SOCIETY OF OBSTETRIC MEDICINE OF AUSTRALIA AND NEW ZEALAND:
TOP FIVE RECOMMENDATIONS ON LOW VALUE PRACTICES

The Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) aims to advance clinical and scientific knowledge of hypertensive diseases and medical disorders in pregnancy. SOMANZ also fosters collaboration with other regional and international societies interested in hypertension in pregnancy and obstetric medicine. It is a specialty society affiliated with the Royal Australasian College of Physicians.

1. Do not perform a D-Dimer test for the exclusion of venous thromboembolism during any trimester of pregnancy

As D-dimer levels are raised during pregnancy, they do not have a high positive predictive value for venous thromboembolism (VTE) in pregnancy (i.e. they are unreliable for ruling in VTE in pregnancy). However, nor are they a reliable rule-out test for VTE. One study estimated the sensitivity of the D-Dimer test at 73 per cent, meaning that 27 per cent of patients with a negative D-Dimer had VTE. There have also been case reports of pregnant women with pulmonary embolism presenting with a negative D-Dimer. Therefore, there is no value in performing a D-Dimer test for the exclusion of venous thromboembolism at any trimester in pregnancy.

Supporting Evidence


2. Do not test for inherited thrombophilia for placental mediated complications

While older retrospective studies suggested that inherited thrombophilia is associated with adverse pregnancy outcomes such as stillbirth, recurrent miscarriage and placental abruption, more recent and more rigorous studies have either failed to find an association or have found only a weak association. Moreover, the association is a moot point as there is now good quality evidence from randomised controlled trials that low-molecular-weight heparin does not significantly reduce the rate of placental mediated complications.

Supporting Evidence


3. Do not do repeat testing for proteinuria in established pre-eclampsia

Measuring proteinuria is useful as a diagnostic but not as a prognostic criterion for pre-eclampsia. This is because the level of proteinuria does not correlate with the severity of maternal complications in women with pre-eclampsia, nor are these levels useful in determining the timing of delivery. Thus, repeat testing for proteinuria in managing established pre-eclampsia is not recommended, particularly given the availability of superior prognostic models.

Supporting Evidence


4. Do not undertake methylenetetrahydrofolate reductase (MTHFR) polymorphism testing as part of a routine evaluation for thrombophilia in pregnancy

Patients with the thermolabile variant of the methylenetetrahydrofolate reductase (MTHFR) polymorphism are at higher risk of hyperhomocysteinaemia which has been associated with venous thrombosis. However, these associations appear to hold only in countries lacking grain products nutritionally fortified as a public health measure. Moreover, homozygous variants are found in up to 15 per cent of some populations, so that detection of this variant would lead to many women undergoing complex counselling unnecessarily and may also be a cause of distress. Polymorphism is not more prevalent in women with pregnancy-associated venous thromboembolism and testing for this polymorphism is not recommended as part of a routine evaluation for thrombophilia in pregnancy.

Supporting evidence

5. Do not measure erythrocyte sedimentation rate (ESR) in pregnancy

Measuring the erythrocyte sedimentation rate (ESR) is a non-specific test to identify inflammation. An elevated result indicates inflammation but does not indicate where it is in the body or the cause. The normal range outside of pregnancy in women aged 18–50 is <20mm/h. One study found that levels varied from 4-70mm/hr and another found a range from 4-112mm/ hr, with levels being affected by gestational age and haemoglobin concentration. This is likely to reflect normal changes in pregnancy, meaning that testing for an elevated ESR does not sufficiently differentiate between healthy pregnant women and those who may be suffering from inflammatory diseases.

Supporting evidence


How was this list created?

SOMANZ Council members considered potential low value clinical practices in obstetric medicine of relevance to SOMANZ members, and developed a shortlist of nine items. Council members then worked with the RACP to compile and review the published research on each of these practices. Based on the review, the list of potential items of interest was refined down to seven and recommendations for these were formulated.

All Fellows and advanced trainees of SOMANZ were surveyed online for their views on these seven draft recommendations and provided with evidence summaries for each, and for their suggestions of other practices not already included. They were asked to score each recommendation based on whether they thought it was evidence based, currently undertaken in significant volume, and important for reducing harms and/or unnecessary healthcare costs. Based on the scores and feedback, the final top-five recommendations were then finalised and approved by SOMANZ Council.