Indications for oesophagogastroduodenoscopy

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- Diagnostic procedures +/– biopsy
- Biliary or pancreatic stenting • Device-assisted enteroscopy without polypectomy Continue warfarin Warfarin Check INR 1 week before endoscopy • If INR is within therapeutic range continue usual daily dose • If INR is above

therapeutic range but <5 reduce daily dose until INR returns to therapeutic range High-risk procedure • Polypectomy • ERCP with sphincterotomy • EMR/ESD • Dilatation of strictures Warfarin Low-risk condition High-risk condition • Prosthetic metal heart valve in mitral or aortic • Xenograft heart valve position • AF without high-risk factors • Prosthetic heart valve and AF (CHADS ≤4) 2 • AF and mitral stenosis • >3 months after VTE • AF with previous stroke/TIA and 3 or more of: • Congestive cardiac

failure a • Hypertension • Age >75 years • Diabetes mellitus • AF and stroke/TIA within 3 months • <3 months after VTE • Previous VTE on anticoagulation Stop warfarin for 5 days before Stop warfarin for 5 days before endoscopy • Check INR prior procedure to ensure • Start LMWH 2 days after stopping warfarin INR <5 • Omit LMWH on day of procedure • Restart warfarin evening of the procedure • Restart warfarin evening of the procedure with usual daily dose with usual daily dose • Check INR 1 week later to ensure • Continue

LMWH until INR adequate adequate anticoagulation Low-risk condition • Ischaemic heart disease without coronary stent • Cerebrovascular disease • Peripheral vascular disease Stop clopidogrel, prasugrel or ticagrelor 7 days before endoscopy • Continue aspirin if already prescribed • Restart clopidogrel, prasugrel or ticagrelor 1–2 days after procedure Figure 9.2 British Society of Gastroenterology and European Society of Gastrointestinal Endoscopy 2021 guidelines for management of

endos copy in patients on antiplatelet or anticoagulant therapy. AF , atrial /f_i brillation; CHADS, score for stroke risk assessment in atrial /f_i brillation; DOAC, direct oral anticoagulant; eGFR, estimated glomerular /f_i ltration rate; EMR, endoscopic mucosal resection; ERCP , endoscopic cholangiopancreatography; ESD, endoscopic submucosal dissection; EUS, endoscopic ultrasound; INR, international normalised ratio; LMWH, low molecular weight heparin; PEG, percutaneous

endoscopic gastroenterostomy; TIA, transient ischaemic attack; VTE, venous thrombo a embolism. Blood pressure >140/90 mmHg or on antihypertensive medication. c Depends on haemorrhagic and thrombotic risk; consider extending interval for ESD. (Adapted from Veitch • Oesophageal, enteral or colonic stenting • EUS without sampling or interventional therapy DOAC • Dabigatran Omit DOAC on • Rivaroxaban morning of the • Apixaban procedure • Edoxaban • Therapy of varices • PEG • EUS-

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malabsorption and chronic diarrhoea. However, increasing ease of access to OGD with the availability of ‘open access’ endoscopy has resulted in a significant number of unnecessary procedures being performed in young patients with dyspepsia or gastro-oesophageal reflux disease (GORD). This has led to a number of international gastroenterology societies proposing guidelines for the management of dyspepsia and GORD, including the empirical use of acid suppression and non-invasive H. pylori tests, such as urease breath tests and stool antigen assay (e.g. the National Institute for Health and Care Excellence guidelines on dyspepsia: https://www .nice.org.uk/ guidance/cg184/chapter/1-recommendations). In addition

(c) Figure 9.3 A normal upper gastrointestinal endoscopy showing the gastro-oesophageal junction the gastric antrum (c) and the second part of the duodenum (a) Figure 9.4 Grade 2 oesophageal varices (a) , which can be treated by the application of bands to ligate the vessel and reduce blood /f_l ow (d) (a) , the gastric fundus in the ‘J’ position (b) , (d) . (b) (b) .

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Revision #1
Created 2025-12-31 15:32:07 UTC by Omar Ayman
Updated 2025-12-31 15:32:07 UTC by Omar Ayman