Management of Patients with Acute Lower Gastrointestinal Bleeding: An Updated ACG Guideline
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Introduction
• The purpose of this newly published guideline was to update the previously published 2016 ACG guideline on lower GI bleeding (LGIB).
• For the purposes of this abstract, LGIB refers to hematochezia or bright red blood per rectum originating from a colorectal source.

Recommendation 1: Use risk stratification tools to identify low-risk patients with LGIB who are appropriate for outpatient evaluation.
• Validated clinical prediction tools include the Oakland Score and SHAPE Score.
  • Oakland score <8 predicted safe discharge.
  • SHAPE score <1 indicates hospital-based intervention is unlikely.
• Risk tools should always be used in conjunction with clinical judgement.

Recommendation 2: A restrictive strategy of RBC transfusion (Hgb > 7.0) should be employed in hemodynamically stable patients with LGIB.*
• A threshold of 8 g/dL can also be considered in patients with ACS and GIB; however, data is limited in this population.

Recommendation 3: Management of Vitamin K Antagonists
• Endoscopic intervention is safe in patients with an INR <2.5.
• If reversal is needed, prothrombin complex concentrate >> fresh frozen plasma.

Recommendation 4: DOAC Reversal Management
• Reversal should be considered only in patients that do not respond to initial resuscitation and cessation of DOAC alone.
  • Use targeted reversal agents if DOAC taken <24 hours with life-threatening bleed
    - Dabigatran  →  Idarucizumab
    - Rivaroxaban/Apixaban  →  Andexanet Alfa

Recommendation 5: Tranexamic acid (TA) is NOT indicated for use in LGIB.
• TA made no difference in transfusion rates or volumes, intervention rates, or lengths of hospital stay.

Recommendation 6: Role of Colonoscopy in LGIB
• Colonoscopy is recommended for most patients hospitalized with LGIB.
  • If colonic source of bleeding not found  →  intubate TI
  • Colonoscopy may not be needed if bleeding has subsided AND patient has had an adequate prep colonoscopy within 12 months showing diverticulosis with no neoplasia.

Recommendation 7 & 8: Role of CTA in LGIB
• CTA should be performed in hemodynamically unstable patients.
• If CTA is positive, then either interventional radiology IR for embolization OR colonoscopy.

Recommendation 9: Timing of Colonoscopy
• Nonemergent colonoscopy should be performed in LGIB.
• Urgent colonoscopy within 24 hours has NOT been shown to improve mortality and morbidity.

RBC = red blood cell
HGB = hemoglobin
UGIB = upper GI bleeding
DOAC = direct oral anticoagulation
INR = international normalized ratio
TI = terminal ileum
CTA = computed tomography angiography
EBL = endoscopic band ligation
CV = cardiovascular
PUD = peptic ulcer disease
pHTN = portal hypertension

**Recommendation 10: Treatment of Diverticular Hemorrhage**

- Diverticular bleeding should be treated endoscopically with 1) **through-the-scope clips**, 2) **EBL (endoscopic band ligation)**, or 3) **coagulation**.
  - Direct clipping should be performed onto the vessel at the diverticular **neck or dome**.
- If a patient re-bleeds after initial cessation, a repeat colonoscopy can be considered depending on patient’s stability.
  - **Limited role for surgery in LGIB**.

**Recommendation 11: Resumption of Antiplatelet Medications and Risk of Recurrence after Hospitalization for Diverticular Bleeding**

- **Discontinue** non-aspirin NSAIDs after diverticular bleed.
- **Discontinue** aspirin for 1° CV prevention after diverticular bleed.
- **Continue** aspirin after diverticular bleed for patients that have an established CV event history.
- **Risk versus benefit** discussion to be had regarding resumption of non-aspirin antiplatelets after diverticular bleed.

**Recommendation 12: Resumption of Anticoagulation and Risk of Recurrence after Hospitalization for Diverticular Bleeding**

- **Resume** anticoagulation after cessation of LGIB.
  - Overall ↓ the risk of post-thromboembolic events and mortality.

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**Lower GI Bleeding Clinical Algorithm**

**Severe Hematochezia**

- **Initial Steps**: IVF Resuscitation, pRBC transfusions to Hgb >7.0 (or higher in CV patients), exclude UGIB*
  - *Risk factors: History of PUD, pHTN, BUN/Cr > 30, aspirin/NSAID use

**Ongoing Significant Bleeding**

- **CT Angiography****
  - **Predictors of positive CTA**: CTA within 4 hours of bleeding, recent bowel surgery, transfusion > 3 pRBCs, use of antiplatelets or DOACs, hemodynamic instability.

**Extravasation**

- Embolization with IR

**No Extravasation**

- Urgent colonoscopy (purge prep) with intervention in centers with endoscopic excellence

**Milder LGIB or Bleeding Subsided**

- Non-urgent colonoscopy (split-dose prep) vs. observation if bleeding has stopped AND recent colonoscopy

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**References**