

Induction of labour

Oral Presentation**Efficacy of mifepristone and misoprostol in termination of pregnancy in second and third trimester versus intraamniotic application of prostaglandins**

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Introduction: According to the published data, a combination of mifepristone and misoprostol is recommended in literature for labour induction in the second and third pregnancy trimester after a foeticide due to a fetal malformation or intrauterine fetal death and for abortion induction in the first pregnancy weeks. At our department we perform foeticide by applying Fentanyl and Xylocaine into the fetal heart. Since the intraamniotic input is applied in this procedure, we also perform labour induction by intraamniotic prostaglandin application. During the first weeks of pregnancy we perform abortion induction with mifepristone and misoprostol. Through the analysis of our own data, we aimed at establishing in what time fetal expulsion occurs after abortion induction with mifepristone and misoprostol compared to labour induction through intraamniotic prostaglandin application.

Methods: The retrospective study included all women on whom abortion or labour induction was performed between 2010 and 2015 due to fetal malformations established by means of ultrasound. The first group included all participants in the 16th–24th week of pregnancy or with the fetus weight under 500 g determined through ultrasound where the abortion induction was performed with mifepristone and misoprostol according to the following protocol: mifepristone 200 mg orally, followed 36–48 h later by misoprostol 800 µg vaginally, then misoprostol 400 µg orally, 3-hourly, to a maximum of four further doses. The second group included women after the 24th week of pregnancy or with the fetus weight above 500 g determined through ultrasound. Labour induction was performed through intraamniotic 1000 µg prostaglandin application. We compared the time at which the fetal expulsion occurred after the beginning of induction in the first group with the same time in the second group.

Results and conclusions: Based on the data from literature, the best abortion or labour induction method is the application of mifepristone and misoprostol regardless of the duration of pregnancy. The aim of our research was to establish whether the cases when a foeticide needs to be performed and therefore intraamniotic input is already being used it also makes sense to apply prostaglandins in order to commence induction at the same time. Compared to the protocol with mifepristone and misoprostol we benefit from extra time since it is recommended to wait 36–48 h after mifepristone application before misoprostol application is continued. Based on the data from literature, the time to fetal expulsion in case of induced abortions or labours is proportional to the duration of pregnancy. With our research, we aimed to prove that in the group with the labour induction by means of intraamniotic prostaglandin application despite being further into the pregnancy, the time to fetal expulsion is shorter due to the 36–48-h-long break in the mifepristone and misoprostol protocol.

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C-section

Oral Presentation**Efficacy of intraoperative application of levobupivacaine on postoperative analgesia after cesarean section**

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Introduction: Childbirth by caesarean section is becoming more frequent. The caesarean section requires an anaesthetic, either spinal, spinal epidural, epidural block, or general anaesthesia. Post-operative pain is managed with a combination of an opioid and other analgesics. Opioids cause sedation and they can transfer to breast milk, also sedating the newborn infant. Improvements in pain relief that make the postanaesthesia period less uncomfortable are important. Local anaesthesia wound infiltration was of benefit in women having a caesarean section requiring regional or general anaesthetics because of a reduction in the use of opioid analgesia. With the analysis of our data, we tried to confirm the reduction of the need for opioids after a caesarean section in women in which a local anaesthetic was applied subcutaneously.

Methods: The retrospective study included 50 women in which 50 mg levobupivacaine was applied intraoperatively subcutaneously during the caesarean section, as well as 50 women in which no local anaesthetic was applied during the caesarean section. In both groups, it was the first, elective caesarean section performed under spinal anaesthesia. The anaesthesiologists gave to all the women during the procedure the same analgesics, i.e. 1 g of paracetamol and 30 mg of ketorolac. 24 h after the procedure, they all regularly received 1 g of paracetamol/6 h IV as well as diclofenac (Neodolpasse) 250 ml/12 h IV. When they estimated that the pain was too strong despite the regular treatment of pain, they received Piritramide Dipidolor 2.5–7.5 mg/4–6 h IV or Matamizole Analgin 1.5–2.5 g IV, or both. By analysing the documentation, we compared the quantity of opioids the women in the first and second groups received within the first 24 h after the procedure.

Results: Women who received a local anaesthetic subcutaneously during the caesarean section needed a lesser amount of opioids in the first 24 h after the procedure. The results of our research are comparable with the data so far released in the professional literature.

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Assisted reproduction

No Preference**Review of the use of clomiphene citrate (CC) in the Assisted Reproduction Unit (ARU) – Hartlepool**

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Introduction: Infertility affects 1 in 7 British couples of which ovulatory disorders account for 25% [1]. Clomiphene citrate (CC) is the first line treatments for anovulatory infertility. CC is relatively inexpensive and can be used before other more complicated

fertility treatments. CC therapy increases the rate of multiple pregnancies (6.5%) [1]. The NICE fertility guidelines (2013) recommended to offer ultrasound monitoring during at least the first cycle of treatment to minimise the risk of multiple pregnancy and that treatment should not continue for longer than 6 months. The aim of the work is to study the adherence of the ARU-Hartlepool to the NICE recommendations for CC treatment. And to assess the clinical pregnancy rate and multiple pregnancy rates (MPR).

Methodology: We conducted a retrospective review of all patient notes that were prescribed CC between January 2014 and March 2015.

Results: 92 patients were identified. 60 patients were included in the study. 32 patients were excluded as they had CC for other indications like intrauterine insemination (IUI) and modified natural cycle IVF. The average age of the patients was 30 years (range 21–43). 52 (87%) patients had a BMI between 19 and 30, 8 patients (13%) had BMI above 30. 43 patients (72%) presented with primary infertility and 17 (28%) had secondary infertility. 30 (50%) of the women were diagnosed with PCOS and 25 (42%) had anovulatory infertility. The mean duration of infertility was 25 months. The dose of CC ranged between 25 and 150 mg. The average number of treatment cycles was 4 (range 1–7). 100% of the patients had ultrasound scan for follicle tracking in at least one cycle during the treatment. CPR was 28%. All pregnancies were singleton. 2 (3%) patients did not respond to the maximum dose of the treatment and one cycle was abandoned due to over response.

Conclusion: The ARU-Hartlepool has been adherent to the NICE guidelines regarding ultrasound scanning with CC treatment. This has contributed towards the prevention of multiple pregnancies. The clinical pregnancy rate is in line with the national pregnancy rate for anovulatory patients. There were deviations from the NICE recommended standards in treating patients with a BMI above 30 and in treating patients with unexplained infertility. In conclusion, adherence to NICE guidelines for CC treatment of non-ovulatory infertility will help to greatly reduce the risk of multiple pregnancy [2].

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Maternal mortality and morbidity

No Preference

A case of intractable vomiting and weight-loss in pregnancy following bariatric surgery



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Introduction: An increasing number of women of reproductive age are undergoing bariatric surgery in the UK, leading to a rise in pregnancies following weight-loss surgery. Weight-loss surgery may protect obese women and their babies from obesity related problems during pregnancy, however the complications from these procedures during pregnancy are less well known.

Case report: A 33-year-old gravida 2 was booked for high dependency antenatal care, due to having undergone gastric band surgery two years previously. She had achieved a weight loss of 57 kg, with a booking weight of 75 kg and a BMI of 28 (reduced from 41). She had persistent nausea and vomiting despite deflation of gastric band in early pregnancy and was treated with anti-emetics. A weight loss of 3 kg was noted at 23 weeks and a marginal weight gain of 1.9 kg was seen at 26 weeks. Continued vomiting prompted referral to the bariatric team. A gastroscopy at 31 weeks revealed slippage of the gastric band and erosion into the stomach but without perforation. Removal was deemed unsuitable during pregnancy and high-energy dietary supplements and a proton pump inhibitor were commenced. At 35 weeks, her symptoms had slightly improved and her weight was 75.9 kg. Ultrasound fetal growth surveillance was satisfactory and she had an uncomplicated vaginal delivery at 39 weeks with birthweight of 2350 g. She underwent laparoscopic gastric band removal following delivery and her symptoms subsequently resolved.

Discussion: Gastric banding is a restrictive type of weight-loss surgery. Vomiting may be caused by eating rapidly or by not thoroughly chewing food. This restriction-related vomiting is often exacerbated by pregnancy. Rapid weight loss immediately after surgery has prompted the recommendation that pregnancy should be avoided for 12–18 months afterwards. Deflation of the band in pregnancy is thought to reduce the risk of vomiting and poor nutritional intake. Intractable vomiting in pregnancy should raise the suspicion of surgical complications such as band slippage or migration. Persistent vomiting in pregnancy may lead to malnourishment and micro-nutrient deficiencies, which can cause fetal growth restriction, low birth-weight and preterm delivery. These high risk pregnancies are best managed by a specialist multidisciplinary team of Obstetricians, Dieticians and Bariatric Surgeons. Close monitoring of symptoms, weight gain and evaluation of micro-nutrient deficiencies is important, along with screening for gestational diabetes and fetal growth surveillance.

Conclusion: We recommend the following, for pregnancy following bariatric surgery: (1) avoidance of pregnancy for 12–18 months; (2) consultant led care; (3) involvement of expert dietician; (4) evaluation for and treatment of micro-nutrient deficiencies; (5) screening for gestational diabetes; (6) Early referral to bariatric surgeons if required; (7) regular assessment of fetal growth; (8) weight and BMI monitoring, aiming for optimal weight gain.

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Infections in obstetrics and gynaecology

Poster Presentation

Secondary postpartum haemorrhage: prevalence, morbidity and management from a teaching hospital in Oman



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Objective: To determine the incidence, risk factors, presentation, treatment and morbidity associated with secondary postpartum haemorrhage.

Design: Analysis of women who presented with secondary postpartum haemorrhage from September 2014 to December 2015.

Setting: The maternity unit in a teaching hospital serving an annual delivery rate of around 4500 women.