

Autumn Conference 2012

Parkway Hotel, Cwmbran, Newport

Royal Gwent Hospital

Aneurin Bevan Health Board

19th October 2012



Introduction

We would like to welcome everyone to the Autumn Meeting of the Welsh Obstetric and Gynaecology Society, 2012 held in the Parkway Hotel, Cwmbran, Newport.

We have excellent Guest Speakers of National and International fame who have given their valuable time and effort to support the meeting. A wide variety of topics will be covered taking care of everyone’s interest. The meeting is held in the Pembroke suite and posters will be displayed in the Monmouth suite. Tea, Coffee and lunch will be provided in the lounge along with the medical representative stalls.

We hope that you will have an enjoyable and informative time in the warm hospitality environment. We also thank all the representatives who have supported our meeting.

Sajitha Parveen, MSc MRCOG Makiya Ashraf, FRCOG

Consultant Obsterician and Gynaecologists / Meeting organisersWelsh Obstetrics & Gynaecology Society Meeting

**19 th October 2012**- **Programme**

9:00 Registration, Coffee and Tea

Session 1 Maternal Medicine Chairperson – Mrs Anju Kumar

9:15 Hypoxia in labour: Myths and reality Mr Lawrence Impey, Consultant in Foetal Medicine

John Radcliffe Hospital, Oxford

10:00 Early prediction of pre-eclampsia Mr Ranjit Akolekar, Consultant Obstetrician

King’s College Hospital, London

10:45 Obituary Mr Weerakkodi and Mr Daniel

11:00 Mothers of Africa- Volunteering in Liberia Dr Tei Sheraton, Consultant Anaesthetist,

Royal Gwent Hospital

11:10 Poster viewing, Coffee and Tea

Session 2 Gynaecology Chairperson - Mr Abdelmajid

11:30 Laparoscopic Simulation Training - Ray O’Sullivan, Consultant Gynaecologist

Can the Dublin Model be applied in Wales? St Luke’s Hospital, Kilkenny.

12:15 Oncology update – Nigel Acheson, Consultant Gynaecologist,

Enhanced recovery – fulfilling the potential Royal Devon and Exeter NHS Foundation Trust

13:00 Lunch and Poster viewing

Session 3 Free Communication Chairperson - Ms Goddard

14:00 Oral Presentations 5 x 10 minutes presentations

15:00 Coffee and Poster Viewing

Session 4 Medico legal Issues Chairperson – Mrs Gokhale

15:15 Medico legal issues in Obs & Gynaecology Mr Roger Clements,

-How to reduce it? Fellow of the Academy of Expert Witness

16:00 ‘HRT, dare we use it?’ Mr David Sturdee, Consultant Gynaecologist,

Solihull Hospital

16:30 Medicine in Writing Dr Lyn Griffiths, Medico-legal Adviser for MPS

17:15 Prizes and closing Remarks

17:30 Society Business Meeting

SPEAKER PROFILE

**David William Sturdee**

MB BS (Lond), MD (Birm), DA, FRCOG

He qualified from St Thomas' Hospital Medical School in London in 1969 and has had a special interest in the menopause and hormone therapy since 1975, when he was appointed as research fellow and took over the running of the first menopause clinic in England at Birmingham University. He was awarded MD from Birmingham University for a thesis based on research, particularly of the hot flush and the effects of hormone therapy on the endometrium and bleeding. He has continued research in these and other areas and has published extensively, including 40 original articles in peer-reviewed journals and 7 books. He was a founder member of the International and British Menopause Societies, a past honorary treasurer and chairman of BMS. He was co-editor in chief of Climacteric, the journal of IMS, from 1998-2008 and is the immediate past President of IMS.

SPEAKER PROFILE

**Dr Lawrence Impey BA, MBBS, FRCOG**

NHS Consultant in Obstetrics and the Fetal Medicine lead at the John Radcliffe Hospital, Oxford, OX3 9DU, UK since 2001.

He was qualified from Oxford University and The Middlesex Hospital, and trained in London, Oxford and Dublin.

**2. Books**

1. Undergraduate textbook in Obstetrics and Gynaecology (1st ed 1999). This won the 1999 RSM Asher Prize and has been translated into Portuguese and Danish. The 4th ed was published in 2012 as ‘Obstetrics and Gynaecology’, L. Impey and T. Child.

2. Co-senior editor (with S Arulkumaran) of the ‘Oxford Handbook of Obstetrics and Gynaecology’ 2nd edition. S. Collins, S. Arulkumaran, K. Hayes, S Jackson, L. Impey.

**3. Research interests**

1. The role of labour in adverse neonatal outcomes

*Selected publications:*

P Yeh, K Emary, **L Impey**

The relationship between umbilical cord arterial pH and serious adverse neonatal outcomes: analysis of 51 519 consecutive validated samples.

BJOG 2012; 119:824-831

**L. Impey**, C. Greenwood, R. Black, P. Yeh, O Sheil, P. Doyle. ‘The relationship between intrapartum maternal fever and acidosis as risk factors for neonatal encephalopathy’. American Journal of Obstetrics and Gynaecology 2008; 198: 49.e1-6.

**L. Impey**, K. MacQuillan, M. Reynolds, S. Gates, J. Murphy, O. Sheil ‘Admission cardiotocography: a randomised controlled trial’. The Lancet 2003; 361: 465-70

2. Investigation of early pregnancy ultrasound markers for IUGR

Collaboration with Oxford University Dept of Engineering, funded by BRC:

*Selected publications:*

S Collins, G Stevenson, A Noble, **L Impey**

Developmental changes in spiral artery blood flow in the human placenta observed with colour Doppler ultrasonography

Placenta 2012 (in press)

S Collins, G Stevenson, A Noble, **L Impey**, A Welsh. ‘Influence of power Doppler gain setting on Virtual Organ Computer Analysis (VOCAL) indices in vivo: Can use of the individual sub-noise gain (SNG) level optimise information?’ Ultrasound in Obstetrics and Gynaecology (in press)

A Welsh, S Collins, G Stevenson, A Noble, **L Impey**

Inapplicability of the Fractional Moving Blood Volume (FMBV) technique to standardise VOCAL indices for quantified power Doppler.

Ultrasound in Obstetrics and Gynaecology 2012. doi: 10.1002/uog.11139. [Epub ahead of print]

S Collins, J Birks, G Stevenson, A Papageorghiou, A Noble, **L Impey**

‘Measurement of the spiral artery jets: general principles and differences observed for small for gestational age (SGA) babies’

Ultrasound in Obstetrics and Gynaecology 2011. doi: 10.1002/uog.10149. [Epub ahead of print]

3. Breech presentation

*Selected publications:*

S. Collins, P. Ellaway, D. Harrington, M. Pandit, L. Impey. ‘The complications of external cephalic version: results from 805 consecutive attempts’. BJOG 2007 114: 636-8

**L. Impey** and M. Pandit. ‘Tocolysis for repeat external cephalic version after a failed version for breech presentation at term: a randomised double-blind placebo controlled trial’.

BJOG 2005; 112: 627-31

**4. National Guidelines**

With Justus Hofmeyr I wrote the RCOG Greentop Guidelines on ECV, and on Breech presentation.

SPEAKER PROFILE

Ranjit Akolekar:

Ranjit Akolekar is a consultant in Fetal Medicine at the Medway Maritime Hospital in Kent and King’s College Hospital in London. He trained in obstetrics and gynaecology initially at the Royal Infirmary in Edinburgh and following completion of his general training went on to work in London at King’s College Hospital. He took up a clinical research fellowship in Fetal Medicine at Harris Birthright Research centre under the guidance of Professor Nicolaides and worked on several research projects. Following completion of the research fellowship, he subsequently went on to pursue sub-specialty training in Fetal Medicine at Kings college. His main research work focused on prediction of preeclampsia in first trimester and he has several peer-reviewed publications in this field. He leads the Fetal Medicine department at Medway and continues his research interests in placental dysfunction.

Selected recent publications:

1.    Akolekar R, Syngelaki S, Poon L, Wright D, Nicolaides KH. Competing risks model in early screening for preeclampsia by biophysical and biochemical markers. Fetal Diagn Ther 2012 DOI: 10.1159/000341264.

2.    Akolekar R, Finning K, Kuppusamy R, Daniels G, Nicolaides KH. Fetal RHD genotyping in maternal plasma at 11–13 weeks of gestation. Fetal Diagn Ther 2011;29:301-306.

3.    Akolekar R, Bower S, Flack N, Bilardo CM, Nicolaides KH. Prediction of miscarriage and stillbirth at 11-13 weeks and the contribution of chorionic villus sampling. Prenat Diagn. 2011;31:38-45.

4.    Akolekar R, Syngelaki A, Sarquis R, Zvanca M, Nicolaides KH. Prediction of early, intermediate and late preeclampsia from maternal factors, biophysical and biochemical markers at 11-13 weeks. Prenat Diag. 2011;31:66-74.

5.    Akolekar R, Farkas DH, Vanagtmael AL, Bombard AT, Nicolaides KH. Fetal sex determination using circulating cell-free fetal DNA (ccffDNA) at 11 to 13 weeks of gestation. Prenat Diagn. 2010:30:918-923.

6.     Chiu RWK, Akolekar R, Zheng YWL, Leung TY, Sun H, Chan KCA, et al. Noninvasive prenatal diagnosis of trisomy 21 by multiplexed maternal plasma DNA sequencing. BMJ 2011;342:c7401.

SPEAKER PROFILE

 **Mr Ray O’Sullivan FRCOG FRCEd FMIGS**

Qualified in Ireland 1992 followed by 3 years surgical training. General O&G training in Ireland followed by 2 fellowship programs in Urogynaecology and Minimally Invasive Gynaecological Surgery, both in Sydney, Australia. Currently a full time Ob/Gyn and Senior Lecturer in the Royal College of Surgeons in Ireland. Co-founder of Endosim, a surgical education company specialising in minimal access surgical simulation and education.

SPEAKER PROFILE

**NIGEL ACHESON**

Consultant Gynaecological Oncologist, Royal Devon and Exeter NHS Foundation Trust

Medical Director, Peninsula Cancer Network

National Clinical Advisor to the Enhanced Recovery Partnership, NHS Improvement

Hon Secretary, British Gynaecological Cancer Society

Born and brought up in Belfast, spent 20 years in Birmingham as a student, junior and consultant..

Consequently moved to Exeter in 2004, and has spent the last 8 years developing his clinical interest alongside his other interests – patient safety and service improvement.

This has taken him on a journey through NICE (VTE Guideline), a postgraduate certificate in patient safety, and most recently to his involvement in both Enhanced Recovery and the Peninsula Cancer Network.

SPEAKER PROFILE

**ROGER V CLEMENTS FRCS FRCOG (Ed) FAE**

**111 Harley Street,**

**London W1G 6AW.**

Consultant (O&G) North Middlesex Hospital 1973 - 1994. Medical Executive Director 1991 - 1994.

Risk Management Consultant QRM Healthcare Ltd.

Founding Editor: Clinical Risk.

Author: ‘Safe Practice in Obstetrics and Gynaecology’ 1994,

‘Clinical Directors Handbook 1995/6’,

‘Risk Management and Litigation in Obstetrics and Gynaecology’ 2002,

‘Medical Evidence’ 2002

Contributor to ‘Medical Negligence’ (Ed. Powers and Harris), ‘Clinical Risk Management’ (Ed. Charles Vincent), ‘Gynaecology’ (Ed. Shaw, Soutter & Stanton), ‘Turnbull’s Obstetrics’ 3rd Edition (Ed Chamberlain & Steer) Fetal and Neonatal Neurology and Neurosurgery (Ed Malcolm Levene and Frank Chervanek) 4th Edition 2009 and ‘Medicine for Lawyers’

Member Clinical Disputes Forum

Founding Governor: Expert Witness Institute. Fellow of the Academy of Experts.

Over 3000 Medico-Legal Reports in Civil Litigation (plaintiff and defendant), Crime, Disciplinary Inquiries and Industrial Tribunals. Oral evidence on some 100 occasions in the High Court, County Court, Disciplinary Inquiries, General Medical Council and Industrial Tribunals, in United Kingdom, Republic of Ireland and New South Wales..

SPEAKER PROFILE

**Dr Robert Lyn Michael Griffiths LLM MBBS MFFLM**

Lyn graduated with an MBBS degree from St Mary’s Hospital in 1976. He worked overseas in Bermuda in 1978 and 1979 before returning to undertake GP post graduate training in Warwickshire. He was a principal in General Practice in Rugby from 1983-1999. During this time he facilitated the establishment of a number of GP out of hours co-operatives and became a council member of the NAGPC. He was also a senior medical officer at a number of racecourses over a period of 28 years

Having been a Non-Executive Director of Warwickshire Health Authority from 1996, he was later appointed the Executive Director of Primary Care in 1999. He remained in this post until starting work as a Medico-legal Adviser for the Medical Protection Society in 2002.

He graduated with a Masters degree in Healthcare Law from Nottingham Law School in 2004 and is a founder member of the Faculty of Forensic and Legal Medicine at the Royal College of Physicians.

He continues to have a special interest in sports medicine and the health care provided by sporting organisations. Lyn is married with three children and still lives in Rugby.

**Session Three**

**Open Communication**

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| 2:00 PM | Welcome by Ms Goddard |  |
| 2:05 PM | Lynch syndrome diagnosis – A series of unfortunate events: A case report | Dr D Hughes |
| 2:15 PM | O&G trainees’ study day attendance survey in Wales 2012 | Dr F Drews |
| 2:25 PM | Improving vulval surgery patient information in the gynaecology department at UHW | Dr C Morgan |
| 2:35 PM | Severe pelvic Actinomyces infection diagnosed medically | Dr M Milward |
| 2:45 PM | Psychosocial impact of obstetric fistula in women presenting for surgical care in Tanzania | Dr Siddle |

**Panel of judges for Panel of judges for**

**Oral presentations Poster presentations**

Ruth Howells Simon Emery

Adnan Bunkheila Asoka Weerakkody

Anju Kumar Makiya Ashraf

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| **Title: LYNCH SYNDROME DIAGNOSIS - A SERIES OF UNFORTUNATE EVENTS: A CASE REPORT** |
| **Author(s): Daniel Llwyd Hughes,** Mr Richard Husicka. Withybush General Hospital |
| **Abstract:** |
| **Background:**  Recently, clinicians have become more confident with identifying cancer. This has stemmed from a combination of factors; such as an increase in education and the facilities to request for specific tumour markers. There is a universal understanding that early detection is key. Cancer may be the first presentation of an underlying hereditary cancer syndrome. These syndromes are associated with a much higher morbidity and mortality. How confident are doctors with identifying these syndromes?  Lynch syndrome is a hereditary cancer syndrome. Individuals have defective DNA mismatch repair genes, thus predisposing them to multiple malignancies.  **Case presentation:**  A 51 year old post-menopausal female presents with a 3 month history of intermittent vaginal bleeding. She was shortly diagnosed with an endometrial carcinoma. Her treatment regime consisted of a total hysterectomy and adjuvant radiotherapy. The patient then suffered 2 further episodes of malignant recurrence in the vaginal vault. A year later, the patient was diagnosed with a new primary cancer of her colon. Despite having an extensive family history of cancer, the patient was only referred to cancer genetic service after her colon cancer diagnosis. Shortly after her diagnosis with Lynch syndrome the patient was diagnosed with a recurrence of malignancy in her bladder.  **Conclusion:**  This case report highlights the importance of keeping an open mind when dealing with new cancer patients. Clinicians should ask the question "Does this patient have a hereditary cancer syndrome?” Diagnosis at a young age, multiple cancers and a strong family history are all strongly suggestive. The threshold for referring these individuals to a genetic service must be lowered. Early identification of hereditary cancer syndromes would enable patients to be placed in a high risk group where they can receive thorough surveillance. It provides them with invaluable information and the option to undergo preventative measures. |

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| **Title: O&G trainees’ study day attendance survey in Wales 2012** |
| **Author(s): Florian Drews MD DFSRH, ST5 O&G, RCOG trainee representative for Wales** |
| **Abstract:** |
| Aim: To survey the reasons for the poor study day attendance 2012 amongst O&G trainees. The results were fed back to the STC in order to improve the delivery of training in the Wales deanery.  Methods Used: Online survey on TWOGS website from April to June 2012.  Results and Discussion: 21 replies were received from approx. 100 Welsh O&G trainees. Ten submissions came from ST1&2, 8 submissions from ST3-5 and 3 replies from ST6/7 and SST. No one attended all available study days in the last two years (apart from one ST1 who recently joined the deanery). The majority of trainees missed three to five study days. The main reason for not attending was cancellation of the study day (38.1%), declined study leave (38.1%) or being on call (28.5%). Other reasons included being on leave (14.2%), having previously attended the study day (9.5%), less than 6 weeks notice given for study leave (9.5%), 4.7% respectively for reduced study leave budget, dates clashing with other courses, bad content/quality and date changes.  The trainees were further asked to comment on the application process. While nine were happy with the current application system (42.9%), twelve (57.1%) expressed dissatisfaction. The following improvements were suggested: online application and online payment (42.8%), pay on the day (14.3%), limitation to application numbers (9.5%), longer notice (9.5%) and 4.7% respectively for reducing clinical activity/get locum cover and reduce time for approving study leave applications. When asked about the nominal 25£ fee only 11 (52.3%) found the fee to be appropriate. Of the ten (47.6%) dissatisfied trainees, seven proposed the study day to be free. Other comments we received included 10£ for the study day, fee should benefit trainees and queries were raised about what the payment is actually for.  Lastly, the survey attempted to gauge the trainee’s view on the reason for the experienced low application numbers. The majority (8, 38.1%) thought this due to declined study leave, six (28.5%) said topics were of low quality/not relevant and repetitive, five (23.8%) though on call commitments to be the reason. Other ideas included: missed application deadline/short notice (4, 19.0%), being unaware of study day (2, 9.5%), and one (4.7%) respectively for no locum cover, costs, annual leave, North Wales’ own study days, EWDT.  The following suggestions were made to make trainee attendance more likely: relieve trainees to attend (28.5%), earlier notice (19.0%), better programme (14.2%), 9.5% for no cancellations, online booking/payment and more hands-on simulation. And, 4.7% each for compulsory attendance, external speakers, joint study days, lower number of study days, no repetitions, more available places on certain study days.  Conclusion: The training day organisation needs to be reviewed. A new revised training rota should be published in advance. The training day topics should be repeated only every few years in order to avoid unnecessary repetition. A stricter attendance might be necessary with review of attendance during ARCPs. |

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| **Title: IMPROVING VULVAL SURGERY PATIENT INFORMATION IN THE GYNAECOLOGY DEPARTMENT AT UHW.** |
| **Author(s):** Catherine Morgan (Medical Student, Cardiff University), Jac Soasra (Leturer in Fine Art, Cardiff Metropolitan University), Dr. Amanda Tristram **(**Senior Lecturer and Honorary Consultant in Gynaecological Oncology) |
| **Abstract:** |
| **Aim:**  To evaluate the effectiveness of a patient information leaflet given to women undergoing Vulval surgery, specifically Wide Local Excision for VIN, at UHW. Performed in two parts; the current level of information was evaluated to determine patient satisfaction and additional kind of information that should be provided. A patient information leaflet was designed and re-evaluated.  **Methods Used:**  Using a semi-structured interview format, feedback was gathered from post-operative patients and healthcare professionals at Llandough Hospital. Interview questions focused on improving information, psychosexual support and drawings as an aide. The artwork was created by Jac Soarsa, in response to the interview material.  **Results and Discussion:**  12 patients and 8 healthcare staff interviewed from the Gynae-Oncology department at Llandough covering patients from South east Wales.  *Part 1:* The current leaflet available was insufficient for women having VIN wide local excision surgery. Information should focus on wound care, practicalities of the operation, access to further information and provide awareness of psychosexual support available. Personal accounts and drawings would be beneficial.  *Part 2:* The specifically designed leaflet was appropriate for VIN wide local excision surgery and an effective accompaniment to the verbal information provided in clinic. Women understood, felt prepared, and were made aware of psycho-sexual support available. The personal accounts were very effective. The drawings received mixed responses with the biggest discrepancy being between healthcare staff against and patients in favour. The drawings were therefore included to the final version.  **Conclusion:**  The Service Evaluation highlighted the need for a patient information leaflet specific to VIN wide local excision surgery to complement the verbal information given to patients. Developed using patient and healthcare professional centred feedback, it effectively delivered information in a clear and understandable manner on the nature of VIN, practicalities of the operation, psychosexual aspects of surgery and access to further information. |

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| **Title: SEVERE PELVIC ACTINOMYCES INFECTION DIAGNOSED MEDICALLY** |
| **Author(s):** **Dr Megan Millward**, Mrs Anju Kumar |
| **Abstract:** |
| I**nstitutio**n  Royal Gwent Hospital, Newport, Wales  **Aims / Objectives**  We illustrate a case of severe actinomycosis, diagnosed and treated without surgical intervention. This case illustrates how a multidisciplinary approach and thorough follow up can prevent unnecessary operations.  **Background**  Pelvic actinomycosis is an extremely rare chronic granulomatous suppurative disease caused by *Actinomyces israeli*. The infection mimics ovarian tumours during presentation and is diagnosed after surgery in most cases.  **Materials and methods**  A 47 year old female was referred to Gynaecology outpatients with abdominal pain, bloating, and weight loss. Initial blood tests and tumour markers were normal. Further investigation with pelvic ultrasound and computer topography scanning showed a large pelvic mass, a cystic adenexal mass, thickened sigmoid colon, bilateral hydroureter and hydronephrosis. Following discussion with Urology, General Surgery, and Microbiology, this lady was managed conservatively with oral co-amoxiclav.  **Results, Summary / Conclusions**  This case illustrates preoperative diagnosis of pelvic actinomycosis. The patient is improving symptomatically and a recent repeat ultrasound shows resolution of her left hydroureter. Actinomycoses is difficult to diagnose both clinically and microbiologically. Symptoms are vague, blood results are often normal and imaging is of little diagnostic use. Culture is the gold standard for identifying the organism, but due to specific handling and the time required this is not routinely useful. Awareness of the organism, clinical acumen and a multi-disciplinary approach enabled timely diagnosis of this patient without unnecessary surgical intervention. |

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| **Title: PSYCHOSOCIAL IMPACT OF OBSTETRIC FISTULA IN WOMEN PRESENTING FOR SURGICAL CARE IN TANZANIA** |
| **Author(s): Kathryn Siddle MBBCh (presenting author – foundation year 1 doctor in Princess of Wales Hospital, Bridgend. Completed as 5th year medical student, Cardiff University, Cardiff, CF14 4XN), Subila Mwambingu (Comprehensive Community Based Rehabilitation in Tanzania (CCBRT), Dar es Salaam, Tanzania PO Box 23310), Theodora Malinga (CCBRT), Alison Fiander DM FRCOG (CCBRT, Obstetrics and Gynaecology, Cardiff University, Cardiff, CF14 4XN)** |
| **Abstract:** |
| **Aim:** As part of an expanded fistula programme in Tanzania, Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) introduced an evaluation strategy to include impact of surgery on psychosocial aspects of obstetric fistula. This is an initial report documenting morbidity on admission.  **Methods Used:** A questionnaire assessing the impact of obstetric fistula was developed taking into account literature in the field including sections on: patient contact information, transport costs and a set of statements regarding the effects of fistula. The effects were spread across 5 domains: the physical consequences of obstetric fistula; the effects of a difficult delivery and possible stillbirth; the experience of isolation; the inability to undertake daily living activities and feelings of depression. The questionnaire was administered in Kiswahili by Tanzanian counsellors shortly after admission of patients onto the fistula ward and the ones completed between 15/03/12 and 24/05/12 were analysed via simple descriptive statistics.  **Results and Discussion:** The sample population of 100 fistula patients reported high rates of physical and psychosocial morbidity. All were affected to some degree by feeling wet and smelling bad. 92% of those who lost their baby felt affected by it; with 56% reporting feeling constantly affected. Unkindness was shown to 74% of the women, most commonly by their husband or partner. 80% felt unable to participate in community activities; most commonly religious activities. Fistula left 90% feeling depressed and 94% feeling useless to some degree. Over half of the patients said they would not have been able to access treatment without the transport costs being covered.  **Conclusion:** Fistula patients are affected by extremely high rates of physical and psychosocial morbidity. Further work is required to confirm these findings, validate assessment tools, assess contributing factors in greater detail over time, such as the effect of stillbirth, as well as the impact of surgery. |

**POSTER PRESENTATIONS**

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| 1 | Royal College of Obstetricians and Gynaecologists Consent advice for instrumental deliveries – is University Hospital Wales reaching the mark? | Dr Katherine Louise Leonard |
| 2 | Review of Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) Disability Hospital’s Obstetric Fistula Programme 2011 | Dr Kathryn Siddle |
| 3 | Audit of management of obesity in pregnancy | Dr Aditi Miskin |
| 4 | Review of prolapse surgery with Surgisis mesh in Princess of Wales hospital, Bridgend – 2005 to 2010 | Dr Florian Drews |
| 5 | Affects of ataxia telangiectasia in pregnancy and delivery: a case report | Dr L Speers |
| 6 | Laparoscopic approach to hysterectomy: a retrospective study of short term outcome | Dr C Jones |
| 7 | Code red audit | Dr Rahul Savant |
| 8 | To Review the Management of Pelvic Mass in Pelvic Mass Clinic | Dr Nisha Kadwadkar |
| 9 | Acute Fatty Liver of Pregnancy: Case report | Dr Rudaina Hassan |
| 10 | Ectopic mammary tissue of the vulva | Dr Rudaina Hassan |
| 11 | Audit on management and follow up of micro invasive carcinoma of cervix at Royal Gwent and Ysbyty Ystrad Mynach hospitals | Dr J Cherian |
| 12 | A patient centred case study of Caesarean scar ectopic pregnancy; a patients’ perspective | Dr Kate Slader |
| 13 | Klippel-trenaunay syndrome and a successful pregnancy: a case report | Dr Lisa Bentham |
| 14 | Congenital Dyserythropoetic anemia and pregnancy outcome | Dr M Kolli |
| 15 | Dyspareunia – Is it tricky? | Dr Ganeshselvi.P |

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| Title: Royal College of Obstetricians and Gynaecologists Consent advice for instrumental deliveries – is University Hospital Wales reaching the mark? |
| **Author(s):** Dr Katherine Louise Leonard (presenting author), Mr Jonathan Lippiatt MRCOG DFSRH. Cardiff and Vale University Health Board. |
| **Abstract:** |
| **Aim:** To assess the quality of the consent process for operative vaginal deliveries and analyse the opinions of women undergoing these procedures.  **Methods Used:** A retrospective study involving 40 women who had a trial of operative vaginal delivery. The cohort included 28 forceps deliveries, 6 ventouse and 6 emergency caesarean sections. Using consent advice and Green-top guidelines, a pro-forma was designed for data collection. Maternity notes and consent forms were examined. Women were interviewed using a patient questionnaire.  **Results and Discussion:**  100% of consent forms contained clear documentation that it was a ‘trial’ and documented consent for both an emergency caesarean section and blood transfusion. Only 50% documented the risk of episiotomy and serious maternal risks. 21% had frequently occurring fetal risks documented. Only 5.9% had the risk of repair of perineal tear documented. No forms documented: intended benefits, serious fetal risks and additional manoeuvres. None of the women were given patient information prior to the procedure. None of the women who had an instrumental delivery in the delivery room had documentation of verbal or written consent.  Interviews: 91% of women remembered being informed about an episiotomy. Of those women who were not informed about all the risks involved, 72% would prefer to know all the risks. If women were not informed about extra procedures that could occur, 60% of women would prefer to know.  **Conclusion:** The consent process in UHW for instrumental deliveries is currently not reaching RCOG standards. Certain risks are documented well, however, there are many parts of the consent form, which are inadequately completed. Mostly, the women in this cohort would like to know all of the information and risks associated with instrumental deliveries; hence introduction of a pre-printed consent form for instrumental deliveries is likely to change practice, improve the consent process and enhance patient care. |

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| **Title: Review of Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) Disability Hospital’s Obstetric Fistula Programme 2011** |
| **Author(s):** Prof Alison Fiander, Dr Kathryn Siddle, Obstetrics and Gynaecology, Cardiff University & CCBRT, Dar es Salaam, Tanzania |
| **Abstract:** |
| **Background:**  The World Health Organization estimates that approximately two million women live with fistula worldwide and that an additional 50,000–100,000 women are affected each year (Murray & Lopez, 1998). In Tanzania alone, approximately 2,500–3,000 new cases of fistula are estimated to occur each year (Raassen, 2005). In addition to the medical problems that result, women with fistula face numerous social, psychological, and economic challenges because of the constant leakage of urine (and sometimes faeces).  Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) Disability Hospital in Dar es Salaam started providing free obstetric fistula repairs in 2002*.* Since this time the service has grown and more recent developments include provision of free transport from a patients home to hospital for treatment and a programme of holistic care during admission.  In 2011 CCBRT’s target was to treat 300 women with obstetric fistulae.  **Methods:**  Patients’ medical records were reviewed to determine type of surgery performed and the region of Tanzania in which they resided.  **Results**  CCBRT attained its target for 2011 undertaking 339 obstetric fistula repairs. The types of procedure and region of residence/origin will be presented.  **Total Procedures done in 2011:**   |  |  | | --- | --- | | **VVF** | **205** | | **VCVF** | **48** | | **RVF** | **11** | | **Anal Sphincter Repair** | **31** | | **Ureter re-implantation - vaginal** | **2** | | **Ureter re-implantation - abdominal** | **14** | | **Urinary diversion** | **6** | | **Others** | **22** | | **Total** | **339** |   **Discussion**  CCBRT is committed to increasing access to free Obstetric Fistula repair for women in Tanzania and improving Obstetric Fistula services. Having received funding from Vodafone UK, targets for 2012 include development and maintenance of an electronic database of obstetric fistulae patients; long term follow up of patients to assess outcome of surgery; assessment of the psychological burden of obstetric fistulae; awareness raising of the availability of treatment for obstetric fistulae particularly in ‘hard to reach communities’ and working in collaboration with other hospitals/agencies to provide services nearer to home where possible. |

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| **Title: AUDIT OF MANAGEMENT OF OBESITY IN PREGNANCY** |
| **Author(s):** Dr Aditi Miskin, Dr Emma Jones, Mr Hatel Tejura |
| **Abstract:** |
| Maternal obesity has become one of the most commonly occurring risk factors in obstetric practice. The prevalence of obesity in pregnancy has also been seen to increase, rising from 9–10% in the early 1990s to 16–19% in the 2000s. Obesity in pregnancy is associated with an increased risk of a number of serious adverse outcomes  **Methods Used:** We performed a retrospective audit. Notes were identified from 2011 (1 year after guidelines introduced) by Audit Department. Total number of notes audited was 50 case notes.  We used CMACE/RCOG Joint Guideline Management of Women with Obesity in Pregnancy (March 2010) and Cwm Taf Health Board Guideline (June 2010) as a standard for our audit.  **Results :** We weremanaging patients with more than BMI 40 according to Trust and RCOG guidelines. We also identified Poor management for BMI more than 35-40**.** In our hospitalVitamin D is not offered to all patients**.** There wasPoor compliance with discussion and documentation regarding complications with raised BMI as well as with suturing of subcutaneous fat during caesarean section**.** We hadpoor compliance for Thromboprophylaxis.  **Conclusion:** We presented our Audit at Audit Meeting. Recommendations were made.  It is recommended that Vitamin D to be made available at pharmacy. We proposed to introduce Information leaflet for raised BMI patients regarding pregnancy and delivery complications.We identified that there is need for postnatal thrombi-prophylaxis documentation in antenatal notes for patients with raised BMI.  As a result of this audit currently our GTT guideline and Obesity guideline are being reviewed. A re-audit is planned in 1 year. |

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| **Title: REVIEW OF PROLAPS SURGERY WITH SURGISIS MESH IN PRINCESS OF WALES HOSPITAL, BRIDGEND – 2005 TO 2010** |
| **Author(s):** Florian Drews MD DFSRH |
| **Abstract:** |
| **Aim:** To review and evaluate the outcome and anatomical success of anterior and posterior repair with Surgisis Mesh when repairing anterior and posterior vaginal wall prolapse and compare it to international standards.  **Methods Used**: Retrospective case review of 63 anterior and 74 posterior repairs with Surgisis. The data includes the entire amount of gynaecological prolapse operations where Surgisis was used in Princess of Wales Hospital, Bridgend, and was retrieved from consultation letters written between 2005 to 2010. Subjective and objective failure rates were then compared to the results published in Jia et al.’s (2008) meta-analysis of mesh use in prolapse surgery.  **Results and Discussion**:  The operations were carried out either as an isolated or as part of a more complex prolapse procedure. The anterior repairs were carried out by five different surgeons, while the posterior repairs were done by six surgeons. The majority of patients however was operated by a urogynaecologist (69.8% - 44 anterior repairs and 58.7% - 44 posterior repairs).  The objective failure rate for anterior repair (recurring prolapse in the anterior compartment) after 5 years was 12.7% (8 of 63), which is lower than the set standard of 17.9% in the Jia review. The Subjective failure rate (recurrence of symptoms with no objective anterior/posterior compartment prolapse) after 5 years was 4.8% (3 of 63), which as well is lower than the set standard of 7.4%. Overall, a good outcome of anterior repair with Surgisis could be demonstrated.  For the posterior repairs, the objective failure rate after 5 years of follow up was 4.0% (3 of 75), which is lower compared to 20.4% failure rates in our standard. The subjective failure rate was 9.3% (7 of 75), compared to the 11.5% standard. Overall, a good outcome of posterior repairs with Surgisis could be shown.  Furthermore, no major or long term complications were experienced in any of the 137 cases over 5 years.  When comparing the outcome of posterior repairs to anterior repairs, it seems that posterior repairs show more promising results. As the study is underpowered, no such conclusions can be drawn.  **Conclusion:**  This local study seems to provide further evidence for the excellent role Surgisis plays in the surgicial treatment of vaginal prolapse. In particular the outcomes of posterior repairs appear to show good results. The low subjective and objective failure rates alongside no major complications ensured high patient satisfaction in our cohort. |

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| **Title: AFFECTS OF ATAXIA TELANGIECTASIA IN PREGNANCY AND DELIVERY : A CASE REPORT** |
| **Author(s):** Dr L Speers (presenter), Dr C Scarr, Dr H Al-Saygeh, Mrs S Parveen (Royal Gwent Hospital) |
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| **Aim:** To discuss a Primigravid patients’ successful pregnancy and delivery given her pre-existing condition of ataxia telangiectasia  **Methods Used:** Retrospective review of hospital case notes  **Results and Discussion:** Ataxia telangiectasia is a rare (3 in 1 million Caucasians) neurodegenerative disorder with an autosomal recessive inheritance pattern. Caused by a defect in the ATM gene encoding for a kinase protein essential for p53 activity, errors in DNA are subsequently not recognised or repaired correctly. This creates an increased sensitivity to ionising radiation and other clinical features such as decreased immune response, cerebellar ataxia, ocular and cutaneous telangiectasia.  Prior to conception this 27 year old female and her husband were counselled by Cancer Genetics Service Wales and calculated as having a 1 in 400 to 700 possibility of having a baby with AT.  During early pregnancy the patient was routinely reviewed by her Neurologist in UCL Hospital. Locally she received Consultant-lead Obstetric care in a large District General Hospital and was reviewed regularly with little concerns or change in physical condition. The only addition to management was addition of thromboprophylaxis due to the patients’ limited mobility. Early referral to the Anaesthetic team enabled acceptable routes of analgesia and anaesthetic options to be confirmed prior to the intra-partum period.  This lady underwent a planned induction of labour at 39 weeks. Despite an emergency Caesarean Section for failure to progress with a primary postpartum haemorrhage a live male infant was delivered in good condition, with mother and baby discharged three days later.  **Conclusion:** Regular review and interaction between clinicians within the multi-disciplinary team enabled this pregnancy and subsequent delivery to continue successfully. Despite little documented evidence of successful pregnancy in women with AT, no adverse affects occurred. Although delivery involved a major PPH this complication was not linked to the pre-existing ataxia telangiectasia, which, overall remained unchanged throughout pregnancy and delivery. |

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| **Title: LAPAROSCOPIC APPROACH TO HYSTERECTOMY: A RETROSPECTIVE STUDY OF SHORT TERM OUTCOME** |
| **Author(s):** Dr.C.Jones, Dr.M.Elbadrawy, Mr.Islamaramadan (West Wales General hospital) |
| **Abstract:** |
| **Objective**: To evaluate clinical short-term outcomes of a laparoscopic approach to hysterectomy performed at a District General Hospital.  **Background:** Current evidence according to NICE show significant benefits of laparoscopic techniques for hysterectomy compared to the conventional ‘open’ approach. Benefits included a reduction in length of hospital stay, recovery time and overall patient satisfaction.  **Design:** Retrospective cohort study.  **Setting:** Department of Obstetrics and Gynaecology, West Wales General Hospital.  **Sample:** The study included 33 women who underwent laparoscopic hysterectomy (including Laparoscopic Assisted Vaginal Hysterectomy (LAVH), Total Laparoscopic Hysterectomy (TLH), and Subtotal Laparoscopic Hysterectomy with or without bilateral salpingoophorectomy) between September 2010 and September 2012 for various indications.  **Methods:** All the women that underwent a laparoscopic hysterectomy were included in the study. Every procedure was performed by one surgeon to eliminate bias.    **Results:** A total of 33 women were included in the study. Most of the patients had a total laparoscopic hysterectomy and none needed to be converted to a laparotomy. Age of the patients varied between 28 and 82 (average of 47.) Duration of surgery seem to improve with time as surgeon, assistants, theatre staff became more efficient and familiar with the laparoscopic equipment. Mean of hospital stay was 3 days with every patient only requiring simple analgesia post-operatively. 2 women out of the 33 had a minor post-operative complication, including a low haemoglobin level requiring transfusion and a wound infection that resolved with antibiotic therapy. Reoperation was required with one patient as she presented 10 days later with heavy vaginal bleeding.  **Conclusions:** Results show significant benefits of a laparoscopic hysterectomy, with short period of hospital stay and no major post-operative complications. Overall patient satisfaction was high and therefore a technique that needs to be considered by practising surgeons as an alternative for open surgery. |

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| **Title: CODE RED AUDIT** |
| **Author(s):** Dr Rahul Savant, Mr Chandra Reddy. Dr Annesimo Fernandes.  Glangwili General Hospital, Carmarthen |
| **Abstract:** |
| **Aim**: To audit the appropriate use of code red  **Methods Used**:  Retrospective audit conducted from Jan 2012 to June 2012. Data collected from datix and case notes.  **Results and Discussion**:  Code red was used 16 times over a period of 6 months. Bradycardia was the indication in 14 cases and shoulder dystocia on 2 occasions. 10 delivered by caesarean and 6 vaginally. General anaesthesia was used in 7 cases, spinal anaesthesia in 7 and perineal infiltration in 6 cases. Cord blood ph was normal in 10 cases, abnormal in 5 and not recorded in 1. Decision to delivery target of 30 min was achieved in 15 cases. The consultant was not informed in only one case. Events were recorded along with the time in all cases. Clinical risk forms were filled in all the cases. The use of code red was considered inappropriate in only one case.  **Conclusion**:  Code red was used appropriately in all but one case.  Midwives and doctors need to be regularly briefed to use the code red correctly.  We need to reaudit at a later date to assess compliance. |

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| **Title: To Review the Management of Pelvic Mass in Pelvic Mass Clinic** |
| **Author(s):** Dr. Nisha Kadwadkar, Dr. Anju Sinha, Mr Kenneth Lim |
| **Abstract:** |
| **Aim:**  To assess the management of ovarian and non-ovarian pelvic lesions in the pelvic mass clinic and analyse the accuracy of scoring systems.  **Methods Used:**  322 women, who attended pelvic mass clinic during the period of December 2010 to December 2011, were assessed retrospectively.  Cardiff Malignancy Index (CMI) scoring system and Risk of Malignancy Index (RMI) scoring were used for the management of these women.  **Results and Discussion:**  200 were new patients and 122 were follow-up visits. A total number of 227 women were managed in the clinic. 124 women were premenopausal and 103 were postmenopausal.  83 women were discharged, 66 women operated and 78 women were followed-up.  Discharges and follow-ups were further analysed based on the CMI and RMI scoring system to verify which scoring system performed better.  Amongst the women who were operated, the CMI and RMI risks were compared with their histology results to check the accuracy of scoring system.  **Conclusion:**  CMI was more beneficial than RMI in decreasing the number of unnecessary surgical interventions.  In low risk women, CMI helped discharge more patients (42% CMI compared to 36% RMI) and follow-up more (74% CMI compared to 36% RMI), thus reducing the number of surgeries (20% CMI compared to 28% RMI).  RMI performed well in High Risk women.RMI was better than CMI in improving the diagnosisof malignant caseswith a specificity of 96% and positive predictive value of 71%.    A combination of both scoring systems, led to improved performance in the management of pelvic mass in these women. |

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| **Title: Acute Fatty Liver of Pregnancy: Case report** |
| **Author(s):** Rudaina Hassan ST5, Royal Gwent Hospital, Newport  Mrs S Hemmadi, Consultant Obstetrician and Gynaecologist, Princess of Wales Hospital, Bridgend |
| **Abstract:** |
| **Aim**: Acute fatty liver of pregnancy (AFLP) is a serious, but rare condition with substantial maternal and perinatal mortality and morbidity. We present this case to highlight the importance of optimal management to prevent foetal or maternal compromise.  **Methods Used**: Information extracted from the patients hospital records.  **Results and Discussion**: We describe the case of a 29 year old multigravida who developed AFLP in the third trimester. The antenatal period was complicated by severe gestational diabetes for which she was commenced on insulin. She presented at 36 weeks complaining of pain and swelling of her thighs. She had also been suffering with nausea and vomiting for several weeks. A provisional diagnosis of cellulitis was made and a range of blood tests requested. At the time creatinine was found to be elevated at 162, bilirubin was 135 and both ALT and ALP elevated. An inital diagnosis of AFLP and HELLP was made. A clotting screen was subsequently done which was severely derranged with a fibrinogen of 0.6. In view of the results a decision was made to deliver the baby by caesarean. Prior to the caesarean she received FFP and fibrinogen to correct her clotting. She had a caesarean section and by then she had developed disseminated intravascular coagulation and further blood products and clotting factors were given. Postoperatively she was managed on ITU and she received N-acetylcysteine, antibiotics and more blood products. She was transferred to the Liver unit in Birmingham for further supportive management and consideration of liver transplant. Fortunately she improved and made a full recovery and was discharged home on the 12th postnatal day.  **Conclusion**: Her case is presented to draw attention to AFLP as a differential diagnosis to liver diseases in pregnancy. Appropriate diagnosis and prompt delivery is essential for optimal maternal and fetal outcome and this should be followed by intensive care treatment of the dysfunctional maternal multiorgan system. |

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| **Title: Ectopic mammary tissue of the vulva** |
| **Author(s):** Rudaina Hassan ST5, Royal Gwent Hospital, Newport  Tehmina Riaz, Speciality doctor, Princess of Wales Hospital, Bridgend |
| **Abstract:** |
| **Aim**: To report a rare case of ectopic mammary tissue presenting as a vulval mass.  **Methods Used**: Information extracted from the patients hospital records and a review of the literature performed.  **Results and Discussion**: We report a case of a 46 years old woman who presented with an unknown progressively enlarging lump in the vulva over a period of two years. The mass was located adjacent to the clitoris and measured approximately 2 x 2 cm, smooth and mobile. The mass was excised completely under local anaesthetic and histology demonstrated an ectopic mammary tissue with features of a benign fibroadenoma.  Ectopic breast (extramammary) fibroadenomas of the vulva are rare, cosmetically disfiguring, and very difficult to distinguish from other labial masses on physical examination. Extramammary tissue is susceptible to similar benign and malignant changes seen in the breast. Some patients with ectopic breast lesions may harbor an underlying urinary tract anomaly.  **Conclusion**: Clinicians should include extramammary lesions in their preoperative differential diagnosis of vulvar masses since some may become neoplastic. Treatment is complete excision and renal imaging should be considered after a confirmed histopathologic diagnosis. |

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| **Title: AUDIT ON MANAGEMENT AND FOLLOW UP OF MICROINVASIVE CARCINOMA OF CERVIX AT ROYAL GWENT AND YSBYTY YSTRAD MYNACH HOSPITALS** |
| **Author(s):** Mrs JayaCherian, Ms Rohini Gonsalves |
| **Abstract:** |
| **Aim**: Audit on Management and Follow up of Microinvasive carcinoma of cervix- to see if we are following the management protocols set by the NHSCSP(May2010)  **Methods used**: Looked at all patients diagnosed by Histology as having Carcinoma of the cervix and then identified patients diagnosed as having Microinvasion - regarding their management and follow up  **Results and Discussion**: More than 80% of women with microinvasion was detected on smears and more than 70% had smears reported as showing Severe Dyskaryosis.  Less than 40% had fertility sparing treatments like LLETZ or Knife cone.  All patients were followed up either in Colposcopy or Oncology.  No pregnancies in the patients followed up.  There was some crossover with Oncology in management and follow up.  **Conclusion**: Even though we are following most of the recommendations of NHSCSP there need to be some streamlining of care at local level in agreement with Oncologist. As risk of lymph node metastasis is <1% is MRI mandatory ? |

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| **Title: A patient centred case study of Caesarean scar ectopic pregnancy; a patients’ perspective**. |
| **Author(s):** Dr Kate Slader, Glangwilli Hospital, Carmarthen West Wales (Presenting), Sylvia Jones (EPAU Sister) , Dr M. Elbadrawy (Consultant) |
| **Abstract:** |
| **Aim**: Caesarean scar ectopic (CSE) pregnancy is a rare condition that is increasing in incidence with the increase in caesarean section rates. This case of CSE pregnancy was diagnosed in a district hospital and discusses how the case was diagnosed and managed from the patients’ perspective and looks at the psychological implications of such a diagnosis.  **Methods Used**: Literature review.  **Results and Discussion**: This case was diagnosed in 35 year old women with two previous caesarean sections. The ultrasound diagnosis was protracted due to the difficulty in distinguishing between a true CSE, a lowly implanted intrauterine pregnancy and a spontaneous miscarriage in progress. Counselling the patient was complex because of the lack of evidence based literature on the likely outcomes of CSE pregnancies. The uncertainty surrounding the outcome made this a traumatic experience for the patient in deciding how to proceed with a much wanted pregnancy. The patient was counselled and ultimately felt confident in her decision to proceed with a termination. The pregnancy was terminated with minimal complications via evacuation under ultrasound guidance following the insertion of McDonald suture.  **Conclusion**: Due to the rarity of CSE pregnancy there is only a small evidence base on which to base management decisions. Difficulty and therefore delay in diagnosis and lack of clear management options has a major impact on maternal psychological health. Due to the potential for catastrophic bleeding during pregnancy and at delivery (in the unlikely event that the pregnancy continues) termination is recommended. There are no good comparative studies to be guided by and there is no established optimal way to manage these pregnancies. This uncertainty has major consequences on the how the patients view their pregnancy and their own health risks. |

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| **Title: KLIPPEL-TRENAUNAY SYNDROME AND A SUCCESSFUL PREGNANCY: A CASE REPORT** |
| **Author(s):**  Dr Lisa Bentham, Dr Cerys Scarr, Dr Hanan Al-Sayegh, Mrs Singh.  Royal Gwent Hospital, Newport, South Wales.  Presenting author: Dr Lisa Bentham |
| **Abstract:** |
| **Aim:**  To present a rare case of a successful pregnancy and delivery of a 21 year old woman with a longstanding diagnosis of Klippel-Trénaunay Webber Syndrome.  **Methods Used:**  Review of case notes of the patient who was managed in a large district hospital.  **Results and Discussion:**  Klippel-Trénaunay Webber Syndrome (KTS) is a rare congenital condition, first described in 1900 by French physicians [Maurice Klippel](http://en.wikipedia.org/wiki/Maurice_Klippel) and [Paul Trénaunay](http://en.wikipedia.org/w/index.php?title=Paul_Tr%C3%A9naunay&action=edit&redlink=1). The aetiology is, as yet, unknown, and displays sporadic incidence.  KTS is characterised by a clinical triad of cutaneous capillary malformations – commonly a capillary haemangioma (‘port-wine stain’), bone and soft tissue hypertrophy – commonly affecting one limb and varicose veins or venous malformations. Although there is a wide clinical variability common complications include chronic venous stasis (and associated risk of venous thromboembolism), visceral bleeding and orthopaedic complications such as gait disturbances and scoliosis.  This 21 year old primiparous women was successfully managed during her pregnancy under consultant care with multi-disciplinary input – namely anaesthetic opinion regarding analgesia options in labour and haematological opinion due to the high thromboembolic risk. KTS manifested in this patient as severe kyphoscoliosis, left sided hemihypertrophy and mild learning disability. She was delivered by emergency caesarean section for failure to progress, giving birth to a healthy male infant. She suffered 1000mls estimated blood loss intra-operatively due to multiple prominent vessels on the lower segment of her uterus and slight uterine atony. She had an uneventful post-operative recovery and was discharge with 6 weeks of prophylactic low molecular weight heparin due to her high risk of venous thromboembolism.  **Conclusion:**  Pregnant patients with complex medical conditions such as KTS require integrated multi-professional involvement to ensure high quality patient centred care. Early involvement of appropriate specialities allowed the composition of a robust birth plan for this patient. facilitating this successful outcome. |

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| **Title: Congenital Dyserythropoetic anemia and pregnancy outcome** |
| **Author(s):** Dr M Kolli, Mrs S Parveen, Dr Sarah Lewis, Royal Gwent Hospital |
| **Abstract:** |
| **Aim:** To report a rare case of congenital dyserythropoetic anaemia in a pregnant woman and the outcome of the pregnancy.  **Methods Used:** Case report  **Results and Discussion:** The congenital dyserythropoietic anaemias (CDAs) are a heterogeneous group of diseases in which the anaemia is predominantly caused by dyserythropoiesis and markedly ineffective erythropoiesis. CDA I is an autosomal recessive disorder. In children and adults, the anaemia is usually mild to moderate and transfusion is only required when the hemoglobin (Hb) falls below base-line levels in association with an intercurrent infection or pregnancy. Maternal anemia is associated with suboptimal pregnancy outcome, mainly high rates of preeclampsia, Caesarean delivery and low birth weight. We report a rare case of Congenital dyserythropoetic anemia type I in a 28 year old Caucasian woman. She required repeated blood transfusions during the antenatal period due to her symptomatic anemia and was monitored closely in a joint haematology- antenatal clinic. She developed preeclampsia at 37 weeks gestation and had a semi-elective caesarean section for failed induction of labour.  **Conclusion:** Pregnancies in women with CDA I are at high risk of antenatal and delivery-related complications. Blood transfusions, if hemoglobin level drops to less than 8 g⁄dLor if the woman is symptomatic of anemia, should be considered. Awareness of the risk of iron overload for these patients is important and serum ferritin levels should be monitored regularly. To improve pregnancy and fetal outcome, regular follow up with close hematological involvement is essential. |

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| **Title: Dyspareunia – Is it tricky?** |
| **Author(s):** *Dr. Ganeshselvi P. Dept of Obstetrics & Gynaecology, Singleton Hospital, ABM University Health board, Swansea, Wales.* |
| **Abstract:** |
| **Case Report**: 23years nulliparous attended gynae-outpatient in April2011 with 8years cyclical lower abdominal pain, positional dyspareunia and heavy regular periods for 5years with intermittent odourless brownish discharge per vaginum for 2weeks before periods. Normal up-to-date cervical smear. She tried pill then mirena for heavy periods for 3years with no effect on pain. No psychosexual abuse history. Examination attempted in clinic during periods elicited severe vaginismus.  This tearful and psychologically affected woman said, *“For years and years, doctors think that I am crazy, liar and it’s all in my head. No one believes me”*.  Examination under anaesthesia showed normal vulva, cervix, and immobile smooth 2cm soft cystic lesion in the right lateral fornix with normal vaginal mucosa. Laparoscopy showed minimal endometriosis over left uterosacral ligament, excised. The vaginal cyst was deroofed, chocolate coloured material drained, no capsule noted, few endometriotic spots at the base was diathermised and left open. Postoperatively said, *“I am so relieved that you found a reason for my pain. After all I am not crazy”*. Histology showed benign endometrial glands in endometrial stroma confirming endometriotic cyst of vagina.  **Discussion :** Benign cysts of vagina and vulva are relatively frequent encounter in gynaecology. Estimated prevalence of vaginal cyst is 1 in 200 women although many are asymptomatic with possible under representation. Reported incidence of Mullerian cyst (44%), epidermal inclusion cyst (23%), Gartner’s cyst (11%), Bartholin’s cyst (7%) and endometriotic cyst (7%).    Endometriosis is ectopic implantation of endometriotic stroma and glands. Primary vulva and vaginal endometriosis is rare. Superficial vaginal endometriosis vaginal vault without involving pelvis, usually secondary to trauma/previous surgery. Deep vaginal endometriosis typically occurs in posterior fornix with typical chocolate like appearance associated with pelvic endometriosis (Eilber KS & Raz S, 2003).  Schmidt states, *“the vagina attracts too little serious or sustained study.”* (Schmidt WA 2003). Even though endometriotic cysts are rare, can cause significant symptoms with effect on quality of life. Listening to woman/acknowledging, careful elicitation of history and adequate examination helps to aid diagnosis of this, avoid patient dissatisfaction/depression due to the feeling of not being trusted by doctors. The small risk of malignant transformation of vaginal endometriosis should not be ignored. Therefore early diagnosis and treatment of these rare lesions is important.  To our knowledge, this is the first case reported with right lateral fornix vaginal endometriotic cyst with no typical brown, blue or red appearance on gross examination. |

**Notes**

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