THE INSTITUTE OF OBSTETRICIANS AND GYNAECOLOGISTS
- FOUR PROVINCES MEETING -

JUNIOR OBSTETRICS & GYNAECOLOGY SOCIETY
- ANNUAL SCIENTIFIC MEETING -

ROYAL ACADEMY OF MEDICINE IN IRELAND
- DUBLIN MATERNITY HOSPITALS REPORTS MEETING -

Royal College of Physicians of Ireland,
No. 6 Kildare Street, Dublin 2

Friday 28th November 2008
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00 - 09:30</td>
<td>Registration &amp; Tea/Coffee</td>
</tr>
<tr>
<td>09:30 - 11:00</td>
<td>JOGS Oral Presentations</td>
</tr>
<tr>
<td>11:00 - 11:30</td>
<td>Tea/Coffee &amp; Homemade Biscuits</td>
</tr>
<tr>
<td>11:30 - 13:00</td>
<td>JOGS Oral Presentations</td>
</tr>
<tr>
<td>13:00 - 13:30</td>
<td>JUNIOR OBSTETRICS &amp; GYNAECOLOGICAL SOCIETY Annual General Meeting</td>
</tr>
<tr>
<td>13:00 - 14:00</td>
<td>Lunch</td>
</tr>
<tr>
<td>14:00 - 14:30</td>
<td>Older Mothers: Naming and Counting the Issues</td>
</tr>
<tr>
<td></td>
<td>Dr. Susan Bewley</td>
</tr>
<tr>
<td></td>
<td>Consultant Obstetrician/ Maternal Fetal Medicine</td>
</tr>
<tr>
<td></td>
<td>Guy's &amp; St Thomas' NHS Foundation Trust, London</td>
</tr>
<tr>
<td>14:30 - 15:00</td>
<td>JOGS Poster Presentations</td>
</tr>
<tr>
<td>15:00 - 15:30</td>
<td>Tea/Coffee</td>
</tr>
<tr>
<td>15:30 - 16:00</td>
<td>Future Challenges to Delivering Urogynaecological Care</td>
</tr>
<tr>
<td></td>
<td>Dr. Rhona Kearney</td>
</tr>
<tr>
<td></td>
<td>Consultant Gynaecologist &amp; Subspecialist in Urogynaecology</td>
</tr>
<tr>
<td></td>
<td>Addenbrooke's Hospital, Cambridge</td>
</tr>
<tr>
<td>16:00 - 16:30</td>
<td>Obstetrics in Malawi</td>
</tr>
<tr>
<td></td>
<td>Dr. Valerie Donnelly</td>
</tr>
<tr>
<td></td>
<td>Consultant Obstetrician &amp; Gynaecologist</td>
</tr>
<tr>
<td></td>
<td>Mount Carmel Hospital</td>
</tr>
<tr>
<td>16:30 - 17:00</td>
<td>Tea/Coffee/Homemade Biscuits</td>
</tr>
<tr>
<td>17:00 - 19:00</td>
<td>Royal Academy of Medicine in Ireland</td>
</tr>
<tr>
<td></td>
<td>Dublin Maternity Hospitals Annual Reports Meeting</td>
</tr>
<tr>
<td>20:00</td>
<td>Dinner</td>
</tr>
</tbody>
</table>
JOGS ORAL PRESENTATION PROGRAMME

Abstract No. 86
THE TRANSCRIPTION FACTOR SOX11 IS A PROGNOSTIC FACTOR FOR IMPROVED RECURRENCE FREE SURVIVAL IN EPITHELIAL OVARIAN CANCER
Donal Brennan, Emma Doyle, Sara Ek, Thomas Drew, Grainne Flannelly, Michael Foley, Carl A Borrebaeck, Karin Jirstrom and Colm O’Herlihy

Abstract No. 3
LISTERIA AWARENESS AMONGST RECENTLY DELIVERED MOTHERS
LFA Wong, K Ismail, U Fahy

Abstract No. 57
NEONATAL MORBIDITY CORRELATES CLOSELY WITH GESTATIONAL AGE AND NOT THE AETIOLOGY OF ATE PRETERM BIRTH
Niamh Daly, Claire O’Sullivan, Rhona Mahony, Michael Foley

Abstract No. 4
CLINICAL AUDIT TO EVALUATE THE OUTCOME OF INSTRUMENTAL DELIVERIES IN OLOL
S.Hiremath, Dr T.Hassan, Dr S.Higgins

Abstract No. 59
BREECH PRESENTATION AT TERM
Biza Akbar, Rishi Roopnarinesingh

Abstract No. 42
AUDIT ON THE INDUCTION OF LABOUR AND ITS OUTCOME
Anjola O, Jayamala G, Das A, Murphy C, Gardeil F, Dunn E.

Abstract No. 110
UPTAKE OF INVASIVE TESTING FOR ANEUPLOIDY AFTER A POSITIVE FIRST TRIMESTER SCREEN
A O'Higgins, E Kent, K Dorschner, K Flood, A Fleming, FD Malone

Abstract No. 85
UNPLANNED PREGNANCY IN CORK
Babiker E, Gaughan E, Higgins JR, O’Donoghue K

Abstract No. 20
THREE-DIMENSIONAL SONOGRAPHY: COULD IT BE A GOLD STANDARD IN DIAGNOSING UTERINE ANOMALIES?
N Kondaveeti, C Walsh, M Martin, J Maycock, W Prendiville

Abstract No. 44
RISK OF DEATH IN UNCOMPLICATED MONOCHORIONIC TWINS
J Hogan, N Farah, B Stuart, S Daly
Abstract No. 69
HISTONE DEACETYLASE INHIBITORS AND A FUNCTIONAL POTENT INHIBITORY EFFECT ON HUMAN UTERINE CONTRACTILITY
Mark P Hehir, Aidan M Sharkey, Stephen C Robson, GN Europe-Finner and John J Morrison

Abstract No. 49
OXYTOCIN IN PREVENTION OF HAEMORRHAGE AT CAESAREAN SECTION - A SURVEY OF PRACTICE IN IRELAND AND GREAT BRITAIN
Sheehan SR, Wedisinghe L, Macleod M, Murphy DJ

Abstract No. 9
ASYMPTOMATIC RECURRENCES OF ENDOMETRIAL CARCINOMA FOLLOWING PRIMARY THERAPY IN SOUTH INFIRMARY VICTORIA UNIVERSITY HOSPITAL (SIVUH) CORK
PV Ooi, S Ali, A Curtain, J Coulter

Abstract No. 81
USE OF FETAL LACTATE IN INTRAPARTUM MANAGEMENT
M McMenamin, S Canny, F Cullinane

Abstract No. 112
FORCEPS DELIVERY – A SOON TO BE EXTINCT OBSTETRIC PROCEDURE?
R Akkawi, E Kent, M Geary, M Robson, C Fitzpatrick, F D Malone

Abstract No. 72
CLINICO-PATHOLOGICAL CORRELATIONS IN PERIPARTUM HYSTERECTOMY
O O’Sullivan, D. O’ Brien, W. Babiker, M Geary, F McAuliffe, B Byrne

Abstract No. 50
POLISH WOMEN’S EXPERIENCE OF MATERNITY CARE IN AN IRISH HOSPITAL
Sabina Gejdel-Koltuniewicz, Gerry Burke

Abstract No. 33
CAN MATERNAL BIOELECTRICAL IMPEDANCE ANALYSIS (BIA) PREDICT BIRTH WEIGHT?

Abstract No. 37
A RANDOMISED CONTROLLED TRIAL OF COMPARISON BETWEEN STANDARD METAL STAPLES AND ABSORBABLE SUBCUTICULAR STAPLES FOR SKIN CLOSURE AT CAESAREAN SECTION
Rupak K Sarkar, P Akhter, M Akram, A Khashan, D McKenna, B A O’Reilly

Abstract No. 31
PET/CT IN THE STAGING OF CERVICAL CANCER – EXPERIENCE OF A SINGLE IRISH INSTITUTION
Helen Ryan, Darra Murphy, William Boyd, Leo Lawler
JOGS POSTER PRESENTATIONS

Abstract No. 1
SUCCESSFUL PREGNANCY AFTER ENDOMETRIAL ABLATION-CASE REPORT
N T YUSUF, J MONAGHAN

Abstract No. 2
STUDY OF AVERAGE GESTATIONAL AGE AT BOOKING IN PHB
N T Yusuf

Abstract No. 5
A REVIEW OF UTERINE RUPTURE IN THE ROTUNDA HOSPITAL FROM 2001 TO 2007
Dr Abutu N C, Dr Purandare N, Dr Ogunlewe F, Dr Geary M

Abstract No. 6
PLACENTAL HISTOLOGY TO DETERMINE CHORIONICITY: HOW ACCURATE IS IT?
J Hogan, N Farah, Z Galvin, A Radomski, J O'Leary, B Stuart, S Daly

Abstract No. 7
WHERE IS THE PLACENTA LOCATED AFTER ONE PRIOR CAESAREAN SECTION?
J Hogan, N Farah, B Stuart, MJ Turner

Abstract No. 8
AUDIT OF THE PREVENTION AND TREATMENT OF OSTEOPOROSIS IN MENOPAUSAL WOMEN OR THOSE WHO HAD HYSTERECTOMY

Abstract No. 10
ONCE A PRIMIP ALWAYS A PRIMIP
Vicky Gleeson

Abstract No. 11
O. Ogunlewe, S. Coulter-Smith, M. Cafferkey, V. Jackson, M. Brennan, B. Kelleher, K.B Grundy, J.S. Lambert

Abstract No. 12
A CASE REPORT OF SWYER’S SYNDROME
DR ISHRAT SHAFI DR. DJD CORCORAN

Abstract No. 13
OUTCOME OF WOMEN WITH THREATENED EARLY PREGNANCY LOSS WITH INCONCLUSIVE SCANS ON THE 1ST VISIT AT EPAU (EARLY PREGNANCY ASSESSMENT UNIT).
Dixit. S, Sarkar. S, Asif. S.

Abstract No. 14
AUDIT OF CAESAREAN SECTION IN THE SECOND STAGE OF LABOUR
I Abdelrahim and F Cullinane

Abstract No. 15
MEDICAL MANAGEMENT OF ECTOPIC PREGNANCY IN OUR LADY OF LOURDES HOSPITAL
Hamada Abdoun, S Higgins

Abstract No. 16
FETAL SUPRAVENTRICULAR TACHYCARDIA (SVT): A CASE SERIES & LITERATURE REVIEW
Hamada Abdoun, M Milner, S Higgins
Abstract No. 17
TROPONIN-T AND PRO-B NATRIURETIC PEPTIDE IN FETUSES OF TYPE 1 DIABETIC MOTHERS
NE Russell, MF Higgins, M Amaruso, M Foley, RG Firth, FM McAuliffe

Abstract No. 18
OBSTETRICAL RISKS AND CAUSES FOR INTENSIVE CARE ADMISSIONS (ICU): A 5-YEAR RETROSPECTIVE
MA Dempsey, T Hassan, M Scully

Abstract No. 19
ELECTIVE SINGLE EMBRYO TRANSFER: PRELIMINARY EXPERIENCE AT THE MERRION FERTILITY CLINIC
N Maher, P Milne, E Cottell, M Wingfield, M Eogan

Abstract No. 21
SEX AND FETAL ABDOMINAL SUBCUTANEOUS TISSUE (FAST)
N Farah, E Harrold, C Fattah, S Barry, V Donnelly, G Rafferty, B Stuart, MJ Turner

Abstract No. 22
CAN WE PREVENT UNEXPECTED EMERGENCY CAESAREAN SECTIONS FOR SECOND TWINS?
J Costa, R Collins

Abstract No 23
IMPACT OF OVERFLOW FROM OTHER SPECIALTIES ON GYNAECOLOGY SERVICES AND ITS EFFECTS ON MAINTENANCE OF CONSULTANTS’ SKILLS AND NCHDS’ TRAINING IN OUR LADY OF LOURDES HOSPITAL
Hamada Abdoun, M Milner

Abstract No. 24
BODY MASS INDEX (BMI) IN WOMEN BOOKING FOR ANTENATAL CARE: COMPARISON BETWEEN SELF-REPORTED AND DIGITAL MEASUREMENT
C Fattah, N Farag, F O’Toole, E Harold, S Barry, D Murray, P Doran, G Rafferty, V Donnelly, B Stuart, MJ Turner

Abstract No. 25
APLASTIC ANAEMIA: UNCOMPLICATED PREGNANCY FOLLOWING ALLOGENEIC BONE MARROW TRANSPLANTATION
F Martyn, MP O’Connell

Abstract No. 26
WOMEN’S COMPLIANCE AFTER COLPOSCOPIC MANAGEMENT
Srwa Khalid, Xavier Carcopino, Georges Michael, Ronan Conroy, Walter Prendiville

Abstract No. 27
ADVANCES AND CHALLENGES IN THE MANAGEMENT OF UTERINE FIBROIDS
Helen Ryan1, Darra Murphy2, William Boyd1, Leo Lawler2

Abstract No. 28
A RAPIDLY ENLARGING PELVIC MASS: A CASE REPORT
HM Ryan1, DT Murphy2, B Boyd1,3, LP Lawler2, B Gaughan3

Abstract No. 29
A STUDY COMPARING THE USE OF PIPELLE VS. ENDO Sampler DEVICES IN SAMPLING THE ENDO METRIUM OF WOMEN PRESENTING TO HYSTEROSCOPY CLINIC.
Sarkar. S, Asif. S, Dixit. S, Deshpande, R.
Abstract No. 30
AUDIT OF INTRAUTERINE GROWTH RETARDED BABIES AND CURRENT MANAGEMENT STRATEGIES.
Dr Madhu Sunghal, Dr Elaine Craig, Mr David Sim

Abstract No. 32
PRENATAL FINDINGS OF AN ENLARGING FETAL UPPER ABDOMINAL MASS IN THE THIRD TRIMESTER - CASE REPORT
Akram M, Ravikumar N, Azam M, Dunne, K, Morrison JJ.

Abstract No. 34
CAN BIOELECTRICAL IMPEDANCE ANALYSIS (BIA) OF MATERNAL BODY COMPOSITION PREDICT THE OUTCOME OF LABOUR?

Abstract No. 35
IMPACT OF VIRAL INFECTION AND SUBSTANCE ABUSE IN PREGNANCY ON PERINATAL OUTCOME
Foyeke Olatunbosun, Valerie Jackson, John Lambert, Marian Brennan, Mary Cafferkey, Michael Geary, Fergal D. Malone, Sam Coulter-Smith

Abstract No. 36
UNUSUAL PRESENTATIONS OF CERVICAL NEOPLASM
Chummun K., Moses Abe*, Bill Boyd

Abstract No. 38
TO REVIEW PRACTICE IN THE MANAGEMENT OF RHESUS D-NEGATIVE WOMEN DURING PREGNANCY
Nisha Kadwadkar, Jenny Lo

Abstract No. 39
SEROUS CARCINOGENESIS IN THE DISTAL FALLOPIAN TUBE – IS PREVIOUS HYSTERECTOMY FOR BENIGN DISEASE A PROTECTIVE FACTOR?
Helen Ryan, Donal Brennan, William Boyd, Michael Foley and Colm O’Herlihy

Abstract No. 40
TWIN REVERSE ARTERIAL PERFUSION SEQUENCE
Deidra Lim, Nidita Luckheenarain, Ulrich Bartels

Abstract No. 41
CERVICAL CANCER IN PREGNANCY: RESULTS OF A MULTICENTER PROSPECTIVE IRISH STUDY
Helen Ryan, Michael Foley, Grainne Flannelly, William Boyd

Abstract No. 43
VENOUS THROMBOEMBOLISM: A CASE PRESENTATION
Anjola O, Das A, Byrne B, O’Donnell J Murphy C, Gardeil F, Dunn E.

Abstract No. 45
WHERE DO WE STAND IN THE DELIVERY OF TWINS?
J Hogan, N Farah, B Stuart, S Daly.

Abstract No. 46
GASTROSCHISIS
K Flood, M Barrett, E Kent, C Kinsella, A Foran, F Malone

Abstract No. 47
SHOULD THE KIELLAND’S FORCEPS COME OUT FROM OUR CUPBOARDS?
Ugwu VC, Alhusain HA, Osasere M, Taiwo A, Yuddandi NV, Hayes T
Abstract No. 48
**ECSSIT – ELECTIVE CAESAREAN SECTION SYNTOCINON® INFUSION TRIAL: THE FIRST 100 PATIENTS**
Sheehan SR, Carey M, Murphy DJ

Abstract No. 51
**ECTOPIC PREGNANCY MANAGEMENT – WOMEN’S SATISFACTION SURVEY**
M Osasere, F Elmubarack, C Ugwu, H Al Husain, NV Yuddandi, P Wogan, R O’Sulllcan, T Hayes, H Bourke

Abstract No. 52
**PRIMARY OMENTAL ECTOPIC PREGNANCY - A CASE REPORT**
M Osasere, S Farooq, NV Yuddandi, R O’Sullivan

Abstract No. 53
**AN AUDIT OF UTERINE ARTERY EMBOLIZATIONS FOR SYMPTOMATIC UTERINE LEIOMYOMAS**
S Gejdel-Koltuniewicz, AS Khalid, G Burke, P O’Brien

Abstract No. 54
**IMPROVING THE CLINICAL MANAGEMENT OF WOMEN WITH SEVERE PRE-ECLAMPSIA**
Hill A, Walsh CE, Byrne B.

Abstract No. 55
**A COHORT OF REACTIVE THROMBOCYTOSIS IN PREGNANCY**
AS Khalid, VV Wong, S Gejdel-Koltuniewicz, G Burke.

Abstract No. 56
**EVALUATION OF MMP-9 INHIBITOR AND CISPLATIN CYTOTOXICITY IN A CHEMORESISTANT OVARIAN CANCER CELL LINE USING HIGH CONTENT SCREENING (HCS) CELL-BASED ASSAYS**

Abstract No. 58
**HYPEROSMOLAR NON-KETOTIC COMA: A RARE LIFE-THREATENING METABOLIC EMERGENCY IN A PREGNANT PATIENT WITH PREVIOUSLY UNDIAGNOSED DIABETES AND PRE-ECLAMPSIA**
Daly N, Murphy C, Foley M

Abstract No. 60
**MOLAR PREGNANCY IN A 54 YEARS OLD PERIMENOPAUSAL WOMAN: A CASE REPORT**
S N Johnson, A Curtain.

Abstract No. 61
**THE NEED TO TARGET THE 20 WEEK ANOMALY SCAN**
Ismail SK, Wong VV, Gejdel S, Ismail KI, Slevin J, Burke G

Abstract No. 62
**SPONTANEOUS RUPTURE OF THE UNSCARRED UTERUS**
P Ajith, M Gannon

Abstract No. 63
**UNUSUAL VAGINAL SITE RECURRENCE IN OVARIAN CANCER- TWO CASE REPORTS**
G Visvalingam, N Farah, H Butt, N Gleeson

Abstract No. 64
**A CLUSTER OF HETEROTOPIC PREGNANCY IN SPONTANEOUS AND LOW RISK CONCEPTION: CASE REPORTS**
Alabi OY., Ajeigbo O, Fadare KM, Yekinni IO, Hughes P
Abstract No. 65
FEMALE GENITAL MUTILATION.CASE STUDY
Hala Abu-Subeih

Abstract No. 66
WOUND INFECTION AFTER CAESAREAN SECTION: A PILOT STUDY
Khalifeh A, Meenan AM, Hannify R, O’sullivan N, Fitzpatrick C and Turner MJ.

Abstract No. 67
OVARIAN MYOFIBROBLASTIC TUMOUR FISTULATING ON TO THE ANTERIOR ABDOMINAL WALL
G Khan, P Byrne, M leader, B Png, J.P Garvey.

Abstract No. 68
MRSA SEPTICAEMIA AFTER FAILED UTERINE ARTERY EMBOLIZATION IN A PATIENT WITH UNDERLYING LEIOMYOSACOMA
M Akram, AWI Edoo, B. Gill, H Langan

Abstract No. 70
CAESAREAN SECTION RATE VS MATERNAL BODY MASS INDEX (BMI)
Broderick V, Broderick S, Farah N, Stuart B, Turner M J

Abstract No. 71
FETAL MACROSOMIA VS MATERNAL BODY MASS INDEX (BMI)
Broderick V, Broderick S, Farah N, Stuart B, Turner M J

Abstract No. 73
SYPHILIS: A REVIEW OF MANAGEMENT & OUTCOME IN A TERTIARY REFERRAL UNIT
M. Ramphul, O. Phelan, M. O’Connell.

Abstract No. 74
MATERNAL MORBID OBESITY AND PREGNANCY OUTCOMES
Maher N, Farah N, Fattah C, Broderick V, Stuart B, Turner MJ.

Abstract No. 75
MANAGEMENT OF DYSGERMINOMA IN A 24 YEAR OLD WOMAN
D Hayes-Ryan, M McMenamin, F Cullinane

Abstract No. 76
ENDOMETRIAL CURRETTINGS: CORRELATION BETWEEN VISUAL AND HISTOLOGICAL IMPRESSIONS
Dunne E, Moses Abe, Bill Boyd

Abstract No. 77
SUCCESSFUL PREGNANCY FOLLOWING CONSERVATIVE SURGERY FOR STAGE 1C OVARIAN CANCER IN A 36 YEAR OLD WOMAN: A CASE REPORT
F Martyn, R O’Connor

Abstract No. 78
REVIEW OF CASES OF CLINICALLY SUSPECTED MALIGNENCY
Singh S., Gleeson N.

Abstract No. 79
TWO PLACENTAS, ONE BABY: A CASE OF BI-LOBATED PLACENTA
Alabi OY, Varughese A, Harkin R
Abstract No. 80
**NEUROFIBROMATOSIS PRESENTING AS A PELVIC MASS TO GYNAECOLOGY**
Alabi OY, Freyne A, Akpan ES, Hanson J, Ryan J

Abstract No. 82
**THE IMPACT OF ANHYDRAMNIOS AT TERM ON MATERNAL AND FETAL MORBIDITY AND MORTALITY**
G Visvalingam, N Purandare, S Cooley, R Roopnarinesingh, M Geary

Abstract No. 83
**ENDOMETROID ADENOCARCINOMA IN A KNOWN CASE OF ENDOMETRIOSIS**
Nikhil Purandare, Kara Purcell, Fathi Ramly, Andrew Curtain, Mr Morgan McCourt

Abstract No. 84
**OBSTETRIC FACTORS AND TRENDS THEREOF FOR WOMEN ≥ 40 YEARS**
Gupta S, Ravikumar N, Hession M, Morrison JJ.

Abstract No. 87
**PERINATAL MORTALITY AT THE ROTUNDA HOSPITAL, A 5 YEAR REVIEW.**
McVey RM, Murray A, Geary M.

Abstract No. 88
**A CASE REPORT OF SQUAMOUS CELL CARCINOMA OF THE NEOVAGINA FOLLOWING AMNION VAGINOPLASTY IN MAYER–ROKITANSKY–KUSTER–HAUSER SYNDROME**
P Sibartie, B Png, K Astbury, V Broderick, A Wong, A Laios, N Gleeson, P Crowley

Abstract No. 89
**SUSPECTED URINARY TRACT INFECTION IN PREGNANCY-A CAUSE OF UNNECESSARY HOSPITAL ADMISSIONS?**
Kennelly M, Singh S, Crowley P

Abstract No. 90
**EVALUATION OF ANTENATAL ULTRASOUND MARKERS IN PREDICTING CHORIONICITY**
T Hassan, A Freyne, G Visvalingam, S Higgins

Abstract No. 91
**A CASE REPORT OF LATE RECURRENCE OF GRANULOSA CELL TUMOUR OF THE OVARY**
B Png, K Astbury, A Wong, V Broderick, A Laios, N Gleeson

Abstract No. 92
**CLINICAL RISK MANAGEMENT OF OBSTETRIC ANAL SPHINCTER INJURY. HAVE WE IMPROVED?**
Burke NM, Corcoran S, Ryan H, Barrett N, Afaneh I, Geary MP

Abstract No. 93
**AUDIT OF SHOULDER DYSTOCIA- THE ROTUNDA 2008**
S Corcoran, N Burke, N Barrett, H Ryan, I Afaneh, M Geary

Abstract No. 94
**A CASE OF INDIRECT MATERNAL DEATH AT UNIVERSITY COLLEGE HOSPITAL GALWAY**
S Mullers, G Gaffney, H Langan, JJ Morrison

Abstract No. 95
**OUT PATIENT HYSTEROSCOPY – WE NEED TO BROADEN OUR SCOPE**
Barrett N.A., Mc Millan H.M., Fitzpatrick C
Abstract No. 96
EARLY ONSET PRE-ECLAMPSIA REQUIRING PREGNANCY TERMINATION – A REPORT OF 2 CASES
Deane RP, Unterscheider J, Gaffney G, Morrison JJ

Abstract No. 97
PREGNANCY RELATED HEPATIC RUPTURE
M. Kamath, B. Smyth, D. Sim.

Abstract No. 98
PROLONGED AMENORRHEA FOLLOWING EVACUATION OF PRODUCTS OF CONCEPTION: A CASE REPORT
Zara Fonseca-Kelly, Maeve Eogan

Abstract No. 99
RUPTURED UTERUS IN THE SECOND TRIMESTER OF A NULLIPAROUS PATIENT
Butler MM, O’Brien DJ, O’Connor H

Abstract No. 100
SUCCESSFUL OUTCOME OF PREGNANCY WITH SEVERE HYPERTRIGLYCERIDEMIA: A CASE REPORT
RK Sarkar, C Vaughan, K O'Donoghue, LC Kenny

Abstract No. 101
DOES THE LUNAR EFFECT ALTER BIRTH RATE?
K. Purcell, A. Arya, J.R. Higgins, R.A. Greene

Abstract No. 102
NATURAL HISTORY OF ANENCEPHALY
N. Obeidi, N. Russell, JR Higgins, K. O’Donoghue

Abstract No. 103
AN INDUCTION OF LABOUR AUDIT
Dr WPV Ooi, C Everard, Dr D Buckley, Dr M Hewitt

Abstract No. 104
CONTROL OF HYPOTHYROIDISM IN PREGNANCY...IT’S ALL ABOUT THE FIRST TRIMESTER
J Walsh, M Foley

Abstract No. 105
ENDOMETRIAL ADENOCARCINOMA IN THIN POSTMENOPAUSAL WOMEN IN ASSOCIATION WITH RARE BRENNER TUMOURS .... A REPORT ON TWO CASES.
J Walsh, C O’Herlihy

Abstract No. 106
IS THERE ANY ROLE OF CHEST X RAY IN PREGNANCY
B. Akbar, M. O’Leary, M. Geary

Abstract No. 107
SURVIVING LIVER RUPTURE IN EARLY PREGNANCY
K Field, J Walsh, A Curtain, K O’Donoghue

Abstract No. 108
LIVER DYSFUNCTION IN PREGNANCY – A RETROSPECTIVE REVIEW OF 29 CASES
Al Husain HA, Farooq S, Osasere M, Ugwu VC, Taiwo A, Bourke H, Yuddandi V, O’ Sullivan R, Hayes T.
Abstract No. 109
PERSISTENT TROPHOBLASTIC DISEASE
ALI GAWISH

Abstract No. 111
THE AIM OF THIS STUDY IS TO EXAMINE THE OBSTETRIC RISK FACTORS ASSOCIATED WITH MATERNAL REHOSPITALIZATION FOLLOWING CHILDBIRTH
Tunijitola Ade-Conde

Abstract No. 113
PERRY ROMBERG SYNDROME

Abstract No. 114
TRUE KNOTS: KILKENNY’S PERSPECTIVE
Al Husain HA, Osasere M, Taiwo A, Ugwu VC, Yuddandi V, Hayes T, Bourke H, O’ Sullivan R.
Abstract No. 1

SUCCESSFUL PREGNANCY AFTER ENDOMETRIAL ABLATION-CASE REPORT

N T YUSUF, J MONAGHAN
Portiuncula Hospital, Ballinasloe, Co. Galway

Pregnancy after endometrial ablation is not common but few have been reported. It is associated with increase morbidity and mortality.

Ours is a case of successful outcome without complication.

A 38 year old gravida 4 para 3 lady booked at 24 weeks gestation in Portiuncula in March 2008. It is an unplanned pregnancy. She had 3 previous spontaneous vagina deliveries at term. Her last delivery was complicated with secondary PPH due to retained products and had ERPC done at which uterus was perforated.

She had thermal balloon endometrial ablation in 2006 for menorrhagia which was effective. She booked with us 2 years after with unplanned pregnancy. The Pregnancy was uneventful till 36 weeks when she came in with SROM and Breech presentation. She had a caesarean section the following morning and was uneventful.

Conclusion
Incidence of pregnancy after endometrial ablation is less than 0.7% and successful outcome is much rarer. However, with 2nd generation techniques of endometrial ablation, we might as well see more of this outcome in reproductive age group women. The need for effective contraception cannot therefore be overemphasised.

Abstract No. 2

STUDY OF AVERAGE GESTATIONAL AGE AT BOOKING IN PHB

N T Yusuf
Department of Obstetrics & Gynaecology, Portiuncula Hospital, Ballinasloe

Study to assess the average gestational age at a booking clinic and interval time between GP referral and attendance

Prospective study to estimate the gestational age at booking
All women that attended public booking clinic in PHB from 01/02/08 to 30/04/08 have estimated gestational age by ultra sound. Date on referral letter from GP used to calculate the interval of the visit to GP and booking.

The CEMACH report 2007(2003-2005) concluded that late booking increased maternal morbidity and mortality. It recommended that each obstetric unit should assess % of women booking by 12 week as of April 08 and target 80% by December 2009. A total of 306 pregnant public patients were included. One hundred and four women (34%) were 12wks or less, 155 (50%) women were booked between 13-17 weeks, 24 (8%) between 18-22 weeks and 23 (8%) were over 22 weeks. 67 women (22%) visited their GP beyond 12 weeks, 37 (55%) of them were seen within 2 weeks of referral, the rest (45%) were seen after more than 2 weeks. The Average interval between GP visit and booking visit was 4.5 weeks for all women.

There is a need for improved liaison with GPs to increase early booking and attain the target of 80% by Dec. 2009. Women more than 12wks pregnant should have the priority for urgent appointment.
Abstract No. 3

LISTERIA AWARENESS AMONGST RECENTLY DELIVERED MOTHERS

LFA Wong, K Ismail, U Fahy
Limerick Maternity Hospital, Ennis Road, Limerick

Listeriosis is a rare disease caused by ingestion of infected food. Pregnant women have increased susceptibility to infection with listeria, which can have serious consequences for the baby such as intrauterine fetal death and neonatal sepsis. Our aim is to evaluate the level of knowledge of recently delivered mothers regarding listeria infection and its potential prevention.

This is a prospective questionnaire study of recently delivered mothers in the postnatal ward.

Six hundred and twenty nine questionnaires were administered with a response rate of 98%. Participants were aged between 15 and 45 years. 43.9% (271/617) of mothers had heard about listeria infection but only 64.9% (176/271) knew that it was a food borne pathogen. 83 (13.5%) participants recalled being told about listeria infection by a midwife or doctor and 33 (5.3%) recalled receiving written information. 36.3 % (224/617) of mothers were aware of the increased risk of listeriosis during pregnancy while 40.5 % (250/617) knew the potential complications to the unborn fetus. 81.8 % (505/617) of mothers knew that they should avoid certain high risk foods during pregnancy but 55.4 % (342/617) admitted to having consumed high risk foods during their pregnancy.

In conclusion, we note that mother’s knowledge about listeriosis and its prevention was limited. Many mothers ate high risk food during pregnancy. Antenatal advice regarding listeria prevention needs to be improved.

Abstract No 4

CLINICAL AUDIT TO EVALUATE THE OUTCOME OF INSTRUMENTAL DELIVERIES IN OLOL

By Dr S.Hiremath, Dr T.Hassan, Dr S.Higgins
Obs &gynae Department, Our Lady of Lourdes Hospital, Drogheda.

Methods: The study was undertaken from January -July 2008.
Primary outcome measures:
• Primary instrument used for instrumental deliveries.
• To evaluate the success rate of the instrument.
• Analyze the outcome following the failed delivery involving primary instrument.
Maternal and fetal complications.

Results:
2235 women delivered of which 396 women [18%] were instrumental deliveries. 317 [80%] were vacuum and 79 [20%] were forceps deliveries as the primary instrument. Kiwi cup was the primary instrument in 274 women [86%]. and Metal/silastic cups in 43 women [14%]. The success rate of kiwi was [225 women] 82%, Metal/Silastic cups were successful in 40 women [93%]. Forceps had highest success rate of 98% [77 women].
The vacuum group has a low 3\textsuperscript{rd}/4\textsuperscript{th} degree tears [<1\%] in comparison with forceps group with 6\% of 3\textsuperscript{rd}/4\textsuperscript{th} degree tears. There was no significant reduction if tears in women with episiotomy. Vacuum group had PPH in 13\% [42 women] compared to 17 women [22\%] in forceps group. There was no marked difference in the neonatal morbidity between the vacuum and forceps group when apgar at 5 minutes and admission to NICU were analyzed as the outcome measures.

**Conclusion:**
Our audit shows kiwi omni cup as the most commonly used instrument for assisted vaginal delivery. It has success rate of 82\% and a failure rate of 18\%. It also has a very low 3\textsuperscript{rd} and 4\textsuperscript{th} degree tear rate of <1\% all comparable with the gold standards.

### Abstract No. 5

**A REVIEW OF UTERINE RUPTURE IN THE ROTUNDA HOSPITAL FROM 2001 TO 2007**

*Dr Abutu N C, Dr Purandare N, Dr Ogunlewe F, Dr Geary M*

**Background:**
Uterine rupture though uncommon is associated with serious feto-maternal morbidity and mortality. Therefore, there is need for a periodic review of these cases in our hospitals.

**Aim:**
To determine the incidence of uterine rupture; the interval of rupture from last uterine surgery or scar (caesarean section or myomectomy) and ascertain cases associated with use of oxytocin and prostaglandins.

**Method:**
A retrospective study of uterine rupture from 2001 to 2007. Data were collected from case records over this period and analysed.

**Result:**
table to be presented.
- 11 Cases were identified: 10 multiparous and 1 primiparous. Oxytocin was used in 7 cases of whom 6 were multiparous and 1 primiparous. Misoprostol was used in 1 case of IUD in a multiparous.
- Incidence of Uterine rupture for the period: 11/49484 Deliveries = 0.022\%.
- Age range: 19 to 35 years
- 8 cases (72.7\%) associated with oxytocic use
- 9 (81.8\%) cases were associated with previous c/s scar. In 2 cases, there was no history of previous
uterine perforation or surgery.

- Interval of rupture from previous c/s scar ranges from 1 to 5 years.

**Conclusion:**
The incidence of uterine rupture was consistent with the literature (0.05%). Though previous uterine scar appeared to be the main factor associated with rupture, interval from last surgery could not be demonstrated as an independent risk factor. Most cases were associated with oxytocic use.

**Abstract No. 6**

**PLACENTAL HISTOLOGY TO DETERMINE CHORIONICITY: HOW ACCURATE IS IT?**

J Hogan, N Farah, Z Galvin, A Radomski, J O’Leary, B Stuart, S Daly
Coombe Women and Infants University Hospital, Dublin.

The placenta from twin pregnancies is routinely sent for histopathology in some institutions. Pathological assessment to determine chorionicity is considered by many to be the gold standard. We sought to investigate if this is actually the case.

A retrospective analysis of our hospital’s database of all twins (delivered at or after 24 weeks gestation or weighing equal to or greater than 500g) from July 1999 to July 2007 was undertaken. The sex of the infants, the placental pathology and the ultrasound reports were reviewed.

Using the above criteria, there were 972 twin pairs. Of these, 806 pairs had the placenta sent for histological examination (82.9%). Table 1 displays the classification of chorionicity by pathology. There were 198 classified as monochorionic but 16 of these had different sex infants. This means that 8% had been wrongly classified as monochorionic when they were in fact dichorionic twins. In 12 of these cases, ultrasound concurred with the fetal sex and these twin pairs had been classified as dichorionic during their pregnancy.

Our study suggests that the placental pathological assessment of chorionicity is accurate in most but not all cases. If these results are replicated in other institutions, radiological plus histological determination of chorionicity may become the gold standard in the future.

**Table 1. Chorionicity of twin pairs determined at histological assessment of placenta**

<table>
<thead>
<tr>
<th>Chorionicity</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dichorionic</td>
<td>583</td>
</tr>
<tr>
<td>Monochorionic</td>
<td>198</td>
</tr>
<tr>
<td>Unknown</td>
<td>25</td>
</tr>
</tbody>
</table>

**Abstract No. 7**

**WHERE IS THE PLACENTA LOCATED AFTER ONE PRIOR CAESAREAN SECTION?**

J Hogan, N Farah, B Stuart, MJ Turner
UCD School of Medicine and Medical Science, Coombe Women and Infants University Hospital, Dublin.

A prior lower segment caesarean section has been reported as a risk factor for placenta praevia. Women with a
prior caesarean section are more likely to require repeat caesarean section and abnormal placental localisation makes it technically more challenging. To our knowledge, there are no studies reported which identify the placental site in women with one prior caesarean section.

We reviewed women with one prior caesarean section who delivered over a four month period and who had the placenta localised during a formal ultrasound in the second or third trimester. The smoking history, previous uterine curettage and parity were also recorded.

Of 262 patients delivered with one prior caesarean section, 170 had a departmental ultrasound. Three patients had placenta praevia and there was no case of placenta accreta. Table 1 shows the placental site distribution. We found no association between placental site and either parity or previous uterine curettage. The three patients with abnormal placental sites all had a smoking history but the numbers are too small to be conclusive.

Previous ultrasound studies have focused solely on abnormal placentation. Our study highlights that while the incidence of placenta praevia after caesarean section is low (1.8 %), it is advantageous for the obstetrician to know the site of the placenta preoperatively to plan the uterine incision.

Table 1. Placental localisation on antenatal ultrasound

<table>
<thead>
<tr>
<th>Placental site</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placenta praevia</td>
<td>3</td>
<td>(1.8)</td>
</tr>
<tr>
<td>Upper segment anterior</td>
<td>75</td>
<td>(44.0)</td>
</tr>
<tr>
<td>Upper segment posterior</td>
<td>65</td>
<td>(38.2)</td>
</tr>
<tr>
<td>Upper segment lateral</td>
<td>18</td>
<td>(10.6)</td>
</tr>
<tr>
<td>Fundal</td>
<td>9</td>
<td>(5.3)</td>
</tr>
</tbody>
</table>

Abstract No. 8

AUDIT OF THE PREVENTION AND TREATMENT OF OSTEOPOROSIS IN MENOPAUSAL WOMEN OR THOSE WHO HAD HYSTERECTOMY

In 1994 WHO defined Osteoporosis based on low BMD with reference to the number of SDs from the BMD in an average 25 year old woman ( T score)

Aim:
To ensure all patients at risk from osteoporosis are identified, managed properly, advised regarding appropriate measures and receive optimal treatment.

Audible standard:
The Clinical Resource Efficiency Support Team (CREST) issued guidance in 2001 regarding the prevention and treatment of Osteoporosis

Methodology:
Retrospective Audit
51 patients from menopausal clinic from January 07 to April 07.
Patients at high risk of osteoporosis were identified. Risk factors included hysterectomy and not on HRT, radiograph evidence of osteopenia, hyperthyroidism, patients on long term steroids, low BMI < 19, early menopause age < 45 yrs (also includes 45 yr old women in this group) and family history

Result:
28 patients were at high risk. Among these, only 78% had a discussion about osteoporosis. Lifestyle advice was
given to 50% of patients. DEXA scan was done for 57% of these patients: 5 patients had osteopenia; 3 patients had osteoporosis; 82% of patients were on HRT.
In low risk group 23 pt, 22 % had discussion about osteoporosis, 22 % had DEXA scan, all were normal.

**Recommendation:**
Benefits of HRT and change of lifestyle should be discussed with women in high risk group. DEXA scan should be offered to all high risk patients. Those who had osteopenia or osteoporosis should have appropriate treatment.

**Abstract No 9**

ASYMPTOMATIC RECURRENCES OF ENDOMETRIAL CARCINOMA FOLLOWING PRIMARY THERAPY IN SOUTH INFIRMARY VICTORIA UNIVERSITY HOSPITAL (SIVUH) CORK

PV Ooi, S Ali, A Curtain, J Coulter
Gynaecology Department, South Infirmary Victoria University Hospital, Cork

Current recommendations for follow up of patients with endometrial carcinoma following potentially curative primary treatment advocate these patients to be routinely monitored 3 monthly for the first 2 years, then 6 monthly until the fifth year and annually after that. However, several retrospective studies indicate no significant survival advantage for those patients with asymptomatic recurrence detected at regular follow up. This audit examines the asymptomatic recurrence rates of endometrial carcinoma following primary therapy in SIVUH and evaluates the benefits of the intensive follow up protocol practiced.

A retrospective chart review of 77 patients diagnosed with endometrial carcinoma from 2003 to 2007 was performed to look at disease stages, identify recurrences as well as to analyze presentation, method of diagnosis, treatment and subsequent outcome of patients with recurrent disease.

Ninety one percent of women treated are clinically disease free after primary therapy. Nine percent (7 patients) developed recurrent disease, only 1 of which was asymptomatic, diagnosed at routine vault smear. Following primary therapy, 86% of recurrent disease occurred within 2 years and 1 symptomatic recurrence was diagnosed at 6 years. Eighty percent of symptomatic recurrences presented with vaginal bleeding or discharge. The vaginal vault was the only site of recurrence in 86% of women.

An appropriate strategy for follow up of patients with endometrial carcinoma following potentially curative initial treatment should be based on the risk of recurrence. There remains a need for a prospective randomized trial to determine the optimum follow up for women with endometrial carcinoma after primary therapy.

**Abstract No. 10**

ONCE A PRIMIP ALWAYS A PRIMIP

Vicky Gleeson

**Aim**
To look at women who had 10 years or more between their first and second pregnancies, in the coombe women and infants university hospital

**Method**
165 women over a 5 year period were delivered of their second baby 10 years or more after the birth of their 1st child in the coombe women and infants university hospital. Mode of delivery for both pregnancies was recorded. With regard to the 2nd pregnancy age, gestation at delivery and progress in the first and second stages of labour was recorded. Induction of labour augmentation with syntocinon and epidural analgesia was noted. For those women who had a caesarean section for their 2nd delivery the indication was highlighted. Lastly the rate of caesarean section was divided classified by maternal age.
**Results**

The caesarean section rate for 2nd pregnancy was 25% and the induction rate was 24.8%. 25 women were induced with prostaglandin, 26 with syntocinon, 37 were augmented with syntocinon and the epidural rate was 18%. The main indication for caesarean section was fetal distress followed by breech presentation. The majority of women delivered at term, with 45 women delivering at 41 weeks or more. Most women had a 1st stage of labour of less than 5 hours and a 2nd stage of less than 1 hour. Caesarean section rate increased with increasing maternal age.

**Conclusion**

The rate of induction and caesarean section was similar to rates seen in primiparous women. Gestation at delivery and the indication for caesarean section was also similar to primparous women. Progress in labour was as expected for multiparous women.

**Abstract No. 11**

**THE PREVALENCE OF HEPATITIS B IN PREGNANT WOMEN ATTENDING THE ROTUNDA HOSPITAL 2006-2007**

O. Ogunlewe, S. Coulter-Smith, M. Cafferkey, V. Jackson, M. Brennan, B. Kelleher, K.B Grundy, J.S. Lambert
The Rotunda Hospital, Parnell Square, Dublin 1
The Rainbow Clinic, The Children's University Hospital, Temple Street, Dublin 1
Ireland
The Catherine McAuley Research Centre, Mater Misericordiae University Hospital, Nelson Street. Dublin 7
University College Dublin, Dublin

Vertical transmission of Hepatitis B virus (HBV) isa leading cause of chronic infection and depends largely on maternal infectivity status. The aim of this study is to examine the seroprevalence of hepatitis B surface antigen (HbsAg) and other serological markers of HBV infection in women attending the Rotunda Maternity hospital in 2006 and 2007.

Data on all HBsAg positive women between 1st January 2006 to 31st December 2007 was retrospectively gathered from the hospital's patient administration system (PAS) and patient charts. Data collected included demographic, antenatal registration, laboratory, medical history and delivery data. Data was analysed using SPSS v15.0

During the review period 17,749 women booked for antenatal care at the Rotunda hospital, of these 166 (0.94%) were positive for HbsAg; 24(14.5%) women were also positive for HBeAg. 41% of women were newly diagnosed at antenatal screening. Subsequent screening of partners where applicable, allowed further identification of both acute and chronically infected individuals and vaccination of those at risk. 91.6% of HBV positive women were from countries of high prevalence including China (27%), Nigeria (17.5%) and Romania (12%) The incidence of Hepatitis B in Ireland has increased in recent years, largely due to immigration from countries of high prevalence. As many chronic casea are asymptomatic, detection of these cases relies mainly on opportunistic testing. HBV antenatal screening, while essential for identifying infected women and reducing the risk of vertical transmission, allows prevention and treatment for other affected and infected contacts.

**Abstract No. 12**

**A CASE REPORT OF SWYER’S SYNDROME**

Dr. Ishrat Shafi, Dr. DJD Corcoran
Mayo General Hospital, Castlebar

J.P, 24 yrs old, single, nullipara referred to GOPD on 17.12.07 with history of oligomenorrhoea since menarche. .She had her menarche at 15 yrs. Examination revealed a tall girl. Breasts showed immature development. Prominent clitoris on genital examination. Small vagina, small cervix & tiny uterus. Adnaxae NAD. .Blood for hormone profile was taken & she was booked for pelvic USS.Blood report showed high FSH & LH at menopausal level, FSH=89.7 iu/l
& LH=31.8 iu/l. Blood for chromosomal analysis was taken. Report showed 46XY karyotype. Blood sent for repeat karyotype on Lab request. Pelvic ultra sound scan reported-tiny uterus 11x 19 x49mm size. Ovaries not visualized on scan. Repeat Chromosomal report confirmed 46XY & gene SRY on Y chromosome. Patient referred to tertiary centre for further management.

**DISCUSSION**

Swyer’s syndrome is a condition known as gonadal dysgenesis & occurs in a fetus during the first few wks of pregnancy. Girls with Swyer’s syndrome have XY chromosomes. In Swyer’s syndrome the Y chromosome & the gonads do not function in the usual way & uterus, vagina, clitoris & labia develop. The gonads are present as small streaks near the uterus. Usually it is diagnosed when there is amenorrhea or oligomenorrhea. Patients with Swyer’s syndrome have little or no breast development very small uterus present & 46 XY karyotype. Women with Swyer’s syndrome can get pregnant by embryo transplantation in the uterus & then to support pregnancy with hormones. Management is by surgery to remove streak gonads & treatment with hormone replacement therapy.

**Abstract No. 13**

**OUTCOME OF WOMEN WITH THREATENED EARLY PREGNANCY LOSS WITH INCONCLUSIVE SCANS ON THE 1ST VISIT AT EPAU (Early Pregnancy Assessment Unit).**

Dixit. S, Sarkar. S, Asif. S.
Department of Obstetrics and Gynaecology, Derby City General Hospital, Derby.

Moore. J
Department of Obstetrics and Gynaecology, Nottingham City Hospital, Nottingham.

This study looked at the outcome of women attending EPAU at Nottingham City Hospital with symptoms of abdominal pain and/or vaginal bleeding in 1st trimester, who have ultrasound scans which are inconclusive either for location of pregnancy or viability.

This retrospective study included 300 consecutive cases attending EPAU in 1st trimester with early pregnancy concerns during a four months period. All women attending for reassurance scans were excluded. Thirty four women were found to have inconclusive scans and were followed up 7-10 days later as per protocol with a repeat scan and/or B-hcg or urine pregnancy test.

Out of 266 conclusive scans 88% were viable pregnancy, 8% had nonviable pregnancy, 2.5% had complete miscarriage and 1.5% had ectopic. The breakdown of outcome of inconclusive scan (34) is detailed below:

![Bar chart](chart.png)

**IUP (13) - Intrauterine pregnancy. E. Ut (17) - Empty uterus. SA (4) – Sonoluscent area.**
Green-top guidelines for diagnosing failing intrauterine pregnancy were followed in 100% of cases. Viability was inconclusive in 13(4%) of the cases and location was uncertain in 21(7%) at 1st visit. This is comparable to standards set by RCOG, of 10% and 8-31% respectively, for viability and pregnancy of unknown location (PUL) ¹. None of the ectopics were missed. Resolving trophoblast was diagnosed in 5 cases on 2nd follow-up, but only 1 case was further followed up till B-hcg levels of <25miu/ml. Remaining cases should have had a similar follow up. Serum Progesterone could have been utilized in diagnosing resolving trophoblast more conclusively.

Ref: 1. The management of early pregnancy loss; RCOG Green-top guideline no. 25, October 2006.

**Abstract No. 14**

**AUDIT OF CAESAREAN SECTION IN THE SECOND STAGE OF LABOUR**

I Abdelrahim and F Cullinane, University Hospital Galway

CS performed during the second stage of labour is associated with increased maternal & neonatal morbidity and mortality compared to CS performed during the first stage of labour (¹).

The aims of this clinical audit were to determine (a) CS rate during the second stage of labour (b) the indications and(c) the rate of maternal and fetal morbidity. The hospital numbers of women who were delivered by CS during the second stage of labour at University Hospital Galway (UHG) from 1st January 2006 until 31st December 2007 were identified from the hospital database, their medical records were reviewed retrospectively and demographic and outcomes data collected.

1763 women were delivered by CS during the study period (26.7%), 69 of which (1.1%) were performed during the second stage. 53 women (77%) were primigravidae. 38 women (55%) went into spontaneous labour. 36 women (52.2%) were delivered by CS without an attempt at an instrumental delivery. 20 of the unsuccessful trials (60.6%) were attempted in theatre. Forceps were used in 9 trials. A metal cup was used in 21 trials. Two instruments were used in 3 trials. Regional anaesthesia was used in 66 (96%) cases. The arterial pH was < 7.20 in 10/53 cases. The time interval between decision to perform a CS and delivery of the baby was < 30 minutes in 51 cases (74%). 21 women (30%) had a PPH but non required blood transfusion.

Second stage CS was not associated with major maternal or neonatal morbidity but the numbers studied were small.


**Abstract No. 15**

**MEDICAL MANAGEMENT OF ECTOPIC PREGNANCY IN OUR LADY OF LOURDES HOSPITAL, DROGHEDA**

Hamada Abdoun, S. Higgins, Department of Obstetric & Gynaecology, (OLOL), Drogheda, Co.Louth

A review of the efficacy of introducing medical treatment of ectopic pregnancy to suitable patients, in reducing surgical intervention and hospital stay, between the period January 2006- September 2008, where no medical treatment was used before.

Early Pregnancy Assessment Unit (EPAU), in the hospital.

All patients attending the EPAU with suspected ectopic pregnancy.

Reviewing the eligibility for medical treatment.

18 cases of ectopic pregnancy out of 164 cases were found to be suitable for medical treatment with Methotrexate.
in a single dose of 70-100mg (IM).

All the 18 cases were treated with single dose of Methotrexate. Two of them needed a second dose while a third needed surgical intervention.

Medical treatment for suitable women reduces surgical intervention and hospital stay.

**Abstract No. 16**

**FETAL SUPRAVENTRICULAR TACHYCARDIA (SVT): A CASE SERIES & LITERATURE REVIEW**

Hamada Abdoun, M Milner, S. Higgins , Department of Obstetric & Gynaecology, Our Lady of Lourdes Hospital, Drogheda, C.O. Louth.

To review the management & outcome of foetal supraventricular tachycardia (SVT) over 3 cases at Our Lady of Lourdes Hospital, Drogheda in 2007( case serie).

In this case series we had three cases of fetal tachycardia diagnosed and treated in a multidisciplinary teams involving the obstetric, paediatric teams in our lady of Lourdes Hospital, Drogheda, together with consultation and cooperation of the Crumlin Hospital in Dublin.

A fetal tachycardia was defined as a heart rate of 160-200 bts/min. Baby A was diagnosed parentally when ultrasound detected hydrops and fetal tachycardia (SVT) at 32 weeks. Immediate maternal antiarrythmic therapy was started (flecainide), the hydrops resolved, & the baby converted to sinus rhythm. Spontaneous delivery ensued at 34 weeks.

The second infant presented at 34 weeks with decreased fetal movement & CTG showing foetal tachycardia. Following emergency LSCS a postnatal diagnosis of SVT was made. Baby commenced on Flicainide & is doing well.

The third presented at Term+11 for induction of labour, when foetal tachycardia of 180/min was noted in an otherwise reassuring CTG Instrumental delivery was done. Postnataly SVT was detected, referred to Dublin and started on Flicainide & doing well.

No deaths or morbidity occurred in our cases

The safe delivery of a full-term, non-hydropic infant with sinus rhythm is the desired outcome of a pregnancy complicated by SVT.

Early management of non-hydrops cases decreases infant morbidity and mortality

Flecainide is an effective therapy, especially in the foetal hydrops

**Abstract No. 17**

**TROPONIN-T AND PRO-B TYPE NATRIURETIC PEPTIDE IN FETUSES OF TYPE 1 DIABETIC MOTHERS**

NE Russell ¹, MF Higgins¹, M Amaruso², M Foley¹, RG Firth ³, FM McAuliffe¹

¹University College Dublin School of Medicine and Medical Science, Obstetrics & Gynaecology, National Maternity Hospital, Dublin 2, Ireland,
²National Maternity Hospital, Holles St., Dublin 2, Ireland
³University College Dublin School of Medicine and Medical Science, Endocrinology, Mater Misericordiae Hospital, Dublin 7, Ireland.
Objective
Cardiomyopathy is noted in up to 40% of infants of diabetic mothers, the exact mechanisms of which are unknown. The aim of this study is to determine if fetal serum markers of cardiac function differ between normal and type 1 diabetic pregnancy and to examine any correlation between these markers and fetal cardiac structure and function.

Research Design and Methods
This is a prospective observational study of 45 type 1 diabetic pregnancies (T1DM) and 39 normal pregnancies. All participants had concentrations of pro B-type natriuretic peptide (proBNP) and troponin T (TnT) measured in cord bloods taken at the time of delivery. All T1DM patients had Doppler evaluation of their umbilical artery, middle cerebral artery and ductus venosus and a subset (n=21) had a detailed fetal echocardiogram performed.

Results
Cord blood proBNP and TnT concentrations were higher in the diabetic cohort than in the normal cohort (p<0.005) especially those with poor glycaemic control at booking. There was a significant correlation between proBNP and interventricular septum thickness (p<0.05) but no correlation with cardiac function indices. In diabetic patients with poor glycaemic control there was a significant correlation (p< 0.05) between TnT and umbilical artery pulsatility index (UAPI).

Conclusion
Cord blood proBNP and Troponin-T are higher in fetuses of diabetic mothers than in the normal population. Hyperglycaemia in early pregnancy may affect the developing myocardium and thus increase the risk of developing cardiomyopathy. This may contribute to the susceptibility to hypoxia seen in these pregnancies.

Abstract No. 18
OBSTETRICAL RISKS AND CAUSES FOR INTENSIVE CARE ADMISSIONS (ICU): A 5-YEAR RETROSPECTIVE COHORT ANALYSIS.
M. A. Dempsey¹, T. Hassan¹, M. Scully¹, S. O’Coigligh¹
¹Our Lady of Lourdes Hospital, Drogheda.

To Analyse patient admissions to ICU, outcomes post ICU, and to determine antenatal risk identifiers.

A consecutive cohort of 18,272 delivering women, delivered of infants in Our Lady of Lourdes Hospital from 01/03 to 12/07 was analyzed for admissions to ICU. There were a total of 26 (0.0014%) admissions to ICU, excluding potential admissions where no bed was available in ICU.

Haemorrhage is a leading cause of obstetric admission to ICU (73%) in this study. Identifiable risk factors for admission to ICU included maternal cardiac pathology, antepartum haemorrhage, placenta praevia, HELLP syndrome and PET, acute fatty liver, road traffic accidents, and multiple pregnancies. 65.4% of delivering mothers had risk factors identified antepartum. 65.4% of patients spent no longer than 24 hours in ICU and 85% no longer than 48 hours. 20% of patients needed level 3 ICU care. 80.8% of patients had caesarean sections, of which 52.4% were emergency sections. 20% (5/26) people required further surgery following delivery, including one emergency hysterectomy. In 2004 the percentage of women aged greater than 35 years was 19.3%, compared to 58.8% of women with haemorrhage in ICU.

Of the ICU admission for obstetric patients nearly three in four is for major haemorrhage. Since the introduction of the massive blood loss protocol in Dec 05, there was a 2 fold increase in the amount of admissions to ICU each consecutive year in 2006 and 2007. Intensive care intervention was effective and efficient with short stay and no maternal mortality.
Abstract No. 19

ELECTIVE SINGLE EMBRYO TRANSFER: PRELIMINARY EXPERIENCE AT THE MERRION FERTILITY CLINIC

Nicola Maher, Philip Milne, Evelyn Cottell, Mary Wingfield and Maeve Eogan
Merrion Fertility Clinic and National Maternity Hospital

The traditional practice of transferring two or more embryos has led to a significantly increased risk of twins and higher order multiples [1] with an associated increased morbidity and mortality for mother and child as well as health economic implications. Elective transfer of a single embryo (eSET) is an effective method for reducing twin pregnancies, with several European countries making eSET compulsory for some patients [2].

From January 2008, at this unit, elective single embryo transfer has been actively encouraged for couples deemed to have a good prognosis (first treatment cycle, age <36 years, at least one top quality embryo with 2 additional embryos available to freeze). This paper summarises experience to date.

Data were prospectively collated on women undergoing IVF and ICSI treatment cycles at the Merrion Fertility Clinic from January 2007 until 14th October 2008. The cumulative pregnancy outcome following 1 fresh and 1 frozen cycle for suitable women having eSET in 2008 was compared with the pregnancy and twinning rates for women who had double embryo transfer in 2007 but would have been suitable for eSET had the policy existed at the time of their treatment.

Ten women who had double embryo transfer in 2007 would have fitted the criteria for eSET if they had been attending following introduction of the eSET policy. 7 of these patients conceived, 5 (50%) had viable pregnancies in which there were 4 sets of twins. Unfortunately one set of twins miscarried at 19 weeks gestation.

In 2008, 19 women fitted the criteria for eSET and 13 consented to it. 6 of these conceived, 5 had viable singleton pregnancies. Of the 7 women who had eSET but did not conceive on their fresh cycle, 5 have completed a frozen cycle, 4 of whom are currently pregnant with viable singletons. This gives a cumulative viable pregnancy rate of 77% with no multiple pregnancies.

This study reports data since introduction of an eSET policy. Although the numbers are small to date, it emphasises the success of single embryo transfer in this good prognosis population while also highlighting the positive impact on twin pregnancy rates with their attendant risks.


Abstract No. 20

THREE DIMENSIONAL SONOGRAPHY: COULD IT BE A GOLD STANDARD IN DIAGNOSING UTERINE ANOMALIES?

N Kondaveeti, C Walsh, M Martin, J Maycock, W Prendiville
Department of Gynaecology, AMNCH, Dublin

A 32 year old nulliparous woman referred to colposcopy clinic for severe dyskaryotic smear. During colposcopy examination two cervices were identified. A 3-D Transvaginal scan showed uterus didelphys. An examination under anaesthesia with hysteroscopy and diagnostic laparoscopy further confirmed the uterus didelphys and LLETZ biopsies of cervices was performed.

Congenital uterine anomalies are often asymptomatic and the prevalence in general population is about 2-4 per-
cent. In the infertile and recurrent miscarriage group the incidence is much higher. Although the mullerian anomalies are classified into seven groups according to the American Fertility Society, the final diagnosis is based on the subjective impression of the clinician performing the test. Two dimensional ultrasound, hysterosalpingography or sonohysterography are first line investigations. A combined hysteroscopy and laparoscopy is a definitive diagnosis. Magnetic resonance imaging and three dimensional sonography are the best non invasive modes of diagnosis for mullerian anomalies.

The advent of three dimensional ultrasound is one of the most important advances in gynaecology recently. We reviewed the literature regarding the efficacy of 3 D sonography in diagnosing mullerian anomalies compared to other diagnostic modalities. Studies from 1995 to 2008 were identified through MEDLINE search; all relevant references were further reviewed. All these studies conclude that three dimensional sonography is extremely sensitive and specific in relation with its ability to demonstrate the congenital uterine anomalies. However future work should ensure that 3D sonography is compared with conventional imaging in randomised trials where observer is blind to the outcome.

Abstract No. 21
SEX AND FETAL ABDOMINAL SUBCUTANEOUS TISSUE (FAST)

UCD School of Medicine and Medical Sciences, Coombe Women and Infants University Hospital, Mount Carmel Hospital*.

Abnormal fetal growth increases the complications of pregnancy not only for the baby but also for the mother. Despite the use of more than 50 different formulae to estimate fetal weight (EFW), ultrasound has its limitations especially at the extremes of fetal weight. There is emerging interest in fetal body composition. Babies born to diabetic mothers or born growth-restricted have abnormal adiposity. After birth, the pattern and distribution of subcutaneous fat has been assessed by various methods and gender differences have been reported. The purpose of this study was to determine if the FAST measurements using antenatal ultrasound differ between the sexes.

Women who had an ultrasound examination for fetal growth between 20 and 40 weeks gestation were analysed. Women with diabetes mellitus were excluded. The fetal anterior abdominal subcutaneous tissue was measured in a standardised way. The fetal sex was recorded after delivery (EH).

A total of 557 fetuses were measured, 290 male and 267 female. The FAST increased at the same rate for both male and female fetuses and at any given week there was no gender difference.

The increased fat composition in females reported after birth was not found in abdominal wall subcutaneous fat measurements using ultrasound during pregnancy. Antenatal centile charts for FAST do not need to be based on gender.

Abstract No. 22
CAN WE PREVENT UNEXPECTED EMERGENCY CAESAREAN SECTIONS FOR SECOND TWINS?
J Costa, R Collins
Department of Obstetrics and Gynaecology, Craigavon Area Hospital, Craigavon.

Twins delivered by emergency caesarean section (EMCS) after the vaginal delivery (VD) of the first twins are known to have the highest neonatal morbidity of all the twin deliveries. Current practice in UK is to offer VD to all uncomplicated twins if the first twin is in cephalic presentation, irrespective of the presentation or the estimated foetal weight (EFW) of the 2nd twin. Our aim was to find out whether we can plan the delivery for uncomplicated twins depending on the EFW of the 2nd twin, in order to minimise the possibility of EMCS for the 2nd twin.
We reviewed maternal charts of all the twins delivered in our hospital, during a period of one year, to identify uncomplicated twins in cephalic presentation. 20 sets of such twins were identified and data collected from both maternal and neonatal charts.

There were 13 second twins with birth weights > 2500g and 7 of them were delivered vaginally while 6 were delivered abdominally. Among the 6 delivered abdominally, one twin had its first-twin delivered vaginally and proceeded to EMCS due to its persistent malpresentation. This didn't happen in the group of 7 second twins with birth weight <2500g.

Possibility of EMCS for the 2nd twin after VD of the first twin, seems to be higher when the EFW of the 2nd twin is >2500g. Therefore it is reasonable to offer elective abdominal delivery for twins when the EFW of the second twin is >2500g, even if the first twin is presenting cephalic.

**Abstract No. 23**

**IMPACT OF OVERFLOW FROM OTHER SPECIALITIES ON GYNAECOLOGY SERVICES AND ITS EFFECTS ON MAINTENANCE OF CONSULTANTS SKILLS AND NCHDS TRAINING, IN OUR LADY OF LOURDES HOSPITAL, DROGHEDA (OLOD), C.O. LOUTH**

HAMADA ABDOUN, M. MILNER, DEPARTMENT OF OBSTETRIC AND GYNAECOLOGY,(OLOD)

Inpatients gynaecology services at OLOD Hospital in Drogheda are based in 15- bed ward, located within the Maternity unit. Increase overflow from other specialties is growing in term with increasing local population, centralization of trauma in the operating theater, cessation of major gynecology surgery at other hospitalities.

In theory beds are protected for major gynecology surgery, and women with miscarriage.

In practice, hospital activity prevents this protection on regular basis.

Beds usage was documented from April 9th 2008 till October 9th. Operations were collected from the theater register. Results were collected in an Excel spread sheet.

There were 130 potential elective operating days, but only 90 major operations were carried out. Mean major operations carried out varied between 0.54(Tuesday) and 0.83(Monday).

Occupancy by Gynecology cases were 56-63%, maximal on Wednesdays and Fridays, least at weekends 53%.

Overflow occupancy was 27-32%, maximal on Tuesday (21%). Empty bed at 8-12% between Monday and Friday, maximal at week ends (25%).

Our figures reflect the major impact by general hospital activity on elective gynecology services. This also has implications for skill maintenance by consultants, training of NCHDS.

**Abstract No. 24**

**BODY MASS INDEX (BMI) IN WOMEN BOOKING FOR ANTENATAL CARE:COMPARISON BETWEEN SELF-REPORTED AND DIGITAL MEASUREMENT**

Fattah C, Farah N, O`Toole F, Harold E, Barry S, Murray D, Doran P, Rafferty G, Donnelly V, Stuart B, Turner MJ. UCD School of Medicine and Medical Science, Coombe Women's and Infants University Hospital, Dublin.

Maternal obesity is associated with increased pregnancy complications for both the mother and baby. Conventionally obesity is diagnosed using the WHO classification of Body Mass Index (BMI) based on height and weight (kg/m²). The World Health Organization (WHO) classifies a BMI > 30 kg/m² as obese.

We compared self-reported BMI with digital measurement of BMI in women booking for antenatal care in the first trimester of pregnancy. The women reported their height and weight and the measurements were converted to centimetres and kilograms respectively to calculate the sel-reported BMI. Their height was measured digitally (Seca
and weight was measured digitally (TANITA MC 180). Measured BMI was calculated.

Of the 100 women, the mean gestation was 10.9 weeks. Agreement analysis for self-reported and digital measurements of BMI is shown in Table 1. In total, 22% were misclassified if the BMI was based on self-reporting. Self-reporting also underestimated the prevalence of obesity by 4%. Self-reporting of BMI was inaccurate because 59% of women underreported their weight (p<0.001).

Our results are consistent with previous studies outside of pregnancy. These finding have important implication for both clinical practice and research. We strongly recommend that self-reporting of BMI in pregnancy is abolished.

<table>
<thead>
<tr>
<th></th>
<th>Normal (n=51)</th>
<th>Overweight (n=29)</th>
<th>Obese (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reported Normal (n=59)</td>
<td>47</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Overweight (n=25)</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Obese (n=16)</td>
<td>0</td>
<td>1</td>
<td>15</td>
</tr>
</tbody>
</table>

**Abstract No. 25**

**APLASTIC ANAEMIA: UNCOMPLICATED PREGNANCY FOLLOWING ALLOGENEIC BONE MARROW TRANSPLANTATION**

F Martyn, M P O’Connell

Aplastic anaemia may relapse during pregnancy but the majority of women who achieve long term remission of the disease can go on to have a normal pregnancy with no foetal complications. We report on a 33 year old woman who had remission of her aplastic anaemia following allogeneic bone marrow transplant with cyclophosphamide conditioning at age 12 and who proceeded to have an uncomplicated pregnancy with a normal outcome. Pregnancy following stem cell transplant for which there is pretransplant conditioning with total body irradiation have a significantly higher rate of preterm delivery and low birthweight babies but this is not seen with chemotherapy-only conditioning.

**Abstract No. 26**

**WOMEN’S COMPLIANCE AFTER COLPOSCOPIC MANAGEMENT**

Srwa Khalid, Xavier Carcopino, Georges Michael, Ronan Conroy, Walter Prendiville

**Aim:** To evaluate the compliance rate to the recommended follow up cytology guidelines of patients being discharged from the colposcopy clinic and identify predictive factors of poor compliance.

**Materials and methods:** Patients who attended the colposcopy clinic in the Coombe Women & Infants University Hospital for the first time in 2001 due to abnormal cervical smear with proven cervical intraepithelial lesion at first visit were enrolled in the study. Patients’ characteristics and clinical data were recorded. Patients were secondarily contacted by the telephone and asked about their compliance regarding recommendations they received when they were discharged from our institution. Women who had cervical smear as recommended were considered as perfectly compliant. Women who had sporadic cervical smears were considered as poorly compliant while those who had no smears done at all were considered as non compliant.

**Results:** We enrolled 142 women in the study. One hundred women were interviewed successfully via the phone and answered satisfactorily (70.4% response rate). Among them, 60% reported perfect compliance, whether poor
and no compliance represented 29 and 11%, respectively. We observed no significant association between the compliance rate and parity, smoking status, number of visits, referral smear, practice of treatment and grade of cervical abnormality. Younger patients were significantly more likely to achieve a perfect compliance (OR: 0.920, 95% CI: 0.8702-0.9733, p=0.004).

**Conclusion:** Compliance of patients who were managed for CIN to the cytology recommendation they received prior to their discharge from colposcopy clinic was insufficient. Specific attention must be given to older patients.

**Abstract No. 27**

**ADVANCES AND CHALLENGES IN THE MANAGEMENT OF UTERINE FIBROIDS**

Helen Ryan¹, Darra Murphy², William Boyd¹, Leo Lawler²

¹Department of Gynaecology, Mater Misericordiae University Hospital, Eccles Street, Dublin 7
²Department of Radiology, Mater Misericordiae University Hospital, Eccles Street, Dublin 7

**Aim**
To discuss and illustrate uterine fibroid assessment and patient therapy options in 2008.

**Background**
Uterine fibroids are a common gynaecological problem that, although benign, cause significant morbidity for women of reproductive age. Management depends on the patient’s symptoms & desire for future fertility.

**Clinical Management**
Clinical features, fibroid location and imaging features that suggest patient suitability for each therapy are reviewed. The roles of conservative, medical, surgical and endovascular management are discussed. The advances in the spectrum of therapies currently available are divided into uterus preserving and non-uterus preserving approaches. A series of cases illustrate the typical and atypical appearances of fibroids pre- and post-therapy. We look at the advantages and disadvantages of newer non-invasive radiological techniques. Lesions that may mimic fibroids and features of leiomyosarcoma are also distinguished.

**Summary**
With management options becoming more diverse and advanced, patients now have a range of choices for fertility preserving and non-fertility preserving therapies for this benign condition. Current imaging can discriminate which patients are best suited to each therapy as well as providing a non-invasive means of following up therapy. We highlight the challenge of choosing the most appropriate treatment method for each individual patient.

**Abstract No. 28**

**A RAPIDLY ENLARGING PELVIC MASS: A CASE REPORT**

HM Ryan¹, DT Murphy², B Boyd¹,³, LP Lawler², B Gaughan³

¹Department of Gynaecology, Mater Misericordiae Hospital, Dublin 7 ²Department of Radiology, Mater Misericordiae Hospital, Dublin 7 ³Department of Gynaecology, ROTUNDA HOSPITAL, DUBLIN 1

**CASE REPORT:**
We present the case of an eighteen-year old Caucasian female who presented to our gynaecology service with a painless pelvic mass, which was rapidly enlarging over three months. She had worsening menorrhagia as well as intermenstrual bleeding during this time. Her pregnancy test was negative. She was noted to be mildly anaemic on routine blood investigations. On examination, she was found to have a large, mobile mass, arising from the pelvis, measuring 28/40 size.

An MRI Pelvis showed a rapidly growing 18x11x14cm, well-circumscribed soft tissue mass arising from the posterior uterus. On imaging findings alone, a sarcoma could not be outruled. CT thorax showed no evidence of metastatic
disease to the thorax.

An ultrasound-guided biopsy was suggestive of a leiomyoma.

Given the rapid presentation, large size and unusual imaging findings, a decision was made to proceed with surgical management. Fertility preserving surgery was carried out, with a midline laparotomy and incision of the posterior aspect of the uterus. A myomectomy of the soft tissue mass was performed, without breaching the uterine cavity. Histology was consistent with a leiomyoma, with no mitotic figures or necrosis suggestive of malignancy.

We highlight an unusual case of a common clinical problem. The presentation in this case was unusual, given the patient's young age, Caucasian race and the rapid growth of the pelvic mass. Imaging modalities as well as early histological evidence of benign disease aided the decision as to the most appropriate management of this patient.

Abstract No. 29

A STUDY COMPARING THE USE OF PIPELLE VS. ENDOSAMPLER DEVICES IN SAMPLING THE ENDOMETRIUM OF WOMEN PRESENTING TO HYSTEROSCOPY CLINIC.

Sarkar. S, Asif. S, Dixit. S, Deshpande, R.
Department of Obstetrics and Gynaecology, Derby City General Hospital, Derby.

Endometrial sampling is a common gynaecological procedure widely used for the evaluation of menstrual abnormalities especially post menopausal bleeding. Several new devices are available for effectively sampling the endometrium with the commonest being the pipelle or endosampler tube. The aim of the work was to compare the efficacy of sampling and pain experienced by patients undergoing pipelle and endosampler procedures in hysteroscopy clinic.

This is a prospective study conducted over 6 months. All patients requiring endometrial sampling who attended outpatient hysteroscopy clinics were included. Prior to sampling, the uterine cavity was inspected with a flexible hysteroscopy. The level of pain experienced was analysed using the visual analogue scale from 0-10 with 0 being the least pain and 10 being the most pain experienced.

A total of 43 patients were included in this study. The majority of patients were aged between 41-50 (33%). The patients were equally divided between the two techniques (21(49%) cases in the pipelle group vs.22 (51%) cases in the endosampler group). Both devices were equally effective in obtaining endometrial tissue for histological analysis with at least 95% of the specimen retrieved by both methods. However, the endosampler group had higher pain scores (27.2%) compared to the pipelle group (4.77%).

![Pain experienced during procedure](image)
Despite the small sample size, this study demonstrates that endometrial sampling with a pipelle device is equally as effective as the endosampler. These results encourage the use of the pipelle tube as the preferred method of outpatient endometrial sampling both for its efficacy and patient compliance.

Abstract No. 30

AUDIT OF INTRAUTERINE GROWTH RETARDED BABIES AND CURRENT MANAGEMENT STRATEGIES

Dr Madhu Sunghal, Dr Elaine Craig, Mr David Sim
Daisy Hill Hospital January – June 2007

Objective
Identify the incidence of IUGR in the daisy hill obstetric population. To review current practice with regard to the RCOG guideline 2002 ‘Investigation and management of the Small for gestational age fetus.’ This guideline states that: there should be fetal surveillance with umbilical artery Doppler and biometry as a minimum, Corticosteroids should be offered to all women who may need delivery between 24-36 weeks and all women who smoke should be given full information regarding the significance of smoking in pregnancy. These criteria were audited with a view to highlighting areas of potential practice improvement.

Methods
Babies with a birth weight of <2500g were identified from labour ward register. A retrospective chart review was performed. Data was divided into two groups- IUGR babies diagnosed antenatally and postnatally. Information was collected regarding the presence of risk factors for IUGR e.g. age sex, ethnicity, past obstetric history, smoking, BMI and past medical history. Information pertaining to antenatal care including administration of corticosteroids, the use of Doppler studies and need to expedite delivery was collated.

Results
49 babies were identified, 3 were excluded. 59% of deliveries had IUGR diagnosed antenatally. Only 67% of those diagnosed antenatally had Umbilical artery Doppler +/- biometry. In 30% of deliveries it felt that the patient may need delivery between 24-36 weeks, only 85% of these deliveries were corticosteroids offered. 18 babies were only diagnosed postnatally despite 7 of these had risk factors for IUGR.

The total incidence of IUGR in DHH was 4.8% of all deliveries (corresponds to general incidence of 5%)

Conclusions.
This audit examines the management of the IUGR pregnancy in accordance to the RCOG guideline.

Abstract No. 31

PET/CT IN THE STAGING OF CERVICAL CANCER – EXPERIENCE OF A SINGLE IRISH INSTITUTION

Helen Ryan¹, Darra Murphy², William Boyd¹, Leo Lawler²
¹Department of Gynaecology, Mater Misericordiae University Hospital, Eccles Street, Dublin 7
²Department of Radiology, Mater Misericordiae University Hospital, Eccles Street, Dublin 7

INTRODUCTION
There are approximately 300 new cases of cervical cancer diagnosed annually in Ireland. Cervical cancer is traditionally staged with the FIGO Classification of Staging, which is clinical, rather than surgically based. MRI scans are commonly used for regional staging in the pelvis. PET/CT can be used to evaluate extrapelvic metastatic disease.

AIMS
To assess the value, clinical impact and added benefit of integrated PET/CT using (18)F-FDG in the primary staging and management of women with newly diagnosed cervical carcinoma.
METHODS AND MATERIALS
We retrospectively reviewed the clinical staging, MRI pelvis and whole-body PET/CT studies of 142 women with a newly diagnosed Stage IA-IV cervical carcinoma over a two year period (2005-2006). The clinical impact of information provided by PET/CT on patient staging and management was compared to that provided by clinical staging and MRI alone. Findings on PET/CT were correlated with intra-operative findings where available.

RESULTS
All cases had clinical staging performed in the form of vaginal examination and biopsy. Where radiological staging was required, patients underwent MRI pelvis alone and 20% of patients had both MRI pelvis and PET/CT. PET/CT changed the extent of disease in 31% of patients, resulting in changes in the treatment plans.

CONCLUSION
In patients with a new diagnosis of cervical cancer, integrated PET/CT provides both good anatomical and functional localization of metastatic spread. In our experience, initial staging with PET/CT has an impact on clinical management and treatment planning of these patients and may have a favourable impact on both prognosis and survival.

Abstract No. 32
PRENATAL FINDINGS OF AN ENLARGING FETAL UPPER ABDOMINAL MASS IN THE THIRD TRIMESTER - CASE REPORT
Akram M, Ravikumar N, Azam M, Dunne, K, Morrison JJ.
Department of Obstetrics & Gynaecology & Neonatology
Clinical Science Institute, University College Hospital, Galway Newcastle Road, Galway Republic of Ireland.

This lady booked at 19 weeks gestation in her second pregnancy having had an emergency caesarean section at term for obstetric reasons in her first pregnancy. She had normal fetal anomaly scan. Ultrasound scan at 34 weeks gestation, revealed circumscribed echogenic mass 4.5cm in size, with multiple cystic spaces, contiguous with the stomach bubble but separate from left kidney. The fetal growth, liquor and Doppler were normal. Repeat scan at 37 weeks gestation, revealed the mass to be increasing in size (7.0cm). An elective caesarean section was carried out at 37+1 week. A male infant weighing 3700 grams was delivered in good condition. At delivery the baby was found to have a palpable mass in the left hypochondrium.

On day 1 of life, plain film of abdomen, ultrasound scan and CT scan of abdomen confirmed large poorly defined soft tissue mass in the left upper quadrant, measuring 10 cm in diameter. The neonatal serum alpha fetoprotein level (AFP) level was 255,496 ng/ml, total human chorionic gonadotrophin (HCG) level was elevated at 11 iu/l (0-3).

The baby underwent laparotomy on day 10 of life when a large cystic, solid mass arising from the posterior wall of stomach was noted and resected. The histology was consistent with grade 3 immature teratoma. Gastric teratoma of the neonate is rare, accounting for less than 1% of all teratomas in infants and children. The baby did not receive chemotherapy. Clinical follow up, serial AFP levels, Ultrasound and CT scans are normal at 9 months of age.

References:

Abstract No. 33
CAN MATERNAL BIOELECTRICAL IMPEDANCE ANALYSIS (BIA) PREDICT BIRTH WEIGHT?
UCD School of Medicine and Medical Science, Coombe Womens and Infants University Hospital, Dublin.

Previous research has reported an association between obesity based on increased maternal Body Mass Index (BMI) and birth weight, including fetal macrosomia. BMI, however, is only a surrogate marker of body composition.

This study aimed to assess the value of Bioelectrical Impedance Analysis (BIA) as a predictor of birth weight in women who delivered a live baby weighing 500g or more.

Seventy six women were recruited postnatally after a singleton pregnancy. Women with diabetes mellitus or significant co-morbidities were excluded. All babies had birth weight recorded at delivery. Each subject had Bioelectrical Impedance Analysis (Tanita) performed using multifrequency, eight electrode measurements. All measurements were postnatally as inpatients at the same time of day using standardised methodology.

The mean birth weight was 3525g (± 472g SD). The mean BMI was 28.9 ± (SD 4.4 kg/m$^2$). Correlation analysis was performed between birth weight and BMI at booking, postnatal BMI, bone mass, upper limb fat mass, lower limb fat mass and trunk fat mass. Fetal weight correlated significantly with booking BMI (p=0.04), postnatal BMI (p=0.009), bone mass (p=0.004) and upper limb fat mass (p=0.014). Multiple regression analysis revealed that using a prediction model for birth weight which included all measures of body composition and BMI, the only significant predictor of fetal weight is maternal bone mass.

Maternal bone mass measured by BIA, and not BMI, is the most useful component of maternal body composition for predicting birth weight. To our knowledge, this has not been previously described.

Abstract No 34

**CAN BIOELECTRICAL IMPEDANCE ANALYSIS (BIA) OF MATERNAL BODY COMPOSITION PREDICT THE OUTCOME OF LABOUR?**

UCD School of Medicine and Medical Science, Coombe Womens and Infants University Hospital, Dublin.

Aim of study: To evaluate Bioelectrical Impedance Analysis (BIA) in predicting the mode of delivery and the duration of labour.

Overall, 76 women were recruited postnatally after a single live birth. Each woman had multifrequency eight electrode BIA (Tanita) performed. All measurements were taken using standardised methodology.

We compared the women delivered vaginally with those delivered abdominally. The mean BMI (kg/m$^2$) in those delivered vaginally (VD) was 28.54 ± 4.43 while the BMI in the caesarean (CS) group was 30.51 ± 4.42. The bone mass in the VD group was 2.74 ± 0.35, and in the CS group was 2.88 ± 0.36. The upper limb fat mass in the VD group was 1.55 ± 0.63 and in the CS group was 1.72 ± 0.59. We also analysed the duration of labour for women delivered vaginally (Table 1).

**Table 1: Duration of labour vs Body composition**

<table>
<thead>
<tr>
<th></th>
<th>Bone Mass</th>
<th>UL Fat Mass</th>
<th>Trunk Fat Mass</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤8hours (n=39)</td>
<td>2.66 ± 0.34*</td>
<td>1.47 ± 0.60</td>
<td>9.8 ± 4.1</td>
<td>28.0 ± 4.1</td>
</tr>
<tr>
<td>≥8hours (n=20)</td>
<td>2.83 ± 0.32</td>
<td>1.69 ± 0.67</td>
<td>10.4 ± 3.7</td>
<td>29.6 ± 4.8</td>
</tr>
</tbody>
</table>

We used independent sample t testing to compare both groups and found that there was a significant difference in bone mass between the groups (p=0.05). * (p=0.05)

Our findings confirm that increased maternal BMI is associated with caesarean delivery and longer labours. It also
Abstract No 35

IMPACT OF VIRAL INFECTION AND SUBSTANCE ABUSE IN PREGNANCY ON PERINATAL OUTCOME

Foyeke Olatunbosun¹, Valerie Jackson², John Lambert ²,³,⁴, Marian Brennan², Mary Cafferkey²,⁵, Michael Geary², Fergal D. Malone¹, Sam Coulter-Smith²

1. Royal College of Surgeons in Ireland, Department of Obstetrics & Gynaecology, Dublin, Ireland
2. The Rotunda Hospital, Dublin, Ireland
3. UCD School of Medicine & Medical Science, Dublin, Ireland
4. The Catherine McAuley Research Centre, Mater Misericordiae University Hospital, Nelson Street, Dublin 7, Ireland
5. The Rainbow Clinic, The Children’s University Hospital, Temple Street, Dublin 1, Ireland

Infant birth outcomes are inextricably linked to maternal health status and prenatal care. The aim of this study is to evaluate the correlation between viral infectious diseases and substance abuse in pregnancy and poor perinatal outcome.

A retrospective review of all women attending a dedicated specialist clinic for viral infectious diseases and substance abuse in pregnancy between January and December 2007 was carried out. Data gathered included demographics, sonographic surveillance and perinatal outcome. Data was analysed using SPSS v15.0.

The study cohort consisted of 287 women, of whom 204(71%) were infected with HIV, hepatitis B (HBV) or hepatitis C (HCV); 68(24%) were on prescribed methadone programmes. In comparison with matched controls there was a trend towards reduced birth weight in both the HIV and the HCV groups (p=0.05; p=0.1). HIV, HCV or HBV infection did not increase the risk of preterm delivery. Methadone use conferred an increased risk of birthweight less than the 10th centile (16.2% vs 6.6% in matched controls, p=0.02), with delivery occurring at an earlier gestation in this group (mean gestation at delivery 269.4 days vs 274.6 days in controls p=0.04). In all groups the sonographic surveillance findings correlated with subsequent birthweight.

While HIV and HCV infection in this population showed a trend towards lower birthweights, there was no overall significant impact on perinatal outcome. Pregnant patients with a current or past history of substance abuse represent a population at significant risk for low birthweight and preterm delivery. Intensive fetal surveillance with regular ultrasound is warranted in this group.

Abstract No. 36

UNUSUAL PRESENTATIONS OF CERVICAL NEOPLASM

Chummun K., Moses Abe*, Bill Boyd

INTRODUCTION

This is a case series of the 3 unusual presentations of cancer of the cervix over a year period in a Gynaecology Oncology Centre in Dublin.

CASE HISTORIES

1). 44 yr old P2 referred from family planning clinic with clinical features of pelvic abscess. EUA & laparoscopy revealed unsuspected stage 3B cancer of cervix

2). 55 yr old P2 undergoing investigation by Urologist for persistent Lt Loin pain. CTKUB revealed 3cm Lt renal pole mass (renal cell carcinoma). Co-existing stage 3B SCC cancer of cervix found at Lt Nephroureterectomy.
3). 73 yr old P4 undergoing investigations by Urologist for recurrent UTI’S. Cystoscopy & CT Urogram subsequently revealed stage 3B cancer of the cervix.

DISCUSSION
Cancer of the cervix is common. It accounts for about 70 cancer deaths annually in Ireland. Asymptomatic and atypical presentations still pose considerable challenge to GP’s, speciality doctors and gynaecologists alike. In this study atypical presentation accounts for 3/152 (2%) of all cases.

We strongly recommend that:
1. All unexplained urological symptoms should prompt thorough gynaecological evaluation/opinion
2. The cervix must be visualised in all suspected cases of pelvic inflammatory conditions.

Abstract No. 37
A RANDOMISED CONTROLLED TRIAL OF COMPARISON BETWEEN STANDARD METAL STAPLES AND ABSORBABLE SUBCUTICULAR STAPLES FOR SKIN CLOSURE AT CAESAREAN SECTION
Rupak K Sarkar, P Akhter, M Akram, A Khashan, D McKenna, B A O’Reilly.
Department Of Obstetrics and Gynaecology
Cork University Maternity Hospital. Ireland.

Background:
Traditionally Metal staples have been used as an alternative to sutures for skin closure at caesarean section. Staples are quick to apply and are associated with a low rate of infection, however metal staple removal requires time and is associated with post operative discomfort. The newly introduced Absorbable subcuticular staple has the speed of stapling with the cosmetic outcome and patient friendly benefits of absorbable material.

Aims:
To compare the effectiveness of traditional Metal skin staples and absorbable subcuticular staples for skin closure at caesarean section.

Methods:
One hundred women, undergoing a primary caesarean delivery at the CUMH were prospectively randomised to skin closure with either metal staples or subcuticular absorbable staples. Exclusion criteria included a history of previous caesarean delivery or laparotomy or any vertical abdominal incision and/or any history of allergies to staples or suture material. Out come data were available on 90 women. Statistical analysis was performed using Mann Whitney test. A ten-point visual analogue scale (VAS) was used to assess outcome measures in respect of wound pain, cosmetic appearance & patient satisfaction on discharge and 6 weeks postpartum.

Results:
While operating time was significantly shorter when using metal staples, the use of absorbable subcuticular staples resulted in less wound pain at discharge. Wound pain was comparable at six weeks postpartum. Closure with absorbable subcuticular staples also yielded a better cosmetic result at week 1 and was comparable at the six week post-operative visit. However, assessment of pain and, in particular cosmetic appearance was highly subjective.

Abstract No. 38
TO REVIEW PRACTICE IN THE MANAGEMENT OF RHESUS D-NEGATIVE WOMEN DURING PREGNANCY
Nisha Kadwadkar , Jenny Lo
Maternity Department, Worthing Hospital, Worthing
The Department of Health has recommended that 'Routine Antenatal Anti-D Prophylaxis' (RAADP) should be offered to all non-sensitised RhD-negative pregnant women at 28 and 34 weeks of gestation [1]. The difference between RAADP and prophylactic anti-D given because of likely sensitisation event should be clearly explained [1]. The Royal College Of Gynaecologists has recommended the administration of additional antenatal prophylaxis following sensitisation events and post-natal prophylaxis to all non-sensitised RhD-negative women with RhD-positive babies [2].

This retrospective study aimed to find out whether the management of Rhesus D-negative women during pregnancy was adhered to in accordance to the NICE and Green-top guidelines.

Thirty-one cases of non-sensitised RhD-negative pregnant women selected randomly between January 2006 and September 2007.

Our results showed that 93% of women had RAADP and 96% of women had additional antenatal anti-D prophylaxis following sensitisation events. Sixteen per cent of women who declined RAADP received post-natal prophylaxis without documentation of their consent. The reason[s] for their refusal to administer RAADP but accepted post-natal prophylaxis was not documented.

Our study showed that majority of women received RAADP and additional antenatal anti-D prophylaxis. Whether women truly understood the actual implication of refusal of RAADP was unclear. Improvement in documentation regarding the reasons for declining antenatal prophylaxis might help the improvement in uptake of anti-D prophylaxis.

References:
NICE technology appraisal guidance No 41, Guidance on the use of routine antenatal anti-D prophylaxis for RhD-negative women, May 2002.
RCOG Green-top guidelines, Use of Anti-D Immunoglobulin for Rh prophylaxis (22), Revised May 2002.

Abstract No. 39

SEROUS CARCINOGENESIS IN THE DISTAL FALLOPIAN TUBE – IS PREVIOUS Hysterectomy FOR BE-NIGN DISEASE A PROTECTIVE FACTOR?

Helen Ryan1, Donal Brennan1, William Boyd2, Michael Foley1,3 and Colm O’Herlihy 1,2,3
Departments of Gynaecology, National Maternity Hospital1, Mater Misericordiae University Hospital2, UCD School of Medicine and Medical Science3

The presence of a premalignant lesion in the distal fallopian tube has recently been proposed as a precursor to serous ovarian carcinoma (SOC) [1, 2]. Previous hysterectomy for benign disease might thus protect against subsequent development of SOC, although current surgical practice does not involve entire resection of fallopian tube when the ovaries are conserved. Our objective was to evaluate the prevalence of SOC in women who had undergone a previous hysterectomy with ovarian conservation for benign disease.

Case notes of 105 women who underwent primary surgical management of epithelial ovarian cancer (1998-2008) were reviewed. Patient demographics, tumour differentiation and histological subtype were recorded.

Twenty one women had previously undergone a hysterectomy for benign disease (group 1) whereas 84 patients had no previous surgery (group 2). There were no significant clinicopathological differences between the two groups; mean age at diagnosis was 58.6 years (range 37 -75) in group 1 and 55 years (31 – 77) in group 2; 57% (n=12) in group 1 had SOC and 55% (n=47) in group 2 had SOC. The groups did not differ in respect of stage at diagnosis or tumour differentiation.

Hysterectomy as currently practiced does not protect against SOC. Given the recent evidence suggesting a premalignant serous focus in the distal fallopian tube in women who develop SOC, total salpingectomy is warranted at hys-
terectomy for benign disease when the ovaries are conserved.


Abstract No. 40

TWIN REVERSE ARTERIAL PERFUSION SEQUENCE

Deidra Lim, Nidita Luckheenarain, Ulrich Bartels
Department of Obs/Gynae, Mayo General Hospital, Castlebar

Case report

A 38 yr-old para 1 lady with normal singleton pregnancy on booking visit scan was found to have a right-sided circu-
lar mass with mixed echogenic appearance on 28\textsuperscript{th} week ultrasound. Ultrasound showed intra amniotic amorphous mass with small visible pulsation and minimal vascularity. On 31\textsuperscript{st} week scan, the healthy twin had developed mod-
erate right hydronephrosis. At 34 weeks, she started contracting & a healthy male baby of 2.005 kg and an ovoid
structure of 15x10 x8 cm with no head, chest or visceral organ identifiable were delivered. Placenta was confirmed
to be monochorionic.

Discussion

The diagnosis of TRAP Sequence pregnancy has never been easier. There are 4 classifications and the most com-
mon is acephalic. The most serious one is amorphous.

All clinicians need to be aware of this rare anomaly where the pump twin develops normally and recipient twin has
cardiac maldevelopment from complete absence of heart tissue to some rudimentary myocardia. It occurs in 1%
monozygotic twin pregnancies and 1 per 35,000 pregnancies. There is reversal of circulation in anomalous twin re-
sulting from large arterio-arterial and veno-venous placental anastomosis.

Ultrasound is key for early diagnosis & prompt treatment as the perinatal mortality rate is up to 50% in pump twin
and pregnancy loss occurs due to polyhydramnios and haemodynamic decompensation of pump twin. This condition
can be confused with cystic hygroma and singleton pregnancy with intraamniotic or placental tumours. Coil emboli-
sation, fetoscopic ligation, laser coagulation, radio frequency ablation, hysterotomy and selective delivery of acardiac
twin have been used in the management.

Abstract No. 41

CERVICAL CANCER IN PREGNANCY: RESULTS OF A MULTICENTER PROSPECTIVE IRISH STUDY

HELEN RYAN\textsuperscript{1}, MICHAEL FOLEY\textsuperscript{1,3}, GRAINNE FLANNELLY\textsuperscript{1}, WILLIAM BOYD\textsuperscript{2}
Gynaecology Department, National Maternity Hospital, Holles Street\textsuperscript{1}
Gynaecology Department, Mater Misericordiae University Hospital, Eccles Street, Dublin 7\textsuperscript{2}
University College Dublin School of Medicine and Medical Science\textsuperscript{3}

Cervical cancer is the commonest malignancy in pregnancy. The objective of this study was to analyze the inci-
dence, diagnosis and management of cervical cancer in pregnancy, and to compare the outcome with non-pregnant
cases.

Data on all patients with invasive cervical cancer were collated prospectively and women presenting in pregnancy or
within 3 months of delivery were identified. A control for each case was matched on the basis of age, stage, and
Over the study period (1984 – 2007), 24 cases of cervical cancer associated with pregnancy were identified. The incidence of cervical cancer in pregnancy was 1.3/10,000. 62% (15/24) women presented with irregular vaginal or post-coital bleeding; 25% (6/24) were undergoing investigation of abnormal cytology; 12% (3/24) had a suspicious cervix on vaginal examination. 54% (13/24) of women were diagnosed in the first trimester, 21% (5/24) in the 2nd – 3rd trimester and 25% (6/24) were identified in labour or in the postnatal period. FIGO stage at diagnosis did not differ between cases and controls. 29% (7/24) of patients delayed treatment to allow for fetal maturity following diagnosis and 2 women died of disease.

Cervical cancer diagnosed in pregnancy makes up 3% of all cervical cancer cases in this institution. The majority of cases (75%) are diagnosed opportunistically during pregnancy. Comparing management and outcome of cases and controls, our findings suggest that pregnancy does not adversely affect either stage at diagnosis or prognosis significantly.

Abstract No. 42

AUDIT ON THE INDUCTION OF LABOUR AND ITS OUTCOME

Anjola O, Jayamala G, Das A, Murphy C, Gardeil F, Dunn E.
Department of Obstetrics and Gynaecology, Wexford General Hospital. Wexford.

OBJECTIVE:
To audit the practise of induction of labour and the outcome in comparison to the spontaneous labouring population.

STUDY DESIGN:
A prospective study of all patients over a three month period between July and September 2008 in a general maternity hospital.

RESULTS:
The overall induction rate was 21.1% (136) with prolong pregnancy 61.8 % (84), as the commonest indication followed by Pregnancy induced hypertension 12.5 % (17). The mean induction to delivery interval was 19 hours for primiparous women, 11.3 hours for Para one and 9.1 hours for Para two and above. The vaginal delivery rate was 64% (87) in the induced group compared to 74.6% (320) in the spontaneously labouring group, with an instrumental delivery rate of 21.3% (29) in the induced group compared to 12.1% (52) in spontaneous labouring group. The caesarean delivery rate was 14.7% (20) for induced group compared to 13.3% (57) in spontaneous group. Failure to progress was the major indication for caesarean delivery 80% (16), followed by Non reassuring CTG 20% (4).

CONCLUSION:
The induced population is at an increased risk of an operative delivery. It is important that all units audit their indication for induction and assess its impact on their operative delivery rates. We recommend that there should be clear indications for induction and a clear protocol for its assessment and management.

Abstract No. 43

VENOUS THROMBOEMBOLISM: A CASE PRESENTATION

Anjola O, Das A, Byrne B, O'Donnell J Murphy C, Gardeil F, Dunn E.
Department of Obstetrics and Gynaecology, Wexford General Hospital. Wexford.

INTRODUCTION
Venous thromboembolism comprises deep vein thrombosis (DVT) and pulmonary embolism (PE).
Pulmonary thromboembolism is the most common direct cause of maternal death in the UK, 1.62% of women with fatal antenatal PTE died in the first trimester and 71% of post partum deaths followed vaginal delivery. (maternal death survey)

BACKGROUND
Case of a nineteen years old Para 0 + 2, who presented at 34 weeks gestation, formally resident in the UK with difficult social circumstances and a significant history of deep venous thrombosis and pulmonary embolism. She is heterozygous for the factor V Leiden mutation and has a congenital absence of the Inferior Vena cava. A multi disciplinary approach was instituted involving the Obstetricians, Haematologist, anaesthetist and social services.

She was placed on Low molecular weight heparin but with poor compliance.

Subsequently managed for bleeding disorders two weeks after undergoing a caesarean delivery and currently being followed up by the haematologist.


Abstract No. 44

RISK OF DEATH IN UNCOMPLICATED MONOCHORIONIC TWINS

N Farah, J Hogan, B Stuart, S Daly
Coombe Women and Infants University Hospital, Dublin

Monochorionic twins are considered high risk compared to dichorionic twins. This is largely attributed to twin-twin transfusion syndrome which occurs in 15-20% of monochorionic twins and discordant intrauterine growth restriction which complicates an additional 25%. Heightened fetal surveillance in monochorionic twins aims to detect these. Despite vigilant monitoring, unexpected fetal death still occurs in seemingly uncomplicated monochorionic twins. We aimed to determine the prospective gestational age specific risk of unexpected intrauterine demise in uncomplicated monochorionic twins after viability (24 weeks gestation).

A retrospective analysis of our hospital’s database of all twins (delivered at or after 24 weeks gestation or weighing equal to or greater than 500g) from July 1999 to July 2007 was undertaken. We excluded pregnancies with twin-twin transfusion syndrome, growth restriction, structural abnormalities, or twin reversed arterial perfusion sequence.

Included in our analysis were 146 monochorionic twin pregnancies. 12 unexpected intrauterine deaths occurred in ten of 146 previously uncomplicated monochorionic pregnancies. The prospective risk of unexpected antepartum stillbirth after 32 weeks was 1 in 32 monochorionic pregnancies, after 34 weeks was 1 in 28 monochorionic pregnancies, after 36 weeks was 1 in 45 pregnancies and after 38 weeks was 1 in 16 pregnancies.

A high rate of unexpected intrauterine death occurs in previously uncomplicated monochorionic twin pregnancies despite intensive surveillance. After 38 weeks this rate appears to rise dramatically so our data suggests that monochorionic twins should be delivered between 36 and 38 weeks.

Abstract No. 45

WHERE DO WE STAND IN THE DELIVERY OF TWINS?

J Hogan, N Farah, B Stuart, S Daly.
Coombe Women and Infants University Hospital, Dublin
The mode of delivery for twins is controversial. Some institutions suggest that all twin pregnancies should be delivered by caesarean section as there is significant morbidity in delivering the second twin by caesarean section.

We analysed our twin database from July 1999 to July 2007 and included all twins where one twin weighed more than 500g or delivered at greater than 24 weeks gestation. There were 972 sets of twins identified that met this criteria. In 11 sets of twins the chorionicity could not be assigned and these were not included in the analysis.

In 509 sets both twins delivered vaginally, in 17 cases the first twin delivered vaginally while the second twin was delivered by an emergency caesarean section. Of those delivered by emergency caesarean section there was only one case where the apgar score at five minutes was less than seven. In eight cases the second twin was heavier than the first twin and in 13 cases the consultant was present at the delivery.

Vaginal delivery should be anticipated in twin pregnancies as in our population it occurred in 53%. The need to perform an emergency caesarean section for the second twin is rare (3.2%). We found that if the second twin is delivered by caesarean section, this is not associated with any significant morbidity.

Abstract No 46

GASTROCHISIS

K. FLOOD¹, M.BARRETT², E. KENT¹, C. KINSELLA¹, A. FORAN² AND F. MALONE¹
1Royal College of Surgeons in Ireland, Rotunda Hospital., Obstetrics and Gynaecology, Dublin, ; ²Dept. Neonatology, Children’s University Hospital, Temple Street, Dublin.

OBJECTIVE
To review in detail the rising incidence of cases of gastrochisis in a tertiary maternity unit.

STUDY DESIGN
Retrospective review of antenatally diagnosed fetal gastroschisis cases over a ten year period. Cases were identified from the perinatal diagnosis register. Manual review of individual patient charts was performed.

RESULTS
There were 68,473 deliveries from 1998 to 2007 inclusive during which time there were 26 antenatally diagnosed fetal gastroschisis cases (3.8/10,000 deliveries). The incidence rose from 1.23/10,000 deliveries during the first half of the decade to 6.1/10,000 in the second half (p<0.001). There was a marked rise in 2007 with ten cases diagnosed (12.01/10,000 deliveries p<0.00002).

62% of the mothers were nulliparous and 30% of the remainder had a history of preterm labour. The average age of the mothers was 23.3 years with 42% less than 20 years old. 92% were single and 48% were unemployed at booking. 44% of mothers were smokers with 15% admitting to use of recreational drugs.

The median gestation at diagnosis was 23+6 weeks. The median gestation at delivery was 35+6 (range 29+3 to 38+4 weeks) with an average birthweight of 2.18kg (range 1.34kg to 2.9kg). 56% of mothers were delivered by cesarean section, 21.4% of which were elective procedures.

There was one intrauterine death at 36 weeks’ gestation and one early neonatal death. The remaining 24 babies underwent successful surgical repair with an average hospital stay of 52.9 days.

CONCLUSION
The rising prevalence of gastroschisis is a trend acknowledged worldwide. We have witnessed this trend both at a national level and at a worrying rate in our maternity unit. Given the need for close monitoring antenatally, the high cesarean delivery rate and length of hospital stay for these babies post repair this rise has huge resource, financial and manpower implications.
Abstract No. 47

SHOULD THE KIELLAND’S FORCEPS COME OUT FROM OUR CUPBOARDS?

UGWU V.C; ALHUSAIN H.A; OSASERE M; TAIWO A; YUDDANDI N.V; HAYES T.
Obstetrics and Gynaecology department, St Luke’s General Hospital Kilkenny.

The art of rotational forceps use is disappearing. The Kielland’s forceps has been criticised for its claimed complications and encircled by litigation, leading to it’s near to complete abandonment. But should this really be? Consideration should be given to the fact that second stage caesarean section is not without attendant morbidity.

Our aim is to determine the use of Kielland’s forceps and its associated morbidity. The study design involved a retrospective review of the maternal and neonatal charts between the years 2007 and 2008. Strict selection criteria were used; absence of foetal distress, foetal head at or below the spines and all procedures were done in the theatre under epidural analgesia.

There were a total of 10 cases; all were primigravidae, 8 were successful; 2 ended up with caesarean section. The birth weights ranged between 3.06 -4.25kg and the Apgar scores averaged 8-10. No immediate or delayed morbidity was attributable to the procedure. One neonate required short observation in SCBU following a caesarean section.

Kielland’s forceps is safe in experienced hands and is applicable in appropriately selected cases. Its key role is to manage the second stage when the head is arrested with occipito posterior or transverse position. Proper management of the second stage definitely will go along way in reducing the astronomical rise in caesarean sections.

REFERENCES:

1. P.M Dunn; Dr Christian Kiel land of Oslo; Archives of Disease in Childhood, fetal and neonatal edition 2004; 89; F465-467

Abstract No. 48

ECSSIT – ELECTIVE CAESAREAN SECTION SYNTOCINON® INFUSION TRIAL: THE FIRST 100 PATIENTS

Sheehan SR 1,2, Carey M 2, Murphy DJ 1,2, on behalf of the ECSSIT Group
1 Department of Obstetrics and Gynaecology, Trinity College Dublin
2 Coombe Women and Infants University Hospital, Dublin 8

The aim of ECSSIT is to compare blood loss at elective lower segment caesarean section with administration of oxytocin 5IU bolus versus oxytocin 5IU bolus and oxytocin 40IU infusion. We analysed the first 100 patients recruited at the Coombe Women and Infants University Hospital to this trial. The baseline characteristics, operative factors and peri-operative outcomes of these patients were assessed blinded.

Women booked for elective caesarean section are recruited to the randomised controlled trial and randomised to receive either oxytocin bolus and placebo infusion or oxytocin bolus and oxytocin 40 IU infusion. The outcome measures are measured blood loss at caesarean section and the need for an additional uterotonic agent.

Of the first 100 women recruited, 70% had a previous caesarean section. The total mean measured blood loss was 822mls. 27 women had a major haemorrhage (measured blood loss >1000ml). An additional uterotonic agent was required in 15 women. 18 women had pre-op anaemia (Hb<10.5d/dl), whilst 55 women had post-operative anaemia. The trial infusion was used in 96 women and discontinued in 12.

It is interesting to see the high incidence of major obstetric haemorrhage (27%) among this population. We eagerly await the conclusion of the trial and the unblinded analysis.
The study aims to recruit 2000 women, 1000 in each arm. To date (end October 2008), 500 have been recruited across the 3 Dublin maternity hospitals. We hope to add a further 2 centres before the end of the year. The target end date is Summer 2010.

Abstract No. 49

OXYTOCIN IN PREVENTION OF HAEMORRHAGE AT CAESAREAN SECTION - A SURVEY OF PRACTICE IN IRELAND AND GREAT BRITAIN

Sheehan SR¹, Wedisinghe L², Macleod M³, Murphy DJ¹
¹ Trinity College Dublin and Coombe Women and Infants University Hospital, Dublin 8
² Glasgow Royal Infirmary, Scotland
³ Ninewells Hospital & Medical School, University of Dundee, Scotland

Operative morbidity of caesarean section includes haemorrhage, anaemia, blood transfusion and in severe cases hysterectomy or maternal death. The optimal use of oxytocin to prevent haemorrhage at caesarean section has received little attention to date. The aim of the study was to establish the views and current practice of obstetricians and anaesthetists regarding oxytocin use to prevent haemorrhage at caesarean section.

We conducted a survey of practice in Ireland and Great Britain. A postal questionnaire was sent to all lead consultant obstetricians and anaesthetists for the labour ward with one subsequent reminder to non-responders. The outcome measures were use of oxytocin bolus and infusion, perceived side-effects of intravenous oxytocin and estimated blood loss at caesarean section.

The response rate was 82% (390 respondents). A slow bolus of 5 IU oxytocin was the preferred approach of obstetricians and anaesthetists (85% and 92% respectively). Oxytocin infusions were used routinely by 21% with selective use for particular clinical circumstances by 78%. Clinicians used either 30 IU (41%) or 40 IU (53%) infusions, with a total of 38 different regimens. The perceived risk of side effects with an oxytocin infusion was low. Estimated “average” blood loss varied (150-1000ml) with 15% and 24% reporting a >20% risk of postpartum haemorrhage for elective and emergency caesarean sections respectively.

There is wide variation in the approach to prevention of haemorrhage at caesarean section, reflecting a lack of robust evidence. This survey supports the need for further research into this important aspect of obstetric care.

Abstract No. 50

POLISH WOMEN’S EXPERIENCE OF MATERNITY CARE IN AN IRISH HOSPITAL

Sabina Gejdel-Koltuniewicz, Gerry Burke
Mid-Western Regional Maternity Hospital, Limerick

Aim
We undertook this study to document the experience of Polish women accessing services at an Irish maternity hospital.

Methods
A survey was carried out of 100 recently delivered Polish women. All were interviewed by a native Polish obstetrics trainee. Interviews were structured and took approximately 18 minutes. Patients were asked to rate various parts of the service on a 1-5 scale. Data were stratified according to whether they had had a previous delivery in Ireland or in Poland.

Results
There were 69 primigravids and 31 multigravids. All had completed secondary education and 33 had completed third level. 44 Had a good standard of English, 35 moderate and 21 poor. 27 Availed of interpretation services. The
average duration of their living in Ireland was 2.2 years. None drank alcohol during the pregnancy and 14 smoked. Three quarters saw a doctor in Poland approximately twice during the pregnancy. Three-quarters obtained a scan in Poland, of which one quarter were 3D. They spent an average of €20 per visit in Poland and €46 per scan. Women who had previously delivered in Ireland were less likely to utilise Polish antenatal services. The caesarean rate was 20%. The preterm delivery rate was 6%. 89% Breast-fed. Patients rated their in-patient experience and the empathy of staff very highly; they were less satisfied with screening for congenital anomalies and the antenatal clinic.

Conclusions
Polish women tend to organise a personalised form of shared antenatal care, typified by obtaining private antenatal services, particularly ultrasound, in Poland.

Abstract No 51
ECTOPIC PREGNANCY MANAGEMENT – WOMEN’ S SATISFACTION SURVEY
M Osasere, F Elmubarack, V Ugwu, H Al Husain, NV Yuddandi, P Wogan, R O’Sullican, T Hayes, H Bourke
Department of Obstetrics and gynaecology, St. Luke’s General Hospital, Kilkenny

As more women attend Early Pregnancy Units, more women are being screened and diagnosed with ectopic pregnancy earlier. This allows management with minimally invasive techniques. This study is undertaken to assess patients’ satisfaction of care, specific to the management of ectopic pregnancy with a view to improve care and services.

Study design involves a retrospective review of case notes of women who were diagnosed with ectopic pregnancy over four year period from 2005 to 2008(to date) at St Lukes Hospital, Kilkenny. Women’s satisfaction in relation to their management is assessed using a 6 point scoring system by telephone interview. The clinical data is analysed from the Microsoft excel sheet. The following are the 6 point satisfaction covering promptness of diagnosis, effectiveness communication, willingness to listen from their perspective, pain relief, maintenance of privacy and confidentiality, provision of psychological support, promptness of treatment and General Practitioner’ role.

6 POINT WOMEN’S SATISFACTION

There were 61 ectopic pregnancies over 4 years; 45 responded (74%), 2 women did not participate, 10 women were un-contactable, mean age 33yr, nullips 18, multips 27, risk factors were noted in 11(25%), 18 had laparotomy, laparoscopy 36, laparoscopy & laparotomy in 15 cases, clinically stable 28, haemodynamically unstable 5, salpingectomy 34, expectant management 7, methotrexate 6.

Ectopic pregnancy counselling is complex and very sensitive. Women often feel disillusioned for their loss and when they were contacted for this study, continued to seek help & support. This study emphasizes the need for follow up
REFERENCES

Abstract No. 52
PRIMARY OMENTAL ECTOPIC PREGNANCY - A CASE REPORT
M Osasere, S Farooq, NV Yuddandi, R O'Sullivan
Obstetrics and gynaecology department, St Luke's hospital, Kilkenny.

Omental pregnancy is an uncommon variety of abdominal ectopic pregnancy which is prevalent in 1 in 10,000 deliveries. Omental pregnancy is associated with seven times higher mortality than tubal ectopic pregnancy. It became exceptional to see an advanced abdominal pregnancy. This case was managed laparoscopically.

28 year old Para1 operated for suspected ectopic pregnancy at 6 weeks gestation and abdominal pain. The trans-vaginal scan revealed an empty uterus, free fluid 6 cm depth with a cyst floating at the fluid margin. The serum HCG was 4650 IU/L. The initial diagnosis was tubal ectopic pregnancy. The laparoscopy showed grossly normal uterus, tubes and ovaries with minimal blood in the pouch of Douglas. There was a haemorrhagic mass adherent to the omentum, Laparoscopic omentectomy and dilatation and curettage was performed. The histology established the diagnosis of omental pregnancy.

Omental pregnancy is the rarest form of abdominal pregnancy and its mortality seven times higher than nonabdominal pregnancies. Early detection of rare ectopic sites is feasible with extensive use of serial serum HCG, transvaginal scan, MRI (Yi KW et al, 2008) and advanced skills in laparoscopy. The symptoms may vary from lower abdominal pain to haemorrhagic shock. Laparoscopic management is feasible once the ectopic site is identified.


Abstract No. 53
AN AUDIT OF UTERINE ARTERY EMBOLIZATIONS FOR SYMPTOMATIC UTERINE LEIOMYOMAS
S Gejdel-Koltuniewicz, AS Khalid, G Burke, P O'Brien
Mid-Western Regional Hospital, Limerick

Aim
The aim of this study was to report the outcome of uterine artery embolization for symptomatic fibroids at Mid-Western Regional Hospital, Limerick.

Methods
We performed a retrospective chart review. A consultant interventional radiologist with extensive experience of the procedure performed all embolizations. The patients had been assessed and referred by consultant gynaecologists. All had preoperative MRI assessments. Bilateral uterine artery embolizations were performed with 500-900 µm Embospheres.

Results
Thirty-three patients had embolization procedures. Follow-up data between 3 and 12 months post-procedure were available for 30 patients. The mean age was 46.5 years. 14 Had a single fibroid and 16 had two or more. The mean maximum size of the largest fibroid was 10cm. Symptoms included menorrhagia (93%), pressure (66%) and...
dysmenorrhoea (60%). Adequate devascularization was obtained in 90%. Two patients had unilateral embolization for technical and procedure intolerance reasons. Pain (77%), pyrexia (17%) and bleeding (10%) were the main postoperative complications but no case of serious morbidity occurred. Improvement in symptoms was reported by 79% at 3 months and in 66% the symptoms resolved completely. The mean reduction in the size of the dominant fibroid was 52% (range 20-90%). Three patients had more than one embolization. Three patients (10%) required hysterectomy for persistent symptoms. The post-operative stay in hospital was one day in 70% and two days in 17% (range 1-4).

Conclusion
Uterine artery embolization is a safe alternative to hysterectomy for symptomatic fibroids. Resolution of symptoms occurred in two-thirds of patients with a single treatment.

Abstract No. 54
IMPROVING THE CLINICAL MANAGEMENT OF WOMEN WITH SEVERE PRE-ECLAMPSIA

Hill A, Walsh CE, Byrne B.
Coombe Women and Infants University Hospital, Dublin

Pre-eclampsia is associated with considerable maternal and foetal morbidity and is an important health care issue where high dependency management can prove invaluable.1,2 Audit both identifies current levels of care in the acute obstetric setting and facilitates improvements to practice.

Retrospective audit of pre-eclamptic women admitted to the high dependency unit (HDU) in 2007 was performed. Consultant discussion and the use of published guidelines enabled examination of 16 set standards of care. Data was analysed using SPSS.

Eligibility criteria were met by 52 women totalling 57 HDU admissions. 57.7% patients were nulliparous with a mean age of 30 years. Admissions occurred antenatally in 61.4%, during the intrapartum period in 10.5% and postnatally in 28.1% of women. Mean length of stay was 39 hours. Average maximum systolic and diastolic blood pressures were 176 mmHg and 111 mmHg respectively. Mean proteinuria detected was 2.2 g/ 24 hours. Average delivery gestation was 34 weeks with 73% requiring emergency caesarean section. In 5 of the assessed standards of care, 100% achievement was demonstrated. The remaining standards were met in 53% to 98% of cases. The management of severe hypertension and fluid balance were identified as two areas requiring review.

The disease severity justified HDU admission in all cases. Standards of care were excellent overall, but there are clearly identified areas for clinical improvement. Realistic targets have been set for re-audit in six months time and these should be achievable by developing and improving protocols for the management of severe pre-eclampsia in the HDU setting.


Abstract No. 55
A COHORT OF REACTIVE THROMBOCYTOSIS IN PREGNANCY

AS Khalid, VV Wong, S Gejdel-Koltuniewicz, G Burke.
Mid-Western Regional Maternity Hospital, Ennis Road, Limerick

Platelets are acute-phase reactants: they increase in response to various stimuli, including systemic infections, inflammatory conditions, bleeding, and tumours. This is called reactive or secondary thrombocytosis, which is benign. While the management of essential thrombocytosis in pregnancy (platelet count >600 x 10^9 L^-1, persisting
more than three months) is established, the management of persistent reactive thrombocytosis with a moderate increase in the platelet count ($>400 \times 10^9 \text{L}^{-1}$ and $< 600 \times 10^9 \text{L}^{-1}$ persisting for three months) is unclear. Pregnancy is a hypercoagulable state and therefore reactive thrombocytosis carries theoretical risks of venous thromboembolism and intrauterine growth restriction. The aim of this study was to document the obstetric outcome of patients with persistent moderate thrombocytosis.

Charts of patients with a platelet count $>400 \times 10^9 \text{L}^{-1}$ at booking and persisting for at least three months were reviewed retrospectively.

Thirty patients were identified, none have essential thrombocytosis. Platelet counts fluctuated between $400 \times 10^9 \text{L}^{-1}$ and $707 \times 10^9 \text{L}^{-1}$. Eight patients had persistent high platelet counts which returned to normal at delivery. Fifteen patients, who had persistently high platelets after delivery and had more than three moderate risk factors for VTE, were treated with low-dose aspirin and prophylactic low-molecular weight heparin. Seven patients who had persistently high platelet counts after delivery but no other risk factors did not receive any treatment. There was no instance of IUGR, miscarriage, VTE, or poor perinatal outcome.

In this cohort of patients with persistent moderate thrombocytosis, there was no adverse pregnancy outcome.

**Abstract No. 56**

**EVALUATION OF MMP-9 INHIBITOR AND CISPLATIN CYTOTOXICITY IN A CHEMORESISTANT OVARIAN CANCER CELL LINE USING HIGH CONTENT SCREENING (HCS) CELL-BASED ASSAYS**


Department of Obstetrics and Gynaecology/Histopathology, Department of Clinical Medicine, Trinity College Dublin, St James’s Hospital and Coombe Women’s Hospital, Dublin, Ireland.

Resistance to cytotoxic drugs principally limits long-term treatment success against ovarian cancer. We previously identified MMP-9 as a potential marker of recurrence/chemoresistance. We hypothesized that using a chemical inhibitor of MMP-9 (MMP-9i) alone or in conjunction with cisplatin the chemoresistance phenotype seen in ovarian cancer cells could be overcome.

A2780cis (cisplatin-resistant) human ovarian carcinoma cell line was used. The cytotoxic effect of MMP-9i and MMP-9i+cisplatin in combination was determined using the multiparameter cytotoxicity 1 Kit by Thermo Fisher. Cells were plated in triplicate in 96-well plates overnight and then treated with various concentrations of drugs for 3, 6 and 24 hours. A preincubation for 3 and 6 hours with MMP-9i prior to treatment with cisplatin was also assessed. Cells were then stained with a three-in-one fluorescent dye to image nucleus, cell permeability and lysosomal pH respectively. Image acquisition analysis was performed by using HCS tool (an automated fluorescent microscope) and the optimized software. The relative fluorescent intensity was used to quantify the above changes.

MMP-9i alone had a cytotoxic effect in cisplatin-resistant at high doses (260-520uM) at 3h, 6h and 12h time points but also at an early time course (3h) even at a sublethal dose (56um) The combined treatment of MMP-9i+cisplatin enhances cytotoxicity compared to cisplatin alone. Preincubating cells with MMP-9i at all doses were significantly cytotoxic at 3h but not 6h suggesting an early apoptotic response.

Specific MMP-9i might have a place in treatment of recurrent/chemoresistant ovarian cancer but their role in vivo remains to be evaluated.
**Abstract No. 57**

**NEONATAL MORBIDITY CORRELATES CLOSELY WITH GESTATIONAL AGE AND NOT THE AETIOLOGY OF ATE PRETERM BIRTH**

Niamh Daly, Claire O’Sullivan, Rhona Mahony, Michael Foley.
National Maternity Hospital, Holles Street, Dublin 2.

Recent interest in late preterm neonatal morbidity prompted us to analyze outcome in this centre where the overall preterm birth rate is low.

A prospective study of neonatal outcome among late singleton preterm births was conducted during a 6-month period.

For the 6 months, Jan- June 2008, 3.4% (144/4200) presented between 34 and 37 week’ gestation. There was a highly significant inverse correlation between the rate of admission to the neonatal unit and increasing gestational age at delivery (34 weeks -91% admission rate, 35 weeks – 60 %, and 36 week- 24.7%, P<0.001) and also for duration of stay in the neonatal unit and decreasing gestational age (5.9, 8.5, and 10.4 days respectively) (r=0.99). Overall 36 % (52/144) were admitted to the neonatal unit (> 24 hours) for an average of 8.1days (423/52). The reasons for admission included: - respiratory distress (n=5, 9%), transient tachypnea (n=15, 27%).

Overall, septic screens were carried out on 35% of neonates (51/144) producing one positive culture and 15% (22/144) required phototherapy; not all were admitted to the neonatal unit and there was some overlap between the different indications for admission. There was one Grade 1 intraventricular hemorrhage and no case of necrotising enterocolitis. Three required ventilation – 2 RDS and one Group B streptococcal sepsis. There were no neonatal deaths. Precursors of preterm birth included :-spontaneous labor -50%(72/144), PSROM( >24hrs) – 21% (30/144), PET –11%(16/144) and other -17% (25/144) and did not appear to correlate with neonatal outcome.

The rate of preterm birth (3.4%) was low as was neonatal morbidity. Admissions to and duration of stay in the neonatal unit correlated very closely with gestational age at delivery and not with the etiology preterm delivery of which preterm labor and PSROM were the most common causes.

**Abstract No. 58**

**HYPEROSMOLAR NON-KETOTIC COMA: A RARE LIFE-THREATENING METABOLIC EMERGENCY IN A PREGNANT PATIENT WITH PREVIOUSLY UNDIAGNOSED DIABETES AND PRE-ECLAMPSIA**

Daly N, Murphy C, Foley M
National Maternity Hospital, Holles St, Dublin.

We present the case of a young woman, 30+5 weeks gestation, with no prior history of diabetes, who presents with hyperosmolar non-ketotic coma (HONK). This is a condition characteristic of uncontrolled non-insulin dependent diabetes mellitus, usually found in elderly patients and mostly associated with intercurrent illness, and extremely rare in pregnancy. It has a reported mortality of 20-30%. In this case intrauterine death was diagnosed at presentation. We believe this to be the first reported case in Ireland.

**Abstract No. 59**

**BREECH PRESENTATION AT TERM**

B.Akbar, R. Roopnarinesingh
Department of Obstetrics & Gynaecology, The Rotunda Hospital, Parnell Square West, Dublin 1.

**Objective:**
To assess success rates of External Cephalic Version (ECV) at term and to determine its effect on maternal and fetal outcome.
Materials & Methods:
A retrospective analysis of all women attending the Antenatal Clinic with breech presentation at the Rotunda Hospital, Dublin 1 between January 1st and December 31st 2006. Data was collected from the hospital case notes and delivery notes for each patient. Maternal details reviewed included age, parity, gestation at the diagnosis, ultrasonographic findings (type of presentation, liquor volume, fetal weight, and placental localization), ECV undertaken and mode of delivery. Fetal weight, Apgar Scores, resuscitation and NICU admission were also assessed.

Results:
The study group comprised 239 patients. The mean maternal age was 30+/− 5.8 years, with parity ranging from 0-5. The mean gestational age was 39.4 weeks with a mean fetal weight of 3.2 Kgs. One hundred and forty seven patients were deemed unsuitable for ECV. The commonest reason ECV was not undertaken was undiagnosed breech (42%). Other reasons included previous surgery to uterus (29%), oligohydramnios (16%), the deeply engaged breech (1%), conversion to cephalic presentation (1%). Placenta previa, big baby contributed to less than 1%. Ninety two women were suitable and 20 women were not offered ECV. Forty five women (49%) refused ECV following counseling. A uterine muscle relaxant was given between 10 and 15 minutes pre-ECV. No woman complained of abdominal pain during the procedure. Overall ECV was performed on 27 patients and 10 had successful outcome (37%). Only one patient had fetal distressed that recovered and there were no long term complications during the procedure. Of the 10 women who had successful ECV the vaginal delivery rate was 80%. No differences were seen in maternal and fetal outcome between the patients with ECV and the general hospital population.

Conclusion:
External Cephalic Version at term is associated with an 80% vaginal delivery rate and in our study had no additional maternal or neonatal morbidity. However, half of all women offered ECV refuse the procedure following counselling. In conclusion, ECV should continue to offer to patients at term.

Keywords:
External Cephalic Version (ECV), breech, lower segment cesarean sections (LSCS)

Abstract No. 60

MOLAR PREGNANCY IN A 54 YEARS OLD PERIMENOPAUSAL WOMAN: A CASE REPORT.

S N Johnson, A Curtain.
Department of Gynecology, South Infirmary Victoria University Hospital, Cork, Ireland

Gestational trophoblastic disease (GTD) is an abnormal pregnancy with placental villous abnormalities ranging from benign hydatidiform mole, invasive mole; choriocarcinoma to placental site trophoblastic tumor. The mean maternal age of patients with GTD is 27-28 years. GTD in women more than 50 years is usually malignant. To date, there are few series (ref 1, 2) reported in the world literature of gestational diseases occurring in women older than 50 years. Even rarer are reports of benign trophoblastic disease in women of perimenopausal and postmenopausal status (ref.1, 2)

We present the case of a 54 year perimenopausal women who presented with two months amenorrhea followed by irregular PV bleeding, pedal edema and abdominal distension. She was referred by GP with 16-18 weeks sized uterus and pelvic scan suspicious of endometrial carcinoma. Her initial serum beta HCG was 1895236mIU/mL. She had a dilatation & curettage done in April 2008 and histology showed benign complete molar pregnancy. Postoperatively her serum beta HCG level fell rapidly. She is currently doing well with undetectable beta HCG levels. The plan is to follow her up for a year with monthly serum beta HCG, and to do hysterectomy or chemotherapy if there is any plateau or rise in beta HCG level.

Though molar pregnancy is rare in women more than 50 years, it’s important to consider the diagnosis while evaluating patients with perimenopausal abnormal bleeding and any postmenopausal bleeding because of high incidence of malignant GTD in this age group.
Abstract No. 61

THE NEED TO TARGET THE 20 WEEK ANOMALY SCAN

Ismail SK, Wong VV, Gejdel S, Ismail KI, Slevin J, Burke G
Mid-Western Regional Maternity Hospital, Limerick, Ireland

Aim
The aim of the study was to determine the value of an anomaly scan at 20 weeks.

Method
An audit of 262 anomaly scans. Data were stratified according to the referral indication. The indication groups were (1) advanced maternal age, (2) maternal medical conditions, (3) previous fetal anomaly, (4) multiple gestation, (5) family history of congenital anomaly, (6) abnormality on earlier scan, (7) maternal request.

Results
There were 11 (4%) anomalies in this group, of which 9 (82%) were detected. There were no anomalies among 96 patients scanned for maternal request alone.

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Anomaly present</th>
<th>Anomaly detected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>50</td>
<td>3 (6%)</td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>36</td>
<td>1 (3%)</td>
<td>100%</td>
</tr>
<tr>
<td>3</td>
<td>26</td>
<td>2 (8%)</td>
<td>0%</td>
</tr>
<tr>
<td>4</td>
<td>20</td>
<td>0 (0%)</td>
<td>n/a</td>
</tr>
<tr>
<td>5</td>
<td>27</td>
<td>1 (4%)</td>
<td>100%</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>4 (57%)</td>
<td>100%</td>
</tr>
<tr>
<td>7</td>
<td>96</td>
<td>0 (0%)</td>
<td>n/a</td>
</tr>
<tr>
<td>Total</td>
<td>262</td>
<td>11 (4%)</td>
<td>9/11 (82%)</td>
</tr>
</tbody>
</table>

Anomalies detected in Group 1 were anencephaly, encephalocele and enlarged liver, spleen and heart. In Group 2, a renal transplant mother had a fetus with severe ventriculomegaly. Two anomalies in Group 3 were not detected: arthrogryphosis and VSD. In Group 5, a cleft lip and palate was correctly diagnosed. Anomalies detected during earlier scans, Group 6, included multicystic kidney, two cases of gastrochisis and ascites due to fetal anaemia.

Conclusion
In a routine two scan programme, the value of an additional anomaly scan at 20 weeks is questionable, except in targeted groups. Such screening should be concentrated on patients with a suspicious earlier scan, a previous anomaly and advanced maternal age.
Abstract No. 62

SPONTANEOUS RUPTURE OF THE UNSCARRED UTERUS - A CASE REPORT AND REVIEW OF THE LITERATURE

P Ajith, M Gannon
Midlands Regional Hospital, Mullingar, Co: Westmeath

Background:
Uterine rupture is a major obstetric complication, most commonly involving a previous uterine scar. It is an uncommon event but associated with high perinatal and maternal morbidity and mortality. The incidence of rupture in an unscarred uterus is rare occurring in about 1 in 20,000 deliveries.

Case:
A 40 year old para1 patient presented with worsening severe lower abdominal pain and vomiting at 37 weeks gestation. Of note in the history was evacuation of retained products of conception for missed miscarriage five months before. She underwent emergency laparotomy due to sudden hemodynamic instability and loss of fetal heart. The intraoperative finding was rupture of uterus at the fundus and a well grown dead fetus free in the peritoneal cavity. The uterus was repaired in three layers and the patient did well postoperatively.

Literature review:
There are studies done to compare uterine rupture in scarred and unscarred uterus. The risk factors outlined for rupture in an unscarred uterus are grand multiparity, dilatation and curettage, abdominal trauma, labour induction, malpresentations, macrosomia, previous invasive mole, uterine anomalies and connective diseases. Uterine rupture has also been reported in primigravida with these risk factors.

Conclusion:
Spontaneous rupture of a previously intact uterus, although rare and unexpected, can be a devastating complication of pregnancy and labour. It is imperative that a high index of suspicion is required for diagnosis of uterine rupture in all women presenting with abdominal pain, hypovolemia and fetal compromise regardless of parity. Prompt recognition of rupture and expeditious recourse to laparotomy are the critical factors influencing perinatal and maternal morbidity and mortality.

Abstract No. 63

VAGINAL RECURRENCE IN OVARIAN CANCER- TWO CASE REPORTS

G Visvalingam, N Farah, H Butt, N Gleeson
Department of Gynaecology Oncology, St. James’s Hospital, Dublin 8

Aim:
To highlight the unusual vaginal site of recurrence in ovarian cancer and hence emphasize the importance of thorough PV exam in all ovarian cancer patients presenting at follow up visits.

Materials & Methods:
2 case reports with literature review.

Results:
Two patients post surgery and chemotherapy for ovarian cancer stage 1A and FIGO stage IIIc were found to have sub-urethral and para-urethral vaginal nodules respectively and histology of which showed recurrence of ovarian cancer. In both cases the vaginal nodules were picked up during routine follow-up outpatient PV examination. They proceeded to have CT thorax, abdomen and pelvis which showed no evidence of metastatic disease elsewhere in both cases. It was decided that this isolated recurrence in the vagina heralds a more widespread recurrence of their cancer and that they would benefit from further chemotherapy.
Conclusion:
Ovarian carcinoma is the most common cause of death from a gynaecologic malignancy. The most important prognostic factors are the presence and magnitude of residual or recurrent disease after therapy. Recurrent ovarian malignancy usually manifest as pelvic masses in the surgical bed, peritoneal seeding, nodal recurrence and pleuropulmonary lesions and liver metastasis. In our unit we have found two cases with unusual vaginal site recurrence that was picked up on routine follow up outpatient PV examination. Hence a thorough PV exam in addition to follow up of tumour markers is crucial for all patients with ovarian cancer.

Abstract No. 64
A CLUSTER OF HETEROTOPIC PREGNANCY IN SPONTANEOUS AND LOW RISK CONCEPTION: CASE REPORTS
Alabi OY., Ajeigbo O, Fadare KM, Yekinni IO, Hughes P
Department of Obstetrics and Gynaecology, Kerry General Hospital, Tralee, Co. Kerry
Though heterotopic pregnancy is rare and difficult to diagnose, this paper seeks to reiterate the need to have a high index of suspicion and institute a robust investigation to exclude co-existing extra-uterine pregnancy in a pregnancy complicated with sudden abdominal pain, hypotension and falling haemoglobin.

Two cases of heterotopic pregnancies seen in our hospital in the last two years are presented with a review of literature.

Two women with no risk factor for ectopic gestation and with about 6-8 weeks of gestational amenorrhoea who presented at acutely with abdominal pain, hypotension and falling haemoglobin levels, each had a viable intra-uterine gestation diagnosed with ultrasound scan and an ectopic gestation diagnosed at surgery with histological confirmation. The outcome of these two cases were good. Case 1 had a spontaneous vaginal delivery of live female infant and case 2 has an EDD of 21/02/2009.

Heterotopic pregnancy is a rare clinical phenomenon occurring in about 1 in 30,000 spontaneous pregnancies. The incidence is much higher in assisted reproduction. A figure as high as 1 in 100 has been quoted in literatures. It is very difficult to diagnose it radiologically; therefore the clinician’s index of suspicion should not be lowered by the presence of intra-uterine pregnancy gestation in a symptomatic woman until a co-existing extra-uterine gestation has been excluded.

Abstract No. 65
FEMALE GENITAL MUTILATION - CASE STUDY
Hala Abu-Subeih
Department of Obstetrics, Limerick Maternity Hospital, Limerick

A case study of a patient who had a long-term sequelae of female genital mutilation and how she was diagnosed and treated.

B.O is a 36 year old lady who presented to gynecology clinic in Limerick regional hospital with long standing complaint of perineal mass. Patient history dates back to 23 years when she had circumcision as a child in Nigeria. Patient noticed that the mass is getting bigger causing a dragging sensation at perineum. She denied any urinary symptoms but she complains of anorgasmia. No abnormal discharge. On examination to perineum a cystic mass at paraclitoral area of about 4 by4 cms, not reducible, non tender, no signs of inflammation and no enlarged lymph nodes.(PICTURES BELOW)

The diagnosis of epidermal inclusion cyst at clitoral area was established which is a long term sequel of female genital mutilation.

Female genital mutilation (FGM) is the partial or total removal of the female genitalia for non-medical reasons.
The practice is illegal in the United Kingdom and Ireland.

It is estimated that one woman dies every 10 minutes from the sequel of the procedure. The World Health Organization (WHO) has outlawed it on the grounds that it is a violation of human rights. The practice has been banned in many countries around the world but not eradicated.

Classification of FGM by WHO

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Excision of the prepuce with or without excision of part or all of the clitoris</td>
</tr>
<tr>
<td>II</td>
<td>Excision of the clitoris with partial or total excision of the labia minora</td>
</tr>
<tr>
<td>III</td>
<td>Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)</td>
</tr>
<tr>
<td>IV</td>
<td>Unclassified – includes applying corrosive substances for narrowing the vagina, pricking, piercing, incising, stretching, scraping or other harming procedures performed on the clitoris and/or labia</td>
</tr>
</tbody>
</table>

Acute complications of FGM are haemorrhage, shock, infection, tetanus & septicaemia. Retention of urine from pain and direct mechanical obstruction. Injury to the urethra, vagina, perineum or rectum; and urinary or faecal incontinence.

Long-term complications are Keloid formation, Paraclitoral cyst, Sexual dysfunction and marital disharmony, Anorgasmia, Recurrent urinary tract infection, Renal failure and Hematocolpos.

REFERENCES:
DR KEVIN HICKEY (CONSULTANT OBS/GYN) MID-WESTERN REGIONAL HOSPITAL-LIMERICK
DR JERRY BURKE (CONSULTANT OBS/GYN) MID-WESTERN REGIONAL HOSPITAL-LIMERICK

Abstract No. 66

WOUND INFECTION AFTER CAESAREAN SECTION: A PILOT STUDY

Khalifeh A, Meenan AM, Hannify R, O'Sullivan N, Fitzpatrick C and Turner MJ.
UCD School of Medicine and Medical Science & the Micobiology Department, Coombe Women and University Hospital, Dublin 8, Ireland

Objective
To determine the incidence of wound infection and independent risk factors following caesarean section.

Methods
A prospective audit was conducted on 99 women who delivered by caesarean section in July-August 2008. All women received prophylactic intravenous cefuroxime (1.5 g intravenously) given at cord clamping. All wounds, belonging to the clean-contaminated class, were reviewed before discharge. Their microbiological results were also reviewed if they presented to the hospital after discharge. Different clinical parameters were recorded using a protocol adapted from Northern Ireland on caesarean section surveillance (See Table 1). The definition of surgical site infection was standardised.
Results
The overall wound infection incidence was 7% (7 patients); 5 were diagnosed as inpatients and 2 as outpatients. Three were elective caesarean sections and four were emergency caesarean sections, one of which not in labour. All sections lasted less than one hour. There were no independent risk factors identified, including Diabetes Mellitus and immunosuppression. The commonest organisms isolated were anaerobes followed by staphylococcus aureus. Wound infection did not prolong length of stay as inpatients.

Conclusion
The incidence of 7% is similar to previous studies elsewhere. The datasheet used in our analysis will be rolled out nationally by the Health Protection Surveillance Centre (HSE) as part of the strategy for the control of Antimicrobial Resistance in Ireland (SARI). The next step is to assess the timing of prophylactic antibiotics on a larger number of patients; would that influence the incidence of infection after caesarean section?

Table 1

<table>
<thead>
<tr>
<th></th>
<th>BMI (Average)</th>
<th>Membrane rupture</th>
<th>Previous CS</th>
<th>Diabetes Mellitus/ Gestational Diabetes</th>
<th>Immunosuppression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total n=99</td>
<td>25.3kg/m²</td>
<td>4.6hrs</td>
<td>38</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Infected wounds n=7</td>
<td>26.0 kg/m²</td>
<td>2.6hrs</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Abstract No. 67

OVARIAN MYOFIBROBLASTIC TUMOUR FISTULATING ON TO THE ANTERIOR ABDOMINAL WALL

G Khan a, P Byrne a, M leader b, B Png c, J.P Garvey. c

a Department of Obstetrics and Gynaecology, Beaumont Hospital, Dublin 9
b Department of Histopathology, Beaumont Hospital, Dublin 9
c Department of Nephrology, Dublin 9

To report an unusual case of ovarian myofibroblastic tumour making a fistulous communication with the anterior abdominal wall.

Inflammatory myofibroblastic tumours (IMT) are unusual lesions of unknown aetiology that have been reported in numerous anatomic sites. Also known as inflammatory pseudotumours or plasma cell granulomas, they were originally reported to be in the lungs of young adults. These tumours have potential for recurrence, persistent local growth, and rarely metastases.

The authors report an unusual case of an ovarian inflammatory myofibroblastic tumour in a 47-year-old woman that fistulated onto the anterior abdominal wall. Two cases of inflammatory myofibroblastic tumour of ovary have been reported previously, but none has presented with a fistulous communication to the anterior abdominal wall.
Abstract No. 68

MRSA SEPTICAEMIA AFTER FAILED UTERINE ARTERY EMBOLIZATION IN A PATIENT WITH UNDERLYING LEIOMYOSACOMA

M Akram, AWI Edoo, B. Gill, H Langan
Department of Obstetrics & Gynaecology, Sligo General Hospital, Sligo

Uterine sarcoma accounts for 3-7% of all malignant diseases of uterine corpus. Leiomyosarcoma are the commonest, accounting for about 25-36% and they are notorious for their aggressive nature and poor prognosis. Approximately 0.1-0.5% of women who have hysterectomies for uterine fibroids are found to have Leiomyosarcoma. With the increasing use of conservative techniques for treating uterine fibroids, the likelihood of a delay in diagnosis of these tumours remains a particularly disturbing problem. Also the ability of currently available imaging techniques in differentiating malignant from benign disease is disappointing.

We present the case of a 49 years old lady who presented 10 months post uterine artery embolization (UAE) with history of profuse vaginal discharge and abdominal pain on a background of MRSA infection since the therapeutic procedure. On examination, cervix was replaced by a large necrotic mass, the biopsy of which came back as necrosis with suggestion of sarcoma.

The patient underwent laparotomy and a bulky necrotic uterus of about 20 weeks size was removed. Dense adhesions of uterus to bladder, bowel and omentum were noted. She developed high grade pyrexia during the procedure and blood cultures grew Methicillin-Resistant Staphylococcus Aureus (MRSA). The pathological report confirmed uterine leiomyosarcoma. Follow-up CT scan showed extensive lung parenchymal metastasis and direct invasion of bladder from residual disease.

Uterine sarcomas cannot be diagnosed except by pathological examination of a resected specimen. Women considering UAE for treatment of apparent leiomyomata should be informed of the risk of delaying diagnosis and treatment of uterine sarcomas.

References:
Acharya S, Hensley ML, Montag AC, Fleming GF, Rare uterine cancers; Lancet oncology 2005; 6:961-971

Abstract No. 69

HISTONE DEACETYLASE INHIBITORS AND A FUNCTIONAL POTENT INHIBITORY EFFECT ON HUMAN UTERINE CONTRACTILITY

Mark P Hehir1, Aidan M Sharkey1, Stephen C Robson2, GN Europe-Finner2 and John J Morrison1.
1Department of Obstetrics and Gynaecology, National University of Ireland, Galway, Ireland and 2School of Surgical and Reproductive Science, University of Newcastle Upon Tyne, United Kingdom.

Histone Deacetylase Inhibitors (HDACi’s) have been shown on a molecular level to induce the expression of genes involved in the maintenance of myometrial quiescence (1). The aim of this study was to evaluate the effect of the HDACis Trichostatin A (TSA), Suberic bishydroxamate (SBHA) and Valproic Acid (VPA) on human uterine contractions and hence their potential role as tocolytic agents.

Biopsies of human myometrium were obtained at elective caesarean section (n=36). Dissected myometrial strips suspended under isometric conditions, undergoing spontaneous and oxytocin-induced contractions, were exposed to cumulative additions of three HDACi’s: TSA and SBHA in the concentration range of 1 nmol/L to 100 mmol/L and VPA (100nmol/L-1mmol/L). Control experiments were run simultaneously. Integrals of contractile activity were measured using the powerlab hardware unit and chart 4.0 software. Data were analysed using one-way ANOVA followed by post-hoc analysis.
All 3 HDACi compounds exerted a potent and cumulative inhibitory effect on spontaneous (n=18) and oxytocin-induced (n=18) contractility. The mean maximal inhibition values for the three compounds were as follows: TSA, 46-54% (P<0.05), SBHA, 53-65% (P<0.05) and VPA, 35-36% (P<0.05).

These results raise the possibility that HDACi’s may have tocolytic potential, in addition to their current clinical indications. We speculate that the inhibitory effect observed may be linked, at least in part, to the ability of HDACi’s to induce the expression of genes involved in the maintenance of myometrial quiescence via epigenetic mechanisms but may potentially also potentially involve non-epigenetic pathways.

Ref

Abstract No 70

CAESAREAN SECTION RATE VS MATERNAL BODY MASS INDEX (BMI)

Broderick V, Broderick S, Farah N, Stuart B, Turner M J
UCD School of Medicine and Medical Science, Coombe Women and Infants University Hospital, Dublin

Obesity is defined as a BMI > 29.9 kg/m\(^2\). Maternal obesity has been associated with increased intervention rates. The calculation of BMI in previous reports is usually based on prepregnancy or self-reported pregnancy weight which are inaccurate.

Using the Hospital computerised database we analysed all women who delivered a baby weighing >500g between January 2005 - June 2008. Only women weighed at their booking visit were included.

The total number of women studied was 14,887. The incidence of obesity in primigravidas was 11.1% and in multigravidas was 20.3%. The Table shows the caesarean rate analysed by parity.

As BMI increased, the total caesarean section rate increased. In developed countries the incidence of caesarean section is rising and the prevalence of obesity is increasing. Analysis by parity shows that the prevalence of obesity is higher in multigravidas but the incidence of caesarean section is higher in primigravidas. Obesity intervention studies intended to decrease caesarean section rates should focus on primagravidas.

<table>
<thead>
<tr>
<th>BMI (kg/m(^2))</th>
<th>&lt;18.5</th>
<th>18.5-24.9</th>
<th>25.0-29.9</th>
<th>30.0-34.9</th>
<th>&gt;35.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Elective CS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primip</strong></td>
<td>2.9%</td>
<td>4.0%</td>
<td>4.3%</td>
<td>4.5%</td>
<td>6.8%</td>
</tr>
<tr>
<td>(n=6)</td>
<td>(n=148)</td>
<td>(n=67)</td>
<td>(n=21)</td>
<td></td>
<td>(n=14)</td>
</tr>
<tr>
<td><strong>Emerg CS</strong></td>
<td>7.9%</td>
<td>13.6%</td>
<td>19.4%</td>
<td>31.1%</td>
<td>37.1%</td>
</tr>
<tr>
<td><strong>Primip</strong></td>
<td>(n=16)</td>
<td>(n=497)</td>
<td>(n=300)</td>
<td>(n=146)</td>
<td>(n=76)</td>
</tr>
<tr>
<td><strong>Total CS</strong></td>
<td>10.8%</td>
<td>17.6%</td>
<td>31.2%</td>
<td>35.5%</td>
<td>43.9%</td>
</tr>
<tr>
<td><strong>Primip</strong></td>
<td>(n=22)</td>
<td>(n=645)</td>
<td>(n=367)</td>
<td>(n=167)</td>
<td>(n=90)</td>
</tr>
<tr>
<td><strong>Elective CS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Multips</strong></td>
<td>11.6%</td>
<td>8.1%</td>
<td>11.1%</td>
<td>13.9%</td>
<td>20.6%</td>
</tr>
<tr>
<td>(n=19)</td>
<td>(n=348)</td>
<td>(n=306)</td>
<td>(n=152)</td>
<td></td>
<td>(n=97)</td>
</tr>
<tr>
<td><strong>Emerg CS</strong></td>
<td>7.3%</td>
<td>5.8%</td>
<td>6.9%</td>
<td>10.1%</td>
<td>11.4%</td>
</tr>
<tr>
<td><strong>Multips</strong></td>
<td>(n=12)</td>
<td>(n=253)</td>
<td>(n=191)</td>
<td>(n=111)</td>
<td>(n=54)</td>
</tr>
<tr>
<td><strong>Total CS</strong></td>
<td>18.9%</td>
<td>13.9%</td>
<td>18.0%</td>
<td>24%</td>
<td>32.0%</td>
</tr>
<tr>
<td><strong>Multips</strong></td>
<td>(n=31)</td>
<td>(n=601)</td>
<td>(n=497)</td>
<td>(n=262)</td>
<td>(n=151)</td>
</tr>
</tbody>
</table>
Abstract No. 71

**FETAL MACROSOMIA VS MATERNAL BODY MASS INDEX (BMI)**

Broderick V, Broderick S, Farah N, Stuart B, Turner M J
UCD School of Medicine and Medical Sciences, Coombe Women and Infants University Hospital, Dublin.

Previous studies have reported an association between fetal macrosomia and maternal obesity. However, differing definitions of macrosomia were used and obesity was usually based on prepregnancy or selfreported Body Mass Index (kg/m²).

The study was confined to women who had their weight measured at their booking visit and who delivered a baby weighing ≥500g between January 2005 and July 2008. The results analysed by parity and the WHO BMI classification is shown in the table.

Using the Pearson’s Correlation Coefficient, the relationship between BMI and birth weight was weak for both primigravidae and multigravidae.

Further research is required to determine whether the “weak” is due to genetic factors, gestational diabetes or other environmental cofactors rather than maternal adiposity.

<table>
<thead>
<tr>
<th>BMI (kg/m²)</th>
<th>&lt;18.5</th>
<th>18.5-24.9</th>
<th>25.0-29.9</th>
<th>30.0-34.9</th>
<th>&gt;35</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthweight 4.0-4.5kg Primip</td>
<td>3.4% (n=7)</td>
<td>8.7% (n=316)</td>
<td>12% (n=187)</td>
<td>13.8% (n=65)</td>
<td>13.1% (n=27)</td>
</tr>
<tr>
<td>Birthweight &gt;4.5kg Primip</td>
<td>1.5% (n=3)</td>
<td>1.2% (n=44)</td>
<td>2.6% (n=41)</td>
<td>3.6% (n=17)</td>
<td>5.8% (n=12)</td>
</tr>
<tr>
<td>Birthweight 4.0-4.5kg Multips</td>
<td>2.4% (n=4)</td>
<td>12.3% (n=528)</td>
<td>16.8% (n=466)</td>
<td>16.7% (n=184)</td>
<td>25.5% (n=121)</td>
</tr>
<tr>
<td>Birthweight &gt;4.5kg Multips</td>
<td>0.6% (n=1)</td>
<td>2.2% (n=96)</td>
<td>2.7% (n=76)</td>
<td>5.5% (n=61)</td>
<td>7.8% (n=37)</td>
</tr>
</tbody>
</table>

Abstract No. 72

**CLINICO-PATHOLOGICAL CORRELATIONS IN PERIPARTUM HYSTERECTOMY**

The Coombe Women's Hospital, The Rotunda Hospital, National Maternity Hospital, Dublin

Peripartum hysterectomy is a rare event complicating 0.42/1000 deliveries\(^1\). The main indication is placenta praevia/ accreta in women with one or more caesarean sections and rates are increasing as CS rates increase. Histopathological examination of these specimens can be difficult and clinical suspicions are not always confirmed. The aim of our study was to investigate the clinicopathological correlation in this setting.

A retrospective study of massive obstetric haemorrhage (MOH) (i.e. transfusion ≥ 5 RCC) was carried out in three Dublin maternity hospitals from Jan 2004 to Dec 2007 inclusive. Cases of hysterectomy were identified and clinical and pathological data were examined.129 women with MOH were identified out of 90400 deliveries and 28 required hysterectomy, yielding an incidence of 0.3 per 1000 deliveries in this setting. The mean age was 35yrs, 11% were-
para 0, with 78% para 1-3, the remaining 11% were greater than para 3. 78% were delivered by CS.

Clinical details provided to the pathology dept were detailed, sparse or absent in 60%, 25% and 15% respectively. Thus clinical and pathological findings correlated in (20/25) 80%. Pathology added additional information in (11/28) 39%. The better the clinical data provided the greater the correlation.

Clinical and pathological findings don’t always correlate in the setting of peripartum hysterectomy for MOH and it is important that this is appreciated in medicolegal cases. Correlations can be enhanced by improving communication between obstetricians and pathologists.


Abstract No. 73

SYPHILIS - A REVIEW OF MANAGEMENT & OUTCOME IN A TERTIARY REFERRAL UNIT

M. Ramphul, O. Phelan, M. O'Connell.
The Coombe Women & Infants University Hospital, Dublin.

The emergence of syphilis in recent years has posed many problems in the antenatal period. Syphilis can affect both the mother and her baby. An infected mother has a high risk of having a stillbirth or a live infant suffering sequelae of congenital syphilis. However, these can be prevented by prompt, appropriate treatment of the woman antenatally and of the infant at birth.

This study aims to identify management and outcome of those seen in the antenatal period with positive serology in the Coombe Women’s & Infants’ Hospital. Data was collected retrospectively from 2005 to 2007 and prospectively in 2008. A review of antenatal and paediatric charts was undertaken.

A total of 39 cases were identified, 18 of which were of known history of syphilis. A total of 20 women underwent treatment in the pregnancy. Of the 39 cases, 20 were of Eastern European origin, 12 African, 1 South American, 4 Asian with only 2 of Irish origin. All cases identified were reviewed by the GUIDE clinic and all babies were referred to the Rainbow Clinic.

There was no adverse perinatal outcome in the cohort. Syphilis is an emerging albeit rare antenatal management issue. This study illustrated the value of a multidisciplinary approach to the study.
Abstract No. 74

MATERNAL MORBID OBESITY AND PREGNANCY OUTCOMES

Maher N, Farah N, Fattah C, Broderick V, Stuart B, Turner MJ.
UCD School of Medicine and Medical Science, Coombe Women and Infants University Hospital, Dublin, Ireland.

Based on the WHO classification, obesity is diagnosed when the Body Mass Index (BMI) is >29.9 kg/m$^2$. Morbid or severe obesity is diagnosed when BMI is >39.9 kg/m$^2$. The aim of this study was to examine pregnancy outcomes in morbidly obese women.

Retrospective analysis was conducted on women with a BMI >39.9 kg/m$^2$ at the antenatal booking visit who delivered a live baby weighing ≥ 500g in 2007. Labour outcomes included induction of labour, mode of delivery, and macrosomia. Maternal outcomes included diabetes mellitus, hypertension and wound infection.

There were 95 patients studied. The mean BMI was 43.3 kg/m$^2$ (40.1-52.9 kg/m$^2$). Glucose Tolerance Test (GTT) was not done in 16 (18%) patients. In those who had their GTT (n=79), there were 12 cases of gestational diabetes and 13 cases of impaired glucose tolerance diagnosed. Fourteen percent of the patients developed pre-eclampsia and 14% had hypertension, compared to 7% and 10.5% respectively, in all mothers delivered. The caesarean section rate was 50% as opposed to an average of 22%. The induction rate was 42%. The mean birth weight was 3,600g; 31 (33%) babies were >4,000g and 6 (6.3%) babies were >4,500g. There were 9 wound infections and two cases of postpartum haemorrhage. There was no case of venous thromboembolism.

Morbidly obese women are at high risk of obstetric intervention and complications. This study highlights the need for prepregnancy assessment. We also recommend that pregnant women who are morbidly obese should be supervised by a senior obstetrician and, if necessary, a multidisciplinary team.

Abstract No. 75

MANAGEMENT OF DYSGERMINOMA IN A 24 YEAR OLD WOMAN

D Hayes-Ryan, M McMenamin, F Cullinane
Department of Obstetrics and Gynaecology, University Hospital Galway

A 24 year old woman with a 4 day history of severe lower abdominal pain was found to have a 16 week size pelvic mass. MRI showed a 19cm x 11cm x 13cm mass arising from the right ovary with associated right hydronephrosis and right hydroureter. CT thorax, abdomen and pelvis showed no evidence of lymphadenopathy. βhCG: 55 IU/L, LDH: 2617 U/L, Ca125: 52.8 U/mL, AFP: 7.9 ng/ml.

She was referred to a Gynaecological Oncologist. A malignant dysgerminoma (stage 2B) was diagnosed following CT guided biopsy. She is currently having nine cycles of neoadjuvant chemotherapy (bleomycin, etoposide, cisplatin). This will be followed by re-imaging, with a view to unilateral fertility preserving surgery. A rigid cystoscopy and JJ stenting of right ureter were performed prior to commencing chemotherapy.

Dysgerminoma is the most commonly occurring germ cell tumour. All dysgerminomas are considered malignant but only one third behave aggressively. They account for 1-5% of ovarian cancers and affect girls and young women. For patients with early stage disease cure rates approach 100%, while for those with advanced-stage disease are at least 75%. The exact aetiology of dysgerminomas has not been determined.

75-80% present at stage I and can be treated by surgical resection alone with a unilateral salpingo-oophorectomy. The management of dysgerminoma with fertility-sparing surgery is a safe and practicable treatment option. The majority of these women can retain normal ovarian function and reproductive potential after chemotherapy treatment. There is no correlation between tumour size and prognosis.
References


Abstract No. 76

ENDOMETRIAL CURRETTINGS: CORRELATION BETWEEN VISUAL AND HISTOLOGICAL IMPRESSIONS

Dunne E., Moses Abe*, Bill Boyd
Mater Misericordiae Hospital Dublin

Aim:
To determine the correlation between clinical (visual) impressions of endometrial curetteings obtained at EUA, hysteroscopy, D&C and histological diagnosis while investigating abnormal uterine bleeding.

A retrospective study of all women who underwent EUA, hysteroscopy D&C at a tertiary referral centre for gynaecology-oncology over a three-year period. A total of 287 cases were examined. Data collected include age of patient, indication for undergoing D+C, grade of operator, clinical appearance of currettings and histological report.

Out of the 287 currettings examined, 14 (4.8%) had histological diagnosis of endometrial carcinoma. 10 out these 14 samples (71.4%) had been labelled as clinically suspicious of malignancy at EUA, hysteroscopy, D&C.

There is excellent correlation between clinical appearance of endometrial currettings and histological evaluation. This should have significant impact on communication with patients post EUA, prioritising histology samples and scheduling follow up appointments.

Abstract No. 77

SUCCESSFUL PREGNANCY FOLLOWING CONSERVATIVE SURGERY FOR STAGE 1C OVARIAN CANCER IN A 36 YEAR OLD WOMAN: A CASE REPORT

F Martyn, R O’Connor

Background: Surgery for ovarian cancer in young women wishing to maintain reproductive capability – can less radical surgery preserve fertility without compromising survival?

Case: A 33 year old lady presented to our services in August 2004, with a two day history of severe left sided lower abdominal pain. Her last menstrual period was two weeks prior and she had been using the combined oral contraceptive pill for 2 years. She had no urinary or bowel symptoms and had no past medical history of note. Ultrasound scan identified a large complex pelvic mass measuring 15cm by 15cm. She underwent an emergency laparotomy due to pain. At operation, a large right multi-locular ovarian cyst was found and a right salpingo-oophorectomy was performed. Peritoneal fluid was taken at the time of the operation. The cyst was difficult to mobilise due to dense adhesions and unfortunately ruptured at the time of operation. Histopathology confirmed that this was a poorly differentiated mucinous cystadenocarcinoma of the right ovary with microacinar infiltration close to the capsule of the ovary but with no breach of the capsule. Peritoneal fluid showed no malignant cells. The patient went on to have chemotherapy with carboplatin and paclitaxel. The patient returned two years later with pv spotting at 10 weeks gestation and ultrasound scan confirmed a missed miscarriage at 7 weeks gestation. An evacuation of retained products of conception was performed and histopathology revealed a partial mole. Follow up serum HCG at 6 months was negative. Four months following this first pregnancy, another pregnancy was achieved and she had a booking ultrasound scan at 21 weeks gestation which was entirely normal. She had a routine antenatal course and was induced at 40 weeks and 10 days. She had a normal vaginal delivery of a healthy 4.3 kg baby. Her postpartum course was uneventful and she remains well with normal CA125 levels.
Conclusion: Long term survival of patients having conservative surgery for stage 1C ovarian cancer is excellent. As women postpone having their families into their late thirties, more, early stage ovarian cancers will be diagnosed and consequently their will be an increased requirement for fertility sparing operations.

Abstract No. 78

REVIEW OF CASES OF CLINICALLY SUSPECTED MALIGNENCY

Singh S., GleeSon N.
St James Hospital, Dublin

All cases with suspected diagnosis of Malignency, referred from different hospitals all over the country. Cases with confirmed diagnosis of malignancy were excluded.
Total – 27 patients

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>ovary</td>
<td>21</td>
</tr>
<tr>
<td>uterus</td>
<td>3</td>
</tr>
<tr>
<td>vulva</td>
<td>2</td>
</tr>
<tr>
<td>other</td>
<td>1</td>
</tr>
</tbody>
</table>

Tumor markers in ovarian cases-
Normal- 14
<50 2
>50 but <100 4
>100 1

Histology-
Ovarian-Benign functional cyst/ Dermoid/Torsion-3
Cystadenoma/ Fibroma/Brenner -8
Bilateral Hydrosalpinx-1
Mesenteric cyst-1
Crohns disease, mucocoel of appendix-1
Fibroid, broad ligament, cervical -4
Endometriotic cyst 2
Inflammatory tuboovarian mass 1
Uterus-Simple hyperplasia-1
Fibroid - 2
Vulval- Pagets disease-1
Angiomyxoma-1
Other-Fibroid -1

Duration of stay- Average- 8 days

Benefits Of treatment In Tertiary Centre – Patients get appropriate management.
Disadvantage- Anxiety, Away from their own surroundings, overtreatment, morbidity, Cost.
Abstract No. 79

TWO PLACENTAS, ONE BABY; A CASE OF BI-LOBATED PLACENTA

Alabi OY, Varughese A, Harkin R  
Department of Obstetrics & Gynaecology, Our Lady of Lourdes Hospital, Drogheda, Co. Louth

Bi-lobated placenta is a morphological abnormality which is often missed on ultrasound scan during the prenatal period. Nevertheless, it poses potential risks to the index pregnancy and carries a possibility of recurrence in subsequent pregnancies. This is what this paper sets out to highlight.

A case of bi-lobated placenta in a woman who had an essentially uneventful pregnancy and delivery is presented with a brief review of literatures.

A 33-year old Para 2+0 was booked at 14 weeks. Her previous deliveries were by Caesarean section. The course of pregnancy was uneventful. She had straightforward elective Caesarean section at 39 weeks culminating in the birth of a live female infant with Apgar score of 9 and 10 and birth weight of 2.9 Kg. Routine examination of the placenta revealed two separate lobes. The histology revealed a bi-lobated placenta. The umbilical cord has three vessels with a Velamentous insertion.

Bi-lobated placenta is a morphological abnormality which is associated with increased risk of vasa previa. It is a recognised cause of first trimester bleeding, polyhydramnios, antepartum haemorrhage and postpartum haemorrhage. It is very difficult to diagnose antenatally. The main advantage would be to ensure that there is no vasa previa and to manage accordingly if present. Prior knowledge of the placental structure should help avoid retained products of conception and subsequent Post Partum Haemorrhage. The patient should be adequately counselled of the potential risks and the clinicians should exercise a great deal of caution especially during the peripartum period.

Abstract No. 80

NEUROFIBROMATOSIS PRESENTING AS A PELVIC MASS TO GYNAECOLOGY

Alabi OY, Freyne A, Akpan ES, Hanson J, Ryan J  
Department of Obstetrics & Gynaecology, Our Lady of Lourdes Hospital, Drogheda, Co. Louth  
Department of Radiology, Our Lady of Lourdes Hospital, Drogheda, Co. Louth  
Department of Pathology, Our Lady of Lourdes Hospital, Drogheda, Co. Louth

Retroperitoneal mass is a rare presentation of neurofibromatosis. It is very rare that this condition would present first to the gynaecology team. We seek to highlight that not all supposedly pelvic masses are gynaecological in origin and to emphasize the importance of multidisciplinary approach, not only in management but also in the diagnosis of any medical disorder.

A case of neurofibromatosis presenting as a pelvic mass to the gynaecological team with a brief literature review.

A 30-year old woman was referred by her GP because of abdominal pain to our casualty department. She had a personal and strong family history of neurofibromatosis. On admission, she was not in acute distress but had a palpable abdominal mass arising from the pelvis. An ultrasound scan revealed a dermoid cyst. She then had a diagnostic laparoscopy which showed that the mass was retroperitoneal. This was confirmed by CT-scan and subsequently had ultrasound-guided biopsy. The histology of the biopsy confirmed malignant tumor of the peripheral nerve sheath. She was then referred on to oncology and urology services. She subsequently had a laparotomy to remove the mass.

Neurofibromatosis is an autosomal dominant disorder which may be complicated with abdominal mass. This may present to any specialty and when in doubt, the opinion of other team(s) should be promptly sought for diagnosis and/or management.
Abstract No. 81

USE OF FETAL LACTATE IN INTRAPARTUM MANAGEMENT

M McMenamin, S Canny, F Cullinane
University Hospital Galway (UHG)

Fetal lactate sampling in labour has been validated by randomised controlled multicentre trials to be as effective as pH in identifying babies at risk of acidaemia and has the benefit of requiring a smaller sample size.

Fetal scalp lactate measurement was introduced to UHG in 2008. The aim of this retrospective audit conducted between 1 April 2008 and 31 October 2008 was to correlate fetal scalp lactate with fetal scalp pH, cord pH and neonatal outcome. Women were identified from the lactate analyser database.

To date, 76 women have had 96 lactate samples. 51 women had one fetal blood sampling (FBS), 19 women had 2, 5 women had 3 and 1 woman had 4 FBS. 61% of women were in spontaneous labour and 68% had oxytocin in labour. 39% had an emergency caesarean section and 35% had an instrumental delivery. 39% had an emergency caesarean section and 35% had an instrumental delivery. 61/96 samples (63.5%) had concurrent scalp pH measurement. The scalp lactate was < 4.2mmol/L in 44/61 samples (88.6%). The scalp pH was ≥ 7.25 in 39/44 samples (88.6%). It was between 7.20-7.25 in 5 samples. The scalp lactate was ≥ 4.2mmol/L in 17/61 samples. The scalp pH was ≥ 7.25 in 7/17 samples (41.2%). It was between 7.20-7.25 in 8/17 samples and was less than < 7.20 in 2/17 samples. The scalp lactate was ≥ 4.8mmol in 12 samples. Eight of these samples were associated with a pH of less than 7.25.

Fetal scalp lactate measurement would appear to be applicable to the Irish setting.

References

Abstract No. 82

THE IMPACT OF ANHYDRAMNIOS AT TERM ON MATERNAL AND FETAL MORBIDITY AND MORTALITY.

G Visvalingam, N Purandare, S Cooley, R Roopnarinesingh, M Geary
Department of Obstetrics and Gynaecology, Rotunda Hospital, Dublin 1.

Aim:
To assess the maternal, fetal outcome and complications in women induced for anhydramnios after 37 completed weeks of gestation.

Materials & Methods:
A retrospective study in the Rotunda Hospital from 1/1/2003 to 31/12/2007. Inclusion and exclusion criteria were established. All women with anhydramnios at term identified on review of ViewPoint® data and the labour ward register were eligible for inclusion. To avoid confounding factors women with a history of previous caesarean section (LSCS), or a current significant medical illness such as diabetes, hypertension or pre-eclampsia (PET) were excluded. Maternal and fetal obstetric outcome parameters reviewed included: maternal age, parity, gestation, method of induction, mode of delivery, duration of labour, fetal weight, Apgar Score and the requirement for obstetric or neonatal intervention.

Results:
A LSCS rate of 56.6% for primigravida was observed. The LSCS rate for multigravida was 19.0%. All babies delivered by LSCS or spontaneous vaginal delivery (SVD) had normal Apgar scores. Three babies requiring instrumental delivery had sub-optimal Apgar scores.
Conclusion:
Anhydraminos is associated with a 56.6% LSCS rate in primigravida and a 19.0% LSCS rate in multigravida. Our study did not show significant neonatal morbidity.

Abstract No. 83
ENDOMETROID ADENOCARCINOMA IN A KNOWN CASE OF ENDOMETRIOSIS
Nikhil Purandare, Kara Purcell, Fathi Ramly, Andrew Curtain, Mr Morgan McCourt

INTRODUCTION
Malignant transformation of endometriosis occurs in 0.7–1% of patients with endometriosis, with 78.7% of the cases occurring in the ovary (1). Among extragonadal sites, the colorectum is involved in only 5% of endometriosis-associated malignant tumours (2).

CASE PRESENTATION
A 57-year-old woman (P0 +1) presented with excreting stool via the vagina with the background history of left pelvic mass. She also had abdominal and pelvic pain, weight loss, altered bowel habit and vaginal bleeding. Background history of endometriosis and Sertoli-Leydig cell tumour of the ovary, subtotal hysterectomy and bilateral salpingo-oophrectomy. Examination under anaesthesia with biopsy of the cervix was performed. The tumour cells were immunopositive for cytokeratin 7 and EMA, but negative for cytokeratin 20, Inhibin, Chromogram and the tumour was histologically diagnosed as Endometroid adenocarcinoma of high grade type. The patient was later found to have tumour of the midsigmoid and was treated with palliative radiotherapy.

CONCLUSION
It is imperative to appreciate the possibility of tumours arising from endometriosis when evaluating pelvic masses with intestinal involvement in women, even in the patient who has previously undergone a subtotal hysterectomy and bilateral salpingo-oophrectomy, particularly if the patient has a history of endometriosis and has received hormone replacement therapy.


Abstract No. 84
OBSTETRIC FACTORS AND TRENDS THEREOF FOR WOMEN ≥ 40 YEARS - A 19 YEAR STUDY
Gupta S, Ravikumar N, Hession M, Morrison JJ.
Department of Obstetrics & Gynaecology
Clinical Science Institute, University College Hospital, Galway Newcastle Road, Galway, Republic of Ireland.

The aim of the study was to investigate the obstetric factors pertinent to women ≥ 40 years and the trends in such factors over a 19 year period, 1989-2007.

Of a total of 52,245 delivered over this time period, n= 2330 (4.5%), were women ≥ 40 years of age at the time of delivery. There was a gradual increase from 4.2% (n=97) in 1989 to 5.7% (n=191) in 2007. The parity details were as follows: para 0 n=376 (17.2%); para 1-4 n= 7476(68.6%); para ≥ 5 n=297(14.2%), and trends in parity are reported. The overall average incidence of hypertensive disease was 12.5%, varying annually from 7-20%. The prevalence of other medical disorders was as follows: anaemia 8.6% (n=48), psychiatric disease 8.13% (n=45), UTI (n=63)11.4%. Trends in delivery mode over the study period are presented.
Delivery at preterm gestation was 9% (n=34) and the gestation breakdown as follows: The multiple pregnancy rate overall was 0.02% (n=34 twin pregnancies, n=68 babies), with no significant variation over the years. The overall stillbirth rate was 1.6% (n=20). The early neonatal death rate was 0.5% (n= 14). Overall perinatal mortality was less than 1.7 per 1000. The number of infants with Down syndrome was n=25 (0.01%). Other congenital anomalies were n=20 (0.008%).

There is a gradual increase in women delivered ≥ 40 years of age, with trends for a different mode of management.

Abstract No. 85

UNPLANNED PREGNANCY IN CORK

Babiker E, Gaughan E, Higgins JR, O’Donoghue K
Cork University Maternity Hospital (CUMH), Cork

Unplanned pregnancy has been highlighted as a risk factor for inadequate use of prenatal care. Pregnancy intention, specially unwanted pregnancy or ambivalence is suggested as an indicator of increased risk of poor perinatal and maternal outcomes.

The purpose of this study was to identify the local demographics and risk factors for women with unplanned pregnancy. We also we aimed to highlight the circumstances surrounding unintended conception. A detailed questionnaire was given to women booking in CUMH (n=200 analysed)

66% of women planned their pregnancy, while 34% pregnancies were unplanned. All women with unintended conception did not take folic acid before pregnancy, but almost all commenced it after diagnosis. Among the planned group, 21% of women were not taking folic acid before pregnancy. Regarding family planning in the unplanned group, 47% were not using any form of contraception, while 26% were on the combined pill and 22% were using barrier contraception. No specific lifestyle factors were identified by either group as responsible for or contributing to the conception.

This survey revealed that a significant number of women attend CUMH with an unplanned pregnancy. There is a direct link between unplanned conception and the inappropriate use of family planning. Lack of uniform pre-pregnancy counselling might explain the numbers of women planning pregnancy who are not taking folic acid pre-conceptually. Our findings highlight a need for improved access to and distribution of family planning information.

Abstract No. 86

THE TRANSCRIPTION FACTOR SOX11 IS A PROGNOSTIC FACTOR FOR IMPROVED RECURRENCE FREE SURVIVAL IN EPITHELIAL OVARIAN CANCER

Donal Brennan1, Emma Doyle3, Sara Ek3, Thomas Drew2, Grainne Flannelly1, Michael Foley1,2, Carl A Borrebaeck3, Karin Jirstrom4 and Colm O’Herlihy1,2

1Dept of Gynaecology, National Maternity Hospital, Holles Street Dublin 2; 2UCD School of Medicine and Medical Science; 3Dept of Obstetrics and Gynecology, Karolinska Institutet; 4Karolinska Institutet University Hospital, Stockholm, Sweden

Table 1.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Count</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>SVD</td>
<td>1309</td>
<td>56.20</td>
</tr>
<tr>
<td>Elective LSCS</td>
<td>428</td>
<td>18.4</td>
</tr>
<tr>
<td>Emergency LSCS</td>
<td>253</td>
<td>10.8</td>
</tr>
<tr>
<td>Ventouse</td>
<td>207</td>
<td>8.9</td>
</tr>
<tr>
<td>Forceps</td>
<td>92</td>
<td>3.9</td>
</tr>
</tbody>
</table>
Current prognostic molecular markers for epithelial ovarian cancer (EOC) are insufficient. Members of our group have previously identified Sox11 as a diagnostic marker for mantle cell lymphoma [1]. The aim of the current study was to investigate the role of Sox11 in EOC.

Using an in silico transcriptomic screen, containing data from 9783 samples analyzed using Affymetrix gene expression microarrays, Sox11 was identified as a potential EOC biomarker. Sox11 protein expression was evaluated using immunohistochemistry (IHC) in a tissue microarray (TMA) containing 76 EOC cases, which was analyzed using automated algorithms to develop a quantitative scoring model in similar fashion to previous work by our group [2]. Sox11 mRNA expression was up-regulated in EOC compared to normal tissues. Automated analysis of Sox11 in the EOC cohort revealed high expression of Sox11, in 40% of tumours, who had an improved recurrence free survival (RFS) (p= 0.002). Multivariate analysis confirmed Sox11 was an independent predictor of improved RFS after controlling for stage and grade.

SOX 11 is a potential new prognostic marker in EOC. Loss of SOX 11 is associated with a decreased RFS and a more aggressive phenotype. Data mining of large transcriptomic and antibody-based proteomic resources can establish a pathway for the discovery of new predictive and prognostic biomarkers in EOC. These biomarkers can then be validated in a high-throughput fashion using TMAs.


Abstract No. 87

PERINATAL MORTALITY AT THE ROTUNDA HOSPITAL, A 5 YEAR REVIEW.

McVey RM, Murray A, Geary M.
Department of Obstetrics & Gynaecology, Rotunda Hospital, Parnell St., Dublin 1.

Aim:
To review all the perinatal mortality cases from the Rotunda Hospital Annual Reports 2003 – 2007. The overall rate applies to all babies greater than or equal to 500g who were stillborn or died in the first seven days of life. Each year the Dublin maternity hospitals produce annual reports covering all aspects of the previous year’s activity. Rarely, however, do we examine perinatal mortality in detail over a number of years in order to identify trends. Improving patient care and outcome is our aim.

Methods
The individual Perinatal Mortality Cases in the Annual Reports for the years 2003-2007 were reviewed and results collated. Data was stratified according to age, parity, gravity, stillbirth/intrapartum death/neonatal death, gestational age booking, anatomy scan details, antenatal care events, background history, presentation problem, method of initiation of labour, method of delivery, birth weight, gender, postmortem findings, intrauterine death bloods details.

Results
343 cases of perinatal mortality were identified, including 234 stillbirths of which 39 were cord accidents, and 23 unexplained cases. Congenital abnormalities accounted for 65 cases, giving a corrected perinatal mortality rate of 5.16. We will discuss in detail the management of individual cases with a view to improve standards of care for this patient group.
Discussion
Identifying trends in perinatal mortality cases over five years facilitates the improvement of patient care and helps with planning for the future.

Abstract No. 88

A CASE REPORT OF SQUAMOUS CELL CARCINOMA OF THE NEOVAGINA FOLLOWING AMNION VAGINOPLASTY IN MAYER–ROKITANSKY–KUSTER–HAUSER SYNDROME

P Sibartie, B Png, K Astbury, V Broderick, A Wong, A Laios, N Gleeson, P Crowley
Department of Obstetrics and Gynaecology, St. James’s Hospital, Dublin, Ireland

Vaginal cancer is uncommon and primary carcinoma of the neovagina in patients with vaginal agenesis is of a rarer occurrence. The authors report a case of a 39 year old female with congenital absence of vagina and uterus consistent with Mayer–Rokitansky–Kuster–Hauser Syndrome. In 1989, a neovagina was constructed using an amnion graft with no intra or post operative complications. She was diagnosed with HIV 5 years ago and she presented with a 5-month history of vaginal pain and discharge. An irregular area in the upper anterior vagina was identified on examination and punch biopsy was performed. Microscopic findings confirm invasive moderately differentiated squamous cell carcinoma of the neovagina with evidence of human papilloma virus infection at Figo Stage IIb with puborectalis muscle and ischiorectal fossa infiltration. She is currently undergoing radiotherapy.

Neovaginal construction has been performed using a variety of tissues: bowel, skin graft, vulvar skin flaps, rectus abdominus (myocutaneous) flaps, inverted penile skin, and amnion. Review of the published literature has revealed a number of case reports of carcinoma of the neovagina in patients with vagina reconstruction. According to our knowledge, there was another reported case of malignancy in amnion vaginoplasty.

Given the potential risk for neovagina carcinoma post vagina reconstruction, we propose routine follow-up gynaecological examinations on a regular basis. Particularly in immuno-suppressed patients such as in our case report, they are more susceptible to developing carcinoma.

Abstract No. 89

SUSPECTED URINARY TRACT INFECTION IN PREGNANCY-A CAUSE OF UNNECESSARY HOSPITAL ADMISSIONS?

Kennelly M, Singh S, Crowley P
The Coombe Women and Infants University Hospital

Urinary tract infections are frequently encountered medical complications of pregnancy. They are also the most common bacterial infections that affect this group. Our aim in this review is to analyse the percentage of admissions with clinically suspected urinary tract infections that were actually confirmed microbiologically with this diagnosis.

A retrospective review of charts of 87 women admitted to the Coombe Women and Infants University Hospital beginning from July 2007 to June 2008. Women included in the study were between 24 and 42 weeks gestation admitted to the antenatal ward with symptoms suggestive of a UTI +/- positive dipstick

87 patients spent 214 days in hospital. Of these 44(50.5%) had IV antibiotics, 28(32.18%) had oral and 15 (17.24%) had no antibiotic treatment at all. The most common antibiotic prescribed IV was Co-amoxiclav (40.9%) followed by cephadrine (15.9%) and cefotaxime (15.9%). Interestingly only 21(24.13%) had a positive MSU. As would be predicted, E.coli was the most common uropathogen (57.1%) followed by enterococcus (14.28%), Klebsiella (4.76%) and pseudomonas (4.76). 4 patients were documented to have severe infection/pyelonephritis

There is a major discrepancy between clinically perceived UTI and laboratory confirmation. Factors that may lead to
over diagnosis include: lack of specific criteria for the distinction between mild, moderate and severe UTI and pyelonephritis, not having blood results available including acute inflammatory markers prior to patient review. Treatment protocol was not adhered with inappropriate use of IV antibiotics where oral therapy and out patient management would have sufficed.

Abstract No. 90

EVALUATION OF ANTENATAL ULTRASOUND MARKERS IN PREDICTING CHORIONICITY

T Hassan, A Freyne, G Visvalingam, S Higgins
Department of Obstetrics and Gynaecology, Our Lady of Lourdes Hospital, Drogheda

To evaluate the accuracy of antenatal ultrasound markers in predicting chorionicity in twin pregnancy.

Retrospective analysis of twin pregnancies delivered in OLOLH, Drogheda was carried out over a 4 year period (2004 – 2007). During this period 14868 patients delivered of which 202 were twin pregnancies. Ultrasound scan reports and gestational age at assessment were obtained from the database in Fetal Assessment Unit. Antenatal determinants of chorionicity used were the presence or absence of twin peak sign, the number of identifiable placental masses and fetal gender and were compared postnatally with neonatal sex and placental histology where necessary.

Where placental histology was available the following correlation in predicting chorionicity occurred. 148 sets of twins have placental histology available to compare it with antenatal chorionicity. Chorionicity was correctly predicted in 120 cases by histology alone and 141 cases where histology was combined with postnatal gender. A disparity was seen in antenatal diagnosis of chorionicity and placental histology in 28 cases and in all except 4 cases the scan was done after 14 weeks.

Ultrasound assessment of chorionicity can achieve 99 % sensitivity and 97% specificity, when performed between 10-14 weeks and by an experienced operator. Adequate first trimester evaluation of a twin pregnancy makes the subsequent second and third trimester ultrasound examination much more meaningful.

Abstract No. 91

A CASE REPORT OF LATE RECURRENCE OF GRANULOSA CELL TUMOUR OF THE OVARY.

B Png, K Astbury, A Wong, V Broderick, A Laios, N Gleeson
Department of Obstetrics and Gynaecology, St. James’s Hospital, Dublin, Ireland

Adult granulosa cell tumors (GCTs) of the ovary are rare, hormonally active neoplasms, characterized by endocrine manifestations with an indolent course and has been known to present with late recurrences.

We describe a case of a 55-year old lady, who presented with recurrent GCT, 11 years after her initial diagnosis of a FigO Stage 1a, GCT of the left ovary. She did not receive any adjuvant chemotherapy. Two years after her initial diagnosis, she was diagnosed with a left breast ductal carcinoma in-situ and had a wide local excision with adjuvant radiotherapy.

In her current presentation, she complained of a 3-month history of abdominal pain, radiological scans which include PET scan revealed a solid/cystic left upper retroperitoneal mass suggestive of recurrence. This was confirmed on biopsy. The mass measuring 11x6x4cm was resected, histology of which confirmed a recurrent adult type GCT in the para aortic region with a focus of deposit in the omentum.

There has been much debate regarding the benefit of using chemotherapy in primary or recurrent GCTs. The long natural history of this disease highlights the importance of extended follow-up for patients with GCTs and the need of radiological and immunohistochemical surveillance. In this case, we will be reviewing the incidence, management and prognosis of this rare tumour.
Abstract No. 92

CLINICAL RISK MANAGEMENT OF OBSTETRIC ANAL SPHINCTER INJURY. HAVE WE IMPROVED?

Burke NM, Corcoran S, Ryan H, Barrett N, Afaneh I, Geary MP
Dept of Obstetrics and Gynaecology, Rotunda Maternity Hospital, Dublin 1

In recent years there has been an increasing trend towards litigation for obstetric anal sphincter injury (OASI). This in turn has led to an evolving role for clinical risk management. A retrospective study of all OASI in the Rotunda between Jan 2005 and Dec 2006 suggested that an improvement in documentation was necessary to meet best practice guidelines (RCOG). In Feb 2008 a proforma for the management of 3rd and 4th degree perineal tears was introduced in the Rotunda hospital. This study aims to assess the role of this proforma in the clinical risk management of OASI and to see if its implementation has facilitated us reaching best practice standards.

All cases of OASI were identified using the McKesson Obstetric Management System from Feb 2008 until August 2008. During this time a proforma for the management of 3rd and 4th degree tears was completed and filed in the patient chart. A retrospective review of the patient chart and proforma took place.

During this period there were 73 cases of OASI. Of these 82% (n=60) were classified as 3rd degree, 11% (n=8) as 4th degree and 7% were unclassified. This compared dramatically with the statistics from the previous study where 56% were unclassified. Maternal, fetal and intrapartum features were also examined with 74% (n=54) primiparous, 25% (n=18) of the babies weighing over 4kg and 60% (n=44) were operative vaginal deliveries. In 67% (n=49) of the cases the proforma had been completed. Intra operative and post operative care details were investigated. The documentation of swab counts increased to 77% from 23%. Post natal follow up was attended by 80% (n=59). The incidence of incontinence of flatus was 15% (n=8) however there were no incidents of faecal incontinence/knot migration/abscess formation or need to refer for colorectal opinion. There was also an improvement in patient debriefing from 59% to 68% (n=50) after the introduction of the proforma. Information offered regarding future pregnancies went from 27% up to 42% (n=31).

It is evident from this study that the introduction of a proforma for the management of 3rd and 4th degree tears may assist in attaining best practice standards. By utilising methods of clinical risk management we can improve communication with patients, reduce litigation, and decrease morbidity.

Abstract No. 93

AUDIT OF SHOULDER DYSTOCIA - THE ROTUNDA 2008

S Corcoran, N Burke, N Barrett, H Ryan, I Afaneh, M Geary

Introduction:
A Standardised Proforma of management and documentation of Shoulder dystocia cases was introduced at the Rotunda Hospital in February 2008 following a study which concluded a poor documentation of management and events of Shoulder dystocia cases delivered at our hospital in 2005 & 2006.

Aim
To review shoulder dystocia outcome and documentation after introduction of a new Proforma.

Methods:
Shoulder dystocia was defined as a delivery that requires additional maneuvers to release the shoulders after gentle downward traction has failed. (RCOG Dec 2005)

The new standardised proforma was implemented for shoulder dystocia cases from 1st February and the Audit loop closed on 30th August 2008. The proforma was available in labour ward and was filled by birth attendants soon after delivery.
Standard management was MacRoberts position, lateral suprapubic pressure, internal rotation or delivery of posterior arm. Specific regular training was used to describe how these manoeuvres needed to be performed.

Results
Of 3811 delivered vaginally over the Audit period (seven months) 51 cases (1.3%) had shoulder dystocia. Thirty (59%) cases were multiparous women, 35 (68%) laboured spontaneously and 22 (39%) had an instrumental delivery.

One patient had a history of shoulder dystocia and two patients were gestational diabetics.

Most babies (48) were delivered in McRobert’s position and suprapubic pressure, 3 babies required additional manoeuvres. Birth weight range was 3100-5170 gr, 31 (61%) babies had a birth weight ≥4000 gr and 67% were male. Four babies had Apgar 5 at 1 min and one baby had Apgar 7 at 5 min, One baby had reduced shoulder movements after delivery.

Two mothers had 3rd degree and one had 4th degree tears.

43 (84%) cases had the shoulder dystocia proforma filled and 39 (77%) had documented explanatory notes postnatally.

Conclusion:
Standardisation of management and documentation of shoulder dystocia can lead to higher reporting of cases as reflected by doubling of Incidence in this audit (1.3% vs 0.56%). There was also improved documentation, better communication and follow up of patients when compared with first part of the audit.

Abstract No 94

A CASE OF INDIRECT MATERNAL DEATH AT UNIVERSITY COLLEGE HOSPITAL GALWAY

S Mullers, G Gaffney, H Langan, JJ Morrison
Departments of Obstetrics & Gynaecology, University College Hospital Galway, Newcastle Road, Galway & Sligo General Hospital.

A 42 year-old Para 3 woman was transferred to UCHG with a DCDA twin pregnancy at 28 weeks gestation. She initially presented to Sligo General Hospital with constitutional symptoms over 6 months, a sternal mass she noticed 2 weeks earlier and right sided Bell’s Palsy. A biopsy of the sternal mass revealed disseminated metastatic adenocarcinoma of unknown origin with markedly elevated tumor markers. MRI showed metastatic disease to lung, lumbar and thoracic spine and brain. She was referred for multidisciplinary care involving oncology, obstetrics and palliative care. Fetal ultrasound demonstrated a biometry consistent with dates normal amniotic fluid and Doppler waveforms. Maternal abdominal ultrasound scan showed multiple hepatic lesions, in keeping with deranged liver function tests. Maternal condition deteriorated with dropping oxygen saturations and haeomoptysis requiring emergency lower segment Caesarean Section at 28+2 weeks. Two female infants, both weighing 920 grams, were delivered in good condition. They were transferred to the special care unit. Postoperatively CT scan revealed a complete collapse of the left lung with bilateral pleural effusions. Palliative radiotherapy was commenced thereafter but her condition continued to deteriorate, and she passed away 11 days following delivery secondary to respiratory arrest. She did not undergo a post-mortem examination.

This case outlines the problems associated with prenatal care at early gestation with deteriorating maternal lung function and systemic malignant disease. In addition, the difficulties associated with aggressive chemo-radiation in pregnancy, and when to resort to palliation, are highlighted.
Abstract No. 95

OUT PATIENT HYSTEROscopy – WE NEED TO BROADEN OUR SCOPE

Barrett N.A., Mc Millan H.M., Fitzpatrick C
Coombe Women and Infant’s Hospital, Dublin

This study aims to investigate the availability of outpatient hysteroscopy in hospitals in Ireland. Specially designed outpatient hysteroscopes avoid the need for a general anaesthetic and decrease associated morbidity and costs. It is also associated with high patient satisfaction. However, we suspect that it is not being used to its full potential.

For this study, gynaecology units were directly contacted to establish which units performed out patient hysteroscopy. Details of the number of sessions performed and grade of staff were noted. Specialist registrars on the Irish training scheme were then contacted to identify their level of interest in learning and performing out patient hysteroscopy. This included an enquiry as to whether they would be willing to travel to other units to do this procedure.

A minority of gynaecology units perform outpatient hysteroscopy. This number has decreased since the Higgin’s report in 2006. The majority of these units provide one session per week. This service is usually provided by a specialist registrar. Specialist registrars appear keen to be involved in outpatient hysteroscopy. Indeed, this is a requirement of higher medical training.

In conclusion, we need to broaden the scope of outpatient hysteroscopy. We therefore need to invest in the future by training specialist registrars in this skill, if necessary by encouraging that they attend other units for training.

Abstract No 96

EARLY ONSET PRE-ECLAMPSIA REQUIRING PREGNANCY TERMINATION – A REPORT OF 2 CASES

Deane RP, Unterscheider J, Gaffney G, Morrison JJ
Department of Obstetrics & Gynaecology, Galway University Hospitals, Newcastle Road, Galway

We present 2 cases of early onset pre-eclampsia requiring pregnancy termination for maternal complications at Galway University Hospitals.

Case 1
A 36 year old woman, para 1+1, booked for antenatal care at 12 weeks gestation following IVF with a donor oocyte. At 20 weeks gestation she was admitted with pre-eclampsia. Over the following 2 weeks her renal and liver function deteriorated and her hypertension was poorly controlled requiring three antihypertensive agents. At 22 weeks gestation fetal measurements were below the 5th centile with abnormal umbilical and uterine artery Dopplers. Her condition continued to deteriorate and she underwent a hysterotomy. She delivered a male infant weighing 320 grams. She was advised against any further pregnancies.

Case 2
A previously healthy 30 year old woman, para 0+0, was admitted at her booking visit at 19 weeks gestation with pre-eclampsia and abnormal LFTs. She required antihypertensive treatment for persistently elevated blood pressures. Investigations revealed an evolving HELLP syndrome with liver infarction. A decision was made to terminate her pregnancy 5 days after admission. Following labour induction with RU486 and misoprostil she delivered a female infant vaginally. Postnatal follow up is ongoing.

Pre-eclampsia can have a profound impact on maternal and fetal well-being confronting clinicians with the dilemma of early onset toxaemia before fetal viability. These cases illustrate the aggressive nature of this multisystem disorder and the difficult decisions that women, their families and healthcare professionals face in its management.
Abstract No 97

PREGNANCY RELATED HEPATIC RUPTURE

M. Kamath, B. Smyth, D. Sim
Daisy Hill hospital, Newry

Introduction:
Spontaneous liver rupture is a rare but serious complication of pregnancy, which may be associated with preeclampsia. High maternal and fetal mortality rates have been reported.
In this report we describe a patient with spontaneous hepatic rupture diagnosed in the post-partum period. The presentation, diagnosis and treatment of this condition are discussed. The related literature was reviewed.

Case report:
Mrs SW, a 38 year old primigravida, was seen in the clinic at 38 weeks with raised blood pressure on 15th February 2007 and arrangements were made for induction of labour on 18th February 2007. Her diastolic blood pressure in labour prior to epidural was at 112-116 mmHg [2 readings]. She delivered by vacuum extraction. Following delivery, her blood pressure settled.

The following morning she complained of acute lower right sided chest pain with hypertension. The probable diagnosis of pulmonary embolism was made. She subsequently developed right upper quadrant pain with hypotension and was resuscitated and a diagnosis of potential liver rupture made and confirmed on CT scan.

At the time, her liver enzymes were hugely elevated and HELLP syndrome was also developing. She was surgically managed and transferred to Edinburgh for further management. Her recovery was long term with subsequent left sided weakness and the need for physiotherapy.

Discussion:
Various disease conditions can be complicated by spontaneous liver rupture including pregnancy induced hypertension. Some reports have pointed out that the elderly multipara with preeclampsia is at a higher risk of developing both uterine and liver rupture. Recurrence rate in future pregnancy is still not known due to rarity of the disease. In 1992, Alleman et al reported a successful pregnancy post liver rupture in previous pregnancy. We conclude that spontaneous liver rupture with pregnancy although rare but are attended by a high mortality rate.

Abstract No. 98

PROLONGED AMENORRHEA FOLLOWING EVACUATION OF PRODUCTS OF CONCEPTION: A CASE REPORT

Zara Fonseca-Kelly, Maeve Eogan
Department of Obstetrics, National Maternity Hospital, Holles Street, Dublin 2

We present the case of a twenty-nine year old multiparous woman who presented with a missed miscarriage at ten weeks gestation. She underwent Evacuation of Retained Products of Conception and five weeks later her menstrual cycle had not returned. She therefore carried out a urinary pregnancy test which was positive. Serum HCG was 8IU/ml and an ultrasound showed an area suggestive of retained products of conception. Beta-HCG was repeated forty-eight hours later to ensure this was not a new pregnancy and the patient underwent an evacuation of retained products in theatre.

Unfortunately her menstrual cycle failed to return to normal over the next four months at which time the patient presented to infertility services. Hormone profile was within normal limits as was pelvic ultrasound. The patient underwent a diagnostic hysteroscopy which showed intra-uterine adhesions.

This paper discusses Asherman's syndrome, its aetiology, treatment and prognosis.
Abstract No. 99

RUPTURED UTERUS IN THE SECOND TRIMESTER OF A NULLIPAROUS PATIENT

Butler MM, O’Brien DJ, O’Connor H.
The Coombe Women and Infant’s University Hospital, Dublin.

We present a case of uterine rupture in a nulliparous patient during the second trimester. The case illustrates the difficulties in recognising and diagnosing this rare but life-threatening condition.

A 33 year-old nulliparous patient presented to the emergency room at 15+1 weeks gestation complaining of generalised abdominal pain. Booking scan at 11+6 weeks had shown an intrauterine single pregnancy consistent with dates. The patient presented with severe generalised abdominal pain with vomiting and diarrhoea. She was distressed. Vital signs were normal. There was marked bilateral iliac fossae and rebound tenderness. Transabdominal U/S showed a ‘single active fetus’. The patient was admitted with a provisional diagnosis of acute appendicitis.

Four hours later the patient became distressed with shoulder tip pain. There was abdominal distension and tenderness with guarding. Ultrasound was repeated. This showed a foetus with a heartbeat. The uterus was empty and there was significant free fluid. The viable foetus was extraterine. A suspected diagnosis of abdominal pregnancy with haemoperitoneum was made. At emergency laparotomy a ruptured rudimentary uterine horn pregnancy was identified. The rupture was fundal. The foetus and half the placenta were expelled into the abdomen. Estimated blood loss was 2215ml. The rupture was repaired and haemostasis achieved. The patient had an uncomplicated post-operative course.

This case highlights the problems in identifying and diagnosing ruptured uterus in the second trimester. This is a difficult but important diagnosis to make because of its high risk of maternal mortality.

Abstract No. 100

SUCCESSFUL OUTCOME OF PREGNANCY WITH SEVERE HYPERTRIGLYCERIDEMIA: A CASE REPORT

RK Sarkar (1), C Vaughan (2), K O’Donoghue (1) LC Kenny (1)
(1)Department of Obstetrics and Gynaecology, Cork University Maternity Hospital, Cork
(2) Department of Medicine/Cardiology, Mercy University Hospital, Cork.

A 35 year old lady of SE Asian origin, attended the combined Perinatal Medicine/Cardiology clinic at 8 weeks gestation in her second pregnancy. Details of her previous pregnancy were limited due to loss of medical records, but she was delivered by Caesarean Section (CS) at 39 weeks with acute pancreatitis related to undiagnosed hypertriglyceridemia. While she made an uneventful recovery, no further investigations were performed.

This pregnancy was managed with weekly monitoring of fasting cholesterol and triglycerides levels, serum amylase and liver function tests as well as surveillance of fetal growth from the late second trimester. Very low fat diet was advised. Oral glucose tolerance test was normal at 28 weeks. Fish Oils (Omacor, 3g/day) and therapeutic low molecular weight heparin were started at 34 weeks when CL was 24mmol/l and TG levels were 66mmol/l. While she had recurrent abdominal pain in the third trimester, ultrasound of abdomen was normal. She did not develop stigmata of chronic hyperlipidemia. In view of rising triglycerides which peaked at 68mmol/l at 36 weeks she was delivered of a healthy 4.2kg female infant by elective caesarean section at 37 weeks. Triglyceride levels had returned to normal at her 3 month postnatal follow-up. Pancreatic enzyme deficiency is suspected as an underlying aetiology and genetic studies are ongoing.

Pregnancy is a physiological condition where plasma triglyceride levels are moderately increased. The risk of acute pancreatitis threatens the life of both mother and fetus. Early recognition of severe hypertriglyceridemia and appropriate management are essential for a successful pregnancy outcome.
Abstract No. 101

DOES THE LUNAR EFFECT ALTER BIRTH RATE?

K. Purcell, A. Arya, J.R. Higgins, R.A. Greene
Department of Obstetrics and Gynaecology, Cork University Maternity Hospital, Cork.

The lunar effect is a theory which overlaps into sociology, psychology and physiology suggesting that there is correlation between specific stages of the Earth's lunar cycle and deviant behavior in humans. People may dismiss the belief that more births occur on days where the moon is full as an old wife's tale but many midwives state that the number of women going into labour does seem to increase during the full moon.

Aim was to study the birth rates to see if they alter with the lunar phases and tides between April - June 2007. Correlate them to the moon phases and the tides .The lunar and tide data supplied by FreeTideTables.com. In addition gravity, parity, gestation mode of delivery and sex of the infant were recorded.

The total number of births was 2,056, of which 1247 (61%) where spontaneous onset. 49% were males and 51% females. Within the spontaneous labours, 8% were premature, 40% were term and 53% were post dates. Spontaneous vaginal delivery accounted for 70%, vacuum delivery 14%, forceps delivery 4% emergency LSCS 12%. The New and 3rd moon phase had a larger number of births in the high tide cycle (p-value < 0.05).While there was no significant variation in births in the tide cycle in the 1st and Full moon phases. In the total three months 56% of births occurred at high tides and 43% at low tides.

Overall there was no established correlation between the lunar effect and birth rate in the study period.

Abstract No. 102

NATURAL HISTORY OF ANENCEPHALY

N. Obeidi, N. Russell, JR Higgins, K. O'Donoghue
Cork University Maternity Hospital (CUMH), Cork.

Anencephaly is a neural tube defect that occurs due to failure of neural tube closure at the cranial end of the embryo. Ireland has the highest incidence of neural tube defects (4.2/1000 livebirths) worldwide. We aimed to investigate the natural history of these pregnancies from diagnosis to delivery and to determine timing of death.

This was a retrospective review of all cases of anencephaly diagnosed in Cork between 2003 and 2008 (n=16 analysed).

The median maternal age was thirty years (range 17–41) and 62% were primigravidae. The majority of cases (94%) were diagnosed antenatally at a median gestation of 20.5 weeks (range 13.4–28). In one case the diagnosis was made postnataally after spontaneous vaginal delivery at 32.5 weeks. The median gestation at delivery was 35 weeks (range 24–42.6). Sixty-seven percent of patients (n=12) underwent induction of labour and one patient had an elective caesarean section at 33 weeks. The remaining 3 patients went into spontaneous labour between 30 and 39 weeks. Two patients had a pre-labour intrauterine death and six patients had an intrapartum fetal death. Of the eight babies that were born alive the median survival time was 21 hours (5 minutes–four days). Only half of these women had documented evidence of being advised to take higher dose folic acid in future pregnancies.

This study provides useful information for doctors caring for patients with a diagnosis of anencephaly. The majority of these infants die prior to delivery but short-term survival is possible and it is important that parents are appropriately counselled.
Abstract No. 103

AN INDUCTION OF LABOUR AUDIT

Dr WPV Ooi, C Everard, Dr D Buckley, Dr M Hewitt
Cork University Maternity Hospital, Wilton, Cork.

Induction of labour (IOL) is a common intervention in current obstetric practice. It is important to have a detailed knowledge of induction practice in a local unit to enable appropriate planning of resources, obtain data to audit outcomes and to enable appropriate counselling of patients prior to induction.

A prospective study was carried out from 2nd of May 2008 until 2nd June 2008 during the inaugural opening of the CUMH Induction Room. A questionnaire proforma was completed contemporaneously by the midwife at the time of labour. The overall monthly labour ward statistics were also collected.

There were a total of 737 deliveries in this study period 193 of which were Caesarean sections and 544 vaginal deliveries. IOL rate reached 38.4% with 23.7% of total inductions resulting in Caesarean section. This compares with spontaneous onset deliveries in which the Caesarean section rate was 8.2%. Of the 216 vaginal deliveries following IOL, 32.4% were operative vaginal deliveries. Caesarean section rate in primigravidae were substantially higher when induced at 41% as compared with 13% in spontaneous onset of labour cohort. Caesarean section rate in multigravidae however, were similar in both cohorts at 4.5% following IOL and 5% in spontaneous onset of labour. The most common indication for IOL was prolonged pregnancy (29%), but up to 10% of these were less than 41 weeks gestation.

This study has given important information to assist appropriate counselling of women on the outcomes of IOL in this unit. We also need to examine why 10% of prolonged pregnancy inductions were carried out on pregnancies less than 41 weeks which is contrary to international guidelines. This baseline data will enable us to audit future interventions designed to reduce the IOL and caesarean section rate.

Abstract No. 104

CONTROL OF HYPOTHYROIDISM IN PREGNANCY.....IT’S ALL ABOUT THE FIRST TRIMESTER

J Walsh, M Foley
National Maternity Hospital, Holles Street, Dublin 2.

Background:
Thyroid disease, despite affecting more than 1% of all pregnancies, remains one of the most diversely managed medical diseases in pregnancy, with little consensus on when treatment adjustments should occur or how often biochemical testing in pregnancy is necessary.

Evidence on optimal management is often conflicting, however it is clear that only first trimester control influences fetal outcome, therefore if optimal replacement doses are reached prior to conception or early in the first trimester subsequent dose adjustments and frequent testing should not be necessary.

Aim:
Our aim is to audit the management of women with thyroid disease in pregnancy, and in doing so ascertain when the optimal time for dosage adjustment is, and how often repeated testing of thyroid function in pregnancy is.

Methods:
We have prospectively audited the management of all women attending the combined obstetric/endocrinology antenatal clinic in the National Maternity Hospital from August 2008 to date and gathered data on their pre pregnancy control, timing and indications of any dose adjustments, and subsequent thyroid function results.
Results:
To date we have data on 57 pregnancies. Of these, five pregnancies were in women with hyperthyroidism, the re-
mainders were hypothyroidism.

Of the women with hypothyroidism, ten women had their dose of eltroxin increased by their general practitioner
early in the first trimester once a pregnancy test was positive. 32 women had their dose adjusted in the first trimes-
ter at the combined endocrinology / obstetric clinic.

12 women required dose adjustments after the first trimester. Of these, one was diagnosed during the pregnancy,
three patients were not taking any medication pre pregnancy, 2 patients had thyroidectomies, and three attended
for the first time in the second trimester, leaving just two women who required further dose adjustments after the
first trimester increases, and both of these were of just 25 micrograms.

Only three women had poor control at booking requiring more frequent testing and dose adjustments in the first
trimester, and all of these had normalised by the end of the first trimester.

Conclusion:
Overall, control of thyroid disease in women of childbearing age is usually good prior to conception. If optimal re-
placement is reached early in the pregnancy then control should remain good and repeat thyroid testing needed
only again late in the second or in the third trimester and thus their care may be similar to that of a low risk popula-
tion.

Abstract No. 105
ENDOMETRIAL ADENOCARCINOMA IN THIN POSTMENOPAUSAL WOMEN IN ASSOCIATION WITH
RARE BRENNER TUMOURS - A REPORT ON TWO CASES

J Walsh, C O’Herlihy
National Maternity Hospital, Holles Street, Dublin

Brenner tumours are a rare ovarian neoplasm representing just 1-2% of all ovarian tumours. They are known to
produce hormones starting from fibroblasts of their stromal component, which resembles theca cells of a normal
ovary. It has been reported that up to 50% of Brenner tumours may produce hormones. However, other than rare
single case reports in the literature, there is no considerable evidence that the possible oestrogenic production of
this tumour may be the cause of endometrial disorders.

However, we report on two cases of endometrial adenocarcinoma in multiparous women, of normal body mass in-
dex and with no other identifiable risk factors for endometrial carcinoma, both of which had incidental findings of
these rare tumours on pathological examination post total abdominal hysterectomy and bilateral salpingooopherec-
tomy.

Abstract No. 106
IS THERE ANY ROLE FOR CHEST X-RAY IN PREGNANCY

B. Akbar, M. O’Leary, M. Geary
Department of Obstetrics & Gynaecology. the Rotunda Hospital, Parnell Square West, Dublin 1

Objective:
To assess the diagnostic value of chest x-ray in pregnancy in clinically indicated cases and also its effect on manage-
ment of patients.

Materials & Methods:
A retrospective analysis of all women who had a chest x-ray in pregnancy at Rotunda Hospital, Dublin between
January 1st and July 30th 2008. Data was collected from the hospital case notes and delivery notes for each patient.
Maternal details were reviewed included age, parity, gestation at the presentation, clinical indication for chest x-ray, medical problems, personal history, x-ray findings and change in treatment plan.

Results:
The study group comprised 20 patients. The mean maternal age was 30+/- 5.8 years with parity ranging from 0-5. All women in pregnancy who had clinical suspicion of cardiac or respiratory problems underwent chest x-ray. The commonest reason chest x-ray was undertaken was respiratory problem (90%). Among this group 8 patients (44%) had suspicion of infection and 10 (55%) had a suspicion of pulmonary embolism (PE). Two (10%) patients with underlying heart problem had chest x-ray when indicated and both showed pulmonary oedema. Maternal management was changed by adding diuretics. There were 4 cases of suspected chest infection that required change in the treatment plane after results of chest x-rays. Four other cases continued on antibiotics despite a normal chest x-ray. One woman had signs of tuberculosis on chest x-ray, was started on anti-tuberculosis therapy. Ten patients of suspected PE had normal chest rays and CTPA was also normal in all these cases.

Conclusion:
Chest x-ray is useful in assisting diagnosis in pregnant patients where clinically indicated. Patient should be reviewed by senior doctor before ordering chest x-ray in pregnancy.

Keywords:
Chest x-ray, heart condition, respiratory tract infection; pulmonary embolism (PE)

Abstract No. 107

SURVIVING LIVER RUPTURE IN EARLY PREGNANCY

K Field, J Walsh, A Curtain, K O'Donoghue
Cork University Maternity Hospital, Cork

Hepatic rupture is a rare complication of pregnancy, associated with high maternal morbidity and mortality. We report a recent case and review the literature.

A 35yr old primigravida presented at 18weeks gestation in an IVF donor oocyte pregnancy, complaining of epigastric pain and peripheral oedema, with hypertension and proteinuria. Although liver function was mildly deranged, abdominal ultrasound was normal, and 2.8g protein was collected in 24hours, confirming pre-eclampsia (PET). One week later, she complained of severe abdominal pain, and rapidly became hypotensive, thrombocytopenic, acidotic and hyperkalemic. Ultrasound diagnosed fetal intrauterine death and a liver haematoma. At laparotomy, a 12cm linear laceration of the right lobe of the liver was discovered. Temporary surgical packs were inserted, and a hysterotomy performed. The patient spent 3weeks on ITU with multi-organ failure, but recovered to discharge home. She has residual hypertension but normal renal function, and has been counselled against further pregnancy.

Spontaneous hepatic rupture is a life-threatening condition of uncertain pathogenesis, occurring between 1:45,000-1:225,000 deliveries. The majority of ruptures occur in older multiparous women in association with PET or HELLP syndrome. Management ranges from a conservative approach, to surgery, including temporary packing, lobectomy, arterial embolisation and transplantation.

Fewer than 20% of spontaneous ruptures occur in primiparous women and this is the earliest reported gestation of a pregnancy-related liver rupture. Pregnancies achieved from oocyte donation are associated with an increased incidence of hypertensive disorders of pregnancy. We speculate this led to early development of PET in this case, complicated by spontaneous hepatic rupture.

(248)
Abstract No. 108

LIVER DYSFUNCTION IN PREGNANCY – A RETROSPECTIVE REVIEW OF 29 CASES

Al Husain HA, Farooq S, Osasere M, Ugwu VC, Taiwo A, Bourke H, Yuddandi V, O’ Sullivan R, Hayes T.
Department of Obstetrics and Gynaecology, St. Lukes General Hospital, Kilkenny.

Liver dysfunction in pregnancy is predominantly pregnancy related with an incidence of 3 – 5 % and is associated with significant maternal and perinatal morbidity and mortality. Pre-eclamptic toxaemia is the commonest form of liver dysfunction in pregnancy, and may present with or without superimposed HELLP syndrome. Early, accurate diagnosis and a multi-disciplinary team approach are vital.

A retrospective review of 29 cases of liver dysfunction with an AST/ALT ≥ 200 mmol/L was done from January 2007 till October 2008. Data was entered into Microsoft Excel and analyzed.

Of 3689 women delivered, 29 fulfilled study criteria with a rate of 8/1000 deliveries. 14 were primigravidae and 15 were multigravidae. Diagnosis was established at 25-34 weeks gestation in 17, and after 34 weeks in 12. PET with HELLP was diagnosed in 14 cases, Obstetric cholestasis in 11 and 4 had severe PET alone. Ten patients required HDU care, four patients were transferred to ICU and seven neonates admitted to SCBU. There were three postpartum haemorrhages, three patients with deteriorating hepatic function, three patients with acute renal failure, one of them needed dialysis. One of the patients deteriorating liver function resulted in hepato-renal failure, however, she made an unexpected, spontaneous recovery only two days prior to a scheduled liver transplant.

As a general Obstetric unit, there have been significant numbers of hepatic dysfunction in pregnancy. All cases were diagnosed and managed appropriately, with multi-disciplinary support and onsite Hepatology, Anaesthesia, Haematology, Intensive Care and Radiology facilities with direct access to Ultrasound and CT.


Abstract No. 109

PERSISTENT TROPHOBLASTIC DISEASE

Ali Gawish
Department of obstetrics & gynaecology, Midland Regional Hospital, Mullingar

41 years old, p1+2. Had an ERPC for missed miscarriage at six weeks, histology confirmed products of conception with some hydropic changes. She presented after four months with per vaginal loss. Ultrasound scan showed 3cm intrauterine solid cystic mass, D & C was performed. Histology confirmed degenerative POC. ThCG remained detectable at about 50 IU/l. USS and pelvic MRI showed intrauterine mass of 3cm with suggestion of molar lesion. Hysteroscopy revealed well defined tumour attached to posterior uterine wall, which was removed using loop diathermy. The histological diagnosis was not clear initially, the last histology finding was in keeping with gestational trophoblastic disease. Her post operative ThCG was < 2 IU/l, we are waiting ploidy studies.

The unique about this case are the uncommon presentation & the different treatment approach.

The management of persistent GTD usually involves hysterectomy with or without chemotherapy. Second evacuation is not routinely recommended, however it may be useful for symptom control in selected patients, or curative if the molar tissue is confined to the uterine cavity, particularly in those with low hCG. However our patient wished to keep her uterus. The location and the low level; of ThCG favour a placental site lesion. This is an unusual case of persistent GTD managed conservatively.

To improve the outcome for patient with persistent disease, more research & development is needed for identification of those patients at risk of developing persistent disease.
Abstract No. 110

UPTAKE OF INVASIVE TESTING FOR ANEUPLOIDY AFTER A POSITIVE FIRST TRIMESTER SCREEN

A O'Higgins, E Kent, K Dorschner, K Flood, A Fleming, FD Malone
Royal College of Surgeons in Ireland, Rotunda Hospital, Dublin

Aim:
To determine rates of invasive testing for chromosomal abnormalities following a high risk first trimester screen in the Irish population.

Methods:
Retrospective review of all patients attending for first trimester screening in the Rotunda Hospital and RCSI unit over a 1 year period. Information was obtained from the Viewpoint system and the prenatal diagnosis register.

Results:
614 patients attended for first trimester screening with a combination of ultrasound for Nuchal Translucency and maternal serum ßhCG and PAPP-A. Of these 77 (12.5%) were given a risk of greater than or equal to 1 in 250 for having a pregnancy affected by Trisomy 21. 40 (51.9%) of these women proceeded to have an invasive diagnostic test performed. 82.5% of these chose to have chorionic villus sampling and 17.5% amniocentesis. Patients were more likely to have invasive testing if the first trimester screen returned a risk of greater than 1 in 100 for Trisomy 21. (69% vs 41% LR 4.77, p = 0.002) and if the result of the screen increased their age-related risk. (63% vs 26% LR 9, p = 0.002) 7 of the diagnostic tests performed returned abnormal karyotypes – 6 Trisomy 21 and 1 Triploidy. 6 of these patients elected to terminate the pregnancy.

Conclusion:
There is increasing demand within our population for prenatal screening and diagnosis. A large proportion of women will elect to have an invasive procedure performed if deemed to be at high risk of having a baby with Trisomy 21. A risk of 1 in 100 or greater or an increase in a patient’s background age-related risk increased the likelihood of proceeding to invasive testing.

Abstract No. 111

MATERNAL REHOSPITALISATION FOLLOWING CHILD BIRTH: A 3-YEAR RETROSPECTIVE REVIEW

Tunijitola Ade-Conde

We conducted a retrospective review of deliveries in Our lady of Lourdes Hospital Drogheda over 4 years with a view to identifying the factors associated with readmission of women within 6 weeks of initial discharge from hospital following delivery.

Materials and Methods: These patients were identified via the hospital information database and their obstetrics records were retrieved and reviewed and relevant information were obtained and displayed on a spread sheet, patients delivering in between 2005 and 2008 september constitute the study group.

Result: Hospital readmission is related to the average length of stay both in patients delivered by caesarean section and vaginal delivery with shorter length of stay associated with higher rate of rehospitalisation. The commonest reason for rehospitalization in patients who deliver via vaginal delivery is secondary Post partum haemorrhage while caesarean and perineal wound infection is the commenest reason for rehospitalization among patients with operative delivery.

Conclusion: Shorter hospital stay and operative delivery are the major factors responsible for rehospitalisation following delivery.
Abstract No. 112

FORCEPS DELIVERY – A SOON TO BE EXTINCT OBSTETRIC PROCEDURE?

R. AKKAWI, E. KENT, M. GEARY, M. ROBSON, C. FITZPATRICK, F. D. MALONE
Department of Obstetrics & Gynaecology, Rotunda Hospital, Royal College of Surgeons in Ireland, Dublin

OBJECTIVE:
To describe changing trends in operative vaginal deliveries (OVD) over the past 30 years, in a single large urban population.

STUDY DESIGN:
A detailed report of all pregnancies delivered in the Greater Dublin area from 1977 to 2006, inclusive, was reviewed for mode of delivery. We compared variation in rates of spontaneous vaginal delivery, forceps-assisted delivery, vacuum-assisted delivery and caesarean delivery.

RESULTS:
During the 30 year study period there were a total of 626,929 deliveries. During this time period the caesarean delivery rate has increased from 6.3% to 22.6% (p <0.0001). Comparing the first five years (1977-81) with the last five years (2002-6) the OVD rate has not changed significantly (10.2% and 14% respectively, p =0.69 ). However, the use of forceps has decreased from 9.5% to 3.8% (p =0.03) while vacuum use has increased significantly from 0.7% to 10.2% (p <0.0001) during these time periods.

CONCLUSION:
While the caesarean delivery rate has increased significantly over the last 30 years, the overall OVD rate has remained remarkably stable. There has, however, been a steady and significant decline in the use of forceps, representing a favouring by obstetricians of vacuum for OVD. The preference for vacuum reflects concerns among obstetricians regarding excess maternal morbidity associated with forceps use and also litigation issues. There are serious implications for training as obstetricians become less skilled in forceps deliveries. If this trend continues it may not be possible to provide adequate training in forceps use, which will further undermine the role of this instrument in contemporary obstetric practice.

Abstract No. 113

PERRY ROMBERG SYNDROME

U. Mahmood, Y. Kamal, J. Slevin

Case report
34y primigravida, known case of Perry Romberg Syndrome with uncomplicated antenatal period, presented at 36/40 with complaint of left sided facial discomfort, tingling sensation, tinnitus, and change in colour and increase in size of facial veins.

On examination, all cranial nerves were normal, but fundal atrophy in left eye was seen. There was enophthalmia of Lf.eye, left sided facial muscles atrophy, lipodystrophy, mandibular bone defect, absent teeth in Lf jaw and Lf sided port wine stain. Motor and sensory examination were normal. CVS examination normal

MRI brain showed: extensive atrophy of lt hemisphere especially temporal and frontal lobe, associated ipsilateral dilatation of lt ventricle. An arterial venous malformation seen in relation to lt PCA where there is an abnormal collection of vessels seen in medial aspect of the temporal lobe.

Diagnosis made was hypervolumic state of pregnancy affecting the micro vascular abnormalities secondary to the Perry Romberg Syndrome. Because of arterio-venous malformations and worsening symptoms, elective CS was performed at 39/40. Healthy baby boy was born. Gradual improvement of the symptoms noticed after CS.
In 6wks postnatal check no further worsening of facial atrophy was seen. Less prominence of port wine stain and facial veins noted. Mild depressive symptoms were present.

**Discussion:**
Described by Perry (1825) & Romberg(1846). Characterized by localized facial bony depression, contralateral Jacksonian epilepsy, trigeminal neuralgia, hyper pigmentation, vitiligo, alopecia, hemi atrophy of tongue, delayed dental eruption, enophthalmos and refractive error. PRS is an uncommon degenerative condition in which a slow and progressive atrophy, generally of facial tissue, including muscles, bone and skin occurs. A cerebral disturbance of fat metabolism has been proposed as a primary cause. Trauma, viral infections, endocrine disturbances, autoimmunity and hereditary are believed to be associated to the pathogenesis of the disease. Onset is in first or second decade of life. Atrophy progresses slowly during many years and then becomes stable. Higher incidence in females. Usually ipsilateral. 5-10% cases was described as being bilateral.

A global survey of 205 people using internet was done in which 68% women reported that it got worse either during pregnancy or after childbirth. Out of 25 cases, 7 got worse during pregnancy and 7 after child birth.

**Abstract no. 114**

**TRUE KNOTS: KILKENNY’S PERSPECTIVE**

Al Husain HA, Osasere M, Taiwo A, Ugwu VC, Yuddandi V, Hayes T, Bourke H, O’ Sullivan R.
Department of Obstetrics and Gynaecology, St. Lukes General Hospital, Kilkenny

True knots of the umbilical cord are rare occurrences with a reported incidence of 0.3 – 2%. The majority of true knots are clinically insignificant, but there is an association between cord knots and intrauterine fetal demise. At term the average length of the umbilical cord is 55cm. Predisposing factors for the formation of a true knot include long cords, polyhydramnios, small fetuses, monoamniotic twins, male fetuses, gestational diabetes mellitus, amniocentesis and multiparity.

All cases of true knots were documented from January 2008 till October 2008. Out of 1796 deliveries, 14 cases were documented and patient charts reviewed.

Six primigravidae and eight multigravidae with singleton, term pregnancies had true knots of the cord. Maternal age ranged from 22 – 43. Maternal morbidities included one case of polyhydramnios and one case of pre-eclamptic toxemia. The predominant mode of delivery was by emergency caesarian section, for fetal distress in 7 cases, while 7 true knots were incidentally found. There were 10 male infants and 4 female infants. Apgar scores ranged from 2 – 8 at one minute, and 8 – 10 at five minutes. Two infants were admitted to the Special Care Baby Unit and discharged within one week with no abnormal sequelae.

The incidence of 0.8% for these cases is within the reported incidence. The presence of a true knot of the cord in labour is associated with variable fetal status, from normality to fetal demise with cord occlusion. Paying attention to gross examination of the placenta and cord routinely, for all interventions in labour, may provide hidden answers for causes of suspected fetal distress.
The Institute of Obstetricians would like to thank the pharmaceutical companies for their continued support.