

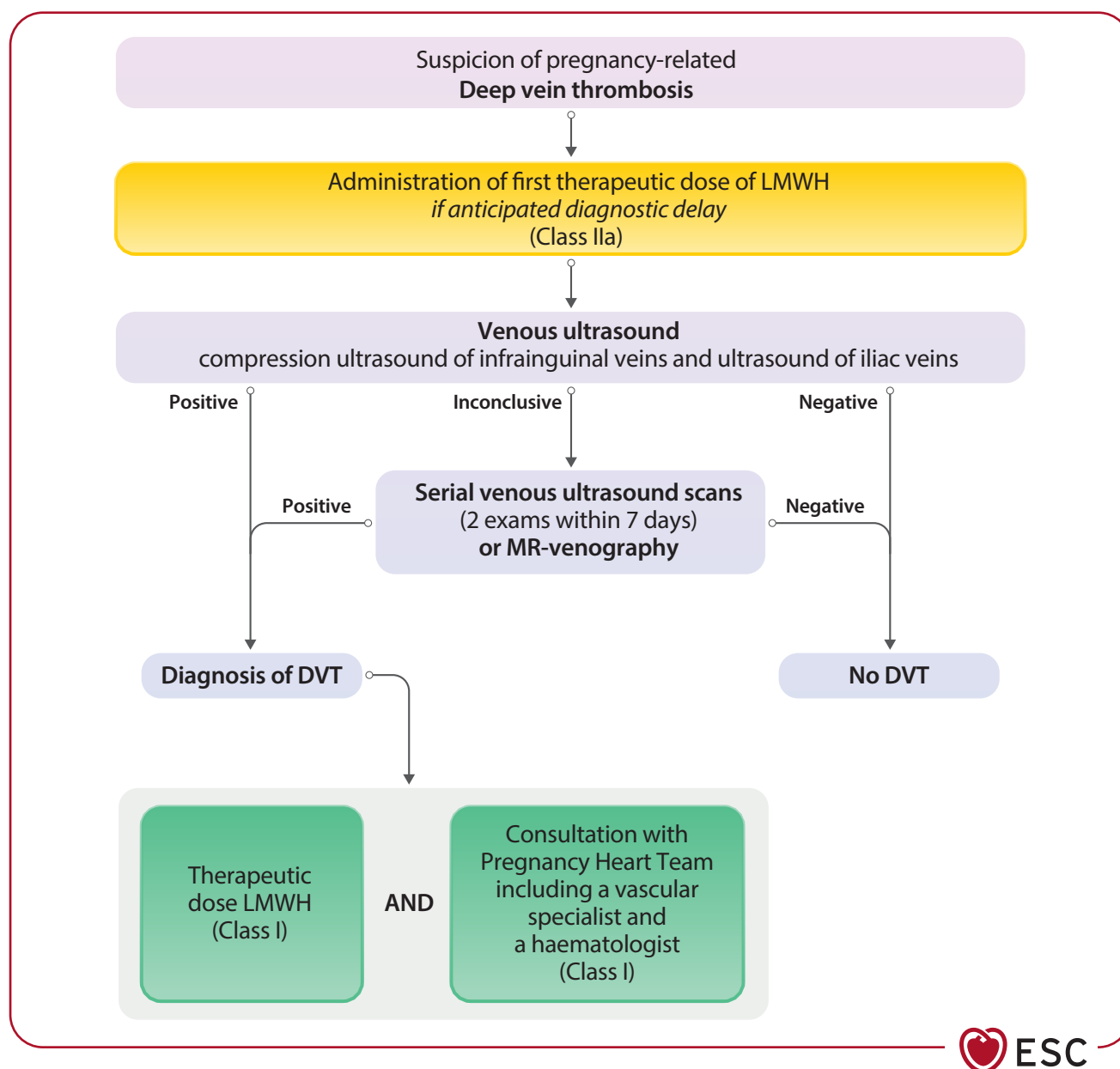


Figure 9 Algorithm for the diagnosis and treatment of deep vein thrombosis during pregnancy. DVT, deep vein thrombosis; LMWH, low-molecular-weight heparin, MR, magnetic resonance. Adapted from Chan et al.⁵²³

11.4.1.2. Pulmonary embolism

Clinical signs and symptoms of PE in pregnancy do not differ from those of PE in non-pregnant women. The diagnostic approach in haemodynamically stable pregnant women with suspicion of PE aims to reduce the need for computed tomography pulmonary angiography (CTPA) by implementing additional diagnostic strategies, such as clinical features, D-dimer, and venous ultrasound. Levels of D-dimer increase physiologically up to 39% per trimester.⁵²⁴ A multinational study demonstrated the efficiency of a diagnostic strategy involving clinical probability, D-dimer measurements (threshold <500 µg/L), and peripheral venous compression ultrasound to reduce the need for CTPA.⁵²⁵ Using both the YEARS criteria (1, clinical signs of acute DVT; 2, haemoptysis; 3, PE is the most likely diagnosis) and adapted D-dimer thresholds allows a further reduction in the need for CTPA (D-dimer threshold if YEARS criteria present <500 µg/L, if

YEARS criteria absent <1000 µg/L).⁵²⁶ Another meta-analysis confirmed the value of including D-dimer in a diagnostic algorithm to rule out PE in pregnant women with suspicion of PE (Figure 10).⁵²⁷

11.4.2. Treatment of venous thromboembolism in pregnancy

In pregnant women with a suspicion of VTE, anticoagulation with therapeutic LMWH should be commenced immediately, even before imaging, until the diagnosis of VTE is either excluded or confirmed. In pregnant women with confirmed acute VTE, therapeutic anticoagulation with weight-adjusted LMWH based on early pregnancy weight is recommended by using either a twice-daily or a once-daily regimen, each one resulting in a therapeutic daily dose⁵¹⁸ (see also Section 5.2.1). Currently, there is insufficient evidence to favour once- or twice-daily regimens.^{217,218,518}