Always follow local guidelines and discuss with Senior / Haematology if unsure

WARFARIN INITIATION

Rapid:

- Acute Thromboembolic Disease
- Loading programs vary between trusts
  - **Always consult local guidelines**
- Commonly used loading Dose:
  - Days 1 and 2: 5mg or 10mg
    - Consider 5mg for:
      - Elderly
      - Low body weight
      - Liver disease
      - Cardiac failure
      - High risk of bleeding
- Check INR day 3:
  - Adjust Warfarin dose and decide next INR check based on local guidelines

Slow:

- Prevention of Thromboembolic Disease
- 1-2mg OD as starting dose
- Check INR 5 days later
  - Adjust Warfarin dose and decide next INR check based on local guidelines

Bridging Therapy:

- Warfarin is initially pro-thrombotic:
  - Inhibits Protein C quicker than Coagulation factors
- Patient who require Rapid loading should have 'Bridging' LMWH or Heparin until INR within therapeutic range AND have had at least 5 days of dual therapy

WARFARIN ADJUSTMENT

Maintenance Dose:

- Below are general guidelines on adjusting Warfarin dose
- If INR outside expected range, investigate reason why i.e:
  - Poor adherence to warfarin
  - Alcohol
  - Liver disease
  - **Medication interactions:**
    - Due to vast number of medication interactions you are advised to consult BNF for details

INR > 5.0
See High INR and Bleeding Advice Below

INR over Target range but < 5.0

- The warfarin dose will need to be reduced

-and/or-

- 1 or 2 doses may need to be omitted
- INR measured 2 or 3 days later

INR under Target range

- The warfarin dose will need to be increased
- INR measured 2 or 3 days later

15% dose adjustment = approximately INR change of 1

10% dose adjustment = approximately INR change of 0.7–0.8

HIGH INR AND BLEEDING ON WARFARIN

If patient has metallic heart valve / clotting disorder discuss with SENIOR

INR LEVEL BLEEDING STATUS	RECOMMENDED ACTION
INR 5.0-8.0 No Bleeding	• Stop Warfarin (1-2 doses) • Restart Warfarin when INR <5.0
INR 5.0-8.0 Minor Bleeding	• Stop Warfarin • Restart Warfarin when INR <5.0 • Phytomenadione (Vit K1) 0.5-1mg IV - slow
INR > 8.0 No Bleeding	• Stop Warfarin • Restart Warfarin when INR <5.0 • Phytomenadione (Vit K1) 5mg PO using IV preparation
INR > 8.0 Minor Bleeding	• Stop Warfarin • Restart Warfarin when INR <5.0 • Phytomenadione (Vit K1) 0.5-1mg IV - slow
Any INR Major Bleeding	• Stop Warfarin • Immediately discuss with Haematology • Phytomenadione (Vit K1) 0.5-1mg IV - slow • Prothrombin Complex or FFP

Repeat INR after 24 hours and repeat management as required. Restart Warfarin when INR < 5.
Discuss with **SENIOR** if any concerns.