Gateshead Health
NHS Foundation Trust

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Enoxaparin Guidelines

Approved by:	VTE Steering Group
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Next Review Date:	Author:
January 2025	Polly Cranmer

This clinical guideline/protocol supersedes all previous issues

1 Introduction and Scope

Low molecular weight heparins (LMWH) are used in the prophylaxis and treatment of venous thromboembolism (VTE).

Enoxaparin (Inhixa®) will be the drug of choice during the current international supply shortage of tinzaparin 3,500 and 4,500 unit syringes for patients requiring prophylaxis for VTE.

Note: Higher strength tinzaparin syringes and vials are still available for treatment of venous thromboembolism.

This document should be used instead of the current Trust guidance for the prophylaxis of venous thromboembolism. It provides guidance for the use of Inhixa® in adult patients (including pregnancy), including recommendations for prescribing in patients with impaired renal function and for those at extremes of body weight.

For the prophylaxis of VTE in COVID-19 patients please see Trust guidance within the Trust COVID guideline page on the Intranet.

Please note that this is guidance only. Prescribers must take into consideration individual patient factors including bleeding risk, renal function and procedural risk factors before selecting a dose.

2 Dose and administration guidance

Inhixa® is available in 20mg, 40mg, 60mg, 80mg and 120mg pre-filled syringes for deep subcutaneous injection into the abdomen.

2.1 Prophylaxis of venous thromboembolism

Prior to initiating prophylaxis with Inhixa® the clinician must ensure that the patient is not taking other drugs that may affect clotting e.g. Warfarin, DOACs.

If renal impairment creatinine clearance <30ml/min see section 2.1.4 for dose adjustment.

2.1.1 Medical Patients

Actual body weight	**Dose of Inhixa®**
< 50kg	20mg in the evening
50– 99kg	40mg in the evening

100 – 150kg	60mg in the evening
>150kg	80mg in the evening

2.1.2 Critical Care, Surgery and Trauma Patients

Actual body weight	**Dose of Inhixa®**
<50kg	20mg in the evening
50 – 99kg	40mg in the evening
100 – 129kg	60mg in the evening
130 – 150kg	80mg in the evening
>150kg	120mg in the evening

2.1.3 Preganancy and the Puerperium - See RCOG guidelines for VTE risk assessment

Booking weight (or most recent weight)	**Dose of Inhixa®**
<50kg	20mg in the evening
50 – 90kg	40mg in the evening
91 – 130kg	60mg in the evening (may be given in 2 divided doses)
131 – 170kg	80mg in the evening (may be given in 2 divided doses)
>170kg	0.6mg/kg in the evening (may be given in 2 divided doses)

2.1.4 Patients with renal impairment

Patients with a creatinine clearance less than 30ml / min should have a dose reduction.

- Patients 50 to 100kg with a creatinine clearance less than 30ml /min should receive a dose of 20mg in the evening.
- Patients >100kg with a creatinine clearance less than 30ml /min should receive a dose of 40mg in the evening or a 50% dose reduction.

For dosing advice in patients who are dialysis dependent or under 50kg with creatinine clearance less than 30ml / min please contact the haematology team.

2.1.5 Anti-Xa monitoring

- If the clinician has concerns about the efficacy of the dose or if the patient is at high risk of bleeding an anti-Xa level may be taken 3-4 hours after the third dose. Effective prophylaxis should provide a peak level of 0.3 to 0.35 units/ml and a trough of less than 0.1 units/ml. However, in the majority of patients monitoring of anti-Xa levels is not necessary with prophylactic doses. Haematology will provide advice on interpretation of results and dosing for patients whose peak and trough levels are out of range

- For short periods of thromboprophylaxis (less than one week) it is unlikely that Inhixa® will accumulate in patients with renal impairment. However if Inhixa® is used for longer periods accumulation may occur. Anti-Xa levels may be taken 30 minutes prior to the next dose as a trough less than 0.1 units/ml will confirm that clearance is adequate.