Background

Despite that upper gastrointestinal hemorrhage (UGIH) is relatively common, it is an emergent disease of the gastrointestinal system which can threaten the lives of patients. Despite major improvements in endoscopic devices and therapeutic endoscopy for the treatment of UGIH or prevention of rebleeding, higher than a 10% death rate has been reported. Due to the high incidence of aspirin and nonsteroidal anti-inflammatory agent use, the most common cause of UGIH remains peptic ulcerative bleeding due to gastric and duodenal mucosal injury. In addition to peptic ulcers, the incidence rate of variceal bleeding is 10%–30% and that of Mallory–Weiss tears is 5%–15%. Other common causes of UGIH include esophageitis, erosive lesions, angiodysplasia, Dieulafoy’s lesion, and malignant tumors. The goal of UGIH treatment is to maintain the hemodynamic stability of patients, hemostasis, and the prevention of rebleeding. Endoscopic hemostatic intervention is the most important treatment for hemostasis and the prevention of rebleeding for high-risk patients. A variety of endoscopic treatment modalities including hemostatic grasper, thermocoagulation using argon plasma coagulation, hemostatic clipping, mechanical hemostasis with a band material, and injection materials such as epinephrine or histoacryl have exhibited greater impact in terms of reducing the incidence of blood transfusion, emergent surgery, and mortality. However, these conventional endoscopic therapies are often challenging as they depend on lesion location and on the extent and characteristics of bleeding or bleeding deterioration due to mucosal injury or perforation. In recent years, new topical hemostatic modalities have been introduced to allow for easier and more effective hemostasis. This article introduces several hemostatic materials that have been recently used and studied in clinical practice.

Hemospray

Hemospray (Cook Medical Inc., Winston-Salem, NC, USA) is a highly adhesive proprietary inorganic biologically inert powder which can be sprayed onto bleeding lesions. This mineral powder absorbs liquid from the blood and forms a sticky film when adsorbed by a bleeding lesion. The adsorbed powder increases the concentration of the coagulation factor, activates the platelets, and ultimately forms a plug on wounded blood vessels. Following hemostasis, the powder is removed from the intestinal mucosa and is completely removed from the GI track. Although this material forms membranes on the exposed sites which had been actively spurting or oozing blood, it may be less effective on inactive bleeding sites such as nonbleeding visible vessels which are still at high risk of bleeding. Hemospray was first widely used in Asia. In a prospective pilot study conducted by Sung et al, 20 adult male and female with actively bleeding peptic ulcers underwent endoscopic hemostasis within 24 hours of their hospital visit, and 95% (19/20) showed successful hemostasis; however, one patient underwent arterial embolization due to an evidence of pseudoaneurysm. Hemoglobin declined by over 2 mg/dL in two subjects within 72 hours, suspected of rebleeding, but none of the endoscopies revealed bleeding. There were no procedural complications. Holster et al studied the effects of Hemospray on UGIH in patients receiving antithrombotic therapy, the results of which showed no difference in terms of the effect on hemostasis nor rebleeding rates from those patients who had not received antithrombotic agents. The largest study reported so far was conducted in France, involving a total of 202 patients and 64 endoscopists at 20 centers. In the paper 31.7% of the doctors participated in this study answered ‘very easy’ and 55.4% of them answered ‘easy’ regarding the application of Hemospray. The initial hemostasis success rate was 96.5% with a rebleeding rate of 26.7% on the 8th day and 33.5% on the 30th day. No procedure-related adverse events were reported on the use of Hemospray. However,
one of important cautions is not to spray too closely to the lesion. This is because powder can obstruct the sight of the endoscope or block the catheter. Another caution is a trial not to tear the mucous membrane due to the catheter. In addition, the possibility of embolism, intestinal obstruction, and allergic reaction due to the characteristics of the powder are very rare, but remain possible.7

**EndoClot**

EndoClot Polysaccharide Hemostatic System (EndoClot Plus Inc., Santa Calra, CA, USA), is a powder product made from an absorbable modified polymer with a polysaccharide of vegetable starch. This material features excellent adhesion and high hydrophilicity, so that the injected powder absorbs water rapidly from the blood and concentrates red blood cells, platelets, and coagulation factors on the bleeding site, thereby inducing hemostasis. Much like Hemospray, EndoClot is delivered from an inserted catheter through the endoscope channel and 3 g of powder is injected onto the bleeding sites by an air compressor.9 Due to that the powder is spread out in multi-directions, it is useful for lesions difficult to access such as the posterior wall of the duodenum. Prei et al10 performed a prospective open-label study, including 70 subjects, and 64% of patients in the study showed successful hemostasis while rebleeding occurred in 11% (8/70). Park et al10 by propensity score matching, compared to the conventional endoscopic methods, found that there were no significant differences from the immediate hemostasis success rate of the 30 patients treated with EndoClot nor the incidence of rebleeding rate after 7 and 30 days.11,12 However, Singh et al13 conducted a study of hemostatic materials showing that the hemostatic success of commercially available microporous polysaccharide hemispheres was much lower than that of bovine-derived gelatin particles.

**Ankaferd Blood Stopper**

Ankaferd Blood Stopper (ABS; Ankaferd Health Products Ltd., Istanbul, Turkey) contains 5 mg of thymine-dried herbal extract, 9 mg of Glycyrrhiza glabra (licorice-dried leaf extract), 8 mg of Vitis vinifera (wine-dried leaf extract), 7 mg of Alpinia officinarum (lessor galangal-dried leaf extract), and 6 mg of Urtica dioica (stinging nettle-dried root extract). This material precipitates fibrinogen and forms a protein network which acts on erythrocyte aggregation independent of platelet activity and coagulation in the blood. The topical use of ABS has previously been approved by the Turkish Ministry of Health and is being used to address hemorrhage within 30 days. We also found that Nexpowder was adherent to hydrogel-like lesions in 69% (11/16) of patients who underwent follow-up endoscopy 24 hours after initial hemostasis. However, since the product has not yet been released, more clinical studies are necessary.

**Conclusion**

Several hemostatic materials have been developed to overcome the limitations of conventional endoscopic hemostasis which are presently in clinical use (Table 1). Despite the high success rate of early hemostasis, there is still an insufficient level of hemostasis. There are various problems facing injection which have yet to be resolved. Some materials, on the other hand, overcome these issues of existing hemostatic powders and display higher efficacy with respect to adhesion and durability. In conclusion, hemostatic powder offers immediate hemostasis using a simple, safe, and minimally operator dependent technique. We hope that continued and effective clinical research will lead to an easy and productive hemostatic material.
Conflicts of Interest

No potential conflict of interest relevant to this article was reported.

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