North West Gynaecology nwg

Newsletter

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Dear Colleagues,
This is the first in a series of regular newsletters from North West Gynaecology. We hope that you will find the attached review article helpful and interesting. We have attached some information about the services that we provide and look forward to working with you in the future.

Best wishes
Dr Rick Clayton, Dr Edmond Edi-Osagie, Dr Kristina Naidoo & Dr Tony Smith

About Us...

N.W.G- WHO ARE WE?
North West Gynaecology are a group of four consultant gynaecologists; Rick Clayton, Edi Edi-Osagie, Kristina Naidoo and Tony Smith.

WHERE ARE WE?
North West Gynaecology is based at the Alexandra Hospital, Anson Road Medical Centre and The Spire Hospital for private practice. We all work at St Mary's Hospital, Manchester in NHS practice.

WHAT DO WE OFFER?
North West Gynaecology provides comprehensive, private gynaecology care with sub-specialist expertise in all areas of gynaecology including incontinence, infertility and oncology.

WHAT MAKES US DIFFERENT?
North West Gynaecology matches your patient needs to the most appropriate subspecialist consultant, with the right expertise to care for their specific problem.

We are experts in the latest 'State of the Art' minimal access surgery techniques covering the sub-specialty areas of urogynaecology, infertility, oncology and general gynaecology. No single gynaecologist would offer this range of techniques.

DO YOU NEED CPD SUPPORT?
North West Gynaecology would be delighted to speak to your practice or PCT group at lunchtime or evening meeting on one or more gynaecological topics of your choice. We can tailor the talk to suit your need, but here are a few suggestions:

- Update on the management of menorrhagia and dysfunctional bleeding in primary and secondary care
- Modern management of female incontinence in primary & secondary care
- Investigation and management of infertility the role of the GP
- What's new in gynaecology cancer - a primary care perspective
- Update on HRT and the menopause - what the GP needs to know
- How to manage pelvic pain from the first presentation

Recurrent miscarriage

About 1 in 6 confirmed pregnancies end as miscarriages and most of these (9 in 10) occur in the first three months of pregnancy.

What is recurrent miscarriage?
Recurrent miscarriage (RM) is the consecutive loss of three or more pregnancies. This condition unfortunately affects about 1% of pregnant women. RM is a most frustrating condition for affected couples and healthcare providers and even more so if investigations reveal no underlying cause.

What causes recurrent miscarriage?
We do not find any underlying cause for RM in 50% of women we investigate but it can be caused by a number of conditions including:

Antiphospholipid syndrome:
This is the single most common cause of RM. It denotes increased levels of anticardiolipin antibodies and lupus anticoagulant.

Acquired thrombophilias: reduced levels of Protein C, Protein S, Antithrombin III or Factor V Leiden.

Uterine abnormalities:
The presence of a uterine septum, submucosal fibroids or uterine synechiae (adhesions) can cause repeated miscarriages.

Chromosomal disorders:
the presence of a balanced chromosomal translocation in either partner can predispose to RM.

Genital tract infections:
Some infections like bacterial vaginosis have been implicated in miscarriage.

Other suggested but unproven causes of recurrent miscarriage include:

Uterine natural killer (NK) cells:
There is currently no robust evidence that these play a role in miscarriage and so they remain a research tool for now.

Sperm abnormalities:
There is no evidence that these are implicated in miscarriage.

Blood group incompatibilities:
There is no evidence that these are implicated in miscarriage.

Who do we offer RM investigations to?
We recommend investigation of couples who have suffered three or more consecutive miscarriages irrespective of whether they have had live births previously. We also offer investigations to childless women over the age of 35 years with two or more consecutive miscarriage. We now also recommend investigating women following a single miscarriage if this occurs after a normal pregnancy scan after 10 weeks of pregnancy.

How do we investigate RM?
Haematological screen: blood tests for Lupus Anticoagulant, Anti-Cardiolipin antibodies, Protein C, Protein S, Factor V Leiden, Prothrombin Gene variant and Anti-Thrombin III levels.

Hormonal screen:
Blood tests for FSH, LH and Oestradiol.
Genetic screen: blood tests for chromosomal karyotype in both partners.

Ultrasound investigations:
This will usually be a transvaginal ultrasound. We sometimes employ hydrosonography for better definition (injection of fluid into uterus during the scan).

How do we treat recurrent miscarriage?
The treatment we offer for RM depends on whether an underlying cause is found and what that cause is.

When there is no underlying cause:
affected couples will be reassured that there is no underlying cause for the miscarriages and that in such situations their chances of achieving a live birth in future can be good. The prognosis for this depends on the woman's age and number of prior miscarriages but can be as high as 90%. We offer such couples repeated ultrasound scans

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(1-2 weekly) up to 12 weeks in future pregnancies as this has been found to improve the chances of achieving a live birth. The role of progesterone in these situations is not yet proven and we await the findings of an ongoing national study. Low dose aspirin has been shown to be ineffective in this situation and so we do not recommend it.

When there is an underlying cause: Couples are offered the recognized treatment for that problem if it exists.

Heparin and low dose aspirin combination - is used to treat antiphospholipid syndrome and acquired thrombophilias and this has been proven to significantly improve their chances of live birth.

Uterine metroplasty - surgery through a hysteroscopic day case procedure to divide uterine septa or synechiae.

Hysteroscopic myomectomy - Surgery through a hysteroscopic day case procedure to remove submucosal uterine fibroids.

Antibiotics - To treat genital tract infections.

Genetic counselling - We provide avenues for genetic testing of the pregnancy (fetus) at an early stage in future pregnancies.

What couples can expect from NWG:

- Outpatient consultations and ultrasound scans
- Full hormonal screen
- Testing for inherited and acquired thrombophilias
- Testing maternal and paternal chromosomal Karyotypes
- Outpatient Hydrosonography
- Aspirin and Heparin treatment in early pregnancy
- Hormonal interventions in early pregnancy
- Laparoscopic cervical cerclage in-between pregnancies when appropriate.

We provide an evidence based approach to treating recurrent miscarriage and do not offer unproven interventions.

Is there a role for complimentary therapies?

There is no scientific evidence for the effectiveness of any complimentary therapy. However, we do know that stress plays a role (albeit unquantifiable) in RM and any measures that help to reduce stress might lead to benefit. Therefore, although we would not recommend taking any non-traditional medicines for this condition, some women might find that techniques like acupuncture help to reduce their stress levels.

USEFUL CONTACTS:

The Miscarriage Association
c/o Clayton Hospital, Northgate,
Wakefield, West Yorkshire WF1 3JS
Tel:01924 200799
www.miscarriageassociaiton.org.uk

Association of Early Pregnancy Units
www.earlypregnancy.org.uk

Meet the consultants

Dr Rick Clayton

Dr Clayton qualified in medicine at Leeds University. He is a consultant gynaecologist and accredited as a sub-specialty trained surgeon in gynaecological oncology by the Royal College of Obstetricians and Gynaecologists.

His research degree (MD) studied potential novel treatments for endometriosis. During this time he was trained to an advanced level in laparoscopic (keyhole) surgery.

He has undertaken fellowship training in gynaecological oncology and laparoscopy in Australia and gynaecological oncology in London (Barts and the Marsden).

In NHS practice, he works at St Mary's Hospital, Manchester and Christie Hospital, Manchester as a gynaecological oncologist. In addition, he is a general gynaecologist and looks after patients with a variety of problems including abnormal smears, vulval disorders, menstrual problems, post-menopausal bleeding, ovarian cysts and endometriosis.

Research interests include gynaecological oncology, laparoscopic surgery and endometriosis.

Dr Edmond Edi-Osagie

Dr. Edi-Osagie underwent specialist training in Obstetrics and Gynaecology in the North West of England obtaining the MRCOG in 1995. He underwent further specialist training in Reproductive Medicine and Surgery, during which time he obtained an MD for research into the ultrastructure and function of the human endometrium.

He underwent further surgical training in advanced laparoscopic and hysteroscopic gynaecological surgery and is an accredited RCOG preceptor for both. He currently works as a Consultant Gynaecologist at St. Mary's Hospital in Manchester, where he maintains specialist clinical and research interests in Reproductive Medicine and Surgery.

He is one of the few specialists in the UK who undertakes advanced laparoscopic operations including the removal of rectovaginal endometriosis, hysterectomy, myomectomy and reversal of female sterilisation. His other clinical interests include recurrent miscarriage and early pregnancy complications.

Dr Kristina Naidoo

Dr Naidoo qualified from the University of Sheffield in 1985 and after training in hospitals in Sheffield and Manchester obtained her current post as Consultant Gynaecologist at St Mary's Hospital, Manchester in 1999.

She is a general gynaecologist with a special interest in hysteroscopic surgery (minimal access surgery on the womb) and outpatient gynaecology, performing a number of procedures in the clinic setting thus avoiding hospital admission and a general anaesthetic.

Dr Naidoo runs several courses a year to train other consultants in out-patient hysteroscopic surgery. Dr Naidoo also carries out pelvic ultrasound scanning and runs courses in gynaecological scanning. She set up the first "one stop" menstrual problem and post-menopausal bleeding clinics in the north west of England in which she performs ultrasound scanning, hysteroscopy and biopsy where appropriate.

Dr Tony Smith

Dr Smith became a consultant at St Mary's Hospital in 1990. His research and clinical training focused on the causes and treatment of genito-urinary prolapse and urinary incontinence (pelvic floor disorders). He has continued his clinical interest in urogynaecology and has been at the forefront of development of laparoscopic techniques ("keyhole surgery") in the surgical treatment of prolapse and incontinence. He has lectured and performed surgical demonstrations of these techniques throughout the world over the last 15 years. He directs a research programme which investigates surgical techniques and alternative treatments for pelvic floor disorders.

In addition to administrative positions in St Mary's Hospital Dr Smith has been President of the British Society of Gynaecological Endoscopy and Chairman of the International Collaboration on Incontinence committee researching Surgery for Incontinence in Women. Dr Smith is currently Vice-Chairman of the British Society of Urogynaecology.

Dr Smith has published extensively including outcomes from his own surgical practice. He has written a number of chapters and edited several books on urogynaecological problems.