

題名:Prior use of anticoagulants; but not antiplatelet agents; is associated with worse short-term outcome of intracerebral hemorrhage.

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摘要:INTRODUCTION: Prevention and treatment of venous thromboembolism during pregnancy are complicated since the use of antithrombotic drugs carries a certain risk to the mother, the fetus or both. Coumarins cross the placental barrier and may be responsible for bleeding, teratogenicity and central nervous system abnormalities. The risk of embriopathy is particularly high between 6 and 12 weeks of gestation. TREATMENT: Heparin is the treatment of choice for thrombosis during pregnancy because it is entirely safe for the fetus, unlike oral anticoagulants. The frequency of heparin-induced thrombocytopenia and osteoporosis is significantly lower if LMWH is applied, so this heparin type is preferable to UFH during pregnancy. Treatment of women with VTE during pregnancy, especially those with thrombophilia, requires individualized dosing and duration of antithrombotic therapy. PERIPARTAL MANAGEMENT: In order to avoid the peripartum anticoagulant heparin effect and possible bleeding, heparin should be discontinued prior to the delivery and reintroduced after the parturition. PROPHYLACTIC REGIMEN: Prophylactic antithrombotic regimen during subsequent pregnancies should also be individualized. The use of low molecular weight heparins is becoming more widespread. They have reliable pharmacokinetics, require less frequent injections than unfractionated heparin and carry a lower risk of treatment complications. LMW heparins are safe and effective and they are replacing UFH as the

anticoagulant of choice during pregnancy. Both UFH and LMWH are not secreted into breast milk and can be safely given to nursing mothers. Warfarin does not induce an anticoagulant effect in the breast-fed infant, so it can be safely used in women who require postpartum anticoagulant therapy.