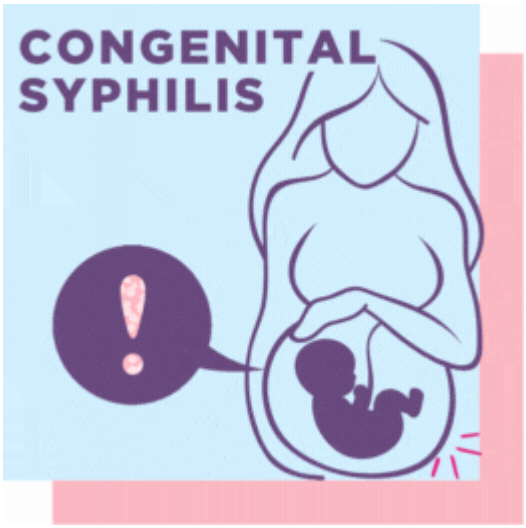
the women's
the royal women's hospital

# GP News

In this latest quarterly edition of GP News, you'll find a wealth of information including resources for GPs and training opportunities.

If you have any feedback or questions, please email us.

## Syphilis update




Unfortunately, cases of syphilis in Australia have more than tripled over the last decade.

According to the Kirby Institute's latest figures, over the past seven years:

- the number of Australian women diagnosed with syphilis has increased by 600%
- there have been 69 cases of congenital syphilis, resulting in 18 infant deaths.

If a woman with undiagnosed syphilis becomes pregnant, or is infected during pregnancy, untreated syphilis can have serious impacts on her pregnancy and baby, including pre-term birth and neonatal death.

Congenital syphilis is entirely preventable. Early diagnosis is important to provide adequate time to treat the infection during pregnancy, thus preventing congenital syphilis.

Syphilis guidelines remain largely locally based, dependent on prevalence and risks within particular areas.

At the Women's, syphilis serology checks are routine, included at both the initial bloods and the 26-28 week bloods. The latter check commenced about a year ago. If you have a woman at higher risk, you may also consider checking at about 36 weeks.

For more information on syphilis, see the Victorian Department of Health website.

## Iron deficiency in pregnancy

The Women's receives many requests for intravenous iron infusion in pregnancy where the criteria for infusion are not met.

We hope the information below assists your conversations with women and supports your management.


**Iron Deficiency Anaemia (IDA) and Non-Anaemic Iron Deficiency (NAID) in pregnancy**

- Anaemia in pregnancy has no universally agreed definition. A reasonable threshold is a Haemoglobin (Hb) of <110 g/L until 20 weeks and xtagstartz105g/L after 20 weeks, with severe anaemia a Hb <70g/L.

- Physiologic anaemia of pregnancy and iron deficiency are the two most common causes of anaemia in pregnant women. However, other potential causes of anaemia such as haemoglobinopathy and other nutritional deficiencies should not be overlooked.
- Demand for iron increases during pregnancy and insufficient iron intake, absorption or blood loss can result in iron deficiency or microcytic anaemia.
- Iron deficiency anaemia is generally accompanied by a ferritin <30ug/L (different laboratories use different assays, so cut-offs vary).
- It is being increasingly recognised that NAID (as well as IDA) may cause symptoms for the mother such as weakness, fatigue, difficulty concentrating, restless legs and increased perinatal depression. It may also result in issues for the developing fetal brain.
- As such, it is important to identify and treat both IDA and NAID.
- Routine investigations of FBE and ferritin are undertaken on initial bloods and a FBE at 26-28 weeks. When a woman has low or borderline ferritin or risk factors for iron deficiency, consider measuring ferritin along with FBE at 26-28 weeks and at 36 weeks.
- Risk factors for iron deficiency include vegetarian diet, use of proton pump inhibitors, previous postpartum haemorrhage, short inter-pregnancy interval, multiple pregnancy, Aboriginal and Torres Strait Islander women, young mothers.

## Management

### Oral Iron

Women with IDA and NAID should be recommended to start regular, sufficient and properly taken oral iron supplementation and increase their dietary iron:

- An increase in dietary iron should be routinely recommended, but is not sufficient in itself.
- Only some pregnancy multivitamin supplements have iron, and the amounts vary. As they often contain calcium, their absorption is lowered.
- Iron supplementation should contain at least 100mg elemental iron per dose (ask the woman to check, as it is frequently lower than this).
- Women should generally take elemental iron 100mg per day (if Hb 100 or above) and 100mg - 200mg per day (if Hb less than 100).
- Iron absorption is increased if taken with a food/drink containing Vitamin C.
- Iron absorption is decreased with many other supplements and foods, including calcium, tea/coffee, legumes and cereals.
- If taken every second day, the absorption percentage may slightly increase and the gastrointestinal side effects decrease. However as the amount of iron ingested is overall decreased, every second day is only recommended if a lower dose of iron supplementation is sufficient.

- Gastrointestinal side effects such as constipation and nausea may be decreased by taking at night and having adequate fluid intake. Iron as iron polymaltose (e.g. “Maltofer”) as opposed to iron sulphate is generally better tolerated, but may be less well absorbed.

### About iron infusions

Intravenous iron is not risk-free. The safety of infusions to the fetus has not been established and there are theoretical risks of the large concentration peak of iron on the fetal liver.

- Due to fetal safety concerns, iron infusions in the first trimester are contraindicated, except in very rare circumstances of severe maternal anaemia.
- The risk of anaphylaxis to the mother is low with the commonly used “Ferrinject” (severe adverse reactions in about one per 1,000 women). However, the consequences can be dramatic. As such if iron infusions are needed, they are best undertaken in hospitals with maternity capacity.
- Iron infusions can cause permanent skin staining and are costly to the health care system and its capacity.

### Iron infusion – who is eligible and how to refer

Women should only be referred to the Women’s for assessment for iron infusion in limited circumstances. These include:

- Iron deficiency anaemia (Hb <100g/L) in late gestation (>36 weeks).
- Iron deficiency anaemia (Hb <100g/L) < 36 weeks where 4 weeks of sufficient oral iron replacement has failed or *has been well tried* but cannot be tolerated, or is likely to be poorly tolerated (e.g. previous gastric bypass surgery).
- Severe symptomatic anaemia (Hb <90g/l), to avoid imminent decompensation/transfusion.

Women with NAID should not receive an iron infusion except in certain circumstances late in pregnancy where there is an increased risk of major blood loss (e.g. placental adhesion disorder) or it is reasonably anticipated anaemia will result.

After an iron infusion:

- Oral iron supplements should be ceased after an iron infusion.
- FBE and ferritin should be checked 2-4 weeks after an iron infusion.

To have your patient assessed for an iron infusion, please send FBE and ferritin results and cover letter to shared.care@thewomens.org.au

If criteria are met, an appointment with a hospital doctor will be made, where the situation will be assessed. Please do not raise expectations with your patient that she will receive an infusion.

## Homebirth program

The Women’s has recently established a Homebirth Program, which enables a small number of women to give birth in their own home with the support of the hospital’s maternity team.

While the program is still in its infancy, there are limited places available each month for women meeting strict eligibility criteria for low-risk pregnancy and birth.

Suitability for a homebirth will not be confirmed with the woman until 36 weeks.

Please continue to send referrals around 16 weeks (unless high risk) and indicate if a woman is interested in a homebirth.

For more information on our homebirth program, see the Women's website.

## Rapid Access Hysteroscopy


The Women's new Rapid Access Hysteroscopy Clinic provides outpatient gynaecology procedures, including diagnostic hysteroscopy and removal of polyps and retained IUDs.

The clinic is within our new Day Procedure Centre on level 5 at the Women's (Parkville).

During these rapid access hysteroscopy procedures, the woman is awake with the total time taking approximately 45 min (the procedure itself usually only takes 5-10 minutes). Patients can leave the hospital immediately afterward.

### The unit can:

**Investigate:**

- heavy or irregular periods
- post-menopausal bleeding
- findings of a thickened endometrium.

**Remove:**

- endometrial or endo-cervical polyps < 2cm (cervical polyps are usually removed in a standard outpatient setting)
- difficult to remove intrauterine devices.

### Exclusion criteria

The Rapid Access Hysteroscopy Clinic is not appropriate for women with the below circumstances:

- weight >120kg
- age < 18 or > 65
- who are likely to need laparoscopy (e.g. pelvic pain)
- who have never been sexually active
- who have poor tolerance of speculum examination
- who have known cervical stenosis
- who have significant medical comorbidities.

**The Clinic is not appropriate for the following:**

- removal of endometrial or endo-cervical polyp >2cm
- removal of cervical polyps only (usually removed in a standard outpatient setting)
- removal of fibroids
- insertion of IUCD only (refer instead to Abortion and contraception services)
- investigation of subfertility and recurrent miscarriages (direct referrals not taken, please refer to the Public Fertility Care Service or Recurrent Miscarriage Clinic).

## Referral

GPs can refer directly to the Rapid Access Hysteroscopy Clinic (RAHC) by:

- completing a **Fast Fax Referral form** (available at Women's Health and Gynaecology referrals or providing your own) and faxing it to (03) 8345 3036
- including the information required to triage the woman and determine her suitability for this clinic, including presenting complaint and previous management, weight, and the mandatory pre-referral tests as relevant. GPs can attach this GP Referral Questionnaire to their referral.
- for guidance on mandatory referral information and tests by gynaecological condition, visit Women's Health and Gynaecology referrals.

The current estimated wait time is 4-6 weeks. Prior to the procedure, patients will have a telehealth consultation to confirm their suitability.


*Webinar recordings*

## Shared maternity care workshops

Two shared maternity care workshops held in late 2023 are now available for viewing on the Women's website.

The workshops cover a range of topics from leading obstetrician and gynaecologist experts.

They were hosted by the Women's, Mercy Hospital for Women, Western Health, Northern Health, and the

North Western Melbourne Primary Health Network.

*Webinar*

## Let's talk about sex: Sexuality and sexual difficulties


**Date:** 15 March and 23 March

**Time:** 8.30am-5.30pm (both days)

**Type:** Online

**Cost:** $770 incl. GST

**Hosted by:** Department of Obstetrics and Gynaecology, Monash University

**Main course facilitator:** Dr Anita Elias, Head of Sexual Medicine and Therapy Clinic at Monash Health

**Description:** This course will discuss the need to talk about sex, the obstacles to talking about sex and will empower participants to raise and discuss topics of sexuality and sexual difficulties with their patients/clients.

**Registration or more information:** Monash University website

*New workshop dates*

## ImplanonNXT training


**ImplanonNXT training**

**Dates:** 19 June, 22 June, 27 June, 22 July, 1 August

**Times:** Two hour workshops, held at various times. You only need to attend one workshop.

**Type:** In-person at the Women's (Parkville)

**Cost:** Free

**Description**: In this workshop, you'll gain the knowledge and skill necessary to safely insert and remove ImplanonNXT through supervised simulated practice. You'll learn about: clinical information, safe insertion and removal, indications and contraindications, and management of side effects. Suitable for doctors, nurse practitioners, nurses, and midwives.

**Please note:** Completion of online ImplanonNXT training is required as a pre-requisite to attend a workshop.

**Registration and more information:** the Women's website.

Contact us

A/Prof Ines Rio, Head GP Liaison Unit
P: (03) 8345 2064
E: gp.liaison@thewomens.org.au

Fast Fax Referral
F: (03) 8345 3036

GP Quick Access Number
P: (03) 8345 2058

Shared Maternity Care Coordinator
P: (03) 8345 2129
E: shared.care@thewomens.org.au

The Women's Switchboard
P: (03) 8345 2000

The Women's Abortion & Contraception Service
P: (03) 8345 2832 (professional line only – not for use by women needing the service)



*The Royal Women's Hospital acknowledges and pays respect to the peoples of the Kulin Nations, the Traditional Custodians of the Country on which our hospital stands.*