

Ten Things Physicians and Patients Should Question

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 use meperidine for labour analgesia due to its long-acting active metabolites and negative effects on neonatal behaviours.**

Meperidine (Demerol) as an opioid analgesic relieves pain of labour but there are superior agents. Furthermore it passes to the fetus and has a particularly long time before elimination. It persists in the neonate and thus interferes with adaptation to extrauterine life and adversely affects breast feeding. Because there are superior choices for analgesia without these adverse effects, meperidine should not be used if alternatives are available.

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

Screening should be initiated at 21 years of age in asymptomatic, immunocompetent women. 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 women 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 women greater than 70 years who have had prior routine screening.

7 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.

8 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 did 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.

9 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.

10 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.

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 specialty: obstetrics; gynaecology and generalist) was generated and circulated to the wider SOGC membership to obtain the final list.

Sources

- 1** Carroli G, et al. Episiotomy for vaginal birth. Cochrane Database Syst Rev. 2000;(2):CD000081. PMID: 10796120.
Lee L, et al. Management of Spontaneous Labour at Term in Healthy Women. J Obstet Gynaecol Can. 2016 Sep;38(9):843-865. PMID: 27670710.
- 2** Alfievic Z, et al. Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. Cochrane Database Syst Rev. 2017 Feb 3;2:CD006066. PMID: 28157275.
Leveno KJ, et al. A Prospective Comparison of Selective and Universal EFM in 34,995 Pregnancies. N Engl J Med. 1986 Sep 4;315(10):615-9. PMID: 3736600.
Liston R, et al. Fetal Health Surveillance: [Antepartum and Intrapartum Consensus Guideline: Fetal Health Surveillance in Labour](#) [Internet]. J Obstet Gynaecol Can. 2007 Sep [cited 2017 May 29];29(9):S27.
Mires G, et al. Randomised controlled trial of cardiotocography versus Doppler auscultation of fetal heart at admission in labour in low risk obstetric population. BMJ. 2001 Jun 16;322(7300):1457-60; discussion 1460-2. PMID: 11408301.
- 3** Akkerman D, et al. [Routine prenatal care](#) [Internet]. 2012 Jul [cited 2017 May 29]. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI).
Atacag T, et al. Asymptomatic bacteriuria screened by catheterized samples at pregnancy term in women undergoing cesarean delivery. Clin Exp Obstet Gynecol. 2015;42(5):590-4. PMID: 26524804.
Committee on Obstetric Practice, The American College of Obstetricians and Gynecologists. Committee Opinion No. 692: Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period. Obstet Gynecol. 2017 Apr;129(4):e90-e95. PMID: 28333820.
National Institute for Health and Care Excellence. [Diabetes in pregnancy: Management of diabetes from preconception to the postnatal period](#) [Internet]. 2015 Feb [cited 2017 May 29].
Sperling JD, et al. Screening for Preeclampsia and the USPSTF Recommendations. JAMA. 2017 Apr 25;317(16):1629-1630. PMID: 28444259.
US Preventive Services Task Force, et al. Screening for Preeclampsia: US Preventive Services Task Force Recommendation Statement. JAMA. 2017 Apr 25;317(16):1661-1667. PMID: 28444286.
- 4** Alfievic Z, et al. Fetal and umbilical Doppler ultrasound in high-risk pregnancies. Cochrane Database Syst Rev. 2013 Nov 12;(11):CD007529. PMID: 24222334.
Alfievic Z, et al. Fetal and umbilical Doppler ultrasound in normal pregnancy. Cochrane Database Syst Rev. 2015 Apr 15;(4):CD001450. PMID: 25874722.
- 5** Fleet J, et al. A comparison of fentanyl with pethidine for pain relief during childbirth: a randomised controlled trial. BJOG. 2015 Jun;122(7):983-92. PMID: 25558983.
Fleet J, et al. The influence of intrapartum opioid use on breastfeeding experience at 6 weeks post partum: A secondary analysis. Midwifery. 2017 Apr 3;50:106-109. PMID: 28411530.
Reynolds F. The effects of maternal labour analgesia on the fetus. Best Pract Res Clin Obstet Gynaecol. 2010 Jun;24(3):289-302. PMID: 20005180.
- 6** Kulasingam SL, et al. Screening for Cervical Cancer: A Decision Analysis for the US Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (US); 2011 May. Report No.: 11-05157-EF-1. PMID: 22553886.
Miller AB, et al. Report of a National Workshop on Screening for Cancer of the Cervix. CMAJ. 1991 Nov 15;145(10):1301-25. PMID: 1933712.
Moyer VA, et al. Screening for cervical cancer: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med. 2012 Jun 19;156(12):880-91, W312. PMID: 22711081.
Murphy J, et al. [Cervical Screening: A Quality Initiative of the Program in Evidence-Based Care \(PEBC\), Cancer Care Ontario \(CCO\)](#) [Internet]. 2001 Oct 5 [cited 2017 May 29].
Sasieni P, et al. Effectiveness of cervical screening with age: population based case-control study of prospectively recorded data. BMJ. 2009 Jul 28;339:b2968. PMID: 19638651.
- 7** Harlow SD, et al. Executive summary of the Stages of Reproductive Aging Workshop + 10: addressing the unfinished agenda of staging reproductive aging. J Clin Endocrinol Metab. 2012 Apr;97(4):1159-68. PMID: 22344196.
National Institute for Health and Care Excellence. [Menopause: diagnosis and management](#) [Internet]. 2015 Nov [cited 2017 May 29].
Reid R, et al. Managing menopause. J Obstet Gynaecol Can. 2014 Sep;36(9):830-833. PMID: 25222364.
- 8** Buhling KJ, et al. The role of transvaginal ultrasonography for detecting ovarian cancer in an asymptomatic screening population: a systematic review. Arch Gynecol Obstet. 2017 May;295(5):1259-1268. PMID: 2835755.
Guirguis-Blake JM, et al. Periodic Screening Pelvic Examination: Evidence Report and Systematic Review for the US Preventive Services Task Force. JAMA. 2017 Mar 7;317(9):954-966. PMID: 28267861.
Luzak A, et al. Clinical effectiveness of cancer screening biomarker tests offered as self-pay health service: a systematic review. Eur J Public Health. 2016 Jun;26(3):498-505. PMID: 26733629.
Pinsky PF, et al. Extended mortality results for ovarian cancer screening in the PLCO trial with median 15years follow-up. Gynecol Oncol. 2016 Nov;143(2):270-275. PMID: 27615399.
Reade CJ, et al. Risks and benefits of screening asymptomatic women for ovarian cancer: a systematic review and meta-analysis. Gynecol Oncol. 2013 Sep;130(3):674-81. PMID: 23822892.
US Preventive Services Task Force, et al. Screening for Gynecologic Conditions With Pelvic Examination: US Preventive Services Task Force Recommendation Statement. JAMA. 2017 Mar 7;317(9):947-953. PMID: 28267862.
- 9** Knight J, et al. Tissue extraction by morcellation: a clinical dilemma. J Minim Invasive Gynecol. 2014 May-Jun;21(3):319-20. PMID: 24646445.
Parker WH, et al. Uterine sarcoma in patients operated on for presumed leiomyoma and rapidly growing leiomyoma. Obstet Gynecol. 1994 Mar;83(3):414-8. PMID: 8127535.
Vilos GA, et al. Miscellaneous uterine malignant neoplasms detected during hysteroscopic surgery. J Minim Invasive Gynecol. 2009 May-Jun;16(3):318-25. PMID: 19423062.
Vilos GA, et al. The management of uterine leiomyomas. J Obstet Gynaecol Can. 2015 Feb;37(2):157-178. PMID: 25767949.

Health Quality Ontario. [Heavy Menstrual Bleeding: Care for Adults and Adolescents of Reproductive Age](#) [Internet]. 2017 [cited 2017 May 29].

Laberge P, et al. [SOGC clinical practice guideline: endometrial ablation in the management of abnormal uterine bleeding](#) [Internet]. J Obstet Gynaecol Can. 2015 Apr [cited 2017 May 29];322:362-76.

Munro MG, et al. [Acute uterine bleeding unrelated to pregnancy: a Southern California Permanente Medical Group practice guideline](#) [Internet]. Perm J. 2013 [cited 2017 May 29];17(3):43-56.

National Collaborating Centre for Women's and Children's Health (UK). Heavy menstrual bleeding. London: RCOG Press; 2007 Jan. PMID: 21938862.

Sukhbir S, et al. [Abnormal uterine bleeding in pre-menopausal women](#) [Internet]. J Obstet Gynaecol Can. 2013 May [cited 2017 May 29];35(5):473-9.

Vilos GA, et al. [SOGC clinical practice guideline: the management of uterine leiomyomas](#) [Internet]. J Obstet Gynaecol Can. 2015 Feb [cited 2017 May 29];318:157-81.

About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help clinicians and patients engage in conversations about unnecessary tests, treatments and procedures, and make smart and effective choices to ensure high-quality care.

For more information on Choosing Wisely Canada or to see other lists of Things Clinicians and Patients Should Question, visit www.choosingwiselycanada.org. Join the conversation on Twitter @ChooseWiselyCA.

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.