

ENOXAPARIN - SAFE PRESCRIBING - CHECK IT OUT!

- ▶ CHECK RENAL FUNCTION IS NORMAL
- ▶ CHECK INR, APTT, PLATELET COUNT AND LIVER FUNCTION ARE NORMAL
- ▶ CHECK OTHER ANTICOAGULANTS
- ▶ CHECK IF THERE IS AN INCREASED RISK OF HAEMORRHAGE; DEATHS HAVE RESULTED
- ▶ CHECK PATIENT WEIGHT
- ▶ CHECK ADMINISTRATION TECHNIQUE

Enoxaparin is used for the prevention and treatment of VTE (Venous Thromboembolism) and for the treatment of acute coronary syndromes. Before prescribing, check the following parameters:

Check that renal function is normal. If eGFR <60ml/min or for older patients, check the creatinine clearance (CrCl). Adjust the dose if CrCl <30ml/min (see table).

Check that INR, APTT, platelet count and liver function are normal before initiating therapy and during treatment. Inform all patients to report signs and symptoms of VTE (complication of Heparin Induced Thrombocytopenia) or painful lesions at the injection site.

Check if the patient is taking other anticoagulants (e.g. warfarin), antiplatelet agents (e.g. aspirin, clopidogrel, ticlopidine), thrombolytics or NSAIDs. These should be discontinued prior to enoxaparin therapy unless strictly indicated.

Check if there is a risk of haemorrhage; deaths have resulted. Enoxaparin is contraindicated if there is a history of haemorrhagic stroke, or if the patient has active peptic ulcer disease or ulcerative colitis. Since 1998, there have been 20 deaths reported to CARM (Centre for Adverse Reactions Monitoring) due to bleeding/haemorrhage that are thought to be related to enoxaparin. Bleeding can occur at any site, so a fall in haemoglobin or blood pressure should be investigated immediately.

Check patient weight. If the patient is at extremes of weight (<45kg or >100kg) adjust dosing (see table). Refer to a specialist for anti-factor Xa monitoring.

Check the administration technique. Do not expel the air bubble. Administer by deep subcutaneous injection at 90 degree angle, into a skin fold. Hold the skin for the duration of the injection and do not rub the injection site. Alternate sites between the left and right abdomen.

PROPHYLAXIS OF VTE

STANDARD DOSE: 40mg once daily

DURATION:

High risk surgery: 7-10 days post-op or until risk diminished
Medical patients: 6-14 days or until full ambulation

EXCEPTIONS:

Low weight <45kg: 20mg once daily

CrCl <30ml/min: 20mg once daily

Hip replacement: May continue for 30 days post operatively

Note: no need to increase dose above 40mg for those >100kg

TREATMENT OF VTE

**STANDARD DOSE*: 1.5mg/kg once daily (usually more convenient)
or 1mg/kg twice daily**

DURATION:

Minimum 5 days. Initiate warfarin within 72hrs if appropriate.
Continue enoxaparin until therapeutic anticoagulant effect (INR 2-3)

EXCEPTIONS:

CrCl <30mL/min: 1mg/kg once daily (after initial standard dose)

Weight >100kg: Use twice daily regimen

Weight >150kg: Consider dosing as per lean body weight

Pulmonary embolism: Use twice daily regimen

Cancer protocol: 1.5mg/kg once daily for 4 weeks then 1mg/kg once daily ongoing

*For convenience, prescribe to the nearest 10mg dose (until 120mg then round to 135 or 150mg)

KEY REFERENCES

Low molecular weight heparin use in primary care. Best Practice Journal Nov 2009 (24) 32-36.
Sanofi-Aventis. Clexane datasheet. 2008. Available from: www.medsafe.govt.nz/profs/datasheet/c/clexaneinj.pdf [Accessed November 2010].

[CLICK HERE FOR FURTHER INFORMATION ON ENOXAPARIN AND A FULL REFERENCE LIST](#)

For a full reference list and information on other high-risk medicines visit: www.saferx.co.nz