

**Management of common maternal medicine conditions during COVID-19 pandemic – ANC & PAC settings**

Based on RCOG/ BMFMS guidance 30/03/2020. Full guidance can be found on

 <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/>

**Main principles**

1. Minimise appointments. Telephone consultations. Piggy-back obstetric care on medical care / other investigations
2. CMW appointments continue to measure and plot SFH
3. Remote prescribing – PAC / direct pick-up from Pharmacy at specified time. Contact GP for repeat prescriptions
4. Joint clinics – email / phone communication (few instances at CRH seek specialist advice prior to “seeing” / phoning the woman
5. Minimise growth scans to decision making points (eg. 28, 36 weeks if not high risk IUGR*) See Ultrasound scan during COVID-19 Pandemic guidance*
6. At end of each appointment question when the next appointment needs to be: can it be conducted remotely? Can it be at same time as an investigation?
7. Investigation of potential COVID-19 in a pregnant woman should follow national guidelines for adults. Women presenting with fever, cough, headache, shortness of breath or other symptoms suggestive of COVID-19 should be fully investigated according to usual principles considering all differential diagnoses. ***General medical teams may not be able to provide prompt review. Use the expertise “in house” (consultants, obs anaesthetists) and RCP Acute Care Toolkit 15*** (<https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-15-managing-acute-medical-problems-pregnancy>)
8. Antenatal steroids for any condition where preterm delivery contemplated:
* 24-33+6 – OFFER
* 34-35+6 – CONSIDER (does benefit outweigh risk of repeated attendances?)
* >35+6 – AVOID (unless benefit outweighs risk of repeat attendances)
* For elective caesarean – give only if already an inpatient / does not require additional appointments
1. **GDM diagnosis by booking and/or 28/40 HbA1c rather than OGTT**

**At booking –** women with NICE risk factors for GDM should have **HbA1c & random plasma glucose** (**RPG)**

* Women with **HbA1c ≥48 mmol/mol** **or RPG ≥11.1mmol/L** should be managed as having **type 2 diabetes**
* Women with **HbA1c 41-47 mmol/mol, or RPG 9-11 mmol/L** should be managed as having **GDM**

**At 24-28 weeks -** women with NICE risk factors for GDM repeat **HbA1c and fasting or random plasma glucose** (**RPG)**

* Women with either **HbA1c ≥39 mmol/mol** or **fasting plasma glucose ≥5.6 mmol/L** or random plasma glucose **RPG ≥9 mmol/l** will be diagnosed to have GDM

**At any time during pregnancy** women with heavy glycosuria (2+ or above), high clinical suspicion of 12 diabetes (symptoms – nocturia, thirst, polydipsia), or large for gestational age (LGA) / polyhydramnios on ultrasound should be tested for GDM.

**Postnatally**, women with GDM can be offered **HbA1c screening at 3-6 months** after birth instead of the current recommendation of 3 months

1. Aim no routine growth scan after 36/40 (may miss late FGR) - *(See guidance re ultrasound scanning during COVID-19 guidance)*
* If growth crossing centiles at 36/40 offer IOL 37-38
* If growth consistent at 36/40 offer IOL 39-40
1. Pre-conception counselling – appointments suspended, give phone advice to use reliable contraception and defer face to face discussion for after the pandemic has passed

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| ***Condition*** | ***To do at booking/first contact/diagnosis*** | ***Growth scans/review*** | ***Management/ delivery*** | ***Other*** |
| Gestational hypertension | Teach to self-monitor BPLow threshold for sFlt/PlGF in suspected pre-eclampsia | 28,32,36 | Aim >39Consultant r/v prior to decisionif treating BP aim for </= 135/85 |  WOMEN TO USE standardised device to check BP every 2 days; update CMW for entry on K2. urinalysis weekly / if BP changing /symptoms*Currently in the process of procuring BP monitors for home BP monitoring where appropriate* |
| Chronic hypertension | Baseline U+E/LFT + urine PCRAspirinPlan for accessing antihypertensive medicationSelf-monitor BP | 28, 32,36Obs r/v at same timesFlt/PlGF if suspected pre-eclampsia*(See guidance re ultrasound scanning during COVID-19 guidance)* | Aim> 39Consultant r/v prior to decisionNew Rx of BP1st - Labetolol2nd Nifedipine3. Methyl Dopa | IOL prioritisation needs daily consideration by on call teamSelf monitoring as above once weekly Urinalysis – at face to face visits |
|  Pre-eclampsia  | If past history sFlt/PlGF and baseline U+E/LFTs at booking | First diagnosis senior obstetrician to assess severity in face to face appointmentBaseline growth scan /bloodsTwice weekly senior r/v if outpatient management (can be remote with self BP and urine)Face to face review and growth scan every 2 weeks | Use a risk calculator to predict risk of complications (PREP-S, fullPIERS) if preterm; women likely to need delivery within 7 days of diagnosisSurveillance schedule / delivery plan | IOL prioritisation needs daily consideration by on call team PREP-S link <https://www.evidencio.com/models/show/1038>fullPIERS link <https://www.evidencio.com/models/show/1155> |
| Pre-existing diabetes | Blood glucose monitoring and remote reviewSet up prescriptions through primary careFolic acid / aspirinHome BP monitoring / urinalysis | Retinal screening only if prior retinopathyScans 28,32,36Timely obs anaesthetic r/v*(See guidance re ultrasound scanning during COVID-19 guidance)* | Comprehensive obstetric review to plan delivery  | JLC and diabetic team have some electronic documents to pass on to women – link in |
| GDM | Diagnose at booking if previos GDM and booking HbA1c 41-47mmol/molAspirin if additional risk factorsTeach BG monitoring at diagnosis | 28,32,36 if insulin / metformin***No additional growth scans if well controlled on diet***Remote BG reviewsRemote prescribing metformin / insulinIf diagnosed at any gestation based on clinical suspicion (glycosuria, big baby/polyhydramnios, symptoms) do a fasting OR random BG – GDM is fasting>5.3 or random >9*(See guidance re ultrasound scanning during COVID-19 guidance)* | Comprehensive r/v 36/40, ?remote?face to face | Risk calculators for predicting GDM are available<https://www.evidencio.com/models/show/2106>Youtube video teaching BG monitoring<https://www.youtube.com/watch?v=ldvtZia0EMQ&feature=youtu.be> |
| Hypothyroidism | TFTs through Endo tab on ICE at booking and/or 20 weeks | Recheck TFTs and random glucose with 28/40 bloods if booking TFT normalTSH<7.5 – increase thyroxine by 25-50mcg/day and recheck bloods at next face to face review TSH>7.5 – increase thyroxine by 50mcg/day and recheck bloods in 4 weeksTSH low or woman complaining of hyperthyroidism symptoms reduce dose by 25-50mcg/day and check bloods in 4 weeks No routine growth scans | Normal obstetric careDelivery mode and timing based on obstetric indicators |  |
| Hyperthyroidism | TFTs at regular CMW visits, once per trimesterCheck TSH receptor antibodies once at anomaly scan (Endocrinologist tab on ICE) | Check FH for fetal tachycardia every CMW visit if elevated TRAb – consider scan | Delivery plan at 36/40 |  |
| IBD | Keep taking medication as prescribed“Shielded” group esp if on biologics/ immunosuppression / 20mg steroids a dayAspirin | Growth scans only if periconceptual flare otherwise assess risk of FGR based on obstetric historyAccess to faecal calprotectin may be compromised | Aim vaginal delivery unless perianal Crohn’s or obstetric indicators for Caesarean birth | Kath Phyllis (IBD specialist nurseIBD Covid-19 plan<https://www.bsg.org.uk/covid-19-advice/bsg-advice-for-management-of-inflammatory-bowel-diseases-during-the-covid-19-pandemic/> |
| Intrahepatic cholestasis of pregnancy (ICP/OC) | Booking LFTS if previous history.Explain no current proven medication but symptomatic treatment exists | Check LFTs/BA when symptoms develop (by CMW) and teleconference re results | BA<100 – repeat at 34 and 37 weeks and aim delivery 39/40 if BA remain <100BA>100 – repeat LFTs/BA at 34/40 and if still >100 discuss risks and benefits of planned delivery at 35-36 weeksIf other co-morbidities (pre-eclampsia, diabetes, twins) then risk of stillbirth higher so offer earlier delivery | www.icpsupport.org |
| Cardiac(rare at CRH) | Increased risk from Covid-19 need individualised care with Cardiology, likely tertiary centre. Good communication is key | Growth scans for obstetric indicationsLocal Antenatal review in liaison with Tertiary units  | Face to face care around dating / anomaly scansLocal growth scansAnaesthetic review earlyWomen with metal heart valves need anti Xa levels frequently | <https://www.britishcardiovascularsociety.org/__data/assets/pdf_file/0028/9559/UKMCS-Statement-COVID19.pdf> |
| Renal | CKD and renal transplant are more vulnerable to Covid-19. See at start of clinicBaseline U+EAspirin | See with anomaly scanBP/urinalysis at homeRepeat renal function with 28/40 bloods | Senior obstetrician to make delivery plan around 36/40 | Renal association guidance<https://renal.org/wp-content/uploads/2020/03/COVID-Pregnancy-Kidney.pdf> |
| Epilepsy | Remote MDT to involve neurologists if unstable | Minimise reviews around Minimal growth scans | Blood levels for AED only if suspected drug toxicity / non-compliance | Steffi Ashford (epilepsy nurse)Risk of seizure can be estimated using <https://www.evidencio.com/models/show/1799> |
| Suspected VTE | Risk likely increased with social distancing and reduced mobility. Warn about red flags and lower threshold for thromboprophylaxis | Growth scans not necessary Ensure supplies of tinzaparin from primary care | Decisions on imaging and thromboprophylaxis should be made on a case by case basis involving senior obstetricians, haematologists and radiologistsDelivery decisions should, take into account duration of prior anticoagulation and can be discussed on phone | Peter Toth (haematology, hospital VTE committee) |
| Anaemia | Diagnosis at booking or 28/40 | Remote prescribing |  | Remote prescribing of ferrous sulphate/fumarate vs stocks held in ANC tbc |

For all other rare diseases (Neurology, Rheumatology, Cancer, HIV, Sickle cell) case by case discussions with relevant specialist at consultant level and plan obstetric care in line with principles above and any specialty specific national guidance.