Over-the-scope clip placement is effective rescue therapy for severe acute upper gastrointestinal bleeding

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Background and study aim: The novel over-the-scope clip (OTSC) allows for excellent apposition of tissue, potentially permitting hemostasis to be achieved in various types of gastrointestinal lesions. This study aimed to evaluate the usefulness and safety of OTSCs for endoscopic hemostasis in patients with upper gastrointestinal bleeding in whom traditional endoscopic methods had failed.

Patients and methods: A retrospective case series of all patients who underwent placement of an OTSC for severe recurrent upper gastrointestinal bleeding over a 14-month period was studied. Outcome data for the procedure included achievement of primary hemostasis, episodes of recurrent bleeding, and complications.

Results: Twelve consecutive patients (67% men; mean age 59, range 29–86) with ongoing upper gastrointestinal bleeding despite previous endoscopic management were included. They had a mean ASA score of 3 (range 2–4), a mean hemoglobin of 7.2 g/dL (range 5.2–9.1), and shock was present in 75% of patients. They had all received packed red blood cells (mean 5.1 units, range 2–12). The etiology of bleeding was: duodenal ulcer (n=6), gastric ulcer (n=2) Dieulafoy lesion (n=2), anastomotic ulceration (n=1), Mallory–Weiss tear (n=1). Hemostasis was achieved in all patients. Rebleeding occurred in two patients 1 day and 7 days after OTSC placement. There were no complications associated with OTSC application.

Conclusions: OTSC use represents an effective, easily performed, and safe endoscopic therapy for various causes of severe acute gastrointestinal bleeding when conventional endoscopic techniques have failed. This therapy should be added to the armamentarium of therapeutic endoscopists.
Discussion

This study shows that the OTSC system readily provides hemostasis and can function as a “rescue therapy” in patients with severe nonvariceal upper gastrointestinal bleeding in whom prior endoscopic therapies have failed. Historically these patients would have required more invasive procedures such as embolization or surgery, [4, 5] with embolization being relatively contraindicated in patients with renal disease because of the need to administer intravenous contrast.

Our study adds to the growing literature on the utility of the OTSC system in the treatment of upper gastrointestinal bleeding. The largest multicenter study, which included three tertiary centers in the United States, reported on a total of seven patients who had been treated with OTSCs for gastrointestinal bleeding, which probably reflected the initial experience and sporadic use of the OTSC for gastrointestinal bleeding [8]. Therefore, additional data such as ours are important in the evaluation of the potential utility of OTSCs for gastrointestinal bleeding.

In contrast to other studies, we have also provided a description of the technical steps necessary for the use of this device in acute nonvariceal upper gastrointestinal bleeding. We believe that this short, but clear, description of the OTSC system enables the
endoscopist to better comprehend the utility and applicability of this endoscopic hemostatic device. We want to emphasize that we used endoscopes that are available as standard. In the largest North American series published to date, all seven patients were treated with therapeutic gastroscopes [8]. Although the use of large-diameter scopes with larger suctioning and working channels could have advantages when managing larger lesions, most endoscopy units have standard gastroscopes, so our data may be more applicable to general practice. Although first-line clipping devices have achieved excellent rates of hemostasis, the rebleeding rates are clinically significant [3, 10, 12]. The OTSC system utilizes a very contractile, superelastic nickel titanium alloy, which provides tissue apposition that is far superior to that of traditional clipping. Based on our experience and the published data, the OTSC system appears promising for the treatment of bleeding lesions with large-diameter visible vessels or those located in awkward positions, such as the greater curvature of the stomach or the posterior duodenal wall, which may not always be amenable to treatment with standard endoscopes and endoscopic devices [1, 5, 13]. The transparent cap can be directed onto lesions that are in awkward positions, and once the cap is in place, suction can be applied to draw larger volumes of tissue into the cap. This tissue is then squeezed by the clip, further compressing the centrally located vessels. On the basis of our experience, we are convinced that the tissue-apposition capabilities make the OTSC an essential part of the endoscopist’s armamentarium for the control of bleeding lesions that are considered to be high risk or difficult to treat using other endoscopic methods.

We want to address potential limitations of our study. First, it is retrospective and therefore has the limitations of any such study. Second, it reflects the experience of a tertiary-care center; however, the scopes used are present in most hospitals.

In summary, the OTSC system represents an effective, easily performed, and safe endoscopic therapeutic modality for various causes of severe acute gastrointestinal bleeding. We were able to demonstrate its usefulness as a “rescue therapy,” that provided hemostasis for both large lesions and lesions that were in awkward positions. This endoscopic hemostatic therapy should be considered when conventional endoscopic techniques have failed. We recommend interventional endoscopists add this therapy to their armamentarium. Early results demonstrate efficacy of the OTSC system in the treatment of nonvariceal gastrointestinal bleeding; however, more prospective clinical trials are needed to demonstrate its superiority over traditional clips and closure devices.
**Table 1** Demographic, clinical, laboratory, and endoscopic findings for the 12 patients who were treated with an over-the-scope clip (OTSC) for recurrent gastrointestinal bleeding.

<table>
<thead>
<tr>
<th>Demographic, clinical, laboratory, and endoscopic findings</th>
<th>12 patients treated with OTSC</th>
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**Abbreviations:** ASA, American Society for Anesthesiology; Hb, hemoglobin; Hct, hematocrit; D1, duodenal bulb; D2, second part of the duodenum; N/A, not applicable; APC, argon plasma coagulation; IR/Emb, intervention radiology/embolization.

**Competing interests:** KM has received a one-time travel grant from Ovesco, USA in the amount of $1500 to attend a meeting at UEGW Berlin 2013 which he gave a lecture on techniques for endoscopic closure and hemostasis using various endoscopic devices. None of the other authors have any conflicts of interest to declare.

**References**

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