The Women’s @ Sandringham

The most significant clinical development this year, is that the Women’s began to manage maternity and gynaecology services at Sandringham Hospital on 1 October 2013. Sandringham is a community hospital currently managed by Alfred Health. It has four birth suites and a level two special care nursery which has cared for about 1,400 births a year. The special care nursery and paediatric service will continue to be managed by Sandringham Hospital. On the gynaecology side, there are currently over 800 operations a year.

The potential for a partnership with a tertiary O&G service was highlighted in Sandringham Hospital’s 2012 consultation with staff and the community, and this development follows many months of discussion and review between Alfred Health and the Women’s. As a leader in women’s health, the Women’s is committed to sharing its specialist expertise to improve
The Women’s @ Sandringham
(continued from front page)

the health and wellbeing of women and newborns now at Sandringham as well as centrally in Parkville.

At a practical level, the Women’s will manage the Sandringham medical staff, midwives and appropriate clerical staff. They will be Women’s hospital employees. Alfred Health will manage the nursing staff, theatre staff and corporate services. The medical records will be a Women’s medical record with an eight digit UR number (unlike the current Sandringham record which is a six digit UR number), however the Sandringham pathology department computer system will recognise and translate both UR numbers. All maternity bookings and gynaecology surgery waiting list bookings will be triaged and managed by our Access Centre in Parkville.

A large group of people from both hospitals have been meeting regularly working on details, troubleshooting potential problems and finding solutions for the transition and the new arrangements going forward. From the Women’s, alphabetically, Chris Bessell, Julie Collette, Tanya Farrell and Donna Fisher have led this initiative and spent much of their working week at Sandringham.

Ricardo Palma-Dias has been appointed to the position, Head of Obstetrics and Gynaecology for the Women’s at Sandringham. Ricardo will provide clinical leadership as the maternity and gynaecology services at Sandringham transitions from Alfred Health to the Women’s. He is working closely with the Directors of Maternity Services (Mark Umstad and Tanya Farrell) and the Gynaecology, Cancer and Perioperative Services (Les Reti and Carolyn Bell) at the Women’s to ensure a smooth transition, to influence and implement change, and to oversee the clinical governance of the service.

We welcome the new staff at Sandringham to the Women’s and look forward to a fruitful collaboration which will benefit the women and babies in Victoria, and in the Sandringham area in particular.

Leslie Reti
Editor

Correction

With regard to the article on the Victorian Audit of Surgical Mortality (VASM) in the last issue of the newsletter, at present the important issue of obstetric surgical mortality monitoring is not included in the VASM process. However, with the high rates of delivery by Caesarean Section in this country and now RANZCOG representation on the national and regional committees, the inclusion of obstetric surgical mortality in this audit process may not be far off.
Professor Michael Quinn

Senior medical staff held a function in August to celebrate the contribution of Professor Michael Quinn to the Women's. It was a well attended, lighthearted event with reminiscences, anecdotes and images from a distinguished and colourful 35 years.

Michael qualified from Glasgow University in 1973. After initial training in general medicine in Glasgow, he took up Obstetrics and Gynaecology and started collecting letters after his name, (currently MB, ChB, MGO (Melb), MRCP (UK), FRANZCOG, FRCOG, CGO). In 1978 he moved to the Royal Women's Hospital, as Research Scholar in the Department of Obstetrics and Gynaecology.

An inexorable rise through the ranks of medical training in Melbourne was interspersed with specialist training as the Felix Meyer Scholar in Gynaecological Oncology at Dalhousie University, Canada in 1981. He became a Consultant Gynaecologist at the Women’s in 1983, and Director of Oncology from 1988 to 2007. Michael was appointed Professor in O&G at the University of Melbourne in 2005. He holds appointments as a Consultant Gynaecologic Oncologist at the Royal Women’s and Royal Melbourne Hospitals, and at the Peter MacCallum Cancer Institute.

His diverse research interests include immune function and ovarian cancer, clinical trials and a lead clinician role in a laboratory investigating drug resistance in ovarian malignancy. He has published over 225 articles in peer-reviewed journals, and has written three books, nine book chapters and two monographs. He has also served in many high offices of several international societies.

Michael is currently a Senior Editor for Gynaecological Oncology and for the International Journal of Gynaecological Cancer, and is Chair of the Australian and New Zealand Gynaecological Trials Group, and of the Gynaecological Cancer Intergroup. He serves as a Member of the Advisory Board for the Australian National Centre for Gynaecological Cancer.

His tireless advocacy of the rights of women with cancer prompted his involvement with the Women’s Cancer Foundation, and his charitable work has generated millions of dollars. He was one of the Victorians Of The Year in 1996.

He manages all this together with a passion for exercise. He has competed more than 10 marathons and in June 2010, climbed Pisco in the Andes with his son.

Michael is a surgeon of consummate skill, and he has taught generations of trainees in the diverse skills of gynaecological oncology. We, along with his almost countless patients, have much to be grateful for.

Dr Phil Popham
Staff Anaesthetist

Pictured: (left) Michael Quinn as he will be remembered at the Women’s and (right): as we have never seen him, in 1973.
Gers, cashmere and maternity medals

In everything we do, we value – courage, passion, discovery & respect.
The Women’s

Our story
It sounds fairly easy, almost routine day-to-day obstetrics. A young 26-year-old woman in her first pregnancy asks an obstetrician if her unborn baby is okay. She is 28 weeks pregnant and is concerned her tummy looks ’too small’. But this is not the Women’s in Melbourne. Our patient is Mongolian and she is working in a tourist outpost of ‘Gers’ or tents in the middle of the isolated Gobi Desert. She has no immediate access to antenatal care.

Before commencing our teaching program for 2013 in Ulaanbaatar, Dr Samantha Hargreaves and myself travelled to an area near Dalanzadgad in the Gobi Desert. It was here that one of the kitchen workers soon learnt of our professional role as obstetricians. In the middle of the Gobi Desert together we had the privilege of performing an antenatal consultation for this young woman. The smile on her face and words of gratitude were priceless.

At the same time the rest of our team were in the capital, Ulaanbaatar, being shown the sites by our Mongolian hosts. In the accompanying photos you will see midwife Jacqueline Gherardin and Dr Kirsten Connan with a group of Mongolians in traditional dress. These people were not our hosts but a group of high school friends meeting for a reunion so wearing traditional dress for their celebration.

On hearing that our team was a group of Australians teaching midwifery and obstetrics, the women in the photo were excited to share their stories. They both had been awarded medals of the ”First Order of Glorious Motherhood” because they had had at least six children. Along with their medals, they received 200,000 Tugriks (about $AUS150), which equates to the monthly wage. The medal of the ”Second Order of Glorious Motherhood” is awarded for four children along with 100,000 Tugriks (about $AUS70).

Quite by accident, we discovered that Mongolians had developed the ”baby bonus” long before Australia. Mongolia is the most sparsely populated country on the planet and the government offered incentives like these medals and money from the 1950’s until the 1990’s to encourage childbearing. Currently the fertility rate sits at 2.49 births per woman (2011).

In June this year, a multidisciplinary team of six doctors, a midwife and a sonographer travelled to Ulaanbaatar, Mongolia’s capital, to provide an obstetric conference in two major hospitals. The theme of this year’s program was ”When to Deliver” and it was facilitated as an interactive lecture series with a strong multidisciplinary focus.

Concurrent to the obstetrics program, a team of eight doctors taught a gynaecological education program in Ulaanbaatar and rural Mongolia. The obstetric program and logistics for both the obstetric and gynaecology groups was coordinated this year by WorldObGyn (www.worldobgyn.com). This organisation is a recently developed venture by current and recent staff of the Women’s to further facilitate ongoing education in the fields of obstetrics, midwifery and gynaecology.

Nine of the 15 team members from 2013 are current or recent employees of the Women’s. This team included senior midwife Jacqueline Gherardin, Dr Kirsten Connan, Dr Rebecca Szabo, Dr Samantha Hargreaves, Dr Kym Jansen, Dr Khai Mohamed-Noor, Dr Hugo Fernandes, Dr Sian Griffiths and Dr Phillip Popham.
Each year for the last 12 years, a group of Australian doctors has been travelling to Mongolia to provide medical education. Initially the focus was on anaesthetic education. Over time this has extended into gynaecology (in 2009), obstetrics and midwifery (2010) as well as the new addition of primary trauma care (2013).

You might ask why we keep going back to Mongolia? Well it’s definitely not the traditional Mongolian diet of mutton or sheep’s intestines. For some (they’ll remain nameless!) it might well be for the opportunity to sample the world’s best vodka or seek out fabulous cashmere! For all of us in fact, the drive to visit and subsequently return to Mongolia is the acknowledgement of the opportunity to share knowledge in a country where the need is great and the genuine interest is learning and progress palatable. With their warm and similarly dry sardonic sense of humor that we Australians often possess, it is hard not to relish in these new forged friendships.

**The country**

Mongolia is the most sparsely populated country in the world with only 2.6 million people (population of Brisbane is 2.1 million) in a large land mass (roughly the size of Queensland). Most people live in the capital with others dispersed through the countryside. So it is not dissimilar to our large continent having a small population mostly concentrated on the eastern seaboard. Both countries have dramatic disparities in health care between city and rural areas and logistical difficulties for those in rural and remote areas to access healthcare. Once you’ve made the 26 hour journey it’s easy to forget we come from over 10,000km away.

Mongolia is a landlocked country wedged between Russia and China. Historically famous for the great Mongol invasions by Genghis Khan, Mongolia is fast becoming better known for its rich resources below the surface of its barren lands. Touted as one of the world’s fastest-growing economies, things are improving slowly in this vibrant young democracy. But more than half of Ulaanbaatar’s population, still live without electricity or running water in a tent city on the outskirts of town.

All around the capital city new apartment complexes are springing up, but without the support of functional sewerage and electricity systems they loom incomplete. Despite the influx of foreign investment and the mining boom, little of this money appears to have found its way into the hospital system. The hospitals in Ulaanbaatar lack what we would consider minimal equipment. They function with the barest of essentials but with great enthusiasm.

Despite the lack of resources, Mongolia is on its way to meeting MDG 5* and has reduced maternal mortality consistently since 2001. Mongolia was able to achieve an almost 50 percent reduction in maternal mortality in 10 years from 120/100,000 deaths in 2000 down to 63/100,000 in 2010 (WHO, 2012).

**The 2013 venture**

This year the inaugural Annual Australian Mongolian Obstetric conference was held with the theme ‘When to Deliver’. The fundamental goal was to promote excellence in women’s health through education.

There are many challenges organising a conference from across the other side of the world, communication being the most obvious! Our lectures had to be prepared a long time in advance to allow our slides to be translated into Mongolian. This is no easy task. The Mongolian doctors who did this huge task, while continuing to work in their usual roles, deserve an enormous amount of recognition. The translated slides made for a much easier presentation and also assisted our interpreters with the more difficult concepts.

The midwifery component of this year’s conference focused on normal labour and the role of the midwife in the Australian context. In Mongolia, midwives still function as obstetric nurses with all normal deliveries being performed by doctors. An emphasis on the Australian multidisciplinary team based approach to maternal care remains vital to work towards a changing role of the Mongolian midwife.
The obstetric component of the conference covered areas including the management of maternal physiology, pre eclampsia, post partum haemorrhage, fetal monitoring, obstetric ultrasound and many others requested by our Mongolian counterparts. Our obstetric anesthetists covered topics including maternal collapse, pregnancy and trauma, cardiac disease and analgesia in labour.

The group of Australian doctors, nurses and midwives, who have travelled each year to Mongolia do so self-funded. They come from no one organisation, hospital or body. What has tied them together is their willingness to give of their time and enthusiasm for teaching and sharing their skill and knowledge whilst at the same time being open to learning from their colleagues and experiences abroad.

The Women’s was established to benefit under-privileged women and has always aimed to lead the way in providing the best training and education for nurses, midwives and doctors. It is a testament to the heartbeat of the Women’s that so many are interested in giving of their time and skills to teach so far away.

Prevention of perinatal Group B streptococcal disease

Dr R. Phillips Heine, Director of the Department of Obstetrics and Gynaecology at Duke University Medical Center in Durham, North Carolina recently presented a Grand Round on “Prevention of Perinatal Group B Streptococcal Disease”. It was standing room only with a wide range of staff attending, including Obstetrics, Neonatology and Laboratory Services. Streptococcus agalactiae (Group b Streptococcus; GBS) remains a significant and potentially preventable cause of invasive neonatal disease and Dr Heine provided background and some clear directions for the future of GBS disease prevention.

GBS was the leading cause of neonatal infection in the 1970’s and the mortality rate was 50 percent.

Dr Heine walked us through the history of GBS and showed how far we had come since GBS was the leading cause of neonatal infection in the 1970’s and the mortality rate was 50 percent. The first randomized trial of intrapartum ampicillin in the 1980’s showed greater than 70 percent reduction in neonatal GBS infection rates. National consensus guidelines on the management and prevention of GBS disease were published in the United States in 1996. Dr Heine reminisced about the heated discussions that occurred at the time regarding the merits of the three main GBS prevention strategies: screening by culture, universal treatment and treating on risk factors (such as maternal fever and prolonged ruptured membranes). Although universal antenatal screening is now common place, it was far from clear at the time what the best approach was.

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* MDG 5 – (Millenium development goal 5) a reduction in the maternal mortality ratio (MMR) by three quarters between 1990 and 2015 and universal access to reproductive health by 2015 [WHO, 2012].
Studies have confirmed the Australian practice of screening for GBS carriage at 35-37 weeks gestation: the positive predictive value of vaginal/rectal swabs collected in the five weeks prior to delivery approaches 90 percent, but more than six weeks before delivery it is only 43 percent predictive of GBS carriage at delivery.

While we focus on the prevention of neonatal disease, the maternal disease burden is often forgotten. Five percent of all episodes of asymptomatic bacteriuria and UTI, up to 20 percent of all episodes of chorioamnionitis (which can lead to premature delivery and neonatal infection) and between two and 15 percent of wound infections are caused by GBS.

In regards to laboratory GBS detection issues, Dr Heine spoke of the importance of collecting both vaginal and anal swabs (the primary reservoir of GBS is the bowel) to increase the carriage detection rates by 30 percent and that swabs should undergo overnight incubation in selective broth medium to double the detection rate. These are standard practice at the Women’s.

Dr Heine discussed the potential risks from using intrapartum antibiotics, particularly “sepsis drift” to other pathogens and increasing antibiotic resistance. However, ampicillin resistance does not appear to be increasing amongst other pathogens (particularly E. coli) causing early onset neonatal sepsis. Ongoing surveillance is warranted.

While GBS remains susceptible to penicillin, resistance rates to clindamycin and erythromycin (used in penicillin allergic women) are increasing around the world. Resistance rates up to 48 percent for erythromycin and 25 percent for clindamycin have been reported. Monitoring of the local population is essential.

The future challenge is that most early onset neonatal GBS disease is occurring in women who have negative screening swabs. Reasons for this include poor quality specimens that contain little vaginal or rectal flora and culture sensitivity. Non-hemolytic strains of GBS, which in many studies number four percent (but is lower in Australia), are not detected in common culture systems. Molecular detection techniques (such as PCR) are more sensitive, increasing carriage detection from 20.5 percent to 25.6 percent in one study. The main drawback is cost and the lack of antibiotic susceptibility information. Dr Heine asked the audience to consider the cost of NICU care and potential long term disability following GBS infection versus the cost of screening.

The structure of the healthcare budget, with different buckets of money allocated for different purposes, leads to difficulty in implementing more expensive screening programs.

Dr Heine finished where most presentations on GBS end – with a discussion on future GBS vaccines. Multivalent vaccines against different GBS serotypes have been developed, although immunogenicity is an issue as well as the high cost of vaccine development.

A/Prof. Andrew Daley
Microbiologist and Infectious Diseases Physician
Penicillin allergy: be aware

Antibiotic allergy is one of the most commonly reported allergies. For penicillins, 5-10 percent of patients reported allergic reactions, and anaphylaxis occurs at an estimated frequency of one to four cases per 10,000 courses, with 10 percent of these reactions being fatal.

Patients with hypersensitivity to penicillin are more likely also to be hypersensitive to other structurally related medicines:
- Cephalosporins (e.g. cephalixin, cefalexin, ceftriaxone)
- Carbapenems (e.g. meropenem)

However, the exact prevalence of cross-reactivity is not known. For example, in patients who report penicillin allergy, administration of a cephalosporin has been reported to result in an adverse reaction in between 0.17 percent and 8.4 percent of patients.

Patients with a clear history of an immediate hypersensitivity means penicillins or other related antibiotics should not be administered without appropriate precautions (e.g. desensitisation). Patients with non-immediate hypersensitivity should not receive penicillins where possible, and caution with cephalosporins or carbapenems.

Commonly prescribed product containing penicillins:

<table>
<thead>
<tr>
<th>Common brand</th>
<th>Active ingredient</th>
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<tbody>
<tr>
<td>Augmentin Duo Forte®</td>
<td>Amoxycillin/clavulanic acid</td>
</tr>
<tr>
<td>Augmentin Duo®</td>
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</tr>
<tr>
<td>Tazocin®</td>
<td>Piperacillin/tazobactam</td>
</tr>
<tr>
<td>Timentin®</td>
<td>Ticarcillin/clavulanic acid</td>
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<tr>
<td>Flopen® Flucl®</td>
<td>Flucloxacillin</td>
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<tr>
<td>Amoxil® Fisamox®</td>
<td>Amoxycillin</td>
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Medication reconciliation

A patient safety problem around the world is the lack of accurate and complete information about patients’ medicines when their care is transferred between healthcare settings (e.g. nursing homes, hospitals or between wards). It has been estimated that more than 50 percent of the medication errors that happen in hospital occur on admission and/or at discharge. There are discrepancies between the medicines patients take at home and the medicines ordered on admission to hospital, and around 30 percent of these errors can potentially cause harm and are an economic burden to health services.

Medication reconciliation is the process of obtaining and verifying a complete and accurate list of patient’s current medicines, ensuring all regular medicines the patient should be on are actually prescribed on admission and/or discharge. Medicines should be reconciled as soon as possible, at least within 24 hours of a patient’s admission to hospital or earlier for high risk medicines.

A multidisciplinary process of medication reconciliation involving medical, pharmacy and nursing/midwifery staff, together with the patient, their carer or family members have shown to reduce medication errors that occur at interfaces of care.

Medication reconciliation is an important process to improve patient safety and cost effectiveness for healthcare.

Useful websites:

References

1. Department of Health VIC Australia – Medicine Reconciliation Website accessed on 14/07/13

Please let the editor have your views on the contents of this newsletter, or any other matters involving clinical practice which may be of interest to our readers.
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