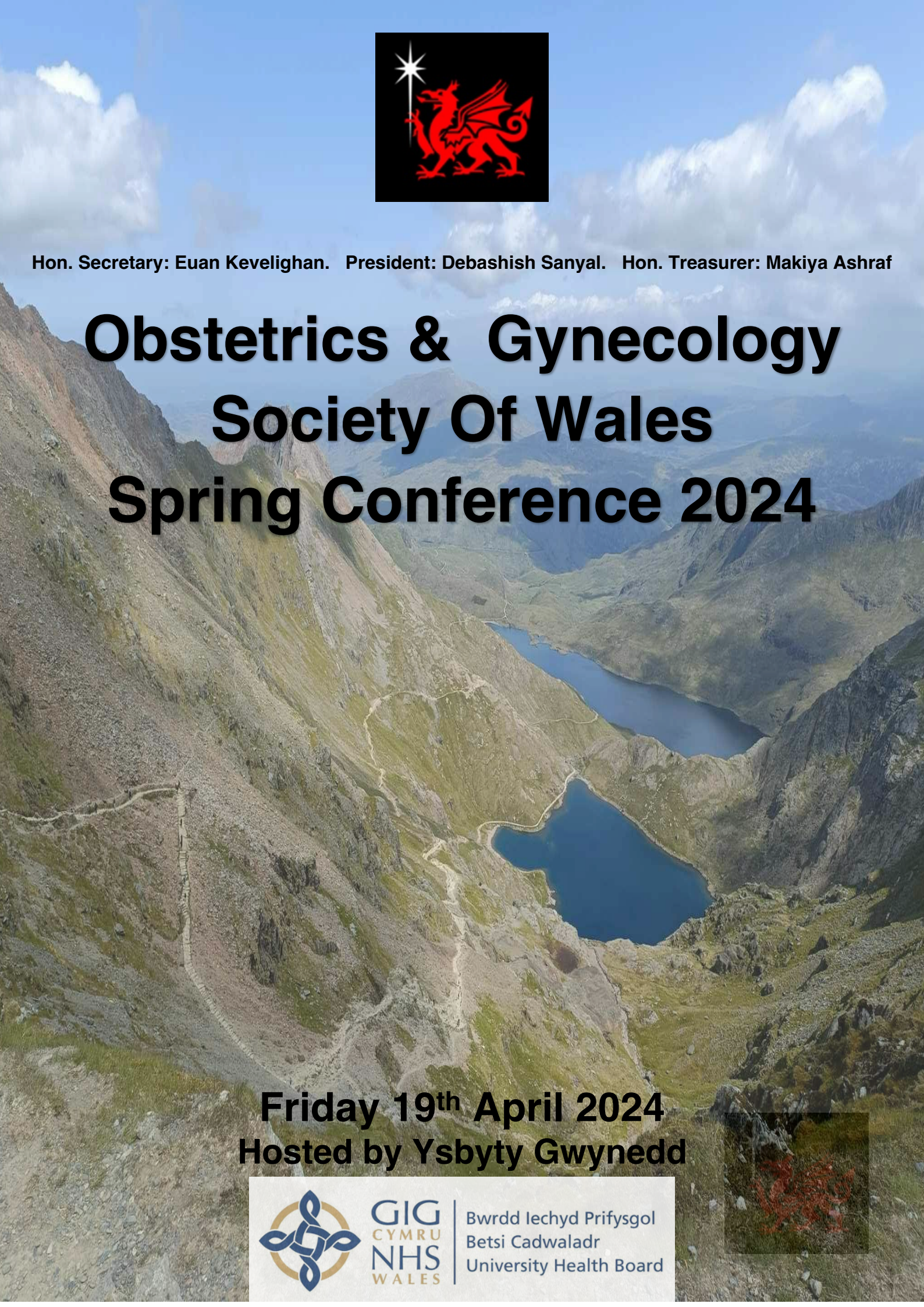


Hon. Secretary: Euan Kevelighan. President: Debashish Sanyal. Hon. Treasurer: Makiya Ashraf

Obstetrics & Gynecology Society Of Wales Spring Conference 2024

Friday 19th April 2024

Hosted by Ysbyty Gwynedd

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Not for printing, use for layout purposes

Introduction

It is a pleasure to welcome you all to the Obstetrics and Gynaecology Spring Conference 2024, held here the beautiful Hilton Garden Inn Hotel in Snowdonia.

This year the conference is proudly hosted by Ysbyty Gwynedd, bringing you an exciting and thought-provoking programme packed with internationally recognised medical professionals within our speciality, to share their insights on current topics that affect us all.

We would like to take this opportunity to thank all the speakers for providing their time to help broaden knowledge of their specialist areas, and without whom the conference would not be possible.

Congratulation are in order to all colleagues whose abstracts were selected for oral or poster presentation. Please use coffee and lunch breaks to view the poster displays, voting for the best posters using the card provided.

This year we are kindly sponsored by some of the best organisations that have longstanding relationships with Obstetrics and Gynaecology services. We encourage you to visit our sponsors stands and welcome their representatives who are here with us today.

We hope you enjoy the conference and benefit from the fantastic day ahead, whilst also making new connections with others in the field of Obstetrics and Gynaecology.

Dr Zainab Ilyas
Miss Rosalind Jones
Dr Noreen Haque

Professor Hassan Shehata

Hassan Shehata is Professor of Obstetrics and Gynaecology and Consultant Obstetrician, Maternal Medicine Subspecialist and the RCOG's Senior Vice President for Global Health.

His NHS base is at Epsom and St. Helier University Hospitals. He is also the Clinical Lead for South-West London Maternal Medicine Network, creating clinical pathways and safe referral systems, ensuring all women with pre-, ante- and post-natal complex medical conditions have equal accessibility and care.

Hassan has a strong research background with over 100 peer-reviewed publications including NEJM, Lancet and BMJ. His research interests include recurrent miscarriages, obesity, diabetes, renal disease, and obstetric cholestasis.

Mrs Geeta Kumar

Geeta Kumar is the Vice President for Clinical Quality at the RCOG. Geeta has been a Consultant Obstetrician & Gynaecologist since 2003 and in Oct 2022, she was appointed as the Clinical lead for Women's Services at Betsi Cadwaladr University Health Board, the largest health board in Wales. She also holds a Visiting Professor role at Glyndwr University, Wrexham.

Geeta has led on and contributed to the development of multiple national clinical guidelines, quality standards and patient information resources. She did a 3-year Fellowship with NICE and is an expert adviser for NICE guidelines and interventional procedures. In recognition for her excellence in medical leadership, the Faculty of Medical Leadership and Management, U.K awarded "Senior Fellowship" to Geeta in 2021.

Geeta is a strong advocate for patient empowerment and her clinical interests include menopause, menstrual disorders, and ambulatory gynaecology. Promoting patient involvement in their own healthcare is her motto in life. "Passionate advocate for women empowerment and a compassionate clinical leader" is how she expects to be described by her peers and people she serves.

Dr Sabrina Cardillo

MBBS, BSc, MRCOG, MA, DFSRH, DLM

Sabrina joined the MDU as a Medico-Legal Fellow in 2022 and has been a Medico-Legal Adviser since May 2023.

Before joining the MDU, she worked in Obstetrics and Gynaecology, gaining her MRCOG in 2019. She has an MA in Medical Law and Ethics and obtained the Diploma of Legal Medicine in 2022.

Dr James Barrett

Dr Barrett is the Director of the oldest and largest gender identity clinic.

He's worked in this field for thirty-five years, interviewing twenty-five thousand trans people.

He wrote the first UK textbook on the subject and co-authored the textbook accompanying the RCP Gender Healthcare Diploma course (on which he is a Tutor).

He was twice elected President of the British Association of Gender Identity Specialists.

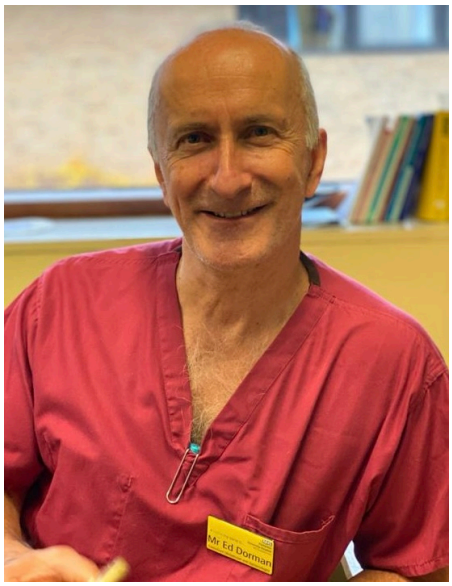
Professor Catherine Nelson Piercy

Catherine Nelson-Piercy is a Consultant Obstetric Physician at Guy's and St. Thomas' Hospitals Trust and the Lead Obstetric Physician for the Southeast London Maternal Medicine Network. In 2010 she was awarded the title of Professor of Obstetric Medicine at King's College London. Her undergraduate studies were at King's College, Cambridge University and St Bartholomew's Hospital. She trained as a physician and was taught Obstetric Medicine by Professor Michael de Swiet.

Professor Nelson-Piercy is past President of the International Society of Obstetric Medicine (ISOM). She was founding co-editor in chief of the journal 'Obstetric Medicine: the medicine of pregnancy.'

Professor Nelson-Piercy is a member of the NHS England expert group that developed the Networked model for maternal medicine and has been involved in the development of several evidence-based National Guidelines notably the RCOG Green top guidelines on "Reducing the risk of thromboembolism during pregnancy, birth & the puerperium" and 'Management of nausea vomiting of pregnancy and hyperemesis gravidarum". She has over 280 publications and has edited five books and written the successful Handbook of Obstetric Medicine, now in its sixth edition. She is also one of the central physician assessors for the UK Confidential Enquiries into Maternal Deaths.

Mr Edgar Dorman FRCOG



Ed Dorman has been a consultant Obstetrician and Gynaecologist at Homerton Hospital in East London since 2000.

He is an expert in high-risk pregnancy and in fetal and maternal medicine. He has been an abortion care provider throughout his career, having been trained in Dilatation and Evacuation while working as a registrar for Wendy Savage.

He is co-chair of the RCOG Abortion Taskforce, a member of the Education and Training committee of the BSACP, UK representative on the board of FIAPAC (International Federation of Abortion and Contraception Professionals).

He has recently been appointed to the board of trustees of the British Pregnancy Advisory Service (BPAS).

Ms Rosalind Jones

Rosalind Jones is a consultant gynaecological oncology surgeon at Ysbyty Gwynedd. Rosalind completed obstetrics & gynaecology training in South London, Kent, Surrey & Sussex before undertaking sub-specialty training back in her home nation, at University Hospital of Wales, Cardiff.

Rosalind moved to Ysbyty Gwynedd in April 2020 and took on the role of RCOG college tutor in January 2023. Rosalind is passionate about surgical innovation and played a key role in the introduction of robotic assisted surgery to Betsi Cadwaladr University Health Board and in September 2022 Rosalind performed the first robotic assisted hysterectomy in Wales.

In addition to her surgical interests Rosalind is passionate about equality in all things; particularly care provision and training, and hopes, that in leading by example, this passion can translate into improving gynaecological cancer care in Wales and trainee experience in the Wales deanery.

Mr Samuel Yousef

Sam is a Doctoral Student in the Cultural Competency Unit under the supervision of Dr Shuangyu Li and Prof. Katherine Woolf (UCL Medical School). His PhD project is funded by the Economic and Social Research Council (ESRC) through the London Interdisciplinary Social Sciences Doctoral Training Partnership (LISS-DTP) and is focused on understanding and addressing the influence of colonialism on postgraduate specialty training in Obstetrics and Gynaecology in the UK through Participatory Action Research (PAR).

He received an MA in European Studies (Cum Laude) from the University of Groningen, an MA in Languages Cultures and Society from the University of Strasbourg and a BA in International Cooperation and Development from the University of Rome – Sapienza.

Before returning to academia for his PhD, Sam held various roles in medical education with different organisations including the General Medical Council (GMC), the British Society of Abortion Care Providers (BSACP), and the Faculty of Sexual and Reproductive Healthcare (FSRH) of the Royal College of Obstetricians and Gynaecologists (RCOG). He is the current Chair of the Board of Trustees of the Reproductive Justice Initiative.

Programme

08:45 – 09:00	**Coffee and Registration**
09:00 – 09:10	Introduction Dr Zainab Ilyas, Clinical Director, Consultant Obstetrician & Gynaecologist, Ysbyty Gwynedd
	Chair: Miss Rosalind Jones
09:10 – 09:40	**Metformin: Is it the new Aspirin of the 21st century** Professor Hassan Shehata, Vice President RCOG, Consultant Obstetrician & Maternal medicine subspecialist, Epsom & St Helier University Hospitals
09:40 – 10:10	**Unscheduled bleeding on HRT** Mrs. Geeta Kumar, Vice President RCOG, Clinical Lead N. Wales, Consultant Obstetrician & Gynaecologist, Wrexham Maelor Hospital
10:10 – 10:40	**Consent: A medicolegal update** Dr Sabrina Cardillo, Medico Legal Advisor, MDU
10:40 – 11:20	**Trans folk - what a jobbing gynaecologist might usefully know.** Dr James Barrett, Consultant in Adult Gender Medicine, Charing Cross
11:20 – 11:40	**Break/Tea/Coffee**
11:40 – 12:30	**Acute medical problems on labor ward** Professor Catherine Nelson Piercy, Consultant Obstetric Physician, Guys & St Thomas Foundation Trust
12:30 – 13:00	**Termination and Maternal mortality** Mr. Edgar Dorman, Consultant Obstetrician & Gynaecologist, Homerton University Hospital NHS Foundation Trust
13:00 – 14:10	**Lunch & Poster review/Society meeting**

Chair: Dr Zainab Ilyas

14:10 – 14:25	**Bursary presentation: Towards a Net-Zero NHS – Enhancing maternal care through sustainable practices** Anangsha Sharma, ST3 Singleton Hospital
14:25 - 15:15	**Oral Presentations**

1. **Pain relief measures in outpatient Intrauterine contraception device (IUD) insertion: a survey of current UK clinical practice**
   Dr Sindhu Sekar, Dr Prajwal Shetty
2. **Gastric rupture in pregnancy**
   Dr Lakshmi Jayaraj, Dr Anqa Khan
3. **Herpes Simplex Meningitis in pregnancy, a clinical dilemma – case report and literature review**
   Dr Nosheen Akhtar
4. **Case series of cervical intraepithelial neoplasia 2 and negative human papilloma virus**
   Dr Manal Taha

15:15 – 15:30	**Break/Tea/Coffee & Poster review**
15:30 – 16:00	**Robotics in Gynaecology** Ms Rosalind Jones, Consultant Gynaecological Oncologist, Ysbyty Gwynedd
16:00 – 16:30	**Understanding the influence of Colonialism on Obstetrics & Gynaecology** Mr. Samuel Yosef, Kings College London
16:30 – 16:40	**Obituary** Dr Roopam Goel
16:40 – 16:50	**Prizes** Mr Debashish Sanyal OGSW President
16:50 – 17:00	**Close**

Abstracts

1. Pain relief measures in outpatient intrauterine contraception device (IUD) insertion: a survey of current UK clinical practice
2. Gastric rupture in pregnancy
3. Herpes simplex meningitis in pregnancy, a clinical dilemma – case report and literature review
4. Case series of cervical intraepithelial neoplasia 2 and negative human papilloma virus
5. Placental site nodule an uncommon diagnosis: case series
6. Foetal sacrococcygeal teratoma
7. Assessing diagnostic compliance in women with endometrial cancer against suspected cancer pathway standards in Southwest Wales
8. Assessment of referrals with postmenopausal bleeding following new or changed hormone replacement therapy.
9. Malignant mixed germ cell tumour with combination of immature teratoma and yolk sac tumour: a case report
10. Uterine angiosarcoma diagnosed via endometrial biopsy: exploring the impact of oral progesterone therapy on associated lung metastasis – a case study.
11. Audit to review informed consent process in obstetrics and gynaecology.
12. Reauditing caesarean births, how good we are in VBAC success.
13. Postpartum choriocarcinoma: a light in a dark time
14. Antenatal fetal moulding caused by leiomyoma in pregnancy: a case report.
15. Pressurised intraperitoneal aerosolised chemotherapy (Pipac) in the management of cancers of the colon, ovary, and stomach: a randomised controlled phase ii trial of efficacy in peritoneal metastases.
16. To assess surgical compliance with the national optimal pathway for endometrial cancer in Southwest Wales
17. Diagnostic challenges and management of pelvic mass with endometrial adenocarcinoma: a case report
18. Management of Gitelman syndrome in pregnancy
19. An audit of patient's satisfaction in an outpatient hysteroscopy clinic setting
20. A case of maternal McArdle disease associated with fetal supraventricular tachycardia.
21. Enhancing maternal and Neonatal Outcomes: A Quality improvement Initiative in Instrumental Deliveries

Pain relief measures in outpatient Intrauterine contraception device (IUD) insertion: a survey of current UK clinical practice

Sindhu Sekar, Manisha Dealwis, Prajwal Shetty, Sujeewa Fernando.
Wrexham Maelor Hospital, Betsi Cadwaladr health board, UK

Aim: Intrauterine Contraception Devices (IUDs) are a highly effective, long-acting reversible contraceptive method used globally. Despite this, Public Health Wales reported a decline in IUD uptake from 7,082 to 6,315 between 2021 and 2023. Recent concerns have been raised about the discomfort experienced during IUD insertion. This study aims to explore current clinical practices in the Wales for mitigating pain associated with IUD insertions in outpatient clinics.

Methods Used: A questionnaire was distributed to practitioners regularly performing IUD insertions. The questionnaire, aligned with recent FSRH guidelines, comprised 23 structured questions and was created using Microsoft Forms. The survey targeted contraception clinics, sexual health clinics, GP surgeries, and various specialists within the Wales NHS healthcare trusts.

Results and Discussion: Out of 200 participants contacted, 35 (17.5%) responded. Among these respondents, 85% had formal training, 94% felt confident in inserting IUDs, 97% provided pre-placement counselling, and all utilized an assistant for patient support and offered alternative options before the procedure. Areas for improvement are identified: Ensuring all facilities have proper equipment, mandating formal training for practitioners, and standardizing analgesia options (82.9%). Only 17% use patient satisfaction surveys, suggesting a need for broader implementation.

Action plan: Standardize pre-placement counselling within 6 months led by clinical lead and training department. Implementing a patient satisfaction survey system using the BSGE Patient Survey Template within 6 months through quality improvement team. Initiate formal training for identifying high-pain-risk patients and IUD insertion and different pain relief strategies within 6 months.

Conclusion: The study provides valuable insights into current practices and areas for improvement in pain management during IUD insertion. Enhanced training, better facility provision, and consistent use of patient feedback are crucial for improving patient experiences in intrauterine contraception procedures.

Gastric rupture in pregnancy

Dr Lakshmi Jayaraj, Dr Sindhu Sekhar, Dr Anqa Khan, Mrs Sujatha Kumari

Background: Upper gastrointestinal rupture is extremely unusual in pregnancy. This case report explains the rare presentation of gastric fundal rupture in pregnancy causing pneumothorax necessitating emergency preterm caesarean birth, thoracotomy and repair.

Case Presentation: A multiparous lady in her mid-forties, who was 29 weeks pregnant conceived by IVF, presented with two-week history of worsening vomiting, shortness of breath, and back pain. She had undergone Nissen's fundoplication in the past. During admission, clinical examination and chest x-ray revealed left pneumothorax. She developed severe respiratory compromise requiring antibiotics, chest drain and ITU admission. CT Pulmonary Angiography revealed a large left hydropneumothorax, a herniated stomach with significant contrast leak in the chest cavity. A diagnosis of rupture of upper gastrointestinal system was made. The MDT involving the critical care, medical, surgical, and obstetric teams discussed the need for urgent thoracotomy and repair of rupture to prevent further deterioration of respiratory function and decision was taken to deliver the baby by caesarean section prior to thoracotomy to facilitate better exposure and optimum positioning. Patient was counselled of the need for delivery and implications of preterm birth. The PERIPrem passport was initiated. Antenatal corticosteroids and magnesium sulphate were given. An uncomplicated caesarean section was performed. The baby was delivered in good condition. On thoracotomy an obvious gastric perforation in the fundus at the site of the fundoplication was found and repaired. She had an uncomplicated postoperative period.

Discussion: Diagnosing gastric perforation and rupture during pregnancy is extremely challenging and can easily be missed. The ethical dilemma in this case revolved around the intricate decision-making process for the iatrogenic premature birth of a baby, conceived through IVF, to a mother in her forties, via caesarean section. The MDT discussions facilitated safe and effective decision making and has resulted in a good outcome.

Herpes Simplex Meningitis in pregnancy, a clinical dilemma – case report and literature review

Nosheen Akhtar, Hari Muppala. Glan Clwyd Hospital, Betsi Cadwaladr University Health Board

Aim: We present a case report of a woman with a headache in early pregnancy, diagnosed as viral meningitis.

Methods: Case report

Background: Most often causes for headaches in pregnancy are benign, however a thorough assessment with multidisciplinary input is required to rule out more serious causes. Meningitis is one of the differentials of headaches in pregnancy. HSV-2 meningitis most often occurs in people with no history of genital herpes, and a severe frontal headache is among the most common presenting symptoms. In most cases, treatment for viral meningitis is supportive, pain relief, and hydration.

Case report: A 31-year-old woman presented at 10 weeks of gestation with a headache of 48 hours duration. She presented with sudden onset severe global headache, throbbing in nature, associated with nausea, vomiting, and photophobia. The initial assessment and neurological examination were unremarkable except for mild neck stiffness. The initial differentials were subarachnoid haemorrhage or cavernous venous thrombosis. CT scan was normal, so a lumbar puncture was performed and showed a raised white cell count of 525 x10^6/L with Polymorph 10% and Lymphocyte 90%. A provisional diagnosis of viral meningitis was made and commenced on IV acyclovir whilst awaiting PCR results. PCR of CSF revealed Herpes simplex Type-2. As there was no evidence of encephalitis acyclovir was stopped. She gives no history of genital herpes infection but was advised prophylactic acyclovir from 36 weeks of gestation.

Discussion and conclusion: A decrease in adaptive immunity in pregnancy can lead to higher susceptibility to infections. Thorough assessment and multidisciplinary input of women presenting with headaches is essential to rule out serious and life-threatening causes of headaches. Acyclovir although reduces adverse outcomes, its benefit at lower gestation is undocumented.

Case series of cervical intraepithelial neoplasia 2 and negative human papilloma virus

Manal Taha, Eman Elkhattan, Elaina Hoss, Withybush general hospital

Aim: To examine cases where women had negative HPV results but were diagnosed with high grade cervical lesion

Materials and methods: Retrospective case series We looked in 2021 data at withybush general hospital for women who had CIN2 or worse with negative HPV.

Results and discussion: We had eight cases of Cervical Intraepithelial Neoplasia grade 2 (CIN 2) At their follow-up in Colposcopy they were HPV negative on smear and CIN 2 on biopsy All of them were under 50 years old, all had high-grade colposcopy findings. Subsequent biopsy results confirmed histopathology consistent with CIN 2 in all cases. Notably, all these women had previously tested positive for HPV at some point in their life. HPV testing is now the primary test for cervical screening. If HPV negative no cytology will be done. We would not expect women to have high grade CIN with a HPV negative smear - which is the core message. Fortunately, these women were kept in the colposcopy clinic - which is how we knew they had HPV negative and high-grade CIN at the same time.

These cases highlight the complexity of cervical cancer screening and the potential challenges in managing patients with a history of HPV positivity and previous cervical interventions. Despite negative HPV results in some instances, the persistence of high-grade lesions underscores the importance of vigilant follow-up and tailored management strategies based on individual patient history and risk factors.

Conclusion: HPV negative women had an increased long-term risk of CIN2+ when the HPV test in the previous screening round was positive. This emphasizes the necessity of adopting risk-based screening intervals that consider HPV results from both the current and prior screening rounds.

Placental site nodule an uncommon diagnosis: case series

Dr Divya Agarwal, Prof.Kerryn Lutchman Singh, Mr. Nagindra Das

Aim: Three cases to discuss the various clinical presentations, diagnosis, histology, and management of placental site nodule.

Methods Used: A retrospective study of three case presented between September 2023-February 2024.

Results and Discussion: The mean age of our patients was 34(23-44) years.1st case presented 9 years after last caesarean section with heavy menstrual bleeding, dyspareunia, and non-healing CS scar non responsive to mini pill. 2nd case presented 5 years after vaginal birth with heavy menstrual bleeding not given any treatment and 3rd case presented 5 years after her last caesarean section with irregular bleeding not responding to Mirena coil. All these cases highlight the importance of suspecting the diagnosis of placental site nodule in a parous woman with persistent undiagnosed vaginal bleeding.

Conclusion: In, patients presenting with undiagnosed persistent abnormal vaginal bleeding after childbirth suspicion of placental site nodule should be considered. Placental site nodule develops due to remnants of trophoblastic tissue, so placental examination after childbirth is important to ensure completeness of placenta removal. Although, considered to be a benign disease, placental site nodule could undergo malignant transformation so serial follow up with beta Hcg is vital.

Foetal sacrococcygeal teratoma

H Jeetun, R Roberts, W Taylor, L Nithin, S Sekar Wrexham Maelor Hospital, Betsi Cadwaladr

Aim: To raise awareness of this rare fetal condition and discuss the challenges of managing fetal sacrococcygeal teratoma. Sacrococcygeal teratomas are a congenital tumour rising from a subtype of germ cell tumors, with an incidence of 1 in 20 000 – 40 000 live births.
Methods Used: Case Report

Results and Discussion: A 20-year-old primigravida was originally midwifery lead care had a 20-week anomaly scan revealing a cystic structure at the base of the spine. She was referred to the Foetal Medicine Unit (FMU). The FMU scan showed a large complex mass with cystic and solid components arising from the caudal region of the fetus. Differential diagnosis at this time included caudal spina bifida or sacrococcygeal tumour. The patient was referred to a tertiary unit for expert opinion. The tertiary centre confirmed a diagnosis of type II sacrococcygeal teratoma with significant polyhydramnios. Their plan was for delivery was a Caesarean birth at 38 weeks to minimise the risk of bleeding into the cyst. Amnioreduction and steroid administration was done at 32+1.At 33+5/40 the patient to the maternity triage unit with reduced foetal movements. Whilst on the ward her waters broke, She started tightening 30 minutes later and was transferred to labour ward. She was contracting 2/3 in 10. A multidisciplinary team meeting was organised between the paediatricians, obstetricians at both the DGH and tertiary unit and the local anaesthetists. It was clear that the ideal place for delivery was the Tertiary unit given the proximity to the tertiary paediatric hospital and their surgical expertise. To facilitate transfer, nifedipine regime was commenced despite the pre-term pre-labour rupture of membranes. Contractions settled, there were no cervical changes, and the patient was safely transferred to the Tertiary centre. She went onto deliver a day later.

Assessing diagnostic compliance in women with endometrial cancer against suspected cancer pathway standards in Southwest Wales

Dr Alifya Mukadam (SBUHB), Dr Muhammad Alshuaibi (SBUHB), Dr Isobel Stuart (CTMUHB), Dr Tanitia Dooley (HDUHB), Mr Nagindra Das (SBUHB), Prof. Kerryn Lutchman- Singh (SBUHB)

Aim: To evaluate diagnostic compliance with National Optimal Pathway for endometrial cancer in Southwest Wales.

Material and Methods: The gold standard for endometrial cancer SCP is a compliance rate of 75%. Patients with a diagnosed endometrial cancer were identified from a prospectively collected SBUHB database. SGOC provides a central review of all cases diagnosed with endometrial cancer for Southwest Wales. The review compares data from January to June 2022 and January 2023 to June 2023, collected and confirmed Welsh Clinical Portal, and Patient Administrative Systems. Data collection focused on the pathway from the Point of Suspicion (PoS) to the decision to treat, any delays and causation was identified, and statistical analyses performed using SPSS.

Results: The total number of patients identified was 79 (54/27) in both years. Compliance with patients being seen in <7 days from PoS decreased from 15% in 2022 to 11% in 2023, likely due to clinic capacity. Adherence to same- day OP hysteroscopy increased from 91% in 2022 to 100% in 2023. The mean histology reporting time increased from 10 days in 2022 to 12 days in 2023. Compliance with MRI requests for suspected cases decreased from 69% in 2022 to 63% in 2023; however, the percentage of MRI reports ready by the MDT date (day 21) increased from 72% in 2022 to 80% in 2023. The median duration of the diagnostic pathway increased from 59 days to 70 days within the second year, the standard being 28 days.

Conclusion: Delays in review by the one-stop clinic, increased pathology reporting times, and instances of additional diagnostic tests being requested were the primary causes of delays. Fast-tracked processes will be implemented to enhance the pathway and mitigate the issues, with a further service improvement evaluation.

Assessment of referrals with postmenopausal bleeding following new or changed hormone replacement therapy

Dr Alexandra Buckle, Dr Daniel Sim, Dr Sean Watermeyer

Aim: To assess the extent of inappropriate referrals to the Gynaecology Rapid Access Service (GRAS) for postmenopausal bleeding (PMB) following new/ changed hormone replacement therapy (HRT) in the previous 6 months.

Methods: Audit standard - The British Menopause Society advises unexplained vaginal bleeding in postmenopausal women should be referred after 4-6 months following new or changed HRT on an urgent suspected cancer pathway. This is a prospective audit, running May 2023 to present in GRAS, Royal Glamorgan Hospital, South Wales. Those included are patients with PBM on HRT referred from General Practice (GP) to GRAS. A percentage was calculated of those with new/changed HRT within 6 months of referral (aka inappropriate referral), plus review of investigations for neoplastic diagnosis.

Results: Sample size at the time of writing was 37(19/02/24). In 16% (6/37) of referrals, HRT had been started/changed within 6 months. Of these, 50% (3/6) were within previous 3 months. The referrals were spread throughout the audit time frame. None of the patients referred within 6 months had a neoplastic diagnosis.

Conclusion: This audit demonstrates patients with PMB following new/changed HRT are consistently being inappropriately referred. This does not meet the audit standard. The ramifications are felt at a patient level as the process causes avoidable inconvenience and stress. Additionally at a service level, in both primary and secondary care, with unnecessary referral administration and the opportunity cost of resources & services used.

Going forward, two interventions will be delivered. First, an advice sheet on referral guidelines circulated within GP. Second, return of referral if within 6 months of new/changed HRT with request to re-refer once appropriate. The audit will continue data collection for a further 6-months and re-audit to assess for change in practice.

Malignant mixed germ cell tumour with combination of immature Teratoma and yolk sac tumour: a case report

Dr Divya Agarwal, Prof.Kerryn Lutchman Singh, Mr Nagindra Das
(Singleton Hospital, Swansea)

Aim: We report a rare case of a malignant mixed germ cell tumour in a young patient with aim of raising awareness in terms of early diagnosis and highlighting the key issues with clinical findings and management issues.

Methods: The case presented is a lady on one patient who in her early thirties presented with abdominal pain and distension with right adnexal mass and was reported to be non-malignant initially.

Results and Discussion: She had markedly elevated Alpha fetoprotein at 2374 kU/L, elevated CA125 at 81 kU/L and slightly elevated LDH at 306 U/L. Imaging showed a heterogenous solid mass of 17.8 X 10 X 14.6 cm in right adnexa and after discussion with multi-disciplinary team, patient was planned urgently for exploratory laparotomy with right salpingo-opherectomy and infracolic omentectomy for suspicious germ cell tumor. Conservative surgery was done with aim of preservation of fertility and diagnosis and staging of disease which is recommended. Patient was surgically stage 1C2 due to preruptured ovarian tumour. Lymphadenectomy was not done as node dissection has no better outcome and the only indication is when the nodes are enlarged. Histopathological examination revealed mixed germ cell tumour with 99% immature teratoma and 1% yolk sac component, which is the 2nd most common presentation. Patient was planned to start with standard regime of bleomycin, cisplatin and etoposide and was followed up with tumour markers weekly, which showed a declining trend Also, clinical examination and imaging showed resolution of mass.

Conclusion: Malignant mixed germ cell tumours of ovary are rare tumours affecting reproductive age group women but with multi-disciplinary approach, early diagnosis, fertility sparing surgery and multi agent chemotherapy and extensive follow up, prognosis can be improved. Treatment must be individualized on the basis of tumour type, surgical staging, and availability of combination chemo- therapy.

Uterine angiosarcoma diagnosed via endometrial biopsy: exploring the impact of oral progesterone therapy on associated lung metastasis – a Case study

Rafeef Abu Shamleh, Professor Kerryn Lutchman-Singh, Dr Nagindra Das and Dr Shaun Roberts, Liam Mcknight. Swansea Bay University Health Board

Aim: Primary angiosarcoma affecting pelvic organs, including those of the female reproductive system, represents a rare yet highly aggressive malignancy characterized by a poor prognosis. Due to its rarity, comprehensive studies regarding this category of neoplasms remain limited. Consequently, elucidating prognostic factors and determining optimal treatment strategies remain challenging. In this report, we present the case of a 54-year-old female patient diagnosed with uterine angiosarcoma following an endometrial pipelle biopsy prompted by complaints of heavy uterine bleeding and the presence of an endometrial polyp. Remarkably, comprehensive evaluation revealed an incidental finding of lung metastasis, which exhibited regression in size during the patient's course of treatment for the uterine bleeding utilizing oral progesterone therapy.

Methods Used: Histopathological and Immunohistochemical Analysis: The excised tissue underwent fixation in 10% buffered formalin followed by embedding in paraffin. Sections were meticulously prepared for IHC staining. A panel of antibodies targeting specific antigens was employed for staining, including ERG, CD31, p53, CD34, CK7, p16, Pax8, WT1, CD45 and others.

Results and Discussion:
The observed characteristics on immunohistochemical analysis were indicative of a poorly differentiated malignancy. Positivity for vascular markers strongly supported the diagnosis of angiosarcoma, underscoring the pivotal role of immunohistochemistry in accurate diagnosis. Particularly intriguing was the response of the lung nodules, exhibiting regression followed by subsequent enlargement with progesterone therapy, notwithstanding the tumor cells testing.
negative for progesterone receptor expression. This paradoxical response warrants further investigation and underscores the complexity of tumor biology and treatment response.

Conclusion: The prevailing literature predominantly advocates for the surgical approach of total abdominal hysterectomy (TAH) along with bilateral salpingo-oophorectomy (BSO) for the management of this condition. However, a consensus
regarding the optimal treatment strategy remains elusive, particularly concerning the necessity of pelvic lymphadenectomy. Existing data regarding chemotherapy regimens are scarce and lack established protocols. Notably, our investigation revealed that in cases where the tumor diameter measures 5 cm or less and invasion of less than half of the myometrium is observed, there may be potential to enhance prognosis through wide resection surgery alone.

Audit to review informed consent process in obstetrics and Gynaecology

Dr Neha Uddin (Singleton Hospital)

In the realm of surgical specialties, particularly within obstetrics and gynaecology, the process of obtaining informed consent stands as a cornerstone of patient-cantered care.

Aim: Our study aimed to comprehensively review the consent process across surgical specialties, particularly in obstetrics and gynaecology, to assess compliance with the 90% standard and enhance patient-centred care.

Methods Used: Retrospective data collection involved randomly sampling 30 case notes from patient who underwent elective procedure in Swansea Bay University Health Board during April/May 2022. Utilizing the Audit Management and Tracking system (AMaT), data on demographics, consent dialogue documentation, two-stage process implementation, shared decision-making, risk and benefit discussion, and informational leaflets were collected while ensuring patient confidentiality. A re-audit was conducted after 12 months to assess practice improvement.

Results and Discussion: Analysis revealed that 80% of cases were done in Singleton Hospital. Elective procedures comprised 80% of cases with an equal distribution between day cases and inpatient surgeries. While consent dialogue was present in all cases, only 40% were documented in the notes, and shared decision-making was observed in 90% of cases but documented in only 50%. There was full compliance with using correct consent forms and comprehensive risk-benefit discussions. However, documentation regarding PIL distribution remained only at 33% and 16% mentioning the title.

Conclusion: To improve the practice changes were suggestive in the audit meeting which included prefilled consent forms with risk and benefit stickers. Additionally, importance of meticulous documentation was to enhance the quality of consent dialogues. Furthermore, it was emphasized PILs could be referenced directly on the consent form. The reaudit demonstrated encouraging progress, consent dialogue documentation increased to 90% from previously recorded 40%, shared decision-making documentation to 95% from initial 90%. All consent forms were complete with risk and benefit. However, PIL distribution documentation remained suboptimal at 40%. These findings highlight the ongoing journey toward enhancing patient care.

Reauditing caesarean births, how good we are in vbac success

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Aim: To complete the cycle of a previous audit on the caesarean section and VBAC rates by reauditing our care after implementing the recommended changes drawn from the previous audit.

Methods Used: Collecting and analysing data of all caesarean sections done (228) during a similar period and time of the year as the previous audit (April to June 2023). More emphasis has been given to emergency caesarean sections and VBAC this time.

Results and Discussion: The analysed data showed the following main results: 60% of women who were eligible for VBAC chose to have elective CS during the previous audit, where it has become 50% in the reaudit after implementing the birth choice clinics. Women received more support by seeing a consultant midwife in a dedicated session. Out of the 50% who attempted VBAC, 57% had a successful VBAC delivery which was around 48% previously, but that's still below RCOG standard (72%). The reaudit showed similar results on postdates pregnancies, as it was associated with almost 50% of "failure to progress" labours. Reauditing data confirmed that neither high BMI nor large babies directly affected CS numbers as the number of women with BMI 30- 40 who delivered vaginally was almost twice the number of who delivered by EMCS, and the number of babies weighing > 4kg that delivered vaginally was almost twice that delivered by EMCS. Failure to progress was still the most frequent reason of EMCS (40%) in the reaudit, followed by foetal distress (21%). However, 90% of babies were born with normal cord blood gases and only one baby had cord blood pH below 7. Only 2% of EMCS were done after unsuccessful operative delivery, compared to 6% in the previous audit.

Conclusion: Providing dedicated sessions for women who had a caesarean section has helped to encourage more women to attempt and attain VBAC, consequently reducing maternal morbidities and mortality associated with high order caesarean sections. Hence, having a designated VBAC clinic is recommended. Postdates pregnancies increased the likelihood of EMCS, therefore, IOL at term + 7 is a justified clinical recommendation that in keeping with the latest evidence and NICE guidance. An annual local departmental workshop on instrumental birth for middle grade doctors has improved the expertise in using forceps and ventose resulting in a reduction in the rate of unnecessary and riskier second stage caesarean birth.

Postpartum Choriocarcinoma: A light in a dark time

Claudia Hardy

A 28-year-old woman attended the maternal assessment unit two weeks after her second normal vaginal birth. She had been suffering with right "sciatic" pain two weeks before delivery. Had epidural during labor and spinal anesthesia for manual removal of placenta. Since delivery she was noticing numbness and hypersensitivity through her right leg. Attended after her symptoms got worse with lower back pain, right buttock shutting pain spreading down her leg with tingling sensation on the right leg and some numbness on the right foot. No past medical history other than a previous left breast lump biopsy 10 years ago, that was benign. No previous medications or family history. Bladder retention was noted, and indwelling catheter inserted. She was assessed promptly by anesthetic team and an MRI spine was performed, which showed abnormal signal in L3, L4, L5 vertebral bodies and in the sacrum with moderate enhancement of the dura throughout the sacrum. There was abnormal soft tissue along the sacral plexus and sacral nerve roots on the right-hand side with soft tissue enhancement around L3. A brain MRI showed an 8 mm lesion in the right occipital lobe region with mild oedema but no mass effect. CT chest, abdomen and pelvis shown multiple lung and liver metastasis with diagnosis of metastatic cancer of unknown primary, was discussed with neurosurgeons and the MDT plan was to give steroids and have urgent radiotherapy of the sacrum and arrange liver biopsy. Tumor markers were obtained, and HCG was actively chased with a hope of a treatable cause. As soon as HCG came back raised at 42.157iu/L a referral to the Trophoblastic Centre was arranged.

In the Trophoblastic Centre the basal HCG was 37427 iu/L and a CSF HCG after lumbar puncture was 1101 iu/l (higher than the 1/60 ratio. Low dose induction Etoposide and cisplatin (EP) was given for two days, that was repeated one week later with the first Methotrexate intrathecal. The level of HCG before this second cycle reached 213.298 iu/l. Two weeks after induction dose she started management with EMA (with the Methotrexate given at 1g per m2 due to known CNS disease.) Completed 7 full cycles, complicated with pancytopenia, a chest infection, complete hair loss, fatigue, tiredness, and some hearing changes. Was on weekly serum hCG for 6 weeks then monthly serum and urine hCG for 6 months, 12 weekly urine for 2 years and finally will be sending 6 monthly urine hCG for 10 years.

Antenatal fetal moulding caused by leiomyoma in pregnancy: a case report

Dr Pandey A, Dr Themis L, Mr. Mechery J, Ysbyty Glan Clwyd, BCUHB.

Aim: We report an exceedingly rare case of antenatal foetal moulding diagnosed on MRI secondary to a large intra-mural fibroid.

Methods Used: A 31 years primigravida was incidentally found to have a large intra-mural fibroid in the lower uterus on her dating scan. The implications of this fibroid were discussed in the high-risk consultant-led antenatal clinic and serial growth scans requested. The possibility of an elective Caesarean section if the fibroid encroaches lower segment was discussed as well.

At 27+3 weeks gestation, she presented with signs of threatened preterm labor and received corticosteroids. At this time MRI was done which showed- an intramural fibroid in the right lower uterine wall measuring 12cm by 4cm and associated with fetal skull moulding and occipital oedema. Subsequently, she represented with preterm rupture of membranes at 29+4weeks gestation. She started contracting with an abnormal CTG. Consequently, an emergency caesarean section was performed.

Intra-operatively there was 10x10cm intramural fibroid on the right lateral wall of the uterus involving the lower segment. There was evidence of swelling of the fetal head at delivery. Both mother and baby progressed well post-operatively.
Results and Discussion: This case demonstrates an atypical presentation of fibroid causing antenatal fetal head moulding and occipital oedema. The dilemma in such cases is the uncertainty of progression of the moulding and timing of delivery. There is no universally accepted guidance on managing pregnancy and labor in such cases.

Conclusion: Leiomyoma in pregnancy can increase the risk of intra-uterine growth restriction, placental abruption, miscarriage, pre-term labour, malpresentation, obstructed labour, retained placenta and post-partum haemorrhage. The management during labour depends on whether the fibroid is obstructing delivery. This is a unique case where foetal moulding developed without the women going in labour secondary to compression effect of large intra-mural fibroid.

Pressurised intraperitoneal aerosolised chemotherapy (pipac) in the management of cancers of the colon, ovary and stomach: a randomised controlled phase ii trial of efficacy in peritoneal metastases

Anu Ajakaiye[1], Elena Brogden[2], Jamie Murphy[3], Christopher Peters[3], Jonathan Frost[4], Richard Adams[2], Sarah Gwynne[5], Emma Hudson[6], Kitrick Perry[3] Angela Casbard[2], Rebecca Hamilton[2], Lisette Nixon[2], Karen Arndell[1], Sadie Jones[1], Jared Torkington[1]

Aim: Up to 13%, 50% and 14% of patients with bowel, ovarian and stomach cancer respectively, present with peritoneal metastases (PM) which is difficult to treat with conventional chemotherapy. Pressurised Intraperitoneal Aerosol Chemotherapy (PIPAC) which delivers chemotherapy into the peritoneal cavity, directly to the tumour site, as an aerosol during keyhole surgery is emerging as a potential new strategy. This trial aims to determine if PIPAC given with (colorectal, stomach) or instead of (ovarian) systemic anti-cancer therapy (SACT) improves Peritoneal Progression Free Survival (pPFS) compared to standard SACT

Methods: PICCOS trial (PIPAC In Cancers of the Colon, Ovaries and Stomach) is a multi-arm, prospective randomised controlled trial (RCT) in the UK designed to provide high quality evidence regarding the efficacy of PIPAC in improving pPFS. Each cancer type will have individual eligibility criteria and protocols to allow for the necessary variations in treatment. In all cancer types, patients will be randomised in a 1:1 ratio to receive either standard SACT or a combination of standard SACT and/or PIPAC, where three PIPAC procedures are performed. We aim to recruit 78 colorectal, 66 ovarian and 72 stomach cancer patients over 2.5 years and follow-up will last for a minimum of 6 months.

Conclusion: This is the first UK RCT assessing the efficacy and impact on quality of life of PIPAC in the treatment of PM. PICCOS aims to provide high quality evidence to guide clinical practice and further research.

To assess surgical compliance with the national optimal pathway for endometrial cancer in southwest Wales

Dr Muhammad Alshuaib, Mr Nagindra Das, Prof. Kerryn Lutchman Singh, Swansea Bay University Health Board

Aim: To ensure compliance with the National Optimal Pathway (NOP) for Endometrial Cancer with a target rate of 70%, identify areas of non-compliance, and provide recommendations for improvement.

Methods Used: Utilizing electronic medical records and reviewing clinical letters and surgery logs for 80 patients, the audit compared data from January to June 2022 with that of January to June 2023.

Results and Discussion: Findings revealed significant non-compliance, with only 3.75% of patients adhering to NOP. Reasons for non-compliance varied, including insufficient surgical capacity (76.25%), patient-related issues (8.75%), surgeon unavailability (5%), inadequate theatre time (3.75%), and the need for further investigations (2.5%). However, from an audit conducted on the diagnostic pathway within the same cohort, we discovered that most patients entered the surgical pathway after already breaching the SCP target. Recommendations were proposed to address these issues, such as increasing surgical capacity, optimizing diagnostic pathways, enhancing theatre scheduling, ensuring adequate staffing, expediting investigations, and improving documentation for cancellations.

Conclusion: While justifiable reasons for non-adherence were identified, the overall compliance with the NOP remains unacceptably low. We have implemented short-term measures to improve surgical capacity, however, definitive measures have been put in place with the aim to conclude the diagnostic pathway by day 28. The process will be re-audited for the first 6 months of 2024.

Diagnostic challenges and management of pelvic mass with endometrial adenocarcinoma: a case report

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Aim: To report unusual presentation of endometrial cancer with unusual initial presentation. A literature review is conducted to speculate symptoms presented by endometrial cancer other than vaginal bleeding.

Methods Used: Involve a retrospective review of the patient's medical records, diagnostic evaluations, treatment interventions, and follow-up outcomes.

Results and Discussion: The 69-year-old female patient presented with urinary incontinence. Subsequent imaging showed a hugely distended fluid filled pelvi-abdominal mass. It was difficult to clarify if the mass was tubo, ovarian or uterine in origin following imaging and attempted hysteroscopy. A hysterectomy was offered to the patient to obtain a definitive diagnosis on a recommendation of Gynae MDT. Pathology revealed fluid filled uterus which on microscopic examination contained grade II endometrioid-type endometrial adenocarcinoma not underscores the complexities in managing uterine masses and endometrial adenocarcinoma, emphasizing the importance of individualized treatment approaches and close follow-up.

Conclusion: This case identifies the importance of obtaining a definitive diagnosis of post-menopausal women with pelvic masses, especially when the typical symptom of PMB is not evident.

Management of Gitelman syndrome in pregnancy

Khalid Alloush, Tabitha Oosterhouse. Betsi Cadwaladr University Health Board

Aim: To describe management of Gitelman syndrome in pregnancy

Methods Used: Case review

Case report: A 30-year-old, gravida 2 para 1 patient presented for booking with history of Gitelman syndrome. Early joint management of the patient's pregnancy started involving obstetric medicine and nephrology. Patient-initiated follow-up and regular monitoring of electrolyte profile while adjusting the medications accordingly led the doses to almost double over the pregnancy period. By term, they were adjusted to 30 mmol of potassium chloride 4 times daily, 15 mg of amiloride twice daily, and 40 mmol of magnesium glycerophosphate 4 times daily. This caused gastrointestinal upset and omeprazole was started on a when-required basis because it may reduce magnesium level. Delivery plan by a multi-disciplinary team advised intravenous replacements of potassium if it goes below 3.2 and magnesium if below 0.55. The patient had forceps delivery at term due to fetal distress in second stage having a healthy baby. On the first day postpartum, magnesium level dropped to 0.45, which was corrected by intravenous magnesium sulphate. The patient was discharged from obstetric care for nephrology follow-up. Postpartum, the patient went back to pre-pregnancy doses and the gastrointestinal upset resolved.

Discussion: Gitelman syndrome is a rare autosomal recessive condition causing salt-losing tubulopathy leading to hypokalaemia and hypomagnesaemia. Patients are often asymptomatic or present with symptoms such as muscle weakness, fatigue, cramps, or hypotension. Individualised oral replacement of potassium, magnesium or both is the mainstay of management. Potassium-sparing diuretics, and renin angiotensin system inhibitors have been proposed. Aggravation of hypokalaemia and hypomagnesaemia is known in pregnancy and should be anticipated and managed on an individual basis.

Conclusion: Careful monitoring, patient-initiated follow-up and multidisciplinary team approach are advised in management of Gitelman syndrome in pregnancy.

An Audit of Patient's Satisfaction in an Outpatient Hysteroscopy Clinic Setting

H S Naseem, Z Ilyas. Ysbyty Gwynedd

Outpatient hysteroscopy (OPH) is performed in conscious patients; therefore, the qualitative questionnaires can be reflective of quality of care provided to the women.

Aim: We aimed to review experiences of women attending the outpatient hysteroscopy clinic (OHC) in Ysbyty Gwynedd Hospital.

Methods Used: Data collection was prospective. BSGE Outpatient Hysteroscopy Patient Satisfaction Survey was used for data collection.

Results and Discussion: Number of patients were 62. All patients undergoing diagnostic and operative hysteroscopy were included for the month of December23 and January24. Majority, 95.1% received written information prior to appointment in the form of information leaflet.85.4% strongly agreed that they were offered opportunity to discuss pain relief and 93.6% strongly agreed to the fact that they felt they were involved in decision making. Over 90% strongly agreed they were treated with dignity, respect, and given privacy. Moreover, 98.4% felt aspects of care were dealt with confidentiality and staff were courteous and polite, 83.9% strongly agreed that they will choose outpatient hysteroscopy if they were in the same situation again, 95.2% felt the care was excellent. Mean score for level of discomfort /pain during hysteroscopy was 4.5 out of 10 which was lower than the worst level of pain experienced during a period (5.3/10). The Global rating of overall care was extremely high, with a mean score rating of 9.6 out of 10. These findings suggest that for the vast majority of women, OPH is a safe and tolerable experience.

Conclusion: The survey comprehensively assessed all aspects of the patients OPH journey. Overall, the mean pain score for OPH was less than the worst level of pain or discomfort experienced during a menstrual period as reported in published literature. Outpatient hysteroscopy is an acceptable experience for women attending our gynaecology services.

A case of maternal McArdle disease associated with fetal supraventricular tachycardia

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Background: McArdle disease, also known as glycogen storage disease type V, is a rare genetic disorder characterized by a deficiency in myophosphorylase enzyme. This enzyme is crucial for glycogen breakdown in skeletal muscle. Its impact on pregnancy and fetal development remains poorly understood with only a few cases published in the literature. Here we present the case of a 32 year old, nulliparous woman with McArdle disease whose antenatal period was complicated by the development of fetal supraventricular tachycardia.

Case presentation: She was booked for consultant led antenatal care and was first seen at 17 weeks' gestation. At a 30 week antenatal appointment the fetal heart was auscultated at 220 beats per minute. Subsequent ultrasound scan confirmed a persistent fetal tachycardia, no structural cardiac anomaly, and no evidence of hydrops fetalis. Referral was made to the tertiary fetal medicine center where the diagnosis of supraventricular tachycardia (SVT) was made. The woman was commenced on digoxin to control the fetal heart rate which was ineffective and subsequently changed to flecanide. This was successful at reducing the fetal heart rate to 180 bpm. A planned delivery by elective caesarean section is booked at 39 weeks gestation.

Conclusions: To our knowledge this is the first reported case of maternal McArdle disease associated with fetal SVT. Little is known about McArdle disease in pregnancy, the rarity of both conditions in this case raises the possibility of an association. This case report contributes to the limited existing evidence base.

Enhancing maternal and Neonatal Outcomes: A Quality improvement Initiative in Instrumental Deliveries

Aysha Afzal Qureshi, Saima Naseem, Madhu Kolli. Grange University Hospital

Aim: To audit trial of instrumental deliveries at Grange University Hospital (Wales) , comparing performance against RCOG standards to enhance health care service delivery and improve maternal-neonatal outcome.

Methods Used: Retrospective data collection over a period of 3 months involved reviewing patient records, including uploaded clinical and surgical notes. A total of 69 patients were included who underwent either assisted vaginal delivery in theatre or failed trial leading to emergency caesarean section.

Results and Discussion: Out of 69 patients, 47 had instrumental deliveries, 22 had Emergency Caesarean section. 6 patients were under 25 years old,13 were over 35, and 50 were aged 25-35. 60 patients were P0,8 were P1 and 1 >P1. Documentation rates for per abdominal examination were 17% and for vaginal examination were 98%. Among patients who had assisted vaginal delivery, documentation rates for cervical dilatation were 100%, caput was 83% and moulding 45%, station mentioned in 78% cases and delivery position in 55% cases. Indications for instrumental delivery and instrument type were clearly documented in all cases, with 89% documenting number of pulls. Timings of instruments applied documented in 34% cases and time of delivery in 38% cases. Any complications if occurred were documented in all cases along with measured blood loss in 96% cases.

Conclusion: The RCOG standards and criteria for assisted vaginal deliveries were generally followed in all cases, but some essential documentation was lacking, such as abdominal examination, details on the number of pulls, timings, and neonatal head extraction. We recommended implementing standardized Instrumental delivery proforma for all cases, including theatre trials, and uploading scanned copies onto digital system to streamline documentation during digital integration. Additionally, a proposal was made to implement the WHO checklist for Instrumental deliveries in the room, with plans for a re-audit in 3 months to confirm compliance.

WISDOM

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