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GASTROINTESTINAL PEARLS FOR THE CARDIOVASCULAR CLINICIAN

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1. Acute exacerbation of gastroesophageal reflux disease (GERD) in the postoperative period: Patients with even mild-to-moderate reflux disease may develop severe complications of GERD after being intubated for ventilator support, remaining bedridden, receiving nasogastric tubes, and receiving narcotic analgesia for several days. Frequently, the first sign of a problem is postoperative dysphagia secondary to stricture formation and/or severe inflammation of the distal esophagus. Management should include reverse Trendelenburg positioning and aggressive proton pump inhibitor (PPI) therapy to keep the gastric pH above four. Simply elevating the head of the bed will not prevent reflux to the distal esophagus.

2. Fecal occult blood testing will be positive with as little as 10 mL of blood per day in the gastrointestinal (GI) tract. This test will not be of any clinical significance in the evaluation of the acute anemia occurring during hospitalization. If gross blood is not visible, the anemia is from an etiology other than clinically significant GI blood loss.

3. Metronidazole-resistant strains of Clostridium difficile have become significantly more frequent. In frail or severely ill patients, it is recommended to start treatment with oral vancomycin (125-250 mg) four times daily for 14 days when Clostridium difficile infection appears.

4. When considering a percutaneous coronary intervention with possible placement of a drug-eluting stent, also consider obtaining a colonoscopy prior to that for those who may have iron-deficiency anemia, who have tested positive for fecal occult blood, or for whom screening colonoscopy is indicated. Patients will be at higher risk for bleeding events and unable to interrupt antiplatelet agents for a long time.

5. Consider the prophylactic use of methylnaltrexone (RELISTOR®) 0.15 mg/kg body weight, subcutaneously, once every other day, to prevent narcotic-induced constipation and abdominal distention for every patient on narcotic analgesia.

6. Sucralfate (Carafate®) depends on an acid environment to bind to collagen in eroded/ulcerated areas of the GI tract to allow more efficient healing. Using both a PPI and sucralfate significantly interferes with the efficacy of the binding process, making sucralfate ineffective.

7. Sucralfate also is not recommended on patients with upper GI bleeding as it interferes with endoscopic visualization, particularly when combined with blood in the lumen.

8. Before transfusing a patient with chronic anemia, make sure iron studies are obtained, specifically transferrin saturation (serum iron level, total iron binding capacity) and serum ferritin level.

9. Oral iron replacement will not cause a fecal occult blood test to become positive but will make stools black. A positive fecal occult blood in the presence of oral iron replacement does indicate blood in stools.

10. Pantoprazole requires that gastric proton pumps are actively secreting protons (H^+) in order to effectively inactivate that particular pump. For that to happen, it has to have adequate circulating blood levels at the time the gastric proton pumps become active. Since the most potent physiological stimulus for acid secretion is food, oral pantoprazole must be given approximately 1 hour prior to meals. Inadequate timing of this medication is the most common cause of therapeutic failure for pantoprazole use.