Osborne Park Hospital (OPH)
GP Shared Antenatal Care Newsletter

October 2018

In this edition:
- Departmental Update
- GP Care of Obstetric Patients Before 20 Weeks
- Nicotine Dependence Assessment and Intervention
- Alcohol Consumption During Pregnancy
- MBS Changes to Pregnancy Care Item Numbers
- Late & Incomplete Antenatal Referrals

Contact for advice:
If you have any questions regarding a shared care patient please do not hesitate to call the on-call Obstetric Registrar on (08) 9346 8000.
Contact OPH Liaison GP: clare.matthews@health.wa.gov.au

Message from OPH Liaison GP
Message from OPH Liaison GP Dr Clare Matthews

Welcome to the 8th edition of the GP Shared Care Newsletter. I hope this specialised content assists you in caring for your antenatal patients.

In this edition I have included articles on the risks of smoking and alcohol use in pregnancy and assisting the patient to quit. I have also documented the MBS item numbers available to GPs when performing pregnancy care (always confusing to me) - this includes a new item number.

The content of this newsletter is checked by the ever helpful Women’s and Newborn Services specialists at OPH. As always I welcome feedback and suggestions for future editions.

Dr Clare Matthews, OPH Liaison GP

Departmental Update
Osborne Park Hospital has a great team of specialists in the Women’s and Newborn Services Department. Joining the full-time team of Dr Paul McGurgan Head of Department, Dr Patty Edge and Dr Jega Rao, is Dr Su Abdul-Hamid who has been an obstetrician/gynaecologist since 1994 and attained her specialist qualifications in the UK, before moving to Australia and attaining FRANZCOG here in 2008. There are three GPs employed in the antenatal clinic - Dr Clare Matthews, Dr Lisa O'Rourke and Dr Susan O’Connell.

GP Care of Obstetric Patients Before 20 Weeks
First Trimester Screening and Non-invasive Testing Update
Care of women in the first half of pregnancy takes place in General Practice. It is important for GPs to be aware of the screening tests that are recommended during this time.

All women should be offered the opportunity to engage in screening for Down Syndrome and other chromosomal abnormalities. They also need to be offered ultrasound screening for other abnormalities.

i. First Trimester screen (FTS)
The FTS is a blood test at 10 weeks followed by USS nuchal fold assessment at 11+4 weeks to 13+4 weeks. This test should be offered to all pregnant women and has 90% sensitivity and 95% specificity for Down Syndrome.
Women with a high risk screen; Risk > 1:300 should be offered CVS, amniocentesis or Non-invasive prenatal testing (NIPT). See below.

A low Pregnancy-associated plasma protein-A (PAPP-A) in the first trimester may indicate an increased risk of Trisomy 21. A low PAPP-A in the first trimester with normal chromosomes is associated with stillbirth, infant death, intrauterine growth restriction (IUGR), preterm birth and pre-eclampsia. For low PAPP-A < 0.4MoM, more intensive obstetric surveillance is recommended, including USS at 28/40, 34/40.

ii. Non-invasive Prenatal testing (NIPT)

NIPT is a maternal blood test detecting fetal DNA fragments in maternal blood and is available from 10 weeks. This testing is currently only available privately and is not funded by Medicare. NIPT is not intended to replace other prenatal screening. It has > 99% sensitivity and specificity for trisomy 21. It can identify trisomy 18, 13 and 45X. It cannot detect all the chromosomal abnormalities found by amniocentesis. This test does not replace FTS.

FTS is also able to offer accurate dating, recognition of structural anomalies and identification of multiple pregnancies. Part of the FTS is the PAPP-A test, a low reading is able to recognise pregnancies at risk of pre-eclampsia and fetal growth restriction- see above.

NIPT is most useful when used for patients at intermediate to high risk (e.g. 1/50-1/1000). If the NIPT returns a negative result, patients can be reassured that the original FTS test was a false positive and no amniocentesis is required, the fetus being unlikely to be affected. If a positive test is returned, it is still recommended that amniocentesis is performed since false positives have been reported.

iii. Anatomy scan is recommended at 18-20 weeks and should be organised by the GP since the Hospital Antenatal Clinics often do not see the patient until after this time. Please organise for the radiology provider to forward a copy to the appropriate antenatal clinic. Osborne Park Hospital Radiology can perform this test and it will be Bulk billed for Medicare eligible patients. (Tel: 9346 8236)

Nicotine Dependence Assessment and Intervention

Alongside the well documented health problems for the pregnant woman who smokes, there are significant detrimental effects upon the fetus. Maternal smoking in pregnancy increases the risk for low birth weight, pre-term delivery, and premature rupture of the membranes, placental abruption and placenta praevia. Evidence indicates that there is an increased risk of fetal death and stillbirth, and sudden infant death syndrome (SIDS). It is also connected to a reduction in lung function in the neonate.

Key Points

1. Smoking cessation programs in pregnancy reduce the number of women who smoke and consequently reduce low birth weight and preterm birth.
2. GP advice and support has been demonstrated to increase success in people quitting smoking.
3. Ideally smoking cessation during pregnancy should be achieved without nicotine replacement therapy (NRT). However, for women who are unable to quit on their own, the use of NRT should be encouraged.
4. If recommending NRT, intermittent dosing products are preferable (e.g. gum, lozenges, inhalers or sprays). Transdermal patches may provide an option for a nauseated woman. The 16 hour patches are preferred as they allow a nicotine free period in the evening.

The main benefits of using NRT are the removal of the other toxins contained in tobacco smoke and the lower dose of nicotine delivered by NRT compared to tobacco smoke. Nicotine Replacement Therapy should be considered when a pregnant woman is nicotine dependent, otherwise unable to quit and/or when the likelihood and benefits of cessation outweigh the risks of NRT and potential continued smoking. http://kemh.health.wa.gov.au/~/media/Files/Hospitals/WNHS/For%20health%20professionals/Clinical%20guidelines/OG/WNHS_OG_NicotineDependence.pdf
Alcohol consumption during pregnancy

- More than half of all women of childbearing age (18 to 44 years of age) report alcohol use, and one in eight reports binge drinking in the past month.
- Alcohol consumption appears to have negative effects throughout pregnancy. Infants whose mothers consume alcohol during pregnancy can manifest fetal alcohol effects (FAE), alcohol-related birth defects (ARBD), fetal alcohol syndrome (FAS), or they may be normal.
- There is no confirmed 'safe' threshold of alcohol exposure. Abstinence at conception and during pregnancy is recommended (Grade 1C).
- Identification and counselling of women who use alcohol can decrease intake during pregnancy (Grade 1B). Maternal cessation of alcohol intake at any point during pregnancy is beneficial, as children born to women who stop drinking even late in gestation have better outcomes than those who continue to drink throughout pregnancy.
- The T-ACE, TWEAK, or AUDIT-C screening tool can be used to identify women who may be at risk for prenatal alcohol use.
- For pregnant women who consume alcohol but are not heavy drinkers, brief intervention is recommended (e.g. educational sessions, motivational counselling) (Grade 1A). Women with heavy drinking patterns who are unlikely to reduce their consumption should be referred to undertake professional alcohol treatment e.g. Women and Newborn Drug and Alcohol Service (WANDAS) clinic at KEMH.

MBS Changes to Pregnancy Care Item Numbers

There have been some changes to the MBS item numbers available for GPs taking part in pregnancy care:

- **Item 16500** - antenatal attendance item remains.
- **Item 16591** - GPs taking part in shared care can bill once per pregnancy after 28 weeks gestation. This assessment MUST include a mental health assessment, drug and alcohol and domestic violence screening. This must be recorded in the patients’ medical record.
  - **Fee:** $142.65 Benefit: 75%=$107.00 85%=$121.30
- **Item 16407** - A new item number is available for a mental health consultation in the postnatal period between 4-8 weeks postpartum lasting at least 20 minutes and to include mental health, DV and drug and alcohol assessment. This must be recorded in the patients’ medical record.
  - **Fee:** $71.70 Benefit: 75%=$53.80 85%=$60.95
- **Item 4001** - Pregnancy support counselling lasting at least 20mins (3 services per pregnancy). Available to women who are pregnant or who have been pregnant in the past year. This service may only be provided by a GP who has completed appropriate non-directive pregnancy counselling training, available from RACGP GP Learning:
  - **Fee:** $76.60 Benefit: 100% = $76.60

Useful resources

**Edinburgh Postnatal Depression Score**

Domestic Violence Screening

1. Has someone in your family or household ever put you down, humiliated you or tried to control what you can or cannot do?
2. Has someone in your family or household ever hurt or threatened to hurt you?
3. Are you worried about the safety of your children or someone else in your family or your household?
4. Would you like help with any of this now?

Drug and Alcohol screening Tools


Late and Incomplete Antenatal Referrals

There has been a recent concerning trend for GPs to refer antenatal patients late in their pregnancy (after 18 weeks). In order for any of the Antenatal Clinics to triage a patient and arrange a booking appointment, the referral needs to arrive prior to 18 weeks (preferably by 12-13 weeks). Delaying the referral will lead to reduced opportunity for the patient to engage with the Hospital Antenatal Clinic, and the possibility of missing the opportunity for medical intervention if required.

The GP is responsible for antenatal care up until the first booking visit at the Hospital, which occurs at 20-22 weeks for some hospitals. The GP will need to organise all antenatal testing including the anatomy scan.

Urgent Referrals

If the GP has clinical concerns about any aspect of the care of the pregnant lady in the first 20 weeks, they may speak to the Gynaecology/Obstetric registrar on call at the referral Hospital.

**OPH Telephone:** 9346 8000 request registrar or consultant on call.

Incomplete referrals continue to be a concern. In a recent audit of GP referrals to OPH, 32% were inadequate for triage, requiring the GP to be contacted to provide additional information. This will cause the patient further delays.

When sending in the antenatal clinic referral it is requested that the GP attach the required routine antenatal blood test results and any scan results.