Diagnosis and treatment of diverticular bleeding

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# **Historical perspective**

- Clinical context
  - 25-40% of painless rectal bleeding
  - May be massive in  $\sim 5\%$
  - Self-limiting

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# **Historical perspective**

#### Clinical context

- 25-40% of painless rectal bleeding
- May be massive in ~5%
- Self-limiting
- Diagnosis of exclusion ?
- Epidemiological/demographic overlap with angiodysplasia
  - Latter more likely to be R sided
  - But 40% of BLEEDING diverticula are on right

Longstreth '97

# Why do diverticula bleed ?

- Not known
- Probable chronic injury to vasa recta adjacent to lumen of diverticula
- Fragmentation of internal elastic lamina and loss of media
- ? more common on R because larger lumen (so more vasa recta exposed)





#### Standard initial management

- Standard resuscitative measures
- Exclude UGI cause for bleeding
- Clinical diagnosis "supported by" rigid sigmoidoscopy
- Surgical or (usually) conservative management according to progress

## Can we do better ?

- Colonoscopy
- Nuclear scanning
- Angiography methods

# Can we do better ?

- Colonoscopy
- Nuclear scanning
- Angiography methods
- Evidence base unfortunately not strong

# **Diagnosis from angiography**

#### Specific but not sensitive

- 0.5-1.0ml/min
- Technically difficult when IMA territory
- Distinguishes diverticula from angiodysplasia
- Therapeutic potential

Fiorito AJG '89, Zuckerman AJR '93

# **Diagnosis from nuclear scanning**

- More sensitive but less specific

  0.1ml/min detectable
  Difficult to localise bleeding site
  Doesn't distinguish diverticula
  Insufficient for operative planning
  - No therapeutic potential

Dusold AJG '94

# **Diagnosis from colonoscopy**

Specific and sensitive if possible
 Not dependent on continued bleeding



# **Diagnosis from colonoscopy**

- Specific and sensitive if possible

   Not dependent on continued bleeding
   Technically difficult when bleeding persists
   Issues of preparation
- Therapeutic potential

# **Diagnosis from colonoscopy**

Said to exceed 72% accuracy Jensen '88, Peura '98, Rossini '89, Zuckerman '98

May speed up discharge from hospital Strate '03

#### **Preparation for colonoscopy**

- Probably best to employ lavage approach
- PEG by NGT probably safest option
- Typically need >5L for clear effluent
- ± metoclopramide/domperidone
- Safe (but caution in renal failure)





#### Is it worth the trouble ?



**Smoot 2003** 

#### Results of standard therapy

- Nearly half of patients do well
- But >50% rebleed

Jensen 2000

# Therapeutic angiography

Transient control with vasoactive agents
 ->90% control but ~50% rebleed
 Sherman '79, Browder '86, Eavari '04

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More definitive control with embolisation

 40-90% control and ~20% rebleed
 Funaki '01, Ledermann '98, Nicholson '98, Gady '03

# Therapeutic angiography

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- More definitive control with embolisation

   40-90% control and ~20% rebleed
   Funaki '01, Ledermann '98, Nicholson '98, Gady '03
- Risk of major ischaemia is low

#### **Therapeutic colonoscopy - options**

- Transient control with vasoactive agents
- "Definitive" control with diathermy or other thermal techniques
- "Definitive" control with clips or other physical devices
- ? risk of major ischaemia

#### Therapeutic colonoscopy

- Adrenaline or bipolar diathermy or both
   0% rebleed to 30 months (!)
- Band ligation small numbers

Witte '00, Farrell '03

• Hemoclips – small numbers

Hokama '97, Simpson '04

# Adrenaline & diathermy

**Bloomfield 2001** 



# Hemoclips (Simpson 2004)



# Surgery if other measures fail

Failure =

- Failure of diagnosis in shocked patient
- Failure to identify specific bleeding site
- Failure to control bleeding when bleeding site identified
- Complications of other treatments (eg ischaemia)

# Surgery

- Segmental colectomy usually appropriate
- Primary anastomosis usually appropriate

#### University College Hospital London



