Appendix C. Holding Antithrombotics for Outpatient Endoscopy Procedures

How to Use this Appendix

This appendix provides additional details regarding how UW Digestive Health Center (DHC) providers categorize the bleeding risk of specific outpatient endoscopic procedures, and their corresponding recommendations for stopping oral antithrombotics prior to the procedure. This appendix is meant to facilitate communication of recommendations between DHC providers and providers managing the patient's antithrombotic therapy.

Step 1. Identify the bleeding risk category of the patient's procedure
Step 2. Identify the recommendation for stopping the antithrombotic prior to the procedure
Step 3. The provider managing the antithrombotic therapy should determine whether they agree with the DHC recommendations for stopping antithrombotics prior to the procedure, based on their knowledge of the patient's thromboembolic risk and past medical history

- If Yes → please confirm instructions with the patient or their caregiver
- If No (or if further discussion is needed) → please contact DHC at 608-890-5000 or (for UW Health providers) via Health Link In Basket: DHC ENDOSCOPY CLINICAL ALL

Step 4. Decisions about restarting antithrombotic therapy after the procedure should be made by the provider managing the antithrombotic therapy; DHC providers may provide updated post-procedure instructions, based on what occurred during the procedure

Outpatient Endoscopic Procedure Bleeding Risk Categories[4,10]

MINIMAL BLEED RISK 30 day bleed risk: ~0%	LOW/MODERATE BLEED RISK 30 day bleed risk: 0-2%	HIGH BLEED RISK 30 day bleed risk: > 2%
• Video capsule endoscopy	• Argon plasma coagulation (APC) • Balloon dilation of luminal stenoses • Colonoscopy +/- biopsy • Enteral stent deployment • Esophagogastroduodenoscopy (EGD) +/- biopsy • Flexible sigmoidoscopy +/- biopsy • Marking (including clipping, electrocoagulation, tattooing) • Push enteroscopy and diagnostic balloon-assisted enteroscopy	• Ampullary resection • Colonic polyp resection[a] • Cystogastrostomy • Endoscopic hemostasis (excluding argon plasma coagulation) • Endoscopic mucosal resection (EMR)/ endoscopic submucosal dissection (ESD) • Endoscopic retrograde cholangiopancreatography (ERCP)[b] • Endoscopic ultrasound (EUS) with fine needle aspiration (FNA)[c] • Laser ablation and coagulation • Percutaneous endoscopic gastrotomy (PEG) placement • Percutaneous endoscopic jejunostomy (PEJ) placement • Peroral endoscopic myotomy (POEM) • Pneumatic or bougie dilation for achalasia or esophageal strictures • Radiofrequency ablation • Therapeutic balloon-assisted enteroscopy • Treatment of varices (including variceal band ligation) • Tumor ablation

[a]Polypectomy < 1 cm may be considered low/moderate bleed risk; polyp size may not be known prior to procedure
[b]ERCP without sphincterotomy may be considered low/moderate bleed risk
[c]EUS without FNA may be considered low/moderate bleed risk

When to Stop Oral Antithrombotics Prior to Procedure[4,5]

- For minimal bleed risk procedures, antithrombotics may be continued uninterrupted
- For low/moderate bleed risk and high bleed risk procedures, see recommendations below
- This table is not all-inclusive; for more information, see Step 2 of the full guideline

1 day = all doses on the calendar day prior to the procedure

Antithrombotic Medication	Patient-Specific Criteria	Low/Moderate Bleed Risk Procedure	High Bleed Risk Procedure
Warfarin (Coumadin)	INR 2.0-3.5	Stop 5 days prior	
	INR > 3.5	Stop 6 or more days prior	
Apixaban (Eliquis)		Stop 1 day prior	Stop 2 days prior
Dabigatran (Pradaxa)	CrCl ≥ 50 ml/min	Stop 1 day prior	Stop 2 days prior
	CrCl < 50 ml/min	Stop 2 days prior	Stop 4 days prior
Edoxaban (Savaysa)		Stop 1 day prior	Stop 2 days prior
Rivaroxaban (Xarelto)		Stop 1 day prior	Stop 2 days prior
Aspirin (ASA)		Continue ASA uninterrupted	
Cilostazol (Pletal)		Stop 1 to 2 days prior	
Clopidogrel (Plavix)		Stop 5 days prior[d]	
Prasugrel (Effient)		Stop 7 days prior[d]	
Ticagrelor (Brilinta)		Stop 5 days prior[d]	

[d] For patients taking dual antiplatelet therapy (DAPT) with stents in place, ANY interruption in antiplatelets should be coordinated between the proceduralist, anesthesiologist (if applicable), and the prescribing provider (e.g., cardiologist, neurosurgeon, vascular surgeon); elective procedures should be delayed at least 30 days after bare metal stent and at least 6 months after drug-eluting stent