Warfarin Reversal

Without bleeding

Australian Red Cross Lifeblood®

Management of patients on warfarin therapy with high INR and without bleeding

<table>
<tr><th>INR</th><th>Bleeding risk</th><th>Warfarin</th><th>Vitamin K</th><th>PTX-VF</th><th>Check INR</th><th>Comments</th></tr>
<tr><td>INR higher than therapeutic range but < 4.5</td><td></td><td>Reduce or omit next dose</td><td></td><td></td><td></td><td rowspan="6">Resume warfarin at reduced dose when INR reaches therapeutic range</td></tr>
<tr><td rowspan="2">INR 4.5–10.0</td><td>Low</td><td>Cease</td><td></td><td></td><td rowspan="2">Within 24 h</td></tr>
<tr><td>High</td><td>Cease</td><td>1–2 mg PO or 0.5–1 mg IV[1]</td><td></td></tr>
<tr><td rowspan="2">INR > 10.0</td><td>Low</td><td>Cease</td><td>3–5 mg PO or IV[2]</td><td></td><td rowspan="2">Within 12 h</td></tr>
<tr><td>High</td><td>Cease</td><td>3–5 mg PO or IV[2]</td><td>15–30 IU/kg</td></tr>
</table>

[1] Child: 0.03 mg / kg IV (max 1 mg) [2] Child: 0.1 mg / kg IV (max 5 mg)

Suggested doses of Prothrombinex-VF to reverse the anticoagulant effect of warfarin according to initial and target INR

Patient's initial INR	1.5–2.5	2.6–3.5	3.6–10.0	> 10.0
Target INR 0.9–1.3	30 IU/kg	35 IU/kg	50 IU/kg	50 IU/kg
Target INR 1.4–2.0	15 IU/kg	25 IU/kg	30 IU/kg	40 IU/kg

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Management of patients on warfarin therapy with bleeding

<table>
<tr><th>INR</th><th>Bleeding risk</th><th>Warfarin</th><th>Vitamin K</th><th>PTX-VF</th><th>FFP</th><th>Check INR</th><th>Comments</th></tr>
<tr><td>INR ≥ 1.5 with life-threatening (critical organ) bleeding</td><td></td><td>Cease</td><td>5–10 mg IV[1]</td><td>50 IU/kg</td><td>150–300 mL If PTX-VF not available administer FFP 15 mL/kg</td><td>In 20 mins</td><td rowspan="2">Resume warfarin when bleeding has ceased and adjust dose to maintain INR within therapeutic range</td></tr>
<tr><td>INR ≥ 2.0 with clinically significant bleeding (not life-threatening)</td><td></td><td>Cease</td><td>5–10 mg IV[1]</td><td>35–50 IU/kg</td><td>If PTX-VF not available administer FFP 15 mL/kg</td><td>In 20 mins</td></tr>
<tr><td rowspan="2">Any INR with minor bleeding
or
INR > 4.5 with minor bleeding</td><td>Low</td><td>Cease</td><td></td><td></td><td></td><td rowspan="2">In 24 h</td><td rowspan="2">Resume warfarin at reduced dose when INR reaches the therapeutic range</td></tr>
<tr><td>High</td><td>Cease</td><td>Consider 1–2 mg PO or 0.5–1 mg IV[2]</td><td></td><td></td></tr>
</table>

[1] Child: 0.3 mg / kg IV (max 10 mg) [2] Child: 0.03 mg / kg IV (max 1 mg)

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