

First trimester aneuploidy nuchal translucency screening with first trimester placental health and quantitative preeclampsia risk assessment

Preeclampsia screening - ACOG Practice Advisory. December 2021

Low dose aspirin use for the prevention of preeclampsia and related morbidity and mortality.

High risk factors - 8% incidence of preeclampsia:

Previous preeclamptic pregnancy

Family history of preeclampsia (mother or sister)

Chronic hypertension, chronic renal disease, or both.

Type 1 or type 2 diabetes mellitus.

Multi fetal pregnancy.

History of thrombophilia.

Systemic lupus erythematosus.

Kidney disease

Factors independently associated with moderate risk for preeclampsia:

In vitro fertilization.

Advanced maternal age (≥ 35 years)

Obesity (BMI ≥ 30)

Nulliparity

Black race as a proxy for underlying racism

Lower income

Previous adverse obstetric outcomes.

Personal history factors - low birth weight or small for gestational age, >10 year pregnancy interval.

Supporting ICD 10 codes

O09.892 - supervision of other high risk pregnancy

O36.512 - maternal care for known or suspected placental insufficiency.

When recommended, low-dose aspirin should be initiated between 12 weeks and 28 weeks of gestation (optimally before 16 weeks) and continued daily until delivery.

Low-dose aspirin can be considered if the patient has one or more of the following moderate-risk factors: Black race (as a proxy for underlying racism), or lower income.

For some institutions and practices, the majority of patients may be at high or moderate risk for preeclampsia and would therefore be candidates for low-dose aspirin prophylaxis. In these instances, universal implementation (eg, offering low-dose aspirin to all patients within such practices or institutions) may be medically reasonable.