CLINICAL GUIDELINE

Antiplatelet or Anticoagulant Therapy: Management of Patients Undergoing Minor Gynaecological Procedures

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The online version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Title: Antiplatelet or Anticoagulant Therapy: Management of Patients Undergoing Minor Gynaecological Procedures (712)

Objectives: To provide guidance for healthcare staff involved in the perioperative care of women undergoing minor gynaecological procedures (outpatient, day surgery and inpatient) who are also using antiplatelet or anticoagulant therapy

Scope:

Audience: All healthcare workers involved in the management of those undergoing minor gynaecological procedures whilst taking antiplatelet of anticoagulant therapy

Body of Guideline:

This guideline will discuss the management of patients taking anticoagulants (warfarin or DOACs (direct oral anticoagulants) e.g. apixaban) and antiplatelet agents (clopidogrel, aspirin) when undergoing minor gynaecological procedures. Risks and management are stratified according to the risk of haemorrhage associated with the particular procedure.

A patient with a high risk of bleeding or thrombosis, or on dual antiplatelet therapy (DAPT) should be discussed with the wider team which may include operating surgeon, anaesthetist, haematologist, stroke medicine team and cardiologist.

Antiplatelet therapy not covered in this document e.g. ticagrelor, can be discussed with wider team as above.

Gynaecology procedures and risk of bleeding

Gynaecological procedures according to bleeding risk are summarised in the table below.

Consideration should also be made to type of anaesthetic e.g. spinal. Further information about these considerations can be found in the Pre-op assessment GG&C guidelines, and can be discussed with the anaesthetic team.

Minor gynaecological and urogynaecological procedures with low risk of bleeding (bleeding infrequent and low clinical impact)	Minor gynaecological and urogynaecological procedures with moderate risk of bleeding (bleeding infrequent and non-severe clinical impact)
• Hysteroscopy • Pipelle endometrial biopsy • Colposcopy including punch biopsy • Vulval punch biopsy • Insertion of IUS/IUD • Cervical polypectomy • Endometrial ablation • Flexible cystoscopy with or without biopsy (not under general anaesthetic) • Botox injection to bladder • Bladder neck injection with urethral bulking agent	• LLETZ • Endometrial polypectomy/Myosure • Endometrial curettage • Planned manual vacuum aspiration (MVA) or medical/surgical management of miscarriage* • Insertion of Word catheter for Bartholin's cyst/abscess* • Vulval excision biopsy (without plastic surgery closure) • Cystoscopy with/without biopsy under general anaesthetic **These procedures may require discussion with Haematology in an acute emergency setting.*

Table 1 Minor gynaecological procedures categorised by risk of bleeding

Management of gynaecological and urogynaecological procedures with low risk of bleeding

Local anaesthetic using a vasoconstrictor should be considered if appropriate.

- ***DOACs***

UKCPA 2024[(1)], suggests that when undertaking minor procedures with a low risk of bleeding (Table 1), DOACs should omitted on the morning of the procedure and should be restarted 6-12 hours following the procedure.

If there is any doubt as to the pre-operative cessation of DOAC therapy in a patient, due to specific patient characteristics i.e. Creatinine Clearance (CrCl) less than 30ml/min, weight less than 50Kg, advanced age, concomitant interacting medication; it may be prudent to discuss with a Haematologist regarding timing of last dose prior to procedure[(1)].

- ***Clopidogrel***

Clopidogrel does not need to be withheld for minor gynaecological procedures at low risk of bleeding.

- ***Aspirin***

Aspirin does not need to be withheld for minor gynaecological procedures at low risk of bleeding.

- ***Warfarin***

Perioperative warfarin decision-making should take into account the patient's underlying thrombotic risk balanced against the bleeding risk associated with the intended procedure.

The UK Clinical Pharmacy Association (UKCPA)[1] suggest warfarin may not need to be stopped for minor procedures with low risk of bleeding. However it is still recommended that the INR is checked 48 hours prior to the procedure to ensure INR is not supra-therapeutic and ensure at least < 3.5 [2]

Management of gynaecological and urogynaecological minor procedures with moderate risk of bleeding

Local anaesthetic using a vasoconstrictor should be considered if appropriate.

- ***DOACs***

UKCPA[1] suggest the procedure should be delayed to allow withholding of DOAC prior to the procedure. *The DOAC should not be taken the day before in addition to the morning of the procedure.*

If there is any doubt as to the pre-operative cessation of DOAC therapy in a patient, due to specific patient characteristics i.e. CrCl less than 30ml/min, weight less than 50Kg, advanced age, concomitant interacting medication; it may be prudent to discuss with a Haematologist regarding timing of last dose prior to procedure[1].

Pre-op bridging low molecular weight heparin (LMWH) is not usually required but will depend upon indication for anti-coagulation. Please discuss with haematology.

The post-operative dose of the DOAC should be deferred until 24 hours after the procedure[1]. If this is an inpatient procedure, consider prophylactic low molecular weight heparin 6hours post op until DOAC restarted.

There may be a longer time to restarting DOAC if there is concern about haemostasis. This may also be longer depending on the extent of the procedure or the use of regional anaesthesia however this is out with the scope of this guideline.

- ***Clopidogrel***

Stop clopidogrel 7 days before any minor gynaecological procedure at moderate risk of bleeding[3]. Low dose aspirin (75mg) may be used in place of clopidogrel during these 7 days if indicated.

This may require discussion with Cardiology or Haematology based on indication for clopidogrel therapy.

Recommence clopidogrel 48 hours after the procedure.

- ***Aspirin***

Low dose aspirin (75mg) does not need to be withheld before any minor gynaecological procedure at moderate risk of bleeding. Patients should be informed however of the greater risk of bleeding +/- haematoma formation.

- ***Warfarin***

Stop warfarin 5 days before any invasive gynaecological procedure at moderate risk of bleeding. The target INR should be ≤1.4 for the procedure and should be check 24hours prior to the procedure.

LMWH may need to be given on each day pre-operatively and continued post-operatively until INR within the patient specific therapeutic range. Please see GG&C LMWH bridging policy for details GGC Medicines - Management Plan for Patients on Warfarin in the Peri-operative Period.

The anticoagulant clinic should be informed of the date of the procedure and appropriate anticoagulant follow up should be in place following the discharge from hospital.

Vitamin K may be given as an IV bolus to reverse anticoagulation effect of warfarin if INR is >1.5 on day before procedure GGC Medicines - Reversal of Antithrombotic Therapies.

Warfarin should be restarted the following evening after procedure. LMWH can be administered 6hours post procedure.

	Number of doses to withhold before procedure				
Risk of bleeding	**Apixaban**	**Edoxaban**	**Aspirin**	**Clopidogrel**	**Warfarin**
Low	1	1	Continue	Continue	Continue, consider INR 48hours prior to procedure (see details in text)
Moderate	3	2	Continue	7 doses (consider if aspirin required)	Stop 5 days prior to procedure and bridge with LMWH (see details in text)

Table 2 Summary of perioperative recommendations for management of anticoagulants and antiplatelets for minor procedures in gynaecology

References:

1. UKCPA Handbook of Perioperative Medicines Handbook, Direct oral anticoagulants 2024

Apixaban - UKCPA Handbook of Perioperative Medicines

Edoxaban - UKCPA Handbook of Perioperative Medicines

2. Management Plans for Patients on Warfarin in the Peri-operative period, GGC Medicines, Adult Therapeutic Handbook

   GGC Medicines - Management Plan for Patients on Warfarin in the Peri-operative Period

3. UKCPA Handbook of Perioperative Medicines, Clopidogrel

Clopidogrel - UKCPA Handbook of Perioperative Medicines

4. Apixaban, Edoxaban and Rivaroxaban: Management of Haemorrhage, Surgery and other Invasive Procedures, Clinical Guideline, Greater Glasgow and Clyde, September 2020 factor-xa-inhibitors.pdf

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