LETTER TO THE EDITOR

Diagnostic yield of capsule endoscopy in elderly patients with obscure GI bleeding

Rendement diagnostique de la capsule endoscopique au cours des saignements digestifs obscurs chez la personne âgée

Letter to the editor

About 37% of iron deficiency anemia (IDA) remains unexplained after bidirectional endoscopy in the elderly [1,2]. Since 2000, capsule endoscopy (CE) has been widely used to investigate obscure GI bleeding (OGIB) from small bowel origin. However, data are limited in the elderly.

Therefore, we decided to perform a prospective multicenter study to assess the diagnostic yield of CE in elderly patients who had a previous negative endoscopic evaluation (at least one upper endoscopy and one colonoscopy) for OGIB and one rebleeding episode. Rebleeding was defined as a drop in the hemoglobin level from the upper one of 2 g/dL or more, or by new overt bleeding. A multivariate analysis was performed to identify predictors of lesions and determine factors associated with rebleeding.

From January 2006 to April 2007, 76 patients (42 women and 34 men, 76.6 ± 9 yrs) were included for an occult (n = 47) or an overt OGIB (n = 29). Forty percent of patients took NSAID (n = 2); aspirin (n = 12); vitamin K antagonist (n = 11), clopidrogel (n = 10). Visualization of the entire small bowel was achieved in 90%. No complication related to CE occurred. A lesion was identified in 49 (63%) cases, angiodysplasias were observed in 73% of cases. The diagnostic yield (defined by OGIB related to lesion) of CE was 58%, resulting in a potential specific treatment in 82%.

Treatment consisted of:

• argon plasma coagulation in 29 cases;
• surgery for tumors in four cases;
• long-acting octreotide in three cases and betablockers in two cases. The yield of CE for occult OGIB was 55% vs 65% for overt OGIB (p = 0.7).

Predictive factors of small bowel lesions were (OR [IC], p): male sex (6.7 [1.5—30]; 0.014) and cardiac disease (8.2 [1.7—39], 0.008). Forty-eight (63%) patients were followed-up during a median period of 15.4 months (3.2—21.2 months). Rebleeding was observed in 11 (23%) cases. A trend towards rebleeding (not significant because of small sample size) was observed in cases of: overt OGIB (36% vs 18%); identified lesion (27% vs 14%) and untreated lesion (42% vs 18%).

Discussion

This study confirms the high value of CE and its safety in a population of elderly patients with OGIB. The diagnostic yield of CE was high, as observed in studies with younger patients with OGIB allowing an appropriate treatment in most cases [3]. The relative high yield of CE may be explained by the study design, which enrolled patients only if they had recurrent bleeding. We think that elderly patients with unexplained IDA after bidirectional endoscopy could be placed on iron supplementation and managed expectantly, letting further work-up be dictated by the patient’s clinical course. This expectancy management is appropriate, as after a negative evaluation of the GI tract the rate of rebleeding was low, between 11 and 30% [1,2,4]. The indication of CE may be discussed for patients who do not respond to iron therapy or for those where iron deficiency anemia recurs at the end of treatment.

As expected, angiodysplasia was the most frequent lesion as observed by Carey et al [3] and not surprisingly cardiac disease was a factor associated with lesion although this observation is controversial [5].

After a median follow-up of 15.4 months, we observed a low rate of rebleeding as previously described by Lai et al [6]. Rebleeding was observed in 11 (23%) patients, but this small sample size does not allow clearly-identifiable relapse factors to emerge. However, a trend towards rebleeding (non-significant because of small sample size) was observed.
in cases of: overt OGIB (36% vs 18%); identified lesion (27% vs 14%) and untreated lesion (42% vs 18%).

In conclusion, CE was safe in the elderly and its diagnostic yield was as effective as that observed in other studies with younger patients. It should be shortly recommended after a negative bidirectional endoscopy and rebleeding.

Disclosure

Each author warrants that he or she has no commercial associations (e.g., consultancies, stock ownership, equity interest, patent/licensing arrangements, etc.) that might pose a conflict of interest in connection with the submitted article.

References


