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Treatment of pregnant women with acute bleeding syndrome in the lumen of the digestive duct

Trofimov M.V.[1], Lyashchenko P.V.[1], Guzenko B.V.[1], Grabchuk V.N.[1], Mykolaivna P.T.[1]

Department of molocular microbiology, Science research Institute of Experimental Medicine, Russian Federation[1]

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ABSTRACT

Rectal bleeding is a common symptom experienced by pregnant women. Although the majority of cases are attributable to benign conditions such as haemorrhoids and anal fissures, other more serious diagnoses such as inflammatory bowel disease and malignancy should not be overlooked. Most investigations are safe during pregnancy and these should not be withheld as significant implications on both foetal and maternal morbidity may result. In these cases, a multidisciplinary team approach is essential. This review explores the differential diagnosis, investigation and management of rectal bleeding during pregnancy.

1. Introduction

Rectal bleeding is a symptom commonly reported by pregnant women. The physiological changes associated with pregnancy and the gravid uterus can exacerbate common benign conditions such as haemorrhoids and anal fissures. It is imperative, however, that alternative diagnoses are not overlooked. Conditions such as inflammatory bowel disease (IBD), if not appropriately managed can be associated with significant adverse pregnancy outcomes, so prompt diagnosis and assessment of disease activity are imperative [1]. In addition, women are increasingly deferring childbirth and as maternal age is rising, malignancies identified during pregnancy are increasing [2]. Thorough investigation and management should therefore not be deferred and a multidisciplinary team approach involving obstetricians, radiologists, gastroenterologists and surgeons is imperative.

2. Assessment

A thorough history is essential to determine the characteristics of the bleeding and any other concomitant symptoms. Specific features may help discern the cause, including volume, frequency, whether it is fresh blood covering the stool (indicative of more distal pathology such as haemorrhoids) or mixed with the stool (consistent with more proximal pathology). Localised peri-anal symptoms are important as pain during defecation is commonly noted with an anal fissure, whilst haemorrhoidal bleeding is typically described as being painless. It should be noted whether symptom onset occurred after eating certain foods or following travel and whether other close contacts are also unwell with diarrhoea or vomiting, as this may indicate an infective cause. A history of change in stool frequency or abdominal pain should be elicited, as it is relevant to other causes of rectal bleeding such as IBD or colorectal malignancy. However, some of the ‘red-flag symptoms’, [3] which may alert to these conditions in the non-pregnant population (see Table 1), including

anaemia and alterations in bowel habit, can overlap with symptoms attributable to the physiological changes that occur during pregnancy and other features, such as weight loss, may be more difficult to detect. Enquiring whether these symptoms preceded the pregnancy is therefore imperative. Extra-gastrointestinal problems such as skin, eye or joint symptoms or signs can be suggestive of IBD and a family history is relevant to both colorectal malignancy and IBD. The drug history should enquire as to whether the woman is taking any anticoagulants such as low-molecular-weight heparin or antiplatelet agents such as aspirin, both commonly used during pregnancy. Although not causative, these may exacerbate rectal bleeding.

3. Conclusion

Rectal bleeding in pregnancy is a common presentation, with a range of differential diagnoses. Haemorrhoids should not be the assumed diagnosis and a thorough history, examination and targeted investigations are essential. Appropriate investigations should not be withheld due to pregnancy.

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