
Obstetrics and Gynaecology

Twelve Things Physicians and Patients Should Question

by

Society of Obstetricians and Gynaecologists of Canada

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1 **Avoid the use of routine episiotomy in spontaneous vaginal births.**

Routine episiotomy has been shown to cause more harm than good. Studies demonstrate that restrictive episiotomy policies are associated with less posterior perineal trauma, less suturing, and fewer complications, with no difference for most pain measures or severe vaginal and/or perineal trauma. When the perineum is preventing delivery, particularly if the fetal heart rate is abnormal, an episiotomy may expedite a vaginal birth.

2 **Don't do electronic fetal monitoring for low risk women in labour; use intermittent auscultation.**

Continuous electronic fetal monitoring (EFM) leads to significantly greater rates of caesareans and operative vaginal deliveries in low risk patients compared to those monitored with intermittent auscultation. Intermittent auscultation results in no significant difference in the number of infant deaths during and shortly after labour, cerebral palsy rates, use of drugs for pain relief, and cord blood acidosis in low risk patients. Further, EFM restricts movement and positioning, excludes the option of using a birthing pool, and requires greater resource use to continuously interpret fetal heart rate tracings. EFM therefore increases risk of intervention and decreases choice without providing meaningful benefit to patient or neonatal outcomes in low risk patients.

3 **Don't perform routine urinalysis (protein, glucose) at every antenatal visit (in low risk normotensive women).**

Routine urinalysis (for glucose and protein) in low-risk pregnancies is not recommended. For screening of healthy pregnant women, urinalysis for glucose to assess the risk of developing gestational diabetes is not recommended due to low sensitivity. For assessing the potential development of preeclampsia in pregnant women, routine urine dipstick or urinalysis are not recommended as the test for albumin levels is unreliable. Do not rely on proteinuria to screen for gestational hypertension; periodically check the blood pressure.

4 **Don't perform umbilical artery Doppler studies as a routine screening test in uncomplicated pregnancies with normal fetal growth.**

Placental integrity, specifically vascular resistance, may be assessed by evaluating flow in the umbilical arteries using Doppler ultrasound. When this is done with high risk pregnancies the perinatal death rate is reduced and interventions may be appropriately timed or withheld. "High risk" in these investigations were principally intrauterine growth restriction and maternal hypertension. When Doppler studies were extended to low-risk pregnancies however there was no improvement in outcome and abnormal results were more likely to be false positives.

5 **Don't routinely screen with Pap smears if under 21 years of age or over 69 years of age.**

Screening should be initiated at 21 years of age for those who are asymptomatic and immunocompetent. Studies have shown the largest number of false positive test results occurring in adolescents younger than 21 years and have the lowest incidence of cervical cancer. There is no protective effect in screening those younger than 21 years. There are few studies that address the age of cessation. Modelling studies have not shown increase in protective effect when screening those greater than 70 years who have had prior routine screening.

6 **Don't routinely order hormone levels including estradiol, progesterone, follicle-stimulating hormone and luteinizing hormone in postmenopausal women or after a hysterectomy, either to diagnose menopause or to manage hormone therapy.**

The frequency and severity of menopausal symptoms do not correlate to the levels of either follicle-stimulating hormone (FSH) or serum estradiol. Reproductive estrogen levels are typically much higher than required to reduce symptoms. Management with hormone therapy is based on using the lowest effective dose to reduce symptoms to an acceptable level. Relying on elevated FSH to make a diagnosis may result in women being denied effective therapy for disruptive symptoms; use of an unreliable test may in this way contribute to less than optimal care. Using blood levels to adjust hormone therapy may result in higher doses of hormone therapy than are needed to reduce and manage symptoms.

7 Don't screen for ovarian cancer in asymptomatic women at average risk.

Screening for ovarian cancer does not improve clinical outcomes in asymptomatic women without a family history of the disease. Screening does not decrease all-cause mortality, ovarian cancer mortality or the risk of diagnoses of advanced stage ovarian cancer. There is no demonstrable benefit on mortality following transvaginal ultrasonography or routine pelvic screening examinations and the use of CA125 or other biomarkers for ovarian cancer but such screening resulted in false-positive tests, overdiagnosis, and overtreatment with inevitable complications.

8 Don't offer hysterectomy to women with asymptomatic fibroids on the basis of risk malignancy.

Rapid growth of a fibroid is not a predictor of leiomyosarcoma. In women undergoing surgery for fibroids approximately 1 in 400 (0.25%) is at risk of having a leiomyosarcoma. However, growth and/or new onset of symptoms post-menopause should carry a higher index of suspicion for malignancy. Incidental uterine leiomyosarcomas have been encountered during routine resectoscopic myomectomy, though their incidence appears to be lower than that reported following hysterectomy (0.13%). Leiomyomas and leiomyosarcomas cannot reliably be distinguished clinically or by any imaging technique.

9 Don't do any surgical intervention, including ablation, for abnormal uterine bleeding until medical management (including the progesterone intra-uterine system) has been offered and either declined or found unsuccessful.

There are several non-hormonal and hormonal agents that have proven to be effective in the treatment of abnormal uterine bleeding. Some of these may have the added benefit of providing symptom relief for dysmenorrhoea and offer contraceptive coverage. These agents may help stabilize anaemia and provide symptom relief alone, or may be utilized prior to surgical management of heavy menstrual bleeding. Medical management allows for early initiation of treatment in a primary care setting whereas surgical intervention may be limited by access to specialist consultation and operating facilities. All potential treatment options for abnormal uterine bleeding should be discussed with the patient and their side-effects, relative effectiveness, risks, costs and impact on fertility outlined so that an informed shared treatment decision can be made and a treatment plan instituted.

10 Don't remove ovaries in premenopausal women without strong clinical indications.

Large US population-based databases have estimated the rate of bilateral salpingo-oophorectomy (BSO) at the time of hysterectomy for benign indications to be 46.4%. When stratified by age, the rates of oophorectomy in women 45-49 years is approximately 60%, and in women >55 years is 65-75%. Studies have shown increase in all-cause mortality, coronary heart disease and cardiovascular death in women with BSO <50 years. These risks may be modified with hormone therapy. BSO has also been shown to increase risk of cognitive impairment and dementia, as well as increase long-term risks of depressive and anxiety symptoms. While BSO has been shown to reduce incidence of ovarian and breast cancer, there are conflicting studies on the impact of BSO on colorectal and lung cancer. Clinical indications for BSO in premenopausal women include women with increased genetic risk for ovarian cancer (BRCA 1, BRCA 2, and Lynch Syndrome) and endometriosis.

11 Don't do a caesarean delivery for the sole indication of failure of progress in labour in the latent phase of labour for a woman at term with a singleton fetus and cephalic presentation.

Women who do not make progress in cervical dilatation at less than 4 cm can be managed expectantly, with analgesia and rest as needed. They generally have good outcomes and can often deliver vaginally with no further complications, similar to women who did not have a prolongation of the latent phase of labour. According to the SOGC Clinical Practice Guideline on Management of Labour, "Dystocia cannot be diagnosed prior to the onset of labour or during the latent phase of labour; caesarean section carried out at this time for an indication of dystocia is inappropriate." The end of the latent phase is subject to reassessment, the transition to an active phase is easier to diagnose retrospectively. A description of labour curves suggest that the end of the latent phase may be at 6 cm, rather than 4 cm and that overall progress is slower than that originally described. Each obstetrical unit must decide the definition of entry into the active phase of the first stage of labour. Regardless, intervention for a diagnosis of presumed dystocia is inappropriate in whatever may be considered the latent phase. Women should be allowed the opportunity to advance in labour, which many will do if given time, and achieve a vaginal delivery and avoid a caesarean delivery.

12 Don't give antenatal corticosteroid therapy unless the pregnant woman meets the gestational age criteria and the risk of delivery within the next 7 days is very high.

The likelihood of preterm delivery and also the gestational age need to be carefully considered when contemplating the use of antenatal corticosteroid therapy among pregnant women. The efficacy of such therapy is highest when the course is given 24 hours to 7 days prior to delivery. Administration more than 7 days before delivery leads to reduced benefit and potentially unnecessary adverse effects. Trials enrolling pregnant women from 24 + 0 to 34 + 6 weeks gestation at high risk of preterm birth show that antenatal corticosteroid therapy significantly reduces perinatal death, respiratory distress syndrome, and intraventricular hemorrhage in the infants who in fact delivered pre-term. Evidence from cohort studies shows a significant reduction in perinatal mortality among infants exposed to antenatal corticosteroid therapy at less than 24 weeks gestation. Women between 22 + 0 weeks and 23 + 6 weeks gestation at high risk of preterm birth within the next 7 days should be provided with a multidisciplinary consultation regarding the high likelihood for severe perinatal morbidity and mortality, and associated maternal morbidity. Steroids should be given if intensive care for the baby is planned.

How the list was created

The Society of Obstetricians and Gynaecologists of Canada (SOGC) struck a small working group to oversee the Choosing Wisely Canada list development process. An initial list of recommendations was compiled from all published SOGC guidelines. The list was reviewed by the Choosing Wisely committee, who provided input and guidance. A long list was then created from four sources: SOGC guidelines, Choosing Wisely recommendations published by American societies (notably the American College of Obstetricians and Gynaecologists), Canadian Choosing Wisely recommendations relevant to Ob/Gyn, and other proposals from SOGC members. The refined list was circulated to all members of the Clinical Practice – Obstetrics and Gynaecology committees then further refined by the Board of Directors. A list consisting of 24 recommendations (sorted based on speciality: obstetrics; gynaecology and generalist) was generated and circulated to the wider SOGC membership to obtain the final list.

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About The Society of Obstetricians and Gynaecologists of Canada

The Society of Obstetricians and Gynaecologists of Canada (SOGC) is a proud partner of the Choosing Wisely Canada campaign. The SOGC promotes excellence in the practice of obstetrics and gynaecology and to advance the health of women through leadership, advocacy, collaboration, and education. It has over 3,500 members, comprised of obstetricians, gynaecologists, family physicians, nurses, midwives, and allied health professionals working in the field of sexual reproductive health.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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