Western Health

Warfarin reversal: updated consensus guidelines

Management of patients on warfarin therapy with high INR and no bleeding	
Clinical setting	Recommendations and levels of evidence*
INR higher than the therapeutic range but <4.5 and no bleeding	• Lower or omit the next dose of warfarin • Resume therapy at a lower warfarin dose when the INR approaches therapeutic range • If the INR is only minimally above therapeutic range (up to 10%) dose reduction is generally not necessary *(2C)*
INR4.5 – 10.0 and no bleeding	• Cease warfarin therapy; consider reasons for elevated INR and patient-specific factors. Vitamin K_1 is usually unnecessary *(2C)* If bleeding risk is high:† • consider vitamin K_1 1mg - 2mg orally or 0.5mg -1mg IV *(GPP)* • measure INR within 24 hours • resume warfarin at a reduced dose once INR approaches therapeutic range
INR>10.0 and no bleeding	• Cease warfarin therapy, administer 3mg –5mg vitamin K_1 orally or IV‡ (2C) • Measure INR in 12–24 hours. Close monitoring of INR daily to second daily over the following week (GPP) • Resume warfarin therapy at a reduced dose once INR approaches therapeutic range If bleeding risk is high:† • consider Prothrombinex-VF, 15 – 30 IU/kg *(GPP)* • measure INR in 12–24 hours. Close monitoring over the following week • resume warfarin therapy at a reduced dose once INR approaches therapeutic range

INR=international normalised ratio. IV =intravenously. * Level of evidence in parentheses in italics

Recommendations with no evidence level are standard practice and not based on gradable evidence.

† Recent major bleed (within previous 4 weeks) or major surgery (within previous 2 weeks),thrombocytopenia (platelet count, $<50x10^9$/L), known liver disease

‡ Extrapolated from oral vitamin K_1 data in absence of IV data.

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