AND CORRECTION
SHE DID NOT
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AVOIDE.

39% and no phospholipid antibodies were detected during her prior stroke evaluation.

While the patient’s POC INR is elevated, the CL INR is within the therapeutic range. A local policy is in place requiring POC INRs >5.0 to be confirmed with a venipuncture sample and CL INR. However, the patient’s INR is not above this threshold and the pharmacist remains perplexed as to which value to believe. Ultimately, the pharmacist leaves the warfarin dose unchanged and instructs the patient to return in 1 week for a follow-up INR. At this follow-up visit, the patient’s POC INR is 2.9. Although she did not suffer any harm, had a POC INR correction factor been available and applied, the patient’s inconvenience and cost of follow-up INR could have been avoided.

Conclusion
POC INR testing for chronic anticoagulation monitoring enables patient self-testing and self-monitoring, and is more convenient and efficient than CL INR testing. POC INR testing is widely used in outpatient labs and anticoagulation clinics, although CL INR testing remains the reference standard. Laboratory professionals should be aware of the potential for POC INR and CL INR disagreement and work to develop institutional procedures for confirmatory testing. POC INR correction factors are promising tools to improve INR agreement and clinical decisionmaking.

REFERENCES