

for bleeding, which tends to occur 48–72 h after the acute injury or insult.

Histologically, stress injury does not contain inflammation or *H. pylori*; thus, “gastritis” is a misnomer. Although elevated gastric acid secretion may be noted in patients with stress ulceration after head trauma (Cushing’s ulcer) and severe burns (Curling’s ulcer), mucosal ischemia, breakdown of the normal protective barriers of the stomach, systemic release of cytokines, poor GI motility, and oxidative stress also play an important role in the pathogenesis. Acid must contribute to injury in view of the significant drop in bleeding noted when acid inhibitors are used as prophylaxis for stress gastritis.

Improvement in the general management of intensive care unit patients has led to a significant decrease in the incidence of GI bleeding due to stress ulceration. The estimated decrease in bleeding is from 20–30% to <5%. This improvement has led to some debate regarding the need for prophylactic therapy. The high mortality associated with stress-induced clinically important GI bleeding (>40%) and the limited benefit of medical (endoscopic, angiographic) and surgical therapy in a patient with hemodynamically compromising bleeding associated with stress ulcer/gastritis support the use of preventive measures in high-risk patients (mechanically ventilated, coagulopathy, multiorgan failure, or severe burns). Meta-analysis comparing H₂ blockers with PPIs for the prevention of stress-associated clinically important and overt GI bleeding demonstrates superiority of the latter without increasing the risk of nosocomial infections, increasing mortality, or prolonging intensive care unit length of stay. Therefore, PPIs are the treatment of choice for stress prophylaxis. Oral PPI is the best option if the patient can tolerate enteral administration. Pantoprazole is available as an intravenous formulation for individuals in whom enteral administration is not possible. If bleeding occurs despite these measures, endoscopy, intraarterial vasopressin, and embolization are options. If all else fails, then surgery should be considered. Although vagotomy and antrectomy may be used, the better approach would be a total gastrectomy, which has an exceedingly high mortality rate in this setting. Concerns with the effect of PPIs on