Stop taking warfarin? No way!

Peter D Brukner

I am a sports physician. Until recently, the only clots of any interest for me were sportspeople who missed easy goals, dropped catches or couldn't hit a ball. Clinically, my only interest in thrombosis was in the differential diagnosis of calf tears.

All that changed one morning 18 months ago. I was sitting at the kitchen table reading the paper, having just finished breakfast. Suddenly, I felt horrible, the worst feeling I had ever had, but one that is difficult to put into words. I remember calling out to my son in the adjoining room that I felt terrible. That was the last thing I remembered for a while.

My son came into the room to find me slumped on the floor, not breathing. He tried unsuccessfully to lift me up and then called my wife who was in another part of the house. Together they were able to sit me up and, after a minute or two, I apparently made some choking sounds and commenced breathing again. A few minutes later, I regained consciousness, blissfully unaware that anything had happened. The ambulance arrived soon after and I was taken to hospital, where I was diagnosed, after a ventilation–perfusion lung scan, with a pulmonary embolus (PE).

I had not had any calf swelling or pain and an ultrasound failed to demonstrate any calf thrombus. My only risk factor was that I had returned from a week-long trip to China 3 days previously.

I do a lot of flying. I have been looking after national sporting teams for 25 years and have attended numerous world championships, Olympic, Commonwealth and university games, as well as doing many other tours. In all my flights with teams, the recent trip with the Socceroos to China was my first in business class. So much for "economy class syndrome"!

I was placed on the usual regimen of short-term subcutaneous enoxaparin sodium therapy and oral warfarin, and my progress was quite uneventful. I was seen by a consultant haematologist, who suggested that I keep taking warfarin for 6 months, then stop taking it and have further blood tests to determine whether I have any risk factors. He also suggested that I subsequently use subcutaneous enoxaparin whenever I flew.

As I knew very little about deep vein thrombosis or PE, I decided I would do some reading. I ascertained that my recommended treatment regimen of 6 months of oral warfarin and subsequent use of subcutaneous enoxaparin when travelling was almost universally recommended. Yet I felt uneasy. I felt very reassured while I was taking warfarin, particularly as all the literature says it is virtually impossible to have a recurrence of venous thromboembolism (VTE) while taking warfarin. The prospect of discontinuing warfarin did make me feel uneasy.

The general consensus among medical people with whom I discussed my condition was that, as there was a "roughly similar chance" of having a haemorrhage while taking warfarin and having a recurrence of PE while not taking it, there was probably no point in staying on the drug. Interestingly, they always seemed to qualify their advice with the words "but of course it is up to you".

I was not totally convinced by that argument, for two reasons. Firstly, I had never had a haemorrhage, but I certainly had had a PE, and a near-fatal one at that. It's amazing how such an experience concentrates the mind. If the risks were indeed 50:50 then I figured I would err on the side of preventing the PE rather than worrying about a haemorrhage.

My second reason was more objectively based. When I looked further at the literature, I began to doubt the mantra that the chances of a warfarin-induced haemorrhage and a recurrence of VTE in the absence of warfarin were similar. The three major studies in this area[1-3] all showed a significant risk of recurrence of VTE in the first year after cessation of oral anticoagulant therapy — in the order of 10%, rising to about 15% after the second year.

Readers, I don't know about you, but a 15% chance of having a potentially fatal event in the next 2 years is not a prospect I relish. I would much rather take the 1%–3% risk of a haemorrhage.

Quite apart from playing the percentages, there is also the matter of peace of mind. I would feel extremely anxious about my health if I were not taking anticoagulants, and I would certainly not fly. This would involve giving up an important and enjoyable aspect of my job, including, I hope, accompanying the Socceroos to South Africa for the next World Cup, not to mention the prospect of overseas holidays and visits to children working and studying overseas.

Clive Kearon, Chair of the American College of Chest Physicians (ACCP) evidence-based clinical practice guidelines on antithrombotic therapy for venous thromboembolic disease, stated recently that a general recommendation of 3–6 months of anticoagulant therapy is no longer appropriate.[4] He quoted the 2008 ACCP guidelines, which strongly recommend that

> . . . in the absence of risk factors for bleeding, which include being older than 75 years . . . patients with a first episode of proximal deep venous thrombosis or pulmonary embolism remain on indefinite anticoagulant therapy, provided that good anticoagulant monitoring is achievable and indefinite treatment is consistent with patient preferences.

I will certainly be following those guidelines and I strongly suggest that clinicians who are still giving out the "warfarin for 6 months" mantra reconsider their position in light of the clinical evidence and the potential to improve patients' quality of life by reducing anxiety.

See also pages 659 and 674

Author details

Peter D Brukner, OAM, MB BS, FACSP, Associate Professor in Sports Medicine
Centre for Health, Exercise and Sports Medicine, University of Melbourne, Melbourne, VIC.
Correspondence: p.brukner@unimelb.edu.au

References

1 Kearon C, Gent M, Hirsh J, et al. A comparison of three months of anticoagulation with extended anticoagulation for a first episode of idiopathic venous thromboembolism. *N Engl J Med* 1999; 340: 901-907.
2 Ridker PM, Goldhaber SZ, Danielson E, et al. Long-term, low-intensity warfarin therapy for the prevention of recurrent venous thromboembolism. *N Engl J Med* 2003; 348: 1425-1434.
3 Rodger MA, Kahn SR, Wells PS, et al. Identifying unprovoked thromboembolism patients at low risk for recurrence who can discontinue anticoagulant therapy. *CMAJ* 2008; 179: 417-426.
4 Kearon C. Stopping anticoagulant therapy after an unprovoked venous thromboembolism. *CMAJ* 2008; 179: 401-402.

(Received 16 Dec 2008, accepted 18 Mar 2009) ❑