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GYNAE SPECTRUM

Dear Doctor,

Greetings from Micro Labs, We are happy to bring you "**Gynae Spectrum**", which contains latest and interesting news in the field of Obstetrics and Gynaecology.

This issue contains:

- Impact of new diagnostic criteria of Preeclampsia on the diagnosis.
- ACOG algorithm: COVID-19 in pregnant women.

Should you require any article or, medical information, please feel free to contact us
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Looking forward to your valuable feedback.

Best Regards,

Medical Team, Micro Labs Limited



Impact of new diagnostic criteria of Preeclampsia on the diagnosis.

Background:

Preeclampsia (PE) is traditionally defined on the basis of the development of hypertension and proteinuria.

This has been revised off late to include cases which donot have proteinuria but have evidences of renal, hepatic or hematological dysfunction.

Objective:

The main objective of the study was to decipher the impact of the new definition of Preeclampsia on the incidence and severity of the disease. It was also undertaken to estimate the performance of the competing risks model for first trimester assessment of risk for Preeclampsia.

Method:

This study is a retrospective study. 66,964 women were enrolled. These women were known to have singleton pregnancies. They were classified as Preeclampsia, gestational hypertension (GH) or no Preeclampsia or gestational hypertension as per the traditional criteria of the International Society for the Study of Hypertension in Pregnancy (ISSHP). This defines Preeclampsia by the presence of hypertension and proteinuria.

The records of gestational hypertension and those women with high creatinine or liver enzymes or low platelet count were reviewed. They were reclassified as

Preeclampsia, as per the new criteria of ISSHP and the new criteria of the American College of Obstetricians and Gynecologists (ACOG).

The older & newer groups were compared for gestational age at delivery, percentile of birthweight, incidence of SGA neonates with birthweight

Results:

According to older definition of ISSHP 1,870 (2.8%) cases were diagnosed as Preeclampsia.

2,182 (3.3%) patients were diagnosed as gestational hypertension.

62,912 (94.0%) had neither of them.

As per ACOG: the incidence of Preeclampsia was 3.0%, i.e. 2,029 / 66,964.

The new definition of ISSHP determined 3.4% incidence, which is 2,301 / 66,964.

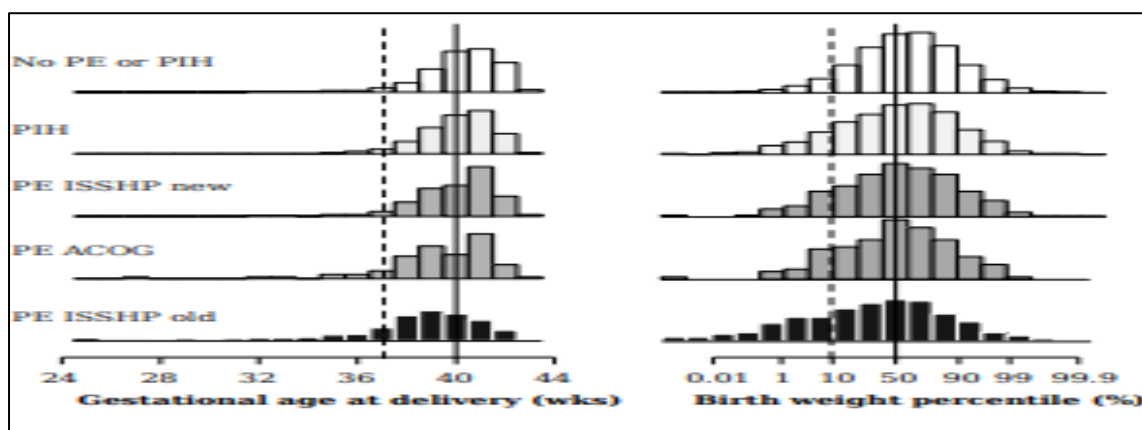
Median gestational age at delivery for Preeclampsia according to ISSHP-old definition is 38.4 weeks, was lower than in the extra cases of PE according to AJOG (difference 1.3 weeks, 95% CI 0.71-1.71) and extra cases of PE according to ISSHP-new (difference 1.5 weeks, 95% CI 1.29-1.71).

The incidence of SGA neonates in PE according to old definition of ISSHP was 33.34%, which was higher than the extra cases of PE according to AJOG and extra cases of PE according to ISSHP-new (relative risk 0.52%, 95% CI 0.42- 0.65).

Pregnancy outcome in the cases of PE and GH according to ISSHP-old and in those with PE according to ISSHP-new and ACOG excluding PE according to ISSHP-old.

Gestational age at birth in weeks	Median	Difference (95% CI)
ISSHP-old PE	38.43	
ISSHP-old no PE or GH	40.00	1.57 (1.52, 1.71)
ISSHP-old GH	39.80	1.37 (1.29, 1.57)
Extra cases of PE ACOG	39.71	1.29 (0.71, 1.71)
Extra cases of PE ISSHP-new	39.93	1.50 (1.29, 1.71)
Birthweight percentile (%)	Median	Difference (95% CI)
ISSHP-old PE	28.42	
ISSHP-old no PE or GH	49.25	20.83 (18.22, 24.38)
ISSHP-old GH	43.10	14.68 (11.18, 19.26)
Extra cases of PE ACOG	42.28	13.86 (3.94, 25.27)
Extra cases of PE ISSHP-new	43.39	14.97 (9.70, 22.00)
Incidence of SGA neonates	Percentage	Relative risk (95% CI)
ISSHP-old PE	33.64	
ISSHP-old no PE or GH	11.58	0.34 (0.32, 0.37)
ISSHP-old GH	20.26	0.60 (0.54, 0.67)
Extra cases of PE ACOG	19.50	0.57 (0.42, 0.79)
Extra cases of PE ISSHP-new	17.63	0.52 (0.42, 0.65)
Incidence of perinatal death	Percentage	Relative risk (95% CI)
ISSHP-old PE	1.34	
ISSHP-old no PE or GH	0.39	0.29 (0.20, 0.44)
ISSHP-old GH	0.41	0.31 (0.15, 0.65)
Extra cases of PE ACOG	1.26	0.94 (0.25, 3.51)
Extra cases of PE ISSHP-new	0.46	0.34 (0.09, 1.31)

* Comparison of each group with PE ISSHP-old



Conclusion:

The new definitions of Preeclampsia increases no. of pregnancies diagnosed with PE. The added cases had milder disease.



IN FOCUS

ACOG algorithm: COVID-19 in pregnant women

Very little is known about COVID-19, mainly its effect on pregnant women. Currently available data does not indicate pregnant women to be at increased risk. Currently it is not clear if COVID-19 has transplacental transmission.

Travel history is of paramount importance in medical history, as well as a history of exposure to people with symptoms of COVID-19. Health care practitioners should immediately notify infection control personnel in the event of a PUI for COVID-19.

Community mitigation efforts are being implemented. However, unintended impacts are inevitable which may limit access to routine prenatal care. It should be ensured that patients with high-risk conditions receive necessary prenatal care when necessary. It is important to plan in order to address the potential shortage of HCPs, personal protective equipment, limited isolation rooms. Telehealth should be used as far as possible to provide prenatal care. The American College of Obstetricians and Gynecologists encourages physicians and other obstetric care practitioners to read and familiarize themselves with the complete list of recommendations.

Their recommendations include:

- Prompt notification by health care practitioners to infection control personnel of the anticipated arrival of a pregnant patient who has confirmed COVID-19 or is a PUI.
- Patients or suspects should be treated in a single room with closed door. Airborne Infection Isolation Rooms should be used to treat patients getting aerosol-generating procedures.
- Facemasks are an acceptable alternative to respirators. Available respirators should be used for procedures that are likely to generate respiratory aerosols.
- Infants born to mothers with confirmed COVID-19 should be considered PUIs and should be isolated.
- To reduce the risk of transmission of the virus from the mother to child, the baby should be temporarily separated from the mother who has confirmed COVID-19 or is a PUI.
- Due to the knowledge on COVID-19, the recommendations are based on infection prevention and control considerations for other respiratory viruses.

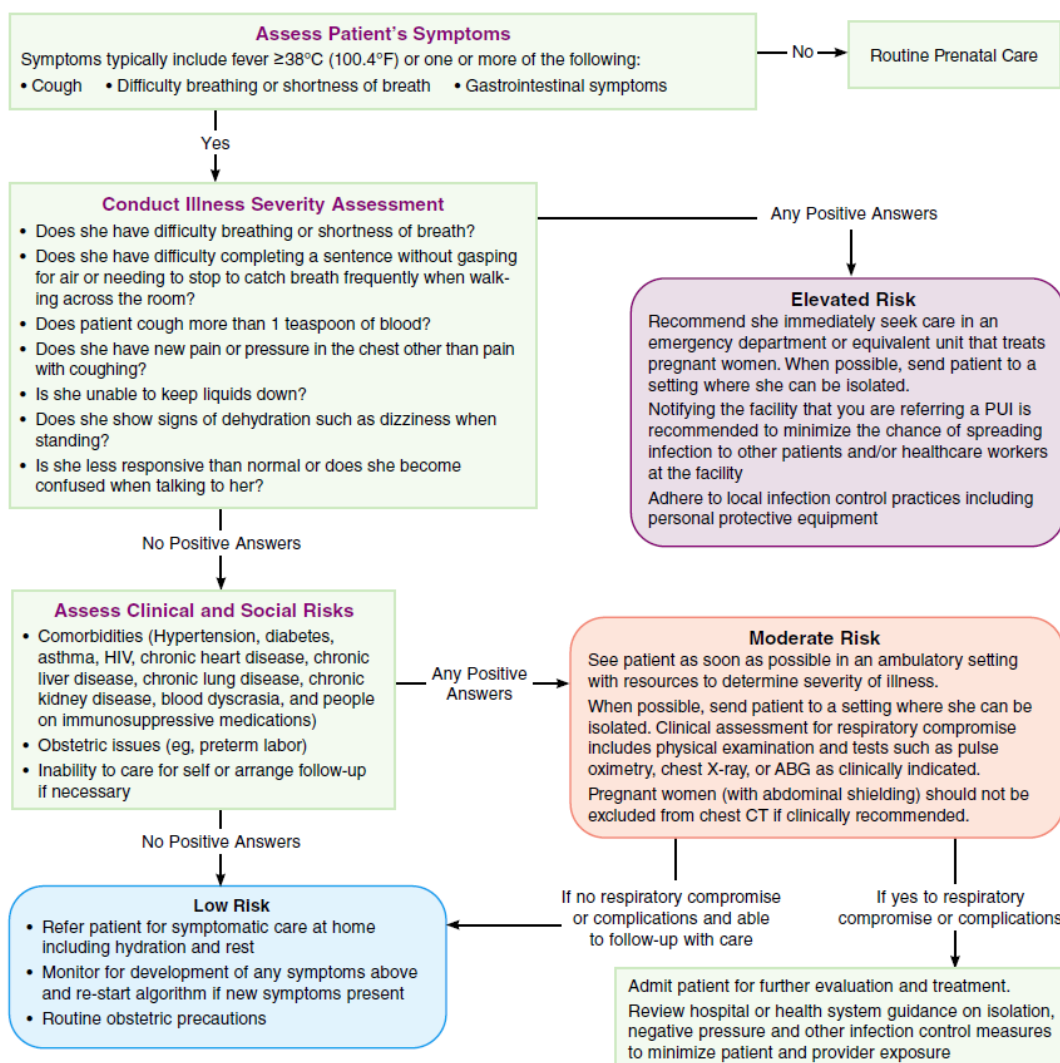


Outpatient Assessment and Management for Pregnant Women With Suspected or Confirmed Novel Coronavirus (COVID-19)

Unlike influenza and other respiratory illnesses, based on a limited number of confirmed COVID-19 cases, pregnant women do not appear to be at increased risk for severe disease. However, given the lack of data and experience with other coronaviruses such as SARS-CoV and MERS-CoV, diligence in evaluating and treating pregnant women is warranted.

This algorithm is designed to aid practitioners in promptly evaluating and treating pregnant persons with known exposure and/or those with symptoms consistent with COVID-19 (persons under investigation [PUI]). If influenza viruses are still circulating, influenza may be a cause of respiratory symptoms and practitioners are encouraged to use the [ACOG/SMFM influenza algorithm](#) to assess need for influenza treatment or prophylaxis.

Please be advised that COVID-19 is a rapidly evolving situation and this guidance may become out-of-date as new information on COVID-19 in pregnant women becomes available from the Centers for Disease Control and Prevention (CDC). <https://www.cdc.gov/coronavirus/2019-nCoV/index.html>



Abbreviations: ABG, arterial blood gases; CDC, Centers for Disease Control and Prevention; HIV, human immunodeficiency virus.

Healthcare providers should immediately notify their local or state health department in the event of a PUI for COVID-19 and should contact and consult with their local and/or state health department for recommendations on testing PUIs for COVID-19.

This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. The American College of Obstetricians and Gynecologists reviews its publications regularly; however, its publications may not reflect the most recent evidence. Any updates to this document can be found on www.acog.org or by calling the ACOG Resource Center. While ACOG makes every effort to present accurate and reliable information, this publication is provided "as is" without any warranty of accuracy, reliability, or otherwise, either express or implied. ACOG does not guarantee, warrant, or endorse the products or services of any firm, organization, or person. Neither ACOG nor its officers, directors, members, employees, or agents will be liable for any loss, damage, or claim with respect to any liabilities, including direct, special, indirect, or consequential damages, incurred in connection with this publication or reliance on the information presented.

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