CONTEMPORARY ISSUES IN WOMEN’S HEALTH

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The editors of Contemporary Issues in Women’s Health solicit reporters and correspondents from throughout the world to make contributions to this section. Please e-mail the editors if you have reports or items that you would like to have included. We would be happy to attribute the items to those reporters and correspondents who give permission in their transmittal. Otherwise, we will share those reports that we think are of the greatest interest to our readership without attribution.

High plasma estradiol and the risk of dementia in older postmenopausal women

A recent publication has reported that older women who are exposed to high levels of endogenous estrogen may have a greater risk of dementia [1]. To investigate this association, French researchers developed a case-cohort study using biological samples from a total of 5644 postmenopausal women aged 65 years or older included in an ongoing French prospective cohort study (The Three City Study). After exclusion of women receiving hormone therapy, a total of 132 incident dementia cases and 543 random controls from the cohort were selected. For a 4-year period of time, the diagnosis of dementia was done in a 2-step procedure with a first neuropsychological examination and, if there was a potential diagnosis of dementia, a second evaluation by an independent committee of neurologists.

The researchers compared the baseline endogenous total estrogen level, bioavailable estrogen, and total testosterone of women with dementia and their controls. During the analyses, many other potential risk factors were considered, such as cardiovascular risk factors, diabetes, inflammatory markers (C-reactive protein and fibrinogen), and hypercoagulability (fibrin d-dimers and thrombin generation). After adjusting for confounding variables the Cox proportional hazards model suggested an association between total endogenous estrogen and the risk of dementia. This association was not linear, and the risk was increased in the lower and upper quartiles of total estrogen. Sensitivity analyses with the exclusion of women presenting cognitive impairment at baseline or developing dementia within the first 2 years of follow-up showed that the association between low estrogen and dementia was no longer increased. The authors explained this finding as a potential reverse causality between the low estrogen level exposure and the outcome. However, the association with higher estrogen levels in blood samples and the risk of dementia persisted after all analyses.

One interesting finding was that an important interaction was identified when diabetes was present in the population. Women with diabetes and in the upper quartile of estrogen levels showed more than a 14-fold increased risk of dementia. One explanation may be that higher endogenous estrogen and diabetes may promote unfavorable vascular processes that increase the risk of dementia in postmenopausal women. Even though these findings do not establish a causal relation, because it is an observational study, the authors concluded that a high estrogen level is an independent predictor of dementia, with a significant emphasis in postmenopausal women with diabetes. Their results were consistent with data from clinical trials indicating a null or deleterious impact of hormone therapy on cognitive function and dementia [2;3]. The authors concluded that their data strongly suggested the need for more investigations into the interaction between postmenopausal age and diabetes and their relationship with dementia.

References


Female genital mutilation: Increasing advocacy in the UK

Female genital mutilation (FGM) also known as female genital cutting or female circumcision is defined by the World Health Organization

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(WHO) as “all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.”

It has been estimated that over 125 million girls and women worldwide have undergone FGM. There are about 27 countries, mainly in Africa and the Middle East, where the practice is common. There has been international effort to eradicate FGM since the 1970s. In 2012, the United Nations General Assembly voted unanimously to take all necessary steps to end the practice.

According to the International Development Committee report on Violence Against Women and Girls, in the UK it is estimated that over 20000 girls are at risk of FGM annually. FGM is illegal in many countries, including the UK although there has never been a single case of a successful prosecution since FGM became a criminal offence in 1985. The consensus is that the existing procedures in tackling FGM, which is regarded as a form of child abuse, have failed. With this in mind, the Intercollegiate recommendations for identifying, recording, and reporting FGM was published in November 2013 [1]. This report looks at an action plan that addresses barriers to prosecution of FGM and raising awareness of the need to intervene early to prevent FGM. The report also highlights how the social care agencies, the department for education, and the police can act together to integrate FGM prevention strategies at local and national level for safeguarding children.

Malala Yousafzai the Pakistani teenager who was shot in the head by the Taliban—recently nominated for the Nobel Peace Prize—has also joined the British campaign to end FGM. The increase in advocacy on this subject by such high profile individuals as Malala is very welcome.

Reference


UK Education Secretary acts against female genital mutilation

Michael Gove, the UK Education Secretary, has made a move that communicates great support from the UK government to the campaign against FGM [1].

The Guardian newspaper embarked on a campaign against FGM that resulted in a petition of almost 250000 signatures condemning this form of abuse against girls and women. The campaign, led by 17-year-old Fahma Mohammed, aimed to get legislation to support teaching about FGM in schools in the UK.

Fahma was able to meet Michael Gove and brief him on the campaign and the effect of FGM on girls. Michael Gove’s response was to pledge to write to all schools in the UK about FGM, drawing the attention of all teachers to the existing guidelines around the issue. The letter will also alert teachers to their responsibility to protect girls in the UK from FGM. The Education Secretary also agreed to consider ways in which age-appropriate teaching about FGM can be done in schools. The Guardian reported Mr Gove as saying: “I was very pleased to meet Fahma Mohamed today. She has been running an inspirational campaign. Fahma and her supporters have done fantastic work in raising awareness of female genital mutilation. It is a truly horrific crime. We must do everything we can to end it.”

The campaign, one of the biggest hosted on Change.org was supported by the United Nations Secretary General, Ban Ki-Moon, as well as by many police commissioners in the UK and the Royal College of General Practitioners.

Reference


World Health Organization guidelines on family planning and human rights

The World Health Organization has released a new publication that addresses the issue of contraception and human rights [1]. These guidelines provide recommendations on how family planning programs can be structured and family planning services delivered in a way that ensures human rights are respected, protected, and fulfilled, while the services are still able to meet program targets and reduce unmet need for contraception. The guidelines are available for free at the WHO publications website.

The guidelines were developed using health data and international human rights laws and treaties. These have all been incorporated into the publication. The new publication addresses the following in relation to contraception and human rights: identification of priority questions and outcomes; retrieval, assessment, and synthesis of evidence; formulation of recommendations; and planning for dissemination, implementation, impact evaluation, and updating.

The WHO website states that the new guidelines are “complementary to existing WHO recommendations for sexual and reproductive health programmes, including guidance on family planning, maternal and newborn health, safe abortion, and core competencies for primary health care.”

The publications seeks to serve as a guide for policymakers, managers, providers, and other stakeholders in the health sector on some of the priority actions that need to be taken to ensure that different aspects of human rights are an integral part of the provision of contraceptive information and services.

While developing the guidelines, there was much debate on whether it was more appropriate to use the word “contraception” rather than “family planning.” The details of this discussion can be found in Rodriguez et al. [2].

The guidelines will be formally launched March 6, 2014, at a side panel at the Council of Human Rights meeting in Geneva, Switzerland.

References


Proteinuria no longer needed in diagnosis of severe pre-eclampsia

The Task Force on Hypertension in Pregnancy, convened in 2013 by the American College of Obstetricians and Gynecologists (ACOG), has recently published their recommendations on the diagnosis and management of hypertension in pregnancy. Using the GRADE (Grading of Recommendations, Assessment, Development, and Evaluation), the group has reviewed the best available evidence and has come up with recommendations on a number of topics. Notable among these is the removal of proteinuria as a prerequisite for the diagnosis of severe hypertension. Drawing from results of recent studies showing a minimal
relationship between the quantity of urine protein and pregnancy outcome, massive proteinuria has been removed from the features needed to diagnose severe pre-eclampsia.

Pre-eclampsia with severe features is now diagnosed when any of the following 6 criteria is present: (1) systolic blood pressure of 160 mm Hg or higher, or diastolic blood pressure of 110 mm Hg or higher on 2 occasions at least 4 hours apart; (2) thrombocytopenia of less than 100,000/mL; (3) impaired liver function indicated with at least twice the normal concentrations of liver enzymes, severe persistent right upper quadrant pain or epigastric pain unresponsive to medications, or both; (4) progressive renal insufficiency with serum creatinine concentration greater than 1.1 mg/dL or a doubling of serum creatinine concentration in the absence of known renal disease; (5) pulmonary edema; or (6) new onset visual or cerebral disturbances. Another change proposed by the recommendations is changing the term “mild pre-eclampsia” to “pre-eclampsia without severe features,” thus emphasizing the continuum of the disease and the continuing risk of women with mild pre-eclampsia.

Reference


Cesarean delivery and the law courts

The issue of cesarean delivery and the law courts generally concerns obstetric malpractice and complications related to the procedure. It is rare for doctors and health services to appeal to the court for permission to carry out a cesarean delivery. However, this rare event has occurred twice in England in the space of 3 months.

In December 2013, a news report appeared of a woman whose obstetricians had applied to the Court of Protection for her to undergo a cesarean delivery [1]. The woman had refused to take her medication for a bipolar mental health disorder and had become “profoundly unwell.” The woman was sectioned under the Mental Health Act and a cesarean delivery was performed 2 months later. A spokesperson for the North Essex Partnership NHS Foundation Trust said that the pregnancy had made it very difficult to treat the patient as “medications would have affected her unborn child.” Following cesarean delivery, social services took the baby into care because the mother was too unwell to care for her child. Essex County Council stated that it had pursued adoption for the child after exhausting all possible alternatives. The lawyer for the woman has described her treatment as invasive and brutal.

In February 2014, another report emerged that after a 5-hour hearing, a High Court judge authorized specialists at the Royal Free London NHS Trust to perform a cesarean delivery for a woman who was suffering from paranoid schizophrenia, had stopped eating, and had tried to kill herself [2]. The woman was 38 weeks pregnant. Doctors applied for permission to carry out the delivery in order that the patient’s “unstable mental state” could be treated. The woman, who was also diabetic, “lacked the mental capacity to regulate her diabetic medicine and monitor her own intake of food and water.”

The Judge said: “The decision to compel a Caesarean section on an incapacitous woman who is mentally and physically ill is an extremely draconian one. Doctors do not embark upon this lightly. It occurs extremely rarely. It is one that the lawyers also take very seriously indeed. I am perfectly satisfied that at the moment [this woman] is not able to make any reasoned evaluation of the advantages and disadvantages of a Caesarean section.”

References


Resources for women’s health

The Reproductive Health Library (RHL) is a regularly updated resource for clinicians and policymakers in women’s reproductive health, maternal health, and newborn health. Some of the new topics addressed by the recent update include:

- Prophylactic interventions for reducing bleeding after delivery of the placenta.
- Inpatient versus outpatient induction of labor to improve outcome.
- School-based education programs to prevent child sexual abuse.
- Maintenance therapy with calcium channel blockers to prevent preterm birth.

The RHL can be accessed at: http://apps.who.int/rhl/en/