Metro North **GP Alignment Program**

MATERNITY WORKSHOP

Saturday, 7 October 2017

Skills Development Centre, Royal Brisbane and Women's Hospital

Physiotherapy Services

Cara Masterson
Physiotherapist
Allied Health Services
Royal Brisbane and Women's Hospital

This is a joint initiative between Metro North Hospital and Health Service and Brisbane North PHN

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Queensland Government

Overview of services

- Antenatal
  - Evening classes - Active Pregnancy, Active Labour
  - Antenatal pelvic floor dysfunction class
  - YPP Class
  - Musculoskeletal conditions of pregnancy
  - Teach use of TENS for labour
  - Antenatal hydrotherapy
- Postnatal
  - Ward physiotherapy consultation 7/7
  - 3rd and 4th degree perineal tear follow up
  - Postnatal classes – DRAM, LBP, Pelvic Floor
  - Baby massage class
  - Individual treatment as needed

Antenatal education classes

- Physiotherapists and Midwives run a coordinated program of classes – booked through maternity bookings
- Physios hold 2 of these classes
  - Active Pregnancy
  - Active Birth
- YPP (young parents program)

Active pregnancy class

- Pelvic floor exercises and their benefit
- Back care during pregnancy
- Avoidance of supine
- Comfortable sleeping positions
- Perineal massage
- General exercise advice – SMA guidelines

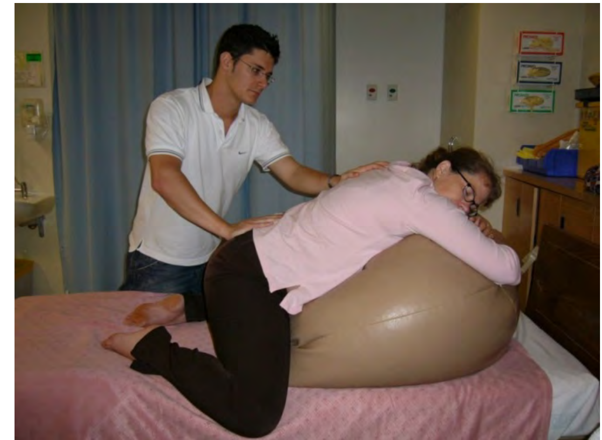
Exercise during pregnancy

- Aqua aerobics:
  - pregnancy specific exercise classes
- Avoid:
  - high impact exercise
  - supine position
  - overstretching
  - contact sports and activities with a risk of falls

Source: RANZCOG Guidelines

Active birth class

- Labour focused
- Aims to reduce fear of childbirth and provide strategies to cope with labour pain
- Practice of active pain relief strategies for use in labour
- Massage
- Positioning
- Pelvic circles
- Heat, TENS
- Breathing patterns



Images source: Women's and Newborn Services RBWH

Specific conditions of pregnancy
suitable for physiotherapy management

- Back Pain
- Pelvic Girdle Pain
- Urinary Incontinence
- Varicose veins
- Carpal tunnel syndrome
- Diastasis of the Rectus Abdominus Muscle (DRAM)

GP referral accepted for women booked into RBWH

Postnatal classes

- Postnatal pelvic floor class
  - OASIS (3rd and 4th degree tear)
  - Urinary/faecal incontinence
  - Referral required
- Postnatal class
  - DRAM
  - LBP
  - General progression of postnatal exercises
  - Self referral

Image source: RBWH Physiotherapy Department

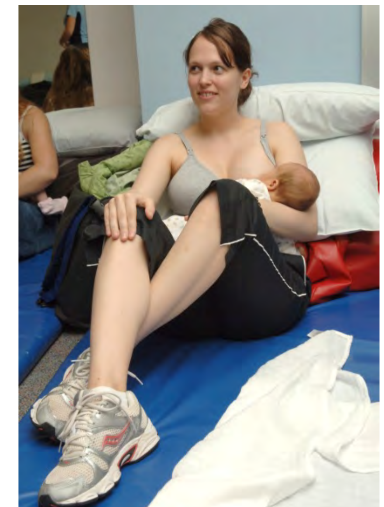


Image source: Women's and Newborn Services RBWH

Neonatal services

- Outpatient appointments
  - 0 – 6 months
  - Musculoskeletal – talipes, torticollis, plagiocephaly, Erb's palsy
  - Neurological / Developmental review
- Baby massage classes – self refer
- Playgroup for preterm babies
  - (0 – 12 months CA)
- Infant Follow up clinic
  - review babies post discharge from maternity ward and neonatal unit

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Breastfeeding

Jeanette Tyler
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Women's and Newborn Services
RBWH

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Recommendations

- Exclusive breastfeeding until around 6 months
- Continued breastfeeding for at least 12 months with addition of appropriate complementary foods at around 6 months (NHMRC)

Recommendations

Australasian Society of Clinical Immunology and Allergy (ASCIA) May 2016

- When your infant is ready, at around 6 months, **but not before 4 months**, start to introduce a variety of solid foods, starting with iron rich foods, while continuing breastfeeding.
- All infants **should be given allergenic solid foods** including peanut butter, cooked egg and dairy and wheat products in the first year of life. This includes infants at high risk of allergy.
- **Hydrolysed** (partially and extensively) **infant formula are not recommended** for prevention of allergic disease.

http://www.allergy.org.au/about-ascia/info-updates/659-ascia-releases-guidelines-for-infant-feeding-and-allergy-prevention

Incidence

- Initiation rate approximately **90%**
- At 1 month **40%** of women have introduced some formula
- At 6 months - only **15%** of breastfed babies are exclusively breastfed

Why is breastfeeding important?

	Health outcome associated with breastfeeding	No. Studies	Pooled Effect	95% CI	Interpretation: odds (OR) / risk (RR) of outcome is:
For baby	Performance in intelligence tests[14]	17	3.44 points	2.30–4.58	increased
	Overweight/obesity in later life[15]	113	OR: 0.74	0.70–0.78	reduced
	Type 2 diabetes[15]	11	OR: 0.65	0.49–0.86	reduced
	Malocculsion[16]				
	Ever versus never breastfed	18	OR: 0.34	0.24–0.48	reduced
	Exclusive versus ever breastfed	9	OR: 0.54	0.38–0.77	
	Dental caries[17]				
	If breastfed beyond 12 months	5	OR: 1.99	1.36–2.96	increased
	If breastfed up to 12 months	7	OR: 0.50	0.25–0.99	reduced
	Acute otitis media (until 2 years)[18]				
	If exclusive breastfeeding for first 6 months	5	OR: 0.57	0.44–0.75	reduced
	More versus less breastfeeding	12	OR: 0.65	0.59–0.72	
	Childhood leukaemia[19]				
	Any breastfeeding for 6 months of longer	18	OR: 0.81	0.73–0.89	reduced
	Ever versus never breastfed	15	OR: 0.89	0.84–0.94	
	SIDS[20]				
	Exclusive breastfeeding	8	OR: 0.27	0.24–0.31	reduced
	Any breastfeeding	18	OR: 0.40	0.35–0.44	
	Severe respiratory infections[8]	16	RR: 0.68	0.60–0.77	reduced
	Mortality due to infectious diseases[8]	9	OR: 0.48	0.38–0.60	reduced
	Protection against diarrhoea morbidity/hospital admission[8]	15	RR: 0.69	0.58–0.82	reduced
Maternal	Breast cancer[21]	98	OR: 0.78	0.74–0.82	reduced
	Ovarian cancer[21]	41	OR: 0.70	0.64–0.77	reduced
	Type 2 diabetes[22]	6	RR: 0.68	0.57–0.82	reduced
	BMI in postmenopausal women[23]	1	0.22 kg/m^2	0.21–0.22	reduced

Queensland Clinical Guidelines www.health.qld.gov.au/qcg/

Breastfeeding not recommended

- Galactosaemia
- Maple syrup urine disease
- Phenylketonuria (PKU). Some BF may be possible with careful monitoring
- Human immunodeficiency virus (HIV) positive
- Active TB while the mother is infectious
- Illicit drugs and some medication

Medications

- Very few contra-indications
- Individualise care
- Refer to a breast milk pharmacopeia E.g.
  - LactMed - U.S. National Library of Medicine https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm
  - Medications and Mothers' Milk Online http://www.medsmilk.com/

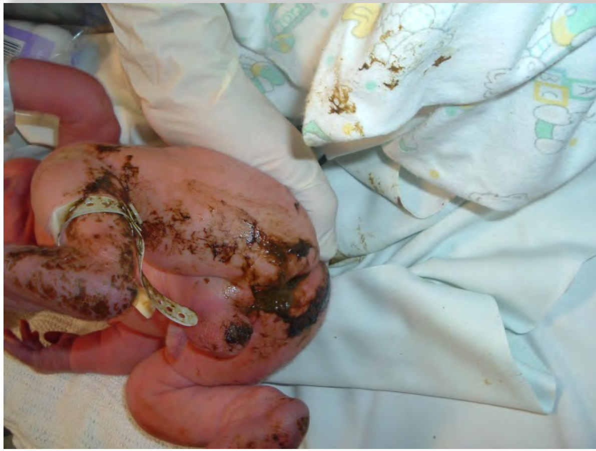
During pregnancy

- Discuss and encourage
  - Many women decide how they will feed their baby before or early in pregnancy
  - More likely to initiate and continue to breastfeed if their doctor encourages them to
- Check for hormonal problems or chronic disease. E.g. Diabetes, Thyroid disease, PCOS
- Check breasts and nipples if appropriate
- Refer if required

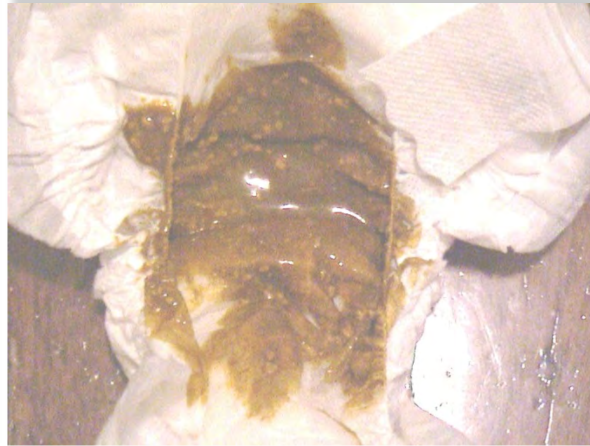
Postnatal check day 5 to 7

- Ask targeted questions to ascertain if feeding is progressing normally
- Weigh baby
  - If not seen regularly in first 5-10 days
- Discuss health promotion
  - Safe sleeping
  - Role of child health nurse/community midwife

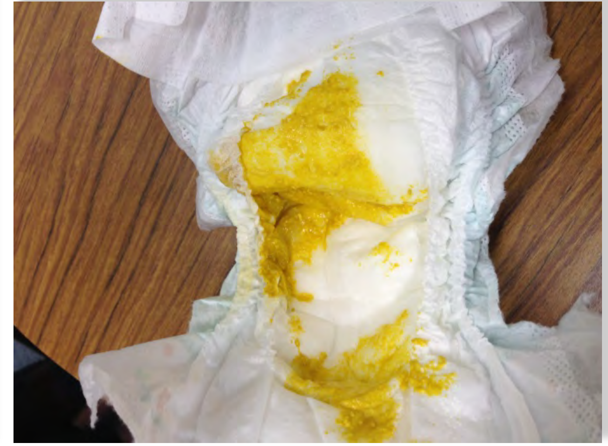
Breastfeeding is going well when…



Meconium
At birth



Transitional Stool
Day 2-4



Within 24 – 48 hours of "milk in" - from Day 5 - 7

- Feeding on cue 8-12 times every 24 hours
- 3-4 yellow stools and 6-8 wet nappies each day
- Mother can hear baby gulping or swallowing milk
- Breastfeeding is comfortable
- Baby is receiving only breast milk

Input/output checklist

Age (hours)	Breast milk intake	Number of breastfeed	Number of wet nappies	Stooling	Stool colour	Stool consistency	Baby weight
0–24	0–5 mL colostrum at first feed 2–10 mL per feed Average of 7 ml per feed 7–123 mL of colostrum in first 24 hours	First 8 hours: 1 or more Second 8 hours: 2 or more Third 8 hours: 2 or more	1 or more	1–2	black	tarry/sticky	Loses 7% average 10% maximum
24–48	5–15 mL per feed Increasing volumes	8–12	2 or more	1–2 1–2	greenish/black then brownish 'transitional'	softening	
48–72	15–30 mL per feed Increasing volumes	8–12	3 or more	3–4	greenish/yellow	soft	
72–96	30–60 mL per feed 395–800 mL per day	8–12	4 or more	4 large or 10 small	yellow/seedy	soft/liquid	
End of first week	395–800 mL per day Increasing volumes 440–1220 mL per day by one month	8–12	6 or more	4 large or 10 small	yellow/seedy	soft/liquid	Weight loss plateaus then starts to regain weight

- Between 4–6 days of age, babies start to regain weight and by two weeks will have returned to birth weight
- Most babies have returned to birth weight by 10 days of age
- Average weekly weight gain of 150 to 200 grams to three months of age
- Babies usually double their birth weight by six months of age, and triple their birth weight by 12 months of age
- Weight gain or loss is only one aspect of wellbeing—assess every mother and baby on an individual basis
- Urates may be present before secretory activation when milk flow increases–urates not expected after 96 hours of age
- Number of bowel motions of breastfed babies tends to decrease between six weeks and three months of age

Queensland Clinical Guidelines www.health.qld.gov.au/qcg/

6 week check

- Discuss
  - Mother's satisfaction with baby's progress
  - Feeding including patterns and growth
  - Continuing breastfeeding – supply/demand
  - When to introduce solids
  - Stool changes
  - Mothers lifestyle - nutrition, physical activity, alcohol, contraception

Common presentations to GP

- Need for information, affirmation and reassurance
  - Tell mothers not to wait if worried
- Baby not attaching to breast
- Painful feeding/nipple trauma
- Concerns about milk supply
- Blocked ducts/Mastitis

Source: Breastfeeding Concerns at 3 and 7 Days Postpartum and Feeding Status at 2 Months Erin A. Wagner et al, PEDIATRICS Volume 132, Number 4, October 2013

Recommendations for common concerns

- Consider specific recommendations listed below in addition to the universal recommendations and supportive care strategies outlined in the guideline
- Refer to appropriately qualified health professional (e.g. IBCLC, medical officer, child health nurse) if concerns persist and/or interventions require monitoring after discharge from the service

Concern	Signs/Consideration	Recommendations
Sleepy baby not exhibiting feeding cues	• Prolonged periods of not feeding require investigation • Exclude causes such as effects of maternal analgesia during labour and birth, effects of the birth process and illness	• Reassure mother this is usually temporary • Refer to Flow Chart: Sleepy baby • Refer to Queensland Clinical Guideline: *Neonatal jaundice*
Alert baby who is exhibiting feeding cues but unable to attach	• Reason may not be apparent • Can be distressing for both the mother and her baby as ba may back arch, cry when approaching the breast and pusl away • Woman related reasons include: ○ Inverted or flat nipples, areola engorgement/oedema • When nipple is flat or inverted, or areola engorged, it obliterates nipple and makes grasping nipple/areola difficu impossible for baby • Reverse pressure softening (RPS) uses gentle positive pressure to soften areola and surrounding tissue by temporarily moving swelling slightly backward and upward the breast • Baby related reasons include: ○ Birth trauma ○ Ankyloglossia (tongue-tie)	
Delay in secretory activation or poor milk transfer	• Common cause of poor milk transfer is sub-optimal attach • Possible causes of delay in secretory activation include: ○ Postpartum haemorrhage, diabetes, obesity • Possible causes of low milk production at stage of initiatio include, breast surgery, hypoplastic breasts, chronic disea or medical conditions	

Concern	Signs/Consideration	Recommendations
Nipple pain and trauma	• Nipple discomfort in the first few days is common • Commonly cited reason for ceasing breastfeeding • Sub-optimal positioning is the most common cause • Other causes include tongue-tie, flat or retracted nipples, poor skin health (e.g. eczema, bacterial, thrush, herpes), nipple vasospasm • Regardless of treatment used, most women report a reduction in nipple pain to mild levels approximately 7–10 days' after birth • Sore nipples occurring beyond the first weeks of breastfeeding may be caused by: ○ Infections such as staphylococcus aureus and candida ○ Vasospasm	• Reassure if nipples tender but no sign of compression after a feed • Review and optimise positioning and attachment • Soften areola sufficiently to enable baby to grasp adequately • Review nipple care ○ Avoid soaps and synthetic bras ○ Change breast pads frequently ○ Expose breasts to air briefly after breastfeeding ○ Wash daily ○ Allow expressed breast milk to dry on the nipple after breastfeed • Limited evidence exists about the effectiveness of treatment for nipple pain and/or trauma • Refer if pain/trauma persists beyond first week or infection suspected
Breast engorgement	• Physiologic breast fullness when 'milk comes in' is normal • Engorgement:"swelling and distension of the breasts usually during early days of initiation of lactation, caused by vascular dilatation as well as arrival of the early milk" • More frequent breastfeeding (or expressing, if baby is not feeding at the breast) in first 48 hours is associated with less engorgement • Symptoms occur most commonly between days 3–5 • In the presence of oedema reverse pressure softening shown to improve attachment	• Best management is prevention • Reduce engorgement so baby can breastfeed effectively ○ Encourage reverse pressure softening before attempting breastfeeding or hand expressing • Manage discomfort ○ Paracetamol and Ibuprofen are safe options for breastfeeding women in appropriate doses ○ Cold packs may provide comfort • Provide anticipatory guidance regarding possibility of engorgement to women prior to hospital discharge
Blocked duct or mastitis	• Blocked duct presents as a tender lump in otherwise well women • Mastitis may or may not involve bacterial infection • Staphylococcus aureus is most common pathogen in milk of women with mastitis • Clinical presentation: ○ Tender, hot, swollen, wedge-shaped area of breast, temperature of 38.5 °C or greater, chills, flu-like aching, systemic illness • Common during first six weeks • Predisposing factors are those which result in milk stasis (e.g. nipple damage, infrequent feeding and poor attachment) • A continuum exists from blocked duct or engorgement to mastitis to breast abscess	• Improve milk removal ○ Increase feed frequency, optimise positioning and gently massage during feed from the blocked and/or tender area toward the nipple, express after feed if required ○ Apply heat (shower, warm cloth, heat pack) to facilitate milk ejection reflex • Supportive/comfort measures ○ Rest, adequate fluids and nutrition, analgesia and cold packs • Antibiotics indicated if symptoms not improving within 12–24 hours or if acutely ill

Queensland Clinical Guidelines www.health.qld.gov.au/qcg/

Infant feeding support

- Hospital based Community Midwifery Service (CMS)
- Hospital-based Lactation Service

Home > Royal Brisbane and Women's Hospital > Services at the Royal Brisbane and Women's Hospital > Feeding my baby

Royal Brisbane and Women's Hospital

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Feeding my baby

Women's and newborn » Maternity » Feeding my baby

Feeding my baby

The Royal Brisbane and Women's Hospital (RBWH) recognises the importance of breastfeeding for both mothers and babies. However, if you choose not to or are unable to breastfeed, your informed decision will be fully respected and you will be supported with your feeding choice.

Breastfeeding support

We recognise that whilst breastfeeding is normal and may progress naturally, some mothers will require additional support from a midwife or lactation consultant.
When you have consistent support and advice in the early days, breastfeeding becomes easier with time.
We offer lactation support services to mothers who have given birth at the hospital. Our breastfeeding support services are staffed by International Board Certified Lactation Consultants (IBCLC).

Fact sheets:

- How to use a breast pump (PDF, 168KB)
- Nipple shields (PDF, 122KB)
- Mastitis fact sheet (PDF, 217KB)
- How to bottle feed (PDF, 168KB)
- Making more breast milk (PDF, 188KB)
- Hand express technique (PDF, 542KB)
- Dummies and pacifiers fact sheet (PDF, 119KB)
- Infant feeding cues (term) (PDF, 154KB)
- Infant feeding cues (preterm) (PDF, 207KB)

Pregnancy

- I am pregnant what do I do now?
- What options of care are available to me?
- Childbirth education classes
- Specialist Services available for myself and my baby
- Aboriginal and Torres Strait Islander support
- Video: My first appointment at the hospital

Labour and birth

- Complications during my pregnancy
- Video: When its time to have my baby

Leaving hospital

- Feeding my baby
- Supportafter being discharged from hospital

Royal Brisbane and Women's Hospital
https://www.health.qld.gov.au/rbwh/services/maternity-q5

Child Health Service Brisbane north side

Early feeding and support drop-in clinics

For parents in the first four weeks after discharge from hospital. No appointment required.

Child health nurses provide help, support and advice with:
- infant feeding and sleep
- breastfeeding support, assistance and helpful advice
- referral to other support services for specific needs.

Clinic days and hours

All clinics are open between **9am and noon** on the days specified in the table below (closed on public holidays).

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Alderley	Alderley	Alderley	Alderley	Alderley
Caboolture	Burpengary	Caboolture	Caboolture	Caboolture
Deception Bay	Caboolture	Kallangur	Deception Bay	Indooroopilly
Kallangur	Nundah	Nundah	Strathpine	Kallangur
	Redcliffe			Nundah
	Strathpine			Redcliffe

Clinic locations

Alderley Shop 4, 24 South Pine Rd

Burpengary Burpengary Meadows State Schoo Early Years Centre, Kurrajong Drv

Caboolture Early Years Centre Cnr Tallon and Manley Sts

Deception Bay Moreton Medical Centre Market Square Shopping Centre Cnr Bay Ave and Deception Bay Rd

Indooroopilly Cnr Lambert and Clarenc

Kallangur 126 School Rd

Nundah 10 Nellie St

Redcliffe 181 Anzac Ave

Strathpine 568 Gympie Rd

Please turn over

For further support Child health 1300 366 039 | Breastfeeding helpline 1800 686 268
Call 13 HEALTH (13 432584) 24 hours, 7 days and ask to speak to a Child Health Nurse
www.childrens.health.qld.gov.au/community-health/child-health-service

Child Health Service (for children from birth to eight years)

The Child Health Service provides a range of community health and support services for children and their parents/carers to give every child the best possible start in life.

By providing early intervention and prevention services at the right time, the service aims to ensure children and young people are nurtured, safe and able to realise their full potential.

Our dedicated teams of child health nurses and early intervention clinicians (either social workers or psychologists) offer:
- Health surveillance and screening
- Growth and developmental checks
- Early feeding support
- Nutritional information
- Immunisation clinics
- Parent support groups
- Counselling to enhance parenting

These services are delivered in our child health centres or in the home.

Our services

Early feeding support

Early feeding and support drop-in clinics are available for parents of newborns in the first four weeks after leaving hospital. Brief consultations are available at select venues throughout the greater Brisbane area – for a full list of sites, see: www.childrens.health.qld.gov.au/community-health/child-health-service/early-feeding-support-drop-clinics

For additional feeding support, the Infant Feeding and Parent Support Program is available by appointment for parents with infants aged birth to six months.

Self-weigh facilities

Self-weigh facilities for infants under 12 months are available at some of our community centres. Hours may vary. Contact your nearest child health centre for more information (see contact details on next page).

Key age child health checks

By following a schedule of visits at key ages set out in a child's Personal Health Record book, parents can monitor the health, wellbeing and development of their child in partnership with health professionals.

Parenting groups

Early parenting groups allow for the sharing of health information around parenting with a focus on support. For further information, contact your local clinic.

Parenting programs

Designed for parents of toddlers and young children up to eight years. Parenting programs, seminars and individual counselling sessions offer parenting solutions to help solve current problems and prevent future problems before they arise. Bookings required.

Immunisation services

A free immunisation clinic for children (birth to five years) is held on the first and third Thursday of every month at the Zillmere Community Child Health Centre (426 Zillmere Rd). The clinic runs from 10am to noon. No bookings required.

Brisbane City, Logan and Moreton Bay regional councils also provide free vaccinations. For clinic times and locations, contact the councils directly. General Practitioners also provide immunisation services.

Interpreter Services

Interpreter services are available on request.

Source: Children's Health Queensland Hospital and Health Service
https://www.childrens.health.qld.gov.au/chq/our-services/community-health-services/child-health-service/

Lactation Consultants
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WESTERN SYDNEY REGIONAL EVENT

Thursday 30th March 2017 Westmead Public Hospital, Westmead

Join us in the Lecture Theatre 4, Education Block, Westmead

WEBINAR AVAILABLE

LCANZ is pleased to announce the first webinar for 2016. This webinar will provide current evidence on the facilitation of skin-to-skin contact after caesarean section. It will be of interest to all midwifery, nursing and medical staff working in operating

ABOUT

LCANZ is the professional organisation for International Board Certified Lactation Consultant's (IBCLCs) and others who have an interest in lactation and breastfeeding. Our core business is to provide members with information and educational opportunities.

more

MEMBERSHIP OF LCANZ

Provides you access to valuable career support, educational opportunities and networking events. You can join as an individual or as a group, and if you are in private practice, be listed in lactation consultant directory. All listed consultants are members of LCANZ and have qualified as International Board Certified Lactation Consultant (IBCLC).

Source: Lactation Consultants of Australia & New Zealand
http://www.lcanz.org/

Resources for families

- Pregnancy, Birth and Baby http://www.pregnancybirthbaby.org.au/
- Breastfeeding Queensland Health https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/maternity/nutrition/breastfeeding
- Australian Breastfeeding Association https://www.breastfeeding.asn.au/

Resources for health professionals

- Queensland Clinical Guideline: Establishing breastfeeding http://www.health.qld.gov.au/qcg/
- Academy of Breastfeeding Medicine http://www.bfmed.org/

Milk Bank facts

- Established 2012
- ~ 1028 babies fed (RBWH)
- Priority given to babies:
  - < 34 weeks
  - <1500 grams
- 320 milk donors
- Contracts to supply with 11 hospitals
- For more information
  - p: 36460542 e: Milk_Bank_RBWH@health.qld.gov.au

Current as @ March 2017

Infant formula feeding

- Respect intention/informed decision not to breastfeed
- Cow’s milk-based formula suitable for newborn for first 12 months
- Special formulas under medical supervision
- Changing type of formula because of minor rashes and irritability is usually of no benefit
- Show parents how to safely prepare formula and how to bottle feed (refer to Child Health book)

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Skills Development Centre, Royal Brisbane and Women's Hospital

Newborn examination-DVD

Authors:
Dr David Cartwright
Dr Mark Davies

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Issues in neonatal and early infant periods

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Week 1 – action points

- Primary care role has increasingly been brought into focus
- Trend toward 6 hour discharges
  – direct from birth suite, no admission to postnatal ward
- Early discharge programme

Neonatal examination by day 7

If baby is discharged from hospital within 72 hours of birth this examination should be conducted by a GP.

Date ___/___/___ Age _______ Weight __________ NNST* (see page 13) ☐ Done now ☐ Done previously

Head Circ__________ Feeding ____________________ Signature ______________________________

Hearing screen (see 17) ☐ Further assessment indicated ☐ No further assessment indicated ☐ Screen not done

Family history (including deafness) ______________________________

Mother's medication/supplements ______________________________

Baby's medication/supplements ______________________________

Feeding concerns ______________________________

Birth marks ______________________________

Examination

✔ = normal, ✘ = abnormal (explain in comments), O = not examined.

☐ jaundice

☐ fontanelle/sutures

☐ eyes & red reflexes

☐ face/palate/ears

☐ limbs

☐ spine

☐ genitalia

☐ anus

☐ meconium within 24 hours

☐ abdomen and umbilicus

☐ respiratory

☐ cardiac (auscultation)

☐ cardiac (femoral pulses)

☐ hips

☐ neurological/reflexes

Comments ______________________________

Recommendations, follow ups, medication ______________________________

Health promotion issues discussed with parents or care giver

☐ Feeding ☐ Safe infant sleeping information ☐ Injury prevention ☐ Hearing and ear health

☐ Role of GP ☐ Vaccinations funded/non-funded ☐ Roles of child health nurse/community midwife/health worker

Doctor's signature ____________________ Name ____________________

* NNST = Neonatal Screening Test

General

- Feeding issues
  - Need to ensure adequate intake and access to supports (lactation consultant, child health nurse)
- Lethargy
  - **Think of** infection, hypoglycaemia, jaundice, neurological issues
- Irritability
  - **Think of** Hypoxic Ischaemic Encephalopathy (HIE), drug withdrawal, hypoglycaemia, hypoxia, other neurological issues, pain, infection (NB normal infant crying and parent-child dyad)

Respiratory and Cardiac

- Respiratory Distress
  - Primary respiratory disease
  - Congenital cardiac disease with cardiac failure
  - Combination of both
- Cyanosis/pallor
- Preductal saturations < 90% (oximeter on right hand/wrist)
- Murmur with other abnormal cardiac findings
- Inspiratory stridor at rest

Jaundice

- Any jaundice within the first 24 hours of life
- Significant jaundice
  - Rhesus disease now rare however other antibody mediated haemolytic jaundice still occurs
  - Haemolytic jaundice from other causes
  - Have a lower threshold for testing in late preterm infants and where there is a family history of jaundice requiring phototherapy

Gastrointestinal

- Failure to pass meconium in first 48 hours
- Bilious vomiting – malrotation until proven otherwise
- Inguinal hernia
- Scrotal swelling associated with tenderness (possible testicular torsion)
- Abdominal distension or masses

Renal

- Failure to pass urine in first 24 hours
- Decreased urine output
    - By Day 3 should be producing ≥ 3 wet nappies per day

Ophthalmological

- Abnormal or asymmetric red reflexes

Endocrine

- Abnormal genitalia, including bilateral cryptorchidism
- Goitre

Dermatological

- Neonatal rashes common and usually benign
- Vesicular rash
  - Consider HSV, Varicella, Incontinentia pigmenti (linear distribution)

Orthopaedic

- Unstable hips – orthopaedic review
- Torticollis – physiotherapy input
- Not moving an isolated limb
    - Think of possible fracture or neurological injury

Weeks 2-5

- Prolonged jaundice
  - Jaundice persisting beyond 14 days
  - Most often breast milk jaundice
  - BUT important to exclude haemolysis, conjugated jaundice, hypothyroidism, UTI
  - Conjugated jaundice requires referral to paediatric gastroenterologist for further investigation & management
- Feeding issues
  - Usually feeding issues are related to breast attachment or supply issues
  - Tongue tie…

Week 6 – when to refer

- Murmur with abnormal cardiac findings
- Respiratory distress / Stridor
- Failure to Thrive
- Increasing jaundice
  - NB If previous diagnosis of breast milk jaundice, jaundice should be improving by this stage
- Abnormal red reflexes, nystagmus or failing to fix and follow
- Capillary haemangiomas – if large or in critical areas eg eyelid, may require propranolol treatment – refer to vascular malformations clinic at LCCH

Week 6 – when to refer

- Neurological concerns
  - Abnormalities of tone, not fixing or following or beginning to smile, large changes in head circumference centiles
- Unstable hips
- *Cryptorchidism – continue to monitor but refer to surgeon if undescended by 6 months

Late Preterm Infants

- 34 weeks to 36+6 weeks
- Some late preterm infants may have had no or minimal admission time to a special care nursery
- Not term infants and shouldn't be treated as such
- In the short term, increased feeding problems, increased risk of apnoea, hypothermia and hypoglycaemia
  - NB May seem to be feeding well until maternal breast milk supply"comes in" and baby is challenged with larger milk volumes
- Late preterms are also at increased risk of neurodevelopmental problems

RBWH 35 and 36 weekers

- 35 weekers are routinely admitted to special care nursery for an initial period of observation (may be < 24 hours)
- 35 and 36 weekers may be managed on and discharged from the postnatal wards but recommendations include
  - 1. At least 72 hours old before discharge
  - 2. Have at least one bilirubin check prior to discharge
  - 3. All receive at least 24 hours of BGL monitoring

Ex-prem Nursery Graduate

- Usually only provide paediatric follow-up for patients less than 32 weeks gestation
- Still an increased risk of developmental delay and CP in late preterm infants
    - If any concerns refer to a paediatrician and physiotherapist
- Correct for prematurity with respect to growth and development for the first 2 years of life
- Give immunisations according to chronological age, not "corrected age"

Ex-prem Nursery Graduate

- Extra immunisations given for premature groups
  - <28/40: Require 4 doses of Prevenar ie extra dose at 12 months
  - <32/40: Require 4 doses of Hep B ie extra dose at 12 months
- Babies with CNLD may have slower weight gain, and also have increased risk of hospital admission for respiratory illnesses in the first 2 years of life
- Medications at discharge
  - Usually only Ferroliquid and Pentavite/Vitamin D
  - NB If infant is formula fed, only needs Vitamin D

**

Maternal Graves Disease

- Antibodies can cross the placenta to affect the baby, even if the mother is adequately treated
- Requires careful examination soon after birth looking for goitre, tachycardia
- Baby requires fT4 and TSH to be done at 4-5 days of age and again at 14 days of age
- Maternal medications NOT a contraindication to breastfeeding

Maternal Hypothyroidism

- If TSH >3.0 mU/L in second or third trimester, infant needs a fT4 and TSH level at 4 weeks of age. If abnormal, refer to paediatric endocrinologist
- If TSH 3.0 or less, then the NNST is adequate

Vitamin D Deficiency

- Recommend Vitamin D 400 IU daily for 6 months for at risk patient groups
  - Birth Weight < 2000g or GA < 34/40
  - Dark-skinned mothers with unknown Vit D status
  - Veiled mothers with unknown Vit D status
  - Previous maternal Vit D deficiency corrected to > 50 nmol/L by 2nd or 3rd trimester

Vitamin D Deficiency

- Mild-Moderate Maternal Deficiency (25-50 nmol/L)
  - Give Vitamin D 400 IU daily for 12 months
- Severe Maternal Deficiency (<25 nmol/L)
  - Give Vitamin D 1000 IU daily for 3 months
  - THEN Vitamin D 400 IU daily until 12 months of age
- Don't do routine testing unless infant is symptomatic
- NB Formula does have more Vitamin D than breast milk, but usually need about 1L/day to attain 400 IU/day
- Vitamin D can be given by:
  - Pentavite 0.45 mL/day (compliance issues, more expensive, vomiting)
  - Vitamin D drops (200 IU/drop)
- If needing 1000 IU/day, require Vitamin D drops

Maternal Hepatitis C

- Follow-up serology at 18 months of age
- If Hep C Ab present, refer to paediatric gastroenterologist
- NB Can do HCV RNA testing earlier, but requires more tests, and still need to have the antibody testing done at 18 months. No treatment is offered earlier in infants/toddlers
- Breastfeeding not contraindicated (temporarily suspend if cracked and bleeding nipples)

Maternal Hepatitis B

- Given HepB immunoglobulin and Hep B vaccination as soon as possible after birth
  - Still have a 5-10% risk of vertical transmission (more likely if HbeAg positive and or high viral load)
- Immunisation schedule as usual
- Followup serology at 12 months of age
  - If immune and HbsAg negative, no further followup
  - If HbsAg negative but not immune ie HbsAb <10 refer to immunology clinic at LCCH
  - If HbsAg positive refer to paediatric gastroenterologist at LCCH

Maternal HIV

- Baby treatment will depend on maternal risk (viral load)
- Have bloods done on Day 1 and Week 6
- Have followup with Infectious Diseases team at Week 2 and Week 8
- Most patients are low risk and are therefore discharged on zidovudine for a total of 4 weeks

Immunisation Reactions

- Preterm infants at increased risk of immunisation reactions
- At RBWH we give first immunisations at 6 weeks in ICN or SCN if medically stable. Infrequent complications include:
  - Apnoea, very occasionally requiring ventilation
  - Increased or new oxygen requirement for 24-48 hours

  *If there is a significant immunisation reaction, refer to immunisation clinic at LCCH for the subsequent immunisations post discharge

Metro North **GP Alignment Program**

MATERNITY WORKSHOP

Saturday, 7 October 2017

Skills Development Centre, Royal Brisbane and Women's Hospital

Case work 3: Postnatal care

This is a joint initiative between Metro North Hospital and Health Service and Brisbane North PHN

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Blue group - post partum

- Julia - G1P1 had an uncomplicated pregnancy, a straightforward birth and post partum course
- She is now 6 days post partum and presents for a routine postnatal check, along with baby Jack
- She has two appointments booked, 15 min for Julia and 30 min for Jack
- What do you complete for Julia's checkup?

Post partum care – Day 5-10

- Review
  - birth & complications
  - feeding & breasts
  - immunisations (MMR, Pertussis)
  - contraception & intercourse resumption
  - psychological wellbeing
  - ongoing follow up (GP, Child and Youth Community Health)
- Examine baby as per personal health record
- Check
  - perineum or caesarean section wound
  - bowel & bladder function

Contraception

- Options at 5 – 10 days post partum include:
  - Abstinence
  - Condoms
  - Lactation amenorrhoea method (LAM)
  - Minipill
  - Depo/Implanon
  - NOT COCP, even if not planning to breastfeed
  - NOT IUCD

Red group - post partum

- Megan - G1P1 had well controlled GDM, a vaginal birth and third degree perineal tear
- Now 6 weeks post partum, she presents for her routine visit
- Baby Jasmine has the following appointment for 6 week review and immunisations
- What do you complete for Megan's checkup?

Post partum care – Week 6

- Review
  - birth & complications
  - feeding
  - immunisations
  - psychological wellbeing of mother & partner (EPDS)
  - medical issues (OGTT if GDM)
  - ongoing follow up (GP, Child Health)
  - need for referrals

Post partum care – Week 6

- Examine
  - BP/abdomen/perineum/breasts
  - baby as per personal health record
- Check
  - Bladder & bowel function
- Offer
  - Pap smear (if due)
  - Contraception

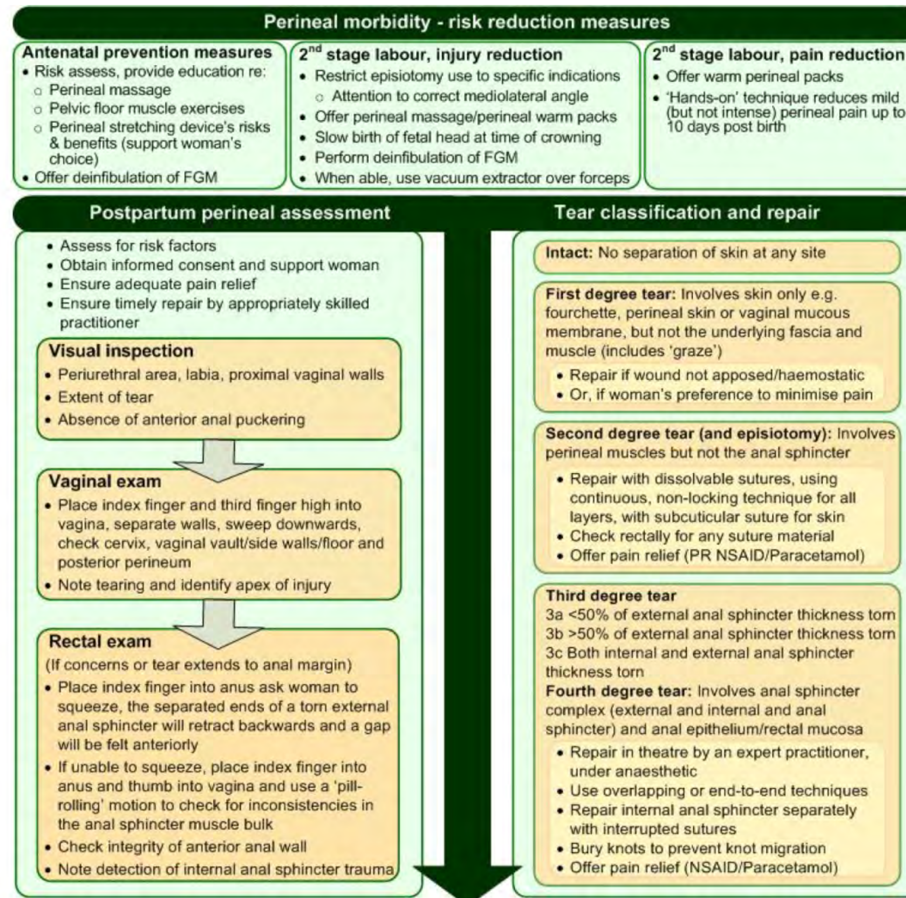
- *National Collaborating Centre for Primary Care. Routine Postnatal Care of Women and their babies (Internet). 2006 (updated 2014) (cited 2011 July). Available from: www.nice.org.uk*
- *Australian Capital Territory. Checklist for Shared Care Pregnancy (Internet). 2008 (Cited 2011 July). Available from: http://www.health.act.gov.au/publications/*

Perineal care

- Anal sphincter injury and anal sphincter dysfunction:
  - Refer to gynaecologist or uro-gynaecologist or colorectal surgeon
  - Consider:
    - endoanal ultrasound
    - anorectal manometry
    - secondary sphincter repair
  - Refer to physiotherapist for assessment and individualised PFME

Source: Queensland Maternity and Neonatal Clinical Guidelines Program http://www.health.qld.gov.au/qcg/

Perineal care - resources



Perineal Care Queensland Clinical Guidelines www.health.qld.gov.au/qcg/

Perineal care - resources

Postnatal perineal care

All perineal injury

- Inspect daily (and if excessive pain)
- Apply cool packs
- Offer regular oral analgesia (NSAID)
- Educate woman for self-care:
  - Perineal hygiene
  - Signs of infection or wound dehiscence
  - Positions to reduce perineal oedema
  - Pelvic floor muscle exercises
- Advise 6 week GP or midwife review:
  - See GP earlier if signs of infection or wound dehiscence
- Advise GP review if experiencing dyspareunia

Add for anal sphincter injury

- Administer:
  - Prophylactic IV antibiotics - assess need for postnatal antibiotics
  - Laxatives & stool softener for ≥ 10 days (with high fibre diet & fluids)
- Advise woman re:
  - Morbidity risks
  - Benefits of follow-up
  - Options in subsequent births
- Refer to physiotherapist for PFME
- Refer to Continence Clinic, where available
- Review at 6 weeks with obstetrician:
  - Consider endoanal ultrasound & anal manometry

Add for genital haematoma

- Observe for:
  - Excessive pain/pelvic pressure
  - Signs of shock
  - Urinary retention
  - Unexplained pyrexia
- Assess for haemodynamic resuscitation & surgical care
- Give prophylactic IV antibiotics
- Monitor T, P, BP for recurrence
- If packing – remove at 12-24 hours
- If drain – remove when loss minimal
- For vulval site – apply cool packs
- Treat anaemia
- If muscle trauma – refer to gynaecologist/physiotherapist

Queensland Maternity and Neonatal Clinical Guideline: MN12.30-V1-R17 Perineal care

Perineal Care Queensland Clinical Guidelines www.health.qld.gov.au/qcg/

Continence advisory service

Referral reasons may include:		
Lower urinary tract symptoms: Frequency; urgency; urge incontinence; stress incontinence; voiding difficulties; poor stream; feeling of incomplete emptying	**Bowel symptoms:** Constipation; diarrhoea; faecal soiling; flatus incontinence	Issues with 3rd and 4th degree tears

Pre work up for referral acceptance:

- Bladder symptoms – MSU M/C/S
- Bowel symptoms – Stool M/C/S if indicated

Referrals

Fax: 07 3646 0888 – attention to **Continence Advisory Service WNS**

Email: RBWH-Continence-Advisor-WNBS@health.qld.gov.au

Green group - post partum

- Nicole - G1P1. She had a healthy pregnancy and uncomplicated vaginal birth
- She presents at 5 weeks requesting a checkup, looking pale and tired
- She reports that she is still bleeding very heavily, with pain, blood clots and regular flooding
- Nicole also complains of pain in her left thigh
- What do you check?

Postpartum haemorrhage (PPH)

- Secondary PPH = excessive bleeding that occurs between 24 hours post birth and 6 weeks
- Primary PPH = excessive bleeding in first 24 hours post birth

Queensland Maternity and Neonatal Clinical Guideline: Primary postpartum haemorrhage
http://www.health.qld.gov.au/qcg/documents/g_pph.pdf

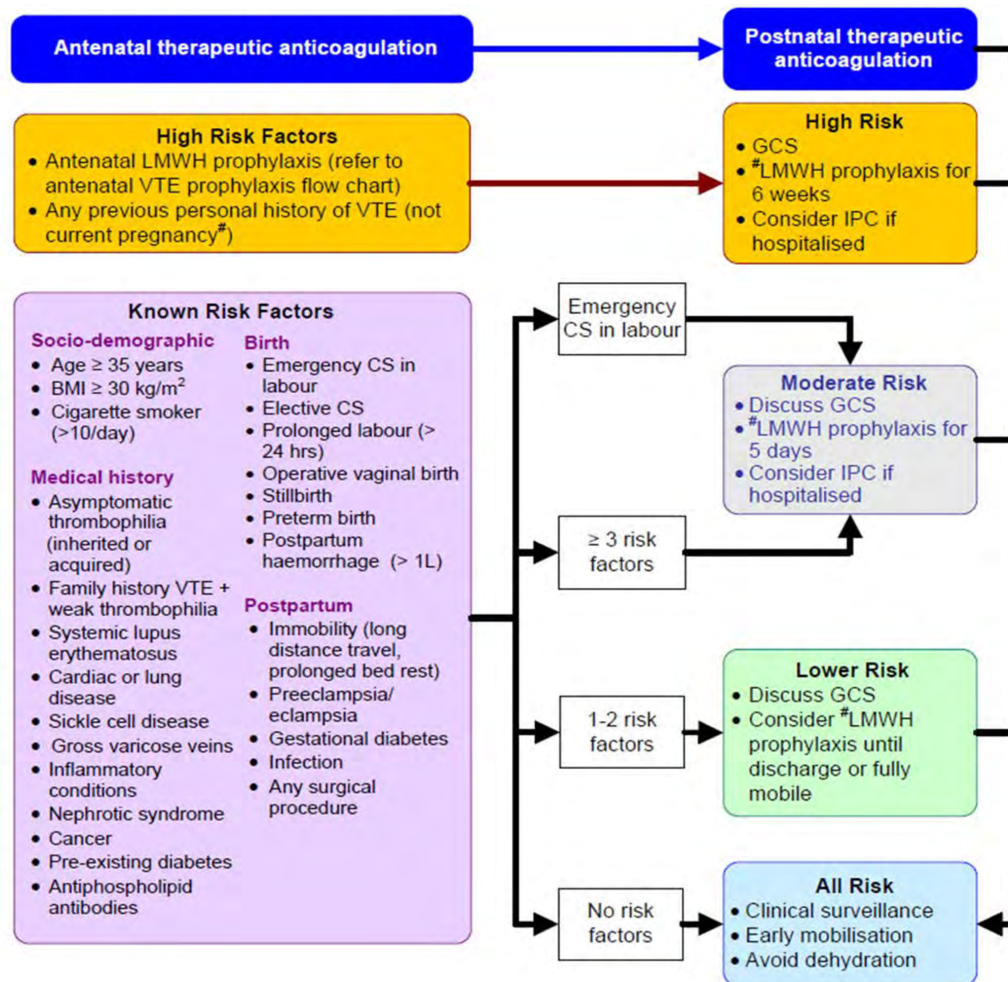
Secondary PPH

- Common causes:
  - Endometritis +/- Retained products of conception (RPOC)
- Rare causes:
  - Bleeding diathesis
  - Pseudo aneurysm / AV malformations of uterine artery
  - Choriocarcinoma

Secondary PPH

- Investigations:
  - Infection screen
  - Pelvic USS and Doppler flow
  - BHCG levels
- Treatment:
  - Antibiotics +/- uterotonics
  - If excessive / continued – investigate for RPOC (irrespective of USS findings)
  - Check histology

VTE Postnatal Assessment



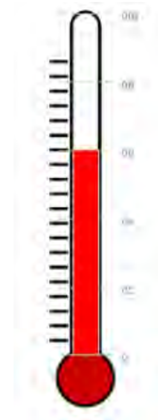
Queensland Clinical Guidelines www.health.qld.gov.au/qcg/

Orange group - post partum

- Carol - G2 P2. GTT was positive at 28 weeks; she was referred back to ANC and you haven't seen her since
- She had a caesarean birth, and has a healthy baby girl weighing 4900g
- She presents at 5 days post partum, looking flushed and moving slowly. She is accompanied by her husband and her mother is caring for the baby at home
- Your preliminary observations reveal a temperature of 39.2, BP 105/68 and PR of 112
- What is your approach?

Post Partum Pyrexia

- Definition:
  - Oral temperature of 38.0° C or more on any two of the first 10 days postpartum, exclusive of the first 24 hours
- Common Causes:
  - UTI / endometritis / mastitis / breast abscess / pneumonia / pharyngitis
  - Surgical site infection / septic thrombophlebitis
  - Drug reaction
  - Clostridium difficile diarrhoea
  - Infections related to regional anaesthesia
  - Peri partum cardiomyopathy



Post Partum Pyrexia - Management

- Refer urgently if any ‘Red flags’:
  - appears seriously ill
  - temperature >38° C
  - sustained tachycardia (>90 bpm)
  - breathlessness (RR>20 breaths/minute)
  - abdominal or chest pain
  - diarrhoea and/or vomiting
  - uterine or renal angle pain

Post Partum Pyrexia - Management

- History, examination and investigations to identify cause and direct optimal therapy
- Multidisciplinary approach
- Amoxycillin with Clavulanic Acid, Metronidazole, Clindamycin, Piperacillin-Tazobactam, Gentamicin

Source: RCOG*: Bacterial Sepsis following Pregnancy* Green-top Guideline No. 64b 1st edition I April 2012

Pink group - post partum

- Anna - G1P1 had an uncomplicated pregnancy, a straightforward birth and post partum course
- She is 5 days post partum and presents for her routine visit, along with baby Trinity
- As you commence your routine post partum check, you enquire about feeding and Anna reports *"Trinity is unsettled and not breastfeeding well, so this morning I gave her some formula".*
- How do you manage Anna's checkup?

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In conclusion…

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Take home messages

- Complete history, examination & investigations
- Promptly send referral to CPI
- Document in PHR at every visit, including results
- Notify ANC of adverse events such as a miscarriage

Item numbers for maternity shared care

- *16500 Rebate $40.10 ($47.15) Antenatal Attendance*
- *16591 Rebate $121.30 ($142.65) "Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery if the care of the patient will be transferred to another medical practitioner, payable once only for any pregnancy that has progressed beyond 20 weeks, not being a service to which item 16590 applies" (16590 = planning to undertake the delivery for a privately admitted patient)*

Source: http://www.mbsonline.gov.au

Medical Indemnity

- **Adhere to Metro North HHS Maternity GP Shared Care Guideline**
- All appropriate ante-natal screening tests must be performed and results followed up
- Woman must be **referred** to Obstetric Hospital/Clinic, Consultant Obstetrician or GP Obstetrician **before 20 weeks** gestation
- Obstetric Hospital/Clinic, Consultant Obstetrician or GP Obstetrician must see woman at 36/40 (or as dictated by relevant Shared Care Guidelines) & again at term, providing ante-natal course is uneventful

Medical Indemnity

- Should problems occur before 36 weeks (or as dictated by relevant Shared Care Guidelines), Obstetric Hospital/Clinic, Consultant Obstetrician or GP Obstetrician must be advised & consulted
- GPs may continue to see pregnant women for ante-natal visits or for intercurrent medical problems, but in shared care, **obstetric care and delivery of baby** must rest with **Obstetric Hospital/Clinic, Consultant Obstetrician or** with a **GP Obstetrician**

Contacts at each facility

- Guideline
  - Metro North Hospital and Health Service Maternity GP Shared Care Guideline
- Decision support tool
  - Metro North Hospital Antenatal Services – GP Shared Care

Contact information

Program Coordinator

Metro North Maternity GP Alignment Program

Phone: (07) 3646 4421
Email: mngpalign@health.qld.gov.au

MMH Alignment options

- This event together with a 30 min online bridging update will meet Mater's requirements
- If aligned with MMH and due for realignment this event will count as your update
- For more information
  - Phone: 3163 1967
  - Email: mscadmin@mater.org.au
  - Website: http://www.materonline.org.au/whats-on/professional-development/gp-maternity-shared-care-alignment

Thank you!

- Please …
- Complete Reinforcing activity
- Let us know if you consent to have your contact information available for pregnant women who don’t have a regular GP
- Provide your email address to enable us to provide you with updates