Risk Factors Traced for Postpolypectomy Bleeding

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WASHINGTON — Large polyp size and the use of anticoagulants raised the risk of delayed postpolypectomy hemorrhage, but aspirin and a history of hypertension did not, according to a study presented at the annual Digestive Disease Week.

The results stand in contrast to studies finding that hypertension, polyp location, and sessile (as opposed to pedunculated) polyps were risk factors for delayed bleeding, wrote Dr. Nadim Salfiti and associates at the University of Minnesota, Minneapolis.

In the case-control, retrospective chart review, the researchers analyzed 41 cases of postpolypectomy bleeding and 132 control cases at the Minneapolis VA Medical Center in 1999-2006. Mean age of the 41 case patients was 64 years, all were male, and most were white. Inclusion criteria for cases were delayed hematochezia occurring 6 hours to 14 days after polyp resection, and one of the following: hospital admission, blood transfusion, drop in hemoglobin of more than 1 g/dL, or repeat colonoscopy.

The mean polyp size was 10.5 mm for cases and 6.7 mm for controls, a significant difference; 37% of cases and 11% of controls had a polyp size greater than 1 cm. Heparin or warfarin were used within 1 week after polypectomy in 34% of the patients with hemorrhage, a rate significantly higher than the 9% rate among controls.

At least one dose of aspirin was administered to roughly 40% of both cases and controls within the time period from 1 week before to 1 week after polypectomy, and slightly more than 60% of both cases and controls were hypertensive. Diabetes and lung disease were moderately significant risk factors, and coronary artery disease was present in 59% of cases and 32% of controls, a significant difference.

"This is the first study evaluating the risk of [using] anticoagulant medications after polypectomy," Dr. Salfiti noted in an interview. "These results …provide some information that could facilitate the decision regarding the timing of resuming anticoagulation."

Dr. Salfiti cautioned, however, that "each patient should be evaluated individually, and the risks of postpolypectomy bleeding versus the risk of some form of thromboembolic event in the short-term need to be assessed to decide how long anticoagulation should be delayed, if at all." ■

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Those with complicated diverticulitis and an abscess requiring percutaneous drainage should be advised to undergo colectomy because severe recurrent sepsis occurs in 41% of such patients.

Urgent sigmoid colectomy is necessary in patients with diffuse peritonitis and those who fail nonsurgical management for acute diverticulitis.

After resolution of an initial episode of acute diverticulitis, colonoscopy or contrast enema x-ray should be performed to confirm the diagnosis and to exclude other diagnoses, primarily cancer, ischemia, and inflammatory bowel disease.

Long-term fiber supplementation after an initial attack of acute diverticulitis may prevent recurrence in more than 70% of patients for at least 5 years.

Whether to recommend elective sigmoid colectomy after recovery from an acute episode of acute diverticulitis should be an individual decision. Roughly one-third of patients with an initial attack will have a second; after a second attack, a further one-third will have another attack. Patients who have a severe initial attack, especially if treated nonoperatively, and those in whom carcinoma cannot be excluded have stronger indications for elective colectomy.

Laparoscopic colectomy is appropriate in selected patients with diverticular disease; in experienced hands, it carries no increased risk of complications or cost. Pain and recovery time are potentially less with laparoscopic colectomy than with open laparotomy. ■

Reference

J. Rafferty, P. Shellito, N.H. Hyman, W.D. Buie, and the Standards Committee of the American Society of Colon and Rectal Surgeons. Practice parameters for sigmoid diverticulitis. Dis. Colon Rectum 2006;49:939-44.