

Research Article

Open Access, Volume 3

Pseudo upper GI bleed in prisoners**Parveen Malhotra***; Yogesh Sanwariya; Mahima Vohra; Lakshay; Shalini; Jyoti

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Received: Nov 21, 2022

Accepted: Dec 15, 2022

Published: Dec 22, 2022

Archived: www.jcimcr.org

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DOI: www.doi.org/10.52768/2766-7820/2210

Abstract

Introduction: The upper gastro-intestinal bleed is one of the most common indication for endoscopy. There are various reasons for the same and include gastric or duodenal ulcer, erosive gastritis or duodenitis, esophagitis, Mallory Weiss tear, gastric malignancy etc. Many prisoner feign to be having hematemesis but their history and clinical presentation does not match with it.

Aims and objectives: To determine the etiology of upper Gastro-intestinal bleed in Prisoners who reported in outdoor patient Department of Medical Gastroenterology.

Materials & methods: It was prospective study conducted at Department of Medical Gastroenterology, Post Graduate Institute of Medical Sciences (PGIMS), Rohtak, over a period of three years from 01.10.2019 to 30.09.2022. Out of thirty prisoners who reported in department in above duration, twenty five who gave consent, were subjected to upper gastro-intestinal endoscopy.

Results: In none of 25 prisoners, any evidence of fresh or recent bleed was noticed and all endoscopies were found to be normal.

Keywords: Upper Gastro-intestinal bleed; Endoscopy; Melena; Hypotension; Tachycardia.

Introduction

Acute Gastrointestinal (GI) bleeding is a life-threatening condition and is a common cause of hospitalization [1,2]. The Upper GI Bleeding (UGIB) is defined as bleeding originating from a source proximal to the ligament of Treitz [3]. The incidence of UGIB is approximately 100 cases per 100,000 population per year [4]. The bleeding from the upper GI tract is four times more common than bleeding from the lower GI tract and is a major cause of morbidity and mortality. The mortality rates from UGIB are 6%-10% overall [4].

Aims and objectives

To determine the etiology of upper Gastrointestinal bleed in Prisoners who reported in outdoor patient Department of Medical Gastroenterology.

Material and methods

It was prospective study conducted at Department of Medical Gastroenterology, Post Graduate Institute of Medical Sciences (PGIMS), Rohtak, over a period of three years from 01.10.2019 to 30.09.2022. In above duration, total thirty prisoners gave history of upper gastro-intestinal bleed and were subjected to detailed general physical and systemic examination, followed by detailed investigations like complete haemogram, liver & renal function test, viral screen including HbsAg, Anti HCV antibody, Anti HIV antibody, Thyroid and Complete lipid profile, urine complete examination, ultrasonogram abdomen, chest X-ray. Out of thirty prisoners who reported in department in above duration, twenty five who gave consent, were subjected to upper gastro-intestinal endoscopy on same day.

Statistical analysis

All the data was entered in Microsoft Excel and was analysed using SPSS 15.0 version.

Observation & results

All the twenty five patients were males i.e. 100%. Majority of patients were illiterate, belonged to poor socio economic status and had rural background i.e. 20 patients (80%). The maximum number of patients belonged to 20-30 yrs of age group i.e. 18 (72%) and rest 7 patients (28%) belonged to 30-40 yrs of age group. All of these 25 patients had no co-morbid illness and gave history of hematemesis of one to weeks duration. All of these 25 patients reported in outdoor department, walking on their own and had no hemodynamic compromise. The detailed physical and systemic examination was normal in all twenty five patients. All were hemodynamically stable and none gave history of melena. No abnormality was detected in the biochemical tests and X-ray of all the patients. The ultrasonogram showed fatty liver in three patients and in rest twenty two, it was absolutely normal.

Discussion

The Comorbid illnesses were noted in 98.3% of mortalities in UGIB and in 72.3% of patients, Comorbid illnesses were the primary cause of death [5,6] but in our study group of 25 patients, none of them had any co-morbid illness. The comorbidities are now more commonly seen, as the patient population with UGIB has become progressively older. In a retrospective analysis by Yavorski et al, 73.2% of deaths occurred in patients older than 60 years [6]. The UGIB is twice as common in men as in women and increases in prevalence with age (>60 y). However, the death rate is similar in both sexes [6,7]. In our study group, all the 25 patients were male. In a study to evaluate national 30-day readmissions after upper and lower Gastrointestinal (GI) bleeding in 82,290 patients admitted for UGIB, the all-cause 30-day readmission rate was 14.6% (vs. 14.4% for LGIB) [8] and most common causes of readmission after UGIB were GI disease (33.9%), followed by cardiac (13.3%), infectious (10.4%), and respiratory (7.8%) etiologies. In our study group, none of the patient reported with re-bleeding. Patients who present in hemorrhagic shock have a mortality rate of up to 30% but in our study group as expected in view of hemodynamically stability and normal endoscopy, there was no mortality. The history and physical examination of the patient provide crucial information for the initial evaluation of persons presenting with a Gas-

trointestinal (GI) tract hemorrhage [3]. Important information to obtain includes potential Comorbid conditions, medication history, and any prior history of GI bleeding, as well as the severity, timing, duration, and volume of the bleeding [3]. History findings include weakness, dizziness, syncope associated with hematemesis and melena. The goal of the patient's physical examination is to evaluate for shock and blood loss. In our study group every patient gave history of hematemesis but none has melena. The clinical examination and investigations were characteristically normal in all 25 prisoner. The alarming signs and symptoms of hemodynamic compromise include tachycardia of more than 100 beats per minute, systolic blood pressure of less than 90 mm Hg, cool extremities, syncope, and other obvious signs of shock, ongoing brisk hematemesis, or the occurrence of maroon or bright-red stools, which requires rapid blood transfusion [9] but all above parameters were absolutely normal in all patients in our study group.

The reality is that all these 25 prisoners in our study group were intentionally giving false history of hematemesis with sole purpose of getting medical documents prepared for getting bail or for visiting hospital for outing purpose and meeting family members in hospital. These all facts were brought up by few prisoners in our group, after persistent convincing and assurance of not being shared with anyone. Some prisoners were fed by their legal team and rest also imbibed the same idea. All of them never knew that once hematemesis is there and in majority of patients melena will occur and can lead to hemodynamic compromise. There has to be some etiology for UGIB which is reflected on investigations including endoscopy. They concocted story of hematemesis, as jail doctor will be forced to refer them to higher centre for further evaluation. Out of total thirty patients, five patients even refused for endoscopy either they never knew that they will be subjected for this invasive procedure or due to fear of being caught for their false story of UGIB. All these patients were brought in a normal condition, walking comfortably on their own, belonging to younger age group, without any co-morbid illness. The initial group of patients stimulated us to closely follow all the future prisoners with iota of doubt for genuineness of their hematemesis complaint. Our doubt was confirmed, once we were able to confirm endoscopy findings in all of them. Our team also has experience for last 12 years of doing emergency endoscopies for UGIB, including for prisoners. In that scenario, majority of patients including prisoner were found to be having clear cut etiology for UGIB. In some where no finding was seen, in major-

Table 1: Showing Age, Sex and Geographical Distribution Among Patients.

Total Number of Patients	Males	Females	Rural Background	Urban Background	20-30 yrs of Age Group	30-40 yrs of Age Group
25	25 (100%)	0 (0%)	2 (80%)	5 (20%)	18 (72%)	7 (28%)

Table 2: Showing Clinical Parameters Distribution Among Patients.

Total Number of Patients	Co-morbid Illness	No Co-morbid Illness	Hemodynamic Stable	Hemodynamic Not Stable	History of Melena	No History of Melena
25	0 (0%)	25 (100%)	25 (100%)	0 (0%)	0 (0%)	25 (100%)

ity of them, it was haemoptysis which was wrongly interpreted as hematemesis. We as a treating team give psychotherapy to all these prisoners, that by lying, they will have no advantage but it will be reverse because, all of them were evaluated in detail and it was labeled that they are totally healthy. No prisoner in our study group reported back with rebleed, may be due to psychotherapy or fear of repeat endoscopy, need of which was clearly explained to all of them, at time of first endoscopy, with a view to act as a deterrent for repeat false complaint of UGIB in future. We on our level, informed the jail authorities, so that same may be communicated to the prisoners, thus by reducing further pseudo complaint of UGIB.

Conclusion

All the doctors performing endoscopy should always make a probable diagnosis in their mind on first clinical presentation which is further supported by investigations. You may encounter rare phenomenon, as our team noticed feigning of UGIB by prisoners. The factor which helped us that as our department is sole government set up with endoscopy facility, thus all of them were referred to us for endoscopy. After few initial cases, we already had doubt, thus these prisoners were being closely observed for pattern of their complaint of UGIB. The crux is learn from your experience gained from patients, every complaint is important, true or false.

Limitation of study: In the present study, there is no comparison with prisoners who reported in emergency department, even at odd hours, with our group of prisoners who all were hemodynamically stable and reported in routine hours, in outdoor patient department.

Conflict of interest: The authors disclose that there is no conflict of interest.

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