

25th November 2016

**Institute Of Obstetricians And Gynaecologists,
RCPI Four Provinces Meeting**

**Junior Obstetrics & Gynaecology Society
Annual Scientific Meeting**

**Royal Academy Of Medicine In Ireland Dublin
Maternity Hospitals Reports Meeting**

WELCOME

Dear Friends and Colleagues,

On behalf of the Institute of Obstetricians and Gynaecologists in Ireland and The Junior Obstetrics and Gynaecology Society (JOGS) we welcome you to this year's scientific meeting.

This year we received 246 abstract submissions and with great difficulty narrowed it down to 23 oral presentations. The standard was exceptionally high this year and we appreciate the great time and effort everyone has put into their submissions. The JOGS committee would like to thank everyone who submitted their work for consideration and acknowledge the quality of research taking place in Irish hospitals and without everyone's continued support this meeting would not run to such a high standard each year. We would also like to thank the reviewers for taking the time to judge the abstracts prior to the meeting and presentations here today.

This afternoon will focus on gynaecological oncology. Dr Dominique Farge from Hôpital Saint-Louis and INSERM in Paris, internationally renowned for her work on thrombosis in cancers, will present guidelines for thromboprophylaxis in the gynae-oncology population. This will be followed by an interactive case-based session. Dr Ciaran O'Rian, Consultant pathologist from St James's Hospital will update attendees on the overlap between Fallopian tube and Ovarian cancers and the implications of making a diagnosis. Dr Claire Thompson will discuss risk reduction surgery as it relates to ovarian cancer.

The Institute of Obstetricians and Gynaecologists will posthumously award a special Institute Gold Medal to George Mahony FRCOG - that will be accepted by his grandson, Mr Patrick Walker FRCOG. This is the first time that this medal has been awarded. It is awarded *'in recognition of the exceptional dedication to patient care in circumstances of extreme personal danger that was demonstrated by Lieutenant George Mahony during his time as a Prisoner-of-War in Dublin during the Easter 1916 Rising'*. We are also delighted to welcome Dr Alison Wright, Vice President of the RCOG who will be attending the meeting to attend on behalf of the RCOG.

In another first, the Institute Clinical Reports Meeting focusing on Perinatal Mortality will take place in the late afternoon. This was traditionally the slot occupied by the Dublin Maternity Hospital's Annual Clinical Reports Meeting hosted by RAMI. The format will change from being a general review and rebuttal of the Dublin Maternity Hospital Clinical Reports to focusing on a particular topic covered by all reports and including submissions from other hospital Groups around the country. Each Hospital Group will be represented. In addition, Prof Richard Greene will present NPEC data and Professor Lawrence Impey will give an external opinion on the reports that he has received. Following this, there will be an open panel discussion.

We look forward to seeing as many of you as possible at this year's Annual Dinner and Awards ceremony. For the first time, we are having the JOGS dinner off site in Fire. We are hoping that this may be a more relaxed environment for dinner and hope to welcome as many trainees as possible. This

meeting could not happen without the financial assistance of our sponsors and we would like to take the opportunity to thank them for their ongoing support.

Kind regards,

Dr Jennifer Donnelly
Convenor of Meetings

Dr Gillian Ryan
Chair of JOGS

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'THIS ONE THING...': FACILITATING COMMUNICATION IN ANTENATAL CLINICS AT THE NATIONAL MATERNITY HOSPITAL

Abstract ID: 81

Dr. Ruth Roseingrave (University College Dublin), Dr. Emma Tuthill (The Mater Misericordiae University Hospital), Prof. Mary Higgins (UCD Obstetrics and Gynaecology, National Maternity Hospital)

The National Maternity Hospital (NMH) is invested in providing the highest levels of care for its patients, and considers communication to be a key aspect of this care.

This study aimed to gather information about communication between the antenatal patient and their team from the patient and professional perspective.

A questionnaire named 'This One Thing...', was adapted from an award-winning UK communication initiative. Patients were invited to participate in the study by filling in the questionnaire during their antenatal visit. In order to sample a wide population, questionnaires were distributed at a variety of clinics: a consultant-led clinic, a midwife-led clinic, a maternal medicine clinic, and two satellite clinics. Informal interviews were conducted with doctors and midwives to obtain their perception of the questionnaire and its impact on the clinics.

151 women were invited to participate, with 39 returning questionnaires, a response rate of 25.8%. Examples of questions ranged from "What position is my baby in?" to "Is it possible to get tubal ligation after the birth?" 24 out of 39 respondents (61.5%) believed that the questionnaire was very useful to them, of which 10 also answered that it was not required at every visit. Staff members interviewed reported that the questionnaire did not increase consultation time nor the number of questions asked by patients.

This study contributed to the ongoing efforts made to encourage communication between patients and their clinical team. There was a positive response to the initiative from both patients and staff.

: POST MENOPAUSAL BLEEDING – MANAGEMENT IN THE AMBULTORY GYNAE SETTING

Abstract ID: 222

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The audit aim was to assess the efficacy of the ambulatory gynae clinic in assessing and treating women who attended the unit with post menopausal bleeding (PMB). This was done by analysing the number of women presenting to the unit with PMB who went on to have either further follow up in the ambulatory setting or procedures as inpatients.

One of the key performance indicators in the assessment and management of women presenting with PMB is the percentage of these women having a one-stop approach, including the availability of hysteroscopy and biopsy in the outpatient setting. The clinic in Mayo University hospital was set up with this aim in 2008.

The audit data was gathered retrospectively using the Mediscan electronic patient filing system. Patients who attended between July 2015 and January 2016 were included. Only women presenting for the first time with PMB were included.

A total of 116 women attended the clinic with a first presentation of PMB in the aforementioned time period. Of these 74 (64%) were discharged following the first visit. 23 (20%) women required further treatment in the operating theatre and 17 (15%) required further follow up in the ambulatory clinic.

The majority of women who attended the clinic with PMB were managed effectively in one visit. This is reflective of the efficacy of the unit in the provision of care to this cohort of women.

A RETROSPECTIVE ONE-YEAR SINGLE-CENTRE ANALYSIS OF OBSTETRIC RED CELL TRANSFUSIONS

Abstract ID: 231

Dr. Rupak Kumar Sarkar (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda), Ms. Amanda Casey (Our Lady of Lourdes Hospital, Drogheda), Ms. Grainne Sarsfield (Our Lady of Lourdes Hospital, Drogheda), Dr. Rosemary Harkin (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda)

Background:

Blood is a scarce and expensive resource. Decision to treat postpartum anaemia with blood transfusion is often made empirically by physicians. The number of blood transfusions are increasing annually. (IMIS 2015)

Aim & Methods:

We performed a retrospective, observational study of Obstetric red cell transfusions from Jan-Dec 2015. Data was collected from maternity case notes on demographics, location, amount and reason for transfusion, ordering physician and pre and post transfusion laboratory indices.

Results :

3240 women delivered in our unit in 2015.

68 women received a blood transfusion (2.09%)

Maternity charts were available for 54 cases.

Three women received an antenatal RCC transfusion

Haematological parameters in transfused patients (n =54)

Baseline haemoglobin (g/dL) 10.8(7.7-14.3)

Pre-transfusion haemoglobin (g/dL)6.8(4.6-10.8)

Estimated blood loss (mL)1803(200-7000)

Red blood cells transfused (units)3 (1-13)

Post-transfusion haemoglobin (g/dL)9.1 (7.1-12.6)

Mode of delivery in transfused patients (n=54)

Caesarean Section23(43%)

Spontaneous vaginal delivery17(32%)

Ventouse6(11%)

Forceps4(7%)

Ventouse/Forceps1(2%)

Speciality and grade of requesting clinician

Consultant Obstetrician20(37%)

Consultant Anaesthetist8(15%)

Registrar in Obstetrics14(26%)

Registrar in Anaesthetics5(9.25%)

SHO6(11.1%)

Location of blood transfusion

Post Natal Ward22(41%)

Labour Ward (Room 6 HDU)8(15%)

Theatre21(39%)

Antenatal Ward3(5%)

Conclusion:

We would recommend implementation of an educational programme to promote evidence based transfusions, develop guidelines, optimise antenatal Hb%, reduce blood use & explore the role of IV Iron in management of stable post partum anaemia

Haematological parameters in transfused patients (n =54)		
Baseline haemoglobin (g/dL)	10.8	(7.7-14.3)
Pre-transfusion haemoglobin (g/dL)	6.8	(4.6-10.8)
Estimated blood loss (mL)	1803	(200-7000)
Red blood cells transfused (units)	3	(1-13)
Post-transfusion haemoglobin (g/dL)	9.1	(7.1-12.6)
Mode of delivery in transfused patients (n=54)		
Caesarean Section	23	43%
Spontaneous vaginal delivery	17	32%
Ventouse	6	11%
Forceps	4	7%
Ventouse/Forceps	1	2%
Speciality and grade of requesting clinician		
Consultant Obstetrician	20	37%
Consultant Anaesthetist	8	15%
Registrar in Obstetrics	14	26%
Registrar in Anaesthetics	5	9.25%
SHO	6	11.1%
Location of blood transfusion		
Post Natal Ward	22	41%
Labour Ward (Room 6 HDU)	8	15%
Theatre	21	39%
Antenatal Ward	3	5%

Bt1 results.png

A 10-YEAR REVIEW OF PREMATURE OVARIAN INSUFFICIENCY IN THE NATIONAL MATERNITY HOSPITAL

Abstract ID: 218

Dr. Rebecca Moore (Department of Adolescent Gynaecology, The National Maternity Hospital, UCD Obstetrics & Gynaecology, The National Maternity Hospital.), Ms. Marie Culliton (Department of Pathology and Laboratory Medicine, National Maternity Hospital), Prof. Mary Wingfield (Merrion Fertility Clinic, National Maternity Hospital), Dr. Venita Broderick (Department of Adolescent Gynaecology, The National Maternity Hospital), Dr. Orla Sheil (UCD Obstetrics and Gynaecology, National Maternity Hospital)

Background:

Following the recent ESHRE guideline, published in December 2015, for the management of women with Premature Ovarian Insufficiency (POI), we wanted to review the management of such women in the National Maternity Hospital. We were particularly interested in establishing the prevalence, the age and the investigations performed at diagnosis, along with management including counselling, choice of hormonal replacement therapy and advice regarding fertility options.

Methods:

An FSH ≥ 30 IU/L and age < 40 years were used to identify potential cases of POI. All FSH values ≥ 30 IU/L, processed in the laboratory between January 2005 and December 2014, were identified from the electronic laboratory system, Winpath. These were correlated with age at the time of testing. From this we identified all raised FSH values in women < 40 years of age. The available medical records of these women were reviewed to confirm the diagnosis of POI and gain additional details.

Results:

Following the removal of duplicates a total of 111 women were identified with an FSH ≥ 30 IU/L and age < 40 years over the 10-year period. The average age at diagnosis was 32 years with an age range of 14-39 years. 5.4% (6/111) were aged ≤ 20 years and 28.83% (32/111) were aged ≤ 30 years at the time of diagnosis.

Conclusions:

The diagnosis of POI is thankfully rare but carries a significant burden for those affected. It is important to standardise our management in line with the recent ESHRE guideline and to ensure all aspects of their well-being are addressed.

A borderline ovarian tumour in the presence of bladder extrophy in an adult female

Abstract ID: 169

Dr. Grace Ryan (MMUH), Dr. Dr Niamh Maher (MMUH), Dr. Katie Beauchamp (MMUH), Mr. Tom Walsh (MMUH)

Abstract

We present an unusual case in which a 37yr old lady presents with obstructive nephropathy secondary to a large ovarian mass in the presence of bladder exstrophy.

Introduction

Borderline ovarian tumours comprise of approximately 15-20% of all epithelial ovarian malignancies. Bladder exstrophy is a defect in the anterior midline of the abdomen with variations including external genitalia, pelvis and urinary tract, exposing the distal urinary tract onto the outer abdominal wall. The incidence varies from 1:30,000-1:50,000 live births.

Case Report

A 37yo Romanian lady presented with severe abdominal pain. Background of separation from her conjoined twin at birth and apparent urinary incontinence. Physical examination revealed a tender, distended abdomen with distorted anatomy. CT findings showed a cystic mass measuring 20x 22cm, with mural nodularity arising from the left adnexa, omental metastasis and retroperitoneal lymphadenopathy. Mild left proximal hydroureter and hydronephrosis, along with abnormal anatomy of the abdominal wall.

Intraoperative findings included extensive adhesions, a large ovarian mass was found arising from the left ovary, normal right ovary, fallopian tube and uterus. The ureter was anastomosed to the sigmoid colon eliciting to previous corrective surgery. Histology revealed a borderline mucinous tumour. She received post op care in the high dependency unit recovering well with no post op complications.

Discussion

This case demonstrates difficulties and challenges of management of ovarian tumours in the context of a rare urogenital anomaly. Therefore it is advisable to adopt a multidisciplinary approach to create a safe, optimal surgical environment to minimize the risk of complications.

A CASE OF CENTRAL VENOUS SINUS THROMBOSIS IN PREGNANCY

Abstract ID: 117

Dr. Jennifer Byrne (Portiuncula University Hospital, Ballinasloe), Dr. Michael Brassil (Portiuncula University Hospital, Ballinasloe)

Introduction: Cerebral venous stroke is a dysfunction of the brain caused by thrombosis in cerebral veins or thrombosis in the sinus of the dura mater. It is a rare but potentially fatal cerebrovascular condition. Pregnant women are at greater risk because of their hypercoagulable state.

Case report: TM is a 24 year old lady Gravida 4 Para 2+1. She presented with a 2 week history of headaches at 37 + 4 weeks gestation. The pain radiated into the left side of her ear and was associated with nausea and vomiting, dizziness and light sensitivity. She was initially diagnosed with otitis media and started on oral antibiotics.

She re-presented two days later with worsening symptoms and was admitted for treatment with intravenous antibiotics and analgesia. Due to the fact that she was not improving, an MRI of the Brain was requested. This showed a cerebral transverse sinus vein thrombosis.

She was transferred to a tertiary centre and had haematology input. She was commenced on unfractionated heparin and this was stopped the next morning to facilitate induction of labour. She had a vaginal delivery of a male infant weighing 3.22 kilos. Around the time of labour she was treated with prophylactic low molecular weight heparin (LMWH). She was recommenced on therapeutic anticoagulation on day two postnatal and will require one year anticoagulation in total.

Discussion: Cerebral transverse venous sinus vein thrombosis is a rare event but identifying and treating it in pregnant women is essential.

A CASE OF HORMONE-SENSITIVE MENINGIOMA PROGRESSING WITH PREGNANCY

Abstract ID: 283

Dr. Amy Claire O Higgins (Univer), Dr. Sucheta Johnson (University Hospital Limerick), Dr. Kalsum Khan (University Hospital Limerick), Dr. John Slevin (University Maternity Hospital Limerick)

A 35 year old woman, para 2, presented at 5 weeks gestation. She had been diagnosed with an oestrogen and progesterone receptor positive meningioma of her left cerebellopontine angle in 2015. The meningioma extended to the clivus and caused indentation of the brainstem medulla.

The patient initially presented at 32 weeks gestation with neck pain radiating to her shoulder. Postnatal imaging revealed a meningioma. Following craniotomy and biopsy of the lesion she developed a bulbar 7th nerve palsy with a vocal cord palsy and inability to swallow requiring placement of a percutaneous gastrostomy tube. Given this decompensation she was deemed unsuitable for surgical reduction. Radiation therapy is contra-indicated in pregnancy.

Multi-disciplinary input was sought. Consensus decision was that continuation of the pregnancy could result in serious or fatal consequences for the mother. She underwent an uneventful surgical termination of pregnancy and tubal ligation.

Brain tumours in pregnancy are rare, occurring in about 5/100,000 pregnancies. Meningiomas are the most common form of brain tumor accounting for one third of primary central nervous system tumors. Their aetiology is multi-factorial though hormonal influences are believed to be significant. Rapid growth can occur in pregnancy due to hormone induced cellular proliferation as well as haemodynamic changes. The current literature regarding management of meningiomas during pregnancy is limited, consisting primarily of case series.

This case highlights the importance of multi-disciplinary decision-making in the management of these complex cases and provides an example of the importance of the Protection of Life during Pregnancy Act.

A CASE OF POSTPARTUM HELLP SYNDROME

Abstract ID: 69

Dr. Sara Siddique Khan (Portiuncula University Hospital, Ballinasloe), Dr. Mohamed Abbas (Portiuncula University Hospital, Ballinasloe)

HELLP Syndrome (haemolysis, elevated liver enzymes and low platelets) represents the severest form of pre-eclampsia (PET). It is associated with high maternal and foetal morbidity and mortality. Early diagnosis and prompt management is essential. The incidence of HELLP syndrome is 0.1 – 0.8 percent in overall pregnancies and 10 -20 percent in cases with severe PET/Eclampsia. This case report is of a Para 1, 34 years old woman with PET. She had an uneventful pregnancy up to 34 weeks, when she developed raised blood pressure and proteinuria and was diagnosed as PET. The patient was prescribed anti-hypertensives and had close follow up. She had an induction of labour at 37 weeks for Intra uterine growth restriction (IUGR). She gave birth to a 2.4 kg baby by vacuum delivery. Post Delivery her liver enzymes showed a rapid increase with an excessive fall of her platelets and decreasing haemoglobin level with no bleeding. A case of post-partum HELLP syndrome was diagnosed. The patient needed Intensive care unit admission and close follow up until recovery.

A CASE REPORT OF ATYPICAL POLYPOID ADENOMYOMA

Abstract ID: 226

Dr. Amy Fogarty (Gynaecology Department, Tallaght Hospital, Dublin 24), Dr. Aoife McSweeney (Cork), Dr. Gunther Von Bunau (Gynaecology Department, Tallaght Hospital, Dublin 24)

Atypical Polypoid Adenomyoma (APA) is an extremely rare condition. It was first described in 1981 and since then only 200 cases have been described in the English literature. The incidence has yet to be formally established. It is most prevalent in premenopausal nulliparous women with prolonged oestrogen stimulation. APA is considered to be a benign uterine tumour with low malignant potential. However, as more cases are described, there is growing evidence of the risk of recurrence or co-existing endometrial cancer. To date, there has been wide variation in management of APA, ranging from definitive surgical resection or hysterectomy, to more conservative approaches.

We present the case of a patient who attended our hospital with new onset menorrhagia for ten months. She is a 46 year old nullipara with a BMI of 37 and a background history of polycystic ovarian syndrome. Transvaginal ultrasound revealed a thickened endometrium of 30mm that was poorly defined. She underwent a hysteroscopy with dilation and curettage which revealed a fundal uterine polyp. Histologic diagnosis was that of APA.

Due to paucity of reported cases, the aetiology and pathophysiology of this rare condition are yet to be defined. In this respect, there is a lack of guidance on management and patient counselling. Fertility-sparing management should encompass careful surveillance due to the risk of recurrence or malignant transformation.

A CASE REPORT: SQUAMOUS CELL CARCINOMA ARISING IN A MATURE CYSTIC TERATOMA

Abstract ID: 225

Dr. Sarah McDonnell (St James's Hospital Dublin), Dr. Claire Thompson (St James's Hospital Dublin), Dr. Dr Feras Abu Saadah (St James's Hospital Dublin)

Mature Cystic Teratomas (MCT), more commonly known as dermoid cysts, are the most common ovarian germ cell tumour. Malignant transformation, although rare, is well-documented in the literature. Squamous cell carcinoma is the most commonly associated malignancy with MCT, occurring at a documented rate of 0.3 to 2%. This discussion considers the case of a 36 year old nulliparous woman who presented with abdominal pain and bloating. Features consistent with an MCT were observed on transabdominal ultrasound. Subsequent MRI revealed findings consistent with a large mature teratoma, however radiological features concerning for malignancy were also documented. A unilateral salpingo-oophorectomy and subsequent histopathologic analysis of the specimen revealed an invasive, poorly differentiated squamous cell carcinoma arising in a mature cystic teratoma. Staging CT demonstrated para-aortic lymphadenopathy and biopsy of same confirmed the presence of metastases and FIGO stage IIIC disease. Completion surgery was performed at a tertiary referral centre. Adjuvant chemotherapy and radiotherapy complemented surgical management and there is no evidence of recurrence, clinical or radiological, 11 months post-completion of treatment.

Despite the rarity of this type of tumour, a growing compilation of case reports is contributing to the knowledge surrounding malignant transformation of MCTs. Factors which may arouse suspicion of malignancy involving this frequently encountered gynaecological neoplasm, as well as optimal treatment regimens, are over time becoming evident with increasingly documented cases.

A COMPARISON OF THE MATERNAL AND NEONATAL OUTCOME BASED ON THE BOOKING MATERNAL BODY MASS INDEX OF WOMEN DELIVERED IN PORTIUNCULA UNIVERSITY HOSPITAL IN 2015

Abstract ID: 49

Dr. Aoife Mc Goldrick (Portiuncula University Hospital, Ballinasloe), Dr. Mary Barrett (Portiuncula University Hospital, Ballinasloe), Dr. Mohamed Abbas (Portiuncula University Hospital, Ballinasloe)

Ireland has one of the highest rates of obesity in Europe. Multiple studies showed that obesity is directly linked to maternal and neonatal morbidity.

To study the relation of the maternal body mass index (BMI) to the maternal and neonatal outcomes.

This was a retrospective study for women delivered in 2015. The data was collected from the patient's antenatal charts. BMI was calculated at the booking visit.

In 2015 there were 1853 women delivered in our Hospital. A third of the charts (612) were randomly selected. Of these, 50 were excluded as the BMI was not recorded.

Results showed a rise on the rates of Gestational Diabetes Mellitus (GDM), Induction of Labour (IOL), Caesarean Section and admission to the Special Care Baby Unit (SCBU) with increasing maternal BMI.

There was a direct relation between normal vaginal delivery (SVD) and lower BMI (100% in BMI group <18.5, and 34.5% in the > 35).

Instrumental delivery was higher among the normal weight group (BMI 18.5-24.9) 30% vs 10.3% in BMI >35. Caesarean sections delivery was 60% in the BMI 30-34.9 and 55% in the BMI >35.

Admissions to SCBU were also increasingly related to Maternal GDM in the Obese BMI categories; 42.8% with BMI >30kg/m² and 83.3% with BMI >35kg/m².

Increased intervention was evident in our population of women when BMI was greater than 30kg/m² except for instrumental delivery. There was also an association with increased neonatal admissions to SCBU.

A COMPLETE AUDIT CYCLE OF THE MANAGEMENT OF THIRD AND FOURTH DEGREE PERINEAL TEARS

Abstract ID: 98

Dr. Sarwat Khan (Our Lady of Lourdes Hospital, Drogheda), Dr. Rupak Kumar Sarkar (Coombe Women and Infants University Hospital), Dr. Rosemary Harkin (Our Lady of Lourdes Hospital, Drogheda)

Purpose of study: The aim of this audit was to assess compliance with current HSE and RCOG Guidelines-The Management of Third and Fourth Degree Perineal Tears.

Study Design and Methods: First audit was performed between January and May 2013. A Re-audit was performed between 1st of January and 31st of December 2015. All women sustaining a 3rd or 4th degree perineal tear were identified from the Maternity Information System and data collected against HSE and RCOG standards.

Findings of Study: There were 2239 vaginal deliveries over the period of re-audit. Mean maternal age was 29.43 yrs. Average BMI was 25.71. There were 70% nulliparous women in the study. Mean gestational age at delivery was 40 weeks and 2 days. There were 43 (1.92%) Obstetric anal sphincter injuries. 97% were repaired in theatre compared to 72% in the previous audit. Regional anaesthesia was used in 97% cases. Appropriate suture materials were used in all cases. An existing proforma for documentation of repair was used in 63% cases compared to 29% patients in the original audit. 46% cases had documented debriefing compared to 29% previously. All patients were prescribed antibiotics and stool softeners. All patients had physiotherapy follow-up and 100% were referred to gynae outpatient (GOPD). 95% attended GOPD. Two patients (4.6%) reported faecal incontinence at follow-up.

Conclusion: There was improved compliance in management of obstetrics anal sphincter injury(OASIS).The existing proforma was used in 63% cases.46.5% cases had documented debriefing. We recommend further emphasis on adherence to protocol and re -audit in 1 year.

A longitudinal observational study of delivery outcomes after a previous preterm delivery over a five years in a tertiary maternity hospital.

Abstract ID: 71

Dr. Laura O Byrne (Coombe Women and Infants University Hospital), Dr. Aoife McKeating (Coombe Women and Infants University Hospital), Dr. Eimer O Malley (Coombe Women and Infants University Hospital), Prof. Michael Turner (Coombe Women and Infants University Hospital)

Preterm birth is a leading cause of neonatal morbidity and mortality. Predicting women at risk of preterm delivery (PTD) is pertinent in reducing neonatal mortality and morbidity. This study used a database of 42,362 deliveries between 2009 – 2014 in the Coombe Women and Infants University Hospital. The aim was to identify women at high risk of preterm delivery.

The incidence of PTD was 6.8% (2,863). The demographics of the term and preterm groups differed statistically in age, BMI, smoking status, parity, fertility treatment, smoking and alcohol use. Correcting for multiple gestations, 517 women had a subsequent delivery, 79.1% (409) term and 20.9% (108) PTD. The incidence of subsequent preterm delivery for spontaneous onset of delivery was 24.3% (64), induction 11.9% (13), elective LSCS 25.6% (11) and emergency LSCS 19.6% (20) ($P=0.049$). In 48.7% (199) of subsequent term deliveries and 59.3% (64) of subsequent preterm had a previous spontaneous preterm delivery ($P=0.05$).

In conclusion, 20.9% of the preterm group went on to have a subsequent preterm delivery. This was higher than the literature suggests at least a 3fold increase in the risk of PTD 6.8%. Smoking and spontaneous onset of delivery were statistically associated with subsequent preterm deliveries. This study helps to identify those at high risk of subsequent PTD in a large tertiary centre population.

A ONE-YEAR REVIEW OF AN ELECTIVE INDUCTION POLICY: IS ELECTIVE IOL AN EFFECTIVE AND SAFE POLICY?

Abstract ID: 229

Dr. Claire M McCarthy (University Hospital Limerick), Dr. Dmitry Loktionov (Uni), Dr. Mark Skehan (University Hospital Limerick)

Induction of Labour (IOL) in Ireland occurs at a rate of 23.3 per 100 deliveries, and is a significant economic burden, and is associated with higher operative delivery rates. The aim of our study is to show that an elective IOL policy with management by a sole obstetrician can decrease Caesarean Section (CS) rates, as well as maternal and neonatal morbidity.

We conducted a retrospective review of women attending a named obstetrician over a one-year period. In total, 22 variables were collected, including patient demographics, onset and mode of labour/delivery delivery and maternal and neonatal outcomes.

In total 175 patients were identified, with a mean age of 38.84 (range 21-45) years. The overall CS rate of the group was 18.8% (n=33), and 12.6% (n=22) when elective CS excluded. 49 (28%) women presented in spontaneous labour and 115 (65.7%) had an IOL.

The relative risk of undergoing CS following IOL compared to spontaneous labour was 0.46 (95% CI 0.254-0.84; $p < 0.05$). Following an IOL, there was a higher risk of having an operative vaginal delivery (RR 1.422 (95% CI 0.86 – 2.5; $p = 0.25$)), but a no significant difference in CS rate. Mean total labour time in the IOL group was less than mean total labour time in spontaneous labour group by 2.02 hours (95% CI -2.1 to -1.9).

There are no significant adverse outcomes resulting of elective induction of labour. However, more studies are needed to produce statistically significant results.

A PILOT STUDY TO ASSESS POST ABLATION TUBAL STERILIZATION SYNDROME IN IRELAND

Abstract ID: 173

Dr. Syeda Farah Nazir (CWIUH), Dr. Rupak Kumar Sarkar (Coombe Women and Infants University Hospital), Dr. Maebh Horan (Wexford General Hospital), Dr. Cliona Murphy (Gynaecology Department, Tallaght Hospital, Dublin 24)

BACKGROUND

Post Ablation Tubal Sterilization Syndrome (PATSS) has an incidence of 6% to 8% over a period of 2 to 3 years following endometrial ablation. Symptoms include unilateral or bilateral cyclical pelvic pain with or without vaginal bleeding. This is the first study to evaluate these symptoms in an Irish population.

STUDY METHOD

A questionnaire based retrospective study was carried out in Tallaght Hospital over a 2 year period (2010-2012) of patients who underwent endometrial ablation and tubal ligation either at the same time or as interval procedures. Data was collected regarding improvement in menorrhagia, pre-existing pelvic pain and post ablation pain with or without bleeding

RESULTS:

A total of 90 patients had endometrial ablation and tubal ligation either at the same time or as interval procedures during the study period. Data was available on 70 patients. 14% showed moderate improvement of menorrhagia, 57% showed complete resolution of symptoms, 21% had pre-existing pelvic pain, and 14% had cyclical pain and bleeding post procedure requiring analgesia. 28% of patients had hysterectomy for continuing bleeding and pain.

CONCLUSION:

This single centre pilot study showed the incidence of post ablation tubal sterilization syndrome to be 14% in our patient population. We hope to expand this study to other major hospitals in the future.

Reference :

Post Ablation Tubal Sterilization Syndrome (PATSS). A Systematic Literature Review
Journal of Obstetrics and Gynaecology, Vol 2. No 6, 2014 pp91-94.

A RANDOMIZED CONTROLLED TRIAL AND COST-EFFECTIVENESS ANALYSIS OF LOW DOSE ASPIRIN WITH AN EARLY SCREENING TEST FOR PRE-ECLAMPSIA IN LOW-RISK WOMEN: RESULTS OF THE MULTICENTER TEST STUDY

Abstract ID: 142

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The objective was to; (i) determine feasibility and acceptability of routine aspirin versus screening test indicated aspirin in low-risk nulliparous women; (ii) assess cost-effectiveness of a universal aspirin policy.

Low-risk nulliparous women were randomised to; (i) routine aspirin, (ii) no aspirin, (iii) aspirin based on a Fetal Medicine Foundation pre-eclampsia screening test. In addition to primary outcome measures of the acceptability and feasibility of each approach, a health economic decision analytical model was devised to estimate discounted net health and cost outcomes. This study was carried out by Perinatal Ireland and the HRB Mother and Baby Clinical Trials Network.

In terms of acceptability, 546 of 1054 (51.8%) approached took part in an RCT involving routine aspirin. Median adherence was 95% amongst the aspirin arm, and 92.3% (489/530) of women asked were willing to take aspirin in a subsequent pregnancy. The feasibility of performing the screening test in the routine setting was limited by the time taken to obtain PAPP-A and PLGF results; 7.6 (0-26) days. In terms of cost-effectiveness universal aspirin was the preferred strategy with 12.4 life years gained vs. 6.7 for the screen-and-treat. Universal aspirin would result in an estimated cost saving of €200 million based on a population of four million women.

Low-risk nulliparous women are willing to take aspirin in pregnancy and are compliant. Universal aspirin is an optimal preventative strategy to prevent pre-eclampsia in nulliparous women with the largest health gain and cost saving. A universal aspirin approach for pre-clampsia prevention should be considered.

A RARE CASE OF SMALL BOWEL OBSTRUCTION FOLLOWING CAESAREAN SECTION FOR PLACENTA PRAEVIA

Abstract ID: 57

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Placenta praevia is an obstetric complication where the placenta either totally or partially covers the internal cervical os. It complicates 0.4-0.5% of pregnancies¹ and leads to significant maternal and fetal morbidity and mortality. Caesarean delivery is a surgical procedure to deliver a baby through incisions in the mother's abdomen and uterus. One of the indications for caesarean delivery is placenta praevia.

A healthy 32 year old primiparous woman, underwent elective caesarean section for a minor placenta praevia at 38 weeks gestation. Initially she recovered well, however was found to have a large pelvic haematoma requiring transfusion of four units of blood on day three post-operatively. She continued to improve and was discharged on day seven.

She presented to the Emergency Department on day 19 with symptoms of constipation, abdominal pain and vomiting, and was subsequently diagnosed with a small bowel obstruction. She was initially managed conservatively, however required laparoscopic adhesiolysis and evacuation of the pelvic haematoma seven days later. Intraoperatively, the small intestine was noted to be adherent to the site of the haematoma.

Small bowel obstruction is a rare complication of caesarean section, with an overall incidence of 0.1%². The most common cause of mechanical small bowel obstruction is post-surgical adhesions³. Adhesions may be the cause of acute small bowel obstruction within 4 weeks of surgery and may arise due to bleeding into the pelvis or peritoneal cavity. Placenta praevia is a major cause of heavy postpartum bleeding which may increase the risk of adhesion formation.

A RARE CASE REPORT: GLIOMA IN THIRD TRIMESTER OF PREGNANCY

Abstract ID: 109

Dr. Mona Hersi (University Hospital Waterford), Dr. Bart Goldman (University Hospital Waterford)

Maternal mortality due to non obstetric causes, CNS including intracranial tumours particularly malignant brain tumours and trauma remain a leading cause of indirect maternal mortality.

Glioma during pregnancy is rare. At present, the association between glioma and pregnancy is poorly understood.

This case report shows a recent rare case of glioma in pregnancy.

A 35yo, parity 1+1, at 26+4 weeks gestation presented with a history of 4 days of vomiting and headaches. An uncomplicated pregnancy till date with good fetal movements, received dexamethasone, stemetil, ondansetron and ranitidine. Further questioning it was determined headaches was ongoing for 4 weeks, worse at night and associated with focal neurological symptoms. On examination cranial nerves 2 to 12 intact, no limb weaknesses, left visual field defect and no seizures.

Following CT Brain findings showed a large frontal lobe brain tumour extending to the corpus luteum described by radiologist as a butterfly type tumour consistent with a primary glioma . Findings were explained to patient A and her family.

Patient A underwent primary resection of frontal lobe structured at least grade 3 glioma. However all performed tests were insufficient to establish a final histopathology/ molecular diagnosis and differential diagnosis included glioblastoma, anaplastic xanthoastrocytoma and undifferentiated ganglia glioma.

Treatment was planned using IMRT Technique and fusion of the CT and MRI scans. Delivery planned at 32 weeks gestation to facilitate starting radiotherapy and chemotherapy treatment.

A RESTROSPECTIVE ANALYSIS OF URETHRAL SLING PROCEDURES PERFORMED AT THE UNIVERSITY HOSPITAL WATERFORD OVER A 10 YEAR PERIOD.

Abstract ID: 44

Dr. Bart Goldman (University Hospital Waterford), Dr. Jasmeet Kumari (University Hospital Waterford), Dr. Oyenike Olowo (University Hospital Waterford), Dr. Mona Hersi (University Hospital Waterford), Dr. John Stratton (University Hospital Waterford)

The mid urethral sling procedures performed at our institution are: Tension free vaginal tape, Trans obturator tape and suprabubic ARC procedure. With little evidence available comparing the efficacy and long term outcome of these procedures we decided to gather the relevant information to draw comparisons. The aim would be to gather information on each procedure leading to better patient information, pre operative counseling and consent.

By evaluating the lifestyle impact of incontinence pre-operatively and post operatively comparisons could be drawn. The duration of improvement and the immediate post operative complications were also noted.

The study was conducted as a retrospective analysis with the Kings Health Questionnaire being used as our tool for assessing lifestyle impact of incontinence. The cases were collected from the theater register and telephonic interviews were conducted. Pre operative and post operative comparisons were made. Post operative complications and duration of improvement were also compared. All the patients who underwent mid urethral sling procedures during this period were included in the study. Patients who were unreachable after at least three attempts to contact them and patients who withdrew from the study were excluded. Recall bias and the small number of surgeons, each predominantly performing a preferred procedure, was identified as weaknesses.

Findings and conclusions will be presented at our local education events and the JOGS conference at this stage. Further presentation and possible publication of the results are being assessed as these results would improve patient education, consent and might also influence the procedure of preference.

A RETROSPECTIVE ANALYSIS OF DELIVERY OUTCOMES IN PREDICTED FETAL MACROSOMIA

Abstract ID: 268

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The management of the suspected fetal macrosomia is a contentious issue with many professionals not inducing labour or performing an elective caesarean section below an estimated fetal weight of 5kg in non-diabetic women and 4.5kg in diabetic women. There is a growing body of evidence to suggest that induction of labour versus expectant management should be offered to women with suspected fetal macrosomia as a means to lower the incidence of shoulder dystocia and its associated maternal and neonatal morbidity.

The aim of this audit was to evaluate delivery outcomes in women who were induced for suspected fetal macrosomia with an abdominal circumference or estimated fetal weight >95th centile.

We retrospectively examined induction lists of women induced for fetal macrosomia over a select time period. We obtained further parameters from patient charts including: parity, maternal BMI, biometric measurements, actual birth weight, mode of induction and delivery, shoulder dystocia, brachial plexus injury, fractured clavicle and anal sphincter injury.

In this cohort of patients, we found a mean parity of zero, mean gestational age at birth 39/40, mean maternal BMI 28, mean abdominal circumference 367.4 mm, mean birth weight 3991g. 62% had a vaginal delivery, 8% had operative vaginal delivery and 38% underwent a caesarean section. We conclude that there is a lower rate of poor obstetric outcome in those who are appropriately induced for suspected fetal macrosomia.

A RETROSPECTIVE COHORT STUDY OF PERINATAL OUTCOMES IN WOMEN WITH A HISTORY OF DEPRESSION OR ANXIETY

Abstract ID: 221

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The aim of this study was to assess whether a diagnosis of depression or anxiety was significantly associated with adverse perinatal outcomes.

A database of all women who delivered in the Coombe Maternity Hospital between 2009 and 2013 was used to identify women with a history of depression or anxiety.

Of the 42365 women included in the database, 7056 (16.7%) had a history of depression or anxiety.

We found no significant difference in modes of delivery or rates of induction of labour. There was no significant association found between depression and low birth weights and no increase in the rates of low apgar score or admissions to NICU.

Patients with a history of depression or anxiety were, however, more likely to have other risk factors for adverse outcomes. They were more likely to be smokers (26% vs 12%, $p < 0.005$), to have a history of illicit drug use (18.6% vs 5.4% $p < 0.005$) and more likely to consume alcohol in the pregnancy (2.7 % vs 1.7% $p < 0.005$). There was a significantly higher rate of domestic violence (4% vs 0.6%, $p < 0.005$). They were more likely to have poor attendance (1.5% vs 0.6% $p < 0.005$) and be unemployed (18% vs 11% $p < 0.005$).

This study concludes that depression does not appear to adversely affect perinatal outcomes however these women are more likely to have other confounding social issues that may require a higher level of care antenatally.

A Retrospective Review of Endometrial Hyperplasia and the Assessment of BMI

Abstract ID: 196

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A Javaid, N Joyce, U Bartels

Department of Obstetrics and Gynaecology, Mayo University Hospital

The aim of this retrospective study was to ascertain the incidence of endometrial hyperplasia and examine risk factors, method of diagnosis, treatment and follow up histology in symptomatic women presenting to the ambulatory gynaecology unit at Mayo University Hospital.

Clinically relevant details of women with all subtypes of histologically confirmed endometrial hyperplasia were collected from January–December 2015. Out of 1090 women, 40 were diagnosed with endometrial hyperplasia. Twenty-seven (67.5%) had simple hyperplasia, 10 (25%) complex hyperplasia, and 3 (7.5%) complex hyperplasia with atypia. Mean age was 55.3 years

Eight patients with simple hyperplasia were treated with IUS-mirena coil, 6 had oral progesterone, 1 decapeptyl and 1 underwent polypectomy. Follow up histology resolved in twenty (74%) patients, 2 had no follow up and 1 progressed to complex hyperplasia. Out of the ten patients with complex hyperplasia, 5 were treated with an IUS-mirena coil and 2 underwent surgical management. Follow up biopsies were normal in 50%. Out the 3 cases with atypical hyperplasia, 2 patients underwent surgical management. One of these women subsequently received brachytherapy for endometrial cancer and the other was treated with oral progesterone.

Regarding associated risk factors 6 had HTN, 5 PCOS and 3 DM. Only 4 pts had BMI recorded.

Best practice suggests assessment of risk factors associated with endometrial hyperplasia. BMI was recorded for only 10% of patients. We plan to re-audit in 1 year.

A Retrospective Review of Slow-release Dinoprostone for Induction of Labour

Abstract ID: 251

Dr. Emma Sheehan (Obstetrics and Gynaecology, Coombe Women and Infants University Hospital, Dublin), Dr. Cathy McNestry (C), Dr. Sharon Sheehan (Coombe Women and Infants University Hospital)

The aim of this study is to review outcomes following administration of Propess dinoprostone pessaries for cervical ripening, focusing on how many patients require further doses of Prostin gel after Propess administration. A database of all patients who receive Propess is kept in the antenatal ward. This was used to obtain details of 100 women. Further information was gathered from the women's charts. Women with multiple pregnancies were excluded. All women were 37 weeks gestation or above.

Sixty-eight primiparas and 31 multiparas were induced over the study period. The majority of inductions were carried out by registrars. 16 primiparas (23.5%) and 15 multiparas (48.3%) laboured with Propess only. 11 primiparas (16.1%) and 5 multiparas (16.1%) needed at least one dose of Prostin gel following Propess. 24 primiparas were delivered by Caesarean section (35.3%). All of the multiparas achieved vaginal delivery. 10 (41.7%) of the CS were performed for failed induction, of which 3 (12.5%) were unsuitable for ARM (4.4% of total primigravida inductions). 11 were performed for fetal distress, 1 for undiagnosed breech and 2 for failure to progress in the second stage.

In conclusion, our current rates of successful induction with Propess are 100% in multiparas and 64.7% of primiparas. We intend to expand the study to power it more highly, and to implement quality improvement measures by educating the NCHDs regarding optimal insertion of Propess. Thereafter we will reassess our successful induction rates.

A RETROSPECTIVE REVIEW ON THE CYTOGENETIC ANALYSIS OF FETAL TISSUE

Abstract ID: 3

Dr. Claire M McCarthy (University Hospital Limerick), Mr. Kevin Hickey (University Hospital Limerick)

Following pregnancy loss, the chromosomal analysis of tissue can form an important part of the investigative process in all pregnancy loss. In couples with recurrent miscarriage, chromosomal abnormalities of the embryo account for 30–57% of further miscarriages.

The aim of this review was to assess the rate of chromosomal abnormalities detected on cytogenetic analysis of products of conception.

We conducted a retrospective review of all miscarriages where tissue was sent for cytogenetic analysis over a one-year period from September 2014 until September 2015.

In total, the products of conception of 148 women were sent for cytogenetic analysis during the study period. The average maternal age was 34.3 years (range 18-46). 28.3% (42/148) of patients had a history of recurrent miscarriage. The average gestation of pregnancy loss was 15+6 (range 5- 41) weeks' gestation. Of the samples that achieved a culture, 55 (44.7%) revealed an abnormal karyotype. There were 25 failed cultures, leaving a 16.8% failed culture rate. .Of the 72 first trimester pregnancy losses, 39 (54%) cases had cytogenetic abnormality. Of the 31 (43%) recurrent miscarriages, 14 (45%) had a cytogenetic abnormality.

This study shows a high rate of karyotypical abnormality in patients who have cytogenetic testing following pregnancy loss. It can define the precise reason for miscarriage and thereby dispel any self-blame that couples can experiences with regard to work or lifestyle practices as contributing causes.

A RETROSPECTIVE STUDY ON LENGTH OF HOSPITAL STAY AMONG 100 CONSECUTIVE PATIENTS UNDERGOING TOTAL LAPAROSCOPIC HYSTERECTOMY IN A TERTIARY GYNAECOLOGY ONCOLOGY REFERRAL CENTRE.

Abstract ID: 195

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The international best practice for length of stay post-total laparoscopic hysterectomy (TLH) in a tertiary gynaecology oncology referral centre is currently 1-2 nights.

We proposed analysing discharge patterns with reference to this international practice among 100 patients undergoing TLH in an Irish tertiary referral centre to identify if Irish standards correlate.

The study analysed the past 100 consecutive TLHs in the Mater Misericordiae University Hospital for length of stay, age, BMI, surgical indication, and whether histology was benign or malignant. Data from our internal patient database was then used to identify reasons for prolonged length of stay.

Of 100 cases analysed 57 were malignant, 43 were benign. 44% of benign cases were risk reducing. Only 18% of patients stayed only 1 night. The range of stay was 1 – 12 nights, mean stay 2.8 nights and median stay 2 nights. Of those who stayed more than 1 night the causes were as follows: 57% no cause cited; 17% pain; 7% infection; 7% anti-coagulation; 4% patient preference; 3% major complications; 3% drug reactions; 2% nausea. Mean length of stay for TLHs indicated for malignancy was 3.2 nights versus 2.3 nights for benign cases. Mean length of stay for risk reducing surgery was 1.7 nights.

The mean length of stay post-TLH currently exceeds international best practice. Optimizing postoperative pain control seems to be of predominant importance in reducing duration of stay. Indeterminable causes – which we extrapolate are most likely due to patient preference rather than clinical indication - merit further investigation.

A REVIEW OF INDUCTION INDICATIONS AND IMPLICATIONS IN A TERTIARY MATERNITY UNIT

Abstract ID: 145

Dr. Michelle Ni Mhurchu (Cork University Maternity Hospital), Dr. Orfhlaith O Sullivan (Cork University Maternity Hospital), Prof. Richard Greene (Cork University Maternity Hospital)

Patient experience of obstetric care is of ever-growing importance. Induction of labour is well-known to have the potential to impact significantly on the mother's experience of labour and outcomes of labour with subsequent consequences for future deliveries.

To investigate the number of inductions in our institution in a selected month, their indications and adherence to hospital policy. To determine mode of delivery and any subsequent complications. To identify if further education of staff was needed with a view to avoiding future inappropriate inductions and associated complications.

Retrospective study of all inductions for the month of April 2016. Parity, gestation, indication, mode of delivery and complications (including PPHs, 3rd degree tears and shoulder dystocias) were documented for each induction.

235 inductions were carried out in April 2016 in CUMH. 193 had vaginal deliveries. 42 had emergency caesarean sections (41 were Category 2, Robson Classification System). Of the vaginal deliveries, there were 129 SVDs, 57 Ventouse and 7 forceps deliveries. There were 3 documented cases of PPH and 1 third degree tear associated with shoulder dystocia. The most common indication for IoL was postdates pregnancies. These ranged from 40+7/40 to 40+15/40 despite hospital policy of 40+10/40.

17.9% of mothers induced had a Caesarean Section and 1.3% had a PPH. Of note, all of these women were primigravidas. This study reminds us of the potential consequences and future implications of our decisions to induce labour-especially in primigravidas, and the ongoing need to educate staff about appropriate indications for induction and hospital policy.

A REVIEW OF MALE FACTOR FERTILITY IN A ONE YEAR PERIOD IN A TERTIARY REFERRAL CENTRE

Abstract ID: 150

Dr. Fiona Reidy (Cork University Maternity Hospital), Dr. Moya Mcmenamin (Cork University Maternity Hospital)

Male factor infertility accounts for up to 30% of subfertility cases¹. Age is one contributing factor, with male fertility decreasing after 30 years, but most significantly after 50 years². Lifestyle factors including smoking, cannabis, and anabolic steroid use may also contribute. Other causes include hypogonadotropic hypogonadism (e.g. Kallman's syndrome, head trauma); testicular failure; varicoceles; and post testicular or obstructive causes (e.g. trauma, surgery, infection).

The purpose of our study was to review male factor subfertility in a public fertility clinic in a 1 year period. We aimed to discover the most common diagnoses and contributing factors.

This is a retrospective review of all men investigated for infertility in Cork University Maternity Hospital in 2015. All semen analysis results, hormone profiles and testicular ultrasounds were reviewed.

70 semen analyses were performed for 55 men. The mean age was 35.65 years (range 22-50). Just 34.5% (19/55) had a normal initial semen analysis result. 15/55 did not meet all normal criteria but were deemed suitable for intrauterine insemination (IUI) or in vitro fertilisation (IVF). In 5 cases with an abnormal result, a repeat semen analysis was normal or sufficient for IUI or IVF treatment. 11/55 (20%) had a final sample that would be suitable for intracytoplasmic sperm injection only. There were 3 cases of azoospermia. All 3 had raised FSH levels and normal testicular ultrasounds.

Male factor is a significant contributor towards subfertility. In our cohort, we found significant pathology in 29% of patients. Many potentially treatable diagnoses may be made during investigation. Also, many reversible factors may be present such as smoking or anabolic steroid use. Therefore, a thorough history of the male partner is vital as part of the investigation of the subfertile couple.

A REVIEW OF POSTNATAL PRESENTATIONS TO THE EMERGENCY ROOM OF A TERTIARY MATERNITY HOSPITAL

Abstract ID: 237

Dr. Ciara Shiel (Cork), Dr. Rebecca Cole (Cork University Maternity Hospital), Dr. Noirin Russell (Cork University Maternity Hospital)

The purpose of this review was to examine trends in postnatal presentations to the emergency room in a tertiary maternity hospital. We aimed to identify associations with mode of delivery and to highlight risk factors for postpartum complications.

We looked at all postnatal presentations to the emergency room from the 1st May 2016 to the 31st August 2016, recording their date of delivery, parity, mode of delivery and reason for presenting.

In 4 months there were 285 postnatal presentations to the ER, indicating >10% of women have reason to seek postpartum medical attention. Presentations ranged from 2 days to 14 weeks postnatal. 28% were admitted. 45% were primips with only 20% of those having a spontaneous delivery. 50% had an instrumental delivery and 23% an emergency cesarean section. There were high levels of interventions noted in the multip group also with only 39% having an SVD, 33% an elective cesarean, 21% an emergency section and 7% an instrumental delivery. Overall presentations were varied, recurring themes among primips included secondary postpartum haemorrhage or abdominal pain (57%) and perineal concerns (26%) versus 33% and 4% in multips, respectively. Multips had a higher presentation rate for hypertension (14%) and wound concerns (14%) compared to primips, 7% and 10%, respectively.

Intrapartum interventions are associated with increased postpartum complications which is reflected in our data as only 29% of patients presenting had an uncomplicated SVD. Rising levels of intervention lead to increased burden on emergency maternity services.

A Review of Primiparous Caesarians - Can we lower the rate ?

Abstract ID: 288

Dr. Niamh Fee (Wexford General Hospital), Dr. Sorca O'Brien (National Maternity Hospital), Dr. Munaza Wahajat (Wexford General Hospital), Dr. Elizabeth Dunn (Wexford General Hospital)

Much has been made of the rising caesarian section rate and the sequelae that can follow. Discussion has focussed on ensuring caesarians are performed in the right cohort of patients under the correct circumstances. The primiparous antenatal patient remains the target for study to tackle this problem. This is a retrospective review of primiparous antenatal patients looking at caesarian outcomes in a unit with approximately 1900 deliveries annually.

All primiparous patients undergoing caesarian delivery over a 5 month period were identified in the labour ward registry. Charts were reviewed to clarify induction of labour vs augmentation. Indications for induction and methods used were recorded.

43 primips who underwent induction of labour were delivered by caesarian.

Average age 29.8 (17-42). Bishops score was recorded prior to induction in 16%, 72% received prostaglandin, 51% underwent ARM and 58% received oxytocin to induce. FBS was performed in 25%. Average cervical dilatation was 3 cm (range 0-10cm) with 3 performed in the second stage.

The overall caesarian rate in the unit during this period was 25.6% (group 1 9.5%, group 2 24.4%).

In conclusion it is vital that induction of labour is performed in the appropriate patient for the appropriate indication. Commencing induction in any patient may set in action events that dictate the rest of their future obstetric outcomes. Management should have senior involvement particularly in the event of second stage caesarian.

A REVIEW OF REPRODUCTIVE PREGNANCY OUTCOMES OF WOMEN WITH TWO CONSECUTIVE MISCARRIAGES AND NO LIVING CHILD.

Abstract ID: 35

Ms. Deirdre Green (University College Cork), Dr. Keelin O Donoghue (Cork University Maternity Hospital)

Recurrent miscarriage is usually defined as three consecutive first-trimester pregnancy losses. However, there is an increasing tendency to define those with two consecutive first-trimester miscarriages and no living child as also recurrent and in need of investigation. For expectant parents, any pregnancy loss is devastating and many request investigation irrespective of clinical guidance.

This study aimed to examine the management and subsequent pregnancy outcomes of nulliparous women who attended our Pregnancy Loss Clinic between 2009 and 2014, with their second consecutive first-trimester miscarriage.

A search of the Pregnancy Loss Clinic database identified women suitable for inclusion. Information was sourced from the database, the electronic hospital patient management and laboratory systems, and clinical letters. Risk factors identified during clinic visits, results of medical investigations, details of therapies initiated and subsequent pregnancy outcomes were recorded.

We identified 294 women, with a mean age of 33.4 years (range 16 – 46). Following investigation, 69.4% had no identifiable cause found for their miscarriages. 56.8% of women were started on pharmacological treatment. A subsequent pregnancy was achieved in 82.3% (242/294), with increased age and smoking status found to significantly affect the likelihood of conception ($p=0.017$, $p=0.012$ respectively). Of the 242 subsequent pregnancies, 72.7% (176/242) resulted in a live birth. Increased maternal age ($p=0.045$) and use of pharmacological treatment ($p=0.008$) were found to significantly affect next pregnancy outcome.

Current investigation is unlikely to identify an underlying pathology. The role of medical therapy in this cohort is not fully understood. Subsequent pregnancy outcomes are excellent.

A TRI-HOSPITAL THREE MONTH RETROSPECTIVE AUDIT OF POSTNATAL READMISSIONS

Abstract ID: 234

Dr. Aoife Freyne (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda), Dr. Ita Shanahan (Department of Obstetrics and Gynecology, Royal College of Surgeons in Ireland, Rotunda Hospital, Dublin, Ireland.), Dr. Rosemary Harkin (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda)

Are our postnatal readmission rates an increasing cause for concern? Maternal postnatal readmission is unexpected and can be an indicator of maternal morbidity. Factors for maternal postpartum readmission include length of initial postnatal hospital stay, mode of delivery, maternal co-morbidity.

This audit documented the postnatal readmission rate in Our Lady of Lourdes Hospital, Drogheda, in both number of deliveries per year and number of post-natal presentations to ED. We investigated whether presentations were initially GP referrals or self-referrals. These findings will be compared with other hospitals in the RCSI hospital group.

A retrospective audit of all ED presentations over a three month period was undertaken. Data was obtained from iPMS, ED statistics and direct chart review.

Average number of deliveries per month was 259 births. An average of 12 postnatals out of 145 ED presentations per month were readmitted. This is a readmission rate of 4.6% of deliveries per month and 8.2% per total ED presentations. The commonest mode of delivery was SVD. The commonest indicator for admission was endometritis. Other presentations included postpartum PE and Group A Strep septic shock. Results from Cavan Hospital and Rotunda Hospital will be correlated with our data.

Readmission rate can be seen as a valid indicator of quality of care. It can be used to control costs. This audit is useful in terms of standardised comparisons between RCSI hospital group. It determines whether postnatal ED presentations are influenced by maternal comorbidities, mode of delivery and access to GP care in the primary setting.

Abdominal Pain in early Pregnancy: a case presentation

Abstract ID: 227

Dr. Martina Schembri (Midland Regional Hospital, Portlaoise), Dr. Aisling Heverin (Midland Regional Hospital, Portlaoise)

Appendicitis in early pregnancy can be very difficult to diagnose in view of abnormal presentation as well as the other differential diagnoses which could be causing the symptoms.

We describe a case of a 39yr old para 3 presenting with vomiting 12 hours prior to presentation, generalised abdominal pain and dysuria. She was 4 weeks pregnant by her LMP. On examination she was found to have a temperature of 38.2°C, BP 110/70 and pulse of 90bpm. Her urine was negative and her abdomen was visibly distended but soft.

She was started on antibiotics and baseline bloods taken. Her white cell count was found to be 19.9, CRP 72 and lactate of 1.4. During her admission she developed signs hypotension, tachycardia as well as an increasing lactate. Her abdominal pain continued and her dysuria persisted. After discussion with the surgical team, an ultrasound was carried out showing no evidence of an ectopic pregnancy and was inconclusive for appendicitis. A laparoscopy was carried out and a necrotic pelvic appendicitis was found. Post appendectomy she had an uneventful recovery and a repeat ultrasound on day 7 post op showed an intrauterine gestational sac.

25% of appendicitis are pelvic and have different presentation such as dysuria. This together with her being pregnant posed difficulty in diagnosis and thus the importance of multidisciplinary team involvement. Appendicitis in pregnancy may have a higher morbidity and mortality on both patient and pregnancy and should always be included in the differential diagnosis even if the presentation is not typical.

ABDOMINAL WALL ENDOMETRIOSIS

Abstract ID: 282

Dr. Suha Abdalla (St Lukes hospital .kilkenny), Prof. Ray O Sullivan (St Lukes Kilkenny)

Endometriosis is a common gynaecological condition that usually presents as an abdominal lump. It can be a diagnostic dilemma and should be considered as differential diagnosis for lumps in the abdomen in females.

Abdominal wall endometriosis (AWE) is a rare condition that usually develops in surgical scar resulting from caesarean section while commonly seen in the cutaneous and subcutaneous fat tissue at caesarean scar level. Its intramuscular localization is quite rare.

Its treatment options consist of excision of the lesion and/or hormonal therapy, although wide surgical excision is the treatment of choice in literature. Wide surgical excision may create a defect in the abdominal wall and may increase the risk of hernia formation and mesh complication. Patient with scar endometriosis may be asymptomatic or present with cyclical pain corresponding to the menstrual cycle. Cross-sectional imaging findings vary from the nonspecific to those suggestive of the diagnosis when combined with clinical history. In particular, the presence of blood products in anterior abdominal wall mass at MRI imaging with no other explanation is strongly suggestive of scar endometriosis.

We report in case presentation a 39-year-old female, mother of two, with 2 previous caesarean sections, diagnosed as anterior abdominal wall endometriosis clinically, radiologically, and histologically.

AWE is difficult to diagnose clinically and radiologically. A high index of suspicion is recommended when a woman presents with postoperative painful abdominal lump.

In conclusion, if previous surgical history exists in a case with no primary pelvic endometriosis, it should be considered in the differential diagnosis of palpable anterior abdominal wall masses at the scar site.

ABNORMAL HEMODYNAMIC PARAMETERS IN PREGNANCY COMPLICATED BY UTERO-PLACENTAL DISEASE OBTAINED BY NON-INVASIVE CARDIAC OUTPUT MONITORING (NICOM) – RESULTS OF THE PROSPECTIVE HANDLE STUDY

Abstract ID: 157

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There are several studies detailing the altered hemodynamic profile of pregnancy in the presence of co-existing uteroplacental disease via invasive or labour intensive means. Non-Invasive Cardiac Output Monitoring (NICOM) using bio-reactance techniques provides a novel, non-invasive, validated method of interrogating maternal haemodynamics.

To establish the different hemodynamic profiles amongst nulliparous women who develop either gestational hypertension or pre-eclampsia (GH/PET) versus those who develop normotensive intrauterine growth restriction (IUGR) using NICOM.

A large unicentre prospective observational study was performed in the low risk nulliparous women (HANDLE study). NICOM was performed during the first, second and third trimesters and at least 6 weeks postpartum and data was obtained on total peripheral resistance (TPR), heart rate (HR), systolic blood pressure (SBP) and stroke volume (SV). Two way ANOVA was used to assess change over time.

Of 369 women prospectively recruited, 45 had a pregnancy complicated by uteroplacental disease. Women developing GH/PET (n=24) demonstrated higher TPR $p < 0.05$, SBP $p < 0.05$, faster HR and a lower SV. Conversely women with a pregnancy complicated by normotensive IUGR had lower TPR, a lower SBP, slower HR and increased SV.

Women with evolving GH/PET develop a differing hemodynamic profile to those developing IUGR and unaffected pregnancies. These differences are apparent from as early as 14 weeks' gestation. This presents us with a potential novel screening tool for hypertensive disease in pregnancy and at a gestational age where preventative measures may be possible.

ABNORMAL PLACENTAL CORD INSERTION AND ADVERSE PREGNANCY OUTCOMES: RESULTS FROM A PROSPECTIVE COHORT STUDY

Abstract ID: 144

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Abnormal placental cord insertions (PCI) including velamentous cord insertion (VCI) and marginal cord insertion (MCI) have been associated with adverse pregnancy outcomes.

This prospective cohort study examined 1005 placentas from consecutively delivered singleton pregnancies in a tertiary centre. Standardised images of each placenta were taken, blinded to the pregnancy outcomes, following delivery according to a defined protocol. Distance of PCI to the placental margin was measured digitally using ImageJ software. PCIs were categorised as central/eccentric (>2cm from placental margin), marginal (<2cm from placental margin) or velamentous (insertion into the membranes). Outcomes including small for gestational age (SGA) infants (<10th centile), low birthweight (<2500g), preterm labour (<37 weeks gestation) and emergency caesarean section (CS) were compared using logistic regression, adjusting for maternal age, parity and smoking status. Odds ratios (OR) and 95% confidence intervals were estimated.

The rates of VCI and MCI in a total of 1,005 singleton pregnancies were 3.6% (n=36; 95% CI=2.5–4.9%) and 6.4% (n=64; 95% CI=4.9–8.1%), respectively. Abnormal PCI were found to be significantly associated with maternal smoking (14.8% vs 22.7%, p=0.04), and an increased risk of SGA (13.3% vs 21.0%, p=0.048) and low birthweight infants (3.5% vs 11.0%, p=0.001) after adjusting for maternal age, smoking status and parity. Preterm labour was more common in abnormal PCI (5.1% vs 10.0%, p=0.04) but the adjusted OR was not significant. There was no difference in emergency CS rate.

In this large prospective cohort, abnormal PCI were significantly associated with an increased risk of SGA and low birthweight infants.

Abnormal Uterine Bleeding: A re-audit of new referrals

Abstract ID: 285

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The Abnormal Uterine Bleeding (AUB) clinic at Tallaght Hospital is a service provided to allow for efficient assessment and management of AUB in pre- and post-menopausal women. A step wise approach is used: history, examination, transvaginal ultrasound scan, outpatient hysteroscopy and endometrial sampling leading to inpatient hysteroscopy if required. We report the findings of a re-audit of the performance of this service.

161 new patients attended between January and July 2016. A chart review was conducted to identify the referral source, indication for referral, wait time, patient demographics and risk factors for endometrial cancer, investigations and findings. These data were compared with a 2013 audit of the service.

Indications for referral included menorrhagia (38.5%), PMB (31.2%), polymenorrhagia/IMB (20.5%), Mirena retrieval (3.3%) and cervical pathology (1.6%). The average wait times were 6.8 weeks for PMB, 22.9 weeks for Polymenorrhagia/IMB and 38 weeks for menorrhagia.

In total outpatient hysteroscopy was indicated in 59.8% of new patients. 91.8% of indicated hysteroscopies were completed successfully in the clinic. 13.9% of patients required inpatient hysteroscopy due to the inability to perform outpatient hysteroscopy or the need for operative intervention (e.g. Polypectomy). One malignancy was identified in this group. Two cases of endometrial hyperplasia with atypia were found.

Overall the clinic greatly reduced the need for inpatient hysteroscopy. Average wait time for PMB remain similar in this audit to previously (6.8 vs 6.2 weeks). However the wait times have increased for other indications likely due to increased referral numbers.

An 11 year review of the changing prevalence of Pre-eclampsia in the East of Ireland

Abstract ID: 280

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Pre-eclampsia (PET) is quoted to affect 2-3% of all pregnancies internationally, rising to 5-7% in nulliparous women. Increasing maternal age, body mass index (BMI) and medical co-morbidities could impact on PET rates.

This study aimed to assess local change in the incidence of PET, in the context of a recognised increase in maternal morbidities.

A retrospective review was performed from 2004-2014 of two Dublin tertiary maternity units via interrogation of the annual reports.

During the study period a total of 181,329 women were delivered of whom 7755 (4.2 %) had a pregnancy complicated by PET. There was a fall in the overall incidence during the study period of pregnancies affected by PET, from a peak of 5.8% in 2006 to 2.6% in 2013. Comparing the first and second halves of the study time-period this decrease was statistically significant ($p < 0.0001$). In nulliparous women, the overall rate was 4.6% for the study period, with a similar reduction from a peak of 5.3% in 2005 to a trough of 3.3% in 2014.

Despite anticipating a potential rise in PET rates due to increases in known risk factors such as advancing maternal age, BMI and complex co-morbidities, this study has demonstrated the converse with a reduction in PET rates.

An Audit of Antenatal care and pregnancy out of GDM women

Abstract ID: 185

Dr. Saroj Kumari (Wexford General Hospital), Dr. Asish Das (Wexford General Hospital)

Background –

Gestational diabetes affects approx. 12% of pregnant women. It is associated with pregnancy complications like Pre-eclampsia, induction of labour, shoulder dystocia, macrosomia, neonatal hypoglycaemia, preterm birth.

Purpose of study-

Aim was to Audit the current Antenatal care of GDM women and check whether care is in compliance with HSE guideline and to measure the pregnancy outcome.

Study Design and Method-

This was a prospective study of GDM women attending Diabetic Obstetric Clinic in WGH ,Wexford between Oct 2015 to May 2016. Most of women were diagnosed at 28 weeks of gestation. 109 women diagnosed with Gestational Diabetes during study period.

Finding-

During this period, 1034 women booked in Antenatal clinic and 472 women were offered Oral GTT based on risk factors as recommended in HSE guidelines, of which 109 women tested Positive for GDM. Incidence of GDM during study was 10.54%.

88.07% women had antenatal Growth scan in third trimester. Caesarean section rate was 25.88% & Instrumental delivery rate was 9.1%. Incidence of macrosomia (Birthweight >4.5kg) was 2.7%.

Postnatal GTT documented in 10.53% women.

Conclusion- Overall pregnancy outcome is good in comparison to normal obstetric population . Significant number of women donot have postnatal GTT at 6 weeks .

Recommendation- Protocol for Growth scan once the diagnosed with GDM .

Post natal GTT at 6weeks and yearly afterward. Aim to re audit in one year.

An Audit of antenatal care and pregnancy outcomes in a selection of obese patients over a 6 week period at St Lukes Hospital, Kilkenny.

Abstract ID: 7

Dr. Helena Bartels (Wexford General Hospital), Dr. Naveen Usman (St Lukes Kilkenny)

Obesity is defined as a Body Mass Index $> 29.9 \text{ kg/m}^2$ and is one of the major challenges of modern obstetric care. A recent study predicts that by 2025, 37% of Irish women will be obese, which will have huge consequences for Maternity units in Ireland on how best to manage these patients.

The purpose of this audit was to identify the prevalence of obesity in the pregnant population and to compare their antenatal care and outcomes to the national guideline on obesity.

The audit was carried out prospectively over a 6 week period. All patients who delivered during this period with a BMI $>29.9\text{kg/m}^2$ were included in the study. In total, 49 patients met the inclusion criteria. For each patient the following data was collected; patient demographics, BMI, use of pre-conceptual folic acid, oral glucose tolerance test, antenatal and intrapartum complications. The data was analysed and compared to the auditable standards. The audit found an obesity prevalence of 25%. The study highlighted a number of areas where improvement is needed, for example education regarding pre conceptual folic acid and breastfeeding. Furthermore, almost a quarter of patients had gestational diabetes or hypertension, and 60% delivered via caesarean section.

In summary, this audit highlights the high prevalence of obesity and the numerous challenges it presents to the healthcare service. Education prior to conception via pre-conceptual counselling presents a unique opportunity to modify the factors contributing to obesity.

An Audit of Haemoglobin Checks during Routine Antenatal Care

Abstract ID: 278

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The prevalence of iron deficiency anaemia at 30-40% of pregnant women (WHO). Iron deficiency may contribute to maternal morbidity through effects on immune function with increased susceptibility or severity of infections, poor work capacity and performance and disturbances of postpartum cognition and emotions.

RCOG recommends as best practise Hb check at booking and repeat at 28 weeks. The British Society of Haematology recommends referral to secondary care when anaemia is detected in late gestation, i.e. 34 weeks.

The aim of this study was to assess the proportion of women who have suitable antenatal haemoglobin checks. A cohort of women who delivered over a 2 week period were identified. In total 155 were identified with gestation at delivery noted. The lab system was then used to review Hb checks during the pregnancy. Five were excluded due to late booking/preterm delivery.

All women had a booking haemoglobin prior to twenty weeks. Twenty four (16%) had no recheck of their Hb during pregnancy. Sixty-eight (44%) had a Hb check between 27 and 30 weeks. Twenty four (16%) had a repeat Hb check between 31 and 36 weeks. Eighteen had a Hb check after 37 weeks. Eighteen (12%) had a repeat Hb after booking prior to 27 weeks. Sixteen (10%) had a Hb <10.5g/L at repeat Hb check.

In conclusion over half of women were shown to have inadequate Hb checks during antenatal care. A significant number had no repeat Hb check or was performed at a late gestation when oral supplementation would be inadequate.

AN AUDIT OF OPTIMAL SURGICAL DEBULKING IN OVARIAN CANCER IN UNIVERSITY COLLEGE HOSPITAL GALWAY

Abstract ID: 140

Dr. Mei Yee Ng (University College Hospital Galway), Dr. Elzahra Ibrahim (University College Hospital Galway), Ms. Joanne Higgins (University College Hospital Galway), Dr. Michael O Leary (University College Hospital Galway), Dr. Katharine Astbury (University College Hospital Galway)

The Gynaecology Oncology unit in University College Hospital Galway received referrals for suspected ovarian cancer from all hospitals under the Saolta University Health Care Group. A number of studies have shown that patients experienced improved survival rates when they undergo aggressive cytoreductive surgery by gynaecological oncologist surgeons. As we are a centre of high surgical volume, it is expected that our centre should achieve a high percentage of optimal ovarian debulking. From the period of 1st January 2015 till 31st March 2016, 80 patients underwent either interval debulking surgery or primary debulking surgery. We achieved a high optimal debulking percentage in both interval debulking surgery group (74%) and primary debulking surgery (91% overall; 73% malignant histology types).

AN AUDIT OF PLACENTAL SITE DOCUMENTATION IN CORK UNIVERSITY MATERNITY HOSPITAL

Abstract ID: 201

Dr. Caitriona Fahy (Cork), Dr. Mairead O riordan (Cork University Maternity Hospital)

There is no national screening programme for placenta praevia, however the majority of antenatal patients will have a placental site documented as part of routine ultrasound in pregnancy. In Cork University Maternity Hospital, patients are scanned in a variety of locations, including formal departmental ultrasounds and less formal scans in the antenatal clinic; therefore the documentation of the placental site may not always be obvious in the patient's chart.

In this audit, we aimed to assess the overall documentation of placental location, the timing of this documentation, the location, and the compliance with rescanning if patients were initially noted to have a low lying placenta.

A retrospective chart review of 168 patients was carried out over a three week period in April-May 2016. This was a random selection of postnatal charts of singleton pregnancies, including both public and private patients. Data was analysed using Microsoft Excel.

Approximately 90% of patients had a placental site documented at less than 24 weeks gestation, and all those noted to have a low lying placenta were rescanned at a later date.

The majority of patients have placental site appropriately documented. However the documentation may be ambiguous at times and it may be difficult to find the necessary information in the chart. Almost one third of patients did not have a formal departmental ultrasound after the first trimester, therefore it is important to ensure that all doctors are appropriately trained in ultrasound when working in antenatal clinics.

An Audit of Pregnancy Loss Ward Checklists

Abstract ID: 34

Dr. Roisin McConnell (Cork University Maternity Hospital), Dr. Keelin O'Donoghue (Cork University Maternity Hospital)

Pregnancy loss (PL) is the most common complication of pregnancy with 20% of clinically-recognised pregnancies estimated to end in miscarriage. In CUMH, women with PL requiring medical or surgical care are managed on Ward 4South. Checklists were developed in 2010 to address the activities to be covered in caring for women with PL.

The aim of the study was to audit the charts of women admitted to the ward with a PL and determine the completion of the checklists.

This was a retrospective audit of PL charts from August to September 2016. Completion of the checklists was cross-checked against the patient's notes.

Of the 42 charts audited, 5 (11%) had no checklist. Three early miscarriage charts had no checklist and had no documentation of receiving the miscarriage booklet. All second-trimester miscarriage charts had checklists. "GP informed" was incomplete and was not recorded as performed in 80% of cases. "Consultant Meeting" was also incomplete on the checklists. A checklist was absent in two ectopic pregnancies, with one having no note of receiving a miscarriage booklet.

No checklist correlated, with a significant number of PL activities not being recorded and/or completed. Of the charts without a checklist, 30% were in the medical management of an ectopic pregnancy; currently the checklist is for surgical management only. This study highlights the need for a medical management checklist of ectopic PL and increased communication with GPs.

Checklists are efficacious in ensuring a consistent standard of care is met in every PL.

AN AUDIT OF THE USE OF THE RISK ASSESSMENT SECTION IN THE NATIONAL MATERNITY HEALTHCARE RECORD

Abstract ID: 255

Dr. Emily O Connor (Cork University Maternity Hospital), Dr. Tamara Kalisse (Cork University Maternity Hospital), Prof. Richard Greene (Cork University Maternity Hospital)

The national maternity healthcare record (NMHCR) was developed in 2011 in an effort to standardise and improve maternity healthcare nationally¹. This audit aimed to assess the use of the risk assessment section of the NMHCR.

This was a retrospective audit of the use of the “risk factors assessment” page of the NMHCR in Cork University Maternity Hospital. Charts were audited over a three month period, from June to September 2016. The standards for this audit were identified from the current risk management assessment page in the NMHCR. The data were stored in an Excel database and analysed using SPSS v23.

100 charts were randomly selected from inpatients in CUMH who had undergone caesarean section (CS). Seven variables were identified and deemed necessary to document. No chart had all seven variables documented. 37% of charts audited had no documentation in the risk factors assessment section. 47% of charts audited had some form of plan documented in the management box on the page. 45% of charts had one or more boxes ticked, which identified that patient as having a specific risk factor. 18% of charts had the risk assessment box completed by the surgeon who went on to perform their CS; 15% of these patients had private cover and the consultant who completed their risk assessment box also performed their CS.

This audit suggests there is room for improvement within this section of the NMHCR. This is an area that may be improved in an electronic environment and with further clinician re-education.

AN AUDIT OF THROMBOPROPHYLAXIS IN THE POST-PARTUM PERIOD IN UNIVERSITY HOSPITAL WATERFORD

Abstract ID: 99

Dr. Eddie O'Donnell (University Hospital Waterford), Dr. Karim Botros (University Hospital Waterford), Mr. Sahr Yambasu (Trinity College Dublin)

Venous thromboembolism (VTE) is a significant cause of mortality in pregnancy. It manifests as deep vein thrombosis (DVT) or pulmonary embolus (PE). In 2015, 0.5/1,000 deliveries were complicated by PE.

Revised clinical practice guidelines on venous thromboprophylaxis in pregnancy were released by the Health Service Executive in November 2015. Applying these guidelines, an audit was carried out to assess the standard of thromboprophylaxis in the post-partum period in UHW.

The medical records of 100 consecutive post-natal patients were retrospectively analysed risk factors for VTE. If patients met criteria for prophylaxis, it was noted whether or not they had been treated with prophylactic heparin therapy.

Analysis of 100 patients found that 31% (n = 31) met criteria for prophylaxis. A significant proportion of this group did not receive prophylactic heparin. Of the 22 patients with three risk factors for VTE, 41% (n = 9) did not receive heparin. There were seven patients with four risk factors for VTE and 72% of them (n = 5) were not treated prophylactically. Of the two patients with five risk factors, one was not treated with prophylactic heparin.

According to clinical guidelines, prophylactic heparin was underprescribed to women at risk of VTE. The authors recommend that the discharging SHO documents clearly if patients should be prescribed heparin on discharge and, if so, the duration of treatment. Risk factors for VTE are to be reassessed at every admission, after delivery, and on discharge. A repeat audit of practice changes will be carried out in six months.

An Audit of Timeframe for Actioning Abnormal Results in the Outpatient Department

Abstract ID: 253

Dr. Ellen McMahon (Coo), Dr. Cathy McNestry (C), Dr. Sharon Sheehan (Coombe Women and Infants University Hospital)

This audit looked at the average timeframe taken for hard copy reports to be signed and actioned in the outpatient department. A build-up of unsigned reports had been noted as an issue.

The purpose of the study was to audit current average timeframe for taking actions on abnormal results.

The sample was selected at random from the results for outpatients in the antenatal clinic. A sample size of 84 high vaginal swab (HVS) and 50 mid-stream urine (MSU) sample results were audited, a total of 134. The standard we compared with is the HSE Standards and Recommended Practices for Healthcare Records Management V 3.0" document, Section 2.4.51., which states that "all printed reports should be signed no later than twenty-four hours of results being available".

54 (40.2%) of samples had no growth. 27 (20.2%) needed treatment but this was not given. 53 (39.5%) needed treatment and were treated. For three of these the time to treat was not documented. The average time to treat was 6.86 days, and the range was from 0-27 days.

In conclusion, we are not matching the recommended standard for reviewing outpatient results. There is also a broad variation in time taken. One in three positive results are not being treated. We plan to review the current system in place for signing reports to see where changes can be made to improve efficiency. We will re-audit after six months to see if our times have improved and to complete the audit cycle.

AN AUDIT ON TIME MANAGEMENT IN A MATERNITY THEATRE

Abstract ID: 12

Dr. Olumuyiwa Ayodeji (University Hospital Limerick), Dr. Claire M McCarthy (University Hospital Limerick), Dr. Mendinaro Imcha (University Hospital Limerick)

Time management is an essential skill for physicians to develop, and delays in time management are an issue of healthcare quality, and a cause of waste of healthcare resources. Specifically, operating theatre inefficiency is a recognised problem.

We aimed to evaluate use of theatre time, ascertain delays in theatre productivity and introduce changes to optimise theatre function.

We carried out a retrospective audit of all theatre cases in a stand-alone maternity hospital over a two week period, examining time intervals in all theatre domains.

In total, 77 procedures were performed, comprising of 35 (45.4%) elective and 42 (54.6%) emergency cases. Of the 38 (49.3%) of procedures done out of elective operating hours, 14 (36.8%) were elective- comprising of caesarean sections (CS) (6; 42.8%) and evacuation of retained products of conception (ERPC) (8; 57.1%). The main areas of delay were between start of anaesthetic to start of procedure (mean 12.28 mins, range 0-50 mins) and time spent in recovery (mean 52.59 mins; range 1-304 mins).

Following this, recommendations in the areas of teamwork, communication and design and use of an electronic scheduling system were introduced to improve operating theatre efficiency. Following identifying inefficiencies in theatre time management, changes have been introduced to correct this, and we hope a re-audit will demonstrate improvements in all areas.

An audit to review the outpatient hysteroscopy service over a 6 month period at Wexford General Hospital.

Abstract ID: 20

Dr. Helena Bartels (Wexford General Hospital), Dr. Kate Glennon (Wexford General Hospital), Ms. Regina Tirbhowan (Wexford General Hospital), Dr. Asish Das (Wexford General Hospital)

Outpatient hysteroscopy is a safe, effective and economical service to manage women with abnormal uterine bleeding. The outpatient hysteroscopy unit at Wexford General Hospital has been running a successful clinical service since November 2013.

The purpose of this audit was to review every patient seen in the clinic over a 6 month period and identify any areas where the service could be improved.

A retrospective audit was conducted over a 6 month period (January-July 2016). Every patient who attended the department during the audit period was included. Demographic data recorded included patient age, parity and menopausal status. In addition, the reason for referral, ultrasound findings, findings at hysteroscopy, complications encountered and the follow up plan were recorded.

The OPD hysteroscopy service reviews a wide range of patients, with an average age of 47 years; the majority were post-menopausal (68%). Prior to assessment, 80% of patients had a pelvic ultrasound performed. The most common referral indication at 40% was abnormal uterine bleeding. Findings at hysteroscopy showed the majority (62%) had no identifiable abnormality. This allowed a significant number of patients to be reassured and discharged safely from care without the need for further intervention. 15% of patients were referred for further management in the operating theatre.

Overall, 85% of patients reviewed in the outpatient hysteroscopy clinic had a successful procedure requiring no further assessment under general anaesthetic.

The results of our audit show the hysteroscopy clinic continues to provide a safe and efficient service that is extremely cost effective.

AN COMPARATIVE STUDY OF INDUCTION OF LABOUR WITH PROSTAGLANDINS VS AMNIOTOMY AND OXYTOCIN FOR INDUCTION OF LABOUR IN OLOLH DROGHEDA.

Abstract ID: 108

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Back Ground:

Prostaglandins E2 should be used as a primary method of Induction of labour. Amniotomy alone or with oxytocin should not be used as a primary method of Induction of labour unless there is specific contraindications for PGE2.

Aim:

The Aim of this study was to compare the methods of induction in accordance with NICE clinical guidance on IOL 70 _July 2008.

Methods:

Retrospective analysis performed, Data collected from Maternity Information system. Sample of 246 patients selected who had labour induced between June-August 2016.

Results:

Out of 246 patients 158 (65%) were induced with PGE2 as a primary method of induction while rest of the 35% were induced with Amniotomy with or with out Oxytocin.

Conclusion:

All patients should have IOL with PGE2 unless contraindicated. We recommend development of Hospital policy in accordance with the NICE Guidance.

Reference:

Nice Clinical Guidance 70 _IOL July 2008.

AN EIGHT YEAR HIV PREVALENCE STUDY AMONGST THE DUBLIN PREGNANT POPULATION

Abstract ID: 66

Dr. Rebecca Horgan (St. Vincent's University Hospital), Dr. Cathy Monteith (Department of Obstetrics and Gynecology, Royal College of Surgeons in Ireland, Rotunda Hospital, Dublin, Ireland.), Dr. Sieglinde Mullers (Department of Obstetrics and Gynecology, Royal College of Surgeons in Ireland, Rotunda Hospital, Dublin, Ireland.), Prof. Fergal Malone (Department of Obstetrics and Gynecology, Royal College of Surgeons in Ireland, Rotunda Hospital, Dublin, Ireland.)

The universal antenatal screening programme for HIV was first introduced in Ireland in April 1999 and screening uptake has been consistently >99% since 2007.

The greater Dublin area, Ireland comprises of a population of 1.8 million people. For obstetric care, this area is solely served by three large tertiary maternity hospitals (Rotunda Hospital Dublin, National Maternity Hospital, Coombe Women and Infants' University Hospital) with a combined annual delivery rate in excess of 26,000.

A review of the three Dublin maternity hospitals' Annual Clinical Reports spanning eight years (2007-2014) was performed, maximizing case ascertainment. The prevalence was calculated by determining the number of HIV positive women attending antenatal care as a percentage of the total pregnant population attending the three Dublin maternity hospitals.

During the study period, 230,925 women attended for prenatal care, and a total number of 586 pregnancies were complicated by HIV infection, yielding an incidence of 2.54 per 1,000 births. The number of HIV positive pregnant women attending for antenatal care in the greater Dublin area has decreased by 34.5% from 87 women in 2007 to 57 women in 2014. The prevalence of HIV has decreased by 34% from 0.32% in 2007 to 0.21% in 2014 ($p < 0.0001$).

Our study demonstrates that the prevalence of HIV amongst the pregnant population of Dublin has decreased dramatically from 2007 to 2011, and has remained stable since then. The demonstrated reduction in the prevalence of disease may be due to enhanced education efforts to eradicate new HIV infection in this population.

AN ELECTIVE INDUCTION OF LABOUR POLICY- DOES IT DECREASE THE RATE OF OPERATIVE DELIVERY FOR WOMEN OF ADVANCED MATERNAL AGE?

Abstract ID: 228

Dr. Dmitry Loktionov (University Hospital Limerick), Dr. Claire M McCarthy (University Hospital Limerick), Dr. Mark Skehan (University Hospital Limerick)

Historically, women of advanced maternal age (AMA) have an increased risk of Caesarean Section (CS) and adverse outcomes than their younger counterparts.

We aimed to examine whether an elective induction of labour (IOL) had an impact on both mode of delivery and maternal and neonatal outcomes.

We conducted a one year retrospective review on women attending a named obstetrician with an elective induction policy. We examined patient demographics, mode of delivery and onset of labour, as well as maternal and neonatal outcomes.

In total, 175 women delivered over the study period, with an average CS rate of 18.8% (n=33). Three were excluded from analysis as age was missing. The average maternal age was 34.84 years, with 102(59.3%) women of AMA; 49% (n=50) of these were primigravida. 30.3% of the AMA group (n=31) and 36% (n=18) of the non-AMA group had a spontaneous onset of labour, with 14.7% (n=15) of those in the AMA group having a CS, compared to 14% (n=7). There was no statistically significant difference between gestation at delivery, onset of labour, mode of delivery or neonatal outcomes.

Our rates of CS are significantly better than described in other studies, and there are no difference in outcomes between those of AMA and those under 35 years of age. Further large scale studies would be needed to investigate whether employing an elective IOL policy such as by this obstetrician could reduce rates of operative outcomes and improve womens' and neonatal outcomes.

An indepth analysis of induction of labour in primiparous women- an audit report

Abstract ID: 170

Dr. Tamara Kalisse (Cork University Maternity Hospital)

Background: Our previous study, “Anatomy of caesarean section in a single maternity unity,” highlighted that the rising CS trends in CUMH is attributed to a rise in caesarean sections in primiparous women undergoing induction of labour.

Objective: We aim to audit and evaluate our adherence to hospital induction of labour guideline and assess the outcomes of primiparous labour induction based on indication and mode of delivery.

Method: Cases of primiparous labour inductions were indentified by examining printed induction lists over a one month period (August 2016). Charts were then retrospectively reviewed.

Results: During the studied period, there were 87 primiparous women booked for induction of labour. Of those, 7 women (8%) presented in spontaneous labour and all had vaginal deliveries. Of those who underwent labour induction, 33 women (41%) were delivered by caesarean section, notably more than one quarter of the indication for abdominal delivery was failed induction (27%). The indication for labour induction varied and included postdates, liquor volume abnormality, fetal growth abnormalities (including small and large for dates), hypertensive disorders, medical complications and prolonged rupture of membranes.

Conclusion: A considerable number of labour induction in our primiparous population is culminating in caesarean delivery. Our hospital policy lacks clarity regarding certain parameters, for example what is considered oligohydramnios at term requiring induction. We believe if such parameters are set and an induction of labour proforma is introduced, then un-indicated inductions, and hopefully, unnecessary caesarean sections could be avoided.

AN INTERESTING CASE OF POST-OPERATIVE TACHYCARDIA IN AN ENDOMETRIOSIS PATIENT

Abstract ID: 236

Dr. Rebecca Conlan-Trant (Gynaecology Department, Tallaght Hospital, Dublin 24), Dr. Aoife McSweeney (Cork), Dr. Amy Fogarty (Talla), Dr. Aoife O Neill (Gynaecology Department, Tallaght Hospital, Dublin 24)

Thyroid storm is a thyrotoxic crisis, in which there is an acute release of thyroxine(T4) and tri-iodothyronine(T3). Incidence amongst hospitalised patients is 0.20 per 100,000. Clinical manifestations include tachycardia, pyrexia and gastrointestinal symptoms. Mortality rates are reported to be 20% - 30%.

We present the case of a 23 year old lady admitted electively for laparoscopic adhesiolysis and excision of endometriosis, on a background of stage four endometriosis. Her past medical history was significant for anxiety. She was noted intraoperatively to be tachycardic despite minimal blood loss. She was managed with fluid resuscitation. Immediately post-operatively, she became increasingly tachycardic at 155/bpm, hypertensive at 160/90mmHg, pyrexia to 38.1°C, as well as nausea and vomiting. An urgent full blood count and septic screen were sent, as well as thyroid function tests. Her blood results revealed Hb 11.6g/dl, an elevated fT4 of 68.0 pmol/L (12–22) and a low TSH of < 0.05mU/L (0.3-4.2). Diagnosis of thyroid storm on a background of undiagnosed hyperthyroidism was made. Metoprolol and carbimazole were commenced and the patient was observed in the Post Anesthetic Care Unit. An isotope thyroid scan demonstrated findings consistent with Graves' disease. With treatment, the patient's condition stabilized and she was discharged day 3 post op.

A 2016 study found a higher prevalence of Graves' disease in endometriosis patients. It is postulated that this may be related to autoimmune factors and interestingly Anti Nuclear Antibody positivity has been found to be elevated in both groups. This association should be considered in endometriosis patients.

An international assessment of trainee experience and confidence in operative vaginal delivery

Abstract ID: 156

Dr. David Crosby (UCD), Prof. Mary Higgins (National Maternity Hospital)

Objective

A combination of both reduction in operative vaginal deliveries (OVD) and trainee working hours has limited exposure for trainees in Obstetrics in OVD. The objective of this study was to assess trainee confidence, comfort and knowledge in performing OVD in Ireland and Canada.

Study Design

The resident training scheme lasts eight years in Ireland and five years in Canada; only those Irish residents at similar years of training were included in this study. Residents training in Obstetrics and Gynaecology in the University of Toronto (n=56) and the RCPI (n=48) were invited to participate in an anonymous online survey. Trainee confidence was assessed based upon their last 2-3 forceps deliveries using a modified version of a six-item five point tool (maximum score out of 30) previously validated for gynecology trainees to measure self-confidence.

Results

The response rate was 55% amongst Canadian residents (31/56) and 44% amongst Irish residents (21/48). When comparing Irish with Canadian trainee experience, the mean numbers of vacuum and forceps deliveries performed by Irish trainees as primary operator were reported to be higher (67.8vs26.4;p<0.0001, 42.4vs.19.9;p=0.002). Despite this, trainee confidence between the groups did not differ (18.7(SD 3.2) vs 17.8(SD3.5),p=0.3).

Conclusion

With falling OVD rates worldwide, training experience is declining. Despite higher numbers of OVD within the Irish resident group there was no difference in trainee confidence between the two groups. These results suggest that a high number of cases as primary operator may not be required in order to obtain confidence in performing a procedure.

AN INVESTIGATION OF HEALTH LITERACY IN THE NON-IRISH ANTENATAL POPULATION

Abstract ID: 200

Dr. Caitriona Fahy (Cork University Maternity Hospital), Dr. Mairead O riordan (Cork University Maternity Hospital)

Increased immigration to Ireland has consequences for the provision of healthcare services. Twenty per cent of deliveries in Irish hospitals are to non-Irish women. Research finds that migrant women are at increased risk of poorer outcomes, compared with the native population. Poor health literacy and limited communication skills make a significant contribution. Health literacy is the ability to obtain and understand basic health information in order to make appropriate health decisions.

We aimed to quantify health literacy in non-Irish pregnant women compared with Irish women by using a validated questionnaire. We also aimed to investigate practices of use regarding information technology, and to assess preferences in this area.

Patients were recruited from the antenatal population in Cork University Maternity Hospital and Kerry General Hospital. The REALM questionnaire was used to assess health literacy, while a second questionnaire evaluating communication technology use and preferences was administered simultaneously. Results were analysed using SPSS.

206 women were recruited. Non-Irish women had significantly lower literacy scores compared with their Irish counterparts. Regarding technology use, the vast majority of women owned smart phones, had a PC or laptop, and had internet access at home. Over 90% of women used the internet to obtain pregnancy information.

There is a significant difference in health literacy between Irish and non-Irish women. Our service provision should adapt to their needs. The vast majority of our patients are obtaining health information from the internet. We should be modify our practices to communicate effectively with patients.

An Observational and Comparison Study of Obstetric Handover in CUMH

Abstract ID: 241

Dr. Lydia Simmons (Cork University Maternity Hospital)

Handover is increasingly highlighted as a vital part of patient care. Handover processes can be variable and often verbal which can lead to misinformation, making this a high-risk activity. We at CUMH encourage the use of the ISBAR handover tool, however this is not always put into practice.

The purpose of this study was to re-audit our practices and evaluate any improvements in communication before the introduction of an electronic handover app. This will then be re-audited after introduction of the app.

Initially we surveyed a random selection of NCHD's and consultants regarding handover practices and compared this to previous results. We are recording attendance at handover for further assessment. This will be compared to previous results to assess for improvements and deteriorations.

Thus far we have 26 surveys completed which show wide variation in knowledge and use of ISBAR. All agree that handover is a high-risk activity and critical for patient care, but only 15 doctors use ISBAR and only 9 have had formal training in its use. This is very little improvement on our previous audit where 6/18 doctors had formal training. Despite this most doctors felt confident that the tasks they handed over would be dealt with efficiently.

Our study has shown that there has been improvement in the handover process since this study began but much more improvement is required for patient safety. This will be re-audited again after the introduction of electronic handover.

AN OBSERVATIONAL STUDY OF ANATOMICAL AND CLINICAL OUTCOMES OF LAPAROSCOPIC SACROCOLPOPEXY AND SACROHYSTEROPEXY

Abstract ID: 29

Dr. Hana Ahmed (Department of Obstetrics and Gynaecology, Mullingar Midlands Regional Hospital), Dr. Sam Thomas (Mullingar Midlands Regional Hospital), Dr. Shahbaz Mansoor (Mu), Prof. M. Gannon (Mullingar), Dr. Majda Almshwt (Mullingar Midlands Regional Hospital)

AN OBSERVATIONAL STUDY OF ANATOMICAL AND CLINICAL OUTCOMES OF LAPAROSCOPIC SACROCOLPOPEXY AND SACROHYSTEROPEXY

Hana Ahmed, Sam Thomas, Shahbaz Mansoor, Micheal Gannon, Majda Almshwt.
Obstetrics and Gynaecology Department, Mullingar General Hospital

Background:

Risk of having pelvic organ prolapse increases with different factors, such as, age, parity, body mass index, number of vaginal deliveries, macrocosmic delivery and hysterectomy. The incidence of vault prolapses following hysterectomy is unknown but about 0.2 -43% of hysterectomies women were affected., surgical intervention such as, Laparoscopic Sacrocolpopexy and Sacrohysteropexy both have a high success rate (90-98) %.

Aim of study:

The aim of this study is to evaluate the clinical and anatomical outcome of laparoscopic sacrocolpopexy and sacrohysteropexy in Mullingar regional hospital.

Method:

Retrospective observational study of women undergoing laparoscopic sacrocolpopexy and sacrohysteropexy between 2012 and 2015 in Midland Regional Hospital - Mullingar.

Result:

This study includes 14 women with mean age of 67.4 years who had laparoscopic sacrocolpopexy or sacrohysteropexy between 2012 and 2015. those ladies were seen after procedure in outpatient department, 73.3 % showed improvement in their symptoms and vaginal / vault prolapse in 6 weeks. They also reviewed in time of this study 50% are free from any degree of prolapse.

Conclusion:

Study confirms that laparoscopic Sacrocolpopexy and Sacrohysteropexy is efficacious surgical treatment with high successful rate of 73.3%.

References:

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Anaemia and Iron Supplementation prior to elective caesarean section

Abstract ID: 190

Dr. Clare Kennedy (National Maternity Hospital), Dr. Claire O Reilly (National Maternity Hospital), Dr. Anthony Klobas (National Maternity Hospital), Dr. Dr Fiona Martyn (National Maternity Hospital), Dr. Larry Crowley (National Maternity Hospital)

Increasing caesarean section (CS) rates have increased the burden on operating theatres in Ireland. Bleeding is a well known potential complication of Caesarean section. To minimise the need for postop blood transfusion, it is imperative that haemoglobin (Hb) levels are optimised prior to surgery. Guidelines at the NMH recommend that a Hb is checked as part of booking bloods and at 28 weeks. It is also standard policy that a full blood count (FBC) is done 2 weeks prior to surgery.

The purpose for this study was to audit whether the current policy of FBC testing antenatally and prior to CS is being implemented in our hospital and to investigate the use of iron supplementation.

60 elective CS patients were asked about iron supplementation in pregnancy. Their charts were then reviewed to determine whether the hospital guidelines had been followed.

Only 22/60 women were commenced on supplemental iron during their pregnancy. 20 of those 22 women had their Hb rechecked. 14/20 had an improvement in their Hb level, 5/20 deteriorated, 1 was left unchanged. 39/60 patients had a FBC performed within 4 weeks of CS. The remaining 11 had their FBC carried out on the day of surgery. 32/60 women had a post-op Hb of <11. Of those 32, only 10 had been on oral iron antenatally.

Hospital guidelines on FBC testing need to be rigorously followed to ensure women who need iron supplementation are identified, thus ensuring that if bleeding occurs a blood transfusion may be avoided.

ANALYSIS OF WOMEN WHO UNDERWENT EMERGENCY CAESAREAN SECTION DELIVERY, DESPITE RECEIVING AN ANTENATAL LOW PREDICTIVE RISK SCORE FOR SAME

Abstract ID: 89

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Our group previously developed a predictive risk tool with the aim of predicting those women most likely to undergo emergency caesarean delivery (CD), by identifying high risk patients antenatally.

The GENESIS study was a prospective, blinded observational study carried out by the Perinatal Ireland Research Consortium from October 2012 to June 2015. A cohort of 2,336 nulliparous uncomplicated singleton pregnancies was recruited. Maternal anthropometric and demographic data were assessed, along with sonographic fetal parameters including head circumference, abdominal circumference and estimated fetal weight. Peripartum events and decision for emergency CD were recorded.

This study analysed the cohort of women who underwent emergency CD, despite receiving a low predictive risk score for same.

36 women, with a predictive risk score <10% of requiring CD underwent emergency CD.

69% of women (n=25) underwent CD for non-reassuring CTG. 56% of these women (n=14) were having continuous CTG monitoring performed due to the presence of an epidural.

From this group, median 1 minute apgar score was 9 and median 5 minute apgar score was 10.

The remaining 31% (n=11) underwent CD for failure to progress or treat.

The majority of the women in this study who underwent emergency CD for non reassuring CTG were undergoing continuous monitoring due to an epidural. Overall fetal outcome was good. Intermittent monitoring, with alternate analgesia, may have resulted in a lower CD rate. This would have been in keeping with our predictive

score and may have reduced the potential morbidity associated with emergency CD

Antenatal and delivery outcomes of women with Gestational Diabetes Mellitus with two raised sugar values

Abstract ID: 174

*Dr. Suzanne Smyth (University Maternity Hospital Limerick), Ms. Yvonne Moloney (University Maternity Hospital Limerick),
Dr. John Slevin (University Maternity Hospital Limerick)*

Gestational Diabetes Mellitus(GDM)has become more prevalent with increasing rates of maternal obesity, sedentary lifestyles and advancing maternal age in recent years. Our study aimed to assess the antenatal course and delivery outcomes of women diagnosed with GDM who had two blood sugar values raised.

This was a retrospective review of a prospectively updated database of all women with raised blood sugar values at the time of glucose tolerance testing. All women who booked for antenatal care in UMHL in 2015 fulfilling this criteria were included in the final analysis.

Overall 124 records were analysed. Women had a median age of 29 years and were diagnosed at a median of 28 weeks gestation(10 weeks – 37 weeks). BMI ranged from 18 – 55 with a median of 29.0. The most common nationality was Irish. The most common indications for performing a glucoase tolerance test in this group was previous GDM(n=37), glycosuria(n=24) and macrosomia(n=18). The median fasting level was 5.2mmol/l, one hour fasting was 11.4 and two hour fasting was 8.6mmol/l. The majority of cases were diet controlled(n=68). The median HbA1c at booking was 36 and at delivery was 33. There was an equal divide between Caesarean delivery and vaginal delivery. Admission rates to neonatal ICU was 18.5%.

Maternal glycemia affects fetal and neonatal morbidity and as such has become an important target for health-care professionals in antenatal care. Pregnancy also offers a unique opportunity to improve lifestyle for women known to be at risk of type two diabetes in later life.

ANTENATAL INFLUENZA VACCINATION UPTAKE IN A GENERAL PRACTICE SETTING

Abstract ID: 115

Dr. Vanessa Flack (University College Dublin), Dr. Paschal Larney (University College Dublin)

Pregnant women with influenza are at greater risk of developing serious complications due to immune system changes and cardiorespiratory physiology.(1) Influenza during pregnancy increases rates of premature births and lower birth weights may ensue. Thus the influenza vaccine is recommended and can be administered safely during any trimester.(1) Vaccination rates in previous hospital based studies in Ireland ranged from 39.1%(2) and 70%. Studies report no increase in pregnancy complications or adverse perinatal events in those vaccinated.(3)

This audit was conducted on all the antenatal patients in a rural practice over a one-year period and aimed to establish vaccination status. Also examined were maternal age, smoking status and asthma status to determine if a link existed between these factors and vaccination uptake.

The HealthOne system identified antenatal cases. Data was compiled in an anonymous spreadsheet and analysed.

39 antenatal cases were identified, 4 of whom received the vaccination giving an uptake rate of 10.25%. 4 patients were asthmatic but none of these received the vaccination. The average age of these women was 28, and the average age of those vaccinated was 35. Smoking status was difficult to determine.

Vaccination rates in this general practice are lower than the estimated national average of 32.5%.(4) There was no link established between asthma and vaccination uptake suggesting those who need it most are not availing of it. Older mothers were more likely to vaccinate. Increased awareness among general practitioners and pregnant women regarding the importance of the influenza vaccine is essential.

APPENDICITIS IN PREGNANCY - A DIAGNOSTIC CHALLENGE

Abstract ID: 223

Dr. Hannah Glynn (University College Hospital Galway), Dr. Susmita Sarma (University College Hospital Galway)

APPENDICITIS IN PREGNANCY - A DIAGNOSTIC CHALLENGE

H. GLYNN, S. SARMA.

Department of Obstetrics and Gynaecology, University College Hospital Galway.

Assessment of abdominal pain in pregnancy presents a diagnostic challenge. There is a high prevalence of gastrointestinal symptoms in normal pregnancy secondary to both anatomical changes associated with the enlarging uterus and normal physiological changes of pregnancy. Pregnancy is associated with a physiological leukocytosis thus white cell count (WCC) must be interpreted cautiously. Acute appendicitis (AA) in pregnancy is relatively rare with an approximate incidence of 1/1500. Over a one week period in Galway three pregnant patients were diagnosed with histology proven AA requiring emergency appendicectomy.

The aim of this study is to highlight the atypical presentation of AA in pregnancy.

The antenatal notes and lab work of the patients involved were reviewed.

AA presents atypically in pregnancy. Only one patient presented with classic RIF pain, another patient presented with RUQ pain over breech of baby and another had right flank pain. 2 cases of AA occurred at 27 weeks gestation, 1 case occurred at term - all 3 cases presented in the 3rd trimester. Studies in this field would suggest that AA is most common in the second trimester. WCC and CRP at presentation were not indicators of AA. Imaging is of limited value in pregnancy. Ultrasound was performed on both patients who were 27 weeks pregnant. Neither study found any acute pathology which questions the role of ultrasound in evaluation of such patients.

Assessing the impact of funding on success rates of assisted reproduction in Ireland

Abstract ID: 131

Dr. Nicola O Riordan (Nation), Dr. Yvonne O brien (Merrion Fertility Clinic, National Maternity Hospital), Dr. Mary Wingfield (Merrion Fertility Clinic, National Maternity Hospital)

Background: Despite infertility impacting one in six Irish couples, Ireland is one of three EU countries failing to provide public ART (assisted reproduction treatment). Merrion Fertility Foundation (MFF) is a charitable organisation which aims to fund ART for those who are otherwise unable to afford it. Funding is granted based on clinical and financial criteria.

Aims: Evaluation of success of ART in Merrion Fertility Clinic, comparing private cycles with MFF funded cycles.

Method: Retrospective analysis comparing clinical pregnancy rates (CPR's) and live birth rates (LBR's) for fresh IVF cycles, MFF-funded vs privately-funded.

Results: 49 couples received funding: 26 full and 23 partial funding based on financial criteria. Eight of these couples had no chance of spontaneous conception without IVF. 22 MFF-funded couples had a clinical pregnancy and 16 had a live-birth. The overall CPR rate was lower in MFF-funded cycles compared to privately-funded and those with full funding had lower rates than those with partial (42% Full, 47% Partial, 50% Private). The LBR showed a larger difference (27% Full, 39% Partial, 42% Private). In good prognosis women the difference in LBR was stark (Full 36%, Partial 37%, Private 54%). The average time to conception for those MFF-funded was four years.

Conclusion: MFF facilitates the provision of ART to couples on low incomes. Our numbers are small but initial analysis reveals a worryingly poorer outcome in funded cycles. This may be due to socioeconomic factors and delay in time to treatment. Our study supports the need for publicly-funded ART in Ireland.

ASSESSMENT OF EFFECTIVENESS OF LIFESTYLE MODIFICATION EDUCATION FOR WOMEN WITH NEWLY DIAGNOSED GESTATIONAL DIABETES.

Abstract ID: 53

Mr. Hamed Alayoub (University College Dublin), Ms. Usha Daniel (Midwifery, National Maternity Hospital), Ms. Ciara Corcoran (Midwifery, National Maternity Hospital), Ms. Eimear Rutter (Midwifery, National Maternity Hospital), Ms. Mary Coffey (Midwifery, National Maternity Hospital), Dr. Mensud Hatunic (Endocrinology, Mater Misericordiae University Hospital), Ms. Laura Harrington (Dietitian, National Maternity Hospital), Ms. Hilary Devine (Dietitian, National Maternity Hospital), Ms. Sinead Curran (Dietitian, National Maternity Hospital), Prof. Mary Higgins (UCD Obstetrics and Gynaecology, National Maternity Hospital)

Gestational diabetes mellitus (GDM) is a form of diabetes that occurs in pregnancy and resolves after delivery. It increases maternal and foetal morbidity and is associated with an increased risk of future type 2 diabetes. Women diagnosed with GDM need high-quality multidisciplinary education in order to have ownership of their diagnosis.

The aim of this study was to assess the effect of such an educational intervention on women's knowledge of GDM.

All women with a diagnosis of GDM are invited to attend an educational session aiming to impart knowledge on GDM management. For the initial stage of the study, all pregnant women diagnosed with gestational diabetes were invited to complete a questionnaire before and after the educational intervention; only individuals who have completed both have been included. The questionnaire reviewed knowledge of suitable foods, implications of GDM diagnosis and management of GDM.

Total of 716 women completed both questionnaires; mean age of the participants was 34.5 years. Just under a half (46.9%, n=333) were primiparous. The majority of the patients (62.5%, n=439) were Irish; 53.4% (n=382) presented with a family history of diabetes. There was a significant increase in median score for knowledge following the educational intervention (pre-intervention score 8 (-2-12); post-intervention score 12 (1-12); p<0.001). The initial study demonstrates the benefits of an educational session in reinforcing and expanding the patients' knowledge in GDM. The next stage of the study is to validate a questionnaire allowing comparison between other units both nationally and internationally.

Audit and follow up of outcomes pertaining to attendees to a gestational thyroid clinic in a one year period

Abstract ID: 104

Dr. Michelle McCarthy (South Tipperary General Hospital), Dr. S.M.Tajul Millat (South Tipperary General Hospital), Dr. Vijayashree Hiremath (South Tipperary General Hospital)

Due to local prevalence, every pregnant woman booked in South Tipperary General Hospital has thyroid function tests performed. Any abnormal results are referred to a specialised gestational thyroid clinic, along with those with pre-existing disease. Sub-optimal control is linked to increased risk of miscarriage, stillbirth and hypertensive disorders of pregnancy. According to the British Endocrine Society Guidelines, TFTs should be performed pre-conception, at diagnosis of pregnancy, 2 weeks after change of dose, at least once per trimester, and 2-6 weeks postpartum.

We examined the charts of new referrals to this clinic over one year to establish the reasons for referral, the timing of the TFTs performed, and the outcomes of such pregnancies. Information was combined with booking forms to determine past miscarriages.

Of the thirty-seven referrals to the clinic, twenty-two (59%) had pre-existing thyroid disease, three (8%) had a family history of thyroid disease, and twelve (32%) had no risk factors. Eighteen(49%) had bloods recorded once per trimester. Out of those with had pre-existing thyroid disease, fourteen(64%) had preconception TSH levels performed. Fifteen(41%) had TSH levels measured at 2-6 weeks postpartum, this fell to 25%(n=3) in those with new onset in pregnancy. One pregnancy ended in miscarriage, but taking into consideration past pregnancies, there is a 19.5% prevalence of miscarriage in this population. One pregnancy was complicated by pre-eclampsia and one woman experienced hypertension.

The importance of screening is demonstrated by the numbers with no risk factors. Miscarriage rates do not appear elevated in this population. Follow-up must be optimised.

AUDIT OF ADHERENCE TO REFERRAL PATHWAY FOR PREGNANT WOMEN WITH HISTORY OF GENITAL HERPES SIMPLEX VIRUS(HSV)

Abstract ID: 132

Dr. Nikita Deegan (Coom)

Genital HSV can be transmitted in the perinatal period with potential for serious and devastating consequences for the infant(1). Transmission most commonly occurs due to exposure during delivery(2). Acyclovir and its analogues used for prophylaxis can reduce the risk of viral shedding at delivery and therefore reduce transmission risk(3). The National document 'Prevention of Perinatal Transmission: A practical guide to the antenatal and perinatal management of HIV, Hepatitis B, Hepatitis C, Herpes Simplex & Syphilis 2015'(4) resulted in the introduction of a new guideline and care pathway in our unit.

All women booking for antenatal care in CWIUH who declare a history of genital HSV should prompt referral to our clinical midwife specialist infectious disease(ID). Referrals are then triaged and reviewed at our fortnightly combined specialist Obstetric/ID team at CWIUH where appropriate intervention can be implemented. A retrospective audit was undertaken to ascertain adherence to this pathway.

All women whom declared a history of genital HSV at booking from 1/8/2015– 30/4/2016 were identified via our IT PAS system. A retrospective chart review was performed.

Results showed that adherence to our pathway was only 10.2%(only 5 of 49 women referred directly from booking with history of genital HSV).

Audit of practice, in particular following introduction of a new care pathway, is essential for demonstrating adherence.

A change in our hospital guideline is planned to ensure that all women who provide a history of genital HSV will automatically be booked for antenatal care with our specialist ID obstetric team.

AUDIT OF COMPLIANCE WITH LOCAL GUIDELINE FOR ESTABLISHING ESTIMATED DUE DATE IN PREGNANCY IN CORK UNIVERSITY MATERNITY HOSPITAL

Abstract ID: 284

Dr. Aoife McSweeney (Cork), Dr. Keelin O'Donoghue (Cork University Maternity Hospital)

Accurate dating of pregnancy is crucial to ensure consistency of gestational age assessment and reduce the incidence of induction of labour for prolonged pregnancy. NICE guidance recommends that all women are offered dating scan between 10 and 13+6 weeks gestation.

This audit was carried out to assess the assignment of estimated due date for pregnancy as compared to the local guideline. This included the timing of dating scans, the frequency with which dates were changed, whether the reason was documented and if it was in line with CUMH recommendations.

This was a review of 100 antenatal and postnatal case notes and was performed in a retrospective manner. Data was collected by myself and I utilised an electronic data spreadsheet.

90% (n=90) of patients had their dating scans before 14 weeks gestation. 53% (n=53) of patients were assigned EDD based on ultrasound. 47% (n=47) were assigned based on dates of last menstrual period. Of the private patients 72% (n=13) did not have their EDD changed from the LMP date, whilst 28% (n=5) did. 10% (n=10) of dates were changed without a documented reason.

In conclusion, in this audit of 100 patients, 90% were scanned within the optimal time frame, with more than half having their EDD changed based on this. Correct assignment of dates is vital for timing of appropriate obstetric care, determining the appropriateness of fetal growth and managing post dates pregnancy.

AUDIT OF COMPLIANCE WITH NATIONAL CLINICAL GUIDELINE ON THE INVESTIGATION OF POSTMENOPAUSAL BLEEDING.

Abstract ID: 272

Dr. Sabina Tabirca (Cork University Maternity Hospital), Dr. Cathy Burke (Cork University Maternity Hospital)

The Postmenopausal Bleeding (PMB) Clinic is a consultant-led clinic which runs fortnightly and specifically assesses women referred with bleeding after the menopause. A clinical history, physical examination and ultrasound scan with endometrial biopsy if indicated are performed. The National Clinical Guideline “Investigation of Postmenopausal Bleeding” recommends investigation of women with PMB who have an ET of > 3mm.

We analysed the datasheets of all women attending the PMB clinic from November 2015 to September 2016 to assess compliance with the guideline. Patient demographics, medication history, BMI, ultrasound findings, clinical follow up and histology findings were analysed.

198 women were scheduled to attend the PMB clinic over the 10 month period. There was a “did not attend” (DNA) rate of 16%, thus 166 women were reviewed in the clinic. Of these, 40 (24%) women had an ET of <3mm and either a normal clinical examination or vaginal atrophy and were thus discharged from further investigation with topical estrogen if required. Women with an ET >3 mm were investigated with either endometrial biopsy, outpatient hysteroscopy and endometrial biopsy or inpatient hysteroscopy and D&C.

All women attending the PMB clinic who were found to have an ET of greater than 3 mm were investigated with an endometrial biopsy either by an endometrial biopsy or performing a hysteroscopy, dilation and curettage either in the outpatient hysteroscopy service or in theatre. Our study shows that we are in compliance with the national clinical guideline on PMB for assessment of all women with ET >3mm.

Audit of sample Mislabelling in the Gynae ward in Coombe Women & Infants University Hospital

Abstract ID: 116

Dr. Marwa Mohamed (Coombe Women and Infants University Hospital), Dr. Sharon Sheehan (Coombe Women and Infants University Hospital)

INTRODUCTION:

Correct sample labelling is essential in ensuring patient safety. Any error during sample labelling has the potential to result in serious, life-threatening complications. In addition, inappropriate or inaccurate treatment may result or indeed unnecessary treatment.

METHODOLOGY:

A questionnaire was developed for staff and patients asking if each of the standards for correct sample labelling had been followed. During a one-week period, members of staff and patients completed the questionnaires. Posters highlighting the standards used for correct sample labelling were then developed and displayed in staff and patient areas on the ward. On a weekly basis, over the course of the next three weeks, staff and patients completed the questionnaires. Any sample labelling errors identified in the laboratory during the four-week period were also recorded.

RESULTS:

In the first week, a total of 6 staff member and 30 patients were surveyed. Overall compliance with the standards was 70%. Over the following three week period, the overall compliance improved from 83% in the second week, to 100% in the third week and fourth week. During the four-week period, there were no mislabelled samples reported in the laboratory.

Conclusion:

The results of these audits demonstrate improved compliance following targeted staff and patient education. Involving the patient in her care provides an important opportunity to maximise patient safety. We plan to roll out these poster displays to other clinical areas and assess their effect on ensuring that sample mislabelling is eradicated and that the improvements are embedded within the hospital.

AUDIT OF THE OUTCOMES OF LABOUR INDUCTION USING PROPESS® (DINOPROSTONE VAGINAL INSERT) IN WOMEN WITH SINGLETON PREGNANCIES, STRATIFIED BY MATERNAL BMI.

Abstract ID: 182

Dr. Marie Rochford (Coombe Women and Infants University Hospital), Prof. Michael Turner (Coombe Women and Infants University Hospital), Dr. Sharon Sheehan (Coombe Women and Infants University Hospital), Dr. Angela Vinturache (Coombe Women and Infants University Hospital)

AIM: To evaluate the single-dose Propess® (dinoprostone vaginal insert) indications and outcomes of labour induction in women with singleton pregnancies stratified by maternal BMI.

METHODS: Consecutive medical records of 2695 women with singleton pregnancies who delivered between May 1st and 31st August 2015 in the Coombe Women and Infants Hospital, Dublin, were surveyed. 878 women underwent labour induction and, of those, 303 were induced using Propess®. Descriptive and univariate analyses compared pregnancy and birth outcomes between women categorized as normal weight, overweight and obese based on the pregnancy BMI.

RESULTS: Of the 303 women induced with Propess® 187 (61.7%) were primiparous and 116 (38.3) were multiparous. Over half of women in the study had non-optimal BMI during pregnancy, with 82 (27.1%) of women being overweight and 71 (23.4 %) being obese. 195 women (64.4%) were at term, gestational age between 37 and 40 weeks, and 35 % were post-term (gestational age > 40 weeks). Bishop score, formally evaluated in 87. 5% of the inductions, showed that 92.8 % of women had an unfavourable cervix with a score lower or equal to 5. When analysed by maternal BMI, we observed that there was no difference in maternal age, parity, Propess® duration, mode of delivery and Apgar score at birth between overweight and obese women and normal weight women.

CONCLUSION: This audit shows that the birth outcomes of PROPESS® induction system were similar in obese and normal weight women. Therefore, this is a safe method of induction for patients of all BMI categories.

Audit of the use of Fetal Fibronectin in a tertiary referral centre to assist in the assessment and management of threatened preterm labour.

Abstract ID: 70

Dr. Laura O Byrne (Coombe Women and Infants University Hospital), Dr. Gillian Ryan (Coombe Women and Infants University Hospital), Prof. Sean Daly (Coombe Women and Infants University Hospital)

Preterm labour(PTL) remains a major cause of neonatal morbidity and mortality. Fetal fibronectin(ffn) is a glycoprotein that exists between the chorion and decidua. fFN testing has been investigated as a screening test for PTL, its negative predictive value found to be 99.5% within 7 days and 99.2% within 14 days.

This was a retrospective audit of prospectively collected data for all women who had fFN testing to evaluate threatened PTL over a three month period and re audit over the same timeframe. The aims of the audit were to compare current use of fFN against the hospital guideline and to examine the outcome of women where fFN was used as part of the management of suspected PTL.

fFN testing in the unit increased across the audit by 59%. Management of women in accordance with the guideline improved with 9 women (25.7%) inappropriately admitted and or given steroids in the negative fFN group in the first audit and 18.3% (n12) in the second. Across both groups (113 women) there were 100 women who had a fFN <50ng/ml. None of these women delivered within two weeks of a negative result.

In conclusion, this unit fFN has been used to successfully triage low risk women presenting with TPTL, reducing the interventions required in this group. There were no preterm deliveries in those women with negative fFN, allowing confidence to discharge patients in the low risk group and put resources to better use in the higher risk groups.

AUDIT OF THROMBOPROPHYLAXIS DOSING POST CAESAREAN SECTION DELIVERY

Abstract ID: 78

Dr. Teresa Treacy (Wexford General Hospital)

Thrombosis and thromboembolism remain the leading cause of direct maternal death. (1) It is recommended that all women who have had a caesarean section (CS) should receive venous thromboembolism (VTE) prophylaxis until women are fully ambulant, usually coinciding with discharge from hospital. A weight-adjusted regimen should be used. All women should be reminded of the importance of postpartum thromboprophylaxis. (2)

The purpose of this audit was to review low molecular weight heparin (LMWH) thromboprophylaxis prescribing post CS delivery; and whether it was prescribed correctly as per recommended guidelines. The primary outcome of the audit was to assess if implementation of a simple visual system could improve LMWH dosing practices post CS delivery.

A retrospective chart review of patients delivered by CS was performed. 40 charts were randomly selected and each case was reviewed. Correct weight based dosing was based on suggested thromboprophylaxis doses for postnatal LMWH, adapted from RCOG guideline 2009, as presented in RCPI clinical practice guideline. (3)

Of the 40 charts reviewed, LMWH thromboprophylaxis was prescribed for all cases post CS delivery. 23 cases were delivered by emergency CS, 17 by elective CS. 38 of 40 cases DID NOT have weight documented on their drug Kardex. 7 out of 40 cases had incorrect LMWH dose prescribed and administered: 6 out of the 7 cases were given sub-therapeutic doses.

Findings illustrated areas for improvement, and prompted NCHD education and visual prompts on Venous Thromboprophylaxis in Pregnancy. Upon re-audit, an improvement in appropriate prescribing practices was seen.

AUDIT OF TRANSFUSION AND OBSTETRIC MANAGEMENT OF HAEMORRHAGE AT UNIVERSITY MATERNITY HOSPITAL LIMERICK.

Abstract ID: 5

Dr. Breffni Anglim (University Hospital Limerick), Dr. James Nolan (University Hospital Limerick), Dr. Helena Daly (University Hospital Limerick), Ms. Bridget Lane (University Hospital Limerick), Dr. Sie Ong Ting (University Hospital Limerick), Dr. Hilary O leary (University Hospital Limerick), Dr. Mendinara Imcha (University Hospital Limerick)

Background

Obstetric haemorrhage is a major cause of preventable maternal mortality and morbidity. The confidential enquiry in UK reported major suboptimal care in those women who died as a result of obstetric haemorrhage.

Aims

This study aims to determine whether major obstetric haemorrhage (MOH) was managed appropriately in a large, stand-alone, maternity hospital. This included a review of adequacy of identification of women at risk for obstetric haemorrhage and of multidisciplinary involvement in ensuring optimal management of blood transfusion.

Methods

This was a retrospective study of data from 3 months in a large obstetric unit with approximately 5,000 deliveries a year. All cases of obstetric haemorrhage requiring blood transfusion were identified from the blood transfusion records and medical records.

Results

A total of 25 patients with obstetric haemorrhage were identified. Fifteen were MOH (9 moderate, 2 severe and 4 life threatening). Communication was lacking in the majority of cases. A consultant obstetrician was recorded as being present for 52% of cases, and a consultant anaesthetist present in 35% of cases. A consultant haematologist was informed of 2/15 (13%) cases of MOH. Timing of haemorrhage included 9 antenatal, 3 intrapartum and 13 postnatal cases. The source of bleeding was identified as uterine atony, genital tract trauma, miscarriage, placental abruption, placenta praevia, retained products of conception and ruptured ectopic pregnancy.

Conclusions/recommendations

This study identified need for timely multidisciplinary input for management of obstetric haemorrhage. Standardised protocols and early notification of the multidisciplinary team will enhance quality and safety in at risk situations.

AUDIT ON UPTAKE AND SUCCESS RATE OF OUTPATIENT MEDICAL MANAGEMENT OF FIRST TRIMESTER MISCARRIAGE IN THE ROTUNDA HOSPITAL

Abstract ID: 149

Dr. sahar ahmed (The Rotunda Hospital), Dr. Karen Flood (The Rotunda Hospital)

Spontaneous miscarriage occurs in up to 20% of clinical pregnancies. Medical management is save alternative to surgical evacuation with success rate up to 80-91%, and should be offered to women when counselling them about options of management.

The objectives of this audit are to determine the uptake and the success rate of medical treatment in EPAU in the Rotunda hospital .

Our current practice compared against national and hospital guidelines of management of first trimester miscarriage regarding :Diagnosis ,Counselling ,Misoprostol dose used (800mcg) ,Susses rate (80-90%),documentation ,compliance expected in 100% of patients.

Data collected retrospectively from (EPAU) register from August –October 2015.Primary outcome measure for successful medical management was the absence of retained products on follow up ultrasound scan.

A total of 902 women attended EPAU during this period.,149(16.5%) were diagnosed with either missed or incomplete miscarriage, 85 (57 %) opted for intervention . women elected to have medical management were 64 (43%), 55 only involved in this audit . 28 (51%) diagnosed with missed miscarriage and 27 (49%) with incomplete spontaneous miscarriage. Discussion of management option was documented in 95% (n=52), 82% (n=42) of women received single dose of Misoprostol 800 mcg and 18% needed 2nd dose (n=10). Success rate was 82 % for missed miscarriage and 90 % for incomplete miscarriages.

Conclusion: Misoprostol has high success rate for outpatient medical management of miscarriage (82% for missed miscarriage and 90% for incomplete)despite that still the uptake of surgical management is higher (57%) .

AUDIT ON THE USE OF PROPESS IN A TERTIARY REFERRAL UNIVERSITY TEACHING HOSPITAL

Abstract ID: 242

Dr. Syeda farah Nazir (CWIUH), Dr. Eimer O Malley (Coombe Women and Infants University Hospital), Dr. Sharon Sheehan (Coombe Women and Infants University Hospital)

INTRODUCTION:

International shortage of PGE2 gel led to the introduction of an alternative agent for induction of labour, Propess, a long-acting PGE2 pessary. A guideline was developed and Propess was introduced.

METHODOLOGY

A proforma was designed to assess guideline adherence with established inclusion/exclusion criteria, appropriate fetal monitoring, timing of insertion, review and removal if appropriate. In addition to this, the timings from admission to insertion and insertion to delivery were recorded and the use of additional prostaglandin was documented. The proforma was used to prospectively collect this data over the first two introductory weeks in the hospital. The findings were presented to the relevant medical and midwifery staff with further education and training and a re-audit was performed.

RESULTS:

Data on a total of 29 patients were collected initially and 100% compliance was demonstrated for adherence to many areas being monitored. This level of compliance was maintained at the time of re-audit (37 patients) with other improvements seen in other areas: compliance with appropriate timing of cardiotocograph monitoring (92.3% v 97.3%), documentation of removal time (80.8% v 100%) and timing of medical review if propess remained in situ at 24 hours (85.7% v 100%). Improvement was also achieved in timing from admission to insertion of propess in response to changing practices after the initial results (4.8 hours +/-4.5 SD to 1.6 hours +/- 0.9 SD).

Conclusion:

Targeted retraining and education resulted in improved compliance with appropriate practices for propess induction and was also associated with improvement in efficiency in the induction process.

BARRIERS TO ROUTINE ANOMALY SCANNING IN AN IRISH MATERNITY UNIT

Abstract ID: 230

Dr. Ciara Carroll (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda), Dr. Vineta Ciprike (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda)

National guidelines recommend routine anomaly scanning in all pregnancies. Only selected women attending Our Lady of Lourdes Hospital Drogheda (OLOLH) for antenatal care have an anomaly scan. There are no guidelines as to which patients should be offered anomaly scanning. Heavy fetal assessment unit (FAU) workload is a barrier to universal anomaly scanning.

This study had two goals, to get a detailed breakdown of unit activity and to determine which women are offered anomaly scanning.

This was a retrospective analysis of ultrasounds performed in the FAU in OLOLH in August 2016. Patient information was found from medical records and the Maternity Live database.

1003 scans were performed. Booking scans, growth scans and biophysical profiles accounted for the bulk of workload at 26.42%, 24.82% and 18.74% respectively. Of note, 70 scans (6.98%) had no indication recorded and 34 scans (3.3%) were done at inappropriate gestational age. 63 (6.28%) anomaly scans were performed. Less than a quarter of women (23.77%) had an anomaly scan. Indications included maternal age, BMI, exposure to teratogens, family history of congenital anomaly, abnormality on booking scan and maternal comorbidity. 17 (26.98%) anomaly scans were performed with no clear indication. Fetal anomaly was present on four (6.35%) scans.

No guidelines exist in OLOLH regarding fetal assessment or anomaly scanning. Consequently, ultrasounds are performed without indication while anomaly scanning is not provided to over 75% of women. By introducing guidelines unnecessary scans could be avoided, potentially enabling the unit to perform universal anomaly scanning at current staff levels.

Bilateral fetal ventriculomegaly with agenesis of Corpus Callosum

Abstract ID: 55

Dr. Sara Ahmed (UNIVERSITY HOSPITAL KERRY), Dr. Richard Horgan (UNIVERSITY HOSPITAL KERRY), Dr. Camelia Popescu (UNIVERSITY HOSPITAL KERRY)

The brain system comprises of four ventricles: lateral ventricles right and left (one for each hemisphere, third ventricle and fourth ventricle, embryologically derived from the neural canal). Corpus callosum is a bundle of neural fibers that connects both hemispheres and facilitates inter-hemispheric communication. Abnormal development in any of the structure has different outcomes and prognosis.

In our case, 36 yrs old Polish origin, para 1, previous SVD 16 yrs ago, known Hypothyroidism (TFTs 2.90) booked at 18 weeks with the normal booking scan. She was seen by the endocrinologist at 24 weeks and dose of Eltroxin was increased. At 31 weeks ANC visit scan finding showed, Bilateral Ventriculomegaly R 1.48 cm, Left 1.35 cm (Normal up to 1 cm) Dilated 3rd ventricle, absent corpus callosum (ACC), remainder of the anatomy unremarkable. TORCH screen and parvovirus IgM negative. Fetal MRI scan showed similar findings and ventriculomegaly may be dysgenetic or secondary to an insult rather than representing obstructive hydrocephalus. Amniocentesis was performed at 35wks verified 46 XX, no major chromosomal abnormality seen. Patient was closely monitored, no issues at 37+4 U/S showed Breech position, Lateral ventricles remained dilated Rt 1.8 cm 2.6 cm, slightly increased. Patient was delivered at 39+1 wks due to breech position. Baby 3.17 kg BW remained stable, BF and F/U in Crumlin with Neurosurgeon.

Outcomes of patients with prenatally diagnosed ACC with ventriculomegaly could be uncertain ranging from normal outcomes in some cases to mild to moderate disability and neuropsychiatric disorders.

BIOMARKERS IN ENDOMETRIOSIS, COULD miRNA OFFER A SOLUTION

Abstract ID: 193

Dr. Katie Field (T), Dr. Mark Ward (Trinity College Dublin), Dr. Hugh O Connor (Coombe Women and Infants University Hospital), Dr. Dr Feras Abu Saadah (Trinity College Dublin), Dr. Lucy Norris (Trinity College Dublin), Dr. Noreen Gleeson (Trinity College Dublin)

This study aimed to investigate miRNA as a diagnostic biomarker for women with endometriosis and the effect of surgical treatment on serum levels of miRNA.

This was a case controlled, prospective clinical study looking at women undergoing laparoscopy for diagnostic and operative indications, consisting of 54 women with endometriosis and 14 women with normal pelvises. A serum sample was taken prior to surgical intervention and also following laparoscopy.

Total RNA was extracted from serum using a commercial column-based system. The RNA spike-in kit (UniSP6/cel-miR-39) were used as internal controls. RNA eluate was reverse transcribed using the miRCURY LNA™ Universal RT cDNA Synthesis Kit. Each microRNA (miR-21, miR-103, miR-122, miR-199a, miR-223 and let-7A) was assayed using ExiLENT SYBR® Green master mix using Mx3000P qPCR system. Furthermore any sample assay data point with a Ct < 37 to did not pass the criteria for inclusion for this study.

There was no difference in the pre-operative expression of miR-21, miR-103, miR-122, miR-199a, miR-223 and miR-let-7A, only miR-103-5a showed a trend towards decreased expression.

When comparing pre-and post-treatment groups, there is an upregulation in miR-103-5a expression ($p < 0.013$) and a downregulation in the expression or miR-122 ($p < 0.0007$).

In our patient sample miR-233, miR-122 and miR-21 were the highest expressed micro RNAs and the most had the most consistent expression.

The miRNA expression profiles failed to show potential to work as predictive biomarkers for endometriosis, miR-103-5a and miR-122 may offer some benefit in the monitoring of the disease progression and treatment.

BIRTH OUTCOMES IN MEMBERS OF THE TRAVELLING COMMUNITY

Abstract ID: 65

Dr. Ailbhe Duffy (UCD Research Centre, Coombe Women and Infants University Hospital), Dr. Niamh Daly (UCD Research Centre, Coombe Women and Infants University Hospital)

The All Ireland Traveller Study found that Travellers have poorer birth outcomes than the general population. Travellers have a higher prevalence of low birthweight, Traveller infants are 3.6 times more likely to die and Traveller women have babies younger and in quicker succession.

We aimed to compare booking information and birth outcomes in members of the Travelling Community with the general population.

A random sample of 4000 was taken from an extensive obstetric database with information from 2009-2013. Analysis was retrospective using SPSS.

Travellers accounted for 1.3% of the sample (n=53). Age at booking differed between Travellers (24.3 ± 5.1) and the general population (30.2 ± 4.9); $p < 0.01$. Parity was higher in Travellers (1.6 ± 1.7) than general population (0.9 ± 1.1) $p < 0.01$. Travellers were more likely to have unplanned pregnancies $\chi^2 (2, n = 4000) = 17.70, p = < 0.05$, and book late ante-natally $\chi^2 (10, n = 4000) = 786.88, p = < 0.05$. Preconception folic acid use was lower amongst Travellers $\chi^2 (6, n = 4000) = 16.40, p = 0.012$. A difference between groups was observed for the onset of labour, $\chi^2 (6, n = 4000) = 17.58, p = 0.07$, with Travellers more likely to be induced. No differences were observed for mode of delivery, perineal outcomes or post-partum complications. NICU admissions were higher amongst Travellers $\chi^2 (2, n = 4000) = 13.65, p = 0.01$, but birthweights did not differ.

Awareness of the differences between the Travelling Community and the general population aids us in providing optimum obstetric care.

BOCHDALEK DIAPHRAGMATIC HERNIA RUPTURE IN PREGNANCY: A CASE REPORT

Abstract ID: 127

Dr. Ike Uzochukwu (Cork University Maternity Hospital), Dr. Adriana Olaru (Cork University Maternity Hospital), Dr. Karen Sheehan (Cork University Hospital), Prof. Richard Greene (Cork University Maternity Hospital), Dr. Suzanne O Sullivan (Cork University Maternity Hospital)

Diaphragmatic hernia rupture in pregnancy is a very rare event hence diagnosis is extremely difficult. This is associated with significant feto-maternal complications including a fetal mortality rate of 13% and a maternal mortality rate of 10%.

We present a case of a 36year old primigravida at 35+2weeks gestation with known history of asthma that self-referred to the emergency room with severe generalized abdominal pain radiating to the back and vomiting. Examination revealed a maternal heart rate of 130beats/min and respiratory rate of 24cycles/min. Her abdomen was soft with non-specific tenderness. Fetal bradycardia of 80beats/min was noted. An emergency caesarean section for suspected placental abruption was performed under general anaesthesia. A live male infant was delivered with no evidence of placental abruption seen.

Postoperatively, she was managed in the intensive care unit following significant pulmonary aspiration at the time of her general anaesthetic induction. Chest X-ray and CT Thorax revealed ruptured left hemi-diaphragmatic hernia with loops of small bowel in the left hemi-thorax and right mediastinal shift. She received broad-spectrum antibiotics for aspiration pneumonia and was extubated on day two postpartum. Twelve days postpartum she was discharged.

At ten weeks postpartum, elective laparoscopic diaphragmatic hernia repair was performed. This involved mesh repair of a 5x5cm posterolateral left hemi-diaphragm defect consistent with Bochdalek hernia.

Bochdalek hernia is a very rare cause of peripartum dyspnea and abdominal pain however recognition is of utmost importance as it poses significant fetomaternal risk. A high index of suspicion and multidisciplinary care cannot be overemphasised.

CAESAREAN SECTION DOCUMENTATION IN A TERTIARY LEVEL HOSPITAL; AN AUDIT

Abstract ID: 256

Dr. Emily O Connor (Cork University Maternity Hospital), Dr. Tamara Kalisse (Cork University Maternity Hospital), Prof. Richard Greene (Cork University Maternity Hospital)

National guidance on the accepted standard for surgical notes in obstetrics and gynaecology does not exist. This allows for discrepancy in the quality of surgical notes between doctors and institutions.

This audit aimed to assess the quality of surgical documentation in Cork University Maternity Hospital (CUMH). A retrospective audit of surgical notes was undertaken for inpatients in CUMH undergoing Caesarean Section (CS) from June to September 2016. Standards for documentation were identified using the NICE CG132 on CS, guidance from RCSI, and the proforma in the national maternity healthcare record. The data were stored in an Excel database and analysed using SPSS v23.

100 charts were randomly selected from inpatients in CUMH who had undergone CS. 43 separate variables for inclusion in a CS operative note were identified and set as the standard. Of the CS notes audited, 28% were documented by consultants, 38% by senior registrars, 28% by junior registrars and 7% by senior house officers. A note that had all 43 variables documented was not identified. Among the more poorly documented variables were start time (only 51% documented), time of knife to skin (30%), delivery time (6%), category (73%), and MCRN of the operator (50%). Postoperative instructions such as antibiotic therapy and DVT prophylaxis were also poorly documented (only 15% and 52% respectively).

Even with a CS proforma in each patient chart, there are inconsistencies in documentation. This could be improved by clinician training and may prove less challenging with an electronic proforma for the CS operation note.

CAN MATERNAL HEAD CIRCUMFERENCE CONTRIBUTE TO THE PRENATAL PREDICTION OF SUCCESSFUL SPONTANEOUS VAGINAL DELIVERY-RESULTS FROM THE PROSPECTIVE MULTICENTER GENESIS STUDY

Abstract ID: 86

Dr. Niamh Murphy (Obstetrics and Gynaecology, Royal College of Surgeons in Ireland, Dublin), Dr. Naomi Burke (Obstetrics & Gynaecology, Royal College of Surgeons in Ireland, Dublin), Dr. Gerard Burke (Obstetrics & Gynaecology, Graduate Entry Medical School, University of Limerick, Limerick), Prof. Fionnuala Breathnach (Obstetrics & Gynaecology, Royal College of Surgeons in Ireland, Dublin), Prof. Fionnuala M McAuliffe (Obstetrics & Gynaecology, UCD School of Medicine and Medical Science, National Maternity Hospital, Dublin), Prof. John Morrison (Obstetrics & Gynaecology, National University of Ireland, Galway), Prof. Michael Turner (UCD Centre for Human Reproduction, Coombe Women and Infants University Hospital, Dublin), Dr. Samina Dornan (Obstetrics & Gynaecology, Royal Jubilee Maternity Hospital, Belfast), Prof. John Higgins (Obstetrics & Gynaecology, University College Cork, Cork University Maternity Hospital, Cork), Prof. Amanda Cotter (Obstetrics & Gynaecology, Graduate Entry Medical School, University of Limerick, Limerick), Dr. Michael Geary (Obstetrics & Gynaecology, Rotunda Hospital, Dublin), Ms. Fiona Cody (Obstetrics and Gynaecology, Rotunda Hospital, Dublin), Dr. Peter McParland (Obstetrics and Gynaecology, National Maternity Hospital, Dublin), Ms. Cecilia Mulcahy (Obstetrics and Gynaecology, National Maternity Hospital, Dublin), Prof. Sean Daly (Obstetrics and Gynaecology, Coombe Women and Infants University Hospital, Dublin), Dr. Patrick Dicker (Epidemiology and Public Health, Royal College of Surgeons in Ireland, Dublin), Dr. Elizabeth Tully (Obstetrics and Gynaecology, Royal College of Surgeons in Ireland, Dublin), Prof. Fergal Malone (Obstetrics and Gynaecology, Royal College of Surgeons in Ireland, Dublin)

Our group previously showed an association between fetal head circumference >90th centile and an increased risk of caesarean section.

Our objective was to ascertain if there is an association between maternal head circumference (MHC) and spontaneous vaginal delivery (SVD), operative vaginal delivery (OVD), or adverse perinatal outcome.

GENESIS was a prospective, blinded observational study carried out by Perinatal Ireland from October 2012 to June 2015. 2,336 nulliparous uncomplicated women with singleton pregnancies were recruited. Logistic regression was used to determine the risks of OVD and adverse perinatal outcome with increasing MHC. Linear and non-linear models for risk were explored.

1,845 pregnancies which resulted in either an OVD (n=864) or an SVD (n=981) were compared. Mean MHC was 56.2cm (SD=1.8cm, range=50cm-65.5cm). There were 551 vacuum deliveries (59%), 248 forceps deliveries (29%) and 105 combined OVDs (12%). There was a linear increase in risk for OVD, OR=1.08 (95% CI=1.02-1.13, p=0.004) for every 1 cm increase in MHC. This change in risk may be illustrated with categorizations of MHC: Those with a MHC < 54.4cm (Quartile 1) had a 42% risk compared to a 52% risk in those with MHC > 57.5cm (Quartile 3) p=.004. There were no statistically significant differences in birth injury (p=0.525), 3rd/4th degree tears (p=0.525), shoulder dystocia (p=0.392) or five minute Apgar <7 (p=0.729).

This study shows an association between increasing MHC and increased rates of OVD, with no increase in adverse perinatal outcomes. We therefore suggest considering the inclusion of MHC in routine antenatal assess-

ment. This may aid clinical decision-making

CEREBRAL VENOUS SINUS THROMBOSIS IN THE POSTPARTUM PERIOD: A COMPARISON OF TWO CASES

Abstract ID: 252

Dr. Aisling Heverin (Midland Regional Hospital, Portlaoise), Dr. Ciara McCormick (Midland Regional Hospital, Portlaoise), Dr. Miriam Doyle (Midland Regional Hospital, Portlaoise), Dr. Nagabathula Ramesh (Midland Regional Hospital, Portlaoise)

Headaches are a common postpartum presentation[1]. Pregnant women are at higher risk of atypical causes of headaches such as cerebral venous sinus thrombosis (CVST)[2] due to the hypercoagulable state associated with pregnancy and the puerperium[3]. A high index of suspicion should be balanced against the risks associated with overtreatment as demonstrated by the following case reports.

We present two cases of women presenting with postpartum headaches. Firstly, a 33 year old primigravida with multiple risk factors for thromboembolism. She re-presented 3 weeks postpartum with a left sided headache and seizure activity. Diagnosis of venous sinus thrombosis was made by contrast CT. Treatment involved anticoagulation and antiepileptic medication.

Our second case was a 36 year old primiparous patient who had a normal vaginal delivery at term+10 with epidural anaesthesia. Day 1 postpartum she developed a headache which persisted. On day 5 a CT brain demonstrated a non-occlusive thrombus in the right transverse venous sinus. She was commenced on therapeutic tinzaparin. On day 13 she experienced a PPH of 1950mls requiring return to theatre, Bakri balloon insertion and admission to HDU. Multidisciplinary team discussions, including review of imaging by tertiary centre neuroradiology, lead to a revised diagnosis of arachnoid granulation and anticoagulation was discontinued on discharge.

As parturients are at increased risk of unusual pathologies such as CVST these serious conditions should always be considered. In such cases multidisciplinary management is desirable. However the balance between haemorrhage and thrombosis is challenging and the perils of therapeutic anticoagulation should not be overlooked.

CERVICAL CANCER IN PREGNANCY

Abstract ID: 163

Dr. Mei Yee Ng (University College Hospital Galway), Dr. Elzahra Ibrahim (University College Hospital Galway), Ms. Joanne Higgins (University College Hospital Galway), Dr. Michael O Leary (University College Hospital Galway)

Cervical cancer is the most common cancer in pregnancy. However, its occurrence is rare: 1 per 1200 to 10,000 pregnancies. We report a rare case of a 37 years old woman who was diagnosed with cervical cancer in the second trimester of her second pregnancy. She had first presented with post-coital bleeding at her local maternity unit in Castlebar and a cervical polyp biopsy was suspicious of invasive tumor. She was then referred to University College Hospital Galway Gynaecology Oncology unit for further management which resulted in a radical Caesarean hysterectomy with pelvic lymph node dissection and left oophorectomy to ASIS. This is a case report that details the difficult management of cancer diagnosed in pregnancy and highlights the importance of basic skills such as history taking and speculum examination.

Cervical cancer relapse rates in patients with para-aortic negative PET scans: A retrospective five-year analysis in an Irish Gynaecology centre

Abstract ID: 63

Dr. Ann Rowan (The Mater Misericordiae University Hospital), Dr. Tom Walsh (Mater), Mr. Ruaidhrí McVey (The Mater Misericordiae University Hospital), Mr. William Boyd (The Mater Misericordiae University Hospital), Prof. Donal Brennan (Mater)

International studies have shown that micro-metastasis to the para-aortic nodes (PA nodes) in PET negative reported scans occur in 10% of cases of cervical cancer when PA nodal dissection is undertaken. Our aim was to review the rate of relapse in our patients with PA node-negative disease at diagnosis, as defined on PET imaging.

Data contained in our gynaecology cancer registry was combined with hospital records. All cervical cancers over a period August 2011-July 2016 were selected for analysis. Data on patients staged \geq 1B2 to Stage 4A was collected.

Of the 105 patients in the registrar, 98 had a reported PET scan. Twenty-one (21.4%) adenocarcinoma, 76 (77.6%) SCC, 1 (1%) other. Seventy-two percent (n=71) of patients were PA node-negative. Twenty seven percent (n=19) of PA node-negative patients relapsed compared to 15% (n=4) of PA node-positive. Of PA node-negative patients, 37% (n=26) had pelvic nodes positive on PET scan at diagnosis. Ninety six percent (n=25) received pelvic chemoradiation with 44% (n=11) receiving extended field radiation treatment. Forty-four patients had no evidence of pelvic or para-aortic nodal disease on their PET scan. All these patients received pelvic chemoradiation, but 25% recurred.

Although PET imaging is the standard for assessment of gross metastatic disease, overall 27% of PA node-negative patients experienced a subsequent relapse. We advise these patients should undergo formal nodal dissection as part of their staging. Furthermore, the 25% recurrence rate in patients with node-negative disease, suggest that a sentinel node biopsy may be warranted in these patients also.

CERVICAL TEARS AT CAESAREAN SECTION - A RISK FACTOR FOR OBSTETRIC HAEMORRHAGE

Abstract ID: 171

Dr. Ciara Nolan (Rotunda Hospital), Dr. Meena Ramphul (Rotunda Hospital), Dr. Jennifer Donnelly (Rotunda Hospital)

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Rotunda Hospital, Dublin

Cervical tears are a rare but serious risk factor for massive obstetric haemorrhage and relaparotomy after Caesarean section (CS). Relaparotomy complicates 1% of CS and is associated with a high maternal mortality and peripartum hysterectomy. Haemorrhagic complications such as atony or placenta praevia are the main indications for reintervention and are well described in the literature. However little is known of the incidence or etiology of cervical tears.

Case

A 31-year old, primigravid woman underwent emergency CS in 2nd stage of labour (6cm dilated). The procedure was uncomplicated, estimated blood loss (EBL) 400mls, liveborn infant delivered. However, in recovery heavy vaginal bleeding was noted despite well-contracted uterus and prophylactic 40 IU oxytocin infusion. There was further EBL 1500mls. After failure to control the bleeding with bimanual compression, misoprostol and haemobate, the patient was transferred back to theatre for examination under anaesthesia (EUA) and relaparotomy. A large 6cm defect was identified internally on right lateral cervix at EUA. The uterus was reopened and the cervical defect repaired with interrupted absorbable stitches. A total EBL 10 litres was calculated, requiring massive blood transfusion. Intrauterine balloon tamponade was utilised for 24 hours post-procedure, and the patient was discharged home well on day 5.

Conclusion

Cervical tears account for 5% of cases of relaparotomy after CS and 16% of peripartum hysterectomy. Careful consideration is needed for the indication and frequency of vaginal exams performed during labour in order to avoid inadvertent trauma to the cervix.

CIGARETTE SMOKING DURING PREGNANCY AND PREGNANCY OUTCOMES

Abstract ID: 151

Dr. Fionan Donohoe (Coombe Women and Infants University Hospital), Dr. Niamh Daly (UCD Research Centre, Coombe Women and Infants University Hospital), Ms. Ciara Reynolds (Coombe Women and Infants University Hospital), Dr. Aoife McKeating (Coombe Women and Infants University Hospital), Dr. Maria Farren (Coombe Women and Infants University Hospital), Prof. Michael Turner (Coombe Women and Infants University Hospital)

Background

The effects of maternal cigarette smoking on pregnancy outcome in terms of birth-weight, prematurity, stillbirth and neonatal death are widely reported.

Purpose of Study

To determine if smoking has an impact on onset of labour, mode of delivery and rates of caesarean section. We also examined smoking trends and neonatal outcomes.

Study Design and Methods

We collected data and delivery outcome information for all deliveries in the Coombe from 2009 to 2013. Details regarding cigarette consumption were collected during the booking history by midwives. Statistical analysis was performed using SPSS.

Findings

During the study period, smoking rates fell from 16.6% to 12.6%($p<0.001$). However, rates of moderate and heavy smoking (10 or more cigarettes/day) during the same period increased from 3.9% to 6.9%.($p<0.001$)

Smokers were less likely to undergo induction of labour than non-smokers 1959/6274(31.2%)vs.11957/36088(33.1%)[OR 0.9,CI0.86-0.97, $p=0.003$], and less likely to have an elective caesarean delivery 559/6274(8.9%)vs.4727/36088(13.1%)[OR0.6, $p<0.0001$]. Rates of emergency caesarean delivery prior to labour were similar (199/6274(3.4%)vs.1236/36088(3.2%)[OR 0.9,95%CI0.8-1.1, $p=0.3$].

Smokers were more likely to achieve a spontaneous vaginal delivery (4096/5515(74.3%)vs.20187/30122(67.02%)[OR1.4,95%CI1.3-1.5, $p<0.0001$] than non-smokers. They were also less likely to have a caesarean delivery in labour 621/5515(11.3%)vs.3821/30122(12.7%)[OR 0.9,95%CI0.8-0.96, $p=0.003$] and less likely to undergo operative vaginal delivery (724/5515(13.1%)vs.5555/30122(18.4%)[OR 0.66,95%CI0.6-0.7, $p<0.0001$].

Smokers delivered smaller babies (mean birthweight 3192g(+/-609g)vs.3450g(+/-589g)($p<0.0001$) and were more likely to deliver preterm than those who were not smokers (487/6265(7.8%)vs.1849/36038(5.1%)[OR 1.56, $p<0.0001$].

Conclusions

Smoking in pregnancy has decreased over time. However, given the increase in numbers of women reporting heavy smoking, the risk of preterm delivery and lower birthweight has not been reduced.

CLINICAL AUDIT OF SAMPLE MISLABELLING

Abstract ID: 175

Dr. Syeda farah Nazir (CWIUH), Dr. Marwa Mohamed (Coomb), Dr. Sharon Sheehan (Coombe Women and Infants University Hospital)

INTRODUCTION:

Correct sample labelling is essential in ensuring patient safety. Any error during sample labelling has the potential to result in serious, life-threatening complications. In addition, inappropriate or inaccurate treatment may result or indeed unnecessary treatment. Earlier this year, on-going audit in one clinical area revealed increased compliance with the standards following staff and patient education using poster displays.

AIM AND OBJECTIVE:

The aim of our audit was to identify patient-reported compliance with the standards for sample labelling in another clinical setting (the Emergency Department) using the staff and patient education poster displays which had previously been validated.

METHODOLOGY:

Posters highlighting the standards used for correct sample labelling were displayed in staff and patient areas within the Emergency Department. A questionnaire was developed for patients asking if each standard had been followed. Any sample labelling errors identified in the laboratory were also recorded.

RESULTS:

A total of 50 patients were surveyed. All reported full compliance with the standards for correct sample labelling. During this period, there were no mislabelled samples reported in the laboratory.

Conclusion:

All patients reported full compliance with the standards for corrected sample labelling. The poster displays which were shown to improve patient compliance in the previous audit have likely contributed to this, in addition to increased staff awareness in general in the hospital as the project is rolled out from one clinical area to another. Full compliance reduces risk and improves patient safety. A re-audit is planned to ensure that the improvements are embedded

CLINICAL AUDIT ON THE TIME INTERVAL FOLLOWING PRE-LABOUR RUPTURE OF MEMBRANES/SPONTANEOUS RUPTURE OF MEMBRANES WITH PROPESS, TO COMMENCEMENT OF OXYTOCIN.

Abstract ID: 191

Dr. Daire Nevin Maguire (Coombe Women and Infants University Hospital), Dr. Laurentina Schaler (Coombe Women and Infants University Hospital), Dr. Aoife Mullally (Coombe Women and Infants University Hospital), Dr. Naomi Burke (Obstetrics & Gynaecology, Royal College of Surgeons in Ireland, Dublin)

We present an audit carried out at the Coombe Women and Infants University Hospital in order to analyse if the time standards following pre-labour rupture of membranes (PROM) / spontaneous rupture of membranes (SROM) with Propess were being met in accordance with the hospital guideline for induction of Labour.

We retrospectively analysed all women induced for PROM and all women induced with Propess with SROM during the month of January 2016. A re-audit was carried out for the month of September 2016 following staff education.

In total, 30 women were included in the audit. 26 were induced with oxytocin alone for PROM with 4 induced with Propess for other indications and SROM occurring. A total of 23 (77%) women were induced with a time interval greater than the recommended 24 hours outlined in the hospital guideline. Maternal pyrexia occurred in 2 patients, both of whom had a PROM for over 35 hours. There were no incidences of infectious morbidity in the neonates.

In conclusion, the main finding of this audit is that the target of 24 hours after PROM to induction of labour, as set out in the hospital guidelines, is not being met. We recommend a review of the hospital guidelines considering whether the hospital should offer immediate induction of labour or expectant management for this cohort of patients.

CLINICIANS AND PATIENTS ACCEPTANCE OF A STUDY TO VALIDATE A RISK EVALUATION TOOL FOR MODE OF DELIVERY

Abstract ID: 88

Dr. Niamh Murphy (Obstetrics & Gynaecology, Royal College of Surgeons in Ireland, Dublin), Ms. Fiona Cody (Obstetrics and Gynaecology, Rotunda Hospital, Dublin), Ms. Lisa Mc Sweeney (Obstetrics & Gynaecology, Royal College of Surgeons in Ireland, Dublin), Dr. Naomi Burke (Obstetrics & Gynaecology, Royal College of Surgeons in Ireland, Dublin), Mr. Colin Kirkham (Obstetrics and Gynaecology, Rotunda Hospital, Dublin), Dr. Elizabeth Tully (Obstetrics and Gynaecology, Royal College of Surgeons in Ireland, Dublin), Prof. Fergal Malone (Obstetrics and Gynaecology, Royal College of Surgeons in Ireland, Dublin), Prof. Fionnuala Breathnach (Obstetrics & Gynaecology, Royal College of Surgeons in Ireland, Dublin)

The GENESIS study was used to develop a risk evaluation tool for Caesarean Delivery (CD). This multi-center, prospective, blinded study produced a model with the 5 most influential risk factors for CD in 2,336 women.

We sought to clarify if stakeholders would participate in a follow up validation study

An anonymous questionnaire was completed by clinicians and healthy, nulliparous women to ascertain participation in a study outlining the risk of CD and voluntary randomisation to trial of labour (TOL) or CD

43 women participated. 65%(n=28) would welcome the information revealed in order to inform birth choices. 72%(n=31) were more likely to request an elective CD if their risk of an emergency CD was >60%. Overall, 70%(n=30) would willingly be randomised to either CD or TOL if they had >50% risk of a CD during labour. 37 clinicians participated. If presented with a patient in clinic that had a study-generated risk >50% of requiring an emergency CD, 0% of midwives would welcome randomisation to planned CD compared with 12.5%(n=2) of registrars and 67%(n=6) of consultants (p-value .006). If a patient had an intrapartum risk of CD >50%, 5.6%(n=1) of midwives would probably consider a CD which compares with 40% of registrars(n=4) and 56%(n=5) of consultants (p-value .048)

Patients and clinicians would be willing to receive a calculated risk, however medical staff were more supportive of randomisation to CD or TOL than midwifery staff. A follow up study to validate a risk evaluation tool for mode of delivery would be worthwhile

COLPOSCOPY CLINIC NON-ATTENDANCE AT TALLAGHT HOSPITAL

Abstract ID: 48

Dr. Ailbhe Duffy (Gynaecology Department, Tallaght Hospital, Dublin 24)

National data from the Cervical Check 2012-2013 report revealed that non-attendance rates at colposcopy clinics stand at 11.8%.

The aims of this audit were to identify the factors influencing 'did not attends' (DNAs) and to establish the non-attendance rates at Tallaght Hospital colposcopy clinics.

This retrospective study randomly selected 100 patients from a total of 1238 DNA episodes between July 2014 and June 2015. Data was collected by means of short phone interviews and analysed using excel.

The mean age was 37.8 years. DNAs were higher amongst the follow-up cohort. Non-attendance was more common in morning clinics with people most likely to DNA before 10.30 (n=38). In the afternoon, DNAs were most common between 12.30 and 14.30 (n=26). The month of June had the greatest number of DNAs (n=12). The reason mostly commonly cited for non-attendance was the patient being unaware of the appointment (n=30). Illness (n=11) and childcare (n=7) were also common explanations for DNAs. The overall non-attendance rate was 16%, higher than the national figures.

To improve rates of attendance at colposcopy clinics, it is recommended that: morning clinics commence at 10am and afternoon clinics at 14.30pm to facilitate the school run and minimise DNAs due to traffic; phone calls are made to patients who DNA more than once to establish the correct address; a hospital crèche is developed to enable outpatients to attend appointments without childcare concerns; communication with the follow-up group is improved as this cohort are more likely to DNA.

Comparison of Cold Coagulation and LLETZ for the treatment of CIN II in our Colposcopy Unit

Abstract ID: 254

Dr. Tara Rigney (National Maternity Hospital), Dr. Venita Broderick (National Maternity Hospital)

Cold coagulation is an ablative method for treatment of cervical intraepithelial neoplasia (CIN). It has been largely superseded by Large Loop Excision of the Transformation Zone (LLETZ). LLETZ may have adverse obstetric outcomes such as pre term labour and mid trimester loss. Cold coagulation is easily performed in the outpatient setting, requiring minimal or no analgesia, with minimal complications.

The aim was to compare the effectiveness of cold coagulation with LLETZ for the treatment of CIN2.

We looked at all patients who had cold coagulation for the treatment of CIN2 over 6 months. We compared post treatment outcomes with a similar number of patients who underwent LLETZ for CIN2.

The number in our study was 70 - 35 had cold coagulation and 35 had LLETZ treatment. All patients had biopsy proven CIN2.

The referral smears of the cold coagulation group included LSIL 54%(19), ASCUS 29%(10), HSIL 14%(5), ASC-H 3%(1).

The referral smears of the LLETZ group included - LSIL 57%(20), ASCUS 23%(8), HSIL 14%(5), ASC-H 6%(2).

The 6 month follow up smear in the cold coagulation group included - Normal 80%(28), LSIL 8%(3), ASCUS 6%(2), Inadequate 6%(2). 26%(9) tested positive for HPV.

The 6 month follow up smear in the LLETZ group included - Normal 80%(28), ASCUS 12%(4), LSIL 8%(3). 29%(10) tested positive for HPV.

Cold coagulation for treatment of CIN2 performs favourably when compared to LLETZ. There were no adverse outcomes amongst those who had cold coagulation. Cold coagulation is a good treatment option for CIN2 in suitable patients.

COMPLEX PELVIC INFLAMMATORY DISEASE: A RARE ORGANISM

Abstract ID: 199

Dr. Jennifer Stokes (Gynaecology Department, Tallaght Hospital, Dublin 24), Dr. Daniel Galvin (Gynaecology Department, Tallaght Hospital, Dublin 24), Dr. Aoife McSweeney (Gynaecology Department, Tallaght Hospital, Dublin 24), Dr. Cliona Murphy (Gynaecology Department, Tallaght Hospital, Dublin 24)

Pelvic Inflammatory disease (PID) is an infection of the upper female genital tract usually caused by an ascending sexually transmitted infection. Typical organisms included Chlamydia Trachomatis and Neisseria Gonorrhoea accounting for 25% of PID infections. Fusobacterium Necrophorum is a rare organism typically associated with Lemierre's syndrome (Septic thrombophlebitis of the internal jugular vein). It has been extremely rarely described as the causative organism for PID however it is a common organism present in the alimentary canal. We present a case of severe PID caused by Fusobacterium Necrophorum requiring multidisciplinary input. A 29-year-old (Gravidity 2, Parity 2) presented to the emergency room with severe lower abdominal pain, fever and tachycardia. She had undergone a LLETZ and removal of Mirena two weeks prior to presentation. Transvaginal ultrasound showed a 7.7x10.5x8.5cm tubo-ovarian abscess. Empiric antibiotic therapy for PID was initiated. Anaerobic blood cultures were positive for Fusobacterium Necrophorum. The patient continued to spike fevers over the course of 7 days despite escalation of antimicrobial therapy. CT scan on day 7 of admission showed the persistence of a 7.2cm pelvic mass. On discussion with interventional radiology the abscess was drained using a trans-gluteal approach. CT on day 3 post drainage showed complete resolution of the abscess and the drain was removed. The patient was discharged on day 4 post drainage and remained well on review 4 weeks later. This case demonstrated a rare complication of LLETZ, with an unusual organism. Interventional radiology provided a safer alternative to surgical management of persistent large tubo-ovarian abscesses.

COMPLIANCE WITH THE INTRODUCTION OF ROUTINE ANTENATAL ANTI-D PROPHYLAXIS AT UNIVERSITY HOSPITAL GALWAY

Abstract ID: 213

Dr. Siobhan Quirke (University), Dr. Mark Dempsey (University College Hospital Galway), Dr. Katherine Astbury (University College Hospital Galway), Prof. John Morrison (Perinatal Ireland, Royal College of Surgeons in Ireland, Rotunda Hospital)

Our study aimed to discover rates of compliance with routine antenatal anti-D prophylaxis (RAADP) at 28 weeks gestation following its introduction to routine practice at University Hospital Galway.

Background: Prior to the development of anti-D immunoglobulin the incidence of Rh D alloimmunization was 16% in rhesus negative women. With the introduction of post-partum administration of anti-D, this rate fell to 1-2%. A further reduction in the sensitization rate to 0.1-0.3% was achieved with routine antenatal prophylaxis during the third trimester.

Methods: Our study was designed to review patients who were Rhesus negative at booking and review whether they received RAADP. We reviewed each patient who booked at an antenatal clinic in February & March 2016, RAADP was introduced as a routine antenatal intervention in January 2016. We reviewed the laboratory references to see who received RAADP and reviewed the charts of those who did not.

Results: A total of 601 women booked antenatally in February and March. 12.8% of these were Rhesus negative. Of the total number of rhesus negative women, 14.28% experienced early pregnancy miscarriage or failed to carry the pregnancy to completion. Of the remaining 66 women, 10 (15%) did not receive prophylactic anti-D in accordance with the guideline. 5/10 refused despite strong clinical reasoning, 1/10 was to receive a bilateral salpingectomy and did not need RAADP. 1/10 husband rhesus negative. Reasoning was unclear in the case of three patients.

Conclusion: In the two months following introduction of RAADP, compliance rates of 85% were achieved.

Computed Tomographic Pulmonary Angiogram (CTPA) in Pregnancy and the Puerperium– A Five-Year Retrospective Review

Abstract ID: 146

Dr. Fiona O Toole (University College Hospital Galway), Dr. Kate O Doherty (University College Hospital Galway), Prof. John Morrison (University College Hospital Galway)

Objective testing is frequently needed to definitively exclude, or confirm, the diagnosis of pulmonary embolism in pregnancy and the puerperium as the presenting symptoms and signs are common, variable and unreliable. A five-year retrospective review was undertaken of all computed tomographic pulmonary angiograms (CTPA) performed on obstetric patients at Galway University Hospital between 2011 and 2016. The purpose of this study was to examine the use of CTPA in these patients and the positive yield. Formal reports of each CTPA were reviewed via the hospital's electronic record. Data including age, presenting symptoms/signs, pre/post-natal status, and results were collected. The proportion of suboptimal images was noted as was the incidence of other relevant pathology detected by scan.

A total of 149 CTPA scans were performed. 84 of these were on antenatal patients; 65 on postpartum patients. Only 4 of the CTPAs performed antenatally were positive whereas 9 were positive in the postnatal group. The total positive yield was 8.7% (13). For each positive result there were 10 negative CTPAs performed. A total of 32 of scans were reported as suboptimal images. Subsegmental emboli could not be fully excluded in this group and further imaging was required in cases on on-going clinical suspicion. 16% of scans reported other relevant pathological findings.

There are currently minimal published data on this topic. CTPA exposes maternal breast tissue to radiation that can increase women's lifetime risk of breast cancer. This study highlights the dilemma of clinical management in pregnant and postnatal women with chest symptoms.

Correlation of DNA fragmentation to semen analysis parameters

Abstract ID: 279

Dr. Katie Beauchamp (MMUH), Dr. Andrew Downey (St Lukes Kilkenny), Prof. Ray O Sullivan (St Lukes Kilkenny)

Infertility is the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected intercourse. 15% of couples are infertile and up to 50% is due to male factors.

Initial investigation involves semen analysis. More recently DNA fragmentation (DF) testing is being performed. Studies have shown that 80% of couples diagnosed with idiopathic infertility have sperm DNA damage (>25% damage per sperm).

Our study aimed to compare routine semen analysis parameters and DF and to identify if DF is a surrogate marker for these parameters.

We used an online database at an infertility clinic and through this we identified the most recent 52 patients who had undergone investigation. All men had semen analysis and DF performed.

Patients ranged between 28-62 years of age with the average being 40 years. We studied and compared their semen analysis and DF levels.

The graph highlights the correlation between low progressive motility and high DF. This correlation and others will be discussed.

Male investigations are safe and noninvasive. DF identifies abnormalities in patients with “normal” semen analysis. Men with abnormal semen analysis are more likely to have abnormal DF and hence DF should be done routinely with semen analysis as this is known to assist with the guidance of couples with respect to fertility treatments.

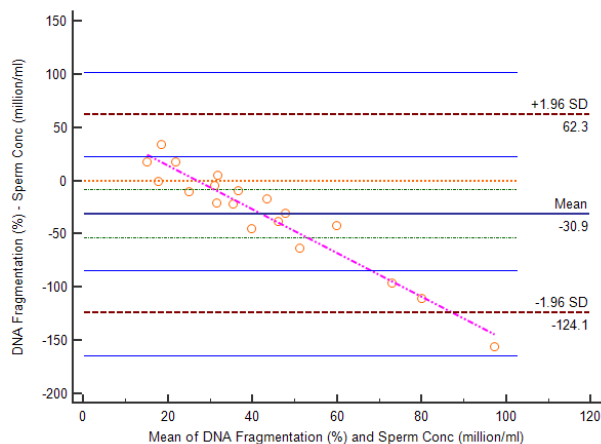


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COST REDUCTION BY SUBSTITUTING MEDIUM WITH SALINE SOLUTION USED FOR FOLLICULAR FLUSHING DURING EGG RETRIEVAL IN ASSISTED REPRODUCTIVE TECHNOLOGIES.

Abstract ID: 168

Dr. Dmitry Loktionov (Department of obstetrics, Galway University Hospital (GUH)), Dr. Dayo Oduola (Department of obstetrics, Galway University Hospital (GUH)), Dr. Dr Nikhil Pundarare (Department of obstetrics, Galway University Hospital (GUH)), Ms. Jenny Cloherty (Galway Fertility Clinic), Ms. Sharon Warner (Galway Fertility Clinic)

There are no studies comparing saline solution to the medium solution available in the literature. Existing ones compare flushing versus no flushing methods and their outcomes. This study is the first one to make such comparison. We were interested in outcomes of two solutions commonly used for follicular flushing during oocyte retrieval in Assisted Reproductive Technologies (ART). We retrospectively collected data at the Galway Fertility Clinic (GFC), Ireland from January 2015 to August 2016. Data was classified into two groups: patients who underwent follicular flushing with normal saline or medium solution. The primary outcomes looked at are: fertilization rate, oocyte yield rate, embryo utilization rate, biochemical pregnancy rate, and procedure cost. In total we observed 422 egg collection procedures, where medium was used as a flush, and 277, where saline solution was used. There was no statistically significant difference in fertilization rates between medium and saline groups, 58.7% and 57.8% respectively ($p=0.65$). There was no significant difference between mean positive biochemical pregnancy tests, 172 in medium group and 102 in saline ($p=0.73$). Total cost for the medium solution was €25,668 per year. Total cost for saline solution was €415.5 per 8 months. Switching from culture medium to saline solution for follicular flushing allows significant reduction in cost for the unit without adversely affecting outcomes of Assisted Reproductive Technologies.

Cytogenetic testing by PCR and Multiplex Ligation-Dependent Probe Amplification (MLPA) in the investigation of pregnancy loss

Abstract ID: 136

Dr. Manal Younis (Cork University Maternity Hospital), Dr. Keelin O'Donoghue (Cork University Maternity Hospital)

Manal Younis, Keelin O'Donoghue
Cork University Maternity Hospital

Cytogenetic evaluation of products of conception (POC) for chromosomal abnormalities can determine the cause of pregnancy loss and establish risks for future pregnancies. Traditionally, cytogenetic investigation was performed by karyotyping after culture of chorionic villi. Testing by PCR and MLPA has higher success rates and faster reporting times than karyotyping.

We aimed to review our numbers of samples, indications, failure rates, laboratory reporting times, and cytogenetic results.

All samples sent for PCR/MLPA testing from 2013 to 2015 were recorded. Data were collected from laboratory reports and sample tracking books, supplemented by chart reviews.

A total of 735 samples were sent for cytogenetic analysis during the three years audited.

Of these samples, 677 were successfully processed, giving a 92% success rate. Overall, 49% of processed samples revealed abnormal cytogenetics. Further analysis of the failed samples showed that in 42/58 (72%) only maternal tissue was sent to the laboratory, in 13/58 (22%) the tissue was of insufficient quality for analysis and in only 3 cases did testing fail. The most common indications for testing were recurrent miscarriage (224/735; 30%), and second-trimester miscarriage (136/735; 18%), however some cases were incorrectly recorded and others sent for inappropriate clinical indications.

These data confirm high success rates with the PCR/MLPA technique, and we recommend its continued use as the cytogenetic investigation of choice in pregnancy loss. Local protocols for testing and documentation need to be followed and education may be needed to improve clinical sample collection and processing.

DELIVERY METHODS AMONG THOSE WITH ONE PREVIOUS SECTION IN OLOL HOSPITAL, DROGHEDA

Abstract ID: 84

Dr. Ita Shanahan (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda), Dr. Nikita Deegan (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda)

The current Irish LSCS rate is 26% and has risen in the last decade. A driving factor is the number of repeat elective LSCS. Robson group 5a refers to women with a single LSCS. Therefore, they have potential for VBAC and a reduction in LSCS rates. OLOL Drogheda advocates the use of a "pink sheet" which is completed at booking indicating review of previous obstetric notes, documented suitability and counselling for a VBAC.

A retrospective chart review was used to investigate the VBAC rate in Group 5a over September 2016. Education of women by pink sheet or other documented counselling was identified. It investigated how many women wished for a TOLAC/VBAC and their delivery outcome.

OLOL had 265 deliveries, with a 34.4% LSCS rate. Group 5a contained 28 women, of which 93% had a previous Emergency LSCS. Age range was 25-40 years (average 33.7, median 33.5). BMI range 20-50 (average 29.24, median 27). Parity range 1-5 (average 1.3). "Pink sheet" was not completed in 75% of cases. 86% had some form of documented counselling for VBAC/TOLAC. 36% (n=10) of these women opted for VBAC/TOLAC. 90% (n=9) presented in SOL. Of those who laboured, 60% (n=6) resulted in a Vaginal Delivery.

OLOH has a successful VBAC rate of 60%, lower than the 72-75% rate quoted by RCOG. It highlights the importance of appropriate debriefing following the first LSCS and individualised, neutral, evidence-based counselling in subsequent pregnancies. A plan should be discussed for those who present in SOL before an elective section date.

DEPRESSION SCORES FOLLOWING FIRST TRIMESTER MISCARRIAGE MANAGEMENT

Abstract ID: 270

Dr. Somaia Elsayed (Early Pregnancy Assessment Unit, Coombe Women & Infant's Hospital, Dublin), Dr. Amaliya Morgan-brown (Department of Obstetrics, The Coombe Women & Infant's Hospital, Dublin), Ms. Janis Gowran (Early Pregnancy Assessment Unit, Coombe Women & Infant's Hospital, Dublin), Dr. Nadine Farah (Early Pregnancy Assessment Unit, Coombe Women & Infant's Hospital, Dublin), Dr. Mary Anglim (Coombe Women and Infants University Hospital), Prof. Michael Turner (UCD Centre for Human Reproduction, Coombe Women and Infants University Hospital, Dublin)

Miscarriage is a common complication in early pregnancy with a significant emotional burden. The psychological distress following a miscarriage can last for weeks following the diagnosis.

The aim of this study was to evaluate the psychological distress of women undergoing miscarriage management. Women were recruited prospectively following the diagnosis of first-trimester miscarriage between October-2015 and August-2016. Six to eight weeks post recruitment, an online survey including the Edinburgh Postnatal Depression score (EPDS) was emailed to the women.

A total of 172 women were recruited with a response rate of 84%. The average age of the recruited women was 34 years, with 38% being nulliparous. The majority were Caucasians (91%), employed (83%) and in a relationship (91%). Just over half of the women opted for surgical management (54%); while 33% opted for medical management and 12% opted for conservative management.

The Average EPDS was 11.18 [Median=11; Range (0-28)]. Women who opted for medical management had higher scores in comparison to conservative ($p=0.01$) and surgical ($p=0.07$) managements. There was no statistically significant association between EPDS and the outcome of management. There was an association between the time taken off-work and the EPDS ($p<0.01$). Women taking 0-7 days off-work had lower scores compared to women taking over 14-days off ($p=0.01$).

Women going through a miscarriage can have depressive symptoms for up to 8-weeks following their diagnosis. Depression scores appear to be associated with the type of management chosen. Women with higher EPDS were more likely to take more time off work.

Diagnosing and Managing a cornual ectopic pregnancy : a comparison of two cases

Abstract ID: 40

Dr. Martina Schembri (Midland Regional Hospital, Portlaoise), Dr. Tejas Naidu (Midland Regional Hospital, Portlaoise)

The incidence of an ectopic pregnancy is 1% with 2-4% being cornual - meaning that implantation has occurred at the proximal end of the fallopian tube. These cases are very rare and pose great difficulty in both diagnosis and management.

We describe two cases of cornual ectopic that occurred in our hospital over a three month period. The cases are compared to show the different presentations but more so the different methods of management.

We carried out a retrospective review of the two cases and looked at the presentation, diagnosis and management of the two. A literature review regarding the management of cornual ectopic was also carried out.

A 32 year old lady was admitted with painless bleeding at 9 weeks amenorrhoea. On ultrasound a mass was seen in left cornual region and BHCG levels at 33,027. She went on to have a cornual wedge resection and normalising BHCG.

A 36 year old lady was seen with painless bleeding at 8 weeks amenorrhoea and found to have a pregnancy of unknown location and BHCG of 7024. She went on to have a diagnostic laparoscopy and once a cornual ectopic was diagnosed, she was managed with methotrexate injection.

The decision of the chosen management should be based on the stability of patient and should aim in preserving fertility and minimising morbidity of the patient. The cases highlight the difficulty in decisions taken for intervention or otherwise and the importance of multidisciplinary input.

DO YOU PAY TO GO PRIVATE? A SINGLE CENTRE COMPARISON OF INDUCTION OF LABOUR AND SUBSEQUENT CAESAREAN SECTION RATES IN PRIVATE VERSUS PUBLIC PATIENTS.

Abstract ID: 183

Dr. Simon Craven (National Maternity Hospital), Ms. Fionnuala Byrne (National Maternity Hospital), Dr. Michael Robson (National Maternity Hospital), Dr. Rhona Mahony (National Maternity Hospital), Dr. Peter Boylan (National Maternity Hospital), Dr. Jennifer Walsh (National Maternity Hospital)

The aim of this study was to compare rates of induction and subsequent caesarean delivery among nulliparous women with private versus publicly funded health care at a single institution.

Data were extracted from the National Maternity Hospital (NMH) Patient Administration System (PAS) on all nulliparous women who delivered a singleton, liveborn infant at ≥ 34 weeks gestation during the 6-years 2010-2015. At NMH all women in spontaneous labour are managed according to a standardised intrapartum protocol. We compared rates of IOL and subsequent caesarean section (CS) between those with and without private health cover.

During 2010-2015, 22,995 women met the inclusion criteria. Of these, 2,600 were private patients; the remainder (20,395) were public. Women with private cover were more likely to have a pre-labour CS (346/2600(13%) vs. 1386/20,395(6.8%), OR=2.1,[CI 1.85-2.39], $p < 0.001$), or induction of labour (1005/2600(39%) vs. 6687/20,395(33%), OR=1.3, [CI 1.18-1.41], $p < 0.0001$). They were also more likely to be delivered by CS following IOL (348/1005(35%) vs. 2043/6687(30.5%), OR=1.2,[CI 1.04-1.38], $p = 0.01$). In cases of spontaneous labour (SOL) there was no difference in CS rates (114/1249(9%) vs. 1028/12,322(8.3%), OR=1.1,[CI 0.99 -1.02], $p = 0.37$).

These findings show that there are significant differences in rates of obstetric intervention between those with private and public health cover. This division is unlikely to be explained by differences in clinical risk factors as no significant difference in outcomes following SOL were noted. Further audit and research is needed to determine the roots of the disparity between private and public decision-making, and the potential clinical implications for both mothers and their infants.

DOCUMENTATION OF SHOULDER DYSTOCIA IN THE MATERNITY CHART

Abstract ID: 27

Dr. Ciara Nolan (Rotunda Hospital), Dr. Jennifer Donnelly (Rotunda Hospital)

C Nolan, J Donnelly

Rotunda Hospital, Dublin

Accurate reporting in the medical chart is important for communication and record-keeping. Shoulder dystocia (SD) is an obstetric emergency and there is significant perinatal morbidity and mortality associated with its occurrence. Comprehensive and chronological documentation of actions taken during the event are important for medico-legal purposes and audit of care.

This study assessed the completeness of documentation regarding shoulder dystocia in the maternity chart.

Hospital In-Patient Enquiry (HIPE) database of a large Dublin maternity hospital was reviewed retrospectively to identify cases of SD over a 6 month period. We assessed the completeness of documentation as recommended in HSE and local hospital guidelines.

31 events of SD were reviewed. There was 100% recording of intrapartum events: personnel in attendance, chronological sequence of actions, manoeuvres used, Apgar scores. In 70% cases of SD the woman was debriefed on the same day as the event. Only 35% women were debriefed prior to discharge or had the risk for future pregnancies explained.

Overall, documentation regarding events in SD was very good. It was better in cases where a proforma was used. However, the low proportion (35%) of women being debriefed prior to discharge is concerning as they may not be fully informed of the implications for future pregnancies. The rate of SD in women with a previous SD is 10 times higher than the general population. It is important to be aware of this risk, so that senior staff can be present at subsequent deliveries.

Ectopics - Time from Triage to Theatre in a Tertiary Gynaecology Oncology Centre

Abstract ID: 148

Dr. Eimear McSharry (C)

Ruptured ectopic pregnancy is an obstetric emergency requiring prompt diagnosis and surgical management. Delayed management can lead to complications including hypovolaemic shock, avoidable blood transfusion and death.

This study aimed to examine the timeline of ruptured ectopic pregnancy cases, from initial emergency room triage to surgical management, in a tertiary gynaecology oncology centre.

All patients who were diagnosed with an ectopic pregnancy and underwent on site surgical management over a three year period (2012-2014) were included (n= 8). Patient notes were retrospectively reviewed. Patient demographics including age, nationality, first language, occupation, relationship status, insurance status, parity and LMP were noted. Mode of arrival to ER, vitals on triage, times of ER triage, review by ER staff, urinary pregnancy test and serum BHCG results, time referred to gynaecology and time seen by gynaecology and time of surgery were explored.

First language other than English and insurance status did not impact on time interval from triage to theatre. Failure to perform serum HCG levels, vaginal examination and refer to gynaecology in a timely manner delayed TAUSS and time to surgical management.

Education is required in the non-obstetric hospitals on the guiding principle that all women of reproductive age are pregnant until proved otherwise and it is an ectopic until clearly demonstrated to be intrauterine. The potential for sudden deterioration of ruptured ectopic patients must be highlighted and result in an accelerated pathway to reduce time from diagnosis of ruptured ectopic to definitive surgical management.

ELECTIVE CAESAREAN SECTION PRIOR TO 39 WEEKS GESTATION AND ANTENATAL CORTICOSTEROID USE

Abstract ID: 129

Ms. Jennifer Enright (University Hospital Limerick), Ms. Dearbhla Byrne (University Hospital Limerick), Dr. Sie Ong Ting (University Hospital Limerick), Mrs. Ciara Ni Laighin (University Hospital Limerick), Dr. Khadijah Irfah Ismail (University Hospital Limerick), Dr. Mendinaro Imcha (University Hospital Limerick)

According to NICE, "Risk of respiratory morbidity is increased in babies born by Caesarean Section (CS) before labour, but this risk decreases significantly after 39 weeks. Therefore, planned CS should not routinely be carried out before 39 weeks."¹ The RCOG recommends "antenatal corticosteroids be given to all women for whom an elective caesarean section (ELCS) is planned prior to 38+6 weeks gestation."²

This audit was conducted to examine the use of antenatal corticosteroids prior to ELCS carried out before 39 weeks gestation in the University Maternity Hospital Limerick (UMHL).

Data was collected from 27/01/16 - 28/04/16. The frequency and timing of ELCS was recorded by chart review and data regarding the administration of steroids.

On analysis, 60% of ELCS were carried out at greater than 39 weeks gestation. Of the remainder, 66% were carried out at 38 weeks gestation. 12% were before 37 weeks gestation with the earliest occurring at 34+6. In those having ELCS before 39 weeks, 52% received antenatal corticosteroids. This proportion increased with decreasing gestation with 100% of patients delivered before 37 weeks receiving corticosteroids.

In conclusion, the RCOG guideline on corticosteroid administration in cases of ELCS prior to 39 weeks is adhered to 52% of the time in UMHL. Compliance is much higher when the ELCS is performed before 37 weeks. This information will prove helpful when reviewing hospital protocols. Further study may be useful to investigate clinical opinion on this guideline to find out why this trend exists and if it exists in other institutions.

ELECTIVE LOWER SEGMENT CAESAREAN SECTIONS PRIOR TO 39 WEEKS AND INDICATIONS-AN AUDIT

Abstract ID: 180

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Elective caesarean sections (ELCS) carry higher risks of respiratory morbidity than vaginal delivery. This is significantly reduced after 39 weeks. NICE guidelines recommend ELCS should not be routinely carried out prior to 39 weeks.

The aim of this audit is to examine the timing of ELCS (CS4) at University Maternity Hospital Limerick (UMHL). In addition, to record indications for these deliveries; comparing those delivered prior to 39 weeks gestation with those who completed 39 weeks.

1006 consecutive births between January and April 2016 were audited revealing 333 caesarean sections. Gestation, category, and indication were recorded through chart review.

50% (168) were CS4. Of these, 40% (67) occurred prior to 39 weeks gestation ranging from 34+6 to 38+6, the majority (44) falling in the 38th week. 8 cases of ELCS prior to 37 weeks were found, 5 of which were admitted to NICU (total of 7 in <39 week cohort). Previous CS was the most frequent indication both pre and post 39 weeks. Other indications followed similar patterns. In those delivered before 37 weeks none were due to previous CS. At UMHL 60% of ELCS occur after 39 weeks revealing scope for improvement. Of those that do not achieve 39 weeks of gestation, most are delivered less than a week in advance for similar indications. This pattern may be due to capacity and scheduling limitations. In cases of very early ELCS (<37 weeks) the indications recorded vary greatly and it appears that underlying medical reasons for intervention are at play.

EMERGENCY REFERRALS BY A MATERNITY HOSPITAL

Abstract ID: 206

Dr. Catherine Windrim (National Maternity Hospital), Dr. Lucy Mcshane (St. Vincent's University Hospital), Dr. Michael Robson (National Maternity Hospital), Dr. Nigel Salter (St. Vincent's University Hospital)

Our Maternity Hospital is supported in the evaluation of acute non-obstetric complications by a tertiary referral centre. In order to evaluate this service we reviewed all referrals from our ED over a 2 month period.

With the mentorship of Consultants from both Hospitals, we undertook a retrospective chart analysis. Our intentions were to evaluate the proportion of patients in our ED that was referred; the most common reasons for referral and to assess their prevalence of true disease

2410 pregnant women were seen in the Maternity ED, approximately 40 patients each day. 25 (1.03%) were referred for medical or surgical review. The leading cause for referral were suspected pulmonary embolism (28%), right iliac fossa pain (24%), severe headache (16%), cardiology review (8%), and deep venous thrombosis (8%). Of the 7 patients with suspected PE, 1 had multiple PEs confirmed and 1 had a large pneumothorax. Neither of the patients with suspected DVT had a confirmed thrombosis. Of the patients referred with RIF pain, 67% underwent diagnostic laparoscopies. Of the four patients referred with severe headaches, 3 did not attend the general hospital and the other left against medical advice.

This review suggests that while the Maternity ED is a busy unit, only 1% of women require referral for non-obstetric evaluation. However, among those women referred there is a high prevalence of significant, potentially threatening conditions. Audit of these patterns of referral may help both Departments to optimize communication, streamline care and plan the provision of services for unwell pregnant women.

ESTABLISHING WHETHER ALL CASES OF CIN 2 NEED EXCISIONAL TREATMENT FOR FEAR OF MISSING HIGHER GRADE DISEASE

Abstract ID: 219

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Around 70% of CIN2 will regress without treatment within 2 years, though as many as 24% will progress to CIN3. The treatment of CIN2 is a topic of debate. This paper aims to look at whether the grade of referral smear impacts on the incidence of underlying CIN 3 and above in patients with CIN2 on a punch biopsy.

A total of 287 women who had a punch biopsy that showed CIN2, with a known referral smear that underwent a LLETZ treatment, between 1/1/2013 to 1/1/2016 were included in the study.

When comparing the incidence of underlying CIN3 and above, in patients with a high grade smear [42.7%(n=68)] vs those with low grade smear [21.8%(n=28)] the difference was statistically significant.(RR 1.95 (CI 1.3 – 2.9), P value of 0.000193.)

The incidence of an underlying CIN3 and above in patients <30 years with a high grade smear was 46.2% (n=49) and with a low grade smear was 21.3% (n=13)

[P =0.001,RR = 2.2 (CI 1.3 – 3.9)].

This paper concludes that the referral smear does impact the incidence of finding underlying higher grade disease when a LLETZ is performed for CIN2 and that it is not unreasonable to perform a LLETZ in a women with CIN2 with a high grade smear but much consideration must be given prior to performing a LLETZ on a woman (age <30) with a low grade smear whose histology is incidentally CIN2 because of its long term repercussion on pregnancy such as preterm labour.

EVALUATING THE VALUE OF IL-6, MMP-2 AND MMP-9 AS BIOMARKERS FOR ENDOMETRIOSIS

Abstract ID: 192

Dr. Katie Field (St James's Hospital Dublin and Trinity College Dublin), Dr. Hugh O Connor (Coombe Women and Infants University Hospital), Dr. Mark Ward (Trinity College Dublin), Dr. Dr Feras Abu Saadah (Trinity College Dublin), Dr. Lucy Norris (Trinity College Dublin), Dr. Noreen Gleeson (St James's Hospital Dublin)

This study investigated the diagnostic potential and effect of treatment of serum levels of interleukin-6, IL-6, matrix-metalloproteinases, MMP, MMP-2 and MMP-9 in patients with endometriosis.

This was a case controlled, prospective clinical study looking at women undergoing laparoscopy for diagnostic and operative indications. The study consisted of 54 women with confirmed endometriosis at laparoscopy and 14 women with normal pelvises. A follow-up serum sample was taken postoperatively.

Women were recruited preoperatively, consent was given and serum samples were taken prior to surgical intervention and at routine clinical follow-up post-treatment. IL-6, MMP-2 and MMP-9 levels were measured using the ELISA method.

Pre-operative IL6 levels were no different in women with endometriosis and normal pelvises, however in women with endometriosis, there was a significant drop in IL6 levels following laparoscopic treatment ($P < 0.02$). There was also a trend towards lower levels in women with infertility and higher levels in women with dysmenorrhoea.

MMP2 showed no difference in pre-operative serum levels between endometriosis patients and controls however post treatment women with endometriosis showed a significant increase in MMP2 levels ($P < 0.05$). There were also higher levels of MMP2 in women who complained of infertility compared to those who did not ($P < 0.01$).

MMP9 showed no difference in levels between women with endometriosis and those without.

In conclusion IL6, MMP2 nor MMP9 appear to have potential as predictive biomarkers for endometriosis. IL6 and MMP2 may be of use in screening asymptomatic women with infertility and may offer some benefit in monitoring the disease progress and its treatment.

EVALUATION OF RISK FACTORS ASSOCIATED WITH CERVICAL CARCINOMA IN WOMEN PRESENTING TO COLPOSCOPY AT AMNCH TALLAGHT HOSPITAL

Abstract ID: 95

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In Ireland, cervical cancer has an incidence rate of 13 cases per 100,000 women and the most common types of cervical cancer are adenocarcinoma and squamous cell carcinoma.

This project explored the frequency and distribution of risk factors with known associations to the main types of cervical cancer (adenocarcinoma and squamous cell carcinoma) in a cohort of women referred to Tallaght hospital colposcopy clinic.

This is a retrospective study (n=148) using the Mediscan database to assess new referrals to colposcopy clinic between 01/01/2009 and 15/03/2015. Subjects were included based on a histological grade of squamous cell cancer or adenocarcinoma. Results were analysed using SPSS v. 22.0 software.

In this study we assessed the frequency and distribution of contraceptive use, parity, smoking status and abnormal bleeding in women diagnosed with cervical cancer subtypes of adenocarcinoma (n=64) or squamous cell carcinoma (n=84). A significantly higher proportion of women diagnosed with squamous cell carcinoma experienced abnormal bleeding (18% vs 42%, P=0.003) and had a higher mean parity (2.34 vs 1.48, P=0.003) than those with adenocarcinoma. In the squamous cell carcinoma subgroup, a higher proportion of patients were active smokers, while in the adenocarcinoma subgroup, a higher proportion of women were using oral contraception, however these results did not reach statistical significance.

Overall our results show that both high parity and abnormal bleeding have a higher prevalence in cases of cervical squamous cell carcinoma than adenocarcinoma. Most of the adenocarcinoma cases were asymptomatic and were mainly picked up via smear testing.

EXAMINING THE RELATIONSHIP BETWEEN DOPPLER ULTRASOUND AND HBA1C LEVELS IN DIABETIC PREGNANCIES

Abstract ID: 45

Mr. Brian McDonnell (UCD School of Medicine), Mr. Liam Sharkey (University College Dublin), Dr. Nóirín Russell (Cork University Maternity Hospital), Ms. Cecilia Mulcahy (Midwifery, National Maternity Hospital), Prof. Fionnuala M McAuliffe (UCD Obstetrics and Gynaecology, National Maternity Hospital), Prof. Mary Higgins (UCD Obstetrics and Gynaecology, National Maternity Hospital)

Pre-gestational diabetes mellitus (PGDM) is associated with an increased risk of fetal and neonatal morbidity and mortality [1].

The aim of this study was to assess fetal vascular Doppler ultrasound measurements (measured at 30, 33 and 36 gestational weeks) based on glycaemic control in early pregnancy (booking HbA1c).

Serial third trimester ultrasound measurements of 231 pregnancies affected with maternal PGDM were analysed; clinical measurements were recorded including measures of glycaemic control (HbA1c). Umbilical Artery Pulsatility Index (UAPI), Middle Cerebral Artery Pulsatility Index (MCAPI) and Middle Cerebral Artery Peak Systolic Velocity (MCAPSV) measurements at 30,33 and 36 weeks were studied and compared based on booking HbA1c (<6.5% as a marker of “good glycaemic control” and ≥6.5% as “poorer control”). Subgroup analysis was performed based on type of PGDM (Type 1 diabetes (T1DM), n=167; Type 2 diabetes (T2DM), n=64)

There was no consistent pattern of significant differences in UAPI, MCAPI and MCAPSV between groups based on booking glycaemic control. Women with HbA1c >6.5% had a statistically significant increased 33 week MCAPI measurements (MCAPI “good control” 1.87+/-0.263; MCAPI “poorer control” 1.86+/-0.376; p=0.02); this difference held in women with T1DM (p<0.01) but not in T2DM.

No consistent pattern has yet been identified in Doppler ultrasound measurements based on booking glycaemic control in PGDM pregnancies. This study is ongoing.

References:

1. Higgins M, Galvin D, McAuliffe F et al. Pregnancy in women with Type 1 and Type 2 diabetes in Dublin. *Ir J Med Sci.* 2011; vol 180: 469-473

Factors Affecting Fallopian Tube Patency Using Hysterosalpingo-Contrast Sonography (HyCosy) In A Sub-Fertile Population

Abstract ID: 274

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Occlusion of the fallopian tubes is a leading cause of sub-fertility in women. Laparoscopy has been regarded as the gold standard for assessing tubal patency. HyCoSy however, is a safe and efficient alternative method. HyCoSy reports were reviewed retrospectively from February-2010 to July-2015 using ViewPoint database and patient's hospital notes where necessary.

A total of 1043 HyCosys were performed. The mean age was 33.9yrs(Range 20-47). The majority of women referred were nulliparous(73.3%;n=625). Most of HyCosys attempted were completed(96.3%;n=1003), with 3.7% not completed due to being unable to cannulate the cervix (1.9%) or the procedure was not tolerated(1.2%). Tubal-patency was demonstrated in 82% of cases. This was maintained when patency was analysed separately for the right, left or the remaining fallopian tube following previous salpingectomy. With advancing age, it was less likely that tubal-patency would be demonstrated(p=0.004). Multiparous women were also less likely to have patent-tubes(p=0.001). Other factors like previous miscarriages, ovulation status and BMI did not show statistical significance.

A subset of patients underwent laparoscopy after HyCosy for suspected tubal-occlusion. HyCosy was found to have high specificity when bilateral-occlusion was diagnosed(81%). Specificity was low when only unilateral-occlusion was diagnosed(44.4%), which was more evident in obese women(33.3%vs.66.7%).

HyCosy is a reliable technique to assess tubal-patency with a high completion rate. Older and multiparous women are more likely to have tubal-occlusion. Unilateral-occlusion at HyCosy is more likely to be spurious compared to bilateral-occlusion. Raised BMI makes HyCosy more challenging technically, and tubal-occlusion HyCosy results in the obese should be interpreted with caution.

FACTORS ASSOCIATED WITH INCREASED CHANCE OF VAGINAL DELIVERY IN GROUP 2 OF ROBSON'S CLASSIFICATION.

Abstract ID: 277

Dr. Workineh Tadesse (Rotunda Hospital), Dr. Chris Elizabeth Philip (Rotunda Hospital), Dr. Sharon Cooley (Department of Obstetrics and Gynecology, Royal College of Surgeons in Ireland, Rotunda Hospital, Dublin, Ireland.)

This study was conducted to determine factors associated with increased chance of vaginal delivery following induction of labour (IOL) at term in nulliparous women with singleton cephalic pregnancy (Robson's Group 2). This is a retrospective cohort study of Group 2 women who delivered in a large tertiary hospital in 2014 and 2015. Variables were generated from the hospital database and compared between women who had caesarean delivery and those with vaginal delivery. Odds ratio and chi-square test were calculated to determine differences between the two groups.

Of the 2256 women included for analysis, 791(35.1%) required caesarean delivery. Compared to women delivered by caesarean, women who delivered vaginally were more likely to have epidural during labour (OR 1.59, 95% CI 1.26 - 2.01, p value = 0.0001), an occiput-anterior position (OR 3.44, 95% CI 2.57 – 4.60, p value < 0.0001), or to carry a female fetus (OR 1.25, 95% CI 1.05 – 1.49, p value = 0.01). Odds of vaginal delivery following IOL at 38 weeks was 1.6 (95% CI 1.1 – 2.2, p value = 0.005), however, there was no difference at the other gestational ages. Additionally, there was no difference between public, private or semi-private patients, or with method of IOL (p value = 0.1, 0.4 respectively).

Our study indicated that multiple factors are associated with increased chance of vaginal delivery in Group 2. However, except for the use of epidural analgesia for labour, none of these factors may be modified to impact the vaginal delivery rate.

FACTORS ASSOCIATED WITH THE NEED FOR HYPOGLYCAEMIC AGENTS IN THE TREATMENT OF GESTATIONAL DIABETES.

Abstract ID: 259

Dr. Workineh Tadesse (Coombe Women and Infants University Hospital), Prof. Sean Daly (Coombe Women and Infants University Hospital), Prof. Brendan Kinsley (Coombe Women and Infants University Hospital)

The objective of this study was to identify factors associated with the need for hypoglycaemic agents in the treatment of gestational diabetes mellitus (GDM).

This is a prospective study of women with GDM, who were treated in a large tertiary university hospital during the calendar year 2014. We divided the women into two groups: those who remained on dietary therapy and those who advanced to either metformin or insulin or both. Odds ratio was calculated to determine differences between the two groups.

A total of 540 women with a diagnosis of GDM were included for analysis. A third of the women (33.3%) remained on diet therapy to control their blood glucose levels. Compared to women treated with diet, women who required hypoglycaemic agents were more likely to be older than 37 years of age ($p = 0.014$), heavier than 95 kg ($p = 0.019$), have history of GDM in a previous pregnancy ($p = 0.026$), or have been diagnosed before 20 weeks of gestation ($p = 0.009$). Additionally, women who were treated with hypoglycaemic agents were more likely to carry a fetus with abdominal circumference (AC) measuring $\geq 90\%$ at 27 – 28 weeks ($p = 0.013$), or a male fetus ($p = 0.044$), however, less likely to have a booking body mass index (BMI) of less than 25 kg/m² (odds ratio = 0.5, $p = 0.002$).

The study indicated that a number of maternal and fetal factors are associated with the need for hypoglycaemic agents in the treatment of GDM.

FACTORS INFLUENCING WOMEN'S CHOICE OF MISCARRIAGE MANAGEMENT IN THE FIRST TRIMESTER

Abstract ID: 271

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Early miscarriage is a difficult time for couples. When discussing management options, women's preferences should be considered. Few studies have investigated the factors that influence the woman's choice of management.

The aim of this study was to evaluate the factors which influence the choice of management in first-trimester miscarriages.

Women were recruited prospectively following the diagnosis of first-trimester miscarriage between October-2015 and August-2016. Women were offered surgical, medical and conservative managements. Six to eight weeks post recruitment, an online survey was emailed to the women. Women were asked to score how various factors influenced their choice of management.

A total of 172 women were recruited with a response rate of 84%. The average age of the recruited women was 34 years, with 38% being nulliparous and 38.5% having had at-least one previous miscarriage. The majority were Caucasians(91%), employed (83%) and in a relationship (91%). Just over half of the women opted for surgical management (54%); while 33% opted for medical management and 12% opted for conservative management. Partner's opinion appeared to have a high influence on the decision of choice of management (66.4%), followed by "experience with previous miscarriage" (61.2%) and family commitments (58.5%). Social commitments (21.7%) family member's opinion (37%), distance to hospital (28%) and transport to hospital (20%) had low influence on women's choice of management. There was no significance statistically when factors were compared by the type of management chosen.

Partner's opinion and previous experience with miscarriage have a high influence on women's choice of miscarriage management.

Fertility sparing treatment for management of early cervical cancer

Abstract ID: 43

Dr. Katie Beauchamp (MMUH), Dr. Dr Niamh Maher (MMUH), Dr. Grace Ryan (MMUH), Prof. Donal Brennan (MMUH), Mr. Tom Walsh (MMUH)

Cervical cancer is the third most common gynaecological cancer. 52% are under the age of 45. Traditionally treatment involves surgery or chemo/radiotherapy. Fertility saving surgery is increasingly being offered in selected cases.

Our unit performed laparoscopic radical trachelectomies for 3 women with early cervical cancer wishing to preserve fertility. This involves excision of the cervix, upper 2cm of the vagina, parametrium and paracolpos. All cases underwent laparoscopic pelvic lymph node dissection. When frozen sections were negative it was deemed appropriate to proceed to radical trachelectomy.

The first patient, a 32 year old nulliparous lady had FIGO stage 1B1 adenocarcinoma of the cervix. Postoperative histology showed this to be moderate to poorly differentiated multifocal adenocarcinoma. She was advised to undergo adjuvant radiotherapy however opted for close surveillance with 3 monthly colposcopy and 6 monthly vaginal vault smears.

The second patient, a 29 year old nulliparous woman with a stage 1B1 squamous cell carcinoma (SCC) of the cervix measuring 12x15mm on LLETZ. She underwent 3 cycles of neoadjuvant taxol carboplatin off market as this was a larger tumour. Postoperative histology showed residual a tumour 6x3.5mm with clear margins. She will undergo 3 adjuvant cycles of chemotherapy.

The third patient, a 25 year para 1 with SCC underwent trachelectomy. Final histology and management is pending.

The risk of recurrence, 5-12% is similar to more traditional, fertility compromising treatments.

A diagnosis of cancer is devastating for any young woman.

Laparoscopic trachelectomy offers women the hope of retaining their fertility after treatment for cervical cancer.

FOLIC ACID USE IN WOMEN REPORTING INFERTILITY

Abstract ID: 138

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Background

There is strong evidence that two thirds of neural tube defects may be prevented by periconceptual folic acid supplementation and it is recommended that all women should start, ideally at least three months, before they conceive.^{1,2}

Purpose

To assess compliance with folic acid supplementation amongst women reporting a history of infertility.

Methods

A prospective database of women delivering an infant weighing $\geq 500\text{g}$ which was gathered from 2009-2013 in a large Dublin Maternity Hospital was analysed. The relationship between compliance with periconceptual folic acid and reporting of infertility +/- assisted reproduction treatment was studied and statistical analyses were performed.

Findings

Of 1508 women reporting a history of infertility at time of booking (3.6% of the total cohort of 42,042 women), 26.4% did not take folic acid supplementation as currently advised with 12.9% reporting preconceptual use only, 12% commencing it post-conceptually and 1.5% reporting no use in the periconceptual period. Of this cohort, 443 reported assisted reproduction treatment was required to conceive. Within this cohort, 2.9% reported no folic acid use, 12.6% commenced supplementation post-conceptually and 11.3% reported preconceptual use only.

Conclusions

It is a concern that under medical supervision considerable resources are devoted to investigating and treating women who are trying to conceive for at least twelve months, yet one in seven infertile women presenting for antenatal care remain at increased risk of a major congenital malformation due to lack of compliance with an inexpensive dietary supplement.

From worst case to better than ever!

Abstract ID: 269

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A 26 year old female had an uncomplicated antenatal course in her first pregnancy. The patient's background history included an RTA nine years previous to the index pregnancy in which she suffered an haemopneumothorax, a ruptured left hemidiaphragm and splenic rupture necessitating a splenectomy.

The patient was on erythromycin prophylaxis post-splenectomy as she has penicillin allergic. The patient was currently unemployed, non drinker and a current smoker with 10 pack year history. Family history included maternal history of terminal lung cancer.

The patient was delivered by emergency caesarean for a pathological CTG. On Day 2 post caesarean the patient desaturated to 85% on room air with dyspnoea and chest pain. CTPA showed no evidence of pulmonary embolism but a 7cm mass with bulky presumed neoplastic adenopathy in the mediastinum and appearances concerning for extensive neoplastic disease.

Endobronchial ultrasound with transbronchial biopsy revealed histology demonstrating lymphoid tissue with no evidence of high grade lymphoma, differential included low grade lymphoma and ectopic splenic tissue. Red cell scintigraphy confirmed confirms the presence of abnormal red cell accumulation in the left hemithorax corresponding to the abnormal soft tissue masses on the CT scan, confirming that these masses most likely represent ectopic splenic tissue.

Splenosis is autotransplantation of viable splenic tissue to ectopic sites where draws its blood supply from surrounding tissue. Thoracic splenosis has been described less than 60 times in English literature and there is an ongoing debate regarding splenic function with anecdotal evidence of both hyper and hyposplenism.

HAEMOGLOBIN ASSESSMENT PRE & POST CAESAREAN SECTION

Abstract ID: 179

Dr. Fabio Margiotta (University Hospital Limerick), Mrs. Ciara Ni Laighin (University Hospital Limerick), Dr. Céire Mc Guane (University Hospital Limerick), Dr. Khadijah Irfah Ismail (University Hospital Limerick), Dr. Mohd Ismail (University Hospital Limerick), Dr. Mendinaro Imcha (University Hospital Limerick)

Caesarean section is major surgery and accordingly NICE guidelines recommend Full Blood Count (FBC) as a routine pre-operative test^{1,2}. We aimed to audit local practice of pre- and post-op Haemoglobin (Hb) testing. 100 elective and 100 emergency caesarean sections (CS) performed between January and April 2016 were studied. CS category data was obtained by chart review. Pre and post-op Hb was obtained from the laboratory online system.

Pre-op Hb was available in almost 100% of cases. Post op Hb was checked in 91% of emergency CS, rising to 96% for elective.

The mean pre-op Hb for all categories of CS was 11.8 g/dL, while post-op Hb was 10.6 g/dL. The 95% Confidence Interval (CI) for pre-op Hb was 11.70-11.96, while post-op Hb CI was 10.41-10.74. Post-op Hb was taken on average 1 day post-op. There was a significant difference between pre-op and post-op levels of Hb across all categories with a mean drop of 1.5. A significant difference was also observed between the drops in Hb recorded in emergency and elective categories.

In conclusion, NICE recommendations for pre-op FBC was met in all elective CS and in all but one emergency CS. Post-op testing was also achieved in most cases.

Post-op Hb levels were significantly lower after all CS. The drop in Hb levels seen in emergency settings was significantly higher than during elective surgery. Routine post-op FBC should be performed after CS and in particular with emergency CS as it is associated with more maternal and post-natal complications³.

Healthcare professionals' perception of onco-fertility services in Ireland

Abstract ID: 224

Dr. Lucia Hartigan (Cor), Dr. Mary Wingfield (Merrion Fertility Clinic, National Maternity Hospital), Prof. Donal Brennan (University College Dublin)

Impaired reproductive function and infertility are major concerns for many oncology patients. Recent years have seen major advances in the field of fertility preservation, which has gradually become an imperative aspect of a multidisciplinary approach to cancer patients. A number of professional bodies recommend onco-fertility counselling by a specialist for all young cancer patients undergoing treatment that may reduce their fertility potential. This, unfortunately, is currently not standard practice in Ireland.

Our aim was to gain insight into the challenges which currently face healthcare professionals when caring for patients who could benefit from fertility preservation.

We prepared a survey asking healthcare professionals specific questions about how they view current onco-fertility services in Ireland. The survey was distributed via electronic mail to doctors, nurses and allied health professionals working in medical oncology, radiation oncology, urology, haematology, breast cancer, gynae-oncology and paediatrics.

(Please note that the survey is still active and there will be further results to follow). 66.6% of responders said that they almost always discuss fertility preservation with their patients. 83.3% strongly agree that the following services should be available for patients: Clinical psychologist with special interest in onco-fertility, advice regarding hormone replacement therapy, gamete preservation services, preconceptual counselling and an onco-fertility liaison nurse. 83.3% think that a central service with satellite regional centres would be the best model of care for onco-fertility services with the remaining 16.6% favouring a central service only. 83.3% of those surveyed consider that the onco-fertility services in Ireland are inadequate.

The majority of health care professionals working with patients who require onco-fertility services are of the opinion that current onco-fertility services in Ireland are inadequate.

HETEROTOPIC PREGNANCY: CASE SERIES AND LITERATURE REVIEW

Abstract ID: 276

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Heterotopic pregnancy (HP) refers to the simultaneous presence of intrauterine pregnancy (IUP) and ectopic pregnancy, which is very rare but potentially life-threatening. HP can be spontaneous or the consequence of assisted reproductive technology (ART). The spontaneous incidence of HP in the general population is 1 in 30,000. However, with the widespread of ART, the incidence rises to 0.09- 1.00%.

This case series describes four cases of heterotopic pregnancy from our unit that presented from October-2015 to October-2016. In each case the presentations and outcomes were different.

Case1: Asymptomatic spontaneous heterotopic pregnancy on a background of a previous right-salpingostomy for an ectopic pregnancy. A viable IUP was identified with a right-sided live ectopic pregnancy for which a right-salpingectomy was performed.

Case2: Asymptomatic heterotopic pregnancy on a background of ovulation induction. A viable IUP was identified and a left-tubal ectopic for which a left-salpingectomy was performed.

Case3: A spontaneous heterotopic pregnancy with a non-viable IUP and a delay in the diagnosis of the ectopic pregnancy. This case highlights the need for a high index of suspicion.

Case4: Heterotopic pregnancy following In Vitro Fertilisation with 2 embryo transfer. The ectopic pregnancy was diagnosed twelve days following surgical evacuation for a non-viable IUP.

In Conclusion, early and accurate diagnosis of heterotopic pregnancy can be challenging. An early trans-vaginal ultrasound plays an important role in making the diagnosis in women with risk factors and following ART. A High index of suspicion is required for timely diagnosis and appropriate intervention, specially in spontaneous heterotopic pregnancy.

Hidradenoma papilliferum in a 47 year old lady

Abstract ID: 246

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Hidradenoma papilliferum is a benign, cystic, papillary apocrine gland tumor. It is rare with an estimated incidence rate of 5.1 per million annually. This occurs virtually exclusively in women in the skin of the vulval and anal region.

A GP referred a 47 year old woman who noticed a labial swelling which had increased in size of the past year. On examination there was a firm 1cm nodule which was non-tender, non-secretory and located between the labia majora and minora. Our impression was that this was a simple labial cyst and the lady was scheduled for an excision as a day procedure. Histology results showed hidradenoma papilliferum with focal oncocytic metaplasia.

Our case report includes a review of literature related to perianal nodules, clinical presentation and pathological features.

How would Mary Poppins fare in labour? Practically perfect? Unlikely.

Abstract ID: 23

Ms. Lucy Bolger (Royal College of Surgeons in Ireland), Mr. Richard Sweeney (Royal College of Surgeons in Ireland), Prof. Michael Foley (National Maternity Hospital), Dr. Rhona Mahony (National Maternity Hospital)

With growing influence from social media, there is potential for first time mothers to have unrealistic expectations of labour and delivery. This can present an area of challenge for both physicians and midwives.

The purpose of this study was to calculate the percentage of “practically perfect” births in nulliparous women, defined as a labour without intervention, an intact perineum and a positive neonatal outcome. This statistic can be used to help provide realistic expectations for first time mothers.

This was a retrospective study of data collected at the time of birth from all the nulliparous deliveries that occurred in the National Maternity Hospital over a period of 2 years (2014/2015). To extract the perfect births, we excluded deliveries <38 weeks, induction/pre labour Caesarean Section (CS), Artificial Rupture of Membranes (ARM), use of oxytocin, fetal blood sample, emergency CS/instrumental deliveries, perineal damage and suboptimal Apgar scores.

Of all of the nulliparous mothers, 0.7% had a practically perfect birth.

This research was carried out in a maternity unit that practises Active Management of Labour. Over half of women in spontaneous labour received ARM, which yielded a significant reduction in “practically perfect” births. Our results provide a useful statistic for clinicians and first time mothers, which could be further validated by similar studies in other Irish maternity hospitals. The study had a large cohort which objectively quantified practically perfect births, future research on the subjective perception of a perfect birth could also add value to these findings.

HYSTEROSCOPIC MORCELLATION OF ENDOMETRIAL POLYP AND FIBROID: A DESCRIPTIVE STUDY

Abstract ID: 72

Dr. Sucheta Johnson (University Hospital Limerick), Dr. Kalsum Khan (University Hospital Limerick), Dr. Una Fahy (University Hospital Limerick)

Hysteroscopic removal of endometrial pathology has become a standard treatment¹. In contrast to monopolar hysteroscopic resectoscopes, modern morcellators have been fairly recently introduced^{2, 3}.

Hysteroscopic morcellation was introduced in our unit nearly two years ago. We wished to audit the outcome of patients who had treatment with this modality.

Retrospective analysis of medical records was carried out for the procedures performed between July 2014-July 2016. Patients were identified using the theatre book. Data collection and analysis was done using Microsoft Excel.

Total of 23 patients were identified as having undergone the procedure. Mean age at the time of procedure was 51 years. Main indications were PMB (10/23) and menorrhagia (6/23). Other indications included intermenstrual bleeding (1/23), use of Tamoxifen (1/23), secondary amenorrhoea (1/23) and presence of endometrial polyp (1/23). Polyp removal was done in 18 patients and 5 had submucous fibroid removal. Myomectomy was performed after giving GnRH analogue in 4/5 cases and Esmya was used in 1/5 cases. Histological examination confirmed benign endometrial polyp in 16/18 cases and fibroid uterus in 5/5 cases. One case of simple and one case of complex endometrial hyperplasia were noted. Twenty procedures led to complete removal of pathology. Only two patients needed overnight stay postoperatively. No complications were noted. Mean interval for postoperative follow up was 12 weeks. Resolution of symptoms was seen in 78% patients.

To conclude hysteroscopic morcellation was found to be a highly effective and a safe way of surgically treating endometrial polyps and fibroids.

IMPACT OF WEEKENDS ON POST OPERATIVE EPIDURAL REMOVAL

Abstract ID: 15

Dr. Emmanuel Hakem (University College Hospital Galway), Dr. Hugh O'connor (University College Hospital Galway), Dr. Michael O'leary (University College Hospital Galway)

Epidural catheterisation is an established method of providing effective postoperative analgesia. However prolonged use of epidural analgesia is known to increase the risk of post-operative complications.

It is the established practice within our unit that epidural catheters should be removed 48 hours post operatively unless otherwise specified by the operating consultant. This is in keeping with the principles of enhanced recovery after surgery. We sought to assess the management of post-operative epidural analgesia in our unit.

This Audit was performed retrospectively over a 3-month period from October to December 2015. All Gynaecology patients who underwent laparotomy and had epidural catheter during this time period were included. Post-operative epidural analgesia was utilised in 22 patients during the study period. The day of the week that surgery was performed was found to be an influencing factor on length of epidural catheterisation. Of those performed on a Friday, the epidural was removed on day 2 in 56%, while in cases performed on a Monday the epidural was removed in 71% on day 2. In 68% of cases clear instructions for the timing of removal of the epidural catheter was documented in the operative notes or in the postoperative notes on day 1 or 2.

This audit establishes that clear documentation of instruction for the removal of epidural catheters in the operative or early postoperative notes is associated with earlier removal of epidural and reduced length of hospitalisation. It is also clear that the use of epidurals is potentially unnecessarily prolonged at weekends.

Induction of labour: A comparison between controlled release dinoprostone vaginal pessary (Propess®) and gel (Prostin®).

Abstract ID: 267

Dr. Orla Smith (Rotun), Dr. Rachel Elebert (Rotunda Hospital), Dr. Maeve Eogan (Rotunda Hospital)

Prostaglandin E2 is commonly used in induction of labour. There are various prostaglandin preparations available which differ in their dose, administration and potential side effects. Prostin® gel was used for induction of labour in the Rotunda Hospital until May 2015. The induction process was then changed from Prostin® to dinoprostone vaginal pessary (Propess®) due to a national shortage of Prostin®. The purpose of this study was to compare dinoprostone slow release pessary (Propess®) and gel (Prostin®) for induction of labour.

A comparison was made retrospectively between two time periods. The data on prostaglandin gel was obtained from the 2014 annual report. Prostin® was the only prostaglandin E2 used to induced labour during 2014. This was then compared to data collected prospectively following the introduction of Propess® for induction. It was collected over a 6 month period from July 2015 - January 2016 and was analysed using microsoft excel.

In 2014, the total number of inductions was 2,631, 55% were primips (n=1,436), 45% were multiples (n=1,195). Between July 2015 and January 2016 the total number of Propess® inductions was 521, 66% of these were primips (n=343), 34% were multiples (n=178). Following Propess®, 61% (n=317) required oxytocin infusion while 50% (n=682) required oxytocin following Prostin®. In the Propess® group 7.5% (n=39) required Prostin® gel additionally after 24 hours of Propess®. Both Propess® and Prostin® had a similar failed induction rate. The rate of LSCS in 2014 was 23% while the rate from January 2015 to July 2016 was 29%.

INFLAMMATORY BOWEL DISEASE IN PREGNANCY – THE COOMBE EXPERIENCE

Abstract ID: 249

Dr. Fionan Donohoe (n), Ms. Catherine Manning (Coombe Women and Infants University Hospital), Dr. Bridgette Byrne (Coombe Women and Infants University Hospital), Dr. Caoimhe Lynch (Coombe Women and Infants University Hospital), Dr. Carmen Regan (Coombe Women and Infants University Hospital)

Background:

Inflammatory bowel disease (IBD) affects women of childbearing age and so is commonly encountered in pregnancy.

At the Coombe, any patients who are taking medications for these conditions are seen in the Medical Clinic and managed collaboratively with their gastroenterologists.

We audited these patients to determine their baseline demographic characteristics, rates of medication usage as well as labour and delivery outcome data.

Findings:

We identified 70 women who attended the clinic from 2011 to 2015.

75.7% of our patients were taking medication for IBD. Of these, 20.8% were on biologic therapy. Two thirds were taking a single agent while the others were on 2 or more.

Considering primiparous patients, 48% went into spontaneous labour, 39% were induced and 13% were delivered by caesarean section prior to labour. Of those who did labour, 50% were delivered by spontaneous vaginal delivery, 29% by operative vaginal delivery and 21% by caesarean section.

With regard to multiparous patients, 26% went into SOL, 38% were induced and 36% were delivered by caesarean section prior to labour. Of those who did labour, 92% were delivered by SVD, 4% by OVD and 4% by LSCS in labour.

The majority of women delivered after 37 weeks (88.6%). Of the 8 who delivered <37 weeks, half delivered <34 weeks.

5% of the infants weighed <2.5kg at delivery and 6% were admitted to the SCBU/NICU.

Conclusion:

Patients attending the Coombe with IBD had broadly similar rates of LSCS, SVD, OVD and IOL as the background rate for the hospital.

INITIAL EXPERIENCE OF COLD COAGULATION IN THE ROTUNDA HOSPITAL

Abstract ID: 97

Ms. Adrienne Wyse (Royal College of Surgeons in Ireland), Mr. W.A. Seah (Royal College of Surgeons in Ireland), Ms. J O Neill (Rotunda Hospital), Prof. Paul Byrne (Rotunda Hospital)

Large Loop Excision of the Transformation Zone(LLETZ) is the gold standard treatment for cervical intraepithelial neoplasia(CIN)(1). However, there is increasing evidence that LLETZ may associated with obstetrical complications(2,3,4). A recent metaanalysis looked at the efficacy of cold coagulation(CC) and found it to be as effective as LLETZ with no documented negative impact on fertility and subsequent pregnancies(5). In 2015 we introduced CC as an option for our patients.

This study assesses our initial experience with CC.

We reviewed 6 month follow up data of the first 200 women who underwent CC using test of cure indicators, cytology results and HPV status. A random sample of 200 patients treated by LLETZ during the same period was used to compare treatment outcome.

Six months following treatment, 173(86.5%) of the women treated by CC and 167(83.5%) treated by LLETZ had normal cytology ($\chi^2=P>0.05$). 148(74%) treated by CC and 166(83%) treated by LLETZ were HPV negative ($\chi^2=P<0.05$). 139(70%) women treated by CC and 152(76%) treated with LLETZ had normal cytology and were HPV negative ($\chi^2=P>0.05$).

The results of our initial experience with CC have been reassuring. Assessing cytology alone, there was no significant difference in cure rates between those treated by CC and LLETZ. Regarding HPV status alone, those treated by CC compare less favourably to LLETZ and the difference is statistically significant. However there is a lack of reliable data on the natural history of HPV infection and studies suggest that testing HPV at 6 months may be too early to assess outcome(6).

INSTRUMENTAL DELIVERY AND FAILURE THEREOF OVER A 25-YEAR PERIOD

Abstract ID: 243

*Dr. Sarah Marie Nicholson (University College Hospital Galway), Dr. Kate O Doherty (University College Hospital Galway),
Prof. John Morrison (University College Hospital Galway)*

Instrumental delivery accounts for a significant proportion of all deliveries. There is frequently a debate over which instrument to use with a significant input from trainee experience and individual clinician preference. However, it is well established that in recent years use of the obstetric forceps has declined, with a concomitant increase in vacuum assisted delivery rates. It has been speculated that this change in practice has resulted in a higher rate of failed instrumental delivery, and hence caesarean section at full dilatation.

The aim of this study was to examine the rates of use of the forceps, and vacuum, over a 25-year period, 1990-2015, alongside the rates of failed instrumental delivery.

The data were obtained from an obstetric database, the EuroKing system, to which all information had been added prospectively over the time period of the study. There were 75,918 deliveries, of which 9,138 were vacuum assisted (VD) and 4,676 were forceps assisted deliveries (FD). The FD rate varied from 13.5% - 5.3%, and the VD rate varied from 5.9% - 13.3% for the duration of the study ($P < 0.01$). There were $n=350$ failed instrumental deliveries during the time period of the study, with a prevalence in 1990 of 0.4% of all deliveries, increasing to 0.6% at the end of the study.

There was no evidence that the altered patterns of use of either instrument exerted a significant effect on the failed instrumental delivery rate. Annual data for each year of the study are demonstrated graphically.

INTERVAL BETWEEN DECISION TIME AND DELIVERY TIME BY CONTINUUM OF URGENCY IN CAESAREAN SECTIONS VERSUS NEONATAL OUTCOMES

Abstract ID: 83

Dr. Sie Ong Ting (University Hospital Limerick), Ms. Jennifer Enright (University Hospital Limerick), Ms. Dearbhla Byrne (University Hospital Limerick), Dr. Khadijah Irfah Ismail (University Hospital Limerick), Dr. Mendinaro Imcha (University Hospital Limerick)

Background

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has recommended a colour scale to reinforce “continuum of urgency” in caesarean section with category 1 and 2 performed within 30 minutes and 75 minutes respectively; category 3 needing immediate attention and category 4 performed electively. APGAR score is most commonly used for neonatal outcome which is the outmost crucial determinant of the urgency for caesarean section.

Aim

This audit aims to ensure the maternity unit in UMHL is compliant with standard guideline for decision-to-delivery time while providing optimal neonatal outcome.

Methods

150 emergency caesarean sections were randomly chosen from January to June 2016. The decision and delivery time were retrieved and compared with the neonatal APGAR score.

Results

This audit showed that UMHL was able to reach the standardised goal of delivering baby within 31 minutes for category 1 and 73 minutes in category 2, while taking 262 minutes for category 3 caesarean sections. Most newborn had APGAR score of 9 and 10 in the 1st and 5th minute of life respectively. There were 9 cases with suboptimal APGAR score of 4 to 7 and 4 cases with APGAR score of 1 to 3 needing transfer to neonatal unit.

Conclusion

Recommendations are made for consultant in charge to be informed and agreed on each urgency of caesarean sections for better time management. The urgency should be communicated across multi-disciplinary team for the patient’s transfer to theatre and most suitable anaesthesia for the best maternal and fetal outcome.

INTRACTABLE PNEUMOTHORAX IN PREGNANCY: A CASE REPORT

Abstract ID: 210

Dr. Catherine Windrim (National Maternity Hospital), Prof. Mary Higgins (National Maternity Hospital), Prof. Fionnuala Mcauliffe (University College Dublin), Mr. Michael Tolan (St. Vincent's University Hospital)

Spontaneous pneumothorax is a serious complication of pregnancy. When recurrent, there is little guidance for care from the literature, as there are no case series and fewer than 20 case reports in the literature.

In this report we add to the literature in order to further inform clinicians faced with care of these patients. We review strategies for care of intractable pneumothorax in a pregnancy which was further complicated by maternal drug use and intrauterine growth restriction.

The author worked with the Consultants involved in the patients care: Maternal-Fetal Medicine, and Cardio-Thoracic Surgery in order to review the lessons to be learned from this case.

In previously reported cases, spontaneous pneumothorax in pregnancy is treated conservatively with chest tube placement. In this case, while a chest tube allowed full lung re-expansion and resolution of pneumothorax, any effort to withdrawal negative-pressure resulted in full re-development of the pneumothorax so that surgical intervention was required. Substance abuse requires both adult dependancy care and plans for newborn dependency problems. Medical complications are often associated with intrauterine growth restriction and this was encountered in this case.

In the absence of any Surgical or Obstetrics Guidelines on the management of spontaneous pneumothorax in pregnancy, each case should be managed by a multidisciplinary team taking into account the clinical situation, gestational age, obstetrical complications and the patient's wishes. The potential complications during pregnancy and at delivery should be anticipated and clinicians must maintain a high suspicion for recurrence of pneumothorax to enable early and effective intervention.

INTRAPARTUM DEATH AND THE EFFECT IT HAS ON OBSTETRIC DOCTORS

Abstract ID: 102

Dr. Karen McNamara (Pregnancy Loss Research Group, University College Cork), Dr. Michelle McCarthy (Cork University Maternity Hospital), Ms. Sarah Meaney (National Perinatal Epidemiology Centre, University College Cork), Prof. Richard Greene (National Perinatal Epidemiology Centre, University College Cork), Dr. Keelin O'Donoghue (The Irish Centre for Fetal and Neonatal Translational Research, University College Cork, Ireland)

Intrapartum death (IPD) is a tragic complication of pregnancy that most obstetricians will experience. The effects on parents are well known and acknowledged, however the impact on obstetricians is largely overlooked. Using a detailed questionnaire, we documented the experiences of doctors following IPD, and identified opinions surrounding education and suitable support strategies. The response rate was 58% (69/118, 58/101 NCHDs and 11/17 consultants). Data analysis was conducted using IBM-SPSS 22 and NVIVO 11

Some 42% of doctors thought it beneficial to leave work immediately following an IPD, citing "emotional and physical exhaustion" and being "too upset" to continue providing care as the main reasons. Those who would continue working did so to provide "continuity of care and support to the patient" or out of a sense of duty to the hospital. Almost all recognised a need to talk about the event and 87% had a preference to meet with a nominated support team immediately following the event. Doctor's also advocated the use of professional counselling services.

Despite identifying an emotional toll following IPD, only 12% of doctors were offered and partook in a formal debriefing process. Over 80% advised this would have been beneficial.

Only 13% of doctors agreed they were adequately trained to deal with IPD, while less than 10% had received education on self-care following an IPD.

Maternity hospitals need to improve their support structures for doctors following an IPD. It is hoped this study will inform future educational practice and identify potential support strategies.

INTRAPARTUM DEATHS AND INTRAPARTUM EVENT RELATED NEONATAL DEATHS IN THE REPUBLIC OF IRELAND, 2011-2014

Abstract ID: 101

Dr. Karen McNamara (Pregnancy Loss Research Group, University College Cork), Prof. Richard Greene (National Perinatal Epidemiology Centre, University College Cork), Dr. Keelin O'Donoghue (The Irish Centre for Fetal and Neonatal Translational Research, University College Cork, Ireland)

This is a descriptive analysis of intrapartum deaths (IPDs) and Intrapartum event-related neonatal deaths (IPERNNDs) in the ROI from 2011 to 2014.

Information was available from the NPEC database on all IPDs in the ROI from 2011 to 2014 (N=81), and on IPERNNDs for 2012, 2013 and 2014 (N=36). Maternal and fetal demographics, in addition to available intrapartum details were analysed.

The corrected IPD rate was 0.16/1000 births.

Regarding IPDs, 35 (43.3%) were secondary to major congenital malformation (MCM), 18 (22.2%) due to chorioamnionitis, 8 (9.9%) following placental abruption and intrapartum asphyxia respectively. The remaining 9 infants died from a range of other conditions, with 4 deaths being unexplained.

Term normally formed infants accounted for 13 IPDs, and of these 11 were normally grown. The main cause of death (6/13) in this group was asphyxia.

A Post mortem examination (PM) was conducted in 22/81 (27.2%) deaths, 9 of which were coronial.

With respect to the IPERNNDs, all of these infants were normally formed and the main cause of death (21, 58.3%) was hypoxic ischaemic encephalopathy (HIE). Most of these infants were delivered at term (27, 75%). IUGR was present in 5 infants. All bar two infants had a PM, and most were coronial (31, 86.1%).

There were 6 unexplained IPERNNDs in this population. Coroner's reports are pending for 1.

This analysis reveals a wide range of causes for intrapartum event-related deaths. The rate of post-mortem examinations, particularly in the case of IPDs needs to be improved.

INVESTIGATIONS FOR WOMEN WITH PRETERM PRELABOUR RUPTURE OF MEMBRANES

Abstract ID: 166

Dr. Aenne Helps (Department of obstetrics, Galway University Hospital (GUH)), Dr. Dr Nikhil Pundarare (Department of obstetrics, Galway University Hospital (GUH))

Complications associated with PPROM include chorioamnionitis and sepsis. The Irish guideline states that a weekly HVS and at least weekly FBC should be considered. ¹ The British guideline maintains that a weekly FBC as well as CRP is not necessary due their low sensitivity of detecting intrauterine infection. ²

This audit was carried out to examine the frequency of blood tests and HVS in cases of PPROM between 24+0 and 37+0 weeks from 1/1/2015 and 20/10/2016.

44 patients were identified. Details regarding gestation at admission, days to delivery, type of labour and delivery, any signs of infection were recorded. Number of blood tests as well as HVS were obtained from the electronic system.

In total, the 44 patients spent 206 days in hospital until delivery. Mean gestation was 34.8 weeks at admission. In total 114 blood tests (FBC/CRP) were performed. Two women did not have any blood test. In total 45 HVS were carried out, though 10 patients had no HVS taken. Three of the ten developed signs of chorioamnionitis, 14/44 patients had documented signs of infection and 6 (43%) had rising blood results (WCC $>12 \times 10^9/L$, CRP $>10\text{mg/L}$). Fourteen (47%) of the remaining non-infected patients (30/44) also had raised/rising blood results. The 6 positive HVS all grew GBS (none had chorioamnionitis).

Patients were having more frequent investigations than recommended by both the Irish and the British guideline. The presence of raised or rising blood results may be useful clinically in cases where there is doubt about the diagnosis of chorioamnionitis.

IS AN INCREASING RATE OF INDUCTIONS IN NULLIPAROUS WOMEN CONTRIBUTING TO MORE CAESAREAN SECTIONS? – A 10-YEAR RETROSPECTIVE STUDY OF INDUCTION OF LABOUR IN A TERTIARY MATERNITY HOSPITAL

Abstract ID: 134

Dr. Simon Craven (National Maternity Hospital), Dr. Jennifer Walsh (National Maternity Hospital), Dr. Michael Robson (National Maternity Hospital), Dr. Rhona Mahony (National Maternity Hospital)

Induction of labour (IOL) is common, and caesarean delivery is regarded as its major complication. Recent literature comparing the effect of IOL with expectant management has provided conflicting results.

This study reviewed rates of IOL in nulliparous women in a large tertiary referral maternity hospital over a 10-year period.

Data were obtained from the Annual Clinical Reports of the National Maternity Hospital for the 10 years 2005-2014. Trends in rates of IOL and subsequent caesarean section (CS) were analyzed using regression analysis.

During the study period, 40,110 nulliparous women delivered an infant weighing ≥ 500 g. On linear regression analysis there was a significant increase in the incidence of IOL, from 28.2%(n=922) in 2005 to 32.6%(n=1,316) in 2014 ($r^2=0.83, p=0.0002, [95\% \text{ CI}=0.67-0.97]$). The proportion of women who had an IOL that subsequently led to a CS did not increase however, ranging from 33.2%(n=306) in 2005 to 30.9%(n=406) in 2014($r^2=0.02, p>0.05$). By comparison, women who had spontaneous onset of labour (Robson Group I) had CS rate of 7.4%(n=146) and 8.4%(n=175) respectively.

This study demonstrates that nulliparous IOL rates in one of our largest maternity hospitals have increased significantly. This rising trend may be contributing to the upward trajectory in overall CS rates. Although increasing the number of nulliparous women induced does not increase subsequent CS rates, overall rates are still significantly higher than in those who labour spontaneously. Given the increasing complexity of our obstetric population and the impact IOL has on maternal and neonatal outcomes, further research is required to contemporise current IOL policies.

IS DR GOOGLE RELIABLE? TOP RESULTS FOR CERVICAL SCREENING-RELATED TERMINOLOGY FROM A POPULAR INTERNET SEARCH ENGINE

Abstract ID: 258

Dr. Nicholas Kruseman (Rotunda Hospital, Dublin), Dr. Patrick J Maguire (Rotunda Hospital, Dublin)

Anxiety-related morbidity experienced by women referred for colposcopy following routine cytological screening can be significant. National cervical screening organisations have developed improved triage of smear results using HPV testing and have sought to allay fears by providing clear information regarding positive screening results. This may take the form of internet-based material given that many patients seek out information online.

We sought to determine the top ten results returned by the Google search engine for commonly used cervical screening and colposcopy terminology.

The search terms 'abnormal smear test', 'colposcopy', 'CIN' and 'cervical cancer' were entered into the Google search engine in October 2016. Where multiple results from different pages on the same website appeared these were counted as one result. The top ten results were then recorded. Webpages published by health service or charitable organisations were deemed 'approved' while others, including the collaborative encyclopedia Wikipedia, were deemed 'unapproved'.

'Abnormal smear test' had seven approved webpages out of the top ten Google results, as did 'colposcopy'. There were seven, six and five approved top ten results for CIN I, II and III respectively. 'Cervical cancer' returned six approved webpages. The website cervicalcheck.ie featured in all top ten results with the exception of searches for 'CIN'.

While approved webpages featured in all top ten results, the need for careful patient counselling following positive screening results remains vital. Further ethnographic studies should examine whether women preferentially access webpages published by health bodies or whether pages such as those recording informal patient experiences are preferred

Is nationality a risk factor for cervical cancer?

Abstract ID: 198

Dr. Dr Niamh Maher (MMUH), Dr. Gillian Corbett (The Mater Misericordiae University Hospital), Dr. Grace Ryan (MMUH), Dr. Katie Beauchamp (MMUH), Dr. William D Boyd (MMUH)

Almost 60% of new cases of cervical cancer are in women aged under 50.

It appears that women of non Irish background may have an increased incidence of presentation at a younger age of more advanced cancers. This audit looked at the number of women with a new episode of cervical cancer diagnosis attending a tertiary referral unit over a 5 year period, focussing on nationality/background, age, group and stage.

Data was collated from a hospital database involving 262 women diagnosed with cervical cancer over a 5 year period, 2010-2015. All had attended the gynaecology oncology services in the Mater hospital in Dublin.

The relevant variables for this audit included age,stage and nationality. Retrospective individual chart review was also undertaken.

10% of women were non Irish. 48% had stage 1 and 10% stage 2 cervical cancer.

26% of this non Irish population were aged less than 40, 71% had stage1-2 disease, 29% stage 3-4.

In the Irish population, 54% had CIS/stage 1, 32% stage 2.

38% were under 40 years, none had stage 3-4 cervical cancer.

There is a documented increase in the diagnosis of cervical cancer in women under 30 years of age. Reasons stated are an increased incidence of STIs or previous childhood cancers.

The above audit supports the idea that the non Irish population are presenting at a later stage with more advanced disease. This may be related to a language barrier, delayed presentation or recognition.

Is the trend for Salpingectomy as a method for sterilisation increasing? - a data analysis carried out in a local hospital

Abstract ID: 232

Dr. Martina Schembri (Midland Regional Hospital, Portlaoise)

In recent years, there has been an increasing body of evidence that high grade epithelial ovarian tumours originate from the fimbriae in the fallopian tube. This has prompted the suggestion of salpingectomy to be carried out in cases of benign hysterectomy as well as sterilisation procedures.

The purpose of this study is to assess the trend in the method of sterilisation carried out in our hospital over the past three years. We looked at the sterilisation procedures carried out during caesarean sections and as elective sterilisation procedures from January to July of 2014-2016. There were a total of 19 in 2016, 28 in 2015 and 24 in 2014. These were divided according to operator, technique and if the sterilisation was carried out during a caesarean section or as an elective procedure. The trend according to operator and technique used were looked at and showed that overall there was an increase in the use of salpingectomy as a method of sterilisation. It was noted however that some operators have not changed their practice over the years.

In view of the evidence showing the possible fimbrial origin of high grade epithelial ovarian tumours, one would question if salpingectomy should be carried out in all cases of sterilisation. Further assessment of the reason for the choice of technique should be looked at. Should the consent for sterilisation include the technique used? The aim of this data analysis was to start a discussion regarding the future techniques in sterilisation used in different units.

LAPAROSCOPIC UTEROSACRAL FASCIAL SUSPENSION- AN ALTERNATIVE TO A VAGINAL OR MESH APPROACH FOR PROLAPSE

Abstract ID: 77

Dr. Audris Wong (St Vincent's Hospital, Sydney), Dr. Phoebe Hong (St Vincent's Hospital, Sydney), Dr. Vincent Lamaro (St Vincent's Hospital, Sydney)

BACKGROUND

With the current controversy surrounding mesh complications, there has been a shift back towards native tissue repairs for prolapse surgery with the anatomic restoration of native support structures and normal vaginal axis and symmetry.

This procedure involves the reattachment of the proximal uterosacral ligament to the prolapsing segment, be it the rectovaginal septum, pubocervical fascia or pericervical ring fascia. It enables improved tissue dissection and identification of the deeper aspects of ligament with safe visualisation of ureters bilaterally avoiding ureteric and bowel injury during the procedure. Rardin et al 2009 reported a 0% ureteric injury versus 4.2% in a vaginal approach. Recurrence rates of apical prolapse in the literature has been reported at 1-5%.

FINDINGS

Over a 5 year period (2011-2016) our unit performed 262 cases of laparoscopic vault suspension. 65 were performed with the uterus intact, and 125 cases following a total laparoscopic hysterectomy. There were no reported complications such as ureteric injury, bleeding, return to theatre or sensory neural issues. Mean Preoperative POP-Q assessment Point C was -4 and mean post POP-Q Point C assessment at 6 months and 12 months was -10 and -8 respectively. Only 2 patients felt recurrence and vaginal laxity at 18 months post op. There were no revision procedure in the 5 years but our recurrence rate for prolapse over 7 years was around 2-5%.

CONCLUSION

Laparoscopic uterosacral fascial plication is a simple, safe, effective technique for pelvic organ prolapse. This technique achieves excellent short term and long term success rates.

LEARNING FROM EXPERIENCE: A QUALITATIVE STUDY OF EXPERT OPINION ON CAESAREAN SECTION DELIVERY IN THE OBESE PARTURIENT

Abstract ID: 26

Dr. Sarah Marie Nicholson (National Maternity Hospital), Dr. Ming Fan (Monash Health), Dr. Ryan Hodges (Monash Health), Prof. Mary Higgins (UCD Obstetrics and Gynaecology, National Maternity Hospital)

The prevalence of maternal obesity is increasing. There is an increased risk of caesarean section (CS) in the obese patient and of subsequent complications for both mother and baby. Despite such well documented risk there is a lack of guidance when it comes to performing a caesarean section in this cohort.

The aim of this study was to establish a task list for CS delivery in the obese parturient, based on techniques used by experienced operators.

This was a multicenter qualitative study between The National Maternity Hospital, Dublin, Ireland; and Monash Health, Australia. Experienced consultants were asked to give an interview describing their technique for a CS in a patient with a BMI of 48 in a described scenario. Interviews were analysed using grounded theory until thematic saturation was achieved.

A total of 22 responses were recorded. Interviews covered preoperative, intraoperative and postoperative technique of CS delivery. There were major themes identified during this process.

The interviewing of 22 consultants gave an in-depth instruction on the preferred operating technique for CS in the obese patient. Strengths include the collective experience of the participants and sampling of participants from different centres. One of the limitations of this study includes the potential for bias, given the qualitative data. We would suggest that this study has provided an experienced insight into the optimal technique when it comes to operating on this cohort of patients. We would hope that the described techniques may provide a framework for obstetricians when faced with a similar situation.

LEARNING FROM EXPERIENCE: A QUALITATIVE STUDY ON CAESAREAN SECTION DELIVERY IN THE SETTING OF EXTREME PREMATURITY AND INTRAUTERINE GROWTH RESTRICTION

Abstract ID: 39

Dr. Sarah Marie Nicholson (National Maternity Hospital), Dr. Ming Fan (Monash Health), Dr. Ryan Hodges (Monash Health), Prof. Mary Higgins (UCD Obstetrics and Gynaecology, National Maternity Hospital)

Preterm birth results in major perinatal morbidity and mortality across the globe, as well as major financial burden. There have been increasing rates of preterm births and those with extreme prematurity needing delivery. Despite this there is a paucity of data into the best surgical techniques used to deliver these preterm infants in the setting of a caesarean section (CS).

This study aimed to develop a guide as to how to best carry out a CS in the setting of an extreme preterm infant with intra-uterine growth restriction in a described scenario.

This was a multicenter qualitative study between The National Maternity Hospital, Dublin, Ireland; and Monash Health, Australia. Experienced consultants were asked to give an interview describing their technique for CS. Interviews were analysed using grounded theory until thematic saturation was achieved.

A total of 18 responses were recorded. Interviews covered preoperative, intraoperative and postoperative technique of CS delivery. There were major themes identified during this process which are described in detail.

The strengths of this study involved the collation of the collective experience of 18 senior clinicians, and the sampling of two separate large maternity units. Limitations of this study included the potential for bias given the use of qualitative data. We would suggest that this paper is a good guide to developing a technique for a potentially difficult delivery in the complicated extreme prematurity setting.

LEIOMYOMATOSIS PERITONEALIS DISSEMINATA FOLLOWING PREVIOUS HYSTERECTOMY

Abstract ID: 14

Dr. Claire M McCarthy (University Hospital Limerick), Mr. Kevin Hickey (University Hospital Limerick)

Leiomyomatosis peritonealis disseminata (LPD) is a rare condition characterised by the development of multiple smooth-muscle like nodules in the peritoneal cavity. It occurs due to a metaplasia of submesothelial multipotent mesenchymal cells. We describe a case of LPD, eighteen months following total abdominal hysterectomy (TAH). A 43 year old lady presented with a four week history of abdominal swelling on a background of a TAH, salpingectomy and infracolic omentectomy for a fibroid uterus in January 2015. Abdominal examination revealed a firm mass extending above the umbilicus. Her previous histology revealed a leiomyoma 28 x 27 x 15 cm with focal areas of degeneration and no evidence of malignancy.

Following her second presentation, a CT revealed a large solid heterogenous mass arising from the pelvis, measuring 20cm in diameter.

Subsequently, a midline laparotomy, removal of the abdomino-pelvic mass, bilateral oophrectomy and appendectomy and mesoappendectomy were performed. The mass weighed 4.135kg, and was closely adherent to both sigmoid colon, with a large vascular supply. There was a small lesion on the meso-appendix. An intra-operative transfusion of three units of red cells was administered, as the estimated blood loss was 3.1 litres. Histology from this specimen revealed a benign leiomyoma with necrosis and increased mitotic activity, with benign ovaries and a mesoappendix with focal small benign leiomyoma.

LPD was first described in 1952, with less than 200 reported cases worldwide since. It has been associated with both overproduction of female gonadal steroids and a mullerianosis.

Listeriosis complicating pregnancy. A Case Report

Abstract ID: 262

Dr. Rupak Kumar Sarkar (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda), Dr. M. Milner (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda)

Background

Listeriosis is a food borne infection that affects pregnant women 18 times more commonly than the general population. Presenting often as a mild flu like illness Listeria in pregnancy can cause pre term labour, neonatal sepsis, meningitis and even death.

Case

28 yr old lady of Asian origin (gravida 2, para 1) had booked for antenatal care in our hospital, presented at 26+5 weeks gestation with crampy severe lower abdominal pain and per vaginal bleeding and feeling generally unwell. She had a history of recent travel to her home country and consumption of indigenous food. She had chills on admission and had a complete septic work up. She was noted to have cervical changes and was managed as a case of Threatened Pre Term Labour with steroids, antibiotics and MgSO₄ infusion for fetal neuroprotection. She delivered a live female infant weighing 860 gms 18 hrs later.

Investigations and Outcome

A working diagnosis of Extreme prematurity and possible congenital sepsis was made. Maternal blood cultures revealed Gram Positive bacilli and on full culture Listeria monocytogenes was isolated. Both mother and baby were treated with high dose Amoxycillin .

Discussion

While maternal illness due to listeriosis may be mild , neonatal illness is often severe and may be fatal. Because listeriosis in pregnancy is serious and difficult to diagnose, blood cultures should be considered and treatment should be started if suspicion for listerial infection is high. More antenatal education needs to be provided regarding Listeria infection and practices around food safety.

LONG TERM OUTCOMES OF TRANSOBTURATOR TAPE FOR THE TREATMENT OF STRESS URINARY INCONTINENCE

Abstract ID: 6

Dr. Claire M McCarthy (University Hospital Limerick), Dr. Orfhlaith O Sullivan (Cork University Maternity Hospital), Dr. Barry O reilly (Cork University Maternity Hospital)

Transobturator tape(TOT) is a minimally invasive treatment for stress urinary incontinence(SUI), demonstrating good safety and efficacy. Long term follow-up studies over five years are less frequently reported, including those with concomitant pelvic floor surgery.

We assessed patient demographics, rates of concomitant surgeries and post-operative complications. We examined rates of re-referral and re-operation to establish regional success rates.

We conducted a retrospective observational study, assessing five to ten-year follow-up of female patients who underwent TOT tape placement(with a Monarc sling) from October 2004 to October 2009 in a tertiary level hospital under general anaesthesia.

During the study period, 235 patients underwent TOT placement, with 57(24.2%) patients having concomitant urogynaecology surgery. The average age and parity of patients was 51 years(range 29-85) and 3(range 0-10) respectively. 118(50.2%) were symptomatic of SUI for more than five years, and 57(24.2%) were diagnosed with mixed urinary incontinence. 4(1.7%) patients had previous surgery for SUI. Only 1 patient (0.4%) had an intra-operative bladder perforation, with 3(1.27%) patients suffering anaesthetic complications. De-novo overactive bladder (OAB) symptoms occurred in 20(8.5%) patients, with 8 (3.4%) patients experiencing voiding difficulties. Following discharge, 37(15.4%) patients were re-referred to a urogynaecology clinic, largely for OAB(12; 5.1%) and recurrent urinary tract infections(8; 3.4%). 6(2.5%) patients required a repeat sling operation, with 4(1.7%) people having division of TOT.

We demonstrate a large cohort of patients, demonstrating high levels of cure, and a low rate of recurrent SUI over a five to ten-year period, which is comparable to other retrospective studies, with low complication rates.

Lymphocytic Lymphoma & Uterine Prolapse: two cases

Abstract ID: 110

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AL Sudani AA, Sargent J*, & Milner M

Obstetrics & Gynaecology and Haematology*, Our Lady of Lourdes' Hospital, Drogheda

Lymphoma can present with pelvic organ prolapse, through several mechanisms: intra-abdominal pressure, direct involvement of the uterus or pelvic floor, & treatment for lymphoma. We present 2 cases of uterine prolapse where lymphoma was found to be underlying, which improved with treatment.

Case 1: A 76 year old lady had been attending for pessary support for uterine prolapse for 4 years. This progressively worsened whereby the ring could not be retained, she had 10 kg of weight loss, & a nonspecific skin rash of her face & body. Ultrasound imaging revealed significant mediastinal & pelvic lymphadenopathy, confirmed on whole body CT scan. para aortic lymph node biopsy demonstrated small cell lymphocytic lymphoma, & a staging bone marrow was performed. It was she had 4 cycles of chemotherapy (rituximab and chlorambucil). She has had a moderate reduction in both lymphadenopathy & prolapse symptoms.

Case 2: A 46 year old lady had vaginal hysterectomy for worsening menorrhagia & uterine prolapse. Post-operatively she developed a low-grade pyrexia when pelvic ultrasound to rule out a collection demonstrated retroperitoneal lymphadenopathy. Axillary node biopsy confirmed follicular lymphoma. her bone marrow was not involved. Clinically she is not symptomatic & has not required treatment.

Short to medium term worsening of pelvic organ prolapse should always prompt the gynaecologist to consider intra-abdominal pathology, including systemic disease e.g. lymphoma. treatment should be individualized based on the disease and patient best interest.

MANAGEMENT OF SEVERE OVARIAN HYPERSTIMULATION SYNDROME COMPLICATED BY DRAIN INFECTION

Abstract ID: 208

Dr. Sabina Tabirca (Cork University Maternity Hospital), Dr. Sie Ong Ting (University Hospital Limerick), Dr. John Waterstone (Cork University Maternity Hospital)

Ovarian hyperstimulation syndrome (OHSS) is a medical condition in women undergoing fertility treatment in which the ovaries are stimulated to increase the number of oocytes retrieved for assisted reproductive technology. In Ireland, the incidence of OHSS is reported as 0.8%. OHSS can be categorised into early onset which presents within 10 days after hCG treatment and late onset of 10 or more days.. OHSS is commonly self-limiting with spontaneous resolution but might sometimes persist for a longer period of time requiring medical attention.

We present a 40-year-old lady who attended CUMH with symptoms of severe OHSS 9 days post embryo transfer. On admission she had massive ascites and bilateral crackles on lung auscultation. A pigtail drain was inserted with a total drainage of 5 L. She was put on 8 hourly IV fluids with fluid input and output monitoring, LMWH and TEDs. LFTs, albumin, and FBC were checked daily. Throughout her admission her albumin level dropped below 20 on two occasions, day 2 and day 6. She received 2 units of albumin on both occasions.

On day 11 she started complaining of uncontrollable shakes, sweating and anxiety, with stable vitals. A full septic screen was taken. The aerobic blood cultures came back positive for gram + cocci with the focus of infection being the pigtail drain. She was put on Meropenem for 7 days, and oral Co-amoxiclav for another 7 days. The pigtail drain was removed before discharge. She is currently 16 weeks pregnant and doing well.

MANAGING A PREGNANCY IN A PRIMIGRAVIDA WITH END-STAGE RENAL FAILURE

Abstract ID: 214

Dr. Fiona O Toole (University College Hospital Galway), Dr. Kate O'Doherty (University College Hospital Galway), Dr. Siobhan Quirke (University College Hospital Galway), Prof. John Morrison (Perinatal Ireland, Royal College of Surgeons in Ireland, Rotunda Hospital)

This was an unplanned pregnancy in a thirty-one year old with chronic kidney disease, stage 4-5. The diagnosis was made incidentally two years previously, possibly related to childhood infections. Investigations revealed no definite cause. She was on a renal transplant list and had not yet required dialysis. She attended the high-risk obstetric clinic at nine weeks gestation for counselling and multi-disciplinary input. Her ACE inhibitor was changed to labetalol following a positive pregnancy test.

Dialysis commenced at twelve weeks gestation with an initial twice-weekly regime and target urea levels of 15-20mmol/L. Anti-hypertensives were increased regularly to maintain strict control and a portacath was sited to facilitate intensification of dialysis. She required in-patient admission at nineteen weeks gestation for severe hypertension. Proteinuria diagnostic of pre-eclampsia was found by twenty weeks gestation. She remained asymptomatic. Serial growth scans were performed from 14/40 and her normal anomaly scan demonstrated fetal biometry on the 50th centile. This patient was discharged at 21+2 with daily monitoring and dialysis six days a week.

Unfortunately this patient presented with a clinical abruption and subsequent intra-uterine demise at 21+5 weeks gestation. Fetal viability, pre-eclampsia and mode of delivery were all discussed during management. This patient was commenced on MgSO₄ and induced.

This case highlights the risks and potential poor outcomes in patients with advanced CKD despite maximal care and input. Intensification of dialysis has been associated with improved outcomes however risks remain significantly high. Close multidisciplinary collaboration between the nephrology and feto-maternal teams is required.

MEDICAL MANAGEMENT OF UNRUPTURED INTERSTITIAL PREGNANCY; CASE REPORT

Abstract ID: 54

Dr. Ahmed Koura (University Hospital Limerick), Mr. Mustafa Mohamed (University Hospital Limerick), Prof. Amanda Cotter (University Hospital Limerick), Mr. Gerard Burke (University Hospital Limerick)

Cornual pregnancy is a very rare type of ectopic pregnancy with an incidence of 2-4 % of all tubal pregnancies. It occurs in the part of fallopian tube which penetrates the muscular layer of the uterus. It has the highest mortality rate among all ectopic pregnancy cases (about 2.5%). Management is generally surgical, with only a small number of case reports have described medical treatment, our case is one of them.

It is associated with abnormal transportation of the fertilized ovum within fallopian tube. Possible risk factors as pelvic inflammatory disease, previous tubal surgery, congenital tubal anomalies and history of previous ectopic pregnancy have been suggested but exact cause is not known. Diagnosis depends mainly on ultrasound and on evaluation by laparoscopy.

Surgery can be associated with decreased fertility and increased rate of rupture uterus. Catastrophic hemorrhage can result from surgical intervention in this highly vascular area or from uterine rupture.

Our case is a 31 year primigravida, was diagnosed by ultrasound at 7 weeks with unruptured ectopic left cornual pregnancy. Patient was vitally stable. She was admitted and counselled re medical management. First dose methotrexate was given at 7 weeks and follow up by serum B-HCG and ultrasound. Fetal heart was still present. Second dose was given at 8 weeks and follow up by serial B-HCG levels and Ultrasound continued until complete resolution.

The diagnosis and treatment are challenging. In the hemodynamically stable patient, Methotrexate is safe option and can be an alternative to traditional surgical management, however close follow-up required.

MERMAIDS ARE REAL! TWO CASE REPORTS

Abstract ID: 38

Dr. Ahmed Koura (University Hospital Limerick), Dr. Sara Ahmed (Cork University Maternity Hospital), Dr. Edward Corry (University Hospital Limerick), Dr. Mendinaro Imcha (University Hospital Limerick)

Sirenomelia also known as “mermaid syndrome”, is a congenital anomaly presenting with lower limbs partially or completely fused, appearing like a fish tail. It is rare with probability of 1:100,000. It is associated with genitourinary, cardiovascular, respiratory and gastrointestinal defects. Due to renal agenesis and pulmonary hypoplasia, it is fatal.

First case was a 34 years old primgravid who presented with reduced fetal movement at 25 weeks of gestation. Anomaly scan showed bilateral renal agenesis, anhydramnios with suspected Potters syndrome. Lower limbs were not visualised. Induction of labour was planned at 36 weeks but patient presented in labour at 34 weeks. Spontaneous delivery of 1.5 kg stillbirth with fused lower limb and ambiguous genitalia. Chromosomal microarray from umbilical cord blood showed normal female karyotyping.

Second case was 28 years old G6p4+1 who had a booking scan at 12 weeks that showed single lower limb confirmed on anomaly scans. Patient was induced at 20 weeks due to absent fetal heart. Chorionic villous sampling and placental chromosomal analysis confirmed normal female karyotyping. Histology showed single umbilical artery.

No history of diabetes or radiation exposure, nor any family history of genetic or congenital malformation in both patients. Post-mortem autopsy was declined by both patients.

The etiology of sirenomelia remains unclear. Maternal diabetes, genetic predisposition, environmental factors and vascular steal phenomenon have been proposed as possible causative factors. Sirenomelia is easier to diagnose in first trimester. More extensive epidemiologic study is needed to identify etiology of this very rare congenital malformation.

METHOTREXATE FOR THE PRIMARY MEDICAL MANAGEMENT OF ECTOPIC PREGNANCY AND PREGNANCY OF UNKNOWN LOCATION

Abstract ID: 13

Dr. Claire M McCarthy (University Hospital Limerick), Dr. Mendinaro Imcha (University Hospital Limerick)

Ectopic pregnancy (EP) is a leading cause of maternal morbidity and mortality. There are strict selection criteria for administration of methotrexate for pregnancies of unknown location (PUL) and EPs.

We aimed to assess current compliance with the inclusion criteria for national protocol of medical management of EP and examine the management of PUL.

We carried out a retrospective audit of all patients receiving methotrexate over a one year period, interrogating pharmacy registers and then performing a chart review.

34 doses of methotrexate were dispensed to treat PUL and EP. 3 patients did not receive this, and 7 charts were not available for review. In total, data of 24 patients were analysed- 14 patients having an EP and 10 patients a PUL. The average gestational age was 6 weeks (range 3-9). The average hCG was 1274iu/L and 4 (16.6%) women had a hCG above 1500iu. The average mass size was 1.94cm (range 1.2-2.6cm), with 3 (12.5%) patients having free fluid. 4 patients did not have pre- methotrexate bloods done. The success rate of primary medical management was 83.3%, with 4 (16.6%) failed treatments, with 2 patients (8.3%) being treated out of protocol. Despite a high success rate, issues were identified with the recording of methotrexate, correct patient identification and failure to perform pre-methotrexate investigations. A number of changes were implemented, including education and the introduction of EP and PUL proforma for physicians and nursing staff. A re-audit will be carried out in 2017.

NEW ONSET OF GUILLAIN-BARRÉ SYNDROME IN POSTPARTUM PERIOD FOLLOWING CAESAREAN SECTION UNDER SPINAL ANAESTHESIA

Abstract ID: 80

Dr. Sie Ong Ting (Cork University Maternity Hospital), Dr. Mairead O'riordan (Cork University Maternity Hospital)

Background

Guillain-Barré syndrome (GBS) is a rare autoimmune disorder caused by demyelination and axonal degeneration resulting in acute polyradiculoneuropathy. The incidence of GBS in pregnancy is 6-24 cases per 100,000 and carries a higher maternal morbidity and mortality.

Case presentation

A 36-year-old Pakistani woman, para 3 presented to the emergency unit in CUMH 19 days post her elective caesarean section with bilateral leg weakness and unsteady gait as well as slight numbness on the sole one week post-surgery. Neurology consult was requested and her nerve conduction study revealed findings consistent with GBS. She received IVIG of 0.4g/kg for 5 days and physiotherapy. Symptoms improved and she was discharged home with neurology outpatient clinic follow-up.

Discussion

Guillain-Barré syndrome does not influence the nerve conduction for uterine contraction and cervical dilation, hence vaginal delivery is permissible. Vacuum extraction may be required as the ability to bear down is weakened. GBS can occur at any stage of the pregnancy but the incidence is increased in the third trimester and 2 weeks postpartum.

GBS is commonly presented as progressive symmetrical weakness starting from lower extremities in ascending pattern, areflexia, paraesthesia or neuropathic pain. Laboratory and electrophysiological investigation for the diagnosis of GBS is often non-specific. Lumbar puncture, antibody screening, electrocardiogram and nerve conduction study are included to diagnose GBS.

GBS is treated with 400mg/kg of IVIG for 5 days or immunomodulation with plasmapheresis.

Conclusion

GBS is a very rare disorder seen in obstetrics field and multidisciplinary approach is warranted for a better outcome.

NEW TREATMENT OPTION : HYSTEROSCOPIC TISSUE REMOVAL SYSTEM - A CASE SERIES

Abstract ID: 112

Dr. Teresa Treacy (Wexford General Hospital), Dr. Kate Glennon (Wexford General Hospital), Dr. Asish Das (Wexford General Hospital), Ms. Regina Tirbhowan (Wexford General Hospital)

Hysteroscopic Tissue Removal System (HTS) is a novel method of treating intrauterine pathology in symptomatic women; it can be implemented for polypectomy, morcellation of submucosal uterine fibroids, resection of uterine septum and evacuation of retained products of conception. Wexford is the only institution in Ireland currently utilizing the TRUCLEAR™ device as a method of hysteroscopic tissue removal. We present 52 cases of hysteroscopic tissue removal system performed in Wexford general hospital.

This was a retrospective review of all cases using TRUCLEAR™ device. A proforma of indication, method, findings and follow up is documented at each case; results were analysed using excel.

52 women with evidence of an intrauterine lesion had TRUCLEAR™ HTS performed in the operating theatre under general anaesthesia. The mean age of patients undergoing the procedure was 56 (range 31-85). Referral for HTS was for polyps (48), uterine fibroids (3) and retained products of conception in (1). In 52 women undergoing HTS, mean morcellation time was 3.0 minutes, mean fluid balance was 250ml and all procedures were uneventful. All patients were discharged on the day of the procedure and no intra-operative or post-operative complications were reported.

This case series has demonstrated HTS as a means of diagnosing and treating endometrial polyps, intrauterine fibroids and retained product of conception in a safe and time efficient way. HTS is a day case procedure and patients reported minimal postoperative pain. It is anticipated that TRUCLEAR™ HTS will be utilised in the outpatient setting within the next year in our centre.

NON-INVASIVE CARDIAC OUTPUT MONITORING (NICOM) CAN PREDICT THE EVOLUTION OF UTEROPLACENTAL DISEASE – RESULTS OF THE PROSPECTIVE HANDLE STUDY

Abstract ID: 161

Dr. Cathy Monteith (RCSI Rotunda), Ms. Lisa Mc Sweeney (RCSI Rotunda), Ms. Lucy Shirren (RCSI Rotunda), Dr. Anne Doherty (Rotunda), Dr. Colm R Breathnach (RCSI Rotunda), Dr. Elizabeth Tully (Perinatal Ireland, Royal College of Surgeons in Ireland, Rotunda Hospital), Dr. Patrick Dicker (Perinatal Ireland, Royal College of Surgeons in Ireland, Rotunda Hospital), Prof. Fergal Malone (Department of Obstetrics and Gynecology, Royal College of Surgeons in Ireland, Rotunda Hospital, Dublin, Ireland.), Prof. Afif El-khuffash (RCSI Rotunda), Dr. Dr Etaoin Kent (RCSI Rotunda)

To assess the ability of Non-Invasive Cardiac Output Monitoring (NICOM), a novel method of non-invasive maternal hemodynamic assessment using bioimpedance, to predict the evolution of pre-eclampsia (PET), gestational hypertension (GH) and intrauterine growth restriction (IUGR).

Low risk nulliparous women were enrolled in a single center prospective study. NICOM assessment was performed at 14 weeks gestation and data was obtained on cardiac output (CO), total peripheral resistance (TPR), indexed TPR (adjusted for maternal body surface area; TPRi), systolic blood pressure (SBP) and diastolic blood pressure (DBP). Logistic regression was used to model GH, PET and IUGR with NICOM measurements as predictors. Linear, non-linear and interaction terms were assessed using the Akaike Information Criterion.

The hemodynamic profile of pregnancies complicated by uteroplacental disease- GH (18), PET (6) and IUGR (18) were compared to 282 healthy unaffected pregnant controls. The best independent predictor for the evolution of uteroplacental disease at 14 weeks' gestation was TPR/ TPRi ($p=0.007$ and $p=0.005$ respectively) in the prediction of GH. The performance of hemodynamic variables was enhanced when combined in a multivariate logistic model. We demonstrated that CO and TPR when combined with BP were significant predictors of pregnancies complicated by IUGR (AUC =0.67, $p=0.02$). Whereas in pregnancies complicated by PET, HR and SVi in combination with BP were also statistically significant predictors (AUC= 0.77 $p=0.006$ and $p=0.008$ respectively). NICOM derived maternal hemodynamic profile at 14 weeks' gestation has the novel potential to discriminate pregnancies which will ultimately develop uteroplacental disease.

Novel management of ITP resistant to IVIG and steroids

Abstract ID: 167

Dr. Grace Ryan (MMUH), Dr. Vicky O dwyer (National Maternity Hospital), Prof. Mary Higgins (National Maternity Hospital), Dr. Shane Higgins (National Maternity Hospital), Ms. Celine O brien (National Maternity Hospital), Dr. Karen Murphy (St. Vincent's University Hospital), Ms. Ja Byrne (National Maternity Hospital), Prof. Fionnuala Mcaulife (University College Dublin), Ms. A Clohessy (National Maternity Hospital)

Management of Immune thrombocytopenia (ITP) in pregnancy can be challenging. ITP has implications for intrapartum care, maternal and fetal outcomes.

We present two cases of ITP in pregnancies that were resistant to treatment with IVIG and oral steroids.

The first patient attended for a booking visit at 11 weeks gestation. Her platelet count was 11. She had no previous medical history. She was treated with IVIG and azathioprine with a good but short-lived response. At 18 weeks her platelet count was 33 and she was commenced on rituximab. At 37 weeks she went into spontaneous labour, with a platelet count of 154. She had epidural analgesia and a vaginal delivery of a healthy baby with a normal platelet count. At 6 weeks postpartum her platelets were 194 off medication.

Our second patient had a history of ITP. She transferred care from a peripheral hospital at 24 weeks gestation with a platelet count of 21. At 27 weeks despite IVIG and prednisolone her platelet count was 25. She was commenced on azathioprine. At 31 weeks due to no improvement she started cyclosporine. At 39 weeks her platelet count was 112. She was induced at 40 weeks and had caesarean section for a non-reassuring CTG. She had a healthy baby with a normal platelet count. Postpartum her platelet count was 47.

Consideration can be given to the use of rituximab and cyclosporine for ITP resistant to standard treatment and appear to be safe and effective treatments in pregnancy.

NOVEL MEASUREMENT OF MATERNAL FUNCTIONAL PHYSICAL CAPABILITY IN EARLY PREGNANCY

Abstract ID: 209

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Objective data on maternal physical fitness and function during pregnancy is limited. There are no established indices for fitness or function developed for pregnancy.

We aimed to explore the use of modified exercise tests for assessment of physical fitness and function in pregnant women, and the influence of BMI on these measurements.

Women were recruited conveniently and prospectively at their first prenatal visit. Height was measured to the nearest centimetre using a wall-mounted stadiometer. Body mass index (BMI) and body composition (BC) were measured using bioelectrical impedance analysis (Tanita MC-180). Heart rate was determined at rest and immediately after each exercise test. Each woman performed a one-minute step test, a timed 10-repetition chair-rise test, and a hand-grip strength dynamometer test. Results were analysed according to BMI category and maternal adiposity.

Of 150 women 32.0% were obese and 47.3% were nulliparas. Only one post-exercise heart rate exceeded 152 bpm. All three tests combined took on average 8.5 min. No woman reported any ill effects or safety concerns. Performance in all three functional tests in early pregnancy were impaired in obese women compared with women with a normal BMI.

Functional exercise testing is quick, inexpensive and safe in early pregnancy, and discriminates physical function across BMI categories. It remains to be determined whether the differences between normal and obese women are a consequence of lower habitual physical activity in the latter. Further studies will examine the relationship between physical fitness and function as pregnancy advances and with fetomaternal clinical outcomes.

OHVIRA Syndrome – An unusual cause of dysmenorrhoea & abdominal pain in adolescents

Abstract ID: 91

Dr. Niamh Fee (Natio), Dr. Venita Broderick (UCD Obstetrics and Gynaecology, National Maternity Hospital), Dr. Orla Sheil (UCD Obstetrics and Gynaecology, National Maternity Hospital)

OHVIRA1 syndrome represents the triad of Obstructed HemiVagina Ipsilateral Renal Agenesis & Uterus didelphys. We wish to highlight awareness of this condition. We present 3 recent cases of OHVIRA syndrome.

1)17-year old referred by her GP with a 6 month history of abdominal pain, back swelling and severe dysmenorrhoea. Menarche at age 13 with regular periods. Ultrasound revealed a solitary right kidney and a large pelvic mass. MRI revealed a large haematocolpos 18cmx10cmx9cm. EUA was performed and division of the vaginal septum with drainage of the haematocolpos and haematometra.

2)14-year old referred with abdominal/back pain with menarche at age 12. On examination, a large mass was palpable arising from the pelvis. Ultrasound revealed a bicornuate uterus and absent left kidney. EUA was performed and the left vagina incised with drainage of large haematocolpos and haematometra.

3)25-year old was referred from colposcopy clinic. She had an abnormal uterus diagnosed in Mexico age 12. MRI revealed a vaginal septum, uterine didelphus and haematocolpos. On examination a right-sided vaginal mass was identified. This patient is currently awaiting EUA and excision of vaginal septum; she is likely to have a communicating tract which is preventing accumulation of a large haematometra.

Early diagnosis is important to treat acute symptoms and prevent long term complications such as endometriosis and pelvic adhesions. OHVIRA syndrome should be considered in girls presenting with recurring abdominal or worsening dysmenorrhoea. An absent or dysplastic kidney warrants investigation for Müllerian abnormality.

OHVIRA SYNDROME: AN UNUSUAL PRESENTATION

Abstract ID: 281

Dr. Aoife McSweeney (Gynaecology Department, Tallaght Hospital, Dublin 24), Dr. Daniel Galvin (Gynaecology Department, Tallaght Hospital, Dublin 24), Prof. Richard Deane (Gynaecology Department, Tallaght Hospital, Dublin 24), Dr. Aoife Mullally (Coombe Women and Infants University Hospital)

Introduction

Obstructed HemiVagina with Ipsilateral Renal Agenesis (OHVIRA) is a rare complex uterine anomaly consisting of uterine didelphys, unilateral obstructed hemivagina and ipsilateral renal agenesis. It typically presents either in infancy due to collection of secretions in the vagina or shortly after menarche with dysmenorrhea or pelvic pain. We present a more atypical presentation.

Case

A 13 year old girl presented to the emergency department with urinary retention for 20 hours. She was systemically well. She had a background of a solitary left kidney. She had experienced menarche 6 months prior and her LMP was 2 months earlier and associated with dysmenorrhea. Examination was unremarkable. No abnormality was detected on urinary dipstick and her bloods revealed a leukocytosis but normal renal function. Ultrasound was performed which revealed uterine didelphys. The left hemiuterus appeared normal whilst the right was distended with a haematometra. This was in continuation with the vagina, which showed a haematocolpos and a vertical septum.

EUA, incision of septum, drainage of haematometra and haematocolpos and hysteroscopy were performed. The patient was passing urine comfortably the following morning. Subsequently MRI pelvis confirmed the earlier findings.

Discussion

OHVIRA syndrome occurs due to developmental arrest of the unilateral mesonephric duct. Potential sequelae include pelvic pain and endometriosis due to retrograde menstruation. Surgical management involves formal resection of the septum. Hemihysterectomy is no longer recommended and pregnancy is achievable in both hemiuteri. This case highlights the value not only of ultrasound, but also MRI in the diagnosis of these complex uterine anomalies.

ONE YEAR RETROSPECTIVE AUDIT OF CAESAREAN SECTIONS PERFORMED FOR BREECH PRESENTATION IN UNIVERSITY HOSPITAL WATERFORD

Abstract ID: 47

Dr. Bart Goldman (University Hospital Waterford), Dr. Shazia Iqbal (University Hospital Waterford), Dr. Sara Muddasser (University Hospital Waterford), Dr. Oyenike Olowo (University Hospital Waterford)

To investigate if our caesarean section(C/S) rate for breech presentation was within normal limits and whether women were offered an external cephalic version attempt.

The aims were to determine if the patients who met the criteria for external Cephalic Version (ECV) were offered an attempt and a second attempt if needed. We also looked at the usage of muscle relaxants, fetal monitoring, complications, rates of undiagnosed breech presentations and the uptake of ECV amongst patients.

A questionnaire was designed based on the RCOG guideline on ECV, the following inclusion criteria had to be met: nulliparous women from 36 weeks gestation and Multiparous women from 37 weeks gestation onwards at the time of delivery. Both elective and emergency C/S were included. Women who had contra indications to ECV, vaginal breech deliveries and a previous uterine scar were excluded from the audit. A Retrospective file review was used to complete the questionnaire.

Our C/S rate for breech is 11%. 57% of the cases were primigravida women and 43% Multiparous women. The majority of the C/S were performed on an elective basis. 42 of the cases were diagnosed antenatally and 3 were undiagnosed.

No ECV attempts were performed with tocolytic cover. 2 Cases had no fetal monitoring before the ECV attempt. 1 case had no monitoring before or after the ECV attempt. No second ECV attempts were offered.

Greater patient and clinician education regarding ECV should be offered. Tocolytic cover should be used.

Optimising the Approach to Questionnaire Development for Evaluation of Women's Perception of Bedside Teaching

Abstract ID: 42

Dr. Nicola O Riordan (National Maternity Hospital), Ms. Michelle Carty (University College Dublin), Prof. Mary Higgins (UCD Obstetrics and Gynaecology, National Maternity Hospital)

Optimising education of future obstetricians/gynaecologists is fundamental to the preservation of the current high standards of practice and to future advancement of the speciality. Bedside teaching (BST) is a traditional and unsurpassable method of educating within the clinical environment. However, in the era of advancing technology and an increasing "consumer-based" approach to medical care, there is a palpable threat of decline of this valued education method. This threat is most pertinent for Obstetrics and Gynaecology, where due to the sensitive nature of examinations there is an increased reluctance from patients to participate in BST.

We recently conducted qualitative research focused on the psychological impact of BST on obstetric/gynaecology patients using a series of interviews. Our study aimed to follow on from this by systemically designing a questionnaire to further explore the themes identified in our previous study.

Beginning with a thorough literature review, we progressed to expert analysis of data. Information was then collated from the previous study and analysed it to develop a questionnaire which represented all relevant identified themes. Following this, cognitive testing of the questionnaires on a sample population was performed, prior to statistical analysis of the results.

Our study aims to demonstrate the importance of a rigorous approach to formulation in order to produce a robust questionnaire, allowing for more precise extrapolation of data and a focused exploration of patient-centered results.

Osseous Metaplasia, a cause for secondary infertility

Abstract ID: 186

Dr. Clare Kennedy (National Maternity Hospital), Dr. Claire O Reilly (National Maternity Hospital), Dr. Dr Fiona Martyn (National Maternity Hospital), Dr. Helen Spillane (Merrion Fertility Clinic, National Maternity Hospital)

An unusual cause of secondary infertility was found in a young woman attending our clinic. Endometrial osseous metaplasia is a rare entity described in the literature but this case was unusual due to the large sheet of bony tissue present in the uterus.

A 36 year old woman presented with a 2 year history of infertility. She had a history of a surgical termination of pregnancy which was carried out 15 years previously. As part of her initial workup she had a transvaginal ultrasound performed. This revealed a very echogenic focus in her endometrial cavity extending along the endometrial stripe.

Outpatient hysteroscopy revealed a large sheet of thin bone extending through out her endometrial cavity, acting almost like an intrauterine device.

As the bony fragment was too large to remove in the outpatient setting, she had a hysteroscopy under general anaesthetic and the fragment was removed in one piece with a large polyp forceps. Histological examination confirmed the suspicion of osseous metaplasia.

Osseous metaplasia is a rare complication of surgical termination of pregnancy. There are a number of theories for the cause of bone formation including persistence of fetal bone and metaplasia of stromal cells. The most widely accepted theory appears to be the latter. It is thought that pluripotent mesenchymal cells undergo metaplasia to osteoblastic cells perhaps in response to irritation from inflammation or curettage.

Endometrial osseous metaplasia while rare, should be considered in women who have had previous surgical terminations. It is important to highlight this condition as a potentially treatable and reversible cause for infertility.

OUTCOME OF MOTHER AND NEONATES WITH RHESUS AND OTHER BLOOD GROUP ANTIBODIES

Abstract ID: 184

. Laure Experton (Graduate Entry Medical School, Royal College of Surgeons in Ireland, Dublin), Mr. Colin Kirkham (Obstetrics and Gynaecology, Rotunda Hospital, Dublin), Dr. Cathy Monteith (Department of Obstetrics and Gynecology, Royal College of Surgeons in Ireland, Rotunda Hospital, Dublin, Ireland.), Dr. Mary Holohan (Obstetrics and Gynaecology, Rotunda Hospital, Dublin), Dr. Jennifer Donnelly (Department of Obstetrics and Gynecology, Royal College of Surgeons in Ireland, Rotunda Hospital, Dublin, Ireland.)

Haemolytic disease of the fetus and newborn (HDFN) results from maternal red blood cell (RBC) antibodies directed against fetal RBCs and can lead to serious perinatal complications.

To review the prevalence of clinically significant antibodies among a cohort of pregnant women attending a tertiary maternity hospital and to assess their obstetric and neonatal outcomes.

A five year retrospective review of all pregnant women (including miscarriage, hydatidiform moles and ectopic pregnancy) who had an antibody screen in a tertiary referral centre between 1/1/2011 and 31/12/2015. Haematological, obstetric and neonatal data were identified from hospital databases. Ethical approval was obtained. Statistical analysis was carried out using SPSS v22.

The prevalence of clinically significant antibodies among pregnant women screened was 0.53% (279/52150). Anti-M (n=77, 22.7%), anti-E (n=70, 20.6%) and anti-D (n=60, 17.7%) were the most common. Of the thirty four percent liveborn neonates (79/229) with a positive direct Coombs test (DCT), those associated with anti-D or anti-c had a lower mean gestational age (37.1 and 38.4 weeks) and haemoglobin level (123.8 and 146.2 g/L) at delivery compared to other antibodies. They were also more frequently admitted to the neonatal intensive care unit (22/33, 65% and 7/12, 58%) for phototherapy (23/34, 72% and 6/12, 50%) and exchange transfusion (11/34, 32% and 1/12, 8%).

In our population, the frequency of clinically significant antibodies was 1 in 187 pregnancies. As expected, the presence of rhesus (Rh) antibodies D or c was associated with worse perinatal outcomes. Results support current practices for antibody screening and RhD prophylaxis.

OUTCOMES OF ASCUS AND LSIL REFERRALS SEEN AT OUR COLPOSCOPY UNIT IN TALLAGHT HOSPITAL AND A REVIEW OF THE MANAGEMENT, OUTCOMES AND FOLLOW UP OVER A 12 MONTH PERIOD

Abstract ID: 247

Dr. Maebh Horan (Wexford General Hospital), Dr. Niamh Rafter (tallaght hospital dublin), Dr. Nadine Farah (Gynaecology Department, Tallaght Hospital, Dublin 24)

Background:

The National Cervical Cancer Screening Programme was launched in Ireland in 2008. The successful introduction of a national cervical screening programme has the potential to reduce current incidence rates from cervical cancer among women in Ireland by up to 80%.

Study Method:

We looked at patients referred to our colposcopy unit in 2013 with a diagnosis of ASCUS or LSIL. Of these, we audited the outcomes of those classified as low grade by our colposcopists, and retrospectively reviewed their demographics, management and outcomes with their follow up histology and cytology results.

Results:

In our study, 492 patients out of 890 referrals were deemed low grade at colposcopy. A biopsy was performed in 334 patients. 225 were classified as CIN 1, 52 as CIN2 and 21 as CIN 3, histology was unsatisfactory in 58 cases. 158 of our patients did not undergo biopsy.

Within the biopsy group, 21% remained both HPV and cytology positive; 57% had cleared HPV and demonstrated no cytological atypia. Of those deemed as appearing normal at colposcopy, only 18% were both HPV and cytology positive at one year; 56% demonstrating neither HPV or cytological atypia at one year. A twelve month review of patients classified as low grade who did not undergo biopsy 20% were HPV and cytology positive, while 55% were HPV negative with normal cytology.

Conclusion

HPV testing for cancer-associated HPV DNA along with repeat smear and follow up colposcopy, is a viable option for the conservative management of women with ASCUS and LSIL.

OUTCOMES OF INDUCTION OF LABOUR FOR POST DATES IN OLOLH DROGHEDA.

Abstract ID: 106

Dr. Shazia Babur (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda), Dr. Ciara Carroll (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda), Dr. Vineta Cipriki (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda)

Back Ground:

Women with uncomplicated pregnancies should usually be offered induction of labour at 41+0 and 42+0 weeks of gestation to avoid the risks of prolonged pregnancy. The timely onset of labour and delivery is an important determinant of perinatal outcome.

Aim:

To look into the process of induction for post dates in our unit in line with recommendations of NICE guidance (clinical guide line 70_IOL July 2008).

The current policy for IOL for post dates in our unit is T +10-14.

Methods:

Retrospective study performed. Sample of 51 patients who were induced for post dates from June-August 2016 were selected from the Maternity information system.

Results:

Out of 51 women in our study group, 8 women were induced less than 41 weeks of gestation. The over all cesarean section rate in IOL for post dates group was 27.4% but for women who were induced less than 41 weeks of gestation the cesarean section rate was much higher at 37%.

Conclusion:

In our unit 15% women are being induced before the recommended criteria for post dates, this is increasing the C section rates. We recommend a review of our Hospital policy. There is an opportunity to introduce a new policy to induce women at T + 10-13 which will aim to reduce the cesarean section rate.

Reference:

Nice Clinical Guidance 70-IOL July 2008.

Outpatient Hysteroscopy - Correlating Imaging with Hysteroscopy

Abstract ID: 287

*Dr. Andrew Downey (WGH), Ms. Regina Tirbhowan (Wexford General Hospital), Dr. Sorca O'Brien (Wexford General Hospital),
Dr. Asish Das (Wexford General Hospital)*

OPD hysteroscopy is a safe and economic way to manage patients with abnormal uterine bleeding. When compared with day case hysteroscopy under general anaesthetic, outpatient hysteroscopy has comparable safety and economic benefits for patients and the health service. OPD hysteroscopy was established in Wexford General Hospital in 2014. We audited cases to assess the service.

This was a retrospective audit from January 2014 to January 2015. The in house register of all cases was consulted with additional details acquired from the NIMIS radiology system. Results of radiological investigation, gross findings and histopathology findings were compiled.

Results

164 patients attended the OPD hysteroscopy service during the reference period.

Average Age = 49ys

Main indication for referral was Post-Menopausal Bleeding = 44 (26.8%), Menorrhagia = 44 (26.8%) and Irregular Period Bleeding = 41 (25%)

Transvaginal USS was performed in 62.8%

Endometrial Thickness was measured in 72.6%

The most common findings at ultrasound were Normal (65.8%) and Fibroid 20.7%

The most common hysteroscopic findings were Normal 35.9% and polypoid 27.4%.

The most common histopathological findings were Benign Endometrial Polyp 23.1% and proliferative 22.6%

There was low rate of concerning pathology.

Focal Complex Hyperplasia without Atypia 0.6%

High Grade Spindle Cell Tumour 0.6%

In conclusion, OPD hysteroscopy is an excellent addition to the gynaecology services in Wexford General Hospital run by dedicated staff. It continues to provide departmental economic savings while providing a rapid access point for patients with potentially concerning bleeding patterns and suspected pathology.

OVARIAN SMALL CELL CARCINOMA HYPERCALCEMIC TYPE: A CASE REPORT.

Abstract ID: 93

Dr. Muna Rahma (Obstetric and Gynaecology Department, South Tipperary General Hospital, Clonmel, Co. Tipperary), Dr. Mohamed Abbas (Portiuncula University Hospital, Ballinasloe)

This is a case report of small cell carcinoma of the ovary hypercalcaemic type (OSCCHT) . A rare aggressive ovarian tumour of which less than 300 cases were reported.

A 31 year old nulliparous female was referred by GP with lower abdominal pain for 3 weeks. Her medical history was insignificant except for irregular periods for the last 2 months. She had ultra sound scan (USS) report, which showed a 6.8cm cystic tumour found in the left ovary. Gynaecological examination revealed a large tender pelvic mass in the pouch of Douglas (POD) palpable at the upper anterior wall of the vagina.

USS was repeated and confirmed a large mass with solid and cystic areas in POD between the rectum and the uterus .The solid part measured (6.08x5.32x6.1cm) and the cystic part (2.87x2.18x6.1cm). Ovaries could not be visualized. Tumour markers were normal. Liver, renal, coagulation profile and blood counts were normal. Serum calcium was not measured.

A CT scan confirmed USS findings. It showed the mass arising from the left adnexa and displacing the uterus. Left ovary was not identified. The right ovary appeared normal.

At laparoscopy, view was difficult and laparotomy was performed. The uterus and right ovary appeared normal. There was haemoperitoneum and a ruptured left adnexal mass , left oophorectomy was performed . Abdominal toilet was done. All samples were sent for urgent histology. The histology diagnosis was “small cell carcinoma of the ovary, Hypercalcaemic type”. Patient was referred to gynaecological oncologist where she received chemotherapy.

OVARIAN VEIN THROMBOSIS:A COMMON INCIDENTAL FINDING INPATIENTS UNDERGONE TOTAL ABDOMINAL HYSTERECTOMY BILATERAL SALPINGO-OOPHORECTOMY.(TAH BSO).

Abstract ID: 118

Dr. Shazia Babur (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda), Dr. Vineta Ciprike (Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda)

Introduction:

Ovarian vein thrombosis (OVT) is rare but serious condition that affects mostly postpartum but may also be associated with Pelvic inflammatory disease, Malignancies and Pelvic surgical procedures. A high index of suspicion required in order to diagnose this unusual cause of abdominal pain.

Case Presentation:

A 59 years old women undergone TAH BSO for large uterine fibroid. Mid line incision was used from symphysis pubis up to the umbilicus, large fibroid of 4.2 kg was removed.

Pt has been well in post operative period and was discharged home on D7. Followed up in Gynae out patients (GOPD) 6 weeks post operative, histopathology suggestive of benign disease, discharged from GOPD.

Pt presented to emergency dept after 3 months of surgery with history of right iliac fossa pain (RIF) pain, on admission pt was quite tender in RIF. CRP was 62mg/l rest of the bloods were normal.

Pt was admitted under surgeons & computed tomography (CT) abdomen & pelvis was performed. CT showed 7mm of right renal stone along with incidental finding of right ovarian vein thrombosis. Pt was referred to urologists for the management of renal stone.

Pt was referred to medical team in relation to OVT and was started on anticoagulants for 3 months.

Discussion:

Common signs & symptoms of OVT include lower abdominal pain or flank pain, fever & leukocytosis. Anti coagulants & antibiotics are the main stay of treatment.

References:

The New England Journal of Medicine 2011,364,21.

Anatolian Journal of Obstetrics & Gynaecology 2011, issue 3.

World Journal of Emergency Surgery 2011,645.

PARROT Ireland; Recruitment Feasibility Study

Abstract ID: 10

Ms. Lucy Bolger (Royal College of Surgeons in Ireland), Dr. Deirdre Hayes-ryan (Cork University Maternity Hospital), Prof. Louise Kenny (Cork University Maternity Hospital)

Background: A recent study (PELICAN) has shown a low Placental growth factor (PIGF) to have a high sensitivity and negative predictive value for the need for delivery for confirmed pre-eclampsia (PET) within 14 days in women presenting before 35 weeks gestation. The PARROT Ireland study is a stepped wedge cluster randomised control trial that aims to establish the effectiveness of PIGF measurement in reducing maternal morbidity, with the assessment of neonatal morbidity in parallel in women presenting with suspected PET at <37 weeks.

Purpose: To quantify the number of suitable women presenting over one week to CUMH. This information will be used to estimate the numbers presenting annually to the 7 maternity units involved and thereby assess if the observation targets for the forthcoming PARROT Ireland study are achievable.

Methods: This was a prospective observational study conducted in CUMH from 20th-26th June 2016. The Emergency Room (ER), Antenatal Wards (ANW) and Fetal Assessment Unit (FAU) were observed for women fulfilling the inclusion criteria for PARROT Ireland.

Results: Over the course of the entire week 21 women that met the inclusion criteria presented to CUMH.

Discussion: With PARROT Ireland having an observation target of 4000 over 24 months, broken down to 700 for CUMH and the other equivalently sized units, we would hope to include 29 per calendar month, excluding weekends and bank holidays. These figures show that the observation targets for the study are achievable in the projected timeframe.

PATIENT SATISFACTION WITH JOINT UROGYNÆCOLOGY – COLORECTAL PELVIC FLOOR SURGERY

Abstract ID: 59

Dr. Bobby O Leary (Pelvic Floor Centre, St. Michael's Hospital), Ms. Ann Hanly (Pelvic Floor Centre, St. Michael's Hospital), Dr. Gerard Agnew (Pelvic Floor Centre, St. Michael's Hospital)

Background

Pelvic floor dysfunction is a global term used to describe conditions such as pelvic organ prolapse, and faecal or urinary incontinence. Traditionally these problems are dealt with by a variety of specialists working independently. The Pelvic Floor Centre (PFC) is a multi-disciplinary clinic with consultant colo-rectal and urogynaecology surgeons, with physiotherapy and clinical nurse specialist support.

Purpose of Study

The aim of this study was to assess patient satisfaction following joint colo-rectal and urogynaecology surgery in the Pelvic Floor Centre.

Study Design and Methods

All patients who underwent a joint procedure over the last year were identified and contacted via telephone. Patient satisfaction was assessed using the Surgical Satisfaction Questionnaire (SSQ-8).

Findings

15 patients underwent joint surgeries between October 2015 and October 2016. All patients consented to the questionnaire. 10 (66.7%) patients underwent vaginal repair, 8 (53.3%) underwent anal sphincter repair, 3 (20%) had mid-urethral slings, one (6.7%) underwent a PTQ injection, and there was one (6.7%) Stapled Trans-Anal Resection of the Rectum (STARR).

Overall 13/15 (86.7%) of patients were satisfied with their surgery, and would recommend it to others with a similar condition. All patients were satisfied that their pain was well controlled after discharge. 11/15 (73.3%) of patients were satisfied with the time taken to return to daily activities, work, and their exercise routine.

Conclusions

There is a high level of satisfaction amongst patients undergoing joint colo-rectal and urogynaecology surgery at the PFC. Further investigation into patient's satisfaction with the clinic itself, and international comparison is warranted.

PATIENTS' PERCEPTION OF PRIVACY AND CONFIDENTIALITY IN THE EMERGENCY ROOM OF A BUSY OBSTETRIC UNIT

Abstract ID: 32

Dr. Lucia Hartigan (Cork University Maternity Hospital), Dr. Leanne Cussen (Cork University Maternity Hospital), Ms. Sarah Meaney (University College Cork), Dr. Keelin O'Donoghue (Cork University Maternity Hospital)

Privacy and confidentiality are central components of patient care and are of particular importance in obstetrics and gynaecology, where clinical situations of a very sensitive nature occur regularly. Obstetric emergency rooms (ERs) are invariably busy locations, where it can prove difficult to provide the level of sensitivity many presentations require. Additionally, the layout of such departments is often ill-conducive to maintaining privacy at such critical junctures.

We aimed to discover if changing the environment can change patient perception of their experiences in the ER.

We conducted a survey asking patients questions about their perception of privacy and confidentiality in our ER. We then repeated the survey following renovations. The size of the unit remained the same, however, individual cubicles were installed to replace curtains which had previously separated the beds. There were 75 pre-renovation surveys and 82 post-renovation surveys completed. 86% (n=135) of those surveyed were pregnant with the remaining 14% (n=22) comprising post-natal or gynaecology patients. 24.2% (n=38) of those surveyed attended a consultant privately.

Before the renovations took place, only 21.3% (n=16) found their privacy to be adequate during their visit to the ER however this rose to 89% (n=73) in the post renovation survey which is a highly significant finding. $p < 0.000$. 49.3% (n=37) of the patients who were surveyed pre-renovation admitted to overhearing a conversation about themselves during their visit to the ER whereas post-renovation this fell to 11% (n=9) $p < 0.000$. 49.3% (n=37) of the patients who were surveyed pre-renovation also had overheard a conversation about another patient while in the ER and this fell to 9.8% (n=8) $p < 0.000$ following refurbishments.

Our study has shown that patients' perception of privacy and confidentiality significantly improved following the refurbishment of the ER.

Pelvic inflammatory disease in a virgin girl

Abstract ID: 203

Dr. Oana Grigorie (Cork University Maternity Hospital), Dr. Olumuyiwa Ayodeji (University Ho)

Introduction: Literature describes very few cases of pelvic inflammatory disease in virgin women. There were only 8 cases described, the majority of which had no bacterial growth on cultures.

Case presentation: 15 years old girl with history of pelvic inflammatory disease diagnosed at 11 years of age came to emergency room pyrexial and unwell. Vital signs, blood results and imagistic findings were consistent with tuboovarian abscess. She underwent laparotomy and the bacterial growth revealed E. coli infection. She was discharged home 9 days after her admission.

Discussion: Although extremely rare in virgin women, a tuboovarian abscess is a diagnosis that should be taken into consideration when the clinical picture is present. Rare cases of tuboovarian abscess in virgin girls may require surgical intervention to clarify the differential diagnosis. Early diagnosis and surgical treatment are essential to prevent further sequelae and improving outcome.

PERINATAL BLOOD TRANSFUSION IN A TERTIARY LEVEL UNIT

Abstract ID: 207

Mr. Shane Kelly (University College Dublin), Dr. Joan Fitzgerald (National Maternity Hospital)

The circumstances in which a physician decides to transfuse have been shown to vary greatly dependent on both physician and patient factors. The aim of this study was to review transfusion procedures correlated to clinical outcomes over a one year period.

Retrospective review of transfusion procedures and outcomes in pregnant and postpartum women delivering in the National Maternity Hospital. Obstetric patients who received a red cell transfusion in 2015 were identified. Demographics, blood transfusion events and blood tests were retrieved and recorded with transfusion location, prescribing physician, reason for transfusion, record of consent and iron intake.

166 women received a RCC transfusion in 2015; results are presented on 113 women. Median number of units transfused was 2 (1-19); the most common indication was due to anaemia (77.8%) with 25 women transfused due to active bleeding.

In general, consultant physicians had a lower Haemoglobin transfusion threshold than trainees (consultant median Hb 6.6g/dL, residents 7.0g/dL).

In the absence of active bleeding, <11% of women had their haemoglobin checked after the first unit of blood transfusion.

All women had at least one second or third trimester check of Haemoglobin status; the majority (81%) had normal levels; half of those with anaemia had documented iron therapy.

A written record of consent was present in 43% of cases.

Several factors have been highlighted that may reduce the number of future RCC transfusions. As well as improving demand on blood supply, this also affects patient care, avoiding possible complications of transfusion.

Pilot study on the use of Dilapan-S osmotic dilators for cervical ripening prior to labour induction

Abstract ID: 248

Dr. David Crosby (UCD Obstetrics and Gynaecology, National Maternity Hospital), Dr. Claire O'Reilly (National Maternity Hospital), Ms. Helen Mchale (National Maternity Hospital), Prof. Fionnuala M McAuliffe (UCD Obstetrics and Gynaecology, National Maternity Hospital), Dr. Rhona Mahony (National Maternity Hospital)

Background

The mechanisms for induction of labour are generally divided into two categories: mechanical and pharmacological. Both methods employ prostaglandins (excluding oxytocin) to promote cervical ripening; mechanical methods cause physical dilation of the cervix and increase the release of endogenous prostaglandins while pharmacological methods involve oral or vaginal administration of exogenous prostaglandins .

Purpose of study

The purpose of this pilot study is to evaluate Dilapan-S, a mechanical dilator, for cervical ripening in labour induction with main focus on Bishop score change, and vaginal delivery rates compared with dinoprostone (pharmacological).

Study Design and Methods

We propose a prospective pilot study in the National Maternity Hospital, Dublin. 50 primiparous women, scheduled for induction of labour for post dates will be recruited from July to mid-November 2016 (25 Dilapan/25 Dinoprostone). Exclusion criteria include maternal age < 18 years or >40 years, BMI $\leq 30\text{kg/m}^2$ and complicated antenatal course. Recruitment will be complete in mid-November 2016 and maternal and neonatal outcome data will be analysed using SPSS version 23.0.

Conclusion

This pilot study will be the first clinical trial to compare the effectiveness of mechanical and pharmacological methods (Dilapan-S and dinoprostone) for cervical ripening prior to labour induction, prior to introduction in our institution.

PLACENTAL AND UMBILICAL CORD MORPHOMETRY OF PREGNANCIES WITH SMALL FOR GESTATIONAL AGE INFANTS

Abstract ID: 137

Dr. Khadijah Irfah Ismail (University Hospital Limerick), Prof. Ailish Hannigan (Graduate Entry Medical School, University of Limerick), Dr. Brendan Fitzgerald (Department of Pathology, Cork University Hospital), Dr. Peter Kelehan (Department of Pathology, National Maternity Hospital, Dublin), Dr. Keelin O'Donoghue (Cork University Maternity Hospital), Prof. Amanda Cotter (Graduate Entry Medical School, University of Limerick)

Multiple factors contribute to infants being small for gestational age (SGA), including placental and umbilical cord (UC) abnormalities. Research focuses on timely antenatal detection of SGA, to reduce associated risks of perinatal mortality and morbidity. We aimed to examine different morphological characteristics of the placenta and UC, focussing on pregnancies with SGA infants.

This prospective cohort study examined 1005 placentas from consecutively-delivered singleton pregnancies in a tertiary centre. Standardised images of each placenta were taken. Measurements on gross examination included placental weight and thickness; umbilical cord length, diameter and handedness. Distance from placental cord insertion site to placental margin, length and breadth of the placenta and placental chorionic surface area were measured digitally using ImageJ software. Birthweight and gestational age were recorded. Classification and regression models were used to identify the best subset of measurements to correctly classify infants as SGA (< 10th centile).

Overall, 141 (14%) infants were SGA. A regression model with maternal age, placental weight, surface area and birthweight to placenta weight ratio correctly classified 98% of infants >10th centile and 47% of infants <10th centile. Of the potential antenatal measurements, diameter of UC (placental and fetal ends), and distance from placental cord insertion to placental margin were statistically significant ($p < 0.05$) predictors after adjusting for maternal age, with smaller diameters and shorter distances associated with increased odds of SGA.

SGA infants can be identified using placental and UC morphometry. Further research on antenatal detection may improve our understanding of the pathophysiology and contribute as predictors for SGA.

PLACENTAL CHORIOCARCINOMA: AN OBSTETRIC CASE

Abstract ID: 33

Dr. Aoife McSweeney (Cork University Maternity Hospital), Dr. John Coulter (Cork University Maternity Hospital), Dr. Keelin O'Donoghue (Cork University Maternity Hospital)

Background

Placental choriocarcinoma(IC) is a rare subtype of gestational trophoblastic disease, with an estimated incidence of 1/50,000-160,000. It is usually diagnosed in symptomatic women with metastatic disease. The incidental finding of a choriocarcinoma confined to the placenta with no evidence of dissemination to the mother, or infant is the least common scenario.

Case

We present the case of a 30year old, para 2 in her third pregnancy. She was rhesus negative and had a negative antibody screen at booking. At 29 weeks her antibody screen showed AntiD quantification 1.82iu/L. No history of a sensitising event was obtained. Repeat quantification at 33weeks was 15.58iu/L. She was referred to a tertiary centre for weekly MCA Doppler measurement. At 35+1 ultrasound showed MCA Doppler 80 cm/sec (plotted above the 1.5MOM line). There was no evidence of hydrops or ascites. Decision was made for induction of labour. She underwent emergency Caesarean section due to a non-reassuring CTG and delivered a female infant in good condition, 2080g. Placenta was sent for histopathology. Results revealed a 3.5cm placental choriocarcinoma. CT of thorax abdomen and pelvis did not show any evidence of metastasis. The infant's beta hCG was within normal range and the mother's beta hCG levels normalised at day 49.

Discussion

FMH is the only known early sign of IC reported in the literature. In this case, anti D antibodies were likely the result of a subclinical FMH due to IC. Histopathological examination of the placenta should therefore be performed in each case of unexplained FMH.

POLYCYTHEMIA SECONDARY TO UTERINE FIBROID

Abstract ID: 289

Dr. Mohamed Barakat (St Lukes Kilkenny), Mr. Raouf Sallam (st'lukes kilkenny)

Since 1953 the association of polycythemia with uterine fibroids has been reported 13 times. Various theories have been advanced as to the possible cause of the polycythemia, but none have been proved. One of the theories advanced was that the tumor might produce erythropoietin (erythrocytosis stimulating factor—ESF). This factor has been shown to be the etiological agent in the development of polycythemia associated with other tumors, such as renal carcinoma, cerebellar hemangioblastoma, and renal cysts.

case report, 57 years of age female, mother of 7 children, presented with picture of polycythemia and found to be secondary to uterine fibroid.

in conclusion, Uterine fibroid or leiomyoma is the commonest benign uterine tumour. Its occurrence in the postmenopausal age group is rare and if enlargement of the fibroid noted during this time, the diagnosis of leiomyosarcoma is provisional until proven otherwise.

POST PARTUM CHORIOCARCINOMA - A CASE REPORT

Abstract ID: 205

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Choriocarcinoma occurring after a non molar pregnancy is rare with 2 to 7 cases per 100,000 in Europe, with higher incidence in Southeast Asia and Japan(1,2). Choriocarcinoma is the most aggressive histologic type of Gestational Throphoblastic Neoplasia and is characterized by early vascular invasion and widespread metastases. EMA/CO chemotherapy comprises of EMA therapy (etoposide, methotrexate, actinomycin D), which alternates every week with vincristine and cyclophosphamide. It is administered continuously until normalization of hCG ; and patients with high risk disease need therapy for 3 cycles after normalization(3).

The case report describes the case of a 39 year old, para 2+1, lady who presented with heavy vaginal bleeding 6 weeks post spontaneous delivery of a healthy baby boy at term. Her hCG level at admission was >250,000. Ultrasound showed evidence of retained products and an Evacuation of Retained Products of Conception was performed. Histology showed choriocarcinoma. CT TAP showed evidence of 6 lesions in the pulmonary parenchyma with clear abdomen and pelvis. MRI Brain was negative for brain metastasis. WHO prognostic score was calculated as 9. EMA/CO therapy was commenced.

Reference:

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POSTMENOPAUSAL BLEEDING: MANAGEMENT BY TRANSVAGINAL ULTRASONOGRAPHY

Abstract ID: 212

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Depending on the endometrial cancer prevalence, a strategy with Trans vaginal scan (TVS) as an initial investigation is cost effective (1)

A retrospective audit was carried out on the women attending the outpatient hysteroscopy clinic (OHC) at University Hospital Kerry (UHK) with Postmenopausal bleeding (PMB) from January 2012 to December 2014, the objective of the study was to audit if TVS for endometrial thickness was routinely performed for women with PMB prior to being referred to OHC as per guidelines.

Routinely GP letters are triaged by consultant in charge of OHC, then these women are referred for an ultrasound pelvic scan for endometrial thickness (ET) followed by a decision to proceed with an Outpatient Hysteroscopy, if $ET \geq 3\text{mm}$. Data for this audit was collected from information stored on excel sheet at OHC.

□ Total number of women who attended OHC from Jan 2012-2014 = 404

□ Number of women with PMB = 92/404

o 59/92 (64%) of women had a TVS scan prior to hysteroscopy, whereas 33/92 (36%) had no US performed prior to being referred to OHC. TVS showed suspicious findings in 4 cases of endometrial Ca.

□ 75/92 (82%) women had a successful hysteroscopy procedures.

□ Endometrial Cancer 4/92 (4.3%)

□ Benign results 52/92 (69.3%).

□ Atrophic changes 19/92 (25.1%)

This concludes that high-resolution Transvaginal scan (TVS) can reliably assess thickness and morphology of the endometrium and can thus identify a group of women with PMB who have a thin endometrium and are therefore unlikely to have significant endometrial pathology.

POSTNATAL BREASTFEEDING RATES IN LOW RISK NULLIPAROUS WOMEN IN A TERTIARY HOSPITAL

Abstract ID: 58

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To assess current breastfeeding rates in nulliparous women in a tertiary hospital setting at delivery, discharge and six weeks postpartum and to evaluate sociodemographic factors predictive of breastfeeding.

A secondary analysis was performed of nulliparous women recruited to a prospective observational study on maternal hemodynamics in pregnancy. Participant baseline information was collected at recruitment and information on breastfeeding was obtained at a follow up visit at least 6 weeks postpartum. Rates of breastfeeding were calculated after delivery, at discharge from hospital and at 6 weeks postpartum. The influence of ethnicity, maternal education, employment status and smoking status on breastfeeding was analysed. Frequencies were compared using chi-squared test; p-value < 0.05 was considered significant.

Of 251 participants enrolled to the study, 77% initiated breastfeeding. This fell to 73% at discharge, with 61.3% continuing breastfeeding beyond 6 weeks. Irish women were significantly less likely to breastfeed at all time-points than non-Irish (p < 0.0001). Education status was also associated with breastfeeding, with women educated to third-level or beyond more likely to breastfeed than those completing education at or before second level (p = 0.006). Maternal employment and smoking status were not predictive of breastfeeding.

Our findings suggest that cultural background and education status have a strong influence on breastfeeding behaviour in Ireland. A continued effort to promote breastfeeding and provide additional support following discharge is necessary to ensure continued breastfeeding in infants, especially among Irish nationals.

POSTPARTUM LENGTH OF STAY AND BARRIERS TO DISCHARGE IN A PERIPHERAL MATERNITY UNIT

Abstract ID: 220

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Length of stay is an important issue in hospitals and especially in maternity units. An appropriate stay duration for mother and baby postpartum reduces complications and allows establishment of breastfeeding. Duration of stay is of particular relevance in our unit, where delivery numbers have increased in recent months.

We aimed to compare length of stay in our unit to international standards (no Irish standards), identify barriers to discharge and obtain demographic data to aid service planning.

Prospective chart review, including women delivering >24/40 weeks gestation, over a 3 week period. NICE guidelines and USA institutional data used as standards, i.e. vaginal birth 1-2 days, and caesarean delivery 3-4 days.

82 women delivered, with 55 vaginal (67%) and 27 caesarean (33%) deliveries. Mean length of stay was 58.2 hours (range 12-170, median 51). 83% of women, 73% of vaginal and 93% of caesarean deliveries, were discharged within the recommended time period. Barriers to discharge were identified and divided into maternal and neonatal. Main maternal barriers included breastfeeding (n=4), and social issues (n=4). Neonatal primarily involved admission to NICU.

Increasing birth rates place additional demands on hospital services, and improved length of stay efficiency may alleviate this strain. While length of stay conformed with international standards in 83% of cases, modifiable barriers to discharge were identified. Early discharge team formation, enhanced community assistance, and additional lactation supports may reduce length of stay. Even modest improvements may lead to reduced complications, greater satisfaction and an increase in bed days available for the hospital.

PRE-IMPLEMENTATION AUDIT OF SEPSIS SCREENING FORM IN ROTUNDA HOSPITAL

Abstract ID: 74

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Sepsis is the leading cause of direct maternal death in the UK. It carries a financial burden with a typical episode costing around €25,000. Prompt identification and management is critical. The sepsis 6+1 screening form sets patients on a sepsis pathway according to a revised set of diagnostic criteria.

By comparing current strategies for the identification of sepsis within the ED against those who would have retrospectively triggered on the Sepsis 6+1 Tool, the potential cost of implementing this Tool within our hospital is evaluated.

This was a retrospective chart review of obstetric ED attendances in the Nov-Dec 2015 period who presented with suspected infection identifying:

- those triggering the Sepsis Six +1 criteria
- previous attendances less than 72 hours ago
- admitted patients.

Standards used were the Sepsis 6+1 Tool, ED Triage Forms and IMEWS chart.

Total number of presentations was 3000 cases, of which 280 met inclusion criteria. Antenatal patients (60%, n=169); postnatal patients (40%, n=111). Of these, only 2.5% triggered on the Sepsis Six+1 Tool. Bedside glucose wasn't taken and 28% received a FBC. 18.8% of patients were admitted. Almost 21% of women triggered one parameter on the tool.

Sepsis cases occur at a rate of about 1 per week, which doesn't suggest a significant increase in resources. Bedside glucose and FBC are suggested for all those with suspected infection, which is currently not part of routine work-up. Patients without suspected sepsis fall outside recommended parameters (temperature, HR) emphasising the importance of clinical judgement and perhaps restructuring of parameters.

PREDICTORS OF GOOD OUTCOME IN CYSTIC HYGROMA

Abstract ID: 25

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The objective of this study was to predict factors associated with good outcome among cases of Cystic Hygroma (CH).

This was a prospective cohort study of all cases diagnosed from July 2014 to July 2016.

There were 59 cases of CH examined giving an incidence of approximately 1:288. There were 46 karyotypes obtained mostly by CVS (76%). The karyotype was Trisomy 21 in 19 cases (41%), 45X in 5 cases (10.8%), Trisomy 18 in 5 cases (10.8%), Trisomy 13 in 4 cases (8.8%), Triploidy in 1 case and normal in 12 cases (26%). The outcomes were Termination of Pregnancy in 28 cases (47%), IUD 11 cases (18.6%), early pregnancy loss 3 (5%) and one NND. There were 5 cases of a normal baby being delivered (8.4%) and there are 7 cases ongoing of which 5 are presumed normal with one Trisomy 21 and one hypoplastic right heart syndrome. An evaluation of the diagnostic scan revealed a CH confined to the head and neck in 16 cases (27%). The mean transverse measurement was 6.29 sd (4.0)mm. The mean value for the transverse measurement in the normal group was 4.0mm sd (1.6), compared to a mean value of 6.29mm in the overall population $p < 0.0001$. Using a normal outcome as the dependent variable the extent of the cystic hygroma was more important than the transverse measurement ($p = 0.02$).

Overall the outcomes for CH in our population were similar to published reports. We identified the extent of the CH as an additional outcome variable.

PREGNANCY MEDIATED AUTOIMMUNE HEMOLYTIC ANEMIA (AIHA): A CASE REPORT AND RELATED LITERATURE REVIEW

Abstract ID: 87

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AIHA has a prevalence of 17:100,000 and is rare in pregnancy. Seepage of fetal antigens into the maternal system represents one possible etiology. It is characterized by hemolysis and a positive Coombs test for IgG autoantibodies against red cell antigens. Fetomaternal risks are involved and recurrent cases are reported, however guidance on management remains controversial.

We present a case of severe pregnancy-induced AIHA. We examined 23 such cases already reported and the available literature.

A 36 year old para 2 lady with a history of positive Coombs test on her previous pregnancy, presented at 23 weeks with severe dyspnea, pallor and lethargy. Blood tests revealed severe anaemia (Hb 4.6g/dl), reticulocytosis (168 x 10⁹/L), macrocytosis (MCV 114fl), raised LDH (33μmol/L) and bilirubin (567U/L). Direct Coombs test was positive (IgG 3+ C3bC3d 2+). After excluding other hemolytic causes, the diagnosis of AIHA was confirmed. The patient responded well to prednisolone, IV immunoglobulins and received 4Units of blood. Haematological markers remained normal for the remainder of the pregnancy. Serial fetal scans and middle cerebral artery doppler excluded fetal anaemia. Maternal autoantibodies resolved by term. She had normal delivery of a healthy female infant, 2.53Kg at 37+6 weeks.

This case highlights a rare cause of severe anemia during pregnancy. The case was successfully managed with immunoglobulins and steroids, unlike the 23 cases we observed. Fetomaternal complications, such as fetal anemia/hydrops, preterm deliveries, miscarriages, thromboembolism, toxemia and renal failure, as evidenced in 14 cases, did not occur. As AIHA recurs, subsequent pregnancy requires vigilance.

Pregnancy outcomes in underweight women

Abstract ID: 239

Dr. Cathy McNestry (Coombe Women and Infants University Hospital), Ms. Ciara Reynolds (Coombe Women and Infants University Hospital), Dr. Aoife McKeating (Coombe Women and Infants University Hospital), Dr. Niamh Daly (UCD Research Centre, Coombe Women and Infants University Hospital), Dr. Maria Farren (Coombe Women and Infants University Hospital), Prof. Michael Turner (Coombe Women and Infants University Hospital)

There is increasing focus on the implication of maternal weight and body mass index (BMI) on pregnancy outcomes due to the current obesity epidemic. There is a dearth of research on low BMI, but it has been associated with an increased incidence of low birthweight and preterm delivery. Our study aimed to examine the incidence of underweight in our population and to assess associations with pregnancy outcomes.

Data from all deliveries over 500g. from 2009-2013 were obtained from the computerised information system. BMI was categorised using the World Health Organisation categories. Data were analysed using logistic regression, independent t test and chi-square comparing outcomes for women with low BMI (<18.5kg/m²) against those in women with a normal BMI (18.5-24.9kg/m²).

Of 41,550 singleton deliveries included, 1.9% (n= 773) of women were underweight, 51.7% (n=21,494) had a normal BMI, 29.0% (n=12,049) overweight, 16.3% (n=6,824) obese I-III. Underweight was associated with a lower birthweight (3,148g. vs 3396g.; p<0.05). Underweight women were more likely to have a baby less than 2.5kg (3.5% vs. 2.1%; p<0.05), more likely to labour spontaneously (63.0% vs. 57.7%; p<0.05) and more likely to require episiotomy (20.8% vs. 16.7%; p<0.05). Underweight women were less likely to have a third degree tear (0.6% vs. 1.4%; p<0.05).

In conclusion, underweight is not common. A BMI <18kg/m², however, is associated with an increased risk of low birthweight and prematurity. Further studies are required to determine if targeted multidisciplinary care with dietetic input may improve pregnancy outcomes in these women.

Preoperative staging imaging of the chest for endometrial cancer

Abstract ID: 90

Dr. Grace Ryan (MMUH), Dr. Katie Beauchamp (MMUH), Dr. Dr Niamh Maher (MMUH), Mr. Tom Walsh (MMUH)

Background:

Endometrial cancer is the most common gynaecological cancer with an incidence of 13.6 per 100000 in Europe. Current national guidelines recommend preoperative imaging of the thorax for all patients in the diagnostic work up for surgery and adjuvant treatment.

Aim:

The objective of this study was to investigate the role of CT thorax in the work up of endometrial cancer and chest X-Ray as a sole alternative imaging modality for the lungs.

Methods:

A retrospective cross-sectional study was carried out on a group of patients undergoing evaluation for treatment of endometrial cancer at a single institution from 2010-2015. This study comprised of 134 patients diagnosed and treated for endometrial cancer, who were identified from a prospectively collected pathological database.

Results:

A total of 134 patients over a 5 year period were identified who underwent pre-operative thoracic investigations. Of these, 110 had CT TAP, 10 had positive findings for metastatic disease, and 15 had benign findings requiring follow up. The group with metastatic findings had high grade endometrial cancer types. 27 patients had Chest X-Ray as part of their preoperative work up, 0 of which had positive findings suspicious for lung metastasis. Lung metastases were not detected in low grade endometrial cancers.

Conclusion:

This study demonstrated that CT thorax is not essential in the diagnostic work up of low grade endometrial cancer. Present data suggests that chest X-Ray may suffice in the diagnostic work up of low grade endometrial cancer.

Presentations to the Emergency Department prior to 6 weeks pregnancy

Abstract ID: 139

Dr. Deborah Lanca (Cork University Maternity Hospital), Dr. Noirin Russell (Cork University Maternity Hospital)

Introduction

Approximately 1500 patients attend the Emergency Department(ED) at Cork University Department (CUMH) each month. One in five patients attend due to pain and bleeding in the first trimester. This research aimed to determine the pregnancy outcomes of this cohort and determine the follow up they receive.

Methods

A retrospective review of ED logbook was performed on all women with estimated gestation less than 6 weeks, who presented to the CUMH ED from October 2015 to January 2016. Electronic data from the early pregnancy clinic (EPC), ultrasound scan reports and serum hCG levels were also reviewed.

Results

In the study period, 979 first trimester patients attended ED. Of these 11% (n= 109) presented at a gestation <6/40 according to last menstrual period (LMP). The majority presented with vaginal bleeding (n=60) or abdominal pain (n=46).

72% of patients had a transvaginal ultrasound performed. The median number of scans per patient was 1 (range 0-4). The median number of serum hCG samples per patient was also 1 (range 0-8). There were 13 ectopic pregnancies, two which presented as clinical emergencies and 11 were diagnosed in the EPC.

The eventual diagnosis was viable pregnancy 53% (n=58), miscarriage 26% (n=28), ectopic pregnancy 12% (n=13) and not pregnant 9% (n=10).

Conclusion

Many patients present to the ED with pain and bleeding prior to 6/40. There is a need for patient education regarding the limitations of diagnostic tests in early pregnancy and the benefit of attending the EPC instead of the ED.

PREVALENCE OF ANTI NUCLEAR ANTIBODIES IN PRIMARY AND SECONDARY RECURRENT MISCARRIAGE

Abstract ID: 194

Dr. Aoife McSweeney (Cork), Ms. Anna Maria Verling (Cork University Maternity Hospital), Dr. Cristina Georgescu (Cork University Maternity Hospital), Dr. Keelin O'Donoghue (Cork University Maternity Hospital)

Introduction

Anti Nuclear Antibodies (ANAs) are antibodies which show an affinity for nuclear antigens, including DNA. They have been associated with recurrent miscarriage, defined as the loss of three or more consecutive pregnancies. We sought to determine the prevalence of ANAs in women with recurrent miscarriage compared to a control population in order to establish the significance of the test in this population.

Methods

We reviewed the population who attended the Pregnancy Loss Clinic, Cork University Maternity Hospital between 2011 and 2015 and identified 672 women with two consecutive miscarriages, and primary or secondary recurrent miscarriages. We recorded the ANA status for this group and compared it to a control group of healthy pregnant women, tested between 10-14 weeks gestation.

Results

ANAs were detected in 40 of 284 (14.1%) women with two consecutive miscarriages, 17 of 179 (9.5%) with three or more consecutive miscarriages, 16 of 214 (7.5%) women with secondary recurrent miscarriage and 10 of 118 (8.4%) controls. ANA positivity was not significantly more prevalent in those with two consecutive miscarriages ($p=0.12$), three or more consecutive miscarriages ($p=0.88$) or secondary recurrent miscarriage ($p=0.77$) compared to the control group. Of all of those with ANA positivity, just five were known to have autoimmune conditions at the time of review.

Conclusion

In our cohort, ANA positivity was not significantly more prevalent in patients with recurrent miscarriage than in the control population. These findings call into question the previously suggested association of ANAs with recurrent miscarriage and its addition to testing protocols in this group.

PROLONGED URINARY RETENTION FOLLOWING A COMPLICATED VAGINAL DELIVERY: A CASE STUDY

Abstract ID: 204

Dr. Mary Barrett (Portiuncula University Hospital, Ballinasloe), Dr. Aoife Mc Goldrick (Portiuncula University Hospital, Ballinasloe), Dr. Mohamed Abbas (Portiuncula University Hospital, Ballinasloe)

Prolonged urinary retention is an uncommon event following vaginal delivery. Studies suggest a prevalence of 0.05% - 0.19% of clinically overt postpartum urinary retention that persists for more than 3 days. This case study demonstrates a number of known risk factors for its development, importance of early detection and the difficulties in management.

The purpose of this study is to highlight risk factors, appropriate management and prognosis of urinary retention in the postpartum period.

This is a case study of a 16 year old, primiparous woman, with a difficult instrumental delivery complicated by shoulder dystocia. She developed prolonged urinary retention in the postpartum period.

Our study found that the concurrence of multiple risk factors in a single patient may result in prolonged postpartum urinary retention. Social factors are crucial in successful management.

Recognition of continence issues early in the postpartum period is vital as delay in diagnosis may result in a prolonged course. A standardised management plan should be available in maternity units to optimise outcomes. Social factors need to be addressed in the management of urinary retention.

Pseudomyxoma peritonii rare presentation

Abstract ID: 266

Dr. Elzahra Ibrahim (Department of obstetrics, Galway University Hospital (GUH)), Dr. Oana Martis (galway), Dr. Michael O leary (University College Hospital Galway)

Introduction:

Pseudomyxoma peritonii is a rare malignant growth characterized by the progressive accumulation of mucus-secreting tumor cells within the abdomen and pelvis.

very rare disorder with approximately 2 cases per million individuals. The exact cause of pseudomyxoma peritonii is not known. It is attributable to a ruptured mucinous cystadenocarcinoma (appendiceal origin in most cases).

Case

55 year presented to a private hospital with stress incontinence symptoms not improving with medical treatment. She had urodynamics, 24 hours later readmitted with distended abdomen, shortness of breath and feeling unwell. CT urogram reported a large complex mass 23x15x10 cm with septation, extensive ascitis and dilated small bowel loops ? Small bowel obstruction. A peritoneal drain inserted drained only 300ml of green yellowish fluid.

Her condition deteriorated, O2 saturation dropped to 83% requiring 10L of oxygen. She was transferred to GUH. Her short breath got worse associated with palpitation, haemoptosis and calf pain. Impression was Pulmonary embolism. She was commenced on therapeutic inohep.

The patient symptoms deteriorated and became septic. Septic screen and antibiotics was given. CTPA reported bilateral pulmonary embolism, bilateral pleura effusion and ascitis with distended small bowel loops. Based on her condition an urgent laparotomy was called.

The operation lasted 3 hours. Intraoperatively 3.5L of green mucinous ascitis removed.

Large left ovarian mass and a large appendicial mass attached to the caecum resected and loop ileostomy was done.

Postoperative recovery was unremarkable.

Histopathology came as mucinous cystadenoma. She was referred to the mater hospital for completion of Total hysterectomy right salpingoophrectomy and HIPEC.

RATES OF 'ONE PREVIOUS SECTION' AND VBAC RATES OVER A 25 YEAR PERIOD.

Abstract ID: 245

Dr. Sarah Marie Nicholson (University College Hospital Galway), Dr. Kate O'Doherty (University College Hospital Galway), Prof. John Morrison (University College Hospital Galway)

There is much focus recently on management of the woman who has had one previous caesarean section (CS), firstly because of reducing VBAC rates, and secondly because there is great hospital variation in this area of practice. There are minimal data available pertaining to the following: 1. Number of women who book for antenatal care having had one previous CS; 2. How the recent rise in CS rates has affected this statistic; and 3. Actual hospital VBAC rates.

The aim of this study was to examine these parameters over a 25-year period from 1990-2015.

The data were obtained from an obstetric database, the EuroKing system, to which all information had been added prospectively over the time period of the study.

There 75,918 deliveries during the study, and n=6,589 (8.6%) women entered the antenatal booking system having had one previous CS. This varied from n=126 (5.1%) in 1990 to n=394 (13.5%) in 2015. Annual data for each year of the study are demonstrated graphically. For the time period of the study the VBAC attempt rate declined from 70 - 51%, while the VBAC rate declined from 55 - 33%.

These data clearly demonstrate that the increased CS rates from all reasons, combined with reduced VBAC rates, act as a double stimulus towards increased CS rates in coming years. These statistics are not available for many hospitals. The clinical area of VBAC management needs attention in view of these findings, and the variation that exists between hospitals.

REAUDIT OF MAGNUSIUSM SULPHATE ADMINISTRATION FOR FETAL NEUROPROTECTION

Abstract ID: 261

Dr. Maryanne Siu (Rotunda Hospital), Dr. Jennifer Donnelly (Rotunda Hospital)

Premature birth is the leading cause of neonatal morbidity and mortality. Cerebral Palsy (CP) is a disorder of movement with or without cognitive impairment that is a potential devastating complication of preterm delivery. Studies have identified maternal administration of magnesium sulphate prior to delivery as an effective strategy in reducing incidence of CP. A national guideline for administration of magnesium sulphate has been in place since 2013 and revised in 2015 with a similar guideline implemented at the Rotunda Hospital. The compliance of the guideline was audited in 2013 at the Rotunda hospital with 79% compliance.

The purpose of the study was to determine if there are any improvements in the compliance of magnesium sulphate administration.

Details of patients delivered in the Rotunda Hospital between 24-32 weeks gestation from July 1st to September 30, 2016 were obtained and data collected. The standards used in this audit are both the HSE and Rotunda guidelines.

26 preterm deliveries between 24-32 weeks were identified. 22 charts were analyzed.

Magnesium sulphate loading dose was administered for 20 cases (91%). Of those, 10 also had maintenance dose. Magnesium sulphate was administered within 4 hours of delivery for all cases. CTG was performed on 19/20 patients. Only 50% have baseline vitals recorded and 40% have urine output recorded.

The overall compliance for the administration of magnesium sulphate for fetal neuroprotection is high at 91%. However, monitoring of administration of needs to be improved.

REPEAT CYTOREDUCTIVE SURGERY FOR RECURRENT ENDOMETRIAL CANCER: WHEN IS ENOUGH ENOUGH?

Abstract ID: 76

Dr. Sara Mohan (St Vincent's University Hospital), Dr. Michael Wilkinson (St Vincent's University Hospital), Dr. Donal O'Brien (St Vincent's University Hospital)

Recurrent endometrial cancer carries a poor prognosis(1) and considerable morbidity. Optimal debulking is associated with improved survival(2) but may involve multivisceral resection. In this case, operative findings favoured a less aggressive approach while achieving disease clearance.

This is the case of a 53-year-old lady diagnosed with a large pelvic tumour 3 years ago, treated with primary cytoreductive surgery. Initial diagnosis was endometrioid adenocarcinoma of ovarian or endometrial origin with omental and appendiceal deposits (FIGO stage IV). Recurrence occurred within 4 weeks post-operatively, subsequently treated with liposomal doxorubicin. She developed multiple subacute bowel obstructions, and bilateral hydronephrosis requiring long-term nephrostomies. Prognosis appeared poor, with palliative care involvement for symptom control. However, the recurrence remained stable in size, localized to the pelvis with no distant metastases. Imaging showed a 17.8cm mass near the pelvic sidewall suggesting difficult surgery. Ureteric stents were placed pre-operatively and the mass carefully dissected from the bladder and bowel, with no bowel diversion. She returned home without nephrostomies 12 days post-op. Histology demonstrated endometrioid endometrial adenocarcinoma (FIGO stage IIIA).

This case highlights the role of repeated cytoreductive surgery in selected patients with recurrent endometrial cancer. Complex intraoperative decision-making enables balance between complete excision and major operative morbidity. Interestingly in this case, despite rapid recurrence and significant morbidity, the mass remained stable, without distant spread, allowing resection relieving symptoms and hopefully improving survival.

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RETZIUS SPACE HAEMATOMA AFTER AN ELECTIVE CAESAREAN SECTION: A CASE REPORT

Abstract ID: 135

Dr. Sabahat Zafar (UNIVERSITY HOSPITAL KERRY)

Post partum haemorrhage (PPH) is a major obstetric complication and a cause of severe maternal morbidity in almost all 'near miss' audits. The Retzius space is a potential avascular space with vascular borders posterior to pubic bone and anterior to the bladder. (1) The Retzius space hematoma is a very rare but serious post caesarean section complication. (2)

A 33 year old , gravid 4 para 1 woman with history of one previous Caesarean section underwent an uneventful elective repeat caesarean section for maternal request. Two hours post caesarean section, she became hypotensive and tachycardiac her blood pressure dropped from 112/51 to 62/43 over 30minutes. She was alert, her abdomen was soft and uterus well contracted, there was fullness in the left iliac fossa and she had minimal vaginal loss. Conservative management resulted into no improvement in blood pressure and pulse.

She underwent an exploratory laparotomy; hemorrhagic infiltration in abdomen and retzius space was noted. Three litres of pelvic haematoma was evacuated. She required 10 units of red cell, 2 octaplas and 4 units of platelets. Retzius space was packed with 3 large abdominal packs and curaspon to maintain tamponade. The packs were removed after forty eight hours. She continued to improve and was discharged on day seven.

Hematoma in the Retzius' space is a rare complication. It needs urgent diagnoses and management. The condition may pose diagnostic problems, as pelvic bones let only a limited examination, but requires an undelayed handling. Serious maternal complication can occur if bleeding is not identified and managed diligently.

Review of Adolescent Gynaecology referrals to The National Maternity Hospital

Abstract ID: 217

Dr. Claire O'Reilly (National Maternity Hospital), Dr. Sean Mcdermott (National Maternity Hospital), Dr. Orla Sheil (National Maternity Hospital), Dr. Venita Broderick (National Maternity Hospital)

Introduction

A consultation with the gynaecologist can be a daunting experience for many women, irrespective of age. Adolescents in particular can feel embarrassed and exposed, many persevering with symptoms long before presenting to their General Practitioner for advice. The adolescent gynaecology service at the National Maternity Hospital is an outpatient, consultant led service, providing specialized care for these patients. Our aim was to determine the numbers of patients attending the clinic and to review the reasons for referral.

Method

All referrals from 2015 were retrospectively reviewed, looking at age, reason for referral & BMI. Diagnosis and follow up was also recorded.

Results

59 new referrals attended the adolescent gynaecology service. All were referred by general practitioners. Of the 59 referrals, 31% (n=18) were aged 17-18, 53% (n=31) were aged between 14-16, 11% (n=7) aged between 10-13 and 5% (n=3) aged below 10. The youngest was 5 years of age. Menstrual disorder was the most common reason for referral, followed by abdominal pain, delayed puberty and issues regarding appearance of the vulva. Developmental abnormalities (Müllerian abnormalities/Disorders of sex differentiation) were less common. All new referrals had BMI recorded.

Conclusion

The adolescent gynaecology clinic provides an important service for adolescents and referrals continue to increase. As the majority of referrals were for menstrual disorders, perhaps further adolescent gynaecology teaching aimed at general practitioners could help decrease some of these presentations to the gynaecology clinic.

REVIEW OF ENDOMETRIAL ABLATION AT COOMBE WOMEN AND INFANTS UNIVERSITY HOSPITAL (CWIUH).

Abstract ID: 165

Dr. Anna Durand O Connor (Coo), Dr. Hugh O Connor (Coombe Women and Infants University Hospital)

Endometrial ablation is a recommended therapy for the treatment of heavy menstrual bleeding (HMB). At CWIUH, endometrial ablation is performed using the Novasure device. This device delivers radiofrequency energy until tissue impedance reaches 50 ohms. This device has the benefit of a proactive safety test, the Cavity Integrity Assessment, prior to activation of the device. This ensures a treatment is not performed if a uterine perforation has occurred. In my clinical practice however, treatment has been suspended on several occasions due to failed cavity assessment, despite the absence of a uterine perforation.

To review cases of endometrial ablation performed at CWIUH, with a view to establishing rates of 'failed cavity assessment'.

A retrospective cohort study, of women who underwent endometrial ablation, using a Novasure device, in 2016. From January 1st to October 31st 2016, there were 66 cases of endometrial ablation performed, using the Novasure device at CWIUH. Women ranged in age from 33 to 54, with an average of 44, mode 46. 98% of patients treated were multiparous. The total uterine length, ranged from 6 to 11cm. 58% of cases were performed by junior doctors. There were 5 cases of failed cavity assessment where treatment could not be performed, despite repeat hysteroscopy outruling uterine perforation.

Endometrial ablation is a very effective form of treatment for HMB however this study shows that almost 8% of treatments cannot be performed due to a failed cavity assessment. Patients should be counselled about this potential and perhaps alternatives discussed.

Review of endometrial ablation effectiveness in MRH over a year period

Abstract ID: 238

Dr. Reham Alkhalil (Midland Regional Hospital, Mullingar), Dr. Majda Almshwt (Mullingar Midlands Regional Hospital), Prof. M. Gannon (Department of Obstetrics and Gynaecology, Mullingar Midlands Regional Hospital)

Background:

□ Endometrial ablation as a treatment for abnormal uterine bleeding has evolved considerably over the past several decades.

□ In 20 women aged 30 and 55 are consulting their GP with menorrhagia problem every year

□ Endometrial ablation is recommended for use in patients with normal uterine cavity and no desire for future fertility its safe procedure and provides an alternative for hysterectomy

Aim of study:

To audit the practice and effectiveness of endometrial ablation techniques in MRHM

Study Design and Method:

Retrospective women undergoing Second-generation endometrial ablation (roller ball and novasure)

In January 2011 to January 2012 in Midland Regional Hospital - Mullingar.

44 medical charts were reviewed to collect data (roller ball 15 and noasure 29) between January 2011 to January 2012.

A questionnaire was also completed to evaluate patient satisfaction.

Result:

35 patients was satisfied and they have amenorrhea at one year their bleeding was already reduced significantly at six month period satisfaction rate 79.6% after 1 year .and 9 patients were unsatisfied still had heavy bleeding at one year had hysterectomy 1 year unsatisfied rate is 20.4% had hysterectomies.

Conclusion:

Second generation ablation techniques are safe and effective methods of treating dysfunctional uterine bleeding, and are easy to use and its good alternative to hysterectomy

References:

1. The Investigation and management of menorrhagia (Guideline Royal College of Physician of Ireland).
2. An overview of endometrial ablation (Up To Date).

REVIEW OF FETAL BLOOD SAMPLING IN REGIONAL HOSPITAL MULLINGAR OVER A PERIOD OF 1 YEAR

Abstract ID: 41

Dr. Umme Farwa Shah (Mullingar Midlands Regional Hospital), Dr. Majda Almshwt (Mullingar Midlands Regional Hospital), Prof. M. Gannon (Mullingar Midlands Regional Hospital), Dr. S. Thomas (Mullingar Midlands Regional Hospital), Dr. Nandini Ravikumar (Mullingar Midlands Regional Hospital)

Fetal blood sampling is indicated in the presence of a pathological CTG unless there is clear evidence of acute fetal compromise requiring urgent delivery (NICE guideline on intrapartum CTG)

The aim was to determine how FBS has influenced the management of labour & delivery and did it reduce the rate of caesarean section

A retrospective audit was done from March 2014 to March 2015 & data was collected from the labour ward register, fetal blood sampling record and medical notes.

50(n=50) cases were identified. Documented verbal consent was taken in 47% of the cases. 94% of FBS were performed by the registrars & 6% by the Consultant. 90% were done in first stage of labour & 10% done in second stage of labour. In 91% of cases it was performed once & in 9% of cases it was performed twice. 32% of FBS were performed due to Pathological CTG and 68% due to suspicious CTG. Overall, 26% had SVD, 38% had Emergency caesarean

In Conclusion we found out that FBS was over done unnecessarily for suspicious CTGs due to pressure from the labour ward staff. Recommendation is to emphasize on the training of midwife for CTG or to provide proforma for CTG before performing FBS. Overall, FBS definitely helped to reduce the caesarean section when done properly.

REVIEW OF INFORMED CONSENT PRACTICE FOR ELECTIVE GYNAECOLOGICAL PROCEDURES AT MULLINGAR REGIONAL HOSPITAL OVER A 1 YEAR PERIOD

Abstract ID: 244

Dr. Jayavani Panchala (Midland Regional Hospital, Mullingar), Dr. Alex Dakin (Mullingar Midlands Regional Hospital), Dr. Majda Almshwt (Mullingar Midlands Regional Hospital), Prof. M. Gannon (Department of Obstetrics and Gynaecology, Mullingar Midlands Regional Hospital), Dr. S. Thomas (Department of Obstetrics and Gynaecology, Mullingar Midlands Regional Hospital), Dr. Nandini Ravikumar (Mullingar Midlands Regional Hospital)

Background:

Consent is a patient's legal agreement for a healthcare professional to provide care. When obtaining consent, medical professionals provide sufficient information to patients, regarding the nature of the procedure and the potential risks and benefits involved, to allow them to reach an informed decision.

Objective:

To review compliance with the guidelines when taking consent for elective gynaecological surgeries (Hysterectomies, Laparoscopy and pelvic floor repair).

Study Method:

We thoroughly investigated patients charts and their consent forms who underwent elective gynaecological surgeries from the start of September 2015 to the end of August 2016, in Mullingar Hospital.

Total number of gynaecological surgeries reviewed were 307; 197 Laparoscopies (55 diagnostic, 142 therapeutic), 39 Abdominal & 54 Vaginal Hysterectomies, 12 Pelvic-Floor repairs. Consent forms were reviewed to establish grade of consenting doctor and legibility of their name, time between consent and surgery, and documentation of general and specific risks associated with the procedure.

Result:

All 307 of patients charts contained a consent form. The names of all doctors were legible apart from 7 (2.3%). 47 (15.3%) patients were consented by Consultants, and the remainder were consented by NCHDs, mainly interns and SHOs. The longest duration between the consent and surgery was 3 weeks and shortest was a few hours. 98 (31.9%) clinical notes include documentation of general risks of surgeries whereas operation-specific risks were found only in 9 charts (2.9%).

Conclusion:

Our study reflects incomplete documentation. Use of operation-specific consent forms and introducing proforma will ensure accurate and comprehensive discussion.

REVIEW OF THE MANAGEMENT OF THIRD AND FOURTH DEGREE PERINEAL TEARS IN MULLINGAR MIDLAND REGIONAL HOSPITAL

Abstract ID: 21

Dr. Ream Langhe (Department of Obstetrics and Gynaecology, Mullingar Midlands Regional Hospital), Dr. Zahra Shah (Department of Obstetrics and Gynaecology, Mullingar Midlands Regional Hospital), Dr. Grant Montgomery (Mullingar Midlands Regional Hospital), Dr. Melanie Langorsm (Department of Obstetrics and Gynaecology, Mullingar Midlands Regional Hospital), Dr. Majda Almshwt (Mullingar Midlands Regional Hospital), Dr. S. Thomas (Department of Obstetrics and Gynaecology, Mullingar Midlands Regional Hospital), Prof. M. Gannon (Department of Obstetrics and Gynaecology, Mullingar Midlands Regional Hospital)

The overall risk of obstetric anal sphincter injuries (OASIS) is 2.9% of all vaginal deliveries. OASIS encompass both third & fourth degree perineal tears.

The aim of this audit was to assess the management of 3rd and 4th degree perineal tears in Midland Regional Hospital Mullingar and compare it with the most up-to-date RCOG Green-top Guideline No 29.

71 patients sustained OASIS during the data period of 1/01/13 to 31/12/15 were included in the audit. The data was retrospectively reviewed through details from patient records and patients were contacted for details regarding follow-up.

The classification of perineal tears as per RCOG guideline was documented in 68/71 cases, however, only 57 charts were accessible. Episiotomies were performed in 20/23 cases of instrumental deliveries. 83% of the perineal tears were repaired by obstetric registrars and 17% were repaired by obstetric consultants. Mode of repair was documented in 79% of perineal tears. There was no documentation justifying the number of repairs in labor ward and theater. The PR exam was documented in 63% of cases. All women received management post operatively, and 97% attended physiotherapy. Only 51/57 patients were accessible via phone; 3/51 did not attend follow up and 4/51 had experienced anal incontinence.

This audit revealed a significant downfall in proper documentation which must be addressed from a risk management point of view. A re-audit to be carried out following implementation of the above.

RITUXIMAB - A NOVEL THERAPY FOR SEVERE ITP IN PREGNANCY - A CASE REPORT

Abstract ID: 37

Dr. Fionan Donohoe (National Maternity Hospital), Prof. Mary Higgins (National Maternity Hospital), Dr. Shane Higgins (National Maternity Hospital), Prof. Fionnuala M McAuliffe (UCD Obstetrics and Gynaecology, National Maternity Hospital), Dr. Karen Murphy (St. Vincent's University Hospital)

Background:

Rituximab is a novel second line agent for the treatment of Immune Thrombocytopenia (ITP). Minimal data exists on use of rituximab in pregnancy. This case illustrates the successful treatment of severe ITP diagnosed in pregnancy, refractory to all other medical management.

Case:

A 32-year-old nulliparous woman was diagnosed with severe ITP at the time of booking for antenatal care (platelet level of $13 \times 10^9/L$). Standard treatment failed to adequately increase platelet counts. Therapy with rituximab was instituted and platelet counts rose to normal levels, without side effects, and remained at a normal level throughout the pregnancy. There were no maternal or neonatal ill-effects of rituximab therapy.

Conclusion:

Rituximab is potentially a safe treatment option for the management of ITP in pregnancy with good maternal and neonatal outcome, when conventional treatments have been unsuccessful. Research is limited to case reports and therefore limited information currently exists to guide clinicians.

ROUTINE ANTENATAL ANTI-D PROPHYLAXIS IN THE REPUBLIC OF IRELAND – ARE ALL WHO SHOULD GETTING IT?

Abstract ID: 164

Dr. Sarah Marie Nicholson (University College Hospital Galway), Ms. Helen Ryan (University College Hospital Galway), Ms. Margaret Tarpey (University College Hospital Galway), Dr. Geraldine Gaffney (University College Hospital Galway)

Routine antenatal anti-D prophylaxis (RAADP) was first suggested in the 1990s. Following endorsement by NICE guidelines, it was recommended by the Institute of Obstetricians and Gynaecologists in the National clinical guideline no. 13. This recommends a single dose of anti-d immunoglobulin at 28 weeks to all non-sensitized women.

This study aimed to establish how many maternity units in the republic of Ireland offer RAADP to eligible women.

To do this a questionnaire was distributed to all 19 maternity units in the republic of Ireland during May 2016. A reminder was sent 6 weeks later for those who hadn't responded.

There was 100% response rate. In 75% of surveys all questions were answered. RAADP has been implemented in 15/19 units (79%) since 2012, with the majority (92%) doing so after 2014. In the 4 units who have not implemented RAADP, the greatest barriers to doing so were personnel and organizational reasons. One unit also cited financial reasons.

There has been a relatively good uptake of RAADP in the Republic of Ireland, especially after 2014. Hospital groups did not necessarily have universal implementation throughout the whole group. However, 966 women annually are at increased risk of sensitization at present.

Routine Third Trimester Ultrasound Scans – can Ireland buck the trend?

Abstract ID: 176

Dr. Suzanne Smyth (University Maternity Hospital Limerick), Dr. Mendinaro Imcha (University Hospital Limerick)

Internationally there are conflicting reports on the merits of routine third trimester ultrasound scans (USS) in low risk pregnancies.

This study aimed to assess whether routine USS during the third trimester of pregnancy is a valuable resource in low risk pregnancies in Ireland.

The routine 31 week USS appointments for January – March 2016 were acquired from the Viewpoint Booking System data. Parameters of fetal growth, anomaly and wellbeing were reviewed.

Of the initial 507 records reviewed, 491 were included in the final draft. The USS were at a mean of 31.1 weeks gestation. The mean estimated fetal weight at the time of the scan was 1.8kg. This resulted in 46 (9.3%) diagnoses of small for gestational age and 89 (18.1%) diagnoses of large for gestational age. Repeat scans were performed on 260 women who did not originally meet requirements for re-scan. Assessment of growth (n=150) was the most common reason documented in these cases.

In addition to estimating fetal weight, useful parameters such as presentation and markers of fetal wellbeing can be assessed at 31 weeks. In this low risk population while the prevalence of abnormalities is expectedly low, offering a routine third trimester ultrasound scan allows for identification of evolving high risk pregnancies. This can lead to increased intervention rates and underlines the importance of appropriate interpretation of scan findings by qualified ultrasonographers and fetal medicine specialists. This much debated question of validity of third trimester USS requires more robust studies in Ireland and internationally.

RUPTURED RUDIMENTARY HORN PREGNANCY IN A MULTIPAROUS PATIENT: A CASE REPORT AND LITERATURE REVIEW

Abstract ID: 100

Dr. Sarwat Khan (O), Dr. Adeola Adewole (Our Lady of Lourdes Hospital, Drogheda), Dr. Uta Irsigler (Our Lady of Lourdes Hospital, Drogheda)

Abstract: Pregnancy in a rudimentary horn of uterus is a rare condition. We present a case report of 31 yrs old Gravida 4 para 2+1 patient with rupture of rudimentary horn of uterus at 18 weeks.

Introduction: Mullerian duct anomalies occur due to defective development of female reproductive system.¹ According to the European Society of Human Reproduction and Embryology (ESHRE), Mullerian duct anomalies are divided into class U1 to U6. The U4 variant describes the Hemi-uterus (unicornuate uterus) which may or may not be associated with a rudimentary horn.²

Case history: A 31 year old Gravida 4 para 2+1 presented to the emergency department (ED) at 18+ 2weeks gestation, having collapsed at home and sudden onset abdominal pain. Intrauterine pregnancy was confirmed on ultrasound at 13+4weeks gestation. On examination in ED, she was pale, her blood pressure was 73/37 mmHg, and Pulse was 78bpm. On examination there was guarding in the iliac fossa with abdominal distension. Despite initial fluid resuscitation, she deteriorated rapidly and developed hypovolaemic shock. Massive transfusion protocol was activated. A bed side ultrasound confirmed intrauterine pregnancy with evidence of haemoperitoneum. Emergency Laparotomy was performed and ruptured rudimentary horn with ipsilateral tube was excised. She had good postoperative recovery.

Conclusion: Pregnancy in a rudimentary horn carries grave risk to the mother. There is need for increased awareness of this rare condition. A high index of suspicion and early diagnosis using ultrasonography +/- MRI is discussed.

SCREENING FOR MACROSOMIA IN DIABETIC PREGNANCY

Abstract ID: 19

Mr. Liam Sharkey (UCD School of Medicine), Mr. Brian McDonnell (UCD School of Medicine), Dr. Nóirín Russell (UCD Obstetrics and Gynaecology, National Maternity Hospital), Ms. Cecilia Mulcahy (Midwifery, National Maternity Hospital), Prof. Fionnuala M McAuliffe (UCD Obstetrics and Gynaecology, National Maternity Hospital), Prof. Mary Higgins (UCD Obstetrics and Gynaecology, National Maternity Hospital)

Pre-gestational diabetes mellitus (PGDM) is associated with an increased risk of fetal macrosomia. Macrosomia is associated with complications such as labour dystocia, instrumental delivery and perineal tears, including third degree tears¹.

The purpose of the study was to assess whether third trimester biometric measurements could predict macrosomia in diabetic pregnancy and improve clinical planning and intervention.

A total of 230 PGDM mothers (167 Type 1 Diabetes and 63 Type 2 Diabetes) underwent routine serial third trimester ultrasound examination (30, 33 and 36 weeks gestation). Standard biometry measurements included abdominal circumference (AC) allowing an estimation of fetal weight (EFW). Two additional measurements, the anterior abdominal wall thickness (AAW) and AAW:AC ratio were also assessed.

The measurements of AC, EFW and AAW were significantly higher in women delivering infants with macrosomia compared to non-macrosomic infants ($p < 0.01$), whilst there was no difference with the AAW: AC ratio ($p = 0.60$). ROC curve analysis revealed AC as the best predictor of birth weight at 30, 33 and 36 weeks, followed by EFW and AAW. The poorest predictor of macrosomia was AAW:AC. The accuracy of AC, EFW and AAW in predicting macrosomia improved with increased gestational age.

In conclusion, in women with PGDM pregnancies the measurement of AC was a better predictor of macrosomia than EFW. This would suggest that AC should be weighed more heavily in the formula used to predict macrosomia in women with a PGDM pregnancy. The measurements of AAW and AAW:AC were not as sensitive in prediction of macrosomia.

SEPSIS COMBAT ROAD MAP OF UNIVERSITY MATERNITY LIMERICK

Abstract ID: 181

Dr. Ayesha Cheema (University Hospital Limerick), Dr. Mendinaro Imcha (University Hospital Limerick), Dr. Mohamed Mustafa (University Hospital Limerick), Dr. Una Fahy (University Hospital Limerick), Dr. James Shannon (University Hospital Limerick), Dr. Sidra Irum (University Hospital Limerick), Dr. David Rooney (University Hospital Limerick), Ms. Mary Doyle (University Hospital Limerick)

Overall, the maternal death rate from sepsis in 2011-13 was 1.56 per 100,000 maternities. After initial audits in May 2015 and September 2015, we re-audited our adherence to national and local guidelines. Data collection was retrospective chart review, IMEWS charts, I laboratory and pilot sepsis screening form.

Fifteen in-patients with a diagnosis of maternal sepsis between 7 June to 11 July 2016 were identified. Using the SIRS criteria septic screens were mainly performed based on temperature, heart rate, respiratory rate and WCC, blood glucose, acutely altered mental status, signs of new organ dysfunction or septic shock. Our standard was 100% compliance with sepsis 6+1* within 1 hour of diagnosis of sepsis. Within 1 hour 92% of patients had blood cultures and FBC done, 69.2% had urinary output measured, 38.4% had IV fluid bolus, 23% patients had O2 saturation measured and 100% Oxygen administered and 84.6% patients received antimicrobials. Fetal wellbeing was checked in 61.5% and was not applicable in 38.4%. 8% patients had their blood cultures and FBC done and received IV fluids and 15.38% received antibiotics after 1 hour. Antimicrobial prescribing was 100% effective and according to local guidelines. We noticed a 34% improvement in obtaining blood cultures and administering antimicrobials within the first hour compared to 50% in our previous audit. We also performed a documentation audit of the sepsis screening form and a survey of its impact on users i.e., doctors and midwives, all for insight to identify main areas of improvement in our maternal sepsis combat.

SERUM BIOMARKER HUMAN EPIDIDYMIS PROTEIN 4 (HE4) AS A SUPPLEMENTAL TRIAGE TOOL IN ENDOMETRIAL CANCER

Abstract ID: 114

Ms. Megan Power Foley (Trinity College Dublin), Dr. Shireen Rizmee (Trinity College Dublin), Dr. Lucy Norris (Trinity College Dublin), Dr. Dr Feras Abu Saadah (Trinity College Dublin), Ms. Anna Bogdanska (Trinity College Dublin), Ms. Ellis Silva (Trinity College Dublin), Dr. Mark Ward (Trinity College Dublin), Dr. Wasem Kamran (Trinity College Dublin), Dr. Cliona Murphy (Gynaecology Department, Tallaght Hospital, Dublin 24), Dr. Mary Anglim (Coombe Women and Infants University Hospital), Dr. Tom D arcy (Coombe Women and Infants University Hospital), Dr. Nadine Farah (Gynaecology Department, Tallaght Hospital, Dublin 24), Prof. John O leary (Trinity College Dublin), Dr. Noreen Gleeson (Trinity College Dublin), Dr. Sharon O Toole (Trinity College Dublin)

Background: Endometrial cancer (EC) is the most common gynaecological malignancy. EC commonly presents with abnormal uterine bleeding (AUB). As there are no sensitive and specific biomarkers for EC, women with suspicious symptoms undergo an invasive endometrial biopsy.

Study Purpose: Human Epididymus protein 4 (HE4) is a promising diagnostic and prognostic marker for EC. We investigated the sensitivity of HE4 at detecting EC, compared to CA125.

Methodology: 330 patients (210 malignant and 120 benign controls) were recruited from the DISCOVERY biobank, 2011-2016. Demographic and tumour characteristics were recorded. Preoperative serum HE4 and CA125 was measured using Fujirebio Diagnostic ELISA Kits, with the cut-off points of HE4 70 pmol/L and CA125 35 U/ml. ELISA results were correlated with clinicopathological details. Statistical analysis was performed using SPSS.

Results: HE4 was 58.1% sensitive and 95.8% specific for detecting EC. The AUC of a Receiver Operating Curve for HE4 was 0.851, compared to 0.661 for CA125. HE4 had a positive predictive value (PPV) of 96% and a negative predictive value (NPV) of 56.65%. HE4 was 42.34% sensitive and 95.9% specific for predicting Stage IA EC.

Conclusion: Clinically, a sensitive biomarker would provide a non-invasive method of triaging women presenting to gynaecology outpatients with AUB as high-/low-risk of EC, optimising follow-up scheduling. HE4 is more sensitive than CA125 at detecting all-stage and early-stage EC. However, the NPV of HE4 is still too low for consideration as a stand-alone triage tool. Going forward, HE4 has the potential to complement transvaginal ultrasound (TVUS) assessment in AUB management.

Setting standards in outpatient hysteroscopy

Abstract ID: 172

Dr. Catherine Finnegan (Mayo University Hospital), Dr. Hilary Ikele (Mayo University Hospital)

The RCOG outlines the best practice in outpatient hysteroscopy for centres which provide it. As it has started to become available in more centres in Ireland I decided to look at the numbers and success rates in the service in an established centre.

A total of 1288 patients attended ambulatory Gynae in the year august 2015-july2016.

A total of 1182 transvaginal ultrasounds were performed.

159 outpatient hysteroscopies were performed in the same group. At the same time 85 hysteroscopies were done in theatre. This was the group of interest in particular the reasons for attending theatre instead. 19 were noted as "not tolerated" and procedure abandoned, while others also required polypectomy, had a stenosed cervix, abnormal endometrium on US or never sexually active.

This is the group worth noting to define how best to prepare patients pre-operatively to make the procedure more tolerable.

From an economic point of view the added cost of these being performed in theatre adds to the burden of cost of healthcare. Where an outpatient hysteroscopy costs approximately €400, the same cost alone is required for a bed for a day case for theatre, and then follows the equipment and staff fees.

The purpose of these numbers will be to go forward and look at setting standards in Ireland for the same procedure.

SEVERE MATERNAL MORBIDITY AND COMORBID RISK IN HOSPITALS PERFORMING <1000 DELIVERIES PER YEAR

Abstract ID: 4

Dr. Mark Philip Hehir (Columbia University College of Physicians and Surgeons, New York Presbyterian Hospital New York.), Dr. Cande Ananth (Department of Epidemiology, Joseph L. Mailman School of Public Health, Columbia University, New York), Dr. Jason Wright (Columbia University College of Physicians and Surgeons, New York Presbyterian Hospital New York.), Ms. Zainab Siddiq (Columbia University College of Physicians and Surgeons, New York Presbyterian Hospital New York.), Dr. Mary Dalton (Columbia University College of Physicians and Surgeons, New York Presbyterian Hospital New York.), Dr. Alexander Friedman (Columbia University College of Physicians and Surgeons, New York Presbyterian Hospital New York.)

More than half of obstetric units in the United States perform <1000 deliveries per year and improving care at these hospitals may be critical to reducing risk nationwide. We sought to characterize maternal risk profiles and severe maternal morbidity at low-volume hospitals.

We used data from the Nationwide Inpatient Sample(NIS) to evaluate trends in severe morbidity and comorbid risk during hospitalizations in the US from 1998-2011. Comorbid maternal risk was estimated using a comorbidity index validated for obstetric patients. Severe maternal morbidity was defined as the presence of one of fifteen diagnoses representative of acute organ injury and critical illness.

A total of 2,300,279 deliveries recorded by the NIS occurred at low-volume hospitals. There were 7,849 cases(0.34%) of severe morbidity in these hospitals and this risk increased over the course of the study from 0.25% in 1998-99 to 0.49% in 2010-11(p<0.01). The risk in hospitals with ≥ 1000 deliveries increased from 0.35% to 0.62% during the same time periods. The proportion of patients with the lowest comorbidity decreased, while the proportion of patients with highest comorbidity increased. The risk of severe morbidity increased across all women including those with low comorbidity scores. Risk for morbidity associated with obstetric haemorrhage, infection, hypertensive disease, and medical conditions all increased during the study period.

Our findings demonstrate increasing risk at hospitals performing <1000 deliveries per year distributed over the patient population. Rates of morbidity at larger centers have also increased. We suggest that maternal safety improvements are necessary at all centers regardless of volume.

SPONTANEOUS SILENT FETOMATERNAL HAEMORRHAGE - A CASE REPORT

Abstract ID: 73

Dr. Siobhan Quirke (University College Hospital Galway), Dr. Gillian Ryan (Coombe Women and Infants University Hospital), Prof. Ruth Gilmore (University College Hospital Galway), Dr. Michael O'leary (University College Hospital Galway)

Introduction: We report a case of massive silent feto-maternal haemorrhage.

Clinical Details: The patient presented at 35+4 with a two day history of reduced fetal movements. Her antenatal course had been uneventful. At booking she was found to be rhesus negative and had one hospital presentation at 20+2 following minor abdominal trauma. She was well, Kleiheuer was negative, she received prophylactic anti-D before discharge. On presentation at 35+4 her CTG had a pathological pattern with markedly reduced variability and late decelerations. An emergency caesarean section was performed. At delivery the infant had a haemoglobin of 3.5 and massive silent FMH was diagnosed.

Discussion: Massive FMH is a rare phenomenon, presenting in 1/5000 deliveries. [3] It refers to the passage of fetal blood into the maternal circulation either before or during delivery. [1][3] Although the placenta is considered a barrier separating maternal from fetal circulation, bidirectional passage of a small number cells across the placenta is a physiological process and occurs commonly at delivery without clinical consequence. [1] Clinical manifestations are dependent on the volume of blood loss; potential outcomes include non-reassuring fetal heart patterns, neonatal haemodynamic instability or anaemia, hydrops fetalis, intrauterine/neonatal death. Potential maternal haematological outcomes include requiring large amounts of anti-D postnatally and sensitization.

A high index of suspicion is required in those presenting with reduced fetal movements. Fetal assessment with ultrasound, CTG and laboratory tests to detect FMH should be considered, as this rare condition can have devastating outcomes.

Spontaneous uterine rupture at 21 weeks gestation in a primiparous patient

Abstract ID: 36

Dr. Katie Beauchamp (MMUH), Dr. Dr Niamh Maher (MMUH), Mr. Tom Walsh (MMUH), Dr. Maeve Eogan (Rotunda Hospital)

Uterine rupture is a serious obstetric complication with high risk of foeto-maternal morbidity and mortality. The incidence is <1% in women with scarred uteri, and 0.006% in unscarred uteri which are “virtually immune to rupture”, especially before contractions.

Ms X, 32 year old para 0+1, presented at 21 weeks gestation with a 2 hour history of sudden onset severe abdominal pain, 2 episodes of diarrhoea, without vaginal bleeding. Background history included conservatively managed miscarriage and a diagnostic laparoscopy.

Her blood pressure and heart rate fluctuated and she spiked a temperature to 38.1oc. Fetal heart rate was normal. Haemoglobin at presentation was 11.6 g/dL. There was a clinical suspicion of appendicitis. Septic screen was performed and empiric antibiotics given before transfer to general hospital for general surgical review.

An MRI to assess for appendicitis was performed. Post MRI she became hemodynamically unstable. Her abdomen was tender and peritonitic. MRI abdomen demonstrated a uterine defect with placenta extrusion and large volume haemoperitoneum. A diagnosis of uterine rupture was made.

At emergency laparotomy a 3cm defect at the uterine fundus was discovered with placental protrusion, and a haemoperitoneum of 2L. Hysterotomy was performed and delivery of the fetus. The uterine defect was repaired and patient recovered with resuscitation.

This case highlights the importance of history taking, examination and the role of MRI in obstetrics. Future pregnancies would have a guarded prognosis, due to the unknown risk of a repeat event. The management would be complex and high risk, hence antenatal counselling is paramount.

STICKLER SYNDROME: A CASE REPORT

Abstract ID: 31

Dr. Sadhbh Lee (Portiuncula University Hospital, Ballinasloe), Dr. Marie Christine De Tavernier (Portiuncula University Hospital, Ballinasloe)

MK is a 38 yo para 1+0 who presented to Portiuncula Hospital for her booking visit at 12+5 weeks. Her previous baby was diagnosed with Stickler Syndrome. As Stickler Syndrome is associated with a 50% chance of recurrence, it was decided to arrange an anatomy scan at 22 weeks.

At 22+5, anatomy scan was normal and referral was made to the Rotunda. USS in the Rotunda at 25+5 revealed no obvious foetal anatomical abnormality, although profile views showed a flattened foetal face.

On repeat scan in the Rotunda at 34+5, 3D evaluation showed an abnormal profile with a strong suspicion of micrognathia, making a diagnosis of Stickler syndrome likely. The decision was made to transfer care to the Rotunda, to allow for optimal neonatal management, specifically the potential complications of a difficult neonatal airway.

Stickler Syndrome is an autosomal dominant genetic disorder of connective tissue, affecting an estimated 1/7500 newborns (1). It results in orofacial deformities, ocular manifestations, hearing loss and joint problems. Affected individuals characteristically display a flattened facial appearance and often the Pierre-Robin sequence – cleft palate, glossoptosis and micrognathia. The most common mutated gene is the collagen gene COL2A1. The mutation in this case was carried on the paternal side.

Antenatal diagnosis primarily involves ultrasonography, and in certain familial cases, genetic testing. For those displaying the Pierre-Robin sequence, the mother may present with polyhydramnios, which should prompt investigation for a foetal swallowing difficulty. Genetic testing can be performed by chorionic villus sampling or on amniotic fluid (2,3).

SUCCESS RATE OF COLD COAGULATION FOR THE TREATMENT OF HIGH GRADE CERVICAL INTRAEPITHELIAL NEOPLASIA IN CILL IDE COLPOSCOPY UNIT FROM 2012-2016

Abstract ID: 121

Dr. Eoghan Scally (Univer), Dr. Nóirín Russell (UCD Obstetrics and Gynaecology, National Maternity Hospital), Ms. Susan Foley (UNIVERSITY HOSPITAL KERRY), Ms. Maureen Hayes Considine (UNIVERSITY HOSPITAL KERRY)

Cervical cancer screening is aimed at early detection and treatment of premalignant disease. Current literature suggests that cold coagulation is a successful treatment in >90% of high grade Cervical Intraepithelial Neoplasia (CIN). Cold coagulation involves ablation of the cervical transformation zone and it is used as an alternative to excisional treatments, especially in young women who have not completed their family.

The study aimed to determine the success rate of cold coagulation for treatment of high grade CIN in our unit. A retrospective review of cold coagulation treatment for high grade CIN from 2012 to 2016 at the Kerry Colposcopy Unit.

The Compuscope database was used to identify cases. Cytology at 6 months post-procedure was reviewed to assess success.

Cold coagulation for histologically confirmed CIN 2 or 3 was performed for 355 patients during the study period. At 6 months post-treatment, 278 (81.5%) had normal cytology; 25 (7%) had LSIL/mild dyskaryosis; 19(5.3%) showed ASCUS/BNA; 5 (1.4%) cases had HSIL/severe dyskaryosis. Fourteen (3.9%) patients were lost to follow-up and one patient was pregnant at her 6 month follow-up (0.28%). Six cases yielded inadequate cytology (1.7%). In our unit, cold coagulation is a successful method of treating CIN 2 and 3 in the outpatient setting with only 1.4% of patients having persistent HSIL at 6 month follow-up. Further work is required to determine data at 18 months post-treatment. Cold coagulation should be considered when lesion margins are fully visible and there is no suspicion of invasive disease.

SURGICAL ANATOMICAL OUTCOMES USING POSTERIOR REPAIR QUANTIFICATION (PR-Q) TO IDENTIFY DEFECTS

Abstract ID: 79

Dr. Audris Wong (St Vincent's Hospital), Dr. Bernard Haylen (St Vincent's Hospital, Sydney), Dr. Phoebe Hong (St Vincent's Hospital, Sydney), Mr. Stephen Kerr (Kirby Institute, University of New South Wales, Kensington, NSW), Dr. Warwick Birrell (Mater Hospital, North Sydney, NSW)

Aims of study:

Posterior repair quantification (PR-Q) provides a clear, alternate set of four measurements to the equivalent POP-Q posterior compartment measurements. Using PR-Q (and POP-Q) measurements, posterior compartment defects have been found more at the vaginal vault (Level I) and vaginal introitus (Level III) than at the mid-vagina (Level II). The use of PR-Q as surgical indicators might facilitate consistent and favourable postoperative surgical anatomical outcomes.

Study design, materials and methods:

Cross-sectional study of 300 consecutive posterior repairs (PRs), mostly following prior or concomitant hysterectomy, the following were measured pre- and immediately postoperatively: (i) from POP-Q2: points C, Ap and Bp and genital hiatus (GH); from PR-Q: perineal gap (PG), posterior vaginal vault descent (PVVD), mid vaginal laxity (MVL) vault undisplaced, rectovaginal fascial laxity (RVFL -n/a postop). Demographic, surgical factors are included and surgical initiatives documented.

Results:

Demographic data for the 300 were; (i) Age: 63.6, Weight (kg) 71.7, Height (cm) 162.9, BMI (Kg/m²) 26.7, Parity 2.6. Mean cumulative surgical outcomes (%) at the different Levels were: (i) Level I: Overall 98% reduction in defect (PVVD - Point C similar reduction), 99% if SSC performed (84% cases) or 83% if SSC not performed (16% cases); (ii) Level II: 85% reduction in defect (MVL - Points Ap, Bp similar reductions); (iii) Level III: Elimination (100% reduction) of defect (PG) with 30% reduction in GH.

Conclusion:

PR-Q posterior prolapse surgical markers facilitate (i) identification of anatomical defects at the different Levels I-III; (ii) exact surgical planning for each Level; (iii) consistent, favourable and statistically interpretable anatomical surgical outcomes for each Level.

SURGICAL APPROACH FOR DRAINAGE OF A 40 L GIGANTIC OVARIAN CYST

Abstract ID: 216

Dr. Oana Martis (Department of obstetrics, Galway University Hospital (GUH)), Dr. Elzahra Ibrahim (University College Hospital Galway), Dr. Martin Keenan (Department of obstetrics, Galway University Hospital (GUH)), Dr. Michael O'leary (University College Hospital Galway)

Oana Martis (Galway University Hospital, NUI), Martin Keenan (Galway University Hospital, NUI), Elzahra Ibrahim (Galway University Hospital, NUI) and Michael O'Leary (Galway University Hospital, NUI)

Introduction: Ovarian cystadenofibromas are relatively rare benign tumors that contain both epithelial and fibrous stromal components representing 1.7% of all benign ovarian tumors.

Case: A 65 year old postmenopausal female patient was referred with 10 year history of progressively increasing abdominal girth and related walking disturbance.

Examination revealed a grossly distended abdomen. A CT scan revealed a 60x45.8x37cm septated mass in the peritoneal cavity, extending to the posterior aspect of the pelvis and firmly attached to the uterus and pelvis. Associated hydronephrosis on the right side. Investigation: CA125=290U/mL.

The patient was admitted to Galway University Hospital for an urgent TAH,BSO on- ifraombilical midline incision. The challenge was draining 40L of fluid from the cyst. The drainage technique included packing with gauze, a purse-string suture with a monofilament thread was put around a laparoscopy port attached to suction inserted to the 1 cm cut to the cyst wall, tighten the purse-string but not tying it. After completion of suction suture was tied. reducing the size, rest of the cyst was easily manipulated.

Post-operative: Weight dropped 40kg, bounding to wheelchair due to altered center of balance needed physiotherapy to adapt to the new center of balance had urinary retention requiring catheterisation and trial of void, plastics consult for pendulous skin.

Conclusion: The case highlights the importance of and interdisciplinary team approach and the new techniques for drainage .

THE BURDEN OF ENDOMETRIOSIS: PAIN DESCRIPTORS AND IMPACT ON ACTIVITIES OF DAILY LIVING AND RELATIONSHIPS IN WOMEN ATTENDING A DEDICATED ENDOMETRIOSIS CLINIC

Abstract ID: 189

Dr. Ciara Shiel (Cork University Maternity Hospital), Dr. Cathy Burke (Cork University Maternity Hospital)

The objective of this project was to identify recurring themes in the experience of endometriosis and to highlight the physical and emotional burden of this disease. We sought to qualify the impact of endometriosis on daily living and relationships.

This was an observational study of new presentations to a dedicated endometriosis clinic between September 2012 and September 2016 in Cork University Maternity Hospital.

A questionnaire was designed and distributed to all attendees at the clinic as a mandatory part of their consultation. Open-ended questions encouraged patients to describe their experience of endometriosis related pain. The information was then entered into a database and themes identified.

Patients ranged in age from 17 to 45, mean age 32 at first presentation. Overall health score was 68. 81% reported dysmenorrhea, 67% midcycle pain, 77% premenstrual pain, 46% postmenstrual pain, 57% dyschezia, 24% dysuria and 70% dyspareunia. Recurring descriptors were stabbing (69%), cramping (57%), sharp (19%) and burning (14%). 74% reported a negative impact on their personal relationships and social lives. 37% admitted difficulties with their partners, 29% relating this to dyspareunia. Pain, lethargy and weakness severely hindered 27% of patients in carrying out activities of daily living, 30% reported disruption to work and career. 53% were nulliparous with 27% reporting infertility problems.

Data gathered in this study demonstrates the debilitating nature of endometriosis; pain and associated symptoms heavily impact on patients' quality of life, extending to the lives of those around them. This study lends greater understanding to the quality of pain experienced.

THE DEVELOPMENT AND IMPLEMENTATION OF A SENIOR HOUSE OFFICER INDUCTION PROGRAMME FOR OBSTETRICS AND GYNAECOLOGY IN CORK UNIVERSITY MATERNITY HOSPITAL (CUMH).

Abstract ID: 8

Dr. Breffini Anglim (Cork University Maternity Hospital), Dr. Keelin O'Donoghue (Cork University Maternity Hospital)

Introduction

Practical educational training in obstetrics and gynaecology should be part of the doctor induction programme in all maternity hospitals. The majority of Senior House Officers (SHOs) have no post-graduate training in obstetrics and gynaecology, despite this they are expected to manage complex emergencies within a very vulnerable patient population.

Aims

The aim of this initiative in CUMH was to develop a more interactive, clinically orientated, obstetric and gynaecology-specific SHO induction programme, to provide SHOs with the necessary knowledge, skills and confidence required to practice safely.

Methods

The clinical induction programme took place over a seven-week period in July 2016. The induction programme consisted of a combination of interactive teaching, hands-on clinical skills and question and answer sessions. Topics covered included; general induction, pregnancy loss, labour ward and induction of labour, gynaecology, risk management and consent, and perineal suturing.

Results

Overall the induction programme was well received by SHOs. An average of seven SHOs attended each session. A questionnaire was used at the end of each session to determine its level of relevance, suitability and interest for the SHOs. The approachability of teachers, time management and enjoyment of each session was also assessed. All seven sessions were well received with 87-96% of SHOs finding the sessions useful and all felt the sessions enhanced their confidence and competence levels.

Conclusion

The clinical induction programme carried out in CUMH was well received and will be repeated in January as it was felt that this will improve confidence and competence amongst new SHOs.

THE DOCUMENTATION OF ESTIMATED BLOOD LOSS VERSUS MODE OF DELIVERY AT THE UNIVERSITY MATERNITY HOSPITAL LIMERICK

Abstract ID: 162

Dr. Céire Mc Guane (University Hospital Limerick), Dr. Fabio Margiotta (University Hospital Limerick), Mrs. Ciara Ni Laighin (University Hospital Limerick), Dr. Khadijah Irfah Ismail (University Hospital Limerick), Dr. Mendinaro Imcha (University Hospital Limerick)

According to the Confidential Maternal Death Inquiry in Ireland 2009-2012, major obstetric haemorrhage was the leading cause of maternal morbidity at 2.38/1000. It follows that compliance with best practice for the documentation of estimated blood loss (EBL) is essential. The HSE Standards and Recommended Practices for Healthcare Records Management (2011) outlines the need for full documentation for high quality and safe care. The objectives of this study was to review compliance at The University Maternity Hospital Limerick (UMHL) with the recording of EBL and to highlight awareness of the rate of compliance.

1006 consecutive births at UMHL between January 27th 2016 and April 28th 2016 were included in the audit. The data was collected by chart review and was categorized into three areas: spontaneous vaginal delivery, instrumental delivery and caesarean section. The documentation of EBL in each case was categorized as either recorded or not recorded.

The audit showed that spontaneous vaginal deliveries and vacuum deliveries each had a 9% rate of non-compliance with EBL documentation requirements. All forceps deliveries were fully compliant. All the caesarean section sub types CS1, CS2, CS3 and CS4 each had a non-compliance rate of 3%.

The documentation of EBL at UMHL is deficient for spontaneous vaginal births and vacuum deliveries compared to other modes of delivery. The results imply that the awareness among staff to document EBL increases with more invasive procedures. The audit highlights the need to reflect on procedure and practice of full documentation of EBL for all modes of delivery.

THE EFFECT OF MEDIA REPORTS ON HEALTHCARE PROFESSIONALS WORKING IN MATERNITY SERVICES IN IRELAND

Abstract ID: 11

Dr. Laurentina Schaler (Coombe Women and Infants University Hospital), Dr. Sarah Meaney (Cork University Maternity Hospital), Prof. Richard Greene (Cork University Maternity Hospital)

In recent years there has been a dramatic increase in media reporting on maternity services in Ireland. The effects of the constant media scrutiny on the second victim have yet to be analysed.

The objective of this study is to investigate the impact media reporting on maternity services in Ireland has had on healthcare professionals working in these services.

An online questionnaire was issued from May to August 2016. Respondents were questioned on the effect the media reporting has had on their profession. Descriptive statistics were used to analyse the data.

Of the 104 responses, over half stated that they feel angry (53.3%; n=48) or anxious (34.4%; n=31) as a result of media reports; 54.45% (n=56) considered the reporting to be negative and 46.6% (n=48) found it unhelpful. Overall one third of participants (30.4%; n=31) stated that media reporting has affected their career plans, with 36.5% (n=35) stating that they have changed their approach to patients in order to protect themselves. Non-consultant hospital doctors felt that the reporting highlighted the need for ongoing staff training and the development of national guidelines (41.7%; n=15).

Healthcare professionals are suffering as a result of media reporting. Staff have highlighted the need for improved training and standardisation of care in order to improve maternity services and to restore public confidence. A balanced representation is essential to protect and boost staff morale and to increase public confidence in maternity services.

THE HPV VACCINE CRISIS

Abstract ID: 250

Dr. Maria Cheung (Mater), Dr. Ellen Cosgrave (Mater), Dr. Zara Fonseca-kelly (Mater), Dr. Eimear McSharry (Coombe Women and Infants University Hospital), Dr. Orla Smith (Rotunda Hospital), Dr. Catherine Windrim (National Maternity Hospital), Dr. Sorca O'Brien (National Maternity Hospital), Prof. Donal Brennan (Mater)

A survey was developed to assess the opinions of nurses, midwives and allied health professionals towards the HPV vaccine and how recent media coverage has impacted this.

A 12-question paper survey was compiled, assessing basic demographic information, vaccination status and the perceived impact of the media coverage on their opinion of the HPV vaccine.

188 people completed the survey, of whom 76 have children and 122 do not. With regard to routine vaccinations, 93.4% of participants with children and 97.3% of those without, have vaccinated or would vaccinate their children. However, only 30.2% of participants with eligible children have consented to HPV vaccine, compared to 61.6% of those without children, who hypothetically would vaccinate. 86.1% of participants were aware of the media coverage about the HPV vaccine. The media coverage made 23.9% more likely to give consent for the HPV vaccine, 34% less likely and 39.9% stated it would make no difference.

It is clear from these results that the media coverage is affecting opinions and decisions to vaccinate, even within the nursing and allied health professions. Participants stated they felt media coverage was the only source of information around the vaccine and adverse effects. This highlights that there is a role for staff education within the hospital.

The Impact of emergency Caesarean Section prior to scheduled elective date

Abstract ID: 153

Dr. Dylan Deleau (UCD Obstetrics and Gynaecology, National Maternity Hospital), Dr. David Crosby (UCD Obstetrics and Gynaecology, National Maternity Hospital), Dr. Stephen Carroll (UCD Obstetrics and Gynaecology, National Maternity Hospital)

Background

It is recommended that a planned elective Caesarean Section (CS) is conducted after 39 weeks gestation. However, up to 10% of women scheduled for ERCS go into labour before their scheduled CS date(1).

Aims

To assess immediate maternal and neonatal outcomes in women scheduled for elective CS, not suitable for vaginal birth who present in labour prior to their scheduled date.

Methods

The prospective study was conducted from July to September 2016. Data was collected from the theatre logbook and patient notes.

Results

Of the 217 women booked for an elective CS and not suitable for vaginal birth, 26(12.0%) had an emergency CS prior to their scheduled date. The mean age was 32.3 years(SD 4.2) and mean BMI was 25.8kg/m²(SD 4.1). The median gestational age of CS was 38+6weeks (Range 36+5-40+0weeks) and the median scheduled elective CS date was at 39+3weeks. Table 1 shows indications for CS. The mean EBL was 470ml(SD 205). 1/26(3.8%) had a general anaesthetic. 2/26 and 0/26 had Apgars < 7 at 1 and 5 minutes respectively. There were no admissions to NICU. 19/26(73.1%) CS were performed between 8pm and 8am.

Conclusion

In this study, 12% of women not suitable for vaginal delivery presented in labour prior to their scheduled CS date and had an emergency CS. 73.1% occurred between 8pm and 8am. The current guideline recommending elective CS after 39 weeks gestation has an impact on emergency management resources.

References

1) Birth after Previous Caesarean Birth, GTG 45, RCOG

THE IMPACT OF HYPEREMESIS GRAVIDARUM ON QUALITY OF LIFE: A MIXED METHODS STUDY

Abstract ID: 92

Ms. Liyana Sheik Muhamed (College of Medicine and Health, University College Cork), Ms. Sarah Meaney (National Perinatal Epidemiology Centre, University College Cork), Prof. Richard Greene (National Perinatal Epidemiology Centre, University College Cork)

Hyperemesis Gravidarum (HG) is defined as intractable nausea and vomiting in pregnancy that associated with ketosis and weight loss. Affecting 0.3%–2.0% of pregnancies, this condition often interferes with daily activities. This study aimed to investigate the physical, psychological, social, and environmental issues experienced by women with HG.

A mixed method study was undertaken. Firstly, a case control study was conducted involving 80 pregnant women using the World Health Organization Quality-of Life questionnaire (WHOQOL-BREF). The WHOQOL-BREF examines quality of life in four key domains; physical health, psychological, social relationships and environment. In-depth interviews were then carried out with 10 women who experienced HG.

Women with HG reported significantly lower quality life scores in all for domains; physical health (38.6% versus 80.3%; $p < 0.001$), psychological (48.8% versus 82.7%; $p < 0.001$), social relationships (50.5% versus 83.5%; $p < 0.001$), and environment (59.6% versus 86.3%; $p < 0.001$), compared to controls. Qualitative interviews illustrated the debilitating nature of HG. In particular these women raised concerns about missing work, the strain placed on their partner as well as the emotional stress they experienced throughout their pregnancies.

In patients with HG, significant deterioration of quality of life was identified in the key domains of physical health, psychological, social relationships and environment. Management of HG should be focused on managing dehydration and electrolytes, controlling the symptoms and preventing complications. However, a holistic approach is crucial for these patients.

The Management of Late Postoperative Complications Associated with Midurethral Slings in our Urogynaecology Unit

Abstract ID: 257

Dr. Tara Rigney (Nation), Dr. Gerard Agnew (Pelvic Floor Centre, St. Michael's Hospital)

The midurethral sling is the most common type of surgery used to alleviate the symptoms of stress urinary incontinence. The sling comprises of a narrow synthetic mesh that is placed under the urethra to lift and support it. While generally well tolerated and safe, it's not free of complications. Potential intraoperative complications include bleeding, urethral and bladder injury. Early postoperative complications include lower urinary tract symptoms and voiding dysfunction, infection and pain. Late postoperative complications are often the most challenging to treat and include extrusion (vaginal exposure), erosion (mesh inside lower urinary or gastrointestinal tract), obstruction/voiding dysfunction, recurrent urinary tract infections and dyspareunia.

The aim of this study was to assess the late postoperative complications amongst women who had a midurethral sling procedure and their subsequent management.

We looked at all patients who had a midurethral sling procedure in our hospital in 2015.

There were 130 midurethral sling procedures performed in 2015. All patients were followed up 6 weeks post-operatively. 9 patients (7%) reported postoperative complications. These included mesh extrusion (5), mesh extrusion with dyspareunia (3) and voiding dysfunction (1). All 9 patients returned to theatre for a repair of tape extrusion, or excision in the setting of voiding dysfunction. All patients were subsequently followed up in the outpatient clinic and are not reporting further complications.

While relatively uncommon, late postoperative complications are a feature of midurethral slings and it's important that women are counselled appropriately

prior to their insertion. Overall our complication rates compare favourably with expected outcomes.

THE PRESENTATION AND MANAGEMENT OF VARIOUS PLATELET DISORDERS IN PREGNANCY: A CASE-BASED APPROACH

Abstract ID: 17

Dr. Bart Goldman (University Hospital Waterford), Dr. Oyenike Olowo (University Hospital Waterford), Mr. Sahr Yambasu (Trinity College Dublin), Dr. Eddie O Donnell (University Hospital Waterford)

Thrombocytopenia is defined as platelet count less than $150 \times 10^9/L$. Thrombocytopenia in pregnancy often leads to difficulties of diagnosis and management, despite being relatively common. 7-12% of pregnancies are complicated by thrombocytopenia.

According to the 2016 Irish Maternity Indicator System report, 2039 babies were delivered in University Hospital, Waterford (UHW) in 2015. Although UHW is a minor healthcare facility in terms of deliveries, a broad spectrum of unique platelet disorders presented to the hospital over a 1yr period. Case studies were used to highlight the clinical presentation and management of these disorders, which, despite being perceived as uncommon in pregnancy, must be recognised and treated appropriately when they present.

Five pregnancies involving unique platelet disorders that presented to UHW over a period of 12mths were selected and analysed retrospectively. Aspects of the pregnancies, such presentation, management, complications and outcome were examined to provide insight into the quality of clinical management.

Platelet disorders that were examined include gestational thrombocytopenia, immune thrombocytopenic purpura, thrombotic thrombocytopenic purpura, thrombocytopenia absent radius syndrome and foetal & neonatal alloimmune thrombocytopenia. Each presentation had its own challenges, but every pregnancy that was assessed had good maternal and neonatal outcomes on delivery, as is discussed in the case studies.

The fact that such a range of platelet disorders were seen in a minor healthcare facility within a one year period highlights the importance of being able to recognise and manage a variety of platelet disorders in pregnant women. This study illustrates the presentation and clinical management of such cases.

The prevalence of ovarian cyst in women with abdominal pain.

Abstract ID: 50

Dr. Tushar utekar (Mullingar Midlands Regional Hospital), Dr. Sarah Keavney (Mullingar Midlands Regional Hospital), Dr. Majda Almshwt (Mullingar Midlands Regional Hospital), Dr. S. Thomas (Department of Obstetrics and Gynaecology, Mullingar Midlands Regional Hospital)

The number of ultrasonography scans done in acute hospitals for suspected ovarian cyst were enormous, without any heed paid to the history and/or clinical examination, and so were the referrals for ruling out ovarian cysts. We had to prove this to make our (and sonographer's) lives easier.

We wanted to study the incidence of ovarian cyst in women presenting with abdominal pain in ED, inter departmental referrals and by GP ordered scans.

We studied the number of sonography scans done in MRHM in the over the period of 6 months Feb 2016- August 2016, in women. Then we looked at the indications and the person who ordered it (GP, ED, speciality SHO), All those scans which were booked for pain in abdomen were looked in detail and the results were analysed and tabulated.

We found that over a thousand scans were ordered over the study period of which 605 were done for abdominal pain, a third were ordered by the hospital doctors, rest by GP and not so surprisingly the incidence rate found was 3.5% for any ovarian cyst requiring any form of intervention there was also significant difference between the pick up rate based on which speciality ordered the scans, gynaecologist fared better in that list.

Only a fraction of patients with abdominal pain have cysts, The need for detailed history taking and clinical examination couldn't be more emphasized more instead of taking the easy way out and just ordering a scan without examination, or looking at past number of scans done.

THE PSYCHOLOGICAL IMPACT OF OVARIAN RESERVE TESTING: A QUALITATIVE STUDY

Abstract ID: 30

Dr. Yvonne O'Brien (Merrion Fertility Clinic, National Maternity Hospital), Dr. Caroline Kelleher (Royal College of Surgeons in Ireland), Prof. Mary Wingfield (Merrion Fertility Clinic, National Maternity Hospital)

The introduction of universal ovarian reserve screening is being increasingly debated. We wanted to investigate the psychological and emotional responses of women being informed of their Anti-Mullerian Hormone (AMH) result with a view to informing the possible introduction of universal AMH screening.

This was a prospective qualitative study using semi-structured in-depth interviews of women who had ovarian reserve testing performed via measurement of serum AMH levels.

A broad range of women, in terms of age and AMH levels, were recruited (n=10). Interviews were audiotaped, transcribed verbatim and imported into QSR NVivo for analysis. Using thematic analysis, the sorted categories evolved into a coding system, which was applied independently to each transcript.

Women were often unaware of the clinical relevance of the test, and their main source of information was the internet. Those with a low AMH level reported feelings of devastation, isolation and loss of femininity and purpose. With a normal result, the overwhelming theme was reassurance and surprise that the result was normal.

This is the first study to investigate the psychological impact of AMH testing. Although an exploratory study, the women in this study advocated to provision of ovarian reserve testing. However, knowledge of a low AMH result has a negative psychological impact. This must be anticipated and appropriate supports put in place prior to implementing universal screening. These results will be used to develop a detailed quantitative questionnaire for the next stage in this study which will recruit a larger and more representative sample of women.

The PUQE factor- Compliance with Hyperemesis Guidelines

Abstract ID: 143

Dr. Eimear McSharry (Coombe Women and Infants University Hospital)

Hyperemesis gravidarum is intractable nausea and vomiting which occurs in 1% of pregnancies 1. Persistent vomiting can result in dehydration, ketosis, weight loss, electrolyte imbalance, thyrotoxicosis and vitamin deficiency 2.

The aim of this study was to determine the level of compliance with the new Irish hyperemesis guidelines 3 in an emergency room of a tertiary obstetric centre.

All patients who presented to the emergency room with intractable nausea and vomiting and diagnosed with hyperemesis gravidarum over a three month period were included (n=100). Patient notes were reviewed for documentation of PUQE score, clinical signs of dehydration, weight, bloods, electrolyte disturbance, ketonuria, MSU, differential diagnosis, admission and prescription of IV fluids, thromboprophylaxis, antiemetics and vitamin supplementation.

100% compliance was noted with documentation of ketonuria and prescription of IV fluids and antiemetics. Poor compliance was noted in a number of areas including documentation of PUQE (Pregnancy Unique Quantification of Emesis and Nausea) score (1%), weight 8%, clinical signs of dehydration (2%), electrolyte disturbance with appropriate supplementation (10%). 53% received vitamin supplementation. Worryingly only 33.3% of those admitted were prescribed thromboprophylactic innohep.

Education is required on the new hyperemesis guideline especially regarding the importance of thromboprophylaxis in this vulnerable group and the use of the PUQE score, a validated assessment tool to determine the severity of nausea and vomiting in pregnancy and guide treatment. In-patient management should be considered when PUQE score ≥ 7 , with a PUQE score ≥ 13 indicating severe nausea vomiting of pregnancy.

THE SIGNIFICANCE OF INCOMPLETE EXCISION MARGINS IN WOMEN TREATED WITH LARGE LOOP EXCISION OF THE TRANSFORMATION ZONE

Abstract ID: 107

Ms. Adrienne Wyse (Royal College of Surgeons in Ireland), Prof. Paul Byrne (Rotunda Hospital)

Large Loop Excision of the Transformation Zone (LLETZ) is the current gold standard treatment for Cervical Intraepithelial Neoplasia (CIN) (1). To date there has been conflicting evidence on the significance of the resection margin status as a determinant of residual or recurrent disease (2,3,4,5).

The aim of our study was to examine the correlation between excision margin status and eradication of CIN in women who were treated by LLETZ.

We reviewed all women who underwent a LLETZ procedure between 1.1.2012 and 31.12.2014 and for whom excision margin status and test of cure outcome was available at 6 months. Treatment success was evaluated based on the presence of a negative cervical smear and a negative HPV test.

The final analysis group consisted of 1077 women. 399(37%) had completely excised margins and 678(63%) were incompletely excised. Six months following treatment, 536(79%) patients with incomplete excision margins and 321(80%) with complete excision margins had negative cytology ($\chi^2=P>0.05$). 527(78%) with incomplete excision margins and 327(82%) with complete excision margins were HPV negative ($\chi^2=P>0.05$). 471(69%) with incomplete excision margins and 295(74%) with complete excision margins had both negative cytology and negative HPV status ($\chi^2=P>0.05$).

Our study shows that excision margin status is not correlated with test of cure outcome for women with CIN. We would recommend that women treated for CIN should have the same follow up protocol regardless of excision margin status.

The value of biochemical markers in gynaecological malignancy: A retrospective 4 year review of biomarkers in an Irish Gynaecology centre

Abstract ID: 113

Dr. Ann Rowan (The Mater Misericordiae University Hospital), Ms. Anne-marie Dolan (The Mater Misericordiae University Hospital), Dr. Peadar Mcging (The Mater Misericordiae University Hospital), Mr. William Boyd (The Mater Misericordiae University Hospital)

The sensitivity and specificity of tumour markers alone in diagnosis of gynaecological malignancy is known to be poor. Our aim was assess the value of tumour markers in our population at estimating risk of malignancy (range □ reference).

Data from 156 patients was recorded prospectively from January 2012-December 2015. These patients had concurrent CA125, CA199 and CEA sampling and were under review by the gynaecology service. On retrospective analysis, using hospital records data was collected on all patients. The standard reference ranges in our hospital were applied to data for threshold of normalcy.

Five patients (5/156) were removed as non-gynaecological malignancies. Sixty-nine (46%) of patients had benign histology, 23 (15%) borderline, 59 (39%) malignant histology. Mean patient age at presentation differed between benign, borderline, and malignant histology (55, 43, and 56 years). Of those with malignancy this was diagnosed by biopsy in 13 (22%), surgery 44 (75%), cytology 2 (3%). Mean CA125 was highest in malignant cases (1137). Mean CA199 was highest in benign cases (1661). In malignant cases CA125 was reported in the normal range in 29% (n=17), 59% (n=35) in CA 199, and 86% (n=51) in CEA. Of malignant cases 25% (n=15) had all three tumour markers within the normal range, 14 (93%) had surgical diagnosis.

Tumour markers alone are not a reliable predictor of malignancy, using our hospital standard reference range 25% of patients would not meet the criteria for malignancy. This study highlights the risk of reliance on markers alone in assessing patient's malignancy risk.

TIME TO STANDARDIZE THE NATIONAL CAESAREAN SECTION CONSENT- BEST PRACTICE.

Abstract ID: 61

Dr. Deena Basha (St Lukes Kilkenny), Dr. Sehrish Nafees (St Lukes Kilkenny), Dr. Mohamed Barakat (St Lukes Kilkenny), Dr. Nagaveni Yuddandi (St Lukes Kilkenny)

Background: Caesarean section rate is exponentially raising nationally and internationally, along with its associated morbidity and mortality.

A valid informed consent is important for understanding the procedure and enhancing patient satisfaction. It is important to introduce a national procedure specific consent form to uniform the standard nationally for all the maternity units along with the national maternity chart.

Purpose of the study: To encourage the introduction of a National Consent form for caesarean sections to promote consistent and adequate information to all women who need a caesarean section.

Study design and methods: HSE and RCOG (2009) caesarean section consent information has been used for an audit purpose. All the 19 maternity Institutional caesarean section consent forms were collected and reviewed. Findings of study: The majority of maternity units in Ireland are not using the special caesarean section consent form. Most of the units are documenting the caesarean section risks but there is no consistency and standard in taking the consent. Only 3 hospitals are using the procedure specific consent form, with local modifications. One unit is using the HSE consent form.

Conclusion: A valid consent is a valuable document and genuine communication is essential to make an informed consent. All 19 maternity units have divergent consent forms and introduction of a standard form will provide a structured approach for efficient preoperative information.

TWICE FAILED BILATERAL TUBAL LIGATION: A CASE REPORT

Abstract ID: 233

Dr. Chris Elizabeth Philip (Rotunda Hospital)

We present a case of a woman who is pregnant after undergoing 2 procedures of bilateral tubal ligation. Patient is a 30 year old woman, parity 4 with one vaginal delivery and three caesarean sections. She had a bilateral tubal ligation using tubal clips in 2011 during her second caesarean section. Shortly after that she conceived again and delivered in 2013. A partial salpingectomy was performed during that section. She recently presented to the early pregnancy unit (EPU) after testing positive on multiple urine pregnancy tests. On a scan in EPU an empty uterus was noted with no free fluid seen in the pouch of Douglas. Following an initial assessment of her beta human chorionic gonadotropins (bHCG) of 2800 mIU/ml she was admitted for a departmental scan and serial bHCG. A departmental scan showed possible early signs of 2 gestational sacs with no fetal pole or yolk sac noted. No signs of ectopic were seen in the scan and both ovaries were clearly visualised. The patient is very stable and does not report any pains or bleeding however there has been a suboptimal rise in her bHCG. The largest study to date on tubal ligation failure is the CREST study. This study found that tubal ligation failures do occur and can be as high as 3%. The effectiveness varies by the ligation method employed as well as factors such as patient's age, race and ethnicity.

Reference: Tubal Occlusion Failures: Implications of the CREST Study on Reducing the Risk

TWO CASES REPORTS OF CORNUAL ECTOPIC PREGNANCIES

Abstract ID: 202

Dr. Amy Fogarty (Gynaecology Department, Tallaght Hospital, Dublin 24), Dr. Daniel Galvin (Gynaecology Department, Tallaght Hospital, Dublin 24), Dr. Dr Feras Abu Saadah (Trinity College Dublin), Dr. Gunther Von Bunau (Gynaecology Department, Tallaght Hospital, Dublin 24)

Cornual or interstitial ectopics are a rare form of ectopic pregnancy. An ectopic pregnancy is defined as a pregnancy that has implanted outside the uterine cavity. A cornual or interstitial pregnancy is when that implantation occurs in the intramural segment of the fallopian tube. They account for 2-4% of all ectopic pregnancies and carry a 2-2.5% mortality rate. They carry an increased mortality rate due to their late presentation, risk of uterine rupture and intra-operative complications. They were traditionally treated with laparotomy and hysterectomy or cornuectomy but are increasingly being managed using laparoscopic techniques.

We present 2 cases, one managed with laparotomy and the other using laparoscopy. The purpose of presenting the two cases is to highlight the difficulty in identifying and managing this condition.

Although both approaches to management differ, ultimately what is the safest option for the patient is paramount and multiple factors need to be considered. The clinical condition of the patient, previous surgeries and prior health concerns should be identified. It is also important that the hospital and the staff involved in the case feel they have the necessary skills and abilities to appropriately deal with the situation.

UNDERSTANDING PARENTS' NEEDS - A PROSPECTIVE OBSERVATION OF THE PSYCHOLOGICAL EFFECTS ON PARENTS OF FOLLOWING THE DECISION TO EXPECTANTLY MANAGE FETAL MELAFORMATIONS: A PILOT STUDY.

Abstract ID: 188

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In Ireland, where termination is illegal on grounds of fetal anomaly, continuing with pregnancy after prenatal diagnosis is the route taken by the majority. There is a wealth of research pertaining to psychological outcomes regarding termination of pregnancy.

We aim to address the dearth of research concerning psychological outcomes and experiences of care while continuing pregnancy following a diagnosis of fetal anomaly.

A quality of life questionnaire was developed using FertiQoL, and administered to couples whose baby had been prenatally diagnosed with an anomaly in the Rotunda Prenatal Diagnosis Clinic. Fourteen couples received questionnaires at diagnosis and at six months post-delivery. Eight couples returned completed questionnaires. Descriptive analysis of the data was performed.

A reduced ability to move ahead with life goals, a perceived negative impact on the relationship with their partner, impaired attention and concentration, anger, frustration and grief was observed in participants followed the diagnosis. These responses were more pronounced in females compared to males. Satisfaction with care was high, in relation to information received, medical and emotional support, and interactions with staff. Overall, females coped worse with the pregnancy than males.

Significantly negative psychological symptoms were identified in parents following diagnosis of fetal anomaly, consistent with other studies. The differences between females and males may indicate a need to differ our counselling approach. While this pilot has a small sample with potential selection bias, the levels of satisfaction are in stark contrast to findings of international studies, where continuing pregnancy after prenatal diagnosis is far less common.

UNICORNUATE UTERUS WITH ECTOPIC OVARY; A CASE REPORT

Abstract ID: 235

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Unicornuate uterus is a rare malformation of the Mullerian system. It has an incidence of about 0.3% of the whole population and 0.6% of the infertile population. The incidence of ectopic ovary is around 20% when the uterus is absent and more than 40% in cases of unicornuate uterus. Only a few cases of ectopic ovaries are reported because many cases go unrecognized. To our knowledge, a very limited number of case reports are available in literature to describe concomitant occurrence of gonadal and uterine abnormalities. We hereby present a case of unicornuate uterus with an ectopic ovarian tissue.

Failure of Mullerian duct to develop or to migrate to its normal location is the main cause of Unicornuate uterus. Multiple genetic and familial factors are attributed.

Our case is a 19 years old non sexually active virgin female who presented with right iliac fossa pain for two days exacerbating with movement. Menarche was when patient was 13 years old. Last menstrual cycle was 6 days previously. History of left ovarian cyst treated with oral contraceptive pills. Her vital signs were stable, her urine pregnancy test was negative, and laboratory examinations were within normal limits. Transabdominal and pelvic sonography were negative for any abnormalities. Patient underwent diagnostic laparoscopy, which revealed unicornuate uterus with normal left tube and ovary. Rudimentary ovarian tissue was noted on the right lateral wall.

Further imaging by MRI is needed to fully delineate congenital anomalies, to locate ectopic ovarian tissue and to detect associated urinary tract anomalies.

Unusual Twins: First Ever Liveborn Twin/Complete Molar Pregnancy in Ireland.

Abstract ID: 265

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Twin pregnancy with a complete hydatidiform mole represents a very rare obstetric conundrum. This condition has an incidence of 1 in 22,000 to 1 in 100,000 pregnancies. The management of such pregnancies is challenging; the potential for fetal survival needs to be weighed against the real risk of severe maternal morbidity associated with molar pregnancy. Only 56 liveborn babies have been documented worldwide. This study reports the first ever case in Ireland of a twin pregnancy in which there was a complete hydatidiform mole and a liveborn, healthy baby. The patient, a 43-year female, para 2, presented for an early pregnancy scan and a DCDA twin pregnancy was identified. Additionally, a retroplacental mass was noted. Further interrogation confirmed the presence of a normally growing live fetus alongside a normal placenta and an additional intrauterine mass with features of a hydatidiform mole. The patient was closely monitored throughout her pregnancy for possible complications associated with molar pregnancy; she was diagnosed with new-onset hyperthyroidism in the first trimester and hyperemesis gravidarum. Here we outline the clinical features, management, outcome and follow up of a patient with a viable fetus coexistent with a hydatidiform mole.

Uptake of influenza vaccination in pregnancy: A cohort study

Abstract ID: 154

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Introduction

Influenza vaccination use in pregnancy is associated with a reduction in maternal and perinatal mortality and morbidity.

Objective -

The objective of this study was to determine the uptake of the annual influenza vaccine in a pregnant population and ascertain the reasons why some pregnant women did not receive it.

Methods-

We conducted a prospective cohort study over a two-week period in January 2016.

Results -

There were 504 women studied over the study period. The mean age was 32.2years(SD 5.9). There were 239(47.4%) primiparous women and 265(52.6%) multiparous women. The mean BMI at the booking visit was 25.4 kg/m²(SD 4.7) and the mean gestational age when studied was 31.3 weeks(SD 7.5).

Overall, 197 (39.1%) women received the vaccine at a mean gestational age 20.9 weeks (SD 7.0, range 4-36 weeks). 41.8% of primiparous women and 36.6% of multiparous women received the influenza vaccine. Overall, 48.1% of those classified with a medical co-morbidity received the influenza vaccine. When analysed by maternal age less than 30 years(n=145), there was a 27.6% (n=40) uptake compared to a 43.7%(n=157) in those 30 years or greater (n=359), (p=0.0008). Of those less than 30 years of age who did not receive it, 38.1% did not know it was recommended in pregnancy.

Conclusion -

Given the increased rates of influenza in the community and the associated implications for both mother and infant, it is important that we educate pregnant women regarding the risks of influenza in pregnancy and encourage this cohort in particular to be vaccinated.

Use of Propess® for Induction of Labour in Rotunda Hospital

Abstract ID: 286

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Prostaglandin E2 has been used for many years for induction of labour. There are numerous preparations on the market which vary in dose, administration and side effect profile. The preparation of choice in the Rotunda Hospital was Prostin gel until a national shortage in May 2015 prompted a change. Propess® (dinoprostone) was then introduced temporarily for the induction of labour.

The aim of this study was to examine the success of Propess® for induction of labour.

Data was collected on a spreadsheet prospectively following the introduction of Propess®. Information on parity, induction indication, gestation, prostin gel usage, oxytocin usage, SROM or ARM and mode of delivery was noted. It was collected over a 6 month period from July 2015 - January 2016 and was analysed using microsoft excel.

The total number of inductions in this period was 521, 66% were primips (n=343), 34% were multiples (n=178). 61% required an oxytocin infusion. 7.5% required an additional prostin gel after 24 hours. 47.5% had an SVD, 29% had a LSCS and 23.5% had an instrumental delivery. Of those who had a LSCS, 83.5% were primips, 16.5% were multiples and 30% of these were for failed induction. The failed induction rate with Propess® was 8.5%.

The majority of patients induced with Propess® had a vaginal delivery. The failed induction rate with Propess® was 8.5% which is higher than that quoted in similar studies in the literature (Worcester), possibly secondary to less rigorous exclusion criteria eg. the inclusion of prolonged SROM in our study.

Uterine and peripheral Natural Killer cells in endometriosis associated infertility.

Abstract ID: 155

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Background

Implantation is critical for successful pregnancy and natural killer (NK) cells are key players. However, the merits of testing and treating presumed NK cell dysfunction are disputed. We previously showed aberrant maturation of NK cells in endometrium from women with endometriosis¹.

Purpose of study

The aim of this study was to correlate NK findings with pregnancy outcome.

Study Design and Methods

Endometrial tissue was obtained by aspiration biopsy and matched blood samples were collected. NK cells were investigated by flow cytometry using antibodies to CD45, CD56, CD10, CD34, CD117, CD94.

Findings of Study

31 women with endometriosis underwent ART within a median of 8 months of surgery. 21 (67.7%) had successful implantation. Women with successful implantation fewer mature uNK cells (22.6% vs. 38.2%, $p=0.07$) and more immature uNK cells (5.2% vs. 1.0%, $p=0.02$) than women with failed implantation. Peripheral blood mature NK cells were higher in women with successful implantation. Baseline characteristics were similar between the groups.

In women with endometriosis who conceived spontaneously ($n=25/41$), there were no differences in the numbers of mature uNK cells compared with controls. However, there was a trend towards increased progenitor NK cells in those who conceived.

Conclusion

These data demonstrate significant differences in NK repertoires in blood and uterine compartments. Our findings certainly merit further study but, given the heterogeneity of the data, and the limitations of current knowledge, we concur with others that at the present time 'measurement of peripheral blood NK cell numbers as a surrogate marker of events at the maternal-fetal interface is inappropriate' and 'no better than tossing a coin'⁽²⁾.

Uterine Sacculatation during Pregnancy - Case Presentation

Abstract ID: 159

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We report a case of uterine sacculatation noted on caesarean section of a 37 year old primigravida, IVF pregnancy, who presented with PPROM at 32 weeks' gestation. Her medical and surgical history was unremarkable except for a history of primary infertility. She was managed conservatively until a decision was made for LSCS at 33+5 weeks in view of static foetal growth and breech presentation.

During LSCS, after delivery of the baby, the placenta was retained. The uterus was exteriorized which revealed a saccular shape area herniating from the right uterine fundus containing the placenta. The placenta was removed manually with difficulty. There was an estimated blood loss of 1 litre. The patient had an uneventful postnatal recovery.

Uterine sacculatation is a rare pregnancy complication and is difficult to diagnose. It arises as a local, temporary distension of the uterine wall during pregnancy and disappears again after birth. Any part of the uterus can be affected, primigravidas are more commonly affected and may be associated with uterine malformation. Sacculatation can contain part or all of the fetus and/or the placenta. The aetiology is uncertain and primary sacculatation differs from secondary incarcerated sacculatation with a retroverted uterus¹.

Without diagnosis, this can cause spontaneous miscarriage, intrauterine foetal death, uterine rupture, preterm delivery, placenta accreta, retained placenta and postpartum haemorrhage. US and MRI may aid in the diagnosis of this condition²⁻³.

This case indicates that malformations such as uterine sacculatation are difficult to diagnose and carry a significant risk to mother and foetus.

UTILISATION OF THE ESTABLISHED VENOUS THROMBOEMBOLISM RISK ASSESSMENT TOOL THROMBOCALC IN A PERIPHERAL OBSTETRIC UNIT

Abstract ID: 240

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Background:

Venous thromboembolism (VTE) remains a leading cause of maternal death and morbidity. Guidelines suggest VTE risk assessment at every visit, and again at delivery. The Rotunda Hospital developed an electronic tool, Thrombocalc, which enabled calculation of risk, and provision of recommendations on dosing and duration of thromboprophylaxis. Thrombosis risk was estimated by assigning a score to each VTE risk factor, determined from published literature.

This risk stratification took place prior to discharge from the delivery unit.

Study Method:

We looked at the feasibility of utilizing the tool in our unit, Wexford General Hospital. We retrospectively audited the deliveries in our unit over a month long period (n=138), using a hard copy of the electronic VTERA proforma used by the Rotunda hospital on their labour ward. We classified patients as low, moderate or high risk as per the Rotunda VTERA guidelines and proforma, and then assessed whether VTE prophylaxis with low molecular weight heparin had been administered appropriately in our population.

We subsequently provided an education session for all staff working on the labour ward – midwives and doctors that would be performing the risk assessment and calculation. We then prospectively risk assessed another cohort of patients over a further 30 day period.

Conclusion:

Despite small numbers in both our retrospective and prospective groups of women, a VTE risk assessment tool such as Thrombocalc is a valuable tool in the assessment and appropriate prescribing of VTE prophylaxis.

WHO'S TALKING ABOUT GYNAECOLOGICAL ONCOLOGY ON TWITTER

Abstract ID: 211

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Patients and physicians live in an information era dominated by the Internet and social media. Patients have unparalleled access to medical information from all sources. Much of present-day patient education occurs online through social media platforms like Twitter.

The aim of this study was to gain a better understanding of what online conversations about gynaecological cancers are taking place and what sources most commonly provide information to the general public.

Over an 80 day period, individual tweets containing hashtags relating to women's cancer were collected via the Twitter API. Data collection was limited to 14 terms relating to women's cancers, sourced from the CDC web site. Of the 200 most linked websites on Twitter, 14% were social media (e.g. www.youtube.com), 13% were general news (e.g. www.telegraph.co.uk), 12% were medical/science news (e.g. www.medicalnewstoday.com), 12% were charity/advocacy websites (e.g. www.jostrust.org.uk), 11% were commercial websites (e.g. www.amazon.co.uk) and 8% were academic journals (e.g. oncology.jamanetwork.com).

The dissemination of good quality information by Healthcare professionals to patients has always presented challenges. Social media presents further challenges, as any users may broadcast or promote content without regulation. Also, social media organizations need to generate revenue and depend on advertising and other commercial entities. Our results demonstrate that only 20% of Twitter conversations that specifically tag gynaecological cancers contain links to web sites associated with credible medical or scientific professional sources. Analysis and deeper understanding of social media content allows healthcare professionals to enter this global social conversation and to leverage it for the benefit of patients.

WOMEN SATISFACTION LEVELS WITH FIRST TRIMESTER MISCARRIAGE MANAGEMENT

Abstract ID: 273

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As miscarriage is a frequent complication in early pregnancy, assessing patient's satisfaction of the different forms of managements is of vital importance.

The aim of this study was to evaluate the satisfaction levels following miscarriage management in the setting of an Early pregnancy assessment unit.

Women were recruited prospectively following the diagnosis of first trimester miscarriage between October-2015 and August-2016. Women were offered surgical, medical or conservative managements. Subsequently, an online survey was emailed to the women after a period of six to eight weeks.

A total of 172 women were recruited with a response rate of 84%. The average age of the recruited women was 34 years, with 38% being nulliparous and 38.5% having had at-least one previous miscarriage. The majority were Caucasian (91%), employed (83%) and in a relationship (91%). Just over half of the women opted for surgical management (54%); while 33% opted for medical management and 12% opted for conservative management. The overall satisfaction rate was 78.2%. The satisfaction rate was associated with the type and outcome of miscarriage management ($p<0.001$). Women were more likely to be satisfied with surgical management compared to medical management ($p<0.001$). Women were also more likely to recommend surgical management compared to medical management ($p<0.001$).

In conclusion women undergoing miscarriage management appear to be more satisfied with surgical management in comparison to medical management

WOMEN'S EXPERIENCE OF A DIAGNOSIS OF GESTATIONAL DIABETES – A QUALITATIVE STUDY

Abstract ID: 94

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Gestational diabetes mellitus (GDM) is a form of diabetes occurring, or first detected in pregnancy, affecting approximately 5% of pregnancies in Ireland.

The objective of this research was to gain an insight into the emotional impact of a diagnosis of GDM at different stages of pregnancy.

In this cross-sectional qualitative study, women who had been diagnosed with GDM in the National Maternity Hospital (NMH) in Ireland were interviewed. A total of 94 women, grouped into three cohorts based on the stage of their pregnancy, participated. Women were interviewed within a week of diagnosis (Group 1), several weeks after diagnosis (Group 2), or in the days following delivery (Group 3). Consenting women were asked to describe their emotions relating to their diagnosis of GDM. Ethics approval was received from the NMH.

Worry and fear were the predominant emotions of the first group; secondary themes included upset, responsibility and frustration. In the second group the strongest themes were acceptance, adjustment to the lifestyle and commitment to continue with the necessary lifestyle changes. After delivery the primary emotion was relief: that their baby was alright and that their GDM was at an end. There was some apprehension and worry of developing diabetes in the future.

This study found that with time, support and information the initial feelings of anxiety, annoyance and guilt can be diminished to present a view of GDM as a manageable part of the pregnancy. Women also realised that the diagnosis had significant implications for their future health.

“PRACTICE REVIEW OF HYSTEROSCOPY PATIENTS WITH POST MENOPAUSAL BLEEDING AT MIDLAND REGIONAL HOSPITAL MULLINGAR OVER 18 MONTHS PERIOD”.

Abstract ID: 178

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Abnormal uterine bleeding is one of the leading causes of seeking gynecological advice. Transvaginal ultrasound (TVS) is a simple examination allowing clear visualization of most uterine conditions. Hysteroscopy is not as cost-effective and convenient as ultrasonographic imaging modalities, which are associated with relatively less patient discomfort and do not necessitate anesthesia. (TVS) gained popularity for evaluating PMB in the early 1990s due to its ready office availability and its value in ruling out significant endometrial disease. An endometrial thickness >5 mm would identify 96% of endometrial cancers. Conversely, an endometrial thickness ≤5 mm was associated with a 4% chance of endometrial cancer.

The purpose of the study was to determine whether the patients with PMB had (TVS) prior to Hysteroscopy or not and whether our management is complying with HSE standards or not.

The Study design was retrospective clinical audit for patients who had PMB and underwent Hysteroscopy from Jan, 2014 to June, 2015 were included in the study. Data collected from healthcare records and analysed on MS Excel through Descriptive statistics.

Total 177 (n=177) patients had hysteroscopy for PMB, mean age=60.3 yrs. 120 patients (61.38%) had prior TVS, among them 90% had endometrial thickness assessed. While 31.13% patients had Hysteroscopy without any TVS.

Our results reveal that 61.38% of pts had TVS. Our recommendations are that every patient with PMB should have a TVS for endometrial thickness assessment and those with thickened endometrium should have further invasive testing to exclude Endometrial pathology. That will save the patient from the risks related to procedure and financial expenditure.

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