

Universal first trimester placental health and quantitative preeclampsia risk assessment QPERA

First trimester multi-factorial preeclampsia screening is superior to ACOG guidelines.

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Quantitative Preeclampsia Risk Assessment QPERA at the time of 11 - 14 week nuchal translucency aneuploidy screening

Preeclampsia and other hypertensive disorders of pregnancy occur in 5-8% of all pregnancies of women who have no known risk factors. <https://www.preeclampsia.org/faqs>

QPERA best determines which patients would benefit from aspirin treatment.

QPERA is the earliest and single most comprehensive maternal, fetal and placental health evaluation casting a wide net for aneuploidy, preeclampsia, congenital heart disease, preterm delivery, low birth weight, fetal loss and stillbirth.

For insurance coverage purposes

*CPT codes - uterine artery Doppler 93976.

*ICD10 codes - ACOG preeclampsia risk factor ACOG PE risk

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

The International Society Study of Hypertension in Pregnancy recommends:

_women should be screened at 11-14 weeks for preterm pre-eclampsia risk, using a combination of clinical risk factors, BP, uterine artery pulsatility index, and biochemical analytes, as available, even if they have been already been identified as having clinical 'high-risk' factors.
_women at increased risk of preeclampsia after multivariable screening, aspirin should be given at a dose of 100-162 mg to be taken at bedtime preferably before 16 weeks and discontinued by 36 weeks.

*The 2021 International Society for the Study of Hypertension in Pregnancy - classification, diagnosis & management recommendations for international practice. *Pregnancy Hypertension: An International Journal of Women's Cardiovascular Health* 27 (2022) 148-169

Major advances in preeclampsia screening have been made over the last decade. The traditional approach to screening, as proposed by the NICE or ACOG guidelines, which are based on a checklist of maternal risk factors, has limited predictive performance, and can no longer be considered sufficient for predicting preeclampsia effectively. Such guidelines should be updated to reflect recent scientific evidence that the target of screening should be preterm preeclampsia, the best way to identify the high-risk group combines maternal factors and biomarkers, aspirin should be started before 16 weeks gestation, and screening should be done during the first trimester of pregnancy.

