Pregnancy VTE prophylaxis

- Indications:
    - History of a pregnancy related VTE
    - History of a VTE that was associated with another hormonal risk factor (such as estrogen or oral contraceptive related)
    - History of a single idiopathic, unprovoked VTE; and in those with a history of multiple VTEs, regardless of the cause
- No indication if previous VTE associated with a nonhormonal, temporary provoking risk factor such as trauma, immobility, surgery, and no additional risk factors
- The drug of choice in pregnancy for both thromboprophylaxis and for therapeutic anticoagulation is subcutaneous LMWH over IV or subcutaneous UFH.
    - Low-dose LMWH throughout the pregnancy and generally for at least 6 weeks after delivery
    - LMWH is preferred over UFH because of convenience and reliability and lower risks of osteoporosis/osteopenia, and thrombocytopenia
- Vitamin K antagonists should not be used antepartum because of teratogenicity, particularly in early pregnancy, but can be used during lactation
- DOAC are not as well studied and should not be used during pregnancy or lactation
- There are some data regarding the use of fondaparinux in pregnancy or during lactation, and it can be used in cases of heparin allergy or heparin-induced thrombocytopenia