Chronic GI Bleeding – a difficult to manage situation

Dr S Punnoose, SpR Gastroenterology
Dr A Dhar, Consultant Gastroenterologist
Dr M Mahmoud, Consultant Haematologist

BW

- 76 year old lady
- PMHx:

  Diet controlled T2DM

  HTN

  Prev. Caecal Cancer and Rhemicolectomy 1997

  Normal OGD/Colonoscopy for anaemia 2008

  Myelodysplastic Syndrome diagnosed 2009

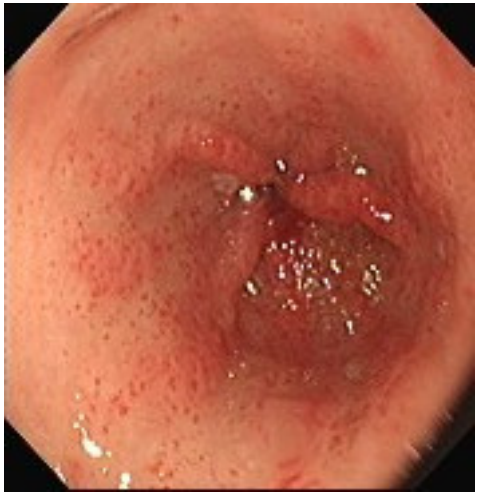
Referral Gastroenterology Aug 2012

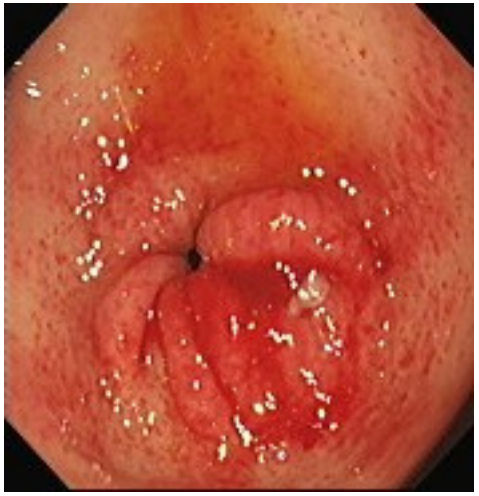
- Although known MDS with refractory anaemia, her anaemia is progressively worsening with Iron deficiency (Hb 7.5g/dl and Ferritin 8µg/l) and increasing symptoms, and transfusion requirements
- September 2012:

OGD: diffuse haemmorrhagic appearance of antrum and fundus with visible ooze consistent with active bleeding GAVE. Initially advised PPI therapy. Re-refer if no improvement for consideration of APC.

Colonoscopy: Normal to terminal ileum , normal anastomosis (previous Right hemi-colectomy)

Index OGD September 2012



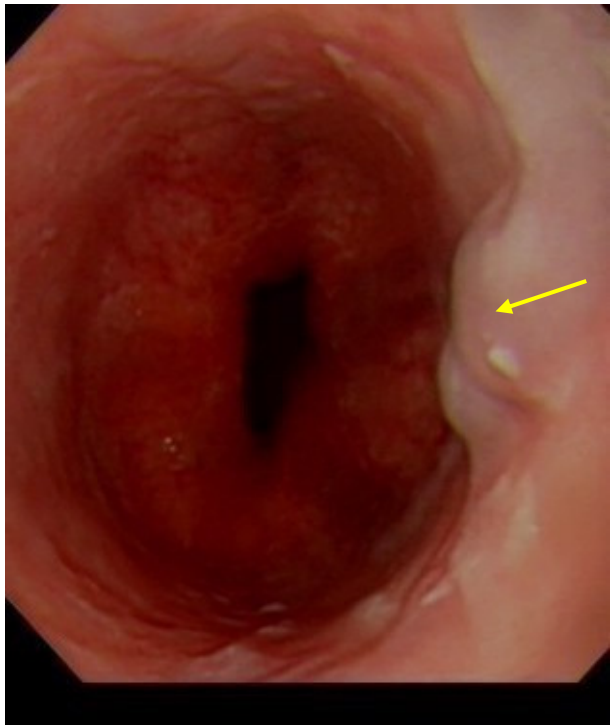


Gastric antrum showing characteristic vascular ectasia in punctuate form radiating from the pylorus

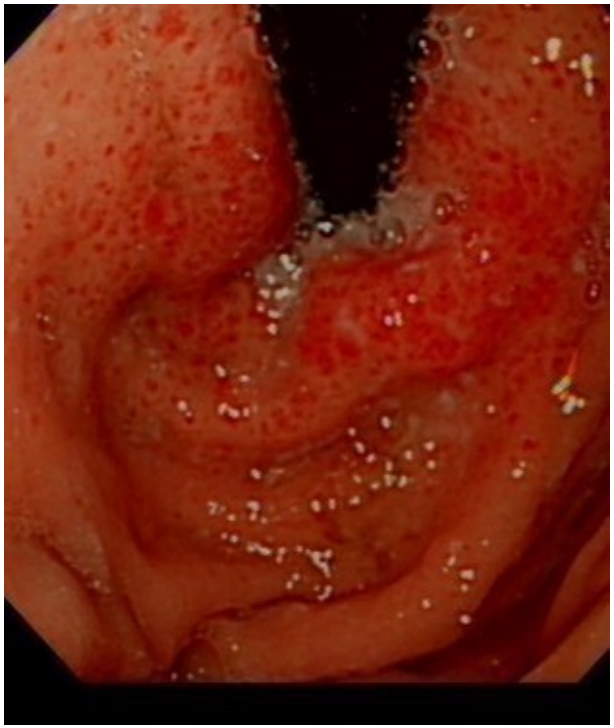
- Re-referred by Haematology, continued symptoms of intermittent melaena and increased transfusion requirements.

- OGD Jan 2013: Grade II Oesophageal varix and bleeding GAVE, injected with 1 in 10,000 Adrenaline and APC of GAVE, planned further APC

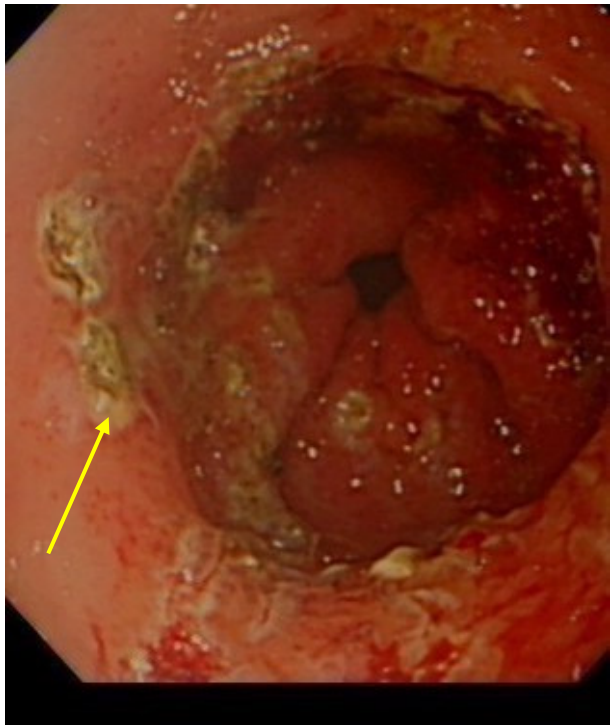
OGD Jan 2013



1. Oesophageal Varix



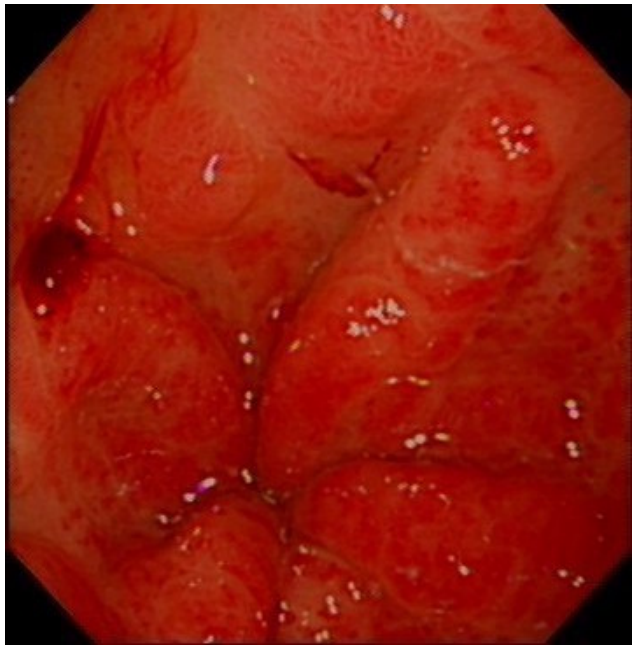
2. Fundal vascular ectasia

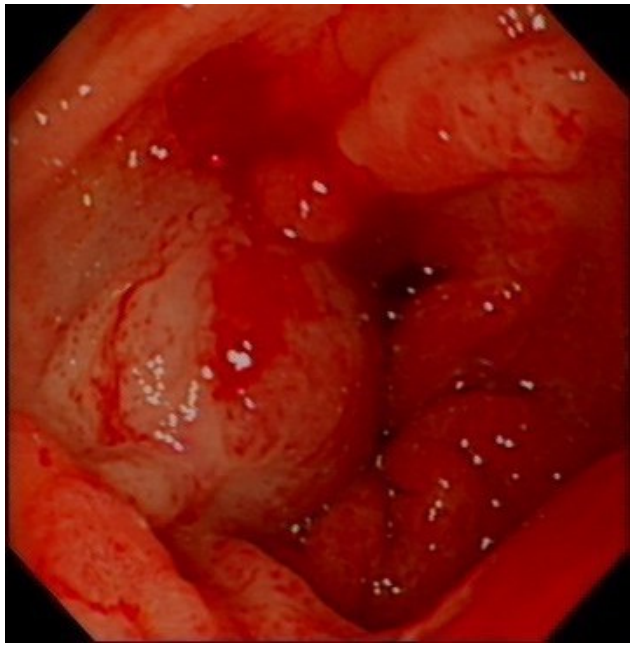


3. Antral GAVE post APC

- Liver work-up: Liver screen normal, USS abdomen suggested cirrhotic appearance of liver, dilated portal vein but normal antegrade flow and splenomegaly (?NAFLD related)
- OGD March 2013 : 3 columns of Grade II varices, Bleeding GAVE injected with adrenaline 1 in 10,000 and APC treatment. Further planned APC and oesophageal varices banding in 6/52

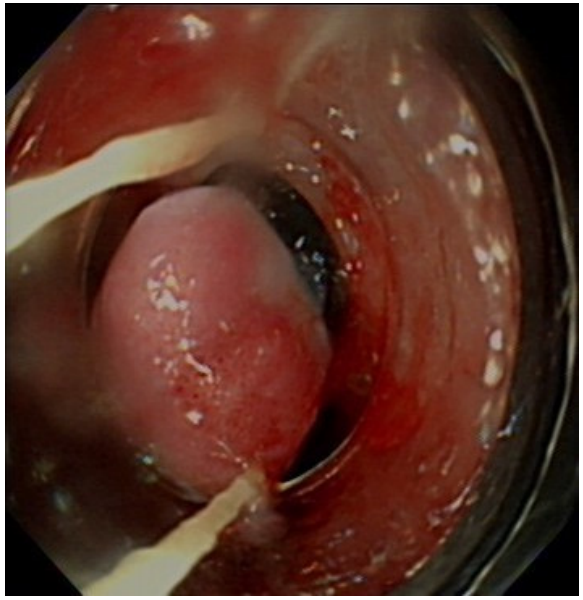
OGD March 2013



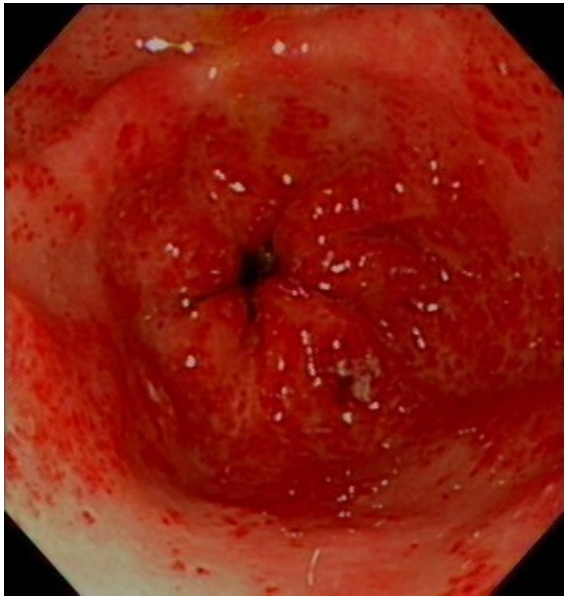


Bleeding Antral GAVE

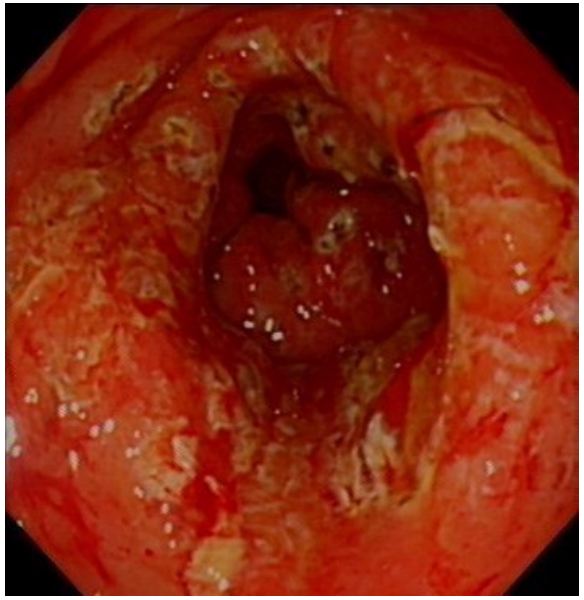
OGD May 2013



Oesophageal band ligation



Antral GAVE

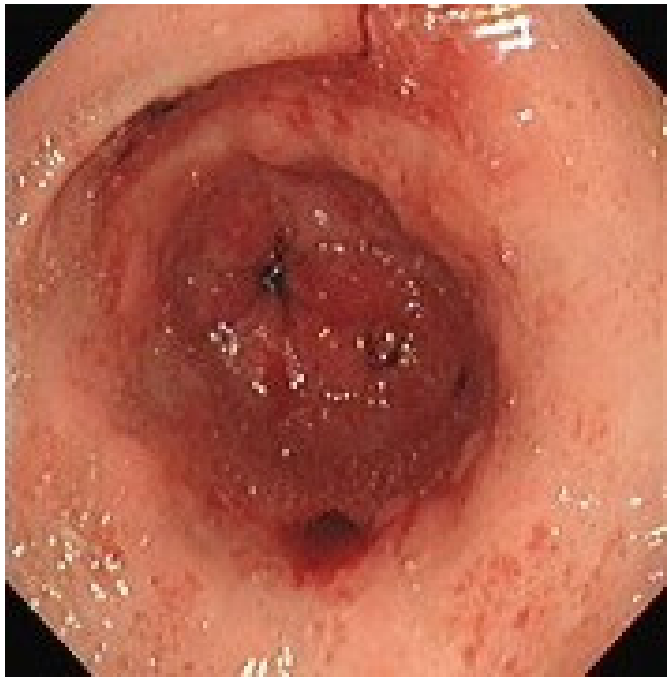


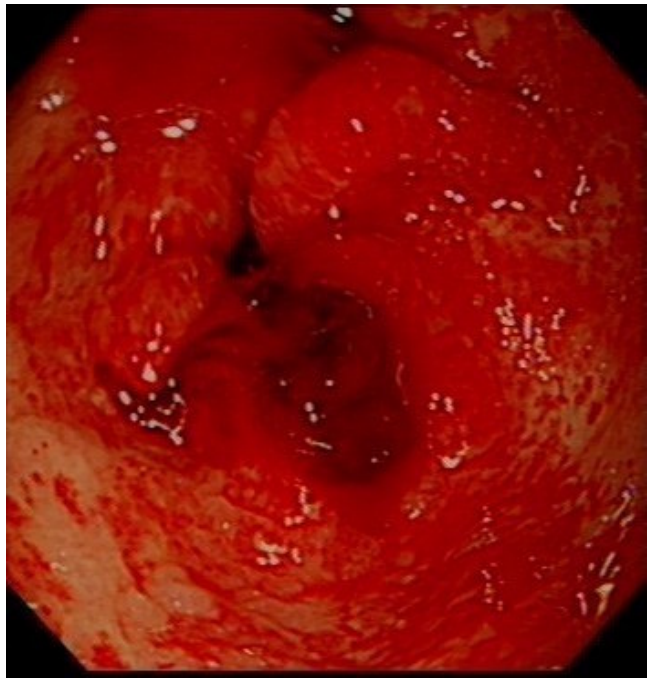
Antral GAVE post APC

- Since completion of 3 x APC sessions by May 2013, noted to have short term benefit with decreased packed red cell requirement but by November 2013 back to 2-3 unit PRC weekly.

- Re-referred in view of above, history re-visited, repeat OGD and colonoscopy to re-assess/ exclude lower GI cause.

OGD Feb. 2014

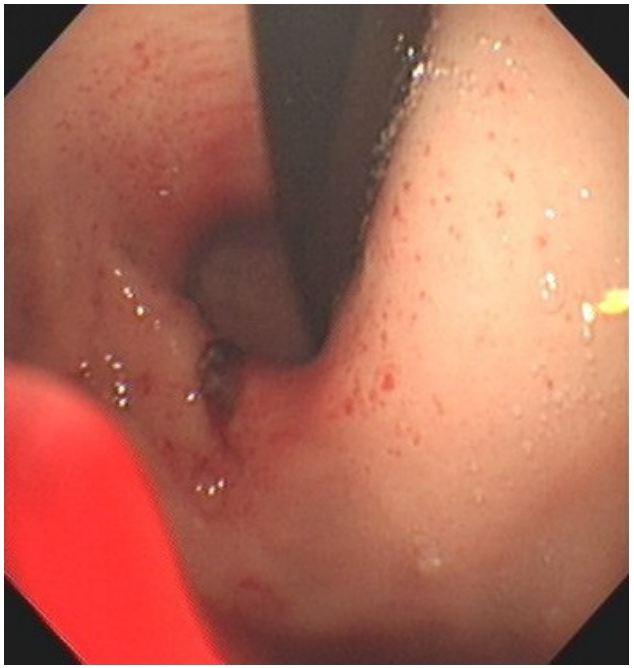




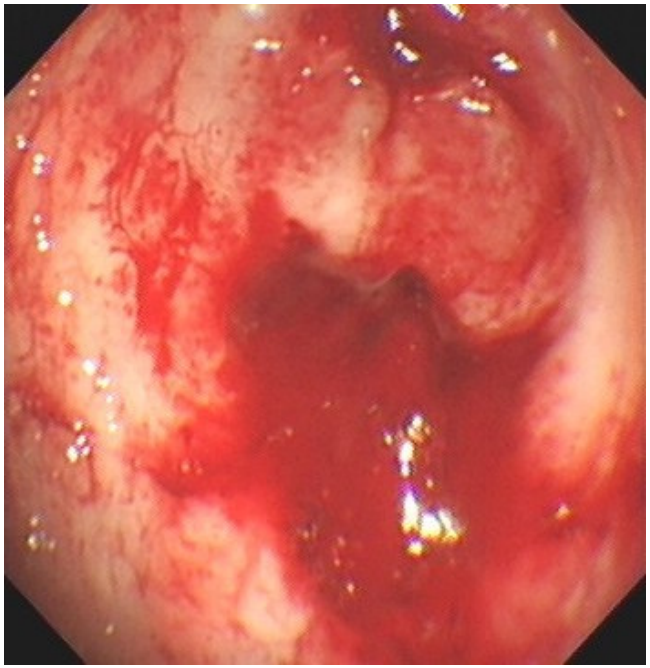
Diffuse/nodular bleeding GAVE in distal body and antrum of stomach

- OGD Feb. 2014: No oesophageal varices, extensive bleeding diffuse nodular antral GAVE treated with adrenaline 1 in 10,000 inj. and APC treatment. Planned further APC
- Colonoscopy Feb. 2014: minor left sided diverticulosis, nil else seen.

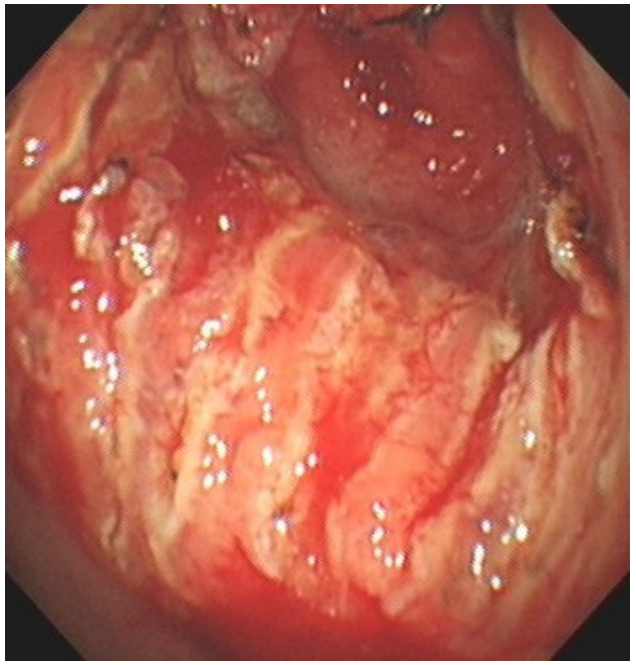
OGD June 2014



1. Fundal ectasia



2. Bleeding GAVE

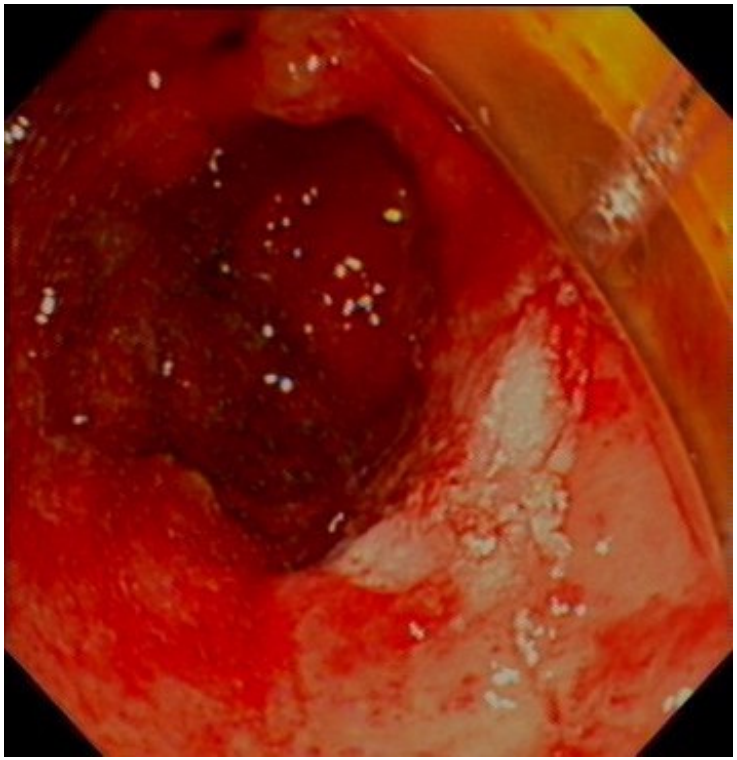


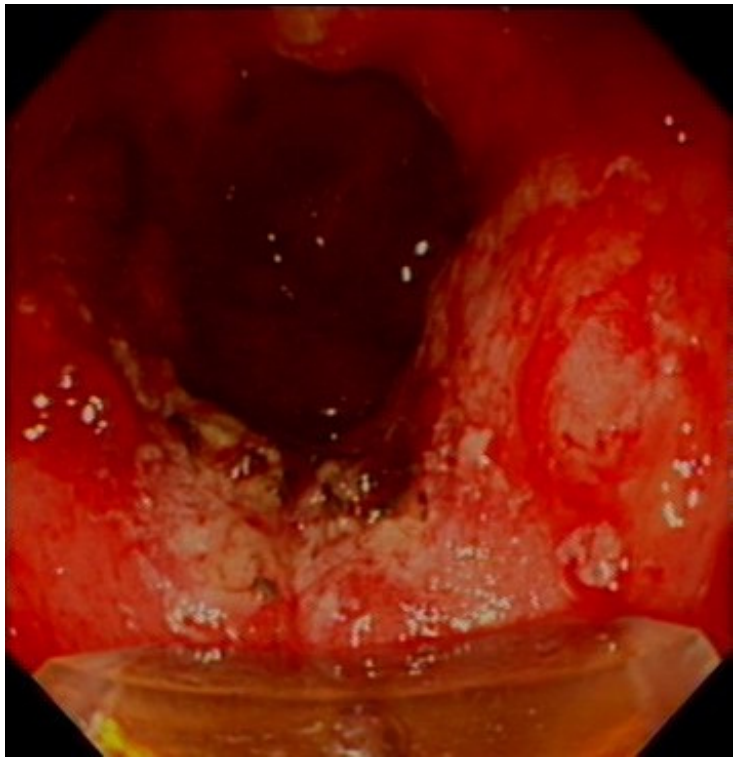
3. GAVE post APC

- Further APC treatments March and June 2014 with minimal improvement and continued high red cell requirement. High PPI dose continued.

- Discussed further treatment options with patients: RFA or partial gastrectomy. Patient agreeable to RFA, individual exceptional treatment application for funding.

OGD August 2014



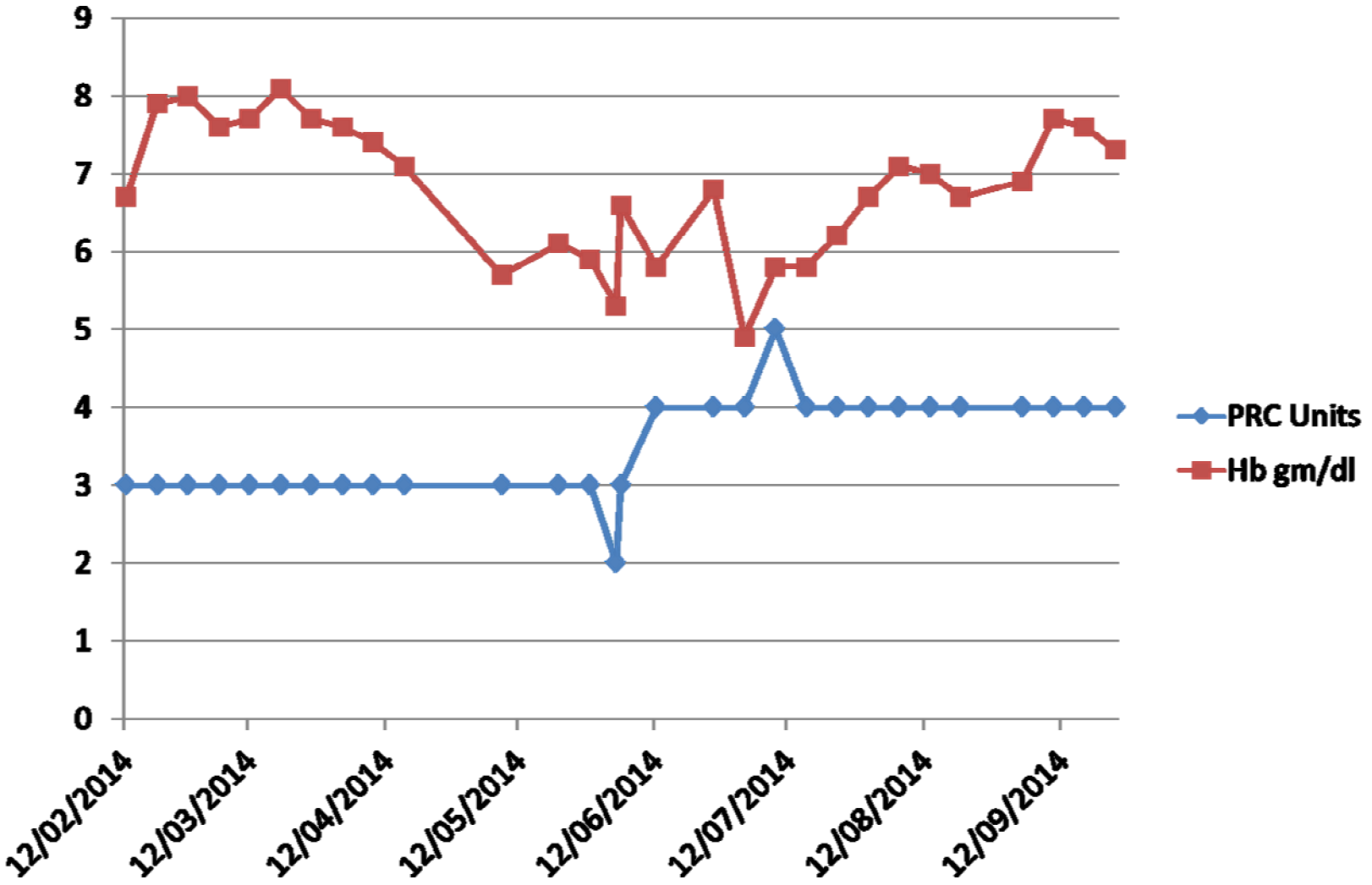


Antral GAVE post HALO 90 RFA

Radiofrequency ablation (RFA)

- OGD August 2014: GAVE treated with HALO 90 focal ablation device from distal pylorus to antrum 4 hits/site at 12 Joules/cm with good results. PPI changed to Esomeprazole 40mg BD and added Sucralfate 1gm TDS for 2 weeks. Repeat planned RFA in 8/52

Weekly blood transfusion requirements:



Summary:

- 76 year old lady with MDS, Cirrhosis – possibly NAFLD related and secondary GAVE.
- Unsuccessful obliteration of vascular ectasia with APC and significant blood transfusion requirements (~ 12-16units PRC/ month).
- On going treatment with RFA planned at 8-12 week intervals for a year.
- ?Partial gastrectomy if no therapeutic benefit.

Literature review

Radiofrequency ablation for refractory gastric antral vascular ectasia (with video)

Tim McGorisk, MD, Kumar Krishnan, MD, Laurie Keefer, PhD, Srinadh Komanduri, MD, MS

Chicago, Illinois, USA

Conclusions: RFA is safe and effective for treating patients with refractory GAVE after attempted APC. (Gastrointest Endosc 2013;■:1-5.)

Thank you

Questions?