The Role of Endoscopic Hemostasis Therapy in Acute Lower Gastrointestinal Hemorrhage

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KEYWORDS

• Lower gastrointestinal bleeding • Endoscopic hemostasis • Endoscopic therapy • Endoscopic clipping • Diverticulosis

KEY POINTS

- The authors stratify lower gastrointestinal bleeding (LGIB) patients with an on-going bright red blood per rectum, hemodynamic instability, syncope, history of aspirin or anticoagulant use, and/or 2 or more comorbidities but with nontender abdominal examination to have severe bleeding, then proceed with rapid bowel purge for urgent colonoscopy.
- The authors perform urgent colonoscopy after (1) the patient has been hemodynamically resuscitated, is clinically stable, and has completed a rapid bowel purge; and (2) the appropriate resources and equipment are made available at the bedside (scopes and accessories); and (3) an endoscopist with experience and skill in the treatment of LGIB is present at the bedside.
- The authors treat diverticular bleeding using endoscopic clipping directly when bleeding is from the neck of the diverticulum; using clipping or band ligation from within a cap when bleeding is from the dome; or, more recently, using the over-the-scope clip for bleeding from anywhere in a diverticulum.

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There comes a time to every life when the past recedes and the future opens.
It's that moment when you turn to face the unknown.
Some will turn back to what they already know.
Some will walk straight ahead into uncertainty.
I can't tell you which one is right. But, I can tell you which one is more fun.
Philip H. Knight (1938–)

INTRODUCTION

The authors began to incorporate endoscopic hemostasis to treat acute lower gastrointestinal bleeding (LGIB) into their practice in the late 1990s out of necessity. Patients with acute LGIB were predominantly elderly with significant morbidity and mortality. Interventional radiology and surgery pose high risk for morbidity and mortality.[1] At that time, the authors turned their faces to the unknown and walked straight into the uncertainty. The authors made emergency colonoscopy service available, and worked diligently to make it safe and effective by applying and adapting our therapeutic endoscopy knowledge to treat severe LGIB. As soon as they showed the potentials of endoscopy, which happened relatively quickly, their endoscopy service became the de facto primary diagnostic and therapeutic modality for acute LGIB. Along the way, they collected their experiences and shared them widely.[1–7]

Outcome data pertaining to the efficacy of endoscopic treatment in patients with LGIB is heterogeneous and sparse, although there is a growing recent literature, especially from our Japanese colleagues. Thus, the guidelines to manage patients with LGIB have been difficult to develop and are not yet robust.[8] Herein, based on available literature and the authors' 20-year experience, they summarized the role of endoscopic hemostasis therapy in acute severe LGIB with a focus on how to perform the hemostasis techniques.

DEFINITION AND CLASSIFICATION

LGIB is traditionally defined as bleeding that originates from a source distal to the ligament of Treitz to the anus. More recently, however, the definition has been changed to refer to bleeding originating between the ileocecal valve and the anus. Bleeding from a source between the ligament of Treitz and the ileocecal valve is defined as middle gastrointestinal (GI) bleeding.[9]

Patients with severe upper GI bleeding may be thought to have acute severe LGIB. In select cases with clinical presentation or risk factors for upper GI bleeding, placement of a nasogastric tube for aspiration of gastric and duodenal contents can be very useful. When the authors aspirate blood (old or fresh), they classify patients as having upper GI bleeding and, thus, pursue an emergency upper endoscopy. When they aspirate bile, the authors classify patients as having LGIB and proceed with preparation for colonoscopy.[10] In cases in which a colonic source of bleeding is not identified, they intubate the terminal ileum (**Fig. 1**) and, if still unrevealing, perform an upper endoscopy immediately. In essence, the possibility of an upper or a middle GI source is always considered in the management of acute severe LGIB, until a colonic source has been identified.

The stratification of the severity of LGIB is important to identify patients who may benefit from an urgent colonoscopy. In contrast to the Blatchford score,[11] which is used to stratify patients presenting with acute upper GI bleeding and aids in assessment to target high-risk patients who may benefit most from an emergency endoscopy, a well-validated scoring system to stratify patients with LGIB has not yet

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