AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

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PO Box 99-614, Newmarket, Auckland. Ph (09) 520-5175
Email: awhc@womenshealthcouncil.org.nz
Website: www.womenshealthcouncil.org.nz

MULTI-CENTRE STUDY OF YOUNG WOMEN WITH CIN 2.

An informative and somewhat controversial presentation by Peter Sykes at the National Women's Annual Clinical Report day on 8 August described a multicentre study at National Women's, Middlemore, Hawkes Bay, Nelson, and Melbourne's Royal Women's hospitals on young women diagnosed with CIN 2 – cervical intraepithelial neoplasia. CIN 2 is defined as the presence of moderately abnormal and potentially premalignant cells on the surface of the cervix.

Cervical Intraepithelial Neoplasia
Although a cervical smear test may reveal the presence of abnormal cells a biopsy is needed to confirm the cervical smear test result. Sometimes the biopsy reveals that the cell changes are less severe or more severe than smear test result.

Traditionally the CIN result has been divided into three grades with CIN 1 meaning there are mildly abnormal cells, CIN 2 meaning there are moderately abnormal cells, and CIN 3 meaning there are severely abnormal cells. None of these is cancer.

The majority of cases of CIN will regress spontaneously. If left untreated about 70% of CIN 1 will regress within one year, and 90% will regress within two years. About 50% of CIN 2 will regress within 2 years without treatment. The progression of CIN 3 to cancer typically takes 15 (between 3 and 40) years.

The case for regression
It is accepted practice to allow cases of CIN 1 to regress without intervention or treatment, especially in young women. A similar case can be made for CIN 2, as CIN 2 is also known to regress, it is frequently diagnosed in young women, and it is recognised that repeated treatment harms the cervix and is associated with an increase in preterm birth (including extremely spontaneous preterm birth, very preterm and moderately preterm) when women subsequently become pregnant. The data also shows there is a very low risk of cancer in women under the age of 25.

Dr Sykes' study aims to document the safety of follow-up of CIN 2 in young women under the age of 25; to identify the rate of regression of CIN 2 in this group of women; and to identify predictors of regression and progression of CIN 2 in these women.

Safety measures
A number of safety measures have been put in place to ensure the safety of the women in the study. They include obtaining fully informed consent from the women, exclusion criteria, a multidisciplinary review, the taking of more than one biopsy, obtaining two addresses so that women are not lost to follow-up, a careful follow-up process, monitoring of the study, and rules around stopping the study.

A controversial study
Dr Sykes revealed that this study was a somewhat controversial one which has a tendency to polarise people. Of course, including a slide in his powerpoint presentation that featured the front cover of the June 1987 issue of *Metro* magazine with the "An Unfortunate Experiment at National Women's Hospital" article by Sandra Coney and Phillida Bunkle at the National Women's Annual Clinical

Report day was likely to cause a bit of a stir. It is difficult to know whether Dr Sykes was being deliberately provocative or not, but there were a few passionate and predictable responses from the audience during question time.

Dr Sykes described how on one side of the debate were those who considered this an important piece of research, who would happily invite their patients to enrol in it, who believed that the treatment of CIN 2 in a 22-year-old woman was criminal, and thought that CIN 2 should be considered a low grade abnormality.

On the other side were those who thought this was an ill-conceived study that posed a risk to patients, who stated that CIN 2 does not exist and CIN 2/3 should be considered as one entity, who believed the diagnosis was non reproducible, it was too much work and it would be stressful for women.

After outlining the case for large multicentre prospective studies prior to the incorporation of conservative management into common practice, Peter Sykes concluded his address by saying that in his opinion:

- Many young women with CIN 2 will undergo spontaneous regression
- There is a political risk to non screening in those under 25 years
- Gardasil vaccination rates are too low to have a major impact
- Currently conservative management of CIN 2 cannot be considered standard treatment
- Those wishing to offer conservative management should enrol patients in this study.

As soon as Dr Sykes had finished his presentation, Dr Tony Baird, an obstetrician and gynaecologist who worked at NWH prior to, during and since the Cartwright Inquiry, rushed to the front of the lecture theatre and claimed there was a mistake in the presentation. He insisted that there had been no “unfortunate experiment” at the hospital, the phrase was a sensationalist one used by the media, and the study described by Dr Sykes was exactly what Herbert Green had been doing all along. His views on the Cartwright Inquiry drew a burst of applause from some members of the audience who either agreed with what he was saying, or were merely trying to egg him on. It was hard to tell.

As co-ordinator of the Auckland Women’s Health Council I responded immediately to Dr Baird’s outrageous claims and pointed out that there had been a number of papers published over the past decade that revealed the terrible outcomes for the women who were unknowingly part of Dr Green’s experiment, and that Cartwright Inquiry documents were now available on a new website.

Unfortunately, this is not the first time that Dr Baird has used the NWH Annual Clinical Report day to push his views on the integrity of the Cartwright Inquiry. In August 2009 at the end of the presentations he waved a copy of the latest *Listener* and told the audience that they must all go and buy a copy as the truth about the Cartwright Inquiry had finally been revealed – it was indeed a scam. Dr Baird obviously identifies with the final slide in Dr Sykes’ presentation:

“***NEVER GIVE UP. EVER.***”

2011 ANNUAL REPORT FROM NATIONAL WOMEN'S

National Women's released its Annual Clinical Report for 2011 in August 2012. The report is the 19th in the current series.

The 250-page report contains a wealth of statistical information on the 7493 women who gave birth at NWH in 2011 and the 7657 babies they gave birth to, plus the 33 women who gave birth before they actually got to the delivery unit. In 2011 there were 159 sets of twins (149 in 2010) and 4 sets of triplets (4 sets in 2010).

Normal births

The intervention rates have remained much the same over the past few years. In 2011 55.6% (4183 out of 7493 birthing mothers) had what the report refers to as a "spontaneous vertex birth," and 0.8% (60 birthing mothers) had a vaginal breech birth.

Only 46.7% of first-time mothers had a spontaneous vertex birth compared to 45.2% in 2010.

Induction of labour

More than one in three first time mothers – over 38.5% – had an induction of labour in 2011. The rate for multiparous mothers was 35%.

The report notes that diabetes was the most frequent reason for induction of labour in 2011. In previous years the most frequent causes have been term PROM (premature rupture of membranes) and post dates pregnancy. When post dates was the primary indication for induction, 10% occurred prior to 41 weeks and 21.5% occurred at or beyond 42 weeks."

The establishment of "the **post** dates virtual clinic at the end of 2011 has meant that referrals for postdates induction of labour prior to 41 weeks will not be accepted in women meeting the criteria for a normal birth pathway."

32.5% caesarean section rate

In 2011 the caesarean section rate was 32.5%, compared to 32.3% in 2010, and 20.8% in 1995 and 1996. There was little difference between the caesarean section rate for first-time mothers (34.5%, compared to 33.5% in 2010) and for mothers having subsequent births (30.8%, compared to 31.2% in 2010).

The elective caesarean rate is highest among women attending a private obstetrician (37%) and lowest among independent midwives (7%). European women are twice as likely to have an elective caesarean section as women of other ethnicities.

Forceps and Ventouse

The rate of forceps and ventouse deliveries (combined under the term "instrumental vaginal birth") decreased in 2011. It was 11% of all births and the report notes that it had not been below 12% since 1997.

Some mothers are subjected to more than one instrument – forceps and ventouse, or different types of forceps, and to the birth of a baby by caesarean section after an attempted vaginal instrumental birth. In 2011 34 mothers had a double instrumental birth, and 67 mothers had an attempted vaginal instrumental birth prior to emergency caesarean section compared to 47 in 2010. The report notes that these figures are very concerning due to the significantly increased maternal and neonatal

morbidity associated with double instrumental delivery and with emergency caesarean following a failed attempt at an instrumental delivery.

Epidurals

The epidural rate among labouring women was 60.8% in 2011. For first-time mothers it was 83% if labour was induced and 55.8% if labouring spontaneously. For multipara it was 53.2% if labour was induced and 27.4% if labouring spontaneously.

The use of epidurals is highest in first-time European women (76.2%) who are over the age of 40 (87.2%), with a private obstetrician (85.2%).

Breech birth

Of the 314 singleton babies presenting as a breech, 268 were delivered by caesarean section. Among the 35 breech births at 32-36 weeks the percentage of caesarean deliveries was 81%, despite there being no evidence to support such a practice. For the 213 breech births at 37 weeks and over the percentage of caesarean sections was 97%.

As in previous years the report again acknowledges that the findings of the Hannah Term Breech Trial has had a major effect on clinical practice and resulted in a dramatic increase in the number of caesarean sections performed for breech births, despite the flawed methodology of this trial.

Both the Royal Australia and New Zealand College of Obstetrics and Gynaecology and the Royal College of Obstetrics and Gynaecology have added a statement to their guidelines on breech births to the effect that women should be treated as individuals and that a vaginal birth can be safe. The NWH guideline on mode of birth for breech presentation will be updated in 2012.

Postpartum Haemorrhage

The postpartum haemorrhage (PPH) rate continues to rise and it remains a cause for considerable concern. It is associated with the increasing caesarean section rate. The overall primary PPH rate (500mls and over) was 35.5%. It was 16% for spontaneous vaginal birth to 78.7% for emergency caesarean section and 64.1% for elective caesarean section. It also varied by onset of birth, from 24.8% in spontaneous onset to 34% in induced labour.

Postpartum Hysterectomy

In 2011 twelve women had an emergency postpartum hysterectomy compared to seven in 2010. Hysterectomies following birth are usually associated with repeat caesarean sections.

Maternal Mortality

There were two maternal deaths in 2011. Details of these deaths were sent to the Perinatal and Maternal Mortality Review Committee (PMMRC).

Breastfeeding

In 2011 81% of mothers were discharged from National Women's exclusively breastfeeding their babies.

- A copy of the 2011 Annual Clinical Report is available at: http://nationalwomenshealth.adhb.govt.nz/health-professionals/annual-clinical-report/annual-clinical-report-past-presentations

WHY DES STILL MATTERS

Professor Charlotte Paul was one of the speakers at the Breast Cancer Network's July seminar on "Breast Cancer and Environmental Risks." Her topic was diethyl stilboestrol (DES), a drug prescribed for pregnant women from the 1940s to 1960s and whose effects on the children and grandchildren of the women who took the drug are still being felt today.

DES is a synthetic form of oestrogen that was prescribed to pregnant women between 1940 and 1971 to prevent miscarriage, premature labour and various other related complications of pregnancy.

In the early 1950s, a clinical trial at the University of Chicago assessed pregnancy outcomes in women who were assigned to either receive or not receive DES. The study showed no benefit of taking DES during pregnancy, and that adverse pregnancy outcomes were not reduced in the women who were given DES. By the late 1960s, six of seven leading textbooks of obstetrics said DES was ineffective at preventing miscarriage.

Between 1966 and 1970 seven young women were treated at the Vincent Memorial Hospital in Boston, for a very rare condition – clear cell adenocarcinoma of the vagina. A chance encounter between two doctors in a lift and a remark by one of the mothers of the seven girls resulted in doctors making the link between the relatively high incidence of this very rare cancer and the drug DES. One of the mothers mentioned to the doctor that she had been prescribed DES during her pregnancy and inquiries revealed that several other mothers had also taken the drug. The link was confirmed by a case-controlled study, and in 1971 a report was published in the *New England Journal of Medicine* which showed a probable link between DES and vaginal clear cell adenocarcinoma in girls and young women who had been exposed to DES in the womb.

DES daughters

As well as an increased risk of clear cell adenocarcinoma of the vagina and cervix, studies have shown that women exposed to DES in the womb may also have fertility problems, an increased risk of premature birth, miscarriage and ectopic pregnancy, as well as an increased risk of breast cancer.

The mothers who were prescribed DES have also been shown to have an increased risk of breast cancer.

DES sons

The sons of mothers who used DES during pregnancy have an increased risk of testicular abnormalities, including undescended testicles.

DES grandchildren

Ongoing research into the long-term impact of DES suggests that adverse effects are also showing up in the grandchildren of pregnant women who were prescribed DES through epigenetic effects, meaning there has been a change in how the gene is expressed without the DNA sequence of the gene being altered.

DES use in New Zealand

In New Zealand about 1000 pregnant women were prescribed DES mainly in the 1940s and 1950s, although the drug was used well into the 1960s. In the 1980s Professor Paul and her colleagues investigated the use of

DES in New Zealand and found that 650 women were known to have been prescribed the drug. However, due to major problems with undertaking long-term follow-up research, including the issue of NZ medical records only being required to be kept for 10 years and records not being reliable enough to determine the risks, Professor Paul believes that the 650 women may be just the top of the iceberg.

Endocrine-disrupting chemical

DES is now known to be an endocrine-disrupting chemical, and one of a number of substances that interfere with the endocrine system to cause cancer, birth defects, and other developmental abnormalities. The effects of endocrine-disrupting chemicals are most severe when exposure occurs during foetal development.

Professor Paul pointed out that DES is the first known carcinogen to cross the placenta, and that this has implications for research into other endrocrine-disrupting chemicals.

The DES story is an ongoing one. It still matters now because of how the link was discovered, because it demonstrates very clearly the need to keep medical records for much longer than 10 years, and because the adverse effects of DES are still being identified 60 - 70 years after it began being prescribed for women during pregnancy.

References

- Professor Charlotte Paul. "DES: Why does it matter now?" 21 July 2012.
- www.cancer.gov/cancertopics/factsheet/Risk/DES
- http://en.wikipedia.org/wiki/Diethylstilbestrol

AWHC GENERAL MEETING 23 August 2012

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

- Financial reports
- Grant applications
- Ethics committee meeting
- Cervical screening committee
- Antenatal HIV screening
- 2013 AABHL bioethics conference

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

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UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for September 2012:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 19 September 2012 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 10 October 2012.

Auckland DHB (Website address: www.adhb.govt.nz)
The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 12 September 2012 followed by the Full Board meeting at 2pm. Both meetings will be held in the A+ Room, Clinical Education Centre, 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 5 September 2012 at 19 Lambie Drive, Manukau City.

The Hospital Advisory Committee meeting will be held at 9am on Tuesday 25 September 2012 and will be followed by the Community & Public Health Advisory Committee meeting at 12.30pm at the Board Room at 19 Lambie Drive, Manukau City.

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

A SEMINAR ON CLINICAL ETHICS:

The Clinical Ethics Advisory Group of Waitemata DHB is holding a seminar, ***Resource Use in a Recession*** on Friday 21 September 2012 at the Awhina Conference Centre, Waitakere Hospital, Lincoln Road, Henderson, Auckland.

Speakers include Anthony Hill, Health & Disability Commissioner, Brandt Shortland, Northland Coroner, Professor David Richmond, geriatrician, Dr Barry Snow, neurologist, Dr Ian Dittmer, renal physician, Dr Martin Wilkinson, and Dr Jocelyn Benatar.

For further information contact Dr Alan Jenner: Alan.Jenner@waitematadhb.govt.nz