Colonoscopy on Rise for Acute Lower GI Bleeding

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SEATTLE — Colonoscopy for the evaluation of acute lower gastrointestinal bleeding has several potential advantages and may be growing in popularity, Dr. Charles Whitlow said at the annual meeting of the American Society of Colon and Rectal Surgeons.

The burgeoning literature indicates that colonoscopy makes a successful diagnosis 80%-90% of the time and that a bleeding source amenable to colonoscopic intervention is identified about 10%-15% of the time, said Dr. Whitlow of the colon and rectal surgery department at the Ochsner Clinic Foundation, New Orleans.

"There's some opportunity for us to rethink the role of colonoscopy in acute lower GI bleeding pretty much at every step of the way in the algorithm," he said.

In the time it takes for a nuclear medicine specialist to see a patient with acute bleeding and do scintigraphy and/or angiography, the patient can be readied for colonoscopy with a rapid purge. And if the source of the bleeding is found, it can be treated immediately, thereby reducing hospital costs, he added.

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Guidelines are evolving to suggest the merits of colonoscopy for these evaluations, but Dr. Whitlow said he had little experience with using it until Hurricane Katrina hit New Orleans, disrupting medical supplies and preventing his clinic from obtaining radioactive tracer for nuclear medicine studies.

The bowel preparation for colonoscopy for an acute bleed can be done in 3-4 hours.

Because the procedure may have to be done at an unusual location, however, it is important to have all the routine tools at hand before starting, including those needed for irrigation and suction.

If a fresh clot is found, it may be advisable to remove the clot to see what is underneath, Dr. Whitlow said. He recommended the use of a submucosal epinephrine injection around the clot for safety before the removal, which can be done with a snare.

Diverticula or vascular ectasias and malformations, the most common sources of lower GI bleeds, reportedly occur at 30%-40% of identified bleeds.

For bleeding diverticula, treatment modalities include epinephrine injection followed by electrocautery, hemostatic clips, and more recently, band ligation.

Dr. Whitlow commented that he does not recommend using band ligation, even though it is highly successful in the upper GI tract, because a recent ex vivo study of its use in the colon found that specimens that were removed appeared to show evidence of injury, including serous membrane thickening.

The advantage of using the clips is that they can be seen with radiography and found again, he noted.

Rebleeding rates appear to be about the same—anywhere from 0% to 30%—for the different techniques.

For vascular malformations, the three commonly used techniques are epinephrine injection, contact thermal coagulation, and argon plasma coagulation.

The technical consideration in treating these lesions is that one should start at the periphery, with the feeder vessels, and then work in toward the center of the lesion, Dr. Whitlow said.

For radiation proctitis, plasma argon coagulation has recently become the preferred method of treatment. But because multiple procedures are needed, some surgeons have done only a colonic irrigation rather than a complete bowel preparation, and there have been three reports of colonic explosions, Dr. Whitlow noted.

Of the other possible indications for intervention, postpolypectomy bleeding is sometimes just left alone, depending on severity.

Bleeding related to colon cancer has been treated with a laser, but few reports have appeared in the literature.

More experience is needed to identify the scenarios in which colonoscopy is most advantageous relative to other approaches, Dr. Whitlow said. ■