Treatment of Blood Clots
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This Cardiology Patient Page will focus on medical treatment of blood clots that can cause critical illness by blocking the blood supply to the heart, brain, lungs, or legs. Blood clots that develop in the arteries can cause heart attack, stroke, and severe leg pain and difficulty walking. Blood clots in the veins or venous system can cause deep venous thrombosis (DVT) in the pelvic, leg, and upper extremity veins. When these DVTs break off and travel through the bloodstream to the heart and then to the lung blood vessels, they cause acute pulmonary embolism (PE).

What Medications Will Be Used to Treat My Arterial Blood Clots?
Treatment of arterial clots may include aspirin and clopidogrel (oral antiplatelet agents), intravenous antiplatelet agents, heparin (a blood thinner and anticoagulant), and clot busters (thrombolytic agents). In addition to medications, special interventional catheters may be used to remove or compress these arterial clots.

Antiplatelet Agents
Chewing an adult-strength aspirin tablet (325 mg) at the onset of heart attack symptoms can improve survival by 20%. Consequently, healthcare professional personnel administer aspirin to patients who may be experiencing a heart attack, thereby avoiding further injury to the heart muscle before the arrival of emergency medical services. The Clopidogrel in Unstable angina to prevent REcurrent events (CURE) Trial showed that clopidogrel, another oral antiplatelet agent, given in conjunction with aspirin, reduces the risk of death even further in the setting of certain types of heart attacks. Intra-venous antiplatelet agents may also be used to treat impending or evolving heart attacks in combination with aspirin and clopidogrel. This triple antiplatelet therapy is highly potent and predisposes the patient to bruising. However, major bleeding complications, such as stomach ulcer bleeding, are rare.

Anticoagulants
Intravenous (IV) heparin, administered continuously, is the traditional anticoagulant prescribed to prevent growth of a blood clot. Achieving the most effective dose requires frequent blood test measurements with a laboratory clotting test that records the activated partial thromboplastin time (aPTT). To treat heart attack patients, the heparin dose is adjusted to a target aPTT in the range of 50 to 70 seconds.

Low molecular weight heparin (LMWH) constitutes an important advance over traditional heparin. LMWH, administered once or twice daily by injection based on the patient’s weight, ordinarily requires no dose adjustment and little or no blood test monitoring. The two Food and Drug Administration (FDA)-approved agents for treatment of certain types of established or impending heart attack are enoxaparin and dalteparin. Like traditional heparin, they may cause unintended bleeding as a side effect.

Thrombolytic Agents
These clot busters can dissolve arterial clots but cause more serious bleeding problems than antiplatelet agents or anticoagulants. The thrombolytics cannot differentiate a bad clot that is causing a heart attack from a good clot that has sealed over a stomach ulcer or weak brain artery. Consequently, the approximate 20% improvement in heart attack survival is complicated by a brain hemorrhage rate of about 1%.
Additional clots and permit the body’s natural blood thinner to mitigate the risk of pulmonary embolism (PE). Anticoagulants prevent formation of blood clots from reaching the lungs after breaking off from the pelvic or deep leg veins. However, the filter does not halt the blood clotting process.\(^5\)

**LMWH**

LMWHs have transformed acute uncomplicated DVT from a disease requiring at least a 5-day hospitalization to an illness that can usually be managed either on an outpatient basis or with an overnight hospital stay. The only FDA regimen specifically approved for outpatient treatment of DVT is the LMWH agent enoxaparin administered as 1 mg per kilogram of body weight twice daily. The dose is reduced in the presence of kidney disease or marked obesity. The blood-thinning action of LMWH is fully effective within several hours of administration, and patients or family members learn how to inject it.

**IV Heparin**

Standard treatment of acute PE requires a continuous IV infusion of heparin, used in a higher intensity than for arterial blood clots, with the dose adjusted to a target aPTT of 60 to 80 seconds. IV heparin is administered throughout the hospitalization, which typically averages 5 to 7 days, until the oral blood thinner, warfarin, has become fully effective. There is an evolving trend toward using LMWH rather than IV heparin, especially after the first day or two of hospitalization, once clinical improvement has become apparent. Some low-risk patients with PE are being discharged after several days of using LMWH as a bridge to warfarin.\(^6\)

**Warfarin**

Warfarin (also referred to by its brand name, Coumadin) functions as an oral anticoagulant by disrupting the body’s natural vitamin K-clotting system. Warfarin is the foundation for long-term treatment of DVT and PE and is essential for the prevention of stroke from atrial fibrillation\(^7\) and for prevention of clotting in mechanical heart valves.

Warfarin poses a greater challenge in safe and effective administration, requires more patient-healthcare provider collaboration, and generates more questions than any other drug that we prescribe. Patients walk a tightrope: too little warfarin can lead to catastrophic clotting; too much warfarin can cause life-threatening major bleeding. Warfarin, like IV heparin but unlike most other drugs, cannot be prescribed in a fixed or weight-adjusted dose. Instead, the dose must be adjusted according to a laboratory blood test that measures the length of time it takes for clotting to begin, or prothrombin time (PT). The test is standardized to account for different laboratory processes and is called the International Normalized Ratio (INR). The INR of a healthy individual not taking warfarin is 1.0. The INR increases with increasing intensity of anticoagulation. For patients with DVT or PE, the usual target INR is 2.0 to 3.0. For the occasional patient requiring even more intensive anticoagulation, the target INR may be raised to levels as high as 4.0.

When warfarin is used, there are multiple drug-drug and drug-food interactions that affect the INR. Regular monitoring of the INR is therefore essential to provide optimal dosing. The INR is usually obtained several times weekly at the initiation of treatment with warfarin. Once a stable INR and warfarin dose are achieved, the INR frequency is gradually decreased to once monthly. More frequent monitoring is essential when other medications are started or discontinued, including over-the-counter medications, vitamins, and nontraditional natural herbs, minerals, or plants. For example, the commonly prescribed antiarrhythmic drug amiodarone and many antibiotics markedly increase the anticoagulant effect of warfarin, causing an excessive rise in the INR. Sudden binges or abstinence from vitamin supplementation can cause an INR to fall dangerously low.

**International Normalized Ratio (INR)**

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K-containing foods such as spinach, broccoli, and brussel sprouts will affect the INR. The combination of alcohol and warfarin will increase the likelihood of bleeding, even in situations when the INR does not rise markedly. Sometimes, important fluctuations can occur in the INR without an identifiable reason.

What Are the Alternatives to Warfarin?

Alternative strategies are very limited. For now, they include self-injected LMWH once or twice daily and self-injected traditional heparin twice or three times daily. In the future, other agents will become available and provide immediate anticoagulation with much less frequent blood test monitoring.

References

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Circulation. 2002;106:e138-e140
doi: 10.1161/01.CIR.0000038923.61628.3D
Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2002 American Heart Association, Inc. All rights reserved.
Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/106/20/e138

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