## Anticoagulation Patient Guidelines

<table>
<thead>
<tr>
<th>Questions to Ask / Necessary Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for agent (warfarin, Coumadin), dosage, how often monitored, stability of dosage over time, most recent INR value/date, any complications, anticipated time that will be on medication</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk for Medical Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased clinical bleeding, urgency of treatment, presence of local factors that increase the potential for hemorrhage, block anesthesia requirement, number of anticipated visits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pertinent Laboratory Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>• INR &lt; 3.5 (Expected range for most indications 2.0 - 3.0, for prosthetic heart valves 2.5 - 3.5) Laboratory results should be available within last 2 days for all surgical procedures</td>
</tr>
<tr>
<td>• Coagulation monitoring is usually not required for rivaroxaban or dabigatran (factor Xa inhibitors) and reliable tests are not available. There are no evidence-based guidelines for the dental management of patients receiving these agents.</td>
</tr>
</tbody>
</table>

**Management For Dental Treatment**

- **Preoperative Management**

  **For Routine Dental Treatment**
  - Dental care should be coordinated with normal monitoring of patient’s INR by physician. This commonly is done every 4-6 weeks.
  - All care may be safely performed without altering anticoagulation levels up to INR 3.5.
  - For patients on short term anticoagulation therapy, it might be appropriate to defer dental treatment until after cessation of therapy.
  - Block anesthesia poses risk of excessive, difficult to control, hemorrhage and needs to be done carefully.
  - Infiltration and periodontal ligament injections are particularly well suited for patients with deficiencies of coagulation.

  **For Surgical Procedures Including Initial Root Planing of Patients with Extensive Disease**
  - Confirm INR value < 3.5 within 48 hours of surgery
  - Most surgical procedures can be safely performed if INR < 3.5
  - For extensive surgical procedures individualize treatment and consider (in
consultation with physician) reduction of anticoagulation using partial withdrawal protocol to INR 3.0 or less. There is rarely an indication for complete elimination of anticoagulation.

- Discontinuation of factor Xa inhibitor approximately two days before elective surgery without the need for bridging anticoagulation and resumption of the medication 6 to 10 hours after surgery with attainment of adequate hemostasis have been suggested in the medical literature. A consult with the treating physician is advised.

**Management During Treatment**

- Consideration should be given to subdividing extensive procedures into smaller surgeries to minimize risk of hemorrhage.

**Postoperative Management**

- Avoid ASA, NSAIDs for analgesia. Use acetaminophen for postoperative pain control.
- Make sure hemorrhage is under control before dismissing the patient.
- Many medications including common antibiotics affect the anticoagulation produced by warfarin.
- Give clear/ complete post-operative instructions including after hours contact information.

**Oral Manifestations**

- Spontaneous gingival bleeding, especially in those with thrombocytopenia
- Petechiae, ecchymoses, jaundice, pallor and ulcers of the oral tissues
- Hemarthrosis of TMJ (rare)
- With the following co-morbidities,
  - Chronic liver disease – enlargement of parotid glands
  - Leukemia – gingival hyperplasia
  - Neoplastic disease – radiographic osseous lesions, oral ulcers and tumors, drifting and loosening of teeth, paresthesias (e.g. burning tongue, lip numbness)

**References**