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Objectives: Gastrointestinal Bleed

1. In a patient with blood in their stool who is hemodynamically stable, use history to differentiate between an upper vs. lower gastrointestinal (GI) bleed as the investigations differ.
2. In a patient with suspected blood in the stool, explore other possible causes (e.g. beet ingestion, iron, Pepto-Bismol) before doing extensive investigations.
3. Look for patients at high risk for GI bleed (e.g. previous GI bleed, ICU admission, NSAID use, alcohol use) so as to modify treatment to reduce the risk of GI bleed (e.g. cytoprotection).
4. In a patient with obvious GI bleeding, identify patients who may require timely treatment even if they are not yet in shock.
5. In a stable patient with lower GI bleeding, look for serious causes (e.g. malignancy, inflammatory bowel disease, ulcer, varices) even when there is an apparent obvious cause for the bleeding (e.g. hemorrhoids, oral anticoagulation).
6. In a patient with an upper GI bleed,
    a. Include variceal bleeding in the differential diagnosis
    b. Use history and physical examination to assess the likelihood of a variceal bleed as its management differs (e.g. Octreotide vs. Pantoprazole for PUD).

** Mapped to the CFPC's 105 priority topics: #42-GI Bleed