Before Surgery

If preoperative international normalized ratio (INR) is 2.0–3.0, stop warfarin 5 days before surgery (ie, hold four doses)

If preoperative INR is 3–4.5, stop warfarin 6 days before surgery (hold five doses)

Start low-molecular-weight heparin 36 hours after last warfarin dose, ie:
Enoxaparin 1 mg/kg subcutaneously every 12 hours (adjust for renal failure).

Give last dose of low-molecular-weight heparin approximately 24 hours before procedure

Educate patient on self-injection and provide with written instructions

Discuss plan with surgeon and anesthesiologist

Check INR in morning of surgery to ensure that it is less than 1.5, or in some cases (eg, neurologic surgery) less than 1.2

After Surgery

Restart low-molecular-weight heparin approximately 12-24 hours after procedure or consider thromboprophylactic dose of low-molecular-weight heparin on first postoperative day if patient is at high risk for bleeding

Discuss above with surgeon

Start warfarin at patient's preoperative dose on postoperative day 1

Daily prothrombin time and INR until patient is discharged and periodically thereafter until INR is in the therapeutic range

Daily phone follow-up with patient by the Anticoagulation Clinic to assess for adverse effects such as bleeding

Complete blood cell count with platelets on day 3 and day 7

Discontinue low-molecular-weight heparin when INR is 2–3 for **2 consecutive days**

Important Note: This document is a guideline, and not a policy statement. Always use clinical judgment when making decisions for an individual