WELSH
OBSTETRIC & GYNAECOLOGY
SOCIETY

Spring Meeting

Held at Singleton Hospital

on

Friday, 26 April 2002
Abstract of oral presentations

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Title: Who is responsible for the rising caesarean section rate?
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Introduction & Aim:
Caesarean section rates are increasing worldwide. Some of the reasons for this rising trend are increasing multiple births, maternal age, use of continuous fetal monitoring and fear of litigation leading to defensive medical practice. Fear of vaginal birth coupled with increasing safety of caesarean section is said to have led to increasing number of women requesting caesarean section without a definite medical indication. We as obstetricians are eager to blame the women, media, and lawyers for this turn of events. However, we do not know if we are expressing our own fears and preferences without actually realising that it might be having an effect on maternal decision making. This study was designed to determine if the clinicians are influencing these decisions made by women either intentionally or unintentionally.

Materials & Methods:
Postal questionnaires were sent to one hundred and fifty Consultant Obstetrician and Gynaecologists covering the England, Wales, and Scotland. This sample was chosen after systematic random sampling from the RCOG list of NHS consultants in the UK. The questionnaires were sent to the hospital addresses and repeat questionnaires were sent to those who failed to respond. The questionnaire contained two sections. The first section requested for details regarding age, sex, year of qualification and type of hospital unit (high risk or low risk) at which they were based. The second section consisted of questions related to their opinion regarding 1) whether the caesarean section rate was rising? 2) Who did they think was responsible for this trend? 3) Did they think that women’s right to autonomy was being abused? 5) What measures were to be undertaken to decrease this trend? Finally, four obstetric situations where decision making is known to vary among clinicians and women request caesarean section due to emotional and social necessity than medical problems were listed and the obstetrician’s choice of mode of delivery was asked.
Results:

The response rate was 72% (n=108). More than 90% (n = 102) agreed that the caesarean section rate was rising and 37% (n = 40) accepted that doctors were responsible for this trend in conjunction with other factors like midwives, media and women themselves. However, 69% (n=75) blamed the media and 9% (n = 10) felt that media was solely responsible for this trend. Women were held responsible in addition to others by 42% (n = 46), whereas midwives were thought to be responsible by 28.7% (n = 31). More than half of them (n = 60) did not feel that the patient’s right to autonomy was being misused. Seventy six percent (n=82) agreed that patient education was important in decreasing caesarean section rates and 42.5% (n = 46) were of the opinion that media coverage was essential to achieve this aim. Majority of them preferred to perform elective caesarean in the situations presented to them. Female obstetricians and those with experience of less than 20 years appeared to favour caesarean section more often in these situations as opposed to male obstetricians and those with more than 20 years of clinical experience. However, these differences were not statistically significant. (X² p >0.05)

Conclusions:

In view of this above-mentioned evidence, obstetricians need to assess the situation within before holding media and patients responsible for this rising trend of caesarean section. If we have female obstetricians preferring elective caesarean section and proponents of caesarean section without medical indications within our field, it would be unreasonable to blame others. Education of our medical colleagues in the field of obstetrics seems as much essential as patient education. It is important to empower women by offering them choice when it comes to mode of delivery. However, it is also important that this issue is not clouded by information that maybe biased coming from the media, clinicians or the public as a whole as to the perception that elective caesarean section is necessarily the answer to a much wider problem of safety in childbirth.
Female Genital Tract Morbidity and Sexual Function following Vaginal Delivery or Lower Segment Caesarean Section.

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**Objective:** To determine the outcome up to two years post-delivery of subjective urinary and faecal incontinence, incontinence of flatus, dyspareunia, subjective depression, and sexual satisfaction in women who delivered by spontaneous vaginally, ventouse, forceps or those who had an elective caesarean section.

**Sample:** 208 women who had delivered at the University Hospital of Wales or Llandough Hospital, Cardiff between January 1999 and January 2000.

**Methods:** A sample population selected from the *Cardiff Birth Survey Database*, in accordance with strict inclusion and exclusion criteria. Each was invited to complete and return a postal questionnaire addressing symptoms of pelvic floor dysfunction.

**Results:** There was a significant decrease in sexual satisfaction scores in women who underwent vaginal delivery in comparison to those who underwent elective caesarean section at two years follow up. There was also a significant increase in the prevalence of urinary incontinence, incontinence of flatus, dyspareunia and subjective depression in women who underwent vaginal delivery especially forceps compared to ventouse delivery.

**Conclusions:** Primiparous women undergoing vaginal delivery complain of a higher prevalence of urinary incontinence, incontinence of flatus, depression, dyspareunia and a less satisfactory sex life in comparison to women delivering by elective caesarean section at follow up, one and half to two years later.
Echovist Temperature and Patients Pain Score During Hysterocontrastsonograph - A Randomised Controlled Study

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Introduction
Hysterocontrast sonography (HyCoSy) has revolutionised the investigation of tubal patency. Pain during the injection of contrast medium is a common complaint.

Aim
To investigate and compare the subjective pain experienced with the aid of a visual analogue scale (VAS) when either contrast of room temperature or 37 C is injected. In addition the volume of contrast used was recorded and compared to the pain score.

Method
71 patients attending clinic between March and November 2001 for tubal assessment were included in this study. Patients undergoing HyCoSy were randomised to receive either contrast at room temperature (n=38) or contrast at 37 C (n=36). Randomisation was carried out according to the last digit of the patients’ year of birth (odd numbers received Echovist medium at room temperature and even numbers received Echovist medium warmed to 37 C). Pain experienced at the time of transvaginal scan, insertion of the catheter and injection of the contrast medium were recorded on a VAS. The VAS was graded 0 to 10. Zero corresponds to no pain and ten to the worst pain ever.

Results
The mean pain score for the transvaginal scan, insertion of the catheter and injection of the contrast was 2.31, 4.71, 4.38 respectively. Pain score for the injection of the contrast at room temperature and at 37 C was 5.37 and 3.33 respectively (p<0.002). 30 patients required less than 5 mls of contrast to demonstrate tubal anatomy, 41 patients required a volume of greater than 5 mls. The mean pain score was 3.32 and 4.24 respectively (p=0.652).

Conclusion
There was a significant statistical difference in the pain scores when either contrast of room temperature or 37 C was used. Pain experienced at the time of fluid injection was decreased when the contrast medium was warmed to body temperature before insertion.
The 20 week scan: What do women know?
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Judith Biss
R.W Llewellyn
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Introduction
The RCOG standard for ultrasound screening is that all women should have a detailed information leaflet explaining anomalies which can be picked up and also giving them local detection rates for these anomalies.

Background
In view of very variable counselling about ultrasound it was perceived that women having a 20 week scan were unaware of the potential of the scan to pick up anomalies. A questionnaire was designed to estimate women’s knowledge of this scan to plan a better information leaflet to meet the RCOG standard.

Materials and methods
A questionnaire about the 20 week scan was prospectively and randomly distributed to 50 women booking for antenatal care in Singleton hospital. A letter explaining the purpose of the study was given to each woman.

Results
64% of women had had no information about problems which may be picked up on scan. 50% of women who said they had been given information said it had been given by their midwives. Though 70% said they were aware that the scan was a screening process 44% had refused the biochemical screening test. Only half the number of women were aware they could refuse to have a scan.

All the women wished to be informed of a problem detected on scan and 86% would have liked more tests if a problem was detected. Detection of limb anomalies was high on most women’s list of problems diagnosed and cardiac anomalies was second with 78% thinking cardiac problems would be picked up all or most of the time. 6% thought spina bifida is never diagnosed on scan when this is one anomaly for which which ultrasound detection is the gold standard for diagnosis.

More worrying was the finding that 16% of women thought Down’s would be diagnosed and 24% thought autism and 26% thought cerebral palsy would be detected.

94% of the women were white and 30% had a college education 16% were postgraduates. 58% were between 26 and 35 years of age.

Conclusion
Better education of medical and midwifery staff through compulsory courses on antenatal screening is essential. An information leaflet explaining the types of scan and detection rates of various anomalies with a consent form for women would be the way forward in view of Welsh assembly plan to introduce uniform antenatal screening practice across the region.
Abstract Title: Computer skills among trainee doctors

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Objective: To assess the extent of training and the opinion of trainee doctors regarding computer skills in Obstetrics and Gynaecology in Wales.

Methods: This was a questionnaire survey in Wales. One hundred and forty five trainee doctors in the field of obstetrics and gynaecology were sent postal questionnaires. The questionnaire included four questions enquiring the doctors, regarding their existing skills, any courses attended, their opinion on the necessity of computer skills in medical education and the inclusion of skills courses in the training curriculum. During analysis of the results, no differentiation was made regarding the training grade of the doctors (senior house officers, registrars, or senior registrars) and whether there were overseas trainees or not.

Results: Out of 145 trainee doctors, 75 answered and returned the questionnaire. This resulted in a response rate of 51.72%. All the trainees agreed that computer skills are essential for doctors. The extent of knowledge regarding use of different programmes varied. Sixty-seven (89.3%) were able to use Microsoft word programme, 47 (62.7%) were able to use Microsoft power point programme and 32 (42.7%) were able to use Microsoft excel programme. On the other hand, only 10 (13.3%) were familiar with use of statistical packages. Seventy one (94.7%) agreed that computer skills courses should be included in the curriculum training and only 17 (22.7%) had attended a computer skills course.

Conclusions: Information technology has radically changed the way that many people work and think. General Medical Council has stated that ‘a working knowledge of modern medical information technology will be essential to the doctor in the future’ (1) and some of the hospitals have incorporated computer skills training in their curriculum (2). However, we have a lost generation of doctors who are consultants, general practitioners, and postgraduate trainees who have missed out on this opportunity. It is
crucial that an effort is made by the trusts to educate these doctors in computer skills to assist them in adapting to the advancing technology in medicine.

References


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Abstract Title: The outcome of teenage pregnancies in South Glamorgan.

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OBJECTIVE

Teenage pregnancy is a world wide social problem. The UK has the highest incidence in Western Europe. Several studies have shown an increase in various antenatal, intrapartum and postnatal complications. The aim of this study was to quantify the age related risk of adverse obstetric outcome in primigravid women less than 20 years of age.

METHODOLOGY

This was a population-based study of all primigravid women less than 35 years at delivery. The study sample was drawn from Cardiff births survey (a computerised maternity information database) comprising of 66,271 deliveries in the South Glamorgan region during 1990-99. Pregnancy outcomes were compared by age at delivery in women less than 20 years old (n=4,126) and 20-34 years old (n=17,615); women 35 years or older were excluded. A subgroup analysis was also performed on the early teenage group less than 17 years to ascertain if they had a different outcome. Demographic information, antepartum complications, intrapartum details, neonatal outcome measures were recorded. Data are presented as percentages of women less than 20 and 20-34 year old women, with odds ratio and 95% confidence intervals.

STATISTICAL ANALYSIS

SPSS version 10 was used for statistical analysis. Independent sample t test, Chi square, Fishers exact tests were used wherever appropriate. A p value of less than 0.05 was considered significant.

RESULTS

Teenage pregnancy accounted for 17.8% of all pregnancies. Of the total number of 4,126 teenage pregnancies surveyed, 587 (14.2%) belonged to the early teenage group i.e. less than 17 years at delivery.

Women less than 20 years were significantly more likely to be unemployed (OR=7.6, 95% CI 6.4-7.6), not married (OR=15.7, 95% CI 14.1-17.4), lack stable relationships (OR=4.7, 95% CI 4.2-5.3), book late (OR=3.5, 95% CI 3.1-4) and smoke (OR=2.8, 95% CI 2.6-3.1). Uptake of AFP screening was significantly lower (OR=0.5, 95% CI 0.5-0.6) amongst the women less than 20 years. There was a lower incidence of multiple pregnancies (OR=0.3, 95% CI 0.2-0.4), premature rupture of membranes (OR=0.7, 95% CI 0.6-0.9), pregnancy-induced hypertension (OR=0.9, 95% CI 0.6-0.8) amongst teenage primigravidae, a higher incidence of anaemia (OR=1.8, 95% CI 1.6-1.9), pyelonephritis (OR=1.5, 95% CI 1.2-1.8) and preterm labour (OR=1.2, 95% CI 1.1-1.3) was noted. The teenage group had a lower mean gestational age at delivery but there was no significant difference in the incidence of early preterm labour (<32 weeks) in the two age groups. The early teen group however had a higher incidence of preterm labour < 32 weeks (OR=2.4, 95% CI 1.4-4.1) compared to the older teen group.

There was a lower incidence of induction of labour (OR=0.7, 95% CI 0.7-0.8) and use of conductional analgesia (OR=0.8, 95% CI 0.7-0.9) for labour or delivery in the teenage group. Duration of first and second stage of labour was significantly less in the younger women. Women less than 20 years were more likely to have a spontaneous vaginal delivery (OR=2.1, 95% CI 2.3) compared to the older age group. The teenage mother had a significantly lower incidence of assisted vaginal delivery (OR=0.5, 95% CI 0.4-0.5), Caesarean Section (OR=0.5, 95% CI 0.4-0.5) as well as a lower incidence of primary postpartum haemorrhage (OR=0.6, 95% CI 0.5-0.6). There was no difference in the mode of delivery between the early and older teenage group. Duration of postnatal hospital stay was significantly less among teenage mothers.

The mean birth weight was significantly lower among teenage mothers. The incidence of babies with low birth weight (OR=10.9, 95% CI 12.6) was significantly higher, while the incidence of macrosomia (OR=0.7, 95% CI 0.8) was significantly lower in the teenage age group. There was no significant difference in the incidence of low birth weight babies between the early teenage group and the older teens. Inspite of lower birth weight and higher incidence of preterm labour the perinatal outcome measures between the teenage group and the control group were not significantly different.
CONCLUSION
Teenagers were more likely to deliver preterm and low birthweight babies. Despite this, they have lower rates of maternal morbidity, obstetric interventions and are more likely to have a spontaneous vaginal delivery. Although the obstetric risks are low, these pregnancies have socioeconomic implications. There is a need to reassess the services available to teenagers, and place an emphasis on postnatal contraception to avoid a repeat pregnancy.

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Abstract of poster presentations

P1  JG JadHAV et al
The effect on incidence of caesarean section for cervical dystocia following large loop excision of transformation zone of the cervix for CIN

P2  PJ Arumugam et al
Functional bowel disorders – does rectocoele and intussusception mean anything?

P3  A Singh et al
Outpatient hysteroscopy – a patient’s perspective

P4  TS Shyslaree et al
Uterine papillary serous tumour – a case report

P5  J Karuppaswamy
Leiomyomatosis peritonealis disseminata

P6  U Rajesh et al
Silent uterine rupture following second trimester medical termination of pregnancy in a woman with an artificial urinary sphincter and 3 previous caesarean sections

P7  S Vijayanthi et al
Haemoperitoneum due to placenta percreta in the third trimester mimicking placental abruption

P8  V Gopalan et al
A case of undiagnosed atrial septal defect complicated by pregnancy

P9  M Ragunath et al
Efficacy of endometrial samplers in the investigation of post-menopausal bleeding

P10 S Vijayanthi et al
Medical termination of pregnancy at 9-12 weeks of gestation

P11 J.Bibby et al
The uptake and concordance of hormone replacement therapy in women after hysterectomy

P12 S Purmessur et al
Obstetric Cholestasis: Is it significant?

P13 Angela Hamon et al
Urate levels in twin pregnancy. A prospective longitudinal study in women developing clinically significant pre-eclampsia compared with women remaining well.

P14 Arianna D’Angelo et al
Echovist temperature and patients pain score during hysterocontrastsonograph – A randomised controlled study
The effect on incidence of Caesarean sections for cervical dystocia following large loop excision of transformation zone of the cervix for CIN.

Jadhav JG, Parveen S, Perera M.

Department of Obstetrics & Gynecology, Royal Gwent Hospital, Newport, Gwent. Sept. 2001.

OBJECTIVE: Our purpose was to determine whether large loop excision of the cervical transformation zone increases the incidence of caesarean section for cervical dystocia.

STUDY DESIGN: Retrospective study. 63 women who underwent LLETZ for CIN and delivered at Gwent in the period between Jan 1999 – Dec 2000 were identified. The labour ward statistic for the similar period was used as control. Variables included smoking, duration between loop excision & delivery, maternal performance in labour & perinatal outcome. Maternal factors analysed included period of gestation, duration of labour and mode of delivery. Perinatal outcome measured were whether the infant was live born & birth weight.

RESULTS: LLETZ did not increases the incidence of caesarean section for cervical causes. The incidence of caesarean section for failed induction of labour and failure to progress was 3.17% in the post LLETZ group, as against the 4.73% section rate for similar indications for the non LLETZ deliveries.

In our study, 39 (62%) were in the 20-30 yrs age group & 21 (33%) were in 31-40 yrs group. Only 25 (40%) were smoker with more than 2/3rd of them smoking >10 cigarettes per day. 26 (45.6%) cases conceived for the first time after the loop excision. Most of them 39(62%) delivered within 1-2 yrs of loop excision. Normal delivery was possible in 49(78%), Instrumental in 7 (11%) and Caesarean sections in 7 (11%) cases. All were live births, majority (96.4%) of the babies born at term were weighing > 2500gms.

CONCLUSION: Studies done so far to investigate pregnancy outcome after large loop excision of transformation zone have been generally reassuring. Our medline search could identify two such studies. These were involving 149 and 40 cases at Aberdeen (1989-1991) and Birmingham (1989-1992) respectively. Present study of 63 cases has demonstrated the similar results. However larger controlled trials should be performed before colposcopists can be justified in adopting a liberal attitude to treating all women with abnormal smears.

COMMENT: The highlight of this study was the technique used to identify the LLETZ cases who went on to deliver in the specified period. This was achieved by programming the Medical Coding Department Computer to scan the list of LLETZ and delivered patient simultaneously and to identify the common ID. This has avoided manual searching of all LLETZ cases of the study period. This technique can be used for future larger studies based on the present 'pilot study'.

(Jadhav, JG Specialist Registrar, Birmingham Heartlands Hospital, Birmingham. Parveen, S Specialist Registrar, Royal Gwent Hospital, Newport, Gwent. Perera, M Specialist Registrar, Singleton Hospital, Swansea.)
Functional Bowel Disorders- Does rectocele and intussusception mean anything?

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Introduction: Colorectal units specialising in functional bowel disorders deal with a variety of problems ranging from constipation to obstructed defaecation. Colorectal specialists have tried to define the criteria for surgical treatment in these patients. Gynaecologists also routinely perform rectocele repair. We performed a complete anorectal assessment in a group of women who did not volunteer any bowel symptoms.

Methods: The subjects are part of an ongoing study on abdominal hysterectomy and its impact on the anorectal function. Detailed obstetric history and clinical assessment of descent was also recorded. 34 women had their function assessed before their respective surgery by a questionnaire (Cleveland continence score, functional bowel score) and by endoanal ultrasound (U/S), anal manometry, defaecatory proctogram and colonic transit. Their preoperative anorectal assessment is presented in this study.

Results: The median age of subjects was 41. Surprisingly, on further questioning some women had bowel symptoms and their functional bowel score ranged from 4 to 26. 28(82%) moderate rectoceles and 19(56%) intussusceptions were noted. Rectoceles and intussusceptions were not always associated with bowel symptoms. Nullipara and women who delivered only by caesarean also had anorectal abnormalities. 2 women had poor puborectalis function. Cough incontinence was noted in 7. 4 women had abnormal colonic transit. 9 had abnormal anal manometry. Endoanal U/S was normal in all subjects.

Discussion: Majority of women who were deemed to be normal had physiological and proctographic abnormalities. The functional bowel score did not correlate with the abnormalities on proctographic assessment. It is still a mystery to identify a subset of patients who will benefit from surgery. In light of these abnormalities in a relatively normal population, surgeons and gynaecologists should carefully counsel and be cautious in offering surgery for patients with functional bowel disorders.
Poster Abstract

OUTPATIENT HYSTEROSCOPY - A PATIENTS PERSPECTIVE

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Introduction
Outpatient hysteroscopy is a valid tool for the investigation of menstrual disorders. It is suggested 93.3% of women undergoing this procedure find it well tolerated (BJOG 1998 672-676). Previous audit in 1998 found 88% of patients found it well tolerated. To improve this figure it was recommend to generate an amended patient information leaflet.

Aim
1. To quantify the usage of patient information leaflets.
2. To assess patient satisfaction of the procedure and assess whether the use of the patient information leaflets improved patient satisfaction.

Method
Retrospective re-audit of 35 patients with the aid of a patient questionnaire and telephone interviews. The format of data collection was identical to the previous audit.

Result
The number of patients reading the information leaflet increased from 28% in 1998 to 100% in this sample. There was a significant reduction in pre-treatment anxiety level, reduction in discomfort experienced with the procedure and a significant improvement in overall patient satisfaction.

Conclusion
Outpatient hysteroscopy without the use of local anaesthetics is a well tolerated procedure. The level of patient satisfaction can be improved and pre treatment anxiety decreased with the use of a patient information leaflet.
UTERINE PAPILLARY SEROUS TUMOUR - A CASE REPORT

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Background: Hendrickson et al described Uterine papillary serous tumour (UPSC) as a distinctive entity in 1982. It is considered an aggressive variant of uterine cancer. The incidence of UPSC is 4-10%.

Case: A 69 year old lady had endometrial biopsy for postmenopausal bleeding which revealed high grade papillary serous endometrial adenocarcinoma with myometrial invasion. She had past history of left-sided multifocal breast carcinoma for which she had undergone left mastectomy and was on tamixifen for five years. There was no history of breast or ovarian cancer in the family. MRI pelvis showed moderate ascites and endometrial disease with myometrial invasion. Laparotomy revealed stage IIIC endometrial cancer. Total abdominal hysterectomy, bilateral salpingo-oophorectomy, omentectomy, lymphnode sampling and debulking of the tumour was performed. Histopathology of the surgical specimen revealed high grade uterine papillary serous carcinoma with one third myometrial invasion and with cervical stromal, bilateral ovarian, left tubal, omental, peritoneal and pelvic lymph node metastasis. There was tumour cell immunochemical negativity for estrogen and focal weak positivity for progesterone receptor antigens. Immunohistochemistry of the surgical specimen for P53 protein expression was negative. She is started on postoperative adjuvant chemotherapy with platinum and taxol.

Discussion: UPSC tends to occur more in older postmenopausal women, they are estrogen independent, 80% of these tumours have p53 mutations and microsatellite instability. Lymph node metastasis is found in more than one third of the women with little or no myometrial invasion. The recurrence of the disease is 30% even in organ confined disease. There are many studies contemplating UPSC to be a BRCA1 related or hereditary breast ovarian cancer syndrome, but this theory has not been proved yet. The presentation, progression, prognosis, treatment and follow up of these tumours is similar to ovarian serous cancers.

Currently, the standard management of early endometrial carcinoma is surgical staging with total abdominal hysterectomy and bilateral salpingo-oophorectomy with or without adjuvant radiotherapy and the survival figures are good. Uterine papillary serous carcinoma (UPSC) is a rare and aggressive variant of endometrial cancer, which resembles serous papillary cancers of the ovary, and is far more advanced than the conventional endometroid tumours. It is preferable such tumour types are diagnosed preoperatively and managed in cancer centres with a multidisciplinary team approach.

Conclusion: This case is reported for its rarity and poor prognosis. Reporting of UPSC and its management should be encouraged as the disease process has not been completely evaluated and will help in comparing data in the future. Further studies should be done to examine the hereditary predisposition of these cancers which will have a bearing on screening and prevention in the high risk population.
ABSTRACT

Background

Leiomyomatosis Peritonealis Disseminata is a rare condition characterized by the development of multiple subperitoneal leiomyomatous nodules found in women, presents in their reproductive years and rarely in the postmenopausal age group. It is also found to be associated with pregnancy and oral contraceptive intake suggesting hormonal factors may be involved in the pathogenesis of LPD. The disorder has a grossly malignant appearance, but has benign histology and a favourable prognosis. Approximately 100 cases have been described in the literature worldwide.

Case

A 45 year old woman who was not pregnant and has never taken oral contraceptives was found to have leiomyomatosis peritonealis disseminata on histology but clinically thought to have intraabdominal secondaries possibly to ovarian malignancy when she underwent a hysterectomy for menorrhagia.

Conclusion

As there are only small number of cases of LPD published worldwide, it is uncertain how this condition should be managed. The suggested figures may indicate a high malignant potential, necessitating further research into the causation and management aspect of this rare condition.

Keywords: Leiomyoma, Leiomyomatosis peritonealis disseminata
ABSTRACT

SILENT UTERINE RUPTURE FOLLOWING SECOND TRIMESTER MEDICAL TERMINATION OF PREGNANCY IN A WOMEN WITH AN ARTIFICIAL URINARY SPHINCTER & THREE PREVIOUS CEASAREAN SECTIONS

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Uterine Rupture following a second trimester medical termination of pregnancy is a rare but a recognized complication. One or more previous cesarean sections pose an increased risk of uterine rupture or scar dehiscence.

We present a case of uterine rupture with minimal clinical signs following medical termination of pregnancy at 24+ weeks gestation for multiple fetal anomalies in a patient with three previous caesarean sections and an artificial urinary sphincter for spina bifida, the management dilemmas in her case and a brief review of literature.

We aim to highlight that there is evidence of an increased risk of uterine rupture following second trimester termination of pregnancy in patients with one or more previous cesarean sections and that these women have to be counseled carefully regarding risk of uterine rupture, possible need for a laparotomy +/- hysterectomy pre TOP. The need for careful & gentle exploration of lower uterine segment at time of examination under anaesthetic has been emphasised in our case. The optimum or safest regime for second trimester medical termination in these cases however remains to be recommended by larger studies.
HAEMOPERITONEUM DUE TO PLACENTA PRECAREA IN THE THIRD TRIMESTER MIMICKING PLACENTAL ABRUPTION


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Abstract

Placenta percreta is a condition of abnormal placentation which is associated with significant maternal morbidity and mortality. Life threatening haemorrhage often necessitates emergency hysterectomy with resulting loss of fertility. Placenta percreta is usually only diagnosed accidentally when complications occur. Though several diagnostic modalities have been suggested to help in the diagnosis antenatally very rarely is the diagnosis known prior to the acute presentation. We present here a case of placenta percreta which presented at 33 weeks mimicking concealed placental abruption. Predisposing risk factors, diagnosis and management aspects are discussed
CASE REPORT - ABSTRACT

A CASE OF UNDIAGNOSED ATRIAL SEPTAL DEFECT COMPLICATED BY PREGNANCY.
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Clinical presentation
A 24 year old Asian lady (G2P2) presented postnatally with a history of increasing shortness of breath and a non-productive cough. Four days earlier at 36 weeks gestation, she had a spontaneous vaginal delivery of a live male infant weighing 2.010kg. Her symptoms had been present for few weeks prior to her delivery but had recently worsened. On examination she was dyspnoeic at rest and had a raised jugular venous pressure. Auscultation of chest confirmed a systolic murmur, loudest at the left sternal edge.

Past Obstetric History
1998: Full term normal vaginal delivery of a baby boy weighing 2.03kg.

Investigations
- Oxygen saturation: 86% on air
- ECG: Sinus tachycardia
- Right Bundle branch block & Right Axis Deviation
- Chest x-ray: Cardiomegaly and prominent pulmonary vasculature

Management
She was transferred to medical ward and underwent further investigations including Cardiac Catheterisation and Trans-oesophageal Echocardiogram. A large atrio-septal defect (ASD) with an increased pulmonary vascular resistance was diagnosed. She subsequently underwent surgical closure of ASD, and after a stormy postoperative period, made a slow recovery. She was discharged home after two months in hospital.

Discussion:
The incidence of serious cardiac disease complicating pregnancy is approximately 1%. An ASD is the most common congenital heart condition, with a maternal mortality rate of less than <1%. In the absence of pulmonary hypertension, pregnancy and labour are well-tolerated. Larger defects associated with pulmonary hypertension or Eisenmengers syndrome pose significant risks. Fetal outcome is also poor, with spontaneous abortion, intra-uterine growth retardation and preterm labour being widely reported. Prepregnancy counselling, optimisation of status and meticulous multidisciplinary management during pregnancy, delivery and postpartum period can improve outcome.

Lesson: Although some cardiovascular changes during pregnancy are not cause for alarm some do demand prompt attention. In some cases previously unrecognised heart disorders may be unmasked by pregnancy. Therefore attention to cardiac signs and symptoms is important because some disorders although uncommon can threaten maternal and fetal well-being.
Efficacy of endometrial samplers in the investigation of post-menopausal bleeding

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Background
Post-menopausal bleeding (PMB) is a common complaint and represents more than a third of referrals to a general gynaecology outpatients clinic. Despite forming a significant part of general gynaecology there are no nationally agreed protocols for the investigation of PMB. Previous studies have shown that endometrial sampling, using the Pipelle or Endocell samplers, is effective in excluding endometrial pathology and the manufacturers quote a 27% rate of failing to obtain a sample. The technique may fail due to sampling errors or due to an atrophic endometrium. In the absence of a normal histology report after sampling, these women often undergo hysteroscopy under general anaesthesia.

Aims
The aims of this study were to determine how many endometrial samples were inadequate for diagnosis, to determine what other diagnostic procedures had been carried out and to derive an evidence-based clinical care pathway for the investigation of post-menopausal bleeding.

Methods
The results of all endometrial samples taken over a 3 month period (January to March 2001) were scrutinised. Women were included if they had post-menopausal bleeding (at least 12 months since their last menstrual period). For those women whose sample was inadequate for diagnosis the further management was determined by examining the case notes.

Results
Histology reports were examined for 118 women of whom 40 (34%) had inadequate pipelle sampling. All of these women had a pelvic scan and 19 women had a thickened endometrium (≥5mm) and had a hysteroscopy and curettage.

The results of the remaining 78 endometrial samples included 4 cases of endometrial carcinoma, 1 case of complex hyperplasia and 2 cases of mild atypical hyperplasia.

Conclusions
♦ The rate of failed sampling is higher in clinical practise than suggested by the manufacturers literature.
♦ Half of those women with failed samples had an endometrial thickness of <5mm on scan suggesting an atrophic endometrium.
♦ Endometrial sampling was effective in diagnosing endometrial carcinoma.
MEDICAL TERMINATION OF PREGNANCY AT 9 –12 WEEKS OF GESTATION

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ABSTRACT

Background: Current RCOG guidelines advise that surgical termination should be offered to those within the 9-12 weeks gestation band. Whilst auditing the quality of services offered for termination of pregnancy in our unit, it became apparent that many women presenting at this gestation were requesting a medical method. There has been little clinical research into medical method of abortion at this gestation.

Aim: To assess the efficacy of medical termination of pregnancy at 9-12 weeks of gestation.

Method: Retrospective analysis of 25 cases who underwent medical termination using a regime of Mifepristone followed 48 hours later by a course of vaginal gemeprost.

Results: Complete abortion was achieved in 96% of cases. 92% of women required 2 pessaries or less to achieve abortion. All but one patient were suitable for discharge on the same day. One woman underwent surgical evacuation in view of heavy bleeding.

Conclusion: Medical TOP is a safe alternative to surgical method at 9 –12 weeks gestation.
The uptake and concordance of hormone replacement therapy in women after hysterectomy

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Background
Up to 80% of post menopausal women complain of symptoms which can last from 2 to 5 years after the menopause. The onset of these symptoms appear to be more severe after surgical menopause (bilateral oophorectomy). There are long term health concerns related to oestrogen deficiency including osteoporosis, cardiovascular disease, Alzheimer’s disease and colonic cancer. Bilateral oophorectomy in pre-menopausal women increases the duration of oestrogen deficiency and theoretically may increase the risk of adverse events. Hormone replacement therapy (HRT) is highly effective in reducing menopausal symptoms and proven to reduce osteoporosis yet the majority of British women who start taking HRT discontinue treatment within 9 months. The reasons for stopping HRT include bleeding problems, side effects and concerns over breast cancer. This study investigates the uptake of HRT and long term continuation of treatment for a group of women undergoing surgical menopause.

Methods
All women who had a surgical menopause under the age of 56 years for benign disease in Singleton Hospital over a 12 month period (Jan-Dec 1998) were sent a questionnaire about their HRT since their operation. Non-responders were sent a second questionnaire after 2 months. The information collected included the women’s recollections of advice given about the need for bilateral oophorectomy and the benefits of HRT, the type of HRT taken, the duration of use and the reasons for discontinuation.

Results
The response rate to the questionnaire was in excess of 67%. Approximately 20% of women cited fear of developing ovarian cancer as the reason for opting for bilateral oophorectomy. More than 70% of women were continuing to take HRT 2 years after their surgical menopause. The majority of women were using a transdermal preparation, patches or oestrogen gel.

Conclusions
- The fear of developing ovarian cancer is out of proportion to the true risks and influences the women’s decisions about oophorectomy in 1 in 5 women.
- Concordance with HRT after surgical menopause is high and may be due to the lack of bleeding side effects in hysterectomised women.
OBSTETRIC CHOLESTASIS: IS IT SIGNIFICANT?

S Purmessur, Registrar  Miss T G Maulik, Consultant

Case Report 1

A 27 year old primiparous woman developed generalised pruritus at 33 weeks' gestation with a general sense of feeling unwell. Urine was noted to have grown darker and stools paler. There was no past history of blood transfusions and no recall of contact with hepatitis carriers. Moreover, there was no past history of autoimmune disorders and the only known allergic condition was to septrin. Alcohol intake, which was occasional prior to pregnancy, had been nil during pregnancy. Clinically, there was no evidence of typical dermatoses or of jaundice. A diagnosis of intrahepatic cholestasis of pregnancy was made on a clinical basis which was thereafter substantiated by laboratory investigations. Investigations included screening for hepatitis, autoimmune disease, thyroid function test, full blood count, and serial liver function tests. Ultrasound scan for maternal gall bladder and serial ultrasound scans for fetal growth and liquor volume as well as regular cardiocographic tracings were planned.

The only abnormality noted was Aspartate Transaminase (AST) at 120 U/L and Alanine Transaminase (ALT) at 207 U/L. No drug therapy was instituted and serial follow-up with maternal Liver Function Tests (LFTs) revealed AST at 46 U/L after 10 days and remaining stable at 41 U/L thereafter and ALT level falling to 46 U/L and persisting at that level thereafter. Fetal cardiocographic tracings and ultrasound scans were reassuring.

At 37 completed weeks' gestation, an induction of labour was effected with prostaglandins and artificial rupture of membranes and intravenous oxytocin thereafter. Labour and delivery were uneventful but a primary postpartum haemorrhage of 1000 ml occurred due to uterine atony. This was successfully treated with intravenous oxytocin and transfusion of three units of blood. The neonate was of normal birth weight with Apgar of 9 and 9 at 1 and 10 minutes. Postpartum period was uneventful with LFTs normal three days post partum. Postnatal review at six weeks confirmed maternal and infant wellbeing.

Case Report 2

A multiparous 39 year old lady developed facial itching at 16 weeks' gestation along with rashes appearing intermittently on the limbs. Her three previous term pregnancies had been uneventful ending with vaginal deliveries of normal, healthy babies. She did not drink alcohol and had no history of past blood transfusions, contact with hepatitis carriers. Clinically, there was evidence of excoriated papular rash on the limbs but no jaundice. An amniocentesis performed at the patient's request on the basis of her age revealed a normal fetal karyotype. A multidisciplinary team approach was organised including Obstetrician, Physician and Dermatologist. Investigations included LFTs, Bile salts, hepatitis screening, antibody screening for primary biliary cirrhosis, full blood count, coagulation profile, urea and electrolytes and Thyroid Function Tests. Ultrasound scan of maternal gall bladder, detailed fetal survey and serial fetal growth and liquor scans were planned. Treatment included calamine lotion and cholestyramine thereafter.
All investigations were normal apart from the LFTs which revealed:

<table>
<thead>
<tr>
<th>Gestation (weeks)</th>
<th>AST (u/l)</th>
<th>ALT (u/l)</th>
<th>GGT (u/l)</th>
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</thead>
<tbody>
<tr>
<td>16</td>
<td>86</td>
<td>113</td>
<td>73</td>
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<tr>
<td>18</td>
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<td>32</td>
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</table>

Bile salts at 18 weeks and 22 weeks were normal but at 33 weeks, came up to 54 umol/l. Doppler of the umbilical artery revealed a normal blood flow and ultrasound scan of fetus and liquor volume was equally normal. The cardiotocographic tracing was reassuring. Maternal steroid injections were administered and an elective caesarean section was performed two days later. No operative or postoperative complications were noted and the neonate was normal and healthy. LFTs took three weeks to come back to normal.

Discussion

Obstetric Cholestasis is usually associated with generalized pruritus in the second or third trimester and jaundice is relatively uncommon and is only present in the most severe and prolonged cases. The European incidence of the condition is 0.1 to 1.5 per 1000 pregnancies whilst in South American countries this incidence might be up to 28%. The UK incidence might therefore be an underestimation as over the last 2 decades the incidence in USA has risen from 0.1% to 0.7% probably from a growing awareness of the condition. The condition appears to be linked to abnormal function of liver canalicular transporter proteins. This tends to cause an increase in the concentrations of oestriadiol and progesterone metabolites and an accumulation of bile salts. An association with gall stones has also been made. As the condition is multifactorial and includes environmental and genetic conditions, the fetus might moreover be prone to inherit any gene mutation and can thereby be predisposed to bilesalt accumulation. In up to 33% of cases of Obstetric Cholestasis, fetal compromise occurs with preterm births occurring spontaneously or iatrogenically in up to 60% cases. The risk of intrauterine fetal demise is also increased and can occur in up to 2% of cases. The serum bile acids are raised in the vast majority of cases whilst raised transaminases are noted in 60% of cases and raised biliubin in about 25% of cases. The gammaglutamyltransferase is raised in about 33% of cases and the rise has been associated to mutation of the multirug resistance proteins. Management options include the use of Ursodeoxycholic acid which reduces the accumulation of bile acids and is effective in decreasing pruritus and LFT abnormalities. Although not licensed in pregnancy, its use has only given rise to occasional mild diarrhoea. Close maternal and fetal surveillance are obviously warranted. Given the risk of intrauterine demise, induction of labour should be considered at 37 completed weeks. Biochemical normality is usually rapidly obtained within one to two days postpartum. Persistence of abnormal LFTs thereafter should prompt further investigations of underlying liver disease.

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Urate levels in twin pregnancy. A prospective longitudinal study in women developing clinically significant pre-eclampsia compared with women remaining well
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Abstract
Objective To establish whether urate levels are significantly higher in twin pregnancy in women developing clinically significant pre-eclampsia compared with women remaining well and to determine the upper limit of the normal range at booking, 28, 32 and 36 weeks and delivery.
Design Prospective longitudinal study.
Setting Maternity unit with 5,500 deliveries per annum.
Participants Women with a twin pregnancy attending the maternity unit.
Main outcome measures Urate levels.
Results Urate levels were significantly higher in the women developing clinically significant pre-eclampsia compared with women remaining well at 28 weeks (mean 0.27 compared to 0.20mmol/litre, p<0.01), at 32 weeks (mean 0.36 compared to 0.24mmol/litre, p<0.0005), at 36 weeks (mean 0.44 compared to 0.30mmol/litre, p<0.0005) and delivery (mean 0.46 compared to 0.33mmol/litre, p<0.0005) and no different at booking (mean 0.22 compared to 0.17mmol/litre, not significant). The upper limits of normal (2 standard deviations above the mean) for urate levels in twin pregnancies in this study were 0.29, 0.31, 0.37, 0.45 and 0.51mmol/litre at booking, 28, 32, 36 weeks and delivery respectively.
Conclusion The measurement of urate levels in women with a twin pregnancy is useful in the management of pre-eclampsia.
Echovist Temperature and Patients Pain Score During
Hysterocontrastsonograph - A Randomised Controlled Study

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Introduction
Hysterocontrast sonography (HyCoSy) has revolutionised the investigation of tubal patency. Pain during the injection of contrast medium is a common complaint.

Aim
To investigate and compare the subjective pain experienced with the aid of a visual analogue scale (VAS) when either contrast of room temperature or 37 C is injected. In addition the volume of contrast used was recorded and compared to the pain score.

Method
71 patients attending clinic between March and November 2001 for tubal assessment were included in this study. Patients undergoing HyCoSy were randomised to receive either contrast at room temperature (n=38) or contrast at 37 C (n=36). Randomisation was carried out according to the last digit of the patients’ year of birth (odd numbers received Echovist medium at room temperature and even numbers received Echovist medium warmed to 37 C). Pain experienced at the time of transvaginal scan, insertion of the catheter and injection of the contrast medium were recorded on a VAS. The VAS was graded 0 to 10. Zero corresponds to no pain and ten to the worst pain even.

Results
The mean pain score for the transvaginal scan, insertion of the catheter and injection of the contrast was 2.31, 4.71, 4.38 respectively. Pain score for the injection of the contrast at room temperature and at 37 C was 5.37 and 3.33 respectively (p<0.002). 30 patients required less than 5 mls of contrast to demonstrate tubal anatomy, 41 patients required a volume of greater than 5 mls. The mean pain score was 3.32 and 4.24 respectively (p=0.652).

Conclusion
There was a significant statistical difference in the pain scores when either contrast of room temperature or 37 C was used. Pain experienced at the time of fluid injection was decreased when the contrast medium was warmed to body temperature before insertion.