



## News

### Primary Care Women's Health Forum

2015 ended with the CMO publishing her report *The Health of the 51% of women*. This was attached to the last e-letter but it is worth revisiting this and considering some of the important points she covered.

The overriding theme of the report was to raise the concerns about obesity and the risks to health caused by the current epidemic. This issue will receive further publicity over the next month as the obesity in children report is published.

Dame Sally Davies also uses her report to raise the profile of some conditions that we are frequently consulted about in our primary care settings, which cause considerable distress and concern to our female patients but are not high profile in the commissioning priorities of most CCGs.

An excellent example of this is the management of female incontinence, which can be found in chapter 10 of the report.

Incontinence affects:

- Over 5 million women in the UK
- 50% of those affected, who are aged between 18 and 65 years, report that they are moderately or greatly bothered by it
- 23% say their incontinence reduces their activity.
- 31% dress differently because of their symptoms
- Social implications include absence from the workplace
- It is associated with falls and strokes in the women aged over 80 years of age
- Faecal incontinence is an even greater taboo and estimated to affect 1-10% of adults.

The costs to health and social care resulting from incontinence are significant and will increase as our population ages. Female urinary incontinence is the second most frequent reason that women require care home admission, secondary only to dementia.

Our role in the prevention and management of female incontinence is paramount. Educating women and girls at a young age about maintaining good pelvic floor muscle strength is important but is often left until problems occur post-childbirth.

Self help advice includes: weight reduction, maintaining a regular bowel habit, avoiding bladder irritants such as caffeine, alcohol, smoking and carbonated drinks as well as having a regular pelvic floor exercise regimen.

Good care is also dependent on optimizing the expertise of the multi-disciplinary team comprised of specialist nurses and urotherapists. And by correct prescribing and improving compliance when required.

The majority of care should be delivered in primary care settings with high quality specialist centres for those women with complex or recurrent problems.

The Bladder and Bowel Foundation website is an excellent resource for patient and healthcare professional information. <https://www.bladderandbowelfoundation.org>

You can access the recommendations from this report here: [http://www.pcwhf.co.uk/PCWHF\\_cmo\\_report.html](http://www.pcwhf.co.uk/PCWHF_cmo_report.html)

#### PCHWF moving forward

In 2015 the Primary Care Women's Health Forum:

- Advised NICE on relevant recommendations, including the menopause guidance.
- Advised the All Party Parliamentary Group on SRH about concerns for provision of contraception, especially LARC, in primary care settings.
- Submitted a report to the NHS select committee on commissioning concerns for contraception provision, using the results from the latest survey.
- Held our 7<sup>th</sup> annual conference, which was the most successful to date.
- Developed the PCHWF top tips for menopause management in primary care.
- Supported the FSRH in the development of a practice nurse training programme in contraception.
- Supported the BMS in the menopause workshops.
- Started to develop a webinar based educational programme with Events 4 Healthcare Ltd.
- Continued to circulate these regular e-letters.
- Started to update the website.

We will be continuing to develop these and other initiatives over the next year. But we do need your advice about which topics are relevant and thoughts on how best to support your needs in your primary care and community based workplace.

We are also keen to continue to share best practice and would like to know 'who is out there' delivering primary care based enhanced services. So if you have developed an enhanced service for aspects of women's health (other than for contraception services) please can you email me at [anne.connolly@bradford.nhs.uk](mailto:anne.connolly@bradford.nhs.uk) with your details and information about your service. This will help us to continue to develop our map of primary care women's health services around the UK.

And on behalf of the board of the PCWHF can I wish you all well for 2016.

Anne Connolly

Chair of the Primary Care Women's Health Forum

## Book Recommendations

*Managing the Menopause 21<sup>st</sup> century solutions* by Nick Panay, Paula Briggs, Gab Kovacs – Cambridge Press

This book is a series of chapters written by the world experts on different aspects of menopause management and is really useful for those of us who do menopause consultations.

## Meetings & Events

### Other Meetings



**SAVE THE DATE:** Primary Care Women's Health Forum's 2016 Conference  
23rd November 2016 at the St John's Hotel, Solihull. Registration opens soon.



### **A one day update on Gynaecology**

National Association for Premenstrual Syndrome Conference 2016

**BOOK NOW:** Friday 1st July 2016, Nottingham University Sutton Bonnington Campus

The National Association for Premenstrual Syndrome (NAPS) Conference will provide you with a one day update on gynaecology. Presentations from eminent speakers together with interactive workshops and discussion groups. The conference will be aimed at GPs, GP Registrars, Practice Nurses, GPwSI in women's health, Hospital Doctors.

**(5 hours of CPD available)**

[More Information](#)

[Register Here](#)



## Menopause Academy

5 half day regional events with a focus on treatment and management of the menopause. **(3 hours of reflective learning available)**

## Useful Papers & Guidelines

### Recent Papers

The Health Technology Assessment of the ECLIPSE study was published in 2015. This study compares the use of the LNG-IUS against medical management for control of HMB in primary care. The results confirm that the recommendations made by NICE in the Management of HMB guidance 2007 are correct and that women with HMB and no abnormal pathology should be managed by non-surgical means (LNG-IUS or medical management) in primary care.

A randomised controlled trial of the clinical effectiveness and cost effectiveness of levonorgestrel-releasing intrauterine system in primary care against standard treatment for menorrhagia: the ECLIPSE trial, can be read by clicking [here](#).

Ovarian cancer screening and mortality in the UK Collaborative Trial of Ovarian Cancer Screening (UKCTOCS): a randomised controlled trial, which can be read [here](#).

The results of this recently published and long-awaited trial provide mixed evidence for whether or not a screening programme for detection of Ovarian Cancer Screening is useful.

The Women's Health Journal continues to publish useful articles on line which are relevant for our work. The latest is based on recommendations for fast track referrals and can be found at:

Gynaecology referrals – on the right fast track information found [here](#)

### Recent Guidelines

NICE QS on intrapartum care:

<https://www.nice.org.uk/guidance/qs105>

#### **The BASHH CEG 2015 summary guidance on tests for Sexually Transmitted Infections(Updated).**

This has recently been updated and along with other guidance on management of STIs can be found at <http://www.bashh.org>

## Patient Information

## RCOG Patient information leaflet on smoking in pregnancy

RCOG patient information leaflet on smoking in pregnancy

<https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-smoking-and-pregnancy-2.pdf>

Pregnancy Sickness Support website

<https://www.pregnancysicknesssupport.org.uk>

*"Pregnancy Sickness Support (PSS) is a UK registered Charity which provides information and support to women with all levels of nausea and vomiting in pregnancy (NVP) and particularly the severe end of the spectrum; hyperemesis gravidarum (HG).*

*The charity runs a National staffed helpline during the week from their office in Cornwall where the support co-ordinator, Karen, works alongside the charity Chairperson, registered nurse Caitlin Dean, a specialist in HG. In addition the Trustee team includes a consultant Ob/Gyne, a midwife and GP.*

*Women who call the helpline receive immediate information about up-to-date evidenced based treatments and help with how to advocate for themselves. In addition, women who would like further support are offered one-to-one support from our volunteer network. PSS volunteers have all had first-hand experience of HG and have been interviewed, references and trained. The volunteers receive ongoing support for their work and provide quarterly feedback. The network is fully insured and a member of both National Voices and the Helplines Partnership.*

*In addition to supporting women, their partners and families, PSS can also offer tailored information and support to healthcare professionals providing care to women with NVP or HG.*

*Healthcare professionals are welcome to call our office directly on 01208 872801 to speak with a member of our team. For 2016 we are planning online tutorials for healthcare professionals about NVP and HG and would welcome input from frontline staff on content and style."*

See [here](#) the guidelines for management of nausea and vomiting in early pregnancy

## Other News

### Jo's Cervical Trust

The 24<sup>th</sup> – 30<sup>th</sup> January 2016 is Cervical Cancer Prevention Week The campaign 'Smear for a smear' is co-ordinated by Jos Trust.

Information can be found at [www.jostrust.org.uk](http://www.jostrust.org.uk) and the smear campaign kit can be found [here](#) and [here](#).

### Public Health

**Health promotion for sexual and reproductive health and HIV**

Strategic action plan, 2016 to 2019

This strategic action plan sets out PHE's approach to improving the public's sexual and reproductive health and reversing the HIV epidemic. It identifies the key areas for PHE action, and describes how PHE can work with partners at a national and regional level to improve health and reduce inequalities.

You can find the plan [here](#).

## FGM Resource Pack

<https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack>

## Tips from PCWHF members

Dr Carrie Sadler, one of our board members, is a GP with Special Interest in Gynaecology in South Derbyshire. Over the last two and a half years she has been working with other interested GPs, consultants from the Royal Derby Hospital and the Southern Derbyshire CCG on developing patient pathways for a range of gynaecological conditions. The following are now completed and are available on the CCG's website:

- Heavy menstrual bleeding
- Intermenstrual bleeding
- Postmenopausal bleeding
- Cervical polyps and benign cervical problems
- The recognition and initial management of suspected ovarian cancer
- Polycystic ovarian syndrome
- Amenorrhoea
- Ovarian cysts (simple) in premenopausal women, asymptomatic
- Ovarian cysts (simple) in postmenopausal women, asymptomatic

Guidelines will vary from one area to another but she and her colleagues are happy to share their work. They are now looking at ways of improving implementation of the pathways locally.

The pathways can be found at the following link:

<http://www.southernderbyshireccg.nhs.uk/primary-care/a-z-of-specialties-conditions/gynaecology/>

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### **A case of protein C deficiency and menorrhagia from Helen Connell**

GPSI Lancaster

A 39 year old lady was referred to gynae PwSI clinic with a history of menorrhagia. The menorrhagia had been a problem for a few years but had been worse over the preceding 24 months and was significantly affecting her quality of life. There was no IMB or PCB.

Her PMH included a diagnosis of protein C deficiency.

She had a DVT aged 17 years when on the COCP and a PE during pregnancy.

There was no other significant relevant history.

Initial GP investigations revealed normal Hb but a low ferritin and she was prescribed an iron supplement. Thyroid function had been checked as there was a FH of hypothyroidism in the mother, but this was normal.

Physical examination was unremarkable revealing an anteverted normal sized uterus and speculum examination was also normal.

The ideal treatment was to proceed with a Mirena but the UKMEC for a PMH of VTE and protein C deficiency was 2 for each category.

Advice was sought from a consultant haematologist as it was unclear if both these risks were compounded, or if they were regarded as a single risk category of 2, in light of the fact the VTE history was likely to have been precipitated by the protein C deficiency. The haematologist agreed that the protein C deficiency was the likely cause of the increased VTE risk and therefore the risk overall was UKMEC2 to using the IUS as contraception.

Therefore after full discussion with the patient she was happy to have the Mirena inserted.



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