In Profile: QUARISMA project examines Cesarean rates in Quebec

Critical Context: Child marriage

Update on Listeria and Pregnancy

Talking Postpartum Hemorrhage on Parliament Hill
Because of recent public concerns, the SOGC has produced the following update on Listeria and Pregnancy. This update has been produced and reviewed by the Infectious Disease Committee of the SOGC.

What are *Listeria monocytogenes* and Listeriosis?

*Listeria monocytogenes* is a gram positive bacterium. Listeriosis is a food borne illness that most commonly presents as a self-limited syndrome with fever, malaise, diarrhea, and no long-term sequelae. In certain populations, however, such as pregnant women, the elderly, and immunocompromised individuals, it can lead to serious consequences such as meningitis, sepsis, fetal loss, and death.

How are Humans Exposed to *Listeria monocytogenes*?

*Listeria monocytogenes* is widespread in the environment, and found in soil, vegetation, water, and sewage. It is also found in humans, and has been isolated in the stool of 1%-5% of healthy adults. It may contaminate a variety of foods: uncooked meat and vegetables, raw milk, and processed foods that become contaminated after processing, such as soft cheeses and cold cuts at the deli counter. In certain ready to eat foods such as hot dogs and deli meats, contamination can occur after cooking but before packaging. Contaminated food looks, smells, and tastes normal. Unlike most bacteria, it can survive on food stored in the refrigerator. It is killed with proper cooking and pasteurization procedures.

Many people may be carriers of *Listeria monocytogenes*, but listeriosis is a rare disease in Canada. People who develop listeriosis become ill with symptoms of what most people describe as “food poisoning”. Symptoms may include nausea, vomiting, diarrhea, headache, fever, myalgias, and fatigue. Less commonly, central nervous system involvement can lead to symptoms such as severe headache and neck stiffness. The mild form of the illness usually occurs within 1-2 days of eating the contaminated food, but the serious form can have a long incubation period of 70-90 days.

Pregnant Women

Pregnant women are about 20 times more likely to get listeriosis than other adults, and pregnant women and their babies account for about one third of all cases. Infection early in pregnancy may result in spontaneous abortion. Infection in the third trimester leads to the highest risk of invasive disease, with an increased risk of bacteremia. For the majority of pregnant women who develop listeriosis, the fetus will also be infected. In most cases, the fetus or newborn is more likely to experience severe manifestations of listeriosis. About one fifth of infections result in stillbirth or neonatal death, and two thirds of surviving infants develop clinical neonatal listeriosis.

Infected pregnant women ordinarily experience only a mild, flu-like illness manifesting as fever, chills, headache, and myalgias. They may also have gastrointestinal symptoms such as nausea, vomiting, and diarrhea, or a more severe sepsis syndrome.

Diagnosis

Testing for asymptomatic pregnant women who believe they may have ingested...
It has recently come to our attention that fetal scalp blood sampling kits sold by GE Healthcare are no longer available. Although the issue is unclear, its discontinuance is allegedly related to the issue of using unfractionated Heparin in capillary tubes. This existed, in part, in relation to keeping capillary intravenous lines flushed open in neonates. The two are very much unrelated. Nevertheless, a safety concern has arisen.

SOGC is currently working with HIROC in an attempt to find a solution, and GE Healthcare has also been contacted on the issue. In the meantime, should you experience difficulties in renewing fetal scalp sampling stock orders, LiNA medical produces a fetal blood scalp sampler. To receive additional information about this product, members are encouraged to contact the product distributor, Superior Medical Limited, available by phone at 1-800-268-7944, or by email at info@superiormedical.com.

Fetal scalp sampling is considered an integral part of intrapartum surveillance, useful for avoiding a Cesarean section. It is referred to in algorithms of our Fetal Health Surveillance Guideline, released in September 2007 as a special supplement to the Journal of Obstetrics and Gynaecology Canada (SOGC Clinical Practice Guideline Number 197 – available online at www.sogc.org).

The SOGC will continue to provide updated information on this issue through our website, www.sogc.org. SOGC members are urged to consult the website for additional information relating to the availability of these kits.
Upcoming Meetings

SOGC Meetings

4th Quebec in Obstetrics CME
November 13–14, 2008, Montreal, Quebec

27th Ontario CME
December 4–6, 2008, Toronto, Ontario

22nd International CME
March 2–6, 2009, Cancun, Mexico

ALARM

Program Schedule

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<td>Toronto, ON</td>
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(in conjunction with W/C CME)
(in conjunction with GYN CME)
(in conjunction with ACM)

Other Meetings

Hosted at the Radisson SAS Oslo Plaza Hotel, Oslo, Norway. For more information, visit www.stillbirthalliance.org/conference/2008.

8th Annual General Meeting – Canadian Association of Midwives. November 12–14, 2008, Delta Hotel, Québec, QC. For complete details visit www.canadianmidwives.org.

Napa 2009: Urogynecology and Female Urology Course. Jointly offered by the Urology Department of McGill University, the Obstetrics and Gynecology Department of Queen's University and the Cleveland Clinic. Hosted May 21–24, 2009, Napa Valley, California. For complete details visit www.urogyne2009napa.com.

Register ONLINE at: www.sogc.org

In association with l’Association des omnipraticiens en périnatalité du Québec (AOPQ)

4e Quebec CME
in Obstetrics

Preconception to post-partum

In the heart of the vibrant cultural and commercial district of Montreal, you will find the most grandiose and gracious hotel in the city, the Fairmont Queen Elizabeth. Join us for this friendly congress to acquire knowledge and skills for the progression of your day-to-day practice!

November 13–14, 2008

Conference Site: Fairmont The Queen Elizabeth Montreal
900 René-Lévesque West, Montreal, QC
Fairmont Room: $179 single/double occupancy;
Reserve before Friday, October 10, 2008
Tel.: (514) 861-3511 or 1-800-441-1414
Group code: SOGC

This program is offered in French.

THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA
780 Echo Drive, Ottawa, Ontario K1S 5R7
Tel: 1-800-561-2416 or (613) 730-4192 Fax: (613) 730-4314 events@sogc.com www.sogc.org
In association with the Ontario Society of Obstetricians and Gynaecologists

27th ONTARIO CME
DECEMBER 4–6, 2008
Marriott Downtown Eaton Centre, Toronto

Updated Scientific Program
visit us www.sogc.org or email us at events@sogc.com

ALARM Course
Limited space for the ALARM course – please check availability before registering!

Program offered in English

Hotel Reservations: Toronto Marriott Downtown Eaton Centre
525 Bay Street, Toronto
Standard room: $155 per night single/double occupancy
Reserve before: Monday, November 3, 2008
Tel.: 1-800-905-0667
Group code: SOGC

Note: Rates will not be available after the deadline date and/or once the room block is sold out.
**RN REPORT:** Welcoming our new Ontario representative, Laura Payant

By Margaret Quance, Chair, RN Advisory Committee

The RN Advisory Committee is pleased to welcome its newest member, Laura Payant. Laura is replacing Ann Holden who ably represented RNs from Ontario for several years.

Laura holds a BScN (1988) and MScN (2006) from the University of Ottawa. She has many years of experience in the perinatal setting as a staff nurse and team leader in a tertiary level birthing unit. Laura has also worked as a perinatal research coordinator. Currently, she is a perinatal coordinator for the Perinatal Partnership Program of Eastern and Southeastern Ontario (PPPESO).

Laura not only holds a membership in SOGC, but also RNAO and AWHONN Canada. She explains that such memberships allow her to maintain currency on the standards of practice and education, but also provides opportunities to network with other experts who can provide a tremendous wealth of resources. As a member of the RN Advisory Committee, she feels she can play a part in standardizing education and practice as well as translating knowledge into practice at the bedside. Laura is currently working with the committee that is looking to standardize fetal health surveillance education in Canada.

Laura was the first author of a publication titled “Nurses’ intentions to provide continuous labour support to women” in the July/August 2008 issue of Journal of Obstetric, Gynecologic and Neonatal Nursing, JOGNN. This article reflects her on-going clinical research interests of labour support for women in childbirth and the labour support needs of women with epidural anaesthesia.

Laura balances her professional life with mothering two children, 12 and 17, teaching, exercise and tole painting. Laura brings a wealth of expertise to the RN Advisory Committee. RN members of SOGC in Ontario may contact Laura at lpayant@pppeso.on.ca with any issues or concerns.

**2009 MEMBERSHIP RENEWAL Is Coming to You!**

It’s that time of year again! In October, you should receive your 2009 SOGC membership renewal form. Or, you can log on to www.sogc.org to renew your membership quickly and easily online. While you are renewing, please remember to make any necessary changes to your membership profile to help us serve you better.

With your continued support, the Society can remain strong, sustain growth and continue to effectively represent you, our members. Our strength is in our membership, and without you, our continued success would not be possible.

The SOGC would like to remind you that special consideration will be given to SOGC members who are:

- on special leaves such as maternity, health, prolonged education or prolonged sick leave;
- married/common law individuals who are both physicians.

If you have any questions or concerns related to membership or to your subscription to the Journal of Obstetrics and Gynaecology Canada (JOGC), please do not hesitate to contact Linda Kollesh, Membership & Subscription Services Officer at lkollesh@sogc.com.

**NEW MEMBERS**

Welcome, New Members

The SOGC is pleased to welcome some of the newest members of our society:

**Ob/Gyn Member:** Dr. Anna Katarzyna Chomej; Dr. Mohammad Anwar Paurobally;

**Junior Member:** Dr. Marie-Pierre Bedard; Dr. Rati Chadha; Dr. Vincent Della Zazzera; Dr. Dawn Edgar; Dr. Jessica Lefebvre; Dr. Sephora Anne-Marie Pierre; Dr. Laura White;

**Junior Member – Family Practice:** Dr. Maryse Lavoie;

**Associate Member – Midwife:** Mrs. Sandra Livia Gervais, RM;

**Associate Member – RN:** Ms. Jennifer Ann Collette, RN; Ms. Joley Johnstone, RN; Ms. Caroline Lefebvre, RN; Ms. Kim Ann Sheehan, RN; Ms. Carol Mary Suthers, RN;

**Associate Member – Allied Healthcare Professional:** Dr. Patricia Powell;

**Associate Member – MD:** Dr. Catherine Laurendeau; Dr. Jill Newstead-Angel; Dr. Rua Louise Read; Dr. Grover Wong;

**Associate Member – Students in Healthcare Training:** Ms. Desiree Boudreau; Ms. Lindsey Forest; Ms. Kristen M. Godin; Ms. Meghan Marie O’Mara; Mr. Chandrew Rajakumar; Ms. Robin Ryan; Ms. Suzanne Turner.

**SOGC is thinking Green!**

Online Membership Renewal… help us do our part!

The SOGC is implementing a new system for online membership renewal that will reduce paper waste and make renewing your membership a snap. Please refer to the enclosed flyer to learn more about this exciting initiative.
Greetings to All! It has been an exciting year at Sherbrooke! To begin, we would like to congratulate some of our residents on major milestones this year. Our two senior residents, Jack A. Long and Carolyne Gervais, did well in their Royal College exams and have joined the healthcare teams of Victoriaville and Shawinigan, respectively.

Also, two of our residents presented research projects at this year’s SOGC Annual Clinical Meeting in Calgary. Sylvain Ménard won second place in the Best of Four Posters in gynaecology with his University Update: UNIVERSITY OF SHERBROOKE
By Drs. Julie Boucher, PGY-2, and Mélanie Arbour-Levert, PGY-4

Retrospective Study on the Efficacy and Satisfaction towards the Original Hysteroscopic Sterilisation with Essure Micro-inserts, and Korine Lapointe-Milot, presented her study entitled Closure of the Uterine Incision with One or Two Layers after Cesarean Section: A Randomized Controlled Study in Sheep. Congratulations to you all.

We also have some new program changes to report this year. A new course for PGY-1s is now offered by PGY-5s on current techniques in obstetrics-gynaecology. The course covers techniques such as the placement of Word catheters, intra-uterine devices, internal fetal heart monitor electrodes, and internal contraction monitors, to name but a few. The response from our PGY-1s has been clear - they love the new course.

On a social note, it has been a very fertile year for us here at Sherbrooke! Congratulations to Fanny Lamb and Julie Boucher, who gave birth to beautiful boys; Isabelle Girard, who became the proud mother of twin girls; and Justine Ouellette just gave birth to a daughter in July. Also, congratulations are in order for Korine Lapointe-Milot and Sandrine Dionne, who are expecting, and Evelyne Raîche, who was married in September.

From all of us at Sherbrooke, we wish you an excellent year!

THE SOGC-JSOG EXCHANGE PROGRAM

The SOGC would like to congratulate Dr. Heather Cockwell, Dr. Ariadne Daniel and Dr. Caroline Laroche, who were selected to visit Japan to attend the Japan Society of Obstetrics and Gynecology (JSOG) meeting, hosted in April in Yokohama, Japan. The three were part of a larger delegation from the SOGC. The exchange is part of a regular partnership between the SOGC and JSOG. A delegation from Japan also had the opportunity to take part in the SOGC Annual Clinical Meeting hosted in Calgary this past June.

Visit the Junior Members section of www.sogc.org to learn more about the SOGC-JSOG Partnership, or to read the full report submitted by Drs. Cockwell, Daniel and Laroche from their time in Japan.

WHAT’S YOUR STORY?

The SOGC News wants to hear from you, our membership! Each issue, the SOGC News publishes articles, profiles, and features highlighting the latest news in obstetrics and gynaecology. We love to hear about innovative new programs or approaches to ob/gyn care that tell us what’s new, where we stand as a specialty and where we are headed. We also love to highlight our members’ achievements and contributions to the specialty, and to the health of Canadians. So, if one of our members is winning an award, pioneering an innovative new approach to care, or simply deserves recognition for a distinguished career, we want to hear about it!

If you have a story that you think Canada’s healthcare professionals in ob/gyn would like to read about, let us know. All of our readers are encouraged to send submissions, articles or story ideas for the SOGC News to Mike Haymes, Editor of the SOGC News, by email at mhaymes@sogc.com, or toll-free by phone at 1-800-561-2416 ext. 325.

Drs. Heather Cockwell, Caroline Laroche, and Ariadne Daniel travel to Japan as part of an SOGC exchange program with the Japan Society of Obstetrics and Gynecology.
Earlier this year, the SOGC News issued a call to Junior Members to share their most interesting on-call experiences. Below, the SOGC News is pleased to publish this submission by Dr. Ciaran Goojha, a resident at the University of Saskatchewan.

Books can only teach you so much. As a medical student, a professor once told our class to be careful about spending inappropriate time in the library at the expense of being at the bedside. Medical school and residency challenge all of us to excel as scholars. At times, the information and skills necessary to practice seem never-ending. However, our pursuit of knowledge and mastery of skill must be balanced between reading books and being at the bedside of our patients. I learned this early in my clinical rotations as a medical student, and continue to practice by it today as a resident in obstetrics and gynaecology. Although reciting the staging of gynaecological cancers is necessary and important, one must also be able to provide reassurance, support, and empathy for a woman experiencing a term IUFD. This is not taught in the books. You adapt to your patient’s needs at the bedside. Patients are all different. Listen to and learn from your patients – in the end, they will always provide you with more information than you could possibly provide to them.

As a first year resident, I once had a conversation with the Chief Resident regarding tips on approaches to studying, suggestions of books to purchase, and so on. She told me, “You will not have time to read in second year, you will be too busy.” This seemed absurd to me at that time. No time to read — how am I supposed to learn? She was right though. PGY-2 was completely overwhelming at the beginning and call was relentless. If you were not preparing for a night on-call, you were recovering. The cycle continued for months. Before I knew it, six months went by and I hardly opened a book. However, I learned more in that time than I have in my entire time in medicine. Books can only teach you so much. My patients provided all my learning experiences, and I easily achieved my learning objectives, without opening a book. Don’t get me wrong, residency is a time to become well-versed in all the suggested textbooks, and one must take the time to do this.

But, books can only teach you so much. Seriously. Here is an example. A few months ago, early in my PGY-3 year, I got a consult while on-call. The pager rang with the same irritating sound, but the number was not one I recognized. I answered promptly, and discussed the case with a nurse on the other line. The call was from the oncology ward. At this stage of residency, I had little experience with oncology patients. However, as a PGY-3, my responsibility and expectations have increased, and there seems to be more time to read. We were asked to consult for the hematology service. The patient was a young, G0P0 woman. Her working diagnosis was Acute Myeloid Leukemia. The details of this disease rang a bell in my head, but it had been a while since I came across a patient with this condition. She was unwell and very upset with this news. She was unwell and very upset with this news. We were asked for our opinion and counseling regarding chemotherapy and fertility preservation. As I mentioned, at this stage of my residency, exposure to oncology was limited, but I felt as a PGY-3 that I should be able to counsel this woman appropriately. It was not an urgent call. I took a few minutes to familiarize myself with AML and fertility preservation with chemotherapy. Books (and Up To Date) can teach you a lot. I thoroughly read the chart. I wanted to provide all the facts and options available to this woman regarding her fertility. I proceeded with my history and physical exam. The patient was scared, frustrated, and expressed feelings of hopelessness. Her husband was visibly upset. The news they received over the last few days was very surprising and overwhelming. Doctors from various services were asked for their opinion on management. I realized that this young woman wanted specific information from me regarding fertility and chemotherapy. I gave her the facts, figures, and support to the best of my ability. It was a difficult consult — telling a patient who desperately wanted children that her fertility potential would be decreased was a very hard thing to do.

The attending physician on-call suggested we review this case during the weekly REI teaching rounds. The residents all discussed options for fertility preservation in women undergoing chemotherapy. This patient provided all of us with an opportunity to apply our knowledge from the books we read to a real life situation. Again, books can only teach you so much.

One week later, we got the unfortunate news that our patient passed away. It was a shock to me. I had become so focused on providing the proper information as her obstetrician, ensuring I gave her accurate counseling and options. I confirmed this after discussing the case with my colleagues in teaching rounds. I have to admit, I lost sight of one thing — she was a patient with a severe illness, with many issues besides fertility preservation. The low platelet count associated with her condition made her susceptible to catastrophic bleeding. She fell down in her bathroom, hit her head, and passed away from a severe intracranial hemorrhage.

I think about this patient often and everything she taught me. You will never find this in a book. As specialists, we have a duty to provide expert advice and counselling to our patients. However, we are only part of a multidisciplinary team, each caring for a particular aspect of our patients’ health concerns. I will always keep this in mind: Some of our patients face hurdles we cannot even imagine, but we must be aware of them. Of course fertility preservation was very important to this patient’s management, but it was only a small component. Don’t get me wrong, I will continue to tackle the texts by Williams, Berek and Hacker, Sporoff, and so on. I will also keep my eyes and ears open and listen to my patients, follow their course, and learn from each encounter. Books can only teach you so much.
‘TILL DEATH DO US PART’: Understanding the sexual and reproductive health risks of early marriage

Childhood and adolescence are usually the greatest years of one’s life. This period is cut short, though, when marriage and adult responsibilities come too early. Although most nations have declared 18 as the legal minimum age to enter into marriage, in many developing countries the practice of girls being married before this age is widespread. In 2002, the Population Council predicted that over the following decade more than 100 million girls worldwide would marry before their 18th birthday. Some of these girls will marry as young as eight or nine, and many will marry against their will.

There are many consequences of child marriage on young girls’ sexual and reproductive health, and many of the meaningful life experiences of adolescence are lost forever.

(Not so) Good Intentions

The decision for a young girl to marry is most often made by her parents or the community. Social and gender norms, cultural beliefs and economic situation all contribute to the pressure put on girls to marry at a young age. Some parents believe that, by marrying their daughter at an early age, they are helping her to fulfil her main societal function — that of wife and mother. They may also believe that they are providing her with protection by limiting sexual relations to only one partner (and therefore reducing the risk of STIs and HIV), and by ensuring some kind of financial stability for both the daughter and the family.

No matter how good their intentions may be, the reality is that an early marriage generally offers no protection at all — in fact, the opposite is generally true — and many young girls are stripped of their childhood, their dreams, their basic human rights, and their health.

Sacrificed Health

Whereas parents may believe they are protecting their daughter from STI and HIV transmission, they are typically putting their child even more at risk. Husbands are often considerably older and have more experience with sexual relations, sometimes joining into marriage already infected with STIs or HIV. Studies in parts of Kenya and Zambia show that teenage brides are contracting HIV at a faster rate than sexually active single girls in the same location.

Child brides face much pressure to have children soon after marriage, which not only interrupts efforts to reduce STI transmission through use of condoms, but also puts the girl at an increased risk of maternal death. Girls between the ages of 15 and 19 are more likely to experience complications during pregnancy and childbirth, including obstetric fistula. They are also more likely to have children with low birth weight, inadequate nutrition and anemia. The health of these young mothers is further compromised, as they are more likely to develop cervical cancer later in life.

Powerless

The lack of power associated with child marriage poses additional reproductive health risks. Young wives often have limited autonomy and freedom, and are unable to negotiate sexual relations, contraceptive use, childbearing, and other aspects of domestic life. The inability to negotiate condom use puts them in a vulnerable position for contracting STIs and HIV.

Unequal gender norms and the large difference in age between husbands and young wives also increases the likelihood of domestic violence. Women who marry young are more likely to be beaten or threatened, and are most likely to believe that a husband’s violence is justified.

Isolated

Once married, the young girl is typically forced to leave her family, friends and community behind and move to her husband’s home. Her ability to attend school is disrupted, eliminating yet another source of social support and continued education. With limited freedom to leave the home and converse with others, the girl is left in isolation with little or no means of receiving information on reproductive health issues. She is often powerless to access health care services, as she may be required to ask permission to receive

Child marriage is a violation of a girl’s sexual and reproductive rights, which include the right to:
- The highest attainable standard of sexual health
- To be free from coercion, discrimination, violence and abuse
- Consensual sexual relations
- Pursue a satisfying, safe and pleasurable sexual life
- Choice of partner and consensual marriage
- Seek, receive and impart information and education related to sexual health, including information on how to protect themselves against unwanted pregnancy, STIs and HIV/AIDS
- Deciding freely and responsibly the number, spacing and timing of her children and to have the information and means to do so
- Access to sexual and reproductive health services. (Married girls seeking sexual and reproductive health services are often turned away from health facilities because they require the consent of the husband before care is provided).

“Married adolescents have been largely ignored in development and health agendas because of the perception that their married status ensures them a safe passage to adulthood. Nothing could be further from the truth.”

— Thoraya Ahmed Obaid, UNFPA Executive Director

(Continued on page 10)
Critical Context
Understanding Women’s Sexual and Reproductive Health and Rights Internationally

Marking Ten Years of the SOGC’s International Women’s Health Program

(continued from page 9)

such services, and, if refused, she is typically unable to pay for health care on her own. Without health information or social services, the girl is unable to seek support. Her problems remain unknown or ignored by the community and she becomes an invisible victim.

Dream No More

Early marriage results in a loss of childhood. The girl is inhibited from realizing her dreams and aspirations. Her rights are violated and she loses the ability to choose how her life is fulfilled. Her right to choose when she becomes pregnant and how many children she will have is no longer hers. Her sexual and reproductive health is sacrificed, sometimes to the point of taking her life.

In some countries, the majority of girls are married before the age of 18:

- Niger 76%
- Democratic Republic of Congo 74%
- Nepal 60%
- Afghanistan 54%
- India 50%

Change is Difficult

Changing social and gender norms is never easy. Families and communities, including boys and men, need to understand the risks associated with child marriage and become engaged in the process of making change. Powerless and isolated, married girls are in need of our support. But what can be done?

Providing opportunities for girls to continue their education or earn money is one strategy to delay marriage, while expanding their skills and available choices in life. In Bangladesh, the implementation of a secondary school scholarship program for girls resulted in a declined rate of early marriage. The expansion of schooling and provision of job training helps to increase the autonomy and freedom of girls.

Although laws forbidding early marriage exist in most countries, much effort is still needed to ensure enforcement of such laws.

Further work needs to be done to reduce the barriers young women face in seeking out health services and information outside their marital households, including access to family planning programs.

Youth programs are effective in educating and empowering young women (as well as young men) about reproductive health and rights. Such programs should be encouraged and available not only in schools, but in communities and rural areas as well.

Public education and advocacy projects which target policy-makers could be useful in preventing early marriage and also in making visible the problems and risks that young brides face.

No matter what efforts are used to install change, one thing remains certain: young girls’ health, education, social and economic needs should be addressed holistically and simultaneously. In addressing change in attitudes amongst communities, cultural and religious traditions need to be considered and integrated into the solution.

“I was promised to a man before I was 10. It was a traditional wedding. When the time came, I was sent over to my husband’s family. And when I saw him, I realized he was older than my daddy.”

— Excerpt from the film Too brief a child

Knowledge is power.

Menopause can be a challenging time of life for some women. So many changes and, understandably, so many questions.

The menopauseandu.ca website was created by the Society of Obstetricians and Gynaecologists of Canada (SOGC) as a reliable, reassuring source of information. Complete and clinically approved, it details the symptoms of menopause and perimenopause and offers practical management strategies.

Downloadable fact sheets on key topics such as lifestyle, sexuality, bladder health, cancer, osteoporosis, and hormone therapy are available.

Empower your patients:
menopauseandu.ca

Menopause Education and Awareness Program
Your change. Your life. Take charge.
contaminated products is not routinely recommended. For women with symptoms, a full clinical evaluation for all differential diagnoses is important, including two aerobic and anaerobic blood cultures for *Listeria monocytogenes*. The diagnosis is confirmed by positive blood cultures. Antibody testing is not recommended as it has not proven useful for the diagnosis of acute listeriosis. In the setting of an outbreak, or following ingestion of suspected contaminated products in a woman with symptoms (gastroenteritis or threatened labour) without fever, some provinces recommend that stool cultures for *Listeria monocytogenes* be performed. In strongly suspected cases with negative blood cultures and intact membranes, amniocentesis may be considered. In suspected cases, the placenta should be sent for pathologic testing after delivery.

**Treatment**

In the setting of an outbreak, empiric therapy may be considered for women presenting with fever in labour or threatened labour, or women with fever and uterine irritability.

For women with gastroenteritis and no other systemic symptoms with proven or suspected listeriosis, oral therapy can be considered. The recommended oral treatment is Amoxicillin 1-2 grams daily, divided into three doses, for 14 days. In patients with a history of penicillin allergy, an alternative is Erythromycin (not estolate form).

For women who are systemically unwell with fever and associated symptoms, treatment is recommended with high dose antibiotics. The agent of choice is ampicillin. Most experts recommend adding gentamicin to the treatment of pregnant women. Trimethoprim-sulfamethoxazole is an alternative for penicillin-allergic patients. Cephalosporins are ineffective and should not be used. Bacterial pregnant women should be treated for 2 weeks, and longer durations of therapy are sometimes required in complicated infections. Infected women do not need to be isolated unless they have gastrointestinal symptoms (diarrhea, vomiting).

Infants exposed to infected mothers need to be evaluated and possibly treated. Consultation with a Pediatrician or Pediatric Infectious Disease Specialist is recommended.

**Antibiotic Dosing**

- Amoxicillin 2 grams IV q4h x 2 weeks
- Gentamycin 2 mg/kg IV loading dose, then 1-2 mg/kg IV q8h x 2 weeks
- Trimethoprim-sulfamethoxazole 5 mg/kg IV q6h x 2 weeks

**How can Listeriosis be Prevented?**

**General Recommendations**

- Wash hands with soap and water after handling raw food
- Read and follow all package labels and instructions on food preparation and storage
- Clean and sanitize all surfaces used for food preparation after handling raw foods
- Clean all utensils after use with raw foods before reusing them
- Thoroughly clean all fruits and vegetables before eating
- Do not defrost food at room temperature
- Keep leftovers for a maximum of 4 days, and reheat them to an internal temperature of 74°C (165°F) before eating
- Keep refrigerator temperature at 4°C (40°F) or below
- Frequently wash and disinfect the refrigerator

**Additional Recommendations for Pregnant Women**

- Eat hot dogs only after heating to steaming hot. Do not eat hot dogs directly from the package as the fluid in the package may contain *Listeria monocytogenes*. Avoid spreading fluid from the package, and wash hands after handling fluid or hot dogs.
- Avoid eating non-dried deli meats.
- Avoid eating soft and semi-soft cheeses such as brie, camembert, feta, and blue-veined cheese if they are made from unpasteurized milk.
- Avoid eating refrigerated pate and meat spreads. Canned pate and meat spreads may be eaten.
- Avoid eating refrigerated smoked seafood and fish. Canned smoked seafood and fish may be eaten.
- Avoid eating raw or undercooked meat, poultry or fish.

A Smear Campaign Against Cervical Cancer

The Federation of Medical Women of Canada (FMWC) is launching a Pap test campaign during Cervical Cancer Awareness week October 27-31, 2008. Women who do not have a family doctor or gynaecologist will be able to drop-in or book an appointment with participating doctors during this campaign.

“Cervical cancer remains a significant problem,” says Dr. Kathleen Gartke, FMWC President. “The Canadian Cancer Society predicts that there will be 1300 new cases of cervical cancer diagnosed in Canada this year. The tragedy is of course, that up to 90% of these cases could be prevented through regular screening programs (Pap test).”

According to the FMWC, every Canadian woman should have access to Pap testing to protect themselves against cervical cancer. The Pap test detects abnormal cells in the cervix before they become cancerous and when they are easily treatable. Not enough women are getting the Pap test. According to the Public Health Agency of Canada, 15% of women have never been screened; 30% have not been screened in the last 3 years! There are multiple reasons for this including Canada’s doctor shortage.

This campaign is primarily targeting women who do not have family physicians. For those who do, the FMWC hopes that this campaign will serve as a reminder to book a Pap test with their own doctor. A list of participating doctors and clinics will be posted on the FMWC website at www.fmwc.ca.

“While new HPV vaccines may prevent up to 70% of cases of cervical cancer in the future, there is no substitute for a Pap test for early diagnosis,” said Dr. Gartke.

For more information about the campaign, or if you would like to participate (all doctors are welcome), please contact Susan Dallin O’Grady, FMWC Executive Coordinator, at 1-877-771-3777 or by email at fmwcmain@fmwc.ca. Additional information is also available at www.fmwc.ca.
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ELECTION QUESTIONNAIRE SURVEYS POLITICAL PARTIES on domestic, global health issues

In preparation for the recent election, the SOGC produced and distributed a new election questionnaire to Canada’s major political parties, surveying them on several key domestic and global health issues.

The questionnaire polled Canadian political parties on their platforms relating to important issues such as abortion, Aboriginal health, sexual and reproductive health, international assistance, maternal health, and Canada’s commitment to achieving the Millennium Development Goals. The questions were posed to the Bloc Québécois, Conservative, Green, Liberal, and New Democratic parties.

The questionnaire was produced as a joint project between the SOGC, the Canadian Federation for Sexual Health, and Action Canada for Population and Development. The document has been distributed to SOGC members, and is available through the SOGC website, www.sogc.org. Responses received from the parties will also be made available through the website.

TALKING POSTPARTUM HEMORRHAGE on Parliament Hill

On November 3rd, 2008, the SOGC will be hosting a round table discussion in the West Block of Parliament Hill to highlight the important topic of postpartum hemorrhage (PPH) around the world. The focus of the event will be on innovative low-cost solutions to help reduce PPH, which is one of the major contributing factors to maternal mortality worldwide. The event is open to the public and media, and will be hosted by The Honourable Lucie Pépin, Canadian Senator and corresponding member of SOGC’s Executive Council.

The round table discussion will include feature talks by experts on the topic including SOGC Executive Vice-President Dr. André Lalonde, as well as expert spokespersons from the International Confederation of Midwives (ICM), The Prevention of Post Partum Hemorrhage Initiative (POPHI) and Gynuity Health Projects. For more information about this event, please visit the SOGC website at www.sogc.org, or contact Christine Butt, Communication/Promotion & Special Projects Officer for SOGC’s International Women’s Health Program, at 1-800-561-2416 ext. 236, or by email at cbutt@sogc.com.

A VISIT FROM OUR PARTNERS IN HAITI

The SOGC recently had the pleasure of hosting a visit from Ms. Wesline Juste, Administrative Assistant of the Société Haïtienne d’Obstétrique et de Gynécologie (SHOG) and Dr. André Lalonde, SOGC Executive Vice-President.

The visit allowed for a better understanding of the internal working of the organization and its different programs. Working closely with the IWHP team, she was able to finalize a budget and report for the Croix des Bouquets project, learn about effective management of administrative tasks, finalize details pertaining to our partnership program with Haiti, and create a new SHOG website.

The Partnership Program, funded by the Canadian International Development Agency, aims to strengthen the capacity of national organizations by providing them with technical assistance, training, financial support and educational materials. The outcome is beneficial to both partners. As we have seen from our visit from Wesline, we are just as grateful for the learning experience that she has given us, as she is for the professional development training she received during her visit at SOGC.
IN PROFILE: THE SOGC’S QUARISMA PROJECT
(Quality of Care, Management of Obstetrical Risks and Birthing Mode in Quebec)

The QUARISMA research project, undertaken jointly by the SOGC and Ste-Justine University Hospital Center, is designed to assess the impact of professional training on the reduction of C-section rates in 16 Quebec hospitals.

The Issue
Canada’s C-section rate has risen steadily since the mid 1990s, causing concerns that this is also leading to increased risks during pregnancy.

- In Canada, C-section rates increased from 21.2% in 2000 to 23.7% in 2003.
- In Quebec, it increased from 18.5% in 2000 to over 22.6% in 2004.
- The World Health Organization (WHO) recommends that no more than 15% of births should be performed by C-section.
- In Quebec, a small feasibility study focusing on three hospitals in 2005–2006 found that 38% of the assessed C-sections could have been avoided.

Several studies have highlighted an increase of maternal and prenatal morbidity associated with a C-section.

The main objectives of QUARISMA are:
- An optimal management of the birthing mode;
- The continuing improvement of the quality of obstetrical services;
- A decrease of C-sections identified as avoidable according to the clinical practice guidelines in effect;
- A decrease of the maternal and fetal morbidity among women who are at low risk of complications;
- A decrease of lawsuits through the improved quality of obstetrical services.

Structure of the project:
Founded on the concepts of evidence-based practice, the QUARISMA project will offer SOGC-led training in optimal practices relating to the decision to offer a C-section.

Thirty-two Quebec hospitals will participate in the research project. Training will be offered at 16 of these hospitals, and the remaining hospitals will be studied as controls. Training programs are based on SOGC’s peer-reviewed clinical guidelines.

Training will commence in April 2009 and will be completed over the following year. Health indicators from all 32 hospitals will be collected and ongoing analysis will assess the impact of this training on health outcomes. Results of the project will help to inform policy decisions about training protocols relating to C-section.

Next Steps
Currently, a team of experts is working to review the nine principle SOGC clinical guidelines upon which the training will be based. These guidelines will be reviewed by two special committees, one consisting of Quebec experts, and a second consisting of international experts. These committees will include multidisciplinary members specializing in maternity care, including representatives from ob/gyn, midwifery and nursing. Following the review process, an intervention manual will be developed for the hospitals participating in the experimental group that will offer the training. A list of instructors will be determined. They be responsible for establishing the training programs in the hospitals participating in the experimental group. The training of the instructors will begin in January 2009, so that instructors are prepared to begin offering the training in April 2009. To further evaluate the training components, a special pilot training program will take place in Montreal in January 2009.

For more information about the QUARISMA Project, please contact Hélène Langlois, Project Manager, at 1-800-561-2416 ext. 370 or by email at hlanglois@sogc.com.

MyObClinic.ca

MyObClinic.ca is a web-based tool designed by the SOGC to help busy health professionals create their own websites.

MyObClinic shows you how to:
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- Post maps to your clinic
- Share important health information and updates

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The SOGC Review, One Year Later

By Becky Skidmore, Medical Research Analyst

Since launching our newest online service, the SOGC Review: Evidence-Based Research one year ago, members have raved about this monthly compilation of evidence-based research. Sent directly to members’ email, the SOGC Review includes citations, brief summaries, ratings and commentaries of important items in the field of obstetrics and gynaecology. The information is derived from a variety of monitoring services, including but not limited to BMJ Updates (McMaster), the Centre for Reviews and Dissemination at University of York, Medscape Best Evidence, the National Electronic Library for Medicines, the National Guideline Clearinghouse, listservs and various table-of-contents services.

The SOGC Review is an extremely important vehicle for tracking clinical and research issues relevant to its members and the Society is delighted with the positive impact it has had to date. The program is an important tool for giving our members a quick at-a-glance update on the latest clinical research.

By far, the most frequently requested enhancement to the SOGC Review is the ability to access the full text of these citations. While links to publicly available materials are always included, access to subscription-based resources is not possible due to copyright or proprietary restrictions. Here is a list of possible, alternate sources (let us know if we’ve missed anything):

- Hospital library
- University library
- CMA’s Clinical Resources journal collection (available to CMA members)
- Various association or personal memberships

Also, if you live in New Brunswick, Nova Scotia, Saskatchewan, Northwest Territories, Nunavut or the Yukon, The Cochrane Library is available free to all residents.

As always, we love to hear our members’ feedback about our projects. We hope that you enjoy this service, and we will continue to refine the SOGC Review based on your comments.

For further information, or to comment on the SOGC Review, please contact us by email at bskidmore@sogc.com.

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