Trust Policy

Worcestershire Acute Hospitals NHS Trust

ENDOSCOPY

STANDARD OPERATING PROCEDURE

Prescribing/omission of oral anticoagulants for elective endoscopy –
taken from WAHT–HAE-002 V6 and British Society of Gastroenterology guidelines for management of anticoagulation

Department / Service:	SCSD
Originator:	Helen Livett, Loraine Mahachi, Dr Mark Crowther, Dr Helen Routledge
Accountable Director:	Lynne Mazzocchi
Approved by:	Endoscopy Directorate
Date of Approval:	April 2017
Review Date: **This is the most current document and should be used until a revised version is in place**	29th September 2020
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	
Target staff categories	

Policy Overview:

This SOP 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

Latest Amendments to this policy:

29/06/2020 – Document extended for 3 months whilst review process is completed.

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Quick Reference Guide

Minor procedures/diagnostic procedures

Low Risk Procedure includes:

Diagnostic procedures +/-, biopsy, Biliary or pancreatic stenting, Diagnostic EUS, Device-assisted enteroscopy without polypectomy

(BSG, 2016)

Warfarin

Certain minor procedures do not require interruption of warfarin and as long as the INR is within the target range or below 3 for diagnostic procedures and biopsy.

Direct Oral Anticoagulant (DOAC)Therapy

The direct oral anticoagulant (DOACs) provide a similar level of anticoagulation to warfarin with a target INR of 2.5 but produce more peaks and troughs. Therefore:

AM procedure: Withold morning dose of DOAC. For Rivaroxaban or Edoxaban take missed dose 2 hours after procedure as long as haemostasis is secure, for others take evening dose as planned as long as haemostasis is secure and 2 hours has elapsed from end of procedure.

Procedure after 2pm: Take morning dose of DOAC before 7am and restart when next dose is due as long as haemostasis is secure and 2 hours has elapsed from end of procedure.

Clopidogrel, Prasugrel, Ticagrelor

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

Biopsy taking is based on endoscopist discretion at the time of procedure.

Therapeutic/high risk procedure

High risk procedure includes:

Polypectomy, ERCP with sphincterotomy, Ampullectomy, EMR/ESD, Dilation of strictures, Therapy of varices, PEG, EUS with FNA, Oesophageal, enteral or colonic stenting

(BSG, 2016)

Warfarin

Patients who have had a recent thrombosis (within the last 6 weeks) or have a target INR>2.5 should be discussed with Clinical Haematology

Low Risk Condition

Prosthetic metal heart valve in aortic position/Xenograft heart valve/AF without valvular disease/>3months after VTE/Thrombophilia syndromes

Stop warfarin 5 days before endoscopy. Check INR (preferably the day before or on the day) prior to procedure to ensure INR <1.3

Restart warfarin as per endoscopist instruction on Endoscopy report

Check INR 3 - 4 days later to ensure adequate anticoagulation

High Risk Condition

Any other cardiac condition should be discussed with cardiology/haematology prior to cessation of medication. For example:

Prosthetic metal heart valve in mitral position/Prosthetic heart valve and AF/AF and mitral stenosis/<3months after VTE

Stop warfarin 5 days before endoscopy. Start LMWH 2 days after stopping warfarin

Give last dose of LMWH > 24 hours before procedure. Restart warfarin as per endoscopist instruction on the Endoscopy report. Continue LMWH following procedure for 2 days then check INR 3 – 4 days later to ensure adequate anticoagulation.

Dabigatran

Renal function (CrCL in ML/min)

>80 stop Dabigatran 2 days before procedure

50 – 80 stop Dabigatran 3 days before procedure

30 – 50 stop Dabigatran 4 days before procedure

Apixaban, Edoxaban, Rivaroxaban

Stop Apixaban, Edoxaban, Rivaroxaban 48 hours prior to procedure

Clopidogrel, Prasugrel, Ticagrelor

Low Risk Condition

Ischaemic heart disease without coronary stent/Cerebrovascular disease/Peripheral vascular disease

Stop Clopidogrel, Prasugrel or Ticagrelor 5 days before endoscopy**.**

Continue aspirin if already prescribed

High Risk Condition

Coronary artery stents, liaise with cardiologist, They may advise to stop Clopidogrel, Prasugrel or Ticagrelor 5 days before endoscopy if:

>12 months after insertion of drug-eluting coronary stent

>1 month after insertion of bare metal coronary stent

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 (2016)

The policy aims to provide firm guidance on the processes of cessation and readministration 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.

1. Scope of this document

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

2. Definitions

References
WAHT-HAE-002 V6
http://www.bsg.org.uk/images/stories/docs/clinical/guidelines/endoscopy/bsg_esge_anticoag_16.pdf

3. 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 WHAT
Any pre assessment nurses seeing patients prior to their endoscopy procedure

4. Policy detail

If these guidelines aren't 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 lead for endoscopy.

5. Implementation

5.1 Plan for implementation

As soon as approved at Directorate meeting

5.2 Dissemination

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

6. 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 cessation of anticoagulant/antiplatelet medication prior to gastrointestinal endoscopy.	Monitoring of Datix reporting discussed at directorate meeting	Discussion at the directorate meeting	Lynne Mazzocchi/ Mr Lake	Endoscopy directorate meeting	Monthly

7. Policy Review

2 yearly as per WHAT guidance

8. References

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, 2016

9. Background

9.1 Equality requirements

9.2 Financial risk assessment

9.3 Consultation

To be approved at the Endoscopy Directorate meeting

Contribution List

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

Designation

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

Committee

9.4 Approval Process

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

9.5 Version Control

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

Date	Amendment	By:

Supporting Document 1 - Equality Impact Assessment Tool

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

		Yes/No	Comments
1.	**Does the Policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the Policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the Policy/guidance without the impact?**		Patients attend clinic for review of histology
7.	**Can we reduce the impact by taking different action?**	No	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

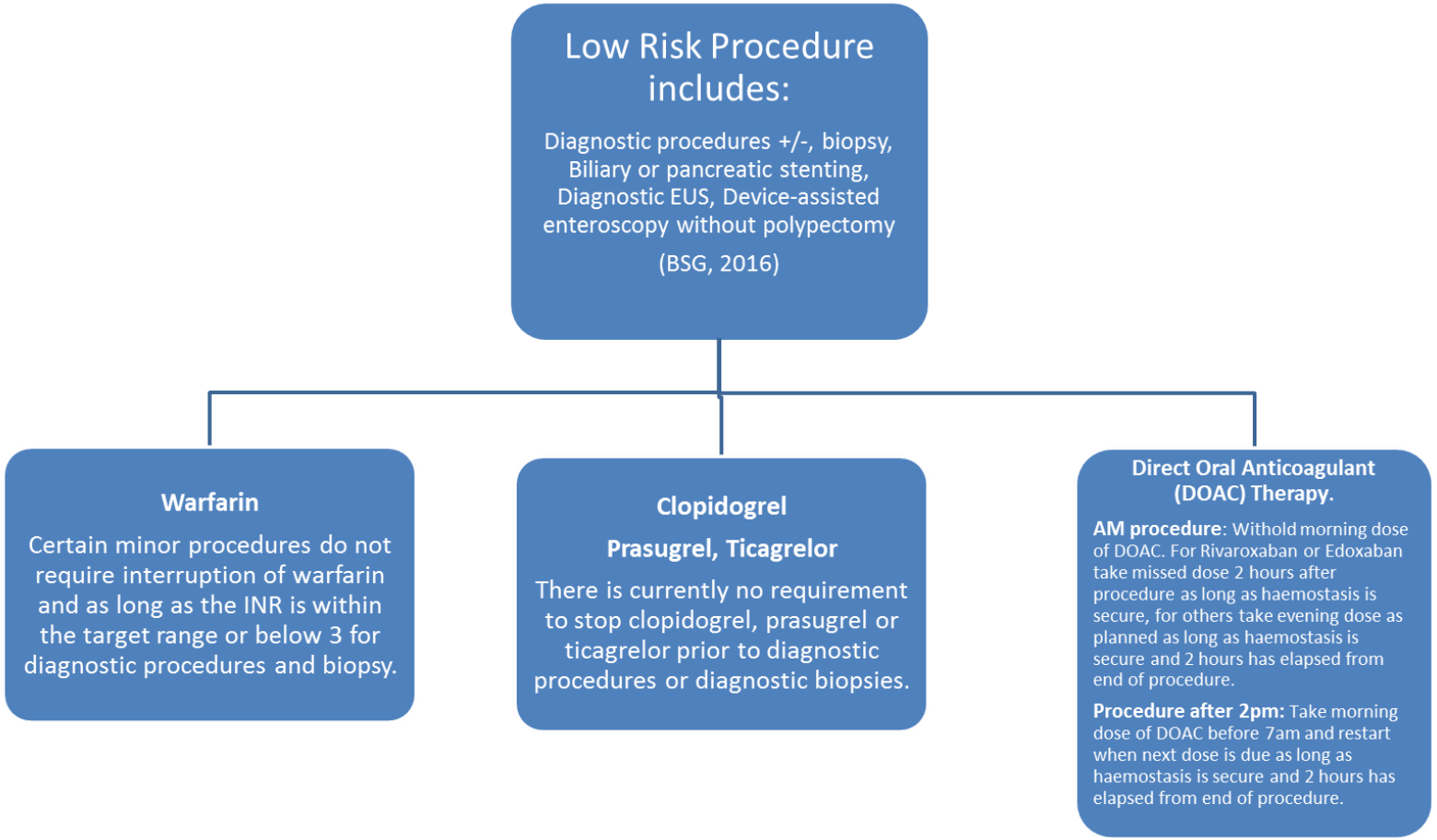
Supporting Document 2 – Financial Impact Assessment

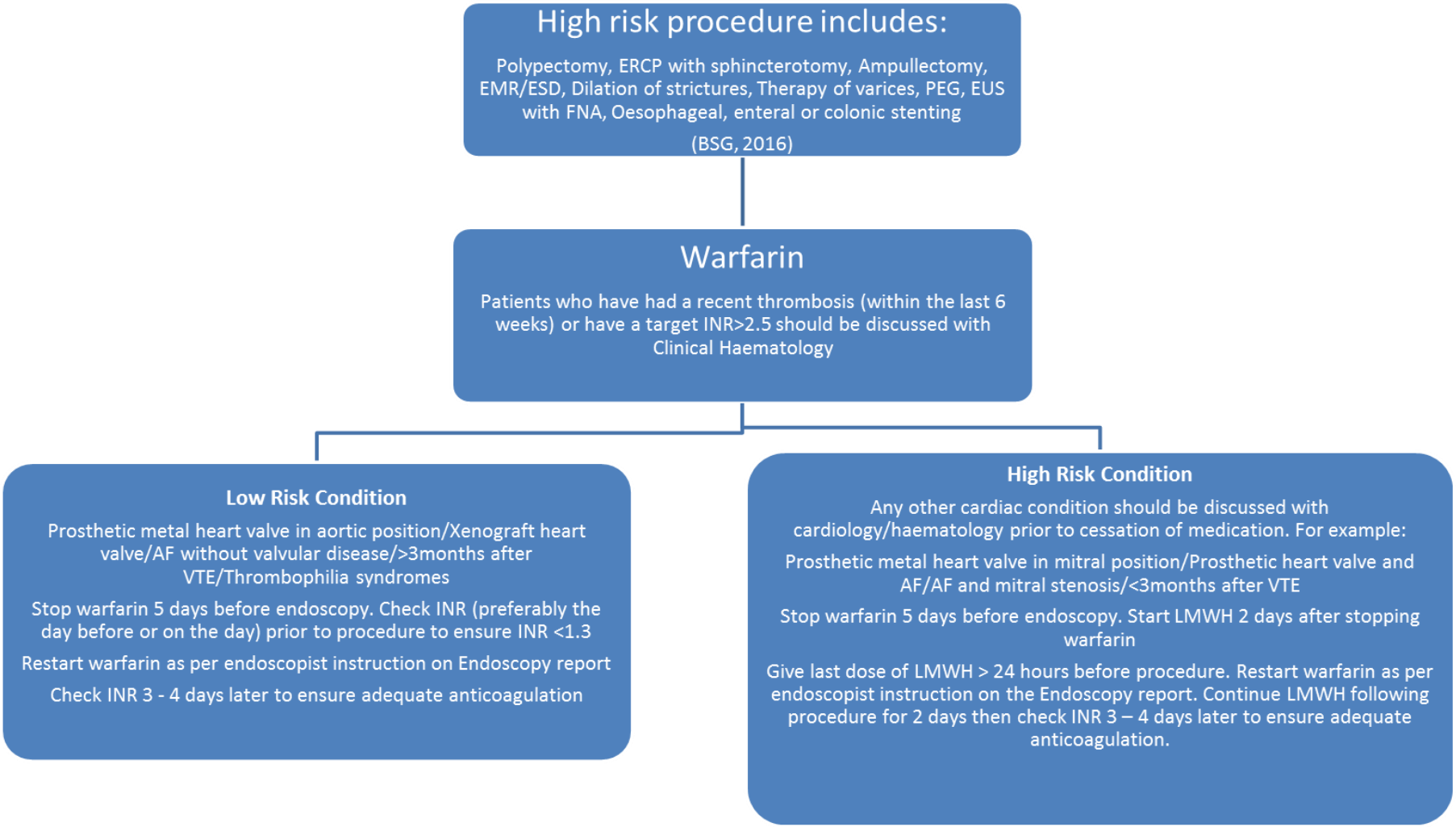
To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	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

Appendix- Prescribing/omission of oral anticoagulants for elective endoscopy
(Colonoscopy is classed as a diagnostic procedure unless there is planned polypectomy or where radiological findings suspect a polyp)

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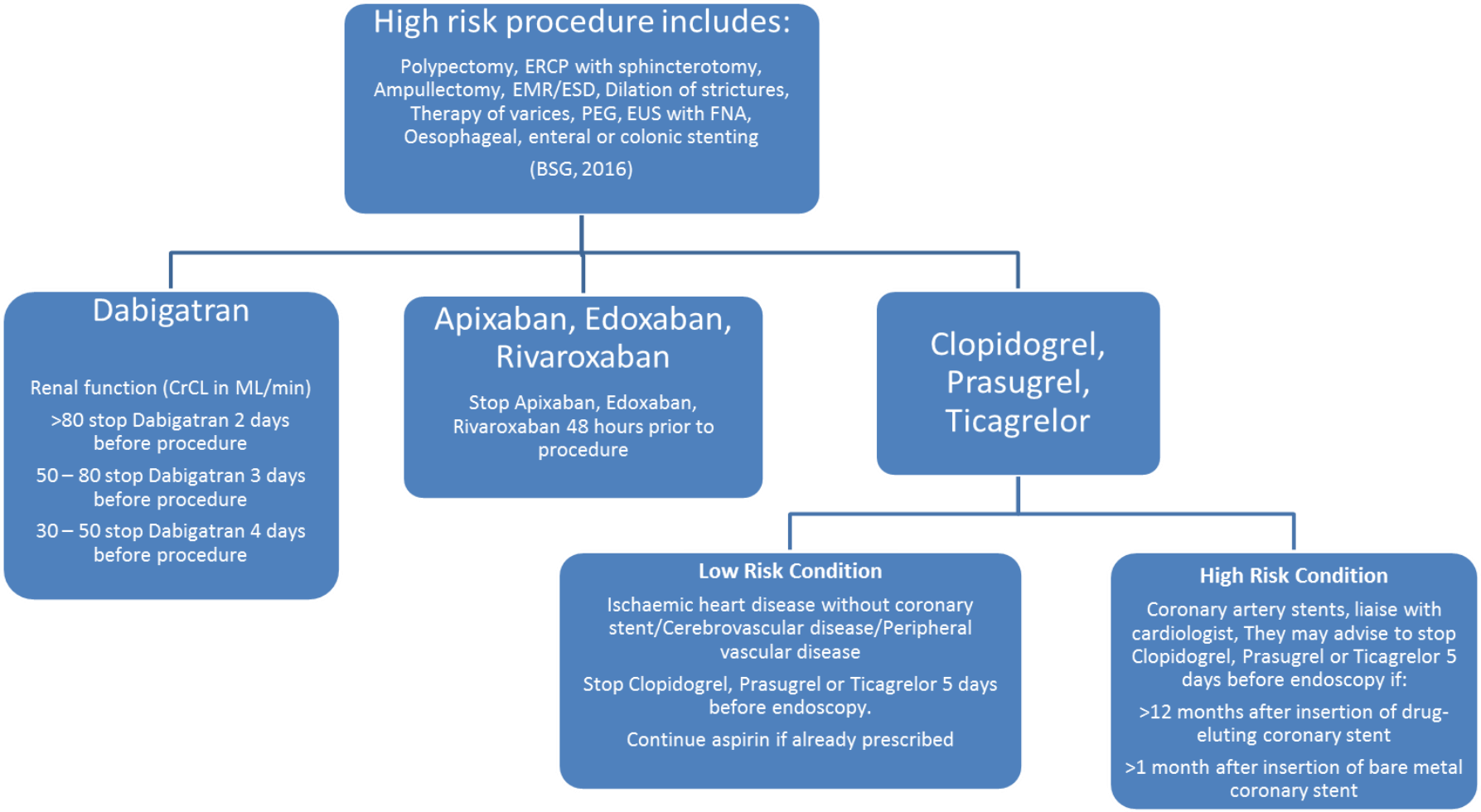
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