Letter Reply Re: “Endoscopy-Guided Empiric Arterial Embolization for Angiographically Negative Upper Gastrointestinal Bleeding: Use it Without Fear!”

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To the Editor,

We thank the author's constructive comments and appreciate the opportunity to respond to the comments about our article [1]. We agree with the comment that the rate of active bleeding at angiography in our study was low at 32.5 % comparable to some studies [2, 3]. However, our figure is similar to a study by Padia et al. [4] where approximately 33% of patients showed active contrast extravasation during angiography. In our study, a majority of the patients who underwent empiric embolization had prior endoscopy (82 %, 14/17) with either refractory or failed attempted endoscopic treatment. This attempt to achieve hemostasis combined with the known intermittent nature of upper gastrointestinal bleeding (UGIB) may have been contributing factors to the low contrast extravasation rates observed.

The use of provocative angiography was first described in 1982 [5]. In our institution, we do not routinely use vasodilator and anticoagulants to induce bleeding. This may have increased the number of positive cases; however, in the few cases for which we have used them, we did not find them particularly useful. There is increasing evidence for using empiric GDA embolization [1–4, 6]. The literature has demonstrated that provocative angiography has been useful and safe in lower gastrointestinal hemorrhage

[6], but there is little evidence for its use in UGIB. In patients who are already compromised, there is still a theoretical risk of provocative-related hemorrhage, thereby making them further unstable.

We agree that empiric embolization of the suspected culprit artery is important and the role of a multidisciplinary team is fundamental. As we adopt an increasingly aggressive approach to empiric embolization, the need for provocative angiography also will decrease.

Conflict of interest None.

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