AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

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PERINATAL & MATERNAL MORTALITY IN 2011

The Perinatal and Maternal Mortality Review Committee (PMMRC) recently released its report on perinatal and maternal mortality in New Zealand for the year 2011. This is the committee's seventh PMMR report. This year the report was able to analyse and report on six years of data for the period 2006 – 2011.

Maternal mortality in 2011
There were two direct maternal deaths, five indirect maternal deaths and one unclassifiable death in 2011. A direct maternal death is one that is the result of obstetric complications during pregnancy, birth and up to 42 days postpartum, and from interventions, omissions or incorrect treatment. An indirect maternal death is one that is the result of a pre-existing disease or a disease that developed during pregnancy that was not due to obstetric causes, but was aggravated by the physiologic effects of pregnancy.

The causes of the two direct maternal deaths were sepsis and venous thrombo-embolism.

The five indirect deaths included one suicide, and four mothers with pre-existing medical conditions.

Six years of data
The 65 direct and indirect maternal deaths from 2006-2011 included:

- 24 antepartum and 41 postpartum
- 42 occurred in hospital and 23 in the community
- 45 births and 20 undelivered babies
- 23 with potentially avoidable factors present, 39 with none and three were unknown.

Potentially avoidable deaths
The report notes that in the six years from 2006-2011 the MMR working group believed that 35% of maternal deaths were potentially avoidable. The factors relating to the potentially avoidable deaths involved 21 cases relating to organisational and/or management factors, 21 relating to personnel, one relating to technology and equipment, three relating to geography (long distance transfers) and 26 relating to barriers to access/ engagement with care. The barriers to access included five women with maternal mental illness, two with language barriers, one with a cultural barrier and one woman who was not eligible for publicly-funded health care. Substance abuse featured in four potentially avoidable maternal deaths, family violence in four, and a lack of recognition of the complexity or seriousness of the condition in 10 cases.

Deprivation
Maori and Pacific mothers had a higher maternal mortality ratio when compared to New Zealand European mothers, which mirrors the statistically significant trend of an increasing maternal mortality ratio with increasing deprivation.

The report states that "Although the absolute numbers are small, pre-existing medical conditions, suicide and amniotic fluid embolism continue to be the leading causes of maternal mortality in New Zealand."

Maternal morbidity
Two years of surveillance (2010-2011) of severe maternal morbidity reveal

that the rate of eclampsia is 2 per 10,000 maternities, the rate of placenta accreta is 3.9 per 10,000 maternities, and the rate of peripartum hysterectomy is 4.5 per 10,000 maternities. The latter two are a direct result of the rising rate of caesarean sections.

Recommendations

This year's report includes just two recommendations relating to maternal mortality. They are:

- In maternal deaths, where a coroner declines jurisdiction, post-mortem should be offered as part of a full investigation of cause of death.
- Women with pre-existing medical conditions (such as epilepsy, hypertension or mental health) should have individualised pre-conceptual counselling about their condition and the medication they are taking. Health professionals providing care to these women need to communicate the importance of continuing their medication in pregnancy, if appropriate, and to advise women to seek early medical review.

Maternal Mental Health

Previous PMMRC reports have also made recommendations on maternal mental health including the integration of maternal mental health services into maternity services, and confirmed the need for mother and baby units in the North Island, two initiatives that the AWHC has supported and lobbied for since the mid 1990s.

Perinatal mortality

In 2011 there were 665 perinatal related deaths – perinatal mortality being foetal or early neonatal deaths after 20 weeks gestation and up to 7 days after the birth. The report notes that the total perinatal related mortality rate has not changed significantly since 2007 using the New Zealand definition.

The rates of both full term intrapartum death and hypoxic peripartum death decreased significantly from 2007 to 2011.

However, there has been a significant increase in perinatal related mortality among babies born in multiple pregnancies from 2007 to 2011.

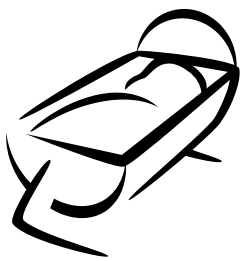
Some other key points in the report:

- Maori and Pacific mothers were significantly more likely to have potentially avoidable perinatal related deaths than NZ European mothers.
- There is a significant increase in potentially avoidable perinatal related death with increasing socioeconomic deprivation.
- The rate of late termination of pregnancy has increased in the last two years with 35 terminations performed after 24 weeks gestation.

Recommendations

The report also has a number of recommendations relating to the audit of congenital abnormalities, relating to reducing perinatal related mortality associated with multiple pregnancy, as well as that associated with neonatal encephalopathy.

The PMMRC report can be found at:
http://www.hqsc.govt.nz/publications-and-resources/publication/958/



Taking Back Our Breast Cancer Genes

On 13th June 2013 the US Supreme Court made a unanimous ruling that human genes cannot be patented, thus striking down patents held by the Utah biotechnology company, Myriad Genetics Inc on BRCA1 and BRCA2, the two genes linked to a higher risk of breast and ovarian cancer.

The ruling effectively ended the monopoly held by Myriad Genetics for almost two decades after the company discovered the precise location and sequence of the two genes. The ruling stated "we hold that a naturally occurring DNA segment is a product of nature and not patent eligible merely because it has been isolated." The court said that laws of nature, natural phenomena and abstract ideas lay outside patent protection.

However, it was not all bad news for Myriad Genetics and the rest of the biotechnology industry, as Justice Thomas also ruled that synthetic genetic material, referred to as cDNA (complementary DNA), could be patented. A cDNA is something that is created in the laboratory, as opposed to being a DNA sequence that occurs in nature.

Some bio-technology industry officials and patent lawyers were reported as saying that the decision should have little effect on the pharmaceutical industry and on developers of genetically engineered crops. (1)

Others were more cautious, referring to it as a "compromise decision." Dr Penny Gilbert, a partner at a UK law firm and an expert in life sciences was reported as saying "I'm not convinced it will have a major impact. It is hard to assess," and pointed out that shares in Myriad Genetics went up after the ruling. (2)

The ruling can be seen as a great decision for patients and their families as it allows other companies to develop alternative genetic tests, including the BRCA tests. As noted in the May issue of the AWHC newsletter, once the BRCA genes were discovered, Yale University developed its own genetic test which was superior and much cheaper than that offered by Myriad. Myriad then began ruthlessly enforcing all rights associated with the BRCA genes. The Supreme Court's decision refers to the University of Pennsylvania's Genetic Diagnostic Laboratory (GDL) which was also forced to stop testing after Myriad sent letters to them asserting that the genetic testing infringed Myriad's patents.

The Yale Cancer Genetic Counselling website features a blog entitled "US Supreme Court Liberates Breast Cancer Gene" by genetic law expert Lori Andrews. (3) She states that the decision is well-founded in law, and great news for patients, doctors, and scientific researchers. "Some biotechnology companies might grumble about the decision, but the decision will actually stimulate innovation by pharmaceutical companies and the new generation of biotech companies."

In her blog Lori Andrews also explains why she believes the decision is important in re-establishing the trust of research subjects:
"In addition to the negative impact that gene patents had on access to and the quality of genetic testing, the

possibility of patenting genes caused some physicians and university researchers to view patients as treasure troves. Doctors, health care institutions, researchers and hospitals have gone to court to gain ownership of patients' cell lines, tissue, and genes in order to commercialize them, even over patients' objections. Genetic research was undertaken on people without their consent as researchers prospected for genes. This deterred many people from participating in genetic research altogether." (3)

She also believes that the decision is good for international relations, pointing out that the USA had been an outlier. "In Europe, Asia, and elsewhere, there's a research exemption in patent law, which doesn't exist in the United States. Prior to the Myriad decision, US researchers were not able to explore genes that could readily be explored in other countries. Now they can."

"Paying Myriad nearly $4,000 for each look at your breast cancer genes was like having to pay a car thief for the right to drive your own car," she wrote.

References

1. http://www.nytimes.com/2013/06/14/business/after-dna-patent-ruling-availability-of-genetic-tests-could-broaden.html?pagewanted=all&_r=0
2. http://www.guardian.co.uk/law/2013/jun/13/supreme-court-genes-patent-dna
3. http://blogs.kentlaw.iit.edu/islat/2013/06/13/u-s-supreme-court-liberates-breast-cancer-gene/

6th Biennial Joan Donley Midwifery Research Forum

19 – 20 September 2013

Rydges Lakeland Resort Queenstown

The theme of this year's Forum is "*Using the right evidence to inform midwifery practice: Does choosing the right methodology have a part to play*?"

Presenters include:

Liz Smythe and Judith McAra-Couper discussing "The nature of 'right' evidence."

Suzanne Miller on "Homebirth outcomes with LMCs 2006-2010."

Rae Daellenbach, Jacqui Anderson and Mary Kensington on "Using the right methodology to inform midwifery practice" Do ethics have a part to play?"

Billie Bradford on "Women's perception of fetal movements."

Andrea Gilkison, Marion Hunter and Joanne Houston explore what sustains LMC midwives in practice in New Zealand.

Sally Pairman on the "Retention of new graduate midwives in New Zealand."

For more information see website: http://www.midwife.org.nz/research/joan-donley-midwifery-research-collaboration/the-jdmrc-forum/

A MOTHER AND BABY UNIT FOR AUCKLAND

Hidden in the inaccessible depths of the May Budget was a line announcing that there was an extra $18.2 million of funding over four years for new dedicated acute inpatient beds for new mothers experiencing postnatal depression and other mental illness in the greater Auckland region, and new specialist community services around the North Island. These services are expected to help around 650 mothers and their babies a year. Apparently this was as much of a surprise to the Auckland District Health Board as it was to women's health groups who have been advocating for this for the past two decades.

In a press release dated 27 May 2013 Health Minister Tony Ryall said: "The Government has taken on board expert advice. This recommends that supporting mothers and babies together at this critical early stage not only has an immediate positive impact upon their mental health and well being, but also helps prevent potential future mental health issues for the baby.

Currently new mothers with severe mental illness are often treated and supported in adult acute mental health units separated from their babies and families. Mothers will now get the support of the new specialised maternal mental health services with their babies beside them." (1)

Unfortunately, it seems that the new dedicated acute in-patient beds will probably be located at Auckland hospital, with an additional 10 – 14 community residential beds, mostly in the Auckland area. The AWHC along with the Maternity Services Consumer Council, the Postnatal Distress Support Network, the Postnatal Psychosis Support Group, and other community groups have lobbied hard for a mother and baby unit for over 15 years. Meetings were held, we wrote numerous letters to the Minister/ Ministry of Health and various other health agencies about the need for such a facility, as well as other respite care facilities. We wanted a separate unit in the community, where the focus is on the mother and her baby, and where the mother is provided with mental health services in the context of the maternity care she and her baby are receiving, and not the other way round.

In his press release Tony Ryall says he expects that these services will start providing the help that is needed in 2014 with full capacity in 2015.

It is to be hoped that the DHBs will involve the maternal mental health groups that have worked so hard and, until now, so fruitlessly to bring the vision into reality. Given our long term investment in this endeavour we will be writing to the DHBs and inviting ourselves to their planning meetings.

Reference:

http://www.beehive.govt.nz/release/budget-2013-18-million-extra-help-mothers-post-natal-depression

BREAST IMPLANTS AND BREAST CANCER

In April 2013 the *British Medical Journal* published a meta-analysis of the effects of cosmetic breast implants on the diagnosis of breast cancer. The systematic review found that women with breast implants are diagnosed with later stage tumours. The authors said their results "should be interpreted with caution, considering the current gaps and limitations in the available literature." (1)

There are a number of explanations for this finding. The first is that both silicone and saline implants create radio-opaque shadows on mammograms, which interferes with the ability to see all the breast tissue. The amount of tissue obscured is known to be between 22% and 83%.

There is also the problem of not being able to adequately compress the breast which makes reading the mammogram difficult. Also contracture of the breast implant which develops in about 15-20% of women with implants reduces mammographic sensitivity by 30 – 50%.

The authors conclude that the accumulating evidence suggests that women with cosmetic breast implants who develop breast cancer have an increased risk of being diagnosed as having non-localised breast tumours more frequently than do women with breast cancer who do not have implants. Moreover, current evidence also suggests that cosmetic breast implants adversely affect breast cancer specific survival following the diagnosis of such disease."

http://www.bmj.com/content/346/bmj.f2399.pdf%2Bhtml

AWHC GENERAL MEETING 13 June 2013

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- Grant applications
- NSU consultation meeting
- ACART submission
- Cartwright anniversary event
- Ethics committee meetings

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.

AWHC NEWSLETTER SUBSCRIPTION

The newsletter of the Auckland Women's Health Council is published monthly.

COST: $30 waged/affiliated group
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UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for July 2013:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 3 July 2013 and will be followed by the DHB Full Board meeting which starts at 1.30pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 24 July 2013.

Auckland DHB (Website address: www.adhb.govt.nz)
The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 26 June 2013 followed by the Full Board meeting at 2pm. Both meetings will be held at the A+ Trust Room in the Clinical Education Centre at Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)
The Counties Manukau DHB Full Board meeting will be held at 1pm on Wednesday 3 July 2013 at 19 Lambie Drive, Manukau City.

The Hospital Advisory Committee meeting will be held at 9am on Tuesday 23 July 2013 and will be followed by the Community & Public Health Advisory Committee meeting at 1pm at 19 Lambie Drive, Manukau.

ETHICS COMMITTEE meetings – dates for the four new ethics committees are at:
http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes

Preventing Overdiagnosis Conference

Winding back the harms of too much medicine

10th – 12th September 2013 in Hanover, New Hampshire, USA

This conference is being hosted by The Dartmouth Institute for Health Policy and Clinical Practice in partnership with one of the world's most respected medical journals, the *British Medical Journal*, the leading New York based consumer organisation Consumer Reports and Bond University.

Further information is available at http://www.preventingoverdiagnosis.net/