

REFERENCES:

1. Goodwin ML, Nishimura JM, D'Souza DM. Atypical and typical manifestations of the hiatal hernia.
2. Tamene A, Mela M. A large hiatal hernia with Cameron ulcer presenting as refractory sever iron deficiency anemia: A case report. Journal of pediatric surgery case reports. 2018 Oct 1; 37:16-8.
3. Maganti K, Smith RL. Cameron lesions: an unusual cause of gastrointestinal bleeding and Anemia. Digestion. 2008 Jul 12; 77(3-4):214-7.
4. Cook JD. Diagnosis and management of iron-deficiency anaemia. Best Practice & Research Clinical Haematology. 2005 Jun 1; 18(2):319-32.
5. Shih TC, Shih HH, Chang YT, Dai ZK, Chen IC. Hiatal hernia: a rare cause of iron-deficiency anemia in children. Pediatrics & Neonatology. 2017 Oct 1; 58(5):460-1.

DOI: 10.9756/INTJECSE/V14I4.303

6. Parikh K, Ali MA, Wong RC. Unusual causes of upper gastrointestinal bleeding. Gastrointestinal Endoscopy Clinics. 2015 Jul 1; 25(3):583-605.
7. Tamene A, Mela M. A large hiatal hernia with Cameron ulcer presenting as refractory sever iron deficiency anemia: A case report. Journal of pediatric surgery case reports. 2018 Oct 1; 37:16-8.
8. Lamture, Y., Gajbhiye, V., 2019. Migration of Thecoperitoneal Shunt into a Hernial Sac. JOURNAL OF CLINICAL AND DIAGNOSTIC RESEARCH 13, PD01–PD02. https://doi.org/10.7860/JCDR/2019/42805.13320
9. Swarnkar, M., Jindal, R., 2019. Obstructed Obturator Hernia: A Diagnostic Dilemma. JOURNAL OF KRISHNA INSTITUTE OF MEDICAL SCIENCES UNIVERSITY 8, 115–117.
10. Andhale, A., Acharya, S., Devde, K., Gupte, Y., Pratapa, S.K., 2020a. Subdural Haematoma (SDH) Leading to Subfalcine Herniation in a Case of End Stage Renal Disease. JOURNAL OF EVOLUTION OF MEDICAL AND DENTAL SCIENCES-JEMDS 9, 2919–2920. https://doi.org/10.14260/jemds/2020/638
11. Sharma, S.K., Upadhyay, V., 2020b. Hiatus hernia resulting in interstitial lung fibrosis due to repeated gastro-oesophageal aspirations. INDIAN JOURNAL OF MEDICAL RESEARCH 152, 667. https://doi.org/10.4103/ijmr.IJMR_2420_19
12. Badwaik, Nitesh Ganesh, Pankaj Gharde, and Meenakshi Yeola (Pate). "The Quality of Life of Inguinal Hernia Patient in India: The Application of Hernia- Specific Quality of Life Assessment." Journal of Pharmaceutical Research International, July 28, 2021, 337–45. https://doi.org/10.9734/jpri/2021/v33i38B32132.
13. Lomte, Sunayana, Sourya Acharya, and VijendraKirnake. "Efficacy of Octreotide Versus Terlipressin along with Endoscopic Variceal Ligation (EVL) in Preventing Re-Bleeding and Mortality in Acute Bleeding Esophageal Varices in Cirrhosis: A Randomized Prospective Study." Journal of Pharmaceutical Research International, June 22, 2021, 95–102. https://doi.org/10.9734/jpri/2021/v33i32B31748.

DOI: 10.9756/INTJECSE/V14I4.303