

# Practice Guidelines

## Management of Acute Lower GI Bleeding: Guidelines From the American College of Gastroenterology

### Key Points for Practice

- Risk stratification tools, such as the Oakland score, have some evidence of helping determine which patients with lower GI bleeding do not need hospitalization, but clinical judgment is still needed.
- For hemodynamically significant lower GI bleeding, CT angiography can accurately locate the bleeding source.
- For hemodynamically stable patients, with or without continued lower GI bleeding, performing colonoscopy within 14 days of presentation is as effective as performing it within 24 hours.
- Transcatheter embolization within 90 minutes of positive CT angiography results can stop bleeding 98% of the time, although 30-day mortality is 13%.

From the *AFP* Editors

**Acute lower gastrointestinal (GI)** bleeding, with hematochezia or bright red blood from the rectum, is cause for more than 100,000 hospital admissions annually. The American College of Gastroenterology (ACG) has published updated guidelines for the management of acute lower GI bleeding.

### Risk Stratification

Risk stratification tools such as the Oakland score (<https://www.mdcalc.com/calc/10042/oakland-score-safe-discharge-lower-gi-bleed>) can be used to assist physicians in determining which patients may be suited for outpatient management. The Oakland score and other similar tools have demonstrated small-scale validity without randomized controlled trials or large-scale data

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This series is coordinated by Michael J. Arnold, MD, assistant medical editor.

A collection of Practice Guidelines published in *AFP* is available at <https://www.aafp.org/afp/practguide>.

**CME** This clinical content conforms to AAFP criteria for CME. See CME Quiz on page 205.

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verification. Physicians should primarily use clinical judgment when risk-stratifying patients with lower GI bleeding.

### Evaluation

In patients with hemodynamically significant bleeding, computed tomography (CT) angiography can identify the source and associated vasculature with a sensitivity of approximately 90%. Nearly 80% of patients with negative CT angiography results will have no rebleeding and require no further evaluation.

Colonoscopy is the standard for diagnostic testing in hemodynamically stable patients with lower GI bleeding. In a European cohort, colonoscopy led to a definitive or presumptive source

### G-TRUST SCORECARD

Score	Criteria
Yes	Focus on patient-oriented outcomes
Yes	Clear and actionable recommendations
Yes	Relevant patient populations and conditions
Yes	Based on systematic review
Yes	Evidence graded by quality
Yes	Separate evidence review or analysis in guideline team
Yes	Chair and majority free of conflicts of interest
No	Development group includes the most relevant specialties, patients, and payers (no payers or patients)

Overall – useful

**Note:** See related editorial, Where Clinical Practice Guidelines Go Wrong, at <https://www.aafp.org/afp/gtrust.html>.

G-TRUST = guideline trustworthiness, relevance, and utility scoring tool.

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## PRACTICE GUIDELINES

in 79% of patients. For hemodynamically stable patients without continued bleeding, moderate-quality evidence supports completing a colonoscopy within 14 days of spontaneous hemostasis. For these patients, performing a colonoscopy in the first 24 hours after presentation does not improve outcomes. No bowel preparation appears superior to any other for colonoscopy after lower GI bleeding.

Patients who have had a colonoscopy within the past 12 months may not need repeat testing if bleeding has subsided and a suspected bleeding source, such as diverticulosis, was identified.

### Transfusion

Low-quality evidence supports a restrictive transfusion approach at a threshold hemoglobin level of less than 7 g per dL (70 g per L) in hemodynamically stable patients. In a retrospective analysis, restrictive vs. nonrestrictive transfusion strategies demonstrated similar mortality and rebleeding rates. A higher threshold of 8 g per dL (80 g per L) can be considered in patients with known cardiovascular disease or acute coronary syndrome.

### Management

Transcatheter arteriography is nine times more likely to detect the bleeding source and enable embolization therapy when performed within 90 minutes of a positive angiogram compared with delayed arteriography. Embolization therapy has a 98% success rate, but it can cause an ulcer or bowel infarction in nearly 5% of patients. Even after embolization, 30-day rebleeding and mortality rates are 16% and 13%, respectively.

Despite higher colonoscopy treatment rates after a positive CT angiogram result, routine use of CT angiography before colonoscopy does not reduce mortality or rebleeding.

### Anticoagulant Medications

Endoscopic procedures can generally be performed safely in patients with an international normalized ratio of 2.5 or less. Although the evidence is limited, use of reversal agents is

discouraged unless the patient remains hemodynamically unstable despite resuscitation.

For severe lower GI bleeding, the target platelet level should be greater than  $30 \times 10^3$  per  $\mu\text{L}$  ( $30 \times 10^9$  per L) and a threshold greater than  $50 \times 10^3$  per  $\mu\text{L}$  ( $50 \times 10^9$  per L) is needed before endoscopy. Transfusing to higher platelet levels increases mortality without improving rebleeding risk.

Because rebleeding risk appears small, the ACG recommends that patients taking aspirin for secondary prevention of cardiac disease continue therapy. For dual antiplatelet therapy in patients with a recent cardiac stent, a multidisciplinary team should compare risks.

Antifibrinolytic agents such as tranexamic acid should be avoided in lower GI bleeding because the evidence shows increased rates of thromboembolism and seizure without any improvement in outcomes.

Following hospitalization for lower GI bleeding, the ACG recommends that patients discontinue aspirin for primary cardiovascular prevention and nonsteroidal anti-inflammatory drug treatment after diverticular bleeds. In contrast, aspirin for secondary cardiovascular prevention and anticoagulation taken following venous thromboembolism or ischemic stroke should be continued. For other anticoagulation therapy, a multidisciplinary team should compare risks.

The views expressed are those of the author and do not necessarily reflect the official policy or position of the Uniformed Services University of the Health Sciences, U.S. Air Force, U.S. Department of Defense, or U.S. government.

**Guideline source:** American College of Gastroenterology

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**Available at:** [https://journals.lww.com/ajg/fulltext/2023/02000/management\\_of\\_patients\\_with\\_acute\\_lower.14.aspx](https://journals.lww.com/ajg/fulltext/2023/02000/management_of_patients_with_acute_lower.14.aspx)

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