BOOK OF ABSTRACTS

INSTITUTE OF OBSTETRICIANS & GYNAECOLOGISTS, RCPI
FOUR PROVINCES MEETING

JUNIOR OBSTETRICS & GYNAECOLOGY SOCIETY
ANNUAL SCIENTIFIC MEETING

ROYAL ACADEMY OF MEDICINE IN IRELAND
ANNUAL CLINICAL REPORTS

FRIDAY, 28TH NOVEMBER 2014
ROYAL COLLEGE OF PHYSICIANS OF IRELAND
NO 6 KILDARE STREET, DUBLIN 2
Dear friends and colleagues,

On behalf of the Institute of Obstetricians and Gynaecologists in Ireland, The Junior Obstetrics and Gynaecology Society (JOGS) and the Royal Academy of Medicine in Ireland (RAMI) welcome to this year’s scientific meeting.

This year we had the highest number of abstract submissions since the JOGS meetings began 26 years ago. We would like to thank everyone who submitted their work for consideration and acknowledge the quality of research taking place in Irish hospitals. We would also like to thank the reviewers for taking the time to judge the abstracts and presentations here today.

The afternoon session will commence with a focus on safety and quality assurance issues. We welcome Dr Tim Hillard, Consultant Obstetrician & Gynaecologist in Poole Hospital Foundation Trust who will present on the importance of surgical audit. This is followed by a presentation by Dr Kim Hinshaw a Consultant Obstetrician & Gynaecologist at Sunderland Royal Hospital and Director of Research & Innovation for the Trust. As the past-Chairman of the ALSO UK Board, and a member of the MOET UK Working Group, he is well placed to talk on human factors training in the labour ward.

Following this, will be a multidisciplinary presentation on management of HIV and HSV in pregnancy, launch of new guidelines on these topics and a case-based discussion on challenging aspects of perinatal infectious disease management. The panel will include Obstetrics, Dr Nicola Maher, Paediatrics, Dr Wendy Ferguson and Prof Karina Butler and Dr Fiona Lyons, GU/HIV Medicine.

The RAMI Reports meeting welcomes Professor Patricia Crowley and Professor Tom Matthews who will present their review of the 2013 maternity reports followed by an opportunity for each of the Masters and Clinical Director to present on the outcomes and challenges detailed in the reports. As always, we are expecting an informative review of the high quality of obstetric and neonatal care provided in our maternity hospitals.

We look forward to seeing as many of you as possible at this year’s Annual Dinner and Awards ceremony. This meeting could not happen without the financial assistance of ours sponsors and we would like to take the opportunity to thank them for their ongoing support.

Kind regards,

Dr Jennifer Donnelly  Dr Vicky O’Dwyer  Dr Aoife Mullally
Convenor of Meetings  Chair of JOGS  RAMI
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ABSTRACTS
The Systemic Inflammatory Response Syndrome (SIRS) criteria have been used to diagnose sepsis in adults since 1992. However, SIRS does not allow for the physiological changes of pregnancy.

The aim of this retrospective cohort study was to compare, in cases of maternal bacteraemia, the SIRS criteria used by the Surviving Sepsis Campaign (SCC) with the newly developed Irish Modified Obstetric SIRS (IMOS) criteria, customised for the physiological changes of pregnancy.

Women with maternal bacteraemia who attended between January 2009 and March 2014 were included. Records from the episode of bacteraemia were reviewed to compare the SCC and IMOS criteria: ≥2 simultaneously abnormal parameters caused by suspected infection fulfilled the criteria for sepsis.

Of the 81 cases, 62% of cases would have been diagnosed with sepsis based on the SCC criteria compared with 54% based on the IMOS (NS). Thirteen women fulfilled the criteria of SCC but not of IMOS: in 11 cases the leucocyte count was considered abnormal and in two cases the heart rate was abnormal but the abnormal criteria were physiological for pregnancy. Seven women fulfilled the criteria of IMOS, but not of SCC, because IMOS has a lower threshold for pyrexia. No case had hyperglycaemia or an acutely altered mental state.

Use of either SCC or IMOS criteria may assist with sepsis diagnosis but neither set of criteria will identify early all cases of maternal bacteraemia. Further research is required to optimise the modifications of the IMOS criteria for pregnancy to maximise clinical sensitivity and specificity.
Pelvic floor dysfunction (PFD) resulting in incontinence and prolapse is common. Women are living longer, more active lives than previously and are presenting for surgical correction. Regular audits are vital to ensure comparative results with international norms.

We aimed to evaluate patients' subjective assessment of their bladder and bowel function 6 to 12 months following corrective surgery.

Questionnaires were distributed to all women who had surgery for PFD from January 1st to December 31st 2013. All operations were performed by the same surgeon. Procedures included vaginal hysterectomy (VH), vaginal vault suspension, anterior and posterior vaginal repairs, and mid-urethral sling (MUS) insertions, in various combinations depending on symptoms and examination findings.

One-hundred-and-forty-two questionnaires were distributed, with a response rate of 60.8% (n=87). Mean age was 56.8 years (range 34-81). Overall, 73 (83.9%) of the cohort reported improved bladder function, 46 (52.9%) had improved bowel function. Thirty-seven had MUS insertion for stress incontinence, either alone or combined with VH and/or vaginal repairs. In this group 97.3% reported improved bladder function. Sixty-four women had posterior repairs, either alone or combined with other procedures. The indication for posterior repairs were sensation of bulge and/or second degree or greater rectocele. Sixty of these women (94%) reported improved or unchanged bowel function. Interestingly, 26 of those (41%) who underwent a posterior repair for other indications reported improved sexual function, only 2 (3.1%) reported a disimprovement.

We demonstrate high rates of symptom improvement in women attending our service for surgical correction of PFD comparable to international best practice.
COMPARING THE TRIAGING OF GYNECOLOGY REFERRALS BY DIFFERENT GYNECOLOGIST

Somaia Elsayed (Rotunda Hospital), Maryanne Siu (National Maternity Hospital, Holles St. Dublin 2), Peter McKenna (Rotunda Hospital)

Gynaecology referrals are received by the Rotunda hospital from different sources. The referrals are triaged by consultant gynecologist or senior-registrar into routine or urgent. The recommended waiting period for urgent referrals is four-weeks, while for routine referrals up to six-months.

The aim of the study is to investigate the consistency in the triaging of gynaecology referrals by different doctors.

Fifty gynaecology referrals were anonymised. Six different participants at different levels of experience in gynaecology were chosen to participate in this study. There were two consultant/registrar/senior house officers (one male, one female).

Every participant was given the same pack of gynaecology referrals and was asked to assign urgent or routine to each referral. The participants were not given any guidelines to assist them in the triaging process. 48 referrals were used in the study (2 excluded). Between all the 6 participants, there were 23 referrals triaged as urgent out of 48. There was agreement of \( \geq 50\% \) on the level of triaging of urgent referrals in only 8\% of the referrals. (8.3-9.1 \%) of referrals were given "urgent" priority by the female participants compared to (16.7-25\%) male participants. The concordance between urgent triaging between doctors at the same level of experience ranged from 2-4\% only.

There was very little consistency in the triaging of referrals seen at all levels of experience. There seemed to be a significant difference in the number of referrals given urgent priority between male and female doctors. This difference was similar at all level of experience.
ENDOMETRIAL CANCER IN A TERTIARY REFERRAL CENTRE - A FIVE YEAR REVIEW

Zara Fonseca-Kelly (Dept of Gynaecology Oncology, Mater Misericordiae University Hospital, Eccles St, Dublin 7), Edward Corry (Department of Gynaecology Oncology, Mater Misericordiae Hospital, Eccles St, Dublin 7), Jennifer McInerney (Department of Gynaecology Oncology, Mater Hospital, Eccles St, Dublin 7), William Boyd (Department of Gynaecology Oncology, Mater Misericordiae Hospital, Eccles St, Dublin 7), Tom Walsh (Department of Gynaecology Oncology, Mater Misericordiae Hospital, Eccles St, Dublin 7)

Background: A number of sentinel papers on early stage endometrial cancer have made recommendations on its optimum management. Those identified at high risk are women over 60 with a grade II or higher histology and greater than 50% invasion of the myometrium.

Aim: To review the surgical intervention and adjuvant therapy that high risk women with early stage disease received in the Mater Hospital gynaecology oncology service over a 5 year period.

Methods: We reviewed all women from the period September 2009 to September 2014 who were registered on our cancer registry database with a uterine malignancy. We then focused on those whose histology showed endometrioid adenocarcinoma.

Results: In total 280 cases were reviewed and of these 91 were excluded with alternate histopathology and 56 for reasons including palliative treatment from diagnosis, original surgery carried out elsewhere or inability to locate full histology report. This left 133 cases for analysis.

Of these 30(22.5%) were identified as high risk, 22(73%) had laparoscopic hysterectomy and 8(27%) had open hysterectomy. Only 7(23%) had lymph node dissection (LND) at the time of their primary surgery - 5 of these women had negative lymph nodes and of these 3 avoided external beam radiation.

Conclusion: LND showed clear benefits for a number of women in removing the need for external beam radiation and chemotherapy, that only 23% had LND may indicate a cohort who should be considered for LND in the future unless investigations such as intra operative frozen section shows LND to be unwarranted.
ENVIRONMENTAL AWARENESS: EVALUATION OF A PROCESS-BASED
INDUCTION PROGRAMME FOR OBSTETRIC EMERGENCIES

Aoife McTiernan (Rotunda Hospital), Mary Whelan (Clinical Skills Facilitator, Dept of Midwifery, Rotunda Hospital), Niamh Hayes (Dept of Anaesthesia, Rotunda Hospital), Jennifer Donnelly (Obstetrics and Gynaecology, Rotunda Hospital, Dublin, Ireland.)

Background: HIQA and the HSE have issued a number of reports following adverse outcomes in maternity services highlighting the need for improved communication between healthcare workers. Unfamiliar environments can contribute to poor communication and adverse outcomes. A multidisciplinary induction programme was introduced in July 2014 to orient new medical staff in their new environment.

Aim: To evaluate the response of clinical staff participating in the process-based multidisciplinary induction programme.

Methods: This was a descriptive study, using a semi-structured questionnaire. The questionnaire was circulated to all participants, including training staff, 3 months after the programme by email and hard copy. A multi-choice questionnaire was also included that only new Non-Consultant Hospital Doctors (NCHDs) were required to complete.

Results: 18 NCHDs participated with 4 team leaders and 8 additional staff running programme. Questionnaires were completed by 88.8% (n=16) of NCHDs and 87.5% (n=7) of participating staff. 82% (n=19) respondents recalled at least one item they had learned, which were categorised into practical medical (33%), location and equipment (28%), teamwork & communication (19%), and unrelated (17%). 63% of participants felt less nervous about emergency obstetric situations following the induction. 100% of participants recommended that it be run at every changeover. 93% felt that the simulation was helpful in orienting them on their first night on call.

Conclusion: Even 3 months after the induction, participants felt that the programme was helpful with orientation and had a reasonable recall of information obtained. Information retained was related to environment and knowledge based.
A REVIEW OF INTRA-PARTUM PYREXIA AT THE NATIONAL MATERNITY HOSPITAL (NMH), DUBLIN

Ogugua Iloabachie (National Maternity Hospital, Dublin), Susan Knowles (National Maternity Hospital, Holles St. Dublin 2), Chizube Iloabachie (Wexford General Hospital), Michael Robson (National Maternity Hospital, Holles St. Dublin 2)

Background: Pyrexia in labour is associated with both infectious and non-infectious causes like epidural analgesia, prostaglandin therapy, overheating and dehydration. It is the policy at NMH to commence all women presenting with intra-partum pyrexia of ≥38°C on intravenous antibiotics, irrespective of aetiology.

Objectives:
• To investigate the prevalence, risk factors and management of intra-partum pyrexia.
• To determine how many cases met the criteria for Systemic Inflammatory Response Syndrome (SIRS).

Method: A retrospective analysis of hospital records and laboratory test results of women who presented with intra-partum pyrexia in January and August 2014. Standardardised international definitions where used to determine the following infections: blood stream infection, chorioamnionitis, urinary tract infections and SIRS.

Results: 50 cases of febrile women were reviewed. There were 25 cases out of 764 births (3.27%) in January 2014 and 25 cases out of 757 births (3.30%) in August 2014. Among the 50 febrile women, 24(48%) had a BMI within normal range, 42(84%) were nulliparous, 33(78.57%) of the 42 nulliparous women where induced, 18(36%) had prolonged rupture of membranes and 40(80%) received epidural anesthesia. Only one woman with pyrexia (2%) received neither septic workup nor antibiotics. 36(72%) of the 50 women met the criteria for SIRS and 5(10%) had blood stream infection.

Conclusion: Using the SIRS criteria to identify women who should be commenced on antibiotic therapy for pyrexia may significantly reduce the number of women commenced on antibiotics. Induced nulliparous women have a higher rate of intra-partum pyrexia. Compliance with hospital policy is approximately 98%.
TISSUE FACTOR INHIBITOR 2 (TFPI-2) IN CLEAR CELL CANCER AND BENIGN OVARIAN TUMOURS

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Tissue factor pathway inhibitors are serine proteases that modulate the coagulation pathway. Their role in the growth, invasion and metastases of tumours is emerging. Clear cell carcinoma (CCC) carries has the worst prognosis and the highest thrombosis risk of all the epithelial ovarian cancers.

Aims of this Study: To determine the expression and compare the levels of TFPI-2 in serum and tissue in patients with CCC and benign ovarian tumours (BOT). To assess the correlation between levels of serum and tissue TFPI-2.

Study design and Methods: Samples were obtained from the TCD ovarian cancer bio-resource. TFPI-2 antigen levels were determined using an ELISA assay.

Findings of study: Fifteen serum and 29 tissue samples were analysed. Tissue TFPI-2 expression was lower in CCC than BOT (median values 3.34 vs 6.07, p<0.08) which did not reach statistical significance. Serum TFPI-2 was higher in CCC than BOT (median values 1.61 vs 0.75, p<0.05). Serum TFPI-2 expression correlated negatively with tissue TFPI-2 levels 0.38 (n.s.).

Conclusion: An inverse relationship between tissue expression and serum levels of TFPI-2 emerges in CCC. Possible explanations are altered outflow from the cancer, reduced clearance from the plasma or additional peripheral source(s) of TFPI-2 triggered by CCC. Studies to localise the source and quantitate TFPI-2 in CCC are in progress. The substantial increase in serum TFPI-2 in CCC means that it has potential as a biomarker.
ENDOMETRIAL CANCER IN OLDEST AGE: CHALLENGES AND TREATMENT APPROACHES

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We anticipate an increase in the number of octogenarian and older women with newly diagnosed endometrial cancer because of the improved life expectancy of Irish women. To prepare for the special diagnostic and therapeutic challenges that will arise we undertook a review of endometrial cancer presenting in women over 80 years old at a Gynaecology Oncology Unit in Dublin.

All new cases of endometrial cancer in women over 80 years of age were identified from the gynaecology oncology database between January 2008 and September 2014. Demographics, co-morbidities, histological type, treatment approach (planned and implemented) and survival were reviewed.

Fifty-three endometrial cancers presented in women > 80 years: Age 80-91 (median 84), BMI 30.6 Co-morbidities cardiovascular disease +/-hypertension 34 (64.2%), diabetes 4 (7.5%), severe osteoarthritis/osteoporosis 10 (18.9%), CVA/TIA/dementia 5 (9.4%) and COPD 3 (5.7%).

Treatment intent was curative in 33 (62.3%), palliative in 16 (30.2%). Four (7.5%) patients declined treatment. Endometrioid adenocarcinoma was the most common histological morphology, n=32 (66%). Primary treatment modality was surgical for 28 (52.8%), radiotherapy for 8 (15%). Surgeries were TAH/BSO / lymphadenectomy 14 (50%), TAH/BSO 12 (42.9%), vaginal hysterectomy 2 (7.1%). There were no peri-operative deaths. Survival at median 2.4 years yielded fourteen (18.9%) alive/no disease, twenty-two (41.5%) alive/ with disease, three (5.7%) dead of disease, fourteen (18.9%) dead of other causes.

Despite a high prevalence of major co-morbidities we considered a curative option for almost two thirds of very elderly women with endometrial cancer. Deaths from other causes are likely within the standard follow-up period.
MMPS AND IL-6 AS POTENTIAL BIOMARKERS FOR ENDOMETRIOSIS

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Endometriosis is the presence of endometrial-like tissue outside the uterus and biomarkers would circumvent the need for diagnostic laparoscopy as well as discriminate between endometriomas and cancer containing ovarian cysts. Matrix metalloproteinases (MMPs) are enzymes that mediate normal tissue turnover. They may be involved in the establishment of endometriosis and the invasion of malignant cells and angiogenesis. Interleukin (IL)-6 is a multifunctional cytokine found at high concentrations in the peritoneal fluid of endometriosis patients. This study investigates the potential of MMPs and IL-6 as diagnostic tools for endometriosis.

MMP2, MMP9 and IL-6 were measured using ELISA in serum for patients with endometriosis [E] (n=29), clear cell cancer [CCC] (n=20) and compared with patients with other benign gynaecological pathology [OBGP] (n=14). IL-6 levels were also measured in the peritoneal fluid/washings in benign and endometriosis cases. Serum levels of MMP-9 were significantly higher in the E and CCC groups when compared to the OBGP group (P<0.05). There was a trend towards higher levels of MMP-2 in groups E and CCC compared to OBGP group. IL-6 was raised in CCC compared to OBGP (P<0.001) and E (P<0.001) groups. Within the E group there was a trend towards higher levels of IL-6 in the peritoneal fluid of patients with more extensive endometriosis.

MMP-9 may have potential as a serum marker of endometriosis. IL-6 may help identify those endometriomas that have undergone malignant change to clear cell cancer. Larger studies are required to confirm these findings.
Human epididymis protein 4 (HE4) is a secreted protein that is overexpressed in some cancers. HE4 is emerging as a useful biomarker in diagnosis and follow-up of ovarian and endometrial cancers. Complex endometrial hyperplasia (CAH) is precancerous and has already progressed to well differentiated/grade 1 endometrial cancer (ENCA gr1) in many women at presentation. Confident exclusion of ENCA gr1 on CAH curettings is challenging for the histopathologist and important in best treatment planning for patients.

**Aim of the study:** To evaluate the potential role of serum HE4 in identifying ENCA in cases of CAH.

With ethical committee approval, women with CAH on endometrial biopsy were recruited prior to hysterectomy. Demographic, clinical, radiological and laboratory data were reviewed. Serum for measurement of HE4 and CA125 was stored preoperatively. CA 125 and HE4 measured by ELIZA. Standard cut-off points of 70 pmol/L for HE4 and 35 U/ml for CA125 were used.

Fifty women were recruited. The histopathological outcomes on hysterectomy specimens were CAH (11) and ENCA gr1 (39). The median HE4 serum levels were 26.36 pmol/L in CAH and 83.01 pmol/L in ENCA gr1 (p<0.0001). CA125 levels were 7.2 IU/ml in CAH and 8.2 IU/ml in ENCA gr1 (p=0.4959).

**Conclusions:** HE4 has potential as a serum test to discriminate between CAH and ENCA gr1. This could assist in the surgical planning for women CAH/ENCA gr1 undergoing definitive treatment as well as the triage and monitoring of women with CAH who want to defer surgery.
MID-TRIMESTER RUPTURE OF MEMBRANES: A CLINICAL REVIEW

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Prolonged mid-trimester rupture of membranes (MT-ROM) is associated with adverse outcomes. There is a paucity of data on outcomes and no peer-reviewed data from Ireland.

We reviewed all cases occurring in our hospital between 2008 and 2013.

MT-ROM was defined as rupture of membranes over 24 hours occurring between 13+0-23+6 weeks. Cases were retrospectively identified through computerised clinical records. The maternal and paediatric medical records were reviewed.

There were 88 cases confirmed. There were no differences between this cohort and the general hospital population for age, BMI, parity or country of birth. Mothers experiencing prolonged MT-ROM were more likely to be smokers (p=0.01), have a multiple pregnancy (p<0.001) and have a previous delivery < 34 weeks gestation (p< 0.001); 8% (7/88) had previous cervical surgery and 12.5 % (11/88) had previous second trimester loss. The mean gestation at rupture was 20.3 weeks (13.4-23.9), the mean duration of rupture was 4.3 weeks (0.1-17.1). Of the 88 pregnancies, 30 ended in intrauterine demise and 58 in a livebirth. Of the 58 livebirths, 19 were < 23+6 weeks and all these died; 39 were born ≥ 23+6 weeks and 29 of these survived to discharge. All 12 babies delivered after 28+0 weeks survived to discharge. The earliest gestation of membrane rupture that resulted in a surviving baby was 17+0 weeks. One mother required Intensive Care Unit treatment for sepsis.

Prolonged mid-trimester rupture of membranes is a risk for serious maternal sepsis. Survival to discharge occurred for all babies born after 28+0 weeks gestation.
**DRILLING IN A MINEFIELD ! - ELECTROMECHANICAL MORCELLATION - AN IRISH PERSPECTIVE**

*Oral - 12*

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**Background:** There have been many advances in minimally invasive surgery allowing patients innovative laparoscopic procedures that would previously have required laparotomies. Recently in the US one of these procedures - laparoscopic morcellation for hysterectomies and the removal of presumed leiomyomas - has come under intense scrutiny due to cases of upstaging of occult malignancy (1:386) following use of electromechanical morcellation (EMM).

**Purpose of Study:** This study is an attempt to gauge the usage of laparoscopic morcellation in Ireland, the knowledge gynaecologists have of the controversy surrounding EMM and if this has resulted in a change in their practice.

**Study Design and Methods:** An online survey of consultants using the Institute of Obstetrics and Gynaecology email database was conducted in order to assess the practice of and knowledge surrounding the use of EMM. We concurrently conducted a literature review in regards to EMM in order to assess the risk versus benefits to provide information to practitioners regarding appropriate counselling of patients.

**Findings:** A majority of respondents were aware of the controversy surrounding EMM (71%). While only 35% had used EMM, the controversy has caused a majority of these to change their practice, with some ceasing it altogether.

**Conclusions:** Consultants in Ireland appear to be well informed of the newly identified risks of EMM. Given the catastrophic consequences to the patient of dissemination of occult uterine sarcoma and the inevitable medicolegal repercussions it is incumbent on the profession to give clear guidance in this area.
**Perinatal outcomes for couples who suffer from recurrent miscarriage: A high risk pregnancy group**

*Oral - 13*

Katie Field (Coom), Deirdre J Murphy (Coombe Women and Infant's University Hospital, Cork St, Dublin 8, Professor of Obstetrics and Gynaecology, Trinity College Dublin.)

Recurrent miscarriage (RM) may be associated with an increased risk of adverse perinatal outcomes. Published data are conflicting with some studies reporting an increase in adverse perinatal outcomes in association with RM while others report little or no increase. Large-scale population-based studies are lacking.

We performed a retrospective cohort study of 30,053 women with a singleton pregnancy who booked for antenatal care and delivery between January 2008 and July 2011.

All women who booked for antenatal care at the Coombe Women & Infants University Hospital had a detailed obstetric history taken recording the outcome of all previous pregnancies. We compared the obstetric and perinatal outcomes of 2030 women (6.8%) who had a history of RM with the outcomes of 28,023 women (93.2%) who did not. Logistic regression analyses were performed adjusting for potential confounding factors. Women with a history of RM were more likely to be obese, to have undergone assisted conception, to have had a previous perinatal death, and to be delivered by scheduled caesarean section. RM was associated with an increased incidence of preterm birth (<37 weeks gestation, 8.1% versus 5.5%, adjOR 1.54; 95% CI 1.29-1.84), very preterm birth (<32 weeks gestation, 2.2% versus 1.2%, adjOR 1.80; 95% CI 1.28-2.53), and perinatal death (1.2% versus 0.5%, adjOR 2.66; 95% CI 1.70-4.14). The results were similar for both primary and secondary RM.

This study reports an association between RM and adverse perinatal outcomes, highlighting the need for specialist obstetric care, particularly in relation to the risk of preterm delivery.
WHAT'S TO BLAME FOR THE PAIN? A RARE CASE OF LOWER ABDOMINAL PAIN IN PREGNANCY

Oral - 14


CW was a 39 year old primigravida who presented at 24+0 with lower abdominal pain with no guarding or rebound no vaginal bleeding and a viable pregnancy, (IMEWs 0). She had a history of infertility and PCOS. She had recently been treated in primary care for a UTI and SPD. The patient was admitted for antibiotics and analgesia (normal blood results).

Following admission she began to require increasing analgesia (IMEWS 0). She was reviewed by medical staff on several occasions and the fetal heart auscultated/observed). 22 hours post admission her clinical picture deteriorated, and she showed signs/symptoms of shock. An ultrasound scan revealed an IUD. Condolences were offered, and resuscitation commenced. Bloods confirmed hypovolaemia with normal clotting. An amniotomy was performed (clear liquor).

Labor did not progress and a decision was made to perform a laparotomy as she was still showing signs of shock. A departmental ultrasound was performed demonstrating free abdominal fluid (no evidence of aneurysm or perforation). At laparotomy there was >4 litres of blood in the abdomen, and a 2cm defect in the right anterior lower uterus.

Rupture of the primigravid uterus is an extremely rare event and is exclusively described in the literature in scarred uterus or women prescribed uterotonic drugs. This case highlights an exceptionally rare occurrence and illustrates some important learning points in management of the ill antenatal patient.

Young women can be unwell despite a normal IMEWS score.

If the clinical picture and symptoms/signs do not fit the diagnosis think of an alternative.
The Institute of Medicine (IOM) recently published revised guidelines on gestational weight gain (GWG) but were unable to comment on the relationship between GWG and gestational diabetes mellitus (GDM) due to "lack of sufficient evidence".

We examined the relationship between GWG, including fat gain, and the development of GDM.

White European women with at least one risk factor for developing GDM were recruited before 18 weeks gestation. Maternal body composition was analysed at recruitment and at 28 weeks gestation. Screening for GDM was performed in accordance with the national guidelines. Difference between groups was tested using a t-test. A p value <0.05 was considered significant.

There were 213 women recruited. The mean age was 31 years (18-44), the mean BMI was 28.2 kg/m² (17.4-48.3) and 37.6% (80/213) were obese. The mean weight gain at 28 weeks gestation was 6.7 kg (-4.4-14.7), the mean fat gain was 3.9 kg (-5.8-3.9). Overall 14.6% (31/213) of women developed GDM. These women gained less weight (5.7 kg (2.6-7.6)) and less fat (2.5 kg (0.9-3.4)) by 28 weeks gestation compared to women who did not develop GDM (who gained a mean 7.0 kg in weight (5.6-8.3) and 4.2 kg in fat (3.3-5.4)). This relationship was consistent for all BMI categories. Weight gain appeared to protect against developing GDM in obese women.

Limiting gestational weight gain, particularly in obese women, will not protect against the development of GDM. Public health measures should focus on optimisation of pre-pregnancy BMI rather than limiting GWG.
PLACENTAL CAUSES OF PERINATAL DEATH AND THEIR CONTRIBUTION TO THE INSTITUTIONAL PERINATAL MORTALITY RATE

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Placental conditions such as abruption and placental insufficiency are widely recognized causes of perinatal morbidity and mortality. Despite this they can be difficult to predict. We examined the incidence of placental causes of perinatal death and their contribution to the institutional perinatal mortality rate.

This was a retrospective analysis of clinical records for the 10-year period from 2003-2012. All cases of perinatal death of infants with a birthweight>500g were reviewed; those with a placental cause of death on histopathological examination were evaluated.

There were 80,969 deliveries over the 10-year period. There were 392 fetal and early neonatal(≤7 days) deaths of infants without congenital anomaly. Placental causes were responsible for nearly 32%(124/392) of perinatal deaths, making it the leading cause of death in normally-formed infants. Abruption accounted for 50%(63/124) of placental causes of perinatal death, with placental insufficiency accounting for 44%(55/124). There were three cases of villitis, two of chronic histiocytic intervillousitis, and a single case of fetal thrombotic vasculopathy. Most deaths were diagnosed in utero (87%(108/124)), 5.6%(7/124) occurring intrapartum and 7.3%(9/124) in the early neonatal period. 80%(99/124) of patients had a spontaneous vaginal delivery, 7%(9/124) had a vaginal breech delivery and 13%(16/124) required cesarean delivery. 16%(20/124) of patients needed a blood transfusion, one of these patients required hysterectomy. Two patients had eclamptic seizures; there was one maternal mortality.

Conditions, particularly abruption and placental insufficiency, are the leading cause of perinatal mortality in contemporary obstetrics. Most deaths occur in utero; these cases are associated with significant rates of maternal morbidity.
KNOWLEDGE OF, ATTITUDES TOWARD, BEHAVIOURS RELATING TO VITAMIN D IN A COHORT ATTENDING FOR SUBFERTILITY TREATMENT IN DUBLIN, IRELAND

Oral - 17

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Research in relation to vitamin D and its effects on fertility has escalates considerably in recent years; however, much of the evidence is of poor quality and largely conflicting.

We wished to correlate knowledge, attitudes and practices of vitamin D with serum levels amongst both male and female patients attending for subfertility treatment (IVF or ICSI).

We conducted a cross-sectional study of 75 males and 64 females including 64 couple pairs. Vitamin D status was determined by measurement of serum 25-hydroxyvitamin D (vitamin D levels). We examined knowledge, attitudes and practices concerning vitamin D using an adapted version of a previously validated questionnaire. Overall knowledge of vitamin D was good with 98.7% of males and 100% of females claiming to have previously heard of this vitamin.

58.7% males and 65.1% females were taking vitamin D containing supplements. 78.7% of males and 87.3% of females reporting eating oily fish at least once in the previous month. 66.7% males and 79.4% of females reported drinking fortified milk. Average sun exposure was 3.24 hours and 2.321 hours for males and females respectively.

Male sunscreen use (<0.001), supplement use in both genders (p=0.019, p=0.004), high self reported knowledge of vitamin D in females (p=0.012), awareness of fortification in females (p=0.026) and younger male age (ro= 0.132) are all associated with higher vitamin D status.

High levels of knowledge of vitamin D and behaviours consistent with optimising vitamin D status were demonstrated in this urban, well educated cohort of private patients attending for subfertility treatment.
PERINATAL OUTCOMES OF REDUCED FETAL MOVEMENTS: A PROSPECTIVE COHORT STUDY

Oral - 18

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Reduced Fetal Movement (RFM) is associated with adverse outcomes such as stillbirth and neonatal morbidity. We aimed to evaluate and compare pregnancy characteristics and outcomes of women with RFM.

We conducted a prospective cohort study of women presenting with RFM over 28 weeks gestation with a singleton pregnancy to a tertiary-level maternity hospital. Pregnancy outcomes and patient characteristics were compared to a randomly-sampled control group delivering contemporaneously, without RFM.

In total, 275 women presented with RFM, with 264 in the control group. Of those with RFM, average gestation at presentation was 36 weeks (range 28-40+5 weeks). Cardiotocography was performed in 276 (97.8%) cases, 20 of whom were non-reassuring. 197 (69.8%) of patients had an ultrasound examination to assess Amniotic Fluid Index, with 34 demonstrating oligohydramnios. Between groups, there were no differences in maternal age, birth weights, parity or gestation at delivery. There were 4 stillbirths in the RFM cohort, translating to a rate of 14.5 per 1000. Women with RFM were more likely to be nulliparous (50.2% vs 37%; p=0.002), have had an induction of labour (42.4% vs 27.9%; p=0.02), and their infants to require Neonatal Admission (10.1% vs 7.2%; p=NS). Following assessment, 26.5% (n=73) of patients were admitted, with 79.4% (n=58) of these delivered during admission. Of the total cohort, 15.2% (n=42) were induced for RFM.

RFM is an important obstetric issue as it infers greater perinatal risk, with no intervention to improve outcome. This prospective study demonstrates increased neonatal admission rates, increased operative delivery and higher surveillance demands, thus demonstrating the need for increased attention to this area of practice.
TRENDS IN VAGINAL BIRTH AFTER CAESAREAN SECTION (VBAC) IN TWO LARGE IRISH MATERNITY HOSPITALS

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In the United States caesarean section (CS) rates have escalated dramatically because of an increase in elective repeat CS associated with a decrease in women attempting at VBAC.

This study reviewed the VBAC rates in two large Irish tertiary referral maternity hospitals over 20 years. Data was obtained from the Annual Clinical Reports of the Coombe Women and Infants University Hospital (CWIUH) and the National Maternity Hospital (NMH) for the 20 years 1992-2012.

Between 1992-2012, 157,192 women delivered a baby in CWIUH weighing ≥500g. The overall CS rate increased from 12% (n=779) in 1992 to 27% (n=2,282) in 2012. The elective repeat CS rate, amongst those women eligible for VBAC increased from 35% (n=153) to 67% (n=662) respectively. The VBAC rate decreased from 65% (n=280) in 1992 to 33% (n=319) in 2012.

Between 1992-2012, 165,882 women delivered a baby weighing ≥500g in NMH. The overall CS rate increased from 8.5% (n=530) in 1992 to 23% (n=2,045) in 2012. The elective repeat CS rate in those women eligible for VBAC increased from 45% (n=107) to 57% (n=518) respectively. The VBAC rate decreased from 55% (n=133) in 1992 to 43% (n=389) in 2012.

In both hospitals the decline in VBAC rates was not associated with a decrease in the number of peripartum ruptures.

This study demonstrates that VBAC rates in two of our largest maternity hospitals fell during the period 1992-2012 with a concurrent rise in CS rates. Current policies on trial of labour after one previous CS need to be reviewed.
LEARNING FROM EXPERIENCE: DEVELOPMENT OF A COGNITIVE TASK LIST TO PERFORM A CAESAREAN SECTION IN THE SECOND STAGE OF LABOUR

Oral - 20

Sorca O’Brien (National Maternity Hospital, Holles St. Dublin 2), Fionnuala McAuliffe (National Maternity Hospital, Holles St. Dublin 2), Mary Higgins (National Maternity Hospital, Holles St. Dublin 2)

Caesarean section at full dilatation is a challenging procedure with a higher risk of fetal and maternal morbidity. Currently there are no guidelines regarding performing caesarian section at full cervical dilatation and a variety of general techniques exist.

This study aims to elicit the components of a skilled and safe caesarean section at full dilatation based on clinician experience.

Qualitative research study. Senior clinicians were invited to participate and, once consented, interviewed using open-ended questions regarding techniques used for performance of caesarian section at full dilatation. Interviews were recorded and thematic analysis was performed until saturation was achieved.

Fifteen clinicians agreed to participate. Common themes included the advice to routinely re-examine the patient in theatre to assess for changes in clinical status and modifying routine techniques. These modifications included making a higher uterine incision and securing each uterine angle separately before closure in order to help to identify angle extension. Other modifications (such as manual disimpaction of the fetal head before starting the operation) were more controversial. Participants developed these techniques in combination between teaching from senior obstetricians, watching others or adverse experiences.

There is an increasing role for good quality holistic training programs on how best to perform such complex deliveries. By identifying verbal and non-verbal components of caesarean section at full dilatation from multiple skilled clinicians, these can then be translated into a useful educational tool.
**MODE OF DELIVERY OPTIONS IN TWIN GESTATIONS WITH A PREVIOUS CAESAREAN SECTION**

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Caesarean delivery rates in twin pregnancies have been increasing in contemporary practice. Management of patients delivering twins with a previous caesarean section is contentious with many clinicians opting for elective abdominal delivery. We sought to examine management of twin pregnancies with a previous caesarean section (LSCS) in a large cohort of consecutive twin gestations.

This retrospective clinical review of hospital records of all twin pregnancies from 2001-2011 was carried out at a large tertiary referral university institution. Caesarean delivery rates, intrapartum characteristics and neonatal outcomes were examined.

Between 2001-2011 there were 1457 twin pregnancies of which 137 had a previous LSCS. Half of these (69/137) had an elective pre-labour LSCS while 50%(68/137) attempted vaginal delivery (VBAC). Of those who had a trial of labour 59%(40/68) required an emergency LSCS with 41%(28/68) having a successful VBAC. Two-thirds (18/28) of those who achieved VBAC had had at least one previous vaginal delivery. One patient required a combined vaginal-caesarean delivery. The rate of induction of labour was 24%(16/68). Of the 55 infants delivered vaginally 9% (5/55) required operative vaginal delivery and the rate of NICU admission was 38% (21/55). No infants who delivered vaginally had APGARs <7 at 5 mins or a cord pH<7.1.

These results demonstrate that vaginal delivery can be achieved in twin pregnancies after a previous caesarean section. Vaginal delivery was associated with a low risk of poor neonatal outcome and could be considered for carefully selected patients, particularly those with previous vaginal deliveries.
The Impact of Preanalytic Glucose Sample Handling when Screening Obese Women for Gestational Diabetes Mellitus

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The HAPO study, with published standardised sample handling, changed the diagnosis of GDM.

We aimed to compare the impact of research conditions handling of glucose samples on measurements when screening obese women for Gestational Diabetes Mellitus (GDM) with normal conditions.

This prospective observational study was conducted in a large university maternity hospital. Body Mass Index (BMI) was calculated. Obese women were recruited. In one cohort, fasting samples were taken for maternal glucose measurements in early pregnancy. In a second cohort, a 75g Oral Glucose Tolerance Test was taken at 24-28 weeks gestation. Paired samples were taken. The first sample was taken on iced water for immediate measurement (research conditions). Hospital staff handled the second sample tube in the usual way (normal conditions). To detect a clinically significant difference in the mean maternal fasting glucose of 0.4mmol/l (HAPO 2008), with an adequate power (>0.80) and a 5% significance level, 24 paired samples were required. Of 48 women studied, the mean age was 30 years; 29% were nulliparas. In early pregnancy, using the WHO criteria, the result was abnormal in 67% (n=17) of research samples compared with 29% (n=7) of normal conditions samples (p<0.01).

At 24-28 weeks, 54% (n=13) were diagnosed with GDM based on the research conditions fasting glucose, compared with 17% (n=4) of normal conditions samples (p<0.01).

After using strict preanalytic handling of maternal glucose samples to prevent glycolysis, about half of obese women screened met the new WHO criteria for GDM. Without strict sample handling, GDM was missed.
The Cost Of Screening For Diabetes Is Just The Tip of The Iceberg...

Oral - 23

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The incidence of gestational diabetes (GDM) is increasing for many reasons, including, increasing BMI, indications for screening and a lower threshold for diagnosis.

The aim was to examine the effect of a diagnosis of GDM on intervention rates, particularly, induction of labour and caesarean section.

Data for 2012-2013 was collated prospectively on women attending the diabetic antenatal clinic. Included were women, screened for risk factors in a current pregnancy and with a previous history of GDM who did not undergo rescreening. Obstetric intervention was reported using Robson’s classification.

The incidence of GDM was 4.2% (18,000 women). Of 120 nulliparas, 102 were term (>37 weeks) in spontaneous (Robson’s Group 1 n=61, 60%) or induced (Robson’s group 2a, n=41, 40%) labour. The caesarean rate for Group 1, 11.5% (7 of 61) and Group 2a, 61% (25 of 41) was higher than the hospital average, this overall was 22.7%. Among 264 multiparas, 153 were Robson’s Group 3 (n=111, 72.5%) and Robson’s Group 4a (n=42, 27.5%, hospital average 7.6%). 79 (30%) women had a previous caesarean and 68% a repeat section. The caesarean rate among Group 3 was 3.6% (4 of 111) and Group 4, 5% (2 of 42) (hospital average 1.7% and 6% respectively). Among nulliparas requiring insulin (24%) the induction rate was 55% (16 of 29) and the indication "diabetes" in 62.5%.

Intervention rates are over double the hospital average with a diagnosis of gestational diabetes. Cost implications are huge, without even considering the long term effects of caesarean section. Consent for screening for GDM should possibly carry a Government Health warning, considering the benefits of lowering the threshold for screening and diagnosis is of unproven value.
A single centre experience of "Elevate" transvaginal mesh for vaginal prolapse

Hala Abu Subeih (Cork University Maternity Hospital)

Background: The use of mesh in vaginal surgery is a controversial area and research would suggest that overall mesh exposure/extrusion rates are high

Aims: This retrospective review looks at patient characteristics of women with recurrent vaginal prolapse or vault prolapse who had either the Elevate® anterior or posterior system inserted.

Methodology: One hundred and forty two patients had an Elevate® mesh inserted over a 3 year period since 01/10/2010 and a retrospective analysis chart review was performed on these patients.

Results: 70/142 (49.2%) had an anterior elevate system inserted; 71/142(50.1%) had a posterior elevate system inserted. For 115 (78.8%), this procedure was performed for recurrent (N=58, 40.8%) or apical (N=55, 38.7%) prolapse. (N=20, 14.8%) had the mesh inserted as their primary prolapse procedure.

Subjective cure rate was 97.1% (136/142). Of 6 patients (4.2%) who reported dissatisfaction – 4 had an excellent anatomical result, 2 had bowel symptoms and another 2 had vaginal discomfort.

Intraoperative complications included 1/142 (0.7%) bladder injury and intraoperative Hematoma 1/142 (0.7%) Post-operative complications included urinary tract infection (N=3/142, 2.1%), hematoma (N=3/142, 2.1%), discomfort (N=2/142, 1.4%) and urinary retention (N=3/142, 2.1%). Three patients required readmission – for UTI, hematoma and release of mesh arms.

There were 5 cases (3.5%) of mesh exposure of which only 2 needed revision of their surgery.

Conclusion: Despite negative media reports on mesh usage for POP surgery, we would conclude that mesh, when used by appropriately trained surgeons and for the correct indication, still has a place in pelvic floor reconstructive surgery.
PRETERM PLACENTAL ABRUPTION: INCIDENCE, RISK FACTORS AND CLINICAL IMPLICATIONS

Poster - 2

Sahar Ahmed (University College Hospital Galway), David Crosby (University College Hospital Galway), John J Morrison (University College Hospital Galway)

The occurrence of placental abruption at preterm periods of gestation is a major cause of preterm delivery, and contributes significantly to maternal and perinatal morbidity, and perinatal mortality.

The aim of this study was to examine all cases of clinically confirmed preterm abruption, and outline risk factors and the associated obstetric and neonatal sequels.

All singleton pregnancies complicated by antepartum hemorrhage between 24+0 and 36+6 weeks gestation were identified on an obstetric computerized database (EuroKing, Surrey, UK), between 1989 to 2013. Only cases of confirmed clinical abruption were included. The obstetric and neonatal outcome measured outlined below were assessed. Descriptive statistics were performed using SPSS Version 20.0, and Chi2 analysis was used for comparisons between groups.

There were 170 cases of confirmed preterm abruption, (0.23%). Average maternal age was 31.1 (SEM 0.46), 62.9% (107) multiparous, mean gestational age was 31.7 weeks (Range 24-36+6 weeks, SEM 0.34), smoking rate was 35.9%, hypertensive disease 13.5%(23%), previous preterm labour or placental abruption was found in 10 (9.3%) and 10 (9.3%) respectively, preterm rupture of the membranes 46.5%(79).Emergency caesarean section rate was 69.4%. PPH 15.3% (n=26) . Average birth weight 1792 g (SEM 57.2) Range 510-3640g, intrauterine growth restriction 24 % (n=41), stillbirth rate was 12.9 %( 22), neonatal death 6.5 %( 11), intensive care (NICU) admission 121 (71.2%), mean duration in NICU was 34.1 days (SEM 3.49).

Women having preterm placental abruption constitute an exceedingly high risk group of pregnancies. A previous history of preterm labour or abruption is a clear marker of adverse outcome.
**AUDIT OF ANTENATAL CORTICOSTEROIDS ADMINISTRATION IN PRETERM DELIVERED PREGNANCIES**

**Poster - 3**

*Sara Ahmed (UMHL), Kalsum Khan (UMHL), Una Fahy (Dept of Obstetrics and Gynaecology, University Maternity Hospital Limerick), Amanda Cotter (UMHL)*

**BACKGROUND:** It is well established that antenatal corticosteroids significantly reduce mortality and morbidity in preterm neonates born between 24-34+6 weeks, if given at least 24 hours and up to 7 days before delivery.

**PURPOSE:** To audit use of antenatal corticosteroids in women who delivered prematurely in our unit, using RCOG guideline (2010) as our standard.

**STUDY DESIGN:** We performed a retrospective study of women delivered between 24-34+6 weeks from July to September 2014 in UMHL. We used our Labour ward register. Casenotes were reviewed. Datasheet was created on SPSS.

**FINDINGS:** During the study period 27/1169 (3.7%) women delivered between 24 and 34+6 weeks. 6/27 women were excluded from the study, 3 had intrauterine fetal death. 3 case notes were missing.

100% of women received the correct dosage of antenatal corticosteroids, either betamethasone or dexamethasone. The majority (80.95%) completed the steroid course prior to delivery. 9.5% (2) got a rescue dose of antenatal corticosteroid. Of those who completed the course of steroids, 5 had betamethasone, 3/5 had administration of betamethasone 12 hours apart, 2/5 had betamethasone given 24 hours apart. 11 women received dexamethasone 12mg timed 12 hours apart whilst 1 woman had dexamethasone timed 24 hours apart.

**CONCLUSION:** Overall, compliance with the RCOG guideline was satisfactory. All women included in the study received antenatal steroids. 17/21 (80.9%) completed the steroid course prior to delivery. The majority received dexamethasone. The timing of the second dose of betamethasone was incorrect in 60% of cases (relative to RCOG guideline) The lower dose of dexamethasone (6mg) was not used.
The Institute Four Province, JOGS & RAMI Meeting

CATEGORY OF CAESAREAN VERSUS MODE OF ANAESTHESIA

Poster - 4

Andrea Hermann (Sligo Regional Hospital), Sara Ahmed (UMHL), Sie Ong Ting (Sligo Regional Hospital)

BACKGROUND: While regional anesthesia (RA) and general anesthesia (GA) are both acceptable for caesarean delivery, the use of GA has fallen dramatically in the past few decades. Furthermore, GA has been shown to be associated with short term neonatal morbidity of term babies born by category 1 caesarean section (CS) for presumed fetal compromise despite enabling a more rapid delivery of the baby.

PURPOSE: Assess compliance with the guidelines from Royal College of Anesthesia 2012

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<th>Category 1-3</th>
<th>Category 1</th>
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<td>&gt;85%</td>
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<tr>
<td>Regional Anesthesia</td>
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STUDY DESIGN AND METHOD: Manual statistical analysis of all caesarean sections carried out at Sligo Regional Hospital in the first quarter of 2014 extracting data from computerized maternity records. There were 91 caesarean sections performed and the notes reviewed accordingly. 22 notes could not be included because no grading of the caesarean section was performed. 69 cases entered the audit.

RESULTS:

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<tr>
<th>Category 4</th>
<th>Category 1-3</th>
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<td>84.2%</td>
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While the regional anesthesia rate for Category 4 and Category 1 caesarean sections is well within recommendations, there is a shortfall in the Category 1-3 sections.

Conclusion: The guidelines of the Royal College of Anesthetists 2012 were met in the majority of cases but particular attention needs to be drawn to Category 1-3 sections.
The positive association between sleep and behaviour on maternal health

*Poster - 5*

*Maria Kennelly (UCD Obstetrics & Gynaecology, School of Medicine and Medical Science, University College Dublin, National Maternity Hospital, Dublin, Ireland), Kate Ainscough (UCD Obstetrics & Gynaecology, School of Medicine and Medical Science, University College Dublin, National Maternity Hospital, Dublin, Ireland), Karen Lindsay (UCD Obstetrics & Gynaecology, School of Medicine and Medical Science, University College Dublin, National Maternity Hospital, Dublin, Ireland), Fionnuala McAuliffe (National Maternity Hospital, Holles St. Dublin 2)*

There is a direct relationship between shorter sleep duration, lower mood and body mass index (BMI). Lower 'stages of change ' scores are associated with negative lifestyle behaviors. Little is known on the effect of these parameters in pregnancy and their impact on maternal body composition. We sought to assess the relationship between maternal wellbeing, stage of change, sleep patterns and maternal body composition in an overweight and obese pregnant population.

This is a prospective cohort study of 124 women recruited in early pregnancy. Maternal anthropometry and body composition analysis was performed. The following additional data was collected: stage of behaviour change, physical activity (self-reported), sleep patterns and well-being (WHO-5 Item Wellbeing Index).

Maternal wellbeing and 3rd level education positively correlated with sleep duration (p=0.02, p <0.01) respectively. Maternal stage of behaviour change negatively correlated with percentage fat mass (p= 0.04) and positively correlated with percentage fat free mass (p= 0.04). Cluster analysis revealed that as BMI increased from 27 to 29 kg/m2, there is a corresponding increase in fat mass from 33.3% to 37.6%, MUAC from 30.7 to 31.7cm and a corresponding decrease in total wellbeing score from 15 to 13, and sleep duration from 472 to 322 minutes per night.

Greater sleep duration and stage of behaviour change scores are associated with better wellbeing and body composition in an at risk population. Pre-pregnancy and antenatal strategies to improve psychological wellbeing, lifestyle behaviour and sleep patterns, could improve maternal body composition and potentially impact positively on pregnancy outcomes.
AN AUDIT OF MANAGEMENT OF Hysteroscopic Distending Media

Breffini Anglim (Tallaght Hospital), Amy Fogarty (Tallaght Hospital), Cliona Murphy (Tallaght Hospital), Aoife O’Neill (Tallaght Hospital)

Introduction: Low viscosity media such as 1.5% glycine are used in hysteroscopic procedures. Excess absorption of distension fluids can occur causing fluid overload.

Aim and objectives: The aim of this study was to assess how accurately the input and output of glycine during hysteroscopic procedures was documented.

Methods: A systematic review of all operative hysteroscopies undertaken from February 2012 to July 2013 was undertaken. Information was obtained from clinical and operative notes, and postoperative fluid balance documentation.

Results: A total of 25 women were included in our study. Twenty-one women were premenopausal, three were perimenopausal and one was postmenopausal. There were 12 cases of transcervical resection of the endometrium (TCRE), 6 cases of uterine polyp resection, 5 of which also had a TCRE, 7 cases of fibroid resection, two of which also had a TCRE. Indications for treatment included menorrhagia (84%, n=21), intermenstrual bleeding (12%, n=3), and one case of postmenopausal bleeding. Fluid input and output was accurately recorded in 36% of women (n=9). The average operative time was 51.25 minutes. There was one case of uterine rupture and one case of postoperative hypotension requiring admission. One lady was admitted postoperatively due to a fluid deficit of 5.6 litres, with associated hyponatraemia, hyperkalaemia and hypocalcaemia which resolved day 2 postoperatively with strict fluid balance.

Recommendations for improvement: More strict fluid balance and recording of fluid input and output is necessary to avoid potentially fatal hyponatraemia and fluid disturbance. Automated fluid management systems are available and would reduce discrepancies in fluid recording.
SUBMUCOSAL UTERINE FIBROID PROLAPSE

Breffini Anglim (Tallaght Hospital), Noor Azura Noor Mohamad (Tallaght Hospital), Aoife O’Neill (Tallaght Hospital)

Introduction: Uterine leiomyomas are benign tumours. They may present with menorrhagia, pain or pressure symptoms, however many women may be asymptomatic. There have been cases large leiomyoma prolapses in the literature, requiring hysterectomy, and myomectomy in the case of cervical fibroid prolapse.

Case presentation: A 42 year old lady, Para 3 presented to the emergency department complaining of a sensation of lower abdominal pressure and chronic worsening menorrhagia. Transvaginal scan showed a multifibroid uterus, the largest measuring 10.4x9.7cm. Given her symptoms, she was commenced on a gonadotrophin releasing hormone agonist pre-operatively. Six days later, she represented to the emergency room, complaining of a three-day history of worsening lower abdominal pain, offensive vaginal discharge and a day history of contraction-like pain, with a sensation of 'something coming down'. She denied any PV bleeding. On examination she had a large prolapsed with a broad pedicle coming through the cervical os, with the os almost fully dilated. It was not possible to manipulate the fibroid back into the uterus. She was commenced on augmentin and flagy.

Treatment: A subtotal abdominal hysterectomy with bilateral uterolysis and uterine artery clipping was performed. At the time of operation, a large globular uterus filling the pelvis with restricted access to the pelvic side-wall. Histology from the specimen confirmed a necrotic fibroid tissue. She was discharged home day 6 post-operatively.

Follow up: Our patient was reviewed 6 weeks post-operatively, and is doing well. She was prescribed add-back hormone replacement therapy to counteract the GnRH analogue originally administered.
**RIGHT OVARIAN CYST AUTOAMPUTATION**

*Breffini Anglim (Tallaght Hospital), Gunther Von Bunau (T)*

**Introduction:** Ovarian cysts are common in female neonates. Luteinising cysts are common, with malignancy rare in the neonatal period. Complications include intracystic haemorrhage, cystic rupture and ovarian torsion.

**Case presentation:** A 32 year old lady, Para 1 was presented for a routine sonogram at 22 weeks gestation for fetal wellbeing. At this time a right sided cystic structure was diagnosed measuring 6 by 7 cm. Mother's antenatal course was uncomplicated and she delivered a 3100 g female infant by vaginal delivery at 39 weeks without any complications. Ultrasound scans were performed in the postnatal period on a 4 monthly basis.

**Investigations:** Histology of the specimen showed an infacted and calcified haemorrhagic cystic structure, benign in nature. Serum hCG was <0.1 IU/L and AFP was 10.5 IU/ml, both within normal limits.

**Treatment:** At 19 months of life the child was admitted electively for a laparoscopic ovarian cystectomy +/- oopherectomy. At the time of surgery an autoamputated, necrotic appearing, right ovary and cyst were found free floating in the abdomen, with a blind ending right tube. Left ovary appeared normal. This was converted to an open laparotomy to remove the cyst intact. The post-operative course was uneventful, and the child was discharged home on oral antibiotics.

**Outcome and follow-up:** Parents and child were seen at a 6 week follow up visit, and child is doing well. Earlier ovarian cystectomy may have prevented autoamputation and loss of right ovary and tube. Antenatal and postnatal counseling combining paediatric and obstetric input is essential.
Screening for Gestational Diabetes – The patient's perspective

Siobhan Corcoran (RCSI), Sami Backley (RCSI), Fionnuala Breathnach (RCSI)

Background: Detection and appropriate management of gestational diabetes (GDM) significantly reduces the risk of adverse perinatal outcomes. Risk-factor based screening selection is common however there is evidence to suggest a policy of universal screening may be beneficial. The test is cumbersome and expensive to administer, with little data in the literature about the patient's experience of Glucose Tolerance Testing (GTT). This prospective cohort study aimed to assess the impact of the GTT on the patient and the convenience of the test in general.

Methods: All patients attending for GTT over 7 working days were approached and 57 agreed to take part. The investigator administered a questionnaire to investigate the physical symptoms (hunger, nausea, vomiting, jitteriness, syncope, reduced fetal movements) and the psychological symptoms (anxiety regarding own health and health of the fetus). A telephone interview was arranged 2 days post GTT to determine how the patient felt about the screening process now in light of the positive or negative results.

Conclusion: Some studies suggest OGTT is associated with increased anxiety in the screened population. Our study found that the vast majority of patients did not report severe physical side effects, were happy to have undergone GDM screening for reassurance and would undergo screening in future subsequent pregnancies indicating the test is acceptable to the population if universal screening were adopted.
AN AUDIT OF PREGNANT PATIENTS ADMITTED TO BEAUMONT HOSPITAL IN 2013 PRIOR TO THE INTRODUCTION OF THE IRISH MATERNAL EARLY WARNING SCORE (IMEWS)

Poster - 10

Helena Bartels (Beaumont Hospital), Tara Rigney (Beaumont Hospital), Paul Byrne (Beaumont Hospital)

The IMEWS has been in use across Irish maternity units since April 2013 to allow early recognition of critically ill obstetric patients. The IMEWS will be introduced in Beaumont this year and identified an opportunity for the gynaecology department to audit the level of care currently received by obstetric patients.

The audit aims to quantify the number of pregnant patients admitted to Beaumont in 2013, review any consultations with the gynaecology team and identify adverse pregnancy outcomes.

The coding department compiled a list of all patients admitted with a confirmed pregnancy; the charts were then reviewed and relevant information was retrieved.

A total of 45 pregnant patients were admitted; 44 were admitted with a non-pregnancy related issue. Of these, 10 were in the first trimester, 22 in the 2nd and 13 in the 3rd. Their average length of stay was 5.5 days. The majority required no obstetric intervention, except two patients who were subsequently transferred to the Rotunda; one with a SROM at 27 weeks, the other with a threatened miscarriage at 23 weeks. A total of 12 consults were received by the gynaecology team; as such a significant number were unknown to the service.

Our audit has shown that most obstetric admissions to Beaumont Hospital are non-pregnancy related and the occurrence of adverse pregnancy outcomes is low. However, it also highlights the requirement for a more robust mechanism to be put in place to ensure that all pregnant patients admitted to Beaumont have appropriate input from the gynaecology department.
FOLLOW UP OF WOMEN UNDERGOING MEDICAL MANAGEMENT OF MISCARRIAGE

Katie Beauchamp (University College Dublin), Mary Higgins (National Maternity Hospital, Holles St. Dublin 2)

Miscarriage is one of the commonest complications of pregnancy and a source of anxiety to women and their families. Medical management of miscarriage (MMM) with misoprostol is often chosen by women as a method of managing this complication.

This study aimed to study the outcomes of women undergoing MMM in order to guide local management. Prospective study analysing outcomes of 55 women who underwent MMM from September to December 2013 in a large tertiary level unit.

Of the 55 women one did not attend for follow up, and one required an emergency evacuation of retained products of conception (ERPC) for heavy bleeding after taking the misoprostol. 28 women were considered "complete" and therefore successful treatment of miscarriage (51%). 25 had some evidence of retained products of conception, of which 19 required another intervention such as repeated medications or surgical management (34%). 7 women underwent a second course of misoprostol and were still incomplete requiring ERPC.

Internationally it is quoted that the success rate of MMM is nearly 90% with a 5% chance of requiring an ERPC or repeat dose of medications. This study shows only 51% success rate of MMM with a 35% chance of requiring further intervention. Risk factors for requiring repeat intervention include retroverted uterus. Further study is required in this area to determine why MMM is not as successful in this unit including patient demographics, our diagnosis of incomplete miscarriage and medication regimes.
**DIAGNOSIS OF SEVERE FETOMATERNAL HEMORRHAGE: PERSONAL EXPERIENCE AND SYSTEMATIC REVIEW**

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Severe fetomaternal hemorrhage (FMH) is associated with adverse perinatal outcome and it is probably underdiagnosed.

The aim of this study is to evaluate the role of middle cerebral artery (MCA) peak systolic velocity (PSV) in the prediction of severe FMH.

This is a retrospective review of cases with severe FMH seen in our unit and a systematic review of the literature.

36 women at 31 + 4 weeks' gestation (range 16, 39) were included in this study. The most represented indication for referral was decreased perception of fetal movements (DFM) (16). Cardiotocography (CTG) upon admission was available in 30 cases and it was sinusoidal in 18, non reactive in 7, decelerative, tachycardic and bradycardic in 1 case each and in 2 cases it wasn’t performed. FMH was always confirmed by maternal blood tests. The initial hemoglobin (Hb) concentration was 4.77 ± 1.89 g/dL. In all available cases (24) fetuses were transfused, with the exception of 1 stillbirth. The MCA-PSV was 84 ± 18 cm/sec and it was > 1.5 MoMs in all cases but one (1.45 MoM).

DFM and a sinusoidal CTG have been described as the main findings, but the most consistent predictor in this series was Doppler measurement of MCA-PSV. We suggest to include this evaluation of patients with DFM.
Delivering babies safely in the presence of adequate expert staff should be a goal of our Maternity Services. Timing of delivery is unpredictable and remains a challenge. To examine this further we performed a review of births in the National Maternity Hospital over a one year period.

A statistical analysis of all deliveries at the National Maternity hospital for the year 2013 was performed to analyse time of birth and the impact of our induction protocol on time of delivery.

8,954 births were reviewed. 61% of births occurred under the care of the on call service. The rate of instrumental delivery and emergency cesarean section during on call hours was twice that of the normal working day. We frequently liaise with our Paediatric colleagues to ensure the correct resources are available at delivery. However, we found that only 30% of preterm deliveries occurred during normal working hours. Furthermore, we found that 61% of multiple births deliver outside the working day. Sub-analysis of women undergoing induction of labour revealed that 72% of our inductions delivered during on call hours.

Adjusting our induction practices may aid in altering the timing of delivery in this significant group, potentially achieving a more desirable time of delivery, when greater clinical resources are available.

As such, we recommend a review of current practices in induction of labour and staffing needs in a bid to better time the delivery of babies, particularly those most in need of medical care and intervention.
THE RELATIONSHIP BETWEEN NEONATAL ADIPOSITY AND HYPOGLYCAEMIA

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Neonatal hypoglycaemia is related to infant birth weight. However the relationship between neonatal hypoglycaemia and neonatal adiposity is not understood.

We explored the relationship between neonatal hypoglycaemia and direct measurements of infant adiposity. The study included babies of white European women who had a singleton pregnancy and had undergone first trimester ultrasound dating and screening for gestational diabetes mellitus (GDM) in accordance with national guidelines. Neonates had their weight measured at birth and body composition measured within three days of birth using air displacement plethysmography (PEA POD, Cosmed, Rome, Italy). A chart review was performed. Comparison of means was tested using t-tests and a p value < 0.05 was considered significant.

Three hundred and twenty three term neonates had body composition measurements performed. The mean maternal age was 29.6 years, the mean Body Mass Index at booking was 26.3 kg/m2 and 9.7 % developed GDM. Mean birth weight, gestation and body fat were 3.5kg, 39.8 weeks and 10.7% respectively. Of these, 104 neonates (32%) had a blood sugar recorded during admission. Of these 35 (9.2%) had blood sugar < 2.6 mmol/L recorded. Of neonates with a blood sugar recorded, there was no difference in hypoglycaemia incidence between diabetic and non-diabetic mothers (p=0.17). The mean birth weight in hypoglycaemic infants was 3.30 kg compared to 3.52 kg in non-hypoglycaemic infants (p=0.01). The mean adiposity in hypoglycaemic infants was 10.4% compared to 10.8% in non-hypoglycemic infants (NS).

Neonatal hypoglycaemia is related to birth weight rather than neonatal adiposity.
ACUTE ONSET HORNER'S SYNDROME POSTNATALLY

Poster - 15

Michael Carey (Cork University Maternity Hospital), Deirdre Hayes Ryan (Cork University Maternity Hospital), Suzanne O'Sullivan (Cork University Maternity Hospital)

Horner's Syndrome consists of ptosis, miosis and anhydrosis. Sudden onset Horner's syndrome in the post partum period is a rare event, causes include extracranial artery dissection and post spinal and epidural anaesthetic.

Up to 90% of patients with extracranial artery dissection suffer an ischaemic injury in the vascular territory supplied. Mortality associated with extracranial dissection is 5% and morbidity depends on severity of the ischaemic event.

Case: A 29 year-old Para2, reviewed on the post natal ward 2hours post spontaneous vaginal delivery with sudden onset left eye ptosis, left miotic pupil, numbness around her left eye and neck pain. She had presented in labour to the emergency department. She received an epidural anaesthetic. The patient was fully dilated and commenced pushing 2hours following admission to the labour ward. A baby girl was delivered following 20min of active pushing.

Symptoms developed 2hours following delivery.

A subsequent CT Brain with CT Angiogram and Venogram followed by an MRI Brain and Venogram were performed. The patient was commenced on subcutaneous therapeutic tinzaparin. All examinations were normal and following a neurology review the patient was discharged home after stopping her therapeutic tinzaparin.

Acute onset Horner's syndrome in the post natal period may be a complication of spinal or epidural anaesthetic but it should not be assumed that that is the case.

Due to the seriousness of extracranial artery dissection and that the delivery may be a precipitating factor we feel it important that patients who present with acute onset Horner's syndrome are thoroughly investigated.
AN UNUSUAL CERVICAL TUMOUR: RELAPSE OF ACUTE MYELOID LEUKAEMIA (AML)

Poster - 16

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A 40 year old nulliparous woman presented to our service in 2013 with an asymptomatic 5cm pelvic mass detected on ultrasound during investigations for subfertility. She had a background of AML diagnosed in 2002, treated with chemotherapy, followed by a matched sibling bone marrow transplant in the same year. She had remained in complete remission. She underwent lysis of vaginal adhesions in 2004. Physical examination was unremarkable.

MRI-pelvis revealed a bulky left sided cervical mass ~4cm in diameter that appeared homogenous. PET-CT showed an FDG-avid left lateral cervical mass, no FDG avid pelvic/retroperitoneal lymphadenopathy and no FDG-avid distant metastases. EUA, cystoscopy, D&C and hysteroscopy was performed. The bladder, urethra and vagina were normal. The cervix rim was just visible at the narrowed vaginal vault (previous vaginolysis). Within the lower uterine segment and upper cervix there was a solid tumour replacing the stroma and extending into the left parametrium. Biopsies yielded myeloid sarcoma representing extramedullary relapse of AML.

She underwent total abdominal hysterectomy, bilateral salpingo-oophorectomy, left parametrectomy and sampling pelvic lymphadenectomy to the level of the common iliacs. Post-operative histology confirmed a myeloid sarcoma involving the cervix and lower uterine segment. She subsequently underwent further chemotherapy, radiotherapy and donor lymphocyte infusion.

Myeloid sarcomas are extramedullary lesions composed of myeloblasts or immature myeloid cells. Most often they present in association with acute leukaemias, most notably AML. They may occur at any stage of disease, and at any anatomical site, although that of the female reproductive tract is very rare.
ENDOMETRIAL CARCINOMA 14 YEARS AFTER HYSTERECTOMY

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A 64 year old, nulliparous female presented to a peripheral hospital with one episode of postmenopausal bleeding. Of note, she had a subtotal hysterectomy 14 years previously for menorrhagia and endometrial hyperplasia. The histology of uterus was benign. Her medical history included obesity (BMI 60), type 2 diabetes mellitus, hypertension and hypercholesterolaemia. On examination the cervix looked normal, but there was tissue in the canal which appeared endometrioid.

Blood results were normal. An ultrasound of pelvis revealed a 6 cm uterine remnant with thickened endometrium. CT-TAP was negative for extra-uterine spread. MRI-pelvis revealed a focal abnormal high signal present within the uterus and upper cervix consistent with localized tumour. Endocervical curetting yielded fragments of moderately differentiated adenocarcinoma, endometrioid subtype with foci of squamous metaplasia. Findings were consistent with an endometrial primary malignancy.

After MDT discussion, the patient underwent a laparoscopic completion hysterectomy and pelvic lymph node dissection. Postoperative histology showed the presence of a moderately differentiated tumour, invading >50% of the myometrium and the cervical stroma. All lymph nodes were negative. Final diagnosis was FIGO Stage II (pT2 pN0 pM0) endometrioid adenocarcinoma of the uterus.

She made a good post-operative recovery and was referred for adjuvant radiotherapy and vaginal vault brachytherapy.

The extent of subtotal hysterectomy is variable. The uterine remnant can range from a cervical stump to almost complete uterus following fundectomy. The potential for cancer arising in any of the remaining mucosa should be kept in mind. Complete hysterectomy is the preferred for the treatment of hyperplasia.
PERINEAL TEAR AND EPISIOTOMY INFECTION STUDY

Poster - 18

Laura Corkery (University College Cork), Richard Greene (Cork University Maternity Hospital), Dr. Mairead O’Riordan (Cork University Maternity Hospital), Paul Corcoran (Cork University Maternity Hospital), Dr. Clare O’Loughlin (Cork University Maternity Hospital)

Postnatal patients are typically reviewed by their GP and community midwife with little hospital follow up, thus detection of perineal tear and episiotomy infection remains a neglected area in Irish obstetric practice. International studies have similarly raised the issue of underreporting of infection with contemporary studies reporting infection rates as high as 11%.

The aim of this study was to calculate incidence of wound infection amongst women with sutured perineal tears and episiotomies. Further objectives were to determine risk factors for development of infection and what treatment women with infection received.

This was a prospective cohort study. Potential participants were identified from the daily updated patient lists on postnatal wards in CUMH. Initial data and patient consent was collected between 7/7/14 - 25/7/14 with a sample size of 100 individuals. Participants were then contacted by telephone 4 to 6 weeks following initial recruitment and asked a number of questions regarding healing and infection.

A total of 86 women were successfully followed up by telephone of whom 9 had developed infections, an incidence rate of 10.5%. Two women with infection were identified pre-hospital discharge with the remainder diagnosed in the community. Three patients were readmitted for a total of 10 days with perineal infection with 1 patient re-sutured in theatre. Smoking was the sole risk factor to reach statistical significance (p=0.026).

It is clear from this study that a significant number of patients suffer from postpartum wound infection. This study highlights the need for greater postpartum surgical site surveillance.
PROTECTING THE PROFESSIONAL - AN AUDIT OF CONSENT IN A TERTIARY CENTRE

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Background: Informed consent has been recognised by the profession and validated in the judicial system. The "paternalism" once practiced is no longer acceptable in the view of the courts or the public. The "patient centred test" must be recognised as key so that material risks are discussed in the consent process. Documenting this discussion ensures that the process is carried out appropriately and offers protection to practitioners from a medicolegal perspective.

Purpose of Study: To audit the documentation of consent in the gynaecology oncology service in a tertiary centre regarding the discussion of material risks.

Study Design and Methods: A retrospective audit was conducted of the charts and electrically recorded correspondence of patients for non-emergency procedures over a 3 month period.

Findings: Only 31% of major procedures and 11% of minors had documentation of discussion of material risks prior to the day of the procedure. In only one case were specific percentages used to demonstrate the frequency of risk. Consenting on the day of major procedures was done by SPR or fellow 35%, SHO 47% and intern 18% of the time, with material risks being documented in only 47% of major procedures.

Conclusions: Discussion of material risks prior to the day of the procedure is the key component of the informed consent process. Documentation is essential in the event of complications which may lead to medico legal issues. This audit shows the need for the service to improve documentation prior to future re-auditing of the service.
Urinary incontinence and pelvic organ prolapse exist in 40-65% of women. The effect of correcting these disorders on women's sexual function has been poorly studied, with most efforts focusing on cure of incontinence. Many reports on sexual function after vaginal repair surgery have shown higher rates of sexual dysfunction and worsening dyspareunia.

The study objective was to assess the prevalence of dyspareunia following vaginal repair surgery.

All women undergoing vaginal repair surgery from 1 January 2013 to 31 December 2013 were retrospectively enrolled. Participants completed validated sexual function questionnaires (Pelvic Organ Prolapse/Incontinence Sexual Questionnaire (PISQ), and Female Sexual Function Index (FISI)) at an interval of 6 to 12 months post-operatively. Procedures included vaginal hysterectomy (VH), vaginal vault suspensions, sacrocolpopexy, anterior and posterior (AP) vaginal repairs and mid-urethral sling (MUS) insertions in various combinations depending on presenting complaint and examination findings.

One-hundred-and-forty-two questionnaires were distributed, with a response rate of 60.8% (n=87). Mean age was 56.8 (range 34-81). 68% (n=59) women were sexually active post-operatively. Mean age was 56.8 (range 34-81). 90% of the fifty-nine sexually active women reported improved or unchanged sexual experience post operatively, 54% (n=32) had improved sexual experience, 36% (n=21) felt no change, and 3% (n=2) felt deterioration. Both participants with deterioration in sexual function had VH with AP repair.

Our data suggests surgical correction of pelvic floor dysfunction results in improved sexual experience for the majority of women. The risk of deterioration in sexual experience is small and women should be counselled accordingly.
ANTENATAL DISCUSSION OF THE RISKS AND BENEFITS OF VBAC AND ERCS

Poster - 21

David Crosby (Coombe Women and Infant's University Hospital, Cork St, Dublin 8), Meenakshi Ramphul (University Hospital Limerick), Deirdre J Murphy (Coombe Women and Infant's University Hospital, Cork St, Dublin 8)

The challenge of providing safe obstetric care in the context of a previous caesarean section (CS) is part of everyday clinical practice.

What is perhaps missing is a perspective on how women are counselled at antenatal visits in relation to subsequent mode of delivery.

We conducted an audit of the medical records of women with one prior CS who were booked for antenatal care in a University teaching hospital in Dublin, between January and March 2012.

Of the 116 women in the audit, the success rate of VBAC was documented in 41 cases (35%) and the risk of uterine rupture in 64 cases (55%). The risks of ERCS were documented in two cases (2%). A patient information leaflet regarding VBAC was given in four of the cases (3%). At booking, 48 women (41%) wanted a VBAC, 19 (16%) wanted a CS even if spontaneous onset of labour (SOL) occurred, nine (8%) wanted ERCS unless there was SOL, and ten (9%) wished to decide at a later date. There was no preference documented in 30 cases (26%).

Overall, 30 women had a VBAC (26%) and 86 (74%) had a CS. Of the 48 women who hoped for a VBAC at the booking visit, 19 (40%) succeeded.

This data suggest that there may be important deficiencies in the information women receive, and in the documentation of counselling within the routine clinical setting. This has important implications for clinical outcomes, birth experiences and the risk of litigation.
Delivery of infants weighing ≥5.0kg represents a significant risk factor for both maternal and neonatal morbidity.

The aim of this study was to examine these outcome measures in a large cohort of deliveries.

The data used for this study were prospectively entered into an obstetric computerised database during the period 1989–2013. All pregnancies where the delivery resulted in an infant weighing ≥5.0kg were identified. The results were analysed for nulliparous and multiparous women, and a separate analysis was performed comparing the outcome measures observed in the first half of the cases observed (1989-2002), in comparison to the second half of cases (2003-2013). A Chi-squared test was used to evaluate the difference between proportions observed.

There were 201 pregnancies with a mean birthweight 5201g. The mean maternal age was 32.1 years(SEM 0.35). The mean BMI was 30.9kg/m2(SEM 0.59). There were 139 male(69.2%) and 62 female(30.8%) infants(P<0.001). The caesarean delivery rate overall for nulliparous women was 56.3%, and for multiparous women was 30.8%. The median gestation at delivery overall was 40.8 weeks. The intrapartum caesarean delivery rates were 44% for primiparous and 12% for multiparous women and 17.1% overall. The elective caesarean rate was significantly higher in the latter half of the study (12.9% vs 30%, p=0.005). There was no significant difference in the adverse outcome measures between both groups.

This study provides reliable data for the maternal and neonatal morbidities associated with delivery of an infant ≥5.0kg.
WCC IN FIRST TRIMESTER AND RISK OF HYPERTENSIVE DISORDERS

Poster - 23

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The development of hypertensive disease in pregnancy (HTN) significantly increases the risk of cardiovascular disease in later life. Cardiovascular disease outside of pregnancy is associated with a raised white cell count (WCC). There is little evidence regarding the relationship between the WCC in the first trimester and hypertensive disease.

We examined the relationship between the WCC at booking and the development of hypertensive disease.

Women were recruited at their first antenatal visit; their height and weight measured and their BMI calculated. A full blood count was performed at this visit. Clinic details were obtained from the hospital's computerised database.

There were 1140 women in the study. The mean age was 30.1 years, the mean BMI was 25.9kg/m2 and 13.4% developed HTN. The mean WCC for the whole cohort was 8.8x10⁹/L. The mean WCC in women without HTN was 8.7x10⁹/L compared to 9.6x10⁹/L in women with HTN (p<0.001). WCC increased with increasing BMI (p<0.001) and BMI was increased in women with HTN (p<0.001). When controlling for BMI, however, the WCC in the first trimester remained highly predictive of the development of HTN (p<0.001).

The WCC in the first trimester can be used to predict the risk of the development of hypertensive disease.
Is there a place for pre-pregnancy cervical length scanning?

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Excisional treatment for cervical intra-epithelial neoplasia (CIN) can shorten the cervix and increase the risk of preterm delivery. Cervical cerclage may be warranted in women with a short cervix on scan in early pregnancy and occasionally an abdominal cerclage may be required.

The aim of this study was to examine whether pre-pregnancy cervical length scanning can identify women that may benefit from pre-conceptual trans-abdominal cerclage.

Women who attended the colposcopy unit at CWIUH from January 2012 to October 2014 who had a history of at least one excisional treatment and were considering future pregnancy were recruited. Age, parity, indication for scan, and depth of the excised specimen were recorded prospectively and cervical length was measured by trans-vaginal ultrasound.

In total 97 women were recruited. Fifty women had a history of multiple excisional treatments of which 13 had a short cervix (<25mm) and 15 had a borderline short cervix (25-30mm). Thirty nine women had a history of one treatment and a clinically short cervix on examination. In this group 7 had a short cervix and 14 had a borderline short cervix. Eight women had a history of preterm delivery following excisional treatment. Of those 2 had a short cervix and 4 had a borderline short cervix. In total, 22 of 97 women were referred for pre-pregnancy trans-abdominal cerclage.

Our results demonstrate that pre-pregnancy cervical length scanning after excisional treatment to the cervix can identify women that may benefit from pre-conceptual trans-abdominal cerclage.
**A CASE OF PYOMYOMA: A RARE SOURCE OF POSTPARTUM SEPSIS**

*Poster - 25*

*Alison Demaio (Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Miriam Doyle (Midlands Regional Hospital, Portlaoise)*

A gravida 3, para 2+0 Irish woman booked for antenatal care at 12 weeks’ gestation. At her booking scan, a large intramural fibroid measuring 14 x 12 cm was noted. Anatomical survey was normal at 22 weeks; the fibroid was above the vertex and not involving the placental site. The remainder of the pregnancy was uncomplicated. She had a spontaneous vaginal delivery (SVD) at 41 weeks gestation, and was discharged with planned follow up in clinic 3 months later.

5 weeks postnatal, the patient presented with abdominal pain and generally unwell. She was noted to have foul-smelling vaginal discharge and pyrexia of 39C. Transvaginal ultrasound revealed a 9 cm fibroid and no retained products of conception. Blood cultures were positive for anaerobes. 6 weeks postnatal, she complained of the feeling of something coming down; examination revealed fleshy tissue protruding from the introitus. CT scan revealed a large collection in the lower segment, consistent with pyomyoma. She was brought to theatre for examination under anaesthesia (EUA) + hysteroscopy. The cervical os was open and a large (27 x 10 cm), malodourous mass was manually removed from the uterine cavity. Histology revealed degenerating leiomyomata.

Pyomyoma, or suppurative leiomyoma, is a rare clinical complication that occurs when a leiomyoma undergoes infarction and subsequent infection. Fewer than 20 cases have been described, and the vast majority of women undergo hysterectomy. A triad of abdominal pain, sepsis without an obvious source and history of leiomyoma can be used to make the diagnosis and prevent fatalities.
AN UNUSUAL CAUSE OF INTRAUTERINE DEMISE: A CASE FOR ROUTINE ANOMALY SCREENING?

Poster - 26

Alison Demaio (Coombe), Miriam Doyle (Midlands Regional Hospital, Portlaoise), Peter Kelehan (Coombe Women and Infant's University Hospital, Cork St, Dublin 8)

A 25 year-old woman, gravida 3 para 1+1, attended antenatal booking appointment at 25 weeks gestation. Her past medical and obstetric histories were unremarkable, and booking bloods were normal. The booking maternity unit did not offer routine anomaly screening. She subsequently failed to attend routine antenatal appointments. At 32+5 weeks gestation, the patient presented to the maternity assessment unit of a different hospital reporting absent foetal movements for 48 hours. Ultrasound confirmed a diagnosis of intrauterine demise. Medical management was initiated and a male infant weighing 2.11 kg was delivered via spontaneous vaginal delivery. No dysmorphic features were noted at delivery, but a very large, oedematous umbilical cord was evident. Post mortem examination revealed a patent urachus with urine draining into greatly swollen umbilical cord.

Patent urachus is a rare disorder, affecting 1-2:100,000 deliveries, and results from failure of the urachal lumen to close during embryonic development. Oedema in the umbilical cord may result from drainage of liquid from the urachus into Wharton's jelly. This is the first known case of intrauterine demise seemingly attributable to giant cord oedema secondary to patent urachus. Though such cases as above are rare, there have been documented cases detected antenatally by ultrasound. Careful monitoring of fetuses with umbilical oedema is essential. Colour Doppler studies are especially important to monitor for impaired blood flow secondary to compression of vessels by cord oedema. It is worth noting that had routine anomaly screening been in place, this tragic case may have had a very different outcome.
THINKING OUTSIDE THE GUIDELINES: RATES OF MISCARRIAGE WITH YOLK SAC PRESENT AT INITIAL TRANSVAGINAL ASSESSMENT

Alison Demaio (Coombe), Aoife Mullaly (Coombe Women and Infant’s University Hospital, Cork St, Dublin 8)

Spontaneous miscarriage is the most common clinical complication of early pregnancy, affecting about 20% of pregnancies. Current Irish guidelines diagnose miscarriage according to either crown-rump length, or mean gestational sac diameter (mGSD) when the gestational sac is empty. There is limited data about making a diagnosis of miscarriage when initial scan shows a gestational sac with yolk sac present.

This study audited ultrasound parameters for diagnosis of miscarriage within the context of an early pregnancy unit.

This was an observational cross-sectional study. Data was collected retrospectively for women with a diagnosis of pregnancy of unknown viability from January 2012 to December 2013. 1087 women were studied, and 386 noted to have intrauterine gestational sacs with yolk sac (but no foetal pole) at initial scan. Follow-up ultrasonography results were categorised as either viable or a miscarriage. A literature review was performed to obtain data from relevant peer-reviewed articles.

When a yolk sac was seen on initial scan, there was a relatively increased likelihood of a viable pregnancy (56.5%). There was a trend of increased rates of miscarriage as initial mGSD was increased. There were 3 cases that carried on to become viable pregnancies with initial mGSD ≥20 mm. However, there were no viable pregnancies resulting from gestational sacs measuring over 22 mm.

Data such as the above is useful for guiding obstetricians in the diagnosis of miscarriage when findings are outside the scope of current guidelines. This can address any source of confusion that could result in a misdiagnosis of miscarriage.
**A CAUTIONARY TALE: A CASE OF A FALSE POSITIVE IN NON-INVASIVE PRENATAL TESTING**

*Poster - 28*

**Alison Demaio (Coombe Women and Infant's University Hospital, Cork St, Dublin 8)**

Non-invasive prenatal testing (NIPT) has been experiencing a surge in popularity and some have suggested introduction of it into routine clinical practice. The process identifies cell-free fetal DNA (cfDNA) circulating in maternal blood, thereby screening for genetic disorders without putting the foetus at risk. The newest in this group of NIPT is the Panorama™ test. It claims to have >99% specificity and sensitivity for detecting sex chromosome trisomies. It also purports to be the only NIPT test that distinguishes between fetal and maternal DNA, so that it may detect fetal chromosomal abnormalities even in the presence of maternal mosaicism. We present a case of a 37 year-old primigravida woman who underwent Panorama™ testing at 14 weeks gestation. She was of normal stature, appearance and intelligence. Panorama™ results revealed foetal trisomy X; however, genetic testing of the infant postnatally revealed normal 46,XX karyotype. The most likely explanation for this is that the mother's karyotype is 47,XXX and the test had wrongly interpreted maternal DNA as cell-free foetal DNA.

At the time this abstract was written, maternal karyotyping was underway. It is expected that the mother will have a previously-undiagnosed karyotype of 47,XXX or a 46,XX/47,XXX mosaic. Up to 90 percent of women with an extra X chromosome are unaware of their diagnosis. The authors would recommend caution in interpretation of non-invasive prenatal testing in regards to sex chromosome aneuploidy. While useful as a screening tool, their results may need further confirmation via more traditional routes in such cases as above.
CATHETERISATION PRIOR TO LAPAROSCOPY CAN BE AVOIDED WITH SELF-VOIDING AND BLADDER SCANNING

Poster - 29

Mark Dempsey (Coombe Women and Infant's University Hospital, Cork St, Dublin 8), Katie Field (c), Tom D'Arcy (Coombe Women and Infant's University Hospital, Cork St, Dublin 8)

Background: Urinary tract infections are associated with urethral catheterisation. In preparation for all laparoscopic procedures patients are catheterised prior to insertion of a Verre's needle and trocar in order to avoid bladder injury.

Objective: To evaluate the necessity of urinary catheterisation immediately prior to commencement of gynaecological laparoscopy.

Study design: This is a prospective study in which patients designated for routine gynaecological laparoscopy voluntarily emptied their bladders immediately prior to admission into theatre. Once anesthetised and prior to introduction of the Verre's needle, the patients were catheterised and the volume of residual urine in the bladder measured.

Findings: 79 patients were recruited to our study. The first 21 patients were used as controls to establish the volume of urine in the bladder prior to routine laparoscopy. In this group the residual urine volume ranged from 15mls to 220mls. The time interval between urination and entry to theatre ranged from 15 to 210 minutes. 58 patients were then asked to void prior to entry into theatre. Bladder catheterisation following anaesthetic induction was performed to record urinary residual volume. 41 patients had less than 50mls, 16 patients with between 50-100mls and one patient with 120mls of urine. 15 patients also had a pre-theatre bladder scan after voiding urine. Bladder scanning identified all cases of residual urine greater than 50mls. Bladder scanning however detected 2 false positive residual urines in cases of known ovarian cysts.

Conclusion: Catheterisation prior to laparoscopy can be avoided with pre-theatre voiding and bladder scanning prior to laparoscopy.
IRELAND'S FIRST VIRTUAL GYNAECOLOGY CLINIC

Poster - 30

Mark Dempsey (Waterford University Hospital), Edward O'Donnell (Waterford University Hospital), John Stratton (Waterford University Hospital)

Background: Traditionally all referrals to gynaecology services in Ireland occur through letters to the outpatients department. Currently there is no pathway in place to allow queries to be answered by phone. Objective: To reduce the incidence of referral to gynaecology clinics when advice over the phone may have sufficed.

Study design: 79 general practitioners (GP) in 48 practises close to Waterford University Hospital were posted a flyer informing them of a phone in service available for 2 hours every Thursday for gynaecology queries. Findings: There were 27 referrals to the virtual clinical. After the first flyer was circulated there was an average of 2-3 referrals per clinic. As the referral rate reduced after 4 weeks a second flyer was mailed to remind GP’s of the virtual clinic. This resulted in an average increased uptake initially to 3-4 referrals to the clinic. The clinic was abandoned after 15 clinics due to reducing referral rates. Of the 27 referrals 21 patients (77.8%) referral queries were dealt with successfully over the phone avoiding the need for gynaecology review in hospital. 5 patients were referred to other services. The majority of cases were (11/27 40.7%) menstrual cycle disorders with polymenorrhagia and menorrhagia predominating. 3 cases related to infertility, 3 cases of postmenopausal vulval issues and 2 post-operative cases.

Conclusion: This study has shown that having a virtual clinic for answering gynaecology queries can reduce the referral rates to the hospital but unfortunately GP’s must avail of this service for it to work.
A case of Spontaneous Pregnancy in a patient with Mosaic Turner's Syndrome

Aoife Doyle (Mayo), Meabh Ni Bhuidhmain (Mayo), Kamal El Mahi (Dept of Obstetrics and Gynaecology, Mayo General Hospital, Castlebar, Mayo)

This is the case of A.C, a 22 year old Para 1+0 with a known history of mosaic Turners syndrome. She was diagnosed as a neonate due to microcephaly and congenital hypothyroidism. Her Chromosomal complement is 55% 45X and 45% 46XX. She has a height of 154cm. She had menarche at the age of 13 and had spontaneous conception of both her pregnancies.

Turners syndrome is characterized by complete or partial absence of the X chromosome. It occurs in 1 in 1500-2500 live births. It is known to be associated with cardiovascular anomalies such as Coarctation of the aorta and bicuspid aortic valve. It is linked to autoimmune disorders such as Addisons disease, alopecia, vitiligo and Hashimatos thyroiditis. 10-30% will develop congenital hypothyroidism. Impaired glucose tolerance is common.

Most women with Turner syndrome are infertile (95-98%) due to gonadal dysgenesis. Some women may preserve some ovarian function. spontaneous Menarche occurs in 5-20%. Early menopause is common with an average age of 38.

Pregnancy rates among this cohort are low. A high proportion of conceptions are through ART with oocyte donation. Turner's patients pregnancies have been reported to have higher rates of miscarriage, stillbirth, and congenital anomalies. There is an increased risk of aortic dissection and rupture, gestational diabetes and hypothyroidism.

In summary pregnancy in patients with Turners syndrome is rare but may become more prevalent due to the increased use of ART. We must tailor their Antenatal care to the specific risks in these pregnancies.
Methylene blue (MB) is extensively used in gynaecology and is known to give falsely low SpO2 readings by interfering with light absorbance by the spectrophotometer of pulse oximeters.

We present the case of a 37 year old female with a stage IB1 cervical squamous cell carcinoma. The patient had no co-morbidities and was a lifelong non-smoker. Following discussion at the gynaecology MDT, the patient proceeded to theatre for laparoscopic sentinel lymph node biopsy. Following port insertion, MB was injected at 4 cervical points peri-tumourally. Approximately 50 minutes later, the patient became cyanotic and SpO2 fell from 98% to 78%. The pulse oximeter probe was changed, the patient examined, a transoesophageal echo was performed and yet still no cause was identified. PaO2 levels from three consecutive ABGs were above 20 and it was concluded that this was MB-induced cyanosis and the patient was not truly hypoxic. Interpretation of the dye as reduced haemoglobin by the spectrophotometer of the pulse oximeter was responsible for the decrease in SpO2.

One must be aware of this phenomenon when considering the differential for cyanosis and oxygen desaturation in order to avoid unnecessary intra-operative delays and iatrogenic toxic hyperoxaemia. It is also important to recognise that hypoxaemia may co-exist with this phenomenon and of note pulmonary oedema has been reported as a side-effect of MB.
AN UNUSUAL CASE OF HELLP SYNDROME

Anna Durand O’Connor (Wexford General Hospital)

HELP syndrome is a disorder of pregnancy, associated with maternal morbidity and mortality. We describe the case of EC, a 23yo primip, who developed HELLP syndrome postnatally, in conjunction with new onset supraventricular tachycardia (SVT).

EC is a 23yo primip, with no significant medical history.

She presented to the labour ward at term +1, following an uncomplicated pregnancy, in spontaneous labour. Labour progressed, without augmentation, to full dilatation and she had a ventouse delivery in the second stage for suspected fetal distress. She was transferred to theatre for suturing of a 3A tear. Estimated blood loss was 500ml.

In theatre she developed an SVT, though was asymptomatic. She was treated with amiodarone, and transferred to ICU for observation postoperatively. She developed one further episode 1 hour postop, resolved with adenosine. Subsequently, her heart rate was stable at 90bpm, blood pressure 110-120/70-80mmHg. Bloods taken intraoperatively showed abnormal liver function, with normal renal function and normal platelets. She received supportive care in ICU but was transferred to a nephrology unit in a tertiary hospital on day 2 post delivery, due to worsening renal function and oliguria. Her platelet count at this time had decreased to 80, liver function tests remained abnormal.

A renal ultrasound scan was normal and her renal function improved without requiring dialysis. A liver ultrasound was also normal; autoimmune and viral screen was negative. Echocardiogram normal. She was discharged home day 5 post delivery.

At review 2 weeks post delivery, liver and renal function had returned to normal.
A REVIEW OF LARGE FOR GESTATIONAL AGE BABIES IN OUR LADY OF LOURDES HOSPITAL

Poster - 34

Rachel Elebert (Obstetrics and Gynaecology Department, Our Lady of Lourdes Hospital, Drogheda, Co Louth), Noelle Breslin (Obstetrics and Gynaecology Department, Our Lady of Lourdes Hospital, Drogheda, Co Louth), Niamh Murphy (Obstetrics and Gynaecology Department, Our Lady of Lourdes Hospital, Drogheda, Co Louth), Maire Milner (Our Lady of Lourdes Hospital Drogheda)

Background: Fetal macrosomia is associated with maternal and neonatal complications. Risk factors include maternal age, parity, BMI, gestational diabetes and postdates.

Purpose of study: Identify the aetiology and complications associated with macrosomia.

Study design and methods: All babies >4.5kg born from January–September 2014 were identified and maternal age, parity, booking BMI, gestational diabetes, mode of delivery, shoulder dystocia and NICU admission were examined.

Findings of the study: 76 babies >4.5kg were delivered. Mean maternal age was 32years (19 -43years), 78% >30yrs. 82% had parity ≤2. Approximately 30% of mothers who delivered macrosomic babies had BMI 20-25, 42% had BMI 25-29.9, and 28% had BMI ≥30. Three had gestational diabetes, however 31 did not have GTT. 52.5% had spontaneous vertex delivery, 10% had instrumental delivery, and 37.5% had caesarian section: this was similar to the hospital population. Of the 48 vaginal deliveries, 11 had shoulder dystocia (23%). Nine babies were admitted directly to the NICU (12%), 3 of which had shoulder dystocia.

Conclusions: There was a high correlation between BMI and maternal age >30 with macrosomia. The majority of mothers had parity ≤2 and did not have gestational diabetes. We identified a high risk of shoulder dystocia. This review reinforces the importance of identifying fetal macrosomia.
A REVIEW OF INTERNATIONAL GUIDELINES FOR WAITING TIMES IN GYNAECOLOGICAL ONCOLOGY

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Diagnosis and management of malignancy involves timely coordination of multiple specialist services including General Practice, Gynaecology, Radiology, Pathology and Oncology. Increased waiting times for treatment following a diagnosis of cancer decrease survival rates. National standards for waiting times exist for breast and cervical malignancy screening as part of national programmes. However no such standards exist for vulval, uterine or ovarian cancers.

The aim of the study was to review the current available guidelines from other countries that pertain to the provision of gynaecological oncology services and specifically that recommended targets for waiting times. Pubmed and Ovid databases were searched using the terms 'waiting times', 'gynaecological malignancy', 'guidelines'. All studies identified were reviewed by two researchers and six of these were suitable for inclusion in the final analysis. Only three countries had guidelines on waiting times specific to gynaecological oncology. All three of these had a recommended time from referral to review of 2 weeks. The recommended time to treatment was varied, ranging from thirty one to eighty four days depending on the suspected diagnosis.

Few countries worldwide have guidelines for timing of referral and treatment pathways for women with confirmed or suspected gynaecological malignancy. The lack of recommended target times precludes any meaningful audit of the efficiency of these services and makes it difficult to prioritise areas in the service where change could most impact on patient care.

This review highlighted the urgent need for the development of national auditable standards in Gynaecological Oncological services.
CASE REPORT: OVARIAN TORTION IN A SEVEN YEAR OLD

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Ovarian torsion is a rare but important cause of acute abdominal pain in the paediatric population. It is a difficult diagnosis that may mimic other more common pathologies, such as appendicitis or acute gastroenteritis. The potential sequelae if missed are far reaching and as such, a high index of suspicion and prompt investigation and diagnosis are needed to optimise outcomes.

In this report, we describe a case wherein a seven year old girl presented acutely to the accident and emergency department with sudden onset, severe, right iliac fossa pain. She had no associated symptoms. Urinalysis and bloods were normal. After initial assessment by emergency staff she was seen by the surgical team on suspicion of acute appendicitis. An urgent ultrasound abdomen and pelvis was organised and this showed an intrinsic abnormality of the right ovary. A follow up MRI pelvis reported a high suspicion for ovarian torsion and she was referred immediately to the gynaecology team on call. She underwent emergency laparotomy that evening. On entry to the abdomen the right ovary was found to be enlarged and torted to 360 degrees. Detorsion was performed and ovarian salvage was achieved.

Ovarian torsion in the prepubescent population is a rare occurrence but one that has significant implications, including ovarian infarction. Prompt diagnosis and expedient surgical intervention is required as ovarian salvage is a high priority. In our case, a rapid pathway from presentation to diagnosis facilitated rapid intervention and prevented loss of the ovary through early restoration of blood flow.
Complications following LLETZ treatment in National Maternity Hospital in 2013

Azriny Khalid (National Maternity Hospital, Holles St. Dublin 2), Somaia Elsayed (National Maternity Hospital, Holles St. Dublin 2), Myra Fitzpatrick (National Maternity Hospital, Holles St. Dublin 2)

Cervical cancer is the third most common cancer and cause of death among gynecologic cancers. The rate of cervical cancer has declined significantly following introduction of cervical screening. The treatment of high-grade CIN is excision or ablation of the transformation zone of the cervix, which can reduce the risk of invasive cancer of the cervix by 95% in the first eight years after therapy.

Large loop excision of the transformation zone (LLETZ) is the most common treatment for abnormal cervical cells. Complications include intraoperative or post-operative bleeding (0-8%) and infection (0-2%). The British society for colposcopy and cervical pathology (BSCCP) recommend that primary haemorrhage requiring haemostatic technique in addition to treatment should be less than 5% of cases. It also recommends that the rate of cases admitted due to complications of LLETZ treatment should be less than 2%

The purpose of the audit was to assess the rate and type of complications following LLETZ treatment in 2013, and to compare our figures with the BSCCP standards.

The hospital’s gynaecology walk-in service admission book and mediscan were used to get a list of all patients who presented to the hospital following LLETZ treatment from Jan-Dec 2013.

In 2013 there were 1059 LLETZ performed. 43 patients (4%) presented with complications [37% bleeding (overall rate of 1.5%), 37% offensive discharge, 16% pain]. The deferential diagnosis in 53% of presentations was infection. The overall rate of admission was 1.03%.

In conclusion, the hospital rates of complications comply with the BSCCP standards.
Trends in the management and outcomes of placenta accreta in a major maternity hospital

Poster - 38

Somaia Elsayed (National Maternity Hospital, Holles St. Dublin 2), Ogugua Iloabachie (National Maternity Hospital, Holles St. Dublin 2), Shane Higgins (National Maternity Hospital, Holles St. Dublin 2)

Placenta accreta refers to an abnormality of placental implantation in which the anchoring placental villi attach to myometrium rather than decidua, resulting in a morbidly adherent placenta.

The most important risk factor for placenta accreta is placenta previa after aprior cesarean delivery. The marked increase has been attributed to the increasing prevalence of cesarean delivery in recent years. (1) The most useful modality for evaluating placental position and implantation is ultrasound. MRI is an adjunctive diagnostic tool when the diagnosis is uncertain, the placenta is posterior, or to gauge the depth of placental invasion.

The aim of the study is to investigate the management and outcome of placenta accreta in National Maternity Hospital over the last five years. We evaluated the rate and method of antenatal diagnosis, the rate of hysterectomies, the rate of emergency delivery and the maternal mortality and morbidity.

We retrospectively reviewed annual reports, hospital records, Histology reports, ultrasound reports and Theatre records of cases of placenta accreta from 01/01/2009 to 31/12/2013.

Overall there were 17 cases of histologically confirmed placenta accreta. In 29.4% of the cases, placenta accreta was suspected antenataly on ultrasound. 70.5% of the patients had one or more previous caesarean section. 41% of cases were delivered by emergency procedure. 10 out of 17 (58.8%) required hysterectomy. Placenta accreta remains difficult to manage. It’s associated with difficult diagnosis and high rate of hysterectmoies and maternal morbidity.

Clinical features and diagnosis of placenta accreta, increta, and percreta, UpToDate.
When you hear hoof-beats.... sometimes it's a zebra!!

Poster - 39

Somaia Elsayed (National Maternity Hospital, Holles St. Dublin 2), Maeve Eogan (Rotunda Hospital)

J.T is a 34-year-old Para-0 lady who booked at 12 weeks gestation with normal blood pressure (BP) and clear urine. During her second trimester she developed borderline-hypertension (140/100) and complained of palpitations. At 29 weeks she was commenced on Labetolol 200mg-BD for pregnancy induced hypertension (PIH). At 38 weeks she was admitted to hospital due to suboptimal BP control and significant proteinuria. A diagnosis of pre-eclampsia (PET) was made. On admission her BP was significantly elevated at 215-270/115-130. She was delivered by Emergency-Section, following BP stabilization and Magnesium-Sulphate administration. Postnatally her BP remained very difficult to control, requiring daily increase in oral antihypertensive medications. She also described sweats when she was hypertensive. As a result of this she had a 24-hour collection for catecholamines, which showed raised levels of noradrenaline and normetanephrine. She was transferred to Beaumont where she had resection of a pheochromocytoma in her sympathetic ganglia.

Pheochromocytoma is a catecholamine-producing endocrine tumour that occurs mostly in the adrenal gland (85%) or sympathetic ganglia (15%). During pregnancy, the incidence of a pheochromocytoma is 1 in 54 000 pregnancies (1, 2). Maternal and fetal mortality may be as high as 50% if left untreated.

Pheochromocytoma generally presents with hypertension and paroxysmal symptoms such as headache, sweating, nausea and palpitations. The most common reason for overlooking a pheochromocytoma during pregnancy is the much higher prevalence of PIH and PET (3). A high index of suspicion should be used in those with hypertension prior to twenty weeks gestation, orthostatic hypotension with PIH and those with personal or family history of Von-Hippel-Lindau, MEN2-syndrome or Neurofibromatosis.
In women with reduced ovarian reserve does stimulation with 600IU of gonadotrophin offer any advantage over a lower 300-450 IU dose?

Somaia Elsayed (Rotunda Hospital), Srwak Khalid (HARI Unit, Rotunda Hospital)

Three decades after the birth of the first IVF-baby, poor-response to controlled ovarian hyper-stimulation still remains a frustrating limiting factor for IVF. Uncertainty regarding the ideal dose and protocol for women with predicted poor ovarian-reserve does remain a challenge.

This is a retrospective cohort study (n=161) of patients with low-ovarian reserve and expected poor response, comparing the outcome of IVF treatments between patients that started ovarian stimulation on 600IU to ones that received 300-450IU from 2011-2013.

We identified patients that had IVF/ICSI with the background of low ovarian reserve: AMH<5.0pmol/L, (Antral Follicle Count) AFC<6 and FSH>10 IU/L and expected poor response to stimulation. We analysed female age, gonadotrophin dose, stopped cycles and clinical pregnancies.

Of the 1758 IVF/ICSI treatments performed, 161(9.2%) met the inclusion criteria. A 600IU-dose was used by 143 patients, 53(37%) had treatment discontinuation due to poor ovarian response. The clinical pregnancy rate (CPR) was 13% per-cycle started and 20% per-embryo transfer. Stratified by age, the CPR per cycle started was 14% in ≤35 years, 10% in 36-40 years and 15.3% in >40’s.

In the 300-450IU group (n=18), 28% were stopped due to poor response. The CPR per-cycle started was 33.3% and 54.5% per-transfer. Age stratified, the CPR per-cycle started was 60% (≤35 years) and 30% in 36-40 years. No pregnancies established in over-40’s.

In the absence of large randomized trials, we are considering recommending a lower-dose of gonadotrophins to patients with low-ovarian-reserve and expected poor ovarian response during ART. The maximum 600IU dose could be used as last resort prior to donor-eggs.
The relationship between body mass index and infant birth weight in diabetic and non-diabetic pregnancies

Poster - 41

Caitriona Fahy (Dept of Obstetrics and Gynaecology, University Hospital Galway, Galway.), Amy Claire O’Higgins (UCD Centre for Human Reproduction, Coombe Women and Infants University Hospital, Dublin), Aoife Egan (Dept of Endocrinology, University Hospital Galway, Galway), Geraldine Gaffney (Dept of Obstetrics and Gynaecology, University Hospital Galway, Galway.), Fidelma Dunne (Dept of Endocrinology, University Hospital Galway, Galway)

Gestational diabetes mellitus (GDM) is associated with increased infant birth weight (BW). Increasing maternal body mass index (BMI) has also been associated with increased birth weight, and GDM is significantly more common in women who are obese.

We explored the relationship between GDM, BMI and BW in a well defined cohort of patients.

Women were recruited at their booking visit as part of the Atlantic DIP Study. Height and weight were measured at this visit and BMI calculated. All women were screened for GDM with a 75g 2 hour glucose tolerance test, between 24 and 28 weeks gestation. Infants delivered after 37 completed weeks gestation had their weight measured at birth.

There were 4868 women included in the analysis. The mean age was 31.9 years, the mean BMI was 27.6 kg/m². 27.2% were obese and 24.4% had GDM. The mean BW in women with GDM was 3.56 kg (range 1.82-5.36) and the mean BW in non-diabetics was 3.58 kg (range 1.44-5.64) (p=0.20). For the whole cohort, BW increased with increasing BMI (p<0.01). In women with GDM, BW increased with increasing BMI in both obese (p<0.01) and non-obese women (p<0.01). However, in women without GDM, BW increased with increasing BMI only in non-obese women (p<0.01) and not in obese women (p=0.47).

With multi-disciplinary treatment, there is no difference between BW in women with and without GDM. BW is influenced by maternal BMI in diabetic women of all BMI categories, but not in non-diabetic women.
THE PREVALENCE OF GROUP B STREPTOCOCCUS IN WOMEN WITH PRETERM PRELABOUR RUPTURE OF MEMBRANES IN UNIVERSITY MATERNITY HOSPITAL LIMERICK

Caitriona Fahy (Dept of Obstetrics and Gynaecology, University Hospital), Una Fahy (Dept of Obstetrics and Gynaecology, University Maternity Hospital Limerick)

Preterm prelabour rupture of membranes (PPROM) complicates 2% of pregnancies. There is evidence to suggest an association between PPROM and lower genital tract infection. There is no national screening programme for Group B Streptococcus (GBS), and thus the prevalence of GBS in an Irish population is unknown, with studies quoting rates of carriage from 11.7% to 25.6%. There is little evidence regarding rates of GBS carriage in women with PPROM.

We aimed to estimate the prevalence of GBS in women with PPROM.

A review of all women with confirmed PPROM presenting to UMHL from June 2013 to June 2014 was undertaken. GBS was diagnosed on high vaginal swab, low vaginal and rectal swab or urine culture.

62 women were suitable for inclusion in the analysis. The mean parity was 1.16, 7% had had a previous preterm delivery. The mean gestation at PPROM was 32.9 weeks in GBS positive women and 34.2 weeks in GBS negative women, but the difference was not statistically significant (p=0.22). The mean gestation at delivery was 34.8 weeks in GBS positive and 35 weeks in GBS negative women, again not statistically significant (p=0.75). The rate of GBS carriage in the group was 27%.

Although a small study, this GBS carriage rate in PPROM is significantly higher than the rate in the general population quoted in previous studies. This may have implications for antibiotic guidelines in Irish maternity hospitals. Further larger studies are necessary in this area.
**IS THERE A CORRELATION BETWEEN 3D THIGH VOLUME IN THE THIRD TRIMESTER AND BIRTH WEIGHT?**

*Poster - 43*

**Maria Farren (UCD Centre for Human Reproduction, Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Niamh Daly (UCD Centre for Human Reproduction, Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Aoife McKeating (UCD Centre for Human Reproduction, Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Sophie Gray (UCD Centre for Human Reproduction, Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Mairead Kennelly (UCD Centre for Human Reproduction, Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Michael J Turner (UCD Centre for Human Reproduction, Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Sean Daly (Coombe Women and Infant’s University Hospital, Cork St, Dublin 8)**

Previous studies have demonstrated thigh volume to be a more effective predictor of birth weight. This prospective observational study analyzed the correlation between 3D thigh volume at 36 weeks gestation and birth weight.

Women with a singleton pregnancy were recruited at 36 weeks gestation. A 3D thigh volume (3DTV) was performed on a Voluson E8 ultrasound machine. The 3DTV was measured starting with a sagittal view of the femur. Calipers were placed at either end of the femoral diaphysis. Software then sliced the middle 50% of the thigh into five equal sections. In an axial view, the contours of these slices are then manually traced to generate the volume. Ultrasonographers were trained to perform thigh volume measurement under supervision. These infants were then followed up at birth and birth weight was recorded.

Thirty two women were recruited. The mean age was 30.4 years and mean BMI was 30.2kg/m2. Mean gestation at the time of scanning was 36.28 weeks. All babies were born at term. The mean gestation at delivery was 39.64 weeks. When the data was entered on a scatter plot (Figure 1) with a best-fit line, R²=4.9% with R² adjusted=1.8% and p value=0.2650.

Contrary to previous studies of similar numbers we did not demonstrate a correlation between 3DTV at 36 weeks and birth weight.
EDUCATION IN SEPSIS - A SYSTEMATIC REVIEW

Poster - 44

Niamh Fee (UCD), Lucia Hartigan (Nat), Fionnuala McAuliffe (National Maternity Hospital, Holles St. Dublin 2), Mary Higgins (National Maternity Hospital, Holles St. Dublin 2)

Background: Sepsis is a major cause of morbidity and mortality in both the general and obstetric populations. Sepsis is currently the leading cause of direct maternal death, with the majority of cases reported having major degrees of substandard care identified, particularly related to both the lack of recognition of sepsis and guidelines on management. Concerns have been raised regarding substandard care in the management of the septic obstetric patient and there is a real need for continuing multidisciplinary medical education in the recognition and management of the septic pregnant patient.

Purpose: This is a systematic review of studies in medical education in sepsis. The aim was to inform clinicians working in obstetrics and gynaecology and assist in planning educational programmes.

Study Design: This review systematically examined published papers reviewing educational interventions in the teaching of sepsis management.

Findings: We did not identify any studies particular to sepsis education in pregnancy. Development of clear guidelines and concentrated use of specific educational initiatives (such as the Surviving Sepsis Campaign and Sepsis Six) have resulted in substantial reductions in morbidity and mortality in the general medical and surgical populations. Common themes included the need for educational initiatives need to be continuous (to allow for change over of staff) and multifaceted (to allow for different learning styles).

Conclusion: It could be extrapolated that similar improvements in patient care can result with education on the guidelines on Sepsis in pregnancy and the puerperium.
Induction of labour, how does indication influence the outcome?

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Induction of labour (IOL) is the artificial initiation of uterine contractions before their spontaneous onset, the expected outcome being cervical dilatation with eventual vaginal delivery. Failed induction results in emergency section caesarean section (LSCS).

We examined the indications for induction of labour within our hospital and how this influenced mode of delivery. This review took place over a three month period, all patients induced during this period were included and data was collected prospectively, 691 women were induced and 700 babies delivered.

The overall LSCS rate in induced labours was 18.2%. We examined the effect of parity on the rates of LSCS. The incidence of LSCS in primiparous patients was highest in certain subgroups with 30% LSCS rate in postmature pregnancy (beyond 41 weeks), 31% in hypertension, and 39% in suspected fetal growth restriction. Vaginal delivery rates in primarous women with multiple-pregnancy were low, 80% required LSCS. 27% of induced gestational diabetics required delivery by LSCS. Suspected macrosomia had a LSCS rate of 46% and patients with prolonged rupture of membranes the rate was 20%. LSCS rate for oligohydramnios was 21%.

In multiparous women LSCS rates were low at 8% in postmature pregnancies, 9% in patients with prolonged rupture of membranes, 6% in hypertension, and 3% in growth restricted babies. Rates were similarly low in macrosomic babies at 6%, 13% in oligohydramnios and 4% in gestational diabetics.

This information is important as it allows us to counsel women regarding likely outcomes following induction of labour for a variety of indications.
**Induction in women over the age of 40 years, does it work?**

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There is a growing trend among women to delay childbearing; however adverse maternal and perinatal outcomes are associated with older patients. Debate is ongoing regarding the optimal timing and mode of delivery in these patients. We examined our experience of induction of labour in women over the age of 40. This review took place over a three month period from March to May 2014. All patients induced during this period were included and data was collected prospectively.

50 women over the age of 40 delivered during this period. They comprised 33 multiparas (range of P1 to P11), and 17 primiparas. Gestation ranged from 37+5 to 42 weeks with 46% delivering before 40+0. The average birthweight was 3.525kg with only 5 babies weighing less than 3kg.

The casarean section rate in primiparous women over 40 was 53%, significantly higher than the background rate within the induced primiparous group (30.4%). Additionally 12% of these women had significant PPH of greater than 1.5L. Within the multiparous group the LSCS rate was only slightly increased compared with the overall LSCS rate in induced multiparous women (9% compared to 5.9%) with only one case of PPH of 0.5-1L which occurred at LSCS.

This study shows that induction of labour in primigravid women over forty is associated with an increase in LSCS rates and significant PPH. Multiparous women have outcomes similar to their younger counterparts. This information will be useful in counselling elderly primigravidae.
A 31 year old lady had a normal vaginal delivery at term with no epidural. Day one post partum she developed a sudden onset of weakness of both legs, the right being worse. She was unable to stand or mobilise. On examination she had normal tone, power, co-ordination, reflexes and sensation but was unable to straight leg raise or weight bear. She reported a general discomfort to her lower abdomen but no other symptoms and felt generally well. Examination of her abdomen revealed her discomfort to be from a distended bladder, yet she had no urge to urinate. Her symptoms worsened and she was reviewed by a medical consultant. At this point she had lost power and tone of both lower limbs. An urgent MRI spine was requested, querying an anterior spinal infarct. MRI spine was normal and showed no pathology. An x-ray performed did show a large gap at her pubic symphysis measuring 12mm. She was reviewed by orthopaedics and for physiotherapy and conservative treatment with regular follow up.
AMH is a 26-year-old para 1+3 lady, one previous vaginal delivery. She is rhesus negative and her first baby was rhesus positive. She had 3 miscarriages at 8, 12, and 23 weeks. She booked in for this her 5th pregnancy. She had a complicated antenatal period having had 3 admissions to the antenatal ward for pain and pressure but discharged home well from each.

At her booking visit her booking bloods were taken and her anti-D titre was noted to be 2.71iu/ml. The decision was made to repeat her antibody titres 4 weekly until 28 weeks and then 2 weekly until delivery. Her levels rose steadily throughout pregnancy reaching a peak of 9.7iu/ml.

The National Blood Centre advises that haemolytic disease of the newborn is unlikely to occur at levels below 4iu/ml, and there is a moderate risk at levels of 4-15iu/ml. They also recommend fetal medicine assessment. This lady was followed by fetal medicine with 2 weekly ultrasounds for amniotic fluid index and middle cerebral artery doppler.

She delivered at 35+2 weeks by caesarean section and baby was admitted to the NICU for prematurity and jaundice from anaemia. The baby received 2 doses of IVIg and required an exchange transfusion at 36 hours. Both had a full recovery with the baby requiring paediatric follow up for several weeks after birth.
Oxytocin is a hormone secreted by the pituitary. It exerts a stimulatory effect on the muscle fibres of the uterus. Syntocinon is a synthetic oxytocin widely used in the obstetric setting. Some Irish hospitals have created their own guidelines for the use of Syntocinon, however no national policy exists. The purpose of this audit was to highlight if knowledge was lacking due to lack of a policy.

A survey was used to assess staff knowledge of Syntocinon. The survey comprised of 28 questions relating to Syntocinon prescribing, use, side effects and monitoring. It was to be given to members of staff at Cavan General Hospital that use Syntocinon including obstetricians, anaesthetists and midwives.

Each survey consisted of 28 questions addressing prescribing, administration, side effects and monitoring. There were 5 questions relating to prescribing and on average 70.6% of these were correct. There were 7 questions relating to the administration of syntocinon with an average of 62% correct. There were 7 questions relating to side effects with an average of 53.4% answering these correctly. There were 9 general questions relating to syntocinon including monitoring, degradation and half life of which 53% answered correctly.

From this we can conclude that syntocinon is a high risk medication that is poorly understood by those using it most. Staff knowledge is of the utmost importance in ensuring the safe use of such for patients. A policy should be implemented within each hospital regarding use of syntocinon for every scenario in which it is prescribed.
THE RISK OF POSTOPERATIVE URINARY TRACT INFECTIONS IN LAPAROSCOPIC HYSTERECTOMY AND MYOMECTOMY PATIENTS

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Laparoscopic surgery is the preferred method of operating on patients across all fields of surgery. As with any patients catheterised there is a risk of urinary tract infections (UTIs).

The aim of this study was to assess the rates of microbiologically confirmed UTIs in patients who had undergone either laparoscopic hysterectomy or myomectomy in the previous two years.

A retrospective analysis of patients who underwent these surgeries with one consultant gynaecologist was performed by reviewing mid stream urine (MSU) culture and sensitivity (C&S) results at Our Lady of Lourdes hospital. Any positive cultures noted were checked against the patients chart for appropriate antibiotic prescribing.

A total of 43 patients underwent laparoscopic hysterectomy or myomectomy over a two year period. Twenty patients had MSU samples sent for C&S. 85% were requested within 4 days of the surgery. 6.9% (n=3) had microbiologically proven UTI with positive culture. All grew E Coli >10^5.

The rate of microbiology proven UTIs in patients undergoing laparoscopic hysterectomy or myomectomy in this cohort was 6.9%. This rate is in keeping with rates of UTI quoted in the literature for laparoscopic hysterectomy1. Further evaluation of this group of patients is required to establish additional risk factors which may have contributed to this rate and identify at risk patients.

THE ROLE OF SENTINEL NODE BIOPSY IN VULVAL CARCINOMA- AN UPDATED REVIEW

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Background: The aim of this study was to update work previously done on patients from January 1996 to January 2010. This study reviews the continued role of sentinel node biopsy in the management of vulval carcinoma in a gynaecology oncology referral centre from the period January 1996-September 2014. Data were obtained using patient case notes. Age of diagnosis, primary site and size of tumor were recorded, the use of sentinel node biopsy, subsequent treatment, postoperative morbidity and 5-year survival were all included. Staging was performed using the FIGO system for vulval carcinoma.

Results: A total of 85 patients were identified with vulval carcinoma. A total of 24 sentinel node biopsies were performed. Of these, 58.3% (n=14) had a tumor size of <2cm. 58.3% (n=14) in total were negative for malignancy. These patients underwent radical vulvectomy with no further treatment required. 64.3% (n=9) patients are currently disease free. 29.1% (n=7) had primary tumors >2cm. 16.7% (n=4) were positive for malignancy. Of these, all but one were treated with radical vulvectomy and bilateral lymph node dissection followed by radiotherapy.

Conclusion: Lymph node pathological status is the most important prognostic factor in vulval carcinoma but complete inguinofemoral node dissection is associated with significant morbidity. From this study you can see that SNB is an effective modality for nodal status for those who have tumor size <2cm and is associated with decrease in postoperative morbidity.

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A CASE OF TORSION OF THE GRAVID UTERUS AT ELECTIVE CAESAREAN SECTION

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Uterine Torsion during pregnancy is sporadically reported in the literature. Here we present a case of incidental finding of uterine torsion at elective caesarean section.

A 39 year old, multiparous patient with two previous vaginal deliveries, presented for elective Caesarean Section at 39+4 weeks for transverse lie of the fetus. Following Pfannenstiel incision and routine entry, the uterus was found dextrorotated 90 degrees with right round ligament, ovary and fallopian tube presenting anteriorly. Manual derotation of the uterus to neutral position was undertaken and uterus exteriorised. Transverse incision of upper segment of uterus was performed. Fetus then presented cephalic. A live 4.3kg baby was delivered without complication. Uterus was closed in 3 layers. A 2 Litre blood loss occurred but patient recovered well.

Uterine torsion is defined as rotation of the uterus of more than 45 degrees on its long axis. It can range from 60–720 degrees. There is dextrorotation in two-third and levorotation in one-third of cases. It presents most commonly with abdominal pain secondary to uterine venous and artery obstruction.

Aetiology is unknown but documented abnormalities that have appeared with uterine torsion include uterine fibroids, uterine anomalies, pelvic adhesions, ovarian cysts, abnormal fetal presentation and fetal anomalies. Ultrasound and MRI aid in diagnosis. Management requires emergency laparotomy with derotation of the uterus and delivery at term.

Uterine torsion in the gravid uterus is rare. Clinical diagnosis is difficult as symptoms are either absent or non specific. The fetal and maternal mortality rates since 1976 are 12% and 0% respectively.
**OVARIAN TUMOUR & ELEVATED AFP DOES NOT ALWAYS EQUAL YOLK SAC TUMOUR**

*Poster - 53*

Daniel Galvin (Department of Gynaecology oncology, Trinity College Dublin, Trinity Centre for Health Sciences, St James' Hospital, Dublin, Ireland.), Vicki Collins (Department of Gynaecology oncology, Trinity College Dublin, Trinity Centre for Health Sciences, St James' Hospital, Dublin, Ireland.), Feras Abu Saadeh (Department of Gynaecology oncology, Trinity College Dublin, Trinity Centre for Health Sciences, St James' Hospital, Dublin, Ireland.), Noreen Gleeson (Department of Gynaecology oncology, Trinity College Dublin, Trinity Centre for Health Sciences, St James' Hospital, Dublin, Ireland.)

Germ cell tumours are neoplasms which arise from primary oocytes. Germ cell tumours enter the differential diagnosis for young patients presenting with ovarian masses. Tumour markers which may indicate the presence of a germ cell tumour including hCG, AFP and LDH are measured in serum preoperatively. Alpha-fetoprotein (AFP) is a protein found in abundance in the fetal circulation. It may be elevated in the presence of germ cell tumours that contain elements of yolk sac tumour. It is also a marker of liver disease with raised levels described in focal nodular hyperplasia

A seventeen year old girl presented with abdominal pain, nausea and distention. Radiological investigation revealed a 10 cm ovarian mass containing both cystic and solid elements suspicious for malignancy. Preoperative serum AFP was elevated at 8 Ku/L raising the suspicion of a germ cell tumour. Unilateral oophorectomy & regional lymphadenectomy were undertaken and the lesion was delivered intact. Histology was a benign serous cystadenoma. No germ cell elements were identified. Further imaging (CT) revealed nodularity of the liver which was typical for focal nodular hyperplasia. That was confirmed with liver MRI with Primovist. The patient was referred to hepatology and continues to be followed up with their service.

We concluded from this case that:

- Nodular hyperplasia of liver and her complex ovarian cyst were potential sources for an elevated AFP.
- Liver disease must be considered in the presence of an elevated AFP
- AFP is not a specific marker for germ cell tumour.
GENERALISED PUSTULAR PSORIASIS (GPP) IN PREGNANCY

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GPP is a life-threatening form of psoriasis characterised by the eruption of widespread pustules, desquamation leading to whole body skin breakdown/ failure. We present a case of GPP in pregnancy.

The patient was a 34 year old para 2+0 at 31+4 weeks of pregnancy. She had a longstanding history of mild to moderate psoriasis that had abated during her previous pregnancies. She was transferred from a peripheral obstetrical unit for management by a tertiary dermatology service. At presentation she had severe skin hyperaemia and desquamation and was pyrexial, tachycardiac and hypotensive. The fetal size was appropriate for gestational age and the biophysical profile was reassuring. CTG could not be traced because her abdominal skin was too fragile.

IV antibiotics and fluids were commenced. A burns body suit was applied to reduce skin transudative loss. The dermatologists has reservations about corticosteroids lest they cause worsening of sepsis. Bacteremia was not confirmed. Corticosteroids and magnesium were administered after 24 hours of antibiotic treatment. Following a brief, mild improvement with antibiotics and corticosteroids, her condition deteriorated with severe pain, further eruption of pustules and increase in inflammatory markers. Delivery was undertaken by caesarean section under general anaesthesia. A healthy baby boy was delivered. Following delivery cyclosporine induced a rapid resolution of GPP.

GPP is a very rare complication in pregnancy. Joint management by dermatology, infectious disease, bacteriology, anaesthetics, maternofetal medicine, anaesthesia and neonatology optimised the outcome for this mother and baby. She is advised against further pregnancies.
PARAVAGINAL AGGRESSIVE ANGIOMYXOMA

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Aggressive angiomyxoma is a benign but locally aggressive myxoid tumour of the pelvis. It arises from vascular connective tissue. It occurs most commonly in females of reproductive age, commonly affecting the vulva. We present a rare case of angiomyxoma occurring in the paravaginal space.

A 31-year-old nulliparous woman presented with a long-standing history of uterine fibroids, increasing urinary frequency and infertility. She had undergone a complex open myomectomy and uterine artery embolisation in the past to treat a recurrent fibroid. Imaging on referral revealed an atypical 12x11x10 pelvic mass, thought to be a fibroid. Surgery was planned and excision of the mass completed. Intra-operative findings were more consistent with a cystic lesion of the paravaginal space. Histopathology of the specimen revealed it to be an aggressive angiomyxoma.

No adjuvant treatment was recommended. Clinical and radiological surveillance is planned.

We concluded from this case report that:

- Angiomyxoma should be considered as a differential diagnosis in cases of a complex pelvic mass especially in premenopausal women
- Although most common in the vulva, aggressive angiomyxomas can arise within the pelvis from the deep fascia
- Large tumours arising within the pelvic fascia can displace or compress other pelvic organs leading to symptoms such as urinary frequency and dyspareunia
HEADACHE IN PREGNANCY

Augustine Ganda (Cork University Maternity Hospital), Keelin O’Donoghue (Cork University Maternity Hospital)

Data on headache presentation during pregnancy at Cork University Maternity Hospital (CUMH) has not been gathered. Little is known about the prevalence of these presentations, the extent of their investigation and the course of headaches encountered during pregnancy.

We aimed to evaluate headache presentations in pregnant women attending the CUMH emergency room - noting those admitted and discharged; to select those undergoing neuroimaging - noting any positive findings; and to assess through questionnaire the effect of headache in pregnancy; noting any associations.

During the period of study from 2010 – 2013, hospital records were reviewed for pregnant women presenting with headache, those admitted and further investigated. Imaging results were analysed for positive results or normal study. A modified structured headache questionnaire was distributed to 500 post-natal mothers. Data obtained was analysed using descriptive statistics.

513 pregnant women presented with headache. 175 women were admitted, of whom 52 had neuroimaging. 49/52(94.23%) scans were normal, 3/52(5.77%) scans had positive findings: 1) pituitary macroadenoma, 2) Enlarged pituitary and 3) unspecific mass left side of pituitary gland. When the women were asked about their headaches during pregnancy, 246(54%) had rarely experienced headaches in pregnancy, 129(28%) never had headaches in pregnancy, 38(8%) had monthly headaches, 32(6%) had weekly headaches and 10(2%) had daily headaches.

Headache in pregnancy is a relatively common occurrence, with many underlying possible causes and associations. Of these women undergoing neuroimaging 49/52(94.23%) did not have abnormal results. Headache experienced in pregnancy could be influenced by the presence other existing factors.
Vulval lesion in pregnancy

Kate Glennon (Our Lady of Lourdes Hospital Drogheda), Mashhour Naasan (Our Lady of Lourdes Hospital Drogheda), Hassan Rajab (Our Lady of Lourdes Hospital Drogheda)

Vulval lesions in pregnancy are relatively rare and pose a management dilemma to the obstetrician. We present the case of a patient who presented with a vulval lesion at 29 weeks gestation.

A P5+1 at 29 weeks gestation presented complaining of a vulval lesion. She was admitted with a provisional diagnosis of a bartholins cyst. She proceeded to have an MRI to further delinate the nature of the lesion. This demonstrated a 6cm structure in right perineum below the level of the pubic symphysis. It was felt that the appearances were not typical for an abscess and the possibility of vulval leiomyoma was raised. She proceeded to surgery and the mass was removed and sent for histology. This demonstrated a mesenchymal lesion of smooth muscle origin. In view of its size and location, the slides were sent for further analysis to Belfast. It was characterised as a benign leiomyoma.

The patient was later delivered via elective caesarean section due to macrosomia and polyhyramnious.

Vulval leiomyomas are benign soft tissue neoplasms that arise from smooth muscle. Extrauterine leiomyomas are very rare, they can originate from any anatomical size and a present diagnostic challenge. Their appearance can often lead them to be mistaken for a bartholins cyst. MRI is very useful diagnostic tool. They can increase in size in pregnancy and pose an obstruction to delivery, often have a propensity for local recurrence. The treatment of choice is surgical excision. Histopathological confirmation of a benign nature is mandatory.
A Renal Mass in Pregnancy

Poster - 58

Kate Glennon (Our Lady of Lourdes Hospital Drogheda), Mashhour Naasan (Our Lady of Lourdes Hospital Drogheda), Hassan Rajab (Our Lady of Lourdes Hospital Drogheda)

Cases of urological tumours occur very rarely during pregnancy. When they do, the urologist and obstetrician must use judgement to deliver optimal care to the mother without unnecessary jeopardy to the fetus.

We present the case of a 34 year old P8 lady from the Congo, who presented with persistant haematuria at 27 weeks gestation. An msu was negative and her urea and creatine were normal.

The patient had an ultrasound at 30 weeks gestation to rule out renal calculi. A large focal 10cm mass was noted in the upper pole of the left kidney. A CT abdomen demonstrated a heterogenous large mass 9.5 cm x 9.8cm in the upper pole of the left kidney. The appearances were consistent with a renal cell carcinoma, although a oncocytoma could have given a similar appearance.

The patient was then managed conservatively for the duration of her pregnancy and was induced at term. She had a normal vaginal delivery. On day two post delivery she had an ultrasound guided biopsy.

The histology demonstrated a renal oncocytoma. Renal oncocytoma is a type of relatively benign renal tumour, derived from the cells of the distal renal tubule. Up to three quarters of patients with a renal oncocytoma are asymptomatic. In cases where the mass is large, a flank or abdominal mass may be the presenting complaint. Occasionally hypertension, haematuria or pain may be the presenting complaint. Diagnosis during pregnancy is uncommon and to date there have been only a few cases reported in the literature.
Patient notes are an integral part of clinical practice. High quality patient records are used to support safe, effective patient care and good communication within care teams and the patient. Well-kept patient records ensure all members of the healthcare team know what is happening to the patient and have the necessary information to plan ongoing care.

This study aimed to assess the appropriateness of filed items in patients’ casenotes following delivery: specifically, laboratory tests, correspondence, prescriptions, CTG’s, imaging results, and iMEWS charts.

A total of 60 casenotes for women delivering between August and October 2014 were examined. 21% (n=13) had documents incorrectly filed. In seven, baby’s notes (4) and results (3) were filed in the mother’s notes. There were prescription errors misfiled in 3, & 3 patients had results misfiled from another patient.

**Conclusion:** Maternal casenotes contain a vast amount of information. The Office of the Ombudsman in Ireland states that in their investigations they often find that patient records were ‘unsatisfactory’. While human error is inevitable, it is clear that incorrectly filed results can carry significant risks to patient safety, with the potential for poor communication, repetition of investigations and delays in patient care. We plan to present our findings in our Maternity unit, and reaudit in 3 months.
Sexual Health in the North East

Kate Glennon (Our Lady of Lourdes Hospital Drogheda), Rachel Elebert (Obstetrics and Gynaecology Department, Our Lady of Lourdes Hospital, Drogheda, Co Louth), Justin Low (Our Lady of Lourdes Hospital Drogheda)

Ireland is experiencing a steady increase in the numbers of young people presenting to the health services with sexually transmitted infections (STIs). In the North East, the Sexual Health Clinic provides a confidential free health check to those in the Monaghan, Cavan and Louth regions. The clinics are managed and run by a specialist team providing a comprehensive service for people concerned about their sexual health.

The Health Protection surveillance department reports that during 2013 a total of 12,753 STI's were reported in Ireland. The most frequently reported were Chlamydia trachomatis (n=6,262), ano-genital warts (n=2,133) and gonorrhoea (n=1,294). The burden of STIs is greatest among those aged less than 25 years.

This study aimed to assess the demographic of people presenting to the clinic in Louth in conjunction with the number and range of diagnoses. A retrospective chart review from January to June was conducted.

A total of 100 patients were audited. There was a split of 53% females and males (47%). The most common age group was the 20-25 year group (35%). The majority of patients were single (85%) and Irish (85%) and heterosexual (96%).

A total of 55% amount of patients had a negative screen. The most common positive test was Genital warts (14%) followed by chlamydia (7.5%), herpes simplex (genital) 5.5% and bacterial vaginosis 5.5%. Interestingly 4% of patients had more than one diagnosis.

The rising rate of STI's confirms the clinic's importance in providing a comprehensive, confidential and free service to the people of the North East.
THE IMPACT OF SMOKING ON MATERNAL BODY COMPOSITION IN EARLY PREGNANCY

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Maternal smoking is associated with low birth weight (LWB) and fetal growth restriction although the underlying mechanism is not yet fully understood. Besides direct effects of smoking compounds on the fetal-placental unit, altered maternal body composition in smokers may contribute to programming fetal growth.

The purpose of this study was to evaluate the impact of smoking on maternal body composition in early pregnancy.

In this prospective observational study women with a singleton pregnancy were recruited between July 2012 and September 2013. Body composition was measured using Bioelectric Impedance Analysis (Tanita MF-180CA) in a standardised way. Height and weight were measured at recruitment and Body Mass Index (BMI) calculated. Smoking status was obtained from the hospital records. Women <37 weeks gestation at delivery were excluded.

Of the 1033 women, 937 (90.7%) were suitable for final analysis. The mean maternal age was 29.8 years (range 17-45), 41.0% were nulliparous, 5.9% had gestational diabetes mellitus, 14.1% were smokers, 15.9% were obese, 48.5% of infants were male and the mean birth weight was 3533 g. Surprisingly, there was no difference in mean maternal body composition between women who smoked compared with those who did not. In particular, there was no difference in % fat, fat mass or visceral fat levels between women who smoked and those that did not.

Differences in intrauterine fetal growth and birth weight between women who smoke and women who do not cannot be attributed to differences in maternal body composition at the first antenatal visit.
**INFLUENCE OF GESTATIONAL AGE ON THE BIRTH WEIGHT LOWERING EFFECT OF SMOKING**

*Poster - 62*

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Gestational age is one of the most important determinants of birth weight and maternal smoking is associated with low birth weight.

The purpose of this large prospective observational study was to analyse the restriction of intrauterine fetal growth by smoking according to gestational age.

We studied women with a singleton pregnancy who delivered an infant ≥500 g during the five years 2009-13. Clinical and sociodemographic details were computerized at the first prenatal visit and after delivery. All women were offered sonographic pregnancy dating.

Of 40,741 women, the mean age was 30.8 years (18-52), the mean gestation at delivery was 39.5 weeks (20.0-42.9), 14.6% were smokers, 16.6% were obese and 51% of the infants were male. Smoking had a significant birth weight lowering effect from 32 weeks of gestation at delivery.

Our data support the hypothesis that smoking does not affect intrauterine fetal growth until the third trimester of pregnancy.
THE INTERPLAY BETWEEN MATERNAL OBESITY AND SMOKING IN DETERMINING BIRTH WEIGHT AT TERM

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Maternal obesity and smoking influence birth weight (BW) in opposite directions, but they may interact at different trajectories.

We evaluated the interplay between maternal obesity and cigarette smoking at the first prenatal visit and BW at term.

We studied women with a singleton pregnancy who delivered after 37 weeks gestation during the five years 2009-13. Clinical and sociodemographic details were computerised at the first prenatal visit and after delivery. Maternal weight and height were measured at the first visit and Body Mass Index (BMI) calculated. All women were offered sonographic pregnancy dating.

Of 38,491 women, the mean age was 30.8 years, 40.0% were nulliparas, 14.1% were smokers and 16.4% were obese. On multivariable linear regression analysis, mean BW increased with parity, advancing maternal age, advancing gestation, male gender, Irish nativity, obesity and non-smoking. All seven variables added to the model (p<0.001) and explained 25.4% of the variance in mean BW (R²=0.254). In moderately and severely obese women smoking had an impact on decreasing mean BW (p=<0.001, p=0.019 respectively) but increasing BMI had minimal impact on the incidence of babies in the highest BW percentile (p=0.888).

In this large well-characterised population, maternal smoking and increased BMI influenced mean BW in opposite directions. However, smoking had an effect across all BMI categories, but the influence of BMI started to plateau at 30.0 kg/m² particularly in non-smokers. In women who are obese at their first prenatal visit, smoking is a stronger determinant of aberrant intrauterine fetal growth than the degree of obesity.
In the limited research available it is assumed that males born from smoking women are more severely affected by smoking than females.

The purpose of this large prospective observational study was to determine if the restriction of intrauterine fetal growth due to maternal smoking differed depending on fetal gender. We studied women with a singleton pregnancy who delivered after 37 weeks gestation during the five years 2009-13. Clinical and sociodemographic details were computerized at the first prenatal visit and after delivery. Women self-reported their smoking habits and whether they were light (≤10 cigarettes/day) or heavy (>10 cigarettes/day). Maternal weight and height were measured at the first visit and Body Mass Index (BMI) calculated. All women were offered sonographic pregnancy dating. A 2-way ANOVA was conducted to examine the interaction between maternal smoking and gender on birth weight.

Of 38,491 women, the mean age was 30.8 years, 40.0% were nulliparas, 14.1% were smokers, 16.4% were obese and 51% of the infants were male. The mean birth weight of males was 3565 g (1470-5490), which was higher compared with females, 3448 g (1150-5440), \( p < 0.001 \). Smoking decreased mean birth weight in males (-6.2%) and females (-6.9%) in the same proportion \( p=0.140 \).

Maternal smoking and infant gender do not interact. Males and females are evenly affected by maternal smoking.
Smoking affects birth weight negatively. Presumably this would lead to more spontaneous vaginal deliveries. The purpose of this large prospective observational study was to analyse operative delivery rates according to maternal smoking status at the first antenatal visit.

We studied women with a singleton pregnancy who delivered after 37 weeks gestation during the five years 2009-13. Clinical and sociodemographic details were computerized at the first prenatal visit and after delivery. Maternal weight and height were measured at the first visit and Body Mass Index (BMI) calculated. All women were offered sonographic pregnancy dating. Smoking status was recorded and dived in non-smokers, light smokers (<10 cigarettes/day) and heavy smokers (>10 cigarettes/day).

Of 38,491 women, the mean age was 30.8 years, the mean gestation at delivery was 39.8 weeks (37.0-42.9), 40.0% were nulliparas, 14.1% were smokers, 16.4% were obese and 51% of the infants were male. Smokers had more spontaneous vaginal deliveries and less instrumental deliveries and caesarean sections (p<0.001). The relationship was dose-dependent with heavy smokers having less caesarean sections and more spontaneous vaginal deliveries than light smokers (p<0.005).

Smokers have more normal deliveries than non-smokers. This is most likely because of the fact that babies from smoking women are lighter. Although this might assume that smokers are better off in labour, the adverse effects for a light baby in infancy and childhood are far more severe.
THE ASSOCIATION BETWEEN MATERNAL BODY MASS INDEX AND INCREASED MATERNITY CARE COSTS

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Maternal obesity, defined as a body mass index (BMI) >29.9kg/m2 at booking, is the commonest risk factor for maternal mortality in developed countries (1). An elevated pre-pregnancy BMI is associated with a linear increase in adverse maternal and foetal outcomes, and increases the need for obstetric interventions (2).

Research addressing the financial burden of maternal obesity on healthcare services is limited in Ireland. This study aimed to estimate the healthcare costs associated with an elevated pre-pregnancy BMI.

A retrospective study was conducted of women delivering at Galway University Hospital over twelve consecutive months. Women were categorized into six groups based on booking BMI. Health resource use by each patient was identified, and included: mode of delivery, number of antenatal admissions, admission of the mother to the High Dependency Unit, and admission of the infant to the Neonatal Intensive Care Unit. A cost was applied to specified health resources. An average cost of maternity care was calculated for each patient.

There was a strong association between booking BMI and mean total healthcare costs (p<0.01). Costs for underweight, overweight, obese I, obese II, and obese III patients were on average 10%, 9%, 13%, 33% and 58% higher than women of normal BMI, respectively.

This study shows that underweight, overweight and obese women incur greater maternity care costs than women of normal BMI. Health interventions which target maternal lifestyle and reduce health resource usage to that of patients with normal BMI would benefit patients and could be cost-effective.


A CASE REPORT OF TAKAYASU’S ARTERITIS IN PREGNANCY

Poster - 67

Lucia Hartigan (National Maternity Hospital, Holles St. Dublin 2), Grace Neville (National Maternity Hospital, Holles St. Dublin 2), Celine O’Brien (National Maternity Hospital, Holles St. Dublin 2), Mary Higgins (National Maternity Hospital, Holles St. Dublin 2), Shane Higgins (National Maternity Hospital, Holles St. Dublin 2), Fionnuala McAuliffe (National Maternity Hospital, Holles St. Dublin 2)

Takayasu’s arteritis, (“pulseless disease”), is a chronic vasculitis of unknown aetiology that affects approximately 1 in 200,000. It manifests with granulomatous thickening of medium and large arteries typically affecting the aortic arch and/or proximal great vessels. In pregnancy, the main complications include pre-eclampsia and intrauterine growth restriction.

CASE: A 30-year-old Irish primiparous woman booked with a background history of childhood epilepsy and a cerebro-vascular transient ischemic attack (TIA) that occurred when she was aged 22. Radiological imaging, as part of the investigative process at the time, displayed extensive stenosis of the brachiocephalic artery, proximal right common carotid artery, and right and left subclavian arteries leading to a diagnosis of Takayasu’s arteritis.

It was not possible to auscultate this patient’s upper limb pulses and so blood pressure was measured using an electronic cuff on the lower limbs. Her pregnancy was complicated by a tonic-clonic seizure in the second trimester and the development of mild to moderate pre-eclampsia (“normal” blood pressure and 3g proteinuria / 24 hour collection) in the third trimester. Fetal growth remained normal. Labour was induced at 37 weeks due to pre-eclampsia, and a liveborn male infant weighing 3.5kg was delivered vaginally. The mother remained well and was discharged home on day 3 postnatally.

Conclusion: Though Takayasu's arteritis is a rare disease, it has a predilection for women of childbearing age, and confers a high risk of pre-eclampsia. The pregnancy of a patient with Takayasu’s arteritis should be considered high-risk and managed by a multi-disciplinary team.
A review of the success rates of kiwi vacuum deliveries

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The Kiwi vacuum assisted fetal delivery device is now widely used by obstetricians. This is a retrospective study of prospectively gathered data from January to December 2013 in a maternity hospital with approximately 5,000 deliveries per annum. The same obstetrician was involved in all 54 consecutive reviewed cases, either as the principal operator or in a direct supervisory role. All patients underwent a bed-side ultrasound immediately prior to the application of the kiwi. Only 5.55% (3/54) of the attempted kiwi deliveries failed. In each of these cases the baby went on to be delivered successfully by forceps. All three of these infants were in the OA (occipito-anterior) position prior to application of the kiwi cup. There were no caesarean sections performed as a result of failed kiwi deliveries by this operator in 2013. 40.7% (22/54) of deliveries were non-rotational and delivered in the OA position. 9.2% (5/54) of the kiwi deliveries were non-rotational and delivered in the OP position. 16.6% (9/54) of babies were rotated from the direct OP (occipito-posterior) position to direct OA. 9.2% (5/54) were rotated from ROP (right occipito-posterior) to OA and 1.8% (1/54) rotated from LOP (left occipito-posterior) to OA.

12.9% (7/54) were rotated from ROT (right occipito transverse) to OA and 5.5% (3/54) were rotated from LOT (left occipito transverse) to OA.

The mean birth weight of the group was 3.518 kg

We feel that a bed-side scan to ascertain the correct position of the fetal head prior to the application of the kiwi cup is helpful for the operator and may lead to a greater number of successful kiwi deliveries.
Myasthenia Gravis in Pregnancy – an unpredictable and potentially life-threatening condition

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Myasthenia gravis (MG) is an autoimmune disorder characterized by a fluctuating degree and variable combination of weakness in voluntary muscles.

A 33 year old primiparous patient presented with a history of myasthenia gravis. A thymectomy was performed at time of diagnosis. Her pregnancy was uncomplicated but was closely monitored with input from obstetrics, pharmacy, neurology and anaesthetics. She proceeded to have a spontaneous vaginal delivery following induction at term. She was monitored in HDU for 24 hours and was discharged home well at 48 hours. Neonatal review showed no evidence of myasthenia gravis.

Two weeks post partum she recommenced steroids but relapsed three weeks post partum with ocular and respiratory symptoms. She was managed in a general hospital for a total of five weeks, including ICU care and required multiple therapies including intravenous immunoglobulin therapy and plasmapheresis to achieve stabilisation. CT showed residual thymoma that required further resection. She made a complete recovery maintained on azathioprine and low dose steroids.

This patient is now attending for care in her second pregnancy. Multi-disciplinary care has re-commenced with continuation of steroids antenatally and an increased dose of postnatal steroids aiming to prevent a second relapse.

Myasthenia gravis is an unpredictable disease in pregnancy with first trimester and postpartum exacerbations being most commonly described. Multidisciplinary input is needed to maximise maternal and fetal outcome.
CONGENITAL ABNORMALITIES IN A COHORT OF INFANTS BORN USING ASSISTED REPRODUCTIVE TECHNOLOGY (ART); A REVIEW FROM 1996-2010 IN THE CORK AND KERRY REGION AS PART OF THE EUROPEAN SURVEILLANCE OF CONGENITAL ANOMALIES (EUROCAT) NETWORK

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The number of infants born via ART has grown annually, however rates of congenital anomalies in ART babies are often higher than those conceived naturally. With the increasing prominence of ART, it is important to examine the associated rates of congenital anomalies, which may have implications for the management of subfertility.

The purpose of this study was to provide a cohesive longitudinal analysis of reported congenital anomaly data, focusing on the epidemiological information and potential maternal risk factors as related to the various forms of ART.

A retrospective cohort study was undertaken on infants with a congenital anomaly born with or without ART between 1996 and 2010 in the Cork/Kerry region, identified using the EUROCAT database.

58 ART and 2682 naturally conceived babies were born with a diagnosed congenital anomaly. Mothers who gave birth via ART were significantly older (36.03 ± 5.928 vs 31.12 ± 4.176 years, p=0.001), and gave births to infants born both at an earlier gestational age (36.64 ± 3.256 vs 38.12 ± 3.968 weeks, p=0.015) and at a lighter birth weight (2795.34 ± 1013.029 vs 3143.64 ± 971.85 grams, p=0.032). Rates of trisomy 13 were also significantly higher in the ART group (5.2% vs 1.3%, p=0.015).

Mothers who gave birth to ART babies were significantly older and gave birth to babies at an earlier gestational age with a lower birth rate than those conceived naturally, with a higher risk of trisomy 13. Continuing research with larger sample sizes is needed to explore additional significance.
INDUCTION OF LABOUR IN TWIN PREGNANCY AT TERM: DOES CHORIONICITY INFLUENCE MODE OF DELIVERY?

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Induction of labor(IOL) in twin pregnancy is a controversial practice in contemporary obstetrics. We sought to assess the influence of chorionicity on mode of delivery in twin pregnancies undergoing IOL at >37 weeks gestation.

This was a review of all twin pregnancies at a tertiary university institution over a 5-year period from 2007-2011. Details of maternal demographics, intrapartum characteristics and neonatal outcomes of all twins >37 weeks gestation were recorded. Chorionicity was confirmed by histopathological examination.

There were 377 twin pregnancies >37 weeks gestation, with 181 of these twin pairs undergoing IOL. 78%(142/181) were dichorionic, with 22%(39/181) being monochorionic. Monochorionic twins were induced earlier than dichorionic (263 ± 3.6 days vs. 267.6 ± 4.6 days, p<0.0001). Birthweight was similar in both groups (2862±367g vs. 2756±365g, p=0.11) and there was no difference in labor duration (251±198min vs. 217±162min, p=0.32). Chorionicity was not found to have an influence on mode of delivery in induced twin pregnancies at term, with similar rates of cesarean delivery, operative vaginal delivery and combined vaginal-cesarean delivery in both mono- and di-chorionic twins. Apgar scores and rates of cord pH<7.1 were similar regardless of chorionicity. Monochorionic twins had a higher rate of admission to NICU than dichorionic twins (21.8%[17/78] vs. 9.2%[26/284], p=0.003, OR=2.7, 95%CI=1.4-5.4).

This study demonstrates that chorionicity does not influence mode of delivery in twin pregnancies undergoing IOL after 37 weeks. Monochorionic twins are induced earlier and this may play a role in the higher rates of NICU admission seen in these infants.
Shoulder dystocia is an obstetric emergency characterized by additional maneuvers to deliver the shoulders. External maneuvers include McRoberts position and suprapubic pressure. Internal maneuvers include internal rotation and retrieval of the posterior arm. While early recourse to internal maneuvers may lead to shortened delivery time, and decrease potential for hypoxia, this may predispose to traumatic delivery. We sought to compare outcomes between those that do and do not require internal maneuvers.

This is prospectively gathered data from all cases of shoulder dystocias at a single institution from 2008-2012. Records of individual cases were reviewed. Those who did and did not require internal maneuvers were compared. Outcome variables included birthweight, Apgars, cord pH, NICU admission, brachial plexus injury (BPI) and neonatal fractures. Maternal outcomes included anal sphincter injury and PPH>500mls. A multivariate regression model was built to adjust for birthweight.

There were 448 cases of SD, an incidence of 1.2%(448/36549) of all vaginal deliveries. The majority (294[65%]) were relieved by external maneuvers with 154(35%) requiring internal maneuvers to deliver the shoulders. Internal maneuvers were associated with Apgar <7 at 5min(15/154 vs.10/293, p=0.008, OR3.0), NICU admission (39/152 vs. 24/290, p<0.001, OR3.8), and neonatal fracture(9/154 vs. 4/293, p=0.01, OR4.4). No difference in the incidence of BPI was seen. The differences in NICU admission rates, low Apgars and fractures remained significant following adjustment for birthweight with regression analysis.

In a cohort of consecutive cases the use of internal maneuvers to relieve shoulder dystocia is a marker for adverse neonatal outcome. this effect is independent of birthweight.
AMNIOCENTESIS AND CHORIONIC VILLUS SAMPLING PERFORMED AT UNIVERSITY MATERNITY HOSPITAL LIMERICK

Aenne Helps (Obstetric Department, University Maternity Hospital, Limerick)

Amniocentesis and chorionic villus sampling (CVS) are methods of invasive prenatal diagnostic tests. The additional risk of miscarriage with invasive diagnostic testing is around 1%. At least 30 ultrasound-guided invasive procedures should be carried by a skilled operator annually to maintain competency. Bloody taps and culture failures should be audited in each unit performing amniocentesis and CVS (1).

The aim of this study was to confirm that this RCOG standard of care was being followed in our unit.

This was a retrospective study from January 2006 to September 2014. In total, 387 patients were identified from ultrasound department records. Amniocentesis was performed in 303 cases and 84 women underwent CVS. Two operators performed invasive diagnostic testing in our unit. The second operator joined the unit in January 2011. Invasive procedures carried out have increased from 28 in 2006 to 70 in 2013. Sixteen amniocenteses were performed after fetal demise was identified on ultrasound. The pregnancy loss rate post-procedure was <1%. Blood stained samples complicated 1.3% procedures. Cells failed to culture in 2.8% of all cases. The rate of culture failure was 1.5% for ongoing pregnancies (3 cases each for amniocentesis and CVS) and 35.3% for pregnancies with an intra-uterine demise (IUD).

The culture failure rate for amniocentesis done on pregnancies with an IUD is high (35.3%), which is disappointing. RCOG guideline recommendations regarding maintaining competency was adhered to in 2013, 70 procedures were carried out between the two operators.
CASE REPORT OF IDIOPATHIC FACIAL NERVE PALSY IN THE POST-PARTUM PERIOD IN A PATIENT WITH PREECLAMPSIA

Maebh Horan (Coombe Women and Infant's University Hospital, Cork St, Dublin 8), Gillian Ryan (Coombe Women and Infant's University Hospital, Cork St, Dublin 8), Dr Gunther Von Bunau (Coombe Women and Infant's University Hospital, Cork St, Dublin 8)

Introduction: Bell's palsy is defined as a paralysis of the facial nerve resulting in asymmetric facial expression and unilateral weakness of eye closure. There is a 2-4 increase in prevalence during pregnancy, especially in the third trimester or in the first week postpartum.

Obstetrical and neonatal complications are not generally increased among patients with this, but there appears to be an association with preeclampsia.

Case Report: We report a case of facial palsy in the immediate postpartum period.

A 31 year-old, primip was admitted to hospital at 30 weeks gestation with pre-eclampsia (PET). On day 5 of admission the patient reported facial numbness without any evidence of facial droop, difficulty with speech or any objective findings on examination. She had worsening PET requiring delivery by caesarean section.

Day 1 postnatal she had an episode of raised BP, facial parasthesia with dysarthria which lasted approximately 10 minutes. Neurological examination revealed a persistent left sided facial weakness involving the facial nerve. A diagnosis of Bell's palsy was made and following neurology team input, she had an MRI excluding thrombosis or haemorrhage and was treated with a course of prednisolone.

Conclusion: Idiopathic peripheral facial paralysis (Bell's palsy) is the most frequent unilateral cranial nerve pathology affecting pregnant women and although the exact aetiology is unknown it is commonly associated with development of hypertensive disorders of pregnancy. Women who develop evidence of facial paralysis should be monitored closely for hypertension or pre-eclampsia.
A SINGLE-CENTRE EXPERIENCE OF THE USE OF ORAL METHOTREXATE IN THE MEDICAL MANAGEMENT OF ECTOPIC PREGNANCY

Maebh Horan (Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Jessie Elliott (Conway Institute of Biomolecular and Biomedical Research), Michael Gannon (Midlands regional Hospital Mullingar)

Introduction: There has been a marked reduction in mortality from ectopic pregnancy due to earlier and more accurate diagnosis. Treatment has evolved from laparotomy to laparoscopy, and now medical therapy in about a third of cases. Methotrexate, administered IM with antineoplastic precautions, is the standard. Success is judged by a reduction of at least 15% in hCG from day 4 to 7 and studies have shown that up to 15% of women require repeat treatment. We found that this method was burdensome for both hospital and patient.

Methods: We proposed that oral methotrexate would have a similar effect because of its pharmacodynamics. Oral methotrexate (100mg) was introduced for the medical management of women with ectopic pregnancy at our hospital. Those treated, all of whom had an initial hCG <1500iu/L and adnexal mass less than 35mm, were monitored through the EPAU, by serum hCG levels on day 4 and 7, then weekly until return to a non-pregnant level.

Results: We report those treated for ectopic pregnancy from January 2012 until July 2014 (n=62) after the introduction of this method. Thirty-six underwent primary surgical management. Twenty-five women were managed medically with single dose oral methotrexate during the study and these comprise our cohort. Median percentage reduction in hCG between days 4 and 7 following methotrexate was 49.2%(Range -74.19 – 99.24%). Our results show that just three women (12%) demonstrated a <15% reduction in serum hCG.

Conclusion: Our audit establishes the feasibility of oral administration of methotrexate in the medical management of ectopic pregnancy.
AUDIT OF OUTCOMES IN LABOUR IN PATIENTS WITH BLEEDING DISORDERS

Maebh Horan (Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), A Freyne (Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Catherine Manning (Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Kevin Ryan (National Centre for Hereditary Coagulation Disorders, St James), Carmen Regan (Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Bridgette Byrne (Coombe Women and Infant’s University Hospital, Cork St, Dublin 8)

BACKGROUND: Women with inherited bleeding disorders (IBD) are at risk of bleeding complications in labour and optimum mode of delivery for potentially affected infants remains controversial. The study aim was to report outcomes of delivery in women with IBD and to assess the impact of fetal precautions on labour in women with bleeding disorders.

METHODS: 90 women with IBD who attended the clinic and delivered between January 2011 and October 2014 were identified from the maternal medicine database. Charts were reviewed and patient demographics, mode of onset of labour and delivery, anaesthesia, PPH and fetal complications recorded.

RESULTS: Identified bleeding disorders; 36 Von Willebrands disease, 5 Haemophilia A, 5 Christmas disease, 11 Haemophilia carriers, 1 Factor V deficiency, 1 Factor VII deficiency, 2 Factor XII deficiency, 1 Factor X deficiency, 2 Factor XI deficiency, 2 combined deficiency disorder, 16 bleeding disorders of unknown aetiology and 8 with positive family history. Mean age was 31 years and mean gestational age at delivery 39 weeks. 38 were primiparous. Labour began spontaneously in 46, 29 were induced and 12 elective caesarean sections (CS). 33 had epidurals, 13 received spinal, 9 had remifentanyl PCA and 5 general anaesthesia. 54 achieved spontaneous vaginal delivery, 7 instrumental delivery and 14 and 12 women had emergency and elective CS respectively. 12 of the 87 who delivered at our centre had a PPH.

CONCLUSION: Vaginal delivery was achieved safely in 62% of women in the absence of obstetric indications for elective CS, however fetal precautions may limit progression of labour.
**RHESUS DISEASE IN TWINS; THE ANTI-D MYSTERY**

Kevin Hore (Department of Obstetrics and Gynaecology, National Maternity Hospital, Dublin), Fionnuala Mone (Department of Fetal Medicine, National Maternity Hospital, Dublin), John Quigley (Department of Pathology & Laboratory Medicine, National Maternity Hospital, Dublin), Barry Doyle (Irish Blood Transfusion Service, James’s St, Dublin), Moria Woolfson (Irish Blood Transfusion Service, James's St, Dublin), Colm O'Donnell (Department of Neonatology, National Maternity Hospital, Dublin), Joan Fitzgerald (Department of Pathology & Laboratory Medicine, National Maternity Hospital, Dublin), Peter McParland (Department of Fetal Medicine, National Maternity Hospital, Dublin)

**BACKGROUND:** We describe the case of RhD isoimmunisation in twins, where despite both twins having a RhD positive blood group, only one was severely affected.

**CASE:** Ms. X was 32-year-old Para 2+1 with dichorionic diamniotic twins. In her last pregnancy her fetus was affected by RhD isoimmunisation requiring phototherapy post-natally. In the index pregnancy anti-D, anti-C and anti-E antibodies were detected. Non-invasive cell free fetal DNA analysis demonstrated that at least one of the twins was RhD positive. Anti-D quantitation levels at 13+2 and 29+3 weeks were 21IU/mL-1 and 330IU/mL-1 respectively. In this pregnancy Twin 1 required three intrauterine transfusions and Twin 2 did not go over 1.5MoMs on middle cerebral artery Doppler peak systolic velocity surveillance. Elective delivery occurred at 34+3 weeks. Both twins were found to be RhD positive with Twin 1 being O+ and Twin 2 A+ respectively. Twin 1’s haemoglobin was 16g/dL and an exchange transfusion was required for escalating hyperbilirubinaemia. Twin 2’s haemoglobin was 7.7g/dL and phototherapy, intravenous immunoglobulin and blood transfusion were required.

**DISCUSSION:** Although both twins in this case were RhD positive only one was severely affected. Possible theories explaining the disparity include the protective effect conferred by an ABO incompatible fetal blood group, the presence of maternal HLA-DR specific antibodies interacting with fetal Fc receptors (FcRn) or lower numbers of FcRn resulting in a less efficient transfer of IgG from the mother to the fetal circulation.

**CONCLUSION:** RhD isoimmunisation can potentially affect twin pregnancies differently than singleton pregnancy, the definite reason for this is unknown.
Sleep patterns and fatigue in first-time mothers during the first 48 hours postpartum

Oksana Hughes (University Maternity Hospital, Limerick), Amy Claire O’Higgins (UCD Centre for Human Reproduction, Coombe Women and Infants University Hospital, Dublin), Mas Mahady Mohamad (University Hospital Limerick), Patrick Gerard Doyle (University Hospital Limerick), Gerard Burke (University Maternity Hospital, Limerick)

Background: Postpartum women sleep less during the early days following delivery. Long-term sleep disturbance and fatigue can have significant implications for physical and mental health, relationships, employment and parental competence. Most studies focus on the quality and quantity of maternal sleep between weeks one and six postpartum.

Aim: To describe sleep patterns of first-time mothers during the first 48 hours post-delivery.

Methods: A postnatal sleep and fatigue questionnaire was completed by first-time mothers during the first 48 hours postpartum, detailing their total sleep time (TST), the reasons for being awake and their level of fatigue.

Results: Thirty first-time mothers were recruited, with 10 each having had a normal delivery, an instrumental delivery and a Caesarean section (CS). The mean sleep time over the first 48 hours was 9.7 hours, ranging between 5-22 hours for the whole cohort. The amount of time slept did not vary with mode of delivery. The reasons for being awake included settling a crying baby, feeding (90%, n=27), experiencing overwhelming emotions and anxiety regarding the baby (including checking baby’s breathing) at some stage in the first 48 hours (16.7%, n=5). Only one mother had interrupted sleep due to pain (caused by a third degree tear). Of the factors explored only breastfeeding influenced the sleep time. Breastfeeding women slept on average 2.6 hours longer than women who bottlefed (p=0.042).

Conclusions: First-time mothers sleep for average of 10 hours during the first 48 hours after delivery.
ARE REFERRAL TO A URODYNAMIC CLINIC APPROPRIATE?

Poster - 79

Niamh Joyce (University College Hospital Galway, Galway), Susmita Sarma (University College Hospital Galway, Galway)

Urodynamics is carried out to assist in the management of patients with urinary symptoms such as stress incontinence, overactive bladder (OAB) or mixed symptoms. The urodynamic service recommenced in 2012. It became clear that many of those attending had not had appropriate initial workup and management before being referred for assessment. These include a trial of supervised pelvic floor exercises, a trial of an anticholinergic or similar medication and a 3 day bladder diary.

The aim of our study was to audit our population attending for urodynamic assessment and ascertain if the correct initial investigation and management was carried out.

We conducted a retrospective chart review of patients referred for urodynamic assessment from March - December 2012. Following the introduction of a referral card we reaudited the service in 2014. Data collected included number of patients who received physiotherapy, trial of a medication and urinalysis prior to referral. 50 charts were available for retrospective review and 30 patients for prospective. Of the 50 38 (76%) patients were referred for three months of physiotherapy. 15 (30%) had a trial of anticholinergic medication prior to referral. Of the 30 patients reviewed after introduction of the referral card, 83%(25/30) of patients were referred for three months of physiotherapy, and 12/21 suitable (57%) had a trial of one or more anticholinergics.

Our audit has shown that introducing a referral form improved compliance with initial management but more work has still to be done to achieve a figure closer to 100%.
The Institute Four Province, JOGS & RAMI Meeting

ULTRASOUND DETECTION OF PLACETAL ANOMALY

Poster - 80

Niamh Joyce (National Maternity Hospital, Holles St. Dublin 2), Mary Higgins (National Maternity Hospital, Holles St. Dublin 2), Eoghan Mooney (National Maternity Hospital, Holles St. Dublin 2)

SM, 35yo P0+1, 39+5 weeks gestation, presented with reduced fetal movements on three occasions. Ultrasound demonstrated large echogenic cystic areas on the placental surface measuring up to 5cm in diameter. She was admitted for IOL and had a SVD of a 2.9kg female infant who required admission to NICU for thrombocytopenia. Histopathology noted an enlarged placenta with oedematous chorionic villi and aneurysmally dilated vessels on the fetal placental surface.

Placenta Mesenchymal Dysplasia (PMD) is a placental vascular anomaly characterised by placentomegaly and abnormal chorionic villi. It resembles a partial molar pregnancy on ultrasonography due to multicystic regions giving a moth-eaten appearance.

On gross placental examination there are oedematous villi that may occupy up to 80% of the placental volume and chorionic vessels have an aneurysmal appearance. They are distinguished from partial moles because of the absence of trophoblastic proliferation and presence of a normal fetus.

PMD predominantly affects females and is associated with Beckwith-Weideman Syndrome (20%), Intrauterine Growth Restriction (IUGR-50%) and Intrauterine Fetal Demise (IUFD-40%). Maternal illness is not a feature however the presence of chorionic vessel thrombosis may suggest a cryptic maternal thrombophilia. The association with IUFD and IUGR may be explained by chronic hypoxia due to fetal vascular thrombosis and a decrease in maternal-fetal gas exchange. This feature of placental circulation is further compromised by an insufficient amount of normal chorionic villi.

It is important to be aware of this entity and to monitor both in the antenatal and postnatal phase given the association with IUGR and BWS.
Pseudomyxoma Peritonei is an uncommon malignancy that can have a similar presentation to gynaecological malignancies, particularly ovarian cancers.

This is case report of a 71 year old lady with a background history of previous hysterectomy, for benign reasons, who was referred by the surgical team to the gynaecology-oncology service with six week history of weight loss and large palpable pelvic mass. CT showed 22cm multiseptated pelvic mass probably arising from the right ovary with ascites and mesenteric infiltration representing peritoneal carcinomatosis. Tumor markers, Ca 125, CEA and Ca19-9 were all marginally elevated. She underwent bilateral salpigo-oophorectomy, appendectomy, small bowel resection and anastomosis and omentectomy. Histological examination revealed pseudomyxoma peritonei arising from a low-grade tumor of the appendix. Following a multidisciplinary discussion, a decision was made for long-term follow up.

Following literature review, we concluded that pseudomyxoma peritonei can present in a similar fashion to ovarian cancers and diagnosis is usually made intraoperatively. The mainstay of treatment is surgical and is associated with an overall poor prognosis.
WHAT PERCENTAGE OF WOMEN WHO QUALIFY FOR POSTPARTUM THROMBOPROPHYLAXIS FOLLOWING VENOUS THROMBOEMBOLISM RISK ASSESSMENT AT DELIVERY CAN BE IDENTIFIED BY ANTENATAL RISK ASSESSMENT?

Poster - 82

Niamh Keating (Rotunda Hospital), Sharon M Cooley (Rotunda Hospital), Ajita Raman (Rotunda Hospital), Mary Deering (Rotunda Hospital), Alan Holland (Rotunda Hospital), Brian Cleary (Rotunda Hospital), Fionnuala Ni Ainle (Rotunda Hospital), Sam Coulter Smith (Rotunda Hospital)

Venous thromboembolism (VTE) is a leading cause of maternal death in the developed world. The risk of VTE increases significantly during pregnancy and is highest in the post-partum period. Consequently fewer additional VTE risk factors are required to reach a "threshold" for thromboprophylaxis in the postpartum period. International, national and local guidelines recommend that VTE risk assessment be performed at booking, at delivery, upon admission and if VTE risk factors change.

Our aim was to determine the percentage of women who qualified for thromboprophylaxis upon VTE risk assessment at delivery that were identifiable by antenatal risk assessment and how many more become "high-risk" as a pregnancy progresses.

We undertook a complete risk assessment on 423 women who delivered in the Rotunda Hospital between September 8th and October 23rd 2014 as part of a Quality Improvement Initiative project. Their requirement for thromboprophylaxis was assessed at delivery based on currently published international guidelines [2].

Sixty six women (15.5%) were identified antenatally as requiring VTE thromboprophylaxis postnatally based on risk factor assessment. Postnatally an additional 147 women (34.7%) met the requirements for VTE thromboprophylaxis. The primary indication for VTE postnatally was operative delivery. However 24 previously "low-risk" women (16.3%) who had a normal delivery met the criteria for thromboprophylaxis based on intrapartum and postpartum risk factors.

In conclusion, antenatal risk assessment identifies 1/3rd of women needing thromboprophylaxis. Prescribing thromboprophylaxis after caesarean section is also insufficient. This study validates the requirement for a VTE risk assessment tool for all women at delivery.
**Caesarean Hysterectomy in a Patient with Mosaic Turner's Syndrome**

*Poster - 83*

*Niamh Keating (Rotunda Hospital), Rishi Roopnarinesingh (Rotunda Hospital)*

A 40 year old P0 with a history of Turner's mosaicism (45X/46XX) attended for her first visit at 6+/40 having undergone donor egg in vitro fertilization. Her past medical history was significant for primary infertility, hypertension and hypothyroidism. Medications at booking were labetolol, fectmotab, cyclogest, clexane and eltroxin. Her pregnancy was complicated by gestational diabetes mellitus and poorly controlled hypertension. Fetal growth and anatomy scans were normal, showing an upper posterior placenta. At 33+/40 she was admitted with hypertension and headaches. Liver function tests were mildly elevated and 24 hour urinary protein was 0.04g. At 36+ weeks a decision to delivery by caesarean section was made in view of preeclampsia and unstable lie. A liveborn infant was delivered, weight 2.42kg. Following delivery the placenta was morbidly adherent, causing uterine eversion during controlled cord traction. After 25 minutes there were no signs of separation and a decision to hysterectomy was made. Estimated blood loss was 700ml. She was discharged well on D5. Histology confirmed a placenta accreta.

Ovarian failure is a typical feature of Turner’s syndrome. The spontaneous conception rate for patients is 2-7% and is rarely seen in monosomy X. Donor egg in vitro fertilization is a treatment option for patients with Turner’s syndrome wishing to conceive. These are high risk pregnancies with increased maternal morbidity and mortality. Placenta accreta has been documented in this cohort with potential explanations for this including autoimmune, genetic constitution, embryonic maternal disparity, endometrial stimulation or mechanical from curettage.
A 33 year old para 0 unbooked Nigerian woman presented to an Irish maternity hospital at 36 weeks gestation. She travelled to Ireland one week previously. She complained of a two day history of fever, muscular aches, fatigue, and mild abdominal pain. Observations revealed a heart rate of 120, temperature 39°C and oxygen saturations of 93%. Respiratory, cardiovascular and abdominal examination was normal. On further questioning the patient stated that she had not used a malaria net nor had taken malaria prophylaxis during pregnancy. An urgent malaria antigen test was performed which was positive. A subsequent thick and thin film demonstrated Plasmodium falciparum with a parasitaemia of 6.8%. IV quinine and clindamycin was initiated. A cardiotocograph showed fetal tachycardia with shallow decelerations. Broad spectrum antibiotics were commenced (benzylpenicillin, metronidazole and gentamicin) and a caesarean section was performed for fetal distress. The mother was transferred to intensive care in a general hospital. She responded well to treatment with a marked reduction in her parasitaemia level to 0.23%.

Placental (fetal side), cord and peripheral blood from the infant demonstrated a positive/weakly positive/negative malaria antigen respectively. He was treated for congenital malaria with quinine and clindamycin and remained asymptomatic. Placental histology confirmed malarial intervillositis.

Malaria is a major cause of maternal morbidity and mortality in the developing world and should be considered in febrile women who have recently immigrated or travelled to endemic areas. The potential complications for mother and fetus justify the potential risks of treatment in pregnancy.
AN INTERESTING CASE OF MISSED ECTOPIC PREGNANCY

Poster - 85

Bushra Khan (Obstetrics and Gynaecology Department, Our Lady of Lourdes Hospital, Drogheda, Co Louth), Tom O’Gorman (Obstetrics and Gynaecology Department, Our Lady of Lourdes Hospital, Drogheda, Co Louth)

Introduction: The diagnosis of ectopic pregnancy can be challenging at times requiring multiple ultrasound scans (USS) and serial serum beta hcg. We present an undiagnosed case of ectopic pregnancy misdiagnosed as uterine rupture.

Case Presentation: A 29 years old, para 2 lady was referred to Emergency department, Our Lady of Lourdes Hospital, Drogheda with acute onset of severe abdominal pain. She also had PV bleed on and off for two weeks. She was diagnosed with complete miscarriage at 09 weeks gestation at Liverpool two weeks ago. On examination she had generalised abdominal tenderness and severe cervical excitation.

The CT pelvis and abdomen revealed haemoperitoneum and organising haematoma with uterine fundus suggestive of uterine rupture. Patient denied termination or any uterine procedure.

The patient underwent urgent Laparatomy and a ruptured left tubal ectopic was found along with two litres of blood in the abdominal cavity. She had left salpingectomy. The woman made good physical recovery.

Conclusion: The case illustrates the need for careful history taking and the need for considering ectopic pregnancy in woman who have absent gestational sac (GS) in the uterine cavity on USS. It also reveals the importance of serum beta hcg in the absence of intrauterine GS.
Isolated Fallopian tube torsion with pregnancy- A case report

Sarwat Khan (Dept of Obstetrics and Gynaecology, Rotunda Hospital Dublin), Dr Nikhail Purandare (HARI Unit, Rotunda Hospital), Jennifer Donnelly (Dept of Obstetrics and Gynaecology, Rotunda Hospital Dublin)

Isolated torsion of fallopian tube occurring in pregnancy is very rare. This entity should be considered in the differential diagnosis of acute pelvic pain in early pregnancy 1,2. We present a case report of an isolated fallopian tube torsion in a multiparous woman at 8 weeks gestation who had previously undergone IVF.

**Case Presentation:** A 36-year-old woman, presented to Rotunda Hospital Emergency Room at 8 weeks gestation with a three day history of constant right lower abdominal pain. She had undergone ovarian stimulation and IVF with implantation of 2 embryos. An intrauterine gestational sac (IUGS) had previously been confirmed on ultrasound. Vaginal examination demonstrated a palpable right adnexal mass and cervical excitation. Ultrasound examination demonstrated a viable intrauterine pregnancy and a complex mass in the right adnexa. Laparoscopy was performed due to a high suspicion of a heterotopic pregnancy. At laparoscopy, the right ovary was multicystic but not torted, however the right fallopian tube was torted and suffused, but not necrosed. There was no evidence of an ectopic pregnancy. Laparoscopic correction of the tubal torsion was performed. The patient's pain resolved completely post operatively. She is currently 18 weeks pregnant.

**Conclusion:** Isolated fallopian tube torsion is rare. Expedient diagnosis is important to prevent tubal necrosis. Stimulated ovaries can increase the risk of fallopian tube torsion, this condition should be included in the differential diagnosis of lower abdominal pain during pregnancy.

**References:**
Factors contributing to improved success rates in Assisted Reproductive Technologies (ART)

Andrew Knox (Merrion Fertility Clinic, 60 Lower Mount Street, Dublin 2), Mandy Leslie (Merrion Fertility Clinic, 60 Lower Mount Street, Dublin 2), Jennifer Cullinane (Merrion Fertility Clinic, 60 Lower Mount Street, Dublin 2), Mary Wingfield (Merrion Fertility Clinic, 60 Lower Mount Street, Dublin 2)

Background: Clinical Pregnancy rates (CPR) with IVF/ICSI are increasing worldwide. Recent success rates in our clinic have risen from 27.0% CPR per embryo transfer (ET) in 2010 to 55.0% for 2014 (Jan to June) while multiple pregnancy rates have fallen (23% vs 12%).

Aims: To determine factors contributing to rising success rates.

Methodology: Retrospective analysis comparing CPR rates for all IVF/ICSI cycles in 2013 and the first six months of 2014. The impact of embryo transfer (ET) at blastocyst stage (day 5) versus cleavage stage (day2/3) and use of a new time lapse incubator (Embryoscope©) were studied.

Results: The overall CPR was significantly higher in 2014 compared to 2013. As expected, women with day 5 transfer had a significantly higher CPR per ET than those with ET on Day2/3. More couples in 2014 had their embryos in the Embryoscope and had a higher CPR per ET.

<table>
<thead>
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<th>2013</th>
<th>2014 (Jan to June)</th>
<th>p-value</th>
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<td>Overall CPR per ET</td>
<td>40.4%</td>
<td>55.0%</td>
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<tr>
<td>CPR per ET day 5</td>
<td>54.7%</td>
<td>62.6%</td>
<td>0.076 NS</td>
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<tr>
<td>CPR per ET day 2/3</td>
<td>26.9%</td>
<td>40.0%</td>
<td>0.049</td>
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<tr>
<td>% cases day 5</td>
<td>48.6%</td>
<td>66.8%</td>
<td>0.0015</td>
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<tr>
<td>% cases Embryoscope</td>
<td>19.0%</td>
<td>47.7%</td>
<td>&lt;0.0001</td>
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CPR (Embryoscope versus Standard Incubator)

<table>
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<th></th>
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<tbody>
<tr>
<td>Embryoscope</td>
<td>59.0%</td>
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<tr>
<td>Standard</td>
<td>40.3%</td>
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p=0.0003

Conclusion: Blastocyst culture and Embryoscope contibute to higher success rates and safer outcomes. Patients can expect > 50% chance of pregnancy in a fresh IVF cycle. Elective single embryo transfer should be the goal and, given these excellent outcomes, early referral for treatment is advised.
STRETCHED THINLY: DEMAND FOR OUTPATIENT GYNAECOLOGY SERVICES IN NORTH DUBLIN

Joan Lennon (Connolly Hospital Blanchardstown), Brian Pierce (Connolly Hospital Blanchardstown), Jennifer Donnelly (Connolly Hospital Blanchardstown)

**Background:** Access to outpatient gynaecology services in North Dublin is limited due to long waiting lists and low consultant gynaecologist numbers. Connolly Hospital Blanchardstown (CHB) provides one outpatient clinic per week with 7 new patient and 7 return places.

**Aim:** To assess the number and type of referrals received over a one month period

**Methods:** This was a prospective audit of referrals received by the gynaecology service between September 21st and October 21st 2014. Information collected included patient age, reason for referral, menopausal status, source and method of referral and additional information provided. The referrals were triaged into urgent, routine and no follow-up.

**Results:** 54 new patients were referred. The source of referral was GPs (n=24), Connolly Hospital Emergency Dept (n=4), cross specialty outpatient (n=11) and outpatient follow-up of inpatient referrals (n=15). Lower abdominal pain of less than 3 months duration was the most common reason for referral (n=12). Incidental finding of an ovarian cyst was the next most common reason (n=11). 15% of referrals were triaged as urgent and no follow up was required in 11%. 65% of referrals did not include an imaging report.

**Conclusion:** In total, 48 new patients were referred to the gynaecology service in CHB over a one month period. During this time, a maximum of 28 new patients may be seen. Demand for outpatient gynaecological services far outstrips current capacity. Provision of prior investigations such as imaging with the referral would aid in triaging and may help cut down unnecessary appointments.
**Pregnancy, exercise and nutrition research study with smart phone app support (Pears): A randomized controlled trial study protocol**

*Poster - 89*

**Maria Kennelly (UCD Obstetrics & Gynaecology, School of Medicine and Medical Science, University College Dublin, National Maternity Hospital, Dublin, Ireland), Karen Lindsay (UCD Obstetrics & Gynaecology, School of Medicine and Medical Science, University College Dublin, National Maternity Hospital, Dublin, Ireland), Eileen Gibney (UCD Institute of Food and Health), Mary McCarthy (Food Business & Development, Food Business & Development, UCC), Fionnuala McAuliffe (UCD Obstetrics & Gynaecology, School of Medicine and Medical Science, University College Dublin, National Maternity Hospital, Dublin, Ireland)**

**Objective:** Maternal adiposity confers an increased risk of gestational diabetes (GDM). A low glycaemic index (GI) dietary intervention has been found to improve glucose homeostasis and reduce weight gain. Technology assisted interventions like smart phone applications are becoming commonplace as an aid to treating many chronic diseases both in and outside of pregnancy. The aim of this study is to assess the impact of a 'healthy lifestyle package' with smart phone technology as support compared to usual antenatal care on the incidence of GDM in an overweight and obese pregnant population.

**Methods:** We propose a randomized controlled trial of a healthy lifestyle intervention versus standard obstetric care in pregnant women with a BMI >25kg/m2. Recruitment is ongoing. Patients are randomized into two arms: a control arm that receives standard antenatal care and an intervention arm that receives a healthy lifestyle package (targeted low glycemic index nutritional advice, a daily exercise prescription and a smart phone app). The primary outcome is the incidence of GDM at 29 weeks' gestation in each group.

**Results:** A total of 320 women have been randomized to the study at this time-point. We anticipate completion of recruitment in February 2015.

**Conclusion:** Providing consistent healthy lifestyle advice through a combination of targeted educational sessions and smart phone assisted technology from early pregnancy may be valuable in the antenatal management of an overweight and obese pregnant population in preventing GDM.
**NEONATAL AND MATERNAL OUTCOMES FOLLOWING MID-TRIMESTER PRETERM PREMATURE RUPTURE OF THE MEMBRANES**

*Poster - 90*

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Preterm premature rupture of membranes (PPROM) complicates 1% of all pregnancies and occurs in one third of all preterm deliveries. Mid-trimester PPROM is often followed by spontaneous miscarriage and elective termination of ongoing pregnancies is offered in many countries.

We aimed to investigate the natural history of these pregnancies in a jurisdiction where termination of pregnancy is not available.

A retrospective review of 43 cases of PPROM diagnosed between 14 and 23+6 weeks gestation during April 2007 to April 2012, in a tertiary-referral university hospital. Cases where delivery occurred within 24 hours of PPROM were excluded.

The incidence of ongoing pregnancy after mid-trimester PPROM was 0.1%(43/44,667 births). The mean gestation at PPROM was 19 weeks. The mean gestation at delivery was 20 weeks. Ten babies were born alive (23%) with an average birth weight of 740g (range 440-1100g) and an average gestational age of 25 weeks. The remainder (n=33, 77%) died in utero or intrapartum. Nine were resuscitated and admitted to the neonatal intensive care unit (NICU), staying on average 34.6 days (range 2hrs-146 days). Two babies survived to discharge. One later died of necrotizing enterocolitis and the other is currently a healthy 4 year-old. The overall mortality rate was 97%. Six women had clinical chorioamnionitis (14%) with histological chorioamnionitis evident in 70% of examined placentas. Seventeen women (37.7%) required IV antibiotics with one patient developed sepsis. Other maternal complications included retained placenta (25.6%, n=11) and post-partum haemorrhage (14%, n=6).

This study provides useful and contemporary data on outcomes following mid-trimester PPROM. Whilst morbidity and mortality is high, long-term survival is possible. There is an increased risk of maternal morbidity, necessitating close maternal surveillance.
AN AUDIT OF MANAGEMENT OF FIRST TRIMESTER MISCARRIAGE IN CUMH

Poster - 91

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Spontaneous miscarriage is common, occurring in at least 20% of pregnancies. Recently, there has been an increase in outpatient conservative and medical management. Subsequently, a national guideline, Management of Early Pregnancy Miscarriage, was published in April 2012.

The aim of this audit is to evaluate management of incomplete and missed miscarriage in CUMH. Secondary aims include evaluation of documentation of chosen management in the Early Pregnancy Assessment Unit (EPAU) and assessment of treatment failure rates.

The EPAU computer database was interrogated. Women who had an incomplete or missed miscarriage during September-December 2012 were selected. Medical and surgical registers for misoprostol management were also examined. Charts were not pulled for this study. Data was analysed using Microsoft Excel.

There were 4800 EPAU visits in 2012. Two hundred women were eligible for inclusion. Of the patients with an incomplete miscarriage (n=129), 22 chose conservative management, seven chose surgical management and 16 chose medical management. Success rates were 68%, 63% and 100% respectively. A clear management plan was not documented in 26 women. Of the missed miscarriages (n=71), 29 chose conservative management, 38 underwent surgical management, 35 were managed medically and success rates were 45%, 49% and 97% respectively. A clear management plan was not documented in 27. Management was largely adherent to national recommendations regarding CRL and MSD and intervals between scans.

Conservative and medical management are less likely to be successful in cases of missed miscarriage versus incomplete miscarriage. Our success rates for medical and conservative management appear lower than those reported in the published literature, necessitating further investigation.
The use of POC lactate measurement is feasible in the setting of a maternity service. In the first half of pregnancy, the same reference range can be used as in the non-pregnant adult population. We found a positive correlation between lactate levels and maternal obesity and smoking. Further studies will evaluate lactate in the second half of pregnancy and in labour.
A REVIEW OF MATERNAL MORBIDITY IN TWIN PREGNANCIES OF WOMEN OVER 40 YEARS OF AGE OVER A SIX YEAR PERIOD

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Background: More women over 40 years of age are presenting for antenatal care of twin pregnancies due to rising maternal age and artificial reproductive techniques. Advanced maternal age and multiple pregnancies are independently known to increase risks of pregnancy complications e.g. Pregnancy induced hypertension and preeclampsia, gestational diabetes and venous thromboembolism.

Purpose of Study: The purpose was to evaluate the incidence of any maternal morbidity in women over 40 with twin pregnancies.

Study Design and Methods

A retrospective study was carried out on all women over 40 expecting twins who attended for antenatal care between 2008 and 2014. Data recorded included maternal age, parity, pre-existing medical conditions, mode of conception, chorionicity, mode of and gestation at delivery, incidence of preeclampsia, postpartum haemorrhage, venous thromboembolism, pregnancy induced hypertension, and gestational diabetes.

Results: Twenty-two women over 40 attended during the study period. The mean maternal age was 41.7 years (range 40-47yrs). 11 women (50%) were primiparous. The mean gestation at delivery was 35.8 weeks (range 27-38 weeks). There was two cases of preeclampsia including one case of HELLP (9%). Two women had postpartum haemorrhage. One women developed gestational diabetes.

Conclusions: This study does not demonstrate any significant increase in maternal morbidity compared to rates quoted for twin pregnancy in general 1. Other studies have demonstrated an increase in maternal morbidity in women aged over 45 2. Expansion of this study would allow comparison of perinatal and maternal morbidity between this group and the general twin population at this unit.
COULD THE DETECTION OF IL 8 IN CERVICAL MUCUS BE HELPFUL IN DETERMINING WHEN EMBRYO TRANSFER TAKES PLACE?

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Defining the exact role that inflammatory mediators play in the dynamic environment of the female reproductive system is challenging. The cytokine network provides a signalling system through which embryo development, uterine receptivity and pregnancy are regulated. If cervical mucus cytokines could predict uterine receptivity, they would be valuable minimally invasive biomarkers, especially in the IVF setting.

The aim of this study was to determine the concentrations of IL 8 in cervical ovulatory mucus and to investigate if there was any correlation with pregnancy in IVF/ICSI cycles. This was a prospective, observational study. Ovulatory cervical mucus was collected from 55 women at oocyte retrieval. Samples were analysed using a mini ELISA development kit. These women went on to have an embryo transferred.

31 women (56.4%) had detectable concentrations of IL 8 in their cervical mucus and significantly fewer of these women conceived (38.7%, 12/31) than those with undetectable levels (70.1%, 17/24) (Chi-Square, p = 0.02). There was no difference in median age between the pregnant and non-pregnant groups.

<table>
<thead>
<tr>
<th>IL 8 &amp; pregnancy outcome</th>
<th>Detectable</th>
<th>Not detectable</th>
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<tr>
<td>Pregnant</td>
<td>12</td>
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<td>Not pregnant</td>
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Women who had detectable concentrations of IL 8 in their cervical mucus were significantly less likely to become pregnant in an IVF cycle. IL 8 detection may be a useful non-invasive marker of pregnancy outcome and may be helpful in determining when embryo transfer should take place. However the low detection rates of IL 8 in cervical mucus may necessitate a more sensitive assay being used for measurement.
RISK REDUCTION SURGERY (RRS) IN GYNAECOLOGICAL PRACTICE: A CATEGORICAL ANALYSIS OF INDICATIONS AND OUTCOMES


Poster - 95

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Risk-reducing salpingo-oophorectomy is recommended for women with germ line mutations such as BRCA. The value of adnexectomy in those without defined genetic risk is unknown, but these women represent a substantial cohort in prophylactic surgical practice.

Aim of the study: To analyse indications and pathological outcomes of RRS at a cancer risk reduction clinic since its inception in November 2012

RRS were identified from the surgical database. Clinical information and histopathological outcomes were extracted from electronic patient records. The surgical specimens had been analysed using the standardised STIC (serous tubal intraepithelial cancer) protocol.

Seventy-nine women underwent RRS. The surgical procedures were salpingo-oophorectomy (57), hysterectomy + salpingo-oophorectomy (20), and bilateral salpingectomy with conservation of at least one ovary (2). Ages ranged from 32-72 (median 42) years. Group 1: Twenty-three women with BRCA/MLH1 germline mutation carriers BRCA1 (9), BRCA2 (13),MLH1 (1). Group 2: Fifty-six women had personal (predominantly breast) or family history of cancers. Histopathological outcomes were high-grade serous carcinoma of fallopian tube, stage Ic (1) in Group 1; STIC (1), tubal epithelial atypia (1), and atypical endometrial hyperplasia (1) in Group 2.

Five percent of women undergoing RRS had pathological findings. Three of four cases occurred in women without defined genetic abnormality. Detection of pathology gives added value to women without identified germline mutations undergoing RRS. However, careful case selection and counselling is essential when gonadectomy is planned in the absence of defined risk reduction value. For now, we recommend visualization and histological assessment of endometrium as well at RRS.
BENIGN METASTASISING LEIOMYOMA TO THE LUNG; A REPORT OF TWO CASES

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Uterine leiomyomas are the most common benign gynaecological tumours. Three atypical clinical manifestations of these tumours have been recognised; intravenous leiomyomatosis, leiomyomatosis peritonealis and benign metastasizing leiomyoma. We present two cases of benign metastasizing leiomyoma, a condition in which lesions with characteristics of uterine leiomyomas are present at ectopic sites, most commonly the lungs. Our first patient, aged 55, presented asymptptomatically following an incidental finding on chest X ray. A second patient, aged 53, presented with chest pain and dyspnoea. After extensive investigation that included lung biopsy both had hysterectomy and bilateral salpingoophorectomy. Histology confirmed the diagnosis of benign metastasising leiomyomas and benign uterine fibroids. Approximately 150 cases have been reported in the literature. There is little consensus regarding the pathogenesis of the condition or optimum management for these patients. Expectant management of the pulmonary lesions with serial chest XRay/CT is planned for our patients.
**Introduction:** Vaginal evisceration is a rare but recognised complication of hysterectomy. It occurs when there is a prolapse of intraperitoneal content through a defect in the vaginal vault. This rare complication usually occurs within months of the initial procedure. It is a gynaecological emergency that demands early clinical identification and prompt surgical management.

**Case Report:** A 65 year old female presented to hospital with a twelve hour of lower abdominal pain that began during intercourse the previous night. On mobilising the following morning, she felt a mass in her vagina and called an ambulance. She previously underwent an abdominal hysterectomy and external radiotherapy twenty two years previous indicated for endometrial cancer.

On examination in the emergency department, loops of small bowel and mesentery were seen prolapsing out of the vagina past the introitus. Reduced into the abdominal cavity was achieved by saline gauze allowing for the appreciation of a 3cm laceration on the left vaginal wall. An examination under aesthetic was performed and the defect surgically repaired.

**Discussion:** Vaginal wall evisceration is a gynaecological emergency that once promptly diagnosed, can usually be easily and successfully managed.
Out-Patient Hysteroscopy; the way to go

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Outpatient hysteroscopy (OPH) was introduced in St Michael’s Hospital and the National Maternity Hospital in late 2010. The advantages of OPH compared to hysteroscopy under general anaesthetic are obvious but OPH services are scanty in Ireland and little is known about patient accessibility and acceptability.

To determine the impact of OPH on hospital services and to assess patient satisfaction.

Prospective study of patients attending the OPH service at each hospital. Women were surveyed on their experience immediately after hysteroscopy.

Between September 2010 and December 2013 233 aged 29 to 93 years attended. The indications for referral are shown in Table 1. All women had an ultrasound scan on the day if not done previously and 189 required hysteroscopy. 176 (93.1%) of these were successful.

OPH findings are shown in Table 2. The majority of women (136, 72%) had normal or minimal findings not requiring treatment and were discharged back to their referral source (one stop shop). 53 women (28.0%) required a hysteroscopy under general anaesthesia either because of failed OPH or because they required surgery.

123 women were surveyed on their experience of OPH. 116 (94.3%) said that they would undergo the procedure again. 116 (94.3%) would recommend it to a friend. 10.6% described it as a pain-free procedure, with the rest having some degree of pain but the mean pain score was only 3.6/10.

OPH has high success rates and leads to a significant reduction in the number of procedures being performed under general anaesthesia. It is a quick and very tolerable procedure with extremely high satisfaction rates.
LESS RADICAL SURGERY FOR CERVICAL CANCER: IS IT NECESSARY TO REMOVE PARAMETRIUM IN EARLY STAGE CERVICAL CARCINOMA (STAGE IA2 & IB1)?

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The standard treatment for early stage cervical carcinoma is pelvic lymphadenectomy with radical hysterectomy or trachelectomy. Radical hysterectomy & trachelectomy include the removal of parametrium. Parametrectomy can result in impairment of bladder, bowel and sexual function.

We sought to determine the incidence of histological parametrial involvement in early stage operable cervical carcinoma in an effort to identify a low risk subgroup where a less radical surgery could be considered without compromising cure rates.

Retrospective analysis of all cases of stage IA2 or IB1 cervical carcinoma treated at St James's Hospital between January 2004 to December 2013 was undertaken.

224 patients were eligible for inclusion.

Occult cancer was present in the parametrium in 15 (6.7%) patients, by direct extension in 10 and in occult parametrial lymph nodes in 5 patients. Twelve (80%) of the 15 had in addition, metastases to pelvic lymph node(s). In univariate analysis, age, depth of invasion, size of tumour, LVSI and pelvic lymph node involvement were significant predictors for parametrial involvement. On multivariate analysis pelvic lymph node metastasis was the only independent pathologic risk factor for parametrial invasion (OR, 54; [95% CI, 6.20–54.96]; P=0.0001).

Parametrectomy is unlikely to be beneficial when tumour size is <2cm and pelvic lymph nodes are negative. The current SHAPE prospective trial should answer this question.
Gestational weight gain (GWG) has attracted increasing attention particularly in the context of the obesity epidemic. However a causal pathway between GWG and fetal macrosomia has never been established.

We choose to examine directly the relationship between GWG and birth weight (BW).

Women were recruited at the first antenatal visit, maternal demographics were collected and the pregnancy was dated by ultrasound. Only women less than 18 weeks gestation at recruitment were included. Maternal weight and height were measured and Body Mass Index (BMI) calculated. Body composition was measured via bioelectrical impedance analysis at recruitment and again after 37 weeks of gestation and gestational changes calculated. Gross GWG was taken as the total weight gain from recruitment to term. Net GWG was taken as Gross GWG minus the infant birth weight. Correlation between continuous variables was tested using linear regression analysis. Statistical significance was accepted at p <0.05.

There were 520 mother and infant pairs included. At recruitment, the mean maternal age was 30.2 years, the mean BMI was 25.3 kg/m² and 15.6% were obese. The mean gestation at birth was 40.2 weeks and the mean BW was 3.58 kg.

When the weight of the baby is subtracted from GWG, no correlation with BW exists. This is supported by the lack of correlation between maternal fat gain and BW. Interventions focused on limiting maternal weight gain in pregnancy will not affect infant BW.
THE RELATIONSHIP BETWEEN GESTATIONAL WEIGHT GAIN AND INFANT BODY COMPOSITION AT BIRTH

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The Institute of Medicine in the United States acknowledged that "Insufficient evidence is available on gestational weight gain (GWG) and adiposity in infancy" (Chapter 6, Weight gain during pregnancy: Re-examining the guidelines, IOM, 2009).

We examined directly the relationship between gestational changes in maternal body composition and infant body composition at birth.

Women were recruited at the first antenatal visit, maternal demographics were collected and the pregnancy was dated by ultrasound. Only women <18 weeks gestation were included. Maternal weight and height were measured and Body Mass Index (BMI) calculated. Body composition was measured via bioelectrical impedance analysis at recruitment and again after 37 weeks of gestation and gestational changes calculated. Body composition in infants was measured within three days of birth via air-displacement plethysmography (PEAPOD, Cosmed, Rome). The study was limited to white European women with a singleton pregnancy. Correlation between continuous variable was tested using linear regression analysis. Statistical significance was accepted at p <0.05.

There were 211 mother and infant pairs included. At recruitment, the mean maternal age was 30.1 years, the mean BMI was 25.7 kg/m2 and 18.2% were obese. The mean gestation at birth was 40.2 weeks and the mean birth weight was 3.56 kg.

No relationship was found between gestational increases in maternal weight or fat mass and infant adiposity at birth. Infant adiposity was related to increases in maternal fat-free mass (bone and water). Interventions focused on restricting maternal fat gain during pregnancy will not limit infant adiposity.
MENORRHAGIA: OUTCOME OF MINIMALLY INVASIVE TREATMENTS (MOMITS): A THREE TO FIVE YEAR FOLLOW-UP STUDY

Poster - 102

Claire M McCarthy (Cork University Maternity Hospital), Cathy Burke (Cork University Maternity Hospital)

Menorrhagia accounts for around one quarter of referrals to gynaecology clinics in Ireland. The increasing use of minimally invasive treatments for menorrhagia has resulted in many fewer hysterectomies now being performed for this indication.

We aimed to determine the effect of, and compare endometrial balloon ablation (EBA) and Mirena® insertion (MI) on subjective menorrhagia (SM), quality of life (QOL) and patient satisfaction (PS) scores.

A retrospective postal questionnaire-based study in a tertiary referral hospital of all women having EBA or MI over a three to five year period for the treatment of menorrhagia.

111 EBA and 117 MI questionnaires were distributed, with a response rate of 58.5% and 43.6% respectively. The mean age of those having EBA was 47.6, compared to 45.5 in the MI group. Mean pad usage had decreased by 8.4 pads in the EBA group, and 5.2 in the LNG-IUS group (p<0.05). 94.8% patients would recommend treatment with the EBA, compared to 93% of MI patients. PS improved in all areas of life, with improvement in social activity being significantly greater with EBA. Quality of life improved in both groups, by 16.75 points on average in the MI group, and 33.74 in the EBA group.

Success rates for both EBA and MI were excellent, with those following EBA having an overall improved QOL and patient satisfaction scores. This suggests EBA and MI are both effective for the treatment of menorrhagia.
Caesarean Scar Ectopic Pregnancies are high risk pregnancies, which are increasing in incidence. There is currently no consensus on their diagnosis, or identifiable risk factors that are associated with cesarean scar ectopic pregnancies.

We described the case of a multiparous lady with a caesarean scar ectopic diagnosed in the first trimester. A 34 year old Para 3 lady, with 3 previous caesarean sections (1 Classical and 2 lower uterine segment scars) presented at 7 weeks gestation for an early pregnancy scan. Serial ultrasonography over the following three weeks revealed a viable caesarean scar ectopic pregnancy, with evidence of bladder invasion. Following a trial of conservative management, she proceeded to a laparotomy and hysterectomy, owing to evidence of vascular invasion to the bladder, as well as patient preference. This was in addition to pre-operative uterine artery embolization and intra-arterial catheter placement. She had an uncomplicated post-operative course, without need for transfusion of blood products. Histology revealed chorionic villi in the cervical wall, consistent with placenta praevia accreta.

We describe a case of a caesarean scar ectopic pregnancy managed in a multi-disciplinary setting. Further research is necessitated to investigate patients at risk for this condition, as well as the role of early pregnancy ultrasound in patients with a higher risk of this condition.
Reduced Fetal Movement (RFM) is a common antenatal complaint, conferring increased perinatal risk. We aimed to assess the patient experience of the Emergency Department (ED) when presenting with RFM. We prospectively recruited women presenting with RFM over 28 weeks gestation with a singleton pregnancy, without a known congenital anomaly to a tertiary-level maternity hospital. Details of their presentation, including waiting times and outcomes of assessment were collected. Secondly, telephone records were analysed for two months in the study period to assess advice offered to those with RFM.

In total, 295 women presented with RFM over a seven month period, accounting for 4.2% of all attendances to the ED. 14.9% (n=41) of patients attended private antenatal care, with the remainder attending public combined antenatal care. 56% of patients attended the ER between 0800h and 1700h, with the remainder attending outside these hours. 51.1% (n=151) patients were assessed and managed within 3 hours of presentation. Following presentation with RFM, 26.5% (n=73) of patients were admitted to hospital for further monitoring and management. There were 1912 telephone consultations to the ER over two months, with 74 (3.9%) patients complaining of RFM. 1369 (71.6%) patients were advised to attend for assessment.

RFM is a common antenatal presenting complaint. There are currently no standards of care advising appropriate assessment and management of those with RFM. Analogous advice should be offered to all patients both via telephone and in clinical practice to improve performance and minimise risk to patients.
THE USE AND SUCCESS OF COLD COAGULATION FOR THE TREATMENT OF HIGH GRADE SQUAMOUS CERVICAL INTRA-EPITHELIAL NEOPLASIA

Poster - 105

Claire M McCarthy (University Hospital Limerick), Meenakshi Ramphul (University Hospital Limerick), Maureen Madden (University Hospital Limerick), Kevin Hickey (University Hospital Limerick)

Cold Coagulation (CC) is a recognised treatment for Cervical Intraepithelial Neoplasia (CIN). Its' use for high grade lesions is less established compared to Large Loop Excision of The Transformation Zone (LLETZ), which carries significant risk of cervical incompetence and obstetric complications.

We aimed to demonstrate successful long term follow-up of patients treated with CC for high grade CIN.

We conducted a retrospective audit of patients attending the colposcopy service of a tertiary level hospital over a one year period, with a histological diagnosis of CIN 2/3. Follow-up data for three years post-procedure between this group and a control group (CIN 1, CC treated patients) were analysed to determine success of treatment, and need for re-treatment.

93 patients were included in our study. The average age was 29.2 years (SD= 5.5 years), with a mean parity of 0.7 (range 0-4, SD= 0.9). 39 (41.9%) and 54 (58.1%) had CIN 1 and CIN 2/3 respectively. There were low levels of recurrent CIN in both groups, with over 43 (81%) of patients with CIN 2/3 having a negative smear one year following treatment with CC, compared to 31 (79.5%) of our CIN 1 group. No further treatment was required in 33 (84.6%) of the CIN 1 group, and 4 (77.7%) of our CIN 2/3 group, with no statistical significant difference in re-treatment rates between both groups.

This study confirms the efficacy of CC for the treatment of high grade CIN. With its' high success rate and cervical tissue preservation, we advocate CC as a primary treatment for high grade CIN in women contemplating future pregnancy.
A surgical approach to endometrial cancer in a single institution August 2006- July 2014

Poster - 106

Michelle McCarthy (Cork University Maternity Hospital), Matt Hewitt (Cork University Maternity Hospital)

The standard approach to endometrial cancer (TAH-BSO) +/- lymphadenopathy. Current evidence suggests that the minimally invasive laparoscopic approach is comparable to traditional laparotomy in terms of outcomes. Cork University Maternity Hospital commenced a robotic surgical programme in 2008. Preceding this, laparotomy or straight-stick laparoscopy was the modality of choice.

The aim of this study was to compare post-operative recovery measured by of length of hospital stay in women who had a TAH/BSO versus a minimally invasive approach. We performed a retrospective case review using surgical log books, pathology reports and computerised bed management system from a single institution and surgeon.

Between April 2006 and August 2014, 133 patients received surgery for endometrial cancer. Of these, 89 received a robot-assisted laparoscopy, 5 a straight-stick laparoscopy, 38 a laparotomy and one vaginal hysterectomy.

Preceding the introduction of the robot in July 2008, the surgeries were done via laparotomy (76.19% n=16) or straight stick procedure (23.81%, n=5), since abdominal procedures have declined over time and no straight stick procedures have been performed. Between January and July 2014, 87.5% (n=16) of surgical approaches for endometrial cancer were by robot-assisted laparoscopy. The median stay following robotic surgery was 1 day (mean 2.12 days, range 1–25, n=89). This compares to a mean of 4 days (range 1-8, n=5) for straight-stick procedures and median of 6 days for abdominal (mean 6.67 days, range 2-21).

The robotic approach is demonstrated to be associated with better postoperative recovery in terms of earlier discharge, inline with international findings.
Introducing Thrombocalc: a new tool to risk assess venous thromboembolism risk in pregnant patients

Poster - 107

Brendan McDonnell (Obstetrics and Gynaecology, Rotunda Hospital, Dublin, Ireland.), Barry Kevane (Dept of Haematology, Mater Hospital), Ajita Raman (Rotunda Hospital), Mary Deering (Rotunda Hospital), Alan Holland (Rotunda Hospital), Sharon Cooley (Obstetrics and Gynaecology, Rotunda Hospital, Dublin, Ireland.), Fionnuala Ni Ainle (Dept of Haematology, Rotunda Hospital), Brian Cleary (Dept of Pharmacy, Rotunda Hospital)

Venous thromboembolism (VTE), comprising deep vein thrombosis (DVT) and pulmonary embolism (PE), is still one of the leading causes of maternal death in the developed world [1-3]. In addition, VTE can cause significant morbidity in affected women. However, despite the terrible impact of pregnancy-associated VTE, clinically validated risk-assessment tools for prevention and diagnosis do not exist. Of critical importance, VTE risk assessment saves mothers' lives [2]. Care providers report that currently available (non-validated) VTE risk assessment tools are cumbersome and sometimes difficult to interpret [4]. "Thrombocalc" is a new software tool based upon a systematic review of pregnancy-associated VTE risk factors that allows healthcare professionals to quickly and easily risk assess patients and assign a score. This score determines whether a patient requires thromboprophylaxis and the duration of treatment required. A prospective research study to clinically validate it as a VTE risk assessment tool is being planned. Existing tools, including the RCOG risk assessment tool, are not currently clinically validated for VTE risk assessment. Introduction of a simple, user-friendly, electronic VTE risk assessment tool has the potential to save time on busy antenatal and postnatal wards and to streamline VTE risk assessment by providing clear recommendations.
An unusual case of uterine didelphys in pregnancy

Poster - 108

Ann McHugh (Galway University Hospital, NUI), Olga Gonta (Galway University Hospital, NUI), Michael O'Leary (Galway University Hospital, NUI)

Uterine didelphys, or double uterus, occurs when the two müllerian ducts fail to fuse during embryogenesis. This produces a duplication of the reproductive structures. Most commonly the duplication is of the uterus and cervix but duplication of the vulva, bladder, urethra, vagina and anus can occur. It is a rare condition estimated to occur in 1/3,000 women. 20% can have unilateral and renal anomalies.

We present a case of a 29 year old primigravida with uterine didelphys. At age 21 she underwent a laparoscopic left ovarian cystectomy, at that time it was noted that she had a double uterus, double cervix and double vagina. Previous menstrual history was unremarkable with menarche age 12 and normal regular menstrual cycles. A renal ultrasound showed no associated renal abnormalities. An early pregnancy ultrasound at 7/40 showed a gestational sac, consistent with dates, located on the left aspect of the septated uterus. Cervical length measurement at 16/40 was 33.1 mm. Further scans at 20, 24, 28, 34, 37 and 38 weeks showed satisfactory fetal growth, a high posterior placenta and a fetus persistently in breech position. An elective caesarean section was performed at 38+4/40 with a breech extraction of a live male fetus, 3.2 kg. She was discharged home on postoperative day 4.

Women with a didelphic uterus often have good reproductive outcomes. A septated vagina can occur in 75% of cases and may cause difficulty with sexual intercourse or vaginal delivery. These patients have an increased risk of obstetric complications including miscarriage, prematurity, IUGR, antepartum and postpartum bleeding, cervical incompetence, fetal malpresentation and caesarean section.

This interesting case highlights a successful pregnancy outcome in the presence of uterine didelphys.
**Hyperparathyroidism in pregnancy: A case report and review of the literature**

*Poster - 109*

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A 45 year old para 1+3 (c/s x1) booked at 14/40. She had a history of hypothyroidism and essential hypertension. This was an IVF pregnancy with donor egg. Antenatal medications included eltroxin, methyldopa and aspirin.

At 24/40 she presented with weakness, nausea and headaches. Routine bloods revealed an elevated calcium level of 2.82 (adjusted) (Normal range 2.17-2.51), PTH 52.6 (15-65), Vitamin D 62 (<75 suboptimal). Endocrinology review recommended intravenous fluids. Following treatment calcium levels normalised and she was discharged. Two weeks later calcium levels were 2.78, PTH 65. A neck ultrasound revealed a normal thyroid gland, however posteriorly on the right lay a well circumscribed 2cm hypoechoic lesion, in keeping with a parathyroid adenoma.

A parathyroidectomy was performed under GA at 28/40. Post operative calcium and magnesium levels remained stable and the patient was discharged on postoperative day 3.

Primary hyperparathyroidism in the general population is rare (0.15%). It is more common in women and 25% of cases appear in women during childbearing years. Up to 80% of gravid patients are asymptomatic. Moderate to severe hypercalcemia during pregnancy may carry significant maternal and fetal risks. Fortunately, prompt diagnosis and effective management can improve outcomes for both.

Complications in pregnancy have been reported to occur in up to 67% of mothers and 80% of fetuses. Maternal complications can include hyperemesis, nephrolithiasis, recurrent UTI, pancreatitis, muscle weakness and hypercalcemic crisis. Neonatal complications include hypocalcemia and tetany secondary to fetal PTH suppression, preterm delivery and IUGR. Conservative intervention may be appropriate under certain circumstances. Treatment is based upon severity and symptoms. Surgery during the second trimester is the preferred treatment for symptomatic patients. This case details the prompt diagnosis and management of a pregnant patient with primary hyperparathyroidism.
AN UNWELCOME TRAVELLER: A CASE OF A PARASITIC LEIOMYOMA

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Background: Uterine leiomyomas occur in 12-25% of women of reproductive age, increasing to 77% in pathological specimens following hysterectomy. Parasitic leiomyomas are a rare variant of this common condition, with few reported cases.

Case: A 39 year old nulliparous woman was referred with a two year history of vulval swelling associated with offensive brown vaginal discharge. Ultrasonography showed a well-defined, solid 8cm vaginal mass. Pelvic examination was not possible in the clinic therefore an examination under anaesthetic was performed. This confirmed the presence of a large anterior vaginal wall mass that was separate from both the urethra and the cervix. A biopsy taken at this time showed only granulation tissue. An MRI pelvis suggested the mass may be pedunculated from the cervix, but did not extend outside the vagina. Mass effect on the ureter and posterior bladder wall was noted. The body of the uterus was reported as normal. At subsequent laparotomy, the mass was noted to be extraperitoneal, left sided paravaginal and paravesical, with no connection to the cervix or uterine body. Intraoperative cystoscopy showed no invasion into the bladder. The lesion was dissected out bluntly and sent for histology.

Conclusion: Histology confirmed a leiomyoma. There has been a recent increase in the literature of iatrogenic parasitic leiomyomas following electromechanical morcellation. However in the absence of previous surgery, the greatest risk factor is a co-existing uterine leiomyoma. This is therefore a particularly unusual case that adds to the small body of literature on the topic.
Background: Recent advances in medical treatment options and laparoscopic surgery for leiomyomas have significantly reduced the number of open myomectomies performed. There remains a significant cohort for whom laparotomy is the only treatment option, posing a significant challenge in the management of those where preservation of fertility is a priority.

Case: A 32 year old nulliparous Mauritian woman was referred with a large uterine fibroid, suspicious for sarcoma. The patient originally presented one year previously with a pelvic mass equivalent in size to a 36 week pregnancy. Ultrasonography showed features consistent with a fibroid. Management options were discussed, bearing in mind her desire to preserve fertility. A trial of decapeptyl was commenced with no observable decrease in size. Uterine artery embolization was considered but deemed unlikely to be beneficial. At this stage, surgery was discussed, however the patient declined due to risk of hysterectomy. Despite a 3 month trial of ulipristal acetate, the fibroid increased significantly in size, raising concern of sarcomatous change. The case was discussed at a multidisciplinary meeting and recommendation was made for myomectomy. At this stage the patient was willing to proceed with surgery. At laparotomy, a massive uterine fibroid arising from the left broad ligament was removed with no breach of the uterine cavity. No suspicious nodes or omental lesions were noted.

Conclusion: Histology confirmed leiomyoma. This case illustrates the limitations of imaging in outruling sarcomatous change. Even when preservation of fertility is a high priority, myomectomy and full histopathological examination remain the gold standard.
TRENDS IN CANCER INCIDENCE AMONG WOMEN DURING THE REPRODUCTIVE PERIOD IN THE IRISH POPULATION

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Background: Cancer during pregnancy may become more frequent, as pregnancy later in life, when cancer risk is higher, is becoming more common. The aim of this study was to compare cancer in pregnancy with that in women of childbearing age in Ireland and to describe trends in cancer types in these populations.

Methods: Data for 2000-2010 were obtained from the National Cancer Registry Ireland. 11,434 cases of invasive cancer were identified in women of childbearing age (15-44 years), 82 during pregnancy. Incidence rates, time trends and relative risk, with 95% confidence intervals, were calculated using SPSS V20 and Microsoft Excel.

Results: The incidence rate for all cancers combined in women aged 15-44 was 10.8 per 10,000 and increased significantly by 2.7% annually (95% CI 2.2%, 3.2%) over the 10-year study period. The commonest cancers were breast (3236, 28%) and dermatological cancers (3223, 28%). The incidence rate in pregnancy was 2.0 per 10,000 maternities (95% CI 1.6, 2.5) and the commonest cancers were gynaecological (27, 33%) and breast cancer (23, 28%). The risk of cancer in pregnant women was substantially less than for all women of childbearing age (relative risk 0.2; 95% CI 0.15, 0.23) and appeared to be decreasing.

Discussion & Conclusion: These data provide the first statistics on cancer in pregnancy in the Irish population. Cancer in pregnancy is rare, however longitudinal surveillance is recommended given that the overall rate of cancer in women of childbearing age is increasing.
UNINFORMED CONSENT - A SURVEY OF NEW INTERNS

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Background: Obstetrics and Gynaecology is a specialty that involves a high volume of procedures requiring consent. New doctors starting their training must learn about, and begin taking consent in an appropriate manner with senior guidance and support.

Methods: A survey of interns was conducted on their experience consenting patients in the Mater Hospital, Dublin on completion of their first 3-month rotation (14th July-12th October 2014).

Results: A total of 37 completed questionnaires were returned, giving a response rate of 70%. Of these, 46% were medical interns, while 54% were surgical interns. The majority consented patients for minor or intermediate procedures, with only 16% consenting major procedures. 57% did not fully understand all of the procedures they consented patients for. Only 8% had directly observed all of these procedures. The majority had received no formal discussion or written information from their team regarding appropriate consent. 62% felt they had been in a situation where they felt they had no choice but to consent the patient when they did not fully understand the procedure. Only 45% reported always documenting the specific risks. Issues of concern to the intern were time pressure, both on themselves and the patient, to obtain consent and the patients’ lack of understanding of the procedure being carried out.

Conclusion: Meaningful consent is important primarily for the patient undergoing the procedure, however it also protects the doctor in cases where complications arise. The quality of the existing informed consent process is less than ideal and needs to be standardized.
Maternal obesity is strongly associated with pregnancy complications. Although increasing obesity rates in adults (including women of childbearing age) are well-documented, there is a lack of data internationally on maternal obesity rates and trends.

To determine the incidence of maternal obesity in early pregnancy and track recent trends in Body Mass Index (BMI) categories over five years.

A prospective observational study of women who delivered an infant ≥500g during five years 2009 – 13. Maternal weight and height were measured at the first antenatal visit before calculation of BMI. Clinical and sociodemographic details were computerised. Epidemiological associations with maternal obesity were examined using logistic regression, adjusted for confounding variables.

Of 42,362 women, 99.0% (n=41,927) were eligible for analysis with a mean BMI of 25.5 kg/m², 40.7% primigravidas (n=17,054) and a mean age of 30.7 years. The absolute number of severe obesity cases (BMI ≥40.0 kg/m²) increased by 48.5% between 2009 and 2013 (p <0.001). After multivariate logistic regression analyses, maternal obesity incidence increased with increasing parity, advancing age and socioeconomic disadvantage. The rate of maternal obesity among women born in the 13 countries that joined the European Union (EU) following enlargement in 2004 was 8.6%, nearly half that of those born in existing EU countries (p<0.001).

While the overall rate of obesity remained stable, the increased number of cases of severe obesity over five years is concerning. We recommend renewed public health efforts to address obesity before pregnancy and to reinforce attempts to optimise a woman's weight after delivery.
**TRENDS IN MATERNAL FOLIC ACID SUPPLEMENTATION 2009 – 13**

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Neural tube defects (NTDs) are serious congenital neurodevelopmental malformations that are preventable with folic acid (FA) supplementation. A recent comprehensive national audit of births 2009-11 identified an increase in the incidence of NTDs compared with 2005-6.

This prospective observational study analysed recent trends in FA supplementation among women booking for antenatal care.

Women who delivered an infant ≥500g in 2009 –13 were included. Multivariate logistic regression analyses were applied.

Of 42,362 women, 99.2% (n=42,042) were suitable for analysis. The mean age was 30.7 years, the mean BMI was 25.5 kg/m², 40.7% (n=17,054) were primigravidas and 70.6% (n=29,741) were Irish-born. Overall, 43.9% (n=18,473) took periconceptional (preconceptional and postconceptional) FA, 49.4% (n=20,782) took postconceptional FA only and 6.6% (n=2,787) took no FA. However, the number of women taking periconceptional FA, as recommended, decreased from 45.1% in 2009 to 43.1% in 2013 (p=0.01). The number of women taking periconceptional FA decreased from 45.1% in 2009 to 43.1% in 2013 (p=0.01). Over the five years, the decrease in periconceptional FA rates was among women who were multiparous (43.8% to 41.6%, p=0.02), aged 30 – 39 years (58.9% to 55.0%, p<0.001), Irish-born (50.1% to 47.1%, p<0.001) and obese (38.6% to 36.9%, p=0.02). We found that only 37.0% (n=2,656) of obese women took periconceptional FA compared with 46.3% (n=10,107) of women with a normal BMI (p<0.001).

The decreasing rate of periconceptional FA supplementation is concerning in light of the recent increase in NTDs nationally and the fact fortification remains voluntary and not mandatory in Europe.
SEVERE MATERNAL OBESITY AND THE CLINICAL OUTCOMES OF UNPLANNED PREGNANCY

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Maternal obesity is associated with adverse pregnancy outcomes. Half of pregnancies are unplanned worldwide. No study has investigated the outcomes of unplanned pregnancies in severely obese women.

To compare the clinical outcomes of unplanned pregnancies with those of planned pregnancies in severely obese women.

A prospective cohort study of severely obese women (BMI ≥40.0 kg/m²) who delivered an infant ≥500g in 2009–13. Maternal weight and height were measured at the first antenatal visit.

Of 650 women, 30.0% (n=195) were primigravidas, the mean age was 31.6 years and the mean BMI was 43.8 kg/m². Overall, antenatal complications including gestational diabetes mellitus (GDM), hypertensive and thromboembolic disorders occurred in 56.6% (n=368). Compared with planned pregnancies, unplanned pregnancies were associated with increased pre-pregnancy risk factors including essential hypertension (4.0% vs. 1.6%, p=0.03) and depression (6.6% vs. 3.2%, p=0.03). Unplanned pregnancy (n=272, 41.8%) was associated with a higher incidence of macrosomia (birthweight >4.5 kg) compared with planned pregnancies (p=0.03). This was not explained by a higher GDM rate.

Compared with planned pregnancies, unplanned pregnancies were not associated with increased adverse fetomaternal outcomes. Higher rates of macrosomia in unplanned pregnancies were not associated with higher rates of shoulder dystocia or 3rd/4th degree perineal tears. Lower rates of 3rd/4th degree tears in unplanned pregnancies were not explained by lower instrumental delivery rates. The breastfeeding rate was lower in unplanned pregnancies (33.9% vs. 48.0%, p<0.001).

Despite increased pre-pregnancy risk factors, unplanned pregnancies in severely obese women were not associated with increased antenatal complications/adverse fetomaternal outcomes.
MATERNAL OBESITY AND PERICONCEPTIONAL UNDER-REPORTING OF ENERGY INTAKE

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Maternal nutritional status is an important modifiable risk factor in pregnancy. Dietary mis-reporting is an accepted shortcoming in nutritional surveys, however, few studies have investigated the characteristics of mis-reporters in pregnant women.

This cross-sectional study examined periconceptional mis-reporting of Energy Intake (EI). Women were recruited at their convenience after sonographic confirmation of a singleton pregnancy. Women completed a semi-quantitative Willet Food Frequency Questionnaire. Maternal body composition was measured using bioelectrical impedance analysis. Under-reporters were those whose ratio of EI to their calculated basal metabolic rate fell below the calculated plausible threshold for their physical activity category.

Of 524 women, the mean age was 30.1, 45% were primigravidas, the mean BMI was 25.4 kg/m2 and 16.6% were obese. Under-reported EI was observed in 122 women (23.3%) with no over-reporters. Under-reporters were younger (P<0.001), less likely to have a normal BMI (P=0.002) and more likely to be obese (P<0.001) than plausible reporters. Under-reporters had higher percentage body-fat and lower percentage body fat free mass (P<0.001), were more likely to be at risk of relative deprivation (P=0.001) and reported a higher percentage EI from carbohydrate (P=0.02) than plausible reporters.

The observed dietary reporting bias in this study, as well as the biases introduced by the exclusion of dietary mis-reporters may generate misleading associations between dietary and nutrient intakes and obstetric outcomes. The increased incidence of under-reporting in obese women in particular, may result in erroneous conclusions regarding their nutritional status and risk profile compared with non-obese women.
Neural Tube Defects (NTDs) are major congenital malformations that are potentially preventable with periconceptional Folic Acid (FA) supplementation. A recent national study found that the incidence of NTDs had increased in Ireland.

The purpose of this study was to examine the usage of FA supplementation in women presenting for antenatal care in a large university maternity hospital.

Women were recruited in the first trimester after sonographic confirmation of an ongoing singleton pregnancy. Their clinical and sociodemographic details were computerised. Maternal weight and height were measured before calculating Body Mass Index (BMI). A detailed questionnaire was completed under supervision.

Of 587 women, the mean age was 30.6 years, 40.2% were primigravida and 18.1% were obese. While 96.1% (n=564) reported that they took FA after they found out that they were pregnant, only 42.9% (n=252) took before conception and only 24.7% (n=145) took it for >12 weeks as is ideal. Only 5.7% (n=6) of obese women took high dose FA as recommended. Women who complied with periconceptional FA recommendations were significantly more likely to be older, educated, nulliparous, married, non-smokers, at low risk of relative income poverty and to have planned their pregnancy. On multivariate analysis the strongest variable predicting preconceptional FA usage was whether the pregnancy was planned.

Current measures to prevent NTDs by FA supplementation prepregnancy are not succeeding. This may explain in part the increase in the incidence of NTDs recently reported. We recommend an urgent review of public health policies on FA supplementation.
Clinical Handover is an integral but high risk activity with potential for errors and serious consequences for patients and staff. The majority of handover between doctors is informal and verbal, and relies on recall of events from staff working long hours. In CUMH, where handover is only verbal, the use of ISBAR is promoted to aid midwifery-to-doctor handover, but it not widely used by the doctors.

The purpose of this study was to review current handover processes at CUMH in order to develop and introduce an electronic handover tool.

Medical staff were surveyed for their knowledge of handover processes and asked about incidents due to handover errors. Handovers on labour ward were observed and recorded by independent assessors, and timed attendance registers were maintained of those present.

To date, 30 surveys have been completed. There was a wide variation among doctors in their knowledge of ISBAR and opinions on its usefulness. All doctors recognised that handover is a high risk activity but only 6 received any formal training in handover. Seven doctors did not feel confident that tasks they handed over would be dealt with appropriately. Where handovers were observed, ISBAR was not used routinely and the patient was not identified by name. It was difficult to ascertain if “high-risk” patients were appropriately identified, and the handovers were frequently interrupted.

In summary, good handover is crucial for ensuring high quality medical care. We anticipate that the introduction of an electronic tool will improve handover technique and ultimately patient care.
**A CAUTIONARY NEUROLOGICAL TALE IN A SEEMINGLY NORMAL PREGNANCY**

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Karen McNamara (Cork University Maternity Hospital)

We present a 26 year old, multiparous lady, with no background medical history. She presented at 39/40 of pregnancy for repeat elective CS. Her antenatal course was largely uncomplicated. She had, however, complained on multiple occasions of a pruritic rash on her face and right ear. She experienced 2 falls during the pregnancy - at 21 weeks and at 36 weeks. She complained of suprapubic pain and difficulty walking at 38 weeks. In addition she complained of carpal tunnel like symptoms towards the end of pregnancy.

At CS, a right-sided foot drop was noticed. It was also noted that the power in both limbs on the right side was markedly reduced, and she displayed an up-going plantar reflex on this side.

She was reviewed by neurology who concurred with the above findings and diagnosed her with a subacute right hemiparesis. An urgent MRI brain revealed a 3.6cm intramedullary lesion at the cervicomedullary junction. Given its location, biopsy was not possible so MRI spectroscopy was performed which confirmed a primary glial tumour. She is currently undergoing radiotherapy and chemotherapy. Prognosis at this point is guarded.

In addition, the pruritic rash, was reviewed by dermatology and deemed to be para-neoplastic in origin. Given the non-specific nature of her symptomatology, all of which can happen in pregnancy, she, nor the obstetric team, recognized the significance of this combination of symptoms.

This case illustrates the often insidious presentation of tumours in the spinal cord and brain stem and the difficulty with diagnosis.
**CONGENITAL CYSTIC ADENOMATOUS MALFORMATION: WHAT HAVE WE LEARNT?**

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Antenatal diagnosis of lung abnormalities has increased with advances in prenatal diagnosis. Information given to expectant parents is often vague as the prenatal evolution and postnatal management of such cases are variable.

The aim of this study was to review all suspected cases of CCAM/bronchopulmonary sequestration diagnosed prenatally in a large tertiary referral centre and to follow up the antenatal, neonatal and paediatric outcomes. This is a retrospective cohort study of all such cases diagnosed in the Rotunda Hospital between 1998 and 2013. Cases were identified from the database, and the relevant follow up information collected from individual maternal, neonatal and paediatric charts.

Thirty one cases of suspected CCAM were identified; of these five were excluded with further imaging. Two cases were bilateral, sixteen left sided and eight right sided. Many lesions became less apparent as pregnancy progressed. The average gestational age at diagnosis was twenty two weeks. Twenty five pregnancies continued, and 23 reached full term with an average birth weight of 3.42 kg (2.74 – 4.32kg). The Caesarean section rate was 52%, all babies were liveborn, two requiring neonatal intubation and transfer. All were followed by the paediatric services, and to date sixteen children have undergone surgical resection with histological confirmation of the diagnosis.

The reassuring outcomes in our cohort will provide helpful information when counseling future patients. However, the high rate of surgical intervention is acknowledged, and this controversial area needs further examination.
STEROIDS FOR ELECTIVE CAESAREAN SECTIONS AT <39 WEEKS: HAVE WE CHANGED?

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Cathy McNestry (Obstetrics and Gynaecology, Rotunda Hospital, Dublin, Ireland.), Niamh Keating (Ro), Uzma Mahmood (Our Lady of Lourdes Hospital Drogheda), Seosamh O’Coigligh (Our Lady of Lourdes Hospital Drogheda)

The 2010 RCOG guideline on giving antenatal corticosteroids recommends that corticosteroids be given to a patient prior to an elective Caesarean section (CS) carried out before thirty nine weeks of pregnancy.

Compliance with this guideline was audited in Our Lady of Lourdes Hospital (OLOL) earlier in 2013. This study is a re-audit of compliance in OLOL to complete the audit cycle, and assess whether an improvement has been achieved.

A list of all elective CS at less that thirty nine weeks carried out from October 2013 to March 2014 was taken from the maternity database. The charts were reviewed to confirm gestation at delivery, indication for CS and whether steroids were given. The labour ward record books were reviewed for the grade of doctor booking the CS.

Of fifty six such CS, three were omitted as the charts were lost, three were omitted as they were not elective, and one was omitted as the indication was intrauterine death. 50% of the remaining patients were prescribed antenatal steroids. Of those that did not receive steroids four were booked by a registrar, two by a senior house officer, and fourteen by a consultant, with two not recorded.

We are still not compliant with the guideline, but our compliance has improved from 20% to 50%. We have suggested introducing a record of whether steroids have been given to be noted at time of booking, as well as presenting our findings to medical and midwifery staff in a bid to further improve our standards.
GOOD NOTES ARE GOOD DEFENCE: AN AUDIT OF MEDICAL NOTE QUALITY

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Cathy McNestry (Obstetrics and Gynaecology, Rotunda Hospital, Dublin, Ireland.), Maire Milner (Our Lady of Lourdes Hospital Drogheda)

Note writing is becoming more and more important from a medicolegal point of view. This audit was conducted to make a basic assessment of the quality of medical notes in the obstetric department in Our Lady of Lourdes Hospital.

We intended to begin a discourse on the quality of note taking within the medical team, and to identify any basic errors so these may be rectified.

Twenty postnatal charts were audited, focusing on medical notes in the intrapartum section. Thirty two separate doctors' notes were examined for ink colour, inclusion of time, date, signature, medical council number, patient details, and for legibility using a 1-4 scale, 1 being completely illegible and 4 being completely legible.

31% of notes scored 4 for legibility and 69% scored 3. All notes were written in black ink and signed, and only one (3%) did not include patient details. 28% did not include time of writing and 9.375% did not include the date. All times documented were written in the 24 hour clock. 22% did not include a medical council number, and a further 9% had a bleep number written instead.

Our obstetric department has disproven the cliché that all doctor's handwriting is completely illegible - however, there is room for improvement in this, and all other categories. We have presented our findings to the medical team, and will re-audit in six months to complete the audit cycle. Further assessment of note taking quality in future studies would be useful, including details of note content.
INTRAPARTUM FETAL MONITORING: ARE WE COMPLIANT?

Cathy McNestry (Obstetrics and Gynaecology, Rotunda Hospital, Dublin, Ireland.), Maire Milner (Our Lady of Lourdes Hospital Drogheda)

Cardiotocogram (CTG) classification stickers have recently been introduced in Our Lady of Lourdes Hospital, so that each CTG recorded is classified according to the RCPI guideline "Intrapartum Fetal Heart Rate Monitoring" (2012), as reassuring, suspicious or pathological, and an action to be taken is documented.

We audited usage of these stickers and, further, compliance with the guideline as a whole.

Intrapartum notes in twenty charts were audited for use of stickers, whether CTG classification was correct, whether appropriate action was taken, and whether appropriate intrapartum monitoring was used, as well as whether CTGs were labelled appropriately with patient details, date, time, delivery details and signature.

All patients delivered live infants at term. Fourteen patients had CTG monitoring throughout labour, 4 had initial intermittent monitoring changed to continuous and 2 had intermittent monitoring only. Monitoring was appropriate in nineteen cases; one patient had indication for continuous monitoring but this was not applied as she was bearing down. All CTGs had correct settings for date, time, speed and patient details. Fifteen were classified using the sticker. One fetal blood sample was taken, and this was repeated appropriately. Six CTGs had complete delivery details documented. Four CTGs were signed.

The clinically important parts of the guideline were almost completely adhered to, but CTG documentation has significant room for improvement. We presented our results presented to the weekly multidisciplinary meeting, and posters have been displayed in the department to educate staff. We will re-audit in six months time to complete the audit loop.
IMPROVED PERINATAL MORTALITY IN TWINS – MODIFIED PRACTICE OR IMPROVING TECHNOLOGIES?

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We set out to examine rates of perinatal mortality in twin pregnancies from 1996-2012. Changes in mode of delivery were also examined as well as causes of death in twin mortalities.

This retrospective cohort study was carried out at three large tertiary referral centers. It included all normally formed twin infants with a birthweight>500g. All cases of perinatal mortality in twins (infants >500g who suffered an intra-uterine or early neonatal(≤7 days of age) death) were recorded. The changing rate of caesarean delivery as well as varying causes of death in twins were also examined.

During the study period there were 395,830 pregnancies across the three institutions, this included 6727 twin gestations. The perinatal mortality rate was 21.5/1000 twin infants. The perinatal mortality rate in twins decreased over the study (p=0.0006; R²=0.55; Slope= -1.2). Rates of caesarean delivery in twins were found to have increased from 32% in 1996 to 62% in 2012(p<0.0001; R²=0.84; Slope=1.7). There were 288 perinatal deaths in twin infants, 50%(147/288) occurred in twins born extremely premature (<26 weeks). Prematurity was the leading cause of mortality in twins, followed by twin-to-twin transfusion syndrome (TTTS). TTTS had a decreasing contribution to perinatal mortality during the study(p=0.008; R²=0.38; Slope=-1.5).

The perinatal mortality rate in twins improved during the study. This was accompanied by an increase in caesarean delivery of 1.7% for each year of the study, culminating in a cesarean delivery rate of 62% in 2012. TTTS made a decreasing contribution to the mortality rate in twins during the study.
A DRAMATIC PRESENTATION OF A MOLAR PREGNANCY AND ITS MANAGEMENT

Rebecca Moore (Rotunda Hospital), Karen Flood (Rotunda Hospital)

Gestational trophoblastic disease complicates approximately 1/714 live births. Suction curettage is used in most cases to evacuate molar pregnancies and chemotherapy rates are low (5-8%).

We present a case of a 19 year old nulliparous lady who presented to a general hospital feeling generally unwell with nausea, vomiting and abdominal bloating. She was found to have a positive urinary HCG and a mass arising from her pelvis extending to above her umbilicus. An ultrasound showed a classic snow storm appearance and she was referred to our emergency room.

On presentation, her hCG was unrecordable over 1 million, her haemoglobin was 8, her liver function tests were deranged and she was markedly hyperthyroid. An ultrasound again showed the classic ‘snow storm’ appearance and no fetal parts were seen. She was symptomatic of her hyperthyroidism and required treatment with carbimazole. A chest xray was unremarkable and she was worked up for surgical evacuation with cross matched blood on standby. The procedure was uncomplicated and she did not require blood transfusion. She went on to have a CT thorax, abdomen and pelvis which showed multiple small lung lesions - metastases and she was referred to medical oncology for further management.

Her thyroid function tests improved following the procedure and the dose of carbimazole was reduced. Histology confirmed the diagnosis of a complete molar pregnancy, she required a repeat suction curettage 3 weeks later and she was treated with methotrexate.

This case demonstrates the importance of urinary hCG testing in all emergency departments.
AN AUDIT ON THE INVESTIGATIONS AND MANAGEMENT OF POSTPARTUM PYREXIA IN PATIENTS WHO RECEIVED MISOPROSTOL FOR A POSTPARTUM HAEMORRHAGE

Poster - 127

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Background: Misoprostol is part of the routine management of post partum haemorrhage (PPH). Apart from its uterotonic effects, misoprostol is known to have several pharmacological effects including thermoregulation.

Purpose of study: To assess compliance with policies on management of patients with pyrexia (1), who received misoprostol for a PPH.

Study design and methods: We analysed the charts of 20 women who experienced a PPH after a vaginal delivery and managed with misoprostol. We then audited how many of these women experienced pyrexia and underwent appropriate investigations and management.

Findings of the study: 14/20 women experienced a pyrexia (>38 degrees on one occasion) of which 10 were postnatal pyrexias

Of the 10, blood cultures and HVS were saved on 7 but only 5 had an MSU taken.

Of the 7 women that had blood cultures, 4 were placed on antibiotics because of sustained temperature. None of the 7 had positive cultures.

Conclusions and programme implications: The association of pyrexia post misoprostol appears to be dose related. None of the women who received misoprostol for postpartum pyrexia had positive blood cultures. We feel that more work needs to be undertaken to clarify at what point should we consider sepsis in women who experienced pyrexia post misoprostol. This study suggests we may be treating these women too early causing prolonged hospital admissions and potentially unnecessary antibiotics. We have also learned that there is a lack of consistency in performing a full septic screen and aim to address this going forward.
AN INVESTIGATION INTO THE CORRELATION BETWEEN FIRST TRIMESTER PV BLEEDING AND PRIMARY POST PARTUM HAEMORRHAGE

Poster - 128

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Background: We know that 25% of women with ongoing pregnancies will experience a per vaginal (PV) bleed in early pregnancy. We wished to investigate if women were potentially more at risk from a post partum haemorrhage (PPH) if they had experienced a first trimester bleed.

Purpose: To assess the frequency of correlation of PPH after a vaginal birth with first trimester PV bleeding

Study Design and Methods: We analysed a random selection of the charts of 25 women who had experienced a PPH. Inclusion criteria: Vaginal delivery with associated PPH Exclusion criteria: Confounding factors e.g. bleeding disorder, history of fibroids and multiple pregnancy. We then analysed how many of these women had experienced first trimester PV bleeding. We defined an early pregnancy bleed as the loss of a minimal-moderate volume of PV bleed with no cause for bleeding found.

Findings of the study: Four women were excluded from the study. Of the 21 women whose records we analysed, ten had had a first trimester bleed. The cause of the PPH was found to be uterine atony in 90% of these cases.

Conclusions and programme implications: The background risk of a first trimester bleed is 25%, however, our figure of 45% is significantly higher than this. We suggest there should be consideration given to the early usage of uterotonic agents in the event of a potential PPH where the obstetric history indicates a bleed in the first trimester.
Androgen Insensitivity syndrome (AIS) Case presentation

Poster - 129

Mashour Naasan (Our Lady of Lourdes Hospital Drogheda), Kate Glennon (ou), Hassan Rajab (Our Lady of Lourdes Hospital Drogheda)

Androgen Insensitivity syndrome (AIS) is a very rare X-linked inherited disorder with an incidence which varies between 1:20000-64000 females.

We present a case of 13 years old girl admitted under the care of surgical team in November 2013 complaining of severe right iliac fossa pain with an acute abdomen and normal inflammatory markers. On pelvic ultrasound, ovaries could not be seen and a very small was uterus noted.

She underwent diagnostic laparoscopy and had an appendicectomy after an inflamed appendix was noted. A Meckel's diverticulum was also seen.

The surgeon noted abnormal pelvic organs and a gynaecological opinion was sought. On vaginal exam she was found to have a normal blind –ending vagina. The patient was found to have gonads on the pelvic side wall bilaterally. A hemi-uterus was seen on the right. There was no pelvic organs visualised, only a transverse bend above the bladder.

Her family history revealed one sister was diagnosed with AIS and her mother is a carrier. Hence karyotyping was sent which confirmed the diagnosis.

The patient represented in May 2014 with severe pain in right inguinal area. A strangulated gonad at the inguinal area was suspected, and after a multi –disciplinary discussion the decision made to proceed to laparoscopic gonadectomy.

Histopathology later confirmed two testicles, epididymis, spermatic cord from the excised sample.

AIS is very rare disorder, the patient may not present with amenorrhea, prompt diagnosis and gonadoectomy at puberty is recommended to prevent malignant transformation in the gonad.
Case presentation - our lady's of Lourdes hospital Drogheda

Poster - 130

Mashhour Naasan (our lady's of Lourdes hospital Drogheda), Kate Glennon (our lady's of Lourdes hospital Drogheda), Hassan Rajab (our lady's of Lourdes hospital Drogheda)

We present a case of a 33 years old patient P2, one year post caesarean section delivery, with an eight month history of lower abdominal pain.

Clinical examination revealed a mass in the lower abdominal wall measuring 5cm in diameter. This mass was tender on palpation. Pelvic ultrasound revealed, normal size uterus, Mirena ® coil in situ with normal fundal position; normal ovaries; a complex mass in the abdominal wall traversing the caesarean section scar with cystic and solid components measuring 43×50 ×21mm was identified. Ca 125 was normal.

Yasminelle was prescribed for three months. She was followed up with a pelvic MRI. The pelvic MRI confirmed a complex multicystic lesion with haemorrhagic components consistent with a scar endometrioma in the anterior abdominal wall, at the site of the caesarean scar. The uterus and ovaries appeared normal.

The patient was admitted for an elective diagnostic laparoscopy. This revealed normal pelvis with no evidence of scar endometrioma, however there was a prominent bulge above the rectus sheath. The procedure was converted to a laparotomy and an endometriotic lesion in the rectus sheath lesion evacuated. Histopathology confirmed fragments of fibrous tissue with islands of endometrium showing glands and endometrial stroma confirming a diagnosis of a caesarean scar endometrioma.

The incidence of scar endometrioma is 0.3-0.6%. The evaluation of abdominal wall masses in the post-operative patient presents a diagnostic dilemma, which requires multi-modal assessment. This case highlights the role of clinical examination, radiological findings and surgical evaluation in diagnosing this uncommon condition.
Abdominal pregnancy is a rare form of ectopic pregnancy where implantation occurs outside the uterus, fallopian tubes and ovaries. Reported incidence of 1% of ectopic pregnancies and 1 in 10,200 of all pregnancies. Accurate preoperative diagnosis and good management is challenging with a maternal mortality of 20% with continuing abdominal pregnancy. In early pregnancy, high clinical suspicion, close monitoring of serum HCG levels as well as imaging are main tools of diagnosis. Laparoscopy, Laprotomy, and medical management with methotrexate are choices of treatment.

A 36 years old patient presented to our unit with six weeks amenorrhoea, lower abdominal pain and vaginal bleeding. Ultrasound showed no gestational sac, adnexal mass or free fluid. Serum HCG levels raised from 3213iu/ml to 4844iu/ml in 48 hours and her pain was worsening. Laparoscopy performed and the pregnancy noted to have implanted on the mesentry of left colon at pelvic brim. Due to active bleeding, this was partially resected to achieve haemostasis and avoid damage to bowel. Methotrexate administered post-operatively. Serum HCG dropped progressively following treatment.

However an increase to >60iu/ml was noted 2 months post operatively and further two doses of methotrexate were administered with close monitoring of patient condition and serum HCG levels. The last level of serum HCG was 1.9iu/ml.

This was a successful management of a mesenteric ectopic pregnancy both with laparoscopy and methotrexate which highlights the necessity for close follow up of patients postoperatively.
THE EFFECT OF SERUM VITAMIN D LEVELS ON FERTILITY OUTCOMES ON A COHORT ATTENDING FOR SUBFERTILITY TREATMENT IN A WINTER PERIOD

Poster - 132

Grace Neville (National Maternity Hospital, Holles St. Dublin 2), Fiona Martyn (National Maternity Hospital, Holles St. Dublin 2), Mark Kilbane (St Vincent’s University Hospital, Elm Park, Dublin 4), Malachi McKenna (St Vincent’s University Hospital, Elm Park, Dublin 4), Mary Wingfield (Merrion Fertility Clinic, 60 Lower Mount Street, Dublin 2), Dr. Mairead O’Riordan (Cork University Maternity Hospital), Fionnuala McAuliffe (National Maternity Hospital, Holles St. Dublin 2)

Research into vitamin D and its effects on fertility has escalated in recent years; however, much of the evidence is of poor quality and largely conflicting.

We wished to establish whether vitamin D levels influenced fertility parameters (semen analysis results, female Anti Mullerian Hormone Level, egg retrieval rates and egg fertilisation rates) and treatment outcomes (achievement of pregnancy).

We conducted a cross-sectional study of 75 males and 64 females including 64 couple pairs.

The mean vitamin D levels were 51.699nmol/L in males and 47.43nmol/L in females.

No correlations were found between total motility (rho = 0.069), progressive motility (rho = 0.066), count (rho = 0.001), morphology (rho = -0.034) of sperm. Although a weakly negative correlation between vitamin D level and sample volume was noted (rho = -0.111, p=0.348); this finding did not achieve statistical significance.

No correlation was detected between female AMH level and vitamin D level (rho = 0.067) (p=0.629).

A weakly positive correlation between number of eggs collected and female vitamin D status was detected (rho = 0.164, p = 0.198) which did not reach statistical significance. No association between male vitamin D levels and number of fertilised eggs was reported (rho=0.068, p=0.569). A weakly positive correlation between female vitamin D level and number of fertilised eggs was observed (rho=0.190) which did not reach statistical significance (p=0.136).

No correlation between pregnancy outcomes and vitamin D status were shown. However, the weak correlation between egg collection rates and fertilisation rates and female vitamin D status warrants further investigation.
**Sjögren's Syndrome - not just dry eyes... A Case Report of its Potential for Adverse Fetal Outcome**

*Poster - 133*

Grace Neville (National Maternity Hospital, Holles St. Dublin 2), Lucia Hartigan (Nat), Celine O'Brien (National Maternity Hospital, Holles St. Dublin 2), Mary Higgins (National Maternity Hospital, Holles St. Dublin 2), Shane Higgins (National Maternity Hospital, Holles St. Dublin 2), Fionnuala McAuliffe (National Maternity Hospital, Holles St. Dublin 2)

Sjögren's syndrome is a chronic inflammatory disorder characterized by diminished lacrimal and salivary gland function. An estimated 50% of patients possess antibodies to the Ro/SSA or La/SSB antigens.

A 34 year old primiparous woman was reviewed for the first time at 9 weeks gestation. It was a planned pregnancy. She had a background history of Sjögrens Syndrome diagnosed at 19 years and was known to be Anti-Ro positive. Her medications at booking included chlorphenamine and fluticasone propionate nasal spray. Weekly monitoring for congenital heart block (CHB) was planned from 18 weeks gestation. At 26+5 second degree foetal heart block with a rate of 96bpm was diagnosed. A foetal ECHO was otherwise normal. Dexamethasone 4mg was commenced at 26 weeks gestation, weaned at 32 weeks (maternal side effects) and stopped at 36 weeks. The heart rate remained at 60bpm throughout pregnancy. Delivery via Caesarean Section was planned in the foetal interest. A male infant was born in good condition. He remained stable after delivery and was transferred for review by paediatric cardiology at 24 hours of age, with a view for siting of a pacemaker.

CHB appears in utero, is permanent, with a reported mortality of 15-30%. Its mechanism is not fully understood. Multidisciplinary input is required for optimal management of both maternal and foetal wellbeing.
THE EFFECT OF EPIDURAL INSERTION ON BLOOD PRESSURE AND CARDIOTOCOGRAPHY

Poster - 134

Daire Nevin-Maguire (Royal College of Surgeons in Ireland, Medical student), Mark Dempsey (UCD Centre for Human Reproduction, Coombe Women and Infant’s University Hospital, Cork St, Dublin 8), Eddie O’Donnell (Waterford University Hospital), John Stratton (Waterford University Hospital)

Background: Epidurals are associated with a reduction in maternal blood pressure (BP); we sought to evaluate the effects of this on cardiotocography (CTG) and rates of obstetric intervention.

Objective: To investigate if epidural insertion increased obstetric intervention rates secondary to CTG abnormalities.

Study design: A retrospective analysis of 96 patients whom had a normal CTG prior to epidural insertion. A significant reduction in BP was designated as systolic reduction greater than 30 and diastolic reduction greater than 15. CTG and BP readings were reviewed for 2 hours post insertion. CTG changes requiring registrar or consultant presence and a significant reduction in BP were identified and recorded.

Findings: There was no standard protocol for epidural insertion, 4 anaesthetic agents were used: chirocaine, marcaine, lignocaine and L-bupivacaine. Our study found no cases of emergency caesarean section within 2 hours of epidural insertion. However, 21.9% exhibited a significant drop in BP 1 hour post insertion and 6.2% required obstetric review within 2 hours due to CTG abnormalities. The chirocaine group had 6 (19.3%) cases of significantly reduced BP and 1 case (3.2%) requiring obstetric review and foetal blood sampling (FBS). The L-bupivacaine group had 14 cases (26.4%) of significant BP reduction of which 5 (9.4%) required obstetric review and 4 (7.5%) required FBS. The 2 remaining groups were smaller and did not require any intervention.

Conclusion: Epidural insertion has not been shown to be associated with CTG abnormalities requiring obstetric review. However, all cases requiring obstetric intervention were associated with significantly decreased BP.
SUCCESSFUL PREGNANCY IN BICORNUATE UTERUS

Mei Yee Ng (Dept of Obstetrics and Gynaecology, Mayo General Hospital, Castlebar, Mayo), Ulrich Bartels (Dept of Obstetrics and Gynaecology, Mayo General Hospital, Castlebar, Mayo)

Bicornuate uterus occurs when there is a defect in the unification of the Müllerian ducts. It is estimated to account for up to 39% of Müllerian duct anomalies. Pregnancies in bicornuate uterus are generally considered high-risk because of its association with poor reproductive outcomes, such as pregnancy loss, preterm birth, malpresentations, fetal deformity as well as need for Caesarian delivery.

Although it is associated with poor reproductive outcomes, a pregnancy is still possible. We report a case of a patient having two successful pregnancies in one of the horns of a bicornuate uterus managed in our department.

The patient is a 39-year-old Caucasian woman with a bicornuate uterus who presented with two term pregnancies in 2012 and in 2014. Both pregnancies had occurred in the left uterus. The uterine anomaly was identified during infertility investigations. Her pregnancy remained uneventful. In both pregnancies, the fetuses were delivered via Caesarian sections.
LUMPS AND BUMPS: A REVIEW OF BREAST CANCER IN PREGNANCY

Poster - 136

Caoilfhionn Ní Leidhin (SVUH), Anna Heeney (SVUH), Catherine Connolly (SVUH), Anne Foster (SVUH), James Geraghty (SVUH)

Pregnancy-associated breast cancer (PABC) occurs during pregnancy, lactation or the first postpartum year. Pregnancy, despite its long-term protective effects, may transiently increase breast cancer risk. PABC accounts for up to 20% of breast cancers in women under 30. Incidence is increasing as more women delay childbearing.

ET, a 41-year old female, Gravida 2, Para 1, was referred to our symptomatic breast clinic at 5 weeks gestation with a breast lump. She was diagnosed with breast cancer and underwent wide local excision and sentinel lymph node biopsy. Chemotherapy was initiated at the start of the second trimester with plans for axillary clearance, radiotherapy and hormonal therapy post-partum.

GMV, a 30-year old female, G1P0, presented at 33 weeks gestation with a breast lump and was diagnosed with breast cancer. Labour was induced at 38 weeks. Post-partum, she underwent mastectomy and axillary clearance. She was referred to the Human Assisted Reproduction Ireland unit for oocyte freezing prior to initiation of adjuvant chemotherapy. Further treatment will include radiotherapy and hormonal therapy.

In PABC, therapeutic options and sequences should be determined by gestational age, disease stage and patient preference. Treatment must conform as closely as possible to standard protocols. Maternal survival is equal for PABCs & non-PABCs. The majority of pregnancies result in live births with low rates of neonatal morbidity. Women who become pregnant after successful treatment of PABC do not have a worse prognosis.

PABC presents a challenging clinical situation. Optimal management necessitates multidisciplinary involvement.
WHEN IS AN AUDIT REALLY AN AUDIT IN OBSTETRICS AND GYNAECOLOGY?

Poster - 137

Jack Nolan (National Maternity Hospital, Holles St. Dublin 2), Clodagh O’Gorman (University of Limerick), Mary Higgins (National Maternity Hospital, Holles St. Dublin 2)

Background: Audit is a key skill for all clinicians.

Purpose: To evaluate audits published in the subject of obstetrics and gynaecology from 1993 to 2013.

Study Design: An extensive search of multiple sources was performed. Inclusion criteria were predefined for evaluation of an article in this study, including (1) addressing a healthcare topic; (2) developing an audit standard; (3) evaluating actual practice; (4) comparing actual practice to the standard; (5) implementing change; (6) re-auditing.

Findings: 202 studies were identified as 'audits' in either obstetrics or gynaecology. Of the 202 audits reviewed, 195 (97%) evaluated their current practice; 138 (68%) defined a standard and compared their actual practice to this. Change was implemented in 41 (20%) of the audits reviewed and 24 (12%) studies were re-audited, and completed the full audit cycle. Two time periods, from 1993-2002 (n=55) and 2003-2013 (n=147) were then compared. There was no statistically significant difference between the time periods regarding their compliance with audit criteria.

Conclusion: An audit is an incredibly useful tool to evaluate clinical practice and to provide suggestions as how to best improve. While the number of self-reported audits has dramatically increased within the published peer review literature, these results conclude that a large proportion do not meet the pre-defined inclusion criteria to be designated as an audit. This is a pattern that has not changed in the last twenty years. The continued publication of poor quality audits may have adverse effects on the usefulness of such a tool.
**RATES OF STILLBIRTH AND NEONATAL DEATH SECONDARY TO IUGR OVER A 10 YEAR PERIOD**

*Poster - 138*

_Ciara Nolan (RCSI Academic Unit), Etaoin Kent (RCSI Academic Unit)_

**Objective:** Intrauterine growth restriction is the largest contributing factor to perinatal mortality in nonanomalous fetuses. The aim of the study was to evaluate changes in rates of stillbirth and neonatal death secondary to IUGR over a 10 year period.

**Methods:** A retrospective cohort study was performed from 2003 to 2012 in a large tertiary referral hospital. Rates of stillbirth and neonatal death with IUGR as a causative factor were calculated. Comparison was made between the first 5 years and the second 5 years of the study period.

**Results:** 253,061 births occurred between 2003–2012; 117,667 in the first 5 year period and 135,394 in the second 5 years. The overall rate of stillbirths decreased between the two time periods (0.47% vs 0.39%; p=0.005), as did the rate of NND (0.28% vs 0.23%; p=0.01). The proportion of stillbirths attributed to IUGR decreased from 7.4% to 4.1% (p=0.002). However, the proportion of NND with IUGR as a factor increased (1.2% to 0.62%; p<0.001). This resulted in no significant overall change in perinatal mortality rates attributable to IUGR (5.1% vs. 4.0%; p=0.3).

**Conclusion:** The proportion of stillbirths and NND due to IUGR has not significantly changed over 10 years. The proportion of stillbirths attributed to IUGR has decreased, reflecting the increased use of ultrasound surveillance, with both improved access to imaging techniques and more personnel with expertise in performing antenatal ultrasound. However, the proportion of NND with IUGR as a factor has increased. This suggests that we are identifying IUGR babies and opting for timely delivery, but this is not necessarily translating into better outcomes overall.
PHYSICAL ACTIVITY AMONG PREGNANT WOMEN ATTENDING BOOKING VISIT

Poster - 139

Noor Azura Noor Mohamad (Obstetrics and Gynaecology Department, Our Lady of Lourdes Hospital, Drogheda, Co Louth), Saeeda M Wazir (Our Lady of Lourdes Hospital Drogheda), Maire Milner (Our Lady of Lourdes Hospital Drogheda)

Physical activity in pregnancy is beneficial in reducing risk of gestational diabetes and hypertension: additional benefits include reduced length of labour, and fewer complications.

The audit was performed to assess typical physical activity in women in first trimester.

A Pregnancy Physical Activity Questionnaire (PPAQ) (L Chasan-Taber et al) was used to measure patient activity at the booking visit. This captures time spent in 32 activities ranging from household/caregiving, occupational, sports/exercise, transportation, and inactivity. Patients were asked to tick the category that best approximates the amount of time spent in that activity per day or per week. Level of exercise was measured according to the standard weightings given by the epidemiologist.

23 patients participated in the 2-week audit, and age ranged from 22 to 36. Average household or caregiving activity accounted for the highest average duration of 36.5 hours per week, light intensity activity 34.3 hours, moderate-intensity 15.75 hours, and vigorous-intensity was least at 25 minutes only. Occupational activity was 17 hours. 2 patients put down cross-trainer as additional activity (0.25 to 2.5 hours). Yoga and singing were also listed as extra activity. Sedentary activity averaged 28 hours (3.75 to 60).

Most physical activity in our population was spent on everyday duties. Traditional fears of potential harm to pregnancy by exercise, as well as overall increasing sedentary lifestyles in Ireland, are probable contributors. There is much scope for education in this area.
**CHOLEDOCHAL CYST, A RARE DIAGNOSIS IN PREGNANCY**

Poster - 140

Sorca O’Brien (National Maternity Hospital, Holles St. Dublin 2), Mary Higgins (National Maternity Hospital, Holles St. Dublin 2), Fionnuala McAuliffe (National Maternity Hospital, Holles St. Dublin 2)

Choledochal cysts are cystic dilatations found throughout the biliary tree. They remain very rare diagnoses in pregnancy and present diagnostic and therapeutic dilemmas.

This case describes a 25 year old lady presenting at 23 weeks gestation in her first pregnancy complaining of "heartburn" and vomiting. On examination she was stable but appeared distressed and was tender on palpation of the epigastrium. She was admitted for intravenous fluid resuscitation and ranitidine. She recovered quickly and was discharged the following morning, but represented two days later with worsening symptoms and abdominal pain associated with vomiting of bile stained fluid. Investigation revealed LFT derangement, raised amylase and white cell count. Ultrasound showed severe hydronephrosis of the right kidney with no gallstones/gallbladder inflammation and initial working diagnosis was pancreatitis.

Over 48 hours her condition deteriorated warranting transfer for surgical review where she became jaundiced. MRI revealed a 13cm choledochal cyst and percutaneous biliary drain insertion under ultrasound guidance was performed.

Issues included pain management and complications of choledochal cyst with a high output drain in situ as well as abnormalities in liver and coagulation function. Additional issues were planning delivery with consideration for maternal and fetal wellbeing including definitive management plans for intervention/treatment of the cyst. The case outlines diagnostic and therapeutic challenges in pregnant women with such diagnoses, antenatally, during delivery and postpartum complications. Challenges were compounded by the necessity of inpatient stay in a separate unit for specialized care with intensive multidisciplinary involvement reinforcing the importance of excellent communication regarding complex patients.
INCREASING AWARENESS OF FEMALE GENITAL MUTILATION IN IRISH OBSTETRIC POPULATIONS

Poster - 141

Sorca O'Brien (Coombe Women and Infant's University Hospital, Cork St, Dublin 8), Gillian Ryan (Coombe Women and Infant's University Hospital, Cork St, Dublin 8), Alison Demaio (Coombe)

Female genital mutilation (FGM) is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other non-therapeutic reasons. Prevalence is highest in Sub-Saharan Africa, particularly Sudan (95%), Egypt (95%), Ethiopia (90%). With increasing immigration there is increasing incidence of this problem in Ireland and healthcare workers must be aware of this issue and the implications for obstetric management.

To assess detection of FGM antenatally in a high risk group and its management and outcomes.

This is a retrospective audit of cases identified in the hospital database with ‘FGM’ or ‘circumcision’ in the booking history over 18 months (Jan 2013- Jun 2014), & also identified the number of women from countries with high prevalence.

374 women were from countries with a high prevalence of FGM. 7 women reported a history of previous FGM. Out of these all were seen by a consultant at booking visit. 5 had a documented delivery plan. None were examined prior to term and no documentation of FGM subtype was recorded or potential complications discussed. None required caesarean section as a consequence of FGM. 3 had uncomplicated vaginal deliveries. 3 had postpartum haemorrhage. None required defibulation in labour.

FGM appears to be under reported in this group- either due to lack of questioning, language and/or cultural barriers. We need to improve our assessment of this patient group- particularly with regards to identification, antenatal assessment, care planning and delivery management.
THE WHITE CELL COUNT IN THE FIRST TRIMESTER OF PREGNANCY AND
GESTATIONAL DIABETES MELLITUS

Poster - 142

M.A. Furey (University Hospital Galway), Amy O’Higgins (University Hospital Galway), A. Egan (University
Hospital Galway) G. Gaffney (University Hospital Galway), F. Dunne (University Hospital Galway)

Outside of pregnancy, the development of type II diabetes mellitus (T2DM) is associated with a preceding
higher white cell count (WCC). Gestational diabetes mellitus (GDM), a disease predominantly of insulin
resistance, is similar in pathophysiology to T2DM. The relationship between the WCC in pregnancy and the
development of GDM has not been described.

We examined the relationship between WCC in the first trimester and the subsequent development of T2DM.
Women were recruited at their first antenatal visit. Height, weight and BMI were recorded. A full blood count
was performed. Women were screened for GDM with a 75g two-hour glucose tolerance test between 24-28
weeks gestation. Clinical details were obtained from computerised medical records.

There were 1225 women included in the study. The mean age was 30.4 years, mean BMI 25.8 kg/m2, 18.2%
were obese, 18.8% developed GDM. Women with GDM were more likely to be older (p< 0.001) and obese
(p<0.001). The WCC increased with increasing BMI (p<0.001). The mean WCC in women without GDM was
8.64 x10^9/L compared to 9.06 x10^9/L in women with GDM (p=0.004). However when controlling for BMI the
WCC was not independently predictive of GDM in non-obese women (p=0.10) or obese women (p=0.71).

In this novel study, we have shown that in the first trimester of pregnancy, the WCC is predictive of the
development of GDM. However this is due to an increased WCC with increasing BMI.
THE ROLE OF COMMUNICATION BETWEEN HEALTH PROFESSIONALS AND PATIENTS AS A FACTOR IN PATIENT COMPLAINTS IN OBSTETRICS AND GYNAECOLOGY A QUALITATIVE REVIEW FROM AN IRISH MATERNITY HOSPITAL

Poster - 143

Sinead O’Reilly (University College Cork)

Litigation in Irish health services is a significant challenge. It is estimated that 17% of all 2012 settled legal claims in Ireland were related to maternity care services. Often the first step toward litigation is the submission of a formal complaint by the patient.

The purpose of this study was to qualitatively examine formal patient complaints letters to the hospital to explore the relevance of communication as a theme in patient’s complaints.

This study comprised of data collected from two years of complaint letters submitted to Cork University Maternity Hospital. This approach aimed to explore how patients and/or their families interpreted their experience in the hospital and perceived their interaction with staff, which in turn led to the submission of a complaint letter. A total of 139 complaint letters and responses were reviewed across the two years. Detail was also collected on patient’s parity, location of trigger event and staff members involved. The process of thematic analysis was utilised to interpret the data.

Staff patient communication played a key role in 93% of all clinical obstetrics and gynaecology complaints with 60% of these complaints having more than one issue around communication. Key themes included; patient’s perception of a loss of personal autonomy and a loss of trust in staff particularly around their handling of complicated events.

These findings would indicate that there is a need to support multidisciplinary staff training around communication with patients in obstetrics and gynaecology settings particularly during difficult deliveries or challenging clinical events.
"TALK-TIME" A STUDY AIMED AT IMPROVING THE DOCTOR-PATIENT RELATIONSHIP

Poster - 144

Laura O’Byrne (Midlands regional Hospital Mullingar), Laurentina Schaler (The Adelaide and Meath Hospital, Tallaght), Michael Gannon (Midlands regional Hospital Mullingar)

Effective communication is an essential corner stone of building a therapeutic doctor patient relationship. Reports vary but found that only 20% of patients completed their presenting complaint without being interrupted.

We aimed to identify the initial spontaneous talk time of patients without interruption by the doctor. During a one month time-period the spontaneous talk time of a total of 33 patients was monitored in both a rural and tertiary hospital in a gynaecology outpatient's clinical setting.

A total of 33 patients were included in this study, spontaneous talk times ranged from 4 seconds to 4 minutes with a median time of 30 seconds. 80% of all patients completed their narrative within 40 seconds. The interquartile range for the data collected demonstrated that the middle 50% ranged from 20 and 37 seconds much shorter then the proposed average of 90 seconds (Langewitz, 2002)

We concluded that the spontaneous talk time of patients we see are much shorter then published figures. The benefits of this initial step in the consultation process allows increased patient satisfaction and has been shown to decreases the risk of action taken should an adverse event occur(Bunting, 1998)

We conclude that allowing the patient this uninterrupted time, considering it is often less then 37 seconds, should be adopted into routine clinic practice.

References;
1) Langewitz W. Spontaneous talking time at start of consultation in outpatient clinic BMJ. 2002 Sep 28; 325(7366):682-3.
IN-HOSPITAL WAITING TIMES FOR ELECTIVE CAESAREAN SECTIONS THE NEED FOR A MORE EFFICIENT PATHWAY

Poster - 145

Laura O’Byrne (Midlands regional Hospital Mullingar), Clare O (Coo), Laurentina Schaler (The Adelaide and Meath Hospital, Tallaght), Michael Gannon (Midlands regional Hospital Mullingar)

Efficiency is needed in the Irish healthcare system to improve patient’s experiences and reduce costs. There is an international drive toward ‘Lean’ management systems, coined by the Toyota management process, within the healthcare industry. Efficient systems focus on (1) defining value from the patient point of view, (2) mapping value streams, and (3) eliminating waste in an attempt to create continuous flow (Pokinska, 2010)

The aim of this study was to identify the in-hospital value streams for patients undergoing elective caesarean section.

Questionnaires completed by patients partners to self report specific time points during elective section pathway such as, time of arrival, time of review by anaesthetics, time to theatre, skin to skin, bottle/breast feeding.

Thirteen patients with elective c sections returned completed questionnaires. All were admitted between 0730 and 0815; time to theatre (range 75-420mins) was 0-60mins: 0(0%), 60-120mins: 5(38.5%), 120-180mins: 3 (23%), 180-240mins: 2 (15.5%), >240mins: 3 (23%); 13 (100%) had skin to skin and 6 (46%) initiated breast feeding.

We identified an area of unnecessarily high in-hospital waiting time for some elective sections with 38.5% of patients waiting more than 3 hours. By identifying this non-value process we have an opportunity to improve work flow, reduce cost and improve patient experience (Rinehart, 2013).

Examining a patient’s journey through our healthcare system gives a unique viewpoint helping to identify areas of change.

References;
**FETAL GROWTH TRAJECTORIES - A COMPARISON OF CONTEMPORARY METHODS OF MONITORING FETAL GROWTH**

*Poster - 146*

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The objective of this study was to longitudinally investigate and contrast the use of serial biometry using estimated fetal weight centiles (EFWc), customised fetal growth (GROW) and the individualised growth assessment package (IGAP).

The study included 254 high and low risk women. At 28, 33 and 37 weeks an ultrasound examination to assess fetal growth and soft tissue measurements was performed. EFW centiles and GROW centiles were calculated for each fetus at birth. All data were analysed using SPSS version 20.

There were strong associations seen between increased EFW centiles and Irish origin, non-smoking status, increased height and weight, BMI, body fat percentage and waist circumference. Smoking showed a statistically significant effect on EFWc ($p=0.007$).

A fall in centiles was associated with a 23% risk of emergency LSCS rate when compared to deliveries with no fall in centiles (10.6% $p=0.035$). The IGAP was significantly associated with both a fall and rise in EFW centiles. Being overgrown as per IGAP correlated with an increased induction rate. A fall in EFW centiles was also associated with emergency caesarean section despite not being associated with increased induction rates. EFW centile fall of over 20 centiles was superior to the others in its predictive power for the risk of emergency LSCS. GROW centile less than the 10th centile and birth weight centile <10th showed similar predictive power for poor perinatal outcome.

This study highlights a role for customised centiles and individualised growth assessments which could lead to improved identification of fetal growth restriction.
Can serial ultrasound Dopplers improve the prediction of aberrant fetal growth and poor perinatal outcome

Poster - 147

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The principle objective of this longitudinal prospective study was to examine umbilical artery (Ua) Doppler, Mid Cerebral Artery (MCA) Doppler and Ductus Venosus (DV) and correlate results with fetal growth patterns. Women were recruited at their convenience and 254 high and low risk women had serial biometry and Dopplers performed at 28, 33 and 37 weeks gestation. Customised birthweight centiles and individualised growth assessment package growth potential realisation indices (iGAP GPRI) were calculated on all women. All data was analysed using SPSS 20.0.

The relationship between cerebroplacental ratio (CPR) and the iGAP GPRI was examined. A t-test analysis showed correlations at 28 and 38 weeks (p=0.028, p=0.015 respectively), with those babies being classified as overgrown associated with a higher CPR ratio.

The MCA Doppler PI at 38 weeks was associated with a drop off in centiles of >20 (p=0.018) with a higher MCA Doppler PI associated with a fall in centiles. Overgrown babies were shown to have a lower resistance in the UA at 38 weeks (p = 0.008). An association between smoking status and the CPR ratio at 28 weeks was seen (p=0.028).

Our study examined the role of Doppler indices in the prediction of abnormal fetal growth patterns. Our main findings include correlations between the CPR and babies that are classified as overgrown on iGAP and GROW centiles. This may be a potential tool for detecting aberrant growth within normal centiles however further studies are needed.
**Does oxytocin versus syntometrine increase the risk of post partum haemorrhage in the labour ward?**

*Poster - 148*

Clare O (Coo), Laura O’Byrne (Midlands regional Hospital Mullingar), Paula Turner (Midlands regional Hospital Mullingar), Sharon Gorman (Midlands regional Hospital Mullingar), Michael Gannon (Midlands regional Hospital Mullingar)

Recent guidelines recommend the routine use of 10iu of im oxytocin for the management of the 3rd stage of labour. Previously syntometrine was the drug of choice but is now not recommended as first line due to the increased risk of nausea and serious adverse events. Of note this guideline has yet to be universally implemented in Ireland. In our unit we recently changed to routine oxytocin use.

The occurrence of PPH in the immediate period after vaginal delivery in the labour ward over two 6 week periods were compared. The occurrence of immediate PPH was recorded in the birth register and recorded for both time periods. From the 1/5/14 -12/6/14 when syntometrine was routinely employed and for a second 6 week period from 27/7/14-7/9/14 when oxytocin was being utilised. Results were gmaianalysed.

During the first time period (using syntometrine) there were a total of 270 deliveries. there were 187 vaginal deliveries and 83 caesarean sections (30.7%). There were a total of 37 PPHs 24 of which were following vaginal deliveries (12.8%). For the second time period (using oxytocin) there were a total of 305 deliveries including 237 vaginal deliveries and 68 caesarean sections (22%). There were a total of 45 PPHs with 34 following vaginal deliveries (14.3%). The difference in risk was not significant.

There was no statistically significant increase in the risk of PPH using oxytocin in place of syntometrine in our study. This study supports the use of oxytocin in accordance with the guidelines.
Obese pregnant women have greatly increased risk of venous thromboembolism (VTE). However, underlying mechanisms are poorly understood.

To address this, plasma samples were obtained with consent from pregnant women of varying body mass index (BMI) and analysed using an assay that characterises pro-and anticoagulant pathways. Blood samples were collected in citrated tubes with contact pathway inhibitor and platelet poor plasma prepared. Tissue factor (TF)-stimulated thrombin generation was determined by measuring cleavage of a thrombin-specific fluorogenic substrate using Thrombinoscope™ software.

13 otherwise healthy women of similar third trimester gestation (BMI 20-29 kg/m2, n=6; 30-39 kg/m2, n=4; >40 kg/m2, n=3) and 2 non-pregnant volunteers were recruited. Mean endogenous thrombin potential (area under the thrombin generation curve; 0.5 pM TF stimulus) was significantly higher in BMI> 40kg/m2 (2056 +/- 88 nm*min) compared with 20-29 kg/m2 (1350 +/- 97 nm*min; p=0.003), 30-39 kg/m2 (1259 +/- 253.4nm*min; p=0.049) and non-pregnant volunteers (1084 +/- 264.8 nm*min; p=0.0235). Characterisation of the anticoagulant protein C pathway was performed by incubation with activated protein C (APC; 5nM; 1pM TF trigger). Remarkably, while APC resistance was observed in all pregnant plasma samples, those of BMI >40 kg/m2 were most resistant to APC- induced attenuation of thrombin generation compared with patients of BMI 30-40 and 20-30 kg/m2. In these three groups, preincubation with APC attenuated ETP by 20%, 57% and 70% respectively.

VTE is a potentially life-threatening complication of pregnancy. Morbidly obese pregnant women have pro-and anticoagulant pathways variations that may represent potential mechanisms underlying the observed high VTE risk in these patients.
**REDUCING VENOUS THROMBOEMBOLIC EVENTS ASSOCIATED WITH OVARIAN CANCER: ARE WE WINNING THE BATTLE?**

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We previously reported a venous thromboembolism (VTE) incidence of 9.7% in a large cohort of women with ovarian cancer from 2006-2010. In that series, 33% occurred in the first 28 days following surgery. In keeping with current international guidelines we introduced a policy of extended VTE prophylaxis with low molecular weight heparin for four post-operative weeks in January 2012. We present VTE outcomes in the first two years of extended prophylaxis.

Patients undergoing cytoreductive surgery for ovarian cancer from Jan 2012 to Dec 2013 in St. James' Hospital were identified from the gynaeoncology database

Fourteen VTE events occurred in 146 (9.5%) women with ovarian cancer. Eight (57%) occurred prior to treatment, 4 (29%) events occurred in the post-operative period with one case (7%) occurring in the first 28 days post op. Two cases (14%) occurred during subsequent chemotherapy. Analysis of the postoperative events revealed the following: One patient had PE on Day 1 prior to starting LMWH (she had massive intraoperative haemorrhage); the other 3 patients had PEs at 3, 6 and 12 months post operatively. The incidence of immediate post-operative VTE events (first 28 days) was 0.7%, a reduction from 3.2 % prior to extended prophylaxis.

**Conclusion:** Extended postoperative VTE prophylaxis has had no impact on the overall incidence of VTE in ovarian cancer patients. However, there is reduction in the number of VTE events in the first post-operative month. Commencement of LMWH pre-operatively and mechanical compression boots have been introduced in a further attempt to reduce post-operative VTE.
Inguinal Endometrioma- Halban's Proof? A Case Report

Poster - 151

Catherine O’Gorman (Department of Gynaecology oncology, St James' Hospital, Dublin, Ireland), Mo’iad Alazzam (Department of gynaecology, UPMC Beacon Hospital, Dublin, Ireland.)

A 30 year old nulliparous woman was referred with right groin pain and swelling. The pain was worst in the premenstrual period. She had no other gynaecological symptoms. Although she had a previous laparotomy, the scar line was far from the described area. MRI pelvis showed a nodule suggestive of either a benign tumour or endometriosis in the right inguinal area. On examination there was an enlarged right inguinal lesion. She then had an excision of the lesion. Histology showed a 3x2cm lymph node with endometriosis associated with haemorrhage in the nodal connective tissue.

Endometriosis is generally present within the pelvis but may be found elsewhere, for example; the lungs, umbilicus, brain and bowel. It is relatively common; diagnosed in 12-50% of women undergoing laparoscopy for pelvic pain or subfertility at reproductive age.

The pathogenesis of endometriosis and behaviour is yet to be definitively understood: theories include 1) Retrograde menstruation and implantation (Sampson’s theory), 2) Coelomic metaplasia (Meyer’s theory), Vascular and lymphatic metastases (Halban’s theory) and 4) Endometrial disease theory.

Lymphatic spread is akin to the means by which malignant lesions metastasise, and indeed there has even been debate as to whether lymph node clearance may reduce the risk of recurrence of endometriosis as it does with malignancies. Uterine lymphatic drainage to superficial lymph nodes as in this case is rare but clearly illustrates that viable endometrial cells do spread via the lymphatic system and this is likely to be the means of spread to distant sites.
THE RELATIONSHIP BETWEEN INFANT BIRTH WEIGHT AND MATERNAL LIPID LEVELS IN THE THIRD TRIMESTER OF PREGNANCY

Poster - 152

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It is accepted that maternal hyperglycaemia results in increased fetal growth, however the relationship between maternal hyperlipidaemia and fetal growth is poorly understood.

The purpose of this study was to examine the relationship between fasting maternal lipid levels and infant birth weight in women selectively screened for gestational diabetes mellitus (GDM).

Women undergoing an oral glucose tolerance test for GDM screening early in the third trimester of pregnancy had a fasting lipid profile performed. Clinical and socio-economic data were recorded and infant birth weight was measured immediately after delivery.

Of the 189 women recruited to the study, the mean age was 32 years and 35.4% were primigravid, 44.1% were obese and 11.6% were diagnosed with GDM. Increasing birth weight was associated with multiparity, first trimester Body Mass Index, GDM and hypertriglyceridaemia on univariate analysis. On multivariate analysis increasing birth weight correlated positively only with hypertriglyceridaemia. For birthweights less than 3.00 kg, 3.00-3.49kg, 3.50-3.99kg and greater than 4.00 kg the respective mean maternal fasting triglyceride levels were 1.58, 1.88, 1.87 and 2.23 mmol/L.

Fetal growth is influenced by maternal triglyceride levels. Women of childbearing age should be screened for hypertriglyceridaemia in early pregnancy.
MATERNAL OBESITY AND POSTPARTUM WEIGHT RETENTION

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The Institute of Medicine in the United States examined evidence on gestational weight gain to devise recommendations for women in pregnancy. Their report acknowledged that "unfortunately, data on maternal postpartum weights are not widely available."

We examined the relationship between maternal obesity and weight retention postpartum.

Women with a singleton pregnancy were recruited before 18 weeks gestation. Weight and height were measured, BMI calculated and body composition analysed using bioelectrical impedance analysis (BIA). BIA was repeated at 4 months postpartum.

There were 392 women for analysis. At recruitment the mean age was 30.5 years (18.0 - 44.0), the mean BMI was 25.1 kg/m2 (16.3-51.2), the mean gestation at booking was 12.5 weeks (6.0-17.9) and the mean time of postpartum follow-up was 17.8 weeks (11.7-33.0). At four months postpartum obese women were more likely to weigh less than their pre-pregnancy weight compared to normal weight women (p<0.001) and were more likely to have a lower fat percentage compared to their pre-pregnancy fat percentage (p<0.001).

In the absence of medical intervention obese women regain their pre-pregnancy body composition more readily than normal weight women. Interventions focused on preventing an increase in weight postpartum should target normal weight women.
THE RELATIONSHIP BETWEEN MATERNAL BODY COMPOSITION AND INFANT BODY COMPOSITION AT BIRTH

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Increasing maternal Body Mass Index (BMI) is associated with increased infant birth weight (BW). Increased BW has been shown to be related to increases in maternal fat-free mass rather than fat mass. However BW is only a surrogate marker of infant adiposity.

We studied, for the first time, the direct relationship between maternal body composition and infant body composition at birth.

Women were recruited before 18 weeks gestation. The pregnancy was dated by ultrasound, weight and height were measured, BMI calculated and body composition measured by bioelectrical impedance analysis. Women underwent selective screening for gestational diabetes mellitus (GDM) at 24-28 weeks gestation with a 75g glucose tolerance test. Women diagnosed with GDM were excluded from further follow-up. Infant body composition was measured in term infants within three days of birth by air displacement plethysmography (Peapod).

There were 327 mother-infant pairs included. At recruitment the mean maternal age was 29 years (17-41), the mean BMI was 25.7 kg/m2 (18.5-48.3) and 19% were obese. The mean gestation at delivery was 40.0 weeks (37.0-42.0), the mean birth weight was 3.53 kg (2.10-4.84), the mean infant fat percentage was 10.5% (1.1-21.0) and 51% of infants were male. Birth weight correlated with maternal BMI (p=0.03) and maternal fat-free mass (p=0.04). Infant fat percentage did not correlate with maternal fat (p=0.53). When controlling for maternal smoking, parity, gestation at delivery and infant sex there was no correlation between maternal fat percentage and infant fat percentage (p=0.23)

Maternal body composition does not influence infant body composition.
THE RELATIONSHIP BETWEEN MATERNAL C-REACTIVE PROTEIN AND GESTATIONAL WEIGHT GAIN

Poster - 155

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Obesity is increasingly recognised as a condition of low-grade inflammation. Outside of pregnancy, obesity is associated with increased serum levels of C-reactive protein (CRP). There is increasing evidence that the CRP level in the first trimester is associated with the risk of developing gestational diabetes mellitus and pre-eclampsia, which are also associated with maternal obesity. However, the relationship between CRP and gestational weight gain (GWG) has not been previously described.

We examined the relationship between CRP in the first trimester and GWG.

Women with a singleton pregnancy underwent ultrasound dating of their pregnancy and serum CRP measurement at the booking visit. Weight and height were measured and body composition analysed using bioelectrical impedance analysis. Body composition measurement was repeated after 37 weeks gestation. There were 71 women recruited to the study and 46 women had repeat measurements at term. The mean age was 31.0 years, the mean BMI was 26.0 kg/m² and 18.3% were obese. The mean CRP was 3.64 mg/L in non-obese women compared to 8.56 mg/L in obese women (p=0.01). CRP did not correlate with maternal age, parity or smoking status. CRP correlated more strongly with measurement of maternal fat mass than maternal fat-free mass. However there was equal correlation between measures of peripheral fat and visceral fat. CRP did not predict GWG.

First trimester CRP is related to maternal adiposity but does not correlate with weight gain in pregnancy.
C-REACTIVE PROTEIN IN THE FIRST TRIMESTER OF PREGNANCY

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Outside of pregnancy, C-reactive protein (CRP) is used as a marker of inflammation and it is used clinically in the assessment of infection. However, CRP rises due to a wide range of inflammatory conditions that are not infectious in origin, including obesity and pregnancy. The normal values for CRP in the first trimester of pregnancy have never been described.

We aimed to describe normal CRP values in the first trimester of pregnancy.

White European women with a singleton pregnancy underwent sonographic dating of their pregnancy at the booking visit. A serum sample was taken for CRP quantification. Weight and height were measured and Body Mass Index (BMI) calculated. Body composition was measured using bioelectrical impedance analysis.

There were 168 women recruited to the study. The mean age was 30.3 years, the mean BMI was 25.5 kg/m² and 14.8% were obese. The mean CRP was 4.21 mg/L (0.16–26.55 mg/L). CRP increased with increasing BMI (p=0.002). However, a wide range of CRP values were seen within each BMI category. Of the cohort 84.5% had a CRP < 7.00 mg/L, 7.7% had a CRP between 7.0 and 10.0 mg/L and 7.8% had a CRP value > 10.0 mg/L. CRP is influenced by maternal Body Mass Index. We have described the range of CRP values seen in normal women in the first trimester of pregnancy. These findings should inform the interpretation of CRP levels during pregnancy especially in obese women.
AN ANALYSIS OF THE DEVELOPMENT OF GESTATIONAL DIABETES MELLITUS AS ANALYSED BY RISK FACTOR

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The Health Services Executive (HSE) recommends selective screening for Gestational Diabetes Mellitus (GDM) based on the presence of risk factors. Currently about 35% of pregnant women are screened, and 5% are diagnosed with GDM. Screening carries a significant resource burden.

We explored the incidence of GDM based on the presence of one or more risk factors.

Height and weight were measured at the first antenatal visit and a detailed history taken. Women underwent screening in accordance with national guidelines. Differences between groups was tested using chi-squared analysis.

There were 389 women recruited to the study. Of the cohort, 82% (318/389) had one risk factor for GDM development and 18% (71/389) had more than one risk factor. GDM was diagnosed in 9% (27/318) of women with one risk factor, 34% (19/56) with two, 77% (10/13) with three and 100% (2/2) with four risk factors. The presence of more than one risk factor increased the risk of GDM development (p<0.001). The incidence of GDM based on the presence of one risk factor varied with 33% (2/6) positive where the risk factor was previous GDM; 11% (10/93) BMI alone; 9% (9/98) family history alone; 7% (6/90) on clinical suspicions of GDM. None of the women screened on the basis of age (12) or previous baby weighing over 4.5 kg (7) developed GDM.

Risk factors for GDM contribute differently to GDM risk. Women with only one risk factor are unlikely to develop GDM. This data may contribute to reducing the number of GTTs performed.
THE RELATIONSHIP BETWEEN MATERNAL FASTING GLUCOSE AND FETAL GROWTH

Poster - 158

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While maternal diabetes mellitus is a risk factor for fetal macrosomia, the characteristics of hyperglycaemia and their relation to fetal growth are not well understood. We examined the relationship between maternal fasting glucose and infant adiposity and birth weight.

White European women with a singleton pregnancy and at least one risk factor for gestational diabetes mellitus (GDM) were recruited at their convenience. Fasting glucose levels were measured at 24-28 weeks gestation. Birth weight was recorded for term infants and adiposity measured within three days of birth by air displacement plethysmography (Peapod). Differences between groups were tested using a t-test.

There were 347 mother-infant pairs. The mean maternal age was 31 years (range 17-45), mean BMI 25.8kg.m2 (range 17.4-44.2) and 20% (69/347) were obese. The mean gestation was 39.8 weeks (range 37.0-42.0), mean birth weight was 3609g (2320 to 5120g) and 51% (178/347) of infants were male. Of the cohort, 15% (52/347) were diagnosed with GDM. There was no difference in birth weight between infants born to diabetic and non-diabetic mothers (p=0.22). There was no increase in infant birth weight as maternal fasting glucose increased (p=0.74). Adiposity measurements were available for 152 infants. Wide ranges of infant adiposity were seen at all levels of maternal fasting glucose. There was no increase in infant adiposity as maternal fasting glucose increased (p=0.53)

There was no direct relationship between maternal fasting glucose and infant adiposity or birth weight. Fetal macrosomia in diabetic pregnancies is likely to be influenced by factors other than maternal glycaemic control.
**Physiological pyuria in the term pregnancy; a prospective cohort study**

*Bobby O’Leary (National Maternity Hospital, Holles St. Dublin 2), Michael Foley (National Maternity Hospital, Holles St. Dublin 2)*

**Background:** Urinary tract infections are common during pregnancy, and the most prevalent causative organism is Escherichia coli. Obstetricians frequently utilise dipstick urinalysis to screen for the presence of pyuria or bacteriuria at routine antenatal appointments, and on admission to the labour ward. Pregnant women are at increased risk for UTIs due to pregnancy induced ureteral dilatation, changes to bladder volume and tone, and increased plasma volume.

**Purpose of study:** This study was undertaken to determine if patients at term were more prone to pyuria than at preterm, and whether this difference existed in labour.

**Study design and methods:** This was a prospective cohort study of 255 antenatal patients. These patients were recruited at random from routine antenatal clinics, and on admission to the labour ward.

**Results:** 36% (91/255) of patients had a positive urine dipstick, indicating the presence of pyuria. Patients at term were statistically more likely to have pyuria than those at preterm (odds ratio [OR], 2.29; 95% confidence interval [CI], 1.36 – 3.86; p = 0.0019). On univariate analysis, pyuria was not significantly more prevalent in patients in labour (OR, 1.14; 95% CI, 0.52 – 2.50; p = 0.7375).

**Conclusion:** This study has shown that there is a high level of pyuria in the obstetric population. One of the more significant findings is that pyuria is more prevalent in patients at term than at preterm. Admission to the labour ward was not a risk factor for pyuria. On-going research is warranted to prevent inappropriate antibiotic administration to patients.
**Obstetric Postnatal Follow-up. How Are We Doing?**

*Poster - 160*

**Clare O’Loughlin (Cork University Maternity Hospital)**

**Introduction:** It is considered best practice that the conducting obstetrician reviews women requiring operative vaginal or surgical delivery prior to discharge. Postnatal debriefing and medical review is considered to be insufficient by women and they would welcome the opportunity to discuss their delivery.

**Methods:** Charts were randomly selected including public and private patients. Patients were categorised into operative vaginal delivery, emergency (EMCS) and elective (ELCS) caesarean section with 40 patients in each group. We examined length of stay, whether the patient was medically reviewed postnatally, when, by whom and if the doctor who performed the delivery debriefed the patient. We also appraised documentation of the delivery to ascertain if it was complete.

**Results:** The average length of stay was 3.2 days for operative vaginal delivery and 4.3 days for EMCS and ELCS. Of those patients medically reviewed the majority were seen on the day of discharge (59.5%). The delivering obstetricians reviewed 15% (6/40) of operative vaginal, 62% (25/40) of EMCS and 27.5% (11/40) of ELCS deliveries prior to discharge. Ninety per cent (36/40) of EMCS and ELCS patients had a medical review prior to discharge and 30% (12/40) of the operative vaginal delivery group. Complete documentation of the operative vaginal, EMCS and ELCS deliveries was 67.5% (27/40), 60% (24/40) and 45% (18/40) respectively. Discussion about delivery was documented in 10% (4/40) of operative vaginal, 35% (14/40) of EMCS and 0% (0/40) of ELCS deliveries.

**Conclusion:** Only 70% of the patients delivered by obstetricians in this cohort have a medical review prior to discharge. Delivering obstetricians see just 35%. Documentation was incomplete in 42.5% of cases.
**What lies beneath – A Prospective Audit of the Obstetric High Dependency Unit (HDU) in a Tertiary Level Maternity Hospital**

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The Confidential Maternal Death Enquiry, Ireland reported a maternal mortality rate of 8/100,000 maternities for 2009-2010. This compares favourably internationally, however maternal morbidity, representing the base of this proverbial iceberg is difficult to capture and according to the WHO Bulletin, 2013, lacks an adequate definition and criteria.

A prospective audit conducted from May-October 2014 identified the case-mix, interventions and maternal and fetal outcomes in a tertiary level maternity hospital obstetric HDU.

There were 113 admissions including 2 re-admissions, representing a total of 111 patients (compared to 180 in 12 months in 2013). Average age was 31.5 years with 54% primigravidae. Average booking BMI was 26.37 kg/m².

The average length of stay was 27.9 hours. 14.4% of patients were less than 24-weeks-gestation. 37.8% of patients were delivered by emergency caesarean section.

Haemorrhage was the leading cause of admission (36.9%), 73.2% due to PPH, with an average EBL of 2 Litres. 26 patients received a blood transfusion and 7 required an intrauterine balloon. Hypertensive disorders represented 29.7% of admissions with 13 mothers receiving MgSO₄. Sepsis accounted for 20.7% of admissions, with 56.5% due to chorioamnionitis (30.7% at <24/40).

There were no maternal mortalities or transfers for Level 3 care. In addition to on-site anaesthetists and microbiologists, consultations were sought from haematology, neurology, endocrinology, cardiology and gastroenterology.

36% of infants were admitted to SCBU or NICU. In 11/12 cases where delivery occurred before 32/40, MgSO₄ was administered.

Utilisation rate of the obstetric HDU was 2.8% and it allowed provision of level 2 care with the necessary multidisciplinary expertise.
First and Second Trimester Miscarriage and Thrombophilia Testing

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The possible association of inherited or acquired thrombophilia and fetal loss is dependent on the gestation of fetal loss and the underlying thrombophilia. The RCOG guideline 2011 recommends inherited and acquired thrombophilia testing for all second trimester losses and acquired thrombophilia testing in women with three first trimester losses.

The aim of this study was to review the indications and results of the thrombophilia testing performed at the miscarriage clinic in a tertiary level maternity hospital.

In 2013, 73 women attending the clinic had both inherited and acquired thrombophilia testing performed. The mean age was 34 years (range 22-43). Sixty five women reported at least one miscarriage <10/40 gestation with 34/65 reporting 3 or more miscarriages <10/40. Twenty eight women reported at least one miscarriage between 10+1-14+0/40. Thirteen women reported a mid-trimester loss between 18+1 and 22+0/40. Two women had a previous stillbirth and 42 had delivered at least one live infant at >37 weeks' gestation.

Six inherited thrombophilias were detected. Four women were heterozygous for factor V Leiden mutation, which is similar to the prevalence in a normal Irish population. One protein C deficiency and 1 protein S deficiency occurred in women with three first trimester losses only and no personal history of thrombosis. Two acquired thrombophilias were detected, one had a positive Lupus anticoagulant and one a positive Beta-2 glycoprotein. Both fulfilled the criteria for antiphospholipid syndrome.

These findings support the current RCOG recommendations. Improved adherence to the guideline may reduce the cost of investigations in the future.
Postpartum haemorrhage after induction of labour, are we vigilant enough?

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Postpartum haemorrhage, PPH, is a major cause of maternal morbidity and mortality with an estimated incidence of 5%. There are a number of risk factors which might help us to predict those patients who will suffer from PPH including the induction of labour. Oxytocin administration during labour has been shown to be an independent risk factor for severe PPH in some studies.

In this study we reviewed our rate of PPH in those patients who have an induced labour. This audit took place over a three month period from March to May 2014. All patients induced during this period were included, data was collected prospectively.

A total of 114 patients suffered from a PPH (16.8%) with 18 patients losing greater than 1.5L ( 5 LSCS, 5 instrumental, 8 SVD), 15 patients lost 1L-1.5L ( 7 LSCS, 3 instrumental, 5 SVD) and 81 patients lost 0.5L-1L (42 LSCS, 14 instrumental, 25 SVD). Induction of labour was associated with PPH in 23% of induced primiparous patients and in 10% of multiparous patients. Although almost half of all PPHs occurred in patients having a caesarean section in labour’ more than 70% of severe PPHs occurred after a vaginal delivery. In the multiparous group, all bleeds of greater than 1L occurred after spontaneous vaginal deliveries.

This study confirms the higher incidence of PPH in this patient population and we would recommend considering the use of prophylactic uterotonics in those patients undergoing induction of labour.
A 25 year old nulliparous woman presented with dysmenorrhea and deep dyspareunia. She was also distressed by a red, inflamed, perfectly circular lesion on her face, occurring cyclically for 2 years. This was 3cm in diameter, began with menstruation, lasted for 3 days and resolved completely when menstruation was finished. Her medications included the combined oral contraceptive pill for 8 years and mefenamic acid.

A referral was sent to dermatology with a provisional diagnosis of suspected endometriosis on her face. On further questioning the dermatology team noted that with the start of menstruation, she always commenced taking mefenamic acid. A diagnosis of a fixed drug reaction secondary to mefenamic acid was made.

Endometriosis is defined as the presence of endometrial glands and stroma outside the uterus. Ectopic endometrium is usually found in pelvic organs, however cutaneous endometriosis has been described in cesarean-section scars and on the abdominal wall. There are no reported cases of endometriosis on the face. Fixed drug reactions are drug induced reactions of the skin and/or mucous membranes, characterized by lesion(s) at the same site each time the offending drug is taken. Whilst reported cases of such reactions with mefenamic acid, an analgesic routinely used to treat dysmenorrheoa are few, it is important to consider, as early diagnosis can impact greatly on patient quality of life.

This case highlights the need for a detailed medication history in patients with cutaneous disease and to avoid the assumption that all things cyclical have to be endometriosis related.
AN AUDIT OF MANAGEMENT OF WOMEN WITH A HISTORY OF LATE MISCARRIAGE OR EARLY PRETERM LABOUR (18-34 WEEKS)

Poster - 165

Claire O’Reilly (National Maternity Hospital, Holles St. Dublin 2), Hugh O’Connor (Rotunda Hospital), Etaoin Kent (RCSI Academic Unit), Fergal Desmond Malone (RCSI Academic Unit)

The incidence of preterm birth (PTB) is nearly 10%. Women with a history of PTB have an increased risk of recurrent PTB, varying between 16%-40%. Evidence-based care can reduce the risk of subsequent PTB by up to 50%.

The purpose of the audit was to compare antenatal management of women with a prior PTB with best practice according to published data.

An individual chart review of women booking for antenatal care between January 2013/14 with a history of late miscarriage or early preterm labour in a previous pregnancy was performed. Patients with indicated preterm delivery were excluded. Antenatal management was documented.

76% (n=23) booked at or before 14 weeks gestation. At booking, 50% of women were reviewed by a consultant, 100% had an MSU and 60% had a HVS. Cervical length ultrasound was performed in 20% (n=6), with 4 of these having serial assessment of cervical length. 3 women had a cervical cerclage placed; 2 ultrasound indicated and 1 history-indicated.

17% (n=5) received progesterone therapy. In the 10 patients with a PTB at 28 weeks or less, 40% received progesterone. 10 patients had 2 or more prior PTBs, of whom 20% (n=2) received progesterone.

Significant variations in the management of patients at high risk of PTB have been identified by this audit. Despite good evidence for progesterone use in the prevention of recurrent PTB only a minority of eligible patients are receiving this therapy. The deficiencies in care identified highlight the need for a clinical practice guideline in this area.
EXTENDED VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS IN GYNAECOLOGICAL CANCER SURGERY. A SURVEY OF CURRENT PRACTICE

Sarah Petch (Trinity college Dublin, Medical Student), Vicki Collins (Department of Gynaecology oncology, Trinity College Dublin, Trinity Centre for Health Sciences, St James' Hospital, Dublin, Ireland.), Lucy Norris (Department of Obstetrics & Gynaecology, Trinity College Dublin, Trinity Centre for Health Sciences, St James' Hospital, Dublin, Ireland.), Noreen Gleeson (Department of Gynaecology oncology, Trinity College Dublin, Trinity Centre for Health Sciences, St James' Hospital, Dublin, Ireland.), Feras Abu Saadeh (Department of Gynaecology oncology, Trinity College Dublin, Trinity Centre for Health Sciences, St James' Hospital, Dublin, Ireland.)

VTE prophylaxis is critical in gynaecological oncology patients undergoing surgery. Current guidelines recommend extended VTE prophylaxis for 4 weeks with LMWH in patients undergoing major abdominal/pelvic surgery for cancer.

Our aim was to evaluate current awareness and application of VTE prophylaxis guidelines by European gynaecological oncology surgeons.

The survey was distributed to members of the European Society of Gynaecological Oncology using SurveyMonkey, and results were analysed.

353 responses were obtained, 52% were consultants, 48% senior trainees. The mean number of new gynaecological oncology patients was 304 per unit, with a mean of 293 abdominal/pelvic surgeries performed per annum. 70% routinely assess VTE risk on all patients. 59% decide on appropriate VTE prophylaxis based on national/international best practice guidelines. The majority of respondents use a combination of LMWH and mechanical prophylaxis for high risk patients. 60% of respondents begin VTE prophylaxis pre-operatively and 45% continue prophylaxis for 4 weeks post-operatively in high risk patients.

Adherence to current guidelines for extended VTE prophylaxis in the peri-operative period for gynaecological oncology patients is poor. Less than half of respondents said that they prescribe prophylaxis for 4 weeks post-operatively. All pelvic surgeons need to be made aware of the risk of VTE and the need for extended prophylaxis in high risk patients.
**INDICATIONS FOR MRI REQUEST FROM THE ROTUNDA HOSPITAL TO MATER RADIOLOGY UNIT**

*Poster - 167*

**Chris Elizabeth Philip (The Department of Obstetrics and Gynaecology, The Rotunda, Dublin)**

First line imaging in Obstetrics and Gynaecology is primarily performed by ultrasound. However US has limitations in staging malignant diseases as well as complications in pregnancy; leading to increased use of CT and MRI in imaging techniques.

With the hospital bearing the significant cost for every MRI request along with a rise in the number of requests seen, this audit is intended to survey the indication of referrals and the sagacious use of this resource.

This is a retrospective study from the year 2013 to present date. During this period, 53 cases were identified, which were subdivided into obstetric and gynaecological patients.

The main indications identified were Pelvic assessment, headaches, Placenta Accreta, Renal Disorders and back pain. The majority of the indications (25) were for pelvic assessments to diagnose the severity of fibroids/cysts as well as to rule out carcinoma. This was then followed by brain MRI (12) to outrule haemorrhage postpartum and to investigate for pituitary tumours in fertility clinics. (6) Spinal MRI requests sent out by the anesthetic team and (5) suspected placenta accreta cases also warranted an MRI.

Our findings determined there were no inappropriate referrals for an MRI. However, a few cases could have been referred to clinical specialist, as there were underlying diseases which were out of the specialty of the hospital. I propose from my findings, that guidelines be established incorporating both clinical and radiological specialists to improve the overall patient outcome.
**A RETROSPECTIVE REVIEW OF REFERRAL AND SUCCESS OF TREATMENT FOR HEAVY MENSTRUAL BLEEDING**

*Aisling O’Shea (Wexford General Hospital), Meenakshi Ramphul (University Hospital Limerick), Elizabeth Dunn (W)*

Heavy menstrual bleeding (HMB) affects 20-30% of women of reproductive age and has a major impact on a woman’s quality of life.

We aimed to assess the quality of GP referral, primary care management and hospital treatment of HMB as compared to the recommendations outlined in the NICE guideline CG44 and agreed by the Royal College of Gynaecologists.

We assessed compliance with these standards by retrospectively reviewing GP referral letters and the medical charts of 185 women suffering from HMB referred between 2008 - 2013 to the gynaecology services in Wexford.

The results showed that less than half of the women had a vaginal examination (52/185, 28%) or full blood count (64/185, 35%) by their GP before referral. Only 77 (42%) women had medical management or Mirena coil trialed by the GP. Of the 185 referred women, 34 women (18%) were successfully treated with medical management. Of the remaining 151 women, 46 (69%) were successfully treated with the Mirena coil, 42 (28%) had endometrial ablation and 10 (7%) had hysterectomy (4 of these were due to failed ablation).

These results highlight the need for improved referral and medical treatment in primary care to negate the need for referral and reduce the considerable waiting time for gynaecology clinic appointments for HMB. We plan to circulate these results to GPs in the southeast and design a referral proforma to improve the quality of referral and pre-hospital management of menorrhagia.
Prenatal screening and diagnosis in a twin pregnancy: a case report

Aminah Razley (Galway University Hospital, NUI Galway), David Crosby (Galway University Hospital, NUI Galway), John J Morrison (University Hospital Galway)

Twin pregnancies comprise an increasing proportion of total pregnancies in the developed world due to the expanded use of fertility treatments and older maternal age at childbirth. Multiple gestation is associated with higher rates of congenital anomalies, which account for increased perinatal mortality. For this reason, prenatal screening and diagnosis is an integral part of care for these women.

A 44 year old, Para 1+0, who was in a same-sex relationship, successfully became pregnant by intrauterine insemination (IUI) with ovulation induction. She had an unremarkable past medical history. At her 12 weeks visit, her scan showed a dichorionic diamniotic twin pregnancy.

The couple requested the combined screening test for Down Syndrome due to increased maternal age. This was performed at 13+1 weeks and showed a risk of 1 in 45 for Twin1, and 1 in 3100 for Twin2. They opted for amniocentesis and results of karyotyping showed Trisomy 21 for Twin1. Results were discussed with the patient and options were given including selective termination of the affected twin. At 15+6 weeks, selective termination of pregnancy was performed in the UK.

Post selective reduction, the patient had an uneventful pregnancy until 36+6 weeks gestation. She was admitted for oligohydramnios with breech presentation. At 38+0 weeks, a live male 3.56kg infant, extended breech was delivered via elective caesarean section.

Prenatal diagnosis is an integral part of care in the older mother with multiple gestation. This case highlights the difficulties raised in the management options available for these women in Irish obstetric practice.
A CASE REPORT OF DYSGERMINOMA AND 46XY GONADAL DYSGENESIS

Fiona Reidy (Department of Gynaecology Oncology, Mater Misericordiae Hospital, Eccles St, Dublin 7), Tom Walsh (Department of Gynaecology Oncology, Mater Misericordiae Hospital, Eccles St, Dublin 7)

This case is of a 16 year old girl referred with primary amenorrhoea. She was tall, with minimal secondary sexual development. Hormone profile showed raised FSH and low oestradiol. A pelvic ultrasound was performed, and a left pelvic mass was noted. A diagnostic laparoscopy found a small uterus, right streak ovary, and an enlarged, abnormal appearing left ovary. A biopsy was taken which revealed a dysgerminoma. MRI pelvis also found a hypoplastic uterus, right streak ovary, and a solid lesion on the left ovary. A CT Thorax, Abdomen and Pelvis confirmed no distant spread. Genetic karyotyping, revealed a 46 XY genotype. She then underwent laparoscopic bilateral gonadectomy to complete surgical staging. Stage 1c ovarian dysgerminoma was confirmed and she was referred for chemotherapy. She has also been started on HRT, increasing gradually, and will ultimately remain on a combined oral contraceptive.

Ovarian dysgerminomas are the most common malignant ovarian tumours in the adolescent population, with 75% occurring in this age group. They have a histological appearance similar to male testicular seminomas. Often these arise from gonadoblastomas, seen in phenotypic females with a Y chromosome.

This case highlights a number of challenging issues, including a diagnosis of a malignancy in a young girl, as well as the diagnosis of a gonadal dysgenesis. However, outcomes for stage 1 dygerminoma are good, with 91-100% survival reported. Also, fertility options will be available for her in the future, with several reported cases of successful pregnancy from oocyte donation in women with 46XY gonadal dysgenesis.
A WOLF IN SHEEP’S CLOTHING - A CASE REPORT OF CERVICAL ADENOMA MALIGNUM

Poster - 171

Fiona Reidy (Department of Gynaecology Oncology, Mater Misericordiae Hospital, Eccles St, Dublin 7), Zara Fonseca-Kelly (Dept of Gynaecology, Mater Misericordiae University Hospital D7), Tom Walsh (Department of Gynaecology Oncology, Mater Misericordiae Hospital, Eccles St, Dublin 7)

Adenoma malignum, also known as minimal deviation adenocarcinoma, is a rare form of cervical cancer, comprising just 1% of cervical adenocarcinomas. Although usually sporadic, it is also associated with Peutz-Jeger syndrome. It represents a diagnostic challenge as it is a well-differentiated tumour with many benign histological features.

Cervical cytology and biopsy have low detection rates for this subtype, and definitive diagnosis is often only made following hysterectomy. Surgical resection is the treatment of choice as despite bland histological features, it behaves aggressively and responds poorly to chemotherapy or radiation. Recurrence is common, and mean survival for stage 1 disease is 5 years.

Case: A 43 year old lady presented with a history of heavy vaginal bleeding, requiring blood transfusion, on a background history of endometriosis and a previous haemorrhagic stroke. On examination, a large, well circumscribed cervical mass was noted. MRI revealed an 8.5x3.5cm cervical tumour, with possible parametrial invasion. She underwent an examination under anaesthesia, and a lletz biopsy was taken. Histology revealed atypical glandular cells arranged in an infiltrative pattern, and a diagnosis of cervical adenoma malignum was made. On PET CT scan the only other positive findings were bulky obturator and external iliac nodes, with mildly increased FDG uptake. She was admitted for a radical hysterectomy. At laparotomy, a frozen pelvis was encountered, secondary to her history of endometriosis. An 8cm cervical mass was noted at resection. Histology confirmed a well differentiated cervical adenocarcinoma, with all lymph nodes negative, consistent with stage 1b1 adenoma malignum.
REVIEW OF UTERINE SARCOMAS IN A SINGLE INSTITUTION

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Uterine sarcomas are rare tumours accounting for only 3% of uterine malignancies. They have high risk of recurrence, rapid progression and poor prognosis.

The aim of our study is to examine the clinical behaviour and outcomes of different types of uterine sarcomas in our unit.

We reviewed all cases of uterine sarcoma, in a tertiary referral hospital, over a 15 year period. The age, symptoms at presentation, findings on imaging and surgery, stage, grade of disease and adjuvant treatment was recorded. The time from diagnosis to remission/relapse was noted in months.

We identified 53 cases of uterine sarcoma. 2 cases were excluded as charts were unavailable. The median age at presentation was 57 years. The patients were reviewed in groups based on histological subtypes and stage of disease. There were 21 cases of endometrial stromal sarcoma (ESS) and low grade adenosarcoma (AS), 16 cases of leiomyosarcoma (LMS), 11 cases of mixed mullerian tumour (MMMT), 2 cases of high grade undifferentiated sarcoma (HGUS) or AS with sarcomatous overgrowth, and 1 case of rhabdomyosarcoma. 30/51(58.8%) had stage 1 disease at diagnosis, 5/51(9.8%) were stage 2, 7/51(13.7%) were stage 3 and 9/51(1.8%) were stage 4. The recurrence rate for ESS, LMS and MMMT was 33%, 56%, and 27% respectively. The clinical behaviour of various histological subtypes is different and should be taken into account when planning treatment. MMMT has higher association with nodal metastasis, and recent evidence favours its treatment with adjuvant chemotherapy, as was offered to 5/11 cases in our cohort.
HOLOPROSENCEPHALY: A RETROSPECTIVE 10-YEAR REVIEW IN A TERTIARY CENTRE

Fiona Reidy (Department of Obstetrics and Gynaecology, National Maternity Hospital, Dublin), Fionnuala Mone (UCD Obstetrics and Gynaecology, School of Medicine and Medical Science, University College Dublin, National maternity Hospital, Dublin), Chandrasekaran Kaliaperumal (Department of Paediatric Neurosurgery, Temple Street Children’s University Hospital, Dublin), Darach Crimmins (Department of Paediatric Neurosurgery, Temple Street Children’s University Hospital, Dublin), Fionnuala McAuliffe (UCD Obstetrics and Gynaecology, School of Medicine and Medical Science, University College Dublin, National maternity Hospital, Dublin)

BACKGROUND: Holoprosencephy is a developmental field defect of impaired cleavage of prosencephalon which occurs in 1 in 250 conceptions, a significant number of which demise in-utero or within a year of life. There are several attributable causes, notably genetic and environmental factors.

PURPOSE: To determine ante-natal features inclusive of extra-cranial features and aneuploidy in addition to fetal and long-term outcome for all cases of holoprosencephaly diagnosed in a tertiary fetal medicine centre over a ten-year period.

STUDY DESIGN AND METHODS: A prospective collection of retrospective data was performed using a computerised patient ultrasound database system and patient note review. Data was summarised and analysed using EXCEL.

FINDINGS: Thirty cases of holoprosencephaly were identified. The incidence within our own population was 1.36/10,000 births. The average maternal age was 33 years and average gestational age at diagnosis was 21.4 weeks. Regarding extra-cranial features these were present in 20/30 = 66.7% cases (8/30 had cleft lip and palate and 12/30 had cardiac defects). Invasive testing was performed in 24/30 cases and of these fetal aneuploidy was present in two-third of cases, the most common being Trisomy 13 (13/24). In terms of outcome, data was available for 16 cases, of which 6 died in-utero, 3 terminated the pregnancy and 7 died in the neonatal period.

CONCLUSION: Although rare, holoprosencephaly is an important ante-natal diagnosis and counselling of parents can be aided through the knowledge of extra-cranial findings and fetal karyotyping.
UTERINE SCAR DEHISCENCE - A DEMANDING DEFECT

Poster - 174

Tara Rigney (Rotunda Hospital), Maeve Eogan (Rotunda Hospital), Karen Flood (Rotunda Hospital)

Uterine scar dehiscence denotes the disruption and opening of a pre-existing uterine scar. It does not disrupt the overlying visceral peritoneum. It can lead to uterine rupture with catastrophic maternal and fetal consequences.

A 30 year old pregnant woman (Para 1) presented at 14 weeks gestation for her booking visit. She previously had an emergency lower segment caesarean section at term for failure to progress. At her routine antenatal visit at 25 weeks and she reported some mild scar discomfort. Subsequently a complete uterine scar dehiscence with bulging membranes was identified sonographically and confirmed on MRI. She remained an inpatient for the rest of the pregnancy, reporting ongoing suprapubic pain. At 34 weeks gestation she had an elective caesarean section. The open lower segment with bulging membranes did not require a uterine incision. Mother and baby did well postnatally.

Scar dehiscence is a rising complication due to the increasing number of caesarean deliveries. Successful preconception repair has been described to prevent scar dehiscence in future pregnancies, and perhaps preconception repair should be considered. The challenges posed by such a large defect at this gestation are vast. They include inpatient management for a significant length of the pregnancy, the uncertainty of the clinical course, timing of delivery and the potential catastrophic outcome while the pregnancy is allowed to advance. However, at present, despite these difficulties clinicians face there are no guidelines for managing uterine scar defects either prior to or during pregnancy.
A 47 year old woman presented to the gynaecology clinic with irregular periods and abdominal discomfort. On examination she was found to have a palpable mass equivalent in size to an 18 week pregnancy, suggestive of a fibroid uterus. An ultrasound scan reported a "bulky and diffusely heterogenous uterus with a large fibroid". She was commenced on ulipristal acetate (Esmya) for three months to reduce the size and vascularity of the fibroid prior to doing a total abdominal hysterectomy and bilateral salpingo-oophrectomy.

Intra-operatively she was found to have a normal sized uterus with a 14 cm solid left ovarian mass and a similar 6 cm right ovarian mass, both suspicious for malignancy. A 5cm appendiceal mass was noted. A total abdominal hysterectomy, bilateral salpingo-oophrectomy and infracolic omentectomy were done. A colorectal surgeon was called to assess the appendix; a right hemi-colectomy was carried out.

Histological examination reported a mixed adenocarcinoma and goblet cell neuroendocrine carcinoma of the appendix. There was spread to the ovaries, uterine serosal surface, omentum and local lymph nodes to give a staging score of T3N2M1. She was referred to the oncology services and is due to start FOLFOX chemotherapy regime.

Goblet cell carcinoid (GCC) tumours are a rare subgroup of neuroendocrine tumours almost exclusively originating in the appendix. They are extremely rare with an incidence of 0.05/100,000 per year. This case demonstrates that rare non-gynaecological neoplasms may present to the gynaecologist with features that are consistent with a diagnosis of fibroids.
A 36 year old previously well woman presented to the Emergency Department with new onset of acute psychosis on a background of a severe headache in the preceding week. MRI brain was normal. Antibodies to the NR1/NR2 subunits of the NMDA receptor in the patient’s serum and cerebrospinal fluid confirmed a diagnosis of Anti-N-methyl-D-aspartate receptor (anti-NMDAR) encephalitis. The disorder is more common in females and in approximately half of whom it is associated with an underlying ovarian teratoma. Therefore a pelvic ultrasound scan was promptly carried out, however this was normal.

For the next month the patient remained an inpatient under the Neurology team. Treatment modalities included therapeutic plasma exchange and intravenous immunoglobulin. She made little progress during this time, with small transient improvements invariably followed by relapses. She proceeded to have a full body PET scan to look for any other underlying pathology other than an ovarian teratoma which may be responsible for a paraneoplastic syndrome. It reported a right adnexal cyst. Subsequent MRI pelvis showed a "1.2cm focus of fat within a small right adnexal lesion raising the possibility of a small teratoma".

The following day the patient had a laparoscopic right oophorectomy. The left ovary appeared normal. Histology confirmed a benign teratoma. Her clinical condition improved post-operatively and she was discharged five weeks later. Patients treated with tumour resection along with the therapeutic modalities described above respond faster to treatment and have better outcomes. Should a diagnostic laparoscopy be considered in female patients presenting with anti-NMDAR encephalitis?
Assessment of Trisomy 21 Fetal Growth Trajectories

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Although customised paediatric growth centiles for Trisomy 21 (T21) have been developed, customised prenatal growth centiles are currently unavailable. Fetal growth restriction is considered a feature of T21, with consequences for timing and mode of delivery.

We sought to compare serial growth of ongoing T21 pregnancies with standard Hadlock measurements. Study design involved retrospectively identifying 63 ongoing prenatally diagnosed cases of singleton T21 over an 8-year period (2006-2013). Multiple growth measurements from 17 to 39 weeks’ gestation, including abdominal circumference (AC), head circumference (HC), femur length (FL) and biparietal diameter (BPD) were recorded and centile curves and scatter plots for T21 pregnancies were compared with Hadlock measurements. The average maternal age was 37 years (range 21-45), with a mean BMI of 28.13 (range 19-50). Mean gestational age at delivery was 37+1 weeks (range 27 – 41+6) with a mean birth weight of 2636g (range 930 – 3820g), the primary indication for planned delivery being that of a concern due to IUGR. A high proportion of emergency caesarean deliveries was observed (42%), with 46% achieving a spontaneous vaginal delivery. When compiling growth centiles for T21, the plotted curves for all standard parameters measured were significantly less than the 50th centile for gestational age with deviation from singleton norms being most demonstrable after 30 weeks’ gestation.

The resulting centiles generated for T21 pregnancies differ significantly from those of established singleton norms. Customised prenatal centiles should be taken into consideration prior to conferring a diagnosis of fetal growth restriction on a T21 pregnancy.
DO OUR PATIENTS KNOW WHAT WE'RE TALKING ABOUT?

Poster - 178

Marie Rochford (Cork University Maternity Hospital), Sarah Meaney (Cork University Maternity Hospital), Keelin O'Donoghue (Cork University Maternity Hospital)

Ensuring that our patients know what we're talking about is a major consideration in maternity services. There are two patients to care for – the mother and the unborn child, in the antenatal period and the mother and the new born infant in the postnatal period. It is of utmost importance that healthcare workers and patients are working together to ensure health in pregnancy, delivery and in the postnatal period. This cannot be done without understanding why antenatal care, intrapartum care and postnatal care is essential. Opportunities to educate patients and to assess their level of understanding should be made at all encounters with patients and at any time in their pregnancy.

"Do our patients know what we're talking about?" is a study that was performed in Cork University Maternity Hospital and which involved quantitative and qualitative aspects. The quantitative arm shows that multiparous patients, having had that bit more experience of the maternity hospital system are marginally more knowledgeable than the primiparous patients on antenatal, intrapartum and postnatal issues. The qualitative branch of the study then highlights some areas in which there is a complete lack of information which could be easily provided in an antenatal and postnatal setting. Patients remain confused with regard to issues such as bleeding, perineal tears and instrumental deliveries. Some patients feel that their needs are fully met in the maternity service, while others have an appetite for more information. Minor changes in communication of information could result in substantial improvements in patient understanding.
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COMPARISON OF METFORMIN VS INSULIN IN THE TREATMENT OF GESTATIONAL DIABETES

Gillian Ryan (Coombe Women and Infant's University Hospital, Cork St, Dublin 8), Alison Demaio (Coombe), Nikita Deegan (Colpocopy Unit & UCD Centre for Human Reproduction, Coombe Womens and Infants University Hospital.), Sean Daly (Coombe Women and Infant's University Hospital, Cork St, Dublin 8)

Background: Metformin has long been used as a treatment of Type 2 diabetes mellitus and is increasingly used in obstetric populations for the treatment of gestational diabetes (GDM) internationally. Evidence available from large randomized control trials suggest that there are no increased adverse maternal or neonatal outcomes with its use and greater patient satisfaction.

Aims: To assess if maternal and fetal outcomes of women with GDM treated with metformin were comparable to those treated with insulin.

Design: This was a retrospective review of the treatment of women diagnosed with GDM in the Coombe Hospital comparing 50 women from 2012 treated with insulin, with 50 women in 2013 receiving metformin as a primary treatment.

We reviewed various maternal factors including age, booking BMI, weight gain and parity; along with delivery outcomes—gestation, mode of delivery, rates of postpartum haemorrhage and shoulder dystocia; and fetal outcomes—birth weight, Apgar scores and neonatal ICU admissions.

Findings: There was no significant difference in the rates of induction of labour, instrumental delivery, caesarean section, postpartum haemorrhage or shoulder dystocia in the groups whether treated by insulin or metformin. The only statistically significant difference was an increased rate of preterm delivery in the metformin group (p=0.04), which is comparable to international data. Only 12% required additional insulin to achieve glycaemic control— which is lower than available international data.

Conclusion: Metformin is a safe alternative option for the treatment of gestational diabetes, with no significant increase in adverse maternal or fetal outcomes.
Does age influence the treatment of biopsy proven adenocarcinoma and adenocarcinoma in situ of the cervix? A single institutional experience

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Introduction: Cervical adenocarcinoma in situ (AIS) is a recognized precursor to invasive adenocarcinoma (AC). While these abnormalities are relatively uncommon when compared to squamous abnormalities they are increasing in frequency especially among young women. AIS is more difficult to treat because endocervical disease and skip lesions are more likely. Tailored conisation has been recommended to ensure negative margins and to reduce the risk invasive adenocarcinoma. For young women concern regarding subsequent pregnancy can favour the use of LLETZ.

Aim: To determine the influence of patients age on the treatment of biopsy proven AIS in women attending a large colposcopy service with 2500 new referrals per year.

Methods: Retrospective review of the histology, and clinical features of women with biopsy proven AIS from January 1st, 2009 to December 31st, 2012.

Results: 136 women had a diagnosis of AIS; 109 women (80%) had a LLETZ, 27 (19.8%) had a knife cone biopsy. The mean age was 34.4 in women who had a LLETZ and 40 years in those who had Conisation (p=0.0047). Eighty per cent of women under forty underwent LLETZ.

Conclusion: Age was a determining factor in choosing the primary treatment for women with AIS. Further analyses aims to examine the outcome of treatment for this cohort of women.
A CHALLENGING CASE OF SEPSIS IN A MORBIDLY OBESE WOMAN IN SECOND TRIMESTER OF PREGNANCY

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The current incidence of maternal obesity (BMI>29.9) in Ireland is reported around 19%. Maternal obesity poses multiple risks for a mother and for a fetus. A recent CEMACE enquiry suggests that sepsis is now the leading cause of maternal death in the UK.

We report a case of a 39-year-old African woman, in her second pregnancy with a BMI of 63 who presented to the Emergency department with sepsis of unknown origin at 19 weeks gestation.

Right upper quadrant pain was the initial complaint. Rigors, pyrexia (39°C) and tachycardia (118bpm) were associated with the elevation of lactate and of inflammatory markers. Urinalysis demonstrated: Ketones +4, Blood +1, Protein +1, Leucocytes +2. An abdominal ultrasound was inconclusive due to technical difficulties however showed no evidence of hydronephrosis or cholecystitis. Symptoms and clinical markers improved following empirical treatment for pyelonephritis.

The incidence of maternal obesity is rising. The case we present emphasises that it is imperative that we are prepared for the management of such patients in order to minimise the risk and optimise care in a demanding obstetric environment.

AN UNUSUAL CT REPORT

Ita Shanahan (Cork University Maternity Hospital), Deirdre Hayes Ryan (Cork University Maternity Hospital), Matt Hewitt (Cork University Maternity Hospital)

A 42 year old woman attended with vaginal bleeding & abdominal pain for a number of weeks. A CT commented on a bulky homogenous uterus, free fluid & multiple pelvic peritoneal nodules. Three years previously she had a robotic-assisted total abdominal hysterectomy with ovarian conservation for uterine fibroids with menorrhagia in which it was necessary to morcellate the uterus to aid extraction. Histology was benign and she had been discharged from follow up.

An ultrasound and MRI were performed and confirmed the absence of a uterus but the presence of a pelvic mass. She underwent a radiological guided biopsy which showed only fibroadipose tissue. After further discussion at the gynae-oncology MDT it was agreed that further biopsies were required to fully evaluate the nature of the mass. She had a diagnostic laparoscopy with biopsy of the pelvic mass/nodules under direct vision which confirmed benign parasitic leiomyomata associated with the previous surgery with no evidence of malignancy. Her symptoms resolved spontaneously and a follow up ultrasound a number of weeks later showed the pelvic mass to be unchanged in size with normal ovaries.

A uterine fibroid is a benign tumour that originates from the smooth muscle layer (myometrium) of the uterus. The malignant version of a fibroid is extremely uncommon and termed a leiomyosarcoma. This case highlights the potential for seeding of fibroid material with power morcellation and how proper preoperative work up and counselling of patients prior to morcellation is imperative to reduce the risk of spread of leiomyosarcoma.
**A RETROSPECTIVE REVIEW OF POST OPERATIVE OUTCOMES AND PATIENT SATISFACTION FOLLOWING SURGICAL INTERVENTION FOR STRESS URINARY INCONTINENCE**

*Poster - 184*

*Suzanne Smyth (Tallaght Hospital)*

**Objectives:** The aim of this study was to retrospectively audit patient outcomes and satisfaction levels after placement of transvaginal tape (TVT) or transobturator tape (TOT) at a tertiary benign gynaecology unit in Ireland. The study period extends from January 1st 2010 - December 31st 2013. Both methods are commonly used, minimally invasive procedures for management of stress urinary incontinence (SUI).

**Methods:** The surgical log books for the years 2010 - 2013 were screened for all procedures involving placement of a vaginal tape. Medical records were reviewed retrospectively. The audit outcome of patient satisfaction levels were calculated based on written documentation of improvement at post operative review 6 weeks post procedure. Patients were also contacted by phone for further information of their subjective improvement in symptoms.

**Results:** During the study period 40 surgical procedures for management of SUI were performed. Of these 76% are included in the final data. TVT procedures accounted for 94% of tapes. The mean age of surgical candidates was 49 years. Only one woman was nulliparous and 45% (n=14) were smokers or had recently ceased smoking. Documented preoperative physiotherapy was observed in 48% (n=15) of cases with documented urodynamics results in 68% (n=21). Satisfaction was defined as no further leaking or significantly improved quality of life and was observed in 77% of cases.

**Conclusions:** Overall, placement of TVT or TOT in our unit is well tolerated with high satisfaction rates. A dedicated proforma comparing objective symptoms pre- and post-operatively would be a beneficial inclusion to the service.
**Audit of Incidence and Documentation of Shoulder Dystocia at a Large Maternity Unit in Ireland**

*Poster - 185*

**Suzanne Smyth (T)**

**Introduction:** Shoulder dystocia (SD) is an unpredictable obstetric emergency with potentially life changing consequences. Proper management of SD aims towards minimizing fetal and maternal morbidity through an organised, expeditious approach. Variability exists in the incidence rates quoted in the literature ranging between 0.58% - 0.70% (RCOG) and 0.6% - 1.4% (ACOG).

**Objective:** The audit aim was to review the incidence, documentation, management and follow up of shoulder dystocia in an obstetric unit in Ireland to ensure compliance with local, national and international standards.

**Methods:** Chart reviews were performed on all cases of SD between January 1st 2013 – December 31st 2013. Fetal and maternal outcomes were audited. Particular attention was given to documentation and maternal debriefing. Results presented at grand rounds and re-audit performed.

**Results:** The initial study period identified 64 cases of SD. The incidence rate was 0.7%. Average maternal age was 30 years and average BMI 25.0 (18.0 - 36.1). Of the cohort, 55% were multiparous and 14% diabetic. The recurrence rate was 0.04%. The incidence of brachial plexus injury was 16.5% (n=9). A SD proforma was filled in 79% of cases with only 12% (n=7) fully completed. Only 13.7% of women had documented debriefing after the occurrence of SD. Re-audit showed dramatic improvement to 67% documented staff de-briefing post traumatic delivery and a 90% completion rate of the proforma.

**Conclusion:** The management of shoulder dystocia was well documented in our unit however specific aspects of the delivery and postnatal care were deficient. Re-audit showed successful changes in practice.
**Prenatal diagnosis of congenital heart disease in Cork University Maternity Hospital between 2009 and 2013**

*Liliana Szittyà (Department of Obstetrics & Gynaecology, University College Cork Cork University Maternity Hospital), Keelin O'Donoghue (Department of Obstetrics & Gynaecology, University College Cork Cork University Maternity Hospital), Gene Dempsey (Department of Obstetrics & Gynaecology, University College Cork Cork University Maternity Hospital), Hannah Glynn (Department of Obstetrics & Gynaecology, University College Cork Cork University Maternity Hospital), Nicoleta Barbu (Department of Obstetrics & Gynaecology, University College Cork Cork University Maternity Hospital)*

**Background:** Congenital heart disease (CHD) is the most common congenital abnormality in neonates with moderate or severe anomalies occurring in about 6 per 1000 live births. With a detailed second trimester anomaly scan approximately 60% of the CHD cases can be identified antenatally. Currently CUMH routinely offers second trimester anomaly scans for high risk patients, but the availability is limited for low-risk patients. Current literature shows that prenatal diagnosis of CHD is associated with a reduction in perinatal morbidity rates and also allows planned delivery.

**Aim:** To determine the number of CHD cases in CUMH from 2009 to 2013 and to evaluate the impacts of prenatal diagnosis on the mode of delivery and on neonatal outcomes.

**Methods:** This was a retrospective study of all moderate to severe CHD cases in CUMH between 2009 and 2013. Patients were identified from our local obstetric and neonatal databases.

**Findings:** Between 2009 and 2013 191 women had a pregnancy complicated with CHD in CUMH. 39% of the patients had antenatal diagnosis. The diagnostic rate of CHD with anomaly scan was 69.73%. Antenatal diagnosis was associated with the following: greater likelihood of planned delivery, a higher preterm delivery rate, lower gestational age and birth weight at delivery, a lower live birth rate, higher intrauterine and early neonatal death rate. Postnatal diagnosis was associated with a higher rate of emergency transfers.

**Conclusion:** With universally available anomaly scan, significantly higher antenatal detection rate of CHD could be achieved which would allow planned delivery for the severe cases.
A COMPLICATED HETEROTOPIC PREGNANCY

Liliana Szittya (Department of Obstetrics & Gynaecology, University College Cork Cork University Maternity Hospital), John O'Neill (Department of Obstetrics & Gynaecology, University College Cork Cork University Maternity Hospital), Deirdre Hayes Ryan (Cork University Maternity Hospital), John Coulter (Department of Obstetrics & Gynaecology, University College Cork Cork University Maternity Hospital)

A heterotopic pregnancy is a rare complication of pregnancy in which both extra-uterine and intrauterine pregnancy occur simultaneously. In natural conceptions, the incidence of heterotopic pregnancy has been estimated to be 1 in 30 000 pregnancies.

We present the case of a 28 year old para 2 who underwent an ERPC for missed miscarriage at 8/40 with only an empty IUGS present. As she had a bicornuate uterus the procedure was performed under ultrasound guidance with consultant supervision. Histology confirmed chorionic villi & BHCG dropped.

She represented 3 days later with right sided lower abdominal pain and PV Bleeding and was treated initially for endometritis. Ultrasound confirmed empty uterus and normal ovaries however a large amount of intra-abdominal free fluid was noted and a uterine perforation was considered. A CT abdomen/pelvis performed a few hours later however did not appreciate any free fluid or detect any abnormalities. Her pain resolved and she was discharged home after 3 days and IV antibiotics.

She represented a week later with severe lower abdominal pain and went on to have a diagnostic laparoscopy. A haemoperitoneum of 1000mls was seen with organised clot. A ruptured mass with active bleeding was seen at the left proximal fallopian tube/uterine cornua. Left ovary & right fallopian tube and ovary were normal. A laparotomy was performed with left salpingectomy & oversewing of uterine cornua. She made an uneventful recovery.

Histology again showed presence of chorionic villi confirming the diagnosis of a heterotopic pregnancy.
Antibiotics are among the most commonly prescribed drugs used in human medicine. However, studies indicate that 30-50% of antibiotics prescribed in hospitals are unnecessary or inappropriate.

The aim of this audit was to assess the prevalence and appropriateness of antibiotic use in the postpartum period.

The audit was conducted in the maternity unit of one of the regional hospitals in the Midlands of Ireland. Data, including use of antibiotics, indications for initiation of antibiotics, presence of pyrexia, laboratory investigations and mode of delivery, was collected retrospectively from clinical records of one hundred postnatal women.

Of the 100 women included in the audit, 25% have received more than three doses of antibiotics during the postpartum period. The indications for initiation of antibiotic therapy were documented in only 56% of cases. Twenty four percent of those who received antibiotics were pyrexic. One in three women (33%) who delivered by caesarean section, and one in five women (21%) who delivered vaginally received antibiotic therapy. There is high prevalence of antibiotic use in the postpartum period. The lack of documented reasons in some of the women indicates that the use of antibiotics may be inappropriate.

We recommend that the maternity unit should develop a guideline for antibiotic use in the antenatal and postnatal period. When initiating antibiotic therapy, the working diagnosis should be documented and a minimum set of laboratory investigations should be requested to confirm the diagnosis. This will facilitate future audits to monitor the practice.
It is recommended that all pregnant women must have their height and weight accurately measured and documented, and body mass index (BMI) calculated at their first antenatal visit. We conducted this audit to assess if this recommendation is followed in our institution.

The audit was conducted in a regional hospital in the Midlands of Ireland. Data, which includes weight, height and BMI, was collected retrospectively from charts of one hundred postnatal women. The practice in the hospital is that a scale, which measures the weight and height and calculate BMI is used during the booking antenatal visit. We recalculated the BMI in each woman using weight (kg)/height (m)2, which was then compared with the BMI documented in the woman’s chart.

Weight, height and BMI were documented in the charts of 96% of the women. Recalculation of BMI using the weights and heights in the women’s charts, found that the BMI documented in the chart was incorrect in 35% of the women. Sixty five percent of these women were categorised into a different BMI group based on our calculation, with 59% of them falling into a higher BMI category.

Even though, BMI was calculated and documented in most cases, more than a third of these were incorrect. This could change clinical risk assessments for some of the women and results in omission of care, for example, screening for gestational diabetes.

We recommend the use of properly calibrated scales with regular revalidation in order to minimise incorrect values.
SCREENING FOR GESTATIONAL DIABETES MELLITUS AND FOLIC ACID SUPPLEMENTATION IN OBESE PREGNANT WOMEN

Workineh Tadesse (Department of Obstetrics and Gynaecology, Midland Regional Hospital Mullingar, Ireland), Maebh Horan (Department of Obstetrics and Gynaecology, Midland Regional Hospital Mullingar, Ireland), Michael Gannon (Department of Obstetrics and Gynaecology, Midlands Regional Hospital Mullingar, Ireland)

Maternal obesity is associated with an increase in pregnancy complications. Two of such complications are gestational diabetes mellitus (GDM), and congenital malformations. It is recommended that all obese women should be screened for GDM and should take high dose folic acid supplementation periconceptionally to reduce the risk of congenital malformations such as neural tube defects (NTDs).

The aim of this audit was to assess if these recommendations are adhered to.

The audit was conducted in a regional hospital in the Midlands of Ireland. Data, which includes weight, height, body mass index (BMI), oral glucose tolerance test (OGTT), and folic acid supplementation was collected retrospectively from charts of one hundred postnatal women. It was not possible to obtain information on the duration and dosage of folic acid use from the clinical notes.

The prevalence of maternal obesity, as defined by BMI > 29.9 kg/m2, was 27% in the audit group. Only sixty seven percent of these women were screened for GDM, of whom six percent had abnormal results. While 89% of women with BMI > 29.9 kg/m2 took folic acid supplementation, 75% of them commenced this only after conception.

The recommendations for screening of GDM and supplementation of folic acid for obese women were not always followed. The high prevalence of abnormal OGTT results (6%) in those screened reiterates the need for screening all obese women. Although, information on dosage and duration of folic acid use is lacking, the audit indicated that most of the women haven't received preconceptual folic acid.
NOVEL VAGINAL DELIVERY TECHNIQUE FOR BROW PRESENTATION

Poster - 191

Ike Uzochukwu (University Maternity Hospital, Limerick), Mark Skehan (University Maternity Hospital, Limerick)

Brow presentation describes a rare extreme variant of occipito-posterior position where the fetal head is very deflexed.

We describe a new technique allowing vaginal delivery in a case of brow presentation. The diagnosis of brow presentation was made at full dilation in a 34-year-old mother of one. The position was naso-anterior with the orbits and nasal ridge palpable at 12 o'clock. Delivery involved use of the Kiwi Omnicup.

Here, the Kiwi cup was pushed posteriorly aiming to reach the flexion point 2-3cm anterior to the posterior fontanelle. The Kiwi cup was just over 12cm from the introitus before a negative pressure of 0.8Bar was created. Traction was exerted over two contractions. The baby's head flexed so that the brow was no longer palpable but there was no rotation and little descent. We realized that the cup was on the vertex. Maintaining light traction it was now possible to reach the flexion point about 6-7cm further posterior. A second Kiwi cup was applied with more than a finger-breadth between the two cups. Negative pressure of approximately 0.3Bar was created and we ensured there was no undue tension on the skin around either cup. The first cup was removed following release of negative pressure. Negative pressure in the second cup was then increased to 0.8Bar. Minimal traction produced immediate descent and rotation leading to an easy delivery of a 3.65kg baby.

We hope this technique might reduce the need for caesarean section in some cases of brow presentation. Excellent images available.
VACTERL Syndrome in a pregnant woman

Poster - 192

Nada Warreth (Rotunda Hospital), Maeve Eogan (Rotunda Hospital), Peter McKenna (Rotunda Hospital)

We report a case of a pregnant woman, with VACTERL association, who attended for antenatal care in our hospital. VACTERL association is a non-random association of birth defects which is diagnosed when three or more of the following congenital malformations are present: vertebral defect, anal atresia, cardiac anomalies, trachea-oesophageal fistula, renal anomalies and limb abnormalities. It has a prevalence of approximately 1 in 10,000 to 1 in 40,000 live born infants. Our patient had a history of short stature, restrictive lung disease and repaired VSD and tracheo-oesophageal fistula. During her pregnancy, she complained of recurrent lower respiratory tract infections, which necessitated admission to High Dependency Unit. Throughout pregnancy, management was a collaboration between Obstetricians, Anaesthetists, Physicians and Radiologists. Her case was also discussed at multiple multidisciplinary meetings. A CT virtual Bronchoscopy showed a left lower lobe collapse. She was delivered at 35 weeks by elective Caesarean Section in a tertiary general hospital, which has intensive care facilities. This case report shows the importance of a multidisciplinary approach to the management of such cases. To the best of our knowledge this is the only case of VACTERL association to be reported in a pregnant woman in Ireland.
CANNABINOIDS HYPEREMESIS SYNDROME: THE MYSTERY OF COMPULSIVE BATHING

Nada Warreth (Rotunda), Sharon M Cooley (Rotunda Hospital), Rishi Roopnarinesingh (Rotunda Hospital)

A 26-year-old female presented to the emergency room complaining of cramp-like abdominal pain, nausea, and vomiting for the past three days. She was nine weeks pregnant and had had multiple hospital admissions since the start of pregnancy with the same symptoms. During the evaluation she was persistently asking when she would be admitted to the ward. When asked the reason she said "because I want to take a bath" and on further questioning she explained that a bath relieved her symptom. She had suffered from these symptoms since the age of 18 years and had undergone multiple investigations at various hospitals. No definitive diagnosis was ever found. There was nothing significant in her past medical or surgical histories and she was not on any medication. Her examination was unremarkable. The patient's urine toxicology test was positive for Cannabinoids. She admitted to smoking cannabis daily for more than eight years. During her pregnancy she was seen by the hospital Psychiatrist and social worker.

A severe vomiting sickness, called "Cannabinoid Hyperemesis Syndrome", was first described in 2004. It is associated with chronic cannabis use that is characterized by recurrent nausea, intractable vomiting and abdominal pain. These symptoms are associated with a compulsion to bathe as this temporarily alleviates symptoms. The treatment of this condition consists of supportive measures in the acute phase, followed by complete abstinence from cannabis. This is the first case of this syndrome to be reported in Ireland. Our aim is to increase awareness of this unusual adverse effect of cannabis.
FILLING IN OF LAB REQUEST FORMS

Poster - 194

Nada Warreth (Rotunda), Sharon M Cooley (Rotunda Hospital)

Results of laboratory testing are integral to clinical decision making, to assist in diagnosis. It has been found that 48% of errors in lab testing occur in the pre-analytical phase. Minimising mistakes is important as any mistake can have dangerous consequences. Our objective was to determine the number of patient identifiers filled in the lab request form and if the clinical detail were also added.

A random sample of 357 lab request forms from between January to March 2013 was chosen from across the different labs (Haematology, Biochemistry, Endocrinology, Blood Transfusion, Microbiology, Virology and Histology). One hundred percent compliance was expected.

Results showed that we performed well on some of aspects but we did poorly on others. Only 74% of clinical details were filled in and requesting clinician’s details were only present in 63% of forms. The filling in of the clinical details, the time the sample was taken, who requested the sample and a signature should always be included on the form.
AN UNUSUAL LOCATION OF BASAL CELL CARCINOMA: THE VULVA- A
Case Report

Poster - 195

Saeeda M Wazir (Our Lady of Lourdes Hospital Drogheda)

Introduction: Vulvar basal cell carcinoma is rare, accounting for 2-4% of all vulvar neoplasms and less than 1% of all BCCs. They are diagnosed late because they are often asymptomatic. The etiology is unknown but associated risk factors are exposure to ultraviolet radiation and white skin.

Case report: We report an 80 year-old woman presenting with the complaint of a lump on the Left side of her vulva for few years. Examination disclosed a well demarcated growth of approx. 3 x 3cm with irregular margins on the left labia majora. No ulceration or hyperpigmentation noted in the skin. The rest of the genital and pelvic exam was normal. She underwent a wide local excision of the tumour. The histopathology was consistent with the "nodular type BCC". She was reviewed six weeks later and dermatologic evaluation revealed a well-healed incision site on the left labia majora.

Discussion: Vulvar BCC is a rare malignancy with approximately 250-300 cases reported in the literature. It usually affects white women over 70 years of age. Vulvar BCC may manifest itself as a nodule, or an ulcerated or pigmented lesion. The biologic behavior of BCC is that of a slow-growing tumor and vulvar BCC typically demonstrates a locally confined tumor. Metastatic disease is rare. The standard of care for treatment of BCC is wide local excision with pathologically-proven clear margins of approx. 1cm. Postoperative radiation does not appear to affect recurrence rate or overall survival. Surgical excision remains the accepted treatment for primary and recurrent localized vulvar BCC.
POSTPARTUM PYODERMA GANGRENOsum

Poster - 196

Michael Wilkinson (University Maternity Hospital, Limerick), Lucia Hartigan (Nat), Ammara Sultan (University), Mark Skehan (University Maternity Hospital, Limerick)

Background: Pyoderma gangrenosum (PG) is a rare chronic ulcerative skin condition often associated with systemic disease. PG in the immediate postpartum period is an extremely rare entity with very few case reports in the literature.

Case Report: We report a case of postpartum perianal PG in a 28 year old primiparous patient from Romania. A well demarcated, ulcerating lesion with rolled edges developed day one after a spontaneous vaginal delivery with a second degree perineal tear. The lesion came in close opposition to, but didn't involve the perineal wound. Her condition worsened despite various regimens of intravenous antibiotics and local treatments. Serial bacterial and viral swabs were negative. A diagnosis of pyoderma gangrenosum was made upon assessment by a dermatologist. This was substantiated by histological findings of leukocytoclastic and lymphocyte mediated vasculitis consistent with PG. The effected area responded well to local wound care as well as systemic and topical steroids. Associated systemic disease was not found upon investigation.

Conclusion: A diagnosis of peri-anal PG is extremely rare but should be considered in any ulcerative skin lesion unresponsive to antibiotics.

Excellent images available
MATERNAL MORBIDITY ASSOCIATED WITH DELIVERY OF INFANTS WITH DIAGNOSED LETHAL CONGENITAL ANOMALIES

Poster - 197

Michael Wilkinson (University Maternity Hospital, Limerick), Mark Philip Hehir (National Maternity Hospital, Holles St. Dublin 2), Fionnuala McAuliffe (National Maternity Hospital, Holles St. Dublin 2)

Objective: We sought to examine composite maternal morbidity associated with delivery of infants with lethal congenital anomalies over a 10-year period.

Method: This was a retrospective analysis of prospectively gathered data, carried out at a large tertiary referral center serving a single urban population over a 10-year period, from 2002 to 2011. All cases of lethal congenital anomalies were included.

Results: During the ten-year study period from January 2002 to December 2011, there were 87,317 babies weighing 500g or more born at the National Maternity Hospital. During this time there were 234 babies with lethal anomalies delivered at the hospital, over half of these (N=122) were delivered alive while the remaining 112 were stillborn.

The rate of cesarean delivery among infants with a lethal diagnosis was 21.4% (50/234). The majority (64% [150/234]) of women delivering babies with lethal anomalies had a spontaneous vaginal delivery, while 12% (28/234) had a vaginal breech delivery, 6 mothers had an operative vaginal delivery.

The rate of composite morbidity grade I among mothers delivering infants with a lethal diagnosis was 41.5% (97/234). The rate of the more severe composite morbidity grade II was 18.8% (44/234). The rate of severe maternal morbidity was 1.7% (4/234). There were no maternal deaths over the course of the study in women delivering infants with a lethal anomaly.

Conclusion: Delivery of parturients whose babies have a lethal congenital anomaly is associated with a significant rate of maternal morbidity.
THE NATURAL HISTORY OF ANENCEPHALY

Objective: Experience and expertise with management of ongoing pregnancies where the fetus has anencephaly is limited. We aimed to investigate the natural history of these pregnancies from diagnosis to delivery and to determine timing of death.

Method: A retrospective review of cases of anencephaly delivered between 2002 and 2011 at the National Maternity Hospital, Dublin.

Results: The majority of cases (13/15; 87%) were diagnosed prenatally at a median gestation of 17+3 weeks (range 12 –22+3). The median maternal age was 29 years (range 21–38) and 27% were primigravidae. The incidence of composite maternal morbidity grade 1 was 20% while the incidence of composite maternal morbidity grade 2 was 13%. There were no instances of severe maternal morbidity. The median gestation at delivery was 36+3 weeks (range 25+5 –43+3); 42% were induced at a median gestation of 38+2 weeks. The caesarean section rate was 20% (3/15), all of which were performed in an elective setting. Six women (6/15;40%) had a pre-labour intra uterine death while nine women (9/15;60%) had a live born infant. The median duration of survival was 4 hrs 25 min (range 24 min-7 hrs 53 min).

Conclusion: This study provides useful information for health professionals caring for patients with a diagnosis of anencephaly. The majority of these infants are born alive with a very short duration of survival.
EDWARD’S SYNDROME: A TEN YEAR REVIEW

Objective: Edward's syndrome is a condition where the fetus has no prospects of long-term survival outside the womb. We aimed to examine the natural history of Edward's syndrome from diagnosis to delivery and determine what effect, if any it has on maternal morbidity.

Method: A retrospective review of cases of Edward’s syndrome delivered between 2002 and 2011 at the National Maternity Hospital, Dublin.

Results: The majority of cases (26/29;90%) were diagnosed prenatally at a median gestation of 26+2 weeks (range 15 –40+1). The median maternal age was 37 years (range 19–42) and 41% were primigravidae. The incidence of composite maternal morbidity grade 1 was 7% while the incidence of composite maternal morbidity grade 2 was 3%. There were no instances of severe maternal morbidity. The median gestation at delivery was 35+3 weeks (range 27+3 –44+1); 46% were induced at a median gestation of 35+4 weeks. The caesarean section rate was 17% (5/29), one of which was performed as an emergency. Nineteen women (19/29;66%) had a pre-labour intra uterine death while ten women (10/29;34%) had a live born infant. The median duration of survival was 39 hrs 30 min (range 10 min–6 days).

Conclusion: This study provides useful information for health professionals caring for patients with a diagnosis of Edward’s syndrome. The majority of these infants were stillborn with the remainder having a short neonatal life. There was no increased maternal morbidity associated with these pregnancies.
MEDICAL MANAGEMENT OF ECTOPIC PREGNANCY: A TWO-YEAR REVIEW

Yang Lin (University College Dublin), Edward Corry (National Maternity Hospital, Holles St. Dublin 2), Michael Wilkinson (University Maternity Hospital, Limerick), Mary Higgins (National Maternity Hospital, Holles St. Dublin 2)

Purpose: The aim of this study was to review the outcomes of ectopic pregnancies managed with methotrexate over a two-year period in a tertiary level unit.

Study Design: A retrospective review of all cases requiring methotrexate in the National Maternity Hospital from January 2012 to December 2014.

Findings: Sixty one women were prescribed methotrexate within the specified time. Full information is currently available on fifty one. The majority (43/51;84%) of cases were due to a formal ultrasound diagnosis of tubal ectopic pregnancy with five women (5/51;10%) having a diagnosis of non-viable pregnancy of unknown location. One cervical ectopic, one caesarean scar ectopic and one ovarian ectopic were treated with methotrexate.

Of the women treated medically for a tubal ectopic pregnancy, 72% (31/43) required only one dose of methotrexate while 28% (12/43) required a second dose. There was no statistically significant difference in the size of the ectopic pregnancy between those two groups (14mm mean size vs. 15mm). Within the "one dose" group, the median fall in HCG level from Day 4 to Day 7 was 35% and the median time for HCG to fall to undetectable levels was 21 days (range 5-54 days).

Conclusion: The majority of women who received methotrexate within the two-year study period had a formal diagnosis of a tubal ectopic pregnancy. Women choosing medical management had a 72% chance of success with one dose of methotrexate.
Tissue factor pathway inhibitors are serine proteases that modulate the coagulation pathway. Their role in the growth, invasion and metastases of tumours is emerging. Clear cell carcinoma (CCC) carries has the worst prognosis and the highest thrombosis risk of all the epithelial ovarian cancers.

**Aims of this Study:** To determine the expression and compare the levels of TFPI-2 in serum and tissue in patients with CCC and benign ovarian tumours (BOT). To assess the correlation between levels of serum and tissue TFPI-2.

**Study design and Methods:** Samples were obtained from the TCD ovarian cancer bio-resource. TFPI-2 antigen levels were determined using an ELISA assay.

**Findings of study:** Fifteen serum and 29 tissue samples were analysed. Tissue TFPI-2 expression was lower in CCC than BOT (median values 3.34 vs 6.07, p=<0.08). Serum TFPI-2 was higher in CCC than BOT (median values 1.61 vs 0.75, p<0.05). Serum TFPI-2 expression correlated negatively with tissue TFPI-2 levels 0.38 (n.s.).

**Conclusion:** An inverse relationship between tissue expression and serum levels of TFPI-2 emerges in CCC. Possible explanations are altered outflow from the cancer, reduced clearance from the plasma or additional peripheral source(s) of TFPI-2 triggered by CCC. Studies to localise the source and quantitate TFPI-2 in CCC are in progress. The substantial increase in serum TFPI-2 in CCC means that it has potential as a biomarker.