Iodine supplementation is recommended for all pregnant women. 150ug/day should be taken during pregnancy & for the duration of breast feeding. Supplements are available in multivitamin formation (e.g. elevit, blackmores pregnancy vitamin), in combination with folate (i fol), or now on its own (neurotabs).

Testing for Gestational Diabetes in Pregnancy

Perinatal Practice Guidelines changed in August 2015. All pregnant women will now have a GTT (75gm load) at 28 week gestation, and earlier, if risk factors for GDM. In South Australia, the diagnosis of gestational diabetes is confirmed and indicates the need for dietary advice and home glucose monitoring, if one or more of the following values are elevated:

- a fasting venous glucose ≥ 5.1 mmol / L
- 1 hour venous glucose ≥ 10.0 mmol/L
- 2 hour venous glucose ≥ 8.5 mmol / L (Nankervis 2013)

Please note, Pathology reports may not contain new reference ranges for pregnancy so these need to be referred to when reviewing results. If an early GTT is normal, repeat GTT at 26-28 weeks.

Ordering Tests and Results

When ordering any pathology or ultrasounds, please send a copy to birthing hospital. Additionally, include a copy in the SA Pregnancy Record. This will ensure results are seen, save time and facilitate best care for pregnant woman.

First Trimester Screening in Pregnancy

All pregnant women should be offered screening for chromosomal abnormalities. First trimester screening involves a blood test at 9W0d - 13W6d and an ultrasound for nuchal translucency at 11w0d - 13w6d.

This test is usually the responsibility of the GP, whether the GP is involved in Obstetric Shared Care or not. Women are often not seen at the booking hospital until the second trimester and the nuchal translucency scan is not available at all maternity hospitals, hence women are referred to their GP for this screening test. Nuchal scans are available through private radiology providers.
In order to attract a Medicare rebate ‘risk of fetal abnormality’ must appear on the referral form. The blood test may be collected at any collection centre, but the correct SAMSAS form must be filled in completely and correctly. These forms can be delivered to the GP rooms.

The GP OSC Program is in discussion with SAMSAS about ways to simplify the forms and make them compatible with GP computer systems. Any concerns or questions, please contact SAMSAS or the Midwife Co-ordinator for Obstetric Shared Care at the booking hospital.

Management of Low PAPP A

Management of women with a low PAPP-A and normal chromosomes has now been included in the South Australian Perinatal Practice Guidelines and is available at the following website:

http://www.sahealth.sa.gov.au/wps/wcm/connect/067b598044c1bda7b0a5fd3f59363f11/Management+of+women+with+low+PAPP-A_July2014.pdf?MOD=AJPERES&CACHEID=067b598044c1bda7b0a5fd3f59363f11

Pregnancy-associated plasma protein-A (PAPP-A) is one of the hormones measured in the First Trimester Combined Screening between 9 and 14 weeks.

PAPP-A is a large glycoprotein produced by the placenta and decidua thought to have several functions including:
- Prevention of recognition of the fetus by the maternal immune system
- Angiogenesis

A low PAPP-A is descriptive of poor early placentation and may result in adverse pregnancy outcomes such as:
- Mid trimester miscarriage
- Fetal growth restriction
- Intrauterine fetal death
- Preterm birth
- Preeclampsia

An abnormal PAPP-A is defined as a maternal serum PAPP-A concentration < 5th percentile (0.37 MoM), with increased frequency of adverse obstetrical outcomes noted below this level. Accurate maternal weight should be confirmed upon return of the first trimester screen result as this has significant effect of PAPP-A concentrations.

When booking a morphology scan, include information on any first trimester screen result with mention of PAPP-A < 5th percentile (0.37 MoM). For those pregnancies with PAPP-A < 5th percentile (0.37 MoM) morphology ultrasound should include an assessment of uterine artery Doppler. This needs to be performed and interpreted by an ultrasound unit familiar with the use of uterine artery Doppler and detection of early onset IUGR.

If scan is normal, the woman can continue to have routine antenatal shared care. If scan is abnormal, please seek advice from the participating hospital.

Recurrent Miscarriage

One take home message from a recent presentation by Dr Dee McCormack is that recurrent miscarriage is defined as:
- 3 or more consecutive losses of biochemically confirmed pregnancies with the same paternity in a woman ≤ 35 years of age
- A cause for recurrent miscarriage may be identified in approximately 50% of cases.
- In every early pregnancy loss it is important for GPs to try to ensure karyotyping is performed on products of conception.
Upcoming CPD Events for 2015:

There are only two more events for 2015. Planning for the 2016 Obstetric Shared Care Education Program will happen in November. If you have any suggestions for topics next year please send to Kay Gallary.

Remember 2016 is the last year of the current Triennium and to maintain your Accreditation in the OSC Program you need to have 12 Obstetric Shared Care points.

<table>
<thead>
<tr>
<th>Event</th>
<th>Details</th>
<th>Venue</th>
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<tbody>
<tr>
<td>Two Curses of Modern Obstetrics— Maternal Age and Obesity</td>
<td>Date: Wednesday 28th October 2015</td>
<td>GP partners Australia</td>
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<td></td>
<td>Time: 6.30pm – 9pm</td>
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<td></td>
<td>Facilitator: Assoc Prof Robert Bryce, Flinders University</td>
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<tr>
<td>Pregnancy Diagnosed What Next?</td>
<td>Date: Tuesday 10th November 2015</td>
<td>GP partners Australia</td>
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<tr>
<td></td>
<td>Time: 6.30pm – 9pm</td>
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<tr>
<td></td>
<td>Facilitator: Dr J. Goold and Dr C. Price</td>
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If you have any comments or possible news items, please contact Kay Gallary kgallary@gppaustralia.org.au or phone: (08) 8112 1100.