FC5.08
Labiaplasty: the primary care perspective
Simonis, M

1Royal Australian College of General Practitioners, Melbourne, Victoria, Australia; 2Victorian Primary Care Practice-Based Research Network (VicReN), Melbourne, Victoria, Australia; 3General Practice and Primary Healthcare Academic Centre, University of Melbourne, Melbourne, Victoria, Australia

Background Labiaplasty, the surgical reduction of labia minora, has increased in incidence threefold over the past 10 years according to Australian Medicare statistics. Requests for this procedure constitute a new phenomenon in general practice and education regarding the management of patients wanting this procedure is lacking. Practice guidelines would be of great assistance to GPs when faced with such requests, as providing adequate, accurate information to patients may deflect unnecessary surgery and allay patient anxiety. Such guidelines are currently lacking in General Practice.

Case A 17-year-old female patient attended with her mother. The mother spoke for the daughter initially stating, ‘We’re here because my daughter’s vagina has prolapsed’ and ‘We want a referral to a plastic surgeon to have this fixed.’ The girl and mother were unhappy with the appearance of the genital area. Knowledge of both regarding genital anatomy was minimal and the labia minora protrusion was referred to as a ‘prolapsed vagina’. Both became aware of the daughter’s appearance following removal of her pubic hair. Mother and daughter were prepared to risk surgery that was medically unnecessary. The daughter had a history of mental health issues. This was a new type of request in general practice.

Conclusion GPs need better education around labiaplasty as training around this issue has not ever been provided in Australia. There is little knowledge regarding female genital structure, function and vocabulary within the community, and women themselves do not have a good understanding of genital anatomy nor its diversity. General practitioners must not assume that women know what normal genital anatomy is and may need to educate their patients. Skewed digital depictions of genital appearance need to be addressed by providing online information e.g. Labia Library website (a Women’s Health Victoria initiative) and books like 101 Vagina. GPs must examine patients seeking labiaplasty and consider a mental health screen, as body image concerns could be linked with a psychological disorder not yet identified or managed. GPs should consider referring women to a gynaecologist rather than a plastic/cosmetic surgeon when a patient wishes to have surgery.

C23: Reproductive aboriginal and torres strait Islander health

C23.01
A continuous quality improvement initiative: improving the provision of pregnancy care for Aboriginal and Torres Strait Islander Women
Gibson-Helm, M; Rumbold, A; Teede, H; Ranasingha, S; Bailie, R; Boyle, J

1Monash Centre for Health Research and Implementation, School of Public Health and Preventive Medicine, Monash University, Melbourne, Victoria, Australia; 2Robinson Institute, The University of Adelaide, North Adelaide, South Australia, Australia; 3Diabetes and Vascular Medicine, Monash Health, Melbourne, Victoria, Australia; 4Menzies School of Health Research, Charles Darwin University, Brisbane, Queensland, Australia

Introduction Aboriginal and Torres Strait Islander (indigenous) women are at greater risk of adverse pregnancy outcomes than non-indigenous women. Pregnancy care has a key role in identifying and addressing lifestyle-related risk factors that contribute to adverse pregnancy outcomes. With a focus on lifestyle-related risk factors, this study investigated whether provision of pregnancy care by primary health centres, in predominantly indigenous communities, increased after participation in a continuous quality improvement (CQI) initiative.

Methods Maternal health records (n = 2592) were audited at primary health centres (n = 76) participating in a CQI initiative, across five Australian states/territories, 2007–2012. Regression analysis investigated associations between provision of pregnancy care measures and number of CQI cycles, and self-ratings of organisational systems. Key outcome measures included screening for cigarette and alcohol use, counselling regarding cigarette cessation, alcohol, nutrition, physical activity, food security and folate prescription.

Results Women attending health centres with ≥1 completed CQI cycles were more likely to receive all investigated pregnancy care measures than women attending health centres yet to complete one cycle e.g. screening for cigarette use: no cycles = 78%, 1 cycle = 90% [odds ratio (OR):2.1, 95% confidence interval (CI):2.1–3.8], 2 = 91% (OR:4.8, 95% CI: 3.1–7.4), 3 = 93% (OR:6.0, 95% CI: 3.0-12), 4 = 95% (OR:11, 95% CI: 4.1–28). Greater self-ratings of overall organisational systems were associated with greater counselling regarding cigarettes and nutrition, and folate prescription; self-ratings of some systems components were positively associated with provision of alcohol screening and counselling regarding cigarette cessation, alcohol and nutrition, and folate prescription (P-values <0.05).

Conclusion These findings support incorporation of CQI activities, focussing on organisational systems, into primary care settings in Indigenous communities to improve pregnancy care.

Funding sources The ABCD National Research Partnership Project is supported by funding from the NHMRC (No.545267) and the Lowitja Institute, and by in-kind and financial support from a range of community controlled and government agencies. Melanie Gibson-Helm is supported by an Australian Postgraduate
which both damage the kidney. Aboriginal children are also at increased risk of later development of diabetes and hypertension insults such as glomerulonephritis or diabetes. Small babies are at a burden on the nephron that makes it vulnerable to subsequent nephron numbers, each nephron must hyper-filter placing a volumes, a marker of nephron number. In babies with low birth weight destiny these babies for a shorter life span. Nephron number is determined by 34 weeks of gestation and we have shown that Aboriginal babies are born with smaller kidney number. In contrast, premature birth and low birth weight is a determinant of adult health. Aboriginal babies are born growth retarded and premature at twice the rate of non-Aboriginal babies. Specifically, they are also at higher risk of streptococcal infections leading to glomerulonephritis.

Causes of low birthweight in Aboriginal babies likely include: maternal kidney disease, poor nutrition with an excess of carbohydrate to protein, chronic infection in the mother and exposure to cigarette smoke. Data from a cohort of 200 mother infant dyads from rural and remote NSW and the literature support these hypotheses. To close the gap in Indigenous life expectancy, Aboriginal and Torres Straits Islander babies must first be born at full term gestation and at a normal birthweight (between the 50th and 99th Centiles).

C23.02
Disadvantaged rural women in Australia (with focus on outreach)
O’Brien, M; Brown, K
Royal Darwin Hospital, Darwin, Australia

Australia is a vast sparsely populated continent with great variations in topography and climate. Providing 'first world' obstetric and gynaecological care particularly to remote Indigenous women has led to the development of some innovative services run from regional hospitals. ‘FROGS’ in far north Queensland, based at Cairns Base Hospital, and SONT in the Northern Territory, based at Royal Darwin Hospital, are examples of long standing outreach services. City-based RANZCOG trainees with rural placements at these hospitals are given the opportunity to personally experience Aboriginal and Torres Strait Islander culture and its people by travelling to and working in remote clinics. Over time, RANZCOG has increasingly advocated for improvements in Indigenous women’s health and has an active Aboriginal and Torres Strait Islander Women’s Health Committee that hopefully in the future will be comprised mainly of Indigenous Fellows and Trainees.

C23.03
Preterm birth and low birthweight in the Aboriginal and Torres Strait Islander Population
Smith, R; Rae, K; Lumbers, E; Kandasamy, Y; Pringle, K; Weatherall, L
Mothers and Babies Research Centre, HMRI, University of Newcastle, Callaghan, New South Wales, Australia

Australian Aboriginal and Torres Straits Islander people have a 10 year shorter life expectancy than non-Aboriginal Australians. Aboriginal Australians die early from many causes, but, in particular, have high rates of non-communicable diseases including kidney failure, diabetes and heart disease. David Barker proposed that the intrauterine environment is an important determinant of adult health. Aboriginal babies are born growth retarded and premature at twice the rate of non-indigenous Australian babies. It is likely that the premature birth and low birth weight destiny these babies for a shorter life span. Nephron number is determined by 34 weeks of gestation and we have shown that Aboriginal babies are born with smaller kidney volumes, a marker of nephron number. In babies with low nephron numbers, each nephron must hyper-filter placing a burden on the nephron that makes it vulnerable to subsequent insults such as glomerulonephritis or diabetes. Small babies are at increased risk of later development of diabetes and hypertension which both damage the kidney. Aboriginal children are also at higher risk of streptococcal infections leading to glomerulonephritis.

Causes of low birthweight in Aboriginal babies likely include: maternal kidney disease, poor nutrition with an excess of carbohydrate to protein, chronic infection in the mother and exposure to cigarette smoke. Data from a cohort of 200 mother infant dyads from rural and remote NSW and the literature support these hypotheses. To close the gap in Indigenous life expectancy, Aboriginal and Torres Straits Islander babies must first be born at full term gestation and at a normal birthweight (between the 50th and 99th Centiles).

C24: Pre-eclampsia has many faces – an interactive case based clinical session highlighting up-to date evidence based management of pet
C24.01
Interactive session

This session is an interactive case based workshop on Preeclampsia. The session will be topical, educational and of interest to clinicians caring for women with preeclampsia. Attendees will be able to participate throughout the case via the use of interactive software. Attendees will respond to questions on management and the evidence for this. The panel consisting of Obstetricians, a midwife, obstetric physician and anaesthetists will discuss and debate the evidence.

C25: Mental health
C25.01
Metabolic and nutritional factors in pregnant women with severe mental illness
Frayne, J1,2; Allen, S1; Nguyen, T3,4
1King Edward Memorial Hospital, Perth, Australia; 2School of Primary, Aboriginal and Rural Healthcare, The University of Western Australia, Perth, Australia; 3School of Psychiatry and Clinical Neurosciences, The University of Western Australia, Perth, Australia; 4Peel and Rockingham Kwinana (PaRK), Mental Health Service, Australia

Introduction Women with severe mental illness (SMI) appear to be a vulnerable obstetric population. Antenatal care is often complicated by psychiatric instability and the use of psychotropic medication. Our aim is to explore metabolic and nutritional status in order to define necessary intervention strategies.

Methods A retrospective study was conducted between December 2007 and January 2014 (n = 323) from the Childbirth and Mental Illness Antenatal Clinic (CAMI clinic) at King Edward Memorial Hospital in Perth, Western Australia, on pregnant women with SMI aged 18–44 years. Descriptive statistics, one way ANOVA, logistic regression and Chi Squared tests were conducted using