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Dear doctor,
After a few weeks' absence of leave in August and September, while I attended a beautiful study retreat in our magical hinterland, I return to my practice energised and ready for further challenges. Here I deliver to you our next O&G newsletter.

O&G NEWSLETTER

OBSTETRICS

VIRAL GASTROENTERITIS IN PREGNANCY

When on retreat, we had an outbreak of diarrhoea, which affected many of the participants, and, being the only doctor on site, it was I who had to provide medical care. Despite being out of my specialist comfort zone, everybody survived, while I decided to apply myself to the topic in more depth.
The term 'gastroenteritis' refers to inflammation or infection of the gut, but generally it pertains to an episode of nausea, vomiting and diarrhoea. The most common causes for acute GE are viral and bacterial food poisoning. In Queensland the pathogen typically involved in outbreaks in the spring season is norovirus, but also commonly rotavirus and adenovirus. Infants are often affected by the rotavirus.
Although the infection is self-limiting, vulnerable people-immunocompromised, children and elderly, are at risk for dehydration and electrolyte disturbances, and deaths still occur from acute norovirus GE.
Norovirus infection has a typical acute onset of nausea and vomiting in a previously healthy person, and may be associated with malaise, headache, myalgias, watery diarrhoea, and less common fever. Fortunately symptoms last only one or two days. It is highly contagious, with direct and airborne transmission, as well as ingestion of contaminated food and drink, or contact with contaminated surfaces and objects. Affected individuals should be excluded from work until there has been no diarrhoea for 24 hours.
In a pregnant woman, although the clinical picture is quite clear, differential diagnosis should be considered with food poisoning, Clostridium colitis, as well as pregnancy specific conditions, such hyperemesis gravidarum, acute fatty liver, severe preeclampsia, as well as ovarian torsion, surgical causes such appendicitis, cholecystitis, pancreatitis, bowel obstruction, hepatitis, diabetic ketoacidosis.
Diagnosis can be made by PCR testing of faeces, but it is hardly ever required. FBC, electrolytes, liver and renal function might be assessed. Foetus well-being has to be ascertained.
Dehydration needs to be vigorously prevented and treated, be it orally if tolerated or by iv infusion. Oral/parenteral antiemetics are useful. It is important to try to manage pregnant women as outpatients if possible, as the virus can sweep quickly through a maternity ward and affect neonates, so strict infection control procedures have to be instated. This is why the role of the GP cannot be understated in identifying and quickly dealing with these cases at primary level.

GYNAECOLOGY

OVARIAN CANCER RISK AND PROPHYLACTIC SALPINGECTOMY

As probably you are already aware, recently there has been an increase in the number of prophylactic bilateral salpingectomy procedures performed by gynaecologists, as a result of new evidence showing a decreased risk of ovarian cancer in women who have had their tubes removed.
While it is not my intention here to review the aetiology, morphology and behaviour of ovarian cancer, suffice it to say that several studies have identified the presence of high grade squamous intraepithelial carcinoma lesions in the tubal fimbria of up to 60 percent of high as well as low cancer risk women who had their tubes removed for benign pathology. As these studies are mainly cohort and epidemiological, and not randomised controlled, there is no suggestion that bilateral salpingectomy should be performed routinely in low risk women in order to decrease their risk for ovarian cancer.
But there is a trend towards performing opportunistic such procedures with surgery for benign procedures (such as hysterectomy), and the question has risen whether rather bilateral salpingectomy should be offered to women who request a tubal ligation.
There are indeed some advantages (such as lower incidence of hydrosalpinx, lower failure rate and risk of ectopic pregnancy) as well as disadvantages (risk of damage to the ovarian blood supply with premature ovarian failure, more laborious surgical procedure) to this approach, and there is still uncertainty regarding its risk-benefit profile. Moreover, tubal ligation itself has been shown to decrease cancer risk, albeit more modestly, by about 25 percent.
RANZCOG recommends that 'consideration should be given to performing bilateral salpingectomy instead of tubal occlusive procedures for female sterilisation', and the general consensus is that the choice should be made on a case-to-case basis, which should include the patient in the decision-making process.

(summaries of articles published in most recent editions of the O&G Magazine)

I am pleased to advise that I am now also consulting and operating at the St Stephens Hospital in Hervey Bay on a fortnightly basis. All bookings are made via my Buderim rooms.

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