**NHS GREATER GLASGOW AND CLYDE**

**BOWEL SCREENING PROGRAMME**

**Clinical Policy Guidelines**

**Management of patients on antithrombotic agents undergoing colonoscopy procedure following positive FIT test.**

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**INTRODUCTION**

All people aged between the ages of 50 and 74 will be invited to take part in the Scottish Bowel Screening Programme and will be sent a Faecal Immunochemical Test (FIT) kit to complete at home. The first part of the screening process is the analysis of the FIT sample.

Positive results from this patient group will result in an invitation for colonoscopy. Colonoscopy will be classed as a high risk procedure if any of the patient group are currently on anticoagulants or certain antiplatelet regimens.

**AIM OF THE POLICY**

The aim of this policy is to clearly set out the guidelines for managing patients on anticoagulants who require colonoscopy following a positive FIT result after taking part in the Scottish Bowel Screening programme. The policy is based on guidelines published by the British Society of Gastroenterology[[1]](#footnote-1) and has been adapted following discussing with local haematology expertise.

**SCOPE OF THE POLICY**

This policy applies to all clinical and nursing staff involved in the Bowel Screening programme in NHS Greater Glasgow and Clyde.

**PROCEDURE**

For each patient, it will be established if they are on anticoagulants for low or high thrombotic risk conditions. Guidance is then specific for type of anticoagulant.

1. **PATIENTS ON WARFARIN**
2. **Patients on Warfarin – Low Thrombotic Risk Conditions**

*Low thrombotic risk conditions include:*

* + Low risk non-valvular Atrial Fibrillation (ie without valvular disease or previous CVA/TIA or systemic embolism in the last 3 months)
	+ >3 months after venous thromboembolism (VTE)

**Procedure**

* + 1. Inform Anticoagulant clinic of patient’s colonoscopy date to ensure follow up appointment (i.e 5-7 days post colonoscopy)
		2. Advise patient to stop Warfarin 5 days before endoscopy (i.e. to omit 5 doses pre-colonoscopy)
		3. Check international normalised ratio (INR) to ensure INR <1.5 on day of colonoscopy
		4. Advise patient to restart Warfarin evening of procedure with usual daily dose
		5. Anticoagulant clinic check INR 5 – 7 days after colonoscopy to ensure adequate re-anticoagulation
1. **Patients on Warfarin – High Thrombotic Risk conditions**

These patients will require to have low molecular weight heparin cover for colonoscopy. Low molecular weight heparin should be prescribed and supplied by secondary care. GPs should not be asked to prescribe this. A pre- assessment visit for these high risk patients will be required to supply them with low molecular weight heparin and advice on how to self inject and when to stop and restart warfarin.

*High thrombotic risk conditions include:*

* + Anyone with INR target 3 to 4
	+ Prosthetic metal heart valve in any position
	+ Prosthetic heart valve and AF
	+ AF and mitral stenosis
	+ AF and CVA/TIA or systemic embolism within the last 3 months
	+ <3 months after VTE
	+ Major thrombophilia syndromes

*Low molecular weight heparin is contraindicated in the following circumstances:*

* Known heparin hypersensivity

History of HIT (heparin induced thrombocytopenia)

Discuss anticoagulant cover needed in these instances with consultant haematologist and gastroenterologist.

**Procedure**

* + 1. Inform Anticoagulant clinic of patient’s colonoscopy date and ensure appropriate anticoagulant follow up appointment 5-7 days after colonoscopy.
		2. Arrange pre-assessment appointment to supply Enoxaparin, demonstrate to patient how to self inject. Advise patient to stop Warfarin 5 days before endoscopy.

		*Anticoagulant schedule:*
* Day -6 last dose of warfarin
* Day -5 no warfarin
* Day -4 no warfarin
* Day -3 no warfarin; Enoxaparin 1mg/Kg subcut 9 -10 am\*
* Day -2 no warfarin; Enoxaparin 1mg/Kg subcut 9 -10 am\*
* Day -1 no warfarin; Enoxaparin 1mg/Kg subcut 9 -10 am\*
* Day 0 – check INR is <1.5

IF NO POLYPECTOMY

* Day 0 – Enoxaparin 1mg/kg s/c post colonoscopy at 6pm; restart warfarin (usual maintenance dose at 6 pm)
* Day +1 Enoxaparin 1mg/kg s/c at 4-6pm. Warfarin at usual dose at 6pm
* Day +2 Enoxaparin 1mg/kg s/c at 4-6pm. Warfarin at usual dose at 6pm
* Day +3 Enoxaparin 1mg/kg s/c at 4-6pm. Warfarin at usual dose at 6pm
* Day +4 Warfarin at usual dose at 4-6pm. No more Enoxaparin

IF POLYPECTOMY

* Day 0 No enoxaparin; restart warfarin (usual maintenance dose at 6 pm)
* Day+1 No enoxaparin. Warfarin at usual dose at 6pm
* Day +2 Enoxaparin 1mg/kg s/c at 4-6pm. Warfarin at usual dose at 6pm
* Day +3 Enoxaparin 1mg/kg s/c at 4-6pm. Warfarin at usual dose at 6pm
* Day +4 Warfarin at usual dose at 6pm. No more Enoxaparin

Anticoagulant clinic check INR 5 – 7 days after colonoscopy to ensure adequate re-anticoagulation

**Cautions**

Discuss with consultant haematologist and gastroenterologist if:

* Evidence of active or recent bleeding
* Suspected extension/worsening of bleeding
* Suspected adverse drug reaction
* Suspected non compliance

**Action if patient declines or is excluded**

1. Counsel patient regarding their need for anticoagulant therapy

Discuss with consultant haematologist and gastroenterologist

1. **PATIENTS ON DIRECT ORAL ANTICOAGULANTS (DOACs)**

These include the Factor Xa inhibitors Apixiban, Rivaroxiban and Edoxaban, and the Factor IIa inhibitor Dabigatran. Dabigatran is less frequently used but is predominantly renally cleared therefore renal function is of relatively greater importance with this medication.

In general, patients with high risk thrombotic conditions will not be taking DOACs. The exception is patients referred for screening colonoscopy within 3 months of a venous thrombosis or an AF-related cerebrovascular event. In these circumstances the case should be discussed with a clinician and consideration given to CT colonography instead or deferral of colonoscopy.

DOACs have therapeutic anticoagulant effects within a few hours of dosing therefore recommencement of these medications should be delayed in patients who have undergone polypectomy.

**Pre-Procedure**

Take last dose of drug **> 48 hours** before procedure

For dabigatran, if eGFR is reduced, creatinine clearance (CrCl) needs to be calculated. If CrCl 30-50 ml/min take last dose 72 hours before procedure. In any patient with rapidly declining renal function or eGFR <30 a haematologist should be consulted.

**Post Procedure**

If no polypectomy, restart DOAC medication the day after the procedure

If polypectomy, restart DOAC medication **> 48 hours** after the procedure

*\*If purely diagnostic procedure +/- biopsy planned then the DOAC need only be stopped > 24hrs before procedure*

1. **PATIENTS ON P2Y12 RECEPTOR ANTAGONIST ANTIPLATELET AGENTS (CLOPIDOGREL, PRASUGREL, TICAGRELOR)**
2. **Patients on Antiplatelet Agents – Low Thrombotic Risk Conditions**

Low thrombotic risk conditions include:

* Ischaemic heart disease without recent coronary stent
* Cebrebrovascular disease
* Peripheral vascular disease

**Procedure**

1. Advise patient to stop 7 days before colonoscopy
2. Advise patient to continue aspirin if already prescribed
3. If not on aspirin, then consider aspirin therapy while P2Y12 receptor antagonist agent discontinued
4. On the day following the procedure, advise patient to restart antiplatelet agent
5. **Patients on Antiplatelet Agents – High Risk Thrombotic Conditions**

High thrombotic risk conditions include:

* Coronary artery stents
* Recent Acute Coronary Syndrome treated medically (within last 3 months)

**Procedure**

1. Discontinuation of P2Y12 antagonist antiplatelet agent in these patient groups should only be considered after discussion with the patient’s cardiologist
2. Consider stopping P2Y12 antiplatelet agent 7 days before colonoscopy (only after discussion with an interventional cardiologist) if:
* >12 months after insertion of drug eluting coronary stent
* >1 month after insertion of bare metal coronary stent
1. Advise patient to continue aspirin
2. On the day following the procedure, advise patient to restart antiplatelet agent

**Note:**

Some patients may not be easily classified into the above categories. If so, this should be discussed with the relevant senior clinician (e.g. haematologist, cardiologist, surgeon).

1. Endoscopy in patients on antiplatelet or anticoagulant therapy, including directly acting anticoagulants: British Society of Gastroenterology (BSG) and European Society of Gastrointestinal Endoscopy (ESGE) Guidelines. Veitch *et al* *Gut* 2016; **65**: 374-389 [↑](#footnote-ref-1)