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In this Edition

- Traditional Values, Discrimination and their effect on HIV Control
- Continuing Medical Education and Recertification
- CME - Gynaecology
- E. R. Walrond Symposium
- GP case of the month - lost direction?
- Our Lifestyles and Health
- May 2007 CME Notice
- Book Review
- History's Page; 1982, 1987

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Scientific articles, Letters to the Editor, Comment or News should be sent to the editor at the office of BAMP.

Communications are preferred in electronic as well as written formats.

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Editorial

CONTENTS

Pages

1. Editorial	
Traditional values, discrimination and their effect on HIV control ...3	
Continuing Medical Education and Recertification5	
2. CME	
- Carlos Chase6	
3. GP case of the month	
- lost direction?	
- Colin Alert7	
4. Our Lifestyles and Health	
- Colin Alert9	
5. May 2007 CME notice.....14	
6. May 2006 CME Conference	
Obstetrics and Gynaecology	
Infertility an update	
- Juliet Skinner16	
Emergency Contraception	
- Peter Adams.....21	
13 Abstracts.....26	
7. ER Walrond	
Symposium Abstracts.....37	
8. Review of 3rd Pan Caribbean CCFP Conference	
- Colin Alert47	
9. Book Review.....51	
10. History's Page	
Editorial	
Ethics and After-hour Care53	
20 yrs ago	
- Answering the Public55	
25 yrs ago	
- BAMP Newsletter56	

TRADITIONAL VALUES, DISCRIMINATION AND THEIR EFFECT ON HIV CONTROL

It is widely acknowledged that the stigma and discrimination related to persons affected by HIV has had a profound inhibiting effect on controlling the spread of HIV. The inhibiting effect is expressed through a lack of change of sexual behaviours, for a change of behaviour is perceived as an acknowledgment of infection rather than a means to avoid infection. Avoiding this reality, simple sounding solutions such as abstinence until marriage, no marriage without being HIV free, and no deviation for life from that one marital sexual partner have been advanced for behaviour change in the community. These prescriptions are so far removed from the current norms of behaviour, that they ask for a revolution in the community and reversion to a mythical society constructed by those who conjure up in their minds the 'idealised' times of their religious texts. Unfortunately, the same religious texts are also used to justify the continued stigmatization and criminalization of persons who are most at risk for HIV infection. This is done on the premise that taunts, jibes and threats, even threats of death, will be effective in altering the behaviours of those who suffer from deviations from the idealised society 'norms'.

Advocacy for legislative change to alter the stigma and discrimination meted out to those persons most at risk for HIV infection is discounted by those who oppose such change on the basis that changing the law cannot eliminate stigma or discrimination. Whilst such a statement on its face value is true, it is then interpreted to mean that change in the law is useless in affecting any change. Such an assertion flies in the face of history where laws have affected behaviour, for those who discriminate no longer have the law, or the absence of law, on which they can rely when challenged. In fact, law has affected changes in attitude in communities, including religious communities, on a number of issues including slavery, bastardy, racism and equal rights for women. In each of these cases attitudes changed significantly, admittedly not totally, after the law made it clear that the persons stigmatised and/or discriminated against were entitled to equality under the law.

The changes in law cited above were fought against by some religious groups with prognostications of moral or apocalyptic social decline in communities. However, when changes are made in society that benefit the downtrodden or marginalized, the society as a whole has always benefited. Democracy can only exist where minorities are accorded the same rights as those of the majority and those rights include the right to be protected where possible from disease. In 'modern' democracies it is the medical profession which is expected to set the standards for the protection from disease of individuals, groups and the community as a whole. Although our constitution and the law has given freedom for people to follow their own religion, medi-

cal professionals cannot abrogate their responsibilities to the society by seeking to impose their own religious teachings/precepts on their professional obligations to the community.

The expression of human sexuality is feared in many religions and it is not surprising that those most at risk for HIV, the youth, male homosexuals and prostitutes, are seen as having sexual power that must either be suppressed or punished. In medicine we cannot afford the luxury, either ethically or legally, of discriminating against persons because of their sexual behaviours or preferences, for the medical profession have a duty to prevent, diagnose, treat and rehabilitate all those who come under our care.

It is very unfortunate that in the 21st century there are community leaders in many countries who align themselves unconditionally with those who preach adherence to the 'word' of religious texts that advocate the stoning to death of persons for their sexual conduct. It is even more alarming that such views are justified as being in keeping with the traditional values in communities. At one time or another slavery, racial discrimination, the subservience of women and the denial of legal rights for 'bastard' children were the traditional values in our society and indeed the legal standard of the day; should we revert back to them? Perhaps the time has come that some 'traditional values' have to be examined so that we can squarely face the dynamic of HIV transmission in our community?

Prof. E. R. Walrond



Editorial

Continuing Medical Education AND RECERTIFICATION

In this edition of the BAMP bulletin we have an article on non-attendance and disinterest in continuing medical education (CME), papers/abstracts from 2 recent medical conferences, and a report on a regional conference. In the month of January the Barbados Association of Medical Practitioners held its Business of Medicine conference, and the upcoming May BAMP/UWI CME conference is advertised in this bulletin. There is certainly plenty of CME available despite the apparent lack of demand.

Dr. Alert¹ in his article focuses on the gap between what an event titled “GP case of the month” promises and what is actually delivered. Dr. Alert is unaware of the objective of this conference and perhaps herein lies the problem, as one might assume it is a conference that focuses on problems commonly seen by and hence of interest to general practitioners. Would “hospital case of the month” be a better title? Showcasing biomedical knowledge and perpetuating the teacher-student/specialist-GP relationship fostered in medical school is obviously not the intent of the hard working organizers.

If the aim of a conference is to educate general practitioners then it must focus at some point on areas important to general practitioners. It is said that our best teachers are our patients, and the best teaching should be based on cases. If 1000 adults are considered, then 800 might report symptoms in a given month, 327 consider seeking medical care, and 217 of these actually visit a physician’s office. Of these 217, about 113 visit a primary care physician’s office, 65 a complementary or alternative medical care provider, 21 a hospital outpatient clinic, 14 receive home health care, 13 visit an emergency department, 8 are hospitalised and less than 1 would be hospitalised in an academic medical centre². While these figures are not from a Barbados study, it is evident that even here most illness is not presented to general practitioners and specialists only see a tiny fraction. This has been described as the iceberg of illness, with most illness hidden from medical professionals

and almost all from specialists. Specialists see a concentrated collection of disease in one month, which a general practitioner will not see in a career. A bit like a zookeeper tending to the captured animals and perhaps looking after one species, and a nature lover exploring the jungle and hoping for a fleeting glimpse of an animal. A conference based on hospitalised patients can certainly help general practitioners, but by its restricted nature only scratches the surface of what general practitioners need to know.

It is unsurprising that many general practitioners do not attend specialist-oriented conferences, when specialists rarely attend themselves. But even if a conference is geared towards general practitioners will they attend? If they attend will it improve the quality of care they offer patients in the long run? We impart knowledge to our patients on a daily basis, but in many cases this knowledge produces little change. Similarly CME might have the same effect on doctors. If a doctor is providing better care because of knowledge and skills acquired attending CME how will the patient and potential patients know? Who determines that the care provided meets a particular standard, and how is this standard certified? Should certification be done by the Medical Council (an upgrade in efficiency and secretarial staff will be needed), the university, or by a regional professional body (the doctor’s peers)? Even if a physician reads journals, attends conferences and special courses, should the public not expect that the professional standards of all practising physicians be monitored, evaluated and periodically certified?

Unlike most CME of recent times, the recent business of Medicine conference was well attended. Why was this event so popular?

1. GP case of the month- lost direction? BAMP bulletin 2007; 163: 7-8
2. Green LA, Fryer GE, Yawn BP et al. The ecology of medical care revisited. N Eng J Med 2001; 344: 2021-5

Peter Adams

CME

Dr. Carlos Chase
President of BAMP

Continuing Medical Evasion is becoming increasingly popular among doctors. The CME once thought of as a vital part of our landscape is now seen as not relevant and an intellectual exercise not worthy of time, money and energy.

While Continuing Medical Education continues to be the buzz word internationally and our doctors flock to attend these international conferences, our home-grown conferences lack for attendance and participation.

Continuing Mandatory Education may be the way of the future linked to re-certification and re-registration. Then, as is the case in other jurisdictions, failure to attend would have potentially serious repercussions for the practitioner.

Controlling Medical Education, the trend away from self-regulation of the profession to include non medical personnel on key bodies is given more weight if we cannot get ourselves to attend self taught sessions.

Continuing Medical Excision, the artificial lines of divisions along training disciplines is not helpful. It serves to stall a natural process of learning in the spirit of togetherness.

Careful Medical Examination will show the usefulness of CME. Short of subjecting every doctor to a review examination every 5 years or so, this seems the most practical route to deliver relevant information to the conscientious doctor.

Controlling Medical Expenditure is always a concern but with the tools of Current Medical Evidence we can practice evidence based, cost effective Medicine.

Conscientious Medical Exploration is the essence of being a “good doctor” and with the incorporation of CME into our timetables, we will see the maintenance of GOOD medical practice by the Caring Medical Expert

GP case of the month

- LOST DIRECTION?

Dr. Colin Alert
GP/Family Physician
August 2006

Working backwards, the last three GP cases of the month were advertised as:

1. “UTIs in children”, presented by Dr. A. Jennings, Paediatric Consultant.
2. “If it looks like a cat,”, presented by Dr. Bayo Ogunbiyi, Obstetrics/Gynaecology Registrar.
3. “A case of perforated duodenal ulcer”, presented by Dr. M. Walrond and R. Ross, two Surgical Registrars.

Let me state at the onset that I was not present at the ‘duodenal ulcer’ case, so that my comments are not based on what may have actually occurred on the night of presentation.

On the basis of these titles, one could not easily discern that these are scenarios that GPs ‘see every day’, nor are other GPs involved in their presentation, so this may partly explain the non-interest of a majority of GPs in this CME activity. The organizers used BAMP to e-mail invitations to physicians to this activity, and based on the list of invitees at the top of the invitation it is clear that BAMP does not distinguish GPs from any other BAMP member, whether hospital-based or not, whether specialist or not. Unfortunately the educational interests and needs of each group are slightly different; non-recognition of this fact has resulted in various groups refusing to accept the ‘one size fits all’ approach to CME that exists here. It also maintains the divide between hospital based (approx half of the doctors who work in Barbados) and those who work out of hospital, and only a ‘converted few’ generally make the effort to attend local CME.

Certainly the “GP” input in these presentations seems to have dissipated, as far as the advertisement of the ‘GP case of the month’, and in the scenarios of the first two cases above as far as the actual presentation was concerned. Since all the presenters listed above are based full-time at the hospital, one can make a case for

calling this “Hospital case of the month” instead. In fact, the first presentation was not even an actual case at all (although the actual presentation and discussion was an excellent one).

Presumably not many GPs who would attempt to treat a case of perforated duodenal ulcer in their offices.

The second case, “if it looks like a cat,” gained the bulk of my interest. For those who weren’t there, Dr. Ogunbiyi presented a case of a young female patient who presented to a GP with abdominal pains. **The GP found her to be pregnant, there was no history of previous ante-natal care, and promptly referred her to the Accident & Emergency Department with abdominal pains and a ‘foul-smelling’ vaginal discharge. After many hours in the A&E Department without being seen – the presenter described the department as being busy at the time – eventually a nurse asked a medical student to see the patient, the medical student exhibited some initiative/common sense and called the Obstetric registrar, and he arranged transfer to the labour ward. There the registrar saw her immediately, discovered that there was some element of fetal distress – the ‘foul-smelling’ vaginal discharge noted by the GP was probably meconium, suggesting that there was previous evidence of foetal distress many hours earlier, and that this un-booked mother spent ‘many hours’ in the A&E Department with ruptured membranes, with labour pains, with a struggling foetus, before the intervention of a nurse/medical student. In the end, in spite of the valiant attempts of an Emergency Caesarean section the foetus died, and the post-operative course of the mother was complicated by the development of narcotising fasciitis, requiring at least two subsequent trips to the operating theatre.**

The discussion centred on the un-booked status of this young mother, and the long list of complications that

can, and in this particular scenario did, accompany the un-booked status. The audience were able to learn about the ‘rapid-HIV test’, available to hospital –based physicians, in particular clinical scenarios.

There was no discussion on the public health aspects of this case, such as programmes that target our young females on issues of sexual activity and its consequences. A recent newspaper article noted a drop-off in teenage pregnancies, for example, but did not comment on the number of teenage abortions. The physicians who work in public health rarely show up at medical conferences and medical meetings – can public health initiatives, including increased outreach to our young females, prevent future cases like this?

There was no discussion on the medico-legal aspects of this case. This lady was forced to wait for many hours in the A&E Dept. in distress, with a distressed foetus, without being seen – is there a legal responsibility here? What about her eventually having to be seen by a nurse and a medical student- is this what we can/should accept from our only Tertiary Institution in 2006, and beyond? Does any medical student have the appropriate experience and insurance coverage to allow him/her to see patients (without supervision) in an Accident & Emergency situation (or any situation, for that matter)? Where were the A&E consultants? **For years GPs and the general public have complained about the long waiting times in the A&E Department; in spite of an occasional message from the new hospital management team to the contrary we seem no closer to alleviating this problem. The members of the “Haynes Commission” into the functioning of the QEH a few years ago were so concerned that they commissioned the Chronic Disease Research Centre (CDRC) to do an audit of the A&E department functioning, including patient waiting times: is there an effort in progress to implement the recommendations of this commission?** Does the blanket statement “things were busy in the department” – and is there a ‘legal’ definition for this, or is this just a statement of convenience – absolve the department from all manner of medical madness that may occur there? Certainly a browse through the medical literature suggests that there are

many countries in which the ‘particulars’ of this case would have generated a vigorous legal response.

This “GP case of the month” had no GP input, apart for the patient visiting her GP on the morning when she began having pains, which later proved to be labour pains. Her referral to the A&E department than put in train a series of events that are associated with a variety of both medical and medico-legal questions; none of these were answered. None of the actual events that unfolded seemed to be able to make a positive contribution to health improvement in Barbados.

Certainly Dr.R. Massay, Cardiologist, has to be highly commended for ‘stepping up to the plate’ over the last few years in organizing the GP Case of the month on behalf of BAMP, and in securing sponsorship for this event. He has ventured where GPs ‘fear to tread’. But certainly much more GP input is needed; someone suggested that perhaps it is time for the Family Medicine arm of the School of Clinic Medicine and Research, UWI to play a more active role. This ‘unit’ presently conducts courses at both the under-graduate and post-graduate level, but has never extended its mandate to the wider GP –grouping in Barbados. A window of opportunity may be open here.

Thus, based on the experience of the last three episodes of “GP case of the month” there seems to little involvement of the GPs, and little or no focus on the actual needs of GPs in terms of CME activity, or in terms to the overall contribution to improved health care in Barbados. Since I have never seen any written objectives of the “GP case of the month”, if they exist, it is possible that other objectives may be on the road to achievement. But if one has to wait for over one hour past the scheduled start-time for 15-20 doctors to show for a presentation that involves a free dinner as well, one cannot be far off when one suggests that there needs to be another look at the direction in which GP case of the month is headed. And there certainly needs to be a forum in which a multitude of problems within our Health Care System, including the interface between Primary and Tertiary Care, can be effectively addressed.



Our Lifestyles

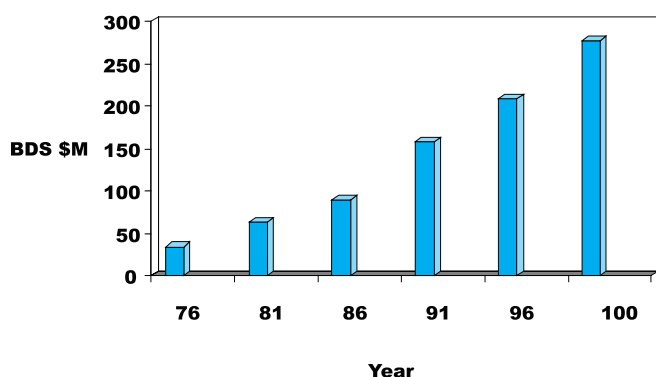
AND HEALTH

Dr. C. V. Alert

Recently the newspapers were kind enough to publish some of my comments on diabetes and obesity in Barbados, in particular my belief that the funding of ‘public’ health, as presently constituted, would be increasingly difficult to sustain by any government. Generally my comments were well received, although one irate man noted that I should be shot for (in his estimation) saying that the Government should not spend more money on the health of its citizens.

As seen in the graph below, the Government’s recurrent expenditure on health has increased more than five-fold over the last three decades, and like a Joel Garner bouncer as it passes the batsman, it is still rising. While I am not an expert on finances it is unlikely that this trend of spending can continue, and especially in the absence of evidence that this expenditure is leading to a significant improvement in the health of our people.

Figure 1: Government’s Recurrent Expenditure on Health – from annual CMO’s reports.



More than 50% of this expenditure is consumed by the Queen Elizabeth Hospital, yet there are frequent reports of non functioning equipment, shortages of doctors and nurses, and complaints of unsatisfactory care received by individuals seeking service there.

This phenomenon of “less-for-more”, where we hear of less staff, fewer drugs and less functioning equipment,

and we are spending more and more money, is of concern to those interested in the health of our nation; however, this phenomenon has not been publicly explained. It does, however, support the notion that ‘business (spending) as usual’ cannot continue indefinitely.

I have argued for some time that, should the load on the QEH be reduced, there would be less ‘overuse and abuse’ of the equipment, making it less prone to breaking down; the staff would feel less overwhelmed by having to work in wards and clinics bursting at the seams; and individual patients could be afforded more time and attention by the scarce hospital staff, perhaps leading to improved patient care and improved patient satisfaction.

Even staff morale, which some believe is one major problem at the institution, would be improved. And of course, importantly from a financial point of view, a lesser demand on the QEH reduces the demand on the Ministry of Finance for financial support.

But how can the load on the QEH be reduced? Most profiles of the patient load attending the QEH describe a number of diseases, particularly diabetes, heart disease, hypertension and strokes. Less frequently noted, perhaps only because we lack sufficient local statistics (cholesterol problems) or because we don’t normally consider this a disease state (obesity), these six conditions account for well over 60% of our hospital admissions, and saturate the out-patient clinics there as well. These are all called the chronic non-communicable (“lifestyle”) diseases, and, perhaps more importantly, they are generally considered as preventable.

Well, if they are preventable, why are we not apparently preventing them? Is there evidence that we are even trying to prevent them? For some time now the health focus, both political and financial, has been on the hospital, a place for sick people: if you have one of these chronic diseases, then the hospital will patch you up,

perhaps until your next hospital admission, but you cannot be cured. It is well established that “diet and exercise” are the cornerstones to better health; but while we ‘talk the talk’ we seem unwilling to ‘walk the walk’.

Lets us look at our eating habits, for example. Over the last 2-3 years all our major supermarket delis have introduced **breakfast** on their menus, where one can get, for example, bacon, eggs, fish cakes, sausages – foods with an abundance of fat and/or salt- but rarely can one get ‘fruits and vegetables’, which our nutritionists advise are good for us. At **lunchtime**, in addition to the same supermarket delis, ‘chicken and chips’ outlets attract long queues, of people inside and cars outside: it is well known that in Barbados we have 11 parishes, 12 outlets of fast-food chain #1, and 14 outlets of fast food chain #2. And while these ‘chicken and chips’ outlets are challenged at lunchtime by vendors at the back of vans that bring the ‘current national dish’- half rice, half pie, and stew - to every worksite, even more challenges occur from Thursday to Sunday **nights**. There, grills and frying pots (and traffic jams) appear at almost every street corner, offering a variety of fried, grilled and barbequed meats and fish, including (salty) pig tails. The smells and tastes are fantastic, and they make a great once-in-a while dining experience: unfortunately far too many people consume such fare far too often (‘pig-out’): the high salt and high fat consumption are the last things needed in a land with many people suffering from hypertension, obesity and heart disease. Fruits and vegetables? – nowhere to be seen.

Is there evidence here that we are trying to reduce the prevalence of conditions related to the over consumption of sugars, salt and fats?

What about our exercise habits? For Crop-over we get out thousands on Spring Garden highway, who all ‘Jump and Wave’ for a few hours. The Nation Fun Walk brings out perhaps 15000 people who are willing to walk for well over an hour (most of them anyway). The Run-For-Life series also gets out thousands of individuals who cover 5K distances with the enthusiasm of the Energizer Bunny. Other events have smaller numbers of participants, but these provide some evidence that there is some interest in exercising. However, our public health officials have failed to utilize this enthusiasm, and

have not promoted, and/or developed, specific programs to encourage ongoing exercise for our population. We thus have a population that, based on the profile of diseases present, are not benefiting from the numerous cardiovascular benefits of being fit and active. There has been significant inactivity in promoting physical activity – the ‘results’ have even been noted by our sporting administrators, charged with the responsibility of producing world-class athletes in the face of diminishing quality of their junior charges.

Primary care offers a low cost alternative to the high-technology medicine that the QEH tries to offer, has the great potential for preventing the lifestyle diseases that currently are contributing greatly to the deterioration of our health. About 10 years ago the Chronic Disease Research Centre (CDRC) of UWI, right here in Bridgetown, conducted a small and short-term (by research standards) but successful study called BDIS, the Barbados Diabetes Intervention Study. In BDIS, it was shown that 120 adults, all of whom had close relatives with diabetes, could be encouraged to incorporate the healthy lifestyle into their everyday lives, and the three month ‘instruction’ period showed benefits up to two years later. In particular, the progression towards becoming diabetic was slowed in a majority of the participants. These results match those of much larger research studies done around the world; at relatively low cost this can be incorporated into our primary care services.

Primary care has the potential of preventing the chronic diseases altogether. Those who work in primary care have the opportunity to promote the healthy lifestyle, by active promotion of ‘diet and exercise’. While this is a good slogan, it requires active exploration of each individual’s life, so that specific advice can be given. For example, afraid to walk alone? – well, Ms. Smith, who lives one block away from you, and some girls from her office walk every morning at 5.15 am – you can join in with them. Too tired after work to come home and cook, wash up pots and pans, while a ‘snack-box’ gets away from all those problems – a fast-food salad is better for you, is high in fibre, and has no salt or cholesterol. Foods too expensive – join a group and buy in bulk, or you can encourage your church or neighbour group to start a ‘kitchen garden’.

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Perhaps we may have missed the boat in terms of the adults in our population, but great emphasis must be placed on our youth – primary and secondary school students, who can still be encouraged to adopt appropriate lifestyle habits, and to practice these in a lifelong manner. They must be encouraged not to start drinking or smoking, including illicit drugs; they must be taught the ABCs of sexual activity; healthy eating must be taught, and healthy foods made easily available to them; and programmes that promote physical activity should target **all** young people. But this entails specific programmes being put in place to do this, and specific resources committed to this important task – it won't happen by accident. We still haven't decided whether this task belongs to the Ministry of Health, or the

Ministry of Education: each Ministry seems quite content in 'standing back'.

Unfortunately, unless more resources are put into preventive efforts, we won't be able to explore whether 'an ounce of prevention can indeed be better than a pound of cure'. We have had, in the last decade, at least three attempts by the Ministry of Health to establish a Chronic Disease Committee: they all died suddenly. The last one of these, of which I was a member, died a sudden death in October 2004 after 10 months, and declarations from the CMO's office (October 2005) and publicly by the Minister of Health himself (July 2006) that a Healthy Lifestyle Commission would *soon* be established, are yet to bear fruit. The inactivity continues.



Upcoming CME

BAMP/UWI May 2007 CME Conference

Primary Care Update

Dear Colleagues,

Welcome to the **61st BAMP/UWI CME conference**. Sixty-one conferences are a lot of conferences. Surviving this long says something about the sustainability of the event, or perhaps demonstrates the importance of the event to BAMP/UWI, and their determination to keep it going. Hopefully you the practising physician will continue to find the conference relevant. Paradoxically the public despite its enthusiasm for alternative medicine will increasingly demand a physician that practises evidence based medicine, has good consultation skills, and perhaps one that is periodically re-certified.

This year the committee has decided to deliver a Primary Care Update. **A Primary Care Update** is best delivered by specialists practising and doing research in this field, and this is exactly what has been lined up for you. The committee has also decided to maximise discussion, and decrease didactic presentations and hence information overload. Many of the presentations will cover areas peculiar to Barbados, and will not be covered at conferences overseas. Some areas will be controversial with no right or wrong answer.

There are **three Keynote Presentations**. The first “*The Doctor and Mandatory CME*” will be delivered by Dr. Hoyos who is the originator of Family Medicine education in Barbados. The second “*Diabetes and Hypertension Care in Barbados: Are primary care physicians following the guidelines?*” will be delivered by myself and will reveal the results of a recent study. Lastly but not least Dr. Rohan Maharaj lecturer in primary care from Trinidad will show us how “*Behaviour Change*” has moved a long way from the days when we gave information and told patients what to do, then complained when our instructions were not followed. A glance at the programme will reveal the names of several other presenters of keynote calibre, and topics deserving of keynote billing.

This conference will not be a success without your attendance, and full participation in the discussion. Wishing us all a successful CME.

Peter Adams
Chairman, BAMP/UWI CME committee
Public Relationship Officer, BAMP

Friday 18 May 2007

- 13:45 Welcome**
Dr. Carlos Chase President, BAMP
Prof. Henry Fraser Dean, SCMR

Session 1: Professional responsibilities

Chairperson: Selwyn Ferdinand

- 14:00 Feature address**
The Doctor and mandatory CME
– Michael Hoyos
- 14:40 Certification in Primary care**
14:40 Sick leave certification
– Abdon DaSilva
- 14:55 Regulatory certificates
(Food Handlers, hairdressers)
– Cheryl McCollin
- 15:10 Discussion
- 15:30 Death certification
– Margaret Hazlewood, PAHO
- 15:55 Discussion
– Margaret Hazlewood,
Llewellyn Harper
- 16:15 Coffee break and exhibits**

Session 2: Infectious Disease and Occupational Medicine

Chairperson: Clyde Cave

- 16:45 Fevers in General Practice**
(influenza, dengue, malaria etc)
– Colin Alert
- 17:15 Use of the laboratory for the patient**
with a fever
– Delores Lewis
- 17:45 Allergies and Sick Buildings**
– Euclid Morris

Saturday 19 May 2007

Session 3: Chronic disease

Chairperson: Rudy Delice

- 10 00 Feature Address**
Diabetes and Hypertension care in Barbados:
Are primary care physicians following the
guidelines?
– Peter Adams
- 10:40 Diet in chronic disease** – Karen Griffith
- 11 20 Elderly and prescribing** – Henry Fraser
- 11:50 Back pain: More than a disease**
– Malcolm Grant
- 12:20 Lunch**

Session 4: Psychosocial aspects of care

Chairperson: Ermine Belle

- 13:20 Feature Address**
Behaviour Change
– Rohan Maharaj
Lecturer in Family Medicine,
St Augustine campus, UWI
- 14:00 Breakout session introduction:**
- 14:10 Breakout sessions begin (30 minutes)**
Death and Bereavement counselling
– Michael Campbell
- Illicit drugs and the Family
– Maisha Emanuel
- Relationship and Family Crisis
– Vijaya Thani
- Psychology and Sport – Adrian Lorde
- 14:40 Presentations from each breakout group;**
5 minutes followed by 5 minutes discussion
- 15:10 Vote of Thanks**

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BAMP/UWI May 2007 CME Conference

Obstetrics and Gynaecology: What is New? What is Important?

Sherbourne Conference Centre, May 19th - 20th , 2006

Infertility: An Update

Juliet Skinner MRCOG MRCPI

When considering causes of female infertility for practical purposes it is best to use an anatomical classification.

Infertility refers to the condition where sexual intercourse fails to achieve a pregnancy. The traditional definition applies a time line to this as the failure to conceive within twelve months of trying.

A General Practitioner can play a vital role in providing guidance to patients trying to have a family. Frequently the GP may be the first doctor that a patient will approach regarding the failure of a pregnancy to occur. In fact in the UK, infertility is the second most common reason why a female of reproductive age will visit her GP. The failure of conception is a sensitive issue for patients. They will seek assurance that "it" will happen. In some respects reassuring the patient is the easy option. However, it is vital that as the one providing guidance that you know when it is time to move to investigation, treatment and /or referral.

This paper will focus on a practical approach to infertility, and most importantly, provide an update on current treatment options available.

Infertility affects 1 in 6 couples worldwide. This figure is relatively consistent in first world countries and is estimated to be even higher in developing countries. The incidence of infertility is increasing. Likely reasons for which include: delayed childbearing, a greater number of second marriages, increasing

prevalence in sexually transmitted diseases, and falling sperm counts.

Infertility can be classified into explained (75%): male (40%), female (40%), combined (20%) or unexplained infertility (25%).

When considering causes of female infertility for practical purposes it is best to use an anatomical classification. Factors may affect the ovary (such as anovulation secondary to polycystic ovaries), tubal function (such as infection, adhesions, endometriosis or fibroids), the uterus (most commonly fibroids, congenital anomalies) or the cervix (such as stenosis, mucus hostility).

Most importantly however, female age is a highly significant cause - as the number and quality of eggs falls significantly as female age increases. This fall begins in the late 20's but becomes more marked after 35, falling steadily until the early 40's. In fact natural conception is very rare after age 42.

Traditionally the causes of male infertility were considered as disorders of sperm production, release or function. For practical purposes this method of classification is of little use. The best practical approach to male factor infertility is classification according to the semen analysis findings as this method also correlates with a therapeutic approach.

Editor's note: Juliet Skinner is a gynaecologist. She runs the Barbados Fertility Centre where the procedures described in this presentation are performed.

Analysis of the ejaculate sample provides an assessment of number, motility and morphology of spermatozoa. A normal semen analysis should have >20 million sperm per ml, > 50% motility score and normal morphology in >14% (WHO criteria).

Abnormal semen analysis findings include reduced sperm number “*oligospermia*”, reduced sperm motility “*asthenospermia*” or often a reduction of both. The absence of sperm in the ejaculate is called *azospermia* (10%). Where the semen analysis is abnormal it is recommended that a repeat semen analysis be performed.

For azospermic men a testicular biopsy will establish whether sperm are present in which case it is obstructive azospermia *or* not present which is non-obstructive azospermia. This is crucial as obstructive azospermia is treatable by intracytoplasmic sperm injection (ICSI). For non-obstructive azospermia donor sperm will be required.

Previously medical and surgical approaches to male infertility were considered. These essentially aimed at improving the sperm count. These treatments are now considered obsolete. Specifically the use of clomid or testosterone in oligospermia has been shown to be not associated with any improvement in pregnancy rates and therefore is no longer recommended. Varicoceles are present in 20% of the male population. There was an old practice to ligate these veins in men with infertility. Studies show that varicocele ligation is of no proven benefit and should not be undertaken to reasons such as infertility.

Current therapeutic options lie solely with the laboratory preparation of sperm either to concentrate and perform an intrauterine insemination (IUI) procedure or to select a normal motile spermatozoon, and inject it into an egg directly (ICSI). This approach means male factor infertility has become one of the most successfully treated causes of infertility.

So why is it that strategies to improve semen analysis parameters are unsuccessful? Advances in research on sperm production and function suggest that the majority of cases of male factor infertility are linked with genetic mutations in the genes linked with production or function. Not surprisingly therefore, the

treatment strategies like ICSI - which allow fertilization with a 1:1 sperm to egg ratio and removes the need for motility and sperm egg interaction, are most successful in male factor infertility, particularly severe male factor - which are even more likely to be genetic.

INVESTIGATIONS:

The first critical question is when is it time to investigate? By definition if the couple has been trying to conceive for over 12 months then the medical definition applies and investigations are warranted. It is current opinion that if the female is over 35 years old and has not conceived within 6 months investigation is warranted. This is based on the fact that the majority of couples who will conceive will have done so within 6 months and because of the significant impact of age and infertility. Obviously in cases where there is one partner with known infertility then investigation and treatment is warranted sooner.

Primary investigations of infertility should include a semen analysis, a test of ovulation (D12 ultrasound, mid-luteal progesterone, LH predictor kit) and a test of tubal patency (HSG, Contrast sonography (SIS) or sometimes a laparoscopy). In women over 30 years a day 3 follicle stimulating hormone (FSH) and oestradiol (E2) provides a useful assessment of ovarian reserve. Other tests may include: Prolactin, ultrasound, Chlamydia, TSH.

At the end of investigations for most couples a diagnosis will have been established. However, in 25% investigations will be normal and conventionally this is called “*Unexplained infertility*”. Unfortunately this is often interpreted as “*nothing is wrong*” rather than “we don’t know what is wrong investigations have not made a diagnosis”. The fact is that <2% of couples with “unexplained infertility” of greater than two years duration will get pregnant without assistance. The treatment approach for couples with unexplained infertility is usually in a stepwise fashion – first to IUI then to in-vitro fertilisation (IVF).

TREATMENT OPTIONS:

Treatment options can be divided into 1) Ovulation induction (OI), 2) Intrauterine Insemination (IUI) or 3) Assisted Reproductive Technology (ART) – such as In-Vitro Fertilisation (IVF) or Intracytoplasmic Injection (ICSI).

Ovulation induction (OI) as the name suggests aims to induce follicular formation and therefore maturation of the oocyte. The goal is to use the agent and the dose that establishes normal ovulatory function with typically 1-2 follicles. Most commonly used are the oral agents – clomiphene citrate or tamoxifen but more potent gonadotrophins may be used with due care. These are generally well tolerated with regard to side effects and if the only reason for infertility is anovulation or sporadic ovulation may be highly effective. As individual variations to response exist it is important to monitor this at least in the first cycle both to rule out response with multiple follicles or failed response, which necessitates a change in dose. It is recommended that treatment is limited to 6 cycles of OI after which an alternative therapeutic option should be used.

The main advances in OI treatment are 1) A meta-analysis of treatment options for polycystic ovaries (PCO) showed that older techniques such as wedge resection or ovarian drilling are no more effective than gonadotrophins, 2) The concurrent use of Metformin with OI for patients with PCO significantly improves the likelihood of response as well as reducing the incidence of gestational diabetes in the resultant pregnancy.

Intrauterine Insemination (IUI) allows the placement of sperm into the upper uterine cavity and thus as close to the egg as possible in vivo. Laboratory preparation and washing is best. It is most effective for cervical factor infertility and can be useful in mild male factor, or unexplained infertility. It is important to remember that patent tubes are required. Single insemination with follicular assessment by TVS is most successful. Success rates are in the region of 10-15%. Treatment should be re-evaluated after 3 failed attempts.

Assisted Reproductive Technology (ART) includes In-vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI). The difference between the two simply refers to the actual fertilisation step. Broadly IVF is made of up 4 steps: 1) ovarian stimulation and monitoring 2) egg retrieval (ER), 3) laboratory phase and 4) embryo transfer (ET).

Indications for IVF/ICSI are multiple. In the case of bilateral tubal factor or severe oligospermia it may be

the only option. It is also indicated after failed OI or IUI, unexplained infertility, severe endometriosis and advanced maternal age.

With IVF a batch of eggs are obtained directly from the ovaries thus not requiring tubal function or avoiding exposure to toxic secretions such as endometriosis. Gamete performance and fertilisation can be confirmed and embryo development assessed. The placement of 2-3 embryos (depending on the age of the female) into the uterine cavity is performed 3-5 days after the ER.

Success rates per cycle are significantly higher than OI or IUI. When considering success rates with IVF it is important to consider these according to female age as success rates fall with age. The best success rates will be seen in the <35 group of 45-55%. By age 40-42 realistic success rates are approx 15-20%. Again the importance of earlier treatment in the older female cannot be over stressed, as this may well make the difference between success and failure.

In terms of advances in ART a full discussion is outside the scope of this paper, but just to touch on a few:

- * The use of donor gametes means that effective treatment options exist for advanced maternal age or premature ovarian failure in the female or non-obstructive azospermia in the male.
- * ICSI using testicular acquired sperm allows effective treatment for the vasectomised male or men with obstructive azospermia.
- * Extended embryo culture systems such as blastocyst may improve success rates.

SUMMARY

In summary effective treatments of infertility exist. In most couples pregnancy can be achieved. However, prompt assessment and treatment remains crucial. It is very important to consider the “couple”. Investigations must be on both male and female. Examples of doctors treating one party for a problem with no consideration of ‘her age’ or ‘his severe oligospermia’ sadly still exist. While it is important to allow a reasonable time for a treatment option to work it is also crucial that we know when it is time to change tack and move to an alternative therapeutic option.



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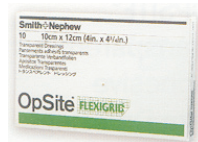
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Emergency

CONTRACEPTION

Peter Adams

Emergency contraception refers to any method of contraception used after intercourse and before implantation, and represents the last chance to prevent an unwanted pregnancy.

An unplanned pregnancy can have many social, personal and financial consequences. Difficult decisions such as termination of pregnancy, adoption, or raising a child without emotional or financial support may be faced. Pregnancy, childbirth, and termination can all have health related consequences. On the other hand freeing women from involuntary reproduction allows the opportunity for non-domestic activity, and represents an important step towards gender equality. As fertility falls in developing countries the participation of women in the workforce has risen. It has been claimed that freedom from the tyranny of excessive fertility is the 5th freedom, the others being the freedoms of speech and worship, and the freedoms from want and fear ¹.

If 100 women have intercourse once in the middle 2-weeks of their menstrual cycle approximately 8 will become pregnant. However, if intercourse occurred one to two days before ovulation 24 women would get pregnant, and in young women between 19 and 26-years of age as many as 50 might become pregnant. Sperm can survive in the female genital tract for five to six days, and therefore fertilisation can occur several days after unplanned unprotected intercourse ².

Single dose administration of 1.5 mg levonorgestrel taken as soon as possible after intercourse and preferably within 72 hours is the World Health Organization's recommended regimen

It has been estimated that 50 million pregnancies are terminated worldwide each year³; and that about half of all pregnancies in the USA are unplanned, although only some of these would be unwanted. Unwanted pregnancy can result from contraceptive failure, for example a burst condom or inadequate contraceptive technique; and from failure to use any type of contraception because of unanticipated intercourse, lack of planning, or lack of negotiation skills. Rape may also be a cause of unwanted pregnancy.

HISTORY OF EMERGENCY CONTRACEPTION

Emergency contraception refers to any method of contraception used after intercourse and before implantation, and represents the last chance to prevent an unwanted pregnancy. Many methods have been tried over the centuries - sneezing, hopping, jumping, and dancing were reportedly tried as early as 1500 BC. Douching with various herbs and roots has been used⁴. In the 1960's post-coital douching with coca cola and other soft drinks were tried. This method of pregnancy prevention proved somewhat popular because not only was it cheap and universally available at a time when reliable birth control methods were hard to come by, it also came in its own handy "shake and shoot" disposable applicator. After intercourse, the girl would uncap a warm Coke, put her thumb over the mouth of the bottle, shake up the beverage, then insert the neck of the bottle in her vagina and move her thumb out of the way. The warm well-shaken Coke became an effervescent spermicidal

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The WHO also states there are no known medical contraindications to the use of emergency contraceptive pills.

douche, with the traditional (at that time) six-ounce bottle providing what was deemed to be just the right amount for one application ⁵. Umpierre investigated the effects of various formulations of Coca Cola (old coke, new coke and diet coke) on sperm motility, and reported that all types of Coca Cola markedly reduced sperm motility ⁶. However, Hong using various formulations of Coca Cola and Pepsi Cola and a trans membrane migration method, showed that none of them could reduce sperm motility to less than 70% of control within one hour, which meant that the method would be useless ⁷. Modern emergency contraception methods include hormone pills and the intrauterine device. The hormone methods evolved from the use of high dose oestrogens by veterinarians, after researchers in the 1920's demonstrated that oestrogen in ovarian extracts interfered with pregnancy in mammals. There is evidence that the method was used in humans as early as the 1940's, but the first published case was in the mid 1960's when Dutch physicians administered oestrogen to a 13-year-old girl who had been raped at mid-cycle. Five mgms of ethinyl oestradiol per day for five days is a typical high dose oestrogen regimen ⁸. In 1972 a Canadian Physician Albert Yuzpe began using combined oestrogen and progesterone, after he noted that 100 µg of ethinyl oestradiol and 50 mg levonorgestrel produced endometrial changes incompatible with implantation. He was at the time conducting research on the endometrium using the combined oral contraceptive Ovral. ^{8,9}. Around the same time as Yuzpe was conducting his research, investigators mainly in Latin America began using levonorgestrel only preparations. In 1973 a report described the results of a large-scale trial investigating five doses of levonorgestrel (150 µg, 250 µg, 300 µg, 350 µg and 400 µg) used as an ongoing post-coital method, rather than an emergency formulation ⁸. More recently mifepristone or RU 486, an antiprogesterone used as an abortifacient, has been shown to be effective when used for emergency contraception.

Because of its safety emergency contraception can be used repeatedly, even within the same cycle.

YUZPE AND LEVONORGESTREL REGIMENS

The Yuzpe regimen consists of 2 doses of 100 µg of ethinyl oestradiol plus 50 mg levonorgestrel administered 12 hours apart. The first dose should be taken as early as possible but preferably within 72 hours of intercourse. Each dose is the equivalent of 2 Ovral oral contraceptive pills. The FDA has cleared 11 other brands of combined oral contraceptive pills for safety and efficacy when used as emergency contraception. These include Alesse (5 pills per dose), and Nordette (4 pills per dose) ¹⁰. It must be noted that the hormone dose is not exactly the same as if Ovral was used.

Single dose administration of 1.5 mg levonorgestrel taken as soon as possible after intercourse and preferably within 72 hours is the World Health Organization's recommended regimen ¹¹. There is some evidence to suggest that both the Yuzpe and levonorgestrel regimens are effective up to 120 hours after intercourse, and therefore either regimen could be used unless this time period has elapsed.

Postinor is the brand available in Barbados and 2 tablets gives the required dose. The Barbados Family Planning Association is expected to make available an alternative brand (Optinor) in the near future.

MECHANISM OF ACTION

Delayed ovulation and anovulation are thought to be the major mechanism of action by which these regimens work, although thickening of the cervical mucus and prevention of implantation might also occur. There is no evidence that it acts as an abortifacient.

EFFECTIVENESS

Analysis of the results of 8 studies estimate that 74.1% (95% CI 62.9-79.2) of expected pregnancies would be prevented by the Yuzpe regimen³. This means that instead of 8 women out of 100 becoming pregnant if intercourse occurred once in the middle 2 weeks of the menstrual cycle, only 2 would become pregnant. The original levonorgestrel regimen was 0.750 mg repeated in 12 hours. A Cochrane review concluded that this is more effective than the Yuzpe method. Two trials were reviewed and the relative risk of pregnancy was

calculated to be 0.51 (95% CI 0.31-0.83) ³. With this regimen approximately one woman out of a hundred would become pregnant with intercourse occurring during the middle 2 weeks of the menstrual cycle (table 1). However, the single dose regimen has been shown by 2 studies to have similar efficacy as the 2-dose regimen. The relative risk of pregnancy with the single dose regimen was 0.77 (95% CI 0.45-1.3) ³. In a worse case scenario a relative risk of 1.3 means that the 2-dose regimen is 30% more effective. Using the pregnancy rate of 1.6% found in the split dose group, the absolute risk increase would be 0.49% with the single-dose regimen which means that one needs to treat 204 women by the single dose regimen to observe one extra pregnancy.

The single dose levonorgestrel regimen should lead to better compliance since it avoids a second dose, which might have to be taken at an inconvenient time, or may require a delay in taking the first dose if this is to be avoided. The levonorgestrel regimen although more effective than Yuzpe tends to be more costly.

Table 1: Expected pregnancy rate if 1000 women have unprotected intercourse once in the middle 2 weeks of the menstrual cycle.

Method	Number of Pregnancies	Reduction %
No Treatment	80	
Yuzpe	20	75
Levonorgestrel	10	88
IUD	1	99

WHO SHOULD USE EMERGENCY CONTRACEPTION?

Emergency contraception generally should be provided any time unprotected or inadequately protected intercourse occurs and the patient is concerned about the risk for unwanted pregnancy. A clinical examination is not needed before prescribing it, and provision should not be delayed in order to test for pregnancy.

TIMING

Most studies of the levonorgestrel and Yuzpe regimens have administered the first dose within 72 hours of intercourse, and some have shown an inverse relationship between this time and pregnancy prevention. A multi-centre randomised controlled trial of levonorgestrel versus the Yuzpe regimen that enrolled 1998 women (the world's largest) showed that the earlier treatment was administered the more effective it was. The pregnancy rate for both methods combined was 0.5% if treatment was administered within 12 hours, and 4% at 61 to 72 hours. There was approximately a 50% increase in odds of pregnancy with every 12-hour delay in treatment ¹². The study was designed to compare the 2 regimens when given within 72 hours, but extrapolation of the results would give a pregnancy rate of 10% at 120 hours ¹⁰. A failure rate of 10% would not suggest that the method was effective. However, a review of 9 published reports (mainly observational studies) found no significant relationship between efficacy and timing of up to 72 hours ¹³, and one subsequent small observational study (317 women) of the Yuzpe regimen suggests that the method might be effective up to 120 hours ¹⁴. In a randomised trial comparing the efficacy of levonorgestrel and mifepristone regimens, delaying treatment to 4 to 5 days as opposed to starting treatment within 3 days did not affect efficacy significantly. However, for the combined regimens there was a significant trend of increasing pregnancy rates in the 5 successive days following unprotected intercourse¹⁵. The small number of women getting delayed treatment especially with levonorgestrel makes any estimation from this study very imprecise. It should also be noted that even with randomised controlled trials, women are randomised to different treatment regimens, but the comparison between delay categories is observational, not randomised.

SIDE EFFECTS

Nausea (30-70%) and vomiting (15-25%) are the major side effects of the Yuzpe regimen, and the use of an anti-emetic 1-hour before a dose was shown in one study to reduce the incidence of nausea to 28% and vomiting to 9.6% ⁴. The levonorgestrel regimen was shown by a randomised controlled trial to cause significantly less nausea (23.1% versus 50.5%) and vomiting (5.6% versus 18.8%) than the Yuzpe regimen ¹⁶, and it is not necessary to give an anti-emetic before the

levonorgestrel dose. Some suggest that repeat dosing be considered if vomiting occurs within one hour of taking a dose. Studies of oral contraceptive use during pregnancy have not shown any increased teratogenic risk, and the limited data has not shown an increased risk after emergency contraceptive use. The WHO also states “there are no known medical contraindications to the use of emergency contraceptive pills”. Women with contraindications to oral contraceptives can safely use emergency contraception, as the duration of use is extremely short. It might be prudent to use the progesterone only regimen in women with a history of thrombosis. WHO criteria note specifically that women with previous ectopic pregnancy, cardiovascular disease, migraines, or liver disease and women who are breastfeeding may use emergency contraception ¹⁷. Because of its safety emergency contraception can be used repeatedly, even within the same cycle.

STARTING OR RESUMING ROUTINE CONTRACEPTION

A follow up appointment is not needed when emergency contraception is prescribed, but it is important to discuss routine contraception with the patient. After using emergency contraception 98% of women menstruate within 21 days (more than half menstruate at the expected time), and the patient should be advised that a pregnancy test should be done after this time has elapsed if there is no period.

Oral contraceptives or depot progesterone injections can be started immediately or at the time of the next menstrual period. If started immediately a backup method of contraception should be used for the first 7 days. An intrauterine device can be inserted at the end of the next period. Condoms, diaphragms and spermicides can be used immediately.

MIFEPRISTONE (RU 486)

Mifepristone (RU 486) is a synthetic steroid that prevents progesterone binding. It is commonly used in China and requires a single dose only. It is not currently available in Barbados. Levonorgestrel has similar effectiveness to mifepristone at doses of 25 to 50 mg (8 trials, RR: 1.64; 95% CI: 0.82 to 3.25) or ≤ 10 mg (7 trials, RR: 1.38; 95% CI: 0.93 to 2.05) ³.

INTRAUTERINE DEVICES

Intrauterine devices are effective when inserted within 5 to 7 days of intercourse. The failure rate has been estimated to be 0.1 to 0.2%.

ADVANCE AND NON-PRESCRIPTION PROVISION

Effective use of emergency contraception depends on good public and professional awareness, as well as access to it in both a timely and cost effective manner. Except for China and a few Western European countries emergency contraception remains a significantly under-used method.

If the woman is not aware of the method it will not be used. Counselling women at routine visits especially when contraceptive use may be unreliable will help. They need to be made aware of when and how to obtain the pills. They have to be aware of its effectiveness and that it is not as good as regular methods. If a physician's visit is required to obtain a prescription this poses a barrier, as the woman will have to make an appointment, pay the doctor a fee, then visit a pharmacist and pay for the medication. This may become an insurmountable barrier especially as time is of the essence.

Studies have shown that advance provision of emergency contraception increases its usage, and without affecting routine contraceptive behaviour Most women use emergency contraception correctly ¹⁸. A study done in San Francisco showed that education plus the provision of emergency contraception in advance, but not education alone, resulted in increased use without affecting routine contraception ¹⁹.

In addition to being safe and having few side effects, modern emergency contraception unlike Coca Cola is not necessarily cheap or universally available. In Barbados emergency contraception is available on prescription only. Some may argue that with our obesity and chronic disease epidemic Coca Cola should be the one that is prescription only. Changing the status of emergency contraception pills to over the counter or pharmacist dispensed is likely to be safe and increase its usage. In addition, health care workers need to be non-judgemental, for a judgemental attitude can also be an effective barrier to use.

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Abstracts

THE PERINATAL INFORMATION SYSTEM (SIP): WHAT IS IT, AND WHY DO WE NEED IT NOW?

Clyde T. Cave

In the 1970's and 1980's, the Barbados Perinatal Mortality Rate (PMR) hovered in the very high 20's. With the acquisition of a Neonatologist and the opening of the Newborn Intensive Care Unit (NICU) in 1990, the PMR was reduced to the high teens , where it has essentially remained.

In 2001, the Barbados Ministry of Health and the Pan American Health Organisation (PAHO) , recognizing the static nature of our PMR and the need for further gains, convened The Barbados Perinatology Workshop. The consensus of this workshop was that by essentially fine-tuning the present system of obstetric and neonatal care, significant improvement and consequent drop in the PMR could be achieved. The targeted PMR in the first part of the 21st Century was 11 – 12 , and a central strategy to achieving this goal was implementation of The Perinatal Information System (SIP) which consists of the following elements:

- the Perinatal Clinical Record (PCR) and Perinatal Card (Passport)
- Partograph (recommended)
- Maternal hospitalization record
- Neonatal hospital record and chart (optional)
- Job aids (obstetric wheel, stethoscope, tapes)
- Software
- Training Programme
- Continuous feedback at all levels

Uses and advantages of the system include:

- providing a standardized, complete, evidence-based record
- having a communication tool for different health care providers over distance and time
- clinical record management (e.g. completeness control)
- easy generation of reports (e.g. discharge summaries, custom reports)
- easy collection, analysis and comparison of data
- improvement in audit and quality care
- empowerment of mothers

SIP has been used in the Bahamas for the past 5 years, and is currently being implemented in St. Vincent and the

Grenadines, in St.Kitts and Nevis, in Jamaica at the University Hospital of the West Indies, Mona , and in Barbados.

POLYCYSTIC OVARIAN SYNDROME

Joanne Paul-Charles

Stein & Leventhal published one of the first descriptions of Polycystic Ovarian Syndrome (PCOS) in 1935. They discussed their findings in seven women with amenorrhea, hirsutism, obesity and a characteristic polycystic appearance of the ovaries. It was viewed primarily as a gynaecologic disorder requiring medical intervention for control of chronic anovulation, abnormal menstrual bleeding and infertility.

Polycystic Ovarian Syndrome is now recognized as a heterogeneous syndrome affecting the reproductive, metabolic and cardiovascular health of women. The aetiology is uncertain. However, insulin resistance plays an important role in its pathophysiology. It is associated with hyperinsulinemia, glucose intolerance/diabetes mellitus, hypertension and dyslipidemia, which can lead to long-term cardiovascular sequelae. Approximately 5-10% of women of reproductive age are affected.

Diagnosis is a challenge and even, at times, controversial. The history, clinical and biochemical evidence of hyperandrogenism, ultrasound scan findings and exclusion of other causes of hyperandrogenism, all contribute to the diagnosis. There is no single defining test.

Therapy is aimed, not solely at managing the gynaecologic problems, but at treating the underlying hyperinsulinemia associated with this condition. Studies show that decreasing insulin resistance can restore menstrual cycle regularity and fertility, and prevent long term metabolic and cardiovascular complications. Weight loss, exercise and the use of insulin sensitizing agents have become the new trend in management.

Pregnancy rates as high as 60% have been achieved with only lifestyle changes in obese PCOS females. Metformin reduces insulin resistance and circulating androgens, has beneficial effects on the underlying metabolic syndrome and is an effective treatment for anovulation. In a metanalysis, ovulation was achieved in 46% of those who received metformin alone compared

to 24% with placebo (NNT = 4.4). Ovulation was achieved in 76% of patients receiving metformin and clomifene compared with 42% receiving clomifene alone (NNT = 3). Oral contraceptives or cyclic progestins are used as adjuncts in patients who do not wish to become pregnant. They have a synergistic effect in improving hormonal patterns. Other modalities such as anti-androgens and steroid hormones are used to treat the hyperandrogenism. Gonadotrophin analogues and ovulation inducing agents are also used in achieving pregnancy, but are not first line. Surgical interventions require specialist care, and are becoming less popular because pharmacological and lifestyle interventions are just as effective and there are no post-operative complications to deal with.

OBSTETRIC ANAESTHESIA AND ANALGESIA

Philip Gaskin

Obstetric Anaesthesia.

Early in the first trimester of pregnancy, a female's physiology changes rapidly under the influence of progesterone secreted from the placenta. These effects are widespread. From an anaesthetic stand-point, knowledge of this change is critical to the safe delivery of anaesthesia to the mother and minimizing effects on the foetus. Lack of specialisation in anaesthesia for the obstetric patient and ignorance of the attendant changes may result in adverse outcomes for both mother and foetus.

Caesarean section

Anaesthesia for Caesarean section is performed either as a general anaesthesia or regional anaesthesia technique. The evidence for regional anaesthesia being the preferred option is compelling, as a number of deaths are directly related to general anaesthesia and the problems of airway management and aspiration. The risk of failed intubation in the general population is 1:2000 compared to that in the obstetric population which is 1:200. Regional anaesthesia avoids manipulation of the maternal airway and reduces the foetus's exposure to depressant general anaesthetic drugs. There is also reduced bleeding at the time of section compared to general anaesthesia; as regional anaesthesia avoids volatile anaesthetic agents which are associated with uterine relaxation. Regional anaesthesia is safe and the benefits do outweigh the risks.

Labour Analgesia

In 2002, the American College of Obstetricians and Gynaecologists and the American Society of Anaesthetists issued a joint statement indicating that a woman's request for pain relief in labour is sufficient medical indication for the use of an Epidural. Epidural analgesia is the most effective treatment of labour pain with minimal risks and side effects. One often hears the statement, "pain never killed anyone" on the labour ward. However severe, prolonged pain may cause serious psychological and potentially physical damage to the parturient. Many women worry that receiving pain relief during labour will somehow make the experience less "natural". The fact is, no two labours are the same, and no two women have the same amount of pain. Labour is a complex and highly individual process; not every woman wants or needs analgesic interventions for delivery. Prenatal education, whenever possible, is the best option for helping women make an informed decision. The decision to receive any form of analgesia is personal and should be made by the patient in consultation with her obstetrical care provider and anaesthetist.

ANTENATAL CARE

V. Rene Best

Pregnancy is an important life event. This period is preceded by the preconception period and usually ends with the delivery and postpartum period. It is recognized that pregnancy does not always go according to plan or as hoped. Therefore, care of the pregnant female offers excellent opportunities for preventative medicine. Antenatal care aims to detect and prevent maternal as well as neonatal adverse outcomes.

Antenatal care has been an important part of medical practice since the early in the 20th century. Ballantyne at the University of Edinburgh is believed to be responsible for its introduction 1913. In the decades that followed, the fall in perinatal mortality rates were attributed to good antenatal care. However, Archie Cochrane, the famous British medical researcher, once stated "by some curious chance, antenatal care has escaped the critical assessment to which most screening procedures have been subjected".

Screening in pregnancy has improved significantly since the mid 1960s. The expectant female now has the benefit of several screening tools such as the history and physical examination, ultrasound, basic blood and urine

tests, α fetoprotein test, chorionic villus sampling, amniocentesis and fetoscopy.

In recent times, many have questioned the optimal frequency of antenatal visits in preventing maternal and foetal complications. Randomised controlled trials have found that reducing antenatal visits did not lead to an increase of adverse outcomes. However the reduction leads to less satisfied women.

Antenatal care entails preventative care, counselling, screening, education and management of common symptoms. This paper focuses primarily on screening and diagnosis in the antenatal period. It looks at this topic in an evidence based manner and presents the various aspects of screening in pregnancy as well as changes expected in the future as research expands our knowledge.

HIV IN GYNAECOLOGY

Garth McIntyre

Of the people infected with the HIV in Barbados, 50% are women and, similarly, about 50% of the HIV infected people registered with the Lady Meade Reference Unit are women. Transmission of HIV in Barbados is largely through heterosexual contact and HIV is transmitted 8 times more efficiently from men to women than from women to men. Women are more than twice as likely as men to contract HIV through unprotected heterosexual sex.

HIV positive women have 35-65% less virus in their bloodstream than HIV positive men, however they progress from HIV to AIDS at the same rate. Certain AIDS related conditions are more common in women than men and vice versa.

Issues pertinent to gynaecology include the following:

Contraception:

Condoms lower HIV transmission and STI acquisition. Spermicides and the diaphragm do not. IUCDs can be used however they do not offer protection against HIV or STIs. Hormonal contraceptives may increase genital tract HIV shedding. Antiretrovirals have differing effects on blood levels, which may increase the side effects of contraceptives or increase failure rates.

Sexually transmitted infections:

Sexually transmitted infections can facilitate HIV transmission and their treatment has been shown to decrease HIV transmission rates. Candidiasis, pelvic

inflammatory disease and genital herpes outbreaks are more common in HIV positive women.

Menstrual disorders:

Menstrual irregularities and menorrhagia are more common in HIV infected women. There is a worsening of PMS symptoms. In the latter stages of the disease there may be amenorrhoea.

Cervical disease:

Cervical cancer is an AIDS defining illness. The frequency and severity of cervical dysplasia increase with advancing HIV disease. There is an increased risk of HPV infection. HIV positivity rates in patients attending colposcopy clinics may be higher than in other outpatient settings.

Fertility:

Sero-discordant couples may present seeking advice on achieving a pregnancy, while not exposing the uninfected partner to the risks of unprotected sexual contact. Options, though limited, are available for these couples.

NON-SURGICAL MANAGEMENT OF FIBROIDS

Carlos Chase

Uterine artery embolisation (UAE) is a new and exciting way of treating symptomatic fibroids without the use of surgery. It involves the selective embolisation or blockage of the main arterial supply to the uterus, the uterine arteries. This reduces the blood flow leading to a reduction in the size of fibroids over time and an almost immediate cessation of symptoms.

This process is rapidly expanding in Europe and the USA and has high patient acceptance. A 2001 Internet survey showed 4115 procedures done at 252 institutions averaging 375 per month with no deaths.

Patients must however, be carefully selected since, as with any medical procedure, it is not a panacea and has its risks and benefits. All patients who are candidates for such surgery should be seen by a gynaecologist who should recommend the procedure only after a careful, history, examination, investigation and counselling of the patient.

There is an average 95% success rate in the reduction of symptoms of menorrhagia and pain. Uterine volume can be reduced by as much as 50%, on average. Caribbean experience comes from Trinidad where, up to

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2004, 135 patients, average age of 41 yrs and average uterine volume of 1110ml, had undergone the procedure with no deaths. There was a 48% reduction in uterine volume and 90% patient satisfaction rate. Barbados recently had its first 4 cases done in January of 2006 with no complications. Follow up at 3 months showed a significant volume reduction in 3 of the 4 cases and all had relief of symptoms.

The value of UAE in carefully selected patients, its availability in Barbados and its proven safety record now makes this procedure a viable alternative to surgery for many patients.

SEXUALLY TRANSMITTED INFECTIONS

Anne Carter

Sexually transmitted infections (STI) are transmitted between humans mainly by sexual activity (genital-genital, anal-genital and oral-genital direct contact) but also in other ways, particularly blood borne and vertically at birth. STI's cause significant disease burden, disability and death and occur primarily in those between age 15 and 35 with multiple sexual partners who do not use condoms. Those with one STI are at high risk of having another. This presentation focuses on the most common STI's in Barbados other than HIV: Chlamydia, Gonorrhoea, Genital Herpes and Syphilis. It follows guidelines issued by the WHO and the US Centers for Disease Control and Prevention, both of which are freely available online.

Primary prevention of STI's involves abstinence, mutual monogamy or consistent and correct use of condoms with all partners. In addition, immediate treatment of cases, follow-up of their contacts and screening of high risk populations for asymptomatic disease contribute to prevention. Immediate treatment of cases (at the initial visit) is based on syndrome when laboratory results are not immediately available. If possible, use directly observed therapy (DOT) in a single dose. The major STI syndromes are: Urethritis/epididymitis (UE) in males, cervicitis/vulvovaginitis (CV) in females, both caused primarily by Chlamydia or gonorrhoea; and genital ulcer disease, caused primarily by genital herpes or syphilis. Treating syndromes UE and CV requires use of antibiotics effective for both Chlamydia and gonorrhoea. Currently administration of azithromycin 1 gm AND ciprofloxacin 500 mg stat is recommended. Since the ulcers of genital herpes are painful and those of syphilis

are painless, specific treatment can be given. For syphilis, Benzathine Penicillin G, 2.4 million units IM and for herpes Acyclovir 400mg tid x 7-10 days are recommended.

All patients must be counselled about prevention and abstinence during treatment. For all but those with herpes, partners must be identified and treated and follow-up for cure is essential. Until these steps are complete, appropriate care has not been given.

EVIDENCE BASED MATERNITY CARE AND THE ROLE OF THE COCHRANE COLLABORATION

Jim Neilson

Editor's note: Jim Neilson is Professor of Obstetrics and Gynaecology & Head of the School of Reproductive and Developmental Medicine, University of Liverpool, UK. This paper was the feature address at the conference Improvements in health care need up-to-date, high quality evidence on the effects of different interventions. This evidence comes from reliable research. Given the vast amount of available research, people making decisions about health care will increasingly need to access, understand and use syntheses of this evidence, such as systematic reviews. The Cochrane Collaboration is the world's largest organization producing and maintaining systematic reviews. These reviews bring together the relevant research on a particular topic, synthesize and present it in a standard, structured way. Cochrane reviews have already contributed to many important improvements in health care. There are more than 10,000 people contributing to the work of The Cochrane Collaboration from over 80 countries. This involvement continues to grow. The number of people involved has increased by 20% annually for the last five years, with successful initiatives to increase the number of participants from low—and middle—income countries.

The Cochrane Database of Systematic Reviews was first published in 1995 and included the full text of 36 Cochrane reviews. There were 500 Cochrane reviews in 1999, 1000 in 2001, and the 2000th Cochrane review was published in 2004. Hundreds of newly completed reviews are added each year. In addition, hundreds of existing reviews are updated so substantively that they are equivalent to new reviews, and hundreds more are brought up-to-date with new information. The Cochrane Database of Systematic Reviews is available on the

Internet and CD-ROM in The Cochrane Library. The dissemination of information to low—and middle— income countries is a priority, and mechanisms are in place to encourage access, free at the point of use. A series of national contracts means that access is also free at the point of use to everyone with Internet access in Australia, Denmark, England, Finland, Ireland and Norway. More countries are added to this list each year. Throughout its work, The Cochrane Collaboration strives to achieve its aim to help people make well—informed decisions by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of health care.

The first Cochrane review group to form was the Pregnancy & Childbirth Group and this remains the most productive group in The Collaboration. Pregnancy reviews will be discussed to illustrate the impact of good evidence on good clinical practice.

Editor's note: The Cochrane Database of Systematic Reviews was until recently available online through the medical library at Queen Elizabeth hospital via Ovid. Ovid is being replaced by another database (EBSCO) and efforts are being made to keep the Cochrane review available.

SAFE AND EFFECTIVE MEDICAL TERMINATION OF PREGNANCY

Bayo Ogunbiyi

Pre and post-abortion counselling, and contraceptive advice should be key areas of any abortion service and must not be forgotten if medical termination is the chosen method.

Barbados is one of the few English speaking Caribbean islands to have legalized the termination of pregnancy. There are strict guidelines and protocols that must be followed by the practitioner in order to be in compliance with legal requirements.

Medical termination is a safe and effective alternative to surgical procedures for terminating pregnancy. Its use as evolved over many years. Many pharmaceutical drugs have been tried, some in proper clinical trials and others through less rigorous clinical experiments. Currently, the mainstay of management for a woman opting for medical termination is the use of a prostaglandin analogue, with the best results obtained by using the anti-progesterone agent, RU486 (mifepristone) 36-48 hours prior to termination.

Medical termination is the method of choice in terminations under 7 weeks gestation and 13-24 weeks (and beyond). It is also a viable, safe, and effective alternative between 7-13 weeks. It is currently recommended that medical termination be carried out in a controlled office or hospital environment with a good follow-up plan and a back-up program for emergencies. Pre and post-abortion counselling, and contraceptive advice should be offered, as with any abortion service.

Medical termination is safe and effective if practiced according to well-established and proven protocols.

BREAKOUT SESSIONS

HIV IN PREGNANCY: PMTCT PLUS ISSUES AND OPTIONS IN THE CARIBBEAN

Alok Kumar

Human immunodeficiency virus (HIV) infection is spreading rapidly in women of childbearing age worldwide. Women of childbearing age constitute nearly half of the adults currently living with HIV globally. The epidemic of HIV in women of this age group signifies a serious threat to children. The World Health Organization has estimated that there were approximately 800,000 newly infected children in the year 2002, the majority of whom acquired the infection vertically from their mothers. The developing countries, those with the least available resources, have been the most severely affected by the burden of the HIV pandemic.

The increasing number of HIV-infected adults, particularly women, makes the prevention of mother-to-child transmission of HIV a public health priority in many developing countries. HIV transmission from a pregnant woman to her infant mostly takes place at or around the time of birth. Interventions to interrupt transmission at the time of delivery, such as antiretroviral prophylaxis given in late gestation or peripartum and elective caesarean section, have been shown to be effective in reducing perinatal HIV transmission. Over past several years we have learned a great deal about available options for antiretroviral prophylaxis. HAART, long course ZDV with single dose nevirapine and single dose nevirapine alone will be discussed. Recently a regional effort to scale up the prevention of mother to child transmission of HIV has resulted in formulation of the Caribbean guidelines for PMTCT. The recommendations contained in these guidelines, all of which are very relevant to this region, will be outlined. With available options it is

possible to almost eliminate the perinatal transmission of HIV.

MODERN MANAGEMENT OF EARLY PREGNANCY COMPLICATIONS

Geoffrey Lafonde

Early pregnancy is defined as the first 20 weeks of gestation. Recognized early pregnancy complications include:

- Spontaneous miscarriage
- Ectopic pregnancy
- Hyperemesis gravidarum
- Gestational trophoblastic disease

The management of each has changed as a result of improvements in diagnosis, both by ultrasound and hormonal markers, and the introduction of new medications or other treatment methods.

Spontaneous miscarriage is the most common complication of early pregnancy and its incidence varies between 10-20% of clinically recognized pregnancies.

Ectopic pregnancy occurs in 10-45 per 1000 pregnancies and usually presents as a surgical emergency. To date, in Barbados, this results in women requiring a laparotomy. However, with earlier diagnosis of pregnancy and improved imaging techniques this condition may now be managed non-surgically, resulting in greater patient satisfaction and less morbidity and mortality.

Improvements in the management of hyperemesis gravidarum have come as a result of greater awareness of causes of the condition and the introduction of new pharmacotherapeutic agents.

With patient education, earlier diagnosis of pregnancy and increased use of imaging and hormonal techniques, most patients with early pregnancy complications may be managed as outpatients.

CERVICAL CANCER SCREENING -PREVENTION AND CONTROL

Patsy Prussia

The aim of cervical screening is to diagnose and treat high-grade pre-cancer lesions before invasive carcinoma occurs. The method of screening in the developed countries is population based. In most developing countries like Barbados screening is opportunistic.

The Old:

Aurel Babes of Rumania and George Papanicolaou, Greek Physician and immigrant to the USA, are pioneers in the field of cervical cytology. In the same year, 1928, Babes published an article entitled *Diagnosis of Cancer of the Uterine Cervix by Smears* and Papanicolaou presented a conference paper entitled *New Cancer Diagnosis*.

The first Atlas of Cervical Cytology was published in 1954. Since then cervical cytology has been an accepted screening method. Barbados commenced opportunistic screening in 1965 under the sponsorship of the International Planned Parenthood Association (IPPA) using the conventional smear made at the bedside.

The New:

Carcinoma of the cervix and the precursor lesions develop as a result of persistent Human Papillomavirus (HPV) infection by high-risk HPV DNA types. HPV DNA testing has been approved by the FDA and can be used in conjunction with cytology to screen women 30 years and over. This test is available in Barbados and is being used in the management of Pap smear abnormalities of those women who can afford the cost of the test.

Up to 75% of sexually active women are exposed to HPV during their reproductive years, yet only a few, approximately 10%, develop high-grade lesions and not all of these progress to cancer. Immunohistochemical tests have been developed to identify the women who are at risk of progressing. These tests measure the increased expression of host cell biomarkers, p16INK4, Cyclin E and Ki-67, that are up-regulated during oncogenesis by the viral genes, E6 & E7. It is important to note that disease progression or persistence can be associated with coexisting Chlamydia, HIV & HTLV 1 infections and immuno-suppression therapy.

Liquid-based cytology (CYTYC and Sure Path) Pap Test (specimens are transported in liquid fixative to the Laboratory where the smears are made) was developed to decrease the false negative rate that was frequent with the conventional smear that was poorly fixed or had obscuring inflammation.

Automated Computer assisted screening has been developed to decrease error due to subjectivity.

A vaccine against HPV 6, 11, 16 & 18 has been developed as a Public Health strategy for primary prevention.

PAEDIATRIC GYNAECOLOGY IN THE OFFICE: CASES AND MANAGEMENT

M. Anne St John

In the broad spectrum of family practice and paediatric practice, paediatric gynaecologic problems are generally uncommon on a day to day basis, when compared with their frequency in older patients. However, the development of skills leading to a comfortable and confident approach to gynaecological assessment of infants, children and young adolescents is essential for all practitioners who may encounter such problems.

This talk is specifically directed towards family practitioners and paediatric practitioners, in the hope that it will maintain and heighten their awareness of the disorders of the reproductive system in infants and children, and also assist in guiding diagnostic and therapeutic decisions. Some case examples will be highlighted.

Topics to be covered:

Malformations of the genital tract, present at ages ranging from neonate to puberty, include imperforate vagina, and labial adhesions.

Vulvovaginitis of varying degrees presents through a range of ages, due to a variety of causes. Treatment is specific. The cause is often identified through history in the younger age group but identification through routine laboratory culture is necessary in the older patient.

Menstrual disorders may present in the 9-15 year age range. Dysmenorrhoea and dysfunctional uterine bleeding predominate.

Breast disorders of children and teenagers remain an often neglected aspect of paediatric care. Masses are among the more frequent breast disorders presenting in office practice, and the causes are not often serious by adult standards.

Statistics on sexual abuse in children, whether through increased detection or reporting, are on the increase. The subtleties of its presentation and early detection, require specific consideration focus, otherwise they will be missed.



6th Annual professor E R Walrond Scientific Symposium

Ramesh Jonnagalada

The School of Clinical Medicine and Research, University of the West Indies, in association with the medical and allied specialties of the Queen Elizabeth Hospital, held the 6th Annual Professor ER Walrond Scientific Symposium on 21st July 2006. The venue was the Queen Elizabeth Hospital auditorium.

The first symposium was organized by the surgical and allied specialties and was held in July 2001 as part of a week of activities celebrating forty years of Professor E.R. Walrond's long career in medicine and his contribution to medicine and the community. Professor Walrond was a Barbados Scholar who trained in medicine, specializing in surgery, at Guy's Hospital in London. After establishing his academic career at the University Hospital of the West Indies in Jamaica in 1964 he moved to Barbados 10 years later, in 1974, as Professor and Vice Dean in charge of the teaching programme at QEH, then known as the Eastern Caribbean Medical Scheme. He contributed greatly both to the development of a teaching environment at the QEH and promoting a wider range of surgical procedures. He later became Dean, with the first re-structuring into a faculty (later to become the School of Clinical Medicine and Research), piloting the QEH into the era of post-graduate training, and playing a major part in developments at the Queen Elizabeth Hospital.

The success of the first symposium encouraged the committee to continue holding it every year. It was very well attended and included nurses, medical students and other members of the medical community, comprising residents, consultants, and family practitioners.

This scientific symposium is primarily organized to stimulate and encourage medical students, junior doctors from different specialties, the nursing community and other paramedical specialties to present original research papers. The organization of the symposium is done by different specialties each year, so that wide sections of the medical community gain experience in organizing and participating in such events. The papers are judged by a panel, and the best three are awarded prizes annually. Monetary prizes as well as medals are awarded to the winners, while the first prize-winner is invited to present at the Annual Sir Arnott Cato Symposium in St. Vincent in October.

We expect to see some of the papers from this year's symposium accepted for publication in international journals.

This year we received a record 18 papers. The topics were interesting and included presentations from many sections of the hospital community. A wide range of original research topics, collated clinical data and interesting cases are presented related to the health of the people of Barbados and the wider Caribbean region. The first prize was won by a paper presented by medical students on the use of cellular (Mobile) phones. We have also introduced a skit by medical students on ethical issues and this year it was a great success.

The next Annual Professor ER Walrond will be held on July 20th 2007. Please start your preparation of projects for papers for next year. One of the committee members can be contacted.

Editor's note: Dr. Jonnagalada is a lecturer in surgery with the School of Clinical Medicine and Research, University of the West Indies.

ORGANIZING COMMITTEE:

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Mr.A.Harris

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The symposium is sponsored by Stokes & Bynoe Ltd, Pharmacy sales Caribbean and the Sir Arnott Cato Foundation

Abstracts

USE OF MOBILE TELEPHONES BY MEDICAL STAFF:

Evidence For Potential Benefits And Harms

J Ramesh, AO Carter, D Lewis, N Gibbons,

C Powlett, MH Campbell, H Moseley Sr., T.Carter

Queen Elizabeth Hospital and School of Clinical

Medicine and Research, UWI

Objectives: To determine the extent and pattern of usage of mobile telephones by medical personnel and identify the potential benefits and harms associated with their use.

Method: A questionnaire was designed to collect information on the patterns of mobile phone use and care and the preferred methods of contact with the hospital. All medical staff including students at the QEH received the questionnaire. Participants' phones were cultured for micro-organisms. The staff working in close proximity to sensitive equipment were also surveyed concerning adverse events associated with mobile phones. Telephone operators were asked to monitor the time elapse as they attempted to contact medical staff by various methods.

Results: There were 266 medical staff and medical students at the time of the study, 116 questionnaires were completed (response rate = 44%). Almost all (98%) used cellular phones, and 67% used their mobile phones for hospital-related matters. Forty-seven percent reported using their phone while attending patients; only 3% reported washing their hands after use; and 53% reported never cleaning their phone. When the sterility of the phones of staff who practise daily phone cleaning were compared with those who did not, there was a significant difference in the 101 mobile phones that were cultured for micro-organisms; 45% were culture-positive. Certain groups, particularly medical students

and surgeons, had phones that carried more bacterial contamination and more pathogens ($p=0.06$). The survey of staff working in close proximity to sensitive equipment revealed only one report of minor interference with life saving equipment. Telephone operators reported contacting doctors most easily by mobile phone.

Conclusions: Mobile phones are used widely by staff and are the most efficient means for communication to doctors concerning patients. However, bacterial contamination is a significant risk probably associated with infrequent cleaning of phones and hand washing. The authors recommend that regulations be developed concerning the use and proper hygiene of mobile phones.

Limitations: This study is a cross sectional survey of volunteers. As such, it may suffer from volunteer bias and reporting bias, both of which have a tendency to over-report behaviour that is deemed to be acceptable. It might be expected that actual hygiene practices are worse than reported. The contamination rates of phones in use in the hospital might be higher than found in this study if, as expected, volunteers have better hygiene behaviour than non-volunteers or may have cleaned their phones prior to the interview after learning about the nature of the study.

EFFICACY OF HONEY DRESSING IN WOUND MANAGEMENT: A SYSTEMATIC REVIEW OF CLINICAL EVIDENCE.

Orimma

Background: Dressing wounds with honey went out of fashion when antibiotics came into use, with the surge of widespread of antibiotic resistance, a renaissance in dressings using honey occurred.

Objectives: To establish the clinical evidence that exist to demonstrate the reported therapeutic efficacy of honey and to promote use of honey in the wound management.

Study design: Systematic review of randomized controlled trials and non- randomised observational studies utilising Medline, Embase, Cinahl, Cochrane library, World wide wounds, Publications of Wounds UK, American academy of wound management, and journals relevant to wound management. Exclusion criteria included randomised animal studies, case series and case reports.

The outcome measures used were:

- Mean time to healing (days)

- Percentage of wound area healed
- Clearance of bacteria from wound in 7 & 21 days
- Mean length of hospitalisation (days)
- Evidence of granulation
- Wound scarring

Results: Eight randomised controlled trials and 2 observational studies were included in this review.

In a study of burns comparing gauze impregnated with honey or with polyurethane, the mean times to healing in each group were 10.8 and 15.3 days respectively ($p < 0.001$). In a study that compared honey impregnated gauze with silver sulfadiazine (SSD) impregnated gauze (52 patients in each group), 87% of the wounds treated with honey healed within 15 days compared with 10% in those treated with SSD ($p < 0.001$). Of the 43 out of 52 cases that presented with a positive swab culture on admission in the honey treated group, 91% became sterile within 7 days in contrast with SSD group where only 7% of the 41 with a positive swab culture became sterile.

In the second burns study that compared honey with SSD, 100% of the wounds treated with honey healed within 21 days compared to 84% in those treated with SSD ($p < 0.001$). Biopsies of the treated areas showed greater histopathological evidence of reparative activity. This activity was seen in 80% of wounds treated with honey dressing compared to 52% of the wounds treated with SSD ($p < 0.005$). Regarding the clearance of bacteria from burns, in the 23 of the 25 cases treated with honey that had positive swab cultures on admission, 65% of the wounds became sterile in 7 days, 96% in 21 days. In contrast, 73% wounds treated with SSD became sterile in 7 days and 86% in 21 days ($p < 0.001$).

In a prospective randomised controlled trial on severe post-operative wound infections, following caesarean section or abdominal hysterectomy, which compared dressing with honey to washing the wound with 70% ethanol and applying povidone-iodine: in the honey group, infection was rapidly eradicated (6 ± 1.9 days vs. 14.8 ± 4.2 days), wounds healed faster (10.7 ± 2.5 days vs. 22 ± 7.3 days), postoperative scars were less than half the size, and the period of hospitalisation was less than half of the patients in the control group (9.4 ± 1.8 days vs. 19.9 ± 7.4 days; $p < 0.05$).

In a trial on patients with dehiscence abdominal wounds following caesarean section, there was healing in less than half the time (mean length of stay in hospital 4.5 days, range 2-7 days) when the wound was dressed with honey, compared retrospectively with the

treatment of wound by cleaning with hydrogen peroxide solution, Dakin's solution and packing with saline soaked gauze and subsequent re-suturing (mean length of stay in hospital was 11.5 day range 9-18 days).

Conclusion: Clinical evidence for use of honey in wound management is steadily accumulating and honey based dressing products are now available in convenient easy to use forms as are the conventional dressing materials, bringing this ancient form of wound dressing into realms of most modern bioactive dressing. Honey provides a moist healing environment with the advantage of having a single product with a range of actions- debriding, deodorising, antibacterial, growth promoting, anti-inflammatory and scar minimizing properties.

This review is not aimed at debunking honey therapy as a myth, but to serve as nidus for future research and to stimulate thought among surgeons to consider honey when making decisions on wound care or to use it as alternative when more conventional therapy has failed.

PREVALENCE AND CLINICAL ASPECTS OF PUERPERAL MENTAL DISORDERS AT THE QUEEN ELIZABETH HOSPITAL.

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Objective: To elucidate on the prevailing risk factors and clinical outcomes of patients with severe post partum mental illness with specific reference to post partum psychosis.

Introduction: Post partum mental illnesses are relatively common but are usually mild and not often recognized. With good care and support, mild post partum illnesses resolve without recourse to psychiatric treatment. However, severe post partum illness is rare with an average incidence of 1:1000 in developed countries. These illnesses require familiarity with and identification of risk factors, early recognition, and institution of appropriate expert treatment in order to avoid adverse outcomes.

Methods: The Obstetric and Psychiatric records of the QEH were searched over a ten-year period from 1996 to 2006. Ten patients were found with diagnoses fitting the criteria for severe mental illness/psychosis. Data was obtained to evaluate the possible risk factors and determine the clinical outcomes of the patients identified.

Results: There were ten patients with an average of one case per year. The age range was 17-36 years with the mean age of 26.4 years. Eight (80%) were diagnosed as post partum psychosis and the remaining 20% as post partum depression.

There were five primiparous women (50%), 3 with one previous birth (30%), one with 2 previous births (10%), and one with 3 previous births (10%). Four (40%) women had caesarean section for obstetric indications of whom 3 were multiparas, the remainder had normal vaginal births. All had single pregnancies and there was an even distribution of gender of the babies. Three (30%) women had a previous history of mental disorder of whom, two were primiparas. Seven (70%) had post partum anaemia of whom two were primiparas. The estimated blood loss range was 50 to 600mls with a mean of 205mls.

The delivery to diagnosis interval was between 1 to 90 days with a mean of 24.9 days. Earlier diagnosis correlated with a worse severity of illness, but was associated with a better outcome. The treatment period was also shorter with earlier diagnosis. Four patients developed subsequent psychiatric illnesses, three of these having a previous history of mental illness. Only one patient had a child afterwards, and there was not a recurrence of a mental disorder.

Conclusion: Severe post partum mental illness is a rare but serious disease with a possible catastrophic outcome. Our study confirms the known risk factors. Vigilance and early involvement of experts in the field will help avoid unwanted outcomes for mother/baby.

PAP SMEARS IN WOMEN IN A SECURE MENTAL UNIT: IS IT NECESSARY?

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Introduction: Cervical cancer has been shown to be caused primarily by the Human Papilloma Virus, which is sexually transmitted. The Papanicolaou smear was introduced as a screening tool to identify pre-malignant cytological abnormalities of the cervix, and has been shown to significantly reduce the incidence of cervical cancer. National screening programs have been demonstrated to be the most efficient way of maximizing these reductions. In any given population approximately 5-7% of smears are reported with significant abnormalities. Of

these 1-2% will be high-grade malignant precursor cells.

Method: The study was conducted at the Psychiatric Hospital of Barbados between January and August 2005. The psychiatric hospital is a 627-bed unit for inpatient psychiatric care. The patients are allowed conjugal visits. All the patients involved were inpatients of the psychiatric hospital. The same doctor performed the Pap smears.

Results: Eighty-four patients were studied, their age range was 19-84 years with a mean of 56.3 years. Forty-two patients were nulliparous, 20 para 1, 11 para 2, 4 para 3, 2 para 4, 3 para 5, and 1 each para 6 and 7. All of the smears taken were adequate, with 6 being limited by no presence of endocervical cells in the smears.

Seventy-eight (93%) of the 84 smears were reported as normal, the remaining 6 (7%) were reported as Atypical Squamous Cell of Uncertain Significance (ASCUS). There were no other lesions found. The abnormalities occurred in patients with an age range of 23-72 (23, 55, 59, 67, 68, 72 years). Only 29% (24) of patients had had Pap smears previously. Of these, only 5% (4) had previous smears within the last 5 years; 24% (20) had their previous smears 6-14 years prior. Seventy-one percent (17) of the patients with previous smears were more than 50 years old. The contraceptive rate amongst the cohort was 39% (32); 23% (19) used injectable contraception, while 16% (13) used condoms.

Conclusion: The abnormality rate reflects that which was expected. However, there were no high-grade abnormal cells. The Pap smear history of the patients mirrors that of the society. There is a need for a targeted national program for screening in order to reduce the death rate from cervical cancer.

TRENDS IN PERINATAL MORTALITY AT THE QUEEN ELIZABETH HOSPITAL OVER A 5-YEAR PERIOD

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Introduction: The Queen Elizabeth Hospital is a tertiary referral centre for the eastern Caribbean for neonatal care. There has been a gradual fall in perinatal mortality since 1990, towards the millennium goal of < 10/1000 per year. However, this fall had become static in recent years.

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Objective: To examine the birth and death trends amongst the neonates born in a five-year period 2001-2005 and try to determine any variable that can be improved upon in order to further reduce the perinatal mortality figures.

Method: The antenatal and neonatal records of mothers and babies born during this period were reviewed and relevant data extracted. The labour ward and neonatal unit records were also reviewed to verify the determined figures. Data from the ministry of health were also reviewed.

Results: The birth rate was on a downward slope from 2001 to 2005 (3634-3277).

The neonatal death rate figures had remained in the range 25-35 per 1000, except for a reduction in 2004 to 18/1000. Other statistical variables such as the perinatal mortality rate (PMR), the stillbirth rate (SBR), and the neonatal mortality (NMR) rate reflect this trend:

	2001	2002	2003	2004	2005
PMR	22.5	19	18	9.3	16.2
NMR	9.2	7.9	9	5.4	9.4
SBR	13	11	12	6	8.5

The admission and ventilated babies statistics remained stable during this period:

Year	2001	2002	2003	2004	2005
No. Admissions	659	578	527	604	624
Patients Ventilated	63	45	58	52	51

The number of babies undergoing phototherapy also showed no significant variation:

Year	2001	2002	2003	2004	2005
No. Patients	140	121	93	149	84

The exchange transfusion rate showed an upward trend from 2002-2003, this soon returned to the norm:

	2001	2002	2003	2004	2005
No. Exchanges.	4	11	11	8	5

Conclusion: The study shows a static trend in the perinatal mortality figures and its related variables. The required nursing level needs to be met in order to further

improve these figures. This scenario has led to the apparent status quo as reflected in this study.

NEONATAL INTENSIVE CARE UNIT PARENT SATISFACTION SURVEY.

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Background: In today's complex, market-driven health-care systems greater emphasis is being placed on customer service. There are few validated surveys with information identifying important aspects of health services to parents.

Objectives: To obtain data about parents' perceptions of specific aspects of their hospital experience and target areas for improvement in our customer service.

Method: A questionnaire addressing some aspects of care giving was distributed to a sample of mothers during the period January to December 2005. The data was analyzed using Microsoft Access.

Results: Fifty-eight questionnaires were answered, representing 9.2% of all neonatal admissions. Twenty-eight (48%) of responding mothers had female neonates on the unit. Most (52%) of respondents had babies who had spent less than 1 week on the unit. Regarding the aspects of care giving addressed, 91% of mothers expressed complete confidence in their caregivers. Eight-two percent were satisfied with the level of communication, while 70% were satisfied with the level of participation, which they were allowed in their baby's care. When asked what they liked best about the NICU, 52% were happy with the care given to the baby, 10% like the environment and 10% enjoyed the emotional support. Seven percent identified a lack of caring as the issue that bothered them most about the unit, however, 48% had declined to answer this question.

Conclusions: Mothers appeared generally satisfied with the confidence, communication and participation aspects of care giving offered. Care given to the baby was identified as the most important factor for mothers.

INTRAUMBILICAL OXYTOCIN FOR THE MANAGEMENT OF RETAINED PLACENTA.

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Objective: To evaluate the efficacy of intra-umbilical oxytocin injection as a treatment for retained placenta after vaginal delivery to reduce the incidence of manual removal and postpartum hemorrhage.

Introduction: The placenta provides nutrition for the foetus in the uterus through the umbilical cord. It is usually delivered shortly after the baby. Retained placenta is diagnosed if the placenta remains undelivered for one hour after childbirth. If this occurs, women have an increased risk of massive haemorrhage, infection, and occasionally death. However, manual removal of the placenta is an invasive procedure with its own complications of haemorrhage, infection, or genital tract trauma.

The Cochrane review database suggests that some evidence exists that an injection of oxytocin into the umbilical vein may reduce the need for manual removal of retained placenta after childbirth.

Method: A case series of 10 patients over a six-month period from October 2005 to March 2006 is described. Ten women with single pregnancies who underwent vaginal delivery and who failed to deliver the placenta after one hour of active management of the third stage of labour were recruited for the treatment. Oxytocin 20 IU in 20 mL of saline was injected into the umbilical vein, then an attempt at controlled cord traction was made 10 minutes following the injection.

Results: The ages of the women varied from 20 to 41 years and the parity from 1 to 7. Two women had had previous dilatation and curettage and one previous cervical cerclage. All the women had a successful outcome with the delivery of the placenta. There were 5 cases of post-partum haemorrhage of between 500 to 1000 mls of blood. No patient required blood transfusion.

Conclusions: This small study supports the growing body of evidence that intraumbilical injection of oxytocin is an effective method of managing the retained placenta. These women are at almost certain risk of post-partum haemorrhage if left untreated, and there was a 50% reduction of this complication.

THIRD-TIME UNLUCKY: RECURRENT BARTHOLIN'S ABSCESS/CARCINOMA

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Primary Bartholin's gland carcinoma is a rare sub-type of vulva carcinoma. Vulva carcinoma itself has an overall incidence of 1.8 per 100,000. The incidence is dramatically increased in women over the age of 75 years to 20 per 100,000.

Bartholin's gland carcinoma accounts for 2-7% of all vulva carcinomas and little more than 200 cases have been reported in the literature.

The squamous and adeno-carcinoma variety account for around 80% of all the carcinomas arising from the gland (each account for approximately 40%). The origin of these varieties are thought to be from the "transformation zone" epithelium in the gland duct. These epithelial cells have also been shown to harbour the high risk Human Papilloma Virus (HPV). Adenoid cystic carcinoma represents around 15% of Bartholin's gland carcinomas. These tend to occur in pre-menopausal women of an average age of 42 years. They are thought to originate from the myo-epithelial cells. They have been shown to have a propensity for peri-neural invasion and early aggressiveness. The remaining classes of Bartholin's gland carcinomas are the much rarer transitional cell carcinomas and other poorly differentiated carcinomas.

The clinical presentation is often, as in the case reports presented, of recurrent inflammatory/cystic lesions of the gland, which are quite often managed conservatively by drainage or marsupialization over several months or years.

Overall survival is predicated on radical local surgery with groin node dissection.

Adjuvant therapy has not been shown to improve survival. Neo-adjuvant therapy however may improve surgical access and therefore enhance overall operative success (avoiding anal sphincter damage).

Three patients with the common variety of carcinomas of the Bartholin's gland are presented. The clinical presentations and the evolution of their histories are highlighted. A practical guideline is suggested for the management of recurrent pre-menopausal ipsilateral Bartholin's gland cysts or abscesses. The advice of excision of the glands in these situations is emphasised.

A CASE SERIES ON SPONTANEOUS BILATERAL TUBAL PREGNANCY

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and Pathology, Queen Elizabeth. Hopsital

Introduction: Three cases of bilateral tubal pregnancy occurred between 2001 and 2005 in Barbados, a country with a total population of 280,000 people.

The incidence of ectopic pregnancy has been steadily increasing worldwide for the past 30 years. This increase has generally been attributed to the improved diagnosis, increased incidence of pelvic inflammatory disease and increased assisted reproduction. In the Caribbean region, the incidence of ectopic gestations reported from Jamaica is 1:28. The worldwide incidence is 1:50/100.

An ectopic pregnancy occurs when the foetus develops in an extrauterine location and is generally a single foetus. Bilateral tubal pregnancy is a rare form of ectopic pregnancy and occurs in some 1:725-1:1580 ectopic pregnancies. Fishback published the first series of 76 spontaneous bilateral tubal pregnancies in 1939, and subsequent publications have been concerned with individual cases.

Discussion: Ectopic pregnancies can present early prior to rupture or late. Two of our three patients presented early and received trans-abdominal ultrasound scans. Both ultrasound scans were flawed as only one ectopic was seen in one case and in another an intrauterine gestational sac was seen but neither ectopic pregnancies visualized. Transvaginal ultrasound is advocated as the technique of choice in patients suspected of having an ectopic pregnancy although it fails to detect the condition in some 20% of cases. Its value might be increased when combined with beta HCG levels to better assist in the accurate diagnosis of these patients. Our case series highlights the limitations of ultrasound findings in confirming the diagnosis of ectopic gestation.

A previous study of ectopic pregnancy in Barbados, found that the incidence varies according to age group. The highest was 33.2/1000 pregnancies in the 35-39 years age group. In this review there were no simultaneous ectopics but some 7.5 percent of the cases had had previous ectopic pregnancies.

Conclusion: User sensitivity of scans must be borne in mind. Ultrasonographers should attempt to locate other pregnancies even if one is found. This is especially important in the patient with assisted reproduction as

they tend to have a higher incidence of bilateral ectopic pregnancy. It is also important that the surgeon take care to examine the entire pelvis as bilateral ectopics can sometimes be missed.

To maintain fertility, the intervention should be as conservative as possible. Methotrexate may be used once the criteria for using it is fulfilled. The patient can be treated by salpingotomy, it is believed that results are better if the tube is left open. In one case a salpingotomy was performed on one of the tubes, the other was removed because it had already ruptured. Particular care was taken to preserve her fertility since she was nulliparous. In the other two cases bilateral salpingectomies were performed. This was appropriate in one patient who had completed her family. It was not known whether the remaining patient had desired any more children and a more conservative approach might have been better.

DAY CARE OBSTETRIC UNIT: A WORKABLE ALTERNATIVE AT THE QUEEN ELIZABETH HOSPITAL

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The prevalence and incidence of hypertension and diabetes in Barbados are high. The aim of this study was to examine alternative healthcare provision concepts that can be offered to antenatal patients with hypertension and diabetes. To this effect, the idea of a day care obstetric unit was explored. Obstetric day care service is an alternative care provision on an outpatient basis, caring for the needs of the clients without compromising outcome. The misuse of healthcare resources results in increasing workload and high financial costs and produces negative effects on the physical, social, and emotional needs of mothers and their babies.

This study explores an alternative way of healthcare provision by a more effective utilization of resources. A descriptive and exploratory correlation design was used to collect and analyse data from a convenience sample of 87 clients who received care at in the Obstetric unit of the QEH. The findings suggest that, the majority of the clients would prefer care from a day care unit. These clients seem to have a clear perception of healthcare not dependent on hospitalisation for their clinical conditions.

A cost/benefit analysis of a practical set up of an obstetric day care unit at the Queen Elizabeth Hospital is also presented.

ADMIT OR NOT TO ADMIT: A CASE FOR AN OBSTETRIC DAY CARE UNIT

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Background: The Obstetric and Gynaecological Department of the Queen Elizabeth Hospital has the highest number of daily throughput of patients after the Accident and Emergency Department. The majority of the patients are discharged after a few days. Day care is increasingly being utilized during managing the complications of pregnancy. There are published reports on its efficacy and acceptability as part of the management of pregnant women with conditions such as pregnancy induced hypertension, mild preclampsia, and diabetes.

Objectives: The objective of this retrospective study was to highlight the workload of the obstetric unit and to identify clinical conditions of pregnancy in which a day care obstetric unit can be helpful in streamlining patient care while optimising resources.

Results: The study period was between January and June 2004. Two hundred and twenty-eight patients were identified in the study period. Of the 228 total admissions, 154 (68%) patients were either diabetic or hypertensive: 49 diabetics in pregnancy (32%), and 105 (68%) hypertensive disorders of pregnancy.

Among the hypertensives, 80% (84) were discharged home without further treatment within 5 days (40 within 2 days) and the remaining 20% (21) stayed longer than 5 days.

Of the diabetics, 61% (28) were discharged within 5 days (20 within 2 days).

Conclusion: Available evidence suggests that a majority of patients with hypertension or diabetes in pregnancy can be managed as outpatients without compromising either the care or the outcome for mother and or foetus.



Conference Review

Third Pan Caribbean College of Family Physicians (CCFP) Conference : A brief review

Dr. C. V. Alert

The 3rd Pan Caribbean Conference of the Caribbean College of Family Physicians (CCFP) was held recently at the British Colonial Hilton, Nassau, Bahamas from November 9-12th 2006. The theme of the conference was “Future trends in Primary Care- Advances, Opportunities & Updates”. This follows similar conferences held in Trinidad and Tobago in 2000 and in Jamaica in 2003. Not surprisingly, as the other country that hosts a UWI medical faculty, Barbados is being looked upon to host the 4th Pan Caribbean Conference, in 2009 – more about this later.

Although the Barbados Chapter of the CCFP was one of the first chapters formed back in May 1988 - 18 years ago – this chapter has more or less been dormant for some years now. On the other hand, the CCFP is expanding in the region and beyond, and there are chapters of the college in Jamaica, Trinidad and Tobago, Antigua, Cayman Islands, Grenada, St. Lucia, and St. Vincent and the Grenadines. In addition, members exist in the Netherland Antilles, French West Indies, and on the mainland in Belize, Guyana and Suriname. The CCFP is also a member of the World Council of Family Doctors (WONCA), and links the CCFP to organizations like the American Academy of Family Physicians (AAFP), the College of Family Physicians in Canada (CFPC), and the Royal College of General Practitioners (RCGP-UK).

Three Barbados based physicians attended the conference in the Bahamas,

and two of these presented scientific papers, both in the “Chronic Diseases in Primary Care” session of the conference. Dr. O.P Adams asked, of the management of type 2 diabetes mellitus in Barbados: Are primary Care Practitioners following guidelines?, while Dr. C.V. Alert attempted to enumerate the number of patients with one, two, three or more chronic disease risk factors in an audit of one primary care clinic – “Chronic diseases in one Primary Care Clinic in Barbados”.

Three prominent Caribbean physicians received awards at this conference (remember our own Dr. M. Hoyos was awarded at the 2nd Pan Caribbean Conference in Jamaica, primarily for his work in developing the Family Medicine program in Barbados): Dr. Christopher Beaubrun, St. Lucia; Dr. Alverston Bailey, Jamaica; and Dr. Bernard Chapman-Boyd, Trinidad and Tobago.

In total, 18 scientific papers were presented. In terms of the countries in which the physicians practice, six papers each came from Jamaica and the hosts Bahamas, three from Trinidad and Tobago, two from Barbados and one from Curacao. In addition, there was a workshop by the “Caribbean Primary Care Research Group (CAPCRG)” – comprising the UWI Family Medicine lecturers of the Cave Hill and the St. Augustine’s campuses, which attempted to identify research interest and skills of primary care physicians in the region, and develop teaching modules that would allow Caribbean primary care physicians to catch up with trends that seem to be the direction in which primary

Editor's note: Dr. Alert is an associate lecturer in Family Medicine with the School of Clinical Medicine and Research.

care medicine is headed worldwide. The CCFP has approached WONCA for assistance in this project, and CAPCRG has been formed as ‘the Research and Publication arm of the CCFP’, with Professor Walter Rosser, Chair Department of Family Medicine, Queen’s University, Canada, lending vital experience and expertise to this important project.

Some of the other papers that generated a lot of interest included one titled “Cardiovascular Medicine in Primary Care” by (Cardiologist) Dr. Conville Brown (Bahamas), which gave a detailed description of an “Executive Medical Evaluation” with comprehensive high-technical cardiovascular and gastro-intestinal screening, and which can cost up to US \$10, 000 per person. Dr. Doroty Janga (Curacao) speaking on “The Elderly in Family Practice, gave us some insight of the problems we are increasingly likely to face as our populations age on us: this is very important to us here in Barbados (as elsewhere) as our clients over 60 years of age approaches 15% of the entire population, a figure considered critical by some epidemiologists, especially in the absence of significant preparation to deal with this growing age group. Dr. V.A. Partapsingh, a final year DM (Family Medicine) candidate in his paper “Applying

the stages of change model to influence glycaemic control among type 2 diabetics in Trinidad” gave notice of the use of this scientific model in an effort to change behaviour – we are forever chided for our inability to change behaviour in large numbers of our clients who have ‘inappropriate’ lifestyles, yet little effort has occurred regionally in attempting to scientifically isolate the factors that can influence behaviour – we look forward to the completion of this important study in the near future..

In anticipation of the 4th Pan Caribbean Conference of the CCFP to be held here in Barbados in three years time, some effort should be made to revive the Barbados Chapter. Dr. O. P. Adams, current lecturer in Family Medicine at the School of Clinical Medicine and Research (SCMR), noted in his citation of Dr. Hoyos at BAMP’s 2006 Award ceremony, that “the vision was to provide continuing medical education and eventually re-accreditation for GP’s”. Dr. Adams has succeeded Dr. Hoyos as Lecturer in the Family Medicine program, and is intimately involved in BAMP’s CME – he has stepped up to the plate in accepting to be host of the 4th Pan Caribbean Conference in 2009. Stay tuned.



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Book Review

Shocking the People's Conscience

An autobiography by Dr. Frank Ramsey

Book Review by Carl Ince

Shocking the People's Conscience, the autobiography of Dr. Frank Ramsey, distinguished Barbadian Paediatrician, goes a long way towards filling the gap in the history of child care in Barbados. It is no exaggeration to say that he awakened the nation's conscience to the importance of child nutrition. His work was undertaken at a time when Barbados was moving out of the shades of colonialism and towards the time when the proud, industrious and ambitious people would have to carve out their own path and find their own solutions. We are still living in those times. Sadly, very few have been interested and energetic enough to tell the story of our earliest and continuing efforts. Frank Ramsey has had the courage and foresight to undertake that task.

Frank's story takes the reader from one of the principal primary schools which have moulded the modern Barbados. St. Mary's, by way of the Combermere School and Harrison College, into the confident and talented, even if a trifle conservative, island-state of the 20th and 21st Centuries. He had glided through that comfortable, hardly rich, but "decent" life of the Barbadian lower middle class, via our best boys' schools; the 1937 Riots; the Second World War and Hurricane Janet; and he had watched from his seaside home in the outskirts of Bridgetown, as thousands of West Indians left for England – as Ramsey later did – to work, to play and to undertake post graduate studies abroad.

Notwithstanding all that, Dr. Ramsey writes his story with the Humby Episode of 1956 at the heart of his effort, not only literally placing it in the central pages of his text, but at the turning point of his life at the moment when his life's mission was about to take off. He was 30 and, although he must have hardly known it, his callow days were about to give way in a trice to the serious and devoted years of his work, and to his family life.

Dr. Graham Humby shook the Government to its foundation, when he diverted the attention of the Advocate newspaper from its daily international fare and social coming and going, to deal with the plight of half-dozen, black, undernourished children photographed on the journal's front page. The Barbados Advocate enjoyed a virtual journalistic monopoly in the 1950's and Grantley Adams and the ruling Barbados Labour Party, shocked by the foreigner's 'impertinence', were having none of this. Adams announced forthwith that Barbados was too small to afford both himself and Dr. Humby. Dr. Humby had observed in his letter, which had accompanied the offending letter, that his repeated request for better conditions for undernourished children had fallen on deaf ears: "You talk, and talk and talk and you spend thousands dressing your children beautifully on Sundays...(but)...first things must come first...nothing will stop me shouting at you from the rooftops until it is stopped. Are you hypocrites or just ostriches?" The Advocate backed Humby. Within days he was on his way back to England, proclaim-

Editor's note: Mr. Carl Ince LLB, LLM is a tutor in Public International Law with the Law Faculty, Cave Hill, University of the West Indies.

ing “Ramsey, we must shock the conscience of the nation.”

The autobiography leaves it beyond all doubt that thereafter Frank Ramsey was a changed man and Child Nutrition in Barbados would see a new dawn.

After the Humby incident, it is clear that Dr. Ramsey was consumed by his concern for Child Nutrition. His work thereafter reached across the Caribbean and far beyond. It was an undying passion, and the autobiographer takes the reader with him in detail. A characteristic of his work is that, while he sometimes seem to understate his own role, he introduces the reader to scores of persons who assisted him in his work, from rich and distinguished of corporations, nurses and doctors, to hard-working secretaries and recording clerks. He kindly fills us in on the successes those who have assisted him have subsequently attained, including the titles which have been

conferred on them sometimes, I believe, at the expense of omitting some of the challenges he faced. He is sometimes rather too kind and charitable, but such is the nature of the man.

Clearly he cherished his family, and he is too private a man to give away too much about them and their relationship with him. Similarly, we know he played and watched cricket – quite a bit, it seems, but his achievements, or lack of them are sedulously avoided. I am sure there is more for a second autobiography, to bring the story of Child Nutrition further forward and to let us a bit more into his life outside his sacred mission, and to let us share his dreams. In the meantime, we owe him an enormous debt for the dreams he has dared to share and for the legacy he has left us. It is hoped that many more of his generation will honour our ever-aging country by sharing their memories, dreams, hopes and fears.



History's Page

20 Years Ago

BAMP BULLETIN

JANUARY 1987

NO:87

EDITORIAL

ETHICS AND AFTER-HOUR CARE

The Barbados Association of Medical Practitioners is fit once again to address itself to the vexing issue of after-hours care in general/family practice. Quite recently a letter was sent to BAMP from a member of the public complaining bitterly about the "inadequacy or non-existence of a medical emergency system in this country". The writer went on to describe how a gentleman, with whom she was in company one Sunday evening suddenly fell ill and needed medical attention. Her family physician was "out for the evening" and the only doctor she managed to contact informed her that he "only dealt with patients registered with him" - a stand she considered to be wholly unethical and even hypocritical. In the end the patient was taken to the Emergency Department of the Queen Elizabeth Hospital and did receive adequate emergency care.

BAMP sympathises with both the patient in question and the writer of the letter in being unable to receive medical help at a time when most needed. One can't help noticing however, that the doctor who refused to see the patient because he was not registered with him came in for more criticism than his colleague, who was out for the evening and did not even bother to make suitable alternative arrangements for his patients. The obvious danger here is that those general/family practitioners who do not provide an after-hour service may be further encouraged not to do so in the hope that some other doctor will be found in an emergency. As a professional organisation BAMP cannot encourage such an approach in the provision of primary care in Barbados.

We are obligated, whether as solo practitioners or doctors working in group practices to make adequate arrangements for our patients during the after-hour period. One suggestion is for individual doctors working in the vicinity of one another to come together as small groups and arrange an 'on call' system. In this way the workload can be equally divided amongst all providers of primary care without producing the burnt out stress syndrome (BOSS) in any group of doctors. It is probably because of this very reason that the second doctor was reluctant to disturb his personal and family life and see a patient not registered with him. Lack of rest can also affect the quality of care he offers to his patients on the following day.

Nevertheless, he erred in this case by not making it clear to the caller that alternative help could have been obtained at the Q.E.H. Emergency Department. (It is the moral responsibility of any doctor, working in any field, when contacted by an anxious patient in an emergency situation to direct them to an alternative source of medical care.)

Much has already been said and written on "after-hour care in Barbadian Family Practice" and whilst some may still view it with academic interest only, it is evident that the public is now demanding such a service. Failure to do so could be seen both as a disservice to them and to our profession.

***Editor's comment:** Modern technology has made it possible for the doctor to evade any personal contact with the after-hours caller. Still you will not hear advice to go the QEH, for the doctor must know that is what the caller was seeking to avoid in the first place. Whatever good the emergency department at the QEH does, and it is sometimes acknowledged that good things happen there, is dissipated by the gross lack of communication with anxious patients and relatives. It is remarkable that the staff in that department remain so apparently immune to the complaints of the public of long waiting times to be attended to. No one goes to an emergency department because they happen to have nothing better to do, they go there out of anxiety, often misplaced to be sure, but very real none the less.*

EDITORIAL

ANSWERING THE PUBLIC

Radio stations, under intense competition among themselves and from other sections of the media, have used modern technology to reach out to every citizen with access to a telephone and to offer him or her a nation-wide forum under cover of anonymity. The public have responded by airing their views and grievances and in many cases have produced questions on a variety of sensitive issues. Recently leaders of Government agencies, entertainment and religion and sports have rushed on the air waves to answer and explain their side of the issues. Is the medical profession immune from all these changes?

Of course the answer is NO. In the past month alone issues such as our availability after hours, our education of the public on AIDS and even our practices with regard to the changing of bed-linen have been raised. The challenge to meet the public, to answer their queries and to explain our difficulties and limitations appears to be a major task of BAMP in the year ahead.

We cannot meet this challenge if we cannot listen for communication is a two way process and to answer effectively we must first listen carefully. But we cannot listen if we are busy in clinics, in operating theatres, on our ward rounds, so the first of our problems will be to set up an effective monitoring service and to convince over-zealous moderators that our responses cannot be instantaneous.

Another problem will be dealing with those who feel that the least said of our deficiencies the better, and that BAMP as an Association should not make public comment unless a clear and undisputed policy is first evolved. In this way our answer will come months late, if at all; and in the public's view we will be seen as running away from the issues.

In effect, there is much in the records and experience of Council over the past 10 years that will allow those who undertake this daunting task to respond to the public to the satisfaction of most of our members. BAMP Bulletin sees the task of public relations as the most onerous and sensitive in the years ahead. It is quite possible that more of our members will be needed to share the burdens of this section of our activities; and certainly more resources and facilities will be needed.

Comment: Deja vu. Twenty years later the problems remain remarkably the same as regards our communication with the public on issues that affect the care of individuals or that of the community as a whole. As regards the issues of emergency care, entrepreneurial colleagues have set up two emergency centres which, although not free of critical comment, have gained wide acceptability in the community. Serious problems still have to be referred to the QEH, and although these emergency services share a lot of the same personnel it is remarkable how much dissatisfaction is both expressed and anticipated with the services provided at the QEH.

BAMP remains paralysed in dealing effectively with important public issues and remain at the mercy of individual members for its image in the community. There is no more vivid example than its failure to respond as an association to the invitation to give a view on the report on Legislative issues related to the HIV/AIDS epidemic. As the editorial 20 years ago implies, to wait for unanimity will ensure that any view is expressed too late or not at all, this leaves the field open to individuals who undertake no responsibility for the profession as a whole to put forward their views which may then be construed to be those of the profession as a whole.

1981 has been an eventful year for the Association. It has included the association agreeing in principle to the first phases of the government's proposed National Health Plan, and the representation of two of our younger members in affairs which had wide public notice.

These matters have not been easy to deal with, and any effectiveness in their handling has been due to the vigour of a number of our council members, the status of the association as a trade union, and the unflagging assistance and advice from our legal advisor.

The association as a trade union is still in its infancy - mere two years, and like many infants these are years when there is the greatest need of support. As has been the wish of members, we have had no support from other unions, indeed we have had to differ sharply from another union representing the nurses, in one of the disputes we have had to handle on behalf of our members. Support for the Association has increased through increased membership particularly from our younger doctors. However, the other support that is needed, in terms of running the association, is still too limited to some of the members of council.

The wider involvement of members is of great concern to me, and I often wonder if it is because appreciation is lacking for the efforts of those who get involved, that more members do not involve themselves. If this letter can help at all in this respect, I would like specially to mention the continuing work of Dr. M. Hoyos and Dr. J. Yeo as your representatives on the Task Force with government officers. In the task force we are attempting to shape the proposed National Health Service into something that would benefit the community and also provide the opportunity for a professionally satisfying and rewarding practice. Dr. Yeo as well as other members in different capacities must also be commended for their efforts in trying to put the drug service on the rails - this is proving to need a lot of effort for reasons which need not be detailed here.

Dr. Nicholson our Public Relations officer has had to pen many a letter to the press usually in defence of the profession as it has been attacked in one way or the other by the press or the government.

The burden on council members in these endeavours as well as on the secretariat and the treasurer will need to be supported by a paid secretary. This will necessitate an increase in annual dues for which you have already voted and which will come into effect in 1982. This increase in dues will naturally be felt hardest by our younger members. However, it is most apt to point out that 1981 has shown that it is our younger members who are most vulnerable, and this was clearly shown by the course of events in the dispute

between one of them and a nursing sister, and the treatment of another by the Chief Justice when appearing as a witness.

I have led the association in its first two years as a trade union and before that for the previous three years, although in one of those years I had to assume the President's role when the previous President resigned. I have decided that the burdens or joys of leadership must be shared and I will not stand for office in 1982.

The President [Prof. E Walrond]
BAMP

Comment: The association has not suffered professionally or ethically as was feared when it became a trade union. During the twenty-five years the association joined briefly with other trade unions when CTUSAB was formed 10-15 years ago. Within the last three years the association has rejoined the CTUSAB as it was realized that BAMP could benefit from the professional experience of the other unions. There was no accompanying protest from members on this occasion and no resignations, indeed one wonders if most members realize that it has happened.

The government abandoned their health plan after the legislation was passed and BAMP had insisted on conditions of service that would be professionally palatable. The drug service which was BAMP's suggestion to the previous government was declared phase 1 and the general's withdrew from the battle field. BAMP's suggestion of a phased introduction of the service starting with the elderly was not taken up and it is rumoured that the PM at the time congratulated the administrators on their measured progress in its implementation.

Some of the 'younger' members who were called upon to take part now have the association under their care. Nevertheless, some of the elders mentioned then are still around and being asked to contribute further.

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