Question and Answer Session

MODERATOR: LISA GANGAROSA

PANEL:

ASHESH PARIKH
KARA REGAN
DOUG REX
DAN WILD

ACG Clinical Guideline: Diagnosis and Management of Small Bowel Bleeding

Am J Gastroenterol 2015; 110:1265–1287

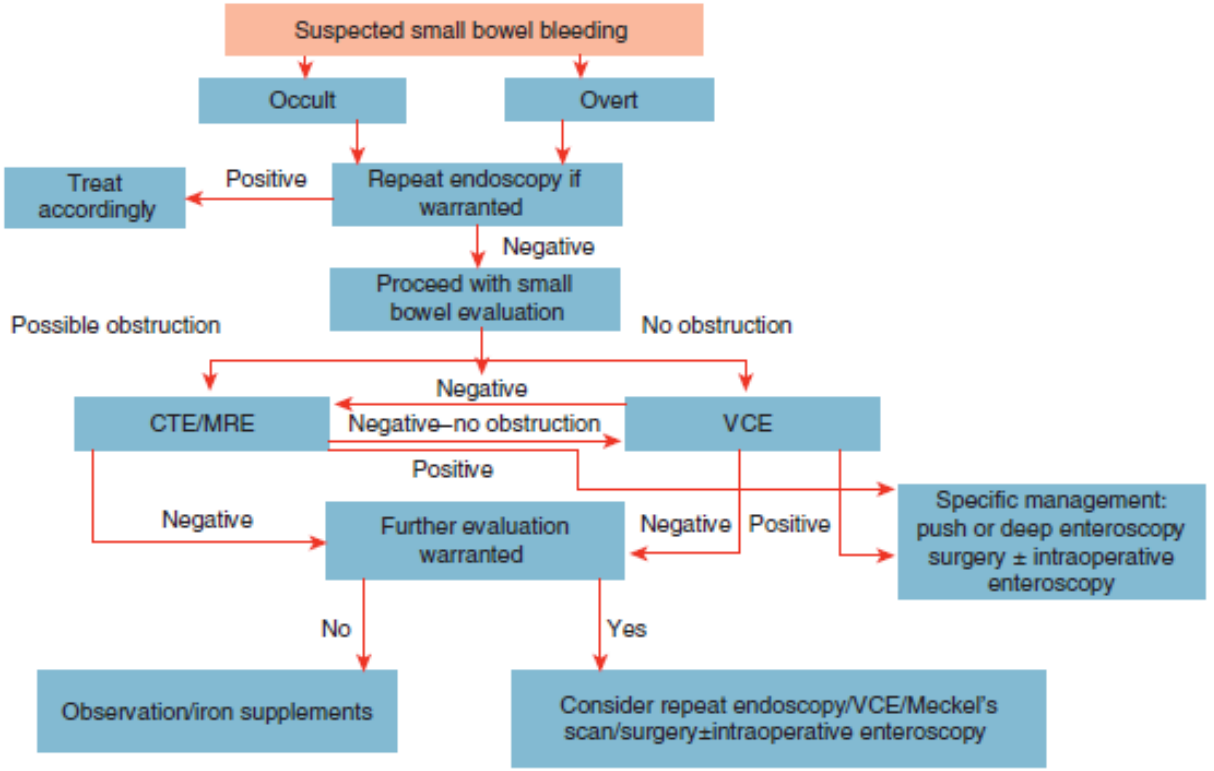


Figure 1. Algorithm for suspected small bowel bleeding. CTE, computed tomographic enterography; MRE, magnetic resonance enterography; VCE, video capsule endoscopy.

Comments on these Recommendations

Total deep enteroscopy should be attempted if there is a strong suspicion of a small bowel lesion based on clinical presentation (strong recommendation, moderate level of evidence).

In practice, how often is this actually done?

Computed tomographic enterography (CTE) should be performed in patients with suspected small bowel bleeding and negative capsule endoscopy because of higher sensitivity for the detection of mural-based small bowel masses, superior capability to locate small bowel masses, and ability to guide subsequent deep enteroscopy (strong recommendation, low level of evidence).

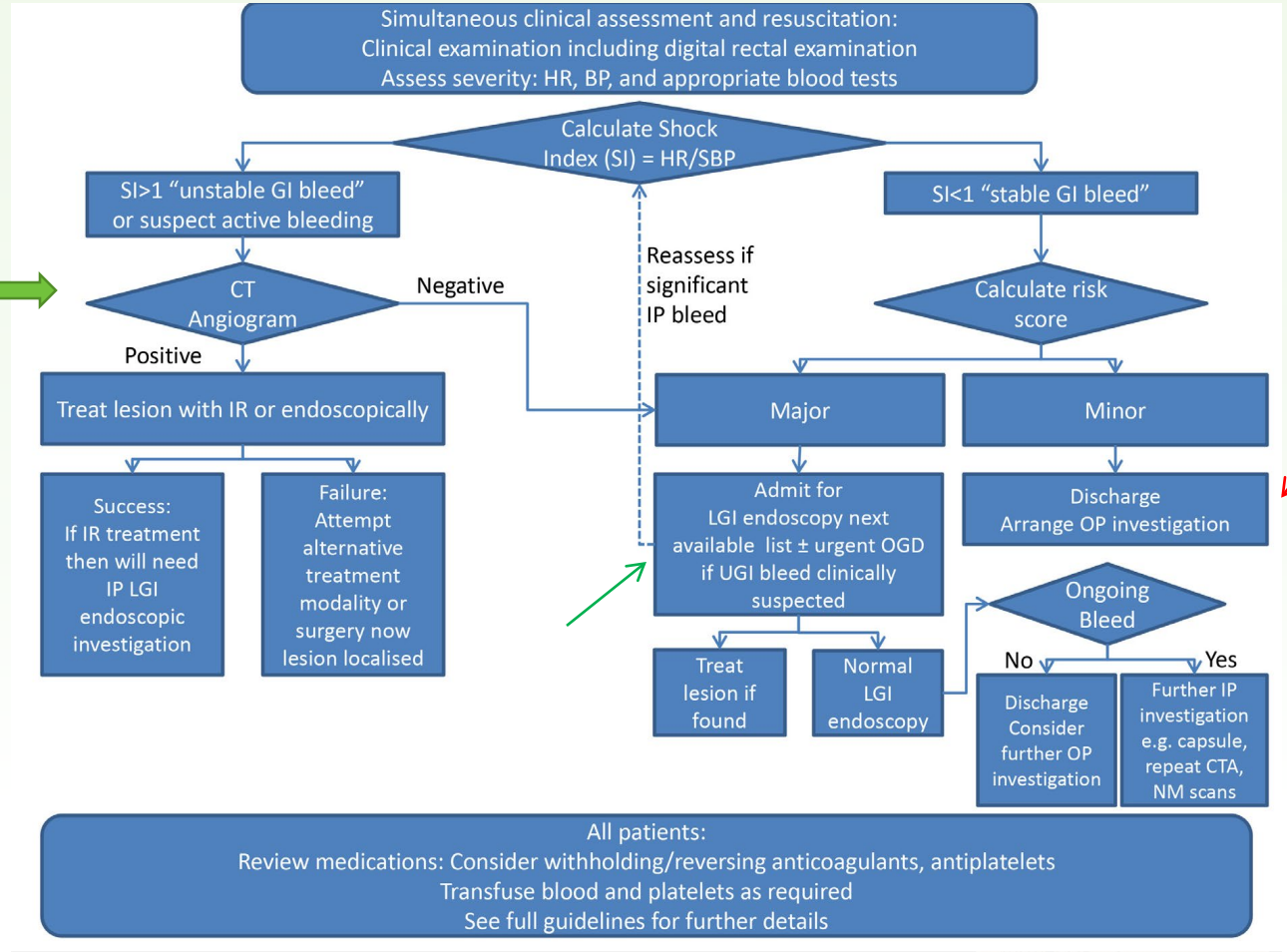
In patients with suspected small bowel bleeding and negative VCE examination, CTE should be performed if there is high clinical suspicion for a small bowel source despite performance of a prior standard CT of the abdomen (conditional recommendation, very low level of evidence).

Provocative angiography can be considered in the setting of ongoing overt bleeding and negative VCE, deep enteroscopy, and/or CT examination (conditional recommendation, very low level of evidence).

In practice, how often is this actually done?

If after appropriate small bowel investigation no source of bleeding is found, the patient should be managed conservatively with oral iron or by intravenous infusion as is dictated by the severity and persistence of the associated iron-deficiency anemia. In this context, a small vascular lesion found on capsule endoscopy does not always need treatment (strong recommendation, very low level of evidence).

Diagnosis and management of acute lower gastrointestinal bleeding: guidelines from the British Society of Gastroenterology



Gut 2019;68:776–789.

Others have questioned whether any stable patient needs admission for colonoscopy

Causes of lower GI bleeding in 210 patients as per the BSG guidelines algorithm including those who would have been suitable for therapeutic intervention

High shock index	Low shock index and low Oakland score (minor)	Low shock index and high Oakland score (major)
Normal endoscopy (n=6) Diverticulosis (n=5) Underlying liver disease (n=3) UC (n=1) Crohns' colitis (n=1) Underlying haematological disorder (n=1).	Normal endoscopy (n=4) Diverticulosis (n=3) Ischaemic colitis (n=3) Inflammatory (n=3) Haemorrhoids (n=3) UC (n=3) Radiation proctopathy (n=1) Crohns' colitis (n=1) Angiodysplasia (n=1) Polyp (n=1)	Normal endoscopy (n=28) Diverticulosis (n=74) Ischaemic colitis (n=15) UC (n=9) Haemorrhoids (n=9) Polyp (n=8) Colorectal cancer (n=8) Inflammatory (n=5) Declined investigations (n=3) Angiodysplasia (n=4) Postpolypectomy bleed (n=2)* Solitary rectal ulcer syndrome (n=2) Colonic stricture (n=1)
1/15 (6.7%) rebled within 30 days and 1/15 (6.7%) died with 30 days.	24 (12.3%) had an Oakland score <9 and would have been considered for early discharge. 0/24 rebled within 30 days and 1/24 (4.2%) died within 30 days.	18/171 (10.5%) rebled within 30 days and 10/171 (5.8%) died within 30 days of admission

no significant difference in rebleeding and mortality rates in all three arms of the algorithm

Gut. 2019 Jul 17. pii: gutjnl-2019-319428. doi: 10.1136/gutjnl-2019-319428. [Epub ahead of print]

Authors comments

In summary, we feel there is too strong an emphasis on acute inpatient colonoscopy for which there is no evidence of benefit due to a very low intervention rate and therefore minimal opportunity to alter outcomes.

Lower GI Bleeding

- Thoughts?

-Post polypectomy bleeding-does every patient who reports hematochezia within 14 days of polypectomy need repeat colonoscopy?