Guy's and St Thomas' NHS
NHS Foundation Trust

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Ref:

PRIVATE & CONFIDENTIAL

26 April 2013

Dear Mr

Re:
Hospital No:
Address:

Date of Birth:
NHS No:

This particular letter is really to put in writing the rationale for the discussion we had about whether you should or should not be anticoagulated. I have had a discussion both with , one of my colleagues in Thrombophilia, and Dr about your condition.

To summarise below:

The reasons for considering anticoagulation were raised by the fact that you were found to have a non-occlusive portal vein thrombosis on ultrasound when you were admitted with your GI bleed in May last year to East Surrey Hospital. It was then you were noted to have oesophageal varices and the concern was raised about whether you had developed hepatic cirrhosis or sclerosing cholangitis. Your platelet counts have always been low, most likely due to an Azathioprine effect for the long-term use of Azathioprine, which is associated. You have never had any significant bleeding problems with the platelets. The main bleeding problem is a result of your varicele bleeds rather than adding low platelet counts per se. The issue about anticoagulation for a portal vein thrombosis is that we do not know how long that thrombosis has been there. You have had several admissions since 2010 for elective surgery and one of those may have been a precipitant for a provoked thrombosis. The evidence for anticoagulating with a portal vein thrombosis is not concrete and we have discussed with my colleagues your risks of bleeding versus thrombosis. Currently there is no evidence as to whether patients with your condition need to have long-term Warfarinisation. We have looked at additional risk factors which have been informative such a lupus anticoagulant and anticardiolipin antibodies. If these were positive, that would increase your thrombotic risk and these have been negative to date both here and at East Surrey Hospital. In addition if you had inflammation or chronically active Crohn's disease, that would also be an additive factor to consider anticoagulation, however, from the recent colonoscopy and clinically, your Crohn's is in remission. In addition, the hepatic biopsy showed that you have very mild cirrhosis and your MRCP MRI does not show any evidence of any PSC.

Reasons for not anticoagulating are the fact that it will increase your bleeding risks with your varices despite your low platelet counts. That Warfarin control may be erratic generally but in view of your

underlying liver condition that may contribute to this. Overall your risks of bleeding are greater than your risks of thrombosis.

None of us can guarantee that you may not have another thrombosis if provoked. So, times that which you need some thromboprophylaxis (protective anticoagulation) would be of high risk such as surgery, a relapse or exacerbation of your Crohn's or prolonged periods of immobility. In addition, if through your gastrointestinal vigilance of scans and gastric banding there is a suggestion that your cirrhosis is progressive, then we may need to think again. There is no evidence that Aspirin will help with protecting from clots and would be really contraindicated in view of the fact that you have oesophageal varices that would increase your bleeding risk.

On balance, we feel that not having any anticoagulation at this point in time would be the better management plan as your risks of bleeding are higher than the risk of further thrombosis.

I hope that this clarifies what we needed to discuss with our management plan, I would be happy to discuss any points.

Yours sincerely

Electronically Authorised

Consultant Haematologist.

CC: Dr
Consultant Gastroenterologist
F01 College House
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