Lower GI Bleed

Acute LGIB · Resuscitate, exclude an upper source, then usually *wait*

URGENT SCOPE ADDS LITTLE
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FIRST MOVE — IS THIS ACTUALLY AN UPPER BLEED *the highest-stakes early question*

HEMATOCHEZIA + INSTABILITY = SCOPE THE TOP

Hematochezia with hemodynamic instability may indicate an upper GI source and **warrants upper endoscopy**. A brisk upper bleed transits fast and presents as red blood per rectum. Missing this is the classic serious error in LGIB.

RESUSCITATE

Two large-bore IVs, crossmatch, and correct coagulopathy. **Restrictive transfusion to a hemoglobin threshold of about 7 g/dL** in the stable patient; use a higher threshold with active cardiac ischemia. Over-transfusion does not help.

REVIEW ANTITHROMBOTICS

Decide drug by drug with the indication in mind. **Do not reflexively stop aspirin for secondary cardiovascular prevention.** Time DOAC and warfarin decisions against thrombotic risk, and involve cardiology for recent stents.

RISK-STRATIFY AND DISPOSITION *many of these patients do not need admission*

1. **Use a validated score to identify low risk** — an **Oakland score ≤ 8** identifies patients suitable for **early discharge with outpatient evaluation**. Scores **supplement, not replace, clinical judgement**.
2. **Most bleeding stops on its own.** The majority of LGIB is self-limiting, which is precisely why urgent intervention has been hard to show benefit for.
3. **Admit** for hemodynamic instability, ongoing significant bleeding, significant comorbidity, transfusion requirement, or an unsafe social situation for outpatient follow-up.
4. **Document a plan for the anticoagulant** before discharge — when to restart, who will check, and what to do if bleeding recurs. This is where readmissions come from.

TIMING THE COLONOSCOPY *the biggest practice change — do not rush it*

Situation	What the evidence supports
Most inpatients	**Non-urgent colonoscopy.** Performing it **within 24 hours has not been shown to improve outcomes** such as rebleeding, so there is no need to scope overnight for its own sake.
Hemodynamically stable with or without ongoing bleeding	Colonoscopy **within 14 days is as effective** as within 24 hours. This allows proper bowel preparation, which materially improves diagnostic yield and safety.
Hemodynamically significant bleeding	**CT angiography first** — it accurately localizes the bleeding source and its role has expanded in the current guideline. It maps the target for angiographic embolization.
Preparation	Adequate bowel prep before colonoscopy. An unprepped urgent scope in a bleeding colon is often non-diagnostic, which is part of why urgency has not paid off.

TREAT THE LESION *what you do once you find it*

DIVERTICULAR BLEEDING

The commonest cause. Treat endoscopically with **through-the-scope clips**, **endoscopic band ligation**, or **coagulation**. Typically painless, brisk, and self-limiting, arising from the vasa recta at the diverticular neck.

THE OTHER CAUSES

Angiodysplasia — argon plasma coagulation, and consider aortic stenosis and von Willebrand disease. **Ischemic colitis** — pain then bleeding, usually supportive. **Post-polypectomy** bleeding — clip. Also **hemorrhoids**, neoplasia, and inflammatory bowel disease. **Persistent bleeding despite colonoscopy** → angiographic embolization, then surgery as a last resort.

ANTITHROMBOTICS — STOP, REVERSE, OR CONTINUE *decide drug by drug, with the indication in view*

Agent	Approach in acute LGIB
Aspirin for secondary prevention	**Generally continue**, or restart promptly. Stopping it after an established cardiovascular indication raises thrombotic events, and the bleeding usually stops anyway.
Aspirin for primary prevention	Usually **stop** — the benefit is small and often no longer indicated at all. Use the admission as a chance to review whether it should ever restart.
Dual antiplatelet after a stent	**Do not stop both without cardiology input.** Premature discontinuation risks stent thrombosis, which is frequently fatal. Usually continue aspirin and discuss the P2Y12 agent.
Warfarin	Hold; reverse with **vitamin K plus prothrombin complex concentrate** only for severe or life-threatening bleeding. Weigh the indication — a mechanical valve tolerates interruption poorly.
DOACs	Hold. Short half-lives mean most correct with time. Specific reversal — **idarucizumab for dabigatran**, andexanet alfa for factor Xa inhibitors — is reserved for life-threatening bleeding.
Restarting	**Restart deliberately and document when.** Most patients should resume anticoagulation once hemostasis is secure, because thrombotic risk usually outweighs rebleeding risk over time.

IF BLEEDING CONTINUES *the escalation ladder*

ESCALATE IN ORDER

1. Repeat resuscitation and reassess for an upper source with endoscopy. **2. CT angiography** to localize. **3. Catheter angiography with superselective embolization**, which is now the main non-operative rescue. **4. Surgery** as a last resort — and only with the source localized, since blind segmental resection has poor outcomes.

OBSCURE OR RECURRENT BLEEDING

When colonoscopy and upper endoscopy are both negative, consider the **small bowel**: capsule endoscopy, CT or MR enterography, or device-assisted enteroscopy. **Angiodysplasia and small-bowel lesions** dominate this group, and Meckel diverticulum in younger patients.

PEARLS & PITFALLS

- **Unstable hematochezia is an upper endoscopy** until proven otherwise. Do not send an exsanguinating patient for a colonoscopy.
- **Urgent colonoscopy is not the standard of care.** Within 24 hours has not improved outcomes, and a well-prepped scope within days is as good.
- **Do not stop secondary-prevention aspirin reflexively.** The cardiovascular cost can exceed the bleeding benefit.
- **CT angiography is the right first test** for hemodynamically significant bleeding, not a rushed unprepped scope.
- **Adequate bowel prep is part of the treatment** — a non-diagnostic scope means a second procedure.
- **Use the Oakland score to discharge safely** rather than admitting every episode of rectal bleeding by reflex.

References: ACG Clinical Guideline: Management of Patients With Acute Lower Gastrointestinal Bleeding, updated (Am J Gastroenterol, 2023) · Oakland score derivation and validation studies.

Educational aid; verify against local protocol, endoscopy availability, and patient factors.