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This guideline was peer reviewed by the principal authors in January 2015 and has been reaffirmed for continued use until further notice.

No. 245-Alcohol Use and Pregnancy Consensus Clinical Guidelines

This Clinical Practice Guideline has been reviewed and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

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Key Words: Fetal alcohol syndrome, Fetal alcohol spectrum disorder, pregnancy, alcohol, teratogen

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Abstract

Objective: To establish national standards of care for the screening and recording of alcohol use and counselling on alcohol use of women of child-bearing age and pregnant women based on the most up-to-date evidence.

Evidence: Published literature was retrieved through searches of PubMed, CINAHL, and the Cochrane Library in May 2009 using appropriate controlled vocabulary (e.g., pregnancy complications, alcohol drinking, prenatal care) and key words (e.g., pregnancy, alcohol consumption, risk reduction). Results were restricted to literature published in the last five years with the following research designs: systematic reviews, randomized control trials/controlled clinical trials, and observational studies. There were no language restrictions. Searches were updated on a regular basis and incorporated in the guideline to May 2010. Grey (unpublished) literature was identified through searching the websites of health technology assessment (HTA) and HTA-related agencies, national and international medical specialty societies, clinical practice guideline collections, and clinical trial registries. Each article was screened for relevance and the full text acquired if determined to be relevant. The evidence obtained was reviewed and evaluated by the members of the Expert Workgroup established by the Society of Obstetricians and Gynaecologists of Canada. The quality of evidence was evaluated and recommendations were made according to guidelines developed by the Canadian Task Force on Preventive Health Care.

Values: The quality of evidence was rated using the criteria described by the Canadian Task Force on Preventive Health Care (Table 1).

Sponsor: The Public Health Agency of Canada and the Society of Obstetricians and Gynaecologists of Canada.

Endorsement: These consensus guidelines have been endorsed by the Association of Obstetricians and Gynecologists of Quebec; the Canadian Association of Midwives; the Canadian Association of Perinatal, Women's Health and Neonatal Nurses (CAPWHN); the College of

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Women have the right and responsibility to make informed decisions about their care in partnership with their health care providers. In order to facilitate informed choice women should be provided with information and support that is evidence based, culturally appropriate and tailored to their needs. The values, beliefs and individual needs of each woman and her family should be sought and the final decision about the care and treatment options chosen by the woman should be respected.

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

Quality of evidence assessment[b]	Classification of recommendations[c]
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 this 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

[a]Woolf SH, Battista RN, Angerson GM, Logan AG, Eel W. Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. Can Med Assoc J 2003;169(3):207-8.

[b]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.[a]

[c]Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.[a]

Family Physicians of Canada; the Federation of Medical Women of Canada; the Society of Rural Physicians of Canada; and Motherisk.

ABBREVIATIONS

ARND	alcohol related neurodevelopmental disorder
AUDIT	Alcohol Use Disorders Identification Test
BI	brief intervention
BMAST	Brief Michigan Alcoholism Screening Test
CAGE	Cut-down
Annoy	Guilty
Eye-Opener CNS	central nervous system
CRAFFT	Car, Relax, Alone, Forget, Friends, Trouble (screening test)
FAS	fetal alcohol syndrome
FAEE	fatty acid ethyl ester
FASD	fetal alcohol spectrum disorder
HTA	health technology assessment
IUGR	intrauterine growth restriction
MAST	Michigan Alcoholism Screening Test
MI	motivational interviewing
SMAST	Short Michigan Alcoholism Screening Test
T-ACE	Tolerance, Annoyed, Cut down, Eye-opener (screening test)
TLFB	Timeline Followback
TWEAK	Tolerance, Worry, Eye-opener, Amnesia, Cut down (screening test)

Summary Statements

1. There is evidence that alcohol consumption in pregnancy can cause fetal harm. (II-2) There is insufficient evidence regarding fetal safety or harm at low levels of alcohol consumption in pregnancy. (III)
2. There is insufficient evidence to define any threshold for low-level drinking in pregnancy. (III)
3. Abstinence is the prudent choice for a woman who is or might become pregnant. (III)
4. Intensive culture-, gender-, and family-appropriate interventions need to be available and accessible for women with problematic drinking and/or alcohol dependence. (II-2)

Recommendations

1. Universal screening for alcohol consumption should be done periodically for all pregnant women and women of child-bearing age. Ideally, at-risk drinking could be identified before pregnancy, allowing for change. (II-2B)
2. Health care providers should create a safe environment for women to report alcohol consumption. (III-A)
3. The public should be informed that alcohol screening and support for women at risk is part of routine women's health care. (III-A)
4. Health care providers should be aware of the risk factors associated with alcohol use in women of reproductive age. (III-B)
5. Brief interventions are effective and should be provided by health care providers for women with at-risk drinking. (II-2B)
6. If a woman continues to use alcohol during pregnancy, harm reduction/treatment strategies should be encouraged. (II-2B)
7. Pregnant women should be given priority access to withdrawal management and treatment. (III-A)
8. Health care providers should advise women that low-level consumption of alcohol in early pregnancy is not an indication for termination of pregnancy. (II-2A)

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