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Need for guidelines on fetal therapy

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Fetal therapy is increasingly emerging as a separate and essential part of maternal-fetal medicine. The background rationale concerning treating unborn babies arises from the idea that some diseases have a progressive nature and, as the pregnancy continues, may negatively influence anatomical structures and lead to poor outcomes. In many cases, the earlier the fetal intervention, the better the prognosis. However, this is not universal for all abnormalities. In some particular cases, if no treatment is implemented, fetal compromise and death are imminent.

Every few years, new high-end ultrasound machines are released with many exciting and extremely helpful functionalities, nowadays also including AI technology. This is very helpful indeed. It is possible to detect more at an earlier gestational age. But still, the most difficult part of fetal therapy is meticulous patient selection and counselling.

Many papers are published every year concerning new research data on fetal abnormalities and fetal therapy. Therefore, scientific and reliable summaries or guidelines are essential to make the counselling process more informative and accessible for clinicians.

"Fetal therapy guidelines of the Polish Society of Gynecologists and Obstetricians — Fetal Therapy Section" by Kosinski et al. [1] is a comprehensive summary of contemporary Knowledge on fetal therapy options. It is most likely the most detailed 30-page guideline on fetal therapy and the first guideline to focus on the fetus as a patient that has been published recently.

It is worth mentioning that it has been divided into sections based on the anatomical type of abnormality and complexity of fetal therapy procedures. Of note, many medical conditions in fetal therapy have many controversies, not only on possible interventions but also on eligibility criteria. One example may be the Twin Anemia Polycythemia Sequence (TAPS) sequence in twin pregnancy — emerging data supports laser ablation as the first line treatment; however, until the results of a randomized trial, the treatment options must be individualized, as there are other treatment options. Almost all complications/medical conditions eligible for fetal therapy are divided into helpful sections: diagnosis, management, fetal therapy options, complications, monitoring and check-up visits and delivery. The literature offers guidelines on the mode and timing of delivery for uncomplicated monochorionic pregnancies but lacks clear recommendations for pregnancies complicated with TAPS. Therefore, it is safe to assume that vaginal delivery, as per the monochorionic delivery protocol, is possible if the obstetric team can monitor for acute fetal-fetal haemorrhage during labour. The decision about timing should remain at the discretion of an experienced team of perinatologists.

Many tables presenting data and eligibility criteria for specific procedures improve the readability of the fetal therapy guidelines. Table 6 presents the management of the Myelomeningocele Study (MOMS) eligibility criteria for open fetal surgery for myelomeningocele (MMC). These are classical criteria for open spina bifida; however, in the era of fully percutaneous fetoscopic procedures and hybrid procedures, most centres use individualized criteria considering fetal leg movements and the degree of ventriculomegaly.

There are plenty of controversies in the fetal therapy field. New procedures are emerging, such as fetoscopic repair of gastroschisis or botox injections in babies with congenital diaphragmatic hernia. On the other hand, other procedures, such as aortic valve balloon valvuloplasty, need more reports on patient selection criteria and, most importantly, the long-term outcomes. This is why we must adhere to evidence-based data and avoid procedures which are not beneficial for the fetus whatsoever. Therefore, the publication of national guidelines within this medical field is essential and valuable in clinical practice.

REFERENCES

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