

Pregnancy & Postpartum: Understanding and Preventing Blood Clots: Questions and Answers

1. For those of us who develop varicose veins during pregnancy, does this increase our risk of future blood clots? Or perhaps vein efficiency?

Two questions to answer here. Varicose veins may predispose to superficial thrombophlebitis which is clot in superficial veins causing hard and painful veins. Only occasionally might this lead to DVT.

Having varicose veins long term does raise the risk of having chronic venous insufficiency down the line, especially with repeat pregnancies. What is chronic venous insufficiency? – it is basically when the valves inside the leg veins don't work properly, so blood struggles to flow back to the heart and pools in the legs. Over time this pooling can cause symptoms like swelling, aching, skin changes and occasionally ulcers.

2. Warfarin is safe after pregnancy. Are LMWH (Low Molecular Weight Heparin) injections more effective, or should some women consider switching to Warfarin once the baby is born? What are the pros and cons of each option? Is it safe for breastfeeding babies?

LMWH and warfarin are roughly equal in effect for reducing the risk of blood clots after birth for most women. There are a few indications where warfarin is better – for those with mechanical heart valves and women with thrombotic antiphospholipid syndrome.

The advantage of heparin injections is that they work immediately, do not need blood monitoring and are safe with breastfeeding but they are daily injections which many women find unpleasant.

Warfarin is a tablet so much more convenient and is also fine with breastfeeding since it does not pass into the milk in a meaningful amount. But it takes several days to become effective and needs regular blood tests to check dosing and must be started under cover of heparin and can't be stopped until heparin has overlapped it for several days and the INR test is in the correct range for that woman.

Women who should switch over to warfarin in preference to low molecular weight heparin, are those with mechanical heart valve. Some women switch because they might have a needle phobia or are just fed up of taking daily injections for a long time.

3. Following a blood clot in pregnancy, are there situations later in life where we should expect to need blood thinners again? For example, future pregnancies, long-haul flights, long car journeys (such as driving for six hours), surgery or other periods of increased risk.

For future pregnancies, women with a prior pregnancy related clot are usually offered blood thinner injections again all way through pregnancy and for 6 weeks after giving birth, since the recurrence risk without prevention is substantial. For surgery it is standard to flag history of blood clots in the past and patient should automatically receive low molecular weight heparin cover around any operation. For long journeys guidance varies quite considerably at the best advice is that you should keep as mobile as possible during the journey and we would not recommend driving continuously for 6 hours- one should stop and get out of the car and have a short walk every few hours as well as making sure dehydration is not a problem.

4. What contraception options are recommended after having a baby if you've had a DVT during pregnancy?

The key thing after a clot during pregnancy is avoiding any contraception that is oestrogen based: so that the combined pill, the patch, contraceptive patch and vagina ring are all off the table, since oestrogen raises classic clotting risk further. Instead, the progesterone only options are the way to go so things like the progesterone only pill, the implant or the coil whether that is the hormonal or copper version are all considered safe. The only exception is the progesterone injection which has recently been thought to carry an increased risk of clots, and we would now definitely avoid it at least in the first 6 working weeks after giving birth.

5. Why only 10 days of LMWH after birth? Based on studies and previous maternal deaths in the UK, we know the risk of blood clots remains elevated for up to six weeks after birth. The RCOG guidance suggests the risk reduces during weeks five and six, but why are many some women prescribed LMWH for only 10 days following birth or a caesarean section?

Good question. It comes down to risk stratification rather than one blanket rule. The 10 days duration is specifically for women who are intermediate risk, meaning they have got some risk factors like a caesarean birth or a couple of the RCOG scoring criteria but not enough to be classed high risk.

The logic is that the clot risk peaks hardest in the first 2 to 3 weeks after birth so 10 days catches most of that early spike sufficiently without over treating everyone for the full 6 weeks, since heparin does carry a bleeding risk and a cost of its own.

Women who are at high risk who might have had prior clots or persistent risk factors such as wound infection or immobility get extended to the full 6 weeks.

It is really a two-tiered system tailored to how much risk each woman actually carries rather than everybody getting the same duration.

6. If Anti-Xa levels are monitored during pregnancy, should they continue to be monitored after birth in women who remain on LMWH for three months postpartum?

The whole reason anti-Xa monitoring to look at the anticoagulant effect of LMWH is done in pregnancy, is because the body is changing: changing blood volume, and kidneys clear LMWH differently in pregnancy, so still fixed weight-based dose can drift out of range in those who are at extremes of body weight. The other reason is if a woman has antithrombin deficiency. Heparin works through making antithrombin work harder, but if you start off with a low or defective level of antithrombin then you are going to need more heparin to make the antithrombin in that woman working even harder. So, these women need higher doses of heparin and anti-Xa monitoring to get the dose correct for them.

Most units no longer monitor anti-Xa levels during pregnancy unless someone falls into the categories above.

7. If we develop a DVT during pregnancy and are prescribed twice-daily LMWH based on our booking weight (our weight at the booking appointment), is that dose usually continued after birth, or should it be reassessed?

Most women who are prescribed twice daily low molecular weight heparin during pregnancy are at high risk of clots and their management has been individualised for them. After delivery with the loss of the extra blood volume that occurs during pregnancy and the restoration of kidney function back to normal, many women who are on twice daily LMWH dosing in pregnancy can return to once daily. However, I want to emphasise that this is an individual risk assessment in each high risk woman.

8. What should a postnatal review include and is there ever a role for a follow -up scan after birth?

A postnatal review is designed to check the mental and physical health of mother and baby. If a woman has had a clot during pregnancy and is recovering well, there is no reason to have a repeat scan after the pregnancy.

9. Does having a DVT during pregnancy affect our risk during perimenopause or menopause? If hormonal treatment is needed in the future, such as HRT, what options are considered safest and are there any preparations that should be avoided?

Transdermal HRT in recommended licensed doses does not increase the risk of blood clots, unlike tablet/oral HRT. So, women with previous clots or thrombophilia who need HRT should receive transdermal HRT.

Answered by Professor Beverley Hunt August 2026