SOGC CLINICAL PRACTICE GUIDELINE

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Ultrasound Evaluation of First Trimester Complications of Pregnancy

This Clinical Practice Guideline has been prepared by the Diagnostic Imaging committee, reviewed by Clinical Practice-Obstetrics and approved by the Board of the Society of Obstetricians and Gynaecologists of Canada.

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Disclosure statements have been received from all members of the committee.

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Abstract

Objective:

1. To identify sonographic features suggestive of early pregnancy loss,
2. To identify sonographic features of ectopic pregnancy, and
3. To provide a diagnostic algorithm leading to improve clinical safety of management decision.

Outcomes:

1. Accuracy and improved safety in the diagnosis of early pregnancy loss, and
2. Accuracy and improved safety in the diagnosis of ectopic pregnancy.

Evidence: A MEDLINE search and review of bibliographies identified articles was conducted.

Values: The evidence collected was reviewed by the Diagnostic Imaging Committee of the Society of Obstetricians and Gynaecologists of Canada. The recommendations were made according to the guidelines developed by The Canadian Task Force on Preventive Health Care (Table 1).

Benefits, Harms, and Costs: Women presenting with first trimester bleeding may be incorrectly diagnosed with a missed abortion, may have an ectopic pregnancy overlooked, or may be inappropriately reassured about viability. Improvement in the identification of the sonographic landmarks of normal embryonic development and awareness of the sonographic risk factors of pregnancy failure may lead to more case-specific management strategies. Diagnosis of suspected ectopic pregnancy often involves an assessment of both hormonal markers and sonographic features. Maternal morbidity and mortality can be reduced with an early diagnosis of ectopic pregnancy.

Recommendations

1. Embryonic demise can be diagnosed when ultrasound imaging documents the following features: intrauterine gestational sac, embryonic crown-rump length $\geq$ 7 mm, no cardiac activity. (II-2A)
2. Anembryonic pregnancy can be diagnosed when ultrasound imaging documents the following features: no embryo and mean sac diameter $\geq$ 25 mm. (II-2A)

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Table 1. Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventative Health Care

Quality of evidence assessment*	Classification of recommendations†
I: Evidence obtained from at least one properly randomized controlled trial	A. There is good evidence to recommend the clinical preventive action
II-1: Evidence from well-designed controlled trials without randomization	B. There is fair evidence to recommend the clinical preventive action
II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in the category	D. There is fair evidence to recommend against the clinical preventive action
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees	E. There is good evidence to recommend against the clinical preventive action
	L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

†Recommendations included in these guidelines have been adapted from the Classification of recommendations criteria described in The Canadian Task Force on Preventive Health Care.

3. In clinically stable or asymptomatic patients, when a suspicion of early pregnancy loss is being considered, a follow-up ultrasound scan should be booked after an additional 7–10 days. (III-A)
4. Failure to detect an intrauterine gestational sac, by transvaginal ultrasound, when the β-hCG value exceeds a discriminatory level of 2000–3000 mIU/mL indicates an increased risk for ectopic pregnancy. With a complex adnexal mass, a tubal ring, or complex fluid in the pelvis the probability of tubal ectopic pregnancy is high, while a live extrauterine embryo is diagnostic of an ectopic pregnancy. (II-2A)
5. β-hCG values in a viable pregnancy rise at least 55% over 48 hours. Deviation from this before 7 weeks is indicative of a nonviable pregnancy, intrauterine or ectopic. (II-2A)

ABBREVIATIONS

β-hCG	beta human chorionic gonadotropin
CRL	crown-rump length
CS	Caesarean section

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