

KEY INFORMATION FOR CONDUCTING AN MCU ON A PATIENT USING WARFARIN

Using the word **WARFARINISED** to prompt key counselling points for warfarin patients

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| W | When to take. Recommended at teatime so INR clinic can ring and make dose adjustments the same day as blood tests. However if teatime is not convenient then the same time each day is essential. |
| A | Alcohol – may increase anticoagulant effect depending on amount consumed (binge drinking) |
| R | Risk of bleeding – increased risk of bleeding because blood takes longer to clot. If patient experiences bleeding from the nose or gums or blood in urine/stools they should go to A&E |
| F | Follow up – INR appointments must be attended so levels can be monitored |
| A | Aspirin – avoid taking unless prescribed by a doctor |
| R | Reason for taking – started to slow down the rate at which blood clots to reduce risk (see below) |
| I | Interactions – Drugs and certain foods* rich in Vit K can interact with warfarin. Always tell pharmacist about warfarin before purchasing OTC meds. Avoid eating large amounts of foods high in Vit K when on warfarin. |
| N | Notify – GP, dentist – warfarin will influence further treatments |
| I | INR – what is your recommended range? Safe range is typically 0.5 either side of target (see below). A patient not on warfarin will have an INR of 1. So an INR of 2.5 means the blood takes 2.5 times longer to clot than non-anticoagulated blood. |
| S | Skipped dose – do not miss doses. If this happens, make a note in yellow book and take the normal dose for that day. Do not double doses. |
| E | End of course – is patient aware of how long they need to take warfarin. Durations can vary depending on indication (see below) |
| D | Dose – INR clinic or GP will inform patient of what dose to take following an INR check. Dose needed to achieve target INR will vary from patient to patient. |

Taken from Pharmacy Practice Vol 19 Issue 1 Jan 2009

Indications and typical durations of treatment

| Indication | Target INR | Duration of anticoagulation |
|--|-------------------------------------|--|
| Atrial fibrillation | 2.5 | Long term therapy |
| Calf vein thrombus | 2.5 | Three months |
| Cardiomyopathy | 2.5 | Long term therapy |
| Cardioversion | 2.5 | 3 weeks before operation and 4 weeks after |
| Prosthetic Heart Valve (PHV) | 2.5 – 3.5 (depending on valve type) | Long term therapy |
| Deep vein thrombosis | 2.5 | Six months |
| Pulmonary embolus | 2.5 | Six months |
| Recurrence of DVT whilst on warfarin | 3.5 | Consider long term therapy |
| Recurrence of DVT once warfarin therapy ceased | 2.5 | Consider long term therapy |

Taken from CPPE Anticoagulation Focal Point Feb 2009

Side effects – fewer than 1 in 10 patients experience side effects from warfarin. For those that do, the most common are: hair loss, diarrhoea, nausea & vomiting, rash, unusual bleeding or bruising.

Herbal drug interactions – the following herbal remedies can all affect INR: Chondroitin, Ginkgo biloba, Ginger, Garlic, Ginseng, Glucosamine (patients should avoid completely) and St John's Wort (patients should avoid completely)

Foods rich in Vitamin K include: green leafy vegetables (e.g. Sprouts, broccoli, lettuce), chick peas, liver, egg yolks, wheat bran, oats, mature and blue cheeses, avocado and olive oil. All can reduce the anticoagulant response.

Yellow book: should be presented every time a prescription is collected. The pharmacy should record the INR is safe, the dose is understood and the INR is monitored regularly.

Recall between INR clinics: Maximum recall period is every 12 weeks (except PHV which have a max of 6 weeks) once a patient has had several therapeutic INR measurements. A patient with one high or low INR should be recalled in 7-14 days before dose adjustment.