Book of Abstracts

30th November & 1st December

Irish Congress of Obstetrics, Gynaecology & Perinatal Medicine 2017

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IRISH PERINATAL SOCIETY

A Case of Early Second Trimester Preterm Prelabour Rupture of Membranes - Exception Rather Than the Rule

Poster

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Preterm previable or midtrimester rupture of membranes also called early PPROM (less than 24 weeks) complicates a small number of pregnancies (approximately 4 per 1000) and is generally associated with poor fetal prognosis. Complications can be maternal and fetal infection/sepsis, fetal pulmonary hypoplasia, respiratory distress syndrome, bronchopulmonary dysplasia, intraventricular haemorrhage, contractures and neurodevelopmental issues in addition to complications of prematurity.

Here we present the case of a 42 year old nulliparous patient with two miscarriages, managed surgically. She presented for reassuring early pregnancy scan due to previous history. At first scan gestational size was less than dates however a live singleton pregnancy was confirmed and she commenced aspirin and cyclogest. Review scan four weeks later revealed severe oligohydramnios with poor visibility of fetal anatomy due to gestational age/size. Referral to a tertiary centre and fetal medicine specialist was arranged for 14 weeks getstation and anhydramnios was diagnosed. Differential diagnosis included renal agenesis or PPROM however the patient gave no history consistent with this. Anatomy scan revealed presence of kidneys and bladder ruling out renal agenesis and further supporting likelihood of PPROM.

The plan was elective caesarean section for fetal interest in the tertiary unit at 37 weeks to optimize neonatal outcome. Unfortunately she presented locally at 36+5 complaining of pain and vaginal bleeding. CTG was non-reassuring warranting emergency local delivery and ex utero transfer. Initially intensive support was required but baby quickly recovered and was discharged back locally day 5. At followup baby is well and undergoing physiotherapy for contractures.

A FIVE YEAR REVIEW OF ANTENATAL DIAGNOSIS OF FATAL FETAL ANOMALY IN A TERTIARY MATERNITY HOSPITAL.

Oral (IPNS)

***Dr. Emily O'Connor* [1], *Ms. Anna Maria Verling* [1], *Dr. Noirin Russell* [2], *Dr. Keelin O'Donoghue* [3]**

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In Ireland, major congenital anomaly was the cause of death in 1 in 4 stillbirths in 2015. From NHS data, 141 Irish women sought a termination of pregnancy (TOP) in England for a major fetal anomaly in 2016. There remains relatively little data on TOP for fatal fetal anomaly (FFA) in the Irish population.

We aimed to identify the outcome of each pregnancy that received an antenatal diagnosis of FFA.

This was a retrospective review over a five year period of fatal anomalies diagnosed through radiological imaging, non-invasive and invasive prenatal testing during 2012-2016 in CUMH.

39,755 women delivered in CUMH from 2012-2016. Of these, 179 women received an antenatal diagnosis of FFA. The average gestational age at diagnosis was 18 weeks (range 11 to 36 weeks' gestation). The two largest subgroups of FFA diagnosed were anencephaly and cranial abnormalities (n=47) and aneuploidy (n=44). Overall, 49 women underwent TOP for fatal anomalies, or 10 women per year, with procedures carried out in other jurisdictions. Of the remaining pregnancies, there were 39 stillbirths (21%), 12 intrauterine deaths (6%), 29 second trimester miscarriages (16%) and 47 neonatal deaths (26%).

There are significant numbers of women who receive an antenatal diagnosis of FFA in our unit each year. A cohort of women will seek elective TOP based on prenatal diagnosis. This review will help to guide bereavement standards and raises awareness of this population, who deserve consistent compassionate care and follow-up.

A Retrospective Audit of Cervical Cerclage Procedures

Poster

Dr. Ike Uzochukwu [1]***, Dr. Karim Botros*** [1]***, Dr. Humaira Tabsum*** [1]***, Dr. Jawaria Khan*** [1]***, Dr. John Bermingham*** [1]

1. *University Hospital Waterford*

Prematurity remains the leading cause of perinatal death and disability. Cervical cerclage is a common preventive intervention performed by obstetricians despite lack of a well-defined population with clear evidence of benefit.
The aim of this study was to assess definitive indications for cervical cerclage insertion and the outcome of these pregnancies following the procedure.
A retrospective audit was carried out from January 2014 to March 2017 involving 20 records of women who had cervical cerclage insertion. Auditable standards assessing the indication for cerclage were developed using the Greentop Guideline on Cervical Cerclage and the NICE Guideline for Preterm Labour and Birth.
Of the 20 women who had cerclage insertion, 12 women had a definitive indication. 6 women had a previous spontaneous preterm birth and cervical length <25mm on transvaginal scan. 3 women had three previous preterm births and/or mid-trimester miscarriages. 3 women had previous cervical surgery with cervical length <25mm. Other indications included 2 women with two previous preterm births and/or mid-trimester miscarriages, 4 women with a previous preterm birth and 2 women who had rescue cerclage insertion. The most common gestational age at removal of cerclage was 37 weeks. 15 women had vaginal deliveries. 13 women delivered after 36^{+0} weeks, 6 women delivered before 33 weeks and 1 woman had a mid-trimester miscarriage at 22 weeks following a failed rescue cerclage.
Although 65% of the women who had cervical cerclage delivered after 36^{+0} weeks gestation, the need for definitive patient selection for cerclage procedures can not be overemphasised.

A REVIEW OF CRITICALLY ILL OBSTETRIC PATIENTS AT TERTIARY LEVEL CRITICAL CARE UNITS IN THE DUBLIN AND CORK METROPOLITAN AREAS

Poster

Dr. Ciaran Costello [1]***, Ms. Deborah Twomey*** [2]***, Dr. Dermot Nolan*** [3]***, Dr. Fionnuala Ni Ainle*** [1]***, Dr. Ignacio Martin Loeches*** [4]***, Prof. Donal Brennan*** [5]***, Dr. Andrew Westbrook*** [6]***, Dr. Robert Plant*** [7]***, Prof. Brian Marsh*** [1]***, Prof. Frances Colreavey*** [1]

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Critically ill obstetric patients are uniquely challenging to critical care teams. Severe Maternal Morbidity increased from 3.83 to 5.93 per 1,000 maternities between 2011 and 2014, with consequent increasing need for critical care [1].

Our aim is to characterize the clinical management, course and admission trends of critically ill obstetric patients at Dublin and Cork tertiary referral centres.

This is a multicentre retrospective study at the Mater, St Vincent's, St James' and Cork University hospitals from 2009-2017. Critically ill pregnant and postpartum (up to 6 weeks) admissions were included

219 critically ill patients, 0.13% of all maternities (175,476) in Cork and Dublin included the following admission diagnoses; Haemorrhage (30%) Sepsis (30%) High Risk Pregnancy (6%) Acute Liver Dysfunction (5%) Acute abdomen (5%) Cardiac Arrest (4%) Seizures (3%) Peripartum Cardiomyopathy (3%) Acute Kidney Injury (2%) & Others (12%)

The rate of admission of patients with sepsis has increased since 2013, surpassing the admission rate for major obstetric haemorrhage during 2014-2016.

The most common cause of sepsis was pneumonia (approx. 50%) followed by genital tract and intra-abdominal infection. Other causes included urinary tract infection, appendicitis, cholecystitis, endocarditis and meningitis.

Since 2011 Extra Corporeal Life Support has been used in three obstetric patients.

There were 6 (2.7%) maternal mortalities in this series; Haemorrhage (2), Pulmonary Embolism (2), Sickle Cell Crisis (1), Respiratory Sepsis (1). This is lower than the expected >25% for critically patients admitted to Level 3 Critical Care.

[1] Audit Critical Care Obstetrics Ireland. National Perinatal Epidemiology Centre 2014

AMNIOCENTENSIS: COMPARISON OF QFPCR AND KARYOTYPE.

Poster

Dr. Helena Bartels [1]

1. *National Maternity Hospital*

To review the number of amniocentesis carried out over a 5 year period in a tertiary maternity unit and compare results between Quantitative Fluorescence-Polymerase Chain Reaction (QFPCR) and full karyotyping obtained from amniotic fluid.

All patients who underwent amniocentesis between the years 2012-2016 were included.QFPCR and Karyotype results were collected. Data was analysed using IBM SPSS version 20.

528 amniocentesis were performed during the study period. A downward trend was observed in the numbers performed over that period, following the introduction of non-invasive prenatal testing (NIPT) in June 2013. Results were analysed using both QFPCR and karyotype. In relation to QFPCR, 32.2% (n=170) returned an abnormal result. The most common mutations were: Trisomy 21 (11.7%, n=62), Trisomy 18 (10.6%, n=56) and Trisomy 13 (5.3%, n=28). Karyotype analysis returned an abnormal result in 36.2% (n=191) of cases, with no discrepancy between karyotype and QFPCR for the most common aneuploidies (Trisomy 21, 18 and 13). However, 3.8% (n=21) of normal QFPCR results were subsequently found to be abnormal when karyotype results become available.

This study shows the number of amniocentesis performed in our unit each year is steadily declining since the introduction of NIPT. QFPCR offers a more rapid and cost effective alternative to full karyotype. In our population, a policy of QFPCR alone would detect 96.2% of abnormalities. However, 3.8 % of clinically significant mutations were missed. Therefore, whilst it would be more economical to offer QFPCR alone, without karyotype a significant number of clinically relevant mutations would be missed.

An audit to evaluate practice and success of ECV in Mayo General Hospital.

Poster

Dr. irum farooq [1], *Dr. Ishrat Shafi* [1], *Dr. Hilary Ikele* [1]
1. *Mayo General Hospital Castlebar*

Breech presentation complicates 3–4% of term deliveries. External cephalic version (ECV) is effective obstetric intervention to reduce need for vaginal breech delivery and caesarean section(CS) rate .It is recommended for all women with uncomplicated single term breech pregnancy. The success rate of ECV is approximately 30-80%.
Purpose was to find out proportion of women with breech presentation
offered ECV in the absence of contraindications and success rate of ECV.
Retrospective chart review of breech deliveries from 01/07/2016 to
30/07/2017 excluded preterm, twins and scar uterus. Incidence of breech
during this period was 3.37%.
Total 30 patients with term breech and 70% were offered ECV and 30% had
no documentation in chart. 5 patients (24%) declined ECV and 16 (76%) had ECV. It was done by consultant in 100% cases and 37% patients were primigravida. Tocolytics used in 75% patients. Placental and fetal position, engagement were documented in 72% cases. Mean gestation for ECV was 37weeks .5 patients (31%) had successful ECV among those 2 revert to breech and had CS. 3 patients remain cephalic, 1 had forceps delivery, 2 had category 2 CS and 2 had major postpartum haemorrhage.
Majority of women were offered ECV but there is room for improvement in
record keeping. Patient acceptance can be improved by giving accurate
information on benefits and risks. Parity, placental site, fetus
position , engagement and amniotic fluid index had a significant effect
on success of ECV. Success rate can be improved by dedicated ECV clinic
led by highly motivated consultant.

Analysis of Fetal Growth Trajectories; association with maternal and child characteristics.

Oral (IPNS)

Dr. Helena Bartels [1]***, Dr. Clare O'connor*** [1]***, Mr. Ricardo Segurado*** [2]***, Prof. Fionnuala McAuliffe*** [3]

1. National Maternity Hospital, 2. UCD CSTAR and School of Public Health, Physiotherapy and Sport Science, 3. UCD Perinatal Research Centre

To identify fetal growth trajectories and to assess their association with maternal and child characteristics using data from a RCT of low glycaemic index diet in secundigravida patients with a previous baby >4kg (ROLO)
Abdominal Circumference (AC), weight and AC:length ratio were examined for trajectory classes using latent class trajectory mixture models. Two-, three-, four-, and five-class models were evaluated for fit, using a linear (first order) trajectory over three time-points. ANOVA and chi-square tests were applied to test associations between trajectory membership and maternal and child characteristics.
For AC, two fetal growth trajectories were identified, 29% of participants on a slow trajectory and 71% on a fast trajectory. Those on a fast trajectory had higher rates of maternal impaired glucose tolerance (28.7% vs 16.5%, $p<0.001$) and higher rates of mean child 5 year BMI centiles (64th vs 58th centile, $p<0.05$). For EFW, four trajectories were identified; 4% on a very slow trajectory, 63% moderate slow trajectory, 30% moderate-fast trajectory and 3% very fast trajectory. Mothers with a fetus on the fastest trajectory had higher BMIs (mean 30 vs 26 $p<0.002$) antenatal glucose levels ($p<0.05$) and rates of caesarean section (59.1% vs 20%, $p<0.001$). At 5 years, children on the fastest growth trajectory had the highest mean BMI centile.
This study shows specific fetal growth trajectories are associated with maternal BMI, serum glucose, mode of delivery and child BMI. Identifying those on an accelerated growth trajectory during fetal life provides a unique opportunity for interventions that have long-lasting health benefits.

Antenatal prediction of fetal macrosomia in pregestational diabetic pregnancies

Oral (IPNS)

Dr. Vicky O'Dwyer [1], ***Dr. Noirin Russell*** [2], ***Dr. Brian Mcdonnell*** [3], ***Dr. Liam Sharkey*** [3], ***Ms. Cecelia Mulcahy*** [3], ***Prof. Fionnuala Mcauliffe*** [3], ***Prof. Mary Higgins*** [3]

1. Nat, 2. Cork University Maternity Hospital, Cork, 3. National Maternity Hospital

Current prediction of macrosomia is challenging.

The purpose of the study was to investigate whether poor glycaemic control and third trimester ultrasound measurements of fetal anterior abdominal wall thickness (AAW) and abdominal circumference (AC) predicted macrosomia in babies born to women with pre-gestational diabetes.

This was a prospective cohort study in a tertiary referral maternity hospital. Serial HbA1c was measured; first antenatal visit, 14, 20 and 36 weeks' gestation were reported for this study. Serial growth scans including measurement of AAW were performed at 30, 33 and 36 weeks gestation. Birthweight data was collected and macrosomia was defined as >90th centile based on gestational age and gender of the baby.

Of the 416 pregnancies analysed, 142 babies were classified as macrosomic. Binary logistic regression showed that AC at 36 weeks predicted fetal macrosomia in 76.5%, followed by AAW at 30 weeks in 68.5%. Using a combination of HbA1c booking, 14, 20, 36 weeks and AAW 30, 33, 36 weeks and AC 30, 33, 36 weeks predicted macrosomia in 80.9%. Of HbA1c alone, the most predictive measurement was that at first antenatal visit.

Abdominal circumference at 36 weeks was the single best predictor of fetal macrosomia. However, a combined model of HbA1c, AC and AAW was the best predictor of macrosomia.

ANTI-D PROPHYLAXIS AND POTENTIALLY SENSITISING EVENTS: AN AUDIT OF COMPLIANCE TO LOCAL GUIDELINES FOR TREATING RHD NEGATIVE MOTHERS IN THE MID-WEST OF IRELAND

Poster

Ms. Rachel van Oostveen [1], ***Ms. Bridget Lane*** [2], ***Ms. Sile Keane*** [2], ***Ms. Sinead Wallace*** [2], ***Dr. Manal Abduljalil*** [2], ***Ms. Sheila Joyce*** [2], ***Ms. Miriam Nolan*** [2], ***Dr. Hilary O'Leary*** [2], ***Prof. Amanda Cotter*** [3]

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Abstract:

Haemolytic disease of the fetus and newborn is most frequently caused by immune anti-D. Consequences include fetal anemia, hydrops fetalis and intrauterine death[1]. Potentially sensitising events (PSEs), which include vaginal bleeding, abdominal trauma or invasive investigations, such as amniocentesis, can cause alloimmunisation if sufficient prophylactic anti-D is not given within 72 hours.

The objective of this audit was to determine whether all PSEs were managed in accordance with the local anti-D guidelines[2].

All RhD negative women who had maternal and baby blood samples sent to the transfusion lab between December 1, 2016 and January 31, 2017 were identified. Data was collected using the laboratory computer system and review of patient medical notes.

Of the 92 women identified for audit, 26 women had a total of 36 PSEs. PV bleeding accounts for 23/36 (63.88%) events, followed by abdominal trauma with 8/36 events (22.22%).

Thirty-three (91.66%) PSEs were found to be compliant with local guidelines. The three cases that did not follow guidelines, involved patients that had a PSE around the time they had routine anti-D prophylaxis (RAADP).

National and local guidelines state that patients who experience a PSE, irrespective of the timing between the event and administration of RAADP, should receive a dose of anti-D for that PSE[2,3]. The majority of PSEs included in the audit were managed in accordance with guidelines. However, clarification of this guideline with staff would be appropriate to ensure proper management of PSEs that occur around the time of administration of RAADP.

ATTITTUDES OF STAFF MEMBERS TOWARDS VIDEO RECORDING IN THE DELIVERY ROOM

Poster

Dr. madeleine murphy [1], *Prof. Colm O'donnell* [1], *Dr. Lisa McCarthy* [1]

1. National Maternity Hospital, Dublin

Use of video recording in the delivery room (DR) to evaluate performance at resuscitation was first reported 17 years ago. It has since been used to appraise many aspects of DR care.
We wished to study the attitudes of staff to video recording in the DR.
We created an anonymous questionnaire to examine the attitudes of staff to video recording in the DR using a 5-point Likert scale.
We surveyed 25 staff members; 19 (76%) were female and 6 (24%) were male. Most (96%) agreed that video in the DR was important and felt comfortable with its use. Less than half (44%) were apprehensive about criticism. Most (60%) were not concerned about a potential for recordings to be used for medico-legal purposes. More doctors than nurses reported feeling apprehensive about criticism [8/15 (53%) vs. 3/10 (30%)] and vulnerable [8/15 (53%) vs. 4/10 (40%)]. More females than males reported feeling apprehensive about criticism [9/19 (47%) vs. 2/6 (33.3%)] and being concerned about a potential for recordings to be used medico-legally [7/19 (37%) vs. 1/6 (17%)]. When asked which aspects they wished to include in teaching sessions respondents suggested reviewing; specific scenarios, timeline of interventions and ventilation.
We plan to use video recordings to implement a neonatal resuscitation teaching programme that addresses the specific wishes of caregivers at our hospital. Awareness of caregivers' attitudes will help us to support staff attending the DR. Through the use of video we aim to improve DR care of newborns.

DOCUMENTATION IN ANTENATAL NOTES: IS IT JUST SQUIGGLES?

Poster

Dr. Andrew Wilson [1], ***Dr. Rachel Calvin*** [1], ***Dr. Katherine Johnston*** [1]

1. *Belfast Health and Social Care Trust*

Antenatal notes are essential for continuity of care and to provide knowledge of previousconsultations to practitioners. They should be easily identifiable to other practitioners, informing them who haspreviously seen the patient and when they were seen.

We aimed to provide a quality improvement project with an emphasis on patient safety, to improve documentation in each antenatal entry, according to our key areas of documentation.

We performed a retrospective analysis of 368 visits to antenatal clinic from 42 patients looking at documentation in notes, focusing on key areas for doctors and midwives, and whether the notes fulfilled these. We performed our intervention by placing posters reminding staff of documentation key areas in all antenatal clinic rooms, and emailed daily reminders to staff for 7 days. We re-audited the notes from visits in antenatal clinic over several days (55 patient visits) to see if documentation compliance had improved.

Our initial audit showed a combined total percent achieved in the goal areas for doctors to be 61.21% and midwives 62.72%. Following the intervention, the combined total percentage achieved in goal areas by midwives was 75% at day 4 post intervention and 100% at day 7 post intervention. For doctors this was 68.36% at day 4 and 72.29% at day 7.

This has shown the effect that installing posters and emailing reminders to staff about best practice has a noticeable beneficial effect,improving practice and therefore patient safety.

DOES AN ELECTIVE INDUCTION POLICY NEGATIVELY IMPACT ON VAGINAL DELIVERY RATES?

Poster

Dr. Claire M McCarthy [1], *Dr. Dmitry Loktionov* [1], *Dr. Mark Skehan* [1]

1. University Maternity Hospital, Limerick

Induction of labour (IOL) rates varies across Ireland averaging at 23.3 per 100 deliveries in 2005-2009. Studies report an increased rate of Caesarean Section(CS) and neonatal and maternal morbidity with IOL. Elective IOL(without medical indication) is contentious for this reason.

We aimed to demonstrate that an elective induction policy with management by a sole obstetrician can decrease Caesarean Section rates, as well as maternal and neonatal complications.

We conducted a retrospective review of women attending a named obstetrician over a 2.5 year period in a tertiary maternity hospital using an institutional audit tool. In total, 22 variables were collected, including patient demographics, mode of onset of labour, method of induction, mode of delivery, length of labour and neonatal outcomes.

In total, 583 patients were identified in the study period delivering with the named Obstetrician. Overall, 8.9% (n=52) had a CS. 126 (21.6%) patients presented with a spontaneous onset of labour (SOL) and 405 (69.4%) of patients had an IOL (at a mean gestation of 38+6). Of the SOL group, 5.5%(n=7) had a CS, and 7.9%(n=32) of the IOL group, which is not statistically significant (p=0.4305). There was no statistical difference in the mode of delivery between spontaneous or induced labours, nor with respect to maternal age.

Elective induction of labour is not associated with a statistically significant increased risk of operative vaginal or abdominal delivery, and is also not dependent on maternal age. This shows that elective induction is an appropriate intervention in selected scenarios without affecting mode of delivery.

DOES MEMBRANE SWEEP WORK?:ASSESSING OBSTETRIC OUTCOMES AND PATIENTS PERCEPTION OF CERVICAL MEMBRANE SWEEPING AT TERM IN AN IRISH OBSTETRIC POPULATION. A Multicentre Prospective Study.

Poster

Dr. Chuckwudi Ugezu [1], ***Dr. Paul Corcoran*** [2], ***Dr. Elizabeth Dunne*** [1], ***Dr. Cathy Burke*** [2]

1. Department of Obstetrics and Gynaecology, Wexford General Hospital., 2. Cork University Maternity Hospital, Cork

Introduction: Recent studies on the efficacy of membrane sweeping at term, and its effect on the duration of pregnancy, have shown contradictory results.

This study aimed to determine if cervical membrane sweep at term has an effect on duration of pregnancy and delivery outcome in an Irish population. We also evaluated postnatal patients' perception and experience of cervical membrane sweep.

Methods: This was a prospective multi-centre patient-control study carried out in two Irish obstetric units. 400 women were enrolled in the study. Women with uncomplicated pregnancy at >38 weeks gestation undergoing membrane sweep were the test group while the control group were randomly selected by computer generated simple random sampling method from postnatal inpatients.

Results: 67% of primiparae and 74% of multiparae undergoing membrane sweep went into spontaneous labour,while 21% and 19% respectively were induced following membrane sweep.

When we compared the time interval between sweep and delivery,most women (75.7%) delivered less than 7 days after the sweep.

91% of our study population had heard of cervical membrane sweep.Midwives caused the least discomfort (7.8%) while SHOs despite doing the least sweep caused most discomfort (50%). In total, 65% of women thought that membrane sweep helped them get into labour and over 80% would recommend it to other women.

Conclusion: Cervical membrane sweeping promotes the onset of spontaneous labour in both primiparae and multiparae; thus avoiding formal induction of labour.Despite being uncomfortable, most women who had membrane sweep performed thought it helped them get into labour and would happily recommend it.

EXERCISE INDUCED ANAPHYLAXIS (EIA) IN PREGNANCY

Poster

Dr. JUNAID RAFI [1], ***Ms. Haroona Khalil*** [1]

1. *Ipswich Hospital NHS Trust*

Background: Exercise induced anaphylaxis in pregnancy is a very rare entity and only three cases have been reported in the past **Case Presentation:** A 33 year old Term +8, Para 1 lady admitted to delivery suite for VBAC with spontaneous onset of labour.She has had three major episodes of anaphylaxis requiring hospital admission in the past. She experiences generalised urticaria with swollen lips and has fainted on one occasion. She has also experienced one episode of restricted breathing in her throat and also vomiting. She has not had wheezing in relation to this. She has required adrenaline and this has worked well to resolve the problem .She has never required intensive care admission. She takes chlorphenamine as part of her treatment.***The delivery plan was*** **a)** to closely observe for any sign / symptom for allergic reaction and early epidural was sited to reduce the stress of labour and which provided good analgesia throughout her labour **b)**Initially Intravenous hydrocortisone 200mg and Intravenous Chlorphenamine 10mg at least two hours before any intervention or as soon as possible once in labour followed by continuous hydrocortisone 200mg and 10mg chlorphenamine 6 hourly .Postnataly hydrocortisone and chlorphenamine was continued for 12 hours. Histamine releasing drugs like Morphine and from anaesthetic point of view drugs like Atracurium and Mivacurium should be avoided in such cases. **Conclusion:** Stress can trigger anaphylaxis; can be associated with both the normal labour as well with caesarean section.The decision of the safest mode of delivery to avoid stress is debatable.

EXPECTANT MANAGEMENT OF PRENATALLY DIAGNOSED ANEUPLOIDY-WHAT HAVE WE LEARNED IN THE LAST TEN YEARS?

Oral (IPNS)

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1. *Obstetrics and Gynaecology, Rotunda Hospital, Dublin,* ***2.*** *Royal College of Surgeons in Ireland, Dublin*

Background : Ireland's current laws do not allow for TOP in the setting of prenatal diagnosis of aneuploidy
Purpose: To examine the outcomes of expectantly managed women with a prenatal diagnosis of T13, T18 or T21.
Study Design: A retrospective review of the Rotunda Hospital database was performed from 2005-2015 to identify cases.
Findings:162 of 382 cases (42.4%) of aneuploidy were expectantly managed.
T13:Rate was 34% (n=13). Incidence of miscarriage or IUD was 38.4% (n=5) with average gestation 18weeks, 1 day <24/40, and average gestation of 24weeks, 6 days >24/40. The live birth rate was 61.6% (n=8)
T18: Rate was 54.6% (n=71). Incidence of miscarriage or IUD was 60.5% (n=73) with average gestation of 15weeks, 4 days <24/40, and average gestation of 35weeks, 4 days >24/40. The live birth rate was 39.5% (n=28)
T21: Rate was 36.4% (n=78). Iincidence of miscarriage or IUD was 42.3% (n=33) with average gestation of 16weeks, 2 days <24/40 and average gestation of 28weeks, 3 days in cases >24/40. The live birth rate was 57.7% (n=45) The caesarean section (CS) delivery rate was 35%.
There were 8 CS deliveries for T13 and T18 exclusively for maternal indications.
Conclusion: T18 was the most likely diagnosis to result in an IUD or miscarriage. CS delivery was highest in T21. With respect to those with T13 and T18, the live birth rates show that some parents may achieve the goal of spending time with their baby in the immediate postpartum period. These findings aid comprehensive counselling for patients.

FETAL GROWTH RESTRICTION AMONG STILLBIRTHS AND ITS ANTENATAL DETECTION IN IRELAND

Oral (IPNS)

Dr. Paul Corcoran [1]***, Ms. Edel Manning*** [2]***, Ms. Irene O Farrell*** [3]***, Dr. Sarah Meaney*** [2]***, Prof. Richard Greene*** [3]

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Fetal growth restriction is a major risk factor for perinatal mortality and morbidity and may be the strongest contributor to stillbirth.

We aimed to estimate the prevalence and the level of antenatal detection of fetal growth restriction among stillbirths in Ireland.

Through a national clinical audit of perinatal mortality, contributors in all 20 Irish maternity units completed and submitted detailed notification forms related to stillbirths in 2011-2015. We derived customised birthweight centiles using the Gestation Related Optimal Weight (GROW) software. Stillbirths <10th customised birthweight centile were considered small for gestational age (SGA) and those <3rd centile were considered severely SGA.

There were 1,547 notifications of stillbirths delivered in 2011-2015 after 24 weeks gestation or with a birthweight≥500g. Forty-two percent (637/1535) of the stillbirths were severely SGA (<3rd customised birthweight centile) and 54.6% were SGA (<10th centile; 837/1535). SGA was more prevalent among the stillbirths complicated by multiple pregnancy, maternal hypertension and congenital anomaly and in stillbirths delivered preterm. Antenatal detection was at 20% (167/833) for SGA and 25% (478/633) for severely SGA. Antenatal detection in the 20 maternity units was broadly consistent with the national level. Antenatal detection varied little across a range of factors but was almost twice as common if a congenital anomaly was present (29% vs. 16%).

Antenatal detection of fetal growth restriction among stillbirths in Ireland is poor. Standardised ultrasound services involving two examinations and customised fetal growth charts should be provided for all pregnant women in Ireland.

FIRST TRIMESTER PREDICTION OF UTEROPLACENTAL DISEASE- RESULTS OF THE PROSPECTIVE HANDLE STUDY.

Oral (IPNS)

Dr. Cathy Monteith **[1]**, ***Ms. Lisa Mcsweeney*** **[1]**, ***Dr. Colm Breathnach*** **[2]**, ***Dr. Patrick Dicker*** **[3]**, ***Dr. Elizabeth Tully*** **[4]**, ***Prof. Fergal Malone*** **[1]**, ***Dr. Etaoin Kent*** **[2]**, ***Prof. Afif El-khuffash*** **[2]**, ***Dr. Anne Doherty*** **[2]**

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Non-invasive cardiac output monitoring (NICOM®) is a novel method of non-invasive haemodynamic assessment using bioreactance.
We aimed to assess NICOM® in combination with first trimester biomarkers to predict the evolution of gestational hypertension (GH), preeclampsia (PE) and normotensive fetal growth restriction (FGR).
Low-risk nulliparous women were enrolled in a single centre prospective observational study. NICOM® was performed at 14 weeks' gestation and data obtained on cardiac output (CO), indexed CO (COI), total peripheral resistance (TPR), indexed TPR (TPRi), stroke volume (SV), indexed SV (SVi) and heart rate (HR). Maternal serum at 14 weeks' underwent the following analyses: placental growth-factor (PLGF); soluble fms-like tyrosine-1 (s-flt-1); Apelin 13 and mean platelet volume (MPV). The following statistical analyses were employed using SAS version 9.0 as applicable: Spearman coefficient for correlation, discriminant analysis modelling predictors and Logistic regression.
The haemodynamic profile of pregnancies complicated by GH (n=13), PE (n=5) and FGR (n=18) were compared to 61 pregnant controls. Apelin 13 demonstrated a negative correlation with TPRi (r=-0.29, p=0.004), and positive correlation with COi (r=0.29, p=0.005). In PE s-flt-1 and MPV had a combined prediction model AUC 0.88 (p=0.01). Whereas in the prediction of FGR s-flt-1, SV and TPRI had an AUC 0.76 (p=0.007).
Downregulation of placental Apelin 13 has been linked with PE and lower serum Apelin with FGR, from 20 weeks' gestation onwards. This association was not present at 14 weeks' gestation. First trimester s-flt-1 may have an role in the prediction of FGR which is strengthened by the addition of haemodynamic variables.

FIVE YEAR REVIEW OF SEVERE EARLY ONSET INTRAUTERINE GROWTH RESTRICTION FROM A TERTIARY REFERRAL CENTRE

Oral (IPNS)

Dr. Siobhan corcoran **[1]*, Dr. Etaoin Kent*** **[2]*, Dr. Anthony Breen*** **[2]*, Dr. Niamh Murphy*** **[3]*, Dr. Ann McHugh*** **[3]*, Dr. Catherine Finnegan*** **[3]*, Dr. Michael Boyle*** **[4]*, Prof. Fergal Malone*** **[5]**

1. *Obstetrics and Gynaecology, Rotunda Hospital, Dublin,* ***2.*** *Rotunda Hospital, Parnell Street, Dublin 1,* ***3.*** *RCSI, Rotunda Hospital Dublin,* ***4.*** *Rotunda Hospital,* ***5.*** *Obstetrics and Gynaecology, Royal College of Surgeons in Ireland, Dublin*

Background; Severe early onset growth restriction (GR) presents a management dilemma for the perinatal team. Balancing gestation and birthweight against the odds of an intrauterine death is challenging. Data used for counselling patients about the expected outcomes is based on small numbers and old studies. Realistic and informed expectations of perinatal outcomes are important for shared decision making regarding intervention.
Purpose; To investigate the perinatal outcomes in the context of severe early onset GR.
Methods; We reviewed 43,231 deliveries at a tertiary referral centre in the Republic of Ireland over a 5-year period (2012-2016 inclusive). We identified all cases where the estimated fetal weight (EFW) was less than the 5th <28 weeks. Electronic databases and medical records were interrogated.
Results; There were 77 pregnancies in 76 women that met the inclusion criteria. There were 51 singletons, 19 sets of twins and 7 higher order multiples. Of the singletons, 35 (69%) were normally formed with no known chromosomal anomaly. Of these 22 (63%) were liveborn and 11(31%) had an intrauterine fetal death(IUFD), 2 of which were at a viable weight.2 were discharged to a local unit with reversed end diastolic flow for conservative management. See Fig 1. Table 1 outlines average gestation at diagnosis, average gestation of IUFD or delivery in the singletons
Conclusions; Approximately 2/3 of normally formed singleton pregnancies with an EFW <5th centile <28 weeks gestation will be liveborn. These figures allow us to counsel patients more effectively. Paediatric follow-up to 2 years is ongoing in this cohort.

FOLLOW UP OF A RARE CASE OF CERVICAL SPINE AND FOREGUT ANOMALY IN A ‘SERPENTINE LIKE SYNDROME’

Poster

Dr. Rupak Kumar Sarkar [1], ***Prof. Christopher Fitzpatrick*** [2], ***Mr. Sri Paran T*** [3], ***Prof. Martin J White*** [4], ***Dr. Mairead Kennelly*** [5]

__1.__ Department of Obstetrics, Gynaecology and Perinatal Ultrasound, Coombe Women and Infants University Hospital. Dublin 8., __2.__ Department of Obstetrics and Gynaecology, Coombe Women and Infants University Hospital. Dublin 8., __3.__ Department of Paediatric Surgery, Our Ladys' Hospital for Sick Children . Crumlin. Dublin 12, __4.__ Department of Neonatal Medicine, Coombe Women and Infants University Hospital, Dublin 8, __5.__ Department of Obstetrics and Gynaecology and Perinatal Ultrasound, Coombe Women and Infants University Hospital. Dublin 8.

Introduction:

We report the follow up of an extremely rare combination of prenatal congenital anomalies. Only six cases have been described in the English language medical literature.

Presentation:

A 28 year old nullipara booked at 14 weeks. Her anatomy scan was normal. At 32+6 weeks, gross polyhydramnios was noted. A GTT was negative. Serial scans confirmed absence of a stomach bubble. A diagnosis of oesophageal atresia and / or tracheoesphageal fistula was discussed. She delivered a live born male infant weighing 2.8Kg at 38 weeks. The diagnosis of a Long Gap Oesophageal Atresia was made. A small ASD, absent C6 vertebrae, absent stomach and small spleen were noted. Karyotype was normal. The infant underwent 3 separate operations involving international expertise in 2015: (1) an exploratory laparotomy and an attempted gastrostomy, however no stomach was identified (2) cervical oesophagostomy and (3) preparation of a part of the jejunum for future oesophageal replacement.

Discussion:

A close relationship exists between the upper gastrointestinal tract and cervical spine during embryonic development. An embryonic aberration at this level could account for the deformities present in this infant. Tethering of the embryonic cervical oesophagus to the somites in the first trimester, preventing foregut elongation and producing ischaemia at the coeliac axis is suggested as the aetiology.

Follow up after 2 years :

This infant is now a busy toddler, requiring PEG feeding and apart from occasional set backs with gastric dumping he is meeting almost all developmental milestones and attends regular paediatric follow up in hospital.

GIVE ME A HEADS UP. UNDIAGNOSED BREECH PRESENTATION IN LABOUR . A CLINICIANS DILEMMA

Poster

Dr. fionnvola armstrong [1], ***Dr. Seosamh O' Coighligh*** [1], ***Dr. M Milner*** [1]

1. *Our Lady of Lourdes Hospital, Drogheda*

Breech presentation accounts for 3-4 % of term pregnancies but there is limited data available as to incidence of undiagnosed breech at term in labour (> 37/40 gestation) . A small number of studies suggest that this is between 20-25%.[1] This study examines the incidence and outcome of undiagnosed breech at term in labour over a 5 year period .

A Retrospective chart review of patient notes for the period 01/01/2012-31/12/2016 was performed .All singleton pregnancies at term with undiagnosed breech presentation where included in the study. Total of 17069 deliveries (average 3413 deliveries per year) Total number of 637 breech deliveries. Incidence of breech presentation of 3.73%.

The incidence of undiagnosed breech in labour was 17.1%(109/637)range 15.8%-19.4%.With an increasing incidence from year to year .

61.9% of undiagnosed breech presentations where discovered on 1st vaginal examination.There was a significant reduction in the number of breech vaginal deliveries especially evident in 2015 and 2016 with 95% of these patients undergoing LSCS.

Over the 5 year period there was 1 adverse outcome.

Overall undiagnosed breech presentation at term remains a clinically challenging scenario. Since the publication of the term breech trial the number of vaginal breech deliveries has decreased with the majority of patients delivering by elective LSCS. New Updated clinical guidelines are now suggesting that vaginal breech delivery may be performed but are there a generation of trainees with little to no vaginal breech experience

HYPOXIC ISCHAEMIC ENCEPHALOPATHY - CONTRIBUTORY FACTORS - A HOLISTIC ASSESSMENT

Poster

Dr. Edward Corry [1], Dr. Emily O'Connor [1], Dr. Mendinaro Imcha [1]

1. University Maternity Hospital, Limerick

Human factors such as communication, assessment, and leadership, have been the most frequently identified root causes of reported maternal and perinatal sentinel events since 2004, as identified by the Joint Commission International.

We aimed to review cases of Hypoxic Ischaemic Encephalopathy (HIE) in a tertiary Maternity Hospital over a three-year period, to identify possible contributory human factors to a potentially catastrophic event.

We identified all Hospital In-Patient Enquiry (HIPE) recorded cases of HIE in University Maternity Hospital Limerick (UMHL) from July 2013 to July 2016. The cases were reviewed by the three team members, each with a differing level of clinical experience. If a team member was involved in a case, that member was recused from review of the case. We constructed an Ishikawa(fishbone) diagram for each case with a holistic focus on care to identify potential contributory factors.

Of the 29 identified cases, 18 were reviewed, as seven were inappropriately coded and four records were unavailable. The clinical events leading to HIE were identified as three shoulder dystocia, four chorioamnionitis, and two foetal haemorrhage. On review of the cases, 50% had deficits in foetal heart rate monitoring, interpretation and communication of concerns regarding the cardiotocograph . System, human and environmental factors were potentially contributory in 66% of cases with the majority impacted by multiple factors.

The labour ward is a dynamic environment. Critical decisions are frequently made in a pressurised time constrained situations. Human factors play a key contributory factor in events leading to HIE.

Implementing antenatal aspirin prophylaxis: A quality improvement project K. McCollum, A. Khan, C. Malone, A. Ali, S. Hamilton, D. Quinn and D. Morgan Department of Obstetrics and Gynaecology Antrim Area Hospital NHSCT

Poster

Ms. Kirsten McCollum [1], *Dr. David Morgan* [1]

1. Antrim Area Hospital, Northern Ireland

Pre-eclampsia is a major cause of perinatal morbidity and mortality. Evidence has shown that prophylactic use of low dose aspirin in high-risk women can reduce the risk of developing pre-eclampsia (NICE 2010). Ensuring that relevant women were offered this simple intervention required a quality improvement project involving many members of the healthcare team. This audit aims to assess progress in maximizing benefit from aspirin prophylaxis.

This study was a quality improvement project utilizing principles of PDSA cycle (Plan, Do, Study, Act). The need to implement aspirin prophylaxis was shared with colleagues in a range of fora, including risk management meetings, team safety briefs and information letters to women and general practitioners. An algorithm and risk assessment tool was devised and included in all maternity notes at booking to prompt professionals to offer aspirin to appropriate women.
Post-natal patient charts were assessed and data collected retrospectively. Initial audits took place in March and September 2015, with a re-audit in June 2017.

- **March 2015:** 21% prescription rate among at-risk patients
- **September 2015:**50% prescription rate following quality improvement intervention
- **June 2015:**cohort of 50 patients, 13 of whom met the criteria. In all but two cases, aspirin was prescribed appropriately (85% prescription rate), with the rationale for not prescribing being clearly documented.

This study demonstrates a clear improvement in aspirin prescribing for at-risk antenatal patients. Continued efforts should be made to assess women during the booking appointment, with the aim of reducing adverse outcomes associated with preeclampsia.

INTRODUCTION OF A GROWTH ASSESSMENT PROTOCOL “GAP-CUSTOMIZED GROWTH CHART” FOR THE FIRST TIME IN THE REPUBLIC OF IRELAND; PRELIMINARY RESULTS

Oral (IPNS)

Dr. Nikita Deegan [1]***, Ms. Grainne Milne*** [1]***, Dr. Alexandru Bogdan Muresan*** [1]***, Ms. Bernie Daly*** [1]***, Dr. Ita Shanahan*** [1]***, Dr. Seosaimh O’Coigligh*** [1]

1. *Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda*

Fetal growth restriction(FGR)is a recognized cause of stillbirth(SB).

In the UK “GAP” has been proven to increase recognition rates of FGR. Our unit adopted “GAP” from UK perinatal institute as a Quality Improvement project with the aim of improving antenatal recognition of FGR.
Project leads were trained in UK. Our unit data was used to produce customized growth centiles for our population. Our rate of FGR(birth weight<10th centile on customized growth charts)and our recognition rate were obtained. “GROW” software was introduced. Staff were trained. Dating USS assigned EDD, criteria were set for serial growth Ultrasounds(USS) for increased risk pregnancies. GAP went live on 3/01/17. Customized growth charts were generated at booking and placed in charts. Symphysiofundal height(SFH)+/-Estimated fetal weight by Departmental USS(EFW)was plotted at all visits from 26/40. SFH<10th centile triggered referral for USS. Birth weights were input at delivery and birth centiles generated.
Our FGR rate *prior to GAP*was 13.3%(55 of 414 patients)and recognition rate was 41.8%(23 patients). 16 of those 23 patients were suspected FGR and referred for USS, 7 were picked up incidentally on USS for other reasons.
Post introduction of GAP 22 of 169 patients(13.01%)had a birth weight<10th centile(FGR), similar to our baseline rate.
12 of these(54.5%)were recognized antenatally via “GAP”.
10 of 12 were detected by SFH<10th centile and confirmed on USS,2 were detected by GAP/GROW as they met criteria required for serial USS.
GAP improved antenatal recognition of FGR by 12.7%.
Preliminary results are encouraging with increased recognition of FGR using “GAP”.

IS IT THE TIME TO RECOGNISE RETROPERITOENEAL HAEMATOAMAS (RPH) IN PREGNANCY AS A CAUSE OF MAJOR MATERNAL MORBIDITY AND MORTALITY

Poster

Dr. JUNAID RAFI [1], ***Ms. Haroona Khalil*** [1]

1. *Ipswich Hospital NHS Trust*

Background: The retroperitoneal haematomas (RPH) in obstetrics is uncommon. The causes and pathogenesis of retroperitoneal haematomas lacks clarity. Management of retroperitoneal hematomas is complex . *Eight Maternal Deaths* in Australia since year 2000 from splenic artery rupture in pregnancy.

•21 cases of RPH reported(2007-2017)

•150 cases of splenic artery rupture in pregnancy have been reported since 1945.

•42 cases of renal artery aneurysms (RAA) in pregnancy

•25 cases of ruptured renal angiomyolipoma (RAML) in pregnancy

• 12 cases of ovarian artery rupture in pregnancy

•1 case of Splenic rupture in malarial case in pregnancy

Method: Literature Review

Discussion and Learning Objectives:

Need to recognise retroperitoneal haematomas as separate entity from vaginal ,infralevator, supralevator and broad ligament haematomas. To learn the pathogenesis, diagnosis and management options for retroperitoneal haematomas. It is the time to raise awareness among obstetricians of retroperitoneal haematomas as an important cause of maternal collapse and requires high clinical suspicion and multidisciplinary input. As RPH are rare but can cause serious threat to maternal wellbeing hence resources should be directed towards its management. Existing guidelines of maternal collapse and morbidity during pregnancy and puerperium needs to include RPH as one of the important cause of maternal shock or morbidity. New learning pathways should be opted to increase awareness of RPH among obstetricians enabling them to reflect on its implications while managing RPH.

ISLAND OF IRELAND PERINATAL MORTALITY REPORT 2014 AND 2015.

Oral (IPNS)

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1. National Perinatal Epidemiology Centre, UCC, Ireland; on behalf of the NPEC Perinatal Advisory Group, 2. National Perinatal Epidemiology Centre, UCC, Ireland, 3. Northern Ireland Maternal And Child Health (NIMACH) , Public Health Agency; on behalf of the Northern Ireland Maternal and Infant Steering Group, 4. Northern Ireland Maternal And Child Health (NIMACH), Public Health Agency, Northern Ireland, 5. Department of Obstetrics and Gynaecology, University College Cork, Ireland and National Perinatal Epidemiology Centre, University College Cork, Ireland

Perinatal Mortality is a significant measurement of quality maternity care. While maternity services are provided by two different healthcare systems in the Republic of Ireland (ROI) and in Northern Ireland (NI), both services provide for a similar maternal population with comparable levels of risk for adverse perinatal outcomes.
This report compares the incidence of perinatal mortality between the ROI and NI and the incidence of perinatal deaths associated with major congenital fetal anomaly.

Anonymised data on perinatal deaths occurring between 1 January 2014 and 31 December 2015 were collected from all maternity units across the ROI and NI using a standardised dataset. Case definitions were directly comparable: perinatal deaths with a gestational age of ≥ 24 weeks at delivery.

*There were 182,600*births that were ≥24 weeks gestational age at delivery across the Island of Ireland in 2014-2015. The perinatal mortality rate (PMR) for both ROI and NI were similar with an All-Ireland PMR of 6.2 deaths per 1,000 births and a corrected PMR of 3.85 per 1,000 births. *Major congenital anomaly was present in 24.3% and 63.6% of all SB and NND deaths respectively. Approximately 40% of perinatal deaths were severely small for gestational age (<3rd birthweight centile).*

This is the first assessment of Perinatal Mortality across the Island of Ireland.
Similarities in factors associated with perinatal death occurring in ROI and NI illustrates the importance of working in a collaborative way in order that we can learn and work together to reduce avoidable perinatal mortality in the future.

Knowledge and attitude of obstetric and midwifery staff towards Perinatal Mental Health, current practices and their opinion regarding Perinatal Psychiatry Services at University Hospital Kerry (UHK)

Poster

Dr. Sabahat Zafar [1], *Dr. Hina Aamir* [1], *Dr. Navroop Johnson* [1]

1. *University hospital kerry*

Background

During pregnancy and postpartum period, a woman undergoes physical, emotional and psychological changes,which demand clear guidance and pathways for management of women with perinatal mental health(PMH) issues. Currently there is limited provision of Specialist PMH Services at maternity units nationwide.

Aim

The authors wanted to ascertain the existing attitudes, knowledge and clinical practise of the Obstetric staff in UHK in relation to women with mental health issues and to explore their satisfaction with current model of care and their opinion regarding the need for specialist PMH services.

Methods

We used Mental Attitudes and Knowledge Scale (MAKS) and a Self-Devised questionnaire.

Questionnaires were distributed to qualified obstetric staff including midwives, NCHDS and Consultants. Self-devised questionnaire data was analysed quantitatively using Microsoft Excel sheet and qualitatively using thematic analysis.

Results

A total of 25 midwives, 6 NCHDs and 1 consultant took part in our survey,making response rate of 41% (32/78).

Majority scored above 25 (total score 30)on MAKS displayinggood knowledge and attitudes towards mental illness.

69% reported regular contact with women with PMH issues.

Almost all of them (30/32) were aware of the referral pathway for obstetric patients with mental illness to psychiatric services and 69% of the respondents had referred patients.

Only 56% were satisfied with current psychiatric services and timeliness of the intervention.

Overwhelming majority 97% (31/32) felt the need for perinatal psychiatric services in UHK.

Conclusions

In conclusion,sample surveyed displayed good knowledge and attitudes towards mental illness and highlighted the need for dedicated perinatal psychiatric services in UHK.

LAPROSCOPIC SALPINGOSTOMY VS SALPINGECTOMY FOR ECTOPIC PREGNANCY

Poster

Dr. tarannum mahedvi [1]***, Dr. Samina Hameed*** [1]

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Obstetric & gynaecology department
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Mullingar

Pregnancy rate was calculated in patient who underwent laproscopic salpingostomy instead of salpingectomy in presence of contralateral healthy tube between the year 2010 to 2015 in midland regional hospital Mullingar. we took 30 patients from each group.

It was a retrospective audit. Patients were identified having the above mentioned procedure and telephonic inquiry was made regarding their subsequent pregnancy.

The intrauterine pregnancy rate was identified to be same in both the groups with slightly higher rate of persistent trophoblastic disease in salpingostomy group.

LARGE FOR GESTATIONAL AGE: ARE WE GETTING IT RIGHT?

Poster

Dr. Andrew Wilson **[1], *Dr. Jess Gomersall*** **[1]**

1. *Belfast Health and Social Care Trust*

Large for gestational Age fetus is defined as estimated fetal weight >90th centile for that gestation on a personalised growth chart. It carries with it additional risks, and it is important that our scans are accurate so we can predict this, appropriately counsel and appropriately manage the pregnancy. This study examined the accuracy of predicting LGA and the management of those pregnancies.

We aimed to investigate outcomes for the fetus and mother who we suspected were LGA and elicit how accurate we were at recognising this. We also aimed to review complications in those with LGA, alongside pre-delivery decisions.

We performed a retrospective analysis of 35 patient charts who delivered a live infant in RJMS, selected at random, with a birth weight >90th centile from January 2017 to March 2017. We reviewed documentation of LGA complications in notes, gestation at diagnosis of LGA, Gestational Diabetes status, mode of delivery, maternal outcomes post vaginal delivery and neonatal outcomes.

100% of those predicted to be >90th centile pre delivery, had a delivery weight >90th centile. All estimated weights were accurate within 14%.

90% of vaginal deliveries with LGA had some degree of perineal trauma, 5.7% of infants required admission to NNICU, and 89% had APGARS >8 at 1 minute post delivery.

With the disparity in management of LGA pregnancies, and outcomes aforementioned, it's important that complications are discussed with the patient and documented. There should be a standardised evidence based guideline in the management of LGA, and this is currently being produced.

MANUAL VACUUM ASPIRATION - AN ALTERNATIVE TO SURGICAL MANAGEMENT OF MISCARRIAGE IN EARLY PREGNANCY

Poster

Dr. leah mcguckin [1]***, Ms. Sharon Watt*** [2]***, Mrs. Jillian Downey*** [1]

1. *South Eastern Health and Social Care Trust,* ***2.*** *Ulster Hospital*

Manual Vacuum Aspiration is a safe, effective alternative to surgical management of miscarriage and can be carried out in outpatients under local anaesthetic. Advantages include decreased patient waiting time and cost, avoidance of the risk of general anaesthetic, low complication rates and increased choice. MVA was introduced in our trust in October 2014 in response to increased waiting times for surgical evacuation and to offer an alternative outpatient option to medical management.

The aim of our review was to assess the effectiveness, safety and patient satisfaction following the introduction MVA in our unit.

The review was carried out prospectively between October 2014 to August 2016. Patients were identified by Early Pregnancy staff after diagnosis of early pregnancy loss (<10 weeks gestation on ultrasound scan) and booked for procedure. Data was collected using a proforma commenced at time of procedure and completed after telephone review at 1 week. 55 patients attended, data available for 53.

The procedure was successful in 96% (100% of parous, 93% of primp). Incomplete procedure (4%) was managed in outpatients with one further dose of oral misoprostal. The majority of patients presented with early fetal demise (87%. Complications rate 4% (2 patients treated for suspected endometritis). Patient satisfaction was 92%.

The introduction of MVA has been a successful adjunct to the management of early pregnancy loss in our unit. It is safe, effective and accepted well by patients and staff. We aim to inprove the availability of the procedure by increased training and providing dedicated MVA lists.

MATERNITY ULTRASOUND IN THE REPUBLIC OF IRELAND 2016; A REVIEW

Poster

Dr. Deirdre Hayes Ryan [1], ***Dr. Karen Mcnamara*** [2], ***Dr. Noirin Russell*** [3], ***Prof. Louise Kenny*** [1], ***Dr. Keelin O'Donoghue*** [2]

1. *The Irish Centre for Fetal and Neonatal Translational Research (INFANT), University College Cork & Cork University Maternity Hospital, Wilton, Cork.*, ***2.*** *The Irish Centre for Fetal and Neonatal Translational Research (INFANT), University College Cork, Pregnancy Loss Research Group, Department of Obstetrics and Gynaecology, University College Cork & Cork University Maternity Hospital, Wilton, Cork.*, ***3.*** *Pregnancy Loss Research Group, Department of Obstetrics and Gynaecology, University College Cork & Cork University Maternity Hospital, Wilton, Cork.*

Antenatal ultrasound is a recognised and necessary component of good antenatal care.
In February 2017 we conducted a telephone survey of all 19 obstetric units to ascertain the current status of maternity ultrasound provision in Ireland.
In total 100% (n=19) of Irish maternity units were successfully contacted and completed the survey. Approximate annual delivery rates for 2016 were provided to us from each respondent for their respective units and ranged from 1062 to 9186 births with the total number of combined births ≈ 65,500. A dedicated maternity ultrasound department is present in 16/19 (84%) of the units. First trimester pregnancy scanning is offered universally to all women in 10/19 units (53%), offered but does not meet international criteria for first trimester ultrasound in 5/19 units (26%) and is not offered in the remaining 4/19 (21%) units. Fetal anomaly ultrasound is offered universally to all women in 7/19 (37%) units, selectively to some women in 7/19 (37%) units and not offered at all in the remaining 5/19 (26%) units. In units offering selective anomaly scanning the variation in percentage of women receiving a scan ranges from 10-42%. Overall ≈ 41,700 (64%) women receive a fetal anomaly ultrasound nationally with large geographical variation.
This study highlights the lack of development in Irish maternity ultrasound services over the last decade. Substantial investment by health care policy makers is urgently needed.

NEW AGE CONSIDERATIONS IN RECURRENT MISCARRIAGE

Poster

Dr. David Crosby [1]***, Ms. Sarah Cullen*** [1]***, Dr. Cathy Allen*** [1]

1. *National Maternity Hospital, Dublin*

The incidence of RM is between 1-5%, with some heterogeneity among the definitions used. Recent reports suggest an increase in the incidence of RM over the past decade. Some of this increase may be attributed to improved case-recognition, while the socio-demographic shift towards delayed childbearing continues to present clinically in age-related pregnancy losses. However, most RM guidelines adopt a standardised approach to investigation and management for women across all reproductive decades. This non-specific approach exposes RM patients to the risk of inappropriate, expensive investigations and missing key diagnoses.

This was a retrospective study of patients attending the RM service in a large tertiary referral centre, between 2014 and 2017. Data on demographics, clinical features, investigations, management, and obstetric outcomes were analysed by female age group (i)25 to 34 (ii)35 to 39,and (iii)≥ 40 years.

170 cases of RM were analysed. The mean age of the women attending the service was 36.3years. 66 women(38.8%) were aged 35-39 years and 49(28.8%) were aged≥40 years. 2.3% of women were diagnosed with antiphospholipid syndrome(APLS), none of these were aged≥40. Where karyotype analyses on products of conception(POC) were available,(27%),76.1% of these demonstrated an underlying chromosomal abnormality. There was no difference in Anti-Müllerian hormone levels across the groups. Over half of the patients conceived again(51% of women≥40years,LBR 52%).

In older RM patients, APLS is uncommon and cytogenetic errors are common. Women≥40 presenting with<3 consecutive miscarriages should be offered cytogenetics on POC, as this is likely to explain the cause and obviate the need for thrombophilia testing.

Obstetric Outcome in High BMI Women

Poster

Dr. Rahul Savant [1]

1. *Belfast Health and Social Care Trust*

R Savant, A Wilson, J Costa. Royal Jubilee Maternity Hospital, Belfast.

Background:Maternal obesity has become one of the most commonly occurring risk factors in obstetric practise.The prevalence of obesity in pregnancy has also been seen to increase, rising from 9–10% in the early 1990s to 16–19% in the 2000s.

Purpose of Study: To study the compliance with the guideline for management of antenatal women with BMI > 40.

Study Design and Methods:This was retrospective audit conducted at Royal Jubilee Maternity Hospital, Belfast for the year 2014 and 2015. A total of 343 patients with a booking BMI of more than 40 were identified. 313 case notes were available for review.

Findings of the Study78% of the patients had BMI between 40 to 45. Two had a BMI exceeding 60. 19 % developed pre eclampsia and 38 % developed Gestational diabetes mellitus.3 women were diagnosed with Deep vein thrombosis.Intra uterine growth restriction was detected in 12% of women.Antenatal scan was difficult in 86% of women because of high BMI.56% had induction of labour with GDM being the most important indication followed by hypertension.Shoulder dystocia was detected in 3 cases.11 women had a successful VBAC.99% of post natal women had DVT risk assessment done.17 women developed postnatal wound infection.19 babies were admitted to the NICU.

Conclusion:There was non-compliance in many of the standards.

Recommendations: Use of standardised proforma at booking for all women with high BMI. Faclilty for dietician referral for all patients.

PAEDIATRIC AND PERINATAL AUTOPSY PATHOLOGY FROM THE FOUR PROVINCES

Poster

Dr. Peter Kelehan [1]***, Dr. John Gillan*** [2]

1. Retired- National Maternity Hospital, 2. Retired-Rotunda Hospital Dublin

The unexpected death of a child in-utero or in infancy is a highly charged event of dismay and loss to the parents and is a corresponding challenge for the caring clinical team.

These tragic and inexplicable events demand a specialist autopsy examination service to all maternity and paediatric units in the state.

The present arrangement, an ad-hoc service to colleagues in the Midland Regional Hospitals in 2009 has been extended since to many small maternity units in the provinces.

The following data reports on autopsies from 2013 to 2016. In that time, of a total of 349 autopsies (hospital consented and coroner directed), approximately 50% were stillborn infants, 15% were neonatal deaths and 15% were infant or child deaths.

For the group of stillborn and newborn babies, autopsy rates for the different maternity hospitals are variable and for most are less than 50%. Fetal death postmortem examinations are predominantly those in the second trimester, most, clustered about the age of viability.

Illustrative cases of pathological diagnosis will be presented from within each group.

Table

Year	**Fetus**	**Stillbirth**	**NND**	**Infant**	**Child**	**Total**
2013	**6**	**24**	**8**	**8**	**0**	**50**
2014	**21**	**55**	**10**	**17**	**3**	**100**
2015	**14**	**48**	**17**	**13**	**3**	**97**
2016	**19**	**52**	**14**	**9**	**3**	**102**
Total	**60**	**179**	**49**	**47**	**9**	**349**
%	17.20%	52.30%	14.04%	13.47%	2.58%	**%**

PARROT Ireland: Placental growth factor in Assessment of women with suspected pre-eclampsia to Reduce maternal morbidity: a Stepped Wedge Cluster Randomised Control Trial

Oral (IPNS)

Dr. Deirdre Hayes Ryan **[1]*, Prof. Declan Devane*** **[2]*, Prof. Deirdre J Murphy*** **[3]*, Prof. Amanda Cotter*** **[4]*, Prof. Fionnuala McAuliffe*** **[5]*, Prof. Fionnuala Breathnach*** **[6]*, Prof. John J Morrison*** **[7]*, Dr. Brendan McElroy*** **[8]*, Dr. Aileen Murphy*** **[8]*, Dr. Ali Khashan*** **[9]*, Dr. Karla Hemming*** **[10]*, Dr. Alyson Hunter*** **[11]*, Prof. Louise C Kenny*** **[1]**

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Pre-eclampsia complicates 2-8% of pregnancies and is associated with significant maternal and neonatal morbidity and mortality. Placental Growth Factor (PlGF) is a protein involved in placental angiogenesis and in women with pre-eclampsia levels of PlGF can be abnormally low. Previous studies suggest that PlGF testing may be an important and innovative adjunct to the management of women with suspected pre term pre-eclampsia. NICE has recently highlighted the need for further research on PlGF based testing.

Our primary aim is to establish the effectiveness of plasma PlGF measurement in reducing maternal morbidity, without increasing neonatal morbidity, in women presenting with suspected pre-eclampsia prior to 37 weeks' gestation. The long term aim is to determine if knowledge of PlGF measurement enables appropriate stratification of antenatal management of women presenting with suspected pre-eclampsia.

PARROT Ireland is a prospective, multi-centre, stepped wedge cluster randomised controlled trial of women presenting with suspected pre-eclampsia from 20 to 36+6 weeks' gestation inclusive. It is being conducted in the seven largest maternity hospitals in Ireland. It commenced recruitment in June 2017 and will continue until April 2019 with a recruitment target of 4000 women.

The study has two co-primary outcomes; maternal morbidity and early neonatal morbidity, as both are equally important. Each will be assessed by use of composite scores. Using trial evidence, a health economic evaluation will assess the intervention's economic impacts. If this trial shows PlGF testing to be beneficial, it will influence healthcare guidelines at both a national and international level.

PERTUSSIS VACCINATION UPTAKE AT THE COOMBE WOMEN AND INFANTS UNIVERSITY HOSPITAL

Poster

Dr. Gillian Corbett [1], ***Dr. Sharon Sheehan*** [1]

1. *Coombe Women and Infants University Hospital, Dublin*

Background and Aim:

Pertussis is a toxin-mediated respiratory infection caused by the gram negative coccobacillus bordetella pertussis. Spread by respiratory droplet it causes flu-like symptoms and prolonged coughing spells in adults. However its highest morbidity and mortality is in infants where it can cause pneumonia, apnoea, seizures, encephalopathy and death. Thus the WHO and the HSE have recommended vaccination of pregnant women between 16 and 36 weeks to confer passive immunisation on to the neonate. We will establish the uptake of this vaccination at the Coombe Women and Infants' University Hospital (CWIUH).

Methodology:

All postnatal women delivered at CWIUH over a two week period will be asked to complete a simple questionnaire. Covariates including a woman's age, parity and mode of delivery, smoking status will be collected. Women will be asked if they received the pertussis vaccination antenatally, at what gestation and by which medical practitioner. If they were not vaccinated, we asked for what reason.

Results:

Uptake will be measured as a percentage of the postnatal women at CWIUH We will compare covariates between vaccinated and non-vaccinated cohort, as well as reasons for non-vaccination.

Conclusion:

Pertussis vaccination is an important part of antenatal care as recommended by the HSE and the WHO. The uptake of pertussis vaccination at CWIUH will be presented here, as well as the underlying obstacles in the non-vaccinated cohort.

PILOT PROJECT: DEVLOPMENT OF AN IRISH PLACENTAL WEIGHT NOMOGRAM

Poster

Ms. Orlagh O'Brien [1], *Prof. mary higgins* [2]

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The weight of the placenta gives a useful representation of placental function in utero [1]. Placental weight is associated with many common complications in pregnancy [1], and has been found to be predictive of perinatal morbidity and mortality as well as childhood growth and development [2]. Currently there is no established average placental weight for Irish women, therefore the development of a population specific nomogram would aid in the examination of placentas after delivery.

The aim of this project was to develop a nomogram of average placental weights among Irish women and establish median placental weights for each gestational age.

This was a prospective cohort study of placentas delivered in the National Maternity Hospital in June/July2017. All singleton pregnancies were included except stillbirths and clinical obstetric complications involving the placenta. The placentas were weighed with Seca 856 scales. Length, breadth, maximum depth and shape of the placenta were also measured and the data was recorded in an excel database. Birth weight, maternal parity and race was also recorded. In order to assess whether placental weight was affected by time since delivery, a subsection of placentas were weighed at multiple intervals after delivery.

430 placentas were weighed over six weeks (June-August 2017). An average placental weight based on gestational age was established. Median placental weight was 460g at 37 weeks, up to 500g at 42weeks.

Presenting Author: Orlagh O'Brien

Supervisor: Prof. Mary Higgins

POST PARTUM HAEMORRHAGE IN AN OBSTETRIC COHORT WITH CONGENTIAL CARDIAC DISEASE

Poster

Dr. Niamh Keating [1]***, Dr. Patch Thornton*** [1]***, Dr. Jennifer Donnelly*** [1]

1. *Rotunda Hospital, Parnell Street, Dublin 1*

Cardiac disease is a leading cause of maternal death in the developed world and the incidence of women with complex cardiac histories becoming pregnant
is rising. The high risk cardiac obstetric service provided by the Rotunda Hospital run in conjunction with the Mater Hospital was established in 2004 and is the only service of its kind nationally.
A retrospective cohort study using data collected at a speciality cardiac
antenatal clinic. We identified all women with congenital heart disease who
delivered in a 2 year period (2015 and 2016) and collected delivery
details of estimated blood loss, mode of delivery, length of second stage,
uterotonic drug class and dose administered, use of anticoagulants
antenatally and interval time between discontinuing and delivery to aid development of a condition specific peripartum guideline. Results pending.

PREGNANCY OUTCOMES AFTER ABDOMINAL CERCLAGE

Poster

Dr. Catherine Windrim [1]***, Dr. Vicky O'Dwyer*** [1]***, Dr. Donal O'Brien*** [1]***, Prof. Donal Brennan*** [1]***, Dr. Shane Higgins*** [1]

1. *National Maternity Hospital*

To examine pregnancy outcomes after abdominal cerclage.

In a retrospective review, data were assessed from women who underwent abdominal cerclage in a tertiary referral maternity hospital between April 2014 and June 2017. Delivery outcomes were obtained from the hospital's computerized database.

There were 17 abdominal cerclages performed. Of these 17, 10 women had 12 pregnancies. The indication for transabdominal cerclage was a short cervix where a cervical cerclage was not possible or previous failed cervical cerclage. All women had 2 or more previous LLETZ procedures. All but one woman had a laparoscopic abdominal cerclage performed prior to pregnancy. There was one laparotomy and abdominal cerclage at 9 weeks gestation.

Of the12 pregnancies, there were 11 liveborn infants. One woman had a first trimester miscarriage, which was managed with misoprostol. The median age of delivery was 38+3 weeks and the mean birthweight was 3188 grams. Most (9/11) were delivered by elective cesarean section; however two (18%) were delivered preterm by emergency cesarean section at 36 and 34 weeks for preterm prelabour rupture of membranes and contractions.

In carefully selected population, there is a high success rate of transabdominal cerclage.

PREVENTION OF PRETERM BIRTH

Poster

Dr. Vicky O'Dwyer [1], ***Ms. Larissa Luethe*** [1], ***Dr. Amy Donovan*** [1], ***Dr. Ann Rowan*** [1], ***Dr. Niamh Fee*** [1], ***Prof. Shane Higgins*** [1]

1. National Maternity Hospital

Preterm birth causes morbidity and mortality.

To examine preterm birth rates in a high risk population of women with a previous delivery between 16-34 weeks or two previous LLETZ procedures.

A prospective review of women in a tertiary referral maternity hospital who underwent surveillance with vaginal swabs and midstream urine(MSU), transvaginal ultrasounds or insertion of cervical cerclage. Proluton injections were given between 17-34 weeks. Outcomes were obtained from the hospital's electronic records.

There were 764 pregnancies in 555 women over the 5-year period. The average age was 33 years and BMI was 25.6kg/m^2. There were 39%(297) primigravidas and 61%(467) multigravidas. The average gestation at delivery was 37.2 weeks and 28.8% delivered preterm(<37 weeks). All women with a previous second trimester loss delivered at ≥28 weeks gestation. The mean gestation at delivery for women with a previous preterm birth was 37 weeks, compared with 30.3 weeks in previous pregnancies. 17.8% of women with two previous LLETZ delivered preterm. Women were treated for a positive HVS, ureaplasma/mycoplasma swab or MSU and this was not associated with preterm birth. Proluton was given to 123 women and 2/3 of these delivered at ≥37 weeks. A cervical cerclage was inserted in 53 pregnancies and their mean gestation at delivery was 33.7 weeks. The mean birthweight was 3102g and 6.8% of babies weighed <1000g. There were 6 stillbirths and 8 neonatal deaths related to extreme prematurity.

Preterm births occurred at a later gestation than in a previous pregnancy in women attending a preterm birth prevention clinic.

Risk Factors for Stillbirth.

Poster

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In Ireland, the stillbirth rate is 4.5 per 1,000. Knowledge of stillbirth may be affected by personal or clinical experience as well as provision /absence of dedicated staff training. This study sought to determine the background knowledge of stillbirth among healthcare professionals.

A cross-sectional survey examining stillbirth risk factor knowledge in healthcare professionals working in a large, tertiary-level maternity unit with 392 midwifery and 54 medical staff was performed. A detailed questionnaire on stillbirth risk factors was distributed to a random sample of staff members. Descriptive analysis was performed using SPSS v23.

212 surveys were completed by 167 midwives (79%) and 45 doctors (21%). Of these, 93.4% were female (n=198). 50% correctly identified the rate of stillbirth and 62.3% correctly identified the definition of stillbirth. 44% had attended a stillbirth delivery. The most common correctly identified risk factors for stillbirth were smoking (98%), pre-existing hypertension (91.7%), obstetric cholestasis (89.4%), previous history of stillbirth (84.7%), BMI > 30 (82%), recurrent pregnancy loss (76.2%) and maternal age > 35 (75.5%). Less well recognised risk factors included previous caesarean section (29.6%) and maternal influenza A infection (35.5%)

Although many risk factors were correctly identified, there was a lot of variation in knowledge and awareness of established stillbirth risk factors among midwives and doctors in our centre. Many respondents were uncertain regarding the relevance of risk factors and left questions unanswered. Dedicated education regarding stillbirth risk factors is essential for patient care optimisation. The informed practitioner creates an informed patient, for the best outcome.

SECOND-LINE TESTS OF FETAL WELL-BEING IN LABOUR – A SYSTEMATIC REVIEW

Poster

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Continuous electronic fetal heart rate monitoring (cEFM) by cardiotocography (CTG) is used in high-risk labours to identify fetuses likely to be compromised and who might benefit from additional assessment of wellbeing and/or interventions including delivery

It is well-recognised that CTG has a high false positive rate and that many fetuses that demonstrate abnormal CTG features are mounting a satisfactory physiological response to the stress of labour.

When an abnormal fetal heart rate pattern is detected and immediate delivery judged not to be warranted, additional test(s) of fetal wellbeing may be undertaken.

This review was completed to evaluate existing evidence for second-line intrapartum tests of fetal wellbeing.

Searches in the MEDLINE, Embase and Cochrane databases identified 482 studies of which 23 were suitable for inclusion. The majority of the studies were observational including 54-844 women (mean 279) with one large randomised controlled trial (RCT) of 2992 women.

A number of second-line tests were described including fetal blood sampling (FBS) for pH or lactate, digital fetal scalp stimulation (FSS) and fetal vibroacoustic stimulation (VAS). Some studies compared alternative second-line tests and others correlated an individual test with fetal outcomes including cord blood results, Apgar scores and admission to NICU. Where reported the negative predictive value of most tests was good but the positive predictive value was variable and often low.

Despite the widespread use of second-line tests of fetal well-being in labour the evidence base to support their use is currently limited. Future large scale RCTs are required to inform best practice.

SPONTANEOUS PLATELET AGGREGATION MAY IDENTIFY DIFFERENT CLINICAL PHENOTYPES OF UTERO-PLACENTAL DISEASE

Oral (IPNS)

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Though implicated in utero-placental disease, the relationship between maternal platelet dysfunction and subsequent placental disease is unknown.

The aim of this study was to correlate spontaneous platelet aggregation (SPA) in pregnancies complicated by utero-placental disease (PET, GH and IUGR) with placental-macro and micro-lesions after delivery.

Over the course of a two-year study period singleton pregnant patients with utero-placental disease had SPA testing (platelet aggregation in the absence of agonists) performed in the third trimester using a modification of light transmission aggregometry. Results were correlated with placental histopathology.

A total of 60 placentas were evaluated. GH/PET compared to IUGR was associated with increased distal villous dysmaturity (13/24(54%) versus 9/36(25%), $p<0.001$), decreased accelerated villous maturation (15/24(63%) versus 36/36(100%), $p<0.0001$), and an increasing placental birth weight ratio (PBWR). A significant positive correlation was found between maternal SPA and PBWR ($r=0.33$, $p=0.03$, $n=60$). Maternal mean platelet volume (MPV) was significantly higher in GH/PET compared with IUGR (12.4 ± 3.5 versus 9.5 ± 1.7, $p<0.001$). There were no differences in mean spontaneous platelet aggregation (SPA) according to classification of placental microscopic disease.

Spontaneous platelet aggregation is positively correlated with PBWR in utero-placental disease. Increasing PBWR, as evident in the GH/PET group may imply the placenta has ‘outgrown’ the demands of the bigger fetus. The increasing SPA and MPV in GH/PET compared with IUGR may indicate placental microthrombus, as younger platelets have higher volumes, and are more prone to aggregation. Spontaneous platelet aggregation may be a marker for clinical sub-types on the spectrum of utero-placental disease.

THE EFFECT OF MATERNAL HYPEROXYGENATION ON FETAL PULMONARY VASOREACTIVITY AND ON BLOOD FLOW PATTERNS IN THE UMBILICAL ARTERY AND MIDDLE CEREBRAL ARTERY IN PREGNANCY

Oral (IPNS)

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We sought to evaluate the changes in fetal pulmonary artery,umbilical artery and middle cerebral artery Doppler waveforms in response to maternal hyperoxygenation.

Nineteen pregnant women with a singleton gestation in the third trimester were prospectively recruited to the study. A comprehensive fetal echocardiogram was performed on all subjects. Pulsatility index (PI),acceleration time (AT) and ejection time (ET) were taken within the proximal portion of the fetal main pulmonary artery (PA). AT:ET was used to assess pulmonary vascular resistance (PVR). Umbilical artery (UAD) and middle cerebral artery (MCA) PIs were also obtained. Measurements were taken at baseline and repeated immediately following maternal hyperoxygenation with 60%$FiO_2$for a 10-minute duration.

The median gestational age was 36[33 – 37] weeks. There was a decrease in fetal PA PI following maternal hyperoxygenation (from 2.47 [2.11 – 2.80] to 2.08[1.75 –2.49], p=0.02) with a mean decrease of 21% [9-36] from the baseline. There was an increase in PA AT (43 [40-47] 57 [47 – 60] ms, p=0.005) leading to an increase in AT:ET (indicating a fall in PVR) following maternal hyperoxygenation (0.25 [0.24 – 0.28] to 0.32 [0.26 – 0.34], p=0.005). There were no changes in the PIs of the UAD or MCA following hyperoxygenation (0.93 to 0.99, p=0.92 and 1.54 to 1.72, p=0.20 respectively).

This study demonstrates that maternal hyperoxygenation diminishes the relative vasoconstriction in the fetal pulmonary vasculature. There were no significant changes to the MCA or UAD PI indices following hyperoxygenation suggesting that this effect is unique to the fetal pulmonary vessels.

THE EFFECTS OF PARENTAL UNEMPLOYEMENT ON OBSTETRIC OUTCOMES

Poster

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1. University Maternity Hospital, Limerick

The socio-economic status of mother and father has been known to influence the obstetric outcome of pregnancies. However, not many studies have been conducted to investigate the impact of parental unemployment on obstetric outcomes. In this study, we looked at whether the one, both or neither parents being unemployed had an effect on obstetric outcome.

Cases were identified using HIPE system and retrospective analysis of clinical notes was carried out. Total of 50 patients were included using strict inclusion/ exclusion criteria. We stratified patient into two groups: unemployed and employed with 25 patients in each arm. Antenatal, intrapartum and postnatal complications were noted.

Antenatally, pregnancies from the unemployed group presented later at booking (70% vs 92%), were more likely to be unplanned (52-58% vs. 8%) resulting in lower uptake of pre-conceptual folic acid (53% vs. 84%), average BMI was higher, and women more likely to be anemic (Hb <11g/dl). The rates of maternal/paternal smoking or alcohol consumption, and prevalence of chronic or psychiatric illness were largely similar in both groups; however, reported domestic violence was more predominant (8 % vs. 0 %) in the unemployed group. Unemployment was associated with higher hospitalization rates during pregnancy, lower vaginal delivery rate and higher C-section rate. Lower adherence to breastfeeding was noted in unemployed mothers (40% vs. 80%).

Overall as expected our study reinforced the hypothesis of detrimental effect of parental unemployment on Obstetric outcome .Larger Multicenter trials would more robustly support the evidence collected.

The Fetal Neurosurgical clinic - a novel approach to improving patient care

Oral (IPNS)

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A specialist neurosurgical clinic was set up in the National Maternity Hospital in Dublin in 2010 with the aim of improving patient care. The rare and complex nature of fetal neurological disease requires unique expertise and experience. The neurosurgical team in Temple St hospital are amongst the most experienced internationally in the treatment of spina bifida due to the relatively high incidence in Ireland.
Since the arrival of an on site MRI machine the neurosurgical clinic has increased in size with referrals from all over Ireland. Data from the clinic has been gathered prospectively since 2013 and includes detailed information of the scan findings, results of invasive testing, mode of delivery and outcome data.
The clinic has seen 117 patients since 2013. The most common reasons for referral include Spina Bifida, n=55 (47%) and isolated ventriculomegaly n=38 (32%). Other reasons for referral include agenesis of the corpus callosum n=5(4%), encephelocoele n=5(4%) and intracranial mass lesions n=4(3%).
The clinic is run bimonthly with direct counselling from a neurosurgeon, specialist nurse and fetal medicine consultant in order to inform patients of likely outcome and support them through the experience of having a child with neurological disease. A further advantage of this clinic is to gather outcome data which will in turn improve how we counsel patients in the future.

The fetus dictates its timing of birth through Exponential Uterine Wall Tension with Dark-Light Cycle modulation, making Pregnancy's Interval and Circadian Timers Constant: A Review

Poster

Dr. Ali Hegazy [1]

1. Obstetrics and Gynecology Deoartment, Portiuncula University Hospital, Ballinasloe, Co-Galway

The duration of pregnancy has two interacting timers: interval and circadian. The fetus dictates its time of birth and subsequently the duration of pregnancy viaexponential uterine wall tension (EUWT). EUWT has functional and molecular adaptations and is measured by Laplace's law and Pascal's principle.
EUWT and the Progesterone/estrogen ratio dictate the duration of pregnancy by inducing both inhibitory and stimulatory systems via mechanotransduction and another direct mechanism. This places pregnancy in a state of balance between two opposing, interactive, inhibitory and stimulatory systems.
The interaction between inhibitory and stimulatory systems is modulated by the dark-light cycle (DLC). This divides pregnancy into five clinical phases: growth, maturation, transition, termination (parturition) and involution. During the maturation phase, the cervix loses its resistance due to its transformation into the lower uterine segment and this eventually terminates the pregnancy.
EUWT is initiated with conception and ends with the complete loss of cervical resistance. Pregnancy duration (interval and circadian timers) is achieved by one mechanism, which leads to complete loss of cervical resistance nocturnally.
Rising EUWT is under complex genetic control. Low UWT terminates pregnancy and high UWT compromises fetal growth. Autonomous creation, maintenance, and termination of EUWT makes pregnancy an automated biologic reproductive cycle. Where pregnancy maintenance is autonomous, pregnancy termination is inherent, environmental, and obligatory. Parturition is deterministic and pregnancy's interval and circadian timers are constant. Rising EUWT secondary to fetal growth with DLC modulation may be the mechanism which dictates the timing of birth and the duration of pregnancy.

THE IMPACT OF INDUCTION OF LABOUR AS MANAGEMENT OF A LARGE FOR GESTATIONAL AGE FETUS, IN NON-DIABETIC MOTHERS, IN A DISTRICT GENERAL HOSPITAL.

Poster

Dr. Caoimhe McCoy [1], ***Dr. Aoife Currie*** [2]

1. Craigavon Area Hospital, 2. Southern trust

THE IMPACT OF INDUCTION OFLABOUR AS MANAGEMENT OF A LARGE FOR GESTATIONAL AGE FETUS, IN NON-DIABETIC MOTHERS, IN A DISTRICT GENERAL HOSPITAL.

C McCoy, A Currie, L Nesbitt
Maternity Department, Craigavon Area Hospital, Northern Ireland.

A number of non-diabetic patients were undergoing induction of labour (IOL) with the indication being a large for gestational age (LGA) fetus based on weight assessments made on ultrasound. This practice is not currently evidence based.

We aim to investigate the outcomes of induction of labour in these patients and compare them to similar patients who are induced at term plus ten days (unit policy). We want to ensure we are providing our patients with the safest care.

We identified patients from our IOL booking system. We then reviewed the patients notes retrospectively to complete an audit proforma – including labour durations and complications, fetal and neonatal complications, mode of delivery and postnatal complications. We will then analyse this data to determine outcomes for the two groups.

We have noted that these women tend to have prolonged induction processes with many being induced at 39 weeks gestation with an unfavourable cervix and wish to investigate this further.

In conclusion, our local protocol for management of a LGA fetus should
be updated and staff members should be educated on this update. We aim to reduce IOL for this indication. In addition, IOL for LGA is common practice in many
maternity units in Northern Ireland, therefore we aim to disseminate the
outcomes when our study is complete.

The Isthmus of the Cervix: Its Anatomical and Functional Existence, Rationale, and Consequences Should be Reconsidered: A Review

Poster

Dr. Ali Hegazy [1]

1. *Obstetrics and Gynecolgy Department, Portiuncula University Hospital, Ballinasloe, Co-Galway*

The mechanisms responsible for the maintenance of pregnancy and the initiation of parturition have not been fully explained in any species. Failure to properly understand the uterine function during pregnancy is a major shortcoming of modern healthcare, and this lack of understanding has many possible causes. Importantly, there may be a flaw in the current concept of human parturition that acts as a barrier to obtaining better understanding of parturition.

The isthmus of the cervix, both anatomically and functionally, does not seem to exist. There has been no convincing evidence to support its existence since Aschoff first proposed it in 1905. In fact, the embryological, anatomical, histological, and biomechanical characteristics of the cervix and the radiological evidence for the cervical changes and function during pregnancy challenge the existence of the isthmus.

These data also challenge the rationale behind the presence of this structure and the consequences of its existence. The current concept of human parturition (the lower uterine segment (LUS) is derived from the isthmus) is doubtful. Furthermore, the current anatomical relationship of the cervix and the urinary bladder during pregnancy and labour are questionable.

If the LUS is derived from the cervix, the role of the cervix in pregnancy and parturition will never be understood so long as the isthmus proposal persists. Anatomical and functional division of the cervix into isthmus and non-isthmus portions may be the main obstacle to understanding cervical function and parturition. The mechanism of human parturition should be revised in light of this hypothesis.

The Prenatal diagnosis of neurological disease and outcome data in a tertiary referral centre.

Oral (IPNS)

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Neurological conditions in the fetus pose a diagnostic challenge due to the heterogenous nature of the conditions and the difficulty correlating diagnostic imaging with disease sequelae in the infant. Ireland has the second highest fetal anomaly rate in Europe (EUROCAT) and has particularly high rates of neurological anomalies such as spina bifida.

The aim of this study was to prospectively gather outcome data on women who were seen in the neurosurgical clinic in a tertiary referral unit.

In 2016 there were 398 recorded fetal anomalies in our unit. 13% of anomalies were neurological in nature. Overall 26% of these women diagnosed prenatally with a neurological anomaly had a caesarean section with 74% achieving a vaginal delivery. In those diagnosed prenatally with a neurological condition, 27% opted to terminate their pregnancy. 40% of those diagnosed with Spina bifida opted to terminate and 20% suffered a pregnancy loss. Ventriculomegaly was another common neurological condition seen in the fetal neurosurgical clinic with 37%,19%,44% categorised as severe, moderate and mild respectively. Of the cases of ventriculomegaly 6% opted to terminate and 6% suffered a fetal loss with 85% having a liveborn baby.

Outcome data can help healthcare professionals to counsel parents faced with these challenges more effectively and thus improve patient care.

VITAMIN D SUPPLEMENTATION IN PREGNANCY - A SURVEY OF COMPLIANCE WITH RECOMMENDATIONS

Poster

Dr. Catherine Windrim [1], ***Dr. David Crosby*** [1], ***Ms. Kelly Mitchell*** [1], ***Ms. Caroline Brophy*** [1], ***Dr. Rhona Mahony*** [1], ***Prof. Mary Higgins*** [1]

1. *National Maternity Hospital*

Vitamin D deficiency in pregnancy has important maternal and fetal implications, with increased risk of developing gestational diabetes, pre-eclampsia, preterm birth and IUGR. It is recommended that every pregnant woman should take 5 micrograms (200 IU) of vitamin D per day during pregnancy and lactation.

This study aimed to determine the prevalence of women taking vitamin D supplementation and to identify the reasons for patients not taking supplementation.

Survey of women attending the antenatal clinic of the National Maternity Hospital Dublin during two weeks in January 2017. Women were asked to record demographics, medical co-morbidities and use of vitamin D supplementation or any other supplements in pregnancy, as well as reasons for non-use if appropriate.

300 women were invited to participate and 175 completed the questionnaire (58%). Overall, 38.9% (n=68) reported to be taking vitamin D supplementation. Of the women that reported not to be taking vitamin D supplementation, 57.9% (n=62) were taking a pregnancy multivitamin that contained vitamin D, and 28.0% (n=30) did not know that it was recommended in pregnancy. 45 women (25.7%) in our cohort were taking no vitamin D supplementation during pregnancy. There was no difference in non-use based on maternal age, BMI, parity or country of origin.

Of the women surveyed, 74.3% reported supplementation with Vitamin D, either knowingly or unknowingly. Public health initiatives need to utilize this relatively safe, low cost intervention to maximize maternal and fetal health. This could reduce the rates of antenatal conditions with associated high morbidity and healthcare burden.

WOMENS EXPERIENCE OF A PILOT STUDY OF ANTENATAL COLOSTRUM EXPRESSION IN PREGNANCIES AFFECTED BY MATERNAL DIABETES.

Poster

Ms. Sarah Egan [1], ***Mrs. Denise Mcguinness*** [2], ***Dr. Elizabeth O'sullivan*** [3], ***Mrs. Usha Daniel*** [2], ***Prof. mary higgins*** [4]

1. *UCD School of Medicine and Medical Science, University College Dublin, Belfield, Dublin 4,* ***2.*** *Midwifery, National Maternity Hospital,* ***3.*** *UCD Perinatal Research Centre,* ***4.*** *National Maternity Hospital, Dublin*

Background
Maternal pre-gestational (PGDM) or gestational diabetes (GDM) may have an effect on establishment of lactogenesis, and increase the risk of neonatal hypoglycaemia. Recent published research has shown that antenatal colostrum expression, aiming to help establish lactogenesis as well as provide expressed breast milk (EBM) for neonatal use, is feasible and safe.
Purpose
The aim of this qualitative study was to investigate the attitudes and experiences of women with PGDM and GDM towards the antenatal expression and collection of colostrum.
Study Design
Qualitative research – interview of consenting women participating in a pilot project within the National Maternity Hospital, Dublin. Thematic analysis of content until saturation.
Findings
Interviews were conducted over the phone with twelve women post-delivery who had taken part in this pilot program. The majority of women had a positive experience with the antenatal expression of colostrum as it gave them a sense of security as well as making them feel prepared for delivery and breastfeeding. Themes for further learning identified included a lack of education amongst the staff on the wards about the programme, a lack of awareness amongst the women about the amount of colostrum to be expected (leading to feelings of disappointment) and time constraints making it difficult to find time to express.
Conclusion and Implications
The findings of this pilot project have resulted in several learning points, allowing adaptation of the programme aiming to ultimately promote and safeguard breastfeeding amongst mothers with GDM and PGDM.

CONTINENCE FOUNDATION IRELAND

3rd & 4th DEGREE TEAR: OASIS RISK FACTORS AND OUTCOMES.

Poster

Dr. ABDELMAGID GABOURA [1]

1. *Midland Regional Hospital Portlaoise*

Obstetric anal sphincter injuries (OASIS) encompasses third and fourth degree tears during vaginal childbirth. The aim of this audit was to assess our local incidence of OASIS, relevant risk factors, method of repair & short term outcomes in comparison to National Clinical Practice Guideline number 8: Management of Obstetric anal sphincter injury.

A retrospective audit was performed between January-August 2017. The birth register was reviewed to identify cases of OASIS. The following variables were reviewed: Demographics: maternal age, parity, gestational age, body mass index, Intrapartum: induction of labour, duration of labour, performance of episiotomy, mode of delivery,shoulder dystocia, grade of operator, estimated blood loss, need for blood transfusion. Repair of OASIS: grade of tear, repaired in theatre, analgesia for repair, grade of operator, method of repair, sphincter suture used. Postpartum course: antibiotic prophylaxis, laxative use, physiotherapy review, patient debriefing, incident report completed, episode of urine or bowel incontinence, date for gynae outpatients review, referral to perineal clinic in National Maternity Hospital.

There were 12 cases of third degree tear. There were no cases of fourth degree tear. A total of 1013 women delivered in the 8 months which equated to an incidence of 1.18% (12/1013).Remainder of results to follow.

A DEDICATED PERINEAL CLINIC - AN AUDIT IN SUPPORT

Oral (CFI)

Dr. Edward Corry [1], *Dr. Mark Skehan* [1], *Dr. Mendinaro Imcha* [1]

1. University Maternity Hospital, Limerick

The incidence of clinical Obstetric Anal Sphincter Injury (OASI) varies widely, reported between 0.5%-3% in Europe. Currently, in Ireland, only three maternity hospitals have a dedicated perineal clinic, staffed with experts to provide a patient-centred service.

We conducted an audit of OASI in the University Maternity Hospital Limerick to determine the quality of care provided post-OASI, at a large maternity hospital without a dedicated perineal clinic.

We audited the mode of delivery, the location and technique of repair, and the follow-up of 48 sequentially recorded cases of OASI from the Hospital's In-Patient Enquiry database from July 2015.

Of the 48 recorded cases, clinical records were available for 44. There were 33 primiparas and 11 multiparas women. There were 19 (43%) spontaneous vaginal deliveries and 25 (57%) instrumental deliveries (20 vacuums, four forceps, one double instrumental). The indication for instrumental delivery was prolonged second stage in nine cases and suspected foetal distress in 16. The location of the repair for 29 (66%) was the OT, and for 15 (34%) in the delivery suite. Of the 15 in the delivery suite, 13 had an epidural; 11 were 3a tear and 4 were 3b,13 repair performed by a consultant. Of the 44 cases reviewed, only 23 (52%) had documented review and follow up noted in the maternal records. Of these, two had persistent flatal incontinence both of which were delivered by forceps.

The absence of a dedicated perineal clinic impacts both the follow up care and the ability to audit post OASI.

DO VBACS DAMAGE PELVIC FLOORS?

Oral (CFI)

Dr. Mark Skehan [1]

***1.** University Maternity Hospital, Limerick*

The author has kept an electronic record of all private deliveries for 22 years. There were 101 attempted VBACs in patients with one previous delivery (a Caesarean) over a 6 year period from 2010 until 2016. 26 patients had a normal delivery, 41 a Kiwi vacuum delivery, 32 a Caesarean section and 2 a forceps delivery.

Almost all patients were assessed at 6 weeks post-natal. A sagittal abdominal ultrasound was done at each visit and the patient was asked to contract her pelvic floor muscles. After a brief training, each patient was given a score of 0 - 5, using half point scores (11 possible scores). A brief video will be shown.

The post-natal charts were examined. Paired results will be presented showing an estimate of the strength after the first Caesarean versus that after the second delivery. All patients have been assessed by the same examiner sometimes many years apart.

From a preliminary view of 36 patients with paired results almost equally divided between normal delivery, vacuum delivery and Caesarean section, only 11 changed by more than 1 point; 7 decreased and 4 increased and only 2 shifted by 2 points.

It is a commonly held view that if a patient has had a Caesarean section that the pelvic floor should not be risked by trying for a VBAC. This study tends to suggest that pelvic floor strength after first delivery is a better predictor than delivery type second time around.

PUBIC DIASTASIS: A CASE SERIES FROM A TERTIARY MATERNITY HOSPITAL

Oral (CFI)

Dr. Katie Beauchamp [1], ***Ms. Leah Bryans*** [2], ***Dr. Gerry Agnew*** [2]

1. National Maternity Hospital, 2. St. Michaels' Hospital, St. Vincents' Healthcare Group, National Maternity Hospital

The pubic symphysis is a midline non-synovial joint connecting the right and left superior pubic rami. Pubic diastasis (PD) is separation of the pubic symphysis >1cm without associated fracture, causing dysfunction of the joint. It is most commonly associated with childbirth but also with trauma. Incidence is between 1 in 300 to 1 in 30,000 pregnancies.

We report a case series of 10 women diagnosed with PD from 2006-2017.

The data was collected retrospectively from charts based on clinicians memory of specific cases. The diagnosis was made by measuring the gap between the pubic rami either on pelvic XR or MRI in the antenatal setting.

90% were post natal with one woman diagnosed antenatally. The distance between the pubic rami ranged from 1-2.8cm. All of the post natal women complained of pubic pain or immobility within 48 hours after vaginal delivery. 8 women had normal vaginal deliveries and 1 had forceps delivery. 44% were multiparous. 66% had epidural anaesthesia. The length of second stage of labour ranged from 12 minutes to 133 minutes. There was 1 case of shoulder dystocia which was delivered in McRoberts position. Birth weight ranged from 3430g-4570g. 90% required assistance mobilising with either zimmerframes or crutches and one woman mobilised independently. 40% underwent repeat XR.

This demonstrates the need for high index of suspicion in women complaining of pubic pain or difficulty mobilising. This is a debilitating condition which is likely underdiagnosed and needs a clear pathway in terms of treatment and follow up.

SINGLE CENTRE EXPERIENCE WITH CYSTOSCOPIC INJECTION OF ONABOTULINUMTOXIN A FOR THE TREATMENT OF OVERACTIVE BLADDER

Oral (CFI)

Dr. Gerry Agnew [1]**, *Ms. Dervla Nimmo*** [2]

1. *St. Michaels' Hospital, St. Vincents' Healthcare Group, National Maternity Hospital,* ***2.*** *University College Dublin*

In 2015 ,the International Continence Society advocated the use of Onabotulinumtoxin A(Botox[R]) for patients with Idiopathic Detrusor Overactivity who had had insufficient benenfit from first line treatment with lifestyle interventions and oral medications (anticholinergic or Beta 3 agonist agents).[1.]

We aimed to review the results from our first eighteen months of treatment of refractory Overactive Bladder with cystoscopic injection of Onabotulinumtoxin A to the bladder.
Data was collected retrospectively by review of the patient records. The review included all patients who underwent treatment from 1/02/16 until 31/07/17. Diagnosis, preoperative urodynamics and six week postoperative follow up with bladder diaries were recorded. All patients received the same dose of 100 units of Onabotulinumtoxin A in 10mls of 0.9% saline. This was administered to the bladder via twenty 0.5ml injections. All procedures were carried out with a rigid cystoscope.
Forty women with refractory overactive bladder received a total of 54 treatments during the study period. Thirty eight women, 38/40(95%) reported a significant improvement in urinary symptoms. One woman, who reported no improvement, had had a stable bladder on preoperative urodynamics. Four women with the concomitant additional diagnosis of Painful Bladder Syndrome all reported significant reductions in bladder pain following treatment. No patient experienced urinary retention as a complication of treatment.
Initial results show Onabotulinumtoxin A to be an effective and safe treatment for refractory Overactive Bladder. Its potential for treating the debilitating and distressing condition of Painful Bladder Syndrome warrants further study.

IRISH GYNAECOLOGICAL ENDOSCOPY SOCIETY

A STUDY TO DETERMINE THE DIAGNOSTIC VALUE OF CT COLONOGRAPHY IN EVALUATING COLONIC INVOLVEMENT IN DEEPLY INFILTRATING ENDOMETRIOSIS.

Poster

Dr. Rupak Kumar Sarkar [1], ***Dr. Stephen Liddy*** [2], ***Dr. Elisabeth O'Dwyer*** [2], ***Dr. John Feeney*** [2], ***Dr. Aoife O'Neill*** [1]

1. *Department of Gynaecology, Adelaide & Meath Hospital incorporating the National Children's Hospital (AMNCH), Tallaght, Dublin 24,* ***2.*** *Department of Radiology, Tallaght Hospital, Dublin 24*

BACKGROUND:

Deeply infiltrating endometriosis (DIE) is characterised by endometriotic deposits infiltrating into the peritoneum to a depth of 5mm or more. Bowel involvement is common and can be associated with diarrhoea, rectal bleeding and non-cyclical pelvic pain. Accurate preoperative evaluation of the location and extent of the colonic lesions allows for precise surgical planning and appropriate preoperative counselling. Pelvic MRI is considered the optimal non-invasive method for evaluating DIE, however its utility in assessing colonic involvement is uncertain. CT colonography may provide a viable alternative.

OBJECTIVE:

To determine the diagnostic value of CT colonography in evaluating colonic involvement in deeply infiltrating endometriosis.

METHODS:

A retrospective review was performed of all patients who underwent CT colonography and surgery for deeply infiltrating endometriosis between January 2014 and January 2016. Clinical, radiological and intraoperative data were recorded. Our institution is a Tertiary referral centre for Deeply infiltrating endometriosis.

RESULTS:

Thirty two patients were diagnosed with DIE during the study period. All patients had diagnostic imaging and MDT discussion prior to surgery. CT colonography was performed in 20 patients (62%). Bowel involvement was suggested in 14/20 (70%). 6 /14 (42%) patients required bowel resection during joint surgical management of deeply infiltrating endometriosis by the Gynaecological and Colorectal team.

CONCLUSION:

CT colonography is highly sensitive in detecting colonic involvement in DIE, however it lacks specificity and is not predictive of the need for bowel resection.

ADDRESSING MODERN CHALLENGES IN GYNAECOLOGICAL ENDOSCOPY TRAINING IN IRELAND THROUGH SIMULATION TRAINING

Oral (IGES)

Dr. Claire Thompson [1], ***Dr. Helen Goodall*** [2], ***Dr. Gemma Ferguson*** [3]

1. *1.Gynaecological Oncology Department, St James's Hospital,* ***2.*** *Royal Jubilee Maternity Service, Belfast,* ***3.*** *Antrim Area Hospital, Northern Ireland*

Gynaecological laparoscopic simulation has been proposed as a method of overcoming the challenges faced by current trainees in obtaining surgical experience. The inaugural Gynaecology Laparoscopic Operating Skills (GLOS) course will take place in October 2017 with the aim of providing tailored high quality training to Gynaecology registrars.

Our aim is to assess the experience of course candidates in terms of performing procedures, dealing with complications and potential barriers to training. The findings will enable the course to be designed to a high standard with a relevant curriculum. Interval assessments will be performed to evaluate the impact of the course on subsequent clinical development.

The GLOS course was advertised to gynaecology trainees at ST4/SpR 1 and above throughout Ireland. The 20 course candidates completed a pre course questionnaire.

Trainees were generally confident at Veress insertion and management of ectopic, however, significantly less confident in Hassan entry, suturing, operative laparoscopy and recognising/managing injuries. Most trainees performed less than 5 common laparoscopic procedures within the last 2 years. 70% of candidates have access to lap trainers, however, no one recorded receiving regular local training. Of concern, 60% of candidates had experienced difficulty during their annual clinical assessment, with lack of consistent senior supervision and rota gaps highlighted as barriers to training.

Trainees are clearly facing difficulty in obtaining adequate clinical training opportunities. Laparoscopic simulation courses, such as GLOS, should play a key role in addressing training challenges and building confidence.

AN AUDIT OF THE TIME REQUIRED FROM REFERRAL VISIT TO DEFINITIVE SURGERY IN CASES OF DEEPLY INFILTRATIVE ENDOMETRIOSIS IN A TERTIARY REFERRAL CENTRE.

Poster

Dr. Rupak Kumar Sarkar [1]***, Dr. Syeda Farah Nazir*** [1]***, Dr. Aoife O'Neill*** [1]

1. Department of Gynaecology, Adelaide & Meath Hospital incorporating the National Children's Hospital (AMNCH), Tallaght, Dublin 24

Background:
Tallaght Hospital is a tertiary referral centre for the management of Deeply Infiltrating Endometriosis (DIE) . This multi-speciality comprehensive investigation, diagnosis and surgical management of DIE, both Gynaecological and Colorectal, is provided without any additional resources in terms of finances , infrastructure or personnel.

Aim:
To audit the duration of time from referral visit to definitive surgery prior to the appointment of a Nurse coordinator to streamline the pathway of patient care.

Methods:
Retrospective case note review of surgically managed cases of DIE attending our hospital from January 2014 to January 2016. Cases were identified from the departmental DIE database. Data was collected and analysed using a standardised performa .

Results:
Thirty two women with DIE were surgically managed during the study period.
Ten charts were reviewed . 50% of our referrals were from GPs, 40% from another Consultant, and 10% seeking second opinion from another hospital.
On average each patient attended 5 (range 2-9) Gynaecology Clinics and 2 (1-2) Colorectal Clinics +/- Colonoscopy & Radiology visits pre-surgery. 100% of patients had radiological imaging and MDT discussion. The average duration from referral visit to Surgery was 14 months (3-27) including medical management during the intervening period.

Conclusion:
Our baseline audit highlights the scope for improvement in streamlining our patients' journey through the various departments and would highly benefit from a Nurse Coordinator and dedicated administrative support with our goal to set up a National Treatment Centre for DIE with future funding for external Collaboration, Research and Training .

Buddy operating: the key to a faster learning curve

Poster

Dr. aaron mcavoy [1]**, *Dr. Shalini Srivastava*** [1]

1. *East Surrey Hospital*

Objectives: The impact of the European working time directive has meant that seven years of surgical training is often no longer sufficient to adequately train a surgeon to perform complex procedures. Buddy operating has been proven to shorten the learning curve in achieving competence in these procedures. Our aim was to assess trainees' confidence in training and assess the desire for regular buddy operating lists as a consultant.
Patients and Methods: A survey was carried out on trainees attending a regional training day within the unit of Surrey and Sussex healthcare NHS trust in March 2017. This data was then collated and reviewed.
Results: Only 53% (n=10) of those surveyed felt that they had adequate exposure to procedures appropriate to their level of training. 84% (n=16) felt that their training had been impaired due to lack of theatre time. Only 26% (n=5) operated regularly with a named consultant. Confidence amongst trainees that they would be able to independently perform procedures such as total laparoscopic hysterectomy, vaginal hysterectomy and total abdominal hysterectomy was low at 16%, 37%, and 37% respectively. 53% (n=10) and 37% (n=7) felt that having a regular or occasional consultant buddy would be useful in their early years as a consultant.
Conclusion: Surgical learning curves for complex laparoscopic and open procedures are often slow and this has been impacted adversely by the European working time directive. This has led to falling confidence in operating abilities which may be helped by working with a regular consultant buddy.

CASE OF A COSY CORNUAL CORNER

Poster

Dr. Ciara Nolan [1], ***Dr. Jenny Stokes*** [1]

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Stokes J, Nolan C, Hassan

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Although all ectopic pregnancies are an important cause of morbidity and mortality, cornual pregnancies are particularly associated with major haemorrhage and uncontrollable bleeding. The maternal mortality rate can be as high as 2.5%, which is 7 times higher than the mortality associated with other extra-uterine pregnancies[1]. For this reason, early detection and timely management by experienced clinicians can reduce unfavourable outcomes.

We present the case of a cornual ectopic pregnancy. A 35 year old primigravid woman presented at 5 weeks gestation to the Emergency Department with left sided abdominal pain and light vaginal spotting. She has a history of Von Recklinghausen Syndrome with 13 previous plastic surgeries for cutaneous lesions. Initial trans-abdominal and trans-vaginal scan showed an empty uterus, normal adnexae and no free fluid, and a diagnosis of pregnancy of unknown location (PUL) was made. Serial serum bHCGs were taken showing a suboptimal rise over 48 hours (from 3881 to 5187 IU/L). Rescan 3 days later showed a left cornual ectopic pregnancy, with areas of mixed echogenicity adjacent to the gestational sac, likely haemorrhagic material. Laparoscopy and removal of the cornual ectopic was performed the same day. Histology showed left cornual ectopic with no evidence of molar change identified. Serial serum bHCGs post-operatively showed return to non-pregnant levels.

[1]Bettaiah R, Kamath SS. Intramyometrial Injection of Vasopressin: A Novel Method for Hemostasis at Laparoscopic Management of Cornual Ectopic. J Minim Invasive Gynecol. 2017 Apr 18.

HETEROTOPIC PREGNANCY POST-EMBRYO TRANSFER: A CASE REPORT

Poster

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1. Roy, 2. Ro, 3. Royal College of Physicians of Ireland (RCPI)

Nolan C, Stokes J, McGuane C, Hehir M, Kent E
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Ectopic pregnancy is the leading cause of maternal morbidity and mortality in early pregnancy, and the incidence increases dramatically with in vitro fertilisation and embryo transfer (IVF-ET). The coexistence of an ectopic pregnancy with an intrauterine pregnancy (IUP) is known as heterotopic pregnancy, affecting 1% of patients using assisted reproduction techniques. Because of their rarity and inherent complexity, such cases represent a significant challenge in diagnosis and management. Early detection and intervention allows the intrauterine pregnancy to be preserved in the majority of cases[1].

We present a case of heterotopic pregnancy post embryo transfer for in vitro fertilization (IVF). A 39 year old woman in her 8th week of gestation presented to the Emergency Department with right iliac fossa (RIF) pain and light vaginal spotting. She had one previous normal delivery 18 years ago, and had undergone IVF and embryo transfer in this pregnancy. Transabdominal and transvaginal ultrasound scan revealed a viable intrauterine pregnancy and an abdominal ectopic pregnancy. Both gestational sacs measured 8 weeks, with a crown-rump length of 7+5 weeks and fetal heart seen in both sacs. The patient was clinically stable and was taken for laparoscopy. The extra-uterine pregnancy was visualized and removed, while conserving the viable intra-uterine pregnancy.

[1]Refaat B, Dalton E, Ledger W. Ectopic pregnancy secondary to in vitro fertilisation-embryo transfer: pathogenic mechanisms and management strategies. Reprod Biol Endocrinol. 2015; 13: 30.

Hysteroscopic Morcellation in outpatients: Patient Satisfaction

Poster

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1. Antrim Area Hospital, Northern Ireland

Background:

Outpatient hysteroscopy without anaesthesia is now established as the most appropriate model of care but often pathology detected is not amenable to removal at time of diagnosis with current techniques, eg hysteroscopic scissors/graspers/electrodes.

Purpose:

To minimise recourse to theatre for our patients we introduced hysteroscopic morcellation to our outpatient hysteroscopy service. We wished to determine safety, acceptability and patient satisfaction.

Methods

The first 25 patients to use the service were asked to privately complete an anonymous questionnaire. Patients were asked if they received enough information about the clinic, and if they experienced pain during the procedure. If yes, they were asked to rate pain by placing a circle on a scale 0-10, were 10 is the worst pain imaginable. Finally they were asked if a friend or relative was attending the clinic would you recommend/Not recommend attending this clinic. Comments were invited in a free text box.

Findings

18 (72%) of women reported pain during the procedure. Mean pain score was 4.1.

Vasovagal attacks occurred in 3 (12%) of cases. All were self-limiting and admission to ward was not required in any case.

80% of women would recommend the clinic to friend/relative, 4% would not. 16% did not answer this question.

Conclusion

Outpatient morcellation is acceptable to patients who appreciate not having to return to hospital for procedures in theatre. These first 25 cases represent the start of our learning curve and it is likely that further experience and careful case selection will minimise vasovagal attacks and pain.

MAJOR COMPLICATIONS ASSOCIATED WITH OVER 1400 OPERATIVE LAPAROSCOPIES: A MULTICENTRE PROSPECTIVE STUDY

Oral (IGES)

Dr. Kathy Niblock [1], Dr. Lisa Bell [2], Dr. David Morgan [3], Dr. Geoff McCracken [1], Dr. Keith Johnston [3]

1. Craigavon Area Hospital, 2. an, 3. Antrim Area Hospital, Northern Ireland

Background: As an increasing number of indications for operative gynaecological laparoscopy evolve, the numbers being performed also increase, as does the laparoscopists' skill and experience. Traditionally associated with higher complications than vaginal and abdominal approaches, this is no longer the case. The advantages and safety of this approach are now well established.

Purpose: To review the incidence of major complications (visceral/urinary tract/ vascular injury + death) following operative gynaecological laparoscopic surgery.

Design and Methods: Prospective multicenter study of 1,413 operative laparoscopies over a 94-month period by three advanced benign laparoscopic surgeons. Patients undergoing operative gynaecological laparoscopies were included. Complications diagnosed intraoperatively and postoperatively were analyzed.

Findings: The overall major complication rate was 1.27% (18/1413). Specifically damage to bowel 0.35% (5/1413), urinary tract 0.42% (6/1413), vascular injury 0.42% (6/1413) and death 0.07% ((1/1413) secondary to pulmonary embolus).

Analysisof the timing of recognition of the complication revealed "at entry" 11.1% (2/18), "intraoperatively" 61.1% (11/18) and "delayed" 27.8% (5/18).

The majority of the complications were managed laparoscopically 72.2% (13/18) with 55.6% (10/18) successfully managed by the gynaecologist.

Conclusion: This study shows the overall major complication rate associated with operative gynaecological laparoscopy is low, and compares favourably with those reported in the literature for open and vaginal equivalent procedures. The majority of major complications can be managed by the gynaecologist using a laparoscopic approach thereby avoiding the morbidity associated with laparotomy.

OUTPATIENT HYSTEROSCOPIC MORCELLATION:CLINICAL OUTCOMES + COMPLICATIONS

Poster

Dr. Lisa Bell [1], ***Dr. David Morgan*** [1]

1. Antrim Area Hospital, Northern Ireland

Background:

Outpatient (OP) hysteroscopic morcellation allows removal of uterine pathology within the “office” setting, avoiding anaesthesia and theatre utilisation.

Purpose:

To assess clinical outcomes and complications within our OP hysteroscopic morcellation clinic.

Design and Methods:

Retrospective audit of clinical activity over 6 months (Sep 2016 – March 2017). A proforma was devised focusing on outcomes relevant to this service - pathology found, resection time, complete resection achieved, fluid deficit, histology, complications, inpatient procedure needed. Patient demographics, indication + USS findings at time of referral were also audited. Patient satisfaction has already been audited with positive feedback.

Findings:

26 patients identified.

Average BMI was 41.4 (Range 21-62).

69% of cases were initial referrals from primary care with postmenopausal bleeding and thickened endometrium at scan (average 10.5mm).

Resection time averaged 110 seconds (Range 18-373).

Complete resection was achieved in 72% of cases. Of the 7 “incomplete”; 4 (15%) required an inpatient procedure.

The overall complication rate was low. Vasovagal rate was 3/26 (11%). No perforations were sustained. 1 case could not proceed due to cervical stenosis.

Fluid deficit averaged 143mls (Range 0-500).

Histology confirmed endometrial polyp in 69% of cases + fibroid in 15%. Complex hyperplasia was found in 3 cases.

Conclusion:

This study highlights to faculty that OP hysteroscopic morcellation is time efficient, effective + safe. Main theatre lists benefit and patients avoid anaesthesia. With further experience, improved patient selection + adaption of fluid management/fasting + medication regimes; we aim to lower our complication rate whilst improving overall complete resection.

RETROSPECTIVE REVIEW OF OUTCOMES FOLLOWING THE INTRODUCTION OF A HYSTEROSCOPIC MORCELLATION SYSTEM IN AN OUTPATIENT SETTING.

Poster

Dr. leah mcguckin **[1]*, Dr. Catriona Nugent*** **[1]**

1. *South Eastern Health and Social Care Trust*

Hysteroscopy is a minimally invasive trans cervical approach to visualising and operating within the endometrial cavity. One limitation to the use of Outpatient Hysteroscopy was the inability to contemporaneously remove polyps once identified. This has changed due to the development of morcellation systems that offer safe and effective resection of uterine pathology under direct vision. The TRUCLEAR morcellator used in this study has small diameter (5mm) and was designed for use in outpatient setting.
As an organization our aim is to embrace the shift in procedures from inpatient to outpatient, which benefits patients and financial resources. The purpose of our study was to show that the Truclear Morcellation System is safe and effective within our outpatient department.
Clinical documents were reviewed of 30 patients attending for Truclear resection from February to July 2016 using Electronic Care Record. Information was obtained from outpatient letters, Laboratory results and MDT discussions.
Patients' age ranged from 50-79 years. 82.1% were 'Red Flag' referrals. 70.3% were classed as obese and frequently had associated medical comorbidities. The most common pathological finding was endometrial polyps (59%) and endometrial carcinoma was found in 7%. The procedure was successful in 92.8% of patients and 'See and Treat' was achieved in 35.7%. 89.2% of patients had no complications (2 patients treated for infection post procedure).
Many patients were high-risk candidates for general anaesthetic, outpatient resection negated this risk. Our study confirmed that Truclear Morcellation was safe and effective in the outpatient setting and allows efficient use of resources.

Robotic Emergency Undocking Protocol

Poster

Dr. Olumuyiwa Ayodeji [1]***, Dr. Matt Hewitt*** [2]***, Dr. Orfhlaith O'Sullivan*** [3]

1. University Hospital Galway, 2. Cork University Maternity Hospital, Cork, 3. Department of Urogynaecology, Cork University Maternity Hospital, Cork.

Background

The role of robot-assisted surgery across gynaecology is evolving with increasing numbers of procedures being undertaken with varying degrees of complexity. While the risk of conversion is low at 1%, the reasons for conversion are variable. These range from technical issues with the robot, surgical complications such as haemorrhage and anaesthetic issues such as inability to ventilate the patient, it is important that theatre staff can perform an emergency undocking effectively and safely as possible when the need arises.

Objective: Examine if staff were aware of the protocol, their roles in case of an emergency undocking and the need for drills.

Methods: Questionnaires were distributed to gynae staff involved with robotic surgery. The questionnaire was designed to assess: if the staff knew the emergency undocking protocol and their roles in case of emergency undocking. Questionnaire was distributed over a three month period in CUMH.

Results. A total of 28 gynae staff participated in the survey. The majority of respondents were NCHDs. 50% of the staff were aware of the protocol and about 20% had been involved with emergencies with the robot. 26% of the sampled respondents had been involved in emergency conversion from robotic to laparoscopy or laparotomy. Majority felt there was a need for drills and were of the opinion that it should be carried twice a year.

Conclusion The majority of staff were not aware of their roles and the protocol. The study highlights the need for training of staff to perform emergency undocking safely and effectively.

TWO YEAR REVIEW OF OUTPATIENT HYSTEROSCOPY IN THE UNDER 45 POPULATION

Poster

Dr. Catherine Windrim [1], ***Dr. Farah Nazir*** [2], ***Dr. Asish Das*** [2]

1. National Maternity Hospital, 2. Department of Obstetrics and Gynaecology, Wexford General Hospital.

To evaluate the indication and diagnostic yield of outpatient diagnostic hysteroscopy in the under 45 population.
We retrospectively reviewed all patients referred for outpatient hysteroscopy in the under 45 years old population over a 2-year period to April 2017. The outcome of 104 outpatient hysteroscopies was analyzed according to patient characteristics and outcomes.
There were 104 patients under 45 years old that underwent outpatient hysteroscopy. The median age was 38 years old (range 21-44). The majority of patients were referred for menorrhagia (31%) and irregular bleeding (31%). An increasing number of referrals were for patients with diagnosed cervical glandular intra-epithelial neoplasm (n=23, 22%). Other indications ranged from infertility (10%), tamoxifen treatment (1%), lost mirena coil (3%) and polyp (2%).
23% of patients were referred without an initial ultrasound examination. A further 52% had a normal ultrasound. The common ultrasound findings were polyp (7%) and fibroid (15%).
The majority of the gross hysteroscopy examinations were normal (88%). The only abnormalities noted were polyps in 7 exams (7%) and fibroids in 2 (2%).
Endometrial curettings or biopsy were taken at each procedure. Of these, 92% were normal, 5% cervical polyp, 2% endometritis, and 1% polyp.
No intrauterine pathology was diagnosed.
Outpatient diagnostic hysteroscopy is both feasible and acceptable with wider utilization. However, the diagnostic yield in the under 45 population remains low. Care must be taken not to burden this service with examinations that will likely not alter the management of these patients.

IRISH FERTILITY SOCIETY

A COMPARISON OF HYSTEROSALPINGOGRAPHY AND LAPAROSCOPY FINDINGS IN WOMEN WITH SUBFERTILITY.

Oral and Poster (IFS)

Dr. Ayodele David Aina [1], ***Dr. Claire M McCarthy*** [1], ***Dr. Rishi Roopnarinesingh*** [1], ***Dr. Edgar Mocanu*** [1]

1. *Rotunda Hospital. DUblin*

Hysterosalpingraphy (HSG) and diagnostic laparoscopy are both utilized in reproductive medicine to identify tubal causes of subfertility. We aimed to identify the spectrum of uterine and tubal pathologies detected on HSG, and correlate its' findings with subsequent diagnostic laparoscopy.

We conducted a retrospective review of women who had a HSG performed during one calendar year (2015), and compared findings to subsequent laparoscopy. The uterine and tubal findings, demographics, any other predisposing factors to tubal damage and their subsequent laparoscopic findings were evaluated.

156 patients were referred for a HSG, 151 patients had a HSG performed during the study period. 22 women proceeded to have a laparoscopy. The mean age was 33.4 (range 21-45); 60 (38.4%) had a diagnosis of primary subfertility, with the majority (87; 55.7%) having secondary subfertility. The mean duration of subfertility was 4.4 years (range 6 months-18 years). 74 (49%) patients had a normal HSG. With regard to HSG abnormalities, 32 (21.2 %) women had unilateral obstruction, 11 (7.2%) had a bilateral tubal obstruction. There were 25 (16.5%) uterine abnormalities identified, of which 20 were classed as congenital anomalies i.e Mullerian abnormalities. Of the patient who underwent a subsequent laparoscopy (n=24) HSG findings were confirmed in 17 (70.8%).

HSG is a useful adjunct and diagnostic tool in the initial assessment of uterine and tubal integrity. HSG is a less invasive modality, although not the gold standard but an acceptable and accurate form of assessing tubal patency. However, diagnostic laparoscopy can add significant information to the clinical case.

BENEFIT OF ANTI-MULLERIAN HORMONE IN AN ASSISTED REPRODUCTION THERAPY SETTING

Poster

Dr. Maryanne Siu [1], ***Dr. Lucia Hartigan*** [1], ***Dr. David Crosby*** [1], ***Dr. Fiona Martyn*** [1], ***Dr. Mary Wingfield*** [1]

1. *National Maternity Hospital*

Ovarian reserve can be predicted using anti-mullerian hormone (AMH) and antral follicle count (AFC). AMH is obtained using a simple blood test and AFC is ascertained using ultrasound scan in the follicular phase. Our aim was to establish a correlation between AMH and AFC and demonstrate the benefit of this information in optimising assisted reproduction therapy (ART).

This was a retrospective analysis of prospectively collected data. AMH levels and AFC were collected prospectively from September 2016 until June 2017 in our unit on an electronic database and then correlated with the dose of stimulation and number of oocytes retrieved as part of in-vitro fertilisation. Data were analysed using SPSS.

AMH levels were obtained from 645 women attending our unit and of these 564 also had AFC performed. There was a direct correlation between both parameters ($p<0.01$ and $r^2=0.73$). 140 of these women went on to have ART. There was no clear correlation between AMH or AFC levels and oocyte number retrieved but this is an expected finding because those with a lower AMH and AFC received a higher dose of stimulation.

Circulating AMH has the ability to predict excessive and poor response to stimulation with exogenous gonadotrophins in the setting of assisted reproductive therapy (ART). It is established that women with a lower AMH will have fewer oocytes. However, by having knowledge of their ovarian reserve markers prior to treatment, the dose of stimulation can be adjusted to optimise oocyte retrieval numbers and treatment outcome.

FERTILITY PRESERVATION IN A TRANSGENDER POPULATION

Oral (IFS)

Dr. Yvonne O'Brien **[1]** ***, Dr. Fiona Martyn*** **[2]** ***, Dr. Mary Wingfield*** **[2]** ***, Prof. Donal O'Shea*** **[3]**

1. *Merrion Fertility Clinic, National Maternity Hospital, University College Dublin,* ***2.*** *National Maternity Hospital,* ***3.*** *St Vincent's University Hospital, St Columcilles Hospital, University College Dublin*

Hormonal sexual reassignment treatments have negative impacts on future fertility options. Currently, best practice guidelines recommend that fertility preservation (FP) options should be discussed prior to initiating treatments. We aimed to ascertain the views on FP of young people recently diagnosed with Gender Dysphoria (GD).

This was a pilot qualitative study. A semi-structured interview schedule was developed. The following areas were explored in the interviews: background of the diagnosis of GD, intention of parenthood, knowledge of negative impact of treatment on fertility, awareness and openness towards FP options. Using thematic analysis, the sorted categories evolved into a coding system.

The average of the study participants (N=6) was 18.5 years of age. The study participants were aware of the negative impact of their proposed treatment, but were less knowledgeable of FP options. Intentions towards pursuit of genetic parenthood or FP were not strong. Many cited financial restraints, lack of family support and lack of knowledge as barriers to accessing services.

To our knowledge, this is the first qualitative study to prospectively investigate the attitudes of young transgender men and women towards FP. While intentions towards genetic parenthood and FP options were low, it is likely that these views may change with time as these young people become established in their new roles and make new relationships.

We must anticipate and address these issues when counselling this population prior to commencing treatment, so that they may preserve the ability in the future to realise any potential desire for genetic parenthood.

Intracytoplasmic Sperm Injection Outcomes - Does it differ for TESE and Sperm Donation?

Oral and Poster (IFS)

Mr. brian sheehy [1], ***Dr. Moya Mcmenamin*** [2]

1. University College Cork, 2. C

ICSI is the process of injecting a singular motile sperm cell into a number of collected oocytes. Such sperm can be derived via TESE or from a sperm donor.

The study reviews the accumulative delivery rate of ICSI cycles where spermatozoa were sourced from TESE, and compares this to the accumulative delivery rate of ICSI cycles where spermatozoa were derived from sperm donation, in the Cork Fertility Centre.

This retrospective cohort study performed at Cork Fertility Centre, Cork identified 617 patients with azoospermia from 2007-2017 on the IDEA'S database. Patients who chose ICSI treatment were seperated according to ICSI sperm source. 3 ICSI cycles were recorded. The cumuative live birth rate of patients who achieved a live birth for either TESE or sperm donaton was calculated by dividing the number of couples who delivered a live newborn by the number of couples who had ICSI/TESE or doner/ICSI treatment. Live birth outcome for NOA and OA were secondary outcomes.

62.2% of TESE/ICSI and 57.1% of sperm donor/ICSI couples had a live birth over 3 ICSI cycles. Logistic regression found that there were no significant difference in ICSI live birth rates when female partner age was included as a variable (P= 0.005). NOA had a significant negative effect on the live birth outcome (P= 0.40).

Candidate ICSI patients attending Cork Fertility should be counselled that there are no significant differences in the live birth outcomes for couples who chose TESE or sperm donation.

IRISH GYNAECOLOGICAL ONCOLOGY SOCIETY

A CASE OF ANDROGEN SECRETING JUVENILE GRANULOSA CELL TUMOUR OF OVARY

Poster

***Dr. Caoimhe O'Sullivan* [1], *Dr. Claire Thompson* [2], *Dr. Richard Flavin* [3], *Dr. Ciaran O'Riain* [3], *Dr. Noreen Gleeson* [1]**

***1.** Gynaecological Oncology Department, St James's Hospital, **2.** 1.Gynaecological Oncology Department, St James's Hospital, **3.** Histopathology Department, St James's Hospital*

Hormone-producing ovarian tumours are a rare cause of hyperandrogenism in women. They account for 5–8% of all ovarian neoplasms and those that are malignant account for less than 10% of all ovarian carcinomas. They are also called sex cord stromal tumours and are composed of cells derived from sex cords or mesenchyme of the embryonic gonads. They contain granulosa cells, sertoli cells, leydig cells, and theca cells either singly or in combination.

This is an interesting case of a juvenile granulosa cell tumour diagnosed in a 22 year old presenting with weight gain, facial hirsutism and amenorrhoea. Laboratory testing revealed raised testosterone levels of 8.61nmol/L, high androstenedione and 17 hydroxyprogesterone, with normal DHEAS levels. Radiological imaging indicated a left ovarian lesion, with cystic/solid components and vascular flow. Laparoscopic left salpingo-oophorectomy was carried out.

Histology revealed a 7cm androgen producing ovarian neoplasm with epithelioid appearance with round nuclei with prominent nucleoli and few nuclear grooves. Immunohistochemically showed positive staining with calretinin, CD56 and Melan A and focal staining with WT1 and inhibin. This immunophenotype is in keeping with a sex cord-stromal tumour and combined with the nuclear appearance is in keeping with a juvenile granulosa cell tumour.

This patient had an excellent recovery post operatively with both laboratory and clinical improvement demonstrated.

Granulosa cell tumours usually produce oestrogens, causing symptoms and signs of oestrogen excess. This case highlights the more unusual androgen secreting tumour and details the investigation and management; as early identification and surgical management results in good prognosis.

A CASE REPORT OF A RARELY ENCOUNTERED GYNAECOLOGICAL TUMOUR: FEMALE ADNEXAL TUMOUR OF PROBABLE WOLFFIAN ORIGIN (FATWO)

Poster

Dr. Nicola O'Riordan [1], ***Dr. Sorca O Brien*** [1], ***Mr. Tom Walsh*** [2]

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Female adnexal tumours of Wolffian origin (FATWO)are a rare neoplasm encountered. These tumours arise as embryological remnants of the mesonephric ducts, and tend to be benign in their course. In certain instances their course can be more aggressive and exhibit metastatic behaviour.

Here we present the case of a 59 year old female referred from her GP with postmenopausal bleeding. Routine ultrasound pelvis was arranged along with a hysteroscopy and endometrial sampling. Hysteroscopic examination of the cavity was reassuring and histological tissue examination was normal. The pelvic ultrasound identified an ovarian mass. She proceeded to staging
surgery and her left ovarian histology revealed the surprising finding of a rare gynaecological condition, FATWO.
In cases such as this, where limited data is available on outcomes and nature of the disease, therapeutic recommendations tend to rely on case reports. This case highlights a number of challenging issues including the monitoring and surveillance of a postmenopausal female with FATWO, as well as diagnosis and surgical management of rare gynaecological pathology.

A case report: Poorly differentiated sarcomatoid carcinoma arrising within mature cystic teratoma

Poster

Dr. Davor Zibar [1], ***Dr. Chris Phillips*** [1], ***Dr. Conor Harrity*** [1], ***Dr. Hassan Rajab*** [1]

1. *Beaumont Hospital*

Mature cystic teratomas (MCT) are the most common ovarian germ cell tumours and the most common ovarian neoplasms in the cohort under 20 years of age. Malignant transformation at 1-2% of the cases is rare event and squamous cell carcinoma is the likeliest malignancy found.
Case report: A 54 year old woman presented in Accident and Emergency department with a history of vomiting, intolerance to oral diet and central abdominal pain for one week.
Medically she has a history of lymphocytic colitis, psoriasis and clipping of cerebral aneurism.
Upon admission under the surgical team, her inflammatory parameters were raised and CT abdomen and pelvis with contrast was done. It showed a 9.5 cm heterogenous right adnexal mass with features in keeping with a dermoid tumour. Medially there was a nodular soft tissue thickening, concerning for a malignant transformation. Mechanical small obstruction in the distal ileum had been noted.
Under joint care of surgical and gynaecological team total abdominal hysterectomy with bilateral salpingooophorectomy, bowel resection, side to side staple anastomosis, sigmoid colectomy and left end stoma was performed. Histology showed poorly differentiated sarcomatoid carcinoma arising within a mature cystic teratoma. MTD input was sought.
Patient re-presented 6 weeks later with a local recurrence in the abdominal wall and new pelvic masses. Currently she is under oncology team on adjuvant chemotherapy with Taxol and Carboplatin.
Despite the rarity of these tumours and benign nature of MCT adequately timed investigations and surgical management should be sought with every case presenting to gynaecology clinics.

A CASE REPORT: UTERINE TUMOUR RESEMBLING SEX CORD TUMOUR (UTROSCT)

Poster

Dr. Emma Tuthill [1], ***Dr. Zara Fonseca-Kelly*** [1], ***Dr. Teresa Treacy*** [1], ***Dr. Meenakshi Ramphul*** [1], ***Dr. Alexander Whately*** [1], ***Mr. Tom Walsh*** [1]

1. *Mater Misericordiae University Hospital*

Uterine tumours resembling ovarian sex cord tumours (UTROSCT) are rare uterine neoplasms, with less that 100 cases reported in the literature.They are predominantly or exclusively composed of sex cord-like elements and usually regarded as having low malignant potential. [1]

This is a case of a 42 year old lady, para 0, with no significant past medical history, who underwent a hysteroscopic transcervical resection of fibroid identified during investigations for fertility treatment. Pathology revealed a uterine tumour resembling a sex cord tumour (UTROSCT).

The patient underwent CT and MRI to characterise the tumour and determine the extent of disease. Small bilateral simple appearing ovarian cysts and a 1cm soft tissue density within the fundus of uterus, which appeared to extend into the uterine cavity was detected. There was no evidence of disease outside the uterus.

Following discussion at MDT the patient underwent total laparoscopic hysterectomy, bilateral salpingectomy with ovarian conservation. Her surgery was uncomplicated and she recovered well post operatively. Hysterectomy histology and immunohistochemistry findings support the diagnosis of a Stage 1A UTROSCT.

[1] Ucar M, Ilhan Gül A et al. Uterine Tumour Resembling Ovarian Sex Cord Tumour – A Rare Entity. J Clin Diagn Res. 2016 Dec; 10(12): doi:10.7860/JCDR/2016/22152.9061

A Case Series of Robot-Assisted Trachelectomies

Oral (ISGO)

Dr. Michelle McCarthy [1], ***Dr. Matt Hewitt*** [1]

1. *Cork University Maternity Hospital, Cork*

Trachelectomy with concurrent cerclage is an established fertility-sparing treatment for early stage cervical cancer. Cork University Maternity Hospital commenced robotic-assisted trachelectomies in 2013.

This study aimed to evaluate operating times via theatre log books. Postoperative recovery was evaluated via inpatient records, investigating length of hospital stay, complications and readmission. Hospital records were searched, to discover subsequent pregnancies and patient progress to date.

Seventeen procedures were performed between 2013 and March 2017. The mean surgical time was 202 minutes (range 110-290). The majority of patients were discharged on day two post-surgery (range 1-2 days). Two patients (12%) had complications postoperatively. One who was found to incidentally have immune thrombocytopenic purpura was readmitted with a vaginal bleed nineteen days following surgery and required transfusion. One lady developed cervical stenosis. To date there have been no pregnancies reported post trachelectomy.

The initial trend of decreasing operating times with subsequent surgeries performed was in keeping with findings reported by by Persson et al (2012), though this appeared to plateau at an early stage. Mean operating times in our institution compared favourably to those reported there (297 minutes, range 242-430 minutes). Observable reductions in operating times, and relative predictability of duration are expected to assist in theatre planning. Post-surgical recovery in respect of discharge and readmission is satisfactory and in keeping with desired outcomes.

A CASE SERIES OF ROBOTIC RADICAL HYSTERECTOMIES: NINE YEARS OF DATA FROM CORK UNIVERSITY MATERNITY HOSPITAL

Oral (ISGO)

Dr. Michelle McCarthy [1]***, Dr. Matt Hewitt*** [1]

1. *Cork University Maternity Hospital, Cork*

Since 2008 Cork University Maternity Hospital has employed robotic radical hysterectomy for the surgical treatment for stage 1B cervical cancer. Relative predictability of duration, recovery and complications are required to assist in theatre planning, bed management and patient education.

This case series aims to report on the surgical times, the hospital stays, the complications, readmission rates and survival rates for patients undergoing this procedure. Data was collected using theatre log books, computerised bed management systems and patient charts.

Forty three procedures had been performed between commencement and the end of 2016. The mean surgical time was 204 minutes, with a clear decrease in annually as surgical expertise was gained (a mean of 260 minutes in 2008, compared with 152 in 2016). The median stay was 2 days. Four major complications (9%) have been recorded; two vesico-vaginal fistulas, one significant lymphoedema and one vault dehiscence. No patient required a blood transfusion. Five year survival could be ascertained for eighteen patients and was found to be 89% (n=2).

Observable reductions in operating times is comparable to other studies (Renato et al, 2013, Schreuder et al, 2010). Complication rates are comparable to that reported by Lowe et al (2009) of 12%. Post-surgical recovery compared favourably, in respect of discharge and readmission, which were lower in our institution than in previously reported findings by Person at al (2009, Sweden) and Sert et al (2011, Norway).

A Rare case of Large Leiomyoma in Mayer-Rokitansky-Küster-Hauser syndrome

Poster

Dr. Helena Bartels [1], ***Dr. Ciaran Redmond*** [2], ***Dr. Ruaidhri Mcvey*** [1], ***Dr. venita broderick*** [3]

1. *National Maternity Hospital,* ***2.*** *St Vincents University Hospital,* ***3.*** *National University of Ireland, Galway*

Mayer-Rokitansky-Küster-Hauser syndrome (MRKH) is a rare congenital anomaly characterised by the absence of the upper 2/3 of the vagina & absent or hypoplastic uterus.The incidence is approximately 1:5000 female live births & arises due to agenesis of the müllerian ducts. Affected individuals have normal ovarian function and external genitalia. The presence of leiomyoma in MRKH is very rare with only isolated cases reported in the literature.

We present a case of a 27 year old with MRKH who attended our gynaecology service. She initially presented aged 17 with primary amenorrhea and was diagnosed with MRKH. She did not require vaginal dilation or vaginoplasty.

On examination a large pelvic mass was noted. Differential diagnosis included ovarian pathology, haematometra, leiomyoma & leiomyosarcoma .

Pelvic ultrasound revealed a large pelvic mass suggestive of a fibroid. MRI confirmed a 18x19cm mass in the pelvis, appearing to arise from a left uterine remnant with two large vascular pedicles, consistent with a large leiomyoma in a rudimentary uterine horn. The patient had no other anatomical variations associated with MRKH such as renal agenesis. Tumour markers were normal and Karyotype 46 XX.

She underwent a midline laparotomy, myomectomy and resection of bilateral uterine remnants. There was minimal intraoperative blood loss and the patient made a good post-operative recovery.

Histology confirmed a benign leiomyoma with ischaemia and degenerative changes.

This case highlights the potential for very large leiomyomata to develop in a rudimentary uterine horn in a patient with MRKH.

ADENOSARCOMA OF OVARY

Poster

Dr. MANJU RAO VANAPALLI [1], ***Dr. Lydia Simmons*** [1]
1. *University Hospital Waterford*

Adenosarcoma arising from extrauterine sites are rare. The authors report a case of 77year old lady who presented with abdominal bloating and increased urinary frequency for a few months.
Sonography and later Laprotomy showed the cystic lesion of the ovary.
Pathology confirmed Ovarian Adenosarcoma with sex cord elements in the stroma of low malignant potential.
Adenosarcoma of the ovary is rare, and about 3 cases have been described as a cystic mass. They have poorer prognosis compared to Adenosarcoma of the uterus. There is lack of evidence as to the management of such neoplasms, as they are low grade lesions. Potential for recurrence even after years have been described in similar pathologies.
In our case, reliance on CA125 was not beneficial for tumour recurrence as the levels were normal at diagnosis.
She underwent TAH and BSO with complete excision of the cystic mass. She is under surveillance for recurrence, and no chemotherapy was given as this was a low grade neoplasm as evidenced by low degree of mitotic activity and no evidence of stromal overgrowth of the mesenchyme.
We believe this is the first case of Ovarian Adenosarcoma with sex cord like differentiation.

ADJUVANT TREATMENT IN STAGE 1 ENDOMETRIAL CANCER

Oral (ISGO)

***Dr. Lydia Simmons* [1], *Dr. MANJU RAO VANAPALLI* [1], *Dr. John Stratton* [2]**

***1.** University Hospital Waterford, **2.** University hospital*

AIM : Although 5 year survival for stage 1 endometrial cancer is over 90% a small proportion develop recurrence. We looked at our stage 1 endometrial cancer patients with a view to determining risk factors for recurrence.

METHODS : We conducted a retrospective review of 211 patients treated for endometrial cancer over a 16 year period at our institution, 121 were stage 1. 41 women received adjuvant treatment. 19 women developed recurrent disease, 13 vault, 2 pelvic and 4 distant metastases.

RESULTS : Risk factors for recurrence were equally represented within the group of women who remained disease free and those who developed recurrence. Adjuvant treatment reduced the risk of developing recurrent disease, both local and distant.

CONCLUSIONS: Although the role of adjuvant treatment remains controversial in early stage endometrial cancer, our study suggests that it has a beneficial effect in reducing the risk of recurrent disease.

BETTER THE FAT YOU KNOW ? MEASURING VISCERAL FAT IN ENDOMETRIAL CANCER PATIENTS.

Oral (ISGO)

Dr. Maria Cheung [1]***, Dr. Danielle Byrne*** [2]***, Prof. Carel Le Roux*** [3]***, Dr. Tony Geoghegan*** [2]***, Prof. Donal Brennan*** [4]

1. *Mater Misericordiae University Hospital,* ***2.*** *3.Mater Misericoridae University Hospital, Eccles St, Inns Quay, Dublin 7,* ***3.*** *University College Dublin,* ***4.*** *UCD Professor of Gynaecological Oncology Consultant Obstetrician and Gynaecological Oncologist Mater Misericordiae University Hospital/ National Maternity Hospital / St Vincent's University Hospital*

Obesity and metabolic syndrome are the most significant risk factors for the development of endometrial cancer (EC). Previous studies relied on weight, BMI and abdominal circumference to measure obesity. These metrics may not reflect actual metabolic risk, which is associated with visceral adiposity. Differences in volumes of visceral and subcutaneous fat have not been reported in EC and may help direct weight-loss initiatives in these patients.

This case-control study aimed to measure differences in the distribution of visceral and subcutaneous fat in endometrial cancer patients, cervical cancer patients and benign controls. ImageJ software was used to measure the volume of visceral fat, as a percentage of the total fat (VFP), in a L3/4 CT slice, for 22 EC, 20 cervical cancer (CC) and 20 benign patients.

The mean BMI of the EC group was 32.6, CC group was 25.9 and benign was 33.4. EC group had a mean VFP of 33.4% (SEM 0.2), compared to 24% (SEM 2.3) in CC group and 27.3% (SEM 2.3) in benign controls. Comparison between groups demonstrated higher VFP in EC versus CC (p=0.002) and benign controls (p=0.033).

This study demonstrates higher VFP in endometrial cancer patients compared to controls and that visceral adiposity may the major driver of obesity related carcinogenesis in the endometrium.

BILATERAL THORACIC ENDOMETRIOSIS. A RARE ENTITY

Poster

Dr. fionnvola armstrong [1]***, Dr. Sean Kelleher*** [1]***, Dr. Donal O'brien*** [1]

***1.** St Vincents University Hospital*

Thoracic endometriosis or Thoracic Endometriosis Syndrome is a rare form of endometriosis where endometrial tissue is found in the lung parenchyma and/or the pleura.It is most commonly unilateral and mainly affects the right . Bilateral disease is rare. There have been few reports of bilateral catamenial disease, and only one report , to our knowledge, of bilateral pathology proven pulmonary parenchymal endometriosis.
33 year old female presented to ED with 5 day history of increasing SOB. 02 sats 98% hr 110, hb 11.4 drop to 9.8, Right sided chest drain inserted and frank bleeding noticed. CXR and CT thorax abdomen pelvis revealed moderate left sided pleural effusion and new lower lobe collapse, no significant right haemopneumothorax following chest drain insertion, nodular irregular thickening of the horizontal fissure , 12cm solid and cystic mass in left adnexae. Transferred to theatre for Left Chest Drain Insertion and right VATS pleural biopsy, lung biopsy, lung wedge resection,betadine pleurodesis and right chest drain insertion. Findings at procedure revealed pleural deposits of tissue on the diaphragm and parietal pleura measuring 5cm x 5cm in some areas. Frozen section negative for malignancy ? endometriosis.
Ca125 496 . Endometriosis confirmed on histology. Patient treated with GNRH analogue.
Still ongoing abdominal pain. Laparoscopy revealed 1.5 litres of blood stained ascites, 10cm friable mass in pelvis ? torted ovarian cyst, small deposits of endometriosis on right diaphragm. Histology confirmed a torted ovarian cyst with necrosis and endometriosis, no evidence of malignacy
Patient was discharged home day 29 clinically well.

BLOOD AND SERUM PROFILES IN WOMEN WITH RECURRENT GYNAECOLOGICAL CANCER. COULD STANDARD LABORATORY PARAMETERS BE USED TO DETECT RECURRENCE?

Poster

Ms. Nikita Naqvi [1], ***Dr. Noreen Gleeson*** [1]

1. *Trinity College Dublin*

Traditionally, women with gynaecological cancers are followed up for between two and ten years after primary treatment. Relapse of disease may be detected at physical examination, such as lesions, lymphadenopathy, pleural effusion or palpable abdominopelvic metastases. Cancer impacts immune, haematological and coagulation systems. We investigated the haematological, biochemical and coagulation profiles of patients at diagnosis of recurrent cancer at a gynaecological cancer centre caring for approximately 350 new cancers per annum and also for relapses in women treated primarily at other centres.

The purpose of the study was to assess whether deviations in routine blood results might signal recurrent cancer.

Records of recurrent cancers in 2016 were taken from the hospital data base and women relapsing more than three months after completion of their cancer treatment were identified. Women on maintenance anti-cancer treatment, with systemic illness, or on treatments that could affect haematological, biochemical or coagulation variables were excluded.

Of 69 patients diagnosed with recurrent cancer, 43 were eligible. They were further subdivided based on their type of cancer. Abnormal haematological parameters, such as low haemoglobin and low lymphocyte counts were seen across all types of recurrent cancer. Aberrations in serum biochemistry, particularly elevated creatinine and low serum albumin were also noted.

Routine follow-up of cancer patients represents a substantial workload for gynaecological oncologists, and alternatives such as assessment by nurse specialist or general practitioner are under review. Attention to abnormalities in haematological, biochemical and coagulation profiles, as potential markers of relapse, should be included in the guidelines for follow-up.

CASE REPORT - SYNCHRONOUS LEFT BORDERLINE MUCINOUS TUMOUR OF THE OVARY AND EXTRA MAMMARY MYOFIBROBLASTOMA OF THE ABDOMINAL WALL

Poster

Dr. Rachel White [1], ***Dr. Claire Thompson*** [1], ***Dr. Aoife Maguire*** [2], ***Dr. Noreen Gleeson*** [1]

1. *1.Gynaecological Oncology Department, St James's Hospital,* ***2.*** *2.Histopathology Department, St James's Hospital*

Synchronous tumours within gynaecology are rare and can pose a pre operative diagnostic challenge. This presentation of a borderline mucinous tumour of ovary alongside a rare extra mammary myofibroblastoma within the abdominal wall highlights the management challenges that can be faced when presented with unusual co-existing tumours.

A 44 year old lady presented with right iliac fossa pain and suprapubic pressure symptoms. CT imaging revealed a large 22cm complex left ovarian cyst and a further large 20cm heterogeneous mass sited within the left anterior abdominal wall. CA125 was mildly elevates at 74. Following MDT discussion this lady proceeded to surgery where the left ovary was replaced by a large intact cystic lesion and was removed intact. Careful dissection of the left abdominal wall revealed a large, lobulated mass found within the fascia, strongly adherent to the left anterior superior iliac spine and tracked as far down as the inguinal ligament inferiorly.

Histopathology confirmed a Stage 1A borderline mucinous tumour of the left ovary and a benign extra mammary myofibroblastoma of the abdominal wall.

Mammary-type myofibroblastoma (MTMF) is a rare benign mesenchymal neoplasm initially described to occur in the breast but has been detected at other anatomical sites. This review will explore the available literature and guidance on management.

As an extremely rare tumor, the correct diagnosis and prompt management of MTMF is important, requiring careful clinical and pathological workup to rule out the possibility of malignancy, as highlighted through this rare case with a co-existing ovarian neoplasm.

CURE RATES OF HIGH GRADE CERVICAL INTRAEPITHELIAL NEOPLASIA OVER A 5 YEAR PERIOD FOLLOWING TREATMENT WITH COLD COAGULATION.

Oral (ISGO)

Dr. Claire M McCarthy [1]**, *Dr. Eoghan Scally*** [1]**, *Dr. Noirin Russell*** [2]

1. *Cork University Maternity Hospital, Cork,* ***2.*** *Pregnancy Loss Research Group, Department of Obstetrics and Gynaecology, University College Cork & Cork University Maternity Hospital, Wilton, Cork.*

Ablative treatment with cold coagulation (CC) has been shown to be an effective treatment for both low and high grade cervical intra-epithelial neoplasia (CIN). We aimed to assess the cure rate of women treated with cold coagulation for high grade disease over a 5 year period.
We conducted a retrospective review of CC treatment for high grade cervical intraepithelial neoplasia from 2012-2016 at a regional colposcopy unit. We examined all smears following treatment, evaluating cytological cure, as well as HPV status.

During the study period, 355 patients had CC performed. The majority of patients 87.88% (n=312) were between 25 and 45 years of age. 329 patients attended for follow-up cytology performed, with 115 and 22 having 2nd and 3rd follow-up periods with an average follow-up period of 241, 501 and 548 days respectively.

Cytological cure with negative HPV status after the first interval was 65% (n=214), which was similar at 18 months for those who had follow-up (62%). Successful cytological cure was demonstrated at each of the three intervals at 83%, 89.5% and 90.9%. Persistence of low grade disease was found in 13% at the first smear interval, and 6% and 9% during the following time periods.

Examining a large cohort of patients we have demonstrated both successful cytological cure, as well as high rates of HPV eradication in a large cohort of patients over a 5 year period. This corroborates with previous studies, demonstrating that CC is an effective treatment for all grades of CIN.

LARGE LOOP EXCISION OF THE TRANSFORMATION ZONE AND PRETERM DELIVERY OVER TEN YEARS IN THE ROTUNDA HOSPITAL

Oral (ISGO)

Dr. Patrick J Maguire [1], ***Dr. Claire M McCarthy*** [1], ***Dr. Peter Molony*** [2], ***Dr. Eilis O'Donovan*** [2], ***Mr. Tom Walsh*** [1]

1. *Obstetrics and Gynaecology, Rotunda Hospital, Dublin,* ***2.*** *Pathology, Rotunda Hospital, Dublin*

The success of cervical screening relies on adequate assessment and treatment of pre-malignant disease. Large loop excision of the transformation zone (LLETZ) has traditionally been the mainstay of treatment for cervical intraepithelial neoplasia (CIN).
The aim of this study was to assess the impact of previous LLETZ treatment(s) on rates of singleton preterm delivery in women attending the Rotunda Hospital.
The pathology laboratory database and the obstetric database were searched concurrently to identify women of reproductive age who had LLETZ treatment with the colposcopy service followed by preterm delivery from 1 January 2007—31 December 2016. Details including gestation at delivery, depth of LLETZ and grade of CIN were extracted. Exclusion criteria included multiple pregnancy, and deliveries identified through the databases as being due to current pregnancy indications.
There were 97 women eligible for inclusion. Mean gestation at delivery was 33^{+2} weeks. CIN 1 was diagnosed in 16, CIN 2 in 24, CIN 3 in 53, and four were negative for CIN. No microinvasive or invasive disease was identified. The average depth of excision was 9.9mm, 11.4mm and 8.5mm for CIN 1, 2 and 3 respectively.
Despite having a lower mean depth of excision, women with CIN 3 comprised the majority of those who experienced preterm delivery, suggesting that factors other than mechanical weakness owing to removal of cervical tissue are implicated in preterm labour for these women. This is in keeping with recent suggestions that the common denominator in high grade CIN and preterm labour is an altered vaginal microbiome.

Morbidity and mortality following maximal cytoreductive surgery in advanced epithelial ovarian carcinoma.

Oral (ISGO)

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Annually in Ireland, over 300 women are diagnosed with ovarian carcinoma (OC). Unfortunately for 70% of them, the disease presents late- due to its vague nature and lack of a suitable screening tool. With ongoing advancements in modern chemotherapy and the advent of cytoreductive surgery, a moderate increase in survival rates has been seen but aggressive surgical management remains high-risk.

We evaluated the effect of maximal cytoreductive surgery on 30 day morbidity and mortality among patients with FIGO stage III or IV epithelial OC in a tertiary referral centre.

This was a retrospective review of patients referred to the Gynaecology Oncology Service of a tertiary referral centre over a 2 year period with stage III/IV OC. We ascertained the effect of maximal cytoreduction on: intra-operative complications, length of hospital + HDU stay, infection, bleeding, and return to theatre. Other factors that considered were: patient age, histological subtype + grade, extent of disease at surgical exploration and residual disease post-cytoreduction. All women with FIGO stage III/IV epithelial OC who underwent aggressive cytoreductive surgery over a period of 2 years following the introduction of the above procedure as a therapeutic option.

Results: N=20. Optimal cytoreduction achieved in>90% of patients. Total length of stay ranged from 4-46 days. Range of HDU stay: 0-7 days. Of the 20 patients;60% required blood transfusion. Despite the complexity of the procedure, only one returned to theatre.

Pipelle biopsy: the simple way to reduce cancer waiting times

Oral (ISGO)

Dr. aaron mcavoy [1], ***Dr. Aoife Currie*** [2]

1. East Surrey Hospital, 2. Southern trust

Title: Pipelle biopsy – The key to hitting cancer waiting time targets?

Institution: Craigavon area hospital

Authors: Aaron McAvoy, Aoife Currie, Geoff McCracken

Objectives: During the year 2015 cancer waiting times across the UK have fallen below established targets of 85% of patients completed treatment from initial referral red flag referral. The purpose of the review was to highlight the reduced waiting times experienced when a pipelle biopsy was performed in patients with suspected endometrial cancer.

Patients and Methods: A retrospective review was performed of all endometrial cancer patients (n=60) in Craigavon area hospital in 2015. From this group patients who had pipelle performed at initial hospital consultation (n=30) were compared with those who had hysteroscopy as the diagnostic tool(n=30). The total waiting time from initial referral to definitive treatment were then compared to assess for reduction in waiting time.

Results: Average referral to appointment time =13.4 days which hits the target as set out by NICE guidelines. The average referral to surgery time for the pipelle group was 61.94 days in pipelle group vs 106 days in the hysteroscopy group.

Conclusion: Average reduction in waiting time for definitive treatment was 64.04 days. This meant that having a pipelle biopsy at initial consultation reduced the waiting time for definitive treatment by 43%.

RECURRENCE OF VENOUS THROMBOEMBOLISM IN PATIENTS WITH GYNAECOLOGICAL CANCER – INCIDENCE AND RISK FACTORS.

Oral (ISGO)

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INTRODUCTION: Patients with cancer have a high risk of developing venous thromboembolism (VTE). Gynaecological cancers are among the highest risk cancer groups with incidence rates of 5-16% for VTE. The incidence of recurrence of VTE in not established for women with genital tract malignancy.
AIM: The aim of this study was to define the incidence and risk factors of VTE recurrence in patients with gynaecological cancer.
STUDY DESIGN AND METHODS: This was a retrospective cohort study on patients with gynaecological cancer treated in St James's Hospital Gynaecologic Oncology Centre between 2006 and 2016. Patients with cancer related VTE were identified from hospital and general practice medical records and the incidence of recurrence was recorded. Demographic data, histology, stage, surgery, chemotherapy, co-morbidities and timing of primary and recurrent VTE episodes were recorded.
RESULTS: 104 gynaecologic cancer patients who had VTE were identified from the database. Standard anticoagulation was with low molecular weight heparin for 3-6 months. VTE recurred in 20 (19%) patients with ovarian (9/60, 15%), uterine (9/32, 28%) and cervical (2/9, 22%) cancers. Fourteen (70%) recurrent VTE events occurred within 6 months of their primary VTE and twelve patients were still on therapeutic dose of LMWH. Sixteen (80%) patients in the recurrent group had open surgery. Four (20%) were receiving chemotherapy at the time of VTE recurrence.
CONCLUSION: Patients with gynaecological cancer treated for VTE remain at high risk of recurrent venous thrombosis despite standard anticoagulation treatment.

Sarcomatoid Variant of Urothelial Carcinoma - A Rare Case of Urethral Cancer

Poster

Dr. Ike Uzochukwu [1], ***Dr. MANJU RAO VANAPALLI*** [1], ***Dr. John Stratton*** [2]

1. University Hospital Waterford, 2. University hospital

Primary urethral cancer is rare with an incidence of 1.5 per million in women and comprising of <1% of the total incidence of malignancies. The male to female ratio is 2.9:1. Mean age incidence is 73years and is almost negligible in those aged <55years.

We present a 57year old para 3 who attended the Gynaecology clinic with a 2month history of a painful periurethral mass with associated difficulty voiding, continuous leakage of urine, dysuria and offensive discharge. She had a previous history of recurrent urinary tract infections treated with broad-spectrum antibiotics. Examination revealed a large fungating mass fixed to the anterior vaginal wall extending to the bladder neck.

Examination under anaesthesia revealed a large periurethral tumour extending to the bladder neck. Cervix appeared normal. Periurethral mass biopsy revealed poorly differentiated sarcomatoid urethral carcinoma. CT Thorax Abdomen & MRI pelvis revealed a 4.8x3.6cm circumferential urethral mass extending from the bladder to the introitus. Suspicious subcentimetre right obturator and internal iliac lymph nodes were revealed. There was no evidence of hydronephrosis. She has been scheduled for bilateral ureteric stenting and neoadjuvant radiotherapy.

Over 90% of urothelial carcinomas originate from the bladder, 8% from the renal pelvis and the remaining 2% from the urethra and ureters. Sarcomatoid urethral carcinoma is an extremely rare and highly aggressive variant presenting at a younger age and higher grade. Urologists, Gynaecologists and Oncologists should be encouraged to report cases of sarcomatoid urothelial carcinoma as this will contribute to the understanding of the biological behaviour of the tumour.

THE INTRODUCTION OF HPV REFLEX TESTING TO BETTER SELECT WOMEN WITH LOW GRADE CYTOLOGICAL ABNORMALITIES WHO NEED COLPOSCOPY

Oral (ISGO)

***Prof. Grainne Flannelly* [1], *Ms. Helen Byrne* [1], *Dr. Therese Mooney* [1], *Mr. John Gleeson* [1], *Prof. Patricia Fitzpatrick* [1]**

***1.** CervicalCheck*

CervicalCheck, the National Cervical Screening Programme offers free smear tests to women aged 25-60 years. In May 2015, CervicalCheck introduced Human Papilloma Virus (HPV) reflex-testing for women with low-grade cytological abnormalities.

HPV testing was added as an adjunct test when low-grade abnormalities are detected on cytology. The laboratory tests these samples for high-risk HPV variants which are associated with CIN (Cervical Intraepithelial Neoplasia) and cervical cancer. The additional information provided by reflex-testing determines the recall recommendation for these women. The aim of HPV reflex-testing is to accelerate the diagnostic pathway for women with low-grade cytological abnormalities. Early colposcopy referral has the benefit of earlier detection/treatment of high-grade CIN and cancer while providing reassurance to women with transient low-grade disease.

The CervicalCheck quality monitoring framework was adjusted to measure the rate of HPV positivity, colposcopy referral rate, colposcopy waiting times and the yield of high-grade CIN and cancer diagnosis. Results were incorporated into the results of the first full year of testing from September 2015 to September 2016. 15,046 women had low-grade changes diagnosed on a smear test. Of these, 8,256 had a result of ASCUS (atypical squamous abnormality of undetermined significance) and 6,790 had LSIL (low-grade squamous intraepithelial lesion). The number of women who were referred to colposcopy due to HPV triage was 8,062. The number of women who were recommended routine screening due to HPV triage was 6,984.

HPV triage achieved its objectives of early diagnosis and treatment of high-grade precancers in women with low-grade cytological diagnosis.

Unusual clinical presentation of choriocarcinoma: A case report on the highly malignant, human chorionic gonadotrophin (hCG) secreting tumour.

Poster

Dr. Nyan Chin Liew [1], *Dr. Fionnvola Armstrong* [2], *Dr. Elizabeth Dunne* [1]

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Choriocarcinoma occurs in approximately 1 in 30,000 pregnancies. The presenting features may be similar to hydatidiform moles, with vaginal bleeding, abdominal pain, a pelvic mass and symptoms due to a high serum B-hCG.
35-year-old female who presented with acute left iliac fossa (LIF) pain and positive urinary beta human chorionic gonadotrophin (B-hCG) with suspicion of ruptured extrauterine pregnancy which turned out to be choriocarcinoma.
She underwent diagnostic laparoscopy as suspicion of a ruptured ectopic pregnancy cannot be excluded.

Intra-operatively, there were haematoma collection into the left broad ligament and received blood products, intubated and nursed in Intensive Care Unit (ICU) but drains continued to drain frank blood with suspicion of an ongoing intra-abdominal bleeding. Serum B-hCG level were raised and hence suspicion of choriocarcinoma.

Decision to return to operating theatre for laparotomy total abdominal hysterectomy (TAH) was made. She developed disseminated intravascular coagulopathy (DIC).

Computed Tomography-Thorax Abdomen Pelvis (CT-TAP)/ Angiogram Renal showed large left perinephric haematoma tracking along the left side of the retroperitoneum with 3.3cm left renal mass lesion. She was transferred to St Vincent's University Hospital and a second CT-TAP imaging revealed differential of renal mass but most likely in keeping with haemorrhage from left renal choriocarcinoma metastasis. She received chemotherapy and was discharged well back after 11 days.

UTERINE TORSION: A RARE CASE REPORT!

Poster

Dr. Emmanuel Hakem **[1]**, ***Dr. Michael O'leary*** **[1]**, ***Dr. Nayha Tariq*** **[1]**

1. *University Hospital Galway*

Uterine torsion in non pregnant humans is an extremely rare condition, only about 200 cases reported over the past 100 years. Majority of the cases reported of uterine torsion in humans occurred in a gravid uterus. The prevalence of uterine torsion is unknown.

We are reporting a case of a 67-year-old lady, who presented to Emergency Department with acute onset of severe lower abdominal pain and back pain as well as swollen abdomen.

On laparotomy, a huge left ovarian mass was found with the uterus and right ovary torted around themselves twice (720°) and a necrotic appearing uterus.

Managing such a rare and possibly very serious condition is very challenging, we are discussing in this paper the literature review on uterine torsion as well as how we managed our patient and how could such patients be managed.

WHAT IS THE IMPACT OF VaIN? A RETROSPECTIVE COHORT STUDY FROM THE NORTHERN IRELAND CENTRE FOR GYNAECOLOGICAL CANCER.

Oral (ISGO)

Ms. Mona Alkayyali [1], ***Ms. Padma Pugalenthi*** [1], ***Dr. Tina Newell*** [2], ***Dr. Kelly Elliot*** [3], ***Dr. Elaine Craig*** [2], ***Dr. Hans Nagar*** [2], ***Dr. Ian Harley*** [2], ***Dr. Stephen Dobbs*** [2], ***Dr. Glenn Mccluggage*** [3], ***Dr. Mark McComiskey*** [2], ***Dr. James Beirne*** [2]

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Vaginal intraepithelial neoplasia (VaIN) is a rare and asymptomatic pre-neoplastic lesion. Its pathogenesis and potential progression into invasive cancer are not fully understood. VaIN may present alone or as a synchronous/metachronous lesion with cervical and vulvar HPV-related intra epithelial or invasive neoplasia. It is more commonly associated with cervical intraepithelial neoplasia than its vulvar counterpart. VaIN is often asymptomatic and is commonly diagnosed at colposcopy clinics following attendance with abnormal cervical cytology. Traditionally, high-grade and multifocal VaIN were managed by radical surgery and radiotherapy. However, there has been a transition to conservative management approaches, generally dictated by the patients' co-morbidities and desires. The range of therapeutic approaches all carry a range of complications and vary greatly in the associated risk of recurrence.

The aim of this study was to explore the diagnostic and therapeutic challenges of VaIN within a single institution. A retrospective patient record review was performed on all cases of VaIN between 01/01/1999 and 31/12/2014. Key outcome measures being assessed were; risk factors, age at diagnosis, time to diagnosis, compliance with follow-up, treatment choice, recurrence rate following treatment, progression to invasive cancer.

The study revealed the key risk factors were age and previous high grade cervical intra-epithelial neoplasia. The rate of progression to carcinoma was <3%. The study also revealed key features of the patients' journey including frequent attendances and interventions.

This data has assisted with the counselling of patients newly diagnosed with VaIN and has provided a baseline for the refinement of the management pathway at NICGC.

JUNIOR OBSTETRICS & GYNAECOLOGY SOCIETY

A CASE OF CONGENITAL LEUKEMIA WITH DOWN’S SYNDROME

Poster

Dr. Sumaira Tariq [1]***, Dr. Tom O’Gorman*** [1]

1. *University Hospital Galway*

A case of a 31 year old P1^{+0} with BMI of 32, booked at 12 +6 weeks. She had no significant medical or surgical history but had low level anti rubella IgG (Anti-Rubella IgG vidas).She had a previous uneventful pregnancy which resulted in a SVD at 37+6 weeks. She had a background history of Eczema and psoriasis, and had past infections with glandular fever and meningitis.

She attended GP for routine check ups at 14+2, 18+2 weeks and 20 weeks gestation and ANC at 20+8 weeks.

Anomaly scan at 21+3 weeks : FH +ve, FM +ve, AFI N, 3 vessel cord, placenta anterior and high, No abnormalities detected. EFW 418g, AC 170.2mm

Presented to Maternity admissions at 29+1 weeks gestation with reduced fetal movements for 48 hours. No history of SROM, PV bleeding or abdominal pain.

Scan confirmed IUD, EFW 847g, sympathies expressed. She had Mifepristone and Misoprostol induction and delivery a male fetus. Degree of hydrops was mild.

Both parents karotyping results showed no chromosomal abnormalities. CMV, parovirus, toxoplasma, anticardiolipin antibodies and anti beta 2 glycoprotein were negative. Anti-Nuclear antibodies was mildly positive, when repeated 6 weeks postnatal were negative. Fetal skin and placental biopsies revealed isolated congenital leukemia. A full postmortem examination confirmed Down’s syndrome.

Neonates with chromosomal anomalies, particularly those with a trisomy of chromosome 21,often have a congenital or neonatal myeloproliferative disorder, which can be indistinguishable from acute myelogenous leukaemia.

Only few cases of Down syndrome with congenital leukemia have been reported in the literature.

A CASE OF OVARIAN MUCINOUS CYSTADENOCARCINOMA IN PREGNACY.

Poster

Dr. Bogdan Alexandru Muresan [1], ***Dr. Sasikala Selvamani*** [2], ***Dr. Seosaimh O'Coigligh*** [2], ***Dr. Etop Akpan*** [3]

1. *Our la,* ***2.*** *Our Lady of Lourdes Hospital, Drogheda,* ***3.*** *Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda*

A case of ovarian cystadenocarcinoma diagnosed during pregnancy is reported. The ovarian tumor was found in a 32-year-old woman, gravida 0, para 0 at 15+6 weeks gestation after presenting in A&E with vague abdominal pains that onset one day before presenting to the hospital.
MRI showed 12.6 x 11.5x 8.6 cm complex cystic lesion with internal cystic component and a 2.1 cm mural nodule. Tumoral markers (CA125, CEA, CA19-9) were all raised.
Primary midline laparotomy with left salpingo-oophorectomy, omental biopsy, and peritoneal washings was performed at 19+1 weeks gestation.
The histological examination revealed the tumor to be a mucinous cystadenocarcinoma with an intact capsule, confined to the ovary pT1a, negative peritoneal washings, negative omental biopsy.
The case was referred for MDT and oncological review. The Oncology team recommendations were for the patient to have antenatal care and delivery in our hospital as routine.
The patient will be reviewed postpartum by Oncology team.The patient and fetus both remained well and to present, both are followed up in our hospital.

A CASE OF UTERINE ARTERIOVENOUS MALFORMATION POST EVACUATION OF RETAINED PROCUCTS OF CONCEPTION MANAGED BY UTERINE ARTERY EMBOLISATION

Poster

Dr. Vanessa Flack [1], ***Dr. Fiona Reidy*** [1], ***Dr. Sorca O Brien*** [2], ***Dr. Nicola O'Riordan*** [2], ***Dr. Tony Geoghegan*** [2], ***Dr. Etaoin Kent*** [1]

1. *Rotunda Hospital, Parnell Street, Dublin 1,* ***2.*** *Mater Misericordiae University Hospital*

Uterine arteriovenous malformations (AVM) are uncommon and potentially life threatening causes of vaginal bleeding. They can be congenital or acquired; usually secondary to uterine surgical intervention. Previously, management would have required hysterectomy, however, with improvements in technology, less invasive techniques are available, enabling the preservation of fertility.

The authors present the case of a 36 year old para 1 lady who underwent evacuation of retained products of conception (ERPC) following an incomplete miscarriage at 8 weeks gestation. She was otherwise a healthy woman with an unremarkable medical history and previously normal menstrual cycles. She presented at 3 weeks post procedure with heavy bleeding and was treated for suspected retained products, with misoprostol. She represented 6 weeks post operation with persistent episodic heavy bleeding. Ultrasound scanning revealed a hypervascular area of mixed echogenicity suggestive of arteriovenous malformation. MRI was subsequently arranged which was also consistent with this diagnosis.

Based on this imaging she was deemed suitable for embolisation, suggested by current evidence to be the most effective approach for management. The patient was subsequently transferred to a specialist centre for radiological intervention. She was discharged with no early complications day 1 post operatively.

The diagnosis of AVM should be considered in any woman presenting with prolonged or excessive bleeding following interventions in the uterus or after delivery. A high index of suspicion is vital as further surgical or medical intervention may inadvertently aggravate the haemorrhage. This case highlights how interdisciplinary discussion and review are required to provide an appropriate management plan.

A Case Report: Unilateral foot drop after normal spontaneous vaginal delivery

Poster

Dr. Grace Ryan [1], *Dr. Raouf Sallam* [1]

1. St Luke's Hospital Carlow Kilkenny

Obstetric related neurological injury is an uncommon but potential complication of childbirth. Common peroneal nerve palsy is the most common lower extremity neuropathy with a reported incidence of 0.008-0.92%. Associated risk factors include instrumental delivery, prolonged second stage, external knee compression from stirrups or hand positioning. Current recommendations include education and awareness of possible neurological injury in labour associated with the risk factors as mentioned above. We report a case of a 35 year old lady who developed a common peroneal nerve palsy after normal delivery.
A 35 year old lady gravida 1 para 0, presented at term in spontaneous labour. She had an uncomplicated pregnancy, with no past medical history of note and a normal BMI of 21. She had a spontaneous vaginal delivery. Shortly after delivery she started to complain of right lower leg and foot weakness. On examination a foot drop was found, demonstrated by a weakened dorsiflexion and foot eversion. A diagnosis of common peroneal nerve palsy was made. Treatment included a conservative approach in conjunction with physiotherapy assisted gait training and rehabilitation. The patient made a full recovery within 8 weeks.

Neurological injury associated with present day labour and delivery is uncommon. This case highlights the importance of changing positions regularly during labour and the need for education and awareness of potential neuropathies that may develop during labour. Early recognition and prompt physiotherapy, involving gait training with assistive devices is advised. Prognosis is good with most cases resolving within 2-6 months.

A COMPARISON OF CONSERVATIVE AND MEDICAL MANAGEMENT FOR THE TREATMENT OF MISCARRIAGE IN OUR EARLY PREGNANCY CLINIC

Poster

Dr. Tara Rigney [1]***, Dr. Noirin Russell*** [2]

1. Cork University Maternity Hospital, Cork, 2. cumh

Miscarriage management must be embarked upon in a sensitive and effective manner in a dedicated early pregnancy unit. Information regarding our outcomes is vital for patients when deciding on management options.
We hoped to compare the outcome of conservative and medical management for those with a diagnosis of silent miscarriage attending our early pregnancy clinic.
We looked at 70 patients who attended the early pregnancy clinic in 2017, who upon diagnosis of silent miscarriage opted for either conservative or medical management. Information was obtained from the electronic chart.
56 patients (80%) chose to have medical management. Of these, 16 (28%) had retained products of conception at their follow up ultrasound scan. With regard to subsequent intervention 11 went on to have surgical management, 2 had medical management and 3 chose to wait a repeat scan. 14 (20%) chose conservative management, of which 7 patients had retained products on follow up scan. Following this 3 opted for surgical management and 4 opted for medical management. The total number of visits combined for these 70 patients was 206, an average of 3 per patient.
The majority of our patients do not wish to adopt a conservative approach, and of those that do half will require follow up treatment. Those that choose medical management can be informed that at least 75% will not require any other intervention. The management of miscarriage is labour intensive with an average of three ultrasound scans and consultations required for those patients who do not chose surgical management.

A COMPARISON OF LEUKOCYTE COUNTS BETWEEN THE UMBILICAL CORD BLOOD OF MOTHERS WHO ARE DIABETIC OR WHO HAVE RECEIVED ANTENATAL CORTICOSTEROIDS AND CONTROLS.

Poster

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Much attention has been given to the use of umbilical cord blood(UCB), and its method of preparation, in the treatment of disease[1].There is little information available regarding optimum donor profiles.

In this study we aim to determine which group of donors produce the highest yield of leukocytes, the hypothesis being that corticosteroid use/diabetes may be associated with higher leukocyte profiles.

UCB samples were collected at 60 deliveries in UHG and were processed in an on-site laboratory. Demographic and obstetric information was obtained, including gestation, delivery method, presence of diabetes, and if they received corticosteroids. Data was analysed using SPSS to determine correlation between clinical variables and an increased number of leukocytes in UCB.

Post-dates deliveries (n=25) were associated with a significantly increased number of white cell counts(WCC) compared to deliveries before 40 weeks' gestation (n=28, p=0.025). There were no significant differences in UCB WCC in pregnancies complicated by diabetes or after corticosteroid use compared with controls.

In conclusion UCB obtained at post-dates deliveries is associated with a higher WCC yield. Preliminary data suggest no difference in UCB blood profiles in diabetes or after corticosteroid use. Further research with larger numbers is required to determine optimum pregnancy phenotype for UCB collection.

1. Cutler C, Ballen KK. Improving outcomes in umbilical cord blood transplantation: State of the art. Blood Reviews. 2012;26(6):241-6.

A LONGITUDINAL STUDY OF HAEMOGLOBIN IN PREGNANCY IN CONTEMPORARY PRACTICE.

Poster

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The prevalence of anaemia in pregnancy varies worldwide and the commonest cause isiron deficiency anaemia[1]. The data is however often historic and predates use of vitamin supplementation and food fortification.

A secondary analysis of 502 women recruited to a nutritional study was conducted. A full blood count(FBC) was taken at their first visit. Further FBC results during advancing pregnancy were recorded. We studied the trend of haemoglobin (Hb) as pregnancyadvanced.

The Hb was 12.9g/dl(SD 0.9)when it was first measured in the first trimester (n=420) and 13.0g/dl(SD 0.8)when it was measured in the second trimester (n=82). Only 1.8% of the 502 wereanaemic. Compliance with folic acid supplementation at the time of phlebotomywas 98.5%. The Hb was 12.1g/dl(SD 1.2) by the late third trimester (37-42weeks) in the 212 women who had a sample taken and 8.5% were anaemic. Haemoglobin was 10.2g/dl(SD1.5) in the 205 women who had a postnatalsample and 43.4% (89 were anaemic). Of the women who delivered (n=472),59 had a postpartum haemorrhage (12.5%) and four required a blood transfusion.There were no cases of macrocytic anaemia detected.

In contemporary practicewith high rates of compliance with vitamin supplementation, the incidenceof anaemia is low in the first trimester. However, the rate of anaemia isincreased in the third trimester and postnatally. This indicates that women maybenefit from continuing supplementation throughout pregnancy which may alsoreduce anaemia postnatally and potentially avoid the need for blood transfusionafter a PPH.

A LONGITUDINAL STUDY OF MATERNAL WEIGHT AND BODY MASS INDEX (BMI) TRAJECTORIES BETWEEN PREGNANCIES

Poster

Mr. Dáire Goodman **[1]*, Ms. Maria Laura Acosta Puga* [1]*, Ms. Rachel Kennedy* [1]*, Ms. Ciara Reynolds* [1]*, Dr. Eimer O'Malley* [1]*, Prof. Michael Turner* [1]**

1. UCD Centre for Human Reproduction Coombe Women and Infants University Hospital, Dublin

Based on a Body Mass Index (BMI)> 29.9kg/m^2, maternal obesity has emerged as a common and important clinical challenge in developed countries. Most studies to date however are based on cross-sectional data analysis. In a longitudinal observational study, we examined maternal BMI and weight trajectories in women recruited at their convenience to a dietary study in 2013-14 and who subsequently delivered another baby in the hospital before June 2017. Statistical analysis was carried out using SPSS.

Of the 139 women recruited, the mean age was 29 years, 56.1% (78) were nulliparous and 20.1% (28) were obese. The mean interval between deliveries was 2.4 years (standard deviation (SD) 0.9). Between pregnancies, the mean weight at the first visit increased by 1.7 kg (SD 4.9) and mean increase in BMI was 0.6 (SD 1.9). Two thirds (68.3%) of women gained weight and 27.8% of women became obese. Of the 31.7% of women who lost weight, 4.5% (2) were no longer obese. Age category (>/< 32 years), time interval between pregnancies (>/< 18 months) and smoking status had no effect on maternal weight trajectory.

This longitudinal study shows that there is a window of opportunity after delivery to modify maternal weight and prevent or decrease rates of maternal obesity in subsequent pregnancies. This is an important finding for healthcare professionals in primary care and public health.

A PROSPECTIVE COMPARATIVE TRIAL OF DILAPAN-S COMPARED WITH PROPESS FOR INDUCTION OF LABOUR AT 41+ WEEKS IN NULLIPAROUS PREGNANCY

Poster

***Dr. Claire O'Reilly* [1], *Dr. David Crosby* [1], *Ms. Helen McHale* [1], *Prof. Fionnuala McAuliffe* [2], *Dr. Rhona Mahony* [1]**

1. National Maternity Hospital, 2. UCD Perinatal Research Centre

The incidence of labour induction has risen worldwide over the past decade and this may contribute to the rising caesarean section rate. The mechanisms for induction of labour are generally divided into two categories: mechanical and pharmacological.

The objective of this study was to determine if mechanical induction with Dilapan-S is an acceptable, safe method of induction of labour in post-dates uncomplicated nulliparous pregnancy.

This was a single-centre prospective comparative trial. 52 low risk nulliparous women with an unfavourable cervix, scheduled for induction of labour for post-dates ≥ 41 weeks gestation were offered induction of labour with Dilapan-S or Propess from May 2016 until November 2016. The primary outcomes measured were compliance to study protocol and maternal (infection, hyperstimulation) and neonatal outcomes (Apgar Score at birth). The secondary outcome measures included change in Bishop's score and caesarean section rate.

Compliance to study protocol was 25/26 (96%), it was possible to insert Dilapan-S in all but one woman. There were no differences in maternal and neonatal primary outcomes between the groups. There were no cases in either arm of hyperstimulation with either induction method. No difference between the groups was noted in caesarean section rate nor in mean change in Bishop's score

Dilapan-S is an acceptable, safe form of induction of labour in post-dates uncomplicated nulliparous pregnancy. No cases of hyperstimulation were found and thereforeDilapan-S may be a suitable option for outpatient induction of labour in lowrisk postdates nulliparas.

A QUALITATIVE STUDY OF THE ATTITUDES OF WOMEN WITH GESTATIONAL DIABETES TO DIET AND EXERCISE National Maternity Hospital , Holles St , Dublin Smyth S. , Ryan A. , Mulligan K. , Higgins M.

Poster

Dr. Suzanne Smyth [1]***, Prof. mary higgins*** [2]

1. *Centre for Perinatal Research, UCD Obstetrics and Gynaecology, University College Dublin, National Maternity Hospital,* ***2.*** *National Maternity Hospital, Dublin*

Prevalence rates of gestational diabetes (GDM) in Ireland are between 9%-12% and have increased significantly in the last decade. Lifestyle changes effected in pregnancy as a treatment protocol for GDM have beneficial effects on long term health if continued following delivery.

This qualitative study aims to explore the attitudes of women newly diagnosed with GDM, to the required lifestyle changes including dietary and exercise alterations. By identifying potential barriers or enablers for achieving intended lifestyle changes, healthcare providers are in a better position to give targeted advice to this obstetric population.

Semi-structured interviews were performed on antenatal women attending the diabetic clinic and on postnatal wards following delivery. Open ended questions were used to explore the lived experience. Potential questions were designed with the input of patient advocates. The interviews were recorded and transcribed. Content analysis was performed to identify themes.

To date,18 antenatal and nine postnatal interviews have been performed. Similar themes have emerged from both groups. Time , support and convenience were common barriers identified to healthy eating. Enablers included meal planning and organisation. Interviewed women reported anxiety around commencing and maintaining their new diet plans. Support from their partners' was another consideration cited by the interviewees as a motivating factor. While most women had negative feelings towards the GDM diagnosis initially, a sense of pride was fostered by the ability to institute changes and keep to target blood sugar levels. Postnatally these women aim to continue implemented changes with a view to maintaining health as they age.

A RARE CASE OF CELLULAR LEIOMYOMATOSIS

Poster

Dr. Raksha Beethue [1], ***Dr. Mona Abdelrahman*** [2], ***Dr. Vineta Ciprike*** [3]

1. ou, 2. Rotunda Hospital, Parnell Street, Dublin 1, 3. Our Lady of Lourdes Hospital, Drogheda

Intravascular Leiomyomatosis is a smooth muscle neoplasm that may extend to involve blood vessels outside the uterus.[1] When confined to the uterine myometrium, the behaviour is considered benign. It is a rare condition with approximately 200 cases reported in literature.

This is a case of a 42 year-old multiparous lady who presented with a two week history of persistent heavy vaginal bleeding. Pelvic ultrasound and MRI demonstrated a bulky uterus with a 3.7cm endometrial thickness containing multiple cystic areas, highly suspicious for endometrial cancer.

An urgent hysteroscopy and D&C was organised. Based on morphology and immunophenotype, the histology report suggested a smooth muscle neoplasm, but a sex cord stromal tumour could not be excluded. A CT Thorax Abdomen and Pelvis (CT-TAP) ruled out focal lung nodules, mediastinal and axillary adenopathy, pericardial and pleural effusions.

A Total Abdominal Hysterectomy and Bilateral Salpingo-opherectomy was performed. The patient had an uneventful good recovery. Histopathology revealed benign smooth muscle neoplasm within the spectrum of dissecting leiomyoma and intravenous/intravascular leiomyomatosis of the myometrium without extrauterine extension.

A CT-TAP was repeated eight months later with no extrauterine pathology identified. The patient was advised possibility of developing any cardiac, pulmonary or neurological symptoms in view that leiomyomatosis can arise from any venous structure. Yearly surveillance with CT-TAPs is recommended given the possibility of extrauterine extensions of these benign lesions. Anti-estrogenic therapy has also been suggested as potentially useful in the control of unresectable tumors.[2]

A REVIEW OF ADOLESCENT GYNAECOLOGY SERVICES AT THE NATIONAL MATERNITY HOSPITAL

Poster

Dr. Aisling Mc Donnell [1], Dr. Helena Bartels [1], Dr. Orla Sheil [1], Dr. venita broderick [1]

1. National Maternity Hospital, Dublin

Paediatric & Adolescent gynaecology is an important part of service provision in the field of Obstetrics and Gynaecology, catering for both adolescents and children with gynaecological complaints.

The purpose of this study was to carry out a retrospective analysis of the adolescent gynaecology service at the National Maternity Hospital.

All patients (age <18) who attended the adolescent gynaecology clinic at the for the year 2016 were included in the study. Patients were selected using IPMS (Integrated Patient Management System) and data was collected by retrospective chart review. Data tables were compiled from information gathered on patient demographics, Body mass index(BMI), presenting symptoms, diagnosis, patient management and outcome.

77 patients attended the service in the year 2016, and 75 charts were available for review. Median age at attendance was 16 (range 4-17). The majority of referrals (82.7%, N=62) were from the primary care setting with 10.7% (N=8) referred from other tertiary centres. The most common indication for referral was menstrual irregularity such as menorrhagia, dysmenorrhoea and amenorrhoea (74.7%, N=56). Other common presentations included pelvic pain (13.3%, N=10) and ovarian pathology (12%, N=9). 47% of the patients were classified as overweight/obese. The median number of clinic visits prior to discharge was two.

The adolescent gynaecology clinic provides an important service to young women. Internal auditing and review is essential for maintaining an outpatient service that is tailored to patients needs by shaping management and resource allocation. We aim to use the information in this review to further develop our service.

A REVIEW OF SECONDARY POSTPARTUM HAEMORRHAGE MANAGEMENT IN A TERTIARY MATERNITY HOSPITAL

Oral (Jogs)

Dr. Rebecca Cole [1]***, Dr. Ciara Shiel*** [1]***, Dr. Noirin Russell*** [1]

1. *Cork University Maternity Hospital, Cork*

Secondary postpartum haemorrhage (PPH) is abnormal vaginal bleeding occuring 24 hours to six weeks after delivery. The most common aetiology is infection, often assumed to be related to retained products of conception (RPOC). Recommended management is unclear in the literature. Commonly, ultrasound investigation is used to identify RPOC. Ultrasound identification postnatally is inaccurate with low histological confirmation. Patients may subsequently undergo medical or surgical intervention. Evacuation of the puerperal uterus is associated with a higher rate of complications.

We reviewed the management of secondary PPH in a tertiary maternity hospital.

Postnatal presentations to the emergency room in Cork University Maternity Hospital from May to December 2016 were reviewed for those presenting with heavy vaginal bleeding, malodourous discharge and/or abdominal pain. Microbiology samples, antibiotics, sonographical investigation, admission, medical and surgical management were recorded.

189 of 512 postnatal presentations fit the criteria for inclusion, 129/189(68%) post vaginal delivery, 60/189(32%) post caesarean section. 116/189(61%) had an HVS with 9/116(15%) having a confirmed infection. 66/189(35%) were discharged home on antibiotics. 62/189(33%) were admitted with 51/62(82%)receiving antibiotics. 59/189(31%) had an ultrasound of which 20/59(34%) were identified as having RPOC. 3/20(15%) went on to have medical management. 9/20(45%) had a uterine evacuation. 2/9(22%) had post operative complications. Only 1/9(11%) had histological confirmation of RPOC.

Low histological confirmation supports previous studies indicating the low sensitivity of ultrasound in the diagnosis of RPOC. Postnatal ERPC is associated with increased risk of complications. Antibiotic therapy should be considered first line in the management of secondary PPH.

A REVIEW OF THE MANAGEMENT OF OBSTETRIC CHOLESTASIS AT MIDLAND REGIONAL HOSPITAL MULLINGAR

Poster

Dr. Samina Hameed **[1]*, Dr. Catherine O'regan*** **[1]*, Dr. tarannum mahedvi*** **[1]*, Dr. Majda Almshwt*** **[2]**

***1.** Midland Regional Hospital, Mullingar, **2.** Department of Obstetrics and Gynaecology, Mullingar Hospital*

Obstetric cholestasis is a condition that is unique to pregnancy and typically presents after 28 weeks of gestation. Clinical presentation includes pruritus, especially on the palms of hands and soles of feet, abnormal liver function tests and/or raised bile acids. It's a diagnosis of exclusion and it affects 0.2-2% of the obstetric population worldwide. It is associated with a high risk of fetal distress, premature birth and intrauterine death. There is no treatment that specifically improves neonatal outcomes.
Our aim was to audit the investigations, management and outcomes of 60 patients diagnosed with obstetric cholestasis over the period of 1 year, and compare these to those set out in the RCOG Greentop guidelines.
We retrospectively audited the charts of 60 patients diagnosed with obstetric cholestasis and collected non-indentifying information about their clinical management right up until delivery.
We found that all patients were monitored with weekly liver function tests, once weekly cardiotocography and 2 weekly growth ultrasound and umbilical artery Doppler. Hepatitis screen was performed in 19%, autoimmune screen performed in 6.3% and liver ultrasound in 13.4%. Ursodeoxycholic acid was used in 80% and vitamin k in 3%. Delivery was planned in 88% cases and gestational age at delivery was 37 weeks in 38 %, 38 weeks in 29% and 23% in 39+ weeks. Vaginal delivery was noted in 54.2% and C-section in 45.2%.
The outcomes of this audit will guide the development of a local guideline for MRHM and improve our management of it to comply with international recommendations.

A SOB STORY; THE SUBTLE SIGNS OF PERIPARTUM CARDIOMYOPATHY

Poster

Dr. Nicholas Kruseman [1]

1. *Our Lady of Lourdes Hospital, Drogheda, Co. Louth*

Peripartum caridiomyopathy (PPCM) is a rare but deadly disease of pregnancy, accounting for 6% of maternal deaths in the most recent MBBRACE-UK report. It is characterised by the development of heart failure secondary to left ventricular systolic dysfunction, in late pregnancy or up to 6 months following delivery, where no other cause of heart failure is found.

In this report, I examine the case of a woman with a history of pre-eclampsia who presented 6 days post-partum feeling generally unwell to OLOL Drogheda in August 2017. Her condition deteriorated while inpatient, eventually resulting in a diagnosis of PPCM. I consider the many challenges posed by her presentation, diagnosis, critical care and management that were present in this case.

I discuss the current position in the literature for the management of PPCM and discuss the key messages for future care of these patients. This includes an early multidisciplinary approach and the co-location of maternity departments with tertiary care services, with access to a cardiac care unit proving critical in the acute management of this patient.

In conclusion, management of this condition is seldom straightforward. If PPCM is misdiagnosed or there is a delay in diagnosis, the consequences for patients can be fatal. Fortunately, early recognition and prompt specialist involement can significantly enhance patient outcomes.

A STUDY OF POSTNATAL PRESENTATIONS IN AN IRISH SECONDARY CARE CENTRE.

Poster

Dr. Rachel Elebert [1], *Dr. Rachel Elebert* [1], *Dr. Ayodele David Aina* [2], *Dr. Ulrich Bartels* [1]

1. Mayo General Hospital Castlebar, 2. Rotunda Hospital.

The peurperium is associated with significant physical and psychological morbidity. Routine follow up in this period is provided by primary care. An anticipated post natal readmission rate is quoted to be 1-2%. In recent years, post natal care has transitioned from hospital to the community. Our hospital had recorded a rise in numbers of post natal presentations to the labour ward in this time, increasing demands on staff and resources. This study aims to examine the sources and content of these referrals.
A retrospective data collection was undertaken. Patients were identified using daily handover sheet and cross checked with medical records. Patient charts were then examined for information.
A total of 74 presentations over 6 month period, of which 9 of those were repeat presentations. Most were self referral (43.2%), GP referral (32.4%), PHN (8.1%), other institutions (5.4%), Planned presentations made up 10.8%. Regarding content of admissions, the most common complaint was wound complications (25.7%), followed by vaginal bleeding 21.6%, and abdominal pain 16.2%. Hypertension involved 8.1%. Of 74 presentations, 12 were admitted (16.7%). Based on annual delivery rates this gives a 1.8% readmission rate.
Our admission rate is within the range of that quoted in the literature. In terms of presentations, there was a high proportion of wound reviews both perineal and abdominal. We recommend increased patient education regarding wound care. Furthermore consider increased support and empowerment of primary care providers regarding management in the community.

A study on Patient's choice in the Management of Missed Miscarriage in Portiuncula Hospital

Poster

Dr. Roisin McConnell [1] ***, Dr. M Abbas*** [2]

1. Portincula Hospital, Ballinasloe, Co-Galway, 2. Portiuncula Hospital, Ballinasloe, Co-Galway

Background

Missed miscarriage (MM) occurs when foetal death occurs prior to viability but expulsion of the foetus has not yet occurred. Management of MM includes expectant, medical or surgical depending on the clinical context and patient preferences.

Aim

To assess patient's preferences regarding management options of MM in Portiuncula Hospital and the outcomes vs. patient's expectation.

Methods

A retrospective study of the charts of 96 women diagnosed with MM from January to July 2017. A total of 93 charts were studied (3 were missing).The study analysed patient's treatment preferences: medical, expectant, the need for ERPC or presentations to emergency department (ED).

Results

In total 86 women received treatment for MM (5 lost to follow up and one miscarried a twin with an ongoing viable 2nd twin pregnancy). Of those, 59 (68.6%) required an ERPC either as their preferred treatment or for failed expectant/medical. 46 (53%) chose ERPC. 28 (32%) women initially wanted expectant management. However, only 9 were successful and 4 (28%) attended the ED due to pain/bleeding.

12 (15%) women wanted medical treatment with 4 requiring ERPC. Only 1 woman presented to ED. One woman required a repeat ERPC. 3 women required emergency EPRC prior to second scan confirming MM.

Discussion

ERPC was the preferred initial treatment choice. The IOG guidelines recommend it only as a first line in certain circumstances, including patient's request.

A SURVEY OF UPTAKE AND THE FACTORS WHICH INLFUENCE THE UPTAKE OF THE SEASONAL INFLUENZA VACCINE IN PREGNANCY

Poster

Dr. Peter Houston [1], ***Dr. Kate O'Doherty*** [2], ***Dr. Sarah M Nicholson*** [2], ***Dr. Geraldine Gaffney*** [2]

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Influenza is a significant cause of maternal morbidity and mortality during pregnancy (1). Vaccination against influenza A and B has been heavily endorsed by the HSE and obstetric professional bodies, for example, RCOG and ACOG (2). The HSE has had a major public health campaign to encourage vaccination of pregnant women against influenza this year.

We wanted to establish the rate of vaccination in pregnant women at Galway University Hospital and to determine the reasons for declining vaccination during pregnancy.

A postal survey was sent to 457 women who had attended for their antenatal booking visit between December 1st to 3rd February inclusive. 172 were returned and an additional 37 were carried out in clinic yielding a total of 209 completed surveys.

82/209 (39.2%) women received the vaccine. The most common reasons why women did not get the vaccine were: it was felt to be unnecessary (28.5%); concerned of side effects to mother and baby (23.6%) and believing the flu vaccine is ineffective (7.3%). The odds ratio for those who had discussions with a healthcare professional and received the vaccine was 15.47 (95% CI: 4.63–51.77). Whereas the odds ratio for having read information in health centres or from advertising campaigns was 4.19 (95% CI 2.02-8.68).

In conclusion, vaccination rates amongst pregnant women during flu season are poor. Greater verbal education from a range of healthcare professionals as to the benefits, safety and efficacy of the vaccine could improve uptake more effectively than written information and advertising campaigns.

A SYSTEMATIC REVIEW OF TASK SHIFTING IN EMERGENCY OBSTETRICS SERVICES

Poster

Dr. Mei Yee Ng [1], ***Dr. Maryanne Siu*** [2], ***Dr. Meabh Ni Bhuinneain*** [3]

1. *Coombe Women and Infants University Hospital, Dublin,* ***2.*** *National Maternity Hospital,* ***3.*** *Mayo General Hospital Castlebar*

Health worker shortage impeded the success of the 2015 Maternal Health Millennium Development Goal 5 and it will continue to impede efforts in attaining the 2030 Global Goal 3 for Sustainable Development – Good Health and Well-Being if not addressed with an effective solution.

This systematic review aims to investigate the presence and rigour of evidence for task shifting interventions in obstetric emergencies to address health worker shortage and to improve access to emergency obstetrics services.

PubMed, POPLINE, Clinicaltrials.gov and Cochrane Central Register of Controlled Trials were included in the search. Reference lists of systematic reviews and relevant articles were also hand-searched.

Studies assessing task shifting in areas of emergency obstetrics service provision where health worker shortage exist in any country or regions. Studies were included if they reported on health worker/patient performance, patient outcome, patient satisfaction and cost effectiveness.

Data were extracted and all relevant studies were independently appraised using Pluye *et. al*'s Mixed Method Appraisal Tools (MMAT) version 2011. A narrative synthesis methodology was used due to the heterogenous type of studies and foci.

There is merit to recommend task shifting in emergency obstetrics services in low and middle-income countries. In high-income countries where health worker shortage is an issue, there is value to conduct more studies to assess the effectiveness and applicability of task shifting in emergency obstetrics services.

A Wound App?

Poster

Dr. Grace Ryan [1]***, Dr. Sara Mohan*** [1]***, Prof. Ray O'Sullivan*** [1]

1. *St Luke's Hospital Carlow Kilkenny*

The dual aim of this study is to firstly audit the prevalence of post-LSCS wound infections and associated factors. Secondly to assess the potential acceptability of a "wound app" a mobile phone application to facilitate closer follow up of post-LSCS wound infections using current technologies.

A telephone questionnaire was retrospectively administered to a cohort of patients undergoing a planned or emergency Caesarean section over a recent one month period(n=52). 48 charts were available for review to gather information on surgical site preparation and surgical skin closure technique along with the level of expertise of the surgeon.

Fifty two patients were included in the study, forty eight charts were available for review. Of the 52 patients, 25 patients partook in the survey. Chloroprep was the most common antiseptic used. Subcuticular skin stitches with 3-0 vicryl was the preferred method of skin closure. 3 patients developed a wound infection treated by the GP in a primary care setting. 21 patients would like the idea of using a "wound app", if they had any concerns over their c-section wound rather than go to their GP or hospital. 4 patients did not think the application would be a good idea due to privacy and confidentiality issues.

From our study it appears there was no correlation between surgical site preparation, skin closure technique and choice of antiseptic agent. Patient opinion about the development of a mobile phone wound app to facilitate postnatal queries about wound concerns received very positive feedback.

abstract of case report of primary ovarian ectopic pregnancy

Poster

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1. *south tipperary general hospital clonmel co tipperary*

Primary ovarian pregnancy is a rare type(variant) of ectopic pregnancy.
It is usually seen in young highly fertile multiparous women using intrauterine devices.
Heartig estimated that ovarian pregnancy occurs one in 25000-40000 pregnancies. It develops approximately o.5 to 3 % of all ectopic gestations.
We present a case where a young primigravida was diagnosed ectopic pregnancy and was confirmed as primary ectopic pregnancy both intra operatively and histopatholgically, managed with laparoscopic ovariectomy.

ACUTE DETERIORATION IN RESPIRATORY STATUS SECONDARY TO ADVANCING PREGNANCY

Poster

***Dr. Aisling Heverin* [1], *Dr. Amy O'higgins* [1], *Dr. Eibhlin Healy* [1], *Dr. Maeve Mccarthy* [2], *Dr. Elizabeth Mary Marliza O'Dwyer* [1], *Dr. Gunther Von Buenau* [1], *Dr. Cliona Murphy* [1], *Dr. Aoife O Neill* [1]**

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Background: Women with pre-exisiting co-morbidities are at greatest risk of dying in pregnancy, with indirect maternal deaths remaining the leading cause of maternal death in Ireland. The fetus and placenta increase the physiological demand for oxygen by about 20%.
Methods: Case report.
Findings: A 22 year old woman, para 1, presented at 30 weeks gestation to a general hospital with three weeks of progressive dyspnoea. She had severe interstitial lung disease secondary to previous pulmonary tuberculosis. She had received close Respiratory and Obstetric care in her first pregnancy and had experienced worsening of pulmonary function during pregnancy with some recovery following delivery.
At presentation she was tachypnoeic and tachycardic, her Haemoglobin was 7.4g/dL and she received a red cell transfusion. She failed to improve and therapeutic anti-coagluation, bronchodilator therapy, steroids and antibiotics were commenced. CT pulmonary angiography scans were inconclusive for an embolus. She failed to improve after 36 hours and was delivered by Caesarean section at 31+0 weeks. On delivery her tachycardia immediately improved although she required ongoing care to optimise her respiratory function.
Conclusion: Our patient had multiple sources of respiratory compromise including pre-exisiting interstitial disease, bronchial disease, anaemia and possible broncho-constriction, exacerbated by the increasing physiological demands of advancing pregnancy. Her marked improvement on delivery shows the impact of the physiological demands of pregnancy on her respiratory function. This case highlights the importance of multidisciplinary input into complex Obstetric patients and the need for maternity services to be structured appropriately for the care of these patients.

ACUTE FATTY LIVER IN PREGNANCY: A CASE REPORT

Poster

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1. Roy, 2. Na, 3. Rotunda Hospital, Parnell Street, Dublin 1

Nolan, O'Reilly, Breen, Flood

Rotunda Hospital, Dublin

A 32 year old, Para 1, Asian woman presented to the Emergency Department at 36^{+5}. She reported a 2 week history of flu-like symptoms: general malaise, fatigue, myalgia, nausea. Vitals were stable and urinalysis was clear. Bloods including FBC, U&E and LFTs were requested, but before results were obtained, there was a prolonged deceleration on CTG and the patient underwent an emergency Caesarean Section in fetal interest. Estimated blood loss was 800mls intraoperatively and a male infant was delivered in good condition. Postoperatively, it was noted that her blood results had severely deranged renal and liver function tests (creatinine 242, bilirubin 80, ALT 116, AST 123, albumin 15, fibrinogen 0.4, INR 2.2). Synthetic function of the liver was markedly decreased. She was hypoglycemic with a blood glucose level 3.3mmol/L. No raised inflammatory markers. She was admitted to the High Dependency Unit (HDU) for observation and further investigation. Clinical picture was not consistent with pre-eclampsia or HELLP (normotensive, no proteinuria, no evidence of haemolysis, normal platelets). No evidence of Thrombotic Thrombocytopenic Purpura (TTP) or Haemolytic-Uremic Syndrome (HUS). No history of drug or environmental toxin exposure or recent travel. She continued to deteriorate both clinically and biochemically over the subsequent 24 hours and was transferred to HDU in The Mater Hospital, then to ICU, then to the National Liver Transplant Unit in St Vincent's Hospital. A suspected diagnosis of Acute Fatty Liver in Pregnancy was made and the patient is still undergoing investigation.

ADDISONIAN CRISIS IN PREGNANCY

Poster

Dr. Fiona O'Toole [1], ***Dr. Katie Beauchamp*** [1], ***Dr. Daniel Kane*** [1], ***Dr. Vineta Ciprike*** [1]

1. *Our Lady of Lourdes Hospital, Drogheda*

BM, a 38yo primiparous woman with known Addison's disease for five years, booked at our unit for antenatal care. Her medical history is also relevant for hypothyroidism and Coeliac's disease. She requires approximately three admissions a year for addisonian crises outside of pregnancy.
She presented prior to her booking visit with nausea and vomiting of early pregnancy. Her bloods showed hyperkalaemia (5.5) and hyponatraemia (129) consistent with an adrenal crisis. Laboratory tests were otherwise normal. She improved with IV fluids and IV hydrocortisone and her electrolytes normalized. She was discharged after two days on her regular steroids and mineralocorticoids.
EDD by dating scan was confirmed to be 20/11/2017. She has been booked under consultant-led care with regular input from endochrinology. Serial growth scans were organised at booking. She required a second two-day admission at 26+3/40 with vomiting and electrolyte abnormalities. Addisonian crisis was managed again with IV hydrocortisone and IV fluids. Dietician review was arranged and BSLs were monitored. Departmental ultrasound scan showed the EFW to be on 10th centile. Follow-up growth scans have confirmed IUGR. Umbilical artery dopplers remain normal.
Addison's disease in pregnancy is rare. Nausea and vomiting of early pregnancy may precipitate an adrenal crisis. This requires prompt treatment and diagnosis. Precipitants also include periods of increased stress, such as infection, and inadequate replacement. Management involves fluid replacement and IV hydrocortisone to correct any hypotension and electrolyte abnormalities. Prior to the availability of glucocorticoid replacement therapy maternal mortality in pregnancy was 35-45% and IUGR common.

ADENOCARCINOMA OF PANCREAS MIMICKING PREGNANCY!

Poster

Dr. Sumaira Tariq [1], ***Dr. Michael O'leary*** [1]

1. *University Hospital Galway*

45 year old lady, Para 2+2, background history of hypercholesterolemia, hypertriglyceridemia and pancreatitis, presented to the emergency department with left sided pain, shoulder tip pain and amenorrhea for four weeks, and positive pregnancy test. Gynaecology team took over her care to investigate for an ectopic pregnancy.

The serum beta Hcg was 2206 mU/L, however, pelvic ultrasound scan showed an empty uterus with large amount of free fluid consistent with hemoperitoneum. She was taken for a diagnostic laparoscopy. Intraoperative findings included normal ovaries and tubes with no bleeding or hyperemia but spleen appeared large and inflamed with capsular rupture.

Beta Hcg levels at 48 hours interval remained static. MRI scan subsequently revealed a pancreatic mass invading the splenic hilum and solid metastatic lesions in the liver. Pain worsened and Hb dropped from 12 to 7.7 g/dl. Splenic artery angiogram was NAD. She became septic and pain was controlled with Morphine PCA.

Patient had ultrasound guided biopsy of the Liver which showed poorly differentiated adenocarcinoma. Immunohistochemistry showed the tumour cells are strongly positive with CK7, CA19.9, CK19, polyclonal CEA and HCG. Tumour cells are negative with CK20, TTF-1 and ER. Possibilities include metastatic choriocarcinoma arising at primary site of pancreas or metastatic poorly differentiated adenocarcinoma from pancreas showing choriocarcinomatous transdormation with HCG expression along with a very high grade, poorly differentiated morphology.

She deteriorated rapidly and died within 20 days of diagnosis with septic shock and pulmonary embolism.

HCG in woman is associated with pregnancy. It can be seen in pancreatic cancer.

AMNIOTIC FLUID EMBOLISM AND PLACENTA PRAEVIA

Poster

Dr. Gemma Ferguson [1], ***Dr. Rebecca Henry*** [2]

1. *Antrim Area Hospital, Northern Ireland,* ***2.*** *Daisy Hill Hospital*

Amniotic fluid embolism (AFE) is an unpredictable and as-of-yet unpreventable complication. The disastrous entry of amniotic fluid into the maternal circulation leads to dramatic sequelae of events, including cardiac arrest, ARDS, coagulopathy with massive hemorrhage, encephalopathy, seizures, and both maternal and infant mortality. AFE can occur during labour, caesarean section, dilatation and evacuation or immediately postpartum.

The United Kingdom Obstetric Surveillance System [UKOSS] reported that elevated risk for AFE is associated with placenta praevia and placental abruption (3-10 times greater risk), possibly related to abnormal placental invasion and predisposition to disruption of the uterine vasculature.

We present a case of AFE after elective Caesarean section in a P1 38+0 weeks pregnant woman complicated by major placenta praevia. Sudden hypotension, haemorrhage and signs of DIC developed postnatally. The course of these events was rapid and life-threatening, consistent with AFE. Thus, we report this case precisely and review pathophysiology, risk factors, diagnosis, and treatment of AFE by referring to up-to-date literatures.

AN ANALYSIS OF SCREENING FOR GESTATIONAL DIABETES IN THE ANTENATAL POPULATION IN UNIVERSITY HOSPITAL GALWAY

Poster

Dr. Caitriona Fahy [1], ***Dr. Hannah Glynn*** [1], ***Dr. Geraldine Gaffney*** [1], ***Prof. Fidelma Dunne*** [1]

1. *University Hospital Galway*

Gestational diabetes (GDM) is an important cause of adverse maternal and fetal outcomes. Previous studies would suggest a prevalence of 12% in the Irish population (1); changing patient demographics including increased maternal age and rising obesity rates would be expected to increase the incidence of GDM further. Universal screening for GDM is controversial, Irish guidelines are in line with international practice, and recommend selective screening based on patient risk factors.

This study aimed to assess the uptake of GDM screening via an oral glucose tolerance test (OGTT) in those deemed at risk in our unit; the GDM prevalence in those tested, and the frequency of associated risk factors.

A database was compiled of all women who were considered eligible for OGTT at booking from January to September 2017 on the basis of selected risk factors, and compared with their OGTT results.

In total, 554 women had risk factors to merit GDM screening. Of these, 122 have not yet had screening due to earlier gestation, and 28 did not attend for OGTT. This corresponds with a 94% uptake rate for OGTT in those eligible. 404 OGTTs were carried out, 68, or 16.8%, were positive. The risk factors most prevalent were BMI >30, and a history of GDM in a previous pregnancy.

The prevalence rate in this study is higher than that previously observed, strengthening the argument for universal screening. High uptake suggests acceptability of the test to patients along with an awareness of the importance of GDM in the antenatal population.

AN AUDIT OF EXTERNAL CEPHALIC VERSION PERFORMED (ECV) BY A SINGLE OPERATOR IN AN IRISH MATERNITY HOSPITAL

Poster

Dr. Mona Abdelrahman [1]***, Dr. Vineta Ciprike*** [2]

1. *Rotunda Hospital, Parnell Street, Dublin 1,* ***2.*** *Our Lady of Lourdes Hospital, Drogheda*

Breech complicates 3-4% of all term pregnancies[1] National RCPI and RCOG guidelines recommend External cephalic version (ECV), a procedure performed that reduces the incidence of breech presentation at term and therefore the caesarean section rate [2,3].

The aim of this audit was to determine the success rate, complications, and mode of delivery following ECV and to compare it with standards in the guidelines.

This was a retrospective study of ECVs performed by a single operator from July 2015 to April 2017. Data was obtained from the online Maternity Information System and patient records. Results were analysed using Microsoft Excel.

39 women had an ECV, of which 54% were primiparous and 46% multiparous. In 69% of cases, ECV was successful at first attempt. Terbutaline was used in 97% of cases. Of the successful ECVs, 50% were primips, 48% had a posterior placenta, and 78% had an extended breech fetus. The average gestation at ECV was 37+5 weeks. 48% of patients had a spontaneous onset of labour and 63% had a vaginal delivery compared to 22% requiring an emergency caesarian section, mainly for failure to progress. In the cohort of unsuccessful ECVs, all patients had a caesarian section at around 39 weeks gestation. None spontaneously reverted to cephalic presentation at follow up. 67% of those were primips with an extended breech fetus. There were no complications.

Selected patients should be counselled and offered ECVs. It is a safe successful procedure that may reduce caesarian sections rates.

AN AUDIT OF INFORMED CONSENT PRACTICE FOR ELECTIVE CESAREAN SECTION AT MATERNITY UNIVERSITY HOSPITAL

Poster

Dr. Darin Ahmed [1]***, Dr. Gunther Von Bunau*** [1]

1. *Obstetrics and Gynaecology, Coombe Women and Infants University Hospital, Dublin*

Opting for delivery by caesarean section is a shared responsibility between the healthcare provider and the patient, an informed consent is meant to empower the patient to make a reasonable valid decision.The purpose of this study is to measure compliance and adherence to RCOG guidelines of obtaining a valid consent. Elective caesarean sections' consents forms, between Dec. 2016 to the end of Feb 2017 (n=289), reviewed retrospectively. 97 charts randomly selected and analysed. Consent forms were investigated for: whether a clear full term is used to describe the procedure, documentation of frequent risks and possible extra procedure; eligibility and MCN (medical council number) of consenting doctor, and date of signing the consent.Findings: about 81.3% had the procedure named fully instead of abbreviations, 72.2 % documented risks of caesarean section, only 24.4% of those mentioned the possibility of needing an extra procedure performed100% of doctors signed the consent, although only 45% of them used their names or a recognized signature, 22.6% had their MCN written, and only one wrote their level of experience. 61% of chart were signed two weeks in advance in antenatal clinics, while 35% were signed the morning of the procedure.

The study Generally showed inadequate documentation, and sometimes inappropriate counselling. Also current consent design relies on consenting doctor's knowledge and memory, making the consenting pattern inconsistent.Thus, we recommend to design standard pre-typed checklist consent to minimize variations in documentations and ensure adequacy of the provided information.

AN AUDIT OF PATIENTS PRESENTING WITH ECTOPIC PREGNANCY AND THEIR MANAGEMENT PATHWAY IN A TERTIARY GENERAL HOSPITAL.

Poster

Dr. Laurentina Schaler [1], ***Dr. Eimear McSharry*** [1], ***Dr. Rupak Kumar Sarkar*** [1], ***Dr. Cliona Murphy*** [1]

1. *Department of Gynaecology, Adelaide & Meath Hospital incorporating the National Children's Hospital (AMNCH), Tallaght, Dublin 24*

Ectopic pregnancy is the leading cause of first trimester maternal death[1.] The rate of ectopic pregnancy in Ireland was 14.8 per 1,000 maternities in 2012[2].

The purpose of this study was to review all patients who presented with an ectopic pregnancy to a general hospital over an 8yr period and their management pathway.

Patients were identified through a hospital database. A retrospective chart review was performed on all cases. Thirty-three women were diagnosed with an ectopic pregnancy during the study period. The average age was 33.1years (range: 27-45yrs). Notably, n=23 (67%) of cases were diagnosed on first presentation with n=10 (30.3%) being referred for further evaluation by a primary care provider. In almost all cases n=32 (96.9%) PV bleeding was present and this was associated with pain in n=14 (42.2%) cases. The time from triage to review by ED doctor ranged from 0min to 495min with a mean of 124min. The time interval to subsequent Gynaecology review ranged from 0min to 465min with a mean of 126min. There was one case that met acute maternal morbidity criteria requiring ICU admission.

Follow up gynaecology appointment occurred in n=24 (72.7%) of cases. There was one death due to multiorgan failure secondary to cardiac arrest.

Our audit hightlights that there is scope for improvement in the time interval following presentation to the emergency department to review by emergency department doctor and referral to the Gynaecological team. A prompt diagnosis can help facilitate effective management of these patients and reduce morbidity.

AN AUDIT OF POST-NATAL VENOUS THROMBOEMBOLISM PROPHYLAXIS

Poster

Dr. Kate O'Doherty [1], ***Prof. mary higgins*** [2]

1. National Maternity Hospital, 2. UCD Perinatal Research Centre

Background: An audit was carried out on a new VTE screening tool in post-natal women
Purpose of Study: To assess whether the screening tool was completed on all patients and based on screening the correct prophylaxis was given
Study Design and Methods: Twenty charts were reviewed on the postnatal ward in September
Findings of the Study: The screening tool was completed in 75% of patients, in those that were completed it was done correctly in 100% of cases. Of the uncompleted forms 40% of patients delivered by caesarean section and 60% by vaginal delivery. The correct prophylaxis was given in 100% of cases audited.
Conclusions and programme implications: As this is a new screening tool, more education is needed to encourage 100% completion rates

AN AUDIT OF THE COMPLIANCE OF THE EARLY PREGNANCY CLINIC SERVICE IN THE SOUTH EASTERN TRUST WITH NICE GUIDANCE

Poster

Dr. Helen Goodall [1], *Ms. Sharon Watt* [1], *Ms. Marion Maxwell* [1], *Ms. Adele Hyland* [1]

1. *Ulster Hospital*

Early pregnancy problems cause patient distress and if managed inappropriately result in morbidity, mortality and medico-legal issues.

• Purpose of Study

- Determine compliance of our Early Pregnancy Clinics with NICE Guidance on pregnancy diagnosis and expectant management of miscarriage
- Identify areas for improvement.

• Study Design and Methods

Retrospective data was collected on new patients during March 2017. 67 women were included. 22 women had expectant management.

• Findings of the Study

There were many areas of good practice in terms of diagnosis and expectant management. However, only 86% of patients were assessed by a healthcare professional before referral, 81% of patients had a Transabdominal ultrasound (TAUS) and 41% were offered a Transvaginal ultrasound (TVUS). When diagnosis was not initially made, subsequent reviews often took place sooner than recommended. Following expectant management, patients were advised to repeat pregnancy tests sooner than recommended.

• Conclusions and programme implications

A nurse led triage system has now been set up to assess referrals.

All women should have TAUS initially and TVUS if diagnosis cannot be made. When diagnosis is not made on initial scan, repeat scan should be performed after ≥7 days for TVUS and ≥14 days for TAUS.

When symptoms suggest that the miscarriage has completed, women should take a urine pregnancy test after 3 weeks to reduce patient anxiety and clinic workload.

Our findings are relevant to all other Early Pregnancy Clinics in Ireland.

AN AUDIT OF THE INDICATION FOR AND RESULTS OF HIGH VAGINAL SWABS TAKEN IN THE EMERGENCY ROOM OF A TERTIARY OBSTETRIC HOSPITAL

Poster

Dr. Bernard Kennedy [1]***, Prof. Chris Fitzpatrick*** [1]

1. Coombe Women and Infants University Hospital, Dublin

Over 15% of women presenting to our Emergency Room (ER) have a High Vaginal Swab (HVS) taken.
This has come to produce a large workload for the hospital's microbiology department.
The aim of this audit was to record the indication for every HVS taken in the Emergency Room over one calendar month, and the results they yielded.
The audit was a retrospective review of patient charts and Microbiology results. All patients who had a HVS taken in the month of August 2017were recorded. The indication for the test was recorded, as was the final microbiology report.
There were 801 clinical consults for the month of August 2017. 126 HVS were taken in the ER. The indications for these test can be categorised as Investigations of Per Vaginal Bleeding (PVB) Antenatally 35%,Antenatal Per Vaginal Discharge 25%, PVB post Gynaecology Procedures 6%, possible Retained Products of Conception 6%, possible Endometritis 6%, Antenatal Abdominal Pain 6%, possible Rupture of Membranes 5.5%, bleeding/discharge due to other gynaecological causes 5.5%, and Pyrexia of Unknown Origin 3%.
The microbiology reports for these samples showed No Growth/ Normal Flora 49%, Candida 15%, Bacterial Vaginosis 14.5%, Anaerobes 5%, Others 6%,E.Coli and Bowel flora 2%. Group B Strep was isolated in 7.6% of swabs.
The vast majority of HVS taken over this period were very unlikely to have an impact on patient care. Hospital guidelines should be implemented to decrease the number of HVS taken, and the inherent resource burden associated with this.

AN AUDIT OF THE MEDICAL MANAGEMENT OF MISSED MISCARRIAGE AND A COMPARISON OF OUTCOMES AT EARLY PREGNANCY ASSESSMENT UNIT IN GALWAY UNIVERSITY HOSPITAL

Poster

Dr. Sumaira Tariq [1], ***Dr. Nayha Tariq*** [1], ***Dr. Tom O'Gorman*** [1]

1. *University Hospital Galway*

We designed a performa collecting data for 72 patients over a 4 month period July 2106 to October 2016. Patient ID, Age, Parity, previous TOP/LSCS, gestation at diagnosis, diagnosis of missed miscarriage, correct misoprostol regime prescribed as per hospital guidelines, compliance with misoprostol regime, outcome of initial management choice, subsequent scans or alternative managements required and complications including failed procedures were considered. We designed the performa based on protocols from current hospital guidelines. Data was collected from case notes and inputted onto Excel for analysis.
72 patients were included diagnosed as missed miscarriage. Out of these 40 patients (55.5%) opted for medical management, 27.8% opted for ERPC & 16.7% opted for conservative management. Patients in the medical management group, 100% were prescribed correct misoprostol regime with analgesia and all the patients had a follow-up scan in 2 weeks time (100%). 2 patients (5%) required emergency ERPC . 30 patients (75 %) had successful management (i.e complete miscarriage on follow-up scan after 2 weeks), 10 patients (25%) had failed medical management of these 2 patients were non-complaint to treatment. 3 patients opted for a repeat dose followed by diagnosis of complete miscarriage. Remaining 5 patients in the failed medical management group opted for elective ERPC.
The audit has shown medical management of missed miscarriage to be a safe & effective option for patients at Galway University Hospital with a success rate of 75% when proper misoprostol regime is followed and keeps the rate of surgical evacuation low.

AN AUDIT OF UNIVERSITY MATERNITY HOSPITAL LIMERICK'S PERINATAL MENTAL HEALTH REFERRAL PATHWAYS

Poster

Dr. David Rooney [1], ***Dr. Mas Mahady*** [2], ***Ms. Louise Reid*** [3]

1. University Hospital Galway, 2. University of Limerick, 3. University Maternity Hospital, Limerick

Psychiatric illness is a leading cause of morbidity/mortality in the perinatal period. The National Institute for Health and Clinical Excellence (NICE) and the Royal College of Obstetricians and Gynecologists (RCOG) recommend defined referral pathways from maternity services to local mental health services (LMHS), alongside training in perinatal mental health for maternity staff.

Our aim is to assess knowledge of current referral pathways from University Maternity Hospital Limerick (UMHL) to LMHS and to assess levels of training in accordance with RCOG & NICE guidelines.
An anonymous 6-part questionnaire with Yes/No answer options was circulated to all obstetric doctors, antenatal and postnatal midwives at UMHL. In total, 19 Doctors and 36 Midwives participated.
21% of doctor's vs 55.6% of midwives were aware of LMHS referral pathways (χ^2=6.019, p=0.014). 38% of postnatal midwives were aware of these pathways in comparison to 78.6% of antenatal midwives (χ^2=5.546, p=0.019). 47% of doctors and 55.6% of midwives know how to access LMHS. 47.6% of postnatal midwives know how to access these services in comparison to 71% of antenatal midwives. Only 26% of doctors and 8% of midwives have received training in perinatal mental health.
There is lack of knowledge among UMHL doctors and postnatal midwives of referral pathways to LMHS. There is insufficient knowledge on how to access LMHS, in addition to lack of education in perinatal mental health. Clarification will be sought from LMHS regarding specific referral pathways. Subsequently we will run perinatal mental health training for UMHL staff with a re-audit in 6 months-time.

AN AUDIT ON THE MANAGEMENT OF TWIN PREGNANCIES AT A TERTIARY REFERRAL HOSPITAL.

Poster

Dr. Laurentina Schaler [1]***, Ms. Julie Sloan*** [1]***, Prof. Aisling Martin*** [1]

1. *Obstetrics and Gynaecology, Coombe Women and Infants University Hospital, Dublin*

The rate of multiple pregnancies in Ireland is rising. The current rate of twin deliveries is 1.8% (Smith et al 2010).
The aim of this audit was to analyse the management of twin pregnancies at a large tertiary referral hospital based on recommendations of the national guideline on the management of multiple pregnancy.
A retrospective analysis was carried out on all twin pregnancies at the hospital between July 2016 and July 2017. Data was collected using an electronic secure database.
Overall there were n=191 twin pregnancies recorded at the hospital during the time period examined. There were n=43 monochorionic monamniotic (MCMA) and n=147 dichorionic diamniotic (DCDA) pregnancies. All cases booked at the hospital had a departmental ultrasound to determine chorionicity prior to 14 weeks gestation and were booked for consultant led care at a dedicated multiple birth clinic. In all cases of MCDA pregnancies antenatal corticosteroids were administered prior to 34 weeks gestation due to increased risk of preterm delivery as recommended by the national guideline. The rate of cesarean section was 60.5% (n=26) for MCDA and 66.6%(n=98) for DCDA pregnancies. There were n=4 cases of single twin demise and two cases of termination of pregnancy.
The outcome of this audit expressed overall compliance with national guidelines within the hospital in the management of twin pregnancies. Re-audit will be performed to ensure continued compliance.

AN UNUSUAL VULVAL LESION IN A SIXTEEN YEAR OLD

Poster

Dr. Joan Lennon [1]***, Dr. Sieglinde Mullers*** [2]***, Dr. Rosemary Harkin*** [3]***, Dr. John Ryan*** [4]

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J.Lennon, S. Mullers, R. Harkin, J Ryan
Departments of Obstetrics & Gynaecology, Pathology; Our Lady of Lourdes Hospital Drogheda

We present a case report of a sixteen year-old who presented to the Emergency Department of Our Lady of Lourdes, Drogheda. She reported a rapidly growing painless vulval lesion, present for six months which had markedly enlarged over several weeks. She denied sexual activity. Her past medical history was unremarkable, though family history revealed a brother with progressive osseous heteroplasia.

On examination, a 3x4cm pigmented, raised lesion was seen on her right labia. Smaller satellite lesions were noted on the left. The appearance was unlike other common vulval pathologies. Dermatological input was requested, and further examination of her skin, buccal and vaginal mucosa was unremarkable. The appearance was concerning for malignancy, therefore CT and MRI were performed. Numerous sub-centimetre pelvic and mesenteric lymph nodes were noted. A punch biopsy of the lesion did not recover sufficient tissue, and we proceeded to excisional biopsy. Initial histological analysis revealed inflammatory infiltration,without signs of infection or neoplasm. International expert opinion was sought, as an initial diagnosis of Histiocytosis X was considered, though later outruled. AF100 staining was negative. Further histological analysis demonstrated inflammatory neoplastic changes and a definitive diagnosis was not reached.

These lesions were highly unusual and concerning, though ultimately benign. Arriving at this conclusion required a multidisciplinary effort, highlighting the importance of specialist input in cases of rare vulval lesions.

ANALYSIS OF COMPARABLE HOME / CLINIC BLOOD PRESSURE READINGS IN THE LEANBH POPULATION

Poster

***Mr. Eoin Roche* [1], Dr. Yoke Lim [2], Prof. Louise C Kenny [3]**

1. School of Medicine, University College Cork, Ireland, 2. Department of Obstetrics and Gynaecology, University College Cork, Ireland and The Irish Centre for Fetal and Neonatal Translational Research (INFANT), University College Cork, Ireland, 3. The Irish Centre for Fetal and Neonatal Translational Research (INFANT) & Cork University Maternity Hospital, Cork.

Background:
Hypertensive disorders of pregnancy consist of a broad spectrum of conditions which are associated with significant negative outcomes for both mother and child. These disorders are common and are estimated to complicate 10-15% of all pregnancies. Regular home blood pressure monitoring can be used as a way of identifying hypertension outside of the hospital clinic.
Aims and Objectives:
To determine the relationship between home and hospital blood pressure readings in a cohort of pregnant women.
Methods:
This study used the LEANBH (Learning to Evaluate and manage ANtenatal Blood pressure at Home) cohort data. This cohort consisted of 52 healthy primigravida singleton women age 21-44 years not receiving treatment for hypertension. SBP (systolic blood pressure) and DBP (diastolic blood pressure) was obtained during hospital antenatal visits and regularly at home via patient self-monitoring using a Microlife WatchBP Home Monitor. The home vs hospital SBP and DBP was investigated to identify cases of white coat or masked hypertension. The effect of increased SBP or DBP on pregnancy outcome was analysed.
Results:
Results demonstrated mean hospital (122+/-15 p=0.001) systolic blood pressure is significantly higher than home (108+/-8 p=0.001). Moreover, hospital (77 ± 10 p=0.001) diastolic blood pressure is also significantly higher than home (64 ± 6 p=0.001).
Discussion and Conclusion:
Home BP monitoring appears to be a potentially useful addition to routine antenatal care. A further large randomised controlled trial is necessary and planned to identify potential statistical significance.

Analysis of Newspaper Coverage of Obstetric and Gynaecology Care – A Mixed Methods Study

Oral (Jogs)

Dr. Sorca O Brien [1]***, Prof. mary higgins*** [1]

1. *National Maternity Hospital, Dublin*

News media plays a central role as a source of
information regarding health care and medical therapies.
There has been increasing interest in healthcare with a rise in media coverage particularly of obstetric and maternity events. General perception anecdotally is that coverage is largely focused on adverse events and the majority are of
negative viewpoint.

Aim to evaluate the content of lay press reporting/coverage
of maternity and gynaecology care (womens health)
between Ireland and the UK.
A prospective qualitative study. The highest circulation
broadsheet and tabloid were identified for each jurisdiction.
Those media resources were sampled for week one of
the month (March-June). The number of
womens issues/health articles were quantified, content
analysis performed and thematic analysis until saturation. Stories were categorized positive, negative or neutral
Ireland - highest circulating paper = The Independent, tabloid = The Star.
U.K. - highest circulating Broadsheet = The Guardian , tabloid = The Sun.
Over 250 articles were published during study period covering womens health or issues . Articles were more likely to be neutral and fact based or negative than positive. The majority of UK tabloid coverage related to "Bump Watch" i.e. celebrity pregnancy. Health related coverage was also more likely to be sensationalist and dramatic. Overall there was more coverage of stories relating to women/maternity than in The Guardian but was largely superficial.
News media are an important source of information for
prospective patients. The material covered and the
methods used can have far reaching results both positively and negatively.

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

Oral (Jogs)

Dr. Niamh Murphy [1]***, Dr. Naomi Burke*** [1]***, Dr. Gerry Burke*** [2]***, Prof. Fionnuala Breathnach*** [1]***, Prof. Fionnuala McAuliffe*** [3]***, Prof. John J Morrison*** [4]***, Prof. Michael Turner*** [5]***, Dr. Samina Dornan*** [6]***, Prof. John Higgins*** [7]***, Prof. Amanda Cotter*** [2]***, Prof. Michael Geary*** [8]***, Ms. Fiona Cody*** [8]***, Prof. Peter McParland*** [9]***, Ms. Cecelia Mulcahy*** [9]***, Prof. Sean Daly*** [10]***, Dr. Patrick Dicker*** [11]***, Prof. Fergal Malone*** [1]

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Background: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 them antenatally. The GENESIS study was a prospective, blinded observational study carried out by the Perinatal Ireland Research Consortium from October 2012 to June 2015. 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 EFW.

Purpose: The aim of this study was to examine those women who underwent emergency CD despite having a low predictive risk score for same.

Study Design: We analysed the outcomes of women with a low predictive risk score who underwent CD. Peripartum events, as well as decision for emergency CD were examined.

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

69% of women (n=25) underwent CD for NRCTG. 56% of these women (n=14) were having continuous CTG monitoring performed

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

Conclusion: The majority of women in this study who underwent emergency CD for NRCTG had 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

ANTIBIOTIC USE IN PROLONGED PREMATURE RUPTURE OF MEMBRANES (PPROM) AND PROLONGED RUPTURE OF MEMBRANES (PROM) AND THE PRESENCE OF GROUP B STREPTOCOCCUS (GBS).

Poster

Dr. Sophie Boyd [1], ***Dr. Amy Fogarty*** [1], ***Dr. Mendinaro Imcha*** [1]

1. University Maternity Hospital, Limerick

PPROM is a complication of approximately 2% of pregnancies but is the cause of 40% of preterm deliveries. The overuse of antibiotics can lead to resistance. The incidence of Early Onset Group B Streptococcal Disease (EOGBS) in prolonged rupture of membranes at term is 1:556. Thus in asymptomatic women at term, 5000 need to be treated to prevent one case of EOGBS.

The purpose of this retrospective study was to establish the extent of antibiotic use in women with PPROM and PROM and their GBS status.

A list was compiled of women admitted with PPROM or PROM to the antenatal ward over a six-month period; 01/07/2016-31/12/2017. The type, dose and duration of antibiotic used was recorded for each woman along with the GBS status and site of sample taken.

A total of 30 women with PPROM and 135 women with PROM were admitted. 31% of women with PPROM and 23% of women with PROM were GBS positive. Antibiotic therapy was administered in 93% of women with PPROM and 59% of women with PROM. The number of intravenous antibiotic doses ranged from 1 to 37 with up to 137 oral antibiotic doses being given.

The data collected highlights the impact delay in obtaining GBS status has on increased antibiotic usage in the antenatal and perinatal period. The results support the benefit a point of care diagnostic test for GBS would provide.

Are we sitting on this labial cyst?

Poster

Dr. Davor Zibar [1]***, Dr. Chris Phillips*** [1]***, Dr. Hassan Rajab*** [1]***, Dr. Conor Harrity*** [1]

1. *Beaumont Hospital*

Vulval abscesses, especially Bartholins abscess are a common gynaecological presentation to the emergency department(ED) and the general practitioner's surgery accounting for up to 2% of all presentations.
Case report: A 74 year old woman presented to the ED with a 4 week history of right labial swelling extending to her suprapubic region.
Medically she suffers from active, seropositive, erosive rheumatoid arthritis, latent tuberculosis, recurrent urinary tract infections and multiple cervical spinal surgeries.
She was immunosuppressed on methotrexate, prednisolone and tocilizumab.
Upon admission her suprapubic region was red, warm to touch, swollen, forming an abscess like structure measuring 10x5 cm. There was a punctum at the right labia but no drainage upon compression through it. IV antibiotics were commenced and CT pelvis performed. It has showed multiloculated collection anterior to the pubic symphysis with enhancing septations containing large locules of air suggestive of abscess. Incision and drainage was performed and group G/C streptococcus was isolated from the sample. Clinically the patient improved but swelling hadn't decreased. Orthopaedics and microbiology teams' opinions were sought and subsequent MRI pelvis was performed. It had shown reduction of the superficial content of the pelvic abscess with a suggestive findings of osteomyelitis of the left inferior pubic ramus.
Patient was transferred to the infectious diseases team and was on a long term antibiotic treatment. Subsequent MRI has shown partial resolution of the abscess.
This case presents a complexity involving several specialities that can arise from a simple gynaecological presentation if not treated on time.

AUDIT OF HIPE CODING OF GYNAECOLOGY PROCEDURES FOR ENDOMETRIOSIS IN TALLAGHT HOSPITAL

Poster

Dr. Eimear McSharry [1], ***Dr. Aoife O'Neill*** [2]

1. Coom, 2. Tall

The Hospital Pricing Office uses HIPE (Hospital in-patient enquiry system) coding to allocate funds to the hospital based on an Activity Based Funding model. Endometriosis is a complex disease process and surgical treatment is associated with significant risks of bladder and bowel injury.

This audit aimed to establish if HIPE coding currently reflects surgical endometriosis in-patient and day-case patient care, including capturing interdisciplinary collaboration with Colorectal and Urology specialists, complications and reflecting the surgical complexity of cases.

A retrospective review of the charts and associated HIPE coding of ten patients who underwent surgery for endometriosis under one consultant Gynaecologist between January 2014 and January 2017 was performed.

Procedures were correctly HIPE coded in 40% of cases. There was a high rate of omission of coding for procedures performed (50%). A total of eight surgical procedures, relating to five cases, were not coded for, including; bilateral ovarian cystectomy, hysterectomy and ureterolysis. In half of the cases a procedure which had not been performed was coded for and wrongly attributed to that care episode, including sterilisation, hysterectomy and staging laparotomy. Colorectal surgical involvement occurred in five of the ten cases however was recorded in only one case (20% n=5).

Activity based funding is the sole mechanism by which care will be funded in the near future in our hospitals. It is imperative departments ensure correct coding of their practice or face serious implications for department funding and thus provision of services.

AUDIT OF PATIENTS IN A PUBLIC INFERTILITY CLINIC

Poster

Dr. Laura O'Byrne [1], ***Dr. Nadine Farah*** [1]

1. *Obstetrics and Gynaecology, Coombe Women and Infants University Hospital, Dublin*

BACKGROUND: The Coombe Womens and InfantsUniversity Hospital runs a publicly funded infertility clinic. The aim of this study was to review the demographics and waiting times of the first 100patients attending the clinic in 2016.
METHODS: Retrospective audit of 100 patientcharts using a proforma detailing referral waiting time, age, parity, BMI,smoking status and investigation findings.
FINDINGS: The women attending the clinic were onaverage waiting 74 weeks from referral from GP to clinic visit. Average age was33 years with range from 21-45. Of all those attending 62% were eitheroverweight or obese. Primary infertility affected 53% of women and there were17 women who were recorded as smokers.
In the under 30 year old group(n23) 65% wereoverweight or obese, 26% were smokers and ovulation dysfunction affected 52%.Inthe 30-35 year old group(n30) ovulation dysfunction affected 36% of patientsand only 46% were overweight or obese. In the 35-40 year old group(n29) 65%were overweight or obese, ovulation dysfunction affected 48% of the women. Inthe above 40 year old group women 72% of the women were either overweight or obese, ovulationdysfunction affected 27% of the women and 28% had unexplained infertility.
CONCLUSION: There is an opportunity withinprimary care to maximize patient lifestyle factors particularly weight andsmoking cessation. If patients are of older age consideration for referraldirectly to IVF centers may be of greater benefit.

Audit of Referral to Review Waiting Times for Women Referred to a Tertiary Unit with Postmenopausal Bleeding

Poster

Dr. Maebh Horan [1] ***, Dr. Cathy Burke*** [1]

1. *Cork University Maternity Hospital, Cork*

Endometrial cancer is the 5th most common cancer among women in Ireland, with an average of 465 new cases diagnosed each year between 2012 and 2014. The UK based National Institute for Clinical Excellence (NICE) recommends a two week waiting time for investigation in this cohort. The Irish National Clinical Guideline on Investigation of Postmenopausal bleeding (PMB) states that patients presenting with PMB should be seen and referred promptly. In the absence of specifically stated waiting time targets in this guideline, a six week referral-to-review waiting target is used in our unit.

We undertook an audit of referral-to-review waiting times for patients attending the postmenopausal bleeding (PMB) clinic at Cork University Maternity Hospital (CUMH) between January and December 2016.

196 women were seen in the PMB clinic in 2016. Average number of days from the date of referral to review in OPD was 49 days (7 weeks).

Our referral-to-review waiting time is one week outside our local target and well outside that of the NICE target. With an increasing rate of endometrial cancer in Ireland, we suggest provision of an appropriate number of PMB and one-stop investigation clinics nationally for this high-risk group. We suggest that a national waiting time target for investigation of PMB be set and included in the National Clinical Guideline. Adherence to this national target would be assured by the National Womens and Infants Health Programme.

AUDIT OF REFERRALS TO THE ROTUNDA HOSPITAL RECURRENT MISCARRIAGE CLINIC

Poster

Dr. Niamh Murphy [1], *Ms. Patricia Fletcher* [1], *Dr. Karen Flood* [1]

1. Obstetrics and Gynaecology, Rotunda Hospital, Dublin

Background: This audit was performed to examine the indication for referral to the Recurrent Miscarriage clinic. The team involved in the clinic felt that there were a high number of inappropriate referrals, which did not fulfil the referral criteria and wished to examine this closer

Purpose of study: The referral guidelines for this clinic are for women who have experienced 3 or more consecutive miscarriages, women aged over 38 who have experienced 2 or more consecutive miscarriages or women who have had 2 or more second trimester miscarriages. Our aim was to assess if our referrals were appropriate given the above.

Study Design and Methods: We retrospectively examined the charts of the last 30 new referrals to the recurrent miscarriage clinic and used Excel to analyse the results

Findings of the Study: Overall 83% of referrals were appropriate. The remainder involved women who did not fulful the criteria for referral and had been referred from either their General Practitioner or the Early Pregnancy Unit

Conclusions and programme implications:

1. The majority of referrals were appropriate and met the referral guidelines
2. 3/5 of the inappropriate referrals were from the EPU and our aim is to inform the relevant midwifery and medical staff of the correct referral criteria
3. 2/5 of the inappropriate referrals were from General Practitioners in the community and we will inform them of our accurate referral criteria in our follow up correspondence with them

AUDIT OF TEENAGE PREGNANCY OUTCOMES

Poster

Dr. Saeeda M Wazir [1], ***Dr. Saba Javed*** [1], ***Dr. Murtaza Essajee*** [1]

1. *Department of Obstetrics and Gynaecology, Cavan Monaghan General Hospital.*

Introduction: Teenage pregnancy is defined as a teenage girl within the ages of 13-19 becoming pregnant (UNICEF).teenage pregnancies are often unplanned & carry extra health risks to both the mother & the baby.
Purpose of Study: The aim of the study was to determine the incidence of teenage pregnancy,identify the associated risk factors & to learn about current guidance on the prevention & management of teenage pregnancies.
Study Design & Methods: This was a retrospective studyTeenage pregnancies between 1st Jan 2011-31st Dec 2015 (5yrs) were identified through the Maternity Information System. Case notes wereretrieved, &analysed.
Findings: Total number of patients were 184 and the rate of teenage pregnancies has been steady at approx 2.0%.Significant risk factors were identified includingSmoking 33%,anemia 21%,unemployment 85%,Late bookers 18%,Drugs 5%,Social Deprivation 3.8%, mental issues 6%,social services involvement 34%,STI 0.5%,hypertensive disorders 1.6%,Preterm labour and delivery 8%,Low birth weight/SGA 2.7%
The mean BMI 23.4,mean birth weight was 33319gms and the mean maternal age was 17.The youngest patient was 14 years of age.13% were primigravidas and 87% were muligravidas.92% delivered at gestation >37 weeks and 3% delivered at <32 weeks.
Conclusions: Reducing teenage pregnancy is central to improved outcomes for young men & women It will reduce the negative consequences on the mother & the child as well as the cost associated with addressing the poor outcomes for young parents & their children.

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AUDIT OF VBAC OF THE ROBINSON GROUP 5

Poster

Dr. Consol Plans [1], ***Dr. Munaza Wajahat*** [1], ***Dr. Elizabeth Dunne*** [1]

1. *Department of Obstetrics and Gynaecology, Wexford General Hospital.*

Caesarean sections (CS) rate is increasing, and repeat CS after a previous CS is a significant contributor to the overall CS rate. Vaginal birth after caesarean (VBAC) is considered a safe alternative, assuming success rates of >70%.

The purpose of this study was to review patients with previous C/S falling in Robinson group 5 and analyse their outcome, to suggest policy changes which may safely increase VBAC success without increasing fetal and maternal morbidity.

A retrospective study was conducted from May 2016 to April 2017. Data was collected from charts classified as Robinson group 5. Demographic data recorded included patient age, parity and BMI. In addition, number of previous SVD or VBACs, previous identified risk factors, aiming for VBAC at booking and reasons for failed VBAC was collected.

The absolute rate of successful VBAC in our study was 24%. However, those who opted for trial of VBAC the rate was 62%. Aiming for VBAC at booking accounts for 56% of our population, but only 39% of them had a trial of labour. It is also worthwhile to mention, that 37% of our population didn't aim for VBAC, and maternal request was the most common indication for repeat elective CS.

Overall, we should emphasize the management in first CS as increase number of repeat CS. Furthermore, Robinson group 2 should be review to reduce number of IOL and consequently the number of CS. Strategies suggested are; early booking by consultant, antenatal clinics counselling and low risk pregnancies should reach term+10 days.

AUDIT ON DOCUMENTATION OF MEDICAL STAFF IN MATERNITY WARD OF MIDLAND REGIONAL HOSPITAL PORTLAOISE

Poster

Dr. sheema yousuf [1]

1. HSE MIDLAND REGIONAL HOSPITAL PORTLAOISE

AUDIT ON DOCUMENTATION OF MEDICAL STAFF IN MATERNITY WARD OF MIDLAND REGIONAL HOSPITAL PORTLAOISE(MRHP)

Dr.Sheema Yousuf, Dr. Niamh Maher.

Documentation is an important element in medical professionalism. It serves as proof of having attended and reviewed the patient and importantly provides better care to our patients. Ideally all documentation should include practitioner's name, medical council registration number (MCRN),job title, bleep number, date, time, patient details (name, healthcare record number and date of birth) or addressograph and should be legible.

The objective of this audit was to assess the local compliance of medical staff in record keeping.

A prospective audit was conducted on 06/09/2017 in maternity ward of Midland Regional Hospital Portlaoise (MRHP). All charts of current inpatients were included in the audit and the most recent medical entry was assessed across the following variables: doctors signature, MCRN, contact details , job title, legibility, date, time and patient addressograph/details.

Eighteen charts from the maternity ward of MRHP were eligible for inclusion. Doctors signature, date and time was documented in all charts showing 100% compliance (n=18). Job title was documented in 50% (n=9), MCRN in 94% (n=17), contact details in 33% (n=6) and patient addressograph/details in 83% (n=15). For legibility compliance was 100% (n=18).

This audit shows that medical staff at MRHP are compliant with good record keeping in the majority of areas assessed. However, further education and reaudit are required especially in relation to documentation of job title and contact details.

AUDIT REPORT ON OPERATIVE VAGINAL DELIVERY

Poster

***Dr. Consol Plans* [1], *Dr. Ahmed Abbas* [2], *Dr. Maria Farren* [1], *Dr. Bushra Faiz* [1], *Dr. Elizabeth Dunne* [1]**

***1.** Department of Obstetrics and Gynaecology, Wexford General Hospital., **2.** Department of anesthesia, Wexford General Hospital*

Operative vaginal delivery (OVD) has an important role in reducing cesarean section (CS) rate and/or fetal adverse outcomes. However, OVD carry their own risks to both mother and baby. Therefore, its indication should adhere to the policy.

The purpose of the study was to review the OVD practice compliance with the hospital policy and suggested changes which may safely reduce OVD rate without increasing CS rate.

A prospective study was conducted from March to May 2017. Data from women delivered within this period were collected in a form, including demographic data, labour analgesia, indication for instrumental and duration of second stage of labour.

In our study 12% of all deliveries were OVDs. Amongst those, 77.6% were nulliparous, 44.9% postdates and 33% induced. 25% of the epidural group had OVD while only 5.04% of the OVD did not use epidural. Oxytocin was administered in 77.7% of cases of maternal indication. Fetal blood sampling (FBS) was performed only in 9.8% of cases. Regarding duration of second stage of labour, only 20% waited > 60 min. before pushing and active pushing for > 60 min. accounted for 39.2%.

In our results, association between epidural analgesia and rate of OVD is evident. We suggest to allow this group to push longer, specially in nulliparous and consider performing FBS in second stage of labour in cases of inconclusive CTG. Furthermore, early epidural when cervix is ≤ 3cm. dilated and use high volume/low concentration of LA agent for loading lose may decrease the rate of OVD.

Audit: The presence of perimortem caesarian section trays on cardiac arrest trolleys in Our Lady of Lourdes Hospital, Drogheda

Poster

Dr. Daniel Kane [1]

1. Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda

Maternal cardiac arrest is a rare event, affecting approximately 1:20,000 to 1:30,000 pregnancies in the United Kingdom.[1] In the US this number was estimated at approximately 1:12,000 admissions over a 10-year period, with survival in one study being 58%.[2] Regardless of the fact that it is a rare event, when a maternal cardiac arrest does occur, the speed at which initial resuscitation begins as well as the performance of a perimortem caesarian section if indicated is a key factor in a positive outcome.
Therefore, the prompt availability of an emergency caesarian kit on all cardiac arrest trollies cannot be underestimated. Effective and prompt resuscitation not only improves the primary outcome for the mother but also of the fetus.[3]This is especially the case as the children and mothers who survive emergency caesarean deliveries are usually delivered within five minutes of maternal cardiac arrest. [4] It should also be noted that in several case reports a return of spontaneous circulation or improvement in maternal haemodynamic status occurred only after the uterus had been emptied. [5,6,7]
All cardiac arrest trollies in areas (5) where pregnant patients could be cared for were audited in Our Lady of Lourdes Hospital in Drogheda. It was found that none of the cardiac arrest trollies had a peri-mortem caesarian section kit contained on them. There were peri-mortem caesarian section kits available in each area, however, some of these were not labelled and were not kept near the arrest trollies.

AVOIDING LOOKING THROUGH ROSE TINTED HYSTEROSCOPES

Poster

Dr. Sumaira Tariq [1], ***Dr. Nikhil Purandare (Cons)*** [1]

***1.** University Hospital Galway*

To reduce operating time and offer a safer technique for hysteroscopic myomectomy.
Submucosal fibroids result in abnormal uterine bleeding and infertility leading to hysteroscopic resections. The data on whether submucous fibroids should be removed is conflicting. The Cochrane(1) suggests that there is not enough evidence to recommend hysteroscopic resection of submucous fibroids. The AAGL recommends the removal of submuscous fibroids in infertility and in selected patients with abnormal uterine bleeding and recurrent pregnancy loss(2). Nevertheless as clinicians we often encounter patients that need submucous fibroids resected either for menorrhagia or for fertility/recurrent miscarriages. Hemorrhage during hysteroscopic morcellation can completely obscure the operator's hysteroscopic visual field leading to uterine perforation, increase in resection time and increase fluid loss, as they dont have electrocoagulation.
To avoid this blinding effect of bleeding, submucosal fibroids can be injected with a vasoconstrictor prior to morcellation.
Single centre case series, 13 patients were recruited with single or multiple endometrial polyps or submucosal fibroids ranging in size from 0.5 cm to 3 cm diameter. Patients were given Misoprostol preoperatively, minimal cervical dilatations were performed and operative hysteroscopes were inserted under direct vision with normal saline as distending media. The submucosal fibroids were injected with 2-5 vials of 2.2 mls of Citanest® with Octapressin safely without causing any systemic adverse effects. Immediate devasularizations effects were noted in all cases. The fibroids were than morcellated. The average fluid deficit of 372.5 mls was obtained.
Unfortunately in 1 case fibroids had a very solid consistency and Octapressin couldn't be injected.

BIRTHDAYS PAST: PREGNANCY AND CHILDBIRTH IN THE ARCHAEOLOGICAL RECORD

Oral (Jogs)

Dr. Joan Lennon [1], ***Dr. Clíodhna Ní Mhurchú*** [2]

1. *Our Lady of,* ***2.*** *Cork University Hospital*

J. Lennon, C. Ní Mhurchú

Department of Obstetrics& Gynaecology, The Rotunda Hospital; Department of Haematology, Cork University Hospital

The archaeological record is a unique source of information. The study of human remains, iconography and art provide intimate insights into past human activity. For most of human existence childbirth and delivery were associated with severe morbidity and mortality. However, the development of modern obstetrics has made parturition safer.

In this presentation we outline both the uniquely human reasons for this danger and the uniquely human responses, exploring depictions of obstetric practice and childbirth. We also discuss instances where maternal or peri-partum deaths were captured in the skeletal record, and explain why these cases are rarer than perhaps expected. The general invisibility of direct obstetric complications, the fragility of neonatal remains and the under-representation of women and infants in archaeological interpretation are responsible for the scarcity of evidence

Our aim is to provide a brief insight into childbirth through the ages, using select examples from a variety of sources. We feel this is a broadly appealing topic and certainly one which deserves attention, as women and children have often been overlooked during historical research. We wish to reflect on the past in order to highlight the full breadth of advances achieved by modern obstetric care

CAN WE INCENTIVISE OUTPATIENT HYSTEROSCOPY AND PROMOTE ECONOMIC EFFICIENCY?

Oral (Jogs)

Dr. David Crosby [1], Dr. Niamh Fee [2], Dr. Lucia Hartigan [1], Dr. Louise Glover [3], Dr. Fiona Martyn [1], Dr. Mary Wingfield [1]

***1.** National Maternity Hospital, **2.** National Maternity Hospital, Dublin, **3.** Merrion Fertility Clinic, Dublin*

An outpatient hysteroscopy (OPH) service has proven to be beneficial for women and healthcare facilities. Analysis of cost saving is an important factor in planning service provision. In the English NHS, a national tariff system, based on “payment by results”, was introduced in 1990. In 2012, best practice tariffs were introduced to incentivise outpatient procedures.

The aim of this study was to assess the OPH service in our unit, theoretically using the NHS tariff system, prior to and after the introduction of incentives. Data was prospectively entered into a computerized database from January to December 2016. The cost of OPH followed by GA hysteroscopy if required was compared to the cost of GA hysteroscopy for all. Cost analysis was performed using the NHS model.
Of the 182 appointments to the OPH service,115(63.2%) underwent an OPH. Of these,27(23.5%) women required a further procedure under GA. Using the non-incentivised NHS system, OPH followed by GA hysteroscopy if indicated would have yielded a lower tariff paid to the hospital then directly performing GA hysteroscopy (£52,327vs.£88,665), losing the hospital £36,338. Using 2016 figures and the incentivised rates, OPH followed by GA hysteroscopy would have yielded a higher tariff paid to the hospital (£64,424vs£32,430), gaining the hospital £31,994.
Our study demonstrates, that if a tariff system was introduced to incentivise outpatient procedures, similar to the English NHS, there would be a theoretical increase in the amount of funding provided to the hospital, focussing on “payment by results” and promoting economic efficiency in the healthcare system.

Case presentation

Poster

Dr. ZULFIYA MAMAEVA [1]

1. *Coombe Women and Infants University Hospital, Dublin*

Second episode of Ectopic pregnancy in the remnant of the fallopian tube.

CASE REPORT: MANAGMENT OF MOYAMOYA DISEASE IN PREGNANCY AND DELIVERY

Poster

Dr. Marwa Mohamed [1]***, Dr. Mudathir Abdelmaboud*** [1]***, Prof. John Higgins*** [2]

1. *Cork University Maternity Hospital, Cork,* ***2.*** *Obstetrics and Gynaecology, University College Cork, Cork University Maternity Hospital, Cork*

Introduction: Moyamoya disease is a rare, cerebrovascular disorder caused by blocked arteries at the base of the brain in the basal ganglia. The difficulty in managing moyamoya disease in pregnancy arise from the fact that its adversely affected by the hemodynamic instability that can develop during pregnancy and parturition exposing the patient to the risks of thrombotic or haemorrhagic cerebrovascular events.

Case:

31years old ,gravid 2 para 1 presented for dating scan at 12+3 weeks. she was diagnosed with Moyamoya disease in 2014 after presenting with excessive dysphasia and right arm in coordination .she was found to have multiple infarct in the left occipital and parietal lobes bilateral intracranial internal carotid artery occlusions and posterior communicating artery aneurysm.She subsequently went for left external/internal carotid bypass in February 2014. She was commenced on a Asprin for life.

she was refer to the high risk antenatal clinic.

She was then followed up regularly under Multidisciplinary team consisting of fetal medicine obstetrician hematologist neurologist and anesthetist. She was delivered at 37+4 weeks by LSCS under Epidural anasthesia.she had no neurological complication in the postnatal period and was discharged on prophylactic innohep for 6 weeks postnatally.

conclusion:

in patient with Moyamoya disease , caesarian section under epidural is considered a safe option to overcome the risks of hemorrhagic and thrombotic cerebral events with valsalva in labour.

Case Report: More than a Secondary PPH

Poster

Dr. Thomas Mc Donagh [1]

1. *Letterkenny University Hospital*

Case Report: More than a secondary PPH

T. Mc Donagh, F. Shireen, C. King

Letterkenny general Hospital, Donegal, Ireland

Choriocarcinoma occuring after a normal pregnancy is a rare event with an incidence of one per 160,000. It is characterized by a malignant tumor of syntiotrophoblasts and cytotrophoblasts with a propensity to metastasize early.Secondary Postpartum Haemorrhage (PPH) is defined as bleeding from 24 hours after the 3rd stage of labour up to 6 weeks post partum. It occurs in just under 1% of women.The main causes are retained products of conception and endometritis.

A 39 yr old presented 6 weeks post partum with heavy vaginal bleeding. She was initially managed medically as a secondary PPH but underwent evacuation of retained products of conception due to profuse bleeding. Histopathological examination confirmed choriocarcinoma and a staging CT demonstrated lung involvement. She was staged as grade 9 WHO metastatic choriocarcinoma and was successfully treated with 11 cycles of EMA-CO at a tertiary center. She remained well and was in disease remission 6 months post treatment.

Clinicians should be aware of this rare cause of secondary PPH which if untreated has a very poor prognosis.

Case report: Ruptured Renal Calyx & Septic Shock in a 22-year-old primigravida

Poster

Dr. Daniel Kane [1]

1. *Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda*

Sepsis in pregnancy is known to be one of the biggest causes of maternal morbidity and mortality. Prompt recognition and treatment results in increased positive outcomes for women and their pregnancies.
SS is a 22-year-old primigravida who presented at 20 weeks gestation with right flank pain and feeling general unwell for 2 days. Her vitals were as follows: HR 113, BP 92/56, Temp of 38.7, Respiratory Rate of 14 and O2 saturations of 96% on room air.
Clinical examination revealed right flank tenderness. A provisional diagnosis of pyelonephritis was made. The 'sepsis 6' was performed within 40 minutes of presentation. Blood results showed a leukocytosis as well as a markedly elevated CRP. Urine dipstick showed +3 blood, +2 ketones, +nitrites and +leukocytes. An ultrasound of her kidneys showed a right dilated ureter secondary to obstruction and free fluid, suggesting a ruptured calyx and pyelonephritis. A urology consult suggested that it be initially treated conservatively.
Over the next 10 hours, SS continued to drop her blood pressure despite aggressive fluid resuscitation and a diagnosis of septic shock was made. She was transferred to the ICU where she was commenced on inotropes. Her condition deteriorated further resulting in SS being intubated and ventilated and being transferred to a tertiary centre for nephrostomy insertion by Interventional Radiology. One day post procedure, SS was discharged from ICU and within three home. She will have a nephrostomy in situ until birth. Fetal well being scans have shown no adverse affects to the fetus.

CATEGORY ONE C-SECTIONS: IS THERE AVOIDABLE DELAYS?

Poster

Dr. Emmanuel Hakem [1]***, Dr. Katharine Astbury*** [2]

1. *Galwa,* ***2.*** *University Hospital Galway*

Background:

Category 1 CS should be performed within 30 minutes from the decision to delivery. Delays could lead to bad outcome.

Purpose of the Study:

To assess the performance of our unit in category 1 emergency CS's and to look for avoidable causes and how to tackle it to achieve better outcomes.

Methods:

Retrospective 1-year audit, included 113 patients who had category 1 CS in Galway university hospital. Variables examined were, decision time, delivery time, indication of the CS, type of anaesthesia given and causes of delay if present.

Findings:

Delay > 30 mins occurred in category 1 CS in 15.9% (n=18), 33.3% (n=6) occurred due to patient being outside the delivery suite, 5.6% (n=1) due to no available free theatre and 5.6% (n=1) due to delay from staff. Patients with effective epidural analgesia at the time of decision of the CS, delivery was achieved in 95.7% (n=45) within 30 minutes from the decision time.

Conclusion:

Effective communication and situational awareness are crucial factors in preventing delays in emergencies such as category 1 CS. The presence of an effective epidural analgesia is another important key factor in achieving a quick delivery in category 1 CS.

Cervical ectopic – a case study

Poster

Dr. Kate Glennon [1], ***Dr. Elizabeth Dunn*** [2]

1. *National Maternity Hospital,* ***2.*** *Department of Obstetrics and Gynaecology, Wexford General Hospital.*

A cervical ectopic pregnancy presents a complex diagnostic and management problem. The incidence of ectopic pregnancies is 1-2% with a cervical ectopic complicating <1% of all ectopic pregnancies.
We present the case of a 32 year old P0+1 who was diagnosied with a cervical ectopic. This case demonstrates the difficulty in diagnosis and subsequent management of this pregnancy. The importance of inclusion of the multi disciplinary team is highlighted.

This 36year old presented to the ED with pv spotting. A gestational sac was demonstrated low in the cervical canal. During a subsequent admission, the crl of the fetus was increasing in size but remained low in the canal. A diagnosis of cervical ectopic was made.
She was transferred to a tertiary unit for further management. The diagnosis was confirmed on ultrasound. Significant trophoblast was noted in the lower fundus. She was treated with mifepristone 200mg and methotrexate 100mg administered at 1240. A plan was made to proceed to an ERPC the following morning.
She began to bleed on the ward 3 hours post methotrexate and lost approximately 1000ml. She was subsequently transferred to theatre. A gentle dilation and curettage under ultrasound guidance was performed. She was transfused 4 units of PRC, 2g of fibrinogen and 2 units of FFP. Uterontonics were administered and bleeding subsided after a total loss of 2.4litres. A rushch balloon was inserted to maintain haemostasis
She recovered well post operatively and was discharged on day three.

Challenges faced by pro thrombotic states in the management of TTTS

Poster

Dr. Suzanne Smyth [1], ***Dr. Keelin O'Donoghue*** [2]

1. *Centre for Perinatal Research, UCD Obstetrics and Gynaecology, University College Dublin, National Maternity Hospital,* ***2.*** *Department of Obstetrics and Gynaecology, University College Cork, Ireland and The Irish Centre for Fetal and Neonatal Translational Research (INFANT), University College Cork, Ireland*

This case represents a challenging medical dilemma where the health of the mother and the potential fetal and neonatal morbidity and mortality are almost contradictory. This patient presented at 10/40 for a dating ultrasound scan and a monochorionic twin pregnancy was confirmed. She had a complex history of venous thromboembolism with no known thrombophilia.

Signs of TTTS were first noted at 18/40 and rapidly evolved to Stage 3. Coupled with progressively developing TTTS the patient had a very high risk for recurrent thrombosis as she had previously developed a pulmonary embolism while receiving therapeutic anticoagulation. Additionally, multiple pregnancy is an independent risk factor for thrombosis and polyhydramnios, one of the recognised stages of TTTS , can further increase this risk. Successful fetoscopic laser ablation was performed at a dedicated fetal unit in the UK with guidance from haematology in both Ireland and the NHS trust responsible. A greenfield filter was temporarily placed , the dose of therapeutic anticoagulation was halved the night preceeding the fetoscopic surgery and again the night following the procedure. Full dose thromboprophylaxis was resumed the following day. In this instance the anticoagulation was successful in that there was no further VTE for the duration of the pregnancy or the puerperium. The fetoscopic laser ablation was also successfully managed and the babies were delivered by elective Caesarean Section at 34 / 40.Prior to delivery fetal MRI did not reveal any interventricular hemorrhage and the babies are currently both well and free of any neurological sequelae.

Complete Uterine didelphys resulting in hematocolpos and pyometra: A case report and review of the literature

Poster

Dr. Michelle McCarthy [1], ***Dr. John Coulter*** [1]

1. *Cork University Maternity Hospital, Cork*

Complete uterine didelphys is a rare Müllerian duct anomaly where embryologic failure of fusion of the Müllerian ducts results in the uterus presenting as a paired organ, with two separate cervices, 2 canals, and a single introitus. Abnormalities can be categorised according to the classifications by Buttram Jr. and Gibbons (1979) and the American Fertility Society (1988). MRI can often aid diagnosis of abnormalities, however it has a detection rate of just 53% (Economy 2002).

We describe the case of as nulliparous 44 year-old with this condition, who experienced recurrent pelvic infections due to hematocolpos.

The patient was diagnosed with bicornuate uterus on ultrasound aged sixteen following ongoing malodorous leucorrhoea and inter-menstrual bleeding since menarche aged 11. Ipsilateral renal agenesis of the right kidney was also diagnosed at this time.

She was attended gynaecology services in 2014 with symptoms of severe abdominal pain and malodorous discharge. She was treated for recurrent episodes of pelvic inflammatory disease with antibiotics. Clinical examination and MRI scan revealed complete didelphys, with a collection in the right cavity. At hysteroscopy, D&C in 2016, examination demonstrated a normal left vaginal canal, cervix and uterine horn, and a right stenosed vaginal canal and stenosed hemi-cervix. Careful dilation was performed to drain purulent fluid from the right uterine horn. Symptoms reoccurred in 2017, and a repeat procedure was performed after which the patient was discharged on antibiotics.

Following surgery, we are trialling progesterone in the form of oral norethisterone to decrease uterine bleeding and reduce outflow obstruction.

CONSEQUENCES OF PREGNANCY AFTER ENDOMETRIAL ABLATION

Poster

Dr. Sara Mohan [1]***, Dr. Grace Ryan*** [1]***, Dr. Jasmeet Kumari*** [1]***, Prof. Ray O'Sullivan*** [1]

1. *St Luke's Hospital Carlow Kilkenny*

Endometrial ablation with bi-polar radiofrequency ablation can be used to manage menorrhagia in pre-menopausal women. Pregnancy can still occur despite destruction of the endometrium[1]. Effective contraception is advised following endometrial ablation due to the risks of morbidity and mortality in such pregnancies following[2].

Here we discuss the case of a 44 year old lady, with two previous normal deliveries, who had a pregnancy 3 years following endometrial ablation for menorrhagia refractory to medical therapy. She was offered lower segment Caesarian section at 37 weeks for transverse lie. She delivered a live male infant with APGARS 9'1, 10'5 and weight of 2610 g.

Intraoperatively there was no obvious development of the lower uterine segment, the uterus had a transverse ovoid shape, baby was in transverse lie, and there was severe narrowing of the cervical canal. The cervical canal required dilatation with Hagar dilators through the uterine wound. She had an estimated blood loss of 1000 mls intraoperatively. She recovered well post-operatively.

This case demonstrated several complications of pregnancy and delivery following endometrial ablation. This supports the practise of counselling women on pregnancy post-ablation and on effective means of contraception.

1. Gill LA, et al. Septic abortion with placenta accreta in pregnancy after endometrial ablation. Obstet Gynecol. 2015 Apr;125(4):822-4.

32 Roux I, et al. Pregnancy after endometrial ablation. A report of three cases. J Reprod Med. 2013 Mar-Apr;58(3-4):173-6.

CONSERVATIVE MANAGEMENT OF CIN II IN COLPOSCOPY CLINIC

Poster

Dr. Gabriela McMahon [1]**, *Ms. Sinead Griffin*** [1]**, *Dr. Clive Kilgallen*** [1]**, *Dr. Paul Hartel*** [1]**, *Dr. Nirmala Kondaveeti*** [1]

1. *Sligo University Hospital*

Traditionally, diagnosis of Cervical Intraepithelial Neoplasia II (CIN II) is managed with long loop excision of the transformation zone (LLETZ). In our unit however, pathology reports after LLETZ done for CIN II often confirm low grade or normal result. We wondered – are we over-managing CIN II?
This study was designed to assess the acceptability and outcomes of the conservative management of CIN II. We wanted to establish if monitoring the disease is sufficient in selected patients.
In this prospective cohort, patients under 30 years were selected by histological diagnosis of focal CIN II from cervical biopsy and discussed at MDT. In clinic, patients were informed of their biopsy results. After explanation of CIN II and its implications, patients were informed of the risks and benefits of conservative management versus LLETZ. Patients who opted for conservative management are seen at colposcopy for repeat biopsy +/- smear at 6 monthly intervals for 2 years. High risk HPV testing is done every 12 monthly.
During the follow-up period, patients were offered treatment with LLETZ if there is progression to CIN III or CIN II has not regressed.
30 patients were included in the study, with a mean age of 26.9 years. At the 6 month follow-up appointment, 8 (27%) of patient's biopsy results showed regression of CIN II to CIN I. One patient progressed to CIN III. Ten patients had LLETZ. The remainder of the patients showed persistence of CIN II and will be continuing in the full 2 year follow up.

DATING OF PREGNANCY AT THE BOOKING VISIT

Poster

Dr. Ciara Carroll [1], ***Dr. Nicholas Kruseman*** [2], ***Dr. Nicola Maher*** [3], ***Dr. Jennifer Donnelly*** [4]

1. *Rotunda Hospital.,* ***2.*** *Our Lady of Lourdes Hospital, Drogheda,* ***3.*** *University Maternity Hospital, Limerick,* ***4.*** *Rotunda Hospital, Parnell Street, Dublin 1*

Accurate dating of pregnancy is important in making decisions regarding diagnosis and management during pregnancy. Ultrasound is more accurate than using the date of the last menstrual period due to inaccurate recall. Dating is most accurate when performed by measuring crown-rump length up to 14 weeks gestation.
This study was performed to assess the gestation women attend for their booking visit, to ensure guidelines on ultrasound dating of pregnancies are being followed and to check that the agreed estimated due date (EDD) is recorded accurately and used to make clinical decisions.
A retrospective analysis of the charts of a randomised sample of 80 women who attended for their booking visit in September 2016 was performed. Data were collected from the booking history, dating scan and antenatal visit sheet.
Of the 80 patients included, 54 (67.5%) booked before 14 weeks, 24 (30%) booked between 14 and 24 weeks and 2 (2.5%) booked after 24 weeks. The appropriate method for dating pregnancies based on gestational age was used in 98.1% of pregnancies below 14 weeks, 91.7% of 14 to 24 weeks and 0% above 24 weeks. The agreed EDD was documented clearly on the antenatal record sheet in 61 cases (76%) and used correctly to guide clinical decisions in 77 (96.3%) cases.

The appropriate method for dating pregnancies was most likely to be used when the booking visit took place before 14 weeks. When the agreed EDD was recorded accurately, it was nearly always used correctly to guide clinical management.

Delayed interval delivery of preterm multiples: experience from a large specialised twin centre.

Poster

Dr. Brendan McDonnell [1], ***Prof. Aisling Martin*** [1]

1. Obstetrics and Gynaecology, Coombe Women and Infants University Hospital, Dublin

Background and methods:

Delayed interval delivery is sometimes employed for pre-viable or peri-viable preterm labour in multiple gestation pregnancies. We performed a retrospective review of all delayed interval deliveries of preterm multiples from 2009 - 2016, defined as >24hrs between delivery of twin 1 and 2.

Results:

During the study period there were 68,845 deliveries with 1377 multiple pregnancies comprising 1331 sets of twins and 46 sets of higher order multiples. 7 delayed interval deliveries were identified - 6 twin pregnancies and 1 triplet pregnancy. The mean gestation of delivery of the first infant was 23+4 weeks (range 22+3 to 30+0 weeks) with a mean interval of 10 days (range 1.5 to 39 days). Outcomes for the first infant delivered were poor, with 5 out of 7 (71%) dying from extreme prematurity. Out of the remaining twins or triplets, 5/8 (62%) survived. The mean gestation of delivery of the remaining infant(s) was 25+0 weeks (range 23+0 to 30+2 weeks). One mother (16%) developed clinical chorioamnionitis requiring iatrogenic delivery of the remaining infant. There were no cases of severe maternal morbidity - however there was one maternal death in the cohort due to an amniotic fluid embolism. Neonatal follow up of the surviving infants to date is normal.

Conclusions:

According to our data, delayed interval deliveries can offer hope for survival for the remaining infant(s) with an acceptable risk profile to the mother. Close clinical and laboratory monitoring is essential to reduce the risk of severe maternal morbidity, particularly via sepsis.

DIAGNOSIS OF PREGNANCY OF UNKNOWN LOCATION TO EARLY PREGNANCY ASSESSMENT UNIT

Poster

Dr. Mei Yee Ng [1]**, *Dr. Nadine Farah*** [1]**, *Dr. Mary Anglim*** [1]

1. *Coombe Women and Infants University Hospital, Dublin*

Since 2012, we observed a steadily increasing rate of pregnancies through the years (from 9.8% to 17.9% in 2015) diagnosed as pregnancy of unknown location (PUL) in our Early Pregnancy Assessment Unit. It is a diagnosis that can cause a reasonable amount of anxiety and stress in patients and clinicians. In our study, we examine the patient demographics and elucidate the reasons for this phenomenon (eg. early referral, inexperienced sonographers, suboptimal ultrasound technology etc) and the number of PUL that actually result in ectopic pregnancies. With the results, we intend to improve our PUL rates and consequently reduce the burden on the patient, clinicians and the unit.

Electrosurgical Vaginal Hysterectomy in patients with a non-prolapsed enlarged uterus, a retrospective cohort study comparing postoperative outcomes.

Oral (Jogs)

Dr. Michael Graham [1], ***Dr. Niamh Doherty*** [1], ***Dr. Colin Prendergast*** [1]

1. *Altnagelvin Hospital*

Institution: Altnagelvin Hospital, Glenshane Rd, Londonderry BT47 6SB

Background: Vaginal hysterectomy is the recommended surgical route if possible however traditionally a large uterus was considered a contraindication.

Purpose of study: The aim of this study is to determine whether there is a significant difference in outcome between patients with a non-prolapsed enlarged uterus undergoing electrosurgical vaginal hysterectomy compared with patients with a non-prolapsed normal sized uterus.

Study design and Methods: In this retrospective study, unselected women undergoing electrosurgical vaginal hysterectomy by a single consultant surgeon between 2010 and 2013 were identified. We compared perioperative and postoperative outcomes in women with normal sized (<280 g) and large uteri (>280 g.)

Findings: 67 women underwent vaginal hysterectomy and all were included in this study (n=24 >280 g, n=43 <280 g). With the exception of indication for surgery there was no difference between the groups with regards to baseline characteristics. There was a significant increase in estimated blood loss (333vs189ml p=0.001) and operative time (66 versus 49.2 minutes p=0.001) in the large uterus cohort however there was no significant difference in length of stay in hospital (32.2 versus 35.2 hours p= 0.983).

Conclusion: This is the first study evaluating the electrosurgical vaginal hysterectomy technique in women with both normal and large uteri. We found that this is a safe and effective form of treatment in patients with a large uterus and should be considered first line treatment, leading to a shorter hospital stay and therefore reduce cost to healthcare services.

ENDOMETRIOSIS NODULE CAUSING SPONTANEOUS HAEMOPERITONEUM IN PREGNANCY (SHiP)

Poster

Dr. JUNAID RAFI [1]

1. *Ipswich Hospital NHS Trust*

BACKGROUND:

Spontaneous haemoperitoneum in pregnancy (SHiP) due to endometriosis is a very rare condition

CASE PRESENTATION:This is a case of a 41 year old primigravida, who presented at 32 weeks, with sudden onset of severe lower abdominal pain without any uterine activity. This was a dichorionic-diamniotic twin pregnancy, following in-vitro fertilisation for subfertility secondary to severe endometriosis. On admission, pain score was eight, ten being the maximum of the scale. The vital signs were stable. Abdominal palpation revealed generalised tenderness with no guarding or palpable contraction. There was no evidence of bleeding and cervical os was closed on speculum examination. The cardiotocograph (CTG) was pathological and the plan was made to deliver the babies with emergency caesarean section. Intra-operatively there was massive haemoperitoneum (from an approximately 4cm spherical necrotic tissue close to left uterosacral ligament) which was managed successfully with the involvement of multidisciplinary input from general surgeons and urologists with optimum maternal and fetal outcome.

CONCLUSION:

Antenatal recommendations for specific stage or severity of endometriosis cannot be made however it is essential to increase awareness among medical professionals suspecting SHiP in pregnant women presenting with severe constant abdominal pain in the absence of preterm labour. As now even more women with severe endometrosis are achieving successful pregnancy with assisted reproductive technologies; the obstetrician should expect increased frequency of occurrence of such cases in the future.

EVALUATION OF TRANSVAGINAL ULTRASOUND SIMULATION FROM TRAINEES' PERSPECTIVES: A PILOT STUDY

Poster

Ms. May Almestehi [1] ***, Dr. Marie Stanton*** [1] ***, Dr. Mary Moran*** [1]

1. *University College Dublin*

Ultrasonography is a fundamental diagnostic tool in obstetrics and gynecology that relies heavily on the operator's psychomotor skills. Developing skills in transvaginal ultrasound (TVS) can be challenging as its intimate nature may restrict a trainee's tendency to gain adequate practice. TVS simulation purports to provide a suitable solution. However very few studies have been performed assessing it's value in improving trainee's clinical skills.

The aim of this pilot study was to assess the research protocols, design methods and analysis, using to explore trainees' perspectives following TVS simulation practice.

A phenomenological qualitative study was undertaken in University College Dublin. Six students taking the MSc Ultrasound program were invited to participate in semi-structured individual interviews following one semester of independent training on the TVS simulator. Thematic analysis was employed using the Braun & Clarke 6-phase guide. The analysis was reviewed by the secondary researchers using a 15-point checklist of criteria for good thematic analysis.

Results showed that participants felt that practicing TVS simulation could be useful in basic skills acquisition, but that clinical-based practice is more helpful in developing advanced skills, obtaining image parameters and measurements. Simulation was felt to be ideal as a stress-free training environment.

This qualitative pilot study shows that simulation can have a role in developing trainee skills in TVS ultrasound. Further qualitative and quantitative studies, involving larger multidisciplinary clinical cohorts are planned with aim of developing better strategies for how to use this tool, and ultimately improve the expertise of TVS ultrasound in practice.

Expectations of an electronic health record

Poster

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Background
Electronic health records (EHRs) have the potential to improve delivery of healthcare services. In addition to improving patient care delivery, the widespread adoption of (EHRs) in the US has created unprecedented opportunities for increased access to clinical data, enabling multiple secondary use purposes such as quality assurance and clinical research.

Objective: To examine the attitudes and expectations of health professionals (future users) in CUMH towards the proposed introduction of an EHRs.

Methods: A questionnaire was distributed to healthcare professionals involved with the future use of MN-CMS. The questionnaire was designed to assess: level of motivation and prior knowledge (computer skills) that might effect users expectations for the proposed change. Questionnaire was distributed over a three month period in CUMH.

Results. 85 health and allied professionals participated in the survey. There was no statistical significance between staff type, age group with level of motivation (p=0.340), (p=0.464). Improved identification of risk factors strongly influenced the motivation of staff for an EHR (p=0.03).

Well-informed responders showed a strong level of motivation to the introduction of an EHR (p=0.045).

The low motivation group did not perceive the capacity for multiple users to have access to the same chart at one time as being beneficial (p=0.060).

Conclusion There was much optimism that the EHRs introduction will improve reduce prescribing errors and enable multiple users access. While there are concerns about adequate training and respondent's knowledge, overall there was positive attitude towards EHR's as in the MNCMS project.

EXPLORING FULL DILATATION CAESAREAN SECTIONS - A RETROSPECTIVE COHORT STUDY

Oral (Jogs)

Dr. Edward Corry [1], ***Dr. Meena Ramphul*** [1], ***Dr. Ann Rowan*** [1], ***Mr. Ricardo Segurado*** [2], ***Dr. Rhona Mahony*** [1], ***Prof. Declan Keane*** [1]

1. *National Maternity Hospital,* ***2.*** *UCD Centre for Support and Training in Analysis and Research and School of Public Health, Physiotherapy and Sport Science*

The rate of full dilatation caesarean sections with their high risk of morbidity continues to rise.

We studied the rate of full dilatation caesarean sections in a tertiary referral unit with over 9,000 deliveries a year. Key labour, maternal and neonatal factors and morbidity were assessed. Where possible, these were compared with successful instrumental deliveries performed in theatre.

This was a retrospective cohort study. We reviewed the rate of full dilatation caesarean sections over a 10-year period. We analysed deliveries (full dilatation caesarean sections and successful instrumental deliveries performed in theatre) in single cephalic pregnancies ≥34 weeks from our unit's database for 2015.

The rate of full dilatation caesarean sections increased by over a third in the ten-year period (56/6947 (0.80%) vs 92/7378 (1.24%), p= 0.01). Of 84 full dilatation caesarean sections who met the inclusion criteria, 63(75%) were nulliparous. The mean maternal age was 33(±5) years. Oxytocin was used in the second stage in less than half of full dilatation cesarean sections (22 out of a recorded 57, 38.6%). There were more fetal head malposition (occipito-posterior, or occipito-transverse) at full dilatation caesarean sections compared to successful instrumental deliveries (41/46 (89.1%) vs 2/21 (9.5), OR=1.38,95% CI, p<0.001). The rate of significant postpartum hemorrhage (blood loss ≥1000ml), neonatal morbidity and birthweights was similar in both groups.

Malposition increases the risk of full dilatation caesarean sections. Further studies are required to determine whether more widespread, but judicious, use of oxytocin in the second stage to correct malposition impact the mode of delivery.

EXPLORING PATIENTS AWARENESS AND HEALTHCARE PROFESSIONALS KNOWLEDGE AND ATTITUDE TO PERTUSSIS AND INFLUENZA VACCINATION DURING THE ANTENATAL PERIODS IN CAVAN MONAGHAN GENERAL HOSPITAL.

Poster

Dr. Chuckwudi Ugezu [1]***, Dr. Murtaza Essajee*** [1]

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Pertussis is a highly contagious bacterial infection of the respiratory tract caused by Bordetella Pertussis. It affects all ages. Newborns of unimmunised women are at risk of severe complications leading to severe morbidity and mortality with case fatality rate as high as 4%. Influenza(Flu) is an infectious respiratory illness caused by the influenza virus with outbreak occurring almost every year during the winter periods with very profound burden on the entire healthcare system.

Objective: We aimed to assess patients awareness of pertussis and influenza vaccination as well as healthcare professionals knowledge and attitude to pertussis and influenza vaccination during the antenatal periods in Cavan Monaghan General Hospital.

Method: Patients were randomly recruited from those attending routine antenatal clinic during the study period. Following informed consents, questionnaires were administered to patients and Healthcare workers in the maternity unit.

Result: Of the 113 women who completed the questionnaire, only 57.6% and 31.9% of women knew that influenza and pertussis vaccine respectively is safe in pregnancy. The overall response rate among HCPs was 75%(50/67) and 44% of respondents had more than 10 years of clinical experience.

Although the majority of healthcare professionals agreed that both vaccinations are useful in protecting susceptible infants,70% of respondents do not know if the effectiveness of the vaccines in providing passive protection to the infant is reduced if given after 36 weeks gestation.

Our study showed the need for more health educational programs to improve health professionals knowledge and vaccine confidence.

FACTORS AFFECTING THE SUCCESS OF EXTERNAL CEPHALIC VERSION

Poster

Dr. Nicola O'Riordan [1], ***Dr. Kate Glennon*** [1], ***Dr. Asish Das*** [1]

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Objective: We aimed to evaluate the factors associated with greater success rates of external cephalic version (ECV) in Wexford General Hospital.

Study design: A retrospective study was performed using records kept on the labour ward of all patients admitted for ECV from January 2016 to January 2017. Each of the 19 recorded cases were then analysed. Maternal age, parity, fetal presentation, gestational age and method of delivery post ECV were recorded from the patients charts.

Results: Of the 19 cases performed over a one year period, three planned ECV's had spontaneous cephaloversion prior to arrival for ECV. There were nineteen ECVs attempted, nine of which were successful. Seven of the successful ECV pregnancies went on to have vaginal deliveries, while two had caesarean sections. Nulliparous females had a 33% success rate (n=3), parous patients had a 50% success rate (n=5). Average birth weights were surprisingly higher in the pregnancies with successful ECV vs unsuccessful (3.74kg vs 3.37kg respectively). The average gestational age for successful ECV leading to vaginal delivery was 35+6 weeks.

Conclusion: Although our numbers are small in this study, the success rates of ECV in Wexford General Hospital are comparable to those quoted nationally. Factors evaluated in this study can be explained to future ECV candidates before attempting version and drawn on for counselling purposes with these patients.

FETAL SCREENING; WHAT IS THE ADDED VALUE OF INTRODUCTION OF ROUTINE 20 WEEK FETAL ANATOMY ULTRASOUND TO AN UNSELECTED POPULATION OF WOMEN IN IRELAND WEST?

Poster

Ms. Jesvin Cheema [1]***, Dr. Meabh Ni Bhuinneain*** [2]***, Dr. Rachel Elebert*** [3]

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In Ireland a screening program or register for fetal or congenital anomaly does not exist. The National Maternity Strategy recommends screening all pregnant women with standardised antenatal ultrasound. Significant human and capital resources are required to deliver routine National anomaly screening. Published detection rates are required for projected cost benefit analysis.

We aim to compare the detection rates for ultrasound diagnosable anomalies before and after the introduction of a routine second trimester fetal anomaly ultrasound in an unselected maternity population in Ireland West. This study is retrospective, comparing a cohort of women who had first trimester anatomy ultrasound with selective recall with a cohort of women who had first trimester anatomy with routine recall. For the purpose of this study, we define major fetal anomalies as those structural and chromosomal abnormalities that produce significant long term disability and/or death.

Results

	MUH 2011-2013	MUH 2014-2016	EUROCAT 2011-2015
US detected major anomaly	44	71	N/A
Live born	16	35	1368
Still born/Miscarriage	7	8	35
Outborn/TOP/Lost follow up	21	28	50
Total no of births	5340	4985	48444
Cases per 10,000 births	82	142	253.31
Detection rates	32.41%	56.13%	N/A

US-Ultrasound

MUH-Mayo University Hospital

TOP- Termination of pregnancy

While there is a 73.1% increase in detection rates by switching from selective recall to routine recall, the overall sensitivity of ultrasound remains low at 56.13%. Health technology assessment may suggest more economic alternatives that focus on first trimester screening rather than ultrasound based screening.

FIRST TRIMESTER BIOMARKER SCREENING FOR GESTATIONAL DIABETES – A PROSPECTIVE COHORT STUDY

Poster

Dr. Siobhan corcoran [1]***, Dr. Natalie Achamallah*** [2]***, Mr. John O'loughlin*** [3]***, Ms. Grainne Kelleher*** [3]***, Mr. Stafford Philip*** [4]***, Prof. Steve Meany*** [4]***, Dr. Elizabeth Tully*** [5]***, Dr. Patrick Dicker*** [6]***, Prof. Fergal Malone*** [7]***, Prof. Fionnuala Breathnach*** [7]

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Background: Gestational Diabetes (GDM) is becoming increasingly common and is associated with a plethora of poor perinatal outcomes. Even modest improvements in glycaemic control are reflected in clinical outcomes. The oral glucose tolerance test is performed relatively late in pregnancy and there is much debate over whether a universal screening approach should be adopted.

Aims; We aimed to interrogate 4 biomarkers in the 1st trimester (C-reactive protein, 1,5 Anhydroglucitol, sex hormone binding globulin and adiponectin) and their potential role in predicting the subsequent onset of GDM

Methods; 248 women with known risk factors for GDM <15 weeks gestation had serum samples drawn. They underwent oral glucose tolerance testing at 28 weeks gestation and had prospectively collected perinatal outcome data.

Results; Adiponectin and SHBG demonstrated a correlation to the risk of onset of GDM in the univariate analysis. However, after adjustment for BMI, family history and ethnicity in the multivariate analysis SHBG loses significance. Following adjustment for BMI, family history and ethnicity 1st trimester 1,5 AG becomes a significant predictor of GDM. Mean 1,5 AG levels are significantly lower in the first trimester in women that will go on to develop GDM. However, none of these biomarkers exhibited a specific threshold value at which onset of GDM could be predicted absolutely with acceptable sensitivity and specificity.

Conclusions; Serum adiponectin and 1,5 Anhydroglucitol in the first trimester have potential to stratify the risk of subsequent GDM and may allow for more targeted early intervention to mitigate against the risks of GDM.

Gentle Birth: Woman-centred approach to Caesarean section introduced at University Maternity Hospital Limerick

Poster

Dr. Maeve Smyth [1] ***, Dr. Mendinaro Imcha*** [1] ***, Ms. Cliodhna O Sullivan*** [1]

1. University Maternity Hospital, Limerick

Caesarean section (CS) rates are increasing in developed countries including in Ireland. Ireland's National Maternity Strategy (2016) identifies possible reasons for this, including reductions in the risk of CS delivery, growing numbers of older primiparous women, increasing multiple births resulting from assisted reproduction and growing concerns over litigation. While vaginal delivery remains the preferred method of delivery for most women, CS is necessary in many cases.

University Maternity Hospital Limerick (UMHL) has become the first unit in Ireland to pioneer the gentle birth approach to CS. The core aim of this approach is to give the patient more autonomy, choice and control over the management of their pregnancy and delivery.

UMHL modified existing procedures to provide a more positive birth experience for the couple and baby. Some of these modifications include placeing the cardiac electrodes on the woman's upper back, achieving IV access in the woman's non dominant hand and lowering the surgical screen between the woman and the surgical team. A technique called "walking the baby out", allows the baby to clear its lungs naturally.

These modifications allow parents experience the discovery of their baby's gender on their own and aid immediate skin to skin contact in the precious moments immediately after birth. UMHL also permits couples to take cameras into the theatre and to take photographs of their new family in the minutes after delivery. UMHL acknowledges the inevitability of CS delivery and has demonstrated a progressive approach towards improving the birthing experience for the mother and child.

GESTATIONAL DIABETES MELLITUS IN CORK UNIVERSITY MATERNITY HOSPITAL: INCIDENCE AND RISK FACTORS

Poster

Dr. Sie Ong Ting **[1]**, ***Dr. Lavanya Shailendranath*** **[1]**, ***Dr. Alya Yousuf*** **[1]**, ***Dr. Mairead Noelle O'Riordan*** **[1]**

1. *Cork University Maternity Hospital, Cork*

The incidence of GDM rising worldwide with rising levels of maternal age and obesity. The prevalence of GDM depends on population being studied ranging from 1 % to 4%. Currently there is register for diabetes in Ireland however figures from annual reports of maternity hospitals suggest that the prevalence of GDM in Ireland is 1% to 2%.

This audit aims to investigate the incidence of gestational diabetes mellitus from year 2014 to 2016 and to identify the association between specified risk factors to the occurrence of gestational diabetes mellitus in the pregnant women in Cork University Maternity Hospital.

The incidence of pregnant women diagnosed with gestational diabetes mellitus in Cork University Maternity Hospital was 6.10% (367/6013) in 2014, 5.79% (351/6057) in 2015 and 6.85% (387/5649) in 2016. Almost half of the group were obese and more than a quarter were overweight.

Our pregnant women should be educated regarding the importance of maintaining a healthy lifestyle in general and exercise support group targeting pregnant women to be offered in Cork University Maternity Hospital. Talks of eating healthy and regular exercise by dieticians or personal trainers can be included in prenatal classes and offered to all pregnant women attending their booking visits. Posters showing healthy lifestyle can be circulated in the antenatal clinics and PowerPoint presentation can be projected on the television screen in the waiting area of the antenatal clinic. Information leaflets regarding healthy diet and exercise can also be included in the antenatal package.

GESTATIONAL DIABETES MELLITUS: PREGNANCY OUTCOME AND POSSIBLE COMPLICATIONS

Poster

Dr. Sie Ong Ting [1]***, Dr. Alya Yousuf*** [2]***, Dr. Mairead Noelle O'Riordan*** [2]

1. *cork,* ***2.*** *Cork University Maternity Hospital, Cork*

Gestational diabetes mellitus (GDM) happened when diagnosed first in pregnancy due to intolerance towards carbohydrate and is associated with significant metabolic changes, increased risk for both maternal and perinatal mortality and morbidity as well as posing a threat to long term consequences if not managed accordingly. This audit aims to identify the possible outcomes and complications of gestational diabetes mellitus in Cork University Maternity Hospital in order to suggest strategy to reduce maternal and neonatal adverse outcome.
All patients with diagnosed gestational diabetes mellitus from year 2014 until 2016 were included in this audit. Data were retrieved retrospectively from the medical records department. All data were then analysed using SPSS Statistics.
Within the index group, 534 women were induced for labor, constituting almost half of the group (48.5%). 14.9% of the babies delivered were macrosomia of >4000g. 65% of GDM women delivered vaginally with higher proportion been delivered operatively (35%). Of those underwent caesarean section, more than half of them (61%) were categorised as emergency caesarean section. During delivery, 15% had second degree perineal tear, 17% needing episiotomy and 10% had third or fourth degree perineal tear. Postpartum haemorrhage occurred in 1.3% and shoulder dystocia were reported in 0.5% in the index group. More than one-tenth of the babies have to be admitted to neonatal intensive care unit for observation and management.

GESTATIONAL DIABETES MELLITUS: TIMING OF DELIVERY

Poster

Dr. Sie Ong Ting [1], ***Dr. Alya Yousuf*** [2], ***Dr. Mairead Noelle O'Riordan*** [2]

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Gestational diabetes mellitus (GDM) is rapidly rising in our population worldwide, posing challenges both medically and obstetrically, needing person-centred management. NICE has advised women with uncomplicated Type 1 or Type 2 diabetes to have IOL between 37+0 to 38+6 weeks or before 37+0 weeks for diabetic-related complications. Otherwise, GDM women can be allowed to carry on the pregnancy up to gestation 40+6 before considering for IOL.

This retrospective audit aims to investigate the outcomes for both induction of labor (IOL) and spontaneous onset of labor (SOL) in gestational diabetes mellitus in our maternity unit in Cork University Maternity Hospital.

All gestational diabetes mellitus diagnose in 2016 in Cork University Maternity Hospital are included in this audit and the data were analysed using SPSS Statistics

43.26% of GDM women underwent IOL approximately at gestational 38.746 weeks as compared to gestational 38.878 weeks in SOL. 70% (271/386) of GDM women had to have operative vaginal deliveries with almost equal numbers in both groups, i.e. 48.7% in IOL versus 51.3% in SOL. It is demonstrated that women having IOL has 3 times higher risk for caesarean delivery as compared to women in SOL.

A structured pathway for IOL specifically tailored for GDM women can be introduced locally in Cork University Maternity Hospital and mode of IOL should be revised for better predicted outcomes for GDM women.

GOING HEAD OVER HEELS TO AVOID A C SECTION

Poster

Dr. Mary Barrett [1], Dr. Vicky O'Dwyer [2], Dr. Katharine Astbury [1]

1. University Hospital Galway, 2. Nat

External cephalic version(ECV) has been used successfully for many years, has a low complication rate and is an acceptable intervention to most women. Caeserean section(CS) rates are increasing, leading to an increase in short and long term secondary complications. This review examines ECV as a way of safely and efficiently reducing our CS rate, particularly for primiparous patients. This review looks at the success rates of ECV at our institution over the past 20 months.

This study aims to highlight success rates of ECV, factors contributing to its success and delivery outcomes for women who have undergone ECV.

All ECVs were performed on the labour ward by consultants. Delivery outcomes were recorded electronically.

Examination of outcomes shows a success rate of 46% in keeping with international standards. 69% of successful cases were multiparous women, who had an average BMI of 23 with 87.5% of the successful group achieving a vaginal birth. In the unsuccessful group the CS rate was 95%.

Although numbers are limited in this review, a vaginal birth achieved in 87.5% of successful ECVs shows favourable outcomes for women and their future pregnancies, when compared to a C section rate of 95% for unsuccessful ECVs. The success rate of 46% and subsequent C section rate of 12.5% is an encouraging statistic for women hoping for a vaginal birth. ECV is a safe way to limit the escalating CS rate and should be offered to suitable women.

HAEMOGLOBIN AND DIETARY AND SUPPLEMENTAL INTAKES IN PREGNANCY

Oral (Jogs)

***Dr. Eimer O'Malley* [1], *Ms. Shona Cawley* [1], *Ms. Rachel Kennedy* [1], *Dr. Daniel Mccartney* [2], *Prof. Anne Molloy* [3], *Prof. Michael Turner* [1]**

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To prevent Neural Tube Defects (NTDs), national recommendations since 1992 recommend that all women take periconceptual folic acid(FA). While there is consensus that it is preferable women start supplementation before pregnancy and continue throughout the first trimester, there is no consensus about when to stop. However, the World Health Organisation (WHO) recommends that all women should take 600 mcg dietary folate equivalent (DFE) throughout pregnancy because of the fetomaternal cellular requirements.

In this observational study we examined the relationship between total maternal dietary folate intake and supplements detailed at their first prenatal visit and maternal haematological indices throughout the pregnancy.

This was a secondary analysis of 502 women who had a full blood count and measurements of serum and red blood cell (RBC) folate with detailed dietary information analysed for 398(79.3%). Subsequent haemoglobin measurements were recorded.

Of the women who had dietary analysis, only 2.5% had an adequate dietary folate intake for pregnancy as recommended by the WHO (WHO; 600mcg dietary folate equivalent). But, 98.5% were taking FA supplementation. In the women taking supplements they all achieved the WHO recommendation for dietary folate intake. Almost half (42.8%) of the women started FA pre-pregnancy and of these women a relationship between taking pre-pregnancy FA and a higher RBC folate in the first trimester and a higher haemoglobin in the third trimester was identified ($p<0.001$ and $p<0.01$ respectively). We believe this provides evidence that women should continue on supplementation in the second and third trimester to potentially avoid anaemia and blood transfusion.

HOW WELL DO WE WRITE : AN AUDIT ON PATIENT'S DRUG CHART/KARDEX WRITING PATTERN IN LETTERKENNY UNIVERSITY HOSPITAL

Poster

Dr. Sumaira Tariq [1], ***Dr. Farhat Shireen*** [2], ***Dr. Mira Hemerich*** [2], ***Dr. Edward Aboud (Cons)*** [2]

1. University Hospital Galway, 2. Letterkenny University Hospital

Aiming to examine prescription writing in the Obstetrics department of Letterkenny University Hospital, to highlight any deficiencies so that corrective action may be taken by the clinicians and to establish if prescription writing is adhering to the recommendations on prescription writing in the British National Formulary and to the nursing and midwifery quality care metrics.

A prospective audit of in-patients during the period 28/03/2016 to 08/04/2016 was performed.Following which education sessions for doctors on prescribing was held.Data was analysed by SPSS Statistics.

Front of Drug Prescription & Administration Record:Height and weight are recorded on the drug kardex on 35/60(58.3%)occasions.For 1 patient it was not recorded if patient had no known drug allergies or if the patient had any drug allergies.All patients in the audit had an addressograph applied to the front of the drug kardex which included full name,date of birth and hospital number.

Individual Drug Prescriptions:The prescription was difficult to read or illegible on 74/601(12.3%)occasions.Brand name was used on 284/601(47.3%)of occasions. The dose was not stated,not fully stated,illegible or difficult to read on 30/601(5%)occasions.Appropriate times were circled on 23/156(14.7%)of occasions.Start date of the drug was not clearly written on 131/601(21.8%)of occasions.There was a legible signature by the prescriber on 186/601(30.9%)of occasions.The word microgram was abbreviated on 5/6(83.3%)occasions.On all occasions(18)in the audit the word unit was abbreviated or not written at all.On 4/5(80%)occasions that a drug was changed it was not re-written or changed clearly,initialed and dated.On 2/30(6.7%)occasions that a drug was discontinued it was not crossed out.

HUMAN PAPILLOMAVIRUS TESTING IN THE MANAGEMENT OF WOMEN FOLLOWING TREATMENT FOR CERVICAL INTRAEPITHELIAL NEOPLASIA

Oral (Jogs)

Dr. Adrianne Wyse [1]***, Prof. Paul Byrne*** [1]

1. Obstetrics & Gynaecology, Royal College of Surgeons in Ireland, Dublin,

Cervicalcheck, the national cervical screening programme, recommends that cytology and Human Papillomavirus (HPV) status are tested at 6 and 18 months following treatment for Cervical Intraepithelial Neoplasia (CIN). Women who have negative cytology but are still positive for HPV at 6 months following treatment require a repeat colposcopic assessment[1].

The aim of this study is to analyze the outcome in women whose first test of cure (TOC) reported a positive HPV test in the absence of cytological abnormality six months following treatment for CIN.

Women who underwent a treatment at our colposcopy clinic between 2012 and 2016 were reviewed.

Of the 3079 women who were treated, 2280 (74%) had a LLETZ and 799 (26%) had cold coagulation. 276 (11%) women had negative cytology but were HPV positive 6 months after treatment. To date, 240 of these women have had a colposcopic assessment. 30 (12.5%) required a punch biopsy because of the presence of an abnormal transformation zone. Of the 30 who had a punch biopsy, six (2.5%) had histological evidence of CIN 2. Five of these subsequently had a LLETZ, the results of which showed no abnormality in three, CIN 1 in one and histology is awaited in one. One woman with CIN 2 on punch biopsy was managed expectantly.

Our study suggests that repeat colposcopy in women with negative cytology and a positive HPV test 6 months following treatment is not only unnecessary, but is potentially harmful. Furthermore, this strategy is causing an avoidable burden on the colposcopy service.

Human Uterine Contractility at Term in Relation to Parity

Oral (Jogs)

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Background:

It is well described that parous women perform better in labour than their nulliparous counterparts. There are no published data to our knowledge, comparing the myometrial contractile parameters of nulliparous women with parous women.

The aim was to examine a range of parameters in human myometrial tissue, and compare the results obtained between the following 3 groups: Primigravid women (P0 n=14); Women with one previous delivery (P1 n=37); Women with more than one previous delivery (P>1 n=23); to determine if there was any difference between the contractile performance which might explain the difference observed clinically.

Design and Methods:

Myometrial biopsies were obtained at caesarean section, performed at term, from n=74 women. Each biopsy was dissected into 8 strips (592 samples) and suspended for in vitro tissue baths. Parameters of spontaneous contractile performance were measured: maximal amplitude(MAMP), mean contractile force (MCF), time to maximal amplitude, maximum rate of rise, frequency and occurrence of simple and complex contractions. Comparisons were made across the 3 groups. Statistical analysis was performed.

Results:

The MCF was significantly greater for myometrial contractions in parous women (P=**0.0061 and**P= **0.00089**respectively). Women P>1 displayed a shorter time to onset of first contraction (P=0.00046). For parous women there was a slower rate of rise and slower rate of relaxation. No difference was observed in any of the other parameters.

Conclusion

These results suggest that there is an inherent biological difference between the contractile parameters of human myometrium in the third trimester, between primigravid and parous women.

Human Uterine Contractility at Term in Relation to Previous Cesarean Section

Poster

Dr. Gillian A Ryan [1], _Ms. Niamh Dundon_ [2], _Dr. Sarah Nicholson_ [1], _Prof. Denis Crankshaw_ [3], _Prof. John J Morrison_ [3]

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The efficiency of myometrial contractility in labour, for women who have had a previous caesarean section (CS), is an important factor for women undergoing trial of labour after caesarean. There are no data, to our knowledge, on this topic. The aim was to examine a range of contractile parameters in human myometrial tissue, and to compare the results obtained between 3 clinical groups: Women with no previous CS(CS=0); Women with 1 previous CS(CS=1); Women with greater than one CS(CS=>1).

Methods

Myometrial biopsies were obtained at CS, performed at term, from n=74 women. Biopsies were dissected into 8 strips (592 strips) and suspended in vitro in tissue baths. Parameters of spontaneous contractile performance were measured:maximal amplitude, mean contractile force, time to maximal amplitude, maximum rate of rise, and occurrence of simple and complex contractions. Comparisons were made across the 3 clinical groups: CS=0 (n=22); CS=1 (n=37); CS=>1 (n=15). Statistical analysis was performed using T-Test Assuming Unequal Variance.

Results

The only significant difference was in the frequency of contractions, with a lower frequency of contractions in the CS=1 group compared to CS=0 and CS=>1 groups (p=6.36E-06 and p=0.000135 respectively).

Conclusion

These data indicate that there is no significant difference in the biological characteristics of human uterine contractions in vitro, in women who have had 1, or >1 previous CSs, in comparison to women who have had none. These findings indicate that factors other than the functional ability of uterine tissue, may be responsible for the increased CS rate among women undergoing VBAC.

IDENTIFICATION OF WHOLE TRANSCRIPTOMIC CHANGES IN MID-LUTEAL ENDOMETRIUM ASSOCIATED WITH SUCCESSFUL IMPLANTATION IN ASSISTED REPRODUCTIVE TECHNOLOGY

Poster

Dr. David Crosby [1], ***Dr. Louise Glover*** [2], ***Dr. Eoin Brennan*** [3], ***Prof. Brendan Loftus*** [3], ***Prof. Donal Brennan*** [4], ***Dr. Mary Wingfield*** [5]

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Failed embryo implantation is a critical factor in infertility, early miscarriage and IVF failure. Successful implantation requires a competent embryo and receptive endometrium. As embryo quality is increasingly being evaluated with PGD and PGS, there is an acute need for a greater understanding of endometrial factors associated with successful implantation. Whole transcriptome RNA-seq studies are anticipated to provide crucial insight[1]. Our objective was to identify whole transcriptomic changes in the endometrium of women with successful implantation following ART.

Women undergoing IVF/ICSI were prospectively recruited between Nov 2016 and Apr 2017. Inclusion criteria included:<38 years, no previous pregnancy and BMI<30kg/m^2. Endometrial samples were taken using a pipelle at the mid-luteal stage of their cycle, timed with luteinizing hormone testing. Women underwent single embryo transfer of a good or top quality blastocyst in the subsequent menstrual cycle;successful implantation was defined as positive serum βhCG. Next generation sequencing libraries were prepared using NeoPrep (Illumina). RNA-seq analysis was performed using BaseSpace Analysis software. Statistical significance was set at $p<0.05$.

Patient baseline clinical characteristics revealed no differences between successful(n=5) and unsuccessful women(n=5). Forty-eight differentially expressed genes (DEGs) were identified;20 were upregulated and 28 downregulated in those with successful implantation, and were predominantly implicated in innate immune function and immune cell transmigration. We propose to validate these findings using real time qPCR.

This study highlights DEGs associated with successful implantation. This approach may provide new insights into molecular mechanisms of implantation for the development of targeted diagnostic and therapeutic strategies to improve reproductive outcomes in ART.

IMPLEMENTATION OF THROMBOCALC POSTPARTUM VTE RISK ASSESSMENT TOOL IN WGH MATERNITY SERVICE

Poster

Dr. Grace Ryan [1], ***Dr. Abdelaziz Satti*** [2], ***Dr. Maebh Horan*** [3], ***Dr. Maria Farren*** [3], ***Dr. Magid Abubakar*** [2], ***Dr. Elizabeth Dunne*** [2]

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Venous thromboembolism(VTE) is a leading cause of maternal death and morbidity. National guidelines recommend screening of risk factors for VTE in early pregnancy. An electronic tool, developed by the Rotunda Hospital, Thrombocalc, allows for risk stratification, recommendations on dosing and duration of thromboprophylaxis. A retrospective audit, carried out over one month(n=138) in our unit demonstrated a 45% rate of insufficient VTE thromboprophylaxis using the Thrombocalc tool.
Our aim was to implement the personalised postpartum VTE risk assessment tool (VTERA),Thrombocalc, into our unit, Wexford General Hospital, with the goal of increasing education, awareness and appropriate thromboprophylaxis postpartum.
A prospective audit was carried out on all deliveries over a one month period, using a hard copy of VTERA proforma, patients were risk stratified according to the guidelines and proforma. Appropriate VTE prophylaxis postpartum was commenced where appropriate using low molecular weight heparin. Education sessions were provided on usage of VTERA tool.
Ninety four deliveries were included; 57.4% were low risk, 41.5% were moderate risk and 1.1% represented low risk. VTE prophylaxis was administered to 34% of patients and 66% received no treatment. Recommended treatment protocol was observed in 84% of cases and 16% of patients received incorrect treatment.

Implementation of the Thrombocalc VTE risk assessment tool showed an increase in the correct management of VTE prophylaxis postpartum in accordance with national guidelines and standards of care. Further implementation at booking clinic and continued use in the postpartum setting is the hope moving forward in an effort to reduce the risk of VTE.

IMPROVING TIME MANAGEMENT IN THE MATERNITY THEATRE

Poster

***Dr. Claire M McCarthy* [1], *Dr. Olumuyiwa Ayodeji* [1], *Dr. Sucheta Johnson* [1], *Dr. John Slevin* [1], *Dr. Mendinaro Imcha* [1]**

1. *University Maternity Hospital, Limerick*

The operating theatre is a high-risk facility in the healthcare environment. Inefficiency lead to delays in patient care, sub-optimal outcome and also poses an economic burden to the healthcare system
The National Clinic Programme in Surgery defines Models of Care for Elective Surgery, which is supported by the National Health Service(UK) Productive Operating Theatre Model.
We conducted a retrospective audit of operating theatre practices over a two week period in a university maternity hospital. We examined case-load and time intervals between cases. Theatre recorded were interrogated. 77 procedures were performed over the study period.
Of the 77 cases, 35(45.4%) and 42 (54.6%) were elective and emergency cases respectively. 9.3%(n=38) occurred outside of working hours, 14 (36.8%) of which were elective.
Changes focussing on teamwork, communication and time management were instituted, including utilising dedicated theatre staff. Communication solutions such as daily “Huddle” and scheduling meetings were introduced, with an electronic scheduling system.
A retrospective review was again carried out over a fortnight period, with 69 cases in this time period.
During this time, 45(65.2%) elective and 24(34.7%) emergency cases were recorded. 49.2%(n=34) were performed out of hours, with 15(44%) cases elective.
There was a 19 minute reduction in mean theatre time, corresponding to an overall reduction of 13%. Difference in the mean and median times shows a positively skewed distribution, and efforts here were effective.
Through implementation of cost-neutral organisational changes with multi-disciplinary teamwork, we achieved a 13% time reduction in our theatre setting, promoting a more productive environment.

INHIBITORY EFFECT OF INSULIN ON UTERINE CONTRACTILITY IN VITRO AND INCREASED RISK OF CAESAREAN SECTION

Oral (Jogs)

Ms. Niamh Dundon [1], ***Dr. Sarah Nicholson*** [1], ***Dr. Gillian A Ryan*** [1], ***Prof. Denis Crankshaw*** [1], ***Prof. John J Morrison*** [1]

1. *Department of Obstetrics and Gynaecology, School of Medicine, National University of Ireland, Galway*

Diabetes Mellitus (DM) in pregnancy is associated with an increased risk of caesarean section (CS). Myometrial tissue from women with DM displays poorer contractility than from non-diabetics. Since insulin is known to reduce the contractility of airway smooth muscle, we tested this hypothesis on uterine smooth muscle - that myometrial contractility at term is reduced by insulin, thus contributing to increased dysfunctional labour and increased CS rates.

The aim of this study was to examine the effect of insulin on spontaneous, and oxytocin-induced, contractions of myometrial tissue *in vitro*.

Myometrial biopsies were obtained from women (n=21) undergoing elective CS, with ethical approval. Myometrial strips were mounted for isometric recording in physiological-salt-solution and stimulated with oxytocin (1 nM). Matched strips (2-3 per biopsy) were challenged with control or insulin and effects on contractility were measured. In the second series of experiments, paired strips were pre-treated with insulin (0.2 μM), or control, before cumulative-addition of oxytocin. Finally, the effect of a single concentration of insulin (0.2 μM) on spontaneous contractility was assessed.

Insulin inhibited oxytocin-induced contractions by 20±8% of controls with an IC_{50} of 0.13 μM (pIC_{50}= 6.8±0.7, n=5). Pre-treatment with insulin shifted the concentration-effect curve to oxytocin when compared to controls, but differences were not significant (paired t-test, P>0.05, n=10). Insulin inhibited spontaneous contractions by 21±7% (n=6), compared to controls.

Insulin exerts an inhibitory effect on human myometrial contractility *in vitro*. This effect may contribute to the higher rates of dysfunctional labour and CS, observed in the clinical setting.

Interesting case of recurrent mature cystic teratoma

Poster

Dr. Davor Zibar [1], ***Dr. Hassan Rajab*** [1], ***Dr. Conor Harrity*** [1], ***Dr. Chris Phillips*** [1]

1. *Beaumont Hospital*

Mature cystic teratomas (MCT) are the most common ovarian germ cell tumors and the most common ovarian neoplasms in the cohort under 20 years of age. They typically consist of mature tissues that have ectodermal (skin, brain), mesodermal (fat, muscle), and endodermal (mucinous or respiratory epithelium) origins.
Case report: Patient is a 24 year old primipara with a recurrence in mature cystic teratoma. First presentation to a hospital was at the age of 20 with diffuse lower abdominal pain predominantly in the right illiac fossa. Transvaginal ultrasound showed 7.78x5.75cmright ovarian mass and 5.88x5.17 cm left sided mass. She was admitted under gynaecology team and urgent laparoscopic cystectomies were performed. In total seven cysts(4 on the right ovary, 3 on the left ovary) were stripped off, largest measuring 7cm with conservation of both ovaries. Histology showed evidence of skin, hair, fatty tissue, bone in each correlating with MCT. Second presentation was five years later with similar symptomatology. Laparoscopic surgery was performed electively and right salpingoophorectomy for a 11x9x6cmmass and left ovarian cystectomy were done. Histology showed replacement of the right ovary with MCT containing skin, bone, adnexal structures, mature glial cells and cerebellum. Left ovarian cyst showed minor immature neuroectodermal component with mature skin, sebaceous glands, bone, glial, ependymal tissue and choroid plexus.
This case presents unlikely event of recurrent, bilateral MCT with a further differentiation of tissue into neuronal cell lines.

INTERESTING CASE OF VASA PRAEVIA IN MONOCHORIONIC DIAMNIOTIC TWINS

Poster

Dr. Hannah Glynn [1]***, Dr. Gillian A Ryan*** [2]***, Dr. Caitriona Fahy*** [1]***, Prof. John J Morrison*** [2]***, Dr. Geraldine Gaffney*** [1]

1. *University Hospital Galway,* ***2.*** *Department of Obstetrics and Gynaecology, School of Medicine, National University of Ireland, Galway*

This is a case of a 35 year old multiparous woman with a spontaneous monochorionic diamniotic (MCDA) twin pregnancy, complicated by placenta praevia and vasa praevia, , diagnosed at 20 weeks gestation.
At 27+4 the patient presenting with bleeding per vagina requiring emergency caesarean section, with delivery of two live female infants.
A vasa praevia describes an aberrant chorionic vessel directly connected to the umbilical cord circulation but running between the amniotic and the chorionic layers of the placental free membranes below the fetal presenting part. It can lead to rapid fetal haemorrhage, exsanguination and death, with the perinatal mortality of undiagnosed vasa praevia reported to be as high as 60%. Survival rates of up to 97% have been described with antenatal diagnosis, early admission and delivery by 34-37 weeks gestation.
Vasa praevia risk factors include conception by assisted reproductive technologies, multiple gestation, umbilical cord insertion in the lower third of the uterus at first-trimester ultrasound, placenta praevia in second trimester, bilobed or succenturiate placenta and velamentous cord insertion. Whilst universal screening is not indicated targeted screening of at risk pregnancies should be considered.[1]
This case highlights the complexities with diagnosis and management of MCDA pregnancies, complicated by vasa praevia and the importance of antenatal diagnosis for improved perinatal morbidity and mortality rates.
1. Ruiter L, Kok N, Limpens J, Derks JB, de Graaf IM, Mol BWJ, Pajkrt E. Incidence of and risk indicators for vasa praevia: a systematic review. BJOG 2016;123:1278–1287

Introducing the Word Catheter to a District General Hospital to Improve Patient Management, a Quality Improvement Project

Oral (Jogs)

Dr. Michael Graham [1], Dr. James Wylie [1], Dr. Geoff McCracken [1], Dr. Kathy Niblock [1]

1. Craigavon Area Hospital

Background: It was noted that patients presenting with a Bartholin's Abscess were waiting significant lengths of time for marsupialisation in theatre under general anaesthesia. Patients were often being fasted numerous occasions with an average time of 43 hours from assessment until discharge. This places a significant burden on healthcare resources and patients.

Purpose of Study: Through this project we aimed to introduce an evidence-based technique so as to improve the patient experience whilst concurrently reducing economic burdens.

Study Design and Methods: Prior to introducing the Word Catheter the extent of the problem was audited. Information on Patient demographics, size of abscess, and time between assessment, management and discharge was collected. These statistics revealed significant delays when undergoing surgical management by marsupialisation under general anaesthesia. The Word Catheter is an evidence based approach to managing Bartholin's Abscesses and was chosen to be piloted in order to tackle the problem identified.

Findings of Study: Significant improvements were found when using the word catheter withregards to time of assessment until intervention. There were good outcomes when using the word catheter with every patient reviewed having resolution of their abscess. A marked reduction in patients requiring surgery in theatre resultedin a reduction to patient risk and also economic burden.

Conclusions and Programme Implications: A low-cost, relatively simple intervention resulted in improved patient management, satisfaction and outcomes for both individuals and the healthcare provider.

INTRODUCTION OF A GROWTH ASSESSMENT PROTOCOL "GAP-CUSTOMIZED GROWTH CHART" FOR THE FIRST TIME IN THE REPUBLIC OF IRELAND; PRELIMINARY RESULTS

Poster

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Fetal growth restriction(FGR)is a recognized cause of stillbirth(SB).
In the UK "GAP" has been proven to increase recognition rates of FGR. Our unit adopted "GAP" from UK perinatal institute as a Quality Improvement project with the aim of improving antenatal recognition of FGR.
Project leads were trained in UK. Our unit data was used to produce customized growth centiles for our population. Our rate of FGR(birth weight<10th centile on customized growth charts)and our recognition rate were obtained. "GROW" software was introduced. Staff were trained. Dating USS assigned EDD, criteria were set for serial growth Ultrasounds(USS) for increased risk pregnancies. GAP went live on 3/01/17. Customized growth charts were generated at booking and placed in charts. Symphysiofundal height(SFH)+/-Estimated fetal weight by Departmental USS(EFW)was plotted at all visits from 26/40. SFH<10th centile triggered referral for USS. Birth weights were input at delivery and birth centiles generated.
Our FGR rate *prior to GAP*was 13.3%(55 of 414 patients)and recognition rate was 41.8%(23 patients). 16 of those 23 patients were suspected FGR and referred for USS, 7 were picked up incidentally on USS for other reasons.
Post introduction of GAP 22 of 169 patients(13.01%)had a birth weight<10th centile(FGR), similar to our baseline rate.
12 of these(54.5%)were recognized antenatally via "GAP".
10 of 12 were detected by SFH<10th centile and confirmed on USS,2 were detected by GAP/GROW as they met criteria required for serial USS.
GAP improved antenatal recognition of FGR by 12.7%.
Preliminary results are encouraging with increased recognition of FGR using "GAP".

Investigating 1,5 Anhydroglucitol as a Novel Early Pregnancy Biomarker in Gestational Diabetes – A Prospective Observational Study of a High Risk Cohort.

Oral (Jogs)

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Background; Serum 1,5 Anhydroglucitol (1,5 AG) reflects glycemic control in the preceding 14 days. Even episodic hyperglycemia causes levels to decrease. Its accuracy has been validated in pregnancy. We aimed to interrogate 1,5 AG as an early pregnancy biomarker for gestational diabetes(GDM) in a high risk cohort.
Study Design; This was a prospective observational study. Inclusion criteria were; gestation <15 weeks, singleton pregnancy, one or more risk factors for GDM. 213 women had 1,5 AG samples taken at the prenatal registration visit and underwent a 75g oral glucose tolerance test (OGTT) using the IADPSG criteria and perinatal outcome data were collected.
Results; 46 (21.5%) screened positive for GDM.Mean serum 1,5 AG was lower in those that subsequently screened positive for GDM.(see Table 1) This difference reached statistical significance. 1,5 AG measured in the 1st 15 weeks does does not relate to risk of macrosomia but does correlate significantly with risk of operative vaginal delivery.
Conclusion; Lower 1,5 AG levels in the 1st 15 weeks of pregnancy in women who subsequently screen positive for GDM later in gestation, indicates a degree of glycemic instability in these patients detectable far before the pathophysiological process and clinical consequences of GDM evolve in the late second and early third trimester. The link with the risk of operative vaginal delivery is interesting and unexpected. Our findings suggest that the capacity of this biomarker as a first trimester prediction tool for gestational diabetes warrants further investigation.

IRISH MATERNITY EARLY WARNING SCORE (IMEWS) PROTOCAL IMPLEMENTATION IN ST JAMES' HOSPITAL- AN AUDIT.

Poster

Dr. Sarah Petch [1], ***Dr. Niamh Garry*** [2], ***Dr. Caleb Powell*** [1], ***Dr. Noreen Gleeson*** [3], ***Dr. Rachel Kidney*** [1]

1. *1.Gynaecological Oncology Department, St James's Hospital,* ***2.*** *Department of Obstetrics and Gynaecology, MRHP (Midlands Regional Hospital Portlaoise), Co Laois,* ***3.*** *Trinity College Dublin*

The IMEWS is a nationally agreed scoring system developed for early detection of life threatening illness in pregnancy and the postnatal period for up to 42 days postpartum. There are no maternity services at St James' Hospital (SJH) but approximately 100 pregnant and post –partum women are admitted annually. All pregnant and post-partum women admitted to SJH should have their vital signs plotted on the IMEWS chart and the Gynaecology team should be informed of their admission.Our aim was to review adherence to the IMEWS protocol, followed by teaching and re-audit.

The charts of 23 pregnant and post-partum patients admitted in Q1 2016 were reviewed, and adherence to the protocol was recorded. Teaching sessions on the IMEWS protocol were given to incoming interns and ED doctors in July 2016 and a re-audit of the 28 patients admitted in Q3 2016 was carried out.

In Q1 2016 the vital signs of 87% of patients were correctly plotted on the IMEWS chart, though the Gynaecology team were informed of only half of these patients. In Q3 this number grew to 68% and the number of patients plotted on IMEWS increased slightly to 90%.

Our teaching sessions marginally increased adherence to the IMEWS protocol but more needs to be done to ensure proper compliance to improve patient care.

IS THERE AN ASSOCIATION BETWEEN ENDOMETRIAL LYMPHOCYTE PROFILE AND ART OUTCOME?

Poster

Dr. Conor Harrity [1], Dr. Chris Elizabeth Philip [1], Dr. Davor Zibar [1], Dr. John Kennedy [2], Dr. Kevin Marron [2], Ms. Sarah Pace [2]

***1.** Beaumont Hospital, **2.** SIMS clinic*

This study aims to assess the endometrial lymphocyte populations in patients with poor reproductive outcomes and corelate levels with etiology
An observational study was designed to assess endometrial populations in patients with poor reproductive outcomes, 250 patients attending for endometrial scratch prior to commencing an ART cycle between Jan 2015 and October 2016 agreed to have their endometrial immunophenotype analysed. Patients were stratified based on their reproductive outcome, and centile ranges were developed for the overall population and separate subgroups

An endometrial biopsy immunophenotype was developed to investigate by flow cytometry the various lymphocyte populations.

Reference ranges for the lymphocyte populations were established in 250 endometrial biopsies. The overall population median levels were pNK 1.2%, uNK 41.3%, and NKT 2.7%. The patients were then characterised by reproductive history, and divided into subgroups for further analysis. Different lymphocyte levels were seen in these groups. In patients with recurrent miscarriage, mean levels were: pNK 6.4%, uNK 32.0% and NKT 6.6%.Patients with repeated implantation failure had different results: pNK 3.3%, uNK 43.1% and NKT 2.4%. interestingly, overall Treg and B Cell results were similar between groups, which is different to some existing data.T Cells were predominantly the Th1 subtype in all groups (50.8% Th1: 8.0% Th2 overall)
This study is limited by the lack of randomisation, as patients were recruited based on attendance for endometrial scratch. Analysis of the endometrium from fertile controls would further validate this data. Patients with recurrent miscarriage demonstrated a different endometrial immunphenotype profile to the overall population.

IS THERE AN ASSOCIATION BETWEEN HORMONAL CHANGES OF MENOPAUSE AND DEVELOPMENT OF GRAVES' DISEASE IN SUSCEPTIBLE WOMEN?

Poster

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Many studies suggest associations between stressful life events and development of antibody-mediated endocrine disorders, including the hyperthyroidism disorder Graves' Disease. The age-specific peak incidence of Graves' Disease is 40-60 years. The average age of onset of menopause is 48-55 years, with a preceding perimenopause period of up to 8 years. Therefore, our hypothesis is that the hormonal changes of menopause are thestressful event triggering Graves' Disease in these patients.
The purpose of this study is to establish if menopause is a risk factor for the development of Graves' Disease in genetically susceptible women.
120 female patients diagnosed with Graves' Disease within the last 10 years were selected from a database of patients that attended an Endocrinology Clinic in Cork University Hospital. A survey was sent to these patients, in which, patients were asked about i.Timing of Graves' diagnosis ii.Recent Menstrual history iii.Smoking iv.Pregnancy v.Concomitant Auto-Immune disorders vi.Family history of Auto-Immune disorders vii.Each patient also completed the Holmes and Rahe Stress Scale.
Of the 48 patients that responded; 22 were pre-menopausal, 9 were peri-menopausal and 16 were post-menopausal. In analysis of the 16 post-menopausal women; 9 womens' post-menopausal status preceded their Graves' diagnosis, whilst 7 womens' post-menopausal status followed their Graves' diagnosis.
No statistically significant association between hormonal changes of menopause and development of Graves' Disease was found. However, the limited numbers in the study may account for this. It would be beneficial to perform a similar study with a larger sample size to uncover an association if one exists.

KELOID SCARRING: A DILEMMA FOR DELIVERY

Poster

Dr. Jenny Stokes [1], ***Dr. Mona Abdelrahman*** [1], ***Dr. Maeve Eogan*** [2]

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Keloid scarring affects between 5-15% of wounds and pigmented skin is more likely to develop keloid.[1] We present a case of a nulliparous African lady with multiple keloid scars at her breasts, left forearm due to burn trauma and a large exophytic scar on the mons pubis extending to her perineum attributed to vulval shaving. She required admission and multidisciplinary care of a breast abscess necessitating incision and drainage. The extent of her keloid scarring concerned us with regard to optimizing decisions around mode of delivery.

A caesarean section would likely lead to further scarring, while perineal trauma during vaginal birth could cause additional scarring at the vulva and introitus. We discussed keloid prevention antenatally with a plastic surgery team who suggested using fine (3/0) subcuticular suture material, with non-absorbable material being recommended in context of LSCS. Happily, she progressed to SVD of a liveborn infant following rupture of membranes. There were three small labial lacerations which were repaired with Polyglactin (Vicryl Rapide®). Cabergoline was prescribed to suppress lactation given the severity of her breast keloid scars and was successful. Her perineum had healed well at review one week post partum.

Given the changing obstetric population in Ireland it is important to identify keloid scarring and its potential complications. Input from Plastic Surgery and Dermatology may help to improve management, and indeed will facilitate prompt post-operative referral if required. In this case, vaginal delivery provided a safer method of delivery for the patient and her future pregnancies.

LAPAROSCOPIC ENTRY TECHNIQUE- A SURVEY OF PRACTICE OF IRISH GYNAECOLOGITS

Poster

Dr. Breffini Anglim [1], *Prof. Declan Keane* [1]

1. National Maternity Hospital

Laparoscopy associated visceral injuries are rare but may cause serious morbidity and even mortality. Complications arising from laparoscopy can be due to the initial entry into the abdomen, or subsequent trocar insertion. The aim of our survey was to evaluate the most commonly employed entry techniques and trocar usage in gynaecological surgery in Ireland.

This was a multicentre anonymous survey sent via email to 221 gynaecologists from all 19 Irish maternity units. Responses were analysed using an Excel spreadsheet.

There was a 56% response rate. Of the respondents, the majority (91%) established a pneumoperitoneum using the Veress needle technique. With regards to the patients position when inserting the scope, 79% used lithotomy and 12% used Trendelenberg, with the remainder (9%) using both. Ninety-six percent used pressure (mmHg) and 4% used volume (litres) to establish the pneumoperitoneum, with the majority (69%) using a pressure of 20mmHg to establish and 15mmHg (70%) to maintain the pneumoperitoneum. Interestingly, the junior doctors (<10-years' experience) were more likely to insert the trocar at 90degrees (60%) compared to their senior counterparts (>10 years) 36%, and senior doctors were twice as likely to perform Hasson entry compared to closed entry technique (8% vs 4%). Twenty-one percent of the sample used a bladed trocar, 45% used a shielded trocar and 34% used an optical trocar.

There is no clear consensus as to the optimal method of laparoscopic entry into the abdomen. However it is important to educate gynaecologists on the safest methods of entry.

LEARNING FROM EXCELLENCE

Poster

Dr. Sunia Bringi **[1], *Ms. Geraldine Mcguire*** **[2], *Dr. Luke Feeney*** **[3], *Prof. mary higgins*** **[4]**

***1.** National Maternity Hospital, **2.** Midwifery, National Maternity Hospital, **3.** Clinical Risk Department, National Maternity Hospital, **4.** National Maternity Hospital, Dublin*

Background

Maternity care focuses on the care provided to women and babies. Often staff receives positive feedback, but may receive negative feedback as well. In recent years, it could be argued that the perception of maternity care has been challenged, leaving staff working in a more challenging environment.

Purpose

To review feedback on maternity care within large tertiary level hospital.

Study Design and Methods

Both formal feedback (postnatal satisfaction surveys with free text responses) and volunteered feedback (patient letters and comments) were studied. Thematic analysis of content was performed until saturation.

Findings

Over 178 feedback sources were reviewed (letters (n=70) and satisfaction survey comments (n=108)). The majority (147, 82%) were positive in nature. Major themes identified included the following: -Humanity, kindness and compassion of staff - Individualization of care by busy staff- Experience, knowledge and professionalism. The most common negative theme related to insufficient and inadequate communication.

Conclusion and Implications

Within medical and midwifery care great emphasis is placed on learning from errors. It is equally important to learn from what is done well, which represents most clinical interactions. It is also important to celebrate these achievements as representations of high quality family centered care. We would encourage other institutions to follow the example of the “Learning from Excellence” movement and explore the true nature of patient feedback.

LISTERIOSIS WITH NON SPECIFIC SYMPTOMS: A DILEMMA

Poster

Dr. Sumaira Tariq [1], ***Dr. Una Conway (Cons)*** [1]

1. *University Hospital Galway*

A case of a 37 year old with average BMI in her second IVF pregnancy. Her first pregnancy was uneventful and resulted in a spontaneous vaginal delivery. She had a background medical history of Hypothyroidism well controlled with Eltroxin.

At 29 weeks gestation, the patient presented to the maternity assessment unit of a different hospital with nausea 5/7, feeling hot, abdominal pain score 3/10, no appetite, vomiting 2 episodes 2/7 ago, no diarrhoea, no urinary symptoms, urinalysis showed 1+ protein. Her IMEWS was 0. She had URTI 2/52 ago and had had Pertussis vaccine 1/52 ago. She had no temperature or sick contacts and her abdominal exam was NAD.

FBC, CRP and liver screen (ANA,ANCA,SMA,AMA,LKM-1, Anti-Parietal cell antibodies) were normal. Raised AST, ALT, Alpha 1 anti trysin and plasma/serum Copper with low IgG.

At 30+3 weeks presented with preterm labour, NRCTG and pyrexia of 38.7 C.Septic screening done, started on broad spectrum antibiotics and had an EMCS which showed meconium stained liquor. Blood culture and placental swabs grew Listeria monocytogenes. Had devastating effects on fetus.

Listeriosis is a rare infection, but is 20 times more common in pregnancy. Should be considered in pregnant women who present with non specific symptoms. It can present as a dilemma to clinicians as there are no data to guide the management of an exposed, afebrile pregnant woman with mild symptoms that do not strongly suggest Listeriosis.

As preventive measure, foods with a high risk of contamination with Listeria should be discussed at booking visit.

Massive Obstetric Haemorrhage in Term and Preterm Gestations

Oral (Jogs)

Dr. Catherine Finnegan [1]***, Dr. Mark Philip Hehir*** [2]***, Dr. Reham Alkhalil*** [2]***, Dr. Niamh Murphy*** [3]***, Prof. Fionnuala Breathnach*** [4]***, Prof. Fergal Malone*** [4]

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Massive obstetric hemorrhage (MOH) is a leading cause of maternal morbidity. We sought to examine causes, characteristics and outcomes of MOH in term and preterm gestations.
This was a retrospective cohort study of MOH over a ten-year period from 2006-2015 in Rotunda. MOH was defined as blood loss of >2500ml, transfused >5 units of red cell concentrate (RCC) or coagulopathy. Variables recorded mode of delivery, blood products, intrauterine balloon and length of stay.
There were 85,139 deliveries over the period and the mean rate of preterm delivery was 6.8%. A total of 143 cases of MOH occurred giving a rate of 0.16%, 68%(98/143) occurred in term gestations with 32%(45/143) in preterm. MOH in preterm gestations occurred at a mean gestation of 31.2±4.9 weeks. The rate of MOH was higher among preterm pregnancies than term 0.77%(45/5816)vs. 0.12%(98/79,323);p<0.0001. Preterm mothers with MOH were likely to have had cesarean (82%[37/45] vs.50%[49/98];p=0.002), and this was more likely to be carried out prelabor (86%[32/37] vs.41%[20/49];p<0.0001). Patients who had a preterm MOH had a longer length of stay(9.4±10 vs.5.8±3.7;p=0.002). There was no difference in use of intrauterine balloon (18%[8/45] vs. 29%[29/98]; p=0.15). Regardless of gestation patients received similar numbers of units of RCC (5.7 ± 5.4 units vs. 6.7 ± 4.9 units; p=0.3).
The risk of MOH is higher in preterm pregnancies, these women are more likely to have a cesarean and a longer stay. Senior advice should be sought when additional blood loss is noted during preterm delivery due to the increased risk of MOH.

MATERNAL ALCOHOL CONSUMPTION AND THE RISK OF AUTISM SPECTRUM DISORDERS

Poster

Mr. Cian Gallagher **[1]**, ***Dr. Ali Khashan*** **[1]**

1. *University College Cork*

Background: Maternal alcohol consumption during pregnancy (MAC) is a potential risk factor for Autism spectrum disorders (ASD) in offspring, however current evidence is limited.

Purpose of study: This study aimed to examine whether MAC is associated with the development of childhood ASD using a nationally representative British cohort.

Study design and methods: We conducted a retrospective analysis of data extracted from a nationally representative UK cohort, the Millennium Cohort Study. Data on MAC and relevant confounders was obtained from parental questionnaires when infants were age 9 months of age. MAC was categorised as either none, light, moderate or heavy. Outcome of ASD was obtained from parental questionnaires at 11 years of age. Crude and adjusted logistic regression was used to analyse the relationship between MAC and ASD.

Findings of the study: No statistically significant association was found between MAC and ASD for light (OR 0.78, 95% CI 0.48-1.29), moderate (OR 0.89, 95% CI 0.35-2.27), or heavy (OR 1.54, 95% CI 0.56-4.21) MAC in initial analysis. Confining the analysis to Caucasian ethnicity or male offspring did not alter the results appreciably.

Conclusions and program implications: Light and moderate alcohol consumption during pregnancy was not associated with the risk of developing ASD in this study cohort. Due to the limited number of cases, results of the high MAC group were limited by statistical power and more research is warranted to investigate the relationship between heavy MAC and ASD.

May be we need to Reclassify Caesarean Section Category 1

Poster

Dr. JUNAID RAFI [1]

1. Ipswich Hospital NHS Trust

Background:

The obstetric units in UK and Ireland use RCOG Good Practice guideline 11 ‘’Classification of urgency of Caesarean section –A continuum of risk” (1) for categorisation of caesarean section.

We may need to re-classify Category 1 caesarean section guidance for further clarity in terms of decision to delivery time interval .

Discussion:

At present; decision to delivery time for Category 1 caesarean section is 30 minutes.

Proposed new classification Category 1 Caesarean section is as below:

Category 1A: Decision to delivery time 15min for Acute Hypoxia Indications

1: Prolonged Bradycardia / deceleration not recovering @6minute

2: Placental Abruption

3: Suspected uterine rupture

4: Cord prolapse with Bradycardia on CTG

Category 1B: Decision to delivery time 30 minutes (Can be done under spinal anaesthesia)

1: Cord prolapse in the absence of bradycardia

2: Sub acute hypoxia(2a,2b)

2a. Variable decelerations with any concerning characteristics(lasting more than 60 seconds; reduced baseline variability within the deceleration; failure to return to baseline; biphasic (W) shape; no shouldering) in over 50% of contractions for 30 minutes as abnormal.

2b: Late decelerations for 30 minutes (or less if any maternal or fetal clinical risk factors).

There is no guidance in NICE CG 55guideline for cases like 2a or 2b needs to be delivered as Category 1 or Category 2 caesarean section especially if not suitable for Fetal blood sampling (FBS) or if FBS is not available.

Conclusion: In future this classification can prove to be a robust tool for doctors for decision making in emergency scenarios.

MECHANICAL AND STRUCTURAL CHARACTERISATION OF THE HUMAN OVARIAN ARTERIES

Oral (Jogs)

Ms. Niamh Conlon [1]***, Ms. Laura Bonin*** [2]***, Dr. Danielle Byrne*** [3]***, Dr. Tony Geoghegan*** [3]***, Dr. Thomas Flanagan*** [1]***, Dr. Aisling Ni Annaidh*** [2]***, Prof. Donal Brennan*** [4]

1. *1.UCD School of Medicine and Medical Science, University College Dublin, Belfield, Dublin 4,* ***2.*** *2.School of Mechanical and Materials Engineering, University College Dublin, Belfield, Dublin 4,* ***3.*** *3.Mater Misericoridae University Hospital, Eccles St, Inns Quay, Dublin 7,* ***4.*** *UCD Professor of Gynaecological Oncology Consultant Obstetrician and Gynaecological Oncologist Mater Misericordiae University Hospital/ National Maternity Hospital / St Vincent's University Hospital*

The architecture of the ovarian artery (OA) is unique, demonstrating a spiral configuration throughout its length. This distinctive structure may reflect a mechanical adaptation for the regulation of ovarian blood pressure. We hypothesise that the conformation of the OA inherently facilitates adaptation to various physiological processes. The aim of this study was to (a) characterise the non-linear anisotropic elastic behaviour of OAs under uniaxial tension and (b) compare against the mechanical behaviour of the inferior mesenteric artery (IMA), which is a similar calibre vessel.

14 OAs/1 IMA were obtained from elective surgical patients and subjected to uniaxial tests in two orthogonal directions. The mean ultimate tensile strength (UTS) of the OA was 0.80±0.39MPa and 0.57±0.26MPa in the longitudinal *(L)*and circumferential (*C)* direction, respectively. The mean failure stretch of the OA was 1.30±0.09 *(L)* and 1.67±0.38 *(C)*, with a mean Young's Modulus of 6.58±3.54MPa *(L)* and 2.26±1.79MPa *(C).* Conversely, the mean UTS of the IMA was 3.03±0.01MPa *(L)* and 0.98±0.52MPa *(C)*, the mean failure stretch was 1.34±0.03 *(L)* and 1.79±0.56 *(C)*, and the mean Young's Modulus was 16.97±3.38MPa *(L)* and 2.28±0.46MPa *(C)*.

These results indicate that the OA is significantly stiffer longitudinally than circumferentially. From initial analysis, the OA is more compliant than the IMA although further testing is required to confirm this.

Ongoing histological and ultrastructural analyses will facilitate quantitative assessment of the mechanical contribution of the arterial microstructure to hypothesised adaptive functions of the ovarian artery.

MOLAR PREGNANCY IN TUBAL ECTOPIC PREGNANCY

Poster

Dr. Mei Yee Ng [1], ***Dr. Somaia Elsayed*** [1], ***Dr. Mary Anglim*** [1], ***Dr. Nadine Farah*** [1]

1. *Coombe Women and Infants University Hospital, Dublin*

The incidence of hydatidiform mole is 1 per 1000 pregnancies. Ectopic pregnancy occurs in 20 per 1,000 pregnancies. Therefore, the incidence of hydatidiform mole in tubal pregnancy is a very rare entity. It is a diagnosis that is aided by histological confirmation. We describe 2 cases of tubal ectopic pregnancy who had surgical excision of ectopic mass and tubal molar pregnancy was subsequently diagnosed on systematic histology examination. These cases convey the importance of histological examination of products of conception which helps the pathologist to provide an appropriate diagnosis which in return aid the clinician in offering appropriate counseling and follow-up for the patient

MORBIDLY ADHERANT PLACENTA; A REVIEW OF MANAGEMENT AND MORBIDITY OVER A 10 YEAR PERIOD AT THE NATIONAL MATERNITY HOSPITAL, DUBLIN.

Poster

Dr. Helena Bartels [1], ***Prof. Donal Brennan*** [2], ***Prof. Fionnuala McAuliffe*** [3]

__1.__ National Maternity Hospital, __2.__ UCD Professor of Gynaecological Oncology Consultant Obstetrician and Gynaecological Oncologist Mater Misericordiae University Hospital/ National Maternity Hospital / St Vincent's University Hospital, __3.__ UCD Perinatal Research Centre

Morbidly adherent placenta (MAP) is a condition associated with a high morbidity and mortality. Its incidence continues to rise worldwide in parallel with increasing rates of caesarean section.
The objective of this study was to review the number of cases of MAP over a 10 year period at the national maternity hospital and to assess the associated maternal morbidity.
Cases of morbidly adherent placenta were identified by retrospective review of the annual reports over a 10 year period from 2006-2016. Maternal demographics, antenatal management, surgical approach and maternal morbidity were recorded. Cases were correlated with pathological reports.
30 cases of morbidly adherent placenta were identified during the study period, with a rising incidence observed. In parallel, the caesarean section rate in our unit increased from 18.9% in 2006 to 26% in 2016. Ultrasound examination successfully diagnosed 57% (n=17) of cases antenatally; 9 patients subsequently had an MRI to confirm the diagnosis. There was a significant maternal morbidity associated with the condition, with 87% (n=26) requiring a peripartum hysterectomy, an average estimated blood loss of 5.5L (range 1-19.5L) and 97% (n=29) requiring a blood transfusion. Cases were also associated with a high rate of preterm delivery, with 55% of patients delivered prior to 36 weeks, contributing an additional neonatal morbidity.
Our study shows the rising incidence of morbidly adherent placenta at the national maternity hospital over 10 years and the severe maternal morbidity associated with this condition.

OBSTETRIC ANAL SPHINCTER INJURIES (OASIS): A SURVEY OF CLINICAL PRACTICE AMONG OBSTETRICIANS AND GYNAECOLOGISTS IN IRELAND

Poster

Dr. Mona Abdelrahman [1]***, Dr. Maeve Eogan*** [2]***, Prof. Michael Geary*** [1]

1. Rotunda Hospital, Parnell Street, Dublin 1, 2. Rotunda Hospital

Obstetric Anal Sphincter Injuries (OASIS) complicate 2% of vaginal deliveries[1] and increase the risk of postnatal anal incontinence. Prompt recognition and repair is optimal to reduce long term sequelae.

The aim of the survey was to evaluate episiotomy techniques used by obstetricians in Ireland and their perspective of training regarding diagnosis, management and postnatal care of women who sustain OASIS.

A 20-question anonymous online survey adapted from one previously distributed in Canada[2]was circulated to all consultants and NCHDs in obstetrics and gynaecology in Ireland between January and September 2017. Results were analysed using Microsoft excel.

136 people responded to the survey, 30% consultants and 57% HST and BST participants. 72% of trainees had clinical teaching and 65% also attended a workshop regarding episiotomy and OASIS repair. More than 75% of participants felt confident identifying and repairing OASIS but a portion of those who had received training still did not feel competent to repair OASIS.

Regarding post-natal care, over 90% prescribe prophylactic antibiotics and laxatives while 80% prescribe physiotherapy review prior to discharge. Patients are equally either followed up in a specialised or a postnatal/gynaecology clinic. This study highlights adherence with guidelines for management of OASIS [3,4].

Most trainees receive training for repair of OASIS, but some have identified needs for further teaching and exposure to diagnose and manage this type of injury. These results will direct curriculum and learning needs for trainees, unify service provision and ensure patient safety.

Obstetric outcomes in women attending a maternal medicine clinic

Poster

Dr. Vicky O'Dwyer [1], ***Ms. Celine O'brien*** [1], ***Prof. Shane Higgins*** [1], ***Prof. Mary Higgins*** [1], ***Prof. Fionnuala Mcauliffe*** [1]

1. *National Maternity Hospital*

To evaluate obstetric outcomes in pregnant women attending the maternal medicine clnic at the National Maternity Hospital.
This was a retrospective review of women who delivered in 2016. There was a multidisciplinary care pathway for each patient. A consultant obstetrician made all decisions regarding timing and mode of delivery.
In 2016, 283 women attended the maternal medicine clinic. There were 5 miscarriages, 10 delivered elsewhere leaving 268 women delivered at the National Maternity Hospital. Of these, 30% were primigravidas. The mean gestation at delivery 38+6 weeks. Thirteen women (5%) had a preterm delivery. Induction of labour was performed in 38% (101) compared with 27.6% overall induction rate for the hospital. One third were induced for their medical condition. Half the women had a spontaneous vaginal delivery, 11% operative vaginal delivery and 37% caesarean section. The caesarean section rate was 28% (11/39) in induced primigravidas and 4% (2/49) in induced multigravidas attending the clinic compared with 38.9% (448/1354) in induced primigravidas and 5.7% (54/950) in induced multigravidas for the hospital overall. Seven women had peripartum complications.
There was a low rate of preterm delivery. There was a high rate of vaginal delivery despite a high induction rate in this high-risk group of patients.

OBSTRUCTED HEMIVAGINA AND IPSILATERAL RENAL AGENESIS (OHIVRA) SYNDROME, A RARE DIFFERENTIAL FOR ABDOMINAL PAIN

Poster

Dr. Donnchadh O'Sullivan [1], ***Dr. Sara Ahmed*** [1], ***Mr. David Waldron*** [1], ***Dr. Mendinaro Imcha*** [2]

1. *University Hospital Limerick (UHL), Limerick,* ***2.*** *University Maternity Hospital, Limerick*

Background:
Herlyn-Werner-Wunderlich syndrome or obstructed hemivagina and ipsilateral renal anomaly (OHVIRA), is a rare Mullerian duct anomaly that consists of uterus didelphys, unilateral obstructed hemivagina and ipsilateral renal agenesis.
Patients with this syndrome usually present after menarche with pelvic pain and/or a mass. The initial clinical diagnosis is often incorrect due to the rare incidence of this anomaly and misleading presenting signs and symptoms. Strong suspicion and knowledge of this anomaly are essential for a precise diagnosis. **Case:**A 15-year-old female presented with a 2 week history of worsening pelvic pain. On examination she had a tender RIF, guarding, Rosving's sign + and Goldflam's sign + giving the initial impression of appendicitis or UTI. Pelvic ultrasound showed a uterus didelphys with unilateral haematocolpus and she diagnosed as a case of OHVIRA syndrome. She had a EUA for drainage of the haematocolpus, a septal division and follow-up with a menstrual diary and MRI.

Summary and Conclusion:OHVIRA syndrome should be considered as a differential diagnoses in young females with renal anomalies who present with pelvic pain shortly after menarche in association with a pelvic/vaginal mass and normal menstrual periods. Other presentations include abnormal vaginal discharge, infertility, vomiting, fever, acute urinary retention and as in this case acute abdominal pain.

OBSTRUCTED HEMIVAGINA WITH IPSILATERAL RENAL AGENESIS (OHVIRA SYNDROME); AN UNUSUAL PRESENTATION

Poster

Dr. Ellen Cosgrave [1], *Dr. Venita Broderick* [1], *Dr. Orla Sheil* [1]

1. *National Maternity Hospital*

OHVIRA Syndrome; A Case Study

Cosgrave, E. Broderick, V., Sheil, O.

National Maternity Hospital, Holles Street, Dublin 8.

OHVIRA syndrome, a triad of Uterus didelphys, Obstructed HemiVagina with Ipsilateral Renal Agenesis is a rare anomaly of the reproductive tract.It results from failure of fusion of the Müllerian ducts with asymmetric obstruction.

It is an uncommon cause of abdominal pain and dysmenorrhoea in young women. Diagnosis may be delayed due to the heterogeneity of symptoms and lack of knowledge of the condition.

A 38 yr old P0 presented with longstanding intermenstrual bleeding & vaginal discharge. She was diagnosed with uterus didelphys at the age of 23.

MRI imaging confirmed a Uterus Didelphys with a high vaginal septum on the left side. A moderate sized haematocolpos was identified. There was no haematometra. She had an absent kidney on the side of the obstruction. She underwent EUA +evacuation of the haematocolpos + excision of vaginal septum.The procedure was scheduled to coincide with menstruation to allow the haematocolpos to accumulate. Her second atrophic cervix was identified ad the vaginal septum was excised. She recovered well post op. The vagina remains patent and her symptoms have resolved.

OHVIRA syndrome should be considered in young women presenting with recurring abdominal pain or worsening dysmenorrhea to prevent delayed diagnosis. Early diagnosis is important to treat acute symptoms and prevent long term complications such as endometriosis and pelvic adhesions.An absent or dysplastic kidney warrants investigation for Müllerian abnormality.

First Mention: E. C.: Dr Ellen Cosgrave

OXYTOCIN FOR THE EXPERIENCED

Poster

Dr. Amaliya Morgan-Brown [1], ***Dr. Kateryna Kachurets*** [1], ***Dr. Niamh Garry*** [1]

1. *Department of Obstetrics and Gynaecology, MRHP (Midlands Regional Hospital Portlaoise), Co Laois*

Oxytocin was first synthesised in 1955, it is now used extensively for the augmentation of labour.
The aim of this audit was to compare local practice of oxytocin administration in multiparous women with the ”National Clinical Practice Guidelines on the use of oxytocin to induce or accelerate labour” April 2016.
Multiparous women in receipt of oxytocin between July and August 2017 were identified and ten cases were chosen for audit. The exclusion criteria included those with a history of previous lower segment caesarean section or prior myomectomy. Variables reviewed included: documented indication, documented discussion with mother; documented verbal consent, documented abdominal palpation, documented vaginal exam, recorded Bishop score, presence of tachysystole, staff response to tachysystole, use of fetal blood sampling (FBS), mode of delivery, Apgar score and performance of cord pH.
There were 10 cases selected for review representing 52% of the total cohort (n=19). The indication for oxytocin use was documented in 90% (n=9); documentation of discussion with mother in 10% (n=1); verbal consent was documented in 0% (n=0). Abdominal palpation was documented in 80% (n=8), vaginal exam was documented in 100% (n=10), and Bishop score was documented in 50% (n=5). Tachysystole was noted in 90% (n=9) with sequential review documented in 22% (n=2).
This audit details sub-optimal documentation surrounding informed maternal consent in regard to the use of intrapartum oxytocin. The findings of this audit and the National Guidelines will be presented at a teaching session and a re-audit will take place 3 months following staff continued education.

OXYTOCIN FOR THE NAÏVE

Poster

***Dr. Niamh Garry* [1], *Dr. Amaliya Morgan-Brown* [1], *Dr. Kateryna Kachurets* [1], *Dr. Miriam Doyle* [2]**

1. *Department of Obstetrics and Gynaecology, MRHP (Midlands Regional Hospital Portlaoise), Co Laois,* ***2.*** *HSE MIDLAND REGIONAL HOSPITAL PORTLAOISE*

Oxytocin is a neuropeptide hormone which is used for induction and augmentation of labour in Irish Obstetric units. Prior to April 2016 there was no national guideline on oxytocin administration and procedures varied across maternity units in Ireland.

The aim of this audit was to assess local practice of oxytocin administration to primiparous patients against the ''National Clinical Practice Guidelines on the use of oxytocin to induce or accelerate labour" April 2016.

Primiparous women in receipt of an Oxytocin infusions between July-August 2017 were identified via labour ward records. A selection of 10 charts were reviewed. Variables assessed included: documented indication for oxytocin by medical staff; documented discussion with the mother; documented maternal consent; performance of abdominal palpation; performance of vaginal examination prior to infusion commencement; recorded bishop's score; presence of tachysystole; performance of Foetal blood sample (FBS) and method of delivery.

The sample represented 50% of the available cohort (n=20). Indication for oxytocin was documented in 20% (n=2); explaination to the mother was recorded in 30% (n=3); verbal consent recorded in 20% (n=2); vaginal examination was performed in 100% (n=10); Bishops score documented in 10% (n=1); Tachysystole was noted in 60% (n=6) and FBS was performed in 20% (n=2)of the cases reviewed.

Despite a requirement for new NCHDs in Obstetrics and Gynaecology in MRHP to read current guidelines surrounding use of oxytocin there was suboptimal documentation regarding its use. Following presentation of this audit and of the guidelines, we hope to improve on re-audit in 3 months.

Pelvis Girdle Pain Survey in Pregnancy: A maternity hospital experience.

Poster

Dr. oladayo oduola [1]***, Dr. Thomas Mc Donagh*** [2]***, Dr. Micheal Oleary*** [3]

1. *Gal,* ***2.*** *Department of Obstetrics and Gynaecology, National University of Ireland, Galway,* ***3.*** *Uni*

Evidences have shown that a raising level of relaxin, progesterone and estrogen increases joint laxity in pregnancy resulting in Pelvis girdle pain (PGP).
Some studies suggest that pregnancy causes an irreversible widening and relaxation of the pelvis that result in instability and laxity of the joint(s).
Physiotherapists have been overwhelmed with multiple referrals for management of pelvis girdle pain which clinicians can manage.
Our aim was to assess the subjective PGP score in patients, in relation to the appropriateness of physiotherapy referral, as defined in the questionnaire from the national guidelines.
We administered an anonymous questionnaire to all antenatal patients within a two-week period.
177 patients responded to our questionnaire, five patients were excluded on the basis of incompletely filled surveys.
Fifty-three (31%) of the patients were referred to the physiotherapists seven (13%) were asymptomatic, twenty (38%) minimal, fifteen (28%) moderate, ten (19%) severe and one (2%) crippled PGP scores.
However, 69% of the patients were not referred and in this group 49% of the patients recorded a moderate pain score.
Our findings suggest that patient with higher PGP scores were not always being referred to physiotherapy. Therefore if the PGP score is used as a screening tool prior to physiotherapy referral, it could help reduce the waiting times and ensure that the right patients are getting the proper management.

PERCEPTION AND OPINION ON CAESAREAN SECTION RATES AND THE ROBSON TCGS IN WEXFORD GENERAL HOSPITAL NATIONAL MATERNITY HOSPITAL

Poster

Dr. Clare Kennedy **[1]** ***, Dr. Lavanya Shailendranath*** **[2]** ***, Dr. Sie Ong Ting*** **[3]** ***, Ms. Margaret Hanahoe*** **[4]** ***, Dr. Elizabeth Dunne*** **[1]**

1. *Department of Obstetrics and Gynaecology, Wexford General Hospital.,* ***2.*** *Cork University Maternity Hospital, Cork,* ***3.*** *cork,* ***4.*** *National Maternity Hospital*

Background:

Against the backdrop of rising caesarean section (C/S) rates,the WHO have recommended the Robson Ten Group system (TGCS) as gold standard for compiling data on c/s rates.It allows comparisons to be made across facilities and a more standardised approach to data collection.The TGCS was introduced into WGH in May 2017.

Purpose:

To investigate awareness and opinions amongst midwives on current c/s rates and the TGCS in WGH.

Study design and Methods:

A questionnaire was circulated to midwives in the hospital.Data was collected anonymously.Our questions aimed to ascertain what the awareness of c/s rates is.We asked for opinions on ideal c/s rates and about the need for audit and whether midwives can effect change at individual level or as a group.We also questioned awareness and understanding of the TGCS.

Findings of the Study:40 questionnaires returned.53% were aware of the current c/s rate in Ireland and 12% knew the rate for WGH. 100% felt this was too high.82%felt midwives could influence c/s rates.77% felt they personally could influence c/s rates.94% feel audit improves quality of care. 88% were aware of the TGCS but 15% said they would be able to create a Robson table.

Conclusions:

Education on the TGCS is key for it's successful implementation and improving our understanding of c/s rates.

PERINATAL OUTCOME AND MANAGEMENT OF PATIENTS WITH PREGNANCY INDUCED HYPERTENSION (PIH) AT OUR LADY OF LOURDES (OLOL)

Poster

Dr. Fatima Bhutta [1], ***Dr. Aliyah Alsudani*** [1], ***Dr. Asifa Andleeb*** [1], ***Dr. Etop Akpan*** [1]

1. Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda

PIH remain one of the leading causes of maternal and neonatal morbidity and mortality in Ireland. PIH can lead to pre-eclampsia, chronic hypertension, and an increase in lifetime cardiovascular risk. The HYPITAT Trial referenced in national guideline suggests that in PIH women, delivery after 37 weeks is associated with a significant reduction in fetomaternal risks.

This audit was conducted to ascertain the compliance at OLOL Hospital Maternity Unit with the national guidelines regarding the management and perinatal outcome in patients with PIH.

All women diagnosed with PIH from December 2016-February 2017 were identified from hospital database. Data was analysed for gestational age at diagnosis and delivery, mode of delivery, and fetomaternal outcome.

20 such cases were identified. 70% (n=14) were diagnosed with PIH at <37 weeks' gestation and 30% (n=6) between 37-40 weeks. 30% (n=6) cases with severe PIH were delivered before 37 weeks' gestation, whereas 70% (n=14) were delivered ≥37 weeks. 55% cases had emergency lower segment caesarean section and 45% were delivered vaginally. 85% (n=17) of the mothers suffered complications due to hypertension: uncontrolled hypertension (n=5), pre-eclampsia (n=6), small-for-gestational-age (n=1), intrauterine-growth-restriction (n=2), oligohydromnios (n=1), and post-partum-hemorrhage (n=2). Of note, 55% of the babies born were over 2.5 kg. 35% (n=7) of the neonates were admitted to NICU: six due to prematurity and one with low APGAR.

Based on this audit, it was concluded that the OLOL Maternity Unit is largely compliant with the national guidelines in terms of management and timing of delivery in patients diagnosed with PIH.

PERINATAL OUTCOMES OF TWIN 2 IN MULTIPLE GESTATION DELIVERY

Poster

Dr. Adriana Olaru [1]***, Dr. Sarah Meaney*** [1]***, Ms. Danielle Clifford*** [2]***, Dr. Keelin O'Donoghue*** [3]

1. *Cork University Maternity Hospital, Cork,* ***2.*** *University College Cork,* ***3.*** *Department of Obstetrics and Gynaecology, University College Cork, Ireland and The Irish Centre for Fetal and Neonatal Translational Research (INFANT), University College Cork, Ireland*

Background: One important concern in choosing the mode of delivery in twin pregnancy is perinatal outcome. Our goal was to examine the mode of delivery in twins and determine if twin 2 was at increased risk of perinatal morbidity.

Methods: This retrospective cohort study was conducted between 2009 and 2015 in Cork University Maternity Hospital, which is a large tertiary maternity hospital with > 8,000 deliveries per annum.

Results: Out of the 1242 twin pregnancies delivered in the 7-year period 66% (n=810) were delivered by caesarean section, with a higher rate seen in primiparous and advanced maternal age (>40 years) women. Twin 1 was more likely to have a spontaneous vaginal delivery 24.7% vs. 20.5% (p=0.01). The rate of instrumental delivery was lower for twin 2 (7.3%) vs. twin 1 (8.8%) (p=0.18). Twin 2 had a rate of breech delivery of 5.1% (n=63). The caesarean section rate following vaginal delivery of twin 1 was found to be 3.8% (16/415). Regardless of the mode of delivery, twin 2 was not at an increased risk of HIE (p=0.233), sepsis (p=0.347) or intraventricular haemorrhage (p=0.376) compared with twin 1.

Conclusion: The best method to deliver pregnancies in which the presenting twin is cephalic remains controversial. Our findings are similar to those of the Twin Birth Study, proving that the perinatal morbidity is not dependent on the mode of delivery and therefore, a trial of labour should be considered for a greater number of women with twin pregnancy.

PERINEAL ENDOMETRIOSIS: CASE REPORT

Poster

Dr. ELMUIZ HAGGAZ [1]
1. Midland Regional Hospital Portlaoise

Endometriosis is the presence of endometrial tissue outside the uterine cavity. Rarely, endometriosis may affect the vulva, vagina, or perineal region, generally secondary to obstetric or surgical trauma. In this case report, This is a case report of a histology-confirmed perineal endometriosis two years following ventouse vaginal delivery.

This case report aims to demonstrate the importance of proper early diagnosis and treatment of perineal endometriosis. Delayed diagnosis can result in extension of the disease process causing damage to nearby structures like the anal sphincter and rectum. This will also prolong the patient agony & can greatly affects her quality of life.

This is a 31 years old Para 1 with a longstanding history of soreness, dyspareunia & tenderness around the perineal area. Started following ventouse delivery with second degree perineal tear, which was complicated by infection & gapping of delivery scar. Following treatment with antibiotics, scar tissue “ridge like” was noted with hard nodule to the right side of midline.

Patient underwent excision of scar tissue plus refashioning of perineum during which two “chocolate lesions” were excised & sent for histology which confirm presence of endometriosis. Uneventful recovery ensued & the patient was asympotmatic eight weeks later.

Perineal endometriosis should be suspected in women with persistent perineal pain & discomfort after vaginal delivery particularly if skin lesion or a palpable nodule or mass is found. A histology will usually confirm the diagnosis. Surgical excision is the first choice of treatment with very good outcome.

PERIPARTUM CARDIOMYOPATHY: A CASE REPORT

Poster

Dr. Nada Warreth [1], ***Dr. Sasikala Selvamani*** [1], ***Dr. Etop Akpan*** [1]

1. Our Lady of Lourdes Hospital, Drogheda

A 32 year old G1 P1 presented day 5 post kiwi delivery complaining of headaches, palpitations and feeling unwell. Other than induction of labour at 38/40 for pregnancy induced hypertension, her pregnancy had been uneventful. On her second night of readmission, she started to complain of shortness of breath and orthopnoea. Her vitals were O_2 Saturations: 91% on room air and Respiratory Rate: 25 bpm. She was commenced on Oxygen. She had a normal JVP, a clear chest and bilateral pedal oedema.

A chest x-ray showed bilateral pleural effusion and a CT Pulmonary Angiogram was negative for pulmonary embolism but showed pulmonary oedema. An Echocardiogram showed an Ejection Fraction of 40%. She also had an elevated natruitic peptide of 3340. An ECG showed left ventricular hypertrophy.

She was transferred to the coronary care unit and commenced on IV Furosemide, IV Co-Amoxiclav, Ramipril, Atorvastatin and Galfer. She improved significantly and was subsequently discharged home on PO Furosemide and Rampril, with a plan for follow up in the heart failure clinic in 2 and 6 weeks.

Peripartum Cardiomyopathy (PPCM)is a life threatening disease which is defined as idiopathic cardiomyopathy frequently presenting with heart failure secondary to left Ventricular systolic dysfunction (LVEF <45%) towards the end of pregnancy or in the months following delivery. It is a diagnosis of exclusion. It has been shown that preeclampsia predisposes to PPCM. Most women present with signs and symptoms of heart failure. Treatment consists of standard heart failure treatment. Mortality rate is significant at 10%.

PERSISTENT TACHYCARDIA IN A POSTNATAL PATIENT

Poster

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Malignancies are being more frequently diagnosed in pregnancy, the most common type encountered being breast cancer, reported 1 in every 3,000 pregnancies. [1,2]

We present a 42 year-old patient, Para 1, who delivered via caesarian section for failed induction of labour. She was reviewed on day 2 post-op with persistent tachycardia of 120-135 beats per minute (bpm). Prior to delivery she had a heart rate of 90bpm and an uneventful pregnancy to date.

She was breastfeeding, asymptomatic and had no complaints. Her breasts were engorged bilaterally; cardiovascular, abdominal and lower limb examinations were unremarkable. There were no signs of infection, mastitis or intra-abdominal collection. ABG, Full Blood Count and Thyroid Function Tests were normal. There were no growths in blood cultures, urine, or vaginal swab as per septic work-up. ECG revealed sinus tachycardia.

A CT Pulmonary Angiogram was performed to rule out a pulmonary embolism. It surprisingly revealed a highly suspicious left breast lesion with axillary node involvement. Urgent referral for breast triple assessment confirmed ER/PR negative HER2 positive ductal carcinoma with metastasis in her left axillary nodes. She is currently awaiting follow up with the breast surgery and oncology team.

Interestingly, after these investigations, the patient admitted having felt a left sided breast lump and noted nipple discharge one month prior to delivery but assumed these were normal pregnancy-related changes.This highlights the importance of increasing awareness for breast cancer and promoting regular breast self-exams in the pregnant population.

PMB – THE PATIENT'S JOURNEY FROM REFERRAL TO DIAGNOSIS AT SIVUH, 2016

Poster

Dr. Cliona McGowan [1], ***Dr. Mairead Crowley*** [1], ***Dr. Angela Verrelli*** [1], ***Dr. Helen Doran*** [1]

1. *South Infirmary Victoria University Hospital*

In Ireland, approximately 300 women are diagnosed with uterine cancer each year.[1] Of those with PMB, 5-7% will have endometrial cancer[2].
This study was conducted to see if current practice regarding PMB at SIVUH is in line with UK NICE Guidelines for suspected cancer[3].

A retrospective study was conducted. Patients referred to the PMB clinic and patients investigated with diagnostic surgery at SIVUH in 2016 were audited. By correlating these figures, the patients journey from referral to diagnosis was calculated.

The total number of patients with PMB was 333. The average waiting time for clinic was 7.5 weeks. Less than 1% of patients were seen within the recommended 2 weeks. The average waiting time for diagnostic surgery was 4.5 weeks. 49% of patients were seen within the 31day recommended time frame.

This study highlights the delays in the patient's journey, from referral to diagnosis. There is a need for more clinics and more theatre time to cater for PMB patients. We also propose a "One stop Shop" system for the patient's first clinic, whereby a scan and hysteroscopy is performed at OPD.

[1] Irish Cancer Society (2017) *Cancer of the uterus* [online], available: **https://www.cancer.ie/cancer-information/womb-cancer#sthash.Pddw3K7v.dpbs** [accessed 20 June 2017]
[2] Yousaf, S., Shaheen M. and Rana, T. (2010) 'Frequency of Endometrial Carcinoma in Patients with Postmenopausal Bleeding' *Annals of KEMU*[online], Vol 16. No. 4, available**:http://annalskemu.org/journal/index.php/annals/article/download/248/207** [accessed 20 June 2017]
[3] British Gynaecological Cancer Society (2017) *BGUS Uterine Cancer Guidelines: Recommendations for practice*[online], available: **https://bgcs.org.uk/BGCS%20Endometrial%20Guidelines%202017.pdf** [accessed 20 June 2017]

POSTMENOPAUSAL BLEEDING- THE TALLAGHT EXPERIENCE

Poster

Dr. Eimear McSharry [1]***, Dr. Nadine Farah*** [2]

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Postmenopausal bleeding represents one of the most common reasons for referral to gynaecological services, due to suspicion of an underlying endometrial pathology (Anderson et al, 2001).

To analyse if the unit was compliant with the National Clinical Practice Guideline on the Investigation of Postmenopausal Bleeding.

In 2016, 106 women with postmenopausal bleeding were seen. Two charts were not located. A chart review was performed of the 104 patients included in the audit using a data collection pro-forma. Data was analysed using Microsoft Excel.

The average age of those referred was 58.52yrs, and the majority of referrals were from GP's (82.69%, n=86). Of note, 8 patients (7.69%, 8/104) had previously been investigated for postmenopausal bleeding. The average waiting time in weeks was 6.7 weeks, ranging from 0 to 25.4 weeks. All patients with postmenopausal bleeding received same day triple assessment (history and exam, USS and endometrial sampling) where indicated, in line with the national clinical guideline on the investigation of postmenopausal bleeding (n=104, 100%). Progression to hysteroscopy, dilation and curettage in the operating theatre setting was required in 49.18% of those that underwent an outpatient hysteroscopy (n=30, 30/61) which is 28.85% (n=30, 30/104) of those referred with postmenopausal bleeding. In total, 11.48% (n=7, 7/61) of those with postmenopausal bleeding and an increased endometrial thickness had positive histology.

Recommendations include the introduction of a target interval of six weeks from referral to first visit for postmenopausal bleeding referral.

POSTPARTUM GROUP B STRPTOCOCCUS SEPTICEMIA: A CASE REPORT

Poster

Dr. Sie Ong Ting [1], ***Dr. Lavanya Shailendranath*** [2], ***Dr. Elizabeth Dunne*** [1]

1. Department of Obstetrics and Gynaecology, Wexford General Hospital., 2. Wexford

GBS is a Gram-positive cocci which can present up to 35% from the genital and gastrointestinal tract in pregnant women.

A 43 years old primigravida woman with a background of corrected ventricular septal defect was admitted to our unit at 34+3 weeks with confirmed PPROM and was managed as per national guidelines. She underwent emergency caesarean section on day 3 of admission with suspicion of chorioamnionitis with placental swab and placenta sent.

She developed pyrexia of 38.2˚C with associated abdominal and chest discomfort on day 1 post operatively. She was commenced on therapeutic Innohep with suspicion of pulmonary embolism. She was treated with Clindamycin due to penicillin allergy. Septic screen showed GBS and she was commenced on weight-adjusted Gentamicin, Teicoplenem and Metronidazole for 2 weeks as recommended by microbiologist in Waterford University Hospital. Part of her workup included transvaginal pelvic scan, CTPA and TOE which were all negative. She made good progress until day 9 when she complained of abdominal distension and a ward ultrasound suspected a haematoma anterior to the rectus muscle. A CT abdomen and pelvis was arranged on day 10 showed a large haematoma with gas locules. She was transferred to tertiary unit for interventional radiology drainage and returned to our unit 2 days later.

A repeat ultrasound showed residual collection and patient was commenced on Teicoplenem and vancomycin for a further 2 weeks. The last ultrasound scan performed 2 weeks after repeat antibiotic regime showed complete resolution of the haematoma and she was discharged home.

PREDICTION OF RECURRENT PRETERM DELIVERY IN ASYMPTOMATIC WOMEN

Poster

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1. Coo

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Coombe Women & Infants University Hospital, Dublin, Ireland

Background:
Preterm birth is a major cause of infant morbidity and mortality. Prediction of preterm delivery has been made possible by cervical length surveillance and fetal fibronectin measurement.

Purpose:
To evaluate the risk of preterm delivery in asymptomatic pregnant women with previous preterm birth, using cervical length and fetal fibronectin (fFN).

Study Design and Methods:
A retrospective cohort study on asymptomatic pregnant women attending the Prevention of Preterm Birth Clinic. Women included in the study had previous preterm delivery. Initial evaluation by cervical length and vaginal fetal fibronectin occurred between 16 to 24 weeks. Preterm delivery before 37 and 34 weeks were the measured outcomes.

Findings of the Study:
26 women were included in the study, all were asymptomatic for preterm birth. A positive fetal fibronectin (>50) was detected in 19% (n=5) of these patients. Of these with positive fFN, only 1 went on to deliver preterm. An additional 4 patients who went on to have preterm delivery did not have a positive initial screening.

Conclusions and programme implications:
In asymptomatic women, fFN at previability does not seem to be effective in predicting recurrent preterm delivery. However, it is worthwhile to keep such patients in a specialised clinic for serial screening. This way patients at risk for preterm delivery may identified and fetal wellbeing can be optimised.

Pregnancy following myomectomy complicated by lower uterine segment leiomyoma

Poster

Dr. Raksha Beethue [1]***, Dr. Sasikala Selvamani*** [1]***, Dr. Etop Akpan*** [2]***, Dr. Seosaimh O'Coigligh*** [3]

1. *Our Lady of Lourdes Hospital, Drogheda,* ***2.*** *Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda,* ***3.*** *Our*

The prevalence of leiomyoma during pregnancy has been reported to be 1-4%. Although fibroids are associated with increased complications during pregnancy, careful surveillance during pregnancy, labor and delivery is associated with good maternal and fetal outcome. Here, we are presenting a case of pregnancy following myomectomy.

G is a 33yr old primigravida with a background history of myomectomy. Ultrasound showed multiple fibroids with the predominant one on the lower uterine segment extending to the cervix. The other fibroids were on the left-lateral and posterior wall.

A pelvic MRI was performed to map the sites and sizes of fibroids. The plan of delivery was discussed at the multidisciplinary forum. A plan was made for elective Caesarean at 39 weeks due to the large fibroid obstructing the lower segment. A slightly high transverse incision was made on the lower segment just above the fibroid and a healthy baby delivered. The estimated blood loss was 1.2L. Patient recovered well.

Although fibroids are associated with increased complications during pregnancy, prophylactic intervention is seldom warranted. Fibroids lying over the lower segment may prove a challenge at the time of caesarean section.

Where the fibroid impinges on the lower uterine segment or are near the cervix careful assessment needs to be made to determine the mode of the delivery. All patients undergoing these procedures should be consented for bakri-balloon, brace suture, interventional radiology and possibly Caesarean hysterectomy. The obstetrician should be well experienced to deal with any untoward events during such delivery.

Keywords: Fibroid, leiomyoma, pregnancy

Pregnancy over 40: Management and Outcomes

Poster

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Background

The average age of childbirth is rising. The incidence of babies born to women aged over 40 in 2006-8 was 3.6%, compared to just 1.2% in the 1980's. There is a continuum of risk associated with rising age. Women aged 40yrs have a similar stillbirth risk at 39 weeks to 25–29 year olds at 41 weeks.

Aim

To review outcomes of women who delivered over age 40 and to assess if they received appropriate management.

Methods

All cases of women over 40 delivering in WGH in 2016 were identified using the HIPE coding system. Charts were reviewed and the data retrospectively collected from this paper source.

Findings

Sixty six cases were included, reflecting 3.7% of all deliveries. The mean age was 41.5yrs. 13.6% (n=9) were primaparous. The mean BMI was 27.7kg/m^2. The mean gestation at booking was 18 weeks, with 78.5% (n=51) having a documented plan to deliver ≤40 weeks. 89.4% (n=59) had a first trimester scan, 16.7% (n=11) underwent first trimester screening and 97% (n=64) had a normal anatomy scan. GDM screening occurred in 86.4% (n=57) with the incidence of GDM 28.8% (n=19). The rate of CS was 33.8% (n=22).

Conclusion

The outcomes for women delivering over the age of 40 in WGH is good. Most had early scans, all had anatomy scans and most had a planned delivery at term. Further work is needed to ensure all are screened for GDM as this is and at risk group and the incidence in the cohort was high.

PREVALENCE OF OBESITY AMONGST ADOLESCENT GYNAECOLOGY ATTENDEES

Oral (Jogs)

Dr. Aisling Mc Donnell [1], ***Dr. Helena Bartels*** [1], ***Dr. Orla Sheil*** [1], ***Dr. venita broderick*** [1]

1. *National Maternity Hospital, Dublin*

One in four adolescent girls in the UK and Ireland are overweight or obese[1,2]. Adolescents with an elevated BMI are more likely to remain obese as adults[3]. Obesity presents numerous challenges in Obstetrics and Gynaecology.

The purpose of this review was to examine the prevalence of obesity in the adolescent population & to examine its possible contribution to gynaecological presentations.

All patients who attended the adolescent gynaecology clinic (age <18) at the National Maternity Hospital for the year 2016 were included in the study. A list of patients was generated using IPMS (Integrated Patient Management System) and data collected retrospectively via chart review. BMI was categorized using the Extended International (IOTF) cut-offs for BMI (ages 2-18) and patients were classified as Thinness Grade 1-3, Normal, Overweight, Obese or Morbidly Obese.

77 patients attended the service in 2016 and, of these, 75 charts were available for review. The median age was 16 (range 4-17). BMI was documented for 85.3% (N=64) patients at the index visit. Of these, 47% (N=30) were classified as overweight/obese and 3% (N=2) as Thinness Grade 1. Only 50% (N=32) were classified as having a normal weight.

There is a paucity of evidence relating to BMI among Irish adolescent girls.The prevalence of obesity in our clinic is very significant.Gynaecology clinic attendances provide an excellent opportunity for early targeted interventions in this age-group with the potential to influence outcomes at each stage of reproductive life. This information supports the case for a multidisciplinary approach with dieticians and endocrinologists.

PREVENTION OF EARLY ONSET GROUP B STREPTOCOCCAL (EOGBS) DISEASE IN NEONATES

Poster

Dr. Wiktoria Wyrzykowska [1], ***Dr. Tushar Utekar*** [1], ***Dr. Corina Oprescu*** [1], ***Dr. Sophie Boyd*** [1], ***Dr. Mendinaro Imcha*** [1]

1. *University Hospital Limerick (UHL), Limerick*

The incidence of EOGBS sepsis in the British Isles is 0.5/1000 and is the most common cause of admission for neonatal sepsis. The mortality of EOGBS is 10.6% and increases with prematurity. The neonatal outcome is also affected by the maternal risk factors, and improves significantly when an intrapartum antibiotic prophylaxis (IAP) has been administered.

However the inappropriate use of antibiotics and screening for prevention of EOGBS has been noticed. Of term asymptomatic women, 5000 have to be treated to prevent one case of EOGBS. Moreover, currently there is no data to support the safety of antibiotics in preterm infants.

The purpose of the study is to establish the number of GBS positive women and women treated with IAP, as well the incidence of EOGBS sepsis in the neonates in the UMHL.

The GBS status was obtained from the patients attending to UMHL as inpatients and outpatients between 1/08/2016 – 31/07/2017 and the site of the sample taken noted. Number of EOGBS sepsis was obtained from the neonatal unit for the same duration. The number of births for the said duration were 4740.

286 women were tested positive for GBS, 46% were detected on MSU, 27% on HVS, 20% had multiple sources of colonisation. There were 3 cases of EOGBS sepsis in neonates in the unit.

This information is obtained to investigate the incidence of GBS colonization rate and its actual translation into invasive EOGBS cases; this pilot will help us examine the validity of mass screening for EOGBS.

PROVISION OF POSTNATAL CONTRACEPTION INFORMATION AND PATIENT SATISFACTION – A SURVEY

Poster

Dr. Teresa Treacy [1]

1. *Obstetrics and Gynaecology, Coombe Women and Infants University Hospital, Dublin*

Postnatal contraception should be discussed at every opportunity. [1] Maternity services should be able to offer all appropriate methods of contraception to women prior to discharge.[2]Inter-pregnancy intervals of less than 6 months have been associated with an increased risk of negative perinatal outcome. Short inter-pregnancy intervals also increase the risks to maternal health; therefore, aside from the socioeconomic benefits, delaying future pregnancies may be beneficial in terms of health. [3]

The purpose of the survey was to identify whether patients are receiving adequate counselling and information with regard to postnatal contraception.

We asked 50 patients on the postnatal ward if they had the opportunity to discuss postnatal contraception in the antenatal period, upon admission to the labour ward, or in the postnatal period prior to discharge. If this was aural, visual or written information and if they were satisfied with the information they received.

The survey identified areas for improvement. Whilst all postnatal patients received written information regarding postnatal contraception prior to discharge, this may have been the first time in the pregnancy when postnatal contraception was discussed, prior to birth, women and partners may have greater time to think through their options than immediately after birth when it may not seem like a priority.

Childbirth presents an opportunity for providing contraception at a time when women are attending a service staffed by healthcare providers with the skills to offer a full range of methods and when women may be highly motivated to start using an effective method.

RECURRENCE OF GESTATIONAL DIABETES MELLITUS IN MULTIPAROUS WOMEN

Poster

Dr. Sie Ong Ting [1]***, Dr. Lavanya Shailendranath*** [2]***, Dr. Alya Yousuf*** [2]***, Dr. Mairead Noelle O'Riordan*** [2]

***1.** cork, **2.** Cork University Maternity Hospital, Cork*

Gestational Diabetes Mellitus (GDM) is a common complication in pregnancy and usually presented with hyperglycemia as a result of carbohydrate intolerance with the onset or first recognised during pregnancy. Previous GDM can be a strong indicator for future recurrent risk and is a useful tool to identify the increased risk of GDM in the subsequent pregnancy with a reported recurrence risk of 30-84%.

This audit aims to investigate the recurrence rate of gestational diabetes mellitus in the Cork University Maternity Hospital in 2016, as well as to identify the compliance of our maternity unit regarding gestational week and method of testing for diagnosis of GDM.

In 2016, there were 70.98% (274/386) of multiparous women were diagnosed with gestational diabetes mellitus in our maternity unit in Cork University Maternity Hospital in which 32.1% of them have had previous GDM and 37.6% of them have family history of diabetes mellitus. The average time for GDM to be diagnosed was at gestational 27+1 week with SD 7 weeks.

Our maternity unit is compliant with the recommended gestational weeks of 24 to 28 weeks for Oral Glucose Tolerance Testing by National Institute for Health and Care Excellence. The estimated recurrence rate of 32% in our maternity unit is quite similar to a few studies conducted worldwide showing a recurrence rate of 40%.

RENAL DISEASE IN PREGNANCY: A CASE SERIES

Poster

Dr. Mary Barrett [1]***, Dr. Gillian A Ryan*** [2]***, Dr. Caitriona Fahy*** [1]***, Prof. John J Morrison*** [2]***, Dr. Geraldine Gaffney*** [1]

1. *University Hospital Galway,* ***2.*** *Department of Obstetrics and Gynaecology, School of Medicine, National University of Ireland, Galway*

Renal disease that predates pregnancy can make a patient's antenatal care complex. Pre-existing complications such as hypertension and proteinuria can make the diagnosis of pregnancy specific illnesses such as preeclampsia very difficult to diagnose, potentially leading to delayed diagnosis or iatrogenic prematurity. Renal disease can often worsen with pregnancy, and can result in permanent loss of renal function.

This study is a prospective case series of 4 women attended our centre in 2017, with chronic renal disease (CKD) of varying aetiology, severity and duration. Two had stage 4 CKD and two had a history of renal transplant. They were jointly managed by nephrology and obstetric teams.

This aims is to highlight some of the difficulties that arise when managing women with CKD in pregnancy, and to review the maternal and fetal outcomes in this group in our centre.

Important factors in management included the severity of the underlying renal disease, medical comorbidities- particularly pre-existing hypertension and, crucially, patient compliance with a rigorous and intensive antenatal management plan.

CHD in pregnancy is becoming more prevalent issue across antenatal clinics with advanced maternal age and improvements in renal medicine allowing women with significant renal impairment to be in a position to consider pregnancy, particularly following transplant.

While intensive and thorough antenatal management can have successful outcomes for both mothers and babies, the impact on long term renal function needs to be monitored, as well as the impact of frequent hospital attendances on a woman's mental, social and professional life.

Reporting of Psychiatric Disorders in pregnancy: An observational study of GP vs Self Reporting of Psychiatric Disorders

Poster

Dr. Maeve Smyth [1], ***Dr. Mas Mahady*** [2], ***Dr. Mendinaro Imcha*** [1]

1. University Maternity Hospital, Limerick, 2. University of Limerick

Pregnancy is usually thought to be a period of well-being for women. However pregnancy and motherhood often increases vulnerability to psychiatric conditions. This was confirmed in the 2015 MBRACE report which found that psychiatric illness was the 5th most common cause of maternal death in the first 6 weeks postnatally. 23% of women who died between 6 weeks and one year postnatally died from mental health related causes.

With this in mind we aimed to investigate the concordance between GP versus patient reporting of mental illness. We also aimed to evaluate the need for a standardised GP referral letter in the ante-natal setting.

283 ante-natal clinic charts were reviewed. The charts were assessed for the content of GP letter, demographics, and self-reported history of mental illness. Demographic data was continuous and other data was coded for analysis. Exclusion criteria of the study was any patients aged below 18.

There was discordance within GP referral letters themselves and between the GP letters and patients self-reporting. 14 GP letters reported previous mental health issues however 15 reported previous treatment, 5 of these letters stated no history of mental health. 24% of patients versus 4% for GPs reported previous mental health illness. 5% of patients versus 0.7% of GPs reported previous perinatal mental health illness.

This study clarified the need for a standardised referral letter with a specific mental health section. It has also highlighted the need for further education among patients and GPs on the importance of mental health reporting and treatment.

Review of Gynaecological Laparoscopic Surgeries In Mullingar hospital

Poster

***Dr. Ream Langhe** [1], **Dr. Sarah Milne** [1], **Dr. Majda Almshwt** [1], **Dr. Nandini Ravikumar** [1], **Dr. Sam Thomas** [1], **Prof. Michael Gannon** [1]*

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Over the recent years, there have been an advancement in minimally access surgery along with instrumentation, which lead to the adoption of laparoscopy as an an alternative surgical approach to gynecological diagnosis and treatment. Gynaecological laparoscopy provides an excellent visualization of the pelvic structures and it is associated with a shorter hospital stay, fewer postoperative complications compared to laparotomy. However, Laparoscopy might result in bowel or vascular injury, which can be minimised in the hands of experienced surgeons.
The aim of this audit compares clinical practices used by obstetric department in Mullingar Hospital, against Royal College of Obstetric and Gynaecology (RCOG) guidelines No. 49.
A total of 189 women that underwent laparoscopy in Mullingar Hospital between 1st January 2016 and the 31st December 2016 were included in the audit. The following criteria were examined: Counseling/consent, grade of clinician, entry techniques and secondary ports.
Out of 189 laparoscopic surgeries performed, 180 (90%) were elective procedures and 19 (10%) were emergency procedures. All women were appropriately assessed and informally consented prior to surgery. Surgeries were performed by obstetric consultants (88%) and obstetric registrar (12%). Primary and secondary ports were inserted as per guidelines in all cases.
The overall outcome of this study shows that we are complaint with the recommended guidelines. A re-audit to be carried out to show that we are maintaining the same level of practice.

REVIEW OF OUTPATIENT HYSTEROSCOPY IN THE INVESTIGATION OF POST MENOPAUSAL BLEEDING IN WEXFORD GENERAL HOSPITAL

Poster

***Dr. Clare Kennedy* [1], *Dr. Consol Plans* [1], *Dr. Asish Das* [1]**

***1.** Department of Obstetrics and Gynaecology, Wexford General Hospital.*

Background: Endometrial cancer is the most common gynaecological malignancy in the Western World.$_{(1)}$OPH is a convenient and cost effective tool in it's diagnosis.**Purpose:**To evaluate adherence to referral criteria for OPH investigation of PMB.To gather figures on the diagnostic yield of OPH for PMB and to see how well tolerated hysteroscopy is in the outpatient setting.**Study Design and Methods:**We reviewed the data from patients referred to OPH between May-Aug 2017.We looked at their endometrial thickness (ET) on ultrasound to assess if the guideline for referral at WGH had been adhered to.We reviewed histology to identify those with abnormalities.Referral criteria in WGH states the following:ET <3mm no OPH,ET of 3-5mm should have a Pipelle biopsy prior to referral,ET >5mm warrants immediate referral to OPH.**Findings:**89 women were referred for OPH,32 had PMB.All 32 had ultrasound carried out.11 had an ET <3mm.12 had ET 3-5mm and only 2 of those had a Pipelle carried out prior to referral.8 had ET >5mm.11 had pathology noted at the time of hysteroscopy,the most common form being endometrial polyp (91%).2 had abnormal histology.OPH was tolerated in all patients.**Conclusions:**OPH is a valuable tool for the investigation of PMB but care must be taken to adhere to referral guidelines to ensure appropriate referrals. (1) Endometrial Hyperplasia, Management of (Green-top Guideline No. 67)

REVIEW OF THE MEDICAL MANAGEMENT OF MISCARRIAGE IN AN IRISH MATERNITY HOSPITAL

Poster

Dr. Andrew Downey [1]**, *Prof. Mary Higgins*** [1]

1. *National Maternity Hospital*

Background: Miscarriage occurs in 20% of clinical pregnancies. The emergence of outpatient medical management of miscarriage is an increasingly used alternative to surgical evacuation.

Purpose of Study: To determine the outcomes of the medical management of first trimester miscarriage in a large maternity hospital.

Study Design and Methods: This was a retrospective study based on a detailed chart review. The sample was of a group of women who presented to the National Maternity Hospital over a one month period for medical management of first trimester miscarriage. The treatment protocol that was used is based on the HSE National Clinical Practice Guideline for the Management of Early Pregnancy Miscarriage.

Findings of the Study: Of the 29 women studied, 23 (79%) underwent successful medical management of first trimester miscarriage without significant side effects or complications.

Of the 6 women (21%) who had retained products of conception demonstrated on transvaginal ultrasound two weeks post treatment, half underwent further medical management and half underwent surgical management.

One patient required hospital admission with heavy bleeding after a second course of medical management. She was managed conservatively.

There were no infections, blood transfusions, or need for emergency surgical uterine evacuation after treatment.

Conclusions and Programme Implications: Medical management is a safe and effective treatment for first trimester miscarriage. The successful management rate in this study is in line with the international literature.

SECOND STAGE DURATION DURING TRIAL OF LABOUR AFTER CAESAREAN

Oral (Jogs)

Dr. Mark Philip Hehir [1]***, Dr. Dwight Rouse*** [2]***, Dr. Russell Miller*** [3]***, Prof. Cande Ananth*** [4]***, Ms. Zainab Siddiq*** [3]***, Dr. Jason Wright*** [3]***, Dr. Mary D'Alton*** [3]***, Dr. Alexander Friedman*** [3]

1. *Columbia University College of Physicians and Surgeons, New York Presbyterian Hospital, New York,* ***2.*** *Division of Research, Department of Obstetrics and Gynecology, Women and Infants Hospital, Warren Alpert Medical School at Brown University, Providence, Rhode Island,* ***3.*** *Columbia University College of Physicians and Surgeons, New York Presbyterian Hospital New York,* ***4.*** *Department of Epidemiology, Joseph L. Mailman School of Public Health, Columbia University, New York*

Allowing a longer second stage of labour may increase the likelihood of vaginal delivery. However, for women undergoing trial of labour after caesarean, probabilities of vaginal delivery based on second stage duration and maternal and neonatal risks are poorly characterised.

This secondary analysis of the National Institute of Child Health and Human Development Maternal–Fetal Medicine Units Cesarean Registry dataset, an observational trial assessing women with a prior uterine scar, included women with one previous caesarean without prior vaginal delivery who reached the second stage of labour. The primary outcome was mode of delivery by second stage duration. Secondary outcomes included individual maternal(chorioamnionitis, atony, endometritis, uterine rupture, and ICU admission) and neonatal(cord pH<7.10, Apgar score<6 at 5 minutes, NICU admission, and ventilatory support) outcomes.

Of 4,579 women with a previous caesarean who reached the second stage, 4,147(90.6%) delivered vaginally. As second stage length increased vaginal delivery rates decreased:97.3% at<1 hour(95%CI 96.6-97.9%), 91.5% at 1 to <2 hours(95%CI 89.8-93.1%), 78.5% at 2 to<3 hours(95%CI 74.5-82.1%), 62.3% at 3 to<4 hours(95%CI 55.2-69.1%), and 45.6% ≥4 hours(95%CI 37.7-53.7%). Risk for all adverse maternal outcomes increased with the length of the second stage. Specifically, risk for uterine rupture increased with second stage length from<1 hour(0.7%), 1 to<2 hours(1.4%), 2 to<3 hours(1.5%), to≥3 hours(3.1%) ($p<0.01$). Risk for adverse neonatal outcomes did not differ by second stage length.

While many women with longer second stages during TOLAC will achieve vaginal delivery these patients may be at increased risk for adverse maternal outcomes and need close monitoring.

SISTER MARY JOSEPH NODULE- AN UNUSUAL SITE FOR ENDOMETRIOID CANCER METASTASIS. A CASE REPORT.

Poster

Dr. Sarah Petch [1], ***Dr. Aleksandra Sobota*** [2], ***Dr. Claire Thompson*** [2], ***Dr. Ciaran O'Riain*** [3], ***Dr. Dr Feras Abu Saadah*** [4]

1. St ja, 2. 1.Gynaecological Oncology Department, St James's Hospital, 3. 2.Histopathology Department, St James's Hospital, 4. (2)Department of Gynaecology Oncology St. James's Hospital, Dublin 8, Ireland

Sister Mary Joseph (SMJ) nodules are rare malignant metastatic umbilical nodules, usually associated with gastrointestinal (50%) or genitourinary (25%) cancers. Unfortunately, they are associated with a poor prognosis, indicating disseminated disease.

We present the case of an 80 year old lady who presented with a SMJ nodule consistent with a diagnosis of endometrioid cancer. She was initially referred to Upper GI Surgery, presenting with umbilical discomfort. On examination she was noted to have a hard nodule at the umbilicus, a bulky uterus and bleeding per vagina. Her background history includes obesity, type 2 diabetes, hypertension, hypercholestrolaemia and atrial fibrillation. CT showed uterine fibroids with a bulky uterus and right sided lymphadenopathy starting from the groin to the para-aortic area. Upper and lower endoscopy were normal. Biopsy of the umbilical nodule revealed endometrioid adenocarcinoma grade 1-2 , positive for Keratin 7, ER, PR. Negative for keratin 20, CDX2 & TTF-1, with endometrium or ovary suggested as potential primary sites.

Patient had a full staging cytoreductive surgery with zero residual, we are awaiting final histology and MDT discussion regarding adjuvant treatment.

This unusual case highlights the diagnostic challenges faced with the presentation of a SMJ nodule. It shows the importance of immunohistochemistry in differentiating the primary site of cancer. Gynaecolpgical malignancy should always be considered within the initial differental diagnosis of a SMJ nodule.

SUCCESSFUL EXPECTANT MANAGEMENT OF AN INTERSTITIAL ECTOPIC PREGNANCY

Poster

Dr. Fiona O'Toole [1]***, Dr. Daniel Kane*** [1]***, Dr. Katie Beauchamp*** [1]***, Dr. Vineta Ciprike*** [1]

1. *Our Lady of Lourdes Hospital, Drogheda*

Interstitial ectopic pregnancy (EP) is rare, representing 1- 6.3% of EP. Diagnosis and management can be challenging with a high risk of rupture at early gestation.
CR, a 37yo para 4, presented with two days of PV bleeding and a positive pregnancy test. Her LMP gave her a gestation of 11 weeks. Examination was unremarkable except for old blood in the vagina.
BHCG was sent and she was discharged with an EPAU appointment in two days.
Transvaginal scan was suspicious for an interstitial EP with an empty uterus, and a mixed echogenic structure measuring 4x4x2cm in the right cornua. Differential diagnosis was a degenerating fibroid. 48hr BHCG decreased from 2376 to 2006. CR was admitted with new mild lower abdominal pain and continued bleeding. She remained haemodynamically stable. Repeat scan by consultant confirmed previous US findings. A further 48hr HCG dropped to 1331. Expectant management was decided upon and CR was discharged with plan for repeat scan and HCG in one week. Follow-up scan was unchanged. CR remained asymptomatic and BHCG dropped to 428. Imaging was reviewed at MDT with a plan for continued expectant management.
An MRI pelvis correlated with ultrasound findings. Weekly HCGs continued to fall and became negative within four weeks. The right cornual lesion has decreased in size and she will have follow-up imaging.
Expectant management of interstitial pregnancy is more likely to be successful with low initial BHCG. It avoids potential morbidity from surgical management or methotrexate, is cost-effective, and safe in selected cases.

TARGETED ANTI-D ADMINISTRATION - THE FIRST IRISH PERSPECTIVE

Oral (Jogs)

Dr. Ciara McCormick [1]***, Dr. Mohammed Abbas*** [1]***, Mr. Leo Mulvany*** [1]***, Dr. Marie Christine De Tavernier*** [1]

1. *Portiuncula Hospital, Ballinasloe, Co-Galway*

The administration of anti-D to prevent rhesus alloimmunisation is one of the major success stories of modern obstetrics. The incidence of alloimmunistaion is now below 1% and has reduced further with routine 28 week anti-D administration. The identification of foetal rhesus status may allow us to reduce the administration of blood products and reduce cost.
We aimed to review the rhesus status of women and babies delivering at our unit over a 6 month period and investigate the amount of anti-D being administered. We sought to evaluate the introduction of foetal genotyping since implementation in July 2017.
Blood groups of babies delivered by rhesus negative mothers over 6 months July-January 2016/17 were reviewed with records of anti-D administration. Clinic records from the newly established rhesus clinic were reviewed.
Of 883 mothers delivered 16% were rhesus negative. Of these rhesus negative mothers, 38% delivered rhesus negative babies. 31 patients received antenatal anti-D. 16 of these women delivered rhesus negative babies.
Since introduction of routine genotyping and prophylactic anti-D, 52 rhesus negative women have been identified and tested. Results to date are as follows: 30 rhesus positive foetuses and 13 rhesus negative. 9 samples have results pending, due to sample timing or labelling errors (n=4), inconclusive results (n=2), awaiting results (n=2), and presence of antibodies (n=1). Data collection is ongoing.
Foetal genotyping presents an opportunity to identify rhesus negative women who do not require anti-D therapy. This will reduce our use of blood products and cost.

Ten Year Review of Maternal Morbidity In A Large Teritary Referral Teaching Hospital In Ireland

Poster

Dr. Suzanne Smyth [1], ***Dr. Keelin O'Donoghue*** [2]

1. *Centre for Perinatal Research, UCD Obstetrics and Gynaecology, University College Dublin, National Maternity Hospital,* ***2.*** *Department of Obstetrics and Gynaecology, University College Cork, Ireland and The Irish Centre for Fetal and Neonatal Translational Research (INFANT), University College Cork, Ireland*

To assess and review rates of maternal morbidity in a large tertiary referral teaching hospital in Ireland over a seven year period , from 2009 – 2016 so that data could be compared to national and international records.
A retrospective review of all maternity patients admitted to the Intensive Care Unit in the adjoining general hospital was performed. Information was gathered on demographics , parity , gestational age , maternal morbidity as well as patient management and outcome. Data was analyzed using SPSS predictive analytic software.

There were 54 admissions to the ICU in Cork University Hospital during the seven year study period. Massive obstetric haemorrhage accounted for the largest proportion of these patients (n= 20) followed by acute respiratory dysfunction and pre-eclampsia. The average length of stay was 2.77 days. There were equal numbers of primiparous and multiparous women. Almost half (48%) of patients had pre-existing medical problems. Mechanical ventilation was required for 70% of the patients. There were a significant number of preterm deliveries (n= 24) and neonatal unit admission as required for 58% of the babies born to mothers who were classified as having a maternal morbidity.
The division of higher level care between two effectively different departments resulted in incomplete documentation. With the introduction of the electronic health record these inaccuracies will be improved upon. The causes of severe maternal morbidity have remained stable over a 7 year period and are largely in line with national and international data.

THAT is NOT Gynae! - A Case of Unusual Labial Odema Pathology

Poster

Dr. Sorca O Brien [1]***, Dr. Siobhan Moran*** [1]***, Mr. Ruaidhri Mcvey*** [2]

1. *Dept. of Gynaeoncology, Mater Misericordiae University Hospital,* ***2.*** *Cons. Gynaeoncologist Dept. of Gynaeoncology, Mater Misericordiae University Hospital*

Background Labial abscesses and swelling are common referrals to the Gynaecology service in general hospital casualty departments. The majority can be managed conservatively or medically with antibiotics and analgesia. Intermittently referrals will be inappropriate due to the true nature of underlying pathology. This is a case of a 53 year old who presented to Casualty following a two week period of feeling generally unwell, nausea, vomiting and postmenopausal bleeding. She had a significant and complex background. At presentation by ambulance transfer the patient was hypotensive, tachycardic, tachypnoeic and hypothermic, bearing all the hallmarks of sepsis. At catheterisation she was noted to have extensive left labial swelling. Gynaecology referral was made on this basis. At assessment the patient was in Trendelenberg position and had already commenced inotropic support. On initial survey extensive left labial oedema was noted. No labial abscess was isolated. Minor echymoses were noted at the left buttock region. CT abdomen/pelvis was advised urgently to assess if intra-pelvic pathology existed. Imaging revealed extensive gas in the tissues extending from labia to perineum. Necrotising fasciitis was suspected and she was reviewed by General Surgeons and Plastics. She was transferred to theatre for extensive resection and cared for in ICU thereafter. This case highlights the importance of reviewing patients personally, efficiently and thoroughly with appropriate escalation on concerning findings/suspicions.

THE ADMINISTRATION OF ANTENATAL CORTICOSTEROIDS IN ELECTIVE CAESAREAN SECTION BEFORE 39 COMPLETED WEEKS GESTATION.

Poster

Dr. Claire M McCarthy **[1]**, ***Dr. Maeve Eogan*** **[1]**

1. *Rotunda Hospital*

The RCOG recommends the use of antenatal corticosteroids (ANCS) prior to elective Caesarean Section (ECS) prior to 38+6/40 to reduce to risk of transient tacchypnoea of the newborn.
We aimed to assess compliance with this guideline had improved, and determine if there were any further obstacles to the administration of this guideline.
We conducted a retrospective two-month chart review of patients undergoing ECS prior to 39 completed weeks gestation. We examined patient demographics of this cohort, and the rate of ANCS. as well as patient demographic.
The average gestation of ECS in the cohort of 77 women was 37+1 weeks (range 33-38+6). 47 patients had a previous CS, with 29 patients having a reoeat ECS.
Overall, 32.4% of women received ANCS, 72%%(n=18) and 28% (n=7) of women received ANCS within one and 6 weeks of their CS respectively. Of 7 multiple pregnancies, 6 received ANCS, while none of the 8 diabetic pregnancies received ANCS. Of the 42.9%(n=33) patients booked by Non-Consultant Hospital Doctors (NCHDs), 60.6% (n=20) received ANCS, compared to 11.3%(n=5) of consultant bookings. The NICU admission rate was 15.5%(n=12).
Poor compliance with ANCS is evident, with consultants less compliant with the guideline than NCHDs. Efforts need to be made to avoid performing ECS prior to 39 weeks' gestation and introduce interventions to improve compliance with international guidance.

THE ADMINISTRATION OF OXYTOCIN TO A SCARRED UTERUS: AN AUDIT OF ADHERENCE TO NATIONAL GUIDELINES.

Poster

Dr. Kateryna Kachurets **[1]**, ***Dr. Niamh Garry*** **[1]**, ***Dr. Amaliya Morgan-Brown*** **[1]**, ***Dr. Miriam Doyle*** **[2]**

1. *Department of Obstetrics and Gynaecology, MRHP (Midlands Regional Hospital Portlaoise), Co Laois,* ***2.*** *HSE MIDLAND REGIONAL HOSPITAL PORTLAOISE*

In women with a previous caesarean section (CS) the use of Oxytocin in labour increases the risk of uterine rupture. Therefore the decision regarding its use should be made by a Consultant Obstetrician.
The aim of this audit was to assess local practice of oxytocin administration in patients with a previous caesarean against the “National Clinical Practice Guidelines on the use of oxytocin” April 2016.
Cases with a previous CS in receipt of oxytocin in labour between June-August 2017 were reviewed. Variables assessed included: documented indication for oxytocin by medical staff; documented discussion with the mother; documented maternal consent; performance of vaginal examination prior to infusion; recorded Bishop’s score; presence of tachysystole; performance of Foetal blood sample (FBS) and method of delivery.
Ten records were reviewed and indication for oxytocin was documented in 80% (n=8); oxytocin started in 1st stage of labour or following artificial rupture of membranes in 100% (n=10); explanation to the mother recorded in 10% (n=1); verbal consent recorded in 10% (n=1); vaginal examination documented in 80% (n=8); Bishop’s score documented in 30% (n=3); continuous CTG monitoring maintained in 90% (n=9); FBS performed in 30% (n=3); frequency of contractions recorded every 20 min in 90% (n=9) and vaginal delivery occurred in 100% (n=10) of cases examined. In 60% (n=6) of newborns delivered cord gases were analysed and 10% (n=1) had pH <7.2.
The overall adherence to national guidelines is above average. Following presentation of this audit, we aim to re-audit to improve documentation surrounding maternal consent.

THE CONTRIBUTION OF A NON-CANCER CARE CENTRE TO CANCER CARE FOR GYNAECOLOGICAL PATIENTS IN IRELAND

Oral (Jogs)

Dr. Elizabeth Mary Marliza O'Dwyer [1], ***Dr. Amy O'Higgins*** [1], ***Dr. Eibhlin Frances Healy*** [1], ***Dr. Aisling Heverin Heverin*** [1], ***Dr. Maeve Mccarthy*** [1], ***Dr. Aoife Mcsweeney*** [1], ***Dr. Cliona Murphy*** [1]

1. *Department of Gynaecology, Adelaide & Meath Hospital incorporating the National Children's Hospital (AMNCH), Tallaght, Dublin 24*

Background: In Ireland, data on referral pathways to Gynaecological Oncology centres are not collected consistently. Strategic provision for cancer care services is restricted without baseline data.

Purpose of study: The aim of this study was to assess the contribution of a Gynaecological service in a non-cancer care centre to the diagnosis and preparation of patients for management of their cancer.

Methods: This was a retrospective cohort study. It included all cervical and endometrial cancers diagnosed at Tallaght Hospital from January 2012 to June 2017. Histological and radiological data was obtained from the Hospital's databases.

Findings: There were 180 cases of gynaecological cancer diagnosed. Of these, 55% (n=99) were cervical in origin, 45% (n=81) were endometrial. Following diagnosis of cancer, the majority of women, 71.6% (n=129) underwent imaging prior to transfer to a cancer care centre. There were 187 scans performed for 180 women. Of these 40.6% (76/187) were Magnetic Resonance Imaging scans and the 59.4% (111/187) were Computed Tomography scans. The total estimated cost of these was €35,241.

Conclusion: Non-cancer care centres contribute significant resources to the care of Gynaecological cancer patients in Ireland. We believe that our data contributes to the understanding of cancer care provision in Ireland and that this data is useful in strategic management of and planning for cancer care resources.

The current management of Hyperemesis Gravidarum at LGH

Poster

Dr. Thomas Mc Donagh [1]

1. *Letterkenny University Hospital*

T. Mc Donagh, N Janjua, O. Yousif, Y. Kassab, M. Mc Kernan.

Letterkenny General Hospital, Donegal, Ireland

Hyperemesis Gravidarum (HG) is a severe form of nausea and vomiting in pregnancy often requiring hospital admission.

An audit was performed on 30 admissions to LGH with HG, case notes were analyzed as follows: Length of stay, Gestational weeks, Ultrasound performed, Electrolyte disturbances adequately corrected, Pabrinex given, Thromboprophylaxis and Anti-emetics agents.

The average LOS,gestational age and urine ketones on admission were 2 days, 9 weeks & 2+ respectively. Percentage of women who received thromboprophylaxis, teds and pabrinex were 66%, 53% and 57 % respectively.First line and 2nd line antiemetics 70% and 30% respectively. None of the patients had abnormal serum electrolytes or required steroids.

Though we are managing HG effectively, if we compare our practice we need to improve on use of 1st line anti-emetics and adequate thromboprophylaxis.

The Doctor is always write: Local compliance with best practice and ease of identification from medical documentation

Poster

Dr. Philippa Fogarty [1], ***Dr. Miriam Doyle*** [1]

1. HSE MIDLAND REGIONAL HOSPITAL PORTLAOISE

According to Health Service Executive Standards and Recommended Practices for Healthcare Records Management, a Doctor's name and medical council number should be legible. Each chart entry should include a clear signature, printed name and Irish Medical Council Registration number (MCRN).

The aim of this audit is to see if doctors could be readily identified from each entry they made in the patients chart.

Five inpatient charts were reviewed retrospectively of both obstetric and gynaecology patients. Entries from inpatient, outpatient, antenatal and postnatal elements were examined. Patient charts were examined to assess complicance of a signature, printed name and IMC number being present. The Irish Medical Council website search tool was then used for a maximum of three attempts to confirm if the doctor could be identified on the register.

Review of 5 charts resulted in a total of 40 Doctor entries for evaluation. Of entries assessed, 25% (n=10) contained a printed name, 75% (n=30) a signature and 70% (n=28) MCRN number. In 55% (n=22) of entries it was possible to match the identity of the doctor as recorded on the IMC website register. Of the 22 identities matched to the register, 95% (n= 21) had included their Irish Medical Council Number.

In conclusion, the easiest way to identify a doctor to their individual chart entry is by medical council registration number. Failure to comply with best practice could cause delay in identification and future consequences for the doctor making the entry.

THE IMPORTANCE OF ADEQUATE TRAINING IN TEN-GROUP ROBSON CLASSIFICATION IN CONTRIBUTING TO ACCURACY OF CAESAREAN SECTION RATE

Poster

***Dr. Sie Ong Ting* [1], *Dr. Lavanya Shailendranath* [1], *Dr. Clare Kennedy* [1], *Dr. Bushra Faiz* [1], *Dr. Magid Abubakar* [1], *Dr. Elizabeth Dunne* [1]**

1. *Department of Obstetrics and Gynaecology, Wexford General Hospital.*

WHO and FIGO have both introduced the Ten-Group Robson Classification in 2014 and 2016 respectively. The Ten-Group Robson Classification has recently been introduced to our maternity unit in April 2017. A pilot audit has been conducted to ascertain that staff members were correctly identifying and categorising each pregnant woman in labour.

All deliveries from 1 June 2017 until 31 August 2017 were reviewed manually from the birth registry book.

There was a total of 431 deliveries from June until August 2017 in which only 63.3% of Robson classification was documented in the birth registry book of which 85.3% were documented correctly, 9.2% incorrectly while 5.5% had missing data.

The largest discrepancy was seen in Group 4 (7.8%), followed by Group 5 (6.8%). The registry also conveyed inconsistency in Robson 6 with 10.4% in correct classification versus 6.3% documented. On the contrary, the birth registry showed a higher incidence than corrected classification in Group 7 (0.5% versus 0.2%) and Group 8 (1.4% versus 1.2%).

Apart from that, it was noted that almost all the Robson Groups had lower contributions to the caesarean section rate with the largest discordance in Group 5 (3.94% documented versus 7.8% correctly classified).

The documentation of Ten-Group Robson Classification is insufficient in our maternity unit in addition to incomplete and incorrect data be entered into the birth registry book. The discrepancies in this audit might be explained by the fact that not all staffs may have received adequate training due to the shift work system.

THE LOST PESSARY

Poster

Dr. Catherine O'Gorman [1], ***Dr. Aoife McTiernan*** [1], ***Dr. Hassan Rajab*** [2]

1. Rotunda Hospital, Parnell Street, Dublin 1, 2. Beaumont Hospital/ Rotunda Hospital

A 70 yo woman was admitted to the gynaecology ward following an ED attendance with abdominal and lower back pain, persistent foul vaginal discharge and malaise. Her background history included a vaginal hysterectomy seven years earlier for prolapse which was complicated by vault prolapse twelve months later. The patient had attended the gynaecology clinic regularly since hysterectomy with vault prolapse for which she had sacrospinous fixation. On assessments in clinic, persistent granulation tissue was noted at the apex of the vault which was biopsied to exclude malignancy and she was treated with topical oestrogen creams. Ultrasound for persistent vaginal discharge demonstrated a collection which was surgically drained vaginally. On the index admission from the emergency department the patient underwent a CT abdomen and pelvis which demonstrated a shelf pessary in the right side of the abdomen with and inflammatory collection involving numerous loops of bowel (see pictures). On further enquiry into her previous management it found that the patient had attended her gynaecologist initially with vault prolapse one year after vaginal hysterectomy. A shelf pessary was inserted in the gynaecology clinic. The patient felt very uncomfortable and attended the GP who could not find the shelf pessary and assumed that it had fallen out. She was referred back to the gynaecology clinic. Our case demonstrates the need for clear communication regarding the use of vaginal pessaries between healthcare providers and the need to clearly determine the location of a missing pessary early on.

THE RELATIONSHIP BETWEEN BODY COMPOSITION MEASURED USING ADVANCED BIOELECTRICAL IMPEDENCE ANALYSIS (BIA) AND MATERNAL BODY MASS INDEX (BMI) AND WEIGHT TRAJECTORIES BETWEEN PREGNANCIES

Oral (Jogs)

Mr. Dáire Goodman [1]***, Ms. Maria Laura Acosta Puga*** [1]***, Ms. Rachel Kennedy*** [2]***, Ms. Ciara Reynolds*** [2]***, Dr. Eimer O'Malley*** [2]***, Prof. Michael Turner*** [2]

1. *University College Dublin,* ***2.*** *UCD Centre for Human Reproduction Coombe Women and Infants University Hospital, Dublin*

The incidence of maternal obesity is rising in most developed countries. Identifying factors leading to maternal weight gain could provide opportunities to intervene. Studies in the literature to date focus on BMI trajectories but BMI is a surrogate measure of adiposity.

This retrospective longitudinal study examined maternal body composition and its relationship with maternal weight and BMI trajectories between pregnancies.

Maternal weight, BMI, fat free mass, fat mass, fat percentage, visceral fat level and bone mass were measured in the first trimester using advanced Bioelectrical Impedance Analysis (BIA) in women recruited at their convenience to a dietary study in 2009. Maternal weight and BMI were gathered for subsequent pregnancies up to June 2017 (n=94).

Mean age was 26.0(SD 5.0)years in the first pregnancy. The mean interval between pregnancies was 3.8(SD 1.8)years with a mean weight increase of 3.7(SD 6.2)kg and BMI increase of 1.2(SD 2.5)kg/m^2 between pregnancies.

Visceral fat and fat mass were the strongest BIA predictors of obesity in the second pregnancy. Of women in the fourth quartile for visceral fat in their first pregnancy studied, 35% were obese but 80.0% were obese by their next pregnancy. Of women in the fourth quartile for fat mass, 30.4% were obese while 78.3% were obese by the second pregnancy studied.

The direct measurement of maternal adiposity by BIA in early pregnancy correlates not only with surrogate measurement using BMI, but results from this longitudinal study suggest it may be useful as a screening tool to predict maternal obesity in subsequent pregnancies.

THE ROLE OF A DEDICATED PRE-TERM SURVEILLANCE CLINIC OFFERING CERVICAL CERCLAGE; CHANGING OUTCOMES FOR WOMEN: A FIVE YEAR ANALYSIS AT THE NATIONAL MATERNITY HOSPITAL HOLLES STREET

Oral (Jogs)

Dr. Ann Rowan [1], ***Dr. Niamh Fee*** [1], ***Ms. Larissa Luethe*** [1], ***Prof. Shane Higgins*** [1]

1. National Maternity Hospital

Purpose
To analyse outcomes for women at risk of spontaneous pre-term labor who attended our pre-term surveillance clinic and had a cervical cerclage.
Study
A prospective observational study between 2012-2017. Inclusion factors: a previous delivery between 16 and 34 weeks or ≥2 large loop excision of the transformation zone(LLETZ) procedures. Cervical cerclages were history indicated or based on cervical length <25mm at <24 weeks gestation on transvaginal ultrasound. Cerclages were McDonalds technique using either mersilene tape or ethilon under spinal or general anaesthetic.
Results
Five hundred and fifty-five women attended the clinic, with 8.5%(47) undergoing cerclage. Average age 33, BMI 26.5kg/m^2, 45%(21) nulliparous, 83%(39) Caucasian, 3 twin pregnancies. At first antenatal visit average gestation was 9 weeks. Fifty-seven percent(27) had a history of preterm labor, 32%(15) ≥2LLETZ, 11%(5) had both. Average gestation at cerclage was 16 weeks; 53% (25)inserted between 12-14 weeks, 47% (22) inserted between 16-24 weeks gestation. Mean continuity of pregnancy post cerclage was 17.7 weeks. Seventy-five percent(35) received prolutin injections.
Forty-one fetus' were born by study completion including 3 twin pairs. Average gestation at delivery 34.4 weeks, 83% delivering ≥28 weeks, 39% ˃37 weeks. Average birth weight 2.5Kg. Majority delivered vaginally 69%(28), 24%(10) by emergency caesarean, 7%(3) by elective caesarean. There were two caesarean sections for chorioamnionitis but both women and their babies were well at discharge. There was one neonatal death.
Conclusion
Individualising the decision to insert a cervical cerclage, followed by attending a dedicated pre-term surveillance clinic results in successful pregnancy outcomes.

THE TEN-GROUP ROBSON CLASSIFICATION: AN APPROACH FOR ASSESSING CAESAREAN SECTION RATES

Poster

Dr. Sie Ong Ting [1]**, *Dr. Lavanya Shailendranath*** [1]**, *Dr. Elizabeth Dunne*** [1]

1. *Department of Obstetrics and Gynaecology, Wexford General Hospital.*

In the recent years, the rate of caesarean sections have increased worldwide especially in middle- and high-income countries, posing a concern to our public health. The Ten-Group Robson Classification was first proposed in 2001 and later been introduced by WHO in 2014 and FIGO in 2016.

This pilot audit analysed the contribution of specific obstetric groups to the caesarean section rate in our maternity ward using the Ten-Group Robson Classification.

All deliveries from 1 June 2017 until 31 August 2017 were manually reviewed from the birth registry book and grouped accurately (previous pilot study showed poor classification in original documentation) to Robson Classification. All data collected were analysed using SPSS Statistics.

The caesarean section rate was 27.15% within 3-months period in which Group 2 and Group 5 both had the highest contributory risk of 7.89%. Unfortunately, 9.5% of the caesarean section rate was unable to be classified due to incomplete data from the birth registry book.

We plan to implement a uniform criterion or a local policy for all induction of labor to reduce the risk of caesarean sections. In addition, we should also look into our target group of women with one previous caesarean section by encouraging and supporting more women for vaginal birth after caesarean section (VBAC) if suitable.

THE UNLIKELY DIAGNOSES: A CASE SERIES.

Poster

Dr. Niamh Garry [1], ***Dr. Cathy Monteith*** [1], ***Dr. Miriam Doyle*** [2]

1. Department of Obstetrics and Gynaecology, MRHP (Midlands Regional Hospital Portlaoise), Co Laois, 2. HSE MIDLAND REGIONAL HOSPITAL PORTLAOISE

PID (Pelvic Inflammatory disease) represents a spectrum of infections of the upper genital tract, most commonly seen between 15-24 years. Risk factors include multiple sexual partners, previous PID and transcervical instrumentation.

Over a two month period in MRHP, we had two climacteric women in stable relationships present to the A+E department who were subsequently diagnosed with tubo-ovarian abscesses necessitating surgical management.

Case 1: 49 Y.O presented to A+E on 20/07/2017 with lower abdominal pain. Vitals: 38.3°C, 109bpm, RR 22/min, 84/54mmHg, Lactate 3.4–SIRS 3. No gynaecological history. Mirena coil in-situ. O/E: abdomen soft, minimal tenderness. Impression: diverticulitis. Referred to surgeons and CT-AP (CT Abdomen Pelvis) performed. Findings: loculated abscess in right adenexa. Gynaecology consultant review, patient brought to theatre for laparoscopic incision and drainage. Patient recovered well. Discharged 27/07/2017.

Case 2: 55 Y.O presented to A+E 08/06/2017 with RIF (Right Iliac Fossa) pain. No gynaecology history. Vitals: BP 97/47, afebrile, other vitals normal. Lactate 0.8 O/E Tender RIF, mass palpated. Impression: appendicular abscess. CT-AP performed, verbal report: appendicular abscess. Brought to theatre for laparoscopic appendectomy. The gynaecology team were consulted to theatre ?right exudating tubo-ovarian abscess. Right adenexectomy performed. Copper Coil Removed from uterus. Postoperatively well. Discharged 12/06/2017.

These two similar cases which presented to our regional gynaecological department within such a short space of time highlight the need for a good initial history and a broad differential diagnosis in general emergency departments in order to correctly diagnose and manage patients who are acutely unwell.

The Use of Methotrexate in the Management of Ectopic Pregnancy

Poster

Dr. Catherine Finnegan [1], *Dr. Jenny Stokes* [2], *Dr. Jennifer Donnelly* [3]

1. Obstetrics and Gynaecology, Rotunda Hospital, Dublin, 2. Ro, 3. Rotunda Hospital, Parnell Street, Dublin 1

Methotrexate is recommended as treatment in women with unruptured ectopic pregnancies <35mm, minimal pain, HCG <1500iu and no intrauterine pregnancy. Large studies have reported that 14% of women will require a second dose and less than 10% will require surgery. The aim of this re-audit was to assess how many patients received methotrexate, were they appropriately selected and whether follow up conformed to guidelines.
This was the second cycle of a retrospective audit carried out between January - November 2014.
The population chosen was anyone who had methotrexate for a suspected ectopic pregnancy. Charts were pulled to review ultrasounds they may have had and if laparoscopy was performed. Day 4 and Day 7 levels were recorded. The length of follow up in days and the final bHCG level taken was recorded.
38 patients received methotrexate. 4 (10.5%) required a second dose and one required laparoscopy (although this subsequently was a molar pregnancy). 94% had FBC, U+E and LFTs done. All had USS performed, 44.8% had an adnexal mass. Of those seen, none were >35mm, none had fetal cardiac activity. HCG was taken in all. The average number of HCGs taken was 9. Day 4 was recorded in 86.2% of patients. Day 7 recorded in 89.6%. 44.8% had a final HCG recorded of <2iu. Of the remainder 3 had a final level recorded >25iu.
Methotrexate is a safe and successful treatment in appropriately selected women and levels of intervention are lower than those recommended as a minimum in international best practice.

USE OF A VISUAL AID IN ADDITION TO A COLLECTOR BAG TO EVALUATE POSTPARTUM BLOOD LOSS: A PROSPECTIVE SIMULATION STUDY.

Poster

Dr. MARION BROOKS [1]

1. *Angers University Hospital*

Postpartum haemorrhage (PPH) is one of the most common causes of mortality in obstetrics worldwide. The accuracy of estimated blood loss is a priority in determining appropriate treatment.

Will the additional use of a visual aid improve physicians' accuracy in estimating blood loss compared to the use of a collector bag and baby scale alone?

Simulation training sessions created three vaginal delivery scenarios for participants to estimate volumes of blood loss: firstly, using only a collector bag and a baby weight scale and secondly, adding a visual aid depicting known volumes of blood. The primary endpoint was to determine if participants could accurately evaluate blood loss within a 20% error margin.

The addition of the visual estimator resulted in overestimation of blood loss. The rates of participants' estimations were significantly more accurate when using the collector bag with the baby weight scale without the addition of the visual aid; 85.5% versus 33.3% ($p<0.01$) for 350 mL, 88.4% versus 50.7% ($p<0.01$) for 1100mL and 88.4% versus 78.3% ($p<0.01$) for 2500 mL, respectively.

Additional use of a visual aid with a collector bag does not seem to be useful in improving the accuracy in the estimation of blood loss.

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USING HUMAN PAPILLOMAVIRUS (HPV) TESTING TO EXAMINE THE SIGNIFICANCE OF EXCISION MARGINS IN WOMEN TREATED WITH LARGE LOOP EXCISION OF THE TRANSFORMATION ZONE

Poster

Dr. Adrianne Wyse [1], ***Prof. Paul Byrne*** [2]

1. royal, 2. Obstetrics & Gynaecology, Royal College of Surgeons in Ireland, Dublin,

Large Loop Excision of the Transformation Zone (LLETZ) is the gold standard treatment for Cervical Intraepithelial Neoplasia (CIN). Most studies assessing the significance of the resection margin status have used cytology as a test of cure (TOC).

Our study aimed to assess the association between excision margin status and eradication of CIN in women treated by LLETZ using HPV status as a TOC.

Women treated by LLETZ between 2012 and 2016 and for whom excision margin status and TOC outcome were available were reviewed. Treatment success was based on the presence of a negative HPV test at six and 18 months following treatment.

1742 women who had been treated by LLETZ had histologically confirmed CIN, known excision margin status and follow up data available. 640(37%) had complete excision and 1102(63%) had incomplete excision of CIN. Six months following treatment 532(83%) patients with complete excision margins and 868(79%) with incomplete excision margins were HPV negative [Chi.Sq.=4.8759(p<0.05)]. At 18 months 308(89%) patients with complete excision margins and 508(87%) with incomplete excision margins were HPV negative [Chi.Sq.=0.8333(p>0.05)].

We found a statistically significant difference in HPV TOC status at six months based on excision margins. This difference became statistically insignificant at 18 months. This would suggest that clearance of HPV is not complete at 6 months for many women treated with LLETZ and raises the concern that testing HPV status six months following treatment is too early. It also supports the observation that excision margin status is a poor indicator of success of treatment.

UTERINE TORSION IN THIRD TRIMESTER OF PREGNANCY - TWICE IN A DECADE Authors: Dr. Morgan Lyons, Dr. Abdelmagid Gaboura and Dr. Nirmala Kondaveeti

Poster

Dr. ABDELMAGID GABOURA [1]

1. *Sligo University Hospital*

Uterine torsion is a rarity in obstetric medicine which has a significant morbidity and mortality rate. This phenomenon has occurred twice in Sligo University Hospital in the past decade, a presentation which many obstetricians would never have witnessed.
30 year old,39 weeks gestation,G6P3+2(3 previous C sections) was brought by ambulance after collapsing at home. Patient became distressed with abdominal pain and PV bleeding. BP unrecordable, severe tenderness on right side of abdomen, weak thready pulse.
US scan showed Intra-uterine foetal death. Vaginal examination showed posterior, long and closed cervix; presenting part not felt in the pelvis.
Patient resuscitated and transferred to theatre for emergency caesarean section.On laparotomy there was 180 degrees torsion of the uterus,posterior surface of the uterus becoming anterior.Attempts to untorsion the uterus were abandoned due to heavy bleeding.Incision made on the posterior wall and noted complete placental abruption.A stillborn baby delivered and the previous uterine scar noted to be intact.There was atonic bleeding of 3000mls which required B-Lynch suture.Recovered well post-operatively in the ICU and discharged home on day5.
Six weeks postnatally, patient was fine and considering another pregnancy. Counselled regarding admission at 34 weeks and delivery around 37 weeks.

VAGINAL DELIVERIES IN THEATRE AT MIDLANDS REGIONAL HOSPITAL PORTLAOISE A.Duffy, M.Gardasanic, M.Doyle Midlands Regional Hospital Portlaoise

Poster

Dr. Ailbhe Duffy [1], ***Dr. Marko Gardasanic*** [1], ***Dr. Miriam Doyle*** [1]

1. HSE MIDLAND REGIONAL HOSPITAL PORTLAOISE

Approximately 2% to 5% of instrumental deliveries, due to anticipated difficult delivery, are conducted in theatre with preparations made for proceeding to caesarean section.
The aim of this audit was to determine the factors influencing vaginal deliveries in theatre and to assess maternal and neonatal outcome.
All vaginal deliveries in theatre from 2006 – 2015 were included. Information from patient's booking histories, labour ward and theatre admissions were collected from charts and analysed using excel.
Thirty-seven vaginal deliveries took place in theatre. The mean age at booking was 28.8 years and mean booking weight was 68.1kg. Twenty-two women were primiparous. The mean gestation at delivery was 39+2 weeks and 26 cases were spontaneous onset. 24 women had an epidural. Non-reassuring CTG was the most common reason for going to theatre and of these, 26 were planned for a trial of instruments and 11 for emergency caesarean section. The most common instrument used for delivery was the metal cup (n=14), followed by the Kiwi (n=8), forceps (n=8) and silastic cup (n=4) respectively. Two women had SVDs and one had a caesarean section. Twenty-six women had an episiotomy and 30 women had a blood loss of less than 500ml. Mean birth weight was 3.5kg and 7 babies were transferred to the special care baby unit from theatre.
At present, the evidence from randomised controlled trials on instrumental deliveries in theatre versus immediate caesarean section is sparse. This audit complies the key information required to carry out further research in this area.

WHAT TO EXPECT WHEN PERFORMING THE FETAL FIBRONECTIN TEST: A RETROSPECTIVE AUDIT IN MRH PORTLAOISE

Poster

Dr. MARION BROOKS [1]

1. *Angers University Hospital*

Preterm Labor (PTL), defined as birth < 37+0 weeks' gestation, is the leading cause of neonatal morbidity and mortality in economically advantaged countries. Identifying which women with threatened PTL will ultimately deliver is challenging whether using the fetal fibronectin test or cervical length.

The purpose of the audit was to review retrospectively the use and outcomes of the Fetal Fibronectin Test in MRH Portlaoise.

A retrospective audit of the use of the fetal fibronectin test was performed between March 2017 -August 2017 (time of implementation). Variables assessed included: gestational age when the test was performed, the test's result and sequential response in terms of maternal care plan (in-utero transfer, steroid treatment, gestational age at delivery).

A fetal fibronectin test was performed in 14 women. Of those with a swab performed 28.6% (n=4) were not processed secondary to the absence of clinical signs of PTL. Of those processed 10% (n=1) had a positive test result, which was performed at 29 weeks' gestation. That patient was appropriately transferred in-utero to a tertiary maternity centre to allow for optimization of neonatal resuscitation, delivery outcome unknown. Of patients admitted with threatened PTL 85% (n=12) had a negative/unprocessed fetal fibronectin test and 50% (n=7) were in receipt of steroids. Only one patient delivered in MRHP <37 weeks and their sample was not processed.

Use of the fetal fibronectin test is new in MRH Portlaoise. Its continued use in guidance of patient management should be performed in tandem with clinical assessment for signs of PTL.

WOMENS LIVED EXPERIENCE OF GESTATIONAL DIABETES

Poster

Ms. Ruth Byrne [1]***, Ms. Ciara Kirwan*** [1]***, Dr. Anamaria Lelia Nicolaiciuc*** [2]***, Dr. Nyan Chin Liew*** [2]***, Dr. Asish Das*** [2]***, Prof. Elizabeth Dunn*** [2]***, Prof. mary higgins*** [3]

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Background

Gestational Diabetes (GDM) is increasing in prevalence and remains a significant cause of maternal, fetal and neonatal morbidity and mortality. When diagnosed with GDM women often describe the shock and distress resulting from the diagnosis.

Purpose

This study aimed to follow on from published work from our group exploring womens lived experience of a diagnosis of GDM and adaptations in their pregnancy.

Study Designs and Methods

Based on previous qualitative research, a questionnaire was developed reviewing women's reaction to the diagnosis, support services and responses to management. Consenting women with a diagnosis of GDM attending either the National Maternity Hospital, Dublin (n=75), or Wexford General Hospital (n=30) completed the questionnaire.

Findings

Over a six-week period 105 questionnaires were completed (90% response rate). One third were primiparous, and 24 had previous GDM. Median gestational age at diagnosis was 28 weeks (4-37 weeks). Women worried more for their babies' health (89%) than their own (68%). A clear majority (97%) were more conscious of the food they ate and found the diet and lifestyle changes manageable (82%). Family (94%) and medical professionals (93%) were significant sources of support. Women were clear about why they had GDM (71%), what they needed to do (85%) and information they were given (85%). A majority (89%) reported disappointment in the diagnosis.

Conclusions and Implications

This study highlight the importance of support and information to women with newly diagnosed GDM.

We wish to acknowledge the help of Midwives M Stafford, U Daniel, C Coveney and E Rutter.

Would elevated sperm DNA damage alter embryological and clinical consequences in donor oocyte programme?

Oral (Jogs)

***Dr. Conor Harrity* [1], *Dr. Chris Elizabeth Philip* [1], *Dr. Davor Zibar* [1], *Dr. John Kennedy* [2], *Ms. Sarah Pace* [2], *Dr. Kevin Marron* [2]**

***1.** Beaumont Hospital, **2.** SIMS clinic*

Reactive oxygen species generated within sperm from ART or indeed natural conception can have detrimental effects on susceptible sperm DNA and thus could potentially have knock-on effects on fertilisation, embryo formation and pregnancy rate.
Many techniques are available to determine this susceptibility, but to-date none have shown a clear correlation between the technique used, the use of IVF or ICSI, and the clinical pregnancy rate (CPR). Some recent data has proposed a link between high amounts of DNA fragmentation in sperm and miscarriage.
A retrospective, observational study to assess the effect of Semen DNA fragmentation analysis (SDA) levels on reproductive outcomes was performed from January 2014 to Dec 2016.
An SDA test was performed on male partners following unsuccessful own oocyte ART cycles prior to progressing to donor oocytes. SDA fragmentation was analysed for patients undergoing 53 donor oocyte treatment cycles. Subsequent sperm samples were frozen and used for ICSI insemination. Embryos were slow frozen at the 2 pronuclei stage and transported back to SIMS IVF, where they were subsequently thawed, cultured to blastocyst and replaced as part of a frozen embryo transfer cycle.
Sperm DNA fragmentation didn't effect outcomes in donor oocyte ICSI cycles. This is important, as female factors were accounted for;
; oocytes were obtained from young donors with normal ovarian reserve and proven fertility history. Although elevated DNA fragment Index(DFI) may potentially have an adverse impact, this study shows that ICSI may compensate.

Prediction of Preterm Labour Study

Oral (Jogs)

Dr. Helena Bartels [1], ***Dr. Vicky O'Dwyer*** [2], ***Prof. Shane Higgins*** [1]

1. National Maternity Hospital, 2. JOGS

Preterm birth (PTB) remains the leading cause of neonatal morbidity and mortality, hence its prediction and prevention provides opportunities for improving outcomes. Up to 30% of patients presenting with threatened PTL may be admitted to the hospital[1,2] Only 5-10% of these will deliver within 7 days[3,4] Thus 85% of admissions are unnecessary.[5]

The purpose of this study was to evaluate the use of a cervical length measurement on transvaginal ultrasound and a partosure test (vaginal swab to detect placental alpha1 macroglobulin) in predicting preterm labour.

Patients ≥18 years of age with a singleton pregnancy between 24+0 and 34+6 weeks gestation presenting with suspected preterm labour were recruited. Inclusion criteria were intact membranes, no vaginal bleeding within the previous 24 hours and a vaginal examination to rule out labour. Each patient had a cervical length and a partosure test performed. Admission and treatment was as per hospital guideline.

Twenty patients were enrolled over a 3 month period. The average gestational age at presentation was 29+2 (range 24+4 to 33+5). 18 patients had a cervical length measurement >1.5mm and a negative partosure test; no patient in this group went into labour in the following 7 days. Two patients had a cervical length <1.5mm and a positive partosure test. Both delivered within 8 hours of presentation.

In conclusion, the study found that cervical length and a partosure test is a reliable tool for predicting pre term labour. Their use in clinical practice may reduce the number of unnecessary admissions.

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