The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

14 October 2016 Our Ref: MT16-168

Dr Alesha Smith
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Dear Alesha

Thank you for the opportunity to provide feedback on the document. **Diagnosis and treatment of hypertension and pre-eclampsia in pregnancy in New Zealand; A clinical practice guideline.**

General practice and the College

General practice is the range of values, knowledge, skills, and practices required to provide first level medical services in both community practice and hospital settings. General practice includes the provision of both first contact and continuing care for all ages and both sexes that is comprehensive, person-centred, and takes into account the roles of family, whānau**,** community and equity in achieving health gains.

GPs comprise almost 40 per cent of New Zealand's specialist workforce and their professional body, the Royal New Zealand College of General Practitioners (the College), is the largest medical College in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists, and sets standards for general practice. The College is committed to:

- Ensuring that New Zealand has a GP workforce that contains sufficient vocationally trained GPs to: ensure appropriate service provision; enable sustainable, safe, high quality primary health care; meet the increased demands of an ageing population and higher rates of co-morbidity; and to meet the Government's expectations of care that is sooner, better and more convenient.

- Improving patient outcomes with regard to continuity and access to quality care by: promoting better integration between primary care, secondary care and social service; and encouraging innovation and the development of new models of care.

- Achieving health equity in New Zealand through: a greater focus on the social determinants of health; reducing the rates of smoking and increasing healthy food options for low-income families; better integration of health and social services; and ensuring that funding for primary care is targeted to the most disadvantaged.

- Improving health outcomes for rural communities through the work of high quality, well trained medical generalists working within multidisciplinary teams.

- Achieving health equity for Maori. Health equity for Māori will be achieved when Māori have the same health outcomes as other New Zealanders. For this to occur, service delivery to Māori needs to be appropriate and effective and ensure equity of access. This does not mean a reduction in service delivery to other New Zealanders, but rather improving service delivery to Māori to ensure fairness.

The College Submission

The College welcomes the production of this guideline. It is a document of substantial size (133 pages) and appears well researched. Members commented that they were pleased to see the inclusion of information such as numbers needed to treat (NNT). The involvement of a general practitioner in the guideline development team is welcomed.

College members suggested a number of areas in which changes could be made which would significantly increase the ease with which the guidance could be implemented by general practitioners and hence the likelihood that the guidance will be followed. We have outlined these suggestions in Appendix 1 using the format requested. Our key suggestion is the need to produce a supplement to the guidelines which summarises the recommendations relevant to non LMC GPs.

Although few GPs undertake intrapartum care or act as LMCs this guidance is clearly important for all GPs. The document states on page 3 that the target audience is providers of care to pregnant women, not specifically providers of maternity care. Women frequently visit their GP for the diagnosis of pregnancy and for first trimester care. Some women and their partners also receive pre conception care. These visits provide opportunities to review risk factors, consider the appropriateness of aspirin or calcium and determine the level of care needed during the pregnancy.

The draft guideline is unclear around the use of calcium and low dose aspirin to reduce the incidence of pre-eclampsia. More clarity is needed on

- Which women should be advised that aspirin and /or calcium may be beneficial
- Whether this should be prescribed by the LMC (usually a midwife) or by the GP
- Whether this differs in those regions of New Zealand where women are able to receive free medical care for relevant medical conditions when pregnant - namely Canterbury, compared to the remainder of New Zealand
- At what stage of pregnancy aspirin and/or calcium should be commenced

Thank you for providing the College with the the opportunity to feedback on the guideline. We look forward to reviewing the revised draft for consideration of College endorsement.

Yours sincerely

Michael Thorn
Manager Strategic Policy

Appendix 1

FEEDBACK RESPONSE FORM

Responses close: **5pm on Monday, 10 October 2016**

Please email feedback to: alesha.smith@inquisit.co.nz

Please use this feedback form to comment on our draft guidelines. The form has space for you to:

- Provide us with your details
- Respond to general questions about the guidelines
- Comment on particular sections
- Provide overall comments
- Provide ideas for successful implementation

	Your details
Your Name: If this is a joint response, please add other people's names too.	**Michael Thorn** Manager Strategic Policy Royal New Zealand College of General Practitioners (RNZCGP)
Organisation name and position: (if responding on behalf of an organisation)	Royal New Zealand College of General Practitioners (RNZCGP)
Telephone number:	04 496 5999
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☐ I wish to keep my contact details confidential

Thank you for taking the time to provide feedback.
If you have any questions please contact:
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General Questions

1) Are the guidelines easy to read? (Please consider the language used, as well as the overall structure and layout.)

From the perspective of non LMC GPs it is very difficult to efficiently identify and navigate to the relevant information. The sections relevant to non LMC GPs are scattered through the 133 pages of the guideline.

There are over 4,000 non LMC GPs. They are a significant target audience for this guidance both in terms of their numbers and in terms of the important role that they play in both early pregnancy care and in the ongoing medical care of women who have experienced hypertensive disorders during pregnancy. Much of the information in the 133 pages is not relevant to non LMC GPs, but they need to navigate the whole document to find the relevant parts.

The College considers that a short supplement designed specifically for use by non LMC GPs would be extremely useful and is essential if these guidelines are to be read and used by GPs.

It is important that GPs are quickly able to locate the information appropriate to a particular woman. If the supplement was available electronically, links to the location of supporting information in the full document would assist in keeping the GP resource brief.

General practitioners in many parts of New Zealand have electronic access to various clinical pathways. This guidance needs to be included in these pathways, and any inconsistencies with existing clinical pathways need to be identified and addressed.

2) What is unclear or confusing?

The guidance on the prescribing of calcium and low dose aspirin in early pregnancy is unclear in two significant areas:

a) Which women are recommended to receive this medication
b) Whether this should be discussed with the woman and prescribed by the GP or the LMC midwife or whether this should wait until the woman is seen by the obstetric team.

a) Which women are recommended to receive low dose aspirin or calcium

The table on page 7 (which also appears on page 34) lists 18 factors in order of the size of the increase in risk of developing pre-eclampsia associated with each. The seven factors that increase risk 3.5 fold and above are identified as '*major* risk factors' (MRF). We assume that women with one or more of these seven major risk factors would be considered at high risk of developing pre-eclampsia and should therefore be recommended to take low dose aspirin and calcium. This is not stated explicitly however. It is important that this is clear particularly as there is wording in other places in the document which suggests alternative interpretations.

For example on page 6 it states:

> "There is insufficient evidence of a cumulative increase in risk of pre-eclampsia if a woman has multiple risk factors."

This evidence statement is graded to indicate that the evidence is of high quality but the recommendation is weak against an intervention. It is presumed that the intervention this is referring to would be prescribing calcium or low dose aspirin but this is not explicitly stated.

It is unclear whether "multiple risk factors" refers to

- multiple *major* risk factors, or
- multiple risk factors including those not deemed to be major risk factors.

In the latter case the statement implies that women with the eleven other listed risk factors should not be offered aspirin and/or calcium, even if the woman has more than one of these (non major) risk factors.

This uncertainty is increased by the mention on p 55 of the risk for women with "two or more *moderate* risk factors" with the implication that aspirin has an effect in reducing pre-eclampsia in such women.

A third term "high risk" is used frequently in the documents but is not defined. For example on page 52 it states The evidence profile shows that low dose aspirin (50 – 150 mg) has a modest protective effect in reducing adverse outcomes in women at *high* risk of pre-eclampsia.

As previously stated presumably women having one or more of the major risk factors (MRF) would be considered 'high risk'. However the guidance is unclear for the larger group of women with one or more of the other risk factors in the table - for example a nulliparous woman with a raised BMI or a family history of pre-eclampsia (or with all three of these risk factors). Women with combinations of these risk factors will be seen by GPs relatively frequently. It is important that those who might benefit from preventative medication or specific lifestyle advice are identified so that they can be made aware of this option and can discuss the benefits and risks with their health provider.

Lastly it appears strange that while the number of high risk women needed to treat (NNT) for calcium is only 7, (table 2, p 10) indicating a high level of effectiveness, whereas for Aspirin it is 56 indicating a lesser effectiveness, the guidance suggests that Calcium should be only 'offered' to women at high risk (p 9) but in the case of aspirin the much stronger recommendation that aspirin is 'indicated' is made.

b) The role of the GP in prescribing low dose aspirin and calcium in early pregnancy

There are a number of contributors to health care in pregnancy, in particular the midwifery team, the general practice team, the obstetric team and of course the woman and her whanau. It is necessary to be clear about respective roles and responsibilities. In this context without such clarity there is a risk of both midwives and GPs assuming that it is the role of the other to discuss the option of prescribing aspirin and calcium to women in whom this is appropriate. As a result women who may have benefited from such medication may end up not having the option of receiving it at the time when it could potentially be most beneficial.

The guidelines tend to mention GPs in passing without actually explaining how the teamwork around caring for women in pregnancy is envisaged to work. Neither is there acknowledgement that women outside Canterbury DHB are not eligible for funding to visit their GP for the management of medical conditions when pregnant. As a result women may be referred to obstetric clinics with medical conditions that could be managed by their GP. This lack of funding for the care of medical conditions in pregnancy will limit the extent to which GPs are able to assist with the monitoring of hypertensive disorders beyond the first trimester to only those women with the financial means to afford GP appointments.

The box below from page 9 provides a good example of this lack of clarity around whether it is the GP or the LMC midwife who initiates the discussion around low dose aspirin and prescribes it if necessary.

> ☑ It is suggested that low dose aspirin is prescribed by the General Practitioner or the obstetric team when possible. Consider issues around scope and guided prescription.

Clarity is needed here in particular regarding the last sentence mentioning scope and the unfamiliar and undefined term “guided prescription”. If it is the GP who prescribes aspirin and calcium then the issue around the extent of the future involvement of the GP in the medical care of the pregnant woman then arises and needs to be resolved.

Other issues of clarity

Non LMC GPs do not have the level of familiarity with the referral guidelines that midwives and obstetricians have. It would be useful to be clear that referral to an obstetric team may only be for consultation and will not necessarily result in transfer of care. A link from the referral codes quoted in the treatment summaries on pages 13 and 14 to the explanation in the referral guidelines might be useful. The GP may refer a woman with hypertension to the obstetric team but if her BP is below 150/90 she will probably still need an LMC. Possibly she would be best advised to proceed with locating a LMC midwife rather than delay until after seen by the

obstetric team as the referral guidelines recommend consultation with an obstetric team rather than transfer of care.

Finally it may be useful to provide more clarification around urine testing for protein. On page 2 of the document proteinuria is defined as as:

> "spot urine protein/creatinine ratio >30 mg/mmol or ≥ 2+ on dipstick testing confirmed by a protein creatinine ratio test".

The term "spot urine" is not widely used by GPs in New Zealand. We assume that it refers to a standard urine specimen rather than a 24 hour urine collection. Clarification would also be welcome on whether dipstick urine testing alone is sufficient. Obtaining a urine protein/creatinine ratio result will not always be possible on the same day, particularly in rural areas. In some clinical situations it may be unwise to delay referral until a confirmatory result is obtained from the laboratory.

3) Are the diagrams/tables and flowcharts easy to follow? Are other diagrams, tables or flowcharts needed?

As mentioned above specific material for GPs is required and there is insufficient clarity around the prescribing of low dose aspirin and calcium. None of the current flow charts address the prescribing of aspirin and calcium.

In addition there needs to be a specific mention of the need to notify the GP of hypertensive problems so that these can be followed up in future years. There is mention of this on page 26 where it states;

> "A comprehensive discharge summary should be sent to the woman's primary carers (e.g. LMC and GP). This is of particular importance so that long-term, ongoing follow-up may be arranged."

This is likely to happen in the event of severe problems that require admission but is also necessary that the GP receives this information even if the woman does not require admission.

IMPLEMENTATION

1. Please let us know if you have any suggestions that would facilitate successful implementation, uptake and use of the guideline within your organisation.

As mentioned earlier a brief supplement to address the specific needs of general practitioners will be necessary to enable implementation.

GPs in many DHBs have access to and use online clinical pathway resources, in particular localised versions of the Canterbury Health Pathways and also the Map of Medicine. Many already include content relevant to hypertensive disorders in pregnancy. To facilitate implementation it is important that the recommendations in these pathways and in the clinical practice guideline are aligned.

When the Guidelines are in a form more accessible to GPs the College will be pleased to include a link to them in the educational material for GP trainees, and to consider the use of other College channels to publicise the guidance.

GPs can apply to provide first trimester maternity care however there is no funding for non LMC care for pregnant women beyond the first trimester, which finishes at the end of the fourteenth week of pregnancy[1] (What funding there is for non LMC first trimester care is limited to $ 113.00 to cover all the appointments required during the first trimester, and unlike the fees for LMCs, has not been increased since 2012). The advice in the guideline is that;

> "Women at high risk of developing pre-eclampsia are recommended to commence taking low dose aspirin and calcium before 16 weeks' gestation to reduce their risk of developing pre-eclampsia and adverse events such as pre-term birth."[2]

As mentioned earlier the lack of funding for primary medical care during pregnancy will limit the extent to which these guidelines can be implemented, in particular GP involvement in monitoring beyond 14 weeks. Consideration should be given to addressing this.

2. Please indicate if you or anyone within your organisation would be interested in being a guideline 'champion' or interested in helping implement these guidelines within the organisation.

As mentioned above the guidelines are not yet ready for use by GPs so it is premature to be seeking a champion at this stage.

[1] http://www.health.govt.nz/system/files/documents/publications/s88-primary-maternity-services-notice-gazetted-2007.pdf page 1042

[2] See page v