Editorial: how can we best promote the routine use of scores that are accurate at predicting outcomes in patients with upper gastrointestinal bleeding?

Acute upper gastrointestinal bleeding (UGIB) remains a common, life-threatening condition with mortality ranging from 5% to 11%. Saffouri and colleagues recently assessed the usefulness of the Shock Index (SI: heart rate in beats/minute divided by systolic blood pressure in mm Hg). In patients with UGIB, a value over 1 has been suggested as a marker of active bleeding at the time of admission. It has also recently been proposed as part of a stratification scheme for patients with lower GI bleeding. The authors of the current paper found that the SI performed worse than existing pre-endoscopy scores including the admission Rockall, AIMS65, and Glasgow-Blatchford (GBS) at predicting major clinical endpoints after UGIB.

Even if this result contradicts a previous assessment of the SI suggesting that it performed as well as other scoring systems, the concern raised by this study does not pertain as much to the SI itself, but rather questioning the utility of any of the existing scores in predicting outcomes of patients with UGIB.

A prognostic scoring system has the potential for ensuring a more objective and reproducible risk assessment than clinical judgment alone; this score can then easily and reproducibly be communicated to different clinicians responsible for the management of patients with UGIB. Education is also needed to embed such a tool into clinical practice (eg into electronic medical records). The use of artificial intelligence may further improve the predictive ability of such scales in this patient population.

Use of prognostic scales, such as the GBS, and early discharge of those at low risk has the potential to reduce the need for endoscopy and obviate hospital stays with their associated costs without increasing harm. At the other end of the spectrum, sensitivity in detecting high-risk patients is also important to avoid mis-classifying such individuals as low-risk when making decisions about early discharge. Patient preferences should also be considered as some may prefer diagnostic certainty, while others may prefer not to be hospitalised. Other factors when considering early release or avoidance of discharge include the care setting (urban versus rural environment), access to hospital or ambulance services, access to out-of-hours endoscopy and reimbursement issues.

Almost three decades after the creation of the GBS, many risk stratification schemes have been published, although none of the existing scores has been widely accepted in clinical practice. As many of these are reasonably straightforward in their components, this poor uptake may reflect a lack of perceived clinical utility by clinicians in improving any of the relevant outcomes for patients with UGIB. No doubt, part of the limited uptake relates to a paucity of actual interventional data, let alone such information based on randomised clinical trials of using or not using a given prognostic scale.

Perhaps rather than developing or assessing diagnostic testing-type validity assessments of new or existing scores, we must now more urgently try undertaking pragmatic trials, ideally randomised, to measure the clinical utility of such tools prospectively.

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Editorial: establishing a joint approach to a common problem for gastroenterologists

Despite their name, the IBDs are systemic diseases in which gut manifestations are the predominant, and usually the initial, features. As such, IBD patients may require cross-specialty referrals through the course of their disease. With increasing specialisation within medicine, it is not surprising that gastroenterologists may feel uncomfortable with the assessment and management of extraintestinal manifestations of IBD. However, ever increasing demand within health care systems does not always allow for unrestrained interdisciplinary referrals. Hence, expansion of gastroenterologists’ familiarity with problems manifesting outside the gastrointestinal tract allowing them to initiate the diagnostic work-up and basic management of extraintestinal manifestations has value. Not only does this augment gastroenterologists’ ability to provide holistic care to their IBD patients, but it should also improve the appropriateness of referrals.

It is within this context that the paper by Varkas et al should be commended for two main reasons. First, it is authored by an appropriate mix of IBD and rheumatology experts. Second, the algorithms presented address a variety of rheumatological presentations that are simple to follow and achievable within the everyday practice of a gastroenterologist.

While most of the algorithms are based on expert consensus, the approach to diagnosing axial spondyloarthritis in an IBD patient with chronic back pain is based on evidence from a general population. The importance of the response to a trial of a nonsteroidal anti-inflammatory drug (NSAID) as a predictor of inflammatory arthritis may, as the authors acknowledge, be problematic for some patients with IBD. Non-selective NSAIDs may exacerbate IBD. While short-term use may be safe, particularly with low-dose NSAIDs, high-dose NSAIDs have been associated with increased Crohn’s disease activity. With regard to COX-2-selective NSAIDs, the available randomised placebo-controlled trials in IBD patients show no significant increased risk of flare. However, these studies are small, only available for celecoxib and etoricoxib, and predominantly include patients in clinical remission. However, large controlled trials of selective vs non-selective NSAIDs in non-IBD patients, have shown differing results with respect to lower gastrointestinal events; lower rates were seen with celecoxib and similar rates with etoricoxib relative to non-selective NSAIDs. This discrepancy has been attributed to their differing chemistry and pharmacodynamics. Hence, whether COX-2 selective NSAIDs as a class are safe in IBD is unknown. Given these uncertainties, we agree that caution or indeed NSAID avoidance should be applied in patients with active bowel inflammation, with referral for a rheumatology opinion made based on inflammatory back pain alone. For patients without active IBD, both physicians and patients should be vigilant for worsening disease activity.

In a multi-system disorder such as IBD, a multidisciplinary, cross-specialty approach is to the benefit of patients with extraintestinal manifestations. The guidelines presented by Varkas et al will enhance our ability to manage rheumatological complaints in patients with IBD efficiently and appropriately, and are a model to follow for other crossover presentations in IBD and beyond.

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