

# ***Good morning and welcome***

<b>Time</b>	<b>Task</b>	<b>Who</b>
<b>10 am</b>	<b>Welcome, housekeeping, learning objectives</b>	<b>Wendy Burton</b>
<b>10:10</b>	<b>Case work: Task 1</b>	<b>GP groups</b>
<b>10:25</b>	<b>Present Task 1 Feedback/ discussion</b>	<b>GPs Michael Beckman; Glenn Gardener (presenting); panel discussion</b>
<b>11:40</b>	<b>Obesity</b>	<b>Michael Beckman presenting</b>
<b>12 noon</b>	<b>Lunch</b>	<b>All</b>

# ***Acknowledgments***

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Today has been put together by a wonderful team of highly committed individuals and supported by several organisations. Special thanks are due to:

- all of the MMH staff who have given up their time to be with us today as well as those who have worked behind the scenes
- Caroline Nicholson, Mater UQ Centre for Primary Health Care Innovation
- SeaGP & BSDGP
- Our wonderful sponsors



# Goal

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The aim of the MMH-GP Alignment program is to educate, equip and empower GPs to provide best-practice antenatal care to low-risk women. The MMH recognises the existing skill base of General Practitioners and is committed to working with GPs to identify and close gaps in current practice and in communication between MMH and providers of care.

Clinically competent GPs providing timely evidenced-based care to women in their local community is a model of care endorsed by the MMH. By working together, using resources appropriately and communicating effectively and efficiently, we aim to reduce the risks and improve the safety and outcomes for both mother and child.



# ***Learning objectives***

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By the end of today you should be familiar with:

- The current MMH MSC Guideline
- The lines of communication between MMH and providers of care
- Specialized antenatal and postnatal services available at or through the MMH
- Current recommendations for screening
- Management of common antenatal presentations
- Management of common antenatal complications

# ***Role of small facilitator***

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Each group will have a group facilitator

- To observe
- To assist GPs to stay on task
- To assist GPs to tease out the cases

These cases are deliberately short on detail.

We want you to be more focused on the process than the particulars. To consider, as GPs do, the probable outcome but also the possible, more risky ones.

## **Red Group**

### **Task 1 - 1<sup>st</sup> trimester pregnancy**

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Julie is a healthy 25 year old whose LNMP was 4 weeks ago and whose uHCG is positive. This is her first pregnancy, she has no private health insurance and she wants to know what comes next.

- She has a 15 min appointment. Outline your approach.

# ***NHMRC Iodine recommendation 2010***

- Iodine is an essential nutrient that humans need in very small quantities. The thyroid uses iodine to produce hormones vital to ensure normal development of the brain and nervous system before birth, in babies and young children. For this reason, it is very important that pregnant and breastfeeding women get enough iodine.
- The National Health and Medical Research Council recommends that **all women who are pregnant, breastfeeding or considering pregnancy, take an iodine supplement of 150 micrograms (µg) each day.**
- Women with pre-existing thyroid conditions should seek advice from their medical practitioner prior to taking a supplement.



# *Iodine supplementation*

- [www.foodstandards.gov.au](http://www.foodstandards.gov.au) —Mandatory iodine fortification of bread since Oct 09 and folate from Sept 09
- This is not at high enough levels for pregnancy— supplementation is still recommended
- Blackmores Pregnancy and Breastfeeding formula contains Iodine, Elevit does not (at present) also, for those who do not require a multivitamin, Blackmores have I-Folic which is 500 mcg of Folic Acid and 250 mcg of Iodine @ \$20 for 150 tablets
- Women of child rearing age should use Iodinated salt.



## **Green Group**

### **Task 1 - 1<sup>st</sup> trimester pregnancy**

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Amina is a 22 year old from Somalia who wears the hijab and has lived in Brisbane for a year. Her LNMP was 5 weeks ago, her uHCG is positive and she wants to know what to do next.

- She has a 15 min appointment. Outline your approach.

# ***Communicating the Concept of Antenatal Care***

- Cultural sensitivity is required when obtaining history and performing examination
- May need interpreter to be able to communicate effectively and obtain detailed history (female usually preferred). An on-site translator is preferred however you need to pre-book as it can take 2 weeks to organise. The TIS is free and available 24/7 Ph 131 450
- May have had minimal exposure to formal, hospital-based antenatal care.
- Options for antenatal care need to be communicated clearly.
- May have beliefs about traditional foods and practices for her pregnancy
- Refugees through the Humanitarian program have full Medicare access and Health care cards as do most Asylum Seekers



# Assessment of Specific Risk Factors:

## Obstetric History

- Multiple spontaneous or elective abortions
- Previous stillbirth
- Female Genital Mutilation (FGM)  
[health.sa.gov.au/ppg/Default.aspx?PageContentID=908&tabid=211](http://health.sa.gov.au/ppg/Default.aspx?PageContentID=908&tabid=211)
- Multigravida
- Short spacing intervals between pregnancies
- Cephalopelvic disproportion (higher incidence in women from Africa)
- Neonatal death

# Assessment of Specific Risk

## Factors:

### Diseases

- Vitamin D Deficiency (dark-skin, Hijab)
- Anaemia: Thalassaemia, sickle-cell
- Pelvic infections (previous sexual assault, FGM)
- Recurrent UTIs (FGM)
- Infectious Diseases: Latent TB
- Hepatitis B & C
- HIV
- Parasites (eg. Schistosomiasis)
- Rubella

# Refugee Health Queensland



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# ***Mater services/information***

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On line information can be found at the following Mater websites:

- <http://brochures.mater.org.au/Home/Brochures/Mater-Mothers--Hospitals/Refugee-Maternity-Service>
- <http://www.materonline.org.au/Home/Services/Refugee-health/Refugee-Health-Queensland.aspx#bris>



## ***Blue Group***

### ***Task 1 - 1<sup>st</sup> trimester pregnancy***

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Anna is a generally healthy 32 year old with a BMI of 40 who is very pleased as her period is overdue and her home pregnancy test is positive! She has been stable on 100 mcg of thyroxine o.d. for several years and is taking no other medication.

- She has a 15 min appointment. Outline your approach.

## Orange Group

### Task 1 - 1<sup>st</sup> trimester pregnancy

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Kate is a 34 year old who has an unplanned pregnancy. It is 11 weeks since her LNMP. She is not sure how she will proceed and wants to rule out any possible pregnancy complication or abnormality in this child. She is a regular blood donor and upon asking, informs you that her blood group is A Rh neg.

- She has a 15 min appointment. Outline your approach.

# *Anti D use changes*

- There is insufficient evidence to support the use of Rh D immunoglobulin in bleeding prior to 12 weeks gestation in an ongoing pregnancy, although if the pregnancy then requires curettage Rh D immunoglobulin should be given. If miscarriage or termination occurs after 12 weeks gestation, 625 IU (125 µg) Rh D immunoglobulin should be offered.

<http://www.nba.gov.au/pubs/pdf/glines-anti-d.pdf> (National Blood Authority)

<http://www.ranzcog.edu.au/publications/statements/C-obs6.pdf>

# Yellow Group

## Task 1 - 1st trimester pregnancy

Nicole is a healthy 37 year old who presents for review after having done a home pregnancy test which was positive. She did do a pregnancy test 3 weeks ago, but this was negative. She is not sure when she fell pregnant though, as her periods have been irregular and the last one was 7 weeks ago. Nicole mentions that she has been taking Folic Acid 0.5 mg daily and she wants to know what to do next.

- She has a 15 min appointment. Outline your approach.

# ***US/S costs—clinics compared***

Accurate as of May 2010—Not an exhaustive list, not Mater endorsed!

<b>Practice</b>	<b>NTS</b>	<b>Morphology</b>
Exact Radiology	No (\$115 at Ipswich)	BB (book weeks ahead)
Oz Radiology	No	BB (book months ahead)
Qld Xray	\$200 (\$60 rebate)	\$200 (\$85 rebate)
Qscan	\$180 (\$60 rebate)	\$205 (\$85 rebate)
Savage Xray	\$180	BB
So + Gi (3D)	\$340 (\$60 rebate)	\$340 (\$153 rebate)

# ***NTS/first trimester US/S rebate list***

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Lots of clinical indications including

- Maternal age > 35
- Risk of miscarriage
- **Risk of fetal abnormality**
- Uncertain dates
- Previous LSCS
- Pregnancy after assisted reproduction

## *Pink Group*

### *Task 1 - 1st trimester pregnancy*

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Carol, a healthy 40 year old presents with a positive pregnancy test. Her first child, now 23 years old was born naturally at term weighing 10lb7oz (4734g). Her BMI is 24, her blood tests from 2 years ago were all normal and her family are all well and healthy. She would like to have an ultrasound scan, “just to be sure” as she knows her risk of miscarriage is high and she wants to see the baby’s heart beat ASAP.

- She has a 30 min appointment. Outline your approach.

# ***Break for lunch***

<b>Time</b>	<b>Task</b>	<b>Who</b>
12 noon	Lunch	All
12:40 pm	Case Work: Task 2	GP groups
12:50	Present task 2 Feedback/discussion	David McIntyre, Treasure McGuire, Michael Beckman, Glenn Gardener
2:10	Physiotherapy	Linda Hickey
2:40	Afternoon Tea	All

## ***Red Group***

### ***Task 2 - Medical conditions in pregnancy***

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Carol is a healthy 40 year old G2P1 whose first child was delivered naturally 23 yrs ago weighing 10lb7oz (4734g). She presents for her regular visit at 28 weeks. She had her bloods taken yesterday and her OGTT is positive.

- Outline your approach to this result including your advice to Carol.

# Green Group

## Task 2 - Pregnancy complications

Julie presents for her 34 week visit. Colleagues at her work have been commenting about how big the baby is going to be. Her symphyseal-fundal height (SFH) measures 38cm and you note that at 30 weeks gestation her SFH was 30cm. She had a negative GCT at 28 weeks.

- Outline your approach including your advice to Julie.

# **Blue Group**

## **Task 2 - Medications in pregnancy**

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- Anna, age 32, whose starting BMI was 40, presents anxiously for advice. Her 11 year old step-daughter, who stayed with her last weekend, has just been diagnosed with Chicken Pox. Anna is 17 weeks pregnant.
- Outline your approach.
- What are the current Australian recommendations for preconception, antenatal and postnatal vaccination? (all vaccines, not just Varicella)

# ***Varicella in pregnancy***

- Varicella-zoster (chicken pox) - At risk times:
- Between 12-20 weeks 2% risk of Varicella Zoster syndrome. Risk of maternal compromise eg. pneumonia. Acyclovir if seen within 24 hours of symptoms.
- Five or less days before birth high risk as baby develops infection without maternal antibodies.
- Refer any woman with varicella in pregnancy, but liaise by phone in first instance to reduce risk to other pregnant women.
- [http://materonline.org.au/Documents/Policies/MMH\\_SharedCareProtocol](http://materonline.org.au/Documents/Policies/MMH_SharedCareProtocol)  
Page 27
- <http://www.asid.net.au/guidelinesandpublications/index.asp>

## Orange Group

### Task 2 - Medications in pregnancy

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- Jane, aged 28 years, has essential hypertension for which she was commenced on an ACE inhibitor some years ago following a full work up. Her BP control has been excellent over the years. She now presents flushed and excited as she has recently fallen pregnant!
- Outline your approach to her care.

# Yellow Group

## Task 2 - Medical conditions in pregnancy

Jane, aged 28 years, has essential hypertension for which she was commenced on medication some years ago. Her BP has been good throughout her pregnancy with readings of 110/70 and 120/80 however she presents at 28 weeks with persistent readings of 140-150/90-100.

- Outline your approach to her care.

## *Pink Group*

### *Task 2 - Medical conditions in pregnancy*

Michelle, age 28, is a new patient who moved to Brisbane earlier this year. Her past medical history includes a strong family history of DVT and she is Heterozygous for the Factor V Leiden mutation and she also has Protein S deficiency. Michelle has had 2 DVTs and is requiring a script for Warfarin and a new INR form. She is not planning a pregnancy just yet, but is interested in any advice you can give her.

- What do you advise her ?



# ***Break for afternoon tea***

<b>Time</b>	<b>Task</b>	<b>Who</b>
<b>2:40</b>	<b>Afternoon Tea</b>	<b>All</b>
<b>3 pm</b>	<b>Case work: Task 3</b>	<b>GP groups</b>
<b>3:10</b>	<b>Present Task 3 EPAU Presentation Panel discussion</b>	<b>GPs Julia Bertolone RN Panel discussion</b>
<b>4:40</b>	<b>Questions from the floor, feedback</b>	<b>All</b>
<b>5 pm</b>	<b>Close</b>	

## ***Red Group***

### ***Task 3 - Pregnancy complications***

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Anna presents at 35 weeks for an unscheduled appointment. Her pregnancy has been progressing smoothly, but she is clearly anxious. Her baby, who usually ‘kicks like a world cup soccer player’, has been noticeably quiet since yesterday afternoon. She asks “Is something wrong with my baby?”

- What do you say to her?
- What do you do if you can hear the fetal heart?
- What do you do if you cannot hear the fetal heart?

## ***Green Group***

### ***Task 3 - Pregnancy complications***

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Amina is now 6 weeks since her LNMP.

She informs you she has been bleeding since yesterday—“sort of like the beginning of a period.”

- Outline your approach to her care.

## ***Blue Group***

### ***Task 3 - Current controversies***

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Jasmine, age 29, is a G1P0 whose LNMP was 5 weeks ago. She is interested in a home birth, with an independent midwife. Can you recommend one? Will the MMH provide backup? She has heard that Medicare is funding this model of care.

- What do you advise?
- Where can you get advice?

# *Home births May 2010*

- Home births accounted for 0.28% of all Qld births from 1988-2007 = 2 672 singleton births. 22.4% of all planned home births from 2001-2007 resulted in transfer for birth elsewhere. (Source: Draft document from Qld Maternal and Perinatal Quality Council, 2010)
- MMH does provide back up care with independent midwives, however if a woman is transferred in labour, her care will transfer to the hospital staff and her independent midwife will become a support person. This may change if visiting rights are granted to independent midwives.



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# *Home births May 2010*

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- MBS rebates for eligible midwives in private practice should be available from Nov 1 for a range of antenatal, intrapartum and postnatal MBS items. The intrapartum items will only be payable for births occurring in a hospital. All items will only be payable for care provided in a "collaborative arrangement", which is yet to be defined



# *Home births May 2010*

- [www.havingababy.org.au/](http://www.havingababy.org.au/) is the website of the Queensland Centre for Mothers and Babies which states that:
  - “To choose private midwifery care, you will usually go to your GP for a check-up early in pregnancy and your GP will give you a referral to a private practice midwife. A GP will also provide a referral to a back-up hospital for a booking visit if you wish.”

[www.havingababy.org.au/toolsAndPlanners\\_planningYourCare.php](http://www.havingababy.org.au/toolsAndPlanners_planningYourCare.php)

- [www.homebirth.org.au/brisbanelist.htm](http://www.homebirth.org.au/brisbanelist.htm) provides a list, but how you would assist a woman to choose an independent midwife is a complicated matter



# Orange Group

## Task 3 - Complicated pregnancies

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Jade is a 22 year old G4P2T1 who presents with an unplanned pregnancy. You have seen Jade and her children on various occasions. Her home life is disorganised, you know she abuses alcohol and you suspect that she also uses illicit drugs. The family is known to the Department of Child Safety. As you take her BP, you notice a suspicious bruise on her arm.

- Outline your approach to her care including what you would say to her.



## **Yellow Group**

### **Task 3 - Medications in pregnancy**

Nicole is now 9 weeks pregnant and is looking decidedly pale and ill at ease as she walks into the consulting room. Her partner is with her, looking worried. “She’s been spewing her guts out Doc, you’ve got to help her!” Indeed, her BP is 90/60 sitting, 80/55 standing, her PR is 104 and she reports that her urine output is down. The chemist has given her some vitamin preparation, which did not help at all.

- **Outline your approach to her care.**



# *Pink Group*

## *Task 3 - Medications in pregnancy*

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Kathy, age 31, is planning her second pregnancy. You provided shared ANC for her first pregnancy 5 years ago and diagnosed her post natal depression, which responded very well to Aropax (Paroxetine). Despite several attempts at weaning her antidepressant medication, she copes much better when she is on it. She has delayed having a second child due to her fear of a return of the depression, but now that her first child is in Prep, she feels it is now or never.

- Does she need to stop the Aropax?
- Outline your approach to her care during and after pregnancy.