

# Colonoscopy in Acute Lower Gastrointestinal Bleeding

## Diagnosis, Timing, and Bowel Preparation



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### KEYWORDS

- Bowel preparation • Hemorrhage • Length of stay • Review • Hematochezia
- Nuclear scintigraphy • CT angiography

### KEY POINTS

- Urgent upper endoscopy should be the initial test in a patient with hemodynamically unstable hematochezia or if the source cannot be localized to the lower gastrointestinal tract.
- Colonoscopy after rapid colon purge should be the initial diagnostic and therapeutic modality used in patients with suspected acute lower gastrointestinal bleeding.
- Early colonoscopy is safe, has the potential to diagnose and treat nearly any lesion causing lower gastrointestinal bleeding, and may decrease the duration of stay.
- More research is needed to determine the true effect of early colonoscopy on clinically meaningful outcomes in patients presenting with lower gastrointestinal bleeding.

### INTRODUCTION

Acute lower gastrointestinal (GI) bleeding (LGIB) is a common cause of hospitalization, and frequently leads to morbidity in the United States and worldwide.<sup>1</sup> Although the mortality rate is generally low (<5%), advanced age, intestinal ischemia, and comorbid illness portend a higher risk of death.<sup>2</sup> In the United States, the incidence of LGIB ranges from 20.5 to 27 per 100,000 persons per year with a greater than 200-fold increase from the third to the ninth decades of life.<sup>1</sup> The increasing incidence with age may be related to comorbid disease and associated polypharmacy, including the increasing use of aspirin, nonsteroidal antiinflammatory drugs, and anticoagulants.<sup>3</sup>

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Disclosures: A.K. Shergill is the recipient of a Pentax research gift for ergonomics.

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Gastrointest Endoscopy Clin N Am 28 (2018) 379–390

<https://doi.org/10.1016/j.giec.2018.02.009>

1052-5157/18/Published by Elsevier Inc.

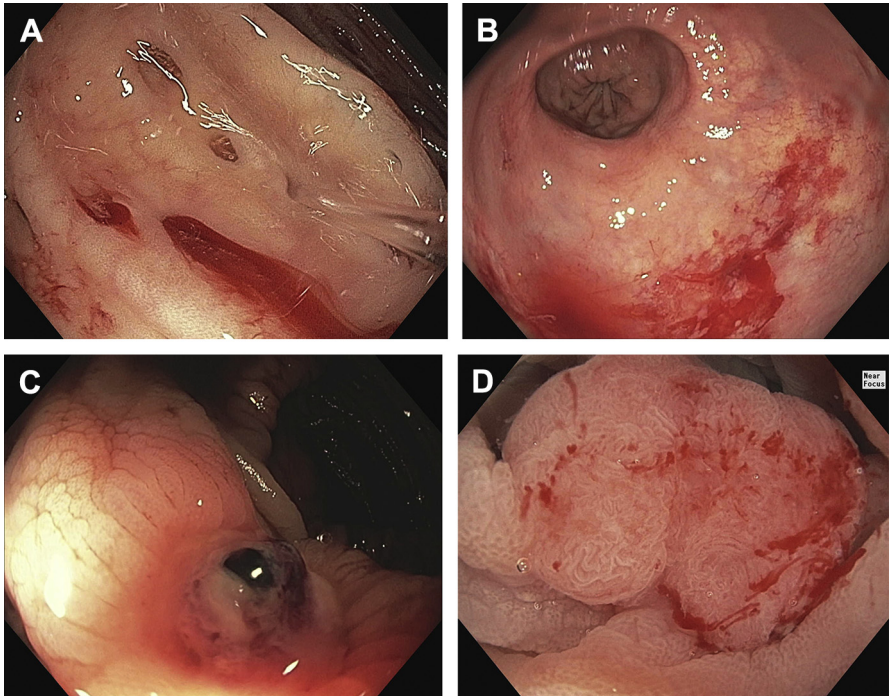
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In addition, GI-specific illnesses prevalent in the elderly may predispose to LGIB, such as diverticulosis, arteriovenous malformation, and colonic neoplasm.<sup>4</sup> Clinical features associated with a worse outcome in LGIB include hemodynamic instability at presentation, comorbid illnesses, age greater than 60 years, a history of diverticulosis or angiodysplasia, an elevated creatinine, and anemia (initial hematocrit of  $\leq 35\%$ ) on presentation.<sup>5</sup> Presentation ranges from a small amount of rectal bleeding to episodes of massive hematochezia with passage of blood clots.

Many aspects regarding the care of patients experiencing LGIB are extrapolated from upper GI bleeding (UGIB) guidelines, such as blood transfusion strategies.<sup>6</sup> However, there is a small but growing body of literature to guide the care of these patients, particularly regarding the role of colonoscopy. Colonoscopy is considered the initial test of choice for most patients presenting with LGIB given its diagnostic capabilities, therapeutic potential, and relative safety,<sup>5</sup> although optimal timing is not well-defined in the literature. This review examines the role of colonoscopy in the diagnosis of acute LGIB, including the timing of colonoscopy and recommendations for colon preparation in the setting of acute LGIB.

## DIAGNOSIS

The most common causes of acute LGIB include diverticulosis, ischemia, hemorrhoids, neoplasm, angiodysplasias, postpolypectomy bleeding, inflammatory bowel disease, and infectious colitis (**Fig. 1**). Less common causes include stercoral ulcer, colorectal varices, radiation proctitis, nonsteroidal antiinflammatory drug-induced



**Fig. 1.** Findings on colonoscopy. (A) Active diverticular hemorrhage. (B) Bleeding arteriovenous malformation. (C) Postpolypectomy ulcer with visible vessel. (D) Bleeding colonic polyp.

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