# Northern Health and Social Care Trust

This is an official Northern Trust policy and should not be edited in any way

## Patients on anticoagulant or antiplatelet therapy undergoing elective endoscopic procedures

<table>
<thead>
<tr>
<th>Reference Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSCT/11/454</td>
</tr>
</tbody>
</table>

**Target audience:**

This policy is directed to all endoscopy units, unit managers, endoscopy nursing staff, endoscopists (gastroenterologists, surgeons, & nurse endoscopists) and related clinical staff within the Northern Trust.

**Sources of advice in relation to this document:**

Dr Paul Lynch, Clinical Lead for Endoscopy  
Mrs Margaret O'Hagan, Assistant Director Acute & Cancer Services

**Replaces (if appropriate):**

N/A

**Type of Document:**

Trust Wide

**Approved by:**

Policy, Standards and Guidelines Committee

**Date Approved:**

17 November 2011

**Date Issued by Policy Unit:**

30 November 2011
Patients on anticoagulant or antiplatelet therapy undergoing elective endoscopic procedures – guidelines for patient management
November 2011

Patients on anticoagulant or antiplatelet therapy undergoing elective endoscopic procedures – guidelines for patient management

Introduction & Purpose of the Policy

Acute gastro-intestinal haemorrhage in patients on anticoagulant or antiplatelet agents is a high-risk situation. The immediate risk to the patient from haemorrhage may outweigh the risk of thrombosis as a result of stopping anticoagulant or antiplatelet therapy. Patients need to be assessed on an individual basis, and it is not possible to give unequivocal guidance to cover all situations.

When preparing for an endoscopic procedure on a patient receiving an anticoagulant or antiplatelet agent considerations include (1) the risk of complications of the underlying gastrointestinal disorder related directly to anticoagulation or antiplatelet therapy; (2) bleeding related to an endoscopic intervention carried out in the setting of anticoagulation or an antiplatelet agent; and (3) a thromboembolic event related to interruption of anticoagulation or antiplatelet therapy. Additional considerations include the utilization of resources for hospitalization, parenteral anticoagulation therapy, and laboratory tests used to monitor and document adjustment of anticoagulation therapy.

Clarity is required for all clinical and clerical staff involved in the care of patients coming to any endoscopy unit within the Northern Trust who are already receiving anticoagulant or antiplatelet therapy.

Policy Statement

This guideline addresses the management of patients undergoing endoscopic procedures who are on either anticoagulant or antiplatelet therapy. Required actions in relation to patient management are outlined within the flowchart.

Target Audience

‘This policy is directed to all endoscopy units, unit managers, endoscopy nursing staff, endoscopists (gastroenterologists, surgeons, & nurse endoscopists) and related clinical staff within the Northern Trust.’

Responsibilities
Managers are responsible for ensuring that all relevant clinical staff are aware of these guidelines and adhere to them.

Relevant clinical staff outlined within the target audience are responsible for taking actions as highlighted within the guidelines.

**Equality, Rights and DDA**

The policy is purely clinical/technical in nature and will have no bearing in terms of its likely impact on equality of opportunity or good relations for people within the equality and good relations categories.

**Alternative formats**

This document can be made available on request on disk, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

**Sources of advice in relation to this document**

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this Policy.
Northern HSC Trust Guidelines for the management of patients on anticoagulant or antiplatelet therapy undergoing elective endoscopic procedures

- **Low Risk Procedure**
  - Diagnostic +/- biopsy: OGD, flexible sigmoidoscopy, push enteroscopy
  - Biliary or pancreatic stenting without sphincterotomy
  - EUS without FNA
  - Capsule endoscopy

- **Thienopyridine antiplatelet agents** e.g. clopidogrel

- **Low Risk Condition**
  - Prosthetic metal heart valve in aortic position without AF
  - Xenograft heart valve
  - AF without valvular disease
  - >3 months after VTE

- **High Risk Condition**
  - Prosthetic metal heart valve in mitral position without AF
  - Any prosthetic heart valve & AF
  - AF and mitral stenosis
  - History of previous TIA or CVA
  - >3 months after VTE
  - Thrombophilia syndromes

- **Warfarin**
  - Continue Warfarin
  - Check INR 1 week before endoscopy
  - If INR within therapeutic range, continue usual daily dose
  - If INR above therapeutic range, but <5 reduce daily dose until INR returns to therapeutic range

- **Stop warfarin 5 days before endoscopy**
  - Check INR prior to procedure to ensure INR < 1.5
  - Restart warfarin evening of procedure at usual daily dose
  - Check INR 1 week later to ensure INR adequate

- **Stop warfarin 5 days before endoscopy**
  - Check INR prior to procedure to ensure INR < 1.5
  - Restart warfarin evening of procedure at usual daily dose
  - Continue LMWH until INR adequate

- **Thienopyridine antiplatelet agents** e.g. clopidogrel

- **Low Risk Procedure**
  - Colonoscopy
  - Polypectomy (any site)
  - PEG insertion
  - EMR*
  - Therapy of varices
  - Any coagulation therapy (e.g. APC, bipolar)
  - EUS-guided FNA
  - Dilatation of any form
  - ERCP with sphincterotomy
  - Endoscopic haemostasis

- **High Risk Procedure**
  - Colonoscopy
  - Polypectomy (any site)
  - PEG insertion
  - EMR*
  - Therapy of varices
  - Any coagulation therapy (e.g. APC, bipolar)
  - EUS-guided FNA
  - Dilatation of any form
  - ERCP with sphincterotomy
  - Endoscopic haemostasis

- **Thienopyridine antiplatelet agents** e.g. clopidogrel

- **Low Risk Condition**
  - Prosthetic metal heart valve in aortic position without AF
  - Xenograft heart valve
  - AF without valvular disease
  - >3 months after VTE

- **High Risk Condition**
  - Ischaemic heart disease without coronary stent
  - History of previous TIA or CVA
  - Peripheral vascular disease

- **Low Risk Condition**
  - Coronary artery stents inserted within 12 months
  - Acute coronary syndrome

- **High Risk Condition**
  - Liaise with cardiologist
  - Consider stopping 7 days before endoscopy if:
    - >12 months after insertion of drug-eluting coronary stent
    - >1 month after insertion of bare metal coronary stent
  - Continue aspirin

- **Stop clopidogrel 7 days before endoscopy**
  - Continue aspirin if already prescribed
  - If not on aspirin, then consider aspirin therapy while clopidogrel discontinued

- **Stop warfarin 5 days before endoscopy**
  - Check INR prior to procedure to ensure INR < 1.5
  - Start LMWH 2 days after stopping warfarin
  - Omit LMWH on day of procedure
  - Restart warfarin evening of procedure at usual daily dose
  - Continue LMWH until INR adequate

- **References:** BSG guidelines (Gut 2008;57:1322-1329), ASGE guidelines (Gastrointest Endosc 2009;70:1060-1070).

- There is no evidence to support the discontinuation of aspirin for any elective procedure but should be withheld during any episode of acute gastrointestinal haemorrhage.
- Continuation or reinitiation of anticoagulation should be adjusted according to the stability of the patient and estimated risks surrounding the specific intervention/procedure performed.
- For high risk procedures, discontinue prophylactic LMWH at least 8 hours in advance and therapeutic LMWH at least 24 hours in advance.
- Following any episode of acute gastrointestinal haemorrhage, reinstitution of antiplatelet or anticoagulant therapy should be individualized.
- * Aspirin & non-steroidal anti-inflammatory drugs are probably best discontinued 7 days prior to elective EMR for large or complex lesions.
