Clinical Question

In patients who require long-term anticoagulation treatment, how accurate and effective is self-management using a home monitoring device for INR, compared to standard practice?

ADVANTAGES OVER EXISTING TECHNOLOGY

Devices to measure international normalised ratio (INR) are intended for both professional use and patient self-testing to monitor oral anticoagulant therapy. INR is a standardised measurement of the prothrombin time, which is the time it takes blood to clot after addition of tissue factor. Point-of-care (POC) INR testing within primary care settings eliminates delays in waiting for the result or prothrombin time measurement to be processed by the hospital laboratory, and the subsequent delay in adjustment of anticoagulation dosing. It also avoids the need to attend hospital anticoagulation clinics.

DETAILS OF TECHNOLOGY

The POC devices use electrochemical methods or function by drawing a precise amount of blood into a micro-channel and detecting clot formation when the blood movement decreases below a predetermined rate. Currently there are three coagulometers on the market which are suitable for self-testing as they use capillary whole blood obtained from a finger prick. The measuring ranges of these devices vary slightly: INR of 0.6 to 8.0 for CoaguChek® XS (Roche Diagnostics), 0.8 to 8.0 for INRratio® (Hemosense), and 0.8 to 9.9 for ProTime®/ProTime 3 (International Technidyne Corporation). The sample volume required is very small (15–30 µL) with few user dependent steps. The results are typically available in less than 5 minutes.1

PATIENT GROUP AND USE

Patients requiring long-term anticoagulation therapy, for atrial fibrillation, venous thromboembolism, prosthetic heart valves, or myocardial infarction and a number of pro-thrombotic conditions.

IMPACT

Oral anticoagulation therapy, usually with warfarin, aims to reduce the risk of thromboembolic events, but requires regular and frequent monitoring to not only ensure INR is within the therapeutic range, but also to reduce the risk of haemorrhage due to over-anticoagulation. An estimated 950,000 people are receiving oral anticoagulation therapy in the UK.2

PREVIOUS RESEARCH

Evidence on patient self-monitoring of oral anticoagulation therapy shows improvement in anticoagulant control and reduced risk of thrombosis compared to clinic-based care. A systematic review of self-monitoring and self-management of oral anticoagulation concluded that self-management (that is, self-testing and self-adjusting warfarin) provided significant reductions in thromboembolic events (relative risk [RR] 0.47, 95% CI = 0.31 to 0.70) and all-cause mortality (RR 0.55, 95% CI = 0.36 to 0.84), while self-monitoring (that is, self-testing and adjustment by clinician) reduced major haemorrhages (RR 0.56, 95% CI = 0.35 to 0.91), but not thrombotic events (RR 0.57, 95% CI = 0.32 to 1.00), or mortality (RR 0.84, 95% CI = 0.50 to 1.41).3 Several subsequent randomised controlled trials have shown that...
anticoagulation self-management was at least as good as or in some cases better than conventional management with INR values showing smaller variance and fewer major thromboembolic and bleeding complications in older people.

The most common testing frequency is weekly, but lower frequency of testing can be justified based on the patient’s condition. Trials carried out in the UK suggest that 24% of patients would agree to carry out self-monitoring, of these 70% could be successfully trained and able to conduct self-monitoring. A UK-based study suggests that self-monitoring patients were significantly more likely to have INR within therapeutic ranges than those receiving routine hospital anticoagulation clinic care (INR range 71% versus 60%, respectively [P = 0.003]) and significantly less time outside critical limits.

A recent systematic review and meta-analysis of individual patient data had 5 years of follow-up data found a significant reduction in thromboembolic events in patients who self-monitored their INR (hazard ratio 0.51, 95% CI = 0.31 to 0.85), but for major haemorrhagic events or death. Participants aged <55 years showed greater reductions in thromboembolic events (hazard ratio 0.33, 95% CI = 0.17 to 0.66), as did participants with mechanical heart valves (hazard ratio 0.52, 95% CI = 0.35 to 0.77).

Cost-effectiveness and economic impact
A Health Technology Assessment report in 2007, which is somewhat out of date, on the clinical effectiveness and cost-effectiveness of different INR models suggests that self-monitoring is effective and safe for long-term oral anticoagulation therapy in selected and successfully-trained patients. However, the economic evaluation found that patient self-management was more expensive than available routine care (£417 versus £122 per patient-year, respectively). Using UK based Self-Monitoring, Analysis, and Reporting Technology [SMART] trial data and pooled results from all available trials, the incremental cost per QALY of self-monitoring versus usual care was £67 387 after 5 years and £19 617 after 10 years. The full report concluded that patient self-management is unlikely to be more cost-effective than the current high-quality care provided by specialised UK anticoagulation clinics. In contrast, more recent evidence from a Canadian health technology assessment report indicates that the ICER (cost per QALY) for self-managing dominates both standard care and self-testing, which means that self-monitoring resulted in significantly more QALYs gained than standard care and is on average cost-saving. A Belgian HTA report reached similar conclusions, where in all scenarios investigated, the ICER (cost per life-year) of self-monitoring compared to usual care is on average the dominant strategy (less costly and more effective) or highly cost-effective compared to usual care. It should be noted that more recent and more favourable evidence of INR effectiveness was used in the Belgian and Canadian cost-effectiveness models. Patient level data was not available for these reviews and the probabilities used in the models were driven by literature findings and expert opinion.

Relevant Guidelines


What this technology adds
Point-of-care tests for INR are as accurate as laboratory-based measurements. There is good evidence that self-monitoring to adjust warfarin significantly reduces the rate of thromboembolic events, but not the risk of major haemorrhage or death. Self-management of INR may be cost effective based on recent estimates. Translation of evidence into primary care settings is limited.

Methodology
Standardised methodology was applied in writing this report, using prioritisation criteria and a comprehensive, standardised search strategy, and critical appraisal. Full details of these are available from madox.org.

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