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Endoscopic haemostasis

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Endoscopic haemostasis should be attempted as the initial approach in most cases of gastrointestinal (GI) bleeding, although cross-disciplinary collaboration is a prerequisite. For variceal bleeding, band ligation is the method of choice in the elective setting, although injection therapy still has a role in acute bleeding. Histoacryl remains preferable for fundic varices in most parts of the world. For peptic ulcer bleeds, injection therapy should be combined with at least one 'mechanical' modality, thermal treatment or clipping. In rebleeding, a single endoscopic retreatment can be attempted, but alternative approaches must be considered. Acute lower GI bleeding is primarily a diagnostic challenge but, if the focus is found, the regular techniques for haemostasis can usually be applied. If small bowel haemorrhage is suspected after upper and lower endoscopy, capsule endoscopy and balloon enteroscopy offer make it possible to address even small bowel foci.

Key words: angiectasias; argon plasma coagulation (APC); coagulation; diverticulosis; endoscopic haemostasis; endoscopic ligation; endoscopy; hemoclips; injection therapy; proton pump inhibitor; recurrent bleeding; ulcer bleeding; ulcer; varices.

INTRODUCTION

Acute gastrointestinal (GI) haemorrhage is among the most urgent and dramatic, yet potentially most rewarding, situations for which endoscopic diagnosis and treatment has a role. Improving endoscopic equipment, better accessories and – probably – increasing operator competence, allow endoscopic handling of a large number of GI bleeds. It is, however, important to acknowledge the partial role of endoscopy in acute upper GI bleeding. General care, pharmacotherapy, endoscopy, surgery, and radiological service with selective embolization all address the specific critical needs that these patients can present, and a multidisciplinary panel of expertise is required to offer the optimal treatment. This important message needs to be remembered; the rest of this

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chapter focuses on the endoscopic options available. The chapter is split into the main areas of: variceal bleeding, nonvariceal upper GI bleeding and acute lower GI bleeding.

TIMING OF ENDOSCOPY

Along with initial resuscitation and monitoring, endoscopy plays an important role in the early handling of a patient with an acute GI haemorrhage. The endoscopy is partly triage, to determine the subsequent level of care (outpatient, general ward, intensive care); partly a precise diagnosis; and partly endoscopic therapy. All are all vital elements in the initial endoscopy, and are usually integrated in a single endoscopic procedure. Based on endoscopic findings and results of the therapy, the subsequent handling can be planned precisely, and the prognosis more accurately conveyed to the patient and the subsequent caretakers.

The timing of the initial endoscopy has been debated. In general, red haematemesis or severe haematochezia indicates emergency endoscopy, whereas black haematemesis and/or melena without hemodynamic instability can wait until normal working hours. However, from a logistic point of view, a more liberal use of early endoscopy has been advocated to ensure optimal utilization of resources, as, for example, a normal upper endoscopy – or the finding of a clean ulcer base – in a stable patient can justify prompt discharge. This type of early triage requires access to prompt endoscopy around the clock, but can easily be economically justifiable, as well as providing an excellent service to the patient. Lee et al¹ were able to demonstrate that a strict algorithm, with discharge of the patient based on low-risk endoscopic stigmata in ulcer bleeding, was associated with a significant lowering of hospital cost, without any adverse events occurring in the discharged patients. Similar triage studies have not been performed for variceal bleeding, but the endoscopic appearance will definitely help guide further measures in such patients as well. Even if discharge is not always the best option, triage results might help choose the correct level of care within the hospital.

VARICEAL BLEEDING

Variceal bleeding remains among the most dramatic indications for acute endoscopy. The mortality in this situation is still high, although probably declining.² Six-week mortality has reportedly been reduced from 40% to 15%, although case selection has a major impact on such numbers. Spontaneous haemostasis can occur, but rebleeding is seen in about 60% of untreated cases within 7–10 days.^{3,4} Failure to control rebleeding appears to be the major determinant of haemorrhage-related mortality, although the underlying liver disease also remains a crucial factor (Table 1). Either way, active treatment of primary and recurrent bleeding from ruptured varices is definitely warranted.

Screening and primary prophylaxis

Effective prophylactic treatment to prevent variceal bleeding exists for patients with oesophageal varices.⁵ As there are no valid noninvasive methods to determine the development of varices in patients with cirrhosis, screening of all patients with verified liver cirrhosis has been recommended.^{6,7} The optimal surveillance intervals for oesophageal varices have not been determined. For patients found to have no varices on initial screening endoscopy, repeat endoscopy at 3-year intervals has been suggested; patients with small varices should undergo endoscopy within 1–2 years.⁸

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