ACOG UPDATES

ACOG PUBLICATIONS

Change of Verbiage

- ***Clinical Advisories*** have been replaced by ***Clinical Practice Guidelines***
- Some Committee Opinions have been withdrawn and replaced with ***Clinical Consensus Statements*** or ***Clinical Practice Updates***
- At the time of this presentation was created, the following ACOG publications can be accessed without a subscription:
  - Consensus Statements
  - Committee Opinions
  - Clinical Practice Updates
- Access to Practice Bulletins continue to require a subscription

As A Reminder.....

- Please keep in mind when accessing and reading ACOG Committee Opinion, Practice Bulletins, and Clinical Practice Guidelines:
  - The Strength of the Recommendations
  - The Quality of Evidence
  - Good Practice Points
  - The definitions and guidelines are listed on the right of this page

STRENGTH OF RECOMMENDATION

STRONG

ACOG recommends

Benefits clearly outweigh harms and burdens. Most patients should receive the intervention.

ACOG recommends against

Harms and burdens clearly outweigh the benefits. Most patients should not receive the intervention.

CONDITIONAL

ACOG suggests

The balance of benefits and risks will vary depending on patient characteristics and their values and preferences. Individualized, shared decision making is recommended to help patients decide on the best course of action for them.

QUALITY OF EVIDENCE

HIGH

Randomized controlled trials, systematic reviews, and meta-analyses without serious methodologic flaws or limitations (eg, inconsistency, imprecision, confounding variables)
Very strong evidence from observational studies without serious methodologic flaws or limitations
There is high confidence in the accuracy of the findings and further research is unlikely to change this

MODERATE

Randomized controlled trials with some limitations
Strong evidence from observational studies without serious methodologic flaws or limitation

LOW

Randomized controlled trials with serious flaws Some evidence from observational studies

VERY LOW

Unsystematic clinical observations
Very indirect evidence from observational studies

GOOD PRACTICE POINTS

Ungraded Good Practice Points are incorporated when clinical guidance is deemed necessary in the case of extremely limited or nonexistent evidence. They are based on expert opinion as well as review of the available evidence.

COMMITTEE OPINION REVISIONS/WITHDRAWALS-REPLACED

Replaced by *ACOG Clinical Consensus No. 10: Cannabis Use During Pregnancy and Lactation*

ACOG Clinical Practice Update: An Update to Clinical Guidance for Delayed Umbilical Cord Clamping After Birth in Preterm Neonates

COMMITTEE OPINION REVISIONS/WITHDRAWALS-REPLACED

Replaced by *ACOG Committee Statement No. 22: Anticipatory Counseling Regarding Ovarian Factor Fertility Decline*

Replaced by *ACOG Committee Statement No. 21: Access to Contraception*

COMMITTEE OPINION REVISIONS/WITHDRAWALS-REPLACED

Updated by ACOG Clinical Practice Update: Elimination of the DATA-Waiver Program

Replaced by *ACOG Committee Statement No. 23. Effective Patient–Physician Communication*

COMMITTEE OPINION REVISIONS/WITHDRAWALS-REPLACED

Replaced by Ethical Considerations for Genetic Testing and Counseling in Obstetrics and Gynecology

COMMITTEE OPINION REVISIONS/WITHDRAWALS-REPLACED

Replaced by Ethical Considerations for Genetic Testing and Counseling in Obstetrics and Gynecology

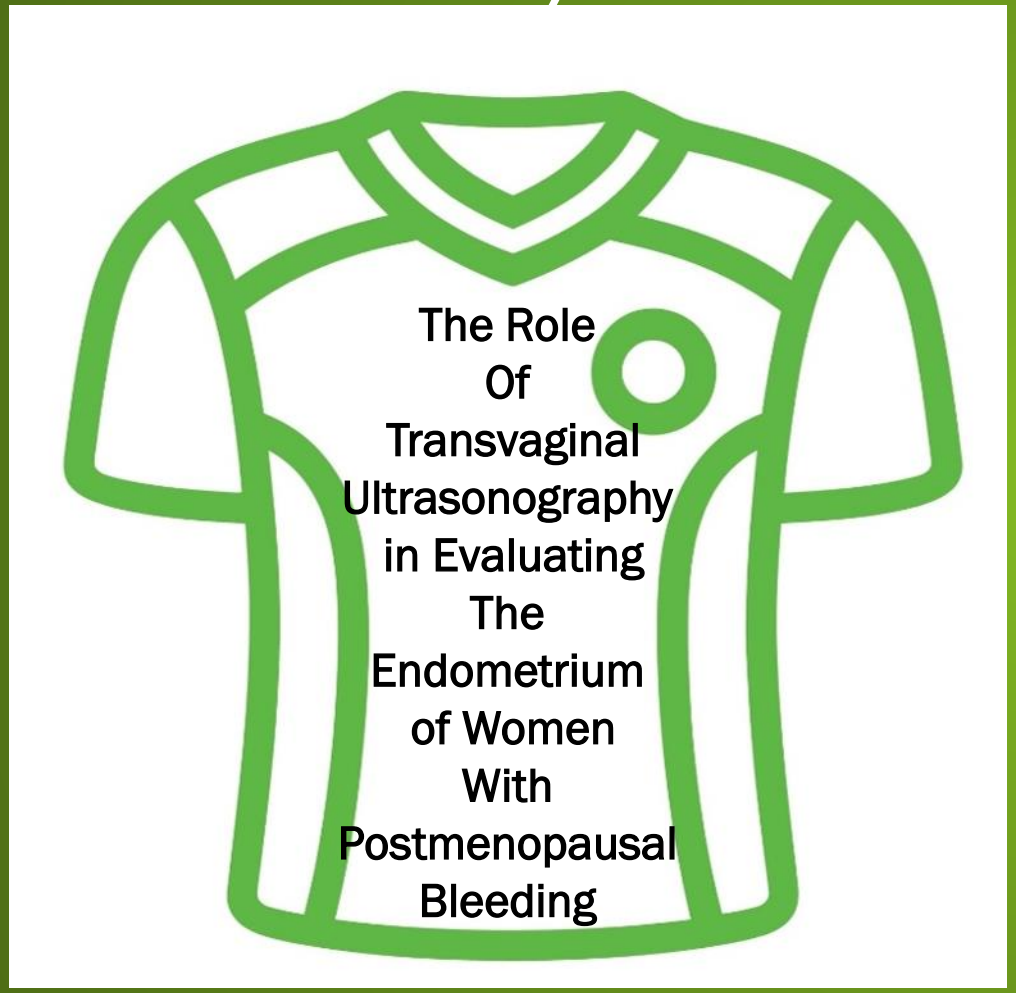
Replaced by ACOG Clinical Consensus No. 11: Management of Positive Human Chorionic Gonadotropin Test Results in Nonpregnant Patients without Gynecologic Malignancy

COMMITTEE OPINION REVISIONS/WITHDRAWALS-REPLACED

Replaced by ACOG Clinical Practice Guideline No. 11: Diagnosis of Endometriosis

Replaced by ACOG Committee Statement No. 26: Maternal Immunizations

COMMITTEE OPINION REVISIONS/WITHDRAWALS-REPLACED



Updated by ACOG Clinical Practice Update: Updated Guidance Regarding the Role of Transvaginal Ultrasonography in Evaluating the Endometrium of Individuals with Postmenopausal Bleeding

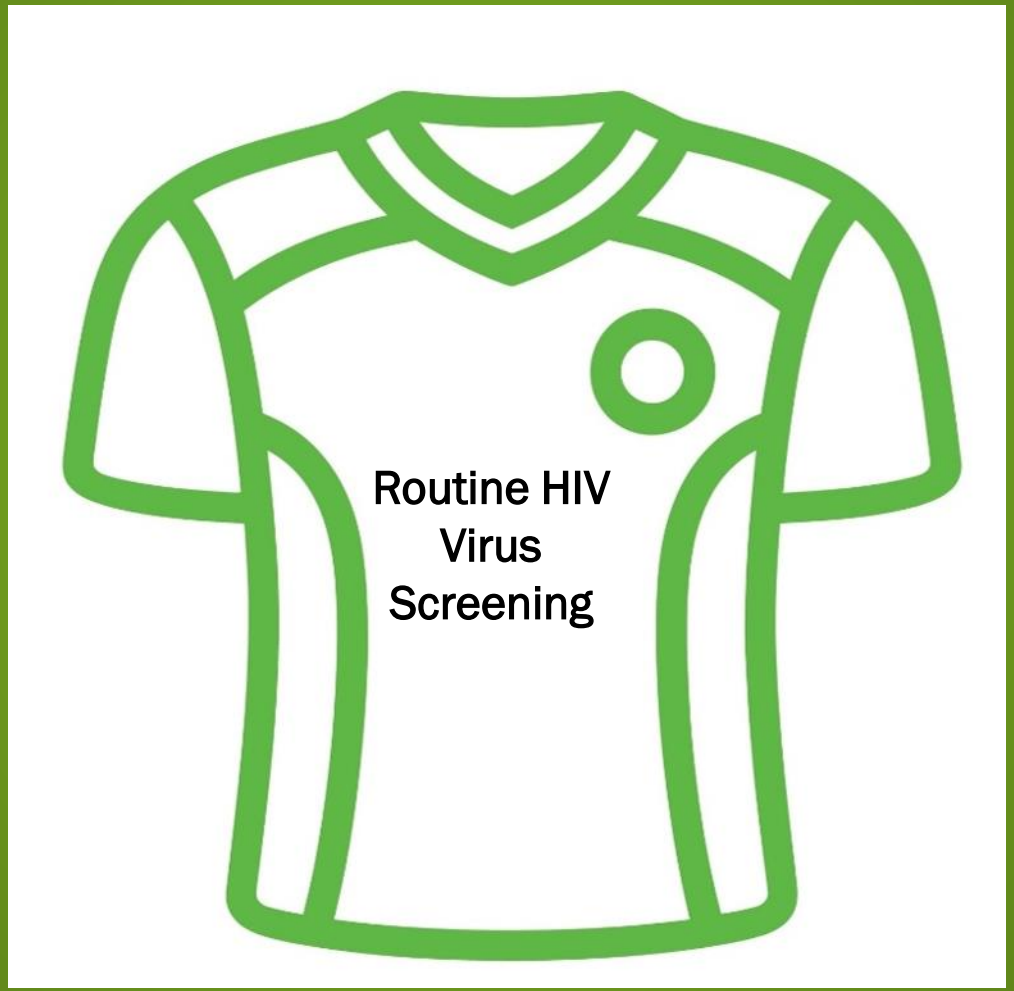
Updated by ACOG Clinical Practice Update: Breastfeeding in Patients With Human Immunodeficiency Virus

COMMITTEE OPINION REVISIONS/WITHDRAWALS-REPLACED

Replaced by ACOG Committee Statement No. 25: Advocating for Safe and Equitable Obstetric and Gynecologic Care for Immigrants

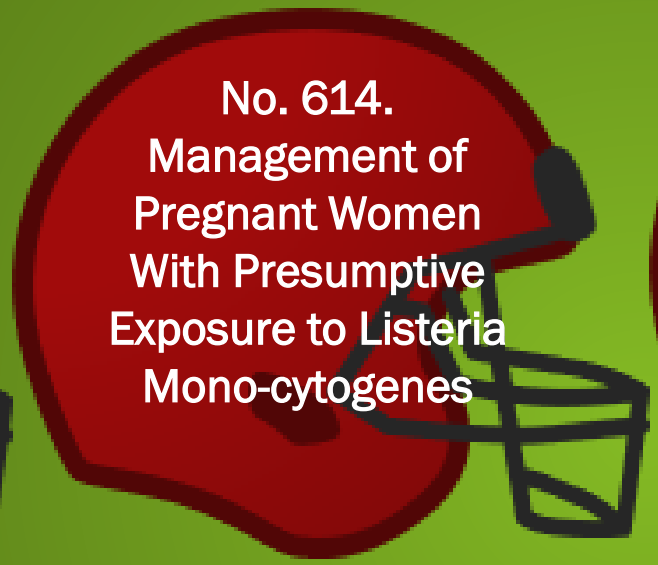
Replaced by ACOG Committee Statement No. 32: Human Immunodeficiency Virus Screening and Preexposure Prophylaxis

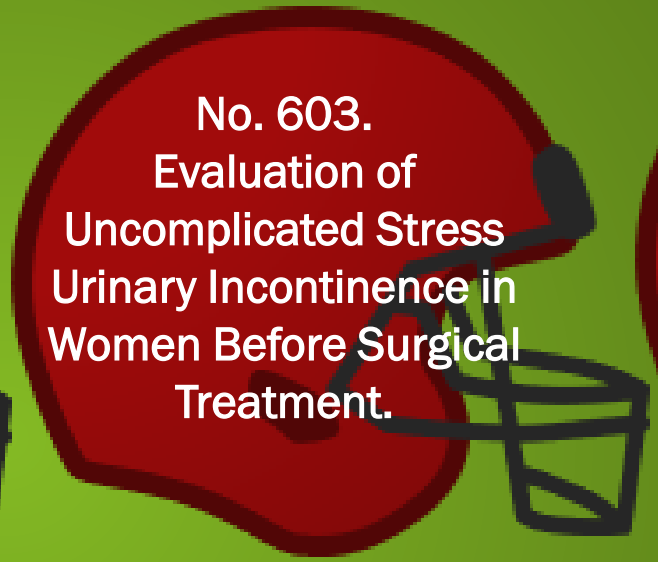
COMMITTEE OPINION REVISIONS/WITHDRAWALS-REPLACED

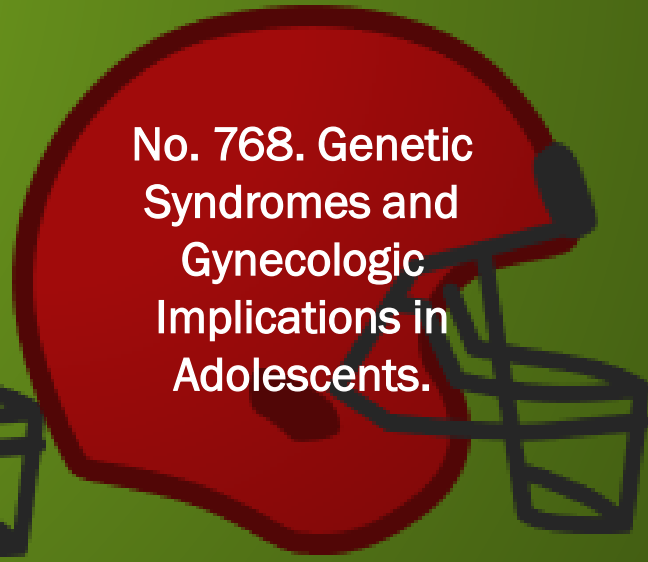


Replaced by ACOG Committee Statement No. 32: Human Immunodeficiency Virus Screening and Preexposure Prophylaxis

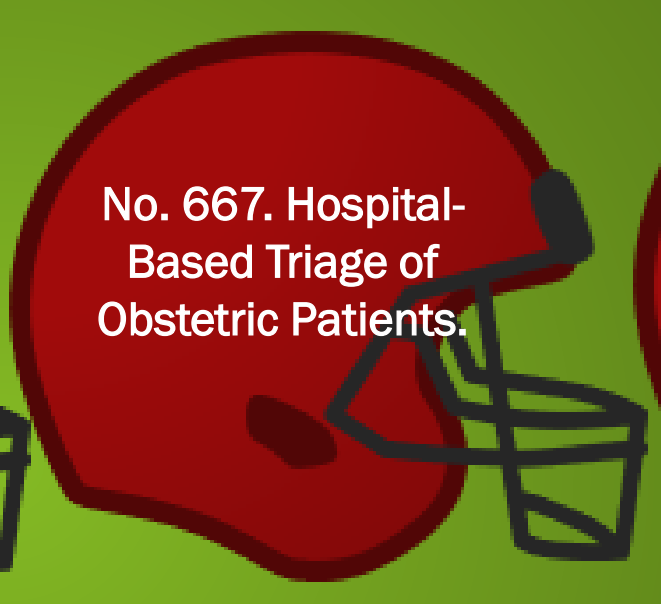
COMMITTEE OPINION REAFFIRMED

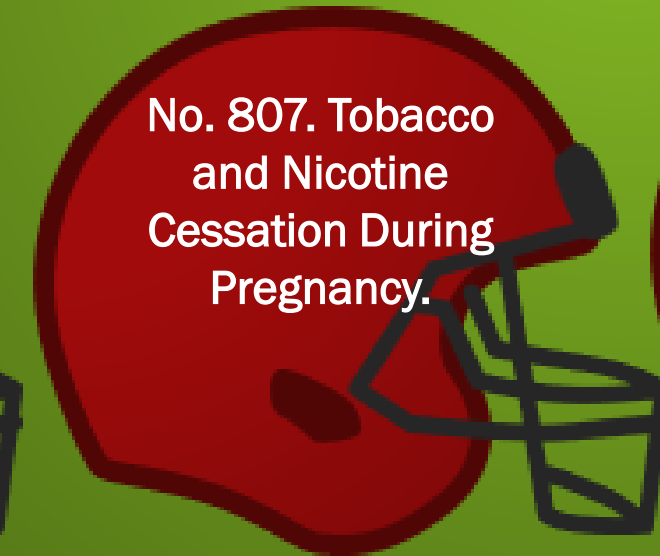


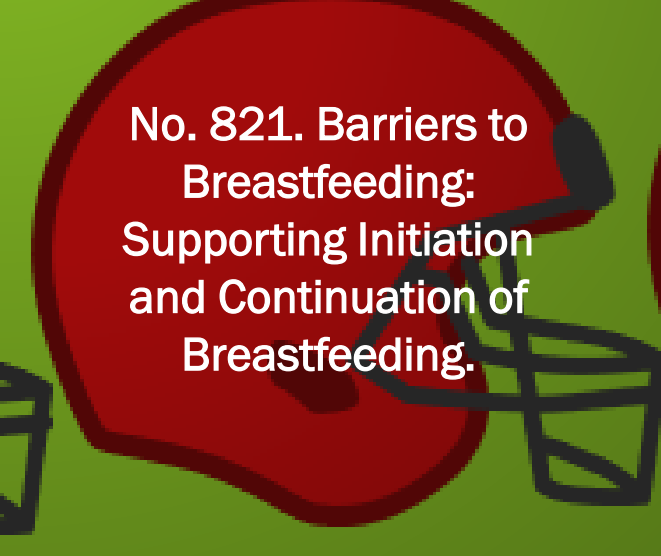




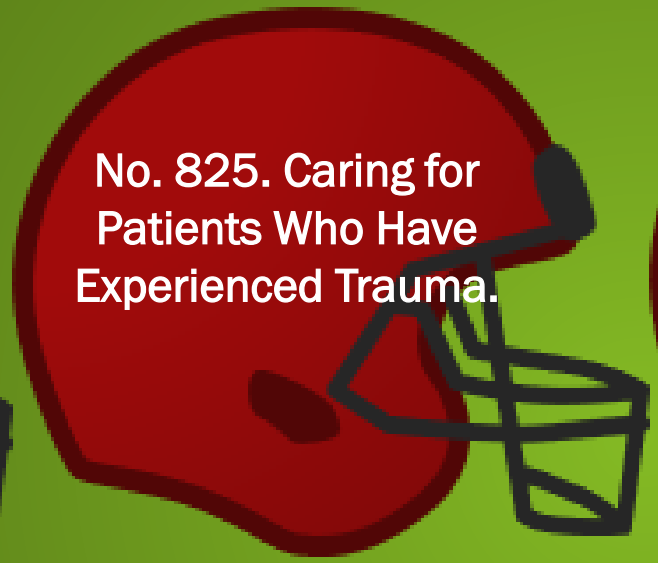
COMMITTEE OPINION REAFFIRMED

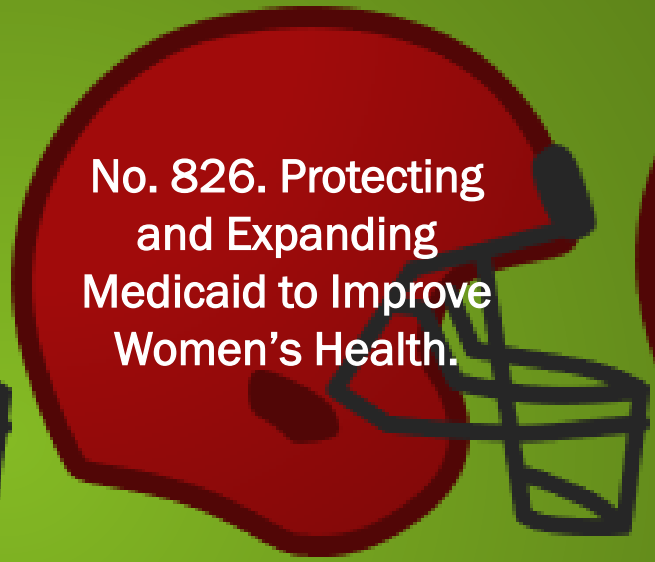


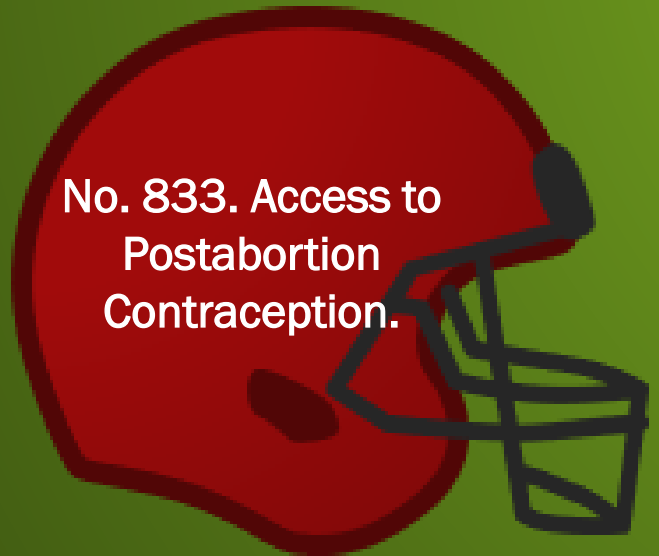


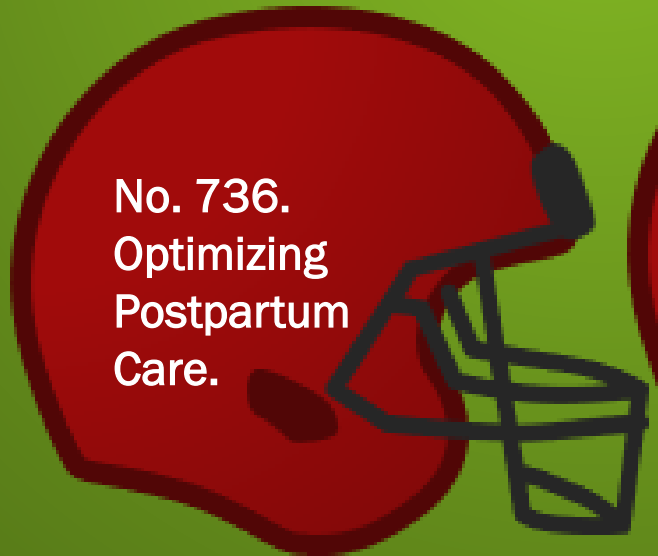


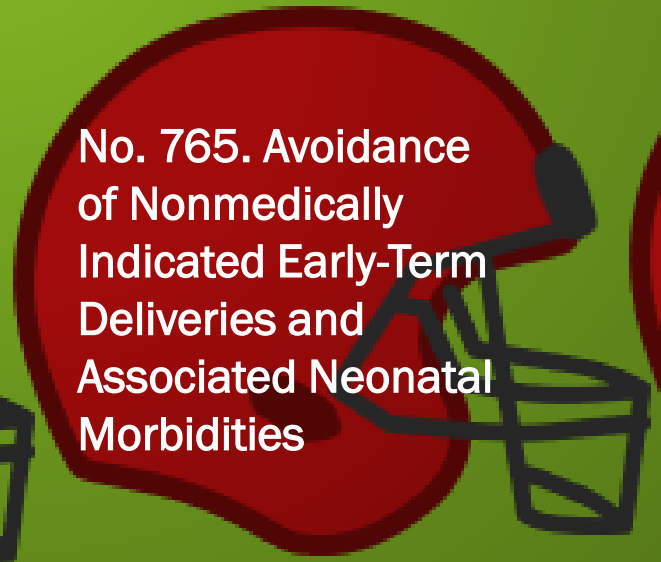
COMMITTEE OPINION REAFFIRMED

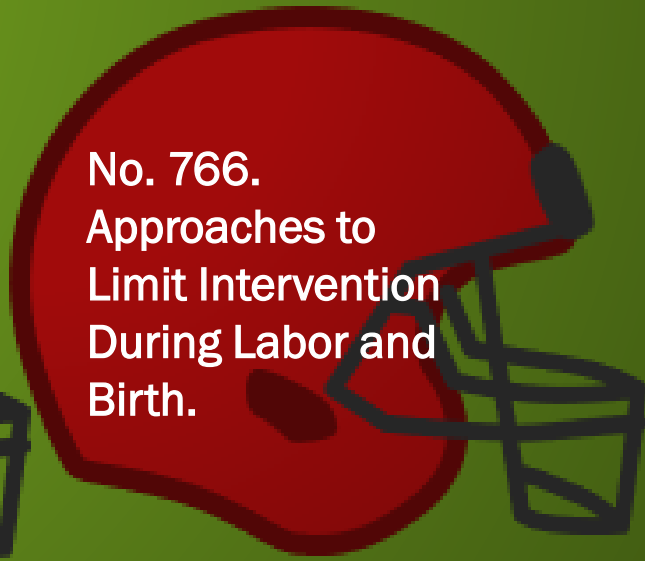




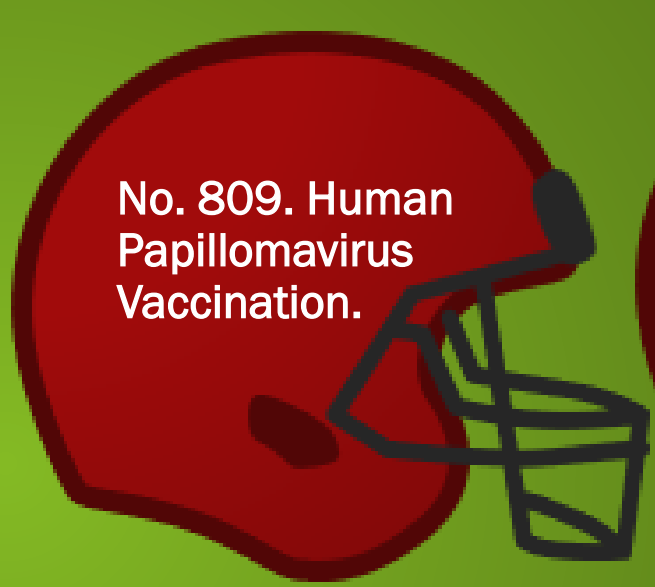


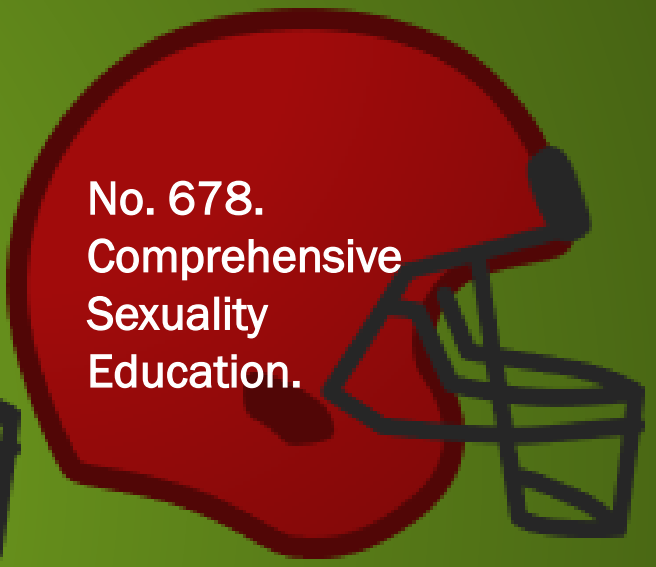


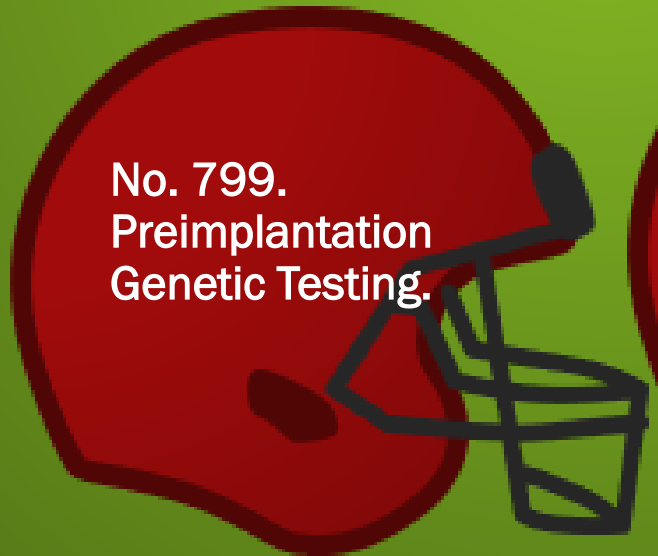


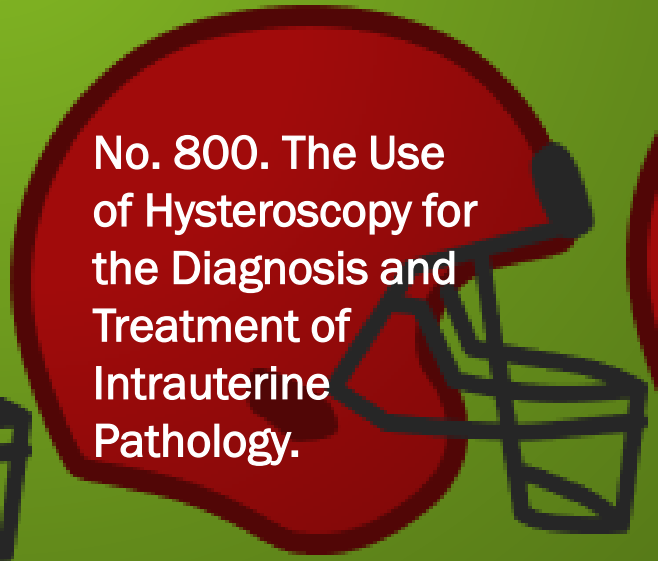


COMMITTEE OPINION REAFFIRMED

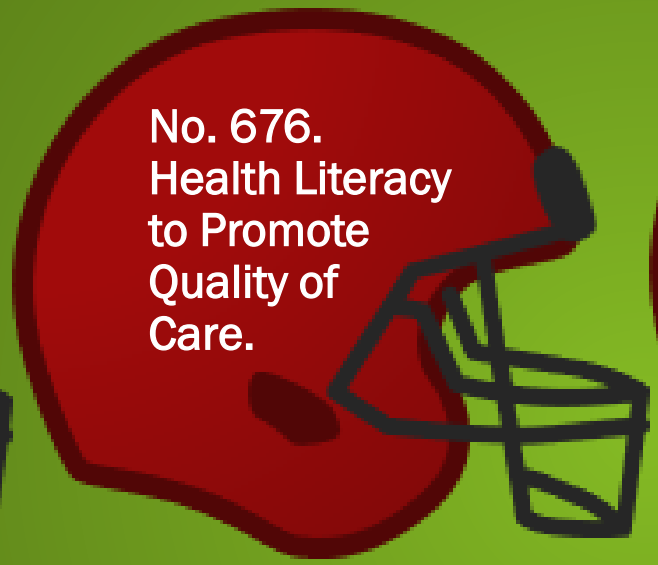


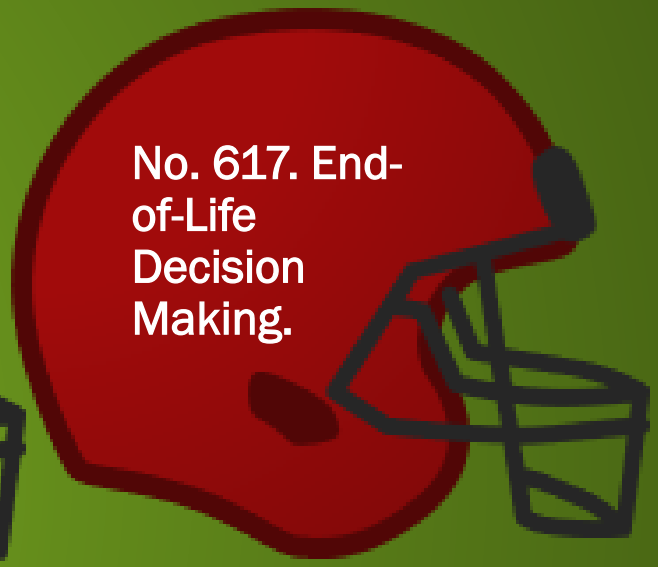


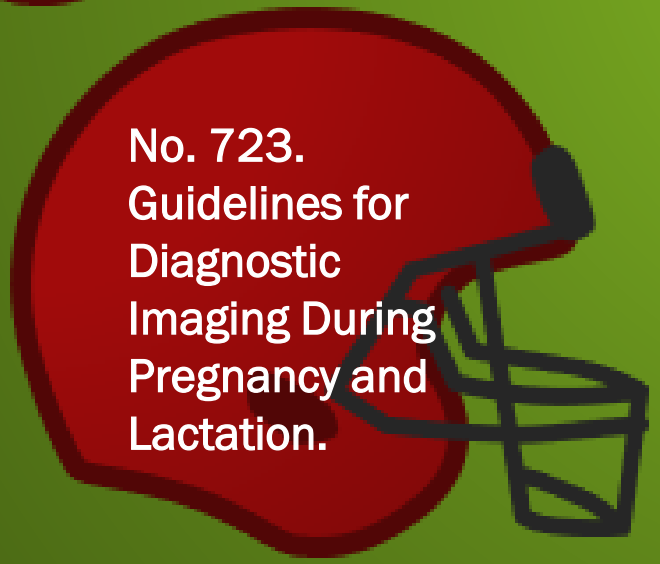


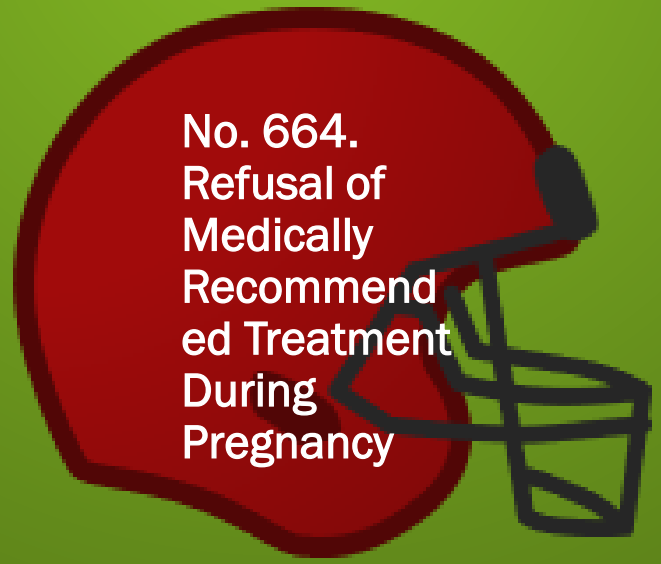


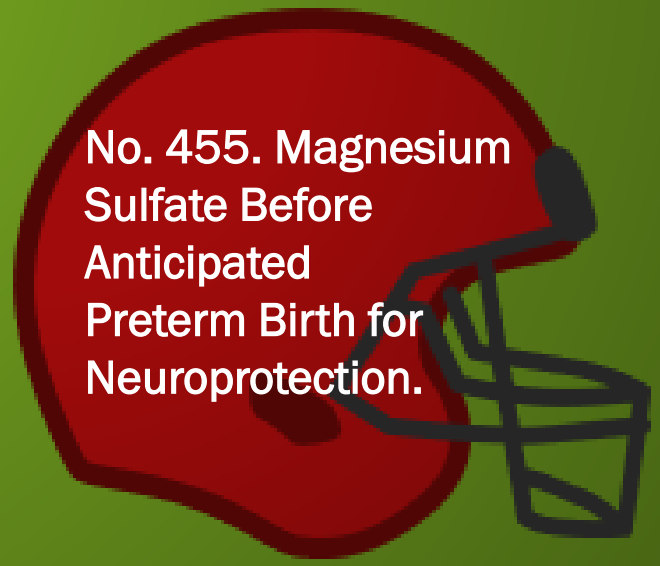
COMMITTEE OPINION REAFFIRMED



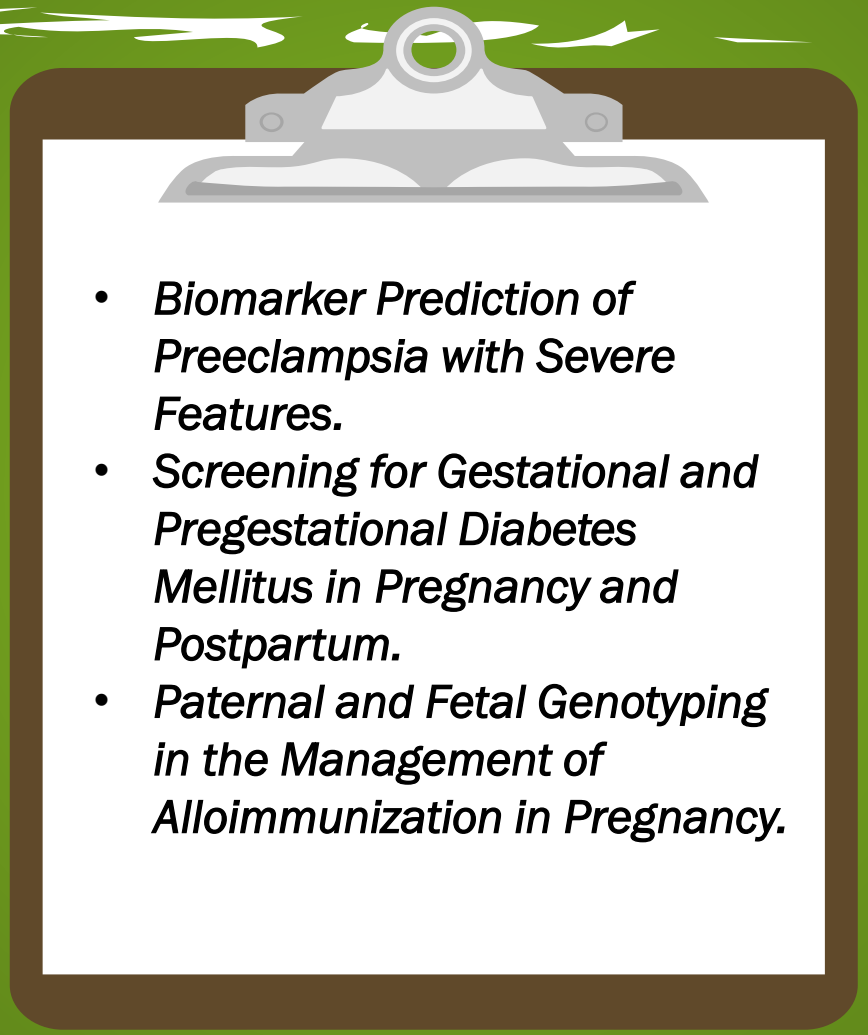








CLINICAL PRACTICE UPDATES REAFFIRMED



- *Biomarker Prediction of Preeclampsia with Severe Features.*
- *Screening for Gestational and Pregestational Diabetes Mellitus in Pregnancy and Postpartum.*
- *Paternal and Fetal Genotyping in the Management of Alloimmunization in Pregnancy.*

COMMITTEE STATEMENTS REAFFIRMED

- ACOG Committee Statement No. 2. Professional Relationships with Industry.

CLICINICAL CONSENSUS REAFFIRMED

- ACOG Clinical Consensus No. 4. Urinary Tract Infections in Pregnant Individuals.
- ACOG Clinical Consensus No. 5. Management of Endometrial Intraepithelial Neoplasia or Atypical Endometrial Hyperplasia.
- ACOG Obstetric Care Consensus No. 11. Pregnancy at Age 35 Years or Older

PRACTICE BULLETINS REVISIONS/WITHDRAWALS-REPLACED

Withdrawn and replaced by ACOG Clinical Practice Guideline No. 10: Intrapartum Fetal Heart Rate Monitoring: Interpretation and Management

PRACTICE BULLETINS REVISIONS/WITHDRAWALS-REPLACED

Updated by ACOG Clinical Practice Update: Use of Nonsurgical Hemorrhage-Control Devices for Postpartum Hemorrhage Management

Updated by ACOG Clinical Practice Update: Concurrent Sexual Partner Therapy to Prevent Bacterial Vaginosis

PRACTICE BULLETINS REVISIONS/WITHDRAWALS-REPLACED

Replaced by *ACOG Practice Advisory: Screening for Fetal Chromosomal Abnormalities*

Replaced by ACOG Clinical Practice Guideline No. 11: Diagnosis of Endometriosis

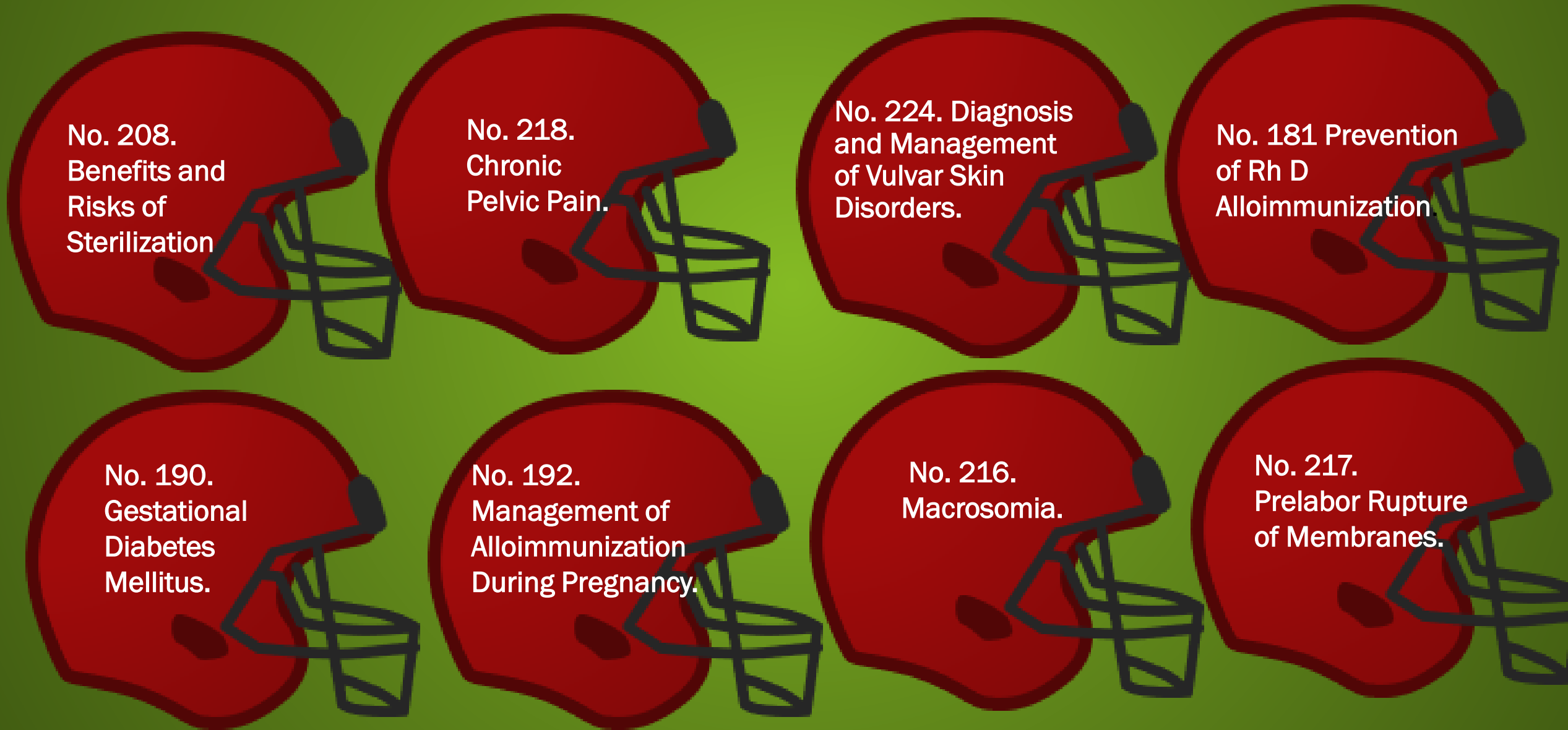
PRACTICE ADVISORY/CLINICAL PRACTICE GUIDELINES/COMMITTEE STATEMENTS WITHDRAWN/REPLACED

Withdrawn and replaced by ACOG Clinical Practice Guideline No. 10: Intrapartum Fetal Heart Rate Monitoring: Interpretation and Management

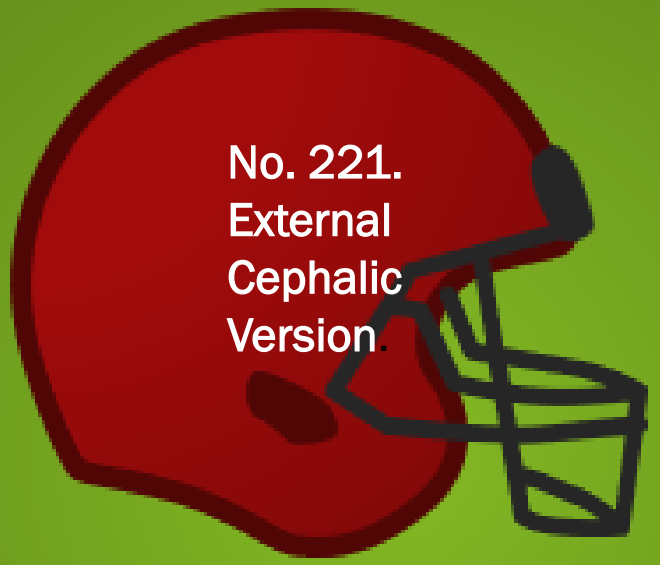
PRACTICE ADVISORY/CLINICAL PRACTICE GUIDELINES/COMMITTEE STATEMENTS WITHDRAWN/REPLACED

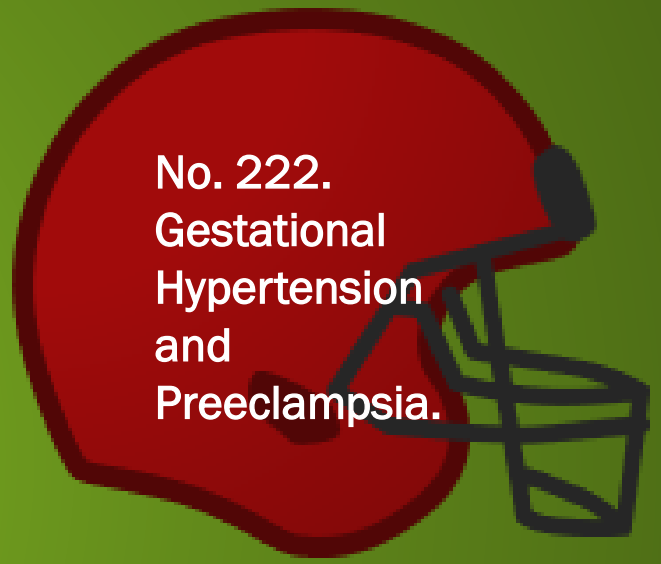
Replaced by ACOG Practice Advisory: Influenza in Pregnancy: Prevention and Treatment

PRACTICE BRIEFS REAFFIRMED



PRACTICE BRIEFS REAFFIRMED





Corrections in Publications

- ACOG Clinical Practice Update. Zuranolone and Brexanolone for the Treatment of Postpartum Depression. ObstetGynecol2026;147:e24–e28 (published correction appears in Obstet Gynecol 2026;147:e96, April 2026 issue)

PUBLICATIONS WITHDRAWN

- ACOG Committee Opinion No. 478. Family History as a Risk Assessment Tool. ACOG Committee Opinion No. 619. Gynecologic Surgery in the Obese Woman..
- ACOG Committee Opinion No. 720. Maternal–Fetal Surgery for Myelomeningocele.
- ACOG Practice Bulletin No. 147. Lynch Syndrome.
- ACOG Practice Bulletin No. 149. Endometrial Cancer.
- ACOG Practice Bulletin No. 227. Fetal Growth Restriction.
- ACOG Technology Assessment No. 9. Digital Breast Tomosynthesis.

PUBLICATIONS ENDORSED BY ACOG

- Gyamfi-Bannerman C. Society for Maternal-Fetal Medicine Consult Series #44: ***Management of bleeding in the late preterm period***. Am J Obstet Gynecol 2018;218:B2–B8. doi: 10.1016/j.ajog.2017.10.019.
- Lee RH, Mara Greenberg, Metz TD, Pettker CM. Society for Maternal-Fetal Medicine Consult Series #53: ***Intrahepatic cholestasis of pregnancy.*** Am J Obstet Gynecol 2021;224:B2–B9. doi: 10.1016/j.ajog.2020.11.002.
- Joglar JA, Kapa S, Saarel EV, et al. ***2023 HRS expert consensus statement on the management of arrhythmias during pregnancy. Heart Rhythm*** 2023;20:e175–e264. doi: 10.1016/j.hrthm.2023.05.017.

PUBLICATIONS ENDORSED BY ACOG

- Miller R, Gyamfi-Bannerman C. Society for Maternal-Fetal Medicine Consult Series #63: Cesarean scar ectopic pregnancy. Am J Obstet Gynecol 2022;227:B9–B20. doi: 10.1016/j.ajog.2022.06.024.
- Lee T, Stone J, Jain V, Avtalion N, Wickersham J, Haddock J, Scott M, Grone C, Hibbs D, Gibson KS, Feltovich H, Iriye B, Lagrew D. Society for Maternal-Fetal Medicine Special Statement: Best-practice recommendations for ultrasound network connectivity. Am J Obstet Gynecol 2022;227:B11–B23. doi: 10.1016/j.ajog.2022.03.039.

PUBLICATIONS ENDORSED BY ACOG

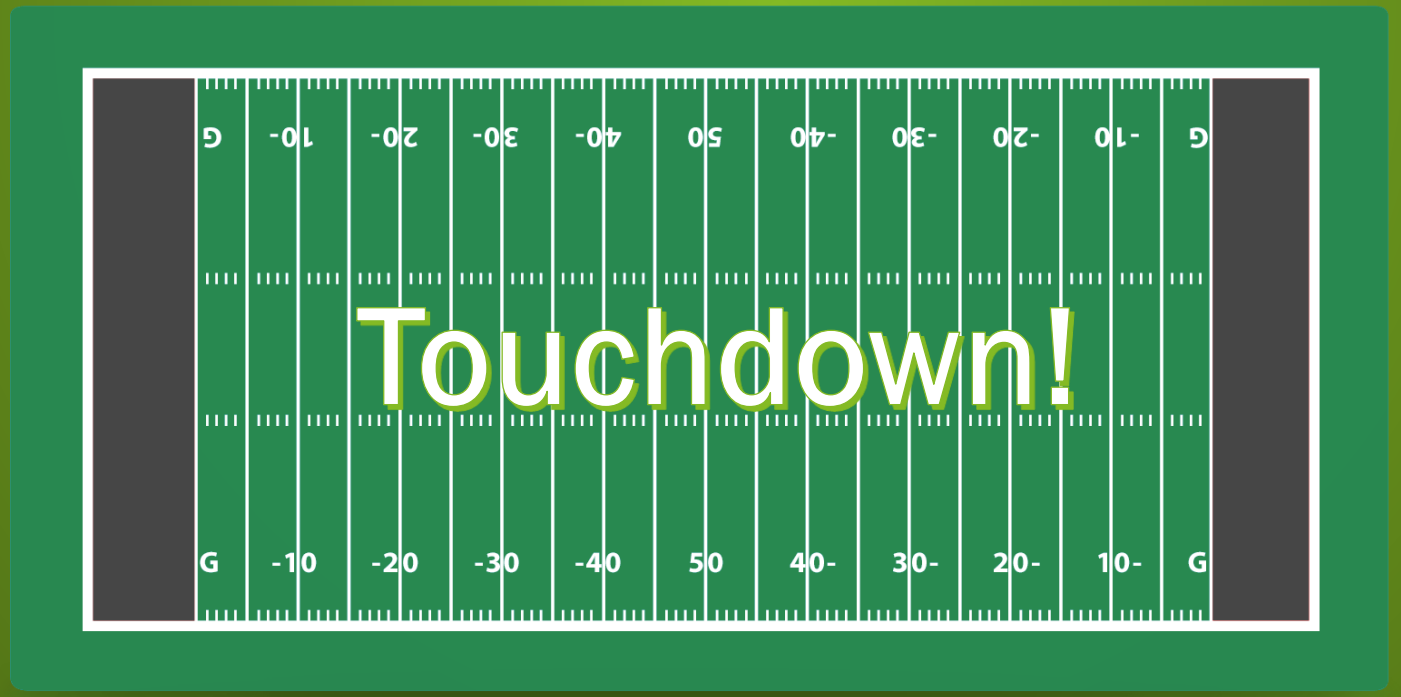
- Sufrin C. *Pregnancy and Postpartum Care in Correctional Settings. National Commission on Correctional Health Care.* https://www.ncchc.org/wpcontent/uploads/Pregnancy-and-Postpartum-Care-2018.pdf
- Society for Maternal-Fetal Medicine (SMFM), Rink BD, Dugoff L, Kuller JA and SMFM Publications Committee (2025), Society for Maternal-Fetal Medicine ***Consult Series #74: Cell-free DNA screening for aneuploidies: Updated guidance.*** Pregnancy, 1: e70139. https://doi.org/10.1002/pmf2.70139

PUBLICATIONS ENDORSED BY ACOG

- *Bauer ME, Arendt K, Beilin Y, et al. The Society for Obstetric Anesthesia and Perinatology Interdisciplinary Consensus Statement on Neuraxial Procedures in Obstetric Patients With Thrombocytopenia. Anesth Analg 2021;132:1531–1544.*
- AIUM Practice Parameter for the Performance of Standard Diagnostic Obstetric Ultrasound. J Ultrasound Med 2024;43:E20–E32. doi:10.1002/jum.16406

PUBLICATIONS ENDORSED BY ACOG

- Miller EC, Bello NA, Chen PR, et al. ***Prevention and Treatment of Maternal Stroke in Pregnancy and Postpartum: A Scientific Statement From the American Heart Association***. Stroke. Published online January 28, 2026. doi:10.1161/STR.0000000000000514



AHA SCIENTIFIC STATEMENT

Prevention and Treatment of Maternal Stroke in Pregnancy and Postpartum: A Scientific Statement From the American Heart Association

Endorsed by the American College of Obstetricians and Gynecologists, January 2026, and should be construed as ACOG clinical guidance.

Eliza C. Miller, MD, MS, Chair; Natalie A. Bello, MD, MPH; Peng R. Chen, MD; Lisa Leffert, MD; Michelle Leppert, MD, FAHA; Tracy Madsen, MD, PhD, FAHA; Katelyn Skeels, MSN, APRN, FNP-C; Alan Tita, MD, PhD; Eduard Valdes, MD; Andrea Shields, MD, MS, Vice Chair, on behalf of the American Heart Association Women's Health Science Committee of the Council on Clinical Cardiology and Stroke Council; Council on Cardiovascular and Stroke Nursing; and Council on Lifelong Congenital Heart Disease and Heart Health in the Young

- Current stroke prevention and treatment guidelines are limited due to exclusion of pregnant/lactating individuals from all major stroke trials
- A growing number of observational research has emerged providing a foundation for clinical decision making and patient counseling on prevention, treatment, and recovery

Stroke during pregnancy and post-partum

- Effects 20-40/100,000 of pregnancies
- Catastrophic consequences for maternal and neonate
- Accounts for 4-6% of maternal deaths
    - Statistics maybe underestimated due to reporting (may be reported as Hypertension Disorders of Pregnancy rather than stroke)

Prevention and Treatment of Maternal Stroke in Pregnancy and Postpartum: A Scientific Statement From the American Heart Association. Stroke

- Although advanced maternal age is considered a risk factor for stroke, even younger pregnant/postpartum patients may be at a higher risk for stroke due to the physiological changes in pregnancy:
  - Hypercoagulability
  - Increase in antifibrinolytic agents
- These changes coupled with possible dehydration in pregnancy, venous status of pelvic veins due to uterine compression and potential vascular trauma r/t delivery, place pregnant/postpartum patients at a higher risk for stroke

Physiological Changes in Pregnancy Increasing the Risk of Stroke

- Cardiovascular and immunological adaptations also play a role. Pregnancy results in decreased systemic vascular resistance and increased plasma volume, stroke volume, and cardiac output.
- Pregnancy induces immune system modulation.
  - Patients with underlying autoimmune conditions such as systemic lupus erythematosus have inherent immunological disruptions and face a 2- to 3-fold higher risk of stroke, particularly at younger ages.
- Infections during pregnancy, particularly genitourinary

infections and sepsis, have been linked to increased stroke risk.

Physiological Changes in Pregnancy Increasing the Risk of Stroke

- Hypertensive Disorders of Pregnancy (HDP), including gestational hypertension, preeclampsia/eclampsia, and chronic hypertension with superimposed preeclampsia, affect ≈10% of pregnancies and increase stroke risk by up to 5-fold.
  - Nearly half of all pregnancy-associated stroke hospitalizations in the United States occur in the setting of HDP.
  - These strokes are often more severe with higher rates of complications compared with strokes not associated with HDP.

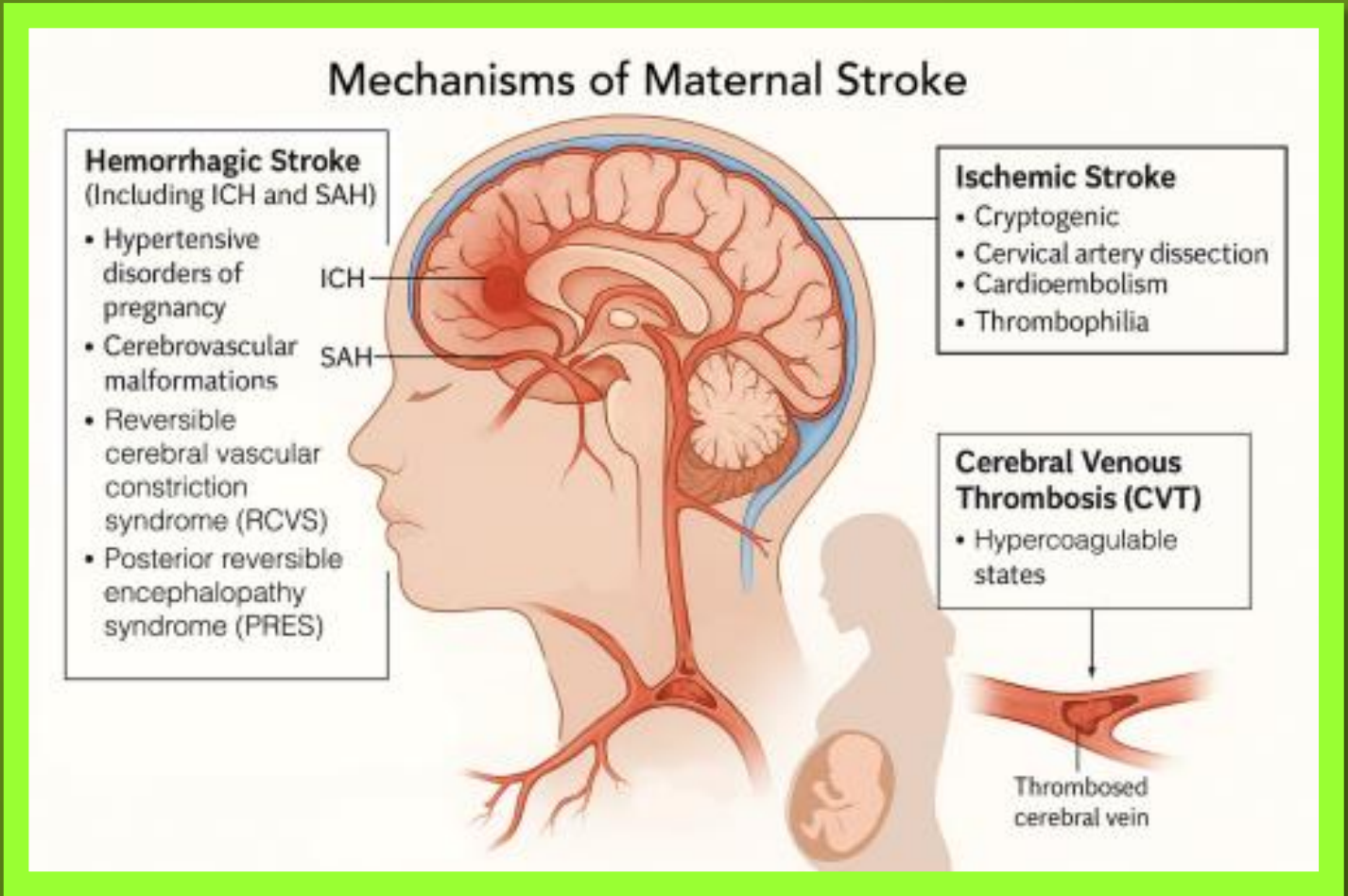
Other Factors/Risks in Pregnancy Increasing the Possibility of Stroke

- Diabetes
- Migraine
- Heart and or cerebrovascular disease
- Hematologic conditions such as; sickle cell disease thrombophilia, antiphospholipid syndrome
- Obesity
- Social Determinants of Health
  - Racial Disparities – Non-Hispanic Black

Mechanism of Maternal Strokes

- Hemorrhage Stroke – More common in pregnancy vs the general population
  - ICH – Intracranial Hemorrhage
  - SAC – Subarachnoid Hemorrhage
- Ischemic Stroke
  - Identifiable causes include cervical artery dissection (11%), cardio embolism (13%), and prothrombotic disorders (6%).
    - Cervical artery dissections are more common in the postpartum period, possibly because of the hormonal vascular changes that affect vascular integrity.
- Cerebrovascular Venous Thrombosis (CVT)
  - Pregnancy-induced hypercoagulability is the key driver, and risk is compounded in those with acquired or inherited thrombophilia.

Mechanisms of Maternal Stroke



PRIMARY PREVENTION OF PREGNANCYRELATED STROKE

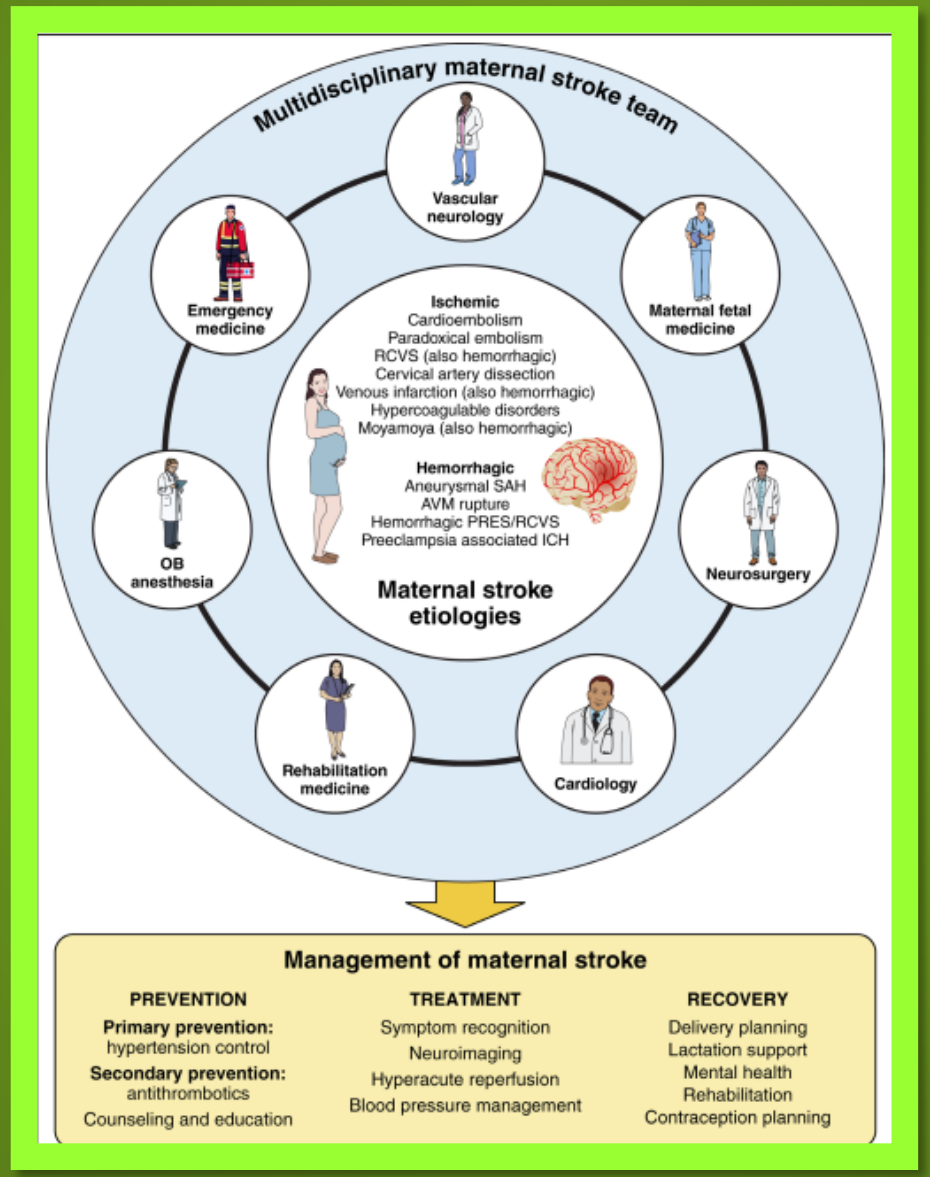
- *“Although some strokes cannot be predicted or prevented, the majority of fatal maternal strokes usually due to ICH have been deemed preventable with earlier and more aggressive blood pressure control”*
  - *The primary goal of antihypertensive therapy during pregnancy and early postpartum is to prevent complication of severe hypertension and preeclampsia (stroke being part of the complications)*

PRIMARY PREVENTION OF PREGNANCYRELATED STROKE

- *“Prevention of pregnancy-related stroke begins before conception, with optimization of prepregnancy health. General primary stroke prevention strategies should be followed for all pregnancy-capable individuals, in line with the 2024 American Heart Association/American Stroke Association Guideline for the Primary Prevention of Stroke, using the using the Life’s Essential 8 Framework”.*
- *“This includes screening for modifiable behaviors, medical conditions, and social determinants of health such as food insecurity or lack of transportation that may contribute to stroke risk However, patients at higher risk of stroke may require targeted primary prevention strategies.”*

https://www.heart.org/en/healthy-living/healthy-lifestyle/lifes-essential-8

Optimal Care Involves a Multidisciplinary Team



Anxiety, Depression, Sexual Dysfunction, and Sleep Disturbances After Maternal Stroke

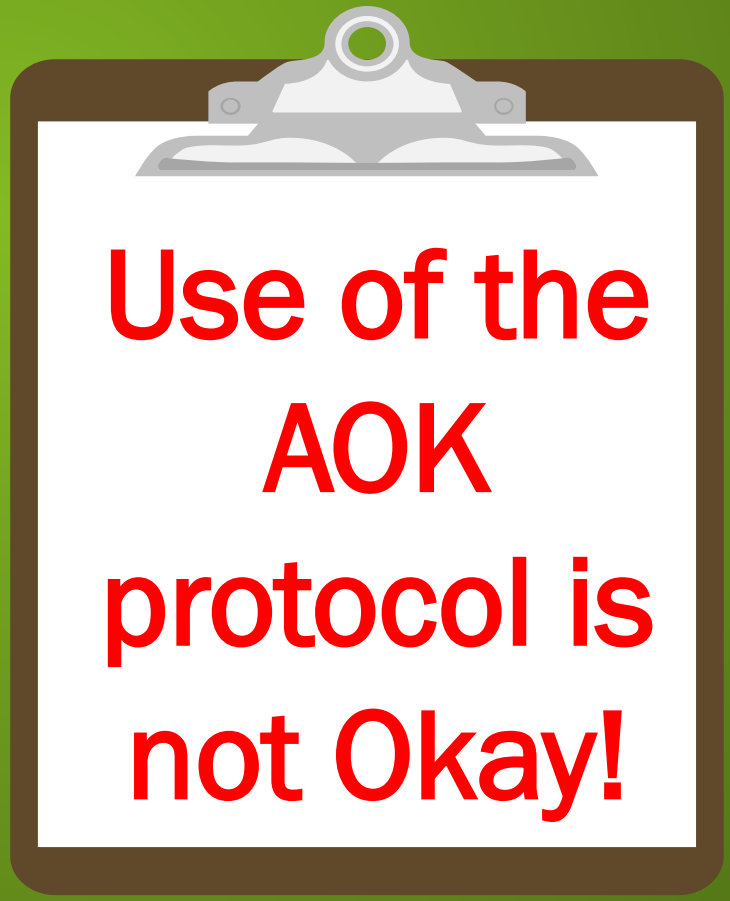
- Mood and sleep disorders are common after stroke
- May be more intensified by postpartum factors such as hormonal shifts, infant care demands and disrupted sleep
- Poststroke fatigue, anxiety and depression may hinder recovery and worsen long-term outcomes
  - Poor-quality sleep may worsen functional outcomes and increase recurrence risk
    - Advisement to screen for insomnia, restless leg syndrome, obstructive sleep apnea, and other sleep disorders

Full article is available in the “Handout Portion” of our Program

This slide is static and does not animate.

Use of Atropine, Ondansetron, and Ketorolac in Suspected Amniotic Fluid Embolism

Luis D. Pacheco, Shannon M. Clark, Karin Fox, Melissa E. Bauer, and Steven L. Clark



Why???????

- Recommendation is based upon Five Case Reports and ***NOT*** Randomized Controlled Trials
- The incidence of true AFE is very rare, the cause is unknown, and time should not be wasted on unapproved protocols
- The focus should be on utilizing approved BLS and ACLS guidelines

Atropine, Ondansetron, and Ketorolac

- ***Atropine*** doses range between 1mg to 0.2mgs. Doses lower than 0.4mg may result in paradoxical bradycardia or asystole attributable to a promuscarinic (stimulation of the parasympathetic nervous system) effect
  - Atropine has been removed from ACLS algorithms due to the lack of benefit and may cause tachycardia which shortens diastolic filling time of the right ventricle which compromises preload and cardiac output
- ***Ondansetron*** is a serotonin receptor antagonist and is associated with QT interval prolongation and an increased risk of cardiac arrythmias, including polymorphic V-Tachycardia
- Proponents of the protocol suggest that inhibiting thromboxane A2 with ***Ketorolac*** “blocks the cause of coagulopathy in AFE
  - Authors are unaware of data to support of this practice
  - The use of NSAIDS (Ketorolac) in the setting of true AFE, may worsen the bleeding or coagulopathy, kidney function, and myocardial injury which is of particular concern in severe multiorgan hypoperfusion

QUESTIONS?

THANK YOU FOR YOUR TIME AND ATTENTION