Bowel Cancer Screening – Anticoagulant or Antiplatelet UHL CHUGGS Guideline	University Hospitals of Leicester NHS NHS Trust C28/2022

1. Introduction and Who Guideline applies to

This work instruction covers patients that are identified by the Bowel Cancer Screening Programme as taking anticoagulation or antiplatelet medication and the management of these patients in the BCSP. It covers all the staff involved in the management of these patients, including SSP's (Specialist Screening Practitioners) and screening colonoscopists. The guidance follows the British Society of Gastroenterology (BSG) guidance (2021). Please note the local reference for this work instruction is WISSP 1.3

2. Guideline Standards and Procedures

Patient is identified at either Positive Assesment Clinic or surveillance as taking an anti-coagulant and/or anti platelet therapy.

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Decision is to be made from discussion between SSP and patient with regards to a diagnostic or a therapeutic procedure (risks and benefits to be fully discussed). Patients are made aware of the benefits and risks of interrupting anticoagulation or antiplatelet therapy to have a colonoscopy. The option of continuing therapy in cases where clinically appropriate should be considered. However, patients must be aware of the potential for subsequent / repeat interventions and the implications for anticoagulation and antiplatelet therapy. This should be documented in the BCSS episode notes.

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Diagnostic only Procedure pathway

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Book a colonoscopy procedure and proceed on low risk pathway and document this clearly on BCSS. Consultant to sign proforma A or B confirming diagnostic only if not patient choice.

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Complete proforma A or B post procedure. If a therapeutic procedure is required (follow therapeutic procedure pathway)

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Therapeutic Procedure Pathway

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SSP to fully complete proforma A or B with full medical history for medical review.

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Liaise with screening consultant or relevant medical consultants for medical review and gain signed proforma or email.

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If Bridging plan is required –
SSP to follow UHL Anticoagulation bridging therapy for elective surgery procedures **(Found on In-site Trust ref: B30/2016)**

If NO Bridging plan is required – proceed with signed proforma.

Written information on risks should be provided to patients . A letter should then be provided to confirm when to stop and restart medication (with specific dates and times).

If the procedure date is changed, check any implications for date changes to stopping anticoagulation/antiplatelet therapy.
Two SSP's to check letter and sign in post book.
All to be documented on BCSS.

SSP to complete peri – op plan in Trust document according to patients co-morbidities and medication.

Screening consultant to then prescribe the correct dose of Enoxaparin as indicated. A sharps bin should also be prescribed.

Ensure Anticoagulation/platelet sticker is attached to the patients consent form and the patient is fully aware.

SSP to take prescription to Lloyds outpatient pharmacy.

SSP to arrange for patient to collect Enoxaparin and establish if they will administer self or carer/ relative. Teaching session required by SSP if needed. Refer to district nurses if needed for assistance with administration.

Written information on risks should be provided to patients .
A letter should then be provided to confirm when to stop and restart medication (with specific dates and times).
If the procedure date is changed, check any implications for date changes to stopping anticoagulation/antiplatelet therapy.
Two SSP's to check letter and sign in post book.
All to be documented on BCSS.

Ensure Anticoagulation/platelet sticker is attached to the patients consent form and the patient is fully aware.

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Endoscopy report to state when patients should recommence Anticoagulant/platelets

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When reporting possible related adverse events or incidents, please provide details and dates of any changes to anticoagulation or antiplatelet therapy.

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs

3. Education and Training

Annual DOPS assessment. All screening staff made aware of SOPS and Work Instructions on induction and any changes/reviews are fed back to the team via email and at team meetings.

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Adverse incidents, AVIs and non-conformance monitoring	Adverse incidents, AVIs and non-conformance monitoring	Alex Bonner	3 monthly	Quarterly Bowel cancer Screening Programme Board

5. Supporting References

VEITCH, A.M., RADAELLI, F., ALIKHAN, R., DUMONCEAU, EATON, D., JERROME, J., LESTER, W., NYLANDER, D., THOUFEEQ, M., VANBIERVLIET, G., WILKINSON, J.R. and VAN HOOFT, J. E. (2021) "Endoscopy in patients on antiplatelet or anticoagulant therapy: British Society of Gastroenterology (BSG) and European Society of Gastrointestinal Endoscopy (ESGE) guideline update" *Gut*, 70: 1611-1628

6. Key Words

Bowel Cancer Screening, anticoagulant, antiplatelet medication

CONTACT AND REVIEW DETAILS	
Guideline Lead Claire Almen and Amanda Smith, Lead Specialist Screening Practitioners, UHL Bowel Cancer Screening	**Executive Lead** Richard Robinson, Clinical Director, UHL Bowel Cancer Screening Programme
Details of Changes made during review: Incorporation of 2021 BSG and ESGE guidelines update on endoscopy in patients on antiplatelet or anticoagulation therapy. Incorporation of UHL Anticoagulation bridging therapy guidelines for elective surgery procedures.	

PROTOCOL FOR ELECTIVE ENDOSCOPIC PROCEDURES FOR PATIENTS ON ANTICOAGULANT THERAPY – APPENDIX A

Patient Name:
Hospital Number:
(Affix Label Here)

WARFARIN / DABIGATRAN / RIVAROXABAN / APIXABAN / EDOXABAN

PROCEDURE RISK – please tick box

High Risk		Low Risk	
Colonoscopic polypectomy or EMR		Diagnostic gastroscopy with biopsy	
Colonoscopy for polyp surveillance		Diagnostic colonoscopy with biopsy	
Argon / Laser treatment		Flexible sigmoidoscopy with biopsy	

CONDITION RISK – Please tick box

High Risk		Low Risk	
AF and mitral stenosis		Xenograft Heart valve	
Prosthetic metal heart valve		AF without valvular heart disease	
< 3 months after venous thromboembolism		> 3 months after venous thromboembolism	
Thrombophilia syndrome			

Warfarin: Procedure risk high/ Condition risk high

- Discontinue Warfarin 5 days before procedure.
- Therapeutic dose LMWH Metal Heart valves at 1mg/Kg twice daily, all other conditions 1.5mg/Kg once daily, omitted on the day of the procedure.
- INR < 1.5 on day of the procedure.
- Restart warfarin at the normal dose on the evening of the procedure, LMWH to restart the following day.
- **Procedure risk high/ Condition risk low**
- Discontinue Warfarin 5 days before procedure. Attach card for INR <1.5 on the day of procedure.
- Warfarin at normal maintenance dose can generally be resumed the night of procedure unless high risk treatment.

Procedure risk low – Continue Warfarin & check INR on day of the procedure.

DOAC: Procedure risk high

- Take last dose of drug 3 days before procedure.

Procedure risk low

- Omit DOAC on the morning of the procedure

Clinical Review Outcome

Stop Warfarin – No Heparin required ☐ Continue – Diagnostic investigation only ☐

Stop Warfarin – Heparin required (Endoscopy will arrange for patient to have LMWH) ☐

Stop DOAC – Omit on day of procedure ☐ Take last dose of DOAC 3 days before procedure ☐

Clinical Decision ……

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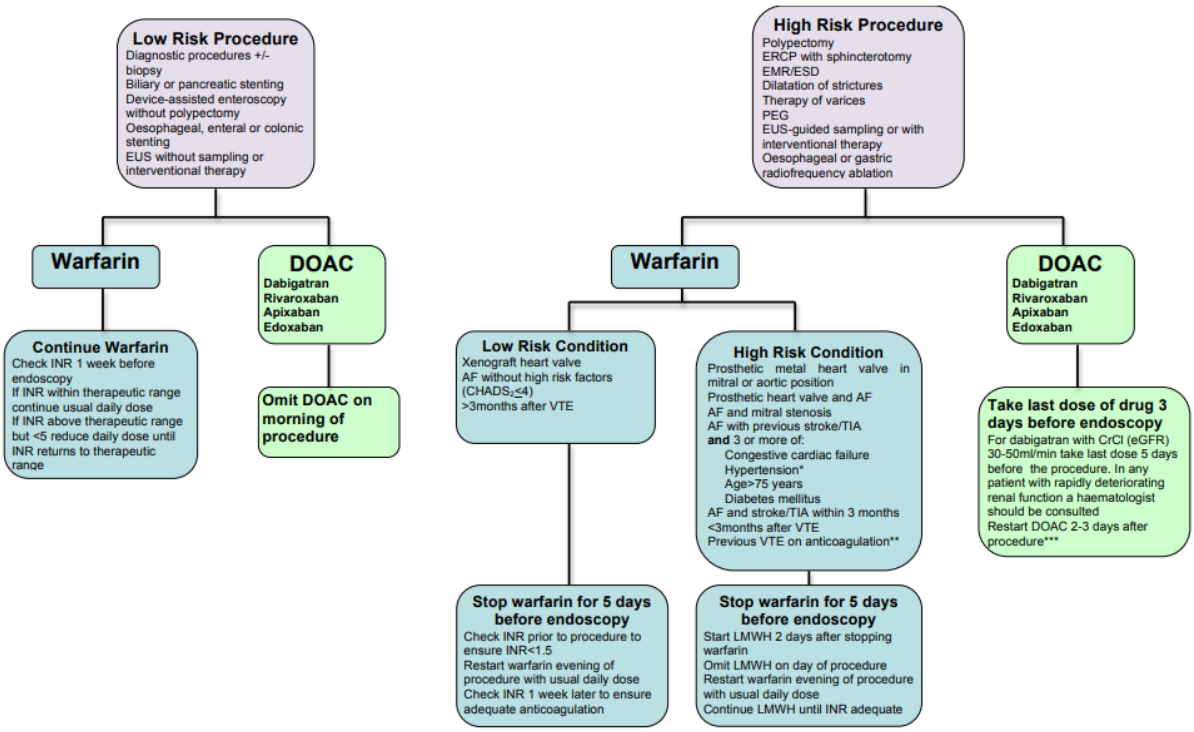
Signature _____ Date_____

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

APPENDIX B

Patient Name: **Clopidogrel/Prasugrel/Ticagrelor Medication –** Provisional date for BCSP Colonoscopy**:**

Hospital Number: **Unsuitable pathway instigated:**

(Affix Label Here)

PROCEDURE RISK – please tick box

High Risk		**Low Risk**	
Colonoscopic polypectomy or EMR		Diagnostic gastroscopy with biopsy	
Colonoscopy for polyp surveillance		Diagnostic colonoscopy with biopsy	
ERCP and sphincterotomy		Flexible sigmoidoscopy with biopsy	
PEG placement		Enteroscopy	
Oesophageal dilatation		ERCP with stent	
Treatment of varices		Diagnostic EUS	
Laser treatment			

CONDITION RISK – Please tick box

High Risk		**Low Risk**	
Coronary artery stents especially:		Peripheral vascular disease	
Drug eluting coronary stent within 12 months of placement		Ischaemic heart disease without coronary stent	
Bare metal stent within 1 month of placement		Cerebrovascular disease	

Procedure risk high/ Condition risk high –

- Liaise with cardiologist. 50% risk of coronary event if Clopidogrel/Prasugrel/Ticagrelor stopped in certain patients.
- Consider diagnostic procedure only and defer any therapy in patients with coronary stents.
- Consider stopping Clopidogrel/Prasugrel/Ticagrelor 7 days before if drug eluting stent placed 12 months ago or bare metal stent 1 month ago.
- If therapy essential and Clopidogrel/Prasugrel/Ticagrelor must be continued, discuss with Screening consultant, cardiologist & endoscopy unit.

Procedure risk high/ Condition risk low –

- Stop Clopidogrel/Prasugrel/Ticagrelor 7 days before and consider using aspirin while Clopidogrel/Prasugrel/Ticagrelor discontinued.

Procedure risk low – Continue Clopidogrel/Prasugrel/Ticagrelor.

Clinical Review Outcome

Stop Clopidogrel/Prasugrel/Ticagrelor 7 days before procedure ☐

Continue Clopidogrel/Prasugrel/Ticagrelor: diagnostic colonoscopy only ☐

Continue Clopidogrel/Prasugrel/Ticagrelor Procedure low risk. ☐

Clinical Decision:

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Signature _____ Date_____

Print Name_____ Bleep Number _____

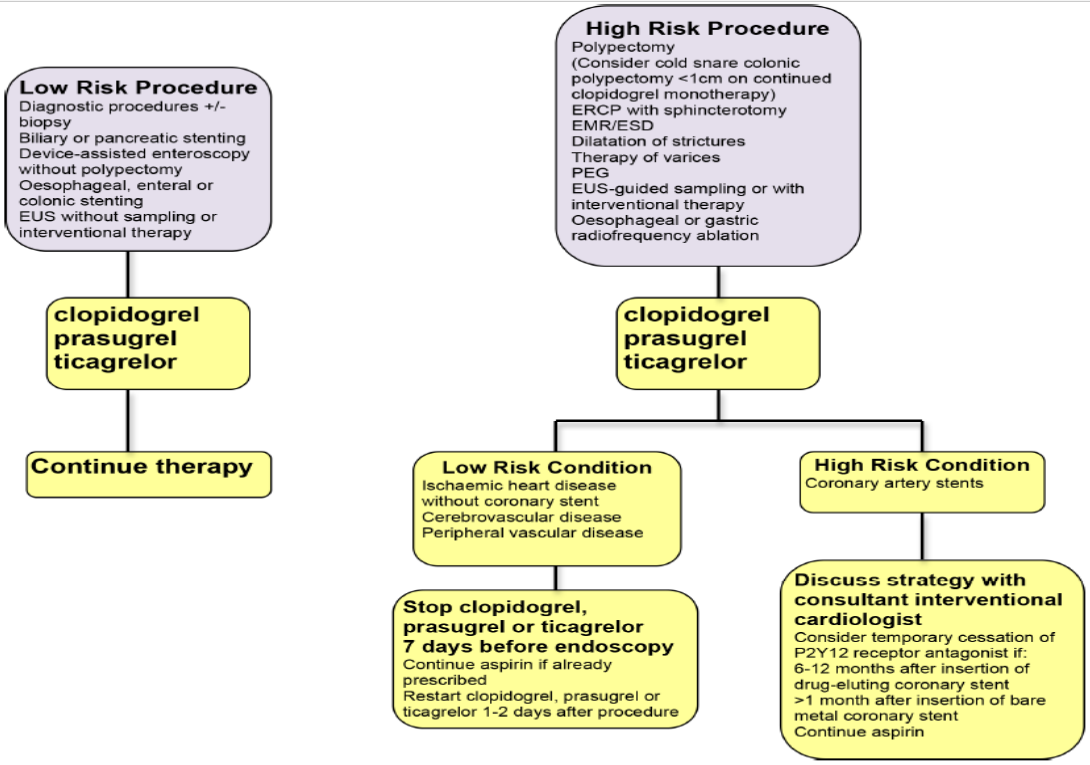

Figure 1 Guidelines for the management of patients on P2Y12 receptor antagonist antiplatelet agents undergoing endoscopic procedures: 2021 update. EMR, endoscopic mucosal resection; ERCP, endoscopic retrograde cholangiopancreatography; ESD, endoscopic submucosal dissection;EUS, endoscopic ultrasound; PEG, percutaneous endoscopic gastroenterostomy.