Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting: https://reachmd.com/programs/cme/severe-gastrointestinal-bleeding-who-needs-reversal-or-repletion-for-upper-gi-and-lower-gi-bleeding/16237/

Released: 10/09/2023
Valid until: 10/09/2024
Time needed to complete: 45m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Severe Gastrointestinal Bleeding: Who Needs Reversal Or Repletion For Upper GI And Lower GI Bleeding?

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Gibler:
Our next speaker is a gastroenterologist, and Vinay, we will also appreciate you making it for this meeting. Dr. Sehgal is a Consultant Gastroenterologist and Interventional Endoscopist. And this is obviously a very, very important topic for emergency physicians. So, please.

Dr. Sehgal:
Good afternoon. And thank you, Professor Gibler and the faculty at EMCREG for the invitation to speak with you this afternoon. So I'm Vinay Sehgal, I'm a Consultant Gastroenterologist and have a specialist interest in Interventional Endoscopy including hemostasis.

So why is this relevant to us as gastroenterologists? Well, this figure quite clearly depicts that the prescription of DOACs has increased significantly, and will continue to do so. And what's highly relevant for us as a community is that the main bleeding side effect is in the gastrointestinal tract. So as gastroenterologists, we will be seeing more of these patients, will be more exposed to these patients, and as a consequence, so will you in the emergency department.

Now, what are the things that you can do at the front door to help identify an increasing cohort of patients however, the ones which are at increased risk? So you're probably familiar with some of these scoring systems already, but I'll just discuss them with you because they do form the premise of care bundles, which we've discussed in the intracranial hemorrhage, but there are also similar ones for gastrointestinal bleeding. So the Glasgow Blatchford score is probably one of the more popular scoring systems which is used at the front door. And its most important tool actually isn't helping define patients who can be safely ambulated and discharged. But we know that a score of more than 6 can predict mortality, and it can be helpful to help you pick out those high-risk patients. The other score which has been around a lot longer is the Rockall scoring system. This actually is a composite score, so by that I mean it requires a score before the patient has their endoscopy and a score after, and its primary utility is in predicting mortality. However, we know that if you correlate the score pre-endoscopy, you can actually also help predict mortality. And both of these scores have formed part of the BSG, or the British Society of Gastroenterology guidelines care bundles, which should be used at the front door.

Fortunately, lower GI bleeding is less common than upper GI bleeding. So just a reminder, anything that is proximal to the ligament of Treitz, or between D3 and D4 is upper GI. Anything distal to that is lower GI. Most of these patients are stable, but you will experience a cohort of patients that are less stable. We recommend using a simple shock index at the front door and including something called the Oakland score, which can help define those patients who are at higher risk. Usually speaking, these are patients that will go on to have a CT angiogram, which does not require bowel preparation. And in parallel, if there is extravasation of contrast seen, the interventional radiologists can hopefully deal with that by embolization. If there's any uncertainty and the patient is stable, they usually will be admitted,

have bowel preparation, followed by a colonoscopy. The important thing I've noticed in my practice is that these patients are now seldom managed by lower GI surgeons. When I first qualified, a lot of these patients historically went to the surgical take. But now they're kind of more streamlined into gastroenterology.

So this is a busy slide. But really, it's an example of the protocol that we've put together at my local institution at University College. And I've highlighted 2 boxes here. And these are the 2 things that I think those in the emergency department need to be aware of, and in when and whom to decide reversal of anticoagulation. So we've done a lot of work on this. And I've actually sat on a Delphi Consensus Committee and also was at a meeting last week for 8 hours to help decide which are the right patients. So it's not easy. That's the first thing. But what we've come up with is that those patients that have ongoing hematemesis, and by that, I mean vomiting bright red blood, not coffee-ground vomit, which is often misinterpreted in my experience, and melena is less significant, usually. So hematemesis is one problem. Patients that do not respond to immediate resuscitation at the front door. So ongoing hemodynamic instability, which may make you wonder whether the patient requires a higher level of care. And also those patients with a history of portal hypertension or known viruses. So those are the 3 kind of groups of patients that we think are at higher risk of coming to harm from an uncontrolled GI hemorrhage. And those who meet the criteria regarding administration and timing of drug, should be considered for reversal. And the next bit just goes through how to actually administer the drug.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC), EMCREG-International, and TotalCME, LLC. and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.