

Evidence Discussion – Small Bowel Bleeding Suspected (AB-22.2)

The goal of identifying the source of GI tract bleeding is to identify lesion, location, and ability to perform therapeutic intervention. Bleeding from the small bowel is uncommon, accounting for approximately 5–10% of all patients presenting with gastrointestinal (GI) bleeding. The initial diagnostic modality of choice is endoscopy or colonoscopy to help identify lesions and execute appropriate interventions.

Video capsule endoscopy (VCE) is considered a first-line modality for small bowel investigation. Its main advantages are that it is noninvasive and allows examination of the entire length of the small bowel in 70-90% patients with diagnostic yield of 38–83% in patients with suspected small bowel bleeding. The main utility of this test lies in its high positive (94–97%) and negative predictive value (83–100%) in the evaluation of GI bleeding. Findings on VCE leading to endoscopic or surgical intervention or a change in medical management have been reported in 37–87% of patients.

Computed tomographic enterography is indicated in patients with suspected obstruction before VCE or after negative VCE examinations, women who are pregnant, and patients who are unable to swallow the VCE capsule.

Cross-sectional imaging techniques optimized for imaging the small bowel are advantageous due to ability to see all bowel loops without superimposition and the visualization of extra-luminal structures. Enterography can be performed with either CT or MR. CT is more widely used in the setting of GI bleeding because of the superior temporal and spatial resolution compared with MR and is more widely available. CT can detect vascular and inflammatory abnormalities, which may be missed on VCE. Because of the small number of studies regarding MR enterography, this exam is not routinely recommended *in lieu* of CT enterography, but can be considered in patients aged <40 years because of lower radiation exposure.

References:

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