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# LETTER TO THE EDITOR

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Mr. Editor:

After an interesting reading of the article “Hemorrhagic shock as initial presentation of Meckel’s diverticulum”,<sup>1</sup> I wish to make a comment.

Lower gastrointestinal bleeding (LGB) represents 14 to 40% of gastrointestinal bleeding episodes, with an incidence ranging between 27.3 and 87 per 100,000 inhabitants per year.

Classically, LGB is defined as gastrointestinal bleeding that originates below the angle of Treitz. However, there is currently the concept of intermediate gastrointestinal bleeding, which originates from the angle of Treitz to the ileocecal valve.<sup>2</sup> Clinically, it represents a challenge for emergency physicians in terms of diagnosis and treatment. The initial management of these patients depends on their hemodynamic status on admission. In those who are stable, the preferred course of action is for a trained professional to perform a colonoscopy after adequate preparation, and in unstable patients, the British guidelines suggest performing computed tomography angiography with endovascular management of the bleeding vessel and delayed colonoscopy for direct evaluation of the affected area.<sup>1</sup>

In their manuscript, the authors carry out an adequate diagnostic and therapeutic approach to the patient, thus obtaining an adequate result. However, it is noteworthy that they do not use a patient risk stratification scale that can guide therapeutic strategies. Risk stratification of patients with LGB using clinical scales allows the treating physician to determine management based on different criteria that include safe medical discharge, endoscopic management or emergency surgical treatment and deferred hospital management.<sup>3</sup>

Unfortunately, the study and stratification of LGB is not as widespread as that of upper gastrointestinal bleeding, for which there are multiple epidemiologically validated assessment scores to determine the risk of mortality and the need for intervention. Among them, the Blatchford-Glasgow, Rockall pre-endoscopic, AIMS-65 and CANUKA scales stand out. However, these strategies have not been adequately validated for use in LGB and therefore cannot be considered optimal for patient analysis.<sup>4</sup>

Here I allow myself to mention the scales of stratification currently available for patients with LGB who have demonstrated adequate validation to predict interventions in this type of situation for future use:

1. NOBLADS Score: It is a scale used to determine the risk of major primary bleeding, secondary bleeding, length of stay, requirement for transfusions and emergency interventions.<sup>5</sup>
2. Oakland score: This scale allows predicting the probability of discharge without interventions, primary bleeding, secondary bleeding, recurrent bleeding, need for transfusion of blood products, requirement of emergency interventions and the possibility of hospital readmission.<sup>4</sup>
3. Sengupta Score: This score is extremely useful in predicting the mortality of affected patients within 30 days after their admission.<sup>6</sup>
4. Strate score: Through this forecasting tool it is possible to determine the risk of major bleeding and recurrent bleeding.<sup>7</sup>
5. BLEED score: This scale allows estimating the risk of complications, hospitalizations and associated mortality in affected patients.<sup>8</sup>

The use of risk scales is considered important in the comprehensive approach to the patient with LGB, since statistically they have shown an optimization in the use of resources, added to a decrease in mortality and adverse outcomes. As a general rule, there is no marked superiority between these scales, so their individual use is not recommended, given that joint use allows a significant improvement in the classification of patients and therefore in their care.<sup>9</sup>

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## REFERENCES

1. Haro C, Duffau C, Muniz M, Mansilla S, Sanguinetti M, Viola M. Shock hemorrágico como presentación inicial de divertículo de Meckel. *Rev Argent Coloproct* 2021; 32:103-105.
2. Bellido-Caparó A, Espinoza-Ríos J, Gómez Hinojosa P, Prochazka-Zarate R, Bravo Paredes E, León Rabanal CP, et al. Hemorragia digestiva baja, factores predictores de severidad y mortalidad en un hospital público de Lima. *Rev Gastroenterol Peru* 2019;39:229-38.

3. Oakland K, Kothiwale S, Forehand T, et al. External validation of the Oakland score to assess safe hospital discharge among adult patients with acute lower gastrointestinal bleeding in the US. *JAMA Netw Open*. 2020;3:e209630.
5. Oakland K. Risk stratification in upper and upper and lower GI bleeding: Which scores should we use? *Best Pract Res Clin Gastroenterol* 2019;42-3:101613.
6. Aoki T, Nagata N, Shimbo T, et al. Development and validation of a risk scoring system for severe acute lower gastrointestinal bleeding. *Clin Gastroenterol Hepatol* 2016;14:1562-70.
7. Sengupta N, Tapper EB. Derivation and internal validation of a clinical prediction tool for 30-day mortality in lower gastrointestinal bleeding. *Am J Med* 2017;130:601e1-8. Strate LL, Orav EJ, Syngal S. Early predictors of severity in acute lower intestinal tract bleeding. *Arch Intern Med* 2003;163:838-43.
8. Kollef MH, O'Brien JD, Zuckerman GR, Shannon W. BLEED: a classification tool to predict outcomes in patients with acute upper and lower gastrointestinal hemorrhage. *Crit Care Med* 1997;25:1125-32.
9. Tapaskar N, Jones B, Mei S, Sengupta N. Comparison of clinical prediction tools and identification of risk factors for adverse outcomes in acute lower GI bleeding. *Gastrointest Endosc* 2019;89:1005-1013.e2.

As an attached comment, the clinical case referred to in the letter to the editor was presented at the institution where I am the Head of the Department of Surgery. The management and therapeutic decisions of this particular patient were consulted with me by the treating surgeon, as we usually do in our environment. We also have the tools to proceed in this way in our institution. The clinical evolution of the patient was very favorable, without complications and with an adequate hospital stay.

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