



Anti- Coagulant Medication Protocol for Gastrointestinal procedures.

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Blood thinning agents may greatly increase the risk of serious haemorrhage following polypectomy. This is a complex problem where the risks of post-polypectomy haemorrhage must be balanced against the risks of stopping or modifying anticoagulant or antithrombotic therapy. Frequently there is NO simple and safe solution. The GIE Policy is:-

Aspirin poses minimal, if any, increased risk of post-polypectomy haemorrhage. If taken simply as a lifestyle measure it should be ceased 10 days before colonoscopy. If taken for a genuine medical indication (eg TIA, AF) then should be continued unaltered. Note that aspirin effects continue for 7 – 10 days after therapy is stopped. Stopping aspirin a few days before colonoscopy is pointless.

Anticoagulants (COUMADIN, MAREVAN [WARFARIN], CLEXANE, DINDEVAN) are usually prescribed for serious medical conditions and stopping treatment may pose serious risks. If therapy can be stopped safely or colonoscopy deferred (eg a six month course of anticoagulants following DVT) then this is appropriate. Where there are risks in ceasing therapy the patient is **unsuitable for open access colonoscopy** unless the referring doctor is prepared to take full responsibility for stopping anticoagulants. If not the endoscopist should discuss risks with the initiating therapist eg some cardiologists feel anticoagulants can be temporarily ceased for particular artificial aortic valves but not for others, and certainly not for artificial mitral valves. The endoscopist then has the legal responsibility to ensure that the patient understands fully the risks of any modification of the anticoagulant therapy, the risks of polypectomy on whatever modified regime is undertaken, or alternatively the risks of not removing polyps if found. **NB** if anticoagulants are ceased then a Prothrombin Time and INR must be done the day before colonoscopy.

Antithrombotic Agents (AGGRASTAT, ARIXTA, ASASANTIN, ISCOVER, PERSANTIN, PLAVIX, REOPRO, THROMBOTROL, TICLID, TILODENE). The bleeding risks of antithrombotic agents are commonly underestimated. At least from a gastrointestinal point of view these agents pose a greater risk than anticoagulants. There is no way of reversing them and once haemorrhage starts it may not stop until the blood which has been affected has been replaced i.e. transfusion of some litres. **A minimum of 7 days** off these drugs is required for coagulation to return to normal. There appears to be a rapidly increasing use of these drugs for relatively minor indications e.g. previous history of myocardial infarction. Where the drug can be safely stopped for a minimum of 7 days before colonoscopy then open access colonoscopy can be undertaken. Where there is considered to be serious risk of stopping the drug, then patients are again unsuitable for open access colonoscopy and the same process described for anticoagulants needs to be followed.

Options where Anticoagulants-Antithrombotics cannot be ceased.

1. **Continue therapy.** In high risk patients it may be best to undertake diagnostic colonoscopy while the patient continues on their normal therapy. If polyps are found they cannot be removed and the patient will have to have a repeat colonoscopy or surgical intervention if a high risk polypoid lesion is found. In some instances the least risky course may be simple surveillance of small polyps.
2. **Modify therapy.** This could include : Aspirin alone
 - : Daily Clexane
 - : Twice daily Clexane
 - : Twice daily Heparin s/c