evidence based guidelines

MANAGEMENT OF ANTICOAGULANTS
THERAPEUTIC BRIDGING

Pre-Procedure Planning Considerations

Patients on warfarin for whom therapeutic bridging is recommended include the following:

- Ischemic stroke within the last 12 weeks
- Venous thromboembolism (deep venous thrombosis or pulmonary embolus) within the last 12 weeks
- Mechanical valve in the mitral position
- Mechanical valve in the aortic position and additional risk factor(s) for thrombosis
- History of chronic or paroxysmal atrial fibrillation with a CHA_2DS_2-VASc* score of 5 or higher
- History of a thrombotic event during temporary stoppage of warfarin in the past

For patients at lower risk of thrombotic events, interruption of warfarin without bridging is recommended (see "Interruption for Elective Procedures" protocol).

For procedures with a very low-risk for bleeding (dental, cutaneous, endovascular, or upper gastrointestinal endoscopy without dilation) it is recommended that patients continue warfarin without interruption.

The protocol below is specific for patients on warfarin. Bridging is not usually necessary for patients on newer oral anticoagulant agents (e.g. Xarelto, Pradaxa, Eliquis). If a provider chooses to bridge with these agents, management will need to be individualized.

> * CHA_2DS_2-VASc score = **+1 point EACH for**: age 65-74, female, HTN, CHF, DM, Vascular disease
> **+2 points EACH for**: age ≥75, h/o stroke or thromboembolism

Patient Education

- No doses of warfarin starting 5 days prior to date of procedure

- On the 3rd day prior to procedure begin enoxaparin SC at 1mg/kg per dose
  - Every 12 hours for patients with creatinine clearance of 30 ml/min or greater
  - Every 24 hours for patients with creatinine clearance of <30 ml/min

- The last dose of enoxaparin before procedure should be given:
  - No sooner than 24 hours prior to procedure
  - Using 0.5mg/kg if creatinine clearance is <30 ml/min

- Restart enoxaparin doses no sooner than 24 hours after procedure and only once hemostasis has been established. Continue enoxaparin until INR is at or above desired therapeutic threshold (usually 3-5 days).

- If the patient is to restart warfarin after the procedure, restart their usual daily dosage of warfarin on the evening of the day of the procedure (assuming hemostasis has been established).

NOTE:

- For patients at risk for recurrent deep venous thrombosis consider using protocol above but substitute an enoxaparin dose of 40mg SC once daily (reduce to 30mg once daily if creatinine clearance <30 ml/min).

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