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2

Managing antithrombotic agents during endoscopy



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A B S T R A C T

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Antithrombotic agents are used widely to reduce the risks of thromboembolic events in patients with a variety of cardiovascular and other conditions. This review focuses on the management of patients undergoing endoscopic procedures who are taking antithrombotic medications, and includes specific information and recommendations.

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Introduction

Antithrombotic agents, namely anticoagulants and anti-platelet agents, are widely used in the population of patients having endoscopic procedures; proper management of these agents at the time of endoscopy is critical. These agents are used to prevent thromboembolic events in patients with a variety of conditions including atrial fibrillation (AF), deep vein thrombosis (DVT), acute coronary syndrome (ACS), and hypercoagulable states. They are also used to prevent clotting of intravascular devices such as coronary artery stents. Appropriate management of these medications in the peri-procedural period involves balancing the benefits of the antithrombotic agent in preventing thromboembolic events against the risks of bleeding related to an endoscopic intervention performed at the time an antithrombotic medication is in use. The urgency of endoscopy should also be considered when planning endoscopy in patients on such medications.

Also critical to decision making around the time of endoscopy is an understanding that potential thromboembolic events, such as strokes and myocardial infarction, which may occur following even

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temporary cessation of antithrombotic medication, can be devastating, whereas bleeding after high-risk procedures, although increased in frequency, is usually easily identified and is rarely associated with any significant morbidity or mortality [1–3].

Procedure risks

Endoscopic procedures vary in their risk, and guidelines [1–3] have stratified procedures to those that are considered low risk and those that are higher in risk. These are outlined in Table 1. Low risk procedures include diagnostic studies such as endoscopy, colonoscopy, and sigmoidoscopy, and include mucosal biopsies done during those tests. Similarly, diagnostic ERCP with stent placement and balloon dilation without sphincterotomy falls into the low risk category. Other lower risk procedures include capsule endoscopy, push enteroscopy, stent placement, EUS without FNA (fine needle aspiration), argon plasma coagulation and Barrett's ablation using thermal techniques.

The therapeutic correlates of those diagnostic procedures are classified as higher risk, and include polypectomy, biliary or pancreatic sphincterotomy, any endoscopic hemostasis, variceal ligation, percutaneous endoscopic gastrostomy (PEG) placement, EUS with FNA or FNB, tumor ablation, ampullary resection, cyst gastrostomy, endoscopic mucosal resection or endoscopic submucosal dissection (EMR/ESD), endoscopic dilation and percutaneous endoscopic jejunostomy (PEJ) placement. Higher risk procedures may be considered those that are more likely to lead to bleeding complications that might require transfusion, hospitalization or surgery.

Condition risks

Much like procedure related risks can be categorized, the risk of the underlying condition which led to the use of the thromboembolic medication can be stratified into low and higher risk. The relative likelihood of a thromboembolic event is an important consideration when weighing decisions about the use or cessation of antithrombotic agents around the time of endoscopy (Table 2).

Relatively low risk conditions include:

1. No prior thromboembolic events.
2. Deep vein thrombosis (DVT) >90 days previously.
3. Uncomplicated atrial fibrillation.

Table 1

Procedure risk for bleeding.

Low risk
Upper endoscopy, colonoscopy, sigmoidoscopy including biopsy
ERCP with stent placement and balloon dilation without sphincterotomy
Push enteroscopy
Double balloon enteroscopy
Capsule endoscopy
Enteral stent placement
EUS
Argon plasma coagulation
Barrett's ablation
High risk
Polypectomy
Sphincterotomy
EUS/FNA
Tumor ablation
Endoscopic hemostasis
Ampullectomy
EMR
ESD
Dilation
PEG/PEJ

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