

## Arranging screening for early onset pre-eclampsia

Screening is available to all pregnant women in Victoria. At the time of your Combined First Trimester Screen (CFTS) for Down syndrome, simply have your doctor select the pre-eclampsia screening option on the VCGS test request form.

### How do I get my results?

A copy of your results will be sent to your referring doctor. You must contact your doctor for your test result. When requested alongside the CFTS, results are usually available within 3 working days of the 12 week ultrasound report being received by the laboratory.

### How much will it cost?

There is some out of pocket cost for the CFTS test as it is not all covered by Medicare. There will be an additional cost for PE screening. See our website for details.

### Where can I get more information?

You can discuss pre-eclampsia with your doctor, midwife or obstetrician.

### Better Health Channel:

[betterhealth.vic.gov.au/health/healthyliving/pregnancy-pre-eclampsia](https://betterhealth.vic.gov.au/health/healthyliving/pregnancy-pre-eclampsia)

### Australian Action on Pre-Eclampsia:

**P** (03) 9330 0441 **W** [aapec.org.au](https://aapec.org.au)

## Contact us

For queries about PE screening, contact Maternal Serum Screening:

**P** 1300 934 355

**F** (03) 8341 6389

**W** [vcgs.org.au/mss](https://vcgs.org.au/mss)



**Pre-eclampsia  
screening in pregnancy**  
What you need to know

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## What is pre-eclampsia?

Pre-eclampsia (PE) is high blood pressure caused by pregnancy. It is one of the more common conditions occurring in pregnancy.

- About 1 in 20 pregnant women develop pre-eclampsia\*.
- Early screening allows for early intervention, which can protect your baby's health.

Screening during the first trimester can identify women at increased risk for early-onset pre-eclampsia. Interventions include low-dose aspirin and early delivery depending on gestation. Without treatment, pre-eclampsia may affect the normal growth of the baby.

*\*Australian Action on Pre-eclampsia [aapec.org.au]*

## Risk factors for pre-eclampsia?

The risk factors for PE include:

- Maternal and paternal family history
- Previous pregnancy with PE
- Multiple pregnancy (e.g. twins)
- Maternal age (over 40 years)
- Body Mass Index (BMI over 30)
- Pre-existing high blood pressure, diabetes, smoking or kidney disease
- Systemic inflammation
- Ethnic origin

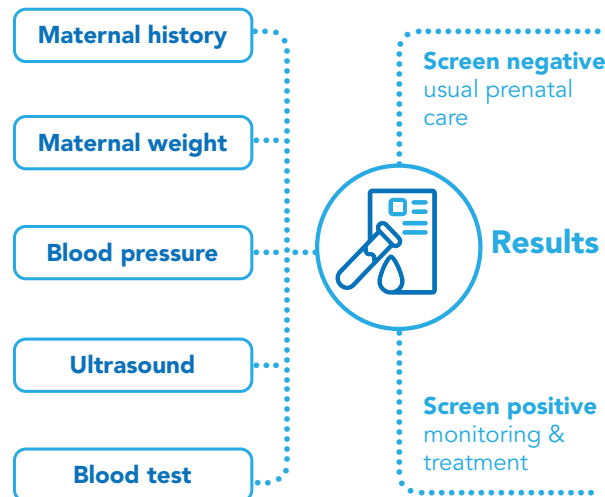
## What does screening involve?

Screening for early-onset pre-eclampsia is an optional test that is performed alongside Combined First Trimester Screening (CFTS).

- Screening uses the same blood as your CFTS test.
- You must opt-in for PE screening on the CFTS test request form.

**Screening requires: A blood test between 11 to 13+6 weeks to measure serum pregnancy-associated plasma protein-A (PAPP-A) and placental growth factor (PIGF) in maternal blood.**

The blood test results are combined with maternal blood pressure, maternal weight and family history information to provide a result.



## Screen negative result

A screen negative result means you are unlikely to develop early-onset pre-eclampsia.

A negative screen however, does not mean you definitely will not develop pre-eclampsia. With this screen result, you will continue to receive normal prenatal care.

## Screen positive result

If you screen positive for early-onset pre-eclampsia, close monitoring during your pregnancy is recommended. The chance you will develop pre-eclampsia is low, but your baby's growth will be checked carefully.

## Why is aspirin effective?

Low doses of aspirin during pregnancy may reduce the risk of early-onset pre-eclampsia\*. Aspirin is thought to prevent problems in the placenta that cause pre-eclampsia and affect the normal growth of a baby.

Aspirin treatment before 16 weeks in high risk women, can delay or even prevent the early-onset of pre-eclampsia. Being able to delay pre-eclampsia gives the baby more time to grow and develop (by avoiding an early delivery).

*\*Rolnik, DL, et al 2017. Aspirin versus placebo in pregnancies at high risk for preterm preeclampsia. N Engl J Med. 377(7):613-622.*