O&G MAGAZINE

OPTIMISING SURGICAL OUTCOMES

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RANZCOG
Djeembana, 1 Bowen Crescent
Naarm (Melbourne), VIC 3004, Australia

(t) +61 3 9417 1699
(e) OGmag@ranzcog.edu.au

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Level 6, Featherston Tower, 23 Waring Taylor Street,
Te Whanganui-a-Tara (Wellington) 6011
PO Box 10611, Te Whanganui-a-Tara (Wellington) 6140
(t) +64 4 472 4608
(e) ranzcog@ranzcog.org.nz

RANZCOG State and Territory Committees

Communications and Engagement
Mel Pietsch **Executive Director**
Suite 13, 18 National Cct, Barton, Ngambi (Canberra), ACT 2600
(t) +61 2 6100 1160
(e) mpietsch@ranzcog.edu.au

Australian Capital Territory
Dr Sim Hom Tam **Chair**
Jess Milton-Edwards **Member Engagement Coordinator**
Suite 13, 18 National Cct, Barton, Ngambi (Canberra), ACT 2600
(t) +61 2 6169 3993
(e) act@ranzcog.edu.au

New South Wales
Dr Mark Ruff **Chair**
Emma Charles **Member Engagement Coordinator**
Suite 2, Ground Floor, 69 Christie Street, St Leonards,
Warrang (Sydney), NSW 2065
(t) +61 2 9436 1688
(e) nsw@ranzcog.edu.au

Queensland
Dr Senaka Abeysundera **Chair**
Sylvia Williamson **Member Engagement Lead**
Level 3, U22-17 Bowen Bridge Road, Herston,
Meanjin (Brisbane), QLD 4006
(t) +61 7 3062 6755
(e) qld@ranzcog.edu.au

South Australia/Northern Territory
Dr Kate Walsh **Chair**
Terri Herrero **Member Engagement Senior Coordinator**
First floor, 213 Greenhill Road Eastwood, Tarndanya (Adelaide),
SA 5063
(t) +61 8 7081 9901
(e) sa-nt@ranzcog.edu.au

Tasmania
Dr Frank Clark **Chair**
Sophie Copus **Member Engagement Coordinator**
Djeembana, 1 Bowen Crescent, Naarm (Melbourne), VIC 3004
(t) +61 3 9114 3925
(e) vic-tas@ranzcog.edu.au

Victoria
Dr Samuel Newbury **Chair**
Andrea Chan **Member Engagement Lead**
Djeembana, 1 Bowen Crescent, Naarm (Melbourne), VIC 3004
(t) +61 3 9412 2961
(e) vic-tas@ranzcog.edu.au

Western Australia
Dr Shin Lee **Chair**
Kelly Challinor **Member Engagement Lead**
(t) +61 8 6102 2622
(e) wa@ranzcog.edu.au

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RANZCOG acknowledges and pays respect to the Traditional Custodians of the lands, waters and communities across Australia, on which our members live and work, and to their Elders, past, present and future. RANZCOG recognises the special status of Māori as tangata whenua in Aotearoa New Zealand and is committed to meeting its obligations as Te Tiriti o Waitangi partners.

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From the President

Dr Gillian Gibson
President

There is no doubt that obstetrics is what drew me to a career in O&G, but the combination of medicine and surgery in our speciality was also very appealing. I reflect over my working life how much progress has been made towards optimising surgical outcomes. These include improvements to the informed consent process, better provision of patient information and perioperative team talk with huddles, timeout and sign out now commonplace. At the time of writing, I have just attended a meeting at my local hospital discussing a new quality tool which invites theatre participants to consider "what went well, what can we change for next time, what would be the action?", with favourable feedback.

Gynaecological surgery is very much a focus for the College coming into 2024. As part of our commitment to improving training opportunities in gynaecological surgery, in 2023 we established the RANZCOG Gynaecological Surgery Training Working Group. This group of experts are tasked with looking at ways that we can ensure our trainees and members maximise opportunities for access to advanced and more complex gynaecological surgery, and to become confident, well-rounded fellows at the completion of training. I see this working group as having a critical role in tackling one of the most challenging aspects of our specialty.

We are actively engaging with regulatory bodies in Aotearoa New Zealand and Australia to advocate for our members undergoing urogynaecological credentialing, one of the requirements to lifting the current pause on use of surgical mesh in New Zealand. The College is committed to supporting our members through the credentialing process, and should any members require additional support we encourage you to contact us. I'd like to make special mention to our New Zealand Vice-President, Dr Sue Fleming, and the New Zealand office for their tireless efforts with negotiations in this area.

I was pleased to see an exemplary completion rate above 93% among our membership with the most recent Fellowship cycle for CPD, with members aligned to a single annual reporting date. The new FRANZCOG curriculum was launched this year and is well and truly underway, with first year trainees being the first group to train under the new framework. We are confident that the changes to our curriculum will be well received by the trainees, and I am excited to see the outcomes of such a comprehensive program.

The implementation of an evidence-based process in the development of College guidelines and statements has led to a significant improvement in the quality of information we provide our members. We look forward to sharing the next tranche of updates to the guidelines and statements with you in 2024, one of which is an evidence-based guideline on miscarriage and ectopic pregnancy. I'd like to recognise the expertise and time contributed by clinicians to date and encourage you to consider nominating for this exciting project work, led by the Research and Policy team.

The AMC/MCNZ reaccreditation report has now been received by the College, and I am delighted that the College has been recognised as a leader among medical colleges, which is reflected in the report. I would like to extend my thanks to all members, trainees and staff that were involved in the reaccreditation process, and I look forward to working with you further to address the recommendations in the report, particularly embedding cultural safety into O&G training.

In closing, it would be remiss not to remark on the impact of respectful behaviour in optimising surgical outcomes and training experience. The recent RANZCOG discrimination, bullying and sexual harassment survey results show there is still room for further improvement, recognising unprofessional behaviour in theatre not only harms the recipient, but potentially compromises patient care and safety.

We hope you enjoy this issue of O&G Magazine!

From the CEO

Vase Jovanoska
Chief Executive Officer

2024 is well underway and all of us here at the College are looking forward to what is ahead this year. 2023 was a very successful year for RANZCOG, with the AMC/MCNZ Reaccreditation, redevelopment of the FRANZCOG curriculum, and opening of the Assessment, Learning and Education Centre, to name a few of our major accomplishments. We are carrying this success into 2024 and are aiming even higher this year.

The reaccreditation report has now been published by the AMC & MCNZ, and we are very pleased with the outcome. The College received very positive feedback across the board, and we will continue to work to address the conditions and recommendations that have been identified as part of the reaccreditation process.

We are now reaching the halfway point of the Fostering Respect Action Plan, which was launched in 2022. The College is committed to improving working environments for our members and trainees, to ensure that all O&G units in Australia and Aotearoa New Zealand are safe and respectful workplaces.

In 2024, we will be releasing the College's Reconciliation Action Plan. This has been a significant undertaking by the College, and we thank RANZCOG's First Nation's members and trainees who have guided the development of this critical document.

Workforce issues continue to be a major concern for the College. We are working with the regulatory bodies in both Australia and Aotearoa New Zealand to advocate for GP Obstetrician-led rural maternity services, increased emphasis on rural training, and reviewing the assessment and placement of SIMG candidates.

We are excited to host the 2024 Regional Symposium in Glenelg, South Australia. This event has an exciting program over the course of two days, and we hope to see many of our members and trainees there. Support for our regional and rural clinicians is a priority for the College, and events such as these provide an excellent platform for targeted information and networking for our members, trainees and GP obstetricians.

In March, we are proud to be hosting the Women's Health Summit at Parliament House in Canberra. The Summit is part of our ongoing advocacy work to improve outcomes in women's health. We anticipate a high number of stakeholders in attendance and have been very pleased with the involvement from the RANZCOG membership in the planning of this important event.

With another busy year ahead of us, I would like to thank all our members and trainees for your engagement with the College, and for your commitment to delivering excellence an equity in women's health across the region.

LEADERS IN FOCUS

Dr Kirsten Black
MBBS, MMed, FRANZCOG, DUU, FFSRH PhD,
Chair RANZCOG Sexual and Reproductive
Health Committee

This feature sees Kirsten Black in conversation with women's health leaders in a broad range of leadership positions. We hope you find this an interesting and inspiring read.

Join the conversation on Twitter
#CelebratingLeadership @RANZCOG

Dr Paddy Moore
AM FRANZCOG MBCHB, BA, MSTR Bioethics

Clinical Associate Professor Paddy Moore AM is a consultant obstetrician-gynaecologist at the Royal Women's Hospital in Melbourne. Previously a generalist obstetrician gynaecologist with a special interest in paediatric and adolescent issues, Paddy is now the lead clinician in the Abortion and Contraception service at The Royal Women's Hospital in Melbourne, Victoria.

Over the past 11 years she's led the hospital's expansion of its abortion service to provide later second trimester surgical and medical abortion. The service plays a key role in supporting clinicians across Victoria providing abortion, and training the next generation of abortion providers. The Women's was the first site to offer the RANZCOG Advanced Training Modules and the Advanced Training Pathway in Contraception, Abortion and Sexual Health.

Here, Paddy talks to Kirsten Black, Professor of Sexual and Reproductive Health at the University of Sydney and Chair of RANZCOG's Sexual and Reproductive Health Committee.

Paddy, tell me what influenced you to become an abortion provider?

As a medical student I was always interested in a career in women's reproductive health and was drawn to obstetrics and gynaecology as a pathway. I assumed that contraception and abortion would be an integral part of the clinical work but while training in New Zealand, the UK and Australia I realised that many of my contemporaries did not see sexual and reproductive health as an important area to understand or develop skills in. To me however, it was apparent that the most vulnerable patients had very limited access to sexual and reproductive health services, and I increasingly appreciated that reproductive choice was key to improving health outcomes for women and their families. Nevertheless, for much of my career there was nowhere to refer the most vulnerable patients as most services were privatised and geographically very concentrated in the metropolitan areas. I sought out nursing and medical colleagues who were involved in this work and became aware that a palpable stigma existed within the profession towards abortion care and those who were involved in the services. After some professional counselling and deep reflection, I decided that abortion care was an area I wished to focus on, but I never envisaged I would be a managing the largest public service in Australia, or that advocacy and service provision would take up an increasing portion of my time.

Who inspired you to work in this field?

Over time I was very affected and impressed by the work of some of my senior colleagues to advocate for reproductive rights. I observed how they were able to articulate this to political power and use their positions to bring about positive change. Observing Caroline De Costa, Margaret Sparrow, and others making early medical abortion possible in Australasia thanks to their gracious determination and creativity, was a time when I started to feel that I should become more actively involved in abortion care. Following decades of advocacy, abortion was decriminalised In Victoria in 2008, which led to waves of similar legislative changes across the country. It became apparent however that equitable access to services was not a guaranteed outcome of legislation change, and I realised I wanted to pivot my work towards improving sexual and reproductive health access. So, I sought out additional surgical training and travelled to other centres internationally to understand how they ran their abortion services.

Why do we need people skilled in second trimester abortion?

Although most abortions, about 80-90%, occur before 12 weeks, there are many reasons women and people need access to abortion after this time period. This includes contraceptive failure, delayed diagnosis of pregnancy, difficulty obtaining services, as well as a myriad of social factors. Advances in antenatal diagnosis of foetal abnormalities also mean that there is more information available to guide people in their understanding about how a condition can impact on the life of the unborn child, and the risks and benefits of continuing a pregnancy. Trained providers of surgical and medical abortion beyond the first

trimester need to feel supported in their choice to provide these services and have a peer group of colleagues.

How do people react to your job?

Well, it can be a conversation starter or lead to an awkward silence! Early on in my career, I was more apprehensive about how people would react to hearing that I was an abortion provider; and in my personal life, I protected my family members from this until I felt they were able to make their own judgements about my choice of work. In terms of my colleagues, I think of my older colleagues and my direct peers; some choose not to acknowledge my area of work at all. I have several close obstetrician/gynaecologist friends who do not support my work and advocacy in this area, and many have a conscientious objection to personally providing abortion care. We have managed to successfully negotiate our friendships by respecting each other's philosophy. They now understand that I feel consciously obligated to provide a service that is both legal and desired by most of the community. There does seem to be growing interest and acceptance of abortion care as a core part of comprehensive women's health. In the last five years, I have been approached by an increasing number of established obstetrician/gynaecologists requesting training in second trimester surgical skills, as they feel they should be able to provide this but did not receive exposure in their training. In my experience, younger colleagues are much less likely to have any concerns about providing abortion care and actively seek out rotations in our service.

Can you describe the training pathways you have set up and what the outcomes have been?

RANZCOG has become increasingly supportive of the work of the Sexual and Reproductive Health Committee and its work in advocacy and curriculum development. Professor Michael Permezel supported Kirsten Black to establish the Sexual and Reproductive Health Special Interest Group in 2013 and the subsequent presidents along with Vase Jovanoska and Stephen White have championed this field within the college. As legislative change occurred across Australia and Aotearoa in line with community expectation, it was recognised that training a sustainable work force was essential. RANZCOG approved an Advanced Training Module (ATM) in Sexual and Reproductive Health. Specifically designed for fifth/sixth year trainees, which can be completed full-time in six months or part-time over 12 months. These modules expose the trainees to the breadth and depth of clinical and surgical skills in contraception and abortion care and are designed for clinicians who wish to embed such services within their professional scope of practice. To date, we have trained 14 senior registrars and the majority of these have continued to provide these services as consultants. Four of the trainees that completed the ATM are now developing services in other hospitals and states. We hope that other institutions will develop a similar training programme for their trainees.

From 2024, RANZCOG is offering Sexual and Reproductive Health as one of the fellowship pathways. This pathway involves the completion of four mandatory modules in abortion, contraception, sexual health and essential obstetrics and gynaecology, as well as two elective modules (selecting from menopause, care of vulvovaginal conditions, acute gynaecology and early pregnancy, colposcopy, paediatric and adolescent gynaecology, and sexual health.

Describe your leadership style?

I aspire to be collaborative and reflective and try to involve staff and colleagues as much as possible in the decisions that shape the service. I also seek out allies to support/advocate for our work, both within the hospital and with external providers. Sexual and Reproductive Health (SRH) is a field that lends itself easily to collaborations across the medical nursing and counselling disciplines and much can be learnt from working in multidisciplinary teams. I have undertaken professional leadership supervision to guide me in negotiating sometimes complex issues. I've found this dedicated time to reflect on situations and workshop strategies to best manage the various challenges of leadership really helpful in my role. I can't recommend this practice highly enough and I really think it has enabled me to stay positive and strategic.

What advice would you give trainees and consultants thinking about working in abortion care?

If you interested in a career in SRH, talk to current providers and seek out a clinical placement, or consider a sabbatical that would enable you the time and space to upskill. I recommend reading about SRH and rights to better understand the past and current political and health landscape. I suggest you check out the college training pathways and resources, as well as attend meetings and conferences to familiarise yourself with the field. I offer much encouragement to pursing work in abortion care. I have found it incredibly intellectually stimulating and personally rewarding.

Meet your councillors

Councillor Kathy Saba is a part-time O&G consultant at the Royal Brisbane & Women's Hospital in Queensland. Photo: Supplied by Kathy Saba

Here, we meet Dr Kathy Saba, a returning councillor from Queensland.

I'm writing this a little sleep deprived after being called in to supervise my registrars for a preterm twin delivery early this morning. Luckily, I made it home in time for present opening and chocolate crêpes for breakfast for my son's birthday before the school run.

I represent other fellows and trainees also residing on "juggle street". I am a part-time public O&G consultant at the Royal Brisbane & Women's Hospital, a busy tertiary unit. I have two children at primary school, and I have a day and a half off a week to help get the family balance right.

Why did I nominate for Council?

I had enjoyed being involved with college activities as a trainee rep and then state committee member since 2008. This is my second term on council. I nominated for council in 2021 so Queensland could have representatives more reflective of current college membership. I cannot remember when Queensland last had a female councillor. On the last council we had two, in our current council we have three. Progress!

I hope to maintain and improve communication and engagement with members and trainees. There is so much rewarding work at RANZCOG – contributing to the various committees, examinations, reaccreditation visits, diploma and pre-exam courses. Before I was on council, I was regularly involved with these activities, and I'd encourage more fellows to be involved in college work (with the bonus of CPD points!). Find your niche area, identify what interests you most or consider how and what you want to advocate for in women's health, and dive in.

What are the key issues in QLD?

I feel one of our biggest issues in Queensland is maintaining the regional and rural maternity workforce. We are such a big state with maternity services dotted in towns up the coast and inland. Each of those towns would support more rural hospitals with GP obstetricians. It's important that rural hospitals have the staff to safely run maternity services and have access to clinical support and upskilling opportunities from their larger regional and tertiary centres. Our other ongoing issue in Queensland is equity in access to abortion care. In my first term on council, I was able to be a voice for women and for our state's Obstetricians and Gynaecologists as a RANZCOG representative at state government meetings on both issues. I found it very rewarding to see progress in areas such as provision of abortion care in Queensland over this time having been involved in the process of change.

What does the college mean to me?

To me, RANZCOG means a sense of belonging and support for members and trainees and being part of the key organisation advocating for, and maintaining, high standards in women's health.

Meet your councillors

Here, we meet Dr Emma Jackson, a councillor based in Christchurch, New Zealand.

I am originally from the UK, raised in North East London, and am a graduate of Manchester Medical School. My journey in medicine took an adventurous turn in 1996 when I left the NHS and three-day weekends behind for a year-long working holiday in New Zealand. Little did I know that this single year would extend to nine and mark the beginning of a pivotal change in my career and life.

Returning to the UK in 2005 as an O&G trainee, accompanied by my Kiwi husband and our one-year-old son, I completed my final 18 months of training, rotating through Chelmsford and Cambridge Hospitals. Juggling the challenges of motherhood (my two other children were born during this time) and the demands of training, my passion for women's health continued to drive me.

In 2009, I returned with my family to New Zealand as a Fellow, eager to contribute to the healthcare landscape at Middlemore Hospital before accepting a Consultant role at Christchurch Women's Hospital, Waitaha, a tertiary unit with around 6,000 births per year. Over the next seven years, I dedicated myself to consolidating my skills, mentoring others, and embracing leadership opportunities. During this time, I was a training supervisor and later became a member of the NZ committee of RANZCOG, now the ANZ committee.

In 2018, I took on the role of Clinical Director in my department, splitting my time between a clinical and a leadership role. I'm Chair of the RANZCOG Aotearoa New Zealand Practice Visit subcommittee who are currently reviewing the Practice RV program and I was Conference Convenor of the 2022 RANZCOG ASM in Otautahi, Christchurch.

I'm now an NZ Councillor on the RANZCOG Council just starting my second term. This position has afforded me the opportunity to contribute towards shaping decisions, providing the Aotearoa New Zealand perspective and working towards equity and consistency of (best) practice between our two countries.

I'm currently a member and Deputy Chair of the CPD committee. In this role, I actively engage in discussions and decisions around our CPD program and the review and approval for circulation of surveys. I have also just joined the Progress review committee ensuring that a just process occurs where trainees are unable to meet the requirements of the training program.

Being part of the College, and now on Council, has allowed me to be actively involved in initiatives aimed at improving healthcare policies and practices. I was part of a working group convened by the Accident Compensation Corporation (ACC), addressing factors affecting ACC cover for perineal tears and leading to the legislation changes and subsequent maternal birth injury cover (MBI). Also, as part of the ANZ committee, I recently represented RANZCOG at a National Maternity Quality and Safety Forum convened by the HDC/HQSC. Currently with such a huge upheaval in our health system in Aotearoa New Zealand, and with what has sadly been a decline in quality of provision of care to our patients at a local level in Waitaha (Canterbury) New Zealand, I am more committed than ever to working with the College to uphold excellence in Women+ healthcare and best practice, and to advocate and push for consistent, capacity planned, appropriately staffed and funded, equitable services for patients across the whole of New Zealand and Australia.

When I'm not in a meeting, buried in my computer, or in the operating theatre where I particularly enjoy laparoscopic surgery, I work to support my clinical team and keep our department running. Outside of work, I can be found running in the hills with my dog daughter Tui and spending time with family and friends.

Councillor Dr Emma Jackson and her dog Tui in Christchurch, New Zealand.
Photo: Supplied by Emma Jackson

Notes from RANZCOG's historical collection - Dr Victor Bonney

Greg Hunter
Archivist/Historical Collections Administrator

Dr Victor Bonney left a remarkable legacy in the field of obstetrics and gynaecology. Here, we explore some of the College's historical collection to discover more about the gifted surgeon and his work.

Born in London in 1872, Bonney was a gifted surgeon whose advances in radical hysterectomy and myomectomy saved countless women from death, debilitating illness, and infertility. Bonney was also a great innovator who devised a number of his own surgical instruments, as well as an antiseptic solution which has come to be his most enduring legacy – Bonney's Blue.

Mastering myomectomy

One of Bonney's most notable achievements was his development of a successful procedure for myomectomy. After his wife developed fibroids and had her uterus removed early in their marriage, Bonney took a great interest in the practice of conservatism in surgery. Prior to Bonney, myomectomy "had fallen into disuse because of excessive blood loss during the operating and the infections that commonly followed"[1], but Bonney saw an opportunity to revolutionise this practice.

In his words:

"I set myself to make myomectomy so feasible, successful and safe as to render it a fair alternative to hysterectomy in every case…Excepting only in a very few instances…I have succeeded, and now enter the operating theatre free of the trammels which at one time too often compelled my hand against my heart."[2]

Bonney's crucial innovation was the development of a new surgical clamp, an instrument which is now referred to as Bonney's myomectomy clamp. The clamp was ingeniously designed to cut off blood supply to the uterus by compressing the uterine arteries, immediately reducing the excessive blood loss that had previously been associated with the procedure.

Bonney's success with this procedure was such that his clamp became a key part of the arsenal of gynae surgery and was widely used for myomectomy procedures for decades after his death. Although it is now seldom used, his innovation helped pave the way for some of the future technological advances that have shaped gynae surgery today.

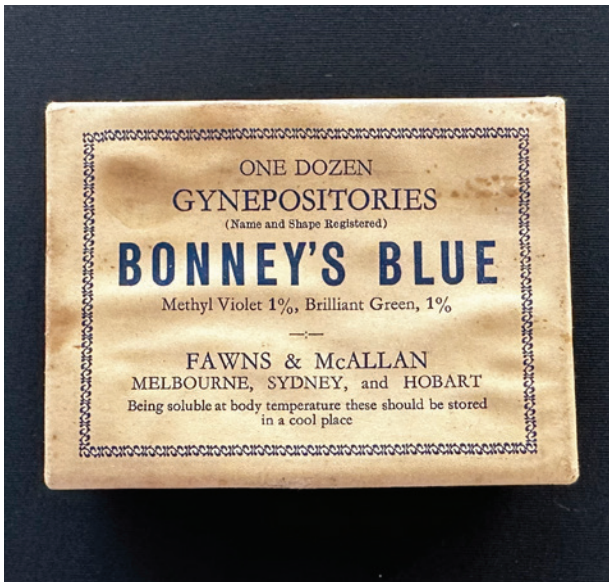
Bonney's myomectomy clamp used by Dr Frank Forster, kindly donated to RANZCOG by Dr Frank Forster. Photo: RANZCOG

Bonney's Blue

In 1918, Bonney and bacteriologist Carl Hamilton Browning delivered a paper outlining the virtues of an antiseptic solution that they called "violet-green". The solution was applied six hours before operation and stained the skin an "intense violet-black", which lasts throughout the operation and "for a week or two afterwards". It was offered as a marked improvement on iodine for sterilisation, as it had much longer lasting effect and caused "no irritation of the skin, nor of more sensitive surfaces such as the vulva and vagina." [3]

This solution came to be known as Bonney's Blue and proved to be a great boon for gynaecological surgery. On top of its antiseptic properties, the bright colouring of Bonney's Blue gave it an additional function as "a beacon for the gynaecologist" during difficult abdominal hysterectomy surgery.[4]

Such was the impact of this innovation, that, despite his many other achievements, Roques proposed in 1953 that "to theatre-sisters, labour-ward sisters and young house-surgeons he [Bonney] will always be remembered as the discoverer of Bonney's Blue." [5]



Bonney's Blue vaginal suppositories, kindly donated by Dr David Grodski in 2008. Photo: RANZCOG

Bonney's portable operating table

The College is fortunate enough to hold a personal connection to Bonney thanks to having one of his portable operating tables in the College's historical connection.

The table was acquired by Dr Frank Forster, who was a relative of Victor Bonney's widow, Mrs Annie Bonney. Dr Forster visited Mrs Bonney in 1953 following the death of her husband, whereupon, knowing of his interest in medical equipment, Mrs Bonney offered him the operating table, "which was stored in a canvas bag in the boot of his [Bonney's] Rolls Royce." [6]

During his career, Bonney had two portable operating tables, two sets of instruments, and two theatre-sisters to assist with his workload.vii By these means, he was able to "complete three or more operations a day by rotating staff and equipment with a chauffeur driven Lanchester or Rolls Royce." [7]

Simply constructed, of plywood, metal, and canvas, the table is clearly designed for transportation. It shows signs of frequent use, including a worn, circular patch on the table which – in a nod to its previous owner – still shows traces of Bonney's Blue. The table is a humble workhorse and provides an evocative touchstone to a remarkable man and his celebrated career.

Bonney's table, and the other artefacts referenced in this article, are currently on display at Djeembana College Place in Naarm Melbourne. Members and trainees are invited to visit the College to view these fascinating insights into obstetrics history.

Bonney's portable operating table, kindly donated to RANZCOG by Dr Frank Forster. Photo: RANZCOG

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ANZJOG: the scientific publication of RANZCOG

Dr Scott White
MBBS, PhD, FRANZCOG, CMFM
Editor-in-Chief Australian and New Zealand
Journal of Obstetrics and Gynaecology

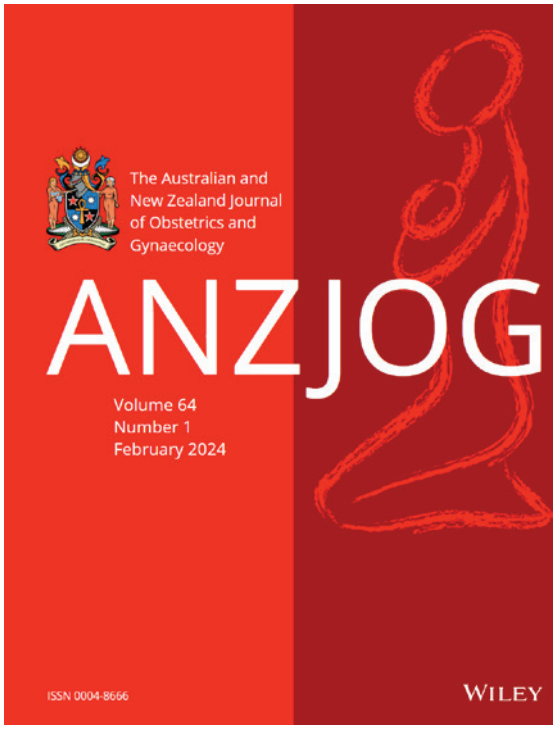
It was my great honour to be appointed Editor-in-Chief of the Australian and New Zealand Journal of Obstetrics and Gynaecology recently, particularly as it meant I now follow in the footsteps of two inspirational colleagues in Professor Caroline da Costa and Professor Jan Dickinson, my two most recent predecessors, both of whom have had a profound influence over my clinical and academic career and my involvement with RANZCOG.

ANZJOG is the scientific publication of our College. Although owned by RANZCOG, the Journal remains editorially independent which allows it to prosecute a pure scientific agenda, free of the constraints of the College's responsibilities as a member-based, training, and advocacy organisation. My vision is that ANZJOG should be a vehicle to drive evidence-based clinical practice and public health policy in obstetrics, gynaecology, and the related disciplines that contribute to women's health. That is not to say that basic science research is unimportant, indeed it is vital, and is warmly welcome in ANZJOG as the discovery research upon which clinical translation is built.

By the time this article goes to press, ANZJOG will have published the first issue of its 64th volume. When I was appointed to this editorial role, I was given a copy of volume 1 issue 1, published in February 1961. It immediately struck me how much clinical scientific publications have changed in that time. Early ANZJOG volumes contained short articles typically by a single distinguished clinician, often describing their own substantial clinical case series. These now stand in quite stark contrast to the controlled clinical trials, methodical systematic reviews, and population-level "big data" analyses that we more commonly read today.

The increased complexity of modern scientific publications brings various benefits. Robust scientific data power evidence-based medicine, allowing clear clinical guidelines to be developed to the benefit of clinicians and the community for whom we care. But with such benefits come challenges. Deficits in research integrity are problematic, and methodologically flawed studies, inappropriate conclusions, misinterpretation, extrapolation beyond the capacity of the data, and more deliberate research misconduct have the very real and clearly demonstrated potential to drive inappropriate clinical practice to the deficit of our patients. Berghella et al describe the importance of research trustworthiness in women's health in an editorial co-published in several leading journals of obstetrics and gynaecology including the current issue of ANZJOG.

Another challenge resulting from the complexity of modern scientific publications is their accessibility to clinicians on the ground. This accessibility is multifaceted, including gaining attention in an ever increasingly information-saturated world, the capacity for busy individuals to quarantine time for academic reading, and the ability for non-researcher clinicians to interpret the information presented in a technical and scientific format and how it applies to the patient in their office, labour ward, or operating theatre. Modern clinical science journals must embrace their role in eliminating these accessibility barriers through effective science communication. Strategies to achieve this include using alternative methods of information dissemination such as video abstracts, online journal clubs, and author interviews, all of which are being considered for the future of ANZJOG.



As a clinician, I hope for ANZJOG to be a vehicle with which we can drive real improvements in hard clinical outcomes. Apart from publishing hypothesis-driven research articles, which will and should always be the backbone of any scientific journal, ANZJOG is a place for clinical guidance documents, such as the recently published SOMANZ guideline on intrahepatic cholestasis of pregnancy which is an excellent resource for clinicians managing this relatively common complication of pregnancy.[2] It is my intention that ANZJOG will publish more evidence-based guidelines both from RANZCOG and other organisations with which our members work.

I'd also like ANZJOG to support the work of RANZCOG in training our future colleagues. The need to do this was highlighted by Calvert and Symonds in their recent editorial.[3] The Journal can make a scientific contribution to our trainees' journeys not only by supporting their research but also but supporting the scientific development and assessment of the College's various training programs.

I would like to thank the many people who support the work of ANZJOG through submission of their manuscripts, research mentoring, and peer review, and to encourage you to engage with the wonderful science of the Australian and New Zealand women's health research community. ANZJOG is published in six issues annually, accessible in full text format online by all members of RANZCOG via the College website (simply using member credentials via the portal) or their institutional libraries.

Sign up to receive email alerts when new articles and issues are published via the ANZJOG Wiley Online Library homepage (use QR code). Author guidelines, submission links and journal metrics can also be found here, as well as the Virtual Issue library, which pulls together collections of articles on a wide range of important O&G topics.

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OGET reaches 1,000 participants

Rosalie Sirotic
Project Coordinator, Rural Health Projects

Cynthia Tapiwa
Lead, Rural Women's Health Projects

RANZCOG's Obstetrics and Gynaecology Education and Training Program, better known as OGET, has reached a significant milestone, welcoming its 1,000th participant in December 2023. The program, funded by the Federal Government and led by RANZCOG, delivers upskilling and education to a range of health professionals involved in providing maternity and gynaecology services. Primarily focusing on Monash Modified Model (MMM) areas 2 to 7, OGET is a multi-disciplinary program that takes a collaborative learning approach, helping to facilitate the safe and equitable provision of maternity and gynaecology services in rural, regional, and remote areas.

The OGET journey

OGET began its journey in 2022 with a pilot program and the establishment of four regional hospital hubs in Warrnambool (VIC), Sunshine Coast, (QLD), Darwin (NT), and Orange (NSW). These hubs offered onsite and outreach training to nearly 20 peripheral rural and remote health services through case-based learning and interactive forums. In addition to clinical skills, the training also addressed other critical skills such as cultural competence, leadership, communication and wellbeing, both from a practitioner and a patient perspective. During this pilot phase, the program helped train and upskill over 250 GPs, registrars, anaesthetists, midwives, nurses and other health professionals.

Recognising the success of the pilot phase, the Federal Government committed further funding in 2023 to expand the program until February 2025. This led to the development of four more hubs in Bunbury (WA), Broome (WA), Toowoomba (QLD), and Mt Baker (SA), increasing the number of rural and remote hospitals supported from 20 to 33. In addition to increasing the number of training health service sites, the funding also covers the purchase of simulation equipment, enabling health professionals to learn and practice in a safe and risk-free environment.

Today OGET is credited to have trained over 1,000 participants and counting, firmly earning its place as one of RANZCOG's most successful rural workforce initiatives.

The people behind the program

RANZCOG is committed to ensuring that OGET is led strategically and operationally by a diverse group of health professionals with an understanding of rural and remote women's health. The OGET governance structure includes:

- **The OGET Steering Committee -** The Committee reports to the RANZCOG Board and is chaired by Associate Professor Jared Watts, a rural O&G from Broome (WA). The Committee has Fellow and GPO representation and oversees the strategic delivery of OGET, ensuring that the program meets its set objectives.
- **The Resource Development Working Group -** The Working Group reports to the OGET Steering Committee and is chaired by Dr Elisha Broom, a Fellow from QLD (a position previously held by Associate Professor Ted Weaver who led the OGET Sunshine Coast, QLD Hub). The Group has Fellow, GPO and midwifery representation and develops educational resources used by the OGET Hubs, with a focus on creating scalable resources that can be customised and replicated across a diverse range of health care settings. This includes case studies, videos, workshop content and e-learning modules.

To help keep the OGET wheels turning, the program relies on dedicated Fellows, GP Obstetricians, and College and hospital administration staff to ensure that the College delivers high quality education to its participants. Each hub also has a dedicated OGET FRANZCOG Lead who leads on the delivery of the program locally.

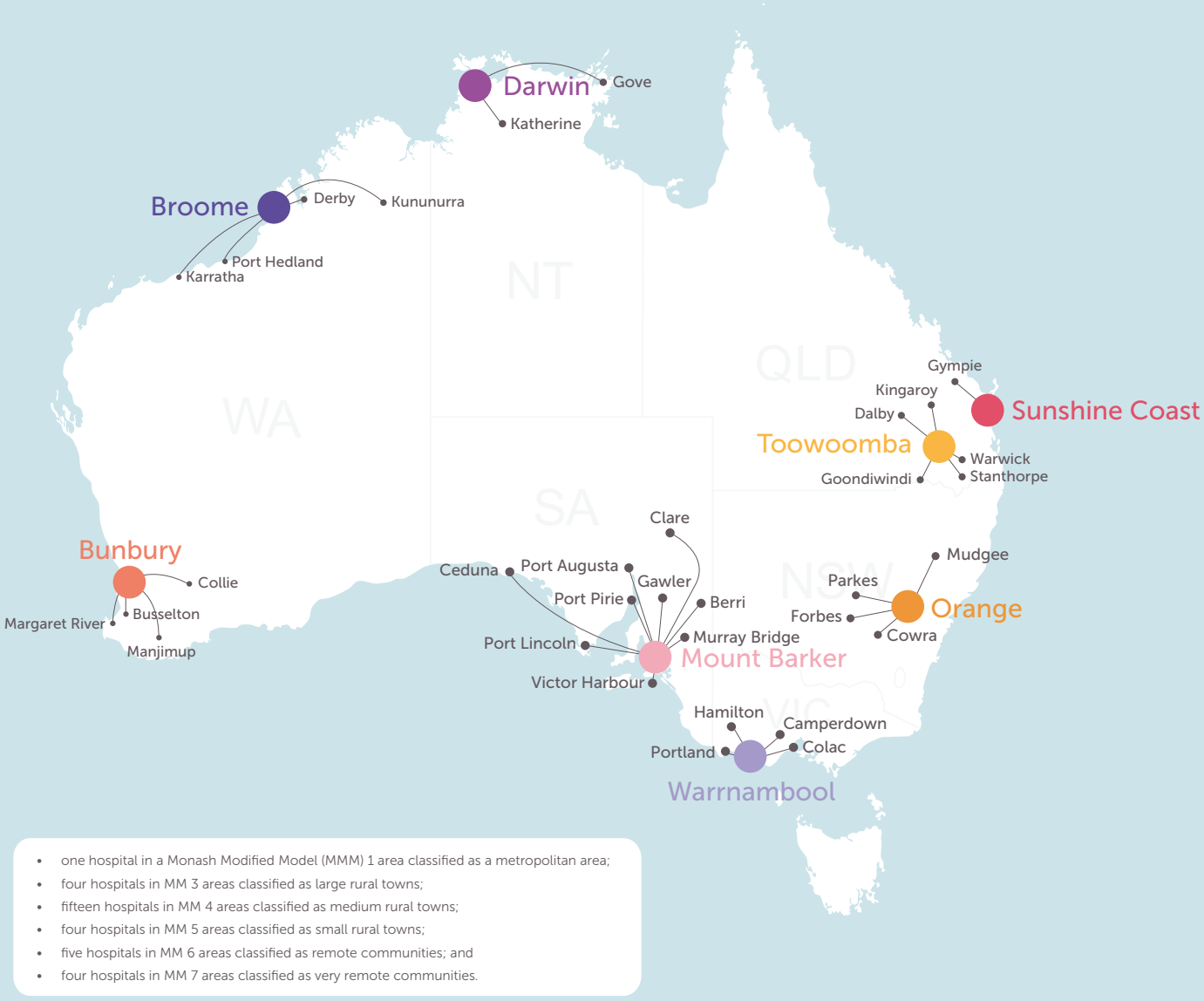
Improving the workforce

The impact OGET has had on the rural maternity and gynaecology workforce is clear, with participants often expressing how valuable the OGET sessions are for their clinical practice. Participants have reported an increase in confidence levels at the end of each session based on their knowledge of the case topic, scope of practice in managing similar types of cases, and their ability to contribute meaningfully as a member of a team managing the case. OGET case topics include Trauma in pregnancy, Difficult birth, Missed antenatal result, Mental health, Renal issues, and Threatened preterm labour in a rural location.

Dr Jake Parker, a GP Obstetrician based on Thursday Island, and a member of the OGET Resource Development Working Group, describes how the program was developed specifically for the rural workforce:

"The OGET program has been designed with the education needs of Australian rural and remote maternity units in mind. With input from both specialist FRANZCOGs and General Practitioner Obstetricians, the OGET program aims to deliver high-quality maternity education sessions that are both contextualised to the rural hospital setting and can be delivered close-to-home. It delivers case studies which explore issues specific to managing obstetric and gynaecological cases in rural and remote Australia, including retrieval medicine."

RANZCOG has also taken into consideration the importance of multi-disciplinary learning as a form of integrating the knowledge, skills, and perspectives of the diverse range of health professionals that play a key role in the delivery of maternity and gynaecology care. This is crucial for rural and remote areas, as the successful delivery of maternity and gynaecology care relies not only on O&G specialists, but also GP obstetricians, anaesthetists, midwives, and other health professionals.



Regional hub map of OGET sites. Remoteness and population size measured on a scale of Modified Monash (MM) categories.

OGET reflections

"The OGET project has enhanced my relationship with the other hospitals in my area in so many ways and allowed me to get to know many clinicians I would not otherwise have met, from Obstetricians, GP Obstetricians and midwives to theatre and ward staff and anaesthetists. This has a massive advantage when we are discussing difficult clinical situations as we often already know each other's thoughts and capacities. I think the learning around the cases is a two-way street, and I have learnt a lot teaching them. We have had some fantastic group discussions over the course of the OGET project."

Dr Rosy Buchanan, OGET Warrnambool (VIC) Hub Lead

"OGET has really helped develop the relationships between larger regional hospitals and the smaller units they support. It has allowed consultants and GPOs who for years have discussed patients over the phone to actually meet in person for the first time. The consultants have then been able to see the local services and resources available in peripheral units who they are giving advice to."

Associate Professor Jared Watts, OGET Steering Committee Chair

"As a clinical midwife it's helped me understand what A/N screening should be ordered by GPO in obstetric clients at risk of PE and allows me to understand what markers are crucial to observe and be more vigilant with."

Program participant

"Appreciate how interactive (the session) was & that the presenter was open to education from the audience."

Program participant

"I just wanted to say what a fabulous study day it was today! So informative!"

Program participant

OGET in numbers

OGET supports **33 rural and remote Australian health services** from eight (8) regional hospitals

28 of the 33 OGET peripheral OGET health services are in medium and small rural towns (MM4 and 5), remote communities (MM6) and very remote communities (MM7)

The largest self-reported OGET cohort is **midwives at 44%**

The second largest self-reported OGET cohort is **nurses at 15%**

The third largest self-reported OGET cohort is **General Practitioners at 11%**

What's next?

Despite the overall success of OGET, there is still much work to be done to improve access to maternity and gynaecology services in areas of need. The growth and evolution of OGET relies on participant feedback, and despite an overwhelming number of positive responses received, there is always room for improvement.

A proposal to the Federal Government was submitted by the College in December 2023 for further funding. This proposal looks to expand the program at the end of the project funding period in February 2025. The expansion of OGET to establish more hubs will help ensure the equitable provision of similar training opportunities for more rural and remote health services.

Further changes are happening from an education and learning perspective. 'The program is expanding its resources to include obstetric skills sessions and will be further tailored using direct feedback from participants,' says Dr Parker.

RANZCOG has also identified the need to provide more sessions, and to continually review their distribution, so that geographically isolated rural and remote health services receive more dedicated training and upskilling opportunities. Ongoing funding and support will help to ensure more health services in medium and small rural towns, remote communities, and very remote communities are part of the proposed OGET expansion.

With continued support from its participants and enthusiasm of its team members, the future of the program looks bright. Provided the recent Federal Government proposal is successful, the program will continue to evolve and better align with the needs of its participants and the communities they serve.

To find out more about OGET, please email the OGET team on oget@ranzcog.edu.au

Late 2021

College met with the Rural Health Commissioner and Chief Medical Officer, Dr Brendan Murphy, to pitch the idea of the OGET project. Project was approved.

June 2022

Pilot phase of the project began across four hubs.

August 2022

The NSW OGET Hub had their first OGET session on Placenta Abruption at Cowra Health Service.

September 2022

VIC The OGET Hub had first OGET session on Secondary PPH and sepsis at Hamilton Base Hospital.

October 2022

The NT OGET Hub had their first OGET session on Trauma in Pregnancy at Broome Hospital (WA).

January 2023

The QLD OGET Hub had their first OGET session on Pre-eclampsia toxaemia at Sunshine Coast University Hospital, Birtinya.

September 2023

The WA (Bunbury) OGET Hub had their first OGET session on Placenta Abruption at Margaret River Hospital.

November 2023

The WA (Broome) OGET Hub had their first OGET session on Pre-eclampsia toxaemia at Kununurra District Hospital.

November 2023

The SA (Mount Barker) OGET Hub had their first OGET session at the Southern Fleurieu Health Service, Victor Harbour on Secondary PPH and sepsis.

December 2023

Proposal submitted for further funding and ongoing expansion of the project. Program welcomes its 1,000th participant.

New directions in Aotearoa New Zealand

Catherine Cooper
Executive Director, Aotearoa New Zealand & Global Health

On the 14 October 2023, Aotearoa New Zealand's citizens placed their votes, but it took until the 24 November for the new government and cabinet to be formed through an agreement of three parties – National, ACT and New Zealand First. The three-way coalition is a first in New Zealand's MMP (Mixed Member Proportional) voting system, although coalitions are far from new. Negotiations to form the government were protracted and the major party in the coalition, National, made separate agreements with each of the parties.

The coalition agreements included a wide range of changes across a variety of areas, signalling among other things, tax cuts, cancellation of public infrastructure projects and cuts for the public service. Not all directly related to health, the agreements also signalled a desire from some of the coalition parties to take a different approach in te Tiriti o Waitangi. Changes included introducing a Treaty Principles Bill, removing co-governance from the delivery of public services, disestablishment of Te Aka Whai Ora – the Māori Health Authority, 'examining' the admission schemes of the two medical schools designed to increase numbers of Māori and Pacific doctors, requiring government departments and crown entities to communicate primarily in English, and one seemingly targeted at health: Issue a Cabinet Office circular to all central government organisations that the Government's expectation is that public services should be prioritised on the basis of need, not race, within the first six months of Government.

Combined, these agreements have painted a picture of a new approach, which has already triggered protests, a Waitangi Tribunal claim, high court proceedings filed by an iwi (tribe), a rare hui-ā-motu (national meeting) of iwi from around Aotearoa, and much debate and some heckling of politicians at Rātana Pā and on Waitangi Day.

Concern has also been raised by Māori and the health sector about repealing the smokefree legislation, which had been seen as world-leading and a step towards creating a 'smoke-free generation', with those born from 2009 never able to buy tobacco products.

Other health related agreements included extending free breast cancer screening to the age of 74 repealing the Therapeutic Products Act 2023, a cost benefit analysis of the National party's proposed new medical school at Waikato University, and fast approval by Medsafe of pharmaceuticals approved by overseas agencies.

The new government is setting five major targets for the health system, including for wait times and cancer treatment. RANZCOG has advocated for access to surgery, especially for gynaecological procedures. In the mix is potentially the directive on prioritisation based on need not race. Māori currently experience a range of poorer health outcomes and face obstacles to care, including systemic barriers and structural racism.

Dr Erena Browne (Hono Wāhine trainee rep) and baby Pākewa. Photo: RANZCOG

An interesting agreement is: Ensure proper funding for birthing units and maternity care, including providing for a three-day stay for new mothers. Who in health would ever argue with the sentiment of 'ensure proper funding'? We are yet to see what this actually means. And providing a three-day stay for new mothers will undoubtedly present resourcing challenges, even if there is 'proper funding'.

A cornerstone of RANZCOG's Te Rautaki Māori me te Ara Whakamua is the goal of growing the Māori O&G workforce (as well as increasing the cultural safety of the whole O&G workforce) to improve health outcomes for Māori. Data shows that the number of Māori doctors graduating from medical schools has increased. We can only presume that examination of the Auckland University Māori and Pacific Admission Scheme (MAPAS) and Otago University's Mirror on Society equivalent will determine that they are delivering desired outcomes.

We are delighted that this is resulting in increasing numbers of Māori FRANZCOG trainees.

Health Minister Hon Dr Shane Reti, a former GP and Board member of Northland District Health Board, has assured the health workforce that he understands the current workforce crisis and the priority of addressing workforce issues. He says that work is going into retention factors such as salary and terms and conditions, as well as the longer-term strategy of an additional medical school at Waikato University.

He has also reassured that there would be no further major structural changes (apart from the significant disestablishment of Te Aka Whai Ora) to a health system already exhausted by change. The removal of smoking reduction legislation and the disestablishment of Te Aka Wahi Ora have been topics of much conversation across the health sector. This raises questions for us as a medical college about how we engage in this debate. How far do we go? How do we balance the opportunity for strong working relationships with Ministers with raising concerns? How do we (indeed should we) avoid being political? Do we stick to principles like equity, or do we advocate for 'the how' (like Te Aka Whai Ora)? These are questions for any organisation with an advocacy role, that also works within a system. Fortunately, across the health space there are numerous organisations making similar points.

RANZCOG's immediate response was to be clear that we will maintain our focus on te Tiriti o Waitangi, on partnership, on equity and on use of te reo Māori. We will continue to implement Te Rautaki Māori me te Ara Whakamua – our Māori Strategy and Action Plan. And this approach, of focusing on what we can do, and focusing on advocating for equity was also the approach going forward, agreed after consideration, by the Aotearoa New Zealand committees.

The coalition announcements came soon before RANZCOG's Aotearoa New Zealand committees held their first meetings of the 13th Council term in December, so this was an opportunity to discuss the new directions and policies signalled by the coalition government. This informed RANZCOG's briefing paper for the incoming Minister of Health. The paper highlighted the need to retain a focus on health equity and concern about reduction in smoking prevention. It focused though on the issues we've long advocated for, and some of the specific actions that would make a difference, such as addressing funding for maternal ultrasound, addressing urogynaecology and the mesh pause, gynaecology care and access to surgery, cervical cancer elimination, strategies for preventing and addressing birth trauma, and the O&G workforce.

RANZCOG's committees, Te Kāhui Oranga ō Nuku, the Aotearoa New Zealand Committee and He Hono Wāhine are committed to pursuing opportunities to advocate for equity and for women's health. To advocate for our trainees, Fellows and other members. We will continue to call upon the Government to ensure that our health system enacts the commitments of te Tiriti o Waitangi and focuses on equity of health outcomes in Aotearoa.

Editorial

Dr Magda Halt
Surgical Gynaecologist, BMBS,
BSc, FRANZCOG, MastMIS

For most of us, life is busy. We work a combination of jobs, often across both the private and public sector, operate at a number of different hospitals with multiple teams, and try to do our best to strive for that elusive 'life/work' balance. The surgical component of our professional life often demands our attention, from that very first appointment and continues throughout the recovery period and sometimes longer. We strive for safety, efficiency and precision. We want our patients to recover well. We want our complications rate to be low, our skills to expand and our reputation to be well rounded. This all translates to job satisfaction, professional longevity, and increased referrals.

In this edition of O&G magazine, we cover some aspects of care that can contribute to improving surgical outcomes, both in terms of recovery and ongoing management, and aim to provide helpful strategies and ideas with direct application to our surgical work. As we are unable to cover the full scope of peri-operative interventions, we hope to start a wider conversation in workplaces to develop these ideas further. In particular, the consideration of unique circumstances that often requires a personalised management plan. For instance, a patient with a history of trauma or chronic pain, with transvaginal mesh, who are gender diverse and/or of advanced age and presenting co-morbidities.

Surgery forms a substantial part of practice for most obstetricians and gynaecologists, and it is an integral part of our curriculum. Our early training starts with dilatations and curettage, and quickly progresses to laparotomies, often while our gynaecology surgical skills are still in their infancy. As we progress through our speciality training, we are exposed to various approaches to care, a raft of surgical techniques and wide-ranging spectrum of management of the peri-operative patient.

As we have heard over the last few years, it is not unusual for trainees to have to advocate for further surgical training due to limited caseloads and disproportionate time allocated to obstetric service[1]. This, and the inconsistencies of the surgical experience, particularly during Fellowship training, have now been more widely recognised and several initiatives aim to address it. At College level, a review of the Curriculum aims to harness the limited surgical contact into streamlined modules: two surgical committees are scrutinising surgical numbers with the aim of providing solutions to ensure surgical competency (Endoscopic Surgery Advisory Committee and Gynaecology Surgery Training Working Group); and excellent work is being done to incorporate simulation to address training needs (through the Simulation Advisory Training Group).

Furthermore, post-Fellowship, specialised surgical training is becoming a frequent extension to training. It aims at achieving and developing specialist skills, such as advanced laparoscopy (AGES), pelvic floor repair (CU) and extensive abdo-pelvic, vulval and groin dissection (GONC). Even without subspecialty training, many opt to complete extra training to feel confident progressing in the independent provision of surgical care. Preparation of the patient for surgery and post-operative care does not currently feature in the RANZCOG curriculum[2] and is mainly taught 'on the job', to various extents. The latter is dependent on program, hospital, and supervisor – and hence often inconsistent.

For many trainees and Fellows, exposure to Early Recovery from Surgery (ERAS) protocols[3,4] happens as part of or continuing professional education. In this issue, Boo and Brand expand on ERAS, as applied within gynaecology oncology[4], although the tenets can be generalised across gynaecology surgery. Benign obstetric and gynaecology pathways also exist and can be freely accessed via www.erassociety.org for minimally invasive, vulval and vaginal surgery and Caesarean section[3]. As a protocol, it encompasses many of the ideas we will discuss in this edition and guides us to best practice peri-operative care. Many of its recommendations are easy to implement and cost effective. ERAS has now been in existence for three decades, and evaluation studies particular to our specialty demonstrate clear benefits, including reduced stay duration, less readmission and ileus; less post-operative nausea and vomiting, and decreased hospital costs[5,6,9]. If we also apply data from Minimally Invasive Surgery in general surgery (with a longer evaluation profile), such studies show a benefit in decreased length of stay, reduced use of opiate analgesia but without increasing complications or readmissions[7,8]. A win-win for patients, surgeons, and health networks.

What we have not covered in this edition are issues of pre-operative counselling and consent. These are both imperative to setting patient's expectations of their surgical journey, developing rapport and trust between patient and surgeon and, from a medico-legal perspective, ensuring the right operation is planned. In our field, surgery can have multiple intents: curative, often diagnostic, adjunct to other treatment, repeat due to recurrence, or refractive to other treatment. As such, appropriate counselling is essential.

Do not underestimate the impact of your relationship with the patient: if you have established this rapport, just by your presence and easy banter by their bed, you will reduce their peri-operative anxiety and increase their chance of a better recovery[10].

Optimising surgery also means looking after the surgeon, in other words: ourselves. This can mean good ergonomics, a familiar theatre team, continuing professional education and appropriate rest from work. There are also multiple aspects of the theatre environment that can affect our performance and patient-centred approach to clinical care. For example, is noise affecting surgical outcomes? High noise levels can apparently impact performance negatively[11]. But is music good for our patients? Yes, if it is gentle and their choice, it can help reduce anxiety[12]. We could easily devote a whole separate edition to these issues and some of these matters were indeed expanded on in *O&G Magazine, Vol. 21 – In Theatre,* which I thoroughly recommend.

For now, we hope to provide an overview of surgical optimisation and we welcome your feedback regarding other novel methods in ensuring good outcomes for our patients.

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Building self-care into healthcare

Dr Simon Craig
FRANZCOG, MApp, PosPsych

It's dark as you walk into the delivery suite. At 4am it feels like the rest of the world is asleep. Like you should be. And it's quiet, at least until you get to the room where your patient is. The gut-wrenching screams of a failed epidural.

Your patient is a multi. Second baby. Feeling pushy. But only just fully – with a high head and malposition. The CTG is ugly. Very ugly. And, of course, there is no anaesthetist or theatre staff in the hospital.

Sound familiar? Many obstetricians will recognise the sinking feeling that goes with this situation. The easy normal birth that you were anticipating while coming in is not happening. What to do? Attempt an instrumental delivery in the Birth Suite? – what if I can't get the baby out? But can I wait for theatre/an anaesthetist? Will a tocolytic help or do I want contractions for a possible instrumental? No one else can help you with these decisions. The labour ward is a lonely place at 4am.

Simply being a doctor means belonging to a potentially lonely profession. In 2018, medicine was deemed as being the loneliest occupation[1].

"Surely this can't be true in O&G?" you might argue. Not in a specialty filled with families, new life and joy? Well, compared with other specialties, Obstetrics also carries enormous expectations of perfect outcomes every time. Perfect babies. Beaming mothers. And what of Gynae? Surely any operation that can be performed through four tiny incisions must be easy – without post-operative pain or risk of complication?

In the not uncommon birth scenario above, the end-result will almost always be favourable in Australia and New Zealand – thanks to a combination of our resource rich systems, excellent clinical training, and input from Mother Nature. Thankfully most of the time the sleep-interrupting and stress-provoking event results in a healthy and happy mother and baby. Does that mean the anxiety (sometimes terror) that you have felt is overblown?

It can certainly feel that way when the experience is shared with a layperson and the response is: "So the baby is okay, right? What's the big deal?" It can be even more frustrating when a non-obstetrician says: "Why didn't you just do a Caesar?" when discussing this (or almost any other) intra-partum scenario.

What they often don't understand is that a major component of the stress associated with these situations is precisely because there is often no obvious or easy solution. What the obstetrician knows is that although the outcomes are almost always good – sometimes they aren't. The wonderful profession of O&G with overwhelmingly positive results and uplifting experiences is balanced by rare devastating outcomes. It goes with the territory. It is either a very fortunate or a very inexperienced Obstetrician Gynaecologist who hasn't been involved in at least one awful complication or tragic episode in their career.

The value of support

Early on in my Consultant career, I had a difficult surgical complication which I had never heard of, or seen before. I couldn't sleep and ruminated on the problem. Was it sheer bad luck that had caused this patient to be damaged, or was I in some way incompetent? My compassion for the woman threatened to become unbalanced. To tip from a feeling of guilt that I was responsible for the patient's suffering, into a sense of shame – that I was somehow defective or inherently flawed.

A few days after the event, I encountered a senior colleague who related that he had been involved with the same complication early in his long career and knew of another similar case. Immediately, I felt a weight lift. I was not the only one who had experienced this situation! I realised that it was not just me. The older colleague was generous, he did not need to share his experience with me – many of us will not admit to ever having had a complication – but by doing so, he eased my worries and taught me a lesson on kindness and leadership.

Many times in my career I have recognised the value of a group-practice tearoom that allowed discussion of clinical difficulties or suboptimal outcomes, and the associated release of tension in sharing these issues. Open discussions normalise some of the pressures we all feel and also facilitate learning. Being able to express vulnerability builds bonds and creates better doctors.

Understanding ourselves

All doctors are high achievers. Many, perhaps most, of us have perfectionistic tendencies. These personality traits may be part of the mix that drives attention to detail and allows provision of excellent care day after day. Together

with this, we often suppress our own emotional response to facilitate effective treatment, especially in emergencies. We need to be decisive and clinical. Yet perfectionism, invulnerability and emotional suppression can have troubling associations with anxiety, burnout, isolation, and poorer health[2,3]. We must get the balance right with the emotional and psychological mindset that allows best patient care, while also recognising what is required for our own wellbeing.

If our personality characteristics can put us at risk of poorer psychological health, and we operate in a pressurised and potentially isolating field where the only people who can really understand our work demands are our colleagues, it appears vital that we have a system of support and care for each other.

What do we need for wellbeing?

To look after our ourselves, support each other and optimise the resilience of our workforce, we need to first understand what it is we need to promote our own health and wellbeing.

In this setting, Self-Determination Theory (SDT)[4] is a sound empirically supported theory of human motivation and wellbeing. According to SDT, the basic needs for optimal functioning and psychological wellbeing are: a sense of autonomy, competence, and relatedness. If any are not satisfied, one's motivation and wellbeing are impacted.

Consultants tend to enjoy relative autonomy and specialty training usually ensures competence. However, occasionally the relatedness component of wellbeing can be lacking. This is due to many reasons including excessive workload, perceived competitive aspects of the profession, and suboptimal team or organisational culture. In my opinion, relatedness is the element that we must build on. Improved relationships, better bonds, higher functioning teams – these all result in improved individual wellbeing and better organisational outcomes, including patient care.

The importance of healthy work relationships

Feeling connected to peers is critical to our own health. Loneliness at work can lead to significant health risks, with increased all-cause mortality akin to smoking half a packet of cigarettes a day[5]. Poorer work connections also impact on one's family and predispose some people to burnout and subsequent increased errors in patient care[6,7].

Just as SDT tells us that we need to feel relatedness and connection to enable motivation and wellbeing, Gallup workplace analytics have found that people in all industries who are not able to identify a 'best friend at work' have reduced engagement and productivity, make more mistakes, are more likely to leave the workplace, and have higher burnout rates[8,9]. These effects of friendship, or lack of, have also been found in medical workplaces[10]. For a doctor, lack of a best friend at work - or even worse, having no friends - reduces wellbeing and translates to poorer clinical outcomes. The benefit of tight bonds with colleagues is highlighted even more starkly when an adverse event occurs in one's practice.

Some may argue that focusing on improving peer-to-peer relationships within the profession is superficial and unnecessary. However, I think this attitude is outdated.

Our world has changed, and the healthcare landscape has new challenges. The burnout epidemic is only one of many reasons why it's imperative to support all staff and colleagues, including trainees.

Building supportive relationships at work

The creation of better bonds at work has multiple benefits for everyone. For doctors, the benefits include enhanced life-satisfaction and health, and will have flow-on effects outside work. Teams will achieve greater success with clinical outcomes; hence team leaders need to value and prioritise inclusion and relationships.

For institutions, the effects of better relationships include patient satisfaction and improved organisational culture. This process starts with each of us, and with every interaction. To be supported by friends at work requires us to have previously nourished our relationships with colleagues. Being available, empathetic, and prepared to listen helps enormously. Recognising the worth of others is essential, likewise we must allow ourselves to feel gratitude and affection. Collaboration as teammates with the same goals rather than competition with co-acting agents in the same space is also key.

The role of organisational leaders is crucial in creating a supportive, learning, caring culture. Becoming friends with another person generally involves spending time together and getting to know each other well. Team and departmental initiatives can prioritise opportunities for colleagues to connect more deeply.

Friendship involves curiosity, empathy, and a degree of joint vulnerability. Leaders who value and model these behaviours display authentic leadership. Leaders must be connectors, too – enabling high-quality connections to be fostered between teammates.

We will all go through difficult times, whether clinical or personal, in our careers. But these problems will be navigated more easily with support. When no one else can truly understand the challenges we face, we need to support each other.

Dr Craig is an experienced Obstetrician and Gynaecologist who also provides coaching for doctors and systems optimisation for teams through his company PosMed. He can be reached at: ***contact@PosMed.com.au***

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Perioperative optimisation for gynaecological oncology patients

Dr Marilyn Boo
MBCHB, FRANZCOG

Professor Alison Brand
AM, MD, FRANZCOG, CGO

Enhanced recovery after surgery (ERAS) is multidisciplinary, evidence-based approach to perioperative care of the surgical patient. It was initially developed in 1995 by Henrik Kehlet, a Danish surgeon, and aimed to minimise surgical stresses and maintain physiological homeostasis[1].

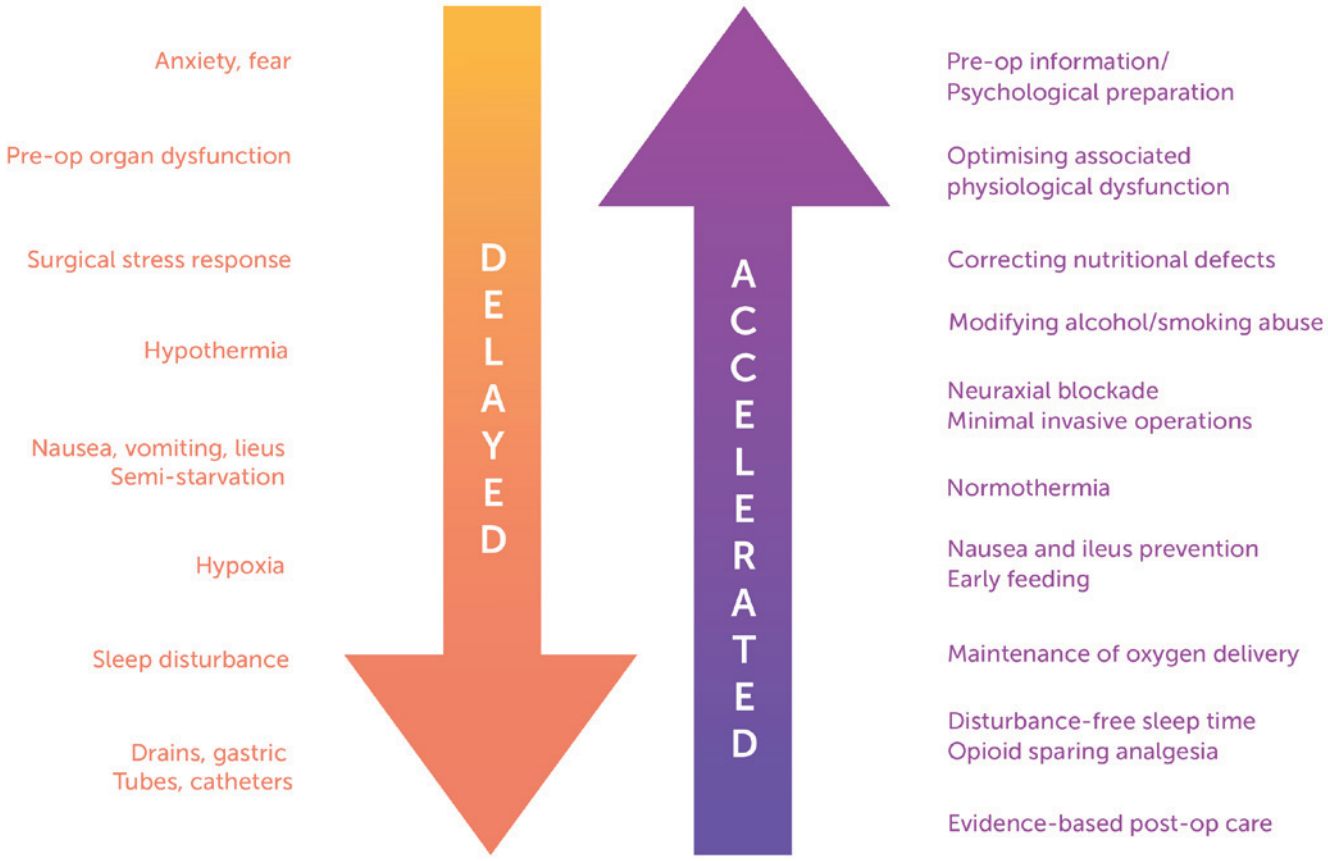

Figure 1. Multimodal interventions in the ERAS pathway as outlined by Henrik Kehlet Source: Kehlet H, Wilmore DW, Multimodal strategies to improve surgical outcome. Am J Surg. 2002 Jun;183(6):630-41

This results in reduced morbidity, faster recovery and quicker return to baseline function. Subsequently, the ERAS Society has developed ERAS guidelines specific to gynaecology oncology[2]. This article explores components of peri-operative management through three key management aspects: pre-operative, intra-operative and post-operative.

Pre-operative management
Preadmission - education and expectation management. Involve clinical nurse specialist in preadmission clinics
Prehabilitation - Support from physiotherapy, dietitian, psychology, treat co-morbidities
Preparation - consider oral carbohydrates, no routine bowel prep

Intra-operative management
Anaesthetic consideration - Goal direct fluid therapy, warming blanket, multimodal opioid sparing analgesia i.e spinal and oral analgesia

Surgical consideration - Minimally invasive surgery whenever appropriate, surgical site infection reduction

Post-operative management
Normal diet within 24hrs, mobilisation day 1 by removing urinary catheter. 3 - 4 different classes of anti-emetics, prevent ileus by reducing opioid use, early feeding and caffeine. Extended VTE prophylaxis for 28 days if high risk. Bundles, VTW prophylaxis i.e. calf compressors and clexana
Intra-operative management

Figure 2. Summary of gynaecology oncology ERAS pathway
Adapted from: Sidhu, Lancaster, Elliott, Brand, 2012

Pre-operative assessment (3Ps) – Goal = optimisation

1. Preadmission
This involves patient education and counselling in order to set expectations about surgical and anaesthetic peri-operative care[3]. This has shown to reduce patient anxiety, facilitate early discharge and reduce post operative pain and nausea[4].

2. Prehabilition
Prehabilition initiatives are relatively new in the field of gynaecologic oncology and have not been standardised.[3,5] Prehab ensures patients are physically and mentally prepared before undergoing complex surgical procedures[5]

Strategies involve a multidisciplinary approach:[5]
- Physiotherapy to improve physical capacity, reduce risk of sarcopenia and expedited recovery to baseline
- Nutritional assessment to identify malnutrition and engage dietetic support.
- Psycho-oncological support should be offered to empower patients and educate on coping techniques in preparation for surgery and recovery.

Best supportive therapy optimises patients so that they are at their best health before surgery[6]. This includes:
- Controlling symptoms: preoperative pain management, drainage of pleural effusions or ascites
- Correcting any metabolic imbalances
- Improving overall health conditions: treating co-morbidities, smoking and alcohol cessation.

3. Pre-operative preparation
Oral carbohydrates administered 2-3 hour prior to anaesthetic induction has been shown to reduce post operative insulin resistance, expedite bowel function restoration and is associated with shorter hospital stays.[7]Most studies included oral beverages containing 50g of carbohydrates. It is unclear if a specific carbohydrate drink is necessary, or whether oral clear fluids would suffice. Results are extrapolated from other abdominal and pelvic surgical data as currently there are no specific gynaecological oncology data.

Routine bowel preparation is discouraged due to the lack of evidence of benefit[3]. If a bowel resection is thought likely, then results from a meta-analysis would favour combination of oral antibiotics (erythromycin) with mechanical bowel preparation to lower surgical site infection risk[8].

Intra-operative management – Goal = Stress minimisation, maintain optimal surgical conditions

1. Anaesthetic considerations
Optimal fluid management through goal-directed fluid therapy (GDFT) utilises parameters such as heart rate, blood pressure, cardiac output to titrate intravenous fluid, inotropes and vasopressor therapy. GDFT is associated with a reduction in morbidity, hospital length of stay, intensive care length of stay and time to passage of faeces[9].

Maintaining normothermia by use of air blanket devices, warmed IV fluids and warming mattress to avoid hypothermia which is associated with increased surgical site infections and cardiac events[3].

Multimodal opioid sparing analgesia has been shown to improve quality of life after surgery by minimising side effects from opioid use[3]. This may be achieved through a combination of non-opioid oral medications and regional anaesthesia or incisional injections with local anaesthetics.

2. Surgical considerations
Minimally invasive surgery (MIS) has been shown to reduce blood loss, length of stay, reduce pain and expedite return to normal daily activities[3]. It should only be selected where appropriate and should not compromise oncological outcomes. Long-term outcomes in MIS have been found to be similar to open procedures for endometrial cancer but not for early-stage cervical cancer[10,11].

Surgical site infection reduction bundles include antimicrobial prophylaxis (first generation cephalosporins), chlorohexidine-iodine-alcohol skin preparation, preventing hypothermia, reducing hyperglycaemia and avoiding surgical drains especially in the subcutaneous level[3].

Venous thromboembolism (VTE) prevention recommendations include dual prophylaxis with mechanical prophylaxis such as sequential compression devices and chemoprophylaxis with low molecular weight heparin (LMWH) or unfractionated heparin while inpatient.[12]Chemoprophylaxis should continue for a total of 28 days following abdominal or pelvic surgery for cancer[12]. Currently, there is low quality and inconclusive evidence for the use of direct-acting oral anticoagulants as alternative thromboprophylaxis to LMWH or heparin.

Post-operative care – Goal = expedite recovery and return to baseline

Early oral nutrition encouraged, ideally within the first 24 hours after gynaecological cancer surgery to support return of gut function[3].

Early mobilisation reduces post operative complications such as VTE and post operative ileus. This can be facilitated by early removal of indwelling catheter, usually removed morning after surgery if suitable. Early referral to physiotherapy and prompt identification of patients who will require short-term rehabilitation is paramount to support recovery[3].

Extra considerations include:
Minimising post operative nausea and vomiting (PONV) by avoiding volatile anaesthetics and nitrous oxide, using regional anaesthetics, and emphasis on multi-modal opioid sparing analgesia. At least 3-4 anti-emetics of different classes should be offered[13].

Prevention of post operative ileus should be a priority following a laparotomy. Interventions to encourage return of gut activity includes reduce opioid use, early feeding, early mobilisation, gum chewing and drinking coffee[3].

Limitations of ERAS guidelines
The ERAS guidelines are based on best available evidence in the current literature. Nevertheless, there are certain interventions where high-quality evidence was unavailable. It is important to recognise that each element is not mandatory and needs to be adjusted according to individual patient and unit circumstances. However, the greater the adherence to most of the guideline elements, the greater the potential benefit to the patient.

Challenges to implementation of ERAS
Despite the documented advantages of ERAS, it has not been universally adopted due to perceived barriers in implementation[14]. These barriers include lack of buy-in from clinicians and hospital leadership, economic and resource constraints such as access to training to implement, and gaps in high quality evidence for certain ERAS recommendations.

It is crucial that implementation of an ERAS program begin with a multidisciplinary team who leads the development of an ERAS program specific to the needs of a particular unit[15]. It should be led by, and include, a surgeon, an anaesthetist, a pain specialist and an experienced nurse who are then responsible for obtaining buy-in from other team members. Subsequent audit of outcomes is essential to make appropriate adjustments as needed and close the implementation loop.

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Gynaecological surgical care for the transgender patient

Dr Rixt Luikenaar
MD FACOG

Transgender patients may desire surgical intervention as part of their gender journeys to align their body with how they feel it is supposed to be. Such a request is medically necessary and should be offered.

The Standards of Care, version 8, by the World Professional Association for Transgender Health (WPATH), has constituted criteria for various gender-affirming surgeries[1]. Surgeries available include chest or breast surgery (top surgery), genital surgery (bottom or lower surgery), facial surgery and other surgeries.

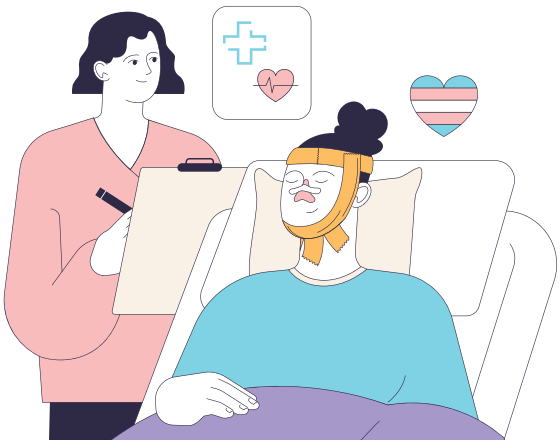
Besides a hysterectomy, patients may request a vaginectomy, or a phalloplasty or metoidioplasty. Gynaecologists may encounter patients returning from another state or country who request post-operative care after vaginoplasty or vulvoplasty. It is beneficial to become familiar with the surgical technique, anatomic alterations, impact on sexuality, general post-operative care, and common complications of these surgeries[2].

Key considerations for treating transgender patients

WPATH recommends one assessment from a mental health professional, some surgeons or insurance companies require two assessments, as well as one from the physician that prescribes gender-affirming hormones to the patient. This may vary between countries. The assessments ensure mental stability and a support system. Persistent gender dysphoria and the ability to give informed consent are required. A person must be on hormone treatment for a year unless clinically not indicated (for non-binary persons). Social transition (appearance or expression as clothing or hairstyles) is not required for a hysterectomy.

Transmasculine patients may request a hysterectomy for gender affirmation as a prerequisite for legal transition, a desire to avoid future gynaecological examinations or complications, and/or for conditions such as endometriosis, ovarian cysts, pelvic pain, dysmenorrhea, or menorrhagia. Combined chest reconstruction and hysterectomy can be considered.

There are no standard guidelines for pre-operative care for transmasculine people on testosterone therapy. During pre-operative visits, the doctor and patient should discuss the risks, benefits, alternatives (informed consent) and the mode of hysterectomy; laparoscopic (robotic) versus a vaginal approach. Consider a salpingectomy at the time of hysterectomy and discuss the risks and benefits of an oophorectomy (based on desired fertility, current age, impact on bone density, cardiovascular and cognitive impact, ovarian cancer risk, and possible need for future gynaecological procedures due to cysts, torsion, ovarian cancer). Future fertility must be discussed, and information offered on egg or embryo cryopreservation. Preventive care after surgery may include CST If the patient has a history of cervical dysplasia, and abdominal ultrasound or a pelvic exam if ovaries stay in situ, as well as a chest exam after a mastectomy, since not all breast tissue is removed.



Other important things to consider

Pre-operative testing includes performing CST, evaluation and optimisation of blood pressure, lipid profile, haematocrit levels, diabetes and thyroid screening if indicated (many transmasculine patients have PCOS, hyperinsulinemia, metabolic syndrome, elevated haematocrit (secondary polycythaemia) and obstructive sleep apnoea associated with testosterone therapy). Secondary polycythaemia by itself does not increase thrombosis risk. Obtain an STD panel if indicated. Smoking and visceral fat distribution can impact ventilation when a patient is in Trendelenburg position during minimally invasive surgery.

It's important to discuss the patient's nutrition status as many transgender patients are neurodivergent and/or struggle with eating disorders, restrictive eating or have a diet rich in fat, salt, and carbohydrates and poor protein and vitamin intake. Also ask about alcohol intake and other substance use and check what medications

and supplements the patient is taking and stop NSAIDS and other anti-platelet agents at least a week prior to surgery. The patient can continue testosterone therapy and does not need to stop it prior to surgery; this can initiate reoccurrence of the menstrual cycle which increases gender dysphoria.

Standard antibiotic prophylaxis for a hysterectomy is recommended, a first-generation cephalosporin, if allergic clindamycin, erythromycin or metronidazole[3]. A typical regimen would be Metronidazole 500mg po bd the day prior to surgery, and Cefazolin 1-3 gram with Metronidazole 500mg iv during surgery to treat potential bacterial vaginosis, which is more prevalent in transgender men due to a change in vaginal microbiome on testosterone[4].

Patients on testosterone therapy require vaginal oestradiol cream of 1 gram three times a week for two-four weeks before, and up to three months post-surgery, which changes the vaginal microbiome[5], decreases BV risk[6], decreases cuff cellulitis and the risk of cuff dehiscence. Penetrative sexual activity should be avoided for 8-12 weeks. Suture choice, closing the cuff in one or two layers does not seem to impact the incidence of cuff dehiscence[7].

Low dose estradiol vaginal cream maintenance for patients on testosterone therapy is recommended, especially after an oophorectomy, as many develop genitourinary syndrome[8,9]. Use of this cream does not appear to affect masculinisation.

Consider thrombosis prophylaxis (compression boots during surgery), accelerated ambulation and same-day discharge. Schedule the patient for surgery early in the day to help avoid nausea prophylaxis and remove the IDC in the operating room prior to taking the patient to recovery and commence regular diet early. Discharging the patient on the same day prevents admission to the gynaecology ward with cisgender women (consider admitting the patient to the surgery ward if staff familiar with post-operative care after having a hysterectomy and if they have had gender-affirming sensitivity training).

Gender-affirming sensitivity training

It is important that staff at the hospital or surgical centre, have received gender-affirming sensitivity training and are aware that the patient receiving surgery is transgender. This can help ensure appropriate name and pronouns are used by everyone (especially if they have not changed their name and gender marker legally and therefore the medical record does not match the chosen name and pronouns.) Make sure everyone involved in the patient's care is aware of the type of surgery that is going to be performed.

Allow the patient to use the bathroom of their choice. Also ask them if the person who accompanies them to the hospital is safe to talk to after surgery about their surgery and transgender status. Never "out" a transgender patient. Ask for preferred terminology of body parts (front canal instead of vagina) and take an "anatomy inventory".

About Dr Luikenaar

Rixt Luikenaar is an Obstetrician-Gynaecologist, who owns Rebirth Health Center, a private practice focused on gynaecology and transgender and gender-expansive care in Salt Lake City, UT. Dr Luikenaar graduated Medical School Cum Laude, from the University of Groningen, The Netherlands, and is Adjunct Faculty at the University of Utah. In 2010, they spent a sabbatical in Cairns, Australia, as a Senior Medical Officer with Dr Paul Howat. Dr Luikenaar has treated over 7,000 transgender patients with gender-affirming hormone therapy since 2011 and has performed hundreds of hysterectomies and orchiectomies for transgender patients. They trained with several surgeons in the United States to learn vaginoplasty and co-edited and co-authored Transgynecology, a textbook published in 2023 by Cambridge University Press[10].

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Spotlight on: Maternally Assisted Caesarean

Childbirth is a unique area of health care that deals with a supposed natural process but one that often needs expert assistance. In well-resourced countries the safe outcome for parents and offspring is often assumed, so the emphasis sometimes shifts to the experience of the labour and birthing process as an end in itself.

Direct involvement of the person delivering and their supporters can often be accomplished in the delivery room when a vaginal birth is taking place. However, as between 30-50% of hospital births are now by caesarean section, some parents feel disempowered. They can also feel removed from the actual experience and want to be more intimately involved. Hence the arrival of the Maternally Assisted Caesarean (MAC).

Here, we present several viewpoints related to this new development in O&G.

Dr Suzanne Meharry
Obstetrician and Sonologist,
MBBS (Hons), FRANZCOG, DDU

I started performing Maternally Assisted Caesareans (MACs) in 2019 when a private patient of mine, a midwife, said: 'I want an elective caesarean, but I want to deliver the baby myself.' I had just started a new private practice at a local maternity hospital, and I was lucky to have a very progressive and receptive medical director. He took it upon himself to write a policy and procedure and we were ready to go.

I performed a handful early on, offering them to women I thought would benefit. But fairly quickly women started coming to me from all around the state, asking for them. Word had clearly got out, and I was finding that women who had experienced trauma with their first birth, were coming to have a MAC for their subsequent birth in the hope of it being a healing process.

For instance, there was the patient who had sustained a fourth-degree tear after a vacuum birth in a small country town. She'd been flown out RFDS to Perth for a repair and been separated from her baby for 48 hours. A priority in this birth was protection of the anal sphincter but she also wanted uninterrupted time with her baby from birth and felt that by assisting in the delivery she would maximise this.

Another patient had undergone an emergency caesarean for obstruction after a very long labour. She had a massive post-partum haemorrhage during the section with a blood transfusion, then a return to theatre for an intra-abdominal bleed. She spent the first three days apart from her baby in ICU and has very little memory of the time. She also had extreme difficulty establishing breast feeding. Her priorities for the next birth were a safe delivery that she felt part of and immediate skin to skin.

There was also a group of women who were having a medically recommended caesarean but were keen to participate more in the birth than a traditional caesarean allows. I have now done a few in breech presentation, women with advanced maternal age and women with a previous classical caesarean.

Feedback has been amazing. Most women expressed gratitude for being able to be part of the birth. For women who had a traditional Caesar the first time they gave birth, and a MAC the second, many said the MAC felt empowering and created a wonderful memory of their child's birth. Some women stated it was 'the next best thing to vaginal birth'.

I have now done 73 MACs. Most of the women were extremely happy with their procedure. There were two women who said they wouldn't do it again. One, because she didn't feel that it was worth the effort of scrubbing and gowning, and the other didn't feel it added much to the overall experience.

The average blood loss from the 73 cases was 480ml. There were two post-partum haemorrhages of 1000ml. Both were in women with large fibroid uteruses. There were three women treated with oral antibiotics for superficial wound infections after discharge. Two diagnosed by their GP and one by me. There were no readmissions for infections.

Patient selection is important. I usually offer a MAC to women for who a caesarean is medically indicated but who are worried they will miss out on the experience of a vaginal delivery. I have done several for babies in a breech presentation and given the whole 'delivery' is done by the surgeon, it certainly loses some of the experience.

Support from the whole team is important and I have had a few anaesthetists who were not keen on the procedure. The IV cannula needs to be placed high in the arm to allow access after gowning and gloving, and the patient can often obstruct the drip with a flexed arm. This often happens just as the oxytocic is given, although fortunately has not translated into an increase in blood loss.

Rebecca Hamilton meets her baby after a successful maternally assisted caesarean at St John of God Mount Lawley Hospital, Western Australia.
Photo: Supplied by Suzanne Meharry

The paediatrician needs to support the process too and I have certainly worked with a few who believe the baby should come straight to the cot post-delivery.
Over time, in my team the paediatricians have certainly become more comfortable coming over to the mother, warming and drying the baby on her chest and performing an initial examination. The midwife is also very important here, helping the mother to support her baby and bringing in warmed towels.

The biggest recurring lesson I have learned over these five years of listening to birth stories and performing maternally assisted caesareans, is that for many women the actual experience of the birth really is critically important. And saying it's all OK as long as there is a healthy baby at the end is not enough for many women, nor their postnatal mental health and wellbeing. Women must come through their birth feeling safe, heard and respected. We are in a very privileged position to be able to help women start as mothers in this way. I am really pleased to have found the MAC to be helpful in facilitating this.

Dr James Griffiths
MBBS, FANZCA, MEpi, PGCertCU

The Maternal Assisted Caesarean (MAC) is an increasingly popular innovation in the conduct of a caesarean delivery. The idea seems to particularly appeal to women who have had a difficult or traumatic birth experience previously, or for women who are disappointed that they have a medical indication for a caesarean birth. For many of these women, having the option of choosing to become an active participant in the delivery of their baby seems to be enormously empowering.

Anecdotally, many obstetric anaesthetists seem quite ambivalent about the relative merits of the MAC. While the actual 'maternal assisted' component of the delivery might only last for a few seconds, obstetricians need to be aware that the MAC represents a significant change to a 'standard' caesarean procedure, which needs to be planned for and communicated across the entire perioperative team.

Reliable intravenous (IV) access and continuous accurate monitoring of vital signs are key priorities for essentially every anaesthetic procedure, including the MAC.

During any caesarean delivery, the anaesthetist needs to be able to ensure timely administration of fluids and medication, including fluids, vasopressor, antibiotics, antiemetics and uterotonics. For a MAC, I generally find placing the IV cannula in the mid-forearm, preferably away from both hand and cubital fossa, where it is particularly prone to kinking and/or dislodgement. I have never found it necessary to use other sites such as veins in the upper arm (above the elbow) or the lower limb. The IV site inevitably becomes totally inaccessible as it lies within the sterile field once the mother's arms are cleaned and she is gowned and gloved. For these reasons, the IV needs to be carefully covered with large occlusive adhesive dressings and then reliably taped prior to sterilising the patient's arms.

Once spinal anaesthesia has been established, it is important that the anaesthetist can carefully check the adequacy of the block prior to the patient donning sterile gloves and gown. Assessing the block becomes much more difficult once the patient's arms and torso are covered with

a sterile gown.

Continuous monitoring of vital signs is important during any caesarean. In my own practice, I have seen several cases where a change in pulse oximeter reading the first sign of an evolving obstetric crisis was, including anaphylaxis and amniotic fluid embolus. During a MAC, a digital pulse oximeter obviously can't be used on the fingers as this is within the sterile field. I have found an ear probe to be a reasonable alternative. However, in an awake moving patient, the trace is often unreliable, and the probes tend to dislodge. Placing the probe on a toe can be a reasonable alternative if the monitoring cable is long enough to reach the feet. Non-invasive blood pressure monitoring can also be unreliable, particularly while the woman is elevating her hands and arms during the sterilising process.

It shouldn't be forgotten that the emotional wellbeing of the partner/support person is an important additional responsibility of the entire team. Many partners are anxious about being in the operating room. The set up for a MAC usually means drapes are a lot lower than for a standard CS and therefore the partner can potentially directly visualise a lot more of the surgery than they otherwise might expect. This can lead to psychological, or in the event of syncope, actual physical injury.

While the MAC is an exciting innovation, there may be alternative approaches that are simpler and easier to implement, but still give women a meaningful sense of participation in their delivery. These might include using a mirror so the patient and partner can view the birth in real time, or removing one arm from the patient's hospital gown so the baby can be lifted directly from the surgical field onto the patient's exposed chest. In many instances, the latter approach seems to actually provide more immediate 'skin to skin' contact than a MAC, where the sterile gown often gets in the way.

Suzanne Meharry (far right) with Tina Blacklock (out of the picture) and her baby twins during a maternally assisted caesarean which took place at St John of God Mount Lawley Hospital in Western Australia. Photo: Supplied by Suzanne Meharry

Dr Jenny Dowd
Obstetrician, MD, FRANZCOG

After performing hundreds of Caesars and having had two myself, I think the most important issue here is the patient's sense of control. Either control in a physical sense or control over the way a decision is made. When a caesarean is deemed to be necessary or desirable, often when not expected or following a previously disappointing delivery, some women feel disconnected from the birth and the idea of pulling their baby onto their chest makes up for this perceived loss.

The concerns raised by some paediatricians relate to immediate assessment of how the baby transitions to the extra-uterine environment. In a standard caesarean the baby is handed to a paediatrician or midwife by the surgeon onto a sterile wrap. They can then be dried and stimulated and moved in a position to assess initial breathing and circulation, often very close to the mother. In a MAC, unless the paediatrician is also surgically scrubbed, they cannot closely interact with the newborn. The natural tendency of the mother is to pull the baby up onto her chest leading to the infant facing downwards, burrowing into the drapes and so initial status may not be easily assessed. As immediate skin to skin doesn't happen on top of a surgical gown temperature loss may also be a problem.

When discussing a MAC, the issues to consider include how comfortable the patient and birth partner are watching a surgical process, the practicalities for theatre staff and other doctors involved, and any maternal medical concerns or anticipated difficulties with delivery.

Social media speeds up the dissemination of new ideas more quickly than some institutions can adapt to, and as with any new procedure the pressure to provide a different experience needs to be balanced against safety and efficiency. The risk is to jump on the bandwagon and not prepare patients or staff well enough. My practice has already had a woman come to us asking for an elective "normal" caesarean, as she felt pressured by her previous obstetrician to have a MAC after a long first labour and finding the experience of this birth traumatic.

Informed consent involves explaining the details and alternatives and should be undertaken antenatally, with MAC done as a scheduled procedure. A full consent process should include a discussion of alternatives that may achieve what the patient wants, such as observing the delivery with a mirror (which can be quickly removed if anyone feels overwhelmed) and then having true skin to skin without surgical gloves and gowns in the way.

Eventually, however, maternally assisted caesarean will find its niche and no doubt become routine for several planned surgical births.

Book review: From Hurting to Healing by Dr Simon Craig

Dr Kristine Barnden
FRANZCOG, DDU Women's Imaging, Hobart VMO in Obstetrics, Royal Hobart Hospital

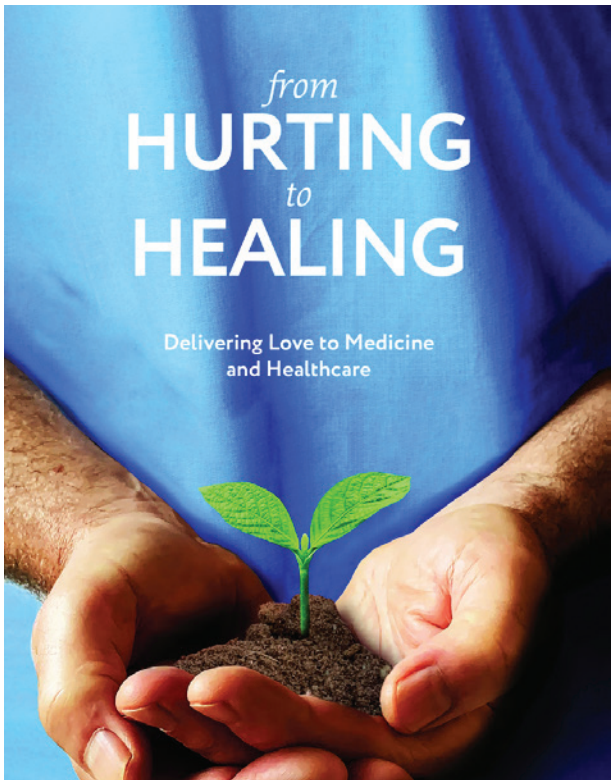
Dr Simon Craig describes his book *From Hurting to Healing: Delivering Love to Medicine and Healthcare* as 'a love letter to hospitals.' It's the sort of love letter you'd write after a long and intimate relationship, affection deepened by living through major life events together, passion tempered by frustration and disappointment. It's the love letter where you suggest it really might be time for some relationship counselling.

Craig trained as an obstetrician-gynaecologist in Melbourne and practiced in rural Victoria, combining a broad clinical practice with administrative roles. He has reflected deeply on all aspects of his work in hospitals and read widely, including completing a Masters of Positive Psychology. He is a lifelong sporting enthusiast, and the book is peppered with analogies to sporting teams and cultures. It also contains many personal anecdotes, told with an unusual degree of emotional honesty, that will make it especially engaging and relatable for readers.

Healthcare is complex, and Craig is not trying to fix the system in its entirety. His interest is in the positive change that can be achieved by examining our attitudes, relationships, and cultures. He points to the way hospital units tend to concentrate on measuring and preventing adverse outcomes, stating that 'reducing bad does not produce good, it just makes things less bad.' Without abandoning review of adverse outcomes, he suggests that we shift our focus to what we do well, with the aim of building positive cultures. He cites evidence that this ultimately leads to better patient outcomes, reduced organisational costs, and improved health and life satisfaction for staff. The book is for all the individuals who work within a hospital healthcare team, not just leaders or managers. Craig is clear that a change in team culture involves the input of the entire team.

In laying out his dream for change in hospital cultures, Craig uses words like 'nurturing', 'love', and 'connection', introduces concepts such as hope-mapping and yarning circles, and even suggests allowing managers 'time to think, dream, create, or contemplate alternative viewpoints.' He acknowledges the risk of coming across as ''airy-fairy" but argues that these are the human elements that must underlie meaningful change in the healthcare system. He successfully combines this approach with a frank assessment of the causes of the widespread suffering currently experienced in hospitals, pragmatic discussion of ways to introduce and measure cultural change, and clear-eyed recognition of the barriers to change. Chapter headings include: 'Damaging', Measuring', 'Leading', 'Communicating', 'Belonging', and 'Motivating', are engagingly written in clear language with relevant examples and research.

Will the book make a difference? Many of us have grown cynical after years of working in the hospital system, and I recognised myself (a little sadly) when Craig described the person who has developed the mindset of just doing their work and going home at the end of the day. Nevertheless, I allowed myself to dream of a place where everyone – ancillary staff, junior doctors, nurses and midwives, consultants and administrators – works through the book and meets after each chapter to discuss how it applies to their unit and brainstorm strategies for change. The results could be amazing.



From Hurting to Healing: Delivering Love to Medicine and Healthcare by Dr Simon Craig was published by Hambone Publishing in 2023

Cultural safety for Aboriginal and Torres Strait Islander women having elective gynaecological surgery

Dr Samantha Scherman & Dr Joyce Wallis

The Cairns and Hinterland Hospital and Health Service (CHHHS) in Far North Queensland covers a geographical area of 142,900 square kilometres, supporting an estimated population of around 260,000 people. The health service also provides support and care for patients from the Cape and Torres Health service to the north. About 12% of people living in the CHHHS catchment area, and over 32% of patients treated by the health service, identify as Aboriginal and/or Torres Strait Islander.

The differences in health outcome measures between Indigenous Australians and non-Indigenous Australians are well known and documented. The objective of the National Agreement on Closing the Gap is: 'To enable Aboriginal and Torres Strait Islander people and governments to work together to overcome the inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians.'

What has become apparent is that improving outcomes for Indigenous Australians is not just a case of ensuring that patients have access to a health service. The 1989 National Aboriginal Health Strategy states that: 'Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.'

This means that for a health service to make a difference in health outcome measures for Aboriginal and Torres Strait Islander patients, it not only must be physically safe and accessible, but must also provide care that is culturally safe. In other words, a health service must have cultural capability. In the Queensland Health Aboriginal and Torres Strait islander Cultural Capability Framework 2010-2033, cultural capabilities refer to the 'skills, knowledge and behaviours that are required to plan, support, improve and deliver services in a culturally respectful and appropriate manner.' The Framework states that cultural capability is: 'An ongoing journey of continuous individual learning and organisational improvement, in order to ensure best practice in health service delivery.'

So, what does the above all mean to clinicians in their individual health services? How can we improve our service delivery "on the ground" to ensure that we are doing our best to improve health outcomes for Aboriginal and Torres Strait Islander women?

Joyce Wallis is one of the many hard working Indigenous health workers employed by the Cairns and Hinterland Hospital and Health Service to provide care and support for Aboriginal and Torres Strait Islander women coming into the service for gynaecological care. Many of the Aboriginal and Torres Strait islander women coming to Cairns Hospital for gynaecology surgery, come from outlying communities. They are usually seen initially by the outreach gynaecology team from Cairns Hospital in their own communities, if possible, via visits which Joyce often attends. They do however need to travel to Cairns Hospital for most gynaecology surgical procedures. This can obviously be a daunting prospect for any woman. I asked Joyce for her views on the important aspects of ensuring cultural safety in the peri-operative setting in this region.

According to Joyce cultural awareness training for surgeons is very important. 'And surgeons being rostered to travel to the remote clinics in Cape York and Torres Strait to see the women in their own communities is also very important. This will help the women because staff can say: 'I have been to your community', and little things like that can immediately put them at ease,' says Joyce.

Joyce also feels that the written information given to Aboriginal and Torres Strait Islander women is too complex, and that it's important to note that there are Indigenous women in some areas who are unable to read. Joyce suggests the provision of more culturally appropriate written information, which includes more visual content.

'Women need to understand what aftercare is required after surgery, and to feel comfortable that their local community health clinic staff will be there to support them when they return to their communities after surgery,'

Joyce is currently only employed in a 0.2FTE capacity but feels that this is inadequate for her to provide care and support for all the Indigenous women coming into the Cairns Hospital for gynaecological surgery. She also feels that if Aboriginal and Torres Strait Islander (ATSI) health workers had access to the surgical lists, 'they would be better able to follow up with the clients and speak to them again before surgery'.

She also feels this would enable the health workers to physically accompany the women to surgery for extra support, particularly women suffering significant anxiety.

In terms of trying to reduce women's fears and anxieties prior to surgery, Joyce feels that the surgeon taking the opportunity to talk to the women from community before their surgery (not just prior to surgery in the anaesthetic bay) will put them at ease, as will surgeons speaking with the woman's partner or a trusted family member about their procedure.

'Giving clear advice regarding the recovery period and ensuring that the women know who to talk to when they return to their communities if they feel there are complications or need reassurance will help smooth their postoperative journey,' adds Joyce.

Ultimately, cultural capability is an ongoing journey for both individuals and organisations, but its importance cannot be overstated if the gap is truly going to be closed.

The Apt App

Dr Jo Levis
Obstetrics & Gynaecology
RMO, MBBS, CWH

Dr Priti Pradhan
FRANZCOG Consultant,
Obstetrics & Gynaecology

With an evolving patient cohort and the rise in use of technology, medicine in the 21st century is rapidly changing. This change in patient cohort extends to those seeking specialist gynaecological opinion and care, with the presence of more complex co-morbidities, increased age, particularly in the setting of fertility optimisation, as well as the increased incidence of metabolic disorders.[1]

As clinicians, we can use comprehensible score calculator applications to optimise and assess our patients for gynaecological surgery. Below are discussion points regarding risk calculators for malignancy, morbidity and mortality, as well as tools that can guide surgical complexity and patient expectations of outcomes from surgery.

For many of these calculators discussed, there is no substitute for collection of information through thorough clinical history, examination and gathering of investigations. Once the above has been collected and surgery deemed an option for management, appropriateness for surgery must be established, including individual patient factors and surgical planning by the operating team.

A common referral to gynaecology services includes the management of adnexal masses. A useful tool for calculating the likelihood of the mass being malignant is the Risk of Malignancy Index (RMI). The RMI requires the following information to identify risk of malignancy; post-menopausal status, ultrasound features of the mass and serum Ca-125 level. A RMI >200 is considered high risk for malignancy and yields a 71% sensitivity and 92% specificity for ovarian cancer.[2] By calculating an RMI as part of preoperative workup for adnexal masses appropriate referral can be made to gynaecology oncology services when a lesion is deemed high risk for malignancy.[3]

Once a gynaecological diagnosis has been made or suspected, patient suitability for surgery should be assessed. With our ageing and increasing comorbid population, morbidity and mortality needs to be considered and discussed with patients, particularly those with higher risk factors such as metabolic disease, respiratory disease and history of venous thromboembolism (VTE). The below table is a summary of easily available calculators (most are available via an app or web browser) that can be utilised as both discussion points when counselling patients for gynaecological surgery and to highlight areas for peri-operative management, such as post operative destination (i.e. intensive vs ward care) and timing and duration of VTE prophylaxis.

Tool Name
Caprini VTE Score[4]
POSSUM for Operative Morbidity and Mortality[5]
NSQIP Surgical Risk Calculator (American College of Surgeons – ACS)[6]
Surgical Outcome Risk Tool (SORT)[7]

Parameters Collected	Score Type	Benefits and Limitations
Age, sex, BMI, type of surgery, recent health (stroke, pneumonia, sepsis etc.), past history (COPD, acute MI, malignancy), history or presence of venous disease or clotting disorders (including present or previous Factor V leiden, lupus anticoagulant etc).	Score 0 to >9 (minimal to highest risk) with associated % risk of VTE. Advises type of pVTE from early mobilisation to pneumatic compression and low molecular weight heparin and duration of prophylaxis.	Widely used and accepted scoring system for pVTE in surgical patients. Requires very thorough history and collection of information for calculation.
Age, vital signs, blood parameters (Haemoglobin, white count etc.), ECG findings, presence of cardiac or respiratory disease, operation mode and severity, estimated blood loss, peritoneal soiling and presence of malignancy (Haemoglobin, white count etc.)	Percentage risk of morbidity and mortality from procedure (morbidity defined as haemorrhage, infection, wound dehiscence, cardiac/renal failure etc)	Can be used for elective and emergency procedures. Not specific for gynaecologic surgery – closest general surgical procedure must be selected (i.e., laparoscopy, laparotomy etc)
Age, sex, BMI, premorbid function (ASA, functional status), medical history (chronic disease, hypertension, diabetes, cardiac disease, COPD), smoking status, type of procedure.	Percentage (%) risk of outcomes (complications, such as infection, VTE, readmission, discharge to rehab and death) for the individual patient vs the average risk. Also provides predicted length of hospital stay.	Readily available via ACS website. Easy to interpret results as number percentage. Average risk is defined by an American population; demographics may differ in Australia hence comparison to average risk may be over or underestimated.
Age, urgency (elective vs emergency), ASA, presence of malignancy, type and severity of procedure.	Risk prediction as a percentage and clinical judgement risk prediction.	Provides accurate 30-day mortality risk of those undergoing inpatient surgery and can be used as an adjunct when considering the pathway post-surgery (i.e. need for Intensive Care admission). Requires senior clinician estimate of mortality as a comparison.

Noting the limitations of each calculator listed above, most scores provided are a simple and accurate way to outline the risk of morbidity and mortality for each individual patient prior to their surgery which can be used as discussion points during the consent process.

A tool that can be utilised by clinicians for assessment of surgical complexity for endometriosis includes the American Association of Gynaecologic Laparoscopists (AAGL) 2021 Endometriosis Classification. Multiple endometriosis classification systems have been proposed and used in the last 40 years, with the most utilised being the 1996 American Society of Reproductive Medicine (ASRM) classification system[8], which provides I-IV staging (mild – severe) and is widely accepted and easy for patients to understand[9].

However, the ASRM classification imperfectly correlates to the extent of endometriosis, pain and infertility[9] and poorly correlates to surgical complexity, hence is limited in use for clinicians to objectively evaluate surgical complexity.[8] The 2021 AAGL Endometriosis Classification was created to help identify objective intraoperative findings that discriminate surgical complexity better than the ASRM staging system which can help clarify communication in medical records and aid future clinical research[8], especially in the setting of more severe endometriosis (AAGL 2 and above). It is worth noting however that both ARSM and AAGL classifications have limitations in reference to pain, especially non-cyclical pelvic pain, where higher score does not necessarily correlate with more perceived pain, further demonstrating the wide variety of presentations of endometriosis.[10]

The above calculators and tools are not an exhaustive list of applications that can be used for preoperative planning and assessment prior to gynaecological surgery but are a guide to the variety of tools that are readily available via applications for clinicians and patients to utilise. It is worth keeping in mind that most of the calculators available are not a substitute for clinician determined indication for surgery but are helpful adjuncts when discussing the risks of proceeding to surgery, helping to inform valid expectations of outcomes for patients and to guide clinical optimisation prior to proceeding with surgery.

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A physiotherapy perspective

Sue Croft
Physiotherapist

Pelvic floor disorders such as pelvic organ prolapse (POP), and stress urinary incontinence (SUI) are strongly associated with vaginal birth and have a significant impact on the lifetime health of a woman [1]. In the US alone, around 300,000 women have surgery annually to repair POP and cure SUI[1]. Pelvic health physiotherapy plays an important role in the pre and post operative journey of a woman undergoing gynaecological repair surgery. Mollah et al (2023) assessed trends in types and incidence of POP surgery in Australia after transvaginal polypropylene mesh was removed as first line treatment of vaginal prolapse for women [2,3]. There has been a 38% decline in the number of POP procedures since a peak in 2005/2006 and over the past 15 years the most common age group having surgery has increased by a decade to 65 to 74 years.

While the decline in numbers of procedures may be due to the changes in TGA recommendations regarding mesh, it is also reflective of recommendations from the evidence that maximising conservative strategies (pelvic health physiotherapy, lifestyle recommendations and the appropriate fitting of a pessary) is considered first line treatment[4]. Postponing surgery until around 70 years of age recognises that activity levels may have decreased in this cohort, and the woman's general health may start to decline, and it is important not to miss the opportunity for surgery.

Conservative strategies for treating vaginal prolapse

Vaginal prolapse is common, with 50% of women who have had a vaginal delivery suffering some degree of prolapse. Only 15% will have bothersome symptoms (vaginal bulge, drag and heaviness, incomplete voiding, obstructed defaecation and sexual dysfunction) and 10-20% will go on to require repair surgery when conservative measures have failed. Up to 30% of those women who elect to have surgery may need to undergo a further repair due to failure of the surgery and recurrence of the prolapse[5,6]. In addition, one in three women suffer with urinary incontinence, some of which is due to SUI with or without urgency incontinence (mixed incontinence). Tahtinen et al. (2016) found there was a twofold increase in the risk of long-term SUI with vaginal delivery over caesarean section in a systematic review and meta-analysis on the long-term effects of childbirth on urinary leakage [7].

Conservative strategies provided by a pelvic health physiotherapist are endorsed in the treatment guidelines (2018) outlined in Australian Commission on Safety and Quality in Health Care documents on Treatment Options for Pelvic Organ Prolapse (POP) and Stress Urinary Incontinence (SUI), following the first recommendation of doing nothing[4].Pelvic health physiotherapy is also recommended in the treatment pathway in 7th ICI for all pelvic health conditions including prolapse and SUI management[8].

Correct posture for emptying bowels

Image from Pelvic Floor Recovery: Physiotherapy for Gynaecological and Colorectal Repair Surgery 5th Edition by Sue Croft 2024

Pelvic health physiotherapy has often been researched through the one-dimensional prism of pelvic floor muscle training (PFMT). Pelvic health physiotherapy has many tools in the toolbox including PFMT, teaching patients the knack (or bracing with increased intra-abdominal pressures such as with coughing, sneezing or lifting), the importance of balancing relaxation of the pelvic floor in any exercise strengthening programme, good bladder and bowel habits, correct defaecation training (position and dynamics), sexual intimacy advice and exercise modification as required.

Adopting a biopsychological approach

Women have often established a close therapeutic relationship with their pelvic health physiotherapist, as they have followed this recommended approach of seeking conservative management of their POP or SUI issues as a first line of treatment. Furthermore, patients seek ongoing advice and preparation from a pelvic health physiotherapist if they are booked to have repair surgery.

However, RCT's conducted by Nyhus (2020, 2021), Duarte (2020) and Jelovsek (2020) into pre, peri (from prior to and after surgery) and longer-term physiotherapy as a treatment intervention for gynaecological surgical repair are somewhat disappointing. Reason being, they fail to show a significant difference in outcomes of surgery with physiotherapy treatment. [9,10,11,12]

These results diminish the importance of an individualised approach to treating patients and do not necessarily acknowledge the psychosocial dimension of a pelvic health physiotherapist's consultation. In clinic, these patients are often anxious and unsure about surgery, and increasingly, pelvic health physiotherapists are adopting a biopsychosocial approach with their management pre-operatively. This helps with calming and reassuring patients that they have fully explored the conservative strategies and surgery is the logical next step. Women may also carry psychological trauma from the vaginal birth injuries that happened years before, therefore it is important to approach any education, examination, and treatment of the woman in a trauma-informed way. This often takes extended consultation time and listening to the patient about their experiences and fears.

A pre-and post-op treatment programme with a physiotherapist provides a framework for the patient, with the physiotherapist playing a valuable role as a support person on this journey. Holistically supporting a woman following surgery in returning to exercise in a 'pelvic floor friendly way' is as equally important as achieving a good anatomical result. Over the past decade, as awareness of pelvic health conditions has grown, some women have become fearful that exercise will worsen their POP and SUI. This is partly due to advice that has blanket recommendations from health professionals and social media alike, rather than providing an 'individualised medicine approach' to exercise prescription for each individual woman.

If women restrict or stop exercising due to pelvic floor dysfunction significant ramifications for their general health such as bone density depletion, poorer cardiovascular status, sarcopenia, mental health dysfunction and reduction in overall wellness may occur. If a woman is afraid to exercise following her POP repair surgery, her general health and wellbeing will suffer. Reassuring the patient that exercise can be modified in a safe way will help make them feel supported in their quest to return to exercise, work and sexual intimacy.

The importance of pre-operative work

With any surgery, it is always advantageous to have a pre-operative work-up prior to surgery. This helps ensure the patient is well educated about the upcoming surgery and has optimised muscle strength and tissue quality, increasing the likelihood of a good result. Assessing vaginal tissue health pre-operatively and suggesting a conversation with their GP about local oestrogen (in a post-menopausal woman), encouraging pelvic floor exercises (which also have beneficial effects on tone, blood flow and lubrication), and advising that sexual function is beneficial for good tissue quality, is all part of the physiotherapy work up. A well-informed, well-prepared patient is always going to have a less traumatic hospital stay and a more confident recovery post-operatively than one who has had little preparation. A good pre-operative work-up by a physiotherapist also reduces the time a surgeon spends answering questions that may seem time-consuming and irrelevant to the surgeon but are important to the patient.

Pelvic health physiotherapists solve problems such as post-operative constipation, which can cause surgical failure if the patient resorts to straining to evacuate. Manipulation of products, analysis of positioning on the toilet and breathing dynamics are important preventative treatments. Performing a pre/post void bladder scan can reveal urinary retention at the pre-op visit if there is significant prolapse, and post-operatively if the patient presents with urinary frequency. Residuals of 100-150mls may be acceptable for release of the patient from hospital, but if the patient has a smaller capacity bladder, this will lead to bothersome urinary frequency. Physiotherapists can use biofeedback to teach the patient how to gain good relaxation of the abdominal and pelvic floor muscles to enhance voiding function post-op.

Many of these patients are also extremely anxious about their surgery failing and perpetually hold significant tension in these muscles, which can lead to pelvic floor muscle overactivity and myalgia as well as obstructed defaecation. Education about pelvic floor and abdominal muscle down-training is routine and pelvic health physiotherapists are well-versed in persistent pain management if post-operative surgical pain is lingering.

More recently physiotherapists have been asked by urogynaecologists to fit a small pessary post-operatively to support the surgery if the woman wishes to engage in a more vigorous post-op exercise programme. Evidence tells us that the younger a patient undergoes repair surgery, the higher the risk of failure [13]. Fitting this small supporting pessary for exercise allows the woman to do more vigorous age-appropriate exercise, which may be advantageous for her mental health as well as her long-term fitness.

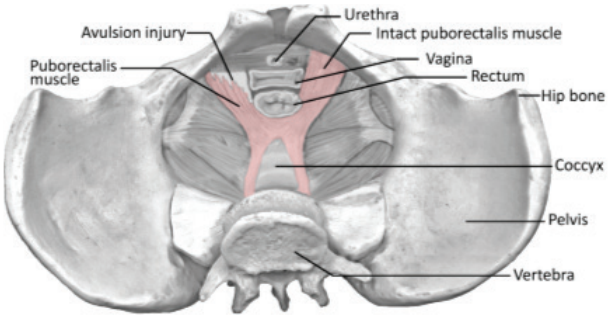

Image from Pelvic Floor Recovery: Physiotherapy for Gynaecological and Colorectal Repair Surgery 5th Edition by Sue Croft 2024

Lifting weights, whether in a gym or at home, is often perceived as risky. Pelvic health physiotherapists look at the evidence about lifting and then apply it to their patient. The factors which heighten the risk of failure for the patient's surgical repair are increased genital hiatus size, the presence and severity of levator avulsion, collagen type, the strength of her pelvic floor muscles and the patient's ability to contract them satisfactorily in a timely fashion and their exercise goals. The physiotherapist analyses risks and gives advice about return to lifting, employment and exercise post-operatively based on the patient's strengths and weaknesses, while communicating closely with the surgeon.

In conclusion, gynaecological repair surgery is expensive when considering the cost of the operation, time off work and health professional appointments. There are financial, physical and mental health costs to the patient if the surgery fails. While the research may not support the routine practice of pre, peri and post operative physiotherapy, this article outlines the obvious benefits to the patient when implementing a personalised medicine approach, which will benefit the patient holistically in the long term.

About Sue Croft

Sue Croft OAM has been a physiotherapist for over 47 years, working in Pelvic Health for the past 36 years. Sue was awarded the Order of Australia Medal in 2023 for contributions to the community and the physiotherapy profession in pelvic health. Sue has authored three books on pelvic health physiotherapy including the recently published updated 5th Edition of Pelvic Floor Recovery: Physiotherapy for Gynaecological and Colorectal Repair Surgery.

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How to manage pain pre-operatively

Dr Marilla Druitt
MBBS, BMedSc, FRANZCOG, University Hospital Geelong, SJOG Geelong, Deakin University

Close your eyes and give me a definition of pain. That's something we should be able to call to mind, right? [1] Did you get sensory? Emotional? Actual or potential? I wonder about our ability to prevent and treat pain if we often struggle to define it. In this article, I'll attempt to discuss the treatment of persistent pain before surgery in less than 1,500 words – no mean feat! Let's start with:

- The more pain you have now, the more pain you are at risk of having in the future
- The better your pain is before an operation, the better it will be after
- Pain is made in the brain and felt in the body
- A bio psychosocial (spiritual) approach has a better chance of treating pain than an exclusively biomedical approach (social – health literacy, work, relationships, racism, loneliness, etc)
- There is a public health emergency of chronic pain in Australia and Aotearoa New Zealand: 1/5 adults
- 2017 was the International Association for the Study of Pain's year of Pain After Surgery[2] to educate clinicians and patients. Surgeons are well placed to reduce pain pre-op, so patients do better post-op
- National guidelines caution against using opiates for non-cancer pain
- Use questionnaires (American surgeon, writer, and public health researcher Atul Gawende says embrace the checklist!) to help you in your consult with knowledge and time, to teach the patient that you care about all their variables, and to help junior staff learn.

A bio psychosocial approach to pain

Ok, so you see a patient; you book them for a laparoscopy to investigate pain. Let's use "the waiting list" as a "preparation list[3]" during this time and teach about a bio psychosocial approach to pain.

Less pain pre-operatively predicts less pain post-op – so will you try for amenorrhoea, anovulation? Down train painful pelvic floor muscles with stretches, breathwork and pain education with physio and other appropriately educated experts of the movement system? What about sleep? You need to consider quantity, quality and routine for a solid base of Maslow's pyramid and for a quick screen for PTSD and yellow flags (i.e. nightmares).

Post-operative movement, once it's safe to move the body, hastens recovery and opiates are good for pain at rest post-op but perhaps not to improve function. Exercise treats pain, encourage your patients to do more than before for the endocannabinoids. For many, exercising in the morning works better than later on in the day, as willpower can often decline as the day goes on. Exercising outside in nature is better for the immune system, and sunshine helps manufacture endorphins and endocannabinoids.

Think about nutrition as a powerful tool to help address the average person's fibre deficiency, trial of low FODMAP for comorbid IBS, to limit constipation confusing the post-op picture[4], and to treat depression[5].

Is your patient trying to conceive? Zinc sulphate with periods[6], tranexamic acid and non-steroidal anti-inflammatories could be suitable. Or a short course of amitriptyline pre-op to improve sleep and pain.

A psychological approach to pain

Mental illness is a common comorbidity in surgical patients and has a bidirectional association with pain. For non-life-threatening problems, we should tell our patients that we need to care for mind and body simultaneously, i.e. you cannot fix mental health first, then pain second, and vice versa.

Catastrophising is a popular area to study in medical literature as a predictor of pain, and I wonder to what degree doctors must take some responsibility for this characteristic. It describes someone who magnifies the threat value of their pain and feels helpless. Somehow this has never sat well with me. We have a role to play in acknowledging our patient's suffering, being explicit about their pain being real, and moving away from an exclusive biomedical approach which can contribute to the sense of helplessness.

Check the patient's beliefs, expectations and meaning of symptoms – have they got extra things going on? Neurodiversity? Gender diversity? Additionally, plenty of psychological therapies are effective in treating pain,including pain where opiates are being prescribed[7]. These include cognitive behaviour therapy (CBT), meditation and hypnosis. Eye movement desensitisation reprocessing (EMDR) also has increasing evidence for pain management, having originally been developed for treating PTSD. Just because we may not know where to access these treatments does not mean we shouldn't tell our

patients they exist. Then join forces with amazing patient advocates to fix our systems to provide access – they are a force to be reckoned with and can effect significant change in our society.

A social approach to pain

Loneliness is as bad for your health as 15 cigarettes a day says the US Surgeon General Dr Vivek Murthy. It's a risk factor for pain. Options include social prescribing, participating in research[8], joining moderated support groups, and getting your body moving in a group.

Pain neuroscience education treats pain[9], and when we take a patient's history, we should learn as we go. Yes, they might have endometriosis, yes that is a decent prolapse, but what happens if the endometriosis is only 5% of your suffering, and undertreated other things 50%? See pain curriculum below[10].

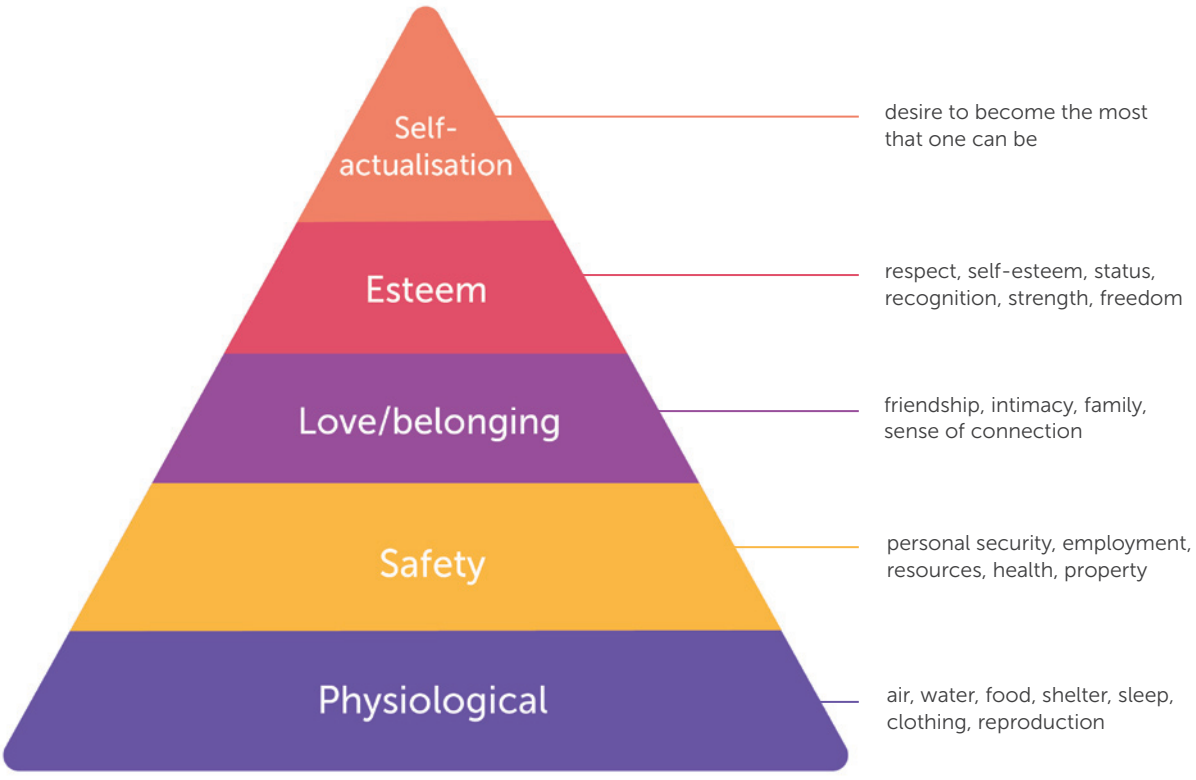
Language can help treat pain – what you say in your consult has evidence for being therapeutic. Be a placebo, not a nocebo[11].

But my patient has a 10cm cystadenoma on scan, you might say, and all she needs is a laparoscopic cystectomy, right? Or a really uncomfortable prolapse and a vaginal hysterectomy is what she needs, not meditation, right?

So, when the patient post-laparoscopic cystectomy has unexpected pain post-operatively and we discover she has had IBS for ten years, along with migraines, PTSD symptoms untreated after childhood trauma, and an awful work environment, we shouldn't be surprised she ends up on ketamine for a week. Or the 55-year-old patient post vaginal hysterectomy and repair has no response to her operation for pain, despite an excellent anatomical result, and it turns out she has fibromyalgia, which predicts around 25% of people having a hysterectomy for pain will not respond to surgery [12]. Could a five second body map have helped? In short, yes. Let's get the word out pre-op!

So, in summary, we can talk to the patient and use that Waiting List time as Preparation Time (taking a history, educating as we go – don't forget that consult is a treatment; give them some notes to take with them as typically, only up to half of the discussion is remembered[16]), talk to the anaesthetist at time out about multimodal analgesia (more things IV), put on the music the patient has chosen to go to sleep to reduce pain and opiate requests in recovery.

Maslow's hierarchy of needs



Helpful definitions

Term	Definition
Pain	An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage
Chronic post-surgical pain (CPSP)	Chronic post-surgical or post-traumatic pain is defined as chronic pain that develops or increases in intensity after a surgical procedure or a tissue injury and persists beyond the healing process, i.e., at least three months after the surgery or tissue trauma[13]
Opiate	A drug/medicine directly derived from opium
Opioid	A synthetic drug/medicine which is an analogue of opium
Opioid-induced hyperalgesia (OIH)	Nociceptive sensitisation caused by exposure to opioids
Enhanced recovery after surgery (ERAS)	Multimodal perioperative care pathway designed to achieve early recovery for patients undergoing major surgery. The ERAS study group has been around since the early 2000s, but in keeping with the Green Gap, it is not implemented for all surgery everywhere yet
Prehab	A process of improving the functional capability of a patient prior to a surgical procedure so the patient can withstand any postoperative inactivity and associated decline
Pain catastrophising	An exaggerated negative mental set brought to bear during actual or anticipated painful experience[14]

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Revolutionising women's health: A virtual education and social media advocacy expedition

Dr Sumaiya Sayed
MBBS, Prevocational Obstetrics and Gynaecology Trainee, PHO Obstetrics and Gynaecology, Ipswich Hospital

Healthcare education is in a constant and dynamic state of evolution, and the significant progress in this area in the last two decades is secondary to the integration of virtual technology. COVID-19 reinforced the need for, and furthered, the boons of virtual technology. However, way before the pandemic, virtual health education was developing as a ground-breaking tool, revolutionising the training of healthcare professionals and arming patients with health-related information. This innovative approach combines technological advancements with modern educational methodologies enhancing learning experiences and bolstering the ultimate goal of improving healthcare outcomes.

A Paediatrician examines a new born baby cradled by their mother in a rural village in India. Photo: Gajendra

My initial experience with virtual health education

My first exposure to virtual health education was through my experience supporting a pregnancy and parenting app in 2018 as a junior doctor. The app focused on assisting and educating pregnant women and new mothers, as well as providing interactions with doctors who would give advice and recommendations. Progressing swiftly through the ranks to lead doctor, I would oversee the medical content creation process and organise live video sessions with approximately 4,000 women every hour. Participants could interact directly with our team of medical professionals. Significantly, understanding the cultural and language barriers in India, the information was delivered in nine vernacular languages of India.

The support for mothers and pregnant women included collaborations between obstetricians, paediatricians and allied health professionals. As a developing country, India is not short of myths, which we strived to debunk by offering evidence-based guidance to support women in making informed decisions about their health. The platform's rapid growth to over 15 million users across the country highlighted the potential, and demand for, reliable virtual health resources, especially in the subcontinents and similar regions, where access to quality healthcare is limited. Being an early provider of this service, not only allowed me to contribute to improving women's lives, but also emphasised the potential of virtual health platforms in positively impacting a large audience, where the possibilities felt endless. We had our share of challenges, but overall, my experience was rewarding, empowering, and enlightening.

How am I managing health education to a Hindi-speaking population from Australia?

Upon relocating to Australia, I had to reduce my hours supporting the app's medical team. However, I continued to volunteer for live women health topic sessions as and when possible. My zest for women's education made me seek further opportunities, including holding virtual sessions with women of different villages in India through Ved education.

My personal social media involvement led me to pursuing virtual health opportunities on social media. I wondered about the use of TikTok and Instagram for providing meaningful education on women's health. I felt it could be beneficial, so I created a series of videos, which ended up being very well received and reached a wide audience. As the onset of the pandemic loomed, I recognised the urgency to address the escalating panic stemming from rampant misinformation about COVID-19. Consequently, I swiftly crafted and uploaded a video in Hindi, outlining fact-based information about the virus on 29th January 2020.

In the following months, I generated a considerable amount of women's health-related content, sharing it on TikTok and YouTube. The uptake from women worldwide was exceptional! I have since amassed over 350,000 followers on different social media platforms and this is growing each day. On TikTok alone, there are over 283,000 followers with over 52 million views. The videos I share cover a wide range of health-related topics, ranging from menarche to menopause, and have received numerous insightful and appreciative comments. I was surprised to observe that 40% of the overall audience consisted of men.

Here, are some comments translated from Hindi in response to some of my videos:

'*Thank you for the eye-opening video, I now understand what my wife has been going through for years. I am apologetic of the way she has been ignored.'*

'I live about two hours away from my closest hospital and do not usually go to the doctor unless extremely worried. I had thought itching is normal and tolerated it until you told me I needed to go to the doctor and do the blood test. I found out I had severe cholestasis and I have had my healthy baby via C-section today.'

Reflecting on my personal experience

My mother suffered with menorrhagia for months before I saw her waking up next to a pool of blood. Due to the taboo associated with menstruation, she never spoke to anyone about the significant bleeding she experienced during her periods. She thought it was normal and happens to every woman close to menopause. I often wonder whether if such education was available seven years ago, her enormous fibroid could have been detected earlier, and it could have spared her from the complications of severe bleeding and pain, which led to urgent hospitalisation and a lifesaving surgery.

Future hopes & goals

My virtual health journey has now spanned over six years and has brought about a profound shift in my perspective. I have become more insightful about the impact of educating women about their health. Some require reassurance, some require recommendations, and some require evidence-based education. In developing nations like India, topics such as menstruation and women's health conditions often carry a stigma.

Women are known to desist from discussing the pain they endure, the anxiety they manifest, and the questions they refrain from asking due to the fear of judgment. It's about time that virtual health education further addresses these barriers, and rest assured, I am motivated to continue to be part of this movement.

Dr Sumaiya Sayed delivering a presentation on Empowering women through virtual health education at Ved Education Seminar Hall, Navi Mumbai. Photo: Supplied by Dr Sumaiya Sayed

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