

# Pride and Prejudice – Compassion and Inequality in today's NHS

12th Annual Conference  
London School of Obstetrics and Gynaecology

## Trainee E-poster Presentations



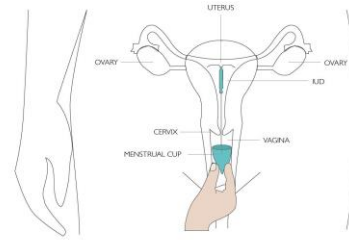
# POSTER 01

## Intra-uterine Contraceptive Device Expulsion with Menstrual Cup Use: A Case Series

Dr Alexandra Edwards

### Background

Reusable menstrual cup use has increased in popularity by 98% in 5 years with consumer environmental and financial concerns fuelling this trend.<sup>1</sup> Over the same time, intra-uterine contraception device (IUCD) use has also increased.<sup>2</sup> A recent meta-analysis reported 13 cases of dislodgment of IUCDs<sup>3</sup> and there is little evidence-based guidance into how we should be counseling users choosing to use these two methods concurrently.



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### 3 Cases of IUCD expulsion on removal of menstrual cups...

- Presenting to integrated sexual health setting in months of October and November 2019

	Case 1	Case 2	Case 3
Age	23	28	24
Parity	0	0	0
Time since insertion (months)	6	18	2
IUCD type	IUD	IUD	IUD
Expulsion type at initial presentation	Complete	Partial	Partial
Uterine position	A/V	A/V	R/V
			8

All had uncomplicated, successful IUCD replacements

### Counselling Points for Consideration

- ✓ Enquire into use of menstrual cup use at time of insertion, particularly with those choosing the copper-containing non-hormonal IUCD
- ✓ Consider cutting threads shorter in women who plan to use menstrual cups following insertion or at follow up
- ✓ Delay use of menstrual cups for 6 weeks post insertion

The cases reported dislodging the coil after attempting to remove the IUCD by pinching the main body of the cup and threads becoming caught and pulled through the cervix

Instead, users should be advised to remove cups by:

- Placing traction on the stem of the cup

OR

- Hooking one finger over the lip of cup

### Conclusions

- The characteristics of the cases are reflective of the demographic using menstrual cups and would be considered otherwise low-risk for expulsion (nulliparous, young, more than 6 weeks post insertion).
- The IUCDs expelled were all copper-containing non-hormonal devices which is expected due to menstrual blood loss being greater in users of this type compared to intra-uterine system users
- Targeted counseling is required to instruct users how to remove menstrual cups in the presence of an IUCD to minimize risk of dislodgement. More clear, evidence-based guidance needs to be developed to better inform clinicians on how best to do this.

<sup>1</sup> <https://www.moonicup.co.uk/why-moonicup/>

<sup>2</sup> NHS Digital. *Statistics on Sexual and Reproductive Health Services (Contraception)*. [Internet]. April 2019. Available from: <https://dig.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/2017-18>

<sup>3</sup> van Elk AM, Zulaika G, Lendner M, Mason L, Svalami M, Nyothach E, et al. Menstrual cup use, leakage, acceptability, safety, and availability: a systematic review and meta-analysis. *Lancet Public Health* 2019; 4: e376–93

# POSTER 02

## Management of unsatisfactory Colposcopy (UC) at Western Sussex Hospitals Colposcopy units, Is it challenging to coloscopist ??

Hend Hadawi ST5, Miss Khine Lead coloscopist

### Colposcopy

It is designed to diagnose premalignant cervical neoplasia with main goal being prevention of cervical cancer. Transformation zone (TZ) is critical area on the cervix where many premalignant and malignant lesions most often arise in more than 90% of cases. If the full TZ can be seen, the colposcopy is deemed satisfactory, if not, the colposcopy is considered unsatisfactory.

### Method

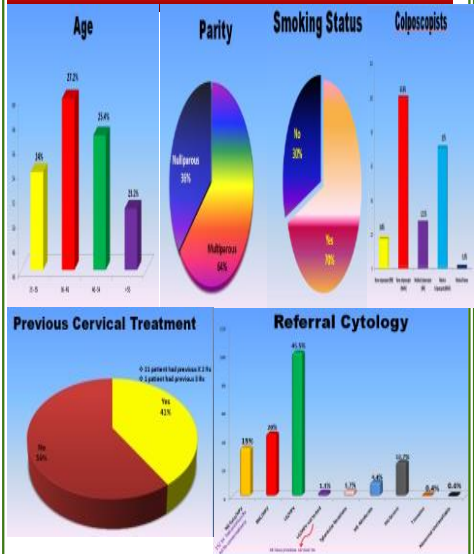
Retrospective data collection. 222 patients identified had unsatisfactory Colposcopy units at Western Sussex Hospitals NHS Foundation Trust between 1/10/2015 and 31/12/2018

### Results

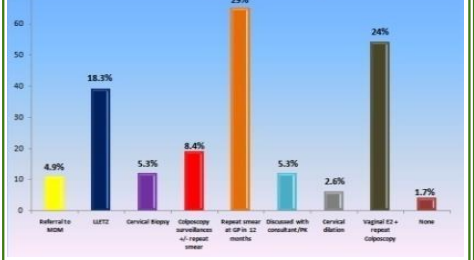
36% of patients were nulliparous. 70% were smokers. 45.5% were referred with low grade cytology and high risk -HPV and only 15% had high grade cytology. 41% of the women had previous cervical treatment.

58% of colposcopy were performed by Nurse Coloscopists and 42% by medical Coloscopists. 18% had LLETZ on first visit, 29% were discharged for repeat smear in the community in a year. 24% was given vaginal E2 and scheduled to repeat Colposcopy. 8.4% listed for Colposcopy surveillance. 5% of the cases were discussed at multidisciplinary team (MDT) meetings. Among the women referred with high grade cytology, 29 had LLETZ on first visit, and 3 women had hysterectomy. After discussion at MDT meetings, 7 had hysterectomy, 2 had LLETZ and decision for repeated smear was

### Factors influencing management of UC



### Colposcopy Management



### Conclusion

Excisional treatment or hysterectomy was the chosen option for the women with high risk factors. The cases were also discussed at MDT meetings. Majority were discharged for repeat smear in the community. Unsatisfactory colposcopy remains challenging for all practising

# A National Survey of Immediate Postpartum Contraception in the UK: Pre-COVID Baseline

Felicia Yeung<sup>1</sup>, Annette Thwaites<sup>2</sup>

<sup>1</sup>CSRH ST2, Leicester Sexual Health, Midlands Partnership NHS Foundation Trust

<sup>2</sup>Academic Clinical Fellow, Institute for Women's Health, UCL, CSRH ST4, King's College Hospital

## Introduction

Immediate postpartum contraception (IPC) is a key strategy to reduce unplanned, rapid repeat pregnancies, which are associated with worse maternal and child outcomes<sup>1</sup>. IPC at the place of delivery is safe, effective and highly acceptable to women<sup>2</sup>.

The range of IPC methods available include intrauterine coils (at elective caesarean sections and after vaginal deliveries), progesterone-only implants, progesterone injections and progesterone-only pills.



## Aims

- To provide an overview of IPC services across the UK
- To highlight barriers and facilitators of IPC services

## Methods

- 15-item SurveyMonkey survey sent to all 38 current Community Sexual & Reproductive Health (CSRH) Trainees across 26 NHS trusts.
- Responses collected October–December 2019.
- Survey enquired about current IPC methods being provided, recipient population, providers, funding, and perceived barriers and supportive factors.

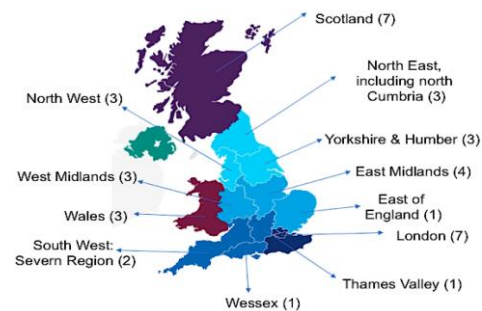
## Results

- 29 responses received, covering all 26 NHS trusts with a CSRH Trainee (Fig 1).
- 21 trusts offered at least one form of IPC to some groups of women (Fig 2). Five trusts reported offering no methods at all. Six trusts offered all methods to some groups. NHS Lothian, Scotland is leading the way as a model of universal provision since 2015.
- Seven trusts highlighted 'high risk' or 'vulnerable' (medical or social) women were more likely to receive IPC. Targeting these groups has also been used for pilot projects or to obtain specific funding.
- Two trusts have delivered the FSRH Essentials for Midwives course. One trust reported a full-time contraceptive nurse. Three trusts have started midwife implant insertion training, with five more planning to follow suit. Five trusts are developing PGDs for midwives.
- Most financing is a fragmented mix of CCG and Local Authority budgets, with individual methods being supplied by different parties. Scottish and Welsh trusts have received with government grants and public health funding also. Currently only four trusts have established, sustainable funding.
- Half of trusts surveyed (13) are in early planning or proposal stages, with current ad-hoc provision. Six trusts are running pilots. One trust reports no future plans.

## Limitations

- Only trusts with CSRH trainees surveyed
- Results reflect perspectives of CSRH trainees
- Not all CSRH trainees who responded are currently working within local maternity services

Fig. 1: Locations of CSRH Trainees, Dec 2019



21/26 trusts surveyed offered at least one method of IPC to some groups of women

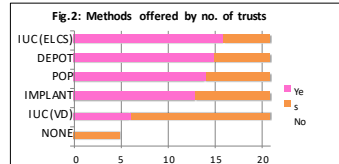


Fig. 3: Barriers to IPC Implementation

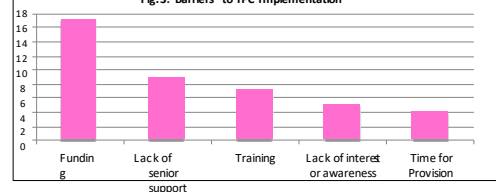
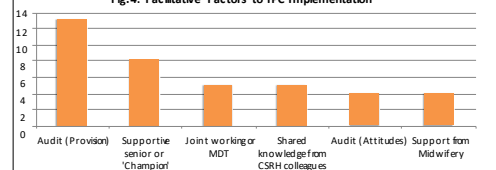


Fig. 4: Facilitative Factors to IPC Implementation



## Conclusions

- IPC provision across the UK is heterogeneous, with most trusts surveyed at early planning stages, targeted, limited or ad-hoc provision.
- Commissioning in England was consistently highlighted as a key barrier.
- We need coordinated, national sharing and evaluation of IPC commissioning and delivery models to make universal IPC a reality for women in the UK.

## References

- Smith GC, Pell JJ, Dobbie R. Interpregnancy interval and risk of preterm birth and neonatal death: retrospective cohort study. *BMJ*. 2003;327(7313).
- Thwaites A, Tran AB, Mann S. Women's and healthcare professionals' views on immediate postnatal contraception provision: a literature review. *BMJ Sex Reprod Health*. 2019;45(8):94.

## Acknowledgements

With thanks to our CSRH Trainee colleagues and Mitesh Chauhan, FSRH Specialty Development Officer

POSTER 03

# Reducing caesarean birth rates: Audit of counselling regarding birth options provided to pregnant women with one previous caesarean at UCLH

Ellie Bard, ST1 Obs & Gynae; Jo Modder, Consultant Obstetrician; Women's Health Division, UCLH NHS Trust

## Introduction

UCLH has a high total and elective caesarean rate (35% and 15% respectively in 2017), outstripping its capacity. In 2016, previous caesarean section (CS) was the indication for 451 (45%) of all elective caesarean sections (ELCS).

Planned vaginal birth after caesarean (VBAC) is a clinically safe choice for the majority of women with a single previous CS. Vaginal birth reduces the overall CS rate, associated morbidity and future high order complex caesareans. According to the RCOG Green Top Guideline, 72-75% of women with a previous CS who labour spontaneously will give birth vaginally.

## Methods and Audit standards

We obtained a list of all births at UCLH in 2016 where the mother had 1 previous CS and no other births (n=631). We excluded multiples, non-cephalic presentation, placenta praevia (n=568) and randomly selected 150 births. 118 case notes were retrieved and we examined paper and electronic notes. 5 women were excluded due to clear VBAC contra-indications. Data were analysed using STATA.

We audited against recommendations in the UCLH VBAC guideline, published December 2015 (see Table 1).

We also collected the following information:

- Initial preference for mode of birth expressed before counselling (collected for 52/113 births)
- Content of counselling given (see Table 2 below)
- Elective (ELCS) and emergency CS rate (EMCS)
- Attempted and achieved VBAC rate (target 72-75% success rate)

Table 1: Compliance with audit standards

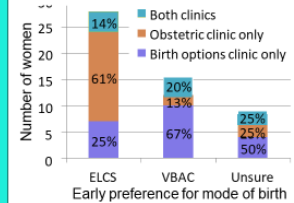
Audit standard	Target	Achieved
Women seen in midwife-led birth options clinic	100%	53%
Patient information leaflet provided	100%	37%
Women's choice of mode of birth documented	100%	95%
VBAC checklist completed	*	12%

\*all women considering a VBAC

## Findings

Women expressing early preference for CS were more often referred to an obstetric clinic while women wishing VBAC were referred to the midwife-led birth options clinic (p-value for association 0.03). Early preference for mode of birth was associated with intended and actual mode of birth (both p<0.001).

Fig. 1: Women's early preference for mode of birth and clinic attended



VBAC rates were low.

Intended VBAC rate: 43/113 = 38%

VBAC success rate: 20/36 = 56%

Overall VBAC rate: 23/113 = 20%

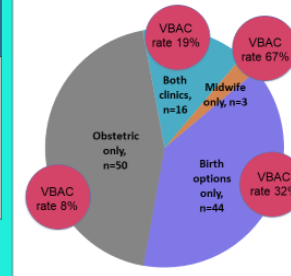
16/36 (44%) of those attempting VBAC gave birth by EMCS, with 9/16 of these due to pathological CTG.

The VBAC success rate of 56% was low compared to the 72-75% RCOG target figure.

The overall ELCS and EMCS rates were 71/113 (63%) and 19/113 (17%) respectively.

Women who attended midwife-led birth options clinic had higher VBAC rate than those attending obstetric clinic (p=0.03).

Fig. 2: Clinic attendance of women and actual VBAC rates



A VBAC checklist was completed for only 23% of women attending midwifery birth options clinic and for none attending obstetric clinics.

The checklist was used only if women wanted a VBAC.

Better information was given in birth options clinic than obstetric clinics (see p-values highlighted in red, Table 2). This was due to completion of the VBAC checklist (data not shown).

Items marked \*\* in Table 2 were included in the VBAC checklist.

Table 2: Information given to women during antenatal appointments by clinic

	All women n/N (%)	Birth options only n/N (%)	Obstetric only n/N (%)	Both clinics n/N (%)	P-value
Leaflet given**	42/113 (37%)	27/44 (61%)	5/50 (10%)	9/16 (53%)	<0.001
VBAC checklist	14/113 (12%)	13/44 (30%)	0/50 (0%)	1/16 (6.3%)	<0.001
ELCS risks	28/88 (32%)	11/30 (37%)	11/40 (28%)	6/16 (38%)	0.646
75% success**	28/113 (25%)	17/44 (39%)	8/50 (16%)	2/16 (13%)	0.019
1:200 rupture**	33/113 (29%)	16/44 (36%)	11/50 (22%)	5/16 (31%)	0.304
IOL ARM only**	28/113 (25%)	16/44 (36%)	5/50 (10%)	6/16 (38%)	0.005
On labour wd**	21/113 (19%)	17/44 (39%)	1/50 (2%)	2/16 (13%)	<0.001
IV/FBC/G&S**	17/113 (15%)	14/44 (32%)	1/50 (2%)	1/16 (6.3%)	<0.001
CTG in labour**	22/113 (19%)	19/44 (43%)	0/50 (0%)	2/16 (13%)	<0.001

## Conclusions

UCLH has a low VBAC rate.

Women's preferences in early pregnancy determined whether they were seen by midwives or obstetricians antenatally.

Information provision was poor overall and worse in obstetric than midwife-led birth options clinic. This was due to the use of the VBAC checklist which was given only to women who want a VBAC.

## Recommendations

- Implement consistent counselling for all women with one previous CS by referral to group seminar in early pregnancy and education of midwives and obstetricians on information to be given
- Update checklist and use it for all women with previous CS
- Consider a counselling strategy after first CS
- Re-audit

With thanks to: Belinda Green, Stephanie Wilson, Seni Subair, Meg Wilkinson

POSTER 04

There are two sources of referral into Homerton Colposcopy clinic, direct referrals from the laboratory and referrals from GPs.

In 2019, we've seen a significant increase in GP referrals and consequent pressure on appointments. Our audit aimed to assess the conditions being referred by GPs and look at the outcomes.

100 GP referrals recorded in Electronic Referrals System for October 2019 were analysed.

For each referral: Patient age, referring practice, referral indication, referring smear result, whether the referral was routine/urgent, colposcopic impression, colposcopy smear/biopsy results and referral outcome were assessed.

Results

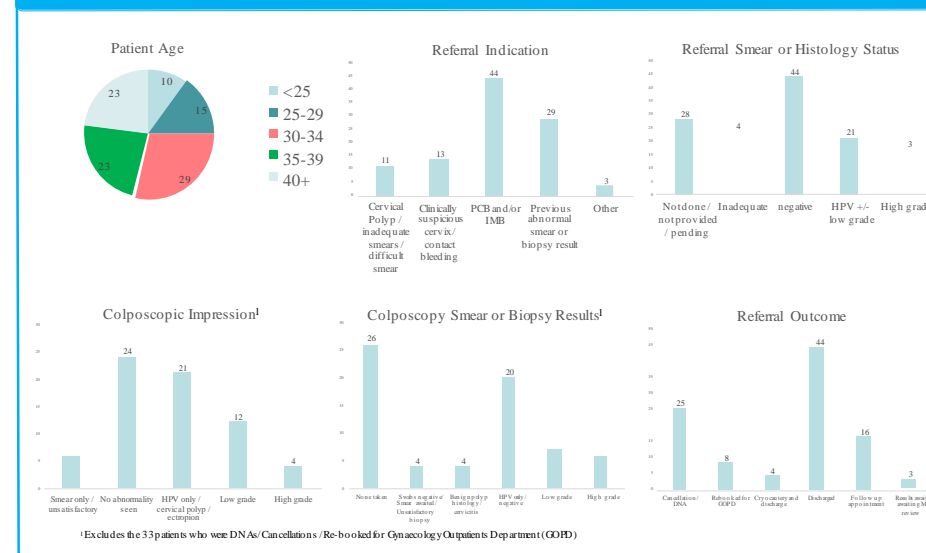
Test results from the 44 patients referred for PCB/IMB:

DNA/cancellations	14
Benign pathology/negative results/non taken	21
HPV only	4
Low grade	4
High grade	0
Unsatisfactory biopsy	1

Test results from the 13 patients referred with clinically suspicious cervix/contact bleeding:

DNA	1
Non taken	6
Negative	5
HPV only	1

Results



- There is a high DNA/cancellation rate which needs to be addressed
- A large proportion of patients (29%) are being referred due to previous abnormal smear/biopsy results where they've missed their appointment
- The 11% who had a cervical polyp/inadequate or difficult smear could potentially be seen in community gynaecology
- The 6% women with biopsy/smear proven high grade disease were all referred due to abnormal smears who had missed their original appointment
- In this sample, purely clinical indications for colposcopy, in the absence of an abnormal smear, yielded no significant pathology which suggests that there is a need for GP education
- A GP education session was subsequently organised where this audit and common cases were presented. A GP colposcopy guideline has also been developed. We have re-instated appointment text reminders and re-designed our colposcopy referral proforma



# VTE assessment in Surgical Management of Miscarriage

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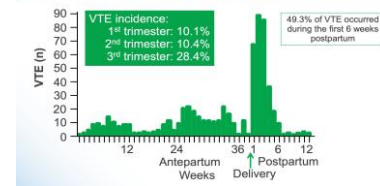
## Introduction

VTE is a leading cause of maternal death representing around 1.39 per 100,000 maternities<sup>1</sup>. Although the majority of these occur in the 3<sup>rd</sup> trimester and post partum, still 10.1% occur in the first trimester<sup>1</sup>. Further 16% of deaths occur in the 1<sup>st</sup> trimester alone<sup>1</sup>.

This highlights the need for obstetric VTE assessment for surgical management of miscarriage (SMM).

Figure 1: Distribution of VTE in pregnancy and puerperium<sup>1</sup>

## Distribution of VTE in pregnancy and puerperium



## Method

Audit of 102 cases of SMM between August and December 2019 in a busy district general hospital

- We reviewed electronic notes looking at
  - VTE assessment done
  - VTE risk factors including age, BMI, smoker, previous VTE
  - TEDS prescribed
  - Obstetric VTE assessment correct – low or intermediate/high risk
  - If intermediate/high risk was clexane given

## Obstetric VTE assessment

Do they need clexane?

Example	Is clexane needed?
41 year old woman BMI 32 No other risk factors	Yes (Green checkmark)
31 year old woman BMI 28 No risk factors	No (Red X)
35 year old woman BMI 29 Smoker and signs of infection	Yes (Green checkmark)

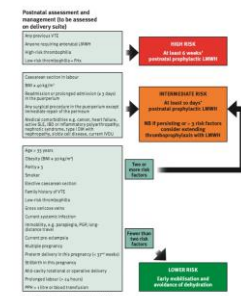


Figure 2: Obstetric VTE assessment flow chart

## Results

- 100% of cases had a computer VTE assessment done
- 100% had age, BMI documented

Figure 3: Demographic of patients by age and BMI

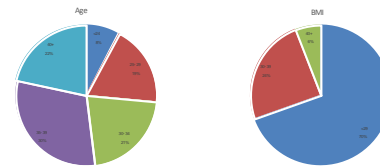


Figure 4: Pie chart of TEDS prescribed for all cases

Figure 5: Pie chart of VTE correct for all cases

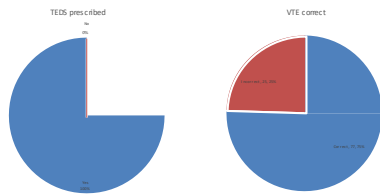
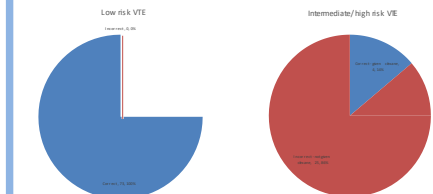


Figure 6: Was clexane correctly given in low risk and intermediate/high risk



## Conclusion

Of our 102 cases, 29 cases were deemed to be intermediate or high risk and only 14% were actually given clexane on discharge. This review highlighted the need for a clear VTE obstetric assessment to add to our units' SMM care bundle. We are also currently educating all our juniors to remember to do the obstetric VTE assessment prior to discharge. We will be re-auditing the results in due course.



# Induction of labour: Is there a role for mechanical induction?

S. Jeyapala, K. Kok, M. Al-memar, K. Gill, I. Derwig (Cons) (Chelsea and Westminster NHS Foundation Trust)

## Background and Objective

There are a variety of agents used to induce labour including prostaglandins, amniotomy and mechanical induction. We performed an audit looking at agents used in our practice in order to help guide clinicians when personalising patient's IOL care plans.

## Methodology

Prospective audit reviewing the notes of 83 randomly selected women between July 2019 to October 2019 on the IOL pathway. Information was collected using hospital records. The agents used for IOL and mode of delivery were reviewed.

## Findings

Fig 1. 1st line induction agents used

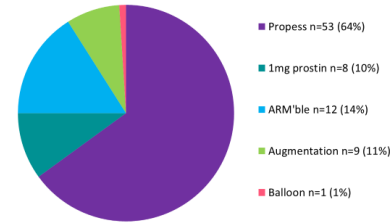


Fig 2. Chart showing final mode of delivery in all IOL patients

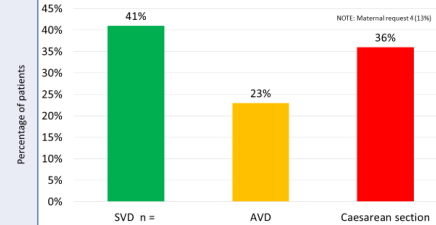
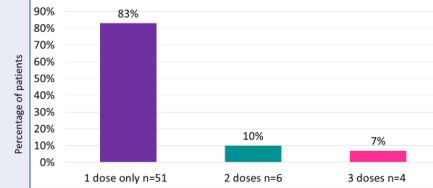


Fig 3. Chart demonstrating percentage of women requiring additional prostaglandin doses



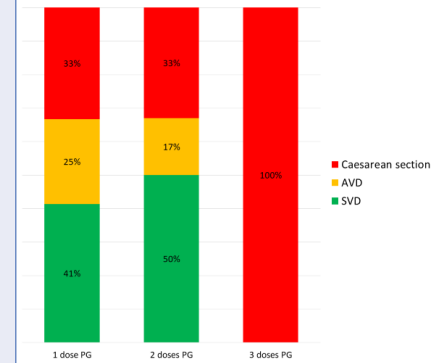
### Additional findings:

- 11% had hyperstimulation with Prostaglandin use
- 5% had tachysystole following Prostaglandin use

### Summary:

- Propress is the most utilised first line induction of labour agent
- There are recognised side effects of using a prostaglandin for induction
- All patients requiring a 3<sup>rd</sup> prostaglandin dose had an emergency caesarean section

Fig 4. Relationship between number of doses of Prostaglandin required and mode of delivery

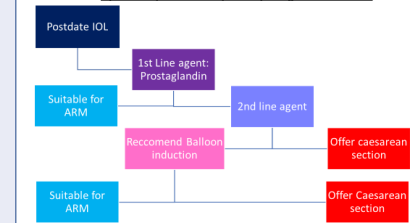


## Recommendations

### Recommendations:

- Continue to use Propress as a first line induction agent in women with an unfavourable cervix
- Consider using mechanical balloon induction if propress fails as a primary method
- Consider mechanical balloon induction in women with a history of tachysystole or hyperstimulation with prostaglandin use. Can use for an outpatient IOL
- Offer caesarean section to patients requiring a 3<sup>rd</sup> dose of prostaglandin. This will reduce the morbidity associated with emergency caesarean later in labour and they have a high chance of requiring an emergency caesarean section

### Option for postdate IOL pathway using Cook's balloon:



POSTER 07

# Postdates induction of labour

S. Jeyapala, K. Kok, M. Al-memar, K. Gill, I. Derwig (Cons) (Chelsea and Westminster NHS Foundation Trust)

## Background and Objective

There has been extensive literature over the years reviewing the outcomes of postdate inductions of labour (IOL); this has helped guide our management of this group of women. However counselling for IOL can be challenging as there are several questions surrounding postdates IOL.

**At what gestation should we be offering a postdates induction of labour?**

- The Lancet Stillbirth series published in 2016<sup>1</sup> highlighted pregnancies continuing beyond 42 weeks account for 14% of stillbirths
- The most recent study of note is the SWEPIST<sup>2</sup> trial published in November 2019. This aimed to compare the maternal and fetal outcomes of low risk pregnancies in Sweden. Women were allocated to either induction at 41+0 weeks versus expectant management until 42 weeks. The study was terminated early following the finding of 6 stillbirths in the expectant management cohort
- The WHO<sup>3</sup> recommends offering post dates induction of labour at 41+0 weeks

**Is there an increase in caesarean section rate with earlier inductions?**

- The 35/39 trial<sup>4</sup> published March 2016 compared mode of delivery in women over the age of 35 randomised to either IOL patients at 39+0 – 39+6 versus 41 – 42 week. There was no significant effect on the rate of caesarean section
- The ARRIVE trial<sup>5</sup> published in August 2018 compared IOL at 39+0 – 39+4 versus 40+5 – 42+2 weeks. This study found a significantly lower frequency of caesarean delivery in the early induction group

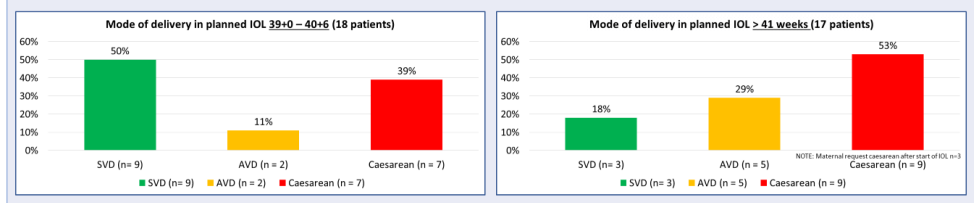
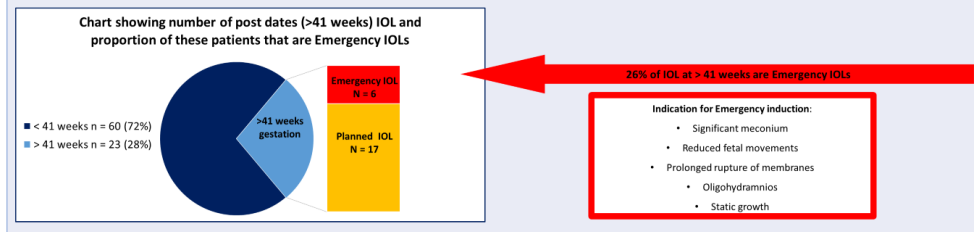
**Objective:**  
To review women on the IOL pathway booked at Chelsea and Westminster Hospital, with the aim of identifying trends and notable outcomes so that current guidelines could be changed appropriately and so that our women could have accurate information when being counselled

## Methodology

**Methodology:**

- Prospective review of 83 randomly selected IOL women between July 2019 - October 2019. The care of these women was audited against trust IOL guidelines. Information was collected using hospital records. The indication for IOL and mode of delivery was reviewed.
- Retrospective review of 34 consecutive women booked for outpatient IOL between March 2019 – April 2019. The onset of labour and mode of delivery was reviewed.

## Our findings



**Additional findings:**

- 50% of patients awaiting a planned outpatient IOL went into spontaneous labour – 23% of these patients had an emergency caesarean section

## Summary of Findings

- 26% of IOL at more than 41 weeks gestation are emergency IOLs
- A larger proportion of planned IOL at >41 weeks have a Emergency caesarean section compared with planned IOL prior to 41 weeks
- Patients who spontaneously labour have a lower caesarean section rate (23%) compared to patients who wait for a planned post dates induction (50%)

## Recommendations

- Given the above literature we should aim for postdates induction of labour at 41 weeks
- The above findings suggest that IOL at a later gestation may correlate to an increased caesarean section risk and therefore this supports an earlier induction
- The above results can be used to counsel our women for an IOL using local statistics
- Offering elective IOL at 41+0 weeks may also reduce the emergency IOL rate for later gestations; allowing people to be counselled appropriately by managing expectations, whilst also reducing birth trauma. This could relieve the pressures associated with inpatient emergency IOL.

## References

<sup>1</sup> Landon B, Blackwell R, Wilmore P, et al. Lancet Ending Preterm Births Series Study Group. Lancet Stillbirth Investigator Group. Stillbirths: rates, risk factors, and prevention towards 2030. Lancet 2016;387:1847-63. doi:10.1016/S0140-6736(15)00887-5

<sup>2</sup> Induction of labour at 41 weeks versus expectant management and induction of labour at 42 weeks (SWEPIST): a randomised controlled trial. Lancet 2019;394:1025-33. doi:10.1016/S0140-6736(19)30887-5

<sup>3</sup> WHO recommendations: induction of labour at 41 weeks or beyond term. Lancet 2015;385:1025-33. doi:10.1016/S0140-6736(15)00887-5

<sup>4</sup> Khan K, Taylor A, et al. Randomised Trial of Labour Induction in Women 35 Years of Age or Older. N Engl J Med 2016;374:1032-40. doi:10.1056/NEJMoa1508117

<sup>5</sup> Williams A, et al. Labour Induction versus Expectant Management in Low-Risk Nulliparous Women. August 9, 2018. N Engl J Med 2018; 379:1533-1540. doi:10.1056/NEJMoa1800566



► **A quality improvement project to standardise care for women with pregnancy of unknown location in Croydon University Hospital using the M6 prediction model**

► *Amokrane N, Warren D, Rose D*

► **Background:** A new prediction model to stratify the risk of patients with a pregnancy of unknown location (PUL), having high risk outcomes ie ectopics (EP) or persistent PUL (FPUL) or intrauterine pregnancy (IUP) has been developed and tested in two large multicentre studies. In our Early Pregnancy Unit, patients are currently managed according to NICE and RCOG guidelines with individualised care plans for patients with PUL. A pilot study was tested in our unit using this model for a trial period of 1 month to see if we could safely use this model to risk assess our patients and standardise care.

► **Methods:** All women who had an outcome of PUL at their initial scan were triaged in a 2-step protocol including the M6 model as proposed by Bodiwala et al. Staff in the early pregnancy unit were trained to use the M6 Model and to record the data and follow-up patients accordingly. Data was collected and analysed using Excel and electronic patient records and reviewed by 2 registrars.

► **Results:**

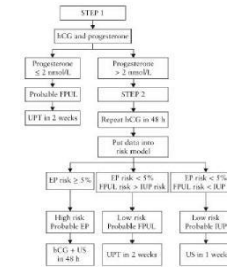
► **Total number of patients classified as PUL in 1 calendar month = 29**

► **After step 1 - 7 patients were suitable for immediate discharge with urine pregnancy test (UPT) in 2 weeks for follow-up (FU)**

► **4/7 patients – (57%) were correctly discharged at this step**

- 1 patient was admitted ward for N&V and therefore treated outside the protocol
- 2 patients had repeat bloods (48hr HCG) although these were not required

► **Figure 1: 2 stage triage protocol including M6 model (Bodiwala et al, 2019)**



**Conclusions & Discussion**

- Almost 25% of patients could be safely discharged after initial presentation
- **ALL** high risk patients were correctly predicted
- **NO** high risk patients in the low risk group
- Reduced follow-up visits compared with previous month and up to 60% reduction in blood tests compared with usual care.
- Good feedback from EPU staff in using this model
- Potential cost-saving

However we had 1 case of rupture in the EP group by time of surgery (Patient had not complied with FU time frames given and presented later to the EPU as an emergency. We also had 3 cases of 'loss to follow-up' in the group therefore, our unit must be cautious in ensuring the patients selected for this follow-up are willing to comply, understand the risks and able to attend the follow-up appointments timely.

**Further Recommendations:**

Flag on Cerner/electronic records if patient is high risk in case of patient presentation to A&E/ Out-of-hours.

New leaflet for patients developed  
Ongoing audit and review of local guideline to incorporate the above protocol.

References:  
Bodiwala S, Chibudalou E, Famen J, Mitchell-Jones N, Kyriacou C, Al-Memar M et al. Triage women with pregnancy of unknown location using two-step protocol including M6 model: clinical implementation study. *Ultrasound Obstet Gynecol* 2020;55: 118-114  
NICE 2020: Assessing Pregnancy of Unknown Location



# An Unlikely Twist

## SFH & Spontaneous Uterine Torsion

Dr Is hak (ST3) and Miss Sally Watkinson Consultant Obstetrician & Gynaecologist  
Queen Elizabeth Hospital, Woolwich

### CASE PRESENTATION

31-year-old G3 P1 (previous EMCS) of 30+2 weeks gestation was brought in by ambulance to labour ward triage in a busy district general hospital (DGH). She complained of:

- Collapse
- Vomiting
- **Severe groin pain**
- Reduced fetal movements

**Symphysis-fundal height 42cm despite being 30cm a week prior**

Observations: BP 90/60, HR 88, RR 20, T 36.6, Sats 99%.

CTG: bradycardia à emergency caesarean section



## POSTER 10

### Findings at EMCS

- Dusky purple and oedematous uterus
- Difficulty reflecting the visceral peritoneum
- Uterus exteriorised: round ligaments criss-crossed
- The uterus had in fact spontaneously torqued 180° and the baby was delivered through the posterior wall

<https://youtu.be/1VXHOYEBwIM>

### Maternal & Fetal Outcomes

- No increased maternal morbidity or mortality; EBL 400ml and the mother made a good recovery
- Baby stabilised in SCBU & shortly discharged.
- Mother debriefed & advised she see an obstetrician in her next pregnancy and deliver by ELCS.

### Spontaneous Uterine Torsion Literature Review

- Uterine torsion is defined as rotation  $>45^\circ$  around the long axis of the uterus.
- Paucity of information: only a **handful of case reports** siting spontaneous uterine torsion.
- It is not possible to clarify why uterine torsion occurs, but numerous abnormalities have appeared with uterine torsion; most often, abnormal fetal presentation, presence of fibroids and uterine malformations.
- When sited these cases typically carry a **high perinatal mortality** (up to 12% for fetus)<sup>1</sup>, high rate of **caesarean hysterectomy**<sup>2-3</sup> and associated major haemorrhage and increased maternal mortality.

### Case Analysis

*In uterine torsion venous blood is unable to leave the organ causing engorgement of the uterine muscle and the 'congested' appearance at EMCS.*

*This also explains the sudden and disproportionate rise in SFH.*

*The history of collapse, groin pain and RFM could be a sensitive indicator for spontaneous uterine torsion.*

*A sudden increase in SFH far beyond what's expected for gestation could be a specific sign of this rare occurrence*

# Mode of delivery of DCDA twin pregnancy: Maternal and neonatal outcomes

*M. Trowsdale Stannard, S. Lingham*

Kingston Hospital, Kingston Hospital Foundation Trust, London

## INTRODUCTION

Kingston Hospital cares for more than 120 DCDA twin pregnancies every year. Twin pregnancies are associated with higher maternal and neonatal morbidity and mortality than singleton pregnancies, with many complications relating to mode of delivery. Given this increased risk, it is essential to choose the appropriate mode of delivery for a woman and her babies.

## OBJECTIVES

To compare maternal and neonatal outcomes following delivery of DCDA twins at Kingston Hospital.

## METHODOLOGY

Data were collected for 126 women with DCDA twin pregnancies who delivered at Kingston Hospital in 2019. Information regarding estimated blood loss (EBL), maternal postnatal complication and neonatal unit (NNU) admission was collected from the digital records and handheld patient notes.

## RESULTS

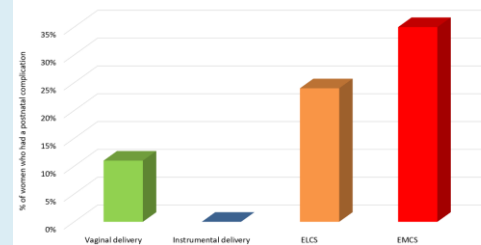
Maternal postnatal complication rate was 11% following vaginal delivery, 0% following instrumental delivery, and 24% and 35% following ELCS and EMCS respectively. EBL was highest following EMCS and lowest following vaginal delivery. Conversely, 27% of babies born by vaginal delivery required NNU admission, whilst only 12% and 15% of babies born by ELCS and EMCS respectively were admitted to NNU.

## CONCLUSION

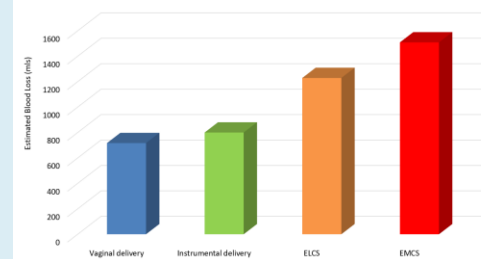
Women who had ELCS had higher rates of postnatal maternal complication and a higher EBL, but their babies had lower rates of NNU admission. Balancing the risk to mother and baby is clearly critical, hence decision-making regarding mode of delivery should be patient centred, take into account individual risk factors, and involve the multidisciplinary team and the patient.

POSTER 11

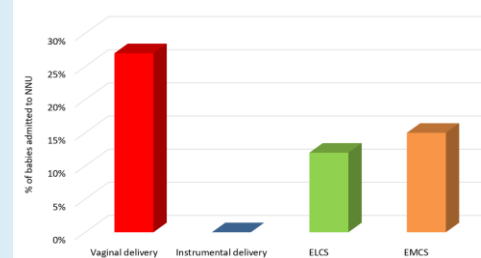
Maternal Postnatal Complication



Maternal Blood Loss



Admission to NNU



# Diagnostic and therapeutic laparoscopy performed in the Day Surgery Unit: indications, pre-surgical management, investigations and outcomes.

Amokrane N, Le Bas A, Ofusua E, Collaris R.

**Background** NICE guidelines published in 2017 advise on diagnosis and management of endometriosis<sup>(1)</sup>. Our hospital has no local guideline. Our practice was audited using the NICE guidelines as gold-standard, to assess practice patterns and identify areas for improvement.

There should be an index of suspicion in any woman (including those aged below 17) presenting with 1 or more of the below symptoms:

- Chronic pelvic pain
- Period-related pain (dysmenorrhoea) of a severity affecting daily activities and quality of life
- Deep pain during or after sexual intercourse
- Period-related / cyclical gastrointestinal symptoms, in particular, painful bowel movements
- Period-related / cyclical urinary symptoms, in particular, blood in the urine or pain passing urine
- infertility in association with 1 or more of the above.

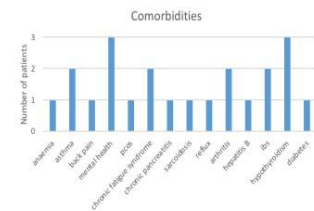
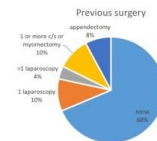
It is important to avoid undue delay in diagnosis. Different organ systems being involved can make diagnosing endometriosis challenging, as can other conditions mimicking endometriosis symptoms. There are some features that may raise the index of suspicion and could lower threshold for referral and/or interventions. Finally, not everyone needs surgery, as a proportion of women will respond to hormonal treatment<sup>(2)</sup>.

**Audit Standards** We took the NICE recommendations as our gold standard therefore, prior to surgery all women should have had:

- Advice to keep a symptom diary
- Pelvic & abdominal examination
- Transvaginal pelvic ultrasound
- 3 month trial of either paracetamol, NSAIDs or both
- 3-6 month trial of hormonal management
- Alternative treatment offered after negative laparoscopy

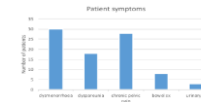
**Methods** Retrospective analysis of 50 patients undergoing diagnostic laparoscopy in a 3-month period (Oct-Dec 2019), using clinic letters, theatre lists and operation notes.

**Results.** Mean age: 30.8 years (range 18-49)  
18/50 (36%) women had comorbidities.

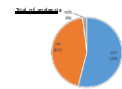


## Pre – surgery

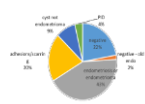
Symptom diary = 1/50 = 0.5%  
Pelvic exam = 12/50 = 24%  
TVS = 39/50 = 78%  
TVS+MRI = 7/50 = 14%



## Intraoperative assessment and management



## US findings



## Laparoscopy findings



- 9 women had no imaging prior to surgery and otherwise did not expect examination.
- 4/20 (20%) women had imaging (TVS and/or MRI) prior to surgery
- 12/41 (29%) had positive imaging. 10/20 (50%) of those had pos. laparoscopy findings.
- 2/4 (50%) had any imaging. 2/2 (100%) had positive laparoscopy
- Overall 12/50 (24%) had imaging. laparoscopy = 10/12 of those who had had normal imaging
- Pelvic surgery comprehensive only documented in 10/12.

## Conclusions & Discussion

- There is scope to improve pre-surgery pelvic exam & imaging.
- There is scope for maximising analgesia & hormonal treatment.
- Positive US findings yield the highest a-priori likelihood of sign. findings on laparoscopy, especially if combined with abnormal VE, though not all of these will be endometriosis.
- Those with negative findings on both US and VE are least likely to have abnormal laparoscopy findings. Particularly in these women it may be justified to initially defer surgery and offer optimisation of analgesia and hormonal treatment.
- Pos. laparoscopy findings are quite common despite negative US findings, justifying surgery after failed analgesia & hormonal management.
- Comprehensive documentation of laparoscopy findings is vital to be confident no endometriosis is missed and for handover of future care.
- 24% negative laparoscopy rate is difficult to benchmark<sup>(3)</sup>, better pre-operative assessment & management could potentially reduce this.

POSTER 12

# Outpatient Hysteroscopy Pain Management Audit

Le Bas, A., Amokrane, N., & Ajay, B.

## Background

NICE recommends outpatient hysteroscopy (OPH) or ultrasound as a first-line investigation for dysfunctional uterine bleeding. Best practice includes advising patients to take analgesia pre-procedure and using vaginoscopic techniques with miniature hysteroscopes. Pain is one reason why OPH can fail and a repeat procedure under GA necessary. We audited our adherence to NICE's pain management recommendations and our patients' perception of their pain and pain management.

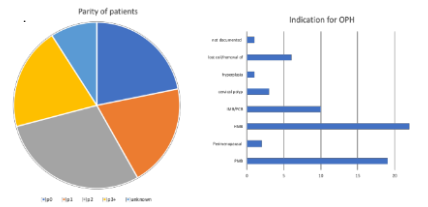
## Standards

100% of patients should:  
 \*take analgesia prior to procedure  
 \*have a vaginoscopic approach to OPH  
 \*have a miniature hysteroscopy (a scope with 2.7mm diameter with a 3-3.5mm sheath)

## Methods

55 consecutive OPH cases over 4week period, Nov-Dec '19 were reviewed. Data was collected from the OPH proforma and where necessary, electronic notes were cross-checked. Patients completed a self-assessment questionnaire at the end of their appointment, anonymously. Data was analysed on Excel.

## Results



## Results

**Pre-procedure:** 72% patients felt **well-informed** and 61% reported they took analgesia. 45% reported adequate time to discuss analgesia during their appointment.

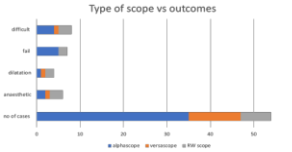


19% of patients had documentation of having taken analgesia pre-procedure.

**Procedure:** 53% deemed OPH 'slightly painful', with 4% feeling pain 'constantly'. 85% deemed the overall experience as 'excellent', the remaining 15% considering it 'good'.

## Results

**Procedure:** 53% deemed OPH 'slightly painful', with 4% feeling pain 'constantly'. 85% deemed the overall experience as 'excellent', the remaining 15% considering it 'good'.



Miniature hysteroscopes were used in 85% of cases and 5mm scopes were used in 13%. Conversion to GA – 5/55 patients (9%)  
 1/5 – too painful  
 4/5 – failed  
 An additional 5 patients went on to have a GA for a further operative procedure.

**Post-procedure:** 89% post-procedure analgesia not documented, 11% 'not needed'

## Conclusions & Recommendations

Failure rates, use of anaesthetic and dilatation of cervix rates were higher for cases with the RW 5mm hysteroscope. This audit confirms miniature hysteroscopes are vital to reduce OPH failure rates and the need for the procedures to be converted to GA, which furthers the proposal for purchasing more miniature scopes in our unit.

Significant discrepancy was noted between patient self-reporting of pre-procedure analgesia compared to clinicians documentation. Improved documentation going forward will enable accurate analysis of interventions.

We have instigated a new practice of calling patients pre-appointment to remind them of analgesia use before OPH. Hopefully this will reduce reported pain and improve the patient experience further. This will be re-audited in due course.

A new information leaflet will be available for patients to help them decide about proceeding with either an outpatient or GA hysteroscopy. Better information and counselling at this stage would hopefully select a pool of appropriate and more prepared patients, reduce failure rates and the associated costs of conversion to GA procedure when OPH is not tolerated.

POSTER 13



# Management of ectopic pregnancy audit

University Hospital Lewisham

June to December 2020 (comparison with 2017)

Dr M Geddes-Barton, Miss H Mehra, Miss S Morgan



## Background

Rate of ectopic is 11/1000 with maternal mortality of 0.2/1000. Fatality rate has decreased over recent years showing early diagnosis and appropriate management make a difference. All women presenting to EPU/ A&E should have a baseline BHCG and progesterone. The options of medical, surgical and conservative management should be offered as appropriate and this discussion documented

## Aim

To assess whether ectopic pregnancy was being managed as per local and national guidelines at University Hospital Lewisham over June to December 2020 and to compare the management to 2017

## Method

Retrospective data collection from June to December 2020 of all women with an ectopic pregnancy via A&E and EPU using icare. Age, parity, presenting symptoms, baseline investigations, time to definitive management, outcomes and documentation were assessed and data was entered using an excel spreadsheet. It was then compared with national and local guidelines and compared to an audit in 2017.

## Results

42% (n=18) managed conservatively (16% (n=3) failure)  
2% (n=1) managed medically  
57% (n=24) managed surgically 1st line (where 100% had salpingectomy)  
19% (n=8) were initially diagnosed with IUL on scan  
7% (n=2) did not have a TVUS before going to theatre and diagnosis was made clinically  
5% (n=2) were interstitial pregnancies  
40% of those managed surgically were ruptured ectopics (from the operation note)  
26% of those managed surgically were live ectopics  
average number of days of follow up if conservatively managed was 24 (range 12-53)

### Areas of good practice compared to last audit (2017-2018)

95% (80%) had a Bhcg and progesterone performed on day of presentation  
81% (70%) of those options for surgical management were operated on within 24 hours of diagnosis  
96% had a laparoscopy and the 1 case who had a laparotomy it was appropriate  
83% (80%) of those who opted for conservative management were successful. Only one medical management failed (management initiated at another trust)  
100% of these negative women received anti d within 24 hours  
85% were given advice re future pregnancies on discharge  
On previous audit only 5 cases were audited looking at conservative management compared to 18 in this audit. Most likely an issue of documentation and documenting on icare rather than much higher conservative management being offered

### Areas which still need to improve/interventions

6 of the women had had previous salpingectomy and then went on to have another salpingectomy. Should we have performed salpingostomy? No documentation  
20% (n=3) of the women managed conservatively were lost to follow up  
38% (n=10) were appropriately advised to take a pregnancy test 1 week after surgical management  
26% (n=4) of conservatively managed women were not discussed with a consultant as per the guideline  
38% (n=5) of conservatively managed women did not have documented discussion of options  
only 1 woman had medical management ? this option not being offered

## Recommendations and learning points

Better documentation of discussion of options - medical, surgical, conservative  
Advice re PT follow up  
Appropriate selection of conservatively managed cases  
Don't rule out ectopic if BHCG > 100000 or < 300  
Discuss and document management options with a consultant in every case  
Address theatre delays  
? Better training in salpingostomy/ better documentation of reason for salpingectomy if appropriate and only 1 remaining tube

POSTER 14



## Developing a new Postpartum Contraception (PPC) Service in Obstetrics at

### Whipps Cross Hospital During the Covid-19 Pandemic

A multi-cycle Quality Improvement Project: 1 Year Evaluation

Amélie Morin, Elisabeth Kostov, Alexandra Cann, Anwen Gorry

#### Introduction

45% of pregnancies in the UK are unplanned and 20% of women who present to local abortion services have had a baby within the previous year (Wellings et al., 2013).

Public Health England (2021) estimates that for every £1 spent on contraception, £9 is saved by the public sector. The "Better for Women" (RCOG 2019) report advocates a one-stop services for women's health.

Access to women's sexual health services significantly reduced during the **Covid-19 pandemic**. We set up a postpartum contraception service at Whipps Cross Hospital in partnership with the local East London Sexual Health clinic during the pandemic and we audit the first year of use (March 2020-February 2021).

#### Methods

This was a multi-faceted project with three main arms:  
1) Patient **questionnaires** on knowledge, attitudes and practices around contraception for preliminary data on supply, needs and demand in our population.

2) **Training sessions** on contraception counselling were given to midwives, GPs and junior doctors.

3) A partnership with local sexual health services to secure funding and facilitate staff training and patient follow-up. This has enabled us to provide: **Mirena Coils (IUS)**, **Progesterone Only Pills** and **Subdermal Implants** to postpartum women in hospital.

We have launched our service at the beginning of the Covid-19 pandemic allowing women to access contraception simply and minimising healthcare visits during lockdown.

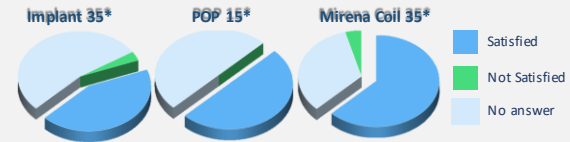
We review our service after one year and collect feedback from women who have used the service.

#### Covid-19 and Women's Health Services

Access to sexual health services has reduced significantly during the Covid-19 pandemic due to safety concerns about exposure to the virus, travel restrictions and reallocation of resources (Green et al., 2020). The RCOG (2021) suggests maternity services are well placed to provide effective postpartum contraception during this period.

#### One Year Results

We randomly selected a sample of patients from each arm of contraception to phone and get verbal feedback on their experience of the postpartum contraception service at Whipps Cross during the Covid-19 pandemic.



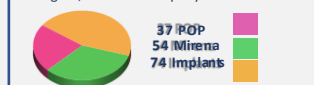
-Overall, >90% of patients were happy with the contraception service across all arms  
-When side effects reported: bleeding, 95% had been counselled on this beforehand  
-5 Mirena coils fell out (out of 35 contacted), no perforations  
-A number of women mentioned difficulty getting in contact with GP/ sexual health services during Covid-19 pandemic  
-Suggestions included; provide leaflets with information, ensure contraception offered to all women, make sure all members of staff knowledgeable about contraception  
-High "no answer" proportion (included in graph) - expected due to tiredness/ business of looking after newborn

#### Pre-service Questionnaires

- 80% planned to use contraception, but only 26% had discussed contraception with a healthcare professional during pregnancy
- 28% were interested in immediate IUCD or implant insertion postnatally
- We identified misconceptions about hormonal contraception and addressed them by improving women's awareness.

#### This year...

165 women were discharged from maternity with contraception. This represents 3.6% of our average 4,500 deliveries per year.



#### September-February prescriber/insertion breakdown (75)

**Mirena**  
19 Consultants 6 SpR  
**Implant** 13  
Midwives 22 SpR  
**POP** 15 Prescribed by SHO's

“ My coil fell out, I contacted my GP who told me to contact local sexual health services. I have been trying for weeks but haven't got an appointment because of Covid ”

One of the patients we contacted reported her coil had fallen out. She had been counselled that this was a possibility, so knew to contact her GP for replacement contraception, who advised contacting local sexual health services. She told us she has been trying for weeks and had been told that **appointments were limited due to Covid-19**. This demonstrates the need for improved "one-stop" services.

#### Conclusion

Covid-19 has presented challenges across healthcare, with access to Women's Health and contraceptive services being affected greatly. We have found that a "one-stop" post partum contraception service has high satisfaction and minimises healthcare visits.

Barriers include language, lack of staff knowledge and ensuring service is offered to all women. Suggestions to improve these include leaflets in different languages and more training for staff. The RCOG also recommends protocols put in place to ensure timely provision and no delay to discharge.

The ongoing provision of this service could lead to improved pregnancy spacing and reduce unplanned pregnancy and abortions. Investment in staff training could improve the provision.

References: Green L, Faten D, Gupta D, Michale T, Nelson T and Mishor R., 2020. Providing women's health care during COVID-19: Personal and professional challenges faced by health workers. *International Journal of Gynecology & Obstetrics*, 151(1), pp 36. Public Health England, 2021. *Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England*. London: Public Health England, p7. Royal College of Obstetrics and Gynaecology, 2019. *Better for Women, Improving the health and wellbeing of girls and women*. London: RCOG, p14. Royal College of Obstetrics and Gynaecology, 2021. *Guidance on the provision of contraception by maternity services after childbirth during the COVID-19 pandemic*. London: RCOG, pp2-3. Wellings K, Jones K, Mercer C, Tanon C, Clifton S, Datta J, Copas A, Erens B, Gibson L, Hladikowal W, Sommerberg P., Phelps A, and Johnson A., 2013. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *The Lancet*, 382(9907), pp 1807-1816.



# Intracorporeal laparoscopic suturing training during Covid19 pandemic



## Computers Vs the Instructor

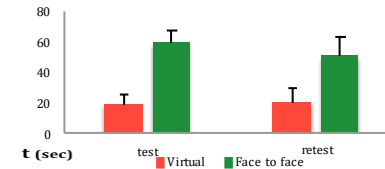
A. Lazaridis, S. Iliodromiti, R. Navaratnarajah, J. Odejinmi

### Purpose:

The unprecedented training decline due to Covid19 restrictions led to the design of a computer-based video instruction (CBVI) package to test the training potential (primary outcome) and effectiveness (secondary outcome) when compared to the traditional instructor guided simulation training (IGST) for intracorporeal laparoscopic suturing

### Results:

Both groups showed similar performance outcomes for task completion, an **intracorporeal laparoscopic knot** ( $P = 0.267$ ) and the secondary outcomes (needle driving and knot tying), without statistical difference.



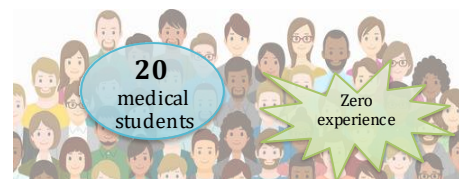
On the 4-week skills retention assessment individuals of the CBVI group performed significantly better compared to the IGST for needle loading time ( $F = 9.758, P = .014$ ) (Gg).

### Conclusion:

This is the first study of its kind where there is a direct comparison of CBVI and IGST and we have demonstrated that it is feasible to acquire advanced laparoscopic skills only via computer-based video instructions without the need of face to face expert or peer feedback.

Moreover, when we take in to account costs for travelling and hiring of training facilities as well as considerable faculty time commitments, then the video-only training is a more effective training approach for laparoscopic suturing and potentially other complex laparoscopic skills training especially during Covid19 restrictions.

### Methods:



2 groups matched for sex, right/left hand dominance, previous exposure to video games or musical instruments and surgical career aspirations.



\*Acknowledgements: Many thanks to the 3rd & 4th year medical students from Barts - QMUL that volunteered and supported this pilot study.

\*\* No conflicts of interest to declare



# “CAN YOU HEAR ME?”

## VIRTUAL ANTENATAL APPOINTMENTS IN THE COVID ERA AND BEYOND

DR CHRISTINA TAVENER, DR CHRISTOPHER KYRIACOU, IMENEELMASCRI, ANTENATAL BIG ROOM, MISSABRINADAS

### BACKGROUND

The COVID-19 pandemic dictated a rapid change to outpatient antenatal services. Pregnant women were advised to 'shield' where possible or, along with staff members, to self-isolate if symptomatic of COVID-19 or following contact with a symptomatic individual<sup>1</sup>. To reduce face-to-face contact, multiple specialties have successfully implemented virtual consultations by using high quality teleconferencing platforms with high patient satisfaction<sup>2</sup>. Our team therefore aimed to introduce telephone and video consultations to the Consultant-led antenatal clinic at Queen Charlotte's and Chelsea Hospital whilst also targeting the longstanding issue of long patient waiting times.

### AIMS

1. To reduce footfall in the Consultant-led Antenatal Clinic by seeing suitable patients remotely with a target of 15%.
2. To reduce patient waiting times for face-to-face consultations to an average of 30 minutes from the appointment time.

### DESIGN

Four Plan-Do-Study-Act (PDSA) cycles were created to assess and scale the interventions, which were introduced in March 2020.

#### 1. Clinic template change

Increasing appointment time from 20 to 25 minutes with built-in administration time at the start and end of clinics.

#### 2. Consultant pre-vetting of clinics

Pre-reading the electronic patient record one week prior to each clinic and informing the woman to stay at home to await a virtual consultation or to attend in-person. NICE guidance was followed to ensure patient safety.

#### 1. Telephone consultations

#### 4. Video consultations

Consultations were conducted using 'AzuRx' software, with a written framework and video demonstration made available to clinicians prior to launch.

### MEASUREMENT

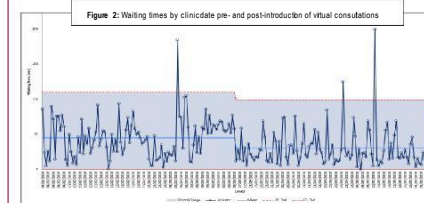
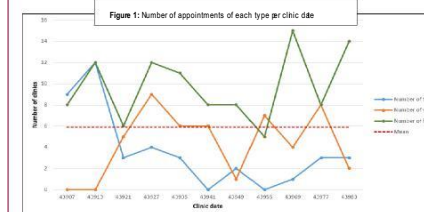
In-hospital waiting time for women attending face-to-face appointments was measured by recording the time from the scheduled appointment to initiation of the electronic patient record. The number of consultations performed virtually was also documented. Qualitative feedback was obtained from service users via electronic surveys, 'listening events' and from staff through departmental meetings.

### REFERENCES

1. National Health Service. Pregnancy and coronavirus. NHS. 2020. Available from: <https://www.nhs.uk/conditions/coronavirus-pregnancy/>
2. Gilbert WJ, Biliary JC, Adam R, Martin L, Tobin R, Baglin S, Galvin N, Farr I, Allan A, Davies L, Gibson J. Rapid implementation of Virtual Clinics Due to COVID-19: Report and Early Evaluation of a Quality Improvement Initiative. *BMI Open Qual*. 2020.

### RESULTS

Implementation of these changes resulted in a reduction of face-to-face waiting times in the Consultant-led antenatal clinic by one third, from a mean of 45 to 30 minutes. The target of 15% remote consultations was met.



### Positive Feedback

- I No need to arrange childcare for appointments
- I Partners able to attend appointments
- I Waiting time spent in the comfort of home and not wasted
- I High-quality video consultations achievable with good interpersonal connection
- I Multidisciplinary consultations easily facilitated with attendance of remote clinician
- I Ability to bring women back to clinic for a 'quick chat' or discussion of blood results

### Negative Feedback

- X Poor internet connectivity resulting in frozen screens or difficulty hearing - particularly difficult for one deaf woman who relied on lip-reading
- X Loss of non-verbal communication in virtual consultations
- X Having to wait to be contacted rather than a specific time being adhered to
- X Not enough administrative time and no robust system for pre-clinic vetting to take place

### CONCLUSIONS

Remote consultations were successfully introduced into our Consultant-led antenatal clinic, reducing unnecessary contact with a clinically-vulnerable patient population, reducing crowding in clinic waiting areas and enabling social distancing, whilst also improving the longstanding issue of long clinic waiting times. Such appointments have had significant benefits for service users. The main limitation is the lack of a robust and accurate automatic process for communicating appointment type to women. The current manual vetting system relies on individual consultant time. Further work is required to ensure sustainability and improvement of this process for the future. However, we have demonstrated significant benefits to utilizing telemedicine platforms in the antenatal clinic setting.

POSTER 17

# POSTER 18

## Developing a shared decision making tool for the treatment of heavy menstrual bleeding during the COVID-19 pandemic

Dr Thomas Mitchell, ST3, Queen's Hospital Romford  
Dr James M. N. Duffy, ST6, Queen's Hospital Romford

### Introduction

Developing a decision aid alongside the Cochrane overview presents a unique opportunity to bring together the best research evidence alongside a women's preferences, circumstances, and values.

### Methods

We co-produced the decision aid with women with lived experience of heavy menstrual and healthcare professionals using formal methods including a systematic review, knowledge prioritisation exercise, and iterative consensus.

### Results

Using formal methods a decision aid to inform shared decision making regarding the treatment of heavy menstrual bleeding treatments during the COVID-19 pandemic was developed.

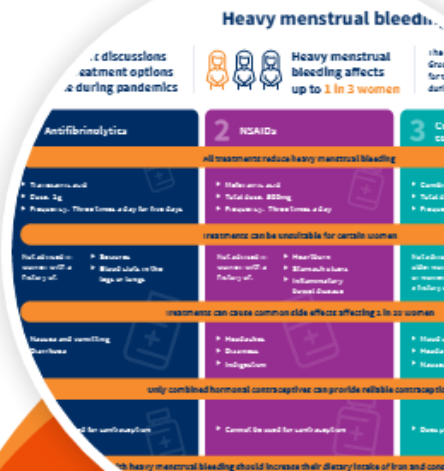
### Discussion

We anticipate the decision aid will support shared decision making. It is important women experiencing heavy menstrual bleeding are able to understand the range of possible treatments available, their risks and benefits, and be afforded the opportunity to consider these decisions within their own context and circumstances.

To continue the conversation,  
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# Pride and Prejudice – Compassion and Inequality in today's NHS

12th Annual Conference  
London School of Obstetrics and Gynaecology

Covid comments/ reflections



## A POEM for health workers during COVID

### The gatekeeper

**You can't come in.  
To be beside her.  
I can see your anguish  
Your anger too  
As we lead her away  
But you can't come in**

**You can't come in  
She is tired  
She juggles the newborn  
She needs more hands  
Hands she loves  
But you can't come in**

**You can't come in  
I know, with you there  
she'd be less frightened  
The pain lessened  
The journey shared  
But you can't come in**

**You can't come in  
To hold her hand  
To shoulder the shock waves  
Of the bomb of diagnosis  
We dropped at her feet  
But you can't come in**

**You can't come in  
She was calm when  
She senses your presence  
Does she remember  
you haven't come?  
But you can't come in**

**You can't come in  
To help me care for her  
You are her family,  
Her loved ones  
Her friends  
But you can't come in**

**I will go in  
Carer, healer, confidant  
Bearer of bad news  
Bringer of relief  
Now I am the gatekeeper  
too  
You can't come in**

**This last year made me question everything.**

**We've really missed out on the social element of training with COVID. I miss our South London dinners and catch ups. A chance to vent with friends from other hospitals who we miss! Hopefully we can start again in the Summer!**

**There is no doubt that 2020 brought huge challenges to our lives and made training and family life very difficult but it also made us work together, collaborating in an spectacular way to look after our patients, keeping them safe. Well done everyone!**

**There was limited support or guidance for Trainees returning to work after a severe covid infection and for those still experiencing symptoms of long covid**

**During the new Covid-times, I have found working and training to be a blessing. Compared to many others, I have a obvious daily purpose, a social job and a role in the "fight" with Covid. Lucky to be with good teams in the last year!**

**I've learnt to prioritise my mental well-being and the pandemic has opened up the dialogue for us as trainees to be able to speak out on our mental health. I'm thankful that I have a job despite the increasing amount of job losses in other sectors**

**Last year I found myself on a COVID rota which had me doing exclusively 12 hour shifts moving form days to nights with not enough recovery time in between. My sleep cycle totally disorientated, working 6 out of 9 weekends and not seeing my partner. I never contracted COVID however the covid working conditions broke me.**

**Although this has been probably, THE most testing time of our careers so far...I am amazed and proud of my colleagues; how they have embraced change and the unknown. I feel that we have grown stronger as a team. I am immensely proud to be part of it.**

**My memories of the Covid pandemic will always be the comradery at CUH, being part of the most amazing team - the Pan-gemic Matrix and debriefing daily with wonderful colleagues. A wonderful friend (and colleague) took it upon herself to plan a matrix of staffing for our department, a covid rota with a difference. Personalised mugs, jewel encrusted lanyards to represent your team, reg room treats, Costa coffee runs daily - all these little extras made our work-life a bit more fun. At the start we were apprehensive and worried. The friendship, teamwork, care for each other when we all inevitably became Covid-positive and daily laughs/debriefs/WhatsApp memes made it a fairly 'enjoyable' time (if one can call working in a pandemic enjoyable!). I ended up feeling grateful to get out of the house every day, to be useful and to have these people as my support network. I wouldn't choose working in a pandemic again but I would choose working with these people everyday if I could!**

Covid-19, oh! I am sure that most of us have been on the treating side of the problem. I have been on both sides, a doctor and a patient.

I was the most senior person in my team at the peak of the second wave. Naturally, if only one doctor to see and evaluate a patient, should be the most senior one. Moreover, as a leader, you have a job to protect your team members as well. Hence, I was exposed to tens of Covid patients. Each time, I have viewed my Covid patient as the bullet that would penetrate my chest and pierce my heart and kill me especially me being one of the BAM community where mortality due to Covid was the highest. Saying that I have enjoyed being on the treating side, helping my patient, and keeping my juniors away from the danger zone. Up until the long waited bullet has found its way to my chest!

I was unwell during my last night as an on-call senior registrar but I kept pushing myself knowing that it would have been difficult to find a cover if I call sick during the festive days. I managed to finish my busy nights safely. The next morning, I dragged my remains to a Covid screening centre before going home. I slept the whole morning to wake up at night time with my body hot to touch. The thermometer read it as 38.2 C. I was not able to move a finger. The home lateral flow test, which I kept not believing that it can detect Covid, tested positive, strong positive two horizontal lines. My line was even darker than the control.

When I was able to collect my thought two hours later, I quickly started writing my will to distribute the few pounds that I have in my bank account and to disclose all my pins and passwords. That was the beginning of the most terrible illness period of my entire life up until now. In the early hours of the next day, I received the unwanted message, confirming a positive PCR and defining my prison sentence for me and my households.

The earlier messages of the track and trace let me feel as if I have committed a crime by catching Covid-19. They gradually got better and supportive.

We were not ready to be prisoned that time despite being expected and my wife has been so brilliant in availing all our kids' needs as well as mine.

The worst moment was when my son, who is in the vulnerable group because of his severe asthma caught the infection. I felt really guilty about being the carrier of the killer virus to his shelter.

The period was full of stories and I hope one day to be able to write all of them.

It took me a while to recover from Covid and up until now, I do not feel all of me is back. However, I insisted to have all my duties back soon after rejoining my work and that has helped in speeding my recovery, at least psychologically, as it gave me a reassurance that, I am still alive. By the way, I managed to change my pins and passwords just on time!

**Firstly, I would like to express my sincere condolences to families who lost their beloved ones and express my empathy to those who suffered hardship, e.g. lost their jobs, suffered from stress and depression.**

**At the beginning of the pandemic, I was like a warrior focussed on the evolving situation, channelling my energy to helping others around me. Only after several months, I realised three things were amiss: happiness, energy and excitement. I introspected and realised I needed to find a way to balance my work and personal wellbeing. I restarted exercising at home, spent more time "present" with my mother and my husband. My conclusion: important to take care of yourself to help others, and important to find the hidden good in a dire situation.**

**How very lucky we are to do a job that is needed and valued. The last year has demonstrated this more than ever and we should all feel proud of what we do.**

**I felt more valued as a doctor in general, there was more awareness of looking after each other's well being. Although it has affected our gynae training.**