

HIGHLIGHTS FROM THE 17th WOMEN'S HEALTH CONFERENCE, GOLD COAST, FEBRUARY 2010

Keynote Speaker on Osteoporosis

Prof Roger Francis, UK

While fracture risk is dependent on bone density, other risk factors are also important, as only 50% of those with fragility fractures have osteoporosis proven on DEXA measurements. Other skeletal risk factors include bone turnover, trabecular architecture, skeletal geometry and previous fragility fracture. Non-skeletal risk factors include postural stability, physical and mental frailty and conditions predisposing to the risk of falling.

WHO has developed an assessment tool, FRAX, to quantify the 10-year risk of major fractures, enabling those most at risk to be targeted for treatment. There is no data for Australia but UK data field could be used if accessing FRAX. www.shef.ac.uk/FRAX

There is no role for the medical treatment of any bone loss in young users of Depo – lifestyle measures are advocated. The Pill is not routinely used as it has not been shown to increase BMD.

Calcium & Vitamin D reduce the risk of hip and non-vertebral fracture in older people. Combined supplementation is required for anti-fracture benefit, with recent meta-analyses revealing modest reduction in both falls and fractures and improved mortality, despite earlier debate. The role of Ca & Vit D supplementation across all age groups is less established.

Bisphosphonates are first line treatment for established osteoporosis, reducing fracture risk overall by 40–60%. Osteonecrosis of the jaw is rare affecting 1/10,000–1/100,000, when oral therapy used. The risk of atypical subtrochanteric fracture, although uncommon, is more concerning. As bone turnover is reduced, the older bone is prone to microfissure fracture. BMD does not vary significantly between 5 or 10 years therapy, but shorter therapy is known to be associated with an increased risk of further fractures. A 'drug holiday' of several years or more is advocated following 10 years of treatment.

Raloxifene is known to increase BMD and reduce vertebral fracture risk in women with osteoporosis and reduces the risk of breast cancer, but increases hot flushes and raises VTE risk.

Strontium has good antifracture data in older women, with a 36% hip fracture risk reduction in those over 74, but also has raised incidence of VTE.

Secondary prevention is particularly important as it addresses therapy where benefit is greatest. 'Fractures beget fractures', treat those at most risk.

Strengthening the back extensors may reduce back pain and reduce kyphosis in patients with vertebral fractures, with further reduction in falls risk possible.

Practice point: *Adolescents and those with eating disorders require lifestyle measures, good nutrition, Calcium and a source of Vitamin D.*

The HPV vaccines and the Cervical Screening Program

Dr Louise Farrell

As the incidence of intra-epithelial abnormalities decreases, the role of Pap smears in primary screening is being questioned. HPV testing is known to be more sensitive though less specific in HSIL detection. One possibility is an exit HPV test at about 60 years. Newer techniques may enable testing for HPV persistence, the pre-requisite for cancer.

20% of women will remain HPV positive following treatment, with consequent increased likelihood of another abnormality developing. Annual surveillance is advised until 2 consecutive negative HPV tests.

Reminder: *HPV vaccination is contra-indicated in pregnancy. Contraception is recommended up to one month following vaccination because a slightly higher rate of congenital abnormalities and foetal death rate has been observed (though not statistically significant).*

Infertility in special circumstances

Dr Clare Boothroyd

Mandatory Success Rate reporting for IVF units as is done overseas was raised, with questions over what numerator or denominator is used for reporting. Selection of clients would avoid those with poorer prognosis, such as increased age, endometriosis, failed past treatments and prolonged infertility, with consequent skewing of promoted outcomes.

Approximately 1000 babies/year are born in Australia as a result of assisted reproduction using third parties. Australian IVF units are required to keep a record of the origin of gametes indefinitely, but legislation re disclosure to the children differs in many states. Ten families are allowed to be the recipients of any individual sperm donor in Australia, but no central registry exists.

Fad diets, fancy water, sports drinks and keeping weight off **Prof Ian Caterson**

All diets will produce weight loss if adhered to. **Dietary compliance not composition is essential for success.** Start with the 'habitual macronutrient intake', reduce portion size and then address individual need as appropriate e.g. reduced saturated fat, reduced glycaemic load etc. Weight loss over 12 months is the same in diets restricted by 500 vs 1000 kCal; the conservative restriction is what can be realistically maintained.

Fancy water and sports drinks are problematic due to the increased energy intake and lack of satiety provided. If the drink was food, the desire to eat would be reduced. Apart from elite sports people, hydration alone is what is needed.

An extra 400 kJ/day intake in the decade since the mid-80s has occurred. A 2 kg/year weight gain will result if activity is not also increased. Women gain more weight than men and need to work harder to burn an equivalent amount of energy. A recent study suggests that Australian women are gaining weight more rapidly than their counterparts in the UK or USA.

The Protein Leverage hypothesis is that people eat to obtain essential protein. High protein diets can reduce weight as less is eaten overall.

Recipe for successful weight maintenance: eat breakfast, have a low fat, low calorie diet, catch slip ups and be active for 60–90 mins/day. 'Metabolic memory' is evident, however, with not all the weight loss benefit disappearing after weight is regained.

Unintended pregnancy: introducing medical abortion **Dr Chris Bayly**

Mifepristone, formerly RU486, remains unregistered in Australia, though an Authorised Prescriber Process is in place in most states. SA had access 20 years after it was first approved in 1988 in France.

Complete miscarriage ensues within a few hours for 95% of women when given before 9 weeks gestation. Follow-up is required to ensure the process is complete, with either serial BHCG or USS. In SA, this is either a phone call or an appointment one week after treatment.

There is increased need for analgesia in nulliparous women and with greater gestation.

Under 9 weeks gestation, 0.3% have continuing pregnancy, 0.2% transfusion and up to 40% experience diarrhoea, nausea and vomiting.

In Australia, where the choice is available, 50% choose medical abortion and costs are comparable. USS is routinely used for accurate gestation for all terminations. The failure rate of 5% compares with 2–3% in surgical abortion. Overall abortion rates have not increased, but earlier presentation may be encouraged.

Infertility questions

Dr Clare Boothroyd & Prof Gab Kovacs

RANZCOG recommends testing for Varicella immunity pre-IVF. Be aware that Severe Male Factor Abnormality (SMFA) is associated with increased risk of testicular cancer, as is undescended testes and infantile hernia. In SMFA, a baseline USS of the testes is recommended, followed by regular self examination as monitoring.

Practice point: *Infertile men need medical review.*

EDUCATION MEETING: APRIL 2010

IUDs: ins & outs & tricky situations

Dr Melissa Sandercock

Practical advice: A dilator, size 2/3, is useful if there is difficulty passing the uterine sound. Dr Sandercock recommends leaving the dilator in the internal os after removing the sound and before loading and inserting the IUD. A useful tip when removing the IUD and preparing for a changeover is to rest the dilator in the canal. The use of L.A. cream is beneficial, including within the endocervical canal. If unable to locate the IUD strings she uses a cytobrush or an endocervical speculum.

Dr Sandercock doesn't use Misoprostol, but recognises it can be used PV in softening and opening the cervix, 1–2 hours before insertion (2x200 mcg tabs), especially in nulliparous women.

Her comments on ultrasound positions of IUDs were reassuring. Mirena's efficacy is not interrupted when odd positions are observed due to its multiple contraceptive effects. Position is more relevant to efficacy with Cu devices. Generally, position doesn't matter in the absence of symptoms, unless the Mirena is penetrating the myometrium. Odd positions don't necessarily make removal more difficult.

For bleeding post-Mirena insertion which hasn't settled by 6 months, she recommends POP (LNG containing), or Provera 5 mg daily or 20 mcg COCP. If no response she will often hysteroscope as endometrial imaging is difficult with Mirena. NSAIDs and Vitamin E may also work.

Fibroids are not a contra-indication for IUDs, but depends on their size, position and whether there is distortion of the uterine cavity. There may be increased risk of expulsion, though Mirena may effectively lead to a reduction in fibroid size.

2010 SHine SA Education Meetings

Thursday 22 July

In the beginning...early life origins of health and disease

Prof Julie Owens, Reproductive Health Scientist

Monday 25 October

The matter of the heart

Dr Patrick Disney, Cardiologist