

Guidelines for diagnosis, treatment, and use of laparoscopy for surgical problems during pregnancy

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Preamble

This document provides specific recommendations and guidelines to assist physicians in the diagnostic workup and treatment of surgical problems in pregnant patients, focusing on the use of laparoscopy. Surgical interventions during pregnancy should minimize fetal risk without compromising the safety of the mother.

Recent data show the safety and efficacy of laparoscopy during all trimesters for many surgical conditions with outcomes similar to conventional operations. Surgeons must be aware of data regarding differences in techniques used for pregnant patients to optimize outcomes.

Disclaimer

Guidelines for clinical practice are intended to indicate preferable approaches to medical problems as established

by experts in the field. These recommendations will be based on existing data or a consensus of expert opinion when little or no data are available. Guidelines are applicable to all physicians who address the clinical problem(s) without regard to specialty training or interests, and are intended to indicate the preferable, but not necessarily the only, acceptable approaches due to the complexity of the health-care environment. Guidelines are intended to be flexible. Given the wide range of specifics in any health-care problem, the surgeon must always choose the course best suited to the individual patient and the variables in existence at the moment of decision.

Guidelines are developed under the auspices of the Society of American Gastrointestinal Endoscopic Surgeons and its various committees and approved by the Board of Governors. Each clinical practice guideline has been systematically researched, reviewed, and revised by the guidelines committee, and reviewed by an appropriate multidisciplinary team. The recommendations are therefore considered valid at the time of its production based on the data available. Each guideline is scheduled for periodic review to allow incorporation of pertinent new developments in medical research knowledge and practice.

Introduction

Approximately 1 in 500 to 1 in 635 women will require nonobstetrical abdominal surgery during their pregnancies [1, 2]. The most common nonobstetrical surgical emergencies complicating pregnancy are acute appendicitis, cholecystitis, and intestinal obstruction [1]. Other conditions that may require operations during pregnancy include ovarian cysts, masses, or torsion, symptomatic cholelithiasis, adrenal tumors, splenic disorders, symptomatic

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hernias, complications of inflammatory bowel diseases, and abdominal pain of unknown etiology.

During its infancy, some argued that laparoscopy was contraindicated during pregnancy due to concerns for uterine injury and fetal perfusion. As surgeons have gained more experience with laparoscopy it has become the preferred treatment for many surgical diseases in the gravid patient [3].

Definitions

Both the quality of the evidence and the strength of the recommendation for each of the guidelines below were assessed according to the GRADE system [4] (see Table 1). This is a 4-tiered system for assessing the quality of evidence (very low, low, moderate, or high) and a 2-tiered system for strength of the recommendation (weak or strong). Additional definitions are provided by SAGES in “The Definitions Document: A Reference for Use of SAGES Guidelines.”

Diagnosis and workup

Managing abdominal pain in the gravid patient presents a dilemma in which the clinician must consider the risks and benefits of diagnostic modalities and therapies to both the mother and the fetus. An underlying principle to the workup of abdominal pain was stated by Sir Zachary Cope in 1921, “Earlier diagnosis means better prognosis” [5]. In pregnant women with abdominal pain, fetal outcome depends on the outcome of the mother. Optimal maternal outcome may require radiologic imaging, sometimes with ionizing radiation. A risk–benefit discussion with the patient should occur prior to any diagnostic study.

Imaging techniques

Ultrasound

Guideline 1 Ultrasonographic imaging during pregnancy is safe and useful in identifying the etiology of acute abdominal pain in the pregnant patient (Moderate; Strong).

Abdominal pain in the pregnant patient can be separated into gynecologic and nongynecologic causes. When radiographic studies are required, ultrasound is considered safe, as no adverse effects to mother or fetus from ultrasound have been reported. It is the initial radiographic test of choice for most gynecologic causes of abdominal pain, including adnexal mass, torsion, placental abruption, placenta previa, uterine rupture, and fetal demise. Ultrasound is also a useful study for many nongynecologic causes of abdominal pain, including symptomatic gallstones and appendicitis [6–12] (Table 2).

Risk of ionizing radiation

Guideline 2 Expedient and accurate diagnosis should take precedence over concerns for ionizing radiation. Cumulative radiation dosage should be limited to 5–10 rads during pregnancy (Moderate; Strong).

Significant radiation exposure may lead to chromosomal mutations, neurologic abnormalities, mental retardation, and increased risk of childhood leukemia. Cumulating radiation dosage is the primary risk factor for adverse fetal effects, but fetal age at exposure is also important [8, 9, 13]. Fetal mortality is greatest when exposure occurs within the first week of conception. It has been recommended that the cumulative radiation dose to the conceptus during pregnancy be less than 5–10 rads [14]. As an example, the radiation dose to the conceptus for a plain

Table 1 GRADE system for rating the quality of evidence for SAGES guidelines

Quality of evidence	Definition	Symbol used
High quality	Further research is very unlikely to alter confidence in the estimate of impact	
Moderate quality	Further research is likely to alter confidence in the estimate of impact and may change the estimate	
Low quality	Further research is very likely to alter confidence in the estimate of impact and is likely to change the estimate	
Very low quality	Any estimate of impact is uncertain	

Adapted from Guyatt et al. [4]

Table 2 GRADE system for recommendations based on the quality of evidence for SAGES guidelines

Strong	It is very certain that benefit exceeds risk for the option considered	
Weak	Risk and benefit well balanced, patients in differing clinical situations would make different choices, or benefits available but not certain	

Adapted from Guyatt et al. [4]

Table 3 Radiation exposure to conceptus in common radiologic studies [15, 33, 34]

Study	Radiation exposure (rads)
Abdominal radiograph	0.1–0.3
Intraoperative cholangiography	0.2
Lumbar spine radiograph	0.6
Intravenous pyelogram	0.6
Barium enema	0.7
CT of pelvis	1–5
ERCP (without pelvic shielding)	2–12.5

abdominal radiograph averages 0.1–0.3 rad, while a CT of the pelvis yields up to 5 rads of fetal exposure [15] (see Table 3 for additional radiation doses).

The most sensitive time period for central nervous system teratogenesis is between 10 and 17 weeks gestation, and routine radiographs should be avoided during this time. In later pregnancy the concern shifts from teratogenesis to increasing the risk of childhood hematologic malignancy. The background incidence of childhood cancer and leukemia is approximately 0.2–0.3%. Radiation may increase that incidence by 0.06% per 1 rad delivered to the fetus [14].

Exposure of the conceptus to 0.5 rad increases the risk of spontaneous abortion, major malformations, mental retardation, and childhood malignancy to one additional case in 6,000 above baseline risk [15]. It has been suggested that the risk of aberrant teratogenesis is negligible at 5 rads or less and that the risk of malformation is significantly increased at doses above 15 rads. No single diagnostic study should exceed 5 rads [9, 13, 14, 16–19].

Computed tomography

Guideline 3 Contemporary multidetector CT protocols deliver a low radiation dose and may be used judiciously during pregnancy (Moderate; Weak).

Computed tomography (CT) may be used in the evaluation of abdominal pain in the gravid patient [20]. Radiation exposure to the fetus may be as low as 2 rads

for pelvic CT scans but can reach 5 rads when a full scan of the abdomen and pelvis is performed [8, 21, 22]. This radiation dose is considered safe but may affect teratogenesis and increase the risk of developing childhood hematologic malignancies [21]. CT protocols and radiation doses vary by institution, and the individual practitioner should be aware of the radiation exposure at his or her institution and attempt to minimize fetal radiation exposure, if possible.

Magnetic resonance imaging

Guideline 4 MR imaging without the use of intravenous gadolinium can be performed at any stage of pregnancy (Low; Strong).

MRI provides excellent soft tissue imaging without ionizing radiation and is safe to use in pregnant patients. Some authors express concern about the detrimental effects of the acoustic noise to the fetus [23], but no specific adverse effects of MRI on fetal development have been reported [24–28]. Intravenous gadolinium agents cross the placenta and may be detrimental; therefore, their use during pregnancy should be confined to select cases where it is considered essential [25, 29, 30].

Nuclear medicine

Guideline 5 Administration of radionuclides for diagnostic studies is generally safe for mother and fetus (Low; Weak).

Radiopharmaceuticals, including technetium-99m, can generally be administered at doses that provide whole-fetal exposure of less than 0.5 rad [31, 32], well within the safe range of fetal exposure. Consultation with a nuclear medicine radiologist or technologist should be considered prior to performing the study.

Cholangiography

Guideline 6 Intraoperative and endoscopic cholangiography exposes the mother and fetus to minimal radiation and may be used selectively during pregnancy. The lower

abdomen should be shielded when performing cholangiography during pregnancy to decrease the radiation exposure to the fetus (Low; Weak).

Radiation exposure during cholangiography is estimated to be 0.2–0.5 rad [33]. Fluoroscopy generally delivers a radiation dose of up to 20 rads/min, but varies depending on the X-ray equipment used, patient positioning, and patient size. During cholangiography, the fetus should be shielded by placing a protective device between the source of ionizing radiation and the patient. Efforts should be made to shield the fetus from radiation exposure without compromising the field of view necessary for proper imaging. No adverse effects to pregnant patients or their fetuses have been reported specifically from cholangiography.

The radiation exposure during endoscopic retrograde cholangiopancreatography (ERCP) averages 2–12 rads, but can be substantially higher for long procedures [34]. ERCP also carries risks beyond the radiation exposure such as bleeding and pancreatitis. In nonpregnant patients, the risk of bleeding is 1.3% and the risk of pancreatitis is 3.5–11% [35]. These additional risks warrant the same careful risk–benefit analysis and discussion with the patient as other operative and procedural interventions [8, 18, 36–38]. Alternatives to fluoroscopy include intraoperative ultrasound and choledochoscopy. These are both acceptable methods provided the surgeon has the appropriate equipment and skills to accurately perform the examinations.

Magnetic resonance cholangiopancreatography (MRCP) is an alternative approach that is gaining widespread acceptance. It is a useful diagnostic tool but offers no therapeutic capability. It has not been studied specifically in pregnant women.

Surgical techniques

Guideline 7 Diagnostic laparoscopy is safe and effective when used selectively in the workup and treatment of acute abdominal processes in pregnancy (Moderate; Strong).

Diagnostic laparoscopy provides direct visualization of intra-abdominal organs. While not enough data are available to recommend this as a primary diagnostic approach in the pregnant patient, it is a reasonable alternative to radiologic imaging. The benefits of operative exploration are avoidance of ionizing radiation, diagnostic accuracy, and the capability to treat a surgical problem at the time of diagnosis. Furthermore, it has been shown that laparoscopy can be performed safely during any trimester of pregnancy with minimal morbidity to the fetus and mother [39–51].

Patient selection

Preoperative decision making

Guideline 8 Laparoscopic treatment of acute abdominal disease has the same indications in pregnant and nonpregnant patients (Moderate; Strong).

Once the decision to operate has been made, the surgical approach (laparotomy versus laparoscopy) should be determined based on the skills of the surgeon and the availability of the appropriate staff and equipment. An appropriate discussion with the patient regarding the risks and benefits of surgical intervention should be undertaken. Benefits of laparoscopy during pregnancy appear similar to those benefits in nonpregnant patients, including less postoperative pain, less postoperative ileus, decreased length of hospital stay, and faster return to work [40, 45, 52–54].

Laparoscopy and trimester of pregnancy

Guideline 9 Laparoscopy can be safely performed during any trimester of pregnancy (Moderate; Strong).

Operative intervention may be performed in any trimester of pregnancy. Historical recommendations were to delay surgery until the second trimester in order to reduce the rates of spontaneous abortion and preterm labor [55]. Recent literature has shown that pregnant patients may undergo laparoscopic surgery safely during any trimester without any increased risk to the mother or fetus [39, 40, 54, 56–59]. Postponing necessary operations until after parturition may, in some cases, increase the rates of complications for mother and fetus [56, 60–62].

It has been suggested that the gestational age limit for successful completion of laparoscopic surgery during pregnancy is 26–28 weeks [44]. This has been refuted by several studies in which laparoscopic cholecystectomy and appendectomy have been successfully performed late in the third trimester [57, 59, 63, 64].

Although laparoscopy can be performed safely in pregnancy with good fetal and maternal outcomes, the long-term effects to the children have not been well studied. One recent study evaluated 11 children from 1 to 8 years old and found no growth or developmental delay [51].

Treatment

There are many advantages of using laparoscopy in the pregnant patient, including decreased fetal respiratory depression due to diminished postoperative narcotic requirements [45, 65–67], lower risk of wound complications

[65, 68, 69], diminished postoperative maternal hypoventilation [65, 66], shorter hospital stay, and decreased risk of thromboembolic events. The improved visualization in laparoscopy may reduce the risk of uterine irritability by decreasing the need for uterine manipulation [70]. Decreased uterine irritability results in lower rates of spontaneous abortion and preterm delivery [71].

Patient positioning

Guideline 10 Gravid patients should be placed in the left lateral decubitus position to minimize compression of the vena cava (Moderate; Strong).

When the pregnant patient is placed in a supine position, the gravid uterus places pressure on the inferior vena cava resulting in decreased venous return to the heart. This decrease in venous return results in significant reduction in cardiac output with concomitant maternal hypotension and decreased placental perfusion during surgery [72–74]. Placing the patient in a left lateral decubitus position will shift the uterus off the vena cava improving venous return and cardiac output [72, 73].

Initial port placement

Guideline 11 Initial abdominal access can be safely accomplished with an open (Hasson) technique, Veress needle, or optical trocar, if the location is adjusted according to fundal height and previous incisions (Moderate; Strong).

There has been much debate regarding abdominal access in the pregnant patient, with preferences toward either a Hasson technique or Veress needle. The concern for use of the Veress needle has been based largely on concerns for injury to the uterus or other intra-abdominal organs [75, 76]. Because the intra-abdominal domain is altered during the second and third trimesters, initially accessing the abdomen via a subcostal approach has been recommended [57, 59, 63, 70]. If the site of initial abdominal access is adjusted according to fundal height and the abdominal wall is elevated during insertion, both the Hasson technique and the Veress needle can be used safely and effectively [57, 59, 77].

It has also been recommended that trocar placement be altered from the standard configuration to account for the increased size of the uterus [78, 79]. Ultrasound-guided trocar placement has been described in the literature as an additional safeguard to avoid uterine injury [80].

Insufflation pressure

Guideline 12 CO₂ insufflation of 10–15 mmHg can be safely used for laparoscopy in the pregnant patient (Moderate; Strong).

The potential for adverse consequences from CO₂ insufflation in the pregnant patient has led to apprehension over its use. As such, some authors advocate gasless laparoscopy in pregnant patients, but this technique not been widely adopted [81–88].

The pregnant patient's diaphragm is upwardly displaced by the growing fetus, which results in decreased residual lung volume and functional residual capacity [89]. Upward displacement of the diaphragm by pneumoperitoneum is more worrisome in a pregnant patient with existing restrictive pulmonary physiology. Some have recommended intra-abdominal insufflation pressures be maintained at less than 12 mmHg to avoid worsening pulmonary physiology in gravid women [50, 79]. Others have argued that insufflation less than 12 mmHg may not provide adequate visualization of the intra-abdominal cavity [57, 59]. Pressures of 15 mmHg have been used during laparoscopy in pregnant patients without increasing adverse outcomes to the patient or her fetus [57, 59].

Because CO₂ exchange occurs with intraperitoneal insufflation, there has been concern for deleterious effects to the fetus from pneumoperitoneum. Some animal studies have confirmed fetal acidosis with associated tachycardia, hypertension, and hypercapnia during CO₂ pneumoperitoneum [90–92], while other animal studies contradict these findings [93]. There are no data showing detrimental effects to human fetuses from CO₂ pneumoperitoneum [44].

Intraoperative CO₂ monitoring

Guideline 13 Intraoperative CO₂ monitoring by capnography should be used during laparoscopy in the pregnant patient (Moderate; Strong).

Fetal acidosis and associated fetal instability in CO₂ pneumoperitoneum have been documented in animal studies, though no long-term effects from these changes have been identified [90–92, 94]. Fetal acidosis with insufflation has not been documented in the human fetus, but concerns over potential detrimental effects of acidosis have led to the recommendation of maternal CO₂ monitoring [95, 96]. Initially, there was debate over maternal blood gas monitoring of arterial carbon dioxide (PaCO₂) versus end-tidal carbon dioxide (EtCO₂) monitoring, but the less invasive capnography has been demonstrated to adequately reflect maternal acid-base status in humans

[97]. Several large studies have documented the safety and efficacy of EtCO₂ measurements in pregnant women [44, 57, 59], making routine blood gas monitoring unnecessary.

Venous thromboembolic (VTE) prophylaxis

Guideline 14 Intraoperative and postoperative pneumatic compression devices and early postoperative ambulation are recommended prophylaxes for deep venous thrombosis in the gravid patient (Moderate; Strong).

Pregnancy is a hypercoagulable state with a 0.1–0.2% incidence of deep venous thrombosis [98]. CO₂ pneumoperitoneum may increase the risk of deep venous thrombosis by predisposing to venous stasis. Insufflation of 12 mmHg causes a significant decrease in blood flow that cannot be completely reversed with intermittent pneumatic compression devices or intermittent electric calf stimulators [99].

Although there is little research on prophylaxis for deep venous thrombosis in the pregnant patient, general principles for laparoscopic surgery apply. Because of the increased risk of thrombosis, prophylaxis with pneumatic compression devices both intraoperatively and postoperatively and early postoperative ambulation are recommended. There are no data regarding use of unfractionated or low-molecular-weight heparin for prophylaxis in pregnant patients undergoing laparoscopy, though its use has been suggested in patients undergoing extended major operations [100]. In patients who require anticoagulation during pregnancy, heparin has proven safe and is the agent of choice [101].

Gallbladder disease

Guideline 15 Laparoscopic cholecystectomy is the treatment of choice in the pregnant patient with gallbladder disease, regardless of trimester (Moderate; Strong).

In the past, nonoperative management of symptomatic cholelithiasis in pregnancy has been recommended [60, 102–104]. At present, early surgical management is the treatment of choice. Early surgical management of gravid patients with symptomatic gallstones is supported by data showing recurrent symptoms in 92% of patients managed nonoperatively who present in the first trimester, 64% who present in the second trimester, and 44% who present in the third trimester [105, 106]. This delay in surgical management results in increased rates of hospitalizations, spontaneous abortions, preterm labor, and preterm delivery compared to those who undergo cholecystectomy [39, 40, 50, 52, 87–89]. Altogether, nonoperative management of symptomatic gallstones in gravid patients results in recurrent symptoms in more than 50% of patients, and 23% of

such patients develop acute cholecystitis or gallstone pancreatitis [56]. Gallstone pancreatitis results in fetal loss in 10–60% of pregnant patients [107, 108].

The significant morbidity and mortality associated with untreated gallbladder disease in the gravid patient favor surgical treatment. Laparoscopic cholecystectomy is preferred because of the salutary outcomes and favorable side-effect profile [58]. There have been no reports of fetal demise with laparoscopic cholecystectomy performed during the first and second trimesters [109]. Furthermore, decreased rates of spontaneous abortion and preterm labor have been reported in laparoscopic cholecystectomy when compared to laparotomy [110].

Choledocholithiasis

Guideline 16 Choledocholithiasis during pregnancy may be managed with preoperative endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy followed by laparoscopic cholecystectomy, laparoscopic common bile duct exploration, or postoperative ERCP (Moderate; Strong).

Complications associated with choledocholithiasis are relatively uncommon during pregnancy [111, 112]. However, these complications can result in significant morbidity and mortality making appropriate management of these patients important. There have been no trials comparing common bile duct exploration at the time of laparoscopic cholecystectomy to ERCP followed by cholecystectomy in pregnant patients. Good outcomes have been described with intraoperative common bile duct exploration, but few cases have been reported [113]. Multiple studies have demonstrated safe and effective management of common bile duct stones with preoperative ERCP followed by laparoscopic cholecystectomy [114–119].

Laparoscopic appendectomy

Guideline 17 Laparoscopic appendectomy may be performed safely in pregnant patients with appendicitis (Moderate; Strong).

The laparoscopic approach is the preferred treatment for pregnant patients with presumed appendicitis [120], and the preponderance of studies have shown the technique to be safe and effective [57, 59, 121–127]. These retrospective series have shown very low rates of preterm delivery and, in most series, no reports of fetal demise.

Accurate and timely diagnosis of appendicitis in the gravid patient may minimize the risk of fetal loss and optimize outcomes. In some circumstances clinical findings may be sufficient for diagnosis. When the diagnosis remains uncertain, prompt use of ultrasound, CT, or MRI is

a useful adjunct to a more accurate diagnosis of appendicitis and decreases the rate of negative laparoscopy. However, the false-negative rates of CT and MRI studies have yet to be fully evaluated in the gravid patient, and some hospitals may not have immediate access to these radiologic modalities.

The published data overwhelmingly attest to the safety of laparoscopic appendectomy in the gravid patient, but one recent study describes a higher risk for laparoscopy compared to laparotomy [128]. This population-based study showed an odds ratio of 2.3 for fetal loss in laparoscopy compared to conventional surgery for appendicitis. This single study does not contraindicate laparoscopic appendectomy in pregnant patients, but it does illuminate a need for further research on the subject. Unless future studies bolster the above observational data, laparoscopic appendectomy remains the treatment of choice for pregnant patients.

Solid organ resection

Guideline 18 Laparoscopic adrenalectomy, nephrectomy, and splenectomy are safe procedures in pregnant patients (Low; Weak).

Laparoscopic adrenalectomy during pregnancy has proven effective in the management of primary hyperaldosteronism [129], Cushing's syndrome [130–132], and pheochromocytoma [133–138]. Laparoscopic splenectomy has also become an increasingly accepted surgical approach in pregnancy [139]. Gravid patients with antiphospholipid syndrome [140], hereditary spherocytosis [141], and autoimmune thrombocytopenia purpura [139, 142, 143] have undergone laparoscopic splenectomy with good outcomes for mother and fetus. Two cases of laparoscopic nephrectomy have been reported in the first and second trimesters without any associated complications and both infants were born healthy at term [144, 145].

Adnexal masses

Guideline 19 Laparoscopy is safe and effective treatment in gravid patients with symptomatic ovarian cystic masses. Observation is acceptable for all other cystic lesions provided ultrasound is not concerning for malignancy and tumor markers are normal. Initial observation is warranted for most cystic lesions <6 cm in size (Low; Strong).

The incidence of adnexal masses during pregnancy is 2% [146]. Most of these adnexal masses discovered during the first trimester are functional cysts that resolve spontaneously by the second trimester [78]. Eighty to 95% of adnexal masses ≤ 6 cm in diameter in pregnant patients spontaneously resolve; therefore, nonoperative management is warranted in such cases [147, 148].

Persistent masses are most commonly functional cysts or mature cystic teratomas with the incidence of malignancy reported at 2–6% [149]. Historically, the concern over malignant potential and risks associated with emergency surgery have led to elective removal of masses that persist after 16 weeks and are >6 cm in diameter [148–150]. Recent literature supports the safety of close observation in these patients when ultrasound findings are not concerning for malignancy, tumor markers (CA125, LDH) are normal, and the patient is asymptomatic [151–154]. In the event that surgery is indicated, various case reports support the use of laparoscopy in the management of adnexal masses in every trimester [155–167]. Perhaps more informative, a retrospective review of 88 pregnant women demonstrated equivalent maternal and fetal outcomes in adnexal masses managed laparoscopically and by laparotomy [70].

Adnexal torsion

Guideline 20 Laparoscopy is recommended for both diagnosis and treatment of adnexal torsion unless clinical severity warrants laparotomy (Low; Strong).

Ten to 15% of adnexal masses undergo torsion [168]. Laparoscopy is the preferred method of both diagnosis and treatment in the gravid patient with adnexal torsion [169]. Multiple case reports have confirmed the safety and efficacy of laparoscopy for adnexal torsion in pregnant patients [170–174]. If diagnosed before tissue necrosis, adnexal torsion may be managed by simple laparoscopic detorsion [175]. However, with late diagnosis of torsion, adnexal infarction may ensue, which can result in peritonitis, spontaneous abortion, preterm delivery, and death [150, 176]. The gangrenous adnexa should be completely resected [177] and progesterone therapy initiated after removal of the corpus luteum, if less than 12 weeks gestation [175]. Laparotomy may be necessary as dictated by the patient's clinical condition and operative findings [178].

Perioperative care

Fetal heart monitoring

Guideline 21 Fetal heart monitoring should occur preoperatively and postoperatively in the setting of urgent abdominal surgery during pregnancy (Moderate; Strong).

While intraoperative fetal heart rate monitoring was once thought to be the most accurate method to detect fetal distress during laparoscopy, no intraoperative fetal heart rate abnormalities have been reported in the literature [56, 110]. This has led some to recommend preoperative

and postoperative monitoring of the fetal heart rate with no increased fetal morbidity having been reported [57, 59].

Obstetric consultation

Guideline 22 Obstetric consultation can be obtained pre- and/or postoperatively based on the severity of the patient's disease, gestational age, and availability of the consultant (Moderate; Strong).

Maternal and fetal monitoring should be part of any pregnant patient's care and should continue throughout her hospitalization, but the timing of a formal obstetric consultation will vary based on availability of the consultant and the severity of the patient's condition. Delaying the treatment of an acute abdominal process to obtain such a consultation should be avoided as treatment delay may increase the risk of morbidity and mortality to the mother and fetus [179].

Tocolytics

Guideline 23 Tocolytics should not be used prophylactically in pregnant women undergoing surgery but should be considered perioperatively when signs of preterm labor are present (High; Strong).

Threatened preterm labor can be successfully managed with tocolytic therapy. The specific agent and indications for the use of tocolytics should be individualized and based on the recommendation of an obstetrician [180–183]. No literature supports the use of prophylactic tocolytics.

Summary of recommendations

More data have accumulated recently as the use of laparoscopy during pregnancy has become common. Most of the data are found in case series and retrospective reviews, which limits the ability to provide absolute guidelines. Further controlled clinical studies are needed to clarify these guidelines, and revision may be necessary as new data appear. The current recommendations for laparoscopy during pregnancy are as follows:

Diagnosis and workup

Imaging techniques

Ultrasound

Guideline 1 Ultrasonographic imaging during pregnancy is safe and useful in identifying the etiology of acute abdominal pain in the pregnant patient (Moderate; Strong).

Risk of ionizing radiation

Guideline 2 Expeditious and accurate diagnosis should take precedence over concerns for ionizing radiation. Cumulative radiation dosage should be limited to 5–10 rads during pregnancy (Moderate; Strong).

Computed tomography

Guideline 3 Contemporary multidetector CT protocols deliver a low radiation dose to the fetus and may be used judiciously during pregnancy (Moderate; Weak).

Magnetic resonance imaging

Guideline 4 MR imaging without intravenous gadolinium can be performed at any stage of pregnancy (Low; Strong).

Nuclear medicine

Guideline 5 Administration of radionucleotides for diagnostic studies is generally safe for mother and fetus (Low; Weak).

Cholangiography

Guideline 6 Intraoperative and endoscopic cholangiography exposes the mother and fetus to minimal radiation and may be used selectively during pregnancy. The lower abdomen should be shielded when performing cholangiography during pregnancy to decrease the radiation exposure to the fetus (Low; Weak).

Surgical techniques

Guideline 7 Diagnostic laparoscopy is safe and effective when used selectively in the workup and treatment of acute abdominal processes in pregnancy (Moderate; Strong).

Patient selection

Preoperative decision-making

Guideline 8 Laparoscopic treatment of acute abdominal disease has the same indications in pregnant and non-pregnant patients (Moderate; Strong).

Laparoscopy and trimester of pregnancy

Guideline 9 Laparoscopy can be safely performed during any trimester of pregnancy (Moderate; Strong).

Treatment

Patient positioning

Guideline 10 Gravid patients should be placed in the left lateral decubitus position to minimize compression of the vena cava (Moderate; Strong).

Initial port placement

Guideline 11 Initial abdominal access can be safely performed with an open (Hasson) technique, Veress needle, or optical trocar, if the location is adjusted according to fundal height and previous incisions (Moderate; Weak).

Insufflation pressure

Guideline 12 CO₂ insufflation of 10–15 mmHg can be safely used for laparoscopy in the pregnant patient (Moderate; Strong).

Intraoperative CO₂ monitoring

Guideline 13 Intraoperative CO₂ monitoring by capnography should be used during laparoscopy in the pregnant patient (Moderate; Strong).

Venous thromboembolic (VTE) prophylaxis

Guideline 14 Intraoperative and postoperative pneumatic compression devices and early postoperative ambulation are recommended prophylaxis for deep venous thrombosis in the gravid patient (Moderate; Strong).

Gallbladder disease

Guideline 15 Laparoscopic cholecystectomy is the treatment of choice in the pregnant patient with gallbladder disease, regardless of trimester (Moderate; Strong).

Choledocholithiasis

Guideline 16 Choledocholithiasis during pregnancy may be managed with preoperative endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy followed by laparoscopic cholecystectomy, laparoscopic common bile duct exploration, or postoperative ERCP (Moderate; Strong).

Laparoscopic appendectomy

Guideline 17 Laparoscopic appendectomy may be performed safely in pregnant patients with appendicitis (Moderate; Strong).

Solid-organ resection

Guideline 18 Laparoscopic adrenalectomy, nephrectomy, splenectomy, and mesenteric cyst excision are safe procedures in pregnant patients (Low; Weak).

Adnexal mass

Guideline 19 Laparoscopy is a safe and effective treatment in gravid patients with symptomatic ovarian cystic masses. Observation is acceptable for all other cystic lesions provided ultrasound is not concerning for malignancy and tumor markers are normal. Initial observation is warranted for most cystic lesions <6 cm in size (Low; Strong).

Adnexal torsion

Guideline 20 Laparoscopy is recommended for both diagnosis and treatment of adnexal torsion unless clinical severity warrants laparotomy (Low; Strong).

Perioperative care

Fetal heart monitoring

Guideline 21 Fetal heart monitoring should occur pre- and postoperatively in the setting of urgent abdominal surgery during pregnancy (Moderate; Strong).

Obstetrical consultation

Guideline 22 Obstetric consultation can be obtained pre- and/or postoperatively based on the severity of the patient's disease and availability (Moderate; Strong).

Tocolytics

Guideline 23 Tocolytics should not be used prophylactically in pregnant women undergoing surgery but should be considered perioperatively when signs of preterm labor are present (High, Strong).

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