Mater Mothers Hospital Alignment 2

June 3, 2023

Welcome to Country

Today's facilitator

Dr Margaret (Maggie) Robin

BSc MBBS FRACGP DCH DRANZCOG (Adv) MPHTM

- Rural Generalist GP Obstetrician
- Senior Medical Officer, Beaudesert Hospital
- Antenatal Clinic GP, MMH
- Community GP, St Lucia Medical

Acknowledgments

- MMH
- Dr Wendy Burton
- Anne Williamson, Erin Hutley-Clarke, Daniele Ralls, (MMH GP Liaison Midwives), Jacqui Binks (PALC midwife)
- Emily Lorimer & Mater Events Team
- Mater Education & IT Departments
- Our speakers
- Our midwifery colleagues

Objectives

- To provide relevant, practical **information** to GPs, obstetricians and midwives about **clinically relevant** topics relating to best practice maternity care

- To improve the **relationships** and highlight the **communication** channels between the primary, secondary and tertiary sectors

Housekeeping

This is an opportunity to reinforce your learning and utilise the expertise of our subject matter experts. We invite you to ask questions in all sessions. Some questions may need to be taken on notice and answered at a later time.

- Have you watched the pre-course resources?
  - If not, do catch up – they are very informative
- Please make sure your phones are on silent

Session 1

Preconception & Fertility

Time	Task	Who
8:00 am	Welcome, housekeeping, learning objectives	Dr Maggie Robin
8:15 am	Preconception planning	Dr Huda Safa
8:35 am	Fertility	Dr Huda Safa
8:55 am	Small group case work on Fertility & Preconception Full group discussion & reflections	Dr Huda Safa Dr Maggie Robin All
10:10 am	Neonatal Examination	Video
10:20 am	Group reflections, Q & A	All
10:30 am	Morning tea	All

Session two

Case scenario discussions

Time	Task	Who
11:00 am	Diabetes in Pregnancy	Dr Vishwas Raghunath
11:20 am	Persistent pelvic pain	Dr Travis Rule
11:45 am	Preterm labour and PPROM	Dr Maggie Robin
12:00 pm	Postnatal small group case work Full group discussion, reflections	All
12:30 pm	Infections in pregnancy, Ectopic pregnancy	Dr Huda Safa
12:50 pm	Updates & summary	Dr Maggie Robin
1:00 pm	Close	

Alignments 1 and 3

Alignment 1 content

- First trimester presentations, recommended screening tests, ultrasound scanning including nuchal translucency recommendations, NIPT, SMA/CF/FXS, gestational diabetes, prescribing in pregnancy, communication with MMH, Rh negative women, hypertension, pre-eclampsia, early pregnancy bleeding, reduced fetal movements, immunisations and depression

Alignment 3 content

- Perinatal mental health, obstetric complications and medical conditions in pregnancy

This presentation is available online, as are AM1 and AM3

It will be updated as required, so may vary in appearance from the power point you viewed when you attended the alignment program.

From www.materonline.org.au go to ***Shared Care Alignment***, find *program resources* and look for Alignment 2 (please note we run three programs, Alignment 1, 2 ,3 and expect to launch Alignment 4 in 2024)

Kahoot! Practice

Online resources

Mater Guideline

Mater Brochures

National pregnancy care guidelines

RANZCOG education resources

Queensland Clinical Guidelines

Australian Society of Infectious Diseases

GP Learning (RACGP)

Australasian Diabetes in Pregnancy Society

Brisbane South PHN Maternity Resources

Brisbane North PHN Maternity Resources

Maternity-Matters

Online mental health resources

Beyond Blue

Centre of Perinatal Excellence

Pregnancy, birth & baby

PANDA

Mind the bump

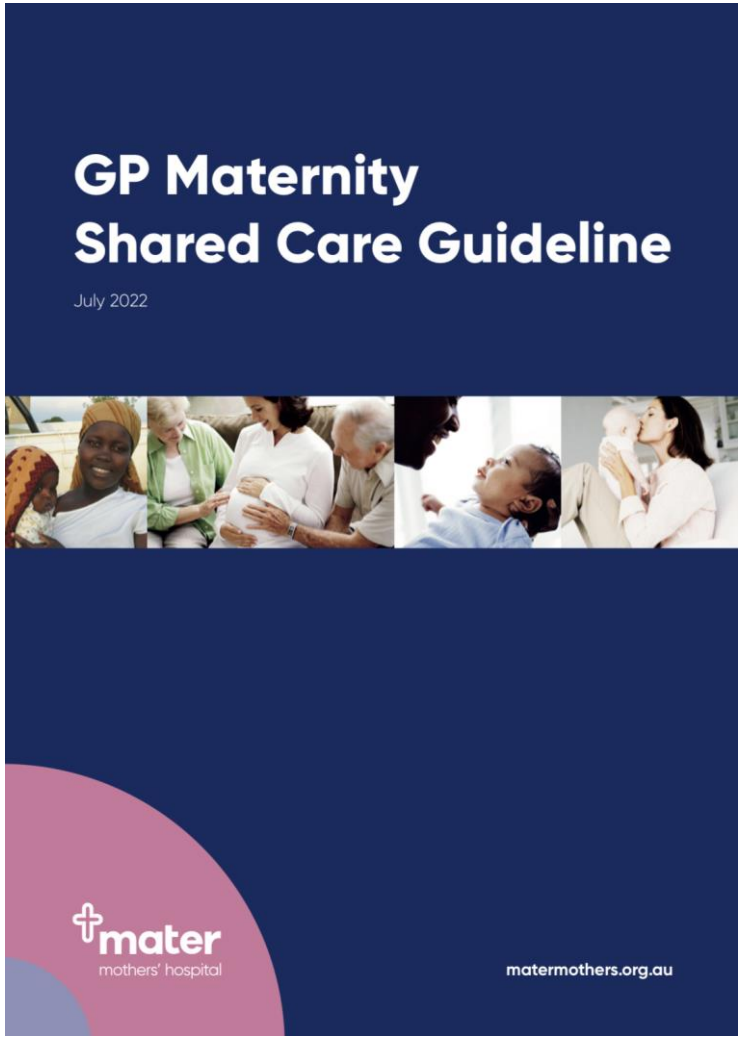
What Were We Thinking

Head to Health

The Marce Society

GP Maternity Shared Care Guideline

This is a 62 page summary of essential principles underlying GP maternity shared care.



Introducing Dr Huda Safa

- A highly experienced, passionate, and caring Obstetrician and Gynaecologist
- Trained at Mater Mothers', Gold Coast, Toowoomba and QEII Hospitals, FRANZCOG 2013
- Consults on gynaecological concerns: period problems, pelvic pain, Pap smear disorders, fibroids and prolapse
- Minor and major gynaecological procedures, including total laparoscopic hysterectomy
- Actively involved in medical education
- **Bloom Women's Health, 201 Wickham Tce, Spring Hill;** operating sessions at Spring Hill Specialist Day Hospital and Mater Private Hospital, South Brisbane

Preconception Care

Dr Huda Safa

MBCHB, FRANZCOG

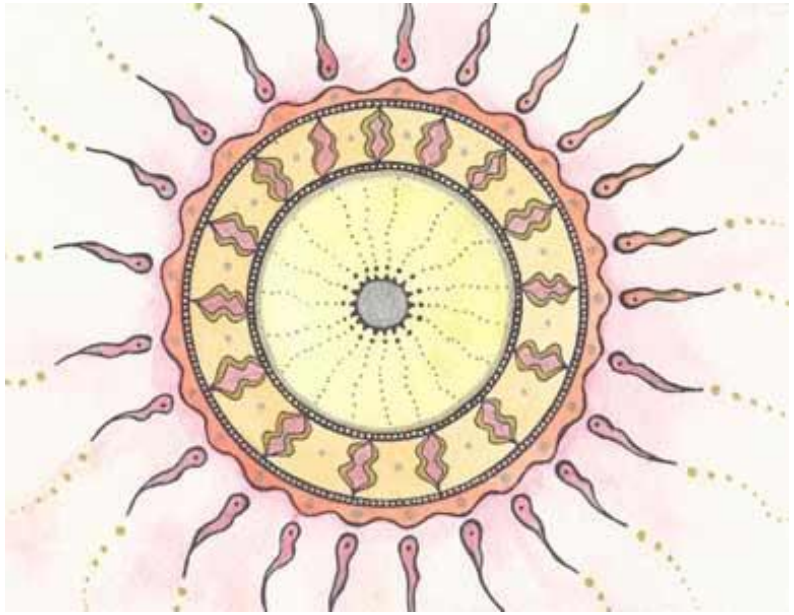
SENIOR STAFF SPECIALIST, OBSTETRICS AND GYNAECOLOGY

MATER MOTHERS' HOSPITAL

SENIOR LECTURER, UQ

Preconception Care

Preconception Counselling



A mindful approach to preparing for and starting a family.
By intentionally preparing your physical body and opening yourself, heart and soul, you "give birth" to yourself as a mother.

Does it work?

- There is a lack of research and evidence except for some specific areas

Does it work?

European Journal of Obstetrics & Gynecology
and Reproductive Biology 84 (1999) 43–49

Original Article

Ten years of experience in periconceptional care

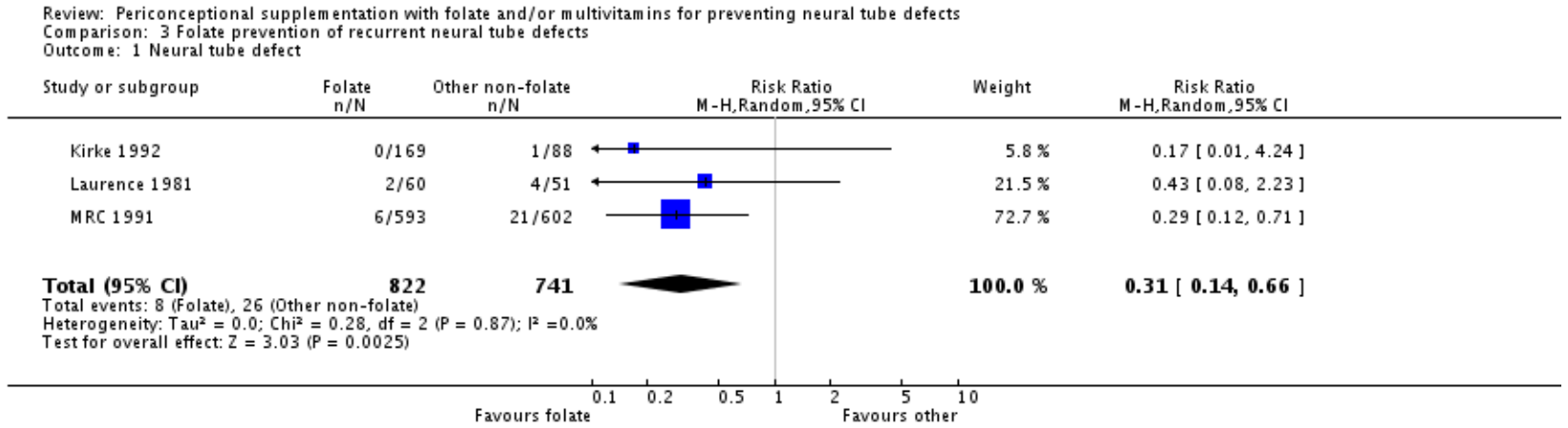
Andrew E. Czeizel*

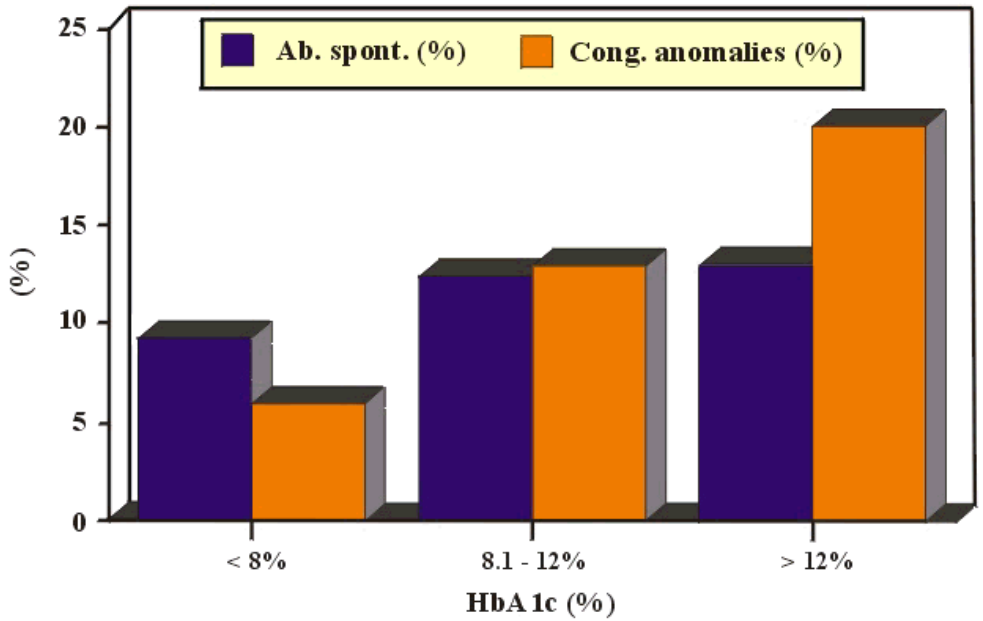
Department of Human Genetics and Teratology, National Institute of Public Health/WHO Collaborating Centre for the Community Control of Hereditary Diseases, Budapest, Hungary

Received 28 July 1998; accepted 30 September 1998

- Infertile couples identified & treated sooner
- Earlier access to STI screening and genetic counselling
- Smoking cessation & ↑ infant birthweight
- ↓congenital abnormalities

Preconception Care-EBP



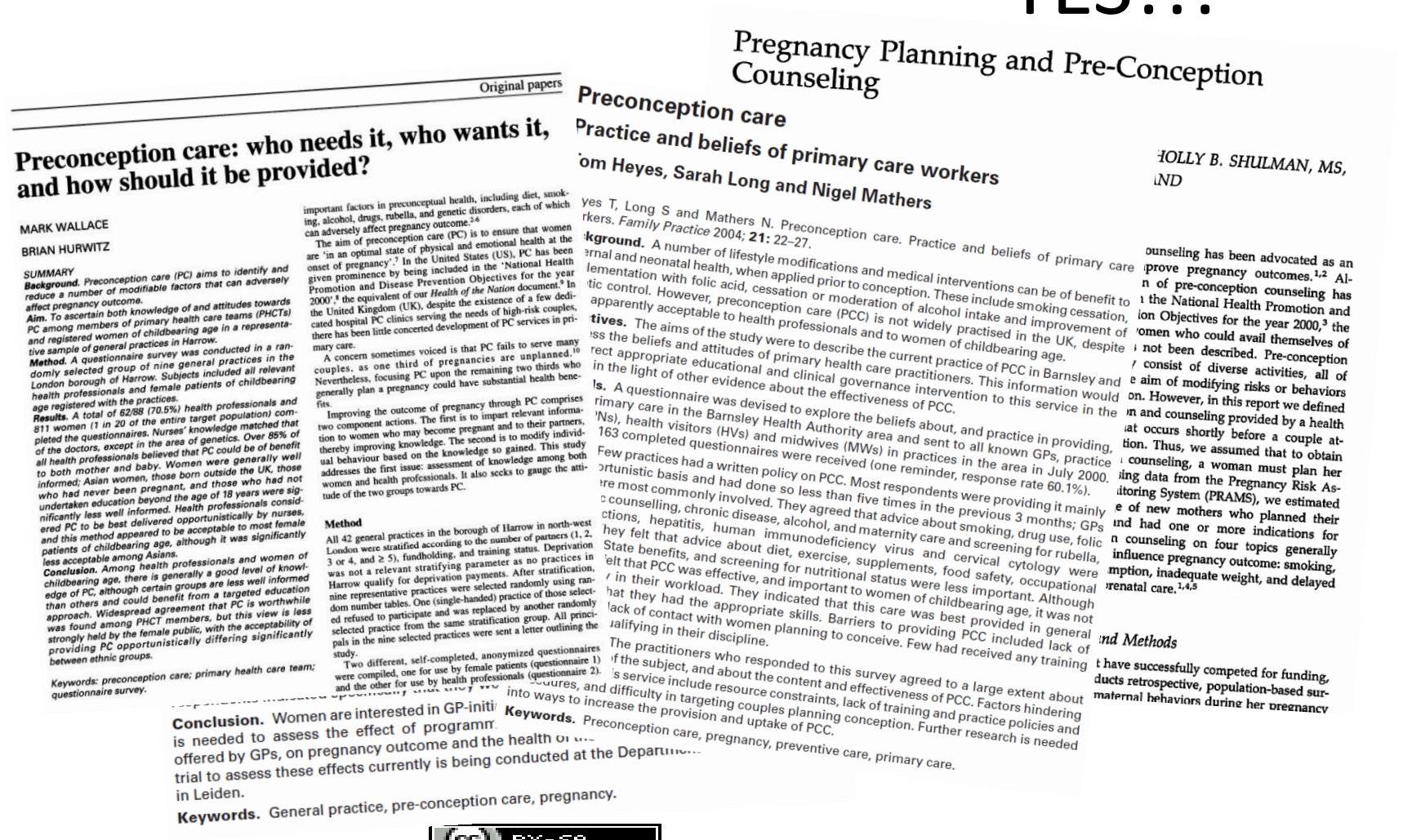


What are we trying to do?

- Identify risks and act to minimise them
- Optimise health
- Educate

Do women and health professionals value preconception care?

YES!!!



Original papers

Preconception care: who needs it, who wants it, and how should it be provided?

MARK WALLACE

BRIAN HURWITZ

SUMMARY

Background. Preconception care (PC) aims to identify and reduce a number of modifiable factors that can adversely affect pregnancy outcome.

Aim. To ascertain both knowledge of and attitudes towards PC among members of primary health care teams (PHCTs) and registered women of childbearing age in a representative sample of general practices in Harrow.

Method. A questionnaire survey was conducted in a randomly selected group of nine general practices in the London borough of Harrow. Subjects included all relevant health professionals and female patients of childbearing age registered with the practices.

Results. A total of 62/88 (70.5%) health professionals and 811 women (1 in 20 of the entire target population) completed the questionnaires. Nurses' knowledge matched that of the doctors, except in the area of genetics. Over 85% of all health professionals believed that PC could be of benefit to both mother and baby. Women were generally well informed; Asian women, those born outside the UK, those who had never been pregnant, and those who had not undertaken education beyond the age of 18 years were significantly less well informed. Health professionals considered PC to be best delivered opportunistically by nurses, and this method appeared to be acceptable to most female patients of childbearing age, although it was significantly less acceptable among Asians.

Conclusion. Among health professionals and women of childbearing age, there is generally a good level of knowledge of PC, although certain groups are less well informed than others and could benefit from a targeted education approach. Widespread agreement that PC is worthwhile was found among PHCT members, but this view is less strongly held by the female public, with the acceptability of providing PC opportunistically differing significantly between ethnic groups.

Keywords: preconception care; primary health care team; questionnaire survey.

important factors in preconceptual health, including diet, smoking, alcohol, drugs, rubella, and genetic disorders, each of which can adversely affect pregnancy outcome.[2-6]

The aim of preconception care (PC) is to ensure that women are 'in an optimal state of physical and emotional health at the onset of pregnancy'.[7] In the United States (US), PC has been given prominence by being included in the 'National Health Promotion and Disease Prevention Objectives for the year 2000',[8] the equivalent of our *Health of the Nation* document.[9] In the United Kingdom (UK), despite the existence of a few dedicated hospital PC clinics serving the needs of high-risk couples, there has been little concerted development of PC services in primary care.

A concern sometimes voiced is that PC fails to serve many couples, as one third of pregnancies are unplanned.[10] Nevertheless, focusing PC upon the remaining two thirds who generally plan a pregnancy could have substantial health benefits.

Improving the outcome of pregnancy through PC comprises two component actions. The first is to impart relevant information to women who may become pregnant and to their partners, thereby improving knowledge. The second is to modify individual behaviour based on the knowledge so gained. This study addresses the first issue: assessment of knowledge among both women and health professionals. It also seeks to gauge the attitude of the two groups towards PC.

Method

All 42 general practices in the borough of Harrow in north-west London were stratified according to the number of partners (1, 2, 3 or 4, and ≥ 5), fundholding, and training status. Deprivation was not a relevant stratifying parameter as no practices in Harrow qualify for deprivation payments. After stratification, nine representative practices were selected randomly using random number tables. One (single-handed) practice of those selected refused to participate and was replaced by another randomly selected practice from the same stratification group. All principals in the nine selected practices were sent a letter outlining the study.

Two different, self-completed, anonymized questionnaires were compiled, one for use by female patients (questionnaire 1) and the other for use by health professionals (questionnaire 2).

Conclusion. Women are interested in GP-initi
is needed to assess the effect of programm
offered by GPs, on pregnancy outcome and the health o
trial to assess these effects currently is being conducted at the Depart
in Leiden.

Keywords. General practice, pre-conception care, pregnancy.

Pregnancy Planning and Pre-Conception Counseling

Preconception care

Practice and beliefs of primary care workers

om Heyes, Sarah Long and Nigel Mathers

yes T, Long S and Mathers N. Preconception care. Practice and beliefs of primary care rkers. *Family Practice* 2004; **21:** 22–27.

kground. A number of lifestyle modifications and medical interventions can be of benefit to ernal and neonatal health, when applied prior to conception. These include smoking cessation, lementation with folic acid, cessation or moderation of alcohol intake and improvement of tic control. However, preconception care (PCC) is not widely practised in the UK, despite apparently acceptable to health professionals and to women of childbearing age.

tives. The aims of the study were to describe the current practice of PCC in Barnsley and ss the beliefs and attitudes of primary health care practitioners. This information would rect appropriate educational and clinical governance intervention to this service in the in the light of other evidence about the effectiveness of PCC.

ls. A questionnaire was devised to explore the beliefs about, and practice in providing, rimary care in the Barnsley Health Authority area and sent to all known GPs, practice 'Ns), health visitors (HVs) and midwives (MWs) in practices in the area in July 2000. 163 completed questionnaires were received (one reminder, response rate 60.1%).

Few practices had a written policy on PCC. Most respondents were providing it mainly ortunistic basis and had done so less than five times in the previous 3 months; GPs re most commonly involved. They agreed that advice about smoking, drug use, folic counselling, chronic disease, alcohol, and maternity care and screening for rubella, ctions, hepatitis, human immunodeficiency virus and cervical cytology were hey felt that advice about diet, exercise, supplements, food safety, occupational State benefits, and screening for nutritional status were less important. Although elt that PCC was effective, and important to women of childbearing age, it was not in their workload. They indicated that this care was best provided in general hat they had the appropriate skills. Barriers to providing PCC included lack of lack of contact with women planning to conceive. Few had received any training ualifying in their discipline.

The practitioners who responded to this survey agreed to a large extent about f the subject, and about the content and effectiveness of PCC. Factors hindering s service include resource constraints, lack of training and practice policies and dures, and difficulty in targeting couples planning conception. Further research is needed into ways to increase the provision and uptake of PCC.

Keywords. Preconception care, pregnancy, preventive care, primary care.

HOLLY B. SHULMAN, MS, ND

ounseling has been advocated as an prove pregnancy outcomes.[1,2] Al- n of pre-conception counseling has the National Health Promotion and ion Objectives for the year 2000,[3] the omen who could avail themselves of not been described. Pre-conception consist of diverse activities, all of e aim of modifying risks or behaviors on. However, in this report we defined n and counseling provided by a health at occurs shortly before a couple at- tion. Thus, we assumed that to obtain counseling, a woman must plan her ing data from the Pregnancy Risk As- itoring System (PRAMS), we estimated e of new mothers who planned their nd had one or more indications for n counseling on four topics generally influence pregnancy outcome: smoking, mption, inadequate weight, and delayed renatal care.[1,4,5]

nd Methods

t have successfully competed for funding, ducts retrospective, population-based sur- maternal behaviors during her pregnancy

Who should we offer it to?

- Likely benefits for both high and low risk women
- Highly valued by patients
- Consider as part of your regular health check-ups
- ? at time of cervical screening test (more challenging now that this is 5 yearly)

Aspects of Preconception Care

- Review of medical and family histories
- Detecting, treating and preventing infections
- Addressing lifestyle factors, nutrition and environmental exposures

Review of medical &family history

- Diabetes
- Hypertension
- Epilepsy
- Thyroid
- Thrombophilia
- Mental illness
- Cardiac disease
- Autoimmune disorders

Review of medical & family history

- Medication review
- Ethnic origin
- Family history
  - NTDs
  - CF
  - Fragile X
  - Tay-Sachs
  - Thalassaemia
  - Sickle cell
  - PKU
- Consanguinity

Personal Obstetric History

- What happened in previous pregnancies?
- What can we do to prepare?

    - GDM
    - Hypertension
    - IUGR
    - Labour and Delivery story

Diagnose, Treat & Prevent infections

- Chlamydia - high risk women

- Rubella
- CMV - high risk women

- HBV
- HIV
- Syphilis

Diagnose, Treat & Prevent infections

- Avoid feeding raw/undercooked meats to pets, avoid cat faeces/litter, wear gloves when gardening
- Hygiene
- Care with urine, saliva, nappies of young children
- Screen STIs
- Vaccinations
  - VZV
  - Pertussis
  - Rubella
  - Influenza
  - COVID-19

Lifestyle factors, nutrition & environmental exposures

- Avoid alcohol
- Quit smoking & vaping, avoid passive smoking
- Avoid cannabis
- Limit caffeine intake
- Review exposures to toxins in household, workplace or at recreational activity

Folic Acid

- 0.5mg daily -1/52 before conception and continuing at least until 12/40

- 5mg if at increased risk
  - Anticonvulsant use
  - Pre-pregnancy DM
  - Previous child or family Hx of NTD
  - BMI >30

Iodine

- Australia is classified by WHO as a mildly iodine deficient nation

- NHMRC recommends dietary supplementation of 150mcg of iodine prior to or as soon as possible after finding out they are pregnant and continuing through pregnancy and lactation

B12

- Vegetarians and Vegans should be supplemented during pregnancy and lactation

- RDI – 6mcg/day

Vitamin D

- Do not test vit D levels in pregnancy as part of routine pregnancy screening, regardless of maternal risk factors.

- Do not re-test vit D in pregnancy, irrespective of previous level.

- Advise all pregnant women, irrespective of their skin pigment and/or sun exposure ,to take 400IU of vit D daily during pregnancy as part of a multivitamin supplement.

RANZCOG statement C-Obs 25

Other Vitamins

- No evidence to support routine supplementation
- Vit A – harmful
- Vit C and E – of no benefit

Iron

- Increased demands during pregnancy
- Discontinuing iron-containing multivitamins for the period that women have symptoms of nausea and vomiting may improve symptoms
- Routine supplementation not recommended but have a low threshold for suspecting and supplementing
  - Vegetarians
  - Multiple pregnancy

Calcium

- Cochrane suggests benefit of calcium supplementation in reducing incidence of hypertensive disorders and preterm labour
- Benefit greater in those with low baseline calcium intake
- Intake should be 1300mcg/day
- If starting supplement – 1000mcg daily

Other minerals

- No evidence to support routine supplementation with Mg, Fl, Zn or rare minerals

- No evidence to support use of other nutritional supplements – (eg. Omega 3 fatty acids etc.)

Exercise and Weight

- Moderate intensity aerobic exercise (swimming, running, aerobics, cycling) has no negative effect on mother or baby in a normal healthy pregnancy

- No association with miscarriage, congenital malformations, ectopic, PPROM, placental insufficiency, IUGR or IUFD (multiple studies!!)

Exercise and Weight

- One study has actually shown that physically fit people who ran or did aerobics during their pregnancy had fewer medical interventions during labour
- Fewer studies on weight training but no adverse findings with light to moderate weight training (free weights or machines) and some suggestion of benefit at reducing low back discomfort (due to increased core strength)

Addressing lifestyle factors, nutrition and environmental exposures

Avoid

- soft cheeses
- Un-pasteurised milk
- Pate
- raw eggs
- hot dogs
- deli meats
- undercooked meats
- reheated left-overs

Aim for normal BMI through regular exercise and balanced nutritious diet

Avoid predatory fish

Wash fruit and vegetables

CASE STUDY

Introducing Jane

- Jane is a 24yo receptionist who presents for a discussion about contraception
- She has never been pregnant and has been a patient of your practice on and off for a number of years although her last visit was 3 years ago when she presented with a sinus infection
- She tells you that she has recently moved in with her boyfriend of 18 months. She thinks that she and her partner might consider starting trying for a baby in the next year or so but are not ready just yet to have a baby
- While they have been using condoms for contraception, they have occasionally had unprotected sex

What would you consider?

- General issues?
- What to discuss?
- Anything to arrange?

Preconception & Fertility Services at Mater Mothers' Hospitals

- **Preconception Care Service**
  - Assists individuals and couples who are planning a pregnancy, to optimise their own health so they may have a healthy pregnancy
  - Both men and women undergo a thorough assessment of their health and lifestyle and are given information on ways to improve their health prior to conceiving
  - They consult with an Obstetrician/Gynaecologist to address specific health conditions that might affect a pregnancy
  - The consultation and some of the investigations performed through Mater Health Services are bulk-billed.

Preconception & Fertility Services at Mater Mothers' Hospitals

- **The Fertility Assessment and Research Clinic (FAR Clinic)**
  - Follows on from the Preconception Care Service
  - Offers specialised care to couples experiencing subfertility and/or recurrent miscarriages and aims to provide couples with information, and to improve their combined fertility.
  - Specialised medical and surgical care is provided
  - The consultation and some of the investigations performed through Mater Health Services are bulk-billed.
  - There is a service fee, if progressing into this service from the Preconception Care Service
  - Clients will receive: formal instruction in the fertility awareness method, the Sympto-Thermal Method (STM), fertility focused investigations, medical and surgical management.

Preconception & Fertility Services at Mater Mothers' Hospitals

- The Mater Mothers' Hospital does not offer ART or IVF services
- The Fertility Assessment and Research Clinic has a particular interest in investigating the value of other therapies to assist couples to conceive an interest in a restorative approach and the value of other therapies to assist couples to conceive.
- The Mater Fertility Service has no catchment restrictions, however catchment restrictions do apply to ongoing maternity care.
- An individual referral is required for both partners to the Natural Fertility Service Address to Dr Sarah Janssens and fax to the Referral Management Centre(RMC) Fax 07 3163 8548
- If you wish to contact Mater Natural Fertility Services phone: 07 3163 8437

Study

- Compare outcomes of pregnancies
    - women who have had a pre-conception consultation VS
    - women who did not
- 8 GOALS OF PERICONCEPTION HEALTH

1. FOLIC ACID	**5. OPTIMIZE MEDICAL CONDITION**
2. WEIGHT MANAGEMENT	**6. GENETIC SCREENING AND COUNSELING**
3. VACCINATION (RUB, VZV,HBV, FLU)	**7. REPRODUCTIVE RISK ASSESSMENT**
4. CEASE SMOKING, ALCOHOL, DRUGS	**8. PSYCHOSOCIAL INTERVENTION**

Preconception care at Mater

Australian and New Zealand Journal of Obstetrics and Gynaecology 2014; 54: 510–514

Background: To date, there is a lack of evidence to suggest that a systematic and coordinated approach to prepregnancy care might make a difference.

Aims: To evaluate whether women who receive preconception care through a structured approach will be more likely to be healthy around the time of conception compared with women who plan their pregnancy but have not been exposed to preconception care.

Methods: A case control study was undertaken of women who attended the preconception care service and subsequently conceived, received maternity care and gave birth at Mater Health Services Brisbane between January 2010 and January 2013. Pregnancy information and birth outcomes for each woman who attended the service were matched with those of three women who reported that they had planned their pregnancy but did not attend the service. Records were matched for prepregnancy BMI, age, parity, prepregnancy smoking status and number of health conditions.

Results: Pregnant women who attended preconception care were more likely to have received adequate peri-conceptual *folate*, to report being *vaccinated* against influenza and hepatitis B, to have *consulted* with a specialist with the specific aim of optimising a pre-existing health condition and to report *less weight gain* up until booking. *Preterm birth and hypertensive disorders of pregnancy were less common* amongst women who had attended preconception care, and there were trends towards a decreased incidence of gestational diabetes, LGA and fetal anomalies.

Conclusion: These preliminary data provide some optimism that a comprehensive preconception care service may positively influence maternal and neonatal outcomes.

But Huda, I only have 15 minutes...!

Covering the basics:

- Cervical Screening Test if due
- Thyroid examination
- Breast examination if indicated
- Cardiac auscultation
- Antenatal screen
  - FBC, iron studies, Blood group/Ab, Rubella/Syphilis/Hep B/Hep C/HIV +/- VZV
- Further bloods and imaging as determined by history

Review appointment to discuss results and provide

- Nutrition advice
- Alcohol, smoking, other substance cessation advice

Folate

- Folate, Folate, Folate, Folate, Folate,
- Folate, Folate, Folate, Folate, Folate,
- Folate, Folate, Folate, Folate, Folate,
- Folate, Folate, Folate, Folate, Folate,
- Folate, Folate, Folate, Folate, Folate,
- Folate, Folate, Folate, Folate, Folate,
- 0.5 mg Vs 5 mg Folate, Folate, Folate
- Iodine, Calcium and Vit D

A quick word on preterm birth prevention…

The information is provided for education and information purposes only. While the information is believed to be accurate at the time of writing, it is not intended in any way as a substitute for professional medical advice or treatment. If there are health complications, the timing of birth should be guided by your healthcare professional. The University of Sydney does not accept any liability for any injury, loss or damage incurred by use of or reliance on the information provided. Our materials reflect current research recommendations at the time of publication.

EVERY WEEK COUNTS

#letstalktiming

www.everyweekcounts.com.au

www.womenandbabiesresearch.com

The Fetus-at-risk approach for calculating rate of stillbirth takes into account all fetuses in utero (yet to be born) at a given gestational age, in addition to those born in that week. For example, fetuses at risk of stillbirth at 35 weeks include babies born at 35 weeks as well as those yet to be born in subsequent weeks. As the pool of women remaining pregnant becomes smaller each week, the weekly rate of stillbirth increases, (as this is the number of stillbirths divided by a decreasing number of fetuses yet to be born and therefore at risk).[3]

Women and Babies Research | THE UNIVERSITY OF SYDNEY | In partnership with Sydney HealthPartners

NSW | Stillbirth | Safer Baby Bundle | WOMEN'S HEALTHCARE | SCV | PSANZ

The University of Sydney | ABN 15 211 513 464
Women and Babies Research, Kolling Institute | Level 5, Douglas Building | Royal North Shore Hospital | St Leonards NSW 2065

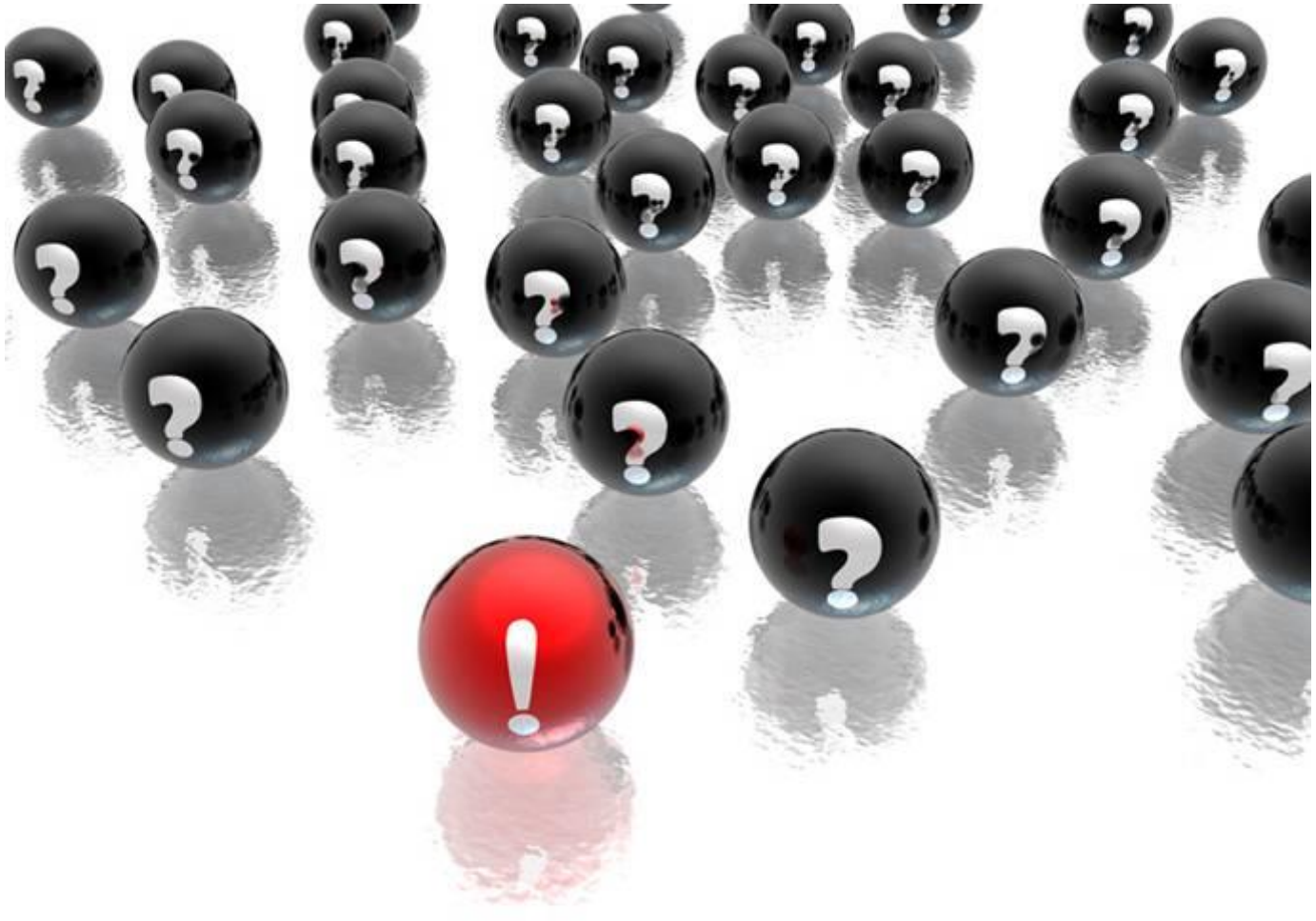
References: **1.** Lain SJ *et al. Matern Child Health J* 2012; 16:600–608. **2.** NSW Perinatal data collection, 2006–2015. **3.** Bentley JP *et al. Pediatrics* 2016; 138(6): 1–10. **4.** Walsh JM *et al. Radiology* 2014; 273(1): 232–240. **5.** Joseph KS *et al. Acta Obstet Gynecol Scand* 2018; 97:454–465

EVERY WEEK COUNTS TOWARDS THE END OF PREGNANCY

Every week that a baby is born close to 40 weeks decreases their risk of morbidity[1] and having to spend time in intensive care

Early (at <39 weeks) planned birth is associated with an increased risk of learning difficulties at school entry[3]

Stillbirth rate remains <1 per 1000 ongoing pregnancies up to 40 weeks, rising to >1 at 41 weeks and beyond[2]



Fertility

Dr Huda Safa

MBCHB, FRANZCOG

SENIOR STAFF SPECIALIST, OBSTETRICS AND GYNAECOLOGY

MATER MOTHERS' HOSPITAL

SENIOR LECTURER, UQ

Infertility—the GP workup

- 15% of couples are affected by subfertility or infertility

- 25-35 years old- 20% per cycle pregnancy rate;
  -85-90% are pregnant <12 months

- Medical evaluation goals for the subfertile/infertile couple are to
  -Find a cause
  -Provide a realistic prognosis
  -Provide options for treatment

Infertility—the GP workup

- GP role involves
  - Educating in normal reproductive physiology
  - Initial assessment and work-up
  - Referral if/when appropriate

Infertility/Subfertility

Female factors	Male factors
Age	Smoking (including cannabis)
PCOS	Drugs (e.g. anabolic steroids)
Obesity (BMI >25, 3 x risk)	Varicocoele
PID	Heat
Endocrine/Auto-immune	Insecticides, CHC
Endometriosis	Y chromosome deletions
Medications/smoking	Structural defects
Ovarian failure	Endocrine
Structural defect/fibroids	

Female History

- Primary/Secondary (GPMET*), duration, contraception
- Cycle – menarche, LNMP, regularity, dysmenorrhoea, menorrhagia, intermenstrual bleeding, midcycle – pain/mucus, premenstrual syndrome
- Sexual – activity, dyspareunia, post coital bleeding
- Gynae History – CST, STD, Breast Examination (opportunistic health screening)
- Infectious Hx – Rubella, VZV, Hep B,C,HIV, PID, Syphilis
- PMHx, PSHx, Treatments, Other, Allergies
- Preconception care issues as per previous slides
- *Gravidity, Parity, Miscarriages, Ectopics, Terminations

Female Examination

- Ht, Wt, BMI, BP, HR, Waist circumference (ideal<80 cm)
- Weight change
- Endocrine – thyroid, PCOS (acne, hirsutism), galactorrhoea
- Cardiorespiratory
- Abdominal (surgical scars)
- Speculum – Cervix/CST, +/- VE

Female Investigations

- Mid-luteal Progesterone (Day 21)
- AN Screen – FBC, blood group/Ab, Serology – Rubella, VZV
- Baseline (Day 3) –
  - LH/FSH (during/after menstruation) or AMH
  - Thyroid
  - Pituitary, Drugs – Prolactin
  - PCOS - SHBG, Androgen profile, ?OGTT/Lipids
- Tubal patency (Day 5-10) – HSG (Hysterosalpingogram, X-ray + dye ~ $346 cost, rebate ~$100), sonohysterogram (USS + saline ~$1220, rebate ~ $600, Pelvic USS included)
- Pelvic USS (Day 5-10) – ovaries, structural lesions, ? fibroids

AMH

- Thought to be a measure of ovarian reserve
- May be elevated in women with PCOS
- Needs to be interpreted with care – the levels fall progressively with age and the use of an AMH nomogram will assist with understanding the value of a reading in an individual woman

Low AMH

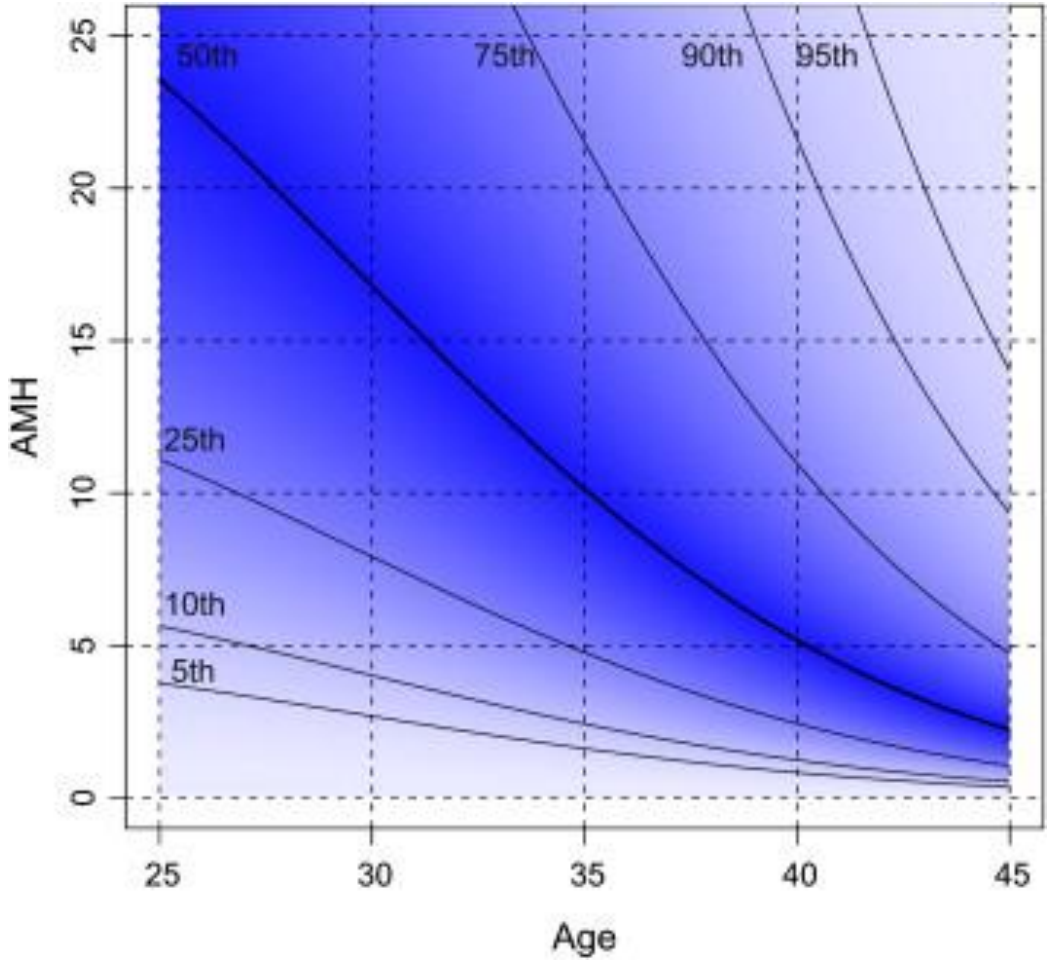
- Assay errors
- Reduced ovarian reserve
  - Idiopathic
  - Genetic
  - Ovarian pathology
  - Endometriosis
- Reduced follicular recruitment
  - Stress
  - Hypogonadotropic hypogonadism

Conclusion

- The AMH is affected by a number of factors
- The assay
  - Limited reproducibility
  - Limited validity
  - Poor predictive capacity for menstrual function, menopause, fertility
- AMH ≠ fertility
  - AMH is an endocrine assay

AMH Nomogram

www.sciencedirect.com/science/article/pii/S0015028210024106



Male History

- Primary/Secondary, duration
- Sexual – activity, dysfunction
- Male Hx – STI, testicular injury, epididymo-orchitis
- Infectious Hx – Hep B,C,HIV
- PMHx, PSHx, Treatments, Other, Allergies
- Diet, Lifestyle, Smoking, Supplements

Male Examination

- Ht, Wt, BMI, BP, HR, Waist circumference (ideal<90 cm)
- Cardiorespiratory
- Stature, body habitus
- Surgical scars – abdominal/inguinal/testicular
- Size – testes, epididymis, spermatic cord, hernia, penis

Male Investigations

- Semen analysis using updated (2021) WHO Classification (>1.4ml, >16M/ml, 42% motility AND 4% normal morphology)
- If needed
  - FSH, LH, Testosterone
  - Consider Karyotype

Summary

- Infertility – sterility/subfertility, primary/secondary
- One year regular unprotected intercourse, unless clinical indications of underlying pathology, e.g. menstrual irregularity, significant pelvic symptoms, scrotal injury/surgery, advanced maternal age > 38.
- Couples should initially have 3 sets of tests: **semen analysis**, **bloods** and **imaging** of the pelvis to assess ovaries, uterus and tubal patency (Pelvic USS + SHG *or* USS + HSG)
- Treatment
  - cause-based (diagnosis/treatment)
  - Symptomatic (IVF overcomes most obstacles and has best pregnancy rate)

Preconception Care and Fertility
Small Group Work

4 groups 15 mins

Consider the cues

- Hypothesise re the specific issues that may unfold
- How might you address these?
- Please appoint a spokesperson for each group

Case 1: Lisa

- Lisa is a 28yo accountant who presents for cervical screening.
- She is a longstanding patient of your practice.
- Her BMI is 37 and she has polycystic ovarian syndrome. She had blood tests last year which showed impaired glucose tolerance, and she has been working with a dietician and exercise physiologist for this.
- Her menstrual cycles range from 28 to 42 days in length.
- She has never been pregnant and is currently single, but has recently met Dean, who she hopes is the man of her dreams.
- During your consultation she brings up that she is keen to have children and is worried about "time running out".

Case 1 continued: Lisa

- Lisa returns five years later for her next CST. She's now 33.
- She and Dean feel they are ready to start a family.
- Lisa's BMI is now 42. Last year, she was diagnosed with Type 2 diabetes mellitus and was commenced on metformin.

Click to add text

What do you advise her?

Case 2: Melissa

- Melissa is a 42yo G3P2M1. Her children are 20 and 18, both spontaneous vaginal births. She and their father are amicably divorced.
- Melissa is now single and the regional manager of a retail company, travelling widely within Australia for work. She has an occasional sexual relationship with Tim, a fellow regional manager, when they're in the same town ("we have fun together, that's all").
- Her father was recently hospitalised with a myocardial infarct at the age of 64 and she has decided to see you for a check up.
- Her blood pressure and BMI have always been normal. She smokes 5 cigarettes / day (recently recommenced after 10 years abstinence, due to work stress). She stopped her OCP two years ago after reading on a blog that it carried a risk of blood clots.
- She "usually" uses condoms but considers that at her age she is unlikely to fall pregnant.

Case 3: Jessica

- Jessica is a 29 yo research scientist, and has never been pregnant. She presents for preconception advice, having had her Implanon removed 3 months ago. She and her partner of four years Peter are hoping to have a baby.
- She has been tracking her cycles using the Clu App and the Fertility Friend website, and is wondering if she should purchase an ovulation kit.
- Jess has a history of a severe depressive episode for which she was briefly hospitalised at age 17. She took an SSRI for several years but then ceased and no longer sees her psychiatrist or psychologist. There is a family history of Type 2 diabetes, coeliac disease and bipolar disorder.

Case 3 continued: Jessica

- Jess presents 14 months later, having not yet become pregnant.
- She has been meticulously documenting her cycles, something which has caused her some anxiety, and been a trigger for some relationship stress between herself and Peter.
- She would like a referral to a fertility specialist. She has been researching fertility treatment however, and is concerned that the medications involved in fertility treatment could affect her mental health.

What do you advise her?

Case 4: Amina

- Amina is a 22 yo veiled woman from Somalia who speaks very little English. She presents accompanied by her husband Ahmed, who translates for her. He is a FIFO worker.

- Amina and Ahmed were married 2 months ago, and are keen to have a baby. They present requesting advice, but appear quite shy.

- Amina's last bloods on record from 6 months ago show a Hb of 95, with low MCV and follow-up testing confirmed thalassaemia trait.

Case 4 continued: Amina

- It is now 13 months later and Amina & Ahmed see you following their third miscarriage.
- Amina avoids eye contact and says nothing during the consultation.
- What do you advise them?

Communicating

- Be culturally sensitive
- An on-site interpreter is preferred
- TIS Ph. 13 14 50
- Communicate clearly
- Traditional beliefs?
- Refugees usually have full Medicare access
- Asylum Seekers generally have limited health and financial support. Asylum seekers can access free care via the Mater Refugee Complex Care Clinic.
- Think about the price of medication as Asylum Seekers can't access the PBS

mater mothers' hospital

Neonatal Examination

Dr David Cartwright

mater
mothers' hospital

Morning tea break

Dr Vishwas Raghunath
Obstetric Physician
MMH

Diabetes in Pregnancy

mater.org.au

Kahoot! Diabetes in Pregnancy

Mater Hospital
Persistent Pelvic Pain Clinic (PPP Clinic) – Dr Travis Rule

Dr Emma Paterson (Staff Specialist O+G)

Dr Jayne Berryman (Specialist Pain Medicine Physician/Anaesthetist)

Kristen Ruhmann (Women's health physiotherapist)

Elizabeth Keays (Psychologist)

Dr Travis Rule (Laparoscopic Fellow)

Persistent Pelvic Pain:

Definition:

- "persistent pain": lasting for >/= 3/12

- "Pelvic Pain" – abdominal pain occurring below the level of the umbilicus → may or may not be associated with menses

- Encompasses many conditions: endometriosis, adenomyosis, painful bladder syndrome, pudendal neuralgia, IBS, PID, vulvodynia, adhesions, ovarian cyst pathology, dysmenorrhea, post surgical neuralgia, neuropathic pain…..

Pain:

IASP definition:

- An unpleasant sensory *AND* emotional experience associated with actual or *potential* tissue damage

- Pain: subjective experience

→ Different for each Pt

What about pelvic pain specifically?

Impacts on:

- Physical
- Emotional
- Mood
- Relationships
- Sex life
- School/ work
- Sleep
- Embarrassed to discuss
- Little empathy → often judged by others to be malingering

Persistent pelvic pain…

Primary indication for:

- 20% Gynaecology OPD referrals
- 40% diagnostic laparoscopies
- 12% hysterectomies

Patients with PPP:

- Use 3x more medications
- Have 4x more gynaecological surgeries
- Are 5x more likely to have a hysterectomy

What is central sensitisation?

Increased excitability of nociceptive system:

- Reduction in pain threshold (allodynia)
- Increased response to painful stimuli (hyperalgesia)
- Increased duration of pain after nociceptor stimulation

Self sustaining pain

- No generator required

Greater anti-nociception is needed

- Endorphins and other analgesics are less effective

What is central sensitisation?

- Viscerovisceral and viscerosomatic convergence and/or cross talk lead to multiple diagnoses
- Exacerbated by low mood/anxiety, sleep disorder, hypervigilance

What are the signs of central sensitisation?

- Allodynia
- Hyperalgesia
- Increased surface area of pain
- Increased duration of pain ie dysmenorrhea vs daily pelvic pain

When managing Pelvic Pain…

- Think of:
  - Organ dysfunction – reproductive, bladder, bowel
  - MSK response to pain
  - Central sensitisation
  - Psychological sequelae of pain

Persistent Pelvic Pain Clinic (PPPC):

- Specialised multidisciplinary clinic for women experiencing longstanding pelvic pain
- **Aim: multimodal approach to managing pain → primary aims of improving global functionality and reducing opiate use**
- **Who**: team made up of:

  -**Pelvic floor Physiotherapist**

  -Psychologist

  -Specialist Pain Medicine Physician

  -Gynaecologist specialising in pelvic pain and endometriosis

Persistent Pelvic Pain Clinic:

- **What patients can expect when attending PPPC:**
- Initial appointment: thorough assessment by multidisciplinary team (MDT)
- GP essential role ensuring Pt has details of prior Rx: operation dates/locations/procedures/outcomes/ current medications…
- Pt at centre!
- Aim 9/12 journey through clinic (3 visits total)
- MDT together with Pt formulate management plan for following 9/12
- At end of 9/12: collaborative plan with GP for ongoing pain management

Referral criteria:

- Referral from specialist Mater gynaecologist (rare exceptions after discussion with team)
- Organic pathology excluded/optimally managed (eg complete excision of endometriosis); must not be awaiting definitive surgical mx
- Primary cause of pain is gynaecological
- Primary issue to be addressed is pain rather than opioid/substance depended/addiction

Referral criteria (cont):

- Not currently under the care of another MDT pain team
- Patient is able and willing to participate in all aspects of the multidisciplinary team
- Pts with frequent ED presentations for exacerbations of pain despite attempts at mx considered for upcategorisation
- Ongoing relationship with GP

Treatment Plan

- Multidisciplinary
- Based on needs identified and plan from initial assessment day
- May involve any combination of MDT

Outcomes

- Health care utilisation (ED/GP/other specialists)
- Number of admissions
- How many investigations (scans, bloods, OT)
- Opioid daily dose
- Sleep
- Mood (DASS21)
- Work/Study/Social function
- Self Efficacy (PSEQ)
- Pain….

Suggestions for interim mx (can have long wait for PPPC)

- Involvement of gynaecologist to mx contributory factors such as dysmenorrhea, PF dysfunction
- Strongly consider referral to physio with interest in pelvic pain
- Consider menstrual suppression if menses driver of pain
- Consider commencing neuropathic pain medication eg amitriptyline, lyrica
- Consider creation of MHCP to allow patient to access psychological support

GP Involvement

'Hub' of MDT

Reinforcing ‘the message’

Initiate basics of management

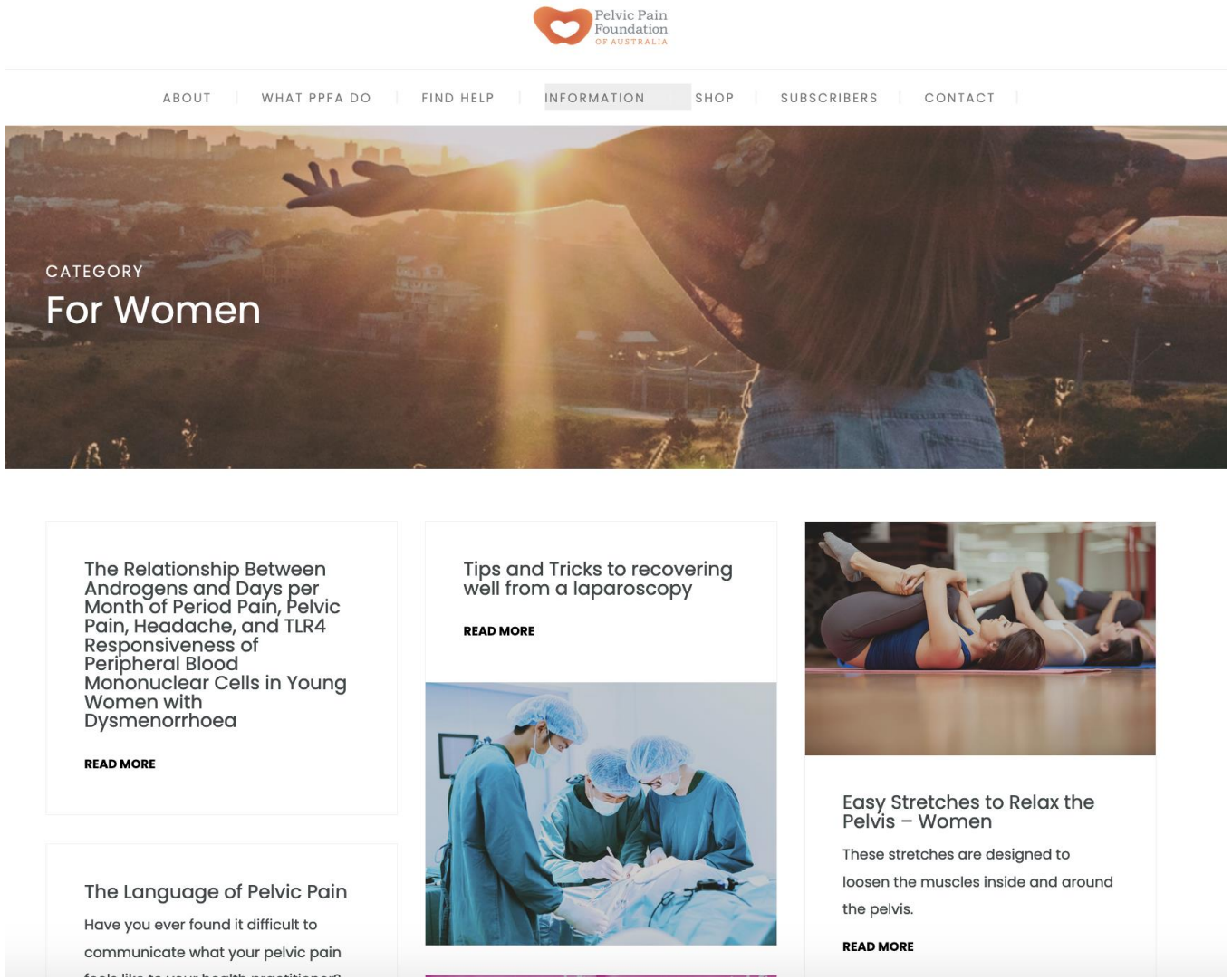
Useful resources:

- Better Pain Management:
  - Written by pain specialists for other medical professionals (CPD points)
  - www.betterpainmanagement.com

- Pelvic Pain Foundation of Australia www.pelvicpain.org.au

- Endometriosis and Pelvic Pain
  - Dr Susan Evans & Deborah Bush

Useful resources:



Pregnancy complications: PROM, PPROM, PTL

Dr Maggie Robin

BSc MBBS FRACGP DCH DRANZCOG (Adv) MPHTM

PTL, PROM, PPROM: What referral to make or test to do when?

- Preterm labour (PTL)
- Prelabour rupture of membranes (PROM)
- Preterm prelabour rupture of membranes (PPROM)

Pregnancy complications

- Krystal—healthy 28 year old G1P0
- 33 weeks presentation
- Uncomplicated pregnancy
- Presents with painful abdominal tightenings for the past couple of days.
- At first these were erratic and uncomfortable
- Now painful, more frequent, lasting longer
- What are the issues that need to be considered?

Summary of routine tests

Abdominal pain

Is she in PTL?

Digital examination can be done if clinically indicated however be aware it may interfere with tests for PTL

Speculum examination – cervix dilated? ROM?

- Swabs
- Specific testing e.g. Actim partus, Fetal fibronectin
- Cervical length on USS

If PTL likely arrange transfer* for management

- Tocolysis
- Steroids
- If in labour IV antibiotics (penicillin)
- If not in labour, antibiotics not indicated

*via Qld Retrieval Service if in a rural or remote area

Pregnancy complications

- Melanie—healthy 26 year old G1P0
- Uncomplicated pregnancy to date
- 38 weeks pregnant
- Presentation = small amounts of clear fluid leaking onto her underwear for the past couple of days
- No abdominal pain or tightening
- What are the issues that need to be considered?

Term PROM

Occurs in around 8% of pregnancies
• Majority (60–95% 2-7) of women will spontaneously establish in labour within 24–48 hours
• Advise women to present for assessment when PROM is suspected

Review history and time of fluid loss • Conduct a clinical assessment

• Avoid digital vaginal examinations as may increase risk of infection
• Sterile speculum examination:
o Visualise pooling of amniotic fluid / leakage from the os with coughing, cervical length and dilatation, exclude cord prolapse
• If required, test vaginal secretions with immunoassay (e.g. AmniSure ® , ActimPROM)

• Low vaginal swab for Group B Streptococcus (GBS)

Term PROM

- Management: expectant, versus active management (induction of labour or CS)
- Indications for active management:
  - Maternal choice
    - PROM greater than 24 hours
    - Group B Streptococcus (GBS) positive or previous baby with early onset GBS (EOGBSD)
    - Signs of maternal infection
    - Concern for maternal or fetal wellbeing
    - Meconium/blood stained liquor
    - Contraindications to vaginal birth

Pregnancy complications

- Sandra, age 30 years, is a healthy G1P0 who presents for her scheduled appointment at 28 weeks. She mentions that over the past 12 hours she has noticed small amounts of clear fluid leaking onto her underwear.

The following issues need to be considered:

- Does she have PPROM?
- Is the fetus viable?
- Is there infection?

Sandra should have a comprehensive assessment, such as would be done at the PAC

Diagnosis of PPROM

- Speculum exam – confirm rupture of membranes, colour of liquor, dilatation of cervix.

Consider signs of complicating factors:

- Temperature – chorioamnionitis (chorio)
- Maternal and fetal pulse rate – chorio
- Uterine tenderness – chorio/abruption
- Fetal heart rate – confirm fetal viability

DO NOT PERFORM a digital examination unless the woman is about to deliver (but consider leaving this to PAC staff)

Investigations:

- Vaginal swabs for MCS; MSU MCS
- Amnisure / ActimPROM test

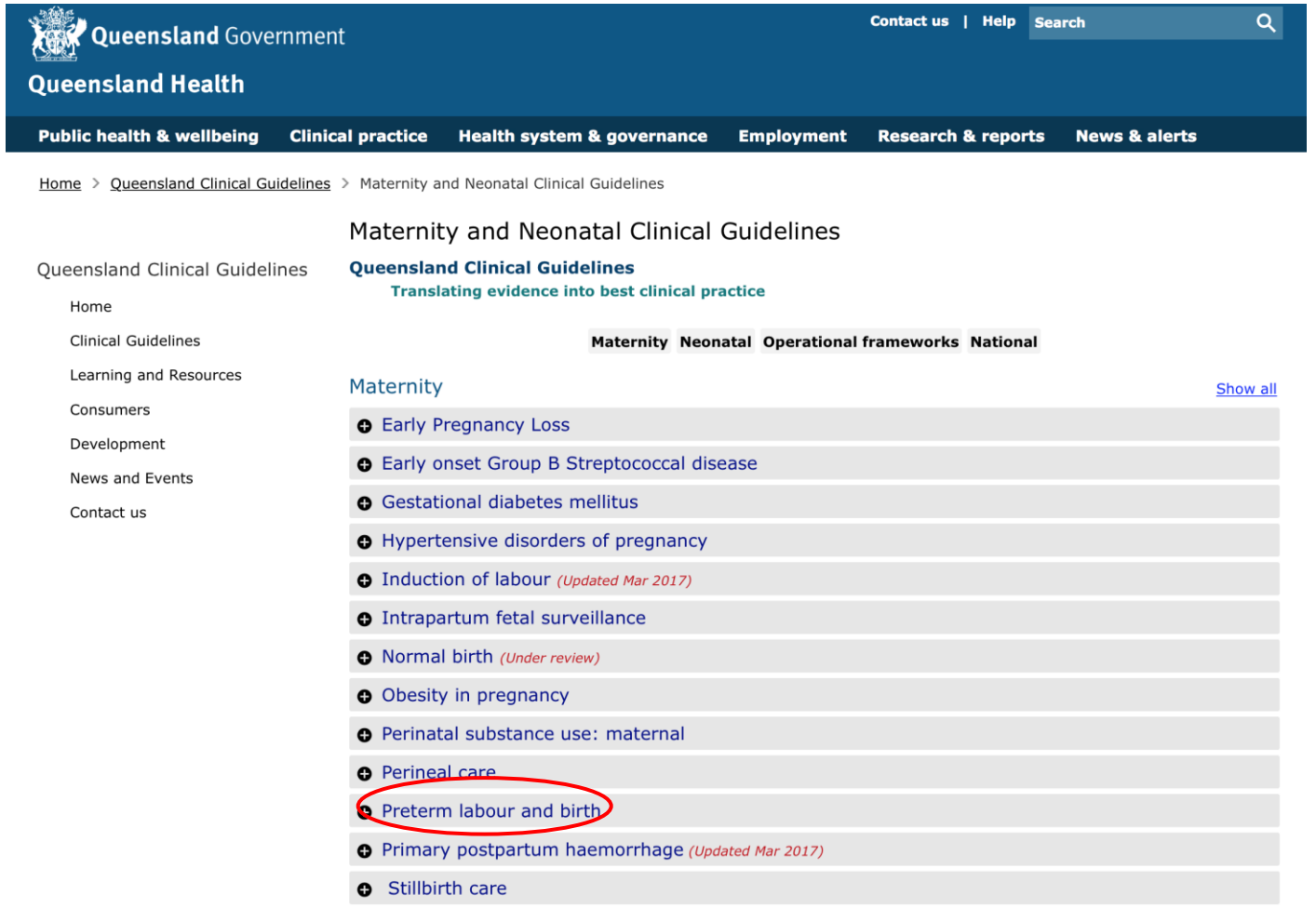
Management PPROM

- Best practice care of PPROM involves transfer to tertiary unit if safe
- Consider
  - Steroids if less than 36weeks (depending upon mode of delivery)
  - MgSO4 if less than 30 weeks and labouring
- If labouring
  - IV antibiotics (penicillin) or known GBS +ve
  - Tocolysis – nifedipine orally
- If not in labour
  - Erythromycin PO

PPROM outcomes

- Most deliver within the first 7 days
- If undelivered, they may be managed as an outpatient
- Positive GBS status – induction of labour (IOL) offered at 34 weeks
- Negative GBS status – IOL offered at 37 weeks
- Breech presentation carries a risk of cord prolapse and head entrapment – Caesarean Section offered with rescue steroids prior to surgery
- If the baby is delivered remotely, arrange transfer* to a tertiary unit along with the placenta
- *via Qld Retrieval Service if in a rural or remote area

Queensland Clinical Guidelines



mater mothers' hospital

Postpartum case discussions

Dr Maggie Robin

BSc MBBS FRACGP DCH DRANZCOG (Adv) MPHTM

Post Partum Care

- You have 10 min for case work
- Each group will need a presenter

Julia

Julia is a G1P1 who had uncomplicated pregnancy, a straightforward delivery and post partum course.

She is now 6 days post partum and presents for her routine visit, along with baby Jack. They have booked two appointments, 15 min for Julia and 30 min for Jack.

What do you complete for Julia's checkup?

Systems based approach to Post Partum Care

Post Partum check at 5-10/7

History:

- **A**dacel/Boostrix/MMR
- **B**reasts
- **C**omplications, calves, contraception
- **D**elivery
- **E**PDS prn
- **F**eeding

Systems based approach to Post Partum Care

Examination:

- **A**bdominal examination to monitor uterine involution; wound check if LSCS
- **B**reasts +/- BP
- **C**areful inspection of perineum if vaginal delivery

Contraception options at 5-10/7 pp

- Abstinence
- Condoms
- Minipill
- Depo/Implanon
- NOT COCP, even if not planning to breastfeed
- NOT IUCD

Mereen

Mereen is a G1P1 who had well controlled GDM, a vaginal birth and third degree perineal tear.

Now 6 weeks post partum, she presents for her routine visit.

Baby Jasmine has the following appointment for 6 week review and immunisations.

What do you complete for Mereen's checkup?

Systems based approach to Post Partum Care

Post Partum check at 6/52

History:

- **A**djustment to parenthood
- **B**ladder, bowels, breasts
- **C**alves, contraception
- **D**elivery debrief prn
- **E**PDS
- **F**eeding
- **G**estational Diabetes follow up prn
- **H**ypertension follow up prn

Systems based approach to Post Partum Care

Examination:

- **A**bdomen
- **B**reasts, BP
- **C**onsider cervical screening test, inspect perineum if tear/episiotomy

Perineal care

- After 6 weeks postpartum for women with anal sphincter injury and those reporting symptoms of anal sphincter dysfunction:
  - Refer to gynaecologist or uro-gynaecologist or colorectal surgeon
  - Care considerations may include:
    - Endoanal ultrasound
    - Anorectal manometry
    - Consideration of secondary sphincter repair
  - Refer to physiotherapist for assessment and individualised PFMT to help manage pelvic floor dysfunction

Source: Queensland Maternity and Neonatal Clinical Guidelines Program
http://www.health.qld.gov.au/qcg/

First degree repair

- If haemostasis evident and structures apposed, suturing not required
- Repair skin with continuous subcuticular sutures or consider surgical glue
- Avoid large volumes of local anaesthetic for clitoral tears

Second degree repair

- Repair muscle with continuous, non-locked sutures
- Use absorbable synthetic suture material
- If skin apposed after suturing muscle layer, suturing of skin is not required
- If skin not apposed after suturing muscle layer, suture the skin

OASIS

- Undertake repair in theatre except in exceptional cases
- Avoid figure of eight sutures
- Trim suture ends and bury knots in deep perineal muscle to avoid suture migration
- Repair of EAS:
  - Use monofilament or modern braided sutures
  - Full thickness EAS tear, use overlapping or end-to-end method
  - Partial thickness EAS tear, use end-to-end method
- Repair of IAS:
  - Repair separately with interrupted or mattress sutures
  - Do not attempt to overlap IAS
- Repair of anorectal mucosa:
  - Use 3-0 polyglactin suture
  - Avoid polydioxanone sutures
  - Use either continuous or interrupted sutures

Perineal tear classification

First degree: Injury to the skin or vaginal epithelium only

Second degree: Injury to the perineum involving perineal muscles but not involving the anal sphincter

Third degree: Injury to perineum involving the anal sphincter complex

- **3a:** Less than 50% of EAS torn
- **3b:** More than 50% of EAS torn
- **3c:** Both EAS and IAS torn

Third and fourth degree tears collectively known as OASIS

Fourth degree: Injury to perineum involving the EAS, IAS and anal epithelium

Rectal buttonhole tear: Injury to rectal mucosa with an intact IAS

Perineal Care Queensland Clinical Guidelines

OASIS = Obstetric Anal Sphincter Injury

Anna

Anna is a G1P1 who had uncomplicated pregnancy, a straightforward delivery and post partum course.

She is now 5 days post partum and presents for her routine visit, along with baby Trinity.

As you commence your routine post partum check, you enquire about feeding and Anna reports that Trinity is unsettled and not feeding well, so this morning she has given Trinity a formula top up.

How do you manage Anna's checkup?

Mater breastfeeding advice

Go to http://brochures.mater.org.au from there you can access the Mater Mothers Hospital link and find a number of topics

Quick Links

- Breastfeeding - the Thompson Method
- The Thompson Method

View other services offered by
Mater Mothers' Hospital

Breastfeeding - the Thompson Method

A new method of breastfeeding, developed by an Australian breastfeeding consultant (Dr RobynThompson) is associated with less pain and nipple damage.

The Midwifery Research Unit is trialling this breastfeeding method in Mater Mothers' Hospital and has introduced a breastfeeding education package for midwives and lactation consultants to become skilled in the Thompson method.

The Midwifery Research Unit will use nonidentified, routinely collected patient information to see if this new approach has reduced complications and increased breastfeeding rates at our hospital.

The Thompson Method

- Cradle baby: comfortably in your arm, elbows relaxed by your side
- First breast: roll baby onto the side to face your breast
- Align baby: baby's lips to mother's nipple
- Baby self-locates: tongue protrudes; mouth opens to a natural width, draws in nipple and breast tissue
- Face to breast symmetry (4-points): nose, chin and both cheeks contact the breast with no gaps
- Fine tune nose and chin points: move baby slightly left or right to fine tune the nose and chin contact
- Fine tune both cheek points: adjust baby's body slightly over or under to ensure both cheeks contact
- Stimulate hormones for milk flow: observe short intermittent stop-start rhythm.
- Swallow reflex: observe change to a long, deep rhythmical draw; baby will swallow as milk flows

Child Health Service

Community health and support services = aims to give every child the best possible start in life.

Free of charge services -- in the home, Child Health Centres, and some community centres

Care is provided by a multidisciplinary team of child health nurses and early intervention clinicians (either social workers or psychologists).

Child Health Service

Services can include:

- Health assessments (surveillance and screening)
- Growth and development checks – as per the Red Book Personal Health Record
- Early feeding support
- Nutritional information and ongoing infant/child feeding support
- Immunisation information and Immunisation Clinics
- Parenting support (seminars, groups and individual interventions)

Appointments can be booked or some clinics offer drop in services

Child Health Service fact sheet

Child Health Service

Parenting support and early feeding drop-in clinics

A free service for parents in the first 12 weeks after discharge from hospital. No appointment required.

An initial, brief discussion with a child health nurse regarding any issues or concerns in the early weeks. This discussion may include:

- infant feeding and sleep
- breastfeeding support and advice.

The nurse can arrange an ongoing appointment with the child health service as required.

Clinic days and hours

Parenting support and early feeding drop-in clinics are located across the greater Brisbane metropolitan area. The tables below list clinic days.

Overleaf you will find a list of the addresses for these clinics.

All clinics are open between **9am and 12pm** (midday) on the days specified in the tables below (closed on public holidays).

As this is a drop-in clinic you may experience a wait during busy times.

Northern suburbs

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Alderley Caboolture Deception Bay Kallangur	Alderley Burpengary Nundah Redcliffe Strathpine Indooroopilly	Alderley Caboolture Kallangur Nundah	Alderley Deception Bay Strathpine	Alderley Caboolture Indooroopilly Kallangur Nundah Redcliffe

Southern suburbs

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Beaudesert Mt Ommaney Springwood Wynnum	Acacia Ridge Coorparoo Cleveland Logan Central	Beenleigh Coorparoo Hillcrest Wynnum	Inala Jimboomba Mt Gravatt East Springwood	Cleveland Hillcrest Logan Central

Queensland Government

North Brisbane clinic locations

Alderley
Shop 4, 24 South Pine Road

Burpengary
Burpengary Meadows State School Early Years Centre
Kurrajong Drive

Caboolture
Caboolture Early Years Centre
Corner Tallon and Manley Streets

Deception Bay
Moreton Medical Centre
Market Square Shopping Centre
Corner Bay Avenue and Deception Bay Road

Indooroopilly
Corner Lambert and Clarence Roads

Kallangur
126 School Road

Nundah
10 Nellie Street

Redcliffe
181 Anzac Avenue

Strathpine
568 Gympie Road

South Brisbane clinic locations

Acacia Ridge
Acacia Ridge Early Years Centre
67 Nyngam Street

Beaudesert
Beaudesert Early Years Centre
4 Michaelina Drive

Beenleigh
84 York Street

Cleveland
Redland Health Service Centre
3 Weippin Street

Coorparoo
236 Old Cleveland Road

Hillcrest
Browns Plains Community Health Centre
Corner Wineglass Drive and Middle Road

Inala
64 Wirraway Parade

Jimboomba
Caddies Community Centre
19-33 South Street

Logan Central
97-103 Wembley Road

Mt Gravatt East
18 Badminton Street

Mt Ommaney
171 Dandenong Road

Springwood
16 Cinderella Drive

Wynnum
130 Florence Street

Updated: January 2018

Contact us

t **Child Health Service** 1300 366 039
t **Breastfeeding helpline** 1800 686 268
t 13 HEALTH (13 432584) 24 hours, 7 days and ask to speak to a Child Health Nurse for child health related telephone advice
w www.childrens.health.qld.gov.au/community-health/child-health-service

Private face to face or telephone services

- Child Health Services
- ABA 1800 686 268 www.breastfeeding.asn.au

Lactation consultants:

- http://www.lcanz.org/find-a-lactation-consultant/
- Mater Parenting Support Centre Ph 3163 2229
- Possums Clinic

Mater Mothers' Parenting Support Centre

The caring continues

Mater Mothers' Parenting Support Centre offers early parenting support and guidance for parents up to six months after the birth of their baby.

Support can be provided to help address issues including:

- breastfeeding and feeding
- sleep and settling
- emotional wellbeing
- infant interactions
- adjusting to your new role as a parent/caregiver.

Services provided include:

- holistic assessment of mothers and babies by a highly trained Mater doctor
- individual lactation consultations
- individual sleeping and settling consultations
- general parenting advice and support
- physiotherapy
- psychological support including postnatal wellness group
- educational workshops.

Who can attend?

Families and individuals with babies up to six months of age born at Mater Mothers' Private Brisbane, Mater Mothers' Private Redland or Mater Mothers' Hospital can access the centre. Self-referrals are welcome.

Appointments

A variety of appointment options are available, to ensure we meet the specific needs of each family and individual.

Options include:

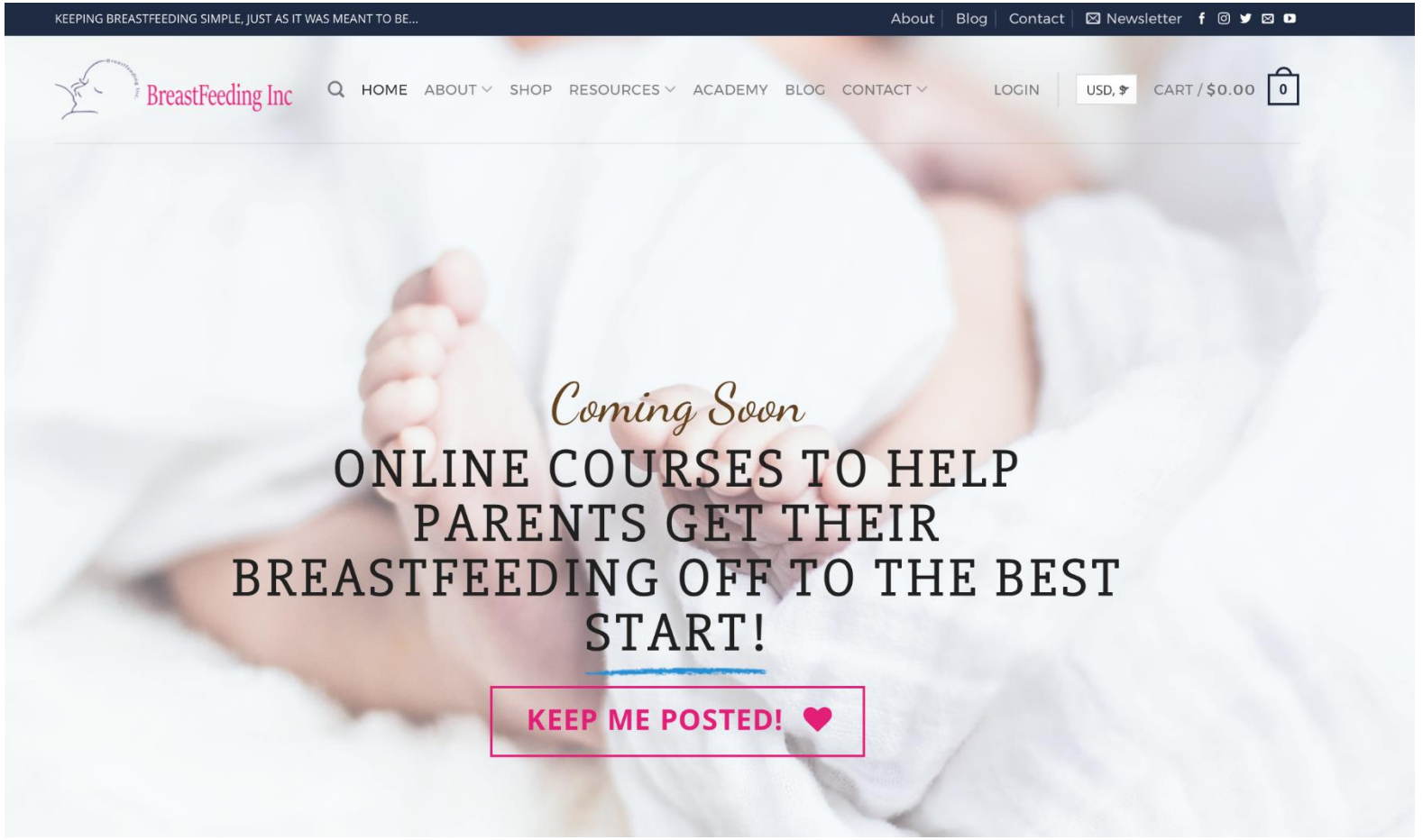
- one on one consultations
- half and full day stay appointments
- online consultation.

Please phone 07 3163 2229 to make an appointment.

Parenting Support at Mater

Online breastfeeding options

BreastFeedingInc



Nicole

Nicole is a G1P1 who had a normal pregnancy and uncomplicated vaginal delivery.

She presents at 5 weeks requesting a checkup, looking pale and tired, reporting that she is still bleeding very heavily, with pain, blood clots and regular flooding.

What do you check?

Infections in pregnancy and Ectopic pregnancy: Kahoot and Q&A

GP SHARED CARE ALIGNMENT PROGRAM –JUNE 2023
HUDA SAFA, MBCHB, FRANZCOG
SENIOR STAFF SPECIALIST, OBSTETRICS AND GYNAECOLOGY
MATER MOTHERS' HOSPITAL
SENIOR LECTURER, UQ

Kahoot! Infections in Pregnancy

mater mothers' hospital

Alignment updates

A quick summary of changes and issues that have arisen since the program commenced in 2008

Pregnancy Assessment Centre (PAC = EPAU + PAOU)

PAC is a specialist area in MMH that deals specifically with pregnancy presentations from conception up to 6 weeks post partum

It has three areas:

- private
- public > k20
- early pregnancy

It is, essentially, an ED for women with pregnancy related problems

The early pregnancy area manages threatened and incomplete miscarriages and investigate causes of pain. They do not provide dating scans.

Women with non pregnancy related conditions e.g. broken arm should still present to ED!

PAC

Haemodynamically unstable women *can* be looked after by the PAC

They are open 24/7

Private patients incur a once only $200 per pregnancy cost

Women < k 20 can present at any time for assessment

- Bookings into the early pregnancy clinic (EPC) are preferred (less waiting)
- EPC operates 8 am – 12 noon Monday to Friday
- Phone 3163 5132 for an appointment
- A referral is not required but is helpful

PAC

- PAC is located adjacent to Birth Suites on level 5 of the MMH
- GP's should contact the PAC before sending a woman in for assessment.
- Team leader 3163 6577 Registrar 3163 6611
- Women can self refer or call their midwife (MGP) or 13HEALTH for advice
- *GPs are encouraged to continue to manage women in the community, where appropriate, and are welcome to phone for advice if required*

Alternative private MOC

- Continuity of midwifery carer, Kaitlyn Reid RM, working with Dr Will Milford, Obstetrician at Kindred Rooms at East Brisbane. Out of pocket expenses for care ~ $1 500*
- Known gap model with mix of private midwifery and obstetric care (but not a continuity of care model) Hatch Maternity ~ $990* Rooms at South Brisbane

* excluding pathology/radiology, extra visits, PAC etc and assuming private obstetric cover

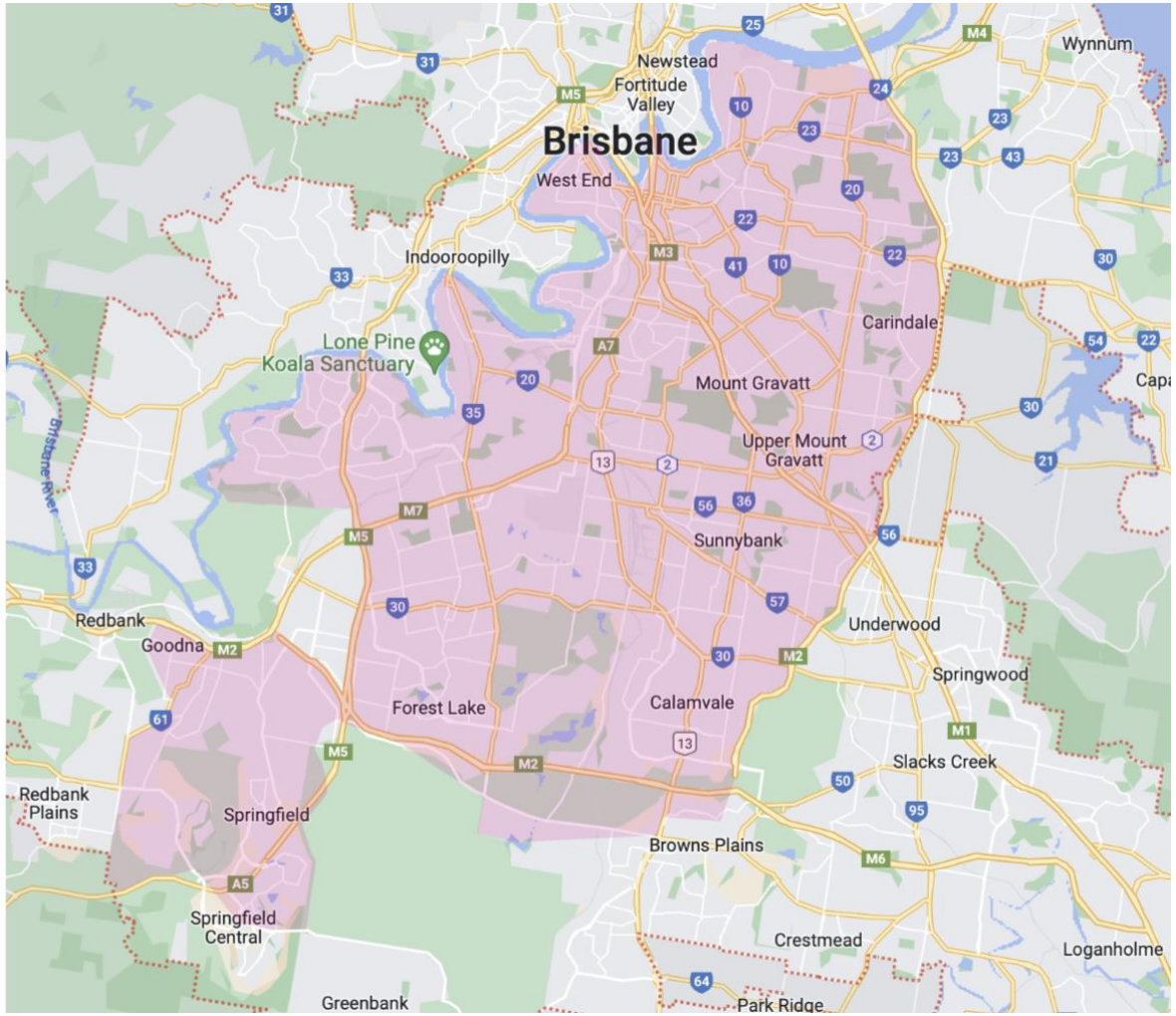
Self insurance

- Women who wish to self fund private maternity care can get a quote from the Mater Mother's Finance Department by ringing switch on 3163 8111 and asking to be put through
- They should expect to be asked to put a $10 000 deposit down and if there are complications, this can escalate rapidly (e.g. NICU admissions)
- For obvious reasons, this is not actively encouraged

MMH catchment area

- Private hospital, public births
- Local hospital, tertiary referral centre
- High demand = no routine low risk referrals outside catchment
  - Except indigenous women
  - Perhaps women requiring a specialist drug and alcohol service
- Refer all women to their local service
- If you are uncertain, or if time is critical = contact GPLM
- Mater Mothers Private? No catchment restrictions

The catchment area



Women living within the catchment area will be accepted, however proof of address is required.

Catchment Map & Postcode List

Mater Mothers' Public Catchment Suburbs

A	
Acacia Ridge	4110
Algester	4115
Altandi	4109
Annerley	4103
Archerfield	4108
Augustine Heights	4300
B	
Balmoral	4171
Balmoral Heights	4171
Banoon	4109
Bellbird Park	4300
Berrinba	4117
Brookwater	4300
Bulimba	4171
Buranda	4102
C	
Calamvale	4116
Camira	4300
Camp Hill	4152
Cannon Hill	4170
Carina	4152
Carina Heights	4152
Carindale	4152
Carindale Heights	4152
Carole Park	4300
Chelmer	4068
Colmslie	4170
Coopers Plains	4108
Coorparoo	4152
Corinda	4075
D	
Darra	4176
Doolandella	4077
Drewvale	4166
Durack	4077
Durack Heights	4077
Dutton Park	4102
E	
East Brisbane	4169
Eight Mile Plains	4133
Ekibin	4121
Ellen Grove	4077
F	
Fairfield	4103
Forest Lake	4077
Fruitgrove	4113
G	
Gailes	4300
Goodna	4300
Graceville	4075
Graceville East	4075
Greenslopes	4120
H	
Hawthorne	4171
Heathwood	4110
Highgate Hill	4101
Hill End	4101
Holland Park	4121
Holland Park East	4121
Holland Park West	4121
I	
Inala	4077
Inala East	4077
Inala Heights	4077
Inala West	4077
J	
Jamboree Heights	4074
Jindalee	4074
K	
Kangaroo Point	4169
Kuraby	4112
L	
Larapinta	4110
M	
Macgregor	4109
Mansfield	4122
Middle Park	4074
Moorooka	4105
Morningside	4170
Mount Gravatt	4122
Mount Gravatt East	4122
Mount Ommaney	4074
Murarrie	4172
N	
Nathan	4111
Nathan Heights	4111
Norman Park	4170
O	
Oxley	4075
P	
Pallara	4110
Parkinson	4115
Q	
Queensport	4172
R	
Richlands	4077
Riverhills	4074
Robertson	4109
Rocklea	4106
Runcorn	4113
S	
Salisbury	4107
Seven Hills	4107
Seventeen Miles Rocks	4073
Sherwood	4075
Sinnamon Park	4073
Springfield	4300
Springfield Lakes	4300
Southbank	4101
South Brisbane	4101
Stones Corner	4120
Stretton	4116
Sumner	4074
Sumner Park	4074
Sunnybank	4109
Sunnybank Hills	4109
T	
Tarragindi	4121
Tennyson	4105
U	
Upper Mount Gravatt	4122
W	
Wellers Hill	4121
West End	4101
Westlake	4074
Willlawong	4110
Wishart	4122
Woolloongabba	4102
Y	
Yeerongpilly	4105
Yeronga	4104
Yeronga West	4104

Updated May 2023

Please consider signing up

Mater has a consumer website www.matermothers.org.au with models of care information

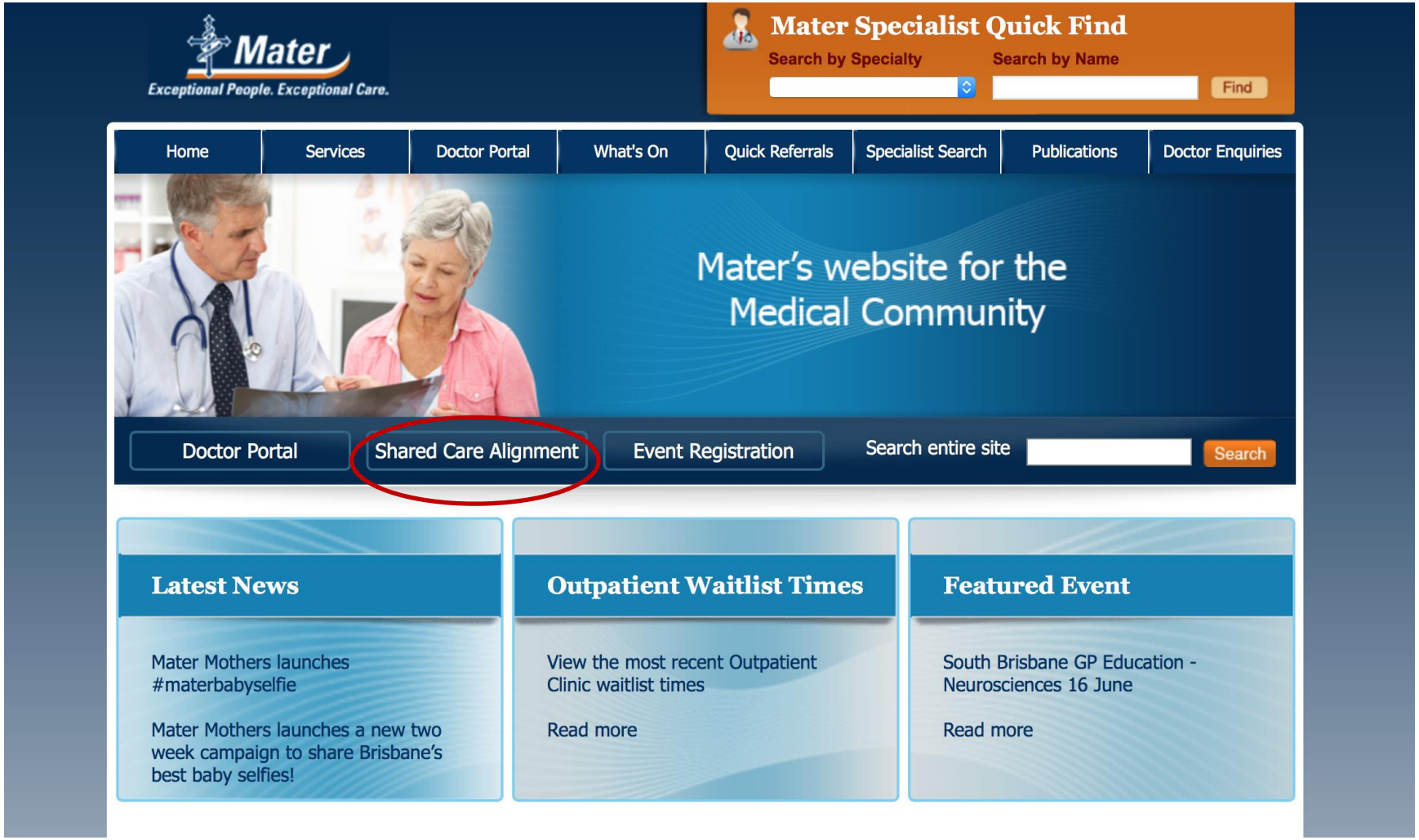
Women who do not have a GP can use this list to locate an aligned GP

- Yeronga
- Wynnum
- Wishart
- West End
- Waterford West
- Underwood
- Toombul
- The Gap
- Sunnybank Hills
- Stones Corner
- Springwood
- Spring Hill
- Slacks Creek
- Seven Hills
- Runcorn
- Rocklea
- Redbank Plains
- Purga
- Paddington
- Norman Park
- Nathan
- Mount Warren Park
- Morningside
- Meadowbrook
- Mansfield
- Macleay Island
- Laidley
- Keperra
- Jindalee
- Indooroopilly
- Holland Park
- Heritage Park
- Greenslopes
- Goodna
- Fernvale
- Eight Mile Plains
- Eagle Heights
- Darra
- Cornubia
- Cleveland
- Capalaba
- Calamvale
- Buranda
- Brookwater
- Bracken Ridge
- Belmont
- Bardon
- Auchenflower
- Annerley
- Acacia Ridge
- Yeppoon
- Woolloongabba
- Windsor
- Wellington Point
- Victoria Point
- Toowoomba
- Tingalpa
- Tenneriffe
- Sunnybank
- Stafford
- Springfield Lakes
- Southport
- Sinnamon Park
- Samford
- Rochedale
- Richlands
- Redbank
- Parkinson
- Oxley
- Newmarket
- Murrumba Downs
- Mount Ommaney
- Moorooka
- McDowall
- Manly West
- Loganlea
- Kuraby
- Kenmore
- Jimboomba
- Inala
- Hillcrest
- Hawthorne
- Greenbank
- Fortitude Valley
- Fairfield
- East Brisbane
- Durack
- Daisy Hill
- Coorparoo
- Carindale
- Cannon Hill
- Burpengary
- Bulimba
- Brookfield
- Bowen Hills
- Beenleigh
- Balmoral
- Ashgrove
- Algester
- Yarrabilba
- Woodridge
- Windaroo
- Wellers Hill
- Upper Mt Gravatt
- Toowong
- Thornlands
- Taringa
- Sumner Park
- St Lucia
- Springfield
- South Brisbane
- Sherwood
- Salisbury
- Robertson
- Redland Bay
- Red Hill
- Park Ridge
- Nundah
- New Farm
- Mt Gravatt
- Mount Cotton
- Middle Park
- Marsden
- Manly
- Loganholme
- Kingston
- Kangaroo Point
- Ipswich
- Holmview
- Highgate Hill
- Gumdale
- Graceville
- Forest Lake
- Everton Hills
- Eagleby
- Dunwich
- Crestmead
- Collingwood Park
- Carina
- Camp Hill
- Burleigh Waters
- Browns Plains
- Brisbane CBD
- Birkdale
- Beaudesert
- Bald Hills
- Ascot
- Albany Creek

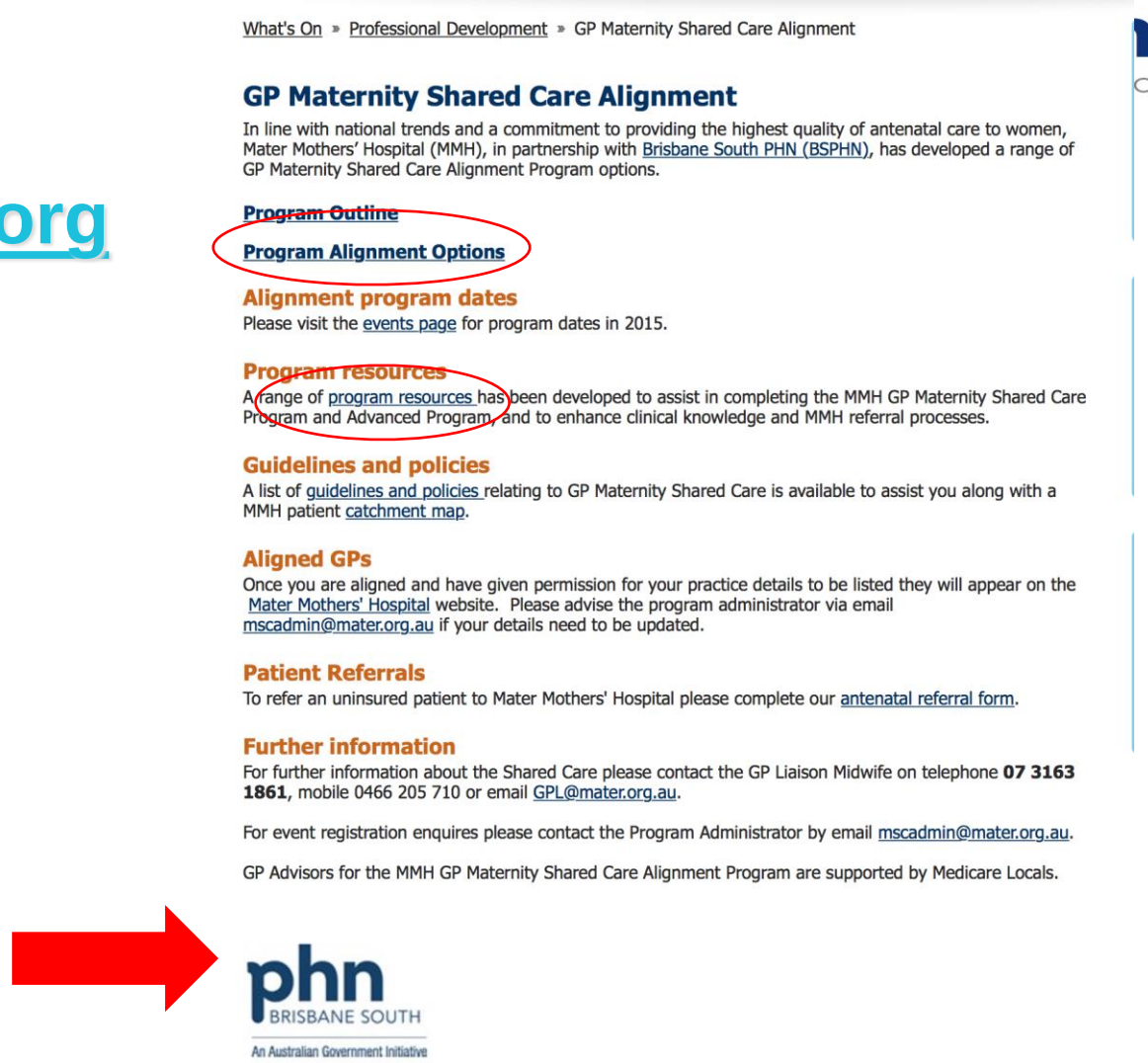
Please watch out for AOTC

We will keep you updated e.g. about changes to the GDM pathway, guideline changes, immunisations, education events. AOTC, including past editions, is available online

www.materonline.org.au



www.materonline.org.au/



What's On » Professional Development » GP Maternity Shared Care Alignment

GP Maternity Shared Care Alignment

In line with national trends and a commitment to providing the highest quality of antenatal care to women, Mater Mothers' Hospital (MMH), in partnership with Brisbane South PHN (BSPHN), has developed a range of GP Maternity Shared Care Alignment Program options.

~~Program Outline~~

Program Alignment Options

Alignment program dates

Please visit the events page for program dates in 2015.

Program resources

A range of program resources has been developed to assist in completing the MMH GP Maternity Shared Care Program and Advanced Program, and to enhance clinical knowledge and MMH referral processes.

Guidelines and policies

A list of guidelines and policies relating to GP Maternity Shared Care is available to assist you along with a MMH patient catchment map.

Aligned GPs

Once you are aligned and have given permission for your practice details to be listed they will appear on the Mater Mothers' Hospital website. Please advise the program administrator via email mscadmin@mater.org.au if your details need to be updated.

Patient Referrals

To refer an uninsured patient to Mater Mothers' Hospital please complete our antenatal referral form.

Further information

For further information about the Shared Care please contact the GP Liaison Midwife on telephone **07 3163 1861**, mobile 0466 205 710 or email GPL@mater.org.au.

For event registration enquires please contact the Program Administrator by email mscadmin@mater.org.au.

GP Advisors for the MMH GP Maternity Shared Care Alignment Program are supported by Medicare Locals.

Brisbane South Antenatal Shared Care

Process

Pre-Conception Unique role for GPs!

- Folate and iodine supplementation for all
- Rubella serology +/- vaccination
- Varicella serology if no history +/- vaccination
- Cervical screening if due
- Chlamydia test/treat <30yrs
- Smoking cessation
- Alcohol cessation
- Discuss genetic screening e.g. SMA/CF/FXS or extended panel
- Consider referral to preconception clinic e.g. Mater, Logan pre-pregnancy assessment

First GP Visit(s)

(May take more than one consultation)

- Confirm pregnancy and dates
- Review medical, surgical, psych, family history, medications, allergies etc. – delete old medications, update GP records ± My Health Record shared health summary
- Identify risk factors
- Scan if dates uncertain ***or*** risk of ectopic (previous ectopic, tubal surgery)
- Folate and iodine supplementation
- Discuss and anomaly and genetic carrier testing, including screening vs diagnosis
- Discuss models of care
- BP, weigh, calculate BMI
- Discuss smoking, nutrition, alcohol, physical activity (SNAP); dietary advice (listeria) and drug avoidance
- Offer influenza vaccination as soon as practical

First Trimester Screening Tests

(cc to ANC on all request forms please)

- FBC, Ferritin, blood group and antibodies, rubella, Hep B, Hep C, HIV, syphilis serology, MSU (treat asymptomatic bacteruria),
- Discuss and offer screening for anomalies:
  1. Nuchal Translucency Scan + First Trimester Screen (free hCG, PAPPA) K11-13^{+6} ***OR***
  2. Non-Invasive Prenatal Testing > K9 (Higher failure rate in multiple pregnancy, not Medicare funded, first trimester scan recommended) ***OR***
  3. Triple Test (AFP, Oestriol, hCG) K15-18 if desired or if presents too late for first trimester testing. Not if twins or diabetes
- Cervical screening test if due
- Varicella serology (if no history of varicella or vaccination)
- OGTT (or HbA1c) if high risk for Diabetes ***(see box below)***
- ELFT, TFTs, Vit D, chlamydia ***only recommended for at risk women (see over)***

Uncomplicated pregnancy

- Refer privately for detailed scan (placenta, morphology) at 18-20 weeks
- First Midwifery Booking visit is at 14-16/52 with a Medical visit at 20/52 (18-20/52 combined RM/doctor visit MMH)
- **You are responsible for her care until she is seen by the hospital, after which the responsibility is shared**
- GP visits to be scheduled around hospital appointments to ensure timely review of results
- **All investigations to be reviewed by referring clinician and required follow up taken or referrals made**

GP Visits: 14, 24, 28, 31, 34, 38, 40 weeks

(More frequent if clinically indicated)

- Record or place printed copy of notes and results in Pregnancy Health Record (PHR)
- Schedule, education and assessment as per the PHR
- K26-28 GTT, FBC, Ferritin, Blood group and antibody screen
- Consider need and timing for repeat Syphilis serology
- K36 Hb, Ferritin if indicated
- Offer influenza (any time) & pertussis vaccination (funded from 20 weeks
- **Routine hospital review** at 36 and at 40-41 weeks
- ***Be sure to cc pathology and radiology to the ANC***

General Information

High Risk for Diabetes in Pregnancy?

- Previous GDM or baby > 4500g, polycystic ovarian syndrome, strong family history, glycosuria, BMI > 30, maternal age ≥ 40, ethnicity
- **OGTT by 12 weeks (or HbA1c if OGTT not tolerated). URGENT Hospital ANC referral if abnormal (Fasting ≥ 5.1 mmol or 1-hr ≥ 10 mmol or 2-hr ≥ 8.5 mmol; HbA1c ≥5.9)**
- Please specify reason and include a copy of the results in the referral letter **to your local service**.

Medical Disease or Obstetric Complications? EARLY or URGENT Hospital ANC referral:

- GP referral letters are triaged by consultant within same week
- Please specify urgency and reasons in the referral letter
- Refer to local service who will liaise or make further referrals if required
- ***Be sure to cc pathology and radiology and give women a copy of their results***

Rh Negative Mothers

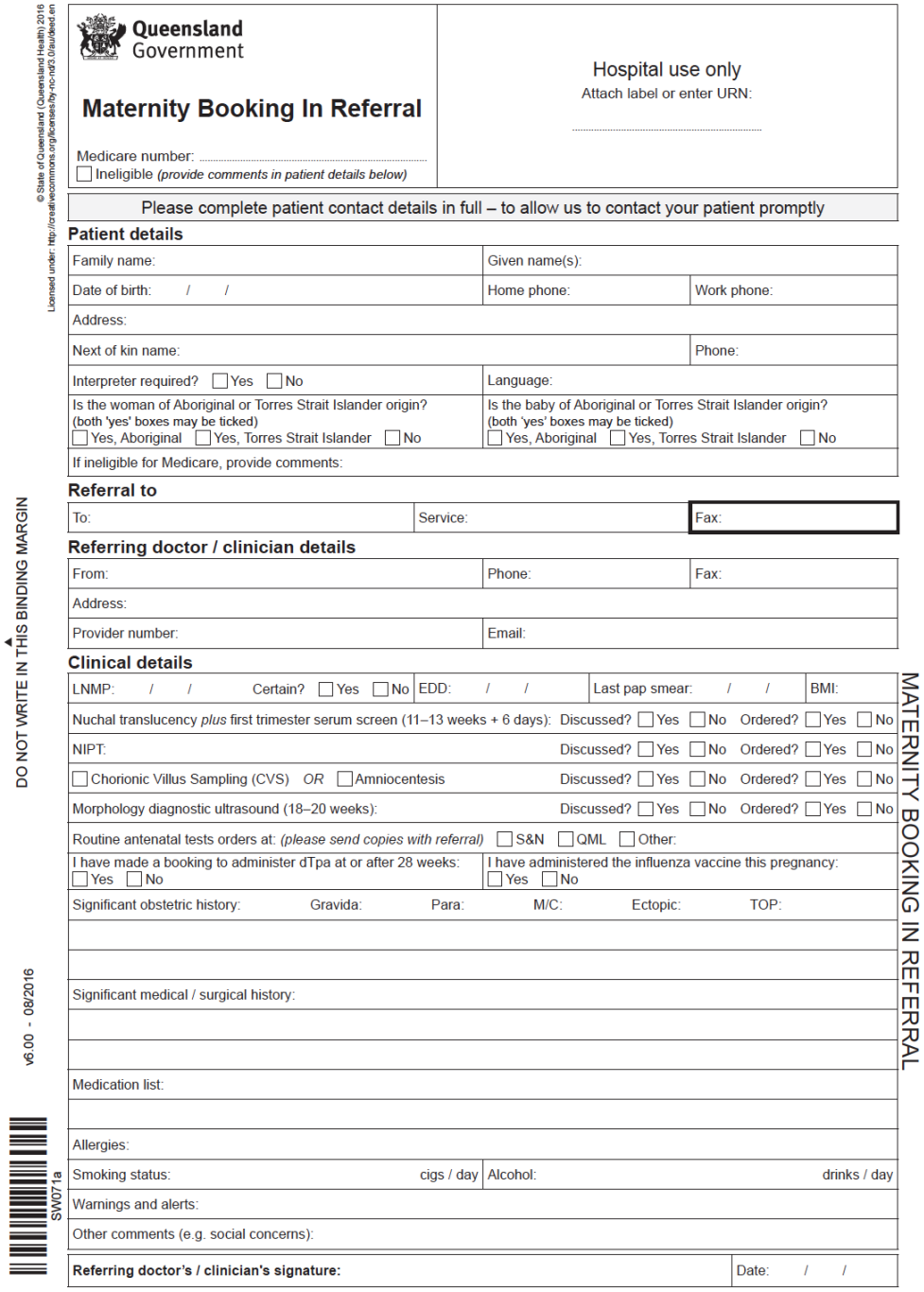
- If antibody negative, offer 625 IU anti-D at 28 and 34 weeks and for sensitisng events
- Dose can be given at local Hospital; or
- Dose can be given by GP—order via Fax from QML or Mater Blood Bank, delivered via courier to surgery
  - QML **3371 9029**
  - Mater **3163 8179**

CONTACTS	Beaudesert	Logan	Redland	Mater
Contact Details for Referrals, Pathology				
Hub fax (for initial referral)	**Central Referral Hub: 1300 364 248**			**3163 8053**
ANC fax (for updated information)	**5541 9132**	**3299 8202**	**3488 3436**	**3163 8053**
Secure e-Referral	**Medical Objects or HealthLink available for all centres**			
ANC phone	**5541 9144**	**3299 8527**	**3488 3434**	**3163 1861**
Perinatal Mental Health Services	**3089 2734**	**3089 2734**	**3825 6214**	**3163 7990**
For Urgent Referral or Advice				
O&G Registrar/GP Obs on Call	**5541 9174**	**3299 8027**	**3488 3758**	**3163 6611**
Obstetrician on call	**-**	**3089 6963**	**3488 3111**	**3163 6612**
Triage Midwife	**5541 9144**	**3299 8811**	**3488 3044**	**3163 1861**
For urgent MH referral/advice	**1300 642255 (1300 MHCALL) for all centres**			
Pregnancy Complications				
Complications, e.g. bleeding, pain, threatened or incomplete miscarriages, phone 24/7 ***Haemodynamically unstable women? Direct to ED/PAC***	**On-Call GP Obstetrician 5541 9111**	**<20 3299 8456** **>20 3299 8811** **EPAU FAX 3089 2016** **ED: 3299 8899**	**On-Call Obstetrician 3488 3111**	**Pregnancy Assessment Centre (PAC) 3163 6577**

Modified by BSPHN and MMH from an original created by Drs Michael Rice, Mano Haran and Heng Tang Version May 2021 www.materonline.org.au | www.bsphn.org.au

QHealth referral template

This helpful document, has decision support built in. An electronic version is available for MD3 on www.bsphn.org.au and is a supplied template on BP (QHealth Maternity). You can also download a paper copy



Queensland Government

Maternity Booking In Referral

Medicare number: .....
☐ Ineligible *(provide comments in patient details below)*

Hospital use only
Attach label or enter URN:
.....

Please complete patient contact details in full – to allow us to contact your patient promptly

Patient details

Family name:	Given name(s):	
Date of birth: / /	Home phone:	Work phone:
Address:		
Next of kin name:		Phone:
Interpreter required? ☐ Yes ☐ No	Language:	
Is the woman of Aboriginal or Torres Strait Islander origin? (both 'yes' boxes may be ticked) ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No	Is the baby of Aboriginal or Torres Strait Islander origin? (both 'yes' boxes may be ticked) ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No	
If ineligible for Medicare, provide comments:		

Referral to

To:	Service:	Fax:

Referring doctor / clinician details

From:	Phone:	Fax:
Address:		
Provider number:	Email:	

Clinical details

LNMP: / / Certain? ☐ Yes ☐ No	EDD: / /	Last pap smear: / /	BMI:	
Nuchal translucency *plus* first trimester serum screen (11–13 weeks + 6 days):	Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No		
NIPT:	Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No		
☐ Chorionic Villus Sampling (CVS) *OR* ☐ Amniocentesis	Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No		
Morphology diagnostic ultrasound (18–20 weeks):	Discussed? ☐ Yes ☐ No	Ordered? ☐ Yes ☐ No		
Routine antenatal tests orders at: *(please send copies with referral)* ☐ S&N ☐ QML ☐ Other:				
I have made a booking to administer dTpa at or after 28 weeks: ☐ Yes ☐ No	I have administered the influenza vaccine this pregnancy: ☐ Yes ☐ No			
Significant obstetric history: Gravida:	Para:	M/C:	Ectopic:	TOP:
Significant medical / surgical history:				
Medication list:				
Allergies:				
Smoking status: cigs / day	Alcohol: drinks / day			
Warnings and alerts:				
Other comments (e.g. social concerns):				

Referring doctor's / clinician's signature: Date: / /

Page 1 of 1

DO NOT WRITE IN THIS BINDING MARGIN

v6.00 - 08/2016

SW071a

MATERNITY BOOKING IN REFERRAL

nater
others' hospital

Queensland Health Maternity & Neonatal Clinical Guidelines

https://www.health.qld.gov.au/qcg/publications

- Low risk women must complete information online before their antenatal booking appointment
- A link is sent via SMS = ***mobile phone number must be correct***
- Mobile phone number changes? Women to contact ANC
- *If unable to be contacted their booking will be cancelled*
- Women who have not completed the online information will have to be *rescheduled* (time pressures)
- Women who need an interpreter have a longer booking appointment, not the online version. Identify them!

You.

If you order it, you are responsible for follow up and referrals

- The cc result is not seen by clinicians until contact with the woman is made
- What to you do with what you have found is in the MMH GP Maternity Shared Care Guideline
- Unsure? Phone a friend

Referral process

- Women with *pre-existing* medical conditions identified in the antenatal referral don't need separate referrals to specialist clinics. The obstetrician will sort it out at the first visit.
- If a woman *develops* a medical condition after referral, fax a new referral to ANC with results.
- HbA1c or OGTT abnormal? Notify patient and ANC promptly.

For clinical advice or if a woman requires urgent review:

- Obstetric registrar: 3163 6611
- Obstetric consultant: 3163 6009
- Obstetric Medicine registrar via switch 3163 8111

The GP Liaison office is open Mon - Fri 0730 - 1600 for general advice and assistance.

- Telephone 07 3163 1861 (you can leave a message) mobile 0466 205 710 or email GPL@mater.org.au

Mater Doctor Portal

Mater Doctor Portal for GPs and private obstetricians (external clinicians)

Summary of routine pathology Ix

- Routine first trimester: FBC, group & antibodies, iron studies, Rubella, Hep B, C, HIV, Syphilis and MSU m/c/s. (CST if due)
- As indicated: Urine PCR for STIs, Vit D, TFTs, HbA1c or early OGTT, E/LFTs, urinary protein/creatinine ratio
- Routine 24-28 weeks: FBC, iron studies, OGTT, group & antibodies, syphilis serology
- Routine 34-36 weeks: FBC, iron studies (group & antibodies if Rh neg only), syphilis if high risk only

Please don't forget to enquire or inform women about….

- Breastfeeding intentions and availability of support e.g. ABA, Mater Breastfeeding Support Centre, http://brochures.mater.org.au
- Antenatal classes
- Vit K and Hep B
- Birthing plans
- When to come to hospital
- Post natal checks

Yes, there's a brochure for that!

You are here: **Home** > **Mater Mothers' Hospital** > Labour and birth—information for women and families

Quick Links

- Birth plans
- Braxton Hicks contractions
- Contractions
- Engagement
- Epidural
- Fetal heart rate monitoring
- First stage of labour
- How does labour start
- Labour contractions
- Massage
- Nitrous Oxide
- Pain management
- Pethidine
- Positioning
- Second stage of labour
- Show
- Signs and symptoms of going into labour
- Sterile water injections for

Labour and birth—information for women and families

Introduction

The final weeks of your pregnancy are often filled with great anticipation as you wait for the birth of your baby. This information has been developed with midwives, doctors and pregnant women to provide helpful advice about ways to make the birth your baby a rewarding experience.

Please use the alphabetical information list on the right or the category list below to navigate this section of the website and find the information you need.

Am I in labour?

Fetal heart rate monitoring

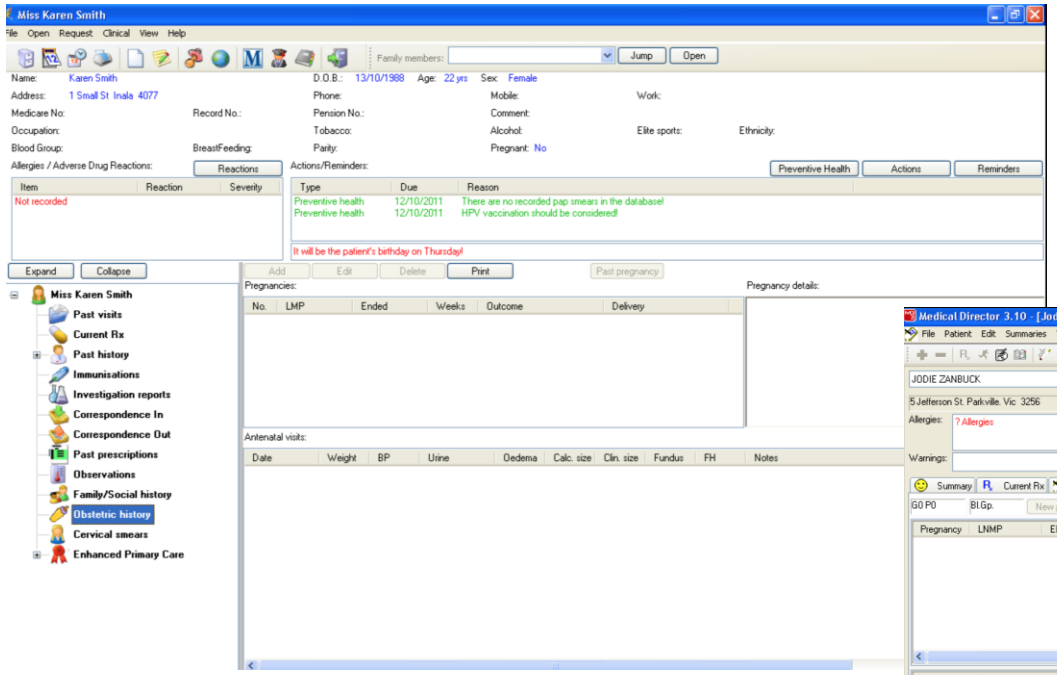
Supporting breastfeeding with skin to skin contact

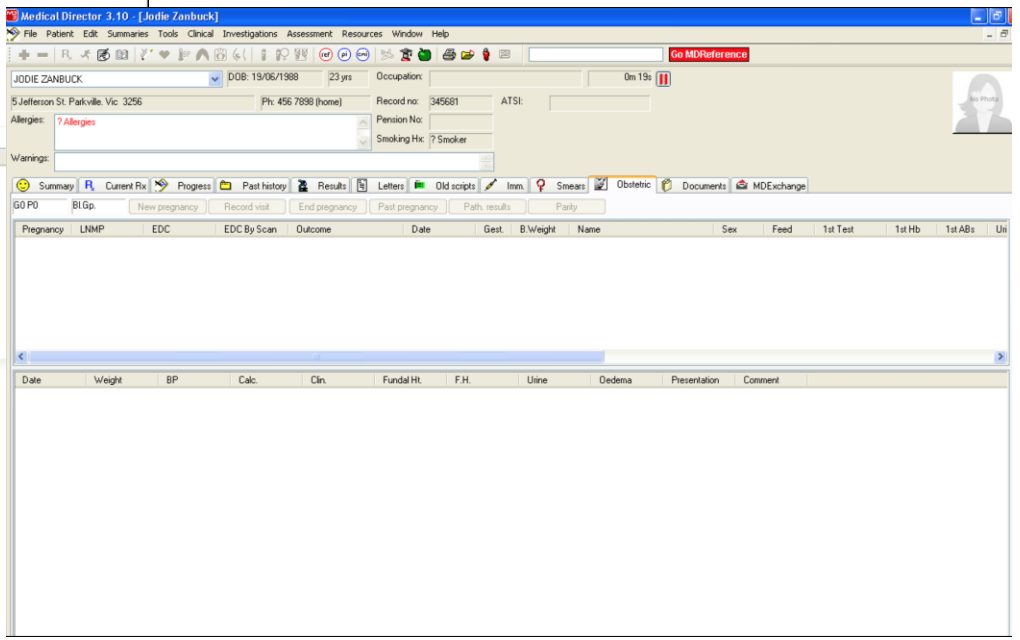
Stages of labour

Pain management

Am I in labour?

Where are you entering your observations?





Use the obstetric tabs

*easy to enter data

*print a copy for PHR

*ready for dPHR

In conclusion….

The Mater Mothers Alignment program has created a significant number of resources which are available online for all to use and to share

We have worked with our colleagues in other hospitals and in general practice to create affiliated programs at Beaudesert, Logan, Redland, RBWH, Redcliffe/Caboolture, Nambour, Ipswich, Biloela and Emerald Hospitals

Please use and share these resources

Contact details

Alignment status, contact details, evaluation training & RACGP enquiries?

- Phone Mater Education on 3163 1500
- Fax 3163 8344
- Email mscadmin@mater.org.au

GPs referring to MSHHS?

Online resources including power points with information on local referral pathways are hosted at Brisbane South PHN

GPs referring to MNHHS?

- **Contact information for the MNHHS Alignment:**
  Brigid Wheaton Program Coordinator Metro North Maternity GP Alignment Program

Phone: (07) 3646 4421

Email: mngpalign@health.qld.gov.au

Online resources are available under Metro North GP Alignment Program on the Education resources page

Item numbers for Maternity Care

16500 Fee $49.85 Antenatal Attendance
16591 Fee $150.75 "Planning and management, by a practitioner, of a pregnancy if:
(a) the pregnancy has progressed beyond 28 weeks gestation; and
(b) the service includes a ***mental health assessment (including screening for drug and alcohol use and domestic violence****) of the patient; and*
(c) a service to which item 16590* applies is not provided in relation to the same pregnancy
Payable once only for a pregnancy"
(16590 = planning to undertake the delivery for a privately admitted patient)

Maternity item numbers

16407
Postnatal attendance: in hospital or at consulting rooms, between 4 and 8 weeks after the birth. Lasts at least 20 minutes and includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient. **Fee:** $75.80

16408

Home visit for woman who was admitted privately for the birth. Midwife (on behalf of and under the supervision of the medical practitioner who attended the birth) Obstetrician or GP can claim. 1-4 weeks post partum, at least 20 min duration. **Fee:** $56.45

4001

Non-directive **pregnancy support counselling** of at least 20 minutes by a **credentialled** GP, for a patient who is currently pregnant; or has been pregnant in the 12 months prior. Up to 3 services claimable per patient, per pregnancy. Fee: $81.00.

TRAINING IS FREE AND AVAILABLE THROUGH BOTH GP LEARNING & ACRRM

YOU ARE NOT YET ALIGNED?!

- You still have to get an 80% pass in the questionnaire (you will be sent a link) and complete paperwork, this may take up to 8 weeks.
- Today's event accrues 4.5 hours of CPD (2 hours Educational Activities, 2.5 hours Reviewing Performance)
- CPD hours need to be self-logged through the RACGP App.

To maintain your alignment, you must realign **every 3 years**:

- repeat one Alignment Seminar (you can repeat this Alignment, attend Alignment 1, 3, 4 or an affiliated Alignment + complete the online bridge) including Q&A;

OR

- attend three relevant antenatal or postnatal/neonatal CPD events and complete online Q & A. The CPD events DO NOT need to be with the Mater Health Services

OR

- Complete a RANZCOG Diploma or Certificate in Women's Health or the RACGP's Antenatal and postnatal ALM + complete the online bridge

OR

- Complete a 2 hour online update.

Good afternoon and would you please?

- Complete the evaluation and give us feedback—let us know what we did we do well and what we could do better
- Let us know if you would be happy to have your contact information available for pregnant women who don't have a regular GP
- Let us know if you would be happy to have BSPHN hold your contact details also
- Give us an email address that we will be able to contact/update you on

mater
mothers' hospital

GOOD AFTERNOON AND THANK YOU!