



Royal College of
Obstetricians &
Gynaecologists

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

Information for healthcare professionals

Version 2: Published 25 May 2021

Table of updates

Version	Date	Summary of changes
3	25.05.21	Throughout: Comprehensive editorial review resulting in rewording and minor changes.
3	25.05.21	Throughout: Updates to text to reflect changes to policy and COVID-19 prevalence.

A note on the implementation of this guidance

RCOG guidance on suggested emergency gynaecology 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 staffing levels are compromised.

When the risk of SARS-CoV-2 infection falls in both the UK community and healthcare settings, emergency gynaecology 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 guideline 126 *Ectopic pregnancy and miscarriage: diagnosis and initial management*¹) 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.

A flexible approach is necessary to respond to fluctuations in risk from local or national COVID-19 prevalence and implications of local or national public health policy.

I. Introduction

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

When reorganising services, units should be particularly cognisant of emerging evidence that individuals of Black, Asian, or minority ethnic backgrounds are at particular risk of developing severe and life-threatening COVID-19. This evidence is detailed in the RCOG guidance *Coronavirus (COVID-19) Infection in Pregnancy*.² Clinicians should encourage women to seek early advice if they are concerned about symptoms suggestive of COVID-19. There is extensive evidence on the inequality of experience and outcomes for women of BAME background during pregnancy in the UK. Particular consideration should be given to the experience of women of Black, Asian, or minority ethnic backgrounds and women of lower socioeconomic status, when evaluating the potential or actual impact of any service change.

Regardless of changes to the provision of early pregnancy services during the pandemic, all women should be treated with dignity and respect, communication and support should be provided sensitively and wherever possible, women's choices and decisions should be taken into account.¹

2. Screening of women presenting to early pregnancy services

Where a woman requires a consultation involving a physical examination or an ultrasound 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 as outlined for [England](#), [Wales](#) and [Scotland](#). 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 of COVID-19, she should be advised to return home immediately if she is clinically stable. A member of the healthcare team should then make contact with the woman to risk assess whether an urgent modified appointment is required, or whether the appointment can be conducted virtually.

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 the relevant members of the gynaecology, 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

3.1.1 Pre-existing appointments

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

3.1.2 In home isolation for suspected or confirmed COVID-19

If delay is clinically appropriate (Table 1), care should be provided virtually. If urgent care is required, the woman (or her partner) should notify the hospital by telephone before attending, to alert the local unit.

3.1.3 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.

3.2 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 guidance for follow-up of women who do not attend.

4. Delaying appointments where appropriate

As well as the usual day-to-day requirements for running an early pregnancy unit, the following is recommended:

- Managers should be aware that staff (or members of their family) may become unwell during the pandemic; a 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.

5. Ensuring that early pregnancy units are used appropriately

Women should not attend early pregnancy units without an initial telephone triage consultation with an experienced healthcare professional, 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 virtual consultations.

The following 'traffic-light' guidance for triage (Table 1) is recommended for use when local infection rates are high AND staffing levels are compromised.

- **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 1. Recommended triage and action for early pregnancy units

Problem	Recommended action
Abdominal or pelvic pain (no previous scan)	Arrange urgent review within 4 hours (this may be within an early pregnancy unit, an emergency gynaecology service or an emergency medicine department), and offer a scan within 24 hours
Heavy bleeding for more than 24 hours and systemic symptoms of blood loss	Arrange urgent review within 4 hours (this may be within an early pregnancy unit, an emergency gynaecology service or an emergency medicine department), and offer a 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).	<p>Arrange urgent review within 4 hours (this may be within an early pregnancy unit, an emergency gynaecology service or an emergency medicine department), and offer a scan within 24 hours</p> <p>Note a fever may also be associated with COVID-19 infection</p>
<p>Pain and/or bleeding together with pre-existing risk factors for ectopic pregnancy including:</p> <ul style="list-style-type: none"> • Previous ectopic pregnancy • Previous fallopian tube, pelvic or abdominal surgery • History of sexually transmitted infections/pelvic inflammatory disease/endometriosis • Use of an intrauterine contraceptive device or intrauterine system • Use of assisted reproductive technology • Current smoker, or aged over 40 years 	<p>Arrange urgent review within 4 hours (this may be within an early pregnancy unit, an emergency gynaecology service or an emergency medicine department), and if the woman is clinically stable, offer a scan within 24 hours</p>
Moderate bleeding	<p>Virtual consultation with an experienced healthcare professional – urine pregnancy test (UPT) in 1 week:</p> <ul style="list-style-type: none"> • Negative – no follow-up • Positive – offer virtual consultation +/- repeat UPT in 1 further week or scan

Heavy bleeding that has resolved	<p>Virtual consultation with an experienced healthcare professional – UPT in 1 week:</p> <ul style="list-style-type: none"> • Negative – no follow-up • Positive – offer virtual consultation +/- repeat UPT in 1 further week or scan
<p>Reassurance</p> <p>Previous miscarriage(s)</p> <p>Light bleeding with/without pain that is not troublesome to the woman</p>	<p>Virtual consultation with an experienced healthcare professional – an ultrasound scan would not routinely be offered in these situations.</p> <p>Women should be provided with information and support in a sensitive manner, taking into account their individual circumstances and emotional response¹</p>

6. Care of women undergoing miscarriage

Women who experience a miscarriage should be cared for in accordance with local guidelines. There should be an effort to reduce inpatient admission to try and prevent exposure to SARS-CoV-2: 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 virtually where possible.

In some cases (e.g. ongoing heavy vaginal bleeding), surgical management of miscarriage will be indicated. Furthermore, some women may wish to have surgical management, and where possible, their preferences should be respected. The availability of surgery will need to be reviewed locally on a daily basis and if surgical management is required, appropriate precautions related to personal protective equipment (PPE) should be taken in line with national [Health Protection guidance](#).³

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

Women undergoing outpatient care should be given advice on analgesia and the process of miscarrying, in order to support them to remain at home.

Those who have expectant or medical management should not be offered further routine ultrasound scans but asked to repeat a human chorionic gonadotrophin (hCG) urine test after 3 weeks. If this is positive, they should be advised to contact the early pregnancy unit to arrange further care.

Units should aim to provide a virtual consultation to women 3 weeks following their miscarriage to assess their physical and emotional wellbeing, if resources are available.

7. Intrauterine pregnancy of unknown viability

No further routine ultrasound scans are recommended.

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

If findings are not consistent with menstrual dates, explain the risk of miscarriage and consider virtual follow-up in 2 weeks.

8. Care of women undergoing miscarriage

Healthcare professionals should be aware that women with a pregnancy of unknown location could have an ectopic pregnancy until the location is determined. The pregnant woman should be given safety netting information about ectopic pregnancy. Use serial beta-hCG monitoring +/- progesterone at presentation, as per local guidelines, to triage women into one of the following categories:

- Low risk failing pregnancy of unknown location:
 - Pregnancy test at home in 2 weeks
 - Contact local unit if positive
- Low risk intrauterine pregnancy:
 - Scan in 1 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.

Guidance on beta-hCG monitoring in women with pregnancy of unknown location is provided in NICE NG126.¹ Alternatively, the M6 model is an example of a decision-making tool that can be used to help women with pregnancy of unknown location in order to reduce the number of hospital visits. It is available at www.earlypregnancy care.co.uk.^{4,5}

9. Management of ectopic pregnancy

Women with ectopic pregnancy should be cared for in accordance with local guidelines 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 and reducing the risk to the woman of needing to attend hospital, where there is potential for transmission of SARS-CoV-2 to the woman, 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, a senior clinician should be involved in the care of women with suspected/confirmed COVID-19, including decisions about the use of methotrexate. Severely unwell women with COVID-19 and ectopic pregnancy should be cared for using a multidisciplinary approach with medical and anaesthetist input.

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

- Methotrexate is a mildly immunosuppressive medication, but there is not thought to be a significant risk to those with 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 self-isolation after administration.
- Medical management of ectopic pregnancy may avoid hospital admission and surgery, potentially lowering overall exposure to COVID-19.

9.3 Surgical management

Surgical management of ectopic pregnancy during the COVID-19 pandemic must be considered if no other management option is safely feasible.

In some cases (e.g. in a woman who is symptomatic of blood loss), surgical management of ectopic pregnancy will be indicated. Furthermore, some women may wish to have surgical care, and where possible, their preferences should be respected. The British Society of Gynaecological Endoscopy/RCOG support the use of laparoscopy, but with certain precautions.⁶

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 the British Society of Haematology guideline⁷ and NICE NG126.¹

11. Management of Nausea and Vomiting in Pregnancy

If a woman has nausea and vomiting in pregnancy, she should be assessed by teleconsultation using the PUQE (Pregnancy-Unique Quantification of Emesis) scoring system and advised regarding antiemetics, as per local guidelines.⁸ Local arrangements for issuing prescriptions remotely after a virtual consultation, where these do not already exist, should be put in place.

Local guidelines should be reviewed in light of the COVID-19 pandemic to ensure services are configured appropriately 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 PPE should be worn by healthcare professionals caring for these women.

The rare possibility of a molar pregnancy should be considered in women with nausea and vomiting 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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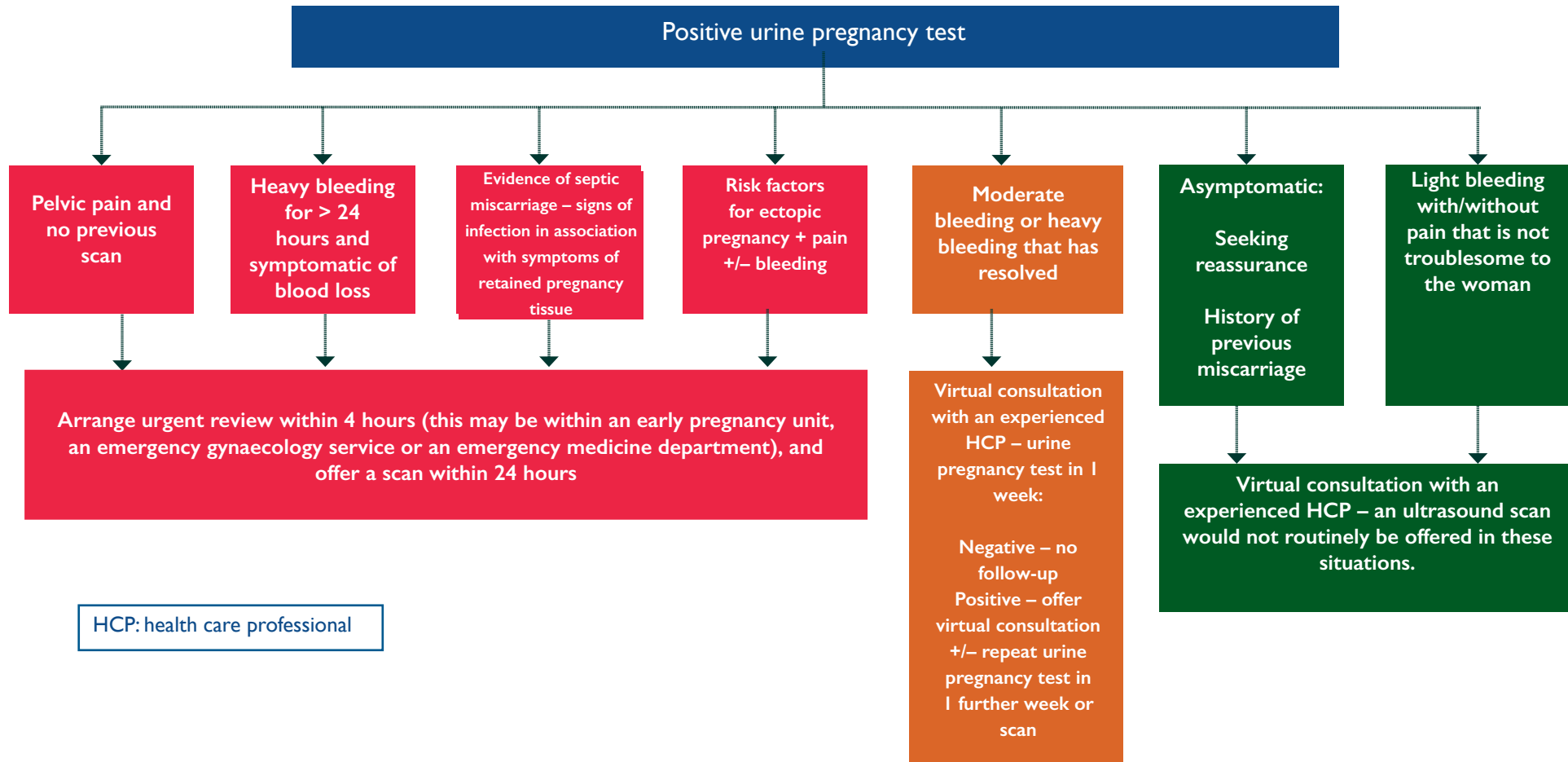
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Appendix I: Summary of updates

Version	Section	Summary of changes
I	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
I	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.'

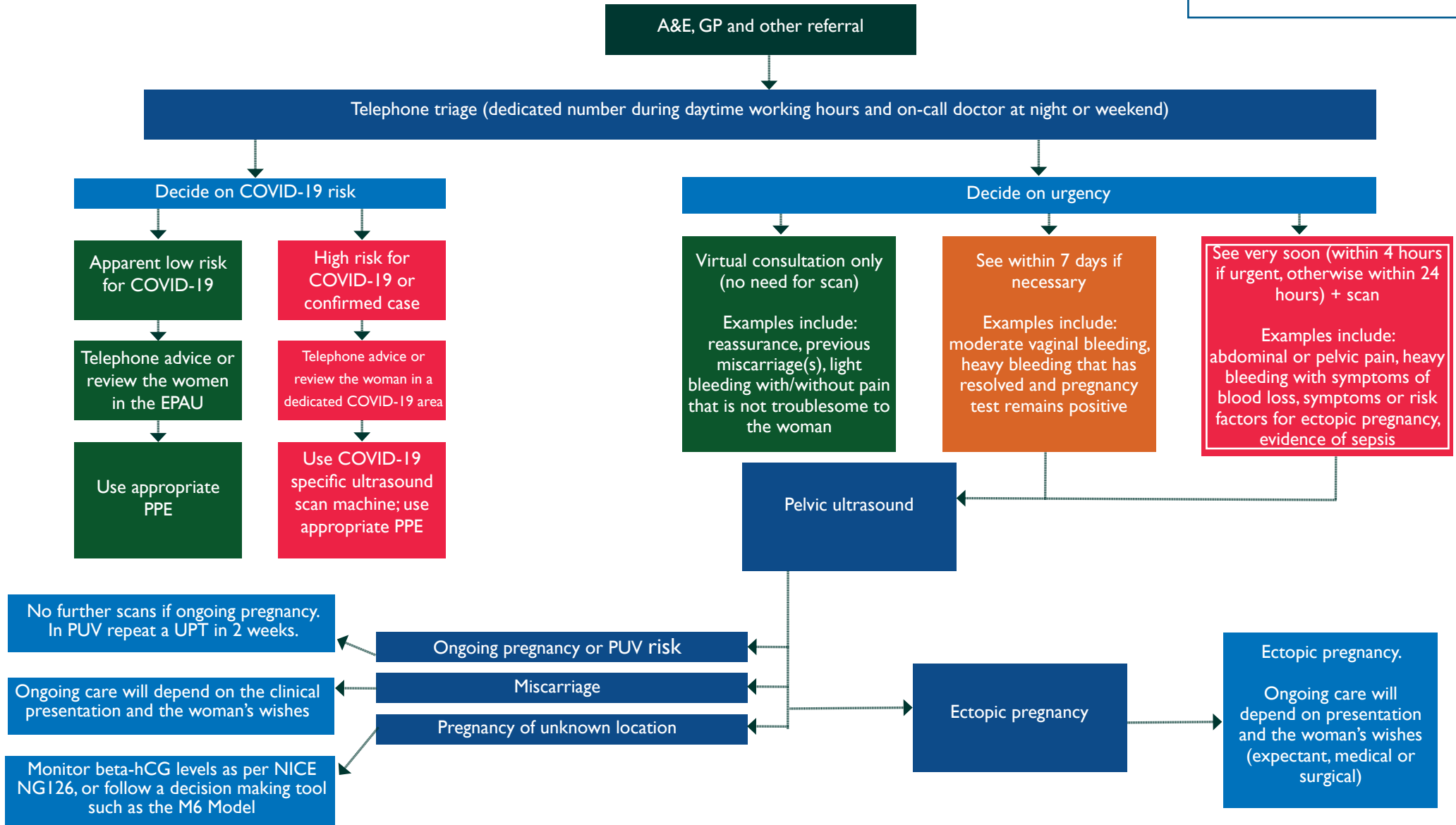
Appendix II: Summary of early pregnancy care during the COVID-19 pandemic

The advice within this guidance is intended for implementation when the risk of COVID-19 is high and staffing levels are compromised. When the risk of SARS-CoV-2 infection falls in both the UK community and healthcare settings, emergency gynaecology services are advised to reflect on their local risk and return to providing clinical care as recommended by pre-existing local and national guidance as soon as it is safe to do so.



Appendix III: Guidance for the care of women with early pregnancy complications during the COVID-19 pandemic

EPAU: early pregnancy assessment unit
 UPT: urinary pregnancy test
 PPE: personal protective equipment
 PUV: pregnancy of unknown viability



References

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8. Royal College of Obstetricians and Gynaecologists. The Management of Nausea and Vomiting of Pregnancy and Hyperemesis Gravidarum. Green-top Guideline No. 69. London: RCOG; 2016.

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