Trust Policy		NHS Worcestershire Acute Hospitals NHS Trust

Endoscopy patients on antiplatelet or anticoagulant therapy, including direct oral anticoagulants

taken from WAHT–HAE-002 V6 and British Society of Gastroenterology guidelines for management of anticoagulation

Department / Service:	Endoscopy
Originator:	Helen Livett, Loraine Mahachi, Dr Salim Shafeek, Dr Helen Routledge
Accountable Director:	Mr Richard Lovegrove
Approved by:	Endoscopy directorate
Approved by Medicines Safety Committee:	10th April, 2024
Date of approval:	6th March, 2024
First Revision Due: This is the most current document and should be used until a revised version is in place	10th April, 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	
Target staff categories	

Policy Overview:

This document will provide a process for the management of patients taking oral anticoagulation attending endoscopy for diagnostic or therapeutic intervention.

Anticoagulants are one of the classes of medicines most frequently identified as causing preventable harm and admission to hospital. Managing the risks associated with anticoagulants can reduce the chance of patients being harmed. This Trust Guideline is based on British Committee for Standards in Haematology (BCSH) and National Patient Safety Agency (NPSA) guidance.

Key amendments to this document

Date	Amendment	Approved by:
29th June, 2020	Document extended for three months whilst review process is completed	
1st July 2020	Amendments:- Page 4:- >12 months after insertion of drug eluding coronary stent (DES) >1 month after instertion of bare metal coronary stent or drug-coated balloon (DCB)	Dr Helen Routledge
29th July, 2020	Document approved	SCSD Governance
3rd October, 2023	Document extended for six months whilst review is completed	Karen Macpherson
10th April, 2024	'Recent updates to reflect BSG guidelines and to seek advice from cardiology in cases of patients with coronary stents in situ.	Endoscopy Directorate/MSC

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1. Introduction:

These guidelines refer to patients undergoing elective endoscopic gastrointestinal procedures utilising the recommendations from the Local NHS Trust guidelines (WAHT-HAE-002) and the British Society of Gastroenterology Guidelines (2021)

The policy aims to provide firm guidance on the processes of cessation and re-administration of anticoagulants and antiplatelet medication prior to and post gastrointestinal endoscopic procedures. In doing so it aims to prevent patient from inappropriate advice regarding these drug interventions.

Exceptional circumstance – Patients with Coronary Stents

Many clinicians increasingly stop all antiplatelets in patients with prior coronary stents when there is a need for long-term anticoagulation for other reasons (e.g. AF), as per the current ESC guidelines. These patients will be at an increased risk of stent thrombosis when anticoagulants are stopped, and they are on nothing. We recommend that all patients on anticoagulants alone with a history of prior coronary stents must either be switched to aspirin (provided there are no contraindications) or discussed with an interventional cardiology consultant first. When switching to aspirin patients should be loaded with 300mg the day prior to anticoagulant cessation and prescribed 75mg daily thereafter. Patients should remain on Aspirin until they are re-established on anticoagulants and within therapeutic range, after which the Aspirin can be stopped.

Advice from cardiology team: to contact the consultant of the week contact CCU.

Minor / Low Risk Procedures include:

Diagnostic procedures +/- biopsy
Biliary or pancreatic stenting
Device-assisted enteroscopy without polypectomy
Oesophageal, enteral or colonic stenting
EUS without sampling or interventional therapy
(BSG 2021)

Warfarin
Check INR 1 week before endoscopy If INR within therapeutic range continue usual daily dose If INR above therapeutic range.

Direct Oral Anticoagulant (DOAC)Therapy

The direct oral anticoagulant (DOACs) have been shown to be as effective as warfarin. The main difference is that DOACs are less influenced by diet and other medications therefore a set dose of DOAC can be prescribed.

For all low risk procedures the BSG recommends omitting the dose on the morning of the procedure regardless of the time of the appointment. Once the procedure has been completed the endoscopist will advise on when the patient should restart the DOAC.

Clopidogrel, Prasugrel, Ticagrelor

There is currently no requirement to stop clopidogrel, prasugrel or ticagrelor prior to diagnostic procedures or diagnostic biopsies.

Therapeutic / High-Risk Procedures includes:

Polypectomy
ERCP with sphincterotomy
EMR/ESD Dilatation of strictures
Therapy of varices
PEG EUS-guided sampling or with interventional therapy
Oesophageal or gastric radiofrequency ablation
(BSG, 2021)

Warfarin

Low Risk Conditions:

Xenograft heart valve

AF without high risk factors

($CHADS_2$ <4)

>3months after VTE

PLAN:

Stop warfarin for 5 days before endoscopy.

Check INR prior to procedure to ensure INR <1.5

Restart warfarin evening of procedure with usual daily dose Check INR one week later to ensure adequate anticoagulation.

High Risk Conditions:

Prosthetic metal heart valve in mitral or aortic position

Prosthetic heart valve and AF

AF and mitral stenosis

AF with previous stroke/TIA

3 or more of the following:

Congestive cardiac failure

Hypertension* Age>75 years

Diabetes mellitus

AF and stroke/TIA within 3 months

PLAN:

Stop warfarin for 5 days before endoscopy.

Start LMWH 2 days after stopping warfarin.

Omit LMWH on day of procedure

Restart warfarin evening of procedure with usual daily dose

Continue LMWH until INR adequate

Dabigatran:

With CrCl (eGFR) 30-50ml/min take last dose 5 days before the procedure.

In any patient with rapidly deteriorating renal function a haematologist should be consulted.

Restart DOAC 2-3 days after procedure

Apixaban, Edoxaban, Rivaroxaban:

Stop Apixaban, Edoxaban, Rivaroxaban 3 days prior to the procedure.

In any patient with rapidly deteriorating renal function a haematologist should be consulted

Restart DOAC 2-3 days after the procedure.

Clopidogrel, Prasugrel and Ticagrelor:

Low Risk conditions:
Ischaemic heart disease without coronary stent.
Cerebrovascular disease
Peripheral vascular disease.

High Risk Condition (coronary artery stents):
Discuss strategy with consultant interventional cardiologist.
Consider temporary cessation of P2Y12 receptor antagonist if:
6-12 months after insertion of drug-eluting coronary stent >1 month after insertion of bare metal coronary stent
Continue aspirin.

2. Scope of this document

Inclusion:
Any patients currently taking anticoagulation or antiplatelet therapy who have agreed and consent for an endoscopic procedure.

3. Definitions

References link to BSG guidelines:

https://www.bsg.org.uk/clinical-resource/updated-endoscopy-in-patients-on-antiplatelet-or-anticoagulant-therapy-including-direct-oral-anticoagulants/

4. Responsibility and Duties

Responsibility and accountability for completion of the process include:

Any healthcare professional who refers patients to endoscopy
Any Nurse Endoscopists working autonomously within WAHT
Any pre assessment nurses seeing patients prior to their endoscopy procedure.

5. Policy Detail:

If these guidelines are not followed, then an Incident Reporting Process should occur and be completed by the endoscopist or healthcare professional who has identified error in prescribing. If the Datix highlights an individual(s) that are not adhering to the policy this should be addressed by the Clinical Director or Matron for endoscopy.

6. Implementation

6.1 Plan for implementation

As soon as approved at Directorate meeting and Medicines Safety Committee

6.2 Dissemination

All endoscopists/nurse endoscopists/endoscopy units and added as an appendix to the WAHT-HAE-002

7. Monitoring and compliance

The NHSLA requirements are –

Organisations should measure, monitor and evaluate compliance with the minimum requirements within the NHSLA Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

Monitoring demonstrates whether or not the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

The table below should help to detail the 'Who, What, Where and How' for the monitoring of this Policy.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Patient safety and correct advice for anticoagulation/antiplatelet cessation medication prior to gastrointestinal endoscopy	Monitoring of Datix reporting discussed at directorate meeting	Discussion at the directorate meeting	Governance Lead	Endoscopy Directorate meeting	At least 10 times per year.

8. Policy Review

3 yearly as per WAHT guidance

9. References:

	Code:
Endoscopy in patients on antiplatelet or anticoagulant therapy, including direct oral anticoagulants: British Society of Gastroenterology (BSG) and European Society of Gastrointestinal Endoscopy (ESGE) guidelines	BSG 2021

10. Background

10.1 Equality requirements

This document is review of an existing document and will impact on patients and referrers and pre-assessment team to ensure that the correct preparation is undertaken for each patient undergoing endoscopy procedure.

10.2 Financial risk assessment

There is no financial risk to this document.

10.3 Consultation

Consultation with Cardiology and to be approved at the Endoscopy Directorate meeting and MSC

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Keith Hinton
Helen Routledge
Richard Lovegrove

This key document has been circulated to the chair(s) of the following committees / groups for comments;

Committee
SCSD governance
Endoscopy Directorate
MSC

10.4 Approval Process

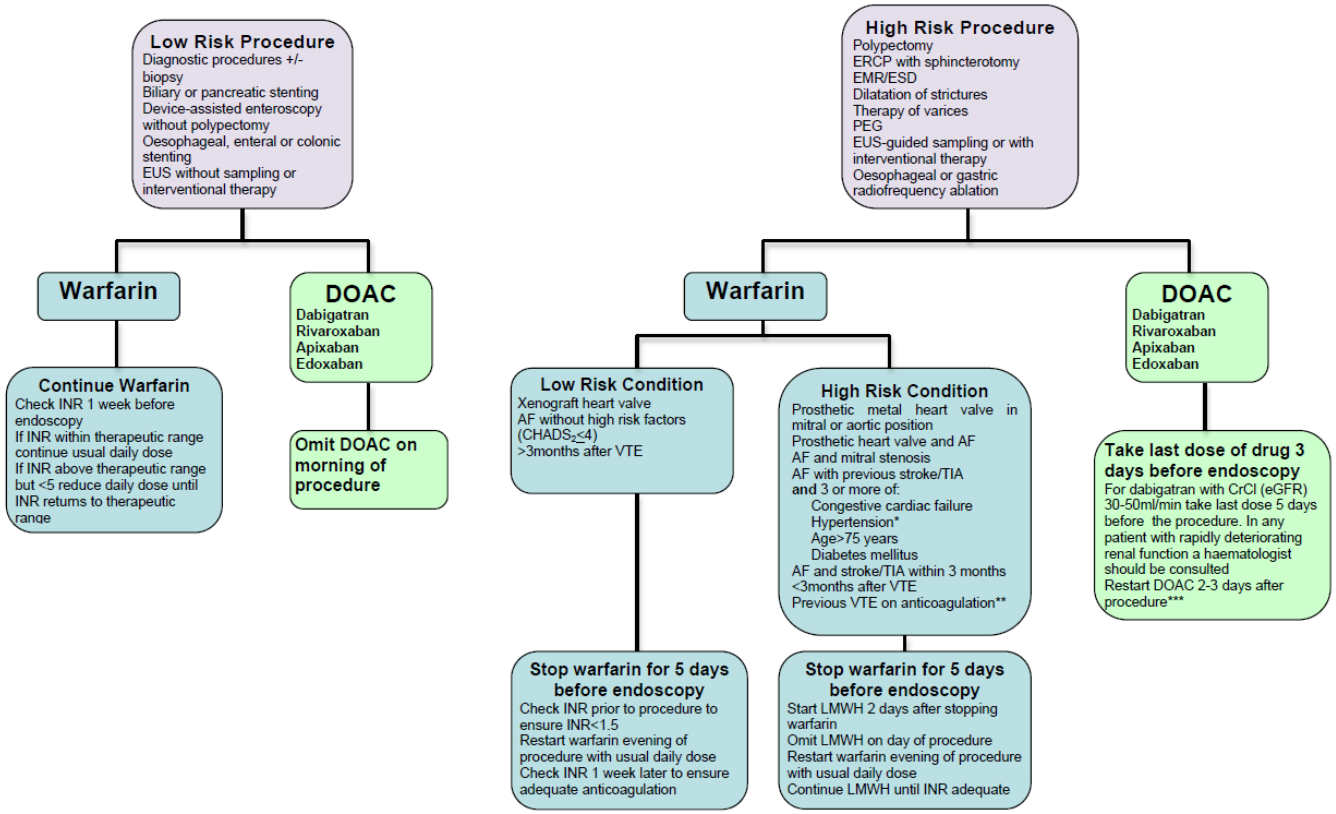
This section should describe the internal process for the approval and ratification of this Policy.

10.5 Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:
01.07.2020	page 4 >12 months after insertion of drug-eluting coronary stent (DES) >1 month after insertion of bare metal coronary stent or drug coated balloon (DCB)	Dr Helen Routledge
20/12/2023	Page 4, 5 and 6 Changes to reflect 2021 BSG guidelines	Karen Macpherson
10/04/2024	Page 6 addition of exceptional circumstances / patients with coronary stents section.	Dr Helen Routledge and Karen Macpherson

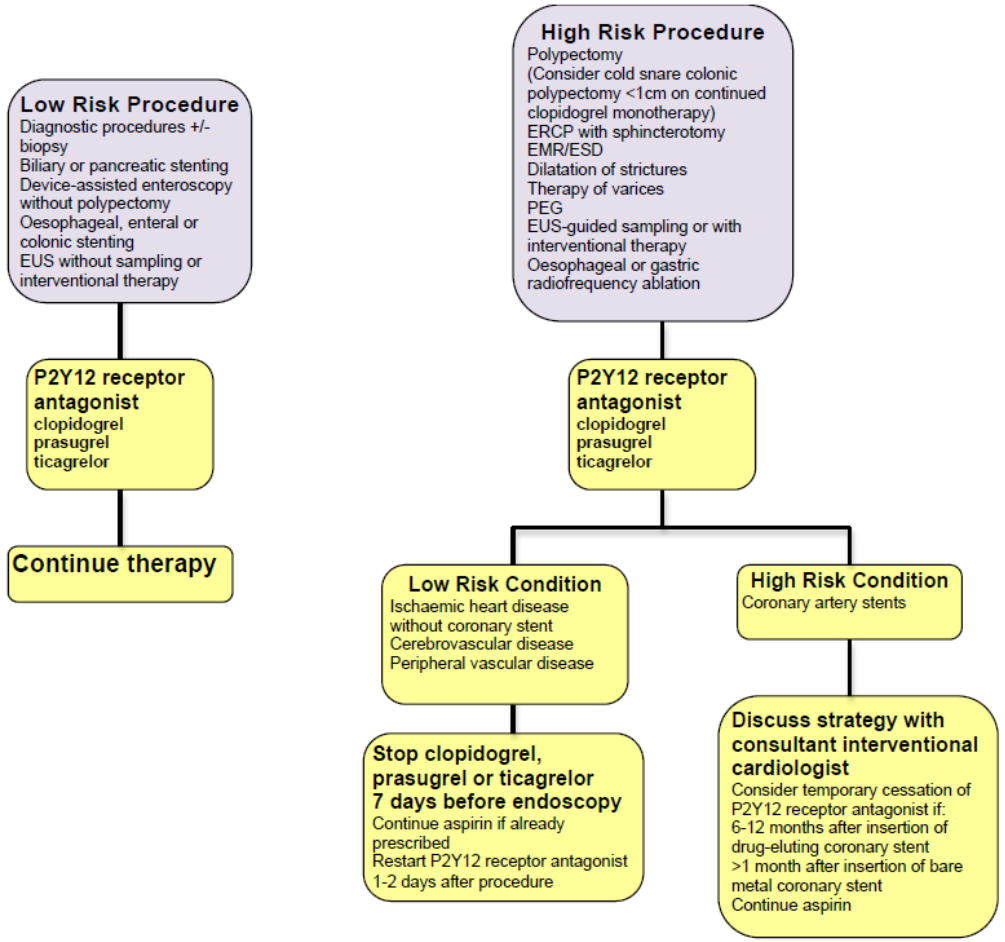
Appendices Guidelines for the management of patients on warfarin or Direct Oral Anticoagulants (DOAC) undergoing endoscopic procedures: 2021 update NB IF PATIENT HAS A CARDIAC STENT PLEASE REFER TO THE FULL GUIDELINES



*Blood pressure >140/90mmHg or on antihypertensive medication **Previous VTE on anticoagulation and target INR now 3.5
***depends on haemorrhagic and thrombotic risk, interval may be extended for ESD
(EUS: endoscopic ultrasound, ERCP: endoscopic retrograde cholangiopancreatography, EMR: endoscopic mucosal resection, ESD: endoscopic submucosal dissection, PEG: percutaneous endoscopic gastroenterostomy, INR: international normalised ratio, AF: atrial fibrillation, VTE: venous thromboembolism, TIA: transient ischaemic attack, LMWH: low molecular weight heparin)

1

Guidelines for the management of patients on P2Y12 receptor antagonist antiplatelet agents undergoing endoscopic procedures: 2021 update



(EUS: endoscopic ultrasound, ERCP: endoscopic retrograde cholangiopancreatography, EMR: endoscopic mucosal resection, ESD: endoscopic submucosal dissection, PEG: percutaneous endoscopic gastroenterostomy)

Supporting Document 1 – Equality Impact Assessment form

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Karen Macpherson**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Karen Macpherson	**JAG/Governance Lead**	**Karen.macpherson5@nhs.net**
Date assessment completed	**20/12/2023**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** **WAHT-HAE-002A**			
What is the aim, purpose and/or intended outcomes of this Activity?				
Who will be affected by the development & implementation of this activity?	❑ ✓ ❑ ❑	Service User Patient Carers Visitors	❑ ❑ ❑ ❑	Staff Communities Other _____
Is this:	✓ Review of an existing activity			

	❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	BSG guidelines and Datix incidents
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	PSIRG meeting members Cardiology team Endoscopy Directorate and medicines safety committee.
Summary of relevant findings	Policy updated to reflect safe practice and national BSG guidelines will change as a result of a section 28 order from the coroner.

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		✓		Improved patient safety measures only
Disability		✓		Improved patient safety measures only
Gender Reassignment		✓		Improved patient safety measures only
Marriage & Civil Partnerships		✓		Improved patient safety measures only
Pregnancy & Maternity		✓		Improved patient safety measures only
Race including Traveling Communities		✓		Improved patient safety measures only
Religion & Belief		✓		Improved patient safety measures only
Sex		✓		Improved patient safety measures only

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sexual Orientation		✓		Improved patient safety measures only
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		Improved patient safety measures only
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		Improved patient safety measures only

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?	**Datix and Complaints**			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**When policy due for review or earlier based on quantity of any complaints.**			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected

characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	20/12/23
Comments:	
Signature of person the Leader Person for this activity	
Date signed	20/12/23
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.