

Guidelines on oral anticoagulation with warfarin – fourth edition

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The writing group was selected to be representative of UK based experts. This guidance is an update of the previous guideline written in 2005 and published in 2006 (Baglin *et al.*, 2006). The guidance is updated with reference to relevant publications since 2005. Publications known to the writing group were supplemented with additional papers identified by searching PubMed for publications in the last 5 years using the key word warfarin and limits clinical trial, randomized control trial, meta-analysis, humans, core clinical journals, and English language. The writing group produced the draft guideline, which was subsequently revised by consensus by members of the Haemostasis and Thrombosis Task Force of the British Committee for Standards in Haematology. The guideline was then reviewed by a sounding board of approximately 50 UK haematologists, the BCSH (British Committee for Standards in Haematology), the British Cardiovascular Society and the British Society for Haematology Committee and comments incorporated where appropriate. The 'GRADE' system was used to quote levels and grades of evidence, details of which can be found at http://www.bcsbguidelines.com/BCSH_PROCESS/EVIDENCE_LEVELS_AND_GRADES_OF_RECOMMENDATIONS/GRADE.html. The objective of this guideline is to provide healthcare professionals with clear guidance on the indications for and management of patients on warfarin.

This guideline replaces the previous BCSH guidelines on oral anticoagulants (Baglin & Rose, 1998; Baglin *et al.*, 2006).

1. Indications for warfarin and recommended target international normalized ratio (INR)

This guideline refers to target INRs rather than target ranges, although the target range is generally taken to be within 0.5 of

the target, i.e. a target INR 2.5 equates to a target range of 2.0–3.0. Specifying tighter target ranges for fully anticoagulated patients e.g. 2.0–2.5 or 3.5–4.0 does not achieve tighter anticoagulation control but results in more blood tests and more INR results in ranges associated with increased risk of thrombosis and bleeding (Meier *et al.*, 2007).

1.1 Venous thromboembolism (VTE)

For acute VTE warfarin should be started along with a parenteral anticoagulant, such as unfractionated heparin (UFH), low molecular weight heparin (LMWH) or fondaparinux (Brandsjes *et al.*, 1992), which should be continued for at least 5 d and until the INR is ≥ 2 for at least 24 h, whichever is the longer.

For the initial period of treatment the target INR should be 2.5. For patients who require anticoagulation beyond 3 months, it is not recommended to lower the target range after 3 months as this has been shown to offer poorer efficacy with comparable bleeding rates (Kearon *et al.*, 2000; Riddler *et al.*, 2008).

Patients who suffer a recurrence of VTE whilst on anticoagulants, where the anticoagulant control is within target, need escalation of their INR target. There are few data that relate to this scenario, but we suggest a target of 3.5.

Recommendations

- First episodes of VTE should be treated with an INR target of 2.5 (1A).
- Warfarin used for treatment of VTE should be introduced along with parenteral anticoagulation (1A) which should continue for at least 5 d and until the INR is ≥ 2 for at least 24 h (1C).
- Recurrent VTE whilst anticoagulated and within the therapeutic range should be managed by increasing the INR target to 3.5 (2C).

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Fourth

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