



CLINICAL PRACTICE GUIDELINE

VTE: Pre and post-operative management of patients on therapeutic warfarin anticoagulation (gynaecology patients)

This document should be read in conjunction with this [Disclaimer](#)

Key points

1. If urgent surgery is required for a woman on [warfarin](#), rapid reversal of warfarin may be required and management should be discussed with the on call haematologist.
2. If elective surgery is planned, and the decision by the treating team is that warfarin is to be ceased for the surgery, then a perioperative anticoagulation plan is required.
3. Advice should be sought from the Haematologist/Physician about when the woman is to stop her warfarin, when her INR is to be checked and whether bridging anticoagulation with low molecular weight heparin (LMWH) is required.
4. If bridging anticoagulation is required, the dosing schedule and the timing of the last dose pre-operatively need to be advised.
5. A post-operative plan is required for when warfarin +/- LMWH are to be restarted

Recommencing warfarin after surgery

1. The timing of recommencement of warfarin therapy post operatively should be guided by the haematologist/physician.
2. Administer the same warfarin brand (e.g. Coumadin, Marevan) that the woman was previously using, as brands are not interchangeable.
3. Patients being re-initiated on warfarin post operatively should be restarted on the dose prescribed prior to intervention and the INR checked on day 3.
4. Modify dosing for day 3 based on the day 3 INR (refer to table below "Initiation dosing for warfarin with target INR 2-3") and from day 4 of treatment, adjust dose according to INR.
5. In acutely ill patients with ongoing warfarin therapy daily monitoring of INR may be appropriate.

Initiation dosing for warfarin with target INR 2-3

Day	INR	Suggested dose
1	1.0-1.4	5 mg
2	No INR	5 mg
3	<1.8	5 mg
	≥1.8	1 mg
4&5	<1.5	7 mg
	1.5-1.9	5mg
	2.0-2.5	4mg
	2.6-3.5	3mg
	3.6-4.0	2mg
	4.1-4.5	1mg
	>4.5	See treatment reversal
6 onwards	Measure on alternate days until stable (daily if drug interaction or high bleeding risk)	As for days 4&5 or per clinical judgement

For younger patients consider 7-10mg warfarin on day 1 and day 2.

Reversal of over-treatment




Discussion with the haematologist is advised in cases where treatment other than withholding warfarin is being considered.

Refer to Anticoagulation Medication Chart MR 810.11

<http://ww2.health.wa.gov.au/~-/media/Files/Corporate/general%20documents/Quality/PDF/Anticoagulation-Medication-Chart-Template.ashx>

Related WNHS policies, procedures and guidelines

- Clinical Guidelines, Pharmacy: [Enoxaparin](#); [Heparin](#); and [Warfarin](#)
- [Pharmacy Learning Hub - WA Anticoagulation Medication Chart Presentation Slides](#)
- Department of Health WA: [WA Anticoagulation Medication Chart](#) (website): [Guidelines for the WA Anticoagulation Medication Chart](#) (WA AMC)

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