

WOMEN'S HEALTH CONFERENCE 2007

NOTES FOR YOUR INFORMATION

HPV Vaccine

Suzanne Garland

Estimated Lifetime risk of HPV related disease

- Genital HPV >50% lifetime risk
- Genital warts around 10%
- Abnormal Pap smear > 35%
- Cervical cancer with regular pap smear <1%
- Cervical cancer (no pap) 3%
- MSM anal cancer 3%

Quadrivalent HPV vaccine provided 100% efficacy against HPV 6-, 11-, 16- and 18-related CIN (all grades) and against HPV 6-, 11-, 16-, and 18-related external genital lesions, including warts, and vulvar and vaginal neoplasias for naïve subjects at baseline (FUTURE 1 Study)

No fall in titres following 3 vaccinations at 4.5 years and 5 years for bivalent & quadrivalent vaccines.

Not currently known what titre needed to confer efficacy nor the duration of efficacy conferred by these titres.

Vaccines with HPV 16 & 18 prevent approximately 70% of cervical cancers, prevent about half of high grade disease

They are an adjunct to cervical cancer screening programmes

Dr Kirsten McCaffery

Factors influencing vaccine acceptability for parents include:

- Strong desire to prevent serious illness regardless of infection source
- Recommendation of health care provider important
- Preference for vaccination of older children (12yrs+)
- 20% parents unwilling to vaccinate.
- Factors assoc with unwillingness
 - Concerns about increased risky sexual behaviour among adolescents
 - General anti vaccine beliefs (safety)
 - Child seen as 'not at risk' of STI
 - HPV seen as preventable by behaviour change

Important messages when discussing HPV:

- HPV viral types (high and low risk)
- Avoid term 'wart virus'
- High prevalence of HPV
- Viral latency and regression
- Uncertainty about timing of infection
- Implications for cancer risk and fertility

Nuvaring

Dr Edith Weisberg

- Daily controlled release:
15 µg ethinyl oestradiol (EE)
120 µg etonogestrel (ENG)
- Once a month method
 - 1 ring for 3 weeks
 - 1 ring-free week
 - New ring inserted
- Primary action:
ovulation inhibition via
 - suppression FSH
 - inhibition LH surge
- Secondary effects on:
 - endometrium
 - cervical mucus
 - fallopian tubes
- Contraindications:
 - Same contraindications as for COCs
 - Marked cystocele, rectocele, uterine prolapse

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- Severe or chronic constipation
- Uncomfortable with vaginal insertion
- Ring specific adverse events:
 - Increase in vaginal discharge
 - Vaginitis
 - Ring expulsion
 - Awareness of ring presence during intercourse

Genital Herpes

Suzanne Garland

- Presentation of Genital Herpes
 - Most patients will present with an episode of genital ulceration (HSV1 or HSV2)
 - presenting episode may not be at the time of acquisition, but may be many years after 1st infection
 - Only 1/3rd have significant localising symptoms during acquisition episode
- Seroprevalence rates of HSV2 in pregnant population ranges 7-33% (Australia approx 14%)
- Factors associated with HSV2 seropositivity:
 - Increasing age
 - Age at first sexual intercourse
 - Increasing number of sexual partners
 - Known history of genital herpes
 - Current &/or previous partner with a history of genital herpes
- Fetus/neonate transmission – 85% intrapartum

- Management of HSV in pregnancy

Primary HSV pregnancy (confirm diagnosis):

- Primary HSV >34w → consider aciclovir Rx → LUSC
- Primary HSV <34w no lesions in labour → vaginal delivery [consider a genital sweep culture]
- Primary HSV <34w lesions in labour → <6 hrs ROM → LUSC

Recurrent HSV:

- careful speculum examination for active lesions should be performed at delivery
- no lesions → vaginal delivery [consider a genital sweep culture]
- lesions: ROM <6 hrs → LUSC
ROM >6 hrs → vaginal (some → LUSC)
- multiple recurrences consider aciclovir Rx
- Australasian Society for Infectious Diseases has HSV algorithms
- "Management of Perinatal Infections" Edited by Dr Pamela Palasanthiran, Dr Mike Starr and Dr Cheryl Jones
- http://www.racp.edu.au/asid/resources_perinatal.htm
- Neonatal HSV – high mortality and morbidity – **Early diagnosis essential**
- Management guidelines for neonatal HSV - www.ihmf.org/guidelines
- Conclusions:
 - genital HSV is very common: Neonatal HSV uncommon
 - type specific HSV serological screening not recommended Australia
 - make a definitive diagnosis & type any HSV isolate
 - first episode: total HSV antibodies [sero(-) status]
 - perform HSV type-specific Ig to demonstrate an initial first infection, i.e. HSV-2 in an HSV-1 (+) Ig
 - primary infection around term → LUSC + acyclovir
 - recurrent lesions around term → LUSC
 - women with a history of HSV no lesions at delivery, no invasive obstetric interventions, obtain maternal cervico-vaginal secretion sample
 - counsel parents re potential signs of Neonatal HSV

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Prenatal Ultrasound test counselling

Fiona Hawthorne

- Prescan counselling includes:

Concrete information:

- screening versus diagnostic;
- false positive rates;
- what the scan can't do;
- impact of maternal habitus (if applicable);
- what the scan is designed to do;
- basic information about T21;
- role of bloods;
- different results (low risk, high risk, unchanged)

Philosophical information:

- notion of disability;
 - the notion of risk;
 - what to do in the event of a positive diagnosis;
 - support systems;
 - relationship dynamics
- Postscan Counselling:
Recap purpose of scan and what brought us to this point
Results:
 - what they mean;
 - what they don't tell us;
 - how this helps in planning pregnancy care;
 - role of invasive testing;
 - place these results in the broader context.

Prenatal Ultrasound scan

Kerry McMahon

NT scan

- Timing important – 11W 2D – 13W6D
- Not just Nuchal translucency measurement but full review of anatomy, dates, uterus, ovaries, identifies multiple pregnancies
- Not just Down's Syndrome
- Other chromosomal abnormalities – Trisomy 18, Trisomy 13, Turner's Syndrome
- Other anomalies – heart defects, diaphragmatic hernia, omphalocele,
- Correct Dates, Uterine Fibroids, Ovarian Pathology

Biochemical screening

- Testing free bHCG, PAPP-A
- Blood taken from 10 weeks to 12 weeks (always preferably prior to US examination)
- Influenced by maternal weight, gestational age of fetus, smoking, IDDM, twins, assisted reproduction

18-20 week scan

- Greater sensitivity in structural abnormalities – congenital heart disease, spina bifida, neurological abnormalities, fingers, toes
- Less sensitive than 12 week scan for chromosomal anomalies
- Detailed study of each organ and body part

Workshop Hormone Queries

Edith Weisberg

Hormone Contraceptives used

Condition	Level of Evidence
Primary Dysmenorrhoea	Good
Secondary Dysmenorrhoea	Anecdotal
Amenorrhoea	Good
Menorrhagia	Limited
Premenstrual Syndrome	Limited
Other cyclical syndromes	Limited
Endometriosis	Limited
Adenomyosis	Anecdotal

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Myomata	Anecdotal
PID	Anecdotal
Acne	Good
Hirsutism	Good

Management of PMS

- Combined oral contraceptives
- Shortening or eliminating pill-free gap
- Lowering dose of hormones
- Using new progestogens eg drospirenone
- Changing lifestyle

Adolescents

Gretchen Hitchins

www.cyh.com.au - information for parents, and young people aged 6 - 25 years; great site, I use it everyday in my practice

www.reachout.com.au - great website designed by young people for young people going through tough times

www.somazone.com.au - website run by the Australian Drug Foundation; young people can send in health questions which are answered by professionals

www.gppartners.com.au - for further information for GPs regarding the new Better Access to Mental Health item numbers etc.

www.druginfo.adf.org.au - information about alcohol and illicit drugs

www.parenting.sa.gov.au - information about many parenting issues, including hosting teenage parties, teenagers & alcohol

www.lawstuff.org.au - information about a variety of legal issues that may impact on young people (age of consent, when can they leave home etc) done state by state throughout Australia

www.adin.com.au - more information about illicit drugs, has good section for young people called 'Where's your head at'.

Books: "Adolescence - a guide for parents" authors Michael Carr-Gregg & Erin Shale "What to do when your children turn into teenagers", authors Dr David Bennett & Dr Leanne Rowe

Parentline 1300 301 300

Kids Help Line 1800 55 1800

Investigation of a new breast symptom

Jenny Bradford

www.nbcc.org.au

Coeliac disease

Bob Anderson

Incidence 1:100

Only 1:5 – 1:10 of those with Celiac are currently diagnosed

Mean age of diagnosis 40 years, (onset of disease usually around 2 years of age)

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Common presenting features:

- Anaemia (Iron, folate or B12 deficiency)
- Tired all the time
- Ongoing GI upset:
 - Diarrhoea &/or constipation or "Irritable bowel"
 - Abdominal pain, indigestion, bloating, wind

Diagnosis:

- Coeliac disease: biopsy
- Wheat/gluten allergy: "blinded challenge"
- Carbohydrate malabsorption: challenge H2/CH4 breath test

Treatment:

- Coeliac disease: strict gluten-free diet (<50mg gluten/day)
- Wheat/gluten allergy: gluten free diet (tolerance limit ill-defined)
- Carbohydrate malabsorption: (e.g. reduce fructose, not gluten)

Genes:

If you don't have the genes for HLA DQ2 or DQ8, you don't have coeliac disease.

Gene tests are useful when the biopsy or blood tests are not "classical" and/or gluten free diet has been started before formal diagnosis

Ideal care includes:

- High awareness by G.P.s/specialists
- Prompt screening for coeliac disease (blood test)
- HLA-DQ gene test if result unclear
- Gastroscopy and biopsy (gluten exposed)
- High quality pathology
- HLA-DQ gene test if result unclear
- Check for complications: e.g. bone density, thyroid function, nutrient deficiency, psychological issues
- Family testing - brother/sisters, parents, children, "symptomatic" blood-relatives
- Gluten free diet: Dietitian
- Confirmation repeat biopsy (~1yr)
- Medical review annual/biannual

Recognition of Coeliac disease in practice

Coeliac serology all patients with:

- "High risk" diseases e.g. Type 1 DM, thyroid disease, osteoporosis, elevated ALT or AST, seronegative arthritis, autoimmunity, infertility
- Family members with coeliac disease
- "High risk" symptoms/signs e.g. fatigue, (depression), low weight/growth, headaches, diarrhoea/indigestion/abdo pain, fractures, anaemia, B12 or folate deficiency, blistering itchy rash
- Audit in general practice: "High risk" conditions

CoeliacResearch.com: Professional education and research

Lung Cancer – an update

Louis Irving

- Overall 5 year survival 13%
(advanced disease at presentation)
- Non-small cell lung cancer (85%)
 - Stage 1,2 – 55-80% cure following surgery
 - Stage 3,4 – few cures, median survival 8-20 m
- Small cell lung cancer (15%)
Very few cures
 - Limited disease – 10-18 m
 - Extensive – 4-8 m
- Suspect diagnosis because of symptoms and mass on CXR
- Confirm diagnosis with sputum cytology, bronchoscopy or FNA
- If non-small cell lung cancer
 - Localised disease (stage 1,2) – surgery (if fit)

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- Locally advanced (stage 3) – chemotherapy and radiotherapy (if fit)
- Metastatic (stage 4) – chemotherapy (if fit), targeted agent or palliation
- If small cell lung cancer
 - Combination chemotherapy
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Safe partying advice

Gretchin Hitchins

- You do have a choice not to drink
- Choose low alcohol drinks
- Alternate non-alcoholic with alcoholic drinks
- Ensure you eat before and during alcohol consumption
- Do not allow people to top up your glass
- Pour your own drinks so you know what is in them
- Do not mix alcohol with other substances, including medications or over-the-counter drugs
- Learn how to say 'No'
- Plan a safe way for leaving a party
- Look out for friends – don't leave drunk friends to 'sleep it off'
- Be contactable by parents/guardians
- Know your standard drinks

www.druginfo.adf.org.au

www.cyh.com.au

www.parenting.sa.gov.au

www.lawstuff.org.au

www.adin.com.au

Mood Disorders in Pregnancy

Anne Buist

Postpartum Mental Illness

- 29% adjustment difficulties
- 14% depression
- high rate of relapse of bipolar disorder and exacerbation of anxiety disorders

Summary

- All neuroleptic drugs pass across the placenta and into breast milk with inter-individual variation
- SSRI's – all associated with small babies and at least slight prematurity
- Increase risk of teratogenicity slight with paroxetine
- Withdrawal syndrome with SSRI's and SNRI's
- individual situation needs to be assessed with risk benefit

Managing body weight

Gary Eggar

Avoid food with >3kcal/g (>12kJ/g)

Avoid drinks with >0.4kcal/ml (>1.5kJ/ml)

Decrease portion size

Portion Size and Energy Density are independent and additive contributors to total daily energy intake

Rolls et al., Am J Clin Nutr., 2006;83:11-17