Viability Scans in Early Pregnancy: Referral Guidance

TARGET AUDIENCE	Secondary care and Primary care
PATIENT GROUP	All women with a positive pregnancy test up to 11+6 weeks of gestation.

Clinical Guidelines Summary

- Asymptomatic women with a history of one previous 1st trimester miscarriage should not be routinely referred for a reassurance scan.
- The following women should be offered one viability scan at 6 weeks of gestation:
  - History of two or more miscarriages requiring clexane and/or progesterone
  - Previous ectopic pregnancy
  - Previous pregnancy of unknown location
  - History of tubal disease
  - Previous pelvic inflammatory disease
- The following women should be offered one viability scan at 7 weeks of gestation:
  - Women referred from genetics to facilitate non-invasive prenatal diagnosis.
- The following women may be offered one viability scan at 8 weeks of gestation:
  - History of two or more miscarriages not requiring treatment
  - Previous molar pregnancy
  - History of previous stillbirth, neonatal death, termination for fetal anomaly or attending MOT clinic
  - History of previous 2nd trimester miscarriage
  - Women with aneuploidy in previous pregnancy to facilitate non-invasive prenatal testing (NIPT)
  - Women with previous genetic diagnosis to facilitate chorionic villus sampling

Contents:

INTRODUCTION

Viability or reassurance scans are ultrasound examinations which are performed in the absence of any symptoms such as PV bleeding and/or pain.

GUIDANCE IF ONE PREVIOUS MISCARRIAGE

- Women with one previous miscarriage should not be referred routinely for a reassurance scan. Community midwife should reassure women that their chances of a subsequent miscarriage are not increased. Women should be advised to call local EPAS if they do develop bleeding and/or pain.
- Women with a history of miscarriage whose last pregnancy was successful should not be routinely referred for a reassurance scan.
- Those women self-referring for scan after one miscarriage should be referred for assessment and support to their community midwife.
- Women with one previous miscarriage occurring after 14 weeks of gestation can be offered a reassurance scan which is usually performed at or after 8 weeks.

GUIDANCE IF HISTORY OF TWO OR MORE MISCARRIAGES

- Women who have confirmed recurrent miscarriage and/or those women taking clexane and/or those women eligible for progesterone treatment should have a reassurance scan at 6 weeks.
- Women not on treatment should be offered scan at 8 weeks.
- If first reassurance scan demonstrates a viable pregnancy, no further routine scans should be offered until the formal booking scan.
- Further reassurance scans can only be offered if clinically indicated.

GUIDANCE IF PREVIOUS ECTOPIC PREGNANCY OR PREGNANCY OF UNKNOWN LOCATION

- Reassurance scan should be offered at 6 weeks provided woman is asymptomatic.

- Reassurance scan should be offered at 6 weeks for women with known tubal disease/previous PID.
- If first reassurance scan demonstrates a viable pregnancy, no further routine scans should be offered until the formal booking scan.

GUIDANCE IF PREVIOUS MOLAR PREGNANCY

- Reassurance scan should be offered at 8 weeks providing woman is asymptomatic.

GUIDANCE IF POOR OBSTETRIC HISTORY

- Women with previous stillbirth, neonatal death, termination of pregnancy for fetal anomaly, attending MOT clinic can be offered one reassurance scan at 8 weeks if required.
- Women who have had a previous pregnancy with aneuploidy should be offered NIPT. This can be facilitated by one viability scan at 8 weeks of gestation.
- Women who have had previous genetic diagnosis and require CVS should have one viability scan at 8 weeks of gestation, to allow appropriate planning.
- Women who require non-invasive prenatal diagnosis (eg cystic fibrosis) can be offered a viability scan at 7 weeks of gestation to facilitate this.
- Consider one scan at 8 weeks of gestation for maternal anxiety if there are significant risk factors in the patient's obstetric/gynaecology history. Request requires to be vetted by MDT.

References/Evidence

1. Ectopic pregnancy and miscarriage: diagnosis and initial management. NICE NG126, 2023.
2. Recurrent miscarriage. RCOG GTG 17, 2023.
3. Management of gestational trophoblastic disease. RCOG GTG 38, 2020.

Appendices

1. Governance information for Guidance document

Lead Author(s):	Evelyn Ferguson and Sheila Hughes
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CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author / Authors	Laura Beaton Michelle Clarke
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Distribution	Midwives, sonographers, trainees, consultants working in EPAS. All consultants in obstetrics and gynaecology. The maternity clinical effectiveness group.

CHANGE RECORD

Date	Lead Author	Change	Version No.
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2.You can include additional appendices with complimentary information that doesn't fit into the main text of your guideline, but is crucial and supports its understanding.

e.g. supporting documents for implementation of guideline, patient information, specific monitoring requirements for secondary and primary care clinicians, dosing regimen/considerations according to weight and/or creatinine clearance