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Who Needs Reversal or Repletion for UGI and LGI Bleeding: Case Presentation

Announcer:

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Dr. Sehgal:

So let's use this opportunity then to discuss a case that I think is typical of what represents day-to-day practice and seeing when we should and when we shouldn't reverse anticoagulation. I think the important thing to bear in mind here is you've heard 2 talks about intracranial hemorrhage. I think timing is far more important in intracranial hemorrhage compared to into the GI tract where you have an open compartment composed to a very, very close compartment. So we can be a little bit more relaxed in timing as gastroenterologists compared to your stroke physicians.

So this is a 47-year-old gentleman who is referred to the medical take with a 3-day history of abdominal discomfort and a more recent history of dark stool. He is on apixaban for a provoked DVT. These are his clinical observations. So, I would say he has a borderline tachycardia. He is however normotensive. He's described as being warm and well perfused. And his abdomen was soft, no specific tenderness, and there is dark stool on the glove, which is probably suggestive of melena. If we look at his biochemistry quickly, the headline points are, he has a hemoglobin of 115 g/dL, and his urea is disproportionately elevated to his creatinine. It usually goes in a 1 to 10 fashion. So I think most of us in the room would agree that this gentleman is having an upper GI bleed.

So the first thing you do is what you do for all of these patients, regardless of whether they are in a DOAC or not. So you keep your patient nil by mouth or give them nothing to eat or drink, you get some IV access established, you want to resuscitate them usually with a crystalloid. There's no strong data on intravenous PPIs; however, I can't remember the last time I saw a patient with a GI bleed that was not on IV PPI by the time I got to them, but there is no strong data on mortality anyway. This patient probably doesn't require blood transfusion at this threshold, and you want to regularly reassess to make sure the measures that you've put in place at the start are working.

These are just some local transfusion protocols that we have. So we tend to aim for a target hemoglobin of more than 70. There's now Level 1 randomized data to show that a restrictive transfusion strategy confers better outcomes compared to a liberal transfusion strategy. We tend to hold platelets in patients unless they are bleeding and have a platelet count of less than 50. And then you can consider giving alternative products as needed based upon the situation.

So if we come back to this gentleman's case, these are the things that I would look at if I was deciding about endoscopy and reversal of anticoagulation. So he's normotensive, he's got melena only, and his hemoglobin is 115. So in this case, I think this is an example in someone who probably does not require reversal of anticoagulation, and standard medical measures, provided that they are working, should be adopted.

However, if we change the case slightly in the similar kind of demographic and presentation, however, the big difference here is that he now is also having persistent hematemesis in addition to melena. He is now tachycardic, he's hypotensive, he is shocked essentially, is

what the clinical examination is describing. His hemoglobin is less than 80. And his urea is again elevated compared to his creatinine. So this is someone that's potentially unstable. And I would argue that once the measures that we've put in place have been put in order, and if they're not working, this is someone that you may want to consider providing reversal of anticoagulation. And this would be a more suitable case than the earlier one that I presented.

And this is really based upon the ANNEXA-4 study, which was a study looking at whether if we gave andexanet alfa in patients with significant GI hemorrhage, we know that 85% of patients in this study had good or excellent hemostatic efficacy as judged by an independent panel.

This is the bit where I get involved, endoscopy. So there's lots of different things that we can use. Essentially, endoscopic therapy is divided into injection-based therapy with epinephrine or adrenaline. Or we can use mechanical therapy based upon diathermy or mechanical pressure with a clip. What you're seeing here, probably most people are kind of the eyes coming down to the video in the bottom, the middle there, that's an arterial bleed in the second part of the duodenum. This is a novel over-the-scope clip which we can use to apply sort of tamponade to this area. So if you keep watching the video, you'll see that the clip is deployed and the bleeding settles down. And what's really important here is you need to get your patient stabilized and resuscitated before we can do all these measures, because if the tap is still wide open and you haven't slowed down the bleed, it can be very difficult to visualize that bleeding, and it can therefore make any attempt to endoscopic therapy more difficult. And that can be sometimes a message that needs to be transferred to the acute team or the emergency team about timing.

So just to summarize, resuscitation remains the cornerstone of emergency therapy for patients with GI bleeding. Fortunately for us as gastroenterologists, the vast majority respond to medical therapy, and we can stay in bed till the morning. All patients should have an endoscopy within 24 hours, but do consider andexanet alfa for those life-threatening, unstable cases, which I hope I've done a good job of describing for you and your clinical practice. Thank you.

Dr. Gibler:

Panel, what do you think?

Dr. Jarhult:

Well, if I have a patient who's vomiting bright red blood in front of me, it's urgent to me. Considering the timing, when would be a good sort of, what's the timeframe for early, late endoscopy?

Dr. Sehgal:

Yeah, so we know that all patients, all-comers, should have an endoscopy within 24 hours. There's good data on that. There was a randomized study that was done looking to answer your specific question about whether early versus super early endoscopy, which was an 8-hour cut off. So if we intervened within 8 hours of presentation, that did not show an improvement in mortality compared to after 8 hours, which is why most gastroenterologists would say resuscitate your patients, stabilize them, put an airway tube down, get them to intensive care or theatres, and then do that. And usually those are reserved for patients with portal hypertension or viruses that don't settle down. But you want to slow down that tap, and you want to stabilize the patient, and then get them to an endoscopy suite. And often that is enough for patients.

And however, if you have an unstable patient that's not responding to those measures, yes, we will have to come in and do that case there and then essentially. But not for everyone is what I'm saying.

Dr. Mockel:

I have an add-on question on that with regard to decision-making. You described you're standing in front of this patient vomiting blood, so who's responsible for decision making? The ED physician in front saying, 'Okay, this is severe, and I'll come in immediately,' or you at the telephone at home at nighttime and say, 'Okay, delayed is also okay,' so who is responsible for decision-making?

Dr. Sehgal:

It's always a contentious issue. Essentially, I would say that it's a joint decision-making process. And actually, often your emergency division will call and say, 'Look, I've tried this, it's not working,' and actually, then you will come in, and you will go in and do that case, provided it's done in a safe environment. That's the key thing.

And if you go in too early, I can tell you from experience, you are not able to see anything but blood. And actually, you've then done an invasive procedure in someone that's critically unwell. And actually, you've not very good got much further and often they go to the radiology suite afterwards.

So there is something about finding that sweet spot in terms of timing of endoscopy. And that's often a joint decision-making process.

Dr. Gibler:

How about hematology? Do you have them as part of your team? We were discussing that as well. And just trying to figure out, you know, is that the team of the future that, in some way, shape, or form has a clotting expert as part of it? Or, I know that won't happen in smaller hospitals, but certainly, larger hospitals, that's a potential.

Dr. Sehgal:

To be honest with you, my experience of hematologists in life-threatening GI bleeding is they don't really want to be involved. They almost want the gastroenterologists and the emergency physician to make the decision. And they say, if you're going to do endoscopy, then yes, give the drug as a bridge to endoscopic therapy. But often they believe that decision can be made independent of them. But the reality is, particularly with andexanet alfa, and I'm referencing the protocol that we've developed, is that it's a relatively new agent. There's a relative, sometimes uncertainty about who to give it and who not to give it, and I hope this addresses that slightly. And often, we've agreed that a hematologist at the beginning should be involved in facilitating that decision-making process, both that it's safe and effective. And also, there is a cost element to this. So we've included the hematologist in our decision-making tool. But I believe, with time, as we get more comfortable with these patients, we get more experience with the reversal agent, and we get more data from registries, they probably won't be as involved as they are at the moment.

Dr. Gible:

Thank you very much.

Announcer:

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