THROMBOPROPHYLAXIS IN PREGNANCY - Primary Care Guidance

NHS
Nottinghamshire Area Prescribing Committee

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.
Please note: VTE remains one of the main direct causes of maternal death in the UK.

Planning for pregnancy

Most women need no pre-pregnancy VTE planning.
Women who are high risk for VTE may have a plan in place for if/when they become pregnant.
Women with previous venous thrombosis can be referred for pre pregnancy counselling to NUH obstetric haematology clinic (for NUH and SFH), to plan for pregnancy management.

Once pregnancy confirmed

- All women with a history of VTE (unless provoked by a single event related to surgery) should have prophylactic enoxaparin throughout pregnancy - initiated as soon as possible after pregnancy is detected. **These women are the highest risk for VTE in pregnancy.**
- If there is a plan for VTE risk reduction in pregnancy prescribe as advised (if contraindications identified contact haematology team for advice).
- If concerns that a patient is high risk and needs prophylaxis, but there is no existing plan, please telephone on-call haematologist to discuss immediate thromboprophylaxis (via NUH/SFH switchboard) or contact Maternity advice line (NUH: 0115 9709777, SFH: 01623 676170).
- Women on **long-term warfarin or other oral anticoagulants** should be advised to contact community midwife or GP as soon as they find out they are pregnant. Oral anticoagulant therapy should be changed to LMWH as soon as pregnancy is confirmed (phone haematology if any queries).

VTE Risk Assessment (VTE RA)

The Royal College of Obstetrics and Gynaecology (RCOG) VTE RA score identifies women who should be offered LMWH in pregnancy: Reducing the Risk of Thrombosis and Embolism during Pregnancy and the Puerperium (Green-top Guideline No. 37a) | RCOG .

- All women should undergo an RCOG VTE RA undertaken by their CMW at **booking, 28 weeks and if new risk factors develop**
- They should have repeat VTE RA undertaken by the hospital team at any **antenatal admission to hospital and after delivery**
- Women who have sufficient risk score should be offered thromboprophylaxis with enoxaparin in pregnancy (see table)
- VTE RA score should be recorded on BadgerNet

Antenatal RCOG VTE RA score
Total score ≥4 risk factors, offer thromboprophylaxis from first trimester and usually for 6 weeks postnatally.
Total score 3 risk factors, offer thromboprophylaxis from 28 weeks

Prophylaxis treatment during pregnancy

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

- **Early pregnancy or booking weight can be used to guide enoxaparin dosing.**
- Some women may score **≥4** on VTE risk assessment at booking. They will require enoxaparin prophylaxis initiating as soon as possible (see tables).
- Women scoring **3** at booking or at 28 weeks will need prophylactic enoxaparin from 28 weeks.
- **Aspirin** is not recommended for thromboprophylaxis in pregnancy. Women may also be on low dose aspirin for pre-eclampsia.

Please Note: If other heparins such as tinzaparin or fondaparinux are required please refer to haematology on the same day as these cannot be prescribed in Primary Care even after specialist recommendation.

Weight	Thromboprophylaxis dose of enoxaparin in pregnancy
<50kg	20mg once daily
50 – 90kg	40mg once daily
91 – 130kg	60mg once daily
131 – 170kg	80mg once daily
More than 170 kg	0.6mg/kg/day

Following delivery

- **ALL** women must undergo a VTE risk assessment immediately post-delivery and on any readmission up to 6 weeks post-natal.
- Hospital will prescribe and supply sufficient medication at discharge for the advised period (10 days or 6 weeks).
- Enoxaparin is safe in breastfeeding.

Postnatal RCOG VTE RA score
Total score 2 risk factors postnatally, consider thromboprophylaxis for 10 day
Total score ≥3 risk factors postnatally, consider thromboprophylaxis for 6 weeks.

PRESCRIBING IN GENERAL PRACTICE

Obstetric 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.
- Only 4 weeks supply to be issued at a time (in case of dose changes, reduce waste).
- 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).

Managing enoxaparin injections in pregnancy - a practical guide

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