

# the medical link

ISSUE 139 | APRIL – MAY 2022



THE OFFICIAL PUBLICATION  
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SOUTH COAST  
RADIOLOGY

## The Silent Condition That May Be Preventing You Falling Pregnant

- March for Endometriosis Awareness
- Destigmatising Cervical Dysplasia & HPV
- Celebrating Females in Science & Medicine
- Local BreastScreen Team Celebrates 30 Years
  - Menopause: Increasing Visibility



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## Editor's Note

This issue was put together with the intention of highlighting the careers of strong women in the medical field and highlighting often overlooked aspects of exclusively women related health topics.

This issue of The Medical Link is a very special start to what we hope will be a very immersive new chapter of the magazine. We aim to be a more present force among the members of the GCMA and create a magazine that members look forward to reading. We are constantly on the scope looking for stories that capture the interest of the medical community, and broader Gold Coast community.

Please do not hesitate to flick us through your suggestions at [admin@themedicallink.com.au](mailto:admin@themedicallink.com.au)





# A Message from the GCMA President

Prof Philip Morris AM, President GCMA  
 MB BS BSc PhD FACHAM (RACP) FRANZCP FPOA FFP ABPN  
 info@drphilipmorris.com | 0422 545 753 | www.drphilipmorris.com

Dear GCMA Colleagues,

How different a world we are in since my last AGM report in March 2021. From a relatively benign environment with the Covid-19 virus well-contained and largely absent within Queensland, we now have unfettered community spread of the Omicron variant, with hospitalisations and ICU admissions, and deaths from Covid-19. A very different environment to the controlled situation we experienced in early 2021.

We are now getting used to 'living with Covid'. While it is reassuring that hospital and ICU admissions are now declining in Queensland, the virus is still circulating and many are getting infected.

Vaccines and immunity from previous infection seem to have reduced the severity of Covid-19 infection among those infected, but the vaccines do not seem to prevent individuals from getting infected. We encourage all to now be 'triple vaccinated' as a way of reducing risk of severe illness and death.

It is unfortunate we still do not have a widely available antiviral drug to prevent or attenuate early Covid-19 infection for most

individuals. The specter of 'long Covid' looms. Many go on to suffer from chronic lethargy and fatigue after the acute symptoms fade and we have little to guide management of this condition so far.

We have much to be thankful for. Our public health advisors have done a great job in containing the virus; our public and private hospital staff have been excellent in dealing with surges in patient numbers, and our primary health services and practices have uncomplainingly and professionally carried a huge burden. The Queensland public has done their bit too, and have largely followed public health advice without protest.

Back in March 2021 I hoped we would see the end of the pandemic by the end of that year. Yet in early 2022 the pandemic still lives on. I am still optimistic that we will be 'breathing a lot easier' and less constrained by the pandemic by the second half of 2022. Perhaps by then it might have morphed into an endemic condition. I am encouraged that colleagues are now starting to travel cautiously around Australia and overseas.

We were planning a gala dinner in early February at Tiger Island in Dreamworld for our members and partners. But because of the Omicron Covid-19 extensive spread of infection we have postponed this event to later this year. Please keep a look out for notices of this important event.

The regular monthly clinical dinner meetings began again on Thursday 17 February at the Southport Golf Club. We have an exciting monthly program planned for 2022 with informative speakers lined up to educate our members and guests.

We have now started to plan for our next Pacific Island joint conference with a local medical association. Our next collaboration will be with the Samoan Medical Association and the Oceania University of Medicine, based in Apia, Samoa. We are hoping to have a medical conference with these two partners supported by the Samoan University School of Medicine and the Samoan Department of Health in Samoa in late September 2023. I hope many GCMA members will offer their services as speakers for this meeting.

A 'fact finding' tour of Samoa is being planned for later in 2022 to begin local planning for this conference. Any GCMA member who is interested in participating in this preparation visit is welcome to be involved. Please contact A/Prof Stephen Weinstein (stephenweinstein@bigpond.com) or me for details.

The GCMA has a new administrative officer, Marnie Masor (gcmasecretariat@gmail.com). Please contact Marnie for GCMA information. We are always looking to expand our membership. I encourage you to invite your doctor colleagues to join the GCMA.

It is very easy to do. Just go to the GCMA website (www.gcma.org.au) and click through to the 'Become a Member' page to join. The registration page can take credit card payments. The \$150 annual membership is extremely good value. It covers 10 monthly evening meetings where salient updates on clinical and professional matters are presented as well as a two-course meal and complimentary beverage, and the opportunity to interact with colleagues from all professional disciplines.

Finally, I would like to acknowledge and thank the GCMA executive team for their hard work and support over the past year.

The executive members are:

- Dr Maria Coliat, Vice President, Secretary & GP Representative
- Dr Geoff Adsett, Treasurer
- A/Prof John Kearney, Specialist Representative
- Prof Gordon Wright, Academic Representative
- Dr Daisy Swindon, Junior Doctor Representative
- Dr Dinesh Palipana, Junior Doctor Representative
- A/Prof Stephen Weinstein, Pacific Partners Program Manager

I look forward to seeing you at our next GCMA meeting.

Yours sincerely,

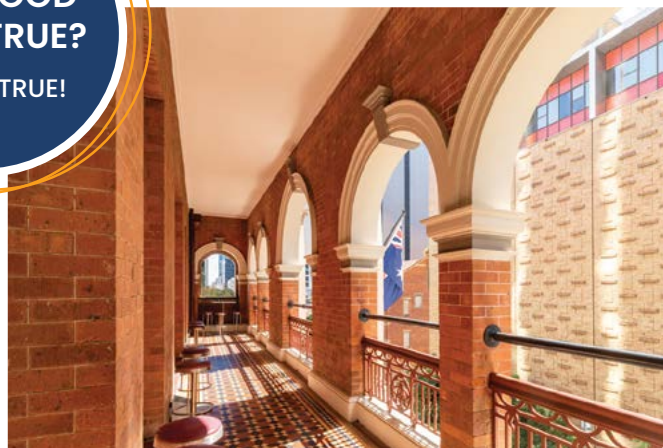
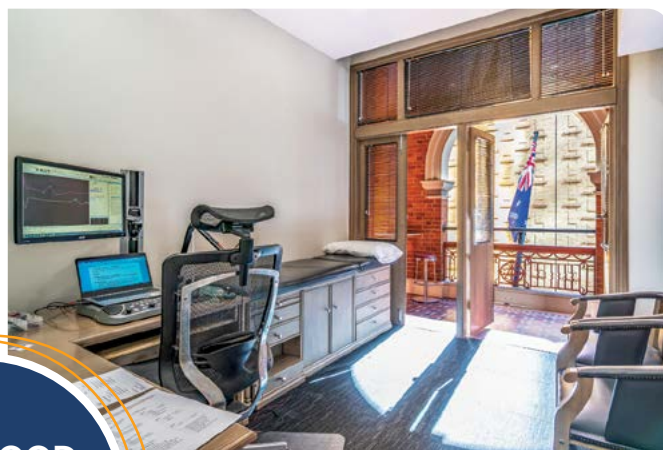
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# KEEPING THE MEDICAL COMMUNITY INFORMED

The Medical Link enriches the Gold Coast medical community by uniting the voice of its doctors and other medical practitioners.

Here you will find insightful stories and the latest trends in field research conducted abroad, and of course, right here on the Gold Coast. Keep informed on new health services, developments in the medical profession and general interest items.

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## Dr Brent McMonagle

MBBS, PhD, FRACS (ORL)



**Dr Brent McMonagle** is an ENT surgeon on the Gold Coast with sub-specialty training in otology, neurotology, sinus and skullbase surgery. He has strong research and teaching interests at Griffith and Bond Universities.

He has just commenced work on olfactory cell transplants in spinal cord repair, continuing the pioneering work of Prof Alan Mackay-Sim, Australian of the Year 2017, as well as further research in peripheral nerve repair and regeneration.

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## APRIL

2022

MON	TUE	WED	THU	FRI	SAT	SUN
NOTE				01	02 Go Blue for Autism	03
04	05	06 Wear Green for Premmies	07 World Health Day	08	09	10
11 World Parkinson's Day	12	13	14	15	16	17
18 Undiagnosed Children's Awareness Day	19	20	21 GCMA Meeting	22	23	24
25 World Immunisation Week	26 World Malaria Day	27	28 World Day for Safety and Health at Work	29	30	NOTE

### REMINDER

- IBS Awareness Month 01-30 April
- World Haemophilia Day 01-30 April

# DOCTOR WHO?

The Medical Link is introducing the opportunity for members of the medical community to nominate their colleagues for a focus story to be featured in the magazine.

Anyone within the medical community is eligible; from Doctors to Practice Managers. From Nurses to Medical Receptionists!

The aim of this new section of the magazine is to create a more immersive reading experience for the members of the Gold Coast Medical Association and to share the general happenings, achievements, highs and lows of the medical industry.

The Medical Link team is excited to bring the community closer together and share the stories of your fellow esteemed colleagues.



## HOW TO NOMINATE

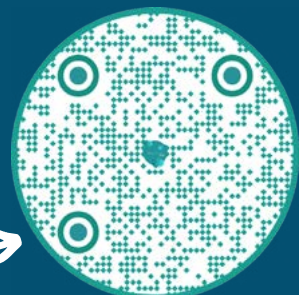
Scan the QR Code below and fill out the form in order for you to send in your nominations.

The chosen nomination will be the next issue's focus for this new integral section, and will have a feature piece written on their career and achievements in their respective field.



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## In Memoriam

This month we are honouring two outstanding members of our medical community who have unfortunately lost their lives.



**Dr Stephen Withers**

In August 2021 we said goodbye to a long-standing member of the Gold Coast Medical Association and former GCMA President, Dr Stephen Withers. Dr Withers passed away peacefully after a long battle with cancer on Saturday 7th August 2021. He was a loving husband to Teresa, champion father to Chris, Caitlyn and Courtney, and his best bud Milo. Dr Withers graduated from the University of Queensland in 1987. He commended his training in paediatrics in 1989 at the Royal Children's Hospital in Brisbane. He completed his specialty exams in 1993 and in 1994 was the Senior Registrar in Neonatology at the Grantley Stable Neonatal Unit at the Royal Women's Hospital, Brisbane. Dr Withers completed his specialist training in 1995 and was made a Fellow of the Royal Australasian College of Physicians. He went on to complete sub-specialty training in the discipline of Clinical Genetics (inherited disorders) at Sydney Children's Hospital. Dr Withers had a master's degree of Medical Science from the University of Queensland and additionally completed two post subspecialty fellowships, one at the Institute of Oncology at the Prince of Wales Hospital, Sydney and the other at the Hospital for Sick Children in Toronto, Canada. Dr Withers returned to Australia in 2000 and was appointed the Director of Paediatrics at Logan Hospital. In 2003 Dr Withers was awarded a prestigious Churchill Fellowship. In 2004, Dr Withers joined the Foundation Staff at the Griffith University Medical School as the first appointed Associate Professor in Paediatrics. ([www.goldcoastpaediatrics.com/about.html](http://www.goldcoastpaediatrics.com/about.html)). He is and was loved, and his presence will be sorely missed by all his friends, family and colleagues.



**Dr Luqman Jubair**

Dr Luqman Jubair unfortunately lost his life trying to save the life of another. Dr Jubair drowned attempting to rescue a struggling swimmer on the Gold Coast in February 2022. Dr Jubair was an outstanding doctor and researcher with Griffith university who made important breakthroughs in cervical cancer treatment. Griffith University released the following statement on behalf of Prof Carolyn Evans and Prof Analise O'Donovan:

"The University is incredibly shocked and deeply saddened by the tragic passing of Dr Luqman Jubair and extend our condolences to his family, friends and colleagues in Australia and his home country Iraq. Dr Jubair arrived in Australia as a qualified doctor, but his real passion was to help others in medical oncology through cancer research. He began his PhD at Griffith and worked alongside Professor Nigel McMillan in cancer gene editing and medicines at Menzies Health Institute of Queensland from 2016 to 2019. Dr Jubair was a dedicated and vital member of Professor McMillan's research team which achieved worldwide recognition for being the first to delete cancerous tumours in mice through CRISPR gene-editing technology. We are grieving the loss of such a talented and selfless humanitarian who throughout his life always placed others before himself."



# The Silent Condition That May Be Preventing You From Falling Pregnant

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**There is a common misconception that once you have your first baby you will easily be able to have more, but for many women this is not the case.**

**G**race Private Fertility Specialist and Gynaecologist Dr Tina Fleming said secondary infertility affects tens of thousands of Australian couples, with potential causes including low sperm count, complications from previous pregnancies and, for one in two women, endometriosis.

For 35-year-old Angela Hyland, secondary infertility and endometriosis was not something she expected to encounter after easily falling pregnant with her daughter, Heidi five years ago.

While her struggle to fall pregnant a second time was emotionally challenging, being made to feel like it was 'her fault' by doctors was crushing.

After a series of previous misdiagnoses and touted IVF plans, Ms Hyland was left confused and frustrated.

"One of my former doctors wrongly diagnosed me with Poly Cystic Ovarian Syndrome (PCOS) while the other blamed my weight and lifestyle," said Ms Hyland.

"I was put on treatment plans that involved weight loss, dietary changes and medication but nothing helped.

"My first daughter was getting older and we were desperate to give her a sibling.

"I knew something was wrong but no one was listening. Instead, I was made to feel like it was my fault I wasn't pregnant. That there was something I was doing wrong."

Dr Fleming said it was important not to play the 'blame game' when it came to infertility.

"By the time I see couples going through secondary infertility they have usually had a lot of investigations performed and received normal ultrasounds and perfect sperm counts," said Dr Fleming.

"They ask 'what am I doing wrong?', but that's not the message we want to be sending.

"Often they aren't doing anything 'wrong', it's just some practitioners haven't considered all the possibilities that may be causing their fertility problems."

Dr Fleming said a thorough investigation required a laparoscopy to discover, or rule out, endometriosis – a condition that affects one in 10 women and half of those experiencing infertility.

"Secondary infertility can really surprise people because they think they've done it once, everything must be okay," said Dr Fleming.

"For this reason, it can surprise some doctors too because the assumption is 'she has normal fertility so it must be something she's doing wrong'.

"The truth is endometriosis is very often the cause of secondary infertility and the only thing that can help is surgical removal."

Endometriosis is a gynaecological condition where tissue, similar to the lining layer of the uterus, grows outside of the uterus. Symptoms can be debilitating and include painful periods, intercourse and bowel movements, but some women are asymptomatic.

Dr Fleming said the condition was progressive.

"In terms of secondary infertility, we need to remember that endometriosis is a lifelong condition that gets worse over time," she said.

"For Angela, it may not have been enough to cause any initial infertility, but as more time passed it did make an impact."

For Ms Hyland, Dr Fleming's diagnosis of endometriosis during laparoscopy was not only an end to a 'lonely journey', but a cure to her infertility.

She gave birth to her second daughter, Macy, in March after surgery to remove her endometriosis in April last year.

"Infertility can feel isolating but I want women to know they are not alone – they just have to find the right people to help," said Ms Hyland.

"My advice is to trust your gut and find a specialist who really listens to you and wants to find answers."

Dr Fleming said she loved being able to care for a patient through their entire journey - from the anxiety, fears and frustrations of infertility to the miracle of a new baby.

"Angela's story highlights the importance of seeking advice from a doctor with expertise in both endometriosis and fertility as this best facilitates global management decisions and holistic patient care," she said.

Grace Private's fertility specialists - Dr Tina Fleming and Dr Tania Widmer – have helped hundreds of women and couples achieve their dream of having a baby.

Designed by women for women, Grace Private for Women provides specialist healthcare, including fertility, obstetrics, gynaecology and ultrasound, to the women of the Gold Coast and surrounding areas. For details and referrals, phone 07 5594 7632 or visit [graceprivate.com.au](http://graceprivate.com.au)





# March for Endometriosis Awareness

BY E.K. DALEY  
THE MEDICAL LINK  
ADMIN@THEMEDICALLINK.COM.AU

Being Endometriosis Awareness Month worldwide this past month of March, it is important to increase awareness and provide a voice for women everywhere suffering with this debilitating condition that affects an estimated 190 million women worldwide.

Endometriosis is an often painful disorder in which tissue similar to the tissue that normally lines the inside of one's uterus – the endometrium – grows outside of the uterus, according to the Mayo Clinic. Endometriosis most commonly involves your ovaries, fallopian tubes and the tissue lining your pelvis. Rarely, endometrial-like tissue may be found beyond the area where pelvic organs are located.

Endometriosis is a chronic condition that is often cited as considerably painful, and can affect fertility and lead to a reduced participation in school, work and sporting activities. The causes of this condition are not completely clear, but there are multiple symptoms such as early age at first period, short menstrual cycles, and heavy or long periods (Jean Hailes for Women's Health 2017b), which may indicate endometriosis at a later stage in life. Endometriosis is also likely to occur if there is a history of endometriosis in the family, or menstrual cycle factors listed prior. While the condition is chronic, some women experience little to no symptoms, while others experience pain, lethargy, heavy menstrual bleeding, bleeding between periods, and reduced fertility among other symptoms.

The recommended method of diagnosing endometriosis is via examination of specimens collected during laparoscopy (a type of keyhole surgery) (Dunselman et al. 2014). Based on the extent and location of the endometriosis, the condition is sometimes staged as minimal (stage I), mild (stage II), moderate (stage III) or severe (stage IV) (American Society for Reproductive Medicine 1997). However, the stages may not relate to the severity of symptoms experienced (Vercellini et al. 2007). Other systems for classifying endometriosis also exist (Johnson et al. 2017).

There is no known cure for endometriosis but can be managed with medical and/or surgical treatments, including painkillers, hormonal contraceptives, among other hormonal treatments and the removal of lesions via laparoscopy or laparotomy. In some cases, the uterus may be removed, however symptoms may still occur.

It is important to note that it has been reported that in most cases of endometriosis, the symptoms subside after the onset of menopause, though this is not always the case.

## Endometriosis – The Human Experience

We reached out to women all over Australia to hear their voice in the everyday struggle of living with endometriosis. They directed us to resource groups and were willing to share their personal experiences in living with this invisible illness.

Natalie, age 27, was diagnosed at age 22, after suffering with endometriosis since the onset of puberty at age 12.

"Every day is a struggle," Natalie admitted. "I struggle with pain and that then affects me going to work. I've had more sick days than days working and that has taken a massive toll financially."

Natalie had her first surgery when she was 22 in the public sector. After living with endometriosis for many years since this surgery, she is now aware that things should have gone differently.

"I felt as if the gynaecologists that performed my surgeries weren't educated enough in how to actually treat it. They know the ablation method which can do more harm than good, and in my case made it much worse as it wasn't removed, it only burnt the tops off. I feel as though if I was diagnosed correctly in the first place I wouldn't be where I am today."



I struggle with pain and that then affects me going to work, I've had more sick days than days working and that has taken a massive toll financially.

Endometrial ablation is a procedure to remove a thin layer of tissue that lines the uterus. This method is only done on women who do not plan on having children in the future. Natalie, however, always wanted to be a mother. This surgery went ahead without appropriate informed consent and dashed her chances of ever having biological children of her own.

Natalie has since found a specialist who knows how to excise endometriosis correctly. And though they have been able to help ease the pain and give her the appropriate care, the damage had been done. Her specialist stated that it was one of the worst cases he had ever seen.

Natalie describes her day-to-day pain as 6/7 out of 10, but sometimes suffers 'violent pain attacks' that leave her immobilised on the ground, unable to get up. The pain is sometimes so intense that she can begin vomiting. She noted that recently she fainted at work and had to have an ambulance called. Her quality of life has significantly decreased because of this invisible illness.

After speaking with some more sources, we were directed to @endohealthhub and @me\_myself\_and\_endometriosis on Instagram as good public awareness platforms for the illness. This where we discovered the Spoon theory, created by Christine Miserandino (@butyoudontlooksick).

Tracey, age 52, was diagnosed at age 37 with both Endometriosis and Polycystic Ovarian Syndrome (PCOS). She had suffered with these conditions since the onset of puberty, but due to a lack of education and awareness, she was unable to put a name to the complexity of her bodily issues.

"Most of my trouble was during my periods my cycle would change every month and there was no consistency. My cycle was a 38-day cycle, or a 33-day cycle, or a 28-day cycle, even 21 days." She stated, "All I want to do is sit down and not move much until my period was over."



Tracey was unable to get a formal diagnosis for endometriosis until after she had her two children, who she stated took her over 12 months to conceive. Tracey received a full hysterectomy shortly after, which she has since regretted after learning of other treatment methods, and the complications that have arisen since having her reproductive organs removed.

Tracey has experienced significant weight gains, severe insomnia, hot flashes, terrible mood swings, depression and migraines, though she noted that after having the surgery her mood swings and depression subsided, but her migraines got worse. In hindsight, she would have refused the hysterectomy, and hopes to spread awareness for other options for women faced with these decisions relating to their care.

The consensus seems to be a call to action for doctors to have a more structured and consistent understanding of endometriosis across the board. Women everywhere need to be taught about endometriosis along with other women's issues at a young age, so that if they are a part of the percentile of women who end up suffering from endometriosis, they can adequately advocate for their health.

Doctors, specialists and other medical practitioners need a more coherent and clear learning criteria when it comes to the subject of endometriosis, so that when they face an enquiry, a possible diagnosis, or treating a patient with a previous diagnosis, their process matches that of any other practitioner, they can recognise the symptoms and offer a wide range of treatment options and exercising appropriate informed consent when suggesting any kind of surgery.

Lastly, all the women who participated in lending a voice to this piece urged people in the medical fields to practise empathy when approaching patients with womanly issues and to take their concerns with completely seriousness, because for most women and all men, medical field or not, will never understand the pain that 10% of females worldwide have to live through every single day of their lives. And to be dismissed by the people who are meant to be there to help ease that pain, is just another pain they should not have to endure.

## Dr Geoffrey Trim

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Infographic made by @themedicalinkgc

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Created by Christine Miserandino. Information from @me\_myself\_and\_endometriosis





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# Many Changes Seen as Local BreastScreen Team Celebrates 30 Years of Saving Lives!

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One in seven women in Australia will be diagnosed with breast cancer in their lifetime. Survival rates are among the highest in the world due to early detection and effective treatment based on robust research.

**B**reastScreen Australia - a joint initiative of the Australian and State and Territory governments - aims to reduce breast cancer morbidity and mortality by detecting this disease in its early stages. The BreastScreen program provides free screening mammograms every two years for asymptomatic women aged 40 and older, and actively invites women 50-74 years to participate.

Breast cancers detected through the BreastScreen Australia program have a 54-63% lower risk of causing death than those diagnosed in women who have never been screened through the national program. Over the last 30 years, BreastScreen Australia has provided more than 20 million mammograms and detected over 20,000 cancers. More than half of breast cancers detected in the BreastScreen program are small ( $\leq 15$  mm in diameter), which is associated with greater treatment options, lower morbidity, and improved survival. Since 1991, the five-year relative survival rates for breast cancer have improved from 75% to 94%.

Locally, BreastScreen Queensland (BSQ) Gold Coast Service has provided more than 750,000 breast screens and diagnosed over 3750 invasive breast cancers since its inception. Last financial year, the local service saw a record number of clients with almost 35,000 women screened, with more than 1700 women (5%) recalled to Southport for further assessment. Only around one-in-two local women aged 50-74 - the group where evidence of screening benefit is strongest - regularly participate in the BreastScreen program, which is below the national 70% goal.

BSQ Gold Coast Service Medical Officer Dr Lesley Robertson - who helped establish the local breast screening clinic alongside Dr Robyn Laver and the late Dr Barbara Craig - has witnessed significant developments in the last three decades.

“From humble beginnings in the former Gold Coast Hospital, our local BSQ service has grown substantially. We now have four permanent clinics in community settings, a mobile service, and a monthly staff clinic at Gold Coast University Hospital,” Dr Robertson said.

“Our local team continues to work very closely with Primary Health Care providers and other stakeholders to deliver quality, accessible client-centred care for women,” she said.

BSQ permanent clinics are located at Helensvale, Robina, Southport, and West Burleigh. A mobile unit also visits several other areas annually.

Over the years, the BreastScreen program has seen many improvements including the transition from wet-film X-ray processing to digital mammography technology. Current use of tomosynthesis (3D-mammography) assists the multidisciplinary team in the assessment of breast cancers for women returning for follow-ups tests. Use of Vacuum Assisted Breast Biopsy (VABB) technology enables larger sampling of tissue from the image guided region of interest, thus decreasing histological underestimation that can occur during core needle biopsies.

On a national level, research continues to explore ways to optimise early detection of breast cancer including Artificial Intelligence use in screening and personalised screening to match individuals' breast cancer risk. BSQ currently offers annual screening to selected clients identified as being at an increased risk.

A dedicated Breast Cancer Family Clinic in Cherside (Brisbane) is also available. This free service offers advice, support, and counselling on tailored management options for women aged 30-49 with a strong family history.

Aligning with other jurisdictions, BSQ services are phasing out Clinical Breast Examinations for clients with a past history of breast cancer. Women are recommended to consult their GP or specialist. The BSQ program has ceased providing breast exams for clients with symptoms during a screening visit.

Symptomatic individuals are advised to see their GP for diagnostic follow-up at an appropriate provider who can provide all required imaging.

Asymptomatic women 40 and older can book a free breast screen at a BSQ clinic by phoning 13 20 50 or online at [breastscreen.qld.gov.au](http://breastscreen.qld.gov.au)

Photo: BSQ Gold Coast Service Medical Director Dr Ellen Dooris (left) celebrates the Service's 30-year milestone with Medical Officer Dr Lesley Robertson.





# Destigmatising Cervical Dysplasia & HPV

BY E.K. DALEY  
THE MEDICAL LINK  
ADMIN@THEMEDICALLINK.COM.AU

**For women, there are many things in life that give cause for anxiety, especially when it comes to our reproductive health. The possibility of infertility and cancer for countless women is a common source of worry.**



In Australia it is typical for prepubescent girls between 11-13 to receive the HPV (human papillomavirus) vaccine for free via the National Immunisation Program Schedule at school. What many people do not know is that this vaccine does not cover all strains of HPV, as there are over 100 strains of HPV in existence. It is estimated that despite the vaccination, up to 80% of people in Australia have HPV at some time in their lives.

It is a common misconception among the general populace that HPV is a result of incautious behaviour such as multiple sexual partners, failing to keep up to date with regular screening or being lax with protective measures. Because of this, women's health has become an almost taboo subject to talk about in day-to-day life.

HPV is classified as a sexually transmitted infection which usually shows no symptoms and goes away by itself but can sometimes cause serious illness such as genital warts, cervical cancer, anal cancer, vaginal cancer, vulvar cancer, penile cancer and oropharyngeal cancer. The virus is spread via genital-to-genital contact and can infect both men and women. While HPV is classified as a sexually transmitted infection, this differs from sexually transmitted diseases in that they present quite differently.

Firstly, not all diseases begin with an infection, but many do. An STD is the later stage of an STI, with symptoms overtly presenting by this stage, whereas a multitude of carriers with an STI will likely show no signs of being infected and will be ignorant to their status.

Secondly, though HPV can be spread from carrier to carrier, it can also occur in monogamous long-term relationships. Anyone who has sex can contract HPV and though it is not common, it does happen. Research confirms that a healthy immune system can clear HPV in 12-14 months from the time of transmission. HPV persistence can occur for up to 10-15 years; therefore, it is possible for a partner to have contracted HPV from a previous partner and transmit it to a current partner.

A common spawn of having HPV is Cervical Dysplasia which can be classified into (Cervical intraepithelial neoplasia) CIN1, CIN2, and CIN3. These classifications help describe the mildness or severity of the disease based on how much epithelial tissue in your cervix has abnormal cells.

CIN1 refers to abnormal cells affecting about one-third of the thickness of the epithelium. CIN1 is quite common and usually goes away by itself with time. CIN2 refers to abnormal cells affecting about one-third to two-thirds of the epithelium. And CIN3 refers to abnormal cells affecting more than two-thirds of the epithelium. CIN2 and CIN3 are more likely to require treatment or laser surgery to prevent cancer.

Cervical dysplasia does usually cause symptoms, which is why it is incredibly important to partake in regular cervical screenings after becoming sexually active. You cannot have cervical dysplasia without first contracting HPV.

In Australia, the National Cervical Screening Program invites women aged 25-74 years of age to partake in five yearly cervical screenings. Though this is a source of contention in younger women who are sexually active as many women under 25 have reported CIN1, 2, and 3 prior to the age requirement being introduced, despite the claim that cervical cancer under the age of 25 is rare. Medicare currently does not cover routine cervical screening for women under 25 years of age, unless prior to the age standard being changed they had previously experienced cervical dysplasia to some extent.

Many women have reported being dismissed by medical professionals because they do not fall into the age bracket. Only after evidence of previous cervical dysplasia is produced are they taken seriously. It is important to tread lightly on subjects regarding women's health and reproductive issues, as this is a source of great anxiety and pain for a large percentage of women in Australia, and to approach any worries with care and caution. Compared to numerous first world countries, Australia boasts a strong healthcare system, with amazingly attentive medical professionals that patients feel comfortable sharing their concerns with, though we are lacking in adequate sexual education in our schools, where prejudice makes its nest initially.

It may be time to call for a reform in these areas. What do you think?

Email your opinions and responses to this article to [admin@themedicallink.com.au](mailto:admin@themedicallink.com.au).



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# The GCMA February Meeting



Dr Michael Slancar, Dr Mohammed Islam, Prof Alfred Lam & Dr Roger Wilson



Prof Philip Morris & Dr Michael Slancar



Dr Michael Slancar



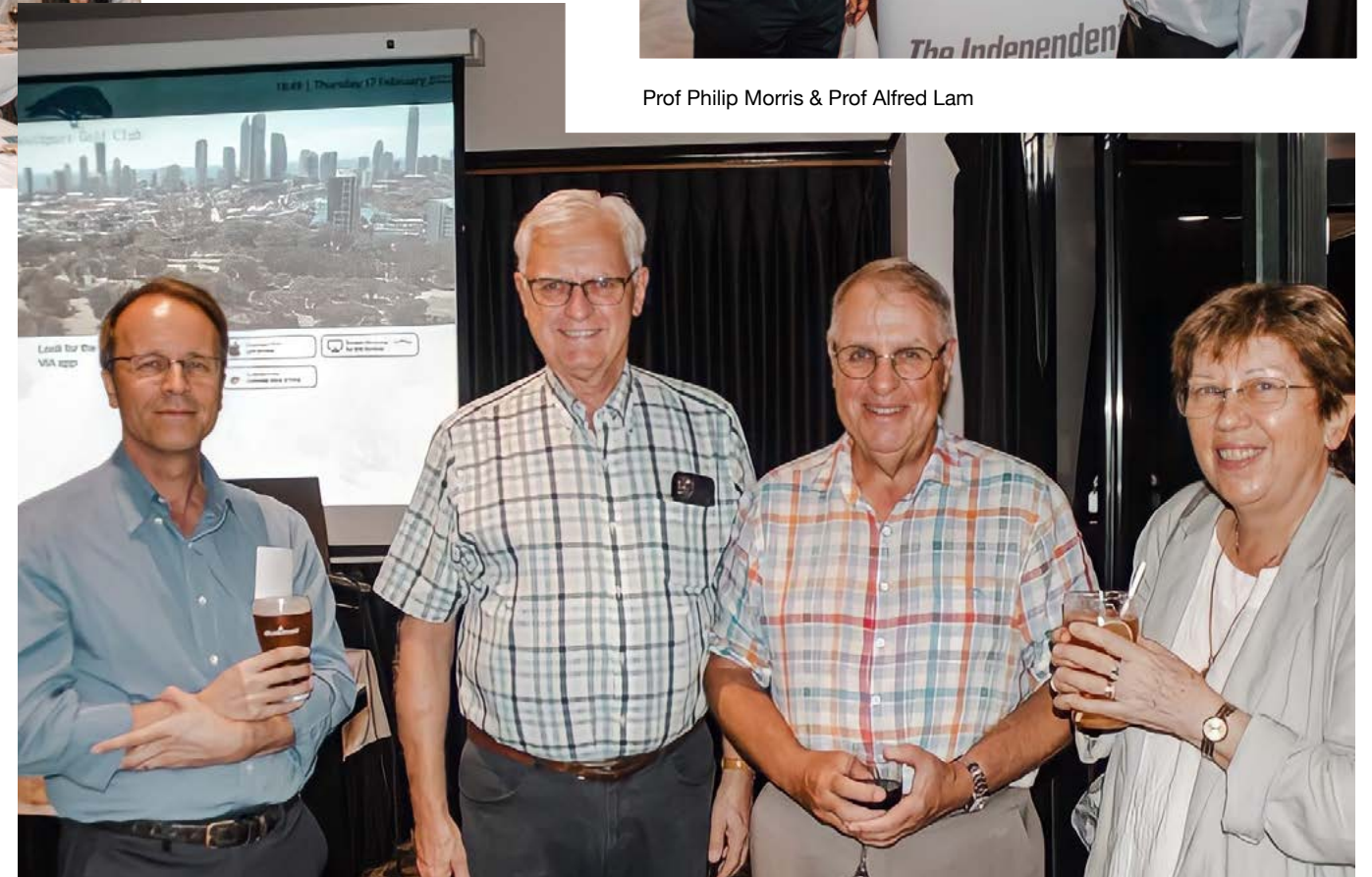
Dr Stephen Weinstein



Prof Philip Morris & Prof Alfred Lam



Prof Philip Morris, Dr Michael Slancar & Dr Stephen Weinstein



David Christie, Dr Graeme Doherty, Dr Gordon Wright & Dr Jane Smith





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**Dr Helen Green**

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**Dr Yasmin Pilgrim**

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**Karen White**

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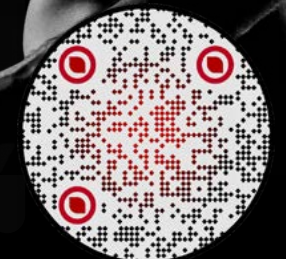
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### Dr Nikki Stamp

Doctor Nikki Stamp FRACS is a heart and lung surgeon, presenter, PhD superstar and author. She is an outspoken advocate for gender equality for surgeons as well as women's heart disease and health lifestyles. Stamp was named Harper's Bazaar Women of the Year in 2017 and TimeOut Sydney's 40 under 40.

Dr Stamp is an extremely sought-after speaker and source of expertise for several websites, print media, radio and television. Dr Stamp contributes regularly to Huffington Post and the Washington Post, detailing her experiences as one of the only eleven female cardiothoracic surgeons in Australia – a traditionally male-dominated field.

Dr Stamp holds a Fellowship of the Royal Australasian College of Surgeons in cardiothoracic surgery. Her research has been widely published and includes mentoring and gender in surgery, improving the patient experience and outcomes of cardiac surgery and using physical activity to prevent cardiovascular disease.

Dr Stamp is a strong advocate for the importance of self-care and work-life balance. Dr Stamp is also the author of two highly acclaimed books; 'Pretty Unhealthy' and 'Can You Die of a Broken Heart?'. Her new book Scrubbed is expected this coming May 2022.

### Dr Jill Tomlinson

Dr Jill Tomlinson is a Melbourne based plastic and reconstructive surgeon – and avid voice for gender equality in the medical field. In 2019 Medical Journal Australia conducted an open letter to the medical community "Is there gender equality in medicine?" Dr Tomlinson responded with a resounding "No."

Dr Tomlinson completed medical school in 2001 at the University of Melbourne and was one of five students to graduate with first class honours in both medicine and surgery. Dr Tomlinson is the Specialty Editor for the Australian and New Zealand Journal of Surgery and has published in international journals including Plastic and Reconstructive Surgery, the Annals of Plastic Surgery, the British Medical Journal and the Journal of the American College of Surgeons.

Dr Tomlinson is a Partner Investigator on the Australian Research Council funded project "Elucidating the increasing demand for genital cosmetic surgery among girls and women in Australia" conducted by a multidisciplinary team of researchers at Monash University, Jean Hailes for Women's Health, Women's Health Victoria, Southern Health/Monash Medical Centre, Family Planning Victoria and the Australian Federation of Medical Women.

She is a Federal Councillor with the Australian Medical Association (AMA). She was Secretary of the Australian Federation of Medical Women in 2011-2014, the Deputy Chair of the Executive Committee of the Women in Surgery Section of the Royal Australasian College of Surgeons in 2011-2014, the Treasurer of the Victorian Medical Women's Society (2005-2009 and 2011-2012) and the Webmaster of the Australian Federation of Medical Women (2008-2013).

### Prof Sandra Eades

Professor Sandra Eades is a proud Noongar woman from Western Australia. Prof Eades completed her medical degree in 1990 and went on to work as a general practitioner, before starting her career in health research at the Telethon Kids Institute.

In 2003 Prof Eades gained her PhD, making her the first Aboriginal medical doctor to gain a PhD – which investigated the causal pathways and determinants of health among Aboriginal Infants in the first year of life. Professor Eades was named NSW Woman of the Year in 2006.

Prof Eades gained the title of NSW's Woman of the Year in recognition of her work in identifying links between social factors such as housing and infant health. Awarded to Prof Eades in celebration of International Women's Day 2006.

Prof Eades has dedicated her life and career to improving the overall wellbeing of indigenous lives across Australia and has gained numerous grants over the years for research in Indigenous Health studies. Prof Eades has led a steady and full career in Medicine and has moved from practice, to research, to teaching in recent years. Prof Eades was appointed Associate Dean Indigenous and Rowden White Chair at the University of Melbourne in January 2022.

### Dr Anita Goh

Dr Anita Goh is a clinician researcher and works at the Royal Melbourne hospital and leads the Huntington's disease research lab at the Academic Unit for Psychiatry of Old Age at the University of Melbourne.

Dr Goh is also involved in the National Ageing Research Institute as a project manager. Dr Goh has focussed her field around creating a safe and supportive environment for Australian's aging population.

Dr Goh is an outspoken advocate for gender equality and is proud to be a part of the collective that is making significant improvements for women in STEM. In 2019 she was selected by Science and Technology Australia to be one of sixty women nationally selected as Superstars of STEM, with the aim to smash the broader societal gender assumptions about scientists and increase the public visibility of women in STEM.

Currently, Dr Goh is the Program Chair of the Alzheimer's Association International Society to Advance Alzheimer's Research and Treatment ISTAART Health Policy PIA – Focussing on the impact of health policy and health systems on dementia. She is a Victorian Executive committee member of the Australian Association of Gerontology. And NHMRC National Institute for Dementia Research (NNIDR) Chair of the Special Interest Group in Young Onset Dementia.

The University of Melbourne has a wonderfully in-depth profile on Dr Anita Goh, which you can visit to learn more about her accomplishments and ongoing research.

# Celebrating Females in Science & Medicine

BY E.K. DALEY  
THE MEDICAL LINK  
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# Menopause: Increasing Visibility

BY E.K. DALEY  
THE MEDICAL LINK  
ADMIN@THEMEDICALLINK.COM.AU

**M**enopause is unfortunately an unavoidable part of life for many women worldwide, though there is an unfair stigma surrounding the phenomenon. It is estimated that one billion women are currently experiencing menopause in 2022, and by the year 2030, there will be 1.2 billion menopausal and post-menopausal women, with an added 47 million new entrants each year (Hill 1996).

Menopause can be described as the end of a woman's reproductive stage of life. Menopause can onset between 45-60 years of age, sometimes occurring unusually early for a small percentile of women. The onset of menopause is known as Perimenopause, as the official diagnosis of Menopause will not be given until a woman has experience a consecutive 12 months of no menstrual bleeding.

Symptoms include hot flushes, night sweats, muscle joints and aches, tender breast, mood swings and changes to the menstrual cycle i.e., larger gaps between menstrual bleeding or no bleeding at all.

Natural menopause occurs when a woman's ovaries no longer have any eggs to release, and symptoms are caused by a drop in the levels of oestrogen. Early onset menopause can occur due to medical treatments such as chemotherapy, radiotherapy or other surgeries that may affect the ovaries such as an oophorectomy or hysterectomy. Early menopause can also onset due to a genetic, autoimmune or metabolic condition.

To relieve the symptoms of menopause, doctors may prescribe hormone replacement therapy, though this may not be appropriate for all cases, especially for women with a history of cancer.

*The Medical Link interviewed three women from Menopause & Peri-Menopause Support Group Australia about their experiences:*

**At what age did you notice the onset of peri-menopause and what were your symptoms?**

**Jo, Victoria, 56:** In retrospect my symptoms started in my early 40s with sleep disturbance and random bouts of inflammatory aches that could not be explained. I had never heard of peri-menopause (I am a widely read environmental scientist). My clockwork periods had stuttered only twice (late by two weeks) but then returned to normal. I was not aware that these sorts of issues could occur in the years leading up to menopause, despite suffering from similar symptoms in the week leading up to my period. In my late 40s, I became very despondent with my once fulfilling career, and increasingly angry and disillusioned with the response of all levels of government to climate change and sustainability.

**Jodie, Queensland, 53:** I was 46 when I first noticed my periods, which were once heavy, long and painful, were becoming shorter, lighter, no longer painful and gradually further apart. By the age of 48 other unpleasant symptoms of poor sleep, aching body and anxiety had begun.

**Naomi, New South Wales, 54:** I became surgically menopausal at age 46, after the removal of my last ovary due to an ovarian endometrioma cyst causing extreme pain. I had previously had a total hysterectomy for adenomyosis, and my first ovary removed for another endometrioma. In retrospect I had been having minor peri menopausal symptoms for a year or two prior to this, some flushes, insomnia, extreme PMS and mood swings at certain times in my cycle.

**At what point did you consult a doctor and how was that experience?**

**Jo, 56:** I discussed the aches and general fatigue and despondency with my GP who did some screening tests which did not show anything untoward (e.g., thyroid function, arthritis markers). I was also regularly seeing a myotherapist and occasionally a physiotherapist to manage the increasing bouts of aches. I was seeing business coaches and mentors about my career despondency and accessing counsellors through an Employee Assistance Scheme. No-one, not once, even mentioned peri-menopause or discussed the wide range of symptoms that it can cause.

**Jodie, 53:** At the age of 50 I was still peri-menopausal (getting a period every three months) and realised that my symptoms (extremely poor sleep, crushing fatigue, waking in the night to urinate when I had never needed to before, aching body and strong anxiety and occasional low moods) had insidiously increased to the point where they were having a significantly negative impact on my life. I was (and still am) an admin of a menopause support group and I had done considerable reading into the options that were available to me from credible sources such as the AMS, Jean Hailes and Dr Ginni Mansberg's excellent book "The M Word" and the pros and cons of those options.

I had decided I wanted to trial MHT, both for its effectiveness at managing menopausal symptoms and the potential longer term health benefits to my bones, brain and heart etc. My experience with the GP I had at the time was absolutely appalling. That GP tried to use the outdated and frequently useless method of blood test results to diagnose me (please read the AMS guideline for Diagnosing Menopause [www.menopause.org.au/images/stories/infosheets/docs/AMS\\_Diagnosing\\_menopause.pdf](http://www.menopause.org.au/images/stories/infosheets/docs/AMS_Diagnosing_menopause.pdf) to understand how it should be done). He refused to discuss options I was interested in and refused to prescribe MHT for me. He quoted outdated information from the WHI. Is there any other field of medicine where a GP can refer to information that has since been largely refuted, refuse to consider new research and get away with it? He then prescribed me antidepressants (Sertraline) without a single word of explanation about what they were, how they should be taken, what the potential benefits or side effects were or how long they should be taken for.

It is unfortunately a very common experience that menopausal people are prescribed ADs when MHT should be prescribed. MHT is the gold standard in menopausal treatment and should be prescribed first to manage menopausal symptoms unless there is a compelling medical reason not to.

GPs regularly fail menopausal people in this fashion. I threw that script right in the bin and immediately went hunting for a far better and more up to date GP. Which I did find quite quickly.

**Naomi, 54:** I had been consulting both gynos and GPs for most of my life due to my endometriosis, however my GP never once discussed peri with me even when I mentioned my symptoms. My endometriosis excision specialist just kept telling me that if I had my last ovary removed, I would be "fixed" and that all my pain would go away. He also insisted that I could not use MHT as it would activate any remaining endometriosis, and that I would feel so better without my ovaries that I wouldn't notice being without hormones. He was very wrong. I spent three years without MHT, and they were honestly the three worst years of my life. I struggled with extreme mood disorders, rage, joint pain to the point where I was crying at night, insomnia, flushes and sweats like nothing else. My relationships with my husband and my son suffered and I was not a nice person to be around.



## How long after did you receive the menopause diagnosis and what treatments were made available to you?

**Jo, 56:** After around 10 years of increasing seemingly unrelated symptoms, and with my periods thankfully becoming light and less frequent, I started to develop more classic symptoms of menopause. First there were night sweats (not flushes) which I didn't relate to menopause. It was only when hot flushes started that I started looking into menopause symptoms and was shocked to find that most of what I had been suffering for years were known peri-menopause symptoms. I watch the menopause episode on SBS Insight, which was a real eyeopener, and through that found the Menopause & Peri-menopause Support Group Australia on Facebook. This led me to evidence-based information from the Australasian Menopause Society and Newson Health in the UK.

So armed with solid information on diagnosis and treatment options, I went to my GP clinic. The young female GP agreed that I was peri-menopausal, then proceeded to proffer antidepressants. I refused the ADs, citing that they are not the recommended treatment and that they only address vasomotor symptoms and not the plethora of other symptoms I was by then suffering including permanent debilitating aches and stiffness. She said that the ADs will "change my perception of pain". Again, I said no thank you, that I would prefer to treat the cause (diminishing hormones) rather than a few symptoms with a drug that can have side effects and withdrawal issues. She kept insisting, so I had to put it to her "Do you have anything against Menopausal Hormone Therapy?" She finally gave in, and basically left it up to me to tell her what MHT I wanted to try. I chose Estradot 50 and Prometrium due to issues with the progestins in the Pill in my early 20s.

My symptoms that had been plaguing me for YEARS abated overnight, with progressive improvements over the following weeks as I caught up on a decade of lousy sleep and increased my activity levels. I could once again open jars, do the daily chores on our small holding, and safely hold power tools in my sculpture studio.

**Jodie, 53:** My new GP was completely on the ball. I did not need a menopause diagnosis as I had already diagnosed myself. My new GP agreed with me. After making sure I was up to date with mammograms, cervical screening and having a transvaginal ultrasound I was prescribed MHT. My symptoms immediately started to improve, and life became a lot lighter and brighter. Due to a pre-existing mild clot risk I needed to use transdermal oestrogen. I chose gel over patches (I dislike sticky things on my body) and chose micronised progesterone (Prometrium) over the Mirena.

**Naomi, 54:** Three years later at age 49 my wonderful GP finally persuaded me to start MHT. She offered me oral, or patch form of oestrogen and I started on a medium dosage. Within a month or so I was substantially improved. My experience with my current GP practice has been amazing. She is educated regarding menopause and happy to discuss my treatment with me, rather than forcing her opinion on me. She has allowed me to trial different methods of oestrogen and testosterone as well. My gyno failed me abysmally however, I could have been put onto MHT immediately following surgery and avoided an extremely nasty three years. My bone density suffered during that time and has not yet sufficiently recovered.

## How would you describe your experience with doctors/specialists and other medical practitioners when discussing your menopause?

**Jo, 56:** They never discussed it, they never raised it, and when I finally figured it out, they tried to prescribe me something inappropriate and I had to advocate for TGA regulated treatment recommended by Menopause Societies around the world. MHT gave me life back eighteen months ago and it still makes me incredibly angry that I had to fight so hard for this and that I suffered for so long. My new GP (the previous one moved on) is more open to MHT, but still hesitant, and is curious about my symptoms and how they improved with treatment. I suspect she is also suffering a variety of symptoms that she may not have attributed to menopause.

**Jodie, 53:** My first experience with my now ex-GP was dreadful. His fragile ego could not cope with my disagreeing with him and trying to discuss the options I wanted (ie advocating for my own health). He interrupted me, spoke over me and was only concerned with how insulted he was that I disagreed with him. If I had not been so incredibly flat and consumed by my awful symptoms, I would have reported him. I fear for any other menopausal person seeking medical assistance from him regarding symptom management. My second experience with my current GP was excellent. She listens, learns, asks my opinion, shares relevant information, makes considered recommendations, wants to know what my health goals are and is respectful of my feelings and wishes. A good GP is worth their weight in gold and worth holding onto.

## What would you like doctors to know about the human aspect side of living with menopause and how can they adjust how they practise treating menopause when dealing with patients?

**Jo, 56:** Firstly, get educated about menopause which affects 50% of the population. At least three quarters of people experience symptoms that have some impact on their lives, and a quarter experience debilitating symptoms that can be destructive to careers, relationships and long-term health, or sadly life itself with the highest suicide rate for females being the 45-55 age group.

The Australasian Menopause Society provides some excellent resources to GPs and specialists, I just wish more would use those resources, or at least refer to them

when they obviously don't know. If a woman (or trans man or non-binary person) in their 40s presents with a cluster of symptoms then peri-menopause should be front of mind, not the last thing that is thought of after a battery of expensive, time-consuming tests for everything else under the sun. Once the obvious things have been eliminated, for many people a trial of MHT will quickly show results over a few weeks.

My heart sinks when I read the terrible stories of so many of our support group members who have been fobbed off by their doctors, or get told it's all in their heads, or to suck it up, or that they are too young, or that their blood test shows their hormones are normal (blood tests are not recommended as a diagnostic tool for over 45s). They can't have MHT because of family history of clots or cancer or heart disease (none of these are contraindications), or that they can't have MHT yet because they are still having periods, or they can't have MHT because their periods have finished and it's too late, or that they won't prescribe MHT because it causes cancer, or they are given a prescription for antidepressants or blood pressure medication thinking that it is MHT only to be told by their pharmacist when filling the script. If they are given a prescription for MHT, sometimes they are inappropriately given a cyclic MHT when they are post-menopausal or are given no instructions for use and no information about the possibility of spotting and bleeds in the first six months even if post-menopausal. Of great concern is the occasional person given a prescription for oestrogen with no progestogen to protect their endometrium.

Conversely, I celebrate when we hear stories of people being listened to by their GP, with treatment options explained, and appropriate treatment prescribed. It is especially heartening when the GP admits that they don't know a lot about it and works in partnership with their patient to navigate this tumultuous stage of their life. As you can see, there is huge room for improvement. There is an enormous education deficit about menopause and its treatment, but there is excellent information readily available through the Australasian Menopause Society and the RACGP.

**Jodie, 53:** Menopause is a significant life event for most women (and some non-binary and trans folk). Untreated symptoms can lead to careers lost, friendships ignored, social isolation, divorces, poorer long term health outcomes, poverty, homelessness and suicide. Menopausal symptoms should never be ignored. The cost to all of us as individuals and a society is far too great. There is a wealth of information online and training available for menopause. [www.menopause.org.au](http://www.menopause.org.au)

**Naomi, 54:** That it isn't all physical. So many of our menopausal symptoms are psychological too. My physical symptoms were horrible but after a lifetime of endo pain I could deal with that. But the psychological hell that I went through and still struggle with to a degree is very real, and very unpleasant, and very treatable for the vast majority of us. There is a reason why the highest age specific suicide rate for women is the 40-44 age group, closely followed by those 50-54. These are right smack bang in the peri group that is most often told they are "too young" for peri menopause and then those offered nothing but platitudes about "it is natural and will pass" or prescribed antidepressants when they are not actually in need of anything but hormones.

The education for both general practitioners and gyno's regarding menopause needs to be expanded, considering a full 50% of their patients (or much more for gyno's) will at some point experience menopause. Both the Australasian Menopause Society and the RACGP have excellent resources, as does Newson Health in the UK. The information is out there! Why are these not taught in detail during medical training, and modern updated information also made available during further education credits that all medical personnel are required to do during their careers. There is a distinct lack of care for women in general let alone when it comes to a subject such as menopause, yet it is a defining physical and mental stage in our lives that needs much better care.

I am incredibly honoured to be able to assist people through being an admin in the Menopause & Peri-Menopause Support Group Australia but saddened at the same time to hear over and over and over again, the same stories of these people being failed by their doctors. We are taught that medical professionals are experts at their job and that we should trust them, and to be honest many of us no longer trust that this is true. Why is it that we non-professionals can find this information, yet they cannot? Naomi, NSW, 53.

*In conclusion, the women of Australia deserve medical care for unavoidable female exclusive experiences such as menopause to be received by medical professionals as completely serious and valid. Too many women have experienced medical bias on women's related issues in Australia and worldwide. It is time to create a shift in focus and work together as both patient and doctor to enable a conducive practice of feminine medicine.*





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