

# Slow Loading Warfarin Regimen for Primary Care

# Background

Patients not requiring rapid anticoagulation can be safely managed using a slow loading regimen which results in therapeutic anticoagulation within 3-4 weeks in the majority of patients. This appears to avoid overanticoagulation and bleeding associated with rapid loading<sup>2</sup>.

## Indications:

For use in patients for whom immediate anticoagulation is not required. These include:

- chronic or paroxysmal atrial fibrillation;
- selected patients with left ventricular thrombus;
- selected patients with mitral stenosis;
- stroke outpatients in sustained AF who have waited 14 days following the acute event with a CT head scan that has excluded haemorrhage;
- selected patients with pulmonary hypertension.

# Aim:

To initiate warfarin therapy with a target INR 2.5

#### Regimen:

- 1. Ensure the patient has no contraindications to warfarin. Generally if a patient is taking aspirin, this should be continued until the INR is therapeutic then STOPPED.
- Ensure baseline bloods (FBC, U&E, LFT, coagulation screen) are satisfactory. If in doubt, discuss with the patient's consultant. If baseline INR>1.2, seek haematology advice.
- 3. Explain to the patient the indication for warfarin treatment and the risks and benefits of it.
- 4. Prescribe 2mg of warfarin daily at 6pm for 1 week.
- 5. Repeat INR after 7 days of warfarin therapy.
- 6. Adjust dose as per nomogram overleaf.

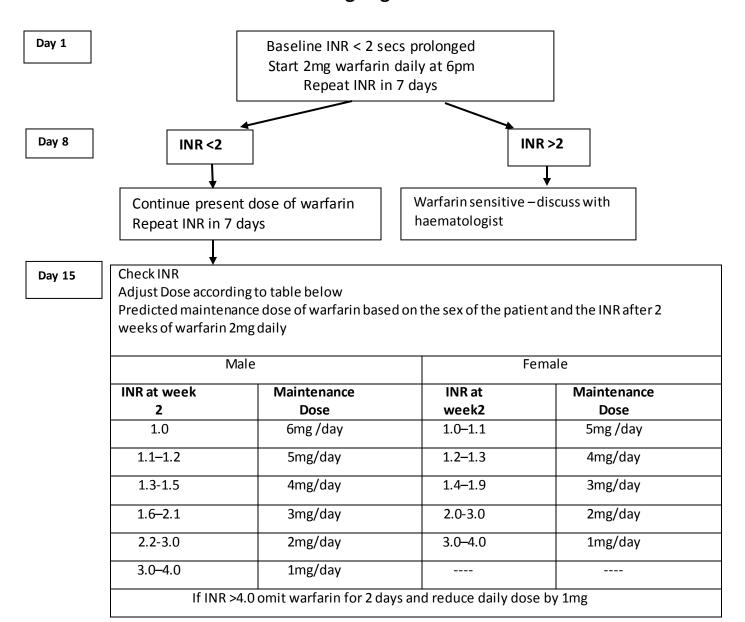
## References

- 1. Oates A. Jackson P.R. Austin C.A. Channer K.S. A new regimen for starting warfarin anticoagulation in out-patients. British Journal of Clinical Pharmacology 1998 46 157-61
- 2. Guidelines on oral anticoagulation (warfarin): third edition 2005 update British Committee for Standards in Haematology

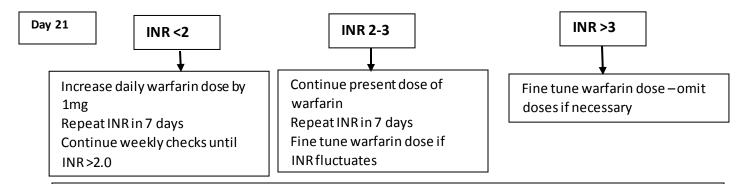
www.bcshquidelines.com/pdf/OAC quidelines 190705.pdf

Adapted from Donacaster and Bassetlaw guidelines

# **Dosing Algorithm**



Recheck INR after a further week and adjust dose as below



By the time the patient has been taking warfarin for 6 weeks, the INR should be within the therapeutic range, Fine tuning of the dose using alternate day regimens (eg 2mg/3mg alternative days) can be used if the INR fluctuating. Please discuss any bleeding complications with a haematologist.