The Slow Bleeder

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RVI

Through the eyes of a Gastroenterologist

- Evidence free zone
- The team
- At risk groups
- What I do .....
- Cases to highlight management diverse and needs to be tailored to the individual

Team based management

- Interested GI physician
- Interested Haematologist
- Dedicated Radiologist
- Rarely (hopefully!) interested GI surgeon

Patients at risk

- Heterogeneous and challenging group of patients
- Anti- coagulated:
  - warfarin, anti-platlets, NOACs
- Inherent risk of bleeding:
  - Haemophilia/ VWD/ ITP/ HHT
- Complex post surgical bleeds – surgical bed almost always the site – aberrant vessels secondary to localised venous/ arterial thrombosis, anastomotic ulcers
- Cardiac patients:
  - LVADs (a ‘new’ disease)
  - The world of significant co-morbidity and polypharmacy – always a challenge

Who??

- Not the chronically Iron deficient…
- Transfusion dependent
- Parenteral iron dependent
- Visible evidence of GI blood loss - melaena
- Recurrent significant severe anaemia
  - Hb less than 100
  - Raised urea

What I do …

- Minimise risk of bleeding
- And optimise
- ‘Break the bleeding cascade’
- Look hard and look again !!

Minimising risk and optimising

- Stop/ fine tune anti-coagulant
  - consider risk/ benefit re continuing versus discontinuing
  - consider lower target range for INR
  - NOACs – ensure appropriate dose, ensure no liver disease/ eGFR
- Switch from warfarin to therapeutic tinzaparin
- BD dosing tinzaparin if renal impairment and monitor Factor Xa
- Monotherapy anti-platlets where possible
- Optimise iron stores:
  - Regular parenteral Iron and load iron stores
  - Target ferritin 200-300
  - Minimise blood transfusions

Break the cascade

- Chronic bleeder - ?low grade DIC, micro-nutrient deficiencies
- Trial of tranexamic acid – parenteral/ oral
- Vitamin K, pabrinex, parenteral Iron
- Thalidomide
  - Start 100mg and titrate with tolerance
  - Bridge to optimising
  - Review 4 weeks ?dose reduce/ stop

Investigations

- Endoscopy –evolving therapeutic field
  - OGD/ Colonoscopy
  - Balloon Enteroscopy – single/ double
- Capsule Enteroscopy – diagnostic, define the site of bleeding
- Radiology
  - CTA rarely helpful unless to define unusual vessel anatomy post surgical or varices
  - CT abdomen/ pelvis

Pathology to consider

- Gastric antral venous ectasia – ‘GAVE’
  - missed if not thought about
  - often mis-diagnosed as ‘gastritis’
  - amenable to APC/RFA
- Angiodysplasia
- Dieulafoy’s – gastric/ small bowel
- If anti-coagulated or inherent bleeding disorder it doesn’t take much to bleed!

The LVAD patient

- Left Ventricular assist device
- Initially intended as a bridge to transplant
- Now so successful cohort of patients too well for transplant and have LVAD long term
- Concern re VAD thrombus so
  - Warfarin INR 3-4
  - Clopidogrel
  - Asprin

And they wonder why they bleed???

- Need Ix to exclude pathology but
  - Majority normal
  - Change to tinzaparin – bd with factor Xa monitoring
  - Stop aspirin
  - Group of patients who have low grade gut ischaemia, venous congestion, liver congestion – minimal lesion to bleed

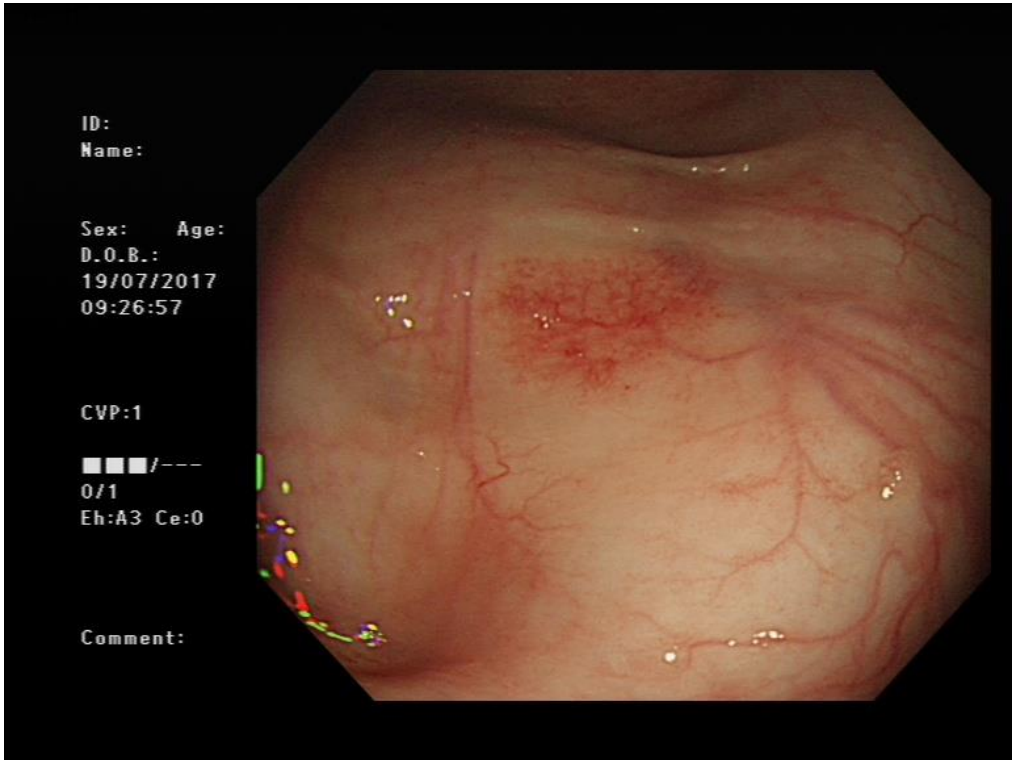
Case 1

- EM
  - 92 year old
  - Colostomy re diverticular disease
  - AF on warfarin
  - 2013: Melaena –normal OGD. CTA showed right colonic extravasation – normal colonoscopy
  - 2015 – recurrent melaena. Warfarin stopped – lacunar infarct. Warfarin re-started
  - 2016 – further bleed. Repeat OGD/Colon normal

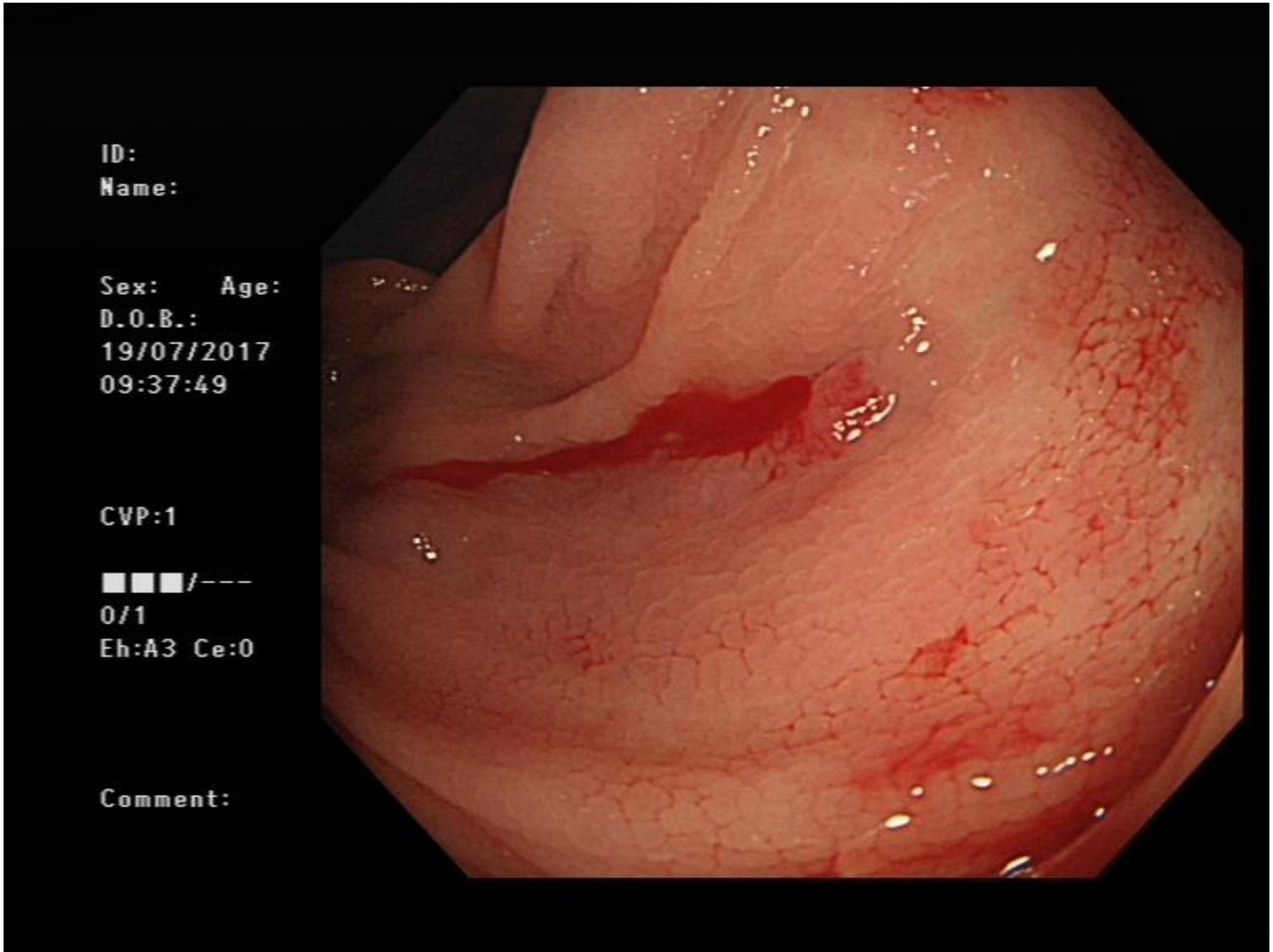
Case 1

- 2017
  - Further melaena Hb 80, normal urea, INR 1.8– transfusion dependent despite stopping warfarin
  - Concern from patient re risk of CVA
  - Repeat OGD normal
  - Repeat colon

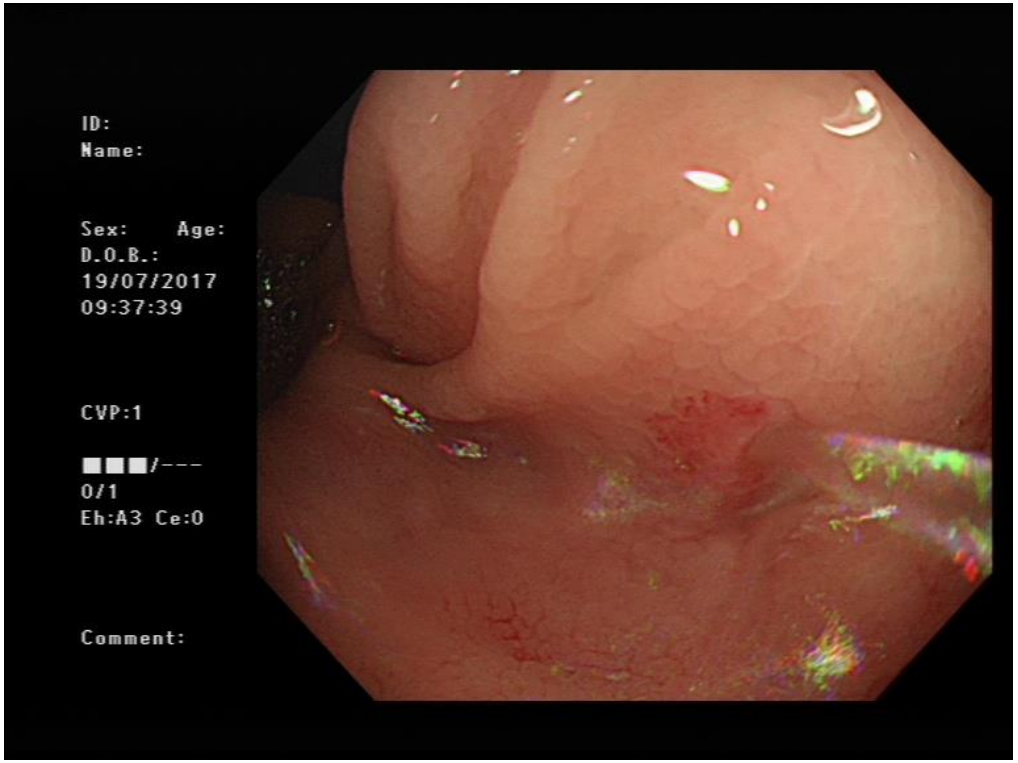
Colonoscopy



Oozing post flush



Post treatment



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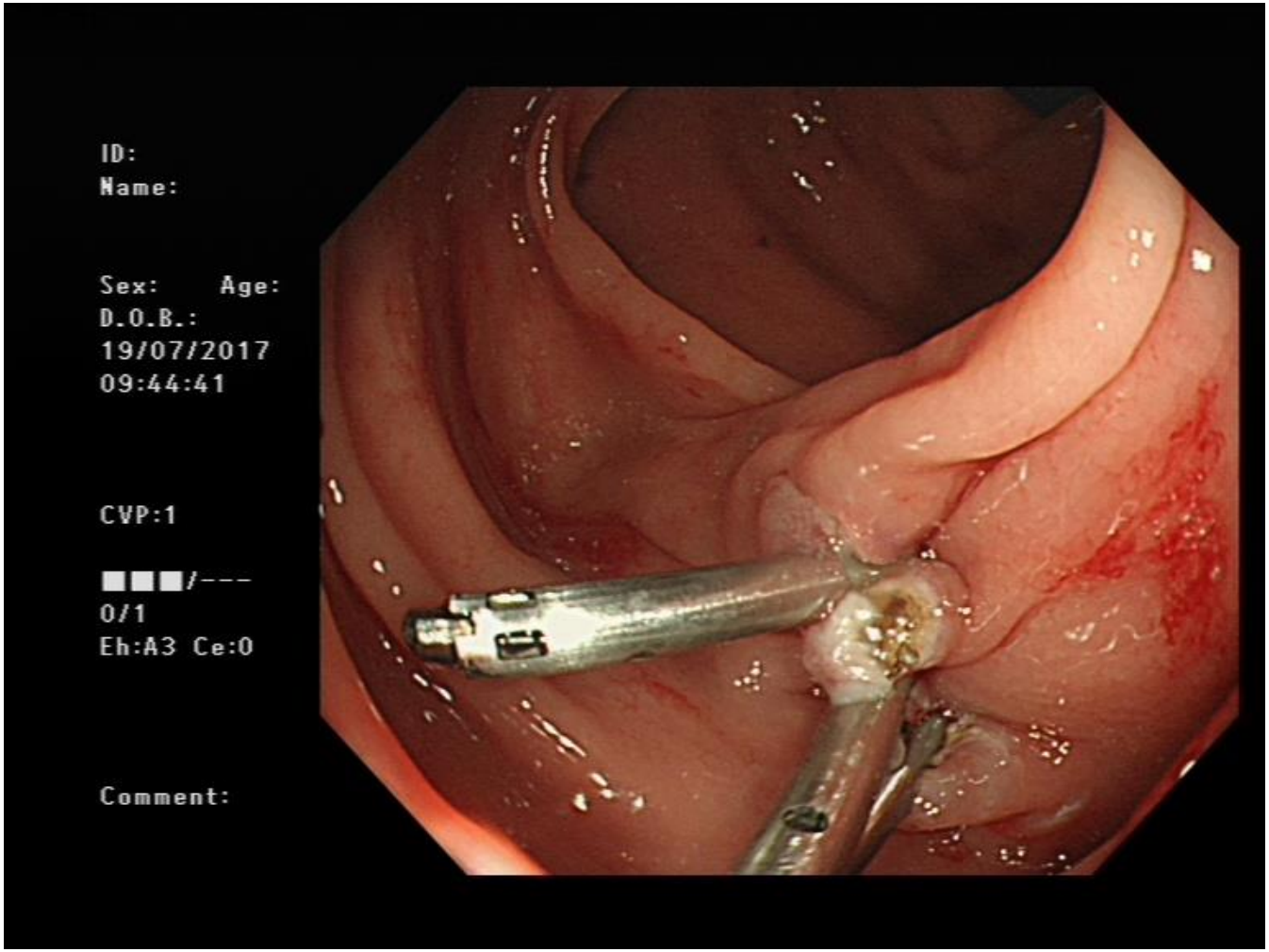


Reviewed 3 months

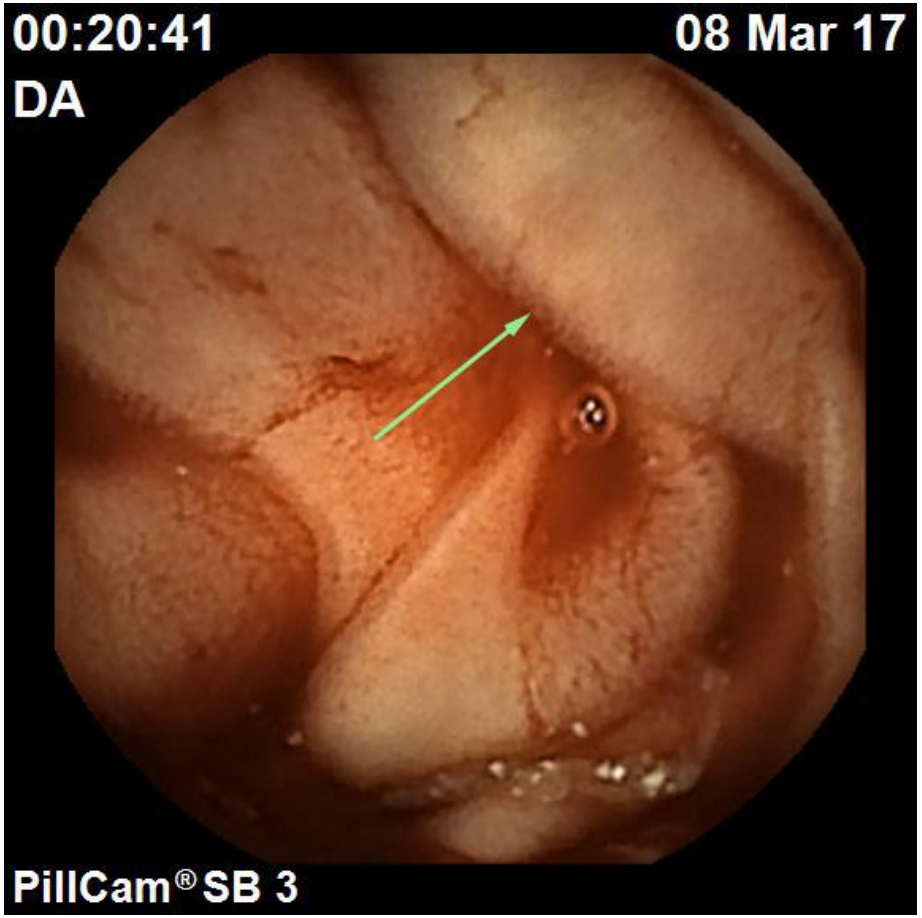
- Well
- No further bleeding on warfarin
- Discharged

Case 2

- DA, 49 year old lady
- PMHx – ovarian teratoma 10 years ago – surgery only
- Carlisle – 2014 ‘dark stool’
  - Hb 80s, increased urea
  - Normal OGD, Colonoscopy
- Referred for capsule
  - Possibility of prominent veins ?varices in small bowel
  - CTA recommended locally

Lost to Carlisle

- Represents with further melaena
  - Admitted to Carlisle - normal OGD
  - On going bleeding – non compromising
  - Transfer to RVI
  - Capsule repeated as in-patient
  - Bleeding settled
  - Capsule findings ;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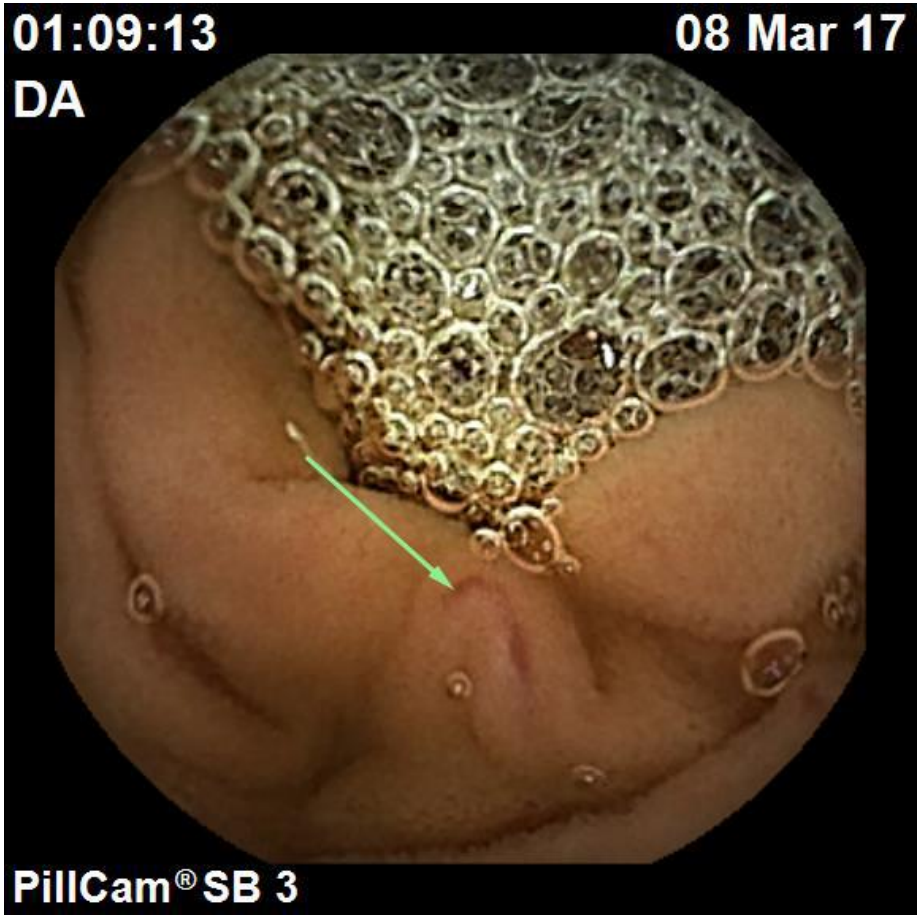
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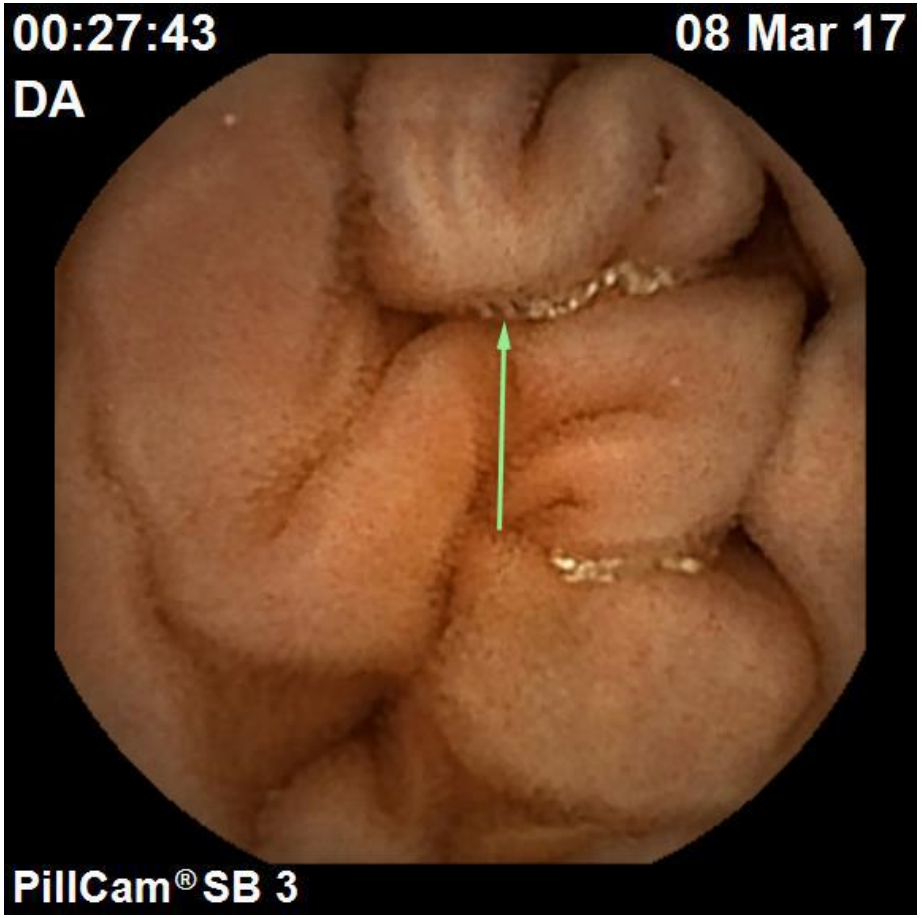
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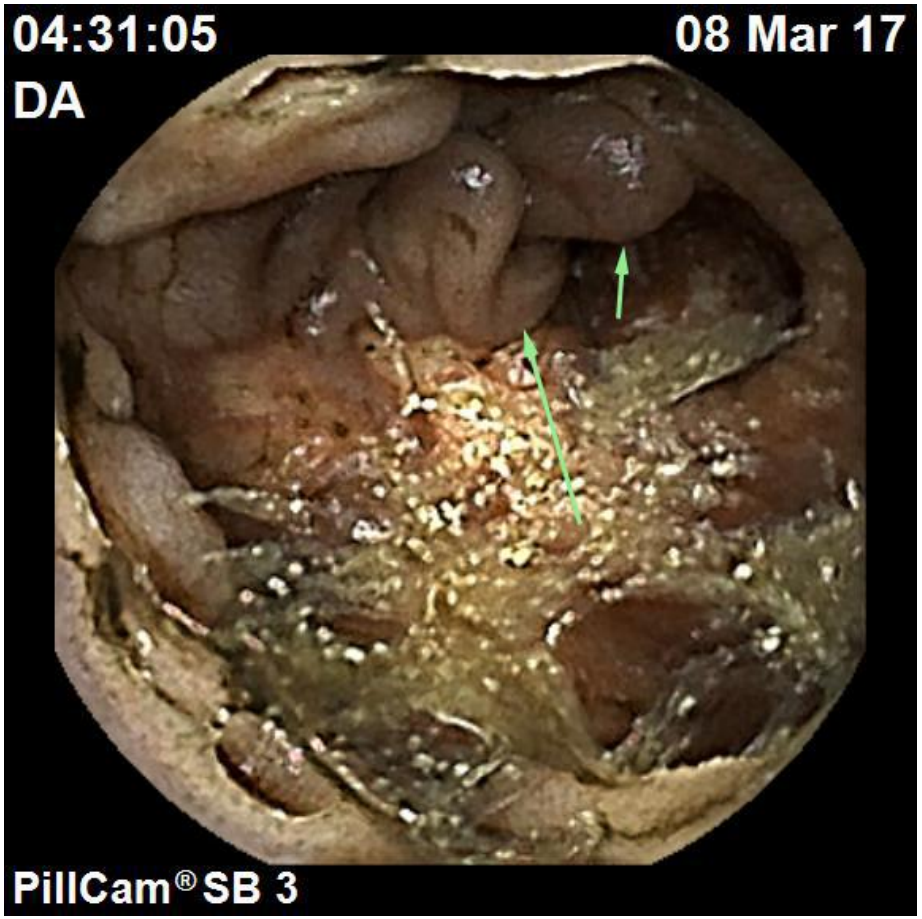
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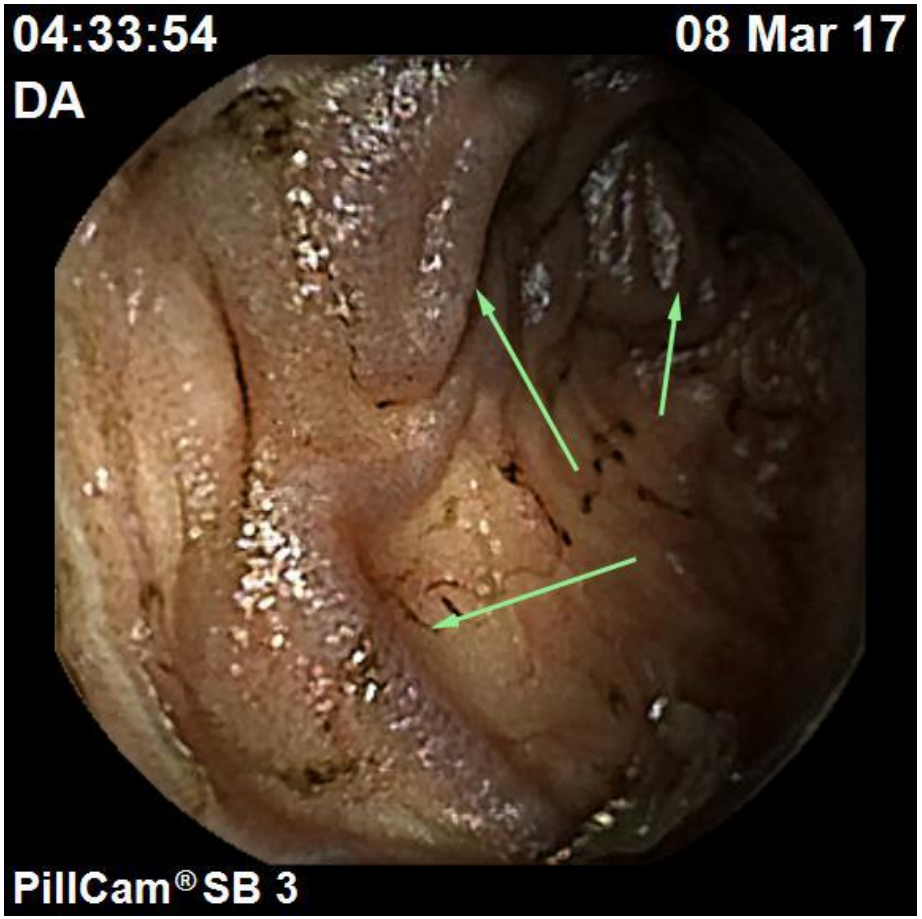
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To date

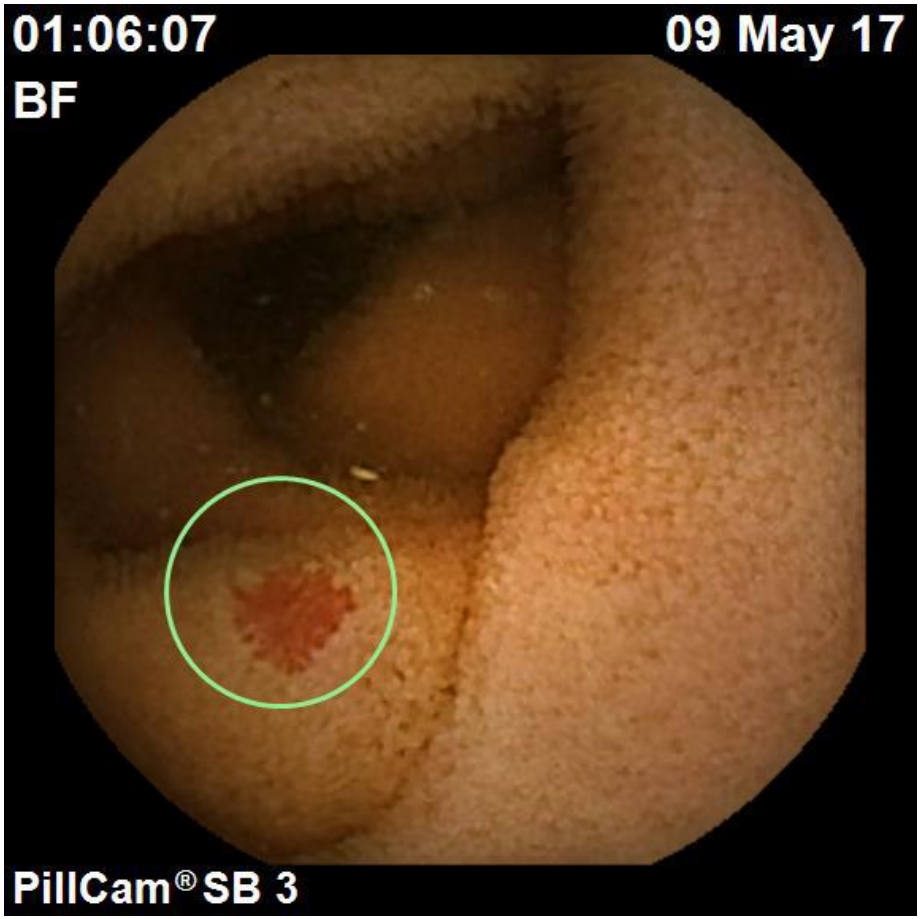
- Confirmed multiple level varices
- Normal LFTs, liver screen
- Abnormal fibro-scan ?for liver biopsy
- Further low grade oozing – requiring regular Iron infusions
- Options ?? SBE/DBE with glue if significant bleed
- ??relevance of teratoma

Case 3

- DC 60 year old male
- Transfusion dependent anaemia many years but increase last 6 months
- Normal OGD/ Colonoscopy
- Episode of possible melaena – admitted local hospital
- Repeat OGD – normal
- CT scan normal
- Meckles scan – no Meckles but bleeding point in small bowel
- Referred to Newcastle for capsule

Case 3

- Telephone assessed
- Capsule performed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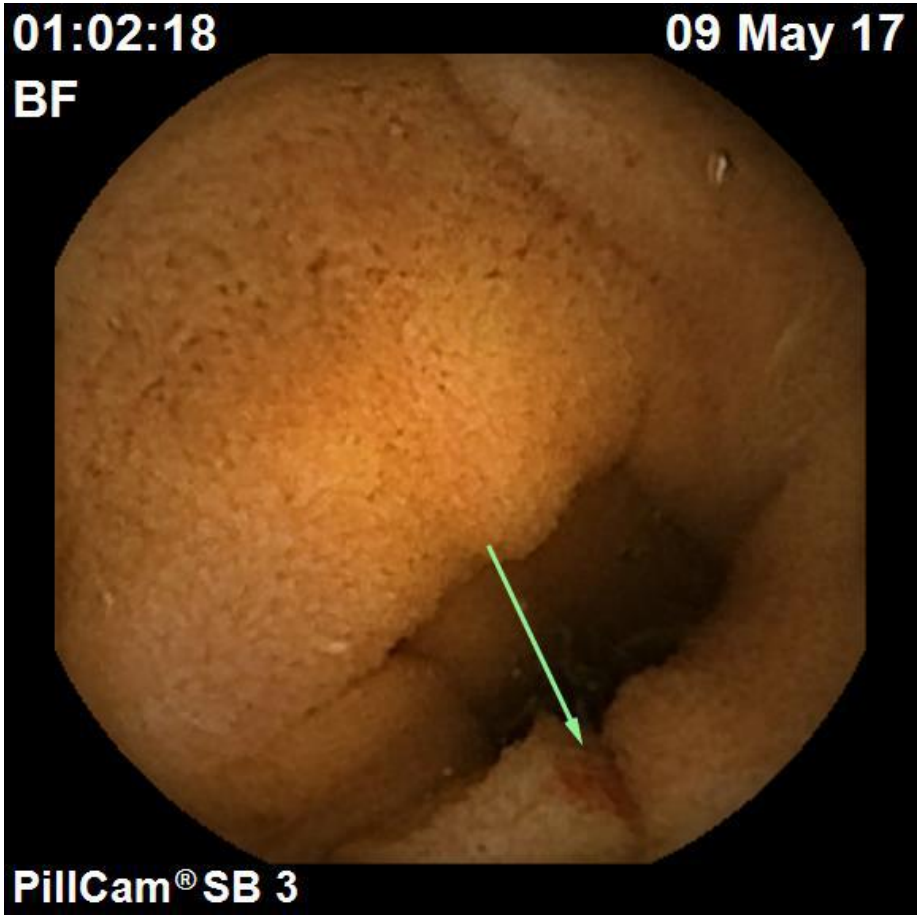
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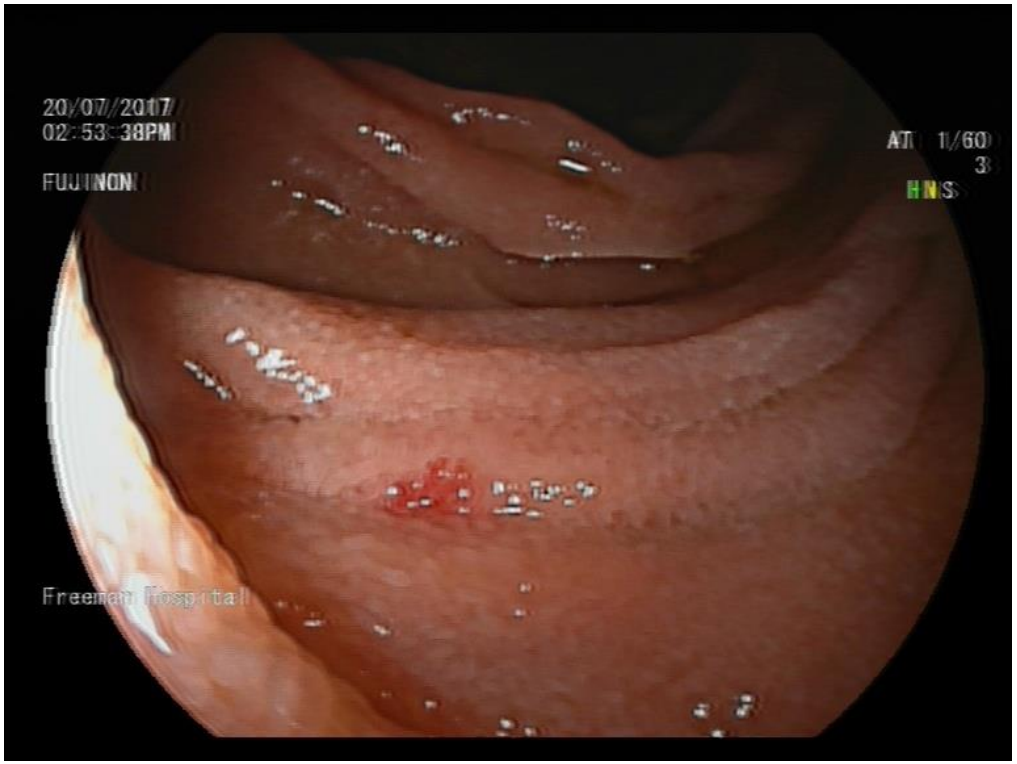
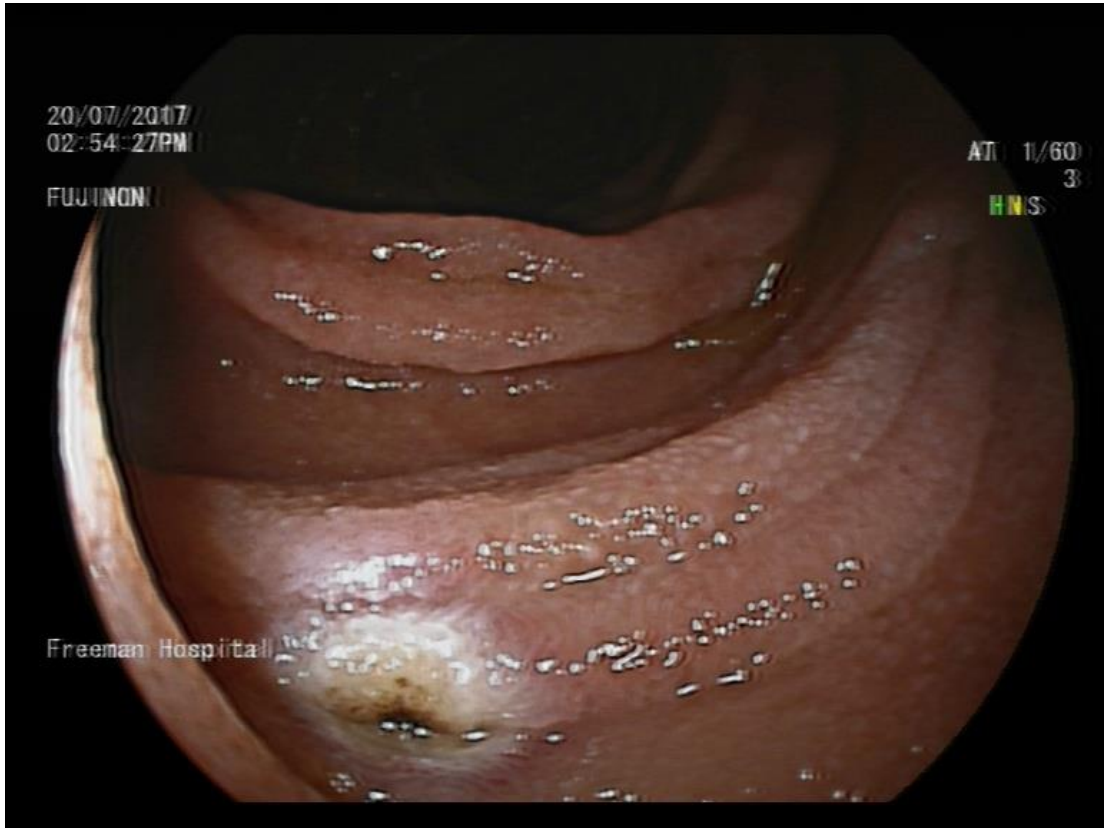
Proceeded to DBE

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Freeman Hospital

Ongoing bleeding

- Further DBE – couple of non specific lesions treated
- History re visited – no visible bleeding despite needing transfusions 3 times per week
- Atypical
  - Haemolysis screen negative
  - Blood film – suspicion of MDS!

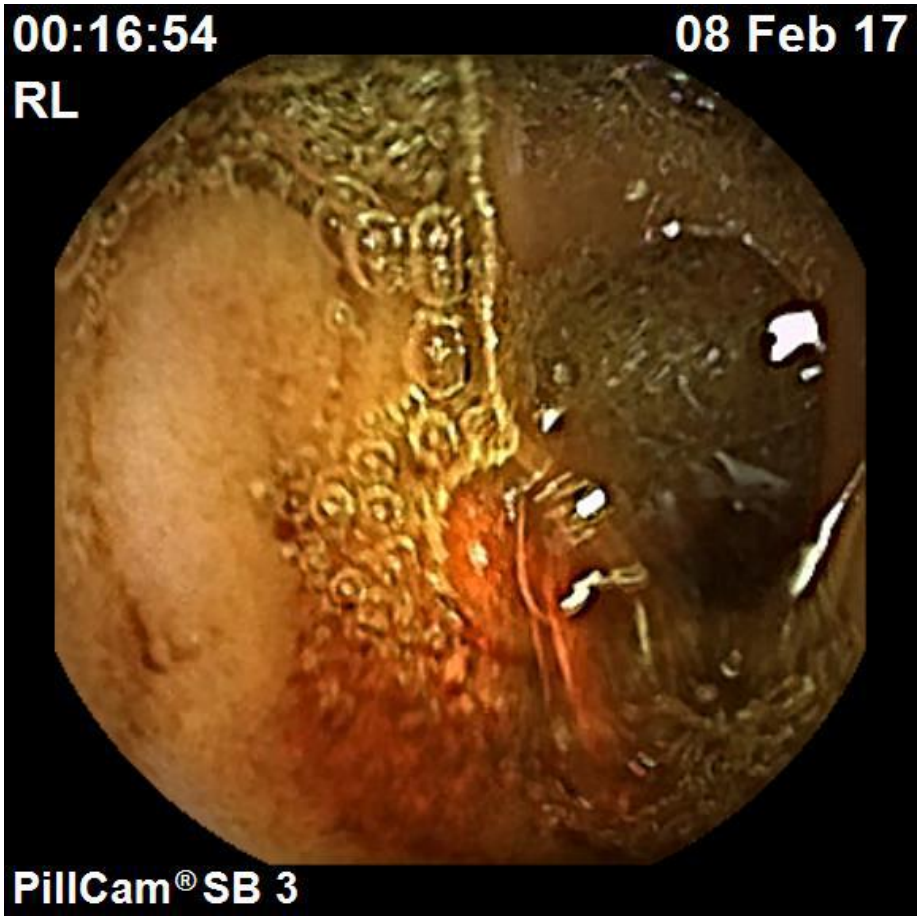
Case 4

- 83 year old lady
- Warfarin re AF and CVA – Rehab in Walkergate
- Melaena – transferred RVI. INR 3.5
- Normal OGD, warfarin stopped
- Continued to bleed – repeat OGD normal
- Capsule – refused then agreed. Poor views and in complete – didn't enter the colon in the test time. Some altered blood in stomach

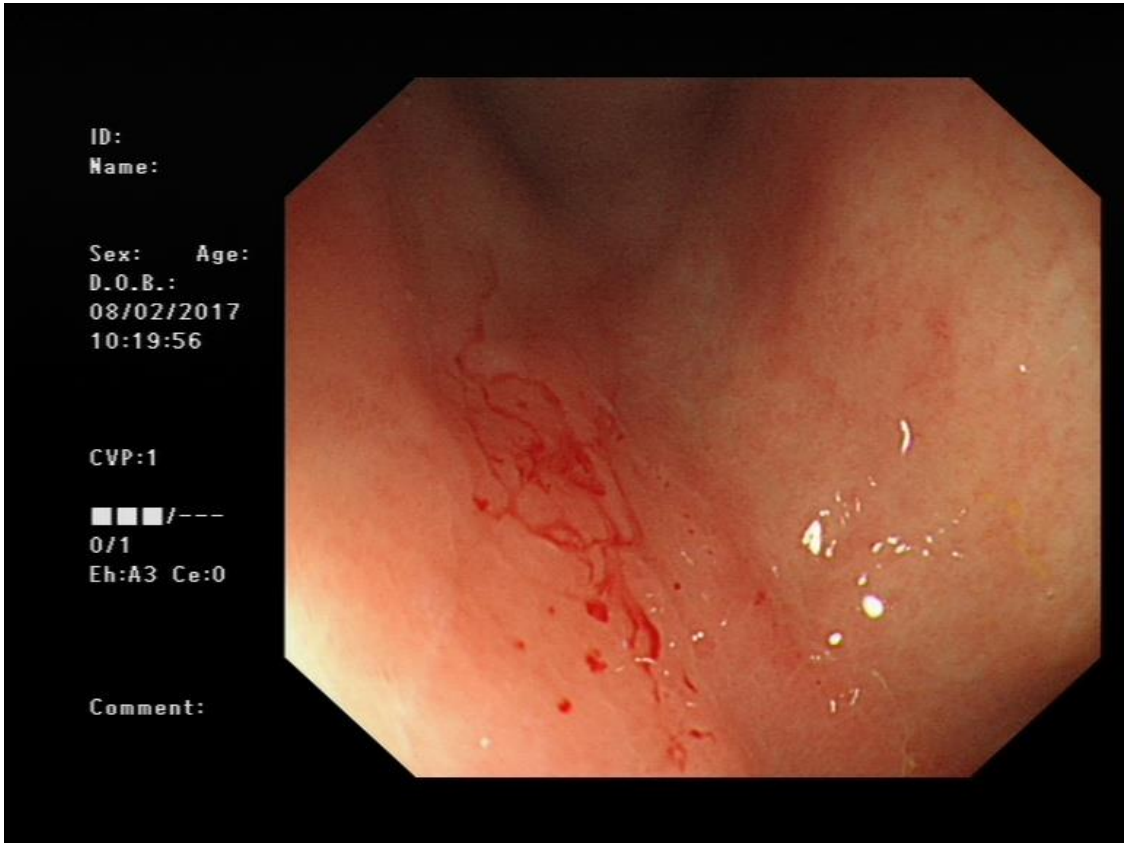
Continued

- Trial of tranexamic acid – stopped bleeding for 72 hours
- Re bled – 2 units per week
- Patient depressed and not agreeable to interventions
- Thalidomide started 100mg
- Persuaded for further OGD with placement of capsule

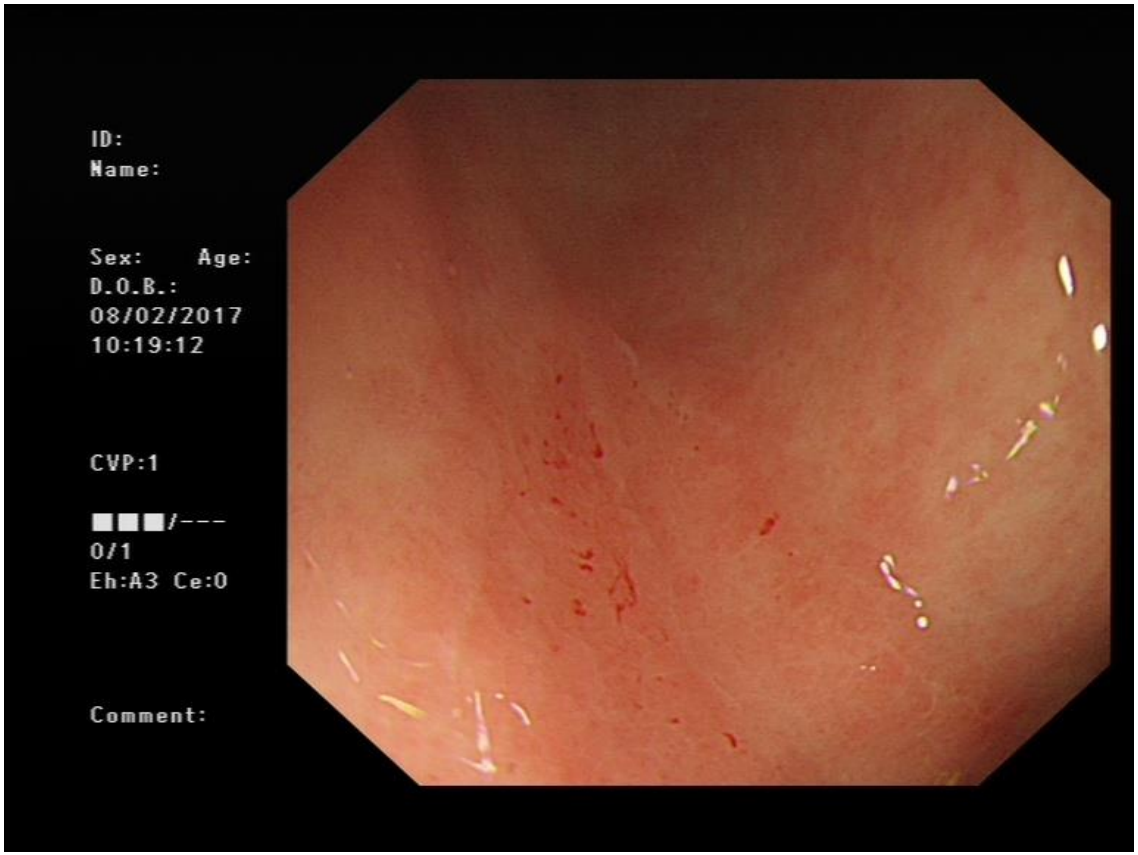
?transported with capsule placement



Re –look OGD



Post flushing



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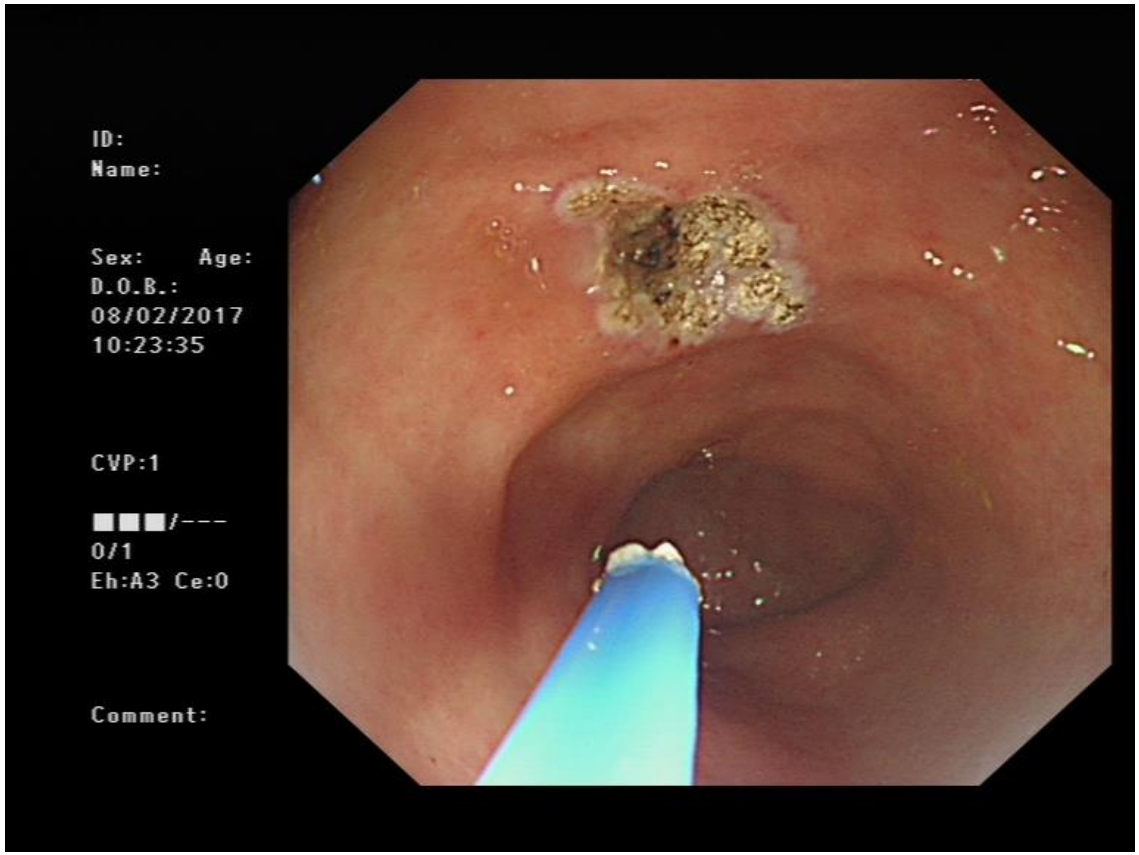

Reviewed 3 months

- Well
- Thalidomide reduced and discontinued
- No CVA so far!

Summary

- Complex heterogeneous group
- Simplify bleeding risk wherever possible
- If complex surgery almost always bleeding from the surgical bed
- Patients subject to multiple and duplication of invasive and un pleasant investigations therefore consider early referral to an interested team
- Give the patient re-assurance that slow bleed therefore have time to access hospital – give them open access, oral tranexamic acid and give them confidence in you that this is a manageable situation!

Questions?

Thank you!