Schedule for the Slow Initiation of Prophylactic Warfarin Therapy in the Elderly

This schedule is intended for use in patients without acute thromboembolism and may be considered where the need for rapid induction is not necessary (i.e., mainly patients with atrial fibrillation). The two studies on which this schedule is based recruited older patients (mean ages 70 and 71), and may not be valid in younger patients.

Start warfarin 2 mg daily

Check INR after one week

INR < 4

Continue warfarin 2 mg daily for a further week. Recheck INR at end of week 2 and use table below to prescribe predicted maintenance dose.

INR > 4

Omit for 2 days, recommence at 1 mg daily and treat outside this schedule—seek specialist advice if unsure.

<table>
<thead>
<tr>
<th>INR at end of week 2</th>
<th>Dose (mg/day)</th>
<th>INR at end of week 2</th>
<th>Dose (mg/day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>6</td>
<td>1.0 – 1.1</td>
<td>5</td>
</tr>
<tr>
<td>1.1 – 1.2</td>
<td>5</td>
<td>1.2 – 1.3</td>
<td>4</td>
</tr>
<tr>
<td>1.3 – 1.5</td>
<td>4</td>
<td>1.4 – 1.9</td>
<td>3</td>
</tr>
<tr>
<td>1.6 – 2.1</td>
<td>3</td>
<td>2.0 – 3.0</td>
<td>2</td>
</tr>
<tr>
<td>2.2 – 3.0</td>
<td>2</td>
<td>&gt;3.0</td>
<td>1</td>
</tr>
<tr>
<td>&gt;3.0</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Week 3 onwards: Check INR weekly for 6–8 weeks and follow advice below:
- if INR > 4.0 → omit for 2 days and recommence at 1 mg lower.
- if INR 1.5 – 4.0 → maintain same dose.
- if INR < 1.5 for 2 consecutive weeks → increase dose by 1 mg.

If INR is not stable by week 6, 0.5 mg dose adjustments can be made.

General Points

Prior to commencing warfarin:
Counsel patient on warfarin usage
Measure INR, U&Es, LFTs and FBC
Fill in warfarin prescription chart

On discharge:
Top copy of warfarin prescription chart goes to GP
Bottom copy goes in notes
Telephone GP regarding INR monitoring

Potential Contraindications to anticoagulant therapy

Bleeding disorder
- e.g., liver failure, renal failure, antiplatelet drugs (NSAIDs, aspirin, clopidogrel)

Risk of bleeding
- e.g., cerebral bleed
- cerebral infarct in last 2 weeks
- active peptic ulcer disease
- GI or GU bleed in last 6 months

Non-compliance/inability to understand therapy

Chronic alcoholism

Risk of fits or falls

Severe hypertension
- e.g., systolic > 200 mm Hg or diastolic > 120 mm Hg

Adapted from Br J Pharm 1998; 46: 157-61
See also SIGN 36 Section 13.2: Initiation, Dosage & Monitoring of Oral Anticoagulant therapy
Dr D W Lowdon and M Logan-Rena, March 2003 / Amended Jan 2004 P G Cachia May 2004 / Amended by Medicines Advisory Committee April 2005