UNC SCHOOL OF MEDICINE

VTE Prophylaxis Guidelines for Inpatient Obstetrics

Antepartum Hospitalized Patient

- All patients should receive SCDs
  - Patient declination must be documented (recommend chemoprophylaxis as alternative)
- Continue chemoprophylaxis (Heparin or LMWH) if previously receiving prophylactic or full anticoagulation
- Add prophylactic anticoagulation (Heparin or LMWH) if:
  - BMI >40
  - Personal Hx VTE not already on prophylaxis
  - ≥2 Risk Factors (see below)
  - Consider if anticipated inpatient stay > 72 hours

Postpartum Hospitalized Patients

- Cesarean
  - All patients receive SCDs placed prior to delivery and continue until fully ambulatory
  - Continue any antepartum prophylactic or full anticoagulation
  - Add prophylactic chemotherapy (Heparin or LMWH) if:
    - BMI >40
    - Personal Hx VTE not already on prophylaxis
    - Family Hx VTE plus any thrombophilia
    - ≥2 Risk Factors (see below)
- Vaginal
  - Continue any antepartum prophylactic or full anticoagulation
  - Add chemoprophylaxis (Heparin or LMWH) if:
    - Personal Hx VTE not already on prophylaxis
    - Family Hx VTE plus any thrombophilia
    - ≥2 Risk Factors (see below)

Discharge Chemoprophylaxis: See VTE Algorithm on mombaby.org

Risk Factors (recommend chemoprophylaxis with 2 or more)	
Any Thrombophilia not already on prophylaxis Age >40 BMI > 30 Medical complications (IBD, Sickle cell, SLE, Heart disease, renal disease, Major infection, Diabetes, etc.) Pregnancy complications (Multiples, HTN, IUGR) Strict bed rest	Peripartum hemorrhage Hysterectomy General anesthesia Severe postpartum infection

Prophylactic dosing: Typical regimen is 40 mg / day LMWH, or heparin regimen below. There is inconsistent evidence upon which to base recommendations for dose adjustments in obese patients. If desired, our suggested regimen is below.

Prophylactic Anticoagulation Regimens			
Enoxaparin		**Unfractionated Heparin**	
<50 kg	20 mg daily	1st trimester	5,000-7,500 U q 12 hrs
50-90 kg	40 mg daily	2nd trimester	7,500-10,000 U q 12 hrs
91-130 kg	30 mg BID	3rd trimester	10,000 U q 12 hrs
131-170 kg	40 mg BID		
>170 kg	0.6 mg/kg/day in 2 divided doses		

Postpartum Dosing Schedule:

- Prophylactic: 6 hours after vaginal delivery; 12 hours after cesarean
  - Must be ≥ 2 hours after epidural removal
- Therapeutic: 12 hours after vaginal or cesarean
  - Must be ≥ 12 hours after epidural removal

Possible Contraindications to Chemoprophylaxis

1. Antepartum bleeding
2. Hemophilia / bleeding disorder
3. Thrombocytopenia (< 75k)
4. Recent CVA
5. Severe renal disease (GFR < 30)
6. Prolonged PT / severe liver disease
7. Uncontrolled HTN

References:

1. Prophylaxis in Adults. UNC Health Care Guidance Document. Oct. 2014. Brain Murray, Pharm.D., Stephon Moll, MD.
2. Reducing the risk of venous thromboembolism during pregnancy and puerperium. Green Top Guideline No. 37a. RCOG. April 2015
3. Abdul Sultan A, West J, Tata LJ, Fleming KM, Nelson-Piercy C, Grainge MJ. Risk of first venous thromboembolism in pregnant women in hospital: population based cohort study from England. *BMJ* 2013;347:f6099 (risk of 1st VTE is 18x higher in hospitalized v. non-hospitalized pregnant women)
4. Abdul Sultan A, West J, Tata LJ, Fleming KM, Nelson-Piercy C, Grainge MJ. Risk of first venous thromboembolism in pregnant women in hospital: population based cohort study from England. *BMJ* 2013;347:f6099 (risk of 1st VTE is 18x higher in hospitalized v. non-hospitalized pregnant women
5. D'Alton ME, Friedman AM, Smiley RM, Montgomery DM, Paidas MJ, D'Oria R, Frost JL, Hameed AB, Karsnitz D, Levy BS, Clark SL. National Partnership for Maternal Safety: Consensus Bundle on Venous Thromboembolism. Obstet Gynecol. 2016 Oct;128(4):688-98. doi: 10.1097/AOG.0000000000001579. PubMed PMID: 27607857

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Notice to Users

These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur during pregnancy. They should not be interpreted as a standard of care, but instead represent guidelines for management. Variation in practices should take into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities.

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