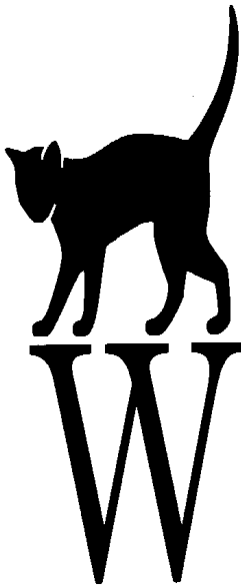


## Lower Gastrointestinal Bleeding

Subject:	Lower gastrointestinal bleeding
Policy Number	N/A
Ratified By:	Clinical Guidelines Committee
Date Ratified:	October 2010 (original), reviewed without change January 2015
Version:	2.0
Policy Executive Owner:	Clinical Directors, Medicine and Surgery
Designation of Author:	Consultant Surgeon (Mr H Mukhtar) Consultant Gastroenterologist (D C Onnie) Consultant Radiologist (Dr M Murray)
Name of Assurance Committee:	As above
Date re- issued:	January 2015
Review Date:	3 years hence
Target Audience:	Medical staff
Key Words:	Acute lower GI (gastrointestinal) bleeding, GI (gastrointestinal)haemorrhage, colonoscopy, interventional radiology, surgery

## Version Control Sheet

Version	Date	Author	Status	Comment
1.0	Oct 2010	Consultant Surgeon (Mr H Mukhtar) Consultant Gastroenterologist (D C Onnie) Consultant Radiologist (Dr M Murray)	OFF LINE	New guideline approved at Clinical Guidelines Committee
2.0	Jan 2015	Reviewed by above	LIVE	Dr Onnie , Dr Murray andMr Mukhtar have undertaken a review of contente and reached to conclusion these are up to date. No changes are required at present. (Jan 2015)

	<p align="center"><b>A Whittington Hospital Clinical Management Guideline</b></p>
	<p align="center"><b>Lower Gastrointestinal Bleeding</b></p>
	<p><b>Author:</b> C Onnie/D Murray/H Mukhtar  <b>Speciality:</b> Gastro/Radiology/Surgery  <b>Owner:</b> <i>(Owner will be relevant Clinical Director)</i></p>
	<p><b>Relevant to:</b> All medical staff.</p>

**Key words:** Acute lower GI (gastrointestinal) bleeding, GI (gastrointestinal)haemorrhage, colonoscopy, interventional radiology, surgery

➤ **Background/ introduction**

**Background:** Acute lower GI beeding is a common cause of hospitalisation, morbidity and mortality. The evaluation and treatment are complex due to the multitude of pathologic processes that can result in GI bleeding, the length of the GI tract and the often intermittent nature of GI bleeding. **A multispeciality approach is often required.**

Moderate lower GI beeding is a common problem in primary care, and requires elective investigation. This guideline considers those with severe enough bleeding to warrant hospital admission.

A large majority of these (80-85%) will stop bleeding spontaneously without specific treatment.

Lower GI bleeding tends to affect elderly patients (i.e. is 200 times more likely to occur in an 80 year old than a 20 year old), and carries a mortality rate of 3.6%.

**Causes of lower GI bleeding:**

Haemorrhoids	Most common
Diverticular disease	25 - 55%
Angiodysplasia	3 - 40%
IBD (e.g UC, Crohns)	6 - 22%
Cancer	8 - 26%
Radiation treatment (70% within 1 year of treatment)	
Ischaemic colitis	Rare

**➤ Inclusion criteria**

Bleeding that originates from a source distal to the ligament of Trietz (the anatomical landmark of the duodeno-jejunal junction) is considered Lower GI bleeding.

NB 15% of those presenting with a significant rectal bleeding will have an upper GI source of bleeding.

Small bowel sources account for 0.7-9%.

Moderate lower GI bleeding is a common problem in primary care, and requires elective investigation.

This guideline considers those with severe enough bleeding to warrant hospital admission, based on clinical assessment i.e. signs and symptoms of hypovolaemia and shock.

**Diagnostic and Therapeutic Options for Acute Lower GI Bleeding**

	<b>Advantages</b>	<b>Disadvantages</b>
<b>Rectal examination</b> (PR/proctoscopy/rigid sigmoidoscopy)	PR is essential to diagnose anorectal causes (accounting for 14% of acute lower GI bleeding)	
<b>Colonoscopy</b>	Effective Biopsy and therapeutic options possible	Risks of invasive endoscopy (perforation, haemorrhage, sedation). Bowel prep improves success. Small bowel not visualised.
<b>Radionuclide imaging</b>	Non invasive Most sensitive technique Allows prolonged imaging times, useful for intermittent bleeding	Imprecise anatomical location of bleeding Time consuming with no after hours availability
<b>CT angiography</b>	Rapid, noninvasive, sensitive Accurate localisation of bleeding, and may determine cause. Good specificity and sensitivity with significant bleed-resulting in systemic hypotension or transfused 4 units in 24 hours. Allows depiction of GI vasculature	Radiation and contrast dose especially if multiple studies. Does not allow prolonged imaging times
<b>Angiography</b>	Allows accurate anatomic localisation of bleeding site. Possible therapeutic intervention. Embolisation is associated with a high technical success rate although with complications (11% require colectomy for colonic ischaemia)	Invasive, radiation and contrast dose. Limited availability.

<b>Surgery</b>	Definitive treatment.	High morbidity. High mortality rates (0-33%). Limited availability.
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## **Management of significant Lower GI bleed.**

Patients should be jointly managed by the Colorectal surgeons and gastroenterologists, in an HDU setting. The patients are admitted under the care of Surgical consultant on call and care to be transferred over to colorectal surgeon as soon as possible.

All patients with acute severe rectal bleeding should be resuscitated and transfused to restore circulatory volume as appropriate according to major haemorrhage guidelines



**Please refer to Whittington NHS Trust Guideline:‘  
Major Haemorrhage in Adults**

A full history, abdominal examination and digital rectal examination including rigid sigmoidoscopy should be undertaken.

Most patients will settle with conservative measures only, and can undergo colonoscopic examination on an elective basis to determine the underlying cause.

## **Localising bleeding:**

**Patients with major GI bleeding, should have an urgent gastroscopy to exclude an upper GI cause.**

CT Angiography should be considered acutely in patients with a significant active lower GI bleed, particularly in the bleeding phase, when the sensitivity is higher.

Early colonoscopy is recommended, preferably following rapid bowel prep (emergency bowel prep takes 3-4 hours).

Consider isotope scanning or capsule endoscopy to assist in localisation if bleeding is intermittent or chronic.

## **Interventions:**

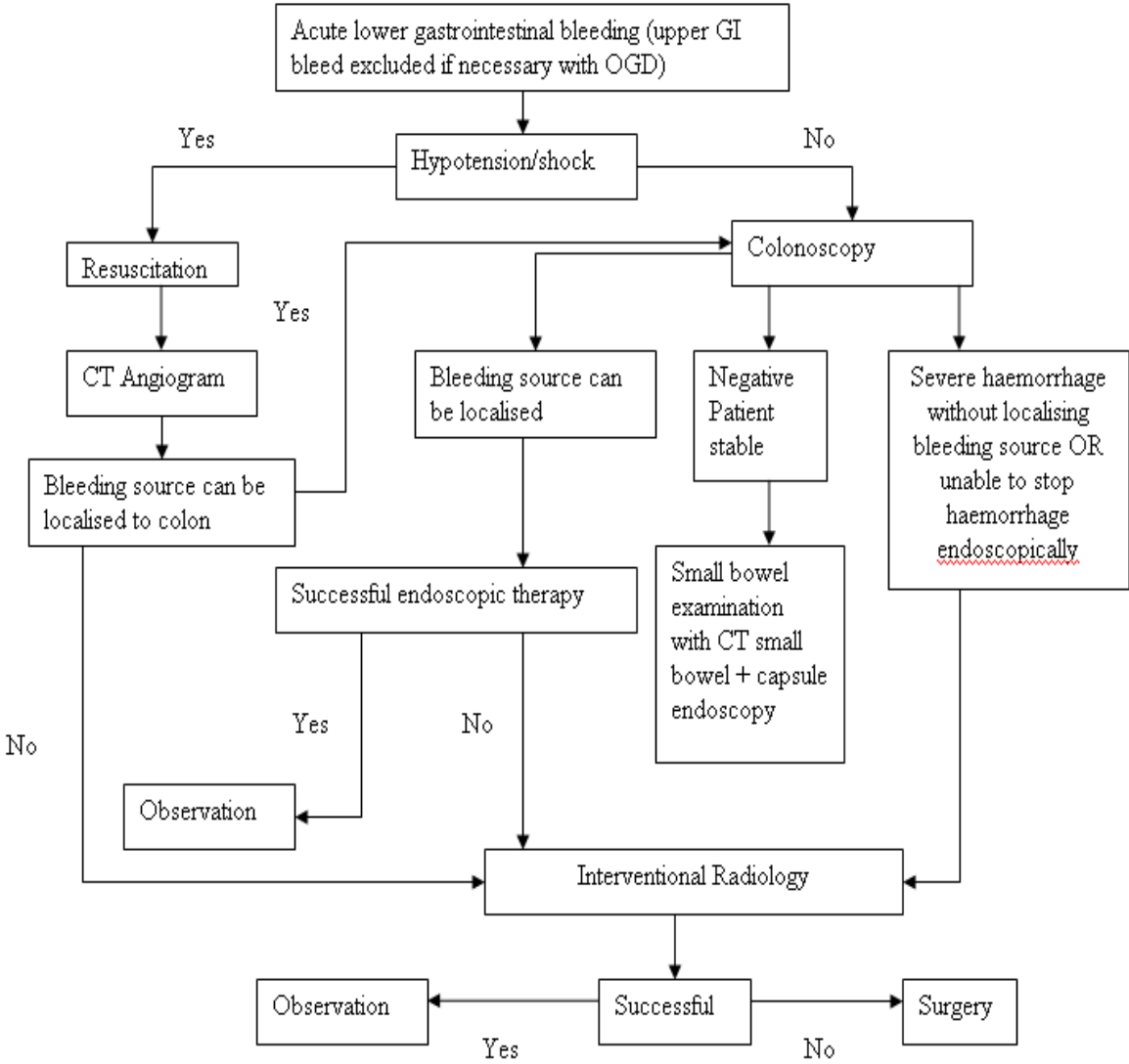
In patients with ongoing lower GI haemorrhage, who are haemodynamically stable, colonoscopic stasis can be an effective means of controlling haemorrhage.

In patients with massive lower gastrointestinal haemorrhage, who are haemodynamically unstable, angiographic transarterial embolisation can be an effective means of controlling haemorrhage.

Localised segmental intestinal resection or subtotal colectomy is recommended for the management of colonic haemorrhage uncontrolled by other techniques.

**Timing of investigations/interventions will be decided by the responsible consultant surgeon, gastroenterologist and radiologist (as per following algorithm).**

## Algorithm for investigation and management of major GI bleed:





➤ **Contacts (inside and outside the Trust including out-of-hours contacts)**

As per major haemorrhage protocol, as well as on call gastroenterology, radiology and surgical teams on call.

➤ **References (evidence upon which the guideline is based)**

SIGN guideline 105: Management of acute upper and lower gastrointestinal bleeding (2008);

Acute Gastrointestinal Bleeding: Emerging Role of Multidetector CT Angiography and Review of Current Imaging Techniques. Laing et al Radiographics 2007;27:1055-1070

➤ **Monitoring compliance with this guideline (how frequently the guideline will be audited and which committee the results will be reported to)**

Guideline to be audited in 1 year and results will be presented to joint gastroenterology MDT.

## Appendix A

### Plan for Dissemination and implementation plan of new Procedural Documents

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Acknowledgement: University Hospitals of Leicester NHS Trust

<b>Title of document:</b>	<b>Management of lower GI bleeding</b>		
<b>Date finalised:</b>	<b>Re-issued January 2015</b>	<b>Dissemination lead: Print name and contact details</b>	<b>MUKHTAR/MURRAY/ONNIE</b>
<b>Previous document already being used?</b>	<b>No</b>		
<b>If yes, in what format and where?</b>			
<b>Proposed action to retrieve out-of-date copies of the document:</b>			
<b>To be disseminated to:</b>	<b>How will it be disseminated/implemented, who will do it and when?</b>	<b>Electronic</b>	<b>Comments</b>
<b>GI/surgical and radiology teams</b>	<b>By e-mail</b>	<b>E</b>	<b>Draft already circulated for approval</b>
	<b>Discussion at weekly GI meeting</b>		
<b>Hospital consultants</b>	<b>E-mail notification once finalised</b>	<b>E</b>	<b>Current interhospital arrangements for interventional radiology are being independently reviewed. The guideline will link with these.</b>
<b>Hospital medical staff</b>	<b>Intranet access once finalised</b>	<b>E</b>	
<b>Is a training programme required?</b>	<b>No</b>		
<b>Who is responsible for the training programme?</b>			

## Appendix B

### Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Impact (= relevance)  1 Low 2 Medium 3 High	Evidence for impact assessment (monitoring, statistics, consultation, research, etc)	Evidential gaps (what info do you need but don't have)	Action to take to fill evidential gap	Other issues
Race	1			
Disability	1			
Gender	1			
Age	1			
Sexual Orientation	1			
Religion and belief	1			

Once the initial screening has been completed, a full assessment is only required if:

- The impact is potentially discriminatory under equality or anti-discrimination legislation
- Any of the key equality groups are identified as being potentially disadvantaged or negatively impacted by the policy or service
- The impact is assessed to be of high significance.

If you have identified a potential discriminatory impact of this procedural document, please refer it to relevant Head of Department, together with any suggestions as to the action required to avoid/reduce this impact.