GUIDELINE DOCUMENT CONTROL SHEET

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Date Ratified	22 March 2016
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VERSION CONTROL TABLE

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December 2009	1.0	Superseded
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TABLE OF REVISIONS

Date	**Section**	**Revision**	**Author**
7/5/2010	Partial	Changes to Risk assessment sheet (page 15)	P J Marsden
8/10/2010	Partial	Changes to risk assessment sheet (Page 15) Clarification re pre-existing risk factors Hospitalization for maternal reasons only Clarification of category of stockings (Page 15))	P J Marsden
06/12/11	Partial	Amended in line with CDDFT policy for the development and management of policy and guidance documents Addition of KPI	J Hatton
04/04/12	Partial	Change to KPI re individualized plan of care	J Hendy
02/11/12	Partial	Date extended awaiting full review	J Woodward
25/3/13	Full	Reviewed – no changes to practice made. CMACE figures updated. New VTE forms added	Dr Vikram JWoodward
Nov 2015	Full	Reviewed in line with changes from RCOG	Evidence Based Practice Group

CONTENTS

1 INTRODUCTION

Thrombosis and thromboembolism remains the leading cause of direct maternal death in the most recent MBRACE report 2009-2012.

- The incidence of Venous Thromboembolism (VTE) in pregnancy is 0.1-0.2%. [1] The incidence of antenatal pulmonary embolism (PE) is 1.3 per 10,000 deliveries.
- Untreated as many as 24% of patients with a DVT will develop a PE, with a 15% mortality, 66% of whom will die within 30 minutes of the embolic event. When patients have been treated with anticoagulants PE occurs in 4.5% and mortality is reduced to less than 1% [3]
- Many fatal antenatal VTE events occur in the first trimester and therefore prophylaxis for women with previous VTE should begin early in pregnancy. Risk increases with gestational age reaching a maximum just after delivery. Caesarean section is a significant risk factor, but women having vaginal deliveries are also at risk [1].
- Pregnancy is a thrombogenic state with a four to six fold increase in the risk of PE, and the risk increases a further five fold postpartum and 10-20 fold following caesarean section. [1]
- A woman on thromboprophylaxis can still get DVT and/or PE, so any signs /symptoms should be taken seriously and investigated. The presence of risk factors should heighten clinical suspicion. (see Figure 1 and Antenatal and Postnatal Thromboprophylaxis guideline)

2 PURPOSE

The purpose of this guideline is to support staff in providing care based on best practice and best available evidence

- To clearly define the management of deep vein thrombosis and pulmonary embolism in pregnancy and in the puerperium.
- To define the management of women who have had a VTE during labour or Caesarean section
- To define the roles and responsibilities of all staff involved in the care of the woman.
- To ensure multidisciplinary postnatal follow up is arranged for women who have been diagnosed with VTE during pregnancy or the puerperium.

3 SCOPE

The scope of this guideline is for all health professionals coming into contact with pregnant or recently pregnant women.

4 DUTIES

This guideline describes the duties of health professionals involved in the care of pregnant women pre conception, antenatally and following delivery.

5 MAIN CONTENT OF POLICY

5.1 Management of DVT and PE in Pregnancy and the Puerperium

Screening/Risk Assessment

Risk assessment: It is paramount that every woman antenatally and following delivery has an assessment of her risk of thromboembolism completed and the appropriate treatment commenced.
(See Guideline on Antenatal and Postnatal thromboprophylaxis)

Lead Professional/Antenatal Care

- The Consultant Obstetrician must be informed of any woman who has a DVT or PE either antenatally or postnatally.
- If a DVT/PE is confirmed in a woman under midwifery-led care then her care must be transferred to Consultant care. An appointment needs to be made with Consultant for 2-4 weeks

Documentation

An individualised management plan should be made by Consultant and clearly documented in the hospital and patient hand held maternity record

Diagnosis and investigation of acute DVT (Antenatal)

Significant preponderance of **left-**sided DVT (9:1)

- Iliofemoral thrombosis is more common than popliteo-femoral (72% in pregnancy versus 9% in non-pregnancy)

5.2 Signs and symptoms –DVT

Classical features of swelling, redness, pain and tenderness of the calf are unreliable in pregnancy and clinical assessment alone will be wrong in 30-50% of cases as leg oedema is common in pregnancy. The presence of antenatal or postnatal risk factors should increase the suspicion of venous thromboembolism.

Signs and symptoms of DVT

- Swelling, redness, pain and tenderness of calf
- Presence of antenatal / postnatal risk factors

All women who present with possible signs or symptoms of DVT/PE should be investigated treatment commenced – do not delay treatment while awaiting results, unless treatment strongly contraindicated.

Diagnosis and Investigation of Acute Pulmonary Embolism

Remember the risk factors (see Antenatal and Postnatal Thromboprophylaxis guideline)

5.3 Symptoms and signs - PE

Symptoms:

Sudden onset of breathlessness
Pleuritic or central chest pain
Haemoptysis
Tachycardia

Woman presenting with cyanosis, circulatory collapse with hypotension, syncope or convulsions and central chest pain should be suspected as having had a massive PE. Refer to Massive PE guideline

- **Tachycardia and a few atelectatic rales may be the only findings on physical examination**
- Symptoms and physical findings must be interpreted with caution during pregnancy because dyspnoea, tacchypnoea and leg discomfort occur commonly as pregnancy progresses
- Clinical evidence of DVT is rarely found in patients with PE
- Massive PE may produce right-sided heart failure with jugular venous distension, an enlarged liver, a left parasternal heave and fixed splitting of the second heart sound

5.4 Investigations for P.E

D-dimers are not recommended for the diagnosis of DVT/PE in pregnancy. Thrombophilia screening is also not recommended during pregnancy. [1].

Request CXR as well as ECG – NB. These tests do not confirm or refute the diagnosis of PE

ECG

(Sinus tachycardia, peaked T waves in lead II, S1Q3T3 right heart strain – this can occur in normal pregnancy).

The changes that occur in normal pregnancy make ECG findings in PE even less specific

Sinus tachycardia is the most common abnormality

Right axis deviation and right ventricular strain pattern may be present with a large PE

S1, Q3, T3 is very rare

1. Chest X-ray

CXR is not necessary for accurate interpretation of V/Q scans but is reasonable to do one to exclude other causes of chest pain

This will exclude pneumothorax and pneumonia

(Pleural effusion, wedge-shaped infarct, oedema, basal atelectasis but can be normal)

Non-specific changes of PE: segmental collapse, raised hemi-diaphragm, consolidation and unilateral pleural effusions

Wedge shaped infarction is a rare finding

The radiation dose to the fetus from a chest X-ray performed at any stage of pregnancy is negligible.

X-ray is normal in over 50% of pregnant women with objectively proven PE

Bilateral Compression Duplex Ultrasound Doppler

Bilateral ultrasound Doppler should be performed if there is also clinical suspicion of a DVT.

- **Positive Doppler i.e. confirmed DVT - indirectly confirms a diagnosis of PE, and since anticoagulant therapy is the same for both conditions, no further investigations are necessary. This limits the radiation dose to the mother and the fetus**
- If both CXR and Doppler are negative but clinical suspicion of acute PE persists consider further imaging - see below**.** The Consultant Radiologist on-call must be informed and be involved in the decision-making. Continue LMWH.

CTPA and V/Q scan

Summary of recommended investigations for PE – See Fig 3. and below for comparisons.

Discuss with Consultant Radiologist but guidance:

- In women with suspected PE without symptoms and signs of DVT, a ventilation/perfusion (V/Q) scan or a computerised tomography pulmonary angiogram (CTPA) should be performed
- When the chest x-ray is abnormal and there is clinical suspicion of a PE, CTPA should be performed in preference to V/Q scan
- Alternative/repeat testing should be carried out where V/Q scan or CTPA is normal but the clinical suspicion of PE remains in 3 days.
- Anticoagulant treatment should be continued until PE is definitively excluded.

V/Q

- **Lower radiation dose to pregnant breast tissue than CTPA**
- Similar accuracy to CTPA providing doing V/Q SPECT scan
- Fetal radiation dose with V/Q scanning 10x that with CTPA during all trimesters of pregnancy (although still extremely small). Estimated risk of fatal cancer to the age of 15 years is less than 1/1,000,000 after in utero exposure to CTPA and 1/280,000 following a V/Q perfusion scan. Radiation risk to fetus can be reduced by performing a reduced dose perfusion scan, and only performing the ventilation part of the study if

the perfusion images are not a) normal or b) clearly a pattern consistent with recent PE

CTPA

- Can identify other pathology, such as aortic dissection but may not identify small peripheral PE
- Lower radiation dose to the fetus than V/Q (except in late pregnancy when the fetus may be very close to the primary beam) - in both it is extremely small
- **But:** Higher radiation dose to the maternal breasts than V/Q (breast dose 30 – 60 times higher) - associated with an increased lifetime risk of developing breast cancer - estimated that the increased risk is 0.0136% over the background risk
- It can be difficult to time the administration of contrast due to increased cardiac output and increased plasma volume. This may result in sub-optimal imaging.
- Potential to alter fetal or neonatal thyroid function (iodinated contrast media) – thyroid function should be checked in the neonate, however, results should be interpreted with caution.
- Only 5% will have a positive result

Figure 2. Probability of PE based on V/Q scan report

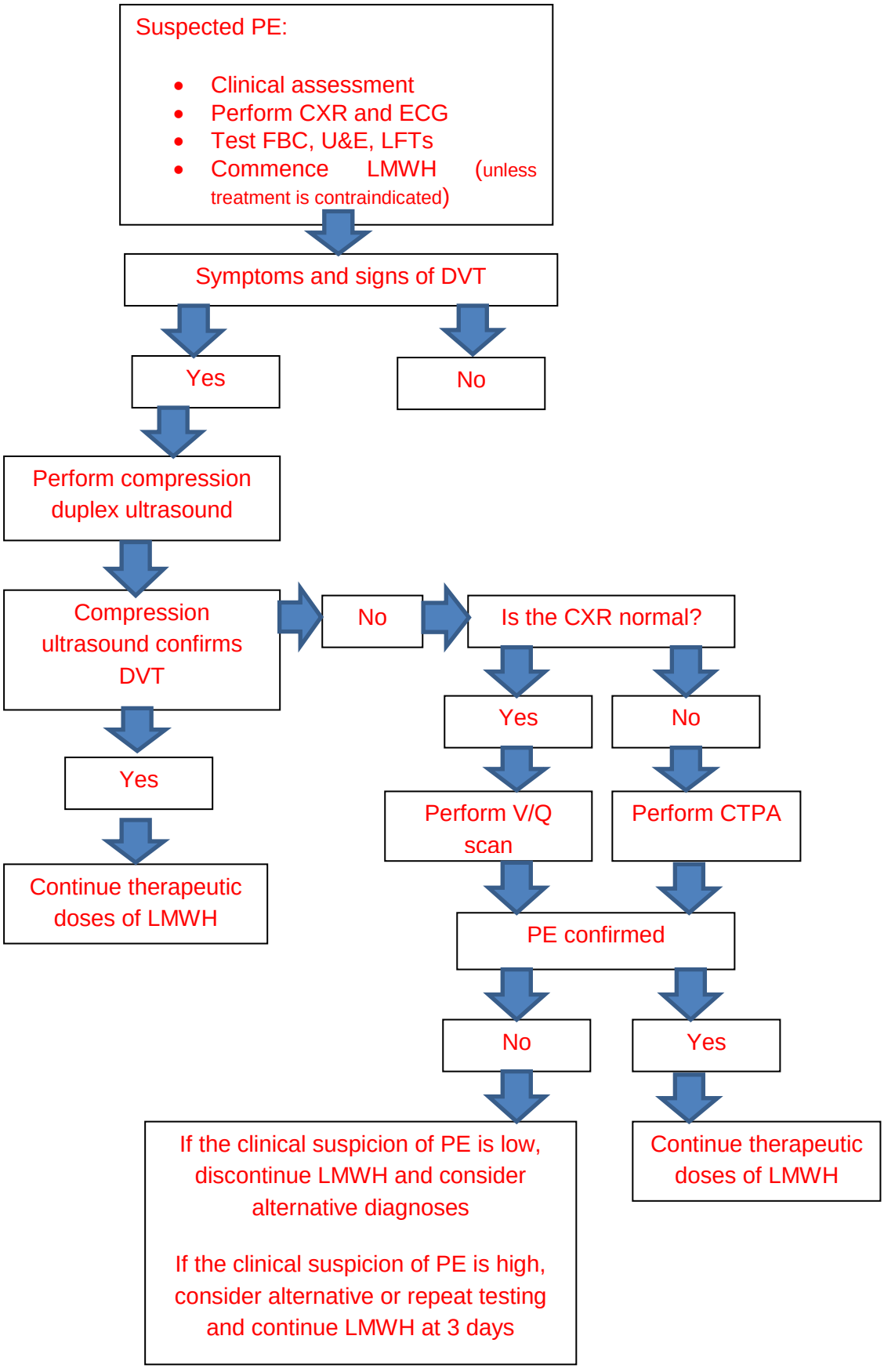
Scan category	Probability (%)
High probability	87
Intermediate probability	30
Low probability	14
Normal	4

Informed consent:

Consent should be obtained from the woman before undertaking these investigations.

Women with suspected VTE should be advised that V/Q scanning carries a slightly increased risk of childhood cancer compared with CTPA (1/280,000 vs. less than 1/1,000,000) but carries a lower risk of maternal breast cancer [1].

Algorithm for the investigation and initial management of suspected PE in pregnancy and the puerperium [1]



5.5 Treatment of DVT and PE

Baseline assessment prior to commencing treatment
FBC, Coagulation Screen U&Es, LFTs

- Do not take a thrombophilia screen at the time of an acute event (unless life threatening, in which case discuss with Haematology).

Initiating treatment

- Dose:
  - Antenatal - Enoxaparin 1 mg/kg subcutaneously, 12 hourly.
  - If a woman's booking weight is more than 125kg discuss dose to be administered with Consultant Haematologist
  - Postnatal – Enoxaparin 1.5 mg/kg subcutaneously daily
- Dose should be given as a twice-daily regimen whilst pregnant (although there is insufficient evidence to recommend once or twice daily doses [1]), with dosage titrated against the woman's booking or early pregnancy weight.
- Lower doses of LMWH should be employed if the creatinine clearance is less than 30 ml/minute
- Refer all cases to the Consultant Haematologist for future management
- Patients should be taught how to self-administer Enoxaparin, and be given sharps boxes to safely dispose of needles.
- Full dose anticoagulation should be continued for a minimum of 3 months (discuss with Haematologist) and should be continued for the remainder of the pregnancy and for at least 6 weeks postnatally.
- Warfarin (and vitamin K antagonists) should not be used antenatally because of their adverse effects on the fetus.
- Consider use of an alternative LMWH or newer anticoagulants (eg fodaparinux) if enoxaparin not tolerated

Booking or early pregnancy weight	**Initial dose of enoxaparin**
Less than 50kg	40mg BD or 60mg OD
50-69kg	60mg BD or 90mg OD
70-89kg	80mg BD or 120mg OD
90-109kg	100mg BD or 150mg OD
110-125kg	120mg BD or 180mg OD
More than 125kg	Discuss with haematologist

Monitoring treatment

- Anticoagulation – Monitoring is not required with LMWH unless the patient has extremes of body weight (less than 50kg and more than 90kg) or with other complicating factors (for example renal impairment, recurrent VTE or anti-thrombin III deficiency). Discuss management with Consultant Haematologist.
- Platelet count does not need to be monitored with LMWH. Heparin Induced Thrombocytopaenia (HIT) is rare.
  - Patients who develop heparin-induced thrombocytopenia or have heparin allergy and require continuing anticoagulant therapy should be managed with an alternative anticoagulant under specialist advice

Other measures in managing VTE

- Elevate leg if suspected of having a DVT
- Use graduated anti-thromboembolic stockings (Grade II if available) on both legs and, after initial leg elevation to reduce oedema, encourage mobilisation. These should be worn for a minimum of 2 years if possible. Accurate fitting and correct application is required.

- With a proximal DVT, NICE recommends below-knee compression stockings with an ankle pressure greater than 23mmHg, only on the affected leg. [5]
- If there is any evidence of post-thrombotic syndrome (occurs in over 60% of cases and consists of chronic leg swelling and pain, heaviness, cyanosis of the limb, eczema, varicose veins and chronic ulceration – made worse by standing or walking) then use of anti-thromboembolic stockings should be continued.
    - Prolonged use of LMWH (more than 3 months) is associated with a significantly lower chance of developing post-thrombotic syndrome
- Consultant Obstetrician and Consultant Haematologist to discuss plan for labour and delivery and this should be clearly documented in the woman's notes

Role of inferior vena cava filters

- Consider use of a temporary inferior vena cava filter in the peri-partum period for patients with:
    - Iliac vein VTE to reduce risk of PE
    - Patients with recurrent PE despite adequate anticoagulation

Treatment of Massive Pulmonary Embolism

Refer to CDDFT Management of Massive Pulmonary Embolism and Appendix 3.

5.6 Management in Labour

Antenatally Consultant Obstetrician and Consultant Haematologist to discuss plan for labour and delivery and this should be clearly documented in the woman's notes

Any queries regarding management during labour discuss with Obstetrician, Haematologist and Anaesthetist

Women receiving antenatal LMWH should be advised that if they have any vaginal bleeding or think they are in labour, they should not inject any further LMWH. They should be reassessed on admission to hospital and further doses should be prescribed by medical staff.

- Consider use of intravenous unfractionated heparin when VTE occurs at term (as it is more easily manipulated – (see guideline on Management of Massive PE for dosing regime))

5.7 Spontaneous Labour/Emergency CS

- There is a high risk of VTE immediately postpartum.
- If LMWH precludes regional techniques (eg the woman who presents in spontaneous labour within 24 hours of taking a treatment dose LMWH) alternative analgesia such as opiate-based intravenous patient controlled analgesia can be offered.
- If a patient is on therapeutic LMWH this should not be discontinued during labour for longer than is necessary to allow safe epidural or spinal administration
- If an emergency CS is necessary within 24 hours of the treatment LMWH dose, a general anaesthetic will be required. The treatment dose (if due) is not to be given until 4 hours following CS.
- Consider prophylactic syntocinon infusion after delivery if delivery within 24 hours of last treatment dose

Insertion/removal of epidural /spinal anaesthesia

- To minimise the risk of epidural haematoma, regional techniques should not be used until **24 hours after the last treatment dose** of Enoxaparin
- Further Enoxaparin can be administered **4 hours after removal** of the epidural catheter and the **cannula should not be removed within 12 hours of the most recent injection**.

5.8 Induction of labour

- In some women there may be an indication for induction of labour to help plan around delivery
- If a patient is on therapeutic LMWH this should not be discontinued during labour for longer than is necessary. Therefore there may be instances (e.g. primigravida where the induction process is likely to be longer) where Enoxaparin can be reduced to 40mg a day on **the day prior to induction** and continued at this dose during labour. This will only allow for regional analgesia/anaesthesia if within 12 hours of administered Enoxaparin but offers a degree of protection against VTE if the induction of labour process is prolonged.
- The treatment dose should be recommenced following delivery (usually 4 hours after a vaginal delivery).

5.9 Elective Caesarean

- If patient is on a treatment dose of LMWH this should be omitted for 24 hours before surgery.
- Enoxaparin (40mg) should be given 4 hours post-operatively after a general anaesthetic and 4 hours after removal of the epidural catheter or spinal as long as haemostasis achieved.
- The full treatment regime can resume after 12 hours **Check**
- Encourage early mobilisation and anti-embolism compression stockings
    - Interrupted sutures/staples should be used and consider the use of drains (abdominal and rectus sheath) due to the high incidence of wound haematomas.
    - Treatment with intravenous UFH during labour/C-section should be considered for any woman in whom treatment is considered essential and who is considered to be at high risk of haemorrhage (e.g. APH, coagulopathy, progressive wound haematoma, PPH and suspected intra-abdominal bleeding) until the risk factors for haemorrhage have resolved.
    - If an IVC filter has been inserted intravenous UFH should be commenced 4 - 6 hours after vaginal delivery and as soon as possible if regional/general anaesthesia has been used. If high risk of bleeding **OMIT** loading dose. Monitor APTT according to Trust Protocol.

5.10 Postnatal Considerations when using anticoagulation

- Length of Treatment
    - After a DVT/PE, anticoagulant therapy (either Warfarin or LMWH) should be continued for at **at least 6 weeks postnatally and until at least 3 months of treatment has been given in total**.
- If the LMWH was given in 2 divided doses (12 hourly) antenatally, postnatally it can be given as a single dose
- Women should be offered LMWH or oral anticoagulation for postnatal therapy after a discussion about the need for regular blood tests for monitoring of warfarin
- If Warfarin is preferred postpartum, this should be avoided until at least the fifth day post delivery or later if the woman is at risk of PPH. **Refer to Trust Guideline on Warfarin Induction**

- LMWH and Warfarin are both safe in breastfeeding.
- Women who have an emergency Caesarean section and women known to have a thrombophilia or those with recurrent episodes DVT/PE may benefit from longer duration of anticoagulation (3 months)
- All women should have anti-embolism stockings at the time of diagnosis and continue to wear these for a minimum of 2 years after delivery
- Prior to discharge from hospital advice should be given on the need for thromboprophylaxis in any future pregnancy and at other times of increased risk. Also discuss hormonal contraception as oestrogens are contraindicated.

Postnatal Follow Up

- The patient's Consultant Obstetrician should be informed when the woman is delivered and a hospital follow up offered at the Consultant clinic.
- Advice should be given on the need for thromboprophylaxis in any future pregnancy and at other times of risk.
- Hormonal contraception should be discussed.
- A follow up appointment with the Consultant Haematologist for further management.

6 MONITORING

Key Performance Indicators

Monitoring Criterion	Response
Who will perform the monitoring?	Maternity Services
What are you monitoring?	• Documented evidence that the process for offering a postnatal appointment with an appropriate clinician to all women who have been have been diagnosed with VTE during pregnancy or the postnatal period has been followed. • Appropriate and timely risk assessment to identify those at risk of VTE. • Significance of signs and symptoms in light of known risk factors. • Action to be taken in response to the risk assessments once the risk of VTE has been identified • Individual management plan in the health records of women who require thromboprophylaxis or treatment for a diagnosis of VTE.
When will the monitoring be performed	Case by case basis - cases reviewed at the weekly risk meeting Annually documentation audit
How are you going to monitor?	Review of maternity records - Maternity audit toolkit Safeguard Reporting
What will happen if any shortfalls are identified?	Audit results will be shared with the Obs & Gynae Operational Group Action plan agreed
Where will the results of the monitoring be reported?	Clinical audit meeting
How will the resulting	Poor compliance will be re audited in 3 months

action plan be progressed and monitored?	
How will learning take place?	Mandatory Days

7 REFERENCES

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8 ASSOCIATED DOCUMENTATION

This Policy refers to the following CDDFT Trust policies and procedures:

- Trust policy on Warfarin induction
- Management of Massive Pulmonary Embolism
- Antenatal and Postnatal Thromboprophylaxis

9.Equality Analysis / Impact Assessment

Full Assessment Form **v2/2011**

Division/Department:	**Care Closer to Home – Maternity Services**
Title of policy, procedure, decision, project, function or service:	**Management of DVT and Pulmonary Embolism in pregnancy and in the postnatal period**
Lead person responsible	**Evidence Base Practice Group - chair**
People involved with completing this:	**Dr Barker** **Evidence Based Practice Group**

Type of policy, procedure, decision, project, function or service:

Existing Yes ☐

New/proposed ☐

Changed ☐

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

To ensure women have the safest care that can be given

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Women with a diagnoses of pulmonary embolism and deep vein thrombosis

What outcomes do you want to achieve?

No incidents – good outcome – good experience for women and their families

What barriers are there to achieving these outcomes?

Not adhering to guidelines and policies - non attendance at training and education

How will you put your policy, procedure, project, decision, function or service into practice?

Monitoring incidents and ensuring lessons are learned

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

None

Step 2 – Collecting your information

What existing information / data do you have?

Incident data

Who have you consulted with?

Clinical colleagues

What are the gaps and how do you plan to collect what is missing?

N/A

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

No

Sex/Gender

No

Age

No

Disability

No

Religion or Belief

No

Sexual Orientation

No

Marriage and Civil Partnership

No

Pregnancy and Maternity

No

Gender Reassignment

No

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills

No

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act?

No

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

Agreed at Obstetrics and Gynaecology Operational Group and approved at the quality & Health Care Governance Committee

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

Audit of maternity records using Maternity audit toolkit annually **IR1 reporting – case by case basis**

Step 6 – Completion and central collation

Once completed this Equality Analysis form must be attached to any documentation to which it relates and must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk