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Ir Med J; March 2025; Vol 118; No. 3; P51
March 20th, 2025

Institute of Obstetricians & Gynaecologists and Junior Obstetrics & Gynaecology Society Annual Meeting 2024

RCPI, 6 Kildare Street, Dublin 2 on Friday 29th November 2024

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RATES OF NEGATIVE LAPAROSCOPY FOR SUSPECTED ECTOPIC PREGNANCY

Topic / Dept:

1. Early Pregnancy Unit, Department of Obstetrics & Gynaecology, Cork University Maternity Hospital, Ireland
2. Pregnancy Loss Research Group, Department of Obstetrics and Gynaecology, University College Cork, Cork, Ireland

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Background:
Ectopic pregnancy (EP), where implantation occurs outside the endometrial cavity, affects about 11 per 1,000 pregnancies with a maternal mortality rate of 0.2 per 1,000[1]. Negative laparoscopy rates for suspected EP vary from 5-25% between units with no accepted national standard[1].

Objective:
The aim of this study was to evaluate the incidence of negative laparoscopy for suspected EP in our unit.

Study design and Methods:
We conducted a retrospective review of electronic health care records of all women who underwent diagnostic laparoscopy for suspected EP on ultrasound in our unit from 1st January to 31st July 2024. Eligible cases were identified from EPU ultrasound records. Anonymised relevant clinical data was transcribed to an Excel file and descriptive analyses performed.

Results:
During the timeframe reviewed, there were 49 women who had a suspicion of EP. Of these, 45% (n=22) underwent primary surgical laparoscopic management; 13% were negative for EP (n=3). Mean duration from decision for surgery until surgery was 11.3 hours (range 1-36 hours). Surgery was performed either by senior registrar (86%; n=19) or consultant (14%; n=3). EP was confirmed

in 87% (n=19) of which 47% (n=9) had ruptured prior to surgery. Negative laparoscopy rate was 13% in this cohort. Mean blood loss was 346mls (range 100-1000mls)

Conclusion:
Our negative laparoscopy rate sits within internationally accepted ranges. However, in order to reduce this rate, we should consider interventions to improve our detection rates, as well as reduce to risk of unnecessary surgeries for our patients.

Tweetable Abstract:

Negative laparoscopy for ectopic pregnancy was reported at 13% in Cork University Maternity Hospital in the period from 1st January to 31st July 2024, which sits within internationally accepted ranges. Rates of negative laparoscopy must be continuously audited and further investigations should be considered to maintain rates as low as possible.

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MID-TRIMESTER RUPTURE OF THE MEMBRANES: IRISH PERSPECTIVE FROM A TERTIARY UNIT FOLLOWING CHANGE OF TOP LEGISLATION.

Topic / Dept: Prematurity

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Abstract Body Field (2,100 characters/<)

Background:

Midtrimester pre-mature pre-labour rupture of membranes (MTPPROM) between 14+0-23+6 gestation age (GA) is a rare complication of pregnancy associated with poor maternal and fetal outcomes. Since the Health (Regulation of Termination of Pregnancy (TOP)) Act, 2018, parents can opt to TOP after 12+0 GA where there is a risk to the “life or health” of the woman or where the fetus is “likely to die within 28 days of life”. This legislative change means that accurate data is critical counselling families.

Objective

To describe the outcomes following MTPPROM and compare to a similar study conducted prior to liberalisation of the TOP legislation.

Study Design and Methods:

This study measures outcomes at a tertiary referral centre in Ireland with approximately 7000 deliveries per annum. Retrospective cohort study of consecutive MTPPROM from January 2018 to February 2024 in National Maternity Hospital.

Findings/Results:

109 patients met inclusion criteria, at a prevalence rate of 0.2%. The median maternal age was 33 and median GA at MTPPROM was 21+0, with an median latency period of 7 days (IQR 26 days, range 0 -147 days). 77% experienced an obstetric complication, with no maternal mortalities. The neonatal survival to discharge (NSTD) was 27.5%. These outcomes are compared to the publication by Linehan et al. paper (Table 1) prior to the Health Act 2018 showing a NSTD rate of 5%.MTPROM between 14+0-19+6 had a lower NSTD compared to those over 20+0 GA (10%vs41%, p value=0.0003). These cases had a higher rate of manual removal of placenta (MROP)(30%vs13%,p value=0.02). Anhydramnios was associated with a 0% NSTD. Singleton pregnancies with oligohydramnios had a lower NSTD compared to those with normal liquor volume (21%vs51%,p value=0.007). 90% of the patients who opted for TOP had a deepest vertical pool of less than 2cm and had a higher rate of chorioamnionitis (34%vs73%,p value=0.01)(Table 2).

Conclusion:

While NSTD is higher for patients with normal liquor volume and PPROM after 20 weeks, mortality and morbidity still continues to be high. The majority of patients who opted for TOP were diagnosed with chorioamnionitis and oligohydramnios reflecting a higher NSTD percentage post legislation.

Tweetable abstract:

Retrospective study of MTPPROM in tertiary hospital since the Health (Regulation of TOP) Act, 2018 reporting majority of patients who opted for TOP were diagnosed with chorioamnionitis and oligohydramnios therefore reflecting a higher neonatal survival to discharge percentage post legislation.

*Maternal morbidity: Any patient who had at least one obstetric complication.

**Neonatal morbidity: Any infant who survived to discharge that had at least one respiratory/gastroenterology/cardiac/neurology/developmental complications.

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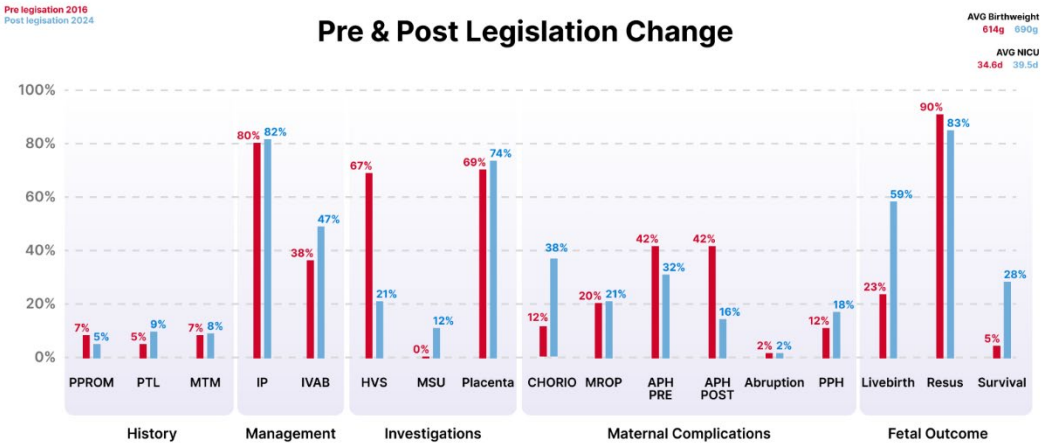

Table 1. Comparative data between pre legislation (Linehan et al. BMC Pregnancy and Childbirth (2016)) versus our post legistation study. Comparing maternal history, management, investigations, maternal complications and fetal outcome.

PPROM = premature prelabour rupture of membranes, PTL = preterm labour, MTM = mid trimester miscarriage, IP = inpatient, IVAB = intravenous antibiotics, HVS = high vaginal swab, MSU = midstream urine, Placenta = Chorioamnionitis on placenta histology, CHORIO = clinical chorioamnionitis, MROP = manual removal of placenta, APH PRE = antepartum haemorrhage before PPROM, APH POST = antepartum haemorrhage after PPROM, PPH = postpartum haemorrhage, Resus = resusication attempt, Survival = survival at discharge.

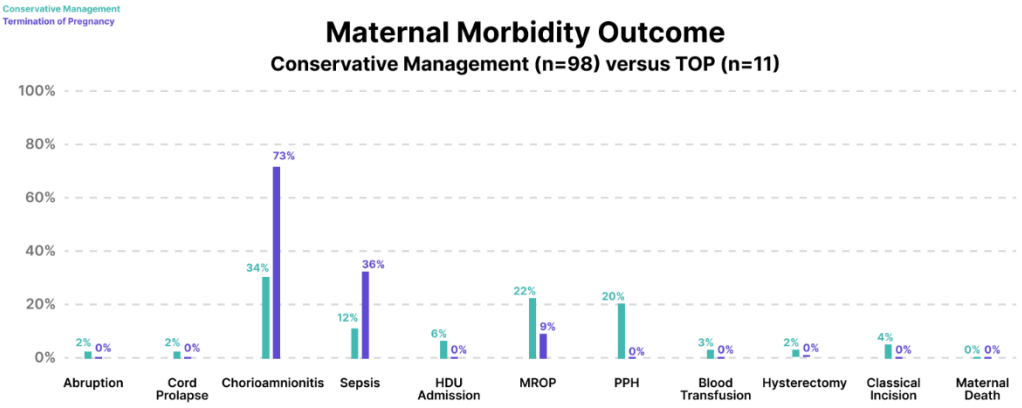

Table 2. Comparative data of maternal morbidities between patients who opted for termination of pregnancy versus conservative management.

TOP = Termination of Pregnancy, HDU = High Dependency Unit, MROP = Manual Removal of Placenta, PPH = Postpartum haemorrhage over 500ml

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A RETROSPECTIVE COHORT STUDY OF MATERNAL AND NEONATAL OUTCOMES IN THE ROTUNDA HOSPITAL'S BARIATRIC PATIENT POPULATION

Topic / Dept:

[1]Royal College of Surgeons Ireland
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Background

Obesity is a growing crisis, and bariatric surgery is a proven, effective approach. The largest cohort undergoing this surgery are women of childbearing age. In recent years, Irish women have started traveling abroad for this surgery resulting in minimal follow-up. Little is known about the impact of bariatric surgery in pregnancy, and on neonatal outcomes.

Objective

The aim of this study was to characterise the maternal and neonatal impacts of bariatric surgery in the growing cohort presenting to the Rotunda Hospital.

Study Design

This retrospective cohort study included 124 patients with a history of bariatric surgery who delivered between January 2022 and July 2024. Over 150 variables were assessed. Data were collected from electronic patient records and analysed on Excel.

Results

Gastric Sleeve surgery was the most popular type of bariatric surgery performed in this cohort (75.85%). Most surgery was performed abroad (83.87%) with 58.06% having surgery in Turkey. Our results showed significantly higher rates of gestational diabetes (67%) and hyperemesis (26%) compared to the normal obstetric population ($p<0.001$). Maternal BMI dropped by a

median 14.84 kg/m^2 between surgery and booking. The median surgery to booking interval was 19 months.

Birthweights were overall lower with a median neonatal birthweight on the 43rd centile. Additionally, the type of surgery performed impacted on birthweight with birthweights significantly lower following a gastric bypass compared to gastric band surgery (p=0.046) figure.1. However, BMI at booking and time from surgery to booking were only weakly correlated to neonatal birthweight centile. (r=0.0325, r= 0.074)

Induction rates were 47.46% in nulliparous and 36.67% in multiparous mothers, while emergency caesarean section rates were 27.12% and 13.33% respectively. The elevated rates of GDM may be driving high induction and subsequent emergency caesarean section rates.

Conclusion

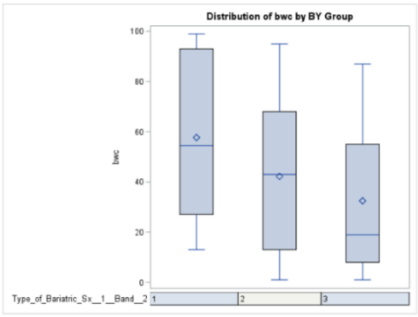
This study highlights the rise of bariatric tourism among Irish women and the implications on the obstetric course.

Table 1

Demographics	**Median (SD) / % (N)**
Age	31.00 (5.91)
Ethnicity	
White Irish	77.4% (n=96)
Black African	4.84% (n=6)
Other	17.74% (n=22)
Parity	
Nulliparous	50% (n=62)
Multiparous	50% (n=62)
Pre-surgery BMI	43.83 (8.56)
Booking BMI	28.99 (6.10)
Bariatric Surgery History	
Type of surgery	
Band	8.06% (n=10)
Sleeve	75.81% (n=94)
Bypass	14.52% (n=18)
Several	1.61% (n=2)
Location of surgery	
Turkey	58.06% (n=72)
Ireland	14.52% (n=18)
Surgery to booking interval (months)	19.5 (33.22)
Antenatal care	
Hyperemesis	26% (n=32)
Mean PUQE score	10.13 (n=24)
PIH	5% (n=6)
PET	3% (n=4)
GDM	
y-diet	66.96% (n=75)
y-insulin	5.35% (n=6)
y-metformin	4.46 % (n=5)
Did not attend	8.93% (n=10)

Neonatal Outcomes	**Median (SD) / % (N)**
Gestation at delivery	39.14 (1.87)
Birthweight for gestation percentile	43.00 (31.23)
Birthweight for gestation < 5th	10.92% (n=13)
Birthweight for gestation < 10th	21.01% (n=25)
Birthweight for gestation >90th	8.40% (n=10)
Birthweight for gestation >95th	1.68% (n=2)
NICU admission	16.81% (n=20)
Pre-term birth	10.17% (n=12)

Neonate Birthweight Centiles by Type of Bariatric Surgery



Surgery type
1: gastric band
2: gastric sleeve
3: gastric bypass

Delivery Outcomes	***Nulliparous***	***Multiparous***
Mode of delivery		
SVD	33.90% (n=20)	58.33% (n=35)
Operative	16.95% (n=10)	1.67% (n=1)
Category 1/2 CS	27.12% (n=16)	13.33% (n=8)
Category 3/4 CS	22.03% (n=13)	26.67% (n=16)

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UTILISING A CARDIAC REGISTRY TO ESTABLISH THE IMPORTANCE OF THE MULTIDISCIPLINARY TEAM IN MANAGING CARDIAC DISEASE IN PREGNANCY

Topic / Dept:

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BACKGROUND: Cardiac disease in pregnancy is linked to significant maternal and fetal risks. A cardiac registry provides a way to systematically collect data on pregnant women with cardiac disease, enabling analysis of outcomes, care approaches, and the development of improved clinical protocols.

OBJECTIVE: This study aims to use data from a cardiac registry recently established in the National Maternity Hospital (NMH) to establish the critical role of a multidisciplinary team (MDT) in managing cardiac disease during pregnancy.

STUDY DESIGN & METHODS: This is a prospective study using a cardiac registry database, which includes patient demographics, cardiac diagnoses, risk stratification, and obstetric & neonatal outcomes, to provide a platform for evaluating the effectiveness of MDT care. We prospectively followed women who attended the joint obstetric/cardiology clinic in NMH from January 2021 to September 2024.

RESULTS: The combined obstetric/cardiology clinic was attended by 108 women, with 149 pregnancies in this group. Of the 149 pregnancies, 88.6% (n=132) had pre-existing disease with 11.4% (n=17) being diagnosed in pregnancy. The results showed that rhythm disease was the most common cardiac disease in pregnancy (59.9%, n=85). 42.9% (n=64/149) of pregnancies attended our joint cardiology clinic before 20 weeks' gestation with 8.7% (n=13/149) having pre-conceptual counselling.

In line with guidelines 32.6% (n=42) were mWHO I, 34.9% (n=45) mWHO II, 23.3% (n=30) mWHO II-III, 8.5% (n=11) mWHO III and only 0.8% (n=1) mWHO IV, a group in which pregnancy is strongly advised against.

17.5% (n=22) had a cardiac event in pregnancy, with these events most commonly occurring in trimester 3 (45.5%, n=10). Reassuringly only 3.2% (n=4), had a deterioration in their LV function post-partum.

CONCLUSION: The cardiac registry data underscores the importance of an MDT approach in managing cardiac disease in pregnancy, highlighting the benefits of early MDT involvement in personalized care, essential for optimising outcomes in this high-risk group.

KNOWING WHEN TO STOP: ARE WE USING TERBUTALINE ENOUGH FOR TACHYSYSTOLE?

Topic / Dept: Dept. of Obstetrics & Gynaecology, Rotunda Hospital, Dublin, Ireland.

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Background: Tachysystole (>5 uterine contractions in 10 minutes, over 20 minutes) is a known complication of labour, especially in cases of pharmacologically-induced labour, which can affect up to 11% of pregnancies. Tachysystole has been associated with non-reassuring CTG, neonatal encephalopathy, low umbilical artery pH and increased umbilical artery lactate, although findings are inconsistent. The IOG/NWIHP Induction of Labour Guideline (2023) states that tocolysis with Terbutaline should be considered to treat tachysystole.

Objective: We aimed to audit our use of Terbutaline in cases of tachysystole.

Study Design and Methods: A retrospective cross-sectional analysis of all uses of Terbutaline in cases of suspected tachysystole between 2018-2022 inclusive was performed.

Results: In the 5 year period, there were 50,347 pregnancies. Terbutaline as administered to 80 patients during labour or induction, an incidence of 0.16%. 78.8% of cases were nulliparous and 21.2% were multiparous. 83.8% were inductions of labour (IOL), 13.8% of cases were in spontaneous labour, 1.3% were after spontaneous rupture of membranes (SROM) and 1.3% were

during caesarean section. The most common indications for IOL were post-dates in 29.9%, reduced fetal movements in 10.4% and intra-uterine growth restriction in 10.4%. Prostaglandins were used in 94% of induction cases. Membranes were intact for 18.75%, 35% had SROM and 46.25% had artificial rupture of membranes. 63.5% were documented cases of tachysystole, 18.75% were documented as tonic uterus and 6.25% were not tachysystole. For documented cases of tachysystole, 6.5% had 6-7 per 10 minutes, 46.25% were 8-10 per 10 minutes and 11.25% were 11+ per 10 mins. 12.5% of cases were admitted to NICU. 5% of cases had APGARs <7 at 1 minute.

Conclusions: Tachysystole is a complication of labour with potentially serious consequences, that can be minimised with judicious use of Terbutaline. While the true incidence of tachysystole in our population remains uncertain, this study demonstrates a possible underutilisation of Terbutaline.
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Tweetable abstract:Tachysystole is a complication of labour with potentially serious consequences, that can be minimised with judicious use of Terbutaline. The true incidence of tachysystole remains uncertain, however this study demonstrates a possible underutilisation of Terbutaline.

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Association between Intrapartum Fetal Pulse Oximetry and Adverse Perinatal and Long-term Outcomes: a Systematic Review and Meta-analysis

Topic / Dept:

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Background: Fetal pulse oximetry may improve intrapartum fetal evaluation by providing non-invasive measurement of fetal oxygen saturation (FSp02).

Objectives: To assess the association between abnormal intrapartum FSp02 and perinatal and long-term neonatal outcomes.

Searh Strategy: Studies published up to February 2024 were identified through PubMed, EMBASE, CINAHL, The Cochrane Library, Web of Science, ClinicalTrials.Gov and WHO ICTRP without temporal or language restrictions.

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Selection criteria: Studies involving women in labour with a cephalic baby were included. Two interventions were reviewed: 1) Low FSp02 (<30%), and 2) the use of fetal pulse oximetry during labour.

Data Collection and Analysis: Independent reviewers screened studies, extracted data, and assessed quality using the Risk of Bias tool and Newcastle-Ottawa Scale. The approach evaluated evidence certainty. A random-effects meta-analysis followed PRISMA and MOOSE guidelines.

Main Results: Forty-seven studies with 13,071 mother-infant pairs were included**.** FSp02 <30% was associated with umbilical artery pH <7.15 (OR=7.86, 95% CI=[3.29-18.75], I^2= 71%, p=0.0007), 5-minute Apgar score <7 (OR=16.63, 95% CI=[5.64-49.01], I^2=30%, p<0.00001) and NICU admission (OR= 5.89, 95% CI =[1.73-20.01], I^2= 0%, p<0.005). FSpO2 monitoring combined with fetal heart rate monitoring was associated with lower odds of Caesarean section for non-reassuring fetal status (OR=0.59, 95% CI=[0.40-0.86], I^2=71%, p=0.006) without impacting 5-minute Apgar scores <7 (OR=0.66, 95% CI=[0.37-1.17], I^2=0%, p=0.16) or NICU admissions (OR=0.98, 95% CI=[0.82-1.18], I^2=0%, p=0.84).

Conclusion: FSp02 monitoring combined with fetal heart rate monitoring may reduce unnecessary Caesarean sections for suspected fetal distress without affecting short-term neonatal outcomes. The association between FSp02 <30% and adverse perinatal outcomes supports its potential as a valuable adjunct in intrapartum monitoring.

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The role of routine day 2 FBC in postoperative care of women with caesarean sections – is it really necessary?

Topic / Dept: Coombe Women and Infants University Hospital, Dublin

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Background

There has been a trend to perform routine full blood counts (FBC) on postoperative Day 2 (POD2) of caesarean sections (CS) across the country. While there are guidelines that support this in presence of risk factors such as anaemia or large blood loss, there is not enough evidence to suggest that a routine POD2 FBC is necessary for all women. It raises important questions regarding sustainability in terms of cost, staff, reagents used etc. Management of anaemia early in pregnancy, and a routine pre-delivery FBC allows ample time to optimise postoperative care for patients.

Objective

The primary aim of this study was to assess whether a routine POD2 FBC is necessary in the absence of other risk factors, for safe postoperative care.

Study Design and Methods

A retrospective audit was conducted for the month of May 2024 in The Coombe Hospital, where a sample of 40 elective and 40 emergency CS was studied. Important criteria assessed were estimated blood loss, haemoglobin at booking/28 weeks/day of CS/POD2 FBC, risk factors such as anaemia, previous postpartum haemorrhage, inherited bleeding disorders, multiple pregnancy etc.

Findings/Results

All women had a POD2 FBC taken. 6 women had a low haemoglobin at booking/28 weeks/day of CS, but none of these required a blood transfusion. Only 1 woman from the emergency CS group received a blood transfusion secondary to routine POD2 FBC, but did not have any previous risk factors or large blood loss.

Conclusions

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We conclude that while a POD2 FBC in symptomatic patients, those with a large blood loss or those with pre-existing risk factors is safe management, a routine POD2 FBC is not necessary and puts undue burden on staff and resources.

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Implementation of the National Women and Infants Health Programme free contraceptive service for vulnerable postnatal patients in Wexford General Hospital

Topic / Dept: Wexford General Hospital

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Background: The National Women and Infants Health Programme has introduced a programme for vulnerable patients to access free long-acting reversible contraceptives (LARC) through maternity and gynaecology services (NWIHP 2022). This project aimed to introduce a pathway for patients to access this service in Wexford General Hospital.

Study design and methods: Lean six sigma methodologies were used in a Define Measure Analyse Design Validate (DMADV) format to design this new pathway. Tools used to design this pathway included Voice of the Customer (VOC), Critical to Quality (CTQ) and Input Process Output (IPO) mapping. Areas for potential errors in the pathway were identified using Fishbone/Ishikawa diagrams and 5 WHY tools.

Findings/Results: This programme has now been introduced for maternity patients to access postnatal or post termination contraception in Wexford General Hospital. It has been written into the local hospital guidelines. This will be accessible through ambulatory gynaecology services already in place in the hospital. There will be the opportunity for these patients to access LARC prior to discharge home or to be issued a return appointment.

Conclusions: Vulnerable postnatal patients and patients post termination of pregnancy in Wexford General Hospital now have the option of free LARC provided by the hospital, in the form of the levonorgestrel-releasing intrauterine system (Mirenaâ). Alternative forms of contraception may be provided in future, potentially including implanon. It may be further expanded to provide this for gynaecology patients in future.

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A Prospective, Pilot, Cross-sectional Survey of Pregnant Women Attending an Urban, Tertiary-Referral, Maternity Hospital on Vaping in Pregnancy

Topic / Dept: 1. University of Limerick, Graduate Entry Medical School, 2. The Coombe Hospital, Dublin, 3. Royal College of Surgeons in Ireland, Dublin

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Topic: Global Women's Health

Background: Smoking is the foremost modifiable risk factor for adverse pregnancy outcomes. Vaping is seen by some woman as a less harmful alternative to smoking – however robust safety data on vaping are lacking. Public Health advice varies on the jurisdiction.

Aim: We sought to sample pregnant women's view of vaping in pregnancy in Ireland in a single, urban, maternity, university institution.

Methods: An anonymous paper survey, with an embedded patient information leaflet, was developed with patient public involvement input, exploring women's views of vaping in pregnancy via Likert scale questions and free text responses gathering quantitative and qualitative data. Research Ethics Approval was granted by The Coombe Hospital. Minimal demographic information was gathered in order to ensure anonymity. The survey was distributed in the antenatal clinical area; emergency room; antenatal ward. Each survey was individually numbered to estimate a response rate. Free-stranding study-specific sealed post boxes were located in prominent sites for return of the completed questionnaires. Consent was implied by return of the questionnaire.

Results: 23 woman returned surveys which gave us a response rate of 100%. A majority of women surveyed, 91% (n=21), strongly disagreed that vaping was an aid to smoking cessation, and 100% of respondents disagreed with the statement that women who chose to vape rather than smoke in pregnancy are making a positive health choice. Almost 20% (n=4) of women believed that there is carbon monoxide in vapes, and 70% (=n16) did not know. Importantly, all respondents,

n=23, believed that the HSE should fund nicotine replacement therapies (NRT) for women seeking to stop vaping in pregnancy.

Discussion:

An unselected group of pregnant women were not supportive of the safety of vaping during pregnancy. The small sample size will be augmented with the roll out of the survey after incorporation of pilot feedback to increase the representativeness of the sample. All supported the supply of free NRT to women seeking to stop vaping.

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DETERMINATION OF SENSITIVITY AND SPECIFICITY OF TVUS IN DIAGNOSIS OF ENDOMETRIOSIS – RETROSPECTIVE STUDY IN ST. JOHN'S HOSPITAL, LIMERICK

Topic / Dept: St. John's Hospital, Limerick

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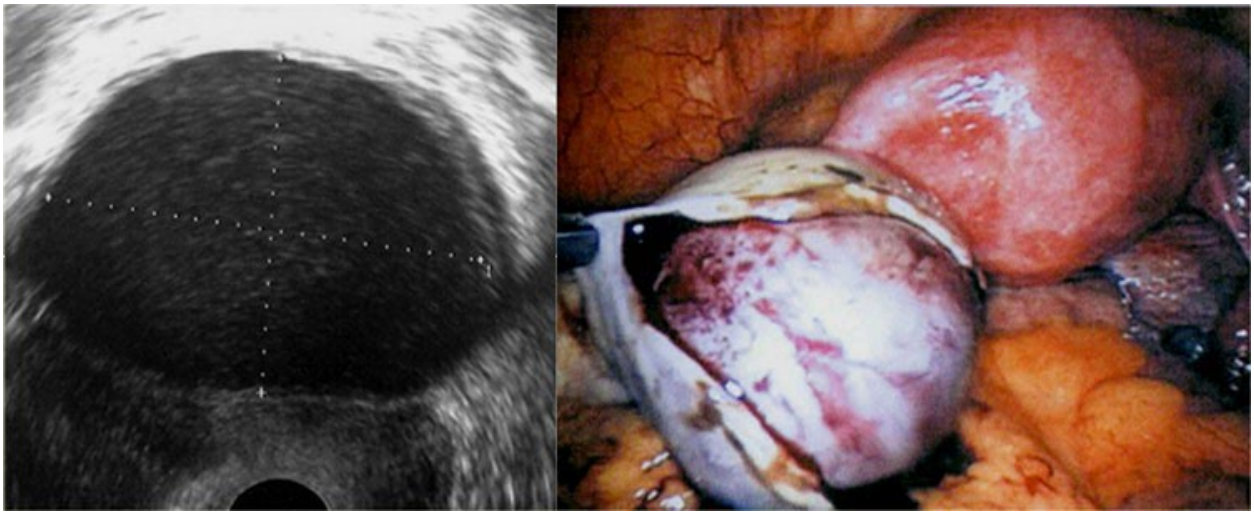
Co Author: SUCHETA JOHNSON

INTRODUCTION

Transvaginal Ultrasound modality is recommended for the assessment of patients with gynaecological concerns. Traditionally, Endometriosis is definitively diagnosed through laparoscopic surgery with histological confirmation. While this method is accurate, it is invasive and associated with risks and costs. TVUS, particularly, is appealing due to its wide availability, cost-effectiveness, and non-invasiveness.

The diagnostic accuracy of ultrasound for endometriosis depends upon the operator's skill, techniques, and experience. However, reported sensitivity and specificity rates still vary, impacting reliability and clinical utility

Sensitivity refers to ultrasound's ability to correctly identify patients with endometriosis (true positive rate), while specificity indicates its ability to correctly identify patients without the disease (true negative rate). High sensitivity is crucial for avoiding missed diagnoses, which could delay treatment and worsen patient outcomes. Conversely, high specificity minimizes false positives, reducing unnecessary interventions and anxiety.



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AIMS AND OBJECTIVES

The primary aim of this study is to evaluate the diagnostic accuracy of ultrasound in the diagnosis of endometriosis by assessing its sensitivity and specificity. This study seeks to provide a comprehensive analysis of the effectiveness of ultrasound as a non-invasive diagnostic tool for endometriosis, thereby contributing to improved clinical practices and patient outcomes.

1. **Determining Sensitivity and Specificity**:
    - We will assess the sensitivity of ultrasound in accurately identifying patients with endometriosis.
    - Additionally, we'll evaluate the specificity of ultrasound in correctly ruling out endometriosis in patients without the disease.
2. **Identifying Sonographic Criteria**:

We focused on identifying specific sonographic criteria and markers that enhance the diagnostic accuracy of ultrasound in cases of endometriosis

STUDY DESIGN:

This retrospective cohort study involves collecting and analyzing data from patient charts from January 2022 to December 2022.

Study Population: 89 patients.

Inclusion Criteria:

- Female patients diagnosed with endometriosis.
- Patients who underwent ultrasound evaluation as part of their diagnostic work-up.
- Patients with histologically confirmed endometriosis following laparoscopy.

Exclusion Criteria:

- Patients with incomplete medical records.
- Patients diagnosed with endometriosis without ultrasound imaging.

Patients whose endometriosis diagnosis was not confirmed histologically

DATA COLLECTION

1. Patient Identification:

- Review medical records from January 2022 to December 2022 to identify patients diagnosed with endometriosis.

2. Data Extraction:

- Extract relevant data from patient charts, including:
- Demographic information (age, fertility, medical problems, etc.).
- Clinical symptoms (pelvic pain, infertility, etc.).

- Ultrasound findings
- Laparoscopic findings and confirmation of endometriosis.

3. TVUS Data:

- Record specific sonographic criteria observed with the level of expertise of the operator conducting the ultrasound.
- 63 patients showed mixed features of endometriosis which include endometrioma, nodule in uterosacral ligaments, bladder peritoneum, rectum, posterior deep infiltrated nodules, and adenomyosis.

4. Laparoscopic data

- Confirm the presence of endometriosis from laparoscopic surgery

RESULTS :

- Total patients who underwent laparoscopy: 89
- Patients with confirmed endometriosis on laparoscopy: 72
- Patients who had a TVUS: 85
- Patients with positive TVUS findings: 63

32 had ovarian endometriomas,8 showed mixed features of endometrioma and adenomyosis,4 had sonographic nodules in the uterosacral ligament and 19 showed mixed features of deep infiltrated nodules.

- Patients with normal ultrasound findings: 22
- Patients with no endometriosis on laparoscopy: 17 (89 - 72 = 17)

For Positive Ultrasound Findings:

- **True Positives (TP)**: Patients with positive ultrasound findings and confirmed endometriosis via laparoscopy.
  - This is a subset of the 63 patients with positive ultrasound findings. Since 72 patients were confirmed with endometriosis via laparoscopy, and some will be false positives
- **False Positives (FP)**: Patients with positive ultrasound findings but no endometriosis confirmed via laparoscopy. This would be among the 17 patients who had no endometriosis.

For Normal Ultrasound Findings:

- **True Negatives (TN)**: Patients with normal ultrasound and no endometriosis confirmed via laparoscopy. These are the patients with normal ultrasound and no confirmed endometriosis. This is a subset of the 22 normal ultrasound findings.
- **False Negatives (FN)**: Patients with normal ultrasound but confirmed endometriosis on laparoscopy. These are the patients who had normal ultrasound but endometriosis was confirmed during laparoscopy.

Organizing the Data:

- **True Positives (TP)**: Patients with positive ultrasound findings and confirmed endometriosis = 63 – (false positives).
- **False Positives (FP)**: Patients with positive ultrasound findings but no endometriosis confirmed via laparoscopy. This can be inferred from the total number of patients without endometriosis confirmed by laparoscopy. Since 17 patients had no endometriosis so FP =9
- **True Negatives (TN)**: Patients with normal ultrasound findings and no endometriosis = part of the 22 normal ultrasound results. TN=8
- **False Negatives (FN)**: Patients with normal ultrasound findings but confirmed endometriosis = part of the 72 confirmed endometriosis cases who had normal ultrasound. FN= 22-8=14

	LAPAROSCOPY POSITIVE	LAPAROSCOPY NEGATIVE
USG POSITIVE	54 (TP)	9(FP)
USG NEGATIVE	14(FN)	8(TN)

- **Sensitivity**: 79.4% — Ultrasound correctly identified about 79% of the patients with endometriosis.
- **Specificity**: 47% — Ultrasound correctly ruled out endometriosis in about 47% of patients who did not have the disease.

CONCLUSION:

According to our calculation, TVUS is a fairly sensitive tool for detecting endometriosis but has lower specificity which means that when the condition is ruled out, some false positives may occur.

This shows that ultrasonography is a useful diagnostic technique for endometriosis, especially when there are clear sonographic indicators of the disease (e.g., endometriomas or deep infiltrating endometriosis). Although there is a moderate risk of false positives, individuals may receive an incorrect endometriosis diagnosis based on ultrasonography results, thus requiring additional interventions.

RECOMMENDATIONS:

- TVUS for high-risk patients can be prioritized in cases like chronic pelvic pain and infertility, based on good sensitivity.

- Future research should explore ways to improve the specificity of ultrasound for endometriosis diagnosis, such as identifying more precise sonographic markers or integrating additional imaging techniques (e.g., MRI) to reduce the rate of false positives.

LIMITATIONS:

- Moderate Specificity: The study highlights a shortcoming in ultrasonography's specificity, indicating the necessity for more reliable diagnostic standards to prevent overdiagnosis.
- Retrospective Nature: Because this study is retrospective, biases about the caliber of medical data and the variability of the operators may be present and may affect the outcome.

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Endometriosis: Radiological-pathological correlation

By Paula Woodware, Roya Sohaey, and Thomas P. Mezzetti Jr 2001 Radiographics 21,192-216

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ALL PAIN NO GAIN? IS ENDOMETRIAL BIOPSY USEFUL IN PATIENTS WITH POSTMENOPAUSAL BLEEDING AND AN ATROPHIC CAVITY? A RANDOMIZED CONTROL TRIAL

Topic / Dept:

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Background
Pain and anxiety are common features of outpatient hysteroscopy (OPH). Endometrial biopsy is often insufficient when investigating post-menopausal bleeding (PMB) with a normal/atrophic hysteroscopic appearance, yet it is still commonly performed.

Objective
The objective of this study was to evaluate outcomes in patients with PMB who underwent an endometrial biopsy with an atrophic-appearing cavity at OPH.

Study Design and Methods
Single-centre, single-blinded randomized control trial. The trial was registered prospectively (ClinicalTrials.gov ID NCT05378152). This study was carried out in an outpatient hysteroscopy service in an academic and tertiary referral hospital in Dublin, Ireland. The primary outcome was to compare pain scores after the intervention using a 100mm Visual Analogue Scale (VAS). Secondary outcomes were differences in costs and change in follow up between groups. Women with PMB who attended for an OPH and had an atrophic cavity on

hysteroscopic evaluation were included. A sample size of 76 was determined to show a 2-point difference in pain scores (Visual Analogue Scale – VAS), assuming 90% statistical power and a 5% level of significance. Women were randomized to either endometrial biopsy (Group 1) or a sham procedure (Group 2) i.e. insertion of the speculum into the vagina.

Results A total of 169 women with PMB were recruited over an 18-month period, 87 were excluded on the basis of hysteroscopic findings during the procedure. There were 44 patients in Group 1 (Biopsy) and 38 patients in the Group 2 (sham). A significant difference in pain scores after the intervention was noted with a mean-VAS score of 5.43 (+/-0.33) in Group 1 and 2.97 (+/-0.45) in group 2 $p<.0001$. There were no cases of emergency admissions or endometrial hyperplasia/cancer in either group at 6 months follow up.

Conclusion Routine endometrial biopsy after a normal hysteroscopy in women referred with PMB should be considered unnecessary and could be stopped to reduce pain for women. A targeted endometrial biopsy approach should be considered but would need further studies.

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Temporal Trends in Sperm Concentration: A Contrasting Perspective from a Single-Centre Review

Topic / Dept:

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Introduction: Male factor infertility contributes up to half of infertility cases(1) and reports suggest a global decline in sperm quality(2–4). However, fertility trends can vary by region and population. Understanding local trends in sperm parameters is crucial for tailoring treatments and counselling.

Methods: We retrospectively analysed 18,306 semen analyses from 15,846 male patients at Merrion Fertility Clinic over 16-years (2008-2023). The primary outcome was sperm concentration (million sperm/mL), with 2021 WHO criteria (<16 million/mL) applied to identify subnormal results(5).

Results: Sperm concentration increased significantly by 13.9%, rising from 62.9 million/mL in 2008 to 71.7 million/mL in 2023 (P<0.0001). The number of semen analyses performed increased by 23.6%, from 1020 in 2008 to 1262 in 2023. The proportion of subnormal results remained consistent, with a mean of 21.2% samples showing subnormal parameters. The mean age of men attending for investigation did not change significantly. In 2008, mean age was 36 years, whereas in 2023 mean age was 37.

Discussion: The observed increase in sperm concentration highlights regional differences in male fertility trends. While global reports indicate a decline(1–4), our findings suggest that localised factors such as socioeconomic status, lifestyle, and environmental influences may impact sperm

quality. Men attend the clinic privately, suggesting a higher socioeconomic class which can contribute to better health(6) and semen parameters(7–9). The ability to self-refer for fertility testing provides quicker access to care. A growing awareness of reproductive health, improved public health campaigns, and lifestyle changes may also have positively impacted sperm quality, as smoking rates and alcohol consumption continue to fall in Ireland(10–12). These proactive health behaviours, coupled with lower environmental pollutant exposure in Ireland(13,14) may have positively contributed to overall better semen parameters. This study underscores that regional variations may challenge global reports on fertility trends.

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Bladder instillation For Bladder Pain Syndrome

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Bladder Pain Syndrome (BPS), also known as interstitial cystitis, is a chronic and debilitating condition with a prevalence of approximately 2.5%, affecting women about four times more than men. It is characterized by pelvic pain, pressure, and discomfort associated with an increased urge to urinate. The etiology of this syndrome remains poorly understood, yet it is believed to involve a complex interplay of factors including altered urothelial permeability, inflammation, and neuromuscular dysregulation(Nizard et al., 2018). Recent studies have indicated that bladder instillations, particularly with agents like Intravesical Sodium Hyaluronate (Cystistat®), aim to restore the glycosaminoglycan layer of the bladder epithelium, potentially alleviating symptoms and improving overall bladder function in affected patients
Our study aims to evaluate the success of Cystistat therapy in women presenting to our institution with BPS and to assess the treatment completion and follow up rates.

Material and Methods:
A retrospective chart review was undertaken from January 2022 to July 2024. Women presenting to our tertiary gynaecology centre, diagnosed with BPS on cystoscopy and/ or urodynamics were included in this review. These women were planned for Cystistat therapy for BPS. Patient undergoing the Cystistat therapy were asked to complete an Interstitial Cystitis Symptom Index

(ICSI) and Interstitial Cystitis Problem Index (ICPI) questionnaire, which was completed pre and post therapy. All patients were planned to be followed up for 2 years post treatment, which included a bladder (symptom) diary, complication assessment and Clinical Nurse Specialist review

Results

25 patients commenced Cystistat treatment during the period of review. 5 patients were actively undergoing treatment at the time of review, leaving 20 who had completed treatment and who met the inclusion criteria.

The results give an interesting insight into the cohort of patients who attend our service for the management of BPS. The average age in our cohort supports the average age of 50-59 years reported in the literature(Lim, Leslie, & O'Rourke, 2024).

Bladder pain syndrome is a challenging illness to treat, and Cysitstat as a treatment exhibits promising results. Of the 18 patients who completed the treatment, with 16 of these reporting an improvement in their symptoms. This high level of improvement in symptoms is in line with previous studies of this nature (Digesu, Tailor, Bhide, & Khullar, 2020).

Cystitsat has an excellent compliance rate in our cohort of patients, which further supports its use as an easily accessible and acceptable treatment for patients. Limitations of our study include a lack of completion of pre and post treatment ICSI/ICPI scores, with only 5 completing both questionnaires.

SUT-URE SELF: OPTIMISING PERINEAL REPAIR KNOWLEDGE AND TEACHING, IN THREE MATERNITY CENTRES

Objectives: Perineal assessment and repair are fundamental to provision of quality obstetric and midwifery care . Up to 80% of women will sustain perineal trauma during vaginal delivery, and 70% will require repair. Vaginal and rectal examination optimises diagnosis and categorisation of perineal injury. Even with experienced clinicians there is room for improving clinical skills with ongoing learning.

Aims: Firstly to establish perineal anatomy knowledge, training exposure and experience. Secondly to establish if ongoing training is needed to strength perineal repair education and skills.

Study Design and Methods: This is a prospective multicentre observational study. Obstetricians and midwives actively involved in perineal repair were recruited in three maternity units from April 2024-July 2024. An initial survey was completed. A teaching intervention (a combination of didactic teaching and videos) was delivered to participants. After the teaching intervention, a

post-survey was also completed. The sample size was appropriately powered and the data analysed accordingly.

Results: During the study period 89 clinicians (70 obstetricians, 19 midwives) completed the pre-survey, and 72 attended the training initiative and completed the post-survey. 84.3% of clinicians had some form of prior training in assessing perineal injury, and 83.1% had some form of practical training in perineal repair. Only 75.3% had received formal training on assessing for obstetric anal sphincter injury. 88.8% of clinicians felt confident carrying out an episiotomy, but only 69.7% felt confident in repairing an episiotomy. After the teaching intervention, the post-survey responses highlighted significant improvement in anatomical knowledge amongst clinicians conducting perineal repair (p=0.0078).

Conclusions: Ongoing learning about perineal anatomy is necessary for clinicians who are learning to, or are actively completing perineal repair. It results in increased knowledge which will ultimately manifest in the delivery of improved care to women requiring perineal repair.

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CLINICAL TEACHING IN OBSTETRICS AND GYNAECOLOGY: DEVELOPMENT OF A QUESTIONNAIRE TO EXPLORE PATIENT OPINIONS

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Background

Clinical teaching is regularly used to train healthcare students where students gain experience interviewing patients, conducting respectful physical examinations, and formulating differential diagnoses and management plans of real patients. While ample research exists regarding students' and teachers' opinions on this form of teaching, little is known about patient opinions.

Objectives

Following on from a previous research project exploring patient opinion of bedside teaching, we followed international guidelines for questionnaire development to develop and pilot a questionnaire exploring the broader topic of clinical teaching.

Study Design and Methods

Seven steps were included: literature review, patient interviews, development of clear and understandable items, expert validation, cognitive interviewing and pilot testing. Following this, patients were invited to complete the new questionnaire on clinical teaching and results were analysed.

Results

From August 2024, 195 patients were invited to complete the study within the National Maternity Hospital; 171 (87.7%) patients were either pregnant or recently had a baby and 24 (12.3%) were presenting for gynaecology services. The median age among patients was 34 years (range 19-79 years).

The majority of patients (61%) believe that clinical teaching would be enjoyable, that they would gain satisfaction from partaking in the education of future healthcare professionals (88.8%), and

that they should not be asked to participate in teachings if they are stressed or unwell (62.2%). Most (75.5%) wished for students to request verbal consent prior to talking to them whereas 45 patients (23%) wished for written consent. Patients reported they are happy to help teach junior doctors, medical students, nursing students or allied health students. Women were proud to help teach students.

Conclusion

Overall, patients are happy to assist in the clinical teaching of all forms of training healthcare professionals. Further questionnaires will further provide valuable insight into the patient's perspective.

A PRETERM BIRTH STORY – MEDICAL STUDENT'S REFLECTIONS ON THE PARENT NARRATIVE – A QUALITATIVE STUDY

Topic / Dept:

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Background

Parents of preterm infants experience a life changing event and each parent has a unique story to share. Within obstetrics and gynaecology medical education students are taught about risk factors, diagnosis and management of preterm birth during didactic lectures and tutorials. Our research is aimed at moving beyond the theoretical framework and providing students with an opportunity to explore the lived experience.

Objective

To evaluate medical student's responses to hearing about the preterm birth experience from a parent's perspective. We explore the key themes which arose from their reflections on the patient story.

Study Design and Methods

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A 30 minute interview was recorded with a parent who had experience a preterm delivery at twenty five plus six weeks and a three month stay in NICU. The parent gave an account of her experience which spanned from the time of delivery to the NICU admission and the subsequent challenges faced on discharge. This video was uploaded to the Brightspace learning platform for students to watch. A reflective essay was incorporated into the module assessment. Students were asked to write a 500 word essay on what they learned from the story. 10% of the reflections were randomly selected and anonymised for inclusion in this study. Thematic analysis was carried out on the reflections using Braun and Clarke's framework.

Results

Key themes highlighted - the student's recognition of the importance of communication and the potential for long-lasting impact either positively or negatively. Student's grappled with the challenges faced by clinicians in attempting to balance clinical care with the emotional and psychological needs of their patients. Students demonstrated an awareness of the duty care expanding beyond the hospital confines and into the community.

Discussion/Conclusion

This demonstrates the power of patient-led education. This project encourages students to look through the parent's lens and aims to provide future clinicians with the capacity to reflect and engage with the person behind the story – to see the bigger picture.

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A CASE PRESENTATION OF A CAESAREAN SECTION SCAR ECTOPIC PREGNANCY

BACKGROUND:
Caesarean scar ectopic pregnancy (CSEP) is a rare condition with a gradual world-wide increase in incidence. If recognised late, CSEP carries significant risk of life-threatening conditions such as haemorrhage, placenta accreta (PAS) and uterine rupture. Recommended first-line diagnostic imaging is transvaginal ultrasound (TVS), with treatment options including minimally invasive therapies, medical and surgical.

CASE PRESENTATION:
In this case report we present a 37-year-old female who presented to ED at 6 weeks gestational age with vaginal spotting. Her obstetric history included two second trimester losses and an EMCS at 31 weeks gestation.
On examination, she was stable with a soft abdomen. No IUGS was identified on abdominal ultrasound. Subsequently a TVS revealed an IUGS at the CS site with foetal cardiac activity.
The following day, a departmental scan confirmed an irregular GS situated at the CS scar site, measuring 12x4x12 mm. Initial BHCG level was 17,592 IU.
Suction & Curettage was done under ultrasound guidance with minimal blood loss. A catheter was inserted for tamponade which was deflated the following day. BHCG was 7725 IU. BHCG one week post procedure was 980 IU, and was repeated weekly until it reached 6 IU one month post ERPC.

DISCUSSION:
With vaginal bleeding often being the sole symptom, US images could easily be misinterpreted as normal findings of an intrauterine pregnancy, especially in a busy emergency room. Early treatment results in decreased costs, a shorter hospital stay, preservation of fertility, and prevention of iatrogenic preterm delivery, which is typical in cases that progress to PAS. Detailed counselling regarding management options with appropriate patient selection is crucial for optimal results.

CONCLUSION:
Our case confirms that early recognition of the sonographic findings of caesarean scar ectopic pregnancy allows prompt treatment to avoid the consequences of a missed or delayed diagnosis. Furthermore, this case presents a successful surgical management of a caesarean scar ectopic pregnancy.

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ABDOMINAL ECTOPIC PREGNANCY: A CASE REPORT

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Ectopic pregnancy is a pregnancy that occurs outside the uterine cavity, most commonly in the fallopian tube around 90% and the remaining implant on the cervix, the ovary, the myometrium, and other sites. In this case we are presenting Abdominal ectopic pregnancy which is the rarest form of extrauterine pregnancies that accounts for 0.3% to 1.4% of all ectopic pregnancies.
Ectopic pregnancy is generally suspected if a pregnant woman experiences any of these symptoms during the first trimester: vaginal bleeding, lower abdominal pain, amenorrhea and an elevated serum BHCG level of 58818 IU/ml above the discriminatory zone (2000 IU/ml) with an empty uterus on a transvaginal ultrasound. In this case study, we report on a 34-year-old woman, G7P6+0 who presented to Letterkenny University Hospital's gynaecology department complaining of mild abdominal pain for two days without any history of vaginal bleeding. Her last menstrual period was uncertain due to lactation amenorrhea. Upon examination, she was clinically stable. Her BHCG level measured 58818 IU/ml and a bedside pelvic ultrasound showed an empty uterine cavity, as well as a live 12 weeks foetus (measured by CRL). The initial clinical impression was an ovarian ectopic pregnancy, nevertheless during successful management by

laparoscopy with unilateral salpingectomy the foetus was found to be floating in the abdominal cavity with the placenta attached to the omentum and infiltrating the tube from outside.

This case report highlights the challenges in diagnosing and managing abdominal ectopic pregnancy. It underscores the importance of considering ectopic pregnancy in the differential diagnosis of abdominal pain in women of reproductive age.

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Are we hitting the mark? A retrospective cohort study of follow-up for pregnancy of uncertain viability in a tertiary referral centre.

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Background

Pregnancy of uncertain viability (PUV) is a common finding in early pregnancy ultrasound (US), and can cause trepidation amongst women. A diagnosis of PUV has a suggested follow-up of repeat US in 7-10 days, but it is unclear how many women have a repeat US within the recommended timeframe. In some cases, a repeat US may not give a definitive diagnosis and further US may be required, but the outcomes for this cohort are unclear.

Design:

We conducted a retrospective cohort study assessing patients with a diagnosis of PUV, and examined follow up outcomes over a 6-month period from December 2023 to July 2024.

Results:

54 cases of women with PUV were identified, ranging in age from 19-44 years. 54/54 (100%) had their first follow up scan within the suggested timeframe. 40/54 (74%) required one scan resulting in a definitive diagnosis. Of these, 20/40 (50%) received a diagnosis of miscarriage and 20/40 (50%) had a viable pregnancy. 14/54 (25%) required additional scans to make a formal diagnosis, with 3/14 (21%) diagnosed with a viable pregnancy and 11/14 (79%) diagnosed with miscarriage.

Conclusion:

All women received a scan within the recommended timeframe. A substantial number of women required more than one follow up scan to make a diagnosis. Whilst most of those requiring additional scans received a diagnosis of miscarriage, there were still a number of women who had a viable pregnancy on repeat scan. This information will be useful for counselling those with a diagnosis of PUV on US.

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Ectopic Pregnancy Post Sterilisation: a rare but important complication

Topic / Dept: University Hospital Kerry- Dept. of Obstetrics and Gynaecology

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Introduction:

Ectopic pregnancy is an important early pregnancy complication, accounting for ~ 9% of maternal deaths worldwide(1). Incidence of ectopic pregnancy is 3-4% of women attending early pregnancy units(2). This may be increasing due to a rise in the incidence of tubal disease, relating to increasing rates of pelvic inflammatory disease(3). Additional risk factors such as smoking, in-vitro fertilisation, as well as surgical damage to tubes may also be contributing and are important to elicit in a woman's history to make a comprehensive assessment of the woman presenting with pain in early pregnancy(2,4).

Case Presentation:

A 27-year-old nulliparous woman presented to the Emergency Department complaining of right sided lower abdominal and flank pain. Last menstrual period occurred 17 days prior. Surgical history was significant for appendicectomy and tubal ligation. She was seen by the Emergency Medicine team who requested an ultrasound KUB to outrule renal calculus. This demonstrated mild right sided hydronephrosis and a 6mm echogenic focus in the lower pole of the right kidney. A urine pregnancy test was then returned as positive, prompting referral to Obstetrics and Gynaecology. Early pregnancy ultrasound showed an empty uterus and hyperechoic structure adjacent to right ovary, as well as a small volume of free fluid in the pouch of douglas. Serum B-HCG was 3351 IU/L. The woman underwent diagnostic laparoscopy which identified a right sided tubal ectopic pregnancy with 200ml of blood in the pouch of douglas. Salpingectomy was performed and the woman was discharged home the following day.

Discussion:

This case highlights the importance of clinician awareness of risk factors and mimics for ectopic pregnancy, not just within Obstetrics and Gynaecology but across all disciplines(5). Of particular concern are those women who have undergone bilateral tubal ligation. Though the risk of conception is low, there is a substantial risk of ectopic pregnancy among those who conceive post sterilisation. One 5-year prospective cohort study identified an ectopic pregnancy rate of 7.3 per 1000 sterilisation procedures. This risk varied according to surgical approach and patient factors

with women aged under 30 years at the time of sterilisation at significantly higher risk of subsequent ectopic pregnancy(6).

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CASE REPORT: MERMAID SYNDROME (SIRENOMELIA) DIAGNOSED ON BOOKING SCAN

Author: M Smyth, OLOL

Co Author: F Alayia, OLOL

Co Author: F Armstrong,OLOL

Sirenomelia has an estimated incidence of 1 in 60,000 to 100,000 births. It is a rare congenital abnormality which typically presents with partial or complete fusion of the lower limbs. It is widely accepted that this condition is not compatible with life due to associated visceral abnormalities. This case describes a 33 para 1+1, previous normal delivery of a live baby girl at term, who was unfortunately diagnosed with sirenomelia (lower limb abnormality) on her booking scan in our lady of Lourdes hospital Drogheda. The diagnosis was confirmed on scan with fetal medicine specialist at 13 weeks. The scan findings confirmed fused lower limbs consistent with sirenomelia. In addition to the lower limb abnormality there was also an ecogenic kidney and a large cystic area where the other kidney should be, and no bladder was visible. There was very reduced amniotic fluid. The case was discussed at the fetal medicine MDT in the rotunda hospital and was deemed to fulfil the criteria for the provision of termination of pregnancy under the section for fatal fetal abnormality. The patient proceeded with medical induction at 14 weeks and five days to terminate her pregnancy in OLOL and delivered a baby boy weighing 56g. Cytogenetics for the pregnancy were normal. The couple had follow up in both OLOL and the rotunda and were thoroughly debriefed and counselled regarding risk of recurrence in future pregnancies.

Tweetable Abstract:

Case report of Mermaid syndrome diagnosed on booking scan in Drogheda.

Ir Med J; March 2025; Vol 118; No. 3; P51
March 20th, 2025

Clinical audit on Hyperemesis Gravidarum in early pregnancy according to clinical practice guidelines.

Topic / Dept:

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Main abstract

Nausea and vomiting in pregnancy (NVP) affect up to 90% of pregnant women and is one of the most common indications for hospital admission. Hyperemesis Gravidarum (HG) is a severe form of NVP, affecting 0.3-3.6% of pregnant women. Symptoms manifest between 4-7 weeks' gestation, peak severity for hyperemesis bring around 11 weeks, with 90% of cases resolving by 20 weeks' gestation.

Objective

This was a retrospective study to assess the clinical diagnosis and management of patients admitted with HG in keeping with standard of care using the HSE Guidelines.

Study Design and Methods

Retrospective data collection of pregnancy less than 12 weeks of gestation admitted with HG from 1/1/2023-31/12/2023. Data collected by notes review, Lab/HIPE/ultrasounds. Data collection, Pro-forma design, report production by team and data analysis done by clinical audit support team.

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Findings/Results

Data analysis of the study group showed that majority (64%) of pregnant women admitted for HG came from the age group between 25-34 years old. All patients (100%) had FBC, Urea and Electrolytes, Liver function test and ultrasound done but did not have PUQE score, weight documentation, vitamin supplementation with Pabrinex/Solvito-N or dietician referrals. Thyroid function test and urine for culture and sensitivity was sent in 68% and 82% of patients, respectively. IV fluids were completed in 91% of patients. Correct first line anti-emetics as per guidelines was given in 95% of patients, with prescription of Cariban (Doxylamine/pyridoxine) given for 3 months in 86% of patients. Anti embolic stockings and thromboprophylaxis (LMWH) was given in 64% and 91% of patients, respectively. Dietary advice in the form of leaflets were only given to half of the patient admitted for HG.

Criteria	Yes	No
Gestation less than 12 weeks	91%	9%
PUQE documentation in chart	0%	100%
FBC	100%	0%
Urea and Electrolytes	100%	0%
Liver Function Test	100%	0%
Thyroid Function Test	68%	32%
MSU	82%	18%
Ultrasound	100%	0%
IV Fluids Regime	91%	9%
IV Solvito/Pabrinex	0%	100%
Anti-Emetics	95%	5%
Anti-Embolic stockings	64%	36%
Thromboprophylaxis	91%	9%
Dietician referral	0%	100%
Diet advice upon discharge	50%	50%
Prescription of Cariban for 3 months	86%	14%

Conclusions

Standards of care could be improved by implementing an assessment and management checklist including all the criteria mentioned and audited above. A re-audit can be carried out in 6 months to assess improvement management of HG.

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Reference

Clinical practice guideline for hyperemesis/nausea and vomiting in pregnancy

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COMPARATIVE ANALYSIS OF INPATIENT MEDICAL MANAGEMENT OF FIRST TRIMESTER PREGNANCY LOSS VERSUS MEDICAL TERMINATION OF PREGNANCY

Topic / Dept:

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2. *Pregnancy Loss Research Group, Department of Obstetrics and Gynaecology, University College Cork, Cork, Ireland*

Author: A Sheppard[1]

Co Author: D. Hayes-Ryan[1,2]

Background:
Women opting for medical management of miscarriage (MMM) or medical termination of pregnancy (MTOP) between 10+0 to 12+0 weeks gestation are electively admitted to hospital owing to increased risks of pain and bleeding. Inpatient medical management of both follow the same principle; a dose of 200mg oral mifepristone followed by administration of buccal misoprostol 24-48 hours later. The dosage of misoprostol differs between the two groups as per current national guidelines.

Objective:
The aim of this review was to examine, compare and contrast both regimes for efficacy and safety.

Methods:
Retrospective audit of all women undergoing inpatient MMM or MTOP between 10 to 12 weeks in our unit from 1st January to 31st June 2024. Eligible cases were identified through the local gynae ward register. Electronic medical notes were reviewed in August 2024 and anonymised data transcribed and analysed.

Results:
During the time frame reviewed, 16 women met eligibility criteria of which 62% (n=10) were MTOP and 38% (n=6) were MMM. Maternal age ≥25 years was more prevalent in the MMM cohort (100%) compared to the MTOP cohort (20%) as was parity (83% vs 30%). Misoprostol was administered within 24-48 hours subsequent to mifepristone for all MTOP but only 67% of MMM. Delivery of pregnancy on day of admission was similar in both groups however incidence of complications requiring medical review was higher for the MMM cohort (50% vs 10%) as was requirement for emergency surgical intervention (33% vs 10%). Discharge home on same day as admission was 80% for MTOP and only 17% for MMM.

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Conclusion: While inpatient medical management of early miscarriage and termination of pregnancy shows comparable overall success, miscarriage management was associated with longer treatment durations, higher complication rates, and increased need for further interventions in our unit. A multi-dose misoprostol regimen may improve outcomes in miscarriage management without significantly increasing risks.

Tweetable abstract:

Inpatient medical management of early miscarriage and termination of pregnancy shows comparable overall success however miscarriage management was associated with longer treatment durations, higher complication rates, and increased need for further interventions in our unit. A multi-dose misoprostol regimen may improve outcomes in miscarriage management without significantly increasing risks

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Submission Title:

Ectopic pregnancy with levonorgestrel-releasing intrauterine device (Jaydess).

Topic / Dept:

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Author: A. Babiker 1.

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Co Author: A. Das 1.

Abstract	*Please complete sections using headings provided:*
Presentation (Describe the condition of the patient on initial examination)	A 31 year old female, gravida 1, para 0, presented to the (ED) with minimal vaginal bleeding and severe RIF and abdominal pain. A Jaydess coil was in situ and history of 3 months diagnostic laparoscopy.
Diagnosis (Briefly describe the tests conducted and state the confirmed diagnosis)	Trans-abdominal and vaginal ultrasound in the ED revealed no evidence of intrauterine pregnancy and a well-defined heterogeneous lesion in the right adnexa. The scan also showed intraperitoneal fluid collection and the coil in the lower uterine cavity.
Treatment (Outline the treatment given to the patient)	A diagnostic laparoscopy was performed where hemoperitoneum was evacuated and a right salpingectomy was done due to a partial rupture of the right tubal ectopic pregnancy. The patient was discharged home with outpatient follow-up and no complications postoperatively.
Discussion/Conclusion (State briefly your discussion/conclusive statement outlining your core outcome of your research or report)	This case highlights that although unintended pregnancies are uncommon in women with an IUD in place, clinicians should remain vigilant about the higher chance of EP. Ultrasound technology has enabled accurate and non-invasive diagnosis of EP and effective management.

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Introduction

The use of levonorgestrel-releasing intrauterine devices (LNG-IUDs), such as Mirena and Jaydess, has been steadily increasing, with more than 150 million women worldwide now utilizing these devices [1]. LNG-IUDs are a reliable contraceptive option with a low failure rate, boasting a Pearl Index (representing the number of unintended pregnancies per 100 woman-years of exposure) of approximately 0.1% [2]. However, if an unintended pregnancy does occur, the risk of ectopic pregnancy is significantly higher [X]. Beyond their contraceptive benefits, LNG-IUDs play an essential role in managing conditions such as menorrhagia and dysmenorrhea. They are also valuable in postmenopausal women requiring estrogen replacement therapy, as they protect the endometrium from the effects of unopposed estrogen [3].

Ectopic pregnancy (EP), characterized by the implantation of an embryo outside the uterine cavity, occurs in approximately 2% of the general population [4]. Among women using LNG-IUDs who experience unintended pregnancy, the risk of EP is notably increased. A recent case-control study by Li et al. highlighted that women using LNG-IUDs face a more than 20-fold higher risk of ectopic pregnancy compared to those using no contraception [2]. Additional risk factors for EP include in vitro fertilization (IVF), smoking, pelvic inflammatory disease (PID), and a previous history of ectopic pregnancy [5,6].

This case report explores the clinical management of a 31-year-old female who presented to the Emergency Department (ED) with severe abdominal pain and vaginal bleeding. She was found to have a ruptured ectopic pregnancy, despite the presence of an LNG-IUD. The report highlights key considerations in managing such cases.

Case Report

A 31-year-old woman, gravida 1, para 0, presented to the Emergency Department (ED) with complaints of minimal vaginal bleeding and severe right iliac fossa (RIF) and abdominal pain. She was unsure of her last menstrual period (LMP) and had been using a Jaydess coil for the past two years. Her cervical smear tests were up-to-date and normal. She is a nonsmoker with no significant medical history aside from anxiety, and her surgical history included a tonsillectomy and a diagnostic laparoscopy with cystectomy performed three months prior.

On clinical examination, the patient appeared well, oriented to time, place, and person but in pain without signs of distress. Her vital signs were as follows: temperature 36.2°C, heart rate 70 beats per minute, blood pressure 150/104 mm Hg, respiratory rate 18 breaths per minute, and oxygen saturation of 97% on room air. Abdominal examination revealed a soft but mildly distended abdomen with tenderness and guarding in the RIF. A speculum examination, performed with verbal consent and in the presence of a chaperone, showed minimal vaginal bleeding. The vulva, vagina, and cervix appeared healthy, with the coil threads visible.

The patient had presented to the ED twice before within the same week, reporting minimal vaginal bleeding and mild abdominal pain. At those times, she had a positive urine pregnancy test but remained hemodynamically stable. A speculum examination, similarly, performed with consent and a chaperone, revealed minimal vaginal bleeding with healthy-appearing genital structures and visible coil threads. An initial ultrasound revealed no intrauterine pregnancy, and her beta-human chorionic gonadotropin (BHCG) level was 1885. The diagnosis of Pregnancy of Unknown Location (PUL) was made, and she was referred to the Early Pregnancy Assessment Unit (EPAU) for follow-up and further scanning.

Considering her current presentation and despite the presence of a contraceptive device (Jaydess coil), there was a high suspicion of a right ectopic pregnancy. A point-of-care trans-abdominal and trans-vaginal ultrasound conducted in the ED confirmed the absence of an intrauterine pregnancy. It also revealed normal findings in the left adnexa but a well-defined heterogeneous lesion, measuring 2.93 cm × 2.3 cm, in the right adnexa overlying the ovary (Figure 1). The scan also showed evidence of intraperitoneal fluid collection, and the coil correctly positioned in the lower uterine cavity. The patient experienced tenderness throughout the ultrasound examination.

The patient was placed under continuous monitoring, and a peripheral intravenous line was established. Baseline blood tests were taken, and two units of red cell concentrate (RCC) were cross matched in preparation. Initial laboratory results showed a hemoglobin level of 12.8 g/dL (reference range: 12.0–15.5 g/dL) and a hematocrit of 37% (reference range: 34.9–44.5%). Her electrolyte, blood glucose, and lactate levels were unremarkable.

She was promptly taken to the operating room (OR) for a diagnostic laparoscopy. Intraoperatively, 100 ml of hemoperitoneum was evacuated, a right salpingectomy was performed, and the coil was removed. The findings included a normal left ovary and fallopian tube and a partially ruptured right tubal ectopic pregnancy (Figure 2). The patient recovered well

postoperatively, remained stable throughout her hospital stay, and was discharged the following day with arrangements for outpatient follow-up.

Discussion

We presented the case of a nulliparous woman who developed an ectopic pregnancy (EP) despite the presence of a levonorgestrel-releasing intrauterine device (LNG-IUD) Jaydess. This case underscores the importance of considering women with a positive pregnancy test and an IUD in situ as being at high risk for EP, prompting crucial discussions about the management of these patients.

A large multinational cohort study conducted in 2015 examined the relative contraceptive effectiveness and risk of EP in women with LNG and copper IUDs in situ [7]. The study found that the LNG-IUD was associated with a lower risk of both intrauterine and ectopic pregnancies compared to copper IUDs.

In our case, the coil was observed to be abnormally positioned in the lower uterine cavity during the ultrasound examination. Research has shown that the risk of unplanned pregnancy is higher when the LNG-IUD is displaced lower in the uterine cavity or perforates into the myometrium [7]. This highlights the importance of routine pelvic ultrasound scans to assess the position of IUDs and the need to counsel women with displaced IUDs about the potential reduction in contraceptive effectiveness. This case also emphasizes the need for urgent investigation in IUD users who test positive for pregnancy, as they face a heightened risk of complications. Clear communication about available management options is essential.

Given the significant morbidity associated with a delayed diagnosis of EP, this case serves as a reminder that while unintended pregnancies are rare among women using IUDs, clinicians must remain vigilant about the increased risk of EP in those who do become pregnant. Advances in ultrasound technology have greatly improved the ability to accurately and non-invasively diagnose EP, enabling timely and effective management decisions.

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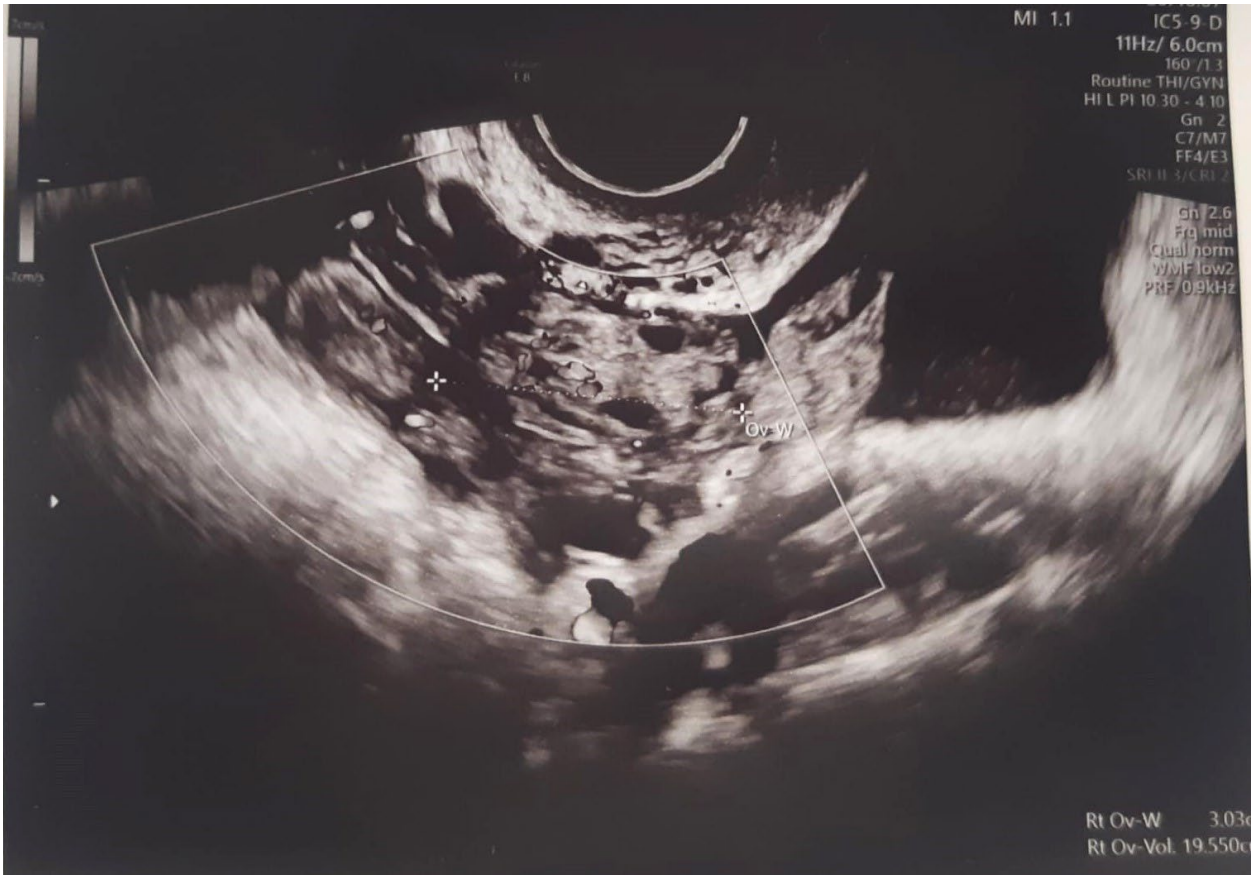

Figure 1: Transvaginal scan showing right sided heterogeneous mass adjacent to the right ovary

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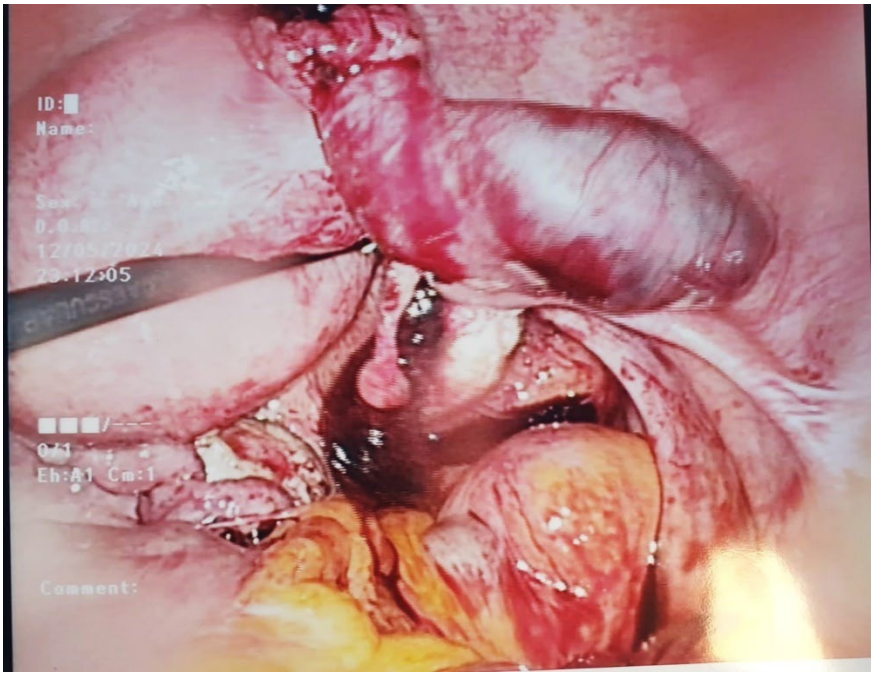

Figure 2: Laparoscopic view showing partially rupture right tubal ectopic pregnancy.

Acknowledgments
I recognise that H. Bashir share with me the first authorship.

Declarations of Conflicts of Interest:
None declared.

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ENHANCING OUTPATIENT MEDICAL MANAGEMENT OF EARLY MISCARRIAGE: EVALUATING URINE PREGNANCY TEST COMPARED TO ULTRASOUND FOLLOW UP IN A TERTIARY MATERNITY UNIT

Topic / Dept:

1. Early Pregnancy Unit, Department of Obstetrics & Gynaecology, Cork University Maternity Hospital, Ireland
2. Pregnancy Loss Research Group, Department of Obstetrics and Gynaecology, University College Cork, Cork, Ireland

Author: *Joshil Selva Jothi [1,2]*

Co Author: *Louise Dooley[1]*

Co Author: *Deirdre Hayes-Ryan[1,2]*

Background

Miscarriage, the loss of a pregnancy before viability, occurs commonly in the first trimester, with an estimated rate of
20% [(1,3,5)]. Outpatient medical management is often preferred for those who are clinically suitable [(2,3,6)]. In late 2023, our local early pregnancy unit (EPU) introduced high-sensitivity urine pregnancy test (HUPT) follow up rather than routine two week ultrasound (US)[(4)].

Objective

The aim of this review was to assess the safety and efficacy of the newly implemented follow-up protocol for outpatient medical management of early miscarriage, including the evaluation of patient outcomes, complications, and the need for further interventions.

Study design and methods

Retrospective review of women who underwent outpatient medical management for early miscarriage at our EPU from 1st January to 31st March 2024. Eligible women were identified from the local medication register. Relevant anonymised clinical information on diagnosis, treatment and follow up was collected and transcribed from electronic healthcare records to a secured excel file and compared between the two groups.

Results

In this timeframe, 82 women opted for outpatient medical management with an even split (n =41) between HUPT and US follow up (Table 1). Demographics of both groups were similar in

terms of parity, gestational age, gestational sac size and need for emergency review within the subsequent week. Those with HUPT follow up required less additional treatments (7.3% v 29.2%) compared to the US group.

Conclusion

HUPT is safe and effective for follow-up for early miscarriage with less further intervention required. We have now modified our US protocol follow up from 14 days to 21 days. Further research is needed to assess patient satisfaction with this approach.

Abstract Character count

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Allowed character count; 2100 excluding the title, author(s) name(s) and address(es)

Tweetable Abstract

This review assessed follow-up protocol for outpatient medical management of early miscarriage, comparing high-sensitivity urine pregnancy tests (HUPT) to routine ultrasound. HUPT was found to be a safe and effective, requiring fewer additional interventions.

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	N= 82	
	HUPT* follow up 21 days n = 41 (50%)	**US follow up 14 days n = 41 (50%)**
Nulliparous	19 (46.3%)	17 (41.4%)
Gestational age by dates at time of diagnosis (days)	6+0 – 14+0 (range) 9+2 (median)	6+0 – 13+1 (range) 9+1 (median)
Size of MGSD** at time of diagnosis (mm)	4 – 36 (range) 18.5 (median)	3 – 37 (range) 17 (median)

Type of miscarriage; • *Anembryonic pregnancy* • *Fetal demise*	 16 (19.5%) 25 (30.4%)	 10 (12.1%) 31 (37.8%)
Emergency attendance within next 7 days	2 (2.4%)	2 (2.4%)
No further treatment required	38 (92%)	29 (70%)
Positive HUPT with retained tissue on ultrasound	3 (7.3%)	N/A
Retained tissue on routine ultrasound follow up	N/A	12 (29.2%)
Required third line: surgical management	0	2(4.8%)

Table 1; Quality improvement in EPC medical management for first trimester miscarriage
*HUPT: High sensitivity urine pregnancy test, **MGSD: Mean Gestation sac diameter test

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Evaluation of elective surgical management of first-trimester miscarriage service

Topic / Dept:

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Background:
First-trimester miscarriage is common, occurring in approximately 20% of pregnant women. Elective surgical management (SMM) is a treatment option that allows timed intervention in a hospital setting, facilitating cytogenetics and histology assessment.

Objective:
The aim of this review was to evaluate our local SMM service provision to identify any obstacles or areas for improvement.

Study Design and Methods:
A retrospective review of all women who underwent elective SMM in our unit from 1st January to 29th February 2024. Eligible cases were identified from the theatre register. Electronic healthcare records were reviewed, and anonymized clinical data were transcribed to an Excel file, followed by descriptive statistical analysis. Data collection included: Maternal demographics, pregnancy information, Early Pregnancy Unit consultation, SMM procedure details, and complications/re-presentation to the Emergency Department (ED) following discharge.

Results:
In January and February 2024, there were 63 cases of SMM in our unit, 30 of which were elective. The median duration from diagnosis of miscarriage to SMM was 3.6 days (range 1-4), with a median gestational sac size of 19.4 mm (range 13.1 to 42). 90% (n=27) were missed miscarriages. Pre-operative phlebotomy at the time of booking was performed in 90% (n=27), and medication for cervical priming was administered in 87% (n=26) of cases. The median delay from the planned start time of surgery to the actual start was 39 minutes (range 20-80). Ultrasound was utilized during surgery in 37% (n=11), while the median blood loss was 75 mL (range 10-500 mL). No

complications were noted. Only 6% (n=2) of patients attended the ED within 14 days after discharge (Table 1).

Conclusions:

Evaluation of elective SMM service in our unit revealed a short duration from the diagnosis of miscarriage to surgery and a high standard of pre-operative preparation. Delays in the commencement of surgery were identified as an area for improvement. No complications and a low rate of ED attendance can be seen as evidence of good clinical practice.

Tweetable abstract

Evaluation of elective SMM service in our unit revealed a short duration from diagnosis of miscarriage to the date of surgery and a high standard of pre-operative preparation. Delays in surgery commencement have been identified as an area for improvement, however.

Twitter handles:

@JJKnoetze @ @deehayesryan @IrelandSouthWID @PrengancyLossIE

	N=30
Maternal age (years)	35 (median), 29-45 (range)
Gestational age by dates (weeks)	10+3 (median), 8+1 to 13+3 (range)
Mean gestational sac size (mm)	19.4 (median), 13.1 to 42 (range)
Type of miscarriage: Missed miscarriage Incomplete miscarriage	 90 % (n=27) 10 % (n=3)
Duration from diagnosis in EPU until SMM (days)	3.6 (median), 1-4 (range)
Early Pregnancy Unit Consultation: Pre-operative phlebotomy performed Medication for cervical priming provided	 90% (n=27) 87% (n=26)
SMM Procedure: Average start time delay (minutes) Performed under US guidance Blood loss (mls)* Private obstetric care Complications	 39 (median), 20-80 (range) 37% (n=11) 75 (median), 10-500 (range) 50% (n=15) None
Post Procedure Emergency Department Re-Presentation	6% (n=2)

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Table 1; SMM in January and February 2024. *EBL not recorded in 33% (n=10)

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NAVIGATING THE CHALLENGES OF INTERSTITIAL ECTOPIC PREGNANCY: CASE REPORT ON TIMELY DIAGNOSIS AND SURGICAL MANAGEMENT

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Co Author: D Hayes-Ryan[1,2]

Introduction:

Interstitial ectopic pregnancy (IEP) is an uncommon but potentially life-threatening condition characterised by implantation of a fertilised egg in the interstitial segment of a fallopian tube[1,2]. Representing 2–6.8% of all ectopic pregnancies, IEP poses significant diagnostic challenges frequently resulting in advanced gestation at time of diagnosis[1]. Early diagnosis facilitates optimal timing and location of treatment [2].

Case Summary:

A 34 year old woman at 7 weeks gestation attended EPU for reassurance ultrasound due to history of previous pregnancy loss. Ultrasound revealed a live right sided IEP (Image 1). There were no signs of rupture and she was asymptomatic. A multidisciplinary team (MDT), including specialists in early pregnancy and complex gynaecology reviewed the case and determined optimal treatment modality. Laparoscopic surgery was performed electively the subsequent day, whereupon a 2 cm right IEP was observed protruding through the uterine serosa. Vasopressin was injected around the ectopic site, followed by a linear incision of the gestational sac and aspiration of contents. Barbed continuous suture was utilised and haemostasis achieved without breeching the uterine cavity or removal of any uterine muscle. Despite preparation for haemorrhage there was minimal blood loss during the surgery. The woman was discharged home

the next day and weekly β-hCG declined and normalised by week five. Histology confirmed ectopic pregnancy.

Conclusion:

IEP is rare and poses diagnostic challenges. Early detection allows for MDT discussion, planned intervention, and reduced morbidity.

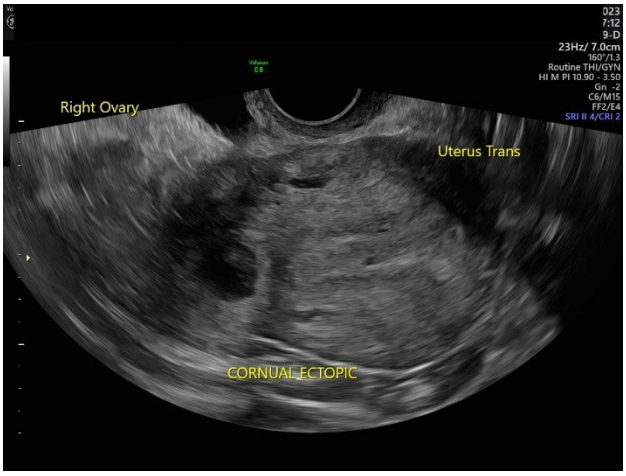

Image 1: Ultrasound image

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OPTIMISATION OF USE OF EARLY PREGNACY SERUM BIOMARKERS: A QUALITY IMPROVEMENT PROJECT

Topic / Dept:

1. Early Pregnancy Unit, Department of Obstetrics & Gynaecology, Cork University Maternity Hospital, Ireland
2. Pregnancy Loss Research Group, Department of Obstetrics and Gynaecology, University College Cork, Cork, Ireland
3. Emergency Department, Department of Obstetrics & Gynaecology, Cork University Maternity Hospital, Ireland

Author: J Jothi[1,2]

Co Author: D Synnott[1]

Co Author: L Quinn[3]

Co Author: D Hayes-Ryan[1,2]

Background

When a pregnancy is not visualised on ultrasound following a positive urine pregnancy test, it is classified as a pregnancy of unknown location (PUL)[1-3]. Serum β-hCG is a biomarker used to triage PUL as high or low risk of ectopic pregnancy (EP)[1-3].

Objective

This Quality improvement project aimed to improve use of serum β-hCG in women attending the Emergency Department (ED).

Study design and method

A retrospective audit, examining a 5 day period in January 24, of women attending the ED with early pregnancy complications was performed. Sampling of serum β-hCG, including timing and indication for same, was reviewed. Following this, education was provided to ED staff and doctors on the appropriate use of serum β-hCG; following focused history, clinical examination and ultrasound demonstrating a PUL or EP. A repeat audit was conducted in March 24 to assess improvement.

Results

Similar numbers of women presented to the ED with similar complications of early pregnancy in both time periods (Table 1). Around a quarter had undergone ultrasound in the current pregnancy prior, with most scans demonstrating a normally sited intrauterine pregnancy. Serum β-hCG sampling was almost universal in the initial audit (93.9%) with a significant reduction noted on repeat audit (44.8%) (Table 1).

Conclusion

Serum β-hCG is a useful biomarker in the setting of ultrasound demonstrated PUL or EP as an adjunct to aid decision making. It has no role outside of PUL/EP and routine sampling is not advisable. We have improved use of serum β-hCG and aim to optimise further.

	January 2024 N=33	**March 2024 N=29**
Presenting with vaginal bleeding	21.2% (7)	44.8% (13)
Presenting with pelvic pain	12.1% (4)	34.4% (10)
Presenting with pelvic pain & vaginal bleeding	51.5% (17)	17.2% (5)
Prior ultrasound in current pregnancy prior to ED review *Intra-uterine pregnancy identified* *PUL/EP identified*	30.3% (10) *70% (7)* *30% (3)*	20.6% (6) *83.3% (5)* *16.6% (1)*
serum β-hCG sampling in ED	93.9% (31)	44.8% (13)
serum β-hCG sampling at time of triage in ED	84.8% (28)	13.7% (3)
serum β-hCG sampling following medical review	9.1% (3)	34.5% (10)

Table 1; Quality improvement in ED serum β-hCG sampling CUMH

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Recurrent miscarriage referral audit

Topic / Dept: The Rotunda Maternity Hospital

Author: Dr Oladayo Oduola

Co Author: Dr Pari Kumar

Co Author: Dr Karen Flood

Recurrent miscarriage clinics, such as our dedicated specialist-led clinic, have been shown to significantly reduce the time between referral and treatment initiation (Habayeb, 2004) as well as
improved livebirth rates.
These clinics play a crucial role in the management of recurrent miscarriage, offering specialized investigation, treatment, and counselling (Berg, 2014; Li, 1998). The evaluation and management of recurrent miscarriage cases should be thorough, with structured history and evidence-based investigation, and should include regular monitoring for women who conceive again (Branch, 2010; Li, 1998).
The aim of this audit is to assess if our Recurrent Miscarriages Clinic in the Rotunda Hospital has received appropriate referrals and whether our referees subsequently received care in accordance to
guidelines standards; o also evaluate if patients had been followed up in an appropriate and timely manner.

Method

This was a retrospective audit conducted after approval from the Rotunda audit committee. All women refereed to the Rotunda recurrent miscarriage clinic (RMC) between May to September 2023 were included for analysis. An audit tool developed by Rotunda Audit department was utilised for our audit purpose.

Results

87 women were referred during the audit period (May – September 2023) but data was only available for 66 women (21 Patients did not attend their follow up appointment).
The mean age was 35.7years (SD- 4.9), the mean number of pervious miscarriages was 3.4 (SD- 1.8), while the mean number of live births was 0.7 (SD- 0.8). About 47 (71%) had greater than 2 previous miscarriages at the time of referral. Of the 66 patients who attended 98% were pre-conceptual. All referrals were deemed appropriate and met definition as per guidelines.

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Conclusion

On review patient who are referred to the RMC were overall deemed appropriate and the majority are reviewed within a 5-month period. We hope to reduce this time period further as the new approach is more efficient in providing the necessary care to patients

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REVIEW OF TERMINATION OF PREGNANCY FOR FATAL FETAL ABNORMALITY SERVICES IN OLOL

Author: M Smyth, OLOL

Co Author: F Alayia, OLOL

Co Author: F Armstrong,OLOL

Background

Termination of pregnancy became legal in Ireland in January 2019. There were two aspects to the legislation: termination of pregnancy prior to 12 weeks for any reason and termination of pregnancy at any gestation for fatal fetal abnormality. Prior to 2023 all patients booked OLOL hospital for their pregnancy had to attend the Rotunda Hospital for termination of pregnancy for fatal fetal abnormality should it be required. Since 2023 this service can be offered locally in OLOL resulting in better continuity of care for patients and their families at a very challenging time.

Objective

To review all the cases of termination of pregnancy in OLOL from January 2023 to present to ensure that the pathway for management of fatal fetal anomalies was followed for each of the patients and to explore potential failings in our system.

Study design and methods

Chart reviews were conducted for all the patients that had a termination of pregnancy during the specified time. We looked to see if all the patients had been seen by fetal medicine within the specified timeframe within the pathway. Had all patients had an mdt discussion? Where they offered choice of care location? Where there any delays in care and why? Did all the patients receive adequate follow-up and future pregnancy advice? Each chart was reviewed looking for the answers to the above questions.

Findings/ results

Four women had termination of pregnancy in OLOL during the timeframe. All patients were seen be fetal medicine within 4 days of their initial scan. They all had MDT discussion and all opted to have the termination of pregnancy performed in OLOL hospital. At the time of this study three out of four patient had been debriefed, the fourth was planned.

Conclusions

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Local access to termination of pregnancy for fatal fetal abnormalities has been a success in OLOL. Patients can avail of better continuity of care and travel shorter distances to receive the care they need.

Tweetable abstract:

Greater local access to termination of pregnancy for fatal fetal abnormality following introduction of facility in Drogheda hospital in conjunction with the Rotunda leading to improved patient care and flow.

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RISK FACTOR IDENTIFICATION FOR EMERGENCY PRESENTATIONS AFTER MEDICAL MANAGEMENT OF FIRST TRIMESTER MISCARRIAGE

Topic / Dept: Department of Obstetrics and Gynaecology, Rotunda Hospital, Dublin

Author: Barbara Guerrini

Co Author: Rebecca Boughton

Co Author: Prof Sharon Cooley

Co Author: Prof Sean Daly

Background

Medical management of first trimester miscarriage has been shown to be safe and effective with an 85% success rate. National guidelines recommend outpatient management for patients with a mean gestational sac diameter (MGSD) <50mm. However, many women present to the emergency department with significant pain and bleeding requiring emergency admission and occasionally transfusion and surgery.

Objective

This retrospective cohort study evaluated emergency room (ER) visits following outpatient medical management of miscarriage, aiming to identify risk factors leading to emergency admission in this cohort.

Study Design and Methods

All women attending the Early Pregnancy Unit (EPU) at a tertiary maternity hospital in 2023 for outpatient medical management of first-trimester miscarriage were included in the study. Patients, 8 to 14+3 weeks gestation, received 200mg mifepristone, followed by 800mcg misoprostol after 48 hours. The MGSD, measured in millimeters before treatment, was categorised into 6 groups (<10, 10-20, 20-30, 30-40, 40-50, >50). Descriptive statistics were obtained using Chi-Square and Mann-Whitney U tests.

Results

A total of 347 women were included in the study. Outpatient management had an 84% success rate, with 16% (55) returning to the ER, primarily for bleeding and/or pain (91%). Of those, 53% (29) were admitted, 9% (5) by ambulance. Emergency ERPC was required in 28% (8) of admissions and 7% (2) received blood transfusions. MGSD was significantly larger in women who returned

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to the ER (p<0.01), with 49% having a MGSD of 20-40mm and 15% of 40-50mm. In contrast, most successfully managed patients (62%) had a MGSD of 10-30mm, and only 3% of 40-50mm.

Conclusion

While medical management of miscarriage was successful in 84% of women the MGSD is a strong predictor of outpatient management success. Only 20% of women with MGSD >40mm continued medical management as outpatients. These findings warrant further investigation, review of pro-bleeding factors in this cohort and consideration of MGSD in counselling patients for treatment.

Tweetable abstract

Medical management for first-trimester miscarriage has an 84% success rate. Larger gestational sacs (>40mm) increased ER visits and emergency admissions.

RUPTURED CORNUAL PREGNANCY: A RARE AND CHALLENGING OBSTETRIC EMERGENCY

Topic / Dept: The Coombe Hospital, Dublin, Ireland.

Author: Brennan, A

Co Author: Abdelrahman, M

Co Author: Muresan, B.A.

Background:

Cornual Pregnancy (CP) accounts for 2-4% of ectopic pregnancies (EP) and carries a high mortality rate of 2-2.5%, 2-5 times higher than that of other EP, due to diagnostic challenges, high risk of rupture and involvement of major blood vessels with severe haemorrhage risk should rupture occur.[1]

Case report:

We present a case of a 28-year-old para 1 (previous SVD) who presented with ruptured CP.
Ms. X had a normal booking scan at 12 weeks. She had no significant medical history or previous surgeries. At 14 weeks Ms. X presented to the emergency department post collapse at home. She was haemodynamically unstable with generalized abdominal pain. Transabdominal ultrasound (USS) showed large volume free fluid and no fetal cardiac activity. Showing signs of haemorrhagic shock, the patient was resuscitated and proceeded to emergency diagnostic laparoscopy.
Upon laparoscopic entry to the abdomen massive hemoperitoneum of 3L was discovered and decision made for conversion to midline laparotomy. Active bleeding from ruptured left uterine cornua was noted and the fetus was located in the abdominal cavity. Intra-myometrial

vasopressin was administered and the cornual uterine rupture was repaired. Haemostasis was achieved further with the use of Tranexamic acid and uterotonic agents. The patient received 6 units of red blood cells, 2g of fibrinogen and 4 units of plasma peri-operatively. Her haemoglobin (Hb) dropped to 6.9g/dL from a booking Hb of 11g/dL.

Ms. X made a full recovery post operatively and was discharged well on day 5 with a Hb of 8.8g/dL. She was advised an inter-pregnancy interval of at least 1 year and elective caesarean delivery for future pregnancies.

Conclusion:

Though rare, CP is a life-threatening early pregnancy complication associated with a high probability of rupture and possible catastrophic haemorrhage. It poses significant diagnostic difficulties in differentiating on ultrasound CP from eccentric intrauterine pregnancies[2] but early detection and prompt action are crucial to limiting maternal morbidity.

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2. (Faraj R & Steel M, 2007)

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STAFF EXPERIENCES IN AN ONSITE MATERNITY HOSPITAL AND OFFSITE COMMUNITY EARLY PREGNANCY UNIT (EPU)

Topic / Dept:

1. Pregnancy Loss Research Group, Department of Obstetrics and Gynaecology, University College Cork, Cork, Ireland
2. Early Pregnancy Unit, Cork University Maternity Hospital, Wilton, Cork, Ireland
3. National Perinatal Epidemiology Centre, University College Cork, Ireland
4. The Irish Centre for Maternal and Child Health Research, University College Cork, Cork, Ireland

Author: D Synnott[1,2]

Co Author: D Hayes-Ryan[1,2,3]

Co Author: K O'Donoghue[1,2,4]

Co Author: S Leitao[1, 3]

Background:
Early pregnancy units' function to assess complications of early pregnancy and are commonly staffed by midwives, midwife sonographers and doctors. Research has shown working in an EPU may result in stress and burnout because of caring for women and men experiencing pregnancy loss.

Objective:
This study examined work-related demands and satisfaction of staff in both an onsite and offsite EPU.

Study Design & Methods:
All EPU staff in a tertiary maternity hospital were invited to complete an online survey. Data were collected in August/September 2023 while the EPU was onsite at the maternity hospital and in January – May 2024 once EPU moved offsite. The survey was modelled on previous EPU staff experience research and used validated scales (job satisfaction, organisational and social isolation and emotional demands).

Results:
Overall, 15 surveys were completed from the onsite EPU and 25 from the offsite EPU. There were no differences in the scale scores between EPU locations. Staff reported high job satisfaction

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(M=8.87; range 4(high)-20 (low)), strong support from colleagues (M=13, range 3-15) and management (M=18.3, range 4-25). Participants considered the offsite EPU better in design, atmosphere, resources for service users and staff, parking and other staff facilities. High levels of emotional demands in this work were reported along with the demand for hiding emotions. Individual workload, logistical organisation of the EPU and lack of accessibility to counselling and/or supports were the main staff stressors.

Conclusion:
Feedback on the offsite EPU was positive, reflecting better working conditions and provision of care. While job satisfaction was strong, interventions for staff to manage stress and emotional demands of their work are needed to ensure wellbeing and health.

Tweetable Abstract:
Working in an EPU may result in stress or burnout. This study examined work-related demands and satisfaction of staff in an onsite and offsite EPU. Feedback on the offsite EPU was positive, reflecting better working conditions and provision of care.

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TIMEFRAME OF EARLY PREGNANCY UNIT REVIEW FOR WOMEN WITH EARLY PREGNANCY COMPLICATIONS PRESENTING TO A TERTIARY MATERNITY UNIT EMERGENCY DEPARTMENT

Topic / Dept:

1. Early Pregnancy Unit, Department of Obstetrics & Gynaecology, Cork University Maternity Hospital, Ireland
2. Pregnancy Loss Research Group, Department of Obstetrics and Gynaecology, University College Cork, Cork, Ireland

Author: Bunmi Adeniji[1]

Co Author: Deirdre Hayes-Ryan[1,2]

Introduction

Bleeding and/or pain in early pregnancy may indicate an underlying complication such as a miscarriage or an ectopic pregnancy. Early pregnancy complications are a common indication for emergency department (ED) attendance. A dedicated early pregnancy unit (EPU) is where women with early pregnancy complications should ideally be seen provided there are no acute concerns. The aim of this review is to determine the duration from the ED to EPU review in our unit.

Methods

Retrospective review of all women who attended the ED in our unit in July 2024 due to suspected complications of early pregnancy. Only women attending for the first time in their current pregnancy were included. Eligible cases were identified from the attendance logbook in the ED and anonymised clinical data transcribed from electronic healthcare records and reviewed.

Results

Of the 98 women that presented to ED, 77 met the inclusion criteria. The median gestational age at presentation was 6+5 weeks (IQR 2-12 weeks) while the most frequent indication for presentation was vaginal bleeding and pelvic pain 42.9% (n=33). Risk factors for ectopic pregnancy were present in 10.4% (n=8).

Of those seen, 42.9% (n=33) had an ultrasound performed in the ED with 1.3% (n=1) having no pregnancy visualised on scan. Only 53.3% (n=41) were subsequently reviewed in EPU within 48 hours although the total EPU capacity utilisation for July was 89.31% (n=493) (Table 1).

Conclusion

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Women with suspected early pregnancy complications presenting to the ED, that are clinically stable for discharge home, should be reviewed in EPU in a timely manner; ideally 24-48 hours. Priority should be given to women with no ultrasound in the current pregnancy, no pregnancy visualised on ultrasound and if risk factors for ectopic pregnancy are present.

	July 2024 N=77
Gestational age at time of ED review (weeks)	6+5 (median) 2-12 (range)
Indication for ED review	
Vaginal bleeding & pelvic pain	33 (42.9%)
Vaginal bleeding	25 (32.5%)
Pelvic pain	16 (20.8%)
Risk Factors for ectopic pregnancy present	8 (10.4%)
Previous ultrasound in current pregnancy	5 (6.5%)
Ultrasound performed in ED	33 (42.9%)
Most senior level of doctor that reviewed patient in ED	
SHO	40 (51.9%)
Junior Registrar	17 (22.1%)
Senior Registrar	15 (19.5%)
Working Diagnosis upon discharge from ED	
Threatened miscarriage	31 (40.3%)
Pregnancy of uncertain viability	14 (18.2%)
Viable Intrauterine pregnancy	8 (10.2%)
Pregnancy of unknown location	1 (1.3%)
Timeframe from ED to EPU review	
< 24 hours	24 (31.2%)
25-48 hours	17 (22.1%)
> 48 hours	33 (42.9%)
Available EPU appointments	552
EPU capacity utilisation	493 (89.3%)

Table 1- Early pregnancy presentation to ED and timeframe to EPU in July 2024

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Tragedy a second time: Recurrent ectopic pregnancy on contralateral tube- gynaecological Perspectives

Topic / Dept: Department of Obstetrics and gynaecology Our Lady of Lourdes Hospital Drogheda Co Louth

Author: Taiwo A.A.O

Co Author: Ahmed S

Abstracts: A past incidence of a poor outcome, often tends to confer the highest recurrence risk in subsequent outcomes. Ectopic pregnancies are pregnancies implanted outside the uterine cavity and reported approximately to affect 1 in 100 pregnancies, most commonly occurring in the fallopian tubes. Ectopic pregnancy often represents a potentially life-threatening emergency diagnosis with high morbidity and potential for mortality when missed. Either ipsilateral or contralateral ectopic after an initial ectopic is a rare occurrence.

The risk factors for recurrent ectopic pregnancy have been enumerated but are not yet clearly defined. Understanding which risk factors are perhaps more common may allow providers to counsel and manage patients with a minimum standard of care, taking cognisance of relevant consideration, ethical issues and prognostic gynaecological concerns as well as managing the potential morbidity and averting mortality.

The primary surgical option offered and used in treatment and management, often confers a great risk and prognosis towards recurrences which could range from 10-27% in subsequent pregnancy.
Evidenced based practice and current surgical management of tubal pregnancy includes conservative (usually salpingectomy) and radical (total or partial salpingectomy) methods.

Case presentation

We report a case of a 32year old, G5P2+2 (twins 2017+ svd x 3) , (ectopic 1 2017, miscarriage 12016), African lady with a previous ectopic pregnancy managed by laparoscopic salpingectomy remotely, as she had a previous right sided ruptured ectopic pregnancy and left salpingectomy done 8 years back. She had no history of contraceptive usage despite given up on reproductive desires, no pelvic inflammatory disease, operative trauma or endometriosis, however she had a bariatric surgery 4 year earlier. She presented with acute onset of right abdominal pain in an otherwise unplanned pregnancy found with ruptured right ectopic pregnancy, which turned out as a case of recurrent ectopic on contralateral tubes managed effectively. Subsequent BHvg was

above the critical zone as initial scan was highly suggestive of ectopic in addition to clinical presentation.

The incidence of recurrent ectopic pregnancy is approximately 10–15% and this likelihood increases to 30% following ectopic pregnancies-A complex adnexal mass, an empty uterus plus a positive pregnancy test is mostly indicative of an extra-uterine gestation and is the most common ultra-sonographic presentation in the presence of amenorrhoea further heightened with a background history of past ectopic . The RCOG Green-top Guideline recommends that *"Laparoscopic salpingotomy should be considered as the primary treatment when managing tubal pregnancy in the presence of contralateral tubal disease and the desire for future fertility"* [24]. Operative morbidity is comparable for both procedures. There is an increased risk of persistent or recurrent ectopic pregnancy in the longer term when the primary surgical procedure is a salpingotomy. Such cases and others that leave a tubal residue may well need to be considered as similar to salpingostomy in terms of the recurrence risk.

Though this case reflects a contralateral tube ectopic , however a partial tube stump or partial tube adherent to the left side wall was noted on the previously operated ectopic a risk factor in recurrence.

Conclusion

Current gynaecologic perspectives , delves much into evidence based practices in informing decisions regarding – follow up , counselling regarding recurrent risk following initial and subsequent surgeries, advice of contraceptive choices and future fertility options. There remains a challenge on a standard of care and consensus for recurrent ectopic pregnancy and indeed it is not feasible to entirely prevent recurrent ectopic in patients with past ectopic pregnancy. Currently there are heterogeneity of approach to care, counselling and evaluation of patients with recurrent ectopic pregnancy. An RCT, guidelines, algorithm and policies maybe a welcome practice.

Figure 1-3 Ultrasound findings

Figure 4-6 Intraoperative findings

Table (Result- HB, Bhcg)

Parameters	Date	Values
HB -Admission	5.02.2024	11.9
Bhcg - Admission	5.02.2024	28,259
HB- Discharge	06.02.2024	10.4

References

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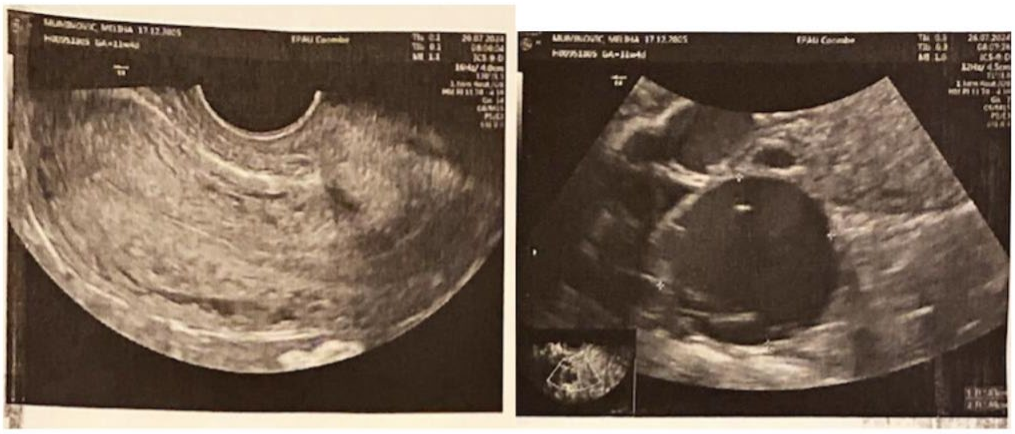
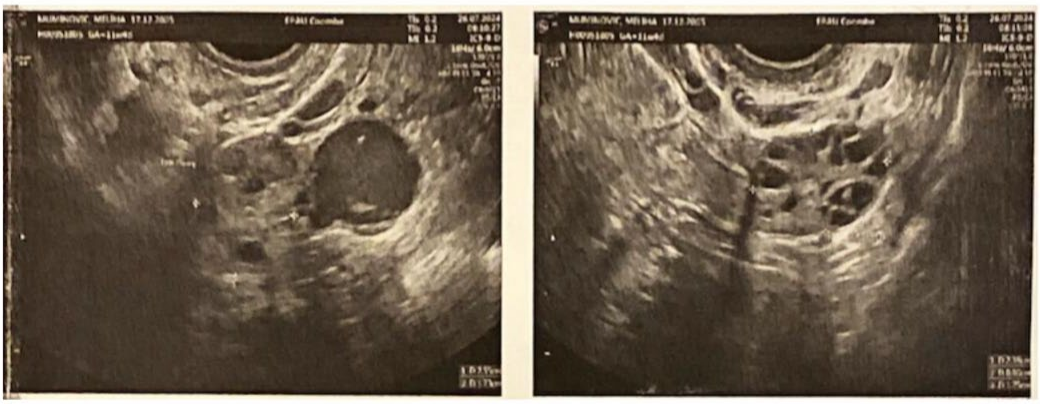
What an Ectopic!





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Workplace experiences following pregnancy loss under 24 weeks: supports and return to work

Topic / Dept:

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Co Author: Caroline Dalton-O'Connor[3]

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Co Author: Claire Murray[5]

Co Author: Daniel Nuzum[1]

Co Author: Sara Leitao[1, 6]

Background
Pregnancy loss affects many people globally and has substantial physical and mental health impacts. Workplace challenges including stigma, secrecy regarding early pregnancy, and difficulties returning to work often compound these issues. Supportive work environments that reduce stigma and encourage open discussion are essential.

Objective
To explore the experiences of individuals following pregnancy loss (<24 weeks) with a focus on workplace characteristics.

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Study Design and Methods

This cross-sectional quantitative study was conducted as part of the PLACES (Pregnancy Loss (< 24 weeks) in Workplaces) project. Women and men in employment completed a survey to capture data on their experience of pregnancy loss while working, workplace characteristics and supports available/accessed. Demographic information and use of leave following pregnancy loss were recorded. Cross-tabulation with chi-squared testing for association was conducted.

Results

Of the 913 participants, 75% experienced at least one first-trimester miscarriage, 16% a second-trimester miscarriage, and 8% reported other types of loss (e.g. ectopic pregnancy, termination, stillbirth or other). While only 45% of participants disclosed their pregnancy, 85% told someone at work after the loss. More second trimester miscarriages were disclosed (95%) compared to first trimester miscarriages (82%) and other types of pregnancy loss (91%)($p<0.001$); there were no differences based on workplace characteristics. 77% took time off work, typically using paid sick leave, and 85% found it difficult to resume duties. Fewer workers with higher incomes (>€50,000/year; $p<0.01$) and in managerial positions took leave after pregnancy loss ($p=0.02$). Support from colleagues and managers did not differ significantly across employment sectors (77-93%; $p>0.05$).

Conclusion

Pregnancy loss under 24 weeks poses significant challenges for those in employment, with similar patterns observed across employment sectors. Increased workplace support and accessible leave policies may facilitate better recovery.

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Ir Med J; March 2025; Vol 118; No. 3; P51
March 20th, 2025

A 10-year review of periconceptual folic acid supplementation in women with epilepsy prescribed anti-epileptic medications

Background

Women with epilepsy (WWE) who conceive whilst taking anti-epileptic drugs (AEDs) have an increased risk of neural tube defects (NTDs). Evidence has shown periconceptual folic acid supplementation could prevent two-thirds of NTDs. National guidelines recommend that all women at increased risk of a pregnancy complicated by a NTD who could become pregnant should commence high-dose (5mg) folic acid supplementation daily, at least three months prior to conception and throughout the first trimester

Objectives

To review periconceptual folic acid supplementation amongst WWE taking AEDs who delivered a baby (≥500g) in a tertiary referral centre over a ten-year period (2013-2022)

Methods

A retrospective review was conducted using the hospital database which contained maternal clinical and sociodemographic details collected during the antenatal booking visit

Results

75,869 babies ≥500g were born over the 10-year study period. 632 babies (0.83%) were born to women who had a diagnosis of epilepsy, 250 of whom were taking AEDs at the time of booking. 15% were taking more than one AED (n=39)

Amongst WWE taking AEDs, 3 (1.2%) did not take any folic acid in the periconceptual period. 23.6% (n=59) commenced after conception. 65.6% were prescribed the appropriate 5mg dose of folic acid preconceptually, with the remaining 9.6% taking the standard over-the-counter dose of 400mcg before conception. Two factors found to be negatively associated with adherence to periconceptual high-dose folic acid supplementation were prescription of valproate ($p<0.03$), as well as AED polytherapy ($p<0.03$), subsets in this cohort with the highest risk of NTDs

Conclusions

Despite the well-documented increased risk of NTDs among this population, only two-thirds took high-dose folic acid periconceptually. Preconceptual counselling is the standard of care, however many pregnancies are unplanned. WWE have frequent encounters with healthcare workers, providing ample opportunity for counselling and prescription of high-dose folic acid in those who may become pregnant.

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A Knot in the Stomach – A Rare Case of Prenatally Diagnosed Pyloric Atresia

Topic / Dept: Fetal Medicine/The Coombe Hospital, Dublin 8, 2. UCD, 3. RCSI, 4. CHI Crumlin

Author: Emma Thompson

Co Author: Eibhlín F. Healy

Co Author: Felicity Doddy

Co Author: Aisling Martin

Co Author: John Kelleher

Co Author: Brian McSweeney

Co Author: Mairead Kennelly

Tweetable Abstract:
Epidermiolysis Bullosa-Pyloric Atresia: In the setting of stomach mass with polyhydramnios at FAS where more common causes have been excluded, it is important to consider EB-PA as a differential. Antenatal MDT management to plan for delivery & postnatal care improves outcomes.

Topic:
Fetal Medicine

Case History:
A 37 year old, nulliparous woman presented for anatomical survey at 21+3. This was a spontaneous, singleton pregnancy, accurately dated, with a low risk NIPT. There was no significant medical history; the couple were not consanguineous.

Ultrasound:
During systematic assessment of the fetal anatomy, as per Irish FASP guidelines, an avascular, echogenic structure was noted within the fetal stomach wall with associated gross polyhydramnios Fig 1, 2. The stomach was dilated Fig 3.; fetal swallowing was demonstrated. The fetus was otherwise phenotypically normal. Invasive testing was declined, and a OGTT was negative.

Management:

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The patient was monitored with serial scans and attended the MDT Fetal Surgical Clinic at The Coombe Hospital. The differential diagnoses included pyloric atresia, very proximal duodenal atresia, a neuromuscular disorder, a neoplasm or gastric debris. Polyhydramnios increased to an AFI of 57.7cm, Fig 4. Amniodrainage was declined. A female infant, 2.9Kg was delivered by elective caesarean at 38+3 due to transverse lie. Her skin was noted to be friable and blistering and she went on to develop skin loss and blistering on her head, forearm and foot. Neonatal abdominal ultrasound and X-ray were consistent with a diagnosis of pyloric atresia – type 1 and surgical repair with a diaphragm excision, pyloroplasty and anastomosis occurred on day 3 of life after transfer to CHI Crumlin. After review by Dermatology, a diagnosis of Epidermiolysis Bullosa-Pyloric Atresia (EB-PA) was made. EB-PA is a rare genetic disorder - affecting skin, GI and GU tracts due a to faults in alpha-6-beta-4 integrins. The incidence is approx 1/100,000 births. Mortality may be as high as 50% with associated anomalies. Prenatal diagnosis and surgical planning likely improves the prognosis.

Discussion:

In the setting of a mass in the stomach with polyhydramnios, where more common causes have been excluded, it is important to consider EB-PA. Prenatal diagnosis, review and management a joint Fetal-Surgical Clinic improves outcomes for infants and parents.

Figure 1.

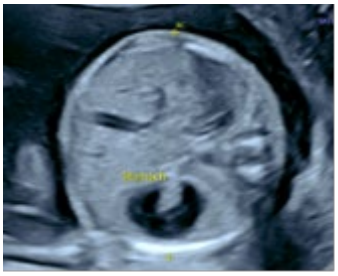

Figure 2.

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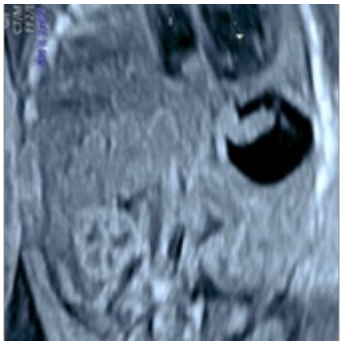

Figure 3.

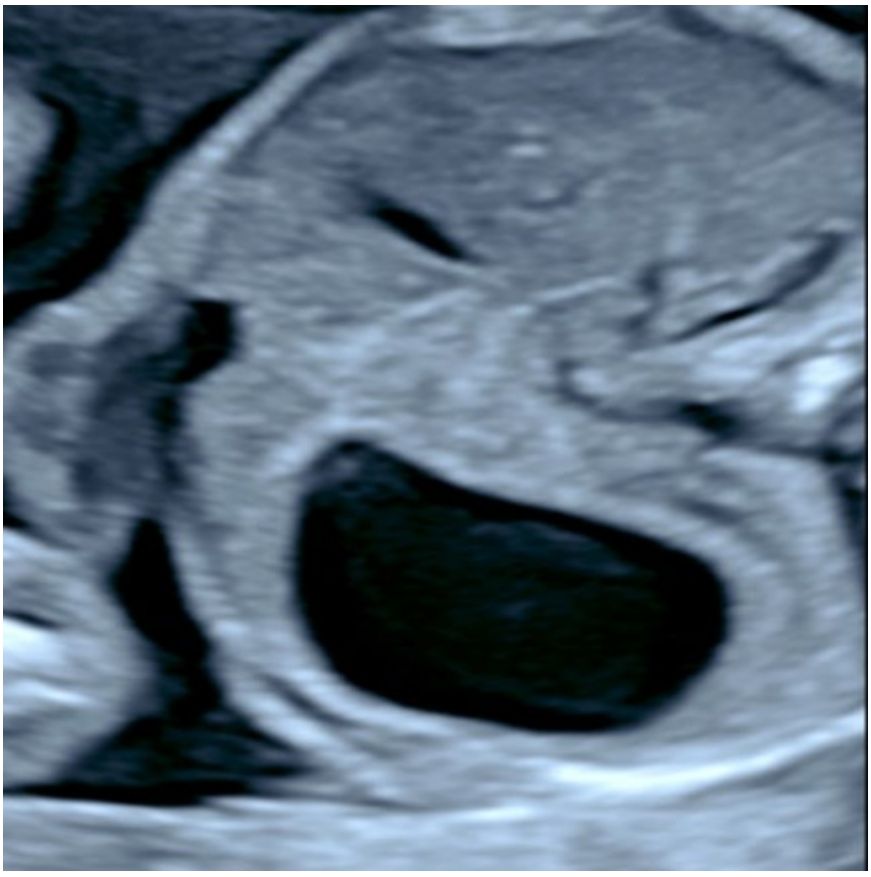

Figure 4.

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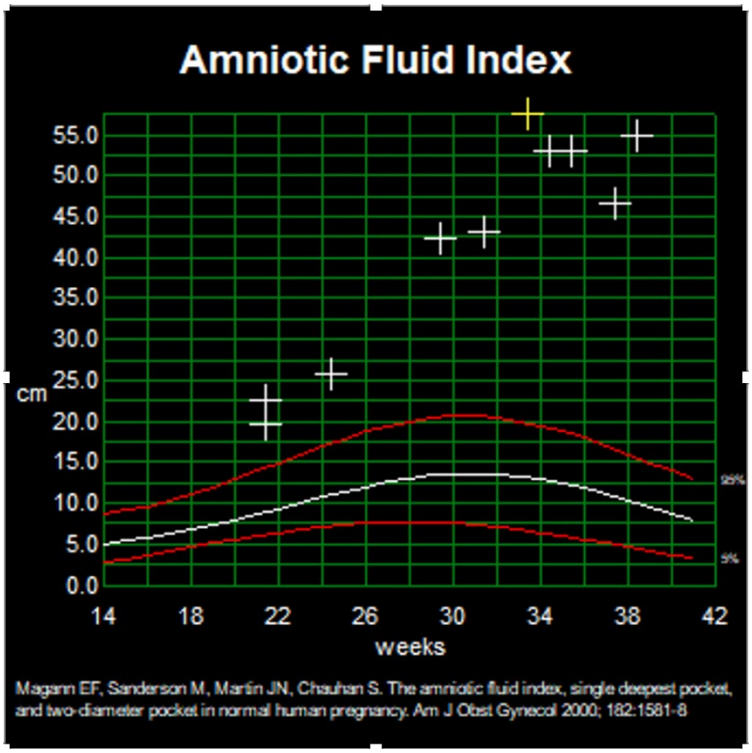

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A Systematic Review of The Utility of Fetal and Maternal Dopplers in the Assessment of Pregnancies Exposed to E-Cigarettes/Vaping

Topic / Dept:

1. The Coombe Hospital, Dublin
2. The Royal College of Surgeons in Ireland
3. Children's Health Ireland, Crumlin, Dublin.
4. University College Dublin
5. The Rotunda Hospital, Dublin.

Author: Eibhlín F. Healy[1,2]

Co Author: Ronan Sugrue[1]

Co Author: Desmond Cox[3,4]

Co Author: Fergal Malone[2,5]

Co Author: Carmen Regan[1,2]

Tweetable Abstract:
This systemic review identifies an evidence gap in pregnancies exposed to Vaping/E-cigarettes. The SR was limited by a paucity of published data on fetal and maternal doppler, our prospective, multi-centre, observational cohort, The @ECHO_infants study will address this deficit.

Background:
Nicotine induces vascular remodelling through its effects on proliferation, migration, and matrix production of both vascular endothelial and vascular smooth muscle cells. The impact of nicotine associated with vaping on fetal and maternal doppler indices are not well described in humans, although has been demonstrated to alter fetal cerebral blood flow in animal models. Fetuses of heavy smokers have been demonstrated to have impaired cerebral perfusion, however, it is difficult to discern if this is related to carbon monoxide or nicotine exposure. Smoking-related differences in the blood flow velocity waveforms and resistance index in the uterine, umbilical and middle cerebral artery have been described.

Aim:

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To assess the utility of fetal and maternal dopplers in pregnancies exposed to Vaping. Our primary outcome was reporting of any doppler indices in humans.

Methods:
We adhered to Conducting Systematic Reviews and Meta-Analyses of Observational Studies of Etiology (COSMOS-E) guidance. Two reviewers independently completed the search. The search protocol was registered and can be reviewed on Prospero CRD42024502149. We did not specify human subjects in order to identify useful pre-clinical trials. The search was undertaken through English, however no language or date restrictions were applied. White and grey literature were searched.

Results:
1100 titles were screened after exclusion of duplicates with 48 full abstracts assessed, and 13 full text papers analysed. No published papers in humans were identified that specified fetal or maternal assessment as a primary or secondary outcomes. First authors were directly contacted to assess if they retained any unpublished data. Data from doppler assessment in mice and rats was summarised (Table 1).

Conclusion:
Strengths of the review are that is has clearly identified an evidence gap in the assessment pregnancies exposed to Vaping. The primary limitation was the absence of published data on the primary outcome and thus the inability to undertake a meta-analysis.

Prisma Diagram.

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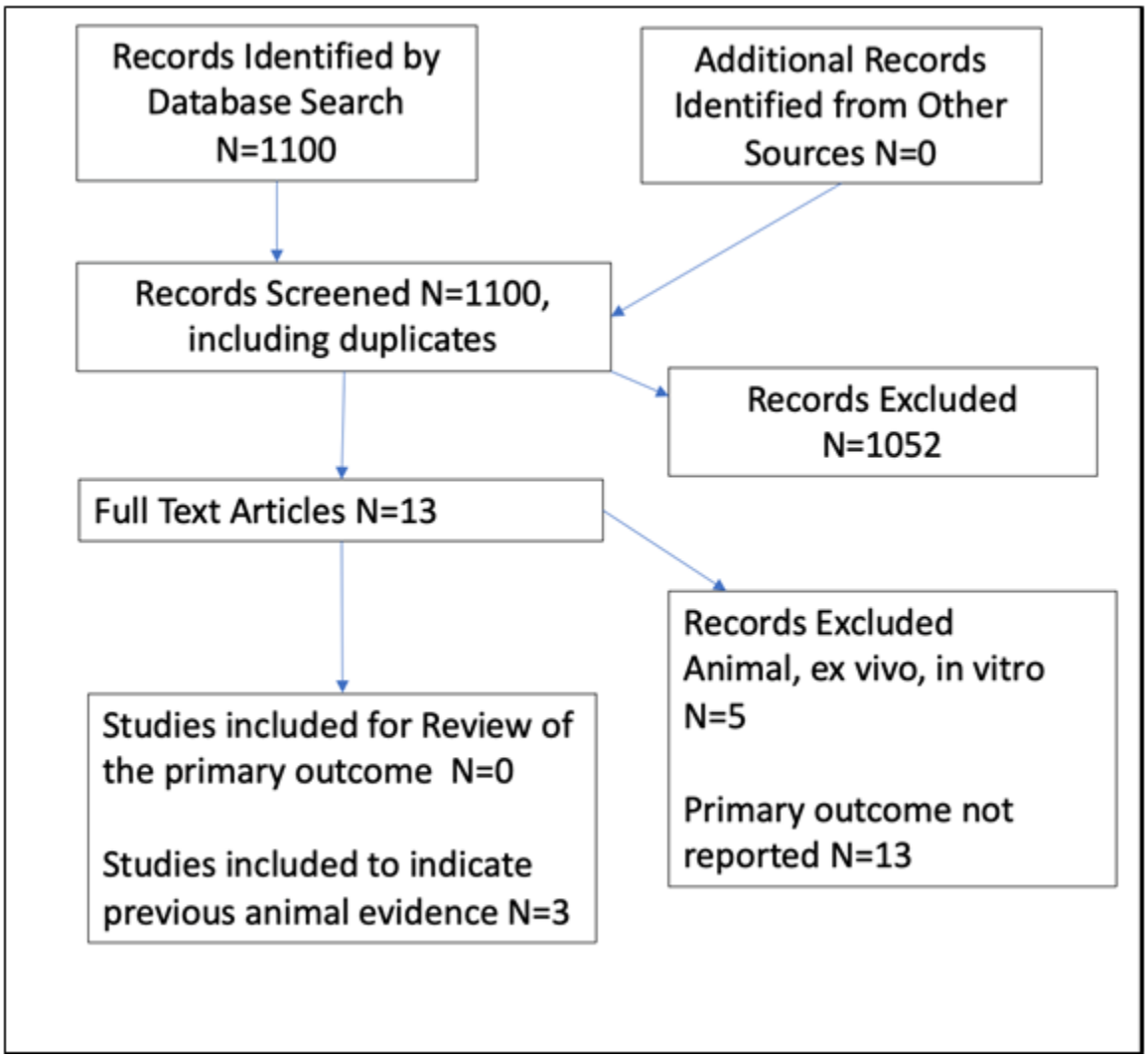

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Systematic review table

Paper	Author	Year	Population	Type of Study	Exposure	Outcome	Results	Time	Quality/Risk of Bias	Validity
Changes in e-cigarette and cigarette use during pregnancy and their association with small for gestational age birth(1)	Shittu	2022	PRAMS* Pregnant women who smoked in the three months previous to the pregnancy, singletons.	Large population dataset United States N=105,438	1. ENDS 2. Dual 3. Cigarettes Quitters	1. SGA 2. Low birth weight 3. Changes in ENDS/cigarette use	ENDS & Smokers significantly higher rates of SGA than non-smokers - RR 1.52 of SGA compared to non-users for ENDS, RR 2.15 for Smokers. Completely switching from smoking to ENDS in later pregnancy was associated with a risk of SGA of non-smokers – ie. normalised the risk.	2016-2018 3 months before pregnancy and last 3 months of pregnancy	Secondary analysis – survey data reliant on self reporting; recall bias, reporting errors and non-disclosure of substance use during pregnancy Risk of bias is therefore moderate to high. Iterative – these data have been previously reported.	Representative of the risk of smoking in addition to ENDS. High rate of missing data.
Impact of E-cig aerosol vaping on fetal and neonatal respiratory development and function(2)	Orzabal	2022	Pregnant rats and their male off-spring N=18	Pre-clinical, experimental murine study	1. ENDS 2. ENDS Vapour only – no nicotine 3. Control (room air)	1. Fetal rat EFW, 2. Birthweight, 3. CRL, 4. Placental efficiency	No difference between groups for placental efficiency, Significant diff. in birthweight for ENDS + nicotine	Gestational age 21 in utero, Day 4 & 10 postnatal	Low – appropriate controls, males only (no confounding for females), use of a nicotine neg group.	Valid for the study population in question (rats). This is a pre-clinical trial and therefore should not be used to strongly inform policy with regard to risk of harm or safety when translated to human subjects
Adverse Birth Outcomes Associated With Prepregnancy and Prenatal Electronic Cigarette Use(3)	Regan	2021	PRAMS Pregnant women who smoked in the three months previous to the pregnancy, singletons. N=79176	Large population dataset United States - enhanced with post hoc questionnaires	4. ENDS 5. Dual 6. Cigarettes 7. Quitters	1. Preterm Birth 2. SGA 3. Low birth weight (<2,500g)	No difference in PTB, SGA LBW more likely in ENDS vs non-users adjusted *prevalence* ratio 1.33; 95% CI 1.06–1.66	2016- 2018 3 months prior to pregnancy, duration of pregnancy then contacted up to 4 months postnatal	Moderate to high – the sample includes analyses with respect to women who reported smoking the 3/12 prior t pregnancy Iterative – these data have been previously reported.	Representative of the risk of smoking in addition to ENDS. High rate of missing data.
Use of Electronic Nicotine Delivery Systems (ENDS) by pregnant women I: Risk of small-for-gestational-age birth(4)	Cardenas	2019	Pregnant women N=248	Observational Cohort	1. ENDS 2. Dual 3. Cigarettes 4. Quitters	1. SGA 2. LBW 3. PTB	ENDS-only users versus the unexposed RR=3.1, 95% CI: 0.8–11.7, for SGA	2015-2017 concurrent data collection	Low to moderate risk of bias, acknowledging the confounders which were controlled for (age, ethnicity). Poverty no adjusted for. Selection method altered half-way through the study	Underpowered to demonstrate a true effect.
Smoking and use of electronic cigarettes (vaping) in relation to preterm birth and small for gestational age in a 2016 US national sample(5)	Wang	2021	PRAMS Pregnant women who smoked in the three months previous to the pregnancy, singletons. N= 31,973	Large population dataset United States	2. ENDS 3. Dual 4. Cigarettes 5. Quitters	2. Preterm Birth 3. SGA	Primary outcomes poorly recorded. Demographic data described. Poorer women more likely to smoker/use E-cigs Higher rates of SGA in smokers Higher rates of PTB in smokers Similar rates of SGA and PTB in ENDS users compared to non-smokers	2016	Moderate to high – the sample includes analyses with respect to women who reported smoking the 3/12 prior to pregnancy. Iterative – these data have been previously reported.	Representative of the risk of smoking in addition to ENDS. High rate of missing data.
Electronic cigarettes and obstetric outcomes: a prospective observational study(6)	McDonnell	2020	Prospective observational cohort study N=620	Pregnant women attending large urban maternity hospital for antenatal	1. ENDS 2. Dual 3. Cigarettes 4. Quitters	1. Birthweight, 2. LBW 3. gestational age at delivery 4. NICU admission; 5. Mean Apgar scores; 6. Breastfeeding at discharge	Birthweight for Non-smokers and ENDS users was equivalent and significantly larger than smokers (3166 ± 502 g, $P < 0.001$). Dual users had a mean birthweight and birth centile similar to that of smokers. ENDS has significantly higher breastfeeding rates at discharge compared with smokers (48.6 versus 27.2%, $P < 0.001$), but the rates were not as high as those of non-smokers (61.1%, $P = 0.03$).	2017-2018	Low risk of bias, prospectively designed with contemporaneous data collection for PROMS of smoking/ENDS use reducing recall bias. Risk of reporting bias.	Representative of the risk of smoking in addition to ENDS. Low rate of missing data Difficulty in assessing exposure to ENDS

*PRAMS – US Pregnancy Risk Assessment Monitoring System

1. Shittu AAT, Kumar BP, Okafor U, Berkelhamer SK, Goniewicz ML, Wen X. Changes in e-cigarette and cigarette use during pregnancy and their association with small-for-gestational-age birth. American journal of obstetrics and gynecology. 2022;226(5):730. e1-. e10.
2. Orzabal MR, Naik VD, Lee J, Hillhouse AE, Brashear WA, Threadgill DW, et al. Impact of E-cig aerosol vaping on fetal and neonatal respiratory development and function. Translational Research. 2022;246:102-14.
3. Regan AK, Bombard JM, O'Hegarty MM, Smith RA, Tong VT. Adverse birth outcomes associated with prepregnancy and prenatal electronic cigarette use. Obstetrics & Gynecology. 2021;138(1):85-94.
4. Cardenas VM, Cen R, Clemens MM, Moody HL, Ekanem US, Policherla A, et al. Use of Electronic Nicotine Delivery Systems (ENDS) by pregnant women I: Risk of small-for-gestational-age birth. Tobacco induced diseases. 2019;17.
5. Wang X, Lee NL, Burstyn I. Exposure-response analysis of the association of maternal smoking and use of electronic cigarettes (vaping) in relation to preterm birth and small-for-gestational-age in a national US sample, 2016-2018. medRxiv. 2021:2021.03. 01.21252530.
6. McDonnell B, Dicker P, Regan C. Electronic cigarettes and obstetric outcomes: a prospective observational study. BJOG: An International Journal of Obstetrics & Gynaecology. 2020;127(6):750-6.

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Late Amniocentesis

Zemet, R., Maktabi, MA., Tinfow, A., Giordano, JL., Heisler, TM., Yan Qi., Plaschkes, R., Stokes, J., Walsh, JM., Corcoran, S., Crosby, D. et al. *Amniocentesis in pregnancies at or beyond 24 week: An international multicenter study.* American Journal of Obstetrics and Gynaecology, June 2024.

Background: Amniocentesis for genetic diagnosis is commonly done between 15 and 22 weeks of gestation but can be performed at later gestational ages. Comprehensive data on late amniocentesis remain sparse.

Objective: To evaluate the indications, diagnostic yield, safety, and maternal and fetal outcomes associated with amniocentesis performed at or beyond 24 weeks of gestation.

Study design: We conducted an international multicenter retrospective cohort study examining pregnant individuals who underwent amniocentesis for prenatal diagnostic testing at gestational ages between 24w0d and 36w6d. The study, between 2011 and 2022, involved 9 referral centers. We included singleton or twin pregnancies with documented outcomes. We analyzed indications for late amniocentesis, types of genetic tests performed, their results, and the diagnostic yield, along with pregnancy outcomes and postprocedure complications.

Results: Of the 752 pregnant individuals studied, late amniocentesis was primarily performed for the prenatal diagnosis of structural anomalies (91.6%). The median gestational age at the time of the procedure was 28w5d, and 98.3% of pregnant individuals received results of genetic testing before birth or pregnancy termination. The diagnostic yield was 22.9%, and a diagnosis was made 2.4 times more often for fetuses with anomalies in multiple organ systems (36.4%). Additionally, the diagnostic yield varied depending on the specific organ system involved, with the highest yield for musculoskeletal anomalies (36.7%) when a single organ system or entity was affected. The most prevalent genetic diagnoses were aneuploidies (46.8%). The median gestational age at delivery was 38w3d, with an average of 59 days between the procedure and delivery date.

Conclusion: Late amniocentesis, at or after 24 weeks of gestation, especially for pregnancies complicated by multiple congenital anomalies, has a high diagnostic yield and a low complication rate, underscoring its clinical utility

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AUDIT OF INITIAL INVESTIGATIONS IN WOMEN PRESENTING WITH REDUCED FETAL MOVEMENT TO A TERTIARY MATENRITY HOSPITAL EMERGENCY DEPARMTENT

Topic / Dept:

1. Department of Obstetrics and Gynaecology, Cork University Maternity Hospital, Ireland
2. National Perinatal & Epidemiology Centre, University College Cork, Ireland

Author: A Ahmed[1]

Co Author: E Rutherford[1]

Co Author: D Hayes-Ryan[1,2]

Background:
Reduced fetal movements (RFM) is defined as any form of change in maternal perception of fetal movements, identified as alternation in strength and frequency, reduction or complete cessation of movements [1]. Normal perception of fetal movement is regarded as an indication of fetal wellbeing, while perceived reduction of fetal movement is considered as an important clinical symptom [2]. Multiple studies have identified that reduced or absent fetal movement may be an early sign of placental dysfunction and thus increased likelihood of adverse fetal outcomes [3] [4] .

Objective:
In May 2024, national guidelines for investigation and management of women presenting with RFM were published [5]. The purpose of this audit is to compare investigation and management of women presenting with RFM in our emergency department (ED) against national standards.

Study design and Methods:
Retrospective review of women presenting to the ED in our unit ≥ 28 weeks gestation with RFM from 1st January to 28th February 2024. Eligible cases were identified from the ED attendance register. Maternal electronic health care records were reviewed by a single researcher (AA) and anonymised data transcribed to a password protected excel file.
Data were compared against standards set in the national guideline.

Results:
During the timeframe reviewed, 54 women were eligible for inclusion. All women had an anomaly scan performed between 20-22 weeks. Pre-existing risk factors for fetal compromise were present in 12% (n=7). Bedside ultrasound was performed in ED on all women, with liquor volume measured and documented in 90% (n=49), visualised fetal movements were documented in 94% (n=51), while estimated fetal weight was measured in 0.54% (n=1).

National Standard	% Compliance
Maternal vital signs checked	100%
Symphysis-fundal height measured	70%
Placenta documented anterior in anomaly	55%
Cardiotocography on Arrival	100%
Bed side ultrasound performed	100%
Liquor volume measured	90%

Conclusion:
Care of women with RFM presenting to ED in our unit is broadly in line with national standards, but there is room for improvement. We plan to provide local education to staff and repeat the audit later in the year.

References:

[1] *Heazell AE, Frøen JF. Methods of fetal movement counting and the detection of fetal compromise. J Obstet Gynaecol. 2008 Feb;28(2):147-54. doi: 10.1080/01443610801912618. PMID: 18393008..*

[2] *Mangesi L, Hofmeyr GJ, Smith V, Smyth RM. Fetal movement counting for assessment of fetal wellbeing. Cochrane Database Syst Rev. 2015 Oct 15;2015(10):CD004909. doi: 10.1002/14651858.CD004909.pub3. PMID: 26467769; PMCID: PMC9270931..*

[3] *Bradford BF, Cronin RS, McCowan LME, McKinlay CJD, Mitchell EA, Thompson JMD. Association between maternally perceived quality and pattern of fetal movements and late stillbirth. Sci Rep. 2019 Jul 8;9(1):9815. doi: 10.1038/s41598-019-46323-4. PMID: 312855.*

[4] *Saastad E, Ahlborg T, Frøen JF. Low maternal awareness of fetal movement is associated with small for gestational age infants. J Midwifery Womens Health. 2008 Jul-Aug;53(4):345-52. doi: 10.1016/j.jmwh.2008.03.001. PMID: 18586188..*

[5] *Kalisse T, Farrell AM, Verling AM, Rutherford E, Ravinder M, Khalid A, O'Donoghue K. National Clinical Practice Guideline: Reduced Fetal Movements. National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists. May 2024.*

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Tweetable abstract:

Women presented with RFM to CUMH ED in the period of 1st January to 28th February all had CTG and ultrasound performed as part of their initial assessment, which compares favourable against national standard. We plan to repeat the audit later in this year.

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Preconceptual Input Reduces Risk of Spontaneous Preterm Birth for Select High-Risk Populations

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Co Author: Larissa Luethe

Co Author: Fionnuala McAuliffe

Co Author: Siobhan Corcoran

Background: Preconceptual counselling for spontaneous preterm birth prevention is highly valued by patients but its impact on preterm birth is not well described.

Objective: To examine the impact of preconceptual counselling on rates of spontaneous preterm birth (sPTB) in high-risk populations.

Methods: This was a quasi-experimental study at a tertiary sPTB prevention service. All preconceptual consultations over a five year period (2018-2023) were collated (n=97). Consultation data was analysed. Subsequent pregnancy outcomes for women who attended for preconceptual counselling (n=42) were compared to a sPTB cohort (n=118), matched for age, BMI and risk factor profile (PTB <34 weeks, Midtrimester Loss (MTL) or cervical surgery).

Results:
In the study period, 97 preconceptual consults occurred with 42 subsequent pregnancies. 43.3%(42/97) had history of sPTB/MTL alone, 20.6%(20/97) had sPTB with risk factors (cervical surgery, caesarean section in advanced labour, prior multiple pregnancy) and 36.0%(35/97) had cervical surgery alone. Median (IQR) cervical length was 19(14.6) mm at pre-pregnancy consultation. 35.1%(34/97) patients chose pre-pregnancy abdominal cerclage, 15.5(15/97) chose elective cervical cerclage in pregnancy and 50.5%(49/97) opted for re-assessment in early pregnancy (Figure 1).

All patients who went onto pregnancy attended the preterm birth service for antenatal care (n=42). Compared to control group (n=118), there was no difference in midtrimester loss, or preterm birth before 34 or 37 weeks. However, on sensitivity analysis for patients with history of sPTB before 28 week, mid-trimester loss or recurrent sPTB, preconceptual counselling was associated with a significant reduction in sPTB <28 weeks (0.0%, 0/18 vs 28.0%, 7/25, p=0.032).

Conclusions:

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Preconceptual counselling is an effective intervention to reduce risk of extreme early spontaneous preterm birth for select high-risk populations, including prior spontaneous preterm birth before 28 weeks, spontaneous midtrimester loss or recurrent spontaneous preterm birth.

Tweetable Abstract:

Preconceptual counselling is an effective intervention to reduce risk of extreme early spontaneous preterm birth for select high-risk populations, including prior spontaneous preterm birth before 28 weeks, spontaneous midtrimester loss or recurrent spontaneous preterm birth.

Figure 1. Decision Making Tree for Preconceptual Consultations to Reduce risk of Spontaneous Preterm Birth

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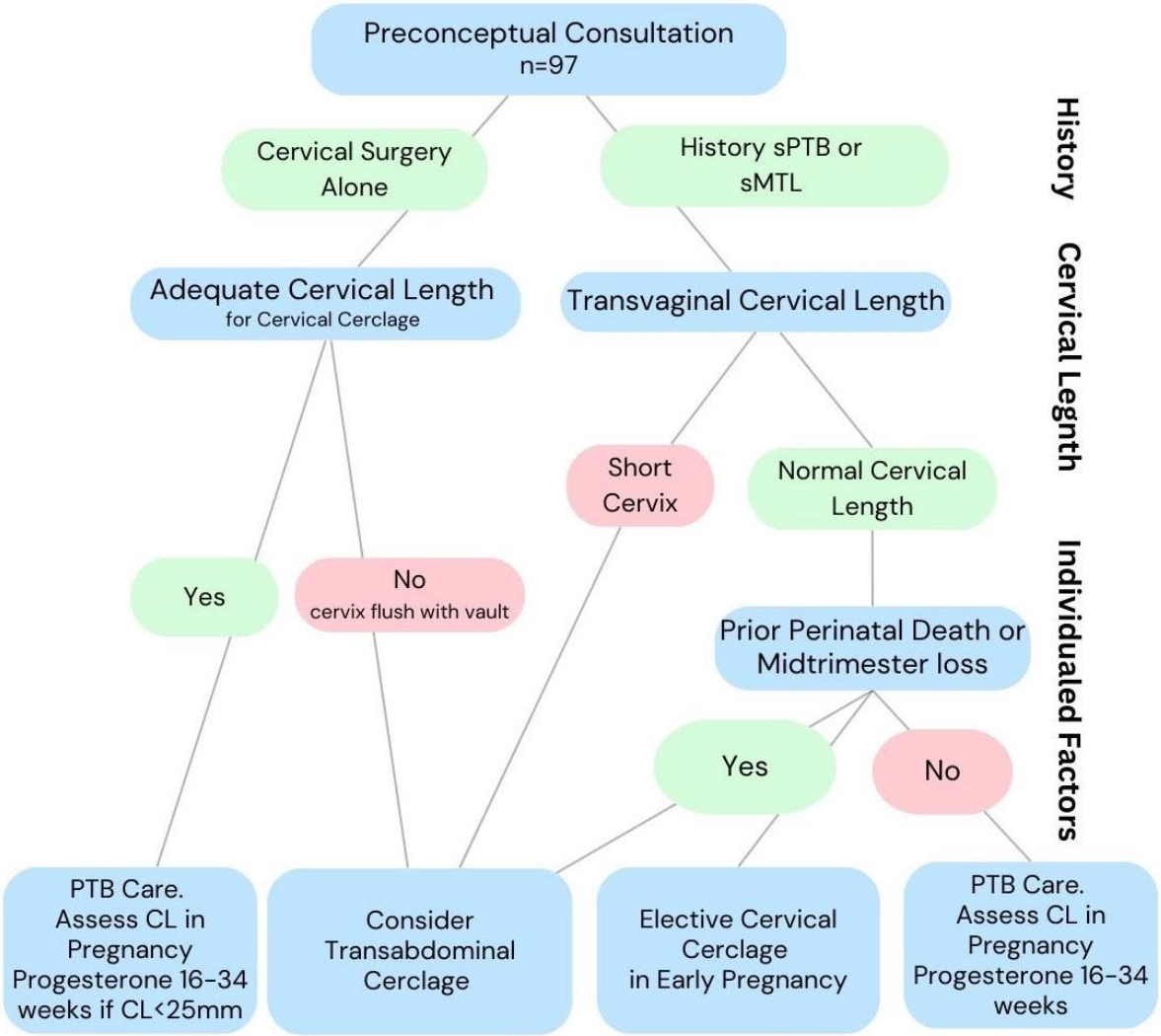

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PREGNANCY AFTER SEVERE EARLY-ONSET FETAL GROWTH RESTRICTION: EVERREST COHORT

Topic / Dept:

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2. Elizabeth Garrett Anderson Institute for Women's Health, University College London
3. University of Leeds, Leeds, UK
4. NIHR University College London Hospitals Biomedical Research Centre

Author: Stokes J.,[1]

Co Author: Maksym K.,[1,2]

Co Author: Spencer R.N.,[3]

Co Author: David A.L.[1,2,4]

Background

Fetal growth restriction (FGR) is a complicated clinical situation that can lead to significant fetal and maternal morbidity and mortality.

Objective

The aim of this study was to ascertain the outcomes of subsequent pregnancy after a previous pregnancy affected by early-onset FGR (EOFGR) where there is a high rate of perinatal loss.

Method

This was a retrospective review of 111 patients recruited to the EVERREST prospective study (2014 - 2020) with EOFGR defined as estimated fetal weight <3rd centile, <600 g between 20+0-26+6 weeks of gestation, and no known chromosomal, genetic, or major structural abnormalities. The following outcome measures were examined: recurrent FGR, perinatal mortality, pre-eclampsia, preterm birth, mode of delivery, and other major obstetric complications, for example placental abruption, postpartum haemorrhage.

Results

Thirty-seven patients had a subsequent pregnancy (33.3% of the initial cohort). There were 27 live births (73%) of which 11 were born via planned caesarean section (40.7%), 29.6% born via unplanned caesarean section (n=8) and 29.6% born via spontaneous vaginal birth (SVB) (n=8)

with one being a breech vaginal birth. The mean gestational age was 37+2 weeks (median 38+1, range 29+0-39+5 weeks). Mean birthweight was 2722g (median 2868g, range 936g - 3670g). Of 37 subsequent pregnancies, there were 3 cases of pre-eclampsia (8.1%). The 2 cases of EOGFR (5.4%) had birth expedited at 29 and 31 weeks' gestation respectively.

Conclusion

In women who conceive after experiencing a pregnancy with EOFGR, the next pregnancy has a relatively favourable outcome with a livebirth rate of 72% and low rates of recurrent EOFGR and associated complications. This is useful data with which to counsel couples after a pregnancy with EOFGR.

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Pregnancy loss representation in high impact journals

Author: Lucy Bolger

Co Author: Sara Leitao

Co Author: Keelin O'Donoghue

Background

Pregnancy loss is common and can have a profound and lasting effect on the individual and their families. Futhermore, stigma around pregnancy loss has been identified as a barrier to improving outcomes and care. Sharing of high-quality research leads to policy change and advancement in care, though, it is likely that pregnancy loss is underrepresented in high impact medical journals.

Objectives

To examine the number, main subject and characteristics of peer-reviewed research on pregnancy loss, published in the top-ranked medical journals and obstetrics & gynaecology (O&G) journals in 2022.

Methods

Key terms on pregnancy loss were applied to search the top 10 peer-reviewed medical journals and O&G journals for papers published on this subject-area. The included journals were selected from the 2022 Clarivate Journal Citation Report. A three-step screening process was carried out by the authors to include peer-reviewed original research where pregnancy loss was the main focus. (see figure 1) Details of selected articles were recorded in a data collection tool.

Results

In the top 10 medical journals, 10 articles met the inclusion criteria from a total of 6899 articles (0.15%) published in 2022; 6 papers related to stillbirth and 4 to termination of pregnancy (TOP). In the top 10 O&G journals, 86 of 5446 articles (1.6%) met the inclusion criteria. Stillbirth (n=25), first trimester miscarriage (n=21) and TOP (n=19) were the most common themes in the top O&G journals, while only 1 article related to TOP for fetal anomaly. In the top 10 medical journals, 60% of included articles originated in the United States or United Kingdom, while this was 45% for the top 10 O&G journals. Only 3 included articles reported on qualitative research.

Conclusion

This study demonstrates a clear publication gap in the area of pregnancy loss and, particularly , in specific types of loss such as TOP for fetal anomaly, molar pregnancy and early neonatal death.

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Despite the dimension and relevance of this issue, pregnancy loss is underrepresented as a topic published in high impact medical journals.

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PREGNANCY OUTCOMES IN WOMEN WHO ARE VEGETARIAN IN AN IRISH MATERNITY HOSPITAL

Background

Vegetarian or plant-based diets are becoming more prevalent in Western society. Vegetarians diets are associated with lowering cardiovascular disease risk, risk of diabetes and cancer development and can contribute towards lowering BMI and blood pressure. Despite the knowledge of the importance of a healthy diet in pregnancy, it has been demonstrated that women do not change their diet during pregnancy and so optimal pre-pregnancy dietary habits are a determinant of outcomes in pregnancy.

Objective

Our objective was to examine maternal demographics and obstetric and fetal outcomes in women following a vegetarian diet vs women following a non-restricted diet in pregnancy in an Irish tertiary maternity hospital.

Method

A retrospective cohort study of 5641 women booked in a tertiary maternity unit for antenatal care from the 1st June 2022 and 31st October 2023. We examined outcomes in 250 self-reported vegetarian's vs 5431 women with an unrestricted diet. Data collection was performed by review of electronic records.

Results

Women following a vegetarian diet were more likely to have a lower BMI, be non- smokers, primiparous and from a south-east Asian background. The mean haemoglobin levels in both groups were equal. The incidence of GDM in both groups was equal. The mean birthweight, gestational age, preterm birth rate, Apgar scores and Caesarean section rate were not different between the groups. There was a significantly higher still birth rate in the vegetarian women (1.2% vs 0.4%, $p < 0.05$) and a significantly reduced rate of blood loss > 500ml with delivery.

Conclusions

In the cohort examined, women following a vegetarian diet in pregnancy did not have an increased risk of pre-term birth, IUGR, low Apgar's or caesarean sections. However, there was a statistically significantly increase in the intrauterine fetal death rate. These results should be interpreted with caution and further investigations with larger numbers should be conducted

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REVIEW OF FETAL ABDOMINAL WALL DEFECTS AND MODE OF DELIVERY IN THE NATIONAL MATERNITY HOSPITAL.

Topic / Dept: Obstetrics – Fetal Medicine

Author: Alex Taylor, Obstetrics & Gynaecology Department, National Maternity Hospital, Dublin, Ireland.

Co Author: Ruta Petuke, Obstetrics & Gynaecology Department, National Maternity Hospital, Dublin, Ireland.

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Tweetable abstract

Mode and timing of delivery for patients with abdominal wall defects is still controversial. In the National Maternity Hospital, 57% delivered vaginally and the remaining 43% delivered by caesarean section, fetal anomaly being the indication for caesarean section in only 18%.

Abstract Body Field (2,100 characters/<)

Background:

Congenital abdominal wall defects are differentiated into two broad groups, gastroschisis and omphalocele. Gastroschisis is not commonly associated with congenital and chromosomal anomalies whereas 50% of omphaloceles are associated with anomalies. The mode and timing of delivery for patients with abdominal wall defects is still controversial. Factors to consider when determining mode of delivery are size of defect, organ exteriorized in the sac, integrity of sac and other associated abnormalities.

Objective:

To review all abdominal wall defects managed in National Maternity Hospital from 2019-2022.

Study Design and Methods:

Data was collected retrospectively. Our sample was selected from all patients reviewed in Fetal Medicine Department in NMH from 2019 to 2022.

Findings/Results:

57 patients with abdominal wall defects were reviewed and the majority diagnosed with omphalocele, 75%. The gestational age at diagnosis ranged from 11+0-25+6. Maternal age

ranged from 17-45 years. 42% had recorded risk factors. 58% of fetuses with omphalocele were diagnosed with additional anomalies. 43% with omphalocele were live births, 56% of these delivered vaginally and the indications for caesarean section included previous caesarean, NRCTG, and fetal anomaly. 86% with gastroschisis were live births, of these patients 58% delivered vaginally and the indications for caesarean section included breech, fetal anomaly, NRCTG and failed induction. All live birth were admitted to the neonatal intensive care unit. The birthweight for the live births ranged from 1150g at 33+4 to 4020g at 41+0.

Conclusion:

57 patients with abdominal wall defects were reviewed. The majority of the abdominal wall defects were omphalocele. 42% had recorded risk factors. 49% of all patients had live births. 57% delivered vaginally and the remaining 43% delivered by caesarean section, fetal anomaly being the indication for caesarean section in only 18%.

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REVIEWING ANTENATAL CARE FOR WOMEN WITH EPILEPSY

Topic / Dept:

1. The Rotunda Hospital, Dublin
2. Regional Hospital Mullingar, Midlands
3. Department of Maternal Medicine, The Rotunda Hospital, Dublin

Author: A. Bou Kalfouni[1]

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Tweetable Abstract: A cohort study among women with epilepsy with improved engagement and high attendance at ANP clinic as well as prescribing and documentation of medication administration.

Keywords: Maternal Medicine, epilepsy, drug administration

Background & Objective: Compare data from the previous audit and ensure that all women who reported a history of epilepsy or seizures during their initial appointment were referred to and seen by the epilepsy in pregnancy service at the Rotunda

Study Design & Methods: We reviewed the cases of 70 patients who had documented epilepsy or seizures in their medical records and attended their booking visit at the Rotunda between January and July 2023. Using the Rotunda's Excel-based audit tool, we retrospectively collected data from the patients' electronic health records.
The audit was conducted against the HSE Guidelines: Practice Guide for the Management of Women with Epilepsy, which includes recommendations following a systems analysis from a recent high-profile coroner's court case. Key areas audited were timely referrals to the epilepsy Advanced Nurse Practitioner (ANP), regular reviews for women with a current epilepsy diagnosis, and the timely and appropriate prescription and documentation of medication, including self-administration.

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Results: This re-audit sample size was 70 compared with 50 in the first audit. The data collected shown that women who disclose a history of epilepsy or seizures at their booking visit who were referred to the ANP in epilepsy dropped from 95% to 78.3%.
In the current study, only 26.1% of patients who reported a history of epilepsy or seizures were found to no longer have epilepsy after a review, compared to 50% in previous studies. This allowed some of these women to follow normal-risk pathways and receive care, such as CMT services.

Out of the 51 patients identified as having an active epilepsy diagnosis, 40 were taking anti-seizure medications, while 3 had discontinued their medication due to pregnancy.

Notably, within this cohort, there was improved engagement and high attendance at the ANP clinic during the first trimester, with similar rates in the second and third trimesters. Attendance during the first trimester was 88.2%, up from 77%. This dropped slightly to 86.3% in the second trimester and 80.4% in the third trimester. However, only 80.4% of women received a third-trimester discussion on safety measures for the peri- and postpartum period, compared to 87% in the first audit.

Among women taking anti-seizure medications, there was a significant improvement in the prescribing and documentation of medication administration compared to the first audit. Of those on medication, 87.5% had their medication prescribed for their delivery admission, and 90% had it prescribed for their postpartum stay, compared to 77.3% in the previous study. Additionally, 65.7% had recorded administration of their medication during delivery, and 88.9% during their postpartum stay, compared to 76.5% in the previous audit.

Conclusion: High levels of attendance and engagement at the ANP clinic were observed. The re-audit also shows improvements in medication prescribing and administration for women with epilepsy during their inpatient stay, delivery, and postpartum period. While most women admitted to the hospital during pregnancy were there for obstetric reasons rather than epilepsy treatment, it remains crucial that all regular medications are promptly prescribed upon admission. Only 12.5% of women did not have their medication prescribed during delivery, and 10% did not have it prescribed during the postpartum stay, a marked improvement from the 23% in the first audit.
Referral rate of women with epilepsy to the epilepsy ANP at their booking visit, dropping from 95% to 78.3%

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The responsibility for medication administration should not fall solely on the patient, and it is vital that each dose is accurately recorded in the patient's medical records. Ongoing education around medication prescribing and administration is essential to maintain and further these improvements.

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SEASONAL VARIATION IN THE INCIDENCE OF PRETERM BIRTHS.

Topic / Dept: [1]Department of Obstetrics and Gynecology, The Coombe Hospital, Dublin, Ireland.

Author: MacBride C[1]

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Background

Preterm birth (PTB) is the leading cause of death in children less than five years old. The causes of spontaneous preterm labor are largely unknown. Several European and Global studies have demonstrated a seasonal pattern to PTB.

Objective

To examine the influence of the season of conception, and the season of birth on the incidence of PTB and neonatal outcomes.

Study Design

This is a single center, retrospective cohort study of singleton births that took place in The Coombe Hospital between January 2013 and December 2022. A comprehensive database was analyzed to determine the incidence of PTB per season of conception and season of birth. Overall neonatal outcomes were reported and stratified per the occurrence of PTB or term birth.

Results

Following exclusions, 76,988 births were analyzed. Women who conceived in winter between December-February had significantly lower rates of PTBs when compared to other seasons (5.4% vs 6.5% (spring) vs 5.6% (summer) and 5.4% (autumn), p<0.001). When considering only spontaneous preterm labor, this trend persists, with most women experiencing spontaneous PTBs conceiving during spring (6.7% vs 5.5% (winter) vs 5.7% (summer) vs 5.5% (autumn), p=0.001). Conversely, women who gave birth in December-February had significantly higher rates of premature births when compared to other seasons (6.2 vs 5.8, 5.5%. and 5.5%, p<0,01). PTBs of spontaneous onset were highest between December and February, however no statistical significance was found (6.2% vs 6.1% (spring), 5.7% (summer) and 5.4% (autumn),

p=0.13). No significant variation in maternal risk factors or neonatal outcomes were identified between the seasons.

Conclusion

This study has shown that there is a seasonal variation in the incidence of PTB in this Irish-based cohort. A low prevalence of PTB was demonstrated when conceptions occurred in the winter months. However, there was a greater incidence of preterm births between December and February. This is suggestive that there are potential risk factors associated with seasonal patterns that may be modifiable.

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ULTRASOUND VS. REALITY: AN AUDIT OF FOETAL WEIGHT ESTIMATION ACCURACY

Topic / Dept: University hospital Kerry, Obstetrics and Gynaecology Department

Author: Ilyas.S

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Background: Foetal growth restriction is a significant cause of perinatal mortality in non-anomalous foetuses. Accurate foetal weight estimation is crucial for prenatal care decisions, but discrepancies between estimated foetal weight (EFW) and actual birthweight (ABW) persist, often falling within 10–15% error range.

Objectives: This audit aims to assess the accuracy of foetal weight estimations by comparing them with recorded birthweights. The goal is to identify factors contributing to inaccuracies and improve prenatal care practices.

Methods: A retrospective study was conducted on women with singleton pregnancies who either underwent induction of labour or scheduled an elective caesarean section for the primary indication of small for gestational age (estimated foetal weight below the 10th centile) in a maternity unit of a University hospital, from January 2023 to June 2024. Data was retrieved by comprehensive review of medical records from the labour ward register and electronic health records (MN-CMS/Cerner) to analyse patient demographics, gestational age at the time of delivery, Mode of delivery and the comparison between estimated foetal weight and actual birth weight at time of delivery.

Results: Among 1641 women, 2% (n=31) were delivered for primary indication of small-for-gestational-
age. The mean gestational age at delivery was 37 weeks and two days. 58% (n=17) of patients were delivered by caesarean section .Notably, 11 out of 31 patients had EFW-ABW discrepancies exceeding 10%, ranging from 11.26% to 25.06%. Conversely, 10 patients had weight differences below 5%, while one-third fell into an intermediate range (5.08% to 9.30%).

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Conclusion: Approximately one-third of patients had incorrect foetal weight estimations, leading to inappropriate management. Recommendations include investigating the root causes of inaccuracies and seeking second opinions for extreme EFW centiles to optimize outcomes for both mothers and infants.

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A RARE CASE OF INTRAPARTUM POSTERIOR CUL-DE-SAC RUPTURE IN A MULTIPAROUS PATIENT WITH LABOUR DYSTOCIA

Topic / Dept: 1.Department of Obstetrics and Gynaecology, Wexford General Hospital

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Background:
Posterior cul-de-sac rupture is a rare obstetric complication with catastrophic potential. The aetiology of this rare entity is often unknown, with few cases reported on in the literature. We report the case of a multiparous patient with a history of one previous vaginal delivery who had an intrapartum posterior cul-de-sac rupture following induction of labour (IOL) for advanced maternal age and polyhydramnios.

Case Report:
A 40-year-old para 1 was induced at term for advanced maternal age and polyhydramnios. She had one previous spontaneous vaginal delivery. Her antenatal course was complicated by bronchiolitis secondary to a rib fracture. She was admitted at term for prostaglandin induction. Following an artificial rupture of membranes, an oxytocin infusion was commenced and an epidural was sited. She progressed slowly with continuous fetal cardiotocography (CTG) and was deemed to be fully dilated at 12 hours on oxytocin. The vertex was presenting occiput posterior (OP) and an attempt to manually rotate was unsuccessful. Following 1 hour of descent, active pushing was commenced. At 60 minutes, delivery was not imminent. The fetal station was at spines with a persistent direct OP presentation. The CTG was reassuring throughout the 2nd stage and clear liquor was draining. Ventouse delivery was attempted with a pop-off at the 2nd traction. A Neville Barnes forceps was then applied. When minimal descent was observed, the instrumental was abandoned and an emergency caesarean section was performed. A live infant

was delivered by breech extraction with normal Apgars. Examination of the pouch of Douglas revealed a transverse 6cm rupture. The uterus had torn off the posterior vaginal wall and due to ongoing postpartum haemorrhage, a caesarean hysterectomy was required with an estimated blood loss of 2.9L. Following admission to ICU she recovered well and was discharged on day 7.

Conclusion:

Examination of the posterior fornix should be considered in all patients undergoing complex delivery. Risk factors associated with posterior cul-de-sac rupture include vaginal malformation, misoprostol use, infection, and a scarred uterus. In our case, the prolonged 2nd stage, complicated by malpresentation, in the presence of excessive uterine distension due to polyhydramnios, likely contributed to the rupture.

A RETROSPECTIVE AUDIT OF RISK FACTORS AND MANAGEMENT OF FULLY DILATED CAESAREAN SECTION IN ROBSON GROUP 1

Topic / Dept: Rotunda Hospital, Dublin 1.

Author: Dr Sarwat Azeem Habib

Co Author: Prof S Cooley

Co Author: Prof S Daly

Background

The incidence of caesarean sections at full dilatation is rising This is attributable to factors including an aging population, increased patient complexity and medicolegal concerns. Full dilatation caesareans are technically challenging and associated with higher maternal and fetal morbidity.

Objective

The aims of this audit were:

1. Determine the percentage of Robson Group 1 caesarean sections (CS) in the overall hospital CS rate.
2. Determine the incidence of full dilatation CS in Robson Group 1.
3. Identify characteristics and risk factors in Group 1 that differ from other spontaneously laboring primips.

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Guidelines

TOG Article July 2014 – Caesarean section at full dilatation: incidence, impact, and current management. [DOI: 10.1111/tog.12112]

Study Design & Methods

Approval was obtained from the audit department. Data was collected retrospectively on all Robson Group 1 full dilatation CS between 1st Jan and 31st Dec, 2023. Maternal and fetal data were extracted from the MNCMS electronic chart, with comparative data collected for other Group 1 patients delivering in the same period.

Results

The incidence of CS in Robson Group 1 is 14.8%. Overall 6.2% delivered at full dilatation during the study. Of these 3% were private patients. Majority of the deliveries (65%) occurred during daylight hours when a consultant was continually present, though this was not documented in one third of cases. The main indications for CS were failure to advance (34%) and failed instrumental delivery (20%). In 78% of cases where instruments were trialled, it was done in the delivery room, with unsuccessful attempts leading to transfer to Theatre. Table 1 compares demographics and labour characteristics with other women in Robson Group 1.

Conclusions

Documentation about personnel present during delivery, and the specifics required in the postnatal debrief were lacking. This prompted discussions around creating a proforma similar to theatre time-out to improve documentation. Trainees need to be aware of the high failure rate of instrumental delivery and plan for appropriate environments in complex cases. Full dilatation caesareans are challenging, and postgraduate training should consider inclusion of a focused module on unique challenges in these cases.

	Full dilatation section	**Other sections Robson Group 1**
Maternal age (Yrs)	31	35
Gestation at delivery(Wks)	40	39
Indication for delivery		
• **Failure to advance**	34%	33%
• **Malposition**	16%	6%

• **Inability to treat**	20%	14%
• **Non reassuring CTG**	18%	7%
• **Maternal concerns**	5%	2%
• **Fetal concerns**	7%	38%
Category 1 section	52%	21%
Category 2 section	48%	79%
Fetal Weight (Grams)	3567	3270
Length of First stage (Hrs)	14	8
Maternal Blood Loss(ml)	643	682
Length of Hospital Stay (days)	5	4

Table 1. Comparison of the characteristics and outcome data of women delivered in our cohort at full dilatation against other women delivered by section in Robson Group 1.

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AN AUDIT OF LABOUR INDUCTION USING PROSTAGLANDINS: INDICATIONS AND OUTCOMES, A MIDWIFE-LED INITIATIVE AT WEXFORD GENERAL HOSPITAL

Topic / Dept: Wexford General Hospital, Maternity Department, Wexford, Ireland

Author: Ahmed M

Co Author: Mongan O

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Co Author: Babu S

Background

Induction of labour (IOL) is often necessary when the risks of continuing a pregnancy outweigh the benefits of delivery. At Wexford General Hospital (WGH), midwives play a crucial role in administering labour induction methods, particularly using prostaglandins like Propess® and Prostin. The integration of midwifery-led care, alongside obstetric services, ensures that the induction process is both safe and patient-centered. The audit was conducted to evaluate the use of these agents, focusing on outcomes, adherence to national and local guidelines, and the overall effectiveness of midwife-led care in improving patient experiences and results.

Objective

The audit aimed to evaluate the effectiveness of labour induction using prostaglandins at WGH, specifically Propess®. It also sought to determine adherence to the National Clinical Guidelines (2023) and assess the impact of midwife-led care on patient outcomes.

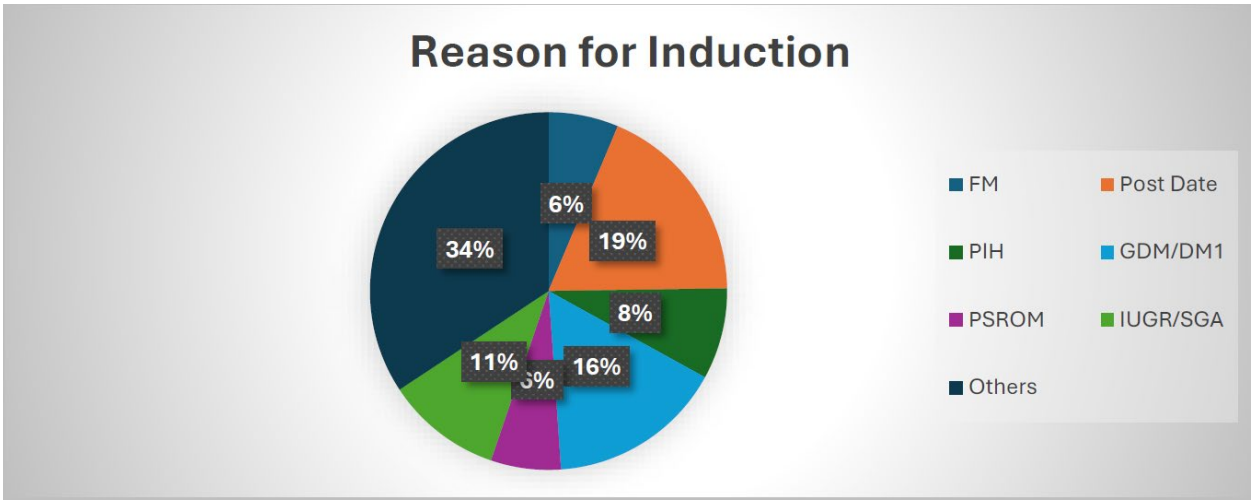
Study Design and Methods

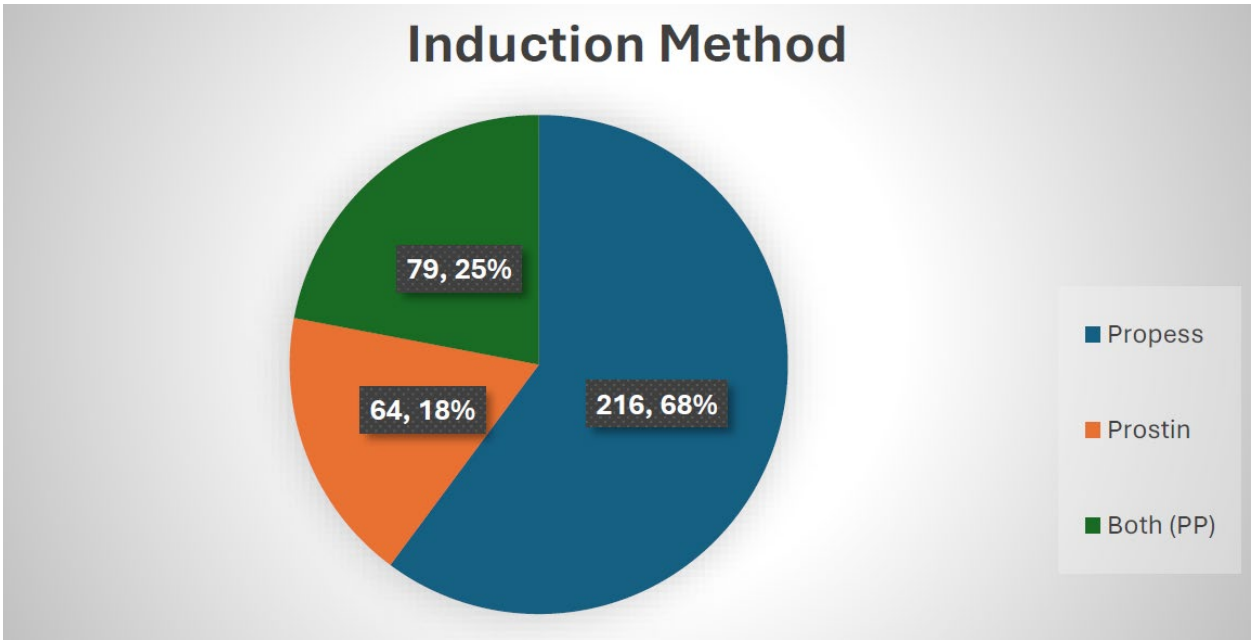
A retrospective review was carried out on the medical records of 315 women who underwent IOL at WGH between August 2023 and May 2024. Key indicators included the reasons for induction, method of induction, Bishop score documentation, and birth outcomes. Comparison of clinical practices to national guidelines was performed. Ethical approval was obtained, and patient privacy was strictly maintained throughout the study.

Findings/Results

The most common indications for induction were maternal factors (34%), postdates pregnancy (19%), and gestational diabetes (16%). The majority of inductions (81%) occurred between 37 and 40 weeks of gestation. Vaginal delivery was achieved in 76% of cases, while 24% required

emergency caesarean sections. Propess® was effective in 68% of cases, and midwives documented Bishop scores in 98% of cases.





Conclusions

Propess® has been proven to be a highly effective agent for inducing labour. The high compliance with guidelines and the success of midwife-led care in ensuring continuity and quality of care

have demonstrated the strengths of this approach. Further audits should focus on improving post-induction documentation and ensuring adherence to the National Guidelines for IOL at 41 weeks. Additionally, continued training and the empowerment of midwives are essential to further enhance patient outcomes and clinical decision-making in complex cases.

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AN AUDIT OF OBSTETRICS ANAL SPHINCTER INJURIES (INCIDENCE, ADHERENCE TO GUIDELINES AND DOCUMENTATION) AT GALWAY UNIVERSITY HOSPITAL, IRELAND.

Topic / Dept:

1. University Hospital Galway, Galway, Ireland
2. University of Galway, Galway, Ireland

Author: Marina Maryem Khan 1

Co Author: Naema Gherbal 1

Co Author: Binish Manzoor 1

Co Author: Gillian Ryan 1,2

Background: Obstetric Anal Sphincter Injuries (OASIS) are a group of severe perineal tears involving damage to the anal sphincter ranging from a superficial tear of the external anal sphincter (third degree) to a complete rupture of both the external and internal anal sphincters and an opening of the rectal mucosa (fourth degree). OASIs is associated with significant maternal morbidity including perineal pain, sexual dysfunction and urinary and faecal incontinence which may persist for many years after childbirth.

Objective: This audit was performed to record the overall incidence of OASIS between 2018 and 2022 at tertiary care maternity centre, to record the demographic characteristics and labour specific factors of the women who sustained OASIS and to audit the management and its outcomes.

Methods: Retrospective study of all the women who sustained OASIS in tertiary care centre over the period of five years (2018-2022). We audited our practice against the RCOG Green Top Guideline no 29 which provides guidance on the immediate and postoperative management of women who sustain OASI. Data of 211 women was included that was collected through Electronic Health Records as well as through charts. All information was plotted on excel sheets and results were prepared.

Results: The 5 years incidence of OASI is 2.4%. The most common ethnicity was white: Irish, followed by any other white background. The average BMI was 25.85. Among 211 females, 81 females labour onset was induced, and 130 females labour was spontaneous. The mean weight of baby in gram was 3608.44± 474.449. The mean blood loss in ml was 450.88± 266.193. The

mean age of gestation at birth was 39.67±1.27. 78.14% filled oasis Performa while 21.86% did not fill oasis Performa. In 99.05% cases antibiotics and Laxatives were given and 96.68% cases were followed up postnatally.

Conclusion: The audit findings on OASI at Galway University Hospital can be compared to the RCOG Green-top Guideline No. 29. Both emphasize accurate OASI documentation, and the audit results show the use of practices like antibiotics and physiotherapy which align with the guideline's recommendations for post-partum care. Addressing the gaps in Performa from completion would ensure accurate reporting and monitoring. By implementing these suggestions, the hospital can work towards improved OASI management and potentially lower the incidence rates. We planned re-audit in 6 months' time.

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ANTIBIOTIC PROPHYLAXIS COMPLIANCE POST OPERATIVE VAGINAL DELIVERY: A RETROSPECTIVE CLINICAL AUDIT

Topic / Dept: Department of Obstetrics and Gynaecology, Rotunda Hospital, Dublin

Author: Barbara Guerrini

Co Author: Etaoin Kent

Co Author: Sam Coulter-Smith

Background

Operative vaginal delivery (OVD) accounts for 10-15% of all deliveries and increases the risk of maternal peripartum infections, which contribute to 10% of global maternal deaths. The ANODE trial (2019) demonstrated that antibiotic prophylaxis significantly reduces morbidity and mortality related to maternal infections. Current guidelines recommend a single dose of intravenous (IV) antibiotics after OVD to prevent these complications.

Objective

This retrospective audit aimed to assess compliance with local and national guidelines on antibiotic prophylaxis following OVD. It also compared 2023 data with a previous audit from 2021 to evaluate changes in compliance over time.

Study Design & Methods

A total of 50 women who underwent OVD between January and October 2023 in a tertiary maternity hospital were included in the study. Data on antibiotic timing and type, as well as postnatal infections within 6 weeks, were collected. Compliance was measured against guidelines recommending 1.2g of Co-Amoxicillin within 6h post-delivery. Descriptive statistics were obtained and results were compared with the 2021 audit to assess any improvements in practice.

Results

Of the 50 women, 45 (90%) received antibiotic prophylaxis. Among them, 30 (60%) were administered antibiotics within 1h, while 14 (28%) received them within 1-6h. Only one patient (7%) received antibiotics after 6h. Compliance improved from 84% in 2021 to 90% in 2023, with timely administration significantly increasing from 30% to 60% ($p<0.05$). 5 patients did not receive antibiotics, but only one returned with suspected infection. Postnatal infections occurred in 6 patients (12%), including 4 cases of endometritis and 2 perineal wound infections.

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Conclusion

This audit demonstrates good compliance (90%) with antibiotic prophylaxis following OVD, with significant improvements in timely administration since 2021. Recommendations include enhancing local documentation protocols to further improve compliance.

Tweetable Abstract

A 2023 audit found 90% compliance with antibiotic prophylaxis after OVD, up from 84% in 2021. Timely administration significantly improved, with 60% receiving antibiotics within 1 hour.

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Clinical Audit : Assessment of Duration of Fasting for elective Cesarean Section at Letterkenny University Hospital, July-August 2023.

Topic / Dept: Letterkenny University Hospital

Author: Dr Mohammedelfateh Adam

Co Author: Mariam Abufatima

Co Author: Dr Elmi Theron

Co Author: Dr Nicole Gallghar

Supervisor: Dr Elamin Dafalla

Introduction:

Fasting is vital before surgery to reduce the risk of complications during anesthesia. However, prolonged fasting can cause discomfort and may not always be necessary. . Women are required to fast from food for 6 hours prior to surgery and are allowed to drink clear fluids (i.e. water, tea/coffee with no milk) until they are called to theatre [1]. All pregnant women should be given information and support to enable them to make informed decisions about childbirth [2].

Aim:

To evaluate adherence to the WAC Group Guideline on preoperative fasting and hydration for elective cesarean sections at Letterkenny University Hospital.

Objectives: This audit assessed:
(a) documented fasting durations.
(b) completeness of patient instructions.

Methodology:

A retrospective audit was conducted using data from the clinical notes of pregnant women who underwent elective cesarean section at LUH between July and August 2023. Patients were included if they underwent an elective cesarean section within the specified timeframe. Data relevant to the guideline recommendations were extracted from clinical notes and entered into an Excel spreadsheet. Descriptive statistical analysis was performed using Excel and Jamovi app 2.3.28 solid version [3].

Results:

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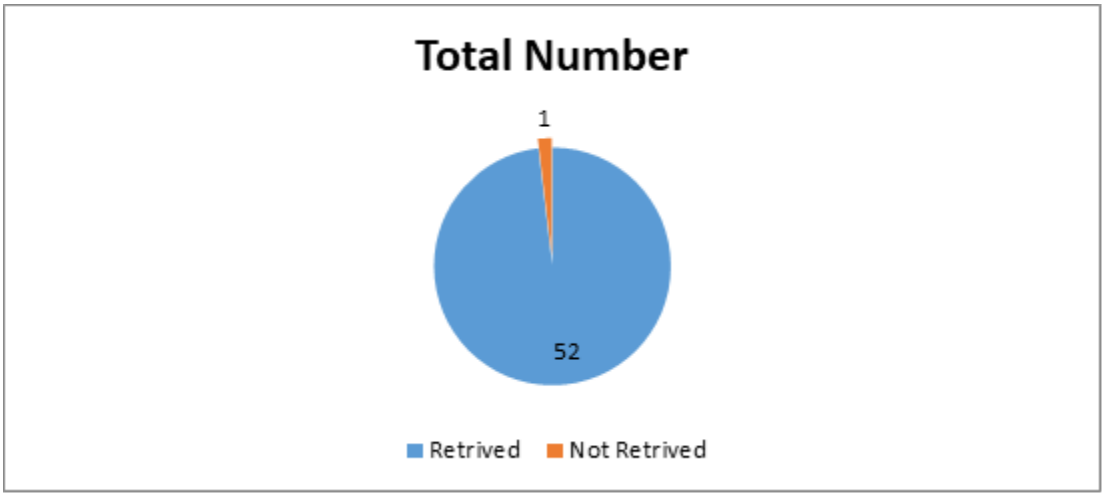

Figure 1: A Pie chart shows the total number of women who had undergone elective cesarean section.

Of 53 elective cesarean sections performed at LUH between July and August 2023, medical records were available for 52, as depicted in Figure 1 above. Analysis of these records, summarized in Table 1 below, revealed that documentation of fasting from solids was present in 86.5% (45/52) of cases, while 13.5% (7/52) lacked this documentation. Documentation of fasting from fluids was more consistently present, with 94.2% (49/52) of cases having it documented and only 5.8% (3/52) without it. Most concerning, no patients (0/52) received a patient information leaflet preoperatively. This finding highlights a significant area for improvement in preoperative patient education and informed consent practices.

	Overall (N=52)
Documentation of Fasting from Solid	
No	7 (13.5%)
Yes	45 (86.5%)
Documentation of Fasting from Fluids	
No	3 (5.8%)
Yes	49 (94.2%)
Provision of PIL	
No	52 (100.0%)
Yes	0 (0.0%)

Table1: Illustrates the documentation of fasting from solid and fluids and provision of patient information leaflets.

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The average fasting duration exceeded recommendations, with patients fasting for a mean of 12.55 hours (SD: 1.86) for solids and 11.75 hours (SD: 2.86) for clear fluids, Table2.

Descriptives		
	Duration of Fasting from Solids	**Duration of Fasting from Fluids**
N	45	49
Missing	7	3
Mean	12.6	11.8
Median	12.5	12.0
Standard deviation	1.86	2.86
Range	8.00	13.5
Minimum	9.00	2.00
Maximum	17.0	15.5

Table 2: A table illustrates the duration of fasting for solids and fluids.

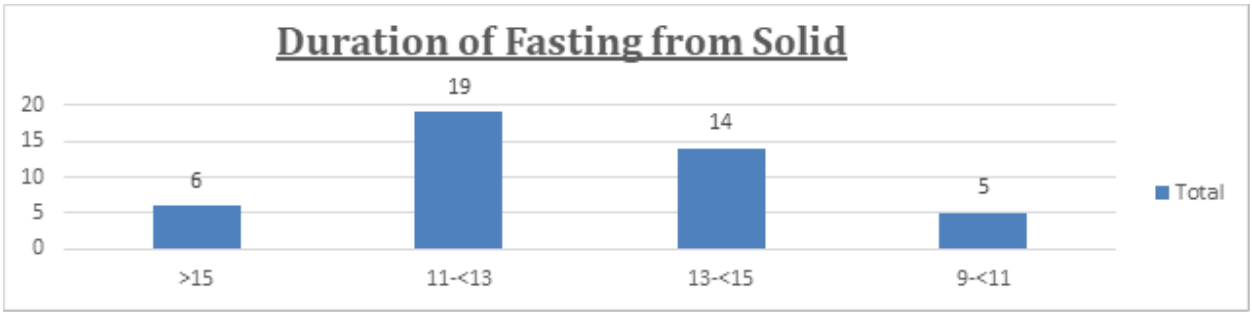

Figure 2: bar chart shows the duration of fasting from Solid food.

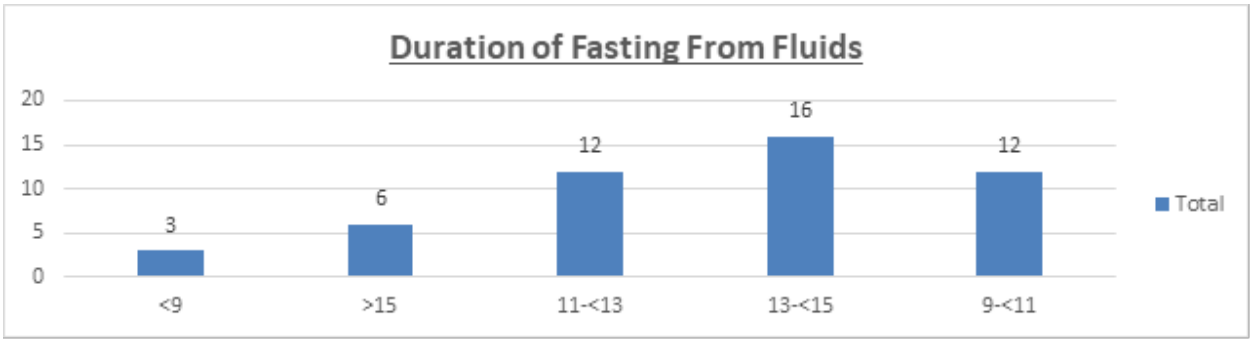

Figure 3: A bar chart shows the duration of fasting from clear fluids.

Conclusion:

This audit revealed a discrepancy between documented practice and current guidelines regarding fasting durations for elective cesarean sections. While documentation rates were

commendable, actual fasting times frequently exceeded recommendations, indicating a need to reinforce adherence to evidence-based guidelines among providers. Furthermore, the lack of documented patient education regarding fasting represents a significant opportunity to improve patient communication and informed consent practices**.**

Recommendations:

1. Reinforce Adherence to WAC Guidelines.
2. Provide education for healthcare providers.
3. Improve patient communication about fasting instructions and provide patient information leaflets in clinic.

Re-audit: in 6 months

Refrences:

1. WAC Group Guideline on Preparation for Caesarean Section (Elective and Emergency)
2. National Institute for Clinical Excellence (2021; updated 2023) *Caesarean Section. Clinical Guideline 192.* NICE: London
3. The jamovi project (2022). jamovi. (Version 2.3) [Computer Software]. Retrieved from https://www.jamovi.org.

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Audit of Advanced Maternal Age Inductions at the Rotunda Hospital

Topic / Dept: [1] Department of Obstetrics and Gynaecology, Rotunda Hospital, Dublin, Ireland

Author: Parijot Kumar [1]

Co Author: Maeve Eogan [1]

Tweetable abstract

This audit of care of 305 pregnant women aged 45 years and over identified good compliance with recommendations to offer aspirin, GTT and induction by term. Multiple pregnancy was common and 3/4 delivered by caesarean section.

Abstract

Background: IOL is a common obstetric intervention, recommended when risk of continuing the pregnancy outweighs the risk of delivering. In the instance of advanced maternal age, it is believed that there are complications, most devastating of these being an IUFD. To avoid such an adverse complication, the recommendation would be to achieve delivery, by 40 weeks of gestation

Objective: This audit aims to assess pregnant women aged 45 years and older, booked in the Rotunda Hospital and ensure they were offered delivery by 40 weeks of gestation, in line with national practices. We will be comparing our practices with the National Clinical Practice Guideline – Induction of Labour

Study Design and Methods: This was a retrospective audit. Our inclusion criteria were women who were over 45 years of age at their booking visit, between January 2018 to December 2023. A total of 305 patients were included in this audit. We assessed – administration of aspirin, GTT performed, and if delivery offered by 40 weeks? A compliance of 100% was set for each criterion.

Results: 305 women were booked, 35 women had multiple pregnancies – 1 Quadruplet, 4 triplets, and 30 twins. 62% were prescribed aspirin. 93% had GTT performed. 99% were offered a delivery between 39 to 40 weeks, in the event there was no spontaneous labour, or other indication necessitating earlier delivery. 74% underwent a caesarean delivery (54% elective and 24% emergency), 19% had SVD and 3% were OVD. The average gestation at the time of delivery

was 37 weeks. Perinatal outcomes included – GDM (29%), IUGR (10%), Hypertensive disorders (14%), PPROM (6%), PTL (4%) and IUFD (0.7%).

Conclusions: With increasing maternal age and the well-established associated perinatal outcomes, it is important to counsel these women with regards to achieving delivery no later than their due date. This can be achieved by inducing labour, if spontaneous labour does not ensue. However, anecdotally, it was noted that woman of this cohort, tend to choose an elective caesarean section as their mode of delivery at 39 weeks.

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AUDIT OF MODE OF DELIVERY IN MORBIDLY OBESE WOMEN AT CORK UNIVERSITY MATERNITY HOSPITAL.

Topic / Dept:

1. Department of Obstetrics & Gynaecology, Cork University Maternity Hospital, Cork, Ireland.

Author: G Paz 1

Co Author: S Hirji 1

Co Author: H Zafar 1

Co Author: M Abdelmaboud 1

Co Author: J McKernan 1

Background:
Obesity is one of the most common medical conditions in women of reproductive age. According to the Royal College of Obstetricians and Gynaecologists, 21.3% of the antenatal population are classified as obese and fewer than half of pregnant women (47.3%) have a BMI within normal range (1). Ireland has the second highest prevalence of obesity in the European Union with 25% of women living with obesity (2).

Objective:
To analyse the mode of delivery in an obstetric population with a BMI >40kg/m2 in the year 2023, from January to December, at Cork University Maternity Hospital. To assess if the occurrence of emergency and elective Caesarean Section and Induction of Labour in this cohort of patients is in line with National and International incidence rates.

Methodology:
Retrospective audit conducted in July 2024, exploring the mode of delivery in women with a BMI >40kg/m2, who delivered in Cork University Maternity Hospital during the year 2023. 553 eligible cases were identified from electronic healthcare records. Data was transcribed from electronic healthcare records to a coded excel file and descriptive statistics were conducted.

Results:
43.39% of patients proceeded to have a Caesarean Section; 80% of which underwent an elective, pre-labour Caesarean Section. Of those requiring a Caesarean Section, 22.91% of patients

required an emergency Caesarean Section. 9.76% of patients had a spontaneous vaginal delivery. 46.8% of patients underwent an Induction of Labour; of those, 55.98% of patients proceeded to have a vaginal delivery; 32.81% of patients had a Caesarean Section and 11.19% of patients had an Operative Vaginal Delivery.

Conclusion:

This audit shows that the incidence of elective caesarean section and emergency caesarean section in patients with a BMI >40kg/m2 is in line with national standards. This audit also shows that the rate of vaginal delivery post Induction of Labour in women with a BMI >40kg/m2 is in line with results from both national and international studies.

References:

(1)-Lee, S., O'brien, Y. and Astbury, K. (n.d.). Patient and Doctor Attitudes Towards Obesity in Pregnancy. *Ir Med J*, [online] 114(6), p.375. Available at: https://www.imj.ie/wp-content/uploads/2021/06/Patient-and-Doctor-Attitudes-Towards-Obesity-in-Pregnancy.pdf [Accessed 10 Sep. 2024].

(2)-Eurostat (2021). *Overweight and Obesity - BMI Statistics - Statistics Explained*. [online] ec.europa.eu. Available at: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Overweight_and_obesity_-_BMI_statistics.

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AUDIT ON BALLOON IOL IN THE ROTUNDA HOSPITAL

Topic / Dept: Rotunda Hospital, Dublin

Author: Luricke Potgieter

Co Author: Niamh Fee

Background

The updated HSE National Clinical Practice Guideline for Induction of Labour (IOL) and the Guideline for Vaginal Birth after Caesarean Section (VBAC) were published in 2023. Both guidelines recommend IOL with a balloon catheter as an option in women with one previous Caesarean section. Balloon IOL can also be used if this is the patient's choice, where prostaglandins have failed or in women with a parity >4.

Objective

The aim of this audit was to determine the number of women offered balloon IOL and the outcome. This information will guide us as to whether this service can be improved to increase the rates of women having a successful VBAC.

Methods

A retrospective electronic health record analysis was done on patients offered balloon IOL during the period of 01/01/2021 and 31/12/2023 at the Rotunda hospital.

Results

Over the three years audited, 23 patients were offered IOL with a balloon catheter. 52% of the patients had a previous vaginal delivery and of those 26% had a previous successful VBAC. The indication for the use of balloon was for VBAC in 84% of cases, for parity of 4 or greater in 9% and one patient was induced for severe IUGR.

48% of patients had a vaginal delivery and 52% of patients had an emergency caesarean section. The indication for caesarean section was for a non-reassuring CTG in 42% of patients; failure to advance in the first stage of labour in 50% and for maternal request in 8%.

Three complications were identified. One PPH and two pyrexia in labour occurred. There were no cases of uterine hyperstimulation. 17% of the babies born after balloon IOL were admitted to NICU. One baby had a significant congenital abnormality; one had IUGR and one was observed due to pyrexia in labour.

Conclusion

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Only a small number of patients were offered balloon IOL. It is possible that this is due to staff inexperience with this method. We recommend that training and awareness of balloon IOL should be promoted as an option and it may decrease caesarean section rates.

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Audit review of prophylactic antibiotic administered immediately following Operative Vaginal Delivery

Topic / Dept: Labour ward, Cork University Maternity Hospital, CUMH

Author: A. Ganda1

INTRODUCTION:
Operative Vaginal Delivery OVD, has been a means to assist vaginal deliveries in the labour ward for various indications. In this audit, no distinction is made as to what form of instrument is used nor does it record operator's level of training. Types of instruments used are: 1. Kiwi omni cup, 2. Ventouse silicone suction cup and 3. Forceps [Neville Barnes and Wrigley's Forceps]
OVD over the period 24/05/2024 to 24/09/2024 were included in this audit
Antibiotics administered were in accordance with the local unit's antimicrobial guide and incorporating patient's allergy status.
These antibiotics were administered with verbal consent obtained and no reported immediate side-effects. The commonest antibiotics used was Co-Amoxyclav.

AIM:
The aim of this audit was to establish whether prophylactic antibiotic was administered during the intervening time on labour ward following an OVD. Antibiotics at the end of OVD could successfully serve as initial prophylaxis and not treatment. Administration of antibiotics post OVD served as meeting agreed protocol and recorded in this audit.

METHODS:
A retrospective review of women who had OVD in the labour with subsequent administration of recommended single dose antibiotic as prophylaxis.
Using LW ledger, patient who underwent OVD during this period were extracted and matched against their electronic medication administration to indicate receipt of single dose antibiotic as indicated above.

RESULTS:
[309] women's details were reviewed as recorded in the ledger.
[11/309] women (3.55 %) had received antibiotic prophylaxis to meet local protocol

The results are detailed in Table 1.

DISCUSSION:

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Various bodies now recommend the use of single dose prophylactic dose of intravenous antibiotic, were allergy allows, amoxicillin and clavulanic acid following assisted vaginal birth to significantly reduce confirmed or suspected maternal infection compared to placebo. 1

In the ANODE trial, it was noted that women who received a single dose of prophylactic intravenous amoxicillin and clavulanic acid at a median of 3 hours post assisted vaginal birth were significantly less likely to have a confirmed or suspected maternal infection compared to women who had placebo. 2

With this in mind, the ANODE trial, supported by august international bodies now incorporate the provision of benefits than harm when antibiotics are administered following OVD.

During the course of this audit , the timing of administration was not recorded. This could form another base for inclusion in a re-audit cycle.

This audit could serve as subject of a longer prospective study in our unit serving to incorporate stricter awareness in administering antibiotics prophylaxis after OVD.

CONCLUSION:

It is right to conclude from the results that significant high proportion of the women include in this audit period received antibiotics prophylaxis as directed the local policy.

Reference:

1. RCOG Green top Guideline No 26
2. Prophylactic antibiotics in the prevention of infection after operative vaginal delivery (ANODE): a multicentre randomised controlled trial

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BEYOND THE NUMBERS: IMPACT OF OBESITY ON OASI OUTCOMES IN WOMEN

Topic / Dept:

[1]Department of Urogynaecology, Cork University Maternity Hospital, Cork, Ireland
[2] Department of Obstetrics and Gynecology, Shaare Zedek Medical Center, affiliated with the Hebrew University School of Medicine, Jerusalem, Israel
[3] Department of Obstetrics and Gynecology, Cork University Maternity Hospital, Cork, Ireland

Author: R Rotem[12]

Co Author: D Galvin[1]

Co Author: K McCormack[1]

Co Author: OE O'Sullivan[1]

Co Author: D Hayes-Ryan[13]

Background:
Obstetric Anal Sphincter Injury (OASI) is a severe complication of vaginal deliveries, and obesity may influence surgical outcomes. Understanding the impact of obesity on OASI repair is essential for optimizing patient care.

Objective:
To compare the risk profiles, anatomical, and functional outcomes between obese and non-obese women who experienced OASI.

Study Design and Methods:
This retrospective electronic database study was conducted at Cork University Maternity Hospital (CUMH). Women with missing data or repairs conducted outside CUMH were excluded. Participants were categorized into obese (BMI ≥30 kg/m²) and non-obese (BMI <30 kg/m²) groups. The primary outcome was a composite adverse outcome 6 months post-delivery, including one or more of the following: resting pressure <40 mmHg, squeezing pressure <100 mmHg, and defects in the internal and/or external anal sphincter. Statistical analyses were performed using SPSS Version 28.

Results:
Of the 349 women included, 285 (81.7%) were non-obese, and 64 (18.3%) were obese. Gestational diabetes was significantly more common in obese women. No significant differences were noted in newborn weight or mode of delivery. Grade 3B tears predominated in both groups.

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Clinic attendance and manometry results were comparable. Internal anal sphincter defects were lower in the obese group (7.0% vs. 15.6%, p=0.15), while external anal sphincter defects were significantly lower in obese women (0% vs. 9.1%, p=0.04). No difference was observed in composite adverse outcomes between groups.

Conclusions:
Functional outcomes and manometry results were similar in both groups. However, non-obese women had higher rates of anatomical defects, suggesting the need for further research on the impact of BMI in OASI outcomes.

Tweetable Abstract:
This study found no significant differences in functional outcomes of OASI repair between obese and non-obese women, though non-obese women had higher rates of anatomical defects. Further research is needed to understand the role of BMI in OASI outcomes

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Cases of Hypoxic Ischaemic Encephalopathy at an Irish Tertiary Referral Centre

Topic / Dept: [1]Royal College of Surgeons in Ireland, Dublin 2, Ireland; [2]Coombe Women and Infants University Hospital, Dublin 8, Ireland

Author: G. Timmons[1,2]

Co Author: D. Arthur[2]

Co Author: A. Deasy[2]

Co Author: J. Geraghty[2]

Co Author: MP. O'Connell[2]

Co Author: MP. Hehir[1,2]

Introduction: Hypoxic ischaemic encephalopathy (HIE) is characterised by disturbed neurologic function in the earliest days post-birth in neonates born at or beyond 35 weeks of gestation. HIE is manifested by altered consciousness or seizures, and is often accompanied by depressed respiration, tone, and reflexes. While rare, HIEs can cause lifelong neurologic injury and be traumatic for both families and healthcare workers.

Objective: To characterize the ante-natal period and management of neonates diagnosed with HIE, and to identify common themes that could be used to optimize patient care.

Study design: This study involved retrospective descriptive analysis of case chronologies involving non-anomalous neonates diagnosed with HIE who were delivered at ≥35 weeks of gestation between January 2020 – December 2023 at the Coombe Maternity Hospital, a tertiary referral centre in Ireland. HIE was defined based on cord gas pH <7.0 or base excess ≥12 in addition to relevant clinical, radiological, and laboratory findings.

Results:
Of 29110 total deliveries recorded over the study period, 28 neonates diagnosed with HIE and their corresponding mothers were included for analysis.
The average age of mothers who gave birth was 32, average BMI was 26.25 and 12/28 were nulliparous. 3/28 pregnancies were complicated by gestational diabetes, 2 by hypertension, and 1 by placenta praevia/accreta.

13/28 neonates were delivered by spontaneous vaginal delivery, 12/28 by caesarean section, and 3/28 by instrumental delivery; shoulder dystocia occurred in 3/28 of deliveries and 1 delivery involved twins.
Mean APGAR scores at 1, 5, and 10 minutes were 1.82, 4.93, and 5.90 respectively.
Mean arterial cord pH/base excess was 6.99/-14.8 and mean venous cord pH/base excess was 7.09/-12.7.
Therapeutic hypothermia was performed in 26/29 cases.

Discussion: HIE occurs in a small number of births. Similar number of HIE were seen in vaginal deliveries and caesarean sections. Mean Apgar scores were low and high rates of therapeutic hypothermia were observed.

Evolving Trends in Obstetric Anal Sphincter Injuries: A Decade of Change in Ireland

Topic / Dept: Obstetric Anal Sphincter Injuries (OASI)

Author: Daniel Galvin

Co Author: Reut Rotem

Co Author: Anna Murray

Co Author: Orfhlatih O Sullivan

Co Author: Deirdre Hayes-Ryan

Background
Obstetric Anal Sphincter Injuries (OASI) represent a significant complication in
obstetric care. Two key shifts have occurred in the field of obstetrics: the increasing prevalence of Caesarean sections (CS) and the introduction of perineal clinics. This study aims to explore how this has impacted the mode of delivery in
subsequent pregnancies following an OASI, as well as the rates of recurrent OASI.

Methods
Women with an index delivery complicated by OASI who subsequently delivered at CUMH were included. The study analysed two time frames: 2007-2012 and 2018-2023, During both periods, a perineal clinic was operational. Data were extracted from both physical charts and electronic records. Statistical analyses were performed using SPSS.

Results

360 subsequent deliveries were identified over both time periods. During 2007-2012, 45 women (24.5%) attended the perineal clinic, compared to 82 women (46.6%) in 2018-2023. 17 women (9.7%) in the latter group reported faecal symptoms following their index delivery. During 2018-2023, 42 women (42.7%) were advised to consider a CS for their next pregnancy, yet 112 women (63.6%) opted for CS. Private obstetric care utilization increased from 13.0% in 2008-2017 to 22.7% in 2018-2023 (p=0.01). The rate of CS in subsequent deliveries increased from 42.4% in the 2008-2017 cohort to 60.8% in the 2018-2023 cohort (p=0.04). The rate of vaginal deliveries declined from 57.6% in the 2007-2012 cohort to 39.2% in the 2018-2023 cohort, corresponding to the rise in CS deliveries. The recurrence of OASI decreased from 5.1% in the 2007-2012 cohort to 2.9% in the 2018-2023 cohort (p=0.50).

Conclusions

The increase in CS rates in the later cohort, particularly beyond what was advised on medical grounds, suggests a more cautious approach to delivery following an OASI. This may reflect heightened concerns about potential complications, leading to more elective CS decisions.

Table 1: Comparison of Obstetric Anal Sphincter Injuries (OASI) at Index Delivery Between 2007-2012 and 2018-2023

		2007-2012, n=184	2018-2023, n=176	p-value
Maternal age, mean±SD		30.60±4.57	30.20±4.56	0.40
Nulliparity n (%)		38 (20.7%)	23 (13.1%)	0.05
Fetal birth weight, grams, Mean±SD		3740.80±455.01	3698.39±478.63	0.58
Degree of OASI, n (%)	3A	49 (26.6%)	50 (28.4%)	<0.01
	3B	19 (10.3%)	45 (25.6%)	
	3C	5 (2.7%)	14 (8.0%)	
	3rd unspecified	111 (60.3%)	44 (25.0%)	
	4	0 (0.0%)	23 (13.1%)	
Perineal clinic attendance, n (%)		45 (24.5%)	82 (46.6%)	
Fecal symptoms, n (%) *		NA	11 (13.4%)	NA
St. Marks score, median (IQR) *		NA	0 (0-2)	NA
Rest pressure, Median (IQR) *		NA	36 (28-49)	NA

Squeeze pressure, Median (IQR) *	NA	59 (47-79)	NA
EUS defect to internal anal sphincter, n (%) *	NA	11 (13.4%)	NA
EUS defect to external anal sphincter, n (%) *	NA	46 (59.1%)	NA
Patient referred to colorectal specialist, n (%) *	NA	0 (0.0%)	NA
Advice given to CS in next pregnancy, n (%) *	NA	42 (42.7%)	NA

OASI: Obstetric Anal Sphincter Injuries, NA: Not Available, IQR: Interquartile Range, EUS: Endoanal Ultrasound, CS: Cesarean Section
*n=82

Table 2: Outcomes and Mode of Delivery in Subsequent Pregnancies Following OASI: A Comparative Analysis Between 2008-2017 and 2018-2023

		2007-2012, n=184	2018-2023, n=176	p-value
Presence of fecal symptoms prior to delivery, n (%) *		NA	17 (9.7%)	NA
Planned mode of delivery at antenatal clinic, n (%) *	Vaginal delivery	NA	64 (36.4%)	NA
	CS	NA	112 (63.6%)	
Private obstetric care, n (%)		24 (13.0%)	40 (22.7%)	0.01
Maternal BMI, Mean±SD			26.65±4.71	NA
Fetal birth weight, grams, Mean±SD		3655.14±451.3	3583.88±425.1	0.12
Actual mode of delivery, n (%)	Vaginal delivery	98 (57.6%)	69 (39.2%)	0.04
	CS	78 (42.4%)	107 (60.8%)	
Repeated OASI		5/98 (5.1%)	2/69 (2.9%)	0.50

OASI: Obstetric Anal Sphincter Injuries, NA: Not Available, BMI: Body Mass Index, CS: Cesarean Section

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FIRST BABY OF THE YEAR IN IRELAND: AN ANALYSIS OF THE PAST 25 YEARS USING THE IRISH TIMES DIGITAL ARCHIVE

Topic / Dept:

1. Medical Student, RCSI, Dublin.
2. Consultant Anaethesiologist, The Rotunda Hospital. UCD, Dublin.
3. Consultant Obstetrician, The Rotunda Hospital. RCSI, Dublin.

Author: JA Loughrey (1)

Co Author: JPR Loughrey (2)

Co Author: M Eogan (3)

Background

The media in Ireland consistently report on the first birth of the year. We performed an analysis of the past 25 years via an Irish Times digital subscription.

Objective

To see if hospitals with the highest birth numbers were reflected proportionately in news reporting of first births

Study Design & Methods

An analysis of the Irish Times Digital archive for the first days of January each year was performed from 2000 to 2024 inclusive. Where the Irish Times report was incomplete, other media news outlets were consulted. Birth data for the 19 maternity units was assessed via the Irish Maternity Indicator System re-ports and Hospital Clinical Reports.

Findings

The Irish Times consistently reported the first and second babies born in 23 of the past 25 years. The birth weight and sex was also consistently reported. Since 2014, baby weights were largely reported in kilos. Although national birth registration does not record birth time with seconds, this was reported by the newspaper in babies born in the first minute after midnight in 16 of the years.

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No reporting was found for one year (2001). For two years, other media were consulted for clarification. The first birth was attributed to The National Maternity Hospital in 8 years, Limerick Maternity in 6 years, followed by The Rotunda Hospital in 5 of the past 25 years.
These 3 Hospitals were therefore listed as the location of the first birth in 19 of 24 years. Births at Lim-erick comprise 6.5% of National Births (2014 HSE data) but 25% of 'first baby of the year'. Births at The National Maternity Hospital comprise 13.5% of National Births but 33% of 'first baby of the year. Cork Maternity and The Coombe Hospitals, being 2 of the larger units nationally are underrepresented in 'first baby' reports but were reported as the location of second baby born in 7 and 6 years respectively.

Conclusion

79% of Irish media reports of 'first baby' of the year in the past 25 years occurred in 3 of 19 maternity units, which together account for only 33% of the births nationally.

Tweetable abstract

@JaneLoughrey @meogan @LoughreyJPR
An analysis of location of the first birth of each year over the past 25 years, using the @IrishTimes Digital archive was performed. This revealed that@_TheNMH, Limerick and @RotundaHospital, who together account for 33% of births nationally, secured almost 80% of first reported births.

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FOLEY CATHETER INDUCTION: OUTCOMES OF MECHANICAL INDUCTION METHODS AS AN ALTERNATIVE TO PROSTAGLANDINS

Results Table: Labour and delivery outcomes for women undergoing foley catheter induction
Table 1.

Mode of Delivery	**Total**	**No. of Primips**	**No. of Multips**	**Uterine scar**	**Adverse Maternal outcome (PPH/Infection/ Postnatal readmission)**	**NICU admission**
Caesarean Section	6	3	3	1	1	2
Operative Vaginal Delivery	1	-	1	1	-	-
Spontaneous Vaginal Delivery	3	3	-	-	-	-

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Immune Thrombocytopenia

Topic / Dept: Obstertic and Gynecology Department, Wexford General Hospital, Wexford, Co. Wexford, Ireland

Author: M. George

Co Author: S. Mohan

Co Author: E. Dunn

Abstract	*Please complete sections using headings provided:*
Presentation (Describe the condition of the patient on initial examination)	A 21 year old Gravida4 Para1 attended routine antenatal visits from 18 weeks of gestation. A low platelet count was found on routine antenatal blood tests with no initial signs or symptoms. She had one minor complaint of bleeding gums at 24weeks gestation only
Diagnosis (Briefly describe the tests conducted and state the confirmed diagnosis)	Platelet levels at her initial visit were 99 x10^9/L. Regular platelet levels were checked which showed persistently low levels ranging between 11 and 100 x10^9/L. Tests (FBC, U&E, LFT, CRP, Peripheral blood film, and MSU) were performed which revealed no other causes, thus Immune Thrombocytopenia was diagnosed.
Treatment (Outline the treatment given to the patient)	This case was discussed with haematology who advised it was safe to aim for vaginal delivery. Prednisone was offered at 25weeks gestation when platelets were 38 x10^9/L, but patient refused at that time. Platelet levels were monitored every 1-2weeks during pregnancy. IVI immunoglobulin and Prednisone was given at term which patient then accepted. Platelets improved post-delivery.
Discussion/Conclusion (State briefly your discussion/conclusive statement outlining your core outcome of your research or report)	ITP can be asymptomatic and diagnosis is then typically made by excluding known thrombocytopenia causes. It is important to monitor platelet levels regularly and to have platelets on standby at time of delivery.

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INDUCTION OF LABOUR FOR POSTDATES – MATERNAL AND PERINATAL OUTCOMES FOR EARLY VERSUS LATE POSTDATES INDUCTION

Topic / Dept: [1] Dept of Obstetrics and Gynaecology, National Maternity Hospital, Dublin 2.

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Background

The risk of adverse maternal and perinatal outcomes increases with duration of pregnancy beyond 40 weeks gestation. For this reason, many centres offer induction of labour (IOL) to avoid prolonged pregnancy. However, optimal gestation for IOL is yet to be determined. In Ireland, HSE policy recommends offering IOL at 41 weeks, but practices vary globally. IOL impacts birth experience and adds to healthcare costs. Thus, it is essential that timing of IOL is evidence based and reduces maternal and perinatal complications.

Objective

To assess maternal and perinatal outcomes in early versus late postdates IOL.

Study Design and Methods

Retrospective data collection on patients admitted for postdates IOL (≥ 40 weeks) at a tertiary centre from January to July 2024. 132 primiparous and 67 multiparous women were included. 2 women undergoing trial of labour after caesarean were excluded.

Comparisons were grouped according to gestation at time of IOL i.e. < 41 weeks (40+0 to 40+6) versus ≥ 41 weeks (41+0 to 42+0). Subgroups included parity (0, ≥1 vaginal deliveries), age (<30, 30-35, >35 years) and BMI (<30, >30).

Maternal outcomes were mode of birth, blood loss and perineal trauma. Perinatal outcomes were Apgar score, meconium stained liquor and NICU admission.

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Results

Induction of primiparous women at the later gestation of ≥ 41 weeks was associated with a higher rate of vaginal delivery (VD). Of 132 primips; 27 were induced < 41 weeks with 14 (52%) delivering vaginally. 105 were induced ≥ 41 weeks with 64 (61%) delivering vaginally. IOL at 41+2, 41+3 and 41+4 correlated with high rates of VD; 83%, 72%, 63%; significantly higher than the rate of caesarean section (CS); 17%, 28%, 37%.

Inducing at this later gestation was associated with higher rates of perineal trauma, but lower blood loss. It was also associated with higher rates of meconium stained liquor; but with minimal difference between the groups for neonatal morbidity (Apgar <7) and NICU admission.

Overall, BMI <30 was associated with lower CS rates. Primips with BMI <30 had a lower CS rate when induced ≥ 41 weeks, those with BMI >30 had a lower CS rate when induced < 41 weeks. Primips < 35 years had a lower CS rate when induced ≥ 41 weeks, those > 35 years had a lower CS rate when induced < 41 weeks.

Conclusions

Our data suggests optimal gestation for postdates IOL is ≥ 41 weeks. However, this is a complex issue with multiple factors influencing delivery outcome; therefore further research is needed. We hope to increase the power of our study by extending the period under review.

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Obstetrics emergency 'Umbilical cord prolapse': A Shared experience 'community and hospital case presentations ' with heightened and multiple risk factors.

Topic / Dept: Department of Obstetrics and gynaecology Our Lady of Lourdes Hospital Drogheda Co Louth

Author: Taiwo A.A.O

Co Author: Ahmed S

Co Author: Harkin R

Abstract: Umbilical cord prolapse though rare, but it is a well-known and serious obstetrics emergency with high morbidity and mortality if prompt response are not anticipated and instituted upon presentation. The incidence is reported to be less than 1% often 0.0-0.6% of presentations with a perinatal mortality rate estimated to be at 91/1000. Risk factors of fetal and maternal origin could increase the outcome and presentation in most instances.

We share the clinical experience and management of two cases of a preterm and term umbilical cord prolapse in the hospital and community respectively, highlighting the peculiarities, anticipation, risk factors, management, outcomes and standard of care in facilitating good, satisfactory outcomes in the presence of emergency while offering an optimal standard of care in both cases.

An antecedence and interplay of occult cord prolapse and presentation could occur before ultimately presenting as a cord prolapse an acute obstetrics emergency.

Heightened Risk factors noted among the two patients were – preterm and low birth weight , non-cephalic presentations(footling breech) , prom at 27 weeks , previous breech for and caesarean section while our second patient was typified and characterized of being polyhydramnios , high presenting part and none engaging presenting part , transverse and unstable lie , grand multi-parity , advanced maternal age ante-natally . While our preterm 29+ UCP was an in-patient with a normal BMI, our community based patient was AMA, Morbidly Obese and a grand multiparous term pregnancy. On the other-hand, peculiarities intra-operative findings could confirmed long umbilical cords.

In offering a prompt acute obstetrics emergency delivery, both were deemed to warrant a Category 1 Caesarean section as per standard. With exposure of the cord to cold and touch, repeated arterial vasospasm and decrease blood flow to the fetus during resuscitative measures

as experienced in both our community and hospital presentation patients, were pointers to a non-reassuring CTG and potential for fetal hypoxia being heightened. Imminent delivery was neither feasible in both patients despite labour-like pains and both ultimately went on to have a category 1 caesarean sections with good fetal outcomes in relation to apgar scores and cord gases.

The principles of '**CORD**' – covering the cord, organizing a prompt category 1 Caesarean section, relieving pressure of the cord and delivery were pivotal to the good outcome in both cases. It was impossible adopting a knee chest position and bladder filling during this acute emergency despite being mindful of manouvre, however both our patient were offered and able to experience an head-down tilt , left lateral positioning , pushing back & holding unto the cord and rapping of the cord from hospital staffs and paramedics with minimum frictions and less rubbing intentions..

Given the infrequent nature and yet the multidisciplinary care of these obstetrics emergency and good fetal outcome , an evidence of stimulation training was critical in management in addition to interventions , documentation as well as maternal and neonatal outcomes. Rapid identification, familiarities with risk factors and interventions remains the backbone of good and satisfactory obstetrics outcomes limiting potential morbidity..

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OMNIOUS INCIDENTAL FINDING OF PLACENTA PERCRETA DURING AN EMERGENCY CAESAREAN SECTION SURGERY – A CASE REPORT

Topic / Dept: Our Lady of Lourdes Hospital, Drogheda, Ireland

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Co Author: Anabela Serranito[1]

Objective: Placenta percreta is a rare and life-threatening condition where the placenta invades the uterus and nearby organs, such as the bladder. It occurs in about 0.2% of pregnancies and is often associated with previous cesarean sections (CS), placenta previa, and multiple pregnancies. The increased rate of CS has led to a rise in the prevalence of this condition. Diagnosis is typically made through ultrasound and MRI, and management involves early CS delivery followed by a hysterectomy to prevent severe bleeding.

Case report: A 40-year-old female with placenta previa underwent an emergency CS due to complications from 3 previous CS and essential hypertension. During the operation, it was discovered that the placenta had penetrated the cervix and bladder, resulting in a massive postpartum haemorrhage.
Single live baby delivered by vertex through cystotomy at the apex of the bladder and ruptured CS scar incision. Massive post-partum haemorrgahge (PPH) of 2750 ml dealt as per protocol.
The patient underwent a hysterectomy, bilateral salpingectomy, cystotomy repair, and adhesiolysis of bowel, omentum and rectus muscle.

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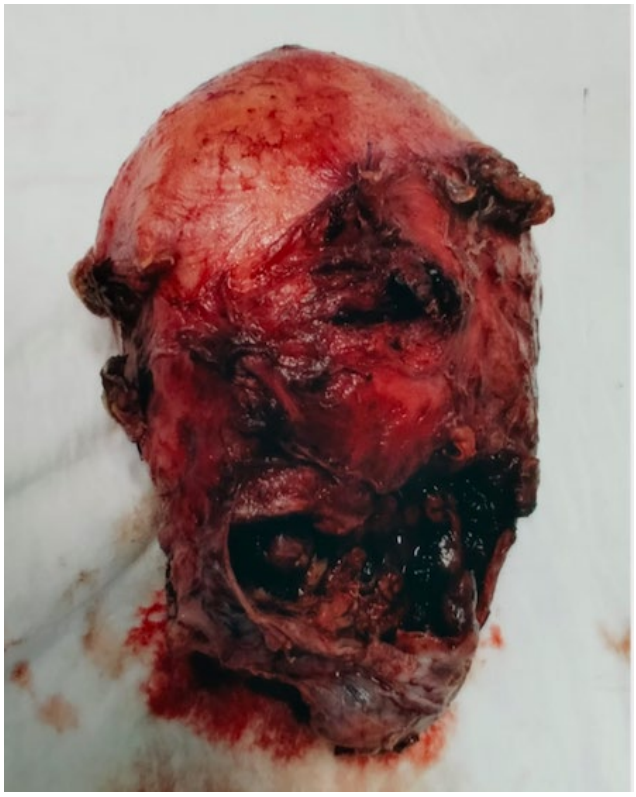

Discussion: Maternal morbidity was prevented by swift, cautious surgical management with the involvement of multiple specialists. A newer technique followed in Argentina involved suspected placenta accreta subjected to intraoperative invasion topography (identification of particular blood supply) classification. Haemostasis achieved by selective ligature of the specific blood vessels, fetal delivery by hysterotomy of upper uterine segment and enbloc removal of involved myometrium and placenta.

Conclusion: Early diagnosis of placenta accreta syndromes is crucial for planning elective caesarean section, preventing excessive bleeding, and minimizing the need for hysterectomy. Despite these measures, heavy bleeding may still occur. In the future, a resective-reconstructive approach could help preserve the uterus and reduce blood loss in around 80% of cases.

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The HOME INDUCTION Randomized Controlled Trial – Logistics for achieving delivery

Background

The ARRIVE Trial has resulted in an increased demand for 39 week induction of labor in normal-risk nulliparous patients, but this creates logistical challenges for busy Labor Wards. A potential solution is commencing induction by means of outpatient cervical ripening at home, using vaginal prostaglandin (Propess) or osmotic cervical dilator (Dilapan-S).

Objective

This secondary analysis evaluates the logistics of achieving vaginal delivery following outpatient induction. This includes changes in Bishop score before and after cervical ripening, the need for additional ripening agents, and time interval from induction to delivery.

Study Design

We randomized healthy normal-risk nulliparous women who agreed to elective induction of labor at 39 weeks' gestation, to one of three forms of initial cervical ripening at home: 12 hours of Dilapan-S, 24 hours of Dilapan-S, or 24 hours of slow-release dinoprostone (Propess). Effectiveness of each agent, time to delivery, and length of hospital stay were assessed.

Results

A total of 180/271 (66%) of all nulliparous women were delivered within 48 hours of induction commencing, and 254/271 (94%) delivered within 72 hours. Participants in the Propess group were more likely to require early readmission than in the Dilapan-S groups (45% vs 9%). Patients randomized to Dilapan-S groups were more likely to require additional Prostin prior to amniotomy being possible (65% vs 34%). Those who did not require additional ripening had very high vaginal delivery rates (80% to 88%). Induction agent removal time to delivery was similar across all groups. The length of hospital stay ranged from a median of 76 to 88 hours.

Conclusion

Outpatient cervical ripening is an efficient option for dealing with the logistical challenges facing busy Labor Wards, with the majority of nulliparous patients delivering within 48 hours. These results provide useful information for women considering induction of labor in terms the process, as well as assisting hospital planning, including optimizing staffing levels and ensuring bed availability.

Table 1: Time-related outcomes for 39 week elective IOL

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Outcomes		D24 (N=96)	D12 (N=88)	P24 (N=87)
Time-related endpoints				
Delivery* within 48 hours of starting IOL		53 (55%)	72 (82%)	55 (63%)
Delivery* within 72 hours of starting IOL		85 (89%)	86 (98%)	83 (95%)
Removal of induction agent to delivery time (hours)#		22 [18,32]	20 [15,29]	20 [10,29]
Length of hospital stay: Return-visit** to discharge (hours)	All	79 [59,104]	88 [67,111]	76 [56,98]
	SVD	59 [56,81]	69 [46,93]	64 [48,80]
	OVD	79 [71,105]	71 [67,86]	74 [54,85]
	CD	102 [83,127]	107 [91,118]	101 [81,119]
Vaginal delivery% timing (commencement of induction to delivery)				
Vaginal delivery timing	Within 36 hours	10 (10%)	33 (38%)	27 (31%)
	Within 48 hours	42 (44%)	47 (53%)	48 (55%)
	Within 72 hours	65 (68%)	55 (63%)	65 (75%)

Summary statistics are presented as n (%), mean (SD) or median [IQR].

D12 = Dilapan-S 12 hours; D24 = Dilapan-S 24 hours; IOL = Induction of labour; OVD = Operative vaginal delivery; P24 = Propess 24hours; SVD = Spontaneous vaginal delivery

Removal time was missing for 1 patient in the D12 group and 1 patient in the P24 group.

* Delivery by any means

**Denotes time in hours from when the patient was re-admitted to hospital after their return with Propess or Dilapan-S in situ, until time of discharge after delivery

% SVD/OVD

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PERINATAL MORTALITY IN WOMEN IN MINORITY ETHNIC GROUPS IN THE REPUBLIC OF IRELAND FROM 2011-2021

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Co Author: Sara Leitao (National Perinatal Epidemiology Centre, University College Cork)

Co Author: Professor Keelin O'Donoghue (Cork University Maternity Hospital, University College Cork, INFANT Centre)

Introduction: Women in minority ethnic groups (MEG) have been consistently overrepresented in annual Perinatal Mortality (PM) Audit reports by the National Perinatal Epidemiology Centre (NPEC). International peer-reviewed literature reports similar findings.

Objective: To examine factors associated with PM in women in MEG and differences between these and their white counterparts.

Study Design and Methods: This was a secondary analysis of PM national clinical audit data reported by NPEC from 2011-2021 in Ireland. Maternal sociodemographic and obstetric characteristics, maternal medical history, infant characteristics, and PM outcomes of women in MEG were analysed and, using c^2 tests, compared to white women.

Results: There were 4314 PM cases in Ireland from 2011-2021, with 2896 stillbirths (SB) and 1418 early neonatal deaths (ENND). Women in MEG with PM were younger ($p<0.001$), and 46.15% were employed, versus 75.18% of white women ($p<0.001$). More women in MEG had previous pregnancies (76.78% vs. 67.73%, $p<0.001$), and more than double had ≥3 previous completed pregnancies versus white women (25.77% vs. 11.96%, $p<0.001$). Women in MEG also had more previous pregnancy medical issues (48.50% vs. 38.04%, $p=0.001$). Nearly double the proportion of women in MEG had their first prenatal appointment after 20 weeks' gestation or never received prenatal care ($p<0.001$). When data were stratified by PM type, these significant differences persisted in both SB and ENND groups. As for causes of PM, women in MEG experienced more placental conditions and obstetric factors, but fewer congenital anomalies as compared to white women ($p=0.047$). These differences only persisted in the SB group when data were stratified by PM type.

Conclusions: The overrepresentation of women in MEG in PM data may be explained by factors including employment status, parity, and prenatal care access. These findings provide a baseline

from which to generate targeted future interventions. Additional research is needed to implement changes to specifically address these systemic inequities.

Tweetable abstract: Women in minority ethnic groups have been consistently overrepresented in annual National Perinatal Epidemiology Centre Perinatal Mortality Audit reports. This may be explained by factors highlighted in this study, including employment status, parity, and prenatal care access.

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POGRESSIVE QUALITY IMPROVEMENT PROGRAM ON INDUCTION OF LABOR

Author: Uroosa Asif

Co Author: Bernadette Toolan

Co Author: Lucia Hartigan

AIM :

- **To reduce the rate of inappropriate indications of induction of labour in the tertiary maternity unit of Ireland by improving the planned induction process.**
- **To access the adherence to national and local guidelines of IOL (Updated in 2023) for shared care pathways to improve the quality of care and reduce the number of deferred inductions.**

BACKGROUND :

A frequent obstetric procedure called induction of labour (IOL) is recommended when the possible hazards of extending a pregnancy exceed the advantages. In recent decades, there has been an increase in the induction of labor. Variability between guidelines and practice has been noted in the literature regarding when induction is necessary and when it is not. The circumstances are frequently ill-defined and shaped by the personal convictions of the caretakers. It is becoming more and more obvious that collaborative decision-making between women and physicians is crucial in light of these conflicts, but it is still unclear how often this happens in normal treatment.

METHODOLOGY :

We used quality improvement and qualitative methods to develop, test, and review the indications of induction of labour along with the number of deferred inductions in March 2024 in Limerick Maternity University Hospital.

We have gathered all the data in an Excel sheet focusing on indications of induction labour along with other parameters including gravida, parity, mode of delivery, and baby birth weight.

RESULT :

A total of 94 inductions were planned from wards and antenatal clinics in March 2024 out of which 18 were deferred (1 covid positive,3 SROM and rest experienced delays in starting IOLs due to unit activity and protracted inpatient stay).

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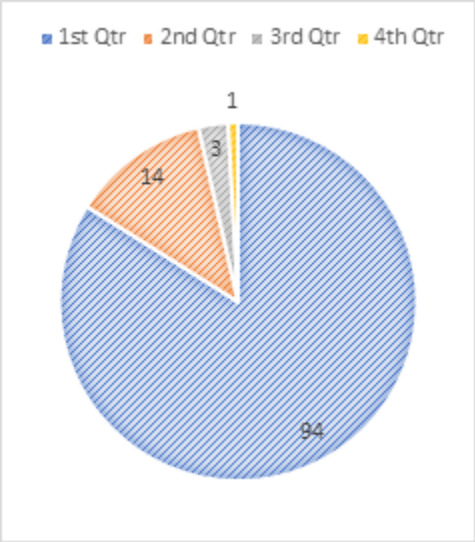

Out of 94 Inductions,20 were ended on LSCS (5 cat 2 -LSCS and 15 cat 3 -LSCS) and 22 resulted in instrumental deliveries (21 Kiwi deliveries and 1 forceps delivery)

Indications of induction of labour included postdate pregnancies (22), GDM diet (15), GDM Insulin (4), reduced fetal movement (8), PIH (2), SROM (4), Large for dates (9) with birth weight varies from 2.8 kgs to 4.0 kg), Small for gestational age (6), Prelabour rupture of membrane (5), IUGR (2), Oligohydramnios (3), VBAC (3), Twin pregnancy (1), maternal age (1), traumatic history of previous birth (2), septic screening (1), tokophobia (1) and in 5 inductions no reasons mentioned.

INDICATIONS OF INDUCTIONS	% OF INDUCTIONS IN 1 MONTH
Postdate pregnancies	23.4%
GDM diet	15.9%
GDM insulin	4.2%
Reduced fetal movement	8.5%
SROM	4.2 %
PIH	2.1 %
Large for dates	9.5%
VBAC	3.1 %
Small for gestational age	6.3 %
IUGR	2.1 %
PROM	5.3 %
Oligohydramnios	3.1 %
Maternal age	1.06 %

Twin pregnancy	1.06 %
Not mentioned	5.3 %
Previous traumatic history of birth	2.1 %
Others (septic screen and tokophobia)	1.06 %

INTERPRETATION

13 Out of 94 inductions were inappropriately planned according to the gestational age and showed a lack of adherence to Local guidelines. These inductions may result in dissatisfaction among staff and service users. The majority were planned with the indication of postdate pregnancy at 40 weeks (7/13), rest include GDM diet at 37+4 weeks (2/13), previous history of 3rd-degree tear(1/13), and Large for date (3/13) at around 37 +weeks with birth weight around 2.6 to 3.5 kgs.

RECOMMENDATIONS :

Clear criteria for Induction :

- According to RCPI Induction of labour guideline and local hospital guideline, women with uncomplicated pregnancies should be offered induction of labour (IOL) at 41+0 weeks after discussion with the mother.
- It is recommended that a review of women aiming for a VBAC should be undertaken before 41+0 weeks to assess the cervix and reconsider the options
- offer IOL at 39+0-40+0 weeks' gestation for women aged 40 and above.
- Recommendations regarding timing of IOL in the setting of gestational diabetes mellitus is beyond the scope, a mother with suspected macrosomia after three or four biometric indices and without gestational diabetes and other risk factors required consultant input and can induce at 39 +0 weeks.

IOL

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GDM on diet With no complications

GDM on insulin with with no complications

39+0 weeks

38+0 weeks

- IOL increase the risk of third- or fourth-degree perineal tears compared with expectant management so it is not recommended to plan induction solely with the indication of previous history of 3rd /4th degree of perineal tear.

Communication and Education :

The changes can be made by communicating it to all the staff members including midwives and doctors, through informal discussion during huddles on the criteria of planned inductions and through meetings and presentations.

All the IOL planned before 38+0 weeks must be agreed by a consultant obstetrician.

Improvement in healthcare system :

It is advisable to plan induction appropriately to prevent deferred inductions and patient dissatisfaction. Women presenting in the maternity unit for planned inductions after organizing their household chores and childminder for their children at home. Sometimes, it is hard to explain the reason for deferred inductions to these women as it may affect their mental health.

Therefore it is strongly recommended to inform the women that when the unit is busy there may be delays in commencing the IOL process.

CONCLUSION

The Quality Improvement Program (QIP) for Induction of Labour (IOL) at the Limerick Maternity Unit has successfully highlighted the key issues associated with inappropriate inductions and deferred cases. This review underscores the need for adherence to both national and local guidelines to optimize clinical decisions and improve patient satisfaction.

The audit results revealed that 13% of the planned IOLs were inappropriate, largely due to a lack of adherence to guidelines, particularly in cases of postdate pregnancies, gestational diabetes, and large for gestational age infants. The findings highlight that inconsistent practices in scheduling IOLs not only increase unnecessary interventions but also contribute to patient dissatisfaction and delays in care.

To address these issues, the program proposed clear criteria for IOL based on updated RCPI and local guidelines. Emphasis was placed on the role of consultant oversight for planned inductions before 38+0 weeks, and specific guidance was provided for cases such as VBAC, gestational diabetes, and macrosomia.

The communication plan, which includes staff education, informal huddles, and presentations, will foster better adherence to guidelines. By enhancing the decision-making process and ensuring all inductions are planned appropriately, this program aims to prevent deferred cases and improve overall patient experience.

In conclusion, implementing these recommendations and ensuring clear communication among healthcare providers and patients will lead to more efficient, evidence-based management of inductions, reducing inappropriate inductions and deferred cases, while improving the quality of maternity care.

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RATES AND OUTCOMES OF SEQUENTIAL INSTRUMENTAL AND FAILED INSTRUMENTAL DELIVERIES IN CUMH

Topic / Dept:

1. Cork University Maternity hospital (CUMH)
2. National Perinatal Epidemiology Centre, Cork

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Background

Rates of operative vaginal deliveries (OVD) are rising nationally, and we have seen a continuation of this trend in CUMH. While OVD's are a safe and necessary intervention, there is an associated increase in maternal and neonatal morbidity and mortality with both sequential instrument use and second stage Caesarean Section (CS) resulting from a unsuccessful instrumental delivery. As OVD rates increase, we expect to see the rates of both sequential and unsuccessful OVD increase, and consequently increasing rates of the associated complications

Objectives

We wish to examine the rates of both sequential and unsuccessful instrumental deliveries in CUMH, and identify any observable change in trends over a six-year period from 2018 to 2023. We also wish to investigate the rates of complications associated with these deliveries.

Methods

Women were identified from electronic medical chart records and a retrospective chart review was conducted. National data on rates of Postpartum Haemorrhage (PPH) and Obstetric anal sphincter injury (OASI) were obtained from HIPE. The Chi-Square test of independence was used to calculate statistical significance.

Results

We identified 302 women in the sequential instrumental group, and 156 women in the unsuccessful instrument group. Rates of PPH were higher in women who had a sequential instrumental compared with all other instrumental deliveries (45% vs 14%, p< 0.00001) and in women who had a unsuccessful instrumental followed by CS compared with all other emergency CS's (73% vs 11%, p<0.00001). Rates of OASI were also higher with sequential instrument use compared with all other instrumentals (8.2% vs 3.4% p<0.00001). One baby over the 6-year period underwent therapeutic hypothermia (TH).

Conclusion

Complications such as PPH and OASI are common in these often difficult deliveries, however the outcomes for babies are overall good. Continued training in these types of delivery is important to improve outcomes, and reduce the rates of complications in the future.

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Abstract: Retrospective Audit of the Management of Pregnancies at 41 Weeks Gestation and Beyond (September 2023 - June 2024)

Author: Dr Mathew George

Co Author: Dr Hani Bashir

Co Author: Dr Sara Mohan

Co Author: Prof. Elizabeth Dunn (supervising consultant)

Background

The updated National Irish Guidelines for Induction of Labor (IOL) in 2023 recommend that IOL be offered to women with uncomplicated pregnancies at 41+0 weeks gestation, to minimize risks to both the mother and baby.

At Wexford General Hospital (WGH), the current protocol for IOL in uncomplicated pregnancies is to initiate induction between 40+10 and 40+12 weeks gestation.

Aims

To audit the outcomes of patients delivered in WGH who went above 41weeks of gestation against the National Clinical Guidelines in Obstetrics and Gynaecology: Induction of Labour 2023.

Methodology

A retrospective audit assessed all patients who delivered at WGH with gestations of 41 weeks or more during the period from September 2023 to June 2024. Ethical approval for the audit was obtained.

Results

The analysis of pregnancies extending to 41 weeks gestation and beyond is summarized in the tables below.

Table 1: Summary of Deliveries at Wexford General Hospital (Sep 2023 - June 2024)

Category	Count
Total Deliveries (TD)	1250
Deliveries ≥ 41 Weeks (T≥41)	165
Percentage of Deliveries ≥ 41 Weeks	13.2%

Table 2: Induction of Labor (IOLs) Outcomes

Outcome	Count	Percentage
SVD	30	39.5%
Vacuum/Forceps Deliveries	22	28.6%
Emergency Caesarean Sections	24	31.6%
Total IOLs	76	100%

As seen in the tables above, 13.2% were gestations ≥41 weeks. 46.1% of these pregnancies were induced according to WGH protocols, while the remaining had spontaneous onset of labour or elective caesarean sections. 68.4% of induced pregnancies ended in vaginal deliveries, with 31.6% undergoing emergency caesarean sections.

Conclusions

This audits highlights the low probability of pregnancies reaching >=41weeks gestation. 53.9% of these cases either went into spontaneous labour or delivered via elective caesarean section between 41+0 and 40+10 gestation.

IOL in accordance to the national guidelines can be offered in WGH. Individualised care for those wishing to avoid the intervention of induction and await spontaneous onset of labour could be offered on a case by case basis

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Right Instrument, Right Patient, Right Time: Vacuum and Forceps Versus Forceps Alone

Author: Dr Deirdre Arthur

Co Author: Mr George Timmons

Co Author: Professor Michael P O'Connell

Co Author: Dr Mark P Hehir

Objective: Forceps delivery has decreased in frequency over time and this has lead to clinicians citing a decrease level of experience and confidence with the instrument. Similarly caution has been urged in the sequential use of delivering instruments at the time of operative vaginal delivery (OVD) due to excessive traction on the fetal head and the potential for associated adverse outcomes. We sought to examine outcomes of deliveries using vacuum followed by forceps with those where forceps was the only instrument applied.

Study Design: This is a retrospective cohort study of all operative vaginal deliveries over a ten year period from 2011 to 2020 at a large tertiary referral academic center in Dublin Ireland. Demographics (age, BMI, onset of labor, gestation and birthweight) and morbidity outcomes (episiotomy, 3rd and 4th degree tear, Apgar < 7 at 5 minutes, arterial cord pH and NICU admission) at operative vaginal delivery were examined for cases of sequential use of vacuum followed by forceps to complete the delivery compared with cases where forceps was the only instrument used.

Results: There were 4573 OVDs included in our study cohort, 661 requiring sequential use of vacuum followed by forceps and 3912 which were carried out using forceps alone. There was no difference seen in maternal age, BMI, onset of labor or being beyond 40 weeks gestation. Those requiring sequential instruments had heavier babies than those requiring forceps alone (3589g ± 433 vs. 3549g ± 445; p=0.03; 95% CI 3.37 – 76.6). Rates of episiotomy were similar in both groups however those requiring sequential instruments had higher rates of 3rd or 4th degree perineal injury (10.3% (68/661) vs. 7.6% (299/3912); p=0.02; 95% CI 0.43 – 5.3). Rates of shoulder dystocia were similar between both groups and infants requiring sequential instruments were no more likely to have an Apgar score of <7 at 5 minutes of life. Infants delivered using sequential instruments had higher rates of arterial cord pH of <7.1 (9.4% (62/661) vs. 6.2% (242/3912); p=0.002; 95% CI 1.05 – 5.8) and admission to neonatal ICU (6.2% (41/661) vs. 4.3% (167/3912); p=0.03; 95% CI 0.16 – 4.1).

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Conclusion: Deliveries involving sequential use of a vacuum followed by a forceps carry maternal and neonatal morbidity in excess of those requiring forceps alone. In embarking on an operative vaginal birth, the operator should prioritise the appropriate use of a single intervention, including consideration for primary forceps selection or recourse to Caesarean delivery.

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SERVICE EVALUATION OF STILLBIRTH CARE PATHWAYS IN CUMH AGAINST NATIONAL STANDARDS FOR BEREAVEMENT CARE FOLLOWING PREGNANCY LOSS AND PERINATAL DEATH (2017-2022)

Topic / Dept:

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2. INFANT Research Centre, University College Cork, Cork 2Pregnancy Loss Research Group, UCC.

Author: Anna Burns [1]

Co Author: Niamh Howard-Jones [2]

Co Author: Keelin O'Donoghue [3]

Background: Stillbirth is a major health burden. In 2021, the stillbirth rate was 3.91 per 1000 live births in Ireland. High-quality consistent bereavement care should be part of the culture of a maternity hospital/unit. The purpose of the National Standards for Bereavement Care is to standardize and enhance bereavement care services for parents after pregnancy loss or perinatal death.

Objectives: This study aims to examine adherence to recommended maternity care pathways provided to women presenting with a stillbirth, in CUMH between 2017 and 2022 against the National Standards.

Methods: This study was a service evaluation by retrospective chart review. Auditable standards were extracted from the National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death and related care pathways. Aspects of maternity care provided in 178 stillbirth cases were examined, including bereavement and loss (B&L) services and medical follow-up.

Findings: There was improvement in B&L inpatient services over the six-year time frame with increasing points of contact year on year during admission. In 2017, 39% of women received three or more inpatient visits from B&L services, compared to 79% in 2022.
Women presenting with pregnancy loss in 2021 and 2022 also had more interactions with B&L services after discharge compared to those presenting in 2017-2019.

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Over the six years examined, 25.8% of bereaved parents were followed up in an appropriate clinic by a consultant obstetrician within the recommended three months, while 45.5% were seen between three- and six-months post pregnancy loss. In 2017, 9.1% of cases were followed up within three months, compared to 33.3% in 2022.

Conclusion: Comprehensive frameworks such as the National Standards outline appropriate care pathways which optimise the quality of maternity care delivered to bereaved parents. An improvement in the quality of maternity care delivered in CUMH is evident since the implementation of this framework in 2017.

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The HOME INDUCTION Randomized Controlled Trial – Logistics for achieving delivery

Background

The ARRIVE Trial has resulted in an increased demand for 39 week induction of labor in normal-risk nulliparous patients, but this creates logistical challenges for busy Labor Wards. A potential solution is commencing induction by means of outpatient cervical ripening at home, using vaginal prostaglandin (Propess) or osmotic cervical dilator (Dilapan-S).

Objective

This secondary analysis evaluates the logistics of achieving vaginal delivery following outpatient induction. This includes changes in Bishop score before and after cervical ripening, the need for additional ripening agents, and time interval from induction to delivery.

Study Design

We randomized healthy normal-risk nulliparous women who agreed to elective induction of labor at 39 weeks' gestation, to one of three forms of initial cervical ripening at home: 12 hours of Dilapan-S, 24 hours of Dilapan-S, or 24 hours of slow-release dinoprostone (Propess). Effectiveness of each agent, time to delivery, and length of hospital stay were assessed.

Results

A total of 180/271 (66%) of all nulliparous women were delivered within 48 hours of induction commencing, and 254/271 (94%) delivered within 72 hours. Participants in the Propess group were more likely to require early readmission than in the Dilapan-S groups (45% vs 9%). Patients randomized to Dilapan-S groups were more likely to require additional Prostin prior to amniotomy being possible (65% vs 34%). Those who did not require additional ripening had very high vaginal delivery rates (80% to 88%). Induction agent removal time to delivery was similar across all groups. The length of hospital stay ranged from a median of 76 to 88 hours.

Conclusion

Outpatient cervical ripening is an efficient option for dealing with the logistical challenges facing busy Labor Wards, with the majority of nulliparous patients delivering within 48 hours. These results provide useful information for women considering induction of labor in terms the process, as well as assisting hospital planning, including optimizing staffing levels and ensuring bed availability.

Table 1: Time-related outcomes for 39 week elective IOL

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Outcomes		D24 (N=96)	D12 (N=88)	P24 (N=87)
Time-related endpoints				
Delivery* within 48 hours of starting IOL		53 (55%)	72 (82%)	55 (63%)
Delivery* within 72 hours of starting IOL		85 (89%)	86 (98%)	83 (95%)
Removal of induction agent to delivery time (hours)#		22 [18,32]	20 [15,29]	20 [10,29]
Length of hospital stay: Return-visit** to discharge (hours)	All	79 [59,104]	88 [67,111]	76 [56,98]
	SVD	59 [56,81]	69 [46,93]	64 [48,80]
	OVD	79 [71,105]	71 [67,86]	74 [54,85]
	CD	102 [83,127]	107 [91,118]	101 [81,119]
Vaginal delivery% timing (commencement of induction to delivery)				
Vaginal delivery timing	Within 36 hours	10 (10%)	33 (38%)	27 (31%)
	Within 48 hours	42 (44%)	47 (53%)	48 (55%)
	Within 72 hours	65 (68%)	55 (63%)	65 (75%)

Summary statistics are presented as n (%), mean (SD) or median [IQR].

D12 = Dilapan-S 12 hours; D24 = Dilapan-S 24 hours; IOL = Induction of labour; OVD = Operative vaginal delivery; P24 = Propess 24hours; SVD = Spontaneous vaginal delivery

Removal time was missing for 1 patient in the D12 group and 1 patient in the P24 group.

* Delivery by any means

**Denotes time in hours from when the patient was re-admitted to hospital after their return with Propess or Dilapan-S in situ, until time of discharge after delivery

% SVD/OVD

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USING ROBSON'S TEN GROUP CLASSIFICATION SYSTEM (TGCS) TO ACCURATELY CAPTURE FULLY DILATED CAESAREAN SECTION RATES: RETROSPECTIVE DATA FROM NMH.

Background

Fully dilated caesarean sections (FDCS) occur when a caesarean is performed during the second stage of labor after full cervical dilation. Despite their clinical significance, FDCS rates are inconsistently reported, posing challenges in assessing their impact and trends. The Robson Ten-Group Classification System (TGCS) offers a standardised framework for analysing caesarean section rates, but its use for FDCS has been limited.

Objective

This study aims to explore how Robson's TGCS can be used to accurately capture FDCS rates, offering a clearer understanding of the patient groups most affected and the clinical circumstances leading to these procedures.

Study Design and Methods

A retrospective analysis of electronic delivery records from the National Maternity Hospital (NMH) was conducted. Caesarean sections were classified according to Robson's TGCS, with additional detail to distinguish caesarean sections performed before and after full dilation. Data was analysed to determine FDCS rates across the ten groups and examine the clinical indications for FDCS.

Results

Preliminary analysis revealed that FDCS occurred most frequently due to obstructed labour and fetal distress, however completed results of FDCS, across each of the ten groups, are still pending further analysis of the data, which will be complete at time of presentation.

Conclusion

Using Robson's TGCS to capture FDCS rates offers an efficient, practical and standardised approach to monitoring these rates. Using the TGCS aids identification of higher-risk groups and highlights the need for targeted interventions to reduce unnecessary FDCS, with the ultimate aim of improving maternal and neonatal outcomes

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Uterine fibroid causing Dextrorotation of uterus and Labour Dystocia

We present the case of an unusually-adherent fibroid resulting in dextrorotation of the uterus and subsequent labour dystocia at full term in a primiparous patient.

Background

LB is a 35 year old P0G1.BMI was 32 at booking. This patient had no Medical or Surgical History. Gynaecological history was significant for previous LLETZ for CIN 1, and a fundal fibroid identified on dating scan in early pregnancy.

Gestational Diabetes was identified at screening at 24 weeks gestation and was managed by Diet and Exercise. Serial growth scans throughout the pregnancy showed appropriate foetal growth and Liquor Volume.

Induction of labour was offered at 40 weeks and 6 days. Vaginal prostaglandin was used, and on Artificial Rupture of Membranes, Meconium 1 was noted.

Oxytocin was used as per protocol, however contractions remained weak and short despite maximum infusion-rate.

Following 8 hours of maximum oxytocin dose, foetal head remained at -3 station, was poorly applied to cervix, and the patient was not in labour.

Decision was made to deliver by Caesarean Section due to labour dystocia.

Intra-operative findings revealed distorted pelvic anatomy;

-Uterus was rotated 90 degrees; left Tube and Uterine arteries at anterior.

-Fibrous elongated fibroid identified; base protruding from Anterior aspect of right upper uterus and appears adherent to Pouch of Douglas.

Uterus was manually rotated to correct anatomical position and lower-segment transverse incision was performed. Delivery and Uterine closure were completed in routine fashion.

Follow-up MRI performed 6 weeks post natally confirmed surgical findings; a 6.6cm pedunculated fibroid arising from the uterine fundus and courses to the Pouch of Douglas. A further follow-up MRI is arranged, and surgical removal is planned

Discussion

This case shows an unusual sequelae of a uterine fibroid that became adherent to the pelvis in pregnancy.

We hope that this case can help inform and educate colleagues, so uterine rotation can be suspected in similar cases where oxytocin appears to be ineffective.

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Voices Matter: Women's Experience of Elective Outpatient Induction of Labour

Introduction

Maternal experience is an essential component when exploring the role of induction of labour (IOL) however this data is lacking particularly with respect to satisfaction and perception of elective induction of labour, and especially for outpatient elective induction. Our objective was to perform a survey of participants in the HOME INDUCTION RCT, who were randomised to receive either prostaglandin (Propess) or osmotic cervical dilator (Dilapan-S) to commence elective induction at home.

Design

A semi-structured questionnaire was distributed to 271 women who completed IOL to assess maternal experience of outpatient elective induction of labour. Quantitative and qualitative analyses were performed on a number of prompts within the questionnaire.

Results

Of 271 randomized patients, 113 (42%) completed the survey, with 104 (92%) recommending outpatient elective IOL, and 96 (85%) reporting no safety concerns with induction being initiated at home. On a scale of 1-10 for discomfort, patients regarded both methods favourably, rating Dilapan insertion 3.6/10 and Propess insertion 2.8/10 ($p=0.46$). Patients receiving Propess were significantly more likely to experience contractions at home (58% vs 10%, $p< 0.001$). A total of 82/113 (73%) respondents found the overall induction process to be a positive experience, 18% were unsure, and only 10% disagreed. A qualitative analysis of the major themes identified was also performed.

Discussion

This RCT patient satisfaction data has confirmed that women find elective home IOL to be a positive experience, and almost all would recommend the experience to others. A phenomenological analysis of themes identified from women's feedback allowed us to explore strengths and weaknesses of the IOL framework. Our data confirm that some negative commentary expressed about routine 39 week IOL after publication of the ARRIVE Trial is not supported by prospectively collected data on patients' own opinions and experiences, thereby supporting the option of outpatient initiation of IOL amongst nulliparous patients.

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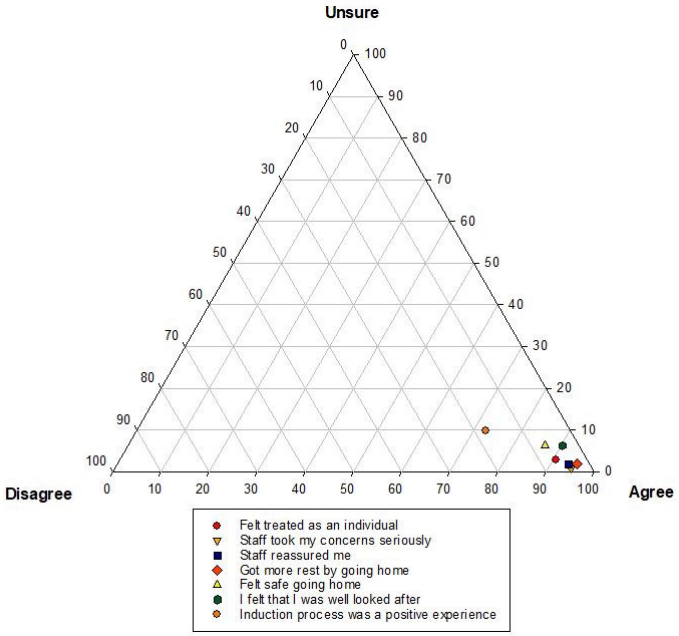

Figure 6.1: Ternary plot showing the trend of responses to Maternal Experience Prompts

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A 5 YEAR REVIEW OF PATIENTS DECLINING BLOOD PRODUCTS IN A TERTIARY MATERNITY UNIT: THE RISE OF SARS-CoV2 VACCINATION AS A REASON FOR DECLINING BLOOD

Topic / Dept:

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Author: AP Worrall

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Objective: Post-partum hemorrhage (PPH) remains a leading cause of maternal morbidity and mortality and the rate of blood transfusion in national units is ~1-2%. Patients declining blood products need to be identified and counselled early. Historically, Jehovah's witness patients would account for most of this patient cohort, but other reasons are on the rise.

Aim: To determine the incidence, reasons for, and outcomes for women who decline blood products at our hospital over a five year period.

Study Design: Women declining blood products at booking at our hospital between 2019-2023 were identified and chart review was conducted. Patient demographics, reasons for declining blood products, and delivery outcomes were recorded. Discussions and counselling around blood products was reviewed.

Results: 70 women were included in the study, of which the median age was 33, and 69% were multiparous. Ethnic group analysis showed Eastern Europeans/Russian (34%), African/Black Africans (21%) and Caucasian/White Irish (21%). Reasons for declining blood included the

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Jehovah's faith (54%), concern for contamination of blood (3%), specifically from donors who have had SARS-CoV2 vaccination (9%), and not believing in blood donation (6%). 28% (n=20) of respondents gave no reason for declining blood. 56% were reviewed by a senior obstetrician, and 49% were reviewed by a consultant hematologist antenatally. After this 67% women chose to accept factor concentrates, blood conservation techniques or medicinal products. Of the 11 RH negative women, two cases declined Anti-D in the presence of a RH positive fetus. Most delivered at term (30% by c-section), with median blood loss 300mL. 12% had a PPH>500mL. No women required red cell transfusion.

Conclusion: Pregnant women decline blood products for a variety of reasons but concern about accepting blood from SARS-CoV-2 vaccinated donors is new. Counselling by senior clinicians is paramount with two thirds of women agreeing to some alternative treatments, and specialist hematology input optimizes patient care.

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A CASE OF AN INCARCERATED MATERNAL DIAPHRAGMATIC HERNIA AT 31 WEEKS

Presentation and history: A 39 year old, P1 presented at 31+0 with a 1/7 history of vomiting. Episodes of vomiting occurred after eating and in the absence of nausea or abdominal pain. She complained of right sided rib pain which was relieved by vomiting. She had been commenced on PO omeprazole for reflux and associated vomiting at 27+0.
She was a G4P1+2. She had 2 previous miscarriages at 8 and 10 weeks and a previous LSCS at 39+2. Her medical history was significant for scoliosis with two previous spinal surgeries.
Initial differential diagnoses included reflux related vomiting, gastroenteritis, pancreatitis, UTI and obstruction.

Examination and investigations: Her abdomen was soft and non-tender. Her fundus was equal to dates. Her IMEWs was 0. The fetal heart rate was 147 on auscultation. Urine dipstick revealed 4+ ketones. Her FBC, LFT's, TFT's, U and E's and amylase were normal with a mildly elevated CRP of 9.2. Her blood glucose level was 3.1 and her blood ketone level was elevated at 4.1. A VBG revealed a pH of 7.34 and a lactate of 0.9. Ultrasound revealed multiple echogenic foci in the liver. MRI abdomen showed an anterior diaphragmatic defect resulting in a significant hernia of upper abdominal contents (distal stomach, proximal pylorus, transverse colon and mesentery) in the anterior thoracic cavity. It showed a likely incarcerated distal body of the stomach with mid gastric obstruction.

Management and outcome: Initial management included admission for IV fluid rehydration and antiemetics. She was also commenced on prophylactic innohep. Following the MRI findings, an NG was inserted and sucralfate was commenced. Steroids were given for lung maturity and a CVC for TPN was placed in her right femoral vein. She had an elective LSCS at 32+6 due to a 5kg weight loss in one week and persistent ketosis and had complete resolution of her symptoms. She developed a DVT distal to her CVC postnatally and was treated with therapeutic clexane and discharged on day 6.

Learning points:
This case highlights the importance of a thorough differentials list with atypical vomiting in pregnancy.

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SPONTANEOUS RECTUS SHEATH HAEMATOMA IN PREGNANCY

Topic / Dept: Cork University Maternity Hospital

Author: B Daly

Co Author: D Galvin

Co Author: A De Haan

Co Author: A McSweeney

In this case report we present the case of a 30 year old woman (gravida 6 para 2+3) who presented at 31+6 weeks' gestation with severe sudden onset left sided abdominal pain.

Past medical and obstetric history

Her obstetric history was significant for a 33 week spontaneous vaginal delivery (SVD) of twins followed by a term SVD. She had a history of mild depression managed with Fluoxetine. She was a smoker of 5 cigarettes per day at booking. Her BMI was 38kg/m^2 (110kg).

Presentation

She presented at 31+6 with severe left sided abdominal pain following an episode of severe coughing. She had been recently treated for a lower respiratory tract infection (LRTI). On assessment she was severely distressed with pain. Our initial concern was for a concealed placental abruption. The was no history of vaginal bleeding, abdominal trauma and fetal movements were felt.

Abdominal examination noted diffuse tenderness on the left side. There was superficial mild bruising noted. The uterus was soft and non-tender.

Investigation

Vitals: Pulse 110bpm, BP 125/78, Temp 36.7, SpO2 97%

Bedside ultrasound showed a large haemorrhagic area on the left side.

Bloods: Hb 10.8 g/dL WCC 22.8 x10^9/L Plts 444 x10^9/L CRP 36.8mg/L INR 1.0

Departmental US and MRI: 23x9x13cm rectus sheath haematoma

CT angiogram: No active bleeding point amenable to embolization

Differential diagnosis

Placental abruption, ovarian torsion, splenic artery aneurysm rupture, subcapsular liver haematoma

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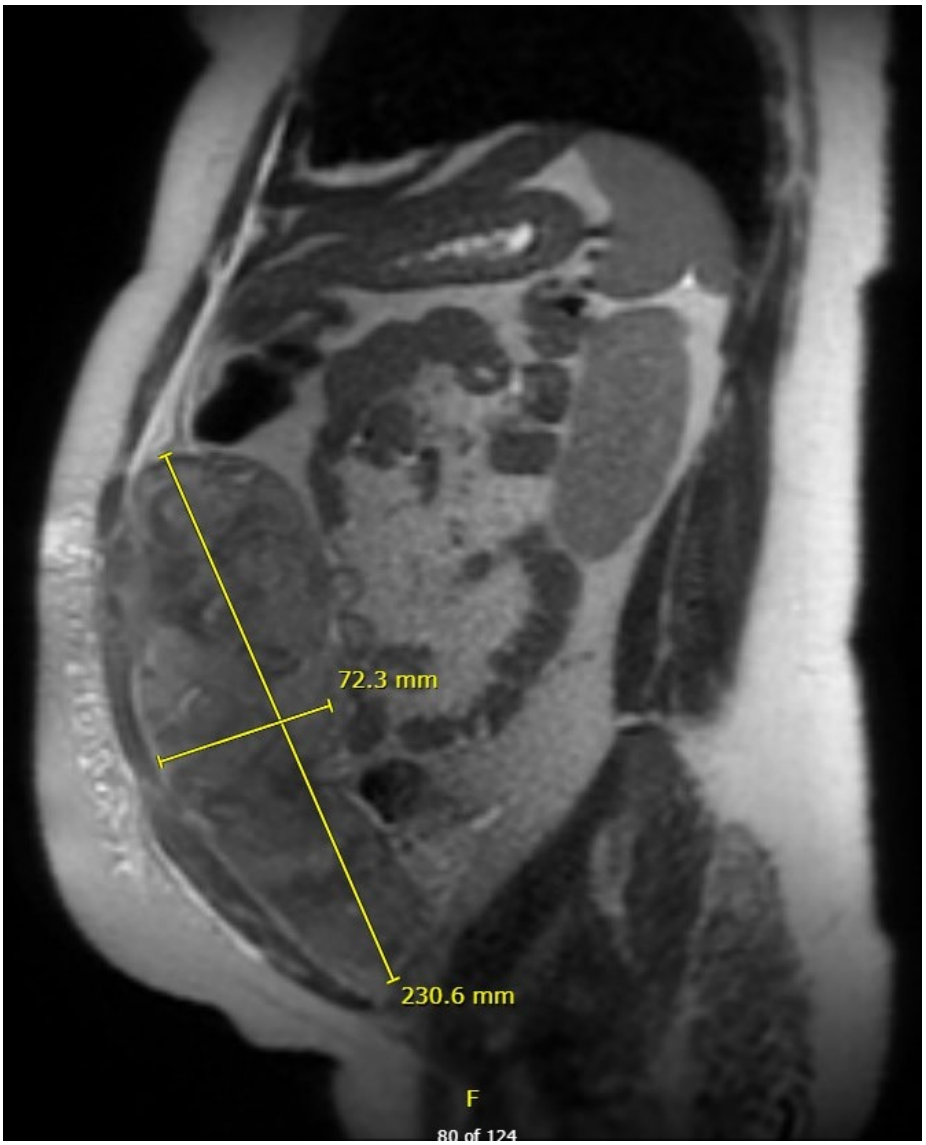
Management, course of pregnancy and outcome

Following consultation with IR, Haematology and General surgery the decision was made for conservative management. The patient received antenatal corticosteroids and was observed in the high dependency unit. She received IV antibiotics and oral corticosteroids to cover her LRTI. She received 48 hours of IV tranexamic acid 1g 8 hourly. Once stable she was commenced on 4500IU of tinzaparin for the remainder of her inpatient stay following haematology advice. She was discharged home on day 7 of admission and remained well. She was induced for maternal request at 38+1 and had an uncomplicated SVD.



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A RETROSPECTIVE AUDIT ON ASPIRIN USE IN PREGNANCY TO REDUCE INCIDENCE OF PRE-ECLAMPSIA

Topic / Dept: [1] University Maternity Hospital Limerick (at the time of this audit)

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Co Author: K Ismail[1]

Background
Aspirin is a cyclooxygenase inhibitor with anti-inflammatory and anti-platelet properties. Low dose aspirin (75 to 150mg) is used during pregnancy to prevent or delay the onset of preeclampsia (PET) if the patient has 1 high risk factor or 2 moderate risk factors (as per the NICE guideline [NG133] Hypertension in Pregnancy : Diagnosis and Management).

Objective
Based on the NICE guideline, aspirin should be prescribed from 12 weeks up to delivery in patients at risk of PET. This audit was performed to assess compliance with this recommendation.

Methods
Data was collected retrospectively from 52 postnatal patient charts. Risk assessment for PET was performed as per the NICE risk stratification guideline for each patient. The number of patients correctly identified as qualifying for aspirin use at booking and the number of eligible patients who were not identified was recorded. The gestational age at which aspirin was commenced, the dose and the gestational age at which it was discontinued was also recorded.

Results
33.3% of the patients audited qualified for aspirin use as per the NICE guideline. However, only 53.8% of these patients had been identified as such during their antenatal care. Every patient correctly identified as requiring aspirin during their antenatal care had received aspirin, with 57% receiving 150mg OD and 43% receiving 75mg OD. None of the patients receiving aspirin had continued to take it up until delivery. 71.4% of these patients continued aspirin until a gestational age of 36 weeks, and 28.6% discontinued aspirin but were switched to low molecular weight heparin (LMWH).

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Conclusion

All patients identified as requiring aspirin to reduce the risk of PET should receive this medication, as per the NICE guideline. This audit has demonstrated clear areas for improvement in the identification of patients who will benefit from aspirin in pregnancy, and the dose and duration of the aspirin prescribed. The use of a risk stratification form in the antenatal section of the obstetric patient chart is likely to be of benefit in ensuring appropriate risk identification and accurate prescribing. This has been recommended to be included in local booking guidelines.

Tweetable abstract (253 characters) –

Aspirin (75-150mg) is recommended from 12 weeks to delivery to prevent preeclampsia in at-risk pregnancies (NICE guidelines). An audit of 52 postnatal patients found only 53.8% of qualifying patients were identified. All received aspirin, but none continued it to delivery. Improvements needed.

None of the authors of this audit have a twitter account.

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A RETROSPECTIVE COHORT STUDY REVIEWING ORAL GLUCOSE TOLERANCE TESTING FOR GESTATIONAL DIABETES MELLITUS

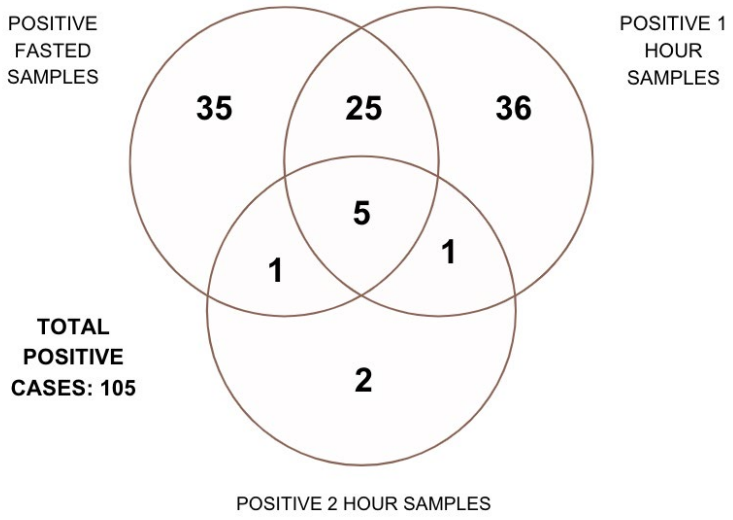
Background*:*
Gestational Diabetes (GDM) remains an important risk factor for obstetric and neonatal complications in pregnancy. Antenatal screening practices worldwide have adopted the IADPSG (International Association of the Diabetes and Pregnancy Study Groups) diagnostic criteria since the publication of the HAPO (Hyperglycaemia and Adverse Pregnancy Outcomes) study. There is currently a paucity of data on the diagnostic importance of each individual test of the OGTT (Oral Glucose Tolerance Test) and the associated pregnancy and neonatal outcomes. One laboratory study of small numbers has shown that it is rare for GDM to be diagnosed based on the 2-hour test alone.

Aim:
Our study aimed to analyse the incidence of GDM in our population on each of the three OGTT results to identify the benefits of the 2-hour glucose sample.

Methods:
A retrospective cohort study of 337 consecutive patients from 2019-2020 assessing maternal and fetal variables including age, BMI, gestation at delivery, mode of delivery, neonatal hypoglycaemia and neonatal ICU admission. The IADPSG diagnostic criteria for GDM were used. The data was analysed to assess which of the three OGTT levels was abnormal and the clinical consequences.

Results:
Of 337 women, 31% (105) were diagnosed with GDM. Of the positive OGTTs, 33% (35/105) were diagnosed based solely on the fasting sample, 34% (36/105) based on the 1-hour test alone and only 2% (2/105) were diagnosed solely from the 2-hour OGTT. Of the sole 2-hour test diagnosis', there were no neonatal complications seen. Only 8.6% (29/105) weighed <10th centile, and 19.29% (65/105) were >90th centile at birth. Neonatal hypoglycaemia affected 1.48% (5/105) out of the 337 infants, 0.89% (3/105) with shoulder dystocia, and 0.3% (1/105) with another birth injury. See figure 1.

Figure 1: Results of the fasted, 1-hour, and 2-hour OGTT



Discussion/Conclusion:

98% (103/105) of GDM cases did not require the 2-hour OGGT test for diagnosis. This study supported the hypothesis and identified the potential for the removal of the 2-hour OGTT in diagnosis of GDM. However, due to limitations, a larger data set should be collected to confirm the hypothesis.

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A SCOPING REVIEW OF NETWORK META ANALYSIS IN MATERNITY CARE AND THEIR FINDINGS

Topic / Dept:

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Author: Abushama H[1]

Co Author: Smith V[2]

Background: Network meta-analysis (NMA) is a statistical technique that extends conventional meta-analysis by assessing direct and indirect evidence from different interventions for a healthcare condition in a single analysis to determine which intervention(s) might be more effective.

Objective: The aim of this scoping review was to summarise NMAs in maternity care, identify evidence gaps, and inform clinical decisions and future research.

Methods: The methodology involved three stages. Reports were identified through systematic searches of MEDLINE, CINAHL, Embase, The Cochrane Library, and Epistemonikos from 01-Jan-2000 to 28-May-2024. Potential reports were screened in Covidence by two reviewers independently against the inclusion criteria. Finally, data was extracted and charted using Microsoft Excel.

Results: In total, 1,141 reports were identified. After screening, 132 met the inclusion criteria. NMAs focused on maternal conditions such as caesarean section, gestational diabetes, and hypertension. NMAs primarily came from China, the UK, and the USA. In this abstract, four key conditions are reported on: i) antiphospholipid syndrome , ii) HIV in pregnancy, iii) preterm prelabour rupture of membranes (PPROM) and iv) postpartum haemorrhage (PPH). Two NMAs on antiphospholipid syndrome found combinations of aspirin, prednisone, heparin, and IV immunoglobulin improved live birth rates. Three NMAs on HIV showed zidovudine monotherapy reduced vertical transmission. Three NMAs on PPROM found clindamycin plus gentamicin and penicillin superior to no treatment in preventing chorioamnionitis. Regarding PPH, one NMA found non-surgical interventions superior to surgical ones in reducing hysterectomies, while three NMAs indicated carbetocin plus ergometrine and oxytocin were more effective in reducing PPH ≥ 500 mL.

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Conclusion: Based on a subset of findings from 12 NMAs addressing four conditions, evidence for superior PPH treatment was robust, but further research is needed to determine optimal treatments for conditions such as antiphospholipid syndrome.

Tweet:

A subset of 12 network meta-analyses (NMA) from 132 NMAs in maternity care, covering 36 health conditions, found strong evidence for optimal treatment of postpartum haemorrhage. However, further research is needed to determine the best treatments for antiphospholipid syndrome

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Among causes of Mid Trimester Loss, Preterm Prelabour Rupture of Membranes has the highest Maternal Morbidity

Tweetable abstract

Mid-trimester loss after preterm premature rupture of membranes comprised 17.06% of all MTL in our population and maternal morbidity is highest in this group.

Background

Mid Trimester Pregnancy Loss (MTL) (14+0 - 23+6) can have various causes, yet there is little research examining how maternal morbidity differs among these.

Objective

We sought to describe and compare maternal morbidity among causes of MTL.

Study Design and Methods

We conducted a retrospective cohort study of all patients that experienced MTL at a tertiary maternity hospital (2018-2023). Data was collected from the electronic medical record. For each of four causes of MTL, six categories of maternal morbidity were compared to references.

Findings/Results

Within the study period, MTL affected 353 of 46,501 (0.76%) booked pregnancies (Fig. 1). 101 cases were excluded.

23.81% (60/252) were due to fetal anomalies. 50.40% (127/252) presented without fetal heartbeat on ultrasound (IUFD). 8.73% (43/252) had spontaneous miscarriage with membranes intact (sMC). Mid-trimester prelabour premature rupture of membranes (MT-PPROM) accounted for 17.06% (43/252).

MT-PPROM had statistically significant increased maternal morbidity in five of six categories (see Fig. 2), including PPH 500-1000mL (OR 16.53, 95% CI 8.99-30.37, p< 0.01), emergency MROP or ERPC (OR 37.66, 95% CI 20.20-70.21, p< 0.01), and inpatient stay of three or more days (OR 8.20, 95% CI 3.93-17.12, p< 0.01). For these, MT-PPROM had higher results than any other group of MTL. Additional significant findings for MT-PPROM included PPH greater than 1000mL (OR 8.14, 95% CI 1.91-34.68, p< 0.01) and referral to perinatal psychiatry (OR 0.12, 95% CI 0.02-0.86, p=0.04).

Notably, all groups of MTL save sMC had significantly lower referral rates to perinatal psychiatry (see Fig. 2).

No statistical analysis was carried out in infective composite as no comparison could be had, though MT-PPROM morbidity was more than four times greater than in other causes of MTL.

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Conclusions

This large tertiary institution has a comparable rate of MTL to international literature. MT-PPROM comprises about one-fifth of all MTL, yet maternal morbidity is generally significant and highest in this group. Perinatal psychiatry referral may be under utilised in this group.

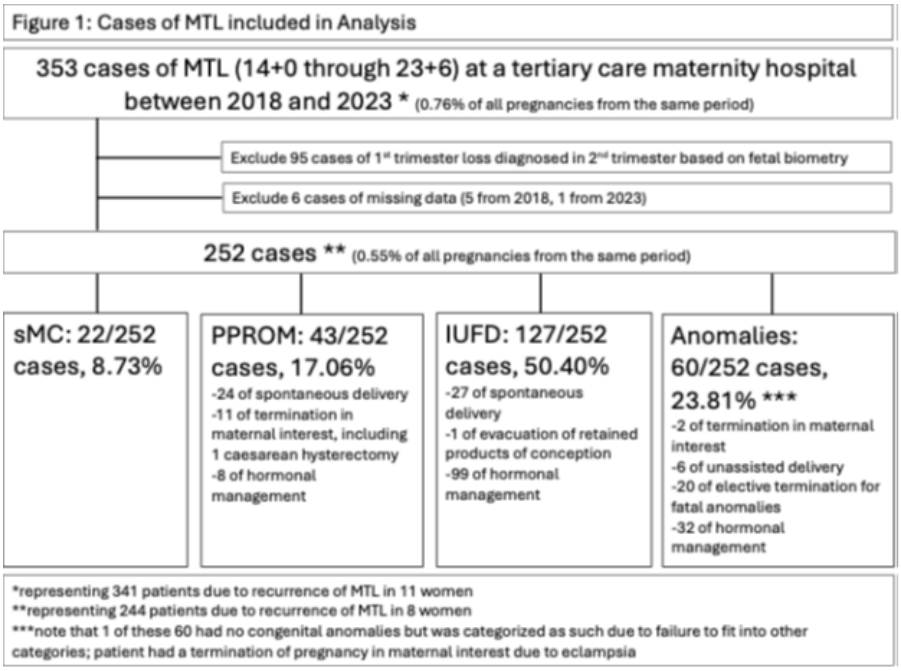

Figure 1

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An audit of compliance with standards of care for induction of labour in a tertiary referral unit.

Author: Patriks Aldersons

Co Author: Sarah M Nicholson

Co Author: Pauline Tarpey

Co Author: Susmita Sarma

Co Author: Tom O'Gorman

Background

Induction of labour (IOL) is becoming increasingly common, and there have been mixed outcomes in the literature in terms of efficacy and practice. There is a paucity of data regarding standards of care for IOL. The new national clinical practice guideline for IOL recommends several standards of care.

Design

We carried out a departmental audit in a tertiary referral centre, which addressed compliance with departmental standards of care based on the IOL guideline. The records of patients who underwent IOL in July 2024 were retrospectively reviewed to evaluate compliance with best practices and standards, focusing on documentation, adherence to protocols, and patient outcomes.

Results

27 charts were assessed. Membrane sweeping was offered in 56% of applicable cases with no sweep offered in 11% of cases. 7% of cases recorded consultations with a senior obstetrician before IOL, and none documented informed consent for the procedure. Discussions regarding analgesia options were noted in only 4% of cases.

89% of inductions occurred before 41 weeks' gestation, with prostaglandins used within the recommended timeframe in 70% of cases. Mechanical dilation using Dilapan-S was not employed in any case. Bishop score was documented in 63% of cases.

Mode of delivery varied, with 60% resulting in spontaneous vaginal delivery, but 22% of cases had failed IOL resulting in caesarean delivery. 70% of deliveries occurred outside of regular working hours, highlighting possible implications for staffing and resources.

Conclusions

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Improvements are needed in documentation practices and adherence to IOL protocols to enhance patient outcomes. Recommendations include standardized documentation of consent, consultation with senior obstetrician regarding IOL and discussion detailing analgesia, reinforcement of guidelines on membrane sweeps, and further investigation into the high frequency of out-of-hours deliveries and failed inductions. Regular audits should be conducted to ensure continuous quality improvement regarding IOL practices.

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AN AUDIT ON THE RECENT NATIONAL GUIDELINES OF WOMEN PRESENTING TO A SECONDARY CARE HOSPITAL WITH REDUCED FETAL MOVEMENTS.

Topic / Dept: Dept of Obs & Gynae, Mayo University Hospital.

Author: M.Mumtaz

Co Author: A.Trulea

BACKGROUND

Reduced fetal movements (RFM) refers to any change in maternal perception of fetal movements, including pattern, strength, or frequency. Clinicians should be aware of the outcomes associated with RFM including the increased risk of stillbirth and/or fetal growth restriction (FGR) [123.] Women reporting RFM should undergo a comprehensive assessment of fetal wellbeing

OBJECTIVES:

Given the significance of RFM, we conducted an audit from May to September 2024 to assess alignment with recent Irish guidelines. We examined the number of women presenting with RFM, their gestational ages, those not eligible for discharge, and the number receiving an ultrasound within 24 hours. We also reviewed those requiring interventions during their visit

STUDY DESIGN AND METHOD:

This was a retrospective data analysis of all women who visited the hospital with RFM. All patient information was anonymized and analyzed with Excel. The NWHIP National Clinical Practice Guideline for Reduced Fetal Movements (2024) was the standard used.

RESULTS:

A total of 52 women were seen. Eleven (21%) were below 28 weeks gestation, while 41 (78.8%) were above 28 weeks. All women (100%) underwent CTG and ultrasound as per guidelines. Of those not eligible for discharge, 20 (38.4%) received a departmental scan within the next working day. Five women (9.6%) required intervention, including induction of labor before or after 39 weeks. Among the women reporting RFM beyond 28 weeks, five had prior gestational diabetes and polyhydramnios, and one case of oligohydramnios was newly diagnosed.

CONCLUSION:

The audit reflects a 100% compliance with the new recommendations despite an increased demands on our services.It highlights the importance of comprehensive verbal and written

information on fetal movements to all women at booking or at 24 weeks gestation, as well as the distribution of patient information leaflets during their initial visit with RFM, accompanied by complete documentation. Additionally, the inclusion of RFM education in antenatal classes should be considered. A re-audit in 6months time will be ideal.

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CAPTURING NOVEL DATA ON SPORTS PARTICIPATION IN PREGNANCY IN IRELAND

Topic / Dept:

[1]UCD School of Medicine, University College Dublin, Dublin 4, Ireland.
[2]UCD Centre for Human Reproduction, The Coombe Hospital, Dublin 8, Ireland.

Author: Shrestha A[1]

Co Author: O'Higgins AC[2]

Background
Despite the recognised obesity epidemic and benefits of exercise during pregnancy, there remains a lack of focus on maternal sports practices in Ireland and absence of quality Irish data. A Sports Ireland study showed declining sports participation in teenage girls, the cohort likely to become pregnant in 5-15 years.

Objective
This study aims to collect high quality data on sporting practices and attitudes to sports participation in a pregnant cohort, to build on the limited data in Ireland and link with measures of baseline health.

Methods
This prospective cohort study was conducted at The Coombe Hospital. Self-administered questionnaires based on the Irish Sports Monitor (ISM) and Pregnant Physical Activity Questionnaire (PPAQ) were given to patients attending antenatal booking visits. Demographic details and body mass index (BMI) were recorded. Results were analysed using Microsoft Excel, SPSS, and RStudio.

Results
112 surveys were completed with 100 consenting for review of medical data. Responses to the ISM questionnaire reported the following in the preceding 7-days: 71.4% (80/112) walked recreationally, 85.7% (96/112) walked for transport, and 32.1% (36/112) did physical activity such as sports participation. A major proportion, 42.6% (46/108), disagreed/strongly disagreed adult women have equal sports participation opportunities as adult men. Regardless, 41.5% (39/94) found motivation to participate very easy/easy and 88.6% (93/105) strongly agreed/agreed they want to do physical activity. Comparing PPAQ scores by BMI, parity, and age returned no statistically significant relationships.

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Conclusions
We found relatively high reported time in sedentary work and domestic tasks. The pregnant women had high levels of motivation but low levels of actual participation, indicating inadequate access to sports participation opportunities. These results should inform nearly expiring government policies in terms of development of sporting and maternity systems, benefiting the current population whilst having a multigenerational impact.

Tweetable abstract:
A study of pregnant women in Ireland found high motivation for physical activity, but low participation due to inadequate access to sports. This highlights the need for policy reforms to improve sports opportunities for women, with potential multigenerational benefits.

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A CASE REPORT OF HEPPATIC RUPTURE SECONDARY TO HELLP SYNDROME

OBSTETRICS AND GYNAECOLOGY DEPARTMENT,ROTUNDA HOSPITAL
DR SHAHZEEL R QURESHI,DR SAMAH HASSAN ,DR FIONA KEOIGH

Introduction:

Hepatic hematoma and rupture are rare complications of HELLP Syndrome first described by Weinstein in 1982. It is characterized by microangiopathic haemolysis, thrombocytopenia and impaired hepatic function. It commonly occurs between 28 and 36 weeks of gestation but it can also occur postpartum or during labour. It is associated with a mortality rate of 3.3%.

Hepatic hepatomas are characterized by pain in the right hypochondrium or epigastrium (70-90%). Management depends on the hemodynamic condition of a patient. If a patient is unstable, laparotomy is required. In a stable patient a conservative approach is suitable.

Clinical Scenario:

Thirty five year old multipara, with a history of GDM, admitted at 38 weeks of gestation with a 48 hour history of epigastric pain. On admission she was hemodynamically stable with tenderness in the right upper quadrant of the abdomen. Initial investigations detected deranged LFTs and thrombocytopenia with no proteinuria. She had a normal CTG with no concerns regarding fetal wellbeing. Bloods: Hb (11.7), platelets (105) ,Urate (434), LDH (555), ALT (544) AST (440) BLOOD SUGAR (5mmol).

The patient was induced the following day and progressed to labour within several hours. She was delivered by Kiwi due to a non-reassuring CTG.

4 hours post delivery she was seen for a routine review and a maternal collapse was witnessed while sitting up in bed. She was initially unstable but she responded well to resuscitation. Repeat blood tests detected significantly worse LFTs, severe thrombocytopenia and a haemoglobin drop of 75. Bedside ultrasound showed small amount of free fluid.

She was transfused one unit of red blood cells and once stable she was transferred to a general hospital for imaging. A CT CAP detected an acute hepatic rupture secondary to HELLP Syndrome.

As she was haemodynamically stable she had conservative management with an admission to HDU. She was transfused blood products and her hypertension was treated.

She was discharged home on day 7 with ongoing follow up from the surgical and obstetric team.

Discussion:

Hepatic rupture in HELLP syndrome is extremely rare but can lead to death if not managed appropriately. Diagnosis should be suspected in any patient who presents with epigastric pain in the setting of HELLP syndrome. A multidisciplinary approach is essential to ensure the best outcome for the patient.

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EVALUATION OF AMNISURE TEST IN SUSPECTED RUPTURE OF MEMBRANES: A PILOT STUDY

Topic / Dept: Department of Obstetrics and Gynaecology, Cork University Maternity Hospital, Cork

Author: K Angkanaporn

Co Author: H Mahmoud

Co Author: SO Ting

Background

Premature rupture of membranes and preterm premature rupture of membranes are diagnostically challenging, particularly with unclear histories, equivocal physical exams. Diagnosis at Cork University Maternity Hospital (CUMH)typically involves observation of fluid leakage through cervical os, liquor in posterior fornix and ultrasound assessment of amniotic fluid. AmniSure test detects placental alpha-microglobulin-1(PAMG-1)is endorse by NICE guidelines, offers additional valuable diagnostic tool with superior sensitivity(92%) and specificity(99%) compared to other tests like insulin-like growth factor binding protein-1(Lee et al.,2007;Cousins et al.,2005).

Objective

Assess AmniSure's effectiveness in diagnosing membrane rupture in cases with inconclusive signs and impact on clinician confidence.

Study Design and Methods

Prospective pilot study conducted at CUMH from April-July 2024. 25pregnant women underwent AmniSure. Inclusion criteria:2negative speculum examinations by same physician 30minutes apart, gestational age≥24 weeks, history suggestive of rupture membranes without definitive clinical signs, unexplained reduced amniotic fluid index. Exclusion criteria were: active vaginal bleeding, post-coital, local infection, pooling of amniotic fluid on speculum, clear history of a gush, gestational age <24+0weeks, abnormal urinalysis, imminent/established labor, threatened preterm labor without history/signs of rupture membranes. After performing the AmniSure test, physicians were asked to rate confidence in diagnoses on a scale 0-5 (0=uncertain).

Findings/Results

16% of patients tested positive using AmniSure, identifying cases likely missed by traditional methods. All physicians rated diagnostic confidence as 5 after AmniSure, a significant increase in certainty.

Conclusions

AmniSure is an effective diagnostic tool. Its high sensitivity, specificity, and ability to enhance clinician confidence support its use as a complementary diagnostic method. Larger studies needed to confirm findings and integrate AmniSure into local protocols.

Higher saturated fats and lower Vitamin D and Omega 6 intakes in pregnancies at risk of Spontaneous Preterm Birth:

Author: Gillian A. Corbett

Co Author: Brian McDonnell

Co Author: Lucy Murphy

Co Author: Siobhan Corcoran

Co Author: Eileen O'Brien

Co Author: Fionnuala M McAuliffe

Background:
Spontaneous preterm birth (sPTB) is an end-stage result of inflammatory cascades, governed by interaction between the female host, her microbiome and her diet and environment. Many nutrients regulate inflammatory activation, holding potential for interventions to protect against sPTB.

Objective:
To compare key dietary differences between pregnancies at high-risk sPTB versus normal-risk pregnancy cohort

Study Design and Methods:
This is a prospective analysis of dietary intakes for two early pregnancy cohorts: women at risk of sPTB versus no elevated risk of sPTB. Dietary intake was assessed at 12-16 weeks' gestation by three day food diaries and food frequency questionnaires. The high-risk group had history of prior

sPTB or mid-trimester loss (60.5%,86/142), cervical surgery (31.0%,44/142) or uterine anomalies(8.5%,12/142) and were seen in a dedicated preterm birth service.

Findings/Results:

In total, 733 women with dietary data in early pregnancy were included in the study, 142 at high-risk for sPTB and 591 controls with normal-risk of sPTB. The sPTB cohort had higher maternal age (median, interquartile range (IQR) 35.0(5.0) vs 33.0(5.4) years, p<0.001) but lower BMI (26.4(7.1) vs 27.5(4.6) kg/m2, p=0.006) than the normal-risk group with higher non-European ancestry (15.5%,22/142 vs 4.7%,28/591, p<0.001).

Women at high-risk of sPTB had significantly higher saturated fats (13.5(4.0) vs 10.4(4.7), p=0.001) than normal pregnancy counterpart, and the majority of sPTB exceeded recommended saturated fats (11% of Energy, p<0.001, Figure 1).

The sPTB group had significantly lower intake of Omega 6 (1.9(0.8) vs 2.4(1.4), p<0.001). Only 1.4% (2/142) consumed adequate dietary Omega.

The sPTB cohort had significantly lower Vitamin D (2.46(1.5) vs 2.9(2.8)µg, p=0.002) than normal risk group (Figure 1). Both groups had low dietary intake of Vitamin C, D, E, B12 and Selenium.

Conclusions:

Women at risk of spontaneous preterm birth report excessive saturated fats intake and low intake Vitamin D, highlighting opportunity for intervention that may reduce risk of preterm birth.

Tweetable Abstract (280 characters)

Women at risk of spontaneous preterm birth exceed recommended daily saturated fats, and have low dietary intake of Vitamin D, highlighting potential opportunity for intervention.

Figure 1. Difference in nutrient intake in high-risk spontaneous preterm birth (sPTB) cohort compared to normal-risk pregnancy. Boxplots of nutrients comparing median(IQR) between group using Wilcoxon signed rank test. (A) Percentage Energy from Saturated Fats was significantly higher for those at risk of sPTB. (B) Percentage Energy from Omega 6, and (C) Vitamin D intake were significantly lower in early pregnancy cohort at high-risk of spontaneous preterm birth.

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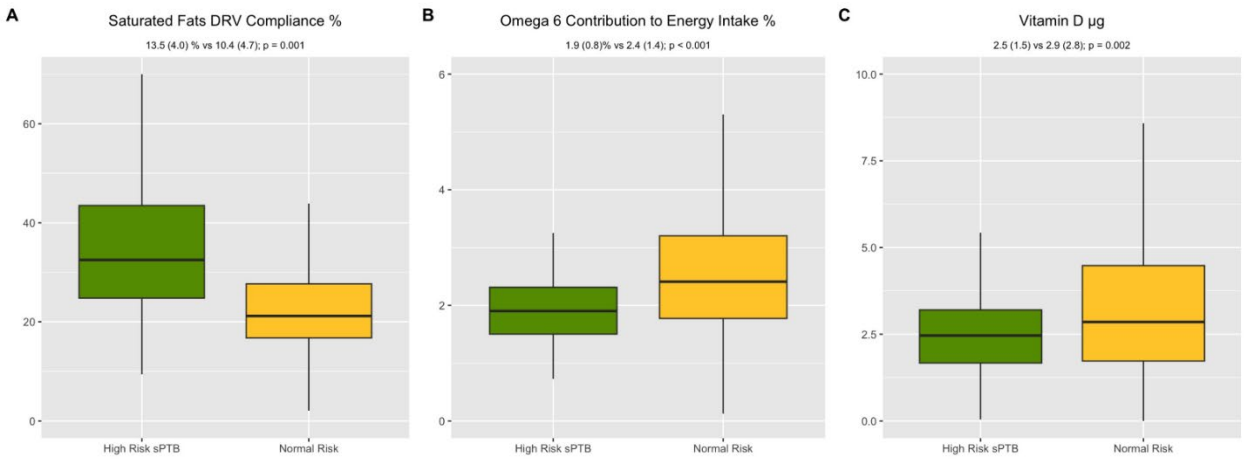

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IDENTIFYING NUTRITIONAL RISKS IN THE FEMALE POPULATION USING THE FIGO NUTRITION CHECKLIST: A MULTI-COUNTRY, MULTI-CENTRED REPORT WITH OVER 2000 PARTICIPANTS.

Topic / Dept: Obstetrics – Maternal Medicine

Author: Alex Taylor, UCD Perinatal Research Centre, University College Dublin, National Maternity Hospital, Ireland

Co Author: Lucy Murphy, UCD Perinatal Research Centre, University College Dublin, National Maternity Hospital, Ireland

Co Author: Sarah Louise Killeen, Department of Clinical Nutrition and Dietetics, National Maternity Hospital, Dublin, Ireland.

Co Author: Hema Divakar. Specialty Hospital, Bengaluru, India

Co Author: Mark Hanson, Institute of Developmental Sciences, School of Human Development and Health, Faculty of Medicine, University of Southampton, UK.

Co Author: Fionnuala M McAuliffe. UCD Perinatal Research Centre, University College Dublin, National Maternity Hospital, Ireland

Tweetable abstract

Over 2000 women participated in the FIGO Nutrition Checklist spanning five global regions. 90.76% had at least one nutritional risk. This checklist identifies risk while promoting health.

Abstract Body Field (2,100 characters/<)

Background:

Non-communicable diseases (NCD) are a leading cause of maternal morbidity and mortality worldwide. Women's dietary practice creates a unique opportunity to influence positive health change and help prevent NCD.

Objective

Our aim is to identify the nutritional risk of women using a validated tool the FIGO Nutrition Checklist.

Study Design and Methods:

Participants were approached in clinics and invited to participant in the online FIGO Nutrition Checklist version. Data as of August 2024 was collated and analysed.

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Findings/Results:

Over 2200 women participated in the FIGO Nutritional Checklist spanning five global regions. The majority of participants (1364/2309, 59%) were between 25 to 39 years. The mean BMI was 24kg/m2. 1669/1839 90.76% of women answered 'No' to at least one of the diet quality questions, therefore, suggesting they had at least one potential nutritional risk. The most common nutritional risk was consumption of less than the recommended fish intake (745/1650 45%). A significant amount of participants of peak fertility age, 25 to 34 years, reported that they did not take folic acid (299/667 44.83%). The peak fertility age group showed a significantly high nutritional risk in pulses and lentils deficiency (286/730 42.88% vs 67/289 25.48%, $p < 0.0001$) compared to post reproductive age. Participants who were pregnant or planning to conceive reported a significantly higher risk in meat deficiency (192/965 22.30% vs 106/858 13.35%, $p <0.0001$) compared to non-pregnant participants. The FIGO five regions were compared and reported. Asia Oceania region is at significantly higher nutritional risk of dairy products compared to the Latin American region, (175/472 40.14% versus 59/313 21.69%, $p<0.0001$). In the European region a significantly higher nutritional risk of pulses and lentil deficiency was identified compared to the North American region, (314/784, 43.07% versus 18/100 20%, $p< 0.0001$). In all regions over 40% of the sample population reported they do not receive the recommended amount of fish, the Africa and Eastern Mediterranean region being at the highest risk of this deficiency, 55/113 57.59%.

Conclusion:

The FIGO Nutrition Checklist is a quick questionnaire utilised to collect simple, yet critically important nutritional information. The FIGO Nutrition Checklist aids healthcare professionals in identifying potential nutritional risks in the diet and supports national and international nutrition in pregnancy guidelines. Dietary information is a simple stepping stone in improving maternal morbidity and mortality associated with NCD.

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Conclusions: This scoping review emphasizes the importance of more investigations, particularly prospective studies, to better understand the risk factors and adverse effects associated with this association., This may have a effect on early identification and treatment options.
2079 charters of 2100 permitted

Tweetable abstract
Research to date suggest an increased risk of gestational diabetes in women with cholestasis of pregnancy but this evidence is limited by heterogeneity. Use of a core outcome set to report research may help.
@KarimaAbubakr @mairenihuigin
(206 characters of 280 permitted)

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KNOWLEDGE AND PERCEPTIONS OF THE IMPACT AND RISKS OF DIABETES IN PREGNANCY

Topic / Dept: 1 The Coombe Hospital, Dublin
2 UCD Centre for Human Reproduction, University College Dublin, Dublin, Ireland
Author: B Burke

Co Author: C MacBride

Co Author: A Tcacenco

Co Author: L Cresswell

Co Author: A McCarthy

Co Author: N O'Gorman

Background
Diabetes in pregnancy (DIP) can cause serious morbidity and impact long-term health. The Coombe Hospital manages diabetic pregnant patients in a specialist multi-disciplinary Diabetic Clinic (DC), with online recording of blood sugars. Those with pre-existing diabetes attend directly, while at-risk patients are screened for gestational diabetes (GDM) by glucose tolerance test (GTT), and seen after diagnosis. Both groups receive education from the specialist midwifery team.

Objective
We aimed to compare the knowledge and perceptions of DIP between those attending the DC and those undergoing GTT. We also examined patients' experience of the DC and online recording.

Study Design and Methods
Two related questionnaires (one for DC group and one for GTT group) were developed and administered online. Data were collected anonymously, and analysed using SPSS. Ethical approval was obtained locally.

Results
We obtained 172 responses; 112 from the GTT group, and 60 the DC group. In the GTT group, 86.6% were informed of their screening indication, but only 47.3% were previously aware that they had a GDM risk factor. Of those undergoing GTT or with existing GDM 68.8% could name at least one GDM risk factor (no difference between groups, p=0.59). Knowledge of individual risk factors was low; "high BMI" was the most commonly reported (by only 30.6%). Most respondents were able to name at least one complication of DIP for babies (74.4%), and for long term maternal health (65.1%). Those in the DC group were more likely to name these complications (p=0.02 & p=0.003 respectively). Patients in both groups reported declines in their wellbeing and health in

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pregnancy, however the DC group had lower perceptions of these realms prior to pregnancy (see Table 1). Most patients attending the DC found online blood sugar record to be useful (95.0%), and 81.7% would choose it again.

Conclusions

Knowledge of individual risk factors for GDM and DIP complications were low, highlighting an area of potential patient education. Online blood sugar reporting was well-received, suggesting a potential platform for delivering further education.

Tweetable Abstract

Knowledge of risk factors for GDM and complications of diabetes in pregnancy are low in those undergoing screening, and can improve with dedicated diabetes education – online blood sugar reporting is well received & may suggest a platform for delivery of education #diabetes

Table 1. Perception of health and wellbeing prior to and during pregnancy for those undergoing GTT and attending the DM clinic. Data collected via Likert scale (1 = very poor, 2 = poor, 3 = average, 4 = good, 5 = excellent), and presented as mean with standard deviation. Scores were compared for each group prior to and during pregnancy using Wilcoxon's Signed Rank test, and between groups using the Mann-Whitney U-test.

		GTT M(SD)	DM Clinic M(SD)	p (GTT - Prior to vs During Pregnancy)	p (DM Clinic - Prior to vs During Pregnancy)	p (GTT vs DM Clinic)
Prior to Pregnancy	**Physical Health**	3.9 (0.71)	3.7 (0.58)			0.117
	Mental Health	4.1 (0.70)	3.9 (0.36)			**0.012**
	Overall Wellbeing	4.1 (0.58)	3.9 (0.30)			**0.014**
	Diet	3.7 (0.70)	3.4 (0.64)			**0.005**
	Ability to Exercise	3.8 (0.84)	3.5 (0.77)			**0.022**
During Pregnancy	**Physical Health**	3.6 (0.84)	3.4 (0.77)	**<0.001**	**0.003**	0.391
	Mental Health	3.8 (0.71)	3.7 (0.55)	**0.001**	**0.003**	0.061
	Overall Wellbeing	3.8 (0.64)	3.7 (0.57)	**<0.001**	**0.007**	0.488
	Diet	3.5 (0.60)	3.6 (0.65)	**0.006**	**0.023**	0.289
	Ability to Exercise	3.1 (0.82)	3.0 (0.96)	**<0.001**	**<0.001**	0.698

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LOCATION, LOCATION, LOCATION: PRE-ECLAMPSIA AT THE THRESHOLD OF VIABILITY

Topic / Dept: (1) Royal College of Surgeons in Ireland, Dublin. (2) Rotunda Hospital, Dublin. (3) University Hospital Waterford, Waterford, Ireland.

Author: Williams, L (1)

Co Author: Daly, R (1,2)

Co Author: O'Donnell, E (1,3)

Background: Pre-eclampsia remains a leading cause of maternal morbidity and mortality. The development of pre-eclampsia at a periviable gestational age can complicate an already challenging diagnosis.

Case description: We present the case of a 36 year-old G3P2 at 23+0 weeks with pre-eclampsia on a background of essential hypertension with superimposed gestational hypertension. The patient presented to Waterford Regional Hospital with asymptomatic hypertension and significant proteinuria 7 days after her initial diagnosis with gestational hypertension. Aspirin and labetalol had been commenced from booking. Her previous pregnancy was complicated by eclampsia leading to a preterm Caesarean delivery at 29+3 weeks gestation.

In this pregnancy, foetal ultrasound revealed oligohydramnios, a falloff in foetal growth from the 57th to 10th centile and a decreased abdominal circumference. She was admitted for observation, blood pressure monitoring and growth surveillance. In view of the patient's hypertensive disease history and periviability, consideration was given for transfer to a tertiary referral centre.

Discussion: The management of evolving hypertensive disease requires consideration of multiple factors, including consideration of delivery. The development of pre-eclampsia at a peri-viable gestational age necessitates a multi-disciplinary team approach involving obstetric and neonatal input. Discussions regarding prognosis and survival at 23+0 weeks of gestation are crucial in order to ensure adequate patient counselling. Other considerations include the availability of neonatal intensive care for a peri-viable foetus. Transfer to a tertiary hospital unit to accommodate a peri-viable delivery has significant implications for a patient, including cost and distance from supports.

Conclusion: This case highlights several factors involved in managing significant gestational disease at peri-viability, including NICU eligibility and prognostic factors. These factors require discussion and communication between hospitals, specialties and healthcare professionals.

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Total characters: 2094

Tweetable Abstract

Location, location, location: Pre-eclampsia at the threshold of viability; a challenging case of severe pre-eclampsia at 23+0 weeks gestation in a regional hospital unit.

Total characters: 170

Twitter handles of authors:
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Official Journal of the Irish Medical Organisation

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MANAGEMENT OF EPILEPSY IN PREGNANCY AND THE NEW EPILEPSY SERVICE AT THE COOMBE HOSPITAL, A SERVICE DELIVERY AUDIT

Topic / Dept: [1]The Coombe Hospital, Dublin

Author: [1]P O'Dwyer

Co Author: [1]J Hogan

Background

Epilepsy is the most common neurological disease in pregnancy. In the latest MBRACE report (2023) seventeen maternal deaths related to epilepsy were recorded[3]. International guidelines recommend that WWE should attend specialist care, where they receive up-to-date information on managing epilepsy in pregnancy[1,2]. This includes medication adherence, intrapartum analgesia and postnatal care. A specialised epilepsy service was established in the Coombe Hospital in 2022.

Objectives

The purpose of the audit was to review the first year of service of the specialist epilepsy service at the Coombe Hospital. It also included adherence to the national guideline for management of women with epilepsy, specifically[1]:

- 5.1.1- All women of childbearing potential should be prescribed 5mg folic acid for at least 3 months into pregnancy.
- 5.2.3: Registered ANP should review the WWE and provide them with relevant information regarding pregnancy that the women needs to consider.
- 5.3.5: WWE should be encouraged to have a written care plan detailing medications to avoid and those to be given if the women has a seizure in hospital.
- 5.5.1: A care plan should be developed for WWE in the postnatal ward based on birth plan developed.

Study design/method

Anonymised data was collected on all woman who attended the combined epilepsy and obstetric clinic during its first year of service between 1st June 2022- 31st June 2023. Data that was collected included patient demographics, obstetric and epilepsy history, medication use and delivery outcomes for all WWE. All charts from this time were reviewed retrospectively. Data was collected and descriptive statistics completed using Windows Excel.

Findings of the study

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A total of 41 women attended the epilepsy clinic during its first year of service. We found that only 68% of women used high dose folic acid during their pregnancy. We found that 100% of women were reviewed at least once per trimester by an epilepsy specialist nurse and that 100% of women were provided with information and education on antenatal, intrapartum and postnatal considerations specific to epilepsy. We found that no women had an epilepsy specific intrapartum or postnatal care plan in their healthcare record.

Conclusion

Overall, we found that antenatal education and access to information for WWE was improved by our specialist epilepsy clinic. Birth outcomes overall were excellent, however improvements in high dose folic acid adherence could be made. We recommend the introduction of a standardised intrapartum and postnatal care plan for WWE detailing analgesic considerations and techniques to minimise seizures.

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Maternal & Neonate outcome among Gestational Diabetic Patients at Midland regional Hospital Portlaoise

Topic / Dept: Midland regional Hospital Portlaoise, Block Rd, Kilminchy, Portlaoise, Co. Laois

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Co Author: Eman Ibrahim[1]

Co Author: Ola Mohamed[1]

Co Author: Dr. Rawia Debo

Conflict of Interest

All authors declare that they have no conflict of interest.

Abstract

Gestational diabetes mellitus (GDM) is a condition characterized by glucose intolerance that is first recognized during pregnancy. Approximately 9-25% of pregnancies worldwide are impacted by the acute and long-term complications of GDM. Key risk factors for GDM in Ireland include increasing maternal age, higher body mass index (BMI), and a family history of diabetes. The condition poses short- and long-term health risks for both mothers and their offspring, including preeclampsia, macrosomia, and increased likelihood of type 2 diabetes later in life. The major concerns during the third trimester in pregnancies complicated by diabetes are foetal distress and the potential for birth trauma associated with foetal macrosomia. This was a cross sectional retrospective study for 30 patients with GDM, who gave birth in the period from 1st/ July to 31st/December /2023, in midland regional hospital Portlaoise were observed to determine their outcome, any maternal or neonatal complications. In conclusion, the study yielded encouraging results. The findings demonstrate that with timely diagnosis, appropriate management, and individualized care, gestational diabetes can be effectively controlled, minimizing adverse maternal and neonatal outcomes. Both maternal and neonatal health indicators, such as birth weights, incidences of preterm deliveries, and rates of caesarean sections, were generally favourable.

Introduction

Gestational diabetes mellitus (GDM) is a condition characterized by glucose intolerance that is first recognized during pregnancy. Approximately 9-25% of pregnancies worldwide are impacted by the acute and long-term complications of GDM, with higher rates observed in populations with increased maternal age, obesity, and ethnic predisposition [1]. GDM is associated with

several maternal and foetal complications, including preeclampsia, macrosomia, neonatal hypoglycaemia, and increased risk of caesarean delivery [2]. Long-term consequences for mothers include a heightened risk of developing type 2 diabetes and cardiovascular disease, while children born to mothers with GDM are at greater risk for obesity and glucose intolerance later in life. The diagnosis of GDM is typically made between 24-28 weeks of gestation using an oral glucose tolerance test (OGTT), though early screening may be performed in high-risk individuals [3, 4]. Management of GDM focuses on controlling blood glucose levels through dietary modifications, physical activity, and regular glucose monitoring. In cases where lifestyle interventions are insufficient, insulin or oral hypoglycaemic agents may be prescribed [5]. Early diagnosis and effective management are critical to minimizing complications. Postpartum follow-up is recommended to monitor for the development of type 2 diabetes, underscoring the importance of long-term care for both mothers and their offspring.

Pregnant women may become critically ill due to pregnancy- and non-pregnancy-related comorbidities. Common causes for peripartum ICU admissions are hypertension, preeclampsia, eclampsia, PPH, and maternal sepsis. Non-pregnancy related conditions include infections, hypertension, diabetes mellitus, asthma, and cardiac defects [6, 7].

GDM is a significant public health concern in Ireland. Key risk factors for GDM in Ireland include increasing maternal age, higher body mass index (BMI), and a family history of diabetes. The condition poses short- and long-term health risks for both mothers and their offspring, including preeclampsia, macrosomia, and increased likelihood of type 2 diabetes later in life. The major concerns during the third trimester in pregnancies complicated by diabetes are foetal distress and the potential for birth trauma associated with foetal macrosomia [8].

Third- and fourth-degree tears are significant complications in women with increased maternal age and birthweight ≥4500g. Women are more likely to have a repeat third- or fourth-degree tear or an elective caesarean section in the second pregnancy [9]. It was found there is no increased risk of lower genital tract tears that pregnant women with diabetes with no previous history of a caesarean section and who gave birth vaginally to a single child at term or near term. Nulliparous women with Type 1 diabetes mellitus were found to have a higher risk of episiotomy [10].

The aim of the current study was to assess neonatal outcome and maternal outcome of pregnant women with gestational diabetes. Maternal outcomes include number of caesarean sections, third- & fourth-degree tears, postpartum haemorrhage, admission to Intensive Care Unit (ICU). Neonatal outcomes include the incidence of shoulder dystocia, hypoglycaemia & admission to Special Care Baby Unit (SCBU).

Less than third of GDM patients delivered with lower segment caesarian section, about 6 % of GDM patients had third & fourth degree tear , same percentage of women (6%) had

complication of PPH . Around 3% had admitted to ICU. Regarding Neonatal outcome : 6% of Neonate were preterm birth (delivered before 37 weeks) & 10 % of neonate were admitted to SCBU.

Method

This was a cross sectional retrospective study for 30 patients with Gestational diabetes (GDM), who gave birth in the period from 1st/ July to 31st/December /2023, in midland regional hospital Portlaoise were observed to determine their outcome, any maternal or neonatal complications. The study was approved by Midland Area Research Ethics Committee.

Results

Figure 1. Number of pregnant women who gave birth at a gestational age < 38 weeks compared with women who gave birth at ≥38 weeks. Figure 2. Number of pregnant women who delivered by vaginal route compared to women who had caesarean delivery. Figure 3. Incidence of third- and fourth-degree tear and PPH Figure 4. Number of women who were admitted to ICU. Figure 5. Number of babies who had preterm delivery and number of babies who required SCBU admission.

Discussion and conclusion

It has been found that pregnant women with a previous history postpartum haemorrhage (PPH) are at increased risk of experiencing a subsequent PPH requiring transfer to obstetric care, compared with other multiparous women who have not had a PPH [11].

Shoulder dystocia complicates up to 3% of vaginal deliveries [12]. Maternal complications with shoulder dystocia include a postpartum haemorrhage rate of 11% and a third- and fourth-degree perineal laceration in 4% of cases [13].

Public health efforts in Ireland are increasingly focused on early detection and improved prenatal care, with an emphasis on preventing long-term complications. However, challenges remain in optimizing care, particularly regarding access to specialist services and managing GDM in high-risk groups such as those from socio-economically disadvantaged backgrounds. Further research and policy development are needed to address the growing incidence of GDM and its associated health burdens in Ireland. Standardized Management of GDM patients will improve Maternal and Neonatal outcome which will lead to efficient management of complication if occurred. Half yearly audit to improve GDM patient care and outcome, and to Raise staff awareness about GDM patients care and management.

In conclusion, the study yielded encouraging results. The findings demonstrate that with timely diagnosis, appropriate management, and individualized care, gestational diabetes can be

effectively controlled, minimizing adverse maternal and neonatal outcomes. Both maternal and neonatal health indicators, such as birth weights, incidences of preterm deliveries, and rates of caesarean sections, were generally favourable.

Acknowledgements:

The authors would like to thank the multidisciplinary teams at Midland regional Hospital Portlaoise for their excellent care of the patients.

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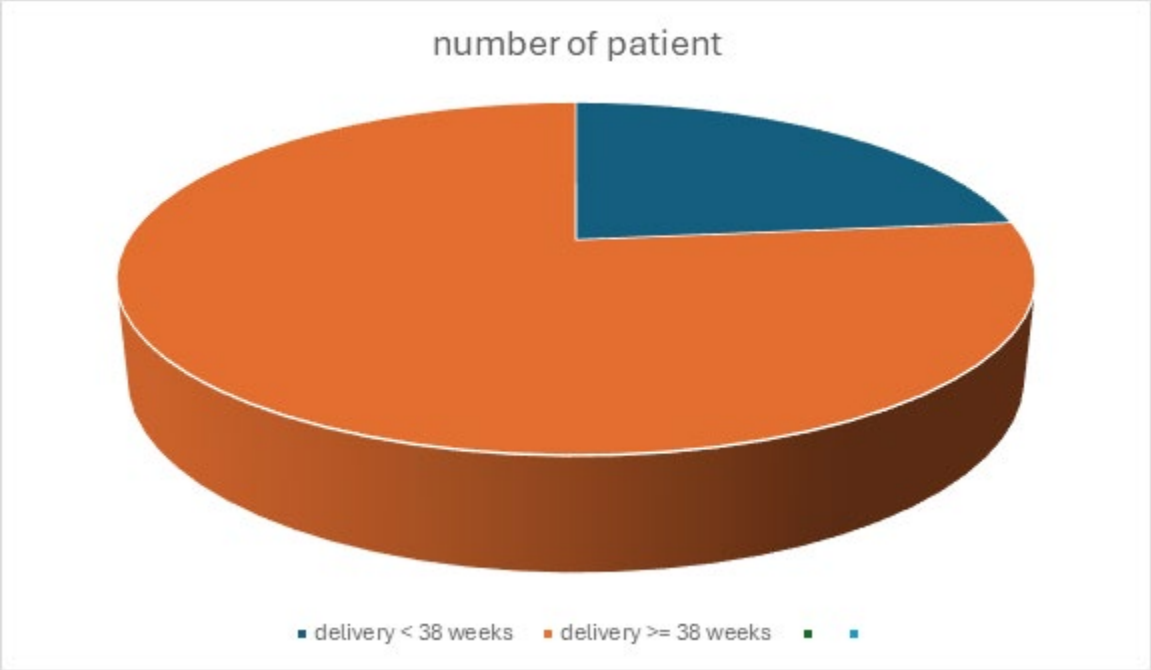

Figure 1. Number of pregnant women who gave birth at a gestational age < 38 weeks compared with women who gave birth at ≥38 weeks.

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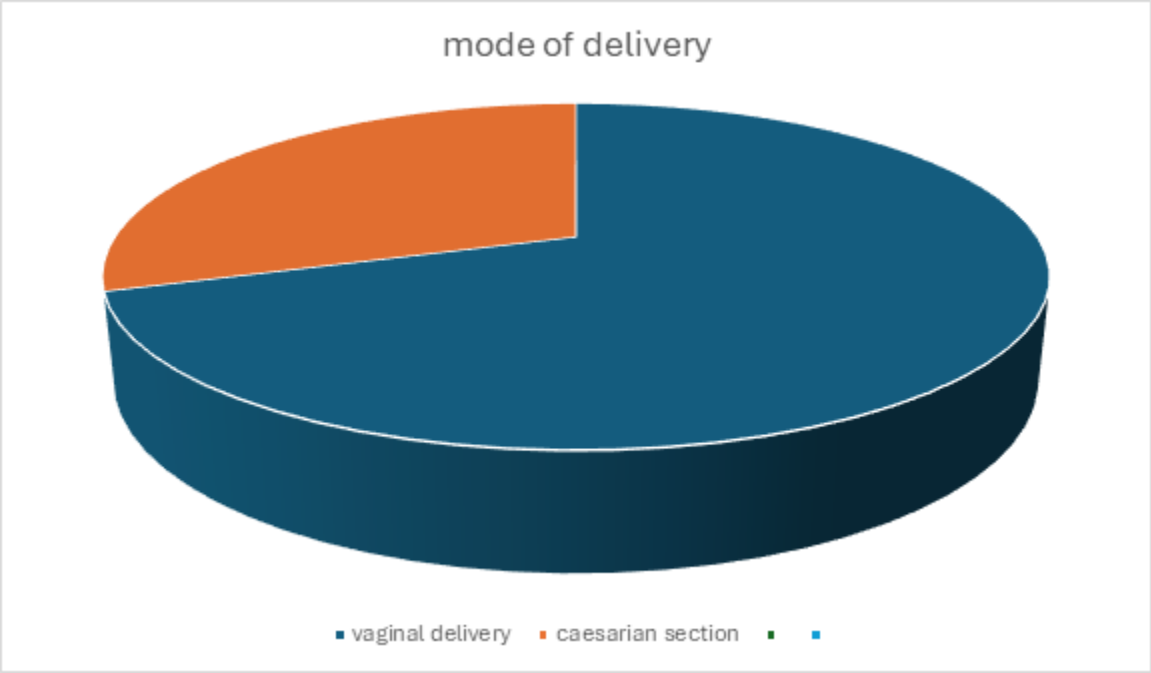

Figure 2. Number of pregnant women who delivered by vaginal route compared to women who had caesarean delivery.

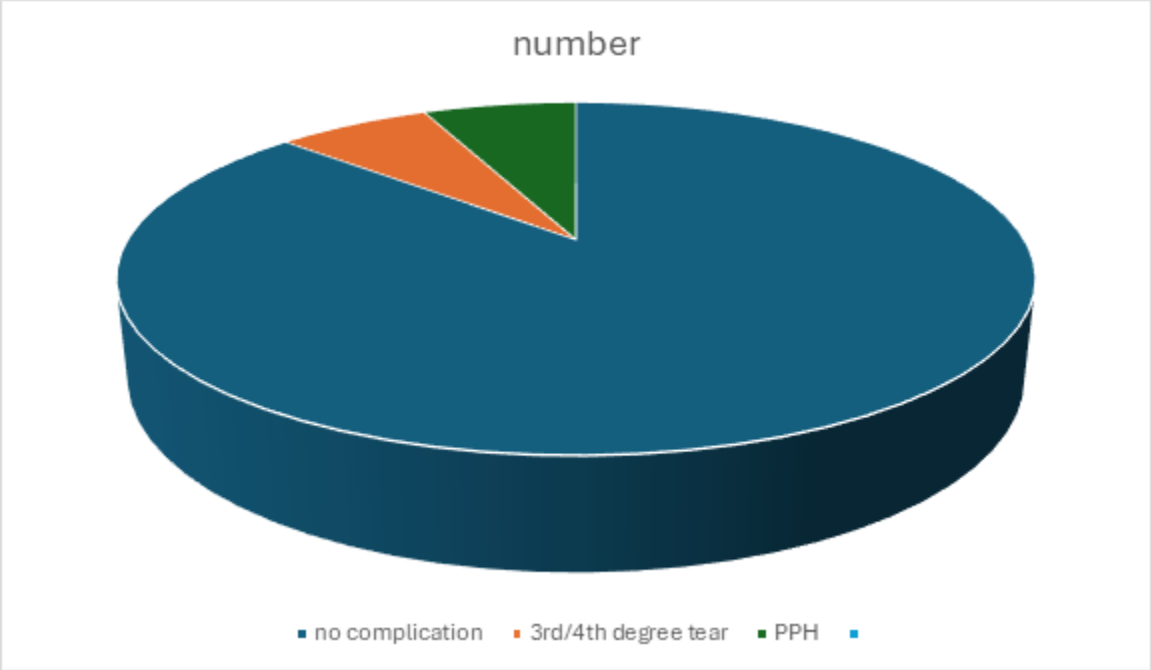

Figure 3. Incidence of third- and fourth-degree tear and PPH

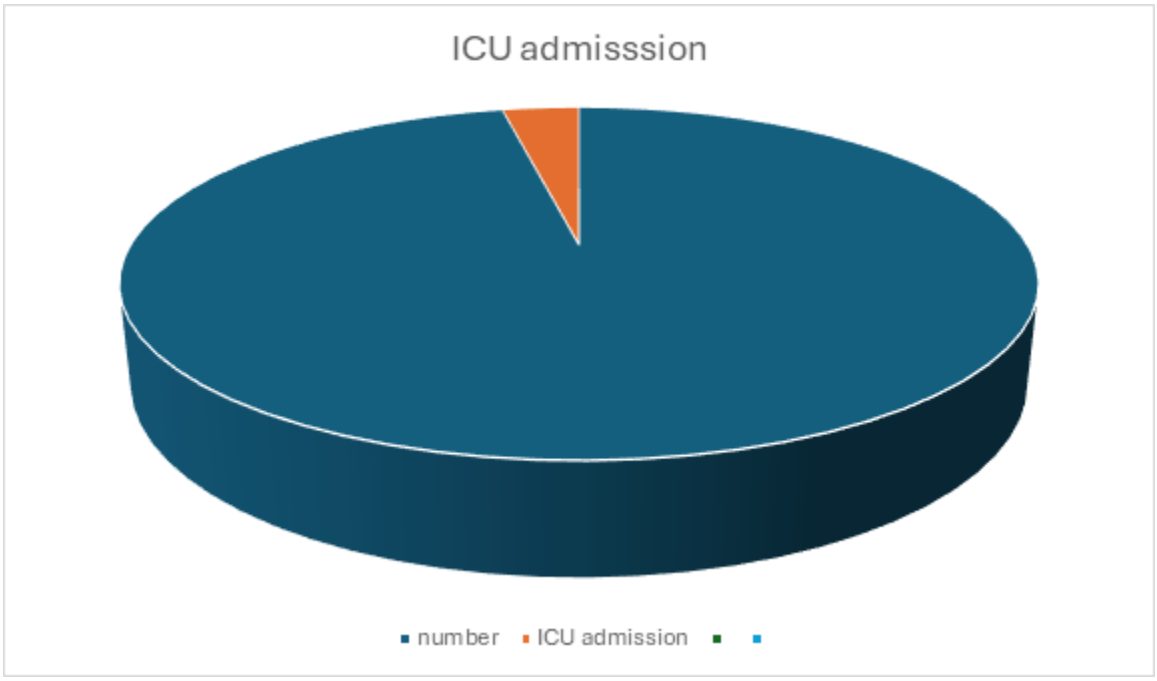

Figure 4. Number of women who were admitted to ICU.

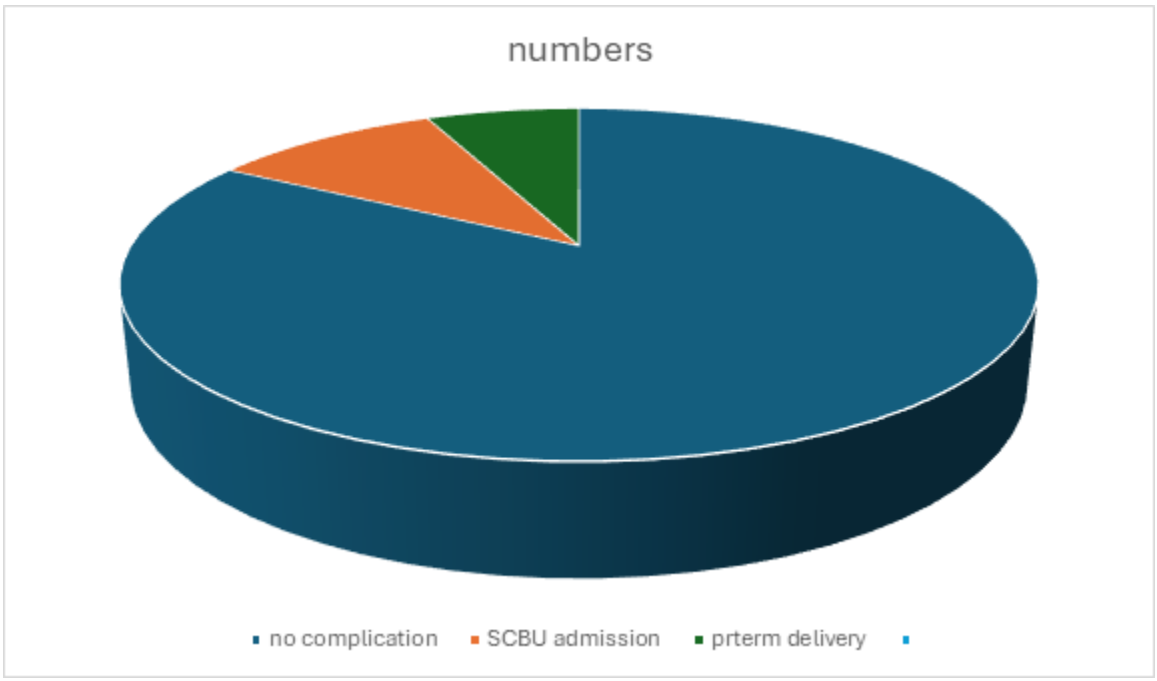

Figure 5. Number of babies who had preterm delivery and number of babies who required SCBU admission.

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OBSTETRIC OUTCOMES FOLLOWING A FAILED NIPT AT A MAJOR IRISH TERTIARY MATERNITY CENTRE.

Topic / Dept:

Rotunda Hospital, Dublin 1, Ireland
Royal College of Surgeons in Ireland, Dublin 2, Ireland.

Author: Shah. A

Co Author: Cooley. S

Co Author: Daly S

Background

Non-Invasive Prenatal Testing (NIPT) screens for fetal chromosomal abnormalities, such as Trisomy 21, 18, 13, and Monosomy X. The test analyses cell-free fetal DNA in maternal blood after the 9th gestational week. A percentage of tests fail to yield a result, raising questions about why this occurs and its implications.

Aim

To investigate obstetric outcomes in women who failed to obtain NIPT results from 2021 to 2023.

Methods

This retrospective cohort study compared maternal characteristics and obstetric outcomes of women with failed NIPT from 2021-2023 at the Rotunda Hospital to the general Irish obstetric population.

Results

Of 5,525 NIPTs at Rotunda Hospital (2021-2023), 2.7% (n=148) failed to yield a result. In this cohort, 29.7% developed Gestational Diabetes Mellitus (GDM) versus 12.4%[1] of the overall Irish maternity population. Hypertensive disorders of pregnancy (HDP) occurred in 10.8% of the cohort, almost double the rate in the general population (5.9%)[2]. Chromosomal aneuploidies were found in 7.4% of pregnancies. The mean Body Mass Index was 29.8 kg/m², and the average maternal age was 37.1 years.

Conclusion

Successful NIPT has a sensitivity rate of >99%, however it can fail to return a result in about 1-3% of women. This is usually due to insufficient amounts of cell-free fetal DNA in maternal blood

which can often be because of early gestational age, pre-existing disease, and increased maternal weight. Our study reports that this "no result" can also give us an insight into future pregnancy outcomes, where these women are more likely to develop adverse obstetric outcomes such as GDM and HDP.

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Oral Bifidobacterium breve supplementation alters Short Chain Fatty Acid Production in the Gut Metabolome: results from a randomised controlled trial

Author: Gillian Corbett

Co Author: Rebecca Moore

Co Author: Fionnuala McAuliffe

Background:

The gut metabolome is a key regulator of human health, with implications on pregnancy physiology including gluconeogenesis, blood pressure regulation and immune activation. These functions are actioned by Short-Chain-Fatty-Acids (SCFAs) in the gut metabolome, generated from the diet by gut microbiota such as Bifidobacterium spp. The objective is to explore the impact of oral supplementation with Bifidobacterium Breve on gut metabolome SCFA production in pregnancy.

Methods:

This is a secondary analysis of a double-blinded randomised placebo-controlled trial, the MicrobeMom Study, conducted at the National Maternity Hospital (NMH), Dublin (2016-2019). Participants in the intervention arm received oral probiotic of Bifidobacterium Breve 702258 from early pregnancy through to delivery. The control arm received placebo. Stool samples were collected at baseline and after 18 weeks of therapy (16 vs 34 weeks' gestation). Faecal SCFA levels were assessed using Nuclear magnetic resonance Spectroscopy (NMR)

panels. Researchers were blinded to allocation. Ethics was approved by NMH Ethics Committee (EC 35. 2015).

Results:

Of 160 women randomised to MicrobeMom, 116 had paired stool samples at 16 (pre-) and 34 weeks' gestation (post-intervention). Treatment with Bifidobacterium Breve oral probiotic saw significantly smaller rise in Phenylalanine (5.6 vs 25.8 nmol/L, p=0.038, Table 1). There was also smaller rise in Glycine (16.4 vs 50.6 nmol/L, p=0.073), Tyrosine (6.0 vs 24.1 nmol/L, p=0.063) and Valerate (6.6 vs 52.2 nmol/L, p=0.088), but these did not achieve statistical significance.

Conclusion:

These novel data demonstrate metabolome benefits of oral Bifidobacterium breve probiotic therapy in the gut via altering Short Chain Fatty Acids. These data demonstrate the functional signature of oral probiotics, illustrating the enigmatic pathways through which probiotics illicit health benefits.

Tweetable abstract:

Oral Bifidobacterium breve supplementation alters Short Chain Fatty Acid Production in the Gut Metabolome

Table 1. Effect of Probiotics vs Placebo on SCFA trends between 16 weeks' and 34 weeks' gestation, measured using NMR Spectroscopy

SCFA Assay	Probiotic therapy	Placebo	p-value
Acetate*	1841 (6554)	2845 (10368)	0.586
Butyrate	543.2 +-2138.4	733.7 +- 2165.8	0.634
Formate	37.5 (108.0)	54.9 (105.0)	0.381
Lactate*	1.1 (29.7)	0.3 (47.1)	0.436
Propionate*	293.0 (1464.0)	451.0 (2815.0)	0.313
Pyruvate*	1.0 (12.6)	-1.0 (12.6)	0.594
Glutamate*	32.1 (510.0)	-15.6 (637.0)	0.851
Glycine*	16.4 (146.0)	50.6 (180.0)	0.073
Phenylalnine*	5.6 (64.1)	25.8 (52.4)	0.038
Tyrosine*	6.0 (73.6)	24.1 (49.4)	0.063

Valerate*	6.6 (333.0)	52.2 (421.0)	0.088

Footnotes: All concentrations are in nmol/Litre. P values are calculated comparing probiotic vs placebo values, using t-test for normal data or Wilcoxin-rank based test for non-normal data. *log-transformed values used to determine p value. Positive values denote an increase in assay between timepoints. Negative values denote decrease in values between timepoints.
SCFA = Short Chain Fatty Acids. NMR = Nuclear Magnetic Resonance

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Placenta praevia: A Bibliometric Analysis

Topic / Dept:

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2. Department of Surgery, RCSI, Dublin, Ireland
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Abstract

Background

Bibliometric analyses have been performed on several obstetric topics, but this is the first bibliometric analysis, to our knowledge, which has been conducted to determine the most cited papers on placenta praevia. This was done to evaluate the impact of scientific contributions and the dynamics of research collaboration on placenta praevia and to identify the evolution of trends and new directives.

Objective

To identify the most cited papers published on placenta praevia, evaluate the evolution of trends and determine new directives and directions in placenta praevia research utilizing VOSviewer software.

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Methods

A comprehensive search was done on the Web of Science Core Collection(WoS) using the terms 'Placenta Praevia' or 'Placenta Previa' in the 'TITLE' search query with no limitations on language or date range. The search yielded 1,558 results with papers spanning the years 1945 to 2023. The WoS was then used to sort these results into the top 100 cited papers. The VOSviewer software 1.6.20 was used to generate bibliometric visualizations for the top 100 cited papers. The WoS Journal citation reports were used to record the Eigenfactor Score and five-year Journal Impact factor for the journals.

Results

The identification of clinical risk factors, guidelines for management and the association with placenta accreta was the focus of most papers in the top 100 cited papers of placenta praevia. The most cited paper was Miller, DA et al(659 citations). The Am J Obstet Gynecol. published the highest number of papers(n=24, 2,587 citations), but the Obstet Gynecol. had the highest number of citations(n=18, 2,735 citations). The US produced the greatest number of publications(n=44).

Conclusion

Placenta praevia is one of the most common causes of antepartum haemorrhage and other obstetric complications affecting pregnant people. It has been researched and described in medical literature, but to our knowledge this is the first bibliometric analysis conducted on placenta praevia providing insight into the research landscape surrounding the topic.

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Pregnancy after vertebral artery dissection and PCA infarct in a young woman

Topic / Dept: SHO, Department of Obstetrics and Gynaecology, Sligo University Hospital

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Co Author: Baskaran, R.B.

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Dr Heather Langan, Consultant Obstetrician, Department of Obstetrics and Gynaecology, Sligo University Hospital

Main abstract:

2% of all ischemic strokes are thought to be caused by vertebral artery dissection, being as high as 10%-25% among 30-45 years. 2.6 out of 100,000 people have both carotid and vertebral artery dissections. Carotid artery dissections occur 3-5 times more frequently than vertebral artery. Ischemic strokes occur when blood cannot flow to cerebral structures. PCA stroke presents as constellation of neurological symptoms. Most prevalent long-term effects of PCA strokes are deficiencies in vision and senses. PCA distribution manifests with less total chronic disability than anterior cerebral, middle cerebral, or basilar artery infarctions.

We present the case of a 23-year-old female who presented with blurring of vision lasting 10-15 minutes while driving home after gym. This culminated in a severe headache, associated with vomiting, intermittent headache and right sided paresthesia. No neck stiffness, palpitations or photophobia were reported. All blood investigations were normal; hence we went ahead with a CT brain and MRA brain and neck. Scans were keeping with a left vertebral artery dissection and distal embolisation to the left PCA. ECHO and an extensive vasculitis screen were done which was normal.

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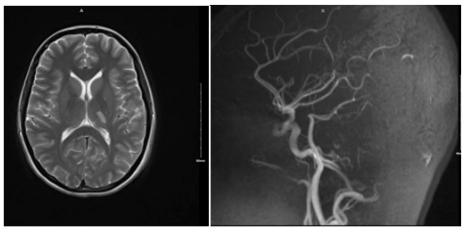

She was treated with Warfarin for 6 months and on lifelong aspirin. She had no residual neurological deficit. She then conceived via IVF and presented 5 years later for her antenatal booking visit at 28 years old, with VTE score of 6 and LMWH for thromboprophylaxis and aspirin was started promptly. Mode of delivery was discussed with patient after thorough MDT querying if vaginal delivery was contraindicated. After routine antenatal care, induction of labour offered at 40+2 weeks, for pregnancy induced hypertension on treatment. She progressed in labour and reached full dilatation after augmentation with oxytocin. Decision was made for ventouse delivery by Kiwi cup for pathological CTG. Healthy baby girl weighing 3430 g was delivered with blood loss of 700 ml. She had routine postnatal care and discharged 2 days after delivery, with 6 weeks LMWH prescription.

Citation:

NIH National library of medicine
Stat-pearls
https://www.ncbi.nlm.nih.gov/books/NBK441827/#:~:text=The%20combined%20incidence%20of%20both,to%20be%202.6%20per%20100%2C000.

Erek K Helseth, MD Vascular and Interventional Neurologist, Vascular Neurology SoCal Erek K Helseth, MD is a member of the following medical societies: American Academy of Neurology

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Conclusions: The percentage of the population screened for IHCP has increased from 2.8% to 6.9%, suggesting either increased awareness or increased symptoms suggestive of IHCP. The new RCOG diagnostic criteria for IHCP dramatically lowered the prevalence of diagnoses of IHCP.

2095 characters of 2100 permitted

Tweetable abstract

Following the publication and assimilation into practice of the RCOG Guideline on Intrahepatic Cholestasis of Pregnancy, the percentage of patients diagnosed with IHCP after screening has reduced by 45%, despite increasing number of pregnant people being screened.

@KarimaAbubakr @mairenihuigi

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Subsequent pregnancy outcomes following mid-trimester loss analyzed by etiological category a retrospective cohort study

Background

Mid Trimester Loss occurs in 2-3% of pregnancies due to many diverse pathologies. MTL is a risk factor for subsequent poor obstetric outcomes.

Objective

This study seeks to describe the subsequent pregnancy outcomes following MTL analyzed by the etiological category of the loss.

Study Design

This was a retrospective cohort study on 353 cases of MTL (14+0 - 23+6 weeks of gestation) at a tertiary level maternity hospital with approx. 7000 deliveries per annum from 2018 to 2023. Cases were identified using the "HIPE" electronic billing system.

After excluding 6 cases for missing data, 95 that were actual first trimester losses but diagnosed after 14 weeks, 60 cases of fetal anomalies and 8 recurrent instances of MTL, we focused on 184 patients. Of these, 111 had at least one second pregnancy during the study period. They were subdivided into two groups: GROUP A n=40 (36.04%) presenting with either a pPROM (preterm prelabour rupture of membranes) or a SM (spontaneous miscarriage) and GROUP B n=71 (63.96%) presenting with an IUFD (intrauterine fetal demise).

Results

Of these 111 women, 86 (77.48%) had a subsequent full-term birth (≥ 37+0), with a slight difference between the two groups (A vs B: 80.00% vs 76.06%, p-value 0.635).

The subsequent pregnancy PTB rate was 12.61% overall (n14), higher in GROUP A (17.50%) than in GROUP B (9.86%).

Recurrent MTL occurred in 13 women (11.71%), with a lower recurrence rate in GROUP A (7.50%) than in GROUP B (14.08%).

First trimester loss (FTL) occurred in 26.13% (n29) overall, and the difference between the two groups was significant: 40.00% (16/40) in GROUP A vs 18.31% (13/71) in GROUP B (p-value 0-013).

Conclusion

A high proportion of women experiencing a MTL (77.48%) will subsequently have at least one FTB.

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However, MTL is associated with a high risk of future PTB, recurrent MTL and FTL. History of MTL should prompt referral to a high-risk care pathway.

Given the differences between GROUP A and GROUP B, it is critical to understand the context of previous MTL in order to properly counsel patients.

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THE ACCEPTABILITY OF CONTINUOUS GLUCOSE MONITORING IN EARLY PREGNANCY

Topic / Dept:

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Background
Gestational Diabetes Mellitus (GDM) is a common metabolic pregnancy disorder which is caused by insulin resistance and can lead to adverse fetal and maternal outcomes. An oral glucose tolerance test (OGTT) is the current gold standard but is known to be flawed due to procedural analytical issues and poor patient compliance. There have been research efforts to ascertain other diagnostic methods, with Continuous Glucose Monitoring (CGM) offering a strong alternative.

Objective
This study aims to investigate the acceptability of CGM sensors by non-diabetic gestational patients for the diagnosis of GDM.

Study Design and Methods
An observational study was conducted including non-diabetic pregnant patients in the first trimester with one or more risk factors for GDM. The patients were given a questionnaire to fill after wearing the CGM sensor for 14 days. The acceptability of the sensors was evaluated through a questionnaire questioning the following key factors: patients' physical comfort and discomfort, ease of use, impact on daily life, attitude towards the sensor, experience in comparison to finger prick tests, perceived value of CGM sensors in pregnancy, and motivation to participate.

Findings/Results
A total of 124 patients completed the questionnaire, with initial findings indicating positive patient experience and high acceptability. The participants disclosed that the sensor was

generally comfortable and that it minimally interfered throughout the day and night. When compared to a common alternative, finger prick test, patients overwhelmingly reported that it was less painful and more convenient. A very small group of patients mentioned discomfort and itchiness when the sensor was worn, there were also a few concerns raised about the sensor potentially falling off or hitting objects while manoeuvring through daily tasks.

Conclusions

CGM was well tolerated and accepted by the cohort, demonstrating its potential in diagnosing GDM. Further research is needed to evaluate the clinical validity and cost-effectiveness of CGM sensors for this diagnostic use.

Tweetable abstract: A study found high acceptability of Continuous Glucose Monitoring (CGM) among non-diabetic pregnant women for diagnosing gestational diabetes, with participants reporting comfort and convenience over finger prick tests. Further research is needed to confirm its clinical validity.

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THE CLINICAL IMPACT OF THE ONETOUCH APPLICATION IN PATIENTS WITH GESTATIONAL DIABETES IN MAYO UNIVERSITY HOSPITAL

Topic / Dept:

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Background:
Gestational diabetes mellitus (GDM) is a major complication of pregnancy which is associated with a range of maternal and neonatal adverse outcomes. These complications may potentially be prevented by tight glycaemic control. Telemedicine assumes a pivotal role which can be used to enhance maternal health and self-management of GDM.

Aim:
This study aimed to investigate the clinical impact of the OneTouch smartphone application on maternal and neonatal outcomes in Mayo University Hospital.

Methods:
This was a retrospective cohort study. Data was collected from hospital patient records and analysed using SPSS. For categorical data chi squared tests were used, whereas independent t tests were used to analyse continuous variables. A binary logistic regression was performed for each outcome adjusting for maternal age, BMI, parity and ethnicity.

Results:
A total of 201 women were in the application group and 178 women were in the pre-application group. Application use was associated with decreased macrosomia, 8.3% (n=17) compared to 16.1% (n=29) (p=0.02).
Several outcomes had very few cases (poly/oligohydramnios, placenta previa, hypertension, intrauterine growth restriction, congenital abnormalities etc). When analysed together, however, all adverse outcomes were reduced in the application group 9.8% (n=20) vs 20.0% (n=36), OR=0.44, 95% CI [0.24, 0.80], p=0.01.

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There was an increase of insulin and/or metformin use within the application group 68.8% vs 58.4% in the pre-application group (OR=1.66, 95% CI [1.07, 2.57], p=0.03).
A total of 54.2% (n=109) of women delivered via cesarean section in the application group vs 41.6% (n=74) in the pre-application group (OR=1.94, 95% CI [1.26, 2.98], p=0.01).

Conclusion:
The OneTouch application provides a patient-monitored service with real-time results accessible to healthcare providers electronically. The results indicate the application to be an effective clinical method of monitoring glycaemic control allowing for fast intervention and improving maternal and neonatal outcomes.

THE VALUE OF A MULTI-DISCIPLINARY TEAM IN THE MANAGEMENT OF PREGNANT PATIENTS WITH TYPE IIIA GLYCOGEN STORAGE DISEASE

Topic / Dept:

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Background: Glycogen Storage disease (GSD) Type IIIa is a rare autosomal recessive metabolic disorder affecting approximately 1 in 100,000 live births[1]. The disorder affects glycogen synthesis leading to ketotic hypoglycemia and diverse multi-organ manifestations affecting liver, cardiac, and skeletal muscle[2,3].

Objective: Managing GSD in pregnancy poses a challenge owing to increased metabolic demands[2]. There is a sparsity of literature on the topic. We aim to describe a case managed successfully within the multi-disciplinary teams at two different institutions.

Study Design: Case report

Findings: We discuss a case of a 22-year-old primigravida who presented at 14 weeks gestation. She had a known history of GSD IIIa since early childhood. Pre-pregnancy, she had reasonable metabolic control, however had previously documented cardiomyopathy, deranged liver function, hepatosplenomegaly and elevated creatine kinase (CK).

During the antenatal period, she was seen fortnightly with regular phlebotomy to assess metabolic control. Serial fetal growth and maternal echocardiography were performed. Antenatal anaesthesiology review was arranged, as well as close liaison with pharmacy, dietetics and midwifery. Pre-eclampsia was diagnosed at 39 weeks' gestation, coincidental with deteriorating metabolic function. She had an emergency Caesarean section following an induction of labour and delivered a liveborn female infant weighing 3.2kg due to non-reassuring fetal cardiotocography. During the intrapartum period, she was strictly managed with titrated 10% dextrose, serial blood glucose levels, aiming to maintain euglycemia of 4-8 mmol/L. During the postpartum period, prolonged fasting was avoided, with resumption of oral high protein diet in the immediate aftermath of the birth. She was discharged home day 5 following improvement in her haematological parameters.

Conclusions: This report emphasizes the importance of collaborative management of complex rare disorders in pregnancy and proposes to enrich the limited data in the literature.

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TRENDS IN PREVALENCE IN BARIATRIC SURGERY IN THOSE ATTENDING FOR BARIATRIC CARE:EXPERIENCE FROM THE COOMBE AND NATIONAL MATERNITY HOSPITALS

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Background: Bariatric surgery increases risks to both the parent and fetus during pregnancy. These include maternal malabsorption and undernutrition and need for surgical intervention for gastric related complication. Fetal risks include intra-uterine growth restriction and pre-term birth. Specialist care is required pre-pregnancy, during pregnancy and postnatally for these patients, however no formalised approach to this exists nationally at present.

- Methods: We undertook a retrospective review of patients reporting a history of previous bariatric surgery at the first antenatal visit. We included data from all those booking for antenatal care at The Coombe Hospital and the National Maternity Hospital from 2017-2022. Data were collected from the electronic health records and analysed using Microsoft Excel and SPSS.

Results: A total of 105, 123 booking visist were reviewed over the study period. The prevalence of those attending for antenatal care with a history of bariatric surgery was 0.28% (294/105,123) over the study period. There was a significant increase in prevalence from 0.05% (9/16,499) in 2017 to 0.63% (85/13,580) in 2023. This represents a 13 fold increase in prevalence over a 7 year period. The mean BMI of those reporting bariatric surgery was 30.9 kg/m2 (19.4 - 59.9). The mean age was 31 years (21 - 46). The most common type of bariatric surgery reported was gastric sleeve (43.5%, 128/294). Other types of surgery reported were gastric bypass (26.5%, 78/294), gastric band (2.4%, 7/295), gastrectomy (1.7%, 5.294) and gastric balloon (1.0%, 3/294). Type of surgery was unrecorded for 3.1% (9.294) of the population.

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Conclusion: There has been a large increase in prevalence of patients attending for antenatal care following bariatric surgery. These are a high risk cohort. This study suggests that a standardised national approach to these patients may have value in optimising care and reducing associated maternal and fetal/neonatal morbidity.

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ZONISAMIDE USE IN PREGNANCY IN THE ROTUNDA HOSPITAL: A CASE SERIES

Topic / Dept:

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Background: Epilepsy in pregnancy increases the risk of preterm birth, intrauterine growth restriction (IUGR), and maternal morbidity and mortality. Up to 30% of patients with epilepsy require polytherapy for seizure control when first-line options fail, with newer anti-seizure medications (ASMs) increasingly used. While older ASMs like sodium valproate are known to be highly teratogenic, data on newer ASMs, such as zonisamide, are extremely limited.

Objective: The aim of this study is to describe the use of zonisamide in pregnant women with epilepsy who attended the Rotunda Hospital in Dublin, Ireland between 2018 and 2023 using a case series approach.

Study Design: This study used the JBI critical appraisal tool for case series. Data were extracted from the Rotunda Hospital's MN-CMS electronic health record. All women prescribed zonisamide in pregnancy between 2018 and 2023 were included. Women with ongoing pregnancies were excluded. Data were pseudonymized after extraction and cleaning. Demographic and clinical data, ASM and folic acid prescriptions, and maternal and neonatal outcomes were collected.

Results: Seven women were exposed to zonisamide in pregnancy. Median age of the women was 34 years [IQR 7], with most (71%) diagnosed with epilepsy before the age of 18. Mean birth weight was 3.23 kg. All infants were born at term with normal Apgar scores. There were no congenital malformations or NICU admissions reported. One neonate (14%) had IUGR with a birth weight of 2.48 kg. All patients took folic acid 5 mg once daily throughout their pregnancies. The majority (71%) took zonisamide as an adjunct treatment for epilepsy in pregnancy, most

frequently with levetiracetam. Two women (29%) received zonisamide monotherapy. Zonisamide doses ranged from 100mg to 400mg daily, in single or divided doses.

Conclusions: This case series describes the use of zonisamide in seven women in pregnancy. Overall good perinatal outcomes were reported. Further research on the relationship between zonisamide dosage, fetal growth restrictions, and seizure control is needed.

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A 5-year review of robotic assisted myomectomies in university hospital limerick

Introduction

Robotic technology is a novel and innovative minimally invasive approach with demonstrated feasibility in gynecological and reproductive surgery

Background

Da Vinci Xi console robot was installed in university hospital limerick in 2016. The usage of robotic assisted surgeries extended to the specialty of gynecology in January 2019. So far there have been 165 procedures to date which includes myomectomies, endometrial excision, hysterectomies and cervical cerclage.
Out of 165 procedures 43 are myomectomies

Materials and Methods

This is a 5-year review of cases of robotic assisted myomectomies from January2019 till February2024.

Results.

All the myomectomies were performed for subfertility reasons.
Age group ranged from 25 - 50, with mean age of 38 years. Body Mass index ranged from 22 - 50, with mean BMI of 30. In relation to ethnicity ,33 were Caucasian, 5 -African and others constituted 5. The size of fibroids as per MRI ranged from1cm-32cm, with mean size of 5cm. The weight of fibroid post- surgery ranged from26gms-3294gms with mean of457 gms.3 out of 43 (6.8%) had to be converted to laparotomy. Out of 43 myomectomies ,7 had additional stage 4 endometriosis and 1 had dermoid cyst. No Breach of uterine cavity
intraoperatively. The docking time ranged from 4-20minutes with mean time of 8minutes.Console to incision close time ranged from 1.5hours to 5hours and 57 minutes with mean time of 3 hours. Average blood loss ranged from 10ml to 2650ml with mean blood loss of 384ml. Average length of inpatient admission ranged from 0-6days with mean of1.6 days. All patients had preoperative
assessment and admitted on the day of surgery. All patients were reviewed 6
-8 weeks post-surgery. No documented Day 7 and day 30 post operative complications.
1 out of 43 (2.3%) developed rectus sheath dehiscence at umbilicus

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A PROSPECTIVE REVIEW OF PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENT FOR SURGICAL WOUND REVIEW FOLLOWING CAESAREAN SECTION

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Co Author: T Phillips

Co Author: M Carey

Introduction:
With the rate of caesarean sections on the rise, complications thereof are also increasing. One of these is wound complications, affecting 3-15%. These include superficial infection, dehiscence and fluid collections, either haematomas or seromas. On top of the physical implications, there are emotional and financial implications. Wound infections carry prolonged hospital admission and recurrent ED presentations. They also negatively affect the mother's experience of the puerperium and can impact maternal bonding.

Aims
To assess the rate of abdominal wound infections and complications requiring review and readmission in the emergency department in National Maternity Hospital, Dublin.

Methods
Data was collected prospectively between September 2023 and April 2024, inclusive. The sample included all patients who presented to the emergency department in the National Maternity Hospital with concerns of surgical wound infection following caesarean section. Excluded from the data were patients who left the department prior to review of the attending doctor. Data was stored on a password protected computer and analysed by two researchers and reviewed by the supervising consultant.

Results
The rate of wound infection following caesarean section was 6.8% (where the total number of caesarean sections performed was n=1600). The total number of wound reviews performed in ED was n=202 which accounted for 20.5% of all post-natal reviews (n=986).
Of those reviewed, 48% (n=97) of patients were found to have wound infection requiring antibiotics while 14.4% (n=29) of wounds were complicated by haematomas, 12 of which were infected. 37.6% (n=76) were healing well and didn't require antibiotics.

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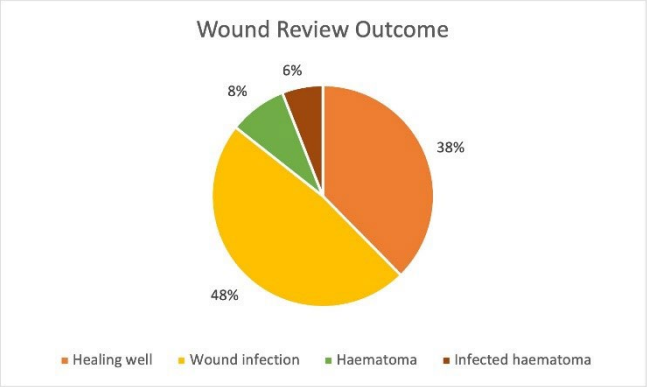
There were 13 readmissions: significant wound infection was the predominant reason for readmission (54%), followed by haematoma (31%) and bleeding from the wound site (15%). 1 patient required haematoma evacuation in theatre.



Conclusion:

The rate of abdominal wound infection following caesarean section in NMH between September ’23 and April ’24 was 6.8%. Of all wounds reviewed, 48% and 14.4% were complicated by infection and wound haematoma, respectively. 13 patients required readmission for IV antibiotics with 1 patient returning to theatre for wound management. As the rate of caesarean section is rising worldwide, it is important to maintain good surgical practice in the prevention of wound infections and provide adequate patient education for wound management in the puerperium.

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Post Caesarean section wound hematoma and infection: A review and approach to care of approximately twenty (20) cases over one year at University Hospital Kerry 2022

Topic / Dept: University Hospital Kerry

Author: A. Taiwo

Co Author: S. Bati

Background & introduction

The rising incidence of caesarean section from multiple indications in modern obstetrics care is a universal concern with diverse sequel of maternal morbidity and mortality often resulting in prolonged period of hospitalization with increased cost and direct health implications. There has been quite a lot of multifactorial issues implicated in possible causes of post-operative complications particularly with post-operative wound hematoma, cellulitis and sepsis. Obesity, closure technique Inadequate aseptic precautions, improper surgical technique, indiscriminate use of antibiotics leading to increasing antibiotic resistance, suboptimal post-operative care and ascending genital infections all contribute to increasing incidence of post-caesarean abdominal sepsis with peculiarities to epidemiology , patient comorbidity and type of caesarean section.

Objective

With an increasing and initially alarming trend of cases in the unit in 2022, the need to review the concerning pattern in order to establish common drifts and ultimate approach to case was necessitated and a total of 20 cases was reviewed within a one year period at the university hospital Kerry.

We reviewed patients who presented with post-caesarean haematomas, septic collections, cellulitis and uterine wound dehiscence with an overview of approach to care of these cases.

Pregnant ladies admitted to the department of obstetrics and gynaecology at UHK, who were deemed to have met this inclusion criteria and within this time frame were reviewed totalling 20.

This cases review was aimed to find incidence of post caesarean section surgical wound hematoma and infection with emphasis on wound hematoma, cellulitis, and dehiscence and overall wound sepsis with the accompanying risk factors surrounding their presentation and approaches to care.

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Materials and methods

Twenty patients were deemed to have fulfilled the inclusion criteria for hematoma , cellulitis and post caesarean section wound infection within this time frame by the clinical assessment for the diagnosis. Both elective and emergency cases were reviewed and all received prophylactic antibiotics as per standard and protocol

Findings and Results

Approaches towards management such as conservative surveillances with antibiotics as against surgical options such as incision & drainage, wound debridement with exploration, re-laparotomy and radiologic drainage are some of the options explored. Similarly determining how superficial and deep the extent of infection or collection also necessitates approach to care
A full assessment was made to evaluate important and essential circumstances surrounding the Caesarean section in a proforma to review and assess all clinical presentations, indication for caesarean section, category of the section, BMI, number of section, operator grade, skin closure, use of 'traxi' and wound dressing with 'pico' , use of abdominal drainage , pre-operative antibiotics , extended antibiotics , serial laboratory inflammatory markers results, imaging offered, need for re-exploration and radiologic drainage approach to care . Similarly findings the complexity of the procedure was also reviewed. Statistical comparison was measured to appraise the approach to care in all the cases reviewing trends, similarities, conservative pattern, MDT approach and sophisticated interventions.

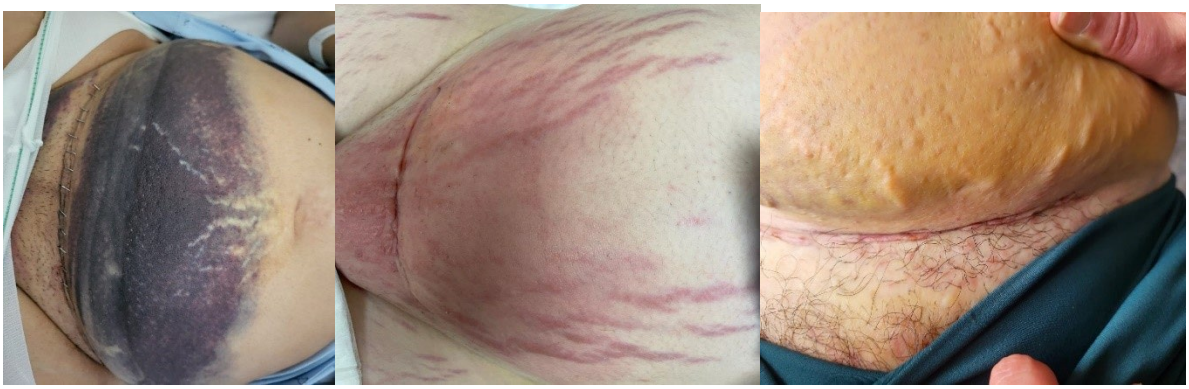
Within the twenty that fitted the inclusion criteria complicated hematoma, cellulitis, wound breakdown and infection, 20% had disruption and dehiscence , 50% were obese with 10 morbidly obese , 75% had between cat 1-2 Caesarean section. 100% were offered prophylactic antibiotics as per protocol and 115% had individualized extended antibiotics of either 3 doses within 24-48hrs .40% of the patients reviewed had repeat CS of between 1-2 . More than 50% of the cases were managed conservatively with intravenous antibiotics ranging from 2-10days and surveillance of inflammatory markers and clinical improvement. Similarly, hospital admission ranged between 3-14 days. Wound debridement was offered for 5% , incision and drainage for 10% , more than 60% of the patient had pico wound dressing and only 40% were diabetic . one patient was initially for intervention radiology but eventually managed conservatively . Ethic variations, geographical distribution, additional comorbidities was not reviewed but a patient was noted to have overt poor general hygiene. There were diverse of cultured organised ranging from anaerobes, normal flora and gram positive and negatives in culture wound swabs. Virtually

all patients had input from TVN wound care specialist [tissue viability nurse] } and the surgeons also had consult and review for 2 patients without surgical intervention.

Conclusions and recommendations

With increasing caesarean section rates with modern obstetrics practice, physicians need sto be weary of the growing incidence of post-operative wound complications in form of hematoma, infections, cellulitis which often causes increased morbidity. Minimum standard of care such as prophylactic antibiotics, extended antibiotics, wound dressing, extra care with at v risk groups such previous infection, morbid BMI, comorbidity may warrant meticulous surgical approach and precautions towards prevention. Despite the individualized approaches to care based on findings, prevention would take precedence in averting this morbidity.

Picture and radiologic imaging



Table

NO	Name	MRN	Clinical presentation, diagnosis & summary	Imaging – CT, USS, MRI- offered [yes / no , type	Approach to care – conservative vs surgical- ID , Re-laparotomy	Others – BMI , Age Emergency vs Elective , Closure , fat stitch , suture ,EBL , drainage , operator	Comments and complexity- operative findings- tissue viability nurse care, microbiology sensitivity and consult

						level, PICO Usage ,	

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AUDIT ON THE DIAGNOSIS AND MANAGEMENT OF POSTPARTUM ANAEMIA AT UNIVERSITY HOSPITAL KERRY

Topic / Dept:

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2. University College Cork South Intern Network

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Co Author: Khattab W. [1]

Background: Anaemia affects approximately one in four pregnant women in Europe, it is estimated for about half these women anaemia is related to iron deficiency.[1] Effective management of anaemia is needed to prevent adverse maternal and foetal outcomes.

Objective: The aim of this audit is to review adherence to World Health Organisation[1] and British Committee for Standards in Haematology[2] guidelines on screening, diagnosis, and management of postpartum anaemia at University Hospital Kerry.[1]

Methods: This was a retrospective cohort study of patients who had singleton live births at ≥23 weeks gestation between 1 May and 31 June 2023 at a single centre. Patient demographics and clinical data were recorded and analysed using Microsoft Excel.

Results: Data from 164 patient charts were included in the final analysis. Overall, 84% of patients underwent screening for postpartum anaemia in line with WHO and BSH guidelines. On review 21.9% of women met criteria for diagnosis of postpartum anaemia of which 12% had uncorrected antenatal anaemia. 75% of patients with postpartum anaemia were prescribed oral iron supplementation in line with WHO and BSH guidelines. (44% were recommended on discharge planning to have further haematinics investigation average 4 weeks to retesting, SD 2.26).

Conclusion: The results of this study highlight the importance of screening for anaemia in the postnatal period, with over a fifth of our sample meeting the criteria for diagnosis. However, despite success in early detection and diagnosis, there exists a lack of adequate treatment and provision of follow-up to this cohort. There is a pressing need to explore the barriers affecting the requisite follow-up of these mothers in the postnatal period.

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BIRTH PREFERENCES, OUTCOMES AND TRENDS AFTER PREVIOUS OBSTETRIC ANAL SPHINCTER INJURY

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Co Author: Amira Alhousni

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Co Author: Maeve Eogan

Objective:
Obstetric anal sphincter injuries (OASI) can cause long term morbidity. Women with one previous OASI are at increased risk of recurrent injury in a subsequent vaginal birth, with recurrence risk ranging between 5.7% and 10.2%. Medio-lateral episiotomy may be protective against recurrent OASI.

A study at the Rotunda hospital between 2011-2012 demonstrated an incidence of repeat OASI of 13.4%. A subsequent re-audit of a similar cohort in 2018-2019 demonstrated an increase in vaginal deliveries with a reduction in instrumental deliveries and repeat OASI (4.3%). This study was carried out to assess change, if any, in birth preferences and delivery outcomes after previous OASI in 2022 and 2023.

Design:
Retrospective chart review

Method:
Electronic health records of all women pregnant with a subsequent pregnancy after previous OASI and attending the Rotunda perineal clinic in 2022 and 2023 were reviewed. Details of index delivery, type of OASI, birth preference for subsequent pregnancy and eventual birth outcome were recorded. Findings were compared to previous audit from the same clinic (2018-2019). Descriptive bivariate analysis using the Chi-square test with odds ratio (OR) estimation was performed. Statistical significance was defined as a p-value <0.05.

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Results:

135 pregnant women who had a previous OASI were seen over the timeframe studied. At 28-week review 74/135 (54.8%) preferred vaginal delivery, 45/135 (33.3%) elective caesarean section (ELCS) and 16/135 (11.9%) were uncertain. Subsequently, 72/135 (53.3%) women went on to have a spontaneous vaginal delivery (SVD), 9/135 (6.6%) an operative delivery and 54/135 (40%) had an ELCS.

When compared to the 2018/2019 cohort, more women had a vaginal delivery (60% n=81/135 Vs 54.7% n=94/172 OR1.24 CI0.78-1.96 p=0.34), with a higher rate of operative delivery (6.6% n=9/135 Vs 3.5% n=6/172 OR1.53 CI0.53-4.44 p=0.42) and a lower rate of repeat OASI (3.8% n=3/81 Vs 4.3% n=4/94 OR0.86 CI0.81-3.98 p=0.85). Of the three women who had a repeat OASI, only one had an episiotomy. The overall episiotomy rate was lower when compared to the 2018/2019 cohort (40.7% n=33/81 Vs 45.7% n=43/94 OR0.81 CI0.44-1.48 p=0.50).

Conclusions:

Since 2012 there has been a decline in the rate of recurrent OASI at the Rotunda hospital. The current rate of recurrent OASI was lower when compared with data from 2018/2019 despite a slightly higher vaginal delivery rate and a lower episiotomy rate, although these findings were not statistically significant.

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BREASTFEEDING BEHAVIOURS AND BONE HEALTH 10 YEARS POSTPARTUM: FINDINGS FROM THE ROLO LONGITUDINAL COHORT STUDY

Topic / Dept:

1. Intern, St Vincent's University Hospital, Elm Park, Dublin, Ireland
2. UCD Perinatal Research Centre, School of Medicine, University College Dublin, National Maternity Hospital, Dublin, Ireland

Author: Saoirse Kennedy[1,2]

Co Author: Kristyn Dunlop[2]

Co Author: Professor Fionnuala McAuliffe[2]

Background: Osteoporosis is a major public health concern disproportionately affecting women in later life. Several hypotheses propose that breastfeeding decreases bone mineral density due to a hypoestrogenic state and increased calcium demand. Paradoxically, some studies have reported protective effects of breastfeeding on bone health. At present there is no clear consensus on the association between breastfeeding and bone health in later life in women.

Objective: To investigate associations between lifetime breastfeeding behaviours and bone health 10 years postpartum.

Methods: This was an analysis of 196 women from the ROLO longitudinal cohort study at 10 years postpartum. Demographics, lifestyle and breastfeeding questionnaires, blood samples and DXA scans were collected. Breastfeeding duration was categorised into duration exclusive breastfeeding, duration any breastfeeding and duration breastfeeding > or < 12 months. Univariate analysis and hierarchical multiple regression analysis were performed.

Results: The mean (SD) age of participants was 42.8 (3.87) years and 97.9% were premenopausal. Ever breastfeeding rates were 70.9%, and duration breastfeeding >12 months rates were 40.3%. Median durations were 8.2 weeks for exclusive breastfeeding (IQR 37.5) and 27.6 weeks for any breastfeeding (IQR 82.6). Breastfeeding duration was not associated with DXA measurements of bone health at 10 years postpartum. Duration breastfeeding >12 months was associated with lower levels of Type I Collagen Cross-Linked C-Telopeptide (CTX1), a bone turnover marker (mean (SD) >12 months = 0.10 (0.05); mean (SD) <12 months = 0.14 (0.08), p= 0.013). This association did not persist after controlling for confounders including age, parity and BMI.

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Conclusions: Breastfeeding behaviours do not appear to be associated with reduced bone mineral density in the later reproductive years. Bone turnover may be lower in women who breastfeed >12 months, a potential protective effect of breastfeeding. Further follow-up is recommended to explore these associations into the postmenopausal period.

Tweetable abstract: Breastfeeding behaviours do not appear to be associated with reduced bone mineral density at 10 years postpartum, however, further follow-up is recommended to explore this association into the postmenopausal period.

A 5-YEAR REVIEW OF READMISSIONS WITH ENDOMETRITIS

Topic / Dept:

1. Coombe Hospital, Dublin, Ireland

Author: N Hughes[1]

Co Author: AP Worrall[1]

Co Author: E Haggaz[1]

Co Author: N Murphy[1]

Objective: The most common site of sepsis in the puerperium is the genital tract, in particular endometritis [1]. Postpartum endometritis is a common problem following 1-3% of vaginal births and up to 27% of caesarean sections [2]. It impacts on patients' wellbeing, patient morbidity, length of hospital stay and readmission rates.

Aim: We present a five year retrospective review of all postnatal readmissions undergoing investigation for endometritis.

Study Design and Methods: A retrospective review of all maternity patient medical records was completed who had postnatal readmissions with endometritis. Medical records, indication for delivery, pyrexia, details of rupture of membranes, delivery outcomes, length of stay (LOS) and management of endometritis were reviewed.

Results: Over a 5 year period, 1,349 women were readmitted postnatally in our unit, representing 0.04% of all deliveries over that same time period. Of the 1,349 readmissions, 20% of these (274/1,349) were readmissions for presumed endometritis. Of the endometritis cases 36.5% (100/274) of cases were delivered by caesarean section, of which 61% were elective cases and 39% emergency cases. Deliveries were completed by consultants in 39 cases, registrars in 55 cases and SHOs in 6 cases. The average LOS was 3.2 days (±2.43).

Conclusion: Postnatal readmissions accounted for 0.04% of all deliveries in our unit. One in five postnatal readmissions were admitted for endometritis, with an average LOS in hospital of 3.2days.

References:

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Compliance With Antibiotic Administration For Instrumental Deliveries

Topic / Dept: Sligo University Hospital

Author: K Flynn

Co Author: S Hassan

Co Author: R Moore

Co Author: E Waters

Introduction

Instrumental delivery is defined as the use of an instrument to aid delivery of the fetus. In Ireland around 1 in 7 women have an assisted birth.

Instrumental Vaginal births carry a higher risk of infection due to their invasive nature and increased number of vaginal examinations that are required with it. Studies have shown that prophylactic antibiotics can reduce the risk of postnatal infections including perineal wound infections and breakdown.

The objective of this audit is to determine if every individual woman who has instrumental delivery received anti-microbial therapy as per RCOG Guidelines.

Method

Data was collected in Sligo University Hospital from 1st January 2024 to 30th August 2024, including all women who had singleton pregnancies and delivered by operative vaginal delivery. Cases were identified using labour ward medical records, Euroking and the clinical notes were reviewed.

The total number of women in this study included was 97.

Results

Approximately 60-70% of the patients with instrumental deliveries had received sufficient doses of antibiotics following their instrumental delivery. However, approximately 30% of women were shown to have either not received the required dose of antibiotics or had no documentation of this. The majority of the women had an uneventful recovery with no infections or re-admissions.

Discussion

Strict compliance is required in prescribing and documenting the doses of antibiotics in drug charts. This ensures the reduction of risk of maternal postnatal infection, without compromising the maternal health or breastfeeding concerns of the patient.

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We aim to conduct a re-audit in order to complete the audit cycle following 6 to 9 months of implementation of our suggested change in practices, according to national guidelines.

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Exploring retention rates for post-partum lifestyle interventions in pregnancies complicated with GDM

Topic / Dept: 1. UCD Centre for Human Reproduction, The Coombe Hospital, Dublin 8, Ireland

Author: Dr. Bassem El Saghir (1)

Co Author: Prof. Amy O'Higgins (1)

Co Author: Dr. Asma Fagear Mohamed (1)

Background: Gestational diabetes mellitus (GDM) is associated with an increased risk of type 2 diabetes mellitus as well as an increased risk of cardiovascular disease (CVD) independent of type 2 diabetes mellitus (T2DM), The HSE has tried to harness the opportunity for early life course intervention by enrolling women with a recent GDM diagnosis in the Chronic Disease Prevention Program where they can avail of an annual primary care review and clinical CVD risk assessment. However, many postnatal interventions have low follow up rates and the efficacy of postnatal intervention in T2DM/CVD risk reduction has not been proven.

Objective: To perform a scoping review of post-partum interventions following a diagnosis of GDM, describing the nature of the intervention, outcomes and retention rates of participants for studies done from 2004 up to August 2024.

Study Designs and Methods: Following the methodology for scoping reviews as outlined by the Joanna Briggs Institute a search protocol was developed using the Mesh terms: postpartum, postnatal, after birth, after delivery, after pregnancy, history of gestational diabetes mellitus, lifestyle, diet, exercise, physical activity, weight management, weight loss, behavioural intervention, health promotion, wellness program, lifestyle intervention, follow-up testing, follow-up screening, gestational diabetes, GDM, pregnancy-induced diabetes, gestational diabetes mellitus, follow-up, follow up, retention, attrition, retention rate, drop out. The following databases were utilized: PubMed, CINAHLs, ClinicalTrials.gov. Inclusion criteria were studies that dealt with individuals in the first-year post-delivery, those dealing with post-partum lifestyle interventions, in the English language, dealt with human subjects and was published after 2004. All study types were included except case reports and series Finally, Covidence software was used to perform the review and analyse articles.

Results: A total of 403 studies were identified for screening, 50 were selected for full text review. The studies included dietary interventions, physical activity interventions and

combinations of lifestyle interventions. Some interventions were delivered in person, remotely and some in hybrid forms. There was a range of follow up periods and frequencies as well as

Conclusions: For many people pregnancy is the only time in their lives they are regularly seeing a medical provider and can thus be seen as a teaching moment for their future health. Having a better understanding about which types of interventions tend to keep patients engaged and interested will help guide public health resource allocation in the future. If resources are then allocated towards the programs that have the best average retention rates, then the health benefits are more likely to be realized in the future, on a personal level and on a societal level.

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OASIS: A clinical re-audit in a tertiary care center

Objective

To evaluate the quality of care in both the initial management of obstetric anal sphincter injury and subsequent follow up postnatally in a tertiary maternity hospital.

Methods

Data was collected retrospectively over a period of two years from July 2021 to June 2023, using a proforma developed at University hospital, Limerick. Results-

There were total of 58 cases of OASI ie 3rd and 4th degree perineal tears.Out of total cases, 52 (89.6%) were of normal BMI. Results showed 16 (28%) cases had prolonged second stage of labour and majority of the cases, 36 (63.1%) were delivered by midwife.Out of total 58 cases, 38 (65.5%) had SVD, 10 (17.2%) combine instrumental delivery, 7 (12%) had kiwi and 3 (5.1%) cases had forceps delivery. Only 15 cases had mediolateral episiotomy performed. In the study, 20 cases (34.4%) had 3A tear, 19 cases (32.7%) had 3B tear, 13 cases (22.4%) had 3C tear and 6 cases (10.3%) had 4th degree tear.All the cases had antibiotic and laxative usage and also physiotherapy referral. In the post natal evaluation it was seen that 7 cases (12%) had urinary incontinence, 2 cases had bowel incontinence, 3 cases had flatus incontinence and in 3 cases there was no documentation about bowel control. It was also seen 12 cases didn't had any post natal clinical review.

Conclusion

In this study primiparity, BMI, induction of labour, use of episiotomy, prolonged second stage, birth weight of more than 4kg and instrumental deliveries were not identified as risk factors for OASI. In majority of the cases compliance with standard practice (suture, technique, antibiotic and laxative use and physiotherapy referral) was noticed. In post natal review proper documentation was not seen in few cases and follow up plan was not done in 12 cases

Recommendation

1.To ensure all the health care staff are familiar with guideline of Obstetric sphincter injury Management.

2.To ensure proper documentation about post natal evaluation and plan for clinic review (lavender clinic).

3. It is also recommended to have debriefing process by primary operator, including discussion about prognosis and future pregnancies.

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A 5-year review of robotic assisted myomectomies in university hospital limerick

Introduction

Robotic technology is a novel and innovative minimally invasive approach with demonstrated feasibility in gynecological and reproductive surgery

Background

Da Vinci Xi console robot was installed in university hospital limerick in 2016. The usage of robotic assisted surgeries extended to the specialty of gynecology in January 2019. So far there have been 165 procedures to date which includes myomectomies, endometrial excision, hysterectomies and cervical cerclage.
Out of 165 procedures 43 are myomectomies

Materials and Methods

This is a 5-year review of cases of robotic assisted myomectomies from January2019 till February2024.

Results.

All the myomectomies were performed for subfertility reasons.
Age group ranged from 25 - 50, with mean age of 38 years. Body Mass index ranged from 22 - 50, with mean BMI of 30. In relation to ethnicity ,33 were Caucasian, 5 -African and others constituted 5. The size of fibroids as per MRI ranged from1cm-32cm, with mean size of 5cm. The weight of fibroid post- surgery ranged from26gms-3294gms with mean of457 gms.3 out of 43 (6.8%) had to be converted to laparotomy. Out of 43 myomectomies ,7 had additional stage 4 endometriosis and 1 had dermoid cyst. No Breach of uterine cavity intraoperatively. The docking time ranged from 4-20minutes with mean time of 8minutes.Console to incision close time ranged from 1.5hours to 5hours and 57 minutes with mean time of 3 hours. Average blood loss ranged from 10ml to 2650ml with mean blood loss of 384ml. Average length of inpatient admission ranged from 0-6days with mean of1.6 days. All patients had preoperative assessment and admitted on the day of surgery. All patients were reviewed 6 -8 weeks post-surgery. No documented Day 7 and day 30 post operative complications.
1 out of 43 (2.3%) developed rectus sheath dehiscence at umbilicus

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A CASE SERIES OF THREE CAESAREAN SECTION NICHES AND THREE DIFFERENT MANAGEMENT OPTIONS

Topic / Dept: 1. Coombe Hospital, Dublin, Ireland

Author: AP Worrall[1]

Co Author: W Tadesse[1]

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Objective: With a rising caesarean section (CS) rate, the incidence of caesarean section niche is also rising. This is being seen world over in gynecology outpatient clinics and fertility clinics. CS niches have been implicated in dyspareunia, dysmenorrhea, post-menstruation bleeding, RPOC and subfertility.

Aim: We present three cases of CS niche that routinely presented through our tertiary maternity and gynaecology unit.

Study Design and Methods: A retrospective review of patient records and imaging was completed. The duration of care spans from 2014-2024.

Results:
The 1st case is a P1 (CS) who presented at 14+2 weeks with a miscarriage. At 16+2 she had an ongoing positive pregnancy test and was found to have retained products of conception in the CS niche. Conservative management with interval scanning gave resolution, but the niche remained.
The 2nd case is a 40yo P1 (CS) who had post-menstruation spotting over a 5 year period. A persistent CS niche was visualized, and medical management with cerazette failed to stop the symptoms. Trial of the Mirena coil were attempted twice with no improvement. The patient is currently awaiting laparoscopic niche resection.
The 3rd case is a 36yo P1 (CS) who attended routinely for her second pregnancy. At 36+0 she had ROM and proceeded to repeat caesarean section, with a two layer hysterotomy closure. She returned 3 weeks postnatally with suprapubic pain. A TVUS showed no RPOC, but revealed a CS scar deficient to the serosa. A second consultant opinion was sought, confirming scar dehiscence. A 9 week and 3 month interval review, and the niche remained present with a 2.6mm RMT, and a 14.8mm niche depth. Surgical intervention prior to the next pregnancy is being considered.

Conclusion: The rising number of CS niches likely reflect rising number of CSs, and obstetricians and gynaeocologists should provide evidence based management options tailored to patient symptoms and future fertility considerations. A hospital guideline and care pathway is currently being developed to harmonise care in our unit.

Words: 325

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A CLINICAL AUDIT ON PAIN MANAGEMENT DURING OUTPATIENT HYSTEROSCOPY (OPH), ROTUNDA HOSPITAL, DUBLIN.

Topic / Dept:

1. Rotunda Hospital, Dublin
2. Our Lady of Lourdes Hospital, Drogheda, Ireland

Author: Arthi Subramanian (Year 2 BST Trainee)[2]

Co Author: Saboohi Tariq (Gynaecology Fellow)[1]

Co Author: Catriona McNeela (Clinical nurse practitioner)[1]

Co Author: Fadi Salameh (Consultant Obstetrician & Gynaecologist)[1]

Background: Outpatient hysteroscopy (OPH) can cause discomfort, pain, uneasiness, and humiliation. To improve patient experience, guidelines recommend pre-procedure analgesia, a smaller hysteroscope size, and a vaginoscopy approach. Studies in Ireland and the UK show a positive patient preference for OPH over hysteroscopy under anaesthesia.

Objective: To assess pain management compliance and its impact on patient pain perception during and after OPH procedures compared to RCOG guidelines at Rotunda Hospital.

Methods: A retrospective audit on 50 OPH patient data using a convenient sampling technique. Data collected electronically from maternal and new-born clinical management system (MN-CMS) using a proforma on information received regarding OPH and pain management, type and size of a hysteroscope, medications or conservative measures used, the effect of analgesia during and after the procedure, if procedure abandoned due to pain, readmission due to pain and documentation of pain management. Current practices were benchmarked against the RCOG – green top guidelines.

Results: Among the 50 OPH procedures, 49 (98%) were diagnostic OPH for postmenopausal bleeding (56%), heavy menstrual bleeding (18%), abnormal uterine bleeding (12%), lost coil/insertion of a new intrauterine device (6%), polyps/fibroids removal (4%) and hyperplasia (2%) with 90% (n=45) vaginoscopy approach. Approximately 82% received pre-procedure analgesia, and 60% (n = 30) received local anaesthesia. Approximately 28% (n=14) of patients experienced pain during the procedure, and 2% (n=1) found it uncomfortable. Many patients

(n=41; 82%) have had a biopsy performed during the OPH. There might be a correlation between the biopsy performed and the pain perceived.

Conclusions: OPH was well tolerated among 70% of patients (n=35), with only 2% (n=1) procedure abandoned due to pain. 82% had received analgesia before the procedure, with 90% (n=45) undergoing vaginoscopy and 60% (n=30) under local anesthesia. 98% (n=49) of patients received an explanation regarding the procedure on the day of the OPH. Suggestions were made to improve documentation regarding patient information, pre and post-procedural analgesia, conventional measures, and hysteroscope size.

References:

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A SERVICE REVIEW OF THE SUSPICIOUS CERVIX CLINIC AT TALLAGHT UNIVERSITY HOSPITAL

Topic / Dept: 1 Department of Gynaecology, Tallaght University Hospital, Dublin, Ireland

Author: B Downey1

Co Author: D McGahern1

Co Author: B Burke1

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Co Author: A O'Neill1

Background

Historically, colposcopy services in Ireland had a referral pathway for patients with a clinical indications (suspicious cervix/intermenstrual or post-coital bleeding). In 2021, changes in CervicalCheck phased this out, recommending referral to gynaecology clinics (GOPD) instead. To manage these patients efficiently and prevent longer GOPD waitlists, an Advance Nurse Practitioner-led clinic was established in Tallaght University Hospital.

Objective

No review of this clinic had been done to date. We aimed to assess the waitlist from 2021 to July 2024; tracking patient's pathways through the clinic, and identify how many required colposcopy type care.

Study Design and Methods

The waitlist for the clinic was obtained for the study period & individual chart reviews conducted. Data collected included age, wait time, referral indication, attendance details, and visit outcomes. Ethical approval was obtained locally.

Results

For this period, 341 patients were seen, with complete data available for 337. There were 270 patients still on the waitlist, with a median wait time of 6 months. The median age of those seen was 42years, and their median wait time was 10 months. The main referral indications were suspicious cervix (41.8%, 141/337) and post coital bleeding (20.2%, 68/337). All patients were examined, 48.1% (162/337) had a transvaginal ultrasound, and 15.7% (53/337) had colposcopy. Only 3.3% (11/337) required a cervical biopsy or LLETZ. No treatment was required in many cases (44.2%, 149/337), but in those that did need intervention, the most common were polypectomy (22.3%, 75/337) and silver nitrate (11.9%, 40/337). The majority attended the clinic in person

only once (95.0%, 320/337), of whom 45.9% (147/320) were discharged from that visit. Overall, 85.2% (287/337) of those seen have been discharged, 14.2% (48/337) are awaiting follow up, and 14.8% (50/337) were referred on to other services, with 8.0% (4/50) required referral to Colposcopy.

Conclusions

Most patients seen at this clinic have been discharged without need for further follow up, with only a small minority requiring colposcopy type care.

Tweetable Abstract

The ANP-led Suspicious Cervix Clinic @TUH_Tallaght, has seen >340 patients since 2021, allowing fast assessment of worrying symptoms for patients & decreasing GOPD waitlists – no treatment was needed in many cases, and 85% have been discharged back to their GP well! #WomensHealth

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AN INTERESTING CASE OF INTRAUTERINE ARTERIOVENOUS MALFORMATION LEADING TO PROFUSE BLEEDING EPISODE

Author: H. Sial

Co Author: R. Almola

Co Author: R. roopnarinesingh

Uterine arteriovenous malformations (AVMs) are uncommon but potentially life-threatening. They can be congenital or acquired (arteriovenous fistulae) and should be suspected in cases of severe or persistent uterine bleeding

We present an interesting case of a 39 yo , p2+2 who had presented to the emergency department with heavy vaginal bleeding for 1 day. At presentation, patient had approximately 300ml blood loss in the emergency department. Her period was regular otherwise with average flow.

She reported a similar episode 5 months ago at home but did not seek medical help as it spontaneously resolved.

Her pregnancy test was negative. Initial resuscitative measures were taken to stabilize the patient. She was seen by the obstetric team on call and on scan endometrial thickness was 1 cm with? blood clot. Coarse blood vessel was seen around endometrium ? AVM ? polyp.

She was admitted for futher management. Consultant on call was informed. Her Hb came back as 119 with PLT 597.

She was stable overnight and was seen by on call team in morning when plan was made to arrange pelvic ultrasound for further evaluation. The scan was reported to be more suggestive of RPOCS and hence she was taken to theatre for hysteroscopy guided ERPC.

0.5cm coiled vessel was seen on posterior wall in mid cavity in midline suspicious of AVM. RPOCs were removed as well and sent for histology. MBL was 370ml during the procedure. Balloon with 50 ml saline was left in situ to give tamponade.

Pre op POC Hb was 85. She was post operatively transferred to HDU, transfused with 2 units of bloods.

She was discussed with radiology department in connolly Hospital and subsequently planned for embolization for AVM.

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ANALYSIS OF READABILITY-SCORES FOR ENDOMETRIOSIS SYMPTOM QUESTIONNAIRES

Background&Purpose

Numerous symptom- questionnaires exist to explore a patient's chronic pelvic pain. These are being adopted into routine clinical practice to establish a baseline at first visit, and then track any improvement with treatments.

Readability of these questionnaires is crucial for effective communication with patients.

When content is easy to read, it helps ensure that the intended information reaches the patient, including those with varying levels of literacy and scientific expertise.

Clear and accessible language fosters better understanding and minimising misunderstanding, maximising the intended benefits of the questionnaire.

The aim of this study was to compare the readability scores of 5 commonly used Pelvic Pain Questionnaires.

Methods

Five questionnaires were identified (table 1) Readability was analaysed using an online tool (webFX.com) and results were compared (table1).

Flesch–Kincaid readability tests were used, giving the Readability-ease score (scored as a percentage, with higher scores indicating greater readability) and the expected reading age required to comprehend the text.

Results

All questionnaires achieved very high readability scores (Table 1), although there was a broad range of results.

Questionnaire	BSGE Pelvic Pain Questionnaire	EndoZone; myEndo Report	The Pelvic Pain Impact Questionnaire	Pelvic Pain Foundation of Australia Questionnaire	Worl Endometriosis Research Foundation Questionnaire - Standard
Flesch Kincaid score	60	65	95	70	93
Reading age required	15-16 YO	14-15 YO	7-8 YO	10-11 YO	8-9 YO

Table 1. Results

Conclusions

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The high readability scores mean that all examined questionnaires can be confidently used as part of research/clinical practice without concerns of marginalising those with limited literacy

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Anti NMDA Encephalitis with Ovarian Teratoma

Topic / Dept: University Hospital Waterford

Author: Warda Maqsood

Co Author: Sarah Taha

Co Author: Aya Eltom

Co Author: Samina Gul

Co Author: Eddie O'Donnell

Background:

Anti-NMDA receptor encephalitis primarily affects women, with symptoms including hallucinations, seizures, and motor disturbances, often associated with ovarian teratomas. Presentations can be variable, thus posing a challenge to clinicians in neurology and psychiatry hence we want to report our case.

Case report:

A 31-year-old woman with no prior medical or psychiatric history developed behavioral changes following emotional distress, delusions, agitation, and a tonic-clonic seizure. Despite initial normal MRI and lumbar puncture, she exhibited worsening confusion, catatonia, and hallucinations. EEG suggested focal encephalopathy, and CSF revealed anti-NMDA antibodies, hence autoimmune encephalitis was diagnosed. CT pelvis revealed a 1.1 cm fat lesion in left adnexa. She underwent emergency oophorectomy and immunotherapy with rituximab which led to significant improvement, restoring her consciousness and functionality. She was discharged with ongoing support and rehabilitation for further recovery.

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AUDIT EXPLORING BARRIERS TO ATTENDANCE OF OUTPATIENT GYNAECOLOGY CLINIC IN BEAUMONT

Author: ROISIN DARBY

Co Author: TARANNUM IBRAHIM

SUPERVISING CONSULTANTS: PROF HASAN RAJAB, DR CONOR HARRITY

Background: I would like to submit an audit exploring the rates of 'Did Not Attend' (DNA) appointments in the outpatient gynaecology clinic in Beaumont.
There is a high DNA rate to gynaecology outpatient clinic here, particularly Friday evening clinic.

Objective: Explore current barriers to clinic attendance and methods to overcome them

Study Design and Methods: Gathered data on the DNA rate over the last three months from the administration staff in the department. Included in person clinic only, not virtual clinic (which also runs in Beaumont). Spoke to the administrative staff about current mechanism in place to contact patients to remind them about their appointments. Previously a reminder text was sent out 7 days/ 3 days before the appointment. The current text reminder system is not working as a new system is being put in place. The issue of what can be done in future to increase clinic attendance is proposed in this audit by exploring the barriers to clinic attendance in the last three months.

Findings/ Results: This research is ongoing at present as we accumulate the data from previous clinics.

Conclusions: This research is ongoing at present, preliminary findings will be ready for JOGS to be presented in November

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CASE REPORT: AN RARE CAUSE FOR SWYER SYNDROME

Topic / Dept:

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Swyer syndrome is a rare syndrome associated with complete gonadal dysgenesis. It is seen in phenotypically female individuals with a 46XY karyotype. It is typically caused by a mutation in the SRY gene located on the Y chromosome. The usual presentation is with primary amenorrhoea and lack of secondary sexual characteristics. The dysgenetic gonad is non functional and therefore at risk of malignant change.

We present the case of a 15-year-old girl who presented with primary amenorrhoea. On examination she had absent pubertal development (Tanner Stage B1). On pelvic imaging, ultrasound and MRI, there was a small prepubertal uterus seen, no definitive visualisation of the gonads. Investigations demonstrated raised gonadotrophins with a karyotype confirming 46XY. Trio exome sequencing identified a missense variant of the *DMRT1* gene; c.315C>G; p.(Cys105Trp). She underwent examination under anaesthetic and a laparoscopic gonadectomy due to the risk of malignant transformation of her dysgenetic gonads. On examination she was found to have typical external genetalia, typical vagina, palpable single cervix. On laparoscopy she had streaked gonads and a typical prepubertal uterus.

Further screening of family members demonstrated that her mother was a mosaic carrier of the same DMRT1 mutation. Given this information, 2 other siblings were screened for the mutation,

one was also found to be phenotypically female but with a 46XY karyotype and same DMRT1 gene mutation.

Doublesex- and Mab3- Related Transcription Factor 1 (*DMRT1*) is a gene, located on chromosome 9, which is involved in sex determination and is necessary for testicular differentiation. Mutations in this gene have previously been implicated in XY sex reversal. The mutation identified in this family has not previously been reported. This case highlights the need for screening asymptomatic family members.

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CASE STUDY: A RARE COMPLICATION FOLLOWING SURGICAL MANAGEMENT OF MISCARRIAGE

Topic / Dept:

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Introduction:

Acquired uterine arteriovenous malformations (UAVMs) are rare, yet potentially life-threatening, vascular anomalies characterised by abnormal connections between uterine arteries and veins. These lesions most commonly develop as a complication of uterine trauma, including surgical management of miscarriage (SMM).

Case Summary:

We present the case of a woman in her 30's with a history of two previous lower transverse caesarean sections (LSCS) who underwent elective SMM at 7 weeks gestation. Her SMM was complicated by haemorrhage of 400mls that resolved with compression and uterotonics. There were no concerns for molar pregnancy on examination of the pregnancy tissue. Eleven days later she presented with heavy vaginal bleeding and suprapubic pain. She was empirically treated for endometritis and investigated for retained pregnancy tissue. Initial ultrasound and subsequent contrast enhanced MRI revealed a large UAVM within the lower anterior myometrium. She continued to bleed and required multiple blood transfusions. She was keen to preserve fertility therefore a multi-disciplinary decision was made to perform uterine artery embolisation (UAE). Both uterine arteries were selectively catheterised and embolised using coils and Gelfoam. The post embolisation angiogram demonstrated complete devascularisation of the UAVM. Multiple follow-up MRI studies demonstrated complete resolution of the UAVM.

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Conclusion:

Acquired UAVMs are rare but should be considered as a differential in patients presenting with unusual post-procedural bleeding, particularly following uterine surgery such as SMM. UAE is an effective and fertility-preserving treatment for UAVM.

Tweetable abstract: Acquired uterine arteriovenous malformations (UAVMs) are rare but serious vascular anomalies that can occur after uterine trauma, such as surgical management of miscarriage (SMM). We report a case of successful uterine artery embolisation (UAE), preserving fertility and resolving heavy bleeding. #UAVM #UAE #WomensHealth

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COMPLEX CONGENITAL GYNAECOLOGY: A REVIEW OF A NEW SERVICE IN A TERTIARY REFERRAL GYNAECOLOGY CENTRE

Topic / Dept: The Rotunda Hospital, Dublin.

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Background:
A dedicated Complex Congenital Gynaecology service was established in our hospital in August 2023.

Study design and methods:
To describe this service, a review was performed of patient attendances in the first 12 months of activity.

Results:
There were a total of 190 new patient attendances in the service's first year (August 2023 – August 2024). 31.5% (n=60) had a Complex Congenital Anomaly, of whom 46.6% (n=28) had Mayer Rokitansky Kuster Hauser syndrome (MRKH). Other patient cohorts seen in this grouping included patients with vaginal septae, patients with persistent cloacal anomaly, and patients with Obstructed Hemivagina Ipsilateral Renal Anomaly syndrome (OHVIRA). 7.8% (n=15) patients had a Difference in Sex Development. Patient cohorts within this grouping included XX and XY DSDs, including Androgen Insensitivity Syndrome, Swyer Syndrome, and Congenital Adrenal Hyperplasia. 44.7% (n=85) had a Complex Gynaecological Endocrinopathy, including Premature Ovarian Insufficiency, disorders of hyperandrogenism/virilisation, Turner Syndrome, and abnormalities of the HPOA axis.

Service activity is multidisciplinary in nature. Gynaecology review is complimented by same-day Radiology evaluation where required. Patients are supported by a Clinical Midwife Specialist, who in addition to clinical review and assessment, runs a dedicated Vaginal Dilator Therapy service. A

Clinical Psychologist reviews patients in clinic, and provides psychological treatment and support for patients as required, both in person and on a virtual basis. The Service is linked with subspecialty Endocrinology, Clinical Genetics, and Urology in Beaumont Hospital and Children's Health Ireland. Patients who require complex operative management are referred to UCLH London.

Conclusion:

This review demonstrates the activity of a new dedicated Complex Congenital Gynaecology service at a tertiary referral hospital, which incorporates a diverse MDT in the management of this patient cohort.

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CORPUS LUTEAL CYST RUPTURE CAUSING SIGNIFICANT HEMOPERITONEUM

Topic / Dept:

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2. O&G SHO, Beaumont Hospital, Dublin
3. Gynae Consultant, Beaumont Hospital, Dublin

Author: T Ibrahim [1]

Co Author: A Subramanian[2]

Co Author: C Harrity[3]

Background

Corpus luteal cyst rupture can cause acute pain in reproductive-age women and, rarely, significant hemoperitoneum. From January 2024 to July 2024, we identified three cases of hemoperitoneum due to the same, two managed conservatively and one requiring emergency laparoscopy. All three had negative pregnancy tests and were two weeks off their LMP. The drop in Hb in all three cases was 2-3 g/dl.

Case 1

A 39-year-old woman with a history of essential thrombocythemia and a previous appendectomy presented with severe right iliac fossa pain commencing post-coitally. Imaging indicated significant hemoperitoneum with a suspected perforated viscus or ruptured cyst. A diagnostic laparoscopy revealed active bleeding from a ruptured corpus luteal cyst with significant hemoperitoneum. The area was cauterized. She recovered well postoperatively.

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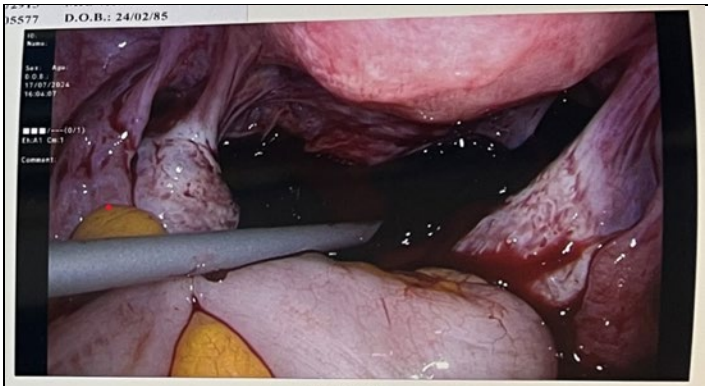
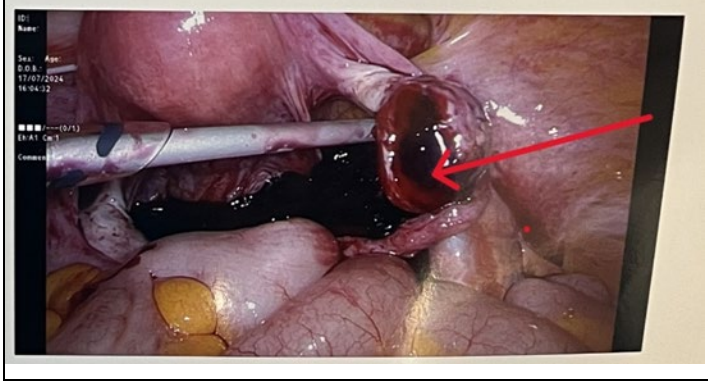
 Image 10 	Right corpus luteal cyst

Case 2

A 23-year-old woman, P0+0, not on pills presented with sudden, severe pain in the periumbilical region and lower right abdomen, along with nausea. No trauma or sex was reported before the pain started. Her vitals were normal, but she had significant tenderness in those areas. CT showed moderate hemoperitoneum, likely due to a possible rupture of a 5.1 cm right ovarian cyst. She was managed conservatively and an ultrasound 8 weeks later showed complete resolution.

Case 3

A 24-year-old, P0+0, woman presented with lower abdominal pain after intercourse. Examination revealed tenderness in lower abdomen and bulkiness in the pouch of Douglas and right fornix. She had a Mirena coil for dysmenorrhea and menorrhagia. CT showed fluid in subphrenic spaces and a mass? clot in the right adnexa. The patient was managed conservatively as her pain improved and she was discharged with follow-up instructions. On subsequent enquiries made virtually, the patient was well and due for a scan in 2 weeks.

Discussion

The features of corpus luteum haemorrhage include patient age within reproductive years, sudden-onset pain (more often on the right side), history of recent coitus or strenuous physical activity, onset during the secretory phase of the menstrual cycle, and increased incidence in

pregnant females. There is no standard algorithm for management, and treatment aims to preserve ovarian function and stop the bleeding source.

Conclusion

Abdominal pain in young females should prompt consideration of hemoperitoneum from a ruptured corpus luteum cyst as a differential diagnosis.

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FAILURE RATES OF OUTPATIENT HYSTEROSCOPY – AN AUDIT ON AMBULATORY GYNAECOLOGY UNIT IN GALWAY UNIVERSITY HOSPITAL (GUH)

Author: Aleksandra Sobota

Co Author: Nurul Rusdi

Co Author: Runagh Burke

Co Author: Michael O'Leary

- Background

Ambulatory Gynaecology Unit (AGU) is a one-stop outpatient service offering consultation, examination and investigations for women with abnormal uterine bleeding.
Failure rates of outpatient hysteroscopy of up to 9% were found in the literature with one large systematic review quoting 4.2%. The BSGE guideline on best clinical practice for outpatient hysteroscopy outlined several recommendations and we evaluate the local practice in GUH based on these aspects.

- Objective

To study failure rates of outpatient hysteroscopies performed in AGU GUH alongside reasons for failures to enable quality improvement.

- Study Design & Methods

This was a retrospective cohort study of 291 women who attended outpatient hysteroscopy from July to December 2023. Variables recorded were age, menopausal status, parity, mode of delivery, procedural indication, type of hysteroscopy, scope size, use of anaesthesia, reasons for failure and follow-up plan. Statistical analysis was performed using t-test and chi-squared test for continuous and categorical variables respectively.

- Findings/ Results

Overall, we found outpatient hysteroscopy failure rate of 11.6% (n=36). The average age of women for whom hysteroscopy failed was 54.2 years. The majority were postmenopausal (75.8%) and had at least one vaginal birth (65.2%). Common reasons for failure were inability to tolerate speculum examination or hysteroscopy (44.1%) and cervical stenosis (41.2%). Where outpatient hysteroscopy failed, most common follow-up plan was for repeat hysteroscopy as a day case in theatre (47.2%).

- Conclusions

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The failure rate of outpatient hysteroscopy recorded in this cohort was 11.6%, exceeding the average rate quoted in literature. The most common reason for failure was in relation to patient discomfort and cervical stenosis. Quality improvement should focus on optimising these in order to reduce failure rates. This is vital to enhance patient care and ensure efficient spending of healthcare resources by avoiding need for surgery.

TWEETABLE ABSTRACT:

Outpatient hysteroscopy failure rate in our study was 11.6%, higher than the literature average. Main reasons: patient discomfort & cervical stenosis. Tackling these can promise a more efficient patient care & healthcare spending. #QI #gynae #hysteroscopy #healthcarebudget

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HEAVY MENSTRUAL BLEEDING: HOW LOW CAN HAEMOGLOBIN GO?

Topic / Dept: Obstetrics and Gynaecology, Our Lady Of Lourdes Hospital, Drogheda.

Author: Jayavani Penchala

Co Author: Adedayo Taiwo

Co Author: Anabela Serranito

A 46-year-old woman presented to the Emergency Department with persistent acute on chronic HMB. She has had two vaginal deliveries and has been experiencing HMB since her last childbirth, which initially did not bother her. About a year ago, she was seen by a private Gynaecologist, and Fibroid Uterus was diagnosed on the scan. She had a Mirena coil inserted, which fell out. When she presented to OLOL, she had been bleeding for the past three weeks and was heavy with clots. She was symptomatic of anaemia for the last week. Her Hb is 1.9g/dl, with low MCV & MCH. She was seen by the Gynaecology team and transfused two units of Red Blood Cells. The treatment was commenced with Tranexamic Acid and Provera, and consulted with the Medical and Haematology teams for anaemia management. The patient had an ECHO and CT TAP, as per the medical team's advice, which were normal. She had a further five units of RBC transfused with gradual intervals and had an Iron Infusion, as per the haematology team's advice. She had an Ultrasound scan and MRI, which confirmed Multiple Fibroid Uterus. Hysteroscopy, Dilatation & Curettage was performed. The cavity was distorted, and histology came back as benign. GnRH was discussed and administered, and she was discharged home while scheduled on her waiting list for a Hysterectomy.

The patient returned in 3 months with HMB, and at that time, her Hb showed 7.3g/dl, and she received two units of RBC and iron Infusion. She is not keen on further GnRH anymore due to undesirable side effects. She was discharged on Provera and Tranexamic Acid. She is going to have a scheduled Total Abdominal Hysterectomy + Bilateral Salpingectomy very soon.

Monitoring iron levels in individuals experiencing chronic or acute HMB is crucial. Early assessment and intervention can prevent severe complications and promote better overall health.

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Hemmed In: Clinical management of LSCS niche

Background: Caesarean section (CS) niches are defined as an indentation in the uterine myometrium at the site of a caesarean scar (CS) >2mm. Also known as isthmoceles, scar defects and insufficiencies to name a few titles. CS niches occur in 19-65% of women post CS. They can cause a plethora of symptoms including dysmenorrhea, dyspareunia, abnormal uterine bleeding (AUB), subfertility, PAS syndrome and uterine rupture. We describe a case of CS niche following an unusual presentation 9 months after a uterine rupture.

Methodology/ Case Report: A 34 yo G2P2, presented nine months after an emergency CS for uterine rupture with severe abdominal pain and vaginal bleeding. A pregnancy test was negative. A CT abdo pelvis showed a haematometra at the lower segment. Examination under anaesthesia with hysteroscopy, dilatation and curettage revealed tissue consistent with retained products. Histopathology confirmed presence of calcified chorionic villi. Serum HCG was 24. Follow up in gynaecology outpatient clinic revealed ongoing AUB and deep dyspareunia. TVUSS revealed a cystic CS niche. MRI confirmed a hyperintense niche with a 1.5x0.7x1.1cm cystic surrounding area, narrowed uterine isthmus and cervical stenosis. Decision to list for repeat hysteroscopy and trial of Mirena LNG-IUS.

Results: Routine saline hysteroscopy revealed a stenosed cervical introitus, funnelling at the cervix and otherwise normal findings. A LNG IUS was inserted. Initial follow-up revealed symptom improvement and better quality of life.

Discussion: CS niches are increasingly on the rise worldwide. Clinical presentations can impact on physical wellbeing, quality of life and fertility in some cases. Management includes no action, trialling the Mirena LNG-IUS or surgical resection from hysteroscopic, laparoscopic to vaginal approaches. The Mirena LNG-IUS is superior to hysteroscopic niche resection in treating niche related symptoms and should be the primary treatment prior to embarking on surgical resection.

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LARGE VOLUME HEMOPERITONEUM SECONDARY TO OVULATION IN A PATIENT WITH NO KNOWN RISK FACTORS – A CASE REPORT.

Topic / Dept: Portiuncula University Hospital

Author: Dr Caoimhe Newell

Co Author: Dr Patricia O'Dwyer

Co Author: Dr Marie-Cristine DeTavernier

Body

Hemoperitoneum secondary to ovulation has been described in patients receiving anticoagulation therapy as well as in patients with heritable bleeding disorders[1,2]. We present an unusual case of a patient with no significant medical history who presented with a large volume hemoperitoneum as a result of ovulation.

Consent was obtained from the patient for publication of the case with images for education purposes.

A 33 year old female presented with a six hour history of chest pain, pre-syncopal symptoms and right upper quadrant pain with referral to right shoulder tip. Initial assessment showed that the patient had hypotension and tachycardia. Initial impression was that of pulmonary embolism (PE) however CT pulmonary angiogram was negative for PE. She was resuscitated with intravenous fluids but subsequently developed lower abdominal pain for which a CT abdomen and pelvis was performed. This showed a left adnexal mass with a moderate volume of free fluid in the peritoneal cavity. A drop in blood haemoglobin from 12g/dL to 8g/dL triggered a CT abdominal angiogram, which demonstrated active bleeding from the left ovary.

An emergency laparoscopy was performed which confirmed a moderate to large volume of hemoperitoneum. There was no active bleeding, and the only identifiable possible source was the left ovary, which showed signs of ovulation. The patient had a straightforward postoperative course and she was discharged home on a combined oral contraceptive pill.

After further investigation, no underlying coagulopathy or strong family history of bleeding was identified. This case highlights an unusual case of a hemoperitoneum from a ruptured ovulatory follicle in a female with no history of a clotting disorder.

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MANAGING A SUBSTANTIAL UTERINE FIBROID IN A PATIENT WITH A COMPLEX MEDICAL HISTORY - EMPHASISING THE IMPORTANCE OF MULTIDISCIPLINARY CARE

Topic / Dept:

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Background
Leiomyomas or fibroids, are common benign tumors in females. We present a case of 48-year-old female with a 36-week-sized fibroid uterus. Despite the patient's morbid obesity and complex medical/ surgical history, she underwent a successful hysterectomy after uterine artery embolization (UAE).

Case Report
A 48-year-old, P0+0 woman with LMP over a year ago and BMI of 44 presented to an emergency in winter with feeling unwell and shortness of breath. She had signs of jaundice and a large abdominal mass on palpation. Tests showed HB of 6 g/dL, high bilirubin, and an enlarged spleen. Imaging confirmed a large fibroid uterus of 27 x 19 x 16.4 cm in size, and further investigation led to a diagnosis of cold hemagglutinin disease (CHAD).
CHAD was managed with blood transfusion and Rituximab infusion. The patient also had a history of midline exploratory laparotomy for acute pain and a diagnosis of tuberculous peritonitis in the past.
The patient's case was discussed in a multidisciplinary meeting, and a decision was made to facilitate UAE prior to surgery to devascularize the fibroid and reduce the risk of bleeding and complications during surgery.
Six months later patient underwent successful UAE, followed by midline laparotomy with subtotal hysterectomy, bilateral salpingectomy, and left oophorectomy a week later. The surgery was challenging due to adhesions and the size of the fibroid, but successful UAE meant that the

estimated blood loss was 800ml. The patient's HB level initially dropped by 1.5 g/dL, followed by a further 2 g drop on day 3, which was triggered by hemolysis and managed with IVIG and rituximab infusion. Additionally, she experienced abdominal wound dehiscence, treated with primary closure. She was discharged on day 11 and recovered within 3 weeks post-surgery.
The histology confirmed the presence of large benign fibroids with ischemic changes.

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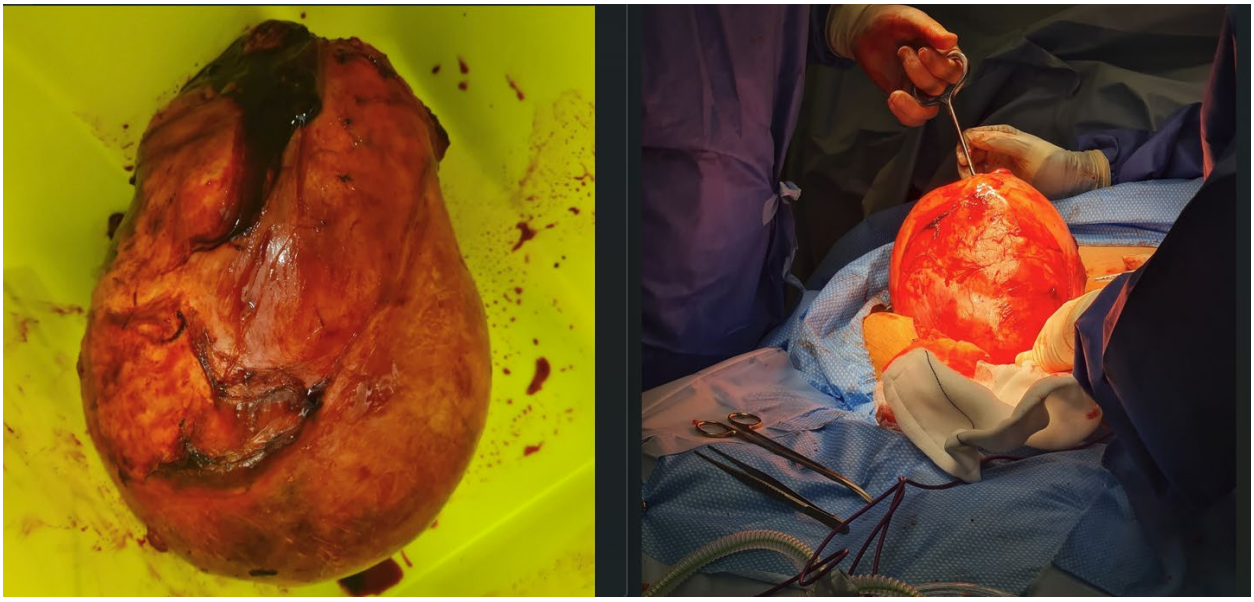

Discussion

Hysterectomy is the preferred treatment for large fibroids if the family is complete. However, it can be challenging to access pedicles in large fibroids. GnRH agonists are ineffective in reducing the size of fibroids over 18 cm. UAE has been used in the past to reduce bleeding during surgery. This technique worked in our case, which was further complicated by CHAD.

Conclusion

Our case demonstrates the successful use of UAE to reduce blood loss during surgery, highlighting the importance of a collaborative, multi-disciplinary approach and step-by-step treatment.

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OHVIRA : A RARE GYNAECOLOGICAL SYNDROME

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OHVIRA is a rare congenital malformation that involves abnormal development of the Müllerian and Wolffian ducts during the development of genitalia in female embryos.

We present an interesting case of a 28 yo female p1+1 (Previous LSCS @ 31 weeks after PPROM, NND multiple congenital anomalies) . Our patient was known to have a bicornuate uterus and a single kidney. she had an MRI imaging which reported : bicornuate uterus. Suspected incomplete vaginal duplication with haematocolpos and was due to have further work up done.

She had presented in the interim to EPAU @ 13+4 weeks for scan on which miscarriage was diagnosed and she was planned for in patient medical management

After receiving 4th dose of misoprostol, she started bleeding very heavily with clots. On examination, cervical os was closed. Plan was made for ERPC given the heavy bleeding. At the procedure, her anatomy was noted to be different, a vaginal pouch at the anterior vagianl wall burst open with hemorrhagic edges noted ,that pouch was connected to uterine cavity confirmed by scan, the Procedure was attended by consultant on call given the unusual anatomy .Dilation of the cervix done and surgical removal of product of conception,Then vaginal connection of the pouch was closed and connection of the pouch with the bladder was out ruled.

She was subsequently seen in complex gynae clinic for follow up and explained the potential diagnosis of OHVIRA. She is planned for MRI for further evaluation.

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POSTMENOPAUSAL BLEEDING - AN AUDIT OF THE OUTPATIENT HYSTEROSCOPY REVIEW TIMES. FOR 2023 IN THE CONTEXT OF THE NATIONAL CLINICAL PRACTICE GUIDELINES

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Co Author: A. Das[3]

BACKGROUND

Post-menopausal bleeding (PMB) is a common complaint seen at all levels of health care provision. Differentiation must be made if the woman is on hormone replacement therapy (HRT) as HRT protocol impacts defining PMB. While many of these presentations have a benign explanation, up to 9% have an underlying endometrial malignancy. The latest HSE clinical practice guideline was released in 2023 and stated any woman experiencing PMB should be referred to a tertiary centre and any patient meeting criteria should be fast-tracked and seen within 28 days

OBJECTIVE

This audit looked at the turn-around times in the Wexford General Hospital Ambulatory Gynaecology service from the period spanning January - December 2023 compared to the latest National Clinical Practice Guideline.

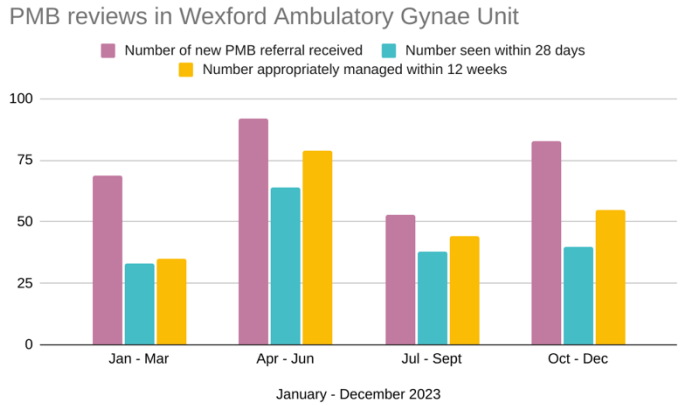
METHOD

Data from the outpatient hysteroscopy unit at Wexford General Hospital was collected including the number of new referrals received and the number of patients seen within 28 days from January - December 2023. Furthermore, we looked to see what proportion of patients were appropriately managed by 12 weeks – seen, tissue sampled and result received, with appropriate follow up thereafter.

FINDINGS

From January - December 2023, 297 new PMB referrals were received by the ambulatory gynae service. Of these, 58.9% (175) were seen within 28 days. 71.7% (213) were appropriately managed within 12 weeks. The busiest periods were April - June with a total of 92 referrals received, followed by October - December. Of the patients who were not seen within the 28 days,

a large proportion did not attend or called ahead of time to reschedule, thus pushing them beyond the appropriate time frame.



CONCLUSION

Overall timing of review falls below national recommendation although there is significant variation month to month. However, data collected had a 28 day cut off, while the guideline states review within 35 days, ideally 28. Complete management percentages were higher than initial review suggesting the delay in care is in initial review or utilisation of services by patients.

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RADICAL VULVECTOMY FOR VULVAL GANGRENE: A MULTIDISCIPLINARY APPROACH

Topic / Dept: [1]Mater Misericordiae University Hospital

Author: A McDonnell[1]

Co Author: T Walsh[1]

Co Author: C Thompson[1]

Co Author: R McVey[1]

Co Author: R McVey[1]

Co Author: M Wilkinson[1]

Co Author: D Brennan[1]

BACKGROUND:
Fournier's gangrene in females is observed less frequently than in males, however it carries a higher mortality rate of up to 20%. An aggressive approach to treatment is necessary, with extensive surgical debridement often required in the acute setting. Vulval gangrene, in particular, due to its anatomical complexity, can pose specific challenges to treatment and recovery.

OBJECTIVE:
We describe a case of advanced gangrene of the vulva treated at the Mater Misericordiae University Hospital (MMUH).

STUDY DESIGN AND METHODS:
This is a case report. Data was collected via retrospective chart review, and processed anonymously with the consent of the patient.

RESULTS:
A 65-year-old female presented to the ED with a 4-day history of vulval pain and swelling. Inflammatory markers were raised and CT imaging demonstrated extensive gaseous necrosis originating in the vulva. Examination revealed a necrotising cellulitis that extended anteriorly over the mons pubis/bilateral inguinal regions, and posteriorly toward the right gluteal region. She was diagnosed with Fournier's gangrene and scheduled for emergent surgical debridement.
A multidisciplinary approach was adopted. While the gynaecological oncology team were the primary operators, senior clinicians from plastic surgery, general surgery and urology were also in attendance. This facilitated a multifaceted surgical approach that allowed for optimal

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debridement. Post-operative course was protracted and included 35 days in high-dependency care. Allied healthcare input from physiotherapy, occupational therapy, dietetics and social work was instrumental in constructing the pathway to recovery.

CONCLUSIONS:
Fournier's gangrene of the vulva is a life-threatening condition that requires aggressive intervention including prompt surgical debridement, targeted antibiotics, and high-level supportive care. A multidisciplinary approach is essential, at every stage of the patient journey, to deliver a tailored treatment plan that will optimise outcomes.

SAVE THE OVARY: HOW LATE IS TOO LATE? – A CASE REPORT ON SUCCESSFUL CONSERVATIVE MANAGEMENT OF PROLONGED OVARIAN TORSION WITH ISCHAEMIA

Topic / Dept:

1. Beaumont Hospital, Dublin, Ireland
2. Our Lady of Lourdes Hospital, Drogheda

Author: Arthi Subramanian (Year 2 BST Trainee)[1,2]

Co Author: Taranuum Ibrahim (Registrar)[1]

Co Author: Conor Harrity (Consultant Gynaecologist)[1]

Objective: Ovarian torsion is a serious condition that can lead to ischaemia, necrosis, and loss of ovarian function. It's more likely in reproductive-aged individuals with ovarian cysts larger than 5cm, but can also occur in pre-menarche girls due to a congenitally long ovarian ligament. Despite the ovarian dual blood supply, viability decreases over time. Appearance during surgery isn't a reliable indicator of future function. Conservative treatment typically involves detorsion rather than removal of the affected ovary and fallopian tube.

Case report: A 20-year-old female was readmitted with severe right iliac fossa (RIF) pain and vomiting. She had been discharged three days earlier after being diagnosed with a right ovarian cyst. Ultrasound revealed two simple right ovarian cysts 8cm and 5.5 cm in size; a laparoscopic procedure done 47 hours later revealed right ovarian torsion with infundibulopelvic ligament twisted twice causing ischaemia. The procedure involved untwisting the pedicle, draining the right ovarian cyst, coagulating it, and removing the paratubal cyst. Post-operative recovery was uncomplicated, and a follow-up ultrasound confirmed bilateral normal ovaries with follicles.

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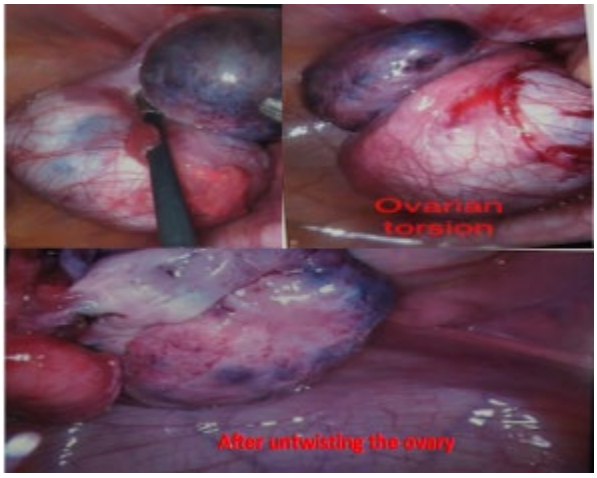
Discussion: Conservative management after prolonged ovarian torsion resulted in successful preservation of ovarian function. Postoperative surveillance, such as laparoscopy or pelvic ultrasound, is recommended to ensure ovarian recovery. The risk of recurrence after ovary torsion persists, and the aetiology is unknown. Oral contraceptives can be used to suppress the formation of further ovarian cysts. Oopheropexy, which involves fixation of the ovary to the pelvic side wall, posterior abdominal wall, posterior uterine wall, or plication of the utero-ovarian ligament, can be performed.



Conclusion: Ovarian torsion occurs in reproductive-age women with 2-15% prevalence with paratubal cyst/mass >5cm. Conservative surgery reduces 30% of perioperative complications, venous thrombus/embolism and sepsis in comparison to scalping-oophorectomy. Hence, the current management of ovarian torsion has shifted to de-torsion and ovarian conservation.

References:

1. Novoa M, Friedman J, Mayrink M. Ovarian torsion: Can we save the ovary? Archives of Gynecology and Obstetrics. 2021 Feb 27;304(1):191–5. doi:10.1007/s00404-021-06008-8
2. Guile SL. Ovarian torsion [Internet]. U.S. National Library of Medicine; 2023 [cited 2024 Apr 5]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK560675/
3. Adnexal torsion in adolescents [Internet]. [cited 2024 Apr 5]. Available from: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/08/adnexal-torsion-in-adolescents

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SMOOTH MUSCLE NEOPLASM OF VAGINAL WALL : A RARE OCCURANCE

Author: R. Almola

Co Author: H. Sial

Co Author: K. Astbury

Vulval leiomyomas are rare and account for only 0.03% of all Gynecological neoplasms and 0.07% of all vulval tumors.
We present an interesting case of a 37 yo female who was booked at university hospital Galway for antenatal care. She booked with us at 16+6 week , had uneventful antenatal course. She had a vaginal wall cyst for few years which had grown slightly in size in pregnancy.

She presented at 40+1 weeks in spontaneous labour. She had a pathological CTG at admission , artificial rupture of membranes was done at which thick meconium stained liquor was seen and she underwent cat 2 LSCS for the same. LSCS was uneventful and it was planned to remove her vaginal cyst as well. On examination, the cyst felt firm and was sent for histopathology with plan to bring her back in GOPD with histology results. The histology result came back as smooth muscle neoplasm. Further plan was made for MRI and to discuss her case at MDT.

Due to such rare occurrence , if in doubt preoperatively , radiological investigations like MRI can help reinforce the diagnosis but for definitive diagnosis histopathology should be sent and immunohistochemistry in addition if needed.

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A CASE OF MALIGNANT TRANSFORMATION OF SMALL BOWEL TISSUE IN AN OVARIAN DERMOID

Topic / Dept: Department of Gynaecology, Connolly Hospital, Blanchardstown

Author: Luricke Potgieter

Co Author: Samah Hassan

Co Author: Eve Gaughan

Introduction

Adenocarcinomas arising from Mature Cystic Teratomas (MCTs) are rare and when they occur, most arise from respiratory ciliated epithelium. A recently published literature review reported only 13 cases of MCT with intestinal-derived adenocarcinoma. Overall MCTs are the most common benign ovarian neoplasm in women of reproductive age. However somatic malignancies develop in 1-3% of cases, with squamous cell carcinoma being most frequently observed.

Case Report

A 35-year-old female presented with a two-week history of worsening lower abdominal pain. On examination, she had a palpable mass in the left iliac fossa. CT then revealed a 17.6 cm left adnexal mass with features in keeping with an MCT. As she was in stable condition, tumour markers were done, and an MRI of the pelvis planned. Before this was completed, she developed pyrexia and acute worsening of her pain, concerning of ovarian torsion. She was tachycardic and CRP was raised. An emergency laparotomy and left salpingo-oophorectomy were done. The left ovarian cyst had the appearance of an MCT.

The CA-125 level returned raised at 131.2. Other tumour markers were normal. Histopathology showed cyst contents typical for MCT but the solid segment showed colonic-type glands with areas of atypical or immature elements analysed to be a moderately differentiated adenocarcinoma with areas of necrosis. The morphology favoured small-intestinal adenocarcinoma. No malignant cells were seen on ascites cytology.

Further work-up was complicated as she was diagnosed with an early pregnancy when she was recalled. An MRI was done, and showed no residual adnexal lesion, or concerning features. She was reviewed by gynaecology-oncology MDT and had an MRI during her pregnancy that showed no recurrence. She delivered a healthy baby boy by elective caesarean section and has ongoing surveillance by the Gynae-oncology team.

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Conclusion

This case of ectopic mucinous adenocarcinoma occurring in an MCT reminds us that although malignant transformation in MCT in pre-menopausal women is rare, it should not be overlooked.

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Clinical Audit : Assessment of Duration of Fasting for elective Cesarean Section at Letterkenny University Hospital, July-August 2023.

Topic / Dept: Letterkenny University Hospital

Author: Dr Mohammedelfateh Adam

Co Author: Mariam Abufatima

Co Author: Dr Elmi Theron

Co Author: Dr Nicole Gallghar

Supervisor: Dr Elamin Dafalla

Introduction:

Fasting is vital before surgery to reduce the risk of complications during anesthesia. However, prolonged fasting can cause discomfort and may not always be necessary. . Women are required to fast from food for 6 hours prior to surgery and are allowed to drink clear fluids (i.e. water, tea/coffee with no milk) until they are called to theatre [1]. All pregnant women should be given information and support to enable them to make informed decisions about childbirth [2].

Aim:

To evaluate adherence to the WAC Group Guideline on preoperative fasting and hydration for elective cesarean sections at Letterkenny University Hospital.

Objectives: This audit assessed:
(a) documented fasting durations.
(b) completeness of patient instructions.

Methodology:

A retrospective audit was conducted using data from the clinical notes of pregnant women who underwent elective cesarean section at LUH between July and August 2023. Patients were included if they underwent an elective cesarean section within the specified timeframe. Data relevant to the guideline recommendations were extracted from clinical notes and entered into an Excel spreadsheet. Descriptive statistical analysis was performed using Excel and Jamovi app 2.3.28 solid version [3].

Results:

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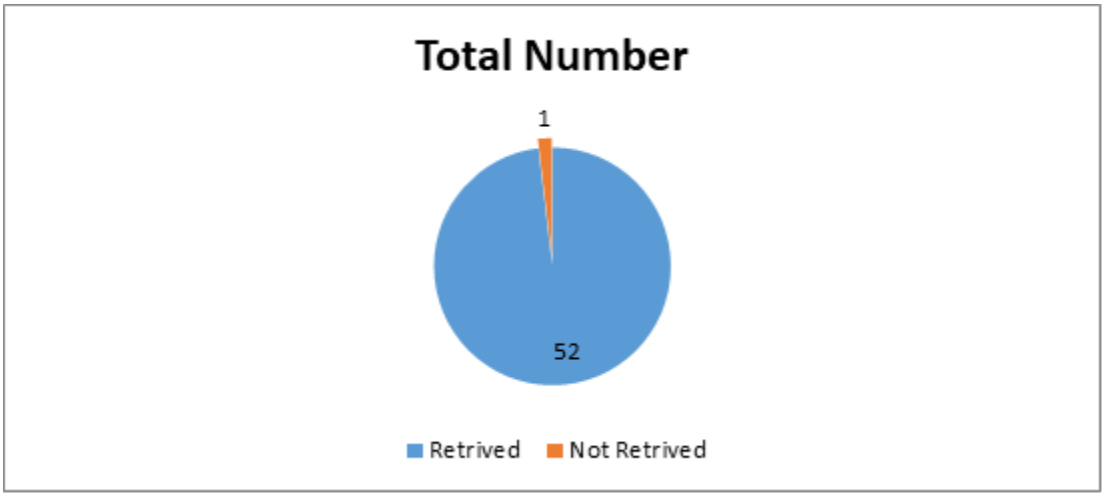

Figure 1: A Pie chart shows the total number of women who had undergone elective cesarean section.

Of 53 elective cesarean sections performed at LUH between July and August 2023, medical records were available for 52, as depicted in Figure 1 above. Analysis of these records, summarized in Table 1 below, revealed that documentation of fasting from solids was present in 86.5% (45/52) of cases, while 13.5% (7/52) lacked this documentation. Documentation of fasting from fluids was more consistently present, with 94.2% (49/52) of cases having it documented and only 5.8% (3/52) without it. Most concerning, no patients (0/52) received a patient information leaflet preoperatively. This finding highlights a significant area for improvement in preoperative patient education and informed consent practices.

	Overall (N=52)
Documentation of Fasting from Solid	
No	7 (13.5%)
Yes	45 (86.5%)
Documentation of Fasting from Fluids	
No	3 (5.8%)
Yes	49 (94.2%)
Provision of PIL	
No	52 (100.0%)
Yes	0 (0.0%)

Table1: Illustrates the documentation of fasting from solid and fluids and provision of patient information leaflets.

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The average fasting duration exceeded recommendations, with patients fasting for a mean of 12.55 hours (SD: 1.86) for solids and 11.75 hours (SD: 2.86) for clear fluids, Table2.

Descriptives		
	Duration of Fasting from Solids	**Duration of Fasting from Fluids**
N	45	49
Missing	7	3
Mean	12.6	11.8
Median	12.5	12.0
Standard deviation	1.86	2.86
Range	8.00	13.5
Minimum	9.00	2.00
Maximum	17.0	15.5

Table 2: A table illustrates the duration of fasting for solids and fluids.

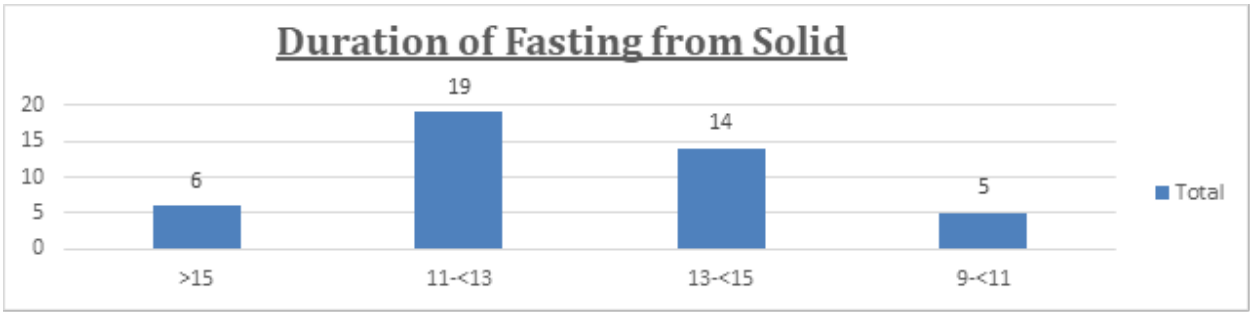

Figure 2: bar chart shows the duration of fasting from Solid food.

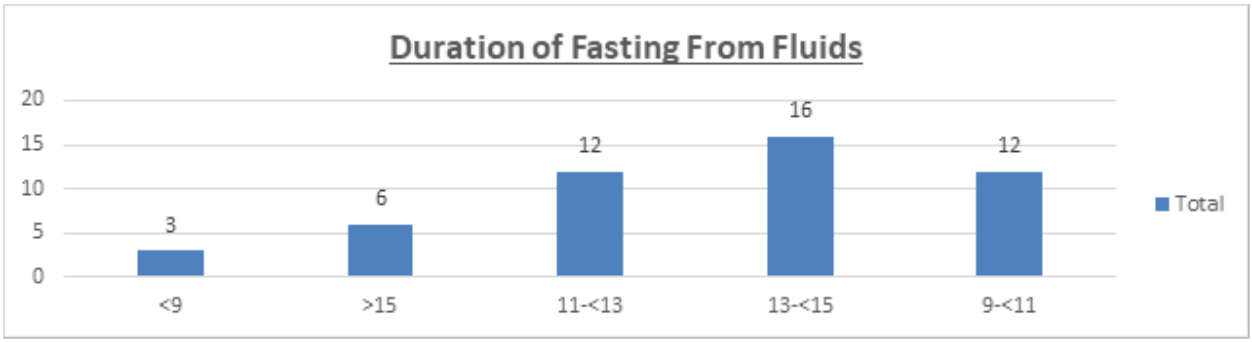

Figure 3: A bar chart shows the duration of fasting from clear fluids.

Conclusion:

This audit revealed a discrepancy between documented practice and current guidelines regarding fasting durations for elective cesarean sections. While documentation rates were

commendable, actual fasting times frequently exceeded recommendations, indicating a need to reinforce adherence to evidence-based guidelines among providers. Furthermore, the lack of documented patient education regarding fasting represents a significant opportunity to improve patient communication and informed consent practices**.**

Recommendations:

2. Reinforce Adherence to WAC Guidelines.
3. Provide education for healthcare providers.
4. Improve patient communication about fasting instructions and provide patient information leaflets in clinic.

Re-audit: in 6 months

Refrences:

2. WAC Group Guideline on Preparation for Caesarean Section (Elective and Emergency)
3. National Institute for Clinical Excellence (2021; updated 2023) *Caesarean Section. Clinical Guideline 192.* NICE: London
4. The jamovi project (2022). jamovi. (Version 2.3) [Computer Software]. Retrieved from https://www.jamovi.org.

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ARE WE ASKING ENOUGH ABOUT ASC-H?

Topic / Dept: Department of Colposcopy, Rotunda Hospital, Dublin, Ireland.

Author: Maria A. Cheung

Co Author: Ciaran D. McKeown

Co Author: Claire M. McCarthy

Tweetable abstract: With primary HPV screening for cervical cancer, ASC-H comprise a greater proportion of colposcopy referrals (3%). With a 53% risk of high-grade dysplasia (CIN2+), LLETZ/cold coagulation are effective treatments (84.1-96.9% cure rate) but conservative management can be considered.

Abstract

Background

ASC-H cytology is uncommon (0.16%-0.43%) and the reported risk of high-grade dysplasia (CIN2+) varies hugely (12-70%), making management a clinical challenge. The shift towards primary HPV screening requires an updated understanding of ASC-H.

Objective

We aimed to review ASC-H colposcopic and histological comparators, and management outcomes to help guide future management.

Study Design and Methods

A one-year retrospective analysis of new ASC-H associated visits to a large colposcopy unit in the Republic of Ireland in 2022 was performed.

Results

The incidence of new ASC-H referrals was 3.6%. The sensitivity of colposcopy for detection of CIN2+ is 69% and specificity is 43%. The positive predictive value (PPV) is 64% and negative predictive value (NPV) is 38%. 95% had a biopsy and CIN1 was found in 42%, CIN2 in 19%, CIN3 in 32% and cGIN in 2%. Two patients had conservative management of CIN2 and both regressed to CIN1. 65% had a treatment performed (Large Loop Excision of the Transformation Zone (LLETZ) 53%, cold coagulation 12%). The first test-of-cure (TOC1) was negative for 74.6%. 9.5% were positive for high-risk HPV with normal cytology so a repeat TOC (TOC2) was performed 12 months

later and all were negative. Persistent HPV with LSIL (1.6%), ASCUS (4.8%) and ASC-H (3.2%) required a TOC2 smear. 3.2% cases were awaiting TOC and 3.2% were awaiting repeat LLETZ due to incomplete excision. 45% of LLETZ specimens were downgraded histology from biopsy.

Conclusions

ASC-H with high-risk HPV has a 53% risk of high-grade dysplasia, thus timely colposcopy and biopsy is imperative. Treatment was curative in 84.1-96.9% of cases so is an effective management strategy. However, almost half LLETZ specimens were downgraded on formal histology, presenting the possibility of over-treatment. Conservative management of selected cases may be a reasonable option.

ATYPICAL PRESENTATION OF OVARIAN MUCINOUS CARCINOMA

Author: Dr Reece Weinberg

Consultant Supervisor: Dr Tushar Utekar

Introduction:

Mucinous ovarian carcinoma (MOC) is a rare form of the epithelial-stromal ovarian cancer subtype, often misdiagnosed due to its tendency to imitate gastrointestinal pathology.

This case report details an atypical presentation of (MOC) in an 85-year-old woman, a notably advanced age for the onset of this malignancy. It highlights the importance of maintaining a heightened clinical suspicion and early recognition in the collaborative effort of a multidisciplinary management approach in such presentations.

Case Description:

An 85-year-old nulliparous, postmenopausal woman, non-smoker with a background of melanoma and hypertension presented to the emergency department with a 3/52 history of abdominal distention, a 5/7 history of obstipation, and a 2/7 history of vomiting and abdominal cramping. A palpable mass in the right iliac fossa was also noted on examination. There were no constitutional symptoms and patient was hemodynamically stable throughout at presentation. A CT abdomen and pelvis showed a large, multiloculated cystic mass arising from the left ovary measuring 13.5 cm with features of metastatic disease. A Risk of Malignancy Index of at 282.6 was also calculated.

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During the inpatient workup, the patient suffered significant bowel obstruction complicated by acute bowl perforation, necessitating an emergency subtotal colectomy and surgical debulking. Histopathological analysis confirmed a primary mucinous carcinoma of the left ovary, with extension to the appendiceal and colonic walls, and the omentum. A histopathological stage of FIGO III was given, with similar immunohistochemistry profiles among the involved sites. The patient was further complicated by a postoperative course involving bilateral pleural effusions.

Conclusion:

The uncommon advanced stage and age at diagnosis and the complexity of the patient's clinical course emphasize the need for a multidisciplinary team approach to ensure timely diagnosis and comprehensive management of such rare ovarian malignancies.

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DIAGNOSING RECURRRENT VULVAL BCC IN A 53-YEAR-OLD

Topic / Dept: Department of Obstetrics and Gynaecology, Sligo University Hospital

Author: Baskaran,R.

Co Author: Ramankutti,T.

Co Author: Langan,H.

Main abstract:

Vulval Carcinoma is rare and less than 1% of all new registered cancer cases. Incidence in the UK is highest in females over 90 years. Age of diagnosing vulval cancer is mostly over 70 years, but dropped down to between 50-59 given increase in Human Papilloma Virus (HPV) - related Vulval Intraepithelial Neoplasia (VIN) and lichen sclerosus. Approximately 90% are Squamous Cell Carcinomas (SCC) with 10% encompassing Basal Cell Carcinoma (BCC), vulval melanoma, adenocarcinoma, bartholin's gland Cancer, and rarely, sarcoma. We present the case of a 53 year old with second recurrence, after 10 years of Vulval BCC with nodular features and focal squamous differentiation. At 43 years, during antenatal care of her 4th child, pea-sized raised lesion with asymmetrical borders was incidentally noted on right labia majora, postnatal biopsy sent. Histology was Vulval BCC, p16 positive, complete excision 2mm from margin. She underwent Wide Local Excision (WLE). As per Mater MDT discussion, she had second incision of scar to ensure clear margins. At 53 years, she noted intermittent 1cm raised lesion on right labia majora mirroring previous presentation, with crusting. She had WLE, and histopathology confirmed recurrence with surgical margins negative for tumour. She had CT of Thorax, Abdomen and Pelvis showing no locoregional disease or distant metastasis. She is referred onto Mater Oncology. BCC is most prevalent form of skin cancer being highly treatable with favourable prognosis and mostly in sun-exposed areas. Conversely, Vulval BCC has more aggressive clinical presentation with higher frequency of recurrence, like our patient. P16 immunohistochemistry (IHC) is useful for vulval BCC diagnosis due to mimic by HPV-related basaloid SCC. Nodular BCC is the most common overall type. Biopsy, histopathology, holistic MDT input and WLE are systematic treatment approaches. Other options include Mohs micrographic surgery, radical and simple vulvectomy. Hence, to avoid delays, any persistent vulvar lesion, especially pigmented, needs biopsy and histology, irrespective of patient age.

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ENDOMETRIAL POLYPOID ADENOMYOMA - A RARE CAUSE OF POSTMENOPAUSAL BLEEDING

Topic / Dept:

1. Department of Gynaecological Oncology, St. Vincent's University Hospital, Dublin 4
2. Department of Gynaecology, National Maternity Hospital, Dublin 4

Author: L Carr[1]

Co Author: SL O'Riordan[1]

Co Author: Z Fonseca-Kelly[1,2]

Co Author: D O'Brien[1,2]

Background:
Polypoid adenomyoma is a rare benign uterine tumour. Endometrial polypoid adenomyomas (EAP) are tumours classified by WHO as being comprised of endometrioid-type glands surrounded by mature smooth muscle. EAPs in patients with postmenopausal bleeding (PMB) pose a diagnostic challenge, often mimicking uterine malignancy on ultrasound and MRI. We report a case of EAP in a 57 year old lady presenting with PMB while on hormonal replacement therapy (HRT).

Case Report:
A 57 year old lady with a history of three previous vaginal deliveries was investigated for PMB while on HRT. A pelvic ultrasound identified an endometrium of 22mm with a cystic appearance. Hysteroscopy was performed with resection of an endometrial polyp superimposed on a fundal fibroid which was partially resected. Histology confirmed benign endometrial polyps with superficial fragments of myometrium. Recurrent PMB was reported by the patient 1 year later. Repeat hysteroscopy identified a fibroid occupying the uterine cavity. Pipelle sampling identified a polypoid fragment of inactive endometrium. An MRI to characterise the fibroid found a cystic endometrial mass measuring 3x5cm with >50% myometrial invasion, highly concerning for malignancy. A staging CT TAP reported a mass-like distension of the endometrial cavity with no evidence of metastatic or nodal disease.

Total laparoscopic hysterectomy and bilateral salpingo-oophorectomy was performed. Histological analysis found a polypoid mass composed of benign endometrial glands within

endometrioid type stroma and smooth muscle, in keeping with a diagnosis of EAP. She was discharged on day 3 and recovered well.

Conclusion:

PMB is abnormal. It is the most common reason for referral to rapid access gynaecology clinics, with studies showing that up to 9% of patients will have an underlying endometrial cancer. 30% of cases of PMB are secondary to endometrial polyps, with EAP accounting for 1.3% of all endometrial polyps. While the standard treatment for endometrial polyps is resection at hysteroscopy, hysterectomy is often performed in cases of diagnostic uncertainty. HRT can cause PMB in patients for the first 2-3 months but often spontaneously resolves. When persistent or recurrent, endometrial pathology must be outruled. The relationship between EAP formation and use of HRT is unknown. It is hypothesized that oestrogen replacement may promote EAP growth in the postmenopausal population.

How are we doing in Colposcopy? Concordance between colposcopic impression and subsequent histological diagnosis

Introduction

A colposcopic impression (CI) is formed based on the highest grade feature of any cervical lesion during a standard colposcopic assessment. The positive predictive value (PPV) is calculated as the proportion of individuals who have a CI of high-grade disease which is subsequently confirmed on histological examination. For quality assurance, the PPV for suspected high-grade lesions should be at least 75%.

Methods

A retrospective review of all cervical biopsies undertaken in a seven-day period in an Irish tertiary level colposcopy department that had almost 5600 attendances in 2022. The study received ethical approval in October 2023 from the hospital's research advisory group (ref:23/609).

Results

In total, 47 patients had a cervical biopsy taken. The mean age of patients in this cohort was 39 years of age (range 25-64, SD 11.3). Of these, 14 (29.8%) had previously attended for colposcopic assessment and been discharged. The most common referral smear was atypical squamous cells of undetermined significance (n=23; 49%). All patients referred with abnormal cytology were also

positive for Human Papillomavirus. The majority of assessments and biopsies were undertaken by qualified nurse colposcopists (n=24; 51.1%).

A total of 6 (12.8%) patients had a CI of high-grade disease with 4 (66.6%) confirmed histologically. A CI of low-grade disease was given for 35 (74.5%) patients. Of these, 25 (71.4%) had confirmed CIN1 on biopsy. In 8 (22.9%) cases when low-grade disease was suspected, histology of CIN2 or higher was returned.

Conclusion

The PPV for suspected high-grade lesions (66.6%) within the time frame studied was lower than the target of 75%. The PPV for suspected low grade lesions was higher (71.4%), although underestimation of grade was noted in 22.9% of cases. The implementation of a formal scoring system (such as the Swede score) may help improve the sensitivity and specificity in identifying high-grade disease in this unit.

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Meigs Syndrome

Background:

Meigs Syndrome is triad of rare benign ovarian tumors presentation (Fibroma) which are high CA125, ascites & pleural effusion. It accounts for 1% of ovarian cancer. Pleural effusion resolves after surgical resection of ovarian tumor. There are other varieties of Meigs syndrome. Pseudo Meigs syndrome which include ovarian tumor (other than Fibroma). Also reported in patients with Systemic Lupus Erythromatosis and enlarged ovaries. While atypical Meigs includes notable leg oedema in the absence of ascites.

Case study:

An 82 years old lady presented with flu like symptoms, interscapular pain and right leg swelling. Computerized Tomography of Thorax, Abdomen and Pelvis (CT TAP) revealed large right sided pleural effusion and 7*6*5 cm left pelvic cystic mass. Ultrasound scan (USS) showed multilocular thick walled cystic lesion with several thin internal Septation in the left ovary measuring 5.2*5.1*7.1 cm & smaller cystic lesion on the right ovary measuring 2.7*1.5 *2.0 cm. Right lower limb Doppler USS was negative for deep vein thrombosis. Cytological study of pleural effusion reported as malignant cells of mesenteric origin neoplasm (mullerian, genitourinary or renal). Tumor markers were mildly elevated with CA125 at a level143, LDH was 269, and the rest (CA19-9,CEA,AFP) were all Normal .

Atypical Meigs syndrome is the most likely diagnosis because of presence of right side pleural effusion and leg swelling in the abscence of ascites. On the other hand Meigs & Pseudo-Meigs syndrome , are unlikely due to the Absence of ascites. Histopathological examination is a necessity for the diagnosis of malignancy. Multidesciplinary referral was sent to a tertiary gynaeoncology centre and their recommendation are awaited.

Conclusion:

Multidesciplinary input is crucial for managing patients with unusual presentations at their initial contact with health service, Referral to tertiary institutes ensure high quality of management of rare cases, management of complicated cases in secondary centres with collaboration of tertiary centres facilitate continuity of learning.

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Ovarian Dysgerminoma

Objective

Ovarian malignant germ cell tumors represent less than 10% of all ovarian tumors. Dysgerminoma is the most common malignant primitive germ cell tumor in young women, known for its curability and low propensity to invade and metastasize when diagnosed early. Here in, we report an unusual type of ovarian dysgerminoma presentation.

Case Report

A 31-year-old nulliparous woman complaining of irregular periods. An ultraosund showed bilateral simple ovarian cysts but also a more complex mass in the midpelvis. Biochemical and hematological investigations were normal apart from an elevated CA125 91, LDH 1197 and HCG 35. MRI showed large bilateral simple appearing adnexal cysts and a large solid pelvic mass which appears to arise from the left adnexa, appearance suggestive of ovarian neoplastic disease . CT TAP showed an unchanged left adnexal cyst measuring 5.2 x 4 cm , an unchanged right adenexal cyst measuring 3.8 x 3.5 cm, an unchanged left adnexal soft tissue vascular mass measuring 8.7 x 5.5 cm, extending to the midline superior to the bladder and no distant disease. At laparotomy, the right ovary was normal and a large complex left ovarian mass was noted. Left salpingo-oophorectomy, omentectomy, left pelvic node dissection and peritoneal biopsies were performed. Histology demonstrated Left ovary dysgerminoma as site of primary tumour, provisional pathological stage ,AJCC 8th ED:Pt1C (FIGO1C)N0MX. No evidence of malignancy in the omentum and benign lymph nodes.

Discussion

Despite the fact that all dysgerminomas are malignant, they do have excellent prognosis after a simple salpingo-oophorectomy up to 96% cure rate of a unilateral tumor without capsular invasion or spread. And because of its excellent response to chemotherapy, those that have extended beyond the ovary can often be cured, with overall survival of greater than 80%. Surgery is not only therapeutic but also required for diagnosis and staging, with scope of procedure dependent on intraoperative findings and the patient's desire to maintain fertility.

Conclusion

Ovarian dysgerminomas should be included in the differential diagnosis for a young female who presents with lower quadrant pain, palpable pelvic mass, elevated β-HCG and LDH. Supporting sonographic findings include a solid, heterogeneous, lobulated adnexal mass. The majority of

tumors are Stage IA at the time of diagnosis and can be conservatively treated with surgery. This case study demonstrated the unique characteristics of this rare type of malignant ovarian germ cell tumor, including age of presentation, symptoms, elevated lab values, and imaging characteristics.

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Secondary ovarian cancer recurrence: what is the best management?: A Case Study

Objective:

Ovarian cancer with complete clinical response to initial treatment has a high rate of recurrence, almost 25% in cases with early-stage diseases and more than 80% with more advance stages. Despite the growing number of promising therapeutic options to treat recurrent ovarian cancer, the available evidence suggests that there is not a single best management option for secondary and tertiary recurrence but treatment should be personalized, based on the disease characteristics, previous treatments, patient characteristics, and patient preference[1]. In this case report, we will present a case of ovarian cancer recurrence and outline the presentation, work-up and multi-disciplinary management of the patient.

Case Report :

A 49-year-old para two, was originally diagnosed with high grade serous ovarian carcinoma in August 2022. She underwent neoadjuvant chemotherapy and had optimal cytoreductive surgery with good evidence of chemotherapy response histologically. The staging that time was pT3a. Unfortunately, 10 months after completion of her chemotherapy, a rising CA125 was noted and a CT suggested nodal recurrence in both the groin and pelvis. On admission for groin node biopsy to confirm recurrence, she complained of difficulty with word finding, slowed speech, right upper limb weakness and headache. A CT brain showed a solitary enhancing metastasis in left frontal lobe with surrounding oedema and mass effect. Radiologically guided left inguinal node biopsy was done and confirmed metastatic serous ovarian carcinoma. Input was obtained from specialists in Medical and radiation oncology and neurosurgery. Surgery for the brain lesion was not deemed appropriate in the context of multi-site metastatic disease. The patient started on dexamethasone and subsequently underwent stereotactic radiotherapy to the brain metastasis. Thereafter, she commenced carboplatin and paclitaxel and following 3 cycles of treatment CA125 has returned to normal and follow-up scans are performed to assess the response to treatment, which showed a reduction in size of enhancing lesion in left frontal lobe of brain.

Discussion:

Cerebral metastases in epithelial ovarian carcinoma generally occur late in the course of the disease, but the incidence is increasing, occurring in patients with a prolonged survival caused by repeated chemosensitive relapses. Most women diagnosed with ovarian cancer and treated with debulking surgery and adjuvant chemotherapy will ultimately relapse. Metastases outside of the peritoneal cavity and abdominopelvic lymph nodes are rare at presentation but are increasingly recognized during treatment. This may be because of improving imaging techniques and because the therapy is increasingly successful at controlling peritoneal disease, so that patients live longer

and show manifestations of distant disease that would not otherwise have become evident. In this case, a cerebral metastasis occurred after primary treatment, an unusual occurrence but demonstrating the importance of investigating any new symptoms in ovarian cancer patients.

Conclusion:

A significant proportion of patients with ovarian cancer develop a secondary, tertiary, or later recurrence and the evidence to guide management is overall limited. However, the general approach used in the first recurrence can guide the approach to subsequent recurrences. Unusual sites of ovarian cancer recurrences are increasingly recognized in clinical practice because of advances in chemotherapy and radiation therapy and longer patient survival, and because of the manifestation of distant metastases that may otherwise not occur or be clinically silent. Radiologists should be aware of this changing pattern of disease spread in ovarian cancer patients who receive aggressive chemotherapy or radiation therapy.

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SQUAMOUS CELL CARCINOMA IN OVARIAN DERMOID

Topic / Dept: University Hospital Waterford

Author: Warda Maqsood

Co Author: Aya Eltom

Co Author: Samina Gul

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Background:
Ovarian dermoids are the most common germ cell tumors with a rare malignant transformation rate of 0.17-2%, primarily to squamous cell carcinoma. This case aims to enhance understanding of such rare gynecologic malignancies for early diagnosis and improved patient outcomes.

Case report:
34-year-old woman, P2+1 with one month of abdominal pain and progressive distension, along with significant weight loss. Baseline labs normal. CA-125 and CA 19-9 were elevated. Imaging revealed a large cyst (19.3 x 11.6 cm) with a solid fat component (6.9 x 4.2 cm), diagnosed as a dermoid cyst. She was planned for laparotomy and unilateral salpingo-oophorectomy, but intraoperatively, a large tumor was found adherent to the bowel, leading to a total abdominal hysterectomy + bilateral salpingo-oophorectomy + omentectomy + pelvic lymphadenectomy and tumor resection. Histopathology confirmed moderately differentiated squamous cell carcinoma (FIGO Stage IIB). She is currently postoperative and awaiting chemotherapy.

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SMOOTH MUSCLE NEOPLASM OF VAGINAL WALL : A RARE OCCURANCE

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Co Author: H. Sial

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Vulval leiomyomas are rare and account for only 0.03% of all Gynecological neoplasms and 0.07% of all vulval tumors.
We present an interesting case of a 37 yo female who was booked at university hospital Galway for antenatal care. She booked with us at 16+6 week , had uneventful antenatal course. She had a vaginal wall cyst for few years which had grown slightly in size in pregnancy.

She presented at 40+1 weeks in spontaneous labour. She had a pathological CTG at admission , artificial rupture of membranes was done at which thick meconium stained liquor was seen and she underwent cat 2 LSCS for the same. LSCS was uneventful and it was planned to remove her vaginal cyst as well. On examination, the cyst felt firm and was sent for histopathology with plan to bring her back in GOPD with histology results. The histology result came back as smooth muscle neoplasm. Further plan was made for MRI and to discuss her case at MDT.

Due to such rare occurrence , if in doubt preoperatively , radiological investigations like MRI can help reinforce the diagnosis but for definitive diagnosis histopathology should be sent and immunohistochemistry in addition if needed.

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YOUNG-ONSET OVARIAN CANCER: AN 18-YEAR RETROSPECTIVE STUDY FROM A TERTIARY REFERRAL CENTRE

Topic / Dept:

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Background

Ovarian cancer (OC) is the third most common gynaecological cancer worldwide with a median age at diagnosis of 63. The disease often presents with an advanced-stage at diagnosis due to non-specific symptoms and the absence of effective screening methods. However, while rare, it can also profoundly impact the lives of younger women including those <50 and adolescents. The clinical pathological features of this cohort are not well-defined and the identification of risk factors for OC in this patient group is crucial for disease prevention and management.

Objective

In this study we aimed to provide clinical and histopathological descriptive trends for OC in women <50 and explore potential risk factors for disease development; parity, height, miscarriages, family history, and alcohol consumption.

Methods

Patients diagnosed with invasive OC <50 years between March 2005 and September 2023 were identified through the Gynaecologic Biobank at St James's Hospital (SJH). Retrospective cohort study design was utilized and clinicopathological data was collected. Patients provided written consent at biobank enrolment and this study was approved by the SJH/Tallaght University Hospital joint Research Ethics Committee Ethics Review Board.

Results

950 patients were included, 140 (14.7%) were diagnosed <50 years. The mean ± SD age was 40.5 years ± 8.01 years, range 17-50 years (Table 1). OC histological classification in this cohort included high-grade serous (n=51, 36.4%), low grade serous (n=10, 7.1%), unclassified serous (n=8, 5.7%), mucinous (n=23, 16.4%), endometrioid (n=15, 10.7%), and clear cell (n=9, 6.4%). Positive correlations of significance were noted between the subtype of ovarian cancer and parity (<0.001), height (<0.027), miscarriages (<0.009), alcohol (<0.004) (Table 2).

Conclusion

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This retrospective cohort study identified OC <50 years in 14.7% of patients consented to the biobank of a tertiary referral centre over an 18-year period. We demonstrate a wide distribution of OC histological subtypes in this age group, and highlight parity, height, miscarriages, and alcohol intake as potential risk factors of significance. Data regarding genetic information is currently being collected for this cohort which will provide further insight into this complex disease. While the identification of risk factors can identify high-risk patients and inform treatment plans, larger studies with international collaboration are essential to further define oncological risk factors in this rare disease.

Tweetable Abstract

Ovarian cancer is typically associated with postmenopausal women, however, it also affects younger women <50 years. We identified a cohort of women <50 years with this disease, examined their histological cancer subtypes and explored possible risk factors for disease development.

	Age (mean, min, max, stddev)			
SUBTYPES	**Mean Age**	**Min of Age**	**Max of Age**	**StdDev of Age**
EPITHELIAL	**40**	**17**	**50**	
Serous	43	23	50	+/- 5.89
Mucinous	37	23	50	+/- 7.11
Endometrioid	42	25	50	+/- 7.40
Mixed	37	17	50	+/- 10.40
Clear Cell	41	35	49	+/- 4.66
NON-EPITHELIAL	**39**	**16**	**50**	
Germ Cell	24	16	36	+/- 7.20
Stromal	46	39	49	+/- 4.09
Sarcoma	49	47	50	+/- 2.12

Table 1. Distribution and mean age of histological subtypes

Variable	**Correlation Coefficient***	**P Value**
Parity	0.3016	0.001
Height	-0.3409	0.027
Miscarriages	0.2162	0.009

Alcohol History	0.2397	0.004
Family History	0.0484	0.565

**Categorical variables use Spearman correlation method, continuous variables use Pearson correlation method*

Table 2. Correlation between OC subtype and multiple variables

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EMBRYO DEVELOPMENT MORPHOKINETICS AND CLINICAL OUTCOMES IN OOCYTES WITH SMOOTH ENDOPLASMIC RETICULUM (SER)

Background

Smooth endoplasmic reticulum aggregates (SERa) are evident in the oocytes of 10% of IVF/ICSI cycles. Their presence in relation to assisted reproductive technology (ART) outcomes has been a subject of debate. SERa+ oocytes, as well as other oocytes derived from the same cohort of eggs in an ART cycle, have previously been linked to poor embryological and clinical results. The Istanbul consensus (2011) recommended that SER+ oocytes should not be injected/inseminated due a reported possible increase in adverse foetal outcomes. However, more recent studies contest this, suggesting that the presence of SERs is not detrimental to outcomes. More knowledge on this subject is required to ensure clinicians and embryologists can appropriately treat and counsel their patients.

Objective

The objective of this study is to evaluate the morphological and kinetic development in embryos that contain SERa clusters, and to examine the outcomes of the ART cycles in these patients.

Study Design and Methods

This was a single centre retrospective study of all ART cycles between January 2019 and December 2020 at Merrion Fertility Clinic, Dublin. SERa+ oocytes were identified and data in relation to these treatment cycles were entered into a computerised database. A control group of SERa- cycles was identified for the same period. Patient age, AMH, parity and BMI at the time of the oocyte retrieval were recorded as well as treatment protocol and duration of stimulation. Previous ART cycles (number, type) was also noted. Individual oocyte outcome was followed, including maturity, fertilisation, blastocyst quality, embryo transfer, positive pregnancy tests and obstetric outcomes. During the time period in question, fertilised oocytes were incubated in an Embryoscope time-lapse integrated incubator (Vitrolife AB, Goteborg, Sweden) and morphokinetic data were recorded prospectively. Embryo morphokinetic parameters were compared between SERa+ and SERa- cycles.

Findings/Results

From January 2019 to December 2020, 951 ART cycles were commenced. From these cycles we identified 76 cycles that contained at least one SERa, and 64 controls. The duration of ovarian stimulation was longer in the SERa+ group. There was a higher blastulation rate and a higher percentage of good/top quality blastocysts in the SERa- cohort. Reassuringly, there was no statistical difference between groups in fertilisation rate, pregnancy rate, live birth rate or

neonatal outcomes. A subset analysis of embryo development by timelapse microscopy showed differences in fixed and dynamic morphokinetics between embryos derived from SERa+ and SERa- cycles.

Conclusions

Our findings suggest that SERa+ oocytes are associated with distinct differences in morphokinetic and embryological development. However, clinical outcomes are not impacted, supporting the use of these oocytes in ART cycles.

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FERTILITY PRESERVATION FOR ADOLESCENTS AND YOUNG ADULTS WITH CANCER – A PATIENT AND PARENT PERSPECTIVE.

Topic / Dept:

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Background
Around 300 children, adolescents and young adults (CAYA) are diagnosed with cancer in Ireland every year, with an 81% five-year survival rate. Infertility is a known long-term sequela of childhood cancer treatment and future fertility is a primary concern for these patients. With the advent of assisted reproduction, it is now possible to preserve fertility prior to gonadotoxic therapies and this is considered best practice internationally. While fertility preservation for adults (>18 years) with a cancer diagnosis is funded through the HSE in Ireland, there is no equivalent public funding scheme for CAYA patients under 18 years. In 2018, Merrion Fertility Clinic (MFC) received a charitable grant from the Irish Cancer Society (ICS) to provide FP to these patients. It is hoped that this program will act as a precursor to a state-funded CAYA FP programme. To enhance and optimise this service, we set out to evaluate the experience of adolescent female patients and their guardians.

Objective
This study investigated the experiences of AYA patients and their parents who underwent FP prior to oncology treatment.

Study Design and Methods
This was a cross-sectional survey-based study modelled on a questionnaire previously validated for paediatric oncology patients. Two groups were surveyed: 1) Female CAYA with cancer (<18years) who underwent fertility preservation in MFC and 2) their parents/guardians.

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Findings/Results

The survey was completed by 7 female patients and 6 of their guardians. Mean age of the patients at the time of cancer diagnosis was 15.4 years (± 1.13). At the time of the survey study, the mean age of the patients was 17.6 years (± 1.99). All (100%) of the participants (n=7 patients; n=6 parents) felt the information they were provided about FP was comprehensive and clear. All participants felt they had made the correct decision about pursuing FP prior to cancer treatment. 100% of parents and 85% of patients felt this service should be publicly funded by the state.

Conclusions

In Ireland, FP for female CAYA patients is a valued service to this patient population and the majority contend that it should be funded publicly. Our study highlights the importance of appropriate, equitable and accessible FP referral structures and pathways for these patients and the need for this to be funded through our public healthcare system.

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INTERVENTIONS TO REDUCE PAIN RELATED TO INTRAUTERINE DEVICE (IUD) INSERTION IN NULLIPAROUS WOMEN: A SCOPING REVIEW

An updated review since 2015

Topic / Dept: University of Limerick School of Medicine

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Co Author: Dhaliwal, Anmol BSc, BMBS

Background: A low level of relative use of Intrauterine Devices (IUD) in young women has led to discussions on how to increase uptake in nulliparous women. One major deterring factor is pain with insertion, and pain relief options have yet to be reviewed specifically for nulliparous women.

Objective: The objective of this article was to conduct a scoping review to capture studies related to interventions to reduce pain with IUD insertion specific to nulliparous women and to summarize these findings and their clinical significance.

Study Design and Methods: Searched databases included EMBASE, PubMed, and the University of Limerick Library Journal Search database. Two authors independently searched articles and extracted data. Articles written in English that evaluated an intervention to prevent or treat IUD-related pain from 2015-2023 were included. Inclusion/exclusion criteria: articles had to be specific to nulliparous women, had a majority of nulliparous women, or separated data by parity. Articles were excluded if they did not investigate a method of preventing or diminishing pain with IUD insertion, did not indicate parity of participants, or did not meet the minimum percentage of nulliparous women outlined above.

Results: Only 10 articles were published specific to nulliparous women in the 8-year capture period. Vaginal dinoprostol or misoprostol, 4% topical lidocaine gel and 2% intracervical lidocaine, and intrauterine mepivacaine all reduced pain. A novel cervical stabilizer device called the Aspivix was also effective. Paracervical lidocaine, oral misoprostol, nitrous oxide gas, and verbal analgesia proved ineffective.

Conclusion: This review found 6 methods that reduced pain with IUD insertion in nulliparous women.

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Discussion: This information could be beneficial for future revisions of guidelines although the limited number of articles indicates a significant need for more research on the subject.

Key Words: IUD, intrauterine device, insertion, nulliparous, pain, treatment, relief, therapy, analgesia

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LIVE BIRTH FOLLOWING LAPARASCOPIC EGG RETRIEVAL IN A WOMAN WITH A BICORPOREAL UTERUS

Topic / Dept:
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Background
Laparoscopic oocyte retrieval (OCR) may be used in selected cases, for women where the usual transvaginal approach is not possible.

Objective
We describe a case of a successful outcome in a woman with a significant Müllerian duct abnormality who had a laparoscopic OCR.

Methods
A 40 year old woman with a bicorporeal uterus, vaginal septum and multiple fibroids wished to conceive using donor sperm assisted conception.
She was assessed by two senior reproductive medicine specialists, the ovaries were deemed to be inaccessible vaginally. Following pelvic ultrasound and magnetic resonance imaging (MRI) and multidisciplinary team discussion, a decision was made for laparoscopic OCR. Of note, the patient also reduced her body mass index from 38 to 31 kg/m2 pre-operatively.

Results
Following controlled ovarian hyperstimulation with gonadotropins for eleven days, she underwent an uncomplicated laparoscopic OCR. Six oocytes were retrieved and inseminated with donor sperm. On day five following OCR, she had four good quality blastocysts to freeze.

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Following her first frozen embryo transfer she became pregnant. A healthy baby boy was delivered by elective Caesarean Section at 36+4 week's gestation.

Conclusion

This is a case of a successful outcome following laparascopic egg retrieval in a woman with complex uterine anatomy. She has three embryos remaining in cryo-storage.

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MALE VIEWS ON FEMALE FERTILITY PRESERVATION

Introduction

Studies have shown that the majority of women are aware of ovarian reserve testing and fertility preservation. Additionally, the majority of women would consider undertaking oocyte vitrification to preserve fertility (1). Data, however, around the views of men in the general population or about male partner's views on ovarian reserve testing and on female fertility preservation are lacking.

Methods

A cross sectional survey was created using an online forum consisting of 32 questions. Men aged over 18 years old in the general population were eligible to participate after giving informed consent. The survey was disseminated through social media and a national online media publication.

Results

In total there were 277 responses. 51% of respondents were <40 years old.
85% believed parenthood was a priority.
76% were aware of ovarian reserve testing and 97% were aware of oocyte cryopreservation. 89% were supportive of a partner undergoing ovarian reserve testing and 84% were supportive of a partner undergoing oocyte vitrification. Responses were similar across all age groups, but awareness and support levels for ovarian reserve testing were lower in single men (58% vs 78% p=0.01 and 75% vs 90% p=0.01)
When asked about their reaction if a partner was informed about having a low ovarian reserve, 70% would prioritise family and fertility treatment over career issues and 64% would support egg freezing.

Conclusions

Men's knowledge and awareness of ovarian reserve testing and oocyte vitrification is high and has improved over the past decade. They are supportive of oocyte vitrification.

1. What women want? A scoping survey on women's knowledge, attitudes and behaviours towards ovarian reserve testing and egg freezing. O'Brien, Yvonne et al. European Journal of Obstetrics and Gynecology and Reproductive Biology, Volume 217, 71 - 76

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MEDICALLY ASSISTED REPRODUCTION Referrals – a fertility hub experience

Author: A Redmond

Co Author: M Omar

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Background

With one in four couples affected by infertility, the introduction of a HSE-funded medically assisted reproduction (MAR) programme in September 2023 marked a significant milestone in access to "paid for" IVF/ ICSI therapies in Ireland. At present, all cycles of MAR occur in private settings and in consequence the indications for MAR at national level have never been published.

Objective

To identify, profile and establish the final diagnosis for all couples referred for HSE-funded MAR therapies from a Dublin Fertility Hub.

Study Design and Methods

Data was collected from the two HSE referral forms and the electronic database of our Fertility Hub and analysed using Microsoft excel. All recorded referrals sent from October 2023 to August 2024, were analysed.

Findings/Results

198 couples were referred for MAR therapy during the 11 months studied. Average female age was 36years(26-41) while male age was 38years(24-60). The average AMH was 14.4 pmol/L(0.07-93pmol/L). A female factor was diagnosed in 33% of cases, male in 29% and 20% of cases had a combined female and male factor. Only 18% of MAR referred cases had unexplained infertility. The recommended therapies were IUI(5.5%), IVF(51%) and ICSI(43.5%).

	Total numbers	**Range/ Percentage**
Referrals	198	100%
Average female age (years)	36	26-41
Average male age (years)	38	24-60

Average AMH level	14.4	0.07
Reasons for referral		
Male factor	66	33%
Female factor	57	29%
Male and female factor	40	20%
Unexplained	35	18%
Recommended treatment		
IUI	11	5.5%
IVF	101	51%
ICSI	86	43.5%

Conclusions

We showed that the diagnosis of infertility requiring MAR is equally shared between females and males and that the parameters dictating outcome (e.g.female age, AMH) remain optimal for conception. Establishing patient profile, diagnosis and indications for MAR offers an important tool for patient counselling at time of fertility investigations. Comparisons between hubs and their populations could further personalise the advice given to couples. The introduction of a state funded MAR programme was long awaited in Ireland, the only country in Europe without such provisions prior to 2023. The “soon to happen” implementation of an electronic database for all fertility hubs should facilitate data collection and analysis at national level. Regrettably, to this day, national MAR results publication remains an aspiration!

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Reproductive Advice - finding the yin and yang

Topic / Dept: Rotunda Hospital and RCSI

Author: A E Redmond

Co Author: R Roopnarinesingh

Co Author: E Mocanu

Background

The total fertility rate in Ireland is now below the level required for sustaining a steady population (OECD 2024). The age at first birth has constantly increased in Ireland (Annual report, Cork). At present, fertility education is modestly provided in schools and contraception advice is not balanced by fertility advice when contraception is offered. Furthermore, the reality of a reproductive window between 13-43 years old and peak fertility between 25-35 years old is not discussed with women receiving contraception.

Objective

To create a patient information brochure to be used at the time of contraceptive advice detailing both aspects of human reproduction: the prevention of pregnancy and education on the ideal interval to establish a family and female versus male fertility.

Study Design

Based on the HSE Guide to Contraception we have devised a Reproductive Advice booklet to detail both aspects, contraception and future fertility.

Findings/Results

The 'Your guide to contraception and fertility booklet' complements the HSE Guide to Contraception and additionally presents in basic information on female and male reproduction, ideal age for establishing a family, how a pregnancy establishes, certain cause for infertility and potential therapies if infertility diagnosed. Foremost, it advises women and men to consider both sides of reproduction, the needed contraception and the potential future desire to establish a family.

Conclusions

The present initiative details a new concept addressing human reproduction from both contraceptive advice when indicated/ needed and fertility advice to prevent involuntary infertility. Two sides of a medical care coin. This will contribute to improving reproductive

literacy, empowering individuals and couples to make informed reproductive decisions, and ultimately reduce undesired pregnancies but also infertility and need for expensive fertility treatments, not to mention the emotional and social stigma associate with infertility. The Booklet will be provided at JOGS meeting.

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SERVICE EVALUATION: IMPLEMENTATION OF PUBLIC FUNDING FOR FERTILITY SPECIALIST TREATMENTS AT A REGIONAL FERTILITY HUB (CUMH)

Topic / Dept: Cork University Maternity Hospital, Cork, Ireland

Author: E. Pons Carrion

Co Author: K. Angkanaporn

Co Author: M. McMenamin

Background:
In September 2023, Ireland introduced publicly funded assisted human reproduction (AHR) services to improve access to fertility treatments. Eligibility is based on strict criteria.

Objective:
This evaluation aimed to assess compliance with eligibility criteria in referrals to the Cork University Maternity Hospital (CUMH) fertility hub, identifying areas for improving the referral process and patient access to treatment.

Study Design and Methods:
The evaluation reviewed the electronic charts of all patients seen in the subfertility clinic from February to March 2024, assessing compliance with the eligibility criteria and analyzing referral pathways and outcomes.

Findings/Results:
A total of 216 female patients (2 women are single, 3 are in same-sex relationships) and 211 male patients were seen. The average time from referral to first visit at consultant-led subfertility clinic was 105 days and first consultation to ART referral was 128 days. 13 patients (12.7%) being referred for ART at first consultation, having completed necessary investigations.
62% of patients met the criteria for publicly funded treatment. Of the eligible cohort, 8.8% underwent ovulation induction, 28.4% had intrauterine insemination, 29.4% were referred for in vitro fertilization and 33.3% underwent intracytoplasmic sperm injection (ICSI+/- Testicular Epididymal Sperm Extraction for 2 patients). Ineligibility was primarily due to BMI (29.3%), age (9.8%), lifestyle factors (22.0%), and previous IVF cycles (9.8%).

Conclusions:
Publicly funded AHR services have improved access to fertility treatments, but 38% of patients were ineligible due to criteria like BMI, age, and lifestyle factors.
Enhancing education on the referral criteria for onward treatment to reduce non-eligible referrals. Encouraging lifestyle changes, such as smoking cessation, optimising BMI, during the waiting period prior to first consultation. Pre-referral checklists for GP (including baseline tests)

and early referrals for key investigations would streamline process and improve timely access to treatment.

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THE DANGER OF FEMALE ABDOMINAL PAIN BEING OVERLOOKED: A RUPTURED ECTOPIC PREGNANCY IN A CROWDED A&E

Topic / Dept: E.G. Beaumont Hospital, Dublin

A 39-year-old P2 lady presented to A&E in a large Dublin hospital at 1am with abdominal pain worsening over a period of 12 hours. She was triaged at 1:10am and not seen again by medical staff until 7:50am. A urine sample had been taken and it had been documented that there was blood in the sample, however, there was no indication in the notes that a pregnancy test had been performed.

In the preceding weeks, the patient had seen her GP and been given medications for termination of an unwanted pregnancy. Despite the patient offering this information it went unnoticed until the patient deteriorated and was brought for emergency diagnostic laparoscopy and left salpingectomy. It was subsequently found that she had a ruptured ectopic pregnancy with large amounts of blood and fluid in her abdomen.

This case highlights how abdominal pain in women can often be overlooked or assumed to be something else. This is despite the fact that we are told very early on in our medical careers that abdominal pain in a female of child-bearing age is assumed pregnancy-related until proven otherwise.

In a busy emergency department, it can be difficult to assign priority to the large number of patients presenting to you, some appearing closer to deterioration than others, however I aim to discuss what lead to this and how it can be avoided in the future. This is a preventable occurrence, and we have the clinical and diagnostic tools necessary to avoid it.

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THE ROLE OF AUTOIMMUNITY AND GENE POLYMORPHISM IN INFERTILITY

Objectives:
The importance of genetic polymorphisms and autoimmune factors in infertility is still uncertain. Autoimmunity has a significant impact on female reproductive success since it decreases fertility and increases the risk of miscarriage. The long arm of chromosome X is important in the control of functional ovarian reserve and the FMR1 gene at Xq17.3 is known to be associated with early menopause and diminished ovarian reserve. Reproductive failure and diminished ovarian reserve may be associated with the number of CGG repeats in the FMR1 gene. Previous studies have shown that there is a statistical correlation between AMH and the FMR1 gene in the premutation range. Genes on the X chromosome have a well-known association with autoimmune conditions, which are known to have a significant impact on female reproductive success.We aim to fined the prevalence of autoimmune parameters in infertile females and to correlate the CGG repeat size in the *FMR1* gene to infertility and decreased ovarian reserve.Also to correlate the autoimmune parameters to CGG repeat size of *FMR1* gene.

Study Design :A total of 100 Female patients with a history of primary or secondary infertility, of unknown cause attending the Artificial Reproduction clinic at Mater dei Hospital in Malta during 2014 till 2016 with unexplained infertility were consented. Cytokine assay for IL-2, IL-4, IL-6, IL-8,IL-10,GM-CSF, IFN-γ, TNF-α was done by luminex Bio-Plex Pco ® on 59 serum samples.The FMR1 gene was studied in 68 samples by PCR using primers across the CGG repeat in exon 1.

Results: A significantly higher IL-10 level was seen amongst infertile patients when compared to controls. Moreover, a significantly higher ratio of TNF-α/IL-10, IFN-γ/IL-4, and IFN-γ/IL-10 was found in infertile females when compared to the controls. Both the pro- and anti-inflammatory cytokines levels and the cytokine Th1/Th2 ratios correlated with each other significantly. PCR analysis identified 4 infertile patients with one allele in the normal range and one allele in the premutation range of the FMR1 gene and 7 patients with one allele in the normal and one allele in the intermediate range, while 57 patients had two normal alleles. The cytokine results in patients carrying an expanded allele within the FMR1 gene showed a significantly high level of IL-10 among premutation carriers. A significantly high ratio of TNF-α/IL-10,IFN-γ/IL-4,and IFN-γ/IL-8 was seen amongst the premutation carriers, when compared to the controls.

Conclusions: A statistically significant correlation was also found between an abnormal CGG repeat of the FMR1 gene and IVF outcome. The study has highlighted the

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importance of autoimmunity in infertility as well as its possible correlation with an expansion of the FMR1 gene in females with unexplained inferility.

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A CASE OF EUGLYCAEMIC DIABETIC KETOACIDOSIS IN A POST-OPERATIVE UROGYNAECOLOGY PATIENT

PMC is a 63 year old lady who underwent a straightforward Manchester repair, anterior and posterior repairs for pelvic organ prolapse. She had a background of type 2 diabetes (T2DM) and goitre. Her regular medications included metformin and dapagliflozin which were taken the day before the surgery. Day 3 postoperatively she was reviewed for feeling generally unwell and nauseous. She became increasingly tachypnoeic and tachycardic and had a normal ECG, bloods and BSL of 12.4mmol/L. She had a serum pH of 6.94, a HCO3 of 3.9mmol/L and lactate of 2.1 on VBG. She was transferred to a tertiary centre by ambulance where she underwent a CTPA and CT-AP which were both normal. Her lactate was 16.9mmol/L on an ABG done on admission to the ED. She was admitted to ICU, started on antibiotics and an insulin-dextrose infusion and intubated with a working diagnosis of pelvic sepsis vs diabetic ketoacidosis (DKA). She was diagnosed with euglycaemic diabetic ketoacidosis (EDKA) secondary to dapagliflozin. She was discharged from ICU day 7 post-operatively and went home day 8. She was seen 6 weeks post-operatively and was well with good symptomatic relief from her surgery.

DKA is a well-known serious complication of T1DM and less commonly T2DM. It is characterised by the triad of hyperglycaemia, ketonaemia and an anion gap metabolic acidosis. EDKA is similar to DKA but lacks the hallmark hyperglycamia. EDKA has become increasing common with the use of sodium-glucose transporter type 2 (SGLT-2) inhibitor medications in the treatment of T2DM. SGLT-2 inhibitors are common in the treatment of T2DM, especially in those with existing cardiac and renal disease. The FDA have recommended cessation of SGLT-2 inhibitors 3-4 days pre-operatively for elective surgeries (3 days in the case of canagliflozin, dapagliflozin, and empagliflozin). Although rare EDKA secondary to SGLT-2 inhibitors is a life threatening and preventable complication of elective surgery in diabetic patients. Care needs to taken by surgical teams in its prevention and in recognition of EDKA should it occur.

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ARE CONSULTANT-LED OASI REPAIRS SUPERIOR? A RETROSPECTIVE ANALYSIS OF OUTCOMES COMPARED TO NCHDS

Topic / Dept:

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Abstract - 2100 characters

Background: Obstetric Anal Sphincter Injuries (OASI) are severe complications of vaginal delivery, affecting approximately 11% of deliveries globally, though the incidence in Ireland is notably lower, at 1.6%. Repairs may be performed by either consultants or non-consultant hospital doctors (NCHDs), with training provided during speciality training. However, the impact of the practitioner's level of expertise on patient outcomes remains unclear.

Objective**:** To compare the demographics, risk profiles, anatomical outcomes, and functional outcomes between women whose OASI repairs were performed by consultants versus NCHDs.

Study design and methods: This retrospective study was conducted at Cork University Maternity Hospital (CUMH). Participants were categorized into two groups: those whose repairs were conducted by consultants and those by NCHDs. The primary outcome was a composite adverse outcome six months post-delivery, including resting pressure <40 mmHg, squeezing pressure <100 mmHg, and defects in the anal sphincters.

Results: Of the 347 women studied, 83.0% (288) had repairs done by NCHDs, and 17.0% (59) by consultants. Private care was more common among consultant-repaired cases (50.8% vs. 0.3%, p<0.01). There were more 3B tears in the NCHD group (51.4% vs. 32.2%, p=0.07), while

consultants handled more complex cases like grade 4 tears (13.6% vs. 1.7%, p<0.01) and buttonhole injuries (3.4% vs. 0%, p<0.01). No significant differences were noted in blood loss, wound infections, or OASI clinic attendance. Functional outcomes were similarly reduced in both groups, with no significant difference in anatomical sphincter defects or composite adverse outcomes. Sub-analysis within the NCHD group did not show differences between senior and junior doctors.

Conclusion: Short-term anatomical and functional outcomes did not significantly differ between repairs performed by consultants and NCHDs. These findings provide reassurance regarding the quality of OASI training in Ireland, as NCHDs demonstrated comparable outcomes in less complex cases.

Tweetable abstract – 280 characters

This study found no significant differences in short-term or functional outcomes of OASI repairs between consultants and NCHDs. Consultants handled more complex cases, while NCHDs performed repairs with comparable outcomes, reflecting the effectiveness of training in Ireland.

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Audit of Flexible Cystoscopy Service for Rotunda Hospital Patients

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Tweetable abstract

Cystoscopy is an endoscopic examination of the urinary bladder and urethra. This retrospective audit assesses our practices against evidence-based literature and standards, which showed that the outpatient flexible cystoscopy service at Rotunda Hospital, is well run

Abstract

Background: Cystoscopy is an endoscopic examination of the urinary bladder and urethra, performed using either a flexible or rigid endoscope, done under general or local anaesthetic. It is a procedure used commonly by our urology colleagues, but also has a significant role in urogynaecology.

Objective: This audit assesses our practices against evidence-based literature and standards, including- procedure technique, indications, complications, diagnostic relevance and patient demographics and create at the very least a local hospital policy for better practices in the future.

Study Design and Methods: This was a retrospective audit. Our inclusion criteria were women who underwent an outpatient flexible cystoscopy in the Rotunda Hospital. Patients were recruited from June 2023 to March 2024. A total of 38 patients were recruited. 5 criteria were assessed – Was antibiotic prophylaxis administered? Was local anaesthetic administered for the procedure? Was there any post – procedure complications? Were the cystoscopy findings documented? What was the indication for referral for flexible cystoscopy? A compliance of 100% was set for each criterion.

Results: 44% were referred with recurrent UTIs, 31% were referred with suspected bladder pain syndrome, and 25% with urinary incontinence. All patients had an appropriate referral indication and achieved a 100% compliance. 18.75% were administered prophylactic antibiotics. 8%

received anaesthetic prior to commencing the procedure. No woman sustained any immediate post – procedure complication and achieved a compliance of 100%. All women had appropriate documentation in their charts post procedure and achieved a compliance of 100%.

Conclusions: Cystoscopy is an important skill, and having a service that is run as an outpatient setting is useful. We recommend, a new template to be designed for outpatient flexible cystoscopy service – allowing for accurate and appropriate documentation, followed by a re-audit in 6 months. Overall, the outpatient flexible cystoscopy service at Rotunda Hospital, is well run

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QUANTIFYING THE IMPACT OF BLADDER COMPLICATIONS FOLLOWING GYNECOLOGICAL CANCER TREATMENT SYSTEMATIC REVIEW AND META-REGRESSION

Background: Gynecological cancer treatments, including radiotherapy (RT) and chemotherapy, leads to various bladder complications. The anatomical proximity of the treatment site to the urinary bladder primarily explains the complications following RT, while chemotherapy contribute to bladder dysfunction through systemic mechanisms.

Objective: This study systematically reviews the nature, extent, and prevalence of bladder complications among women treated for these malignancies, underscoring the influence of treatment modalities on bladder function.

Methods: A comprehensive search of databases including EMBASE, Scopus, PubMed/MEDLINE, CINAHL, and the Cochrane Library was conducted, focusing on women undergoing RT, chemotherapy, or both for gynecological cancers. Meta-regression was performed to quantify the effects of treatments on bladder function, using random-effect models.

Results: From 15,081 citations, 12 studies with a total of 12,469 participants were included. Our analysis revealed a broad spectrum of bladder complications, with urinary incontinence and overactive bladder symptoms being common, alongside with radiation cystitis and anatomical defects formation. The prevalence of these complications varied, reflecting the complexity of treatment modalities, cancer types, and patient characteristics. Specifically, urinary incontinence rates ranged from 2.6% to 84%, while the incidence of fistula formation and ureteral stenosis remained relatively low but clinically significant. Urodynamic findings showed reduced bladder capacity and increased detrusor overactivity in up to 44% of evaluated patients, highlighting treatment's impact on bladder function.

Conclusion: Bladder complications are prevalent among gynecological cancer survivors, with notable occurrences associated with chemotherapy and radiotherapy treatments. Integrated care focusing on both oncological and urological health is essential for enhancing survivors' quality of life.

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ENGAGING FERTILITY PATIENTS IN COVID-19 VACCINE BASED RESEARCH THE MALE PERSPECTIVE

Background:
Engaging male fertility patients in research can be difficult due to societal stereotypes that lead men to feel disconnected from the fertility process. Additionally, misinformation linking the COVID-19 vaccine to infertility has increased vaccine hesitancy among men of reproductive age. This study aimed to explore factors influencing male patients' participation in research on the COVID-19 vaccine's impact on male fertility.

Objective:
To identify factors that influence male patients' decisions to participate in research regarding the effects of the COVID-19 vaccine on male fertility.

Study Design and Methods:
Male patients with appointments at a private fertility clinic between June and July 2021 were invited to participate in a study on the COVID-19 vaccine's effects on sperm parameters and fertility. Of 85 men contacted, 21 were excluded due to prior vaccination, leaving 64 men who were divided into two groups: participants and non-participants. Participants were required to attend the clinic for semen analysis and blood draws three times during the study.

Findings/Results:
The mean age of participants was 35 years. Of the 64 men, 44% (n=28) agreed to participate, while 56% (n=36) declined. The main reason for non-participation was reluctance to receive the COVID-19 vaccine (28%, n=10). Other reasons included distance from the clinic (22%, n=8) and lack of time (14%, n=5). Men in STEM or healthcare fields, or with healthcare partners, were more likely to participate. Men with children were also more likely to engage. There was no significant difference in participation based on age or health funding status (private, GP and public patients).

Conclusions:
A 44% participation rate was unexpectedly high given the study's demands, suggesting that strong vaccination campaigns and concerns about COVID-19's impact on fertility may have driven participation.

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From Complaints to Court Dates : Exploring the Alignment Between Incident Reporting, Complaints and Litigation in Maternity Care

Author: Dr. Charles Leahy

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Summary:

The study investigates the alignment between complaints, litigation cases, and significant untoward incidents (SUIs) in the Coombe Hospital, Dublin, following the release of Ireland's national maternity strategy in 2016. The analysis examines data from written complaints, formal litigation cases, and SUI reports, aiming to understand similarities and distinctions between these categories.

Methods:

A categorisation system was created based on a combination of the Health Service Executive (HSE) charter system and the Coombe Hospital complaint system. If there was more than a single issue in a complaint it was assigned multiple codes as appropriate. The study accessed databases maintained by the Quality Patient Safety Department of the Coombe Hospital, ensuring anonymity of individuals involved. Statistical analysis was performed using SPSS and data visualizations created using R's ggplot2 library.

Results:

Analysis of 1037 complaints, 104 litigation cases, and 124 SUIs revealed significant differences between both complaints and litigation cases ($\chi^2 = 221.4$, $p < 0.001$) and complaints and SUIs ($\chi^2 = 263.1$, $p < 0.001$). However, there was no significant difference between litigation cases and

SUIs ($\chi^2 = 4.0$, $p = 0.14$), suggesting similarities in issues leading to legal action and those classified as SUIs.

Conclusions:

Investment in the SUI system is crucial for promoting a culture of learning and improvement in maternity care. By leveraging insights from SUI investigations, healthcare providers can proactively identify areas for enhancement, ultimately enhancing patient safety and reducing the likelihood of litigation.

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HEALTHCARE ON THE DANCE FLOOR: RAISING AWARENESS OF THE NATIONAL SEXUAL ASSAULT TREATMENT UNIT (SATU) SERVICES AT A LARGE MUSIC FESTIVAL

Background: The Irish Sexual Assault Treatment Unit (SATU) is a HSE funded free and confidential service responding to anyone who has experienced recent sexual violence. We discuss the findings of a prospective observational study of the SATU voluntary interactive interface at Ireland's largest music festival.

Methods: This is an observational study analysing festival attendee engagement with the SATU interactive interface at Electric Picnic August 15th-18th 2024. The SATU interface was strategically positioned within walking distance of the main stage and nearby other support units and vendors, maximising public engagement. Four different initiatives were used, including; 1) HSE online engagement, 2) SATU service awareness, 3) SATU Nationwide engagement and 4) SATU festival essentials. Data from each initiative was analysed.

Results: 75,000 people attended Electric Picnic August 2024. The online initiative included strategic placement of SATU QR codes at hand-washing stations resulting in 75 scans over the three days. The awareness initiative revealed over 500 attendees who engaged with the interactive board. Only 106 (21.2%) indicating prior awareness of SATU. Similarly, the Nationwide engagement board saw over 300 attendees participate to "place yourself on the map". Engagement spanned across 89% of counties in Ireland. The final initiative saw over 5,000 condoms and lubricant, and 1,000 hand sanitizers distributed as part of the SATU festival essentials. On average attendees spent 3-5 minutes at the stand. Additionally, the SATU team were available to signpost care options in the event of onsite reported incidents in conjunction with An Garda Siochana.

Conclusion: Festival-goers' actively seek health resources in real-time, as well as express a general interest in SATU. The initiatives increased public awareness, provided support and contributed to a safe and informed environment for the attendees. On-going outreach and awareness campaigns are needed to continue communicating key messages which can be applied at future public events.

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INVESTIGATING FERTILITY AWARENESS AMONGST MIDWIVES AND NURSES IN IRELAND

Background

Midwives and general practice nurses play a crucial role in providing support for people with infertility.

Objectives

This study aimed to explore their knowledge of, and attitudes towards, fertility investigation and treatment, referral pathways, and the newly introduced public funding for assisted reproductive technology (ART) in Ireland.

Methods

A cross-sectional online survey was distributed to midwives working in Irish maternity hospitals and general practice nurses between February and April 2024. The survey explored attitudes to, and knowledge of, ART including the publicly funded scheme. Free-text questions were analysed qualitatively using content analysis and descriptive statistics were used for quantitative analysis.

Results

Of the 86 respondents, 74% were midwives (n=64) and 26% nurses (n=22). Most midwives and nurses (88%, n=76) felt they would benefit from more education on fertility and diminished ovarian reserves. Forty-four percent of respondents (n=38) reported having no confidence in their ability to interpret Anti-Müllerian Hormone (AMH) and Follicle Stimulating Hormone (FSH) results. Eighty-three percent (n=70) felt those with a family history of early menopause or premature ovarian insufficiency should have AMH tested. Eighty-five percent (n=72) felt it was suitable to test AMH in individuals trying to conceive for over a year. Half of the respondents (n=42) thought it was reasonable to test AMH levels in those undergoing a 'fertility check' but not actively trying to conceive. Qualitative analysis revealed that the current access criteria for public ART were perceived to be too restrictive.

Conclusion

We demonstrated for the first time that there is a lack of knowledge regarding subfertility and its management amongst midwives and nurses as well as a desire for more education. With training and education, knowledge and awareness of fertility investigations and ART amongst Irish healthcare workers the care patients receive will improve.

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PAIN PERCEPTIONS AND MANAGEMENT APPROACHES: UNVEILING OBSTETRICS AND GYNAECOLOGY'S BLIND-SPOTS

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Pain is a common complaint in all healthcare settings. Poorly controlled pain is linked to higher morbidity, mortality, and analgesic misuse. This a complex issue requiring a holistic approach, such as the biopsychosocial model. However, The Coombe lacks data on the consistent use of this model or formal pain management training. This study aims to assess knowledge gaps and offer recommendations for optimising staff education and improving patient outcomes.

The study objectives are: to assess staff awareness of the biopsychosocial model, integrating biological, psychological, and social factors; to evaluate the use of pain assessments beyond the Numerical Rating Scale; to explore staff perceptions of multimodal pain treatment; to assess confidence in non-pharmacological methods; to gauge interest in further pain management training.

A cross-sectional survey was conducted using an electronic questionnaire. Clinical staff were asked about their understanding of pain models, assessment methods, and treatment strategies. Preliminary results were compared to model standards, and responses analysed by professional roles.

Preliminary results showed that 29.03% of respondents lacked time or knowledge to properly assess pain. Most staff, except physiotherapists, preferred pharmacological management. In obstetrics and gynaecology, 35.7% of respondents did not recognise the biopsychosocial model, and 42.8% reported inadequate knowledge of pain. Of these, only 43% declared knowledge of tools other than numerical rating scales, and declared the use of any scales only 'rarely' to 'occasionally' (average 2.57/5). Additionally, 48.3% of obstetrics and gynaecology respondents expressed a need for more training, particularly in pharmacological (45.1%), psychological (51.6%), and non-pharmacological (54.8%) pain management techniques.

Although the biopsychosocial model was not fully adopted, most staff recognised pain as a complex issue requiring multifaceted assessment. Knowledge gaps highlight the need for targeted education to improve patient outcomes and reduce morbidity and mortality.

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PERSPECTIVES OF OBSTETRICIANS AND GYNAECOLOGISTS ON THE USE OF WEIGHT LOSS MEDICATIONS

Author: C Nolan

Co Author: L Glover

Co Author: D Crosby

Introduction: Obesity significantly impacts reproductive health, associated with subfertility, menstrual disorders, and adverse pregnancy outcomes in women(1,2), and impaired semen quality and erectile dysfunction in men(1,3). As obesity prevalence rises, weight management is increasingly important in preconception care. Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) show promise for weight loss and may improve fertility outcomes(4–7). This study explores the attitudes of Obstetricians and Gynaecologists regarding these medications.

Methods: A cross-sectional online survey was distributed to Obstetricians and Gynaecologists in Ireland, assessing familiarity with GLP-1 RAs and prescribing practices when managing obese patients. Questions addressed demographics, scenarios for appropriate medications use, and the need for further training and guidelines.

Results: 62 respondents represented roughly 12% of Obstetricians and Gynaecologists in Ireland (8,9). Most were senior (72.6%) or junior trainees (16.1%), with consultants comprising 11.3%. Nearly all respondents agreed that weight loss medications are appropriate for morbid obesity (90.3%) and subfertile patients with obesity (62.9%). Although 79.0% of respondents encounter obese patients daily, only 12.9% had ever prescribed weight loss medications. 96.8% of respondents desired further training, with a preference for teaching from endocrinologists or bariatric specialists (91.9%), and/or the establishment of national guidelines (91.9%). 70.9% were uncertain about the timing of discontinuation of GLP-1 receptor agonists before conception, and 75.8% were uncomfortable discussing potential teratogenic risks. 71.0% supported using medications to help women meet the eligibility criteria for publicly funded IVF. None of the respondents believed that Gynaecologists should bear primary responsibility for initiating weight loss medications. Instead, bariatric multidisciplinary teams (30.65%) and GPs (29.03%) were most frequently selected.

Discussion: The findings highlight gaps in the knowledge and confidence of Obstetricians and Gynaecologists regarding the use of weight loss medications. While there is recognition of the potential benefits, the lack of clear guidelines and education limits clinical practice.

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SAFETY IN NUMBERS – AN AUDIT OF MULTIDISCIPLINARY TEAM ATTENDANCE AT DAILY "SAFETY HUDDLES" IN THE NATIONAL MATERNITY HOSPITAL, DUBLIN.

Topic / Dept:

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Background: The Safety Huddle/Handover was introduced to the National Maternity Hospital (NMH), in 2019 to enhance team communication, flag safety concerns and enhance the ability of clinical staff to deliver safer care. The safety huddle occurs twice a day in the same location to ensure consistency. Defined multidisciplinary team (MDT) attendance includes the labour and birthing unit team, consultants and registrars/specialist registrars on call (Obstetrics, Anaesthesiology), Theatre team, Assistant Director of Midwifery, Neonatal Intensive Care (NICU) team and Antenatal ward team.

Objective: To audit attendance by multidisciplinary team members at the "Safety Huddles" meetings

Method: Data collection included a retrospective review of the Huddle Sign In Book between July – September 2022. MDT member attendance at the twice daily Safety Huddles was documented and should be within 81-100% to be deemed 'compliant'. After data collection was completed, information regarding team member attendance and correct role sign in was circulated to staff in all locations in NMH. Re-audit was completed in June – August 2024.

Findings:
All multi-disciplinary team members were compliant with standards for 2024 i.e. all teams had attendance of more than 81%. Data identified one meeting cancelled and reason documented – 'activities in theatre.' Data also identified improvement in one specific team attendance from previous audit (65% to 95%).

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Conclusion:

Safety huddles are a key tool for enhancing communication, identifying risks, and promoting teamwork in the healthcare setting.[1] Representation from each discipline is key in ensuring an effective and safe handover. Each team has been compliant in having attendance of over 90% at the huddle thus ensuring 'Safety in Numbers' at NMH.

(2081 characters of 2100 advised).

Tweetable abstract:

The Safety Huddle is a key tool to enhance the ability of clinical staff to deliver safer care. Representation from each discipline is key in ensuring an effective and safe handover. Attendance of each team has been over 90% thus helping 'Safety in Numbers' at NMH.

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UNDERSTANDING THE PERCEPTIONS AND CHOICES OF TRAINEES IN IRELAND REGARDING PROFESSIONAL EXAMINATIONS IN OBSTETRICS AND GYNAECOLOGY

Topic / Dept:

[1] UCD Perinatal Research Centre, Obstetrics and Gynaecology, National Maternity Hospital, Holles Street. Dublin 2.
[2] Obstetrics and Gynaecology, The Coombe Hospital, Cork Street, Dublin 8.

Author: O'Keeffe, R[1]

Co Author: Ng, MY[2]

Co Author: Higgins MF[1]

Background
Trainees in Obstetrics and Gynaecology must complete the Irish Membership of the Royal College of Physicians of Ireland (MRCPI) examination to be eligible for higher specialist training. Many also sit the Membership of the Royal College of Obstetricians and Gynaecologists (MRCOG) examination and increasingly the European Board and College of Obstetrics and Gynaecology (EBCOG) examination.

Objectives
We wished to understand Irish trainees' knowledge of, and reasons for doing, non-mandatory membership examinations.

Study Design and Methods
A cross-sectional online survey was distributed to trainees working in in Ireland in September 2024. The survey questionnaire explored attitudes to, and understanding of the MRCOG and EBCOG fellowship examinations.

Results
The study had 46 respondents. Most (58%) were HST trainees (n=26). The majority were aware of MRCOG (96%, n=45), and less were aware of EBCOG (62%, n=29).
Regarding MRCOG, 31% had completed the examinations (n=14) and 51% were planning to sit Part 2 or 3 (n=23). Reasons for sitting the MRCOG included perceiving it as being required for a consultant post in Ireland (67.4%), to stay competitive amongst fellow trainees (67.4%) or career progression (67.4%). Only 18.6% (n=8) of respondents said it was required for fellowship, with 32.5% sitting it for further education (n=14). Over half (53%, n=24) believe full completion of

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MRCOG in addition to MRCPI is necessary for trainees to obtain a consultant post in Ireland. Only 17% (n=7) felt it should be a mandatory qualification. A minority (6%, n=3) had completed the EBCOG examination. Many (53%, n=24) were not aware of the exam. The most common reasons for completing the EBCOG examination were further education (50%) and interest in European career opportunities (60%). The majority of respondents (85%) felt that the EBCOG examination was not well known amongst their peers.

Conclusion

Irish trainees complete additional professional examinations to remain competitive and because they perceive them as necessary to obtain a consultant post in Ireland.

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USE OF MANCHESTER CLINICAL PLACEMENT INDEX (MCPI) IN OPTIMISING LEARNING AT A TERTIARY HOSPITAL'S EDUCATIONAL ENVIRONMENT FOR UNDERGRADUATE MEDICAL STUDENTS

Topic / Dept:

1. IOG Educational Fellow, RCPI
2. CORK UNIVERSITY MATERNITY HOSPITAL, UNIVERSITY COLLEGE CORK, UCC

Author: DR. N Yasir[1]

Co Author: DR. M O'Riordan[2]

Background:

Clinical learning occurs in diverse socio-cultural scenarios that serve as workplaces as well as academic environments for staff and the students. In the clinical setting, students learn by active participation and engagement with the rest of the community at work. Considering clinical learning is carried out, outside of the medical school, it is critical to ensure the students be provided opportunity to reflect on clinical placements utilizing a resource that allows evaluation from numerous perspectives. The quantitative Dundee Ready Environment Measure (DREEM) is a de facto standard for that purpose. Its 50 items and 5 subscales were developed by consensus. A demand for reliable measurement tools emerged as a consequence of efforts, made to gauge the quality of medical education. the mixed methods Manchester Clinical Placement Index (MCPI), eliminated redundant items, and published validity evidence for its 8 item and 2 subscale structure. Evidence of validation involves a measure's internal framework and the interactions among its variables, and additionally its theoretical and contextual roots of the measurement items, selection of responses steps, and choice of response modalities.

The Manchester Clinical Placement Index (MCPI) has undergone rigorous validation to ensure its reliability and effectiveness in measuring the quality of clinical placements for medical students.

Key points about its validity evidence are Theoretical and Contextual Origins ,Psychometric Properties, Internal Structure, Reliability, Response Processes.

Objectives:

This study aimed at evaluating the credibility and possible practicality of an 11-item measurement tool with theoretical and empirical bases in an Experience-Based Learning (EBL) model that describes how medical students learn in communities of practice (COPs) and contextualized bases in a straight, harmonious, socially conscious undergraduate medical program.

My Particular aim for conducting this study was to highlight the importance of Clinical placement on the current learning and future impact of the Obstetrics and Gynaecology speciality on them. The study was first time ever conducted in department of Obstetrics and Gynaecology, though general survey of this kind had been conducted few years back at School of Medicine UCC.

Study Design and Methods:

This was an observational single centre study, conducted via a Survey Quiz posted on Canvas, the learning management system by UCC and via Microsoft form linked to a QR code generated for easy access. The survey quiz was ungraded and was to be completed by the end of their rotations.

The study encompasses the Final year medical students experience over two academic years, from September 2022 to June 2023 and September 2023 to June 2024, on clinical placement to Cork University Maternity Hospital.

224 students out of 329 total students, in their final undergraduate year participated in the Survey, were told that the study's objective was to determine how to effectively evaluate their clinical placements and that their participation was vital, but they were given no incentive to participate. They were encouraged to fill all parts of the survey. The respondents were male and female both, and their mean age was 22 years

The mixed methods Manchester Clinical Placement Index (MCPI) asked respondents to rate their (dis)agreement with 8 items on 7-point Likert scales and provides options to enter free-text comments on the strengths and weaknesses of placements in relation to each item.

Reception, People, Organisation, Leadership, Facilities, Observation, Feedback and Instruction were assessed as the measures for clinical experience. Its 8 items were used together to measure educational environment and were used separately, 5 items measuring learning environment (leadership, reception, supportiveness of people, organization, and facilities of the placement) and the remaining three assessing the quality of training (instruction, observation, and feedback). The 8 items were rated using 7-point Likert Scales whose extremes are 0 and 6, where 0 means strongly disagree, 3 means neither agree nor disagree and 6 means strongly agree to the item. Additionally, students were given option to give free-text comments on the strengths and weaknesses of the placement related to each of the same 8 items.

Results:

Descriptive statistics were used to analyse the data. Numeric data was summed up to give an overall point score. In addition, the learning environment subscale was calculated by adding up the scores for leadership, reception, people (support), facilities and organization, multiplied by

100 and divided by 30%. The training subscale was calculated by adding up the point scores for instruction, observation and feedback, multiplied by 100 and divided by 18%

Conclusion:

MCPI solicits free text reports as well as numerical ratings of their experiences, its validity as a quality-improvement tool rests on its subjective as well as objective properties.

It provided a robust and reliable measure of the experience-based learning for medical students on their clinical placement. It helped in focusing on the quality of instructions and teaching provided and served as a good quality improvement project. The results helped formulating the clinical education for the upcoming academic year.

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VITAL SIGNS (IMEWS) MONITORING OF PREGNANT WOMEN IN A GENERAL HOSPITAL – AN AUDIT CYCLE

Topic / Dept:

1. Beaumont Hospital, Dublin, Ireland
2. Our Lady of Lourdes Hospital, Drogheda, Ireland

Author: Arthi Subramanian (Year 2 BST Trainee)[2]

Co Author: Karen McGowan (Advanced nurse practitioner)[1]

Co Author: Connor Harrity (Consultant Gynaecologist)[1]

Co Author: Hassan Rajab (Consultant Gynaecologist)[1]

Background: The Irish Maternity Early Warning Score system (iMEWS)[1] monitors the vital signs of pregnant and postnatal women for up to 42 days after delivery. Developed in the UK in 20132, it has been in use in Ireland since 20141,2 and is effective in identifying deterioration in pregnant or postnatal women early, thus helping to prevent mortality and improve clinical judgment[3].

Objective: To analyse the management of obstetric patients in Beaumont Hospital (BH), appropriate usage of iMEWS, examination of the escalation of care as prompted by the IMEWS parameters, and identification of strategies to improve any deficiencies.

Study Design and Methods: A retrospective audit and data collection from the hospital's in-patient enquiry system, the research analyzed admissions of pregnant or postpartum women over a 1.5-year period. (2022-2023). 15 charts were identified; 1 chart was excluded (iMEWS not recorded). Clinical outcomes and documentation deficits were evaluated.

Results: The clinical outcomes showed that one woman was transferred to an obstetric hospital for further care, while 92% were discharged home without complications.
The audit identified areas of good practice in documentation, including the use of the iMEWS system for all emergency department admissions, accurate numerical entries using the 24-hour clock, and recording of pain score assessments. However, deficits were found, such as only 13% of patients having their urine analysis recorded and 71% of escalations being made using the ISBAR tool. Major issues included incorrect gestation week documentation in 17% of patients and

no gestation week documentation in 73% of patients. Additionally, only 1 out of 7 post-C-section patients had the official ISBAR form. One patient was switched from iMEWS to EWS[3] within 24 hours, but fortunately, no adverse reactions occurred.

Conclusions: A significant number of acutely unwell obstetric patients are admitted to general hospitals, where iMEWS is used for clinical monitoring. Additional staff training on iMEWS usage and prompt care escalation using ISBAR and ISBAR3 tools[1] was identified as necessary. To address this, iMEWS training was provided during medical and nursing grand rounds, online videos were made available, and participation in teaching during induction week was made compulsory.

References:

1. Irish Maternity Early Warning System (IMEWS) V2; national guideline no. 4, Feb 2019
2. Resource manual facilitator guide for clinical handover an inter disciplinary education programme, hse.ie
3. Hseland: IMEWS, Sepsis management of adults including maternity

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WHAT IS THE FATE OF ABSTRACTS PRESENTED AT THE EUROPEAN UROGYNECOLOGY ASSOCIATION CONGRESS AND THE JUNIOR OBSTETRICS AND GYNECOLOGY SOCIETY

BACKGROUND

Disseminating research at conferences is part of evidence-based medicine and publishing abstracts from these conferences as full manuscripts validates their findings. Publication rates vary, ranging 24% - 67%.

OBJECTIVES

This study aimed to determine the publication rate for abstracts at the European Urogynecology Association (EUGA) and Junior Obstetrics and Gynaecology Society (JOGS) meetings in 2022.

METHODS

Abstract lists for EUGA and JOGS in 2022 were reviewed. PubMed was searched from January 2022 to August 2024 to determine whether each abstract was associated with a full text publication. A systematic review was performed independently by two reviewers (BOL, RR) and in the event of disagreement, a third reviewer (OOS) made the final decision.

RESULTS

In 2022, 138 abstracts were presented at EUGA, and 166 abstracts were presented at JOGS. In total, 64 abstracts were published, giving an overall publication rate of 21.1% (64/304).

A higher proportion of abstracts submitted to EUGA were published compared to JOGS (31.9% vs 12.7%, $p < .001$). The publication rate for oral presentations was similar between EUGA (50%) and JOGS (40%, $p = .636$). More poster presentations in EUGA were published than in JOGS (22.3% vs 8.9%, $p = .006$).

Abstracts were published in 33 different peer-reviewed journals and open access was available in half of abstracts published.

CONCLUSIONS

This study found that less than one-third of EUGA and only one-in-eight JOGS abstracts go on to be published. Oral presentations at JOGS showed a similar conversion rate to a larger international conference, suggesting that Irish national-level research is of high quality.

The strengths of this paper are the large number of abstracts reviewed and the international nature of the data collection. Abstract review was systematic and independent by a team of three reviewers. Data is limited to 2022 though we felt a two year follow-up to be sufficient.

CONCLUSIONS

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Oral abstracts from JOGS compare well to international meetings. Dissemination of research via 'open access' is limited

Table 1: Comparison of Publication Rates of 2022 EUGA and JOGS Conferences

	Overall	EUGA	JOGS	P-value
Number of Abstracts	304	138	166	-
Oral Presentations	21% (64/304)	32% (44/138)	12% (20/166)	<0.001
Published Oral Presentations	47% (30/64)	50% (22/44)	40% (8/20)	0.636
Poster Presentations	79% (240/304)	68% (94/138)	88% (146/166)	<0.001
Published Poster Presentations	14% (34/240)	22% (21/94)	9% (13/146)	0.006
Open Access Publications	50% (32/64)	51% (22/43)	48% (10/21)	1

EUGA: *European Urogynecology Association*
JOGS: *Junior Obstetrics & Gynaecology Society*

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Adverse outcomes in pregnancies of very advanced maternal age: A retrospective cohort study

Topic / Dept: Department of Obstetrics & Gynaecology, National Maternity Hospital, Dublin 2.

Author: Stokes, J.,[1]

Co Author: Crosby, D.[1]

Background

Older maternal age during pregnancy, particularly first pregnancy, can have significant maternal and neonatal health impacts.

Objective

The aim of this study was to retrospectively review maternal and neonatal outcomes amongst those aged 45 and over attending the National Maternity Hospital. .

Methods

This was a retrospective cohort study of all completed pregnancies in patients 45 years of age and above attending the National Maternity Hospital between June 2019 and February 2024.

Results

One hundred and sixty-five completed pregnancies were reviewed. The mean age at booking was 46 years (range 46 to 49 years). Fifty-six percent were nulliparous patients (n=93). Mean Body Mass Index (BMI) was 26.6kg/m^2 (range 18-40 kg/m^2). Thirty-six percent of patients (n=60) had experienced at least one miscarriage in the past with 14.5% (n=24) experiencing at least three miscarriages before this index pregnancy. In-vitro fertilisation (IVF) was the most common mode of conception (79%; n=131). Seventy-five percent of patients underwent caesarean section delivery (n=124). There were 4 cases (2.4%) of major obstetric haemorrhage (>1.5L). Mean gestational age at delivery was 38+1/40 weeks gestation (range of 23- 40+6 weeks gestation). Extreme pre-term delivery before 28 weeks occurred in 1.8% of cases (n=3). Overall, pre-term birth before 37 weeks made up 15% of all deliveries (n=26). Mean birthweight was 3.1kg (range 0.73-4.23kg). There were no cases of intrauterine demise and there were two neonatal deaths (1.2%). There were 11 congenital anomalies (6.6%), and 32 babies were admitted to the neonatal intensive care unit (19%).

Conclusion

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Increased rates of preterm birth, caesarean section delivery, post-partum haemorrhage and neonatal death in comparison to the general population were observed. Our results echo international findings regarding very advanced maternal age.

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CHALLENGES FACED IN ACHIEVING QUALITY PATIENT CARE IN A GYNAECOLOGY OUTPATIENT DEPARTMENT – A SERVICE EVALUATION

Topic / Dept:

1. Beaumont Hospital, Dublin, Ireland
2. Our Lady of Lourdes Hospital, Drogheda, Ireland

Author: Arthi Subramanian (Year 2 BST Trainee)[1,2]

Co Author: Taranuum Ibrahim (Registrar)[1]

Co Author: Connor Harrity (Consultant Gynaecologist)[1]

Background:
The WHO emphasises that for patient care to be of high quality, it must be effective, safe, and people-centered. The gynaecology outpatient department (GOPD) clinic at Beaumont Hospital (BH) is overseen by a registrar with indirect consultant supervision and serves 500 patients annually. The clinic faces challenges such as missing or insufficient letters from general practitioners (GPs), inappropriate referrals, scheduling appointments before receiving test results (e.g., scan/histology reports), and scheduling repeat appointments.

Objective:
The objective is to identify the factors that affect the quality of patient consultations in the GOPD clinic at BH and to develop strategies to address them for improved effectiveness.

Study Design and Methods:
A retrospective audit conducted using 3 months' patient data (148 patient records), which were accessed electronically. Analysis focused on factors such as the frequency of unnecessary appointments, inappropriate referrals, and scheduling of repeated or premature appointments before test results were available.

Findings/Results:
Out of the 148 patients, 45 (30%) were newly seen. Of them, 17 (37%) had inadequate information, 4 (9%) had no scan results, and 3 (7%) were inappropriate referrals. Of the 85 follow-up patients, 11 (7%) had unnecessary appointments and 6 (4%) had no scan/histology reports. In cases of clinically concerning conditions, such as ovarian cysts and thickened endometrium, 75% (3 out of 4) had no scan/histology reports.

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Conclusions:

The lack of adequate information in 37% of new referrals notably prolonged consultations, impacting the quality of care for the patients and others. No scan/histology results, observed in 9% of new patients and 4% of follow-up patients, led to delays in diagnosis and treatment, causing undue distress to patients. Inessential patient consultations (11% of new referrals and 7% of follow-ups) consumed valuable time and affected the clinic's effectiveness. All stakeholders were briefed on findings and urged to provide adequate information.

References:

1. https://www.who.int/health-topics/quality-of-care#tab=tab_1
2. A guide to measurement and data in outpatient services – Health Service Executive, Ireland (2014).

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COVID-19 IMPACTS ON MATERNITY SERVICES IN CUMH FROM JANUARY 2019 TO MARCH 2023

Topic / Dept:

Department of Obstetrics and Gynaecology, Sligo University Hospital

Cork University Maternity Hospital, Department of Obstetrics and Gynaecology, University College Cork

Cork University Maternity Hospital, Ireland South Women & Infants Directorate, Department of Obstetrics and Gynaecology, University College Cork

Author: Baskaran R

Co Author: Greene R

Co Author: O'Donoghue K

Background:

The COVID-19 pandemic affected Irish maternal care with policies to mitigate impacts. CUMH implemented national policies and guidelines across COVID-19 waves and related lockdowns. However, no study has investigated COVID-19 impact on attendance numbers, treatment decisions and outcomes in CUMH.

Objective:

This study aimed to:

1. Examine patient aggregate data in early pregnancy, labour and delivery, across antenatal care, labour ward and emergency departments.
2. Graphically and statistically trend from 2019 to 2023, comparing pre-COVID-19 (January 2019-February 2020), COVID-19 (March 2020-March 2022) and post-COVID-19 (April 2022-March 2023).
3. Evaluate impacts on maternity services.

Study design and methods: study design, study population, and statistical test(s).

This retrospective cohort study looked at women attending CUMH from January 2019-March 2023. Variables of interest were agreed by authors from literature and guideline review.

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Electronic data were obtained from MN-CMS, HIPE/NQAIS and iPIM while data were acquired physically from 385 logbooks and 41 registries. STATA 18 was utilised to trend Irish COVID-19 data from WHO/Statista/COVID19 Ireland Geohive/HPSC/CIDR and simple linear regression used for statistical significance $p \leq 0.05$.

Findings/results/main implications of study: key statistical data, and response rate.

Complete electronic data and physical records from January 2019-March 2023 were available for 30 of 42 variables. Elective (EL) and Emergency (EM) ERPCs performed (p=0.058) decreased from March 2020-March 2022 during COVID-19. Non-significant relationship observed for all other 29 obstetric variables. Significant decline from January 2019-February 2022 was observed for: Misoprostol administration for medical and surgical management of ERPC (p<0.001) and labour ward admissions (p<0.001). Steady rise from January 2019 to December 2021 was observed for: EM CS (p=0.048) and monthly CS numbers (p=0.013).

Beta variant in December 2020 was followed by highest clinical activity in these obstetric variables when trended from January 2019-March 2023: Early pregnancy issues in the ED (n=387) and transfers into CUMH (n=19) in March 2021, EL CS (n=256) in September 2021, and ED presentations (n=1554) in April 2021.

Tweetable abstract:

National COVID-19 infection numbers and obstetric variables statistically analysed from January 2019-March 2023 in CUMH. COVID-19 peaked in January 2022, followed by decline in labour ward admissions and fetal assessment scans. Beta variant preceded highest clinical activity.

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WHAT A LOAD OF RUBBISH

Topic / Dept: Rotunda Hospital, Parnell Square, Dublin 1

Author: R. Elebert

Co Author: J.Walshe

Co Author: M.Eogan

Background

The healthcare sector is one of the largest industries in the world, generating a vast amount of waste. Healthcare waste (HCW) and its disposal cause pollution and consequent morbidity. The environmental impact of birth and maternity care is increasingly being considered. The American College of Obstetricians and Gynaecologists calls for 'healthcare systems to support environmentally responsible practices in order to decrease the environmental impact and carbon footprint of medicine.' The World Health Organization (WHO) estimates that 85% of HCW is non-hazardous waste, while the remaining is either infectious, toxic, or radioactive. Levels of refuse produced by operating theatres and labour wards are particularly high owing use of to single use equipment as well as high levels of contaminated waste. With more than 9000 births in the Rotunda Hospital per year, reducing the amount and appropriately disposing of HCW is pertinent.

Objective

To compare the level of HCW produced by individual caesarean section and vaginal birth in order to drive quality improvement.

Study Design and Methods

Patients attending for elective caesarean section or those presenting in labour were asked if the volume of waste their birth created could be followed. Apart from contaminated waste, every item of rubbish produced was collected in a refuse bag. The contents of these bags were weighed and assessed after delivery.

Findings/Results

Caesarean sections and vaginal births generated more than 1 kg of non-contaminated waste with a large proportion of this being clean recyclable materials.

Conclusions

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In our hospital, both caesarean and vaginal births generate a large amount of waste. Delivery rooms are small, and space is at a premium, however we propose one strategically placed recycling bin would improve waste segregation for vaginal deliveries. Operating theatres are more spacious but would benefit from recycling bins labelled with educational material regarding waste disposal. Each healthcare worker can reduce the carbon footprint of the delivery they are involved in and should be encouraged to do so.

Amniocentesis in pregnancies at or beyond 24 week: An international multicenter study. American Journal of Obstetrics and Gynaecology, June 2024.

Author: 1. Roni Zemet

2. Mohamed Ali Maktabi

3. Alexandra Tinfow

4. Jessica L Giordano

5. Thomas M Heisler

6. Qi Yan

7. Roni Plaschkes

8. Jenny Stokes

9. Jennifer M Wash

10. Siobhan Corcoran

11. David Crosby

Background: Amniocentesis for genetic diagnosis is commonly done between 15 and 22 weeks of gestation but can be performed at later gestational ages. Comprehensive data on late amniocentesis remain sparse.

Objective: To evaluate the indications, diagnostic yield, safety, and maternal and fetal outcomes associated with amniocentesis performed at or beyond 24 weeks of gestation.

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Study design: We conducted an international multicenter retrospective cohort study examining pregnant individuals who underwent amniocentesis for prenatal diagnostic testing at gestational ages between 24w0d and 36w6d. The study, between 2011 and 2022, involved 9 referral centers. We included singleton or twin pregnancies with documented outcomes. We analyzed indications for late amniocentesis, types of genetic tests performed, their results, and the diagnostic yield, along with pregnancy outcomes and postprocedure complications.

Results: Of the 752 pregnant individuals studied, late amniocentesis was primarily performed for the prenatal diagnosis of structural anomalies (91.6%). The median gestational age at the time of the procedure was 28w5d, and 98.3% of pregnant individuals received results of genetic testing before birth or pregnancy termination. The diagnostic yield was 22.9%, and a diagnosis was made 2.4 times more often for fetuses with anomalies in multiple organ systems (36.4%). Additionally, the diagnostic yield varied depending on the specific organ system involved, with the highest yield for musculoskeletal anomalies (36.7%) when a single organ system or entity was affected. The most prevalent genetic diagnoses were aneuploidies (46.8%). The median gestational age at delivery was 38w3d, with an average of 59 days between the procedure and delivery date.

Conclusion: Late amniocentesis, at or after 24 weeks of gestation, especially for pregnancies complicated by multiple congenital anomalies, has a high diagnostic yield and a low complication rate, underscoring its clinical utility

PROGRESSIVE QUALITY IMPROVEMENT PROGRAM ON INDUCTION OF LABOUR

Uroosa Asif, Bernadette Toolan, Lucia Hartigan

AIM :

- To reduce the rate of inappropriate indications of induction of labour in the tertiary maternity unit of Ireland by improving the planned induction process.
- To access the adherence to national and local guidelines of IOL (Updated in 2023) for shared care pathways to improve the quality of care and reduce the number of deferred inductions.

BACKGROUND :

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A frequent obstetric procedure called induction of labour (IOL) is recommended when the possible hazards of extending a pregnancy exceed the advantages. In recent decades, there has been an increase in the induction of labor. Variability between guidelines and practice has been noted in the literature regarding when induction is necessary and when it is not. The circumstances are frequently ill-defined and shaped by the personal convictions of the caretakers. It is becoming more and more obvious that collaborative decision-making between women and physicians is crucial in light of these conflicts, but it is still unclear how often this happens in normal treatment.

METHODOLOGY :

We used quality improvement and qualitative methods to develop, test, and review the indications of induction of labour along with the number of deferred inductions in March 2024 in Limerick Maternity University Hospital.

We have gathered all the data in an Excel sheet focusing on indications of induction labour along with other parameters including gravida, parity, mode of delivery, and baby birth weight.

RESULT :

A total of 94 inductions were planned from wards and antenatal clinics in March 2024 out of which 18 were deferred (1 covid positive,3 SROM and rest experienced delays in starting IOLs due to unit activity and protracted inpatient stay).

Out of 94 Inductions,20 were ended on LSCS (5 cat 2 -LSCS and 15 cat 3 -LSCS) and 22 resulted in instrumental deliveries (21 Kiwi deliveries and 1 forceps delivery)

Indications of induction of labour included postdate pregnancies (22), GDM diet (15), GDM Insulin (4), reduced fetal movement (8), PIH (2), SROM (4), Large for dates (9) with birth weight varies from 2.8 kgs to 4.0 kg), Small for gestational age (6), Prelabour rupture of membrane (5), IUGR (2), Oligohydramnios (3), VBAC (3), Twin pregnancy (1), maternal age (1), traumatic history of previous birth (2), septic screening (1), tokophobia (1) and in 5 inductions no reasons mentioned.

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INDICATIONS OF INDUCTIONS	% OF INDUCTIONS IN 1 MONTH
Postdate pregnancies	23.4%
GDM diet	15.9%
GDM insulin	4.2%
Reduced fetal movement	8.5%
SROM	4.2 %
PIH	2.1 %
Large for dates	9.5%
VBAC	3.1 %
Small for gestational age	6.3 %
IUGR	2.1 %
PROM	5.3 %
Oligohydramnios	3.1 %
Maternal age	1.06 %
Twin pregnancy	1.06 %
Not mentioned	5.3 %
Previous traumatic history of birth	2.1 %
Others (septic screen and tokophobia)	1.06 %

INTERPRETATION

13 Out of 94 inductions were inappropriately planned according to the gestational age and showed a lack of adherence to Local guidelines. These inductions may result in dissatisfaction among staff and service users. The majority were planned with the indication of postdate pregnancy at 40 weeks (7/13), rest include GDM diet at 37+4 weeks (2/13), previous history of

3rd-degree tear(1/13), and Large for date (3/13) at around 37 +weeks with birth weight around 2.6 to 3.5 kgs.

RECOMMENDATIONS :

Clear criteria for Induction :

- According to RCPI Induction of labour guideline and local hospital guideline, women with uncomplicated pregnancies should be offered induction of labour (IOL) at 41+0 weeks after discussion with the mother.
- It is recommended that a review of women aiming for a VBAC should be undertaken before 41+0 weeks to assess the cervix and reconsider the options
- offer IOL at 39+0-40+0 weeks' gestation for women aged 40 and above.
- Recommendations regarding timing of IOL in the setting of gestational diabetes mellitus is beyond the scope, a mother with suspected macrosomia after three or four biometric indices and without gestational diabetes and other risk factors required consultant input and can induce at 39 +0 weeks.

IOL

GDM on diet	GDM on insulin with
With no complications	with no complications
39+0 weeks	38+0 weeks

- IOL increase the risk of third- or fourth-degree perineal tears compared with expectant management so it is not recommended to plan induction solely with the indication of previous history of 3rd /4th degree of perineal tear.

Communication and Education :

The changes can be made by communicating it to all the staff members including midwives and doctors, through informal discussion during huddles on the criteria of planned inductions and through meetings and presentations.

All the IOL planned before 38+0 weeks must be agreed by a consultant obstetrician.

Improvement in healthcare system :

It is advisable to plan induction appropriately to prevent deferred inductions and patient dissatisfaction. Women presenting in the maternity unit for planned inductions after organizing their household chores and childminder for their children at home. Sometimes, it is hard to explain the reason for deferred inductions to these women as it may affect their mental health.

Therefore it is strongly recommended to inform the women that when the unit is busy there may be delays in commencing the IOL process.

CONCLUSION

The Quality Improvement Program (QIP) for Induction of Labour (IOL) at the Limerick Maternity Unit has successfully highlighted the key issues associated with inappropriate inductions and deferred cases. This review underscores the need for adherence to both national and local guidelines to optimize clinical decisions and improve patient satisfaction.

The audit results revealed that 13% of the planned IOLs were inappropriate, largely due to a lack of adherence to guidelines, particularly in cases of postdate pregnancies, gestational diabetes, and large for gestational age infants. The findings highlight that inconsistent practices in

scheduling IOLs not only increase unnecessary interventions but also contribute to patient dissatisfaction and delays in care.

To address these issues, the program proposed clear criteria for IOL based on updated RCPI and local guidelines. Emphasis was placed on the role of consultant oversight for planned inductions before 38+0 weeks, and specific guidance was provided for cases such as VBAC, gestational diabetes, and macrosomia.

The communication plan, which includes staff education, informal huddles, and presentations, will foster better adherence to guidelines. By enhancing the decision-making process and ensuring all inductions are planned appropriately, this program aims to prevent deferred cases and improve overall patient experience.

In conclusion, implementing these recommendations and ensuring clear communication among healthcare providers and patients will lead to more efficient, evidence-based management of inductions, reducing inappropriate inductions and deferred cases, while improving the quality of maternity care.

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