Worcestershire Acute Hospitals NHS Trust

Thromboprophylaxis in Pregnancy and Puerperium

Key Document code:	WAHT-TP- 094	
Key Documents Owner/Lead:	Dr Hillman	Consultant Obstetrician
Approved by:	Maternity Governance Meeting	
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Key Amendments

Date	Amendments	Approved by

With effect from June 1st 2018 we are adapting RCOG guideline (RCOG Green-top Guideline No. 37a) on Thromboprophylaxis during pregnancy and puerperium.

Please see the link directed to RCOG guideline.

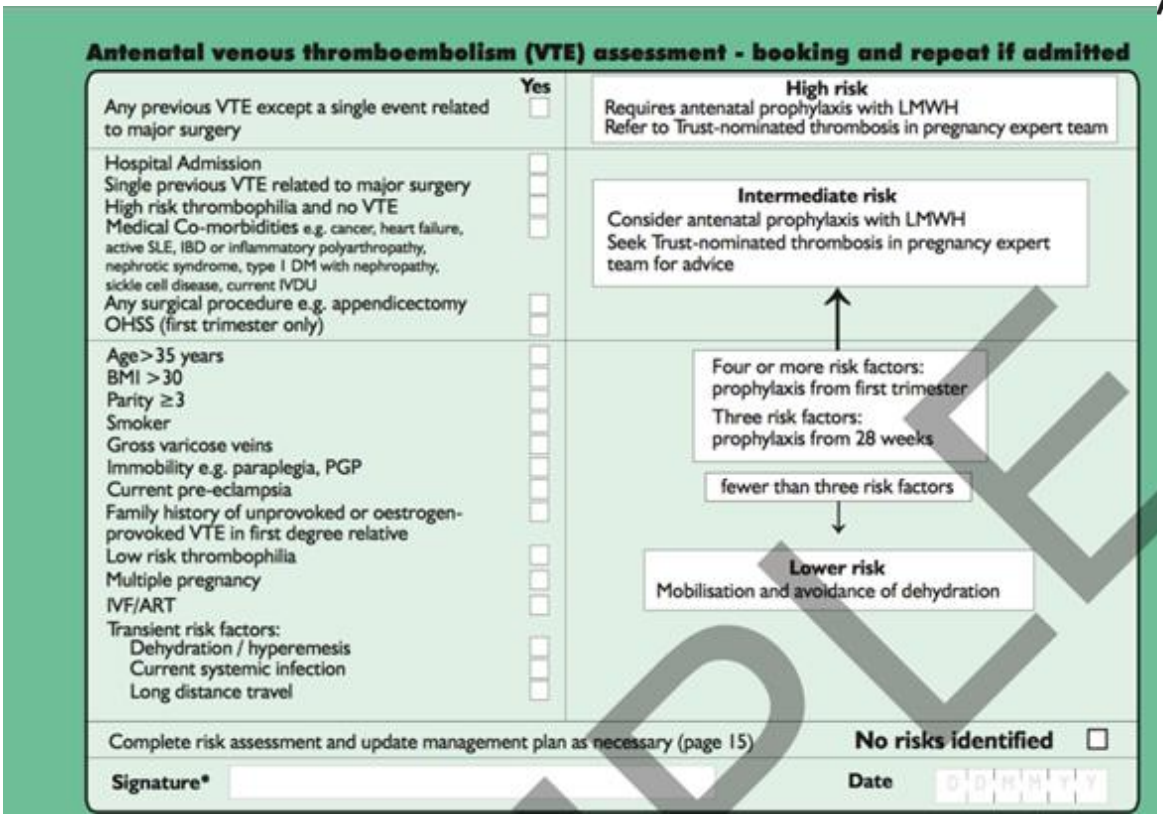
https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-37a.pdf

All women should undergo a documented assessment of risk factors for VTE in early pregnancy or pre-pregnancy. Risk assessment should be repeated again intrapartum or immediately postpartum.

Please see the information below to guide the risk assessment process during booking, AN admission and post-delivery. If further information is needed please refer to RCOG Guideline accessed from the above link

VTE Risk assessment at Booking:

See the copy of VTE risk assessment form from Green handheld maternity records. This must be filled in during booking.



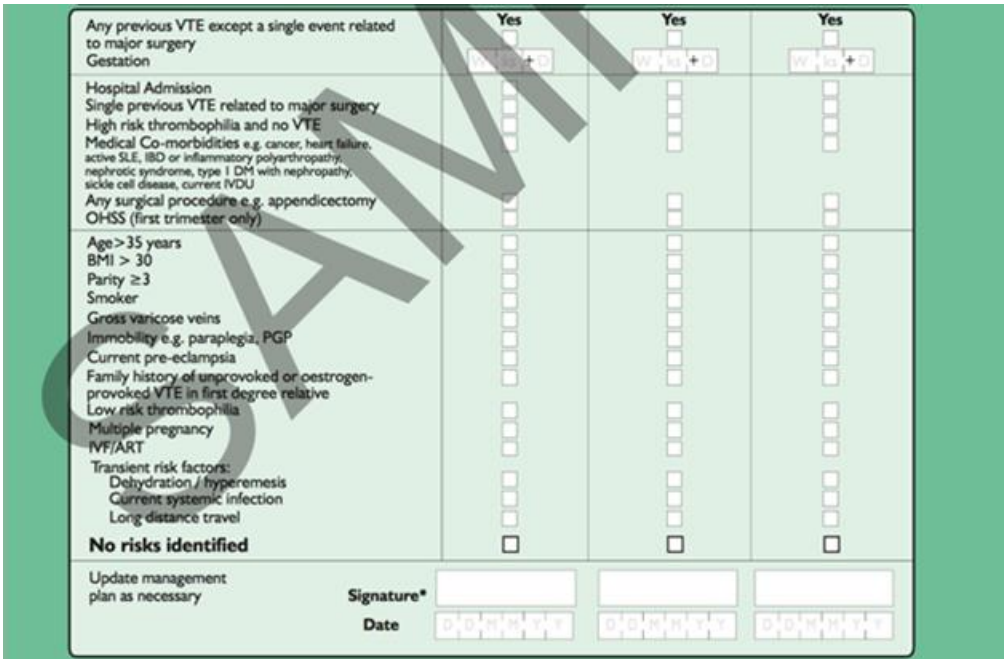
Risk Factors	Management Plan
3 current risk factors (other than previous VTE or thrombophilia)	prophylactic LMWH from 28 weeks till 6 weeks postnatally
4 or more current risk factors (other than previous VTE or thrombophilia)	LMWH throughout the antenatal period till 6 weeks postnatally

Previous VTE	Management plan
• Antithrombin deficiency • APS • Recurrent VTE	Higher dose LMWH (either 50%, 75% or full treatment dose) antenatally and for 6 weeks postpartum or until returned to oral anticoagulant therapy after delivery
• Unprovoked &Idiopathic VTE • VTE-Estrogen related	LMWH throughout the antenatal period till 6 weeks postnatally
• VTE provoked by major surgery (no other risk factors)	LMWH from 28 weeks till 6 weeks postnatally

VTE Risk assessment at AN Admission:

Risk assessment should be repeated if the woman is admitted to hospital for any reason or develops other intercurrent problems.

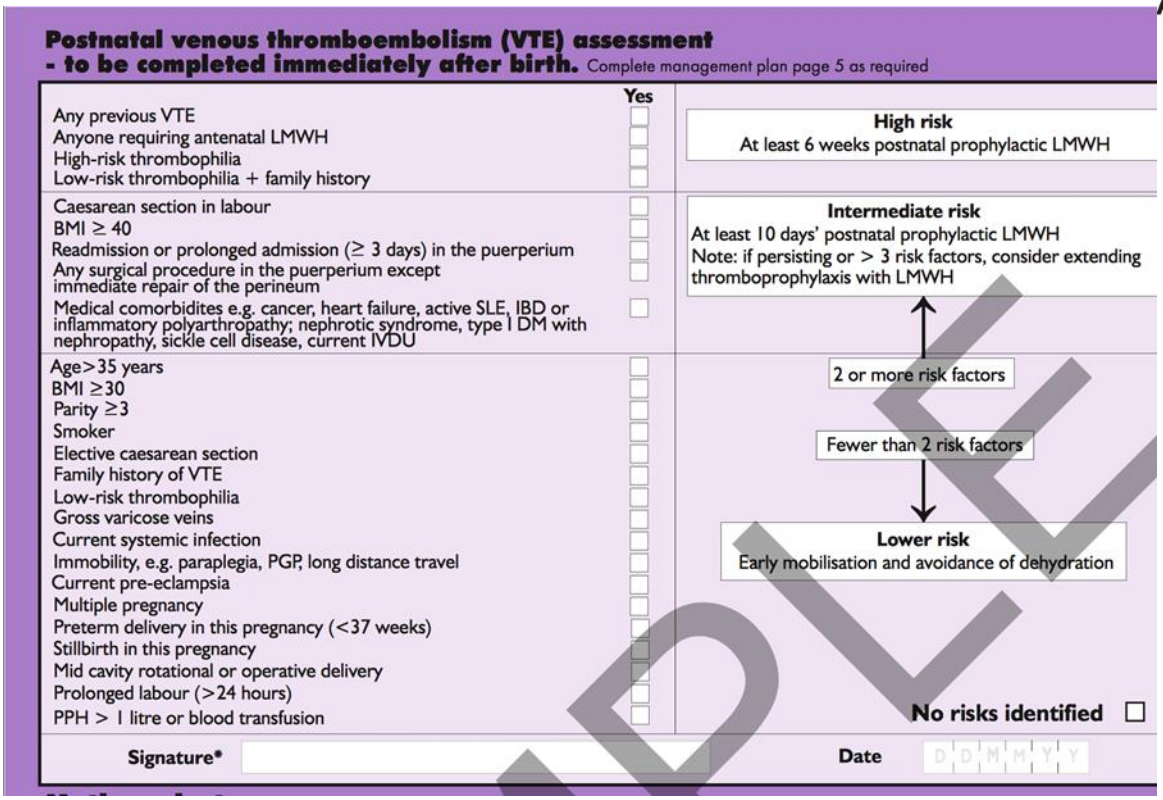
See the copy of VTE risk assessment form from Green handheld maternity records. This must be filled in during any other hospital admission



	Yes	Yes	Yes
Any previous VTE except a single event related to major surgery	☐	☐	☐
Gestation	W + D	W + D	W + D
Hospital Admission	☐	☐	☐
Single previous VTE related to major surgery	☐	☐	☐
High risk thrombophilia and no VTE	☐	☐	☐
Medical Co-morbidities e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy, nephrotic syndrome, type 1 DM with nephropathy, sickle cell disease, current IVDU	☐	☐	☐
Any surgical procedure e.g. appendicectomy	☐	☐	☐
OHSS (first trimester only)	☐	☐	☐
Age>35 years	☐	☐	☐
BMI > 30	☐	☐	☐
Parity ≥3	☐	☐	☐
Smoker	☐	☐	☐
Gross varicose veins	☐	☐	☐
Immobility e.g. paraplegia, PGP	☐	☐	☐
Current pre-eclampsia	☐	☐	☐
Family history of unprovoked or oestrogen-provoked VTE in first degree relative	☐	☐	☐
Low risk thrombophilia	☐	☐	☐
Multiple pregnancy	☐	☐	☐
IVF/ART	☐	☐	☐
Transient risk factors:			
Dehydration / hyperemesis	☐	☐	☐
Current systemic infection	☐	☐	☐
Long distance travel	☐	☐	☐
No risks identified	☐	☐	☐
Update management plan as necessary			
Signature*			
Date	D D M M Y Y	D D M M Y Y	D D M M Y Y

VTE Risk assessment – Post-natal

See the copy of VTE risk assessment form from Green handheld maternity records. Risk assessment should be repeated again intrapartum or immediately postpartum.



Risk Factors	Management Plan
Previous VTE AN LMWH Thrombophilia	6 weeks PN Prophylactic LMWH
BMI greater than or equal to 40 kg/m2	Prophylactic LMWH in doses appropriate for their weight for 10 days after delivery.
2 or more persisting risk factors	Prophylactic LMWH in doses appropriate for their weight for 10 days after delivery.
Less than 2 risk factors	Early mobilisation and avoid dehydration

Thromboprophylaxis during labour and delivery and the use of regional analgesia:

- Women receiving antenatal LMWH should be advised that if they have any vaginal bleeding or once labour begins they should not inject any further LMWH. They should be reassessed on admission to hospital and further doses should be prescribed by medical staff.
- Regional techniques should be avoided if possible until at least 12 hours after the previous prophylactic dose of LMWH.
- LMWH should not be given for 4 hours after use of spinal anaesthesia or after the epidural catheter has been removed and the catheter should not be removed within 12 hours of the most recent injection.
- When a woman presents while on a therapeutic regimen of LMWH, regional techniques should be avoided if possible for at least 24 hours after the last dose of LMWH.
- Women receiving antenatal LMWH having an elective caesarean section should receive thromboprophylactic dose of LMWH on the day prior to delivery and, on the day of delivery, any morning dose should be omitted and the operation performed that morning.
- The first thromboprophylactic dose of LMWH should be given as soon as possible after delivery provided there is no postpartum haemorrhage and regional analgesia has not been used.
- Women at high risk of haemorrhage with risk factors including major antepartum haemorrhage, coagulopathy, progressive wound haematoma, suspected intra-abdominal bleeding and postpartum haemorrhage may be managed with anti-embolism stockings (AES), foot impulse devices or intermittent pneumatic compression devices.

If a woman develops a haemorrhagic problem while on LMWH the treatment should be stopped and expert haematological advice sought. Thromboprophylaxis should be started or reinstituted as soon as the immediate risk of haemorrhage is reduced.