

Salpingectomy for the Prevention of Epithelial Ovarian Cancer

This Clinical Practice Update was developed by the American College of Obstetricians & Gynecologists Committee on Clinical Consensus—Gynecology in collaboration with David Shalowitz, MD, MSHP, FACOG, and Nisha Verma, MD, MPH, FACOG.

The Society of Gynecologic Oncology endorses this Clinical Practice Update and its originating Committee Opinion No. 774, *Opportunistic Salpingectomy as a Strategy for Epithelial Ovarian Cancer Prevention*.

The American Cancer Society supports consideration of opportunistic salpingectomy as a strategy for reducing the risk of ovarian cancer in appropriate patients, consistent with the clinical guidance presented in this Clinical Practice Update and the originating Committee Opinion No. 774.

This Clinical Practice Update provides updated information further supporting the benefit of complete, bilateral salpingectomy at the time of obstetric and gynecologic surgery and to expand the availability of salpingectomy during nongynecologic abdominopelvic surgery for the primary prevention of epithelial ovarian cancer. This document updates Committee Opinion No. 774, *Opportunistic Salpingectomy as a Strategy for Epithelial Ovarian Cancer Prevention* (Obstet Gynecol 2019;133:e279–84).

BACKGROUND

Since the last revision of Committee Opinion No. 774, *Opportunistic Salpingectomy as a Strategy for Epithelial Ovarian Cancer Prevention*, data have evolved, solidifying the benefit of bilateral salpingectomy for the primary prevention of epithelial ovarian cancer. Based on robust pathologic evidence of the origin of high-grade serous ovarian carcinoma (HGSC) in the fallopian tube and evidence supporting the origin of endometrioid and clear cell carcinoma from retrograde spread through the fallopian tubes, the American College of Obstetricians & Gynecologists (ACOG) previously recommended discussion of bilateral salpingectomy with or without oophorectomy at the time of planned hysterectomy and as an option for patients desiring permanent contraception (1, 2).

The purpose of this Clinical Practice Update (CPU) is to strengthen the recommendation for complete bilateral salpingectomy (abbreviated as “salpingectomy” in this document) at the time of obstetric or gynecologic surgery, reflecting the most current data on the potential for this procedure to substantially decrease the incidence of ovarian cancer in patients at average population risk. Additionally, this CPU includes emerging data on cross-specialty collaboration to expand the availability of salpingectomy during nongynecologic abdominopelvic surgery.

The burden of ovarian cancer remains high, with an estimated 20,890 incident cases and 12,730 attributable deaths in 2025 (3). Screening is ineffective for ovarian cancer, and the majority of new diagnoses are made in patients with metastatic disease. Furthermore, although recent advances in treatment have extended life expectancy, mortality is high and treatment is associated with substantial financial and psychosocial burdens for patients and their caregivers (4, 5). It is therefore critical to take advantage of strategies to minimize the incidence of ovarian cancer whenever available. Complete salpingectomy is the most effective method of reducing risk of epithelial ovarian cancer for patients who are not candidates for bilateral salpingo-oophorectomy (6).

This CPU specifically discusses the cancer prevention benefit of salpingectomy; guidance on how to discuss concurrent oophorectomy with patients is included in the original Committee Opinion 774, *Opportunistic Salpingectomy as a Strategy for Epithelial Ovarian Cancer Prevention*. Likewise, surgical risk-reduction guidelines for patients at genetically high risk for ovarian cancer may be found in the National Comprehensive Cancer Network’s Clinical Practice Guidelines in Oncology for Genetic/Familial High-Risk Assessment: Breast, Ovarian, Pancreatic, and Prostate (7). Importantly, the majority of

ovarian cancers occur in patients without any known pathogenic germline mutation that increases risk for epithelial ovarian cancer (8).

UPDATED CLINICAL RECOMMENDATIONS

- **Obstetrician–gynecologists should routinely perform bilateral salpingectomy at the time of hysterectomy.**
- **Bilateral salpingectomy should be recommended to patients who are undergoing nonhysterectomy gynecologic surgery that enters the peritoneal cavity and who do not desire future fertility. Obstetrician–gynecologists should consider successful completion of salpingectomy when counseling patients about potential surgical approaches for planned procedures.**
- **Complete, bilateral salpingectomy is the preferred tubal procedure for patients desiring permanent contraception after shared decision making.**
- **Obstetrician–gynecologists should support other surgical specialists in offering salpingectomy at the time of nongynecologic surgery by providing counseling and technical assistance as needed.**

RATIONALE

Salpingectomy at the Time of Gynecologic Surgery, Including Hysterectomy

Robust data support salpingectomy as resulting in a substantial reduction in risk for epithelial ovarian cancer. A 2016 meta-analysis of three studies involving 3,509 patients who underwent salpingectomy and 5,655,702 patients who did not undergo salpingectomy found an odds ratio (OR) of 0.51 (95% CI, 0.35–0.75) for subsequent development of ovarian cancer (9). A subsequent meta-analysis of studies through 2021 found similar results (OR 0.48, 95% CI, 0.33–0.69) for development of ovarian cancer in patients who underwent bilateral salpingectomy (10).

In a 2022 cohort study from British Columbia, Canada, 14,066 patients who underwent hysterectomy with bilateral salpingectomy and 11,823 patients who underwent bilateral salpingectomy for permanent contraception were compared with 10,446 patients who underwent hysterectomy alone and 21,634 patients who underwent tubal ligation without salpingectomy. After median follow-up of 3.2 years, no cases of serous ovarian cancer and fewer than six cases of epithelial ovarian cancer were identified in the salpingectomy group, compared with an expected

5.3 cases and 8.7 cases, respectively, based on incidence in patients not undergoing salpingectomy (11).

In 2026, a second cohort study from British Columbia, Canada, found a hazard ratio for serous ovarian cancer of 0.22 (95% CI, 0.05–0.95) in 40,527 patients who underwent salpingectomy at the time of another surgery, compared with 45,296 patients who underwent a comparator surgery after a median follow-up of 4.7 years. In the same study, 23.1% of incident ovarian cancers in patients who underwent salpingectomy were of serous histology compared with 68.1% in a historical cohort of patients with fallopian tubes (12). Systematic reviews in 2022 and 2024 (15 and 17 studies, respectively) concluded that, although short-term ovarian function is not adversely affected by salpingectomy, data on assessment of long-term effects (including age of menopause) are needed (13, 14). Although surgical time may be modestly increased by 12 to 16 minutes when adding salpingectomy to an otherwise indicated pelvic surgery (15, 16), the risk of operative and perioperative complications is not significantly changed (17). Furthermore, multiple analyses have concluded that primary prevention of epithelial ovarian cancer with salpingectomy at the time of another planned surgery is cost effective (18–21).

Based on substantial risk reduction of epithelial ovarian cancer, minimally increased operative time without any increase in surgical morbidity, and no effect on the reproductive potential of a patient otherwise undergoing hysterectomy, **obstetrician–gynecologists should routinely perform bilateral salpingectomy at the time of hysterectomy. Bilateral salpingectomy should be recommended to patients who are undergoing nonhysterectomy gynecologic surgery that enters the peritoneal cavity and who do not desire future fertility.** Although ACOG previously recommended that the route of surgery should not be changed to facilitate salpingectomy, ACOG now recommends that **obstetrician–gynecologists should consider successful completion of salpingectomy when counseling patients about potential surgical approaches for planned procedures.** Route of surgery, including circumstances under which this might change intraoperatively, should be discussed with patients during preoperative counseling. The strength of the data supporting salpingectomy to reduce the risk of ovarian cancer obliges obstetrician–gynecologists to prioritize completion of this procedure, consistent with patients' individual clinical circumstances and preoperative counseling. If there is clinical concern that a surgical approach may decrease the likelihood of successful completion of salpingectomy (eg, vaginal vs laparoscopic hysterectomy), this risk should be clearly disclosed to patients.

Salpingectomy for Permanent Contraception

Tubal ligation (ie, tubal occlusion or partial salpingectomy) offers some risk reduction of endometriosis-associated ovarian cancers, including endometrioid and clear cell histologies, through prevention of retrograde dissemination of genetically unstable epithelium. However, this reduction does not extend to the much more common HGSC, because HGSC originates in the tubal fimbriae, which generally are left intact during a tubal ligation procedure. Estimates of the risk reduction for tubal ligation compared with salpingectomy vary; a 2023 case-control analysis of a Danish registry identified an OR of 0.91 (95% CI, 0.83–0.99) for ovarian cancer in patients who had undergone tubal ligation vs patients in a control group, compared with 0.46 for patients who had undergone bilateral salpingectomy vs patients in a control group. Risk reduction in patients undergoing tubal ligation was largely limited to endometriosis-associated histologies (22).

Utilization of complete salpingectomy for patients undergoing postpartum permanent contraception may be low. Analysis of a national sample of 383,338 patients undergoing postpartum sterilization from 2011 to 2022 reported that, in 2022, only 14.8% of patients received salpingectomy after cesarean delivery and 11.0% received salpingectomy after vaginal delivery (23). A 2020 meta-analysis of 11 studies including 320,443 patients undergoing total salpingectomy or other methods of sterilization at the time of cesarean delivery identified no increase in surgical complication and a 6-minute increase in operative time (24). A cohort study of 18,184 patients in British Columbia, Canada, published in 2024 reported similar findings, with an 8-minute average increase in operative time without any clinically significant difference in perioperative complications (25). Limited available data also support the safety and feasibility of salpingectomy compared with tubal ligation when performed after vaginal delivery (26, 27).

The surgical risk associated with laparoscopic salpingectomy as a standalone procedure for reduction of ovarian cancer risk is also very low; a study of a cohort of 7,102 patients undergoing this procedure identified a 0.7% rate of major perioperative complications, defined as intensive care unit admission, return to the operating room, in-hospital surgical complication, or readmission to the hospital (28). No perioperative deaths were identified. A 2020 meta-analysis of five studies comparing tubal ligation with salpingectomy for sterilization, including but not limited to laparoscopic surgical approach, found no significant difference in perioperative outcomes (29). A 2024 multi-center randomized trial concluded that perioperative outcomes from laparo-

scopic salpingectomy are noninferior to laparoscopic tubal ligation (30).

Based on the superior performance of salpingectomy to other tubal procedures for ovarian cancer risk reduction, with equivalent or improved success of permanent contraception, minimally increased operative time, decreased risk of ectopic pregnancy, and no increased perioperative risk, ACOG recommends that **complete, bilateral salpingectomy is the preferred tubal procedure for patients desiring permanent contraception after shared decision making**. Partial salpingectomy is discouraged except when complete salpingectomy is not safe or technically feasible or if patients decline complete salpingectomy after counseling. For example, some patients may be willing to accept a potentially higher likelihood of technical inability to complete salpingectomy to allow for immediate permanent contraception after vaginal birth. This recommendation does not change separate guidance related to contraceptive counseling, including the potential for long-acting reversible contraceptives and permanent contraception through vasectomy in a male partner (31, 32). However, contraceptive counseling should highlight the cancer risk reduction associated with salpingectomy, because patients who do not desire future pregnancy may not be aware of this relevant benefit (33).

Salpingectomy at the Time of Nongynecologic Abdominopelvic Surgery

Consideration of salpingectomy at the time of nongynecologic abdominopelvic surgery offers the opportunity to reduce ovarian cancer risk in patients who are already planning an intraperitoneal procedure, who do not have coexisting gynecologic pathology, and who do not desire future fertility. Salpingectomy is feasible at the time of nongynecologic surgery and is likely to substantially and cost effectively reduce the risk of epithelial ovarian cancer (18, 20, 33). ACOG therefore recommends that **obstetrician-gynecologists should support other surgical specialists in offering salpingectomy at the time of nongynecologic surgery by providing counseling and technical assistance as needed**.

Support from gynecologic surgeons to nongynecologic surgical specialists might include training, intraoperative assistance, and collaborative counseling of patients. Collaboration may be modeled on existing cross-disciplinary relationships for the management of malignancies and hereditary cancer syndromes. Specific implementation protocols (eg, building capacity for nongynecologists to perform salpingectomy primarily vs planned intraoperative consultation) should be tailored to individual clinical care environments.

Salpingectomy for the Primary Purpose of Ovarian Cancer Risk Reduction

Based on existing data regarding ovarian cancer risk reduction associated with the performance of salpingectomy and the low perioperative risk with minimally invasive approaches to salpingectomy, obstetrician-gynecologists, in dialogue with their patients, may consider salpingectomy as a separate, or standalone, procedure to reduce the risk of ovarian cancer in patients who do not desire future pregnancy. However, further research is needed to ascertain benefits and harms of salpingectomy performed only as a standalone procedure for ovarian cancer risk reduction in average-risk patients before this approach can be recommended routinely; it is also important to note that the age at which the procedure would be performed requires further investigation based on some data suggesting that the protective effect of salpingectomy may decrease after menopause (22).

IMPLEMENTATION CONSIDERATIONS

This evidence-based CPU may represent a change in practice for some clinicians. Future investigations should assess dissemination of key evidence supporting the option of salpingectomy to clinicians and to the public. Additional outcomes should include accurate patient counseling about salpingectomy during surgical decision making and the effect of various approaches to implementing salpingectomy on procedure frequency and subsequent changes in ovarian cancer incidence. Decreasing rates of partial salpingectomy and tubal occlusive procedures might be selected for measures of clinical care quality. Notably, in 2025, the code Z40.82 was added to the International Classification of Diseases, Tenth Revision to specify a surgical encounter for removal of the fallopian tubes for ovarian cancer risk reduction in a patient without genetic or familial risk factors. Clinical practices should approach assessment and mitigation of barriers to the implementation of salpingectomy systematically, ensuring that access to this potentially life-saving procedure is prioritized (34). In patients who would otherwise have reproductive potential, counseling must clearly identify salpingectomy as resulting in permanent contraception, and patients must be given appropriate time to consider their reproductive plans before surgery. **Salpingectomy for the sole purpose of cancer risk reduction should therefore not be performed during emergent surgery that would not otherwise result in permanent contraception (eg, hysterectomy) (32).** In particular, data are needed on implementation of salpingectomy immediately after vaginal birth given multi-level barriers to permanent contraception in this population (35). Because one of these barriers is insurance coverage and reim-

bursement, salpingectomy should be covered for contraception and ovarian cancer risk reduction to decrease disparities in access to this procedure. Finally, there is uncertainty regarding the possible effect of salpingectomy on long-term menstrual health; this should be clarified through long-term patient follow-up (36). As always, surgical plans should be the product of shared decision making and individualized to patients' preferences, values, and clinical circumstances (37).

USE OF LANGUAGE

ACOG recognizes and supports the gender diversity of all patients who seek obstetric and gynecologic care. In original portions of this document, authors seek to use gender-inclusive language or gender-neutral language. When describing research findings, this document uses gender terminology reported by investigators. To review ACOG's policy on inclusive language, see <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language>.

REFERENCES

1. Sowamber R, Lukey A, Huntsman D, Hanley G. Ovarian cancer: from precursor lesion identification to population-based prevention programs. *Curr Oncol* 2023;30:10179–94. doi: 10.3390/curroncol30120741
2. Opportunistic salpingectomy as a strategy for epithelial ovarian cancer prevention. ACOG Committee Opinion No. 774. American College of Obstetricians & Gynecologists. *Obstet Gynecol* 2019;133:e279–84. doi: 10.1097/AOG.0000000000003164
3. National Cancer Institute. Cancer stat facts: ovarian cancer. Accessed May 28, 2026. <https://seer.cancer.gov/statfacts/html/ovary.html>
4. American Cancer Society Cancer Action Network. Survivor views: majority of cancer patients & survivors have or expect to have medical debt. ACS CAN; 2024. Accessed May 28, 2026. <https://www.fightcancer.org/policy-resources/survivor-views-majority-cancer-patients-survivors-have-or-expect-have-medical-debt>
5. Liang MI, Harrison R, Aviki EM, Esselen KM, Nitecki R, Meyer L. Financial toxicity: a practical review for gynecologic oncology teams to understand and address patient-level financial burdens. *Gynecol Oncol* 2023;170:317–27. doi: 10.1016/j.ygyno.2023.01.035
6. MacArthur E, Stone R. Current science and practice of surgical and nonsurgical opportunities for ovarian cancer prevention. *Clin Obstet Gynecol* 2024;67:676–86. doi: 10.1097/GRF.0000000000000900
7. National Comprehensive Cancer Network. Genetic/familial high-risk assessment: breast, ovarian, pancreatic, and prostate. NCCN Clinical Practice Guidelines in Oncology. Version 3.2026 [after login]. Accessed May 28, 2026. <https://www.nccn.org/guidelines/guidelines-detail?category=2&id=1545>
8. Wang M, Bi Y, Jin Y, Zheng Z. Global incidence of ovarian cancer according to histologic subtype: a population-based cancer registry study. *JCO Glob Oncol* 2024;10:e2300393. doi: 10.1200/GO.23.00393

9. Yoon SH, Kim SN, Shim SH, Kang SB, Lee SJ. Bilateral salpingectomy can reduce the risk of ovarian cancer in the general population: a meta-analysis. *Eur J Cancer* 2016;55:38–46. doi: 10.1016/j.ejca.2015.12.003
10. Tang Y, Sun H, Fu P, Zhou T, Liu R. Prophylactic salpingectomy as a preventative strategy for ovarian cancer in the general population: a systematic review and meta-analysis. *J Gynecol Oncol* 2025;36:e8. doi: 10.3802/jgo.2025.36.e8
11. Hanley GE, Pearce CL, Talhouk A, Kwon JS, Finlayson SJ, McAlpine JN, et al. Outcomes from opportunistic salpingectomy for ovarian cancer prevention. *JAMA Netw Open* 2022;5:e2147343. doi: 10.1001/jamanetworkopen.2021.47343
12. Sowamber R, Mei AJ, Kaur P, McLeod J, McKay E, Lukey A, et al. Serous ovarian cancer following opportunistic bilateral salpingectomy. *JAMA Netw Open* 2026;9:e2557267. doi: 10.1001/jamanetworkopen.2025.57267
13. Gelderblom ME, Int'Hout J, Dagovic L, Hermens RP, Piek JM, de Hullu JA. The effect of opportunistic salpingectomy for primary prevention of ovarian cancer on ovarian reserve: a systematic review and meta-analysis. *Maturitas* 2022;166:21–34. doi: 10.1016/j.maturitas.2022.08.002
14. Radu T, Mar M, Tudorache V, Marginean C. The impact of opportunistic salpingectomy on ovarian reserve: a systematic review. *J Clin Med* 2024;13:3296. doi: 10.3390/jcm13113296
15. Till SR, Kobernik EK, Kamdar NS, Edwards MG, As-Sanie S, Campbell DA, et al. The use of opportunistic salpingectomy at the time of benign hysterectomy. *J Minim Invasive Gynecol* 2018;25:53–61. doi: 10.1016/j.jmig.2017.07.004
16. McAlpine JN, Hanley GE, Woo MM, Tone AA, Rozenberg N, Swenerton KD, et al. Opportunistic salpingectomy: uptake, risks, and complications of a regional initiative for ovarian cancer prevention. *Am J Obstet Gynecol* 2014;210:471.e1–11. doi: 10.1016/j.ajog.2014.01.003
17. Zadabedini Masouleh T, Etchegary H, Hodgkinson K, Wilson BJ, Dawson L. Beyond sterilization: a comprehensive review on the safety and efficacy of opportunistic salpingectomy as a preventative strategy for ovarian cancer. *Curr Oncol* 2023;30:10152–65. doi: 10.3390/curroncol30120739
18. Kather A, Arefian H, Schneider C, Hartmann M, Runnebaum IB. Ovarian cancer prevention through opportunistic salpingectomy during abdominal surgeries: a cost-effectiveness modeling study. *PLoS Med* 2025;22:e1004514. doi: 10.1371/journal.pmed.1004514
19. Hughes BN, Herzog TJ, Brown J, Naumann RW. Opportunistic salpingectomy at time of nongynecologic elective procedures could reduce ovarian cancer-related costs and mortality. *J Gynecol Surg* 2022;38:43–8. doi: 10.1089/gyn.2021.0047
20. Wright JD, Chen L, Tymm C, Xu X, Ferris JS, Hershman DL, et al. Population-level reduction in ovarian cancer through performance of opportunistic salpingectomy at the time of cholecystectomy. *Ann Surg*. 2025 Sep 15 [epub ahead of print]. doi:10.1097/SLA.0000000000006940.
21. Adjei NN, Yeh PG, Haas A, Sun CC, Zhao H, Stone R, et al. Opportunistic salpingectomy during gynecologic and nongynecologic abdominopelvic procedures for ovarian cancer primary prevention: a cost-effectiveness analysis. *Int J Gynecol Cancer* 2026;36:102884. doi: 10.1016/j.ijgc.2025.102884
22. Duus AH, Zheng G, Baandrup L, Faber MT, Kjær SK. Risk of ovarian cancer after salpingectomy and tubal ligation: prospects on histology and time since the procedure. *Gynecol Oncol* 2023;177:125–31. doi: 10.1016/j.ygyno.2023.08.016
23. Yoh K, Desai VB, Gross CP, Spatz ES, Pollack CE, Wright JD, et al. Physician variation in adopting opportunistic salpingectomy at the time of postpartum and interval sterilization for ovarian cancer risk reduction. *Gynecol Oncol* 2025;202:1–13. doi: 10.1016/j.ygyno.2025.08.033
24. Roeckner JT, Sawangkum P, Sanchez-Ramos L, Duncan JR. Salpingectomy at the time of cesarean delivery: a systematic review and meta-analysis. *Obstet Gynecol* 2020;135:550–7. doi: 10.1097/AOG.0000000000003673
25. Rufin KG, do Valle HA, McAlpine JN, Elwood C, Hanley GE. Complications after opportunistic salpingectomy compared with tubal ligation at cesarean section: a retrospective cohort study. *Fertil Steril* 2024;121:531–9. doi: 10.1016/j.fertnstert.2023.11.031
26. Wagar MK, Godecker A, Landeros MV, Williams M. Postpartum salpingectomy compared with standard tubal ligation after vaginal delivery [published erratum appears in *Obstet Gynecol* 2021;137:961]. *Obstet Gynecol* 2021;137:514–20. doi: 10.1097/AOG.0000000000004285
27. Hsieh GL, Wagar MK, Antony KM, Masand R, Anderson ML. A standardized protocol for post-partum salpingectomy with suture ligation: a prospective feasibility study. *Reprod Med* 2022;3:150–9. doi: 10.3390/reprodmed3020013
28. Lukey A, do Valle HA, Howard AF, Pearce CL, Huntsman DG, Kwon JS, et al. Complications following bilateral salpingectomy by indication: population-based cohort study. *BJOG* 2026;133:1056–64. doi: 10.1111/1471-0528.70143
29. Mills K, Marchand G, Sainz K, Azadi A, Ware K, Vallejo J, et al. Salpingectomy vs tubal ligation for sterilization: a systematic review and meta-analysis. *Am J Obstet Gynecol* 2021;224:258–65.e4. doi: 10.1016/j.ajog.2020.09.011
30. Strandell A, Magarakis L, Sundfeldt K, Pålsson M, Liv P, Idahl A. Salpingectomy versus tubal occlusion in laparoscopic sterilisation (SALSTER): a national register-based randomised non-inferiority trial. *Lancet Reg Health Eur* 2024;45:101026. doi: 10.1016/j.lanepe.2024.101026
31. Patient-centered contraceptive counseling. Committee Statement No. 1. American College of Obstetricians & Gynecologists. *Obstet Gynecol* 2022;139:350–3. doi: 10.1097/AOG.0000000000004659
32. Permanent contraception: ethical issues and considerations. Committee Statement No. 8. American College of Obstetricians & Gynecologists. *Obstet Gynecol* 2024;143:e31–9. doi: 10.1097/AOG.0000000000005474
33. Fisch C, Schauwaert J, Gootzen TA, Piek JM, de Reuver PR, Somford DM, et al. Patients' perspectives on opportunistic salpingectomy at the time of nongynecologic surgery. *O G Open* 2025;2:e089. doi: 10.1097/og9.0000000000000089
34. Hagemann AR, Mutch DG. Invited commentary: opportunistic salpingectomy: a call to implement science arms to prevent ovarian cancer. *J Am Coll Surg* 2025;241:512–4. doi: 10.1097/XCS.0000000000001399
35. Larkin S, Bullington BW, Berg KA, White K, Boozer M, Serna T, et al. Multi-level barriers to equitable postpartum permanent contraception. *Womens Health (Lond)* 2025;21:17455057251325977. doi: 10.1177/17455057251325977
36. Benefits and risks of sterilization. ACOG Practice Bulletin No. 208. American College of Obstetricians & Gynecologists. *Obstet Gynecol* 2019;133:e194–207. doi: 10.1097/AOG.0000000000003111
37. Informed consent and shared decision making in obstetrics and gynecology. ACOG Committee Opinion No. 819. American

CONFLICT OF INTEREST STATEMENT

All ACOG committee members and authors have submitted a conflict of interest disclosure statement related to this published product. Any potential conflicts have been considered and managed in accordance with ACOG's Conflict of Interest Disclosure Policy. The ACOG policies can be found on acog.org. For products jointly developed with other organizations, conflict of interest disclosures by representatives of the other organizations are addressed by those organizations. The American College of Obstetricians & Gynecologists has neither solicited nor accepted any commercial involvement in the development of the content of this published product.

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