STANDARD OPERATING PROCEDURE

Maternal Medicine Pathways

Local ASPH and South West London and Surrey Heartlands MMN

PREPARED BY : **Karin Leslie** **Consultant Obstetrician and Maternal medicine Lead**	**DATE:** 29.01.2024
RATIFIED BY : **Perinatal Guidelines Group**	**DATE:**
VERSION 2.0 Updated Jan 24 with updated MMN pathways	**REVIEW DATE: Feb 2027** **And if national and regional guidance updated**

AIM

To deliver safe and effective care to women with pre-existing medical conditions and those who develop medical conditions during pregnancy as part of the networked regional maternal medicine service.

This document offers guidance in the management of women with underlying medical conditions in pregnancy for the pathways of care and referral criteria.

SCOPE

This guidance is relevant to following staff groups:

- All midwifery, maternity assistant, administrative and phlebotomy staff who work in maternity
- All medical staff working within the Obstetrics and Gynaecology team – Consultants, Middle Grades and Juniors
- All staff working to manage the patient pathway –Specialist Nurses, Consultants, Service Manager and admin teams

COMPETENCIES

As per Trust guidelines: Ante-natal Referral to maternity services, booking appointments and maternity care pathway including antenatal clinical risk assessment and referral for maternal medicine care

INDICATIONS

Criteria for the maternal medicine pathway are detailed in the 'Indications for Obstetric Referral' SOP

Please note these are not exhaustive and clinical judgement can be used, if there is any uncertainty about the need for referral advice can be sought from the team leader, Matron, Complex care team lead, or the Lead Obstetrician.

PROCESS and NAMED CONSULTANT

Women who meet the criteria for the maternal medicine pathway shall be identified at self-referral, booking or at any point in the antenatal care pathway. Email referral via BadgerNet as per the 'Indications for Obstetric Referral' SOP

They should be referred for consideration of care with the Complex care team – email referral via BadgerNet.

All women who meet the criteria for the maternal medicine pathway and maternal medicine Consultant led care will have their named consultant identified in BadgerNet

An individual plan of care will be documented in the management plan box in their maternity records including the need for specialist input from physicians, obstetric anaesthesia and allied health professionals.

Women will be managed in accordance with the SWLaSH maternal medicine pathways for their condition – see operating model.

Referrals to the MMN centre will be made via Refer a Patient in accordance with the regional referral pathway terms of reference.

ASPH Maternal Fetal Medicine service

The maternal fetal medicine service at ASPH consists of:

- 5 Consultant Obstetricians
- 2 Consultant Obstetric Anaesthetists
- Complex care midwifery team

Working in partnership with lead / link clinicians in medical specialties and with tertiary care and the MMN centre as appropriate.

South West London and Surrey Heartlands (SWLaSH) Maternal Medicine Network

The maternal medicine network is made up of:

- maternal medicine centre (hub) – GESH (St Georges and St Heliers)
- local maternity centres (spokes)

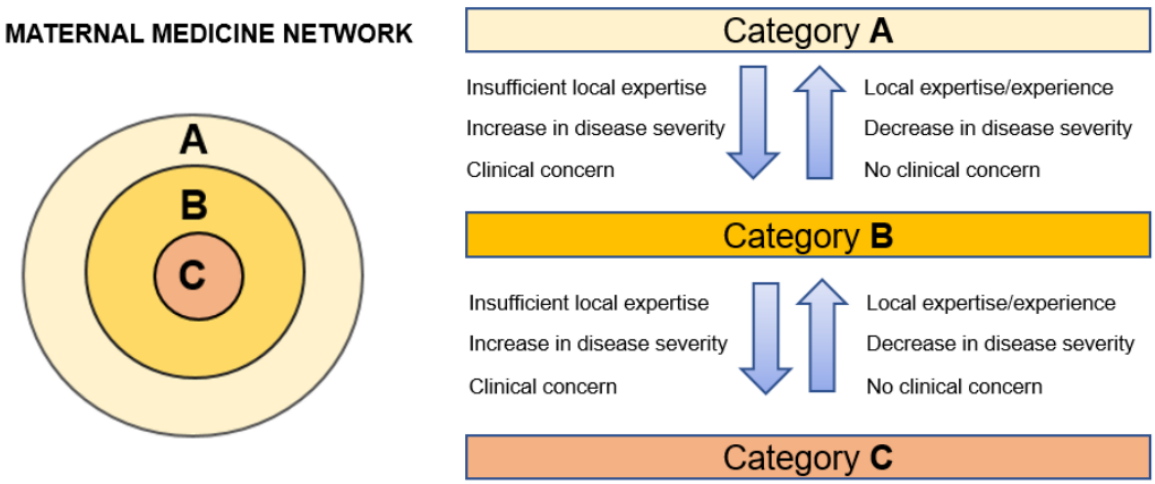
South West London and Surrey Heartlands MMN			
Maternal Medicine Centres	St George's University Hospital Level 3 NICU	Wandsworth SW17	020 8672 1255
	St. Helier Hospital Level 2 NICU	Sutton SM5	020 8296 2000
Surrey Heartlands:			
Local Maternity Unit	Ashford and St Peter's Hospital Level 3 NICU	Chertsey KT16	01932 872000
Local Maternity Unit	Royal Surrey Foundation Trust Level 1 NICU	Guildford GU2	01737 768511
Local Maternity Unit **(Level 2 NICU)**	SASH (East Surrey) Surrey and Sussex Healthcare NHS Trust	Redhill RH1	01483 571122
SW London:			
Local Maternity Centre	Croydon University Hospital Level 2 NICU	Croydon CR7	020 8401 3000
Local Maternity Centre	Epsom Hospital Level 1 NICU	Epsom KT18	01372 735735
Local Maternity Centre	Kingston Hospital Level 2 NICU	Kingston KT2	020 8546 771

Categories of Condition

Depending on the complexity of the condition in pregnancy, at the time of delivery and in the post-partum period, the relative contribution of the maternal medicine hub and local maternity centres may change.

Medical conditions are classified as category A, B or C, depending on complexity:

These categories are a guide only. They can be modified according to local expertise and experience. Where local expertise is sufficient, a condition may move from category C to B, or B to A. Where local expertise is insufficient, when a condition progresses or increases in severity during pregnancy, or when there is clinical concern, a condition should move from category A to B, or B to C



Criteria for Referral

SWLaSH MMN adopted the pan London referral criteria
See Appendix 1 for the SWLaSH maternal medicine network condition criteria
Or here - Regional maternal medicine network criteria

RESPONSIBILITES

All clinical staff are responsible for complying with this policy.

AUDIT

Annual audit 1% of case notes demonstrating compliance with the referral criteria and that the named consultant is identified in the maternity BadgerNet records with oversight by the Perinatal Governance Team.

Appendix 1 SWLaSH Regional Networked Maternal Medicine Referral Criteria

Networked Maternal Medicine Services in London

This document offers guidance in the management of women with underlying medical conditions in pregnancy. Depending on the complexity of the condition the relative contribution of the maternal medicine hub and local maternity centres may change

.

Medical conditions categories

Pan-London pathways

Heart disease

Lung disease

Gastrointestinal and liver disease

Diabetes and endocrine disease

Kidney disease

Rheumatological disease

Neurological disease

Haematological disease

Skin disease

Appendices

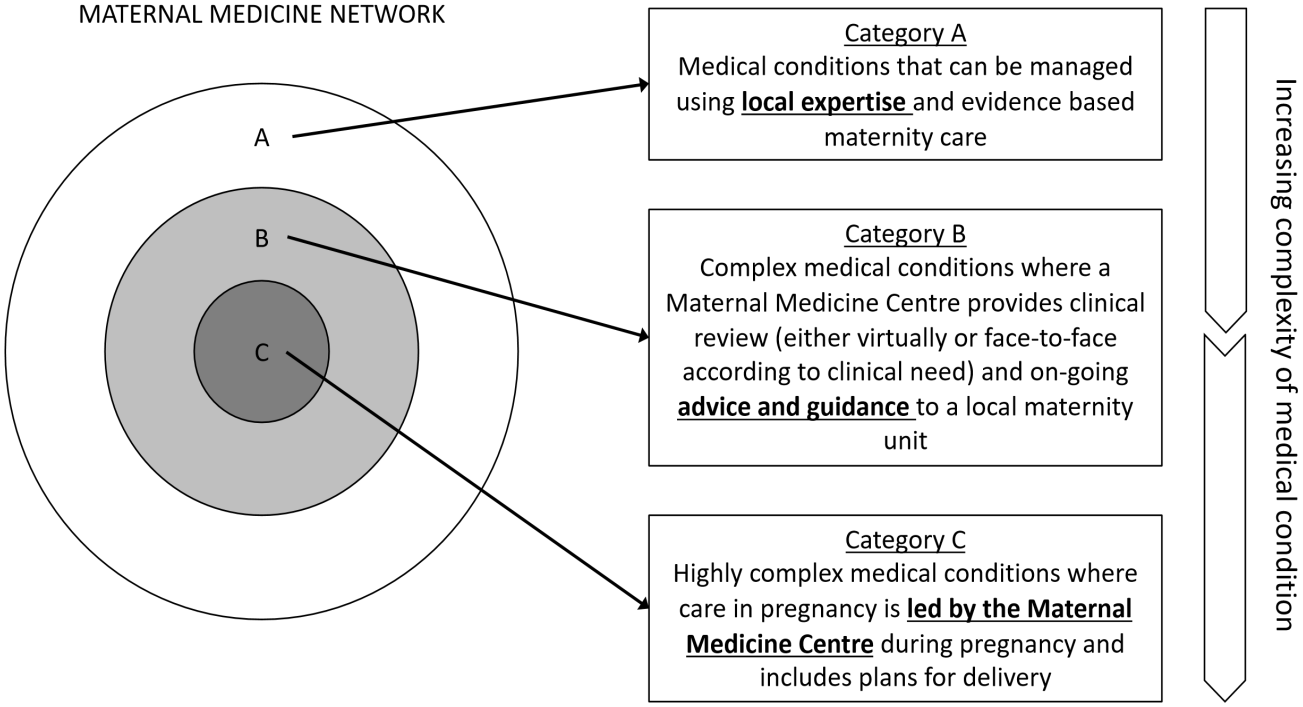
SWLaSH Medical conditions categories

.

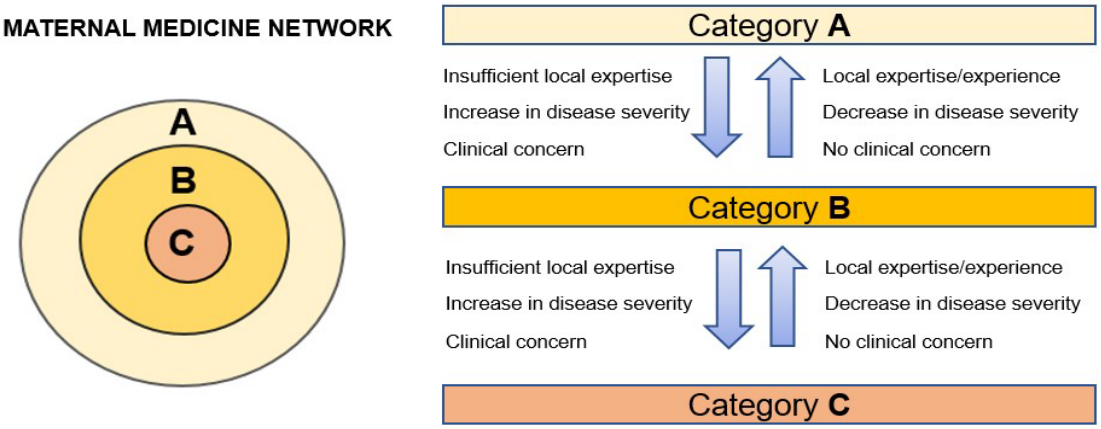
The maternal medicine network is made up of:

- Maternal medicine centres (hub)
- Local maternity centres (spoke)

Medical conditions are classified as category A, B or C, depending on complexity:



These categories are a guide only. They can be modified according to local expertise and experience. Where local expertise is sufficient, a condition may move from category C to B, or B to A. An example would be epilepsy, where there may be a local joint obstetric epilepsy clinic including a neurologist with expertise in epilepsy in pregnancy, in which case care could remain at a local centre. Where local expertise is insufficient, when a condition progresses or increases in severity during pregnancy, or when there is clinical concern, a condition should move from category A to B, or B to C:



Pan-London Pathways

The medical conditions on this page are commissioned services that may not align with maternal medicine networks. Each maternal medicine network will need to agree the provision of these services for pregnancy as care may be affected by the availability of co-located maternity and neonatal services. Each network should provide a list of the centre(s) offering specialist management for the above conditions including information and contact details for co-located maternity services. Whenever possible, pregnant or postpartum women presenting with these conditions should have access to the same specialist medical care as non-pregnant patients, with a plan made for safe obstetric and neonatal management.

ST-Elevation Myocardial Infarction

Primary percutaneous coronary intervention (PCI) centres reduce morbidity and mortality from myocardial infarction. Each network should provide a list of the primary PCI centres both within and geographically close to their network including information and contact details for co-located maternity services. If the nearest primary PCI centre is not co-located with obstetric care, a plan for timely and appropriate management of myocardial ischaemia with appropriate provision of maternity care is required. Pregnant patients ≥ 20 weeks gestation meeting criteria for the STEMI or HR ACS pathway should be conveyed to the nearest Heart Attack Centre that has onsite obstetrics (the only HACs which do NOT have obstetrics are Harefield and Bart's). Pregnant patients of gestation < 20 weeks should be conveyed to the nearest HAC.

Pulmonary Hypertension

Pulmonary hypertension is an extremely high-risk condition in pregnancy. Treatment often involves multi agent targeted therapies that require prescription and oversight by a nationally commissioned PH centre.
Pregnant women with PH should be referred to and managed by one of the centres below, all of which have colocated maternity units and Level 3 neonatal services: • Imperial (non-CHD related PH), contact Rachel Davies

- Guy's and St. Thomas' and Royal Brompton Hospitals, St. Thomas' site (CHD and non-CHD related), contact Hannah Douglas or Laura Price
- St Georges (if already under their care), contact Brendan Madden.

Acute Stroke

Hyperacute stroke units (HASUs) were commissioned to improve the care for patients with acute stroke. They are able to thrombolyse and use clot retrieval for patients with acute ischaemic strokes. Each network should provide a list of the HASUs both within and geographically close to their network including information and contact details for co-located maternity services. If the nearest primary HASU is not co-located with obstetric care, a plan for timely and appropriate management of acute stroke with appropriate provision of maternity care is required.

Neurosurgery

Neurosurgical centres are able to offer intervention for haemorrhagic stroke and other causes of cerebral haemorrhage presenting in pregnancy. The neurosurgical units in London are :• Charing Cross (no co-located obstetric unit)

- Royal Free Hospital (co-located obstetric unit, Level 1 neonatal care)
- Royal London (co-located obstetric unit, Level 3 neonatal care) or
- Queen's Hospital, Romford (co-located obstetric unit, Level 2 neonatal care)
- King's College Hospital co-located obstetric unit, (co-located obstetric unit, Level 3 neonatal care)
- St Georges (co-located obstetric unit, Level 3 neonatal care)

Acute Liver Failure

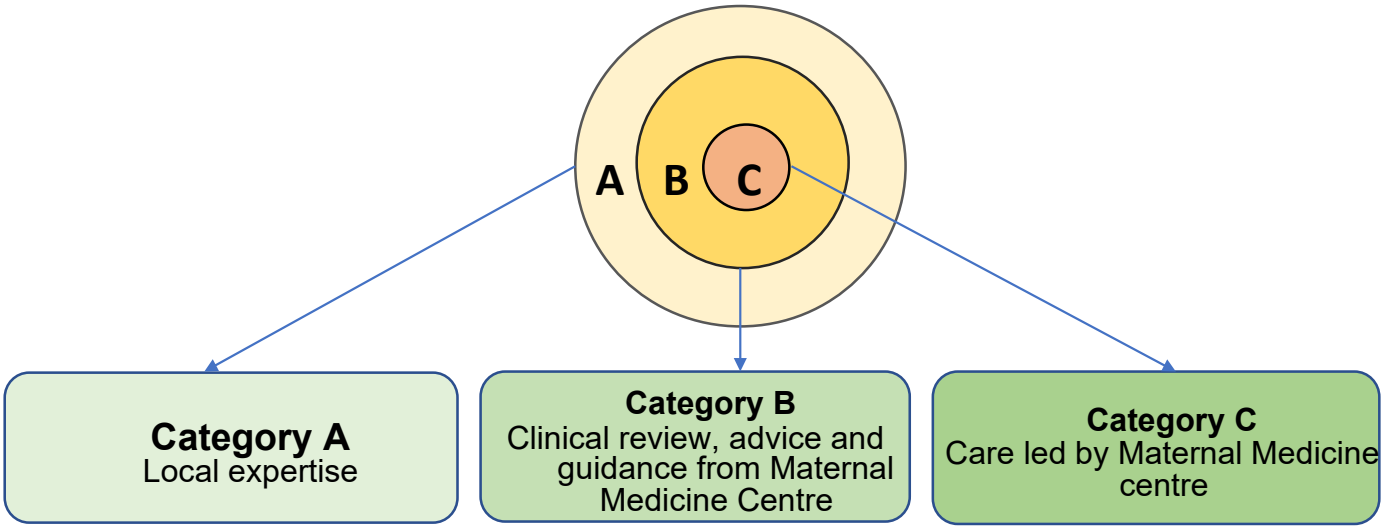
Women with liver failure in pregnancy/post-partum can be referred to:

- Royal Free Hospital (co-located obstetric unit, Level 1 neonatal care)
- King's College Hospital (co-located obstetric unit, Level 3 neonatal care)

SWLaSH Maternal Medicine Networks Contacts

Lead Physician	Lila Mayahi	lila.mayahi@nhs.net
Lead Obstetrician	Hassan Shehata	hassan.shehata@nhs.net
Lead Midwife	Carolyn Romer	carolyn.romer1@nhs.net
LeadAnaesthetist	Renate Wendler	renate.wendler@nhs.net

Heart Disease



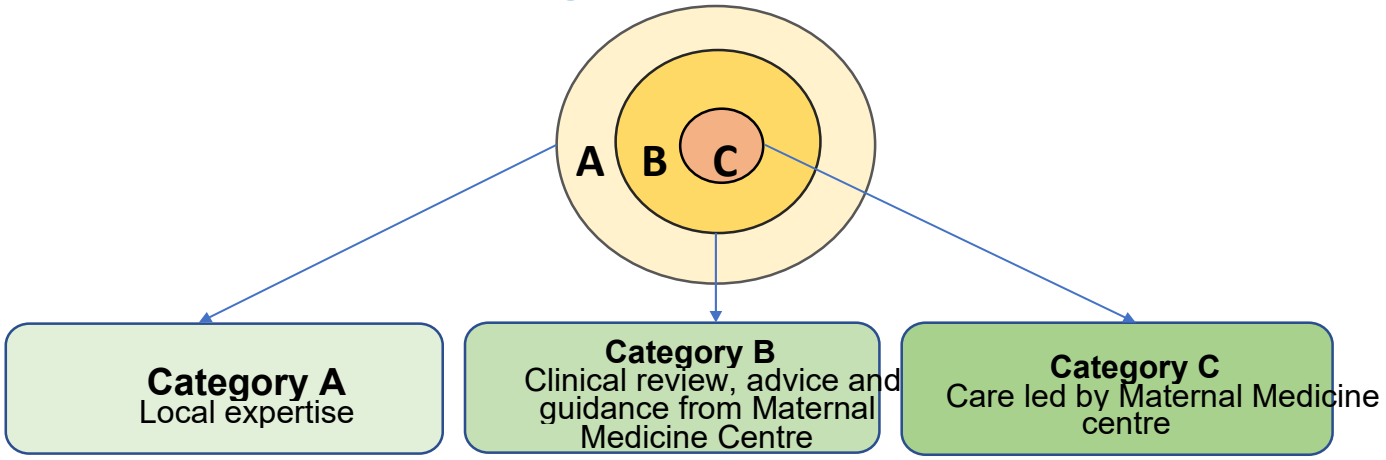
Mild pulmonary stenosis	Mild reduced left ventricular ejection fraction (>45%)	Pulmonary hypertension*
Small/repaired patent ductus arteriosus	Hypertrophic cardiomyopathy with no high-risk features	Left ventricular ejection fraction <45%
Mitral valve prolapse	Repaired aortic coarctation	Severe aortic stenosis
Repaired atrial septal defect	Mild mitral stenosis	Systemic right ventricle
Repaired ventricular septal defect	Mild-moderate aortic stenosis	Fontan
Isolated atrial or ventricular ectopic beats	Other valve lesions not listed in A or C	Previous peripartum cardiomyopathy
Postural tachycardia syndrome (PoTS)	Atrioventricular septal defect	Ventricular arrhythmia
	Repaired tetralogy of Fallot	Mechanical valve
	Supraventricular arrhythmias	Moderate-severe mitral stenosis
	Turner syndrome without aortic dilatation	Aortic dilatation
	Treated ischaemic heart disease	Heart transplant
	Myocarditis	New ischaemic heart disease*

*see Pan-London Pathway

AVAILABLE CLINICAL GUIDANCE:

2018 ESC Guidelines for the management of cardiovascular diseases during pregnancy: The Task Force for the Management of Cardiovascular Diseases during Pregnancy of the European Society of Cardiology (ESC). European Heart Journal 2018; 39 (34):3165–3241.

Lung Disease

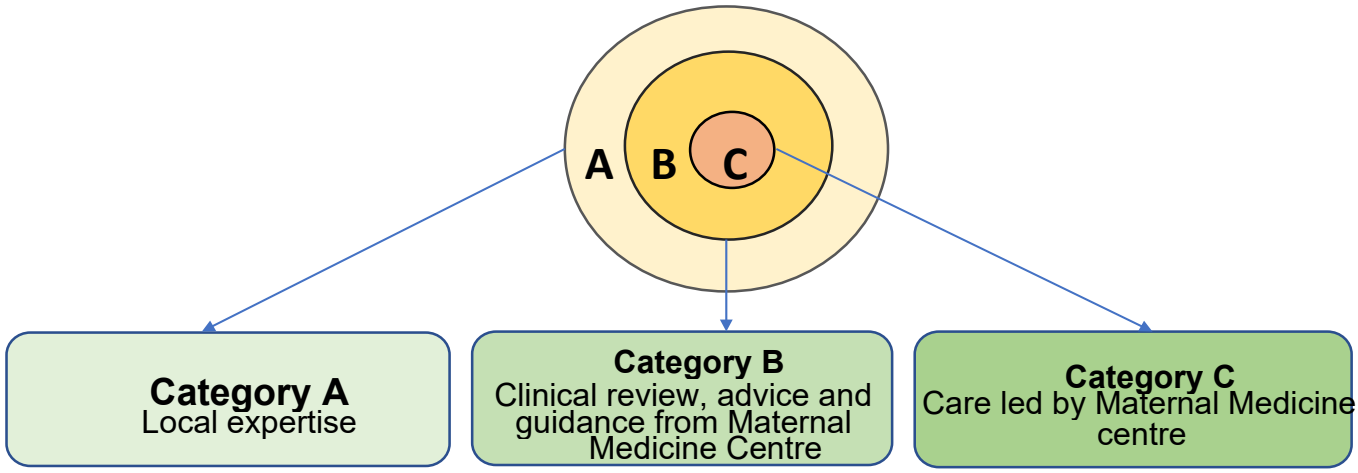


Uncomplicated Asthma	Complicated asthma: • Repeated presentations of asthma (≥3) in pregnancy • Asthma receiving biologics • Long-term corticosteroids	Sickle chest crisis (see Haematology pathway)
Pneumonia	Restrictive lung disease (e.g., ILD, kyphoscoliosis) with FVC >50%	Restrictive lung disease (e.g., ILD, kyphoscoliosis) with FVC <50%
TB	Any respiratory condition receiving immunotherapy / biologics	Neuromuscular disorders with respiratory muscle involvement e.g. myasthenia gravis, Guillain-Barré syndrome
Chronic Obstructive Airways Disease	Bronchiectasis	Cystic fibrosis
Pneumothorax	New diagnosis of obstructive sleep apnoea/obesity hypoventilation in pregnancy	Lung transplant
Sarcoidosis without restrictive lung disease, no renal involvement	COVID pneumonitis	Pulmonary vasculitis
Managed obstructive sleep apnoea/obesity hypoventilation	Lung cancer	
Pulmonary embolus without haemodynamic compromise	Pulmonary embolus with haemodynamic compromise	

AVAILABLE CLINICAL GUIDANCE:

- British guideline on the management of asthma. British Thoracic Society/Scottish Intercollegiate Guidelines Network (SIGN158), 2019.
- Thromboembolic Disease in Pregnancy and the Puerperium: Acute Management. RCOG Green Top Guideline 37b, April 2015

Gastrointestinal and Liver Disease



Uncomplicated inflammatory bowel disease in remission or inflammatory bowel disease managed in a specialist IBD-obstetric service at a local centre	Complex inflammatory bowel disease without access to specialist IBD-obstetric service at a local centre: • Active disease despite treatment • Biologics • Corticosteroids • Peri-anal disease • Pouch/stoma	Complex pancreatitis • Not responding to treatment • Recurrent disease • Hypertriglyceridaemia • IR/surgical intervention
Hyperemesis gravidarum	Acute and chronic pancreatitis	Portal hypertension
Constipation	Treated GI malignancy	Active malignancy
Gallstones	Unexplained jaundice	Decompensated liver disease/liver failure/cirrhosis*
Gastro-oesophageal reflux disease	Acute fatty liver of pregnancy	Liver transplant
Coeliac disease	Achalasia	
Viral hepatitis	Liver infarction/haematoma	
Intrahepatic cholestasis (bile acids <100)	Intrahepatic cholestasis (bile acids ≥100)	
Cholecystitis	Autoimmune hepatitis	
Viral hepatitis**	Wilson's disease	
HELLP	Crigler Najjar syndrome	
Non-alcoholic fatty liver disease with normal fibroscan and no metabolic complications	Non-alcoholic fatty liver disease with abnormal fibroscan or metabolic complications	

	Primary sclerosing cholangitis	
	Primary biliary cirrhosis	
	Haemochromatosis	

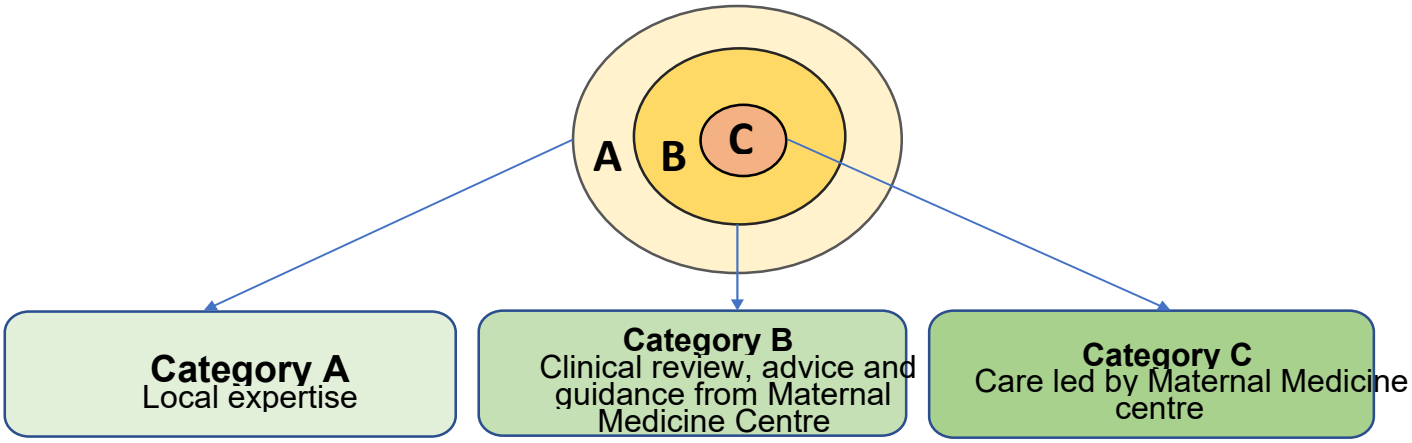
*see Pan-LondonPathway

** New diagnoses of Hepatitis B should be referred directly to local hepatology services

AVAILABLE CLINICAL GUIDANCE:

- British Society of Gastroenterology consensus guidelines on the management of inflammatory bowel disease in adults. Gut 2019; 68:s1-s106. http://dx.doi.org/10.1136/gutjnl-2019-318484
- Standards for the provision of antenatal care for patients with inflammatory bowel disease. British Society of Gastroenterology 2020. doi:10.1136/flgastro-2020-101459.
- The Second European Evidenced-Based Consensus on Reproduction and Pregnancy in Inflammatory Bowel Disease. Journal of Crohn's and Colitis 2015; 9(2): 107–124.
- Intrahepatic cholestasis. RCOG Green Top Guideline, due 2022. .

Diabetes and Endocrine Disease

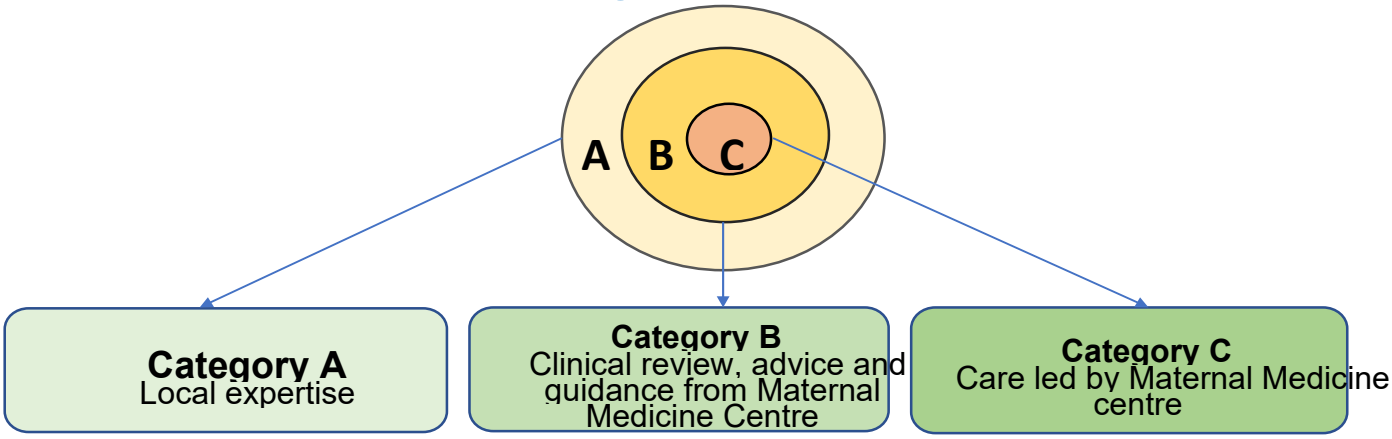


Gestational diabetes mellitus	Diabetes mellitus with: • Nephropathy (see Kidney Pathway) • Cardiovascular disease (see Heart Pathway) • CGM/CSII/Closed loop if support not available at local centre	Primary and secondary hyperaldosteronism
Type I and II diabetes mellitus including diabetic retinopathy	Monogenic diabetes	Phaeochromocytoma or paraganglioma
Hypothyroidism	Thyroid hormone resistance	Cushing's syndrome
Hyperthyroidism and gestational hyperthyroidism	Thyroid cancer	Acromegaly
Thyroid nodules	Pituitary disease on hormone replacement therapy	Pituitary apoplexy
Microprolactinoma	Macroprolactinoma	Hyperparathyroidsm
PCOS	Congenital adrenal hyperplasia	Hypoparathyroidism
Vitamin D deficiency	Dumping syndrome post bariatric surgery	Metabolic disorders such as glycogen storage disorder
	Addison's disease	

AVAILABLE CLINICAL GUIDANCE:

- Diabetes in pregnancy: management from preconception to the postnatal period. National Institute for Health and Care Excellence, updated 2020.
- Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and the Postpartum. Alexander et al. Thyroid 27(3): 315-389, 2017.

Kidney Disease



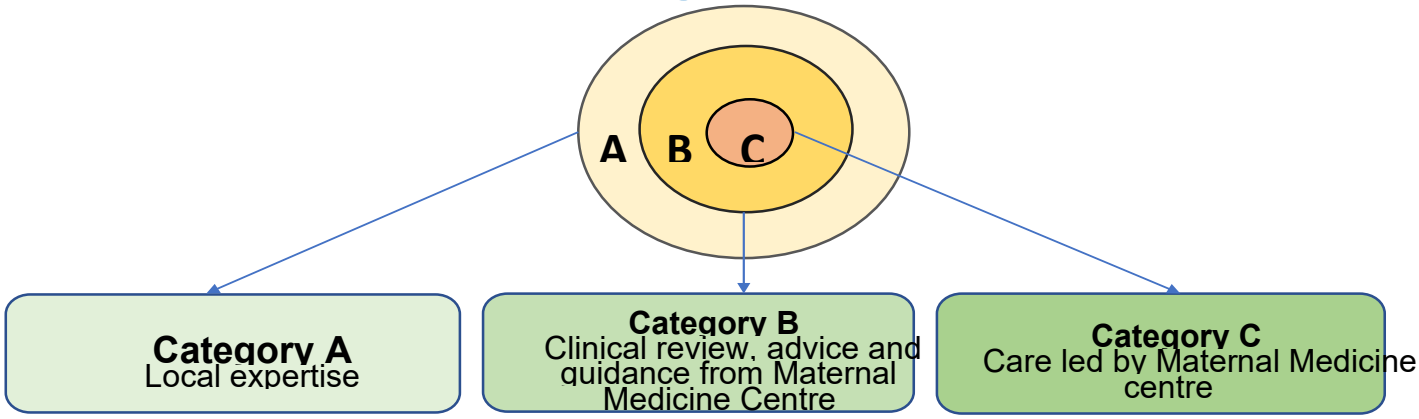
Single kidney	Lupus nephritis in remission or on treatment	Active lupus nephritis
Non-lupus glomerulonephritis/ tubulointerstitial nephritis: • No immunosuppression AND • Stable pre-pregnancy CKD stage 1-2 AND • uPCR <100 or uACR <30 AND • BP <140/90	Non-lupus glomerulonephritis/ tubulointerstitial nephritis: • On immunosuppression OR • Pre-pregnancy CKD stage 3 OR • uPCR ≥100 or uACR ≥ 30 OR • BP >140/90	Pre-pregnancy CKD stages 4 and 5
Kidney stones	Kidney transplant	Combined kidney-pancreas transplant
Recurrent UTI (no immunosuppression)	Recurrent UTI on immunosuppression	Dialysis
Reflux nephropathy with normal kidney function	Reflux nephropathy with abnormal kidney function	New renal vasculitis in pregnancy and vasculitis on immunosuppression
Autosomal dominant polycystic kidney disease with normal kidney function.	Autosomal dominant polycystic kidney disease with abnormal kidney function	Scleroderma renal crisis
AKI responding to treatment	AKI not responding to treatment or not resolving post-partum	
AKI due to pre-eclampsia resolved postpartum	Previous renal vasculitis in remission, no longer on treatment	
	Previous urinary tract reconstructive surgery	
	Kidney disease requiring biologic treatment	
	Progressive kidney disease in pregnancy	
	Kidney disease on biologic treatment	
KIDNEY DISEASE CONTACTS IN LONDON		

South West London	Dr David Makanjoula Joyce Popoola	David.Makanjoula@nhs.net joyce.popoola@stgeorges.nhs.uk

AVAILABLE CLINICAL GUIDANCE:

- Clinical practice guideline on pregnancy and renal disease. Wiles et al. BMC Nephrology 20, 401, 2019.

Rheumatological Disease



Uncomplicated* rheumatoid arthritis	Rheumatological disease requiring biologic therapy	Active lupus nephritis (see Kidney Pathway)
Uncomplicated* seronegative arthritis: • Ankylosing spondylitis • Psoriatic arthritis • Reactive arthritis • IBD related arthritis	Rheumatological not controlled on current treatment	Large and medium vessel vasculitis
Uncomplicated* connective tissue disease: • Lupus • Scleroderma (restricted disease) • Sjogren's	Rheumatological disease with restricted lung disease and FVC >50% (see	Rheumatological disease with restricted lung disease and FVC ≤50%
Osteoarthritis	Rheumatological disease with kidney involvement (see Kidney Pathway)	New small vessel vasculitis or small vessel vasculitis on immunosuppression
Obstetric antiphospholipid syndrome (see Haematology Pathway)	Thrombotic antiphospholipid syndrome (see Haematology Pathway)	Vascular Ehlers Danlos
Hypermobile Ehlers Danlos (type III)	Other Ehlers Danlos syndromes**	Scleroderma renal crisis
	Diffuse scleroderma	Antisynthetase syndrome
	Small vessel vasculitis in remission, no longer on treatment	
	Polymyositis-dermatomyositis	
	Behcet's syndrome***	

*Uncomplicated disease requires all of:

1. no lung/kidney/heart/CNS/thrombotic/muscle involvement
2. controlled on current treatment
3. no current biological treatments

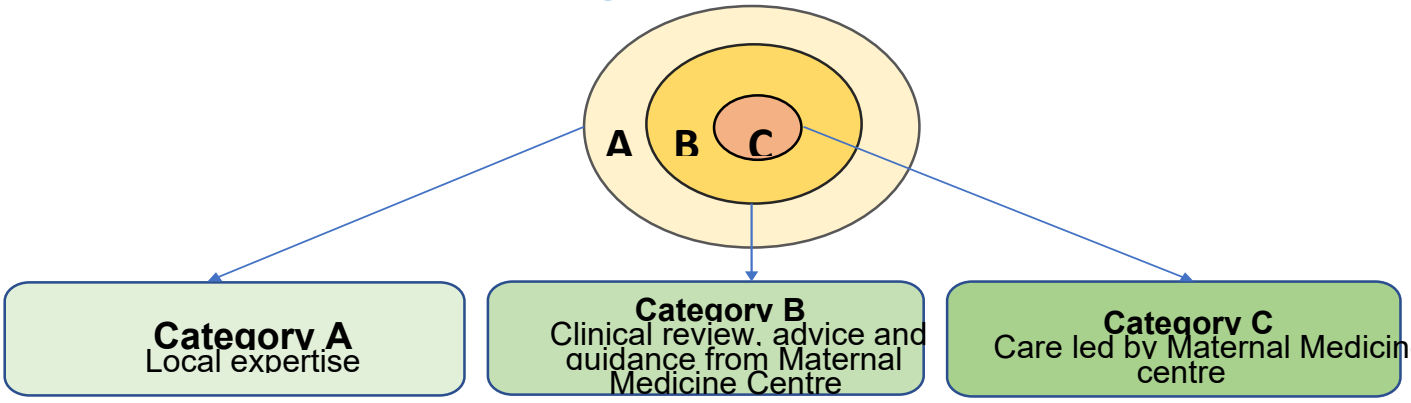
** The Ehlers-Danlos Syndrome National Diagnostic Service for suspected/complex Ehlers-Danlos syndrome is at Northwick Park Hospital

*** The regional centre for Behcets syndrome for London is at Royal London Hospital

AVAILABLE CLINICAL GUIDANCE:

- BSR and BHPR guideline on prescribing drugs in pregnancy and breastfeeding. Flint et al. Rheumatology 55: 1693-1702, 2016.
- The EULAR points to consider for use of antirheumatic drugs before pregnancy, and during pregnancy and lactation. Skorpen et al. Annals of Rheumatic Diseases 75(5): 795-810, 2016
- EULAR recommendations for women's health and the management of family planning, assisted reproduction, pregnancy and menopause in patients with systemic lupus erythematosus and/or antiphospholipid syndrome. Andreoli et al. Annals of Rheumatic Diseases 76: 476-485, 2017.

Neurological Disease



Epilepsy managed in a combined clinic including specialist neurology and obstetrics	Cluster headache	All epilepsy without local access to a combined clinic including specialist neurology and obstetrics.
Migraine	Idiopathic intracranial hypertension	Symptomatic raised intracranial pressure
Stable, small cerebrovascular malformation, reviewed within 2 years of conception, plan for mode of delivery	CVM, not reviewed within 2 years of conception	Unstable CVM/AVM/cavernoma Intracerebral bleed within 2 years
Previous brain tumour	Current brain tumour	Progressive brain tumour
Previous cerebral vein thrombosis (CVT)	New cerebral vein thrombosis (CVT)	Acute stroke*
Meningitis	Previous Guillain Barre Syndrome	New-onset Guillain-Barre syndrome
Previous encephalitis	Treated, stable myasthenia gravis	New diagnosis or flare of myasthenia gravis
Stable multiple sclerosis managed without disease modifying drugs	Unstable multiple sclerosis or disease modifying drugs	Myotonic dystrophy
Mononeuropathy eg: Bell's palsy carpal tunnel, peroneal nerve compression	Progressive or persistent mononeuropathy	
Post-dural puncture headache	New encephalitis	
	Reversible Cerebral Vasoconstriction Syndrome (RCVS)	
	Posterior Reversible Encephalopathy Syndrome (PRES)	
	Spinal cord injury	
	Neurofibromatosis	
	Neuromuscular dystrophy	
	Spinal muscular atrophy	

	Motor neurone disease	

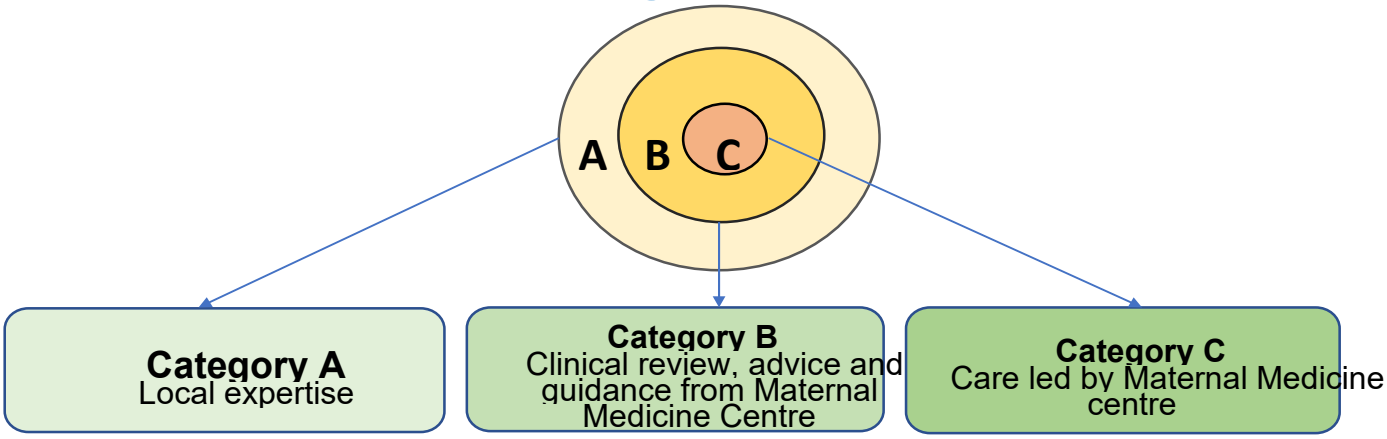
*see Pan-London Pathway

NEUROLOGICAL DISEASE CONTACTS IN LONDON		
South West London	Dominic Paviour	dominic.paviour@stgeorges.nhs.uk

AVAILABLE CLINICAL GUIDANCE:

• Epilepsy in Pregnancy. RCOG Green Top Guideline 68, June 2016. • UK consensus on pregnancy in multiple sclerosis: Association of British Neurologists' guidelines. Dobson et al. Practical Neurology 19(2): 106-114, 2019.

Haematological Disease



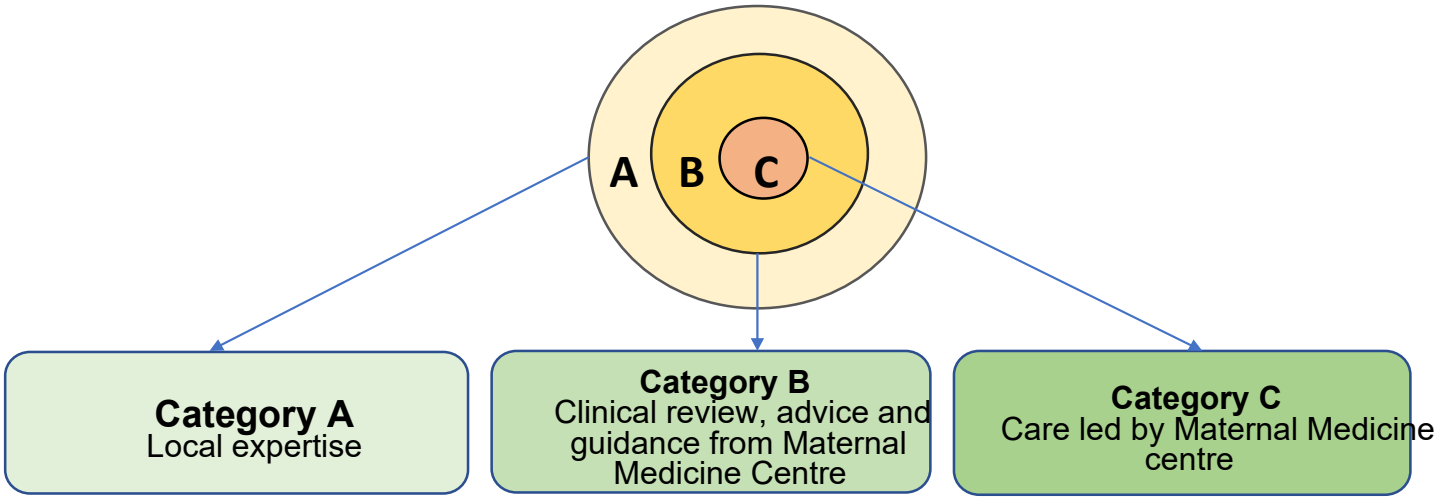
Sickle cell trait	Current immune thrombocytopenia and platelet count ≤75	Sickle cell disease
Historical immune thrombocytopenia and platelet count >75	Thrombocytosis	Beta thalassaemia major
Gestational thrombocytopenia	White cell disorders	Other complex thalassaemia: - iron overload - Endocrine disease - Pulmonary hypertension*
Current VTE or previous single VTE	Recurrent VTE	Current extensive VTE without other access to Factor Xa monitoring
Obstetric antiphospholipid syndrome	Thrombotic antiphospholipid syndrome	Antiphospholipid syndrome with extensive arterial events
Inherited thrombophilia (no VTE, not antithrombin deficiency)	Inherited thrombophilia with previous VTE	Antithrombin deficiency
History of treated haematological malignancy	Stable myeloproliferative/myelodysplastic disease	Active haematological malignancy
Alpha/beta thalassaemia trait	Mild, isolated clotting factor deficiency • Factor II, V, XI or XIII > 0.2iu/ml • Factor X > 0.3iu/ml	Clotting factor deficiency: • Factor II, V, XI or XIII ≤ 0.2iu/ml • Factor X ≤ 0.3iu/ml • Combined deficiencies
B12/folate deficiency	Mild platelet function disorder with platelet count >100	Moderate/severe platelet function disorder or platelet disorder with platelet count <100
	Carriers of haemophilia with known female fetus and normal factor VIII/IX	Carriers of haemophilia with male or unknown gender of fetus
*see Pan-London pathway	Type I Von-Willebrand disease, VWF activity normalised in pregnancy	Von-Willebrand disease: Type 1 if VWF not normalised, Type II and Type III
		Transfusion dependent disease

HAEMATOLOGICAL DISEASE CONTACTS IN LONDON		
South West London	Pamela Kanagasabapathy	pamela.kanagasabapathy@stgeorges.nhs.uk

AVAILABLE CLINICAL GUIDANCE:

- Thromboembolic Disease in Pregnancy and the Puerperium: Acute Management. RCOG Green Top Guideline 37b, April 2015.
- Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium. RCOG Green Top Guideline 37a, April 2015.

Skin Disease



Uncomplicated eczema	Complex eczema/psoriasis: • Biologic therapy • Systemic immunosuppression	Stevens-Johnson syndrome/toxic epidermal necrolysis
Uncomplicated psoriasis*	Impetigo herpetiformis	
Atopic eruption of pregnancy	Pemphigoid	
Polymorphic eruption of pregnancy	Pemphigus	
Prurigo of pregnancy	Vasculitic rash**	
Treated skin cancer	Active skin cancer	
Pruritic folliculitis		
Acne		
Pityriasis rosacea		
Urticaria		
Herpes simplex		
Varicella Zoster		
Cellulitis		
Scabies		

*see Rheumatology Pathway for psoriatic arthritis

** see Kidney Disease Pathway for vasculitis/lupus

AVAILABLE CLINICAL GUIDANCE:

- British Association of Dermatologists. Polymorphic eruption of pregnancy. Available at: https://www.bad.org.uk/ResourceListing.aspx?sitesectionid=159&itemid=352
- Vaughan-Jones et al. Skin disease in pregnancy. BMJ 2014; 348: g3489.

Postnatal contraception

Sexual health - ICS (surreyheartlands.org)

CNWL provide sexual health and contraception for Surrey Heartlands:

STIs and contraception | CNWL Sexual Health Services

- Clinics are available at the following locations (see website for booking details)
- Buryfields Clinic (Buryfields Clinic, Second floor, 61 Lawn Road, Guildford, GU2 4AX)
- Earnsdale Clinic (Earnsdale Clinic, 2 Whitepost Hill, Redhill, RH1 6BD)
- Woking Clinic (Woking Hospital, Heathside Road, Woking, GU22 7HS)
- Epsom Young People's Clinic (Nescot North East Surrey College of Technology, Reigate Road, Ewell, Epsom, Surrey KT17 3DS)
- Weybridge Young People's Clinic (Brooklands College, Heath Road, Weybridge, Surrey, KT13 8TT)

- Guildford Young People's Clinic for 13-17 years old (Buryfields Clinic, Second floor, 61 Lawn Road, Guildford, GU2 4AX) commencing 20 June 2023.

In addition women can access online contraception:
At Home Testing Order Forms | CNWL Sexual Health Services