

ADELAIDE CONFERENCE – ASPOG 2008

Friday 1 August 2008 5

0800 Registration desk opens and arrival tea & coffee **Foyer**

0845-0900 Welcome **Ballroom 3**

John Condon, SA

Lewis O'Brien, Kaurua People

0900-1030 Session 1: WORK/LIFE BALANCE Ballroom 3

Chair: Jenny Thomas

0900-1030 The effective medical professional: Self-management in an unmanaged world!

Maria Gardiner and Hugh Kearns, SA

1030-1100 Morning tea Foyer

1100-1220 Session 2: MEDITATION SESSION Adelaide 1 & 2

1100-1220 Meditation as Therapy in General Practice

Bronwyn Williams, SA

1100-1220 Session 2: FREE COMMUNICATIONS Ballroom 3

Chair: Suzanne Abraham

1100-1120 Long term sexual, urinary and bowel function after Prolift prolapse repair as measured serially by a novel validated Visual Analogue Scale questionnaire

Michael McEvoy and Alan Forbes

1120– 1140 Back to basics: "Lifestyle & Healthy Fertility"

Gillian Homan

1140-1200 Research to policy to practice: the making and implementation of a National Action Plan for ante and postnatal depression

Carol Bennett

1200-1220 Addressing perinatal depression in general practice

Helen Roxburgh and Jenni Goold

1220-1330 Lunch Foyer

1330-1500 Session 3: COMPLEMENTARY THERAPIES Ballroom 3

Chair: Ann Olsson

1330-1400 Hypnotherapy: research & applications in O&G

Allan Cyna, SA

1400-1430 Acupuncture: research & applications in O&G

Caroline Smith, SA

1430-1500 Complementary Therapies and Phytotherapy

Tracey Cook, SA

Friday 1 August 2008 6

1500-1530 Afternoon tea Foyer

1530-1700 Session 4: ENDOMETRIOSIS Ballroom 3

Chair: Jackie Stacy

1530-1600 Aetiology of Endometriosis

Susan Evans, SA

1600-1630 Management of chronic pelvic pain

Susan Evans, SA

1630-1700 Endometriosis – surgery, medicine and beyond

Deborah Bush, NZ

1700-1800 AGM Ballroom 3

1900 for 1930 Conference Dinner Ballroom 1

Chair: Diana Cox

Derek Llewellyn-Jones Oration

"Reminiscences"

Dr John Bunday, SA

Saturday 2 August 2008 7

0830 Registration desk opens and arrival tea & coffee **Foyer**

0900-1030 Session 5: UNPLANNED PREGNANCY & ABORTION Ballroom 3

Chair: Heather Rowe

0900-0930 The SA perspective

Brigid Coombe, SA

0930-1000 Towards excellence in clinical practice

Chris Bayly, VIC

1000-1030 Understanding women's experiences of unplanned pregnancy and abortion

Maggie Kirkman, VIC

1030-1100 Morning tea Foyer

1100-1200 Session 6: Free Communications Ballroom 3

Chair: Karin Hammarberg

1100-1120 Which path leads to peace? Creating space for self-informed choice – managing the social construction of femininity and the socio-political context of abortion in decision making counselling

Krystie Edwards

1120-1140 To have or not to have? The contribution of psychosocial and health factors to Australian women's childbearing decisions

Sara Holton, Jane Fisher and Heather Rowe

1140-1200 Parentage testing in Australia – not always the media stereotype

Andrea Hayward

1200-1330 Lunch Foyer

1330-1500 Session 7: BREAST CANCER Ballroom 3

Chair: Amanda McBride

1330-1400 Breast Cancer update

Stephen Birrell, SA

1400-1430 Genetics of Breast Cancer

Graeme Suthers, SA

1430-1500 Counselling for gene carriers

Jacqui Armstrong, SA

1500-1530 Afternoon tea Foyer

1530-1610 Session 8: DISCUSSION Ballroom 3

Chair: Jane Fisher

1530-1610 Who will deliver the next generation?

Alastair MacLennan, SA

1615-1700 Farewell Drinks and Presentation of Prizes

Abstracts 8

The effective medical professional: Self-management in an unmanaged world!

Maria Gardiner and Hugh Kearns

Glenside, SA

This presentation will cover the key areas of time management, work/life balance and stress management. In particular we will focus on mental wellbeing and behavioural patterns that, both now and in the future influence happiness and longevity as medical specialists. Areas that will be covered include

Time Management

- Planning and prioritising
- Reducing overcommitting
- Reducing procrastination
- Staying on time

Work/Life Balance

- Leaving work on time
- Not bringing work home

- Spending time with family
- Spending time on own interests

Stress Management

- Reducing worry
- Improving physical health
- Feeling less overwhelmed
- Feeling less need to live up to expectations

The seminar is not based on a remedial stress or illness model; it takes a proactive, preventative and evidence based approach. This presentation will be of interest to you if

the following sounds familiar:

- Too busy with multiple demands?
- Patients demanding too much?
- Bureaucracy getting you down?
- Feeling like you are not spending enough time with family (like they come second to the job)?
- Trying to balance families and own needs with the job?
- Feeling stressed and or tire all the time?
- In fear of litigation?
- Not knowing how to say no to excessive demands?

Meditation as Therapy in General Practice

Bronwyn Williams

Health on Kensington, Leabrook, SA

After 30 years as a general practitioner, I had become aware of the limitations of treatment for anxiety and stress that is offered by traditional medicine as we know it. I

became more involved in mental health and developed a therapy using relaxation and

meditation to teach my patients to help resolve stress, anxiety, panic disorder, phobias, depression and PTSD.

In this session, I will explain how I use this in my general practice and give some examples of the people with whom I have had success.

I will follow with a meditation session that you will be able to use for yourself and patients, adapting it to deal with specific issues.

Abstracts 9

Long term sexual, urinary and bowel function after Prolift prolapse repair as measured serially by a novel validated Visual Analogue Scale questionnaire

Michael McEvoy and Alan Forbes

Gynaecologist, Private Practice, North Adelaide.SA

Current QOL questionnaires have significant limitations. We designed and validated a new questionnaire to more accurately measure sexual, bowel and bladder function.

50

consecutive Caucasian patients with severe prolapse were considered suitable for a Prolift

Mesh repair. Preoperatively a King's College P-QOL questionnaire and POP-Q assessment

was made. These were repeated at 3, 6, 12, 18, 24 and 30 months together with our new PROVAS (PROlapse Visual Analogue Scale) questionnaire.

PROVAS and preoperative and postoperative P-QOL scores were correlated with $r=0.89$,

therefore validating the PROVAS questionnaire. 96% responded to the questionnaire and

100% felt the questionnaire was reasonable, understandable and relatively easy. 4% declined or returned the questionnaire unfilled. 20% felt PROVAS was easier, 35% less complex, and 56% less embarrassing than P-QOL. 46% were sexually active post operatively by 3 months and 75% by 6 months. 25% did not have a partner or a potent partner. 43% described an improvement in their sexual relationship and 12% had orgasm more frequently. 4% had female and/or male dyspareunia. These were not all apparent until 6 months. Mesh exposition was noted in 8% with 50% of these being symptomatic. Mesh excision resolved the dyspareunia. Sexual function was not able to be accurately assessed until at least 6 months post operatively. A high degree of improvement in quality of life, sexual and bladder function with low rates of dyspareunia and recurrence occurred. Prolift repair has similar rates of complication as other methods of prolapse repair with a lower rate of recurrence.

Notes:

Abstracts 10

Back To Basics: "Lifestyle & Healthy Fertility"

Gillian Homan

Repromed, Adelaide, Research Centre for Reproductive Health, Adelaide, SA

Introduction

Healthy lifestyle and good pre-conception care may increase the chance of conceiving, a healthy pregnancy and delivering a child that is in good health. If lifestyle behaviours such as smoking and obesity are not addressed the chances of a (good) outcome are reduced. Despite the evidence, the lifestyle of a substantial proportion of the Australian population is affecting adversely, their general health and fertility. The presentation will:

- Present the evidence relating to lifestyle & fertility
- Describe a recent study into the knowledge and behaviours of infertile couples, relating to lifestyle and how this might affect a pregnancy and the chance of conceiving
- Describe a current study to encourage healthy lifestyle changes

Methods

- Systematic review of the literature
- Interviews with 10 infertile couples

Results

Literature:

Evidence relating to lifestyle and healthy fertility:

- Strong evidence of adverse effects of age, smoking and weight
- Suggestive but inconclusive evidence of adverse effects of caffeine, alcohol, psychological stress

Interviews

Infertile couples are aware of the possible impact of lifestyle on fertility, but do not necessarily lead a healthy lifestyle.

Discussion

- The goal of healthy conception should be a highly motivating factor for leading a healthy lifestyle, particularly for infertile couples. Why is this group not proactive in making healthy lifestyle changes?
- Our current study is aimed at motivating couples to make positive lifestyle

changes by using motivational interviewing techniques, and providing individualized advice and support.

Conclusion

Lifestyle is a fundamental component of "healthy fertility". Although there is an awareness of this in the infertile population, there is a need to assist couples in making

"healthier choices". How this is best delivered requires further research and development.

Notes:

Abstracts 11

Research to Policy to Practice; the making and implementation of a National Action Plan for ante and postnatal depression

Carol Bennett

beyondblue, Melbourne, VIC

beyondblue's program of research into postnatal depression identified the need for national action in key areas to improve perinatal mental health. beyondblue based the

development of a National Action Plan (NAP) on this important research.

This paper will outline the development of beyondblue's NAP for perinatal mental health

and the achievement of a significant funding commitment (\$85 million announced in the

2008-09 Federal Budget) from the Australian Government for its full scale implementation.

It will specifically address the need for major workforce education, training and development for professionals providing routine assessment of women, to those who provide intervention and care for women identified as being at risk of, or experiencing,

ante or postnatal depression.

The challenges of achieving a national change in culture, skills and delivery to create more effective ways of supporting women and their families to overcome depression and

anxiety during pregnancy and early parenthood in Australia will be explored.

¹ The *beyondblue* National Postnatal Depression Program. Prevention and Early Intervention 2001-2005. Final

Report. Volume 1: National Screening Program.

² *beyondblue* Perinatal Mental Health National Action Plan 2008-2010 Full Report May 2008

Addressing Perinatal Depression in General Practice

Helen Roxburgh and Jenni Goold

SA GP Obstetric Shared Care Program, Adelaide, SA

The management of mood disorders during pregnancy has a significant impact on the

health of mother, child and family, not only during the antepartum, intrapartum and post

partum periods but also for many years subsequently, with widespread ramifications for

the overall health of society.

Psychological morbidity, especially depression and anxiety, are common both antenatally

and postnatally. With significant perinatal depression (PND) there are associated risks for

the foetus by way of maternal suicide behaviour, associated drug or alcohol abuse, poor

maternal self-care, inadequate maternal nutrition and poor antenatal clinic attendance.

Emerging literature also suggests that depression and anxiety in pregnancy may be associated with poorer neurological and behavioural outcomes in offspring.

Obstetric Shared Care, where the GP is responsible for the majority of antenatal visits, is

a proven model that provides continuity of care and optimal health outcomes.

In South Australia, a Statewide Obstetric Shared Care Program has been established ensuring a uniform structured approach to antenatal care based on best practice obstetrics in the holistic setting of General Practice. This model has significant potential

for reducing both the incidence and impact of PND:

- The GP who often already has a long-term association with the patient, is able to relate to the patient in the context of work, family and social setting.
- Depression often manifests itself postnatally, at which time the GP, given prior knowledge of patient, can detect subtle mood changes enabling early diagnosis and treatment.
- The GP's familiarity with co-morbidities and their treatment enables a holistic approach to treatment of perinatal anxiety and depression.

In summary, the SAOSC program allows early identification of patients at risk of psychological morbidity, timely implementation of preventive and treatment strategies,

activation of family and community support systems, and integration of psychological and

obstetric management.

Abstracts 12

Hypnotherapy: research & applications in O&G

Allan M Cyna

Department of Women's Anaesthesia, Women's and Children's Hospital, Adelaide, SA

Although medical interventions play an important role in preserving lives and maternal

comfort they have become increasingly routine in normal pregnancy and childbirth. This

may increase the risk of associated complications and a less satisfactory pregnancy or

birth experience. Recent research suggests that hypnosis has applications in analgesia

for childbirth, management of hyperemesis and may provide a non pharmacological means of inducing labour. An updated systematic review investigating the effects of hypnosis for pain relief in childbirth found five RCTs, studying 727 women. Compared with controls, fewer parturients using hypnosis required pharmacological analgesia, relative risk (RR) = 0.53 (95% CI 0.36, 0.79). The largest RCT to date studied 520 women who learned hypnosis in the first two trimesters of pregnancy. The authors report

a decreased use of epidural analgesia in women using hypnosis RR = 0.3 (95% CI 0.22,

0.40). In addition, three studies investigating 322 women show that fewer women using

hypnosis require augmentation with oxytocin RR = 0.31 (95% CI 0.22, 0.43) and three

studies investigating 645 women show an increased incidence of spontaneous vaginal

birth in women using hypnosis RR = 1.31 (95% CI 1.18, 1.45). Although trial

heterogeneity and differences in the timing, number of sessions and delivery of the hypnosis intervention were noted. The use of hypnosis preparation for childbirth was found to decrease maternal pharmacological analgesia requirements during labour, decrease the use of oxytocin augmentation during labour and, increase the incidence of

spontaneous vaginal birth. Further research is required to confirm these findings and investigate whether mothers trained to use hypnosis; improve their pregnancy and childbirth experiences, reduce complications associated with pharmacological interventions and decrease their experiences of postpartum complications such as postnatal depression. Cost benefit analyses should be performed in future studies assessing the effects of antenatal hypnosis training during pregnancy and childbirth.

Notes:

Abstracts 13

Acupuncture: research applications in obstetrics and gynaecology

Caroline Smith

Adjunct Associate Professor Complementary Medicine, The University of Western Sydney, Visiting Research Fellow, Discipline Obstetrics and Gynaecology, The University of Adelaide, SA

Research suggests 58% of women have used some form of complementary therapy, with

the greatest use by women in the 25-34 age group. Survey data reported from the United Kingdom in 2006 reported the use of acupuncture for gynecological or obstetric conditions to be 8%.

An overview of research indicates a small but growing body of evidence for the use of

acupuncture to complement treatment of women's health conditions over various stages

of the reproductive health span. The use of acupuncture to treat period pain although based on a small number of studies suggests a benefit with a reduction in the use of medication WMD -0.35, 95%CI -1.06 to 0.36, and overall pain relief pain relief OR 9.49,

95%CI 1.74 to 51.80. There is evidence of efficacy with the treatment of nausea in pregnancy RR 0.47, 95%CI 0.35 to 0.62 $p < 0.001$, and vomiting RR 0.59 95% CI 0.51 to

0.68 $p < 0.001$. During labour, evidence from a Cochrane systematic review of acupuncture demonstrated a decreased need for pain relief RR 0.70, 95%CI 0.49 to 1.00, compared to no treatment.

Studies exploring the motivation of people for their use of acupuncture have reported subjects valued the relief of presenting symptoms but also "expanded effects of care".

This related to effects such as "increases in energy, increase in relaxation and calmness,

reduction in the reliance of prescription drugs, quicker healing from surgery and improvements in psycho-social coping such as increased self awareness, balance, centredness, well being, increases in self efficacy and all round changes in lives".

This paper will present some evidence for the use of acupuncture in relation to reproductive health, and present findings from recent research conducted with women

undergoing assisted reproductive technology describing the psycho-social effects from

acupuncture.

Complementary Therapies and Phytotherapy

Tracey Cook

Botanica Medica Adelaide, SA

In the last twenty years there has been a huge rise in the use of complementary medicines including phytotherapy. Patients often use phytotherapy preferentially in the

belief that they are helping themselves and by using " Natural Medicines" doing less harm than using pharmaceutical drugs .This phenomenon occurs due to criticism about

adverse reactions to chemical drugs, their high cost, iatrogenic illness and increases in

chronic diseases which require long term drug use to improve quality of life but may cause other long term problems.

Providers of complementary medicine generally have a tradition of use to draw knowledge from. Detractors criticise this level of knowledge as compared to the more modern evidence based system of medicine. Modern phytotherapists acknowledge a need

for evidence about safety, efficacy and a standard of quality of the product and the practice of phytotherapy.

This paper will address the current status of herbal medicines and phytotherapy practice

in Australia with some specific examples of commonly used herbs such as Vitex agnus

castus (Chaste tree), the various Ginsengs and the controversial Cimicifuga racemosa

(Black cohosh) .

Abstracts 14

Aetiology of Endometriosis

Susan Evans

Endometriosis Care Centres of Australia, Norwood, SA

It is now 80 years since Sampson proposed his theory of retrograde menstruation as causation for endometriosis. Several factors fit this theory. Endometriosis does not occur

in women before menstruation and it is more common in women with a congenital blockage of the outflow tract. However, there are many factors that do not fit with Sampson's theory. Endometriosis usually develops in a woman's teens and twenties, after only a few years of periods, rather than becoming more and more common as the

years (and periods) pass. Endometriosis may be found in distant sites such as the lung,

where no menstrual blood reaches.

The metaplasia theory suggests that some cells in the peritoneum are destined to 'metaplaste' into endometriosis once conditions are right (e.g. the rise in estrogen at puberty).

The interplay between the immune system, our environment, genetics and inflammation

has also become apparent. Women with endo are different from women without endo in

many ways.

It is probable that all these theories have some truth in them.

Management of chronic pelvic pain

Susan Evans

Endometriosis Care Centres of Australia, Norwood, SA

Many women with endometriosis suffer dysmenorrhoea until their menopause but are

otherwise well. Others progress to chronic pelvic pain, sometimes even after endometriosis has been removed, or after hysterectomy.

By listening to the description of her pain, the cause can often be determined and an effective treatment plan made. Common symptoms include:

- Dysmenorrhoea on day 1-2. This is usually pain from the uterus. Women with endometriosis have nerves in the endometrium not present in other women. OCP, mirena, nsaid, continuous progestogen.
- Dysmenorrhoea for more than 1-2 days, often before a period or pain 'like period pain but less severe' during the month. This is often endometriosis and requires laparoscopic excision
- Sharp, stabbing, burning or deeply aching pains +/- bloating. This is often neuropathic pain. Regular sleep, regular exercise, low dose amitriptyline, gabapentin, or pregabalin.
- Urinary symptoms of frequency, nocturia, urgency, pain. History of 'frequent UTI but MSSU negative'. Often interstitial cystitis. Dietary triggers are common. Amitriptyline, hydrodistension.
- Bowel function becomes abnormal. Food intolerance, interstitial cystitis and IBS are common.
- Pelvic floor muscle spasms and trigger points. Secondary to other causes of pain and poor posture. Treat with physical therapies, low dose amitriptyline, Thiele Massage
- Emotional wellbeing and self esteem. Educate her about endometriosis. Allay her fears. Ensure she has sufficient pain relief to be able to control her pain if needed. Exercise. Time.

Pelvic pain is complex but the enormous improvements in quality of life for these young women make it very worthwhile.

Abstracts 15

Endometriosis – surgery, medicine and beyond

Deborah Bush

Chief Executive Endometriosis New Zealand, Christchurch, NZ, Patient Advisor, Oxford Clinic Womens Health, Endoscopy Manawatu, Endometriosis Auckland, New Zealand

This presentation will demonstrate why a multi-disciplinary holistic approach supports

best practice in the treatment and management of endometriosis.

Many disturbing facts associated with endometriosis will be unmasked and include diagnostic delay, high prevalence, repeat visits to doctors and specialists, and compromised fertility, lifestyle and well being.

The presentation will show how we can combine evidence-based best practice treatment

within a multi-disciplinary, holistic framework dovetailing boundaries across medical disciplines, public and private health sectors and include patient organisations. A breakthrough programme addressing the global nature of symptoms was developed at

Oxford Clinic Womens Health in Christchurch, NZ. From there, a specifically tailored patient-partnering programme has subsequently been introduced into some public hospitals.

The key to the programme success has been the holistic nature of the care provided and

the commitment of the medical professionals to this multi-disciplinary principle.

Patients,

doctors and specialists now have a programme which provides each with an irresistible benefit, but most importantly, gives patients the treatment they deserve inciting positive changes for girls and women with endometriosis and solutions for those who treat it. It may challenge the boundaries in current endometriosis treatment and provoke change in approach.

Notes:

Abstracts 16

The SA Perspective

Brigid Coombe

Pregnancy Advisory Centre, Adelaide, SA

The conditions for Termination of Pregnancy to be legal were first prescribed in the South

Australian Criminal Code in 1970 and were very similar to the conditions prescribed by

the UK Abortion Act which was passed in 1967. This legal framework is restrictive and

remains unchanged since 1970 and is the context in which services are provided in South

Australia.

This legislative framework will be outlined and inform the presentation of information about abortions in SA. Data collated by the Pregnancy Outcome Unit and reported on in

their annual reports on Pregnancy Outcome in SA will be presented.

The challenges presented to health professionals and organisations in delivering high quality and safe services based on evidence and Best Practice Standards within a restrictive and outdated legislative framework will be discussed.

The findings of the UK House of Commons Science and Technology Committee on the Developments Relating to the Abortion Act of 1967 and the relevance for the SA context

will be explored.

Towards excellence in clinical practice

Chris Bayly

Royal Women's Hospital, Melbourne, VIC

In general, excellence in clinical care depends upon:

- staff training, mentoring and supervision;
 - knowledge of relevant evidence;
 - application of established practice standards and clinical guidelines relevant to patients' individual circumstances;
 - audit and review of practice and outcomes;
 - consideration of context including potential for health promotion and prevention;
- and
- ongoing research to support continuing improvement of health service delivery.

Despite extensive clinical and research evidence to support excellence in practice, there

is restricted availability of best practice care to Australian women seeking abortion, accompanied by limitation of training, monitoring, research and prevention activities.

In particular Australian women do not have general access to optimal methods of medical

abortion using mifepristone; the difference that this could be expected to make will be outlined, with reference to implementation experience in other countries. Some of the barriers to research, monitoring, health promotion and training activities will also be outlined, together with examples of good practice and some discussion of recent positive steps.

It is argued that recognition of abortion as a health issue in policy, practice and legislation supports progress towards excellence in all dimensions of clinical care.

Abstracts 17

Understanding Women's Experiences of Unplanned Pregnancy and Abortion

Maggie Kirkman ⁽¹⁾, Heather Rowe ⁽¹⁾, Shelley Mallett ⁽¹⁾, Annarella Hardiman ⁽²⁾, Doreen Rosenthal ⁽¹⁾

1. Key Centre for Women's Health in Society, The University of Melbourne, VIC, 2. Royal Women's Hospital, Melbourne, VIC

Despite considerable public debate about abortion there is little research on women's experiences. The research reported here aimed to increase understanding of the woman's perspective, including women's conceptualisation of the meaning of abortion,

their reflections on their attitudes to abortion over time, and their perception of public and personal discourse surrounding abortion. Sixty women who had contacted a public pregnancy advisory service in Melbourne seeking information, advice, or appointments in relation to an unplanned or unwanted pregnancy were recruited into the study.

Recruitment targeted three categories: women aged 16-18, from rural or regional areas, and presenting at 12-18 weeks gestation. The first two groups are known to be disadvantaged in gaining access to reproductive health services, and women who present for termination after 12 weeks gestation prompt concern about personal or service restrictions on earlier presentation. In-depth telephone interviews were conducted and recordings transcribed. Discourse analysis was performed, drawing on narrative theory to guide insights into explanation and meaning. About a third of the participating women were aged 16-18, a third were from rural or regional areas, and another third presented at 12-18 weeks gestation. Some women fitted more than one category. The women's conceptualisation of abortion was variable, although the dominant discourse was that abortion was a solution, however difficult, to an even more difficult problem. This discourse encompassed being a responsible woman and (actual or potential) mother who took other's needs into account, including those of the potential child. Many women could be understood as feeling that they had to justify their decision to have an abortion or to continue the pregnancy. Women's accounts revealed the complex personal and social contexts within which reproductive events must be understood.

Notes:

Abstracts 18

Which path leads to peace? Creating space for self informed choice - managing the social construction of femininity and the socio-political context of abortion in decision making counselling

Krystie Edwards

Pregnancy Advisory Centre, Adelaide, SA

Decision making in response to unplanned pregnancy occurs within a social context that

includes the ongoing contestation of a woman's right to autonomously control her fertility, the residue of the notion that good women put others before their own well being and the stigmatization of abortion.

For some women, this social context means the space they inhabit while responding to

an unplanned pregnancy feels overcrowded and perplexing. In journeying toward a decision women are often negotiating not only conventional social expectations and pressures, the possibility of grave social, spiritual, emotional or physical consequences

and invitations into guilt and self recrimination, but also issues of identity such as unrealized possibilities, hopes and dreams and the need for a deeper questioning of values, beliefs and relationships.

Standing at a crossroad, these various signposts can guide women toward very different

destinations, some obvious, others not. What position of consideration is most likely to

lead to an ultimately peaceful resolution?

I would like to explore and discuss some of the ways counsellors might bring into relief

powerful social discourses which can prescribe how women should feel and act, in an effort to support women to trust their own values, wisdom and experience.

Notes:

Abstracts 19

To Have or Not to Have? The Contribution of Psychosocial and Health Factors to Australian Women's Childbearing Decisions

Sara Holton, Jane Fisher and Heather Rowe

Key Centre for Women's Health in Society, School of Population Health, The University of Melbourne, VIC

Background: A small number of individual explanatory factors have been identified as

salient in Australian women's childbearing decisions. However, the role and relative importance of psychosocial factors including the influence of women's partners, education

debts, housing conditions, and women's health are not well understood. Few Australian

studies have examined whether such factors differ for each additional parity progression.

Objective: To investigate the contribution of psychosocial and health factors to Australian

women's childbearing decisions.

Method: A descriptive, cross-sectional study of Victorian women aged 30-34 years randomly selected in 2005 from the Australian Electoral Roll was conducted.

Participants

completed a self administered anonymous postal questionnaire which assessed sociodemographic characteristics, and health and psychosocial factors in relation to

childbearing decisions. Principal components analysis was used to reduce the questionnaire items into more manageable and statistically independent smaller sets. Results: 569 of the 1280 women (46.7%) selected completed questionnaires. The sample included mothers (61.5%) (the mean number of children was 1.1) and women without children (38.5%). Most women (71.3%) desired 2-3 children. However, 53.8% said they were unlikely to have (more) children in the future. Participants' reasons for not currently having children included poor health, not having a partner or having an unstable relationship with their partner, and job insecurity. Salient factors in participants' decisions to have their first child included: an interest in being a mother, having an established career, and financial security. Participants' reasons for having subsequent children included not wanting their first child to be an only child, job security, and having paid or reduced their house mortgage. Factors identified by participants as likely to influence their future childbearing decisions included the willingness of their partner to help raise (more) children, the financial cost of children, and their age and health. Conclusions: Our findings suggest that multiple factors contribute to women's decisions to have or not have children, and the importance of these factors varies by parity. The results indicate that women often have fewer children than they actually desire, and many would have (more) children if their circumstances were different. Our results challenge the public discourse that women's childbearing decisions are mostly voluntary and based on lifestyle factors or their career development.

Abstracts 20

Parentage testing in Australia- not always the media stereotype

Andrea Hayward

DNA QLD, Brisbane, QLD

Paternity testing, being the inclusion or exclusion of an alleged male as the genetic parent of a child, is a growing field of molecular science. It is estimated there are 6000 paternity tests conducted in Australia each year. To date, little social research has been conducted in this field. A study long term was commenced in Queensland in November 2007 into the individuals accessing these services from a Paternity Testing facility. The media portrayal of paternity testing appears to report on the negative portrayals of paternity testing such as the Liam McGill case contested in the High Court. This case focused on Liam McGill who had paid child support for many years until establishing by paternity testing that he was not the genetic parent of 2 children. However, for many individuals requesting parentage testing, their scenarios are varied and cover many groups in the population. Some of these scenarios include: mothers confirming to male partners they are the genetic father, mothers proving maternity,

middle aged adults confirming paternity before an elderly parent's death, and testing for

paternity in utero after a casual sexual relationship resulted in a pregnancy.

A survey was conducted with individuals participating in paternity testing. It utilized open and closed questions pertaining to: the participant's demographic background, education, employment and the relationship being questioned. Research questions also

examined the participant's source of information on paternity testing, levels of comfort

with the testing, their reaction to the result and their own thoughts after receiving the

test results.

Worldwide, the demand for paternity testing is predicted to increase. Medical Practitioners and Allied Health Professionals will increasingly be questioned about paternity testing, and a greater awareness of the Australian story will be a valuable tool

for health and paternity testing facilities.

Notes:

Abstracts 21

Breast Cancer Update

Stephen Birrell

Flinders Medical Centre, SA

It would be easier to say what we don't know about breast cancer than what we do know, then explain how we are filling in the knowledge gaps.

- We don't know what initiates breast cancer
- We don't know what promotes breast cancer
- We don't know who needs systemic therapy
- We don't know the optimal systemic therapy
- We don't know why women who initially respond to systemic therapy relapse
- We don't know how to prevent breast cancer
- We don't know the optimal screening process

Obviously with the billions of dollars spent on breast cancer research and treatment each

year, we would expect a smaller list, but there are some serious impediments to our progress. The aim of this talk is to highlight the progress that is being made to address

these deficiencies.

Genetics of Breast Cancer

Graeme Suthers

Children's Youth & Women's Health Service, North Adelaide, SA

Cancer is caused by a combination of inherited (genetic) factors, the environment (encompassing all external events which impact on the individual), and chance. In approximately 5% of women with breast cancer, and 10% of women with ovarian cancer,

the genetic component is sufficiently strong that a familial predisposition to develop cancer can be identified. The genes responsible for a familial predisposition to develop

cancer are often unknown, but mutations in the BRCA1 or BRCA2 genes account for ~20% of multi-case families with breast/ovarian cancer.

One of the primary purposes of testing for BRCA mutations in familial breast/ovarian cancer has been to provide accurate advice to at-risk relatives. The provision of such advice has been hampered by a lack of appropriate data regarding cancer risks.

Chen et

al (J Clin Oncol 2006; 24:863-871) have provided precise estimates of the relative risks of breast/ovarian cancer in 2,000 kindreds with BRCA mutations in North America. But the baseline incidence of breast cancer is lower in Australia than in North America. The relative risks derived from the Chen study have been combined with Australian baseline incidence data to estimate the absolute short- and long-term risks of breast/ovarian cancer for Australian carriers of BRCA1/2 mutations of different ages. The risk of breast cancer is high in premenopausal carriers, but approaches the population incidence after the menopause. Conversely, the incidence of ovarian cancer increases from the age of 40 years. The cumulative lifetime risk of developing breast cancer is 50-60%, and 20-40% for ovarian cancer. An unaffected post-menopausal carrier is at greater risk of ovarian cancer than breast cancer. These observations have important implications for genetic counselling and decisions regarding prophylactic surgery.

Abstracts 22

Counselling for gene carriers

Jacqui Armstrong

Familial Cancer Unit, SA Clinical Genetics Service, Women's and Children's Hospital, North Adelaide, SA

There are approximately 350 individuals from 140 families in South Australia who have

been identified as carrying a BRCA1 or BRCA2 gene mutation. Carriers have a significantly increased risk of developing breast or ovarian cancer during their lifetime.

The risks associated with being a carrier necessarily implies uncertainty for the individual

about what the future may hold for them, and a need to find an adaptive way of coping

and integrating this information usefully in their lives.

Carrier testing raises a number of significant issues for individuals and families which must be taken into account during genetic counselling. It is recognised that being identified as a carrier impacts on individual identity and concepts of self as the lines between health and illness are blurred. A range of emotional reactions may be triggered

including anticipatory grief and loss. These factors will also be influenced by the experience and perceptions of cancer within the family and the beliefs and meaning which individuals and families hold about living with cancer risk. Other dilemmas include

the tension surrounding the disclosure of genetic information within a family and the different decisions relatives make which can lead to family conflict.

Women carriers of a BRCA1 or BRCA2 mutation are also faced with assimilating complex

and often contradictory medical information about managing and reducing their risk of

breast and ovarian cancer. This occurs within an environment of limited medical knowledge and where the most effective risk reducing interventions have the most dramatic personal implications. These contradictions can make women feel isolated and

frustrated; and have a significant impact on their relationships with partners and other relatives.

Using case studies I will illustrate some of these issues.

Notes:

Abstracts 23

Who will deliver the next generation?

Alastair MacLennan

Head of Discipline of Obstetrics and Gynaecology, the University of Adelaide, SA

It has never been safer to have a baby and never more dangerous to be an obstetrician.

Litigation after the diagnosis of cerebral palsy is discouraging practice in obstetrics. Cerebral Palsy occurs in one in 500 babies, this rate has stayed the same over 40 years

despite a six fold increase in caesarean section, and is not preventable. However, a few

rogue "expert" witnesses can be commissioned to say that the baby should have been

delivered an hour earlier and then it would not have had cerebral palsy. This opinion is

based on the traditional and wrong assumption that cerebral palsy is mostly due to a sudden loss of oxygen or trauma to the baby around birth. In fact, the baby first noticed

to be compromised at birth has probably had problems extending well before labour and

the process causing the brain damage was not recognisable or reversible by an earlier delivery.

In most cases of cerebral palsy major antenatal risk factors can be identified e.g. prematurity, intrauterine infection, growth restriction, antepartum haemorrhage congenital brain anomalies, tight nuchal cord, intrapartum fever, and complications in a

multiple pregnancy. Acute intrapartum hypoxia is a rare primary cause of CP.

New research from the South Australian Cerebral Palsy Research Group using molecular

biological techniques and dried neonatal blood spots shows that cerebral palsy is also significantly associated with hereditary thrombophilia (clotting disorders which may predispose to perinatal stroke), cytokine polymorphisms (gene mutations which alter the

fetal inflammatory response to infection) and increased exposure during pregnancy to

neurotropic viruses. The genetic susceptibility factors may interact with the environmental factors to cause cerebral palsy.

As yet there is no obstetric policy that has been shown to reduce the rate of cerebral palsy. Despite this cerebral palsy litigation is common. A small number of plaintiff "expert" witnesses regularly opine that earlier delivery would have prevented CP without

supporting data. Fear of litigation is a major reason for the increasing shortage of obstetricians and closure of maternity hospitals. Solutions include medical courts, peer

review of expert witnesses, dispute resolution, education of the public and judiciary, better peer review audits of cases with neonatal morbidity and "no fault" legislation.

There is an urgent need for cerebral palsy to be removed from the litigation arena if

Australian maternity services are to be saved. It is necessary for each state to introduce such legislation. This will reduce the huge costs of the litigation process, often borne by the State and Federal Governments, will encourage recruitment into the maternity services, and professional counselling, rather than legal advocacy, allows quicker parental closure about causation and better services for the children and families affected by this disabling disorder.

Presenters 24

Ms Jacqueline Armstrong

Jacqueline is a certified cancer genetic counsellor with the Familial Cancer Unit based at the Women's and Children's Hospital. She has been working in cancer genetics for 9 years providing a genetic counselling service to clients seeking information about cancer risk, management and genetic testing. In response to the needs of clients Jacqueline has also been involved in the development of support and information groups for carriers of gene mutations and high risk management clinics. She has a background in social work and worked within a crisis mental health team for a number of years. Her earliest training was as a registered nurse.

Dr Chris Bayly

Dr Chris Bayly is a gynaecologist who has worked at the Royal Women's Hospital, Melbourne for over 20 years in various capacities including clinical care, service development and management. Her clinical experience includes infertility, fertility control and unplanned pregnancy and she aims to bring a public health approach to her work.

Ms Carol Bennett

Carol is Senior Program Manager at beyondblue responsible for the National Perinatal Mental Health Program.

Carol has extensive senior management experience in the health sector including as CEO of a national peak body representing rural and remote workforce issues and EO of a Victorian State health peak body.

Prof Steve Birrell

Stephen Birrell trained in surgical oncology and molecular biology in Adelaide, the USA and UK. He is currently Head of the Breast Cancer Centres at Flinders Medical Centre and Burnside Hospital and Head of Breast Cancer translational research at the Dame Roma Mitchell Laboratories; Hanson Institute.

Ms Deborah Bush

Deborah co-founded the NZ Endometriosis Foundation Inc. in 1985 (now known as Endometriosis New Zealand) and is currently Chief Executive. She co-led the organisation

from a regional support group to a registered Charitable Trust.

She is a recognised authority on endometriosis and is on the International Endometriosis Zone Advisory Board and co-founded and Chairs APEA (Asia Pacific

Endometriosis Alliance). As well she holds independent educational / counselling consultations at private clinics in Christchurch, Auckland and Palmerston North. She has developed unique programmes advocating a multi-disciplinary holistic approach to the treatment and management of endometriosis promoting best practice treatment to ensure quality of life is maximised. The comprehensive Patient Partnering Programme available in some DHB's is one such programme. In 1997 she developed the adolescent educational programme in schools known as **me** (Menstrual Health and Endometriosis). Its success has prompted major changes directly addressing the unacceptable diagnostic delay of endometriosis and dramatically improving health outcomes for young women. **me** was a finalist in the 2007 NZ Health Innovation Awards. Her programmes have attracted interest worldwide. She is known as a dynamic presenter and has addressed audiences at the House of Commons in London and to congresses throughout the world. Deborah has a professional background in teaching and sales and marketing. She has successfully operated her own speech and voice training, drama and dance businesses. Endometriosis New Zealand was awarded the Commonwealth Award for Excellence in Women's Health in recognition of its success. In 2003, Deborah was awarded the Queen's Service Medal (QSM) for her contribution to women's health and in particular endometriosis. In 2007 she was awarded the Newmans Own Foundation Award for her work with adolescent endometriosis.

Presenters 25

Ms Tracey Cook

Tracey Cook was a registered nurse for a number of years before undertaking a career change to Naturopathy. She has over twenty years clinical experience in naturopathy and is registered with the National Herbalist Association of Australia and Australian Traditional Medicine Society. She specializes in herbal medicine and. She has spent the last ten years developing a multidisciplinary natural health clinic, herbal dispensary called Botanica Medica Herbal Centre where she regularly consults along with other complimentary therapists. Tracey has been involved in the Menopause Forum at the Flinders Medical Centre, menopause and breast cancer forum at the Royal Adelaide Hospital, Women's Health Workshop for the Women's Health Advisory Board . She has lectured in Australia, New Zealand and South Africa on Metabolic syndrome in which she has a special interest.

Ms Brigid Coombe

Brigid Coombe is the Director of the Pregnancy Advisory Centre (PAC), a government funded health service for South Australian women with unplanned pregnancy. The Centre has a multidisciplinary staff and provides information, counselling and first and second

trimester abortions.

Brigid's interest in sexual health and fertility control spans over two decades. She worked as a clinical nurse for Family Planning Associations in Darwin, Sydney and Adelaide and as a Community Health Nurse at Adelaide Women's Community Health Centre. Brigid commenced work as a Clinical Nurse at the PAC in 1994 and has been the Director since 2003.

Dr Allan Cyna

Dr Cyna is a Senior Consultant Anaesthetist at the Women's and Children's Hospital in Adelaide and Clinical Senior Lecturer at the University of Adelaide. He is a member of the Australian Society of Hypnosis and his PhD involves an investigation of Hypnosis Antenatal Training for Childbirth which has received funding from the Australian Society of Anaesthetists and the NH&MRC. He is a member of the Pregnancy Childbirth Review Group and Anaesthesia Review Group of the Cochrane Collaboration and is an Academic editor for PlosOne Medicine and an associate editor for the Australian Journal of Clinical and Experimental Hypnosis.

Ms Krystie Edwards

Krystie has been working at the Pregnancy Advisory Centre as a counsellor / social worker for over 3 years. Prior to this she worked for 7 years in women's community health services providing counselling and group work in the areas of violence, abuse and mental health.

She loves working with women around their reproductive health and is particularly interested in how histories that include violence and abuse impact on women's experience of and sense of control over reproduction.

Krystie is currently completing a Masters Degree in Social Work at Flinders University.

Presenters 26

Dr Susan Evans

Dr Susan Evans, is a gynaecologist and laparoscopic surgeon from Adelaide specialising in the management of endometriosis and pain.

She is author of the internationally published book for patients entitled 'Endometriosis

and Other Pelvic Pain' and co-founder of the Asia Pacific Endometriosis Alliance (APEA).

APEA draws together gynaecologists, scientists and educators to achieve a common goal of improved care for women with endometriosis throughout our region.

Dr Evans aims to achieve best possible outcomes by combining modern excisional surgery and a wide variety of adjuvant treatments, with lifestyle stress and dietary modification co-ordinated by a trained nurse counsellor.

Ms Maria Gardiner

Maria Gardiner is a clinical psychologist with many years' experience working with

doctors to improve their well-being and quality of work life. She is currently working with Hugh Kearns to implement one of the most comprehensive, evidence-based wellbeing programs for GP registrars in Australia. In addition she is also a published and respected researcher, holding an adjunct research associate position in the School of Psychology.

Dr Jennifer Goold

Dr Jennifer Goold is the GP Director of Continuing Professional Development for the SA

GP Obstetric Shared Care Program.

Dr Goold is a General Practitioner whose current focuses predominantly on antenatal care

and medical education in General Practice Dr Goold's qualifications include FRACGP, DRANZCOG Dip Clinical Education (NSW), MBBS.

Ms Andrea Hayward

Andrea Hayward is currently the Director of DNA QLD, a Brisbane based DNA paternity

testing clinic. She has a MSc(Hons) in Genetic Counselling which examined inherited male infertility and is currently researching her PhD on the "Experiences, and expectations of women accessing ART for age-related infertility", drawing from experiences as the Semen Cryobiologist at an IVF clinic.

Ms Sara Holton

Sara is currently undertaking her PhD entitled 'To Have or Not to Have? A Study of Australian Women's Childbearing Decisions' at the Key Centre for Women's Health in Society at the University of Melbourne. Her PhD research project is investigating the contribution of psychosocial and health factors to women's decisions to have or not have

children. Sara has a Master's Degree in Gender Studies from the University of Melbourne,

and has worked in the area of equal employment opportunity.

Ms Gillian Homan

For the past 14 years Gillian Homan has been employed at Repromed Adelaide as a Fertility Nurse Specialist. She has combined clinical and research work, completed a Masters degree and published three papers as the primary author.

Mr Hugh Kearns

Hugh Kearns is best known as a dynamic speaker, presenter and educator with international expertise in the areas of time management and work-life balance. He is Head of Staff Development and a Lecturer in the School of Psychiatry at Flinders University. Hugh consults to a large number of doctors' organisations and universities

across Australia and the United Kingdom. Along with Maria Gardiner he is a director of

ThinkWell, an evidence-based self-management consultancy (ithinkwell.com.au)

Presenters 27

Dr Maggie Kirkman

Dr Maggie Kirkman is a psychologist with extensive experience in qualitative research,

including narrative methods and discourse analysis, used particularly in psychosocial aspects of women's reproductive lives and sensitive topics such as abortion, infertility,

teenage pregnancy, donor-assisted conception, and parent-adolescent communication about sexuality. She also has experience in quantitative methods, and coordinates and teaches the graduate subject *Research Methodology in Women's Health* at the Key Centre for Women's Health in Society, The University of Melbourne, where she is director of the current research program on women's experience of unplanned pregnancy and abortion. Maggie's most recent book is *Telling it Your Way: A Guide for Parents of Donor-Conceived Adolescents* (with Doreen Rosenthal & Louise Johnson). She is co-editor, with Jane Fisher, of a special issue of *Women's Studies International Forum*, "Women and technologies of reproduction," to be published later this year.

Prof Alastair MacLennan

Alastair MacLennan is Professor and Head of the University of Adelaide Discipline of Obstetrics and Gynaecology, School of Paediatrics and Reproductive Health. He is a Life Member of ASPOG. Among his many interests in reproduction he researches on the genetic and infective causes of cerebral palsy and the impact that inappropriate litigation in this area is having on obstetric practice and maternity services. He has chaired two International Consensus Conferences on Cerebral Palsy and is Head of the Australian Cerebral Palsy Research Group.

Dr Michael McEvoy

Dr Michael McEvoy, obstetrician and gynaecologist in private practice at North Adelaide and visiting medical specialist to Women's and Children's Hospital with an interest in Pelvic Floor Repair, Colposcopy and Medicolegal matters. A member of the board of examiners, expert witness panel and medicolegal committee of RANZCOG and a director of the Australian Gynecological Endoscopists Society (AGES). Passionate gardener, photographer and father of 4 children.

Dr Helen Roxburgh

Dr Helen Roxburgh is the GP Director of the SA GP Obstetric Shared Care Program. Dr Roxburgh works as a General Practitioner in Belair, South Australia, and has special interests in Women's Health, Counselling and Nutrition. Dr Roxburgh's qualifications include BMBS (Flinders), DRANZCOG, BSC (Sydney), Dip Nut&Diet (Syd) and FRACGP.

Dr Caroline Smith

Caroline's research interests lie with exploring and evaluating the effects of acupuncture in relation to enhancing fertility, and women's health. Her research activities include documenting the benefits of acupuncture and other complementary health treatments (CAM) for selected health conditions from an evidence based perspective, examining the mechanisms underlying successful treatments, documenting the use of CAM and increasing our understanding the social, cultural and economic factors relating to the use of CAM. She has held a number of competitive national grants as well as many

competitive local grants. She has published widely in peer reviewed journals and is an author of seven Cochrane systematic reviews.

Dr Graeme Suthers

Graeme Suthers trained in clinical and laboratory genetics in Sydney, Adelaide, and Oxford. He is Deputy Head of the South Australian Clinical Genetics Service, program director of the State's Familial Cancer Service, and a consultant genetic pathologist.

He is currently a member of a variety of local and national professional committees. His main professional and research interests involve making current research knowledge useful for families and simplifying the management of genetic data for both clinical and laboratory services.