Britische Richtlinien zur unteren gastrointestinalen Blutung

Diagnosis and management of acute lower gastrointestinal bleeding: Guidelines from the British Society of Gastroenterology.

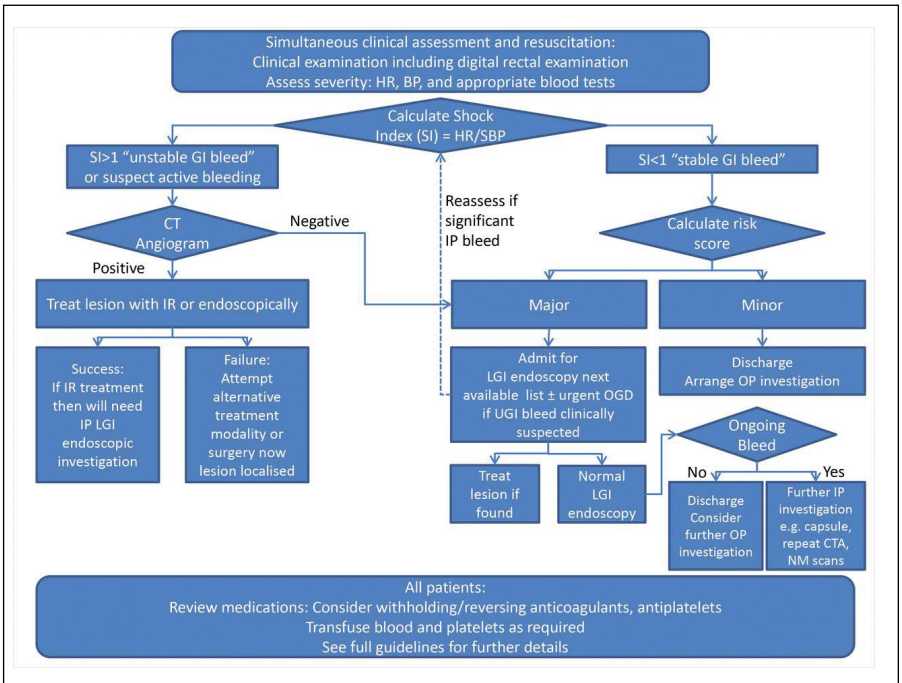
Oakland K, Chadwick G, East JE, Guy R, Humphries A, Jairath V, McPherson S, Metzner M, et al. Gut 2019 [Epub ahead of print]

Full List of Recommendations:

1. We suggest that patients presenting with lower gastrointestinal bleeding (LGIB) are stratified as unstable or stable (unstable defined as a shock index >1). Stable bleeds should then be categorised as major or minor, using a risk assessment tool such as the Oakland score (weak recommendation, moderate quality evidence).
2. We recommend that patients presenting with a minor self-terminating bleed (such as those with an Oakland score ≤ 8 points), with no other indications for hospital admission can be discharged for urgent outpatient investigation (strong recommendation, moderate quality evidence).
3. We recommend that patients with a major bleed should be admitted to hospital for colonoscopy on the next available list (strong recommendation, moderate quality evidence).
4. We recommend that if a patient is haemodynamically unstable or has a shock index (heart rate/systolic BP) of > 1 after initial resuscitation and/or active bleeding is suspected, CT angiography provides the fastest and least invasive means to localise the site of blood loss before planning endoscopic or radiological therapy (strong recommendation, low quality evidence).
5. As LGIB associated with haemodynamic instability may be indicative of an upper gastrointestinal bleeding source, we recommend that an upper endoscopy should be performed immediately if no source is identified by initial CT angiography (CTA). If the patient stabilises after initial resuscitation, gastroscopy may be the first investigation (strong recommendation, low quality evidence).
6. Where indicated, catheter angiography with a view to embolisation should be performed as soon as possible after a positive CTA to maximise chances of success. In centres with a 24/7 interventional radiology service, this should be available within 60 min for haemodynamically unstable patients (strong recommendation, low quality evidence).
7. We recommend that no patient should proceed to emergency laparotomy unless every effort has been made to localise bleeding by radiological and/or endoscopic modalities, except under exceptional circumstances (strong recommendation, low quality evidence).
8. We recommend that in patients who are clinically stable but may need red blood cell (RBC) transfusion, restrictive RBC thresholds (Hb trigger 70 g/L and a Hb concentration target of 70–90 g/L after transfusion) should be used, unless the patient has a history of cardiovascular disease, in which case a trigger of 80 g/L and a target of 100 g/L should be used (strong recommendation, low quality evidence).
9. We recommend interrupting warfarin therapy at presentation (weak recommendation, low quality evidence). In cases of unstable gastrointestinal haemorrhage, anticoagulation should be reversed with prothrombin complex concentrate and vitamin K (strong recommendation, moderate quality evidence). For patients with low thrombotic risk, warfarin should be restarted at 7 days after haemorrhage (strong recommendation, low quality evidence).
10. In patients with high thrombotic risk (i.e., prosthetic metal heart valve in mitral position, atrial fibrillation with prosthetic heart valve or mitral stenosis, < 3 months after venous thromboembolism), we recommend that low molecular weight heparin treatment be considered at 48 hours after haemorrhage (strong recommendation, low quality evidence).
11. We suggest that aspirin for primary prophylaxis of cardiovascular events should be permanently discontinued (weak recommendation, low quality evidence).
12. We recommend that aspirin for secondary prevention is not routinely stopped. If it is stopped, it should be restarted as soon as haemostasis is achieved (strong recommendation, moderate quality evidence).

13. We recommend that dual antiplatelet therapy with a P2Y12 receptor antagonist and aspirin is not routinely stopped in patients with coronary stents in situ, and management should be in liaison with a cardiologist (strong recommendation, moderate quality evidence). In unstable haemorrhage we recommend continuing aspirin if the P2Y12 receptor antagonist is interrupted (strong recommendation, moderate quality evidence). P2Y12 receptor antagonist therapy should be reinstated within 5 days (strong recommendation, moderate quality evidence).
14. We recommend interrupting direct oral anticoagulant therapy at presentation (strong recommendation, low quality evidence). We recommend considering treatment with inhibitors such as idarucizumab or andexanet for life-threatening haemorrhage on direct oral anticoagulants (strong recommendation, moderate quality evidence). We suggest restarting direct oral anticoagulant drug treatment at a maximum of 7 days after haemorrhage (weak recommendation, very low quality evidence).
15. All hospitals should have a GI bleeding lead and agreed pathways for the management of acute LGIB (good practice statement).
16. We recommend that all hospitals that routinely admit patients with LGIB should have access to 7/7 on-site colonoscopy and the facilities to provide endoscopic therapy (good practice statement).
17. We recommend that all hospitals that routinely admit patients with LGIB should have access to 24/7 interventional radiology either on site, or via a formalised referral pathway to another hospital (good practice statement).

- Die Punkte 1 bis 3 erklären die Triagierung.
- Die Punkte 4 bis 7 setzen sich mit Stärken und Schwächen der endoskopischen und radiologischen Methoden zur Lokalisation und Therapie und ihrer optimierten Abfolge auseinander.
- Punkt 8 setzt klare Trigger für Transfusionen.
- Die Punkte 9 bis 14 beschäftigen sich mit Patienten unter Antikoagulation bzw. Thrombozytenaggregationshemmung.
- Die Punkte 15 bis 17 setzen Standards der Betriebsorganisation für Spitäler, die Patienten mit LGIB aufnehmen.



Management algorithm for patients presenting with acute lower gastrointestinal bleeding. Shock index (SI) is calculated by dividing the heart rate (HR) by the systolic blood pressure (SBP).

IP, inpatient; IR, interventional radiology; OGD, oesophagogastroduodenoscopy; OP, outpatient; UGI, upper gastrointestinal *(Kathryn Oakland et al., Gut 2019; 68:776-789; © BMJ Publishing Group Ltd & British Society of Gastroenterology)*

Für uns ungewohnt, aber gut nachvollziehbar ist der prominente Platz der CT-Angiographie in der Abklärung. Damit umgeht man das Problem des nicht vorbereiteten Darms und der hämodynamischen Instabilität bei Endoskopie sehr elegant. Ungewohnt ist auch, dass stabile Patienten mit niedrigen Risiko-Scores nicht stationär aufgenommen, sondern ambulant weiter abgeklärt werden.

In dieser Guideline wird zur Risiko-Stratifizierung einerseits der Schockindex (Herzfrequenz/systolischer RR) und andererseits der Oakland-Score verwendet, doch gibt es mehrere solche Risiko-Scores (Rockall, Glasgow-Blatchford u. a.). Sie setzen einerseits Triggerpunkte für sichere ambulante Behandlung, andererseits versuchen sie Rezidivblutung oder Wiederaufnahme vorherzusagen.

Der Volltext der Guideline kann auf Medline kostenlos heruntergeladen werden. Eine autorisierte Übersetzung ins Deutsche und eine Approbation durch die Arbeitsgruppen für Endoskopie der ÖGC und ÖGGH wären wünschenswert.

Interessenkonflikte: Keine

Prim. Prof. Dr. Rainer Schöfl
4. Interne Abt. – Gastroenterologie & Hepatologie, Stoffwechsel & Ernährungsmedizin, Endokrinologie
Ordensklinikum Linz
rainer.schoefl@ordensklinikum.at