Choosing Wisely Australia
An initiative of NPS MedicineWise

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

5 THINGS
CLINICIANS AND CONSUMERS SHOULD QUESTION

Developed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists

1 Do not perform the following biochemistry tests during pregnancy in the absence of any specific indications: urea and electrolytes (U&E), Liver Function Tests (LFT), Lipids, Iron studies, TSH and vitamin D

Most serological tests conducted at the first antenatal visit return a normal result. Performing any of the listed tests on pregnant women in the absence of risk factors is not recommended as they are commonly normal or, alternatively, a result which is out of the normal range may not change clinical management.

For example, Vitamin D deficiency is common in many populations, particularly during winter months and in those with limited sun exposure. But few will have seriously low vitamin D levels that lead to clinical complications. Most pregnant women do not need a Vitamin D test as the results are unlikely to change clinical management. Only pregnant women at risk for Vitamin D deficiency should be tested in early pregnancy rather than routinely testing all pregnant women at their first antenatal visit. Women at increased risk of Vitamin D deficiency include:

i. those with reduced sunlight skin exposure e.g. veiled women
ii. those who use sunscreen on a regular basis
iii. dark-skinned women
iv. mothers of infants with rickets
v. women with a BMI >30.

Another test that remains controversial is the routine screening of pregnant women for sub-clinical thyroid disease by testing for thyroid stimulating hormone (TSH). Some professional societies have previously recommended universal or widespread targeted screening. However, since the results of the Controlled Antenatal Thyroid Screening Study were published in 2012, which showed no benefit in cognitive function in the children of treated women, more recent guidelines from the American College of Obstetricians and Gynecologists have not supported universal screening and treatment. Similarly, universal screening for thyroid autoantibodies is not recommended in pregnancy. Screening for thyroid dysfunction should only be considered for at risk groups.

Routine iron studies should not be performed however iron studies are recommended in women suspected of having a high risk of iron deficiency, e.g. women who have had two or more pregnancies close together, women with an iron-deficient diet or women with pre-pregnancy heavy menstrual bleeding.

Choosing Wisely Australia
An initiative of NPS MedicineWise

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

2 Do not perform serological testing for parvovirus B19, cytomegalovirus or toxoplasmosis during pregnancy in the absence of any specific indications at the first antenatal visit in pregnancy

Routine screening of pregnant women at the first antenatal visit for Cytomegalovirus (CMV) and toxoplasmosis is not recommended. These tests have a poor predictive value and there are risks associated with false positive results. Screening during pregnancy for these conditions should be reserved for situations in which there is clinical or ultrasound suspicion of maternal or fetal infection.

Screening all pregnant women for past Parvovirus infection at the first antenatal visit is not recommended. Fetal infection is usually benign and self-limiting but, in a small proportion causes severe anaemia and hydrops fetalis, though usually in the second trimester. Around 1 in 10 women infected before 20 weeks of gestation will suffer a fetal loss due to Parvovirus B19. The risk of an adverse outcome of pregnancy after this stage is remote. The maximum possible risk of a congenital abnormality due to Parvovirus B19 is under 1% and long-term development will be normal.

3 Don't perform more than three referred ultrasounds during pregnancy in the absence of clinical concerns, pathological symptoms or specific indications. Point of care ultrasound (performed within the GP or specialist obstetrician's rooms or clinic) will usually be sufficient where the ultrasound scan is performed for dating, determining the number of viable fetuses, confirming viability, identifying the presenting part or assessing the amniotic fluid volume in the third trimester of pregnancy

Although it is recommended that all pregnant women should have an obstetric ultrasound at approximately 20 weeks' gestation, multiple routine ultrasounds should not be performed in the absence of any clinical concerns, pathological symptoms or specific indications. It is recommended that in the absence of complications, there should be a maximum of three referred obstetric ultrasound scans during a pregnancy.

All those performing antenatal care should have the ability to perform point of care ultrasound for dating of the pregnancy, confirming viability, identifying the presenting part in late pregnancy and assessing amniotic fluid volume. Where the practitioner does not have these skills or the equipment, they should both be obtained. Unless it is technically difficult, it is not reasonable to expect women to travel and/or incur significant additional expense without first having had an attempt at point of care ultrasound. Where the point of care ultrasound is technically difficult or produces uncertain results, a referred ultrasound is appropriate. A referred ultrasound is also commonly preferred for other indications in pregnancy, e.g. 20 week morphology scans.

4 Do not perform population screening of women for ovarian cancer with serum CA125 and/or pelvic ultrasound

Current evidence from the largest ovarian cancer screening trial conducted to date (United Kingdom Collaborative Trial of Ovarian Cancer Screening; UKTOCS) does not support screening low risk, asymptomatic women with CA-125 and/or ultrasound for ovarian cancer. These tests do not detect earlier stages of disease and do not reduce ovarian cancer mortality. False positive results of these tests can lead to unnecessary procedures, which present additional risks of complications.

5 Do not perform ablative or excisional treatment of cervical low-grade squamous intraepithelial lesion (LSIL) in women during their reproductive years

In the absence of histologically proven high grade changes, excisional or ablative therapy to the cervix is not indicated. Women who have a loop excision or knife cone biopsy are 1.7 – 2.6 times more likely to have a preterm birth and 1.8 – 2.5 times more likely to have a low birth weight baby.

It is recommended that Pap tests reported as low grade in women less than 30 years be followed by a repeat Pap test in 12 months. If this repeat Pap test is reported as normal, then a further Pap test should be taken in another 12 months. If this Pap test is normal, it is recommended that the woman returns to two-yearly screening. If the repeat Pap test is reported as a low-grade or high-grade abnormality, it is recommended that the woman have a colposcopy.

The recommended management for women aged greater than 30 years with a low-grade Pap test is as follows: if the woman has had a normal Pap test in the preceding two to three years, it is recommended that she have another Pap test in 12 months. If the woman has not had a normal Pap test in the preceding two to three years, it is recommended she either have immediate colposcopy or a repeat Pap test within six months. For both of the above scenarios in women aged greater than 30 years where the Pap test is repeated, the recommended management is the same. If the repeat Pap test is abnormal (either low-grade or high-grade), colposcopy is recommended. If the repeat Pap test is normal, then a further Pap test should be taken in another 12 months. If this Pap test is normal, it is recommended that the woman returns to two-yearly screening.

SUPPORTING EVIDENCE

1.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Routine antenatal assessment in the absence of pregnancy complications. C-Obs 3(b) 2015.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Vitamin and mineral supplementation and pregnancy. C-Obs 25 2015.

Lazarus JH, Bestwick JP, Channon S, et al. Antenatal thyroid screening and childhood cognitive function. N Engl J Med 2012;366(6):493-501.

The American College of Obstetricians and Gynecologists. Thyroid disease in pregnancy. Practice Bulletin Number 148. Obstetrics & Gynecology 2015;125(4):996-1005.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Testing for hypothyroidism during pregnancy with serum TSH. C-Obs 46 2015.

Pavord S, Myers B, Robinson S, et al. UK guidelines on the management of iron deficiency in pregnancy. British Committee for Standards in Haematology 2011.

Rukuni R, Knight M, Murphy MF, et al. Screening for iron deficiency and iron deficiency anaemia in pregnancy: a structured review and gap analysis against UK national screening criteria. BMC Pregnancy and Childbirth 2015;15:269.

Pasricha SS, Flecknoe-Brown SC, Allen KJ, et al. Diagnosis and management of iron deficiency anaemia: a clinical update. MJA 2010;193(9):525-32.

2.

The American College of Obstetricians and Gynecologists. Cytomegalovirus, parvovirus B19, varicella zoster, and toxoplasmosis in pregnancy. Practice Bulletin Number 151. Obstetrics & Gynecology 2015;125(6):1510-25.

Miller E, Fairley CK, Cohen BJ, Seng C. Immediate and long term outcome of human parvovirus B19 infection in pregnancy. Br J Obstet Gynaecol 1998;105:174-8.

Society for Maternal-Fetal Medicine (SMFM), Hughes BL, Gyamfi-Bannerman C. Diagnosis and antenatal management of congenital cytomegalovirus infection. Am J Obstet Gynecol 2016;214(6):B5-B11.

3.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Routine antenatal assessment in the absence of pregnancy complications. C-Obs 3(b) 2015.

Salomon LJ, Alfirevic Z, Bilardo CM, et al. ISUOG Practice Guidelines: performance of first-trimester fetal ultrasound scan. Ultrasound Obstet Gynecol 2013;41:102-13.

4.

Jacobs IJ, Menon U, Ryan A, et al. Ovarian cancer screening and mortality in the UK Collaborative Trial of Ovarian Cancer Screening (UKCTOCS): a randomised controlled trial. Lancet 2016;387:945-56.

The American College of Obstetricians and Gynecologists. The role of the obstetrician-gynecologist in the early detection of epithelial ovarian cancer. Committee Opinion Number 477. Obstetrics & Gynecology 2011;117(3):742–6.

Barton MB, Lin K. Screening for ovarian cancer: evidence update for the U.S. Preventive Services Task Force Reaffirmation Recommendation Statement. AHRQ Publication No 12-05165-EF3. Rockville, MD: Agency for Healthcare Research and Quality 2012.

Buys SS, Partridge E, Black A, et al. Effect of screening on ovarian cancer mortality The Prostate, Lung, Colorectal and Ovarian (PLCO) cancer screening randomized controlled trial. JAMA 2011;305(22):2295-303.

5.

National Health and Medical Research Council. Screening to prevent cervical cancer: guidelines for the management of asymptomatic women with screen detected abnormalities. 2005.

Kyrgiou M, Koliopoulos G, Martin-Hirsch P, et al. Obstetric outcomes after conservative treatment for intraepithelial or early invasive cervical lesions: systematic review and meta-analysis. Lancet 2006;367:489-98.

Choosing Wisely Australia
An initiative of NPS MedicineWise

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

HOW THIS LIST WAS MADE

In the second half of 2015, the RANZCOG Board invited its members to provide feedback on areas they believed should be targeted for inappropriate use of health resources in obstetrics and gynaecology across Australia and New Zealand. The Board subsequently short-listed five areas and put these to RANZCOG Council for discussion in November 2015. Following further refinements, a review of relevant literature was undertaken on the five topics. Although an informal consultation style was intentionally used for this process, every effort has been made to ensure the information is factually correct and supported by the best available evidence.

Information in relation to the five draft items was circulated to the College membership through the eNewsletter and the College website with feedback invited in early 2016 (with a copy of the items available on the College website for review). All feedback from members was considered by the Board and the proposed areas were approved with minor revisions by the Board at its March 2016 meeting.

Declarations of interest have been sought from all members of the RANZCOG Board and Council.

The five areas do not provide a complete picture of where inappropriate practices exist and there are areas which may not be covered. However, these five suggestions are a starting point for conversation.

Current as at: October 2016

About Choosing Wisely Australia

Choosing Wisely Australia® is enabling clinicians, consumers and healthcare stakeholders to start important conversations about tests, treatments and procedures where evidence shows they provide no benefit and in some cases, lead to harm. This initiative is being led by Australia's medical colleges, societies and associations and is facilitated by NPS MedicineWise.

About The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is the leading standards body responsible for the training and education of specialists and GP obstetricians in obstetrics and gynaecology across Australia and New Zealand. RANZCOG has just over 4,600 members, 2,019 active specialists (1,741 practising in Australia and 278 in New Zealand) 2,512 Diplomates and 83 Certificate of Women's Health holders.

About NPS MedicineWise

Independent, not-for-profit and evidence based, NPS MedicineWise enables better decisions about medicines and medical tests. Visit **www.nps.org.au**

NPS MEDICINEWISE