

Intensive Care Practice and Gastrointestinal Haemorrhage

James Stephen*

Department of Gastroenterology, University of Dhaka, Dhaka, Bangladesh

Introduction

Hospitalized patients usually have poor nutrition, which may be made worse by the metabolic needs of underlying diseases. Gastrointestinal (GI) tract damage may be brought on by a medical procedure or made worse by the underlying condition. The evidence supporting system maintenance, stress ulceration, and the delivery of upper GI dying, namely stomach cleaning, is presented in this article. Frequently, patients in the emergency room are unable to prepare their own meals. This may be especially true for cautious patients. Additionally, it has been demonstrated that illness is common before to medical clinic confirmation and that a significant proportion of individuals who were not malnourished may become so upon admission to an emergency room. In the ICU, loss of muscle mass and strength is a typical issue that can be made worse by malnutrition. Patients might also become more susceptible to infections.

Description

This may hinder recovery, necessitating extended hospital stays and critical care. Bes could be lost, causing accidental pneumonic care. Patients may suction unexpectedly. This might make sense in people who have developed stomach balance as a result of underlying illness. Parenteral nutrition necessitates focused venous access, and complications from lines such contamination, demise, and pneumothorax are possible. interest and demand for supplements. Glycogenolysis and gluconeogenesis rapidly deplete muscle and liver glycogen reserves at the cellular level. When fat and mass are consumed, lipolysis and ketogenesis take over. In general, digestion returns to normal. According to conventional instruction, a patient like this would lose fat mass in preference to various tissues, but in reality, all tissue types would be affected. This particular form of famine is adaptable and responds well to care. Stress has a fundamentally varied impact on metabolic function. Inflammation is the main driving force behind the process, and the patient is hypermetabolic in contrast to hunger. The ingestion of lipids, proteins, and carbohydrates is intermingled from the start. Patients experience significant muscle mass loss. These patients have inadequate eating responses. They are unable to manage more calories since the process is being driven by inflammation rather than a lack of energy. The Enduring Sepsis Crusade (SSC) makes extensive recommendations on how and when to treat sepsis² and is generally significant. Guidelines are provided explicitly by the Canadian Basic Consideration Society (CCCS). Both the European Culture for Clinical Sustenance and Digestion (ESPEN)^{4,5} and the UK-based Public Foundation for Wellbeing and Care Greatness (NICE)¹ provide general guidelines. Long believed to be a preventable source of injury in seriously ill individuals, stress ulceration. The 2016 Surviving Sepsis Campaign recommendations support

*Address for Correspondence: James Stephen, Department of Gastroenterology, University of Dhaka, Dhaka, Bangladesh, E-mail: bond451@edu.in

Copyright: © 2022 Stephen J. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Received: 06 September, 2022, Manuscript No. cmcr-23-85923; **Editor assigned:** 07 September, 2022, PreQC No. P-85923; **Reviewed:** 14 September, 2022, QC No. Q-85923; **Revised:** 19 September, 2022, Manuscript No. R-85923; **Published:** 28 September, 2022, DOI: 10.37421/2684-4915.2022.6.225

the widespread practise of prescribing antihistamines or proton-pump inhibitors (PPIs) to lower the risk of bleeding from these ulcers.

Many severely ill patients have endoscopic evidence of gastro-intestinal erosions or ulceration, according to observations. A small percentage of these patients will experience clinically severe bleeding. The exact aetiology is still unknown, despite processes including hypoperfusion leading to ischaemia and reperfusion damage being proposed. The most reliable risk factors are thought to be coagulopathy and prolonged mechanical breathing (more than 48 hours). Prior liver disease, severe kidney damage needing renal replacement therapy, as well as other organ damage, may further increase risk. Treatment of these lesions prophylactically may not be without risk. A risk factor for ventilator-associated pneumonia may be the course of treatment. Additionally, PPIs are linked to greater incidence of *Clostridium difficile* infection, however it's unclear whether this is important for ICU patients. The SSC clearly points out the poor information quality that underlies its suggestion. The agreement simply stated that the nature of benefit proof was more solid than harm proof. Additionally, there are arguments to support the idea that pressure ulcer prophylaxis is beneficial, particularly during the acute stage of a patient's primary illness. Patients that are actively bleeding are affected by platelets. 50 10 platelets as the desired objective [1–5].

Conclusion

9 /L are suitable. The BSG and NICE particularly advise against platelet transfusion in a patient who is not actively bleeding because there is a lack of evidence to support this procedure. Although not covered by recommendations from NICE, the BSG, or the ACG, patients with thrombocytopenia frequently receive platelets prior to invasive procedures like lines or drains, and patients taking antiplatelet medications like aspirin may have normal platelet counts but have a functional platelet defect, in which case platelet transfusion may be considered. In this situation, speaking with a haematologist may be beneficial.

Acknowledgement

We appreciate the anonymous reviewers' helpful comments on the manuscript. The authors are very grateful for the assistance provided by ROMA (Research Optimization and recovery in the Manufacturing industry), of the Research Council of Norway.

Conflict of Interest

There are no conflicts of interest with this paper, the author asserts.

References

1. Gorin, Michael A., Steven P. Rowe and Samuel R. Denmeade. "Clinical applications of molecular imaging in the management of prostate cancer" *Pet Clinics* 12 (2017): 185-192.
2. Bertoluci, Marcello Casaccia and Viviane Zorzanelli Rocha. "Cardiovascular risk assessment in patients with diabetes." *Clin Gastroenterol J* 9 (2017): 1-13.
3. Drucker, Daniel J. "Optical-based molecular imaging: Contrast agents and potential medical applications" *Eur. Radiol.* 13 (2003): 231–243.
4. Schulz, Ralf B. and Wolfhard Semmler. "Principles of optical and fluorescence mediated tomography in turbid media." *Clin Gastroenterol J* 15 (2017): 177-186.

5. Hicks, Rodney J., Guy C. Toner and Peter FM Choong. "Clinical applications of molecular imaging in sarcoma evaluation." *Clin Gastroenterol J* 5 (2005): 66–72.

How to cite this article: Stephen, James. "Intensive Care Practice and Gastrointestinal Haemorrhage." *Clin Med Case Rep* 6 (2022): 225.