Birmingham Women's and Children's
NHS Foundation Trust

Policy for Pregnancy Testing and Contraception for Pregnancy Prevention before Surgery, X-Ray/Diagnostics, Radiotherapy/Chemotherapy and Treatment with Medicines of Teratogenic Potential

Applies to BWH, BCH and FTB sites

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1 Introduction

1.1 The possibility of pregnancy should be considered in all female patients of child-bearing age (Over 12 years of age) before procedures and treatments, which could pose risks to the patient and her pregnancy/unborn child.

1.2 Female patients 10 – 12 years of age who are approaching menarche or have attained menarche whilst there are no requirements for pregnancy testing in this age group if the procedure/treatments falls into a high risk category then the Consultant should consider on an individual basis if pregnancy testing is required.

1.3 Pregnancy testing of all female patients less than 16 years of age needs to be undertaken in a consistent, sensitive and confidential manner. Legal / or child protection issues may have to be considered a priority, and in these instances, the professional's duty of confidentiality to the patient may be overridden.

1.4 The pregnancy status must be ascertained on the day of the surgery, procedure or treatment.

1.5 Written information about pregnancy checking should be given to the patient and parents as far in advance as possible, such as when surgery/procedure agreed at outpatients, or when the young person attends for pre-operative assessment so that the patient and /or parents can have any relevant discussion between themselves and any outside agencies and take appropriate action prior to admission.

1.6 If a pregnancy is detected, the risks and benefits of the surgery procedure/treatment can be discussed with the patient.

1.7 In emergency situations, priority is given to the lifesaving care of the patient.

2 Purpose

2.1 The policy aims to ensure the safe treatment of young women who have commenced menstruation and who are fertile. The policy aims to ensure that a systematic approach is followed by healthcare professionals working in all areas and departments within the Trust to ensure that safe treatment is delivered to young women who have commenced menstruation.

2.2 To assist staff in the process of checking pregnancy status, offering pregnancy tests and dealing with safeguarding children issues that may arise from that process.

2.3 To ensure the information collected from the patient and parent/carer follows a standardised format, which is agreed by the multidisciplinary team.

2.4 To ensure that appropriate action is taken if a positive pregnancy test is discovered in the 12-16year-old female patient according to statutory obligations.

3 Scope

3.1 It relates to all clinical staff

3.2 Excludes non – clinical staff

4 Duties within the organisation

4.1 All qualified staff are responsible for ensuring their practice complies within this Policy. It is the local Managers responsibility to ensure that the Policy is made available to all staff.

All heath care professionals who have a responsibility for the delivery of care within the Trust adhere to this Policy.

4.2 The Consultant medical staff and medical team are responsible for:

- Inform the patient that a pregnancy test is required to be performed to ascertain pregnancy status.
- Ascertain that pregnancy status has been clarified prior to administration of an anaesthetic, performing surgery or x-ray /diagnostics.

4.3 The nursing staff involved in the management of the patient are responsible for:

- At pre-assessment clinic, or at time of admission if not attending pre-assessment clinic to clearly document accurate information relating to the patients menstrual cycle. This information will form the basis of the decision regarding the need for a pregnancy test on the day of the anaesthetic/procedure or treatment.
- At pre assessment clinic or at time of admission if not attending pre assessment clinic, should provide an patient information leaflet.
- On the day of admission assist and support any patients who may require a pregnancy test.
- Be responsible for documenting the patients last menstrual period date, any action taken, if a pregnancy test is required documenting the result of the test in the medical notes.

4.4 The Radiology staff are responsible for:

- Ensuring that when appropriate the patient’s last menstrual period has been checked by the clinician and that this is clearly documented on the radiology request form. This information will form the basis of the decision regarding whether to proceed, override the last menstrual period (LMP), rebook the procedure or request the need for a pregnancy test on the day of procedure.

5 Method for development

5.1 Consultation and communication with stakeholders

This policy has been developed in collaboration with the Named Nurse – Child Protection Service at Birmingham Children's Hospital NHS Foundation Trust (BCH), Birmingham Safeguarding Children Board and young people of the Trust, Consultant Paediatric Radiologist, Radiology Professional Manager, Clinical Lead for Anaesthesia, Clinical Lead for Surgery, Clinical lead for Paediatrics, Teenage Age Cancer Nurse Specialist, Clinical Lead for Oncology, Head of Nursing for Surgery Heads of Nursing and Lead Nurses of all clinical areas.

This policy will be disseminated to all ward/departmental managers and clinical leads and will be cascaded to all clinical staff.

6 Checking arrangements Elective and Emergency surgery pathway

6.1 All females of childbearing age who have started their periods require a check of their pregnancy status prior to surgery. If the patient's last menstrual period (LMP) is within 30 days and the patient states she could not be pregnant, pregnancy testing is not required.

6.2 If the patient has missed a period or their last menstrual period is over 30 days or if the patient is uncertain if pregnancy is possible, testing should take place following consent. If questioning reveals pregnancy is unlikely, The Consultant may decide that no further investigation is necessary and this should be clearly documented in the medical notes.

6.3 Routine pregnancy testing is required for patients who have started their periods and are scheduled for:

a) Abdominal or pelvic surgery, such as scoliosis or hip surgery.

b) Major surgery

c) Surgery involving per-operative x-ray screening to the lower abdomen or pelvis.

These procedures are particularly high risk to an undisclosed pregnancy therefore a routine pregnancy test following consent will be required to ensure that there is no risk of harm to the patient or the foetus. A list of higher risk surgical procedures appears in Appendix A. The flow chart in appendix B details the checking procedure.

6.4 In emergency situations, confirmation of pregnancy should not delay treatment and should be judged within the clinical assessment of risk.

7. Checking arrangements for Diagnostics pathway

7.1 The Ionising Radiation (Medical Exposure) regulations (2017) requires practitioners to check the pregnancy status of all females of childbearing age (over 12years of age) prior to radiological procedures.

7.2 X-rays examinations in which the primary beam will not irradiate the lower abdomen or pelvis can proceed without additional precautions relating to potential pregnancy.

7.3 Practitioners must consult the relevant Consultant Radiologist for advice if there is any uncertainty about a procedure requiring the patient to be assessed for the possibility of pregnancy.

7.4 For X-ray examinations in which the primary beam irradiates the lower abdomen or pelvis (as defined in the table Appendix C) then additional precautions relating to potential pregnancy are required. The patient should be asked when her LMP was and if they are sexually active in a way that could result in pregnancy. The flow chart in appendix D details the checking procedure.

7.5 If the patients last menstrual period falls within the last 10 days continue with the procedure.

7.6 If the patients last menstrual period falls outside the last 10 days but within the last 28 days:

- And the procedure is a low –dose, X-ray procedure (as defined in the table Appendix C) continue with the procedure.
- High dose procedures should be discussed with the relevant Consultant for consideration of postponement. This will be dependent on the type of the procedure, clinical need and patient history. A Consultant may also wave this ruling or ask for a pregnancy test.
- When radiation is involved, only a Consultant Radiologist can legally wave the ruling.

7.7 If the patient has missed a period discuss with the relevant Consultant for consideration of postponement. This will be dependent on clinical need and patient history. A Consultant Radiologist may also wave this ruling or ask for a pregnancy test.

8 Checking arrangements for the Chemotherapy/Radiotherapy pathway

8.1 The potential and risks for a patient to be or become pregnant prior to or during chemotherapy should be clearly discussed with patients undergoing chemotherapy.

8.2 Previous testing for surgery or other investigations should not be assumed to be acceptable due to the time delay between then and the commencement of chemotherapy/Radiotherapy treatment.

8.3 Pregnancy status should be considered and re-assessed throughout diagnosis, investigation and treatment.

8.4 A routine pregnancy test is required in the immediate pre-treatment admission period.

8.5 If a patient is sexually active during chemotherapy or radiotherapy treatment they will require a further routine pregnancy test prior to each treatment.

8.6 Radiotherapy – Ionising radiation is used therapeutically as well as diagnostically. All patients requiring radiotherapy treatment will be referred to the clinical oncology team at the Queen Elizabeth Hospital for assessment. Some patients will be suitable for Proton Beam Radiotherapy and through the national scheme will be referred to centres funded via the Department of Health. Partner organisations will have their own policies relating to pregnancy testing. Young people and their carers should be advised that pregnancy testing may well be part of their treatment package in these partner organisations reflecting these external policies / standard operating procedures.

9. Pregnancy Testing and Contraception for Pregnancy Prevention in BCH patients requiring treatment with medicines of teratogenic potential

Some medicines are known or suspected to have the potential to increase the risk of birth defects and development disorders (teratogenic potential) when taken during pregnancy, especially during the first trimester (up to week 12 of pregnancy), when a woman may not know she is pregnant. The product information for these medicines advise that pregnancy should be avoided during treatment, with advice on the need to use contraception including, in some cases, formal pregnancy prevention programmes.

National guidance from the Medicines and Healthcare products Regulatory Agency (MHRA) (March 2019) states that, *'When using any medicine with teratogenic potential, a woman should be advised of the risks and encouraged to use the most effective contraceptive method taking into account her personal circumstances'.*

Specific guidance regarding the use of Valproate (also based on MHRA advice/alerts) can be found in a separate BWCH policy: *Policy for Use of Valproate Therapy in Female Patients of Potential Childbearing Age.*

The following link (endorsed by Public Health England) provides advice on the effects of drugs in pregnancy:
http://www.uktis.org/html/maternal_exposure.html

For the latest list of medicines associated with teratogenic potential, refer to the list on the trust Pharmacy intranet page. Alternatively, prescribers can discuss with a Pharmacist or consult the BNF/BNFc.

The responsibilities of a prescriber of a medicine of teratogenic potential will vary according to patient age and are outlined below.

9.1 Female Children Less Than 10-Years of Age

The current regulations do not advise against the use of medicines with teratogenic potential in this age group and so such a medicine can be prescribed for girls less than 10 years, if it is considered the best treatment for the patient. There are no requirements for pregnancy testing in this age group, however, the following should take place:

Parents/carers should be made aware that the medicine carries a risk of teratogenicity and this discussion should be documented in the patient records

Patients approaching menarche should be reviewed with a view to consider whether the medicine with teratogenic potential can be discontinued or substituted for an alternative therapy

If a girl attains menarche before 10 years age, they should be managed as per the 13-15 age group

9.2 Female Children 10-12 Years of Age

In young women in this age group, who have potential for future pregnancy, the risk of pregnancy should be assessed prior to each teratogen prescription.

There are no requirements for pregnancy testing in this age group, however, the following actions should be taken for existing patients who remain under the care of a BWCH Consultant:

Parents/carers should be made aware that the medicine carries a risk of teratogenicity and this discussion should be documented in the patient records

Patients should be reviewed *at least* annually

Patients already taking a medicine of teratogenic potential should undergo formal evaluation to see if the medicine can be discontinued or substituted for an alternative therapy

The parents/carers should be made aware of the need to contact the BWCH Consultant once the patient experiences menarche

If a girl attains menarche before 13 years age, they should be managed as per the 13-15 age group

9.3 Female Children 13-15 Years of Age

In young women in this age group, who have potential for future pregnancy, the risk of pregnancy should be assessed prior to each teratogen prescription. If other effective treatments are available, then these should be considered ahead of therapy with a drug of teratogenic potential.

If there are *'compelling reasons to indicate that there is no risk of pregnancy',* information about pregnancy risk should be given, but contraception would not be required. Patients with moderate to severe

learning disability may fall into this category.

The following actions should be taken for existing patients who remain under the care of a BWCH Consultant:

Parents/carers *and the patient* should be made aware that the medicine carries a risk of teratogenicity and this discussion should be documented in the patient records

Patients who have reached menarche should undergo a pregnancy test prior to commencing a medicine of teratogenic potential (unless there are *'compelling reasons to indicate that there is no risk of pregnancy'* - **this should be clearly documented in the patient's clinical records)**

Patients should be reviewed *at least* annually

Patients already taking a medicine of teratogenic potential should undergo formal evaluation to see if the medicine can be discontinued or substituted for an alternative therapy

If there is a concern that a patient in this age group may or has become sexually active, then either contraception should be implemented, or the medicine should be discontinued. (See Appendix E for guidance on contraception effectiveness). Confidentiality of these patients should be respected particularly in discussions about their sex life, but appropriate safeguarding advice should be sought, given the patient's age.

The transition process should be commenced, with a view to formal handover to specialist adult services between 16 and 18 years of age

If there is an unplanned pregnancy then a BWCH Consultant must be available to consult with the patient urgently

9.4 Female Children Aged 16 Years and Older

In young women in this age group, who have potential for future pregnancy, the risk of pregnancy should be assessed prior to each teratogen prescription.

If there are *'compelling reasons to indicate that there is no risk of pregnancy',* information about pregnancy risk should be given, but contraception may not be required. Patients with moderate to severe learning disability may fall into this category.

The following actions should be taken for existing patients who remain under the care of a BWCH Consultant:

Parents/carers *and the patient* should be made aware that the medicine carries a risk of teratogenicity and this discussion should be documented in the patient records

Patients should undergo a pregnancy test prior to commencing a medicine of teratogenic potential (unless there are *'compelling reasons to indicate that there is no risk of pregnancy'* - **this should be clearly documented in the patient's clinical records)**

Patients should be reviewed at least annually

Patients already taking a medicine of teratogenic potential should undergo formal evaluation to see if the medicine can be discontinued or substituted for an alternative therapy

Patients must undergo a formal transition handover to specialist adult services

In girls who are known to be or are felt likely to become sexually active in the near future then contraception should be implemented, or the medicine should be discontinued. (See Appendix E for guidance on contraception effectiveness). Confidentiality of these patients should be respected particularly in discussions about their sex life.

In some female patients requiring treatment with a medicine of teratogenic potential, this may be present in the context of severe neurological disability/global developmental delay; in this case, contraception is likely to be inappropriate and **this should be recorded in the patient records** as *'compelling reasons to indicate that there is no risk of pregnancy'*

If a patient expresses that she is planning on a pregnancy or if there is an unplanned pregnancy then a BWCH Consultant must be available to consult with the patient urgently

10. Patients on Treatment with Medicines of Teratogenic Potential under the Care of Birmingham Women's Hospital

At Birmingham Women's Hospital (BWH), it may be possible that some patients under obstetric care have been continued on a medicine of teratogenic potential during the pregnancy, either intentionally or unintentionally (e.g. unplanned pregnancy). These patients may be under the care of a Consultant Specialist or their GP, who will be responsible for the management of this therapy. Similarly, patients under the care of BWH for termination of pregnancy (TOP) may be identified as being on a medicine of teratogenic potential.

In these cases, the following actions should therefore be taken by the named BWH Consultant:

Determine who is the Prescriber responsible for managing the patient's medicine with teratogenic potential.

- if it is not possible to identify the Prescriber, the patient's GP should be contacted to ensure the actions required below can be completed

In the case of pregnancy:

- if the pregnancy was planned and medicine of teratogenic potential continued due to exceptional circumstances, advise the patient that they must be seen by their Prescriber after the pregnancy for annual review
- if the pregnancy was unplanned, urgently contact the Prescriber to confirm they are aware that the patient has a

confirmed pregnancy whilst on potentially teratogenic therapy and to request an urgent review to see if an alternative therapy may be possible

- an incident report should also be completed, so that the case can be reviewed to identify any learning

In the case of TOP, urgently contact the Prescriber to:

- confirm they are aware that the patient has a confirmed pregnancy whilst taking a medicine of teratogenic potential
- request an urgent review by the Prescriber
- an incident report should also be completed, so that the case can be reviewed to identify any learning

11. Documentation and checking procedure for pregnancy testing

11.1 Privacy and confidentiality must be respected. Ideally the patient has a right to be asked about pregnancy in confidence separate from their parent/carer. Any information disclosed should be used in confidence unless there are overriding safeguarding considerations. It is sometimes difficult to contrive a way to separate patients from their parents/carers to ask sensitive questions, but it may be enough to suggest that as the patient is nearly an adult, there are a couple of questions they may like to answer by themselves in private. The parents/carers may then be asked to leave the room or the patient given the opportunity to move to a private space with the health care professional.

11.2 The practitioner will need to use professional judgment as to whether a young girl is competent to answer questions without a parent/carer or guardian present. If the patient is not considered to be competent to answer such questions, discussion should take place with someone with parental responsibility present.

11.3 For patients with communication difficulties every attempt must be made to overcome the difficulties i.e. interpreting service, sign language.

11.4 An assumption must not be automatically made that a young girl with learning difficulties is not competent to answer questions. Many young people will be competent if information is presented in an appropriate way. There may be a need to include their carer to provide this support.

11.5 In the case of a young patient with severe disability (e.g. severe cerebral palsy), the clinician caring for the patient may consider the possibility of pregnancy to be so remote that neither enquiry nor testing are necessary. This decision must be documented in the medical notes.

11.6 The questioning should be part of a routine assessment process. Prior to any questioning explain that these particular questions which although sensitive are asked routinely of all females in the same age group. The format in which the questioning will take will be to ask the patient if she has started her periods, and if so, when was the date of their last period and whether her periods are regular.

11.7 If the patient has not yet started her periods, record this in the medical notes and proceed with the procedure.

11.8 Patients having a higher risk surgical procedure as detailed in appendix A, will require a routine pregnancy test on the day of surgery. Staff should follow guidance in the flow chart on appendix B.

11.9 Patients having high dose X-ray examinations. After establishing the date of the patient's last period staff should follow the then guidance detailed in flow charts in appendix D.

11.10 Patients starting Chemotherapy or Radiotherapy will require a routine pregnancy test on the day prior to commencing treatment.

11.11 For all other surgical procedures and low dose X-ray examinations if the patient's last menstrual period falls within the last 30 days continue with the Surgery/procedure and clearly document the date of her last menstrual period.

11.12 If the patient's last menstrual period was more than 30 days or they have missed a period before the prosed procedure, they should be asked if there is any possibility they could be pregnant, qualifying this by asking if they are sexually active in a way which could result in pregnancy. They might also be asked at this stage whether they are they taking oral contraceptive medication.

11.13 If the patient reveals a possibility of pregnancy, as yet undetected or disclosed a discussion with the relevant Consultant should take place for consideration of postponement. This will be dependent on clinical need and patient history. To continue the patient should be asked if she will provide a urine sample and her consent gained for a pregnancy test.

If questioning reveals pregnancy is unlikely, the Consultant may decide no further intervention is necessary and this should be clearly documented in the medical notes.

11.14 If the patient has missed a period, a negative pregnancy test on the day of the procedure can be accepted as excluding pregnancy only in consultation with the relevant Consultant. Practitioners must be aware that urine pregnancy tests may give false negative results in early pregnancy (between 14 and 28 days of the last menstrual period for a 28 day cycle)

If a pregnancy test is requested by the Consultant, prior to any questioning, a verbal explanation of the policy will be given to the patient and their consent has to be obtained. An information leaflet will also be given .Staff should assess if the patient is deemed to be Gillick Competent. If she is not, a discussion should take place with the senior person in charge. If the patient refuses to consent all reasonable efforts should be made to encourage her.

11.15 The patient will be asked to provide a urine sample. All reasonable adjustments need to be made to assist a patient with a physical disability or learning disability in providing a urine sample. The actual test on the sample will be performed by either by staff from the Emergency Department or by the laboratory staff in Microbiology, dependent upon the particular situation.

11.16 The reliability of the test can be affected by some drugs. All requests being sent to Microbiology or ED for pregnancy testing should clearly state what medication the patient may have taken and when.

11.17 In the event that the patient refuses to give a urine sample, the Clinical team must discuss whether they are willing to proceed with the proposed surgery with an unconfirmed pregnancy status, or whether the procedure should be postponed. Advice can be sought from Legal Services during office hours or out of hours direct from the Trust solicitors.

11.18 The result of the urine test should be clearly documented in the medical notes.

11.19 In all reported/disclosed cases of sexual activity of a patient aged 13 years or younger, the named nurse or doctor for safeguarding must be informed, and safeguarding procedures will be followed, irrespective if the act was consensual or not. Follow Birmingham Safeguarding Children's Board protection policies and procedures – Section 28.

11.20 In cases of sexual activity in patients aged between 14 and 16years of age, consideration should be given to discuss the case with the named nurse or doctor for child protection. If a decision is made to make a referral to Social Care Services, the practitioner should discuss this with the patient to try to obtain their agreement to pass the information on. However, if the practitioner believes that the health, safety or welfare of the patient is at risk, then they have a duty to disclose the information, but must inform the patient of these actions. Follow Birmingham Safeguarding Board child protection policies and procedures – Section 28.

11.21 The Consultant should be informed immediately of a positive test result and should meet with the patient, with the support of her named nurse, to discuss the result and the implications for the proposed procedure.

11.22 Practitioners should explore the benefits to the patient of confiding in her parents/carers or another trusted member of her family who can support her. If the patient feels that she will be at risk of physical danger if her parents/carers were informed, this must be discussed with a safeguard professional on duty before she is discharged.

11.23 The clinician caring for the patient must make sure appropriate advice is given regarding pregnancy management and advise her that her General Practitioner will be informed. The patient must be given the opportunity to express an opinion on this and where indicated, give

her consent. If the patient refuses, all reasonable efforts should be made to persuade the patient that it is in her best interests to do so, in order to ensure continuity of care for her and to enable the GP to provide care for her on an informed basis.

However, if she continues to refuse to allow her GP to be informed and she is aged 13 years or under or the practitioner considers it to be in the best interest of the young person or the public, the GP should be informed in writing, and the young person advised of this action.

11.24 A record of the communication with the patient and GP and any actions taken, must be documented in the health records

11.25 Staff should respect the patient's right to confidentiality and must not disclose any information to her parents/carers without consent.

12 References

Pre- procedure pregnancy checking in under 16s: guidance for Clinicians (2012) Royal college of Paediatrics and Child health.

Protection of Pregnant patients during Diagnostic Medical Exposures to Ionising radiation (2009) Advice from the Health Protection Agency, The royal college of radiologists and the College of Radiographers.

Checking Pregnancy before Surgery. (2010) National Patients Safety Agency

Pregnancy assessment/testing in teenage and young adult females. (2015) TYAC.. Teenagers and Young Adults with Cancer.

National Institute for Health and Clinical Excellence.(2010) Preoperative tests: the use of preoperative texts for elective surgery. NICE London.

Best Practice Guidance on Pregnancy Testing (2006) Royal College of Nursing

Child Protection Procedures Section 13 – Young people who are Sexually Exploited and Abused. Birmingham Safeguarding Children's Board (2007)

ISA Interagency protocol for Information Sharing (2005) Birmingham City Council

National Service Framework for Children, Young People and Maternity. Services (2004) Department of Health.

Secondary schools SRE and Sexual Health Services Birmingham Health Education Unit.

Sexual Health Education guidelines for Youth Workers (2006) Birmingham Youth Services

Teenage Pregnancy: Working Towards 2010. Good practice and Self-assessment Toolkit (2006) Department for Education and Skills – Department of Health

13. Approval, Dissemination and Implementation

13.1 Approval of document

Approval for this policy will be sought from the Policy Review Group

13.2 Training

All staff will require training in Safeguarding. Staff will attend the Trust mandatory safeguarding training programme.

All staff will require training in confidentiality. Information Governance Training forms part of the Trusts mandatory training programme therefore all staff are required to attend.

Training will be provided using a cascade system following a presentation to the Ward Sisters and Lead Nurses. Lead Nurses and Ward sisters will cascade the implementation of policy to the ward teams. Department leads and Clinical leads will cascade the implementation of policy to their teams.

The trust annual training needs analysis will identify clinical staff's sexual health training requirements.

All staff will have access to the Policy on the trust Intranet

13.3 Dissemination

This policy will be disseminated throughout the Trust to all relevant Trust staff using the following strategy

13.3.1 Addition of the document to the Trust Intranet available in the Trust policy documents

13.3.2 Communication via email to all Trust Clinical staff

13.3.3 Notification via the Trust Intranet Web site

13.3.4 Presentation to the Ward Sisters and Lead Nurses

13.4 Implementation

Distribution to all senior staff via email

14. Monitoring Compliance With and the Effectiveness of the policy

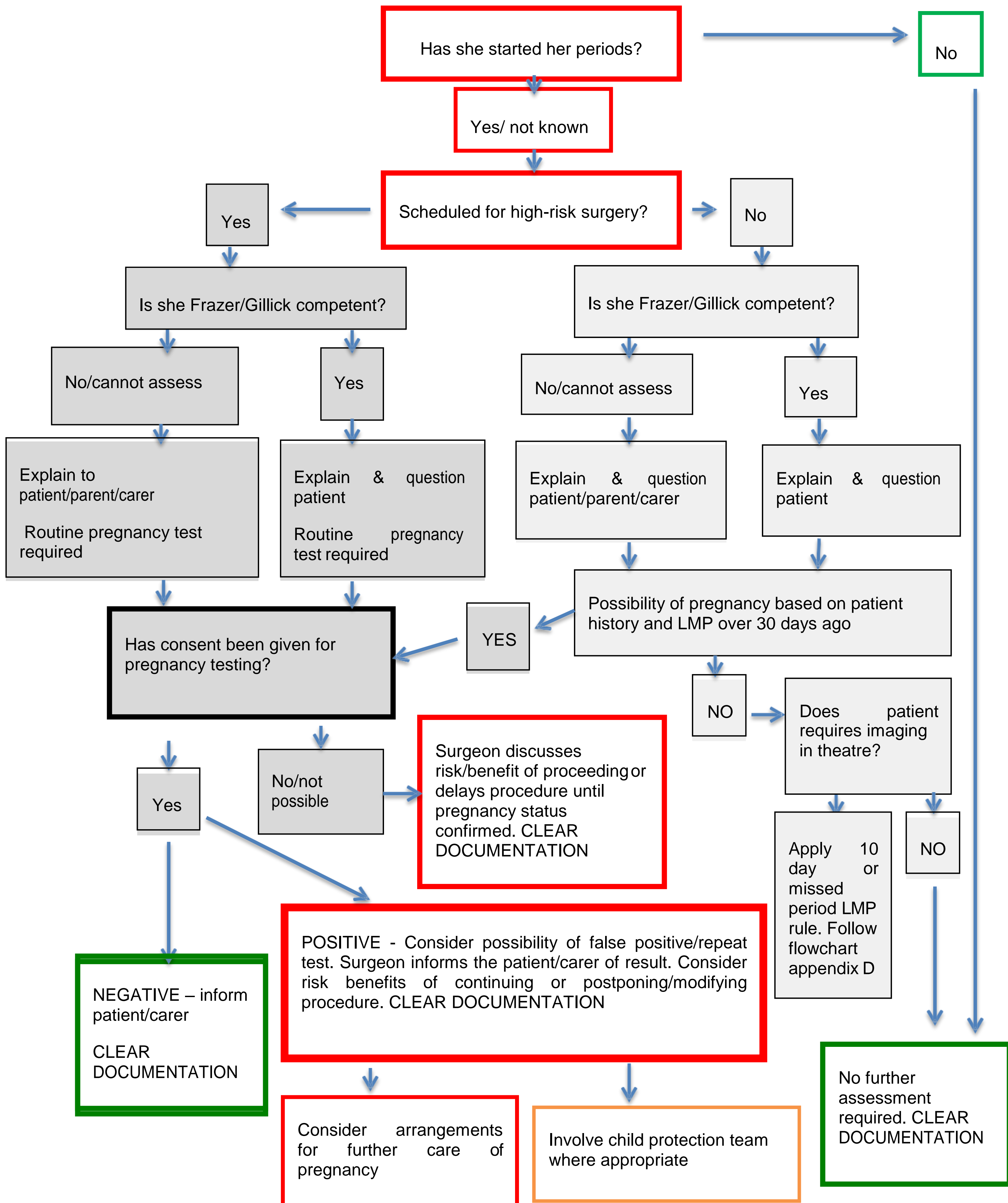
Policy compliance and effectiveness will be monitored through Annual Audit which will be led by the Corporate Nursing Team. The results of this audit should be reported to the Senior Operational Nurses Group and feedback will be given to Training and Education Department. Any risks should be highlighted by exception to the Clinical Safety & Quality assurance Committee. Any issues of non-compliance with this policy should be reported via the incident reporting system and trends monitored by Governance and reported by exception to Clinical safety & Quality Assurance Committee

Appendix A

HIGHER RISK SURGICAL PROCEDURES

Abdominal surgery
Gynaecological surgery
Any intra – peritoneal operation including laparoscopy
Scoliosis/lumbar posterior correction and fusion surgery (due to radiological positioning techniques0
Cardiac surgery
Cardiopulmonary bypass
Transplantation
Renal dialysis access
Renal Biopsy's

Appendix B. Flowchart for checking pregnancy status in girls of childbearing age who attend for surgery



Appendix C

CLASSIFICATION OF RADIOGRAPHIC EXAMINATION INTO HIGH DOSE OR LOW DOSE PROCEDURES

High Dose Examinations **Apply 10 Day Rule**	**Low Dose Examinations** **Apply Missed Period Rule**
Plain Film	
	XR Femur
	XR Pelvis/Hips and lateral
	XR Abdomen
	XR Spine
Fluoroscopy	
	Barium Swallow
	Barium Meal
	NG/NJ/GJ Tube Insertion
	Screening Femur-Diaphragm
	Barium Follow-through
	Small Bowel Enema
	Barium Enema (Paediatrics only)
	IVU
	MCUG
	Screening pelvis/lumbar region
	Urodynamics
Theatre	
Angiography	Cholangiogram
Cardiac Catheterisation	Retrograde Pyelogram
Interventional Radiology	Renal Biopsy under X-Ray control
Screening Pelvis/Lumbar Region	Line Insertion (if below diaphragm)
	OGD (if below diaphragm)
	Screening Femur-Diaphragm
CT	
CT Abdomen and pelvis	CT Head and/or neck
CT Pelvis/Hips	
Nuclear Medicine	
	All nuclear medicine procedures carried out at BCH are low dose and therefore the missed period rule is applied*

*** For Oncology ^{51}Cr EDTA GFR examinations ONLY, the 28 day rule need not be applied.**

The maximum dose of 51Cr EDTA administered is 1.85MBq which gives an effective dose (ED) of 0.0037mSv and a dose to the uterus of 0.005mGy

Under these circumstances the dose and risk in the event of an unknown pregnancy are so small that the exposure would still be justified. The 28 day rule that would otherwise be used need not be applied

All oncology patients who are currently or have recently received a course of chemotherapy will have undergone counselling regarding pregnancy. It is thought sufficient to extend this to 51Cr EDTA investigations. It has been agreed between The nuclear medicine practitioner/AR(SAC) and the clinical service lead for oncology that these investigations can be arranged whenever clinically required.

Appendix D

Flowchart for checking pregnancy status for female patients aged 12-55 years (age range extended when necessary and appropriate) prior to X-ray/diagnostics