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Knowledge of Coumadin Use and Vitamin K Interaction in Atrial Fibrillation Patients

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KNOWLEDGE OF COUMADIN USE AND VITAMIN K INTERACTION IN ATRIAL FIBRILLATION PATIENTS

by

Heidi Michelle Moss

Thesis submitted in partial fulfillment
of the requirements for the degree
of
DEPARTMENTAL HONORS
In
Dietetics
in the Department of Nutrition and Food Sciences

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Logan, UT
Spring 2009
# Table of Contents

Abstract .......................................................................................................................... 3

Introduction ...................................................................................................................... 4

- Atrial Fibrillation and Stroke ......................................................................................... 4
- Risks of Coumadin Use .................................................................................................. 4
- Coumadin anticoagulant Control and Education ............................................................ 5
- Coumadin and Drug Interactions .................................................................................... 5
- Vitamin K and its Role .................................................................................................... 6
- Figure 1: Clotting Cascade and Vitamin K Effects ............................................................ 6
- Interaction Between Vitamin K and Coumadin ............................................................... 7
- Figure 2: Coumadin interaction with Vitamin K ............................................................... 7
- Vitamin K Sources and RDA .......................................................................................... 7
- Table 1: Sources of Vitamin K ......................................................................................... 8
- Table 2: Vitamin K Adult RDA Values ............................................................................ 9
- The Effect of Vitamin K Intake on INR .......................................................................... 9
- Vitamin K and Unstable Anticoagulation ...................................................................... 9
- Vitamin K and Coumadin Dosing ................................................................................... 10
- Patient Knowledge of Coumadin Side Effects ............................................................... 10
- Patient Compliance ....................................................................................................... 11
- Research Objective ........................................................................................................ 11

Research Design and Methods ......................................................................................... 12

Results ............................................................................................................................. 12

- Table 1. Stroke Risk Characteristics .............................................................................. 13
- Table 2. Coumadin Knowledge ...................................................................................... 14

Discussion ........................................................................................................................ 14

References ......................................................................................................................... 20

Appendix A: Patient Questionnaire .................................................................................. 21
Abstract

Background: Atrial fibrillation (AF) is the most commonly observed arrhythmia and is expected to increase to over 12 million in the next few decades. Patients with AF are at high risk of stroke due to the use of Coumadin in combination with stroke risk factors such as age >75 years, hypertension, diabetes, heart failure, and prior stroke or transient ischemic attack. Coumadin specifically targets the blood clotting cascade by inhibiting the regeneration of vitamin K needed for the activation of clotting factors. A 100 mcg increase in vitamin K intake over at least 4 days can reduce patient internationalized national ratio (INR) by 0.2 units. INR values outside of the recommended range of 2.0-3.5 increase the risk of intracranial bleeding and stroke. The objective of this study was to assess the understanding of the AF population related to their role in reducing the risks associated with Coumadin and the effects of proper understanding on stroke risk with a particular emphasis on patient understanding of the interaction between vitamin K and Coumadin.

Methods: Patients with known AF (n=75) who were receiving treatment from the Utah Heart Clinic and were currently taking Coumadin were asked to complete a one-time questionnaire of 52 questions related to Coumadin use and its’ drug-nutrient interactions. Data collected was analyzed to identify any vitamin K and diet knowledge deficits related to nutrition and Coumadin use.

Results: Sixty-eight of the patients had at least one risk factor for stroke with hypertension, the most common stroke risk factor (58.7% of the population). Age > 75 years was the second most common, followed by heart failure. Only 63.9% of the patient population had some understanding of diet/vitamin K and Coumadin use.

Conclusion: This study demonstrates a lack of patient knowledge regarding the interaction of Coumadin and nutrition/vitamin K in patients with additional stroke risk factors.
Introduction

Atrial Fibrillation and Stroke

Atrial fibrillation (AF) is the most commonly observed arrhythmia in clinical practice. The number of people affected by AF is expected to increase from 5.6 to over 12 million in the next few decades (1,2). Both the Framingham study and a cohort from Olmsted County, Minnesota have shown age-adjusted increases in the prevalence and incidence of atrial fibrillation from the 1960’s to 1989 (3-4). While age is a key risk factor for AF, other population demographics may also contribute to the increased prevalence of AF. The epidemiologic changes of AF are a global phenomena. The incidence and prevalence of AF in the Netherlands are similar to those in the US. AF admissions are also on the rise in China (5-6).

In patients with AF, systemic embolization can result from stasis in the left atrium and appendage, leading to stroke, significant morbidity, and/or mortality. Although absolute stroke risk varies among AF patients, stroke risk can be stratified based upon clinical and echocardiographic variables. Stroke risk factors, identified over the course of five AF prevention trials, include age >75 years, hypertension, diabetes, heart failure, and prior stroke or transient ischemic attack. There is a significant benefit obtained from the use of the anticoagulant medication Coumadin, as compared to aspirin, for the prevention of stroke in AF patients, particularly those at highest risk (i.e., those with more than one baseline risk factor) (7-11).

Risks of Coumadin Use

Although Coumadin is effective in reducing stroke, it carries with it the major concern of intracranial bleeding (12). The adjusted odds of developing intracranial bleeding (relative to an internationalized national ratio (INR) of 2.0 to 3.0) were 4.6 and 8.8 for INRs in the range of 3.5 to 3.9 and ≥ 4.0, respectively (12). Elderly patients and those with prior cerebrovascular disease represent some of the highest risk populations for stroke. However, these groups are also at
highest risk for intracranial bleeding with Coumadin anticoagulation. Similarly, risk of thromboembolism increases significantly when the INR is subtherapeutic, less than 2.0 (13). Due to the risks of over- and under-coagulation, chronic use of Coumadin requires frequent INR/protime monitoring.

**Coumadin anticoagulant Control and Education**

To attenuate the risk of intracranial bleeding and stroke, good anticoagulation control becomes essential in the long-term management of patients with AF. However, maintenance doses of Coumadin vary significantly, ranging from less than 2 mg/day to $\geq 10$ mg/day. The variability stems from many factors including: nutritional status, hepatic function, intestinal absorption, compliance, drug interactions, and genetic polymorphisms (14-16). Of these factors, understanding of drug interactions, nutrition, and compliance are those that can be positively influenced through intervention and education, improving patient outcomes.

**Coumadin and Drug Interactions**

Many drugs interact with the metabolism of Coumadin. The number increases almost daily as new drugs enter the patient market. These drugs can lead to overanticoagulation, underanticoagulation, or increased bleeding risk by INR independent changes, such as altered platelet function or gastrointestinal bleeding. Interactions with medications in patients taking Coumadin are a widespread problem in clinical practice. For example, in one study, nearly one-third of patients taking Coumadin had also been prescribed a medication known to adversely interact with Coumadin (17). Consequently, patients must be instructed not to take any new medications, including herbal products/supplements or over-the-counter medications, without the knowledge of their attending physicians. Although education communicating these ideas is widely available and frequently used for patients with cardiac disorders (e.g., Long QT syndrome), it is not frequently used for patients taking Coumadin.
**Vitamin K and its Role**

Related to nutrition, vitamin K intake must be closely monitored, as it is a key nutrient that interacts with anticoagulation therapy. Vitamin K plays a key role in the blood clotting cascade. Vitamin K’s principal action in blood clotting is to enable the generation of the active cofactor needed for carboxylation of glutamic acid, which interacts directly with clotting factors II, VII, IX, X, prothrombin, and specific clotting proteins (see Figure 1). Synthesis of glutamic acid allows for the binding of these factors and proteins to calcium, which is required for incorporation into the clotting cascade (18-20).

**Figure 1: Clotting Cascade - Vitamin K affects clotting factors II, VII, IX, and X (21)**

Interaction Between Vitamin K and Coumadin

Coumadin specifically targets the blood clotting cascade by inhibiting the regeneration of vitamin K from vitamin K epoxide. Thus, the medication blocks the generation of the cofactor required in the carboxylation of glutamic acid and the ability of the clotting factors to bind to calcium and participate in the clotting cascade (18-20). Due to decreased regeneration of vitamin K, the formation of vitamin K dependent clotting factors is much more susceptible to dietary intake (19). Consequently, intake of vitamin K, either through foods or supplementation, can alter the effect of Coumadin.

Figure 2: Coumadin interaction with Vitamin K (22)


Vitamin K Sources and RDA

The primary sources of dietary vitamin K are dark green vegetables such as broccoli, spinach, collard greens, romaine lettuce, and vegetables oils. From diet alone, the mean intake of vitamin K is between 74 and 117 mcg/day in adults, which meets the current adequate intake (AI) requirement of 90 mcg/d for adult women and 120 mcg/day for adult men (23-24). For
those taking Coumadin, the National Institute of Health recommends keeping vitamin K intake constant with no more than one serving of foods high in vitamin K and three servings of foods moderately high in vitamin K per day (23). Research regarding vitamin K and Coumadin has reported intakes as low as 29 to 40 mcg/day (19-24). Vitamin K intake is highly correlated with serum vitamin K, and some studies have noted serum levels less than 1.5 mcg/L compared to a normal value, which is considered to be greater than 4.5 mcg/L, in patients taking Coumadin with unstable anticoagulation control (23).

**Table 1: Sources of Vitamin K**

<table>
<thead>
<tr>
<th>Phylloquinone (Vitamin K) mcg/100g</th>
<th>&lt; 10</th>
<th>10-50</th>
<th>&gt; 100</th>
<th>&gt; 200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk</td>
<td>Asparagus</td>
<td>Cabbage</td>
<td>Broccoli</td>
<td></td>
</tr>
<tr>
<td>Butter</td>
<td>Celery</td>
<td>Lettuce</td>
<td>Kale</td>
<td></td>
</tr>
<tr>
<td>Eggs</td>
<td>Green beans</td>
<td>Brussels sprouts</td>
<td>Swiss chard</td>
<td></td>
</tr>
<tr>
<td>Cheese</td>
<td>Avocado</td>
<td>Mustard Greens</td>
<td>Turnip</td>
<td></td>
</tr>
<tr>
<td>Meats</td>
<td>Kiwi</td>
<td>Soybean oil</td>
<td>Watercress greens</td>
<td></td>
</tr>
<tr>
<td>Fish</td>
<td>Pumpkin (canned)</td>
<td>Canola oil</td>
<td>Collards</td>
<td></td>
</tr>
<tr>
<td>Corn</td>
<td>Peas</td>
<td></td>
<td>Spinach</td>
<td></td>
</tr>
<tr>
<td>Cauliflower</td>
<td>Peanut Butter</td>
<td></td>
<td>Salad greens</td>
<td></td>
</tr>
<tr>
<td>Grains</td>
<td>Lentils</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruits (most)</td>
<td>Kidney Beans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brewed tea</td>
<td>Pinto Beans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tomatoes</td>
<td>Soybeans</td>
<td>Coffee (brewed)</td>
<td>Olive oil</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Vitamin K Adult RDA Values

<table>
<thead>
<tr>
<th>Age/Gender</th>
<th>Vitamin K AI in mcg/d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male &gt; 19 years</td>
<td>120</td>
</tr>
<tr>
<td>Female &gt; 19 years</td>
<td>90</td>
</tr>
</tbody>
</table>

Source: Groper SS, Smith JL, Groff JL. Advanced Nutrition and Human Metabolism. 4\textsuperscript{th} ed. Wadsworth 2005 (25).

The Effect of Vitamin K Intake on INR

When assessing the interaction between vitamin K and Coumadin, it is important to monitor INR to assess the effect of dietary intake on the effectiveness of the Coumadin dose on blood clotting. The ideal INR range for AF patients taking Coumadin is 2.0-3.0 (23). Weekly changes of 714 mcg of dietary vitamin K intake have been found to significantly affect weekly INR values by one unit, equivalent to a weekly change in a Coumadin dose of 14.5 mg (18). Vitamin K intake of 150 mcg in women and 200 mcg in men is enough to significantly decrease INR. For every 100 mcg increase in vitamin K intake over at least 4 days, INR has been found to reduce by 0.2 units (18,23-24). Anticoagulant therapy with Coumadin is targeted at maintaining INR values between 2.0-3.0 to balance the risk between stroke and excessive bleeding. Intakes as low as 250 mcg can contribute to unstable anticoagulant therapy, and once vitamin K intake exceeds 500 mcg, it has been shown to reverse anticoagulation therapy (18).

Vitamin K and Unstable Anticoagulation

Patients with unstable coagulation compared to patients with stable INR values have consistently lower intakes of vitamin K. The impact of changes in vitamin K intake is amplified in patients with compromised vitamin K status and low serum values. In addition, it has been found that a patient’s INR decreases with addition of a multivitamin supplement containing only
25-50 mcg of vitamin K were found to significantly lower dietary intake and serum levels of vitamin K (19,20). Although patients are cautioned about leafy vegetables that can contain very high levels of vitamin K (one-half cup of frozen spinach contains >500 micrograms of vitamin K), other high vitamin K products are less well-known, such as herbal supplements and multivitamins (26).

**Vitamin K and Coumadin Dosing**

Consumption of less than 500 mcg of vitamin K per week requires on average a Coumadin dose of 35 mg/wk compared to 38 mg/wk Coumadin for vitamin K intakes of 500-1000 mcg/wk and 37 mg/wk Coumadin for intakes greater 1,000 mcg/wk of vitamin K (18). An average Coumadin dose increases from 3.5 mg/day to 5.7 mg/day with vitamin K intakes below 250 mcg/d and above 250 mcg/d, respectively (24). Participants, whose vitamin K intake remained constant, manifested little or no change in Coumadin dosing after correcting for other drug and supplement interactions. This finding supports the recommendation to consume a consistent amount of vitamin K (18,23-24).

**Patient Knowledge of Coumadin Side Effects**

Coumadin is a medication that has multiple adverse effects, many of which patients may be unaware of. In addition to using frequent INR testing, the main overt sign of inappropriate anticoagulation therapy is excessive bleeding or bruising. A pre-test administered by Mazor et al. (27) showed that 5% of participants were not aware that it was important to contact the anticoagulation clinic if they had a cut that would not stop bleeding, 13% did not know to contact the clinic if they noticed unexplained bruising or blood in their urine or stools, and 35% of participants did not know that excessive Coumadin could cause a gastrointestinal bleed (27). As INR can measure inappropriate responses to anticoagulation therapy, it is imperative that patients understand the importance of frequent testing.
In assessing patient attitudes towards INR testing, 13% of the pre-test respondents did not believe that missing a lab appointment on occasion was a problem and 12% reported being able to tell if their Coumadin was at the right level by how they physically felt (27). Finally, 83% of participants were aware that too little Coumadin could cause a stroke, but only 21% were aware that too much Coumadin could cause a stroke (27). Patients must be aware of the overt signs of inadequate coagulation and the importance of INR testing to appropriately monitor anticoagulation therapy and reduce risk of excessive bleeding and stroke.

**Patient Compliance**

Compliance to medications of any type is essential to receive study-validated benefits. In a prior study of elderly patients, nonadherence to Coumadin was estimated at 21%; the patients sampled missed pills more often rather than took too many (28). One important additional finding was that patients often perceived that they were more adherent than they actually were throughout the study. It is likely that patients not enrolled in a study will actually have much higher rates of nonadherence and will be at risk for either bleeding or thromboembolism as a result. Even if vitamin K education and knowledge in relation to Coumadin use is adequate it may not translate into appropriate INR values.

**Research Objective**

INR values outside of the recommended range of 2.0-3.5 increase the risk of intracranial bleeding and stroke (11). The relationship between vitamin K intake and changes in INR leading to over- and under-anticoagulation has been established (19-20,23-24). Although medical knowledge is not yet advanced enough to remediate many of the primary causes of variability, intervention and education focusing on proper nutrition and vitamin K intake may improve patient outcomes (14-16).
To date, few, if any, studies have measured patient understanding of Coumadin use and its implications in stroke and intracranial bleeding risk. The objective of this study was to assess the understanding of the AF population related to their role in reducing the risks associated with Coumadin and the effects of proper understanding on stroke risk with a particular emphasis on patient understanding of the interaction between vitamin K and Coumadin.

**Research Design and Methods**

This study was conducted at Intermountain Medical Center (Murray, Utah) in collaboration with Utah State University (Logan, Utah). Patients with known AF (n=75) who were receiving treatment from the Utah Heart Clinic and were currently taking Coumadin were asked to complete a one-time questionnaire of 52 questions related to Coumadin use and its interactions. Participation was voluntary and no identifying information was obtained. The questionnaire was completed under the supervision of a registered dietitian or student dietitian. The study was approved by the Utah State University Institutional Review Board (protocol #2187).

The data collected was analyzed to identify any vitamin K, vitamin supplement, and any knowledge deficits related to nutrition and Coumadin use. The data was stratified by stroke risk.

**Results**

The mean age of the patient population was 69.2 (n=75). The data was stratified by gender to assess differences between male and female. The patients were categorized according to stroke risk, based on the CHADS$_2$ Score. The CHADS$_2$ score is used to estimate risk of stroke in AF patients (7-11).
Sixty-eight of the patients had at least one risk factor for stroke (see Table 1). The seven remaining patients with no stroke risk factors were taking Coumadin because they had recently undergone a cardiac ablation.

Hypertension was the most common stroke risk factor (58.7% of the population). Age > 75 years was the second most common, followed by heart failure.

**Table 1. Stroke Risk Characteristics**

<table>
<thead>
<tr>
<th>Item</th>
<th>M+F n(%)</th>
<th>M n(%)</th>
<th>F n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>75</td>
<td>47</td>
<td>28</td>
</tr>
<tr>
<td>Age</td>
<td>69.2</td>
<td>66.7</td>
<td>72.3</td>
</tr>
</tbody>
</table>

**Stroke Risk**

1. Hypertension                44(58.7)  28(59.6)  16(57.1)
2. Heart failure                25(33.3)  14(29.8)  11(39.3)
3. Age > 75                     26(34.7)  12(25.5)  14(50.0)
4. Diabetes                     12(16.0)  7(14.9)   5(17.9)
5. TIA                          19(25.3)  11(23.4)  8(28.6)
6. TIA on Coumadin              6(8.0)    3(6.6)    3(10.7)

To assess general knowledge concerning Coumadin use, the data was categorized by response to certain questions in the questionnaire. Questions pertaining to diet in regards to Coumadin use were assessed. The following questions were used to assess knowledge: “Do you think getting enough vitamin K is important?”; “What do you think Vitamin K does for us?”; “Do you know how to interpret a supplement facts label?”; “Can changing your diet change your Coumadin dose?”; “Are you aware that you get vitamin K from the foods you eat?”; “Do you know how to interpret a nutrition facts label?”; and “Is it important to watch how much vitamin K you get each day when you are on Coumadin?” If the patient answered yes to one of the aforementioned questions, it was deemed that the patient had some knowledge related to
Coumadin use. Table 2 represents the percent of the patient population who had some understanding of diet and Coumadin use.

**Table 2. Coumadin Knowledge**

<table>
<thead>
<tr>
<th>Item</th>
<th>M+F</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietary influence (%)</td>
<td>63.9</td>
<td>65.1</td>
<td>61.8</td>
</tr>
</tbody>
</table>

**Discussion**

Seventy-five patients participated in this study. Of these, 68 had at least one stroke risk factor. Because only seven participants did not have at least one stroke risk, data was not analyzed by stroke risk versus non-stroke risk as originally intended. In the future, data will be stratified based on the number of stroke risks based on the CHADS₂ score.

This study found that 63.9% of the population had some knowledge related to diet and Coumadin use. Because the data was categorized by response to certain questions, the results do not identify any differences in knowledge regarding the differences in questions asked. In the future, the questions will be weighted by importance to assess the degree of knowledge of diet and Coumadin use.

Changes in INR are observed with short-term vitamin K intake; however, INR values and Coumadin dosing are not affected over an extended period of time if vitamin K intake returns to levels normally consumed by participants (23-24). Schurgers et al. (23) found that meals with a large amount of vitamin K rich foods significantly decreased INR by 0.3-0.6 units. However this effect was not maintained past three to seven days (23). Khan et al. (24) demonstrated a change of 0.2 units in INR with 100 mcg/d increases in vitamin K over a 4 and 7-day period. However, when INR levels were measured over 28 days following changes in vitamin K intake there was
no significant change in INR compared to baseline (24). Once Coumadin dosing has been
established and INR levels stabilize, most patients have their INR tested monthly. Short-term
changes in vitamin K intake that affect INR levels may not be noticed in monthly lab values due
to the stabilization of INR over time. This could be a concern with patients who are not aware of
the interaction of vitamin K and have a great variability in dietary vitamin K intake.

Patients taking Coumadin are instructed to maintain a consistent intake of vitamin K (23).
This can easily be misconstrued to mean that foods containing vitamin K should be avoided. In
addition, if patients are unaware of what foods contain vitamin K, it impacts their ability to
maintain consistency in vitamin K intake and may lead to avoidance of foods, which contain
little or no vitamin K (20). Misinterpretation of vitamin K recommendations may be the cause of
low dietary intake and serum vitamin K levels found in patients with unstable control (20). In
patients with low vitamin K intake and serum levels, use of a multivitamin containing 25 mcg of
vitamin K has been found to decrease INR by a median of 0.51. For those patients with normal
serum vitamin K levels who consume the RDA of vitamin K, use of a multivitamin containing
25 mcg of vitamin K has been found to have no significant change in INR (23).

Chronic low dosing of vitamin K may attenuate INR changes in response to small
variations in vitamin K intake in those patients with low serum values. Sorano et al. (29)
demonstrated an improvement of anticoagulation therapy when patients consume at least 20-40
mcg/day of vitamin K. The effectiveness of chronic supplementation of vitamin K needs to be
investigated further to determine if this is feasible and safe. Furthermore, changes in patient
education regarding Coumadin may help improve patients understanding of appropriate intake of
vitamin K and in what products it can be found.

Couris et al. (30) developed a brief, self-assessment instrument (K-Card) to determine daily
variations in dietary vitamin K intake that could be validated and used in the assessment of patients
receiving oral Coumadin anticoagulant therapy. The K-card included foods that previous studies have shown provide 5 mg vitamin K per serving, foods with lower vitamin K contents that are consumed in larger quantities, and common supplements and herbal products. The items listed were color coded into categories such as vegetables, meat/poultry/fish, mixed dishes, fats/oils/salad dressings, snacks, desserts, beverages, and dietary supplements (30). The mean dietary vitamin K intake estimated using the K-Cards was 138.8 +/- 15.7 mg compared to diet record averages of 136.0 +/- 15.8 (30). Self-assessment measures such as the K-Card can accurately assess vitamin K status and may be helpful in increasing patient understanding of what foods contain vitamin K.

This study showed that over 30% of patients were unaware of the effects of nutrition and vitamin K on Coumadin therapy and stroke risk. While 63.9% of patients had some knowledge of vitamin K and its interaction with Coumadin, they may have only answered one question regarding nutrition and vitamin K correctly. The percent of patients who have some knowledge regarding nutrition and Coumadin may be overstated, as it does not account for the level of knowledge the patient had about this relationship or the level of awareness the patient had pertaining to what foods and products contained vitamin K. In short, many patients are still lacking the necessary education regarding Coumadin to maintain adequate INR values and minimize the risk of stroke and intracranial bleeding.

In a randomized clinical trial conducted by Khan et al. (31), 125 patients over the age of 65 were divided into three groups: patients who received usual clinical care, patients who received additional education regarding Coumadin, and patients who received additional Coumadin education in combination with education on how to self-monitor INR. Coumadin education was done in a two-hour session given to patients in groups of 2-3 that covered information regarding atrial fibrillation, clinical benefits and risk of Coumadin use, and factors that affect INR with emphasis on drug interactions and diet (31). The INR standard deviation
decreased by 0.24 in the combination group, 0.26 in the Coumadin education group, and only 0.16 in the control group meaning that those who received additional Coumadin education beyond usual care had a decreased variability in INR (31).

Although personalized patient education is effective in increasing patient knowledge, it is costly and time consuming for healthcare employees. Mazor et al. (27) compared the effectiveness of videos depicting dialogue between a physician and patient regarding Coumadin use and its interactions to a control group who received standard care. Coumadin-related knowledge and belief in the importance of lab testing improved between pre and post-test for those patients who viewed the educational video, either with statistical evidence, narrative evidence, or a combination of both, compared to the control group who received usual care and not the educational video (27). Additional attention toward administration of appropriate education can lead to increased patient knowledge.

Stone et al. (32) compared the use of personalized patient education with the use of educational videotapes. Both groups scored significantly higher on post education questionnaires designed to assess knowledge. In addition, this study found no difference in knowledge improvement between patients who received Coumadin education through personalized teaching or videotape (32). A follow-up questionnaire showed that patients in each group rated the effectiveness and importance of the education equally (32).

One-on-one teaching by physicians and nurses is time consuming. In the current era of both physician and nursing shortages, one-on-one teaching is not feasible for diseases that are highly prevalent in the community, such as AF. An alternative is group teaching through audiovisual presentations (videotapes, DVDs, or internet-based). Audiovisual presentations have been shown to be effective tools if the presentations are appropriate for the audience, brief and focused, and deliver the necessary information (33-35). Patients can view these presentations in
their homes as frequently as needed. One addition concern to using these educational methods to increase knowledge is how to ensure knowledge is translated to action and improved patient results.

**Conclusion**

This study demonstrates a lack of patient knowledge regarding the interaction of Coumadin and vitamin K in patients with additional stroke risk factors. Inadequate education regarding vitamin K and its interaction with Coumadin can lead to an increased risk of stroke and intracranial bleeding (12,13,18). Education of the drug-nutrient interaction of Coumadin can reduce patient risk when coupled with compliance and can be effectively administered through audiovisual mediums. Further research is warranted to quantify the effect of lack of patient knowledge on morbidity and mortality and appropriate educational interventions (31).
References

3. Tsang, TS et al. The prevalence of atrial fibrillation of incident stroke cases and matched population controls in Rochester, Minnesota. *J of Amer College of Cardiology* 2003;42:93-100


Age ________

Please circle:

Gender
Male
Female

Education Level
Less than the 8th Grade
8-12th Grade
High School Graduate
College Graduate
Advanced Degree

Stroke Risk Factors
1. High blood pressure: Yes/No
2. Heart failure: Yes/No
3. Age greater than 75 years: Yes/No
4. Diabetes: Yes/No
5. Prior stroke or mini-stroke (TIA): Yes/No
6. Prior stroke or mini-stroke when on Coumadin: Yes/No

If you had a stroke on Coumadin, was your blood level:

a. Too low
b. Normal
c. Too high
d. Not sure
Other Cardiac Problems

1. Have you had a prior heart attack: Yes/No
2. Have you had a stent or bypass surgery: Yes/No
3. Do you have any problems with your heart valves: Yes/No
   If yes, was the problem:
   a. Narrow
   b. Leaky
   c. Not sure
4. Have you had surgery for your heart valves: Yes/No

Please answer the following questions:

1. Have you ever experienced bleeding in your urine or stools? Yes/No
2. Have you ever received a blood transfusion because of bleeding? Yes/No
3. Have you fallen in the past year? Yes/No
4. If you have fallen in the past year, how many times? _____
5. How long have you been on Coumadin?
   a. Less than 1 year
   b. 1 year – 5 years
   c. 5 years – 10 years
   d. Greater than 10 years
   e. Not sure
6. Do you take your Coumadin as prescribed by your doctor? Yes/No
7. Do you ever skip your Coumadin dose? Yes/No
8. Do you ever double up your Coumadin dose? Yes/No
9. Do you ever not refill your Coumadin because of cost? Yes/No
10. What is the most common reason why you may not take your Coumadin dose?
    a. Cost
    b. Forgetting
c. Mixing up medications  
d. Lack of desire  
e. Illness  
f. None of the above  

11. Have you gained weight after starting Coumadin? Yes/No  
12. If yes, approximately how much weight have you gained? _____  
13. If yes, why do you think you gained the weight? (Circle all that apply)  
   a. Changed diet and avoided vegetables  
   b. Exercised less  
   c. Ate more at each meal  
   d. Craved new foods that were less healthy  
14. Have you lost weight after starting Coumadin? Yes/No  
15. If yes, approximately how much weight have you lost? _____  
16. If yes, why do you think you lost the weight? (Circle all that apply)  
   a. Changed diet and avoided many foods  
   b. Illness  
   c. Ate less at each meal  
   d. Stopped drinking alcohol  
17. What is considered a normal INR (blood Coumadin level)?  
   a. Less than 1  
   b. 2-3  
   c. 4-5  
   d. Greater than 5  
   e. Not sure  
18. Do you know what your current INR (blood Coumadin level) is? Yes/No  
19. Approximately how often do you get your INR (blood Coumadin level) checked?  
   a. Once a week
b. Twice a month

c. Once a month

d. Twice a year

e. Once a year

d. Never

def. Not sure

20. Do you ever not get your INR (blood Coumadin level) checked because of cost? Yes/No

21. Are you aware that your other medications can interact with Coumadin? Yes/No

22. Do you ask your pharmacist before starting a new medication if it interacts with Coumadin? Yes/No

23. Do you ever take over-the-counter pain medications? Yes/No

24. If yes, which ones? (Circle all that apply)
   Excedrin® Tylenol® (Acetaminophen) Aleve® (Naproxen)
   Advil® (Ibuprofen) Motrin® (Ibuprofen) Aspirin

25. Do you ask your doctor before using over-the-counter pain medications? Yes/No

26. Do you ever take over-the-counter stomach remedies? Yes/No

27. If yes, which ones? (Circle all that apply)
   Tagamet HB® (Cimetidine) Pepto Bismol® (Bismuth Subsalicylate)
   Laxatives Stool Softeners
   Alka-Seltzer®

28. Do you ask your doctor before using over-the-counter stomach remedies? Yes/No

29. Do you take vitamin supplements? Yes/No

30. If yes, which ones (Circle all that apply)
   Multivitamin (Dose: )
   Vitamin A (Dose: )
   Vitamin E (Dose: )
   Vitamin D (Dose: )
   Vitamin C (Dose: )
31. Are you aware that vitamin supplements can interact with Coumadin? Yes/No

32. Do you ask your doctor before using a vitamin supplement if it interacts with Coumadin? Yes/No

33. Do you think getting enough Vitamin K is important?
   a. Yes
   b. No
   c. Not sure

34. What do you think Vitamin K does for us? (Circle all that apply)
   a. Improves eye sight
   b. Strengthens bones
   c. Improves the texture and softness of skin
   d. Helps to form clots
   e. It is an anti-oxidant to help the body

35. Do you take any herbal or natural medications or supplements? Yes/No

36. If yes, which ones? (Circle all that apply)
   Garlic  Ginger  Glucosamine
   Ginko Biloba  CoEnzyme Q10  Green Tea
   St. John’s Wort  Flaxseed  Melatonin
   Papaya Extract  Ginseng  Soy Protein Products
   Fish oil supplements that contain EPA or DHA

37. Are you aware that natural medications or supplements can interact with Coumadin? Yes/No

38. Do you ask your doctor before using a natural medication or supplement if it interacts with Coumadin? Yes/No

39. Do you know how to interpret a supplement facts label on natural medications or supplements? Yes/No

40. How often do you drink alcoholic beverages?
   a. Every day
   b. 4-6 days a week
   c. 2-3 days a week
d. Once a week

e. 2-3 times a month

d. Once a month

e. Less than once a month

f. Never

41. How often do use tobacco products?

a. Every day

b. 4-6 days a week

c. 2-3 days a week

d. Once a week

e. 2-3 times a month

d. Once a month

e. Less than once a month

f. Never

42. Can changing your diet change your Coumadin dose?

a. Yes

b. No

c. Not sure

43. How often do drink grapefruit juice or eat grapefruit?

a. Every day

b. 4-6 days a week

c. 2-3 days a week

d. Once a week

e. 2-3 times a month

d. Once a month

e. Less than once a month

f. Never
44. Are you aware that grapefruit and grapefruit juice interact with Coumadin?
   a. Yes
   b. No
   c. Not sure

45. Are you aware that you get Vitamin K from the foods you eat?
   a. Yes
   b. No
   c. Not sure

46. How much Vitamin K do the following foods contain? Please circle the amount:

<table>
<thead>
<tr>
<th>Food</th>
<th>Amount</th>
<th>0-9 mcg</th>
<th>10-29 mcg</th>
<th>30-89 mcg</th>
<th>99-1200 mcg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooked broccoli (1 cup)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetable Oil (1 Tbsp)</td>
<td></td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
</tr>
<tr>
<td>Canned tuna in oil (3 oz)</td>
<td></td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
</tr>
<tr>
<td>Iceberg lettuce (1 cup)</td>
<td></td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
</tr>
<tr>
<td>Cooked spinach (1 cup)</td>
<td></td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
</tr>
<tr>
<td>Coleslaw (3/4 cup)</td>
<td></td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
</tr>
<tr>
<td>Red grapes (1 cup)</td>
<td></td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
</tr>
<tr>
<td>Green leaf lettuce (1 cup)</td>
<td></td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
</tr>
<tr>
<td>Walnuts (14 halves)</td>
<td></td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
</tr>
<tr>
<td>Grapefruit juice (1 cup)</td>
<td></td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
</tr>
<tr>
<td>Red wine (3.5 fl oz)</td>
<td></td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
</tr>
<tr>
<td>Olive Oil (1 tbsp)</td>
<td></td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
</tr>
<tr>
<td>Food Description</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------</td>
<td>-----------</td>
<td>-----------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Cooked asparagus (4 spears)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>Raw celery (1 stalk)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>Vanilla ice cream (1/2 cup)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>Avocado (3 oz)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>75% lean ground beef (3 oz)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>Roasted chicken (1 drumstick)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>Raw pineapple (1 cup)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>Cooked salmon (1/2 fillet)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>Swiss cheese (1 oz)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>2% milk (1 cup)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>Hard-boiled egg (1 large)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
<tr>
<td>Chunky peanut butter (1 Tbsp)</td>
<td>0-9 mcg</td>
<td>10-24 mcg</td>
<td>25-99 mcg</td>
<td>100-499 mcg</td>
<td></td>
</tr>
</tbody>
</table>

47. Do you know how to interpret a nutrition facts label on food products? Yes/No

48. How many meals do you eat each day?
   a. One
   b. Two
   c. Three
   d. Four
   e. Five
   f. Less than one
49. How many meals do you eat each day with Vitamin K?
   a. One
   b. Two
   c. Three
   d. Four
   e. Five
   f. Less than one
   g. More than 5
   h. Not sure

50. Is it important to watch how much Vitamin K you get each day when you are on Coumadin?
   a. Yes
   b. No
   c. Not sure

51. Do you believe that taking Coumadin negatively influences your quality of life? Yes/No

52. If yes, why do you think Coumadin negatively influences your quality of life? (Circle all that apply)
   a. Frequent blood draws
   b. Don’t get to eat your favorite foods
   c. Diet is too restrictive
   d. No longer drink alcohol or only occasionally
   e. Worry about bleeding
   f. Feel unwell or experience side effects on the medication