Fondaparinux is a safe alternative in case of heparin intolerance during pregnancy

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Abstract

Heparin is the drug of choice for the treatment or the prevention of thromboembolic disease during pregnancy. However, treatment options are limited when heparin cannot be used because of hypersensitivity skin reactions. Despite the recent availability of new anticoagulant agents, data relating to their use during pregnancy is lacking. This report describes the successful management with fondaparinux, during 150 days, of a pregnant patient with protein S deficiency and prior DVT who developed heparin and danaparoid hypersensitivity.
Introduction

Adverse reactions to low molecular weight heparins (LMWH) are rare events. They may present with urticarial rash, a type I immediate hypersensitivity reaction, with skin necrosis due to vasculitis (type III Arthus reaction) or heparin-induced thrombocytopenia (HIT). In absence of severe cutaneous manifestations and HIT, a particular LMWH may be replaced with another one with success. If the skin symptoms do not improve following LMWH change, cutaneous tests may help detect the presence of a cross-reactivity between the available preparations of LMWHs and danaparoid sodium and guide the choice for a suitable anticoagulant. Indeed, in the presence of a negative subcutaneous provocation test, the compound can be used with low risk. If all LMWHs and danaparoid sodium yield a positive skin test, oral anticoagulants or hirudin can be used.

Fondaparinux is a synthetic pentasaccharide that has been extensively studied for use in surgery prophylaxis, and the treatment of thromboembolic diseases. It has been recently reported that anti-PF4/heparin antibodies are generated in a few patients during treatment with fondaparinux however, none developed thrombocytopenia. Indeed, these antibodies do not bind well to PF4/fondaparinux complexes, thus are not able to activate platelets in the presence of fondaparinux. Along the same line a recent case report described successful treatment of HIT with fondaparinux. However, it is still not clear whether cross reactivity exists with fondaparinux in patients known to have hypersensitivity to several LMWH preparations. A few case reports described either formation of eczematous lesions at the injection site of a single dose of fondaparinux or tolerance.

When heparin intolerance occurs in pregnant patients with a high risk of thrombosis, choices of alternative anticoagulation are limited. Danaparoid has been used to treat pregnant women with heparin intolerance or a history of HIT. The successful use of subcutaneous lepirudin has also been reported in women with pregnancies complicated by HIT. Hirudin
derivatives have been accompanied by fetal toxicities and their use in this setting is contraindicated in Switzerland. Vitamin K antagonists cross the placenta and are associated with a risk of embryopathy between the 6th and 12th week of pregnancy. We report here successful treatment of a young pregnant woman, with broad cross-reactivity between several heparins and heparinoids, using fondaparinux.

**Results and discussion**

A 39-year-old pregnant patient with known protein S deficiency, with previous deep vein thrombosis (DVT) and family history of thromboembolic disease (TED) requires anticoagulant prophylactic therapy during pregnancy. Because of severe cutaneous allergic reactions to LMWH and UFH in the past (table 1), she was initially treated with danaparoid sodium (subcutaneous injections twice daily). However, she soon developed severe skin reactions at the site of injections. Danaparoid treatment was stopped and subcutaneous injections of fondaparinux 2.5 mg daily were started. Treatment was continued uneventfully for 150 days until delivery. The patient did not develop any allergic reactions at injection site, and no thromboembolic events or abnormal bleeding were observed. Platelet count remained within normal range, and no anti fondaparinux-PF4 antibodies were detected. Anti-Xa activity was monitored during pregnancy. For this purpose we adapted our standard laboratory method for determination of the anti-factor Xa activity of heparin based on inhibition of a constant amount of FXa which activity is determined by a specific chromogenic substrate (Sxa-11, Hyphen BioMed, Neuville-sur-Oise, France). However, in this setting fondaparinux was used instead of heparin for calibration and measured fondaparinux levels were expressed in mg/l of the fondaparinux calibrator. Peak plasma levels of fondaparinux (about 3 hours post dose) were the following: 0.35 mg/l, 0.43 mg/l, and 0.43 mg/l during the 1st, 2nd and 3rd trimester, respectively. These concentrations are within the expected range of 0.3-0.5 mg/l for patients.
receiving 2.5 mg once daily suggesting that during pregnancy no dose adaptation may be necessary. Cord blood fondaparinux concentration as well as anti-Xa activity were not measured in the newborn since fondaparinux was not administered to the mother during the 24 hours preceding caesarean section. No adverse effects were observed in the newborn. New direct thrombin inhibitors have not yet been formally evaluated during pregnancy. LMWH and UFH are the anticoagulants of choice however, their use may be complicated by occurrence of immunological adverse reactions. Therefore, based on its efficacy and tolerability and on the basis of the present report fondaparinux may be a valuable alternative during pregnancy. To our knowledge this is the 6th case reported in the literature, the longest in terms of treatment duration, of a pregnant patient with heparin and danaparoid hypersensitivity successfully treated with fondaparinux. Fetal safety is always an issue when considering maternal pharmacological treatment. In a recently published report a minor transplacental passage of fondaparinux was found in vivo. Five pregnant patients were treated with fondaparinux for 1-101 days and anti-factor Xa activity in umbilical cord plasma of newborns was found to be 1/10 the concentration of maternal plasma. This concentration was well below that required for effective anticoagulation. However, based on available data one cannot exclude a potential deleterious effect of fondaparinux on the fetus even at very low doses. From animal studies it seems that fondaparinux has no effect in the prevention of fetal death within the context of antiphospholipid antibodies. Therefore, the use of fondaparinux in pregnant women, until larger scale studies are available, should be limited to those patients with either severe allergic reactions to heparin as was the case of our patient or eventually HIT.
References


Table 1. Results of allergological investigations (+: papule > 8 mm with erythema)

<table>
<thead>
<tr>
<th>Anticoagulants tested (tested doses)</th>
<th>Prick test</th>
<th>Intradermal test</th>
<th>Subcutaneous test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20 min</td>
<td>7 days</td>
<td></td>
</tr>
<tr>
<td>Enoxaparin (20mg)</td>
<td>-</td>
<td>-</td>
<td>+ (eczema)</td>
</tr>
<tr>
<td>Dalteparin (2500 UI)</td>
<td>-</td>
<td>-</td>
<td>+ (eczema)</td>
</tr>
<tr>
<td>Nadroparin (2850 UI)</td>
<td>-</td>
<td>positive</td>
<td>+ (eczema)</td>
</tr>
<tr>
<td>Certoparin (3000 UI)</td>
<td>-</td>
<td>-</td>
<td>+ (eczema)</td>
</tr>
<tr>
<td>Unfractionated heparin (5000 UI)</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Desirudin (60mg)</td>
<td>-</td>
<td></td>
<td></td>
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