Warfarin induced hematuria
Dhiren Patel¹, Kamlesh Patel¹*, Sapna Gupta², Supriya Malhotra¹, Pankaj Patel³

INTRODUCTION
Hematuria, defined as the presence of red blood cells in the urine. Visible hematuria, also known as gross hematuria is clearly visible change in urine color due to blood additives, may be a symptom of serious urinary tract disease. Thus, it should always be an urgent diagnostic matter for a clinician. The usage of anticoagulant or antiplatelet drugs is beneficial for patients with several diseases. However, serious complications may appear during such a therapy, including mucosal bleeding in the form of hematuria. Iatrogenic hematuria may be the reason for urological consultation and hospitalization in urological department, during which standard diagnostic procedures are usually performed.¹ This case report points out the occurrence of the hematuria in the patient receiving Warfarin for long time.

CASE REPORT
An 80 year old male presented to emergency medicine department with c/o blood in urine since 1 day, he went to private hospital and inj. Trenexamic acid and Botropase was given along with catheterization. For further management he came to our hospital. Patient was known case of cerebro-vascular stroke, ischemic heart disease and hypertension since 15 years.
For that he was on tab digoxin (0.25 mg) 0-0-1 (Saturday and Sunday off), tab. warfarin (4 mg) 0-0-1, tab telmesartan + metoprolol (40 mg/50 mg) 1-0-1, tab aspirin + atorvastatin (75 mg/10 mg) 0-0-1 since 3 years. Physician diagnosed him as Warfarin induced hematuria after ruling out other causes of bleeding. Patient’s vitals were as follow:

Temp: normal, pulse: 80/min, BP: 210/110 mm of Hg, CVS: S1-S2 normal, CNS: conscious, follows verbal commands. RS: bilateral air entry heard.

Tab. warfarin and tab aspirin + atorvastatin were stopped. 4 units of fresh frozen plasma and vitamin K injection were started on the day of admission. 3 ampoules stat and 1 ampoule of vitamin K injection were given for next 3 days. Inj. labetalol 5 ampoules (5 mg/ml) in 50 cc saline at the rate of 2 ml/hour was started for the hypertension. Other conservative management was also given along with.

On next day, USG KUB shows prostate enlargement with parenchymal calcification. For that cap, Dutasteride 0.5 mg (0-0-1) was started and for hypertension tab Losartan 50 mg (1-0-1) and tab Clonidine 0.1 mg (1/2-1/2-1/2) was started. Macroscopic hematuria subsided on next day and patient was better.

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Table 1: Prothrombin time, INR and APTT of patient on admission and discharge.

| Day of report       | Prothrombin time (12-16) (in seconds) | INR (0.8-1.2) | APTT (control) (in seconds) |
|---------------------|---------------------------------------|--------------|-----------------------------|
| On admission        | 40.8                                  | 3.94         | 36.5 (30.0)                 |
| Next day of admission| 19.1                                  | 1.54         | -                           |
| On discharge        | 17.6                                  | 1.39         | 30.7 (30.0)                 |

CONCLUSION

This case shows common incidence of warfarin induced bleeding in the form of hematuria. The incidence of bleeding could be prevented by choosing proper prescription knowing drug-drug interactions and by taking patient’s drug history.

One should realize that especially, in comorbidity the anticoagulant therapy needs to be administered not only carefully but also individually. And routine prothrombin time and INR should be evaluated and dose of warfarin should adjusted accordingly. Also, one should have proper knowledge of drug interaction before prescribing multiple drugs.

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