Small Bowel Bleeding

Diagnostic sequence, radiographic/angiographic evaluation, and treatment of small bowel bleeding.

2015 ACG Clinical Guideline
Diagnosis & Management of Small Bowel Bleeding
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GRADE — Strong Rec — Conditional Rec

1 Diagnostic Sequence — Endoscopy

STATEMENT	GRADE
Second-look upper endoscopy for recurrent hematemesis/melena or an incomplete prior exam	1 · Strong
Second-look colonoscopy for recurrent hematochezia or a suspected lower source	2 · Conditional
If second-look exams are normal, proceed to **small bowel evaluation**	1 · Strong
Push enteroscopy can serve as the second-look exam for suspected small bowel (SB) bleeding	2 · Conditional
Video capsule endoscopy (VCE) first-line for SB evaluation once upper/lower sources are excluded	1 · Strong
Push enteroscopy if a proximal (duodenal/jejunal) lesion is suspected — VCE has lower detection there	1 · Strong
Total deep enteroscopy if strong clinical suspicion of an SB lesion	1 · Strong
Any deep enteroscopy method (antegrade/retrograde) is acceptable — similar diagnostic yields	1 · Strong
Intraoperative enteroscopy: reserve for when standard enteroscopy is not feasible (prior surgery/adhesions)	1 · Strong
Perform VCE **before** deep enteroscopy to increase yield; deep enteroscopy first if massive hemorrhage or VCE contraindicated	1 · Strong

2 Radiographic & Angiographic Evaluation

STATEMENT	GRADE
Barium studies should **not** be performed in SB bleeding evaluation	1 · Strong
CT enterography (CTE) after negative VCE — better mural mass detection/localization, guides enteroscopy	1 · Strong
CT preferred over MRI; MR reserved for CT contraindications or to limit radiation in younger patients	2 · Conditional
CTE **before** VCE if established IBD, prior radiation, prior SB surgery, or suspected SB stenosis	1 · Strong
CTE if high suspicion for SB source persists despite prior negative standard CT and negative VCE	2 · Conditional
Emergent conventional angiography for hemodynamically **unstable** patients with massive overt bleeding	1 · Strong
Multiphasic CT angiography (CTA) in hemodynamically stable patients with active bleeding to localize/guide management	1 · Strong
Tagged RBC scintigraphy for slower bleeding (0.1–0.2 mL/min) if deep enteroscopy/VCE not performed, to time angiography	1 · Strong
CTA preferred over CTE in brisk active overt bleeding	2 · Conditional
Conventional angiography should **not** be used as a diagnostic test without overt bleeding	2 · Conditional
Provocative angiography: consider with ongoing overt bleeding and negative VCE/deep enteroscopy/CT	2 · Conditional
Meckel's scan in younger patients with ongoing bleeding and normal capsule/enterography	2 · Conditional

3 Treatment & Outcomes

STATEMENT	GRADE
Endoscopic therapy if a source is found (VCE/deep enteroscopy) with ongoing anemia or active bleeding	1 · Strong
If no source found: manage conservatively with oral/IV iron per anemia severity — small vascular lesions on VCE don't always need treatment	1 · Strong
If bleeding persists with worsening anemia: repeat upper/lower endoscopy, VCE, deep enteroscopy, or CT/MR enterography as appropriate	1 · Strong
If bleeding persists/recurs or lesion unlocalized: consider medical treatment — iron, somatostatin analogs, or antiangiogenic therapy	1 · Strong

4 Special Situations & Surgery

STATEMENT	GRADE
Discontinue anticoagulation and/or antiplatelet therapy if possible	2 · Conditional
Surgery for massive SB bleeding — greatly aided by presurgical localization with a tattoo	1 · Strong
Intraoperative enteroscopy available at surgery to help localize the source and deliver endoscopic therapy	2 · Conditional
Heyde's syndrome (aortic stenosis + angioectasia) with ongoing bleeding → aortic valve replacement	2 · Conditional
Recurrent SB bleeding: endoscopic management can be considered per clinical course and prior response	2 · Conditional

Gerson LB, Fidler JL, Cave DR, Leighton JA. ACG Clinical Guideline: Diagnosis and Management of Small Bowel Bleeding. *Am J Gastroenterol.* 2015;110(9):1265-1287.