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Junior Obstetrics & Gynaecology Society
Annual Scientific Meeting 2025

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BOOK OF ABSTRACTS

List of abstracts

ENDOMETRIAL BIOPSY VS. NORMAL HYSTEROSCOPY: RETHINKING DIAGNOSTIC PATHWAYS IN BLEEDING CASES 9

ASSESSING THE IMPACT OF A TARGETED OBSTETRICS AND GYNAECOLOGY TEACHING SESSION ON GENERAL PRACTICE TRAINEES PREPAREDNESS FOR PRACTICE 10

MIRROR SYNDROME IN A 36-YEAR-OLD WOMAN ASSOCIATED WITH DIANDRIC TRIPLOIDY AND PARTIAL MOLAR PREGNANCY: A CASE REPORT 11

ASSESSMENT OF VENOUS THROMBOEMBOLISM RISK AND POST-EVENT DEBRIEFING IN POSTPARTUM HAEMORRHAGE PATIENT CARE: AN AUDIT 12

AUDIT OF EDUCATION ON FEMALE GENITAL MUTILATION IN UNIVERSITY CURRICULA IN IRELAND 13

ASSOCIATIONS BETWEEN SLEEP AND MENTAL HEALTH WITH PRETERM BIRTH IN A HIGH-RISK COHORT: A SECONDARY ANALYSIS OF THE PRE-POP TRIAL 14

EVALUATING EFFICIENCY AND OUTCOMES OF AMBULATORY GYNAECOLOGY CLINICS: A RETROSPECTIVE AUDIT AT MRH PORTLAOISE 16

TRANSITIONS IN MEDICAL EDUCATION: CLINICIAN EXPERIENCES MOVING BETWEEN CLINICAL PRACTICE AND RESEARCH ROLES 17

SYNCHRONOUS BENIGN BRENNER AND BORDERLINE MUCINOUS TUMOUR: A RARE CASE IN A POSTMENOPAUSAL WOMAN 18

ROBOTIC-ASSISTED MANAGMENT OF BLADDER ENDOMETRIOSIS FOLLOWING UNRECOGNISED CAESAREAN BLADDER INJURY: A CASE REPORT 19

SUSPECTED MOLAR PREGNANCY IN A CONTINUING SINGLETON GESTATION: A CASE OF PARTIAL MOLE WITH COEXISTING HEALTHY FETUS AUTHORS: 20

CYCLICAL VULVAL SWELLING UNMASKED AS ENDOMETRIOSIS: A DIAGNOSTIC CHALLENGE 21

INTRODUCTION OF A MANUAL VACUUM ASPIRATION SERVICE AT THE COOMBE HOSPITAL 22

APPLICATION OF THE CLAVIEN-DINDO CLASSIFICATION OF SURGICAL COMPLICATIONS TO PROCEDURES IN A GYNAECOLOGICAL TERTIARY REFERRAL CENTRE 23

ISOLATED PREPUBERTAL MENARCHE IN A 15MONTH OLD CHILD; A CASE REPORT 24

LATE NIGHTS, HIGH STAKES: EMERGENCY CAESAREAN IN CLASS III OBESITY 25

SEASONAL VARIATION IN OBSTETRIC ANAL SPHINCTER INJURY (OASI) RATES, OR RATHER THE LACK THEREOF! 26

INSIGHTS INTO HIGH DEPENDENCY UNIT ADMISSIONS IN A TERTIARY MATERNITY HOSPITAL: AN INSTITUTIONAL REVIEW 27

TRENDS IN MATERNAL FOLIC ACID SUPPLEMENTATION ADHERENCE IN IRELAND: A RETROSPECTIVE ANALYSIS OF 66,690 PREGNANCIES AT THE COOMBE HOSPITAL, 2014–2022 28

AT WHAT COST!: A REVIEW OF THE COST OF MANAGING A BARTHOLIN'S CYST 29

COMPARATIVE EFFECTS OF VAPING, SMOKING, AND DUAL EXPOSURE ON THIRD TRIMESTER FETAL BIOMETRY; A SUBGROUP ANALYSIS OF THE ECHO STUDY 30

AN ASSESSMENT OF CERVICAL LENGTH TRAINING IN THE UK AND IRELAND 32

THE IMPACT OF E-CIGARETTES ON PREGNANCY & CHILDHOOD HEALTH OUTCOMES - THE ECHO STUDY – AN ANALYSIS OF THE OBSTETRIC PRIMARY OUTCOMES 33

OUTCOMES AND MANAGEMENT OF ASC-H CYTOLOGY REFERRALS TO A HIGH-VOLUME IRISH COLPOSCOPY CLINIC 35

INDUCTION OF LABOUR AUDIT 36

TRENDS IN HEALTHCARE PROFESSIONALS PURSUING HIGHER RESEARCH DEGREES: A DOCUMENTARY ANALYSIS 37

THE INFLUENCE OF SEASONAL VARIATION AND LIGHT EXPOSURE ON THE INCIDENCE OF PRETERM BIRTH 38

A RE-AUDIT OF PROPHYLACTIC ANTIBIOTIC ADMINISTERED IMMEDIATELY FOLLOWING OPERATIVE VAGINAL DELIVERY 39

OUTCOMES OF IRELAND'S FIRST DEDICATED FETAL GROWTH RESTRICTION CLINIC AT CORK UNIVERSITY MATERNITY HOSPITAL 40

LIFE IN THE BALANCE – A CASE OF UTERINE ARTERIOVENOUS MALFORMATION AND CONCURRENT DEEP VENOUS THROMBOSIS FOLLOWING TERMINATION OF PREGNANCY 41

BRUSHING UP ON THE BASICS: A LOOK AT CERVICAL SCREENING KNOWLEDGE IN IRISH OBSTETRICS & GYNAECOLOGY NON-CONSULTANT HOSPITAL DOCTORS 42

DERMOID DECEPTION: WHEN TORSION TWISTS THE PLOT IN AN ADOLESCENT WITH OVARIAN TERATOMA 43

FOLATE PRESCRIBING IN PREGNANT WOMEN WITH OBESITY: A CLINICAL AUDIT 45

AN EVALUATION OF THE DECISION TO DELIVERY INTERVAL FOR EMERGENCY CAESAREAN SECTIONS; THE PERIPHERAL EXPERIENCE 46

COMPARISON BETWEEN ABDOMINAL, VAGINAL AND LAPAROSCOPIC HYSTERECTOMIES AND THE SHIFT TOWARDS A MINIMAL ACCESS APPROACH 47

INDUCTION OF LABOUR AT TERM FOR CONCEPTION THROUGH IN VITRO FERTILISATION RESULTED IN A VAGINAL DELIVERY FOR THE MAJORITY OF WOMEN 48

PRIMIGRAVIDA BIRTH INTERVENTIONS: AUDIT OF INDUCTION AND C SECTION INDICATIONS 49

EXTERNAL CEPHALIC VERSION (ECV) CLINIC PERFORMANCE: A RE-AUDIT AT THE NATIONAL MATERNITY HOSPITAL (NMH) 50

OVARIAN RESERVE DYNAMICS AND SUBFERTILITY PROFILES IN AN IRISH REGIONAL FERTILITY HUB: A RETROSPECTIVE REVIEW 51

ASYMPTOMATIC CERVICAL CANCER: A REMINDER OF THE VALUE OF CLINICAL EXAMINATION 52

A REVIEW OF GNRH AGONIST PRESCRIBING PATTERNS AT A SUPRA-REGIONAL CENTRE FOR COMPLEX ENDOMETRIOSIS 53

PREGNANCY WITH TYPE 1 DIABETES MELLITUS AT THE NATIONAL MATERNITY HOSPITAL 54

MANUAL REMOVAL OF PLACENTA: A REVIEW OF TRANSFER TO THEATRE TIME OVER FIVE YEARS IN A TERTIARY MATERNITY HOSPITAL 55

OBSTETRICIANS' SENTIMENT REGARDING BLOOD TRANSFUSION IN PATIENTS WHO ADAMANTLY REFUSE BLOOD TRANSFUSION DESPITE RISK OF DEATH 56

DEVELOPMENT OF AN EDUCATIONAL VIDEO FOR MEDICAL STUDENTS ON SCRUBBING-IN FOR THE OPERATING THEATRE 57

CYCLIC VOMITING SYNDROME IN PREGNANCY: MANAGEMENT CHALLENGES IN THE CONTEXT OF GESTATIONAL DIABETES MELLITUS 58

RISING RATES AND RISKS: A 17-YEAR ANALYSIS OF TERM INDUCTION OF LABOUR USING THE ROBSON TEN GROUP CLASSIFICATION SYSTEM 59

EXPLORING OBSTETRICS AND GYNAECOLOGY PATIENTS' ATTITUDES TOWARDS CLINICAL TEACHING IN IRELAND AND SAUDI ARABIA 60

SUPPORTING SAFE INTEGRATION: A DIGITAL INDUCTION FOR INTERNATIONAL MEDICAL GRADUATES IN IRISH HEALTHCARE 61

ENHANCED RECOVERY AFTER SECTION: IMPROVING PERIOPERATIVE FOR CAESAREAN SECTIONS 62

DEVELOPING, VALIDATING AND EXPLORING OBSTETRICS AND GYNAECOLOGY PATIENTS' ATTITUDES TOWARDS CLINICAL TEACHING 63

DEVELOPMENT AND CHARACTERISATION OF A MICRONEEDLE PH SENSOR FOR INTRAPARTUM FETAL MONITORING 64

DIAGNOSTIC CHALLENGES OF INTERSTITIAL ECTOPIC PREGNANCY IN THE PRESENCE OF UTERINE FIBROIDS: A CASE STUDY 65

ENTERO-UTERINE FISTULA IN THE SETTING OF ADVANCED ENDOMETRIAL CANCER: A CASE REPORT 66

DELAYED DIAGNOSIS OF AN ECTOPIC PREGNANCY - “CORNUAL PREGNANCY” POST IN-VITRO FERTILISATION FOLLOWING A LAPROSCOPIC BILATERAL SALPINGECTOMY 68

IMPLEMENTING A SEXUAL AND REPRODUCTIVE HEALTH EDUCATION PROGRAM FOR RURAL COMMUNITIES IN NORTHERN UGANDA 69

OUTCOMES AMONG WOMEN OVER THE AGE OF 60 YEARS INVITED FOR THE NEW HPV SCREENING TEST IN 2023 70

REFERRALS TO THE ROTUNDA HOSPITAL PAEDIATRIC AND ADOLESCENT GYNAECOLOGY (PAG) SERVICE 71

A RETROSPECTIVE AUDIT OF CAESAREAN SECTION WOUND COMPLICATIONS IN A TERTIARY MATERNITY HOSPITAL 72

CYTOGENETIC TESTING FOR FIRST TRIMESTER PREGNANCY LOSS – HOW OFTEN IS THERE AN ABNORMAL RESULT? 73

SAY MY NAME: A QUALITY IMPROVEMENT SURVEY TO EXPLORE PATIENTS’ VIEWS ON RENAMING THE ADOLESCENT OBSTETRIC SERVICE 74

PROSPECTIVE PERINATAL AUDIT OF INDUCTION OF LABOUR IN NULLIPAROUS WOMEN (ROBSON GROUP 2A): INDICATIONS AND DELIVERY OUTCOMES AT THE NATIONAL MATERNITY HOSPITAL 75

MOVING IN THE RIGHT DIRECTION? A SURVEY OF CLINICIANS’ OPINIONS ON WEARABLE FETAL MOVEMENT MONITORING DEVICES 76

SPONTANEOUS HEMOPERITONEUM IN THE SECOND TRIMESTER: A MULTIDISCIPLINARY CASE REPORT 77

PREOPERATIVE ASSESSMENT CLINIC DOCUMENTATION IN ELECTIVE GYNAECOLOGY: A CLINICIAN SATISFACTION SURVEY 78

RARE CASE OF HETEROTOPIC PREGNANCY IN A HEALTHY ASYMPTOMATIC 40-YEAR-OLD 79

TRAVELLER MOTHERS: OBSTETRIC AND NEONATAL OUTCOMES IN AN IRISH MATERNITY UNIT 80

VAGINAL BIRTH AFTER CAESAREAN SECTION: RECENT TRENDS IN UNIVERSITY HOSPITAL GALWAY 81

LIPSCHÜTZ ULCER: A RARE GENITOURINARY MANIFESTATION OF ACUTE *SALMONELLA SP.* INFECTION 82

THE PREGNANCY OUTCOMES OF DOCTORS COMPARED TO OTHER EMPLOYED WOMEN 83

OUTCOMES OF ADOLESCENTS AND YOUNG ADULTS ATTENDING FOR FERTILITY COUNSELLING AND OOCYTE CRYOPRESERVATION PRIOR TO GONADOTOXIC TREATMENT 84

TRUSTWORTHY ARTIFICIAL INTELLIGENCE IN UROGYNAECOLOGICAL DIAGNOSTICS: A SYSTEMATIC REVIEW OF DIAGNOSTIC ACCURACY AND REPORTING STANDARDS USING CLAIM, STARD, AND FUTURE-AI FRAMEWORKS 85

EOLAS – KNOWLEDGE AT THE TIP OF YOUR FINGERS 86

DEVELOPMENT OF A PREDICTION MODEL FOR MORTALITY IN INFANTS UNDERGOING THERAPEUTIC HYPOTHERMIA FOR NEONATAL ENCEPHALOPATHY 87

BEYOND PRETERM BIRTH PREVENTION: A THIRTEEN YEAR REVIEW OF OBSTETRIC OUTCOMES AND MISCARRIAGE MANAGEMENT AFTER TRANSABDOMINAL CERCLAGE 88

A CLINICAL AUDIT OF CORD PROLAPSE INCIDENCE AND MANAGEMENT IN THE ROTUNDA HOSPITAL FOR THE YEAR 2024 89

WHEN THE SCOPE FINDS NOTHING: A THREE-YEAR REVIEW OF NEGATIVE LAPAROSCOPY FOR SUSPECTED ECTOPIC PREGNANCY 90

RHABDOMYOSARCOMA OF THE UTERUS: DIAGNOSTIC AND THERAPEUTIC CHALLENGES IN A RARE MALIGNANCY 91

A CASE REPORT OF POSTPARTUM MATERNAL IDIOPATHIC BRACHIAL PLEXOPATHY 92

AN AUDIT ON THE OUTCOMES OF LARGE FOR GESTATIONAL AGE BABIES IN NON-DIABETIC MOTHERS 93

AUDIT OF PATIENTS WITH OASI IN WGH..... 94

“FERTILITY – ARE DOCTORS TAUGHT ENOUGH?” 95

PREDICTIVE VALUE OF ANTI-MÜLLERIAN HORMONE IN ASSISTED HUMAN REPRODUCTION: A RETROSPECTIVE COHORT STUDY 97

HOW SUCCESSFUL IS CYTOGENETIC TESTING FOR FIRST TRIMESTER PREGNANCY LOSS? ANALYSIS BASED ON MODE OF MISCARRIAGE MANAGEMENT..... 98

RUDIMENTARY HORN PREGNANCY: A CASE OF EARLY DIAGNOSIS AND TIMELY MANAGEMENT..... 99

BALANCING RISK AND PRESERVATION: FERTILITY-SPARING SURGERY FOR CAESAREAN SCAR PREGNANCY 100

AN ATYPICAL CASE OF MENORRHAGIA IN THE SETTING OF A CAESAREAN NICHE AND ENDOMETRIOSIS 101

DEMOGRAPHICS AND OUTCOMES OF COUPLES SEEKING STATE-FUNDED FERTILITY TREATMENT 102

OPTIMISING THEATRE UTILISATION: AN AUDIT OF EMERGENCY OBSTETRICS AND GYNAECOLOGY THEATRE USE IN MRH-PORTLAOISE 104

AUDIT OF PAIN SCORES DURING OUTPATIENT HYSTEROSCOPY: BENCHMARKING AGAINST BRITISH SOCIETY OF GYNAECOLOGICAL ENDOSCOPY (BSGE) STANDARDS 105

DEMOGRAPHICAL RISK FACTORS FOR THE DEVELOPMENT OF POST CAESAREAN SECTION WOUND COMPLICATIONS 106

HERLYN-WERNER-WUNDERLICH (OHVIRA) SYNDROME: A RARE COMPLEX CONGENITAL MULLERIAN ANOMALY 107

BEYOND THE TUBES: CORNUAL ECTOPIC FOLLOWING BILATERAL SALPINGECTOMY 108

TRIPLE-NEGATIVE BREAST CANCER IN PREGNANCY: MULTIDISCIPLINARY MANAGEMENT IN A RESOURCE-LIMITED SETTING 109

BEYOND PID: BOWEL PATHOLOGY IN DISGUISE – LESSONS FROM TWO CASES..... 110

A CASE REPORT OF A METASTATIC WELL DIFFERENTIATED PRIMARY OVARIAN NEUROENDOCRINE TUMOUR..... 111

UNDERSTANDING PATIENT PERSPECTIVES ON PRE-IMPLANTATION GENETIC TESTING (PGT) IN IRELAND 112

IRELAND’S FIRST OFFSITE EARLY PREGNANCY UNIT; WHAT DO SERVICE USERS THINK? 113

POSTPARTUM HAEMORRHAGE RE-AUDIT 2025 AT GALWAY UNIVERSITY HOSPITAL: PROGRESS IN CLINICAL GOVERNANCE AND MATERNAL SAFETY 114

OPTIMIZING LOW DOSE ASPIRIN PROPHYLAXIS IN HIGH-RISK ANTENATAL CARE: A CLINICAL AUDIT FOR PET PREVENTION 115

AUDIT OF THE INCIDENCE OF OBSTETRIC ANAL SPHINCTER INJURIES AT UNIVERSITY HOSPITAL WATERFORD 116

A MULTIDISCIPLINARY FETAL NEUROSURGICAL SERVICE—12 YEARS OF FETAL OUTCOMES FROM A NATIONAL REFERRAL CENTRE 117

CLINICIAN-LED AI JOURNEY: FROM ZERO PROGRAMMING TO DEPLOYING GUIDELINE-BASED MOBILE TOOLS IN OBSTETRICS AND GYNAECOLOGY 118

CURCUMIN AS A BIOACTIVE SUPPLEMENT FOR PREMENSTRUAL SYNDROME AND DYSMENORRHEA: A SYSTEMATIC REVIEW OF RANDOMISED TRIALS 119

AN EVALUATION OF PATIENT SATISFACTION WITH ELECTIVE CAESAREAN SECTION FOR TOCOPHOBIA: A CROSS-SECTIONAL SURVEY 120

UTERINE ARTERIOVENOUS MALFORMATIONS AS A RARE DIFFERENTIAL DIAGNOSIS OF POST-ABORTAL HAEMORRHAGE. A CASE REPORT. 121

REPRODUCTIVE HEALTH IMPLICATIONS OF RELATIVE ENERGY DEFICIENCY IN SPORT IN ELITE FEMALE GAA PLAYERS 122

LISTENING TO EVERY BEAT: VENTRICULAR BIGEMINY IN PREGNANCY 123

AUDIT OF PROCEDURAL ASPECTS OF CAESAREAN SECTION BIRTH AT UNIVERSITY HOSPITAL WATERFORD 124

EFFICACY OF FERRIC CARBOXYMALTOSE VS IRON SUCROSE IN MANAGING MODERATE IRON DEFICIENCY ANEMIA IN PREGNANT WOMEN 125

A SILENT DRIFTER: LAPAROSCOPIC DETECTION AND CONSERVATIVE MANAGEMENT OF A WANDERING IUCD 126

OPTIMIZING FETAL GROWTH: AN AUDIT OF RECURRENT INTRA-UTERINE GROWTH RESTRICTION (IUGR) IN ASPIRIN- TREATED PREGNANCIES 127

KNOWLEDGE AND ATTITUDE TOWARD BREASTFEEDING AMONG LIBYAN MOTHERS IN LIBYA 128

NOT JUST ANOTHER LUMP: NOVEL DIAGNOSIS OF AN ISCHIOANAL LIPOMA WITH POST-EXCISIONAL NEUROPATHIC PAIN 129

A SAFE START: EVALUATING IRELAND'S FIRST OFFSITE EARLY PREGNANCY UNIT 130

EVIDENCE TO SUPPORT THE USE OF THE INTRAUTERINE BALLOON FOR THE MANAGEMENT OF MASSIVE OBSTETRIC HEMORRHAGE. 131

CLINICIAN-DEVELOPED OFFLINE IOS GUIDE FOR ECTOPIC PREGNANCY & PUL: DIAGNOSTIC PATHWAYS WITH MICRO-LEARNING FOR TRAINEES 132

INVESTIGATING THE CLINICAL APPROACH OF PHYSICIANS IN MANAGING THE PREMATURE OVARIAN INSUFFICIENCY IN THE UNITED ARAB EMIRATES 133

STATE FUNDED FERTILITY TREATMENT – TIME TO LOOK CLOSER AT THE MEN? 134

IMAGING AND ULTRASOUND VIDEO OF RUPTURED FETAL MEGACYSTIS – A CASE REPORT OF A RARE NATURAL PROGRESSION OF THE CONDITION. 136

REDUCING CONTAMINATION OF MIDSTREAM URINE (MSU) SAMPLE USING VISUAL AID TO EDUCATE PATIENTS: A QUALITY IMPROVEMENT PROJECT. 137

''VAN-WYK GRUMBACH SYNDROME IN A 11-YEAR-OLD GIRL: A CASE REPORT''. 138

MENOPAUSE AWARENESS AMONG HEALTHCARE WORKERS: A COMPARATIVE STUDY OF PERIMENOPAUSAL AND POSTMENOPAUSAL WOMEN IN ISLAMABAD, PAKISTAN. 139

A CASE SERIES OF UTERINE PECOMAS: DIAGNOSTIC AND MANAGEMENT CHALENGES IN A TERTIARY CENTRE 140

JUST-IN-TIME LEARNING FOR PPH: AN INTERACTIVE MOBILE GUIDE FOR OBSTETRIC TRAINEES 141

TURNING OFF THE TAP: HEAVY MENSTRUAL BLEEDING MANAGEMENT FOR ADOLESCENT PATIENTS ATTENDING A TERTIARY UNIT 142

GUT MICROBIAL GENE FUNCTION AND GESTATIONAL DIABETES RISK IS ALTERED WITH BIFIDOBACTERIUM BREVE 702258 : A RANDOMISED TRIAL 143

OUTCOMES OF TOTAL LAPAROSCOPIC HYSTERECTOMY AT LETTERKENNY UNIVERSITY HOSPITAL: 2022 BASELINE VS 2023–2025 RE-AUDIT 144

A REVIEW OF A PERINATAL GENETICS AND GENOMICS SERVICE'S ROLE IN PRENATAL DIAGNOSIS ... 145

POST EARLY MEDICAL ABORTION COMPLICATIONS IN SECONDARY CARE: A RETROSPECTIVE FOUR YEAR REVIEW OF ONE TERTIARY UNIT'S EXPERIENCE 146

IMPACT OF GESTATIONAL DIABETES ON NEONATAL BIRTH WEIGHT AND MATERNAL POSTPARTUM METABOLIC CHANGES 147

CLINICAL AUDIT ON PAIN SCORES AND MANAGEMENT DURING OUTPATIENT HYSTEROSCOPY 148

INFLUENTIAL FACTORS ON ATTENDANCE AT A COMPLEX POSTNATAL REVIEW CLINIC: A RETROSPECTIVE COHORT STUDY 149

PICSI VERSUS STANDARD ICISI IN PATIENTS UNDEROING PREIMPLANTATION GENETIC TESTING FOR ANEUPLOIDY- A PROSPECTIVE SIBLING OOCYTE TRIAL..... 150

SINGLE CELL RNA SEQUENCING REVEALS REDUCED EXPRESSION OF MITOCHONDRIAL-RELATED GENES IN GRANULOSA CELLS OF WOMEN WITH DIMINISHED OVARIAN RESERVE..... 151

INDUCTION OF LABOUR RE-AUDIT 2025 AT GALWAY UNIVERSITY HOSPITAL: QUALITY IMPROVEMENT AND COMPLIANCE WITH NATIONAL GUIDELINES..... 152

THE IMPACT OF VAPING ON OVARIAN RESERVE AND FERTILITY TREATMENT OUTCOMES- A SYSTEMATIC REVIEW..... 153

EVALUATING THE PROGNOSTIC ROLE OF ANTI-MULLERIAN HORMONE IN ASSISTED REPRODUCTION OUTCOMES 154

AN UNUSUAL CASE OF VELAMENTOUS CORD INSERTION 155

EVALUATING REFERRAL TIMELINESS FOR POSTMENOPAUSAL BLEEDING: A CLINICAL AUDIT AT UNIVERSITY HOSPITAL GALWAY 156

ENDOMETRIAL BIOPSY VS. NORMAL HYSTEROSCOPY: RETHINKING DIAGNOSTIC PATHWAYS IN BLEEDING CASES

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Background:
Diagnostic hysteroscopy is a minimally invasive and accurate method for evaluating gynaecological conditions such as Abnormal uterine bleeding (AUB), Postmenopausal bleeding (PMB) and Endometrial hyperplasia, etc. Currently, hysteroscopy is often combined with an endometrial biopsy, which can cause discomfort and increase risks and costs.

Objective:
This study investigated the frequency of significant histopathological abnormalities, like hyperplasia and malignancy, in women with normal hysteroscopy findings.

Materials and Methods:
A retrospective observational study was conducted using hospital records of women who attended the outpatient hysteroscopy clinic at The Coombe Hospital from January to December 2024. Women who met the criteria for assessment of the endometrial cavity were included. Exclusions were women with missing records and those unable to tolerate outpatient exams requiring general anaesthesia. The hospital's Audit Committee approved the study.

Results:
Out of the total number of women (n = 709) attending the hysteroscopy clinic, 442 women met the study's inclusion criteria. The majority of women were referred by their general practitioner (95.2%), with a median age of 52 years and a median BMI of 28 kg/m^2. Out of 442 women, 148 (33.5%) had abnormal hysteroscopy, while 207 (46.8%) had normal findings. Among the cases with normal hysteroscopy, 170 (82.1%) had normal histology, 25 (12.1%) had insufficient samples, and 1 (0.5%) showed hyperplasia with atypia. The single case of hyperplasia had normal TVS.

Conclusion:
Our study highlights the reliability of diagnostic hysteroscopy in assessing AUB and PMB, with normal findings strongly correlating to the absence of significant pathology. Among women with normal hysteroscopy results, invasive biopsies were seldom required, as only 0.5% showed hyperplasia with atypia. By balancing diagnostic accuracy and patient comfort, hysteroscopy alone may be sufficient in such cases, reducing unnecessary interventions and enhancing care. Further research is necessary to refine clinical guidelines.

ASSESSING THE IMPACT OF A TARGETED OBSTETRICS AND GYNAECOLOGY TEACHING SESSION ON GENERAL PRACTICE TRAINEES PREPAREDNESS FOR PRACTICE

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Background:
General Practice (GP) trainees in Ireland frequently complete obstetrics and gynaecology (O&G) rotations to build competence in assessment and management of women's health issues. Education in specialist settings is predominantly designed for specialist trainees and may not align with the needs of those intending to practice in community settings (1).

Objective:
This project aimed to address this recognised gap in structured, relevant education for GP trainees through a dedicated teaching block at a specialist maternity hospital.

Study Design and Methods
A weekly teaching programme delivered from November 2024 to March 2025 at the National Maternity Hospital (NMH) addressed common O&G topics pertinent to primary care. Seven GP trainees were eligible to participate. Teaching methods included didactic sessions, interactive discussions and practical demonstrations. Evaluation was conducted using anonymous electronic cross-sectional survey. Analysis was completed using descriptive statistics and thematic analysis. Feedback was used to guide and refine the intervention.

Results
Six trainees completed the survey. All respondents rated the programme positively (50% excellent, 50% good). All participants reported that they found the content relevant to their roles in both hospital and primary care settings and reported feeling better prepared to manage common O&G presentations in primary care. Key strengths included clinical relevance, clarity of objectives and opportunity for practical discussion. Suggested improvements included more gynaecological content, increased interactivity and supplementary digital resources.

Conclusion
The programme was well-received and was associated with increased perceived preparedness and confidence among GP trainees. The outcomes of this initiative support its continuation and development in future rotations. This model provides a practical, low-resource approach to enhance GP training during O&G rotations and could be adapted across other sites to integrate hospital-based training with primary care practice.

1. Peart J, Michels NR, Hanley K, et al. What influences on their professional development do general practice trainees report from their hospital placements? A qualitative study. Eur J Gen Pract. 2023 Dec;29(1):2191947. DOI: 10.1080/13814788.2023.2191947.

MIRROR SYNDROME IN A 36-YEAR-OLD WOMAN ASSOCIATED WITH DIANDRIC TRIPLOIDY AND PARTIAL MOLAR PREGNANCY: A CASE REPORT

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Background:
Mirror Syndrome (Ballantyne Syndrome) is a rare obstetric disorder characterised by maternal oedema, hypertension, and proteinuria, often associated with fetal hydrops or abnormal placentation. It may mimic pre-eclampsia but requires distinct recognition.

Objective:
To report a case of Mirror Syndrome in a 36-year-old multiparous woman secondary to partial molar pregnancy with diandric triploidy, highlighting diagnostic challenges, multidisciplinary management, and follow-up.

Study Design and Methods:
Case Report: Ms. LH, G3P1+1, presented at 15+6 weeks gestation with acute headache, nausea, vomiting, and a 10-day history of oedema and exertional dyspnoea. Assessment included clinical examination, urinalysis, laboratory tests, imaging (US, CT), and fetal genetic analysis. Maternal haemodynamic instability prompted antihypertensives, seizure prophylaxis, fluid management, and ultimately medical termination due to maternal compromise and non-viable fetus.

Findings/Results:
Severe hypertension, nephrotic-range proteinuria, pulmonary oedema, pleural effusions, and ascites were noted. Imaging demonstrated fetal anomalies (omphalocele, microcephaly, absent nasal bone) and a cystic placenta. Amniocentesis confirmed 69,XXY diandric triploidy, consistent with partial molar pregnancy. Maternal condition worsened despite therapy, necessitating termination with mifepristone and misoprostol, resulting in uncomplicated vaginal delivery. Postpartum recovery was uneventful, with follow-up at the National Gestational Trophoblastic Disease Centre for β-hCG surveillance and the recurrent miscarriage clinic for counselling regarding future conception.

Conclusion:
Mirror Syndrome should be considered in patients with pre-eclampsia-like features, particularly in early gestation with maternal oedema or placental/fetal anomalies. Prompt recognition, thorough fetal and placental evaluation, and multidisciplinary care are essential to reduce maternal morbidity and optimise outcomes. Follow-up in specialised centres ensures surveillance and guidance for future pregnancy.

ASSESSMENT OF VENOUS THROMBOEMBOLISM RISK AND POST-EVENT DEBRIEFING IN POSTPARTUM HAEMORRHAGE PATIENT CARE: AN AUDIT

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Background:
Postpartum haemorrhage (PPH) is a leading cause of maternal morbidity and mortality worldwide. It carries risks of multiorgan failure and psychological trauma. Women experiencing massive PPH are at significantly increased risk of venous thromboembolism (VTE) due to immobility, transfusion, and surgical interventions. Post-event debriefing supports psychological recovery and patient satisfaction.

Objective:
To evaluate PPH management with specific focus on adherence to VTE risk assessment and thromboprophylaxis, and the provision of structured patient debriefing.

Study Design and Methods:
A retrospective review was performed over a 17 month period in Cork University Maternity Hospital. Cases were identified through presentation at a monthly multidisciplinary team meeting, which discussed all primary PPH cases with a measured blood loss of more than 1500 mL. Standards were derived from national guidelines and local protocols. At each meeting challenges and areas of improvements were identified with proposed solutions.

Findings/Results:
Sixty-three cases were reviewed, with an average measured blood loss of 2270mL. VTE risk assessment was documented in 70% (44/63); however VTE re-assessment in the presence of new risk factors was often lacking. 71% (45/63) were discharged on thromboprophylaxis; 25% with a VTE score of more than 3 did not receive thromboprophylaxis. 12 (19%) patients were discharged on thromboprophylaxis without a documented VTE risk assessment. Structured patient debriefing was documented in 81% (51/63).

Conclusion:
Compliance with VTE assessment and debriefing did not meet key performance indicators; highlighting the need to strengthen post-event care. The forthcoming 2026 national VTE guideline will inform education sessions. Combined with regular re-audits and staff engagement, this should strengthen clinical consistency and safety.

AUDIT OF EDUCATION ON FEMALE GENITAL MUTILATION IN UNIVERSITY CURRICULA IN IRELAND

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Background:
Over 5,000 women in Ireland live with the consequences of Female Genital Mutilation (FGM), highlighting the need for responsive, informed healthcare. AkiDwA, with HSE support, provides services for migrant women and staff training, comprehensive and standardised FGM education is important.

Objective:
To establish whether, when, and how FGM is taught in Irish medical, nursing, and midwifery programmes, and to identify barriers and enablers to its integration, with a view to informing stronger future educational frameworks in Ireland and beyond.

Study Design & Methods:
A structured questionnaire was sent to department heads of medical, nursing, and midwifery schools. It assessed the presence, scope, mode, timing, and assessment of FGM-related teaching and invited qualitative feedback. Responses were analysed descriptively and graphically. The form remained open for 50 days with two reminder emails.

Results:
Of 20 relevant departments contacted, six responded (one medical, two midwifery, three nursing). Of these, 66.7% reported including FGM in their curricula, typically in Year 3 or across modules like maternity care and health promotion. Teaching methods included lectures (75%), patient educators (50%), overseas placements (25%), and directed reading (25%). Assessment was mostly through end-of-module exams (75%). Of those not teaching FGM, 66.7% had no plans to do so, citing limited curricular space, regulatory constraints, and lack of expertise.

Conclusion:
The low response rate is concerning and may reflect limited recognition of the importance of this education. Responses show significant gaps and inconsistency in FGM teaching, with no standardised framework and varying delivery. Lack of expertise emerged as a major barrier to curriculum development. As Ireland's migrant population grows, integrating comprehensive FGM education is essential to ensure safe, equitable, and culturally sensitive care.

ASSOCIATIONS BETWEEN SLEEP AND MENTAL HEALTH WITH PRETERM BIRTH IN A HIGH-RISK COHORT: A SECONDARY ANALYSIS OF THE PRE-POP TRIAL

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Background:
Almost three thousand children are born prematurely (<37 weeks' gestation) in Ireland per year and many understudied risk factors may play a crucial role (1, 2). Limited data suggests that the preterm birth (PTB) rate is higher in women with a known sleep disorder (3), while psychological factors such as stress, depression and wellbeing are also linked with PTB risk (4). Further research is needed to aid in risk assessment and prevention of this complication.

Objective:
To explore whether sleep and mental health are associated with PTB rate in a high-risk pregnant cohort.

Methodology:
This is an analysis of 125 women at high-risk of developing PTB from the PREPOP (PREterm birth Prevention with Oral Probiotics) trial in the National Maternity Hospital, Dublin. In early pregnancy, women completed the Edinburgh Postnatal Depression Scale (EPDS), the WHO-5 Wellbeing Index, the Perceived Stress Scale (PSS), and the Pittsburgh Sleep Quality Index (PSQI). Gestational age at delivery was obtained from medical records and classed as preterm if birth occurred <37 weeks and term if birth occurred $\geq 37^{+0}$ weeks. Unadjusted associations between sleep, mental health indices, and PTB were analysed using Mann-Whitney test, Chi-squared test and Fishers exact test.

Results:
The mean gestation at early visit was 15.07 (SD 2.34). Over half of the cohort were poor sleepers (52%; 65/125) and 73.6% (92/125) had high wellbeing. The median gestational age at delivery was 38.9 (IQR:37.7, 39.9) weeks and 14.5% (18/124) of the women delivered preterm. We found no association between sleep quality and PTB rate (p=1.0, effect size 0.006) or gestational age at delivery (p=0.8). Sleep duration was not associated with PTB rate (p=0.8). Psychological factors (as measured using the EPDS, WHO-5 Wellbeing Index and the PSS) were not significantly associated with gestation at delivery or PTB rate.

Conclusion:
Sleep and psychological factors were not associated with an increased risk of PTB in a high-risk cohort. Future research should further explore this relationship in a larger cohort.

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EVALUATING EFFICIENCY AND OUTCOMES OF AMBULATORY GYNAECOLOGY CLINICS: A RETROSPECTIVE AUDIT AT MRH PORTLAOISE

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Background:
Ambulatory gynaecology "one-stop" clinics provide screening, diagnosis, and treatment in a single visit, aiming to reduce waiting times, improve patient flow, and limit the need for repeat appointments or theatre procedures under general anaesthesia (GA).

Objective:
To evaluate patient throughput and outcomes in the Ambulatory Gynaecology Clinic at MRH Portlaoise over a 6-month period, focusing on the proportion of new versus return patients, the percentage of patients requiring follow-up appointments, and the proportion requiring escalation to theatre for procedures under GA.

Methods:
A retrospective audit was conducted of all patients seen in the Ambulatory Gynaecology Clinic between January and July. Data collected included the total number of patients, classification as new or return, the number offered a second appointment, and the number referred for hysteroscopy under GA.

Results:
A total of 345 patients were seen during the audit period. Of these, 253 (73.3%) were new patients and 92 (26.7%) were return visits. Thirty patients (8.6%) required a second appointment. Twenty-one patients (6%) required escalation to theatre for hysteroscopy under GA.

Conclusion:
The majority of patients (over 90%) were managed within a single ambulatory clinic visit without the need for follow-up, highlighting the efficiency of the service. A small but clinically significant proportion required theatre-based procedures under GA. These findings support the role of ambulatory gynaecology in improving access and reducing the burden on inpatient services, while also identifying a subset of patients who still require escalation of care.

TRANSITIONS IN MEDICAL EDUCATION: CLINICIAN EXPERIENCES MOVING BETWEEN CLINICAL PRACTICE AND RESEARCH ROLES

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Background:
Medical transitions represent critical adaptation periods requiring role adjustment. While pre-clinical to clinical transitions are well-documented, limited research explores clinician-to-researcher transitions. In Ireland, increasing clinicians pursue higher degrees, highlighting growing academic engagement. This study examined Irish Clinical Academic Training (ICAT) participants' experiences transitioning between clinical and research roles.

Objective:
To explore healthcare professionals' lived experiences transitioning from clinical practice to research and back, identifying challenges and facilitators to inform support system development.

Study Design and Methods:
Sequential mixed-methods study employed semi-structured interviews analysed through Interpretative Phenomenological Analysis using Multiple and Multidimensional Transitions framework. Five ICAT participants were recruited for interviews. Transcripts were analysed using NVivo. Findings validated through questionnaire survey of 77 healthcare professionals. Documentary analysis confirmed growing clinical-academic career integration.

Results:
Six themes emerged: motivations for research, adaptation challenges including work rhythm adjustment and administrative complexity, dual identity management with clinical confidence concerns, critical supervisory and peer support importance, unexpected lifestyle improvements, and professional identity evolution toward evidence-based practice. Time management was primary challenge (71% participants). Return-to-clinical transitions proved easier than initial research transitions, with 79% settling within three months versus six months.

Conclusion:
Clinician-researchers face multidimensional challenges requiring proactive support addressing psychological, social, physical, and cultural needs. ICAT's structured model demonstrates effectiveness through funding, peer networks, and integrated training. Findings inform comprehensive support frameworks for healthcare professionals pursuing dual clinical-research careers, enhancing evidence-based healthcare.

SYNCHRONOUS BENIGN BRENNER AND BORDERLINE MUCINOUS TUMOUR: A RARE CASE IN A POSTMENOPAUSAL WOMAN

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Background:
Brenner tumours are rare surface epithelial tumours of the ovary, accounting for ~2-3% of all cases. A recognised but uncommon association exists between Brenner tumours and mucinous ovarian tumours, with some studies suggesting coexistence in up to 30% of cases. However, the coexistence of a benign Brenner tumour with a borderline mucinous tumour is rare. This case highlights such a presentation, underscoring diagnostic and histogenetic considerations.

Case Report:
A 69-year-old, para 4, postmenopausal woman, presented with left-sided abdominal pain. A CT abdomen and pelvis in May 2023 revealed a 5.2 cm left adnexal cyst. Pelvic ultrasound and MRI confirmed a cystic lesion with internal echoes but no mural nodularity or enhancement, thereby lowering the suspicion of malignancy. CA-125 was within normal range; 15.7 U/mL in March 2024 and 34 U/mL in May 2024.

She was subsequently reviewed in the gynaecological oncology multidisciplinary team meeting. Imaging remained stable over serial assessments, and the lesion was most consistent with a benign ovarian cyst. Given its persistence, laparoscopic bilateral salpingo-oophorectomy was advised locally and performed in February 2025.

Histopathology demonstrated both a borderline mucinous tumour and a benign Brenner tumour within the left ovarian cyst, highlighting a rare coexistence of two distinct epithelial neoplasms in one mass.

Discussion:
This case highlights the limitations of imaging and biomarkers in distinguishing benign from borderline ovarian tumours. The lesion was stable and cystic, lacking suspicious radiological features, with CA-125 levels in normal range. For postmenopausal women, the management of adnexal cysts remains challenging. This case demonstrates the value of histological evaluation in persistent adnexal lesions, as borderline mucinous tumours, despite having a low risk of malignant transformation, still pose a potential for progression.

ROBOTIC-ASSISTED MANAGMENT OF BLADDER ENDOMETRIOSIS FOLLOWING UNRECOGNISED CAESAREAN BLADDER INJURY: A CASE REPORT

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Background:
Endometriosis of the urinary tract is a rare form of deep infiltrating disease, with the bladder being the most common site affected. Clinical presentation may include cyclical haematuria, recurrent urinary tract infections, pelvic pain, or fistula formation. Because these symptoms overlap with urological and gynaecological disorders, diagnosis is frequently delayed.

Objectives:
To report a case of bladder endometriosis following caesarean delivery complicated by an unrecognised bladder injury, and to demonstrate the value of robotic-assisted surgery in complex management.

Method:
A 44-year-old woman with four prior caesarean sections presented with recurrent urinary tract infections, dysmenorrhoea, chronic pelvic pain, and haematuria coinciding with menstruation. During her last caesarean delivery, an intraoperative bladder injury was suspected. A methylene blue test was performed but no leak was identified, though she developed persistent haematuria for one week postoperatively. Subsequent investigations included flexible cystoscopy, which revealed a posterior bladder wall defect, and magnetic resonance imaging (MRI), which confirmed infiltration of the bladder wall by endometriotic tissue. Following multidisciplinary team review, she underwent robotic-assisted total abdominal hysterectomy, bilateral salpingo-oophorectomy, extensive adhesiolysis, and partial cystectomy with bilateral ureteric stenting.

Findings:
Surgery revealed dense pelvic adhesions and deep endometriotic nodules involving the bladder wall and pelvic sidewall. Recovery was uneventful, and cystography before catheter removal confirmed complete bladder healing without leakage or fistula.

Conclusion:
This case highlights the diagnostic challenges of bladder endometriosis in women with prior pelvic surgery and occult bladder trauma. It emphasises the importance of considering endometriosis in patients with cyclical urinary symptoms and illustrates how robotic-assisted surgery can provide safe, precise excision with effective bladder reconstruction.

SUSPECTED MOLAR PREGNANCY IN A CONTINUING SINGLETON GESTATION: A CASE OF PARTIAL MOLE WITH COEXISTING HEALTHY FETUS AUTHORS:

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Background:
Molar pregnancy with a coexisting viable fetus is a rare and complex obstetric condition. Accurate diagnosis is essential due to the associated maternal and fetal risks, and management requires a multidisciplinary approach.

Case Presentation:
A 22-year-old primigravida was referred at 23 weeks' gestation following routine anomaly scanning that revealed a well-circumscribed, multicystic mass (4.2 × 7.2 × 8.0 cm) adjacent to the placental margin. Doppler ultrasound demonstrated internal and peripheral vascularity, with normal fetal growth and amniotic fluid volume. Initial impression suggested a placental haemangioma. However, MRI findings raised suspicion for a coexisting gestation with a hydatidiform mole. Baseline β-hCG and thyroid function tests were within normal range. The patient was managed expectantly with close surveillance. The mass remained stable in size but developed increased echogenicity on follow-up imaging.

Outcome: At 38 weeks, she achieved a spontaneous vaginal delivery of a healthy neonate. Histopathological analysis of the placenta revealed features consistent with partial mole, fulfilling two major and two minor diagnostic criteria.

Conclusion:
This case highlights the diagnostic and clinical complexity of partial molar pregnancy with a coexisting viable fetus. It underscores the importance of radiological expertise, histopathological confirmation, and individualized care in ensuring optimal maternal and fetal outcomes in such rare presentations.

CYCLICAL VULVAL SWELLING UNMASKED AS ENDOMETRIOSIS: A DIAGNOSTIC CHALLENGE

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Background:
Endometriosis is a hormone-dependent disorder where tissue resembling the endometrium grows outside the uterus. It affects 10–15% of reproductive-age women, most often involving the ovaries, peritoneum, or rectovaginal septum. Extrapelvic disease is rare, and vulval involvement represents fewer than 1% of reported cases. Because its presentation often overlaps with commoner vulval lesions—including Bartholin gland cysts, hidradenitis suppurativa, epidermoid cysts, or even tumors—diagnosis is frequently delayed. The key clue is pain and swelling that follow the menstrual cycle, though this feature is not always recognized. Histology is essential, with findings of endometrial glands, stroma, and hemosiderin-laden macrophages being diagnostic. Surgery, usually excision or marsupialization, provides both tissue confirmation and durable symptom control, with low recurrence rates when margins are clear. This case adds to the limited evidence by describing a young woman whose recurrent vulval swelling was initially presumed to be a Bartholin cyst.

Objective
To describe the diagnostic challenge of vulval endometriosis, underline the value of cyclical symptom recognition, and emphasize the role of surgery and histology in establishing diagnosis and achieving resolution.

Methods
A 21-year-old woman presented with repeated episodes of painful swelling of the left vulva. Initially treated as a Bartholin cyst, the lesion recurred with worsening symptoms during menses. At her third visit, a 1.5 cm tender cystic mass was noted. Surgical marsupialization was performed and tissue was sent for histopathology.

Results
Intraoperatively, a cystic lesion without acute inflammation was observed. Histology confirmed endometrial glands, stroma, and hemosiderin-laden macrophages. The patient recovered well and remained asymptomatic at six-month follow-up.

Conclusion
Vulval endometriosis, though rare, should be suspected in reproductive-aged women with recurrent vulval lesions linked to the menstrual cycle. Histology is diagnostic, and surgery provides both confirmation and cure. Awareness of this entity may shorten diagnostic delays, reduce unnecessary interventions, and improve outcomes.

INTRODUCTION OF A MANUAL VACUUM ASPIRATION SERVICE AT THE COOMBE HOSPITAL

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Background:
Pregnancy loss affects up to 20% of all pregnancies (Jayashree et al., 2018). Previously, management options for delayed miscarriage and Retained Products of Conceptions (RPOC) offered at the Coombe Hospital were conservative, medical and surgical evacuation (ERPC) under general anaesthetic. Limitations of ERPC include a requirement for hospital admission, cost associated with theatre access, morbidity associated with anaesthesia and lack of patient choice. Manual Vacuum Aspiration (MVA) is a conscious procedure performed in the outpatient setting using local anaesthetic which has been demonstrated to be an acceptable and safe alternative to ERPC (Azman et al., 2019)

Objective:
The aim of this Quality Improvement Project (QIP) was to introduce an MVA service.

Methods:
A comprehensive assessment of current practice was undertaken and experience drawn from the Options Clinic at the Coombe and other hospital's services. A Standard Operating Procedure (SOP) was created. Engagement sessions were conducted with all stakeholders (doctors, midwives, sonographers, healthcare assistants and clinic administrators) to educate the team about the safety profile, effectiveness, procedure and patient selection. All procedures were performed during scheduled appointments in the Early Pregnancy Unit (EPU) and conducted by the Fellow under direct supervision of an EPU Consultant. Complications were recorded on a prospectively maintained database.

Results:
Between 14/07/2025 and 16/09/2025, 15 MVAs were undertaken. 9 (60%) were performed for delayed miscarriage and 6 (40%) for RPOC. No complications occurred and no patients required admission. Informal feedback from staff and patients to date has been positive and a formal survey will be sent out soon.

Conclusion:
The MVA service appears to be a safe and acceptable service which is reducing costs to the hospital, reducing demands on theatre and increasing patient choice.

Future Direction:
We plan to offer an MVA service on a second day during the week; formally survey patients and staff and maintain a prospective database of all cases for audit and research purposes.

APPLICATION OF THE CLAVIEN-DINDO CLASSIFICATION OF SURGICAL COMPLICATIONS TO PROCEDURES IN A GYNAECOLOGICAL TERTIARY REFERRAL CENTRE

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Background:
The Clavien-Dindo (C-D) classification is used to define and grade surgical complications. It was initially developed for use in General Surgery and has since been used in many specialities, although has had limited use in general gynaecology. A standardised system for grading complications enables comparison across procedures and institutions. We aimed to evaluate the frequency and severity of postoperative complications in a tertiary gynaecology centre, using the C-D classification.

Methods:
A retrospective chart review was conducted of all patients who had a postoperative overnight stay following gynaecological surgery, from 1/1/24 to 31/6/24. Demographic, clinical, and operative data were extracted, including diagnosis, procedure type, length of stay (LOS) and complications. Analysis was conducted using SPSS.

Results:
Ninety procedures were performed on 89 patients. Mean age was 46.2 years (range 20-81). The majority (66.6%, 60/90) had > 1 comorbidity, the most common being hypertension (15.6%, 14/90). ASA score was 2 in 63.3% (57/90). Over one third of patients had a BMI of > 30. Most procedures were performed laparoscopically (70.0%, 63/90), with the most common primary procedure being Total Laparoscopic Hysterectomy (25.6%, 23/90). Joint cases were performed with both Colorectal (16.7%, 15/90) and Urology (3.3%, 3/90). Median postoperative LOS was 3 days (range 2-16). Most procedures had no complication (74.4%, 67/90), while a mild complication (C-D I-II) occurred in 18.9% (17/90), and a severe complication (C-D III-IV) in 6.7% (6/90). The most common complication was infection (10.0%, 9/90). Longer LOS was associated with worsening severity of complications (Kruskal-Wallis 17.1, p=0.002). Five patients required readmission due to their complication, with a median LOS of 6 days (range 2-7).

Conclusion:
Applying the C-D classification allowed objective grading of what complications did occur in this group; severity was linked to longer LOS. This tool offers a simple and standardised way to grade and audit surgical morbidity.

ISOLATED PREPUBERTAL MENARCHE IN A 15MONTH OLD CHILD; A CASE REPORT

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Background:
Isolated prepubertal menarche is an uncommon condition in which prepubertal bleeding occurs in the absence of the development of secondary sexual characteristics[1]. The aetiology of isolated prepubertal menarche is currently unclear, though increased oestrogen sensitivity, benign transient ovarian function, endocrine disrupting chemicals, and rarely tumours, have been hypothesised as causes[2].

Objective:
To describe the investigation and diagnosis of an uncommon presentation of prepubertal bleeding in an infant.

Study Design and Methods:
This is a case report describes the investigation of a individual case of cyclical prepubertal bleeding in a 15-month-old girl, with the first episode occurring age 5 months.

Findings/Results:
Investigations of patient A were notable for a physical examination absent for the development of secondary sexual characteristics. Gonadotropin and oestradiol levels were in the pre-pubertal range, with a bone age assessment in keeping with chronological age. An MRI pelvis was notable for increased prominence of the uterus and vaginal tissue for age, suggestive of oestrogenisation, with a bright endometrial stripe visible. An examination under anaesthesia and vaginoscopy were also notable for the appearance of oestrogenisation of the vulva and cervix.

Conclusion:
This case report represents an uncommon case of isolated prepubertal menarche in a 15-month-old child. Isolated prepubertal menarche is generally a benign condition, however, is largely a diagnosis of exclusion following assessment for precocious puberty, tumours and endocrine disruptors.

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LATE NIGHTS, HIGH STAKES: EMERGENCY CAESAREAN IN CLASS III OBESITY

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Background/Objective:
Obesity in pregnancy increases the risk for maternal and fetal complications. The resultant increased morbidity and mortality from maternal obesity increases health care costs and poses a threat to public health. The aim of this review was to assess the complications associated with obesity and the outcome of these pregnancies.

Study design/Methods:
This was a retrospective review for all the women who delivered in 2024 in Galway University Hospital with a booking BMI of ^{3}40 (Class III obesity). Patient cohort and demographics was retrieved from Maternity electronic patient record (EPR) ã Euroking and analyzed on Microsoft Excel.

Findings/Results:
Of the 2194 women delivered in 2024, 2.9% (n= 63) were of Class III obesity.
57.1% (n=36) were multiparous and 42.9% (n= 27) were nulliparous.
The overall Caesarean Delivery (CD) rate in this group was 81.5%.
66.7% (n=18) nulliparous women had an induction of labour (IOL) out of which there was a 77.8% (n=14) CD rate. Of three in spontaneous labour, 66.7% (n=2) had an emergency CD. 22.2 % (n=6) had elective CD.
47.2% of multiparous women (n=17) had IOL of which 47.1% (n=8) had a VB, the remaining nine had an emergency CD. 29.4% (n=5; 5/17) were previous CD, who had IOL. The remaining had elective repeat CD.
Of note, 70.8% (n=17) had an emergency CD out of hours (5pm-8am).
73% (n=43) had gestational diabetes, 25% (n=15) had pregnancy induced hypertension requiring treatment and 3.3% (n=2) had pre-eclampsia.
15.9% (n=10) had an EBL of ^{3} 1000 mls, nine of these were at CD. 19% (n=12) had postnatal readmission of which five were for wound infection.

Conclusion:
This review shows that obesity is a risk factor for emergency CD. Induction of labour further increased your likelihood of having emergency CD, the majority of which were conducted out of hours. There is notably a 20% chance of postnatal readmission. Woman should be counselled about the high CD rate and consideration given for elective CD in this group.

SEASONAL VARIATION IN OBSTETRIC ANAL SPHINCTER INJURY (OASI) RATES, OR RATHER THE LACK THEREOF!

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Background:
Obstetric Anal Sphincter Injury (OASI) is a recognised complication of vaginal birth and is the leading cause of anal incontinence in women. The incidence of OASI varies globally and is influenced by maternal, fetal, and intrapartum factors. Accoucheur skill level may potentially change throughout the training calendar year, although this has not been assessed as a risk factor for OASI.

Objective:
To investigate if there is any seasonal variance in the incidence of OASI in the Rotunda Hospital.

Study Design:
This was a cross-sectional study of all singleton vaginal births in the Rotunda Hospital from 2017 to 2024, inclusive. We examined whether OASI rates varied across three temporal levels: weekly, fortnightly, and monthly. These levels were to function as a proxy for the expected progression of competency of NCHDs across the training year (July to July). We used One-way ANOVA to examine variance by temporal level and the Chi-Square test for trend to analyse the trend over the years of the study.

Results:
From 2017 to 2024, there were 40,941 vaginal deliveries in our institution, of which 10,428 (25.5%) were by either vacuum (6879) or forceps (3549). Of these vaginal deliveries, 850 (2.1%) were complicated by OASI. There was a significantly higher rate of OASI with OVD (3.6% [375/10,428]) than SVD (1.6% [475/30,513], $\chi 2 = 157.99$, $p = < 0.001$). Over the study period, there was no statistically significant variance when OASI rates were analysed by week ($p = 0.656$), fortnight ($p = 0.696$), or month ($p = 0.916$). These findings were consistent when SVD and OVD were analysed separately. Overall rates of OASI have reduced from 1.66% (126/7591) in 2017 to 1.35% (112/8287) in 2024 ($\chi 2 = 5.17$, $p = 0.023$).

Conclusion:
This study has shown that there is no seasonal variation in the incidence of OASI at our institution, indicating that changes in NCHD proficiency throughout the year have little to no impact on OASI rates. These results highlight the need for more targeted training on the prevention, recognition, and management of OASI for NCHDs.

INSIGHTS INTO HIGH DEPENDENCY UNIT ADMISSIONS IN A TERTIARY MATERNITY HOSPITAL: AN INSTITUTIONAL REVIEW

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Background:
High Dependency Unit (HDU) admission is a recognised indicator of severe maternal morbidity and informs critical care planning. Local analysis supports quality improvement initiatives and risk reduction strategies.

Objective:
To review HDU admissions in a tertiary maternity hospital and identify patterns in maternal morbidity and service delivery.

Study Design and Methods:
A retrospective review of all HDU admissions between September 2024 and May 2025 was conducted. Demographics, admission reasons, interventions, and outcomes were recorded. Descriptive analysis was performed.

Findings/Results:
Among 4884 births, 253 women (3.9%) required HDU admission, averaging 28 per month. Antenatal patients accounted for 49.4% (n=125), most in the third trimester (78.4%). Postnatal patients comprised 38.3% (n=97), primarily for postpartum haemorrhage (61.9%, n=60), with 23.3% (n=14) experiencing massive obstetric haemorrhage. Other frequent reasons included magnesium sulphate administration (28.1%, n=71), pre-eclampsia (19.0%, n=48), and sepsis (4.7%, n=12). Gynaecology cases represented 12.3% (n=31). Documentation of admission duration was inconsistent, limiting calculation of length of stay.

Conclusion:
HDU admission patterns mirrored international findings, with PPH and hypertensive disorders as leading causes. Lack of standardised documentation limited morbidity surveillance. A monthly multidisciplinary HDU review has been introduced to improve case review, escalation pathways, and national reporting, with the aim of enhancing patient safety and obstetric medicine outcomes.

TRENDS IN MATERNAL FOLIC ACID SUPPLEMENTATION ADHERENCE IN IRELAND: A RETROSPECTIVE ANALYSIS OF 66,690 PREGNANCIES AT THE COOMBE HOSPITAL, 2014–2022

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Background:
Ireland has one of the highest global rates of neural tube defects (NTDs). Folic acid from before conception (0.4 mg daily or 5 mg for high-risk women) reduces NTD risk yet adherence remains poor with disparities across groups.

Objective:
To examine patterns in folic acid use among pregnant women at a large Dublin maternity hospital.

Methods:
We analysed electronic health records from all women attending their first antenatal visit at the Coombe Hospital (2014-2022). At booking, women reported folic acid dose, timing and duration. Adherence was classified as full (correct dose 3 months pre to 3 months post-conception), partial, or none. Recommended doses were 0.4 mg for most and 5 mg for high-risk women, including those with obesity (Class I: BMI 30–34.9; Class II: 35–39.9; Class III: ≥40). Covariates included age, parity, pregnancy intention, socioeconomic status and BMI. We used descriptive statistics, chi-squared tests and multivariable logistic regression reporting adjusted odds ratios (aORs) with 95% confidence intervals (CIs).

Results:
Among 66,690 pregnancies, mean age was 32.3 years; 25.5% were unplanned and 18.4% had obesity. 82.6% reported partial adherence, 14.0% met full adherence and 3.4% took none. Half reported preconceptional use; 20.7% met the recommended duration. Among women with obesity, 85.9% received the 0.4 mg dose, but uptake of the 5 mg dose was low; only 3.4% achieved full adherence. Lower odds of any intake were associated with younger age (<20 years: aOR 0.47, CI 0.37-0.59), unplanned pregnancy (aOR 0.46, CI 0.42-0.50), multiparity (aOR 0.44, CI 0.39-0.49) and lower socioeconomic status (aOR 0.37, CI 0.33-0.42). Full adherence was inversely associated with obesity (Class I: aOR 0.13, CI 0.11-0.16), unplanned pregnancy (aOR 0.08, CI 0.07-0.09) and younger age (<20 years: aOR 0.15, CI 0.07-0.30).

Conclusion:
Folic acid adherence remains low especially in high-risk groups underscoring the need for targeted interventions and consideration of additional population-level NTD prevention strategies including food fortification.

AT WHAT COST!: A REVIEW OF THE COST OF MANAGING A BARTHOLIN'S CYST

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Introduction:
Bartholin's duct cysts occur in 2% of all female patients. When these glands become blocked, they can become infected and abscesses form. Management options include a surgical incision and drainage, marsupialization or the placement of an outpatient word catheter. Recurrence rates of a Bartholin's duct abscess are quoted in the literature at levels of 36% for word catheter applications as opposed to a 35% recurrence rate seen with marsupialization.

Methods
A total of 26 women who had been surgically managed for Bartholin's duct abscesses between 1st January 2022 and 30th June 2025 were retrospectively analysed and included. Until 2025, 100% of all Bartholin's abscesses were managed surgically in this regional hospital. The primary outcome of our study was to determine the potential cost effectiveness of using a word catheter programme rather than surgical management.

Results
Retrospective financial impact analysis using ABF guidance was used to determine that the burden of cost on this hospital for 26 women undergoing surgical management for Bartholin's duct cysts between 2022-2025 would have been approximately €110,000 euro including average hospital length stay of 1.7 days and total theatre management cost i.e. to have a surgical intervention for such a relatively common illness would cause a financial burden of €4,241 per person, not to mention the staffing and resources required during their length of stay. Conversely, a Word Catheter kit was determined to cost €1,246.60 for the same 26 women. This equates to €47.95 per person to use a word catheter instead.

Conclusion:
Our economic analysis determined that we would save this regional hospital up to €4,182 per person if we amended our local guideline to a word catheter outpatient programme management of Bartholin's duct abscesses. We could strategize towards reducing unnecessary resource use, better staffing allocation, higher patient satisfaction and shorter hospital stays. We, as clinicians, should always aim for better clinical outcomes and patient-centred care while continually striving for cost effectiveness and less waste.

COMPARATIVE EFFECTS OF VAPING, SMOKING, AND DUAL EXPOSURE ON THIRD TRIMESTER FETAL BIOMETRY; A SUBGROUP ANALYSIS OF THE ECHO STUDY

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Background:
Cigarette smoking during pregnancy is strongly associated with of reduced fetal growth during the third trimester(1). Electronic cigarette-use, known as 'vaping', has become more prevalent and it viewed by some pregnant as a lower risk alternative to cigarette consumption during pregnancy. However high quality studies on the impact of vaping on third trimester fetal growth are lacking.

Objective:
This subgroup analysis aims to establish if vaping is associated with reduced fetal growth in the third trimester compared to cigarette smoking, dual exposure, and no exposure (controls).
Material and Methods : The ECHO study protocol has been published (2). Third trimester fetal sonographs were performed by experienced sonographers using the Voluson E8 and E10 machines, and results extracted from Viewpoint 6, using the Hadlock estimated fetal weight formula. HC, AC, and FL were transposed into centiles using Snijders et al reference sheets (3), and EFW values were transposed into centiles using Nicolaides et al reference sheets (4).

Results:
Outcomes for 584 women were available for analysys. 261 controls, 177 smokers, 120 vapers, and 22 dual vaper/smokers (Table A). Median results were compared across subgroups using the Kruskal-Wallis (KW) test with Dunn's post-hoc (P-H) correction. HC did not differ significantly across groups (KW $p=0.06$). AC was reduced overall (KW $p=0.039$), with a trend towards lower measurements for smokers and dual users (P-H $p\approx0.06$). FL was significantly lower in smokers ($p=0.024$) and dual users ($p=0.007$) compared to controls and vapers. Smokers and dual-users EFW was significantly smaller compared to control and vapers.

Conclusion:
Cigarette smoking and dual smoking/vaping were associated with reduced third trimester FL and overall EFW. However, vaping alone was not associated with significant reduction in fetal biometry compared to controls. These findings suggest vaping does not demonstrate the same effect on fetal growth as smoking and dual use. However, larger studies are required to confirm safety.

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AN ASSESSMENT OF CERVICAL LENGTH TRAINING IN THE UK AND IRELAND

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Background:
Preterm birth affects 8% of pregnancies and remains the leading cause of neonatal morbidity and mortality. Spontaneous preterm labour is the most common cause and is multifactorial, involving cervical, uterine, maternal, fetal, and placental factors. Accurate, objective tools are critical to guide clinical decisions, preventing unnecessary interventions while identifying high-risk patients. Transvaginal ultrasound (TVUS) measurement of cervical length is a key predictive tool, with <25 mm considered short. However, operator variability and inconsistent image quality undermine its reliability. Notably, previous studies have noted over 25% of images submitted during sonographer recertification were of suboptimal quality.

Objective:
Despite cervical length assessment being an important clinical skill in obstetrics and gynaecology, structured training in the UK and Ireland remains lacking. To evaluate current practices, we conducted a survey among UK and Irish obstetric practitioners assessing training availability, confidence in cervical length measurement, perceived training barriers, and clinical usage contexts.

Method:
Over four months, 118 responses were received (98% consent rate). Respondents were from a variety of hospital care levels and experience ranged from junior trainee to specialist consultants.

Results:
Key themes included a lack of formal training, variability in supervision, and training access disparities. While hands-on learning, e-learning modules, and lectures were deemed useful, few had consistent access to TVUS for threatened preterm labour assessments, with only a minority reporting 24/7 availability. The millimetre-scale precision required in cervical scanning makes quality essential, as poor measurements may misdirect management pathways. Currently, online modules are few and non-mandatory, and training access often depends on local initiatives, reinforcing inequities across training centres.

Conclusion:
Standardised, inclusive training frameworks are urgently needed to support consistent and safe clinical practice in preterm birth risk assessment.

THE IMPACT OF E-CIGARETTES ON PREGNANCY & CHILDHOOD HEALTH OUTCOMES - THE ECHO STUDY – AN ANALYSIS OF THE OBSTETRIC PRIMARY OUTCOMES

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Background and Objective:
E-cigarette use is increasingly prevalent in pregnancy, yet fetal, maternal and infant outcomes remain poorly understood. The ECHO Study (The impact of E-Cigarettes on pregnancy and Childhood Health Outcomes – NCT: 06297005) - is a prospective, multicentre, observational cohort study of women and fetuses exposed to E-cigarettes (1) attending for maternity care at The Coombe Hospital, The Rotunda Hospital and The National Maternity Hospital.

Study Design:
Three groups of pregnant women were recruited: cigarette smokers, e-cigarette users and non-users. Their exposure status was objectively determined using biomarkers – exhaled carbon monoxide and a third trimester urinary cotinine - a reliable metabolite of nicotine. Obstetric outcomes examined included birthweight, small for gestational age and gestation at delivery.

Results:
Outcomes for 684 women were analysed: 307 controls, 200 smokers, 143 vapers and 34 vaper/smokers. Multiple regression analysis of birthweights adjusting for age, BMI, parity and gestational age at delivery were completed. Findings were consistent with the univariate analysis. Demographics and obstetric outcomes are described in Tables 1 and 2. Smokers' babies were over 200gs smaller at comparable gestational ages when compared to vapers and controls. When compared to vapers, smokers were significantly more likely to have a low-birth-weight infant, with an odds ratio of 2.79 (p-value 0.05). Smokers were more likely to have a baby born less than the 10th centile compared to vapers and controls (p-value 0.001, OR: 3.84). We report no significant difference in gestational age at delivery, although rates of preterm birth in our cohort were low.

Conclusion:
Unlike cigarette smoking, we found E-cigarette usage in pregnancy was not associated with small for gestational age babies compared to controls. This is a clinically relevant finding and contrasts with earlier registry studies which interpret large datasets. This study is novel, its use of objective biomarker determination of exposure groups is a strength.

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OUTCOMES AND MANAGEMENT OF ASC-H CYTOLOGY REFERRALS TO A HIGH-VOLUME IRISH COLPOSCOPY CLINIC

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Background:
Atypical squamous cells–cannot exclude high-grade squamous intraepithelial lesion (ASC-H) is a high-risk cytological finding with high rates of underlying high-grade disease, prompting review of local outcomes at the Coombe Hospital after they appeared to differ from international benchmarks.

Objective:
To evaluate ASC-H clinical outcomes and management pathways to help guide future management.

Design and Methods:
A retrospective cross-sectional study of new ASC-H referrals from January 2019 to December 2024 to a large Irish colposcopy unit was conducted. Data were extracted from MediScan electronic records including age, smoking status, parity, colposcopic impression, histology, and management pathway. Descriptive analysis was performed in Microsoft Excel.

Results:
A total of 314 ASC-H referrals were included. Initial histology showed 60.6% CIN2-3, 35% CIN1, and 0.95% malignancy. High-grade colposcopy impressions correlated with CIN2-3 in 70.6% of cases, while 53.3% of low-grade impressions were upgraded on biopsy. Overall, high-grade detection was 53.8%, below the 65% national target. Excisional biopsy for unsatisfactory colposcopy was 88.5%, below the 95% standard, though numbers were small.

Excisional treatment was performed in most patients with ≥CIN2 after biopsy confirmation (67.0%), while 18.7% underwent see-and-treat at first attendance. Among patients with ≤CIN1 on biopsy, most were managed conservatively with repeat HPV testing or interval colposcopy (84.4%), with 11.0% proceeding to treatment. Unsatisfactory colposcopy occurred in 5.4%; most of whom underwent excisional management.

Conclusion:
Rates of high-grade CIN among ASC-H referrals were similar to international literature, while cervical cancer and carcinoma in situ rates were lower. Colposcopic impression correlated strongly with histology, although upgrading from low-grade impression to high-grade disease remains common. While biopsy adequacy standards were met, gaps in MDT referral and excisional management highlight areas for quality improvement.

INDUCTION OF LABOUR AUDIT

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Background:
Induction of labour is becoming increasingly common. Recent changes in clinical practice in line with national guidance have contributed to increasing induction rates.

Objective:
To examine induction in nulliparous singleton cephalic pregnancies (Robson Group 2) at Wexford General Hospital.

Design and Methods:
This was a retrospective review of Group 2 inductions between November 1st 2024 and March 31st 2025.

Findings:
Sixty-five inductions were analysed. The mean age at booking was 29.6 years (range 19-39). Seventy-three percent were Caucasian (n=48). Mean BMI at booking was 28.4kg/m^2 (range 17.8-56.2). Most pregnancies were conceived spontaneously (n=58; 89%). Most patients were booked publicly (n=58; 89%). The mean gestational age was 39+5 weeks (range 37-41+4).

Forty percent of inductions were conducted for maternal indications (n=26) followed by 31% for fetal reasons (n=20) and 29% for postdates (n=19). Fifty-five percent of inductions were decided on by a consultant (n=36).

Eighty- six percent began with Propess (n=56), of these 19 patients required Prostin subsequently (33.9%). Half of all patients received Oxytocin (n=33; 50.7%). Of those not administered Oxytocin (n=32), there were 17 caesarean sections (53%), four operative vaginal deliveries (OVD) (12.5%) and 11 spontaneous vaginal deliveries (SVD) (34%).

Overall, there were 19 SVDs (29.2%); 15 OVDs (23%) and 31 emergency caesarean sections (47.6%). When examining post-dates inductions only (n=19), the caesarean section rate was 47% (n=9).

Across the group there were 8 cases of blood loss over 1 litre (12.3%). Mean birthweight was 3.4kg (range 2.3kg to 4.8kg). There were 10 SCBU admissions (15.3%) and 3 maternal readmissions (4.6%).

Conclusion:
These findings highlight the impact of induction of labour on maternity services. The caesarean section rate is the same within Group 2 regardless of whether the induction indication is post-dates or a different reason. This suggests the recent change in national practice is not solely contributing to an increase in caesarean section rate.

TRENDS IN HEALTHCARE PROFESSIONALS PURSUING HIGHER RESEARCH DEGREES: A DOCUMENTARY ANALYSIS

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Background:
Limited evidence exists regarding whether healthcare professionals pursuing research degrees represents a growing phenomenon warranting detailed investigation. Understanding magnitude and trends is essential for contextualising individual transition experiences and informing policy development for supporting clinical-academic careers.

Objective:
To examine trends in Irish healthcare professionals pursuing higher research degrees and assess whether this represents a significant and growing phenomenon requiring systematic investigation.

Study Design and Methods:
Retrospective cross-sectional documentary analysis examining 2019-2024 trends using multi-source approach. Data sources included annual reports from six Irish medical schools, Higher Education Authority statistics, National Doctors Training and Planning reports, and clinical workforce qualification analysis across three Dublin teaching hospitals at strategic time points (2015, 2020, 2025).

Results:
Substantial growth demonstrated across all metrics. University College Dublin showed 20% increase in active graduate research students. Royal College of Surgeons Ireland demonstrated 67% growth in new research registrations. Irish Clinical Academic Training programme expanded 563% from 8 fellows (2017) to 53 fellows (2023). Hospital workforce analysis revealed consultant numbers increased 58.6% while research-qualified consultants increased 74.5%, with qualification rates improving from 47.5% to 52.2%. Research-qualified staff growth exceeded total workforce expansion, indicating systematic preference for research-qualified candidates in recruitment.

Conclusion:
Clinical-research transitions represent significant and growing phenomenon in Irish healthcare. Over half of consultants across major teaching hospitals now hold research degrees. The scale of change justifies detailed investigation of individual transition experiences and institutional support requirements for healthcare professionals pursuing dual clinical-research careers.

THE INFLUENCE OF SEASONAL VARIATION AND LIGHT EXPOSURE ON THE INCIDENCE OF PRETERM BIRTH

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Background:
Preterm birth (PTB) is the leading cause of death in children less than five years old. The causes of spontaneous PTB are largely unknown. Several European and Global studies have demonstrated a seasonal pattern to PTB.

Objectives:
1. To examine the influence of the season of conception and birth on the incidence of PTB.
2. To examine the influence that light exposure has on the incidence of preterm birth.

Methods:
This is a single centre, retrospective cohort study that took place in The Coombe Hospital between Jan 2013 and Dec 2022. The database was analysed to determine the incidence of PTB per season of conception and birth. The data was re-analysed to measure the light exposure that each pregnancy was exposed to.

Results:
Following exclusions, 76,988 births were analysed. Women who conceived in winter between Dec-Feb had significantly lower rates of PTBs when compared to other seasons (5.4% vs 6.5% (spring) vs 5.6% (summer) and 5.4% (autumn),$p<0.001$). When considering only spontaneous preterm labour, this trend persists, with most spontaneous PTBs conceiving during spring (6.7% vs 5.5% (winter) vs 5.7% (summer) vs 5.5% (autumn),$p=0.001$). Conversely, women who gave birth in Dec-Feb had significantly higher rates of PTBs when compared to other seasons (6.2 vs 5.8, 5.5%. and 5.5%,$p<0,01$). The mean daily light exposure for the whole pregnancy were found to be non-normally distributed (Kolmogorov-Smirnov test 0.6 and 0.102 respectively $P<0.001$) therefore non-parametric tests were used. This did not reveal any significant trend towards gestation related light exposure.

Conclusion:
This study has shown that there is a seasonal variation in the incidence of PTB. A low prevalence of PTB was demonstrated when conception occurred in the winter. However, there was a greater incidence of PTBs between Dec and Feb. This study has further shown that light exposure does not influence this seasonal variation in PTB. By ruling out sunlight as a potential contributor, further research should be done to identify the cause of this seasonal variation in PTB.

A RE-AUDIT OF PROPHYLACTIC ANTIBIOTIC ADMINISTERED IMMEDIATELY FOLLOWING OPERATIVE VAGINAL DELIVERY

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Introduction:
As a marker of change in practice, it is recommended to re-audit after a period of time. Operative Vaginal Delivery OVD, in the form of vaccum or forceps delivery remains the intervention in this re-audit. The level of training of the operator or type of instrument was not considered. A 30-day period was randomly considered. 28/08/2025 to 25/09/2025 were included in this re-audit The commonest antibiotics used was Co-Amoxiclav.

Objective:
In this re-audit an establishment as to whether prophylactic antibiotic was administered during the intervening time on labour ward following an OVD was reviewed. They were given at the end of the OVD.

Methods:
A retrospective review of women who had OVD in the labour with subsequent administration of recommended single dose antibiotic as prophylaxis. Data was extrapolated from the labour ward ledger. Patients who underwent OVD during this period were matched against their electronic medication administration to indicate receipt of single dose antibiotic as indicated above.

Results:
[50] women's details were reviewed as recorded in the ledger.
[5/50] women (10 %) had not received antibiotic prophylaxis to meet this local protocol
[45/50] women (90%) were given appropriate antibiotics.

Discussion:
This re-audit indicates the need to emphasise the need to administer the prophylaxis while patients are on the labour ward. Various bodies recommend the use of single dose prophylactic dose of intravenous antibiotic, were allergy allows, amoxicillin and clavulanic acid following assisted vaginal birth to significantly reduce confirmed or suspected maternal infection compared to placebo (1). In the ANODE trial, women who received a single dose of prophylactic intravenous amoxicillin and clavulanic acid at a median of 3 hours post assisted vaginal birth were significantly less likely to have a confirmed or suspected maternal infection compared to placebo (2).

Conclusion:
This re-audit shows a significantly high proportion of the women received the antibiotic prophylaxis. Educating women and staff is vital

Reference:
1. RCOG Green top Guideline No 26
2. Prophylactic antibiotics in the prevention of infection after operative vaginal delivery (ANODE): a multicentre randomised controlled trial

OUTCOMES OF IRELAND'S FIRST DEDICATED FETAL GROWTH RESTRICTION CLINIC AT CORK UNIVERSITY MATERNITY HOSPITAL

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Background:
Cork University Maternity Hospital (CUMH) established a dedicated Fetal Growth Restriction (FGR) clinic in December 2022, led by a Maternal–Fetal Medicine team. The clinic accepts referrals for suspected FGR, defined according to the International Delphi Consensus.

Objective:
To evaluate outcomes among the first 188 patients attending this service.

Study Design:
Retrospective cohort study of women referred between December 2022 and June 2025.

Results:
Of 188 patients, 55.8% were primiparous; 26.1% had prior first-trimester loss; 23% smoked. Ethnic composition: 50% White Irish, 15% Asian/Asian Irish. Key risk factors included overweight (29%), obesity (15%), and advanced maternal age (30% > 35 years; 5% > 40 years).

Preterm delivery (<34 weeks) occurred in 9.6%, of which 44% were due to preeclampsia. NICU admission was required in 32% of infants.

Early-onset FGR (< 32 weeks) made up 51.1% (96/188) with a mean 6.5 week interval from first visit to delivery; late-onset FGR (48.9%, 92/188) averaged 3.5 weeks. Although early onset inherently necessitates longer surveillance, structured follow-up often enabled prolongation of pregnancy toward term.

NIPT was done in 60.1% (113/188), with <1% abnormal. TORCH screening was sent in 84% (137/163) of patients; >96% of these were negative. Placental histology was obtained in 83% of CUMH deliveries (124/149); among those, 88% showed abnormalities.

Conclusion:
The CUMH FGR clinic exemplifies specialist-led, best-practice care. These outcomes underscore both the high-risk profile of the cohort and the benefits of structured surveillance. As the clinic matures, integrating genetic testing and refining which investigations are routinely used can further enhance care pathways.

LIFE IN THE BALANCE – A CASE OF UTERINE ARTERIOVENOUS MALFORMATION AND CONCURRENT DEEP VENOUS THROMBOSIS FOLLOWING TERMINATION OF PREGNANCY

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Background:
Uterine arteriovenous malformations (UAVM) represent a rare but potentially life-threatening cause of uterine bleeding and can be acquired (following uterine surgery or pregnancy) or congenital. In the former, reactive angiogenesis leads to the formation of fistulae between intramural arteries and the myometrial venous plexus.

Case Report:
We present the case of a 42-year-old multiparous woman who presented following mid-trimester surgical termination of pregnancy (TOP) with a background of invasive breast ductal carcinoma treated with a mastectomy and adjuvant chemotherapy, complicated by a right upper limb deep vein thrombosis (DVT). The TOP was complicated by a 2.8 litre haemorrhage and right upper limb DVT, treated with apixaban. She re-presented post-operatively on day 5 with septic shock secondary to retained products of conception (RPOC) necessitating an emergency uterine evacuation and a second intensive care admission. Two weeks post initial surgical TOP she re-presented with a further haemorrhage of 1.2 litres. Anticoagulation was reversed with andexanet alpha and urgent angiography was performed progressing to bilateral uterine artery embolization of an acquired UAVM. This was complicated by a further (provoked) DVT likely secondary to the central venous access placed to aid with management intra- and post-operatively, necessitating further anticoagulation.

Discussion:
This case demonstrates the challenges in managing medically complex patients, as well as the most dangerous sequalae of TOP. This case also highlights the need to strike a delicate balance between bleeding and thrombotic risk in patients at high risk of both, as well as the need for accurate and repeated venous thrombo-embolic assessment at all stages of pregnancy, regardless of care pathway.

BRUSHING UP ON THE BASICS: A LOOK AT CERVICAL SCREENING KNOWLEDGE IN IRISH OBSTETRICS & GYNAECOLOGY NON-CONSULTANT HOSPITAL DOCTORS

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Background:
Cervical screening is a cornerstone of women's health initiatives in the Republic of Ireland. Since Cervical Check began in 2008, cervical cancer rates have declined by 2.8% annually. Understanding the purpose and limitations of cervical screening and colposcopy is crucial for obstetrics and gynaecology (O&G) Non-Consultant Hospital Doctors (NCHDs) to counsel women appropriately. As most screening tests are performed in either primary care or colposcopy clinics - often located outside of acute hospitals - we hypothesized that O&G NCHDs have limited knowledge and exposure to cervical screening and colposcopy.

Objective:
Assess baseline knowledge among NCHDs in O&G at a tertiary level maternity hospital regarding cervical screening and colposcopy.

Study Design and Methods:
All NCHDs in our unit were anonymously surveyed using a 19 item online questionnaire, prior to attending a local education session on Cervical Check and colposcopy. Responses were reviewed and descriptive statistics performed.

Findings/Results:
Of 51 NCHDs, 35 (68.6%) completed the survey. Only half (54%, n = 19) felt confident performing a cervical screening test and 40% (n=14) stated they were confident discussing screening results. While 68.5% (n=24) knew the routine screening interval, 8.6% believed HPV vaccinated women did not need screening. Most (80%, n =28) had no colposcopy training; almost 29% (n=10) had never observed colposcopy.
Knowledge of post hysterectomy screening was fair, 8.6% (n=3) believed women with normal histology and screening tests still required screening, while a further 11% (n=4) were unsure what advice to give.
Knowledge on screening for pregnant women was also poor; 14% (n= 5) would advise against colposcopy in early pregnancy despite abnormal screening results and 23% (n=8) routinely recommended postpartum screening at 3 months.

Conclusion:
Significant knowledge gaps exist among NCHDs regarding cervical screening and colposcopy. We propose educational sessions and increased clinical exposure to colposcopy to bridge these gaps.

DERMOID DECEPTION: WHEN TORSION TWISTS THE PLOT IN AN ADOLESCENT WITH OVARIAN TERATOMA

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Background:
Ovarian torsion is a rare gynecological emergency in adolescents (1–20 years), with an estimated incidence of 4.9 per 100,000 (Guthrie, Adler & Powell, 2010). It is most frequently associated with benign ovarian lesions such as mature cystic teratomas. Vague gastrointestinal symptoms may delay diagnosis and increase the risk of ovarian loss.

Objective:
To report a case of adolescent ovarian teratoma complicated by torsion initially misattributed to bowel obstruction, highlighting risks of delayed gynecology referral.

Methods:
Retrospective single-patient case report with clinical, imaging, operative, and histopathology findings.

Results:
A 17-year-old girl presented with 3 days of left iliac fossa pain, bilious vomiting, and constipation. Initial surgical review suspected bowel obstruction; abdominal radiograph suggested mildly dilated colon, but no cause of pain. Hours later, CT showed a 12 × 9 cm heterogeneous pelvic mass with calcification and hemorrhagic fluid, consistent with ruptured dermoid. At laparotomy, a large dermoid cyst was twisted twice with ~100 mL blood-stained peritoneal fluid and a necrotic left ovary and tube. A left salpingo-oophorectomy and lavage were performed. Cytology showed reactive inflammatory cells; histopathology confirmed mature cystic teratoma with hemorrhagic infarction. Tumour markers were within normal limits. Recovery was uneventful.

Conclusion:
This case demonstrates how ovarian torsion due to dermoid cyst may mimic acute abdomen. Reliance on radiograph and delayed CT postponed referral and surgery. Ultrasound with Doppler remains the recommended first-line modality (Huchon & Fauconnier, 2010). Early recognition is critical, as salvage declines with ischaemia, though viability may persist beyond 24 hours (Anders et al., 2005; Aziz et al., 2004). While conservative detorsion is preferred, oophorectomy may be unavoidable in necrosis. Clinicians should maintain a high index of suspicion in adolescents with acute abdomen to expedite referral and optimise ovarian preservation (Rabinovich et al., 2020).

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FOLATE PRESCRIBING IN PREGNANT WOMEN WITH OBESITY: A CLINICAL AUDIT

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Background
Peri-conceptual folic acid supplementation reduces neural tube defects (NTDs). The HSE recommends 400µg daily for the general maternity population, and 5mg daily for women with BMI ≥30kg/m^2, commencing pre-conception and continuing through the first trimester. Obesity is associated with increased NTD risk (OR 1.70 for obesity; 3.11 for severe obesity). Despite clear guidance, adherence to high-dose folic acid prescribing in primary care is variable.

Aim
To audit:
(1) the proportion of pregnant women with documented BMI at booking (target 100%)
(2) the proportion of women with BMI ≥30kg/m^2 appropriately prescribed 5mg folic acid pre-conception or at first antenatal visit (target 100%).

Methods
A retrospective audit was conducted in a single Irish general practice. All women with estimated delivery dates between 01/01/2023 and 01/07/2023 were included (n=64). Electronic records were reviewed for BMI documentation and 5mg folic acid prescribing in women with BMI ≥30kg/m^2. Following baseline analysis, clinicians were educated regarding high-dose folic acid guidance and a structured antenatal consultation template was introduced to prompt BMI recording and prescribing. Re-audit was performed using an EDD range of 01/09/2024–01/01/2025 (n=22).

Results
Pre-intervention, 71.9% had BMI recorded at any stage, but only 51.6% at booking. Fourteen women (29.8%) had BMI ≥30kg/m^2; 64.3% were prescribed 5mg folic acid. Post-intervention, BMI recording at booking improved to 68%. All women with BMI ≥30kg/m^2 (6/6, 100%) were prescribed 5mg folic acid.

Conclusion
A simple educational intervention combined with a structured electronic template improved appropriate high-dose folic acid prescribing for women with obesity and increased BMI documentation at booking. Early identification of elevated BMI in pregnancy facilitates targeted supplementation and optimises preventative care in primary practice.

AN EVALUATION OF THE DECISION TO DELIVERY INTERVAL FOR EMERGENCY CAESAREAN SECTIONS; THE PERIPHERAL EXPERIENCE

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Background:
In 2023, 39.4% of births in Ireland were by caesarean. As per the National Institute for Health and Care Excellent (NICE) guidelines category 1 caesarean births, where there is immediate threat to the life of mother or infant, has a recommended decision to delivery interval (DDI) of 30 minutes. A category 2 caesarean birth, with maternal or fetal compromise, has a recommended DDI of 75 minutes. DDI delays are associated with adverse neonatal outcomes.

Objective:
Our project evaluated the experience of a Model 3 Hospital, Midlands Regional Hospital Portlaoise (MRHP). Our aim was to evaluate whether recommended DDIs are achieved and to evaluate out of hours services for delays as theatre staff are off site, in hospital accommodation, during these hours.

Methods:
A retrospective chart analysis was performed for maternity patients who underwent a category 1 or category 2 caesarean birth in MRHP between 1/1/25 and 31/3/25 with patients identified via the hospital birth record. Patient demographics included age, BMI, parity, previous caesarean section and indication for delivery. DDIs were recorded including decision time, arrival to theatre, knife to skin (KTS) and delivery. Neonatal outcomes were also recorded including admission to special care baby unit (SCBU).

Results:
50 patients were included. The average age was 32, 46% (n=23) were primiparous, all were singletons and 10% (n=5) had a BMI over 40.
There were 8 category 1 deliveries with 50% (n=4) out of hours. The mean transfer time was 11 minutes, arrival to KTS of 10 minutes and a mean DDI of 25 minutes. 37.5% (n=3/8) exceeded the recommended DDI.
There were 42 category 2 deliveries with 69% (n = 29) out of hours. The average transfer time was 19 minutes, arrival to KTS of 21 minutes and a mean DDI of 47 minutes. 7.14% (n=3/42) exceeded the recommended DDI with one neonate admitted to SCBU.
Of the exceeded DDIs, 4/6 (67%) were out of hours.

Conclusion:
In conclusion, suitability for de-escalation of urgency should be clearly documented. Off-site theatre staff may contribute to longer DDIs and the appropriateness of this should be reviewed by individual units.

COMPARISON BETWEEN ABDOMINAL, VAGINAL AND LAPAROSCOPIC HYSTERECTOMIES AND THE SHIFT TOWARDS A MINIMAL ACCESS APPROACH

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Background:
Hysterectomy is a well-known surgery worldwide. The option between abdominal, laparoscopic, vaginal and robotic are different approaches to hysterectomy. A minimal access approach (vaginal , laparoscopic, robotic) presents as the approach associated with a less post operative complications and a reduced length of hospital stay. Here we conducted an audit on the hysterectomies performed at MRHP and the benefits of each approach used.

Objective:
The aim of this audit is to investigate which route of hysterectomy is associated with less blood loss, reduced post op complications, reduced length of hospital stay. As well as this, this study aims to explore reasons why hysterectomies are still performed through the abdominal route and to try and implement methods to increase the number of cases performed through a minimal access approach.

Methods:
This was a retrospective audit conducted on hysterectomies performed in midlands regional hospital Portlaoise, under audit case reference number CA/I8/225. The patients' records were collected and studied.

Results:
All cases of hysterectomies performed in MRHP in the year 2025 were included in the study. 1/3 of hysterectomies were vaginal hysterectomies, 28% were laparoscopic hysterectomies and 39% were performed abdominally. The indication ranged from heavy menstrual bleeding, uterine fibroids, prolapse, chronic pelvic pain or a combination of these. There was a drastic increase in the number of cases being performed laparoscopically in 2025 in comparison to the year 2024. 80% of laparoscopic hysterectomies went home the following day. 80% of the TLH and 100% of vaginal hysterectomy had measured blood loss of less than 100mls. The abdominal route was associated with higher estimated blood loss of more than 300mls, a higher proportion of postoperative complications as well as an extended duration of hospital stay (average length of hospital stay being 4.6 days).

Conclusion:
A minimal access approach to hysterectomies presents with less complications, shorter length of hospital stay thereby reducing hospital costs... **[CHARACTER LIMIT REACHED]**

INDUCTION OF LABOUR AT TERM FOR CONCEPTION THROUGH IN VITRO FERTILISATION RESULTED IN A VAGINAL DELIVERY FOR THE MAJORITY OF WOMEN

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Background:
There is evidence that the stillbirth rate at term is increased in pregnancies following assisted reproductive technology (ART) (1). For this reason, many units, recommend that women who conceive with the assistance of in vitro fertilisation (IVF) or Intracytoplasmic Sperm Injection (ICSI) deliver at 40 weeks' gestation. There is a concern that intervening by inducing labour may increase the rate of Caesarean Section (CS).

Methods:
This was a single-centre retrospective cohort study of women who had conceived with IVF and underwent induction of labour (IOL) from January 2018 to December 2023. Patients who had an IOL for reasons other than postdates were excluded. Duration and method of induction, mode of delivery, birth weight, obstetric and neonatal complications were recorded and analysed.

Results:
A total of 339 nulliparous women were induced following an IVF/ICSI pregnancy. The median age of patients was 38 years (IQR 34-40 years). The median gestation at delivery was 40+2 weeks (IQR 39+6 – 40+6). The median duration of IOL was 27 hours (IQR 16-44 hours) with a median time on oxytocin of 3.5 hours (IQR of 0-8 hours). The mean estimated blood loss was 626mL (+433.9). Twenty-eight percent (n=95) of women had a spontaneous vaginal delivery, 33% (n=113) had an operative vaginal delivery and 39% (n= 131) had a CS. The mean blood loss at CS was 680.4mL (+383.7). The mean APGARS at 1 minute & 9 minutes was 9. Of all the deliveries, 8.8% (n=30) babies required NICU admission.

Conclusion:
In 2023 in the NMH, the overall rate of women delivered via C/S was 36% (n=2443), with induced nulliparous being 47% (n=802). Nationally, 34% of singleton pregnancies (n=18,906) are delivered by CS. Our study demonstrated that 69% of women who had an IOL at 40 weeks' for conception assisted with IVF had a vaginal delivery which supports continuing this practice. Very few babies required NICU admission.

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PRIMIGRAVIDA BIRTH INTERVENTIONS: AUDIT OF INDUCTION AND C SECTION INDICATIONS

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Background:
A rising trend in inductions and caesarean sections has been observed in primigravidas, with caesarean rates of 59% in June and 56% in July, prompting this audit.

Objective:
To assess adherence to guidelines, identify avoidable interventions, and suggest strategies to reduce unnecessary inductions and caesareans.

Methods:
All primigravidas delivering between 01 May–31 July 2025 who underwent induction or caesarean were included. Data were collected retrospectively from records using a dedicated proforma. Nine charts were unavailable, leaving 73 for analysis.

Results:
Of 82 women, 30 were induced: 40% delivered vaginally and 60% by caesarean, with a declining trend in vaginal births and no operative vaginal deliveries in July. Post-term pregnancy was the leading indication (46%), followed by oligohydramnios (14%), large for gestational age (11%), and hypertensive disorders (11%). Overall, 96.6% of inductions adhered to guidelines. Propess was most frequently used (58.1%). Mean partogram length was 6.6 hours, and mean induction-to-labour ward interval was 19.4 hours. Among 56 caesareans, most were Category II (67.8%), commonly due to abnormal CTG (53%) and failure to progress (32%). Category IV accounted for 16%, mainly maternal request (44%), followed by breech, placenta previa, LGA, and hip surgery (11% each). Two of three breech patients were offered but declined ECV. Eighty percent of maternal request cases had documented counselling. Antenatal scan weights for LGA fetuses were accurate in 87.5% of cases. Low Apgars (<7) occurred in 12.3% at 1 minute, improving to 4.1% at 5 minutes.

Conclusion and Action Plan:
Most inductions complied with guidelines, but conversion to caesarean remained high. Abnormal CTG and failure to progress were the main drivers of emergency caesareans, while maternal request dominated elective cases. Improvements are needed in documentation, intrapartum monitoring, and antenatal counselling. Planned actions include:

- Clear documentation of indications and CTG categorisation.
- Weekly CTG review meetings for emergency caesareans.
- Patient information leaflet comparing outcomes of vaginal birth and primary caesarean.

EXTERNAL CEPHALIC VERSION (ECV) CLINIC PERFORMANCE: A RE-AUDIT AT THE NATIONAL MATERNITY HOSPITAL (NMH)

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Background:
External Cephalic Version (ECV) is a procedure used to turn breech to cephalic presentations between 36 and 37 weeks gestation. The National Maternity Hospital (NMH) runs weekly ECV clinics. A previous 10-month audit, after tocolytic introduction found that 56% of women attending were eligible, 40% of attempts were successful (62% in multiparous women and 38% in primiparous women). Tocolytics were used in 51% of attempts. Outcomes included 62% spontaneous vaginal deliveries (SVD), 19% operative vaginal deliveries (OVD), and 19% caesarean sections (CS). For the 32 (50%) unsuccessful ECVs, 3% had breech VD, 3% had spontaneous version to cephalic, and 94% required CS.

Objective:
The objective of this study was to evaluate the success rate at our ECV clinic and to assess whether our rates align with the RCOG Green Top Guidelines (GTG), which report a success of 60% in multiparous women and 40% in primiparous women (1).

Methods:
A retrospective audit of electronic records over 12 months from NMH's ECV Clinic was conducted.

Results:
94 patients were referred over a 12-month period. 56% (N=53) of which were nulliparous and 44% (N=41) were multiparous. 15% declined ECV (N=14), 2% had contraindications (N=2), and 15% had spontaneous version to cephalic (N=14). 81% (N=43) of the eligible nulliparous women and 51% (N=21) of the eligible multiparous women underwent ECV. Of 64 attempts 39% (N=25) were successful (40% nulliparous (N=10) and 60% multiparous (N=15)). After successful ECV, 8% (N=2) reverted to breech, 52% (N=13) had spontaneous onset of labour and 40% had induction of labour. Successful ECVs led to 60% SVD (N=15), 16% OVD (N=4), and 24% CS (N=6). Tocolytics were used in 95% of cases (N=61). In unsuccessful cases (N=39), 2.5% spontaneously converted to cephalic to allow for a VD (N=1), and 97.5% required CS (N=38).

Conclusion:
The re-audit shows consistent success rates with tocolytic use. Our outcomes align with the RCOG GTG for ECV success. Enhanced antenatal education for patients could potentially lower the rate of those declining ECV.

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OVARIAN RESERVE DYNAMICS AND SUBFERTILITY PROFILES IN AN IRISH REGIONAL FERTILITY HUB: A RETROSPECTIVE REVIEW

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Background:
Duration of trying to conceive (dTTC) and ovarian reserve are key in subfertility evaluation. National guidelines (HSE, 2023) recommend referral after 12 months (<36 years) or 6 months (≥36 years). Their relationship with referral timelines and male/female factors in Ireland remains underexplored.

Objective:
To assess correlations between dTTC, ovarian reserve, male factors, anatomy, and assisted reproduction decisions.

Methods:
A retrospective review of 134 women attending Cork University Maternity Hospital's subfertility clinic (Feb–Mar 2024). Variables included dTTC, age, BMI, anti-Müllerian hormone (AMH), antral follicle count (AFC), ultrasound, tubal patency, and semen analysis. Women with incomplete data were excluded. Analyses used descriptive statistics and Pearson correlations.

Results:
Among women aged ≥36, 52.2% were referred later than the 6-month guideline; 34.3% of those <36 were referred after 12 months. Mean dTTC was 40 months (range 0–216), mean age 34.8 years, and mean AMH 19.4 pmol/L. Correlations between dTTC and AMH (r=0.042) or age (r=0.086) were weak. Ultrasound showed women with uncountable AFC had the lowest mean AMH (9.5 pmol/L). Fibroids and low AFC correlated with reduced AMH; high AFC aligned with higher AMH. Tubal abnormalities were identified in 2.2%. Semen analysis revealed abnormalities in 37.3%, including 7.5% with severe oligoasthenoteratozoospermia (OAT) requiring intracytoplasmic sperm injection. Obese women (BMI ≥30) had the lowest mean AMH (17.1 pmol/L), compared with overweight (22.4) and normal BMI (18.8).

Conclusion:
Most couples (86.6%) were referred beyond guideline timelines, though whether due to late GP presentation or referral is unclear. Many likely present after extended dTTC, highlighting gaps in public awareness. National education, earlier presentation, and timely referral are needed. AMH and AFC provide complementary data where history is insufficient. Male factor abnormalities affected over one-third of couples. Earlier biochemical assessment and semen analysis could improve timely access.

ASYMPTOMATIC CERVICAL CANCER: A REMINDER OF THE VALUE OF CLINICAL EXAMINATION

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Introduction:
Cervical cancer remains a major health burden for women (1). Symptoms may include bleeding or pelvic pain, but it can be clinically silent. Without red-flag symptoms, it is tempting to omit pelvic exam. However, key findings may be missed. We present a case highlighting the dangers of omitting speculum and bimanual.

Case report:
85 year-old referred for incidental finding of intrauterine fluid on surveillance CT AP, following right hemicolectomy for caecal adenocarcinoma two years prior. She denied gynaecological, urinary, gastrointestinal or constitutional symptoms. History included two vaginal deliveries. She was unsure of her cervical screening history and was not HPV vaccinated. Medical history of hypertension, hypothyroidism and hypercholesterolemia. She was an ex-smoker with no significant family history. General exam was unremarkable. Speculum revealed grossly abnormal cervix with ragged, friable surface and heavy contact bleeding. A firm irregular cervix, fixed uterus, no palpable adnexal masses on bimanual. At examination under anaesthesia, multiple cervical biopsies were taken. Cervical stenosis prevented hysteroscopy. Histopathology confirmed endocervical adenocarcinoma. MRI showed 5cm cervical mass with parametrial invasion. A metabolically active left external iliac node seen on PET CT. Staged FIGO 3C1. She started radiotherapy and is for consideration of chemotherapy.

Discussion:
This case of advanced cancer was entirely asymptomatic, yet easily detectable on routine exam. Speculum and bimanual exam can be overlooked at busy clinics or with non-specific symptoms. However, this is linked with delayed and missed diagnoses(2).
Screening and vaccination have transformed prevention and detection, but effectiveness is contingent on patient participation. A substantial proportion of cases occur in inadequately screened women(3). GP records showed no screening history in our case.
Our case shows the diagnostic value of physical exam. While screening programmes, labs and imaging are essential in the diagnostic process, they must complement - not replace - examination.

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A REVIEW OF GNRH AGONIST PRESCRIBING PATTERNS AT A SUPRA-REGIONAL CENTRE FOR COMPLEX ENDOMETRIOSIS

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Background:
Endometriosis is a chronic condition leading to pain, infertility, and reduced quality of life. Gonadotropin-releasing hormone (GnRH) agonists are often reserved for severe cases due to their side effect profile. Despite recommendations for add-back hormone replacement therapy (HRT) and bone density monitoring, prescribing patterns in Ireland are poorly described.

Objective:
We aimed to evaluate GnRH agonist prescribing patterns, treatment duration, use of add-back HRT and bone density surveillance in endometriosis patients at a supra-regional centre in Ireland.

Methods:
A review was conducted of all endometriosis clinic patients, as of March 2025, and was limited to all correspondence available in patients' electronic charts. Demographic, clinical and treatment data were extracted, and analysis conducted using SPSS.

Results:
Of the 724 patients, 425 had been seen to date; 87.1% (370/425) of whom had a diagnosis of endometriosis. Severity of disease was undocumented in 50.3% (186/370) cases, and Stage IV disease in 35.9% (133/370). Median age was 40 years (range 19-61). Surgery had been performed in 42.7% (158/370) patients (laparoscopic excision in 60.1%, 113/188; hysterectomy in 17.0%, 32/188). GnRH agonists were prescribed to 22.2% (82/370), for a median duration of 12 months (3-54), and most commonly in Stage IV disease ($\chi 2$ 23.6, $p < 0.001$). Add back HRT was prescribed in 64.6% (53/82), predominantly tibolone (88,7%, 47/53), and typically started within the first month. Bone density imaging was ordered in 90.0% (18/20) on GnRH longer than 24 months. Most patients (75.7%, 280/270) had tried at least 1 other suppressive treatment (range 1-6); most commonly the progesterone only pill (47.8%, 177/370) or Mirena (35.7%, 132/370). Of patients who were never prescribed any suppressive treatment (16.7%, 62/370), 27.4% (17/62) were actively trying to conceive, and 19.4% (12/62) had declined.

Conclusion:
GnRH agonists were frequently prescribed, especially for Stage IV disease. Use of add-back HRT and bone health monitoring was inconsistent; highlighting potential areas for improvement of care.

PREGNANCY WITH TYPE 1 DIABETES MELLITUS AT THE NATIONAL MATERNITY HOSPITAL

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Background:
Type 1 diabetes mellitus (T1DM) in pregnancy carries significant risk, requiring intensive multidisciplinary care. The introduction of continuous glucose monitoring (CGM) has transformed blood glucose levels (BGL) monitoring and management. National Maternity Hospital (NMH) Diabetes Service oversees 30–40% of T1DM pregnancies in Ireland.

Objective:
This audit reviews diabetic and pregnancy outcomes for women with T1DM booked at the NMH from 2021 to 2023, following the introduction and increasing availability of CGM.

Methods:
Data on pregnancy and T1DM outcomes were extracted from electronic patient charts and compiled on Excel. Maternal outcomes included HbA1c and retinopathy; obstetric outcomes included preterm birth and delivery mode; neonatal outcomes included birth weight and NICU admission.

Results:
During the study period, 86/16,126 (0.5%) women with T1DM booked and 60/14,458 (0.4%) delivered at NMH. CGM use rose significantly in 2023 (95.1% vs. 51.1%, $P < 0.001$), with improved glycaemic control (Booking HbA1c <48 mmol/mol: 39.0% in 2023 vs. 8.9% in 2021, $P = 0.002$). Retinopathy screening increased (87.8% vs. 62.2%, $P = 0.004$). Improved control corresponded with non-significant reductions in fetal macrosomia (34.5% to 16.5%, $P = 0.112$), preterm birth (41.4% to 25.8%, $P = 0.358$), transient tachypnoea (27.6% to 16.1%, $P = 0.102$), and trends toward increased spontaneous vaginal delivery (13.8% to 25.8%, $P = 0.250$) and reduced operative vaginal delivery (20.7% to 9.7%, $P = 0.237$).

Conclusion:
Improved CGM uptake in 2023 correlated with better glycaemic control and trends toward improved pregnancy outcomes. NMH outcomes in preterm birth and neonatal morbidity were significantly lower than international standards, highlighting the importance of optimised diabetes and perinatal care in T1DM pregnancies.

MANUAL REMOVAL OF PLACENTA: A REVIEW OF TRANSFER TO THEATRE TIME OVER FIVE YEARS IN A TERTIARY MATERNITY HOSPITAL

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Background:
Postpartum Haemorrhage (PPH) is a leading cause of maternal morbidity and mortality. Retained placenta (the placenta fails to detach and deliver within 30 minutes of birth of the baby) is a risk factor for PPH. Irish guidelines recommend close observation for PPH in those with retained placenta, advising transfer to theatre for manual removal of placenta (MROP) 30 to 60 minutes after birth, or sooner with active bleeding. A key messages from the MBRRACE-UK Report 2023 highlighted the importance of recognition and management of bleeding, emphasising the importance of assessing blood loss early and regularly, to reduce the rate of PPH, and associated morbidity and mortality.

Objective:
to review the management of those requiring MROP, specifically timing of transfer to theatre, and to determine the rate of primary PPH in this cohort in a tertiary maternity hospital between 2019 – 2024.

Methods:
Ethical approval obtained. Retrospective review of electronic medical charts of patients who underwent MROP in Cork University Maternity Hospital between 2019 – 2024. Data analysed using descriptive statistics. Teaching sessions were subsequently carried out at formal education sessions with obstetricians, anaesthetists, and nursing and midwifery staff. Findings from the review were also presented at a number of multidisciplinary meetings between June-August 2025.

Results:
298 patients included. Mean time to theatre 74 minutes. Primary PPH in 64%. Mean blood loss 908ml. 202 spontaneous vaginal deliveries, 94 operative vaginal deliveries. Mean birth weight 3494g. Prospective re-audit underway.

Conclusion:
Time taken to transfer patients requiring MROP to theatre was outside National Guideline recommendations. A high rate of primary PPH was observed in this group, highlighting an area for practice improvement. Following focussed education sessions with the multidisciplinary team, it is hoped that a prospective re-audit will show an improvement in these findings, to improve outcomes for women requiring MROP in our unit.

OBSTETRICIANS' SENTIMENT REGARDING BLOOD TRANSFUSION IN PATIENTS WHO ADAMANTLY REFUSE BLOOD TRANSFUSION DESPITE RISK OF DEATH

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Background:
In certain cultures blood transfusion is adamantly refused even in major haemorrhage where refusal to transfuse blood will result in death. This creates particular dilemma in Obstetrics where major haemorrhage is relatively common and is a leading cause of maternal death.

Objective:
To examine obstetrician sentiment in adamant blood transfusion refusal (ABTR) in an obstetric setting.

Methods:
Obstetricians at NMH completed a modified standardised moral distress questionnaire tailored to identify clinician distress and determination to transfuse blood in life threatening haemorrhage in patients expressing ABTR. Obstetricians were stratified according to number of years of clinical experience (CE).

Results:
47 clinicians were surveyed. 80% felt morally conflicted in the care of patients expressing ABTR with 79.6% expressing high levels of moral distress. Only 7% surveyed felt free of emotional distress associated with legal and institutional constraints in ABTR, although 43% of respondents were unsure of hospital policy. Overall, 76% of clinicians would transfuse blood in the context of major life threatening haemorrhage and ABTR. Clinicians with less than 5 years CE were less likely to determine to transfuse in ABTR, while 100% of clinicians with 6 and 10 years CE and 87% of those with 11 and 20 years CE determined to transfuse a patient despite ABTR if they believed a patient would otherwise die. Interestingly, this figure fell to 83% in those with over 20 years CE. 82.4% of clinicians who had experienced a maternal death determined to transfuse in ABTR and life threatening haemorrhage.

Conclusion:
In an obstetric setting, ABTR leads to high levels of moral and emotional distress in attending clinicians. Despite this, three quarters of clinicians responded that they would transfuse a patient despite ABTR if they believe a patient would otherwise die. This proportion reduces in clinicians with less than 5 years CE and increases in clinicians with direct experience of a maternal death, reaching 100% in clinicians with 6 to 10 years CE.

DEVELOPMENT OF AN EDUCATIONAL VIDEO FOR MEDICAL STUDENTS ON SCRUBBING-IN FOR THE OPERATING THEATRE

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Background:
Scrubbing-in is a fundamental skill for medical students entering their surgical placements. Although covered in surgical training, students could benefit from a tool to review scrubbing-in prior to theatre exposure. Instructional videos serve as a good reference for students to use before and during their surgical placements. Providing links to these videos within the Operating Theatre allows students to reinforce learning in a clinical placement in a time-sensitive manner.

Objective:
To design and create an accessible instructional video that demonstrates the standardized method of scrubbing-in with a chlorhexidine solution utilising a four-step model in skills teaching. It aims to incorporate audiovisual guidance, to reinforce sterile technique and support safe and active engagement by providing a practical breakdown of steps and common mistakes to avoid while scrubbing-in the operating theatre.

Methods:
Three medical students, two from the Royal College of Surgeons (RCSI) and one from University College Dublin (UCD) worked together during a medical education elective during the summer of 2025 to develop an instructional video. This was recorded within the Obstetrics and Gynaecology operating theatre at the National Maternity Hospital. Students reviewed best practice in scrubbing technique, developed a pilot video, script and reviewed this with three consultants and senior theatre nursing staff.

Results:
An eight-minute video was successfully developed, demonstrating how to scrub in for the operating theatre using chlorhexidine solution while adhering to theatre protocols. This video was uploaded to the UCD Medicine YouTube channel and shared with RCSI Brightspace. As of September 24th 2025, “How to Scrub In Using Hibiscrub: A Step-by-Step Guide for UCD and RCSI Students”, has been viewed 513 times within its first month of publication.

Conclusion:
This video offers students a practical review tool on scrubbing-in, boosting confidence, reinforcing sterile technique and supporting safe and active participation in the operating theatre.

CYCLIC VOMITING SYNDROME IN PREGNANCY: MANAGEMENT CHALLENGES IN THE CONTEXT OF GESTATIONAL DIABETES MELLITUS

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Background:
Cyclic vomiting syndrome (CVS) is a rare functional gastrointestinal disorder characterised by recurrent episodes of severe nausea and vomiting. Its occurrence in pregnancy is uncommon and may be further complicated by comorbidities such as hypertension, gestational diabetes mellitus (GDM), and obesity.

Objective:
To describe the diagnostic and therapeutic challenges of managing pregnancy complicated by CVS, and to highlight the importance of early recognition and coordinated multidisciplinary input in optimising maternal and neonatal outcomes.

Case Report:
We report the case of a 34-year-old gravida 2 para 1 woman, who first presented at 8 weeks with intractable bilious vomiting, reduced oral intake, and upper abdominal pain. Her medical history included CVS, GDM, hypertension, cholelithiasis, and obesity. Clinical assessments, laboratory investigations, and multidisciplinary team reviews guided diagnosis and management. Interventions included parenteral rehydration, antiemetic polytherapy, thromboprophylaxis, proton pump inhibition, insulin titration for gestational diabetes, and parenteral iron supplementation. Maternal and foetal outcomes were monitored throughout admission.

The primary diagnosis was CVS exacerbation in pregnancy. During multiple hospital admissions, which increased in frequency as gestation advanced, the patient developed GDM, pre-eclampsia, iron deficiency anaemia, and obstetric cholestasis. Despite these complications, foetal growth remained appropriate. Delivery by elective caesarean section at 37 weeks resulted in a healthy female infant weighing 2935g, with Apgar scores of 9/9/10.

Conclusion:
This case demonstrates how CVS can complicate pregnancy, particularly in the presence of coexisting conditions. Early multidisciplinary input and coordinated management are essential to optimise maternal outcomes and maintain foetal wellbeing. These findings underline the importance of heightened clinical awareness and therapeutic challenges of CVS in pregnancy.

RISING RATES AND RISKS: A 17-YEAR ANALYSIS OF TERM INDUCTION OF LABOUR USING THE ROBSON TEN GROUP CLASSIFICATION SYSTEM

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Background:
Induction of labour (IOL) rates are rising in developed countries, impacting birth outcomes. Women undergoing IOL are a heterogeneous cohort, impeding standardised analysis.

Objective:
This study aimed to analyse trends and outcomes of term IOL (≥37 weeks) in nulliparous (NP) and multiparous (MP) cohorts. The Robson Ten Group Classification System (TGCS) was used to facilitate comparative analysis of this population.

Methods:
A prospective study was conducted over 17 years (2006–2023) at a tertiary centre in Dublin, Ireland. Data for 2018 and 2019 was omitted as the hospital transitioned to electronic medical records during this time, resulting in limited data collection. Outcomes were classified annually using the TGCS and published. Analysis focused on Robson Groups 1–5, covering term IOL trends and outcomes. Statistical analysis was performed using SPSS.

Results:
143,389 women delivered a baby >500g; 40,889 (28.5%) underwent term IOL. Overall rates rose from 23.6% to 38.5%, with a more significant rise in IOL rates for NP women compared to MP women ($p<0.00001$). Women labouring spontaneously at term (Groups 1 and 3) as a proportion of our hospital population is declining year on year. Total CS rates increased from 27% to 38.5%, most notably in induced NP women (Group 2a) and elective repeat CS (Group 5). Adverse outcomes, including fully dilated CS ($p<0.0001$), obstetric anal sphincter injury ($p<0.0001$), PPH ($p=0.019$), HIE ($p=0.0007$), and NICU admission ($p=0.0003$) were significantly higher in NP vs MP women undergoing term IOL.

Conclusion:
This large 17-year analysis using the Robson TCGS demonstrates a concerning rise in term IOL and PPH, especially among NP women. In particular, the increased rates of adverse outcomes in NP women are of significant concern and warrant urgent action. Targeted strategies are needed to reduce risk and improve care for this growing cohort of women.

EXPLORING OBSTETRICS AND GYNAECOLOGY PATIENTS' ATTITUDES TOWARDS CLINICAL TEACHING IN IRELAND AND SAUDI ARABIA

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Background:
While clinical teaching remains a foundational part of medical education, patients' attitudes towards students may vary, especially in subjects that may be considered more intimate.

Objective:
Having developed and validated a questionnaire exploring patients' attitudes of patients attending for care in Obstetrics and Gynaecology, we wished to compare results between patients in Ireland and Saudi Arabia.

Methods:
We had previously developed and validated a questionnaire exploring bedside teaching using a seven-step method reported by the Association of Medical Education in Europe (AMEE) guidelines. We adapted items to be more specific to general clinical teaching and reviewed them with five patients and clinical educators. With research ethics committee approval, we then distributed questionnaires in the antenatal and gynaecology clinics and antenatal, gynaecology and postnatal wards in the National Maternity Hospital, Dublin, Ireland, and the Sulaiman AlHabib Hospital in Riyadh, Saudi Arabia.

Results:
From August 2024 to August 2025 611 patients answered the questionnaires (Ireland n=233, Saudi Arabia, n=378). Of these, 351 (57%) were obstetrics patients (Ireland n=179, Saudi Arabia, n=172). Most (70%) had completed third level education (81.6% in Ireland, vs 64% in Saudi Arabia, $p<0.05$). Some (20.1%) had experience of clinical teaching previously, higher in Saudi Arabia (27.3% vs 8.6% in Ireland, $p<0.05$).
Across the board participants were broadly supportive of clinical teaching to allied health and nursing students (77% Ireland, 55% Saudi Arabia, $p<0.05$), medical students and non-consultant hospital doctors (for both: 84% Ireland, 68% Saudi Arabia, $p<0.05$). Most were proud that pregnant people could uniquely teach students by learning from their lived experiences (76% Ireland, 80% Saudi Arabia, p=non-significant).

Conclusion:
Across both countries, women were supportive of clinical teaching and the crucial role that they play in healthcare education. Further analysis will assess more detailed similarities and differences between the countries.

SUPPORTING SAFE INTEGRATION: A DIGITAL INDUCTION FOR INTERNATIONAL MEDICAL GRADUATES IN IRISH HEALTHCARE

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Background:
Ireland's healthcare system is among the most reliant on internationally trained doctors, with 42.4% educated overseas, surpassed only by New Zealand and Israel (OECD). The NDTP Workforce Report 2021–2023 highlights a rise in Non-Consultant Hospital Doctors (NCHDs) in non-training posts, from 1,147 in 2012 to 3,081 in 2021.
Between 2017 and 2021, the Irish Medical Council received 38 "Fitness to Practice" notifications, mostly involving non-EU graduates. Of the 27 cases where the doctor's role was specified, nearly half (n=12) were NCHDs, and of the 13 doctors removed from the register, 11 were international graduates. These figures reflect systemic challenges in communication, training, and integration.

Objective:
To address the lack of structured induction for overseas graduates, this project aimed to develop a comprehensive online module to support their transition into the Irish healthcare system, with a focus on patient safety and workforce morale.

Methods:
Funded by the NDTP Development Fund, an e-learning module was developed for both training scheme and non-scheme trainees. A prior in-person pilot where only 17.2% were released from clinical duties and one-third did not attend despite registering, highlighted the need for a flexible, accessible format. The module provides practical guidance on the healthcare system's structure, professional roles and expectations, and patient support pathways. It was peer-reviewed by the Sudanese Doctors Union Ireland and launched with CPSP and SMSB trainees at RCPI in August 2025.

Results:
The platform includes interactive glossaries, structured overviews, and practical resources. Initial feedback has been positive, and further evaluation will assess engagement and impact.

Conclusion:
This module offers a standardized induction for international doctors. It provides practical guidance on the structure of the Irish healthcare system and the roles of those working in the system. It may serve as a scalable model to support international healthcare professionals across the systems.

ENHANCED RECOVERY AFTER SECTION: IMPROVING PERIOPERATIVE FOR CAESAREAN SECTIONS

Tommy Harty, Jennani Magandran, Azy Khalid

Background:
Enhanced recovery after surgery (ERAS) is a set of evidence-based perioperative interventions designed to optimise patient outcomes, reduced complications, shorten hospital stay and improve patient experience. While widely adopted in many medical specialities, the use of such protocols in obstetrics is varied.

Objective:
To evaluate compliance with recommendations for ERAS at caesarean section as set out in the ERAS Society's guidelines and identify key areas for quality improvement.

Methods:
A prospective audit was conducted at University Hospital Waterford in January to February 2025. All women undergoing elective and emergency caesarean sections were eligible. Relevant perioperative data were collected from patient charts and supplemented with patient interviews. Compliance to guidelines was assessed across pre-operative, intra-operative and post-operative domains with a predefined standard of >90%.

Results:
38 cases were analysed, 19 elective and 19 emergency caesarean sections. Pre-operatively one third of women received written information. Intra-operatively, antibiotic use and correct analgesia was well documented, however temperature monitoring was inconsistently recorded and vaginal preparation was only correctly used in 25% of eligible cases. Timely catheter removal, resumption of diet and mobilisation failed to meet the standard of 90% and only 43% of patients received the correct duration of anticoagulation on discharge from hospital. No patient received any written information on discharge.

Conclusion:
This audit highlights multiple areas for improvement in the delivery of perioperative care for women undergoing caesarean section at University Hospital Waterford. Written information both antenatally and postnatally is lacking and is a key area for improvement. Simple interventions including patient information packs, perioperative integrated care documents alongside staff education may significantly improve adherence to guidelines and improve patient outcomes.

DEVELOPING, VALIDATING AND EXPLORING OBSTETRICS AND GYNAECOLOGY PATIENTS' ATTITUDES TOWARDS CLINICAL TEACHING

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Background:
Clinical teaching is central to medical education, yet patient perspectives, especially in intimate fields like obstetrics and gynaecology (O&G), are rarely studied. Building on a validated questionnaire, we explored how demographics, prior exposure, and education level influence patient attitudes toward clinical teaching, aiming to inform ethical and effective practice.

Objectives:
To assess patient attitudes in O&G settings toward clinical teaching and evaluate the impact of student exposure and educational attainment.

Study Design and Methods
A previously validated bedside-teaching (BST) questionnaire was adapted to address general clinical teaching and reviewed with patients and educators. After ethics approval, it was distributed in antenatal and gynaecology clinics and wards at the National Maternity Hospital, Dublin. Participants rated their experiences and attitudes across domains. Chi-squared and t-tests were used to compare responses by demographics, exposure, and education.

Results:
From July 2024 to July 2025, 233 responses were collected. Mean age was 36.1 years (range 19–79); 76.8% were pregnant or postpartum, and 81.6% had third-level qualifications. Only 14.5% reported prior involvement in clinic-based teaching, and 8.6% had BST exposure. Respondents strongly supported clinical teaching, emphasising verbal consent ($M = 4.39$, $SD = 0.82$) and contributing to student learning ($M = 4.3$, $SD = 0.76$). Attitudes did not differ significantly by prior exposure, except professionalism, rated higher among those without previous teaching experience ($p = 0.03$). Higher educational attainment was linked to greater enjoyment ($p = 0.003$), willingness to participate ($p < 0.05$), and stronger expectations around verbal and written consent ($p < 0.001$ across domains).

Conclusion:
Patients expressed positive attitudes toward clinical teaching. Educational attainment, rather than prior exposure, was the key factor influencing willingness to engage and expectations around consent. These findings reiterate the importance and continued need for clear communication and professional conduct in clinical education settings.

DEVELOPMENT AND CHARACTERISATION OF A MICRONEEDLE PH SENSOR FOR INTRAPARTUM FETAL MONITORING

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Background:
This study presents the in vitro and preliminary ex vivo development of a novel microneedle-based pH sensor for continuous intrapartum fetal monitoring.

Objective:
The objective was to evaluate the feasibility of using microneedle sensors to monitor fetal pH during labour and to develop a proof-of-principle microneedle pH sensor that meets clinical requirements, namely: high sensitivity to small pH changes (0.05 units) within a relevant range (6.50–7.45), minimal tissue disruption, and a compact design suitable for transcervical placement on the fetal scalp (<40 mm diameter).

Methods:
Platinum microneedles were passivated with ArCare medical adhesive and coated with iridium oxide via electrodeposition. Sensitivity was tested in phosphate-buffered saline (PBS) and artificial interstitial fluid (ISF), using both external Ag/AgCl and internal platinum pseudo-reference electrodes.

Results:
In PBS, the sensor exhibited linear responses in increments of 0.05 pH units over the clinically relevant range (6.50–7.45), with slopes of –60.49 mV/pH (R^2 = 0.946, accuracy = 97.65%) and -63.2 mV/pH (R^2 = 0.910, accuracy = 93.70%) in the external and internal configurations, respectively. In ISF, a slope of –25.5 mV/pH (R^2 = 0.979) was obtained. Ex vivo testing on human skin confirmed successful microneedle penetration without visible iridium oxide transfer or tissue damage, as indicated by methylene blue staining. The difference between the mean potential measured in PBS solution and in skin preconditioned to pH 7 was not statistically significant (p=0.342).

Conclusion:
These findings support the potential for continuous, minimally invasive fetal pH monitoring during labour, representing a significant step toward more objective and specific intrapartum assessment.

DIAGNOSTIC CHALLENGES OF INTERSTITIAL ECTOPIC PREGNANCY IN THE PRESENCE OF UTERINE FIBROIDS: A CASE STUDY

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Background:
Interstitial ectopic pregnancy (IEP) is a rare clinical entity, representing 2-6% of all ectopic pregnancies. IEP are associated with higher morbidity and mortality than other types of ectopic pregnancy owing to distinct challenges in both diagnosis and management. The presence of uterine fibroids represents adds further complexity to these challenging cases.

Objective:
To describe diagnosis and management of an IEP in a fibroid uterus.

Case Report:
A 40 year old was reviewed in the early pregnancy unit for history of previous pregnancy of unknown location. Transvaginal ultrasound did not identify a pregnancy despite β-hCG levels > 5000 iU/L. Imaging was noted to be technically challenging due to the presence of a large fundal fibroid. The patient was managed conservatively and serial measurement of β-hCG reduced. During a follow up appointment she became acutely unwell and ruptured ectopic pregnancy was the primary differential diagnosis. She underwent emergency laparoscopy, where a right interstitial ectopic pregnancy was diagnosed with associated large haemoperitoneum. Right superficial cornuostomy with right salpingectomy was performed and she had an uneventful recovery.

Discussion:
Challenges in diagnosing and managing IEP are recognised, however, these are further complicated in situations where there is co-existence of other uterine pathology such as large uterine fibroids. This case highlights that with appropriate expertise, safe and successful surgical management of ruptured IEP is possible using a laparoscopic approach, with cornuostomy and ipsilateral salpingectomy.

ENTERO-UTERINE FISTULA IN THE SETTING OF ADVANCED ENDOMETRIAL CANCER: A CASE REPORT

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Background:
Enterouterine fistulas are rare pathological connections between the bowel and uterus, usually arising from malignancy, inflammatory bowel disease, radiation, infection, or prior surgery.[1] While endometrial carcinoma is the most common gynaecological cancer in developed countries, fistula formation between the uterus and gastrointestinal tract is rare as the thick muscular wall of the uterus offers resistance to malignant or inflammatory infiltration.[2, 3, 4]

Case Report:
A 63-year-old woman presented with postmenopausal bleeding and substantial unintentional weight loss (six stone in one year). CT imaging showed an enlarged uterus with endometrial thickness of 2.2 cm and intrauterine air. During hysteroscopy, a suspected foreign body was visualised but not retrieved, then no longer visible. Intraoperative transabdominal ultrasound revealed a dilated bowel with an anechoic cavity, raising concern for perforation. Urgent intraoperative CT revealed an entero-uterine fistula with no evidence of perforation. Postoperative MRI demonstrated a large uterine mass inseparable from bowel with entero-uterine fistula, and adrenal plus possible liver metastases. Histology of curettings confirmed grade 3 endometrioid endometrial cancer. Multidisciplinary (MDT) review deemed surgery unsuitable due to disease extent; the patient received palliative care and sadly died one month later.

Discussion:
Enterouterine fistula is a rare manifestation of endometrial cancer, with only ~20 cases reported.[5] This patient had no typical risk factors, making her presentation unusual. Her initial symptoms of bleeding and marked weight loss suggested malignancy, but intrauterine air was an early clue to abnormal communication. While hysteroscopy is first-line for investigating abnormal discharge[5], CT and MRI are often essential in atypical cases. Management depends on disease extent and comorbidities: surgery may be curative in localised disease, but advanced malignancy often requires palliative care.[5] This case highlights the need for early recognition, multimodal imaging, and MDT input.

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DELAYED DIAGNOSIS OF AN ECTOPIC PREGNANCY - "CORNUAL PREGNANCY" POST IN-VITRO FERTILISATION FOLLOWING A LAPROSCOPIC BILATERAL SALPINGECTOMY

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Background:
Cornual pregnancy is an uncommon and potentially life-threatening form of ectopic pregnancy, representing roughly 1% of such cases. Because of its location in the highly vascular uterine cornua, rupture often results in severe haemorrhage. Recognised risk factors include prior pelvic surgery, pelvic inflammatory disease, uterine malformations, assisted reproductive technology (ART), and salpingectomy. Although salpingectomy reduces the risk of tubal ectopic pregnancy, the interstitial segment of the fallopian tube may persist, permitting implantation during ART cycles.

Objective:
To describe a rare case of ruptured cornual pregnancy following in-vitro fertilisation (IVF) in a woman with a previous bilateral salpingectomy, initially misdiagnosed and requiring surgical intervention.

Case Report:
A 35-year-old woman, gravida 4 para 3, who conceived via IVF and presented at 4+6 weeks' gestation with sudden abdominal pain, nausea, and vomiting. Transvaginal ultrasound revealed an enlarged ovary, free pelvic fluid, and no intrauterine pregnancy. A ruptured corpus luteum was considered initially. Ongoing haemoglobin drop led to diagnostic laparoscopy, which demonstrated a ruptured right-sided cornual pregnancy. An emergency laparotomy was performed, with repair of the cornual defect and evacuation of approximately 1.5 litres of haemoperitoneum. The patient recovered well following surgery.

Discussion:
Cornual pregnancy may still occur after bilateral salpingectomy and in-vitro fertilisation. Clinicians should retain a high index of suspicion for ectopic pregnancy in symptomatic women following ART. Prompt diagnosis and timely surgical management are essential to prevent serious morbidity or mortality.

IMPLEMENTING A SEXUAL AND REPRODUCTIVE HEALTH EDUCATION PROGRAM FOR RURAL COMMUNITIES IN NORTHERN UGANDA

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Background:
Uganda faces a high burden of sexual and reproductive health (SRH) challenges. Maternal mortality is 207 per 100,000 live births. There are high rates of teenage and unintended pregnancy, unsafe abortion, sexual and gender-based violence, and HIV transmission. Participatory health education programs focusing on sexual health have the potential to promote well-being and reduce harm in populations living in low-resource settings.

Objective:
The aims of this project were to develop a sexual health education program for rural communities in northern Uganda, to deliver this program in six communities, and to conduct a post-program survey to assess program success and acceptability.

Methods:
Based on results of a prior needs-assessment conducted in the target communities, an evidence-based sexual health education program was developed to include five topics; contraception, sexually transmitted infections (STIs), menstrual hygiene, teenage pregnancy and respect and consent. This content was developed by an obstetrician-gynaecologist. The program was conducted on a weekly basis over a five-week period in each community. A qualitative survey was created to record community feedback at the end of the training.

Results:
The program was carried out in six communities. 487 people participated and 340 community feedback responses were recorded in the post-program surveys. 96% (326/340) agreed the information was relevant to them. 98% (333/340) of participants learned something new about sexual and reproductive health and felt more empowered about their SRH after receiving the training. 97% (330/340) said they were more likely to engage with SRH services after receiving the training.

Conclusion:
An evidence-based, culturally appropriate sexual health education program was successfully developed and implemented in six rural communities in northern Uganda over a ten-month period. While self-reported satisfaction with the program was high amongst participants, a more in-depth evaluation would provide better insight into it's impact.

OUTCOMES AMONG WOMEN OVER THE AGE OF 60 YEARS INVITED FOR THE NEW HPV SCREENING TEST IN 2023

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Background:
CervicalCheck introduced primary HPV screening and extended the screening age from 60 to 65 years in 2020. In 2023, women aged 60-65 years in 2020 were invited to undergo HPV screening for the first time.

Objective:
To assess the frequency of high-grade histological abnormalities in women invited for HPV screening who had abnormal cytology detected.

Methods:
Women aged 60-65 years in 2020 that were invited to undergo HPV screening in 2023 and had abnormal cytology requiring referral to The Coombe Colposcopy Department were included. Information was collected from MediScan and analysed in Microsoft Excel.

Results:
There were 41 women that met the inclusion criteria. The median age was 67 years old.
High grade referral smears were noted in four women (N = 4/41, 10%), with three cases of ASC-H (N = 3/41, 7%) and one query of squamous cell carcinoma (N = 1/41, 2%). In all cases where satisfactory assessment was possible, the colposcopic impression was normal or low grade (N = 15/41, 37%). However, in most cases (N = 26/41, 63%) the colposcopic impression was unsatisfactory, typically due to a type 3 transformation zone. Most women with an unsatisfactory colposcopy underwent LLETZ (N = 21/26, 81%). The result of the LLETZ was normal/CIN I in 8 of these patients (N = 8/21, 38%). There were five cases of CIN II (N = 5/21, 24%), seven cases of CIN III (N = 7/21, 33%) and one case of HSIL (N = 1/21, 5%). Incomplete excision was noted in 10 patients (N = 10/21, 48%). Two patients with unsatisfactory colposcopy required definitive treatment with a hysterectomy (N = 2/21, 10%). In the group that attended for further screening as a whole, just 11 required no treatment (N = 11/41, 27%)

Conclusion:
Women with abnormal cervical cytology in this age group can be challenging to assess. Screening and subsequent intervention appears worthwhile as the likelihood of a histological abnormality was high in those who underwent LLETZ. The high rate of incomplete excision was also noted.

REFERRALS TO THE ROTUNDA HOSPITAL PAEDIATRIC AND ADOLESCENT GYNAECOLOGY (PAG) SERVICE

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Background:
The Rotunda MDT PAG service cares for adolescents with common gynaecological concerns (e.g. menstrual dysfunction, labial/vulval issues) and people of all ages living with complex conditions (e.g. congenital variations in uterine, vaginal or sexual development and primary ovarian insufficiency).

Objective:
(1) To review patient demographics, waiting times, requirement for phlebotomy/imaging and surgery; (2) To better understand the patient journeys through hospital services and inform future service planning.

Methods:
The charts of patients (n=438) who attended PAG clinics between 01/01/2024 – 31/07/2024 were retrospectively reviewed using the iPMS and MNCMS PowerChart. Data were collected in the audit tool provided by the Rotunda Clinical Audit team and analysed using Excel and RStudio. The standard used for comparison was the HSE National Outpatient Waiting List Management protocol 2022.

Results:
Patient ages ranged from 10-76 years. Referrals were received from: GPs (65%), Obstetrics/Gynaecology services (15%), Endocrinology (4%), Other (16%). The average time to first visit was 87 days (urgent) and 154 days (routine). 13% patients required surgery and 1% were referred to University College Hospital London under the Treatment Abroad Scheme for consultation. 57% and 63% of patients required access to imaging and phlebotomy respectively.

Conclusion:
The average wait time for urgent referrals breached the HSE recommendation <28 days. To improve this, we suggest education sessions for GP/Gynaecology colleagues in first-line management of menstrual disorders and benign PAG presentations. To improve the experience of service users, we recommend on-site phlebotomy and MRI for PAG clinics.

A RETROSPECTIVE AUDIT OF CAESAREAN SECTION WOUND COMPLICATIONS IN A TERTIARY MATERNITY HOSPITAL

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Background:
Approximately 40% of pregnant women in Ireland deliver by Caesarean Section. These women are at risk of developing post operative wound complications. Factors such as obesity, parity and delivery by emergency caesarean section are associated with an increased risk of developing wound complications. Post Caesarean section wound complications can cause significant morbidity for postnatal women.

Objective:
To audit the incidence of, and factors associated with, post-operative wound complications following Caesarean delivery at the National Maternity Hospital during the period of July-August 2025

Methods:
Women who attended the Emergency Department or the Postnatal Morbidity Clinic in the National Maternity Hospital with wound related issues between July-August 2025 were included.
Electronic records were examined. Various maternal, delivery and postnatal care factors were audited to determine a link between these factors and post-operative wound complications.

Results:
468 Caesarean Sections were performed between July- August 2025- 233 elective and 235 emergency.
42 patients presented with wound related concerns (8.9%). Of these 67% had an emergency caesarean section, with 57% being performed out of hours. 55% of patients had a BMI >30. The average age of women in this cohort was 33.9 and 40% had a previous Caesarean Section.
The most common presenting complaint was wound discharge (57%),
followed by pain (38%), erythema (28.5%). 14% presented with wound haematoma.
74% of patients had a wound swab sent for culture and sensitivities with 70% showing bacterial growth. Common pathogens isolated were staph aureus (35%), staph lugdenensis (30.4%), and also E.Coli and P.Aeruginosa
16% of patients required imaging in the form of US, CT or MRI, with post-operative haematomas diagnosed in five of these cases with one requiring incision and drainage

Conclusion
A variety of maternal and delivery-related factors contribute to the incidence of post-operative wound complications, including high BMI and emergency delivery.

CYTOGENETIC TESTING FOR FIRST TRIMESTER PREGNANCY LOSS – HOW OFTEN IS THERE AN ABNORMAL RESULT?

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Background:
One in four pregnancies can end in miscarriage, making this one of the most common complications of pregnancy. Recurrent miscarriage, where there is more than two consecutive miscarriages, is less common but also devastating. Both can result in "silent" or "disenfranchised" grief and parents often search for reasons to explain their loss. Cytogenetic testing is often recommended to ascertain if there is a genetic cause.

Objective:
To ascertain how often an abnormal result can be obtained that may explain a pregnancy loss.

Methods:
Analysis of the pregnancy loss database from the National Maternity Hospital was carried out. We identified all cytogenetic testing in first trimester pregnancy losses that were requested from January to June 2025. We then analysed results based whether there was a genetic cause for the loss or if cytogenetic testing was normal.

Results:
From January 1st to June 30th, 2025, sixty-seven pregnancy losses had cytogenetic testing done. Of these, 45 were in the first trimester and 22 within the second trimester. Focusing on first trimester losses, indications included miscarriage (either two or more previous miscarriages (18/45, 40%), one previous miscarriage (13/45; 29%), patient request/clinician discretion to aid counselling (8/45, 18%)) or molar pregnancy (6/45, 13%). Within the first trimester group, cytogenetic testing was "normal" in 17 patients (38%) and "abnormal" in 28 patients (62%). Abnormal results included trisomy 13 (n-=1), trisomy 15 (n=1), trisomy 16 (n=3), and Monosomy X (n=4). Sixteen were classified as 'other' results.

Conclusion:
Cytogenetic testing for first trimester pregnancy loss was more likely to have an abnormal cytogenetic result than a normal cytogenetic result. This information may offer some peace of mind to parents searching for reasons to explain their loss.

SAY MY NAME: A QUALITY IMPROVEMENT SURVEY TO EXPLORE PATIENTS' VIEWS ON RENAMING THE ADOLESCENT OBSTETRIC SERVICE

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Background:
The adolescent obstetric clinic is a multi-disciplinary service that caters for pregnant and postnatal adolescents. Such patients are at greater risk of experiencing disadvantage and stigma that have the potential to negatively impact their physical and psychological health during pregnancy. It is therefore imperative that the service is accessible and inclusive for patients. Understanding patients' views on the service is needed to optimise engagement.

Objective:
To review patients' satisfaction with the current service name, and assess their desire to rename the service. Methods: From May-September 2025, patients attending the adolescent obstetric service were invited to complete a simple three question survey. The survey asked their satisfaction with the current service name, if a change of name was needed and their preferred new name. Data were analysed using Microsoft Excel.

Results:
17 patients completed the survey, representing 16% of the annual patient cohort. 71% had a positive response to the current service name. 30% were very satisfied, 41% satisfied and 29% remained neutral about the current name. 47% disagreed with changing the name of the service, while 29% were in favour of a name change. 24% remained neutral. 65% of patients opted to keep the current name, Adolescent Obstetric Clinic, while only 35% opted for a new name.

Conclusion:
Fostering an inclusive and stigma-free environment is integral to supporting adolescents' engagement with obstetric care. This patient survey highlighted that naming holds little importance to patients, who possibly place greater value on the quality of the service rather than its name.

PROSPECTIVE PERINATAL AUDIT OF INDUCTION OF LABOUR IN NULLIPAROUS WOMEN (ROBSON GROUP 2A): INDICATIONS AND DELIVERY OUTCOMES AT THE NATIONAL MATERNITY HOSPITAL

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Background:
Induction of labour (IOL) is among the most common obstetric interventions, with rates rising worldwide. The Robson classification offers a standardised framework for comparing caesarean section (CS) rates across populations. Group 2A, comprising nulliparous women with a singleton cephalic pregnancy ≥37 weeks undergoing IOL, contributes substantially to overall CS rates.

Objective:
This study used the prospective perinatal audit philosophy to examine outcomes for women in Robson group 2A with a singleton cephalic pregnancy ≥37 weeks undergoing IOL at the National Maternity Hospital, assessing IOL indications and delivery outcomes over a 20-week period from March to August 2025.

Methods:
Nulliparous women with a singleton cephalic pregnancy at term undergoing IOL were included, and categorised by their IOL indications, maternal characteristics and delivery mode.

Results:
676 women underwent IOL. Indications were: fetal (n=229, 33.9%), SROM (n=162, 24%), maternal (n=39, 5.8%), postdates (n=164, 24.3%), PET/hypertension (n=58, 8.6%), maternal request (n=20, 3%) and postterm (n=4, 0.6%). Overall, spontaneous vaginal delivery (SVD) and CS occurred with equal frequency (37.4% each, n=253), while operative vaginal delivery (OVD) accounted for 25.2% (n=170). In the mode of delivery groups, the fetal indication; 38% achieved SVD, 25.3% OVD and 36.7% CS. For SROM, the respective rates were 35.8%, 24.7% and 39.5%. In women with PET/hypertension, CS was the most frequent outcome (43.1%), followed by SVD (34.5%) and OVD (22.4%). Among maternal indications, CS was slightly more common (38.5%) than SVD (28.2%) or OVD (33.3%). In the postdates group, SVD predominated (42.7%), with OVD (25%) and CS (32.3%) less frequent.

Conclusion:
Delivery outcomes following IOL were evenly divided between SVD and CS, with one quarter requiring OVD. Mode of delivery varied by indication: higher CS rates occurred with PET/hypertension and maternal request, while postdates induction most often resulted in SVD.

MOVING IN THE RIGHT DIRECTION? A SURVEY OF CLINICIANS' OPINIONS ON WEARABLE FETAL MOVEMENT MONITORING DEVICES

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Background:
Reduced fetal movements are associated with adverse perinatal outcome and commonly prompt unscheduled care. We explored clinicians' views on the potential role of a fetal movement monitoring device in clinical practice.

Objective:
To determine the landscape of current opinions of clinicians on wearable fetal movement monitoring devices.

Methods:
An anonymous online survey was distributed in Ireland and the UK. Quantitative and qualitative responses were collected on current advice for reduced fetal movements, perceived anxiety in patient groups, views on potential risks/benefits of fetal movement monitoring devices, desired device characteristics and preferences regarding data access and responsibility. Descriptive statistics and thematic analysis were applied.

Results:
101 clinicians responded. Most practiced in Ireland (75/82, 91%) and in a public healthcare setting (52/82, 63%); 44/82, 53.7% were obstetrician-gynaecologists and 38/82, 46.3% were midwives. Anticipated benefits of a home fetal movement monitor included reassurance (30/53, 56%) and fewer hospital admissions (13/53, 25%). Key concerns were a potential for increased patient anxiety (20/52, 39%), inaccurate information (23/52, 44%) and over-reliance on a device (16/52, 31%). Evidence-base, accuracy and reliability were rated the most important device attributes. Most clinicians wished to be able to view patient-generated data, though a notable minority did not wish to have responsibility for ongoing monitoring. Overall, 36/53, 68% of clinicians surveyed would consider using a fetal movement monitor in their practice.

Conclusion:
Clinicians perceived potential value for home fetal movement monitors as an adjunct to current care but highlighted potential risks related to patient anxiety, data accuracy and professional responsibility. Evidence of clinical efficacy and safety, alongside patient-experience surveys and data governance would be required for the introduction of a clinically indicated home fetal movement monitoring device.

SPONTANEOUS HEMOPERITONEUM IN THE SECOND TRIMESTER: A MULTIDISCIPLINARY CASE REPORT

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Background:
Second-trimester spontaneous hemoperitoneum in pregnancy (SHiP) is rare but life-threatening, with high maternal and foetal morbidity. Early recognition and multidisciplinary management are crucial.

Case Presentation:
A 36-year-old Para 2+2 (C/S 2011, VBAC 2013), with prior complicated appendicectomy and ovarian cystectomy, presented at 16 weeks gestation with syncope, right upper quadrant pain, tachycardia, and hypotension. Ultrasound revealed free intraperitoneal fluid, and haemoglobin dropped from 9.6 to 6.8 g/dL. Diagnostic laparoscopy drained 500 mL blood; source unidentified. She received two units of blood and was discharged after stabilization. One week later, she returned with similar symptoms. Ultrasound showed trace fluid; MRI was not tolerated. Multidisciplinary review diagnosed SHiP. Conservative management included blood transfusions and tranexamic acid, with laparotomy as a contingency. Haemoglobin fluctuated, requiring further transfusions. Ten days later, she developed severe abdominal pain, nausea, shoulder tip pain, hypotension, and abdominal distension. CT revealed moderate complex free fluid and a hepatic haemangioma, with no clear bleeding source or obstruction. Selective hepatic artery embolization via interventional radiology was performed, and she recovered without complications. The patient was discharged in good condition with stable haemoglobin and resolved symptoms.

Discussion:
Spontaneous hemoperitoneum in pregnancy is rare but potentially fatal. Prompt recognition and multidisciplinary care—including obstetrics, surgery, haematology, and interventional radiology—are essential. Conservative management may be feasible in selected cases with close monitoring. Early team-based intervention is key to favourable maternal outcomes.

PREOPERATIVE ASSESSMENT CLINIC DOCUMENTATION IN ELECTIVE GYNAECOLOGY: A CLINICIAN SATISFACTION SURVEY

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Background:
The preoperative assessment clinic (PAC) is a critical component of the surgical pathway. In our unit, documentation for elective gynaecology patients is currently recorded on blank clinical notes without a structured format.

Objective:
This study aimed to evaluate clinician satisfaction with the quality of current PAC documentation.

Methods:
As no validated questionnaire exists for this context, a short survey was designed to assess completeness, clarity, and usability of PAC documentation. An anonymous paper-based survey, using 5-point Likert scales (1 = very dissatisfied, 5 = very satisfied) and free-text feedback, was distributed to clinicians at University Hospital Waterford between 15–25 September 2025. Data were collated in Microsoft Excel 2019 and analysed using descriptive statistics.

Results:
Eighteen clinicians responded (72% doctors in training, 28% consultants). Overall satisfaction and clarity of documentation were low, with 44% and 56% of respondents respectively rating these aspects as dissatisfied (scores 1–2). The majority reported difficulty locating key information (72%) and identifying clinical risks (67%). Over half of respondents (56%) recommended the introduction of a standardised PAC documentation template as a solution.

Conclusion:
Clinician satisfaction with current PAC documentation is low, with frequent difficulties in clarity and risk identification. A structured PAC template is strongly supported and may improve documentation quality, communication, and patient safety.

RARE CASE OF HETEROTOPIC PREGNANCY IN A HEALTHY ASYMPTOMATIC 40-YEAR-OLD

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Background:
Heterotopic Pregnancy (HP) is an exceedingly rare simultaneous occurrence of intrauterine pregnancy (IUP) and ectopic pregnancy (EP), with an incidence of 1 in 30,000 pregnancies. It is a challenge to clinch this niche diagnosis, due to its complex clinical presentation. We present case report of a spontaneous HP.

Case Report:
A 40-year-old G5P1 presented at 7 weeks Gestational Age (GA) asymptomatic for reassurance scan, showing an Intrauterine Gestation Sac (IUGS), fetal pole of 5mm but no fetal heartbeat. She represented 2 days later at 7+2 GA having collapsed at home with severe abdominal pain. She was hypotensive with Haemoglobin of 8.5, Ultrasound (US) scan revealed 18mm IUGS and fluid in right upper quadrant, with no abdominal tenderness or shoulder tip pain. Given hemodynamic instability, immediate exploratory laparotomy was performed which revealed ruptured left fallopian tubal ectopic pregnancy with 2L haemoperitoneum. A left salpingectomy was performed, and histology confirmed an ectopic pregnancy. The IUGS was followed up via US at 8+1 GA (16.6mm MSD) and 9+1 GA (no fetal pole, 20mm MSD irregularly shaped) as per patients' request to determine viability. At 10+1 GA MSD was 15.0mm. Patient initially opted for expectant management, but she accepted Mifepristone at 10+2 GA. However, she opted for Evacuation of Retained Products of Conception (ERPC) at 10+3 GA, which was uneventful. She received holistic bereavement support.

Discussion:
HP typically presents with underlying risk factors of tubal or pelvic surgery, Assisted Reproductive Techniques (ART), and previous ectopic pregnancy. The only deducible risk factor for our patient is advanced maternal age. Our case report reiterates the importance of the possibility of HP in an otherwise asymptomatic patient. The need for prompt surgical or medical intervention based on hemodynamic stability and patient wishes, reduces maternal morbidity and mortality.

TRAVELLER MOTHERS: OBSTETRIC AND NEONATAL OUTCOMES IN AN IRISH MATERNITY UNIT

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Background:
Travellers' ethnicity was only formally acknowledged by the Irish State in 2017. They experience persistent racism and discrimination resulting in poorer outcomes in terms of health, education, employment and accommodation. Previous studies have reported higher rates of infant mortality and stillbirths among Traveller mothers.

Objective:
This study is a retrospective review examining pregnancy and neonatal outcomes for Travellers compared to the general Irish population.

Methods:
The hospital database was interrogated for results of singleton pregnancies between 01.01.2013 and 31.12.2023 inclusively where mothers self-identified as Travellers and variables analysed.

Results:
Traveller women become mothers at a younger age (25 v 33 years, $p<0.001$) and are more likely to be married (72% v 58.5%, $p<0.001$) with higher median BMI measurements (26 v 24.8, $p<0.001$). There are increased rates of prematurity (18.6% v 13.3%, $p<0.001$) and delivering a low weight baby (8.4% v 5.1%). They are more likely to smoke in pregnancy (45.6% v 8.9%, $p<0.001$) and be related to the father of the baby (24% v 0.88%, $p<0.001$). Smoking and drug use were found to be independent risk factors for prematurity (OR 1.734, 95% CI 1.606 – 1.872, $p<0.001$ and OR 1.710, 95% CI 1.316 – 2.223, $p<0.001$ respectively) but ethnicity was not (OR 1.198, 95% CI 0.989 – 1.451, $p=0.065$).

Conclusion:
Being a Traveller itself or consanguinity was not a factor in a premature delivery but smoking and drug use in pregnancy was associated. This is an opportunity to offer and support to Traveller women and potentially to improve neonatal outcomes.

VAGINAL BIRTH AFTER CAESAREAN SECTION: RECENT TRENDS IN UNIVERSITY HOSPITAL GALWAY

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Abstract

Background:
Caesarean section (CS) rates are rising around the world. One of the cited reasons for this is elective repeat CS for those who have had one previous CS delivery. Vaginal birth after caesarean (VBAC) is considered a safe option for women who have had one previous CS with success of approximately 70%.

Objective:
Review recent VBAC activity in University Hospital Galway (UHG) and compare local VBAC success rates to those quoted in the Irish clinical guideline "Vaginal Birth After Caesarean Section" and international literature. VBAC outcomes across BMI, age, and parity groups are also reported.

Methods:
Birth data were obtained using the EuroKing database from 2016 to 2023. Data collected for the number of women with a previous CS, the number who attempted VBAC, and the number of successful VBACs, and patient parity, age, and BMI. Formulas to assess the VBAC rate, the VBAC attempt rate, and the VBAC success rate were applied to the data from each year.
Results: The caesarean section rate in UHG increased over the examined period from 32.3% in 2016 to 40.3% in 2023. The VBAC attempt rate decreased from 48.4% to 32%. The VBAC rate decreased overall from 24% to 21.9%. The VBAC success rate increased from 49.7% to 68.5%. Success rates were highest in women with a low or normal BMI at >70%. Success rates declined in the overweight and obese categories (65.5% to 52.3% respectively). VBAC success rates were similar in all age groups except for women >40 where the VBAC success rate was 60%. The VBAC success rate for women with one previous delivery by CS was 54.9%. This increased for women with a previous vaginal birth from 83.8% for one previous vaginal delivery, to 92% for >3 vaginal births.

Conclusion:
The trajectory of the CS rate and the VBAC rate in UHG are similar to those seen in a previous series in UHG and from other Irish maternity units. The VBAC success rate in this unit has increased and are similar to those in the Irish guidelines. Further research on the decreased uptake in VBAC is needed. VBAC trends in UHG should be re-audited in 2028

LIPSCHÜTZ ULCER: A RARE GENITOURINARY MANIFESTATION OF ACUTE SALMONELLA.SP¡.. **INFECTION**

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Case Report:
A 17-year-old female presented to A&E with complaints of dysuria and vulval lesions for the preceding 24 hours. Her history was significant for gastroenteritis occurring 3 weeks prior. Given her medical history of spina bifida, she regularly self-catheterized. She had noted vulval pain and performed a self-examination, where she noted red, painful lesions affecting bilateral labia minora. She did not report any fevers or myalgia in the preceding 48 hours. On arrival to A&E, she was found to be pyrexial with a temperature of 38.6°C. Her other vital signs were within normal parameters. On examination, she was found to have multiple tender ulcerating lesions on the labia minora. They were non-exudative and there was no inguinal lymphadenopathy. She denied any previous sexual contact and no other source of infection was ascertained in her history. No local trauma was reported. There was no personal or family history of autoimmune or gastrointestinal conditions.

As part of her work-up, routine laboratory investigations were performed including peripheral blood cultures. Initial laboratory results included C-reactive protein 77.6mg/L, white cell count $6.2x10^9$/L and neutrophils $4.52x10^9$/L. High vaginal swabs and viral swabs of the lesions were referred for microscopy, culture and HSV testing. She was admitted for antimicrobial therapy and analgesia. She was initially commenced on broad-spectrum antibiotics and oral antiviral therapy. She was discharged on day 2 of treatment as she had been apyrexial for the duration of her inpatient stay and was systemically well. Blood cultures were subsequently positive for *Salmonella sp.* and the patient was contacted to return to hospital for intravenous therapy at the request of microbiology. The patient remained inpatient for a further 3 days, during which she was systemically well. Her repeat blood cultures were negative at day 3 of antimicrobial treatment and she was discharged to home.

High vaginal swabs cultured *Staphylococcus aureus* (colonization). Viral HSV swabs were returned as negative. Based on appearance of the ulcers and the positive blood cultures, a diagnosis of exclusion of Lipschütz ulcers of the labia secondary to *Salmonella* infection was formed... **[CHARACTER LIMIT REACHED]**

References:
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2. Acute Vulvar Ulcer (Lipschutz Ulcer) in a Sexually Inactive 11-Year-old Girl. Kyoung Won Cho, Shin Hye Kim, Ji Hyen Lee. Ewha Med J 2021;44(1):26-29

THE PREGNANCY OUTCOMES OF DOCTORS COMPARED TO OTHER EMPLOYED WOMEN

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The Coombe Hospital

Background:
The number of female doctors in the Irish Healthcare System has increased substantially over the last few decades. This feminisation of the doctor workforce is associated with a concomitant rise in the number of doctors becoming mothers. Doctors may be at increased risk of adverse pregnancy outcomes due to the nature of their work; working prolonged hours, strenuous working conditions, disordered sleep, overnight shifts, exposure to radiation, toxic pharmaceuticals such as chemotherapeutic agents, anaesthetic gases, infectious disease, bloodborne pathogens through needle stick injuries or carcinogenic smoke generated by surgical electrocautery. Female doctors also report high rates of childbearing delay and fertility treatment. Advanced maternal age is an additional pregnancy risk.

Objective:
As the number of female doctors grows, and the proportion of female doctors in the workplace increases, we felt up to date literature was needed on the pregnancy outcomes of doctors compared to other employed women. To ensure as fair a comparison as possible and mitigate the potential for confounding due to socioeconomic status, we compared doctors with only employed nondoctors.

Methods:
Women who were delivered a singleton baby between 22 weeks 0 days and 44 weeks 6 days gestation between 1st January 2013 and 31st December 2022 were included for analysis. Over the period of the analysis there were 731 doctors and 64966 women who were in other employment delivered of singleton babies at the Coombe hospital. All data was collected on Microsoft Excel and transferred to SPSS (IBM, Armonk, New York USA) for analysis and extra calculations were made using icalcU.com.

Results:
The outcome of pregnancy in doctors was characterised by an increased delivery intervention rate (more Caesareans, ventouse and forceps and fewer spontaneous births) but no significant changes in rates of preterm delivery or stillbirth. The increase in the Caesarean rate is almost all due to the increase in Doctors undergoing an Elective Caesarean section (23% v 17.2%).

Conclusion:
Multi-institutional prospective age-matched and risk-adjusted observational studies are needed to assess outcomes of doctor pregnancy with the highest level of evidence. Such research would provide important data on doctor health in pregnancy and may help inform both preconception and prenatal counselling and care.

OUTCOMES OF ADOLESCENTS AND YOUNG ADULTS ATTENDING FOR FERTILITY COUNSELLING AND OOCYTE CRYOPRESERVATION PRIOR TO GONADOTOXIC TREATMENT

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Background:
Adolescents and young adults (AYA) who receive gonadotoxic treatment are at risk of future infertility. Fertility counselling and oocyte cryopreservation prior to treatment is increasingly recognised to improve long-term quality of life.

Methods:
Single-centre observational study of all AYA patients (<25y) referred for fertility preservation prior to gonadotoxic treatment (November 2018-July 2025). Demographic, clinical and embryology data was prospectively recorded.

Results:
Forty-seven patients were referred for fertility consultation prior to gonadotoxic treatment. Mean age was 16.1 years (range 12-24); all were postmenarche, were at intermediate to high risk of gonadotoxicity and were deemed psychologically mature by referring oncology MDT. Most common diagnoses was haematological malignancy (n=20, 42.6 %) and sarcoma (n=14, 29.8%). Thirty-seven patients proceeded with ovarian hyperstimulation,1/37 did not proceed to oocyte retrieval (OR). Ultrasound monitoring was transabdominal in 29/37 patients (78.4%; age 13-22) and transvaginal in 8/37 patients (21.6%, age 15-24). Transvaginal OR was performed for most patients (34/36 patients; 94.4%), with laparoscopic OR in 2/36 patients (5.6%) due to diagnosis of cervical cancer and vaginal lymphoma. Mean number of oocytes retrieved was 14.1 (range 0-37), with mean oocyte maturity rate of 81.3% (range 50-100%). No serious complications were reported; 3/36 patients required platelet transfusion prior to OR and 2/36 were admitted post-procedure for observation.

Conclusion:
Oocyte cryopreservation prior to gonadotoxic treatment can be safely performed in AYA patients with comparable outcomes to other populations. Multidisciplinary input, access to fertility specialist expertise and provision of state funding will enable this service to further develop and improve care for this patient group.

TRUSTWORTHY ARTIFICIAL INTELLIGENCE IN UROGYNAECOLOGICAL DIAGNOSTICS: A SYSTEMATIC REVIEW OF DIAGNOSTIC ACCURACY AND REPORTING STANDARDS USING CLAIM, STARD, AND FUTURE-AI FRAMEWORKS

Charles Leahy, Dan Galvin, Barry O'Reilly, Barry O'Sullivan

Background:
Artificial intelligence (AI) is increasingly applied in urogynaecology for diagnosing stress urinary incontinence, pelvic organ prolapse, and overactive bladder using ultrasound, MRI, urodynamic studies, and survey data. Despite rapid growth, evidence is fragmented, with unclear diagnostic accuracy, limited methodological rigour, and poor adherence to reporting standards.

Objective:
To assess diagnostic performance, methodological quality, and adherence to reporting and trustworthiness frameworks in AI models developed for urogynaecological diagnostics.

Methods:
This PROSPERO-registered systematic review (CRD420251110276) searched eight databases. A total of 8430 records were screened and 15 studies included. Studies were assessed with CLAIM for imaging, STARD-AI for non-imaging, and FUTURE-AI for broader trustworthiness.

Results:
Of 15 included studies, 12 were conducted in China, one in Spain, one in India, and one in Singapore. All were pilot studies, and only one reported external validation. Seven studies used ultrasound inputs, one used MRI, three applied urodynamic data, and one used a survey instrument. Across studies, diagnostic performance was variably reported, with sensitivity and specificity measures inconsistently applied. Adherence to trustworthy AI principles was poor, with a median FUTURE-AI adherence of 5 out of 32 items (15.6 percent). None of the studies demonstrated compliance with best-practice reporting across all three frameworks.

Conclusion:
Current AI research in urogynaecological diagnostics is limited to small pilot studies, with minimal external validation and poor adherence to established reporting and trustworthiness frameworks. While preliminary results suggest potential for AI-assisted ultrasound and urodynamic interpretation, significant methodological gaps and inconsistent reporting restrict clinical translation. Future research requires robust study designs, larger cohorts, external validation, and stronger alignment with CLAIM, STARD-AI, and FUTURE-AI guidelines to ensure safe and responsible implementation in clinical care.

EOLAS – KNOWLEDGE AT THE TIP OF YOUR FINGERS

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Background:
EOLAS Medical is a mobile and desktop app for healthcare professionals, centralising clinical resouers – guidelines, protocols, calculators, and educational content – for rapid access at the point of care. Hospitals or departments can create dedicated spaces to organise resources, track engagement, support teaching and induction, and ensure alignment with evidence-based practice.

Objective:
In a high-paced maternity unit, clinicians require instant access to routine and emergency protocols. While national and hospital guidelines are typically on desktop systems, feedback from non-consultant hospital doctors (NCHDs) highlighted challenges in locating specific information quickly—especially during emergencies. Our objective was to streamline access to essential clinical resources through a dedicated app, improving efficiency and confidence among NCHDs at all levels.

Methods:
Working with the CEO of EOLAS Medical and a consultant obstetrician/gynaecologist, we created a customised "Space" for our obstetric department. It included:

- Surgical videos
- PDF guidelines
- Teaching presentations
- Electronic books
- Rotas (weekly and on-call)
- Emergency protocols
- Contact directories

An initial pilot was conducted with five NCHDs from three different training levels over two weeks, during which user feedback was collected to guide further refinement. Access to the Space was restricted to hospital staff using verified work email addresses, ensuring data privacy and appropriate access control.

Results:
Six months post-launch, 55 (NCHDs and consultants) were active users, this has since grown to 93. Feedback has been overwhelmingly positive, citing major time savings in locating protocols and increased confidence in managing obstetric emergencies and common presentations.

Conclusion:
As one of Ireland's busiest maternity hospitals, the Rotunda poses challenges for junior doctors adapting to its pace. The EOLAS app has smoothed this transition for new doctors, improved efficiency, and strengthened preparedness for emergency care.

DEVELOPMENT OF A PREDICTION MODEL FOR MORTALITY IN INFANTS UNDERGOING THERAPEUTIC HYPOTHERMIA FOR NEONATAL ENCEPHALOPATHY

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Background:
Accurate early prognostication of mortality after neonatal encephalopathy offers evidence-based risk estimates that enhance parental counselling.

Objective:
To develop and internally validate a prediction model examining the use of neonatal risk factors to predict neonatal mortality in infants with neonatal encephalopathy requiring therapeutic hypothermia (TH) using national data.

Methods:
Data from 385 infants treated with TH across 19 hospitals (2016–2021) were analysed, collected through the National Neonatal Therapeutic Hypothermia Development Project. Multivariable logistic regression with backward stepwise selection was applied. Potential predictors included variables on maternal characteristics, labour and delivery outcomes, and resuscitation and biochemical characteristics. An initial prediction model utilised all variables significant in the univariable analysis, followed by a simplified model that included fewer candidate variables while maintaining predictive performance. Discrimination was assessed using the C-statistic, with internal validation by bootstrapping. The THERM (Therapeutic Hypothermia Early Risk Model for Mortality) tool was developed to calculate individualised mortality risk.

Results:
Forty-six infants (11.9%) died within 28 days. Four predictors were retained: mode of delivery (prelabour Caesarean section), use of adrenaline, base excess ≤ -22 mmol/L, and seizures during the first day of life. The original apparent C-statistic in the final model was 0.903 (0.860, 0.948), suggesting excellent discriminative performance. There was minimal adjustment to the C-statistic after bootstrapping, indicating good internal performance (optimism-adjusted C-statistic: 0.885 [0.827, 0.936]).

Conclusion:
Four routinely collected clinical and biochemical variables were identified as predictors of neonatal mortality in infants undergoing TH. The THERM tool provides a practical resource for clinicians, enabling personalised risk assessment and supporting parental counselling during the first day of life.

BEYOND PRETERM BIRTH PREVENTION: A THIRTEEN YEAR REVIEW OF OBSTETRIC OUTCOMES AND MISCARRIAGE MANAGEMENT AFTER TRANSABDOMINAL CERCLAGE

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Background:
Transabdominal cerclage (TAC) is an established intervention for women with cervical insufficiency when transvaginal cerclage is unsuitable or has failed. While highly effective in preventing preterm birth[1,2] , its permanent nature presents issues, including mandatory Caesarean delivery and challenges in miscarriage management. Evidence on long-term outcomes and complications remains limited and no literature or guidelines currently address the management of miscarriage with a TAC in situ. This study aims to explore pregnancy outcomes and complications after TAC.

Methods:
A retrospective review of 89 women with 104 pregnancies after TAC at the National Maternity Hospital (2012–2025) was performed. Records were examined for pregnancy outcomes, miscarriage management and intrapartum complications. Descriptive statistics were used.

Results:
Sixty-four women (71.9%) conceived after TAC and 62.5% had >1 pregnancy. Of 104 pregnancies, 75 (72.1%) resulted in live birth and 65 of these (86.2%) delivered at term. Thirteen women (17.3%) presented with threatened preterm labour though only 3 (4.0%) laboured spontaneously. PPROM occurred in 4 (5.3%) while chorioamnionitis and abruption were rare (1 each, 1.3%). Intra-operative Caesarean findings included thickened lower segment (3, 4.0%), bladder adhesions (7, 9.3%), bladder injury (1, 1.33%), dense adhesions (3, 4.0%) and adherent placenta (1, 1.3%). The observed incidence of PPH exceeded national background rates, with 18 women (24.0%) losing >500 ml and 3 (4.0%) experiencing major haemorrhage.
There were 25 miscarriages (24.0%) with 19 (76.0%) in the first trimester. Nearly half (48.0%) were managed conservatively and 44.0% surgically. Two women (8.0%) presented with sepsis following a second trimester loss. They both underwent surgical management. One required suture removal (700 ml EBL) and one had an intact suture but a post-operative pyometra.

Conclusion:
TAC is associated with favourable outcomes, with high live birth and term delivery rates. However, miscarriage care and higher haemorrhage risk present management challenges. Uterine evacuation is feasible in most cases regardless of approach. These findings support thorough counselling to optimise outcomes.

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A CLINICAL AUDIT OF CORD PROLAPSE INCIDENCE AND MANAGEMENT IN THE ROTUNDA HOSPITAL FOR THE YEAR 2024

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Background:
Umbilical cord prolapse is a rare but serious obstetric emergency that, if not rapidly recognized and appropriately managed, is associated with high perinatal morbidity and mortality. Given the prevalence we decided to undertake a clinical audit in order to identify whether recognition, timing, and management by all involved stakeholders are optimal, what outcomes have been achieved, and where improvements might be made.

Aim:
To ensure that the management of umbilical cord prolapse in the Rotunda Hospital is safe, effective, and timely, by comparing current clinical practice with established standards and guidelines in order to identify, and act on, areas for improvement.

Methods:
A retrospective chart review was conducted of all cases of umbilical cord prolapse documented in the Rotunda Hospital in 2024. Cases were identified through the HIPE coding system with documented cord prolapse. A proforma was developed to extract key parameters such as maternal characteristics, clinical context, labour factors, monitoring and recognition, and immediate management measures. Data analysis was carried out in Microsoft Excel. Results were compared against established standards for the management of umbilical cord prolapse (e.g. RCOG Green-top Guideline No. 50, 2014).

Results:
85.7% of cases had been induced. Elevation of the presenting part was documented in only 43% of cases. The decision-to-delivery interval (DDI) was short in most cases, with a median of 11 minutes (range 2–30 mins). Neonatal outcomes were generally favourable. Documentation was incomplete in half of the cases.

Conclusion:
Most decision-to-delivery intervals were within acceptable thresholds, two cases exceeded 20 minutes, underlining the importance of ongoing systems review to minimise avoidable delays. Going forward we recommend reinforcement of documentation standards through staff education and use of structured proformas for cord prolapse management, continued emphasis on rapid escalation and teamwork, and regular simulation training to maintain staff preparedness

WHEN THE SCOPE FINDS NOTHING: A THREE-YEAR REVIEW OF NEGATIVE LAPAROSCOPY FOR SUSPECTED ECTOPIC PREGNANCY

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Background:
Ectopic pregnancy (EP) affects approximately 11 per 1,000 pregnancies with a maternal mortality rate of 0.2 per 1,000. Surgery functions as both a diagnostic and therapeutic intervention but is also associated with negative sequelae. Negative laparoscopy rates for suspected EP range from 5-25% with no accepted international standard.

Aim:
To determine the incidence of negative laparoscopy for suspected EP in our unit and characterise associated clinical and operative features.

Methods:
This retrospective study included women undergoing surgical intervention for suspected EP between August 2021 and July 2024. Eligible cases were identified from theatre logbooks, and corresponding healthcare records were reviewed. Clinical data was anonymised and recorded in an Excel database. Descriptive statistics summarised patient characteristics, operative details and the incidence of negative laparoscopy.

Results:
During the study period, 141 diagnostic laparoscopies were performed for suspected EP, of which 9.9% (n=14) were negative. Risk factors for EP were reported in 33.3% (n=47) of women. Ultrasound was performed prior in all cases, with 68.8% (n=97) suspected to have an EP on first scan. More than half the surgeries (52.5%, n=74) were performed out of hours, just over half (56.7%, n=80) were elective and one case (0.7%) required conversion to laparotomy. In two women identified with EP intraoperatively a clinical decision was made to manage these non-surgically, which were successful. Median intraoperative blood loss was 100 mL (range 100–5700 mL). Further details on preoperative and intraoperative findings are summarised in Table 1.

Conclusion:
Laparoscopy may provide valuable diagnostic information and assist in the treatment of suspected EP but is not without associated risks. The rate of negative laparoscopy in our unit falls within internationally accepted standards. Continual audit of these rates is important to identify any change in practice and ensure that clinical management of these patients is optimised.

RHABDOMYOSARCOMA OF THE UTERUS: DIAGNOSTIC AND THERAPEUTIC CHALLENGES IN A RARE MALIGNANCY

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Background:
Uterine rhabdomyosarcoma (RMS) is an extremely rare and aggressive malignancy, accounting for less than 1% of uterine cancers. It is most often seen in postmenopausal women, with embryonal and pleomorphic subtypes more frequent in adults. Presentation in younger women is exceptional, underscoring the diagnostic and therapeutic challenges.

Case Report:
We report the case of a 35-year-old nulliparous woman with hypertension who presented with a 1.5-month history of abdominal pain and a progressively enlarging abdominal mass. Ultrasound-guided biopsy revealed a neoplastic lesion with rhabdoid features, and immunohistochemistry was positive for myogenic markers, confirming suspicion of RMS. CT imaging demonstrated a large solid-cystic pelvic mass measuring 26 × 31 × 16 cm, inseparable from the uterus, with non-visualization of the ovaries. The case was reviewed in a multidisciplinary tumor board, and surgical management was advised. The patient underwent total abdominal hysterectomy, bilateral salpingo-oophorectomy, and pelvic lymph node dissection. Intraoperatively, 600–700 mL ascitic fluid was drained, and a large fleshy uterine fundal mass was identified, with otherwise normal peritoneal surfaces and adnexa. Postoperative recovery was uneventful. Final biopsy confirmed Rhabdomyosarcoma.

Conclusion:
This case highlights the rarity of uterine RMS in young women and emphasizes the importance of early recognition, multidisciplinary decision-making, and multimodal management. Increased clinical awareness, collaborative care, and further research are essential to improve outcomes and guide standardized treatment protocols for this aggressive malignancy.

A CASE REPORT OF POSTPARTUM MATERNAL IDIOPATHIC BRACHIAL PLEXOPATHY

Dr Maeve Smyth, Dr Conor P O'Brien

Background:
Postpartum brachial plexopathy is a rare neurological obstetric complication, with reported incidence from 0.5 to 2.3 per 100,000 deliveries. It typically presents in the immediate postpartum period with unilateral sensory disturbances, upper limb weakness, impaired motor function and often pain. The pathophysiology is thought to involve stretch, ischemia or compression of the brachial plexus during labour and delivery. We present this case of brachial plexopathy in a woman following and elective caesarean section with the aim of raising awareness among obstetric providers and providing diagnostic and treatment options.

Case Report:
36-year-old, P1, elective caesarean. Uncomplicated antenatal and postnatal course and was discharged day 2 post-partum. Day 6 postpartum she had sudden onset right arm weakness associated with pain. She was seen by physiotherapist, had an MRI was reviewed by orthopaedics and eventually referred to a neurophysiologist. She underwent EMG testing to confirm the diagnosis of brachial plexopathy. A course of amitriptyline and prednisolone was commenced for 6 weeks. Nerve function improved from 3% at initial presentation to 50% 6 weeks later. Currently 14 months postpartum nerve function is at 80% and motor is slow to recover.

Discussion:
Maternal brachial plexopathy cases are rarely reported in the literature, Given the relative rarity and nonspecific initial symptoms, diagnosis is often delayed or missed. The differential diagnosis of postpartum upper limb weakness includes positional neuropathy, epidural or spinal complications, cervical radiculopathy, Parsonage-Turner syndrome and central causes. Our case underscores the importance of maintaining a high index of suspicion for maternal brachial plexus injury in the postpartum period, particularly when symptoms are unilateral, focal, and do not correlate with common peripartum complications.

Learning points:
Rare but real, early recognition is key for recovery, diagnosis confirmed via EMG, management includes Pain control, physiotherapy, corticosteroids.

AN AUDIT ON THE OUTCOMES OF LARGE FOR GESTATIONAL AGE BABIES IN NON-DIABETIC MOTHERS

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Background:
The prevalence of fetal macrosomia has increased globally by 15–25% in recent decades. Contributing factors include maternal height, body mass, gestational weight gain, diabetes, reduced smoking, and sociodemographic changes. Macrosomia is associated with higher maternal and neonatal morbidity; however, no universally accepted definition, diagnostic criteria, or standardized management approach exists.

Objective:
To evaluate maternal and neonatal outcomes of LGA infants (>4000 g) in non-diabetic pregnancies and compare complication rates between spontaneous labor, induction of labor (IOL), and elective cesarean section (EL-LSCS).

Methods:
A retrospective review was conducted of all non-diabetic women delivering infants >4000 g at Mayo University Hospital between June and November 2024. Data were anonymized and collected from electronic labor ward records and analyzed using Microsoft Excel. Practice was assessed against 2023 TOG guidance on management of suspected LGA pregnancies.

Results:
Among 107 LGA births, 52 (48.6%) followed spontaneous labor, 35 (32.7%) IOL, and 20 (18.6%) EL-LSCS, mainly for previous uterine scars. Vaginal delivery occurred in 46 (88.4%) spontaneous cases and 25 (71.4%) IOL cases; emergency LSCS rates were 11.5% and 28.6%, respectively. Instrumental delivery occurred in 12 cases (8 IOL). Postpartum hemorrhage occurred in 18 cases (6 IOL). Two third-degree tears were recorded (1 IOL). Ten neonates required SCBU admission, four following induction.

Conclusion:
Neither IOL nor EL-LSCS demonstrated clear reduction in complications compared with spontaneous labor. Many LGA pregnancies resulted in uncomplicated vaginal birth. Management should remain individualized, supported by clear patient information and clinician education.

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AUDIT OF PATIENTS WITH OASI IN WGH

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Background:
Third- and fourth-degree perineal tears, also known as obstetric anal sphincter injuries (OASI), are severe complications that can occur during vaginal delivery. These injuries involve the anal sphincter complex and, in the case of fourth-degree tears, extend to the rectal mucosa. The Royal College of Obstetricians and Gynaecologists (RCOG) provides comprehensive guidelines for the management of these injuries, *Third- and Fourth-degree Perineal Tears, Management (Green-top Guideline No. 29)*

Methods:
This retrospective audit focuses on 32 patients who experienced labor complications resulting in 3rd and 4th degree perineal tears. The audit was conducted in the Department of Obstetrics and Gynaecology at Wexford General Hospital, spanning the period from June 2022 to June 2024. 3014 Charts were reviwed . The primary aim was to analyze the management, and outcomes of these severe perineal tears. Data was collected and analyzed using a rating method to ensure comprehensive evaluation and accurate interpretation of the clinical outcomes. This methodology facilitated a detailed assessment of the factors contributing to the occurrence of third-degree perineal tears and the effectiveness of the interventions employed.

Results:
Results showed an incidence of 0.47% for third degree tears and 0.03% for fourth degree tears. 68%of them had spontaneous onset of labor and 84% delivered in lithotomy position. Gestation diabetes was diagnosed in 3.14% of the cases. 18.8 % of tears were associated with birth weight above 4 kg. No perineal support was documented in about 43%. All patients received antibiotics, analgesia and laxative treatments as per RCOG Guidelines. They also received dedicated physiotherapy and referred to the Perineal Clinic in National Maternity Hospital for evaluation of healing and prognosis for future vaginal deliveries.

Conclusion:
Vast majority of cases of OASIs happen in low risk patients in spontaneous labour in lithotomy position who do not have adequate perineal support at delivery. Recommendation: Apply warm compresses to the perineum during the second stage of labor, Use controlled delivery technique, Perform episiotomies when clinically indicated. A re-audit is recommended in 1 year to ensure that the recommendations from the current audit are being effectively implemented.

"FERTILITY – ARE DOCTORS TAUGHT ENOUGH?"

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Background:
One in six couples struggle with fertility[1], with their first contact about fertility often being with their General Practitioner (GP). Yet 97% of GPs wanted further fertility training prior to the introduction of state-funded fertility treatment (AHR) in 2024[2, 3]. Doctors rely on their undergraduate education when counselling patients either as GPs or Gynaecology Trainees (OBGYNs)[4].

Aim:
Assess confidence and fertility knowledge amongst GPs and OBGYNs.

Methods:
A 34-questionnaire survey was distributed online via SurveyMonkey® to Irish GPs and OBGYNs between June to September 2025. Demographic data including age, gender, undergraduate fertility education plus counselling confidence in fertility was collected. This questionnaire was based on validated fertility assessments[5, 6], plus up-to-date AHR outcome data[7]. Chi-square and independent t-tests were used for statistical analysis.

Results:
In total, 79 participants responded with 68 adequately completing the fertility quiz (30 GPs and 38 OBGYNs). Undergraduate fertility education was deemed insufficient by the majority (n=51/79, 64.6%). OBGYNs were more confident at counselling fertility patients than GPs (p=0.009). There was no difference in mean score between OBGYNs and GPs (46.5% versus 49.9%, p=0.12). Over half identified the age of most precipitous female fertility decline (n=38/68, 55.9%). OBGYNs were more accurate for the miscarriage risk of women aged 40-44 years (p=0.007). The impact of male age on fertility was unacknowledged by 8.8% (n=6/68). OBGYNs were also more accurate at identifying site of fertilisation (p=0.013). For IVF success rates, the live birth rate(LBR) for 30-35 years was mostly underestimated, with 10.3% (n=7/68) reporting a LBR of >50% per embryo transfer.

Conclusion:
Despite higher confidence amongst OBGYNs, both groups obtained a mean score of <50%. Amongst Canadian medical students, 74% correctly identified the age of precipitous female fertility decline[8] compared to 55.9% in our cohort. The majority felt their undergraduate education in fertility was insufficient.

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PREDICTIVE VALUE OF ANTI-MÜLLERIAN HORMONE IN ASSISTED HUMAN REPRODUCTION: A RETROSPECTIVE COHORT STUDY

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Background:
Anti-Müllerian Hormone (AMH) is an established marker of ovarian reserve, yet its predictive value for pregnancy outcomes in Assisted Human Reproduction (AHR) remains uncertain. The utility of AMH as a selection criterion for treatment is unclear.
Objective: This study evaluated the predictive value of low AMH (<5 pmol/L, with subgroup analysis at <2 pmol/L) in women undergoing AHR and explored its potential role in determining eligibility for publicly funded treatment.

Methods:
A retrospective cohort study was conducted at a tertiary centre between January 2024 and May 2025. Demographic, clinical, and treatment data were analysed using chi-square tests, t-tests, and multivariable logistic regression adjusting for female age, AMH(pmol/L), and prior AHR. The primary outcome was ongoing pregnancy, defined as a pregnancy continuing beyond 20 weeks' gestation or delivered during the study period.

Results:
293 women underwent investigation for AHR. Of these, 237 had completed treatment cycles with known outcomes. Within this group, 22.4% (n=53/237) had AMH <5 pmol/L and 7.2% (n=17/237) had AMH <2 pmol/L. Ongoing pregnancy occurred in 26.4% (n=14/53) of women with AMH <5 pmol/L compared with 42.9% (n=79/184) in women with AMH >5 pmol/L (p=0.044). In women with AMH <2 pmol/L, ongoing pregnancy occurred in 29.4% (n=5/17) versus 40.2% (n=82/204) in AMH >2 pmol/L (p=0.59). Women with AMH <2 pmol/L were older (38.0 vs 35.6 years, p=0.004) and had higher BMI (26.3 vs 24.3, p=0.015). Only one woman <35 years had AMH <2 pmol/L. Blastocyst yield was lower with AMH <2 pmol/L (1.5 vs 2.9, p=0.03). Among women completing treatment, age, BMI, AFC, and male age were not predictive of ongoing pregnancy.

Conclusion:
Women with AMH <5 pmol/L had lower ongoing pregnancy rates compared with those with AMH >5 pmol/L. However, 26.4% of women with AMH <5 pmol/L achieved an ongoing pregnancy after one cycle, indicating that AMH should not be used in isolation to restrict access to state-funded AHR. Further study is warranted in younger women with low ovarian reserve.

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HOW SUCCESSFUL IS CYTOGENETIC TESTING FOR FIRST TRIMESTER PREGNANCY LOSS? ANALYSIS BASED ON MODE OF MISCARRIAGE MANAGEMENT

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Background:
Cytogenetic testing is often recommended to ascertain if there is a genetic cause of the pregnancy loss. The aim of this study was to ascertain the success rates of cytogenetic testing, defined as having a genetic result, based on mode of management of pregnancy loss, whether conservative, medical or surgical

Methods:
An analysis of the pregnancy loss database from the National Maternity Hospital was carried out. We identified all cytogenetic testing in first trimester pregnancy losses that were requested from January to June 2025. We then analysed results based on indication and then mode of management, whether conservative alone, medical alone or surgical (either direct or for retained products of conception (RPOC) post medical or surgical).

Results:
From January 1st to June 30th, 2025, sixty-seven pregnancy losses had cytogenetic testing done. Of these, 45 were in the first trimester and 22 within the second trimester. Focusing on first trimester losses, indications included two or more previous miscarriages (18/45, 40%), one previous miscarriage (13/45; 29%), patient request/clinician discretion to aid counselling (8/45, 18%) or molar pregnancy (6/45, 13%). Most were managed surgically (34/45; 75%); 32 samples obtained at surgery provided cytogenetic results (94%). Three additional pregnancies had surgical management and cytogenetic testing of RPOC after medical or conservative treatment, of which one provided cytogenetic results (33%). The overall success rate of cytogenetic testing after surgical management was therefore 33/37 (89%). Combining samples obtained after medical treatment alone (n=5) and conservative treatment alone (n=3), results from cytogenetic testing were available for four (50%) (three after medical and one after conservative).

Conclusion:
Surgical management was more likely to provide a cytogenetic result when tested compared to medical or conservative management, with an overall success rate of 89%. Women who choose medical or conservative management can be advised that it is possible, though less likely, to get results following cytogenetic testing of RPOC.

RUDIMENTARY HORN PREGNANCY: A CASE OF EARLY DIAGNOSIS AND TIMELY MANAGEMENT

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Background:
Pregnancy in a non-communicating rudimentary horn of a unicornuate uterus is an exceptionally rare ectopic pregnancy, with an estimated incidence of 1 in 76,000–150,000 pregnancies. It carries a high risk of rupture (80–90%), usually in the second trimester, and maternal mortality of up to 0.5% (Li et al., 2019; Chatziioannidou et al., 2020). Early recognition with imaging is critical, yet most cases are diagnosed only after rupture. We report a case diagnosed at 6 weeks in a patient with a known uterine anomaly, to emphasise how detailed imaging and surgical planning can prevent significant morbidity.

Case Report:
A 31-year-old G1P0 presented to ED at 5+5 weeks with mild left iliac fossa pain following a private ultrasound suggestive of ectopic pregnancy. She was clinically stable. A unicornuate uterus with a rudimentary horn had been diagnosed laparoscopically in 2012. Transvaginal ultrasound suggested a pregnancy within the rudimentary horn, separate from the uterine cavity, and MRI confirmed this. Beta-hCG increased from 9,059 on admission to 17,869 after 48 hours. Diagnostic laparoscopy was performed and converted to laparotomy to aid excision. The rudimentary horn and ipsilateral fallopian tube were excised, with ovarian preservation. Histology confirmed an unruptured ectopic pregnancy. Postoperative renal imaging was normal. This case demonstrates the importance of early pregnancy imaging in patients with known uterine anomalies. In line with RCPI guidelines, transvaginal ultrasound followed by MRI was used to confirm the diagnosis prior to rupture. Surgical management also followed RCPI guidance, with excision of the rudimentary horn and ipsilateral tube.

Discussion:
While most rudimentary horn pregnancies present late, often with life-threatening haemoperitoneum, early identification here enabled planned intervention, ovarian preservation, and prevention of maternal morbidity. This case highlights the value of a timely early pregnancy scan in women with known Müllerian anomalies to detect rudimentary horn pregnancy before rupture to prevent maternal morbidity.

BALANCING RISK AND PRESERVATION: FERTILITY-SPARING SURGERY FOR CAESAREAN SCAR PREGNANCY

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Background:
Caesarean scar pregnancy (CSP) is a rare form of uterine pregnancy in which the gestational sac implants into a previous caesarean scar niche. The estimated incidence is 1:1,800 - 1:2,226 pregnancies. Type 2 CSP, marked by deep myometrial invasion and progression toward the bladder, confers high risk of maternal morbidity including: placenta accreta spectrum, rupture and life-threatening haemorrhage. Management is challenging and decisions must balance maternal safety with fertility preservation.

Aim:
To present a case of type 2 CSP managed surgically, highlighting the importance of early diagnosis, multidisciplinary team (MDT) decision-making and tailored fertility-preserving intervention.

Methods:
A 38-year-old woman with two prior lower segment caesarean sections presented at 9 weeks' gestation with spotting and pelvic discomfort. Transvaginal ultrasound revealed a non-viable 6 cm CSP with features suggestive of type 2 implantation; including myometrial invasion and prominent vascularity. Subsequent MRI confirmed the diagnosis and suggested possible uterine serosal involvement. MDT discussion was conducted to determine optimal management given the woman's preference to preserve fertility. Primary surgical intervention was employed with laparotomy to directly visualise the CSP and facilitate prompt intervention in the event of perforation or haemorrhage. This was followed by transvaginal vacuum aspiration of the CSP, excision of the niche defect and a multilayer uterine myometrial repair. Blood loss was 250 mL with histopathology confirming implantation within the resected niche. Ultrasound at six weeks demonstrated a well-healed uterine scar and no residual niche. The woman was counselled on a 5–30% recurrence risk and advised early ultrasound in future pregnancy.

Discussion:
This case highlights the diagnostic and operative challenges of type 2 CSP. Early diagnosis, MDT utilisation, and individualised surgical strategies can minimise maternal morbidity while preserving fertility.

AN ATYPICAL CASE OF MENORRHAGIA IN THE SETTING OF A CAESAREAN NICHE AND ENDOMETRIOSIS

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Background:
Caesarean niches are complications on the rise due to increasing caesarean section rates internationally. While many women may be asymptomatic, it is known that they can be associated with prolonged uterine bleeding, intermenstrual bleeding and sub-fertility. Some case reports also associate it with menorrhagia. While not a typical symptom of endometriosis, it too is associated with menorrhagia

Case Report:
We present the case of a 35year old woman, one year post caesarean who presented with severe menorrhagia. Heavy PV bleeding persisted despite appropriate medical and hormonal medication, including tranexamic acid, primolut and depo-provera. An MRI pelvis, ruled out an AVM however did comment on evidence of stage IV endometriosis with bladder tethering to the anterior wall of the uterus and an endometrioma. A caseaerean niche was also visible on imaging. Following this, she went for a hysteroscopy, endometrial biopsy and insertion of Mirena coil. During this, a bleeding point was noted close to the caesarean scar and a further ?endometriotic nodule was noted at fundus. These were treated with 'flowseal'. Despite Mirena, heavy vaginal bleeding persisted and an emergency uterine artery embolization (UAE) was performed. This was successful and effective. In total, she received 11units of red cells. She was discharged home day five post UAE.

Discussion:
This is a complicated case of menorrhagia that did not respond to medical and hormonal management. She required a large volume of blood products and MDT input before stabilisation. She has a known diagnosis of endometriosis and MRI revealed a caesarean niche. While we don't have a tissue diagnosis, we suspect this may be a case of severe niche bleeding or possibly a case of deep infiltrating endometriosis invading through the niche, deficient in myometrium. From our review of the available literature, this has not yet been reported. This proves difficult in counselling, both about a diagnosis and future pregnancy, which she desires. But certainly we suspect, she would be at risk for scar pregnancy, repeat praevia, PAS and PPH.

DEMOGRAPHICS AND OUTCOMES OF COUPLES SEEKING STATE-FUNDED FERTILITY TREATMENT

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Background:
More couples require Assisted Human Reproduction (AHR) worldwide to achieve a pregnancy[1]. Ireland was previously ranked 4th worst country in the EU for fertility policies[2], which improved once the Irish Government introduced state-funded AHR[3]. Currently Ireland is ranked similar to the UK and Germany[4].

Aim:
To assess the demographics and outcomes of couples attending the National Maternity Fertility Hub.

Methods:
A retrospective analysis of couples referred from our Regional Fertility Hub for AHR from January 2024 to May 2025. Demographic data including maternal age, BMI, and time 'trying to conceive(TTC)' were analysed. Sub-analysis was conducted for known AHR outcomes and by the POSEIDAN AMH groupings[5].

Results:
A total of 721 couples were reviewed in the hub, with 403 being referred on for AHR and full outcomes were available for 305 couples. Of the 403 couples, the mean female age was 35.6 (range 23-41yrs), mean TTC was 30.1 months (range 6-240) and mean initial female BMI was 24.0 (range 18.1-37.4). Mean TTC did not decrease between 2024 and 2025 significantly (31.66 months versus 29.81 months, p=0.059). Female occupation impacted the length of TTC prior to seeking fertility treatment (p=0.014). Male factor was the main cause of infertility(n=180/403, 44.7%) followed by reduced ovarian reserve (n=86/403, 21.3%). Of those who had in-vitro fertilisation (IVF)/intracytoplasmic sperm injection (ICSI), 38.9% (n=89/230) had achieved a live birth or ongoing clinical pregnancy (>20 weeks). Women aged under 35 with an AMH above 8.57pmol/L had the highest rate of pregnancy (n=30/54, 55.6%, p<0.001).

Conclusion:
Male factor was the main cause of infertility within our cohort. Introduction of state funding didn't reduce the TTC prior to seeking treatment, with female occupation impacting when couples sought fertility treatment. The pregnancy rate per cycle for our IVF/ICSI patients (38.9% versus 33%) is higher than the UK for women aged under 42 (33%)[6].

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OPTIMISING THEATRE UTILISATION: AN AUDIT OF EMERGENCY OBSTETRICS AND GYNAECOLOGY THEATRE USE IN MRH-PORTLAOISE

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Background:
Efficient operating theatre resource utilization is crucial for optimal patient care and productivity. This audit aimed to assess the utilisation of Operating Theatre 2 (OT2), the designated emergency obstetric theatre, during normal working hours at a regional hospital (Midland Regional Hospital – Portlaoise) and to identify opportunities for improvement.

Methods:
A retrospective analysis was conducted of emergency obstetrics/gynaecology cases over a six-month period between February 1 and July 31, 2025. Data were collected from theatre logbooks, including procedure types, urgency (categorised using the RCOG classification for caesarean sections), and timing of cases. Normal working hours is defined as 0900 to 1700 Monday to Thursday and 0900 to 1600 on Friday. Statistical analysis, including Chi-square testing and t-tests, was performed to identify significant trends and associations.

Results:
During the study period, a total of 230 emergency obstetrics and gynaecology cases occurred, with 68 cases taking place during normal working hours. While OT2 was designated as the primary emergency theatre, OT1 handled a higher proportion of total emergency cases (58.3%, n = 134 vs 36.1%, n = 83). However, OT2 was used most frequently for cases occurring during normal working hours (54.4%, n = 37). Emergency caesareans constituted a significant proportion of cases. During the 6-month time period there was 281 total caesareans of which 156 (55.5%) were emergency cases and 44 emergency cases occurred during normal working hours. Weekday analysis indicated that Thursday was the busiest day, while Monday and Tuesday mornings (0900 to 1300) had the lowest emergency case volume.

Discussion and Conclusion:
This audit highlights opportunities to improve emergency theatre utilization within the ObsGynae department at MRH-Portlaoise. The consistently low emergency case volume on Monday and Tuesday mornings presents an opportunity to optimize staffing levels or schedule elective procedures. The observed discrepancy in theatre utilization, despite OT 2's designation, warrants further investigation. Key Performance Indicators (KPIs) to track theatre utilisation and efficiency should be monitored monthly.

AUDIT OF PAIN SCORES DURING OUTPATIENT HYSTEROSCOPY: BENCHMARKING AGAINST BRITISH SOCIETY OF GYNAECOLOGICAL ENDOSCOPY (BSGE) STANDARDS

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Background:
Outpatient hysteroscopy (OPH) offers rapid access and reduced reliance on general anaesthesia. Despite its benefits, pain remains a key factor influencing patient experience and procedural success. A UK audit by BSGE found 87% of women experienced pain during OPH with a mean pain score (PS) of 5.2 (SD 2.72).

Aim:
To evaluate pain scores during OPH and compare outcomes against UK benchmarks to identify areas for improvement in pain management.

Methods:
A retrospective audit was conducted between June 2024 to November 2024. PS recorded using a 0–10 visual analogue scale (VAS) immediately post-procedure. Descriptive analysis included age, parity, mode of delivery, analgesia use, scope type, procedure performed and local anaesthetic administration.

Results:
53.0% (294/554) of patients completed the optional PS forms. Mean PS was 4.84 (SD 2.31). Diagnostic hysteroscopy was performed in 81.97% (241/294) and operative in 13.26% (39/294). Pre-procedure analgesia was taken by 85.03% (250/294) and local anaesthetic was used in 38.09% (112/294), mainly Instillagel 76.78% (86/112) and Lignospan 17.85% (20/112). OPH success rate was 92.17% (271/294). Higher mean PS were noted in nulliparous (5.18, SD 1.77), those with previous CS deliveries only (5.55, SD 2.77) and patients over 50 years old (5.21, SD 2.41). Interestingly, patients who received local anaesthesia reported mean PS of 5.28 (SD 2.58) which may reflect selection bias, as local anaesthetic was more likely to have been administered in anticipated difficult cases or at patients' request.

Conclusion:
Pain during OPH remains a concern. The mean PS compares favourably to BSGE standards. While most patients tolerated the procedure well, the limited response rate highlights the need to improve documentation and patient engagement. A protocol for analgesia before, during and after OPH should be developed to enhance patient satisfaction and improve quality of care. Routine PS audit should be encouraged as standard practice in every OPH unit.

DEMOGRAPHICAL RISK FACTORS FOR THE DEVELOPMENT OF POST CAESAREAN SECTION WOUND COMPLICATIONS

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Background:
Surgical site infection in caesarean section is defined as an infection occurring within 30 days after caesarean section delivery. There are a wide variety of risk factors increasing the risk of caesarean section wound infections worldwide and this includes the likes of prolonged rupture of membranes, long labour, prolonged duration of caesarean section and high body mass index, emergency caesarean section. However there is not much research conducted on different ethnic groups living in developing countries and their incidence of developing post caesarean section wound complications.

Aim:
Post caesarean section wound complications PCSWC is a widespread concern. This study aims to explore the incidences and demographical risk factors for the development of post caesarean section wound complications and to prove if these risk factors are in concordance to literature findings.

Methods:
200 patients undergoing caesarean section were randomly collected from a university hospital database between the year 2017 and 2023. These patients were randomly selected and then studied to decipher how much patients developed postoperative wound complications. Patients electronic as well as handheld medical notes were thoroughly examined. Patients were included if they had radiological , clinical or microbiological evidence of PCSWC.

Results:
16/200 (8%) patients developed post caesarean section wound complications. Incidence of PCSWC in women with BMI>30 was 13.4%,BMI <30 5.8%, emergency CS 7.8% and in elective CS 6.5%,in different African ethnicities incidence was 10.8%, PCSWC in those with EBL >900mls was 19%. Incidence was similar in those aged above 40 and less than 30.

Conclusion:
Our study proved that obesity, emergency caesarean section , EBL of more than 900mls is indeed a risk factor and is in concordance with literature results. Black ethnicities have a higher incidence, while we proved that age is not a risk factor for the development of PCSWC however further trials need to be performed to prove this.

HERLYN-WERNER-WUNDERLICH (OHVIRA) SYNDROME: A RARE COMPLEX CONGENITAL MULLERIAN ANOMALY

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Background:
Herlyn-Werner-Wunderlich (HWW) syndrome, also known as Obstructed Hemivagina and Ipsilateral Renal Agenesis (OHVIRA) syndrome is a rare congenital Mullerian duct anomaly. It is characterised by a triad of obstructed hemivagina, ipsilateral renal agenesis, and uterine didelphys. We present a case of a 13-year-old female with lower abdominal pain and recurrent haematocolpos following a recent vaginal septum excision.

Case Report:
A 13-year-old girl with chronic worsening lower abdominal pain was found to have a congenital Müllerian duct anomaly with bicornuate bicollis uterus, left haematocolpos, and absent left kidney. Initial treatment involved incision of a high transverse vaginal septum and drainage of 250 mL haematocolpos. Postoperative MRI confirmed bicornuate bicollis uterus, residual left haematometra, and left renal agenesis. She later re-presented with pelvic pain and pressure; EUA revealed right cervix, left haematocolpos, but no visible left cervix. Ultrasound-guided drainage and hysteroscopy were done, and she was discharged on continuous combined oral contraceptive pills to suppress menstruation while awaiting definitive surgical management.

Discussion:
The most common presentation is lower abdominal pain, dysmenorrhoea and abdominal mass. The gold standard for diagnosis is MRI Pelvis and the treatment is vaginal septum excision and drainage of haematocolpos. Early diagnosis and intervention are important to prevent endometriosis and fertility problems.

Conclusion:
HWW syndrome is a very rare condition. The diagnosis can be challenging. This highlights the importance of considering HWW syndrome as a differential diagnosis in female paediatric patients with lower abdominal pain.

BEYOND THE TUBES: CORNUAL ECTOPIC FOLLOWING BILATERAL SALPINGECTOMY

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Background:
Ectopic pregnancies affect 1 in every 80 pregnancies in Ireland, most commonly located in the fallopian tubes. Cornual or interstitial pregnancies are rare, difficult to diagnose, and associated with high morbidity due to risk of rupture. Diagnosis can be particularly challenging following bilateral salpingectomy, where recurrence of ectopic implantation is considered unlikely.

Case Report:
A 30-year-old woman presented to the emergency department five weeks following right salpingectomy for a tubal ectopic pregnancy. Her medical history included conservative management of a left tubal ectopic (2018), left salpingectomy for recurrent ectopic (January 2025), and right salpingectomy (July 2025). She also had previous laparoscopies for ovarian cyst and appendicectomy. On presentation, she reported acute urinary retention and bilateral lower abdominal pain. Serum β-hCG was 234 IU/L. Transvaginal ultrasound demonstrated a 27×28mm heterogeneous mass medial to the left ovary. She reported one episode of unprotected intercourse in the preceding week. Repeat β-hCG 48 hours later had decreased to 130 IU/L. Laparoscopy identified normal ovaries and absence of tubal stumps bilaterally. A mass was seen protruding through the uterine serosa overlying the left cornus, surrounded by old haematoma. No site of implantation was identified in histopathology from the July ectopic.

Discussion:
This presentation raised differential considerations, including incomplete treatment of the previous ectopic, a new conception implanted in the uterine cornus, or a missed heterotopic pregnancy. Cornual pregnancies following bilateral salpingectomy are exceptionally rare, and diagnosis may be delayed due to their unusual location and atypical presentation.

Conclusion:
This case highlights the diagnostic complexity of ectopic pregnancies after bilateral salpingectomy. As clinicians we should remain alert to unusual sites of implantation in symptomatic patients with rising or plateauing β-hCG.

TRIPLE-NEGATIVE BREAST CANCER IN PREGNANCY: MULTIDISCIPLINARY MANAGEMENT IN A RESOURCE-LIMITED SETTING

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Background:
Pregnancy-associated breast cancer (PABC) is rare, affecting 1 in 3,000 pregnancies. Triple-negative breast cancer (TNBC) poses additional challenges due to its aggressive nature, lack of targeted therapies, and limited global data, particularly from resource-limited settings.

Aim:
We aimed to report a rare case of TNBC diagnosed in mid-pregnancy, outline the multidisciplinary management undertaken, and contextualise findings through a narrative review of international evidence.

Methods:
A 35-year-old woman at 19 weeks' gestation presented with an enlarging breast and axillary mass. Diagnostic workup confirmed stage T2N1M0 TNBC. She received neoadjuvant epirubicin/cyclophosphamide followed by weekly paclitaxel until 34 weeks, with fetal monitoring throughout. A narrative review of published cases and guidelines informed management and discussion.

Results:
Chemotherapy was tolerated without major maternal toxicity. Serial ultrasounds confirmed normal fetal growth and wellbeing. Delivery occurred by planned caesarean section at 34 weeks, with definitive oncological surgery deferred postpartum. Literature supports anthracycline- and taxane-based chemotherapy from the second trimester as safe, with prematurity being the most frequent neonatal complication.

Conclusion:
This case demonstrates that safe, evidence-based management of TNBC in pregnancy is feasible in resource-limited settings through coordinated multidisciplinary care. It adds to the limited global literature and underscores the importance of adaptable frameworks to optimise both maternal and fetal outcomes.

BEYOND PID: BOWEL PATHOLOGY IN DISGUISE – LESSONS FROM TWO CASES

Tommy Harty, Azy Khalid, Manju Rao

Background:
Acute pelvic pain in women poses a diagnostic challenge as gynaecological and gastrointestinal conditions frequently have overlapping signs and symptoms. Complex pelvic pathology, gynaecological or otherwise, may distort anatomy, complicating radiological and intra-operative assessment.

Objective:
To highlight the diagnostic complexity of acute pelvic pain and underscore the importance of considering a broad differential diagnosis, even in the absence of gastrointestinal disease.

Methods:
We report two cases of women presenting with pelvic pain and adnexal masses. Clinical features, imaging, intra-operative findings and management are reported to illustrate diagnostic challenges.

Results:
The first case presents a 24-year old with Gardener's syndrome and previous panproctocolectomy with J-pouch presenting with recurrent right iliac fossa pain and repeated imaging consistent with tubo-ovarian abscess (TOA). This presumed TOA failed to resolve with antibiotics and a decision for surgery was made. Diagnostic laparoscopy revealed dense pelvic adhesions but normal adnexal structures. Colorectal surgery were consulted and a pouchoscopy identified a fistula from the J-pouch to the pelvic side wall, mimicking adnexal pathology.

The second case reports a 28-year old with a chronic left adnexal mass managed as recurrent PID with imaging suggestive of same. Failure to resolve with antibiotics led to surgery, with intra-operative findings inconclusive due to the dense rectosigmoid adhesions densely and an obliterated pouch of Douglas. Post-operative colonoscopy confirmed sigmoid diverticulosis with a colosalpingeal fistula, managed definitively with a sigmoid colectomy and left salpingo-oopherectomy.

Conclusion:
These cases demonstrate how bowel pathology can mimick adnexal disease, challenging both radiological and intra-operative diagnoses. Gynaecologists should maintain a high index of suspicion, particularly in patients with prior bowel surgery or incongruent imaging. Early multidisciplinary collaboration and timely referral are critical to optimise patient outcomes.

A CASE REPORT OF A METASTATIC WELL DIFFERENTIATED PRIMARY OVARIAN NEUROENDOCRINE TUMOUR

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Background:
Primary ovarian neuroendocrine tumours account for less than 1% of ovarian neoplasms and are characterised by early metastasis and a poor prognosis. There is a lack of consensus on definitive management for these patients, due to the low incidence of these cases.

Objective:
This case report examined a patient with a rare large primary ovarian neuroendocrine tumour and discussed the importance of multidisciplinary team management in such cases.

Case Report:
A 64-year-old nulliparous individual was referred to our gynae-oncology department from a secondary care facility following presentation with a 6-month history of worsening abdominal distension, early satiety and intermittent right sided abdominal pain. Her background history was significant for alcohol dependence. Computed tomography of the abdomen and pelvis showed a 26cm pelvic mass, appearing to arise from the right ovary with evidence of liver and bony metastases. Her tumours markers were mildly elevated.
Biopsy of the liver lesion indicated a neuroendocrine tumour. Following multidisciplinary team discussion a total abdominal hysterectomy, bilateral salpingo-oophorectomy, omentectomy and peritoneal washings were performed. Histological analysis revealed a stage IV grade 2, well differentiated primary ovarian neuroendocrine tumour arising from a monodermal teratoma with foci of struma ovarii. She recovered well post operatively, with follow-up under gynae-oncology and the neuroendocrine team. She is receiving adjuvant somatostatin analogues, however, this is unlikely to be curative and her prognosis remains unclear.

Conclusion:
This case highlighted a rare histological subtype of ovarian neoplasm and demonstrated the importance of the multidisciplinary team in managing such cases.

UNDERSTANDING PATIENT PERSPECTIVES ON PRE-IMPLANTATION GENETIC TESTING (PGT) IN IRELAND

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Background:
Pre-implantation Genetic Testing (PGT) allows prospective parents to screen embryos for genetic disorders prior to implantation. Its use in assisted reproduction is increasing, aiming to improve outcomes by reducing genetic disease transmission and miscarriage rates (1). While the clinical efficacy and application of PGT is well researched, less is known about patient's comprehension, perceptions and experiences of PGT (2). With the recent introduction of publicly funded fertility treatment in Ireland, understanding patient attitudes toward PGT is essential to strengthen patient education, support informed decision-making and guide future policies.

Objective:
This study aims to explore patient's understanding, attitudes and experiences of PGT.

Method:
A cross-sectional online survey was conducted among patients attending The National Maternity Hospital Public Fertility Hub. Demographics, understanding of genetics and PGT, motivations, perceived risks and ethical concerns were explored. Questions were informed by prior research into patient attitudes toward reproductive genetic technologies. Data was analysed using SPSS.

Result:
The audit captured a broad spectrum of patient experiences and perspectives. Findings suggested variability in baseline knowledge of genetics, with gaps in familiarity with the various forms of PGT and their clinical application. The decision to pursue PGT was influenced by both clinical and personal factors. Ethical, emotional and financial factors were identified as key concerns. Associations were observed between patient demographics, prior fertility treatment, and attitudes toward PGT; however, specific patterns warrant further investigation.

Conclusion:
This project provides the first comprehensive overview of patient perspectives on PGT in Ireland. Insights from this study can assist Ireland's reproductive healthcare providers and policymakers to improve patient-centred care and support the development of national policies that promote responsible, ethical, and compassionate integration of PGT into fertility services.

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IRELAND'S FIRST OFFSITE EARLY PREGNANCY UNIT; WHAT DO SERVICE USERS THINK?

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Background:
Early pregnancy complications affect a significant number of women and require timely, sensitive, and specialised care. Early Pregnancy Units (EPUs) are a service dedicated to improve care, outcomes and patient experience. This study evaluates service users experience of the effectiveness and acceptability of Ireland's first offsite EPU, which accommodates 5500 women per annum.

Objective:
To explore service users' perceptions of the care, environment, and accessibility provided by Ireland's first offsite EPU.

Study Design and Methods:
Prospective survey was conducted from January to December 2024. All English-speaking service users aged ≥18 years attending the EPU were invited to participate. Mean scores of staff interactions, appointment accessibility, environment and overall satisfaction with EPU services were measured. T-test examined potential differences in scores according to selected respondent characteristics.

Findings/Results:
In total, 196 responses were obtained. The EPU environment was rated highly for location, hygiene, design, and information provision. Areas for improvement included access to public transport (26% dissatisfied) and support information (17.4%). Overall, 57.1% received appointments within three days and 30.6% within 24 hours; over half (103, 54.5%) rated appointment and in-clinic wait times as excellent. Staff interactions scored highly for friendliness, empathy, communication, and explanation of diagnoses. Lower satisfaction was reported for information from websites (20.9%), leaflets (16.8%), and support groups (22.4%). Scores for participants' satisfaction with staff interaction were statistically significantly higher for individuals who were referred to bereavement and loss services (p=0.011).

Conclusion:
The offsite EPU rated highly for environment, accessibility, and staff interactions supporting its role in enhancing service user experience. Key areas for improvement include access and provision of information/support resources which is now done.

POSTPARTUM HAEMORRHAGE RE-AUDIT 2025 AT GALWAY UNIVERSITY HOSPITAL: PROGRESS IN CLINICAL GOVERNANCE AND MATERNAL SAFETY

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Background:
Postpartum haemorrhage (PPH) remains the second leading cause of direct maternal mortality in Ireland and a major contributor to severe maternal morbidity. A 2024 audit at Galway University Hospital identified gaps in ocumentation, blood loss measurement, and follow-up care. This re-audit in 2025 aimed to evaluate improvements.

Objective:
To assess compliance with the National Clinical Practice Guideline on PPH (2022) and measure progress compared with 2024 findings.

Study Design and Methods:
A retrospective review of 22 women with PPH between January and May 2025 was conducted. Cases were identified from electronic records, and data were collected using the HSE National Clinical Care Audit Tool. Patient charts were reviewed against national standards for prevention, recognition, and management of PPH.

Findings/Results:
Marked improvements were observed. Antenatal haemoglobin screening improved from 90.3% to 100%, red cell antibody screening improved from 97% to 100%, and transfusion consent improved from 90% to 100%, all achieved full compliance. Documentation of risk assessment improved from 0% to 70%, and care planning from 0% to 60%. Use of PPH scribe sheets rose from 29% to 82%, and blood loss measurement from 42% to 96%. Tranexamic acid administration increased from 74.2% to 91%. Postnatal debriefing improved from 3.2% to 68%, and consultant-led 6-week follow-up from 9.7% to 55%. Venous thromboembolism (VTE) scoring improved to 86%, but was not universally completed.

Conclusion:
The 2025 re-audit demonstrates significant progress in PPH care, reflecting strengthened clinical governance, documentation, and multidisciplinary response. However, universal implementation of risk assessment, structured care planning, and postnatal follow-up remain priorities. Findings support the role of continuous audit cycles in embedding guideline recommendations and can inform practice in other maternity services aiming to improve maternal safety.

OPTIMIZING LOW DOSE ASPIRIN PROPHYLAXIS IN HIGH-RISK ANTENATAL CARE: A CLINICAL AUDIT FOR PET PREVENTION

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Background:
Pre-eclampsia is a hypertensive disorder of pregnancy affecting 2-8% of pregnancies globally, causing maternal and perinatal morbidity and mortality. The pathophysiology is believed to stem from abnormal placentation, endothelial dysfunction, and systemic inflammation.
Low dose aspirin reduces pre-eclampsia incidence by inhibiting platelet cycloocygenase-1 (COX-1) and improving placental blood flow.

Aim:
To evaluate adherence to national guidelines on low -dose aspirin prophylaxis among high-risk pregnant women at The Coombe Hospital, Ireland.

Methodology:
A retrospective audit of 65 high risk singleton pregnancies receiving low dose aspirin between January and July, 2024 with documented pre-eclampsia risk factors.

Results:
Initiation: 84.6% of patients commenced as per guidelines.
Dosage compliance: 92.3% patients received the recommended dosage.
Duration of compliance: 77% continued aspirin for the appropriate duration.
Outcomes: Pre-eclampsia incidence was 15.4%; gestational hypertension 23.1% ; 76.9% of infants had normal birth weight (2.5-4kg).

Conclusion:
High compliance with clinical guidelines affirmed the protective role of low-dose aspirin in mitigating pre-eclampsia risk.
Areas for improvement include standardising documentation and optimising treatment duration.

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5. HSE National Maternity Care Pathways: Hypertension in Pregnancy
6. HIQA National Standards for Safer Better Maternity Services

AUDIT OF THE INCIDENCE OF OBSTETRIC ANAL SPHINCTER INJURIES AT UNIVERSITY HOSPITAL WATERFORD

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Background:
Obstetric Anal Sphincter Injury (OASIS) refers to a specific type of perineal laceration, specifically third and fourth-degree tears, that occur during vaginal delivery and involve the anal sphincter complex. The overall incidence of OASIS is 2.9% , with an incidence of 6.1% in primiparae compared with 1.7% in multiparous patients.

Objective:
To analyse the incidence and risk factors for OASIS at University Hospital Waterford (UHW). The local incidence of OASIS was audited against the incidence highlighted in the Greentop Guideline for 'The Management of Third- and Fourth- Degree Perineal Tears'.

Methodology:
Retrospective audit conducted in April 2025, exploring the incidence of OASIS at UHW. All vaginal deliveries between November 2023 up until November 2024 were assessed for OASIS. 15 cases of OASIS were identified from a cohort of 1100 vaginal deliveries from the Birth Register on the Labour Ward. Data was transcribed to a coded excel file and descriptive statistics were conducted.

Results:
1100 vaginal deliveries were identified from November 2023 until November 2024, of which, 15 patients were identified with OASIS. This equates to 1.36% (15/1100) of patients who sustained OASIS. The majority of these injuries were 3B tears (73.3%). 53.3% of patients were nulliparous, while 46.4% were multiparous. 60% of deliveries were spontaneous and 40% were operative vaginal deliveries- all of which performed were kiwi deliveries. Episiotomy was performed in 33% cases. Subsequent shoulder dystocia was identified in 2 patients (13.3%). 1 patient underwent vaginal birth after caesarean section (VBAC).

Conclusion:
This audit highlights the relatively low number of deliveries that developed OASIS at UHW. This audit suggests that although the incidence of OASIS at UHW is within the range established in the Greentop Guideline for 'The Management of Third- and Fourth- Degree Perineal Tears', improving techniques such as episiotomies, perineal protection and warm compression may further reduce the risk of OASIS.

A MULTIDISCIPLINARY FETAL NEUROSURGICAL SERVICE—12 YEARS OF FETAL OUTCOMES FROM A NATIONAL REFERRAL CENTRE

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Introduction:
A dedicated fetal neurosurgical clinic was established in our centre in 2013 to standardise the management of prenatally diagnosed fetal central nervous system (CNS) anomalies. This clinic delivers a specialised service for patients referred with suspected or confirmed fetal CNS abnormalities. We aimed to evaluate this multidisciplinary service, assess the range of neurosurgical diagnoses encountered, and report on pregnancy outcomes. A significant change in legislation occurred during this period; an objective of this study was to investigate whether this impacted pregnancy outcomes and termination of pregnancy (TOP) rates.

Methods:
This is a prospective study of all consecutive cases referred to our neurosurgical clinic centre between January 2013 and May 2025. Data was collected on antenatal imaging, including fetal ultrasound and fetal MRI, neurosurgical input, genetic testing, and pregnancy outcomes.

Results:
Between 2013 and 2025, 4248 major fetal anomalies were diagnosed prenatally in our tertiary fetal medicine centre. In total, 390 patients (9%) were cared for in the multidisciplinary neurosurgical clinic. The most common indications for referral were spina bifida (n=161 (41%)), ventriculomegaly (n=102 (26%)), agenesis of the corpus callosum (n=28 (7%)), and encephalocele (n=21 (5%)). 165 (42%) patients had invasive antenatal genetic testing, 340 (87%) had in utero MRI, and 44 (11%) opted for termination of pregnancy. The change in TOP rate following the changes in legislation, between studies, for all CNS conditions, and those specifically with spina bifida was not statistically significant.

Conclusion:
The fetal neurosurgical clinic is a valuable resource for families faced with complex CNS conditions. Multidisciplinary antenatal diagnosis of fetal neurosurgical anomalies provides accurate and comprehensive information to counsel families and guide decision-making based on expected neonatal outcomes. Following the introduction of the clinic, we have observed changes in pregnancy outcomes, notably relating to TOP and mode of birth.

CLINICIAN-LED AI JOURNEY: FROM ZERO PROGRAMMING TO DEPLOYING GUIDELINE-BASED MOBILE TOOLS IN OBSTETRICS AND GYNAECOLOGY

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Background:
Time-critical O&G conditions (e.g., PPH and ectopic pregnancy) demand rapid, protocol-concordant decisions, yet junior doctors in non-tertiary units often lack concise bedside support. AI now enables clinician-led, guideline-anchored tools that work offline, support learning, and may reduce variability.

Objective:
To detail a clinician's progression from no programming to deploying AI-assisted mobile decision-support apps, and to outline an education- and quality-improvement framework for safe use in Irish practice.

Study Design and Methods:
Using user-centred design with trainees and consultants, four apps were created: (1) a PPH guide with stage-based algorithms (0–3), CODE RED checklist, dosing cues, and drill mode; (2) an Ectopic/PUL guide with a multi-sample β-hCG calculator (interval hours, % change, colour-coded interpretation), methotrexate protocol, and escalation triggers; (3) a Tumour Marker Calculator (e.g., RMI inputs) for educational triage; and (4) a Pregnancy Wheel using standard dating formulae. All apps are bilingual (English/Arabic), offline-first, store no patient data, and undergo consultant sign-off/version control. Content maps to Irish guidance and is cross-checked with UK/WHO sources. Implementation embeds the tools in trainee induction and simulation drills. Evaluation (service improvement; no patient data) specifies metrics: pre/post knowledge, time-to-information, protocol adherence in simulation, usability (System Usability Scale), and feasibility signals.

Findings/Results:
Deployment for education and simulation is underway. Early feedback indicates faster navigation to critical steps/doses and high face validity for trainee learning. Formal data collection using the predefined metrics is commencing to guide iteration and scale-up.

Conclusion:
A clinician-led, AI-enabled pathway can translate guidelines into safe, offline cognitive aids without prior programming expertise. The programme is governance-aware and positioned to enhance education, simulation performance, and protocol adherence in non-tertiary Irish settings; evaluation is in progress.

CURCUMIN AS A BIOACTIVE SUPPLEMENT FOR PREMENSTRUAL SYNDROME AND DYSMENORRHEA: A SYSTEMATIC REVIEW OF RANDOMISED TRIALS

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Background:
Premenstrual syndrome (PMS) and dysmenorrhea are highly prevalent conditions that negatively affect women's quality of life. Conventional treatments, such as NSAIDs and hormonal therapy, have limitations and side effects, prompting exploration of alternative therapies such as curcumin.

Objective:
To systematically evaluate the evidence from randomised clinical trials on the efficacy of curcumin in managing PMS and dysmenorrhea.

Study Design and Methods:
A systematic review was conducted according to PRISMA and the Cochrane Handbook. Seven electronic databases and trial registries were searched from inception to November 2023. Eligible studies included randomised controlled trials assessing curcumin (alone or with piperine) in reproductive-age women with PMS or dysmenorrhea.

Findings/Results:
Ten RCTs involving women with PMS or dysmenorrhea were identified. Six trials showed a significant reduction in PMS or dysmenorrhea severity using scales such as the PSST and visual analogue scale. Curcumin demonstrated beneficial effects on inflammatory markers (hs-CRP, nitric oxide metabolites, BDNF, IgE) and improved vitamin D status. No significant effect was found on iron profile. One study reported improvements in sleep patterns, though evidence was inconsistent.

Conclusion:
Curcumin appears to be a promising complementary approach for reducing PMS and dysmenorrhea symptoms and modulating inflammatory markers. However, optimal dosing and treatment duration remain unclear. Further high-quality RCTs are needed to confirm efficacy and evaluate safety, particularly regarding iron metabolism.

AN EVALUATION OF PATIENT SATISFACTION WITH ELECTIVE CAESAREAN SECTION FOR TOCOPHOBIA: A CROSS-SECTIONAL SURVEY

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Background:
Tocophobia, a severe fear of childbirth, affects approximately 5.3% of women in Ireland. It is characterised by an intense fear of harm to the mother or the baby during labour and delivery. Women delivering by Caesarean section (CS) are reported to have lower birth satisfaction compared with those who had a vaginal delivery, but it is unclear whether this applies to women choosing elective CS due to tocophobia. Understanding patient satisfaction in this context is important to inform maternity care.

Objective:
To evaluate maternal satisfaction following elective CS where tocophobia was the primary indication.

Study Design and Methods:
This cross-sectional study included primiparous women who underwent elective CS at Cork University Maternity Hospital (2021-2023) for tocophobia. Eligible participants were identified through theatre logbooks. After applying inclusion and exclusion criteria, participants were contacted to provide consent for email communication. Those who agreed subsequently consented to both chart review and survey participation, and received the questionnaire by email. The questionnaire used was the Birth Satisfaction Scale-Revised (BSS-R), a validated 10-item questionnaire assessing birth satisfaction across stress, maternal attributes and quality of care. Quantitative data were analysed descriptively, while qualitative free-text comments underwent thematic analysis.

Findings/Results:
Of 3,478 nulliparous CS during the study period, 48 were performed for tocophobia. Fifteen women completed the survey in full. The median BSS-R score was 31 out of 40 (range: 26-39), indicating high satisfaction overall. Thematic analysis highlighted key themes of communication, emotional response, and quality of support.

Conclusion:
Women undergoing elective CS for tocophobia reported high birth satisfaction, contrasting with trends in the general CS population. These findings support the role of autonomy and tailored care in improving patient experience. Larger studies are warranted to validate these results and inform clinical guidelines.

UTERINE ARTERIOVENOUS MALFORMATIONS AS A RARE DIFFERENTIAL DIAGNOSIS OF POST-ABORTAL HAEMORRHAGE. A CASE REPORT.

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Background:
Uterine arteriovenous malformations (UAVMs) are rare vascular anomalies that can present as a severe and potentially life-threatening cause of vaginal bleeding. We describe a case of UAVM following termination of pregnancy, highlighting the importance of considering this diagnosis in reproductive-aged women with unexplained bleeding.

Case Report:
A 36-year-old para 2 woman presented to the emergency department with a 5 day history of heavy vaginal bleeding on a background of persistent bleeding following medical termination of pregnancy seven weeks prior. Of note, her obstetric history was significant for massive obstetric haemorrhage requiring intrauterine balloon tamponade and blood transfusions. She was haemodynamically stable expect for a mild tachycardia of 96bpm. Examination revealed a soft, non-tender abdomen and speculum revealed a normal cervix with ongoing bleeding with clots from os. β-hCG was repeatedly negative, Hb was 13.7g/dL and coagulation screen was normal. Ultrasound with Doppler demonstrated a 39 × 22 × 38 mm vascular lesion with central arterial flow, consistent with a uterine arteriovenous malformation. Differential diagnoses, including retained products of conception and gestational trophoblastic disease, were extremely unlikely after radiological investigations The patient was admitted for urgent bilateral uterine artery embolization and was discharged on Day-3. At follow-up six weeks post-procedure, she reported intermittent bleeding for one month with complete resolution thereafter.

Conclusion:
This case emphasizes the importance of thorough obstetric history taking, the importance of MDT and including UAVM in the differential diagnosis of abnormal vaginal bleeding in reproductive-aged women. Although rare, UAVMs can mimic more common conditions, and prompt recognition is essential to guide life-saving management.

REPRODUCTIVE HEALTH IMPLICATIONS OF RELATIVE ENERGY DEFICIENCY IN SPORT IN ELITE FEMALE GAA PLAYERS

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Background:
Low energy availability (LEA) occurs when insufficient energy is available to support normal physiological function in athletes, and can lead to Relative Energy Deficiency in Sport (REDS). LEA has been associated with delayed puberty and impaired reproductive function.

Objective:
To assess the prevalence of LEA and REDS in elite female GAA players in Ireland and to examine the impact on reproductive health.

Method:
44 female intercounty GAA players underwent blood-based assessments at three time points across a playing season. Reproductive hormones (LH, FSH, oestradiol, progesterone, testosterone, sex hormone binding globulin and prolactin) and metabolic hormones (TSH, free T3, free T4, leptin) were measured. Medical and menstrual history was recorded and participants completed the Low Energy Availability in Females Questionnaire (LEAF-Q) to assess LEA risk.

Results:
56% were at risk of LEA based on LEAF-Q. Mean age was 23.5 years [18-34]. Mean age of menarche was 13.9 years [12-16]. 34% of athletes reported changes in menstruation associated with exercise. Contraception use was reported by 36% of athletes across the season. The combined oral contraceptive pill was the most commonly used (65%), followed by progestin only implants (25%) and intrauterine devices (12.5%). Among athletes not using hormonal contraception (n=27), 4% had secondary amenorrhoea and 7% oligomenorrhoea.

Conclusion:
This is the first longitudinal study to examine menstrual health in elite female GAA players across a season. The mean age of menarche aligns with findings in other athlete populations and is higher than in the general population. Hormonal contraception use (36%) is lower than prior studies in athlete cohorts. The prevalence of menstrual dysfunction in this study - 4% with secondary amenorrhoea and 7% with oligomenorrhoea - is lower than previously reported, where secondary amenorrhoea has been seen in 30% of volleyball players and oligomenorrhoea in 20% of soccer players. Overall the results are reassuring compared to data from other female elite team sports.

LISTENING TO EVERY BEAT: VENTRICULAR BIGEMINY IN PREGNANCY

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Background:
Pregnancy can increase the heart rate by 25%. Ectopic beats, ventricular bigeminy and non-sustained arrhythmia can be encountered in over 50% of pregnant women investigated for palpations.

Case Report:
We report a case of a 34 year old pregnant woman who developed ventricular bigeminy intra-operatively during an elective caesarean section (CS) at term. Findings: Ventricular bigeminy was noted at the end of an uncomplicated CS with symptoms of flushing and light headedness which subsequently self-terminated. Patient disclosed long standing history of palpitations pre-pregnancy with no history of cardiology review or investigations. Antenatally she was tested and treated for anaemia and vitamin B12 deficiency with intravenous ferritin infusions and B12 supplementation, as she was symptomatic of fatigue, pallor and palpations. Hb pre-op:10.5g/dL. A cardiology review recommended treatment with intravenous magnesium. Laboratory results were normal with no evidence of electrolyte imbalance or myocardial tissue damage. The patient remained well and in sinus rhythm in the postnatal period. Follow-up with cardiology revealed a normal ECHO study.

Discussion:
The most common risk factor for an arrhythmia during pregnancy is a history of arrhythmia. This patient had palpations pre-pregnancy and antenatally. Additionally, haemodynamic and physiologic changes in pregnancy including increased oestrogen and progesterone followed by a rapid decline postpartum contributed to this patient developing ventricular bigeminy.

AUDIT OF PROCEDURAL ASPECTS OF CAESAREAN SECTION BIRTH AT UNIVERSITY HOSPITAL WATERFORD

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Background:
The National Institute for Health and Care and Excellence (NICE) Guideline for Caesarean Birth aims to improve the consistency and quality of care for women who are thinking of having a caesarean birth. The NICE guideline covers the procedural aspects of the caesarean section, and the care of women, post operatively.

Objectives:
To analyse the compliance of University Hospital Waterford to the NICE guideline for Caesarean Section Birth- established in March 2021.

Methodology:
Retrospective audit conducted in September 2024, exploring the established standards implemented in the NICE guideline for Caesarean Section Birth. 120 eligible cases were identified from the Birth Register on the Labour Ward. Patients who delivered by Caesarean Section between January-March 2024, inclusive, were included in this audit. Data was transcribed to a coded excel file and descriptive statistics were conducted.

Results:
78.3% of patients received a spinal anaesthetic; 17.5% received an epidural and 4.16% received a general anaesthetic. 1.66% did not receive antibiotic prophylaxis. Joel-Cohen incision to the abdomen was performed in 50.83% of cases; Pfannenstiel incision was used in 22.5%. Use of forceps was documented in 11.66%. Type of uterus closure included double layer closure-documented in 94.16% of cases. Monocryl to skin was used in 84.16%; 6.66% received clips to the skin. 100% of patients received uterotonics.

Conclusion:
This audit highlights that University Hospital Waterford is largely adherent to the standards included in the NICE Guideline for Caesarean Birth. This audit also highlights a deficiency regarding documentation of certain procedural aspects of Caesarean Birth.

EFFICACY OF FERRIC CARBOXYMALTOSE VS IRON SUCROSE IN MANAGING MODERATE IRON DEFICIENCY ANEMIA IN PREGNANT WOMEN

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Background:
Iron deficiency anemia (IDA) is a major cause of maternal and perinatal morbidity. While intravenous (IV) iron is used when oral supplementation is ineffective, the optimal formulation in terms of efficacy and convenience needs evaluation, particularly in resource-constrained settings.

Objective:
This study aimed to compare the efficacy of IV Ferric Carboxymaltose (FCM) and IV Iron Sucrose (IS) in correcting moderate IDA among pregnant women.

Study Design and Methods:
A quasi-experimental study was conducted from January to June 2025. 200 pregnant women with moderate IDA (Hb 7-9.9 g/dL) were randomized into two groups. Group A (n=100) received a single 1000 mg FCM infusion. Group B (n=100) received five 200 mg IS infusions. Hemoglobin (Hb), serum ferritin, and red cell indices were assessed at baseline, 3, 6, and 12 weeks post-therapy.

Findings/Results:
At 12 weeks, the FCM group demonstrated a significantly greater mean rise in Hb (30.2 g/L vs. 22.5 g/L, $p<0.001$) and serum ferritin (58.6 µg/L vs. 39.4 µg/L, $p<0.001$) compared to the IS group. Red cell indices (MCV, MCH) also improved more markedly with FCM. No major adverse events were reported in either group.

Conclusion:
Ferric Carboxymaltose was superior to Iron Sucrose in rapidly and sustainably correcting moderate IDA in pregnancy. Its single-dose regimen reduces hospital visits, improving compliance and making it a more effective and patient-friendly therapeutic option, especially in busy antenatal clinics.

A SILENT DRIFTER: LAPAROSCOPIC DETECTION AND CONSERVATIVE MANAGEMENT OF A WANDERING IUCD

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Background:
Intrauterine contraceptive device (IUCD) displacement is a rare complication. While most displaced IUCDs can be retrieved laparoscopically, management becomes challenging when the device is embedded near vital structures, posing risks of significant injury during removal.

Objective:
To present a case of a displaced IUCD managed conservatively to avoid iatrogenic colonic injury, underscoring the importance of intraoperative decision-making.

Study Design and Methods:
A case report of a 32-year-old female who presented with lower abdominal pain six months after IUCD insertion by a traditional birth attendant. Imaging confirmed a displaced IUCD in the left iliac fossa. Diagnostic laparoscopy was performed for retrieval.

Findings/ Results:
Laparoscopy revealed the IUCD entrapped within the omentum, with one limb in close proximity to the colonic wall. Dissection was deemed high-risk for bowel perforation and potential need for colostomy. The procedure was abandoned, and the IUCD was left in situ. The patient had an uneventful recovery and was counseled on the decision. At six-month follow-up, she remained asymptomatic.

Conclusion:
This case illustrates that not all displaced IUCDs require immediate retrieval. When surgical removal poses a greater risk than retention, a conservative approach with informed patient consent and regular monitoring is a valid and safe management strategy. It emphasizes careful preoperative counselling and the critical role of intraoperative judgement to prevent major morbidity.

OPTIMIZING FETAL GROWTH: AN AUDIT OF RECURRENT INTRA-UTERINE GROWTH RESTRICTION (IUGR) IN ASPIRIN- TREATED PREGNANCIES

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Background:
Intra-Uterine Growth Restriction (IUGR) is a significant cause of perinatal morbidity and mortality. IUGR refers to a fetus that failed to reach its growth potential due to pathological factors.
Low dose aspirin prophylaxis reduces placental-mediated complications, including IUGR and pre-eclampsia by irreversibly inhibiting cycloocygenase-1 and reducing thromboxane A2 production.

Aim:
To evaluate aspirin prophylaxis effectiveness in preventing recurrent IUGR and assess adherence to national guidelines at The Coombe Hospital, Ireland.

Methodology:
A retrospective audit of 75 women with singleton pregnancies and a prior history of IUGR who received aspirin prophylaxis between January and July, 2024 were selected.

Results:
- Adherence: 86.7% of the patients were initiated aspirin according to guidelines.
- Dose compliance: 93.3% patients were receiving the recommended dosage of aspirin.
- Duration compliance: 80% continued aspirin for the appropriate duration.
- Outcomes: 20 % of the patients developed recurrent IUGR.
  80% of the babies had birth weight between 2510-4000g.

Conclusion:
High adherence to guideline-directed aspirin prophylaxis supports its role in improving fetal growth outcomes. Opportunities for improvement include ensuring aspirin initiation by 16 weeks and continuation through at least 36 weeks' gestation.

References:
1. NCEC GUIDELINES ON FETAL GROWTH RESTRICTION
2. SGA FETUS AND A GROWTH RESTRICTED FETUS, INVESTIGATION AND CARE (GTG 31)
3. HSE NATIONAL GUIDELINES ON PREGNANCY AND CHILDBIRTH
4. NICE GUIDELINE ON ANTENATAL CARE
5. NICE GUIDELINE ON MONITORING FETAL GROWTH
6. BMFMS GUIDELINE ON FETAL GROWTH RESTRICTION
7. NCPG FOR OBSTETRICS AND GYNAECOLOGY
8. HIQA STANDARDS OF MATERNITY CARE

KNOWLEDGE AND ATTITUDE TOWARD BREASTFEEDING AMONG LIBYAN MOTHERS IN LIBYA

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Background:
While breastfeeding is a vital practice for infants' growth, breastfeeding rates in Benghazi, Libya are below global recommendations, with only 25.3% of mothers exclusively breastfeed for six months. Thus, assessing both knowledge and attitudes is essential to identify gaps that hinder exclusive breastfeeding and to enlighten real interventions that offer healthier results for mothers and children.

Objective:
This study aims to assess breastfeeding knowledge, attitudes, and practices among mothers in Benghazi, Libya.

Study design and methods:
This cross-sectional study conducted in Benghazi, Libya implemented convenience sampling. It was held between January 2025 and July 2025 in Benghazi Children's Hospital where students interviewed attending mothers. It included demographics, obstetric and postpartum data and breastfeeding knowledge in addition to statements assessing mothers' attitudes toward breastfeeding, measured by the Arabic version of Iowa Infant Feeding Attitude Scale (IIFAS-A). Analysis was conducted on SPSS version 24, including chi-square, ANOVA and independent t-test, with an alpha level of 0.05.

Results:
The study included 288 mothers. The mean knowledge score was 13.91 ±2.02, which indicated good levels of knowledge. Remarkably, they mostly knew that breastfeeding protects them and their child against diseases and that it strengthens bonding; they were aware of WHO recommendations on exclusive breastfeeding for six months. The mean attitudes measured by IIFAS was 59.9, which is neutral, the majority had a neutral attitude (46.9%). While 35.4% were positive toward breastfeeding and 17.7% were positive toward formula feeding.

Conclusion:
In conclusion, mothers in Benghazi exhibited a high level of breastfeeding knowledge but neutral attitudes. This emphasizes that knowledge is not enough to ensure practice. To increase exclusive breastfeeding, refining the attitudes of mothers, and setting favorable social and workplace regulations are recommended.

NOT JUST ANOTHER LUMP: NOVEL DIAGNOSIS OF AN ISCHIOANAL LIPOMA WITH POST-EXCISIONAL NEUROPATHIC PAIN

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Background:
Lipomas are the most common benign soft tissue tumours, usually arising in the subcutaneous tissues of the head, neck, shoulders, and back. Deep-seated lipomas are rare, and occurrence in the ischioanal fossa is exceptionally uncommon, with only one prior case reported. The ischioanal fossa is an anatomically complex space containing adipose tissue, neurovascular structures, and lymphatics, making diagnosis and excision challenging.

Case Report:
We present the case of a 60-year-old woman with a four-year history of a gradually enlarging right labial swelling, reported incidentally during hospital admission for splenic rupture. The mass caused local and coital discomfort. MRI demonstrated an 11.6 × 7 × 6 cm fat-containing lesion extending from the right labia majora into the ischioanal fossa, with liposarcoma not fully excluded. Multidisciplinary excision was undertaken with gynaecology and colorectal input. Histopathology confirmed a benign lipoma composed of mature adipocytes without atypia. Postoperatively, the patient developed ipsilateral pudendal neuropathic pain, presenting as intermittent electric-like discomfort aggravated by walking and sitting. The pain improved significantly with amitriptyline, though higher doses were limited by side effects. To our knowledge, this is the first reported case of pudendal neuropathic pain following excision of an ischioanal lipoma.

Discussion:
This case emphasises that although lipomas are common, they may rarely arise in deep pelvic compartments such as the ischioanal fossa and can mimic malignant pathology. MRI plays a crucial role in diagnosis and surgical planning within this anatomically complex region. Importantly, even benign tumours in this location may lead to pudendal nerve injury and neuropathic pain, underscoring the need for careful operative technique, thorough patient counselling, and vigilance in postoperative management.

A SAFE START: EVALUATING IRELAND'S FIRST OFFSITE EARLY PREGNANCY UNIT

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Background:
Early Pregnancy Units (EPU) are a dedicated service for investigation and management of early pregnancy complications. In August 2023 the Cork University Maternity Hospital (CUMH) relocated its EPU to an offsite location 4km from the hospital, creating the first offsite EPU in Ireland. A challenge of an offsite EPU is the safe transfer of patients to hospital in emergency situations.

Objective:
The aim of this study was to review patient transfers during the first year of service of the offsite EPU to evaluate the safety of the service.

Study Design and Methods:
Retrospective review of all EPU transfers from the offsite EPU to CUMH from August 28th 2023 to August 31st 2024. Variables of interest included anonymised patient demographics, referral data, transfer data, and patient outcomes, collected from electronic medical records and EPU logbook.

Findings/Results:
In its first year of service the offsite EPU reviewed 4860 individuals of whom 54 (1.1%) required transfer to CUMH. The mean rate of transfers per month was 4.2, with 85.2% self-transferring, 13% transferring by ambulance, and 1.9% by hospital car. Most individuals (88.9%) were transferred due to high-risk ultrasound findings while the remainder (11.1%) were transferred due to clinical symptoms. Of those transferred, 68.5% went directly to the gynaecology ward while 31.5% required review in the emergency department. Mean duration of admission was 1.3 days and no maternal morbidity occurred.

Conclusion:
Irelands first offsite EPU had a low incidence of hospital transfers during its first year of service. Most transfers were of stable, non-emergent patients, with no subsequent adverse outcomes.

EVIDENCE TO SUPPORT THE USE OF THE INTRAUTERINE BALLOON FOR THE MANAGEMENT OF MASSIVE OBSTETRIC HEMORRHAGE.

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Objective:
The incidence of Postpartum haemorrhage (PPH) is rising internationally. Intrauterine Balloon Tamponade (IUBT) is recommended by the World Health Organisation and the American College of Obstetrics and Gynaecology as the second line management for refractory PPH[1]. Despite international support for its efficacy, literature describing effective procedural aspects of IUBT is extremely limited, leaving much to the clinician's discretion. The aim of this study was to describe the current use of the IUBT in the management of PPH.

Study Design:
This was a retrospective cohort study of all cases of PPH managed with IUBT over a 12-month period (2023) in an Irish Tertiary Maternity Unit. Patients were identified through Maternal and Newborn Clinical Management System. Data from electronic patient charts were collated and analysed in Microsoft Excel. Inclusion criteria: deliveries complicated by PPH and the use of IUBT. Exclusion criteria: measured blood loss < 500ml and PPH where IUBT was not used.

Results:
A total of 8283 patients delivered in the 12 month period. In the study time there were 170 (2%) patients admitted to the high dependency unit (HDU) for PPH and there were 41 (0.5%) massive obstetric hemorrhages (>2500mls blood loss). The IUBT was used in 52 cases to control PPH. The average blood loss in this cohort was 1980mls (range 500-3780mls).
- Average age: 35 years
- Multiparous: 50% / Primiparous: 50%
- Caesarean section: 67.3%
- Multiple pregnancies: 9.6%
- Uterine atony: 71.2%
- Average time to IUBT insertion: 137 minutes
- Control of PPH: 88.5%
- Average time of IUBT placement: 18 hours

Further description of the cohort is in table 1.

Conclusion:
The IUBT successfully managed PPH in 88% of the cases as a second line measure. It is most frequently used in the setting of atony and placenta praevia. We noted variation in the timing of insertion and length of duration of use. This supports the continued use of the IUBT for the management of PPH. Further research is needed to standardize the indications for use, duration of treatment and long-term complications of the IUBT.

CLINICIAN-DEVELOPED OFFLINE IOS GUIDE FOR ECTOPIC PREGNANCY & PUL: DIAGNOSTIC PATHWAYS WITH MICRO-LEARNING FOR TRAINEES

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Background:
Ectopic pregnancy and pregnancy of unknown location (PUL) are common and time-critical. Safe care depends on structured β-hCG interpretation, TVUS and timely escalation. Junior doctors in non-tertiary units face high cognitive load; an offline clinician-developed aid may reduce variability.

Objective:
To describe the design and planned implementation/evaluation of an offline, bilingual (English/Arabic) iOS guide that embeds just-in-time micro-learning within Irish guideline–based diagnostic pathways for ectopic pregnancy and PUL.

Study Design and Methods:
User-centred design with obstetric trainees and consultants. Content mapped to the Irish National Clinical Guideline and cross-checked with UK/WHO. Modules: PUL pathway with multi-sample β-hCG calculator (any two samples, interval in hours, % change, colour-coded interpretation); methotrexate protocol (BSA-based dosing, indications/contraindications, day-4/day-7 monitoring with ≥15% fall rule); surgical indications and escalation triggers; patient-counselling cues. Micro-learning tips (≤90 s) appear at decision nodes. The app stores no patient data, works offline, and uses clinical sign-off. Implementation embeds the tool in induction teaching and simulation drills. Planned evaluation (service improvement): pre/post knowledge quizzes, vignette concordance vs consultant standard, time-to-information and protocol adherence in simulation, and usability via the System Usability Scale (SUS).

Findings/Results:
Implementation is underway. Internal try-outs show high face validity and fast navigation to β-hCG interpretation, methotrexate dosing and escalation triggers in low-connectivity areas. Formal collection of knowledge gain, concordance, time-to-information, SUS and adherence in drills is commencing.

Conclusion:
A clinician-developed, education-first, offline diagnostic aid for ectopic pregnancy/PUL is feasible for Irish secondary-care units. By operationalising national guidance with calculators and micro-learning at decision points, it aims to standardise pathways and strengthen trainee readiness. The protocol supports measurable adoption and scale-up.

INVESTIGATING THE CLINICAL APPROACH OF PHYSICIANS IN MANAGING THE PREMATURE OVARIAN INSUFFICIENCY IN THE UNITED ARAB EMIRATES

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Background:
Premature Ovarian Insufficiency (POI) can lead to physical and emotional consequences and might resemble other conditions. Thus, correct diagnosis and subsequently, suitable treatment is essential.

Objective:
To explore current practices surrounding the diagnosis, management, and follow up of POI in women in the United Arab Emirates (UAE).

Study Design and Methods:
An online cross-sectional questionnaire was distributed to physicians involved in the care of women with symptoms suggesting POI in the UAE including Obstetrician Gynecologists, Endocrinologists, Family Physicians, and General Physicians.

Results:
Responses from 336 physicians were obtained. 125/336 (37.2%) have more than 20 years of experience. 65/336 (19.3%) said they often encounter women aged under 40 with oligomenorrhea or amenorrhea. 153/336 (45.5%) always request FSH for women under 40 years old with oligomenorrhea. 114/336 (33.9%) said they observe emotional or psychological distress (such as anxiety or depression) very frequently among women with POI and 78/336 (23.2%) always refer women with POI for genetic/autoimmune testing. 130/336 (38.7%) agree that all women diagnosed with POI should initially undergo a DEXA scan. 190/336 (56.5%) would routinely offer hormonal therapy (HRT) to all patients. 219/336 (65.2%) recommend stopping HRT at natural age of menopause; 50 and above. More than half; 234/336 (69.6%) would recommend semi-annual follow up for women diagnosed with POI. If the initial DEXA scan was normal, 117/336 (34.8%) recommend biennial bone density assessment. Overall, 69/336 (20.5%) always refer symptomatic women with POI for mental health support. For POI patients presenting with menopausal symptoms, 133/336 (39.6%) would prescribe only vaginal estrogen if required in cases of personal history of breast cancer (BC).

Conclusion:
There is variation in diagnosis, choice of HRT, and follow up. This data encourages practitioners to address uncertainties about HRT for POI, ensure suitable treatment, and avoid the multisystem consequences of untreated POI.

STATE FUNDED FERTILITY TREATMENT – TIME TO LOOK CLOSER AT THE MEN?

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Background:
Obesity impacts both male and female fertility[3, 4], however there is only a female body mass index (BMI) criteria for couples to qualify for state-funded fertility treatment (AHR) in Ireland[2]. In fact, male BMI is not measured at a couple's fertility visit. Male obesity and metabolic syndrome impacts spermatogenesis through increased oxidative stress[4]. One in ten infertile European men have metabolic syndrome, with increased physical activity improving male semen parameters including motility and morphology[4].

Objectives:
To assess the self-reported male BMI in our Fertility Hub in the National Maternity Hospital (NMH) and determine any impact on outcomes.

Methods:
A retrospective analysis of all patients approved for AHR in NMH from January 2024 to May 2025. Data including female age, BMI, AMH plus male semen analysis (SA) was collected. A sub-analysis was performed for couples where AHR outcomes were known. Male partners were asked to self-report their height and weight as part of their male fertility questionnaire.

Results:
BMI was available for 269 men and 381 women who attended the Fertility Hub, with 150 couples having completed their treatment cycle. Compared to female patients, men were more overweight (BMI 25.0 – 29.9) (n=127/269, 47.2% versus n=138/381, 36.2%, $p<0.001$) and obese (BMI >30)(n=47/269, 16.5% versus n=27/381, 7.1%, $p<0.001$). In 3 cases the male BMI was >40. Within this 403 couples, male factor infertility was the main cause(n=180/403, 44.7%). Men with oligospermia had a higher mean BMI versus men with a normal SA (26.5, SD 3.6 versus 28.3, SD 3.4, $p=0.02$). Male BMI impacted also day 5 blastocysts formed ($p=0.03$) and the number of embryos if couples had embryos in storage ($p<0.001$).

Conclusion:
Men were more overweight and obese compared to females plus male factor is the main cause of infertility in our hub. Self-reported BMI is less accurate, particularly in patients with obesity[5], hence the need for accurate assessment of male obesity within our infertility clinics.

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IMAGING AND ULTRASOUND VIDEO OF RUPTURED FETAL MEGACYSTIS – A CASE REPORT OF A RARE NATURAL PROGRESSION OF THE CONDITION.

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Background:
Fetal megacystis is defined as an enlarged bladder diameter more than 7 mm. [1, 2, 3] The incidence of megacystis is one in 1,600 - 3,000, with a higher prevalence in male fetuses. [2,3]. In the majority of cases, 60%, the cause is obstructive, such as posterior urethral valves, urethral atresia, cloacal anomalies, while the remainder of cases are non-obstructive, such as megacystis-microcolon-intestinal hypoperistalsis syndrome, prune belly syndrome, or idiopathic [1, 3]. Fetal megacystis is associated with karytope anomalies in 7-20% of cases [3, 4] and is associated with significant fetal complications including oligohydramnios, renal failure and pulmonary hypoplasia [5]. Fetal megacystis rupture is rare and been reported in few case reports [6, 7].

Case Report:
Here, we present the case of a multigravida with a large megacysitis diagnosis at 20 weeks gestation. On transabdominal ultrasound anhydramnios was noted, with the bladder measuring 8.5 by 7.2cm, bilateral echogenic kidneys and no other obvious structural abnormalities on ultrasound. After review by fetal medicine consultant and counselling, the patient elected to continue the pregnancy without prenatal testing. At 26 weeks and 2 days the patient presented with premature preterm rupture of membranes. Ultrasound revealed ruptured megacystis, ascites within the abdomen and grossly abnormal intraabdominal anatomy. The patient elected for conservative management as an inpatient. The patient went into preterm labour at 28 weeks 5 days and delivered a liveborn male infant by spontaneous vaginal delivery. Early neonatal death was confirmed at 1 hour 24 minutes of life. Postnatal genetics reported normal male karyotype, microarray and exome sequencing.

Discussion:
Fetal megacystis rupture is rare and been reported in few case reports [6, 7]. Late fetal megacystis is associated with significant fetal complications including oligohydramnios, renal failure and pulmonary hypoplasia [5, 11]. Perinatal mortality is reported in 35-55% of cases due to oligohydramnios and associating pulmonary hypoplasia [12, 13]. In conclusion, fetal megacystis is rare and can potentially result in significant neonatal morbidity and mortality.

REDUCING CONTAMINATION OF MIDSTREAM URINE (MSU) SAMPLE USING VISUAL AID TO EDUCATE PATIENTS: A QUALITY IMPROVEMENT PROJECT.

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Background:
Urinary tract infection is a prevalent health problem worldwide. Midstream urine (MSU) collection from female patients has a high contamination rate. The diagnosis and treatment of urinary tract infection depend on a thorough physical examination and the results of an uncontaminated midstream specimen of urine. However, improper techniques used in the collection often cause sample contamination, leading to delayed diagnosis and the use of inappropriate antibiotics for treatment. Verbal instruction by staff to patients reduces contamination but is inconsistent owing to lack of time and professional knowledge.

Objective:
This quality improvement project aimed at reducing the rate of urine culture specimen contamination in the antenatal booking clinic by using video guided patient education.

Method:
An initial audit was conducted in March 2025 at booking clinic in University hospital Waterford, reviewing 111 MSU samples. Contamination was defined by laboratory criteria (e.g. mixed flora, epithelial cells). In April, a brief instructional video was introduced and shown to patients prior to sample collection. A reaudit was conducted in May 2025 on 141 MSU samples. Contamination rates before and after intervention were compared using the chi-squared test.

Results:
In March, 24 of 111 samples were contaminated (21.6%). In May, after video implementation, contamination reduced to 14 of 141 samples (9.9%), a relative reduction of 54.2%. Chi-squared testing showed this was statistically significant ($p = 0.012$).

Conclusion:
A brief low-cost patient education video significantly reduced MSU contamination rates in our setting. This digital intervention improved diagnostic reliability and may reduce unnecessary repeat testing. It can be adopted across other outpatient and primary care settings.

‘’VAN-WYK GRUMBACH SYNDROME IN A 11-YEAR-OLD GIRL: A CASE REPORT”.

Amira Sakr, Sasikala Selvamani

OLOL Hospital

Introduction:
We report an adolescent gynaecological problem defined by a triad of hypothyroidism, ovarian masses, and precocious puberty. This syndrome is typically observed as a consequence of prolonged hypothyroidism leading to the formation of ovarian cysts.

Case Report:
In this report, we describe the case of a 11-year-old girl who presented with abdominal pain attributed to a multiloculated ovarian cyst. Comprehensive evaluation revealed delayed bone age, isosexual precocious puberty, and short stature. Following a diagnosis of hypothyroidism, the patient was commenced on thyroxine replacement therapy, which resulted in the spontaneous regression of the ovarian cysts. Though rare, VWGS to be considered in the differential diagnosis of ovarian masses, in patients presenting with precocious puberty and thyroid dysfunction.

Discussion:
In cases of VWGS, and its variations, medical awareness for early diagnosis and intervention are crucial for management and mitigating related risks, leading to more favourable prognosis and to avoid unnecessarily surgical intervention which may affect future fertility in young patients.

MENOPAUSE AWARENESS AMONG HEALTHCARE WORKERS: A COMPARATIVE STUDY OF PERIMENOPAUSAL AND POSTMENOPAUSAL WOMEN IN ISLAMABAD, PAKISTAN.

Background:
Menopause is often poorly understood, even among healthcare workers (HCWs). This knowledge gap can negatively impact patient care. Assessing awareness levels among HCWs is crucial to identify and address educational needs within medical institutions.

Objective:
This study aimed to evaluate and compare the awareness and knowledge of menopausal symptoms and treatment options between perimenopausal and postmenopausal healthcare workers at a tertiary care hospital in Islamabad, Pakistan.

Study Design and Methods:
A cross-sectional study was conducted using a structured questionnaire. A sample of 296 HCWs (170 perimenopausal, 126 postmenopausal) including doctors, nurses, and paramedical staff was recruited via convenience sampling. Data on demographics, awareness of symptoms across various body systems, knowledge of treatments, and attitudes towards menopause and healthcare providers were collected and analyzed using SPSS version 20. Chi-square tests were used for comparisons.

Findings/Results:
Postmenopausal HCWs demonstrated significantly greater awareness of reproductive ($p=0.03$), endocrine ($p=0.04$), musculoskeletal ($p=0.02$), and neurological ($p=0.03$) symptoms, as well as better knowledge of hormonal treatment options ($p=0.01$). However, no significant differences were found in awareness of cardiovascular or metabolic symptoms, or knowledge of non-hormonal treatments. Notably, postmenopausal participants were significantly more willing to seek treatment ($p=0.04$). Overall, high awareness of common symptoms like hot flashes (76%) contrasted with poor understanding of HRT benefits (59%) and risks (61%).

Conclusion:
Significant knowledge gaps exist among HCWs, particularly regarding treatment options. While personal experience (postmenopausal status) enhances awareness of certain symptoms, structured education is essential for all. These findings underscore an urgent need for targeted institutional educational programs to empower HCWs with comprehensive knowledge, enabling them to provide better evidence-based care for menopausal women.

A CASE SERIES OF UTERINE PECOMAS: DIAGNOSTIC AND MANAGEMENT CHALENGES IN A TERTIARY CENTRE

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Background:
Perivascular epithelioid cell tumours (PEcomas) are a rare subset of mesenchymal tumour that co-express melanocytic and smooth muscle markers. Within the gynaecological tract the uterus is the most common site of origin. Clinical presentation can be non-specific – commonly includes pain or bleeding – therefore they may mimic benign conditions such as fibroids, making diagnosis challenging. There is an increased risk associated with tuberous sclerosis.

Objective:
The objective of this case series was to contribute to the limited body of literature on gynaecological PEcomas by describing two histologically confirmed cases that have been managed in our tertiary centre over a three month period.

Study Design and Methods:
This is a retrospective case series of two patients treated in the MMUH between July and October 2025. Data was collected from electronic patient records including clinical presentation, imaging, histopathology, management and outcomes. All data was anonymised.

Case Reports:
Case 1 : 59-year-old woman with a background history of post-menopausal bleeding and tuberous sclerosis underwent a robotic hysterectomy following imaging that showed a growing uterine mass. Histology confirmed Stage 1B uterine PEcoma. She has been referred for adjuvant radiotherapy.
Case 2: 56 year-old-woman with previous hysterectomy for endometrial PEcoma had findings of nodal recurrence on surveillance imaging. She underwent secondary cytoreductive surgery. Histology confirmed PEcoma in the obturator node. She is currently awaiting radiotherapy.

Discussion:
These cases highlight the diagnostic difficulty in the diagnosis of rare malignancies such as PEcomas, due to their similar presentation to benign conditions. Multi-modal imaging, close surveillance for recurrences and MDT involvement are essential.

JUST-IN-TIME LEARNING FOR PPH: AN INTERACTIVE MOBILE GUIDE FOR OBSTETRIC TRAINEES

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Background:
Postpartum haemorrhage (PPH) is a leading cause of maternal harm. Junior doctors often face PPH early in training, when cognitive load and time-to-information hinder protocol-concordant action. Embedding just-in-time learning within a bedside cognitive aid may improve preparedness.

Objective:
To design and implement an interactive, offline, bilingual PPH guide that fuses micro-learning with guideline-anchored decision support for trainees, and to outline an education-focused evaluation protocol for non-tertiary units.

Study Design and Methods:
Using user-centred co-design with trainees and supervising consultants, content was mapped to the Irish National Clinical Guideline for PPH and cross-checked with RCOG and WHO. The mobile app provides stage-based algorithms (0–3), a CODE RED checklist, concise dosing cues (uterotonics, tranexamic acid), and visual summaries of key surgical steps. Micro-learning snippets (≤90 s) appear at decision nodes (e.g., TXA timing, uterotonic sequencing, escalation triggers). A drill mode synchronises prompts with the CODE RED checklist for team simulation. The evaluation plan (service-improvement; no patient data) specifies pre/post knowledge quizzes; simulation tasks measuring time-to-dose lookup and protocol adherence; and usability via the System Usability Scale (SUS).

Findings/Results:
Implementation is underway. Early try-outs show high face validity for micro-learning at critical steps and rapid navigation to doses/checklists in low-connectivity areas. Formal data collection (knowledge gain, time-to-information, SUS, adherence in drills) is commencing to guide iterative refinement.

Conclusion:
An education-first, offline, guideline-anchored PPH cognitive aid with embedded micro-learning is feasible for secondary-care maternity units. It is designed to reduce variability, improve protocol adherence, and strengthen trainee readiness. The evaluation framework enables measurable adoption and scalable dissemination.

TURNING OFF THE TAP: HEAVY MENSTRUAL BLEEDING MANAGEMENT FOR ADOLESCENT PATIENTS ATTENDING A TERTIARY UNIT

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Background:
Heavy menstrual bleeding (HMB) is defined as excessive menstrual blood loss that negatively impacts on one's physical, social and emotional quality of life. HMB impacts up to 40% of adolescents. In the paediatric adolescent gynaecology (PAG) population, HMB can arise commonly due endocrine issues such as anovulation, bleeding disorders and structural anomalies. Tranexamic acid, Mefanamic acid and a 30 microgram Combined Oral contraceptive Pill (COCP) are recommended first line treatments for HMB in this population.

Objective:
To review the management of HMB in the PAG population attending a tertiary unit.

Methods:
This was a retrospective cohort study of 100 PAG patients attending a tertiary unit from all 2024 referrals to the PAG service. Patient records were reviewed and only HMB referrals were included. Of these, investigations and type of initial treatment at community level was explored. Furthermore, any changes to treatment at tertiary level, follow-up type and symptom improvement upon follow-up was recorded.

Results:
Of the 100 patients seen from the 2024 referrals to the PAG service, 66% were for HMB. 60% (40/66) of these patients had investigations completed by their family practitioner including bloods (FBC, iron studies and coagulation screen), bleeding disorder screen (5%) and pelvic ultrasound (32.5%). Family practitioners commenced 76% (50/66) of patients on treatment prior to a tertiary gynaecology referral. If commenced on a COCP by their general physician (GP), only 65% were on a 30 microgram COCP compared to 87.5% at tertiary level when seen by a PAG specialist. The majority of patients had a virtual follow-up (74%). 47% reported symptom improvement at their follow-up. Important to note, of the 66 patients, two had a BMI > 35kg/m2 and both patients were commenced on a COCP by their GP, in spite of the relative contraindication of VTE risk.

Conclusion:
HMB is a common disorder amongst the PAG population. Management and treatment remains an area for improvement, especially prior to tertiary referral given PAG clinic waiting lists.

GUT MICROBIAL GENE FUNCTION AND GESTATIONAL DIABETES RISK IS ALTERED WITH BIFIDOBACTERIUM BREVE 702258 : A RANDOMISED TRIAL

Gillian A. Corbett, Fionnuala M McAuliffe

Background: Pregnancy is a state of dynamic metabolic adaptation. There is correlation between gestational diabetes (GDM) and the gut microbiome in many randomised trials, but the mechanism is not yet understood.

Objective: To investigate if Bifidobacterium breve oral supplementation reduces GDM through action the gut metabolome or gut microbial gene function in a randomised trial.

Study Design and Methods: This is a secondary analysis of a double-blinded randomised placebo-controlled trial at a tertiary maternity centre. Women in healthy pregnancy were randomised to intervention with *Bifidobacterium breve* 702258 supplementation versus placebo from early pregnancy through to delivery. Stool samples were collected at baseline and after 18 weeks of intervention (16 vs 34 weeks' gestation). Shotgun Metagenomic Sequencing and Nuclear Magnetic Resonance (NMR) spectroscopy was performed. Regression analysis examined correlation between gut composition, metabolome, gene functional data and clinical outcomes. Ethics was approved by NMH Ethics Committee (EC 35. 2015).

Findings / Results: 116 women had paired faecal NMR and metagenomic analysis. Supplementation with *Bifidobacterium breve* 702258 was not associated with changes in microbial diversity, but corresponded to lower abundance of several glycolysis-related microbial pathways (galactose degradation (Leloir pathway mean+-SD 249.439+-83.782 vs 292.073+-75.255, p=0.004) and stachyose degradation (mean+-SD 236.024+-94.073 vs 279.594+-92.913, p=0.014) and reduced faecal concentrations of aromatic and branched-chain amino acids in late pregnancy.
No cases of gestational diabetes were observed with the intervention, significantly lower than in the placebo group (0.0%, 0/56 vs 11.7%, respectively, p = 0.025).

Conclusion: These data show that oral Bifidobacterium breve is associated with reduced gestational diabetes, actioned through altered glycolysis-related gene function, demonstrating mechanism of action previously poorly understood.

OUTCOMES OF TOTAL LAPAROSCOPIC HYSTERECTOMY AT LETTERKENNY UNIVERSITY HOSPITAL: 2022 BASELINE VS 2023–2025 RE-AUDIT

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Background:
Total laparoscopic hysterectomy (TLH) offers advantages over open surgery, including reduced pain and faster recovery, but outcomes and process reliability require ongoing surveillance against recognised standards. We audited TLH outcomes and documentation quality in a secondary-care unit against RCOG and NICE guidance.

Objective:
To compare TLH outcomes and compliance measures between a 2022 baseline audit and a 2023–2025 re-audit, close the audit loop, and confirm alignment with RCOG/NICE and local standards.

Study Design and Methods:
Retrospective clinical audit using the same tool and criteria across cycles. Data sources: theatre system, medical records, iPMS. Variables: consent elements, pre-operative haemoglobin, entry technique, intra-operative complications (organ injury, estimated blood loss [EBL], conversion to open), vault closure method, operative time, length of stay (LOS), and 30-day readmission. Descriptive analysis; the re-audit targeted previously identified gaps.

Findings/Results:
Baseline 2022: n=24; Re-audit 2023–2025: n=17. Full informed consent documentation improved from 71% (17/24) to 100% (17/17). Conversion to open decreased from 8% (2/24) to 0%. Intra-operative organ injuries were 0 in both cycles. Readmission was 4.2% (1/24) vs 6% (1/17) (small absolute change; case review planned). EBL documentation improved from limited baseline recording to comprehensive entries in the re-audit; no peri-operative transfusions were recorded. Vault closure was standardised to laparoscopic in all re-audit cases. LOS(Hospital stay) and operative-time documentation improved with fewer extremes. Pre-operative Hb <11.6 g/dL was similar (17% vs 18%), highlighting an ongoing optimisation need.

Conclusion:
Across cycles we achieved 100% consent compliance, zero conversions in the re-audit, sustained zero organ injuries, and improved documentation/standardisation, supporting safe TLH delivery aligned with RCOG/NICE in a secondary-care setting. Priorities include pre-operative anaemia optimisation, continued monitoring of LOS and operative time, and maintenance of the consent checklist.

A REVIEW OF A PERINATAL GENETICS AND GENOMICS SERVICE'S ROLE IN PRENATAL DIAGNOSIS

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Background:
The Perinatal Genetics and Genomics Department in the National Maternity Hospital was established in August 2021. This department provides care to patients with a pregnancy affected with congenital anomalies, predictive testing because of a previous affected pregnancy or family history of genetic diagnosis, neonatology referrals, maternal medicine patients with a genetic diagnosis and reproductive counselling of patients who are known carriers of single gene disorders.

Objective:
The aim of this study was to review prenatal anomaly cases referred to the Department.

Study Design and Methods:
We conducted a retrospective review of all patients who were referred to the Department between August 2021 to April 2025. We included cases referred for consideration of further genetic testing because of a fetal anomaly where initial QF-PCR and chromosomal microarray studies did not reveal a genetic diagnosis.

Results:
Of the 898 families (1592 individuals) seen in the department, 109 patients met our inclusion criteria. A molecular diagnosis was made in 51.4% of this cohort (n=56). This diagnosis was made through exome sequencing in 66% (n=37), a gene panel in 20% (n=11) and single gene sequencing in 14% (n=8) of cases. These diagnoses were apparently de novo in 63% of cases (n=35) and inherited in 37% (n=21). Of the inherited cases, 11 showed autosomal recessive inheritance (19.6% of cohort), 9 were autosomal dominant (16%) and 1 was X-linked dominant (1.8%). Pregnancy outcomes showed 28.7 % (n=31) had a livebirth surviving the neonatal period.

Conclusion:
Our findings demonstrate the high diagnostic yield and clinical value of a dedicated Perinatal Genetics and Genomics service as part of the multi-disciplinary team for prenatal diagnosis in Ireland. The careful selection of cases, pre- and post-test counselling and expert interpretation of results, led by a Clinical Geneticist, is essential. Expansion of such services nationally, with appropriate funding and support will be essential to allow for equitable access to genetic testing in prenatal care in Ireland.

POST EARLY MEDICAL ABORTION COMPLICATIONS IN SECONDARY CARE: A RETROSPECTIVE FOUR YEAR REVIEW OF ONE TERTIARY UNIT'S EXPERIENCE

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Background:
The Health (Regulation of Termination of Pregnancy) Act 2018 facilitated unrestricted termination of pregnancy (TOP) prior to 12 weeks of pregnancy from 1st January 2019. Under the Irish TOP model of care women may have early medical abortion (EMA) up to nine completed weeks of pregnancy with their general practitioner (GP). Approximately 90% of all abortions in Ireland are EMA.

Objective:
This study aimed to determine the incidence and nature of EMA complications requiring medical review in hospital.

Study Design and Methods:
Retrospective review of all women who attended one tertiary maternity hospital with EMA complications from January 2021 to December 2024. Cases were identified from the TOP services database. Anonymised clinical data were transcribed from electronic health care records with descriptive statistics employed.

Results:
Over the four-year period 2,690 women resident in our region underwent EMA of whom 13% (350/2690) subsequently required medical review in our hospital and 9.8% (264/2690) were diagnosed with a complication. Of those reviewed, the mean gestation at time of EMA was 6 weeks and median duration from EMA to hospital review was 16 days. The most frequent indication for review was positive low sensitivity urine pregnancy test (LSUPT) 14 days post EMA (31.7%, n=111) followed by heavy vaginal bleeding (20.9%, n=73). Incomplete EMA was the most frequent complication observed (48%, n=168) followed by infection (12.6%, n=44), continuing pregnancy (7.4%, n=26) and ectopic pregnancy (4.8%, n=17).

Conclusion:
This regional audit, representing approximately 9% of all EMA performed nationally over the four-year period, shows that the incidence of infection, continuing pregnancy and ectopic pregnancy align with international data, supporting the safety of the community-based model. The higher-than-expected rate of incomplete EMA highlights a potential area for improvement. We recommend that national audit of complications following community EMA should be introduced, enabling opportunities to enhance clinical practice.

IMPACT OF GESTATIONAL DIABETES ON NEONATAL BIRTH WEIGHT AND MATERNAL POSTPARTUM METABOLIC CHANGES

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Background:
Gestational diabetes mellitus (GDM) is a growing global concern, linked to rising maternal obesity and glucose intolerance. It increases risks of fetal overgrowth, birth complications, and long-term metabolic disorders. This study evaluated GDM's impact on neonatal birth weight and maternal postpartum metabolic changes. Primary objectives were incidence of macrosomia and small-for-gestational-age (SGA) births. Secondary objectives included postpartum glycemic and lipid profiles, comparison at six weeks and six months, and predictors such as glycemic control, pre-pregnancy BMI, and gestational weight gain.

Methodology:
A prospective cohort study was conducted over 18 months (October 2023–April 2025) at Health Net Hospital, Peshawar. Of 219 screened women, 189 met criteria: 94 with GDM and 95 non-GDM controls. Data were collected in the second trimester, at delivery, and postpartum (six weeks, six months). Maternal metabolic markers and neonatal outcomes (birth weight, NICU admission, hypoglycemia) were recorded. Follow-up adherence was ensured with reminders. Standardized protocols were used. Logistic regression identified independent predictors, adjusting for confounders. Analyses used IBM SPSS v29.0.2.0.

Results:
Neonates of GDM mothers had higher birth weights (mean 3689 g vs. 3143 g; $p<0.0001$), more hypoglycemia (17% vs. 4.2%), and higher NICU admissions (20.2% vs. 5.3%). GDM mothers showed elevated fasting glucose at six weeks (98.5 mg/dL) and six months (94.1 mg/dL) versus non-GDM (85.3 mg/dL and 83.2 mg/dL; $p<0.0001$). HOMA-IR and triglycerides were also higher. Predictors of macrosomia and insulin resistance included GDM (OR=2.8), higher pre-pregnancy BMI, and poor glycemic control (HbA1c >5.9%).

Conclusion:
GDM significantly increases risks of macrosomia, neonatal complications, and persistent maternal metabolic dysfunction. Early diagnosis, strict glycemic management, and structured postpartum follow-up are essential to reduce long-term risks.

CLINICAL AUDIT ON PAIN SCORES AND MANAGEMENT DURING OUTPATIENT HYSTEROSCOPY

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Background:
Outpatient hysteroscopy (OPH) is a minimally invasive method for evaluating intrauterine pathology. Pain is the primary cause of procedure abandonment, and analgesic practices vary internationally. RCOG and BSGE guidelines emphasise patient comfort and pre-procedural counselling.

Objective:
To assess compliance with pain assessment and management standards during OPH and to evaluate the effectiveness of analgesic strategies.

Methods:
A retrospective audit of 261 OPH cases (April–July 2025) was performed. Pain was measured on a 0–10 numerical scale during hysteroscope insertion and endometrial sampling using standardised forms and clinical records. Cases without recorded pain scores (n = 21) were excluded.

Results:
Pain scores were documented in 91.9% of cases (n=240). 96% of patients confirmed receiving pre-procedure information (n=251). Mean age of participants was 50.2. 68.2% of participants had taken oral analgesia prior to the procedure but this did not significantly affect pain scores during insertion (mean 6.1 vs 6.0, $p = 0.72$) or sampling (5.2 vs 5.0, $p = 0.65$). Lidocaine infiltration reduced mean pain scores (1.6 vs 5.7, $p < 0.001$). Entonox was more frequently used in patients with higher pain scores (mean 7.3 vs 5.1, $p < 0.01$), reflecting selective use in more challenging procedures. No significant relationship was observed between parity and pain scores. Overall procedure completion exceeded 80%.

Conclusion:
Compliance with pain documentation and counselling standards was high. Oral analgesia had negligible benefit, whereas lidocaine infiltration produced a clinically and statistically significant reduction in pain. The selective role of Entonox highlights the need for tailored analgesia. Enhanced local anaesthesia protocols and improved counselling may further increase completion rates and patient satisfaction.

INFLUENTIAL FACTORS ON ATTENDANCE AT A COMPLEX POSTNATAL REVIEW CLINIC: A RETROSPECTIVE COHORT STUDY

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Background:
Up to 40% of postpartum women do not attend any postnatal visits, which is concerning given more than half of pregnancy-related deaths occur after the birth of the infant.

Objective:
To identify demographic and clinical factors associated with non-attendance at a dedicated Complex Postnatal Review Clinic, with the aim of informing targeted interventions to improve postnatal care pathways following complicated birth.

Methods:
A retrospective observational cohort study was conducted at Europe's largest obstetric hospital from January–June 2025. Electronic health records of all patients scheduled for review at the Complex Postnatal Review Clinic were reviewed for demographics, maternal outcomes, and indication for clinic attendance. A complicated delivery was considered one or more of the following: admission to high dependency unit (HDU), postpartum hemorrhage, preeclampsia, shoulder dystocia, cord prolapse and pre-term birth. Descriptive statistics were used in this analysis.

Results:
Of the 113 patients scheduled for attendance at the clinic, the mean age was 33 years (SD 5.72; range: 20–49 years) and mean BMI was 28.57 (SD 5.90; range: 17.12–44.43). The most common reason for referral was postpartum hemorrhage (55/113, 49%) followed by admission to HDU (51/113, 45%). One third of patients referred to the service did not attend their scheduled appointment (42/113), of which 25/42 (59.5%) had a cesarean birth. High levels of non-attendance were also observed in women who had a PPH or were admitted to HDU (19/42 respectively).

Conclusion:
A substantial proportion of patients referred to the Complex Postnatal Review Clinic do not attend their appointments. A root cause analysis is needed to identify barriers affecting access to care following a complicated birth experience and to determine how best to support the women impacted. Potential interventions may include both staff and patient education.

PICSI VERSUS STANDARD ICISI IN PATIENTS UNDEROING PREIMPLANTATION GENETIC TESTING FOR ANEUPLOIDY- A PROSPECTIVE SIBLING OOCYTE TRIAL

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Background:
Physiologic intracytoplasmic sperm injection (PICSI) is a sperm selection technique allowing embryologists to select sperm for injection into oocytes based on their ability to bind to hyaluronic acid (HA). Previous studies have demonstrated reduced miscarriage rates in PICSI cycles compared to ICSI cycles without embryo testing. Preimplantation genetic testing for aneuploidy (PGT-A) allows for selection of euploid embryos to transfer, aimed to reduce failed implantation and miscarriage.

Objective:
We compare PICSI to standard ICSI as the sperm selection technique for couples undergoing PGT-A cycles.

Study Design and Methods:
This is a single- centre prospective randomized sibling oocyte trial (NCT06602687) which has ethical approval to run for five years (EC31.2023). We present interim analysis from the first 18 months of the study. Couples undergoing PGT-A using their own fresh gametes and ICSI as the insemination method were invited to participate and provided informed consent. Following oocyte retrieval, mature oocytes were randomized to be injected either with sperm selected using PICSI or standard ICSI. The primary outcome was embryo ploidy. The secondary outcomes were fertilisation rate, degradation rate and blastocyst formation rate.

Results:
Sixty four cycles were performed for 47 couples yielding 528 mature oocytes; 268 oocytes were injected with PICSI selected sperm and 260 with ICSI selected sperm. There was no significant differences in embryo euploidy or aneuploidy between the two groups. There was a direction of effect towards higher fertilisation rates in the PICSI group (76.9%) compared to the ICSI group (69.6%) but this did not reach statistical significance (p=0.06, Chi-squared test).

Conclusion:
Interim analysis of this sibling oocyte trial does not demonstrate improved euploidy in embryos derived from oocytes injected with PICSI selected sperm compared to ICSI selected sperm. As yet the study is underpowered, but we plan to conduct further analysis including clinical outcomes of transferred embryos.

SINGLE CELL RNA SEQUENCING REVEALS REDUCED EXPRESSION OF MITOCHONDRIAL-RELATED GENES IN GRANULOSA CELLS OF WOMEN WITH DIMINISHED OVARIAN RESERVE

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Background:
The follicular microenvironment surrounding the human oocyte comprises follicular fluid (FF), granulosa cells (GCs) and immune cells, and is of marked importance for oocyte function and developmental competence. Somatic cell mitochondria are of particular importance, as GCs have high energy demands.

Objective:
We wished to compare gene changes, at the single cell level, of GCs from women with prematurely diminished ovarian reserve (DOR) compared to women with normal ovarian reserve (NOR).

Study Design and Methods:
FF aspirates from women ≤38 years of age at oocyte retrieval following controlled ovarian hyperstimulation were collected. DOR was defined as an Anti-Müllerian Hormone (AMH) <8pmol/L and NOR as AMH of 8-20pmol/L. Isolated cells were cryopreserved and sent for single-cell RNA sequencing (scRNAseq) using 10x Genomics 5' gene expression system (Single Cell Discoveries). Ethical approval for the study was obtained (EC14.2022).

Results:
ScRNAseq was performed on FF cells of three patients with DOR (AMH 4.3-5.4 pmol/L) and three patients with NOR (AMH 18.3-19.9 pmol/L). Focusing specifically on DEGs, we found 968 DEGs in GCs (625 genes with increased expression and 343 genes with decreased expression) in GCs from women with DOR compared to GCs from women with NOR. Functional annotation analysis revealed a number of mitochondria-related genes as significantly downregulated DEGs in DOR, including *MT-ND3, MT-ND4L, NDUFA1-3, ATP5PD, ATP5ME, COX17, MT-CO1* and *MT-ND2*.

Conclusion:
ScRNAseq analysis revealed GC mitochondrial complex I assembly and function as a key signature of DOR. MT-ND3 plays a significant role in oxidative phosphorylation, and dysregulated expression could increase cellular oxidative stress. Previous work has implicated MT-ND3 in age-related decline in ovarian reserve. We identified MT-ND3 and related genes as significantly downregulated in GCs of women with DOR younger than 38 years of age, which may implicate this gene in prematurely diminished ovarian reserve.

INDUCTION OF LABOUR RE-AUDIT 2025 AT GALWAY UNIVERSITY HOSPITAL: QUALITY IMPROVEMENT AND COMPLIANCE WITH NATIONAL GUIDELINES

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Background:
Induction of labour (IOL) is increasingly utilised worldwide and is recommended when maternal or fetal benefit outweighs the risks of continuing pregnancy. The National Clinical Guideline on Induction of Labour (RCPI, NWHIP 2024) outlines best practice standards. A departmental audit in 2024 at Galway University Hospital (GUH) identified
gaps in documentation, consent, and clinical practice. This re-audit was undertaken to evaluate improvements and ensure alignment with national standards.

Objective:
To assess compliance with the National Clinical Guideline on IOL and measure progress compared with findings from the 2024 baseline audit.

Study Design and Methods:
A retrospective review was conducted of 34 women who underwent IOL between January and June 2025 in the Maternity Department at GUH. Standards were based on the National Clinical Guideline on IOL, supplemented by locally relevant criteria to enable comparison with 2024 findings.

Results:
Documentation of senior obstetrician consultation before booking improved markedly from 7% in 2024 to 88% in 2025. Consent for IOL increased from 0% to 88%, while Bishop score recording rose from 63% to 88%. Documentation of analgesia discussions improved from 4% to 62%. All patients had maternal and fetal observations recorded. Membrane sweep was offered in 56% of cases. Most inductions (88%) occurred before 41+0 weeks. Spontaneous vaginal delivery was achieved in 65% of cases, while 30% required emergency lower segment caesarean section (EMLSCS). Deliveries outside routine hours remained high at 65%.

Conclusion:
This re-audit demonstrates substantial progress in documentation and adherence to key clinical standards, particularly regarding consent, senior involvement, and Bishop score recording. However, membrane sweeping, analgesia discussions, and failed IOL rates remain areas for targeted improvement. Regular audit cycles, reinforcement of checklist use, and focused quality improvement initiatives are essential to sustain progress and further optimise patient outcomes.

THE IMPACT OF VAPING ON OVARIAN RESERVE AND FERTILITY TREATMENT OUTCOMES- A SYSTEMATIC REVIEW

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Background:
The use of e-cigarettes is growing in popularity with approximately one in five women of reproductive age vaping. The negative impact of conventional cigarette smoking on female fertility is well documented, but less is known about the impact of vaping.

Objective:
The aim was to systematically review the literature on the impact of vaping on ovarian reserve and outcomes of assisted reproductive technology (ART).

Study Design and Methods:
Following PRISMA guidelines from the Cochrane handbook, two authors carried out independent systematic searches of the literature was carried out using relevant search terms.

Observational studies with female human participants involving vaping or e-cigarette use as an exposure and Anti-Müllerian (AMH), pregnancy rates or results of ART as outcomes. Animal studies, studies pertaining to male infertility only and review/opinion articles were excluded.

Results:
The initial search yielded 213 articles; 23 full manuscripts were reviewed for eligibility, 3 studies met the inclusion criteria for this review.

One study involved a retrospective review of AMH levels in > 20,000 healthy women of reproductive age. They reported a 7.76% reduction in AMH pmol/L (95% CI -12.24—3.05, p=0.001) in current vapers and a 4.88% reduction in AMH pmol/L (95% CI -8.7—0.9, p=0.017) in occasional vapers compared to never vapers, adjusting for confounding variables.

The other two studies were prospective observational studies on outcomes of ART cycles for infertile couples, comparing smokers (including e-cigarette users) to non-smokers. One study reported significantly lower AMH levels and fertilisation rates in smokers, but neither study reported a difference in clinical outcomes.

Conclusions:
Vaping appears to reduce ovarian reserve and this effect may be dose dependent though it is unclear if this may be reversible. Whether vaping has a negative impact on ART outcomes remains to be proven.

EVALUATING THE PROGNOSTIC ROLE OF ANTI-MULLERIAN HORMONE IN ASSISTED REPRODUCTION OUTCOMES

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Background:
Anti-Müllerian Hormone (AMH) is an established marker of ovarian reserve, yet its predictive value for pregnancy outcomes in Assisted Human Reproduction (AHR) remains uncertain. The utility of AMH as a selection criterion for treatment is unclear. Objective: This study evaluated the predictive value of low AMH (<5 pmol/L, with subgroup analysis at <2 pmol/L) in women undergoing AHR and explored its potential role in determining eligibility for publicly funded treatment.

Methods:
A retrospective cohort study was conducted at a tertiary centre between January 2024 and May 2025. Demographic, clinical, and treatment data were analysed using chi-square tests, t-tests, and multivariable logistic regression adjusting for female age, AMH(pmol/L), and prior AHR. The primary outcome was ongoing pregnancy, defined as a pregnancy continuing beyond 20 weeks' gestation or delivered during the study period.

Results:
293 women underwent investigation for AHR. Of these, 237 had completed treatment cycles with known outcomes. Within this group, 22.4% (n=53/237) had AMH <5 pmol/L and 7.2% (n=17/237) had AMH <2 pmol/L. Ongoing pregnancy occurred in 26.4% (n=14/53) of women with AMH <5 pmol/L compared with 42.9% (n=79/184) in women with AMH >5 pmol/L (p=0.044). In women with AMH <2 pmol/L, ongoing pregnancy occurred in 29.4% (n=5/17) versus 40.2% (n=82/204) in AMH >2 pmol/L (p=0.59). Women with AMH <2 pmol/L were older (38.0 vs 35.6 years, p=0.004) and had higher BMI (26.3 vs 24.3, p=0.015). Only one woman <35 years had AMH <2 pmol/L. Blastocyst yield was lower with AMH <2 pmol/L (1.5 vs 2.9, p=0.03). Among women completing treatment, age, BMI, AFC, and male age were not predictive of ongoing pregnancy.

Conclusion:
Women with AMH <5 pmol/L had lower ongoing pregnancy rates compared with those with AMH >5 pmol/L. However, 26.4% of women with AMH <5 pmol/L achieved an ongoing pregnancy after one cycle, indicating that AMH should not be used in isolation to restrict access to state-funded AHR. Further study is warranted in younger women with low ovarian reserve.

AN UNUSUAL CASE OF VELAMENTOUS CORD INSERTION

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Background:
Velamentous cord insertion (VCI) is a rare condition in which the umbilical cord abnormally attaches to the placenta, causing fetal blood vessels to pass through the fetal membranes. Though many of these pregnancies may be uncomplicated, VCI is associated with perinatal complications such as intra-uterine growth restriction, preterm delivery and stillbirth.

Case Report:
We report on the case of a 34 year old primigravida woman who had an antenatal diagnosis of velamentous cord insertion (VCI) and small for gestational age. The patient booked her pregnancy at 12 weeks. She was otherwise healthy and past medical and surgical history were not significant. She attended fetal medicine clinic with suspected vasa praevia and VCI from 21 weeks gestation. A VCI was confirmed with fetal vessels noted traversing through the fetal membrane from the right lower uterine aspect to the left lower uterine aspect. The fetal vessels were noted to measure less than 9mm from the internal os initially suspicious for vasa praevia. A two vessel cord was also noted.
However as the pregnancy advanced the velamentous vessels were measured 2cm on the anterior aspect and 4cm on the posterior aspect from the cervical os, in a split trajectory on either side of the internal os. At 37+3 weeks gestation the fetal growth was noted to have slowed with the abdominal circumference measuring on the 4th centile. She had a caesarean section at 37 weeks+4 days with delivery of a healthy baby girl. Subsequent placental histology reported two vessel umbilical cord with prominent velamentous umbilical cord insertion and prominent main branch within the membranes which cross the full arc of the membranes to opposite pole of disc. Despite the abnormal course of the placental vessels, there were no significant parenchymal effects suggestive of fetal vascular malperfusion.

Conclusion:
The case highlights the importance of antenatal detection of VCI. Timely identification of complications, such as vasa previa and growth restriction, can improve maternal and fetal outcomes.

EVALUATING REFERRAL TIMELINESS FOR POSTMENOPAUSAL BLEEDING: A CLINICAL AUDIT AT UNIVERSITY HOSPITAL GALWAY

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Background:
Postmenopausal bleeding (PMB), defined as any vaginal bleeding occurring after 12 months of amenorrhea, is a significant clinical presentation that necessitates prompt investigation. While often benign, up to 9%of these women will have an underlying endometrial cancer. Endometrial cancer is one of the most common cancers of the female genital tract, ranking second to cervical cancer in terms of incidence.
The timely assessment and management of women presenting with PMB are crucial to ensure early detection of malignancy, minimize patient anxiety, and optimize treatment outcomes.

Objective:
1. Assessment of the timeline from the initial GP referral to the first outpatient/Ambulatory clinic visit.
2. Assessment of the timeline from the outpatient/Ambulatory clinic visit to the receipt of histological results.

Methodology:
The audit included all 35 women referred to the hospital with a primary presentation of PMB during 2024. Data were collected retrospectively from patient medical records and case notes. The audit assessed performance against the standards outlined in the National Clinical Practice Guideline: Assessment and Management of Postmenopausal Bleeding. The data were entered into a Microsoft Excel spreadsheet, and descriptive statistics were calculated to summarize the time intervals for both referral stages. Additionally, Jamovi statistical software was used to generate histograms to visually represent the distribution of these time intervals.

Results:
Total Number of cases were 35. The timeline from GP referral to the first OPD/AGC appointment was missing in 11 (31.4%) of cases. Of the remaining 24 cases (68.6%), 11 (75 %) were seen within 4 weeks of GP's referral, and the histopathology report was available for 25 (72%) of the cases within 4 weeks of the clinic visit.
Conclusion: This audit revealed delays in referral timelines for postmenopausal bleeding, with 31.4% of cases lacking key data. While histopathology results were timely in 74% of cases, improvements are needed in documentation and referral processes.