Antiphospholipid Syndrome

Antiphospholipid syndrome (APS) is diagnosed by a combination of clinical and laboratory findings (Tables 1 and 2).

Table 1: Clinical Criteria for Diagnosis of Antiphospholipid Syndrome

1. Vascular thrombosis:
   One or more clinical episodes of arterial, venous, or small vessel thrombosis, in any tissue or organ. Thrombosis must be confirmed by objective criteria (e.g., imaging or Doppler studies or histopathology).
   And/or

2. Pregnancy morbidity:
   (A) **One or more unexplained deaths** of a morphologically normal fetus at or beyond the 10th week of gestation, with normal fetal morphology documented by ultrasound or by direct examination of the fetus.
   And/or

   (B) **One or more premature births** of a morphologically normal neonate before the 34th week of gestation because of: eclampsia or severe preeclampsia, or features consistent with placental insufficiency (e.g., abnormal Doppler flow, abnormal fetal testing, SGA <10%, oligohydramnios).
   And/or

   (C) **Three or more unexplained consecutive spontaneous abortions** before the 10th week of pregnancy, with maternal anatomic or hormonal abnormalities and paternal and maternal chromosomal causes excluded.

Abbreviations: AFI, amniotic fluid index; SGA, small for gestational age.
Table 2  Laboratory Criteria for the Diagnosis of Antiphospholipid Syndrome

1. **Lupus anticoagulant** present in plasma, on two or more occasions at least 12 weeks apart. Examples are lupus anticoagulant, DRVVT, or aPTT test. Testing is ideally performed before the patient is treated with anticoagulants.

   And/or

2. **Anticardiolipin antibody** of IgG and/or IgM isotype in serum or plasma, present as >40 GPL or MPL, or > 99th percentile, on two or more occasions, at least 12 weeks apart.

   And/or

3. **Anti-B2 glycoprotein-1** of IgG and/or IgM isotype in serum or plasma (in titer >99th percentile for a normal population as defined by the laboratory performing the test), present on two or more occasions, at least 12 weeks apart.

Abbreviations: DRVVT, dilute Russell’s viper venom time; aPTT, activated partial thromboplastin time.

Women may be seen preconceptionally either by a hematologist, rheumatologist, internist, obstetrician-gynecologist or MFM subspecialist. These should be elements of that care:

- Referral to MFM/OB for preconception consultation
- Proper identification of women with undiagnosed APS (lupus, recurrent pregnancy loss, prior VTE, prior IUFD, prior early severe PE)
- Identify and optimize underlying/co-existing medical morbidities such as lupus, Sjogren’s syndrome, etc
- Discussion regarding the need for early prenatal care and anticoagulation during pregnancy

The following guidelines are intended at the first prenatal visit:

- Early referral to MFM/OB for consultation
- Verify diagnosis by reviewing/repeating inappropriate labs
- Initiate prophylactic anticoagulation
- Recommend weekly antenatal testing starting at 32 weeks of gestation; earlier if prior IUFD prior to 32 weeks of gestation or with onset of FGR
- Patient education
- Goal is delivery at term
- Continue anticoagulation for 6 weeks postpartum
This algorithm and key driver material was written by a group of experts in the field of Preterm Birth. It was then reviewed by the Society for Maternal-Fetal Medicine’s (SMFM’s) Publications Committee, Executive Committee and Risk Management.

Standardization of healthcare processes and reduced variation has been shown to improve outcomes and quality of care. SMFM developed these documents to help facilitate the standardization process. These algorithms and key driver documents are “tools” to assist clinicians and practices. The practice of medicine continues to evolve, and individual circumstances may vary. They reflect clinical and scientific advances as of the date issued and are subject to change. They are not intended to dictate a certain management or course of action. We encourage users to adapt them to their particular situation, environment and patient population.

This publication is not expected to reflect the opinions of all members of the Society for Maternal-Fetal Medicine.

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