Worcestershire Acute Hospitals NHS Trust

Guidelines for patients taking Anticoagulant or Antiplatelet medications within the Bowel Cancer Screening Programme

Key Document code:	WAHT-KD-021	
Key Documents Owner:	Emma Duggan/Felicity Eykyn	Bowel Cancer & Bowel Scope Screening Manager/Bowel Cancer Lead Nurse Specialist Screening Practitioner
Approved by:	Bowel Screening Operational Meeting	
Date of Approval:	24th April 2017	
Date of review:	11th February 2022	

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

FOBt Positive Assessment Clinic

Specialist Screening Practitioners (SSP's) complete the medical assessment of each patient during an FOBt positive assessment clinic appointment using the colonoscopy assessment dataset on the Bowel Cancer Screening IT System (BCSS). Part of this structured assessment will include establishing whether the patient is taking anticoagulant or antiplatelet medications.

The following represents the processes to be followed with respect to the different medications and the level of associated risk. Please see Appendix 1a and 1b for flowchart.

Patients taking Warfarin

Please see Appendix 1a

1. Ascertain normal Warfarin dose and latest International Normalised Ratio (INR) result (within a maximum of 3 months).

2. Using the Guidelines for the management of anticoagulant and antiplatelet therapy in patients undergoing endoscopic procedures (Veitch et al. BSG 2016) assess whether the patient has a high risk or low risk condition.

Low Risk Conditions:

- Atrial Fibrillation (AF) with no arterial event within last 3 months.
- Deep Vein Thrombosis / Pulmonary Embolism more than 6 weeks previously

1. Warfarin should be stopped for 5 days prior to the planned date of colonoscopy.

2. Request that patient makes arrangements to have their INR checked at the General Practitioner (GP) surgery one working day before their colonoscopy.

3. Inform patient and appropriate GP of agreed Warfarin management by letter using the local template on BCSS.

4. Following completion of the colonoscopy the SSP will confirm with the Screening Colonoscopist whether or not the patient is to restart their Warfarin with the usual dose that evening as per normal protocol.

5. Request that the patient has a check INR blood test at the GP surgery 1 week after procedure.

High Risk Conditions:

- Risk of Re-Thrombosis
  - Deep Vein Thrombosis or Pulmonary Embolism within previous 6 weeks
    Discuss patient with Haematologist.

- Patient with Valvular Heart Disease
  Discuss with Cardiologist

- Atrial Fibrillation with arterial event within previous 3 months
  Discuss with Cardiologist

See below for the likely pathway.

Likely Pathway

1. Agree with Cardiologist/ Haematologist that standard Bridging Regime is to be carried out i.e. substituting Warfarin with low molecular weight Heparin (LMWH) immediately prior to the date of procedure.

2. Inform patient and appropriate GP of agreed Warfarin management by letter using the local template on BCSS.

3. Warfarin should be stopped 5 days prior to colonoscopy

4. Request GP to prescribe LMWH (Clexane 1.5mg / kg) or (tinzaparin 175ug/kg) and arrange for District Nurse or Practice Nurse to administer daily LMWH injection;
   1st dose of LMWH to be given 2 days after stopping Warfarin

5. Request that patient makes arrangements to have their INR checked at the General Practitioner (GP) surgery one working day before their colonoscopy.

6. Omit LMWH on the day of colonoscopy

7. Following completion of the colonoscopy the SSP will confirm with the Screening Colonoscopist whether or not the patient is to restart their Warfarin with the usual dose that evening as per normal protocol.

8. Recommence the daily injection of LMWH the day after colonoscopy and continue until satisfactory INR achieved.

Patients taking Direct Oral Anticoagulants

Please see Appendix 1a

1. Ascertain normal medication dose.

2. Using the Guidelines for the management of anticoagulant and antiplatelet therapy in patients undergoing endoscopic procedures (Veitch et al. BSG 2016) assess whether the patient has a high risk or low risk condition.

Low Risk Conditions:

- Atrial Fibrillation (AF) with no arterial event within last 3 months.
- Deep Vein Thrombosis / Pulmonary Embolism more than 6 weeks previously

1. Direct oral anticoagulant should be stopped for 48 hours prior to the planned date of colonoscopy, with the exception of Dabigatran which should be stopped in accordance with the GFR. Please see Appendix 1a for timescales.

2. Inform patient and appropriate GP of agreed anticoagulant management by letter using the local template on BCSS.

3. Following completion of the colonoscopy the SSP will confirm with the Screening Colonoscopist whether or not the patient is to restart their medication with the usual dose the following day as per normal protocol.

High Risk Conditions:

- Risk of Re-Thrombosis
  - Deep Vein Thrombosis or Pulmonary Embolism within previous 6 weeks
    Discuss patient with Haematologist.

- Patient with Valvular Heart Disease
  Discuss with Cardiologist

- Atrial Fibrillation with arterial event within previous 3 months
  Discuss with Cardiologist

See above for the likely pathway.

Patients taking Antiplatelet Medications (Clopidogrel, Prasugrel, Ticagrelor, Dipyridamole)

Please see Appendix 1b.

1. Specialist Screening Practitioners (SSP's) complete the medical assessment of each patient during an FOBt positive assessment clinic appointment using the colonoscopy assessment dataset on the Bowel Cancer Screening IT System (BCSS).

2. Refer to the Local Trust BCSP guidelines for the management of patients on P2Y12 receptor Antagonist (October 2016) and Guidelines for the management of anticoagulant and antiplatelet therapy in patients undergoing endoscopic procedures (Veitch et al. BSG 2016) and assess whether the patient has a high risk or low risk condition.

Low risk conditions

- Ischaemic heart disease without coronary stent(s)
- Cerebrovascular disease
- Peripheral vascular disease.

All more than 3 months previously.

1. Clopidogrel, Prasugrel or Ticagrelor should be stopped for 5 days prior to colonoscopy.

2. Inform patient and appropriate GP of agreed antiplatelet management plan by letter using the local template on BCSS.

3. Following completion of the colonoscopy the SSP will confirm with the Screening Colonoscopist whether or not the patient is to restart their Antiplatelet Medication with the usual dose the following day as per normal protocol.

High risk condition

- Coronary artery stents
- Arterial events within 3 months previous

1. Liaise with patient's Cardiologist

DO NOT stop clopidrogrel, prasugrel, tricagrelor or Dipyridamole unless advised by cardiology.