Royal College of Obstetricians & Gynaecologists

Guidance for rationalising early pregnancy services in the evolving coronavirus (COVID-19) pandemic

Information for healthcare professionals

Version 1.1: Published Tuesday 21 April 2020

The Association of Early Pregnancy Units

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Summary of updates

Version	Date	Summary of changes
1.1	21.04.20	**5.1:** Added 'Evidence of a septic miscarriage - signs of infection (e.g. temperature, offensive smelling discharge) in association with symptoms of retained pregnancy tissue (pain and/or bleeding)' as a reason for assessment within 24 hours. Added additional risk factors for ectopic pregnancy.
1.1.	21.4.20	**10:** Section and recommendation added 'Administer anti-D prophylaxis to women who have a surgical procedure, including manual vacuum aspiration, or have a late miscarriage, in line with British Society of Haematology and NICE guidelines.'

1. Introduction

This guidance is to support early pregnancy services during the evolving COVID-19 pandemic. It outlines which elements of care should be prioritised and recommends modifications to early pregnancy care, given national recommendations for social distancing of pregnant women.

2. Screening of women presenting to early pregnancy services

All women should be asked to attend appointments alone or as per local visiting restrictions during the COVID-19 pandemic.

Where a woman requires a consultation due to the need for physical examination or a scan, a system should be in place for evaluating whether she has symptoms that are suggestive of COVID-19, or if she meets the current 'stay at home' guidance. For similar advice in Scotland, see here. This may be a telephone call before the appointment or an assessment at entry to the department.

If a woman attends an appointment but describes symptoms, she should be advised to return home immediately if clinically stable. A member of clinical staff should then make contact with the woman to risk assess whether an urgent modified appointment is required, or whether the appointment can be conducted via telephone consultation.

If an urgent assessment in person or ultrasound scan is required for a woman with confirmed or suspected COVID-19 infection, a room and an ultrasound machine should be designated for this.

All women with a possible COVID-19 infection must be highlighted to all members of the gynecology, maternity, nursing and anaesthetic teams. If the woman requires admission to hospital, the location will depend on the reason for admission and local policy, until COVID-19 testing confirms her status.

3. Delaying appointments where appropriate

3.1 Pre-existing appointments

A review of the clinical urgency of currently held appointments should be made by the clinical team and women will be contacted as necessary.

3.2 In home isolation for suspected or confirmed COVID-19

If delay is clinically appropriate (Table 5.1), care should be provided via a telephone consultation. If urgent care is required, attendance to hospital should be preceded by a phone call to alert the local unit.

3.3 Rebooking appointments

The local service should decide how best to manage rebooking of appointments (blood tests and/or scans) and the woman should be informed of her new appointment.

3.4 Failsafe

A local failsafe should be established to ensure that appointments for all women are reviewed and, if reoffered, that they are attended. Follow local protocols for follow up of women who do not attend.

4. Coordinating your local early pregnancy unit

As well the usual day-to-day requirements for running an early pregnancy unit, we recommend the following:

- Managers should be aware that staff (or members of their family) may become unwell during the pandemic; daily review of the case load, staffing and contingency planning is advised.
- If a pregnant woman is diagnosed with COVID-19, this should be reported to the UK Obstetric Surveillance System.
- Multi-disciplinary team (MDT) meetings: we highly encourage units to conduct a minimum of a weekly MDT meeting (can be arranged using an online meeting platform).

5. Ensuring that early pregnancy units are used appropriately

Women should not attend early pregnancy units without a telephone triage consultation with an experienced clinician, using a locally agreed structure for triage.

Local units following a walk-in model should adopt a robust triage-based system with a dedicated phone number for referrals. Appropriate triage is essential to allow prioritisation of those at high risk of complications, mainly ectopic pregnancy, where hospital visits will be safer than telephone-based consultations.

The inevitable reduction in resources and capacity, as well as the aim to minimise hospital attendance for social distancing of pregnant women, have led to a recommendation of one of the following three options (Table 5.1):

- Scans and/or visits that need to be undertaken without delay;
- Scans and/or visits that can be delayed without affecting clinical care;
- Scans and/or visits that can be avoided for the duration of the pandemic.

Table 5.1 Recommended triage and action for early pregnancy units

Problem	Recommended action
Abdominal or pelvic pain (no previous scan)	Offer scan within 24 hours
Heavy bleeding for more than 24 hours and systemic symptoms of blood loss	Offer scan within 24 hours
Evidence of a septic miscarriage - signs of infection (e.g. temperature, offensive smelling discharge) in association with symptoms of retained pregnancy tissue (pain and/or bleeding).	Offer assessment within 24 hours (Note a temperature may also be associated with COVID-19 infection.)
Pain and/or bleeding together with pre-existing risk factors for ectopic pregnancy: • Previous ectopic pregnancy • Previous fallopian tube, pelvic or abdominal surgery, • History of sexually transmitted infections / pelvic inflammatory disease • Use of an IUCD or IUS • Use of assisted reproductive technology • Current smoker or age over 40	Offer scan within 24 hours if location of pregnancy not known
Moderate bleeding	Telephone consultation with experienced clinician – urine pregnancy test (UPT) in one week: • Negative – no follow-up • Positive – offer telephone consultation +/- repeat UPT in one further week or scan
Heavy bleeding that has resolved	Telephone consultation with experienced clinician – UPT in one week: • Negative – no follow-up • Positive – offer telephone consultation +/- repeat UPT in one further week or scan

Reassurance	Telephone consultation with experienced clinician – no routine scan
Previous miscarriage(s)	Telephone consultation with experienced clinician – no routine scan
Light bleeding with/without pain that is not troublesome to patient	Telephone consultation with experienced clinician – no routine scan

6. Management of miscarriage

Women who experience a miscarriage should be cared for in accordance with local protocols. There should be an effort to reduce inpatient admission due to COVID-19: offer expectant management for incomplete miscarriage and consider medical management / use of manual vacuum aspiration for missed miscarriage.[1] Counselling should be offered and performed over the phone where possible.

The availability of surgery will need to be reviewed locally on a daily basis and if surgical management is indicated, appropriate precautions related to personal protective equipment (PPE) should be taken in line with national Health Protection guidance.[2]

Regional anaesthesia may be considered in COVID-19 positive women to reduce the risk to staff from general anaesthetic, which is an aerosol-generating procedure.

Outpatient management is preferred where appropriate. Provide advice on analgesia and the process of miscarrying, in order to support women to remain at home.

Those who have expectant or medical management should not be offered further routine ultrasound scans but asked to repeat a hCG urine test after three weeks. If this is positive, they should be advised to call the early pregnancy unit to arrange further care.

Units should aim to provide telephone consultation to women three weeks following their miscarriage to assess physical and emotional well-being, if resources are available.

7. Intrauterine pregnancy of unknown viability

No further ultrasound scans are recommended.

If the ultrasound scan findings are consistent with menstrual dates no follow up is required.

If findings are not consistent with menstrual dates, explain the risk of miscarriage and consider telephone follow-up in two weeks.

8. Management of pregnancy of unknown location

Use serial beta human chorionic gonadotrophin (beta-hCG) monitoring +/- progesterone at presentation, as per local protocol, to triage women into one of:

- Low risk failing PUL:
  - Pregnancy test at home in two weeks
  - Contact local unit if positive

- Low risk intrauterine pregnancy:
  - Scan in one week to confirm location and viability

- High risk for ectopic pregnancy:
  - return for a repeat beta-hCG and/or scan in a further 48 hours

The M6 model can be used to help with decision making in women with PUL to reduce the number of hospital visits due to COVID-19. It is available at www.earlypregnancycare.co.uk.[3,4]

9. Management of ectopic pregnancy

Women with ectopic pregnancy should be cared for in accordance to local protocols with an emphasis on conservative management if possible.

9.1 Expectant management

Ensure follow up is appropriate with an individualised approach. There is a need to balance safety with reducing hospital attendance as much as possible in order to reduce the risk of COVID-19 to women, staff and other patients.

When performing beta-HCG monitoring, where possible, repeat levels on a weekly basis. Repeat ultrasound scans should not be routine unless clinically indicated.

9.2 Medical management with single dose methotrexate

It is likely the detrimental effects of methotrexate in COVID-19 are minimal in well women.

As with any ectopic pregnancy, women with suspected /confirmed COVID-19 should be discussed at the early pregnancy unit multi-disciplinary team (MDT) meeting. Administration of methotrexate must be discussed and signed off by a senior clinician prior to treatment, and any ultrasound and beta-hCG levels reviewed carefully. Severely unwell women with COVID-19 and ectopic pregnancy will need to be discussed at an MDT with medical and anaesthetic input.

In addition to routine information giving when offering the choice of methotrexate, inform the woman that:

- Methotrexate is a mildly immunosuppressive medication but there is not thought to be a significant risk in the case of COVID-19 at the dose used to manage ectopic pregnancy. [1]
- There is a theoretical risk that any immunosuppressive medication can make you more vulnerable to viral illness.
- Expert opinion is that the dose of methotrexate given for medical management of ectopic pregnancy is unlikely to increase vulnerability to COVID-19 and does not require home shielding after administration.
- Medical management of ectopic pregnancy avoids hospital admission and surgery, potentially lowering overall exposure to COVID-19.

9.3 Surgical management

Surgical management of ectopic during the coronavirus pandemic should only be considered following senior review of the ultrasound scan, beta-hCG and clinical findings and if no other management option is safely feasible.

The BSGE/RCOG support the use of laparoscopy, but with necessary caution.[5] Given the limited evidence on the safety of laparoscopy, any laparoscopic surgery should only be undertaken with strict precautions taken to filter any CO2 escaping into the operating theatre and the theatre staff wearing appropriate PPE. Mini-laparotomy can be considered as an alternative to laparoscopy if these strict precautions cannot be confidently met.

10. Anti-D prophylaxis

Administer anti-D prophylaxis to women who have a surgical procedure, including manual vacuum aspiration, or have a late miscarriage, in line with British Society of Haematology[6] and NICE[7] guidelines.

If miscarriage occurs at home, and having to check RhD status would require an additional visit for the woman, it could be omitted if the risk from COVID-19 outweighs the benefit of receiving anti-D immunoglobulin. Providers should discuss the absence of evidence with women and engage in shared decision making.

11. Management of nausea and vomiting in pregnancy

If a woman has nausea and vomiting in pregnancy, she should be assessed over the phone using the PUQE scoring system and advised regarding anti-emetics, as per local protocol.[8] Local arrangements for issuing prescriptions remotely after a telephone consultation, where these do not already exist, should be put in place.

Services should plan how to best configure their local protocols during the coronavirus pandemic for those women who require parenteral hydration. This might include hospital at home, day-case or inpatient admission services. Vomiting is a potential risk for transmission, and appropriate.

The rare possibility of a molar pregnancy should be considered in women with hyperemesis gravidarum and other symptoms such as vaginal bleeding. In the event of routine dating ultrasound assessments being delayed, women should be offered assessment in early pregnancy departments if gestational trophoblastic disease is suspected.

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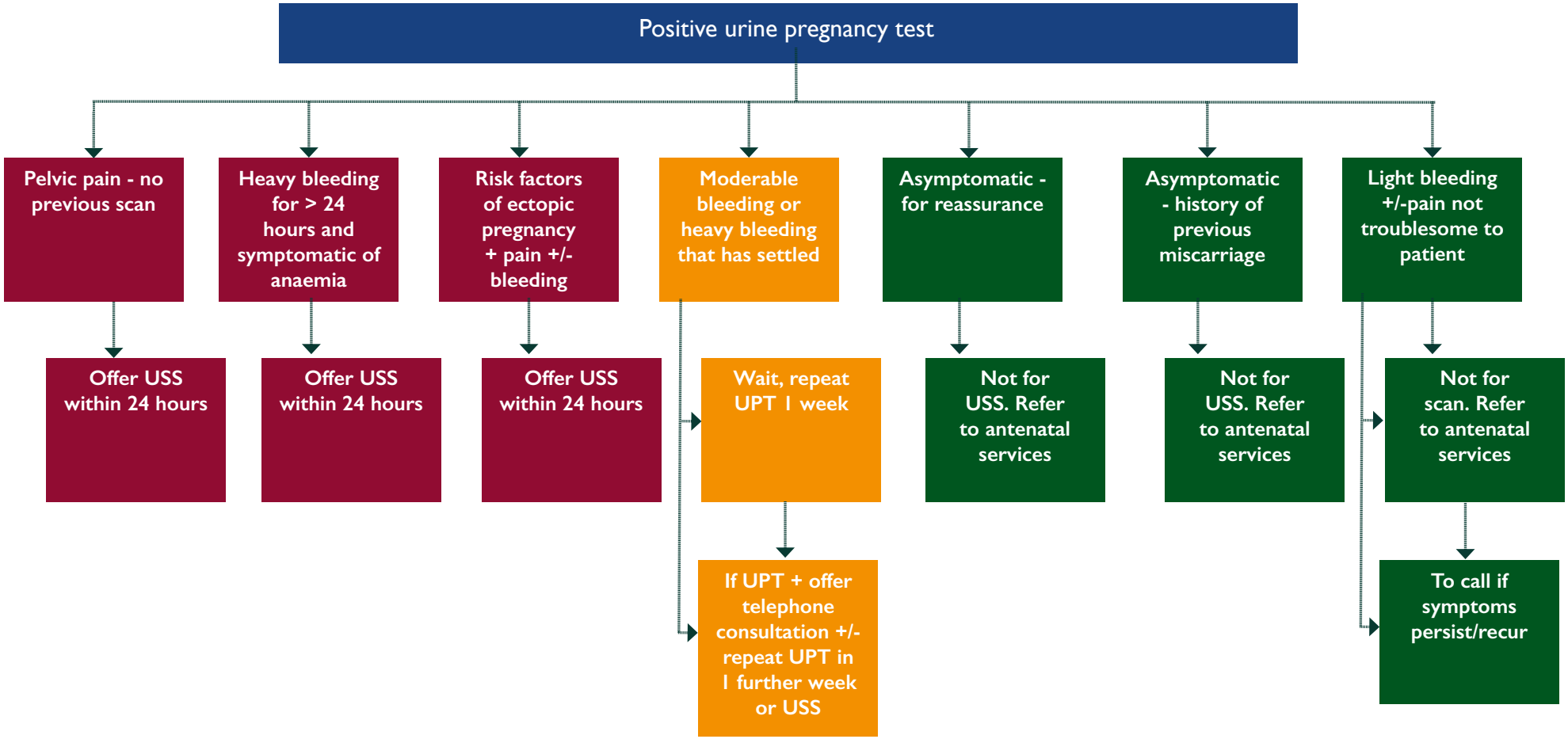
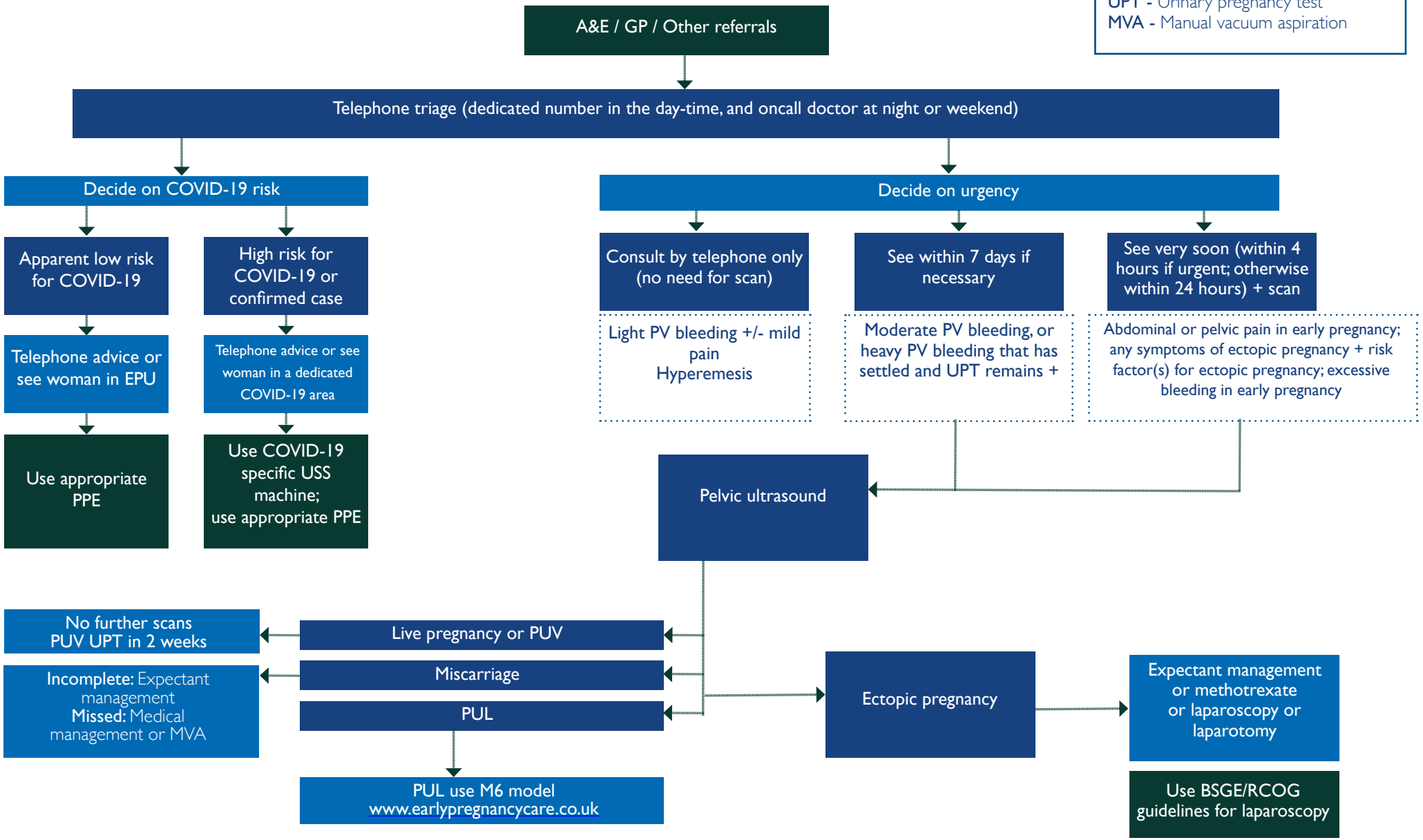
Appendix 1: Summary



Appendix 2: Guidance for management of early pregnancy complications during COVID-19 pandemic

PUV - Pregnancy of unknown viability
PUL - Pregnancy of unknown location
EPU - Early Pregnancy Unit
PPE - Personal protective equipment
UPT - Urinary pregnancy test
MVA - Manual vacuum aspiration



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