



Preconception care and counselling for women with cardiovascular disease

NOTES

This document will use the term 'women'/'woman' throughout. It is important to highlight that it is not only those who identify as women who require access to women's health and reproductive services. For example, some transgender men, non-binary people, and intersex people or people with variations in sex characteristics may also experience pregnancy. All healthcare services should be respectful and responsive to individual needs.

This guidance is not intended to be construed or to serve as a standard of care. Standards of care are determined based on all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. Adherence to guidance recommendations will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available. It is advised, however, that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.

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This document has been prepared by Public Services Delivery Scotland (PSD Scotland) on behalf of the Scottish Obstetric Cardiology Network (SOCN). Accountable to Scottish Government, PSD Scotland works at the heart of the health service providing national strategic services to the rest of NHS Scotland and other public sector organisations to help them deliver their services more efficiently and effectively. SOCN is a collaboration of stakeholders involved in obstetric cardiology care, who are supported by a PSD Scotland Programme Team to drive improvement across the care pathway.

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Background



ESC: Pre-pregnancy risk assessment and counselling is indicated in all women with known or suspected congenital or acquired cardiovascular and aortic disease

MBRRACE:

- Women with pre-existing medical conditions should have pre-pregnancy counselling by doctors with experience of managing their disorders in pregnancy
- Women with complex physical and/or psychological comorbidities need care before, during, and after pregnancy; their health and medication should ideally be optimised before considering pregnancy; and they must be offered contraception and continuing care after and between pregnancies
 - Any woman with a family history or genetic confirmation of an inherited cardiac condition (cardiomyopathy, aortopathy, channelopathy) should be referred for cardiac assessment before pregnancy.
- Clear guidance on contraceptive choices for women with cardiac disease is available and should be consulted
 - All patients should have an assessment of their cardiovascular risk before starting medically assisted reproduction

NICE:

Risk assessment for women with heart disease should follow the principles of multi-disciplinary team working including a cardiologist with expertise in managing heart disease in pregnant women

*ESC: European Society of Cardiology

Preconception care

Preconception care is essential for women with CVD of reproductive age to provide advice and interventions that contribute to improved maternal and fetal outcomes. However, the provision of preconception care is not dependent on a woman pursuing pregnancy. In the UK, 55% of pregnancies are planned¹. Therefore, if healthcare professionals are not proactive in supporting women with preconception care, opportunities to optimise general and CV health will be missed. An audit supported by SOCN identified that preconception care is documented infrequently in women of reproductive age with CVD in the general cardiology outpatient setting².

All women of reproductive age with CVD, including teenagers, should be offered a comprehensive preconception assessment to evaluate CV status, potential risks in pregnancy and provide an opportunity to make informed choices about reproductive options, to optimise CVD, co-morbidities of social determinants of health. Maternal

CV risk can be dynamic during a woman's reproductive years demonstrating the need to embed preconception care into routine cardiology care.

Preconception care also applies to men with CVD, especially those with inherited cardiac conditions or congenital heart disease.

It is appropriate to offer preconception care, including guidance on inheritance or recurrence risk and options for preimplantation genetic diagnosis. Where significant CVD is present, it may be appropriate to support understanding of limited life expectancy in the context of pursuing a family.

Maternal risk assessment

Assessment of maternal CV risk in pregnancy is nuanced and must be individualised. Tools to support risk stratification include the modified World Health Organisation 2.0 classification of maternal cardiovascular risk (mWHO 2.0) and the CARPREG II risk index. Table 1 lists CVD by maternal cardiac risk.

mWHO I	mWHO II	mWHO II-III	mWHO III	mWHO IV
No detectable increased risk of maternal mortality and no/mild increased risk in morbidity	Small increased risk of maternal mortality or moderate increase in morbidity	Intermediate increased risk of maternal mortality or moderate to severe increase in morbidity	Significantly increased risk of maternal mortality or severe morbidity	Extremely high risk of maternal mortality or severe morbidity
		Mild left ventricular impairment: EF >45%. Significantly impaired RV (subpulmonary) function.	Moderate left ventricular impairment: EF 30%–45%. Previous PPCM with not more than mild residual left ventricular impairment.	Severe left ventricular impairment: EF <30% or NYHA class III/IV. Previous PPCM with more than mild left ventricular impairment. PAH.
Atrial or ventricular ectopic beats, isolated.	Most supraventricular arrhythmias. Bradycardia requiring pacemaker.	Low-risk LQTS: no previous events + on full dose beta-blocker therapy. Low-risk CPVT: well controlled by	Sustained ventricular tachycardia from any aetiology. LQT2 (post-partum). Symptomatic CPVT and LQTS not adequately	

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		medical therapy. BrS with no previous events.	controlled by therapy. BrS with previous events.	
HCM: genotype-positive + phenotype-negative		Low-risk ARVC: genotype-positive + no or mild phenotype. HCM without complications. DCM/NDLVC with normal or mild left ventricular impairment: EF >45%.	ARVC with moderate/severe disease. HCM with arrhythmic and/or moderate haemodynamic complications. DCM/NDLVC with moderate left ventricular impairment: EF 30%–45%.	DCM/NDLVC with severe left ventricular impairment: EF <30% or NYHA class III/IV. HCM with symptomatic severe outflow tract obstruction: ≥50 mmHg. HCM with severely symptomatic LV dysfunction (EF <50%).
Successfully repaired simple lesions without significant residual (haemodynamic) complications (atrial or ventricular septal defect, patent ductus arteriosus, anomalous pulmonary venous drainage).	Unoperated uncomplicated atrial or ventricular septal defect. Repaired tetralogy of Fallot without significant residual haemodynamic/arrhythmic lesions. Transposition of the great arteries with arterial switch without significant residual lesions.	Repaired atrioventricular septal defect without significant residual lesions. Uncomplicated Ebstein anomaly: mild to moderate TR, no tricuspid stenosis, no accessory pathway.	Unrepaired cyanotic heart disease (not Eisenmenger). Systemic RV with good or mildly decreased ventricular function. Uncomplicated Fontan circulation: good ventricular function, no significant valve disease or arrhythmias, good exercise tolerance, and normal arterial	Systemic RV with moderate or severely decreased ventricular function. Fontan with any complication. Eisenmenger syndrome.

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			saturations. Ebstein anomaly with any complication.	
Small or mild • pulmonary stenosis • mitral valve prolapse without significant regurgitation.		Native, homograft or tissue valve disease not considered mWHO 2.0 I or IV: mild mitral stenosis, moderate aortic stenosis. Moderate valvular regurgitation.	Uncomplicated mechanical valve with stable well controlled INRs. Moderate mitral stenosis. Severe asymptomatic aortic stenosis. Severe left- sided valvular regurgitation.	Severe mitral stenosis. Severe symptomatic aortic stenosis.
Non-HTAD mild aortic dilatation (<40 mm).	Turner syndrome without cardiovascular features (BAV, coarctation, AHT, aortic dilatation).	Marfan or other HTAD syndrome without aortic dilatation. Aorta <45 mm in BAV pathology. Repaired coarctation.	Moderate aortic dilatation: 40– 45 mm in Marfan syndrome or other HTAD; 45–50 mm in BAV, Turner syndrome ASI 20–25 mm/m2, other aortic dilatation <50 mm. Marfan with previous aortic root replacement. Previous aortic dissection with stable diameter.	Severe aortic dilatation: >45 mm in Marfan syndrome or other HTAD, >50 mm in BAV, ASI >25 mm/m2 in Turner syndrome, other aortic dilatation >50 mm. Vascular Ehlers–Danlos syndrome. Severe (re)coarctatio n. Previous aortic dissection with increasing diameter.
			Prior SCAD. Prior ischaemic cardiac event	

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			(STEMI/NSTE ACS). Prior adverse pregnancy outcome requiring hospitalization. Prior adverse cardiovascular effects of cancer treatment.	
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Table 1: Modified World Health Organisation 2.0 classification of maternal cardiovascular risk

Contemporary risk assessment requires:

- comprehensive medical, family, medication and social history
- electrocardiograph
- echocardiogram
- assessment of New York Heart Association (NYHA) functional classification
- clinical examination
- assessment of cardiovascular risk factors (e.g. smoking, diabetes, hypertension, obesity, family history)
- CVD trajectory
- assessment of previous adverse events in any previous pregnancy (pre-eclampsia, gestational diabetes and pre-term birth)
- for some women CT, MRI, NT-proBNP, CPET, Holter monitoring and genetic testing may be appropriate
- consideration of the impact of medical therapy on CVD status and symptoms including the potential impact of withdrawal of therapies that may be detrimental to the fetus
- the presence of indications for cardiovascular interventions that may reduce pregnancy risk

For detailed information about the risk associated with individual CVD please consult the 2025 European Society of Cardiology CVD and Pregnancy guideline.

Counselling

Preconception counselling provides women and their families with clear information about the maternal and fetal risks associated with their CV condition. This should include a description of the location and frequency of follow-up, psychological impact and other factors that alter care or impact risk. Clinicians should ensure the principles of shared decision-making are embedded in this process. Use of the mWHO classification and other tools assist in the counselling process but should not

be used in isolation. Awareness of the medium to long-term impact of pregnancy on the maternal heart is important and should form part of the counselling process.



Figure 1: Maternal and fetal risks associated with CVD in pregnancy

For many women, even though preconception counselling can initially be overwhelming, it can help to alleviate anxiety by providing a clear explanation of CV risk, whether low or high, and the multi-disciplinary care they will receive in pregnancy. Making decisions about pursuit of pregnancy has many challenges, particularly where there is a high risk of adverse events. Women and their families should have access to appropriate information and support to support decision-making and the psychological distress that may be associated with the process.

While all clinicians have a role in identification of CV risk in pregnancy and delivering preconception care, women should have access to the Pregnancy Heart Team (PregHT) and appropriate specialists. We propose the following approach*:

Local	Regional	Specialist
mWHO class I	mWHO class II, II-III, III and IV	mWHO class III or IV in collaboration with regional PregHT

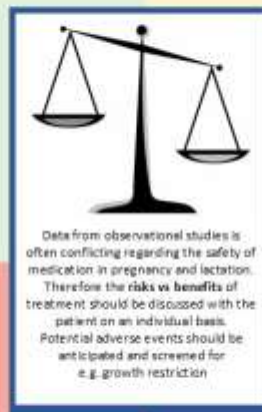
*refers to CVD and not co-morbidities or SDH that could increase risk. Where these are present ensure counselling with the appropriate clinician.

Optimisation and medication adjustments

Optimisation of CVD, co-morbidities and other factors should be addressed prior to pregnancy to improve pregnancy and longer-term outcomes. Where there is a clinical indication and the case has been discussed at an appropriate MDT meeting, cardiovascular optimisation such as structural intervention, arrhythmia management, device optimisation or coronary revascularisation should be recommended prior to pregnancy.

A medication review is required to ensure the regime is compatible with pregnancy (see Figure 2). Many cardiovascular drugs increase teratogenic or fetotoxic risks. However, their withdrawal may have negative consequences for the cardiovascular status of the woman. Embedding preconception care into routine care allows for pregnancy planning and assessment of alterations to pharmacological therapies prior to pregnancy and the haemodynamic stress it brings. The key principle is that maternal health is paramount, and medications should not be withheld if the benefit outweighs fetal risk. Prescribing in pregnancy should be the safest effective drug at the lowest effective dose. Patients should be counselled on the indications for the drug, any potential risks to the fetus and impact of withdrawal of therapies. It is important to advise women to avoid pregnancy during a period of optimisation and facilitate access to appropriate contraception.

Drugs that are considered safe	Drugs with limited/conflicting data/use with caution
Arrhythmia Adenosine, Bisoprolol, Digoxin*, Lidocaine, Metoprolol, Nadolol, Propranolol	Arrhythmia Diltiazem, Flecainide, Procainamide, Propafenone, Sotalol, Verapamil
Hypertension Labetalol, Methyl-dopa, Metoprolol, Nifedipine	Hypertension/Heart failure Amlodipine, Atenolol, Hydralazine, Nitrates, Nitroprusside Hydrochlorothiazide, Metolazone, Torsemide
Heart failure Bumetanide, Carvedilol, Furosemide, Metoprolol Dobutamine, Dopamine, Norepinephrine	Anticoagulation/antiplatelets/thrombolytics Clopidogrel, Prasugrel, Ticagrelor, Warfarin Argatroban, Bivalirudin, Fondaparinux Alteplase, Streptokinase, Tenecteplase
Anticoagulation/antiplatelets/thrombolytics Aspirin, Low molecular weight heparin, Unfractionated heparin	Pulmonary Hypertension/others Epoprostenol, Iloprost, Sildenafil, Treprostinil Statins
Drugs that are considered contraindicated	Drugs to avoid when breast feeding (again discuss the risks vs benefits of each agent)
Arrhythmia Amiodarone**, Atenolol	Amiodarone Clopidogrel
Hypertension/Heart failure ACE-inhibitors, Aldosterone antagonists, ARB class	ACE-inhibitors other than Captopril, Lisinopril or Ramipril Aldosterone antagonists, ARB Class Statins
Anticoagulation/antiplatelets/thrombolytics Direct oral anticoagulants	Direct oral anticoagulants Bosentan & other ERAs
Pulmonary Hypertension/others Bosentan and other endothelin receptor antagonists (ERA)	



* Digoxin serum levels are unreliable during pregnancy
 ** May be used if other therapies have failed

Figure 2: Overview of cardiac medication use in pregnancy and lactation

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Women with a mechanical heart valve prescribed warfarin require preconception counselling with the PregHT to discuss pregnancy risk and anticoagulation regimes in pregnancy. Vigilance is advised to identify pregnancy as early as possible and inform the PregHT (either through self-referral or via GP) to facilitate urgent review and alteration to anticoagulation.

Contraception

Contraception should be considered when obtaining a medication history.

Contraceptive choices for women with CVD are based on several factors:

- desire to avoid pregnancy
- pregnancy risk
- frequency of sexual activity
- safety and efficacy of contraceptive methods in the context of health conditions and family history
- current medication
- presence of heavy menstrual bleeding
- recent pregnancy and breastfeeding
- avoidance of sexually transmitted diseases

There are many contraceptive options, including emergency contraception, available to women with CVD. Again, an individualised approach is required based on medical history and personal choices using published guidance to support safety and efficacy recommendations. Generally, long-acting reversible contraceptive are recommended in the presence of CVD. In women at risk of thromboembolism, oestrogen containing contraceptives should be avoided.

Assisted reproductive therapies (ART)

Women with CVD may require assisted reproductive therapies (ART) due to fertility challenges, underlying conditions (e.g., polycystic ovary syndrome) or to access pre-implantation genetic testing. While ART can enable conception, it can pose cardiovascular risk. Hormonal stimulation, fluid shifts and increased haemodynamic load associated with ovarian hyperstimulation and early pregnancy can contribute to complications such as hypertension, thromboembolism, arrhythmia, and cardiac dysfunction. The risk is particularly high in women with complex congenital heart disease, cardiomyopathy, pulmonary hypertension, or aortopathy, where pregnancy itself carries CV risk.

Multidisciplinary input is essential before initiating ART and should involve cardiologists, obstetricians, reproductive medicine clinicians, and anaesthetists to assess maternal risk, optimise cardiac status, and tailor the reproductive plan. Risk stratification tools, including the mWHO classification and CARPREG II score as well as clinical expertise should guide individualised treatment decisions, with some conditions (e.g., pulmonary arterial hypertension, heart failure) posing contraindications to pregnancy. Careful selection of fertility medications, controlled

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stimulation protocols, and close cardiovascular monitoring are crucial to minimise risk. Additionally, discussions should include alternatives to pregnancy, such as surrogacy or adoption, when maternal health precludes a safe pregnancy.

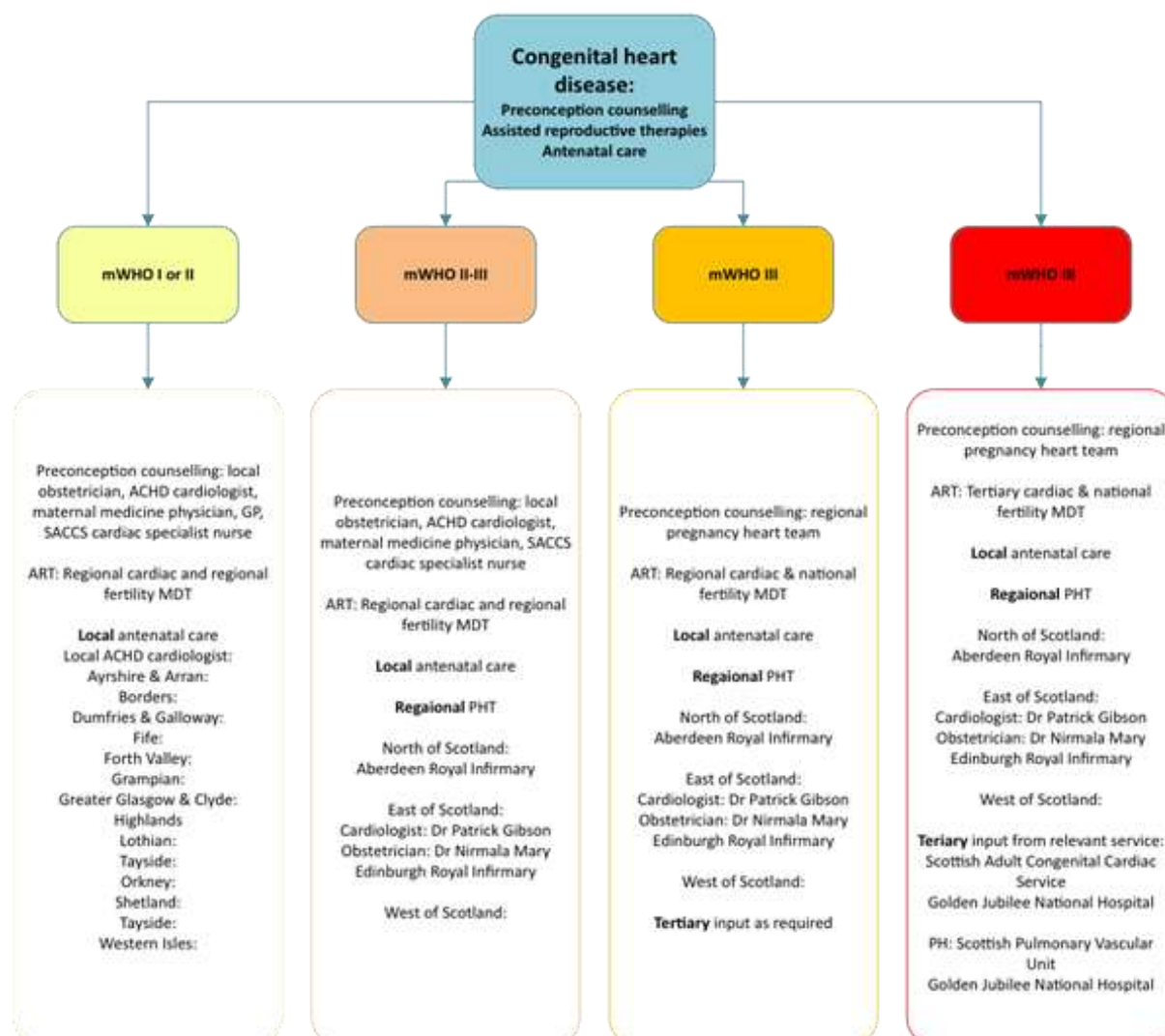
ART multi-disciplinary working in Scotland should be delivered as below.

Local	Regional	Specialist
mWHO I NHS tertiary fertility centre with input from patients named cardiologist	mWHO II, II-III, III and IV NHS tertiary fertility centre with discussion at complex fertility MDT Cardiologist/obstetrician from regional PregHT to advise/attend	mWHO III and IV in collaboration with regional PregHT Discuss case at complex fertility MDT

Adoption/Surrogacy

For women with CVD for whom pregnancy may be high risk, adoption or surrogacy may be an alternative route to a family. Where people can demonstrate that their CVD may not prevent them from meeting the needs of their child until adulthood and they meet other criteria for adoption, it remains an option. The woman's named cardiologist may be approached for information to support the application and should comply with requests for additional information to support agency decision making with the consent of the patient.

Pathway of care



Resources

A range of guidance developed by SOCN is available at www.socn.scot.nhs.uk including:

- Risk stratification and location of care for women with cardiovascular disease - this document outlines the mWHO classification of maternal cardiovascular conditions and delivery of care including preconception, antenatal and intrapartum care. It also includes CVD not included in the mWHO table above.
- Preconception Care and Counselling in Cardiovascular Disease - Guidance and Standards for Healthcare Professionals

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- Preconception Counselling Checklist - this checklist supports provision of the core components of preconception care and counselling.
- Contraceptive options for women with cardiovascular disease – this provides more detail to support contraceptive decision making and healthcare professional advice in the presence of CVD
- Mechanical Heart Valve in pregnancy resources including factsheet, alert card

2025 ESC Guidelines for the management of cardiovascular diseases during pregnancy. *European Heart Journal*, 46(43)

<https://doi.org/10.1093/eurheartj/ehaf193>

UK teratology information service - evidence-based safety information about medication, vaccine, chemical and radiological exposures in pregnancy

www.uktis.org

Transthoracic Echocardiographic Assessment of the Heart in Pregnancy—a position statement on behalf of the British Society of Echocardiography and the United Kingdom Maternal Cardiology Society

<https://echo.biomedcentral.com/articles/10.1186/s44156-023-00019-8>

Patient information on the use of drugs in pregnancy and breastfeeding is available at www.medicinesinpregnancy.org.

Best practice recommendations for medically assisted reproduction in patients with known cardiovascular disease or at high risk of cardiovascular disease' is a consensus statement led by UK Maternal Cardiology Society with contributions from SOCN. <https://www.tandfonline.com/doi/full/10.1080/14647273.2023.2278295>.

Fertility Scotland National Network provides more information on ART services in Scotland <https://fertility.scot/>

References

1. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) <https://pubmed.ncbi.nlm.nih.gov/24286786/>
2. Preconception counselling in women of reproductive age attending cardiology clinics in Scotland <https://pubmed.ncbi.nlm.nih.gov/38627021/>

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Appendix 1 - Document governance

Authors	This document was developed by the Preconception Counselling Subgroup on behalf of the SOCN Steering Group. Full membership of the group is available in Appendix 2.
Stakeholders involved	A wide range of health care professionals working in the area of obstetric cardiology were involved in the development of this document. This includes Obstetricians, Cardiologists, Anaesthetists, Pharmacists, Clinical Geneticists, Specialist Nurses, Midwives and Sexual Health consultants. Feedback from patients throughout the development of all of the SOCN materials was sought.
Methodology used	Evidence-based literature reviews and engagement with clinical experts within the field of obstetric cardiology across Scotland.
Rationale	Cardiac disease remains the leading indirect cause of death in pregnancy. The network was established to support and develop Obstetric Cardiology services throughout Scotland in improving standards of clinical care for pregnant women and their families affected by heart disease in pregnancy. The network supports the delivery of evidence based, patient centred care for both mother and baby through the development and implementation of clinical guidelines, care pathways, clinical standards and information resources.
Scope	The aim of this document is to support the delivery of services to improve outcomes for women with cardiac disease and support implementation of optimal care to any women with a cardiac condition who is contemplating a pregnancy or has a pregnancy in Scotland. .
Approval process	Members of the Scottish Perinatal Network and Network for Inherited Cardiac Conditions Scotland were able to review and provide feedback on the final draft of this document. The SOCN Steering Group endorsed this document on 31 March 2026. Full membership of the group is available in Appendix 2.

Network Contact Details

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Appendix 2 - Group membership

Preconception Counselling Subgroup Membership		
Name	Job Title	Organisation
Dr Janet Brennand	Consultant Obstetrician	NHS Greater Glasgow & Clyde
Mrs Claire Cairney	Cardiac Nurse Specialist (Paediatrics)	NHS Greater Glasgow & Clyde
Dr Susan Cassidy	Clinical Psychologist	NHS Greater Glasgow & Clyde
Dr Patrick Gibson	Consultant Cardiologist	NHS Lothian
Dr Rosie Godseth	Specialist Registrar	NHS Ayrshire and Arran
Dr Lindsey Hunter	Consultant Paediatric & Fetal Cardiologist	NHS Greater Glasgow & Clyde
Dr Ruth McGown	Consultant Clinical Geneticist/ Inaugural Subgroup Chair	NHS Greater Glasgow & Clyde
Dr Lucy Melvine	Consultant in Sexual & Reproductive Health	NHS Greater Glasgow & Clyde
Mrs Lynsey Moir	Pharmacist - Clinical Cardiology/Heart Failure Specialist/ Subgroup Chair	NHS Greater Glasgow & Clyde
Mrs Moira Nelson	Cardiac Nurse Specialist	NHS Lanarkshire
Prof Scott Nelson	Muirhead Chair of Obstetrics & Gynaecology	University of Glasgow & NHS Greater Glasgow & Clyde
Dr John Sharp/ Dr Deirdre Holly	Consultant Clinical Psychologists	NHS Golden Jubilee
Mrs Maggie Simpson	Cardiology Nurse Practitioner	NHS Golden Jubilee /NHS Greater Glasgow & Clyde

SOCN Steering Group Membership (2025/2026)		
Name	Job Title	Organisation
Dr Ros Burns	Obstetric Anaesthetist	NHS Lothian
Dr Rachel Darling	Consultant Anaesthetist	NHS Greater Glasgow & Clyde
Richard Forsyth	Health Systems Insights Manager	British Heart Foundation
Dr Patrick Gibson	Consultant Cardiologist	NHS Lothian
Dr Anja Guttinger	Sexual & Reproductive Health Consultant	NHS Ayrshire & Arran

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Dr Duncan Hogg	Consultant Cardiologist	NHS Grampian
Dr Shahzya Huda	Consultant Obstetrician	NHS Forth Valley
Dr Vera Lennie	Consultant Cardiologist	NHS Grampian
Dr Lynn Miller	Consultant Cardiologist	NHS Fife
Lynsey Moir	Pharmacist - Clinical Cardiology	NHS Greater Glasgow & Clyde
Dr Rebecca Northridge	Consultant Obstetrician	NHS Tayside
Dr Karolina Pesz	Consultant Geneticist	NHS Greater Glasgow & Clyde
Maggie Simpson	Advanced Specialist Nurse	NHS Greater Glasgow & Clyde
Dr Lorna Swan	Consultant Cardiologist	Golden Jubilee National Hospital
Dr Niki Walker	Consultant Cardiologist	Golden Jubilee National Hospital

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