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Summary

# Anticoagulation for IBD flares managed in the outpatient setting: Pro and con

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Education & Training | IBD | Mechanisms & Personalised Medicine | Primary Care

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**The speakers debated anticoagulation for IBD flares managed in the outpatient setting, concluding that while active IBD increases venous thromboembolism risk and most events occur in the community by absolute numbers, routine prophylaxis for all ambulatory patients is not cost-effective and decisions should be individualized based on patient-specific risk factors.**

KEY POINTS

- Active IBD is an established risk factor for venous thromboembolism, with the speaker stating that corticosteroids further increase this risk while anti-TNF therapies may reduce it, and JAK inhibitors showed increased VTE risk at higher doses in one rheumatoid arthritis trial though more IBD-specific data are needed.
- A UK database study the speaker cited reported 139 VTE cases among approximately 13,000 IBD patients, with the speaker noting that while hospitalization confers the highest hazard ratio, the absolute number of thromboembolic events is higher in outpatients due to the larger population at risk.
- The speaker presented retrospective inpatient data from 233 patients showing that thromboprophylaxis was associated with lower odds of bleeding events and no significant hemoglobin change, though a haematology meta-analysis the speaker cited reported major bleeding events were higher with prophylaxis with a number needed to harm of 114.
- A cost analysis the speaker discussed found that prophylaxis in the community had a number needed to treat of 32.3 to prevent one VTE over a lifetime with no difference in quality-adjusted life years, leading the speakers to conclude routine ambulatory anticoagulation is not cost-effective.

- The speakers recommended individualized risk assessment considering factors such as recent surgery, pregnancy or postpartum status, prior VTE history, obesity, steroid use, and immobilization, with the speaker noting that better decision-support tools beyond existing post-operative algorithms are needed for outpatient IBD management.
- In the Q&A the speakers stated their preferred anticoagulant is enoxaparin based on existing IBD evidence, that duration is typically around two weeks for improving outpatients depending on clinical scenario, and that in their view PSC does not influence biologic choice as no advanced therapy shows particular advantage for PSC outcomes.

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