Antenatal Revised Visits Schedule

Background

This document aims to provide a structure for routine antenatal care during the COVID-19 'crisis'.

It attempts to reduce the number of visits and amount of time women need to spend in hospital and to reduce the overall number of visits in the antenatal care schedule. This model may not be entirely applicable for providers outside of RPA and care needs to be individualised.

The traditional program for antenatal care was constructed by consensus (rather than evidence base) in the 1930s. Technologies available to us have changed – and this document seeks to take advantage of this. Some of the adjustments are based on facilities that are available to us in our local service (such as the widespread availability of public ultrasound imaging) and may, therefore, not apply to other services.

NSW Health have released 'Guidance for maternity and neonatal services' and this document includes a section entitled 'Essential elements of maternity care'. This document is aligned with NSW guidance, but has more points of patient contact, in line with concerns of hospital and community-based clinicians.

It is important to recognise that the structure of antenatal care needs to facilitate social support of pregnant women as they move toward delivery as well as requirements for medical surveillance. This schedule should be regarded as a 'baseline'. Women who need more social support or who need a heightened level of medical surveillance will need to have supplementary visits – which can be determined on an 'ad-hoc' basis by their clinician(s).

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Antenatal Revised Visits Schedule for 'Low Risk' Antenatal through Shared Care or Midwifery Models

Colour code for the models: GP visits
Ultrasound scans
Hospital visits

Gestation	COVID Red Alert Model
6-10 weeks	GP visit to confirm pregnancy • Booking bloods • Risk assessment and referral to hospital • Refer for 12-week scan (all) / NIPT (optional) • Refer for anomaly scan • Early GTT for high risk women where appropriate • Influenza vaccine and Covid-19 vaccine discussion **Comment** • Dating scan not necessary – only scan if risk of ectopic/symptomatic for miscarriage • Arrange bloods for >11 weeks to include cFTS tests • Combined first trimester screening: If possible, use provider that performs pre-eclampsia (ePET) screen and checks fetal anatomy (enables reduced visit schedule)[1] • If first trimester screening for preeclampsia not available triage by medical history / BP and give high risk women aspirin
11-13^{+6} weeks	Combined first trimester screen: No change in process Ensure test is done by provider that assesses risk for preeclampsia (measures BP and BMI) **Comment** • Calculate risks for aneuploidy • Check fetal anatomy • Provide risk for preeclampsia (if >1 in 100: start aspirin) • NIPT suggested if cFTS risk > 1 in 2500 (patient pays, available through hospital at cost)[2]
14-18 weeks	Hospital MW booking visit. Complete domestic violence and mental health screen. **Comment** • Use findings of cFTS to define baseline BP, BMI • Define preeclampsia risk and any additional need for BP monitoring[3]
20 weeks	(Teleconference) GP or Hospital (Dr) second visit review depending on risk assessment: • Pertussis vaccination from this time to 32 weeks • Check has form for GTT (performed 26-28 weeks)
22-23 weeks	Anomaly scan: • Check biometry • Check fetal anatomy

	• Check placental site • Check cervical length (TV) **Comment** • Gestation shifted[4] to allow more scans to be completed at first attempt and to allow later growth assessment (to identify potential IUGR cases) • Will also reduce workload burden in ultrasound for four-week period after introduction
23 weeks	Attend ANC for MW review post scan • Measure BP • Pertussis vaccine if not available at GP • Check has form for GTT (performed 26-28 weeks)
28 weeks	MW teleconference • Discuss pregnancy progress / early discussion on birthing • Also check BP result and hx fetal movement • Arrange Anti-D for RhD negative woman **Comment** • Woman to attend BP with GP or at home with own machine prior to appointment
31 weeks	GP / MW review: • Check fetal growth • Review BP profile **Comment** • First face-to-face visit since 23-week scan
34 weeks	GP / MW review: • Check fetal growth • Review BP profile • Arrange Anti-D for RhD negative woman
36 weeks	US Scan to determine presentation and growth GP / MW teleconference or MW review immediately post scan. • Arrange GBS screening • Arrange blood tests as needed **Comment** • Measure BP at ultrasound appointment • Measure sFLT:PlGF (clinician's discretion)[5]
38 weeks	Hospital visit with MW /or GP • **Review BP profile**
40 weeks	Hospital/MW Visit • Routine antenatal care. Review BP profile • Discuss, offer and arrange IOL for 41+ weeks • Discuss and offer a membrane sweep **Comment** • Postdates induction will be discussed and arranged as indicated. • Inductions can now be booked up to 10 days in advance; some dates may change closer to the delivery point to accommodate workflow.

Comments:

1 cFTS
Combined first trimester screening has been shown to be an effective way of identifying women who will develop early onset pre-eclamspia. Low risk women need less intensive surveillance for PET (and less intensive BP assessment). High risk women benefit from aspirin (80% reduction in early pre-eclampsia). A separate educational information sheet for health practitioners is available to discuss processes of screening/preventative therapies for pre-eclampsia.

2 NIPT
If first trimester screening returns a low-risk for aneuploidy (higher than 1 in 2500 but lower than 1 in 300) then NIPT may be considered for further reassurance but the test is not available through Medicare. If the woman wants NIPT we can organise it via the fetal medicine unit at RPA. For women who take this option, the detection rate for trisomy 21 is expected to increase to 97% compared with 90% for first trimester screening alone.
3BP
Women who have not been able to access preeclampsia screening or who have screened as high risk will require more frequent monitoring of blood pressure than what is provided in the above reduced antenatal schedule.
High risk >1:50: eligible for referral to the HDP clinic and home monitoring BP program.
No preeclampsia screening or high risk 1:51 to 1:99: regular BP monitoring in addition to the above schedule either at a pharmacy or GP (additional measurements at 30, 34, 37 and 39 weeks)

4 Anomaly scan
We are making the recommendation to move this appointment to a later gestation. This will first, reduce appointment load for the first four weeks (at the beginning of this COVID period. Second, increase the likelihood of scan completion at one visit. Third, allow assessment of growth (and risk of IUGR) immediately before viability – and allow some AN palpations (24, 28, 30 weeks) to be removed for 'normally grown' babies.

5 sFlt/PlGF ratio
This is a relatively new test that has been developed to assess patients that have high blood pressure to see whether they have preeclampsia rather than gestational hypertension – and whether they are likely to need intervention (delivery) due to preeclampsia in the next few (up to four) weeks. Although the test was not developed for use in all pregnancies, a low sFlt/PlGF ratio has high negative predictive value for pre-eclampsia and will be reassuring given the reduced visits suggested toward term. A separate educational information sheet for health practitioners will be provided to discuss processes of screening / preventative therapies for pre-eclampsia.

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