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The Role of Treatments & Endoscopy in the Anticoagulated Patient

Dr. Buch:
This is *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch, and today we're joined by Dr. Kunal Jajoo, who will be discussing the role of treatments and endoscopy in the anticoagulated patient. Dr. Jajoo is an Assistant Professor of Medicine at the Brigham and Women's Hospital of Harvard Medical School.

Welcome to the program, Dr. Jajoo.

Dr. Jajoo:
Thank you. Thanks so much for having me.

Dr. Buch:
It's a pleasure. Let's dive right in, Dr. Jajoo. Can you discuss the upper limits of the international normalized ratio, or INR, and the lower limit of platelets where you feel comfortable performing and endoscopy on patients with GI bleeding?

Dr. Jajoo:
Sure. Yeah. This question comes up frequently, and actually, some of the earlier data comes from my colleague John Saltzman here at the Brigham, and we really learned that we should not be waiting on treatment, we should not be waiting on correction of the INR to treat the bleeding patient. So in a retrospective study that they did probably about 15 years ago now, they proved that the rebleeding rates were not higher in anticoagulated patients who had INRs up to about 2.7 versus un-anticoagulated patients who had INRs up to 1.2, so I feel comfortable taking on the patient, not waiting for correcting the INR up to an INR of probably 2.7. To make it easy, I'd say 2.5, just since it's an easier number to remember. In terms of platelet count, it's a good question. Our national guidelines don't really address that. To be honest, I think that we probably should not be waiting to correct platelet count at all and probably don't need to correct platelet count at all, and maybe should be using more mechanical methods of hemostasis as opposed to thermal methods to allow for hemostasis without that eschar that could then fall off when the platelets are low.

Dr. Buch:
And do you think the fact that we have clips now as opposed to years gone by has helped us with this adjustment?

Dr. Jajoo:
Absolutely.

Dr. Buch:
Yeah, I think so too. I think that's made a big difference. So let's move on. So for patients hospitalized with acute GI bleeding, is there a benefit of using prothrombin complex concentrates, or PCC, over fresh frozen plasma?

Dr. Jajoo:
Yeah. So our newest guidelines from the American College of Gastroenterology that were published just under a year ago do address this question, and they actually, unfortunately, said that they could not make a decision on a recommendation regarding PCC, but they did say that if you're going to correct the INR, that the prothrombin complex is preferred over FFP. And they actually advise against giving FFP, and that's because the prothrombin complex can more reliably correct the elevated INR and does not have that risk of fluid overload or transfusion reactions or other things that can happen with FFP.

Dr. Buch:
Is there also a speed factor? And with the speed factor in mind, how much faster is it?

Dr. Jajoo:
Correct. The prothrombin complex can work very, very quickly within the order of about 30 minutes. FFP works quickly but has to be given somewhat slowly and has an efficacy of only four to six hours, so yes, absolutely, the speed is there. We don't have randomized trials to show us whether the prothrombin complex is of great benefit in acute bleeding, but I think knowing that it can correct INR reliably and promptly, we can extrapolate that it would be helpful in an acute GI bleeding patient who really is in extremis.

Dr. Buch:
Perfect. And I know there are people out there who are talking about cost factor. What's the cost factor difference?

Dr. Jajoo:
The cost factor is quite high. Prothrombin complex is quite expensive. FFP is not necessarily cheap in the sense that it can be a scant resource in areas where there may not be as much blood donation or plasma donation, but it is expensive, so there is a caveat in those 2022 guidelines that say that if you cannot obtain the prothrombin complex, you can consider giving FFP in a patient who is having a life-threatening bleed, but that otherwise, potentially neither is necessary, but if you have the choice, the prothrombin complex is preferred.

Dr. Buch:
And the other question I have for you is at Brigham, do you have to fill out some special forms to be able to get PCC, or is that automatic based on your requisition?

Dr. Jajoo:
We do not need to fill out special forms any longer. I think early on we needed to, but we do not any longer.

Dr. Buch:
Great. This next question is for my primary care colleagues. Should we ever use vitamin K for GI bleeding patients on warfarin?

Dr. Jajoo:
Yeah. So I think that we know that vitamin K takes 24 plus hours to work. We do know that in somebody who is having a non-life-threatening bleed who might be a little bit supratherapeutic, you can use low doses of oral vitamin K to correct them back down to therapeutic. About a year before the American guidelines came out, the European Society of Gastrointestinal Endoscopy in conjunction with the British Society published similar guidelines, and they actually advised giving the vitamin K, up front IV for acute bleeders who have elevated INR, and then considering the prothrombin complex, secondarily considering FFP. So we do give it to get that slightly more sustained effect of correction of INR, but again, then we have to think about whether the patient needs to be anticoagulated again, and we can discuss that.

Dr. Buch:
Why don't we discuss it now? Because I think that's relevant for this point. So if a patient needs to be anticoagulated soon thereafter, this changes everything, correct?

Dr. Jajoo:
Right. And I think we are learning more and more that we were unnecessarily holding anticoagulation for prolonged periods of time in patients who really needed it. And we all know that the risk of thrombosis in a patient who is not adequately anticoagulated who needs to be is probably greater than the risk of GI bleeding in the sense that we can usually treat or correct GI bleeding, and it's very difficult to treat or correct thrombosis. So the best studies that we have say that the greatest risk of rebleeding occurs in the first seven days but that if you don't reinitiate anticoagulation, the risk of thrombosis becomes quite significant at day 30, so ideally, we should be resuming anticoagulation as soon as we can confirm that hemostasis is achieved and ideally, no later than seven days.

Dr. Buch:
For those just tuning in, you're listening to GI Insights on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Kunal Jajoo about performing an endoscopy and therapies for anticoagulated patients.

So now, Dr. Jajoo, which GI bleeding patients who are taking direct oral anticoagulants need to have reversal agents administered?

Dr. Jajoo:
Yeah, a very good question. And those reversal agents are extremely expensive, more expensive than the prothrombin complex, and actually, our national guidelines from a year ago stated that reversal agents are not indicated and should not be given in general because we do not have adequate data to say that they are useful in reducing of the overall risk of bleeding or death in patients on these anticoagulants. They give one caveat that they say that if a patient is having a life-threatening bleed and took one of the direct oral anticoagulants within 24 hours of that bleed, you could consider the reversal agents, but generally, the cost and risk-benefit ratio does

not favor giving it.

Dr. Buch:
Thank you for that. So again, this is another one for our primary care colleagues out there. Which GI bleeding patients on aspirin should remain on aspirin?

Dr. Jajoo:
Ideally, all. If they are being given aspirin for secondary prophylaxis, we should not be stopping the aspirin. And especially, those who might be on dual antiplatelet therapy for a recent coronary stent if we have to stop the antiplatelet therapy, then we should at least continue the aspirin. We all know that the latest literature from a couple of years ago now shows that primary prophylaxis with aspirin for patients over 60 is not of any great benefit, so if our patients were on primary prophylaxis and came in with bleed, that would be an opportunity to stop the aspirin. In those patients in whom you've now come on to the scene after somebody's already stopped the aspirin for bleeding, ideally, we should get that aspirin back on within three days of hemostasis and at the very latest seven days because the risk of a thrombotic cerebrovascular or a cardiovascular event gets quite high just from cessation, within the 30 days of cessation of antiplatelet therapy.

Dr. Buch:
And just as a clarification, there are some patients out there who, despite a GI bleed, should remain on aspirin, correct?

Dr. Jajoo:
Correct.

Dr. Buch:
So, Dr. Jajoo, in patients with high risk for thromboembolism, how soon after GI bleed may anticoagulation be considered? You talked about that seven days, and that's what I really wanted to hone in on. Is that universal across the spectrum? Or would you feel comfortable starting within a day?

Dr. Jajoo:
I think that if we have provided a hemostatic therapy endoscopically, have confirmed that the patient is no longer bleeding, and they are at high risk for thromboembolism because they have a mechanical valve or a high-risk prothrombotic state, then I would feel comfortable resuming probably within 48 hours because there are definitely increasing data that we were unnecessarily holding anticoagulation for too long. And as I mentioned earlier, in those who had an INR up to 2.7, the rebleeding rate was not different in those who had elevated INR up to 2.7 as compared to those who had an INR less than 1.2.

Dr. Buch:
Thank you for that clarification. So before we conclude, are there any additional thoughts you'd like to leave with our audience today?

Dr. Jajoo:
I think we should be confident in our hemostatic abilities. We should be assessing these patients immediately and trying to understand how quickly we need to provide endoscopy and endoscopic therapy, and once we have confidently done that, guide our colleagues that we don't need to unnecessarily hold medications that patients need because that would just increase their risk of thromboembolic events. Of course, when there's uncertainty, that's the best time for us to be maybe a little bit old-fashioned and pick up the phone and talk to our cardiology colleagues and decide together what's safest for the patient. But bleeding we can stop. Thrombosis is very hard to stop.

Dr. Buch:
Well stated. This was a superb review of endoscopy and other therapies for patients with GI bleeding. I want to thank my guest, Dr. Kunal Jajoo, for sharing his insights.

Dr. Jajoo, thanks so very much for joining us today.

Dr. Jajoo:
Thanks so much for having me.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GIInsights where you can Be Part of the Knowledge. Thanks for listening, and looking forward to learning with you next time.