

The Approach to Occult Gastrointestinal Bleed



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KEYWORDS

- Occult gastrointestinal bleeding • Obscure gastrointestinal bleeding
- Small bowel bleeding

KEY POINTS

- Occult bleeding is not visible and may present with positive fecal occult blood test or iron deficiency anemia.
- Obscure bleeding can be overt or occult, with no source identified despite diagnostic workup.
- The small bowel has been identified as the cause of obscure gastrointestinal bleeding in most patients.
- Video capsule endoscopy should be considered first for small bowel investigation followed by any form of deep enteroscopy when endoscopic evaluation or therapy is required.

INTRODUCTION

Gastrointestinal (GI) bleeding encompasses all bleeding that occurs in the GI tract, which extends from the mouth to the large bowel.¹ The different types of GI bleeding are classified based on their clinical presentation as overt, obscure, or occult.² *Overt GI bleeding* is visible clinically and used to describe hematemesis, hematochezia, or melena.² *Obscure GI bleeding* refers to recurrent bleeding for which no source is identified on multiple diagnostic modalities including upper endoscopy, colonoscopy, or small bowel radiography.² Obscure GI bleeding can either be classified as overt or occult, based on clinical presentation.²⁻⁶ *Occult GI bleeding* is bleeding that is not visible to the patient or the physician. It is detected by either a positive fecal occult blood test (FOBT), or iron deficiency anemia with or without a positive FOBT.^{2,5} Before the introduction of video capsule endoscopy (VCE), the term obscure GI bleeding was used and this could be overt or occult.³⁻⁵ Occult obscure bleeding were classified on the presence of iron deficiency anemia with or without a positive FOBT.⁴

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Recent guidelines have proposed an update in the terminology used to describe small intestinal bleeding.⁴ The proposed changes suggest that the term *occult small bowel bleeding* be reserved for patients presenting with iron deficiency anemia with or without guaiac-positive stools who are found to have a small bowel source of bleeding.⁴ The reason for the suggested change is that, given the advances in small bowel imaging, the majority of these patients (75%) have been found to have a small bowel source.⁴

Given the high incidence and the elusiveness of the diagnosis, occult GI bleeding has been associated with an increase in resource use, including prolonged hospitalizations and procedures.³ Effectiveness in the treatment of occult GI bleeding can be defined as the ability to diagnose, reduce, or stop GI bleeding. It can also be measured by the impact on overall life expectancy to the individual, or the impact to health-related quality of life.⁶ The least costly approach to evaluating occult GI bleeding remains uncertain.³

The concept of cost effectiveness in health care was introduced in the 1970s to help physicians determine optimal therapies for their patients.^{7,8} The question raised is whether the use of a new technology or medication is favored if it is more cost effective.⁶ In this review, the diagnostic modalities available to aid in the diagnosis and treatment of occult intestinal bleeding will be discussed to provide clinicians with an evidence-based and cost-effective approach to care.

ETIOLOGY AND PATHOPHYSIOLOGY

The prevalence of small bowel bleeding is approximately 5% to 10% of patients presenting with GI bleeding.^{1,4,9} About 10% to 20% of patients presenting with GI bleeding have an unclear etiology despite a full workup, and are considered to be obscure bleeds.^{1,4,5,9} Given that most occult GI bleeding is from the small intestine, we focus on causes of bleeding originating from the small intestine. Small bowel bleeding is defined as bleeding that occurs from the region between the ligament of Treitz and ileocecal valve.⁹ Causes of small bowel bleeding can be divided as common or uncommon, further dividing common causes by age. **Table 1** lists common etiologies of small intestinal bleeding.

The most common lesions responsible for small bowel bleeding are vascular, with other causes being benign tumors, inflammatory lesions, and medications.⁹ Other rare causes include hemophilia, haemosuccus pancreaticus, and aortoenteric fistula.⁹

- Angiodysplasia (angioectasia or vascular ectasia) are abnormally dilated, tortuous, thin-walled vessels, involving capillaries, veins, and arteries. They are visualized within the mucosal and submucosal layers of the gut. They are lined by endothelium with little or no smooth muscle, and lack inflammatory or fibrotic changes.⁹ They are the most common cause of small bowel bleeds, particularly in patients older than 40 years of age.^{4,9}
- Telangiectasias are different than angiodysplasias because, in addition to involving the GI tract mucosa, they usually have cutaneous and mucous membrane involvement. They lack capillaries and consist of direct connections between arteries and veins and they have excessive layers of smooth muscle without elastic fibers.⁹
- Dieulafoy's lesion is a rare cause of GI bleeding and is usually located in the stomach but can be located in the small intestine.^{9,10} These lesions are purely arterial and do not exhibit similarities with arteriovenous malformations or varicose vessels.¹⁰

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