Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Correspondence

Provisions for obstetrics and gynaecology - *Letter to the editor on* "impact of the coronavirus (COVID-19) pandemic on surgical practice - Part 2 (surgical prioritisation)": A correspondence

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Dear editor,

We read with great curiosity the article by Al-Jabir et al. on the impacts of the novel COVID-19 pandemic on surgical practice. The article highlighted updates in surgical guidelines, ubiquitous modifications to practices and the impact of delayed surgery on surgical outcomes.

In this letter, we lay out proposed changes to guidelines of antenatal care and gynaecological surgery and provide an insight into the disproportionately negative experiences of black and minority ethnic (BAME) women regarding obstetrics and gynaecology services during the COVID-19 pandemic [1].

The COVID-19 outbreak emerged and escalated in a relatively short space of time, meaning that many pregnancies were already underway as measures were put in place to limit transmission. Pregnancy is often an anxiety-inducing time for many women in usual circumstances, particularly primiparous women.

The outbreak of Severe Acute Respiratory Syndrome (SARS) in 2002 was associated with a high incidence of perinatal morbidity and mortality, with studies reporting maternal death rates as high as 25% due to infection in pregnancy. With current evidence, it appears that COVID-19 does not disproportionately affect pregnant women, though Public Health England (PHE) declared pregnant women to be a 'high risk group' as a precautionary measure.

Despite this, at least one study has highlighted an increased risk of preterm birth in pregnant women testing positive for COVID-19. However, case reports appear to suggest that the majority are iatrogenic, performed over 28 weeks gestation to preserve maternal health. As of yet, it is unclear whether increased neonatal morbidity will occur as a result [2,3].

The World Health Organisation (WHO) guidelines recommend a minimum of 8 face-to-face antenatal clinic visits, facilitating the monitoring of health via blood pressure measurement and urine sampling, alongside establishment of rapport between the woman and her caregiver to encourage healthy communication about any issues that may arise during the pregnancy. The new Royal College of Obstetricians and Gynaecologists (RCOG) guidelines recognises the importance of face-to-face contact and retains that a minimum of 6 physical attendances should be made to antenatal clinic to reduce perinatal morbidity, with a number of additional appointments done remotely via telephone or video calling [3].

Evidence recognises that BAME individuals are at greater risk of developing severe and life-threatening complications of COVID-19. Hence, it is critical to consider implications of reorganising maternity services for vulnerable patients who may already face barriers accessing maternal care. In response to concerns, the Royal College of Midwives (RCM) have lowered diagnosis threshold for investigating symptoms, consolidating their awareness of increased risk to BAME women. Prior to the COVID-19 outbreak, BAME women were five times more likely to die from complications related to pregnancy and childbirth. Additionally, BAME women constituted 55% of hospitalisations during pregnancy related to COVID-19 in the UK, suggesting widening inequalities of outcomes related to pregnancy and birth. In response to disproportionately negative maternal care experience of BAME women, the RCM and RCOG have worked to raise awareness of ongoing maternal services and access to facilities where available [2,3].

From a gynaecological perspective, current evidence suggests that COVID-19 is not present in genital fluid, and gynaecological surgery does not appear to increase risk of transmission to clinicians beyond expected risk. Surgical procedures for gynaecological conditions are being prioritised based on immediate clinical need, similar to that seen in other specialties. With regard to non-urgent operations, priority is given to oncological procedures with expectations to cure.

Non-surgical methods of treatment are recommended where possible, such as the insertion of an LNG-IUS for early stage uterine cancer and deferral of hysterectomy, to limit pressure on surgical services. Chemotherapy and radiotherapy should be increasingly utilised as primary treatment options for gynaecological neoplasms where permitted. There has been a cessation of newly initiated fertility treatment, justifiable with regards to lack of immediate clinical need, however implications may arise for women nearing the age cut-off to meet local funding criteria. Time-sensitivity is also an important factor in abortion

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services, which remain an essential healthcare need. Where surgical termination of pregnancy is required and deferral would result in gestational cut-offs being exceeded, RCOG advises procedures to take place regardless of COVID-19 infection status with appropriate infection prevention and control measures in place, if safe considering the patient's clinical condition [4,5].

The COVID-19 outbreak is having a far reaching and disproportionate impact on the most vulnerable individuals of society, in turn causing considerable psychological sequelae. Whilst essential obstetrics and gynaecology services continue, deviation from standard maternal and gynaecological care may heighten anxiety amongst those most in need of these services.

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