

Name: Miski Scerif
Email: ha06126@qmul.ac.uk
General Practice / Community Medicine

OBST
GTNAE

Elective Report

Objective 1:

Describe the pattern of obstetric and gynaecological disease in an Islington primary care practice and compare to UK/global health statistics.

In terms of obstetric disease, conditions encountered in the practice include gestational diabetes mellitus, pregnancy-induced hypertension and puerperal psychiatric disease.

The most recent data from the triennium 2006-8 shows that UK maternal mortality rate was 11.39 (per 100,000 maternities). During this triennium, 261 women died in the UK from pregnancy-related complications. The leading causes of maternal death were: infection/sepsis, pre-eclampsia/eclampsia, thromboembolic disease, cardiac disease and psychiatric disease.¹

In 2008, the annual figure for worldwide maternal deaths was 358,000. The vast majority of maternal deaths occurred in developing countries (290 per 100,000 versus 14 per 100,000 in developed countries), particularly in sub-Saharan Africa and South Asia. Worldwide, five complications account for 80% of all maternal deaths: haemorrhage, infection/sepsis, unsafe abortion, pre-eclampsia/eclampsia and obstructed labour.² The Millennium Development Goal of reducing maternal mortality by 75% (from 1990-2015) has unfortunately not been progressing quickly enough. The key obstacle appears to be lack of access to skilled health personnel. Only 66% of women in developing countries benefit from the presence skilled care during childbirth and mortality is greater in communities which are remote, financially deprived and less educated.²

In terms of gynaecological disease, conditions encountered in the practice include menstrual disorders, polycystic ovarian syndrome and infertility. I assisted with the cervical screening programme at the practice and I became intrigued about the impact of this national screening programme.

The NHS Cervical Screening Programme (NHSCSP) was set up in 1988. This call-and-recall system invites all 25-64 year old GP-registered women for a free cervical screening test every 3-5 years. The programme screens over 3 million women in England each year, has an annual cost estimated at £157million (including cost of treating cervical abnormalities), prevents approximately 75% of cervical cancers and saves approximately 4,500 lives each year.³

In 2010/11 the coverage (proportion of eligible women screened at least once in the previous 5 years) in England was 78.6%.³ The coverage in this practice was equivalent to the Islington average of 73% (2009/10 data). This disparity can be explained by differences patient demographics (age, ethnicity and socioeconomic status).⁴

Cervical cancer is the 2nd commonest cancer in women worldwide, with about 500,000 new cases and 250,000 deaths each year. Almost 80% of cases occur in developing countries.⁵ In contrast, cervical cancer is the 12th commonest cancer affecting women in the UK. Since the

introduction of the NHSCSP, the incidence of cervical cancer in the UK has almost halved (from 16 per 100,000 in 1988 to 8.5 per 100,000 in 2008) and there has been a drastic reduction in mortality (from 6.4 per 100,000 in 1988 to 2.4 per 100,000 in 2008).⁶ Early diagnosis of cervical cancer plays a key part in mortality reduction, and cervical screening has been pivotal to improving outcomes by detecting cancers earlier thus making treatment more effective.

Most developing countries have been unable to implement a comprehensive cervical screening programme for a number of reasons, including limited cytology services and lack of follow-up services.⁷ In these countries, possible strategies to reducing cervical cancer incidence and mortality rates include human papilloma virus (HPV) vaccination and visual inspection with acetic acid (VIA).⁸

Objective 2:

What is the role of primary care in global health?

Primary care opens opportunities for disease prevention and health promotion as well as early detection of disease. A primary-care-based healthcare system facilitates access. Patients will not need to travel vast distances and thus in some cases will not need to wait days to access healthcare.

Patients would be able to get healthcare for an extensive range of medical conditions in one location, by a professional who is able to provide long term continuity of care. Chronic diseases, ranging from HIV to heart disease, now provide a great burden of disease worldwide and these conditions require successive visits to healthcare institutions. Infectious diseases, such as TB, can also require months of treatment and regular follow-up to prevent drug resistance and complications.⁹

Visits to multiple healthcare providers with potential loss of follow-up can worsen health outcomes and raise costs as patients return later with disease progression. Preventative care avoids the devastating and costly consequences of end-stage disease.

There are many reasons to support the argument that global health promotion initiatives should stop concentrating on tertiary hospitals which are staffed with specialists who treat the urban wealthy, but should instead train and support general practitioners to provide care through dispersed clinics in the communities where the majority of morbidity is located.^{9,10}

Objective 3:

Carry out an audit and suggest methods for improvement in health provision.

I observed the management of a 21-year old student who had previously presented with recurrent syncope. She had four episodes of fainting over a few months. Routine investigations were unremarkable. However, the patient continued experiencing episodes of syncope and developed debilitating myalgia. Vitamin D levels were subsequently checked and results showed severe deficiency (<10 nmol/L). The patient was given an intramuscular injection of cholecalciferol. Surprisingly the patient's syncope ceased in addition to her myalgia. This interesting case instigated an audit into screening of vitamin D levels.

An epidemic of vitamin D deficiency has been sweeping across the Western world, predominantly caused by shifts in the lifestyle of the population. Adults and children are spending unprecedented hours working, living and playing indoors. A previous audit regarding vitamin D was carried out in the practice during August 2010. This audit showed that, over a year, 1% of registered patients had been diagnosed with vitamin D deficiency and prescribed some form of treatment.

In this audit, I used electronic patient records (EMIS) to search for patients diagnosed with vitamin D deficiency. I paid particular attention to patients, who were at high risk of vitamin D deficiency, such as those known to have osteoporosis, history of multiple fractures, chronic backache and fibromyalgia. In total 139 patients (4% of registered patients) had been diagnosed with vitamin D deficiency over the past year. All of these patients were in some way symptomatic at presentation. Vitamin D deficiency was 3.5 times more common in females compared to males: 108 female patients and 31 male patients were diagnosed with vitamin D deficiency. 124 patients (of the total 139 patients) had their serum vitamin D levels recorded in their electronic records. 114 of these patients had significantly reduced vitamin D levels and received dietary/lifestyle advice, oral vitamin D replacement therapy and intramuscular vitamin D injection, whilst 10 patients were successfully managed with oral vitamin D replacement therapy and/or dietary/lifestyle advice alone. 15 patients (of the total 139) were diagnosed and treated in secondary care.

Majority of the patients who were tested for vitamin D deficiency (114/124, 92%) showed significantly deficient vitamin D levels and were subsequently given vitamin D injections. This shows that vitamin D deficiency is highly prevalent. Vitamin D deficiency can potentially have serious health consequences. Thus, routine screening to detect deficiency prior to symptomatic presentation, particularly in at risk groups, can provide additional benefit and enhance efficacy of patient care.

Objective 4:

Further develop history-taking and examination skills and improve prescribing skills in relation to chronic disease management.

I feel that my history-taking and examination skills have improved over the past few weeks. In supervised settings, I have been able to take routine ten-minute consultations. Abiding by a strict time slot has helped me to develop the skills required to obtain thorough yet concise histories. I was also given the opportunity to assist in specialised doctor/nurse-led clinics.

Shadow prescribing during my placement has given me greater confidence with regards to prescribing for chronic diseases such as hypertension, ischaemic/coronary heart disease, diabetes, asthma, chronic obstructive pulmonary disease and eczema.

This placement has highlighted to me the fundamental nature of verbal and non-verbal communication, and the value of holistic patient-centred care through an inter-professional/multidisciplinary approach. I am grateful that this placement has given me some important skills for my foundation year training.

References:

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