ANTICOAGULATION PROTOCOL GUIDELINES

The number of patients who require maintenance on anticoagulation therapy (warfarin/Coumadin®) for minimizing risk of cardiovascular events like stroke or thromboembolism is increasing. Other patients take anticoagulants for chronic atrial fibrillation, prevention of recurrent blood clots or pulmonary embolism, or previous prosthetic heart valve replacement. Patients who have had past transient ischemic attacks, myocardial infarctions, angioplasty, and deep vein thrombosis (DVT) are often placed on anticoagulant therapy, particularly those with additional risk factors such as advanced age (>70 years), diabetes mellitus, or poor left ventricular function.

Many pain management patients require management of anticoagulation therapy when undergoing interventional procedures. Maintaining a balance between hypercoagulation and hypocoagulation before, during, and after the procedure can be difficult or confusing at best and dangerous or life-threatening at worst.

To further complicate matters, many patients take other potentially blood thinning medications like clopidogrel (Plavix®), ticlopidine (Ticlid®), and aspirin in varying strengths to prevent clots and possibly strokes by inhibiting platelet function. These drugs should also be evaluated and usually stopped prior to any interventional procedure.

The challenge is to minimize the risk of ppre-procedure bleeding while also minimizing the risk of thrombotic event that could occur by allowing hypercoagulability (tendency to clot too quickly).

The decision on whether to stop anticoagulation and/or when to stop it depends on the risk of a stroke or other thromboembolism in relationship to the reason the patient takes the blood thinner and the relative risk of the procedure planned.

Anticoagulation Guidelines

1. **Stop NSAIDS (Celebrex, Naproxen, Ibuprofen, etc) 2 days prior to procedure**
2. **Stop Aspirin (baby (81mg) or normal (325mg)) 5 days prior to procedure**

The patient needs to understand that they may not have their procedure if these guidelines are not followed.

REQUIRES BLOOD THINNER CLEARANCE FROM PRESCRIBING PHYSICIANS

3. **Stop Plavix 7 days prior to procedure**
4. **Stop Warfarin/Coumadin 5 days prior to procedure and have PT/INR blood test performed prior to procedure. The PT/INR needs to be within the test normal range or 1.2 or below.**

The patient needs to understand that if they do not have the clearance and follow the protocol the procedure will be cancelled. Under <u>NO CIRCUMSTANCE</u> should they stop either of these medications without clearance from the prescribing physician.