

Five Things Physicians and Patients Should Question

1 Don't do an inherited thrombophilia evaluation for women with histories of pregnancy loss, intrauterine growth restriction (IUGR), preeclampsia and abruption.

Scientific data supporting a causal association between either methylenetetrahydrofolate reductase (MTHFR) polymorphisms or other common inherited thrombophilias and adverse pregnancy outcomes, such as recurrent pregnancy loss, severe preeclampsia and IUGR, are lacking. Specific testing for antiphospholipid antibodies, when clinically indicated, should be limited to lupus anticoagulant, anticardiolipin antibodies and beta 2 glycoprotein antibodies.

2 Don't place a cerclage in women with short cervix who are pregnant with twins.

Women with a short cervical length who are pregnant with twins are at very high risk for delivering preterm, but the scientific data, including a meta-analysis of data published on this issue, shows that cerclage in this clinical situation not only is not beneficial, but may in fact be harmful, i.e., associated with an increase in preterm births.

3 Don't offer noninvasive prenatal testing (NIPT) to low-risk patients or make irreversible decisions based on the results of this screening test.

NIPT has only been adequately evaluated in singleton pregnancies at high risk for chromosomal abnormalities (maternal age >35, positive screening, sonographic findings suggestive of aneuploidy, translocation carrier at increased risk for trisomy 13, 18 or 21, or prior pregnancy with a trisomy 13, 18 or 21). Its utility in low-risk pregnancies remains unclear. False positive and false negative results occur with NIPT, particularly for trisomy 13 and 18. Any positive NIPT result should be confirmed with invasive diagnostic testing prior to a termination of pregnancy. If NIPT is performed, adequate pretest counseling must be provided to explain the benefits and limitations.

4 Don't screen for intrauterine growth restriction (IUGR) with Doppler blood flow studies.

Studies that have attempted to screen pregnancies for the subsequent occurrence of IUGR have produced inconsistent results. Furthermore, no standards have been established for the optimal definition of an abnormal test, best gestational age for the performance of the test or the technique for its performance. However, once the diagnosis of IUGR is suspected, the use of antenatal fetal surveillance, including umbilical artery Doppler flow studies, is beneficial.

5 Don't use progestogens for preterm birth prevention in uncomplicated multifetal gestations.

The use of progestogens has not been shown to reduce the incidence of preterm birth in women with uncomplicated multifetal gestations.

Five More Things Physicians and Patients Should Question

6

Don't perform routine cervical length screening for preterm birth risk assessment in asymptomatic women before 16 weeks of gestation or beyond 24 weeks of gestation.

The predictive ability of cervical length measurement prior to 16 weeks of gestation for preterm birth risk assessment is limited. It should be performed, when indicated, between 16 and 24 weeks of gestation. Routine cervical length screening for preterm birth risk assessment in asymptomatic women beyond 24 weeks of gestation has not been proven to be effective.

7

Don't perform antenatal testing on women with the diagnosis of gestational diabetes who are well controlled by diet alone and without other indications for testing.

Monitoring of glucose levels and maintaining adequate glycemic control for gestational diabetes are paramount to decreasing adverse outcomes, including stillbirth. If nutritional modification and glucose monitoring alone control maternal glycemic status such that pharmacological therapy is not required, the risk of stillbirth due to uteroplacental insufficiency is not increased. Thus, the use of routine antepartum testing (e.g. biophysical profile (BPP) or nonstress test (NST)) in the absence of other co-morbidities is not indicated.

8

Don't place women, even those at high-risk, on activity restriction to prevent preterm birth.

There are no studies documenting an improvement in outcomes in women at risk for preterm birth who are placed on activity restriction, including bed rest. There are multiple studies documenting untoward effects of routine activity restriction on the mother and family, including negative psychosocial effects. Therefore, activity restriction should not be routinely prescribed as a treatment to reduce preterm birth.

9

Don't order serum aneuploidy screening after cfDNA aneuploidy screening has already been performed.

Serum biochemistry and cell free DNA (cfDNA) are both screening tests for fetal aneuploidy. When low-risk results have been reported on either test, there is limited clinical value of also performing the other screen. While serum screening may identify some aneuploidies not detected by cfDNA, the yield is too low to justify this test if cfDNA screening has already been performed.

10

Don't perform maternal serologic studies for cytomegalovirus and toxoplasma as part of routine prenatal laboratory studies.

Routine serologic screening of pregnant women for CMV and toxoplasmosis is not recommended due to poor predictive value of these tests and potential for harm due to false positive results. Serologic screening during pregnancy for both diseases should be reserved for situations in which there is clinical or ultrasound suspicion of maternal or fetal infection.

How This List Was Created

As a national medical specialty society, the Society for Maternal-Fetal Medicine relies on the input of any number of its committees in the development of various documents. In the case of the items included in this list, the Publications Committee reviewed the literature and evidence from SMFM's published documents for possible topics. For SMFM's first set of five recommendations a sub-group of the Committee initially developed a list of 10 items that the Committee then ranked for the top five with input and suggestions by the Society's Executive Committee. For SMFM's second set of recommendations, the sub-group of the Committee developed a list of 12 items that the Committee then ranked for the top five, again soliciting input and suggestions by the Society's Executive Committee. The final list has been reviewed and approved by the Society's Risk Management Committee and Executive Committee.

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