ASPOG
Australian Society for Psychosocial Obstetrics & Gynaecology
NEWSLETTER
December 2012 Editor: *Kirsten Black*

President's Message

"Out with the old and in with the new" a well-used phrase referring only on this occasion to the departure of Heather Rowe as President and the commencement of my two year term.

Thank you Heather for all you have done for ASPOG over the years and infact will continue to do as Past President on the committee for the next 2 years. There is just no escaping! ASPOG has benefited greatly from your clarity, wisdom and steerage.

Welcome to Tonia Mezzini and Jacqui Boyle as two new members at large representing South Australia and Victoria respectively. We greatly look forward to your input.

The Melbourne Conference in August was again a two day feast of excellent presentations and research papers . Thank you to the organising committee and to Scarlett Events for all their hard work. The Roger Wurm award for the Best Scientific Paper, entitled "Health and Wellbeing after Breast Cancer: A Cohort Study of >1600 Victorian Women with their first diagnosis of invasive breast cancer" was awarded to Professor Robin Bell. The ASPOG New Researcher Prize was won by Jo-Lynn Tan presenting a paper entitled "An 18-Month Audit of Patient Needs, Clinical Outcomes, Attendance, and Service Delivery of Australia's First Dedicated Clinic for Female Genital Mutilation" The Deinfibulation Clinic is at the Royal Women's Hospital in Melbourne.

Following on from the hypothetical we had at the conference "Trimming Tassie: the Trend to Female Genital Cosmetic Surgery", I wonder if you have seen the following about "The Great Wall of Vagina" or even seen the exhibit yourselves? Maybe this could be another patient recourse to show the incredible variety of the normal female body.

http://twitter.com/AFMWorgau/status/252661524219432960

(Thank you to all those women who volunteered their external genitalia. I must be still a prude inspite of all my gynaecological exposure because I don't think I could have lined up and done likewise!).

In our daily encounters, readings, and conference goings there must be a lot of material that may be of interest to our Members. Please consider sending a quick email to Bianca ASPOG (Bianca Scarlett) admin@aspog.org.au for inclusion in future newsletters. Also if there are any topics that you feel passionately about that should be included in the Sydney 2013 ASPOG conference or any direction the Society should be going – please also let us know.

It remains for me to wish you all a Very Happy Christmas / Festive Season and hope you manage to get some well-deserved R&R.

Jackie Stacy

2012 ASPOG 38th Annual Scientific Meeting

It was great to welcome all the usual suspects plus a smattering of new attendees to this year's conference, ably organised by Heather Rowe and her team and held at The Alfred Centre in Melbourne. The setting was welcoming and we were all impressed by the varied and interesting program of speakers. The conference was entitled "Everywoman in the 21st Century" and indeed a broad range of aspects of women's lives was canvassed.

Friday started with an enlightening look into some of the difficulties Aboriginal women face in the Northern Territory, with a greatly increased rate of vulvar cancer and a much lower utilisation of treatment services. The influence of cultural factors here is unmistakable. We then heard from the Victorian College of Surgeons' representative who is setting up a web resource to help address some of these difficulties. This is a heartening initiative. After a comprehensive review of PCOS and a bracing and delicious morning tea (we all salute the caterers – the provisions throughout were scrumptious!) we enjoyed Prof Robyn Bell's summary of her study of well-being after breast cancer. This had such an impact that it was awarded the Roger Wurm Prize for this year's most outstanding contribution to the Congress. Other aspects of health and fertility considerations after breast cancer were also excellently presented.

Lunch was followed by viewing a DVD from SHineSA dealing sensitively with the increasingly apparent problem of mismatched sexual desire. The afternoon brought an equally fascinating range of free communications in a broad range of subjects as diverse as electronic health records, pelvic pain, domestic violence, study recruitment and a new presenter to ASPOG, Linda Kirkman, describing her study of "Friends with Benefits" which certainly opened our eyes!

The final plenary sessions of the day also dealt with aspects of sexual health later in life and were followed by the Society's AGM which was efficient and productive, especially with respect to the election of the new Office Bearers for the coming year. We are delighted to have Jackie Stacy as President, Ann Olsson continuing as Treasurer and Fiona Haines as Secretary.

Saturday's presentations were also a treat, with the morning devoted to current obstetric practises and fertility considerations including in women with endometriosis. The afternoon's free communications included the winner of the New Researcher Award for this year, Jo-Lynn Tan, with her outstanding presentation on her research into Female Genital Mutilation in Australia.

The highlight of the Dinner of Friday evening, held at the delightful Quaff Restaurant on Toorak Road, was definitely the thought-provoking Derek Llewellyn-Jones Oration, presented by Prof Elizabeth Farrell. Professor Farrell honoured the work of Derek's and outlined the work of his colleague Jean Hailes' and her ground-breaking contribution

to women's health. All present were greatly impressed by Liz's talk and the breakthroughs attributable to these pioneers who devoted their lives to improving women's health.

The most memorable part of the year's conference for many of us was the closing Hypothetical, dealing with current trends in female genital "topiary" (Thank you Maggie!) and, much worse in many of our minds, cosmetic surgery. This is certainly an alarming development and was graphically represented by this session. Who will forget the relevance of genital hair to dental flossing?

Thank you to Heather and her dedicated team of helpers and organisers for another excellent Annual Meeting, and to Bianca Scarlett for doing such a superb job in organising the event. We look forward to next year's Congress, which will be held in Sydney on the 3rd and 4th of August.

Jenny Thomas

Book review

Vagina- a new Biography

By Naomi Wolf.
Published by Virago. 2012.
ISBN 978-1-8440-8688-7

It was suggested that to do a review of Naomi Wolf's latest book for our newsletter might be a good idea not only as a professional resource for ourselves or our patients but to check out, considering this time of year, if it might be an appropriate Christmas present! Actually to be honest those words were all my idea!

What makes a good book? Three things might be how well it is written (the ease of reading it as well as being grammatically correct), how well researched it is, and does it make you muse, ponder or think?

Well the first thing is that I can say is "Yes" to all three.

Her referenced section is 54 pages long including a 19 page index. She has read articles, carried out surveys, and travelled the globe meeting with significant people either interviewing them or attending their workshops (and not just swallowing their content verbatim). In the text she includes a lot of others' research with personal padding kept to a minimum.

The main thrust (yes, appropriate!) of her book is based on the mind-body-vagina connection feeling that the vagina has become "dumbed down" be it due to our inheritance (how the vagina has been regarded over the ages), or how it has been controlled by society (as a way of controlling women) or abused by society (particularly in the pillages of warring factions and by the influence of pornography.). If the vagina can be allowed to reach its full potential and women are enabled to feel the depth of their sexual response (mainly through heterosexual relationships) and regain the enjoyment and expression of their sexuality then women can take their proper place in society and creation. She bases this on the observation, from her own experience and others, that there are significant emotional sequelae to fulfilling sexual relations such as joy, hope, creativity (over and above that obtained from other fulfilling areas of our lives) which enable her to be the person she was meant to be, to fufill her role in society etc.

Her personal experience (which perhaps catapulted the inception of this book) was a pinched pelvic nerve diagnosed by her gynaecologist *(not bad!*-JHS*)* which reduced her creativity, joy, and hope which normally followed her otherwise good sexual encounters. Surgical decompression enabled her to regain those very positive feelings. The nerve which carries efferents from the vagina and clitoris and are associated with dopamine (mood enhancer), oxytocin (attachments and bonding), and opiod (feel good) release within the brain. So the more the better! *(I am not sure that the literature is so black and white about these hormonal changes but there is certainly discussion about them-JHS)* (She also talks about similar pinched nerves being associated with undiagnosed vulvodynia-*interesting as this sort of pain typically has a neuralgic component*-JHS)

Enough. As you can see I have not approached this from an academic slant- the book does not claim to be a scientific text and so to do this would be a disservice to the author.

If you wish to read it you have 355 pages to muse over. Whatever else you get from the book you will certainly be able to let the word vagina roll off your tongue and think about it in an expanded way!

Jackie Stacy (JHS)

An experience of obstetric care in Tanzania

Having completed 3 post graduate years as an intern, resident and then SRMO in O&G I had reached a point where I felt a little lost. Perhaps I was underwhelmed by my work and needed my passion in medicine to be rekindled. I had lost what I once thought was insatiable, my excitement for the field of O&G. I decided to get out of the daily grind of hospital work and took myself off to Tanzania for a new experience, to submerse myself in a culture different from my own and challenge myself.

I ended up working as a volunteer medical officer in obstetrics and gynaecology at Mt Meru hospital, a large regional hospital in Arusha, Tanzania. My initial work was on the labour floor. Giving birth in Tanzania is certainly different. Forget having any support person by your side during childbirth. If you are in established labour you are admitted to the labour ward. The labour ward is a large room with 8 beds, thus at any one time there may be 7 other naked labouring women with you cramped into this room. There you lie on a bed, which basically is only covered in a piece of plastic. You have to bring your own sheet to give birth onto and most Tanzanian women will use their kanga (their tribal sarong).

Forget epidurals and forget any pain relief, they are not on offer. If the woman was not progressing appropriately we would start them on syntocinon for augmentation, however there were no such things as CTGs, instead monitoring of the fetal heart was only intermittent using the Pinards stethoscope. In the cases of fetal distress or failure to progress we took the mother to theatre for an emergency caesarean section. I use the term emergency loosely here as everyone runs on African time, which basically is not very fast at all. If the woman progresses normally she will deliver onto her kanga (sarong). Once the cord is cut and placenta delivered, we would assess the perineum for tears. Repairing perineal tears were a challenge. For one thing there was no light source, often the midwives or doctors repairing the tears would not use local anaesthetic and you have to bend over whilst standing up to suture up the tear. Meanwhile the other women in the room are able to see most of what is going on with each of the patients that share the room. So much for modesty or confidentiality!

One of the biggest differences and hardest things to come to terms with was the extreme lack of resources. Apparently medical services for pregnant women in Tanzania are free, however many women would have to bring in their own sterile gloves for us to use when delivering the

baby, their own swabs and gauze and even their own scissors so we could cut the cord. For a service that is apparently free, the women have to provide a lot. Once they had given birth we give them their dirty kanga (sarong) to take with them and clean themselves at home.

Resuscitating neonates was often fruitless. The resuscitation area was a table with suction and oxygen, below an electric heater. I recall a baby born to a Maasai woman one day. We had no idea how long she had been labouring or pushing for when she came in and we delivered her baby. At birth it was very flat and I tried to resuscitate it. Despite a good heart rate, it wasn't breathing spontaneously. I had tried suctioning, bag and masking and giving it oxygen. I think I worked on the baby for about 30 minutes and it still wouldn't breath despite a good heart beat. In the end one of the other doctors I worked with told me to stop because a baby with a disability such as cerebral palsy won't survive in Tanzania, the baby was better off dead. Harsh but true. I barely saw anyone with disabilities around here. Survival of the fittest, a reality that was really difficult for me to come to terms with, especially coming from Australia.

I also managed to spend some time working on the gynaecology ward and it was here that the lack of resources was even more apparent. 2-3 women shared a single bed, their arms attached to IV drips with antibiotics running. Often we wouldn't have the complete course of antibiotic so the women's family would be told to go to the chemist to get doses of drugs like ampicillin so we would give it to them. If the family couldn't afford the antibiotics, the woman wouldn't get them. There was no pathologist in the hospital so we depended on rudimentary clinical signs suspicion for our diagnoses. Essentially everyone ended up on broad spectrum antibiotics (when available), which would have done even more damage in breading antibiotic resistance. I saw many women with pelvic inflammatory disease, advanced cervical cancer and threatened miscarriages. The rates of cervical cancer were very high, which was frustrating to me as it is a potentially preventable disease. Pap smears were not commonly performed, due to a combination of lack of education, fear and accessibility. Even female medical students and doctors told me they didn't get them done even though they were offered free by the hospital! I tried to encourage them, but couldn't understand their resistance to pap smears. I hope that the introduction of the cervical cancer vaccine will change this for the women Tanzania and other African countries, but as it stands, it is too expensive for women to afford, so its potential benefit is far from being realised. The other thing that was all too common was the consequences of unsafe abortions. Abortion is illegal in Tanzania, and the repercussions dangerous and traumatic. I saw many cases of terrible abdominal infections, sepsis, retained products and cervical trauma. I remember assisting with a curette on a 15 year old girl who had an illegal abortion a month prior but unfortunately had retained products. Unlike in Australia, they have no such luxury as general anaesthetic for curettes. The women must lie on the table, without any anaesthesia or analgesia and undergo such a horrible procedure. I rarely feel sick when I perform or watch such procedures, but watching this 15 year old girl, still traumatised by the illegal abortion, leaping off the bed in pain, I was disgusted. How can women be subjected to such barbaric procedures in our day and age? I understand moral and religious objection to abortion, but surely there has to be an argument for the legalisation of abortion when botched and unsafe practices result in such pain, harm and suffering?

More devastating were the cases of rape that I saw as well. Having to assess children as young as 2 and 3 years old who had been sexually abused was all too common. One of my colleagues told me that rape of young girls as young as 2 and was promoted by witch doctors as a cure for certain ailments. Witch doctors or medicine men were still firmly relied upon for the treatment of many conditions. This would mean that women would arrive to see us in hospital weeks or months after the initial onset of symptoms after trialling multiple methods of treatment prescribed by the medicine men. This would often mean the disease was well past any hope of cure or significant damage had occurred.

Whilst I was in Tanzania I wanted to learn more about the practice of female genital mutilation there and what efforts were being made to stop the practice amongst the tribes there. One of the tribes who still practiced female circumcision is the Maasai. I had been spending time with a group of volunteers who were working to develop a strategy to educate Maasai communities and stop the practice of FGM. I had been liaising with them and discussing the medical consequences of such a practice. We would often have long discussions regarding the sexual, social and cultural issues surrounding it. It is through this relationship that I came to join them to visit a Maasai village outside Arusha to discuss Maasai culture and female circumcision with the leaders and elders of this community. Earlier on we had also had visited a Maasai school to discuss the issue with young women aged 13- 19 years old. A third of the girls there had been circumcised. From that visit we had learnt that the majority of the students opposed the practice. When we had asked them what they would do if forced to be circumcised by their parents and community, most of them said they would go to the police or NGOs as the practice is illegal in Tanzania following a Government intervention in response to the UN mandate on FGM. If they didn't help, then they would run away to become nuns. This showed two things, firstly that the young women were willing to give up their family and life to escape such a practice and secondly that they had thought about what they would do in this situation, which shows a certain degree of independence amongst these young women. I was encouraged by what I had learnt from talking to these young women. A few days later we went to talk to a small village community, remotely located a couple of hours drive and walk from Arusha. Amongst the group of Maasai that had gathered on this occasion there was a health worker, a female circumcisor, leaders of the different age groups and community elders. The aim of our meeting was to establish a better understanding of their culture and their opinion and views of female circumcision. For the Maasai it is important that they remain true to their traditions and beliefs. For males circumcision defines when they are "born" as a Maasai, their birth date is irrelevant. It is such an important tradition to them that straying from the set ways this must be performed is associated with serious consequences. A young Maasai man had recently been killed in Arusha by other young Maasai as he had abandoned the traditional practice of returning to his village and undergoing the ritual circumcision there, instead having it done in hospital. If anything that shows you how rooted they are in their traditions. For women, they can be circumcised any time from birth. Every woman in the village that we visited had been circumcised, a fact that we found astounding. Obviously the government intervention to stop the practice had not had any effect at all. I asked the tribe why they perform female circumcision

and to explain why it was so important to their culture. Apparently it gives the woman respect, if she were to be uncircumcised she would be considered a child, ostracised by other women, not allowed to interact or participate and unable to be married. Female circumcision is a way of controlling a woman's sexual desires and ensuring she does not stray from her husband. We asked them why they believe the government had intervened to ban the practice and whether that had any effect on them. The majority didn't know why, except for one elderly lady who said they had introduced the ban as female circumcision increases the risk of passing HIV to the child during childbirth, though she doubted this was true. No one else could offer any other answers to why the practice should stop. If anything the ban meant that they now circumcised their girls immediately after birth they said. They then would have the celebration defining their entry into womanhood when they were older. We wondered if they could perhaps abandon the cutting and just have the celebration, perhaps this could be a way of stopping FGM? We asked what would happen if a girl refused, they answered by saying that it never happens, and if it did they would hold her down and force her. When we asked the Maasai at the village if they knew of any communities that had stopped circumcising their females, they answered that they knew of a few individuals who were against it, but on a whole the practice still continued unabated. The answers and discussion we had that day were so different to those from the young female Maasai students. The dichotomy in opinions and beliefs to me demonstrated the profound effectiveness and influence of education. At the Maasai school we found strong, opinionated, independent young women, a far cry from the village which seemed stagnant and steeped in tradition and very resistant to change. It really me how hard it will be to stop the practice amongst these communities, but education has to be the key.

My experience left me humbled yet frustrated. It certainly opened my eyes and has inspired me to continue my work in womens health. If anything I returned to Australia hungry to learn more and return later to hopefully offer more.

Sophia Berkemeier

Sexual Health Conferences Update

Sexual Health Registrars are encouraged to attend a number of conferences during their training, and this year that included the **International Union Against Sexually Transmitted Infections (IUSTI) World Congress** 15th to 17th August (which overlapped with the **Australasian HIV/AIDS Conference** 17th to 19th August 2012 in Melbourne). The IUSTI meeting was combined with the Royal Australasian College of Physicians (Sexual Health Chapter) meeting.

The IUSTI regions include Africa, Asia Pacific, Europe, Latin America and North America and the aim of the organization is to share information on the medical, scientific, social and epidemiological aspects of sexually transmitted infections and their control. This congress had a special focus on the HPV vaccine, adolescent STI vaccines, anal cancer screening, partner notification, control of STIs in lower income countries, Gonorrhea resistance, Sexual networks and STI control, MSM in Asia and controversies in Chlamydia control. The Opening Plenary of the congress, The Gallow Lecture, was given by Dr. Raj Patel and addressed the question of "Will Herpes ever be curable? A review of the problems, the science and the reasons for study failure (but always adding more to our knowledge)". Unfortunately, the answer to that question is still, unfortunately 'no'. Sexual health researches have been working to find ways to cure Herpes most recently as part of a strategy to augment HIV control, as genital ulcer disease is strongly implicated in facilitation of increased HIV transmission. The plenary sessions are available as video recordings on the conference website at: www.iusti2012.com. Another plenary session worth listening to is at Mr. James Ward's passionate address entitled "What's Required to Make a Difference – The need to upscale strategies to address sexually transmitted infections in Australian Aboriginal and Torres Strait Islander communities".

The **Australasian HIV/AIDS Conference** focuses on the latest developments in research into the cause, clinical manifestations, prevention, testing and treatment of HIV and AIDS related diseases. The opening plenary sessions were a 'star-studded line up' and if you were an autograph hunter, it would have been possible to have most of one's sexual health textbooks signed. Not that I would do anything so gauche. But other people might lose their heads…Professor Tom Quinn gave an inspiring and eloquent lecture on the topic of "Is an AIDS-Free Generation Feasible: Science vs. Reality". Fortunately, the answer to this question is 'yes' (we can)… if the political will can be found. I don't think I was the only one in the audience having a Barack Obama moment.

A number of sessions were devoted to discussions on when to commence treatment with antiretrovirals for HIV infection. A controversial topic, as evidence emerges to support commencing treatment at any CD4 level. Briefly, the current Australian guidelines recommend treatment at a CD4 count of 350-500 cell/uL. This change in treatment recommendations is informed by a growing awareness of the important role of 'treatment as prevention'. As well as an understanding of the damage HIV infection does in terms of inflammatory changes and hence an almost accelerated aging process leading to increased cardiovascular, metabolic and neurological disease in HIV positive men and women. It's always reassuring (read: entertaining), for us Registrars to watch the Consultants exchange heated, polite words on stage!

So, no doubt that I'll try to go to both again next year.

Tonia Mezzini

First National Sexual and Reproductive Health Conference Melbourne Nov 20-21st

This year the Public Health Association organised the first national sexual and reproductive health conference in Melbourne. The Key note speakers included Ailsa Gebbie from Scotland who works in a fairly newly established sexual and reproductive health flagship service which provides a comprehensive range of sexual health, abortion and contraception services. This integrated model of care is accompanied by a comprehensive system of data collection. The service was over 10 years in development and involved champions from public health, sexual health (genitourinary medicine) and family planning. One of the other key note speakers was Prof. Dr. Vanwesenbeeck who is Manager of International Research at Rutgers WPF, Dutch centre of expertise on Sexual and Reproductive Health and Rights (SRHR), and affiliated Professor of Sexual Development, Diversity and Health at Utrecht University. She spoke eloquently on the factors that potentially impact on

the relatively good sexual and reproductive health of young dutch men and women. I was particularly interested in the role of parenting styles on sexual health and how these were significantly different in Holland compared to the USA. She said parents that were authoritative but not authoritarian. Authorative parents (as mainly occurs in Holland) are warm but firm and encourage their adolescent to be independent while maintaining limits and controls on their actions. They are open and engage in discussions with their teenagers who then develop skills to negotiate with others around sexual health issues.

I was not present for the final afternoon during which the substantial gaps in the data collection systems available in Australia, particularly around abortion, were discussed. There was also a session to try and resolve to develop a national sexual and reproductive health strategy for Australia. I sincerely hope this occurs.

Kirsten Black

Mind and Heart Conference, Italy

In September I was fortunate to attend the MIND and HEART conference in Italy, held at an outpost of Monash University in Prato. The conference dealt with how mental health status affects cardiovascular health and illness and this field is not as new as I had thought. For decades enlightened people have recognised that psychological well-being and obstetric and gynaecological health are closely connected as evidence by our own ASPOG, ISPOG, Mercé and other such organisations. These assumptions are supported by a large and ongoing body of research. The connection between heart and mind health is well recognised in many countries. Patients in Poland for example are offered routine counselling after myocardial infarction and in America it is standard to attend a psychologist after a cardiac incident.

Studies have demonstrated that there is a fourfold increased risk of re-infarction if depression is inadequately treated after a previous infarct and newer research demonstrates that both transient and long-term impairment of cardiovascular health are increased after stressors. The presentations in Prato included one from a New Zealand psychologist who studied the increase in cardiac pathology in Christchurch after the earthquakes. There were also presentations on the physiological determinants of cardiovascular risk in bereavement and the role of immunological mechanisms in both mental and cardiac conditions. Interestingly, there is substantial ongoing research into the mechanisms of epigenetic modifications which occurs in subjects under stress such as DNA methylation and alterations in various genes like the noradrenaline transporter gene. Easier to understand are the personal behaviours that result from sub-optimal reactions to stress such as smoking and their impact on cardiovascular health. It is fascinating that no more than 50% of clinical coronary disease is explicable in terms of classical risk factors such as hypertension, dyslipidaemia, smoking and diabetes.

It is likely that many physiological systems mediate the effects of psychosocial status, major life events and psychological illness on health. These include the immune system, mediators of endothelial function and thrombogenesis, the autonomic nervous system and many others. Clearly there is a vast potential for further exploration here with huge future implications for public and individual health. It was a privilege to be exposed to some of the current directions of thought and research in the cardiovascular domain, which parallels that in our field of women's health.

Jenny Thomas

Conference Listing

17th Congress of the Australasian Menopause Society

Friday 6 to Sunday 8th September 2013

Hilton Hotel Adelaide

www.sapmea.asn.au/ams2013

STI & AIDS World Congress

July 14-17th 2013

Vienna

International Union Against Sexually Transmitted Infections

www.STIvienna2013.com

Australasian Sexual Health Conference

23-25 October 2013

Darwin

Australasian Sexual Health Alliance

www.shconference.com.au

HIV & AIDS Conference

21-23 October 2013

Darwin

Australasian Society for HIV Medicine

info@hivaidsconference.com.au

AIDS 2014

20-25 July 2014

Melbourne

AIDS 2014 Asia Pacific and Australian Partners

www.AIDS2014.org

ASPOG 39th Annual Scientific Meeting

3rd - 4th August, Sydney 2013

"Women Reconnected and Revitalised"