

Rural maternity care

I can certainly relate to Dr de Leeuw's article in the July issue of *Canadian Family Physician*.¹

My family practice started in Flin Flon in northern Manitoba in 1972. We safely delivered many babies with GP obstetricians, anesthetists, and surgeons. We had a good rapport with our specialist colleagues in Winnipeg, Man.

I moved to Mission, BC, in the Fraser Valley in 1976 and continued to provide maternity care with my GP colleagues. We had access to specialty care in Abbotsford, BC, but we essentially ran a GP maternity unit. Then the regionalization mentioned in the article occurred. We lost our maternity unit, intensive care unit, and pediatric ward, and with this loss came the dilution and eventual loss of our GP anesthetists and surgeons. I also discontinued obstetric care. These were meaningful losses to our community and women had to go elsewhere to deliver.

However, in 2005, I started providing locums in the Northwest Territories, particularly in Fort Smith, Hay River, and Fort Simpson. Even at that time there was a tendency to electively transfer women to Yellowknife for delivery. The importance of community celebrations around birth mentioned in this article cannot be underestimated. Births in Yellowknife denied families this important cultural event. Fortunately, with the efforts of a group of dedicated midwives supported by traditional midwives, there is a robust midwifery program in Fort Smith and another developing in Hay River. Hopefully more programs will be initiated.

Is there a message for the training programs in support of rural obstetric care? It comes down to effective training and mentoring of students and residents. It means giving the opportunity for GP anesthetists, surgeons, and obstetricians to provide appropriate and safe care in rural settings. It means support for the referral centres and their connections to the rural communities. And perhaps most important, it means support of midwifery and nurse practitioner programs and integration of medical training with their programs. Our rural communities deserve better.

—Chris A. Finch MD CCFP
Vancouver, BC

Competing interests

None declared

Reference

1. De Leeuw S. The missing of mums and babes. Addressing Canada's rural maternity care crisis [Cover Story]. *Can Fam Physician* 2016;62:580-3 (Eng), e415-8 (Fr).

Concern is not based on evidence

The Canadian Task Force on Preventive Health Care strongly recommends against routine pelvic examination screening among asymptomatic women for noncervical cancer, pelvic inflammatory disease, or other gynecologic

conditions.¹ These recommendations are based on moderate-quality evidence that there is no benefit to women from pelvic screening examinations.² Indeed, the Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial involving 78 000 women included pelvic screening for the first 5 years, and dropped the screening when no cancers were identified as a result of this intervention.³ However, there was evidence of harm in other studies, which reported that 1.5% of women received unnecessary surgery (open or laparoscopic) as a result of routine screening pelvic examinations,⁴ and more than one-third of women report fear, embarrassment, anxiety, pain, or discomfort associated with the pelvic examination.⁵⁻¹⁹

Dr Ladouceur laments the possibility that family physicians and residents who follow this recommendation will lose their pelvic examination skills.²⁰ He further speculates that this loss of skill will reduce compliance with cervical cancer screening in Canada, ultimately affecting women's health.

For any busy family physician in an academic or community setting, the need for appropriate pelvic examinations and opportunities for teaching are abundant. As the Canadian Task Force on Preventive Health Care report specifies,

pelvic examination is appropriate in other clinical situations, such as diagnosing gynecologic conditions when women present with symptoms or for follow-up of a previously diagnosed condition.¹

Concern that these recommendations would lead to declining skills and therefore poor uptake of cervical cancer screening is not based on evidence and seems tenuous at best. Studies on the topic have found that barriers to cervical cancer screening in Canada are related to ethnocultural, language, and socioeconomic factors among indigenous and immigrant women, as well as preference for female health care providers, rather than provider skill.²¹

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Dr Ladouceur appeals for a return to artful care, in which evidence does not interfere with clinical judgment. I remind Dr Ladouceur that evidence-based care occurs at the intersecting triad of clinician judgment, best available evidence, and patient values and preferences, all of which underlie the shared decision-making paradigm.²² In mourning the loss of a pointless and potentially harmful routine examination, despite clear values and preferences expressed by women and evidence that it would harm but not benefit women, Dr Ladouceur is not making the case for clinical judgment versus evidence. Rather he has made a case for his personal judgment, which does not appear to be shared by patients or by guideline panels in Canada and the United States.

—Ainsley Moore MD MSc(HB) CCFP
Hamilton, Ont

Competing interests

None declared

References

1. Tonelli M, Connor Gorber S, Moore A, Thombs BD; Canadian Task Force on Preventive Health Care. Recommendations on routine screening pelvic examination. Canadian Task Force on Preventive Health Care adoption of the American College of Physicians guideline. *Can Fam Physician* 2016;62:211-4 (Eng), e117-21 (Fr).
2. Qaseem A, Humphrey LL, Harris R, Starkey M, Denberg TD; Clinical Guidelines Committee of the American College of Physicians. Screening pelvic examination in adult women: a clinical practice guideline from the American College of Physicians. *Ann Intern Med* 2014;161(1):67-72.
3. Buys SS, Partridge E, Black A, Johnson CC, Lamerato L, Isaacs C, et al. Effect of screening on ovarian cancer mortality: the Prostate, Lung, Colorectal and Ovarian (PLCO) cancer screening randomized controlled trial. *JAMA* 2011;305(22):2295-303.
4. Adonakis GL, Paraskevaidis E, Tsiga S, Seferiadis K, Lolis DE. A combined approach for the early detection of ovarian cancer in asymptomatic women. *Eur J Obstet Gynecol Reprod Biol* 1996;65(2):221-5.
5. Golomb D. Attitudes toward pelvic examinations in two primary care settings. *R I Med J* 1983;66(7):281-4.
6. Harper C, Balistreri E, Boggess J, Leon K, Darney P. Provision of hormonal contraceptives without a mandatory pelvic examination: the first stop demonstration project. *Fam Plann Perspect* 2001;33(1):13-8.
7. Bourne PA, Charles CA, Francis CG, South-Bourne N, Peters R. Perception, attitude and practices of women towards pelvic examination and Pap smear in Jamaica. *N Am J Med Sci* 2010;2(10):478-86.
8. Hesselius I, Lisper HO, Nordström A, Anshelm-Olson B, Odlund B. Comparison between participants and non-participants at a gynaecological mass screening. *Scand J Soc Med* 1975;3(3):129-38.
9. Wijma B, Gullberg M, Kjessler B. Attitudes towards pelvic examination in a random sample of Swedish women. *Acta Obstet Gynecol Scand* 1998;77(4):422-8.
10. Armstrong L, Zabel E, Beydoun HA. Evaluation of the usefulness of the "hormones with optional pelvic exam" programme offered at a family planning clinic. *Eur J Contracept Reprod Health Care* 2012;17(4):307-13. Epub 2012 Apr 23.
11. Osofsky HJ. Women's reactions to pelvic examination. *Obstet Gynecol* 1967;30(1):146-51.
12. Hoyo C, Yamall KS, Skinner CS, Moorman PG, Sellers D, Reid L. Pain predicts non-adherence to Pap smear screening among middle-aged African American women. *Prev Med* 2005;41(2):439-45.
13. Taylor VM, Yasui Y, Burke N, Nguyen T, Acorda E, Thai H, et al. Pap testing adherence among Vietnamese American women. *Cancer Epidemiol Biomarkers Prev* 2004;13(4):613-9.
14. Fiddes P, Scott A, Fletcher J, Glasier A. Attitudes towards pelvic examination and chaperones: a questionnaire survey of patients and providers. *Contraception* 2003;67(4):313-7.
15. Yu CK, Rymer J. Women's attitudes to and awareness of smear testing and cervical cancer. *Br J Fam Plann* 1998;23(4):127-33.
16. Broadmore J, Carr-Gregg M, Hutton JD. Vaginal examinations: women's experiences and preferences. *N Z Med J* 1986;99(794):8-10.
17. Haar E, Halitsky V, Stricker G. Patients' attitudes toward gynecologic examination and to gynecologists. *Med Care* 1977;15(9):787-95.
18. Petravage JB, Reynolds LJ, Gardner HJ, Reading JC. Attitudes of women toward the gynecologic examination. *J Fam Pract* 1979;9(6):1039-45.
19. Kahn JA, Goodman E, Huang B, Slap GB, Emans SJ. Predictors of Papanicolaou smear return in a hospital-based adolescent and young adult clinic. *Obstet Gynecol* 2003;101(3):490-9.
20. Ladouceur R. Recommendations for the routine screening pelvic examination. Could they have a negative effect on physician competence? *Can Fam Physician* 2016;62:460 (Eng), 461 (Fr).
21. Redwood-Campbell L, Fowler N, Laryea S, Howard M, Kaczorowski J. "Before you teach me, I cannot know": immigrant women's barriers and enablers with regard to cervical cancer screening among different ethnolinguistic groups in Canada. *Can J Public Health* 2011;102(3):230-4.
22. Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ* 1996;312(7023):71-2.

Outdated approach to a common problem

As a primary care provider with a strong women's health practice that includes obstetrics and low-intervention fertility treatment, I was happy to see a discussion of clomiphene citrate by Davidson et al in the June 2016 issue of *Canadian Family Physician*.¹ While adequately researched, the authors' paper does not fully communicate the small but important risks of clomiphene use and its side effects, nor does it accurately reflect the clinical practice of treatment for anovulatory infertility in Canada today. Further, although letrozole is mentioned, the use of letrozole for ovulation induction is not discussed, and the authors fail to mention that letrozole has a higher rate of pregnancy, lower rate of multiples, and lower risk of intrauterine growth restriction for babies conceived compared with clomiphene.

Although the authors correctly identify the small risk of ovarian hyperstimulation syndrome (OHSS) with clomiphene, they do not convey the seriousness of this complication. Although most cases of OHSS can be monitored closely and treated in an outpatient setting, more serious cases require hospital admission and monitoring.² Complications of OHSS can include renal failure, thromboembolism, and adult respiratory distress syndrome, all of which are life threatening.² The risk of OHSS is low but is increased in women who are younger (<30 years of age), have polycystic ovary syndrome, and conceive during the treatment cycle.² Therefore, the risk is greatest in patients who are the best candidates for clomiphene treatment and, for these patients, the risk is likely greater than the 2 in 1095 quoted by the authors from a meta-analysis of a heterogeneous population. Although most patients who develop OHSS while taking clomiphene will have a mild case, this risk should not be underappreciated or dismissed.

The authors mention a risk of multiple pregnancy from clomiphene of 6% based on a randomized controlled trial. This is lower than a more recently published risk of 11.7% for twin birth and of 1.1% for triplet or quadruplet birth.³ The risk of higher-order multiples was not communicated by the authors and is a considerable risk for patients and their offspring. Although uncommon, a 1% risk of higher-order multiples is an important risk for anyone prescribing clomiphene to be aware of and to adequately counsel patients about selective reduction should higher-order multiples occur.