Mersey and West Lancashire Teaching Hospitals NHS Trust

Guideline for the Management of Chickenpox (Varicella) in Pregnancy

Version No: 1

Document Summary:
Chickenpox (or primary VZV infection) is a common childhood disease that usually causes a mild infection, such that over 90% of the antenatal population in the UK and Ireland are seropositive for VZV immunoglobulin (IgG) antibody. For this reason, although contact with chickenpox is common in pregnancy, especially in women with young children, primary VZV infection is uncommon; it is estimated to complicate three in every 1000 pregnancies.

Document status	Approved	
Document type	Guideline	**local**
Document number	PD0496	
Maternity code	C015	
Approving body	Obstetrics & Gynaecology Clinical Governance and Quality Group	
Date approved	29/01/2025	
Date implemented	12/02/2025	
Review date	**31/01/2028**	
Accountable Director	Director of Nursing, Midwifery & Governance	
Policy Author	Consultant Obstetrician and Gynaecologist (Whiston) and Consultant Obstetrician and Gynaecologist (Ormskirk)	
Target audience	Specific staff group	

The intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as "uncontrolled", as they may not contain the latest updates and amendments.

Document Control

[Author to complete all sections apart from Section 4 & 5]

Section 1 – Document Information	
Title	Guideline for the Management of Chickenpox (Varicella) in Pregnancy
Directorate	Surgical
Brief Description of amendments:	
This guideline supersedes Version: 8	
Does the document follow the Trust agreed format?	Yes
Are all mandatory headings complete?	Yes
Does the document outline clearly the monitoring compliance and performance management?	Yes
Equality Analysis completed?	Yes

Section 2 – Consultation Information			
Consultation Completed	☐ Trust wide ☐ Local ☑ Specific staff group		
Consultation start date	09/10/2024	**Consultation end date**	29/01/2025

Section 3 – Version Control

Version	Date Approved	Brief Summary of Changes
1		New guideline
2	Oct 2009	Reviewed and reformatted into the Trust Policy on Policies Format
3	April 2013	Reviewed the guideline and reformat into the Trust Document Control Policy Format
4	Jan 2016	Reformat the guideline into the Trust Policy on Policies Format
5	April 2019	Reformat the guideline and full review, RCOG guidance not yet published but recommendations from Public Health England document re-supply shortage of Varicella Zoster Immunoglobulin (VZIG) included in the guideline. Consulted with Dr Kalani Mortimer in the Laboratory.
6	February 2022	Reformat and review guideline: Appendix 2 amended to clarify the management of the neonate, taken from the Trust guideline for management of Chickenpox as suggested by Dr Kalani Mortimer.
7	July 2022	Guidelines on post exposure prophylaxis (PEP) for varicella/shingles (April 2022) recently launched amendments made to update the management. Amendments made to the guideline by Dr Mortimer and changes made to amend the appendices and create a 3rd appendix to make the management clearer.
8	August 2022	Further amendments by Dr Mortimer, Consultant Medical Microbiologist, to clarify the management of mothers and babies. Removal of Appendix 3 as duplication of section 6.9.3
9 1PD	January 2025	Updated by Consultant Mr Trent Corr following advice from Kalani Mortimer Consultant Medical Microbiologist that the VZ post exposure prophylaxis for neonates exposed to VZV has changed in the publication Guidelines on post exposure prophylaxis (PEP) for varicella or shingles (September 2024) - GOV.UK (www.gov.uk). Reviewed by Sreebha Rajesh, Consultant (Ormskirk site) and contact details added to the flowchart in Appendix 1 for the ANC coordinator and maternity bleep holder for the Ormskirk site. **This is now a harmonised Guideline. Approved at the Drugs and Therapeutic Group Meeting on 23rd Jan 2025.**

Section 4 – Approval – *To be completed by Document Control*			
Document Approved	☐ Approved ☑ Approved with minor amendments		
Assurance provided by Author & Chair	☐ Minutes of Meeting ☑ Email with Chairs approval		
Date approved	29/01/2025	**Review date**	29/01/2028

Section 5 – Withdrawal – *To be completed by Document Control*	
Reason for withdrawal	☐ No longer required ☐ Superseded
Assurance provided by Author & Chair	☐ Minutes of Meeting ☐ Email with Chairs approval
Date Withdrawn:	Click here to enter a date.

Contents

Document Control 2
1. Scope 6
2. Introduction 6
3. Statement of Intent 7
4. Definitions 7
5. Duties, Accountabilities and Responsibilities 8
5.1 Chief Executive 8
5.2 Director of Nursing, Midwifery and Governance 8
5.3 Clinical Director and the Obstetrics Team 8
5.4 Head of Midwifery 8
5.5 Audit and Guideline Development Midwives 8
5.6 Matrons 8
5.7 Ward Manager/Clinical Manager 8
5.8 All Staff 8
6. Management of Chickenpox in Pregnancy (Varicella) 9
6.1 Update on Advice to Health Professionals on post exposure prophylaxis (PEP) for varicella/shingles (October 2024) 9
6.2 Infectious period and routes of transmission 9
6.3 Management of a pregnant woman who has been in contact with chickenpox 9
(See Appendix 1) 9
6.3.1 Booked 10
6.3.2 Unbooked 11
6.4 Results 11
6.4.1 Immune 11
6.4.2 Not immune 11
6.5 Management of a pregnant woman who develops chickenpox between 20 weeks and Term 12
6.5.1 Treatment 12
6.6 Admission criteria 12
6.7 Less than 20 weeks + 1 day gestation and chickenpox diagnosed 12
6.7.1 Antenatal 13
6.8 When and how should the woman with chickenpox be delivered? 13
6.8.1 The timing and mode of delivery of the pregnant woman with chickenpox must be individualised. 13
6.9 Potential side effects of aciclovir and valaciclovir 13
6.9.1 Contraindications and precautions to aciclovir and valaciclovir 13
6.10 Postnatal 13

6.10.1 Chickenpox in mother diagnosed at or around the time of delivery 13
6.10.2 If baby born within 7 days of onset of chicken pox rash in the mother:..... 14
6.10.3 VZV (chickenpox or shingles) CONTACT within 7 days of life with someone other than the mother 14
6.11 Women with chickenpox should breastfeed if they wish to and are well enough 15
7. Training, Equipment / Medication Requirements 15
8. Monitoring Compliance 15
8.1 Key Performance Indicators (KPIs) of the Policy 15
8.2 Performance Management of the Policy 15
9. References 16
10. Related Trust Documents 16
11. Equality Analysis Form..... 17
Data Protection Impact Assessment Screening Tool..... 20
12. Appendix 1 Management of pregnant women in CONTACT with chickenpox 21
13. Appendix 2 Management of a pregnant woman who develops chickenpox 22

1. Scope

This guideline applies to all staff working in maternity services.

2. Introduction

Chickenpox (or primary VZV infection) is a common childhood disease that usually causes a mild infection, such that over 90% of the antenatal population in the UK and Ireland are seropositive for VZV immunoglobulin (IgG) antibody. For this reason, although contact with chickenpox is common in pregnancy, especially in women with young children, primary VZV infection is uncommon; it is estimated to complicate three in every 1000 pregnancies. Women from tropical and subtropical areas are more likely to be seronegative for VZV IgG and are therefore, more susceptible to the development of chickenpox.

Chickenpox infection during the first 20 weeks of pregnancy can lead to fetal varicella syndrome, which includes microcephaly, cataracts, growth retardation limb hypoplasia, and skin scarring. Chickenpox can cause severe maternal disease and this risk is greatest in the second or early in the third trimester.

The rationale for Post exposure prophylaxis (PEP) in pregnant women is two-fold: reduction in severity of maternal disease and theoretical reduction in the risk of fetal infection for women contracting varicella in the first 20 weeks of pregnancy. In late pregnancy, PEP may also reduce the risk of neonatal infection. However, given the risks of severe neonatal varicella in the first week of life, intravenous immunoglobulin (Varitect CP or IVIG) and intravenous anti-virals are given to infants born within 7 days of onset of maternal varicella.

In the absence of PEP, the risk of developing varicella in susceptible contacts is high with 13 of 18 (72%) of seronegative pregnant women developing varicella following a significant exposure.

The primary infection is characterised by fever, malaise and a pruritic rash that develops into crops of maculopapules which become vesicular and crust over before healing. The incubation period is 1-3 weeks and the disease is infectious 48 hours before the rash appears and continues to be infectious until the vesicles crust over. The vesicles will usually have crusted over within 5 days.

Following the primary infection, the virus remains dormant in sensory nerve root ganglia but can be reactivated to cause a vesicular erythematous skin rash in a dermatomal distribution known as herpes zoster (HZ), or simply zoster or shingles.

Women who have not had a past history of chickenpox, or are known to be seronegative for chickenpox, should be advised to avoid contact with chickenpox and shingles during pregnancy and to inform their midwife of a potential exposure without delay (RCOG Green-top Guideline No.13).

3. Statement of Intent

To provide comprehensive guidance on how to manage women who come into contact with chickenpox and the management options available when women develop chickenpox at different stages of pregnancy.

4. Definitions

Definition	Meaning
Chickenpox (Varicella)	VZV is a DNA virus of the herpes family that is highly contagious and transmitted by respiratory droplets and by direct personal contact with vesicle fluid or indirectly via fomites.
IVIG	Is a concentrated preparation of antibodies derived from healthy non-UK blood donors. It is administered intravenously to exposed individuals at high risk of severe complications who are known to be susceptible to chickenpox. These groups are immunosuppressed individuals, neonates in the first week of life, and pregnant women.
PEP	Post exposure prophylaxis

5. Duties, Accountabilities and Responsibilities

5.1 Chief Executive

The Chief Executive has overall responsibility for the strategic and operational management of the Trust including and ensuring that this guideline complies with all legal, statutory and good practice guidance requirements and is implemented effectively and efficiently.

5.2 Director of Nursing, Midwifery and Governance

The Director of Nursing Midwifery and Governance is the Accountable Director for this Guideline.

5.3 Clinical Director and the Obstetrics Team

The Clinical Director and his/her team has primary responsibility for the care of high risk women attending Maternity Services, and will ensure that all aspects of the woman's care is effectively communicated to the woman, using this guideline if necessary. The team will also communicate with other specialities when there is a clinical indication which requires this.

5.4 Head of Midwifery

The Head of Midwifery is accountable to the Trust Board for assuring compliance with this guideline within maternity services.

5.5 Audit and Guideline Development Midwives

The Audit and Guideline Development Midwives are responsible for ensuring that the guideline/policy/standard operational procedure are reviewed and updated by the specified review dates. Where appropriate the documents will be circulated for comments within and outside of maternity services. The Drugs and Therapeutic Group will be asked for their approval where drugs are referred to in these documents.

5.6 Matrons

The Matrons within maternity services are responsible for ensuring clarity and compliance with training requirements for this guideline, supported by the Clinical Practice Educator.

5.7 Ward Manager/Clinical Manager

The ward manager is responsible for ensuring that all staff working in their clinical areas are fully aware of their responsibilities within this guideline and any specific pathways that are available.

5.8 All Staff

All staff are responsible for ensuring they are familiar with Trust procedural documents and local procedural documents. Staff are aware that up to date clinical guidelines are available on the intranet and in hard copy files in Delivery Suite only.

6. Management of Chickenpox in Pregnancy (Varicella)

6.1 Update on Advice to Health Professionals on post exposure prophylaxis (PEP) for varicella/shingles (October 2024)

In summary, antivirals are now recommended for post-exposure prophylaxis for all at risk groups.

In 2023, UKHSA were informed that the major supplier of VZIG was ceasing production and that the intramuscular product would no longer be available after September 30th 2024. Therefore, susceptible neonates exposed within one week of delivery (either in utero or post-delivery), should be treated with both intravenous immunoglobulin (Varitect CP or IVIG) and intravenous anti-virals.

A small supply of Varitect has now been centrally procured by UKHSA. The *UKHSA Guidelines on post exposure prophylaxis for varicella or shingles* and the Varicella Green Book chapter have been updated with this new advice. Local issuing centres that hold VZIG stock have also been made aware of this change. This advice is likely to be relevant to a very small number of exposures, estimated to be fewer than 20 cases per year across the country.

6.2 Infectious period and routes of transmission

Chickenpox infection is transmitted from person to person primarily by inhalation of aerosols from or direct contact with vesicular fluid from varicella or herpes zoster lesions, although transmission may occur if infected respiratory tract secretions are aerosolised. Although historically, the infectious period for chickenpox was generally considered as being from 48 hours before, to 4 to 7 days after, onset of rash, *a recent review suggested that transmission rarely occurs before the onset of rash, and may continue until all the lesions have crusted over.*

In immunocompetent individuals, as a general rule the infectious period the time should be taken as being from 24 hours prior to rash onset to 5 days after rash. For immunosuppressed individuals, it is harder to generalise and therefore the infectious period should be taken from 24 hours prior to rash onset until all lesions have crusted over.

Shingles infection is primarily transmitted by direct contact with vesicle fluid in immunocompetent individuals but may be transmitted via infected respiratory secretions from immunosuppressed patients. The infectious period for localised and disseminated shingles is considered as the time from onset of rash until all of the lesions have crusted over.

6.3 Management of a pregnant woman who has been in contact with chickenpox (See Appendix 1)

Significant exposure is e.g. contact with chickenpox (***from 24 hours*** before onset until lesions have crusted which is usually 5 days) or with shingles which is disseminated or uncovered or in an immunocompromised person in the same room for at least 15 minutes or any face-to-face contact.

The first day of exposure is defined as the date of the onset of the rash if the index is a household contact and date of first or only contact if the exposure is on multiple or single occasion(s) respectively.

Ask the woman if she has had chickenpox:

- If she has **had** chickenpox/shingles or 2 doses of varicella vaccine, reassure her that she is immune and advise her to contact her GP if a rash develops. **Do not test for VZV I g.**

- If she has **not** had chickenpox/shingles or 2 doses of varicella vaccine or is uncertain, check that she has booked and **test for VZV IgG.**

In addition ask:

i) The exact details of the nature of the contact i.e. who was the contact with (including whether that person is immunocompromised), when and how long for:
ii) The date of the onset of the rash in the contact and how (or who) has confirmed that the diagnosis in the contact is either chickenpox or shingles.

- ***If the contact has shingles ask:***
  i) Where on the body the lesions were/are present.

This information is essential to determine whether the exposure is significant and therefore to determine whether the patient requires immunoglobulin prophylaxis in the event the patient is not immune to chickenpox.

History	**Testing**	**Treatment**
A history of chickenpox/ shingles OR 2 recorded doses of varicella vaccine.	Do not test.	Assume immune. No need for PEP.
Uncertain or no history of chickenpox/ shingles AND Unknown or negative varicella vaccine history	Test antenatal booking bloods* (if available) for VZV IgG.	If VZV IgG positive – reassure, patient is immune, do not issue PEP. If VZV IgG negative or equivocal on a qualitative assay, retest with a confirmatory quantitative assay ***which will be done by the Manchester virology reference laboratory.*** If quantitative assay is ≥100 mIU/ml – reassure, PEP is not indicated. If the result from quantitative testing will not be available within 10 days of exposure, AND the individual is VZV IgG negative (qualitative testing) then treat with antivirals. If the result from quantitative testing will not be available within 10 days of exposure, AND the individual is VZV IgG equivocal (qualitative testing) then PEP is not recommended.
*For women with an uncertain or negative history of chickenpox, antenatal booking bloods should be tested unless there is a recorded chickenpox exposure in this pregnancy, in which case a fresh sample should be taken for testing if the booking sample is negative.		

6.3.1 Booked

If the woman has been booked, contact Whiston Microbiology Laboratory on 0151-430-1695 (or 0151-430-1837) and inform them that urgent VZV IgG testing is required on the booking sample

as the woman has had a chicken pox contact in pregnancy. In addition, please provide name and contact number of the member of staff who the result of the test should be communicated to in the event the woman is not immune. All communication with the woman will be documented on Medway.

6.3.2 Unbooked

The woman should be asked to attend the ANC for a blood test to ascertain her immunity. The reason for the test is explained and consent is obtained from the woman. Document the discussion on Medway.

The blood sample is sent in a brown bottle and is accompanied by a microbiology form, requesting "Varicella-Zoster immunity (IgG)" and identifying date of contact. The clinical details must include that the test is URGENT and that the patient has had contact with chickenpox in pregnancy and the contact details of the member of staff who the result of the test should be communicated to in the event the woman is not immune. The Microbiology department should be contacted as soon as the sample is available to ensure it is processed urgently.

Do not include requests for urgent VZV IgG testing with routine antenatal test requests for the same patient or tests being sent to other departments such as Biochemistry or Haematology. A separate sample with its own request from must be sent to Microbiology for such requests.

6.4 Results

The results are usually available within 24 hours and reported, the telephone number to contact is - Antenatal Clinic Co-ordinator, Ext. 1493 or 1527 or out of hours the Maternity Bleep holder can be contacted via switchboard or on bleep number 7472. These staff members will have access to hardcopy records and patient details via the electronic patient record Medway. The Antenatal Clinic Co-ordinator or the Maternity Bleep holder OR ANY STAFF MEMBER can access Careflow for results.

6.4.1 Immune

If the woman is varicella immune the antenatal co-ordinator or the maternity bleep holder (out of hours) will contact the woman and reassure her and document the discussion on Medway. See 6.3

6.4.2 Not immune

- For susceptible women, oral aciclovir at 800mg four times a day from days 7 to 14 after exposure is recommended. Valaciclovir 1000mg three times a day from days 7 to 14 after exposure can be used as a suitable alternative.

- If the woman presents later than day 7 after exposure, a 7-day course of antivirals can be started up to day 14 after exposure, if necessary.

- As oral aciclovir and valaciclovir are not licensed for use in pregnancy, their use for women exposed after 20 weeks would be 'off label'. Clinicians are able to prescribe medicines outside the terms of the licence when it is in the best interest of the patient on the basis of available evidence. This evidence has been considered and recommended by the Public Health England expert working group.

6.5 Management of a pregnant woman who develops chickenpox between 20 weeks and Term

- The woman should be advised **NOT** to attend the maternity unit unless absolutely necessary (see admission criteria 6.6)
- **If the woman presents at the Emergency Department she should NOT be transferred to the maternity unit unless obstetrically necessary (see admission criteria).**
- There is no need for testing the booking blood for VZV IgG if a pregnant woman develops chicken pox or shingles. If there is uncertainty about the clinical diagnosis, send a swab in viral transport medium for VZV PCR from a vesicle.

6.5.1 Treatment

- If the woman has had the rash for less than 24 hours, she should be prescribed oral aciclovir, 800 mgs, 5 times per day for 7 days. (NOTE: if less than 20 weeks + 1 day gestation, discuss with a Consultant Obstetrician).
- Advice regarding symptom relief e.g. Paracetamol, calamine lotion, plenty of oral fluids, should also be given.
- If she has had the rash for longer than 24 hours, aciclovir is not indicated, but advice about symptom relief must be given.
- The woman must be advised to attend her GP ASAP if her symptoms worsen.
- Symptomatic treatment and hygiene is advised to prevent secondary bacterial infection of the lesions.
- Women should be advised to avoid contact with susceptible individuals; that is, other pregnant women and neonates, until the lesions have crusted over. This is usually about 5 days after the onset of the rash.

6.6 Admission criteria

- Respiratory symptoms suggestive of possible pneumonia
- Systemic toxicity (headaches, vomiting, drowsiness)
- Haemorrhagic rash / bruising
- Neurological symptoms
- **Admission is to the Postnatal Ward (24 – 40+ weeks) or Medical Ward before 24 weeks gestation**
- **NOTE:** In these situations Intravenous (IV) aciclovir will be required 10mg/kg 8 hourly.
- The woman needs to be ***isolated and barrier nursed***. If the woman is admitted to a Medical ward she must be reviewed regularly by the Obstetric team.

6.7 Less than 20 weeks + 1 day gestation and chickenpox diagnosed

- There is no need for testing the booking blood for VZV IgG. If there is uncertainty about the clinical diagnosis, send a swab in viral transport medium for VZV PCR from a vesicle as well as a new sample of serum for VZV IgM giving the appropriate clinical details.

Additional management must include:

6.7.1 Antenatal

- A detailed ultrasound scan 5 – 6 weeks post rash
- Complete Paediatric Alert Form to notify Paediatricians and Neonatal Unit

6.8 When and how should the woman with chickenpox be delivered?

6.8.1 The timing and mode of delivery of the pregnant woman with chickenpox must be individualised.

- When epidural or spinal anaesthesia is undertaken in women with chickenpox, a site free of cutaneous lesions should be chosen for needle placement.
- There is no evidence available to inform decisions about the optimum method of anaesthesia for women requiring delivery by caesarean section.
- Cord blood sampling - Brown bottle and Virology form requesting "varicella-zoster virus IgM" antibody and ***provide relevant clinical details of maternal history of chickenpox and at what gestation.***

6.9 Potential side effects of aciclovir and valaciclovir

The most commonly reported side effects from aciclovir include dizziness, headache, nausea, vomiting, diarrhoea, abdominal pain, skin rashes, photosensitivity, pruritus, urticaria and fatigue. Further information about side effects on aciclovir and valaciclovir are available in the BNFs.

6.9.1 Contraindications and precautions to aciclovir and valaciclovir

In individuals with renal impairment or intestinal malabsorption, for example inflammatory bowel disease, a bolus dose of IVIG may be considered. The dose of aciclovir may need to be adjusted in patients with renal impairment. Individuals with glomerular filtration rates less than 10 mL/minute/1.73m2 may need the frequency or dose altered (please see BNF).
If IVIG is considered, it is important to demonstrate that the patient will benefit from the blood product by demonstrating that they are sero-negative with VZV IgG antibody levels < 150 mIU/ml for immunosuppressed patients and < 100 mIU/ml for pregnant women. For immunosuppressed patients only, if time does not permit quantitative testing, a qualitative test must be performed and shown to be negative or equivocal. Similarly for pregnant women who are unable to take antivirals due to renal impairment, intestinal malabsorption or hyperemesis, if time does not permit quantitative testing, a qualitative test must be performed and shown to be negative.

6.10 Postnatal

Refer to paediatrician for follow up that will include:

- An ophthalmic examination
- A blood sample will be requested for varicella-zoster virus IgG antibody at 7 months of age.

6.10.1 Chickenpox in mother diagnosed at or around the time of delivery

- Defer delivery, where possible, until 5-7 days after onset of rash to allow for the passive transfer of antibodies from mother to baby.
- If delivery is 7 days before rash or 7 days after rash the infant does not require specific treatment.

- The mother and baby should be nursed in an isolation room on the Postnatal Ward. Care should only be undertaken by staff who are varicella-zoster immune.

- Transfer mum & baby home as soon as possible.

6.10.2 If baby born within 7 days of onset of chicken pox rash in the mother:

- Complete Paediatric Alert Online to notify Paediatricians and Neonatal Unit

- Give baby intravenous antivirals and intravenous immunoglobulin (Varitect CP or IVIG) post-delivery. Intravenous immunoglobulins can be obtained via the microbiologist and the on-call microbiologist can be contacted out of hours via switchboard.

- **Prophylactic intravenous aciclovir should also be considered in addition to intravenous immunoglobulin for infants whose mothers develop chickenpox four days before to two days after delivery as they are at the highest risk of fatal outcome despite VZIG prophylaxis**

NB: Order intravenous immunoglobulin as soon as you know you will need it, preferably during office hours.

- Isolate mum & baby on the Postnatal Ward
- Care by immune staff only
- Transfer mum and baby home as soon as possible but continue with observation of baby for signs of infection for 14 -16 days.
- Susceptible women who do not acquire infection despite exposure should be advised to contact their GP for vaccination post-partum to reduce the risks in future.

6.10.3 VZV (chickenpox or shingles) CONTACT within 7 days of life with someone other than the mother

Determine the following:

Is the neonate:

- Premature (born less than 28 weeks gestation)
- Weighed less than 1kg at birth
- On SCBU
- Had repeated blood sampling requiring replacement with packed red cell infusion?

If ***YES*** to any of the 4 questions above, test infant for VZV IgG (**regardless of maternal history of chicken pox**).

If neonate is VZV IgG negative, intravenous antivirals and intravenous immunoglobulin should be given within 10 days of initial exposure. If neonate is VZV IgG positive, no further action required.

If ***NO*** to all 4 questions above, then determine the immune status of the mother and treat accordingly, i.e.,

- If mother is immune – No action required for neonate
- If mother is **not** immune – neonate will need intravenous antivirals and intravenous immunoglobulin within 10 days of exposure

6.11 Women with chickenpox should breastfeed if they wish to and are well enough

Women with chickenpox should breastfeed if they wish to and are well enough to do so. If there are active chickenpox lesions close to the nipple, they should express breast milk from the affected breast until the lesions have crusted over. The expressed breast milk may be fed to the baby who is receiving treatment with intravenous antivirals and intravenous immunoglobulin.

7. Training, Equipment / Medication Requirements

- New Midwives, students and medical staff will be informed about the process for accessing guidelines during their induction.
- New or updated guideline/policies will be disseminated as per the Terms of Reference for the Clinical Guidelines Group.

8. Monitoring Compliance

8.1 Key Performance Indicators (KPIs) of the Policy

No	Key Performance Indicators (KPIs) Expected Outcomes
1	Compliance with the guideline

8.2 Performance Management of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Care of the woman in pregnancy if IMMUNE	Midwife or Doctor	Data collection tool to reflect the minimum requirement to be monitored	Tri-annual	O&G Clinical Governance Quality and Safety Group	Midwife or Doctor
Care of the woman in pregnancy if NON IMMUNE	Midwife or Doctor	Data collection tool to reflect the minimum requirement to be monitored	Tri-annual	O&G Clinical Governance Quality and Safety Group	Midwife or Doctor
Management of a pregnant woman who develops chickenpox	Midwife or Doctor	Data collection tool to reflect the minimum requirement to be monitored	Tri-annual	O&G Clinical Governance Quality and Safety Group	Midwife or Doctor
Management of baby born within 7 days of onset of a rash	Midwife or Doctor	Data collection tool to reflect the minimum requirement to be monitored	Tri-annual	O&G Clinical Governance Quality and Safety Group	Midwife or Doctor

9. References

No	Reference
1	Royal College of Obstetricians & Gynaecologists (2015) Chickenpox in pregnancy. Guideline No.13. RCOG press London. https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/chickenpox-in-pregnancy-green-top-guideline-no-13/
2	UKHSA Guidelines on post exposure prophylaxis (PEP) for varicella or shingles (October 2024): Post exposure prophylaxis for chickenpox and shingles - GOV.UK (www.gov.uk)
3	Green Book Varicella Chapter: Varicella: the green book, chapter 34 - GOV.UK (www.gov.uk)

10. Related Trust Documents

No	Related Document
1.	Infection Prevention Manual Chapter 37 – Management of Chickenpox/Shingles (current version on intranet)
2.	

11. Equality Analysis Form

The EIA screening must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process. Where the screening identifies that a full EIA needs to be completed, please use the full EIA template.

The completed EIA screening form must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Head of Patient Inclusion and Experience for monitoring purposes via the following email, cheryl.farmer@sthk.nhs.uk. If the assessment is related to workforce a copy should be sent to the workforce Head of Equality, Diversity and Inclusion for workforce equality&diversity@sthk.nhs.uk.
If this screening assessment indicates that discrimination could potentially be introduced then seek advice from either the Head of Patient Inclusion and Experience or Head of Equality, Diversity (Workforce) and Inclusion.

A full equality impact assessment must be considered on any cost improvement schemes, organisational changes or service changes that could have an impact on patients or staff.

Title of function	Guideline for the Management of Chickenpox (Varicella) in Pregnancy
Brief description of function to be assessed	Management of Chickenpox (Varicella) in Pregnancy
Date of assessment	23/12/2024
Lead Executive Director	Director of Nursing, Midwifery & Governance
Name of assessor	Ann Finch and Susan Page
Job title of assessor	Audit and Guideline Midwives

Equality, Diversity & Inclusion

Does the policy/proposal:
1) Have the potential to or will in practice, discriminate against equality groups
2) Promote equality of opportunity, or foster good relations between equality groups?
3) Where there is potential unlawful discrimination, is this justifiable?

	Negative Impact	Positive Impact	Justification/ evidence and data source
Age	No	Choose an item.	
Disability	No	Choose an item.	
Gender reassignment	No	Choose an item.	
Pregnancy or maternity	No	Choose an item.	
Race	No	Choose an item.	
Religion or belief	No	Choose an item.	
Sex	No	Choose an item.	
Sexual orientation	No	Choose an item.	

Human Rights

Is the policy/proposal infringing on the Human Rights of individuals or groups?

	Negative Impact	Positive Impact	Justification/ evidence and data source
Right to life	No	Choose an item.	
Right to be free from inhumane or degrading treatment	No	Choose an item.	
Right to liberty/security	No	Choose an item.	
Right to privacy/family life, home and correspondence	No	Choose an item.	
Right to freedom of thought/conscience	No	Choose an item.	
Right to freedom of expression	No	Choose an item.	
Right to a fair trial	No	Choose an item.	

Health Inequalities

Is the policy/proposal addressing health inequalities and are there potential or actual negative impact on health inequality groups, or positive impacts? Where there is potential unlawful impacts is this justifiable.

	Negative Impact	Positive Impact	Justification/ evidence and data source
Deprived populations	No	Choose an item.	
Inclusion health groups	No	Choose an item.	
5 child clinical areas	No	Choose an item.	
5 adult clinical areas	No	Choose an item.	

Outcome

After completing all of the above sections, please review the responses and consider the outcome.

Is a full EIA required?	Yes ☐ No ☒ Please include rationale:

Sign off

Name of approving manager	Sarah Howard
Job title of approving manager	Quality and Safety Matron
Date approved	23/12/2024

Data Protection Impact Assessment Screening Tool

If you answer **YES or UNSURE** to any of the questions below a full Data Protection Impact Assessment will need to be completed in line with Trust policy.

	Yes	No	Unsure	**Comments -** *Document initial comments on the issue and the privacy impacts or clarification why it is not an issue*
Is the information about individuals likely to raise privacy concerns or expectations e.g. health records, criminal records or other information people would consider particularly private?		**No**		
Will the procedural document lead to the collection of new information about individuals?		**No**		
Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		**No**		
Will the implementation of the procedural document require you to contact individuals in ways which they may find intrusive[1]?		**No**		
Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?		**No**		
Does the procedural document involve you using new technology which might be perceived as being intrusive? e.g. biometrics or facial recognition		**No**		
Will the procedural document result in you making decisions or taking action against individuals in ways which can have a significant impact on them?		**No**		
Will the implementation of the procedural document compel individuals to provide information about themselves?		**No**		

Sign off if no requirement to continue with Data Protection Impact Assessment:
Confirmation that the responses to the above questions are all NO and therefore there is no requirement to continue with the Data Protection Impact Assessment

Policy author _____**Date** _____

12. Appendix 1 Management of pregnant women in CONTACT with chickenpox

Ask if the woman has had chickenpox; if she has reassure her that she is immune. If she has not had chickenpox or is uncertain, check if she is booked

If booked

Contact Microbiology Laboratory at Whiston

On Ext 1695 or 1837 to urgently request VZV IgG testing on booking serum to determine immunity status

Provide contact details of member of staff for communication of result if woman is not immune

If not yet booked

Patient needs to attend for blood test:

- Microbiology Form
- Requesting URGENT "Varicella-Zoster immunity (IgG)" on the form and clinical details of chicken pox contact in pregnancy
- Write date of contact (if known) on form
- Brown bottle
- Provide contact details of member of staff for communication of result if woman is not immune
- Contact the Microbiology department as soon as the sample is available to ensure it is processed urgently (ext 1695 or 1837)

RESULTS ARE USUALLY AVAILABLE WITHIN 24 TO 48 HOURS

- If patient is VZV IgG positive, the result will be reported electronically. Any member of staff can access Careflow for results
- If the patient is non-immune (VZV IgG negative) the Microbiologist will communicate results to
  - The Antenatal Clinic Co-ordinator, **Whiston site**, Ext 1527 DURING OFFICE HOURS or
  - The Midwifery Bleep Holder, **Whiston site**, bleep number 7274 OUT OF OFFICE HOURS
  - The Antenatal Clinic Co-ordinator, **Ormskirk site**, 01695 656379
  - The Maternity Bleep Holder, **Ormskirk site,** bleep number 3747

IF IMMUNE

The Antenatal Clinic Co-ordinator / Bleep Holder contacts woman and reassures her

IF NOT IMMUNE

For susceptible women, oral aciclovir at 800mg four times a day from days 7 to 14 after exposure is recommended. Valaciclovir 1000mg three times a day from days 7 to 14 after exposure can be used as a suitable alternative.

If the woman presents later than day 7 after exposure, a 7-day course of antivirals can be started up to day 14 after exposure, if necessary.

See section 6.4.2 for more details

13. Appendix 2 Management of a pregnant woman who develops chickenpox

Guidance for staff when a woman has chickenpox at or around the time of birth

↓

Defer delivery, where possible, until 5 – 7 days after the onset of rash

If baby born:

more than 7 days *before* rash
OR
more than 7 days *after* rash

No specific treatment for baby

Isolate mum & baby on Postnatal Ward

↓

Care by immune staff only

↓

Transfer mum & baby home ASAP

If baby born within 7 days of onset of rash

Complete Paediatric Alert Form online to notify Paediatricians and NNU
*Give baby intravenous antivirals and intravenous immunoglobulin (Varitect CP or IVIG) post-delivery obtained via Microbiologist
(contactable via x1837 during normal working hours or if out of hours via switchboard)

NB Order VZIG preferably during office hours, as soon as you know you will need it

Isolate mum and baby on Postnatal Ward
Care by immune staff only

Transfer mum & baby home ASAP but CONTINUE OBSERVATION of baby for signs of infection for 14-16 days