

Sindrome da anticorpi antifosfolipidi

VARIABILITY IN ANTIPHOSPHOLIPID ANTIBODY TESTING AND TREATMENT STRATEGIES IN OBSTETRIC ANTIPHOSPHOLIPID SYNDROME: RESULTS FROM THE OAPS-CARE SURVEY, ON BEHALF OF THE EUROPEAN FORUM ON ANTIPHOSPHOLIPID ANTIBODIES

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Background and aims. Obstetric antiphospholipid syndrome (OAPS) is a major cause of pregnancy morbidity characterized by placental insufficiency, fetal loss, and recurrent miscarriage in association with persistent antiphospholipid antibodies (aPL). Despite international classification criteria and therapeutic recommendations, substantial variability remains in real-world practice. To address this gap, the Obstetric Antiphospholipid Syndrome: Clinical Assessment and Reproductive Evaluation (OAPS-CARE) survey was developed within the European Forum on Antiphospholipid Antibodies framework to document international, real-world practices for assessing and managing OAPS.

Methods. The OAPS-CARE study was designed as an international, cross-sectional, internet-based survey to assess current clinical practices in the diagnosis and management of OAPS. The survey was formulated by a multidisciplinary steering committee comprising rheumatologists, internists, obstetricians, and clinical immunologists with specialized knowledge on APS and pregnancy morbidity. The 60-item questionnaire addressed definitions of obstetric morbidity, indications, timing, interpretation of aPL testing, use of classification criteria, and treatment strategies across pregnancy scenarios

Results. A total of 152 clinicians from 24 countries participated, of whom 123 (81%) completed the survey. The majority were rheumatologists (46.3%) and obstetricians/gynecologists (22.0%), mostly practicing in tertiary care centers. Recurrent miscarriage (93.5%), placental insufficiency (65.9%), and preeclampsia (56.1%) were the most frequently associated obstetric manifestations. Although lupus anticoagulant (98.2%), anticardiolipin (96.3%), and anti-β2-glycoprotein I antibodies (89.9%) were widely tested, variability emerged in timing, interpretation, and repeat testing practices. While most respondents recommended low-dose aspirin plus low-molecular-weight heparin in confirmed OAPS, management strategies diverged substantially between double/single aPL positivity and non-criteria scenarios. Adjunctive therapies, such as hydroxychloroquine, were inconsistently administered. In cases of refractory OAPS and high-risk pregnancies most clinicians prefer to escalate treatment rather than continue the same regimen. Nearly half (46.1%) of practitioners would increase to therapeutic-dose LMWH plus LDA, while almost two-thirds (64.7%) would add HCQ from preconception, making HCQ the most recommended adjunctive strategy.

Conclusions. Our findings indicate that contemporary OAPS management operates in a hybrid space between classification-driven precision and phenotype-driven pragmatism. The predominance of small effect sizes across many comparisons indicates encouraging international alignment; however, the consistent variability in lower-risk and refractory scenarios reveals areas where guidance remains insufficiently operationalized. Future international recommendations should (i) harmonize obstetric definitions, (ii) standardize laboratory thresholds across assay platforms, and (iii) formalize risk-adapted escalation pathways integrating antibody profile, obstetric phenotype, and prior treatment response.