Correspondence on 'EULAR recommendations for the management of antiphospholipid syndrome in adults'

2019 European Alliance of Associations for Rheumatology (EULAR) recommendations for the management of antiphospholipid syndrome (APS) has been successfully launched,[1] with recommendations on obstetric APS for obstetricians to refer to. However, the recommendations for obstetric APS are incomplete, which weakens the application of this guideline in clinical practice of obstetrics. First, the definition of obstetric APS is limited. In the practice, many patients come to see doctors because of threatened abortion or threatened premature delivery, with no history of delivery <34th week of gestation and <10th week spontaneous miscarriage, but the results of laboratory tests show that antiphospholipid antibodies (aPLs) are positive and other pathogenesis is not found. According to 'EULAR recommendations for the management of APS in adults', they are difficult to be diagnosed as obstetric APS, but they are at risk of becoming patients with obstetric APS and cannot get treatment recommendations from the guideline. How to manage these patients? Under what circumstances can low dose aspirin (LDA) and prophylactic doses of low molecular weight heparin (LMWH) be used in these pregnant women? Is it possible to include recommendations for the management of 'aPLs-related adverse pregnancy outcome' in the future guideline?

In addition, the management recommendations for patients with obstetric APS before pregnancy are lacking. For example, is it necessary to start using LDA before pregnancy for patients at high risk of aPLs? And in refractory obstetric APS women with recurrent pregnancy complications despite receiving combination treatment with LDA and LMWH at prophylactic dosage, addition of hydroxychloroquine (HCQ) in the first trimester are considered. We know that HCQ needs to be used 3 months in advance to reach the effective concentration. For these patients, is it necessary to start using HCQ 3 months before the next pregnancy?

Moreover, recommendations for the dynamic management during pregnancy of patients with obstetric APS are lacking in the guideline. For patients with obstetric APS or 'non criteria' obstetric APS, obstetricians tend to intensify monitoring and detect aPLs regularly during pregnancy. Studies have shown that the aPLs level will change dynamically during pregnancy,[2] does these changes have any effect on our prescription? In addition, studies have shown that decreased platelet count may be an indicator of poor prognosis in APS patients,[3] is it necessary to monitor platelet changes during pregnancy? Maybe these questions need more evidence and more clear explanation from experts.

Rui Gao , **Lang Qin**

Reproductive Medical Center, Department of Obstetrics and Gynecology, Key Laboratory of Birth Defects and Related Diseases of Women and Children, Ministry of Education, Sichuan University West China Second University Hospital, Chengdu, Sichuan, China

Correspondence to Dr Lang Qin, Reproductive Medical Center, Department of Obstetrics and Gynecology, Sichuan University West China Second University Hospital, Chengdu, Sichuan, China; cacier@163.com

Contributors Concept and writing: RG and LQ. Revising: LQ.

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ORCID iD
Rui Gao http://orcid.org/0000-0003-1745-9283

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