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Summary

# Bleeding: The endoscopist's and the radiologist's perspective

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**The presentation compared endoscopic and interventional radiology approaches to acute lower GI bleeding, with the speaker stating that current evidence does not support routine urgent colonoscopy within 24 hours for most patients, while IR embolization is recommended as first-line therapy for hemodynamically unstable patients.**

## KEY POINTS

- The speaker reported that a meta-analysis of four randomized controlled trials with almost 500 patients showed no difference in diagnostic yield, mortality, or need for surgery or IR between early colonoscopy (within 24 hours) and elective colonoscopy for acute lower GI bleeding.
- A Japanese retrospective study of over 6000 patients showed no significant benefit of early colonoscopy, though the speaker noted that patients with shock index greater than one or performance status of three or greater may benefit from earlier colonoscopy.
- Guidelines from ESG, British Society, and American College of Gastroenterology recommend non-emergent inpatient colonoscopy for most patients with lower GI bleeding.
- First-line endoscopic treatment options for diverticular bleeding stated by the speaker include through-the-scope clip, over-the-scope clip, or band ligation, with dilute epinephrine injection as an adjunct.
- The interventional radiologist stated that CT angiography with multiphasic protocol has very low false negative and false positive rates for detecting active bleeding and that IR embolization with fibered coils can be completed within 20 to 30 minutes.
- The IR speaker recommended that for hemodynamically unstable patients with extravasation on CT angiography, interventional radiology should be first-line treatment, and emphasized that selective embolization of one to two vasa recta reduces bowel ischemia compared to older unselective techniques.

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