Editorial

Parity Clarity: Proposal for a New Obstetric Shorthand

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There has been considerable discussion in recent years of the exact definitions of maternal parity and the shorthand notation commonly used to summarize a patient's gravidity and parity.[1–6] The questions revolve around, first, whether delivery of a multifetal gestation is counted as a single or as a multiple parous experience, and, second, the gestational age at which a spontaneous abortion becomes a preterm delivery.

One author concluded in 1989 that "we should be honest with ourselves and avoid this confusing shorthand until we have reached a consensus on the definition."[1] In 1991, another suggested that "the best solution is to abandon the term *para* altogether and devise a new way of formulating a woman's reproductive history succinctly and unequivocally."[6] In accordance with this challenge, I present herein a radical modification of the currently popular method of notation. My format is intended to eliminate most of the ambiguity of the current abbreviations for gravidity and parity while simultaneously increasing the amount of clinically useful information conveyed by the shorthand.

In my proposed system, "gravida" (or simply "g") would retain its traditional definition as a patient's total number of pregnancies, including the current one, if applicable. "Para" (or "p"), however, would no longer be followed by a numerical or string of numerals, as at present, but by a series of letters, as defined in the table, representing the outcome of each pregnancy, in historical order. Multifetal gestations would have one letter for each fetus, connected by dashes. No consideration is given to fetal weight, as is done in some previous definitions of parity.

The currently popular four-digit parity notation includes the number of children currently alive. This conveys no information relevant to obstetrical care (as deaths could have occurred long after birth), or to the patient's social situation (as designated children could be living away from home, or other children could have been adopted into the family). I have therefore made no attempt to encode such information.

The table lists 10 different outcomes of pregnancy. These are selected to include virtually all pregnancies, with distinctions that are relevant to prenatal and intrapartum care. The last four outcome types are abbreviated in an intuitive fashion. I was unable to abbreviate the first six categories with single, unique letters in an intuitive manner, and have simply labeled them A through F. Their repeated, logical order within two groups of three should facilitate memorization.

Example 1. A pregnant woman whose three previous pregnancies all produced surviving term infants would be described as "g 4, p AAA." This could be further abbreviated to "g 4, p A_3."

Example 2. A woman whose four pregnancies resulted in one elective abortion, two consecutive singleton surviving preterm infants, and a term stillbirth, would be described as "g 4, p IDDC" (or "g 4, p ID_2C").

Example 3. A pregnant woman whose four previous pregnancies resulted in one term neonatal death, one spontaneous abortion, one term surviving infant, and one ectopic pregnancy would be described as "g 5, p BSAT."

Example 4. A woman whose two pregnancies resulted in one noninvasive hydatidiform mole followed by one set of preterm triplets, the first of whom died in the neonatal period, would be described as "g 2, p M E-D-D."

Any such system will have to make a balance between the amount of information coded and the simplicity of the code. I believe that my proposal greatly increases the informational content and clinical utility of our current shorthand without making it unwieldy or unduly difficult to learn. Although it would be nice to be able to incorporate other aspects of the obstetric history (such as postdates pregnancies, congenital defects, and whether each delivery was spontaneous, induced, augmented, instrumented, or cesarean), I think that the added complexity would make such nomenclature unworkable.

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Proposed New Parity Coding System

Pregnancy Status	Pregnancy Outcome	Symbol
Term delivery (>37 weeks' gestation by menstrual dates)	Live birth, infant survives ≥30 days	A
	Live birth; infant survives <30 days	B
	Stillbirth	C
Preterm delivery (20–37 weeks' gestation)	Live birth, infant survives ≥30 days	D
	Live birth, infant survives <30 days	E
	Stillbirth	F
Abortion	Spontaneous (<20 weeks gestation)	S
	Induced (elective or therapeutic, any gestational age)	I
Other	Ectopic pregnancy	T*
	Hydatidiform Mole (partial, complete, or invasive)	M

**T for "Tubal" is used here to avoid confusion with "E" above. However, the category includes all types of ectopic pregnancies, including the rare abdominal pregnancies that result in live births.*

I see three obvious disadvantages to this proposal. (1) Transition will necessarily result in a period of confusion. This seems inevitable in any change. (2) Grand-multiparous women (another term in need of standardization) will have long summaries. However, these can usually be shortened by the abbreviations discussed above. (3) It abandons the historical and linguistic roots of the term *para* and its derivatives. Since essentially all types of pregnancy outcomes are accounted for under this system, any woman who was previously pregnant is *parous*, which is not always true under current definitions; the term *nulliparous* must refer to a woman who has not experienced the completion of a pregnancy, regardless of whether she is currently pregnant; *primiparous* defines a woman who has completed exactly one pregnancy, regardless of its outcome. Because these terms would not refer exclusively to third-trimester events, as they commonly do at present, they would encompass a greater variety of patients and therefore become less clinically useful.

The proposed system's advantages, which I believe will more than compensate for such deficiencies, are: (1) an end to the discrepancies in definitions currently used; (2) enumeration of more clinically important types of pregnancy outcomes than can be distinguished by present systems; and (3) an accounting for the consecutive order of pregnancies. A history of three spontaneous abortions, for example, has very different clinical implications if they precede a series of successful pregnancies than if they follow them.

As suggested by Dirckx,[6] uniform implementation of such a change, after a suitable period of discussion and, probably, further modification, would be hastened by the imprimatur of official bodies representing family physicians, obstetricians, nurse midwives, and obstetrical nurses. Welcoming suggestions for improving the clarity and utility of my proposal, I commend it to these societies for their consideration.

References

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