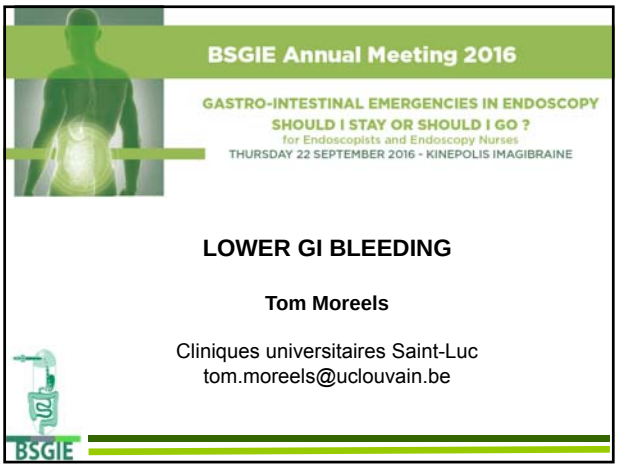

LOWER GI BLEEDING

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♂ 86 years

- Medical history
  - CIHD (PTCA + stent)
  - Ischemic CVA
  - Prostate cancer (RT)
  - Parkinson's disease
  - Knee prosthesis
  - Constipation
- Medical treatment
  - Asaflow / Zocor / Inderal / CoLisinopril
  - Prolopa / Mysoline / Rilatine / Miraprexin
  - Lactulose / Laxoberon

♂ 86 years

- Emergency admission at 05h00
  - Profuse rectal blood loss since 02h00
  - Witnessed by nurse from residence
  - Witnessed by nurse in ER (red blood + cloths)
- Clinical assessment
  - BP 118/74 mm Hg P 71/min SpO2 99%
- Telephone call from ER

QUESTION 1

WHAT DO YOU DO ?

A. Ask for the patient to be admitted to ICU (and take an extensive breakfast)

A. Send the patient home with an appointment for upper and lower endoscopy within the week

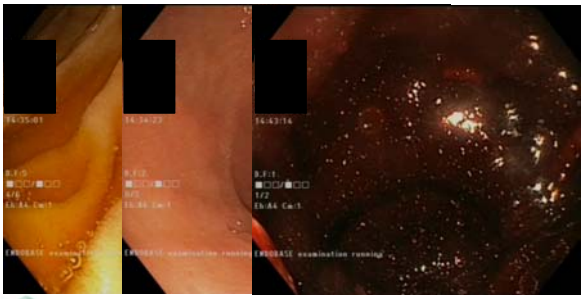
C. Run to the hospital (without breakfast) for urgent upper and lower endoscopy

D. Admit the patient to the GI ward and plan upper and lower endoscopy within <12 hours

♂ 86 years

- Patient was admitted to GI ward
  - Hb 9.6 g/dl TRC 207 000/µl INR 1.1
  - ureum 58 mg/dl creatinine 0.72 mg/dl
  - Hb 12.2 g/dl 18 months ago
  - Nexiam 40 mg iv
  - No transfusion
- Gastroscopy and rectoscopy on day 1

♂ 86 years



QUESTION 2

WHAT DO YOU DO ?

A. Prepare the colon to perform colonoscopy on day 2 (<24h)

B. Angio CT to localize the bleeding

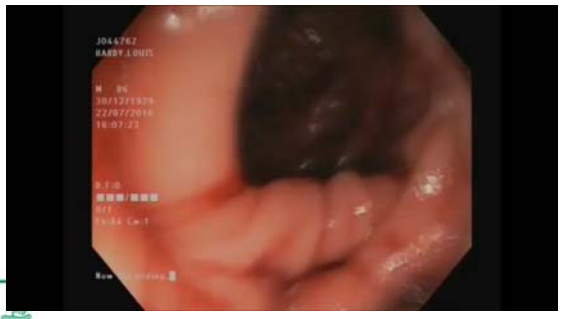
C. Conventional angiography with embolization if possible

D. Transfer the patient to the surgical ward

♂ 86 years

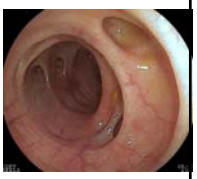
- Patient was prepared for colonoscopy on day 2
  - Hb 8.3 g/dl TRC 177 000/µl
  - Intermittent rectal blood loss
  - Nexiam 40 mg iv
  - 1 UPC transfusion
- Colonoscopy on day 2

Video 1



Rectal bleeding

- Lower GI bleeding
  - Originates distally from ileocaecal valve
  - 20% of acute GI bleeding
- Differential diagnosis
  - Colonic diverticula 20-65%
  - Ischemic colitis 1-19%
  - Angioma 3-15%
  - Hemorroids 2-10%
  - Colorectal cancer <15%
  - Postpolypectomy bleeding 2-8%
  - Other pathologies
    - radiation proctitis, IBD, solitary rectum ulcer, NSAID,…
    - upper or midgut bleeding



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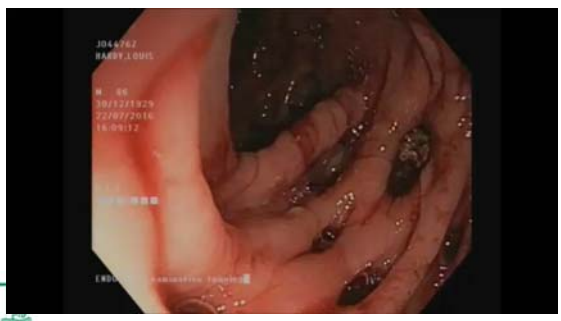
Video 2



QUESTION 3

WHAT DO YOU DO ?

A. Local endoscopic treatment

B. Conventional angiography with embolization

C. Surgical resection of diverticular colonic segment

D. Wait and see since diverticular bleeding usually stops spontaneously in 75% of the cases

Video 3

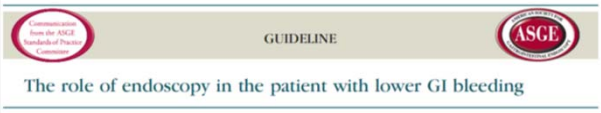
Rectal bleeding

- ASGE guidelines on LGIB

www.asge.org/publications

Rectal bleeding

- ASGE guidelines on LGIB



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Treatment algorithm

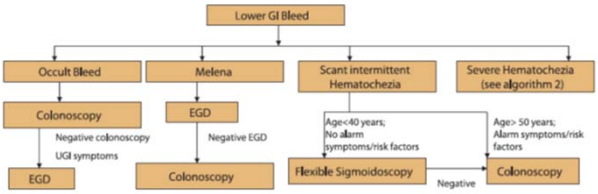

Figure 1. Management of LGIB.

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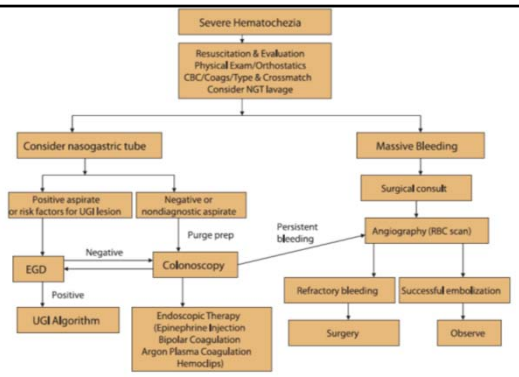

Figure 2. Management of severe hematochezia.

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LGIB

- Endoscopic therapy of diverticular bleeding
  - Preferred method of choice
  - Early rebleeding is uncommon after endoscopic hemostasis (early rebleeding after angiography 22%)
  - Late rebleeding (>30 days) in 18-22%
- Endoscopic techniques
  - Thermal contact bipolar coagulation
    - Bicap 10-16W 2-3s pulse applications mild contact
    - perforation risk of 2.5% (no Argon Plasma Coagulation)
  - Epinephrine (1:10 000) injection
  - Hemoclips at diverticulum base or on inverted diverticulum
  - (Rubber band ligation / Hemospray / Ovesco Clip)
  - Tattoo or hemoclip for future colonoscopy or angiography

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LGIB

- Nonendoscopic therapy of LGIB
  - When endoscopic treatment fails
  - When patient is too unstable to undergo preparation and/or colonoscopy
  - (CT angiography to guide conventional angiography)
  - Angiography with embolization
    ischemia / perforation / stricture / impaired renal function
    early rebleeding
  - Surgery

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♂ 86 years

- Patient was released on day 4
  - Hb 8.4 g/dl
  - 2 UPC transfusion
  - Arterial diverticular bleeding in the right colon
  - No further rectal bleeding after therapeutic colonoscopy on day 2
  - Colonoscopy with bowel preparation is the preferred method of choice to treat diverticular bleeding

♂ 86 years