Tip: I hate the on-call critical INR!

Did you just get a call from the lab about a critical INR while you were heading out the door to have dinner with your family? Here's a quick guideline to get you started

Critical INRs made easy:

If there is any bleeding with an INR >3.6, your patient needs assessment at the ED.

- **INR is 5.0-9.0 WITHOUT bleeding:** No fuss! Just hold 1-2 doses then recheck INR in 2 days and decrease the weekly dose by 10-20% when the INR is therapeutic.
- **INR is >9.0 WITHOUT bleeding:** stop the warfarin, consider giving one dose of vitamin K 2.5mg orally if the patient is at high risk of bleeding, and repeat the same vitamin K dose in 24 hours if INR still greater than 9.0. Resume warfarin when INR is therapeutic and reduce weekly dose by 20%.

Some Useful Resources

1. https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/warfarinmgmt_2015_full.pdf
2. https://thrombosiscanada.ca/wp-content/uploads/2021/01/16.-Warfarin-Out-of-Range-INR_31July2020.pdf

Haven't been able to find vitamin K in the community?
Try the Douglas Street Shoppers Drug Mart and order vitamin K 2.5 mg (1/4 ampule) orally.