check

Independent learning program for GPs

Unit 509 September 2014

Women's health

RACGP

www.racgp.org.au/check

Subscriptions

For subscriptions and enquiries please call 1800 331 626 or email check@racgp.org.au

Published by

The Royal Australian College of General Practitioners
100 Wellington Parade
East Melbourne, Victoria 3002, Australia
Telephone 03 8699 0414
Facsimile 03 8699 0400
www.racgp.org.au

ABN 34 000 223 807
ISSN 0812-9630

check

Independent learning program for GPs

Women's health

Unit 509 September 2014

The five domains of general practice

- Communication skills and the patient-doctor relationship
- Applied professional knowledge and skills
- Population health and the context of general practice
- Professional and ethical role
- Organisational and legal dimensions

RACGP

ABOUT THIS ACTIVITY

Social/cultural roles and expectations of women, as well as biological factors, can affect women's health and wellbeing.[1] Issues of particular concern for women's physical and mental health include perinatal problems and disorders arising from hormonal imbalances. Violence against women, a major human rights abuse that may lead to physical, mental, sexual, reproductive health and other health problems,[2] is also a key area of concern. Worldwide, about 35% of women have experienced intimate partner violence or non-partner sexual violence in their lifetime and about 38% of murdered women are killed by an intimate partner.[2] In Australia, one in three women has been exposed to physical violence, and one in five women aged over 15 years has experienced sexual violence.[3]

This edition of check will consider scenarios of relevance to the management of women's health in general practice.

LEARNING OUTCOMES

At the end of this activity, participants will be able to:

- outline the management options for women with perinatal depression
- list strategies for the management of vaginismus
- summarise the diagnosis and management of polycystic ovary syndrome
- discuss useful strategies for managing women suspected of experiencing domestic violence
- describe the medical management of a woman who has been raped.

AUTHORS

Jacqueline Boyle MBBS, FRANZCOG, MPH, PhD is an obstetrician and gynaecologist and head of The Indigenous and Refugee Women's Health Program at Monash Centre for Health Research and Implementation (MCHRI), School of Public Health and Preventative Medicine, Monash University. She has a special interest in women's health.

Anne Buist MBBS, MMed, MD, FRANZCP is Professor/Director of Women's Mental Health, University of Melbourne, based at Austin Health and Northpark. Over the past 27 years she has worked as a clinician, teacher and researcher in perinatal mental health. Professor Buist led the *beyondblue* postnatal depression program in 2001–2005.

Raie Goodwach MBBS, MPS is a medically trained psychotherapist. She has special interests in psychosexual difficulties, psychosomatic medicine and the complex, long-term effects of sexual violence. She has a private practice in Malvern, Victoria, and is an honorary SMS at Monash Medical Centre, adjunct academic at the School of Medicine, UNDA, Affiliate & National GP Reference Group, Andrology Australia. Dr Goodwach is a past president of the Victorian Medical Women's Society, an executive member of Australian Federation of Medical Women, a member of scientific committee, International Medical Women's Association.

Rosemary Isaacs MBBS, FRACGP, MForensMed (Monash) is medical director of the Sexual Assault Services for Adults and Children at the Royal Prince Alfred Hospital and Liverpool Hospitals in Sydney Australia. Dr Isaacs was a general practitioner prior to training in forensic medicine. She is a member of the Australasian Association of Forensic Physicians. Dr Isaacs mentors doctors involved in the medical and forensic care of victims of interpersonal violence. She is committed to interagency collaboration and advocacy to improve responses to child abuse.

Soulmaz Shorakae MD is an endocrinology advanced trainee at Monash Health, and a PhD student at the School of Public Health and Preventative Medicine, Monash University. She has a special interest in women's health, particularly polycystic ovary syndrome.

Helena Teede MBBS (Hons) FRACP, PhD, is an endocrinologist, head of Diabetes and Vascular Medicine at Monash Health, and professor of Women's Health at Monash University. Professor Teede has an international reputation in polycystic ovary syndrome and led the development of the first international, evidence-based guidelines for polycystic ovary syndrome.

PEER REVIEWERS

Elizabeth Hindmarsh MBBS, FRACGP is a general practitioner who worked in an inner city practice for 28 years. Following this Dr Hindmarsh worked in Aboriginal health in a remote community in NT and, more recently, has been in an Aboriginal practice in outer Sydney. She has contributed to projects for the RACGP for about 24 years in the area of abuse and violence and is an editor of the RACGP White book 4th edition Dr Hindmarsh is a co-chair on the RACGP Specific Interest group – Abuse and Violence.

Sue Reddish MBBS is a general practitioner at Deakin University Medical Centre, Burwood, and has a special interest in women's health.

Jane Smith MBBS, FRACGP, Grad DipFM,MHS, FAICD is an associate professor, head of general practice and deputy head of the MBBS clinical years at Bond University Medical Program in Queensland. Professor Smith is also a general practitioner at Robina Towns Medical Centre and has a special interests in family medicine, preventive health, therapeutics and women's health. She is a co-author of the Red book task force, and is a board member of BEACH, the *Australian Medicines Handbook*, *Australian Prescriber* and the Therapeutics Goods Administration.

REFERENCES

1. World Health Organisation. Why gender and health. Geneva: WHO. Available at www.who.int/gender/genderandhealth/en/ [Accessed 4 August 2014].
2. World Health Organisation. Violence against women: intimate partner and sexual violence against women. Fact sheet No 239. Geneva: WHO; 2013. Available at www.who.int/mediacentre/factsheets/fs239/en/ [Accessed 4 August 2014].
3. Australian Department of Social Services. The National Plan to Reduce Violence against Women and their Children 2010–2022 (the National Plan). Canberra: Australian Department of Social Services, 2011. Available at www.dss.gov.au/our-responsibilities/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children [Accessed 2 June 2013].

GUIDE TO ABBREVIATIONS AND ACRONYMS IN THIS UNIT OF *CHECK*

BMI	body mass index	HBV	hepatitis B virus	PCOS	polycystic ovary syndrome
CAH	congenital adrenal hyperplasia	ß-hCG	ß-human chorionic gonadotropin	PCR	polymerase chain reaction
CBT	cognitive behaviour therapy	HCV	hepatitis C virus	SHBG	sex hormone-binding globulin
COC	combined oral contraceptive	HDL-C	high-density lipoprotein cholesterol	SSRI	selective serotonin reuptake inhibitor
DSM-5	Diagnostic and Statistical Manual of Mental Disorders 5th edition	HIV	human immunodeficiency virus	STI	sexually transmissible infection
EPDS	Edinburgh Postnatal Depression Scale	LDL-C	low-density lipoprotein cholesterol	T2DM	type 2 diabetes mellitus
FAI	free androgen index	OGTT	oral glucose tolerance test	TSH	thyroid stimulating hormone
FSH	follicle stimulating hormone	PANDA	Post and Antenatal Depression Association	VVS	vulvar vestibulitis syndrome
GDM	gestational diabetes mellitus				

CASE 1

JENNY IS FINDING BEING A NEW PARENT DIFFICULT

Jenny is a primary school teacher aged 38 years. She is married and has a daughter, Chloe, aged 2 months. She has been seeing you regularly for PAP smears and contraception, and twice for minor issues during her recent first pregnancy. She presents today with Chloe. You know that Jenny has no past history of any serious illness. Her mother had depression throughout Jenny's childhood years and her grandmother had bipolar disorder. Jenny says Chloe is not sleeping and feeds 'constantly'. She is fully breastfeeding and aspires to attachment parenting (ie understanding and responding to Chloe's emotional and physical needs and building a strong relationship with Chloe). Chloe's chart from the health centre shows she is on the 35th percentile for height and weight and has been since birth. Jenny looks tired, despite having makeup on, but says she is doing fine and that Chloe's routine is the problem.

QUESTION 1

What issues need exploration in this consultation?

FURTHER INFORMATION

Jenny denies being depressed but admits that her husband says she is irritable. He works long hours and doesn't provide much help. Jenny has cried on most days in the past month and says she is sleeping no more than 4 hours per night and cannot get back to sleep after Chloe wakes her. Her concentration is low and she is not enjoying anything. She says, 'motherhood is nothing like I imagined'. She worries that Chloe has allergies and has been searching the internet for causes of crying in babies. Jenny and Chloe's physical examinations are normal and Jenny denies any thoughts of harm or excessive fears. She is agreeable to your suggestion of having her mother stay with her to care for Chloe overnight so she can sleep.

At her next appointment 3 days later, which her husband does not attend because he is too busy at work, Jenny is still not sleeping, although she had an extra hour of sleep when her mother stayed over, and she feels she cannot cope. She starts crying in the consultation.

QUESTION 2

What is the most likely diagnosis? What are your treatment options?

FURTHER INFORMATION

Jenny agrees to see a psychologist for cognitive behaviour therapy (CBT) and her mother has agreed to look after Chloe on 3 days a week so Jenny can rest and go to yoga. When she sees you 2 weeks later, Jenny has had two CBT sessions and seems more anxious. Sleep remains a problem. She admits to having intrusive thoughts more frequently; for example, she fears that something will happen to Chloe and that it will be her fault. On closer questioning she fears she will put Chloe in the microwave by mistake or drop her in the bath. These thoughts horrify her and although she does not believe she would ever act on these thoughts, she thinks she must be the 'worst ever' mother for having them. She is getting her husband to bath the baby and has disconnected the microwave.

QUESTION 3

How are you going to manage Jenny?

FURTHER INFORMATION

You prescribe sertraline, up to 200 mg, after discussion with the psychiatrist to whom she has been referred. Jenny's condition improves significantly after 3 months. She is now sleeping for 6 hours per night on most nights and only occasionally has intrusive thoughts. She takes 200 mg sertraline daily. She has weaned Chloe. She has seen the psychiatrist three times in the past 2 weeks ago and has an appointment in 2 weeks. She has stopped seeing the psychologist but says she finds some of the techniques helpful. She tells you that she still does not enjoy motherhood and is thinking about going back to work. She fusses over Chloe throughout the consultation and the child is irritable. Jenny tells you Chloe is 'always like that' and at playgroups Chloe never leaves Jenny's side. She says 'it's exhausting'.

QUESTION 4

Is there anything else you need to do at this time?

FURTHER INFORMATION

Jenny is now 18 months postpartum and has been back to her normal self for 6 months. She never attended any extra therapy and now that Chloe is in a routine she feels everything is fine. She is working as an emergency teacher and now wants to stop her medication and have another child.

QUESTION 5

What are your recommendations?

CASE 1 ANSWERS

ANSWER 1

Chloe is the presenting issue; however, given Jenny's family history and her tired appearance there is a potential underlying issue with Jenny, although she has hinted that she is reluctant to accept that she might have any problems.[1] Examine Chloe first and rule out any underlying physical disorder, noting how well she is doing. At the same time, tell Jenny that the first few months of motherhood can be tough and that most women find it difficult (ie normalise). Ask Jenny if she has any breaks, how much sleep she is actually getting and if there is anyone who can care for Chloe overnight to give her a break. In particular, ask what role her husband is having and, if not much, whether he could be involved more. Suggest that he comes to the next appointment. You could also ask Jenny if her mother is able to help and whether she has other support networks, particularly other women with babies or young children. Consider any lifestyle issues, such as diet, drugs and alcohol, that might be contributing to her tiredness and suggest that some gentle exercise might help (eg walking with the pram).

You should ask if she has completed an Edinburgh Postnatal Depression Scale (EPDS)[2] with her child health nurse. If she has, you could ask her about her score. A score of 10 or more is suggestive of possible depression.[2] It is important to say how common it is for women to feel a bit down after the birth of a child and to ask Jenny how she is feeling. You could reassure Jenny that feeling tired is normal.

Jenny is still in the high-risk time frame for depression and postpartum psychosis,[3] both of which can be exacerbated by sleep deficit. You need to complete a psychiatric history, concentrating on depressive symptoms, psychotic symptoms, particularly related to whether her ideas about Chloe are realistic or if she has excessive concerns about her child's health, as well as undertaking a risk assessment with respect to suicide and infanticide (including neglect and distraction through tiredness).

Checking for physical issues such as mastitis, urinary tract infection and thyroid dysfunction may also be warranted.

ANSWER 2

If Jenny's physical tests are normal, she most probably has postnatal depression, which, according to the *Diagnostic and Statistical Manual of Mental Disorders* 5th edition (DSM-5),[4] may be an adjustment disorder or major depression. Psychotic depression, postpartum psychosis or a variation of bipolar disorder are diagnoses that need to be considered given her high level of anxiety, sleeplessness and her family history. The latter needs to be clarified. Her risk for major depression includes her family history, having a first baby and being an older mother.[3,5] She has already given you indications that she feels she has failed, that her baby is not perfect and that motherhood is not what she expected.

Reiterate that mood problems are common in the postpartum period. For example, a *beyondblue* postnatal depression screening program reported that 16% of women have depression in the postnatal period and many more have high scores on the EPDS due to adjustment difficulties.[5] Tell Jenny that women improve with time and treatment. Rebalancing expectations will be an ongoing part of any consultation.

Outline treatment options, starting with non-medication strategies. For example, suggest taking breaks from Chloe, perhaps by asking her mother to babysit on a regular basis or, alternatively, using paid childcare. This could be discussed with the reflection that 'it takes a village to raise a child'. Address any other lifestyle issues identified as possible contributing factors. Another option is cognitive behavioural therapy (CBT) with a psychologist or in a group setting (often run at child health centres), which may be supportive and/or therapeutic.[6] CBT is one of several psychological therapies reported to have moderate-quality evidence supporting improved symptoms in postnatal depression. Other options include interpersonal psychotherapy and psychodynamic therapy.[7] Recommend useful, vetted websites (see Resources for patients) and discourage the use of other websites. Ideally, provide Jenny with some fact sheets, for example, from *beyondblue* and the Post and Antenatal Depression Association (PANDA), and the PANDA hotline. With Jenny's permission, contact her husband if he is unable to attend an appointment and look at ways he may be able to help.

Introduce the idea of medication as another treatment possibility. Use of temazepam for a few days could be useful. Jenny is likely to be worried about addiction and transfer of medication to the baby via her breast milk; this is minimal with 10–20 mg temazepam and for 2–3 days only. Given that her current history has now persisted for more than 1 month, you could suggest a selective serotonin reuptake inhibitor (SSRI) such as sertraline, which is reported to be present in low concentrations in breast milk, has little transfer to the infant and poses few risks of side effects in the child.[8] The *Australian Medicines Handbook* 2014 indicates that some people consider sertraline to be one of the preferred antidepressants for use when breastfeeding[9] and suggests using it as an alternative to fluoxetine, which has a long half-life.[10] In general, SSRIs (Australian pregnancy category C), with the exception of paroxetine, are considered relatively safe for use in pregnancy and the postnatal period; paroxetine (Australian pregnancy category D) should be avoided in women of child-bearing potential.[9,11] Warn Jenny that the medication could make her more agitated but it will not sedate her, so she will still be able to care for Chloe. If she has bipolar disorder there is a risk that an antidepressant could cause mania if she is not on a mood stabiliser.[12]

ANSWER 3

A referral to a perinatal psychiatrist is now critical and if an appointment cannot be obtained urgently then the GP should ring and get telephone advice regarding medication. An antidepressant is now likely to be effective if it has not already begun as Jenny may now have a major depressive disorder with obsessional thoughts. Obsessive-compulsive disorder is a possible differential diagnosis.[13] Psychosis is less likely given the intrusive thoughts are ego-dystonic (distressing, unacceptable) and that she avoids any possibility of doing them. Given the family history, bipolar disorder is a possibility but, statistically, it is more likely in the first 3 months (particularly in the first week).[14]

If Jenny's anxiety continues to be a major feature (and it is often the last symptom to improve) then continuing CBT will be important; exercise and yoga might also help. She may require a higher dose of the SSRI. Often, anxious women struggle with breastfeeding and having enough milk, which in turn causes the child to be more unsettled so weaning or a supplementary night feed may be an option worth discussing with Jenny, particularly if infant weight gain or breastfeeding has been an issue for her.

If Jenny's symptoms worsen or do not begin to improve, consider a referral to a mother–baby unit if this is available.

ANSWER 4

It seems that Jenny's depression is resolving but her lack of enjoyment may still be a feature of her illness. It may also be part of the driving stress; that is, there is an underlying attachment difficulty and Chloe's birth and their relationship have rekindled her own early attachment difficulties when her mother had depression and was emotionally unavailable during her childhood. Ask Jenny how depressed her mother was (eg was she hospitalised?) and about their relationship, particularly when Jenny was little; did she feel she could go to her mother for comfort and did her mother help her to become independent and allow her to try things on her own? Are Jenny's attachment problems with her mother being repeated with Chloe? If so, or if this lack of enjoyment persists, consider discussing with her psychiatrist about sending Jenny to a perinatal psychiatrist, mother–infant therapist or mother–infant therapy group (eg Circle of Security).[15]

ANSWER 5

Jenny is at a higher risk of having another depressive episode postpartum, compared with someone who has never had postpartum depression, and her risk of having another depressive episode will be higher still (and possibly occur earlier) if she ceases her medication.[16] Ideally, she should be well for 12 months before ceasing her medication, but as she has been taking it for this long, and given her age, she may not want to wait any longer before trying for another baby. Planning the next pregnancy with a perinatal psychiatrist is essential.

Table 1. Recommendations for making treatment choices for women with mental health issues who are planning a pregnancy, are pregnant or are breast feeding[7,17]

Health professionals should:

- choose medications with lower risk profiles for both the mother and the fetus/infant
- initiate medication at low dose and titrate slowly to the lowest effective dose (to minimise dose-related risks)
- use monotherapy in preference to combination treatment
- consider additional precautions for preterm, low birth weight or sick infants

The risks and benefits of ceasing or continuing medication need to be outlined and discussed, ideally with both Jenny and her husband. Current evidence indicates that an SSRI such as sertraline (avoid paroxetine and fluoxetine, although any increase in risk from them is small) has low risk for malformation and pulmonary hypertension of the newborn; registry studies have significant confounding variables such as higher alcohol and multiple drug use in women who take antidepressants.[8,18,19] As a comparison, the risk of birth defects in the general population is 2–4%.[17] There is a risk of slight prematurity (and possibly miscarriage), neurobehavioural delays and possibly autism but this also exists to a lesser extent in women with depression and anxiety.[18,20] Women who are depressed and anxious in pregnancy (and not taking SSRIs) have infants born with higher cortisol levels, and may be more likely to be at risk of later behavioural, mood and anxiety disorders, as well as poor antenatal care and suicide.[21,22]

If Jenny chooses to cease her medication, she should do so as slowly as possible (ideally over 6 months) and she should be monitored for symptoms of discontinuation and/or withdrawal, and signs of relapse.[17] Taking a reduced dose might be an option, and discussion regarding how to manage a relapse is important in advance. A refresher course of CBT and discussion of general measures, such as keeping Jenny's stress levels low, having regular sleep and engaging in regular exercise, are important regardless of whether she decides to stay on her medication or ceases using it.

REFERENCES

1. Bilszta J, Ericksen J, Buist A. Women's experience of postnatal depression – beliefs and attitudes as barriers to care. Aust J Advan Nurs 2010;27:44–54.
2. Cox J, Holden J, Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. Brit J Psych 1987;150:782–86.
3. O'Hara M, Swain A. Rates and risks of postpartum depression – a meta-analysis. Int Rev Psychiatry 1996;8:37–54.
4. American Psychiatric Associaton. Depressive disorders. In: Diagnostic and Statistical Manual of Mental Disorders, 5th edn (DSM-5). Arlington: American Psychiatric Publishing, 2013.
5. Buist AE, Austin MP, Hayes BA, et al. Postnatal mental health of women giving birth in Australia 2002–2004: findings from the *beyondblue* National Postnatal Depression Program. Aust N Z J Psychiatry 2008;42:66–73.
6. Goodman J, Santangelo G. Group treatment of postpartum depression: a systematic review. Arch Womens Ment Health 2011;14:277–93.
7. National Institute for Health and Care Excellence. Antenatal and postnatal mental health. The NICE Guideline on Clinical Management and Service Guidance. Manchester: NICE, 2007. Available at www.nice.org.uk/guidance/CG45 [Accessed 27 June 2014].
8. Jain AE, Lacy T. Psychotropic drugs in pregnancy and lactation. J Psychiatr Pract 2005;11:177–91.
9. Rossi E, editor. Sertraline (special cases: pregnancy and the postnatal period). In: Australian Medicines Handbook 2014. Adelaide: Australian Medicines Handbook Pty Ltd, 2014.
10. Rossi E, editor. Fluoxetine (breastfeeding). In: Australian Medicines Handbook 2014. Adelaide: Australian Medicines Handbook Pty Ltd, 2014.
11. Rossi E, editor. Major depression (special cases: pregnancy and the postnatal period). In: Australian Medicines Handbook 2014. Adelaide: Australian Medicines Handbook Pty Ltd, 2014.
12. Ghaemi SN, Rosenquist KJ, Ko JY, et al. Antidepressant treatment in bipolar versus unipolar depression. Am J Psychiatry 2004;161:163–65.
13. McGuinness M, Blissett J, Jones C. OCD in the perinatal period: is postpartum OCD a distinct subtype? A review of the literature. Behav Cogn Psychoth 2011;39:285–310.
14. Kendall R, Chalmers J, Platz C. Epidemiology of puerperal psychosis. Br J Psychiatry 1987;150:662–73.
15. Marvin R, Cooper G, Hoffman K, Powell B. The Circle of Security Project: attachment-based intervention with caregivers-pre-school child dyads. Attach Hum Dev 2002;4:107–24.
16. Cohen LS, Altshuler LL, Harlow BL, et al. Relapse of Major Depression during pregnancy in women who maintain or discontinue antidepressant treatment. JAMA 2006;295:499–507.
17. *beyondblue*. Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals. Melbourne: *beyondblue*, 2011. Available at www.bspg.com.au/dam/bsg/product?client=BEYONDBLUE&prodid=BL/0891&type=file [Accessed 27 June 2014].
18. Udechuku A, Nguyen T, Hill R, Szego K. Antidepressants in pregnancy: a systematic review. Aust N Z J Psychiatry 2010;4:978–96.
19. Buist A. Perinatal mental health: identifying problems and managing medications. Aust Fam Physician 2014;43:182–85.
20. Galbally M, Lewis AJ, Buist AE. Developmental outcomes of children exposed to antidepressants in pregnancy. Aust N Z J Psychiatry 2011;45:393–99.
21. O'Connor T, Heron J, Glover V, et al. Antenatal anxiety predicts child behavioural/emotional problems independently of postnatal depression. J Am Acad Child Adolesc Psychiatry 2002;41:1470–77.
22. Bonari L, Koren G, Einarson TR, Jasper JD, Taddio A, Einarson A. Use of antidepressants by pregnant women: evaluation of perception of risk, efficacy of evidence-based counselling and determinants of decision making. Arch Womens Health 2005;8:214–20.

RESOURCES FOR PATIENTS

- PANDA, 1300 726 306, www.panda.org.au
- *beyondblue,* 1300 224 636, www.beyondblue.org.au
- The Royal Women's Hospital Perinatal Psychotropic Information Centre, 03 8345 3190, www.ppmis.org.au

RESOURCES FOR DOCTORS

- The Royal Women's Hospital Perinatal Psychotropic Information Centre 0383453190, www.ppmis.org.au
- *beyondblue*, 1300 224 636, www.beyondblue.org.au

CASE 2

CHERYL IS FRIGHTENED OF HER HUSBAND

Cheryl, 37 years of age, has made an urgent appointment and has specifically asked to see you. She looks white and drawn. She tells you that her husband Bob was particularly nasty and demeaning in an argument with her last night. When he came to bed she was exhausted and did not want to have sex but he was insistent. Cheryl was frightened and says she feels 'If I had said no, he would have taken it anyway.'

QUESTION 1

How would you respond to Cheryl?

FURTHER INFORMATION

You ask Cheryl to tell you more about her relationship with Bob. She says there has been 'trouble' in the past. When invited to say more, Cheryl tells you that Bob has episodically 'lost his cool'. It started when she was pregnant with their daughter Kate. On one occasion Bob beat her and choked her. In the past year Bob has hit out at Cheryl again, knocking her against the door and/or floor. Bob is usually very sorry after it happens. She then tells you Bob is a good father and that Kate loves her dad and is happy in her school.

QUESTION 2

Is Cheryl experiencing domestic violence? How prevalent is domestic violence?

QUESTION 3

What should be documented during Cheryl's visit? Why is it important to make notes of this visit?

FURTHER INFORMATION

Cheryl says she is concerned about who could access the information if it were to be recorded in her medical notes. She is worried and very embarrassed at the thought of other staff reading it when she comes back to the practice for routine medical matters.

QUESTION 4

How can you protect a patient's medical records?

QUESTION 5

What are the most immediate concerns at this time? What important facts would you want to obtain from a further history?

FURTHER INFORMATION

Cheryl says she wasn't aware that she has the right to refuse sex with her husband.

QUESTION 6

How would you respond to Cheryl's comment?

QUESTION 7

When might you need to break the doctor–patient confidentiality?

FURTHER INFORMATION

Cheryl says she really does not want to leave Bob. She does not want to break up the family, cause any distress for Kate or sell the house, but she now acknowledges she may have to leave and that all of this may indeed happen. Cheryl wants to consider her options.

QUESTION 8

How can you arrange a helpful referral for Cheryl?

CASE 2 ANSWERS

ANSWER 1

Careful thought needs to be given to the response and approach to questioning in a situation such as this where a patient has indicated possible intimate partner abuse. GPs may lack confidence in discussing issues related to domestic violence and/or perceive that they cannot help abused women.[1] However, studies have shown that patients want to be asked to discuss abuse and are likely to disclose abuse to their GP, particularly if asked directly and in a sensitive, empathic way.[2] The Royal Australian College of General Practitioners (RACGP) publication, *Abuse and violence: working with our patients in general practice*[2] (the white book), provides guidance about inquiry and disclosure of abuse.

Cheryl has disclosed what seems to be an abusive situation. A helpful response incorporates the following two steps from the 'nine Rs' for intervention described in the RACGP white book:[2]

- recognising symptoms of abuse and violence, and asking directly and sensitively
- responding to disclosures of violence with empathic listening and exploration.

It is important to acknowledge Cheryl's fears; you could respond by saying that what happened sounds very frightening for her but that she has been brave in disclosing her experience to you.

Examples of other questions or statements, which are open and likely to allow Cheryl to give a fuller history include the following:

- I am hearing you say you were frightened of what your husband would do if you did not have sex with him.
- Can you tell me more about your relationship with your partner?
- Has anything like this happened before?

The RACGP white book also suggests following up with more specific questions and statements:[2]

- Has your partner ever physically threatened or hurt you?
- Is there a lot of tension in your relationship? How did you resolve the argument?
- Sometimes partners react strongly in arguments and use physical force. Is this happening to you?
- Have you ever felt unsafe in the past?
- Violence is very common in the home. I ask a lot of my patients about abuse because no one should have to live in fear of their partners.

Responses that are **not** helpful include:

- What were you arguing about?

This question minimises a serious situation. It is normal for couples to argue but it is not normal or OK to feel frightened, or to be compelled to have sex. Cheryl may hear this question as blaming her, with the implication that if she had not argued the incident would not have happened.

- I don't think it is fair to talk about Bob like that. He didn't do anything to you, did he?
- You need to leave him right now.

These responses miss the point that Cheryl may be describing a situation where she is frightened of her partner and may be describing rape in marriage. Criticising her husband or telling her to leave him may provoke Cheryl to defend her husband. Family violence is disempowering.[3] Cheryl will benefit from support in gaining a clearer perspective and making her own decisions.

In studies assessing women's views of encounters with clinicians, consistent themes have emerged about their expectations of how GPs should respond to issues of intimate partner violence.[2] The main expectations are that GPs should have an understanding of the issue, be alert to signs of abuse and raise the issue in a supportive, compassionate and non-threatening way. A non-judgemental but confident approach, with assurances that confidentiality will be maintained, is essential.[2]

ANSWER 2

Domestic violence is not limited to physical abuse and can include emotional, sexual, economic and social abuse, and neglect.[2] It can happen in any social group. The RACGP white book[2] provides excellent information and guidance about this subject for the GP.

From Cheryl's description of Bob's behaviour towards her, it is clear that she has experienced physical abuse. His insistence on having sex when she did not want it is sexual abuse. The demeaning nature of their argument the night before her visit to you indicates that she may also be subjected to emotional abuse.

The Australian Bureau of Statistics Personal Safety 2012 survey[4] found that 17% of women aged 18 years and over had experienced violence by a partner; 1.5% of women in a relationship had experienced physical violence in the previous 12 months and 25% had experienced emotional violence. The violence can continue over many years. In 20% of cases the violence commences during pregnancy. Family violence often continues for many years.

ANSWER 3

It is important to accurately document information that Cheryl gives you at this visit, including any health complaints and symptoms, as you would at any other visit. You could also record Cheryl's descriptions of the events using quotation marks. You should document in detail your observations of Cheryl's condition, behaviour and any injuries she may have, as well a history of how the injuries were sustained.[2]

This situation is directly relevant to Cheryl's mental and physical health, and potentially her life and safety; it is important, therefore, to make detailed notes of the discussions.[2]

It is also important for Cheryl that there be a record of the alleged violence in case of any legal issues that may arise in the future. For example, Cheryl and Bob may need to separate and there may be family court orders about childcare or other legal disputes. It is invaluable for the patient to have a contemporaneous record.[2]

ANSWER 4

This is a difficult issue. Some practice software allows a patient's notes to be restricted to one-doctor access. However, this would not meet Cheryl's needs as she sees other doctors in the practice from time to time. One suggestion is to write a paper medical note and scan it into the record under a title such as 'special note confidential between patient and doctor *(insert your name)*' with the date. It is worth discussing this issue at a practice meeting and confirming the suitability of any innovative arrangements with your medical defence organisation.

ANSWER 5

Immediate concerns are assessing Cheryl's risk and safety. This should be informed by your professional judgement of Cheryl's situation, Cheryl's assessment of her risk and safety, and the presence of risk indicators such as Bob's history of violent behaviour, mental health problems, access to lethal weapons, and use of drugs and alcohol.[2]

You could ask the following questions to assess her safety:[2]

- Does Cheryl feel safe to go home? If not, you should help her to find somewhere safe where she can go. If yes, then help her to develop a safety plan (see below).[2]
- How safe does she feel?
- What does she need to feel safe?
- How safe is Kate?
- Is Bob obsessive about Cheryl?
- Is Bob controlling or abusive in other areas (eg financial, emotional, her relationships with friends and families, isolating her)?
- Is there a weapon in the house?
- Has Bob threatened Cheryl with a weapon?
- What does she mean by 'I can't go on like this'?
- What resources does Cheryl have to call for help or move to a place of safety (eg neighbours, family and money)?

Some women may be followed home from work or become trapped at home with the telephone disconnected and without access to money, car keys, Medicare and ATM cards or other basic means to leave. It is important to help Cheryl to consider her situation and, if necessary, to plan to be able to leave. An example of safety information for women is shown in *Table 1*.

Useful information to obtain from a further history could include:

- whether the violence is escalating now
- additional history about the choking, smothering or strangulation, which is a significant risk factor for future homicide and may often leave no visible marks or injuries[5,6]
- history of any past attempts to leave
- history of prior abuse in other relationships (childhood abuse is a risk factor for being a victim of abuse as an adult[7,8]).

Table 1. Safety planning[9]	
Safety during an abusive incident	**Safety at work**
• Be aware of all exit routes and safety spots • Have a plan that includes how to: – call emergency (000) – safely exit the house – seek help • Ask neighbours to call the police if they hear any disturbance	• Tell someone at work about the situation at home • Avoid using the same route each day to go to work • Have a plan for arriving at and leaving work

ANSWER 6

In all Australian jurisdictions rape in marriage is a crime. In this case, however, Cheryl explains that Bob did not specifically threaten her about the sex and she cannot be sure of what would have happened if she had refused to have sex. Cheryl does not think what took place was rape but it was the trigger that has caused her to seek your help. This case illustrates the important concept that where there is violence with fear and control it is not possible to freely consent to sexual intimacy.

ANSWER 7

The laws for reporting domestic violence vary in different states. However, it may be necessary to break doctor–patient confidentiality under the following circumstances when dealing with cases of domestic violence:[2]

- You believe that the patient is in imminent danger.
  Ideally, you should seek the patient's consent to report the matter to the police; however, if they are unable to give consent (eg they are cognitively impaired) or if they have been threatened with weapons such as guns and knives, the patient's safety overrides doctor–patient confidentiality. The NSW Department of Health recommends notifying the police if the patient has serious injuries. In the Northern Territory reporting to the police is mandatory if a person has been, or is likely to be, seriously physically harmed from family violence.
- There are children involved
  If there is any risk to a child, whether direct or indirect (eg the child witnesses the abuse of a parent), the situation must be reported to the child protection authorities. Northern Territory law also requires all adults to report to the police if a child is likely to be at risk of any type of harm, including sexual offences.

If there is any doubt about the need to break doctor–patient confidentiality, it is advisable to consult your medical defence organisation.[2]

ANSWER 8

There are domestic violence support services in every state/territory. The following resources could be helpful for Cheryl:

- Access to a list of local counselling services and shelters with expertise in managing domestic violence is very helpful. Each Medicare Local and/or practice can ensure that the list is kept up to date.
- The telephone service 1800RESPECT offers 24/7 phone counselling. The 1800RESPECT website has online counselling and information for victims, professionals, and friends and family.
- Local police or emergency services (000) should be contacted if Cheryl and/or Kate are in danger. In some states there are specialist police domestic violence liaison officers. The police can provide information on court orders to restrain or apprehend violent offenders. These orders can exclude a violent person from a home or another location but do not necessarily mean that the couple cannot continue to live together.
- In some states there are programs, such as *Staying home leaving violence,*[10] where the victim and the children stay in their home. The perpetrator is mandated to leave the house and the locks are changed.

Any past history of violence or sexual abuse is relevant and should be addressed when Cheryl is ready. Domestic violence or counselling services can assist with this if and when Cheryl is ready to be referred to the appropriate health professional.

Cheryl may need to be very careful with any material she takes home as it may trigger further abuse if her husband finds it.

SUMMARY

The above discussion illustrates the following nine steps to intervention (the nine Rs), recommended by the RACGP white book:

1. Role with patients who are experiencing abuse and violence
2. Readiness to be open to
3. Recognise symptoms of abuse and violence, ask directly and sensitively and
4. Respond to disclosures of violence with empathic listening and explore
5. Risk and safety issues
6. Review the patient for follow-up and support
7. Refer appropriately and also
8. Reflect on our own attitudes and management of abuse and violence
9. Respect for our patients, our colleagues and ourselves is an overarching principle of this sensitive work.

CONCLUSION

Cheryl decides that she and Kate will stay with her sister for a couple of days so she can think about what she should do. She agrees to phone 1800RESPECT from her sister's house today. She thanks you for your help. She tells you this is the most she has ever told anyone about the violence. You again acknowledge her bravery. You offer to continue to see her and make a follow-up appointment.

REFERENCES

1. Hegarty K, Taft A. Overcoming the barriers to disclosure and inquiry of partner abuse for women attending general practice. Aust N Z J Public Health 2001;25:443–47.
2. Royal Australian College of General Practitioners. Abuse and violence. Working with our patients in general practice. 4th edn. Melbourne: RACGP; 2014. Available at www.racgp.org.au/your-practice/guidelines/whitebook/ [Accessed 27 June 2014].
3. McLennan W. Women's safety in Australia. Canberra: Commonwealth of Australia; 1996. Available at www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/F16680629C465E03CA256980007C4A81/$File/41280_1996.pdf [Accessed 27 June 2014].
4. Australian Bureau of Statistics. Personal safety. Measuring the prevalence of violence. Canberra: Commonwealth of Australia; 2012. Available at www.abs.gov.au/ausstats/abs@.nsf/Lookup/4906.0Chapter2002012 [Accessed 11 July 2014].
5. Block CR, Devitt CO, Fonda D, et al. (2000). The Chicago Women's Health Study: risk of serious injury or death in intimate violence: a collaborative research project. Washington, DC: US Department of Justice; 2000.
6. Evelyn Jacobs Ortner Unity Center on Family Violence. Fact sheet: Strangulation assaults in domestic violence cases. Philadelphia: Evelyn Jacobs Ortner Unity Center on Family Violence; 2009. Available at www.sp2.upenn.edu/ortner/docs/factsheet_strangulation.pdf [Accessed 30 July 2014].
7. Bensley L, van Eenwyk J, Simmons KW. Childhood family violence history and women's risk for intimate partner family violence and poor health. Am J Prevent Med 2003;25:38–44.
8. Classen CC, Palesh OG, Aggarwal R. Sexual revictimization: a review of the empirical literature. Trauma Violence Abuse 2005;6:103–29.
9. Wimlah Specialist Domestic Violence Service. Charmed and dangerous. A woman's guide to reclaiming a healthy relationship. Available at www.wimlah.org.au/wp-content/uploads/2013/03/CharmedDangerous_wimlah-draft3-1.pdf [Accessed 30 July 2014].
10. NSW Government Family and Community Services. Staying home leaving violence. Available at www.community.nsw.gov.au/docs_menu/for_agencies_that_work_with_us/our_funding_programs/shlv.html [Accessed 22 July 2014].

CASE 3

JACKIE FEARS SHE WAS RAPED

Jackie, aged 24 years, comes to see you late on Saturday morning, teary and distressed. She last saw you 9 months ago for a Pap smear. She is in good health. She tells you that she thinks she was drugged the night before and woke up with a man on top of her who was having sex with her. She is worried she may catch something.

QUESTION 1

What is the most strategic approach for managing this consultation?

QUESTION 2

What messages are therapeutic for someone disclosing rape?

QUESTION 3

What are some common emotional responses to rape?

FURTHER INFORMATION

Following discussion, Jackie provides a more detailed history. Jackie has been in a new job at an advertising agency for 2 weeks. On Friday night Jackie and her colleagues had a few drinks after work and then some colleagues invited her to go with them to a party. She felt a bit tipsy in the taxi. At the party, she had one more drink and then felt dizzy and unwell. She stumbled and a man helped her up the stairs and into a bedroom to lie down. She woke up with a man on top of her, having vaginal sex with her. She felt weak and sick and tried to tell him to go away and that she did not want to do this. He did not stop. After he left, she slowly recovered, found her clothes and got dressed. She phoned her sister who came and picked her up and brought her to your clinic this morning.

You are concerned that this consultation should ideally take longer than you can manage on a busy Saturday.

QUESTION 4

As your time is limited on this occasion, what issues should be a priority at this stage?

QUESTION 5

What care and options are open to an adult who has been raped? What help is available to you to manage Jackie's immediate needs?

FURTHER INFORMATION

The nearest sexual assault centre with a forensic facility is 3 hours drive away from your clinic. Jackie wants to talk about risks of STIs and then go home and rest before she does anything else. After further discussion, Jackie insists on going home and says she is not ready to talk to the police at this time.

QUESTION 6

What will you do now? Would you prescribe anything?

QUESTION 7

What advice can you give a patient, to assist in preserving evidence, if the patient has not yet decided whether to report the rape to the police?

FURTHER INFORMATION

Jackie went to the police, who are investigating her case, and she had the forensic examination.

You see Jackie at 2 weeks and 3 months for her sexual health follow-up. She tells you that her flashbacks are subsiding, her sleep is improving and she is beginning to feel normal again. The police have laid charges against a man who was at the party. She is aware that recovery may be a long process and that her appearance in court could be traumatic, but she has decided to go ahead with it and has decided to continue with the support of her sexual assault counsellor.

At her visit today, she has a question to ask you. She has just heard from the police that her urine and blood tests did not show the presence of any drugs.

QUESTION 8

Jackie wants to know how it is possible there was nothing in her system?

FURTHER INFORMATION

Jackie attends your surgery about a year later on an unrelated issue. You have not seen her since some time ago when she told you she was attending counselling.

QUESTION 9

Is it helpful to ask her how she is after the rape?

CASE 3 ANSWERS

ANSWER 1

A helpful approach might be to:

- Respond first to Jackie's distress and the initial concerns she has expressed, which might be considered as providing 'psychological first aid'. This includes making a statement to the effect that sex without consent is a crime.
- Obtain sufficient history to assess the situation.
- Consider what options you can offer Jackie for immediate support when she leaves your surgery today.

The above approach could be achieved using the following examples:

Respond to the sexual assault: 'Jackie I am very sorry to hear that. It is terrible that this has happened to you. From what you have told me it sounds like a man had sex with you without your consent. This is a crime. Drugging is also a crime.'

Respond to her stated concerns: 'I hear what you are saying about the risk of sexually transmissible infection (STI) and we will come back to that.' Jackie has highlighted her concern that she may 'catch something' and she should be reassured that you will address this issue. It is very possible that the stated concern that she may contract an STI is her 'ticket' to see the doctor in a situation where she feels overwhelmed and her life has been completely disrupted.

Obtain a fuller history: 'First can you tell me some more about what happened?'

ANSWER 2

The initial words and response made by a doctor or people close to the victim can have a significant effect. Examples of statements that may be considered therapeutic for someone who discloses rape include:[1]

- I am sorry for what has happened (this is heard as 'I believe you').
- This is a crime (this is heard as 'this is not your fault').
- I will do what I can to help (this is heard as 'you are not alone').

It is important to listen to the patient, believe their story and be non-judgmental and supportive.[2]

ANSWER 3

In the period after a sexual assault, victims may experience a wide range of feelings including fear, anxiety, numbness, disbelief, panic, anger, shame, loneliness, embarrassment, irritability, guilt, powerlessness, loss of control, vulnerability, distress and confusion.[3]

ANSWER 4

The following issues should be addressed:

- Her STI risk
- Pregnancy prevention with postcoital contraception
- Assessing for injury (most people who are raped do not have injuries requiring treatment)
- Expressing support and affirmation for Jackie
- Her social safety:
  - Does she have somewhere safe to go and where she can be supported on leaving the surgery?
  - Will she be physically and emotionally safe at work?
  - What is her emotional/psychological situation (mental health risk assessment)?
- The legal/police situation (Jackie may have been drugged and raped).

Ideally, she should be referred today to a sexual assault service with a counsellor and doctor for psychosocial support, medical care and, if she chooses, a forensic examination, which is best done as early as possible and within 72 hours.

ANSWER 5

The following care and legal options might be available to an adult who has been raped.

Care

This depends on where you practice. New South Wales, Victoria, Adelaide, Perth and other locations have specialised sexual assault services where a sexual assault counsellor and a specially trained doctor offer a coordinated psychosocial and medical response and a forensic medical examination if the patient chooses this. The counsellor will also support the patient during any legal process, if one is undertaken.

Legal

The patient can report the crime to the police for investigation and, where appropriate, for police assistance in promoting the patient's safety (eg to facilitate a court order to prevent future violence or stalking). Police receive training in how to respond to victims of sexual assault and most members of the police force will respond in a sensitive and supportive manner. The police will investigate and, if they can gather sufficient evidence, press charges. This does not depend on whether the patient has physical injuries. In general terms, victims of rape retain control of whether the matter goes to court and in most cases they can withdraw from the police process at any time, up to when the case goes to court.

The police will request that Jackie has a forensic medical examination. This is performed by a forensically trained doctor or nurse, who takes a history, carefully and sensitively examines and documents any injury, and collects swabs from relevant areas to test for the offender's DNA, as well as blood and urine for toxicology testing. The process will be carefully explained to Jackie and she would then have the option to decline any part of the examination (eg speculum use). In dedicated sexual assault centres, the counsellor and doctor work together to provide a holistic service.

It is very valuable to have a local list of services available in your practice, including 24/7 for sexual assault, family violence, etc. This could be prepared and kept up to date by each Medicare Local or by practice staff. You could refer Jackie to the:

- 24/7 telephone counselling service: Rape and Domestic Violence Services Australia (previously known as the Rape Crisis Centre), 1800RESPECT, www.rape-dvservices.org.au
- nearest hospital social worker or emergency department
- police.

Police websites also have useful information on sexual assault (refer to Resources for patients and doctors).

ANSWER 6

At this stage, the next steps must be tailored to the patient's history, local STI risk and their likelihood of returning for adequate follow-up. The latest guidelines are available in the *National Management Guidelines for Sexually Transmissible Infections*.[4] The RACGP white book[2] and Yarrowplace Rape and Sexual Assault Service[5] also provides some guidance. The Royal Prince Alfred (RPA) Sexual Assault Service provides the following protocol:[6]

At presentation consider prophylaxis for:

- pregnancy prevention
  - levonorgestrel 1500 mg, taken as soon as possible or up to 120 hours later (as its risks are minimal)[7]
- chlamydia, gonorrhoea and syphilis
  - azithromycin 1 g or follow local guidelines, especially if follow-up is not likely
- hepatitis B virus (HBV) infection
  - commence vaccination if not immunised
- human immunodeficiency virus (HIV) infection
  - assess whether post-exposure prophylaxis might be required.

It is important to advise the patient that at this stage it is too early to test for most STIs and that follow-up is essential to ensure that appropriate testing takes place.

At 2 weeks follow-up:

- check blood for HBV, hepatitis C virus (HCV), syphilis, HIV (timing of HIV testing may vary to 4 weeks, depending on the laboratory capability) and ß-human chorionic gonadotropin (ß-hCG)
- test for chlamydia/gonorrhoea by polymerase chain reaction (PCR) at potentially exposed sites.

At 3 months follow-up:

- check blood for HBV, HCV, HIV and syphilis.

In cases where there might be an increased risk of HCV transmission (eg infected needles used during the assault), a 6-month HCV test will be required.

As Jackie insists on going home, a suitable plan needs to be discussed with her. It is agreed that her sister will stay with her today. Jackie also agrees that they will telephone the rape crisis counsellor (1800RESPECT) when they go home for advice about her options for reporting to the police and for counselling and care.

ANSWER 7

The following information and advice could be provided to Jackie:[4]

- Do not shower or wash.
- Place the clothes she was wearing in a bag (preferably in individual paper bags). Also advise Jackie to preserve any panty liners, tampons, etc, if relevant.
- If she needs to use the toilet she should press her panties into the vulva before urinating or opening the bowels. Jackie should save these panties in a bag.

There is no approved method of preserving any evidence of drugs that may have been given to her until she can have blood or urine collected. You could consider offering to take samples for your pathology service to screen and hold.

ANSWER 8

Several possibilities could account for the fact that no drugs were identified in her urine and blood samples. These include the following:[8]

- Many drugs are eliminated very rapidly from the body.[4]
- Some of the new designer drugs may not be detected at all with current testing methods.
- A common method for spiking of drinks is the use of 'extra' alcohol.[8]
- It is possible for a person to lose track of how many alcoholic drinks they have had or not realise that the same number of drinks can have a variable response depending on other factors such as fatigue, other medications or drugs.

Discussion of the last point needs to be handled very sensitively, as victims of rape often tend to blame themselves and tend to very easily hear blame from others. The victim being intoxicated does not excuse the perpetrator of a crime, or mean that the victim is to blame. However, if history shows that Jackie does drink to a dangerous level, it may be helpful to discuss the many health risks of excessive alcohol consumption with Jackie.

ANSWER 9

It is helpful to ask how she is and give her an opportunity to talk if she wishes to do so. Research shows rape survivors find 'a wall of silence', where the opportunity to talk is limited or absent, and this does not promote recovery. You also do not want to give the impression that today or every time she sees you she is required to think or talk about the rape. It may be helpful to ask her if she wants to fill you in on how she is going, while reassuring her that it is not necessary to talk about it if she does not want to.[9]

CONCLUSION

Jackie is glad you asked. She is proceeding with the police and court case despite the date of the court case being postponed twice due to legal delays. The counsellor is available on the telephone to support her in this. She is rarely having flashbacks but has occasional anxiety. She is still fearful of meeting the man and had considered moving

interstate. She has decided to leave the advertising world and has commenced retraining as a nurse. She is grateful for your support to her and her sister on that busy Saturday morning and this has influenced her decision to consider a career in health.

REFERENCES

1. Rape and Domestic Services Australia. Available at www.rape-dvservices.org.au [Accessed 24 June 2104].
2. Royal Australian College of General Practitioners. Abuse and violence. Working with our patients in general practice. 4th edn. Melbourne: RACGP, 2014. Available at www.racgp.org.au/your-practice/guidelines/whitebook/ [Accessed 22 July 2014].
3. New South Wales Police Force. Adult sexual assault. Available at www.police.nsw.gov.au/community_issues/adult_sexual_assault [Accessed 24 June 2014].
4. Sexual Health Society of Victoria. National management guidelines for sexually transmissible infections. Melbourne: Sexual Health Society of Victoria, 2008. Available at http://mshc.org.au/Portals/6/NMGFSTI.pdf [Accessed 1 August 2014].
5. Yarrowplace Rape and Sexual Assault Service. Information for health/welfare professionals. Available at www.yarrowplace.sa.gov.au/healthprof_assess.htm [Accessed 25 August 2014].
6. Induction Manual RPA and LIVERPOOL Sexual Assault and Clinical Forensic Medicine. 2013.
7. Rossi S, editor. Levonorgestrel. In: Australian Medicines Handbook. Adelaide: Medicines Handbook Pty Ltd, 2014.
8. Drummer O, Odell M. The Forensic Pharmacology of Drugs of Abuse. London: Arnold Publishers, 2001.
9. Lievore D. No longer silent. A study of women's help-seeking decisions and service responses to sexual assault. Canberra: Australian Institute of Criminology, 2005. Available at www.aic.gov.au/media_library/publications/other/2005-06-noLongerSilent.pdf [Accessed 1 August 2014].

RESOURCES FOR PATIENTS AND DOCTORS

- The Better Health Channel. Sexual assault. www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Sexual_assault?open
- New South Wales Police. Adult sexual assault. www.police.nsw.gov.au/community_issues/adult_sexual_assault
- Queensland Police. Adult sexual assault. www.police.qld.gov.au/programs/adultassault/adultasslt.htm
- Victoria Police. Crime prevention and community safety. Sexual assault. www.police.vic.gov.au/content.asp?Document_ID=10904
- Western Australia Police. Sexual assault. www.police.wa.gov.au/Yoursafety/Sexualassault/tabid/1607/Default.aspx
- Australian Institute for Family Studies. Crisis support. www.aifs.gov.au/acssa/crisis.html

CASE 4

EMILY'S SECRET PAIN

Emily is an art teacher aged 30 years and has been in a relationship for 3 years with Jason, an engineer. She has a 2-year history of increasing pain with sex and with Pap smears. Emily and Jason have not had sex for the past 6 weeks, as Emily cannot bring herself to have sex any more. This situation has precipitated her appointment today.

QUESTION 1

What questions would you ask Emily to collect a relevant history?

FURTHER INFORMATION

On questioning, it transpires that Emily enjoyed her sexual relationship with Jason in the first 6 months, before they moved in together. However, since then there had been a number of stresses and Emily was scared that the relationship would be at risk if something did not change soon.

Vaginal examination and Pap smears used to be fine until her last Pap smear. On that occasion there was a different doctor and he needed to repeat the Pap smear because he did not get enough cells the first time. Emily felt quite tense because he seemed rushed but she said nothing, even though the procedure hurt her a lot. The doctor said that the Pap smear would be over soon and she knew it would be, but found the pain excruciating while it was being performed.

QUESTION 2

Emily asks 'What's wrong with me?' How would you respond?

QUESTION 3

Emily asks 'Am I the only one? I've never heard of anyone else having this.' How would you answer?

FURTHER INFORMATION

Emily is due for a Pap smear but is terrified it will hurt.

QUESTION 4

How would you discuss this with her and how would you proceed?

QUESTION 5

What are the options and rationales for the treatment of vaginismus?

QUESTION 6

What can doctors do to help identify and treat vaginismus?

CASE 4 ANSWERS

ANSWER 1

A psychosexual history helps us understand what life circumstances, including health issues, may have contributed to the patient's symptom(s). Relevant questions for a psychosexual history include questions regarding Emily's personal, medical, sexual and psychosocial history (*Table 1*).

Table 1. Obtaining a psychosexual history[1]

History	Possible questions/discussions points
Personal history (including family's attitudes and beliefs about sex and a brief outline of life history, including school, friendships and work)	What was it like growing up in your family? Was sex talked about or was it unmentionable? Were parents physically affectionate? How did you find out about sex? What were your ideas about it before you got started? How did you find out about periods? Any pain with periods? Tampon use?
Medical and surgical history	Ask especially about history of pelvic surgery, infections (eg recurrent thrush), episiotomies, etc
Relationship history	Relationships with previous partners Feelings of self-worth and desirability Relationship with current partner
Sexual history	Contraception Past-traumatic experiences: physical/sexual abuse, sexual assault or painful vaginal examination
Psychosexual history	Describe the problem in detail Has the problem always been there? Has this been a problem in any previous relationship? The reason for coming now

ANSWER 2

On the basis of her presenting and psychological history, Emily has vaginismus. She has had severe pain with penetration until penetration felt impossible and pain with Pap smears.

Vaginismus is newly classified in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5),[2] as part of a genitopelvic pain disorder/penetration disorder. The DSM-5 states that the most frequent clinical presentation is one in which both psychological and physiological factors contribute. Associated features are described as partner factors, relationship factors, individual vulnerability factors, cultural or religious factors, as well as medical factors.

There has been a fundamental shift over the past two decades from a dualistic view of the aetiology of painful and/or difficult vaginal penetration as being due to either psychological or physiological causes to the current multifactorial perspective, with a biopsychosocial lens, which sees a complex interplay between physiological, psychological and social factors.[3]

Women with vaginismus often avoid sexual intercourse, experience involuntary muscle contraction and anticipate, fear or experience pain or burning with penetration. The degree of distress is more central to the diagnosis than muscle tone.[4]

ANSWER 3

Women feel isolated and ashamed when penetrative sex is painful or impossible. Although the population prevalence of vaginismus remains unknown, it has been reported to be 5–17% in clinical settings.[5] It might also be helpful to explain that vaginismus may be primary (ie pain at first intercourse) or secondary (ie developing after pain-free intercourse, as in Emily's case following a painful Pap smear).[4]

ANSWER 4

It is important to conduct an examination to diagnose organic pathology,[4] but the psychosexual examination, like a Pap smear, is not urgent and can wait until Emily feels ready. She needs to know that she can speak up if she is uncomfortable and trust that her doctor will listen to her and respect her wishes. Avoidance of Pap smears or pain with Pap smears can be indicators of past trauma.[6] Given that the biggest risk factor for cervical cancer is not being screened regularly, it is important to ask women if they have had their routine health checks and if not, why not. Ensuring that women get the help they need to deal with painful or stressful feelings that have resulted in pain or 'tight muscles' will enable them to have normal preventive healthcare when they feel ready.

Several visits may be required before a woman is ready to be examined and any examination should be approached gently.[4] For example, when she is ready to be examined, you could ask Emily to tell you if there is any pain or discomfort, or if she wants to stop the examination at any time. You should be watching for any signs of distress, but you should avoid inadvertently causing pain (iatrogenic pain). Describe in detail everything that you intend to do. Inviting her to contract then relax her pelvic muscles or instructing her to take a deep breath in then exhale slowly, are two physical ways to help her vaginal muscles relax and allow a finger to slide in.

The clinical examination can be used as a learning tool to educate patients on performing self-examinations at home. As Emily familiarises herself with this hidden part of her body in the privacy of her home, fantasies or fears that she has with penetration may emerge that can be discussed as part of her therapy. This helps connect the physical (how it feels) and emotional (what it's like for her) when talking about painful feelings in her body and her life.

ANSWER 5

Some doctors and patients, think that if penetrative sex and pelvic examination were possible (ie symptoms were 'fixed') the patient's problems would be solved; hence the offer of surgery, 'stretching' under anaesthesia, dilators, biofeedback, oral and intravaginal anxiolytics, botox injections, lignocaine gel and nitroglycerin

ointment.[5] The rationale for these treatments is that the problem is 'spastic' vaginal muscles. There is very limited evidence from controlled trials concerning their effectiveness.[7]

The ethics of prescribing medication or performing surgery, which have potential side effects on patients whose problems are not organically based, has not received much attention. This is because of the value placed on 'normality'.[8]

Often, doctors and patients believe that 'getting a Pap smear over quickly' will shorten the duration of pain for a frightened patient and therefore be helpful. However, this can inadvertently re-traumatise a patient who has a history of physical/sexual abuse or sexual assault (iatrogenic traumatic examination).[9–11]

The DSM-5 consensus that vaginismus has biopsychosocial origins[2] suggests that we should treat the patient holistically, not just treat the symptom. Psychosexual therapy is the only therapy to adopt a biopsychosocial model of diagnosis and treatment. In this model, vaginismus is conceptualised as a psychosomatic symptom: the symptom is the result of a complex interplay between physiological, psychological and interpersonal factors, expressed in the body (soma) as a painful symptom, which alerts us to painful feelings. An integrated approach to management is offered on the basis of this understanding. The aim of treatment is not to achieve tolerance of penetration but to encourage participation in sex only when it is pleasurable and pain-free. Individual and relationship issues are important, as is the experience of sex for the patient.[12]

Elements of treatment

The psychosexual history and examination (when the patient is ready) gives the doctor information needed for understanding the patient's problem in the context of her life and diagnoses any physical causes that need treatment (*Tables 2*, *3*). It also begins the process of treatment where the woman, with or without her partner, can begin to make connections between what has happened in her life and how she has been affected by it. It requires a factual, non-judgemental attitude by the doctor.

Table 2. Physical/medical causes of pain that may be contributory factors in vaginismus[4,5]

- Recurrent genital tract infections (eg thrush) and topical treatments
- Vulvovestibulitis
- Oestrogen deficiency (peri/post-menopause, following oophorectomy (surgical menopause)
- Prolonged use of depot medroxyprogesterone contraception
- Trauma associated with childbirth (including episiotomy)
- Genital surgery, radiotherapy and irritation caused by douches, spermicides or latex in condoms
- Diabetes, multiple sclerosis or spinal cord injury (patients may experience pain with penetration because of poor lubrication)

There is controversy around the differentiation between vulvar vestibulitis syndrome (VVS) and vaginismus because patients with vaginismus may also show signs of allodynia on the cotton bud test.

Table 3. Understanding and addressing features of vaginismus

- Many women are unfamiliar with this hidden part of their body (ie the vagina)
- There may be an associated fantasy that the vagina is too small to accommodate a penis when the patient doesn't feel 'big enough' for the adult world of sex
- Their bodies harbour painful feelings (physical and psychological)
- The unresolved issues that lead to pain and tightness may be unconscious. Patients are fearful and the symptom is self-protective. Some may feel disgust[13] with the sexual part of their body
- Address pain and tightness in vaginal muscles (specialist physiotherapy) and address painful feelings (psychosexual therapy)
- The patient needs to feel in control and they need to develop trust, slowly and gently

Patients should be encouraged to talk about their feelings, and their fears, genital pain, pelvic floor muscle tension and issues of sexual pleasure.[5,14] Treatment should be individualised for each woman, with or without her partner.

Encouraging non-penetrative sex is important at times when penetrative sex would interfere with progress of treatment.

Specially trained physiotherapists with skills in patient education (anatomy, physiology of sexual response) and gentle examination are helpful in a multidisciplinary approach. Initially, the woman is encouraged to look at and self-touch in a nonsexual manner, moving on to the insertion of a finger, then a small tampon. This can be combined with pelvic floor physiotherapy. Whilst the use of dilators has been a standard approach for physiotherapist-led treatment, this focus on tolerating increasingly sized dilators can make self-examination at home feel more like stretching exercises than exploration to see how the vagina and the examining finger feel, what that's like for the woman, and what feelings are aroused, increasing her sense of mastery of her own body as she gets in touch with her feelings around sex.

Recommendations on sexual activity

Women often feel guilty and men may feel frustrated by the idea of non-penetrative sex for a period of time. However, with penetrative sex being off the agenda, there may be more experimentation with non-penetrative sex (foreplay). This may lead to an increase in trust, arousal and natural lubrication, and improvement in sexual connection, especially when penetrative sex has been the primary mode of sexual expression. It will also help differentiate between patients for whom penetrative sex is the primary problem (individual issues) and those for whom there are additional relationship difficulties to be addressed, as the latter patients tend to continue to avoid sex.

ANSWER 6

Many women who have sexual pain do not discuss their problems with health providers. A Swedish study reported that only 28% of approximately 3000 women aged 20–60 years consulted their doctor regarding prolonged and severe dyspareunia.[15]

Doctors can take a leading role in identifying vaginismus and ensuring that patients have regular Pap smears by making Pap smears a positive experience for their patients (*Table 4*), as well as offering education, counselling and other support as required.[4]

Table 4. What can doctors do?

- Ask all female patients if they have had routine Pap smears
- Refer patients who have pain with sex or Pap smears for psychosexual therapy with or without pelvic floor physiotherapy
- Ensure there is no pain with Pap smears; Pap smears should be done when the patient feels ready, under her direction
- Ensure that patients understand that they can stop an examination at any time, as many patients have difficulty saying 'no'

CONCLUSION

Jason accompanied Emily to her second appointment. At this visit, information and education on vaginismus were provided. The problem was discussed, as well as how it affected each of them. The importance of a period of non-penetrative sex until Emily was ready was also discussed. Jason said it would be hard for him, as they were already doing the 'no sex' thing and they had not had sex for at least 6 weeks. It was explained that non-penetrative sex did not mean 'no sex' and that their sex life was important. Other forms of sexual activity could continue as long as Emily felt comfortable. Emily confirmed that she had been avoiding anything more than a hug because of her fear that it would lead to attempts at penetrative sex. She knew it wasn't good for their relationship but she didn't know what else to do.

Emily thought it would be helpful for them to continue to attend sessions together to deal with tensions that had built up in the relationship. She was pleased to be referred to a specialist physiotherapist to help at the physical level. After 6 sessions together, Emily came by herself to sort out her feelings about her body and sexuality. She now trusted Jason to go no further than she was comfortable with. Both were finding their (non-penetrative) sexual relationship rewarding. Within 6 months Emily felt ready to guide Jason's finger into her vagina in a way where she felt in control. She was then ready to guide him towards penetrative sex, happy to feel that this was something she wanted and felt ready for, and confident that she could also say 'no' if she didn't want to participate for whatever reason.

REFERENCES

1. Goodwach R. Sex therapy: historical evolution, current practice. Part 2. ANZJFT 2005;26:178–83.
2. American Psychiatric Association. Diagnostic criteria and codes: sexual dysfunctions: genito-pelvic pain/penetration disorder. In: Diagnostic and Statistical Manual of Mental Disorders, 5th edn. Arlington: American Psychiatric Publishing, 2013. Available at http://dsm.psychiatryonline.org/content.aspx?bookid=556&sectionid=41101779&resultclick=24 [Accessed 24 July 2014].
3. Boyer SC, Goldfinger C, Thibault-GagnonS, Pukall CF. Management of female sexual pain disorders. Adv Psychosom Med 2011;31:83–104.
4. Crowley T, Goldmeier D, Hiller J. Clinical review: diagnosing and managing vaginismus. BMJ 2009;338:225–29.
5. Lahaie M, Boyer C, Amsel R, Khalife S, Binik Y. Vaginismus: a review of the literature on the classification/diagnosis, etiology and treatment. Womens Health 2010;6:705–19.
6. Farley M, Golding JM, Minkoff JR. Is a history of trauma associated with a reduced likelihood of cervical cancer screening. J Fam Pract 2002;51:827–31.
7. Melnik T, Hawton K, McGuire H. Interventions for vaginismus. Cochrane Database Syst Rev 2012;12:CD001760. doi: 10.1002/14651858.CD001760.pub2.
8. Moynihan R, Cassels A. Selling sickness: how the world's biggest pharmaceutical companies are turning us all into patients. Sydney: Allen & Unwin, 2005
9. Australian Women's Coalition, Australian Federation of Medical Women, Victorian Medical Women's Society. Happy healthy women not just survivors. Consultation report: advocating for a long-term model of care for survivors of sexual violence. Ingleburn: Australian Women's Coalition, 2010. Available at www.awcaus.org.au/resources/documents/HHW_Consultation_Report.pdf [Accessed 30 June 2014].
10. Taylor SC, Pugh J, Goodwach R, Coles J. Sexual trauma in women. The importance of identifying a history of sexual violence. Aust Fam Physcian 2012;41:538–41.
11. Pedersen B, Mohl B. Vaginismus. Iatrogenic precipitation and maintenance. Acta Obstet Gynaecol Scand 1992;71:525–28.
12. Goodwach R. Sex therapy: historical evolution. Curr Pract Part 1 Aust N Z J Fam Therapy 2005:26:155–64.
13. de Jong PJ, Peters ML, Olatunji BO, McKay D. Sex and the sexual dysfunctions: the role of disgust and contamination sensitivity. Washington DC: American Psychological Association, 2009. p253–70. doi: 10.1037/11856-012.
14. Binik YM. The DSM diagnostic criteria for vaginismus. Arch Sex Behav 2010;39:278–91.
15. Danielsson I, Sjöberg I, Stenlund H, Wikman M. Prevalence and incidence of prolonged and severe dyspareunia in women: results from a population study. Scand J Public Health 2003;31:113–18.

RESOURCES FOR PATIENTS

- The Jean Hailes Foundation, http://jeanhailes.org.au/health-a-z/sex-sexual-health/painful-sex-dyspareunia
- The Society of Obstetricians and Gynaecologists of Canada, http://sogc.org/publications/when-sex-hurts-vaginismus
- Sexual Health Australia, www.sexualhealthaustralia.com.au/page/vaginismus.html

RESOURCES FOR DOCTORS

- Crowley T, Richardson D, Goldmeir: Recommendations for the management of vaginismus: BASHH Special Interest Group for Sexual Dysfunction Int J STD & AIDS 2006;17:14-18.
- Lahaie M, Boyer C, Amsel R, khalife S, Binik Y. Vaginismus: A review of the literature on the classification/diagnosis, etiology and treatment. Womens Health 2010: 6:705–19.
- McGuire H, Hawton K. Interventions for vaginismus. Cochrane Database Syst Rev 2012;12:cd001760.
- Taylor CS, Pugh J, Goodwach R, Coles J. Sexual trauma in women. The importance of identifying a history of sexual violence. Aust Fam Phys 2012;41:538–41.

CASE 5

JESSICA HAS HAD NO PERIODS FOR 4 MONTHS

Jessica is a beautician aged 26 years. She is concerned about oligomenorrhoea, which she has had for the last 4 months. She is not taking any medications. Jessica had menarche at the age of 14 years and her cycles have always been irregular (45–60 days). She is currently sexually active and her partner uses condoms for contraception. They do not have any plans for pregnancy. There is a strong family history of type 2 diabetes (T2DM) and myocardial infarction on Jessica's father's side. Jessica has gained 7 kg over the past 2 years, which she is struggling to lose. She has a sedentary lifestyle as she works full time and has little time for exercise.

On examination she is not cushingoid. She is normotensive and has a body mass index (BMI) of 28 kg/m^2 (weight: 79 kg, height: 168 cm) and central adiposity with a waist circumference of 89 cm. On further questioning, Jessica describes excessive facial hair growth, which requires regular waxing. She gives herself a score of 11 on the Ferriman-Gallway (FG) scoring system for hirsutism.[1]

QUESTION 1

What are the key issues in Jessica's history?

QUESTION 2

What is the most likely diagnosis? What investigations would you perform to confirm the diagnosis?

FURTHER INFORMATION

The results of Jessica's investigations reveal the following:

- serum testosterone: 2.0 nmol/L (normal: 0.1–1.7)
- sex hormone-binding globulin (SHBG): 15 nmol/L (normal: 18–136)
- free androgen index (FAI): 13% (normal: 0.7–10.9)
- thyroid stimulating hormone (TSH), prolactin, follicle stimulating hormone (FSH), luteinising hormone (LH) and β-human chorionic gonadotropin (hCG): normal
- transvaginal ultrasound: multiple follicles consistent with polycystic ovary syndrome (PCOS).

QUESTION 3

What is the diagnosis?

QUESTION 4

What are the key health challenges for Jessica? What general approach should you take to manage her key issues?

QUESTION 5

What therapeutic options for oligomenorrhoea should be considered and discussed with Jessica?

QUESTION 6

What role would weight management have in improving Jessica's metabolic and reproductive features and how will you facilitate this?

FURTHER INFORMATION

Jessica's oral glucose tolerance test (OGTT) shows normal results and her fasting lipids show mild dyslipidaemia with normal total cholesterol and low-density lipoprotein-cholesterol (LDL-C) levels, and a low level of high-density lipoprotein cholesterol (HDL-C). Jessica chooses to start a COC for regulation of her periods and considers laser therapy for hirsutism. She starts seeing a dietician, as well as attending regular aerobic exercise sessions at the local gym to achieve weight loss.

Four years later, Jessica visits you, after presenting to the emergency department the day before for vaginal bleeding and abdominal pain. She was found to be pregnant and was referred for an ultrasound, which confirmed a live pregnancy at 8 weeks of gestation. The bleeding stopped and Jessica was reassured that the pregnancy was still viable at this stage.

On examination, her weight is 73 kg, BMI is 26 kg/m^2 and she is normotensive. Jessica tells you that she stopped taking her COC about 6 months ago with the aim of getting pregnant.

Knowing her previous history of PCOS, you referred Jessica for an early OGTT to screen for gestational diabetes. Her fasting plasma glucose was 5.1 mmol/L and 2-hour plasma glucose was 9 mmol/L.

QUESTION 7

How would you interpret this result? What would be your approach?

QUESTION 8

What information would you give Jessica regarding postpartum screening for diabetes?

QUESTION 9

How would you advise Jessica about her risk of T2DM? How should this be managed?

QUESTION 10

What is the risk of gestational diabetes mellitus (GDM) with Jessica's future pregnancies? What would you advise her about pre-pregnancy screening for dysglycaemia in women with PCOS?

CASE 5 ANSWERS

ANSWER 1

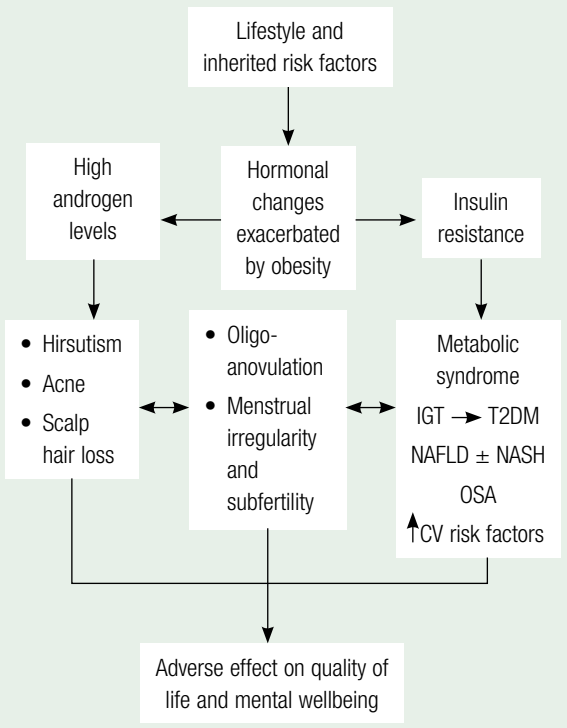
The key issues from Jessica's history include the following:

- oligomenorrhoea and history of irregular menses
- increased body weight with a BMI of 28 kg/m^2
- sedentary lifestyle and difficulty losing weight
- family history of T2DM and cardiovascular disease
- hirsutism.

ANSWER 2

The most likely diagnosis is PCOS. This is the most common endocrine condition in women of reproductive age, affecting 7–28% of women and increasing in frequency with increasing weight.[2] PCOS occurs in 7–12% of lean women and 20–28% of those who are overweight. Women at risk of PCOS include Aboriginal and Torres Strait Islander and Asian women, or women with a family history of PCOS or T2DM.[2]

Insulin resistance and hyperandrogenism are the key hormonal disturbances underpinning PCOS and are independent of, but exacerbated by, weight gain (*Figure 1*).[3]



IGT, impaired glucose tolerance; T2DM, type 2 diabetes. NAFLD, non-alcoholic fatty liver disease; OSA, obstructive sleep apnoea; CV, cardiovascular.

Figure 1. Aetiological, hormonal and clinical features of PCOS.[2]

Diagnosis of PCOS requires two of the three Rotterdam criteria, which are the internationally accepted diagnostic criteria for PCOS, as well as exclusion of other aetiologies, such as hypothyroidism, Cushing's syndrome, late-onset congenital adrenal hyperplasia (CAH), androgen-secreting tumours and hyperprolactinemia.[2] The Rotterdam criteria are:

- oligo- or anovulation
- clinical and/or biochemical signs of hyperandrogenism
- polycystic ovaries on ultrasound.

Recommended investigations to confirm the diagnosis include:

- Measurement of testosterone, SHBG and free androgen index (FAI) or calculated free testosterone. Total testosterone alone or additional androgens, including androstendione and dehydroepiandrosterone sulphate, are not recommended in routine investigation of PCOS.[2]
- A pelvic ultrasound could be performed to assess ovarian morphology, if required for diagnosis, and should be performed in the follicular phase of the menstrual cycle where possible. Pelvic ultrasound is also useful for measurement of endometrial thickness in the setting of oligo-/amenorrhea. However, it is not required in all cases (it should be performed per vaginal and by an experienced gynaecological ultrasonographer to increase accuracy where possible), and is not recommended in adolescents, especially if they are not yet sexually active; 60–80% of adolescents will meet PCOS criteria as they reach reproductive maturity.[2]
- Measurement of TSH, serum prolactin, 17(OH)-progesterone (in the follicular phase to exclude CAH) and β-hCG should be undertaken to exclude other causes.[2]

It is difficult to assess androgen status in women who are on the combined oral contraceptive (COC) pill as its effects include oestrogen-mediated increases in SHBG and reduction in androgens; therefore, COCs should be withdrawn, ideally for 3 months prior to reliable hormonal investigation.[4]

Referral to an endocrinologist is necessary for work-up if other rare causes, including Cushing's syndrome, non-classical CAH or rare androgen-secreting tumours, are suspected clinically (ie rapidity and severity of onset, hypertension, virilisation, markedly elevated androgen levels or cushingoid features).

ANSWER 3

On the basis of irregular menses, clinical and biochemical hyperandrogenism and follicles on pelvic ultrasound, Jessica has PCOS. Note that other causes were excluded on the basis of biochemistry and the absence of clinical suspicion of more severe conditions.

ANSWER 4

Women with PCOS may present with a range of features, including reproductive (hyperandrogenism, hirsutism, anovulation, infertility), metabolic (insulin resistance, impaired glucose tolerance, GDM, T2DM, dyslipidaemia, obstructive sleep apnoea) and psychological (increased anxiety, depression and worsened quality of life) features.[5–8] Women with PCOS are at a higher risk of developing

pre-diabetes, GDM and T2DM, and have higher cardiovascular risk factors, all with onset at an earlier age and all affecting lean as well as overweight women.[6] It is increasingly recognised that PCOS is not only a reproductive issue, but also a metabolic disease that carries important health risks from a young age.

A multidisciplinary approach including evaluation, patient education and consideration of treatment for each of the reproductive, metabolic and psychosocial areas is necessary.[2] Targeted treatment options are summarised in *Table 1*.

Table 1. Targeted treatment options for polycystic ovary syndrome

Oligomenorrhoea/amenorrhoea
• Lifestyle change (5–10% weight loss + structured exercise) • Combined oral contraceptive pill (low oestrogen doses, eg 20 µg may have less impact on insulin resistance) • Cyclic progestins (eg 10 mg medroxyprogesterone acetate 10–14 days every 2–3 months) • Metformin (improves ovulation and menstrual cyclicity)
Hirsutism
• Self-administered and professional cosmetic therapy is first line (laser is recommended)
Pharmacological therapy
• Consider if there is patient concern or if cosmetic treatment is ineffective/inaccessible/unaffordable • Should be trialled for at least 6 months before making changes in dose or medication • Primary therapy is the COCP (monitor glucose tolerance in those at risk of diabetes) • Anti-androgen monotherapy (eg spironolactone) should not be used without adequate contraception • Combination therapy – if 3–6 months of COCP is ineffective, add anti-androgen to COCP (daily spironolactone, and if >50 mg twice daily)
Infertility
• Advise smoking cessation, optimal weight, exercise and folate supplementation • Advise regarding the age-related decline in fertility to allow optimal timing of family planning • Infertility therapies may include clomiphene, metformin, gonadotropins, aromatase inhibitors, surgery and in vitro fertilisation
Cardiometabolic risk
• Lifestyle change with a >5% weight loss in those who are overweight reduces diabetes risk by ~50–60% in high risk groups • Metformin reduces the risk of diabetes by ~50% in adherent high risk groups*
*Prescribed for this indication by specialists only.
Reproduced with permission from the RACGP from Boyle J, Teede H. Aust Fam Physician 2012;41:752–56.

Lifestyle intervention is recognised as the first step in management of women with PCOS.[2] A single or combined approach of diet, exercise and/or behavioural interventions is required. Weight loss (in women with a BMI ≥25 kg/m^2 [overweight/obese]) and prevention of weight gain (in women with a BMI 18.5–24.9 kg/m^2 [lean]) should be actively encouraged lifelong, as there is documented evidence that women who are insulin-resistant gain weight at a faster rate than unaffected women. Prevention of weight gain through regular monitoring, lifestyle efforts and support should be encouraged in all women with PCOS and requires far less lifestyle modification than weight loss.[2]

For women who are overweight, a 5–10% loss of current body weight is an achievable realistic goal to set in the short term and has significant benefits across metabolic and reproductive features including pregnancy. Weight loss can be achieved through moderate reduction of energy intake, and introduction of moderate physical activity including structured exercise of at least 150 minutes per week with 90 minutes of this exercise being aerobic activity at moderate-to-high intensity.[2] A large randomised controlled trial reported weight reductions of 5–10% over 2 years for a range of energy-reduced diets with different macronutrient content. It seems that caloric (energy) restriction per se, rather than macronutrient composition, is effective for weight loss and clinical benefits.[9] Physical activity, even in the absence of weight loss, improves a range of factors including hypertension, insulin resistance, impaired glucose tolerance and ovulatory function, and should be encouraged in women with PCOS.[10]

Management of reproductive features

Initial steps in management include planning early for family initiation, prevention of weight gain and intensive lifestyle programs, all of which are important in the management of PCOS in primary care. COCs are effective in achieving menstrual cycle regularity, providing contraception and controlling hirsutism; however, there may be a negative influence on insulin resistance, and a low-dose COC may be preferred.[4] Fertility is not necessarily impaired in all patients with PCOS and, depending on the severity of their condition, some women conceive without medical intervention. Contraception, therefore, is still relevant. Smoking history, age, weight, metabolic risk and thromboembolism need to be considered when prescribing COCs.[2]

If infertility is an issue, pharmacological options include ovulation induction with clomiphene citrate, metformin, gonadotropins and, more recently, aromatase inhibitors. Additional options include surgery (laparoscopic ovarian drilling) and, if ovulation induction is unsuccessful or there are other infertility factors, *in vitro* fertilisation.[2] Steps to optimise fertility, including lifestyle changes, can be undertaken at the primary care level; however, once infertility (12 months of failure to conceive) is established, referral to a fertility specialist is recommended. In older women referral should not be delayed if infertility is suspected. Additionally, patients should be advised that a history of PCOS increases the risk for GDM, necessitating earlier screening during pregnancy.[11]

When managing hirsutism the choice of therapeutic agents depends on patient preference, impact on wellbeing, access and affordability, and includes first-line cosmetic therapy (laser and electrolysis) and medical options (eg COCs with potential addition of an anti-androgen in generalised hirsutism if required).

Women with PCOS are at increased risk of developing endometrial

cancer due to anovulation with unopposed uterine exposure to oestrogen. In this setting, intermittent progestin every 3 months may be used to induce a withdrawal bleed and protect the endometrium from hyperplasia if the COC is not desired or tolerated.[2,12]

Management of metabolic features

National and international guidelines recommend the following screening program for metabolic risk management in PCOS:[2,12]

- Screen for pre-diabetes (impaired fasting glucose and impaired glucose tolerance) and diabetes
  - Start screening from a young age, especially preconception and early in pregnancy.*
- Encourage smoking cessation.
- Monitor anthropometric factors including weight, BMI and waist circumference at most visits.
- Measure fasting lipids every 2 years if normal and every year if abnormal and/or the patient is overweight or obese. The most common abnormalities are low levels of high-density lipoprotein cholesterol (HDL-C) and high levels of triglycerides.
- Measure blood pressure annually if BMI is <25 kg/m^2, or at every visit if BMI is >25 kg/m^2.

*An OGTT test is recommended every 2 years in all women and every year in those with additional risks for diabetes (age, ethnicity, parental history of diabetes, history of high glucose levels, smoking and use of COCs or antihypertensive medications, physical inactivity and waist circumference >80 cm). Note, even lean and younger women often have impaired glucose tolerance, providing opportunities for prevention; this is missed in 60–80% of cases with fasting glucose alone in this population.

Management of psychosocial features

Anxiety and depression are far more common in patients with PCOS, as is poorer quality of life. Mood disorders warrant screening and need to be addressed if present, to optimise engagement and adherence to lifestyle interventions. The national guideline recommends emotional health screening, especially for depression and anxiety, and provides an evidence-based, simple screening tool to facilitate this in women with PCOS.[2]

Therapeutic benefits of metformin in PCOS

Metformin is not first-line treatment in PCOS and its role in PCOS remains controversial.[2] Nevertheless, large diabetes prevention trials that included women with PCOS have shown that metformin can prevent weight gain, but it is not a substitute for lifestyle interventions, nor will it further reduce weight in patients using effective lifestyle programs.[13,14] Hence, metformin may remain a treatment consideration for prevention of weight gain, and management and prevention of impaired glucose tolerance and diabetes in women with PCOS, if diet and exercise are ineffective.[4,12]

Metformin also has a role in regulation of menses and ovulation, especially where contraception is not desired, as it has been shown to improve menstrual regularity and ovulation rate.[12,15,16] Studies on metformin have not been sufficiently powered to study its effect on acne and hirsutism; some studies show benefit, but it is likely to be less effective than the COC.[4]

ANSWER 5

A stepwise approach to Jessica's health issues is summarised in *Table 2*. Note that lifestyle intervention is always the core part of management.

ANSWER 6

Obesity exacerbates severity of PCOS.[18] It is important, therefore, to explain to Jessica that moderate weight loss of 5–10% will result in:

- improvement of menstrual regularity, improved ovulation and

Table 2. A stepwise approach to Jessica's health issues

Reproductive features	**Irregular menstruation**
	Low dose COC or cyclic progesterone to induce withdrawal bleed (2–3 monthly)
	Discuss potential risk for infertility and emphasise prevention of weight gain and weight loss 5–10% goal and confirm the value of early family initiation
	Metformin could be a potential option for restoration of menstrual regularity, and ovulation particularly if contraception is not desired or if she fails to lose weight with lifestyle interventions (start metformin at 500 mg of slow release daily to enhance GI tolerance and maximise the dose in weeks to months to reach 2 g/day)
	Hirsutism
	Laser therapy was discussed given the concern it caused for Jessica. Other options including the COC pill were also discussed.
Metabolic features	**Obesity and cardiovascular risk factors**
	Aim for weight loss of 5–10% of current body weight
	Refer to a dietician
	Encourage regular exercise
	Regularly test markers of glucose metabolism, and cardiovascular risk (generally 2 yearly) including: • 75 g OGTT • Fasting lipids
	Discuss importance of preconception screening for diabetes, and early antenatal screening for gestational diabetes
Psychosocial features	Screen for current features of depression or anxiety

reduced pregnancy complications[19]

- risk reduction for development of impaired glucose tolerance and T2DM[10]
- improvement in cardiovascular risk factors including dyslipidaemia and hypertension[2]
- improvement in psychological health.[2]

ANSWER 7

GDM is defined as glucose intolerance of variable severity with onset or first recognition during pregnancy.[11] It can be associated with increased risk of adverse pregnancy outcomes affecting both mother and fetus. History of PCOS is among the risk factors that necessitate early screening for GDM.[11]

A diagnosis of GDM is made if one or more of the following is present: [11, 20]

- Fasting glucose ≥5.1mmol/L
- 1-hour glucose ≥10.0mmol/L
- 2-hour glucose ≥8.5mmol/L.

Given her screening results, Jessica is diagnosed with early GDM.

Management[20]

Referral to an antenatal centre where multidisciplinary care is provided, including access to a dietician, diabetes educator and an endocrinologist, is recommended. The initial step is patient education on how to self-monitor pre- and postprandial blood glucose levels. Initial treatment should consist of lifestyle interventions including nutrition therapy and moderate daily exercise for 30 minutes or more.

Pharmacological therapy is recommended for women in whom lifestyle therapy is ineffective.

Regular weight monitoring and recommendations for healthy weight gain in pregnancy should also be discussed with Jessica. According to the 2009 Institute of Medicine recommendations, the total recommended weight gain for Jessica's BMI of 26 kg/m^2 is 7–11 kg.[21]

ANSWER 8

Any blood glucose-lowering therapy being used during pregnancy will be stopped after delivery in women with GDM, unless overt diabetes is suspected. Women are screened for diabetes again at 6–12 weeks after delivery.[20] Jessica will have her blood glucose measured by midwives for the first 48–72 hours after birth to exclude ongoing hyperglycaemia, and thereafter her follow-up will be as explained above. Given that Jessica was diagnosed early in her pregnancy, before conventional pregnancy-related insulin resistance occurs, it is highly likely she will remain with impaired glucose intolerance postpartum and she will have a high risk of early progression to T2DM.

ANSWER 9

Women with a previous history of GDM are at higher risk of developing diabetes in the future. Approximately 50% of these women develop diabetes within 10–20 years.[22] Such women, therefore, require lifelong screening for the development of diabetes or pre-diabetes. Prevention of excess gestational weight gain and postpartum weight retention via lifestyle changes including healthy eating, regular exercise and maintaining a healthy weight is the key component to lowering this risk in the future.

As development of GDM is considered an additional risk factor to PCOS for development of diabetes, Jessica is considered to be at a higher risk and will require annual screening with OGTT.[2]

ANSWER 10

There is 2–3-fold increase in the risk of GDM in women PCOS[7] and, therefore, assessment of BMI, blood pressure and an OGTT prior to conception is recommended in these women.[12] If no evidence of glycaemic abnormalities prior to conception, women with PCOS should undergo early screening for GDM with an OGTT at their first antenatal visit and this needs to be repeated at 24–28 weeks gestation if normal in early pregnancy.[11]

There is also approximately a 30% chance of a recurrent GDM in a subsequent pregnancy in women with a history of previous GDM.[23]

Given the combined increase in risk, Jessica should be advised that planning of future pregnancies is essential. Screening with 75 g OGTT preconception should be discussed with her. Contraception should be encouraged to avoid unplanned pregnancy and, in Jessica's case, the history of GDM should not affect the choice of contraceptive method.[20]

REFERENCES

1. Ferriman D, Gallway JD. Clinical assessment of body hair growth in women. J Clin Endocrin Metab 1961;21:1440–47.
2. Teede HJ, Misso ML, Deeks AM, et al. Assessment and management of polycystic ovary syndrome: summary of an evidence-based guideline. Med J Aust 2011;195:S65–112.
3. Stepto NK, Cassar S, Joham AE, et al. Women with polycystic ovary syndrome have intrinsic insulin resistance on euglycaemic–hyperinsulaemic clamp. Hum Reprod 2013;28:777–84.
4. Meyer C, McGrath BP, Teede HJ. Effects of medical therapy on insulin resistance and the cardiovascular system in polycystic ovary syndrome. Diabetes Care 2007;30:471–78.
5. Teede H, Deeks A, Moran L. Polycystic ovary syndrome: a complex condition with psychological, reproductive and metabolic manifestations that impacts on health across the lifespan. BMC Med 2010;8:41.
6. Moran LJ, Misso ML, Wild RA, Norman RJ. Impaired glucose tolerance, type 2 diabetes and metabolic syndrome in polycystic ovary syndrome: a systematic review and meta-analysis. Hum Reprod Update 2010;16:347–63.
7. Boomsma CM, Eijkemans MJ, Hughes EG, Visser GH, Fauser BC, Macklon NS. A meta-analysis of pregnancy outcomes in women with polycystic ovary syndrome. Hum Reprod Update 2006;12:673–83.
8. Bajuk Studen K, Jensterle Sever M, Pfeifer M. Cardiovascular risk and subclinical cardiovascular disease in polycystic ovary syndrome. Front Horm Res 2013;40:64–82.
9. Sacks FM, Bray GA, Carey VJ, et al. Comparison of weight-loss diets with different compositions of fat, protein and carbohydrates. N Engl J Med 2009;360:859–73.
10. National Health and Medical Research Council. Clinical practice guideline for the management of overweight and obesity in adults. Canberra: NHMRC, 2003. Available at http://obesityconsortium.unimelb.edu.au/news_events/Report&Media/clinical_management_adults.pdf [Accessed 30 June 2014].

11. Nankervis A, McIntyre D, Moses R, et al. ADIPS consensus guidelines for the testing and diagnosis of gestational diabetes mellitus in Australia. Sydney: Australasian Diabetes in Pregnancy Society, 2013. p1–8. Available at www.bhs.org.au/airapps/Services/au/org/bhs/govdoc/files/references/12042.pdf [Accessed 30 June 2014].
12. Legro RS, Arslanian SA, Ehrmann DA, Hoeger KM, Murad MH, Pasquali R, Welt CK. Diagnosis and treatment of polycystic ovary syndrome: an endocrine society clinical practice guideline. J Clin Endocrinol Metab 2013;98:4565–92.
13. Ladson G, Dodson WC, Sweet SD, et al. The effects of metformin with lifestyle therapy in polycystic ovary syndrome: a randomized double-blind study. Fertil Steril 2011;95:1059–66.
14. Nieuwenhuis-Ruifrok AE, KuchenbeckerWK, HoekA, Middleton P, Norman RJ. Insulin-sensitizing drugs for weight loss in women of reproductive age who are overweight or obese: systematic review and meta-analysis. Hum Reprod Update 2009;15:57–68.
15. Tang T, Lord JM, Norman RJ, Yasmin E, Balen AH. Insulin-sensitising drugs (metformin, rosiglitazone, pioglitazone, D-chiroinositol) for women with polycystic ovary syndrome, oligo amenorrhoea and subfertility. Cochrane Database Syst Rev 2010;1:CD003053.
16. Nestler JE, Jakubowicz DJ, Evans WS, Pasquali R. Effects of metformin on spontaneous and clomiphene-induced ovulation in the polycystic ovary syndrome. N Engl J Med 1998;338:1876–80.
17. Boyle J, Teede HJ. Polycystic ovary syndrome – an update. Aust Fam Physician 2012;41:752–56.
18. Teede HJ, Joham AE, Paul E, et al. Longitudinal weight gain in women identified with polycystic ovary syndrome: results of an observational study in young women. Obesity 2013;21:1526–32.
19. Clark AM, Thornley B, Tomlinson L, et al. Weight loss in obese infertile women results in improvement in reproductive outcome for all forms of fertility treatment. Human Reprod 1998;13:1502–05.
20. Blumer I, Hadar E, Hadden DR, et al. Diabetes and pregnancy: an Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab 2013;98:4227–49.
21. Institute of Medicine. Weight gain during pregnancy: reexamining the guidelines. Washington DC: National Academy of Sciences, 2009. Available at www.iom.edu/pregnancyweightgain [Accessed 14 August 2014].
22. Centres for Disease Control and Prevention: National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2011. Atlanta: US Department of Health and Human Services, Centres for Disease Control and Prevention, 2011.
23. Moses RG. The recurrence rate of gestational diabetes mellitus in subsequent pregnancies. Diabetes Care 1996;19:1348–50.

RESOURCES FOR PATIENTS AND DOCTORS

- The Jean Hailes Foundation, www.jeanhailes.org.au
- The Jean Hailes Foundation. Management tool, http://jeanhailes.org.au/health-professionals/tools/

Women's health

In order to qualify for 6 Category 2 points for the QI&CPD activity associated with this unit:

- read and complete the unit of *check* in hard copy or online at the *gplearning* website at http://gplearning.racgp.org.au
- log into the *gplearning* website at http://gplearning.racgp.org.au and answer the following 10 multiple choice questions (MCQs) online
- complete the online evaluation.

If you are not an RACGP member, please contact the *gplearning* helpdesk on 1800 284 789 to register in the first instance. You will be provided with a username and password that will enable you access to the test.

The expected time to complete this activity is 3 hours.

Do not send answers to the MCQs into the *check* office. This activity can only be completed online at http://gplearning.racgp.org.au

If you have any queries or technical issues accessing the test online, please contact the *gplearning* helpdesk on 1800 284 789.

FOR A FULL LIST OF ABBREVIATIONS AND ACRONYMS USED IN THESE QUESTIONS PLEASE GO TO PAGE 3.

FOR EACH QUESTION BELOW SELECT ONE OPTION ONLY.

CASE 1 – JANE

Jane, aged 39 years, is a stay-at-home mum with a 2-year-old toddler. She had postnatal depression and was on antidepressant medication, which she ceased 6 months ago. She remains well. Jane and her husband are planning a second pregnancy and she is concerned about a repeat episode of depression during or after the pregnancy. She has a family history of depression.

QUESTION 1

Which of the following statements is the most correct regarding Jane's situation?

A. Jane's risk for postnatal depression with a second pregnancy is no greater than the background population risk for postnatal depression.

B. If Jane required an antidepressant during her second pregnancy she should be prescribed paroxetine.

C. If Jane developed postnatal depression and wanted to continue breastfeeding, use of a selective serotonin reuptake inhibitor (SSRI) would be acceptable.

D. SSRI use during pregnancy poses unacceptable risks to the fetus and should be avoided.

E. The background risk of birth defects in the general population is 0.2–0.4%.

QUESTION 2

Jane, now 41 years, comes to see you with 5-week-old James. Her husband travels extensively for work and is unable to provide much support. She has been mainly on her own for the past 3 weeks. A teary Jane tells you that she feels flat, irritable, tired and is not sleeping well. She says she cannot cope with two children on her own. She thinks she may have postnatal depression again. Which statement is the most correct?

A. Given her prior history of postnatal depression, Jane should be prescribed an SSRI immediately.

B. A score of 10 or more for Jane using the Edinburgh Postnatal Depression Scale (EPDS) suggests possible depression.

C. Jane has no risk factors for depression in her history.

D. Non-medication strategies are not appropriate for Jane given her history and symptoms.

E. Jane should be referred immediately to a perinatal psychiatrist.

CASE 2 – PENNY

Penny, a university student aged 20 years, has come to see you. She is dating a postgraduate student. When they try to have penetrative sex she feels extreme pain. They have never managed to have 'full sex' while dating. She had the same problem with her first 'real' boyfriend, leading to the break up of the relationship. She likes her current boyfriend and does not want to lose him.

QUESTION 3

Which of the following statements is correct with regard to obtaining a history from Penny?

A. You can assume that Penny has had two relationships.

B. Given her age, asking Penny questions about her medical and surgical history is not relevant.

C. Asking Penny questions about her family's attitudes and beliefs towards sex may provide useful information regarding contributing factors to her current problem.

D. Asking Penny whether her parent's relationship was physically affectionate is not useful.

E. Past traumatic experiences are unlikely to have contributed to Penny's current problem.

QUESTION 4

Regarding Penny's situation, which of the following statements is the most correct?

A. Given her history, Penny probably has secondary vaginismus.

B. Vaginismus does not appear in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5), 2013.

C. Precise details of the population prevalence of vaginismus are unknown, but studies suggest a prevalence of 0.5–1.7%.

D. Penny should be referred for management of her 'spastic vaginal muscles', which may require surgery for stretching under anaesthesia.

E. Management of vaginismus involves treating the patient holistically with the treatment being individualised and patient-focused.

CASE 3 – LUCIA

Lucia, a university student aged 19 years, presents to discuss her infrequent periods, weight gain and increasing facial and body hair. Her periods, which have always been irregular, are becoming more infrequent. She had four periods last year and none so far this year. She has never been sexually active. She has a strong family history of type 2 diabetes and cardiovascular disease. Her blood pressure is normal, her body mass index is 30 kg/m^2 and she has central adiposity with a waist circumference of 91 cm. She has mild hirsutism and otherwise looks normal.

QUESTION 5

Which statement describes the most likely diagnosis for Lucia?

A. Polycystic ovary syndrome (PCOS)
B. Hypothyroidism
C. Cushing syndrome
D. Late-onset congenital adrenal hyperplasia
E. Androgen-secreting tumour

QUESTION 6

Which one of the following statements is the most correct regarding management options for women with PCOS?

A. A multidisciplinary management approach is recommended.
B. Management of psychosocial features is the key priority.
C. Management of reproductive features is the key priority.
D. Management of metabolic features is the key priority.
E. Management priorities should be based on the patient's key concerns.

CASE 4 – EMILY

Emily, aged 26 years, presents in a distressed state. She attended a party in a city apartment last night and got a bit drunk. She met a man she liked, who suggested they go into a bedroom to talk. She recalls kissing the man but when he began to undress her she said she was not interested in sex. He ignored her wishes, became forceful and angry, tore her clothes off and had sexual intercourse with her. He then left the apartment. She was in tears and called her mother. They came to see you right away.

QUESTION 7

Which statement below most correctly outlines appropriate next steps you should take following Emily's disclosure of rape?

A. Careful consideration should be given to the initial words offered to Emily as these words may have a significant impact on her.
B. You should obtain a fuller history by gently asking her questions to further assess the situation.
C. Offer support and empathy.
D. You could refer Emily to the nearest sexual assault centre with a forensic facility.
E. All of the above.

QUESTION 8

Emily reports that she is very concerned about 'catching HIV or some other disease'. She is also alarmed at the possibility of a pregnancy. Which statement below best describes how these concerns should be managed?

A. The key consideration is prophylaxis for chlamydia, gonorrhoea and syphilis.
B. Prevention of an unwanted pregnancy is the most important consideration.
C. The most important consideration is management of viral risk.
D. Management should be tailored to the patient's history, risk of sexually transmissible infection (STI) and the likelihood of them returning for adequate follow-up; following a sexual assault protocol, such as that offered by the Royal Prince Alfred Hospital, or your local sexual health clinic is recommended.
E. Prophylaxis is required for chlamydia, gonorrhoea and syphilis, medication for pregnancy prevention, as well as management of viral risks; however follow-up is not required.

CASE 5 – SALLY

Sally, 29 years of age, attends your practice. She looks pale and gets teary and shaky when she tells you about her weekend. Sam, her partner came home late and was very drunk and disorderly after drinking with the boys. An argument ensued about his drinking, culminating in Sam pushing and slapping Sally. She fell down several times. It continued for 5–10 minutes.

Sam later apologised and made her a cup of tea. She feels achy, tired and unwell, and cannot stop crying when on her own. Sally has bruising on her limbs and torso. She has not gone to work for the past two days.

QUESTION 9

Which of the following questions/statements is the best way of responding to Sally?

A. Has anything like this happened before?
B. Can you tell me more about your relationship with Sam?
C. I always thought Sam was a nice guy.
D. I can't believe he could do something like this.
E. You need to leave Sam right now.

QUESTION 10

In assessing Sally's situation and formulating a plan to help her, which one of the statements below summarises the best action plan?

A. Report the incident to the police.

B. You should obtain additional history and ask Sally what she would like to do and provide her with resources to help her (details of local shelters and counselling services etc).

C. Assume that Sally is safe.

D. Break doctor–patient confidentiality by contacting Sam, whom you also see, to discuss the situation.

E. None of the above.

NOTES

NOTES

NOTES

Livial®
tibolone

Relief and effective management of menopausal symptoms[1-4]

As effective as conventional hormone therapy in the management of **menopausal symptoms**[5,6]

PBS Information: This product is not listed on the PBS.

Please review the Product Information before prescribing, available via www.msdinfo.com.au/livialpi

Minimum Product Information: Livial (tibolone) 2.5 mg. Indications: Natural or surgical menopause, prevention of bone mineral density loss (second line). **Contraindications:** Pregnancy and lactation; breast cancer; oestrogen dependent malignant tumours; undiagnosed genital bleeding; untreated endometrial hyperplasia; venous thromboembolism (DVT; pulmonary embolism); known thrombophilic disorders (protein C, S or antithrombin deficiency)*; history of arterial thromboembolic disease; liver disease; hypersensitivity to any ingredient; porphyria. **Precautions:** Pelvic and breast examinations should be undertaken with periodic check-ups, presence/history of leiomyoma/endometriosis; thromboembolic disorders; risk factors for oestrogen dependent tumours; hypertension; liver disorders; diabetes mellitus; cholelithiasis; migraine/severe headache; SLE; endometrial hyperplasia; epilepsy; asthma, otosclerosis. Discontinue immediately if patient develops: jaundice/deterioration in liver function; significant increase in BP; new onset of migraine-type headache; history of endometrial cancer; breast cancer; venous thromboembolism; coronary artery disease; stroke or ovarian cancer. Women should report any break-through bleeding/spotting; potential thromboembolic symptoms; tolerance to lactose. Women with pre-existing hypertriglyceridemia should be monitored for pancreatitis. **Interactions:** Anticoagulants; CYP3A4 substrates; CYP3A4 inducing compounds e.g. barbiturates, carbamazepine, hydantoins, rifampicin)*; herbal preparations containing St John's Wort.* **Adverse effects:** lower abdominal pain, abdominal hair growth, vaginal discharge, endometrial wall thickening, postmenopausal haemorrhage, breast tenderness, genital pruritus, vaginal candidiasis, vaginal haemorrhage, pelvic pain, cervical dysplasia, genital discharge, vulvovaginitis, weight gain, abnormal cervical smear, others: see full PI. **Dosage:** One tablet daily at the same time each day. Based on PI last amended 12 June 2012. **References: 1.** Archer DF et al. Endometrial effects of Tilolone. J Clin Endocrinol Metab 2007; 92(3):911–8. **2.** Lazovic G et al. Tibolone: the way to beat many a postmenopausal ailments.Expert Opin. Pharmacother 2008; 9(6):1039–47. **3.** LIVIAL Product Information, 12 June 2012. **4.** Kenemans P et al. Tibolone: Clinical recommendations and practical guidelines. A report of the international tibolone consensus group. Maturitas 2005; 51(1):21–8, 2005. **5.** Egarter Ch et al. 1996. Maturitas; 23: 55-62. **6.** Hammar M et al. 1998. Br J Obstet Gynaecol; 105(8):904-11. | Persons depicted herein are models used for illustrative purposes only.

MSD

aspen AUSTRALIA

Aspen Australia is comprised of Aspen Asia Pacific Pty Ltd (ABN 75 146 444 484) and its subsidiaries, including Aspen Pharmacare Australia Pty Ltd (ABN 51 096 236 985), Aspen Pharma Pty Ltd (ABN 88 004 118 594), Aspen Nutritionals Australia Pty Limited (ACN 160 607 509), Orphan Holdings Pty Ltd (ABN 50 115 816 209), Orphan Australia Pty Ltd (ABN 11 067 189 342) and Arrow Pharmaceuticals Pty Ltd (ABN 17 003 144 170). **All sales and marketing requests to:** Aspen Pharmacare Australia Pty Ltd, 34–36 Chandos Street, St Leonards NSW 2065 | Tel. +61 2 8436 8300 aspen@aspenpharmacare.com.au | www.aspenpharma.com.au | Prepared: June 2014.

FD14175 ASP559 WOMN-1119797-0008

Considering **online bookings?**

Join Australia's largest and most trusted **Online Booking System** and **Health Directory.**

HealthEngine connects patients with practices, helping them to find and book available appointments online. Over 6,000 practitioners are already using our Online Booking System and gaining the benefits.

- ✓ Helps patients find, book and manage their appointments online, 24/7.
- ✓ Fills appointment gaps.
- ✓ Reduces no-shows.
- ✓ Minimises front desk pressure.
- ✓ Attracts new patients.
- ✓ Seamlessly connects with practice management software.

Call **1300 650 866** or visit **healthengine.com.au/check**

*Eligibility criteria applies.

Strategic Partners

SEVEN WEST MEDIA

HealthEngine .com.au