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PREVENTIVE ASPECTS OF OBSTETRICS AND GYNAECOLOGY

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PREVENTION IN OBSTETRICS

ANTE-NATAL CARE

I. The whole object of ante-natal care is prevention or prophylactic if we include in this the early diagnosis of developing physical or mental disease with the aim of early treatment.

1) DETECTION OF UNSUSPECTED MATERNAL ILL-HEALTH

a) Anaemia.

b) Rhesus disease. Identification of those women at risk nowadays allows virtual prevention of this erstwhile serious complication.

c) Blood dyscrasias. Particularly important for immigrant women who are at greater risk of sickle-cell disease, etc.

d) Heart disease, including hypertension.

e) Renal disease.

f) Anxiety states including phobias. Occasionally more severe psychiatric disease first becomes manifest in pregnancy.

g) Chronic pulmonary disease, including tuberculosis. Again immigrants are particularly at risk.

h) Venereal disease.
Routine testing for syphilis has a very low pick-up rate but is mandatory if only for medico-legal reasons.

2) SCREENING FOR POSSIBLE FOETAL ABNORMALITIES

Logical only after discussion with parents and when they would want abortion if the particular abnormality were to be detected. An exception is the routine testing of maternal blood for raised levels of alpha-foeto protein as a first step in the detection of open neural tube defects such as spina-bifida or anencephalus.

Blood tests and ultra-sound screening are essentially free of risk whereas amniocentesis carries a small but definite risk of causing an accidental abortion and also of injuring the foetus.

3) GENETIC COUNSELLING

(Often more appropriate before pregnancy or post-natally following an abnormal baby).

Buccal smears and/or blood cultures may be required for chromosomal analysis.

Use of genetic counselling is analogous to pre-natal screening for foetal abnormalities in that it may contra-indicate pregnancy. In certain cases artificial insemination using donor semen may offer a more positive solution.

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4) MEASURES AIMED AT PREVENTION OF FOETAL ABNORMALITY

a) Rubella vaccination of girls before they become pregnant.
b) Education, both of patients and doctors, to avoid potentially teratogenic drugs whenever the woman could become pregnant. Similarly to avoid x-rays in possible early pregnancy.
c) Monitoring of foeto-placental unit.
d) Avoidance of prematurity.

5) EDUCATIONAL ASPECTS OF ANTE-NATAL CARE

Knowledge of the physiological changes which are happening or may be expected relieves irrational fears which are very common in pregnancy, in labour and when faced with the responsibility for an infant. To be effective the education offered should cover the psychological as well as physiological factors.

All pregnant women should be given the opportunity to discuss such matters as:-

a) Hygiene in pregnancy.
b) Diet, exercise, sex - in pregnancy.
c) Infant care and feeding.
d) Norms of infant developement and channels of communication which will be open to her when she is at home with a young baby.
e) Future family planning - almost always the ante-natal period is ideal for discussion of future contraception or sterilisation even though firm decisions on action may have to be delayed until everyone is sure the baby is healthy.
f) Sex education generally. To be effective the consort must be involved in discussions.

II PERI-NATAL CARE

1) EARLY DETECTION OF STRESS IN THE FOETO-PLACENTAL UNIT

a) Good clinical judgement is the most important factor.
b) Careful assessment of those women likely to be particularly at risk.
c) Serial measurements of the bi-parietal diameters of foetuses considered at risk so as to detect failure of foetal growth before it is clinically apparent.
d) Foetal heart monitoring with stress to assess placental reserves.
e) Blood and urine hormone assessment to evaluate placental efficiency and reduce the incidence of foetal hypoxia.

2) AVOIDANCE OF TRAUMATIC DELIVERY

The difficult forceps delivery, the difficult breech delivery and even the prolonged second stage of labour are all indications of inadequate perinatal care.

3) EXAMINATION OF THE NEWBORN INFANT AND BIOCHEMICAL SCREENING FOR METABOLIC DISORDERS

Nowadays this important work falls within the province of the paediatrician.

III. POST-NATAL MATERNAL CARE

a) Physical check-up including cytology.
b) Advice on hygiene, exercises and diet.
c) Definitive action on contraception. This may include puerperal sterilisation if the decision had been made ante-natally and the infant is fit.
d) Counselling or referral when the new family situation has engeandered severe emotional strains.

PREVENTIVE ASPECTS OF GYNAECOLOGY

As in obstetrics, a gynaecologist's role is to establish sufficient rapport with his patient to allow any woman whose real problem (as opposed to the excuse she made for the consultation:) is basically emotional to discuss this. Anxieties, particularly in the sexual sphere, frequently arise from ignorance and can be successfully allayed by simple discussion and reassurance.

Family Planning is now accepted as a part of normal gynaecological practice, but sex education is equally important and can have an important role in the avoidance or alleviation of marital disharmony and anxiety states. Most women understand basic reproductive physiology, but many are surprisingly ignorant of either the physiology or psychology of their sexual role.

I WELL-WOMEN CLINICS

Open access is an important advantage because women with minimal or vague symptoms are reluctant to consult their doctors. On the other hand, the clinic may falsely reassure. Clinics are as good as the staff who run them and if an inadequate history is taken or physical signs missed a negative cytology report may lead to a woman being told that all is well when she has an ovarian tumour or even an endometrial carcinoma.

On the other hand, any gynaecologist carrying out a routine examination should always test the urine to exclude diabetes or renal disease, the blood pressure to detect hypertension and teach the woman a simple technique which she may use monthly to detect any developing lump in her breasts.

II CYTOLOGICAL SCREENING

Mass population screening has not gained universal acceptance and is dubiously cost-effective. Recent work from Aberdeen suggests that we may be screening the wrong age-group. Certainly, sequential gynaecological check-ups on younger women, including the investigation of vaginal discharges etc., might well contribute more to prevention than our present haphazard checks by general practitioners on older women only.

When cytology is used by a gynaecologist it yields much more information than than merely the exclusion of cervical cancer. It is essential in the investigation of a vaginal discharge, the management of senile vaginitis and of hormone replacement therapy etc.

III AVOIDANCE OF UNWANTED PREGNANCY

Contraception and sterilisation are pre-eminently preventive measures and

highly cost-effective.

Ideally, the general practitioner is best placed to give contraceptive advice because he knows the family and the parental temperaments. Because of financial incentive, general practitioners are now rapidly taking over this work and training facilities are being provided on a large scale. It is likely that family doctors will shortly be able to fulfill their proper role here.

Sterilisation is a more definitive procedure and the choice of partner and of method needs careful consideration. Financial incentives have at last induced gynaecologists to make a start on the provision of female sterilisation. Unfortunately, relatively few gynaecologists are widely experienced in contraceptive counselling and very few are able to offer or arrange vasectomy when male sterilisation would be the preferred choice. Finally, the very long gynaecological waiting lists cause great delays and day-stay laparoscopic sterilisation is not yet widely available.

Because of long waiting list delays many gynaecologists are performing puerperial and post-abortal sterilisations when "interval-sterilisation" with time for reflection would be preferable.

A closer integration of hospital gynaecologists into the wider contraceptive scene would be of enormous advantage to fertility control in this country. Since both general practitioners and gynaecologists have responded to relatively minor financial incentives this might well be another area in which such inducements could be effective.

IV ABORTION

This is where the unwanted pregnancy usually first encounters the gynaecologist.

The present organisational set-up is highly inefficient and tends to waste gynaecologists' time - usually he has to devote a great deal of time in a busy Out-patient's clinic to the detriment of his other work. This is almost certainly why the National Health Service is failing to meet it's proper responsibility in the provision of abortion.

The Kingston and Richmond area shows the changing position:-

Table over-leaf →

Year	Estimated Admissions For Criminal Abortion	Estimated Total Criminal Abortions for Area (260,000 people)	Therapeutic Abortions		Other Day-Stay Gynae Operations
			Wards	Day-Stay	
1959	≒ 300	1300 - 1600	0	0	0
1965	234 (Surveyed)	1200 - 1400	65-70	0	0
1974 March-Dec	< 20	< 100	241	152	72
1975	< 10	< 50	113	359	76
1976	< 10	< 50	120	323	77
1977	< 10	< 50	148	341	79
1978 Jan-April	-	-	NA	133	15

The Day Unit, which counsells almost all of our abortions and performs the majority, is staffed by two general practitioners who attend for two sessions (one day) weekly. The four married nurses serve for the same sessions only as part-time employees. We could recruit as many nurses and doctors as we could finance. Our full-time secretary/receptionist is the lynch-pin. A consultant gynaecologist is in charge, but rarely needs to visit.

V HORMONE REPLACEMENT THERAPY

Value as a preventative measure, not yet proven but:-

a. Prior to menopause, women are age-for-age about one-twentieth as liable to coronary thrombosis as men. They become increasingly prone after menopause and achieve roughly parity by the age of 75.

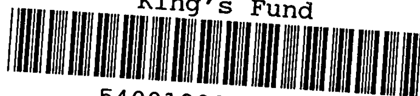
b. For fractured hips, elderly women are at least five times as liable as men - They require 5,000 extra hospital beds for this problem alone. Fractures of the wrist parallel this phenomenon. Back-ache is a major problem in post-menopausal women. All these problems appear to stem from osteoporosis and hormone replacement therapy almost certainly protects.

c. Depression is very common post-menopausally and endogenous depression requiring hospital admission is very common in older women. Hormone

replacement therapy may well avoid much of this as well as alleviating the minor menopausal symptoms.

VI GYNAECOLOGICAL LAPAROTOMY

In the course of their surgical work gynaecologists are constantly opening the abdomen. Many omit a full exploration of the abdominal cavity and thereby fail to detect co-existent disease. A purely technical point, but of obvious preventative significance (as is thorough breast examination on all In-patients).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