RACGP

Royal Australian College *of* General Practitioners

RACGP comments on Pregnancy Care Guidelines – Stage II Review topics

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The RACGP welcomes the opportunity to comment on the Department of Health's *Pregnancy Care Guidelines – Stage II Review topics*. The RACGP provides general and specific comments on the review topics and research questions.

General comments

A large number of research questions are proposed, covering some very complex topics. Most of the questions and topics covered are appropriate, detailed and comprehensive. The RACGP agrees it is important to investigate harms not just potential benefits of proposed screening tests.

The Obstetric Clinical Committee of the MBS review taskforce has recently looked at several topics to be considered in these guidelines. For example, the group has recently prepared a report on imaging in pregnancy as part of the MBS review. It is essential that the two groups work together to ensure consistency in areas of overlap.

Comments on individual topics

Aboriginal and Torres Strait Islanders and culturally and linguistically diverse (CALD) groups

Most of the topics pose the question about additional considerations for Aboriginal and Torres Strait Islanders and for CALD groups. This is particularly relevant when considering the biological effects of body mass index.[1] Another example is dark skinned women and veiled women may have specific issues with vitamin D deficiency.

Weight and body mass index

Additional attention needs to be paid to women who have undergone bariatric surgery. Advice should be provided on how soon after surgery it is safe to plan a pregnancy. Specific guidance for these women would then include how weight gain and a higher requirement for multivitamins should be managed during pregnancy.

Suggested research questions related to bariatric surgery:

Weight and BMI

1. What specific risk assessments are required for pregnant women who have had bariatric surgery?
2. What lifestyle interventions are effective in preventing weight gain for pregnant women who have had bariatric surgery?
3. What are the additional needs of women who have had bariatric surgery?
4. What complications are associated with women who have had bariatric surgery?

Specific weight management advice

1. What physical activities are safe and effective for pregnant women who have had bariatric surgery?
2. What dietary advice should be provided to women who have had bariatric surgery?
3. What are the harms and benefits of bariatric and/or normal prenatal vitamin and mineral supplementation in pregnancy for women who have had bariatric surgery?

Sexually transmitted diseases

Syphilis

A new research question will compare the harms and benefits of routine testing to targeted/no testing for syphilis (Question 2). It is important to note that current guidelines do recommend all pregnant women should be screened for syphilis as part of the routine antenatal screening process.[2]

Routine testing for chlamydia

There is currently no uniformity for routine testing for chlamydia in pregnancy across the healthcare sector. Question 1 in the chlamydia section may be able to address this. A urine sample is usually sufficient for the test. The polymerase chain reaction (PCR) test to detect chlamydia in urine is accurate and extremely sensitive, simple for women to undertake, is non-invasive and does not take up valuable consultation time. Speculum insertion, visualising the cervix and taking a swab from the endocervical canal in asymptomatic women is unnecessary.

If cervical screening is being undertaken at the visit, the new liquid based medium test allows for detection of oncogenic human papillomavirus (HPV), genotype and reflex cytology if indicated and chlamydia. Preparation of a separate sample (such as an endocervical swab to detect chlamydia) is not required.

Chlamydia - cost effectiveness considerations

From an Australian healthcare perspective, chlamydia screening of pregnant women aged 16–25 years has been demonstrated to be cost-effective compared with no or selective screening.[3] The RACGP suggests cost effectiveness should be included in the questions on chlamydia.

Suggested research questions for cost effectiveness

1. What are the costs, harms and benefits of testing for chlamydia among pregnant women in remote communities?
2. What are the costs, harms and benefits of routine testing for chlamydia in pregnancy compared to targeted/no testing?

Follow up care for chlamydia

Follow-up care is an important part of the process after STI screens have been conducted. This should include:

- documenting the woman's preferred contact for follow up and ensuring the woman understands the method of follow up.
- ensuring a sexual history has been undertaken when screening for Chlamydia
- briefly discussing confidentiality and providing reassurance that a woman's privacy is extremely important
- considering a mechanism for partner notification
- practitioners being aware of and meeting notification requirements (this will vary in different states and territories)
- use of patient delivered partner therapy (PDPT) for the treatment of Chlamydia (legislation supporting PDPT varies across states and territories)
- ensuring any prescribed treatment is safe for use in pregnancy

Suggested research question for follow-up care

1. What follow-up processes should be in place after STI screening?

Anaemia

Anaemia is a very complex topic. The World Health Organisation is currently updating its anaemia guidelines (including anaemia in pregnancy) and has a 4 year time frame. The EWG should carefully consider how reference intervals are set and anaemia is defined in pregnancy.

Suggested research question

1. What reference intervals define anaemia in pregnancy?

Diabetes

The questions are currently not ordered in a way that logically guides a response and meaningful outcomes. Asking questions through a more structured process would be beneficial.

Diagnostic threshold for gestational diabetes

The Guidelines International Network (G-I-N) has recently published a paper proposing a checklist for modifying disease definitions. It provides guidance on issues that should be considered when determining a threshold for a disease.[4] Specifically, the paper describes how the definition of gestational diabetes mellitus was used to determine the requirements of the checklist for modifying definitions of disease. This paper and the process undertaken by (G-I-N) demonstrates the complexity of some of the questions the EWG are seeking to answer regarding gestational diabetes. For example, the threshold for gestational diabetes cannot be determined by asking about the diagnostic accuracy of testing. A review of this paper may provide further guidance to the EWG.

Hyperglycaemia

Defining 'hyperglycaemia in pregnancy' will eliminate the necessity to ask the generic question. *'Who should be screened for hyperglycaemia in pregnancy?'* (Question 1). Hyperglycaemia in pregnancy should be defined by answering the proposed questions below.

Research questions

1. Which screening/diagnostic regimen is optimal for maternal and infant outcomes (existing question 8)?
2. What are the diagnostic accuracy of commonly used screening and diagnostic test for gestational diabetes (existing question 6)?
3. What thresholds should be used to diagnose type 2 diabetes in pregnant women – less than 20 weeks and more than 20 weeks and in which populations (amendment to existing Question 3)?

The belief of a linear relationship between an above 'normal' glycaemia cut-off and adverse outcomes in pregnancy is weighted heavily by 1-2 studies with low to moderate levels of evidence. It is of concern this has driven the consensus of gestational diabetes diagnosis by the Australian Diabetes in Pregnancy Society.

Many of the research questions presented here are addressed in the NICE Diabetes in pregnancy guidelines, which use the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) assessment of the evidence and provide in depth review.[5]

Cervical screening

Routine antenatal care should include a review of the woman's cervical screening history.

With regards to Questions 2 and 3, a woman can be safely screened at any time during pregnancy. It is important for women who are due or overdue for cervical screening to be screened.[6] Furthermore; cervical screening in pregnancy is safe provided the correct instruments are used. However, self-collection for HPV testing is not recommended for pregnant women.

With reference to Question 6, pregnant women who test positive for HPV (16/18) should be referred to a colposcopist experienced in performing this assessment in pregnancy. This should not be deferred to the postpartum period as any presence of invasive cancer can be excluded and the woman will be reassured their pregnancy will not be affected by the presence of an abnormal cervical screening test result. Management recommendations for pregnant women who have a positive oncogenic HPV test result are the same as for the non-pregnant woman.

More information on cervical screening for pregnant women is available at the Cervical Cancer Screening section hosted on the Cancer Council Australia website.[6]

Antenatal pathology testing

One additional topic for review might be the development of an Australian antenatal pathology testing set. Testing sets are one of the mechanisms proposed in the MBS review to ensure high value use of pathology. There is the potential to reduce over-testing, and reduce under-testing while achieving efficiency savings for pathology providers and making life easier for physicians.

References

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