The National Maternity Hospital
Vita Gloriosa Vita ~ Life Glorious Life

MARCH 23 | ISSUE 4

THE NMH GP NEWSLETTER

A WELCOME MESSAGE FROM PROF SHANE HIGGINS, MASTER AT THE NMH

Welcome to the NMH's latest edition of our GP newsletter and the first for 2023.I would like to thank you for your referrals and continued support , it is greatly appreciated. As a leading centre of excellence for women's health we would like to provide you with an overview of our specialist clinics available at the National Maternity Hospital. In this edition you will get to meet some our colleagues who provide these unique services as well as details of how patients may be referred.

We have also developed a new feature titled 'Stories From The Couch' where we can share some interesting case studies with you and also provide you with an opportunity to avail of internal CPD points.

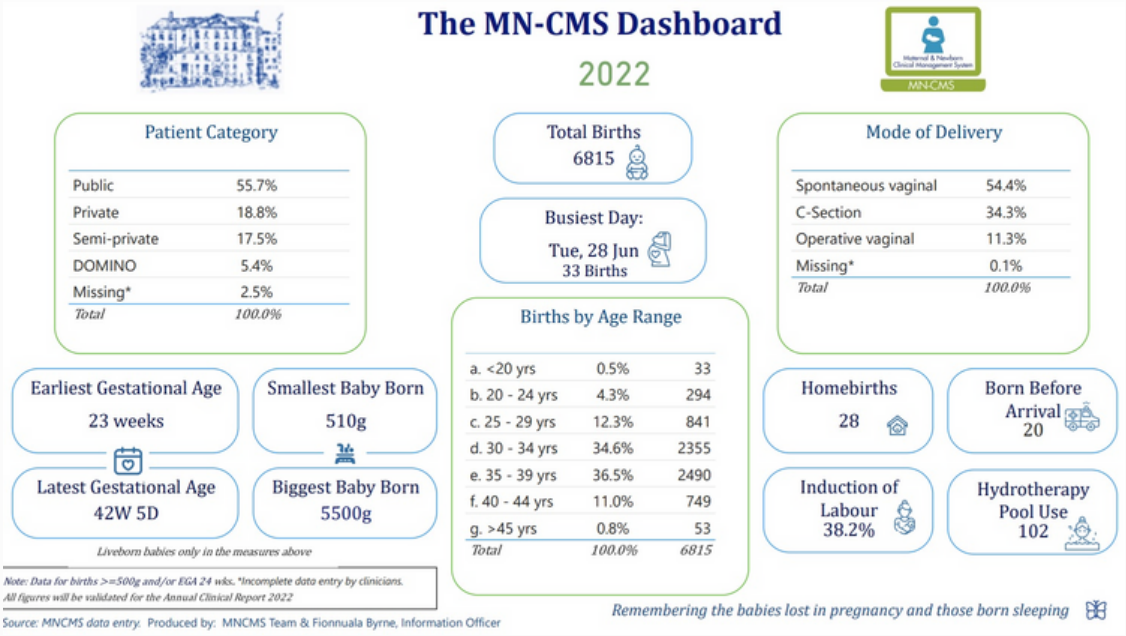
As a point of interest we have also shared our MN-CMS Dashboard which highlights our maternity activity levels for 2022. I hope you enjoy this bumper filled edition.

Yours sincerely.

Professor Shane Higgins

In this issue:

- ***An overview of our specialist clinics and members of the teams.***
- ***New features 'Stories from the Couch' (CPD points available).***
- ***The NMH dashboard.***



We create a monthly Dashboard of Hospital activity that is shared with Staff across all areas of the Hospital allowing all to see some key Hospital metrics. We developed this to show clinicians how important it is to enter accurate and timely data onto the Electronic Health Record, the Maternal Newborn - Clinical Management System (MN-CMS), and to make the data they enter more visible, accessible, and meaningful. The Dashboard is shared with patients now too during the Hospital's Antenatal Classes.

IRELAND EAST FERTILITY HUB AT THE NMH IS OPERATIONAL

Dr David Crosby Consultant Obstretician & Gynaecologist

Head of Department of Reproductive Medicine and Clinical Lead of the Ireland East Fertility Hub at the National Maternity Hospital. He has a special interest in Reproductive Medicine, Surgery & Genetics and is an Assistant Professor at University College Dublin.

Our new publicly funded intrauterine insemination (IUI) service is scheduled to launch this summer 2023.

Our hub accepts direct consultant and GP referrals from within the IEHG for patients who meet the following criteria as defined by NWIHP

***Unable to achieve a pregnancy after 6 months** of regular unprotected sexual intercourse and are **36 years of age** and older.*
Unable to achieve a pregnancy after 12 months** of regular unprotected sexual intercourse and are **under 36 years of age.
If there is a known clinical cause of infertility or a history of predisposing factors for infertility i.e. endometriosis, previous fertility treatment to conceive, not having periods or very few periods per year, pelvic inflammatory disease or undescended testes.

Investigations prior to referral can be extremely helpful

- *Women with regular monthly menstrual cycles should be informed that they are likely to be ovulating.*
- *Women can be offered a blood test to measure serum progesterone in the mid-luteal phase of their cycle (day 21 of a 28-day cycle) to confirm ovulation if required.*
- *Women with irregular menstrual cycles should be offered day 2-4 blood tests to measure serum gonadotrophins (Follicular stimulating hormone (FSH) and Luteinising Hormone (LH)). If polycystic ovarian syndrome (PCOS) is suspected, a hormone profile including FSH and LH, testosterone, sex hormone binding globulin, and free testosterone index levels should be assessed.*
- *Women should have thyroid function tests performed and optimized if there is presence of subclinical or clinical thyroid dysfunction.*
- *Once a referral has been accepted, a fertility hub information pack is posted to the patient/s and following completion of further investigations, an initial consultation is offered and to advise on an individualized management plan.*

Services provided by our Fertility Hub

- *Investigative support to GPs (semen analysis. Serum Anti-Müllerian hormone (AMH) testing and pelvic ultrasound).*
- *Secondary level investigations including testing of tubal patency, hysteroscopy, laparoscopy, fertility related surgeries, ovulation induction and follicle tracking.*

Contact us: Referrals can be made through Healthlink or Post, email fertilityhub@nmh.ie Ph: 01-6373275

Update on the National Mesh Service by Professor Declan Keane

While the mid-urethral sling remains the gold standard for continence surgery worldwide, there are a small percentage of patients who experience pain or other complications years after its insertion. In 2019 the HSE and NWIHP set up two centres nationally to look after women who had complications of vaginal mesh surgery. One center was set up in Cork and the other in Dublin. The referral center for the Dublin service is the NMH, and this is where the administration of the clinic is based.
The Dublin service is comprised of gynecologists, urologists, pain specialists, physiotherapists and clinical nurse specialists from NMH and beyond. Referrals are seen in the NMH but are also seen in Beaumont, Tallaght, the Coombe and Rotunda and a bimonthly MDT involves discussion of the more complicated cases. These meetings are coordinated by the local administration team and a pathway for clinical management is then determined. In some instances this might require partial or complete removal of the mesh implant, although complete removals are rarely required.

PAIN MEDICINE AT THE NATIONAL MATERNITY HOSPITAL

About Dr. Kirk Levins

Dr. Kirk Levins is a Chronic Pain Medicine consultant working across NMH, NRH and SVUH. He has spent the last 6 years treating women with pelvic pain at both St. Vincent's University Hospital and at the NMH. He is also a keen researcher and holds degrees in medicinal chemistry and neuroscience. He has won awards for his research including the American Academy of Pain Medicine award for research and the Abbvie scholarship. He is involved in several research collaborations with institutions in New Zealand, USA, and the Netherlands.

The National Maternity Hospital is delighted to be able to offer treatment to women suffering from chronic pelvic pain and also for women with pain during pregnancy. Our Pain Medicine specialist works with a team of physiotherapists and a psychologist.

Pain in endometriosis

-Is a chronic and debilitating condition affecting ~10% of women
-It is characterized by infertility and chronic pelvic pain
-Women often present with lower back pain and perineal pain.
-Treatments offered include lumbar nerve root pulsed radiofrequency lesioning, ultrasound guided pelvic floor injections with Botulinum toxin and conservative management.
-Most patients will require a combination of treatments .

Vulvodynia

-Defined as vulvar pain of at least 3 months duration without a clear identifiable cause affecting ~15% of women.
-Presents as a neuropathic pain.
-Conservative management involves pelvic floor physiotherapy, anti-neuropathic pain medication such as Amitriptyline.
-Interventional management often involves pulsed radiofrequency lesioning of the pudendal nerve or ultrasound guided targeted injections.

Pain in Pregnancy

-Fifty percent of women will suffer chronic pain during pregnancy.
-Lower back and rib pain are the most common.
-Conservative management involves physiotherapy.
-Interventional management involves ultrasound guided nerve blocks.

The Clinics

The Pelvic Pain Clinic is for women with pelvic pain or post-partum back pain.
Current wait time for an appt is 8 months and 10 months for a procedure.

The Antenatal Pain Clinic is for pregnant women experiencing pain during pregnancy.
Current wait time for an appt is 3-4 weeks and 3-4 weeks for a procedure.

The Private clinic is for women with pain during and outside of pregnancy.
Current wait time for an appt is 1-2 weeks and 1-2 weeks for a procedure.

All referrals to:

Dr. Kirk Levins, The Pelvic Pain Clinic, National Maternity Hospital, Dublin 2, DO2 YH21

PERINATAL GENETICS AND GENOMICS SERVICE AT THE NATIONAL MATERNITY HOSPITAL

The Perinatal genetics and genomics service was established in August 2021. The service is led by Dr Sam Doyle, Consultant Clinical and Biochemical Geneticist with a special interest in perinatal genetics.

The service is expanding with the recent appointment of Dr Tara Rigney as the Aspire Fellow in perinatal genetics and Ms. Lauren Kearns who provides administrative support on a full-t time basis. A principal genetic counsellor will be appointed in March 2023.

Dr Sam Doyle

The service provides care to various groups attending the National Maternity Hospital and is now receiving referrals from all over Ireland for pregnancy genetics care. The services provided include, but are not limited to:

- *Pregnancy care when abnormal results are returned after Non-invasive prenatal screening (NIPS), when there are anomalies detected on ultrasound scan and also in families where there is a risk of a fetus inheriting a genetic condition as a result of parental carrier status or other family histories.*
- *Pre-conception planning for couples attending the National Maternity Hospital (this service is available privately for non-NMH patients) who are concerned about family history or increased risk of having a baby affected by a genetic condition.*
- *Genetic counselling for women attending the maternal medicine clinic at The National Maternity hospital.*
- *Care for couples who have a history of infertility or recurrent miscarriage as part of the Reproductive genomics multi-disciplinary team. (This service is available privately to non-NMH patients).*
- *Provide genetics input to care of women attending the complex menopause clinic and the adolescent gynaecology clinic who have an underlying genetic cause for their problems.*
- *Provide access to comprehensive genetic testing for patients who have lost a baby in pregnancy or in the postnatal period and the cause is likely genetic.*
- *Advise couples regarding recurrence risks and provide the most up-to-date information regarding genetic testing in the future- embryo testing, invasive testing in pregnancy and non-invasive methods etc. which may be available.*
- *The perinatal genetics team is integrated into the multi-disciplinary team at The National Maternity hospital.*

Referrals

- *Can be made by post to: Dr Sam Doyle at The NMH or electronically to clingendepartment@nmh.ie. If genetic reports are available, please send these with the referral.*
- *We can be contacted on 086 1083086 or clingendepartment@nmh.ie if you have any queries.*
- *For further information, please visit our page at: https://www.nmh.ie/support-services/prenatal-genomics-service.15131.html*

GP Liaison Committee at the NMH

The NMH enjoys working with our GP colleagues in the community.
We have an active GP Liaison Committee
which meets on a Monday evening on a quarterly basis.
If you are interested in joining , please email our Quality Manager,
Rachel Irwin rirwin@nmh.ie

Thank you

AMBULATORY GYNAECOLOGY SERVICE

An ambulatory gynaecology service has been running at the NMH since 2014. The service has expanded significantly in recent years both in response to the covid pandemic and also the introduction of the "Ambulatory Gynaecology Model of Care HSE 2020'.

We now run 5 clinics per week. Our clinics are consultant-led and Dr Venita Broderick is clinical lead for this service. Ms Niamh Murray (advanced nurse practitioner candidate) runs our Out Patient Hysteroscopy Clinic.

Ms Niamh Murray

AMBULATORY GYNAECOLOGY

We provide same day diagnostic and treatment service for a variety of gynaecological presentations often in one visit. Referrals to the service are through our dedicated referral form found in the GP section of the hospital website.

In 2022 over 1300 women were referred to our service. Referrals are triaged up to 4 times per week by consultants. We performed over 1000 hysteroscopy cases in the ambulatory gynaecology setting. In cases where a polyp is identified hysteroscopic polypectomy is performed on the same day. These procedures are mostly well tolerated. We advise women to take paracetamol or ibuprofen in advance of the appointment. Local anaesthetic can be administered. If the woman does not wish to proceed in the first instance or cannot tolerate the procedure, hysteroscopy under general anaesthetic is arranged.

We have a rapid access pathway for women with postmenopausal bleeding (see PMB Guidelines). If a scan has not yet been organised externally, we will organise that here. Women referred to St Columcilles, SVUH and St Michaels will be redirected to this pathway in NMH. We see women over the age of 45 with abnormal bleeding, those with suspected endometrial polyps or intracavity fibroids. Other indications for referral include hysteroscopic retrieval of intrauterine devices and fertility/miscarriage investigations.

We are very happy to insert Mirena IUCD s following hysteroscopy/polypectomy etc but the woman needs to bring the device with her on the day. It would be most helpful if you could discuss this with her in advance of the appointment if you think she would benefit from this.

PMB GUIDELINE 2022

·Women with PMB should undergo a focused history & examination including vaginal examination and speculum before referral to gynaecological services.
·Vaginal, vulval and cervical cancers should be considered if differential to the diagnosis.
·All women with PMB not on HRT should be referred for investigation.
·All women with abnormal bleeding on tamoxifen should be referred for investigation.
·Women on continuous combined HRT who have bleeding beyond 6 months after commencing therapy or after a prolonged period of amenorrhoea should be referred for investigation.
·Consider earlier referral if risk factors such as obesity, family history present etc.
·Women on sequential HRT who have irregular bleeding more than 3 months after commencing treatment or if there is heavy/prolonged bleeding should be referred.
·Women should be seen within 28 days of referral.

OPH Referral Pathway

- *Referral from GP- Triage by Consultant.*
- *If patient has not received an ultrasound previously no ultrasound an appointment will be arranged appointment within 3 weeks.*
- *If OPH not indicated a Gynae Outpatient appointment will be booked.*
- *OPH appointment booked , after procedure result letter to patient and GP within 4 weeks or follow up appointment if needed.*

The Future

We have secured funding for the development of a new ambulatory gynaecology facility within the hospital. This will be a dedicated modern and more spacious facility. Our aim is to expand the range of services we provide. We are working on providing a one stop service including same day pelvic ultrasound for women with post-menopausal bleeding.

THE POPPY CLINIC

The postnatal period is often referred to as the "Cinderella of childbirth" where care is perceived as being limited, especially for women with morbidities compared to intensive antenatal and intrapartum care.

The Poppy Clinic (Postnatal Morbidity Clinic) is an Outpatient service established in 2014, a model of care unique to the NMH. The Poppy clinic provides a service that bridges the gap in postnatal follow up, offering structured care for mothers who suffered a morbidity due to a complication of their pregnancy, labour or birthing experience. The Clinic is run by Dr Laoise O Brien Consultant Obstetrician & Gynecologist and Ms Caroline Brophy, Advanced Midwife Practioner. (Special interest: Postnatal Maternal Morbidity).

Who attends:

- *PPH >1.5L*
- *Hb <8g/dl - repeat FBC at 2 weeks postnatal*
- *Hypertensive disorders – severe PET, Eclampsia, HELLP*
- *Outpatient BP monitoring & medication management*
- *OASIS (3rd & 4th) degree tears at 6 weeks postnatal*
- *Wound breakdown, infection - management & surveillance*
- *Perineal*
- *Caesarean Section*
- *Perineal Pain – time, medical management, surgical management*
- *Dyspareunia*
- *Debriefing following traumatic experience*
- *Away from Home - postnatal review for mother outside the Greater Dublin area who have no access to PHN or GP.*

THE REFERRAL PROCESS:

- ***ALL REFERRALS ARE TRIAGED. TIMELY APPOINTMENTS ARE ARRANGE FOR APPROPRIATE CLINIC. WE AIM TO SEE ALL REFERRALS WITHIN ONE MONTH OF REFERRAL.***
- ***REFERRAL ARE SENT BY POST OR ELECTRONICALLY VIA HEALTHLINK FOR ATTENTION OF THE POPPY CLINIC.***
- ***PLEASE DO:***
- ***INCLUDE PATIENT'S FULL CONTACT DETAILS INCLUDING TELEPHONE.***
- ***STATE IF TRANSLATOR IS REQUIRED.***
- ***CLEARLY STATE REASON FOR REFERRAL& RELEVANT CLINICAL INFORMATION – FACILITATING APPROPRIATE TRIAGE.***
- ***INCLUDE DAYS POSTNATAL, TYPE OF DELIVERY & RELEVANT OBSTETRIC, SURGICAL OR MEDICAL INFORMATION***
- ***STATE ANY ADDITION NEEDS.***

WHATSUPPMUM.IE

Dear GP Colleagues,

Whatsupmum.ie has been working with the maternity hospitals in Ireland for the last 7 years, filming and producing the educational content that runs on the waiting room screens.

We are providing an attachment of the QR code leaflet to print for expectant women when confirming their pregnancy. Watching the educational videos early in their pregnancy allows women to make more informed choices for their baby's and their own health and wellbeing.

If you have any questions or would like to discuss this further please contact Michelle Berkery @mberkery@whatsupmum.ie

COMPLEX MENOPAUSE CLINIC

'Our First Year': The Complex Menopause Service

The service was established in November 2021 following recommendations from the Women's Health Taskforce supported by the National Woman and Infants Health Programme. It is dedicated to providing care and support to patients with complex medical conditions to manage their menopausal symptoms. The service is delivered by GPs that are accredited Menopause specialists, Dr Deirdre Lundy and Dr Nicola Cochrane and a Clinical Nurse Specialist, Claire McElroy.

We hold two clinical sessions per week. In our first year there was over 1000 referrals to the service and almost 300 patients seen. The CNS offers 'Menohealth' consultations to women on our waiting list, giving women the opportunity to evaluate their health and lifestyle and discuss ways on how it may be optimised to ensure they are living well through Menopause.

A Clinical Criteria and Catchment Area

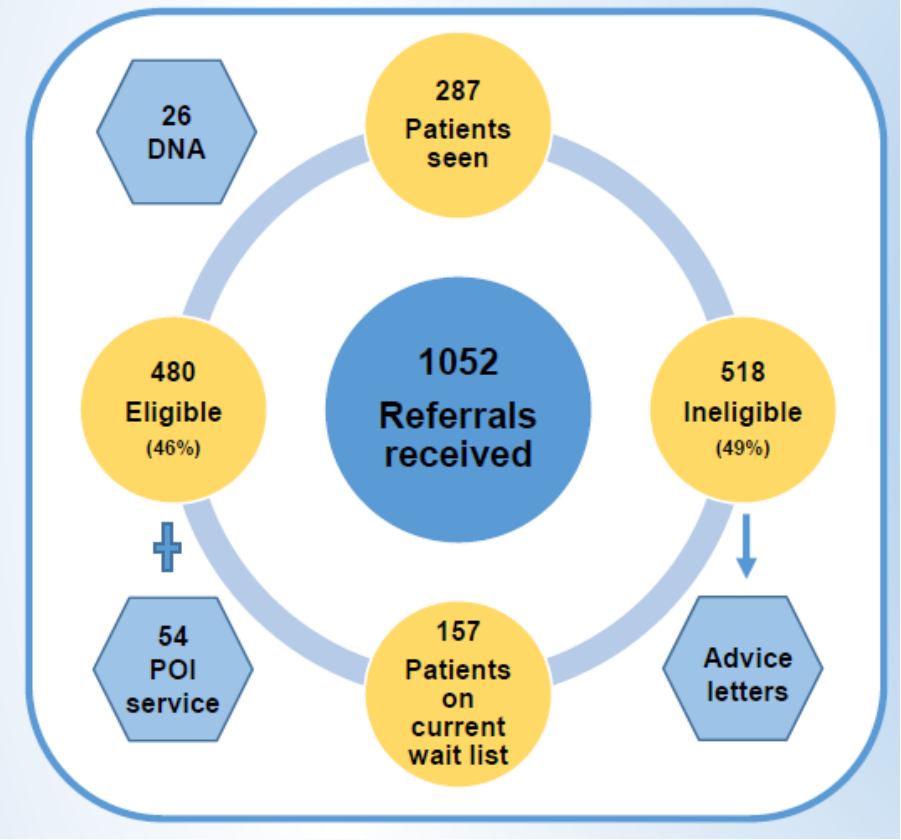
A clinical criteria and catchment area was established for referrals to the service. Unfortunately we are not in a position to accept referrals that are not within our catchment area and do not meet the identified clinical criteria, however, there are other platforms available for you to gain advice on how to manage specific cases. Dr Lundy contributes weekly on 'GP Buddy', a website that you can log in to for free, write in your cases/queries and receive a response.

'Telegram' is an app you can download on your phone, search for 'HRT prescribers in GP' and once accepted by the admin you can text in your cases/queries and receive a very prompt response from one of several Menopause Specialists in Ireland that contribute to that group, including Dr Lundy.

Useful guidance and information can also be found in the Menopause Quick Reference Guide which is available on the ICGP website. Complex Menopause Services have now expanded nationwide and are established at the Coombe Hospital, the Rotunda Hospital, Galway University Hospital, Nenagh General Hospital and Cork University Maternity Hospital.

We will continue to be a source of guidance and support to other hospital sites in the nationwide expansion of the service and to continue to collaborate with GPs and other Health Care Professionals to support and assist them in managing Menopause for their patients.

Catchment- Dublin South, Wicklow, Kildare, Kilkenny and Wexford.



- ***Clinical Criteria***
- *VTE*
- *CVA*
- *IHD*
- *Cancer(particularly*
- *hormone sensitive)*
- *Immunological disease*
- *including HIV*
- *Active liver disease*
- *Family history of the above does not qualify for referral*

Please see our new feature "Stories from the couch" overleaf

STORIES FROM THE COUCH

Dr Deirdre Lundy
Lead clinician at The NMH
Complex Menopause Service.

Of the many hundreds of patient encounters we have had over the last months the vast majority comprise of patients who have been diagnosed with breast cancer and have been warned to avoid HRT. We will focus on those patients in the next newsletter. Another large group being seen in the Complex Menopause Service is made up of people who have been advised to avoid HRT when in fact they could be offered hormones if needed once it is done cautiously and particular attention paid to delivery routes, doses and molecule selection. Here is a nice case.

"AS"

AS is a 61 yo patient we met in the clinic in mid-2022. She is the mother of two grown children and her main complaints included vasomotor sweating and flushing - daytime and night time, fatigue and resultant poor quality of life for over 20 years since she had a radical hysterectomy and bilateral oophorectomy at 40 yrs. of age for advanced cervical cancer.

On further questioning she also told us that she was experiencing stress urinary incontinence which was progressively worsening and some vaginal burning/? recurrent UTI's for which she was repeatedly prescribed antibiotics.

At the time of her TAH/BSO, she does not remember any discussion of the possible consequences of that surgery apart from a warning that she was NOT to consider HRT as she had had a confirmed DVT in her 30's which they felt was provoked by her use of the COCP.

There was nothing else of relevance in her past medical, surgical or family histories and her medications included a single agent anti-HTN and a statin. She is a non-smoker (never smoker) who drinks 6-8 glasses of wine (or gin & tonics) per week. She would like to be more active but struggles to make time due to the fatigue and poor sleep. She is the main carer for her grandchildren while her younger daughter and the daughter's partner live with AS and her husband.

Her BP was 153/84 and her BMI was sl elevated at 27. She is up to date with her BreastCheck screening and was told she no longer needed vault cervical screening.

We had a great discussion with AS explaining the current management of menopause symptoms guidelines around people of her age with her health issues. We listed all the different treatment options available to her, the relative pros and cons of each and gave her time to let us know what she thought about all the different choices. We explained that neither her thrombosis history nor her cervical cancer diagnosis were absolute contraindications to systemic HRT or local vaginal estrogen (LVE) use and that we could talk it over.

We started by addressing the recurrent genitourinary symptoms. We told AS that we suspected some if not all of the vaginal and bladder complaints were linked to the chronic estrogen depletion of her vagina and other pelvic structures over the last 20+ years and we encouraged her to consider immediate LVE for those complaints. We explained the relationship between estrogen and the vaginal wall, the urethra and the pelvic floor using lots of (poorly drawn) cartoons and lots of non-medical terminology. We talked her through the many vaginal estrogen delivery systems; creams, small pessaries delivered by inserter or larger pessaries requiring manual insertion. She gratefully opted for Vagifem - a local vaginal estradiol product.

We advised her that the product information leaflet specifically advises against use of that product if someone has had a blood clot. We told her that information is outdated and incorrect and out of keeping with current guidelines. We advised her that local, vaginally-delivered estrogen does not enter the blood stream in high enough volumes as to have any impact on clot risk and that she could use local vaginal estrogen for as long as she needed it. We highlighted the fact that LVE would only be effective if she used it regularly and consistently. We told her that genitourinary changes associated with menopause and low estrogen do not get better with time and that she would probably need some form of local estrogen therapy for the long haul. She said she was happy to give it a try. We did a script and provided her with our own info sheet since the PIL for the Vagifem is at odds with our advice.

We also suggested she might benefit from pelvic physiotherapy for the stress incontinence and requested a review by the staff in the continence clinic in the NMH.

We then got stuck in on the vasomotor symptoms. We advised her that the warnings about systemic HRT at the time of her oophorectomy in 2001 were understandable as back then there was less certainty about the role of estrogen hormones and the risk of developing a blood clot.

We advised her that someone who has once had a DVT is likely to always be at a higher risk of a subsequent DVT and asked her to be mindful of things she could do to keep her venous flow moving such as keeping hydrated and active every day but especially during long car or plane journeys, etc. We were also able to tell her that current guidelines are more reassuring for systemic HRT use after a DVT. Once modifiable DVT risks are addressed we CAN offer systemic HRT. We told her that low dose (under 50 mcg), non-oral estrogen as found in systemic HRT sprays, gels and patches have a neutral impact on clotting factors. They avoid first pass liver metabolism and so have minimal impact on the clotting cascade and their use is supported by menopausal guidelines. She was understandably cautious having been told something completely different by other professionals but was willing to try.

We also gently weighed in on the alcohol intake and low activity habits she had developed. We discussed the relationship between alcohol use at her level (> 16 units per week) and her health. We showed her the famous pictogram on breast cancer risk impact from things like BMI, physical activity, alcohol intake, HRT use, etc. We pointed out that the data on that pictogram comes from the 2002 WHI study which looked at women using oral equine estrogen. It shows a reduction in the risk of being diagnosed with breast cancer among women using estrogen alone - without progestagen - but warned her that it is hard to know for sure what her personal risk of breast cancer was and advised her to keep current with BreastCheck and to practice breast self-awareness if she was willing.

We did not criticise her lifestyle habits but tried to take the positive approach- offering the advice that maybe, if she were to feel better and sleep better through use of HRT, she might feel more inclined to get some physical activity most days and to be more aware of her alcohol intake.

We mentioned to her that as she was more than 10 years past her LMP and she was already over 60 yrs. of age, the primary prevention of ischemic cardiac disease that younger HRT users get would not benefit her. She did not even know that the use of systemic HRT would have had a cardiac benefit for her all those years ago and although she was sad to hear that the window of benefit had closed, she remained focused on her main goal - which was symptom control.

Having no uterus there was no need for us to add in any progestagen to her HRT and as she was not particularly bothered by low libido at this time we did not even discuss testosterone.

We gave her a hospital script for a 50 mcg estrogen patch and local vaginal estrogen and supplied her with the paper booklet that our amazing CNM has developed. It lists lots of the information that a patient might need after a first visit including: their specific prescription details, our contact details in the event of concerns or questions and when we would next have a scheduled review. It has a symptom checker to monitor response to treatment and QR codes/ email addresses for good online sources of menopause and HRT information.

I spoke to AS by phone 3 months later. Her vasomotor symptoms had all but gone, her sleep had improved and she was drinking less and moving more. She has lost a bit of weight which she attributed to the drop in alcohol and was thrilled. The vaginal symptoms were improving but not completely gone- she had not needed an antibiotic since commencing the LVE though and was pleased with that. I commended her on her compliance - so many people who are prescribed LVE do not take it as instructed maybe because the PIL is so contradictory and confusing. I told her to be patient as it can take many months to get the full benefit of LVE- if she was still aware of problems though, we could always try a different type of LVE. She declined any alterations in her script and was happy to carry on with the current meds for the next 6 mos.

She had been with the Continence clinic in the NMH and was trying a program of pelvic floor toning exercises.

We advised her that she could continue with both the LVE and the systemic estrogen for as long as she chose and that we would discharge her back to her referring GP for future scripts. We wrote to that colleague (and Cc'd AS herself on that letter) to ask that she get her HRT meds renewed in the general practice for the next few years and that the only mandatory renewal requirement for the systemic HRT estrogen was yearly BP and BMI assessment. We mentioned to AS that the main drawback relating to extended use of her HRT estrogen patches is that long term exposure to systemic estrogen is linked to a small increase in the risk of being diagnosed with breast cancer. We reassured her that this has to be weighed up against the benefit she derives for quality of life and symptom control- not to mention the drop in alcohol intake which is itself a significant risk factor for breast cancer detection. She was happy to carry on with her patches for the time being and we wished her the best.

This was an 'easy' lady. The real heart breakers are patients who you know you could do something for if only they were allowed try HRT but guidelines say they can't. More on those patients in the next newsletter!