# Management of Acute Thromboembolism in Pregnancy - Primary Care Guidance

**NEW Diagnosis VTE in pregnancy**

Venous thromboembolic events (VTE) occur in approximately 1-2 per 1000 women during pregnancy and the postnatal period. Thromboembolic disease is 10x more common in pregnant women than non-pregnant women of the same age, with the postnatal period being the time of highest risk. VTE remains one of the main direct causes of maternal death in the UK. Pregnancy is a risk factor for VTE and any woman with a suspected VTE should be referred to the appropriate service urgently and seen on the same day.

**EXISTING diagnosis of VTE who become pregnant**

Women are advised to avoid pregnancy for 6 months after acute VTE. Women who wish to consider pregnancy sooner than this or who would like to discuss a pregnancy with a previous diagnosis of VTE can be referred for a pre pregnancy counselling appointment to the Obstetric Haematology Service at Nottingham University Hospitals Trust (NUHT), this includes Sherwood Forest Hospitals (SFHFT) patients also.

All women who become pregnant whilst on treatment for current VTE should be referred as follows:

- NUHT patients should be referred to the rapid access clinic at NUHT.
- SFHFT patients should be referred to the on-call Consultant Obstetrician at SFHFT.

Women who become pregnant whilst on **prophylactic or treatment doses of low molecular weight heparin (LMWH)** should continue their current dose pending clinic appointment.

Women who become pregnant whilst on **long-term warfarin or other oral anticoagulants** should be changed to LMWH as soon as possible.

- If there is a pre-existing plan for the management of anticoagulation in pregnancy - this should be followed.
- If there is no plan for anticoagulation management – contact haematology on call team for immediate advice (NUHT or SFHFT).

All women with a history of VTE should be advised that if they become pregnant, they should contact GP or CMW team **as soon as pregnancy detected.**

**Initial treatment doses in pregnancy (dose banded)**

**Enoxaparin** is the low-molecular-weight-heparin (LMWH) of choice in Nottinghamshire. It must be prescribed **by brand (Arovi®, Inhixa®, Clexane ®) and is AMBER 2** on the formulary (prescribing advised by a specialist). For further information see APC Enoxaparin Information Sheet.

**Enoxaparin dose: 1mg/kg TWICE a day**, based on early pregnancy or booking weight.

| Early pregnancy weight | Dose of s/c enoxaparin for VTE treatment in pregnancy |
|---|---|
| <50kg | 40mg twice a day |
| 50 – 69kg | 60mg twice a day |
| 70 – 89kg | 80mg twice a day |
| 90 – 109kg | 100mg twice a day |
| 110 – 125kg | 120mg twice a day |
| More than 125kg | Discuss with haematologist |

**Course length and ongoing plan**

- For acute VTE in pregnancy, women will be taught at diagnosis by their treating team how to self-inject LMWH, dispose of sharps and where to highlight any potential complications.
- **Treatment with LMWH should be continued throughout pregnancy and for at least 6 weeks postnatally, to a minimum of 3 months treatment. This will be decided by obstetrics/haematology team and communicated to primary care (duration, dose etc).** This may include a plan for future pregnancies.
- Any dose changes of LMWH advised during pregnancy should be communicated to the GP by the obstetric team.
- A plan on management of anticoagulation during induction of labour, spontaneous labour, or elective surgery, will be made between haematology and obstetric teams.
- **The woman should be advised to omit her dose if she thinks she is in labour,** with all future doses to be prescribed by medical staff.

**Following delivery**

- All women with a VTE diagnosis in pregnancy must have a comprehensive discharge summary for the CMW and GP to follow.
- A postnatal appointment should be made with the appropriate consultant within 6 weeks of delivery, which will include advice for future pregnancies if appropriate.
- Post-delivery anticoagulation will be advised by the obstetric/haematology team and communicated to the GP.
- **Warfarin is not** contraindicated in breastfeeding women.
- **DOACS are contraindicated in pregnancy but growing evidence for use in breastfeeding women; may be advised by the obstetric/haematology only with appropriate counselling of the women.**
- **Women should ensure they have effective contraception if commencing warfarin or DOACs due to potential teratogenic effects.**

**PRESCRIBING IN GENERAL PRACTICE**

Obstetric team/CMW team will provide detailed information about the enoxaparin brand, dose, duration, replacement sharps bin, alongside the name and role of initiating/recommending clinician. GP to add to repeat:

- Detailing when to stop (6 weeks post-natal/3 months post-event, whichever is later/unless otherwise advised).
- Only 4 weeks supply to be issued at a time (in case of dose changes etc.).
- Brand – continue as initiated by specialist but note Arovi® and Inhixa® devices are interchangeable so can be swapped (no new device training needed).
- Replacement sharps bin. Full bins must be disposed of via the local council Domestic Clinical Waste Collection service (see individual websites for details).

**REFER to antenatal clinic/Maternity Advice line if there are concerns.**