Worcestershire Acute Hospitals NHS Trust

Anticoagulant Medication Management within the Bowel Cancer Screening Programme (BCS-037)

Key Document code:	WAHT-KD-021	
Key Documents Owner:	Emma Duggan/Mr S P Lake	Bowel Cancer & Bowel Scope Screening Manager/BCSP Screening Director
Approved by:	Bowel Screening Operational Meeting	
Date of Approval:	9th October 2024	
Date of review: This is the most current document and should be used until a revised version is in place	9th October 2027	

Key Amendments

Date	Amendment	Approved by
19th June 2019	Documents extended for 6 months whilst reviewed	Emma Duggan
11th Feb 2020	Documents extended for 6 months whilst review and approval is processed	Emma Duggan
27th July 2020	Documents extended for 6 months during COVID-19 period	QGC/Gold Meeting
1st March 2021	Document extended for 6 months as per Trust agreement 11/02/2021	
16th July 2021	Documents extended for 6 months whilst review and approval is processed	Emma Duggan/ Mr Stephen Lake
May 2023	Document reviewed and amended. Antiplatelet medications removed and formed separate policy WAHT-BCS-043	Wendy Bland/Avril Turley
July 2024	Amendment as per BSG update about antiplatelet guidelines DOACs- Removal of Hours and replaced with number of days	Laura Meek/Avril Turley
4th September, 2024	As per BSG Addendum to BSG/ESGE Endoscopy in patients on antiplatelet or anticoagulant therapy guideline 2021 - recommendation 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. Approved at Directorate Meeting	Endoscopy Directorate Meeting
9th October, 2024	As above. Approved at MSC	Medicines Safety Committee

INTRODUCTION

This guideline refers to Bowel Cancer Screening subjects prescribed Anticoagulant Medications and Direct Oral Anticoagulants

THIS GUIDELINE IS FOR USE BY:

- Specialist Screening Practitioners (SSP's)
- BCSP Screening Colonoscopists

FIT Positive

Specialist Screening Practitioners (SSP's) undertake suitability assessment, including establishing whether the individual is prescribed Anticoagulant medications.

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When managing Anticoagulation, consideration is afforded to clinical indication along with patient preference. Risk of potential thromboembolic events may be unacceptable even if that risk is very low.

Drug specific instructions prompt SSP's to alert patients to associated risks of temporarily ceasing medications.

Management of Anticoagulation therapy is provided in verbal and written format.

Warfarin

1. Ascertain Target INR and Therapeutic Range – Seek advice (Haematology) for Target INR >3.5

2. Ascertain usual Warfarin dose and latest INR - within 3 months

3. Establish whether the condition is High or Low risk

   Low Risk Conditions:
   - Atrial Fibrillation (AF) and no thromboembolic event >3 months previously
   - Paroxysmal Atrial Fibrillation (AF)
   - Atrial Fibrillation (AF) without valvular disease
   - Xenograft Heart Valve
   - Thrombophilia Syndromes (discuss with haematology)
   - Deep Vein Thrombosis/Pulmonary Embolism >3 months previously
   - AF without high risk factors ($CHADS_2$<4)

   1. Stop Warfarin 5 days prior to Colonoscopy

   2. Discuss proposed Warfarin management; provide written instructions (Patient Letter/GP copy).

   3. Confirm anticoagulation indication with GP and inform of agreed management plan (BCSS letter template).

   4. Ensure INR of <1.5 pre procedure.

   5. Confirm post procedure instructions (Screening Colonoscopist) regarding Warfarin recommencement and document BCSS/Colonoscopy report.

   6. Patient to arrange INR (GP) 7 days post procedure.

High Risk Conditions

Risk of Re-Thrombosis:

- Deep Vein Thrombosis or Pulmonary Embolism <3 months
- Target INR >3.5
- DVT/PE sustained during warfarin cessation (seek Haematology advice)
- Patients with Valvular Heart disease (seek cardiology advice)
- Atrial Fibrillation and CVA/TIA < 3 months
- Atrial Fibrillation (AF) and 3 or more of CCF, Hypertension,>75years, DM

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- Atrial Fibrillation (AF) and Mitral Stenosis
- Prosthetic Metal Heart Valve Mitral/Aortic position
- Prosthetic Heart Valve and Atrial Fibrillation (AF)

Warfarin – High Risk Management (Bridging):

1. Confirm Warfarin indication/identify High Risk condition requiring bridging (substituting Warfarin with low molecular weight Heparin).

2. Discuss Warfarin management (with subject) and provide verbal and documented instructions (Patient letter/GP copy).

3. Obtain and document accurate patient weight (KG).

4. Arrange prescription (GP) LMWH and confirm necessary arrangements for daily administration (District Nurse/Practice Nurse/Self Administration).

5. Stop Warfarin 5 days prior to Colonoscopy.

6. Start LMWH 2 days after stopping Warfarin.

7. Omit LMWH Colonoscopy procedure day.

8. Request INR check (GP) one working day prior to colonoscopy.

9. Confirm post procedure instructions (Screening Colonoscopist) for Warfarin recommencement and document BCSS/Colonoscopy report.

10. Recommence LMWH the day after Colonoscopy and continue until INR within therapeutic range. Ensure adequate prescription of LMWH available until repeat INR (1/52).

11. Patient to arrange INR 1/52 post procedure (GP surgery).

Warfarinised patients are recommended to be appropriately counselled regarding increased bleeding risk compared to non-anticoagulated patients.

It is recommended where anticoagulation has been stopped that it is resumed up to 48hrs post procedure depending upon perceived thromboembolic and bleeding risks.

Patients taking Direct Oral Anticoagulants

In patients undergoing high-risk procedures with a low thromboembolic risk, the last dose of a DOAC is taken 3 days prior to Colonoscopy.

The highest thromboembolic risk for anticoagulated patients, include those with prosthetic heart valves. As Direct Oral Anticoagulants are not presently licenced for such indication those patients prescribed DOAC's will not usually require bridging therapy.

1. Ascertain prescribed anticoagulation medication and indication.

2. Establish whether condition is High Risk or Low Risk.

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Low Risk Conditions:

- Atrial Fibrillation (AF) and no thromboembolic event previous 3 months
- Paroxysmal Atrial Fibrillation (AF)
- Deep Vein Thrombosis/Pulmonary Embolism >3 months previously

Rivaroxaban, Apixaban, Edoxaban should be stopped 72 hours prior to Colonoscopy.

Dabigatran should be stopped in accordance with eGFR.

1. Stop DOAC 3 days prior to Colonoscopy (exception Dabigatran – As per eGFR. (Where eGFR 30-50mL/min last dose is to be taken 5 days prior to Endoscopic test).
2. Discuss proposed DOAC management and provide written instructions (Patient Letter/GP copy).
3. Confirm anticoagulation indication (GP) and agreed management plan (BCSS letter template).
4. Confirm post procedure instructions (Screening Colonoscopist) regarding recommencement of DOAC 2-3 days post procedure and document BCSS/Colonoscopy report.

High Risk Conditions

Risk of Re-thrombosis:

- Deep Vein Thrombosis/Pulmonary Embolism <3 months previously (discuss with Haematology).
- Patients with Valvular Heart Disease (discuss with Cardiologist).
- Atrial Fibrillation with arterial event <3 months previously (seek advice).

References

Crowther 2016 BCSP Local Guideline for the management of patient on P2Y12 antagonist and patients who are taking warfarin or direct oral anticoagulants (DOAC)

Keith Hinton 2013 WAHT–ANA-014 - Nil by Mouth and Peri-operative medicines use guideline. (See Worcestershire Acute Hospitals Trust Intranet via document finder).

Veitch et al. BSG 2016 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.

Woodhouse C, Evans G, Muller A, 2013 The new oral anticoagulants: practical management for patients attending for endoscopic procedures. **British Medical Journal; Frontline Gastroenterology 2013; 4:213 – 218.**

WHAT–HAE-002 - Guideline of Management of patients taking Dabigatran or Rivaroxaban who have bleeding or require surgery. (See Worcestershire Acute Hospitals Trust Intranet via document finder).

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CONTRIBUTION LIST

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Circulated to the chair of the following committee's / groups for comments

Name	Committee / group
Mr S P Lake	BCSP Operational Meeting
Dr Lovegrove	Endoscopy Directorate Meeting

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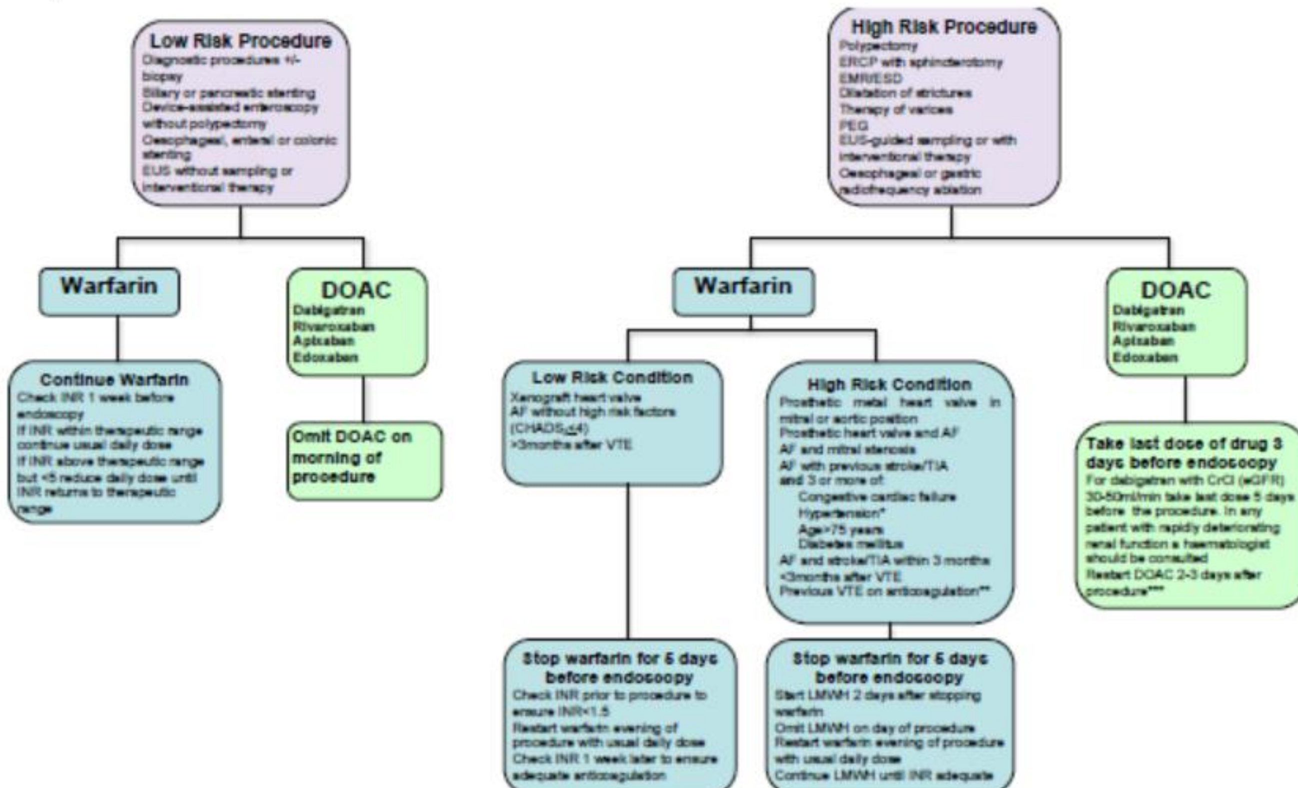
Appendix 1a: Guidelines for the management of patients on warfarin or direct oral anticoagulants (DOAC)

Figure 2: Guidelines for the management of patients on warfarin or Direct Oral Anticoagulants (DOAC) undergoing endoscopic procedures: 2021 update



*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

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3 June 2024

Addendum to BSG/ESGE Endoscopy in patients on antiplatelet or anticoagulant therapy guideline 2021

We thank the Senior Coroner for Worcestershire for bringing to our attention the death of a patient due to a myocardial infarction who had previous coronary stents, but had atrial fibrillation in addition, and at the time of colonoscopy was on sole therapy with rivaroxaban. The rivaroxaban was stopped at least 48 hours prior to the procedure. This particular scenario is not covered by the BSG/ESGE guidelines, and I am grateful to the cardiology author on the guidelines, Dr James Wilkinson, for providing interim guidance. We are aware of at least one other similar case with catastrophic consequences.

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 European Society of Cardiology guidelines. These patients will be at an increased risk of stent thrombosis when anticoagulants are stopped and they are on no antithrombotic medication at all. **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.

It is important to remember that particular care must be taken in any patients with a prior history of having coronary stents. We would encourage discussion with a consultant interventional cardiologist in patients in whom interruption of either antiplatelets or anticoagulants is being considered.

We also plan to publish this guidance as a journal letter prior to a formal update of the BSG/ESGE guideline.

Prof Andy Veitch
President, British Society of Gastroenterology

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Appendix 1b: Patient Instruction Warfarin Low Risk

Insert Hospital Heading

Following on from our telephone conversation, please find details of your Colonoscopy appointment is as follows:

Date:
Location:
Arrival Time:

You have been booked for a Colonoscopy whilst you are taking Warfarin, an anticoagulant drug. If you were to continue taking this prior to your procedure there would be a high risk of bleeding should removal of any polyps or biopsies be required. Current evidence tells us that the risk of you temporarily stopping the Warfarin and forming a clot are lower than the risk of you having a bleed from continuing this medication around the time of your colonoscopy. There does however remain a small chance that you may develop one of these complications, though the screening consultant will assess the risks and if we need to change the instructions given we will contact you.

You will need to stop your Warfarin 5 days before your Colonoscopy.

Please take your last dose on ....

An INR check will be required on the day before your Colonoscopy. This should be arranged through your GP Surgery.

Your INR will be checked on your arrival at the Endoscopy unit.

You will be able to restart your Warfarin with usual daily dose on the evening of your procedure subject to the procedure outcome and the Colonoscopist advice.

An INR check will be required one-week post procedure.

If you would like to discuss any aspect of the appointment, please do not hesitate to contact the screening centre on the above telephone number.

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Appendix 1c: Patient Instruction Warfarin High Risk

Insert Hospital Heading

Following on from our telephone conversation, please find details of your Colonoscopy appointment is as follows:

Date:
Location:
Arrival Time:

You have been booked for a Colonoscopy whilst you are taking Warfarin, an anticoagulant drug. If you were to continue taking this prior to your procedure, there would be a high risk of bleeding should removal of any polyps or biopsies be required. Current evidence tells us that the risk of you temporarily stopping the Warfarin and forming a clot are lower than the risk of you having a bleed from continuing this medication around the time of your colonoscopy. There does however remain a small chance that you may develop one of these complications, though the screening consultant will assess the risks and if we need to change the instructions given we will contact you.

You will need to stop your Warfarin medication 5 days prior to your scheduled procedure.

You will take your last dose of Warfarin on .... and start your Low Molecular Weight Heparin (LMWH) injections 2 days after stopping Warfarin.

An INR check will be required on the day before Colonoscopy through your GP Surgery.

Please omit LMWH injection on the day of your procedure.

Your INR will be checked on your arrival at the Endoscopy unit.

You will be able to restart your Warfarin therapy with usual daily dose on the evening of your procedure subject to the procedure outcome and the Colonoscopist advice.

You will continue LMWH injections until INR is adequate.

Please arrange to have your INR checked again one-week post procedure through your GP Surgery.

I have written to your GP practice informing them of the instructions above.
Please make an appointment at your GP practice to arrange for LMWH injections and INR check.

Please ensure you have someone to collect you and to stay with you for 24 hours.

If you would like to discuss any aspect of the appointment, please do not hesitate to contact the screening centre on the above telephone number.

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Appendix 1d: GP instruction Warfarin High Risk

Insert Hospital Heading

The above named patient is due to attend for a Bowel Cancer Screening Colonoscopy on:

Date:
Location:
Arrival Time:

........(patient name) will need to stop their Warfarin five days before Colonoscopy and to commence on daily Clexane (as per BSG guidelines 2021 update).

.....(patient name) will need to start on LMWH two days after stopping the Warfarin.

Omit LMWH on the day of the procedure.

Warfarin should be recommenced on the evening of the procedure with usual daily dose on the on the evening of your procedure subject to the procedure outcome and the Colonoscopist advice.

Continue with LMWH until INR is adequate.

I have asked ....(patient name) to make an appointment with yourself and I would be grateful if you could make arrangements for .... to receive the required therapeutic dose of LMWH in preparation for their planned Colonoscopy (dose of Clexane 1.5mg/kg body weight daily subcutaneous).

An INR check will be required on the day before Colonoscopy and one-week post procedure.

If you would like to discuss any aspect of the appointment, please do not hesitate to contact the screening centre on the above telephone number.

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Appendix 1e: Patient Instructions for Direct Oral Anticoagulants (DOAC)

Insert Hospital Heading

Following on from our telephone conversation, please find details of your Colonoscopy appointment is as follows:

Date:
Location:
Arrival Time:

You have been booked for a Colonoscopy whilst you are taking a Direct Oral Anticoagulant (DOAC) (Dabigatran, Rivaroxaban, Apixaban, Edoxaban). If you were to continue taking this prior to your procedure there would be a high risk of bleeding should removal of any polyps or biopsies be required. Current evidence tells us that the risk of you temporarily stopping the DOAC and forming a clot are lower than the risk of you having a bleed from continuing this medication around the time of your colonoscopy. There does however remain a small chance that you may develop one of these complications, though the screening consultant will assess the risks and if we need to change the instructions given we will contact you.

Following the Trust Guidelines for (insert name of drug), it is proposed that you stop your (insert name of drug) medication 3 days prior to your scheduled procedure.

You will take your last dose on ......

The Colonoscopist will advise you when to restart your (insert name of drug), this may be 2 to 3 days after the subject to the procedure outcome.

Please ensure you have someone to collect you and to stay with you for 24 hours.

If you would like to discuss any aspect of the appointment, please do not hesitate to contact the screening centre on the above telephone number.

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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?**
	SSP to complete positive assessment clinic appointment, using the BCSP colonoscopy assessment dataset form on BCSS.	SSP to check patient has followed instructed guideline, phone call to patient. At colonoscopy SSP checks patient has complied with guideline process. Obtain further advice, if necessary, from the GP, Consultant or Screening Colonoscopist or Anticoagulant CNS. Using the Guidelines for the management of anticoagulant and antiplatelet therapy in patients undergoing endoscopic procedures (Veitch et al. BSG 2008). Assess whether the patient has a high risk or low risk condition. At colonoscopy SSP checks patient has complied with guideline process. In new anticoagulation drugs refer to Guideline for Nil by mouth and Peri-operative Medicines Use and seek BCSP consultant advice	Following SSP clinic, patient follow up telephone calls. At colonoscopy.	SSP's, Screening Colonoscopists,	At SSP Assessment Clinic, At Colonoscopy Lists.	Every time a patient is identified as taking warfarin.

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