Oral and Poster Presentations

0003
Service planning in paediatric and adolescent gynaecology
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Introduction The British Society for Paediatric and Adolescent Gynaecology (BritSPAG) highlights the need for a specialised clinic, distinct from adult services. This service has been provided in Durham since January 2014. We aim to establish how well the clinic meets BritSPAG recommendations, as well as analysing the patient demographics with the aim to improving the clinic’s suitability.

Methods A retrospective study analysing clinic visits between January 2014 and January 2016. The audit cohort was identified from clinic lists and information gathered from electronic notes onto an anonymised audit toolkit. The structure of the clinic was also evaluated and compared to BritSPAG guidelines.

Results The clinic has seen 59 patients since its inception. Fourteen is the most common age at presentation. Conditions seen included:
- Menorrhagia (15%)
- PCOS or presumed PCOS (15%)
- Labial adhesions (12%)
- Irregular menses (11%)

BritSPAG guidelines are widely followed. However the clinic did not adhere to the following guidance:
- Age appropriate information resources should be available
- Congenital abnormalities should be recorded in local databases
- Input from a paediatric nurse or play specialist is recommended
- Patients should be offered the option of being seen without parents/guardians.

Conclusion The PAG clinic at UHND successfully sees patients within the parameters of BritSPAG recommendations and is well equipped to treat them. By making the clinic more age appropriate, the clinic will become an integrated part of the wheel and spoke model desired by BritSPAG. Leaflet development is now underway to make the clinic more age appropriate.

0005
First of its kind: pubic symphysis diastasis complicated by a pelvic wall haematoma after vaginal delivery
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Background Pubic symphysis diastasis is a debilitating condition with an incidence between 1 in 300 to 1 in 30,000 deliveries, which is often missed and poorly managed. The management is variable and the potential outcomes are still poorly understood. However, delayed diagnosis has great health implications for the woman acutely and in the long term.

Case This is the first recorded case of a pelvic wall haematoma complicating a 35 mm pubic symphysis diastasis after an uncomplicated vaginal delivery in a natural birthing centre. The patient’s haemoglobin fell to 68 g/dL post-delivery, requiring blood transfusion. The patient was treated with a pelvic binder, analgesia, physiotherapy and also treated for a catheter-associated urosepsis.

Conclusion Prompt diagnosis and management is paramount for both acute and long-term recovery. This involves a multidisciplinary approach including obstetrician, orthopaedic surgical team, physiotherapy, occupational therapy and radiologist input. Not only do women need rigorous pain control, they need observation for warning signs for additional complications such as a pelvic haematoma, which significantly delays symptomatic improvement. This case highlights this unusual complication but also raised issues that were poorly addressed in her management in terms of emotional and psychological support. The patient became clinically depressed and attempted suicide. The psychological impact of pain as well as the additional co-morbidity of managing bladder care, which involved prolonged catherisation, prolonged use of venothromboprophylaxis and urinary tract infection were underestimated. This case not only describes this unusual complication but highlighted deficiencies in management that may have improved her clinical course.
Is Kielland’s forceps a valuable tool in the management of second stage of labour or a dangerous instrument? A retrospective study conducted between September 2014 and September 2015

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Introduction I conducted a retrospective study between September 2014 and September 2015 regarding the outcome of Kielland’s forceps. The aim of this study is to prove that the use of Kielland’s forceps in an experienced hand is safe, since it doesn’t increase the risk to enter in SCBU and the potential to cause a third or fourth degree perineal tear is within the accepted RCOG limited percentage of 6%. For the purpose of this study, I included all the rotational forceps deliveries due to malposition (either OP or OT) and checked the outcome of both mothers, and babies.

Methods During this period, we had 2400 deliveries, out of which 19 were done via rotational forceps.

Results From 19 women, 4 (2.2%) had a third degree perineal tear, and the rest (97.8%) had a second degree perineal tear. All women had an episiotomy. From 19 babies who delivered via Kielland’s forceps, only 2 were admitted to NICU due to jaundice and poor breastfeeding reflex, but none of them had any skull fracture or cerebral palsy. The cord gases were ranged between 7.20–7.33. The estimated blood loss ranged between 650 mL–1 L. Both babies who had jaundice and poor feeding reflex were improved on day 4 and 6, respectively. Women who had a third degree perineal tear were assessed 3 months after repair, as per guideline and they didn’t report any dyspareunia, or flatus incontinence.

Conclusion When Kielland’s forceps is used by an experienced obstetrician who recognises the position of the head correctly, it is a valuable tool, since we can avoid an emergency caesarean section at fully dilatation and its complications, like severe PPH, uterine extension, bowel or bladder injury, without increasing the rate of neonatal admission to intensive care unit, or skull fracture, or even OASIS injury. These results correspond with those in the literature.
with an ongoing history of vomiting. On admission she looked clinically dehydrated and there were 3 + ketones. An arterial blood gas showed: pH 7.16, bicarbonate 13.1, base excess -21, paCO2 3.5, paO2 12.3, glucose 4.8, potassium 2.4 and lactate 0.9. On day 4 the patient’s membranes ruptured followed by spontaneous labour. A healthy male infant was born with a weight of 4350 g.

**Conclusion** This first case was one of the most severe cases of metabolic acidosis reported in literature so far. The second case demonstrates how acute on chronic episodes of vomiting can gradually lead to a metabolic acidosis. Once diabetes, acute fatty liver and sepsis had been ruled out, it was diagnosed as starvation in the third trimester compounded by relative insulin resistance.

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**0012**

**Skull fracture at caesarean section**

**Thompson, R; Saxena, S**

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**Background** A skull fracture at caesarean section is a rare occurrence. They are usually associated with traumatic vaginal instrumental deliveries or impacted heads at caesarean section.

**Case** This is a case of a 32-year-old primipara who booked at 8 weeks of gestation. At 38 + 5 she presented with reduced fetal movements and raised blood pressure. A diagnosis of pregnancy induced hypertension was made and an ultrasound showed the fetal growth to be on the 3rd centile therefore an induction of labour was arranged for 48 hours later. The patient progressed well to 4 cm until there was a prolonged deceleration. It was noted that the presenting part felt very soft and therefore a scan was confirmed to check for presentation. The presentation was cephalic and as the fetal heart rate was still low a decision was made for a category one caesarean section. It was a straight forward delivery. Baby was in the LOP position, -1 above the spines. At delivery the head was noted to be very elongated. The baby made no respiratory effort and was transferred straight to ITU. Spontaneous circulation was re-established after two minutes, following a further dose of atropine and adrenaline. Cardiac arrest was confirmed, a cardiac arrest call was put out and CPR was commenced immediately. The operation was stopped, and the externalised uterus replaced. Spontaneous circulation was re-established immediately. The operation was stopped, and the externalised uterus replaced. Spontaneous circulation was re-established after two minutes, following a further dose of atropine and adrenaline. The patient suffered transient pulmonary oedema, the operation was abandoned and the patient was transferred to ITU.

**Conclusion** Following the above case, a guideline was written for the use of vasopressin during gynaecological surgery at Croydon University Hospital.

- Dilution — dilute 1 ampoule of vasopressin (20 units) in 100 mL of 0.9% sodium chloride (0.2 units/mL)
- Inform anaesthetist — when vasopressin is being infiltrated
- Vital signs — monitor closely during and immediately after infiltration
- Infiltration — always draw back on the plunger of the syringe prior to infiltration, and at regular intervals during infiltration, to prevent intravascular injection
- Dosage — do not exceed a total dose of 5 units (25 mL)
- Repeat dose — a repeat dose of up to 5 units may be considered 45–60 minutes after the first, due to the short half-life of vasopressin.
- Insufflation — at laparoscopy, reducing the pressure of the pneumoperitoneum prior to infiltration may reduce the risk of bradycardia. Vasopressin should not be given in patients with cardiovascular disease, uncontrolled hypertension and renal disease; and only used with caution in smokers and patients using nicotine replacement.

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**0014**

**Are local, speciality specific career days beneficial for medical students and foundation doctors?**

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The Health Education Midlands holds an annual career day for all specialties to attend, allowing all medical students and foundation doctors to explore different specialities within the local area. The Royal College of Obstetricians and Gynaecologists also provide a careers day, for anyone to attend. Both of these are useful
resources however do have some limitations due to number of
delegates attending and also number of specialities in attendance.
Our local obstetrics and gynaecology school held a pilot, local,
careers days to allow any medical student from 4th year and
above and any foundation doctor within the region, the
opportunity to attend. The day consisted of a variety informal
presentations about the ‘day in a life’ and was given by a variety
of trainees across the school. The deputy head of school also came
and provided more specific information on training pathways.
The day also included several workshops covering resilience, CV
building, and practical skills. The informal nature meant that the
delegates could feel free to ask any of us any questions they wish
to do so during the process.
The delegates were asked to provide feedback at the end of the
day. We had a total of 42 delegates, of which the majority found
the day useful, we did not receive any negative feedback. We hope
that the delegates can use this experience when deciding on future
careers.
We are intending on repeating the careers day again.

0015
Formula milk supplementation on the postnatal ward: a cross-sectional analytical study of
midwives’ perceptions and behaviour
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Introduction Infant formula supplementation for non-medical
reasons negatively impacts breastfeeding. Midwives play an
important role in supporting early breastfeeding. We explored the
association between midwives’ non-clinical supplementation rates
and their experience, knowledge and attitudes towards formula
milk supplements.
Methods Infant feeding records from 400 infants born during a 7
week period were reviewed and 40 maternity staff were
interviewed at the postnatal unit of a busy London maternity
hospital. Midwives’ non-clinical supplementation rates were
reviewed and 40 maternity staff were
reviewed and 40 maternity staff were
calculated using the total hours worked during the 7 week period.
Generalised linear model was used to assess the relationship
between midwives’ supplementation rate and their experience,
knowledge and attitude.
Results 148 of 400 infants (37%) received formula supplements
postnatally, in 90% cases for non-medical reasons. All staff
received breastfeeding training, however two thirds were unable to
describe three appropriate scenarios where they had administrated
formula supplements on the ward. Midwives reported time
constraints and workload as key barriers to supporting
breastfeeding. Multivariate analyses showed that midwife attitude
toward formula supplementation were independently associated
with non-clinical supplementation rate, with midwives who
judged that infant formula supplementation mattered most,
supplementing least and vice versa ($P = 0.01$).
Conclusion In a busy postnatal unit with high non-clinical
supplementation rates, we found that the only variable associated
with formula supplementation rate was midwife attitude to
formula supplementation. This suggests that midwife attitude may
be an important target for interventions to promote exclusive
breastfeeding in postnatal units.

0017
Religious understanding – does it matter?
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Introduction Abnormal vaginal bleeding has a significant impact
on religious acts among Muslim women. The act of praying and
fasting for example are prohibited at time of menstrual bleeding.
However should the bleeding become prolonged, Muslim women
can perform the acts as usual as the bleeding is considered as an
illness. The objective of this study is to explore what is expected
from the healthcare providers when dealing with abnormal vaginal
bleeding among Muslim women.
Methods A total of 89 healthcare professionals were surveyed on
their knowledge, attitude and practice when treating Muslim
women with abnormal vaginal bleeding and its implication on
religious acts.
Results All of the 89 participants had learned about the impact of
abnormal vaginal bleeding on religious acts with 90% (80/89)
learning it at secondary school. 69% (61/89) of the participants
state that patients will ask them about the religious acts i.e can
they pray during the time of abnormal vaginal bleeding. 54% (48/
89) have been asked before while 89% (79/89) felt that they are in
position to answer such questions. 64% (57/89) were convinced
with their answers while 96% (85/89) stated that patients would
expect them to know the ruling on religious acts at time of
abnormal vaginal bleeding. 78% (69/89) of the participants felt
that both the healthcare professionals and religious scholars are
the best people to be referred to should there be any doubts about
the rulings.
Conclusion Increasing number of patients want greater attention
paid to their spiritual need. The decision made is greatly
influenced by the impact it has on all aspect of a patient’s life.
Understanding a patient’s religious belief will put the health care
professionals at a better position in providing effective role.

0019
Trends in surgical management of ectopic
pregnancy in a district general hospital
Siddharth, A; Gupta, N
Milton Keynes Hospital, Milton Keynes, UK

Methods Data collected pertaining to scan reports, β-hCG values,
mode of surgery, operator performing the surgery, time of surgery
and histology reports from January 2015 to February 2016 of
women who underwent surgical procedures to diagnose and
manage ectopic pregnancies. This data was then analysed and
It is established by the RCOG that ultrasound is an essential tool in decision and management of certain conditions in early pregnancy unit, like e.g. the diagnosis of ectopic pregnancy. For this reason, the college has introduced several assessments of basic ultrasound, like location of pregnancy in early gestation, assessment of the placenta site, etc. The purpose of this study is to show the significance of basic ultrasound scanning for all doctors working in the department of obstetrics and gynaecology in Glan Clwyd Hospital, and how by having competent doctors in basic ultrasound we can avoid unnecessary admissions.

The problem of having competent doctors in basic ultrasound scanning is not new and has been addressed in the past, not only in our hospital, but also in other hospitals in the UK, since unfortunately, teaching of basic ultrasound scanning across the UK is really poor and this leads to many unnecessary admissions for query ectopics, which actually are intrauterine pregnancies and they could be addressed by the on-call doctor, if he/she had a proper teaching and assessments in ultrasound. Of course, I have to admit that, this problem is much smaller in the University hospitals, but we need to remember that, emergencies occur in any district or teaching hospital, and that training in ultrasound should be at the same level, in all hospitals.

Methods For the purpose of the study, I checked retrospectively, all the admissions for query ectopic in Ward 19a (gynaecology ward) of Glan Clwyd Hospital, between January 2016 – March 2016. During this time, we had 11 admissions with the provisional diagnosis of ectopic pregnancy. These cases were scanned next day and saw that they were intrauterine.

Conclusion We had 11 unnecessary admissions which could be avoided if doctors had proper training in ultrasonography.
0022
Large IVC Thrombosis in a 22-year-old postpartum patient, one month after delivery: a case report
Siddharth, A; Nattey, J; Whitelaw, N
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Background Venous Thromboembolism (VTE) remains one of the main direct causes of maternal death in the UK. VTE can occur at any stage of pregnancy but the puerperium is the highest time of risk, which estimates a relative risk of 20 fold.

Case We report a case of a 27-year-old women, one month after a normal vaginal delivery, who presented with severe abdominal pain and generally feeling unwell for 3 weeks, with high grade fever on admission. Investigations revealed a large thrombus filling lower part of IVC, common iliac and external iliac bilaterally. She was managed under joint care with the medical team. She received treatment dose of dalteparin as well as intravenous antibiotics. She recovered slowly post anticoagulation.

Conclusion Inferior vena cava (IVC) thrombosis remains under-recognized with a variety of clinical presentations and it is often not pursued as a primary diagnosis. Hence a high index of suspicion is required. Pelvic vein thrombosis, which account for less than 1% of all cases of DVT are rare outside of pregnancy or pelvic surgery yet account for approximately 10% of DVT during pregnancy and the postpartum period. The signs and symptoms of thrombosis in the puerperal patient have a very low reliability. Contrast-enhanced CT has been reported to be effective for making this diagnosis. Pyrexia can be present, as described by Tsuji et al., who reported a series of 10 patients where 40% were pyrexic at presentation. Learning points:
1) A high index of suspicion is required especially if a pregnant or postpartum women presents with a range of non-specific symptoms.
2) A multi-disciplinary team approach involving obstetricians, midwives, physicians and vascular team is important.

0023
Acute pancreatitis in 26-year-old women at 37 weeks of pregnancy: A case report
Siddharth, A; Ibrahim, S; Pezeshki, M
Milton Keynes Hospital, Milton Keynes, UK

Background Acute pancreatitis is a common problem with an annual incidence of 5 to 80 per 100 000 of the general population. The incidence of acute pancreatitis in pregnancy, however, is a rare event and is approximately 1 in 10 000 births.

Case We report a case of a 26-year-old woman, 37 weeks pregnant, who presented with severe abdominal pain and vomiting for 1 day. She was mildly tachycardic and showed signs of severe dehydration. She progressively became worse after admission, despite aggressive fluid resuscitation. Investigations revealed a very high Amylase levels and deranged liver function tests. A diagnosis of acute pancreatitis was established based on the symptoms and deranged blood tests. Surgical, anaesthetic, ITU and maternal medicine input was sought to stabilize her. The CTG remained normal throughout and she was delivered by caesarean section. An ultrasound revealed gallstones as the cause of pancreatitis.

Conclusion Therefore it is important to consider acute pancreatitis when a pregnant woman presents with upper abdominal pain, nausea and vomiting in order to improve fetal and maternal outcomes for patients with acute pancreatitis.

0024
Are we managing women with recurrent miscarriage appropriately? A survey of clinical practice within the UK
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Introduction Recurrent miscarriage (RM) affects 1–2% couples; however there are discrepancies in its definition with consequent variation in which couples are investigated. There is limited evidence for managing RM; while the RCOG, ESHRE and ASRM have produced guidelines, their recommendations vary. We aim to assess the current management of RM across the UK compared to RCOG guidelines.

Method 150 Early Pregnancy Assessment Unit (EPAU) practitioners completed a structured online survey. Questions concerned their EPAU set-up, RM definition and patient management. Descriptive statistics were used.

Results Analysis was limited to UK-based respondents completing the full survey (102); of which 65 were consultants. 36.3% worked in hospitals with specialist RM clinics, 48% had a dedicated consultant receiving referrals and 72.5% offered women self-referral for early pregnancy scans. The definition of RM varied: 79.4% investigated ≥3 consecutive miscarriages; however respondents investigated ≥3 non-consecutive miscarriages (21.6%), ≥2 consecutive miscarriages (21.6%), and ≥2 non-consecutive miscarriages (5.9%). 86.3% investigated women if RM occurred with different partners. As per RCOG guidance 98% performed antiphospholipid antibodies (APA) screening, 93.1% performed karyotyping for subsequent miscarriages and 86.3% performed pelvic ultrasound as standard management. Other investigations offered routinely included inherited thrombophilas (65.7%), thyroid function tests (31.9%), diabetes mellitus screening (35.3%), parental karyotyping (34.3%), androgen profile (25.5%), 3-D ultrasound (17.6%), hysteroscopy (12.7%), hysterosalpingogram (9.8%), vitamin D (7.8%), peripheral natural killer cells (2.9%) and referral for uterine natural killer cell testing (2.9%). 97.1% offered treatment for APA-positive women; however 23.5% offered treatment for APA-negative women. Other treatments offered included progesterone (27.5%) and metformin (1.9%).

Conclusion We have highlighted considerable deviation from RCOG guidelines. We recommend addressing the gaps in knowledge resulting in experience-based rather than evidence-
Oral and Poster Presentations

0025
A rare cause of pelvic pain post hysterectomy
Tibbott, J; Yamoah, K
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Case A 42-year-old patient came to gynaecology outpatient complaining of 6 months of lower abdominal pain and deep dyspareunia. She is currently being treated for rheumatoid arthritis with hydroxychloroquine but is otherwise fit and well. Three years earlier she had an abdominal hysterectomy for menorrhagia with conservation of both tubes and ovaries. An ultrasound scan prior to this clinic appointment showed a band of scar tissue/ adhesion which extended from the vaginal vault to the left ovary. She was consented for a laparoscopy and adhesiolysis. At laparoscopy findings were of a midline omental adhesion to the abdominal sidewall and densely adherent to the vaginal vault. These structures were freed. In the pouch of Douglas there was a pool of old dark blood, and at the distal end of the sigmoid colon there was a twisted appendix epiploica. This was removed using two endoloops and excised. The patients intraoperative heart rate doubled when the appendix epiploica was grasped indicating a pain response. The patient made an unremarkable postoperative recovery and is now pain free. Histology from the specimen showed a pale smooth outer walled nodule 22 \(\times\) 15 \(\times\) 6 mm which is soft on slicing, appears to be composed of fatty tissue only. Microscopic: Adipose tissue showing vascular congestion, peritoneal reaction and early fat necrosis. The features are consistent with a twisted appendix epiploica. Appendices epiploicae are fat structures lining the colon, in which torsion and inflammation of these structures are rare events. In a study of 1320 diagnostic laparoscopies only 8 patients were found to have a twisted appendix epiploica. The onset of pain can be acute, mimicking appendicitis or mimicking chronic endometriosis.

0026
Are cervical cytokines, antimicrobials and microflora associated with pre-term birth in high-risk women?
Manning, R; James, C; Smith, M; Innes, B; Stamp, E; Peebles, D; Bulmer, J; Robson, S; Lash, G

Introduction Spontaneous preterm birth (sPTB; delivery <37 weeks), accounts for ~10% of births and is a major cause of neonatal mortality and morbidity. Intra-amniotic infection is present in 30–40% of cases. The cervix acts as a barrier to ascending infection, potentially via cytokine and antimicrobial production. These may be altered prior to onset of sPTB in asymptomatic patients. We aim to examine whether asymptomatic women with a history of previous sPTB or cervical surgery who subsequently deliver prematurely have altered expression of biomarkers and/or microflora within cervical fluid at 22–24 weeks of gestation, compared with those delivering at term.

Methods External cervical os fluid was collected from 135 high-risk patients using a cytobrush. Supernatants were washed, centrifuged and concentrated. Cytokines were analysed using FASTQuant\(®\) Human II multiplex protein array and elafin was analysed by ELISA. Genomic DNA was extracted using QIAamp\(®\) DNA Kit and TaqMan\(®\) PCR assays for 7 bacterial species was conducted using ABI Prism 700 detection system. Significance was determined using Mann Whitney U Test.

Results Cervical fluid IL-8 and IL-1β levels were lower in women who delivered at <37 weeks of gestation \((n = 42)\) compared to those delivering at term \((n = 53); IL-8 P = 0.03; IL-1β P = 0.04). There were no differences in elafin levels between the two groups. IL-2, IL-4, IL-6, IL-10, IL-12p70, GM-CSF, MCP-1 and RANTES were not detected. A higher proportion of women who delivered pre-term had 4 or 5 different detectable vaginal microflora species \((P = 0.005)\). IL-8 levels were reduced in pregnancies with placental chorioamnionitis compared to those without placental pathology \((n = 21, P = 0.03)\). There was a trend towards lowered IL-1β and elafin levels in pregnancies with placental chorioamnionitis.

Conclusion High-risk patients who subsequently deliver preterm have reduced cervical fluid IL-8 and IL-1β levels. Multiple cervical bacterial species was associated with women who subsequently delivered preterm. These biomarkers could be utilised together to predict sPTB in high-risk asymptomatic patients; potentially aiding with planning antenatal management.

0031
To treat, but not to diagnose: the use of laparoscopy in ectopic pregnancies
Tempest, N; Page, O; Hapangama, D

Introduction RCOG guidelines advocate the combination of transvaginal ultrasound scan (TVUS) and \(ß\)-hCG measurement for confident diagnosis of ectopic pregnancy without resorting to laparoscopy. The use of laparoscopy should be limited to the treatment of some ectopics only, due to their obvious potential detrimental complications. We aim to determine the specific preoperative clinical and investigatory findings that may increase the accuracy of diagnosing ectopic pregnancy and to reduce the incidence of negative laparoscopy.

Methods We retrospectively analysed all laparoscopies undertaken to treat presumed ectopic pregnancies at Liverpool Women’s Hospital for 12 months from June 2014.
Results 52 diagnostic laparoscopies intended to treat presumed ectopic pregnancies were analysed (44 confirmed (84.6%) and 8 negative (15.4%)). Negative laparoscopies were associated with younger age, low BMI, primiparity and higher pre-theatre β-hCG. Previous history of an ectopic (9.1%), bleeding (59.1%) and abnormalities identified at TVUS (86.4%) were more common in true ectopics. No previous ectopic pregnancies occurred in the negative laparoscopy group. Diarrhoea and shoulder tip pain were noted on admission in 4.5% of the positive group and nil in the negative group. At laparoscopy it was noted in the confirmed ectopic group that out of 44 patients there was 1 ruptured ectopic (2.3%), 8 patients with adhesions (18.2%) and 7 patients with cysts (15.9%). In the negative group 1 patient out of the 8 had adhesions (12.5%).

Conclusion Although diagnostic laparoscopy should not be undertaken unless for the treatment of ectopic pregnancies, accurate preoperative diagnosis can be difficult. Further improvement of current diagnostic tools are needed to reduce associated morbidity and mortality with negative laparoscopies.

0032
Diagnostic laparoscopy is not indicated in young adults with normal findings at physical examination and ultrasound scan
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1University of Liverpool, Merseyside, UK; 2Liverpool Women’s Hospital, Merseyside, UK

Introduction Endometriosis affects 1 in 10 women of reproductive age with definitive diagnosis requiring diagnostic laparoscopy. ESHRE guidelines endorse empirical medical treatment pre definitive diagnosis in women with endometriosis-associated symptoms. There is no evidence that treatment of peritoneal disease influences the natural disease course. We aim to compare the history, examination and operative findings of two cohorts of young women to distinguish if / the most appropriate time for a diagnostic laparoscopy.

Methods We retrospectively analysed all laparoscopies undertaken to diagnose pelvic pain with a normal ultrasound scan at Liverpool Women’s Hospital from June to December 2015 in two different age categories, 16–20 years (n = 41) and 25–29 years (n = 34).

Results Younger women had statically lower BMI and parity and suffered a higher incidence of migraine and irritable bowel syndrome. Both groups had a high prevalence of anxiety and depression, 24% young versus 32% older. Previous diagnostic laparoscopy was reported in 4.9% of the younger cohort and 8.8% of the older cohort. 58% of the younger group and 47% of the older group were on hormonal contraceptives and habitual use of analgesia was reported by 32% versus 41%. Medical treatment was offered prior to laparoscopy in 24% of the younger group and 21% of the older group. At laparoscopy, normal pelvis was seen in 66% of the younger and 62% of the older group, and the diagnosis of stage 1–2 endometriosis was made in 24% and 21%. None had stage 3–4 disease.

Conclusion Many young women are undergoing invasive investigations with normal findings at ultrasound scan / physical examination without a prior trial of medical treatment. The laparoscopic findings did not alter the overall management, therefore should be offered cautiously.

0033
Case study: Conservative management of placenta accreta in the first trimester of pregnancy
Matar, M; Memon, F; Harris, R
Women’s Health Department, Cumberland Infirmary, Carlisle, UK

Case A 36-year-old para 9 presented in her 11th pregnancy for her dating scan at 12 weeks of gestation, having had spotting throughout the first trimester. She had had 5 spontaneous vaginal deliveries then 4 lower segment caesarean sections. On transvaginal ultrasound scan, only an irregular, collapsing gestation sac was seen low in the uterine cavity measuring 44 mm². Conservative management of delayed miscarriage was recommended but 3 weeks later the products remained in situ as confirmed on ultrasound. Following 2 doses of misoprostol with no effect, the patient was taken to theatre for ultrasound guided surgical management of miscarriage. Suction curettage was initiated and products of conception removed. Further products could be seen in the lower part of the cavity but the anterior uterine wall appeared very thin and close to the bladder, therefore the procedure was abandoned due to strong suspicion of placenta accreta. The patient had further episodes of heavy vaginal bleeding over the next 48 hours requiring blood transfusion. An MRI scan performed 2 days postoperatively confirmed placenta accreta showing caesarean section scar thickness of only 2 mm with adherence to the bladder wall. She was discharged on oral antibiotics. Transvaginal ultrasound scans performed 1 month and again at 2 months postoperatively showed gradual thickening of the lower uterine cavity with a normal uniform appearance of the myometrium. Serum β-hCG fell to <1IU/L and her menstrual cycle recommenced as expected. The patient declined hysterectomy throughout and despite the high risk of abnormally invasive placenta and uterine rupture is still considering further pregnancies and declines contraception. This case demonstrates that in carefully selected cases, where hysterectomy is declined or particularly high risk, conservative management of placenta accreta is possible in the first trimester of pregnancy with appropriate counselling and follow-up.

0034
Are we good at identifying small babies?
Frimpong, D; Moore, J; Winstone, L; Bastianelli, A; Ahmed, H; Flint, S; Slack, A
Maidstone and Tunbridge Wells Trust, Tunbridge Wells, Kent, UK

Introduction It is difficult to identify small-for-gestational-age (SGA) babies and their outcome is often poor compared to normally grown babies. Growth restriction is associated with long
Study on stillbirth at a large UK tertiary referral centre before and after the introduction of national guidance on the management of small-for-gestational-age fetuses

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Royal Victoria Infirmary, Newcastle upon Tyne, UK

Introduction Stillbirth is a devastating pregnancy outcome, which affects all nations. Our large tertiary referral centre delivers 7600 babies annually. The purpose of this study is to ascertain the rate and causes of stillbirth before and after the introduction of new national guidance on the diagnosis and management of the small-for-gestational-age (SGA) fetus.

Methods The case notes of all patients suffering stillbirth prior to and after the introduction of new SGA guidelines were studied. The study period was between June 2014 to January 2015. Data for each case was recorded on a predesigned proforma and entered anonymously into an Excel spreadsheet and analysed.

Results During the months June and July 2014 there were 12 recorded stillbirths, stillbirth rate was 10/1000. Following the introduction of new SGA guidelines stillbirth numbers decreased to 4 giving a rate 3.3/1000. The causes for stillbirth in June–July was utero-placental insufficiency (n = 7), placental abruption (n = 3), musculoskeletal abnormality (n = 1), Potter’s sequence (n = 1) and fetal hydrops (n = 1). All fetuses were classified as SGA at postmortem. Two of the fetuses from the December–January 2015 cohort (i.e. after introduction of guideline) were classified as SGA. Causes for stillbirth in the second cohort was uteroplacental insufficiency (n = 2), twin-twin transfusion syndrome (n = 1) and unknown cause (n = 1).

Conclusion The number of stillbirths decreased following the introduction of this guideline. It is clear that this guideline has increased surveillance for the SGA fetus antenatally. Planning elective delivery in this group at earlier gestation has impacted on stillbirth rate. This study could be extended to investigate the impact of increase in the elective work load which has resulted from introduction of this new guideline in this unit.

Ectopic – the forgotten pregnancy loss

Stelling, H

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Introduction Ectopic pregnancy complicates 11 in 1000 pregnancies with a maternal mortality rate of 0.2 per 1000. CEMACE report two thirds of these deaths are associated with substandard care; therefore it is imperative that we strive for high quality care in all cases, encompassing clinical management, aftercare, pastoral care and advice for future pregnancies.

Methods Standards were created using local departmental guidelines for management of ectopic pregnancy, and compared to documented management of all patients treated medically or surgically for ectopic pregnancy at the Queen Elizabeth Hospital, Gateshead, between 01/08/14 and 31/07/15.

Results 21 patients received methotrexate. All patients satisfied the inclusion criteria for the use of methotrexate. 79% had documentation of awareness of tubal rupture risk, with 16% informed of the need for further treatment. Mean time to resolution was 26 days, with 32% having serum β-hCG tracked to <5. No patients required further methotrexate, 1 patient required surgical management following presentation with increased pain. 8 patients had surgical management. 7 underwent laparoscopy. All patients had salpingectomies which all returned positive histology. Indication for surgery was appropriately and clearly documented. Three patients required anti-D prophylaxis but only two received it. The emotional impact of pregnancy loss was not documented as being discussed in any case. Impact on fertility and ectopic recurrence was discussed with 25% and 38% respectively in the surgical group but was not documented in any of the medically treated patients. Future early pregnancy scans were advised in 21% medically managed and 75% having surgical management.

Conclusion Immediate clinical management was appropriate in all cases, however counselling, post treatment advice, and pastoral elements of care appear to be lacking in this unit. Further education/resources should target this aspect of care for patients with ectopic pregnancies.

Ophthalmic indications for caesarean section

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Introduction It is believed that pregnancy may induce or exacerbate pre-existing ophthalmological conditions, such as...
diabetic retinopathy. Existing evidence shows that hypertension and pre-eclampsia are the main drivers of eye disease presenting in pregnancy, potentially leading to retinal detachment and intraocular haemorrhage, as well as transient cortical blindness. This literature review aims to answer if there are any ophthalmological indications for operative delivery, and what are the effects of delivery method on conditions including myopia, glaucoma, diabetic retinopathy and risk of retinal detachment. 

Methods Medline® and Embase® databases were systematically searched from inception to February 2016 using the keywords: 'ophthalmic indications, caesarean section, pregnancy, labour, complications, diabetic retinopathy, retinal detachment, eye disease' including appropriate MeSH terms. Relevant articles were reviewed by two authors with reference lists hand-searched for pertinent publications.

Results 41 appropriate papers were identified: 27 case reports, 13 review articles and 1 non-clinical report. The majority of patients had pre-existing/gestational hypertension or pre-eclampsia/Hypertensive emergency; however preoperative diagnosis is frequently problematic. Reliance on clinical acumen results in only half of cases diagnosed correctly prior to surgery. Recurrent adnexal torsion in women is uncommon with a risk reported around 5%. In cases of a normal ovary the likely cause is an elongated utero-ovarian ligament. Oophoropexy or shortening of the utero-ovarian ligament is often considered to prevent further re-torsion however techniques are not standardised.

Case A 31-year-old woman reported severe abdominal pain immediately post evacuation of retained products of conception. Ultrasound and bloods were normal. Differential diagnosis included broad ligament haematoma secondary to uterine perforation. Diagnostic laparoscopy confirmed torsion of the right adnexa. No predisposing factors were found. Following de-torsion the ovarian ligament was sutured to the round ligament using an absorbable suture (polyglactin 910) to prevent re-torsion. She represented with the same symptoms 6 months later. Ultrasound and bloods remained normal. Diagnostic laparoscopy confirmed recurrent right sided adnexal torsion. Oophoropexy was attempted but abandoned due to the risk of damaging ovarian tissue.

Conclusion This was an unusual presentation of ovarian torsion and illustrates the difficulty in diagnosing torsion in the presence of normal investigations. Clinicians must maintain an open mind and low index of suspicion when assessing patients with non-classical symptoms such as the postoperative pain experienced in this case. The literature reports novel ways reducing recurrence risk including truncation of the utero-ovarian ligament and fixation of the ovary to the uterosacral ligament. However the optimum management of recurrent adnexal torsion remains unresolved.
Oral and Poster Presentations

A new medical device to improve surgical acuity during laparoscopic surgery

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Background Surgical acuity during laparoscopic surgery can be adversely affected by particulate matter, fat, blood and condensation. Suboptimal vision during operating is associated with adverse outcomes and complications. A number of strategies exist to help keep the laparoscope lens clear including touching the laparoscope against tissues, cleaning the lens externally with gauze and FRED antifog solution and devices which warm the CO2 to prevent condensation. We piloted a new device, OpClear®7, a disposable sheath which attaches to the laparoscope and uses CO2 and saline to clear the lens of the laparoscope in situ in the patient’s abdomen.

Methods A sample case of total laparoscopic hysterectomy for menorrhagia was used. The patient had a normal BMI and no previous surgery. The OpClear® controller was set up by scrub staff and a 00 laparoscope scope was used with the OpClear® attachment. 12 mm ports were inserted and the laparoscope + OpClear® device inserted into the abdomen. OpClear® was activated by the primary surgeon using a foot pedal whenever the view was impaired. No FRED or other devices to improve vision were used simultaneously.

Results The OpClear® device was set up without issue. The procedure was uncomplicated, took 72 minutes. The laparoscope remained in the abdomen throughout with good views. There was no need to touch the laparoscope against the organs or remove for cleaning. The pedal was activated 32 times each time resulting in an optimal view through the laparoscope lens. The patient had a routine recovery with no postoperative complications.

Conclusion This is a novel and potentially effective device that offers significant improvements in surgical acuity, thereby reducing intraoperative complications and maximising patient safety. It reduces time delays and allows the primary surgeon to control lens cleaning. Further trials comparing OpClear® to other devices and methods of improving surgical acuity are required.

0053
An audit examining the investigation of heavy menstrual bleeding and the instigation of management at the Royal Bournemouth Hospital Menorrhagia Clinic

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Introduction Heavy menstrual bleeding (HMB), defined as excessive menstruation which interferes with quality of life, is a common condition. The Second Annual Report from the National HMB audit found that one third of women reported that they had not received any treatment for their HMB in primary care. This audit aimed to compare standards at the menorrhagia clinic at the Royal Bournemouth Hospital against national standards and consequently improve service provision. Our objectives were to assess investigations and treatments provided at the clinic in order to improve the effectiveness and efficiency of the service.

Methods A comprehensive search was completed using primary data from the Viewpoint database as part of a retrospective observational study. The search criteria included investigation results and management decisions for all patients who attended the clinic in a period of two years from 25th May 2014 to 25th June 2016 (n = 358).

Results Our analysis found that 76.25% of women who attended the clinic were given a diagnosis of which 57.5% was dysfunctional uterine bleeding. 92.45% of women had an ultrasound examination and 34.35% had hysteroscopy performed. We found that 2.79% of women had a biopsy taken. Regarding management, 18.16% of women were treated conservatively, 35.47% medically and 30.73% surgically, and in 15.64% of cases the management was not recorded. Only 8.9% of women had been treated in the community.

Conclusion We found that the majority of women were investigated and managed appropriately in accordance with NICE guidelines. However many patients had not received any treatment in primary care and this was a potential factor in improving the efficiency of the clinic. We found that our surgical conversion rate was 7% lower than the average in England. We felt that information on differences in local management rates may be useful in aiding decision making in patients.
Benchmarking complication rates in gynaecological oncology at a single tertiary centre against the United Kingdom Gynaecological Surgery Outcomes and Complications (UKGOSOC) Trial

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Introduction Gynaecological oncology is a high-risk field and surgery is frequently not confined to the pelvis. Complication rates may therefore be expected to be higher than in other surgical specialties. This is due to disease complexity, advanced age of patients, and multiple co-morbidities. There is little published data on complication rates in gynaecological oncology. The UK Gynaecological Surgery Outcomes and Complications (UKGOSOC) trial is the only study that has collated surgical complication rates for gynaecological oncology in the UK. To prospectively collect data on surgical procedures and complications in gynaecological oncology at Brighton and Sussex University Hospitals (BSUH) NHS Trust and benchmark this against UKGOSOC figures.

Methods Data was collected contemporaneously, including patient demographics, procedure, diagnosis, stage, and postoperative complications encountered. The complications were classified using the Clavien-Dindo Classification.

Results Between 7th January 2016 and 7th June 2016, 174 surgeries were performed (171 elective, 3 semi-elective). 19% of cases were ovarian cancer, 17% endometrial cancer, 13% vulval cancer, 30% complex benign cases, and 21% other cancers. The most common procedures included bilateral salpingo-oophorectomy (93), total abdominal hysterectomy (44), omentectomy (39), and total laparoscopic hysterectomy (36). Other procedures included small bowel (5) and large bowel resection (7), and a nephrectomy (1). The overall complication rate (Clavien-Dindo Grades 1-5) was 15.5%, however, Clavien-Dindo Grades 3-5 complications only occurred in 4.6% of cases. The highest complication rate was amongst laparotomies (5/68, 7.35%). The majority of patients (5/8, 62.5%) with serious complications had advanced (Stage 3 or above) disease. Semi-elective surgery was associated with higher complication rates compared to elective surgery (2/3, 66%).

Conclusion Serious complications occurred in 4.6% of cases at BSUH NHS Trust, the majority of which were following laparotomies. The overall complication rate was 15.5%. This is in keeping with national data taken from the UKGOSOC Trial (3.4% versus 15.3%).

Complex social factors in pregnancy: an evaluation of our service

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Introduction The obstetric care that women should be offered in the antenatal period is clearly outlined in national guidance (NICE CG 62), however women with complex social factors in pregnancy will have additional needs and optimising their care is often difficult. NICE introduced further guidelines in September 2010 (NICE CG 110) to address these issues. The guideline focuses on four groups of women: those who misuse substances (drugs and/or alcohol); women who are recent migrants, refugees or asylum seekers, or who have difficulty speaking or understanding English; young women aged under 20; women who experience domestic abuse. Worcestershire is predominantly White British, however it has pockets of deprivation and increasing migration, therefore we need to ensure our service meets their needs. We aim to evaluate the use of care by women with complex social factors in pregnancy, against the NICE Guideline CG110 Pregnancy and Complex Social Factors to enable improvement in patient care and to reduce adverse outcomes.

Methods A retrospective service evaluation of 50 patients delivered countywide during a 6 month period in 2015. Data was collected using the patient’s handheld pregnancy notes, hospital records and their computerised labour and delivery record.

Results The majority of women were smokers, however eight women disclosed domestic abuse and five women had difficulty speaking or understanding English. Of these only one woman was offered an interpreter. Thirteen women were not seen at least once on their own.

Conclusion Improvement in the use of interpreters and availability of dual handset telephones for use of telephone interpreters. Commence a ‘red dot’ system in patient only toilets, whereby patients can apply a sticker to their urinalysis sample which alerts a member of staff that they wish to speak to a healthcare professional on their own in confidence.

Complex social factors in pregnancy: a spotlight on two interesting cases

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Background Pregnant women who have complex social factors have additional needs. Consequently, caring for them appropriately is a challenge. Medical teams often require support from specialist midwives and other services to optimise care. We introduce two cases highlighting this difficulty.

Cases Case 1 is a 23-year-old with a history of learning difficulties, dyslexia and depression. She was born to a substance abuser and placed in foster care due to neglect. She used illicit substances from age thirteen and suffered physical abuse from her partner. She booked late: 15 + 3 weeks and failed to engage with
services. After recurrent admissions with abdominal pain she attended at 31 + 4 with a significant antepartum haemorrhage and she underwent an emergency caesarean section. The baby was born in poor condition and died day 2 of age. Although post-natal recovery was unremarkable she was readmitted 12 weeks later and detained under the Mental Health Act. Case 2 is a 33-year-old substance abuser on methadone. Her three existing children were all in foster care. She booked late: 29 + 2, after disclosing her pregnancy to the Police when caught shoplifting. After booking she did not attend further antenatal appointments. She delivered the baby at home at 31 + 6 weeks and became acutely unwell in hospital. She was admitted to ITU with a staphylococcus aureus bacteraemia, complicated by septic emboli, as a result of endocarditis. She then absconded from the ward and has refused further treatment.

**Conclusion** These cases illustrate the vulnerability and risk of complications in this complex group of women. Both demonstrate the difficulties in engaging these women and encouraging attendance for appointments despite identifying risk factors and assigning a Specialist Midwife. It is important to consider novel strategies with the aim of improving engagement and hence improve outcomes for these high risk women.

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**0057**

**Safe laparoscopic entry techniques in gynaecological practice: a survey of Welsh trainees’ experience**

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**Introduction** We aim to analyse the relationship between existing evidence concerning safe laparoscopic entry techniques and gynaecology trainees evaluation of breadth of training in entry techniques, experience obtained and hence influence on subsequent independent practice.

**Methods** Literature search and electronic survey distributed to all trainees. The setting was a large Training Deanery (Wales, UK). Responses received from twenty-one postgraduate trainees within the specialty of obstetrics and gynaecology.

**Results** A recent Cochrane review (Aug 2015) suggests that ‘there is insufficient evidence to recommend one laparoscopic entry technique over another’. The majority of trainees (66.67%) felt a range of laparoscopic entry techniques should be taught with 95% suggesting there was concern regarding the safety of laparoscopic entry. Training in Hasson technique and direct visual trocar entry were deemed inadequate by 61.90% and 66.67% respectively. However, when asked which technique the trainee was most comfortable in performing responses for, ‘Hasson technique’, ‘direct visual trocar entry’, ‘Veress needle’ and ‘all techniques’ were equal. Contradictory to the majority stating the former two techniques were inadequately taught. When asked why trainees thought certain techniques were inadequately taught 61.11% indicated the trainer ‘does not perform alternative techniques’. Lastly 42.86% of trainees felt (in their opinion) that the safest method of laparoscopic entry was the Hasson technique.

**Conclusion** Existing evidence comparing the safety of different laparoscopic entry methods is conflicting and of poor quality. This can be problematic as surgical practice cannot be definitively evidenced-based. This is also reflected through the varied practice reported by the cohort questioned; hence, advocating the need for improved quality randomised controlled trials, although this may be difficult. If clear evidenced-based practice becomes available, trainers could clearly identify the safest entry techniques and subsequently provide varied, evidence-based, quality training to trainees universally.

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**0059**

**Maternal Sweet’s Syndrome: a rare complication of pregnancy**

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**Background** Sweet’s syndrome, also known as acute febrile neutrophilic dermatosis, is a rare inflammatory disorder. It is characterised by acute skin changes, elevated inflammatory markers, fever and malaise. Pregnancy-related Sweet’s syndrome is extremely rare. The largest case series reported to date by Amouri et al, examined 90 cases over a 20-year period. Only three were attributed to pregnancy.

**Case** A 31-year-old, Para 2 Pakistani female presented to the emergency department at 29 weeks of gestation. She complained of arthralgia of the feet and hands, accompanied by a rash on the extremities and a painful breast swelling. She had a high-grade pyrexia and examination revealed inflamed metacarpalphalangeal joints, Achilles tendons and conjunctivitis. A rash was noted on the shins, feet and dorsum of both hands, similar in appearance to erythema nodosum. Her abdomen was soft and the fundus was palpable appropriate to dates. Blood investigations revealed a neutrophilia, raised CRP and negative autoimmune screen. Her clinical condition did not improve on oral antibiotics. Screening and culture for infection was negative. On day 8, antibiotic therapy was stopped and oral prednisolone commenced and the patient began to rapidly improve. Skin biopsy showed neutrophilic lobular panniculitis. Breast biopsy showed prominent chronic and acute inflammation of the breast with no evidence of malignancy. Following review of all histopathological results, the diagnosis of Sweet’s syndrome was made. Serial fetal growth scans revealed a fall-off in growth in 37 weeks of gestation. An elective caesarean section was performed at 37 weeks of gestation, and a vigorous male infant was born. Interestingly, placental histology was normal, indicating that the placenta was spared from the effect of systemic inflammation.

**Conclusion** Pregnancy-related Sweet’s syndrome is exceedingly rare. We appreciate the need for multidisciplinary involvement in achieving the diagnosis and the promising outcome for the pregnancy and the disease following delivery.
Managing pregnancy of unknown location (PUL) based on initial serum progesterone and serial serum hCG: a multi-centre trial on the performance and complications associated with using a two-step triage protocol

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Introduction The management of PUL can lack uniformity and a clear evidence-base. We previously published on a two-step triage protocol based on the presenting serum progesterone (step 1) and hCG ratio two days later (step 2) to select PUL at high-risk of ectopic pregnancy (EP). This study assessed this protocol's performance and complications when implemented into clinical practice.

Methods A multi-centre prospective cohort study was performed on 1734 consecutive PUL across seven UK hospitals. Patients had a progesterone and hCG level at 0 hours and repeat hCG at 48 hours on 80 women with a PUL. The final outcome was recorded: NVIUP (non-viable IUP), VIUP (viable IUP), FPUL, EP/C226. Agreement between the assays and paired urinary and serum samples were assessed using Spearman correlations, scatter plots and Bland-Altman plots. AUCs were calculated to assess discrimination in IUP versus FPUL and EP/C226.

Results Of 1734 PUL, 1593 had complete outcome data. 266/1593 (16.7%) were lost to follow-up. Step 1 (progesterone cut-off) classified 19.5% (239/1223) PUL as low-risk and was correct in 97.1% (232/239) of cases. Step 2 classified 53.7% (545/1015) PUL as low-risk and was correct in 99.4% (542/545) of cases. No misclassified patients had a ruptured ectopic pregnancy or came to harm.

Conclusion This 2-step triage effectively reduced follow-up of 19.5% PUL after the first visit and an additional 57.0% PUL after just two visits. There were few misclassifications and these came to no harm. This protocol is an effective strategy for rationalizing the care of women with a PUL.

The potential use of urinary β-hCG (beta-human chorionic gonadotrophin) for managing pregnancies of unknown location (PUL): correlating urinary & serum β-hCG levels using two immunoassays

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Introduction Serum β-hCG levels are used to triage PUL into low-risk (predicted final outcome: intrauterine pregnancy (IUP)) or failed PUL (FPUL)) or high-risk (predicted final outcome: ectopic pregnancy (EP) or persistent PUL (PPUL)) of complications. We assessed for a correlation between serum and urine β-hCG levels that allows reliable risk-stratification.

Methods Prospective single-centre study on 320 matched, creatinine-corrected urine and serum samples collected at 0 and 48 hours on 80 women with a PUL. The final outcome was recorded: NVIUP (non-viable IUP), VIUP (viable IUP), FPUL, EP or PPUL. Two assays for β-hCG measurement were used: Immulite® and RIA. Agreement between the assays and paired urine and serum samples were assessed using Spearman correlations, scatter plots and Bland-Altman plots. AUCs were calculated to assess discrimination in IUP versus FPUL and EP/PPUL versus all other outcomes.

Results The RIA and Immulite® assays had a Spearman correlation of ≥0.99 and mean percent difference near 0% in Bland-Altman plots. Individual urine β-hCG levels were systematically higher than correlating serum β-hCGs, even when creatinine-corrected. The final outcomes were 17 (21.3%) EP/PPUL, 11 (13.8%) VIUP, 18 (22.5%) NVIUP, 30 (37.5%) FPUL and 4 (5.0%) lost to follow-up. With the β-hCG ratio (β-hCG 48 hours/β-hCG 0 hours), the accuracy for predicting subtypes of low-risk PUL (IUP versus FPUL) gave an AUC 0.829 (urine) versus 0.930 (serum) and 0.811 (urine) versus 0.933 (serum) for the RIA and Immulite® assays, respectively. The accuracy of using the β-hCG ratio to predict low versus high-risk PUL gave an AUC 0.712 (urine) versus 0.933 (serum) and 0.811 (urine) versus 0.933 (serum) for the two assays.

Conclusion Serum β-hCG remains a better predictor of PUL outcome than urine β-hCG. The urinary β-hCG ratio may have a role in identifying different types of low-risk PUL. It also shows some utility in discriminating between low and high-risk PUL.
Tension-free Vaginal Tape insertion for Stress Urinary Incontinence: a 6-year analysis

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Introduction Tension-free vaginal tape (TVT) procedures have proven efficacy in managing stress urinary incontinence (SUI) when conservative methods have failed. However, voiding difficulties following surgery are a known complication. This retrospective review of TVT cases at Heart of England NHS Trust evaluates the associated complications, postoperative morbidity and improvements reported at follow-up.

Methods All cases performed from January 2010 to December 2015 were identified from the British Society of Urogynaecology (BSUG) audit database. Electronic records were utilised to retrieve clinical letters, surgical documents and discharge summaries.

Results TVT insertion was undertaken in 515 women and simultaneous anti-incontinence procedures performed in 111 (21.6%). Complications occurred in 142 (27.6%); 4 (0.8%) intra-operatively and the remaining postoperatively, with voiding difficulties in 92 (17.9%). Complications were observed more frequently with concomitant surgery (47.7% compared to 22.0% with TVT alone), including the risk of voiding difficulty (26.1% compared to 15.6%, \( P = 0.01 \)). In 8 cases the TVT was loosened and another 8 required tape division. Follow-up questionnaires demonstrated improvements in urinary symptoms in the majority (70.3%), but others found no change or a deterioration. Of those with advantageous results, 81.2% had a TVT inserted only. Worsening incontinence was associated with additional procedures (9.5% compared to 2.6% (\( P = 0.004 \))). Prolonged catheterisation (over 10 days) or intermittent self-catheterisation was necessary in 23 (4.5%); these patients were less likely to benefit from symptomatic improvement (\( P = 0.009 \)).

Conclusion TVT insertion successfully treats SUI, with improvements in the majority. Morbidity, especially voiding difficulty, is not uncommon. Simultaneous anti-incontinence surgery seems to increase complications and be associated with poorer long-term outcomes. Voiding difficulties can be managed effectively with tape adjustment or catheterisation; when the latter is required, patients may have less favourable results. Further evaluation of the risks associated with coinciding surgery as well as the appropriate management of postoperative voiding difficulties are required.

0069
An audit of Induction of Labour: a review of practice at Liverpool Women’s hospital in accordance with NICE and local guidelines

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Introduction Induction of labour is common practice with approximately 25%–28% of women undergoing an induction for either fetal or maternal reasons. The increasing number of inductions places more strain on labour wards and induction itself has an impact on the birth experience for women. Induction of labour may be less efficient and more painful leading to increased rates of epidurals and assisted deliveries and for these reasons the need for induction has to be clinically justified.

Methods We conducted an audit of current clinical practice at Liverpool Women’s hospital to ensure that our induction process is compliant with NICE and local guidelines and to identify any deviations, with an aim to improve practice. Objectives included; ensuring inductions were being conducted in a timely fashion and for appropriate indications, that appropriate information and care was provided to women prior to induction, that necessary documentation was recorded during the induction process, that recommended methods of induction and appropriate monitoring were used and to look at outcomes following induction. The case notes of a sample of 50 patients who underwent an induction of labour within 15 days in August 2015 were analysed to get a ‘snapshot’ of current practice.

Results Results showed that all inductions were conducted in a timely fashion and for appropriate indications. Method of induction followed NICE guidance in 84% of cases and 98% had appropriate monitoring during the induction process. Documentation was lacking regarding the information given to women at time of booking induction and membranes sweeps were not always offered when appropriate. Documentation of the necessary initial assessment criteria required prior to commencing induction was incomplete in 78% of cases, prompting the production of an induction proforma. Overall outcomes following induction were positive with a high vaginal delivery rate, a low caesarean section rate and no failed inductions.

0070
Outpatient hysteroscopic polypectomy appointments: Patient satisfaction audit

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Introduction Outpatient hysteroscopic morcellation polypectomy appointments have been offered in gynaecology outpatients for 18 months. They are considered safer, more efficacious and more cost effective than the traditionally used resectoscope. An audit of patient satisfaction was completed to confirm the picture of a successful procedure. The following standards were audited against; all patients will receive adequate information about their condition and treatment at consultant appointment; feel the care and treatment received met their expectations; have adequate pain relief in outpatients; feel confident leaving outpatients and aware of what to do if concerned; and be able to control their pain at home.

Methods A retrospective audit was carried out with 46 patient questionnaires over 18 months; in this time 96 women received outpatient hysteroscopic polypectomy by morcellation. Questionnaires were carried out in two stages by nurses involved: at the appointment and a telephone follow-up. The data was collated and analysed independently.
Results 93% felt enough information was received at consultant appointment. Two felt insufficient information was given, with 1 feeling too much was given. 98% stated care and treatment definitely met their expectations, and their pain was adequately controlled. 2% felt their expectations were partially met and pain partially controlled. 95% were definitely confident leaving outpatients, with the remainder feeling somewhat confident. 90% women were aware of who to contact if concerned, however 4 women were not fully aware, 93% of women fully controlled their pain at home, 5% partially controlled their pain and 3% were unable to control their pain. 50% used some form of pain relief. Conclusion Overall an image of satisfaction is seen, suggesting patients are happy this procedure. The correct amount of information to be given remains uncertain, although it seems apparent clearer information is needed regarding post procedure expectations.

0074
Induction of labour for gestational diabetes: a review of practice in Dumfries and Galloway
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Introduction Gestational diabetes (GDM) affects up to 18% of UK pregnancies. Guidelines recommend at risk women are offered a glucose tolerance test (GTT) at 24–28 weeks, the use of hypoglycaemic agents and delivery between 38 and 40 weeks to reduce maternal and neonatal morbidity. The local perception is that women induced for GDM have a higher caesarean section (CS) rate than the general obstetric population. This retrospective cohort study describes local management of women through their pregnancy and postnatally who had induction of labour for GDM and compares delivery outcomes with the general obstetric population.

Methods Forty women were identified from the labour induction diary as being induced for GDM between 01/01/2015 and 15/03/16. Records were reviewed for demographics; reason for and gestation at GTT; management of GDM; gestation at induction; delivery outcome and whether a postnatal GTT was performed. Delivery outcomes were compared to those for the total local obstetric population as reported for 2010–2013.

Results A majority of the 40 women were primigravidae (21) or para 1 (10). 62.5% of women qualified for a GTT for BMI alone. 75% of women had a GTT before 28 weeks. 95% of women required hypoglycaemic medication at time of induction. Three women were induced before 38 weeks (8%); 72.5% were induced between 38 and 39 weeks and all had been induced by T + 1. Only 2 women required a variable rate insulin infusion during labour. The normal vaginal delivery (NVD) rate was 67.3% compared to a rate of 70% for the total population. The CS rate was 17.5% for the cohort compared to 22.9% for the total population. 72.5% of the cohort had a postnatal GTT performed and all were normal.

Conclusion In conclusion, outcomes were similar to those of the general population with no maternal or neonatal morbidity observed in these cases.

0076
An audit to review current practice of induction of labour for prelabour rupture of membranes at term
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Introduction Prelabour rupture of membranes occurs in approximately 8% of pregnancies at term. Immediate risks of rupture of membranes include cord prolapse, cord compression and placental abruption. Delayed risks include maternal and neonatal infection. Research on factors that are true risks for chorioamnionitis, postpartum endometritis, and neonatal infection suggest that the risk of infection gradually increases with increasing duration of rupture. Published guidelines advise that induction of labour is appropriate approximately 24 hours after rupture of the membranes to reduce these risks. The primary aim of this audit was to evaluate the timing of induction from when prelabour rupture of membranes was diagnosed to assess whether a delay beyond 24 hours resulted in worse maternal and neonatal outcomes. Secondary aims included: determining how a diagnosis of rupture of membranes was made, ensuring that women did not receive intrapartum antibiotics unless clinically indicated, to compare mode of delivery and readmission rates and ensure NEWs charts were commenced for all babies.

Methods Standards were set against NICE guidelines and local policies. Data was collected retrospectively via Meditech for all women who had an induction for prelabour rupture of membranes at term in a 12 month period, followed by a case note analysis. Neonatal data was collected using the national BadgerNet system.

Results Overall 345 women were induced for prelabour rupture of membranes of which 42% were delayed beyond 25 hours. The main reason for delay was due to availability of the next induction slot. Delay in induction was associated with an increased rate of neonatal antibiotics and admission to NICU. Documentation of NEWs score was poor. Delayed induction was also associated with an increased rate of maternal antibiotics given for chorioamnionitis, however there was not an increased rate of endometritis. Delayed induction was also associated with an increased emergency caesarean section rate for fetal distress.

0078
Medical management of miscarriage audit
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Introduction We aim to look at the success rate of medical management in our unit and to assess the number of patients who became hemodynamically unstable requiring surgical intervention and our rate of complications. We aim to assess the feasibility of introducing out-patient management if the success rate is at/above national recommendations and number of patients requiring surgical intervention due to excessive bleeding is low. Early pregnancy loss accounts for over 50,000 admissions in the UK annually. Approximately 20% of pregnancies miscarry, confirmed miscarriage <12 weeks of gestation can be managed
expectantly, medically and surgically. In a prospective observational study in a tertiary hospital 77.3% of the women had successful medical evacuation, 5 women (6.7%) presented as an emergency. 70 (93.3%) women said they preferred to have the treatment at home rather than in the hospital.

**Methods** A retrospective audit, all cases of medical management were identified over a 3 month period June – August 2015.

**Results** A total of 81 cases were identified. 63 case notes were retrieved by the audit department. 13 notes were excluded. 50 case notes were analysed. 10 (20%) cases bled and had passed products of conception prior to treatment and so were excluded. 40 cases received misoprostol. Total success rate (57.5%). 87% had blood loss <250mls. All cases (100%) were haemodynamically stable. 1 (4%) case had an emergency presentation to ED with bleeding and was diagnosed with dysfunctional uterine bleeding. Only 2 (5%) cases had complications – vasovagal with products of conception at cervical os and partial mole referred to Sheffield. The procedure failed in 17 (42.5%) of cases 14 (82%) failed following one dose of misoprostol and 3 (18%) failed following 2 doses. All cases were managed surgically.

**Conclusion** All cases were haemodynamically stable with blood loss <500mls. To introduce out-patient management of MMM as our audit has demonstrated that no patients required surgical intervention due to excessive bleeding.

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**0081**

**Does husband play a role in labour suite?**

**Kh, S**

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**Introduction** We aim to determine the difference in the outcome among low risk primigravida between those who opted to have their partner along in labour suite and those who opted not.

**Methods** This is a retrospective study. A total of 90 low risk primigravida who were term and in spontaneous labour were identified. 63 opted to have their partner in the labour suite while 27 opted not to have their partner in. The outcome of labour include mode of delivery, estimated blood loss and neonatal admission were then reviewed. Women with comorbidity such as diabetes, hypertensive disease in pregnancy, multiple pregnancy and prematurity were excluded from the study.

**Results** 63/90 (70%) of low risk primigravida opted to have their husband in the delivery suite while 27/90 (30%) opted not to have their partner in. Among those who had their partner in the number of spontaneous vaginal delivery, caesarean section and instrumental deliveries were 58/63 (92%), 4/63 (6.3%) and 1/63 (1.6%) respectively. Those who opted not to have their partner in the number were 10/27 (37%), 16/27 (59%) and 1/27 (4%) respectively. There was a significant difference in the mode of delivery with $P = 0.0085$ (Chi-squared). The mean blood loss in those who had their partner in were 283mls and those who opted not were 344mls with significant difference of $P = 0.0061$ (T test). There were 3/63 neonatal admission among those who have their partner in and 3/27 who did not have their partner in.

**Conclusion** Having someone close and familiar at time of labour can help and ease the stress of labour. Nevertheless it is also important for the birth partner to know exactly what to do in order to play their role effectively.

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**0082**

**Obstetrics and gynaecology ultrasound scan training**

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**Introduction** Since the introduction of the Royal College of Obstetricians & Gynaecologists (RCOG) ultrasound scanning (USS)
Introduction In November 2015 NICE released its first guideline pertaining to the diagnosis and management of the menopause (NG23). Healthcare professionals were advised to provide information and counselling prior to iatrogenic menopause.

Methods Between 2013–2015, 32 patients below the age of 50 years underwent bilateral oophorectomy for benign pathology at Leeds Teaching Hospitals. All documentation surrounding preoperative and postoperative counselling, with specific reference to symptoms of the menopause and subsequent provision of HRT, was reviewed. Gynaecologists were asked to complete an anonymous survey regarding their practice with respect to counselling about the expected menopause. A service evaluation by way of a telephone questionnaire to a subset of women responded to DEPO or GnRH injection, surgical excision is the inevitable menopause was not mentioned on the consent form in the majority of cases. Overall, the patients felt unprepared for the sudden onset of symptoms and its psychological impact. The response from consultants was variable, and inconsistent with documentation and testimonials.

Conclusion The counselling surrounding iatrogenic menopause is poorly documented and recalled by patients, suggesting a need for a proactive approach. Patients would benefit from dedicated information leaflets, internet resources, and a specialist nurse whom is available both pre- and postoperatively for advice and support.

0085 Atypical endometriosis: A series of 4 cases

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Introduction Extra pelvic presentation of endometriosis have been reported in literature. Incidence of umbilical and scar endometriosis account for 0.5–1% of all cases. We present a series of 4 such atypical cases.

Case 1 A 35-year-old woman presented with bleeding from the umbilicus during her periods from a nodule at the umbilicus. Though the nodule shrunk in response to GnRH analogues, it continued to persist. The patient underwent a wide local excision of the nodule with umbilical reconstruction. Histopathology confirmed it as endometriosis.

Case 2 A 30-year-old women para 2 presented with a tender and irreducible fatty lump at the right lateral end of caesarean scar. She experienced worsening pain over the lump during periods. Ultrasound revealed an irregular echo poor mass in the anterior abdominal wall in the right iliac fossa. The excised mass confirmed the diagnosis of scar endometriosis on histology.

Case 3 A 40-year-old had a lump in her caesarean section scar which caused cyclic pain and enlargement during menstruation. The lump was excised and histology confirmed endometriosis.

Case 4 A 41-year-old presented with 1 year history of umbilical nodule with cyclical pain and discolouration. She had a past history of endometriosis. She underwent surgical excision of the nodule histology of which confirmed endometriosis.

Conclusion Pelvic endometriosis is a common condition, but the diagnosis of primary umbilical or caesarean section scar endometriosis can be challenging. Though all of the women responded to DEPO or GnRH injection, surgical excision is the treatment of choice. None of the cases had prior history of endometriosis except one. All the cases were cured at follow-up without any recurrence. These cases further reiterates the fact that endometriosis should be considered as a differential diagnosis of an umbilical swelling in a woman in the reproductive period.
0086
Cardiomyopathy secondary to systemic inflammation associated with HELLP syndrome: A case presentation
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Background Cardiac disease remains the most significant indirect cause of maternal mortality according to MBRRACE-UK, with a rate of around 2 deaths per 100000 maternities in 2011–2013. There is very little within literature of cardiomyopathy occurring alongside HELLP syndrome, and diagnosis can be complicated by concurrent pathological processes.

Case A 30-year-old para 1 attended her GP with acute severe upper abdominal pain, two days following delivery. She had required an antihypertensive drug as a one-off dose postnatally. She became briefly unresponsive and was transferred to ED. On presentation she was normotensive but persistently bradycardic. Epi gastric pain increased. After blood liver transaminases came back as significantly raised, a CT abdomen was performed for possible biliary pathology with pre-eclampsia and HELLP syndrome among differentials due to raised urine protein: creatinine ratio.

A 12 hour Troponin I level was markedly elevated. Platelet levels fell and transaminases rose further. A diagnosis of HELLP syndrome was made with haemolysis confirmed on blood film, and the patient was transferred to ITU. She was stabilised on a magnesium sulphate infusion and discharged to Labour Suite on day 2 post presentation. An echocardiogram confirmed a pericardial effusion of 2 cm, and moderately impaired LV function. Metoprolol was commenced and after a follow-up echocardiogram demonstrating moderate-severe LV dysfunction, a diagnosis of cardiomyopathy was made. This was hypothesised to be caused by systemic inflammation secondary to HELLP syndrome.

The patient was discharged eight days after presentation, clinically stable with a normalising haematology and biochemistry picture.

Conclusion Cardiac disease is an important cause of maternal mortality. There are very few reported cases of peripartum cardiomyopathy occurring alongside HELLP syndrome. Increased awareness of cardiac disease in pregnancy and the puerperium will help rapid identification and management of cardiac pathology.

0087
A Ugandan journal club: a report on the initiation of an obstetrics and gynaecology journal club in Western Uganda
Townsend, R1,2
Mountains of the Moon University, Fort Portal, Uganda; 2Knowledge Change, UK

Introduction The practice of evidence based medicine requires a high degree of research literacy. In Ugandan medical schools research methods teaching is often didactic and rarely includes a focus on the appraisal of new information and application to clinical practice. When it became apparent on a teaching ward round that none of the thirty medical students present had heard of the Cochrane library or even a systematic review, a journal club was proposed and enthusiastically commenced.

Methods A model in which students took it in turns to present a research paper weekly followed by a discussion session facilitated by a senior faculty member was adopted. Each week participants choose a topic for discussion based on cases from the hospital and the faculty member guides them in choosing an appropriate paper. The club is multi-disciplinary and includes interested midwives and nurses.

Results Previous studies have highlighted that although the increasing availability of the internet in the developing world has opened access to high quality research, medical students and doctors are not aware of the available resources and lack the skills necessary to interpret the available evidence. Students highlighted a lack of clinical applicability in their research methods teaching and a lack of mentorship in exploring research further. Being able to interpret and use research is critical to the practice of evidence based medicine and is the foundation to building research clinicians for the future. If African medicine requires an African evidence base, as we believe, then promoting medical student and junior doctor engagement with research evidence is of critical importance in preparing this generation to be the research leaders of the future.

Conclusion The journal club model is simple to implement and has been extremely popular with our students and staff here. We strongly recommend it to all senior doctors practicing in the developing world.

0088
Maternal mortality reviews: from words to action in Western Uganda
Townsend, R1,2
Mountains of the Moon University, Fort Portal, Uganda; 2Knowledge Change, UK

Introduction Mandatory notification of maternal deaths is an important tool in analysing the causes of and reducing global maternal mortality. Uganda has a national reporting system in which every maternal death must be audited using a nationally agreed audit tool which includes a section on recommendations for action.

Methods An audit of maternal death reporting forms from 2011–2015 in one regional referral hospital found 124 cases reported but few with any suggestions for change in the quality of care. The maternal mortality review meetings were subsequently adapted to include as many staff as possible and took the form of a multidisciplinary discussion of the positive and negative aspects of care with a focus on making recommendations for change, rather than simply a process of assigning a cause of death.

Results 25 maternal deaths were reviewed between December 2015 and May 2016. The leading causes of death were sepsis, PPH, malaria and pre-eclampsia. In 100% of cases sub-standard care was identified that possibly or definitely contributed to the death. The recommendations of the meeting led to additional
training in PPH, sepsis and pre-eclampsia for hospital staff, the development of a new emergency blood transfusion protocol and a PPH management policy. There has been a substantial fall in the number of new mortality cases from April to June 2016 despite ongoing issues with understaffing and lack of essential medicines that have also been drawn to the attention of the hospital management through the multidisciplinary action focused maternal mortality reviews.

Conclusion Maternal death review must be more than paperwork if it is to have an impact on maternal mortality. The focus must not be on the cause of death but rather on what can be learned from one mother’s care to save the life of another.

0089
Do commercial iodine supplements comply with current iodine recommendations for pregnant and lactating women?  
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Introduction Iodine is an important nutrient required for the production of thyroid hormones. Severe iodine deficiency can lead to cretinism. UK pregnant women are thought to exhibit mild-to-moderate iodine deficiency, which has been linked with adverse neurodevelopmental outcomes in their offspring. We examined the labels of iodine supplements to assess concordance with the iodine guidelines of the European Thyroid Association and the WHO for pregnant and lactating women:

a) iodine recommended daily intake (RDI) of 250 μg which should not exceed 500 μg

b) routine supplementation with 150 μg of iodine

c) iodine supplements should be provided in the format of potassium iodide; kelp and similar preparations should be avoided.

Methods We identified 34 supplements from 20 manufactures in the UK and Cyprus. Whenever necessary we gathered information supplied from official sources.

Results The target population as judged from the labels was as follows: pregnant (n = 13 preparations), lactating (2), both pregnant and lactating (14), non-specified (4; all were single-nutrient iodine preparations) and ‘thyroid’ (1) patients. Out of 29 supplements aimed for pregnancy and/or lactation, four (14%) had no iodine and 25 (86%) had a dose range of 140–200 μg (93–133% of the 150mcg recommended). Furthermore, 23 (79%) preparations contained iodine derived from potassium iodide, one from kelp and one did not specify the format. Amongst single nutrient and ‘thyroid’ iodine supplements, four (80%) used kelp, with a dose range of 140–450 μg (93–300% of recommended). None of the supplements reported a comparison with the RDI of 250 μg. Instead, they misreported the non-pregnant population RDI of 150mcg as applying to pregnant women, whereas one supplement claimed that the RDI was 175 μg.

Conclusion A significant amount of supplements used in pregnancy and lactation do not contain appropriate quantities or the right format of iodine. Obstetricians ought to be aware of such variations and advise these ladies accordingly.

0091
Unnecesareans – not just a first world problem  
Townsend, R1,2
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Introduction Soaring caesarean section (CS) rates are a common discussion point for obstetricians in the developed world, whereas in the developing world there is a significant unmet need for CS. In Uganda the national CS rate is only 5% in contrast to 26% in the UK. The low national CS rate however masks another problem in urban hospital settings where the hospital CS rate can exceed 50%. Although, as referral centres with a large catchment area, a higher than average CS rate might be anticipated, these levels seem excessive.

Methods An audit of 50 patients delivered by CS was performed at a regional referral hospital in Western Uganda. This was a re-audit following an audit undertaken in October 2014 and February 2015. There was a substantial increase in observations being performed on admission and postoperatively and a slight increase in partogram usage in those women where it would have been recommended. After review 48% of all CS were felt to have been unjustified. The most common indication for CS was dystocia. Of the CS performed for dystocia over 80% were unjustified and in the majority of cases these were in primigravidae.

Results Common themes identified were reluctance to rupture membranes, failure to use oxytocin and failure to recognise latent phase of labour despite a clear departmental policy available in all areas of the labour ward that covers these points. In 95% of cases the decision to operate was taken by the intern doctor without senior involvement.

Conclusion Unnecessary CS in the developing world carries not just an immediate risk to the mother but creates a substantial lifelong risk of maternal mortality in subsequent pregnancies. Strong leadership from senior doctors and education on the normal progress of labour is needed to enable the intern doctors to confidently manage the labour ward.
Oral and Poster Presentations

0092
Not another teach and run: local staff initiated multidisciplinary teaching in a regional referral hospital in Western Uganda in the context of a long term sustainable volunteering programme

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1Knowledge 4 Change, UK; 2Fort Portal Regional Referral Hospital, Fort Portal, Uganda; 3NHS Greater Glasgow and Clyde, UK; 4KU Leuven, Leuven, Belgium; 5University of Salford, Salford, UK

Introduction Short term trips abroad to participate in teaching lifesaving skills and techniques can be of significant benefit when targeted at learning needs identified within the host institution and in the context of ongoing on the job learning support and audit. We report on a multidisciplinary teaching program at a regional referral hospital in Western Uganda in the context of an ongoing bi-directional partnership.

Methods The regular multidisciplinary maternal mortality review meetings identified areas of high priority to local staff for further training. Topics selected included post-partum haemorrhage, sepsis, pre-eclampsia, neonatal resuscitation and breech delivery. The learning needs identified were used to guide the development of a teaching programme throughout the year, utilising short term volunteers for intensive multi modal training days with support from long term volunteers working in the hospital to improve long term retention. Trainers included obstetricians, anaesthetists, surgeons and midwives and trainees included intern doctors, medical officers, midwives, nurses, medical students and clinical officers.

Results The training days were extremely popular with over 100 staff members participating. Staff reported increased confidence in the targeted topic areas and desire to continue a rolling training programme.

Conclusion With the Knowledge 4 Change long term volunteer support training can continue in this style without being dependent on any single volunteer. This model highlights areas of good practice for obstetric training in the developing world.

0093
Respiratory distress in a pregnant myasthenia gravis patient

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Background Myasthenia gravis (MG) is an autoimmune condition characterised by muscle weakness and excessive fatigability. It has an incidence of 1 in 20,000 in pregnancy; up to 41% of known cases relapse usually in the first trimester or postpartum, whilst the remainder experience no change or remission in symptoms. A myasthenic crisis may be triggered by several drug groups commonly used in obstetrics, namely magnesium-containing medication, corticosteroids, beta-

adrenergic agonists, macrolide antibiotics and some inhalational anaesthetics.

Case We report a case of severe pre-eclampsia in a patient with known ocular MG, who developed respiratory distress following a magnesium bolus. A case of a 28-year-old pregnant lady with a background of chronic hypertension and seropositive ocular MG. During pregnancy she was started on pyridostigmine and for control of her hypertension methyldopa, then additionally nifedipine. She was admitted at 35 + 1 weeks of gestation for increasing antihypertensive dose requirements (switched to doxazosin and labetalol), proteinuria and a deceleration in fetal growth (25th centile). At 35 + 4 routine electronic fetal monitoring demonstrated an abnormal CTG trace. The decision was made for an emergency caesarean section. The patient’s BP was 154/103; she described no pre-eclampsia (PET) symptoms. A magnesium sulphate bolus was given – her BP rose to 240/120, she became irritable and tachypneic. The magnesium sulphate infusion was not started. She was moved to the high dependency unit and managed with IV labetalol, IV hydralazine, oxygen and pyridostigmine. Once stabilised a male infant was delivered by emergency caesarean section, intubated and cared for in SCBU.

Conclusion This case highlights the difficulties for the obstetric team in managing patients with pre-eclampsia and MG. A multidisciplinary approach involving neurologists and obstetricians is vital in planning a MG patient’s antenatal, intrapartum and postnatal care.

0095
The clinician’s headache: association between symptoms at presentation and severity of hypertensive disorders in pregnancy

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Introduction We aim to evaluate the correlation of the range of symptoms reported in women with hypertensive disorders in pregnancy and the severity of their hypertension in a district general hospital population.

Methods A retrospective review of medical records was performed between January and December 2014. All patients diagnosed with pregnancy induced hypertension and pre-eclampsia were included. 88 patients were identified. 41 case notes were randomly selected.

Results The degree of hypertension was mild, moderate and severe in 47%, 39% and 15% of patients respectively. Significant proteinuria was found in 66% of cases, with a prevalence of 47% in mild, 75% in moderate and 100% in severe group. Overall 37% of women were symptomatic, 32% in mild, 45% in moderate and 50% in severe group. The symptoms prevalence in pre-eclampsia and pregnancy induced hypertension groups were 22% in mild, 41% in moderate, 50% in severe disease and 40% in mild, 25% in moderate disease respectively. Headache was present in 66% of all symptomatic patients (mild hypertension group 100%, moderate 80%). Peripheral oedema in 20% (moderate group 40%, severe
Operative timings during caesarean sections in maternity theatres: implementation of an obstetric whiteboard

Brehaut, G; Haldane, K; Sullivan, C
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Introduction
Teamwork and communication are fundamental for high quality surgical care. NICE provide clear guidance regarding decision to delivery timings dependent on the category of the caesarean section (CS), however, there is no clear guidance for the interval of knife to skin to delivery of baby. In many institutions patient details and operative timings are written on an obstetric whiteboard (OW) during all CS. This creates improved situational awareness for theatre teams during CS, can prove a valuable guide for surgeons and can be particularly useful in emergencies. We aim:

1. To establish whether utilizing an OW for patient identification and operative timings would be a useful tool in maternity theatres
2. To implement an OW if appropriate
3. To improve both patient care and team working in CS

Methods
Approval for the project gained through labour ward lead and trust forum. Trial OW created for use initially at elective CS and theatre team fully briefed. Feedback forms completed following trial and analysed to assess effectiveness, ease of use, impact on patient care or delays in theatre.

Results
The trial included 5 patients at elective CS. The feedback forms had a 100% response rate. 93% found the whiteboard was useful, 100% thought it caused no delay and 100% stated they would like the OW to become a permanent feature, with comments being noted that it would be useful in the emergency setting and that baby details would also be useful.

Conclusion
This trial conducted during elective CS at a busy obstetric unit has shown that an OW is useful to most staff, has no detrimental impact on list timing or patient flow and creates improved teamworking in a high pressured situation. As a result of the positive feedback, the OW is now a permanent feature in maternity theatres.

Turner’s syndrome and pregnancy: a case report and discussion of management

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Background
Turner’s syndrome is one of the most common chromosomal abnormalities, occurring in 1 in 2500 live female births, caused by complete or partial absence of one of the two X chromosomes. There are a number of typical characteristics but the primary feature of Turner’s syndrome is gonadal dysgenesis. Spontaneous puberty occurs in only 5–10% of women. A very small number can become pregnant spontaneously but in most cases IVF with egg donation is required.

Case
A 28-year-old woman with Turner’s syndrome presented to our service with a positive pregnancy test and a viable intrauterine pregnancy. The patient had stopped taking her Hormone Replacement Therapy 3 months earlier of her own accord. She was diagnosed with Turner’s syndrome 7 years ago following a presentation with secondary amenorrhoea.

Conclusion
Pregnancy can be very high risk in Turner’s syndrome and preconception counselling is essential to optimise the condition. Maternal risks of pregnancy include pregnancy induced hypertension, pre-eclampsia, gestational diabetes, obstetric cholestasis, aortic dissection and heart failure. Fetal risks include miscarriage, chromosomal abnormalities (particularly T21), intrauterine growth restriction, prematurity and perinatal mortality. Caesarean section rate can be up to 85% due to cephalopelvic disproportion resulting from stunted growth and an underdeveloped pelvis as well as other maternal and fetal complications. Antenatal management requires a multidisciplinary approach and involves low dose aspirin, glucose tolerance test, regular echocardiogram with particular attention to the aortic root +/- cardiac MRI, monthly renal function tests, frequent BP and urine checks, and serial growth scans. Postnatal echocardiogram is also required. 1% of women with Turner’s syndrome can become pregnant primarily due to mosaicism. Contraception for patients with Turner’s syndrome should be considered. Combined hormonal contraception will serve as both contraception and HRT. Preconception assessment is essential to minimise maternal and perinatal morbidity and mortality.

A case report of placenta accreta after NovaSure® endometrial ablation

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Case
41-year-old women, P3, all NVD, was complaining of chronic pelvic pain and menorrhagia which caused her anaemia. She had hysteroscopy and Mirena® insertion with no benefit. Two years later she removed Mirena® and had NovaSure® endometrial ablation. Two years later, she accidentally got pregnant. She tried medical management with no response at 8 + 1/40. She was counselled about surgical management with risk of bleeding and
hysterectomy and she demanded hysterectomy to stop menses and terminate the pregnancy. Total abdominal hysterectomy was done and uterus sent to pathology. Pathology showed evidence of wide spread invasion of placental trophoblast and villi to superficial layer of myometrium. Appearance are fully keeping with placenta accreta at 8 weeks of gestational age. No evidence of malignancy was seen. Postoperative recovery was unremarkable.

Conclusion
Reinforce importance of prescribing contraception after endometrial ablation and highlight risks associated if pregnancy occurs.

0100
Motor neurone disease in pregnancy: a case report
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Background
Amyotrophic Lateral Sclerosis (ALS), is especially rare in obstetrics with only 6 case reports having appeared in the medical literature since 1977. Consequently, the management of an obstetrics patient suffering motor neurone disease (MND), including ALS, can be particularly challenging for both physician and patient. Little is known about the risks of ALS in pregnancy but with its progressive and degenerative nature, a combination of upper and lower motor neurone deficits can be expected. Even though ALS is not particularly associated with poorer neonatal outcomes, maternal disease does not regress and may in fact worsen throughout the pregnancy due to increased respiratory and weight bearing demands.

Case
We describe the case of a previously healthy 41-year-old who presented to us complaining of slurred speech and generalised weakness in her fingers at 23 weeks of gestation. A complete neurological assessment further revealed evidence of tongue atrophy and fasciculation, and mild bilateral lower limb spastic hypertonia. The diagnosis of Motor Neurone Disease was made via Nerve Conduction Studies and a multidisciplinary approach was adopted for the ongoing management of this patient. Respiratory efforts became increasingly laborious for our patient and an elective caesarean section was performed at 38 weeks of gestation. The operation was uneventful with no neonatal concerns.

Conclusion
Pregnancy in women with ALS is rare and is generally considered a potentially dangerous event. Complications of this disease mainly affect the respiratory system and labour management should be tailored to the patient’s need and severity of the disease. MND does not tend to involve the uterine sensory and motor nerves and therefore pregnancy and the delivery may be normal, but respiratory function should be carefully monitored. Generally, ALS does not have harmful consequences on fetal development but careful assessment of disease in the mother is vital.

0101
Consenting for caesarean section: An audit of consent forms and the implementation of prewritten consent forms
Brehaut, G; Haldane, K; Sullivan, C
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Introduction
The GMC and RCOG provide clear guidance on consenting for surgery and caesarean section (CS). Recent legal cases reinforce the necessity of good consent practice, yet there remains discrepancy in how clinicians consent for this common obstetric procedure. In view of the ever increasing medicolegal nature of our work, and the need for patients to be fully informed, we undertook an audit into the consenting for CS, with the end goal being the implementation of a standardised consent form. Our aims were:

1 To audit standard of CS consenting
2 To create a prewritten consent form for use in the trust.

Methods
Approval gained from labour ward lead and trust forum. Liaised with trust legal team and clinical risk managers. A pre-implementation survey to find out which grades are consenting for CS and specifically what they consent for. An audit of consent forms was then undertaken. All consent forms for a one week period were analysed and compared to 19 RCOG standards.

Results
100% of clinicians had consent training and 73% consented weekly. The audit showed that 100% were consented for haemorrhage, thromboembolism and infection. 94% consented for bladder injury but only 77% for ureteric injury. 88.9% consented for hysterectomy, 88.9% for fetal laceration and 16.7% for death. 16.7% consented for future pregnancy risks.

Conclusion
Consent remains an important part of daily practice. All obstetric trainees and consultants should be involved with consent for CS. Despite clear guidance from the RCOG there is a significant lack of consistency across practice. As a result of this, patients may not be making a fully informed decision when consenting for CS and the individual clinician or trust could potentially be in a position of liability. In light of these findings, we have created a preprinted, standardised consent form, to be used at GWH.

0102
Management of refractory bladder pain syndrome with intravesical instillations of Cystistat®: outcomes from an outpatient treatment pathway at a District General Hospital
Rowland, A; Hextall, A
West Hertfordshire NHS Trust, St Albans, Hertfordshire, UK

Introduction
Bladder Pain Syndrome (BPS) is a common condition defined by pain, pressure or discomfort in the bladder area for greater than 6 months' duration, with accompanying urinary symptoms of frequency, urgency and nocturia. The diagnosis is made clinically following the exclusion of other
Hypertensive diseases of pregnancy remain one of the leading causes of direct maternal deaths in the UK, affecting 4–6% of pregnancies worldwide and resulting in significant morbidity for both the mother and fetus. Severe pre-eclampsia is defined as >300 mg protein in a 24 hour urine collection and a blood pressure of >160/110. We aim to assess management of severe pre-eclampsia and compliance with local guidelines.

**Methods** A retrospective audit of 24 patients who were treated for severe pre-eclampsia at Sunderland Royal Hospital over a 3 year period (2013-2016) using case notes. There were no incidences of eclampsia. Standards were taken from local Trust guidelines, which are based on national guidance.

**Results** The 82 standards assessed were met in 78.6% of cases on average, with 42 of the standards achieving >90% compliance and 11 achieving <50%. The aspects of care which were best managed were use of oral & IV antihypertensives, the use of magnesium sulphate and postnatal management. The areas which required improvement were the use of 24 hour urine collections in diagnosis, fluid management and documentation of communication within the multidisciplinary team.

**Conclusion** Patients were identified on the basis of receiving IV MgSO4, so there may have been some cases of pre-eclampsia within the time period which were not identified. There remains debate on the need for 24 hour urine collection in confirming diagnosis; however this will remain within our guidelines whilst awaiting publication of current research. Although communication was likely to have been more comprehensive than it appears in the case notes, the documentation of this is clearly key from a medico-legal perspective. Generally, patients with postnatal diagnosis were less thoroughly investigated. However, overall, patients were managed well, in compliance with local guidelines.

0103

**Audit of the management of severe pre-eclampsia and eclampsia**

**Gisby, R; Yorke, J; Emmerson, C**

City Hospitals Sunderland, Sunderland, UK

**Introduction** Hypertensive diseases of pregnancy remain one of the leading causes of direct maternal deaths in the UK, affecting 4–6% of pregnancies worldwide and resulting in significant morbidity for both the mother and fetus. Severe pre-eclampsia is defined as >300 mg protein in a 24 hour urine collection and a blood pressure of >160/110. We aim to assess management of severe pre-eclampsia and compliance with local guidelines.

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**Results** The 82 standards assessed were met in 78.6% of cases on average, with 42 of the standards achieving >90% compliance and 11 achieving <50%. The aspects of care which were best managed were use of oral & IV antihypertensives, the use of magnesium sulphate and postnatal management. The areas which required improvement were the use of 24 hour urine collections in diagnosis, fluid management and documentation of communication within the multidisciplinary team.

**Conclusion** Patients were identified on the basis of receiving IV MgSO4, so there may have been some cases of pre-eclampsia within the time period which were not identified. There remains debate on the need for 24 hour urine collection in confirming diagnosis; however this will remain within our guidelines whilst awaiting publication of current research. Although communication was likely to have been more comprehensive than it appears in the case notes, the documentation of this is clearly key from a medico-legal perspective. Generally, patients with postnatal diagnosis were less thoroughly investigated. However, overall, patients were managed well, in compliance with local guidelines.
Oral and Poster Presentations

0105
Postpartum contraception: a missed opportunity to prevent unintended pregnancy
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North Middlesex Hospital, London, UK

Introduction In our unit, we felt there was a ‘missed’ opportunity to educate and supply contraception to postnatal patients. We therefore carried out a face-to-face survey of 50 women in the week after delivery.

Results The hospital serves a culturally and ethnically diverse area of London, with 5300 deliveries annually and where 44% (n = 20) of patients do not have English as their first language. The median age of women completing the survey was 30 years (range 17–43 years) with 72% (n = 36) having a higher education qualification. The average parity following the index pregnancy was two, with 64% (n = 32) having delivered vaginally, 4% (n = 2) had instrumental delivery and 32% (n = 16) had caesarean births.

We asked women what method of contraception they had used previously and found that 36% (n = 18) had not used any contraception method, 18% (n = 9) were using barrier methods and 30% (n = 15) either the progesterone-only pill, or combined pill or patch. Only 16% (n = 8) of women surveyed had previously used a long acting reversible contraception (LARC) method, well below the country average of 37%.

With regard to the immediate fitting of an IUS/IUD, 16% (n = 8) were ‘very likely’ to accept, 6% (n = 3) ‘likely’ and 78% (n = 39) said they were ‘not likely’ to accept. When the same question was asked with regard to immediate fitting of the implant; 18% (n = 9) said they were ‘very likely’ to accept, 10% (n = 5) ‘likely’ and 72% (n = 36) ‘not likely’ to accept. Some of the comments patients made as to why they would not accept these methods included; ‘too early’, ‘don’t feel need for it’, ‘not heard of either’, and ‘no information (provided)’.

Conclusion This small survey has highlighted a significant need for patient education regarding contraception and as a result, we are keen to work collaboratively on training and education opportunities with the Community SRH teams.

0106
Head over heels: development of a dedicated breech service in a London hospital
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Introduction We aim to assess the number of caesareans performed for breech presentation over 6 months, develop a dedicated breech service to streamline management of breech presentation at term and reduce the number of caesareans performed for breech presentation. The incidence of breech presentation at term is 3–4%. External cephalic version (ECV) is the manual rotation of a fetus from breech to cephalic position. Attempting ECV at term reduces the risk of caesarean section. Previously all suspected breech presentation at our hospital were reviewed and scanned by a doctor. ECV was booked on labour ward if appropriate. There was no record of the ECVs offered, performed or their success rates.

Methods Data was collected retrospectively for all women who were delivered by breech from May 2015 until October 2015. Notes were analysed for whether ECV was offered and performed. Exclusions included twins, cord prolapse, bicornuate uterus and delivery of cephalic presentation as breech at caesarean section.

Results 73 cases were identified and 55 cases were included. There were no vaginal breech deliveries in the study period. ECV was offered to 36% of patients and were accepted by 55% of those offered. Counselling was often performed by the most junior doctors and documentation of the discussions was poor. 20% of patients waited over one week for an ECV.

Conclusion Following this audit a dedicated weekly breech service led by a consultant obstetrician and specialist midwife was initiated in May 2016. The service offers presentation scans and then growth scans if breech is confirmed. Once breech is identified the patients are counselled for ECV and then ECVs are performed as part of the one stop clinic. Data for uptake of ECVs, success rates, patient satisfaction and numbers of caesareans for breech will be collected for 6 months after establishing the breech service.

0107
Case report: postpartum spontaneous pneumomediastinum ‘Hamman’s syndrome’
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Case A 38-year-old primigravida presented for induction of labour for prolonged rupture of membranes at 38 weeks of gestation and proceeded to a spontaneous vaginal delivery of a 4 kg baby. Four hours post delivery she presented with neck swelling. Six hours after the initial presentation further symptoms of dysphonia and nasal congestion presented. There was palpable crepitus throughout the neck. A chest x-ray and CT scan confirmed pneumomediastinum and air in the subcutaneous tissue of the neck. CT scan also showed no evidence of Boerhaave’s syndrome. Symptoms settled with conservative management and a repeat chest x-ray 4 weeks postpartum showed resolution of the pneumomediastinum.

Conclusion Hamman’s syndrome is a syndrome of spontaneous subcutaneous emphysema and pneumomediastinum. It is associated with symptoms of neck swelling and on occasion chest pain, dyspnoea, dysphonia and mild pyrexia. It is a rare syndrome with an incidence of 1 in 100,000 live births. It is associated with prolonged labour and pushing especially in primiparous women. The pathophysiology is thought to be due to the vasa saliva manoeuvre in the second stage of labour. This causes an increase in intrathoracic pressure leading alveolar rupture with air dissecting along the bronchovascular sheaths and into the mediastinum and subcutaneous tissue. It is managed conservatively and usually resolves spontaneously. Hamman’s syndrome is a rare (1 in 100,000) postpartum cause of neck swelling.
swelling, chest pain, dysphonia, dyspnoea and mild pyrexia. Diagnosis is made by chest x-ray and CT scan showing a pneumomediastinum.

0109

Conservative management of morbidly adherent placenta: a case report and review of literature

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Background The incidence of morbidly adherent placenta, has risen dramatically. When diagnosed antenatally, planned hysterectomy at the time of caesarean delivery is usually the standard recommended treatment for known placenta accreta. Recently, with advances in maternity services and imaging techniques, there has been gradual shift towards conservative management for retained placenta with the main aim to reduce pelvic injury, retain reproductive potential and achieve haemostasis. In this review we explore our case report, discuss the challenges of conservative management and the associated clinical implications for both clinicians and patients.

Case We describe the case of a 37-year-old patient primip who presented to our department with a history of spontaneous rupture of membranes at 19 weeks of gestation. She unfortunately suffered from miscarriage soon after but had to be transferred to theatre for a manual removal of placenta. Multiple attempts to enter the uterine cavity and reach the placenta failed and a Magnetic Resonance Imaging was ordered to assess the uterine cavity. A total of 4 fibroids were identified distorting the endometrial cavity – the largest measured 10 cm. A multidisciplinary team, involving obstetrician, radiologists and microbiologists, was set up and a conservative approach with regular departmental visits and two-weekly ultrasound scans was organised. The patient was monitored for a total of 10 weeks and successful resorption of the placenta was noted at each scan.

Conclusion Conservative management of retained placenta can be a time consuming process that can only be achieved with a strong multidisciplinary team in place. When opting for a conservative approach, the individualised risk of intra-abdominal infection, uterus damage and associated complications such as fistula formation need to be thoroughly explored and patient involvement and expectations throughout the entire process is vital.

0110

Ultrasound guided cervical dilatation for severe cervical stenosis

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Introduction We aim to report on an innovative technique to dilate the cervix in patients with severe cervical stenosis.

Methods This was a review of 15 procedures, over a 5-year period, which required cervical and/or hysteroscopic assessment in women with severe cervical stenosis. These patients were identified either due to lack of discernible cervix or following failed cervical exploration under general anesthesia. The indications included women who required follow-up cervical smear after high grade CIN treatment by LLETZ/cone biopsy (n = 6), management of haematometra (n = 2), and endometrial cavity assessment (n = 7). Under general anesthetic the bladder was filled with 200–300 ml of sterile normal saline via an indwelling catheter. A second clinician identified the cervical canal by trans-abdominal ultrasonography. The cervix was then dilated, under real-time ultrasound guidance.

Results Cervical smear and HPV test of cure were negative in all six women (100%). Ultrasound guided cervical dilatation was similarly effective in the treatment of two women with haematometra (100%). Five postmenopausal women needed assessment for either bleeding or thickened endometrium. Four had previous LLETZ/cone biopsy. Cervical dilatation and hysteroscopy was successful in two of them (40%). A false passage was suspected in another woman and perforation occurred in one woman. Both complications were managed conservatively. Cervix could not be located in one woman. The latter three women were followed up, up to a year. Two premenopausal women had abnormal bleeding. One had a successful procedure and normal histology. In the other woman cervical dilatation and consequently further conservative treatments were not possible. She, therefore, had hysterectomy for menorrhagia management.

Conclusion Ultrasound guidance allows for a more controlled and therefore potentially safer cervical dilatation in women with severe cervical stenosis as opposed to other techniques without such guidance. It facilitates accurate diagnosis and management thereby reducing the risks of over-treatment and under-treatment.
Impact of domestic abuse on birthweight: a retrospective case control study

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Introduction The effect of domestic abuse (DA) on pregnancy is not well understood. Previous research has suggested that women who report DA are at a greater risk of giving birth to a child with a low birthweight. These women also have less gestational weight gain and are more likely to miscarry than women who do not report DA. Furthermore, previous research has suggested that intrauterine growth restriction, preterm labour and perinatal mortality, as well as neonatal mortality, is increased. However, these associations were found outside of the United Kingdom and in small samples, where confounding factors were not corrected for. We aim to examine the direct impact of DA on birthweight and intrauterine death, after correcting for confounding factors, in a large tertiary centre in the United Kingdom.

Methods This was a retrospective, observational case-control study carried out in patients at the Royal Victoria Infirmary (RVI) between 2011 and 2014.

Results Of the 31,116 women who gave birth at the RVI between 2011 and 2014, 21,272 women had their DA status documented, with 4.1% reporting DA. Of these women, 12.4% had low birthweight babies, compared with 8.8% of control women ($P = 0.001$). The mean birthweight of the control group ($n = 20,226$) was 3318.1 ± 658 g; the mean birthweight for women reporting DA ($n = 865$) was 3179.3 ± 709 g ($P < 0.001$). After correction for the confounding factors of BMI, parity, ethnicity, gestational age, and alcohol and drug use, there was an 82.4 ± 38.3 g reduction in birthweight in women reporting DA. No statistical relationship was found between DA and intrauterine death.

Conclusion DA is independently associated with low birthweight.
patients knew what to expect and were happy with their experience.

Methods  
Point of contact survey of patients who underwent an outpatient hysteroscopy. Patients were asked to evaluate different periods of time during the outpatient procedure.

Results  
32 patients aged over 18 at James Cook University Hospital, South Tees Trust were offered surveys. 32 patients responded to the questionnaire. Not all patients received local anaesthetic, only where treatment was required. Most anxiety was experienced in anticipation of the procedure, with 5 respondents reporting anxiety pre-procedure. Only 1 patient commented on discomfort during the procedure. 31 patients gave positive feedback following the procedure. The overall feedback from all patients was either that they felt supported or happy during the experience. Responders could indicate that they felt frustrated, sad, worried, comfortable, good, safe, supported or happy. Some responders tended to give multiple answers and adding their own words, where some circled only one word for each point. The response ‘worried’ was grouped with other responses, but no patients selected ‘frustrated’ or ‘sad’ in combination with other responses. One responder selected ‘frustrated’ post-procedure, due to bleeding.

Conclusion  
The outpatient department is an acceptable setting for this procedure as shown in our findings. Comprehensive pre-procedure information is key to working towards patient comfort and reassurance.

0116
Audit on management of MCDA twins
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Introduction  
We aim to audit local practice for care in MCDA pregnancy, to compare with local guidelines (June 2012) which are based on the RCOG and NICE guidelines and to assess outcomes of MCDA pregnancy and compare with previous audit.

Methods  
Method: Retrospective audit with data collection from patient’s notes.

Results  
92% scanned between 11–13 weeks dating, in 50% of cases second opinion was sought. Follow-up USS from dating scan every 2–3 weeks (100%), RGH no dedicated multiple pregnancy clinic, 100% of patients with TTTS were identified and referred appropriately to tertiary centre, 55% MCDA were delivered between 36–37 weeks, 83% were delivered by LSCS, 17% had normal deliveries, 43% patients were transferred to SCBU only 4 unexpected admissions. Dedicated multiple pregnancy clinic, however despite general ANC care no difference in outcome compared to previous audit, Pts with anomaly and TTTS are being appropriately referred to FMC and tertiary care.

Conclusion  
NICE recommends that MCDA pregnancies are cared for in dedicated clinics and cared for by specialist obstetrician and specialist midwives. When translated into reality it amounts to funds. However in Royal Gwent Hospital we do not have a specialist clinic, these patients are seen in General Antenatal clinics and then referred to fetal medicine clinics if there were any complications. These patients were further assessed and referred on to tertiary centres if further treatment required. We compared this with our sister hospital in Abergavenny where these patients are seen in the fetal medicine clinic with specialist obstetrician and midwives. We found that there was no difference in outcome.

0117
Do hypertensive disorders in pregnancy affect the chance of achieving planned mode of delivery? A district general hospital experience
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Introduction  
Our aim was to evaluate the impact of hypertensive disorders in pregnancy and the severity of disease at presentation on achieving mode of delivery as planned prior to the onset of hypertension.

Methods  
Medical records of patients diagnosed with pre-eclampsia and gestational hypertension between January and December 2014 were retrospectively analysed. Patients were divided in groups depending on gestational age. Severity of disease was defined according to NICE guidance.

Results  
88 patients were identified, 41 cases were randomly selected for review. The gestational age range was 29 to 41 weeks. Patients were divided as follows: group A: < 34 weeks (n = 8), group B: 34 + 0 to 36 + 6 weeks (n = 7), group C: >37 + 0 (n = 26). The planned mode of delivery (pMOD) was achieved in group A, B and C in 38%, 57% and 81% respectively, with a rate of caesarean section of 88%, 86%, 31%. In group C the chance of achieving the pMOD was high, irrespective of disease severity with rates of 79%, 80% and 100% for mild, moderate and severe hypertension. In group B the attainment of pMOD was 100%, 50% and 0% for mild, moderate and severe disease. In group A the pMOD was achieved in 100%, 0% and 33% for mild, moderate and severe respectively.

Conclusion  
Our results show that the gestational age is the most important factor affecting the achievement of planned mode of delivery, with term pregnancies being most likely to deliver vaginally irrespective of severity of disease. The incidence of caesarean section increased with decreasing gestation in line with NICE evidence. Although our sample size was small, our results would suggest that in preterm pregnancies the severity of disease might have an impact on achieving the planned mode of delivery. These findings may inform the clinicians when counselling patients in regard to their birth plans.

0118
Unusual presentation of cryptomenorrhoea
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Background  
 Imperforate hymen is a rare congenital anomaly. Incidence is 1 in 1000 – 1 in 10,000. The usual age of
presentation is early teenage, and the usual presenting symptom is abdominal pain that lasts for several cycles before patients seek advice. We present to you a case of a 12-year-old who presented with abdominal pain for one day.

**Case** 12-year-old girl presented to A&E unit with complaints of abdominal pain for one day. She was seen by the surgical team who after a period of observation was taken to theatre for a diagnostic laparoscopy for appendicitis. At surgery they found that the appendix was normal, however there was old blood in the abdomen. The gynaecology on call team were contacted for an opinion. The team attended and found that the ovary and tubes looked normal and uterus appeared normal size, peritoneal lavage was performed. A detailed history was taken in retrospect, the patient had never had a period and there was no evidence of sexual activity. The patient responded to the analgesia. An ultrasound scan was performed which diagnosed imperforate hymen and haematocolpos. This was drained by performing a cruciate incision. 500 ml of old blood was drained. She has made an uneventful recovery.

**Conclusion** Haematocolpos is rare and usually presents in teenagers preceded with abdominal pain over several cycles. Urinary symptoms in the form of retention of urine, chronic pelvic pain and change in bowel habit, abdominal distension are the other symptoms that these patients present with. Examination reveals a bluish membrane in case of haematocolpos and pinkish hue in case of transverse membrane.

**0119**

**Acute abdomen in pregnancy associated with enterobius vermicularis infestation**

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Hull and East Yorkshire Hospitals NHS Trust, Hull, UK

**Introduction** Enterobius vermicularis (also called threadworm or pinworm) is the most common parasite infecting humans. The worms are found generally within the gastrointestinal tract but can also enter the vagina and bladder. The transmission occurs by fecal-oral route or via fomites. The most common symptom is perianal itching. We present a rare case of enterobius vermicularis infestation associated with sepsis and acute abdomen in a pregnant woman.

**Case** A 17-year-old nulliparous woman at 33 weeks of gestation was admitted to maternity hospital with abdominal pain, vomiting and persistent vaginal discharge. On examination she was pyrexial, tachycardic but normotensive and there was marked right loin tenderness. Urinalysis was suggestive of possible urinary tract infection. She was therefore commenced on intravenous antibiotics for presumed pyelonephritis. Initial midstream urine (MSU) culture confirmed *Escherichia coli*. Ultrasound (US) scan showed right-sided hydronephrosis and dilated renal pelvis by 19 mm with normal cortical thickness. Left kidney and urinary bladder were reported as normal. Despite targeted treatment with antibiotics as per antimicrobial susceptibility she continued to deteriorate. Subsequent MSU specimens were negative. Three days following admission she developed acute abdomen and peritonitis.

Surgical opinion was therefore sought. Decision was made to perform laparotomy for suspected intra-abdominal sepsis or appendiceal abscess and caesarean section (CS) at the same time. Intraoperatively all abdominal organs including appendix were unremarkable however appendectomy was performed. A healthy fetus was delivered by uneventful CS. Histological examination of appendix revealed acute inflammation associated with threadworm. Patient received appropriate treatment and made good postoperative recovery.

**Conclusion** Threadworm infestation is not a common diagnosis within the obstetric population but could be associated with acute abdomen and pose diagnostic challenges therefore requires high index of suspicion in patients with recurrent abdominal pain associated with vaginal discharge and pruritus.

**0120**

**Vaginal birth after two previous caesarean sections – should we promote or avoid it? A case series from a District General Hospital**

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**Introduction** Trial of vaginal delivery after one caesarean section (CS) is considered acceptable but vaginal birth following two previous CS is generally discouraged. The most recent RCOG guideline on ‘birth after previous caesarean birth’ suggests that women with a history of two or more previous lower segment caesarean deliveries may be offered ‘vaginal birth after caesarean section’ (VBAC) following comprehensive counselling by a senior obstetrician. This should include discussion about the risk of uterine rupture, maternal and neonatal morbidity and the individualised likelihood of success.

**Method** We undertook a retrospective audit of all patients with history of two previous lower segment CSs who attempted vaginal delivery in our trust between January 2012 and March 2015. The audit included all women with a history of two or more previous lower segment CS and attempted VBAC.

**Results** There were seven cases identified, all of whom were successful in achieving VBAC. Six patients presented in spontaneous labour; one required artificial rupture of membranes (ARM) as an induction means. There was one ventouse delivery and one assisted vaginal breech delivery. Two patients had the favourable factor of having had a previous vaginal birth. BMI over 30 was observed in only one patient. Maternal age varied between 18 to 42. There were 3 premature births – two at 36 weeks of gestation and one at 31 weeks of gestation. Birthweight ranged from 1550 to 4280 grams. Low Apgar score at one minute was observed only in the one case of vaginal breech delivery. There was one postpartum haemorrhage with a blood loss of 950mls. There were no other adverse maternal outcomes recorded.

**Conclusion** Our experience supporting women with two previous CS wishing to attempt vaginal delivery has been very positive. We are aware however that we have only reported a small number of cases. We believe that these deliveries are acceptably safe if
conducted in the centres with suitable expertise and recourse to immediate surgical delivery.

0121
One year review of outcomes of multiple pregnancy in a large obstetric unit in UK
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Introduction Incidence of multiple pregnancies (MP) has risen significantly in last 30 years in the UK. Currently, one in every 65 pregnancies results in a multiple birth. There is a clear association between MP and increased risks to both mothers and babies. Maternal mortality is 2.5 times higher as compared to singleton births. The overall stillbirth rate, risk of preterm labour, growth restriction and congenital abnormalities are also notably higher in MP.

Methods We undertook a retrospective audit examining the clinical care that women with MP received within our unit between 1st of January 2014 and 31st of December 2014 and compared it with the one suggested by the national guidelines. The audit evaluated a set of antenatal interventions (timing of booking appointment, provision of screening, ultrasound surveillance etc.) and obstetric outcomes to ensure safe care is being delivered.

Results There were 74 patients with MP identified within this time period. Seventy three cases of twin pregnancy (including one case of conjoined twins) and one case of triplets. Conception occurred spontaneously in 83% of MP. This was true also for the triplet pregnancy. Out of all MP there were 77% of dichorionic diamniotic (DCDA) twin pregnancies and 18% of monochorionic diamniotic (MCDA) type. Most of the women attended the booking appointment by 10 weeks of gestation (55%) and the majority (over 95%) had ultrasound scan (USS) by 13 + 6 weeks. Amongst other outcomes, we achieved high vaginal delivery rates of 54% in MCDA pregnancies with low elective caesarean section (CS) rate of 15% in this group.

Conclusion In view of the increased risk of complications, this high risk population requires expanded antenatal monitoring and contact with healthcare professionals. In order to provide safe and local protocol based care we recommend continuous evaluation of practice by means of clinical audit.

0122
Ambulatory management of Bartholin’s cysts and abscesses with word catheters
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Introduction Bartholin’s cysts and abscesses are common, occurring in approximately 2% of women. There are a variety of management options available, including: incision and drainage, marsupialisation and insertion of a Word catheter. The Word catheter was first described in 1968 as a method for the outpatient management of Bartholin’s cysts and abscesses. It has a 3 cm stem with an inflatable balloon tip which allows the catheter to remain in the cyst/abscess cavity. After 4 weeks the catheter is removed, leaving an epithelialised tract.

Methods We performed a review of the literature to evaluate the use of Word catheters for the outpatient management of Bartholin’s cysts and abscesses.

Results A review of the literature has shown insertion of Word catheters to be an efficacious treatment option with a success rate of 87–97%. The main complications associated with Word catheters are discomfort and loss of catheter prior to 4 weeks. Recurrence rates of cysts/abscesses following treatment were 3.8–17.4%, which is comparable to marsupialisation. Quality of life studies have found that Word catheters are well tolerated by patients, with 87% stating they would recommend the procedure to a friend. Management of Bartholin’s cysts/abscesses with a Word catheter is more economic than surgical treatment; with treatment costs 7 times lower than a marsupialisation.

Conclusion Outpatient management of Bartholin’s cysts/abscesses with a Word catheter should be considered as it has been shown to be efficacious, well tolerated, safe and cost effective.

0125
Retrospective evaluation of outcomes and complications of Stress Urinary Incontinence (SUI) surgery in our unit
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Introduction This study aims to analyse complications and effectiveness of SUI surgery in our unit namely: TVT-Retropubic (TVT-RP), TVT-Obturator (TVT-O), Autologous slings (AS), and primary versus secondary operations.

Methods Retrospective analysis of 102 patients were performed from January 2013 to August 2014.

Results There were 65 TVT-RP, 20 TVT-O, and 17 AS. 65% of TVT-RP, TVT-O, and AS were subjectively cured. Similarly success rates were 30 versus 5% of primary procedures. 35% of expected TVT-RP, 76% of AS, and 1 TVT-O case had void indysfunction (VI) after trial of void. Only 8% of TVT-RP, 59% of AS, and 0% TVT-O had VI at 6 weeks.

Conclusion Overall success rates (cured and improved) for TVT-RP, TVT-O, and AS were similar. However 56% re-do procedures had VI after trial of void compared with 29% primary procedures.
Furthermore 33% re-do’s still had VI compared with 11% of primary procedures at 6 weeks. This could be explained by lower MUCP in re-do operations. Also chronic pain was reported in 28% of re-do procedures compared with 8% in primary. This data would be important when counselling patients going for re-do procedures and choosing different surgical treatments for SUI.

0127
The GP perspective on referrals for suspected endometrial carcinoma: an audit showing compliance with NICE guidelines
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Introduction According to current NICE guidelines, to suspect endometrial carcinoma in a primary care setting, and send an urgent two-week-wait referral, the patient should be 55 years of age or older, and complaining of post-menopausal bleeding (PMB) which is defined as ‘unexplained vaginal bleeding more than 12 months after menstruation has stopped because of the menopause’. We aimed to see whether the NICE criteria for referral for suspected Endometrial Cancer are being followed in the GP setting, and referrals made accordingly.

Methods All patients were searched electronically and those coded as PMB between January 2011 and January 2015 were studied. We looked at the age at time of presentation, nature of presentation, method of referral, time seen by specialist and outcome of specialist review.

Results A total of 23 patients presented with PMB within the aforementioned timeframe with 3 (13%) confirmed cases of endometrial carcinoma and 5 (21%) cases of benign pathology accounting for the bleeding. Six patients were less than 55 years old, but fulfilled the remaining criteria and one of the six was confirmed endometrial carcinoma after specialist review. Four patients were referred as non-urgent, despite fulfilling the criteria. For those referred via the two-week-wait-pathway, the average time interval between presentation and specialist review was 8.75 days. One patient was inappropriately coded as PMB and no referral was made.

Conclusion Over a five-year period, there were 18 cases fulfilling the criteria and appropriately referred, 4 cases referred as non-urgent despite fulfilling the criteria, and one case inappropriately referred while not meeting the criteria. As a practice, we discussed the NICE guidelines for ‘Suspected cancer: recognition and referral’ and will be re-auditing in 12 months. There is also an ongoing national focus for GP education regarding these guidelines, aiming to improve the quality of referrals to secondary care.

0128
Interstitial heterotopic: a case of cornual déjà vu
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Background Cornual ectopic is in itself an uncommon occurrence which can present challenges in its diagnosis, management and carries a significant risk of rupturing leading to maternal morbidity and mortality. Its management varies widely and depends largely on the haemodynamic state of the patient, whether the pregnancy has an FH, the experience of the team and the patients’ future pregnancy plans. Surgery is preferably by the laparoscopic route. The incidence of interstitial pregnancies is in the region off 1–2 in 5000 and occurs in 1–6% of ectopics. Heterotopic pregnancy is the coexistence of an intrauterine pregnancy with an ectopic pregnancy. It is also a rare occurrence although increased with IVF. The incidence of heterotopic pregnancy is 1 in 30000 after IVF it increases to 1 in 3600 to 1 in 100. Case reports have presented successful conservative management, medical managements such as selective pregnancy reduction with potassium chloride, methotrexate use where the concurrent intrauterine pregnancy has failed and surgical management. The management options are dependent on the same consideration as with cornual ectopic.

The objective of this case review is to report our experience in managing a patient in her second consecutive cornual ectopic in the contralateral horn, which in itself is rare, with a viable heterotopic pregnancy. From the literature we found few cases for its management, one case report suggested methotrexate injection into the cornual sac. Others have had successful conservative management of the tubal pregnancy resulting in term delivery.

Case We will present a 30-year-old woman with the above history after IVF and implantation. We will discuss her classical acute presentation, the diagnostic processes and the surveillance required for her successful management and the outcome of her live birth and future postnatal plans.

0129
Inter-deanery transfer: what does it take?
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This editorial is in part a personal walk into my experiences of transferring deaneries. An option I became aware of when my brother an A&E physician forwarded me the details almost 2 years ago.

I will discuss the hoops I had to go through to first even consider applying and the barriers which prevented me from being eligible. Why I continue to wonder about the decision even after tendering my notice. There are many reasons for people desiring transfer; my application stated I needed to move to be closer to my husband. This was true in part and yet much more complex. O&G is a difficult specialty made harder when ‘going it alone’ and my
experiences in training have been a challenge for a multitude of reasons. I will delve into the national process and my experience now on the other side and will review the procedures and requirements for successful transfer. I will also explore the ethics behind the restrictions questioning whether free movement in training is a bad thing and what reasons for requesting transfer are more valid than others.

I will then discuss the offers process, what happens after including how to tender your notice; how to tell your ‘mates’, your comrades in training, your consultants, the deanery and moving your life. This will include the experience of trainees who have also been through the process to different deaneries. A few trainees have approached me since the process, wanting some guidance from the human perspective and in need of support in what can be an intensely difficult process. This is not a step by step guide (which is available on the IDT website) or an aide to making the decision to move; it is, I hope, an insight into the dilemmas one can face.

0131 Medical management of a live interstitial pregnancy
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Background We aim to report a rare case of successful medical management in a live interstitial (cornual) pregnancy. Interstitial pregnancy accounts for 2–4% of ectopic pregnancies with mortality rates of 2–2.5%. The pregnancy develops in the interstitial portion of the fallopian tube with a thin layer of myometrium covering it. Unlike an ampullary ectopic pregnancy, interstitial portion of the fallopian tube with a thin layer of myometrium covering it. Unlike an ampullary ectopic pregnancy, interstitial pregnancy typically presents after 12 weeks of gestation and has higher tendency for significant haemorrhage. This is due to the abundant blood supply from both the uterine and ovarian vessels.

Case A 40-year-old, para-1 lady was referred to our Early Pregnancy Unit (EPAU) with abdominal pain and bleeding at 8 weeks of gestation. Ultrasound scan confirmed a live ectopic pregnancy. Her serum hCG was 14,007. The pregnancy was identified as being a ‘cornual ectopic’ at laparoscopy. Due to the risk of significant haemorrhage with surgical management, a decision was made to manage this pregnancy medically despite the high hCG level. The lady required two standard doses of methotrexate due to a suboptimal fall in hCG level and a persisting fetal heart on ultrasound scan. HCG levels started to fall only after the fetal heart had stopped on day-5, after second dose of methotrexate. She was followed up in EPAU. HCG levels dropped progressively eventually falling below 5, eight weeks after her first dose of methotrexate. Five months after methotrexate treatment, she presented with a viable intrauterine pregnancy along with a small residual sac (1.1 cm) from the previous interstitial pregnancy.

Discussion The diagnosis and treatment of an interstitial pregnancy is challenging. Traditional treatment options include cornual resection or hysterectomy. Early clinical diagnosis assisted by transvaginal scan and laparoscopy provide the option for conservative management. Ultrasound and laparoscopy guided potassium chloride or methotrexate into the interstitial pregnancy is an effective alternative to systemic medical therapy or surgery.

0132 Improving quality of ultrasound imaging in gynaecology: an evaluation of current practice at University Hospitals of Leicester
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Introduction Inconsistencies were noticed on ultrasound images and reports performed by medical and sonography staff in gynaecology at UHL. We aim to assess adherence to standards in UHL trust guidelines on scanning, assessment of adnexal masses and management of ectopic pregnancy. We aim to aid publication of new guidelines, encourage more consistent scanning among gynaecologists and sonographers and provide safer, more reliable diagnoses for patients.

Methods Ultrasound images and reports were assessed from scans requested by the gynaecology assessment unit (GAU), early pregnancy assessment unit (EPAU) and consultant direct (CD) clinic at UHL during one week in June 2015 (n = 143). Data were analysed using Microsoft Excel® software.

Results Images were correctly labelled with patient/scanner identification, orientation and mode of imaging in 80% of cases. Uterine assessment was deemed adequate and in correct planes in 73%. Regarding scans assessing intrauterine pregnancies, features of gestation sac/fetal pole/heart activity, where appropriate, were well documented, in >94%. Clinical evidence for retained products of conception where antero-posterior measurement of echoes was <20 mm was provided in only 25%. Ovaries were assessed adequately and in correct planes in 70%. No scans showing adnexal masses were documented well enough to allow application of international ovarian tumour analysis (IOTA)/risk of malignancy index (RMI) criteria. Only 40% of scans suggesting ectopic pregnancy were adequately detailed. Overall, images saved were adequate for future use in 85% of audited scans, but in 60% of cases suspicious of ectopic pregnancy.

Conclusion Teaching sessions are planned for sonographers and gynaecology trainees on ultrasound scanning and reporting, with particular attention to description of benign and malignant features of ovarian/adnexal masses. Posters displayed in scan rooms will serve as reminders for ideal reporting and application of IOTA/RMI criteria. A re-audit is planned for 2–3 years’ time.
0133
Survey of health professionals views’ on the impact of electronic patient records (EPR) use in maternity services
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Introduction Large number of maternity units are implementing EPR in NHS. We have used EPR at our unit since April 2014; its impact on maternity services has not been formally evaluated. The aim of this study was to survey the views of maternity healthcare staff on the impact of converting from paper to electronic records on work efficiency, access of information, patient care and training. We also wanted to identify strengths of EPR and potential areas for improvement.

Methods Electronic survey was run over two months with regular reminders. Participants included junior doctors, consultants and midwives. Questionnaire was developed after consultation with staff, and piloted. Comments were analysed and grouped into themes. Data was analysed using Microsoft Excel®.

Results We received 64 responses overall (73% response rate from doctors (n = 33/45) and 31 midwives). 67% staff felt that access to information for clinical care was more difficult. 33% felt that quality of records had deteriorated and 61% commented that they were less comprehensive. 80% suggested that EPR requires longer work on regular basis. 44% felt their interaction with patients had deteriorated due to more time working at computers and poor eye contact. 46% staff felt that missing information caused suboptimal care. 63% of trainees felt that quality of their training remained the same. 35% felt they only scribed rather than to learn and participate. 72% staff suggested that EPR training was inadequate.

Conclusion We noted many challenges locally including training of staff, inadequate number and maintenance of computers, delays in clinical work, difficulty in sharing information, problems with network and loss of information. Careful planning and evaluation should be done before implementing the system widely in maternity healthcare services, ideally in randomized trials.

0134
Trends of management of ectopic pregnancies and miscarriage in a large UK teaching hospital: cross-sectional observational study
Ijaz, S; Yang, P; Ewies, A
City Hospital, Birmingham, UK

Introduction Early pregnancy loss used to account for over 50,000 admissions annually in UK. Over the last two decades, there is a shift towards non-surgical management of miscarriage and ectopic pregnancy supported by various governing bodies including NICE. We present the trend of management over the past 5 years in a large teaching hospital with establishment of a modern 7-day ‘Emergency Gynaecology Assessment Unit’ since 2013.

Methods This retrospective study evaluates the management of miscarriage and ectopic pregnancy (including pregnancy of unknown location, PUL) in the first 6 months of year 2010, 2011, 2012 and 2014. The period of every evaluation was from 1st January till 30th June, avoiding bias due to seasonal variations. The data was collected from the ‘Emergency Gynaecology Assessment Unit’ and emergency theatre electronic databases of Sandwell and West Birmingham Hospitals NHS Trust, UK.

Results
- 2010: Miscarriage (n = 192), Ectopic (n = 67)
  - Miscarriage: Expectant 0, Medical 22 (11%), Surgical 170 (89%)
  - Ectopic: Expectant 0, Medical 0, Surgical 67 (100%)
- 2011: Miscarriage (n = 282), Ectopic (n = 63)
  - Miscarriage: Expectant 101 (36%), Medical: 61 (22%), Surgical 120 (43%)
  - Ectopic: Expectant 18 (29%), Medical 8 (13%), Surgical 37 (58%)
- 2012: Miscarriage (n = 293), Ectopic (n = 48)
  - Miscarriage: Expectant 174 (60%), Medical 30 (10%), Surgical 89 (30%)
  - Ectopic: Expectant 13 (27%), Medical 14 (29%), Surgical 21 (44%)
- 2014: Miscarriage (n = 316), Ectopic (n = 85)
  - Miscarriage: Expectant 208 (66%), Medical 70 (22%), Surgical 38 (12%)
  - Ectopic: Expectant 18 (21%), Medical 26 (25%), Surgical 43 (54%)

Conclusion The surgical management of miscarriage decreased by 77%, while the expectant management increased by 66% and the medical management doubled during the study period. Similarly, the surgical management of ectopic pregnancy decreased by 46%, while the expectant and medical management increased by 21% and 25%, respectively. The results indicate that implementing the modern guidelines by a dedicated unit with experienced staff increases patient safety, and reduces theatre utilisation and bed occupancy.

0135
Diagnosis and management of molar pregnancy with a negative pregnancy test
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Case A 42-year-old women presented with right-sided lower abdominal pain and fever. Her LMP was 11 weeks ago. However, 8 weeks ago she reported a miscarriage with one day history of moderate vaginal bleeding. A repeat pregnancy test 3 weeks later on was negative. She had five normal deliveries previously. She was admitted on a medical ward with suspected pyelonephritis. At assessment she was tachycardiac with temperature of 39 degrees. Her UPT was negative. She had guarding and tenderness in RIF with a 20 weeks sized mass palpable. Speculum examination showed a normal cervix. She subsequently had a TV USS which showed IU degenerative fibroid molar pregnancy with obstruction of right sided ureter and hydrenephrosis. Her Hb was 8 g/dL and her serum hCG was noted to be 730,082 IU/ml. She underwent surgical suction evacuation and about 2 L of molar tissue was removed with 4 units of blood transfusion. Histology confirmed complete molar pregnancy. A urine pregnancy test is commonly
used to detect pregnancy and is based on finding intact β-human chorionic gonadotrophin (hCG) molecules in the urine by an immunoassay system. However, the significantly large amount of β-hCG in molar pregnancy may paradoxically lead to a false-negative result due to a phenomenon known as the ‘high dose hook effect’; a rare phenomenon that occurs in sandwich immunoassays when the concentration of the antigen is sufficiently high to saturate both the solid migratory phase and fixed detection antibodies independently. As a result, the gold particle necessary for colour change is never bound, leading to a false-negative test. A 1:10 to 1:1000 dilution of the antigen sample may overcome the hook effect and give a reliable result.

0136
The outcome of induction of labour (IOL) in morbidly obese women
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Introduction Obesity is evidently a well-known risk factor that negatively influences the outcome in obstetric practice. The prevalence in the UK is reported to be in an increase, reaching 16–19% in the 2000s. In our study, we are looking at the outcome of IOL in morbidly obese women (BMI ≥ 40), and compare it to that of women with BMI <40. The aim is to produce realistic figures to improve risk-balance when making decision of IOL in this group of women.

Methods Simulating a retrospective cohort study, the data was collected from the Maternal Register Book at the Royal Stoke University Hospital using a pre-designed proforma and covering a full rear period. The yielded results were, then, compared to a matching data extracted from a previous audit conducted by the first two authors after exclusion of cases with BMI ≥ 40. The latter is a highly detailed project that looked into the various aspects of the IOL process over a full month period in the same year at the same unit.

Results In the 117 cases of morbidly-obese women, the CS rate in nulliparous women was 68%, while, in multiparous women, the rate was 21.5%. In comparison with the 124 cases of non-morbidly obese women, the rate in both nulliparous and multiparous women was precisely 2 folds. Assisted vaginal delivery is more than halved in nulliparous women with BMI ≥40, but has not changed in multiparous ones. Normal vaginal delivery was the likely outcome in multiparous women with BMI ≥40 with a rate of 77% which was not the case in nulliparous ones with only 23% of them delivering vaginally without assistance.

0137
Patients and hospital managers' perceptions of laparoscopic surgery and virtual-reality simulation training in healthcare and patient safety: a qualitative study
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Introduction Surgical procedures are complex and are susceptible to human error. Individual surgical skill is correlated with improved patient outcomes demonstrating that surgical proficiency is vitally important for patient safety. There is a wealth of evidence to demonstrate that simulation training improves laparoscopic surgical skills, however projects to implement and integrate laparoscopic simulation into core surgical curricula have had varied success. We aim to determine the knowledge and perceptions of patients and hospital managers on laparoscopic surgery and simulation training in patient safety and healthcare.

Methods A qualitative study was conducted in the Southwest of England. 40 semi-structured interviews were undertaken with patients attending general gynaecology clinics and general surgical and gynaecology hospital managers.

Results Six key themes identified included: positive expectations of laparoscopic surgery; perceptions of problems and financial implications of laparoscopic surgery; lack of awareness of difficulties with surgical training; desire for laparoscopic simulation training and competency testing for patient benefit; conflicting priorities of laparoscopic simulation in health care; drawbacks of surgical simulation training. Patients would have greater confidence in a surgeon who had undertaken mandatory surgical simulation training, and perceived purchasing simulation equipment as a high priority in the NHS. The majority of patients and hospital managers felt trainees should pass an examination on a simulator prior to live operating.

Conclusion Competency-based mandatory laparoscopic simulation was strongly supported by stakeholders to augment the initial learning curve of surgeons, and should be integrated into future surgical curricula to improve the quality of training. As improved surgical skill is correlated with improved patient outcomes, simulation training should be considered in future patient safety initiatives.

0138
Disseminated trophoblastic peritoneal implants after surgical treatment of ectopic pregnancy: an extremely rare case highly relevant to trainees. ‘Who could have correctly diagnosed it?’
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Background Trophoblastic peritoneal implants is an extremely rare complication after surgical treatment of tubal ectopic pregnancy. Only 23 cases were reported globally since 2001.
Case A 26-year-old woman with one vaginal delivery presented to EPAU with abdominal pain, mild spotting and amenorrhoea for six weeks. Her serum hCG was over 9,000 and her ultrasound showed a 3.5 cm mass adjacent to the left ovary and massive amount of free fluid in the pouch of Douglas (POD), highly suggestive of a ruptured ectopic pregnancy. A laparoscopy showed a haemoperitoneum of 1,000 ml and a ruptured left-sided tubal ectopic mass. A unilateral salpingectomy was performed with two units of blood transfusion. She had an uneventful recovery postoperatively and was discharged a few days later. She returned to A&E with abdominal pain six weeks later. Her serum hCG was 1,800. She had one episode of unprotected sex two weeks before and amenorrhoea since her operation. Her scan showed no intrauterine pregnancy but small amount of free fluid. A repeat laparoscopy showed no evidence of ectopic pregnancy but nodules on multiple sites including left tubal stump, right ovary, uterovesical fold, pelvic side wall and POD with less than 50 ml of free fluid. A decision was made for methotrexate postoperatively with repeat hCG monitoring. However, within 24 hours of her operation, her haemoglobin dropped to 60 g/L from 11.5 g/L and a high index of suspicion of ruptured abdominal pregnancy was made. A third laparoscopy showed a haemoperitoneum of over 2,000 ml and actively bleeding nodular masses from all the sites described including the omentum. A laparotomy was performed with surgical excision of tissue mass. Histology confirmed necrotising chorionic villi with normal trophoblastic lining. The postoperative course was uneventful with a negative hCG 14 days later.

Conclusion Persistent hCG after ectopic pregnancy may highlight the possibility of this disease entity.

0139
Antenatal clinics – moving forward
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Maternity services are used by over 700,000 women a year in the UK and the birth rate continues to rise at around 2% per year. Complexities during pregnancy and at birth are on the rise and so the need to provide a seamless antenatal care tailored to a woman and her family’s needs has never been greater before.

In Bournemouth we see over 4600 high risk pregnant woman in antenatal clinics per year and in order to provide a seamless and bespoke care to these woman we have set up patient centred, condition based clinics replacing the traditional consultant clinics. This is based on similar models in a number of other NHS trusts across the UK. Evidence suggests these clinics reduce the number of antenatal appointments, induction and caesarean section rates, increase patient satisfaction and more importantly reducing antenatal appointments, induction and caesarean section rates, increase patient satisfaction and more importantly reducing variation in care.

One example of our tailored clinics is the ‘weight management clinic’ aimed to meet the needs of obese women who, according to a large body of evidence, are at an increased risk of adverse maternal and fetal outcomes. This is a multidisciplinary clinic with specialist professionals namely obstetrician, anaesthetist, specialist midwife and dietician working in a team to provide holistic care to these women.

Setting ‘condition based clinics’ is a way forward in improving maternity outcomes by reducing variation and providing woman centred antenatal care.

0140
A District General Hospital experience of the management of hypothyroidism in pregnancy
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Introduction Undertreatment of hypothyroidism in pregnancy is related to early miscarriage and neurodevelopmental delay. It is important that treatment is sufficient particularly in the first trimester. National Institute for Health and Care Excellence Clinical Knowledge Summary’s (NICE CKS) recommend that thyroid stimulating hormone (TSH) and thyroxine (T4) are checked within all trimesters and that TSH is maintained between 0.4–2 mU/l with T4 in the upper reference range.

We aim to determine how well North Cumbria Hospitals (NCH) were managing patients with hypothyroidism in pregnancy in keeping with the guidance of NICE CKS.

Methods A retrospective study of a third of the patients (n = 29) with hypothyroidism in pregnancy that delivered between 01/01/2015 – 31/12/2015 at a NCH. Patients’ paper notes were used to determine whether thyroid function tests (TFTs) were taken at booking and serially throughout the trimesters.

Results
- 25 patients’ notes were available and eligible to be assessed. Of these patients:
  - 76% had TFTs checked every trimester
  - 100% had TFTs checked in trimester 2
  - 60% had TFTs checked at booking

40% had thyroxine dose increased upon diagnosis of pregnancy.

Conclusion Follow-up monitoring of TFTs in these patients was good but still below the expected level. TFTs and increasing the thyroxine dose at booking/pregnancy confirmation was done in under half of the patients looked at and requires the most improvement.

0142
Unilateral adrenal infarct in pregnancy: case presentation
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Background Adrenal infarction is a rare cause of flank pain. It is usually due to thrombosis of the main adrenal vein or secondary to microvascular thrombosis within the parenchyma of the adrenal gland. It has best been described in the setting of
antiphospholipid-antibody syndrome, in which case, it is usually bilateral.

Case The patient was a 24-year-old para 1 + 1 with a previous term vaginal delivery and an ectopic following this. All scans were normal and her pregnancy was uneventful until she presented to A&E at 33 + 6 weeks of gestation with a one day history of back pain and vomiting. She was started on IV antibiotics for possible pyelonephritis and kept in for symptomatic treatment. An abdominal USS was ordered. Two days into admission, the patient started to feel even more unwell and continued to have abdominal pain, back pain and vomiting. A venous blood gas showed metabolic acidosis with a pH of 7.30 and a base excess of -10.8. It was noted that despite aggressive fluid resuscitation (13 litres over 36 hours) she had a poor urinary output. An abdominal ultrasound showed gallstones but was otherwise normal. Collaboration with the surgical team resulted in CT chest, abdomen and pelvis being ordered. The imaging revealed a swollen right adrenal gland which was non-enhancing likely representing acute adrenal ischemia. It was decided to proceed with a caesarean section under general anaesthetic and a live infant was delivered in good condition with Apgars of 9 at 1 minute and 10 at 5 minutes. An MRI was ordered post-delivery which confirmed the diagnosis of an infarcted right adrenal gland. The patient was discharged 13 days post caesarean section with a therapeutic INR of 2.1 on warfarin which was started on the advice of the endocrinologists.

0144
Management of moderate to severe renal disease in pregnancy
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About 1 in 1000 pregnancies are affected by moderate to severe chronic renal disease. This can result from a range of renal pathology, which may well be revealed for the first time in pregnancy through inability of the renal system to adapt to physiological changes in pregnancy. For example, a patient may present with haematuria and hypertension in early pregnancy in IgA nephropathy. Gold standard management depends on a multi-disciplinary approach early in the pregnancy, ideally with opportunities for pre-pregnancy counselling if the renal disease is previously known. Discussion with the team and the patient regarding termination of pregnancy may be appropriate as the degree of renal impairment and hypertension appears to be a major determinant for pregnancy outcome and post-partum renal function. Throughout pregnancy monitoring of proteinuria and renal function is essential. Proteinuria in early pregnancy increases risk of renal deterioration. Close management of hypertension is vital along with consideration of the development of superimposed pre-eclampsia, as worsening hypertension is poor prognostic factor. Monitoring of and treatment of associated anaemia and thromboprophylaxis should also be considered. The decision to commence haemodialysis is similar to non-pregnant patients, although it may be started earlier in pregnancy due to concerns regarding fetal growth. It has been suggested that haemodialysis may reduce risks of preterm labour and preterm delivery. After delivery the patient should have follow-up with the renal team and depending on severity may continue with dialysis and management of hypertension.

0145
Practical clinical interpretation of intrapartum fetal monitoring in relation to fetal cord compression – application of the concept in modern obstetrics
Shahin, M
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Introduction Fetal cord compression with cord around the body is one of the commonest causes of intrapartum CTG patterns. There is lack of clear understanding of the application of different cord compression patterns in context of managing pregnant women in labour and minimising the risk of fetal intrapartum hypoxia. This usually results in either excessive interventions as fetal blood sampling (FBS) or operative delivery and caesarean sections or alternatively inappropriate lack of adequate actions.

Methods In the current study 100 cases of fetal cord compressions were carefully evaluated to demonstrate different cord compression patterns and to indicate the relative abundance of cord compression as a cause of abnormal fetal monitoring in labour. The study was a prospective data collection, followed by retrospective expert analysis of the CTG patterns in relation to the management and fetal outcome.

Conclusion A better understanding to the interpretation of fetal monitoring in labour is needed to ensure safe maternal and neonatal outcome.

0147
A puzzling abdominal lesion: a case of recurrent renal-hepatic-pancreatic dysplasia
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Background Renal-hepatic-pancreatic dysplasia is a rare sporadic or autosomal recessive disorder. It is a ciliopathy characterised by pancreatic fibrosis, renal dysplasia and hepatic dysgenesis, described by Ivemark in 1959. An association has been found with the NPHP3 gene on chromosome 3q22. The molecular pathogenesis remains unknown. Renal dysplasia is almost universal and becomes apparent at 16 weeks of gestation, progressing thereafter. Phenotypically other abnormalities are varied. The syndrome is usually fatal in utero or in the perinatal period. Those who survive suffer renal insufficiency, chronic jaundice and insulin-dependent diabetes mellitus.

Case We present a case of a 42-year-old lady with multiple first trimester miscarriages. She had an 18 week miscarriage, prior to anomaly scanning. Perinatal autopsy revealed multiple abnormalities including heterotaxy, congenital heart disease,
multicystic kidneys and asplenia, suggesting Ivemark syndrome. A low recurrence risk was given, given its typically sporadic nature. This pregnancy, an 18 week scan revealed an irregularly shaped cystic mass, extending from the cord insertion to the midpelvis. Both kidneys appeared prominent but not dilated and fetal anatomy otherwise appeared normal. Anhydramnios developed and the cystic structure became tenser. Despite an atypical appearance, it was thought it represented a lower urinary tract obstruction. Recurrence of Ivemark syndrome was thought unlikely. Given the risk of pulmonary hypoplasia with continuing anhydramnios, the parents were counselled about a possible poor outcome. They opted to continue the pregnancy and avoid invasive testing. She had a vaginal breech delivery at 35 weeks of gestation with a baby born in poor condition. Resuscitation attempts were unsuccessful. Postmortem examination demonstrated that the lesion was a large pancreatic cyst and showed multiple other dysmorphic features, situs inversus, cystic renal dysplasia and hepatomegaly. Review of previous pathological specimens showed similar findings and suggested a diagnosis of Renal-hepatic-pancreatic dysplasia in both cases. Genetic testing for NPHP3 is pending.

0148
Reconstruction of the thin lower uterine segment and scar dehiscence during caesarean section – A new concept and a novel technique
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Introduction Lower uterine scar dehiscence is not an uncommon finding during repeat caesarean section (CS). There is a tendency by obstetric surgeons to avoid this thinned-out lower uterine segment scar, to avoid extensive tears to the bladder and to the lower uterine segment. This reflects general lack of understanding of the pathophysiological and anatomical process of scar dehiscence. Inadequate reconstruction of the lower uterine segment could be possibly theoretically related to the weakening of caesarean section scar in those women, with potential risk of further dehiscence, rupture or scar ectopic.

Methods This work is presenting a case series and surgical description of the technique, with adequate details of the steps of effective reconstruction of the lower uterine segment. In this work the anatomical changes in the lower uterine segment in women with previous CS is described and a detailed surgical technique of reconstructing the lower uterine segment in such cases is demonstrated.

Conclusion There is a need of more awareness, education and training in managing such abnormal finding during repeat CS to facilitate better healing and stronger scar with less long term complications.

0149
Myoclonus in pregnancy – management dilemmas
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Background Myoclonus refers to sudden, involuntary jerking of a muscle or group of muscles, occurring sporadically or recurrently. It typically describes a symptom and is not a diagnosis, in response to infection, head or spinal cord injury, stroke, brain tumours, hypoxia, organ failure, drug poisoning, or other disorders. Myoclonus can occur by itself, but most often it is associated with neurological conditions like multiple sclerosis, Parkinson’s, Alzheimer’s or Creutzfeldt-Jakob disease. Antenatal myoclonus presents a challenge for management.

Case We present a rare case of antenatal myoclonus with no apparent underlying cause. Twenty-five-year old women with previous obstetric history of 4 deliveries and no significant past medical history presented at 34 weeks of gestation with non-specific abdominal pain and severe toothache. Shortly after admission she developed refractory myoclonic jerks. She was empirically started on magnesium sulphate due to borderline blood pressure and suspected pre-eclampsia. Broad spectrum antibiotics were also commenced to treat potential underlying infection. Despite these treatments myoclonic jerks persisted. Clonazepam was added in view of possible new onset intractable myoclonic epilepsy but proved ineffective. All investigations including FBC, CRP, LFT’S, U+E, lumbar puncture, toxicology screen, magnetic resonance imaging (MRI) of the head were negative. Blood culture initially identified gram positive cocci but this was thought to be secondary to contamination. Patient was admitted to intensive care for mechanical ventilation. In view of intractable, unexplained myoclonus and suboptimal CTG, she underwent uneventful grade 2 emergency caesarean section. Multidisciplinary team including obstetrician, anaesthetist, neurologist, physician and maxillofacial surgeon were all involved in her care. The woman made a good recovery and remained myoclonus free postnatally.

Conclusion Our case highlights the need for effective multidisciplinary care in this complex and difficult case where diagnosis despite best efforts could not be made but safe management and rational decision making led to a positive clinical outcome.

0151
The care of women with BMI>40 in a large teaching hospital: an audit of practice against national guidelines
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Introduction Obesity is a growing problem in the UK, and a condition seen often in women presenting for antenatal care in Bradford. It is expected that 50% of women in the UK will be obese by 2050, and we need to be able to adapt to this change as these women pose a high risk to obstetric units. It is known that obesity in
pregnancy is associated with an increase in poor outcome, including miscarriage, stillbirth and neonatal death, as well as thromboembolic events, gestational diabetes, dysfunctional labour and PPH. It may also be a factor in maternal death. There is a guideline set out by the RCOG and CMACE for management of obese women in pregnancy, and we audited our practice against this.

**Methods** We identified all women who had delivered in Bradford between 1st July 2014 and 30th June 2015 by generating a database from the online system used for antenatal notes in the hospital, Medway. We were then able to filter these to show all women with a BMI >40 and analyse data on aspects of care set out in the guideline. We also reviewed the online results system for scan frequency.

**Conclusion** We offer every woman a GTT, and 85% of women had additional scans. However there is still scope for improvement in areas such as offering folic acid, perhaps involving primary care and ensuring documenting when an anaesthetic referral is sent. We have developed a prompt sheet for junior to use in clinic to remind them of all risks to cover when seeing women in clinic.

**0154 Consent – Who? When? Where?**

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**Introduction** The GMC provides guidance for consent in their publication *Consent: patients and doctors making decisions together*. It advises us that the patients should be given adequate time and information to make an informed decision. This accompanies the Clinical Governance Advice from RCOG on Obtaining Valid Consent. Within our department a teaching session was delivered on the process of consent taking. Our ideal is that consent is obtained prior to surgery. Junior trainees subsequently complete mini-cex assessments in taking consent under supervision.

**Methods** We retrospectively reviewed the consent forms for the elective gynaecology cases undertaken in a one month period. Areas examined included the procedural detail documented on the consent form, when the consent was taken, in which clinical environment it was obtained and the level of the doctor taking the consent. During the study period there were 11 Day Surgery Lists and 10 Major Inpatients Lists. Of the 61 cases performed, 50 sets of cases notes were available for review.

**Results** All consent forms were fully completed with the patient identifiers and had an appropriate level of detail describing the procedure, benefit and risks. Of the fifty cases, 21 were consented by senior doctors (consultant/registrar). However, 18 of these were day procedures whilst 3 where from the major inpatients lists. Our aim to take consent from the patients in the outpatient clinic only occurred in 15% of the cases. On reviewing ‘when’ the cases were consented it became apparent that the majority (70%) were consented on the day of surgery.

**Conclusion** We are actively encouraging all of the team to take consent in advance in the outpatient clinic where possible. Consent will be confirmed on the day by the senior members of the theatre team. The loop will be closed in the coming months.

**0155 Nodular Hyperplasia of Bartholin’s Gland in a young woman: now presenting bilaterally**

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**Background** Tumours in the Bartholin’s gland are rare. The most common pathology is Bartholinitis and duct cysts. Many solid masses are carcinomas, with other causes being nodular hyperplasia and adenoma. Nodular hyperplasia is a rare benign tumour. Histologically it shows proliferation of mucinous acini maintaining the duct-acini relationship and there is no evidence of encapsulation which would be indicative of adenoma. Hyperplasia may be induced by inflammatory or an infectious process due to chronic cellular lesion or by surgical intervention and local trauma causing glandular proliferation. The main symptoms are vulvar swelling, local discomfort, local pain and dyspareunia. Lesions are more common in postmenopausal women. The initial management is incision with drainage and biopsy to ensure malignant lesions are not missed. While nodular hyperplasia is benign, excision is indicated if the patient’s quality of life is affected.

**Case** This is a 28-year-old who has a background of endometriosis. She was referred four years ago when she was complaining of a vulval lump. This was treated as a right labial cyst and removed under anaesthesia. Two years ago she presented again with a left sided vulval swelling, which was found to be a Bartholin’s cyst and this was marsupialised. She later presented with the same left Bartholin’s mass which was excised in January 2016. Histology showed nodular hyperplasia. She was reviewed in clinic after having an emergency marsupialisation of a right sided Bartholin’s mass in May 2016. There was a deeper calcified portion of the gland which could not be removed. She has been treated with flucloxacillin and we suspect that it is also due to nodular hyperplasia, surgical intervention may be offered in the future. On review of the literature it is noted bilateral nodular hyperplasia is rare and particularly in such a young woman.

**0156 An unusual case of a large pelvic mass and metastases**

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**Background** Actinomycosis is an uncommon chronic infectious granulomatous disease, which can mimic malignancy, tuberculosis and other abdominopelvic inflammatory diseases. The disease is characterised by the formation of multiple abscesses, draining sinuses, abundant granulation tissue and dense fibrous tissue. The
most common pathogen associated with it is Actinomyces israelli. It is classified into orocervicofacial (50%), thoracic (15–20%) and abdominopelvic (20%) forms. Actinomycosis is treated with intravenous penicillin for 6–12 months as per case series. Cure has been reported with treatment from 3 weeks to 4 years. Diagnosis can be challenging as it has been reported that the organism has not been isolated in 42% of cases or not detected in culture in up to 76% of cases. Mortality ranges from 0% to 28% depending on site of infection, time to diagnosis and initiation of treatment.

**Case** A 45-year-old woman presented with abdominal distension, anorexia and weight loss, CA-125 was 22 and a CT scan showed a left adnexal complex mass with muscle involvement, widespread lymphadenopathy and left hydronephrosis. An ultrasound guided biopsy showed fibrous tissue, mixed inflammation and granulation tissue. Over the preceding months her C-reaction protein level was elevated, highest at 359 and her haemoglobin low, requiring transfusion. Her copper coil was removed and sent for culture and she was started on IV antibiotics. Following a week of intravenous antibiotics a CT scan was repeated showing a reduction in size of the pelvic mass and omental deposits. As she was still symptomatic pelvic tuberculosis needed to be considered as a differential, hence she had a chest X-ray and she may require an additional biopsy. Her history of an intrauterine device, intravenous drug use and concomitant bacterial vaginosis make her high risk for actinomycosis and her symptoms and investigations are consistent with cases reported in the literature.

**0157**
**Unusual presentation of Adenosarcoma**

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**Background** Adenosarcoma is a rare but uncommon form of cancer that arises from mesenchymal tissue of the uterus and has a benign glandular component. We present to you a case of unusual presentation of Adenosarcoma.

**Case** Mrs X, 72-years-old presented with mass per vaginum for one week. At initial assessment a differential diagnosis of polycrincenta or cervical growth was considered. On further assessment it was found to be a globular polypoidal mass 8 x 5 cm protruding from the cervix but not involving the cervix. The initial biopsy was inconclusive. The patient had further hysteroscopic examination, which revealed the necrotising friable polypoidal mass arising from fundus and extending up to introitus. A repeat biopsy was performed and that revealed high grade uterine sarcoma. The patient was then referred to a tertiary unit for further management. She underwent total abdominal hysterectomy and bilateral salpingo oophorectomy with pelvic lymph node dissection and adjuvant brachytherapy for uterine sarcoma stage 1.

**Conclusion** Uterine sarcomas are highly malignant tumours of the uterus that originate from mesenchymal tissues, including uterine smooth muscle, endometrial stroma, and supporting tissue. These tumours are relatively rare, accounting for about 3% of all uterine malignancies. They are heterogeneous, consisting of several histologic types. Clinical presentation patterns of uterine sarcomas differ for the histologic subtypes, such as enlarged uterus size or abdominal pain or abnormal uterine bleeding in pre or postmenopausal women. Complete surgical excision is the only curative treatment modality currently known.

**0158**
**The use of MyoSure® device in ambulatory gynaecology clinic**

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**Introduction** Operative hysteroscopic procedures are more commonly performed in ambulatory gynaecology clinics. The MyoSure® system provides a solution for intrauterine tissue removal, including fibroids and polyps. We have assessed its clinical applications in a district hospital. We aim to assess the safety and effectiveness of MyoSure® procedure in outpatient setting.

**Methods** All women undergoing treatment of polyps and fibroids with the MyoSure® device between May 2013 and May 2015 in the ambulatory gynaecology clinic at Heart of England Hospital were included into the study.

**Results** 130 patients with mean age of 57.3 were treated using MyoSure® by 6 different consultant gynaecologists. 93.8% of women had resection of endometrial polyps, while 6.1% of leiomyomas. 52% (68/130) women presented with postmenopausal bleeding, 20.7% (27/130) with menorrhagia, and 13% (17/130) of women presented with intermenstrual bleeding. 6.1% (8/130) with incidental findings of endometrial polyp, in 7.7% (10/130) symptoms were not clearly specified. Incomplete resection of polyps was reported in only 0.8% of procedures, while 23% of removals of leiomyomas were incomplete. 2.3% of procedures were abandoned due to poor views. Only 2 women required hospital admission due to ongoing bleeding, one resulting in emergency TAH. 87.7% of women were found to have reassuring histology report, 4.5% were diagnosed with hyperplasia without atypia. While 7.7% of women required further procedures based on abnormal histology report.

**Conclusion** The MyoSure® can be successfully used in outpatient setting, especially in patients diagnosed with endometrial polyps. Serious complication, even rare, may occur and appropriate patient counselling must take place prior to procedure. Complete resection of intrauterine pathology have been reported in vast majority of women with endometrial polyps, while high number of leiomyomas required repeat procedure. Final clinical outcome, assessing women’s perception on symptoms improvement post procedure is sought.
0161
A confidential enquiry into maternal deaths in Zomba district, Malawi – using CEMACH style of enquiry to identify failings in peripartum care in the developing world

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Background Malawi has among the highest rates of maternal death in the world. As an O&G specialty trainee, I undertook a 6 month placement in Zomba, Malawi. During this time I was struck by the frequency of maternal deaths and the manner in which they occurred. Using a style of inquiry based on the CEMACH/MBRRACE reports, I investigated exactly how many deaths were occurring in this centre, why they were happening, and what could be done to improve the situation.

Cases 17 deaths were recorded in the period of tenure at Zomba Central Hospital (ZCH). 15 of these were direct deaths, and 2 were indirect, giving an overall maternal mortality ratio of 634/100,000 live births. The most common cause of direct death was postpartum haemorrhage (PPH). Cases include grossly prolonged 1st, 2nd and 3rd stages, obstructed labour, and uterine rupture (in this case series, in unscarred uterus). Malaria was the single cause of indirect death.

Conclusion The cases in this series reveal a shocking level of substandard care. For example, a vacuum extraction was attempted on a secondary arrest of labour at 7 cm, with face presentation, resulting in massive PPH. Often, a delay in definitive management meant that patients would present in extremis, for example with necrotic uterus and coagulopathy. In some cases, diuretics were used to treat severe oliguria in sepsis and PPH cases, resulting in cardiac arrest soon thereafter.

From examining these cases, it was apparent that failings were primarily due to deficiencies in training. During my tenure, I provided a system of targeted training based on these elements of care via lectures, seminars and bedside teaching. The sessions were well received and an improvement in practice was observed during my tenure. However, a sustained and significant improvement in the field of obstetric care in this region remains a huge challenge.

0162
Deliberations upon Long QT syndrome in pregnancy. A case report and review of the literature

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Background Cardiac disease is one of the leading causes of maternal mortality in the United Kingdom. It complicates 0.2–4% of all pregnancies in the western world. Long QT syndrome (LQTS) is a rare cardiac rhythm disorder with a prevalence of 1:1100 to 3000. The disorder is associated with prolongation of the QT interval on electrocardiogram, with the potential to develop cardiac arrhythmias such as torsades de pointes or ventricular tachycardia leading to syncope, cardiac arrests and sudden death.

Case We present the case of a 23-year-old Caucasian female presenting in her 4th pregnancy. The patient was discovered to have long QT syndrome at the age of 18 when she presented ten weeks postpartum after her first pregnancy with cardiac arrest following a dose of erythromycin which caused her to develop torsade de pointes.

Conclusion There is currently no consensus on various obstetric interventions such as external cephalic version and the management of postpartum haemorrhage in obstetric patients with LQTS. In this case, the patient successfully underwent elective caesarean section for breech presentation following failed External Cephalic Version and postpartum haemorrhage was successfully managed with oxytocin infusion without any cardiac complications. As part of this report, we review the literature on LQTS and provide a summary of the implications of LQTS for obstetric patients in order to aid clinicians in the management of such patients.

0165
A retrospective study of patients undergoing Uterine Artery Embolisation at Leeds Teaching Hospitals between 2012 and 2014, including short, medium and long term complications

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Introduction Uterine Artery Ablation was first reported for the treatment of symptomatic uterine fibroids in 1991. At that time 60% of all women referred to gynaecology for, what is now termed, Dysfunctional Uterine Bleeding underwent hysterectomy. The literature has established the safety of UAE, which significantly reduced morbidity and mortality over open hysterectomy, however, large sample, long-term, follow-up data has yet to be published.

Methods The Radiology Department at Leeds Teaching Hospitals have kept a database of all patients who underwent UAE. The data sampled was from three calendar years, 2012, 2013 and 2014. 81 of these patients were from the Leeds CCG area and were followed-up within the trust.

Results Of the 81 cases, 52 women (67%) underwent UAE for heavy, or painful periods. In the three year period audited 61 women (76%) were seen by gynaecology post UAE. 20 women were seen on a ‘non-scheduled’ basis. At the time of data collection, 33 of the 81 women (41%) had additional treatments, were pregnant, or under the care of reproductive medicine.

Conclusion The joint RCOG document suggests that 30% of women will require additional intervention in the five years after UAE, rates at Leeds broadly mirror this. There was a high rate of technical success, with only a single procedure abandoned. The majority of women (58%) sought further advice or intervention
for symptoms associated with fibroids after UAE. To date 15% of women who underwent UAE had a hysterectomy. Hysterectomy: 12, Repeat UAE: 5, Mirena®: 2, Esmya®: 2, Hysteroscopic Resection: 1, Hysteroscopy: 1, Endometrial Ablation: 1, Planned Myomectomy: 1. Additional data has been collected on presentation, symptomology, fibroid size and location to identify the fibroid variants which best respond to UAE therapy, with, or without, adjuvant therapies such as GnRH analogues or Ulipristal Acetate.

0166
Audit of antenatal and postnatal mental health
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Introduction Depressive illness is the most common major complication of pregnancy followed by hypertensive and postpartum haemorrhage. Half of all maternal depressions start in pregnancy. Standards for care of women with mental health problems set in NICE and Trust Guidelines were used to check compliance with regards to documentation enable detection, treat, support women with mental health problems, to prevent exacerbation.

Methods 30 cases of mental health disease in pregnancy identified and retrospective collection of data on standardised data collection form performed, data analysed against standards.

Results Communication between maternity services/GP/MH Team can be improved. Mental health questions need to be asked at each antenatal visit and postnatal visit and needs to be documented in the hand held notes. Very patchy care for women depending on the region and only patients with significant mental health had access to psychiatrist/prenatal mental health team/community psychiatry nurse.

0170
Human factors – Do we all speak the same language?
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Introduction Human factors ensure safe working environment is created for best patient care in various situations experienced in clinic practice. Aim of this study is to analyse variations in perception of human factors between a developed (UK) and developing countries (DC); namely Pakistan and Indonesia. This will set the cornerstones in developing educational programmes using the British model in those countries.

Methods Total of 33 British and 40 doctors from DC took part in the survey.

Results 85% of British and 40% of doctors from DC were junior trainees in first two years of training.

Majority of UK doctors had a multifactorial approach to definition of human factors, while doctors from DC had a single outlook which was ‘environmental, organisational and individual factors which influence behaviour at work’. For most of the UK trainees, combination of skills was necessary for achieving safety in theatre, while two thirds of their peers deemed ‘technical skills’ as most important. A high proportion of UK trainees disagreed that blood-loss-estimation in an emergency was improved by increasing seniority. A similar proportion of doctors from DC thought the opposite. Almost all UK doctors disagreed with total obedience to their seniors compared with 70% of their counterparts. All doctors across countries agreed that non-technical skills training should be offered and assessed during their training.

Conclusion This study shows that language of doctors from UK and DC is different when talking about human factors. The perception British trainees in perception of human factors is more diversified and open while the DC trainees tend to have a more rigid and hierarchical approach. What would be interesting to know is if other factors such as gender and age effect the results, which will be included in the next stage of our project from around the world.

0171
Consultants as victims of bullying and undermining: a survey of Royal College of Obstetricians and Gynaecologists consultant experiences (published BMJ Open June 2016)
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Introduction We aim to explore incidents of bullying and undermining among obstetricians and gynaecology (O&G) consultants in the UK, to add another dimension to previous research and assist in providing a more holistic understanding of the problem in medicine.

Methods Design: Questionnaire survey. Setting: Royal College of Obstetricians and Gynaecologists (RCOG). Participants: O&G consultant members/fellows of the RCOG working in the UK. Main outcome measures: Measures included a typology of 4 bullying and undermining consequences from major to coping.

Results There was a 28% (664) response rate of whom 44% (229) responded that they had been persistently bullied or undermined. Victims responded that bullying and undermining is carried out by those senior or at least close in the hierarchy. Of the 278 consultants who answered the question on ‘frequency of occurrence’, 50% stated that bullying and undermining occurs on half, or more, of all encounters with perpetrators and two-thirds reported that it had lasted more than 3 years. The reported impact on professional and personal life spans a wide spectrum from suicidal ideation, depression and sleep disturbance, and a loss of confidence. Over half reported problems that could compromise patient care. When victims were asked if the problem...
was being addressed, 73% of those that responded stated that it was not.

**Conclusion** Significant numbers of consultants in O&G in the UK are victims of bullying and undermining behaviour that puts their own health and patient care at risk. New interventions to tackle the problem, rather than its consequences, are required urgently, together with greater commitment to supporting such interventions.

**0172**
A rare cause of hyperandrogenism in a post-menopausal woman

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**Case** We present the case of a post-menopausal women that presented with virilising symptoms. Biochemistry confirmed high testosterone levels, with otherwise normal bloods. A dexamethasone suppression test and urinary steroid profile was performed but no adrenal cause for her symptoms could be identified. Upon further investigation, a left adnexal soft tissue mass was identified on a CT scan and, following a bilateral oophorectomy, a Leydig cell tumour was diagnosed. Removal of this rare tumour led to a reduction of her symptoms and a dramatic improvement in her quality of life.

Pure Leydig cell tumours belong to a subgroup of rare ovarian sex cord-stromal tumours, known as steroid tumours which typically secrete androgens. Diagnosis is exclusively made by histology.

**0173**
Obstetrics and gynaecology in Ealing Hospital: a survival guide

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**Introduction** Departmental inductions are essential in allowing new doctors to function effectively within their roles when starting work in a new specialty or department. Unfortunately inductions are often of poor quality. There is frequently an emphasis on general administrative tasks but limited time is spent detailing everyday duties including how to manage common presentations and the role of the junior doctor in their new team. Many aspects of obstetrics & gynaecology are entirely unique to the specialty and consequently it can be an extremely daunting new position to start. Inadequate preparation for a new role can negatively impact patient care, potentially putting patient safety at risk.

**Methods** This project was conducted in the O&G department in Ealing Hospital between October 2014 and May 2015 by a group of junior doctors on placement in the department with supervision and input from a senior registrar and consultant. The aim of our project was to provide new doctors joining the O&G department with a concise, user-friendly guide to surviving in their new role as the ’O&G SHO.’ All clinical information provided in the booklet was based on up to date NICE and RCOG guidelines for best practice as well as trust policies.

**Results** The induction booklet was well received by trainees resulting in increased confidence in dealing with common obstetric and gynaecology problems and ensuring that management plans were comprehensive and devised in line with best practice guidelines. All trainees felt that the booklet should be implemented as part of the O&G departmental induction. Subsequently this should be reflected in improvements in standards of patient care and safety.

**0175**
Colposcopy patient satisfaction survey at Northwick Park Hospital 2016

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**Introduction** This is a review of an annual patient satisfaction survey which is carried out in Northwick Park Hospital. The questionnaire was designed by the Clinical Effectiveness Unit at Barts and the London. It is a retrospective audit surveying all patients who had a colposcopy examination over a three month period. It was completed after the examination and handed in anonymously. There were 251 responses in this cycle.

**Methods** The survey included 34 questions which profiled various aspects of service provision: information prior to the appointment, waiting times, the clinic environment, the patient experience of the procedure, post procedural care and patient demographics.

**Results** The results indicated a very positive patient experience in general in the colposcopy department and also provides an interesting look on the demographics of the attendees in a busy District General Hospital in Harrow. The patient feedback has provided various initiatives for service improvement for the department and once these are implemented the survey will be reaudited to ensure continuing service improvement.

**0177**
The effect of hysteroscopic metroplasty on reproductive outcome in women with recurrent first trimester miscarriages: a retrospective study

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**Introduction** We aim to establish whether hysteroscopic metroplasty improves the reproductive outcome of women suffering recurrent first trimester miscarriages, as well as assessing the safety profile of corrective surgery. A uterine septum is the most common congenital Müllerian uterine abnormality, with a
Oral and Poster Presentations

0178 Effect of chronic exposure of losartan in mouse prenatal alcohol exposure (PAE) model

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Introduction Fetal alcohol syndrome (FAS) is a condition that currently affects 1% of babies born in Europe and North America. It is characterised by memory impairment, developmental delay and distinctive facial features. This research uses a mouse prenatal alcohol exposure (PAE) model to explore the effects of PAE on learning, memory and to explore the potentially beneficial effects of common drugs previously shown to have cognitive enhancing effects in both humans and animals.

Methods 60 mice (M = 30 F = 30) C57 breeding harem of mice, were exposed to 5% ethanol throughout pregnancy. After weaning the offspring received losartan (10 mg/kg) via their drinking water for eight weeks. At three months of age, learning and memory was assessed using the novel object recognition paradigm.

Results The results indicate that PAE caused a significant decrease in offspring bodyweight. Treatment with losartan caused no growth impairment or renal damage. Novel object recognition indicated that PAE caused male offspring to spend significantly less time exploring the novel object than controls and that treatment with losartan had the effect of improving awareness of the novel object both in the control and alcohol group; in addition to decreasing anxiety (P ≤ 0.05). A significant opposite effect was noticed in the female alcohol progeny when compared to the male alcohol progeny (P ≤ 0.05). Losartan in female alcohol progeny had no effect on anxiety. Overall, male control losartan spent more time exploring the novel object than male alcohol losartan (P ≤ 0.05).

Conclusion The results suggest that losartan had no deleterious effects on the development of the animals, and was able to improve learning and memory in control animals without effect in PAE mice.

0180 Placental site nodules – a benign or premalignant lesion?

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Background First noted in the literature in the 1970s, intermediate trophoblastic lesions are a relatively recent discovery in gynaecological pathology. Our understanding of their development and progression is limited when compared with other gestational trophoblastic disease (GTD) such as hydatidiform mole and choriocarcinoma. Placental site nodules (PSNs) are benign tumour-like trophoblastic lesions, with a possible association with a malignant counterpart, epithelioid trophoblastic tumours (ETTs).

Case We present a case of a 33-year-old woman presenting with a seven month history of irregular periods following a recent pregnancy resulting in a spontaneous vaginal delivery and manual removal of placenta. On transvaginal scan, a 9 mm x 5 mm x 4 mm hyperechoic mass in the endometrial cavity was noted and queried to be retained products of conception or an endometrial polyp. At hysteroscopy, a 2 mm tan-coloured nodular lesion in the right ostia was removed with polyp forceps. The cavity appeared otherwise normal. Histology confirmed a PSN with no atypical features.

Conclusion This case of a rare condition with a limited evidence base in a young patient illustrates a clinical challenge when counselling patients on management options. Histological classification of atypical features of PSNs is subjective with no strict criteria established. Evidence from a small case series indicate that 10 to 15% of cases of atypical placental site nodules are associated with malignant gestational trophoblastic disease. In addition, several cases of coexistent typical PSN and ETT are documented, which indicates the possibility of typical PSN progressing to malignancy. Whilst some research groups advise no further treatment or follow-up as the lesion is usually removed in its entirety at diagnosis, hysterectomy may still be offered to patients who have completed their families. This patient had yet to complete her family and therefore declined hysterectomy, and is being monitored with ultrasound scan surveillance.
0181
The impact of SUIs on O&G trainees: a national survey of ‘second victims’ and an innovative educational package of support for trainees
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Introduction The ‘second victim’ phenomenon refers to healthcare professionals experiencing emotional distress following an adverse incident. Existing research identifies significant negative consequences on wellbeing and patient safety. However, there is no published evidence in O&G.

We aim to describe the psychological impact of a serious untoward incident (SUI) on trainee wellbeing, understand trainee perceptions of the consequences on future career, create a novel package of ‘SUI Survival’ educational support.

Methods An online anonymised survey of ST1–7 trainees in the UK.

Results There were 227 replies, representing approximately 12.3% of trainees nationally.

52% (n = 117) had been involved in an SUI at some point in their training with the peak incidence between ST3–5 (64%). Nearly 40% had been involved with 2 or more SUIs. 37% had felt undermined or blamed during the process, with the 90% stating this came from internal sources in particular the risk management team. 44% of trainees had become more defensive in their practice and 40% had thought about the speciality as a result of the SUI and investigation. Typical emotions felt were upset, unable to sleep, low mood and overwhelmed. A significant proportion (21%) stated that they continue to be affected present day. 40% of all trainees who completed the survey were concerned that an SUI involvement will severely affect their reputation and career progress in 27%.

Conclusion This survey demonstrates deficiencies in our pastoral support of trainees involved in SUIs, which have detrimental and lasting effects on their wellbeing and practice. We are developing innovative educational modules, which aim to develop the non-clinical skills of trainees:

- Coping strategies during adverse clinical incidents
- Effective working within a multi-professional team
- Building resilience

To prepare for such events with the ultimate aim of reducing psychological harm, undermining and attrition amongst our trainees.

0182
Service evaluation audit of return appointments at Menopause Service, Birmingham Women’s Hospital
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Introduction We aim to complete a service evaluation audit to identify if patients are being appropriately followed up at menopause service to prevent wasted appointment slots, long waiting times, denying access to patients in more need and reduce waste of tertiary resources for what could be managed in primary care with guidance. Birmingham Women’s Hospital is a regional centre for menopause services and leads in the provision of expert advice and management of women in the menopause.

Standards: Set according to Birmingham Women’s Hospital Menopause Service Clinical Guidelines.

Criteria for referral: Multiple treatment failure, history of risk factors for HRT and or patient/GP preference.

Criteria for follow-up: Either medication indicated or those with implants or needing active monitoring. Patients starting new menopausal preparation should have been followed up after 4 months, patients on established medication but requiring dose adjustments should have been followed up after 6 months and patients requiring active monitoring as dictated by clinical need.

Criteria for discharge: Patients stabilised on management plan and need no active monitoring and patient declines intervention with the aim to achieve discharge within 2 appointments.

Methods and results 100 patient notes audited from all menopause clinics from December 2015 – January 2016 inclusive. Data gathered on: initial reason for referral, reason for subsequent follow-up, subsequent follow-up frequency, discharge information and clinician primarily seeing patient. Only 10 patients were discharged within 2 appointments, 4 inappropriate referrals. 27 patients had inappropriate follow-up frequency. 39 potential saved appointments.

Conclusion Is there scope for GPs to do medication stabilisation as this is something that accounted for most of our follow-up cases and should there also be more specific rules on follow-up frequency as patient are being followed by as dictated by clinician need.

0183
Adenomyosis in the hysterectomised post-endometrial ablation uteri
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Introduction Presentation of adenomyosis correlates poorly with its presence. Historically diagnosis was histological, but the accuracy of transvaginal and MRI imaging has been well described. MRI offers less error due to confounders that co-exist in up to half of all cases.

Methods A retrospective study was designed to determine the proportion of women with undiagnosed adenomyosis undergoing hysterectomy after initial endometrial ablation for symptom control. We intended to evaluate whether a greater proportion of patients with pain symptoms had histologically confirmed adenomyosis and if imaging was appropriately used preoperatively.

Results 81 women had endometrial ablation followed by hysterectomy for failed symptom control. Of these, 2/5 of our
cohort had adenomyosis histologically. Only 9 women presented with pain as their primary indicator to proceed to hysterectomy. 2/3 of the cases where adenomyosis was identified had a transvaginal ultrasound prior to endometrial ablation. Only 1/3 had radiological reports that commented on features suggestive of adenomyosis. No women were referred for MRI despite half of the cohort having confounding factors.

Conclusion Adenomyosis presents a unique clinical challenge. In our retrospective study 2/5 women with failed symptom relief from endometrial ablation were found to have adenomyosis at hysterectomy, suggesting that clinical presentation is unreliable and use of imaging to aid diagnosis is underutilized.

0185
Pregnancy outcomes in women with hypothyroidism
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Introduction Hypothyroidism is present in 1% of all pregnancies. In most cases, patients will already be on replacement thyroxine therapy. Consequences of mismanagement of hypothyroidism in pregnancy include miscarriage, pre-eclampsia, gestational diabetes and decreased IQ in the offspring.

Case The patient is a 21-year-old trainee dispenser, with a BMI of 28 kg/m², who presented with a 3 day history of small, painless fresh vaginal bleeding. Her last menstrual period was 12 weeks ago. Prior to this pregnancy, she was on the oral contraceptive pill, Cerazette® (Merck, Hoddesdon, Herts). Her obstetrical history is gravida 3, para 0, abortus 1. The outcomes of her last two pregnancies include a missed miscarriage and a termination of pregnancy. Her past medical history includes hypothyroidism for which she has been on 100 µg of thyroxine for the past two years. She has also been taking folic acid for this pregnancy and is a non-smoker. A transvaginal ultrasound scan showed a 7 weeks gestational sac but no yolk sac or embryo was seen. Her missed miscarriage was surgically managed. Histology confirmed normal products of conception.

Conclusion This patient did not have thyroid function tests during her pregnancy so there are no results to suggest whether the levothyroxine dose was adequate to maintain thyrotropin (TSH) and free T4 levels in the appropriate trimester-specific reference ranges. Controversies exist on the cut off value for TSH during treatment of hypothyroidism and whether levothyroxine dose should be empirically increased by 25-50 µg in pregnancy. Clear guidelines regarding treatment of overt hypothyroidism in pregnancy are required from the Royal College of Obstetricians and Gynaecologists. However, an important take home message includes advising women with hypothyroidism to receive pre-conception counselling, which will enable appropriate dose adjustments to be made.

0186
Audit of small-for-gestational-age babies in North Manchester General Hospital
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Introduction We aim to identify the percentage of small-for-gestational-age (SGA) babies in North Manchester General Hospital (NMGH), and review of cases where SGA babies were identified.

Methods Retrospective snapshot audit of all deliveries in NMGH in August 2015.

Results 415 babies were delivered in NMGH in August 2015. There were 413 live births (99.52%) and 2 stillbirths (0.48%). 50 babies (11.55%) were SGA. Birthweight centile were unknown for 32 babies. There is one stillbirth in the SGA group and no stillbirth in the non-SGA group. We were unable to locate 15 sets of notes for the SGA babies. 12 babies (34.29%) had SGA detected during antenatal period while 23 babies (65.71%) had SGA detected after delivery. Of the 35 SGA babies, 25 (71.43%) had at least one risk factor identified at booking or during antenatal period. 17 babies (48.57%) of the SGA cohort have serial ultrasound scan (USS) arranged. Of the 18 babies who had no serial USS, only 2 babies had symphyseal fundal height (SFH) recorded as per Growth Assessment Protocol (GAP). Of the 23 SGA babies not recognised during the antenatal period, 15 babies had no serial USS arranged. Of the 21 babies who had SFH measured antenatally, 2 babies had at least one incident of incorrectly plotted SFH, and 10 babies had at least one incident of growth problem identified by SFH measurements but were not recognised and not referred.

Conclusion There are evidences that most unexplained stillbirths were associated with growth restriction, and antenatal detection can improve outcomes and reduces stillbirth. Utilisation of GAP, can improve antenatal detection rate. There is room for improvement in this aspect in NMGH. Serial USS for higher risk pregnancies can also improve detection rate but resource implication for the local unit should be taken into consideration.

0188
Awareness and pattern of contraception usage in patients attending the gynaecological outpatient department of Theni medical college, Tamil Nadu, India
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²Theni Medical College, Theni, Tamil Nadu, India

Introduction Contraception usage is key to controlling fertility and limiting unwanted pregnancies in an already booming population, such as India. This study looks at women attending the gynaecology outpatient department of an Indian hospital, to determine their awareness of contraception and the pattern of usage.
Methods A prospective cross-sectional study was conducted amongst the patients who attended the Gynaecology Outpatient Department of Theni Medical College in June 2016. 100 women were selected via random sampling and a questionnaire was used to explore awareness and pattern of usage of contraceptives, as well as a history of induced termination of pregnancy. The selection criteria included married women, who were of reproductive age between 20–50. Analysis was done to show current level of awareness and trends in contraceptive usage as well as influence of factors such as age and education.

Results Out of 100, 79% were aged below 35 years, 63% had attained education at the level of secondary school or higher and 83% reported to have completed their family. Only 19% had self-reported as having full awareness of contraception, while 83% of participants had used at least some form of contraception. Permanent methods of contraception were favoured over temporary methods. 19% of women had reported having sought a termination of pregnancy in the past, and 5% came to the outpatients currently seeking one. Age and education played a role in influencing both the awareness but also the pattern of usage reported by the participants.

Conclusion There is a significant gap between awareness and usage of contraception amongst the study population. There is a need for better health promotion campaigns by public health to target rural populations in not only improving awareness but also improving access to contraception and aid empowerment at user level.

0189
Laparoscopic simulator training: does it lead to improved operating room skills?

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Introduction Laparoscopy is the predominant technique used for the majority of pelvic surgical procedures. This development has been driven by the desire for a quicker postoperative recovery, reduced pain and bleeding, shorter hospital stay, and better cosmetic results. The technical skills needed for laparoscopic surgery are fundamentally different from those for traditional open surgery, leading to a prolonged learning curve. Laparoscopic simulation training has been shown to improve operating skills to that of a more experienced surgeon and decrease operating time. A literature search of similar studies into laparoscopic simulator training found that there was a ‘high quality surgeon-computer interface’ with users demonstrating a ‘significant early learning curve’. A cross-sectional survey of trainers and trainees found that ‘89% agreed that simulator training improved the quality of training’ and they felt that it should be ‘mandatory or desirable for junior trainees’.

Methods We designed a qualitative survey that was sent to trainees (ST1–ST7) following a laparoscopic simulation course at the Birmingham Women’s Hospital. Responses (n = 13) were collated and analysed. Main outcome measures: to assess the educational validity of the laparoscopic simulator in providing trainees with the opportunity to attain a basic level of technical facility that can be transferred from the laboratory to the operating room environment.

Results 83% of trainees felt that the simulation was realistic and 90% felt that their educational needs were met by the training. 92% felt that there was an improvement in their surgical skills and 91% would recommend simulator training to a colleague.

Conclusion Laparoscopic simulation training remains a valuable and evolving component of surgical education. To maximize the educational benefit of simulation in technical skills, we feel that such a program should be integrated into the curriculum, teaching the knowledge and judgment fundamental to laparoscopic surgery.

0191
Maternal heart rate in labour

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Introduction Labour is a physically intensive process eliciting heart rates similar to those recorded during moderate to heavy physical exertion. Maternal tachycardia in labour is a key sign of developing sepsis, dehydration, inadequate pain management and an important cardiovascular stressor. We analysed changes to maternal pulse throughout labour to understand normal physiology in order to tailor obstetric intervention appropriately.

Methods Retrospective review of 62 maternity notes from a tertiary referral centre. Average and highest recorded maternal and baseline fetal heart rates were obtained from CTG recording at admission, first stage, second stage and postnatally. Data collected included: antenatal maternal risk factors (PPROM, GBS, identified source of sepsis, recent significant APH and beta-blocker or terbutaline administration) and intrapartum risk factors (urinary ketones, analgesia, maternal temperature and EBL).

Results On admission, mean average maternal pulse was 89.43 and mean highest recorded pulse 97.75. In the first and second stage these were 92.58 and 110.87, and 102.55 and 123.37 respectively. Postnatally, mean average pulse was 93.41. There was no statistical difference in maternal pulse comparing epidural analgesia with other forms of analgesia in first and second stage. Analysis of four major blood loss groups postnatally (0-500 ml, 501-1000 ml, 1001-1500 ml, >1500 ml) revealed no significant variation in maternal pulse within groups. Only one case had evidence of documented sepsis.

Conclusion Maternal pulse rises throughout labour then normalises post-delivery. Average pulses remained within normal limits on admission and during first stage with mild tachycardia in second stage. Highest recorded pulses showed evidence of tachycardia at each stage which appeared independent of confounding factors including pain and sepsis. Despite a trend in rising heart rate with increased EBL, increased postpartum haemorrhage does not show a statistically significant difference in maternal pulse if appropriately resuscitated.
Patient perceptions of medical students in gynaecology clinics – can these be enhanced to improve both patient and student experience

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**Introduction** Clinical exposure to gynaecology patients and examinations is an essential part of the undergraduate medical curriculum. Patients are generally happy to be involved in student training; however their acceptance of student practical involvement varies. Male students are more likely to perceive gender bias and also more likely to struggle as women may be less likely to accept them in intimate examinations. The gender bias has anecdotally not been observed within our specialist teaching clinics. Patients attending these clinics have been satisfied with their care and 92 percent would be happy to be seen in such a clinic in the future. However these patients are a self-selected group as they have already agreed to be seen by the students. We wish to further explore the views of all women attending our gynaecology clinics.

**Methods** All women attending gynaecology clinics over the 9 month study period were invited to complete a questionnaire regarding their views on medical students’ presence and roles within the clinics.

**Results** There was no statistically significant difference in the baseline characteristics of women who accepted or declined student involvement. Reasons for allowing student involvement were overwhelmingly altruistic while reasons for declining were largely related to anxiety, embarrassment and fear of pain. No patients were caused pain by or disliked being seen by the students. No patients would decline being seen by students in the future.

**Conclusion** Patient characteristics cannot be used to predict medical student acceptance in our population. We will publicise the positive feedback and revisit the questionnaire at a later date. This study reiterates the need to continue dedicated teaching clinics, providing the supervised history the patients prefer. We also plan to review student responses to confirm the absence of a gender difference within our population.

Case report – CTG abnormalities due to clozapine use

**Hodge, F; Amin, P; Smith, S**

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**Introduction** Antipsychotic medication has been associated with major fetal malformations, perinatal complications, postnatal behavioural sequelae and gestational complications.

**Case** We will present the full case details and accompanying pathological CTG’s of a primiparous patient on multi-drug therapy to manage her pre-existing schizophrenia. The CTG’s were pathological from admission, demonstrating reduced variability and absence of accelerations resulting in her initial induction and later delivery by emergency caesarean section although this was initially declined. Her capacity was assessed and felt to be intact. She later consented and a live male infant was delivered with normal Apgars, weight and cord gases. His CRP increased over the first 48 hours of life but there were no other concerns. Postnatally the clozapine levels were unexpectedly found to be raised.

**Discussion** Clozapine is known to affect patient heart rate variability and as it crosses the placenta is likely to have the same effect on the fetus as has been seen in other case reports. In previous studies the fetal heart rate pattern has normalised with maturation around 38 weeks of gestation however this was not seen in this instance leading to difficulty in the intrapartum management of this case. This may be related to the significantly increased clozapine levels and potential toxicity although this was unknown at the time of labour. This case further adds to the evidence that clozapine treatment can induce fetal heart rate alterations. The undertaking of antenatal CTG’s may have a role in assisting the determination of a normal pattern for that baby. However if the fetal heart rate variability does not normalise around full term clozapine levels should be rechecked to ensure they remain within the therapeutic range.
Introduction of GTAs. We then reviewed the results of the introduction of the GTAs. We asked whether they felt that GTA sessions were effective as we’d like? Student feedback of GTA sessions was overwhelmingly positive, with students citing improved confidence and skill. Impressions from clinicians suggested improvements in both student’s skills and confidence during gynaecological examinations. However, formal assessment has not yet shown GTAs to be of any benefit.

Conclusion In conclusion, we would advocate the use of GTAs across undergraduate gynaecology teaching in the UK, and would take this further to consider their use in clinical induction programmes for new junior doctors commencing a gynaecology rotation. Further evaluation of the effects on exam performance over coming years may provide a more substantial evidence base regarding exam performance.

GTAs are used widely across North America, Australia and Scandinavia. The UK has been slow to incorporate them into undergraduate teaching. GTAs were introduced into the Swansea University Graduate Entry Medical Programme in October 2014. GTAs teach medical students the practical aspects of speculum and internal pelvic examinations, in addition to the communication components of intimate examinations. The evidence suggests the use of GTAs improves communication used by students, as well as their practical proficiencies. We compared the OSCE exam results for gynaecological examination for students having experienced GTAs with those who had not (students prior to October 2014).

Methods A questionnaire was distributed to all students attending a GTA session, the gynaecology consultants and registrars working in Singleton Hospital, Swansea. It asked whether they felt that students’ performance of gynaecological examinations had improved in both the clinic and theatre setting, following the introduction of the GTAs. We then reviewed the results of the gynaecology examination station in the final OSCE exams in 2015 (post GTAs) and 2014 (pre-GTAs) and compared the scores to look for any significant improvement in outcome following the introduction of GTAs.

Results Student feedback of GTA sessions was overwhelmingly positive, with students citing improved confidence and skill. Impressions from clinicians suggested improvements in both student’s skills and confidence during gynaecological examinations. However, formal assessment has not yet shown GTAs to be of any benefit.

Conclusion In conclusion, we would advocate the use of GTAs across undergraduate gynaecology teaching in the UK, and would take this further to consider their use in clinical induction programmes for new junior doctors commencing a gynaecology rotation. Further evaluation of the effects on exam performance over coming years may provide a more substantial evidence base regarding exam performance.

Case report: an unusual cause of pelvic pain at the gynaecology clinic

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Background Acute and chronic pelvic pain account for some of the most common presentations in gynaecology. It affects one in six of the female adult population. There are several gynaecological aetiologies that should be considered. However, we present an unusual cause of pelvic pain caused by a urachal cyst in a woman who was referred to the gynaecology clinic. This is rare and is more common in children. It is often asymptomatic but may present with infection. It can prove to be challenging to diagnose and manage due to its rarity.

Case A 58-year-old women with pelvic pain was initially admitted twice to gynaecology as an emergency and the pain was thought to be secondary to a urinary tract infection which was treated with antibiotics. She was then seen at the gynaecology clinic for ongoing pelvic pain and a transvaginal ultrasound revealed a pelvic cyst. This was further evaluated by a CT scan and it was thought to be a urachal cyst. The urologists initially de-roofed endoscopically but it was then completely excised laparoscopically at a later date.

Conclusion Urachal cysts are rare and are more common in males than in females. However, it is an important diagnosis in view of the potential complications. Urachal cysts can be complicated by rupture which leads to peritonitis. They may also lead to urachal colonic fistulae especially if infected. Neoplastic transformation has also been described and it is associated with a very poor prognosis. It should therefore be included in the differential diagnosis of non-gynaecological causes of pelvic or lower abdominal pain. Not every pelvic cyst is ovarian in origin.

Case study: complete miscarriage – a potentially dangerous diagnosis?

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Introduction Ectopic pregnancy is classified as implantation which occurs outside the uterus and 98% are in the fallopian tubes (ampulla: 70%, isthmus: 12% or fimbria: 11.1%). It occurs at a rate of 11 per 1000 pregnancies and carries a mortality rate of 0.2 per 1000 ectopic pregnancies. The majority of deaths due to ectopic pregnancy occur as a result of rupture (CMACE 2006–08). Prompt diagnosis prior to rupture of the ectopic pregnancy is important in reducing morbidity and mortality.

Case The patient was a 35-year-old woman who presented to A&E with left iliac fossa pain and PV bleeding. She was 9 weeks pregnant and on examination was found to be tender in the left iliac fossa. Beta-hCG was 9185 and progesterone was 33.6, the USS was inconclusive therefore a 48 hour β-hCG was performed and results showed a β-hCG decrease to 6643; she was diagnosed with incomplete miscarriage and treated with medical
oral and posterior presentations

0202

Analysis of obstetric anal sphincter injuries (OASIS) over a 6 month period at a Foundation Trust Hospital

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Introduction
OASIS have a major impact on women’s health. Identification and appropriate repair of the injury is vital towards recovery. We aimed to determine the incidence, identify potential recurring themes and assess management of OASIS over a 6 month period.

Method
Women sustaining a third or fourth degree tear at time of delivery at 2 hospitals within our trust were included in our 6 month retrospective audit. Data regarding parity, BMI, duration of 2nd stage, instrumental delivery, birthweight, episiotomy, perineal support and management of OASIS were recorded. Data analysis was performed on Excel®.

Results
43 women were identified within the audit period. The incidence for OASIS across the 2 hospital sites was 1.88%. The overlapping technique for the perineum at delivery. 13/22 (59%) preferred hands off technique. 40.5% (n = 22/41) used hands on the perineum with support. 40.5% (n = 22/41) used the hands off technique. The remaining 6% did not have any particular preference. 47.6% (n = 20/42) midwives would never consider episiotomy in second stage of labour. In the survey, 20/42 (47.6%) midwives were identified with midwifery experience less than or equal to 10 years. Amongst them 8/20 (40%) midwives used hands off technique. 12/20(60%) used the hands on perineum technique. There were 22/42 midwives (52.3%) with midwifery experience more than or equal to 10 years. Amongst this group 9/22 (40.9%) preferred hands on the perineum with support to the fetal head during crowning and delivery. 13/22 (59%) preferred hands off technique.

Conclusion
Primigravida had a higher incidence of third degree tears. More than half of the tears occurred as a consequence of spontaneous vaginal delivery. All fourth degree tears were secondary to normal vaginal deliveries by midwives. 98% (n = 42/43) of the cases lacked documentation about hands on or off technique at the time of delivery.

0203

Hands on or hands off approach at delivery? A survey of midwife preference

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Introduction
We aim to determine midwife preference for the hands on or hands off approach towards perineal care at delivery.

Methods
A voluntary anonymous questionnaire was distributed to 50 midwives working on labour ward at 2 hospitals within our trust. Data were collected on the number of years of experience as a midwife, formal training to perform an episiotomy, training to recognise an OASIS and preference for the hands on or hands off approach for the perineum at delivery. Data analysis was performed on Excel®.

Results
42/50 completed questionnaires were received. 100% of the midwives were taught to perform an episiotomy. 95% (n = 40/42) received formal training and 5% (n = 2/42) received informal training. 90% (n = 38/42) were taught to repair episiotomy. Amongst the 90%, 92% had received formal training.

Regarding management of the perineum during crowning, 53.6% (n = 22/41) used hands on the perineum with support. 40.5% (n = 17/42) used the hands off technique. The remaining 6% did not have any particular preference. 47.6% (n = 20/42) midwives would never consider episiotomy in second stage of labour. In the survey, 20/42 (47.6%) midwives were identified with midwifery experience less than or equal to 10 years. Amongst this group 9/22 (40.9%) preferred hands on the perineum with support to the fetal head during crowning and delivery. 13/22 (59%) preferred hands off technique.

Conclusion
In line with the recent interventional studies, training on both hands on and hands off approach will allow identification, provision of perineal support and potentially help reduce the incidence of OASIS. Contrary to our expectations the junior midwives were using more hands on approach to the perineum as compared to the senior midwives.

0204

Significance of depth of excision and follow-up cytology. Experience in a small district hospital

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Introduction
Retrospective audit to assess depth of LLETZ (large loop excision of the transformation zone) specimens performed from January to December 2014, for high grade Cervical Intraepithelial Neoplasia (CIN) and follow-up cytology results.
Methods 131 patients were identified. The data was entered and analysed via Excel® database. The following parameters were assessed: reason and date for performing LLETZ, depth and volume of LLETZ specimen; excision margins; date and results of follow-up cytology.

Results In 44% cases LLETZ procedure was performed due to high grade changes on biopsy, 24% due to high grade dyskaryosis on cytology and 22% due to high grade changes on colposcopy. For complete excision specimens, depth ranged from 5–21 mm with a mean value of 10.38 mm. Amongst incomplete excision specimens depth ranged from 5–20 mm with a mean of 10.857 mm. In not assessable group, depth range was 6–11 mm with a mean of 8.33 mm. There were 77 cases (58.7%) in the complete excision group (CEG). Follow-up cytology IN CEG showed 52 cases were negative, 3 showed borderline changes, 5 were HPV positive and for 17 cases there were no follow-up results. In incomplete excision group (IEG) 43 cases (33%) were recorded. On follow-up cytology of IEG, 22 were negative, 1 showed borderline changes, 2 had dyskaryosis, 6 were HPV positive and there were no results for 12 cases. 10 cases (7.6%) were in ‘not assessable’ group which on follow-up cytology showed 6 negative, 1 borderline, 2 HPV positive and 1 case with no documented result.

Conclusion Mean depth of excised tissue in complete and incomplete excision groups were the same. On follow-up cytology there were 2 cases of dyskaryosis in the incompletely excised group and none in the completely excised and not assessable group. This justifies having follow-up cytology and HPV assessment.

0205 Volume of LLETZ specimen. Does size matter? Saeed, Z; Ndumbe, F Scunthorpe General Hospital, Scunthorpe, UK

Introduction Retrospective audit to assess volume of LLETZ (large loop excision of the transformation zone) specimens performed from January to December 2014, for high grade Cervical Intraepithelial Neoplasia (CIN).

Methods 131 patients were identified. The data was entered and analysed via Excel® database. The following parameters were assessed: reasons for performing LLETZ, date LLETZ was performed; depth and volume of LLETZ specimen; excision margins; date of follow-up cytology and follow-up cytology results.

Results In 44%, cases LLETZ procedure was performed due to high grade changes on biopsy; 24% due to high grade dyskaryosis on cytology and 22% due to high grade changes on colposcopy. In complete excision, volume range of tissue removed was 0.449–4.975 cm³ with a mean value of 1.97 cm³. In incomplete excision volume range was 0.403–4.609 cm³ with mean value of 1.98 cm³. In LLETZ samples with ‘not assessable’ excision margins, the volume range was 0.622–1.9 cm³ with mean value of 1.0509 cm³. There were 77 cases (58.7%) in the complete excision group (CEG). Follow-up cytology IN CEG showed 52 cases were negative, 3 showed borderline changes, 5 were HPV positive and for 17 cases there were no follow-up results. In incomplete excision group (IEG) 43 cases (33%) were recorded. On follow-up cytology of IEG, 22 were negative, 1 showed borderline changes, 2 had dyskaryosis, 6 were HPV positive and there were no results for 12 cases. 10 cases (7.6%) were in ‘not assessable’ group which on follow-up cytology showed 6 negative, 1 borderline, 2 HPV positive and 1 case with no documented result.

Conclusion Mean volumes of excised tissue in complete and incomplete excision groups were nearly the same. On follow-up cytology there were 2 cases of dyskaryosis in the incompletely excised group and none in the completely excised and not assessable group.

0206 A rare case of a non-functioning pyonephrotic kidney masquerading as an ovarian cyst in a 21-year-old female Rajakumar, D1; Muthusamy, T2 1Newcastle University, Newcastle upon Tyne, Tyne and Wear, UK; 2Theni Medical College, Theni, Tamil Nadu, India

Introduction Pyonephrosis is a rare and deadly condition pertaining to the destruction of the renal parenchyma, most commonly due to an ascending urinary tract infection or an obstruction. Common symptoms may include fever and flank pain, cohabiting with an abdominal mass.

Case Here we have a 21-year-old female presenting to the gynaecology outpatient department with abdominal pain, urinary symptoms, menorrhagia and a palpable abdominal mass. Initially suspected to be an ovarian cyst, the diagnosis of pyonephrosis was made upon surgical removal of the mass. Subtle indications in preoperative investigations which often point towards an alternate diagnosis can be easily overlooked, as in this case. This is the report of a very unusual presentation of pyonephrosis in a young female, it’s subsequent treatment and management.

0207 Outcomes of ultra-radical surgery for advanced ovarian cancer in the Humber and Yorkshire Coast Cancer Network (HYCCN) Ismail, A; Al-Dujaily, A; Lykoudis, P; Booth, S; Giannopoulos, T; Flynn, M Hull & East Yorkshire Hospitals NHS Trust, Hull, UK

Introduction Castle Hill Hospital is the tertiary referral centre for the HYCCN, serving a population of 1.1 million with an average of 76 newly diagnosed ovarian cancer cases annually. We offer a comprehensive surgical service in collaboration with upper/lower GI surgeons for primary and interval debulking. We aim to evaluate the effectiveness and morbidity associated with ultra-radical surgery in the management of advanced stage ovarian cancer from 2012 to 2015 (n = 13).
Results In this cohort, the average age was 66 (48–82) years who either had stage III (85%) or stage IV (15%) disease. Optimal debulking was achieved in 77% with no major postoperative complications or death within a year of surgery. 2 women (15%) relapsed within a year. 92% needed bowel resection (8% hemicolectomy, 85% multiple bowel resection), 46% had diaphragmatic resection, 23% had peritoneectomy and 15% needed resection of liver metastases and cholecystectomy. 2 women (15%) had intraoperative vascular and visceral injury, which were repaired at the time of the procedure, with no long-term consequences. No women had persistent postoperative pyrexia, returned to theatre, or had pleural effusion. The average operative time was 4 hours 23 minutes, the average hospital stay was 6.6 days. The histology was adenocarcinoma (84.6%); sarcoma (7.69%) and clear cell carcinoma (7.69%). All women received chemotherapy within 4 weeks of surgery.

Conclusion Our results show that ultra-radical surgery for advanced ovarian cancer performed in this unit is safe, with acceptable optimal debulking rates.

0208
Audit into the management of operative vaginal delivery at North Cumbria University Hospitals
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Introduction We aim to identify compliance to trust guidelines regarding operative vaginal delivery and assess the current SurveyMonkey® audit tool used departmentally. There is increasing awareness of the potential for morbidity for both the woman and the newborn related to operative vaginal delivery (OVD). However, caesarean section in second stage also carries significant risk of morbidity and implications for future births.

Methods The 34 records audited were evenly spread throughout the period and included a sample from each hospital site. The audit was completed electronically using SurveyMonkey® using pre-set questions.

Results All had the OVD by an appropriately trained member of staff, and the majority had the consultant called as appropriate to the local guidelines. The majority had documented verbal or written consent with the indication for the procedure documented. The documentation of the information given to the women regarding the maternal and fetal risks of the procedure was poor. The documentation of the postnatal management of catheter usage and voiding amounts and timings was also poor.

Conclusion Overall the audit showed that the patients in the trust undergoing operative vaginal delivery are receiving a high standard of care however areas of poor documentation were highlighted. The audit questions were set by a non-medic taken from CNST standards and at times did not reflect national RCOG guidelines and were not practical for the clinical setting. The results of the audit will be circulated around the department and the areas where improvement needed emphasized. There will be education about the importance of avoiding urinary retention, especially with increasing use of epidurals. The SurveyMonkey® audit tool will be updated with RCOG auditable standards and irrelevant questions removed and simplified. There will be a re-audit with recommendations in 6 months to assess if the audit loop has been closed.

0211
Case report of a laparoscopic hysterectomy for a large cervical fibroid
Bentham, C; Hoi Gan, C
Scunthorpe General Hospital, Scunthorpe, UK

Background Laparoscopic surgery has many benefits including quicker recovery time and most patients are able to go home after laparoscopic hysterectomy within 24 hours. Cervical fibroids account for less than 2% of all fibroids.

Case We present an interesting case of a 42-year-old woman with a 18.1 x 11.9 x 10.1 cm fibroid. She was parity 4 and her family was complete. She suffered with a dragging sensation. The fibroid was compressing and pushing the upper uterine segment anteriorly and superiorly. Electively she had the cervical fibroid removed laparoscopically via total laparoscopic hysterectomy and bilateral salpingo oophorectomy. The abdomen was entered with primary port introduced using Hassan’s technique. The pelvic sidewalls were opened and the ureters identified. Enseal device was used to perform bilateral salpingectomy and ligate the ovarian ligaments and uterine artery. The bladder was then reflected. The cervical fibroid was then partially amputated vaginally to allow application of the uterine manipulator. The path of the ureters were then explored to the insertion of the bladder. The cervix was circumscribed and the pouch of Douglas opened. The uterosacral ligaments were then ligated. The fibroid was removed in two parts with the specimen.

Conclusion Laparoscopic hysterectomy was possible for this woman and resulted in a successful outcome for the woman. Lateral pelvic sidewall dissection allowed good visualisation of the ureters and internal iliac and ureteric arteries. This can reduce the risk of ureteric injury. Amputation of the fibroid allowed for the fibroid to be removed in two parts.

0213
Late stillbirths: The Portsmouth Experience 2002–2015
Brown, N; Negus, M; Sengupta, S
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Introduction Stillbirth is a tragic event. Much work has been undertaken to look at underlying causes. We have examined late stillbirths, from our maternity unit, which has approximately 6000 deliveries a year. In particular, looking at the birthweights of the stillborn babies, to see if there is an excess of small-for-gestational-age (SGA) in this population. We also looked to see if there has been any change in our late stillbirth rate, and the proportion of those which are SGA/IUGR, since the introduction
of the ‘GROW’ chart. We also looked at some growth ultrasound data to see if the SGA was foreseen.

**Methods**
We examined the electronic records for all stillbirths from 34 weeks of gestation, which occurred from 2002–15. The maternal height, weight, parity, ethnicity obtained and a customised centile of the birthweights was calculated using software from ‘GROW’. We looked in detail at those with birthweights under the 10th centile, in particular, if they had growth ultrasound scans in the third trimester.

**Results**
There were 195 stillbirths from 34 weeks of gestation, in Portsmouth, from 2002–2015. 38% of these had a birthweight under the 10th centile, and 30% of these had a birthweight under the 5th centile. Overall, there has been no significant change in proportion of stillbirths with low birthweight over the timeframe. Scan data from these small babies was accessed for stillbirths from 2009–2015. A third trimester growth ultrasound scan was performed in 37% of this group, of which SGA was suspected in 19% of those scanned.

**Conclusion**
A disproportionate proportion of late stillbirths are SGA and there has been no significant change over the period examined. More work needs to be done to identify these cases to potentially impact on the stillbirth rate.

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**Hysteroscopic metroplasty of a uterine septum: a two year retrospective audit**

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**Introduction**
A uterine septum is a congenital anomaly. The septum is a muscular or fibrous wall that divides the inside of the uterus, creating 2 cavities. The septum may be complete or incomplete. It is more common in women with primary infertility and in women who have had repeated miscarriages, and may therefore be one cause of these problems. Metroplasty aims to create a normal cavity by removing the septum. A hysteroscopic approach aims to reduce morbidity and shorten the recovery period. However, there are a number of reported risks and the reported efficacy is variable. The aim of this audit is to review the clinical outcomes in our hospital over a two year period.

**Methods**
Metroplasty cases identified by going through Pisces theatre lists over the two year time period (March 2014–March 2016). Data collection criteria identified using NICE Clinical Audit Tool (2015). Evolve, Lastword and Medical Records used to source follow-up information.

**Results**
9 cases identified, 100% written consent compliance, however based on sources available for data collection no evidence of written information given to women. All women had a routine 6–8 week repeat hysteroscopy follow-up booked: 33% had a grade 1 adverse event – requiring further surgical intervention such as adhesions. 100% had no adverse events beyond 8 weeks. Fertility follow-up 20% live birth rate, 40% currently pregnant, one miscarriage, one ectopic, two lost to follow-up and two excluded as insufficient follow-up period.

**Discussion**
Metroplasty is a safe procedure, with no adverse events reported beyond 2 months. It is unclear if there is an improvement in fertility as the sample size is too small to determine significance. Clear counselling of patients is practised, however we have room for improvement by introducing written information material. In conclusion, within our unit this is a safe, appropriately used procedure. Further data collection is required to assess impact on fertility outcomes.

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