

**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 BP  Low threshold for sFlt/PlGF in suspected pre-eclampsia | 28,32,36 | Aim >39  Consultant r/v prior to decision  if 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 PCR  Aspirin  Plan for accessing antihypertensive medication  Self-monitor BP | 28, 32,36  Obs r/v at same time  sFlt/PlGF if suspected pre-eclampsia  *(See guidance re ultrasound scanning during COVID-19 guidance)* | Aim> 39  Consultant r/v prior to decision  New Rx of BP  1st - Labetolol  2nd Nifedipine  3. Methyl Dopa | IOL prioritisation needs daily consideration by on call team  Self 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 appointment  Baseline growth scan /bloods  Twice 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 diagnosis  Surveillance 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 review  Set up prescriptions through primary care  Folic acid / aspirin  Home BP monitoring / urinalysis | Retinal screening only if prior retinopathy  Scans 28,32,36  Timely 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/mol  Aspirin if additional risk factors  Teach BG monitoring at diagnosis | 28,32,36 if insulin / metformin  ***No additional growth scans if well controlled on diet***  Remote BG reviews  Remote prescribing metformin / insulin  If 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 normal  TSH<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 weeks  TSH 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 care  Delivery mode and timing based on obstetric indicators |  |
| Hyperthyroidism | TFTs at regular CMW visits, once per trimester  Check 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 day  Aspirin | Growth scans only if periconceptual flare otherwise assess risk of FGR based on obstetric history  Access to faecal calprotectin may be compromised | Aim vaginal delivery unless perianal Crohn’s or obstetric indicators for Caesarean birth | Kath Phyllis (IBD specialist nurse  IBD 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 <100  BA>100 – repeat LFTs/BA at 34/40 and if still >100 discuss risks and benefits of planned delivery at 35-36 weeks  If 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 indications  Local Antenatal review in liaison with Tertiary units | Face to face care around dating / anomaly scans  Local growth scans  Anaesthetic review early  Women 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 clinic  Baseline U+E  Aspirin | See with anomaly scan  BP/urinalysis at home  Repeat 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 radiologists  Delivery 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.