also rated as strong in 78% and 68% of cases, respectively (Figure). Recommendations were supported by randomized trials 8% of the time and references that summarize primary data (eg, meta-analyses, reviews, previous guidelines) 64% of the time. Recommendations with higher quality evidence ratings were more likely to be supported by references that summarize primary data (69% high-quality, 74% moderate-quality, 49% low-quality). Topics with recommendations authored jointly by the Society for Maternal-Fetal Medicine and the American College of Obstetricians and Gynecologists were supported by higher quality evidence than those by the Society for Maternal-Fetal Medicine alone (high quality, 26% vs 9%, respectively).

**Conclusion**

Recommendations by the Society for Maternal-Fetal Medicine assessed by the Grading of Recommendations, Assessment, Development, and Evaluation system were supported by high-quality evidence in 15% of cases. This suggests that well-designed, high-quality clinical trials remain a priority in obstetrics. Strong recommendations were often made on the basis of Grading of Recommendations, Assessment, Development, and Evaluation strength determinants other than quality of evidence. Increased transparency of the Society for Maternal-Fetal Medicine’s determination of strong recommendations based on strength determinants other than quality of the evidence may be useful to practicing clinicians.

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**CORRECTION**

April 2019 (vol. 220, no. 4, pages B6 and B7)


Two citations of the same value appeared incorrectly in the print edition of the Journal but were corrected in the online edition.

In the last paragraph on page B6, under the subheading “When are vasopressors and inotropes indicated in sepsis?”, a sentence beginning on line 6 contains an inaccurate value. The sentence reads, “Current guidelines recommend norepinephrine as the first-line agent with a target MAP [mean arterial pressure] <65 mm Hg, although the latter threshold has not been studied in pregnant women.” The target MAP should be ≥65 mm Hg.

In the Figure on the following page, “Initial treatment of sepsis during pregnancy,” the third bullet-pointed item in the first column of the decision tree (“Within 1 hour of suspected diagnosis:”) states, “Initiate fluid therapy (up to 30 ml/kg of crystalloid initially) to maintain MAP >65 mm Hg (lower values may be acceptable in pregnancy; individualize).” Again, the MAP should be ≥65 mm Hg.