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

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

<table>
<thead>
<tr>
<th>Prophylactic Anticoagulation Regimens</th>
<th>Unfractionated Heparin</th>
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<tbody>
<tr>
<td><strong>Enoxaparin</strong></td>
<td><strong>Unfractionated Heparin</strong></td>
</tr>
<tr>
<td>&lt;50 kg</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; trimester 5,000-7,500 U q 12 hrs</td>
</tr>
<tr>
<td>50-90 kg</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; trimester 7,500-10,000 U q 12 hrs</td>
</tr>
<tr>
<td>91-130 kg</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; trimester 10,000 U q 12 hrs</td>
</tr>
<tr>
<td>131-170 kg</td>
<td>0.6 mg/kg/day in 2 divided doses</td>
</tr>
<tr>
<td>&gt;170 kg</td>
<td>0.6 mg/kg/day in 2 divided doses</td>
</tr>
</tbody>
</table>

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:


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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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