EDITORIAL

The article *A Review of Hematemesis and Melena in Thomson Road General Hospital* in the current issue serves once more to emphasize that acute bleeding from peptic ulcer is a common condition in Singapore. The operative mortality rates for the various peptic ulcers as reported in the article, though eminently acceptable, are not entirely meaningful. Any operative mortality rate in bleeding peptic ulcer must be defined and viewed in a context of a number of factors, including the severity of bleeding. The fate of the patient entering the operating theatre is often predetermined by the clinical events preceding operative treatment. A lack of appreciation of this fact is responsible for the controversy and inconsistency hovering over the management of this hazardous condition.

The peptic ulcer patient with acute bleeding may follow one of three possible courses. The bleeding may stop spontaneously before it reaches a fatal proportion. The patient may be operated on at an opportune time either with essentially the same risk attendant on elective operations or in circumstances which are still not unduly adverse to a favourable outcome. Finally, the patient may be allowed to deteriorate through inadequate or excessively prolonged 'conservative' management, and the surgeon is called in to deliver the *coup de grace.*

It is, of course, not possible to predict accurately the course of the individual patient. However, there have been enough clinical experiences presented in the world literature concerning bleeding peptic ulcer to enable one to pursue a sensible policy of management based on probability. In the pseudoscientific field of clinical practice, the diagnosis and management of any condition are based essentially on probability, and bleeding peptic ulcer should be no exception.

The peptic ulcer patient with a minor bleed does not face a life-threatening situation. The need for an emergency operation does not arise. When the bleeding assumes a major proportion, all therapeutic measures should be directed towards avoiding a fatal outcome. The question remains how major bleeding should be defined. Among the many criteria used are the amount of blood loss, the amount of blood transfusions, the clinical picture in terms of blood pressure, pulse and other hemodynamic changes, the laboratory parameters such as hemoglobin and hematocrit determinations, and the duration and rate of bleeding. None of these criteria, either singly or collectively, are perfect. The point, nevertheless, should be made that it is better to have some criteria than none at all.

Several clinical facts are well recognised in bleeding peptic ulcer. The patient may succumb to an episode of massive exsanguination. The patient may develop cardiac, renal or other complications as a result of a single or repeated episode of shock. Furthermore, if slow bleeding should persist over several days, the inevitably anemic patient may deteriorate rapidly with superimposed condition such as pneumonia though he has suffered from no manifest clinical shock. It is also common knowledge that the elderly patient does not withstand haemorrhage and shock as well as the younger one. Patients with major concomitant diseases, such as hypertension, arteriosclerotic heart disease, diabetes mellitus, cirrhosis, chronic renal disease, etc., also tend to develop serious complications in the face of haemorrhage and shock. It is, therefore, possible to define rationally the situations when operative intervention becomes advisable. The guiding principle should be that the patient's condition must not be allowed to deteriorate.

In the management of bleeding peptic ulcer, it is the 'poor risk' patients who lay more urgent claim to operative treatment than the 'good risk' ones. The clinician who undertakes to treat a patient conservatively must at the same time assume the responsibility of maintaining the patient in optimal condition by aggressive blood transfusions and other measures. The surgeon who rejects a patient when operative indications are present must do so on very sound grounds for the sin of omission here is no less than the sin of commission.