



Royal College of  
Obstetricians &  
Gynaecologists

# Guidance for fetal medicine units (FMUs) in the evolving coronavirus (COVID-19) pandemic

**Information for healthcare professionals**

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# Table of changes

Version	Date	Summary of changes
<b>1.1</b>	10.7.20	<b>0:</b> Added a note on the implementation of this guidance to clarify that the guidance was intended for the peak of the pandemic and that services should return to normal practice as soon as the local risk of transmission and prevalence allows.
<b>1.2</b>	23.11.20	<b>Note on implementation of this guidance:</b> Updated content to actively reflect current situation

## A note on the implementation of this guidance

RCOG guidance on suggested maternity service modifications during the COVID-19 pandemic has been developed to reduce the risk of nosocomial transmission of SARS-CoV-2, particularly to individuals who are most at risk of the severe effects of COVID-19, and to manage the impacts of acute changes within the NHS as a result of the pandemic (e.g. cancellation of elective services and staff shortages). The advice within this guidance is intended for implementation, when the local risk of SARS-CoV-2 transmission is high and vulnerable individuals require protection.

Maternity services are advised to reflect on their local risk and return to providing clinical care as recommended by pre-existing local and national guidance (e.g. NICE antenatal care schedule, screening including for gestational diabetes) as soon as it is safe to do so. This may include maintenance of local initiatives commenced during the pandemic which have demonstrated an improvement in the quality and experience of care received by women.

# 1. Introduction

This guidance is for fetal medicine services to use in the evolving coronavirus pandemic.

## 2. Ensuring that fetal medicine units are used appropriately

We recommend the following:

- All referrals to be discussed with a FMU consultant
- Patients should be asked to attend alone if possible or with a maximum of one partner/visitor
- Patients referred to FMU for screening e.g. multiple pregnancies, diabetics, cardiac screening should be seen in their local hospital

## 3. Assessment of women presenting for screening and/or scanning

All women should be asked to attend alone if possible or with a maximum of one partner/visitor:

### 3.1 Screening for possible coronavirus infection

All women should be initially screened before entering the department to see if they have [symptoms that are suggestive of COVID-19, or if they meet current 'stay at home' guidance](#).

If a woman currently has symptoms or meets 'stay at home' guidance she should be provided with a surgical mask to wear and shown to an isolation room, and discussed with FMU consultant and/or midwife in charge before accessing the unit. (Please see [RCOG guidance](#), appendix 1).

## 3.2 Delaying appointments until self-isolation period ends, where appropriate

If delay is clinically acceptable, please manage as follows:

- Please provide a patient information leaflet (a template is provided as a guide in appendix A).
- The appointment should be rebooked after the isolation period ends:
  - Symptomatic women: rebook after 7 days from when symptoms started.
  - Living with others who have symptoms of coronavirus: rebook after 14 days (all household members must stay at home for the duration).

## 3.3 Rebooking appointments

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

The woman should be informed that if she remains symptomatic or develops symptoms she must **not attend her appointment, instead she should phone her maternity service for advice.**

## 3.4 Failsafe

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

## 3.5 Situations where delay is not clinically acceptable

Cases where intervention cannot be delayed the women should be seen with appropriate precautions taken by healthcare professionals. Staff should wear appropriate PPE according to the status of the patient and take appropriate precautions in line with [PHE guidance](#).

Indications for seeing these women include:

- Fetal therapy required e.g. laser ablation, radio frequency ablation, amniodrainage, intrauterine

transfusion or shunting

- Hydrops
- Severe growth restriction that is potentially viable

## **4. Modifications for services**

### **4.1 Monitoring delayed assessment**

Cases that have been delayed but require diagnostic testing and/or discussion regarding termination of pregnancy should be discussed at a weekly MDT meeting (consider teleconferencing). If a decision is required prior to this meeting a minimum of two FMU consultants and the appropriate healthcare professionals e.g. neonatology, cardiology, genetics etc should discuss the option of termination taking into account any delays.

### **4.2 Capacity**

Fetal medicine units will have differing capacity issues as the pandemic evolves. A daily discussion should be scheduled with senior team members with oversight of the fetal medicine unit to review service provision.

### **4.3 Staff numbers**

If consultants are self-isolating they should consider telephone or video calls to discuss scan findings and management with the trainee/midwife/patient.

If the consultant is unwell discuss with most senior FMU consultant regarding cover. Options include any consultant in FMU cross covering, extending clinics or cancelling lists.

### **4.4 Referral to regional fetal medicine unit**

If the FMU is unable to provide acute services to their patients they should contact their regional fetal medicine

units to discuss the possibility of urgent review and potential referral.

## **4.5 Specialist fetal medicine clinics – renal, surgical, cardiac, genetics, neurology**

Where possible consultation should be provided by telephone or video call. Fetal cardiac clinic, however, requires specialist fetal cardiologist.

- Triage referrals
- Request scans locally for screening (e.g. diabetic women, multiple pregnancy, anti-epileptic medication, previous history of congenital heart defect, anti Ro/La antibodies).
- Fetal medicine should continue to see any case of suspected congenital heart disease or fetal arrhythmia (excluding ectopics)
- Minimise follow up
- Reduce number of staff attending clinic

## **4.6 Supporting routine ultrasound**

If capacity allows the FMU should support staff or capacity shortages in antenatal ultrasound. Scans should be prioritised in order of clinical urgency by a senior fetal medicine doctor, with the following suggested priority:

- Urgent scans for fetal growth (e.g. where there is already a suspicion/diagnosis of growth restriction, or for persistently reduced fetal movements).
- Anomaly scan at 18<sup>+0</sup>-23<sup>+0</sup> weeks
- Ultrasound +/- screening at 11<sup>+2</sup>-14<sup>+1</sup>
- Growth scans

# Appendix A: Template (that can be adapted with local details) for maternity services to use if they wish

Information for pregnant women who cannot have their scheduled appointment today and need to have their appointment rescheduled due to COVID-19.

If you have [symptoms of COVID-19](#) you must not attend your appointment but phone your maternity service for advice.

**Maternity units may wish to provide additional information to pregnant women which includes the following:**

- Reason they are unable to have their appointment today for example: they have suspected Covid-19 or have been in contact with someone who has recently had the infection.
- When they will have their appointment rescheduled.
- How they will be contacted about the new appointment date.
- If they don't hear from maternity service (it would be advisable to have a time frame for example if you don't hear within 1 week please contact), how and who they should contact

For further information about COVID-19 please visit [here](#).



**DISCLAIMER:** The Royal College of Obstetricians and Gynaecologists (RCOG) has produced this guidance as an aid to good clinical practice and clinical decision-making. This guidance is based on the best evidence available at the time of writing, and the guidance will be kept under regular review as new evidence emerges. This guidance is not intended to replace clinical diagnostics, procedures or treatment plans made by a clinician or other healthcare professional and RCOG accepts no liability for the use of its guidance in a clinical setting. Please be aware that the evidence base for COVID-19 and its impact on pregnancy and related healthcare services is developing rapidly and the latest data or best practice may not yet be incorporated into the current version of this document. RCOG recommends that any departures from local clinical protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

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