UH Sussex Risk Assessment for Obstetric Venous Thromboembolism (VTE)

University Hospitals Sussex NHS Foundation Trust

(Adapted from RCOG No. 37a guideline)

For use on all non-maternity wards at UH Sussex Hospitals for obstetric patients

As a minimum, all pregnant women and birthing people should have a VTE risk assessment completed at their Booking Appointment and at 28 weeks after re-weighing has been offered. Repeat VTE assessments should be completed for **ALL admissions** to any hospital ward or at any time where new risks are noted including proposed long distance travel >4 hours or if excessive weight gain at any stage of the pregnancy.

Patient Name:……..

DoB: ……

Hospital Number: ……..

NHS Number:……..

Patient label

(Please complete daily risk assessment using the described risk factors and score(s). The total score is used whether antenatal or postnatal & the associated suggestive management plan on page 2).

Date:						
Pre-existing Risk Factors (√). Gestation or days P/N:						
Previous VTE	4					
Previous VTE – provoked by major surgery	3					
Known high-risk thrombophilia	3					
Medical co morbidities e.g. cancer, heart failure, active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease, nephrotic syndrome, type 1 diabetes mellitus with nephropathy, sickle cell disease, current IV drug user.	3					
Family history of unprovoked or estrogen- related VTE in first degree relative	1					
Known low-risk thrombophilia (no VTE)	1					
Age 35 years and above	1					
Obesity BMI 30 or more (Antenatally: based on booking weight. Postnatally: reweigh & recalculate BMI)	1					
Obesity BMI 40 or more (Antenatally: based on booking weight. Postnatally: reweigh & recalculate BMI)	2					
Parity 3 or more	1					
Current smoker	1					
Gross varicose veins	1					
Obstetric Risk Factors (√)						
Pre-eclampsia in current pregnancy	1					
Assisted Reproductive technology/ IVF (antenatal only)	1					
Multiple pregnancy	1					
Caesarean section in labour	2					
Elective Caesarean section	1					
Mid-cavity or rotational operational delivery	1					
Prolonged labour (more than 24 hours)	1					
PPH (more than 1 litre or blood transfusion)	1					
Preterm birth less than 37+0 weeks in current pregnancy	1					
Stillbirth in current pregnancy	1					
Transient Risk Factors (√)						
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum e.g. appendectomy, postpartum sterilisation	3					
Hyperemesis	3					
OHSS (ovarian hyperstimualtion syndrome) - first trimester only	4					
Long distance travel more than 4 hours (not exclusively by air) within the past 8 weeks	1					
Current systemic infection	1					
Immobility, dehydration	1					
Surgical procedure in pregnancy or less than 6 weeks postpartum						
(see over page for assessment tool) **TOTAL:**						
Midwife initials						

ObstetricMedicalReviewRequired (Yes/No)

Enoxaparin required (Yes/No)

Bleeding Risks / Relative Contraindications to Enoxaparin (tick as appropriate)			
Haemophilia or other known bleeding disorder (e.g. von Willebrand's or acquired coagulopathy)		Active antenatal or postnatal bleeding or at risk of major haemorrhage (e.g. placenta praevia)	
Thrombocytopenia (low platelets <75 x 109 /l)		Severe renal disease (glomerular filtration rate [GFR] < 30 ml/minute/1.73m2)	
Acute stroke in previous 4 weeks (haemorrhagic or ischaemic)		Severe liver disease (prothrombin time above normal range or known varices).	
Uncontrolled hypertension (BP >200 systolic and / or >120 diastolic)		Allergy to Enoxaparin	
If any ticks, discuss with on - call Consultant Obstetrician			

Antenatal Risk Assessment for Venous Thromboembolism (VTE)

- If total score 4 or more antenatally, consider thromboprophylaxis from the first trimester.
- If total score 3 antenatally, consider thromboprophylaxis from 28 weeks.
- Re-weigh and reassess for thromboprophylaxis at 28 weeks. If already on thromboprophylaxis, check correct dose for weight at 28 weeks has been prescribed.
- If admitted to hospital antenatally, consider thromboprophylaxis.
- Reassess for thromboprophylaxis any time where new risks are noted, including proposed long distance travel >4 hours or if excessive weight gain, at any stage of the pregnancy.

For patients with an identified bleeding risk, the balance of risks of bleeding and thrombosis should be discussed in consultation with a haematologist with expertise in thrombosis and bleeding in pregnancy.

Postnatal Risk Assessment for Venous Thromboembolism (VTE)

- If total score 2 or more postnatally, consider thromboprophylaxis for at least 10 days. NB: If persisting or more than 3 risk factors consider extending thromboprophylaxis with LMWH.
- If prolonged admission (3 days or more) or readmission to hospital within the puerperium consider thromboprophylaxis.
- Calculate dose on current weight. If the woman or birthing person is immobile post birth (for instance post caesarean birth), use the 28-week weight to calculate LMWH dose. Re-weigh and recalculate dose as soon as able to mobilise.
- Previous VTE, anyone requiring AN LMWH, High risk thrombophilia, low risk thrombophilia + FHx = High Risk – should have at least 6 weeks PN prophylactic LMWH.

For patients with an identified bleeding risk, the balance of risks of bleeding and thrombosis should be discussed in consultation with a haematologist with expertise in thrombosis and bleeding in pregnancy.

Antenatal and Postnatal Prophylactic Dose of Low Molecular Weight Heparin (LMWH)

Current weight	Enoxaparin Dose (Inhixa)
< 50 kg	20 milligrams daily subcutaneously
50 – 90 kg	40 milligrams daily subcutaneously
91 – 130 kg	60 milligrams daily subcutaneously
131 – 170 kg	80 milligrams daily subcutaneously
> 170 kg	Seek specialist advice
High prophylactic dose for people weighing 50 – 90 kg	40 milligrams twice daily subcutaneously