National Institute for Health and Clinical Excellence

Clinical Guideline (CG62) – Antenatal Care
Guideline Review Consultation Comments Table
7 March 2011 -21 March 2011

Type	Stakeholder	Agree ?	Comments	Comments on areas excluded from original scope	Comments on equality issues
SH	BMFMS	NO	BMFMS believes that it would be worthwhile updating the sections on; (a) GDM (b) Diet and physical activity in pregnancy (c) Use of Doppler in pregnancy (d) Screening for chromosomal anomalies		
SH	CO-Awareness		I believe we should be working much more closely to protect pregnant mothers from undiagnosed Carbon monoxide poisoning. Please see attached which is the main reason why I started up our charity and founded Carbon monoxide awareness week. I am sure you will see that its not just the danger of smoking that pregnant mothers should be aware of.  CO_Baby_smokingposter2009.pdf  craigs story with pictures embargoed		
SH	Department of Health	YES	the Department of Health has no substantive comments to make regarding this consultation, and that we are content that the guideline does not need to be updated at the present time.		
SH	Newcastle Hospitals NHS Foundation Trust	YES			

PLEASE NOTE: Comments received in the course of consultations carried out by the Institute are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that the Institute has received, and are not endorsed by the Institute, its officers or advisory committees.

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SH	NHS Fetal Anomaly Screening Programme	YES		Down's syndrome screening – changes since original scope (1) The Department of Health and UK National Screening Committee (UK NSC) state that first trimester 'combined screening' (serum and nuchal translucency scanning) for all pregnant women regardless of age from 10 weeks, 0 days to 14 weeks, 1 day gestation. It is within 95% of maternity antenatal care packages. Second trimester 'quadruple screening' (serum only) is also available for women booking later in pregnancy from 14 weeks, 2 days to 20 weeks, 0 days gestation. Integrated and serum integrated screening are not recommended because the care pathways are set across two trimesters (result in the second) and for a number of very good reasons is too complex to deliver within an NHS setting. Cut-off/threshold for screening 1 in 150 cut-off at term for first and second trimester 'higher risk' results Confirmatory testing for 'higher risk' results Chorionic villus sampling (CVS) or amniocentesis under direct continuous ultrasound guidance Confirmatory analysis QF-PCR Crown Rump-Length (CRL) measuring window	The original guideline is fairly comprehensive regarding equality issues. A further inclusion is guidance to consider a woman or her partner's needs when physical disability is present. The guidance addresses this in relation to information provision but not in any other way – such as woman/partner's needs regarding positioning or adaptive considerations at hospital and/or at home. References Pregnancy, Birth and Early Parenthood: a guide for physically disabled parents. London: Disability, Pregnancy and Parenthood International; 2010.

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				The British Medical Ultrasound Society produced a new formula for estimating gestational age for CRL. CRL of 45.0mm now equates to 11 weeks, 2 days gestation with the upper window of 84.0mm equating to 14, weeks, 1 day gestation. Quality Assurance for combined screening All practitioners and clinicians undertaking combined screening must submit measurements for CRL and NT to the Down's syndrome screening quality assurance screening service (DQASS) so that median values and performance can be assessed against programme standards. Biochemistry laboratories analysing serum markers should also submit median values to the DQASS for the same reasons. We have also produced a number of programme statements to inform best practice which includes relevant evidence. Reference (1) Bryant L, Fisher A, Vicente F. Fetal Anomaly Ultrasound Screening Study: Literature Survey. Research and Regeneration Unit A. University of Plymouth; 2007. Fetal anomaly screening In January 2010, the 18+0 to 20+6 weeks fetal anomaly scan: National standards for England were published and implementation started in April that year(2). Full implementation of the document is set	

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				for April 2013. Highlights include: • Women should receive information about the fetal anomaly scan at 'first contact' (including the booking appointment). • The fetal anomaly scan should be an 'option' rather than an inevitable aspect of antenatal care. • The 'window' for fetal anomaly screening from 18+0 to 20+6 weeks gestation • Appointment duration 30 minutes (singleton) and 45 minutes (multiple pregnancy) • Pre-screening information • Women should be seen by an obstetric ultrasound specialist in 3 working days or a fetal medicine specialist/unit within 5 working days of the referral being made. • A list of structures to examine and measure has been introduced guide practitioners - 'ultrasound base menu'. • A fetal cardiac protocol is included which describes the way in which the heart and outflow tracts must be scanned. • Practitioners are no longer expected to look for or report ultrasound soft markers. • Another scan is to be offered at 23 weeks gestation, if the practitioner isn't able to fully complete the requirements for the fetal anomaly scan. • NHS FASP expects local ultrasound departments to audit 11 conditions/abnormalities (as a minimum) that they have selected because they are either incompatible with life or associated with high morbidity. References	

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				(2) Kirwan DM, NHS Fetal Anomaly Screening Programme (NHS FASP). 18+0 to 20+6 Weeks Fetal Anomaly Scan: National Standards and Guidance for England. Exeter: NHS Fetal Anomaly Screening Programme (NHS FASP); 2010. http://fetalanomaly.screening.nhs.uk/standardsandpolicies  Programme_statement_-_The_use_of_CRnt_Vaginal_Bleeding_  Programme_Statement	
SH	NHS Sickle Cell and Thalassaemia Screening Programme	NO	The current guidance states “screening for sickle cell and thalssaemia should be offered as early as possible in pregnancy (ideally by 10 weeks)”. Evidence included in your Literature review (Dormandy et al) show there is a delay of more than 7 weeks between women reporting their pregnancy in primary care and being tested. This failure of health services to provide early screening is supported by Hospital Episode Statistics data which show the proportion of women booked by 10 weeks at individual trusts varies widely between trusts (less than 10% to about 75%). To address this failure we recommend that the guidelines should be strengthened to say “screening for sickle cell and thalssaemia should be offered by 10 weeks gestation. Screening should be offered immediately the pregnancy is confirmed. Offering the test in primary care results in earlier testing.		Sickle cell and thalassaemia are conditions that are more common in some minority ethnic groups than in the majority population. There is a significant positive association between early screening and higher uptake of prenatal diagnosis for sickle cell and thalassaemia (Modell et al 2000). Delays in offering screening potentially limits reproductive choice for women from minority ethnic groups.
SH	No Less Human	NO	***Suggested replacement guidelines for fetal anomaly scan to make them more ‘ women centred’ (as described in Chapter 3***		

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			The purpose of the scan is to identify any health and development problems with the pregnancy and to provide that information to the parents. To inform the parents of any fetal anomalies and provide help and advice to the parents, including accurate information on the disability; any support organizations; any medical treatments; palliative care; any intrauterine therapy; and managed birth at a specialist centre. And, where legal, the option of a termination and those support services.(Pages 20 and 154)		
GDG	Original GDG member	NO	I think it would be useful to review the evidence on alcohol in pregnancy again. I am aware of at least one publication (J Epidemiol Community Health. 2010 Oct 5. [Epub ahead of print] Light drinking during pregnancy: still no increased risk for socioemotional difficulties or cognitive deficits at 5 years of age?Kelly YJ, Sacker A, Gray R, Kelly J, Wolke D, Head J, Quigley MA.) which would suggest that light drinking in pregnancy can be positively beneficial!		
SH	RCGP	YES but…		1. Provision of care. Only Midwife-led and GP-led models are considered and I think shared care between midwives and GPs should also be mentioned and officially sanctioned Ref: Alex Smith, Judy Shakespeare, Anna Dixon. The role of GPs in maternity care – what does	

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				the future hold? The Kings Fund, London 2010 2. The difficulties of arranging haemoglobinopathy screening within the current guideline should be tackled in an update. If this area is not addressed I think it is unlikely that there will be any improvement in the current failing of this programme Ref: Shakespeare J. Antenatal haemoglobinopathy screening. BMJ. 2010; 341: 897-898	
SH	Royal College of Paediatrics and Child Health		The original document stated in references 5 and 8 that the guideline, Induction of labour is expected to be published in 2008 - that has happened and should now be referenced appropriately.		
SH	Tiny Tickers	NO	Tiny Tickers is disappointed that there are no questions about screening for serious congenital heart disease (CHD) in this update, considering that it is the single largest congenital anomaly (25% of all congenital anomalies), more prevalent than Down's Syndrome in women below age 35 (3.5 per 1,000), yet often has good surgical outcome if detected prenatally. We recommend that NICE routinely check for updates in fetal or antenatal CHD to inform antenatal screening guidelines. We have summarised some important new information, below.	**Congenital heart disease (CHD): specifically 3 Vessel & Trachea View (3VT)** **Background** NICE Antenatal Update 2008 was very helpful in bringing the need to screen the fetal Outflow Tracts of the heart to the attention of FASP, which implemented these guidelines in 2010/11. This is already having a very positive impact on prenatal detection and diagnosis of CHD – and subsequent management and surgery. **Looking ahead** We are now looking ahead to the inclusion of the **3 Vessel & Trachea View (3VT)** Studies from 2006 onwards show (referenced below): 1. Importance of prenatal diagnosis of left-sided (aortic) CHD in improving outcome (ref. 1. Brown KL)	Although we do not feel there are any issues, we would like to note that: Congenital heart disease ascertainment varies with location, so there is still widespread postcode inequality, due to the differences in service provision in cities and rural areas.

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				2. 3 Vessel & Trachea View (3VT) increases detection of simple, isolated Coarctation of the Aorta and similar duct-dependent lesions (IAA etc.), which are often fatal if not detected prenatally, yet have a good surgical outcome when detected antenatally (2. Stos, 3. Vogel, 4. Matsui) 3. 3VT reduces false-positives compared to 4-chamber disproportion alone (2. Stos, 4. Matsui) Thus, we recommend that the 3 Vessel & Trachea View (3VT) is considered as part of advanced screening for duct-dependent CHD in future guidelines. Tiny Tickers already trains hospitals to screen the fetal heart using this view as part of a “5 Transverse View” protocol, so this will not be difficult to implement. See **www.tinytickers.org** for more information. **References.** 1. Heart. 2006 Sep;92(9):1298-302. Epub 2006 Jan 31. Delayed diagnosis of congenital heart disease worsens preoperative condition and outcome of surgery in neonates. **Brown** KL, Ridout DA, Hoskote A, Verhulst L, Ricci M, Bull C. Cardiac Unit, Great Ormond Street Hospital for Sick Children, London, UK. BrownK@gosh.nhs.uk 2. Arch Mal Coeur Vaiss. 2007 May;100(5):428-32. [Is antenatal diagnosis of coarctation of the aorta possible?].[Article in French]	

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				Stos B, Le Bidois J, Fermont L, Bonnet D. 3. Am J Cardiol. 2010 Mar 1;105(5):727-34. Fetal diagnosis of interrupted aortic arch. **Vogel** M, Vernon MM, McElhinney DB, Brown DW, Colan SD, Tworetzky W. Department of Cardiology, Children's Hospital Boston, Boston, Massachusetts, USA. 4. Circulation. 2008 Oct 28;118(18):1793-801. Epub 2008 Oct 13. Morphological and physiological predictors of fetal aortic coarctation. **Matsui** H, Mellander M, Roughton M, Jicinska H, Gardiner HM. Institute of Reproductive and Developmental Biology, Faculty of Medicine, Imperial College, Queen Charlotte's and Chelsea Hospital, Du Cane Rd, London, W12 0HS, UK.	
SH	TIPS Ltd	Mostly YES		**5.4** Although *Food acquired infections* and *Nutritional supplements* are mentioned in the antenatal guidelines, it would be useful to include a section called '*Avoidance of allergies*' within this section to include the latest advice: • 'Encouraging the pregnant woman to eat fresh foods containing as few additives and preservatives as possible' or • 'A previous history of allergic symptoms would make it sensible for a pregnant woman to avoid those substances that she knew she was sensitive to [i.e. nut allergies]'. This is based on information submitted to the House of Lords Science and Technology Sub-Committee on allergies by TIPS Ltd, on behalf of the RCM – I would	**Chapter 3** in Full guidelines – page 37 Maybe the term 'parent-centred care' should be used instead of 'woman-centred care' to be truly inclusive of the partner (whoever this may be).

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				be happy to provide this. **5.8** In order to be consistent, the antenatal guidelines need to reflect the same advice used in the Postnatal guidelines. I suggest we change the name of section 5.8 which is presently called 'Over the counter medicines' to 'Over the counter medicines and personal care products' (to encompass a variety of agents including skincare products and household products) so as to highlight the potential risks to the unborn baby by overuse of such products*. I suggest we include: Information on the avoidance of certain skincare/food products that have the potential to sensitise the unborn infant should be given at the first antenatal visit. This could reduce the chances of the baby going on to develop skin and/or allergic conditions in the future. This could include the following statement: • Care should also be taken when using household (detergent residues can be absorbed into the bloodstream through the skin) or personal care products as these too can pose a risk to your unborn child. Even during the antenatal period it is important to introduce the subject of safe skincare guidelines for infants during their early weeks of life. This is when many parents start buying baby products and this should be discouraged. This would complement the new advice in the Postnatal care guidelines (July 2006) which recommends that bathing products are not necessary during the neonatal period. This advice is now repeated in the latest Pregnancy and Birth to Five books with links to the	

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				www.tipslimited.com website on the NHS Choices website at: http://www.nhs.uk/Planners/breastfeeding/Pages/helplines-and-websites.aspx *This information needs to be repeated in the summary care pathway.	
SH	UK National Screening Committee	NO	The UK National Screening Committee felt that changes to the discussion in some areas could help improve the guideline. For example: Since the publication of the guideline the UK National Screening has reviewed the evidence for screening for chlamydia in pregnancy. The Committee is currently considering screening for hepatitis C and asymptomatic bacteriuria. There is concern about the way these conditions are addressed in the guideline and the opportunity should be taken to reconsider them. Also since the publication of the guideline, the standards for screening for infectious diseases in pregnancy, Down's Syndrome and fetal anomalies have been reviewed. The Committee considers that the guideline should be reviewed to ensure consistency with the revised standards in these areas. The Sickle Cell and Thalassaemia screening programme were concerned about the way in which the current guideline addresses some issues within its area of responsibility. Again, the UK National Screening Committee feels that the opportunity should be taken to review these to ensure consistency. We would welcome the opportunity to discuss		

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			these issues in more detail with NICE.		
SH	Group B Strep Support	No	**The section relating to group B Strep prevention needs to be updated – this section has not been reviewed since the guideline was published in 2003.** There is much confusion and highly varied practice in the antenatal care of women known to carry group B Streptococcus during the current pregnancy, those who have previously had GBS isolated from a vaginal, rectal or urine culture and those who have 'risk factors' which mean their baby is at raised risk of group B Strep infection. These situations should be addressed since they form a relatively small but important proportion of women covered by the guideline, namely "The guideline has been developed with the following aims: to offer information on best practice for baseline clinical care of all pregnancies and comprehensive information on the antenatal care of the healthy woman with an uncomplicated singleton pregnancy." The issue of offering routine screening women for GBS carriage late in pregnancy on the NHS needs to be reviewed, particularly in the light of the increasing incidence of neonatal GBS infection since the RCOG's GBS guideline was introduced, plus emerging evidence, especially Ruth Gilbert's modelling study (see http://www.ncchta.org/ProjectData/1_project_re_notpublished.asp?PjtId=1473) and other recent studies (Cost-effectiveness of rapid tests		

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			and other existing strategies for screening and management of early-onset group B streptococcus during labour. Kaambwa B, Bryan S, Gray J, Milner P, Daniels J, Khan K, Roberts T. BJOG. 2010 Dec;117(13):1616-27. Intrapartum tests for group B streptococcus: accuracy and acceptability of screening. Daniels J, Gray J, Pattison H, Gray R, Hills R, Khan K; on behalf of the GBS Collaborative Group. BJOG. 2010 Oct 13.) The current Antenatal Care guideline includes little guidance to health professionals on GBS. The ANC guideline predated the publication in November 2003 of the Royal College of Obstetricians & Gynaecologists' Green Top Guideline No 36 entitled Prevention of Early Onset Group B Streptococcal Disease. The ANC guideline should therefore be updated to incorporate these recommendations, although some of these may need to be revised in the light of evidence which has emerged since that time – the RCOG guidelines were due for review in November 2006 and the revised document should be published in 2011.		
SH	RCOG	Yes			
SH	RCN	Yes			
SH	RCM	Yes			

8 = yes
8 = no
1 = no answer