LETTERS

Authors' reply

We thank Dr Leeds *et al* for their interest and comments[1] on the British Society of Gastroenterology guideline on the diagnosis and management of acute lower gastrointestinal bleeding (LGIB).[2] They are quite correct to highlight the difference in evidence supporting therapeutic endoscopy in LGIB as opposed to upper. There is only one randomised trial that directly compared timing of colonoscopy in patients hospitalised with LGIB, which as the authors' state demonstrated no difference in clinical outcomes, however, the trial was terminated before the required sample size had been reached.[3] Pooled analysis in a systematic review of non-randomised studies demonstrated that early colonoscopy was associated with higher diagnostic and therapeutic yields and most importantly a shorter length of hospital stay.[4] This systematic review is limited by a lack of randomised data, and further studies examining the relationship between timing of colonoscopy and clinical outcomes are needed. In the national audit 48% hospitalised patients underwent no inpatient investigation, but 17% of received red blood cell (RBC) transfusion and 10% were readmitted by 28 days.[5] Arguably if safe to do so, these patients should be investigated. Given the predominantly elderly nature of the LGIB population, fitness for colonoscopy is a key consideration and if the treating clinician deems a patient unsafe for colonoscopy then this must be respected. In the guideline we recommend that colonoscopy should be performed on the next available list as opposed to within 24 hours to reflect uncertainty regarding the optimum timing. We also assess the burden of extra colonoscopies required to support this recommendation, finding that on average there will be an additional five colonoscopies per hospital per month.

We congratulate the authors on using their own data to assess the use of the shock index and Oakland score. The Oakland score was developed in a population of hospitalised patients to predict *safe discharge*; a composite outcome reflecting lack of rebleeding, RBC transfusion, therapeutic intervention, in-hospital death and hospital readmission. Currently a points threshold of ≤8 is recommended to identify patients that can be immediately discharged from the emergency department. This threshold has an intentionally high specificity but may result in patients who would be safe for discharge being flagged as needing admission. The score serves a decision aid and its intended use in the guideline is to strengthen decision making surrounding discharge, not drive additional hospitalisations.[6] Further external validation studies that investigate the safety of extending the threshold for immediate discharge to capture more low-risk patients would be extremely useful and we recognise that evidence in this area will accrue rapidly. With regard to the authors' own clinical data, it would be interesting to see how many patients with a high shock index had extravasation on CT angiography and whether this finding was used to guide embolic or endoscopic therapy. The authors state that in the *major* bleed group only two patients with post-polypectomy bleeding were suitable for endoscopic intervention. It would be useful to understand why the patients diagnosed with diverticular, haemorrhoidal or angiodysplasia bleeding were not suitable for therapy. Aside from the small number of patients in this study, lack of therapeutic intervention in both the high shock index and major bleed groups may explain the lack of statistical difference in terms of re-bleeding and death.

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