

Clinical Topics

The prepregnancy clinic

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Summary and conclusions

A prepregnancy clinic was set up to provide a single referral centre where women not yet pregnant but who were worried about problems when they became so could obtain advice. In the first 18 months 56 women attended. The outstanding feature is the concern of many women and their doctors about previous premature labour or late spontaneous abortion.

Introduction

In January 1978 the Board of Governors at Queen Charlotte's Hospital for Women established a prepregnancy clinic to provide advice to women not yet pregnant but who were worried about problems when they became so. Although their family doctor might send some to a gynaecologist, or if the woman had attended a hospital before she might try to contact her old clinic again, most have no source to which to turn. The prepregnancy clinic was to provide a single referral centre to which family and hospital doctors could send women for authoritative advice about both the likely pattern of management in a future pregnancy and the chances of the risks that pregnancy might have on their or their future baby's health.

Method

The clinic was staffed by one consultant obstetrician only. He saw all patients himself, and there were no junior staff. The only patients not advised were those with problems of a genetic origin, for the hospital was already providing an active weekly genetic clinic.

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In the first 18 months 56 women consulted the prepregnancy clinic; 40 were referred by local practitioners, 11 by hospital doctors, and five former patients of the hospital referred themselves having heard of the prepregnancy clinic. A brief analysis is given of the problems arising from such a group to provide guidance for others who are contemplating running such a service.

Results

An attempt has been made in tables I and II to analyse the factors seen at the prepregnancy clinic. Commonly there was more than one problem, but a judgment was made about which was the most important that had led the woman to seek consultation.

TABLE I—Maternal factors in 23 women attending a prepregnancy clinic

Previous pregnancy problems	Current problems
Pre-eclampsia 2	Prolapse 2
Abruption 1	Fibroids 2
	Epilepsy 2
Previous labour problems	Double uterus 1
Previous caesarean section 2	
Previous forceps 1	Desire for future management
Maternal trauma at delivery 2	Child of predetermined sex .. 2
Anaesthetic difficulties	Leboyer technique 1
General anaesthesia .. 2	Self-control of labour 2
Epidural 1	

TABLE II—Fetal and neonatal factors in 31 women attending a prepregnancy clinic

Multiple births (all babies died)	Normal babies who died
Twins 2	Late abortions 8
Triplets 2	Premature labours 7
Abnormalities	Other problems
Hydatidiform mole 1	Recurrent early abortions .. 2
Hydrocephaly 3	Neonatal convulsions 1
Anencephaly 1	Drug addiction 1
Limb deformities 2	
Other neonatal deaths with abnormalities .. 1	

Among the maternal factors were 11 women who had had problems in previous pregnancies and deliveries. They wanted information about the chances of such a complication recurring and, just as important, how much limitation would be put on their lives in another pregnancy. The same problems were raised by a group of nine women with medical conditions. Several of these also wanted to know about the effect on the fetus of any drugs they were taking, as well as the possibilities of the child being affected by their illness. Two women came (one referred by a family doctor and one self-referred) to inquire about the possibility of producing a child of predetermined sex after publicity in the press about techniques that might enhance the chances of doing this. Three women wanted assurance of the possibility of a greater self-control of labour and the use of the Leboyer technique; this was freely discussed and they were told which hospitals in their areas offered this facility.

A larger number of women (31) presented with previous fetal or neonatal factors. Four had had previous multiple pregnancies and had lost all the babies. They were concerned with the possibility of recurrence of multiplicity and the possible outcome. Eight women had had babies with abnormalities, six of whom had died; they were concerned with the risk of recurrence.

By far the largest group of patients were those who had had previous premature labours. Some had late abortions, fetuses born dead before the 28th week; other babies had been born alive, lived for some hours, and then died, and so were neonatal deaths. All 15 of these mothers had suffered premature uterine contractions and were concerned about the possibility of this in the future. In some cases these labours had occurred years before, and the mothers wished to know about new treatments for suppressing uterine contractions. Two women came after recurrent early abortions and one woman, previously a heroin addict, had had a child born with symptoms of drug withdrawal. She was now apparently cured.

Discussion

This is only a small number of women collected over the first 18 months of a new form of management, but certain points seem to be important. The clinic should be run by a consultant obstetrician who has some interest and knowledge of data collection and analysis at local and national level. Thus he can give reasonably valid probabilities when women ask about risks. It is probably wise to have only one consultant running the clinic for it adds a consistency to the answers given, and it is not a great load. Twice in the 18 months the obstetrician running the clinic was called away to deal with an emergency; then the clinic should stop and should not be continued by a

more junior member as might happen in other medical outpatient clinics.

The doctor running the clinic should have the capacity to refer rapidly to colleagues or to written sources when he does not know the answer; as so often in medicine, knowledge is not so important as the ability to know where to look for knowledge. On several occasions, telephone conversations with colleagues at other centres gave the woman an answer before she left the clinic. In others the woman was told frankly that the risks were not precisely known but an appointment would be made for a few weeks hence so that they could be discovered.

The doctor in the clinic must take care that he does not build up a cohort of women with previous obstetrical or current medical problems who would want to attend his antenatal care irrespective of past medical associations or present geography. This may be done by tactfully phrasing answers and reassurances about the capacity of many centres to deal now with some of these problems. The concept of a centre of excellence is not confined to the medical mind but is present in our patients as well. Discussion about facilities locally available often helps the patient and her medical attendants in the future.

The outstanding feature that comes from this brief analysis is the large number of women and their doctors who are concerned about a previous premature labour or late spontaneous abortion. Since low birth weight is the commonest associated factor of perinatal mortality, this anxiety deserves attention. As mentioned, some of the women had been treated before uterine suppressive agents were available or the use of cervical encirclage was so widespread. The exact usefulness of these is hard to assess, and until properly conducted trials have given us the real answer the obstetrician must continue treating each case on its own merit.

This prepregnancy clinic was not time consuming, for no more than three women were booked for any session so that the consultant had time to talk to each. While in some cases a clinical examination was performed it was rarely revealing; at this clinic, opinion was usually based on a combination of the woman's own history, her past medical records (if available), and a careful assessment of the woman's current fears and future worries. This is set against the background data available for that condition. The clinic may be run in a small room in the outpatient department and can provide a service that the women and their family doctors seem to find helpful.

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What are the likely causes of gynaecomastia in a healthy young man. What treatment is advised?

Most cases of gynaecomastia seen in healthy young men represent a more florid form of the small, firm, subareolar plaque, the so-called "puberty node," which develops in most adolescent boys. The breast enlargement is usually symmetrically bilateral, but it may be unilateral, asymmetrical, or may develop in one breast months before appearing on the other side. In its mild form no treatment is needed and the enlargement usually subsides spontaneously. In more gross examples, however, which may even lead to the appearance of the adult female breast, spontaneous remission is unlikely, and the breast tissue will need to be excised for cosmetic purposes through a circumareolar incision. Several rare causes of gynaecomastia in healthy, normally developed young men need to be excluded. The testes should always be carefully examined since gynaecomastia, nipple pigmentation, and even secretion of white fluid from the nipples may occur in chorion carcinoma of the testis as well as in some cases of testicular teratoma. The urinary chorionic gonadotrophin concentration is raised in these cases. Gynaecomastia may occur in adrenal cortical tumours or hyperplasia, which are rare in men, and has been described in hyperthyroidism. It also occurs when oestrogens are administered to men and is seen in patients with prostatic cancer who are receiving stilboestrol. The physician should inquire about any pills or ointments

that the patient might be using. Gynaecomastia is common in cirrhosis but only when gross other features of the disease are obvious.

Is perennial rhinitis associated with postnasal drip and air swallowing?

A distinction is usually made between perennial rhinitis due to allergic causes and non-allergic vasomotor rhinitis. The symptoms are similar, but in vasomotor rhinitis there is often some evidence of psychological instability. The characteristic symptoms are nasal obstruction, watery nasal discharge, and sneezing attacks. Post-nasal drip commonly accompanies vasomotor rhinitis and must be distinguished from post-nasal discharge caused by infected nasal accessory sinuses. A radiograph is helpful but if the radiograph is suggestive proof puncture of the maxillary antrum is the only certain way to exclude an infection. Air swallowing is not generally a symptom of perennial rhinitis, whether this is allergic or vasomotor. Many patients with vasomotor rhinitis are tense, with an unstable vasomotor system, so that the condition is often marked by a multitude of symptoms and air swallowing is a possible one, although not usual in this condition.

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