Screening for Antiphospholipid Antibodies in Women With Pregnancy Complications

To the Editor:

We read with great interest the article by Bates et al in an issue of CHEST (February 2012), in which the authors evaluate the evidence on the risk of pregnancy complications in women with thrombophilia. In this guideline article, the authors recommend screening for antiphospholipid antibodies in women with recurrent early pregnancy loss with a high level of evidence (Grade 1B).

The antiphospholipid syndrome is an autoimmune condition characterized by vascular thromboses (arterial and/or venous) and/or pregnancy morbidity in the presence of antiphospholipid antibodies. The pregnancy morbidity includes one unexplained fetal death (later than 10 weeks' gestation); three or more consecutive miscarriages (before 10 weeks' gestation); or fetal death (later than 10 weeks' gestation); three or more unexplained consecutive miscarriages (before 10 weeks' gestation); or one or more premature births of a morphologically normal neonate before the 34th week of gestation because of eclampsia, severe preeclampsia, or placental insufficiency. Evidence suggests that the fetal death Sapporo pregnancy morbidity criterion is the most specific, whereas the recurrent early abortion criterion may be the most sensitive; being lupus anticoagulant the greatest predictor of fetal loss after 24 weeks' gestation. We suggest that there is strong evidence to recommend screening for antiphospholipid antibodies in women with late pregnancy loss and/or premature birth because of eclampsia, severe preeclampsia, or placental insufficiency.

Jose Antonio Gonzalez-Nieto, MD
Ibiza, Spain
Ignacio Martin-Suarez, MD
Huelva, Spain

Affiliations: From the Autoimmune Diseases Unit (Dr Gonzalez-Nieto), Hospital Can Misses; and the Autoimmune Diseases Unit (Dr Martin-Suarez), Hospital Juan Ramon Jimenez.

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Correspondence to: Jose Antonio Gonzalez-Nieto, MD, Autoimmune Diseases Unit, Department of Internal Medicine, Hospital Can Misses, C/Corona sn, 07800, Ibiza, Spain; e-mail: josea_gnieto@hotmail.com

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References


Response

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We agree that the International Consensus Classification Criteria state that antiphospholipid antibody syndrome can be diagnosed in women with persistent positivity for a lupus anticoagulant (non-specific inhibitor) or moderate to high titer antibodies to IgG or IgM anticardiolipin or β2-glycoprotein I, and with recurrent early pregnancy loss, late pregnancy loss, or prematurity birth because of eclampsia, severe preeclampsia, or placental insufficiency. We also state in our article that there is convincing evidence that antiphospholipid antibodies are associated with an increased risk of recurrent early loss and late pregnancy loss. However, as outlined in our article and in a recently published meta-analysis, current data do not support a consistent association between antiphospholipid antibodies and the other pregnancy complications that form the basis of the International Consensus Classification Criteria.

Although there is reasonable evidence to support the use of aspirin and either low-molecular-weight heparin or unfractionated heparin in pregnant women with antiphospholipid antibodies and recurrent early pregnancy loss, similar data to support antithrombotic therapy in women who meet the criteria discussed here on the basis of other placenta-mediated pregnancy complications are absent. Thrombophilia testing should only be performed when it has the potential to result in a change in patient management. Given the absence of a consistent association between antiphospholipid antibodies and eclampsia, preeclampsia, or placental insufficiency, and the lack of data supporting antithrombotic intervention in these patients, as well as those with late loss, we respectfully suggest that it would be inappropriate to recommend testing for the presence of antiphospholipid antibodies in women with pregnancy complications other than recurrent early loss.

Shannon M. Bates, MDCM
Hamilton, ON, Canada
Ian A. Greer, MD, FCCP
Liverpool, England
Saskia Middeldorp, MD, PhD
Amsterdam, The Netherlands
David Veenstra, PharmD, PhD
Seattle, WA
Anne-Marie Prabulos, MD
Farmington, CT
Per Olav Vandvik, MD, PhD
Gjøvik, Norway