Management of Periprocedural Anticoagulation (Warfarin)

<table>
<tr><th colspan="8">Warfarin (Coumadin, Jantoven)</th></tr>
<tr><td>Bleeding Risk</td><td colspan="4">High/Intermediate/Low</td><td colspan="3">Minor</td></tr>
<tr><td>Thrombotic Risk</td><td>Ultra High Risk</td><td>High</td><td colspan="2">Intermediate</td><td>Low</td><td>High</td><td>Intermediate</td><td>Low</td></tr>
<tr><td>Days to stop warfarin prior to procedure</td><td colspan="4">Stop warfarin 5 days prior to procedure</td><td colspan="2">Continue warfarin with goal INR ~2.0</td><td>Consider holding warfarin 2 days prior to procedure</td></tr>
<tr><td rowspan="3">Bridging</td><td>Begin therapeutic dose LMWH 3 days prior to procedure</td><td>Consider therapeutic dose LMWH 3 days prior to procedure Base decision on input from patient, proceduralist, and PCP.</td><td colspan="2">Evidence for or against bridging is unclear and recommendations should be based on patient and procedure characteristics. If bridging, then begin therapeutic dose LMWH 3 days prior to procedure.</td><td rowspan="3">Bridging not indicated</td><td colspan="3" rowspan="3">Bridging not indicated</td></tr>
<tr><td>Give last dose of LMWH 24 hours prior to procedure</td><td rowspan="2">Give last dose of LMWH 24 hours prior to procedure</td><td colspan="2" rowspan="2">Give last LMWH dose 24 hours prior to procedure</td></tr>
<tr><td>Admit to hospital for therapeutic IV heparin overnight, stopping 6 hours prior to procedure</td></tr>
<tr><td>Other therapeutic considerations</td><td colspan="4">None</td><td colspan="3">Consider addition of tranexamic acid or aminocaproic acid mouthwash for dental procedures.
Tranexamic acid dosing for dental procedures: Oral rinse, 4.8% solution. Hold 10 mL in mouth and rinse for 2 minutes, then spit out. First dose 10 minutes prior to procedure. Repeat 4 times daily (~every 6 hours) for 2 days after procedure. Patient should not eat or drink for 1 hour after using oral rinse (Carter, 2003).</td></tr>
<tr><td>INR Check</td><td colspan="8">Check INR day of procedure.</td></tr>
<tr><td>Resuming post-op</td><td colspan="8">Resume anticoagulation as soon as possible postoperatively.</td></tr>
<tr><td>Other considerations</td><td colspan="8">Warfarin hold times and INR recommendations are based on the assumption that the patient has relatively good compliance with warfarin and INR values are generally within the range of 2-3. If patient has INR values outside that range or poor medication compliance, the recommendations should be adjusted per physician recommendation.</td></tr>
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