GastroIntestinal Endoscopy

newsletter the insider

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Since 1985, GastroIntestinal Endoscopy (GIE) has provided an efficient 'Open Access' service for colonoscopy and upper gastrointestinal endoscopy. GIE provides an enviable level of medical experience with seven highly skilled and trained Gastroenterologists.

GIE operates an 'Open Access' service from five locations:

- **SUNNYBANK** – Brisbane Endoscopy Services
- **CHERMSIDE** – Chermside Day Hospital
- **EVERTON PARK** – North West Private Hospital
- **AUCHENFLOWER** – The Wesley Hospital
- **SPRING HILL** – St Andrew's War Memorial Hospital

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Dr Neville Sandford and Dr Rod Roberts

Anticoagulants in gastrointestinal procedures

When the principle of open access endoscopy and colonoscopy was introduced it was envisaged that patients managed under this arrangement would generally be in good health, with few significant co-morbidities, and with clear indications for their endoscopic procedures.

There has been a considerable change in the patient demographic referred for open access procedures in the last 25 years, with many patients having significant medical conditions or requiring drugs which may impact on the safety of having their procedures.

In particular, the anticoagulant and antiplatelet agents can cause difficulties during endoscopy and colonoscopy. This article will discuss the issues which need to be considered when dealing with these agents, and although guidelines in managing these patients can be given, the decision in each situation often needs to be individualised. In arriving at the correct decision, the risks of bleeding associated with the procedure must be balanced against the risk of thromboembolic or ischaemic complications related to reduction or cessation of the blood-thinning agent. Will a diagnostic procedure alone suffice in the first instance, or should the procedure be delayed to a safer time? These risks are always going to be difficult to quantify and sometimes advice needs to be sought from the prescribing physician, cardiologist or neurologist. Although it does not occur frequently, thromboembolism can occur during the cessation of anticoagulants for acute GI bleeding, and although the risk of CVA is low, it is 10-fold higher in patients with complex medical problems having endoscopy and the consequences are devastating for the patient. While recurrent DVT carries some risk of fatal pulmonary embolism, the consequences of arterial thromboembolism from atrial fibrillation or prosthetic heart valves are much more serious with 20% of episodes being fatal and 40% causing permanent disability. In addition there is a three to four-fold increased risk of ischaemic stroke or TIA and a two-fold increased risk of fatal heart attack after stopping antiplatelet drugs in patients with coronary stents.

Quality measurements in colonoscopy

Dr Michael Miros

There is increasing evidence that the impact colonoscopy has on preventing bowel cancer is very closely linked to the quality of the colonoscopy performed. Indicators which are now being assessed on preventing bowel cancer would include:

1. An excellent bowel preparation.
2. Slower withdrawal times.
3. The adenoma detection rate of the colonoscopist.

With respect to the adenoma detection rate, a threshold of 20% is regarded as ideal in asymptomatic individuals. Colonoscopists who have a lower adenoma detection rate than this appear to have marked increased risks of bowel cancer developing subsequent to colonoscopy.

We have undertaken a four month audit of all colonoscopies performed at Brisbane Endoscopy Services (June to September 2011).

1. Our polyp detection rate is 58%.
2. Our adenoma detection rate is 40%.
3. The mean number of adenomas per colonoscopy is 0.8.
4. The mean number of polyps detected is 1.3.

This compares very favourably with other data.

(The Queensland Bowel Cancer polyps detection rate after faecal occult blood test overall has been 48%. Values for other bowel cancer screening levels with faecal occult blood tests

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This has to be balanced against the risk of bleeding from the procedure if the drugs are continued but usually such bleeding, if it occurs, can often be managed at the time by application of haemostatic clips.

A new anticoagulant which is now also being prescribed is dabigatran etexilate (Pradaxa). This drug is rapidly metabolized by the liver to the active product, dabigatran, which is poorly protein-bound (<35%) and so mostly cleared by the kidneys with a half-life of 12–14 hours. The dose is adjusted according to creatinine clearance and not according to coagulation tests as is necessary for patients on warfarin. This results in considerable cost saving as monitoring is not required, but as there are no reversal agents, this can become a problem if bleeding occurs while on this drug. Dabigatran acts predominantly as a direct thrombin inhibitor but also has a reversible effect to inhibit platelet aggregation.

If patients on dabigatran are referred for open access endoscopic procedures, we have asked our triage staff to contact the relevant gastroenterologist for further advice to determine the most appropriate action. The gastroenterologist may consider a more detailed consultation is necessary in order to discuss the situation with the patient's other medical advisers. Other information such as the patient's GFR is important in planning the patient's management. As a general rule Pradaxa should be ceased 48 hours before a therapeutic procedure if GFR is >50 ml/min and ceased 72–120 hours beforehand where GFR is < 50 ml/min.

Patients on herbal and dietary supplements may also be at risk from bleeding after endoscopic procedures. In particular, ginkgo biloba, ginseng, garlic and fishoil have antiplatelet and antithrombotic effects which are hard to quantify. There are reports of increased post-surgical bleeding in patients on these supplements. For this reason we recommend that all herbal medicines are ceased one week before endoscopic procedures, and in addition two weeks following the procedure if polyps are removed.

Guidelines for management of anticoagulants and antiplatelet therapy in patients having endoscopic procedures

These guidelines are based on the recommendations of the American Society for Gastrointestinal Endoscopy and the British Society of Gastroenterology. It is important to understand that these are guidelines only and that individual circumstances should be considered in deciding on the management in any individual patient. Because of the complexity of this decision making and the importance of fully informing the patient of the implication of the management plan, these patients are usually not suitable for open access endoscopic procedures and should be referred to a gastroenterologist for a consultation before the procedure.

Table 1: Procedure-related bleeding risk from GI procedures

Low-risk procedures	High-risk procedures
Diagnostic endoscopy and colonoscopy (± biopsy)	Polypectomy
Capsule endoscopy	Dilatation of strictures
	Laser ablation or coagulation
	Treatment of varices

Table 2: Condition-related thromboembolic complications

Low-risk conditions	High-risk conditions
Venous thromboembolism (TE) after three months	Hypercoagulable state or within three months of TE
Uncomplicated atrial fibrillation (AF)	Complicated AF (CCF, ejection fraction <35%, prior TE, hypertension, diabetes or age >75 years)
Bioprosthetic valves	AF with valvular heart disease or mechanical valves
Mechanical valves in aortic position	Mechanical valves in mitral position
Cerebrovascular disease	Coronary stents within one year
Peripheral vascular disease	Acute coronary syndrome

have been around 30–39%).

These results confirm that at Brisbane Endoscopy Services our colonoscopy adenoma detection rate is considered world class.

We will continue with ongoing audits of our polyp detection rate. Eventually it is envisioned there will be an Australia wide reporting system to document every colonoscopist's adenoma detection rate to improve overall quality.

We will keep you informed of this progress.

In the meantime we will continue providing state of the art world class colonoscopies to your patients.

Endoscopic procedures in anticoagulated patients

1. Low-risk procedures
   No modification of the anticoagulant is necessary as long as the level of anticoagulation is in the therapeutic range (check PT-INR if on warfarin).
2. High-risk procedures in low-risk conditions
   Cease warfarin five days before procedure; check PT-INR day before procedure. Restart warfarin on evening of procedure.

   Cease dabigatran 48 hours before procedure if GFR >50ml/min or 72–120 hours before procedure if GFR <50ml/min. Restart dabigatran on evening of procedure.
3. High-risk procedures in high-risk conditions
   Cease anticoagulants as in (2), but add bridge therapy with low molecular weight heparin (eg Clexane 1.5mg/kg sc daily) while off anticoagulants and until the PT-INR is therapeutic.

Endoscopic procedures in patients on antiplatelet drugs

1. Aspirin, dipyridamole and NSAIDs in standard doses do not increase the risk of significant bleeding with low- or high-risk endoscopic procedures, and these drugs should be continued if clinically indicated.
2. Thienopyridines (eg clopidogrel):
   a. Low-risk procedures: Continue clopidogrel.
   b. High-risk procedures in low risk conditions: Cease clopidogrel 7–10 days before procedure. Add aspirin while off clopidogrel.
   c. High-risk procedure in high risk conditions: Try to postpone procedure for 6–12 months after acute coronary syndrome or stent insertion. (Do not stop clopidogrel without discussion with cardiologist.)

These comments are meant to act as a guide to the management of patients on anticoagulants and antiplatelet drugs. All the Partners of GIE are ready to discuss the needs of individual patients with our referring practitioners.

Electronic referral templates

GIE electronic referral templates have been updated and are now available. For the latest templates and instructions to download for Medical Director, Best Practice, PractiX and Genie, go to www.gastros.com.au. If you require assistance, please contact our Business Liaison Officer, Danielle Talbot on 0408 180 435.

Bowel Cancer Awareness Week
A Bowel Cancer Australia initiative
3–9 June 2012

Bowel Cancer Awareness Week runs from 3–9 June 2012 with the 6th June marking Red Apple Day.

GastroIntestinal Endoscopy supports the goal of Bowel Cancer Australia to save lives through early detection.

"Colonoscopy with the removal of polyps that would otherwise have progressed to cancer or with the diagnosis of an early and curable cancer can be lifesaving. Early diagnosis can change destinies and is a major motivator for me to do the work I do. The more people we see and the faster we can see them, the more people we can help."

Dr Andrew Bryant, GIE Gastroenterologist

Frequently Asked Questions Dr Alistair Cowen

Q In a patient with rectal bleeding when would you choose a flexible sigmoidoscopy versus a colonoscopy?

A There is no universally agreed answer. My own view is that if:

1. the blood is "cut finger" bright red; AND
2. is only ever seen on the toilet paper; OR
3. drips or sprays on to the bowel wall during defecation;

then the lesion should be within 60cm of the anus and should be able to be seen at flexible sigmoidoscopy.

HOWEVER if the patient:

1. is unsure of the bleeding details or is a poor historian, visually impaired, "didn't look" etc.;
2. has other risk factors (e.g. family history, previous carcinoma of the colon, previous colonic polyps or inflammatory bowel disease);
3. is anxious about the possibility of carcinoma;

then full colonoscopy is to be preferred.

NB: visualization of bleeding from a haemorrhoid does NOT prove that this is the source of PR bleeding. Digital examination and proctoscopy can precipitate haemorrhoidal bleeding.

Q For what purpose would you order a barium swallow?

A Barium studies of the upper GI tract are significantly less accurate than endoscopy for most upper gastrointestinal diseases and are recommended only in selected patients. Indications can include:

1. Suspected oesophageal dysmotility (order cine barium swallow indicating clinical suspicion of oesophageal dysmotility).

2. Failed endoscopy. Rarely it may not be possible to insert the endoscope into the oesophagus. This can occur following surgery, radio therapy, caustic ingestion etc. Usually a guide wire can be passed under x-ray control to allow dilatation. However, it may be considered advisable to outline the whole oesophagus before attempting dilatation.

3. Contra indications to intravenous sedation. Rarely cardiac or respiratory disease can be a contra indication to intravenous sedation.

4. Demonstrating anatomical relationships in a patient with a large paraoesophageal hiatus hernia.

5. Non barium x-ray contrast (e.g. gastrografin) if oesophageal perforation is suspected.

6. Defining anatomy preoperatively in large pharyngeal pouches.

If you require an electronic referral form or A5 referral pads, please contact one of our five practice locations below or download at www.gastros.com.au/doctor_information.shtml

GIE practice locations and contact details For all appointments, call 1300 4 GASTRO (1300 4 427876)

St Andrew's War Memorial Hospital

Endoscopy Centre
457 Wickham Terrace
Spring Hill
QLD 4000

Phone: 07 3834 4499
Fax: 07 3834 4503

Brisbane Endoscopy Services

Suites 16–18
McCullough Centre
McCullough Street
Sunnybank QLD 4109

Phone: 07 3344 1844
Fax: 07 3344 2739

Chermside Day Hospital

Level 1, Chermside
Medical Complex
956 Gympie Road
Chermside
QLD 4032

Phone: 07 3120 3407
Fax: 07 3120 3443

The Wesley Hospital

3rd Floor
East Wing
451 Coronation Drive
Auchenflower
QLD 4066

Phone: 07 3870 3799
Fax: 07 3870 5069

North West Private Hospital

Endoscopy Unit
137 Flockton Street
Everton Park
QLD 4053

Phone: 07 3353 3322
Fax: 07 3353 9325

Private practice locations and contact details

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