ANTICOAGULATION AND SPINE PROCEDURES

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The decision to take a patient off anticoagulation for an elective pain procedure requires special consideration of multiple distinct factors. The goal is to help alleviate the patient’s pain through procedural intervention, but to do so in a way that minimizes patient risk. The factors to be considered include the risk of the procedure being performed, the indication for anticoagulation (and the risk of an adverse event if the patient is taken off their medication), and the half-life of the anticoagulant. **It is sometimes riskier to hold the anticoagulants than to do the procedure while taking them.**¹ ² **PATIENTS SHOULD NOT TAKE THEMSELVES OFF ANTICOAGULANT MEDICATION WITHOUT DIRECTION FROM THEIR PRESCRIBING DOCTOR/PRACTITIONER.**

Several different expert recommendations have been developed to guide anticoagulation management for pain procedures. Through careful and thoughtful discussions, the providers at Denver Back Pain Specialists (DBPS) made the decision to adopt a blended set of the more conservative guidelines in the literature today (see below). This took into consideration recommendations from the Spine Intervention Society³ and American Society of Regional Anesthesia and Pain Medicine (ASRA)⁴, as well as related clinical research publications¹ ².

The American Society of Regional Anesthesia and Pain Medicine (ASRA) developed an expert panel to provide recommendations on anticoagulation. Committee members stratified interventional spine and pain procedures by potential bleeding risk as low-, intermediate-, and high-risk procedures. An extensive review of the current literature was performed. The recommendations were evidence-based when possible and pharmacologically driven when no solid evidence existed. These recommendations were published in the May-June 2015 issue of *Regional Anesthesia and Pain Medicine*. Please see the attached table outlining these recommendations.

Once the decision has been made that the patient should be taken off their anticoagulant prior to the planned procedure, the next important question to answer is whether it is safe for the patient to be off their anticoagulation for the duration outlined by the ASRA 2015 guidelines. This requires a critical risk assessment by the prescribing provider. **The health care providers at DBPS will not make the decision to take a patient off their anticoagulation, but will defer the decision to the primary care provider or specialist who is managing the patient’s anticoagulation.**
### TABLE 1. Pain Procedure Classification According to the Potential Risk for Serious Bleed

**High-Risk Procedures:**

SCS trial and implant  
Intrathecal catheter and pump implant  
Vertebral augmentation (vertebroplasty and kyphoplasty)  
Epiduroscopy and epidural decompression

**Intermediate-Risk Procedures***:

Interlaminar ESIs (C, T, L, S)  
Peripheral nerve stimulation trial and implant Pocket revision and IPG/ITP replacement

**Low-Risk Procedures***:

Peripheral nerve blocks  
Peripheral joints and musculoskeletal injections  
Trigger point injections including piriformis injection  
Sacroiliac joint injection and sacral lateral branch blocks  
Facet and Medial Branch Blocks (C, T, L)

*Patients with high risk for bleeding undergoing low- or intermediate-risk procedures should be treated as intermediate or high risk, respectively. Patients with high risk for bleeding may include old age, history of bleeding tendency, concurrent uses of other anticoagulants/antiplatelets, liver cirrhosis or advanced liver disease, and advanced renal disease.

C indicates cervical; L, lumbar; MBNB, medial branch nerve block; RFA, radiofrequency ablation; S, sacral; T, thoracic.

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