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Managing and Treating Patients with Lower GI Bleeding

Dr. Buch:
This is *GI Insights* on ReachMD, and I'm Dr. Peter Buch. Joining us today is Dr. David Wan to discuss an article he co-authored, titled "Management of Patients with Acute Lower Gastrointestinal Bleeding: An Updated ACG Guideline," which appeared in *The American Journal of Gastroenterology* in February of 2023. Dr. Wan is an Associate Professor of Medicine at New York-Presbyterian/Weill Cornell Medical Center.

Welcome to the program, Dr. Wan.

Dr. Wan:
Thank you so much. It's a pleasure to be here, Dr. Buch.

Dr. Buch:
Dr. Wan, let's dive right into your article. What subgroups of patients on vitamin K antagonists or direct oral anticoagulants should receive reversal agents? And what should those reversal agents be?

Dr. Wan:
Yeah, that's a great question. That's actually a very common scenario. As you know, many patients are on anticoagulants, such as warfarin. Nowadays, people are on Xarelto and on other medications like ELIQUIS, and so one has to look at the reason why one is taking the medication and how severe the bleeding is, and you have to weigh those two factors. So for instance, if someone is coming with a major GI bleed, they're losing a lot of blood, they're hypotensive, they're tachycardic, that has to be weighed against the bleeding, and so in general, you do stop most anticoagulation simply by holding it. And usually, by holding the warfarin or holding the ELIQUIS and Xarelto, that should be enough to stabilize the situation. But there are times when people are having a life-threatening bleed or their INR is excessively super therapeutic, so for instance, an INR that's way above assay, let's say roughly speaking, eight or higher. There's no absolute threshold, but in those particular scenarios, one has to be very aggressive about reversing their INR, and so they may need specific reversal agent depending on what antithrombotic they're on.

Dr. Buch:
And getting specifically into the reversal agents, does vitamin K have any role to play in this scenario?

Dr. Wan:
Yeah. Vitamin K is what one has traditionally used to reverse agents like warfarin due to more recent data. In fact, there was a guideline from the ACG and the CAG, which is the Canadian Association of Gastro, that shows that using things like four-factor PCC, which is a prothrombin complex concentrate that reverse agents more directly and quicker, even more so than things like FFP so because there are a few studies that show that they're more reliable, more consistent, and they're faster on onset, so nowadays, PCC is considered the first-line reversal agent.

Dr. Buch:
Thank you. So, Dr. Wan, when should we consider a CAT scan angiogram rather than a colonoscopy for acute lower GI bleeding?

Dr. Wan:
Yeah, I'm glad you brought that up. One of the recent changes to the guideline involves patients who could benefit from a CT angiography, and really, the patients that seem to benefit are those who present with severe hemodynamic unstable patients. So patients who are tachycardic, who are hypotensive, those patients may benefit from a CTA upfront. The idea is that the CTA is quick.

You can put someone through a CT scanner without needing to give them a bowel prep. Most ERs are certainly equipped to do a CT scan within minutes. And now it has to be a specific CT scan. It's CT angiography, meaning you don't give oral contrast; you just give purely IV contrast. But the thing with the CTA is that you have to be bleeding pretty briskly for it to be positive, a slow ooze may not be able to be picked up. They always say it's about .5 to one cubic centimeter per minute. And so those patients in theory, if you do a CTA, you can catch them really early on. Traditionally, we often would do a colonoscopy. And so the problem with colonoscopy is that you do have to prep the patient. And so if you want a quick analysis for a patient who's bleeding actively, CTA may be your best upfront diagnostic test.

Dr. Buch:
And, Dr. Wan, why would you do a CT angiogram rather than just do an angiogram and just get it done with?

Dr. Wan:
So an angiogram is a useful test if the CTA is positive. My interventional radiology colleagues often won't take a patient for conventional visceral angiography without a CTA to guide them. The idea is a CTA, if it's positive, really helps predict that the interventional radiologist will get to find the lesion and treat it. For someone who is unstable, it's not necessary to bring every patient into the IR suite for an angiogram is probably too much and low yield for them to really do so, so to increase their yield of success, CTA is very helpful. If it's negative, for instance, then the chance of finding something on a conventional angiography is exceedingly low, and so the yield becomes pretty much close to zero percent. So my IR colleagues will tell me that with a negative CTA, there's no point in bringing them to the IR suite.

Dr. Buch:
Thank you very much. Some of our colleagues may be thinking about the theme of colonoscopy. What are the risks and benefits of an early versus a later colonoscopy in these patients with heavy-duty, lower GI bleeding?

Dr. Wan:
Yeah, that's another major change in the guidelines that we updated in 2023 compared to 2016. In the prior iteration of the guidelines, there was a recommendation to do a rapid colonoscopy within 24 hours for majority of the patients, but looking at randomized controlled data and systematic reviews and meta-analyses, when you look at the RCTs and limit it to the RCTs, there really is no significant benefit seen for urgent colonoscopy that's been defined as doing it within 24 hours, in terms of rebleeding rates, mortality, need for IR intervention, hospital stay, the length of stay. So nowadays, we generally recommend a next available colonoscopy. You don't necessarily need to rapidly prep them, do them overnight in an emergent fashion because that doesn't seem to really alter outcomes in any clinical meaningful way.

Dr. Buch:
Thank you for that. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. David Wan about acute lower GI bleeding.

So, Dr. Wan, what are the warning signs that hematochezia is actually upper GI bleeding?

Dr. Wan:
Yeah. So based on one randomized controlled trial by Lauren Lane, et al., they found that 10 percent of all hematochezia or lower GI bleed is actually from a brisk upper GI bleed source. So it is important to not forget that upper GI bleeds can present as lower GI bleeds. So the clues are risk factors for upper GI bleeds, so if someone is cirrhotic, if someone has a history of peptic ulcer disease, if someone also is hypotensive or tachycardic. Usually, those brisk upper GI bleeds tend to be patients who are hemodynamically unstable. And so if you have a hemodynamically unstable patient with hematochezia, you always have to think about could this be peptic ulcer disease or some other upper GI bleeding etiology?

Another clue sometimes is to look at the BUN to creatinine ratio. So if that ratio is greater than 30, it suggests that there is an upper GI bleed source because when you have blood sitting in the upper GI tract in the stomach, let's say, and it makes its way through, there is some digestion of the proteinaceous blood products, and that is a nitrogenous BUN. The blood urea nitrogen will go up disproportionately high to their creatinine, so that is a clue again for upper GI bleed.

Dr. Buch:
Thank you for that. And lots of our colleagues are asking this question, when is it safe to resume antiplatelet and anticoagulants after bleeding?

Dr. Wan:
Yeah. So first, for antiplatelets, it may not be necessary to stop it in the first place, but if you do stop it, there are studies that show that

if you don't stop it fast and early enough, you do put your patients at risk for thromboembolic events, so as a rule of thumb, it's usually within five to seven days that you need to resume the aspirin. Basically, in my practice, I like to start before they leave the hospital. Some studies say that you could even start it the next day if you achieve hemostasis or the bleeding stops. So in general, most people want to resume the aspirin within three to five days, but you could start it as early as the next day if patients are at a significantly high risk for a thromboembolic event.

For the anticoagulation, things like warfarin, things like Eliquis, Xarelto, depending on the reason, if they have a higher risk of stroke and they have AFib, in general, you want to resume it within five to seven days as well.

But interestingly, when you look at the studies with aspirin and all those, there does not seem to be an increased risk of bleeding with resuming aspirin, and same thing for the anticoagulation. There may be a signal that there is an increased risk of bleeding, but it's not consistent. And certainly, there is a signal where if you don't start the anticoagulation, there is a significant risk for even mortality from a cardioembolic event.

Dr. Buch:
Thank you. We're almost at the end of our discussion. Are there any other thoughts you'd like to share with our audience today?

Dr. Wan:
Sure. One of the things that people don't realize is that lower GI bleed is actually very challenging and frustrating for those of us who are in the hospital managing these kind of conditions. We do have all these recommendations, but a lot of times the patients do very well despite what we do, and the patients will stop bleeding spontaneously over 80 percent of the time. As we discussed earlier, the intermittent nature of the bleed makes it often very hard to precisely localize the bleeding, so it's actually a very minority of the time where we actually find the specific lesion that bled. Unless you catch it in the act, you're really not going to be able to catch the bleeding, and so that goes for both your CT scans and actually the colonoscopies as well.

Dr. Buch:
Thank you. This has been a superb discussion on lower GI bleeding, and I want to thank my guest, Dr. David Wan, for joining us.

Dr. Wan, it's been a pleasure speaking with you today.

Dr. Wan:
Thanks, Dr. Buch. It's been a pleasure speaking with you as well.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit *GI Insights* on reachmd.com, where you can Be Part of the Knowledge. Thanks for listening, and looking forward to learning with you next time.