



Royal College of  
Obstetricians &  
Gynaecologists

# Guidance for antenatal screening and ultrasound in pregnancy in the coronavirus (COVID-19) pandemic

Information for healthcare professionals

**Version 1.2:** Published Wednesday 9 December 2020

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# Summary updates

| Version    | Date    | Summary of changes  |
|------------|---------|---|
| <b>1.2</b> | 9.12.20 | <b>General:</b> Update to ensure language represents current and evolving stages of the pandemic, including national guidance for individuals who are vulnerable, or extremely vulnerable, to the severe effects of COVID-19. |
| <b>1.2</b> | 9.12.20 | <b>General:</b> Update to references and hyperlinks to ensure they represent current versions of documents and websites.  |
| <b>1.2</b> | 9.12.20 | <b>General:</b> Comprehensive editorial review resulting in rewording and minor changes which do not affect meaning. Any changes to meaning and recommendations are detailed elsewhere in this table of changes.              |
| <b>1.2</b> | 9.12.20 | <b>Section 3:</b> Gestational age ranges have been updated to reflect current guidance.   |
| <b>1.2</b> | 9.12.20 | <b>Appendix I</b> Previous appendix I removed.  |

Previous updates to this guidance are detailed in Appendix I.

## A note on the implementation of this guidance

The RCOG has developed guidance on suggested maternity service modifications during the COVID-19 pandemic to reduce the risk of nosocomial transmission of SARS-CoV-2, particularly to those most at risk of the severe effects of COVID-19, and to manage the impact 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 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

There are three antenatal screening programmes:

- Sickle cell and thalassaemia (SCT)
- Infectious disease screening in pregnancy (IDPS)
- Fetal anomaly screening (FASP)

Pregnant women with existing type 1 and type 2 diabetes should also be [offered eye screening](#) at, or soon after, their first antenatal visit and after 28 weeks of pregnancy.

These screening programmes are time critical and should continue to be offered in a timely manner, as specified in each of the devolved nations:

- The [NHS section 7a service specifications](#) (NHS England)
- [Pregnancy and newborn screening programme](#) (NHS Scotland)
- [Antenatal screening Wales](#)
- [Antenatal screening, Public Health Agency, Northern Ireland.](#)

If staffing levels start to impact on such time critical services, the local screening team should inform their senior management team and commissioners (if appropriate) to discuss contingency and mitigation planning. Further guidance is provided below about changes that can be adopted to the fetal anomaly screening pathway.

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

Women who wish to be accompanied to a screening or scan appointment should contact their local maternity unit to determine whether a partner or visitor can attend with them.

### 2.1 Screening for possible coronavirus infection

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

If a woman currently meets 'stay at home' guidance the appointment should be rebooked after the isolation period ends.

### 2.2 Rebooking appointments

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

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

## 2.3 Failsafe

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

# 3. Fetal anomaly screening where appointments are rearranged

## 3.1 Women who decline screening for Trisomy 21, 18 and 13

Book a dating scan and/or anomaly scan.

## 3.2 Women who wish to have screening for Trisomy 21, 18 and 13 but have missed combined screening (11<sup>+2</sup>–14<sup>+1</sup> weeks of gestation)

If seen at:

- 14<sup>+2</sup> to 17<sup>+6</sup> weeks of gestation, perform a dating scan and offer quadruple screening for trisomy 21; use head circumference for the quadruple test.
- 18<sup>+0</sup> to 20<sup>+0</sup> weeks of gestation, perform anomaly scan and offer quadruple screening for trisomy 21; use head circumference for the quadruple test.
- 20<sup>+1</sup> to 23<sup>+0</sup> weeks of gestation, perform anomaly scan only. The anomaly scan is the screening test for trisomy 18 and 13 in this instance.

## 3.3 Anomaly scan

The optimal gestational window for completing the fetal anomaly ultrasound scan is 18<sup>+0</sup> to 20<sup>+6</sup> weeks of gestation. Women who present between 20<sup>+6</sup> and 23<sup>+0</sup> weeks of gestation can have the anomaly scan completed up to 23<sup>+0</sup> weeks of gestation.

If indicated, refer to Fetal Medicine service in line with FASP guidelines.

If the gestation is 23<sup>+1</sup> weeks or greater, sonographers should assess the fetal anatomy and biometry irrespective of gestational age and, if there are concerns, refer to Fetal Medicine service as per local guidelines.

## 4. Modifications for services

### 4.1 Capacity

Trusts will have differing capacity issues as the pandemic evolves. The advice is to continue with usual national screening programmes as specified for as long as possible. If the service is only able to provide a single scan, it is recommended that this is performed at 18<sup>+0</sup> to 20<sup>+0</sup> weeks of gestation, with the option of the quadruple test for women who wish to be screened for trisomy 21. The anomaly scan is the screening test for trisomy 18 and 13 in this instance.

### 4.2 Staffing numbers

Daily discussion should be scheduled with senior team members who have oversight of the pathway to review service provision. In the event that there is insufficient staff to provide the service, scans should be prioritised in the following order:

- Anomaly scan at 18<sup>+0</sup>–20<sup>+6</sup> weeks of gestation
- Ultrasound +/- screening at 11<sup>+2</sup>–14<sup>+1</sup> weeks of gestation
- Growth scans.

If, for any reason, an ultrasound examination is not possible the quadruple test can be offered based on the last menstrual period (LMP) from 14<sup>+2</sup> to 20<sup>+0</sup> weeks of gestation.

Although the performance of the quadruple test with scan measurements is marginally better than without a scan, quadruple testing using LMP remains an acceptable screening test in this instance.

### 4.3 Additional measures

#### Triage growth scans

To reduce the workload of the ultrasound screening unit a local policy should be implemented to review all referrals for a growth scan prior to booking an appointment.

#### Probe cleaning

Refer to public health guidance on [infection prevention and control in healthcare settings](#).

# This guidance was developed by:

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# Appendix I: Summary of previous updates

| Version | Date    | Summary of changes  |
|---------|---------|---|
| I.I     | 10.7.20 | 0: 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. |

**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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