

Management of Periprocedural Anticoagulation (Warfarin)

Warfarin (Coumadin, Jantoven)							
Bleeding Risk	High/Intermediate/Low				Minor		
Thrombotic Risk	Ultra High Risk	High	Intermediate	Low	High	Intermediate	Low
Days to stop warfarin prior to procedure	Stop warfarin 5 days prior to procedure				Continue warfarin with goal INR ~2.0		Consider holding warfarin 2 days prior to procedure
Bridging	Begin therapeutic dose LMWH 3 days prior to procedure.		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.		Bridging not indicated		Bridging not indicated
	Give last dose of LMWH 24 hours prior to procedure	Give last dose of LMWH 24 hours prior to procedure	Give last LMWH dose 24 hours prior to procedure				
	Admit to hospital for therapeutic IV heparin overnight, stopping 6 hours prior to procedure						
Other therapeutic considerations	None				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).		
Day of procedure INR	Check INR day of procedure.						
Resuming post-op	Resume anticoagulation as soon as possible postoperatively.						
Other considerations	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.						