

## Text #1

There is a broad clinical spectrum of gastrointestinal bleeding in children, ranging from subtle laboratory findings to dramatic clinical presentations. This review provides a framework for the evaluation and management of gastrointestinal hemorrhage for pediatricians. It outlines strategies for obtaining a tailored patient history and conducting a thorough physical examination that can shed light on the location, severity, and likely etiology of bleeding. It appraises blood tests, radiologic tools, and endoscopic modalities frequently used to identify and control a source of bleeding.

Text #2

Upper gastrointestinal bleeding is a medical condition routinely encountered in clinical practice. Overt upper gastrointestinal bleeding usually presents as melena or hematemesis but can also present as hematochezia in cases of brisk bleeding. The initial evaluation of a patient with suspected upper gastrointestinal bleeding begins with assessment of hemodynamic status, identification of potential risk factors, and appropriate triage of level of care. After resuscitation measures, endoscopic evaluation can be performed to diagnose and potentially treat the source of bleeding. Risk factors that increase the propensity for recurrent bleeding should be identified and addressed.

Text #3

European Society of Gastrointestinal Endoscopy recommends the use of a protective device in order to avoid esophagogastric/pharyngeal damage and aspiration during endoscopic extraction of sharp-pointed foreign bodies. Endotracheal intubation should be considered in the case of high risk of aspiration (strong recommendation, low quality evidence).

Text #4

Lower gastrointestinal bleeding entails a range of severity and a multitude of options for localization and control of bleeding. With experience in trauma, critical care, endoscopy, and definitive surgical interventions, general surgeons are equipped to manage this condition in various clinical settings. This article examines traditional and emerging options for bleeding localization and control available to general surgeons.

## Text #5

Lower gastrointestinal bleeding (LGIB) arises from a number of sources and is a significant cause of hospitalization and mortality in elderly patients. Whereas most episodes of acute LGIB resolve spontaneously with conservative management, an important subset of patients requires further diagnostic workup and therapeutic intervention. Endovascular techniques such as microcatheter embolization are now recognized as safe, effective methods for controlling LGIB that is refractory

to endoscopic intervention. In addition, multidetector CT has shown the ability to identify areas of active bleeding in a non-invasive fashion, enabling more focused intervention.

Text #6

We consecutively and retrospectively included all patients admitted to our emergency department for acute LGIB proven by CT angiography (CTA) from 2004 to 2017. Patients were divided into two groups depending on whether they first underwent interventional radiological (IR) or surgical treatment. Two radiologists reviewed CTA and angiographic images. Patients' hemodynamic and clinical parameters, delay between imaging and treatment, procedure characteristics, and outcomes were investigated to detect differences between the two groups.

Text #7

Medline, Embase and Embase Classic were searched (until September 2016) to identify population-based studies that reported the prevalence of gastro-oesophageal reflux symptoms in adults ( $\geq 15$  years); gastro-oesophageal reflux was defined using symptom-based criteria or questionnaires. The prevalence was extracted for all studies, and according to the criteria used to define it. Pooled prevalence, according to study location and certain other characteristics, OR and 95% CIs were calculated.

Text #8

The prevalence of gastro-oesophageal reflux symptoms varied strikingly among countries, even when similar definitions were used to define their presence. Prevalence was significantly higher in subjects  $\geq 50$  years, smokers, NSAID users and obese individuals, although these associations were modest.

Text #9

The primary cause of the gastroesophageal reflux disease is the impairment of motility and not that of acidic secretion. The reflux disease develops when the balance between aggressive and defensive factors becomes disequibrated. Among the aggressive factors the gastro-oesophageal (duodeno-gastro-oesophageal) reflux is classified. In its pathogenesis, the major role has the concentration of the hydrochloric acid, presence of bile and of pancreatic enzymes. These factors may be potentiated by the hiatal hernia, gastric dysmotility, insufficient pyloric competency, and subsequent duodeno-gastric reflux.

Text #10

Majority of papers indicates that the essential causes of the gastroesophageal reflux disease are transient relaxations of the lower esophageal sphincter and diaphragm. In patients with massive reflux esophagitis, pressure of the lower esophageal sphincter is weak and amplitude of esophageal contractions is low. Gradient in the region of the lower esophageal sphincter is formed

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in the vicinity of the functioning valve, which is formed by musculo-mucosal fold located in transition of esophagus and stomach. In healthy persons, refluxed fluid is quickly removed from the esophagus, which is the second line of defence.

## Text #11

The role of eicosanoids in the gastroesophageal reflux disease is not yet known because their levels do not correlate with the seriousness of the symptoms. Increased prevalence of the reflux disease during the last years is often correlated with decreased incidence of *Helicobacter pylori* infections. Etiopathogenesis of the reflux disease is multifactorial and can include deficient antireflux mechanisms, frequency of reflux episodes, volume and effectiveness of the refluxed fluid, mucosal resistance, deficient esophageal clearance and emptying of the stomach.

## Text #12

Essential facts Bringing up food after eating is a normal process that can occur in healthy infants, children and young people. Gastro-oesophageal reflux (GOR) is most common in babies, affecting four in ten infants. Gastro-oesophageal reflux disease (GORD) is reflux that is so severe medical treatment is required. Differentiating between GOR and GORD is difficult because the terms are often used interchangeably.

## Text #13

The patients treated for oesophageal atresia present a correlation between the clinical symptomatology after recanalization characterized by dysphagia, dyspnea, recurrent cough, chronic pneumopathies and oesophageal anomalies. Where morphological alterations accounting for the presence of gastro-oesophageal reflux (GOR) were not evident, possible functional alterations of the motility were considered.

## Text #14

The incidence of gastro-oesophageal reflux (GOR) was considerably high and, expression of a congenital alteration of the lower oesophageal sphincter and of oesophageal peristalsis, becomes even more severe due to further stretching of the gastro-esophageal junction. The authors underline that the early demonstration of histological changes, even before recanalization, and the motility disorders of the oesophagus have to be well studied, while the LES is normalized, in order to prevent and treat the possible appearance of the well-known complications of GOR.

## Text #15

The otolaryngological symptoms during gastro-oesophageal reflux disease may be very frequent. When the global estimation in the literature go round 20%, the prevalence in the African studies is

