

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

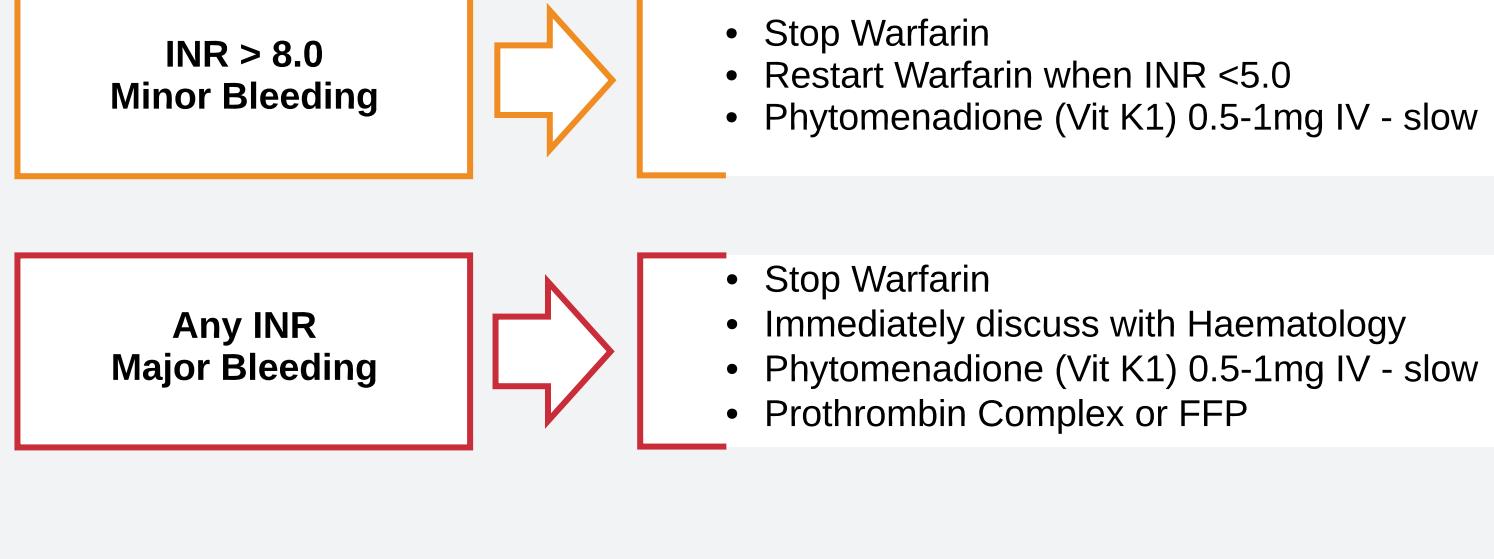
INR > 5.0

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

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



Repeat INR after 24 hours and repeat management as required. Restart Warfarin when INR < 5.

Discuss with **SENIOR** if any concerns.