

Prevention and Management of Venous Thromboembolism in Pregnancy

This QSD is a resource for all clinicians working in healthcare in Ireland who are involved in the care of pregnant women, women up to six weeks postpartum, the preconceptional period, and women at risk of or diagnosed with pregnancy associated Venous Thromboembolism (PA-VTE).

Following a comprehensive literature review a number of evidence-based recommendations for prevention and management of Venous Thromboembolism (VTE) in pregnancy were agreed upon.

Key Recommendations

Prevention

1. Systematic and routine venous thromboembolism (VTE) risk assessment should be incorporated into maternity care pathways to identify women at high risk of VTE and promote the initiation of risk-appropriate VTE prevention in those who require it.
2. Repeated VTE risk assessments should be documented at specific time points in the antenatal and postnatal periods. These include at confirmation of the pregnancy, at the first hospital booking visit, at every antenatal admission, in the third trimester of pregnancy and after birth, as well as at any postnatal/postpartum admission up to 3 months.
3. VTE risk assessment should be documented immediately after pregnancy regardless of pregnancy outcome (live birth, early or late pregnancy loss, termination of pregnancy).
4. VTE risk assessment should be repeated during the pregnancy if any additional risk factors are identified or if there is a change in clinical status.
5. Women undergoing assisted reproductive therapy should undergo a VTE risk assessment prior to commencing treatment.
6. All VTE risk assessments should be documented using a standardised format with a scoring system and this should form part of the woman's care record (paper or electronic). An example is included in this Guideline.
7. Consideration should be given to the implementation of innovative tools and supports for VTE risk assessment into existing care pathways and electronic health records including alerts, Clinical Decision Support Systems (CDSS) and actionable recommendations for thromboprophylaxis based on level of VTE risk assessed and body weight (e.g. VTE risk calculators, pharmacological thromboprophylaxis dose calculators).
8. Standardised VTE risk assessments in pregnant or recently pregnant women should include all VTE risk factors which have shown to be associated with an increased risk of pregnancy-associated VTE (PA-VTE).
9. The recommended first line anticoagulant for thromboprophylaxis in pregnancy women with prior VTE is low-molecular-weight heparin (LMWH) unless contraindications exist.
10. A minimum dose of tinzaparin/enoxaparin once daily is suggested for thromboprophylaxis but in cases of extreme body weight ($\geq 170\text{kg}$), this will need to be individualised.
11. Some women will require higher dose of LMWH based on their risk factors for VTE; dosing should be guided by the relevant specialists. Decision-making should be shared with the woman and conducted by the relevant specialist team.
12. Women with high-risk VTE risk factors – including history of venous thrombosis, high risk thrombophilia, nephrotic syndrome, type I diabetes and sickle cell anaemia, should commence LMWH at a prophylactic dose at confirmation of pregnancy and be referred to the specialist team in the maternity hospital/unit.

13. Women with VTE risk factors that arise during pregnancy – including major surgery in pregnancy, OHSS, critical care admission and severe hyperemesis gravidarum requiring admission with IV therapy, should commence LMWH prophylaxis for 6 weeks. This should be reviewed after 6 weeks as not all women will require LMWH for the duration of pregnancy.
14. At confirmation of pregnancy, in women with a high risk of VTE, there is no requirement for pregnancy ultrasound before commencing LMWH prophylaxis.
15. After birth/the end of pregnancy (including all types of pregnancy loss and termination of pregnancy), women with VTE risk factors should continue on LMWH for a minimum of 10 days. Those with a higher VTE risk score will be advised to continue LMWH prophylaxis for 6 weeks.
16. Women who have been commenced on pharmacological thromboprophylaxis in the antenatal period should be considered for continuation of this thromboprophylaxis for the remainder of the pregnancy and puerperium.
17. Extended thromboprophylaxis (i.e. beyond 6 weeks postnatally/postpartum) should be considered by the specialist team when the woman is at persistent high risk of VTE.
18. If LMWH prophylaxis is contraindicated, women should be referred to the specialist team for advice on alternatives.
19. During hospital admission, women at risk of VTE should also be considered for mechanical thromboprophylaxis.
20. All women, but particularly those at increased risk of VTE should be given a Blood Clot Alert Card (or a locally determined suitable alternative strategy appropriate to the woman) and educated on the signs and symptoms of VTE.
21. Written information provided by health services on VTE should be accurate and easy to understand and should promote engagement with care. This information should be given to all pregnant and recently pregnant women.
22. The content of VTE written information should include information on: the signs and symptoms of VTE, risk recognition and reduction, treatment and breastfeeding, as well as maternity hospital/unit contact information.
23. Women should be instructed to contact the maternity hospital/unit for further instructions in the event of anticoagulant side effects or suspected labour while on anticoagulation.
24. Hospitals should consider prominently displaying VTE awareness posters, which provides accessible information on the signs and symptoms of a blood clot.
25. Acute hospital sites without an associated maternity unit need to be aware of the VTE risk in pregnancy and their role in VTE risk assessment and prevention and should consult with their local maternity hospital/unit as needed.

Diagnosis

26. Pregnant women with signs and symptoms of deep venous thrombosis (DVT) should undergo clinical assessment and diagnostic imaging expeditiously. Women should commence therapeutic anticoagulation pending objective imaging, unless anticoagulation is strongly contraindicated.
27. Objective confirmatory imaging should take place as soon as practicable; pregnant and recently pregnant women (<3 months) should be triaged as urgent by the radiology department.
28. Compression ultrasonography (CUS) is the recommended first line imaging modality to investigate suspected lower limb DVT in pregnant women.
29. Serial CUS may be considered if the initial CUS is negative and if clinical suspicion is high. Reimaging twice within 7 days should be considered where only the proximal limb was imaged and when clinical suspicion of DVT remains high.
30. If there is a high index of suspicion for ileo-femoral DVT with negative CUS, alternative imaging should be discussed with local Radiology Department taking into account local availability of resources and expertise.
31. D-dimer testing and clinical prediction rules should not be used to rule-out DVT in pregnant women.

32. D-dimer testing and clinical prediction rules may be considered in the diagnostic evaluation of pulmonary embolism (PE) during pregnancy if there is expertise on interpretation.
33. A chest X-Ray and ECG should be performed for pregnant women with suspected PE.
34. In suspected high-risk PE, (defined by haemodynamic instability), point-of care echocardiography or emergency CT pulmonary angiogram (CTPA), depending on availability, feasibility and safety, is recommended.
35. Specific investigations for PE include CTPA (low-radiation dose protocol) or perfusion lung scan.
36. CTPA is safe in pregnancy and in most hospital/units is the first line imaging modality for PE in pregnancy. If the chest X-Ray is normal, a lung perfusion scan is an option and may be considered. CTPA should be considered as the first-line option if the chest X-Ray is abnormal.
37. An indeterminate CTPA result occasionally occurs. In such cases, multidisciplinary discussion may be considered. Clinical factors should be taken into account (level of suspicion) and a decision made either to treat/not treat or consider the need for a repeat imaging procedure (CTPA versus perfusion scan).
38. In women with a confirmed DVT, and where there is clinical suspicion of PE, imaging may not always be required to confirm a PE diagnosis unless clinically indicated/necessary.
39. In pregnant or recently pregnant women with a new diagnosis of any pregnancy-associated VTE (PA-VTE), the local maternity hospital/unit/specialist team should be informed. Multi-disciplinary team involvement should include Obstetrics and Haematology.

Management of PA-VTE

40. In the setting of a suspected or confirmed high risk PE (defined by hemodynamic instability), IV anticoagulation with UFH should be started as quickly as possible with urgent critical care review, urgent echocardiography and consideration for reperfusion strategies.
41. Women with acute PA-VTE that are haemodynamically stable should be treated with a therapeutic dose of LMWH unless strong contraindications exist.
42. Therapeutic dose of LMWH for PA-VTE in pregnancy should be similar to dosing in non-pregnant women (either with once daily or twice daily weight-adjusted regimens).
43. Anticoagulation type, dose and treatment duration should be guided by a multidisciplinary team.
44. The multidisciplinary team (obstetrics/haematology/midwifery) should guide further monitoring, and local policies should direct the frequency of follow up visits for antenatal women with PA-VTE.
45. In patients with a confirmed PE, they should be risk stratified in a similar way to non-pregnant patients, based on the National Clinical Guideline on Venous Thromboembolism (NCG-VTE).
46. Women with a PA-VTE should be treated for the remainder of pregnancy and until 6 weeks postpartum; treatment duration should be a minimum of 3 months but may be longer.
47. All women with PA-VTE should undergo measurements of vital signs and fetal monitoring. The frequency of monitoring is dependent on clinical status and is determined by obstetric team.
48. For women diagnosed with acute PA-VTE, initial in-hospital treatment is suggested but early discharge could be considered if there is good response to initial treatment, minimal symptoms, no other obstetric or other concerns; and the woman is able to self-administer medications, with stable social supports and follow-up care arranged.
49. A management plan for the remainder of the pregnancy, labour and delivery should be provided and discussed with the woman. This should be jointly agreed with the woman and all relevant caregivers and documented in the medical chart (paper or electronic).
50. For women on therapeutic dose LMWH, a timed delivery should be considered (scheduled induction of labour or Caesarean birth); however individual risks and benefits should also be considered and discussed with involvement of multidisciplinary specialists where relevant.

Peripartum Care

51. Prior to any neuraxial procedure, LMWH should be held for >12 hours and >24 hours, when used at prophylactic and therapeutic doses respectively, assuming normal renal function.
52. Once daily doses of prophylactic LMWH should be administered no sooner than 4-6 hours after neuraxial anaesthesia or epidural catheter removal.
53. LMWH should be recommenced at therapeutic doses at 24-48 hours post delivery, according to individual assessment of bleeding risk by the specialist/multidisciplinary team.

Postnatal Care and Post-VTE Long Term Management

54. Women with a PA-VTE should be offered a clinic appointment (in the appropriate specialty clinic) at 3-6 months after the event (especially if the VTE event was a PE), in order to assess for long term sequelae. Earlier or later visits should also be scheduled as appropriate.
55. For breastfeeding women LMWH or warfarin are the anticoagulants of choice
56. Direct oral anticoagulants (DOACs) should not be used when breastfeeding; however, their use can be considered in women that are not breastfeeding.
57. Patients should be screened for post thrombotic syndrome and post PE syndromes in a similar way to non-pregnant patients (See *NCG-VTE*).
58. Safe contraceptive options should be documented.
59. Future pregnancies should be discussed in terms of risk of recurrence, thromboprophylaxis plan and how to access specialist care.
60. Use of hormone replacement therapy (HRT) in the future should be discussed.

Algorithm

Algorithm 1: Antenatal Risk Assessment

Does this woman have a previously agreed plan from Maternal Fetal Medicine/Haematology? If YES, no need to complete this form, follow that plan.

Is this woman on a therapeutic* dose of anticoagulation outside of pregnancy? If YES, switch to a therapeutic dose of LMWH and refer to haematology

All pregnant and recently pregnant women require risk assessment for VTE:

- At confirmation of pregnancy
- At hospital booking visit
- At every antenatal admission
- In the third trimester of pregnancy

MAJOR RISK FACTOR

Previous VTE	Commence LMWH prophylaxis and refer to Obstetrics & Haematology,
High risk thrombophilia* or thrombotic Anti-Phospholipid Syndrome	
Nephrotic syndrome	
Sickle Cell anaemia	
Severe Chorioamnionitis	
Prophylactic anticoagulation outside of pregnancy*	

TRANSIENT MAJOR RISK FACTOR

Surgery in pregnancy*	Commence LMWH prophylaxis for 6 weeks and review
Critical care admission	
Ovarian Hyperstimulation Syndrome	
Hyperemesis gravidarum requiring hospital admission for ≥24 hours	

RISK FACTOR	SCORE	Y/N
Family history VTE in a 1 st degree relative*	1	
BMI >30* kg/m ²	1	
BMI >40* kg/m ²	2	
Parity >3	1	
Maternal age >40years	1	
Current Smoker	1	
Multiple Pregnancy	1	
RISK FACTOR	SCORE	Y/N
Gross varicose veins	1	
Pre-existing (type 1) Diabetes	1	
Current IV drug use	1	
Immobility*	1	
Heart failure	1	
Active Thrombophlebitis	1	
Active inflammatory or autoimmune disorder	1	

Cancer – current, active treatment	1
Other relevant risk factors, please specify*	1
Hospital admission for ≥ 24 hours	1
Current infection requiring hospital admission/treatment*	1
Pre-eclampsia*	1
Dehydration	1
TOTAL SCORE If score 3 or more = LMWH prophylaxis	

*DEFINITIONS

- Therapeutic anticoagulation: warfarin INR target 2-3/apixaban 5mg BD/rivaroxaban 20mg OD/edoxaban 60mg OD/dabigatran 150mg BD
- Prophylactic anticoagulation: any agent at a dose less than therapeutic.
- High-risk Thrombophilia: antithrombin deficiency, protein C or S deficiency, compound heterozygous or homozygous for low-risk thrombophilia.
- Low-risk Thrombophilia: heterozygous for factor V Leiden or prothrombin G20210A mutations.
- Anticoagulation outside of pregnancy refers to women who are on anticoagulation prior to pregnancy, unrelated to the pregnancy.
- Family History of VTE: VTE occurring in a first-degree family member (or members) at a young age (typically <50 years) either unprovoked or in the context of a minor provoking factor (e.g. Oral contraceptive pill (OP) use, pregnancy, long-distance travel).
- BMI to be calculated on booking weight.
- Medical comorbidity: Presence of a severe co-morbidity for which the women receive specialist care, e.g. Ulcerative colitis, Crohn's disease, Rheumatic disease, Systemic Lupus Erythematosus, Type 1 Diabetes Mellitus, Cardiac disease, Sickle cell anaemia.
- Any surgical procedure: e.g. appendicectomy.
- Pre-eclampsia: Gestational hypertension: $\geq 140/90$ mmHg on 2 occasions ≥ 4 hours apart with proteinuria of at least 300mg in a 24-hour urine collection, arising de novo after the 20th week of gestation in a previously normotensive person or protein: creatinine ratio (PCR) above 30mg/mmol
- Current systemic Infection: Proven infection, e.g. chorioamnionitis, pyelonephritis, pneumonia, bacteraemia. Systemic Inflammatory Response Syndrome (SIRS) as defined by early warning score. Less serious infections (e.g. sinusitis, intrapartum fever with no proven infection) are not considered.
- Immobility: Prolonged bed rest with no mobilisation (>3 days) or prolonged seat immobility, e.g. wheelchair user or after a long-distance travel (>4 hours).

Algorithm 2: Postnatal Risk Assessment

Does this woman have a previously agreed plan from Maternal Fetal Medicine/Haematology? If YES, no need to complete this form, follow that plan.

Is this woman on a therapeutic* dose of anticoagulation outside of pregnancy? If YES, remain on a therapeutic dose of LMWH until appropriate to switch to pre-pregnancy anticoagulant.

Maternal weight measurement after birth.

All pregnant and recently pregnant women require risk assessment for VTE:

- After birth
- At every postnatal readmission within 3 months

MAJOR RISK FACTOR

Previous VTE	Remain on LMWH prophylaxis for 6 weeks post pregnancy/postpartum
High risk thrombophilia*; thrombotic Anti-Phospholipid Syndrome	
Nephrotic syndrome	
Sickle Cell anaemia > 28 weeks gestation	
Prophylactic anticoagulation outside of pregnancy*	

TRANSIENT MAJOR RISK FACTOR

Surgery in pregnancy*	Commence LMWH prophylaxis for 6 weeks and review
Critical care admission	
Severe Chorioamnionitis	
Active thrombophlebitis	

PRE-EXISTING RISK FACTOR	SCORE	Y/N
Family history VTE 1 st degree relative*	1	
BMI >30* kg/m ²	1	
BMI >40* kg/m ²	2	
Parity >3	1	
Maternal age >40years	1	
Current Smoker	1	
Gross varicose veins	1	
Pre-existing (type 1) Diabetes	1	
Current IV drug use	1	
Heart failure	1	
Active inflammatory or autoimmune disorder	1	
Immobility*	1	
Cancer – current, active treatment	1	
Other relevant risk factors, please specify*	1	

TRANSIENT RISK FACTOR	SCORE	Y/N
Readmission in postnatal period	1	
Current infection requiring hospital admission/treatment*	1	
Pre-eclampsia*	1	
Stillbirth in current pregnancy	1	
Prolonged active labour, >12 hours	1	
Emergency Caesarean birth in labour	2	
Elective Caesarean birth	1	
Assisted vaginal birth	1	
Postpartum haemorrhage > 1L/Need for transfusion	1	
TOTAL SCORE	If score 3 = LMWH prophylaxis for 10 days	
	If score 4 or more = LMWH prophylaxis for 6 weeks	

*DEFINITIONS

- Therapeutic anticoagulation: warfarin INR target 2-3/apixaban 5mg BD/rivaroxaban 20mg OD/edoxaban 60mg OD/dabigatran 150mg BD
- Prophylactic anticoagulation: any agent at a dose less than therapeutic.
- High-risk Thrombophilia: antithrombin deficiency, protein C or S deficiency, compound heterozygous or homozygous for low-risk thrombophilia.
- Low-risk Thrombophilia: heterozygous for factor V Leiden or prothrombin G20210A mutations.
- Anticoagulation outside of pregnancy refers to women who are on anticoagulation prior to pregnancy, unrelated to the pregnancy.
- Family History of VTE: VTE occurring in a first-degree family member (or members) at a young age (typically <50 years) either unprovoked or in the context of a minor provoking factor (e.g. Oral contraceptive pill (OP) use, pregnancy, long-distance travel).
- BMI – women should be weighed in the postnatal period to determine BMI for the purposes of risk assessment.
- Medical comorbidity: Presence of a severe co-morbidity for which the women receive specialist care, e.g. Ulcerative colitis, Crohn's disease, Rheumatic disease, Systemic Lupus Erythematosus, Type 1 Diabetes Mellitus, Cardiac disease.
- Any surgical procedure: e.g. appendectomy.
- Pre-eclampsia: Gestational hypertension: $\geq 140/90$ mmHg on 2 occasions ≥ 4 hours apart with proteinuria of at least 300mg in a 24-hour urine collection, arising de novo after the 20th week of gestation in a previously normotensive person or protein: creatinine ratio (PCR) above 30mg/mmol.
- Current systemic Infection: Proven infection, e.g. chorioamnionitis, pyelonephritis, pneumonia, bacteraemia, postpartum wound infection, or endometritis requiring IV antibiotics. Systemic Inflammatory Response Syndrome (SIRS) as defined by early warning score. Less serious infections (e.g. sinusitis, intrapartum fever with no proven infection) are not considered.
- Immobility: Prolonged bed rest with no mobilisation (>3 days) or prolonged seat immobility, e.g. wheelchair user or after a long distance travel (>4 hours).

Tables

Suggested dosing guide of Prophylactic Low Molecular Weight Heparin (LMWH) Thromboprophylaxis in pregnancy and Postpartum Periodⁱ.

Maternal weight (booking weight for antenatal dosing; after delivery for postnatal dosing)	Low molecular weight heparin (LMWH)	
	Tinzaparin	Enoxaparin
<50kg	3500 IU OD	20mg OD
50-100kg	4500 IU OD	40mg OD
101-129kg	7000 IU OD	60mg OD
130-169kg	9000 IU OD	80mg OD
≥170kg	Seek local advice	
OD – once daily IU – international units		

Early mortality risk for pulmonary embolism (PE) adapted from 2019 ESC guidelines.

Early mortality risk	Risk Indicator			
	Haemodynamic instability ^a	Simplified Pulmonary Severity Index Score ^b	Right ventricular dysfunction on cardiac echo or CTPA	Elevated cardiac troponin levels
High	Yes	≥ 1	Yes	Yes
Intermediate	No	≥ 1	One or no positive findings	
Low	No	0	No	No

^a Cardiac arrest, obstructive shock or persistent hypotension

^b Simplified Pulmonary Severity Index Scoreⁱⁱ

Simplified Pulmonary Severity Index (PESI) Score

Parameter	Point
Age >80	1
Cancer	1
Chronic heart failure or chronic pulmonary disease	1
Pulse rate ≥ 110 bpm	1
Systolic BP < 100 mmHg	1
Arterial oxygen saturation < 90%	1

- i Reducing the Risk of Thrombosis and Embolism during Pregnancy and the Puerperium (Green-top Guideline No. 37a). Position statement – September 2026
- ii Konstantinides SV, Meyer G, Becattini C, *et al.* 2019 ESC Guidelines for the diagnosis and management of acute pulmonary embolism developed in collaboration with the European Respiratory Society (ERS). *Eur Heart J.* 2020;41(4):543-603.
- iii Jiménez D, Aujesky D, Moores L, *et al.* Simplification of the pulmonary embolism severity index for prognostication in patients with acute symptomatic pulmonary embolism. *Arch Intern Med.* 2010;170(15):1383-1389.

Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary, and to provide evidence of quality improvement initiatives.

Auditable standards for this guideline include:

1. The percentage of women who underwent VTE risk assessment in early pregnancy or at the antenatal booking visit (100%).
2. The percentage of women who underwent VTE risk assessment following hospital admission (100%).
3. The percentage of women who underwent VTE risk assessment following delivery (100%).
4. The percentage of women at risk of PA-VTE who received patient information resources on PA-VTE signs, symptoms and prevention (100%).
5. The percentage of women at risk of PA-VTE who received appropriate pharmaceutical thromboprophylaxis (100%).
6. The percentage of women suspected of PE who had a chest x-ray and ECG (100%).
7. The percentage of pregnant or postnatal women with suspected DVT who underwent diagnostic imaging (100%).
8. The percentage of women with PA-VTE with a documented antenatal, peripartum and postpartum anticoagulation management plan (100%).
9. The percentage of women with PA-VTE who were offered evaluation for the long-term complications of DVT and/or PE (100%).

Recommended reading:

1. Health Service Executive (2025), National Centre for Clinical Audit Nomenclature - Glossary of Terms, National Quality and Patient Safety Directorate. https://assets.hse.ie/media/documents/HSE_National_Centre_for_Clinical_Audit_Nomenclature_2025.pdf
2. HSE National Framework for developing Policies, Procedures, Protocols and Guidelines [How_to_Develop_HSE_National_Policies_Procedures_Protocols_and_Guidelines_gQBQ4os.pdf](#)
3. Konstantinides, S. V., Meyer, G., Becattini, C., Bueno, H., Geersing, G. J., Harjola, V. P., Huisman, M. V., Humbert, M., Jennings, C. S., Jiménez, D., Kucher, N., Lang, I. M., Lankeit, M., Lorusso, R., Mazzolai, L., Meneveau, N., Ní Áinle, F., Prandoni, P., Pruszczyk, P., Righini, M., ... ESC Scientific Document Group (2020). 2019 ESC Guidelines for the diagnosis and management of acute pulmonary embolism developed in collaboration with the European Respiratory Society (ERS). European heart journal, 41(4), 543–603. DOI: [10.1183/13993003.01647-2019](https://doi.org/10.1183/13993003.01647-2019)
4. National Clinical Guideline on Venous Thromboembolism (NCG-VTE): Eve Protocol Phase 1: Diagnosis & immediate treatment, physical & psychological recovery; awareness of signs & symptoms; general aspects of prevention in non-pregnant adults. HSE. July 2025. <https://www2.healthservice.hse.ie/organisation/national-pppgs/national-clinical-guideline-on-venous-thromboembolism-ncg-vte-eve-protocol/>
5. Lindqvist PG, Westerlund E, Hellgren M. Swedish obstetric thromboprophylaxis guideline: background and update. J Obstet Gynaecol. 2023 Dec;43(2):2241527. DOI: [10.1080/01443615.2023.2241527](https://doi.org/10.1080/01443615.2023.2241527)
6. Thrombosis Canada. 2023. Pregnancy thromboprophylaxis. Available from: clinical guides/pdfs/THROMBOPROPHYLAXISINPREGNANCY_39.pdf [Accessed 15 Jun 2023]. <https://thrombosiscanada.ca/>
7. Bistervels IM, Buchmüller A, Wiegers HMG, et al. Intermediate-dose versus low-dose low-molecular-weight heparin in pregnant and post-partum women with a history of venous thromboembolism (Highlow study): an open-label, multicentre, randomised, controlled trial. Lancet. 2022;400(10365):1777-1787. DOI: [10.1016/S0140-6736\(22\)02128-6](https://doi.org/10.1016/S0140-6736(22)02128-6)

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<https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/>

