GP Study Evening

Welcome and Introduction

Mandish Dhanjal
Clinical Director Maternity

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Agenda

17.50	MBRRACE-UK
17.55	Pre-pregnancy counselling/ Obstetric Medicine
18.00	Antenatal Services – an update
18.45	Dealing with complaints
18.55	Refreshments *(dinner)*
19:15	St Mary's services
19.25	Intrapartum care – an update
19.55	The postnatal period
20.20	Bereavement services - supporting pregnancy loss
20.30	Perinatal Mental Health
20.40	Tour of the Unit, Feedback on our care and services; Q&A
21.00	Close of meeting

Our sites

Imperial has maternity service on two sites:

- Queen Charlotte's and Chelsea Hospital
- St Mary's Hospital

Queen Charlotte's and Chelsea Hospital

Dating back to 1752, Queen Charlotte's is the oldest maternity hospital in the country

St Mary's Hospital

- Founded in 1845
- Alexander Fleming discovered penicillin in 1928

Maternity Hospitals

- Deliver approximately 9100 women per year
- Alongside midwifery-led birth centres
- Fetal medicine service
- Obstetric medicine service
- Prematurity service
- Perinatal mental health service
- Bereavement service
- Neonatal units: Level 3 QCCH; level 2 SMH
- Caseload model of midwifery care for vulnerable women
- Community based midwifery providing continuity of care to women in the antenatal and postnatal period
- Private care

Our recent achievements & awards

2014

- Level 3 Clinical Negligence Scheme for Trusts quality & safety standard
- Care Quality Commission rated maternity services as “Good”
- Caseloading Midwifery team awarded Royal College of Midwives team award
- Community lead Midwife won MAMA Midwife of the Year award

2015

- Consultant awarded Royal College of Obstetricians and Gynaecologists (RCOG) award for excellence in training

2016

- Perinatal mental health midwife awarded “Rising Star” Nursing Times award
- Professor Lesley Regan appointed President of RCOG
- Dr Felicity Plaat appointed as President of Obstetric Anaesthetists Association

2017

- Consultants highly commended for Obstetric training and Professional development by RCOG

Key statistics ICHNT

Metric	2016-17
Bookings	11,649
Maternities	9,134
Babies	9,332
Home births	0.7%
Midwifery led unit (birth centre)	17.0%
Labour Ward	82.3%
Stillbirths	54 (5.8/1000)
Maternal Deaths	1 (1/10,000)

Key statistics 2016-17

Metric	QCCH	SMH
Maternities	5694	3440
Normal vaginal delivery	59%	56%
Instrumental delivery	13.9%	13%
Caesarean section	27.1%	30.9%
Elective CS	13.4%	11.8%
Emergency CS	13.7%	19.1%
3rd/4th degree perineal tears	1.8%	1.9%
Postpartum haemorrhage >1.5 L	3.5%	2.5%
Hysterectomies	9 (0.16%)	0
Admission to ITU	17 (0.3%)	1 (0.03%)

Maternity referrals- not capped

- Self referral on-line
- Self referral through our maternity helpline
- Referral from the GP (ASAP)
- Information required from the GP:
  - Social history any known DV or mental health illness
  - Medical history
  - LMP

Trust values

- **Kind** – We are considerate and thoughtful, so you feel respected and included
- **Expert** – We draw on our diverse skills, knowledge and experience, so we provide the best possible care
- **Collaborative** – We actively seek others' views and ideas, so we achieve more together
- **Aspirational** – We are receptive and responsive to new thinking, so we never stop learning, discovering and improving

GP Study Evening

Miss Muna Noori BSc PhD MRCOG
Consultant Obstetrician
Head of Service for Maternity at QCCH

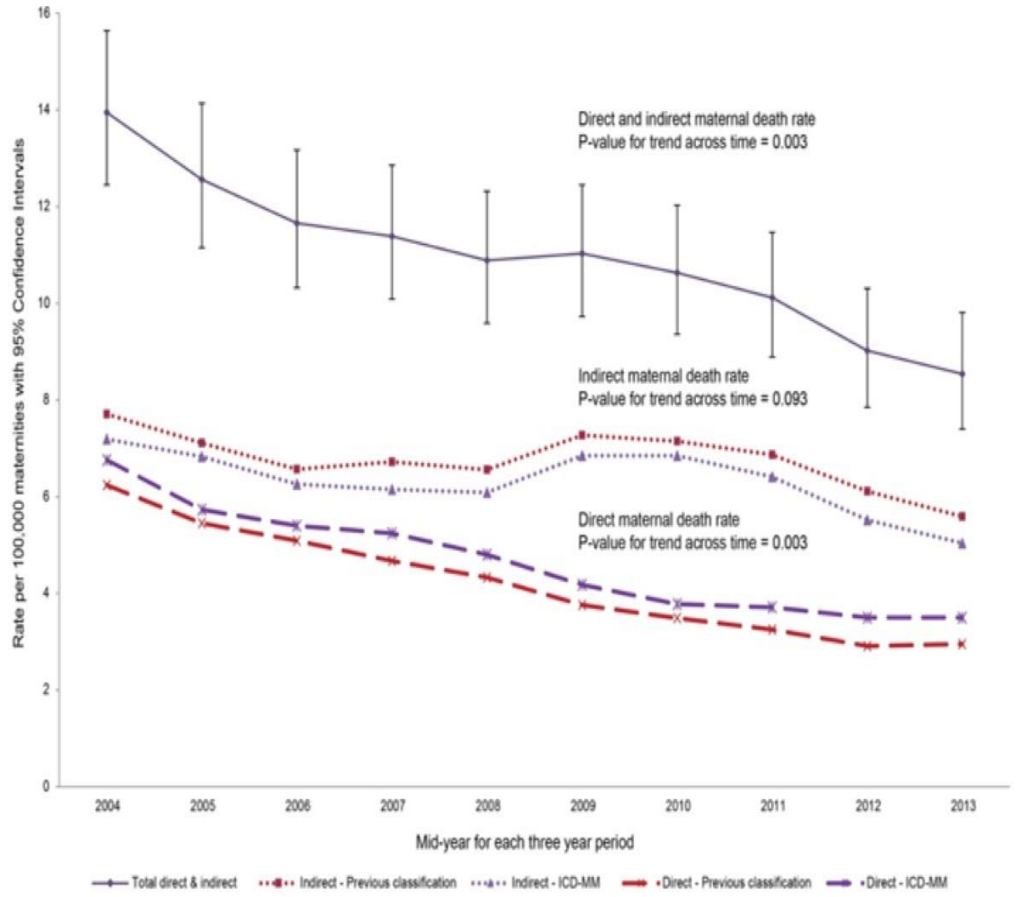
26th January 2018

m.noori@nhs.net

Kind **Aspirational** **Collaborative**
Expert

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Maternal mortality UK 2003-14



Direct deaths
A consequence of a disorder specific to pregnancy eg. haemorrhage, pre-eclampsia

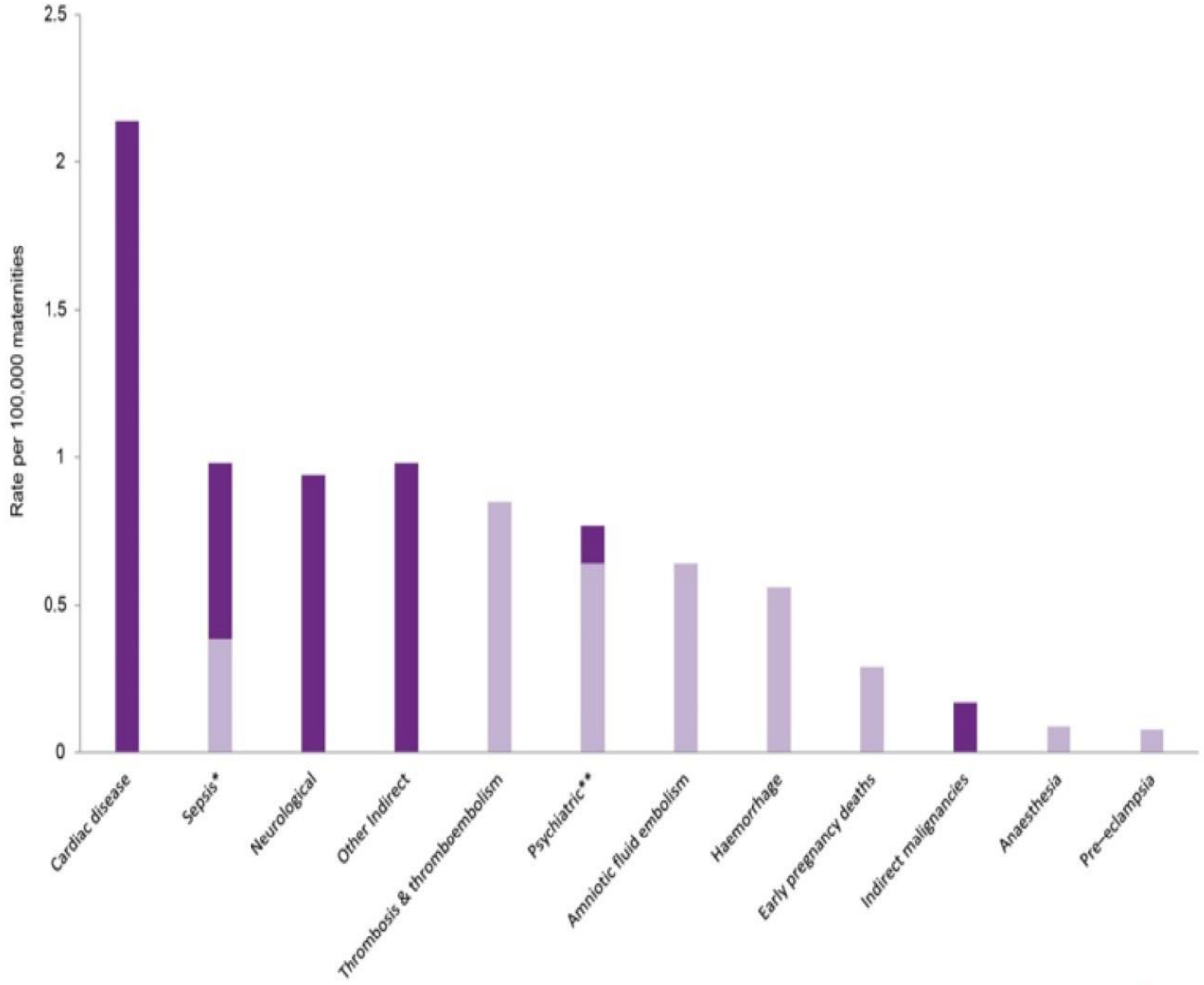
Indirect deaths
Due to pre-existing disease made worse by pregnancy eg. Cardiac, psychiatric, sepsis

Coincidental
Incidental / accidental eg. traffic accident

Late
After 42 days but within 1 year of end of pregnancy

MBRRACE-UK

Causes of maternal death 2012-14



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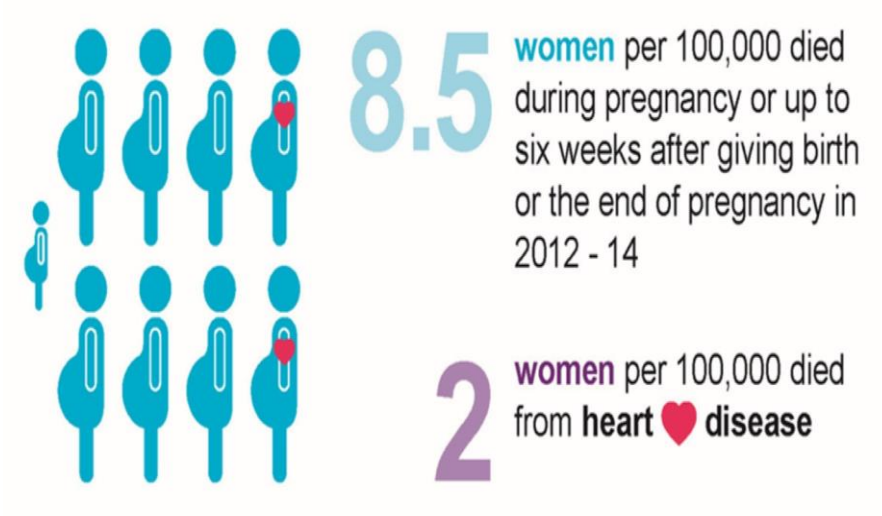
The women who died: UK 2012-2014



- **241** women died during pregnancy or up to 42 days postpartum
- **41** women's deaths were coincidental

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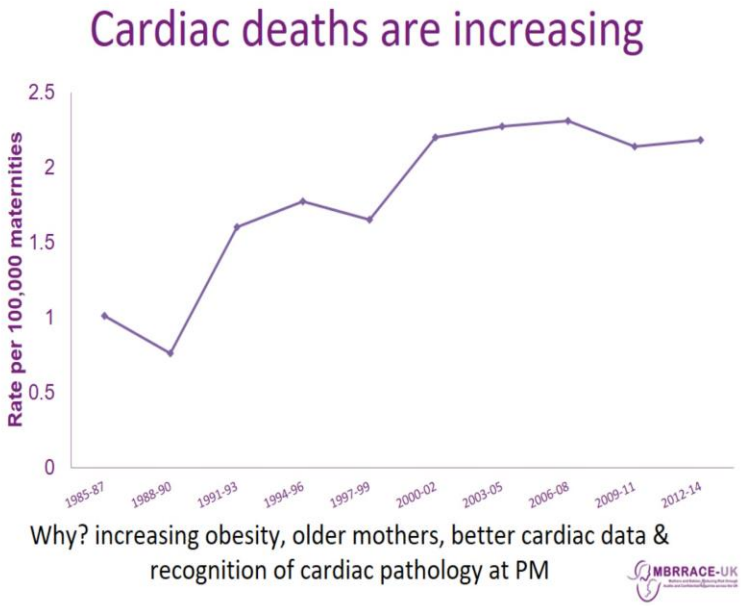
Cardiac deaths – risk factors identified

- 75% had pre-existing medical problem
- 50% were overweight or obese
- 36% were ≥ 35 years old
- 28% were from the most socially depri quintile
- 26% smoked (compared with 11% of pregnan population)
- 7% of women had congenital heart disease



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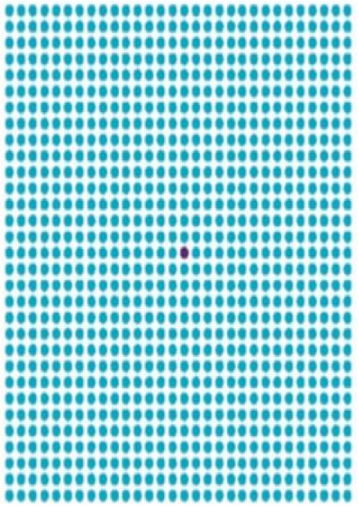
Direct Maternal Deaths 2012-14

- Thrombosis and thromboembolism the leading direct cause of death
  - 0.85 per 100,000 maternities
- Good care makes a difference

Less than **1 woman in every million** who gives birth now dies from **pre-eclampsia**



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Reducing morbidity and mortality in pregnancy

Pre-pregnancy counselling (PPC) clinic

Women with pre-existing medical conditions should receive pre-pregnancy counselling:

- to ensure they understand the implications of their condition on their pregnancy and vice versa
- to enable them to optimise their health prior to conception
- women with cardiac risk factors (advanced age, raised BMI, hypertension) should have PPC before ART or fertility treatment

Consultant Obstetrician
Miss Muna Noori

Specialist midwives
Catherine Baker
Helene Theophanous

Pre-eclampsia prophylaxis

NICE Guidelines

Advise women with one high risk factor or more than one moderate risk factor to take aspirin 75mg from 12 weeks until birth

High risk factors

- Hypertensive disease during a previous pregnancy
- Chronic kidney disease
- Auto immune disease
- Diabetes
- Chronic hypertension

Moderate risk factors

- First pregnancy
- Age 40 years or older
- BMI >35
- Pregnancy interval of >10 years
- Family history of PET
- Multiple pregnancy

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Assessing the need for thromboprophylaxis in pregnancy

Antenatal assessment and management (to be assessed at booking and repeated if admitted)

Any previous VTE except a single event related to major surgery	**HIGH RISK** Requires antenatal prophylaxis with LMWH Refer to trust-nominated thrombosis in pregnancy expert/team
Hospital admission Single previous VTE related to major surgery High-risk thrombophilia + no VTE Medical comorbidities e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy, nephrotic syndrome, type I DM with nephropathy, sickle cell disease, current IVDU Any surgical procedure e.g. appendicectomy OHSS (first trimester only)	**INTERMEDIATE RISK** Consider antenatal prophylaxis with LMWH
Obesity (BMI > 30 kg/m²) Age >35 Parity ≥ 3 Smoker Gross varicose veins Current pre-eclampsia Immobility, e.g. paraplegia, PGP Family history of unprovoked or estrogen-provoked VTE in first-degree relative Low-risk thrombophilia Multiple pregnancy IVF/ART	**Four or more risk factors:** prophylaxis from first trimester **Three risk factors:** prophylaxis from 28 weeks **Zero to two risk factors:** prophylaxis if admitted to hospital
Transient risk factors: Dehydration/hyperemesis; current systemic infection; long-distance travel	**LOWER RISK** Mobilisation and avoidance of dehydration

RCOG Green-top Guideline No.37a, April 2015

Key messages from the Confidential Enquiry

- ***"Get as healthy as possible"*** before pregnancy. Take the right medications for your condition and do not stop taking them without consulting your doctor.
- ***"Right care, right place, right people"*** Pre-pregnancy counselling, specialist services if required
- ***" Speak up for safety"*** Access to senior midwife or Consultant if you are worried about your care or if you feel unsafe.

- Women with risk factors for pre-eclampsia or who have pre-eclampsia need to have a appropriate schedule of care planned
- Keep BP <150/100 or <140/85 if pre-existing hypertension /CKD etc.

- A raised respiratory rate, persistent tachycardia and orthopnoea are important and must

  be investigated
- Emphasis should be on making a diagnosis rather than excluding a diagnosis

Lessons from the Confidential Enquiry

Case 1

An obese woman had an emergency Caesarean section for pre-eclampsia.

She was prescribed the correct dose of LMWH.

She attended the Emergency Department twice with pleuritic chest pain.

Chest X ray (CXR) was normal

Low suspicion of PE as already on LMWH

She died a few weeks later of a PE

Case 2

A woman with a previous VTE and thrombophilia on long term warfarin was changed to LMWH in early pregnancy

She went to see her Dr with buttock pain – no action taken
She went to the Emergency Department with chest pain.
Hypoxic but normal CXR

PE was not suspected as she was already on LMWH. She died of a PE.

Lesson

VTE can occur despite prophylactic or treatment doses of LMWH. Always assess and investigate for PE if having symptoms suggestive of PE.

A normal CXR does not exclude a PE

Case 3

Morbidly obese parous woman
Prescribed inadequate dose of LMWH during pregnancy
Underwent LSCS and given 2 weeks of LMWH from hospital and was due to get further 4 weeks from GP.
She contacted GP 4 times with leg pain before she was referred to hospital
She collapsed on her way to hospital.
Thrombolysed but died the following week

Case 4

A pregnant woman presented on five occasions within 2 weeks to different hospitals and her GP complaining of cough, dyspnoea and orthopnoea. She was tachycardic. She was prescribed multiple courses of antibiotics to which she failed to respond. No further investigations were done. Eventually a diagnosis of peripartum cardiomyopathy was made and she was delivered by LSCS. Despite insertion of a balloon pump, ECMO and attempted LVAD insertion, she died shortly after delivery.

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Case 5

Paramedics were called to a woman who was found ***collapsed at her home****.*
She was ***cold, clammy, pale*** *and shocked with* ***no cardiac output****.*
She was given ***CPR*** *and* ***transferred*** *to the* ***Emergency Department*** *after* ***two hours****, with a* ***presumed diagnosis of pulmonary embolism.***
Blood tests in the ***Emergency Department*** *found that she was* ***severely acidotic*** *and had a* ***haemoglobin of 6.9g/dl****.*

She was ***thrombolysed*** *for the* ***presumed diagnosis of pulmonary embolism****. A computerized tomography* ***(CT) scan after thrombolysis*** *ruled out a pulmonary embolism but found a large amount of* ***blood in the abdomen.*** *At subsequent surgery a ruptured bleeding ectopic pregnancy was discovered. She* ***died*** *the following day from* ***multi-organ failure.***

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Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Common Antenatal Presentations

Miss Muna Noori BSc PhD MRCOG

Consultant Obstetrician and

Sub-specialist in Maternal and Fetal Medicine

25th January 2018

Maternity Day Assessment Unit / Triage

Overview

- We assess and monitor pregnant women beyond **20 weeks** of pregnancy who are **booked at Imperial** with **urgent** or ongoing **pregnancy-related** problems.
- We accept telephone referrals from GPs, community midwives or the antenatal clinic.
- Referrals for postnatal women (up to 6 weeks following delivery) can be made through the GP or community midwife
- Women booked at Imperial are able to self-refer by contacting us via telephone

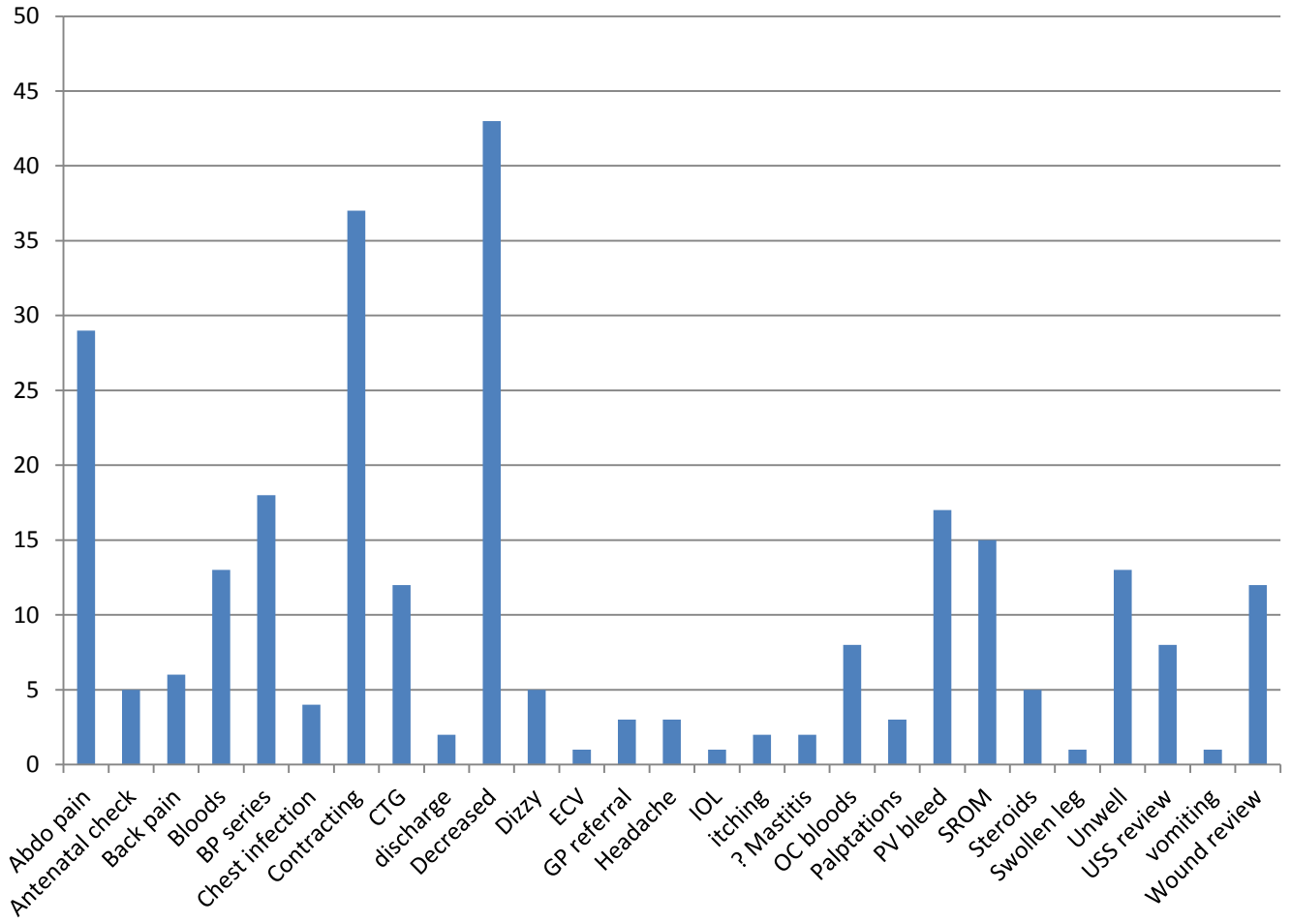
What we offer

- **Labour assessment**
- **Assessment and monitoring of pregnancy-related medical conditions**
- **Fetal wellbeing assessment** – heart rate monitoring using cardiotogography (CTG)
- **Fetal ultrasound** – to check fetal presentation from 36 weeks
- **External cephalic version (ECV)**

MDAU and Triage is NOT:

- **A walk-in centre** *(we need a verbal referral from your GP / Midwife/ or for you to have called us or the Maternity Helpline)*
- For problems **unrelated** to pregnancy – women should see their GP or attend the Urgent Care Centre (UCC) e.g. Hammersmith Hospital UCC or A&E at SMH)
- **For non-urgent pregnancy-related concerns –** women should make an appointment to see a midwife or named Consultant team in the Antenatal Clinic.

DAU/ Triage attendances



Over 7 days: 269 attendances

Average 38/day

Hypertension - definitions

Chronic hypertension	Hypertension present at booking or before 20 weeks or if the woman is already taking antihypertensive medication when referred to maternity services. It can be primary or secondary in aetiology
Gestational hypertension	New hypertension presenting after 20 weeks without significant proteinuria
Mild hypertension	Diastolic blood pressure 90–99 mmHg; systolic blood pressure 140–149 mmHg
Moderate hypertension	Diastolic blood pressure 100–109 mmHg; systolic blood pressure 150–159 mmHg
Severe hypertension	Diastolic blood pressure 110 mmHg or greater; systolic blood pressure 160 mmHg or greater
Pre-eclampsia	New hypertension presenting after 20 weeks with significant proteinuria.
Severe pre-eclampsia	Pre-eclampsia with severe hypertension and/or with symptoms, and/or biochemical and/or haematological impairment
Significant proteinuria	Greater than 300mg/24 hours or >30mg/mmol

Pre-eclampsia: definition (ACOG Committee opinion, 2002)

New onset hypertension (>140/90) after 20 weeks

New onset proteinuria

> 1+ proteinuria on urine dipstick

>300mg/24 hours - 24° urine collection

Spot protein: creatinine ratio >30mg/mmol (in absence of UTI)

Biochemical abnormalities

Low platelets, deranged LFTs, deranged renal function, coagulopathy

Exceptions?

IF CONCERN REGARDING PRE-ECLAMPSIA, BP >150/100, OR SYMPTOMATIC OF PET, PLEASE REFER URGENTLY TO DAU/ TRIAGE

Pre-eclampsia – management of hypertension

Aim to keep BP <150/100 or <140/85 if evidence of end-organ disease (chronic hypertension, CKD etc)

Drug treatment options

Prophylaxis:

Low dose Aspirin; Calcium /Vitamin D

If high risk of Vitamin D deficiency, should check blood level and prescribe high dose replacement if necessary (eg. 20,000 IU cholecalciferol weekly for 4-8 weeks)

Antenatally:

- **Labetalol, Nifedipine (MR preparations), Amlodipine, Methyldopa, Doxazocin, Hydralazine (IV)**
- If patient is on ACEI or ARB prior to pregnancy, consider switching to one of the above agents pre-pregnancy or at positive pregnancy test at the latest

Postpartum:

- **Atenolol; Amlodipine, Nifedipine, Enalapril**
- Aim for once daily dosing if possible to facilitate compliance

Intrahepatic Cholestasis of Pregnancy (ICP) / Obstetric Cholestasis (OC)

CLINICAL MANIFESTATIONS

- Pruritis in **absence** of skin rash
- Palmar & solar
- Generalised itch
- Excoriations
- Dark urine
- Steatorrhoea
- Jaundice
- Onset at any gestation (usually in 3rd trimester)

CONSEQUENCES

Preterm birth

Meconium-stained liquor

Fetal distress

Stillbirth – clusters around 38 weeks

Diagnosis of Exclusion

Need to rule out:

- Autoimmune hepatitis
- Hepatitis B & C, CMV
- Gallstone disease
- ?PET
- ?AFLP

Biochemical changes

Deranged liver function – ALT, AST, γGT, **Bile acids**

PLEASE REFER TO DAU/TRIAGE

ICP Treatment options

- Ursodeoxycholic acid (URSO)
- Rifampicin
- Aqueous cream with 2% menthol
- Piriton rarely helpful (other than with sleep)
- Vitamin K

When do we deliver?

Insufficient evidence to support or refute the popular practice of early induction and the widespread use of ursodeoxycholic acid (UDCA) in the management of ICP

Gurung V, Williamson C, Chappell L, et al. Pilot study for a trial of ursodeoxycholic acid and/or early delivery for obstetric cholestasis. BMC Pregnancy and Childbirth 2009; 9:19.

UK survey demonstrated that 88% of obstetricians and midwives actively manage pregnancies with intrahepatic cholestasis of pregnancy (ICP) by offering induction at 37–38 weeks and prescribing UDCA for the amelioration of maternal pruritus

Saleh MM, Abdo KR. Consensus on the management of obstetric cholestasis: National UK survey. BJOG 2007; 114:99–103.

Reduced Fetal Movements (RFM)

Reducing stillbirth is a priority for the NHS

- Reducing stillbirth is a Mandate objective from the government to NHS England
- Better Births (February 2016) identified the 'Saving Babies Lives' care bundle as good practice in reducing stillbirths:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

- If patient is concerned regarding fetal movements >20 weeks, please refer woman to Triage for assessment (Sonicaid, CTG, USS)

- If RFM associated with abdominal pain and bleeding, consider calling an ambulance

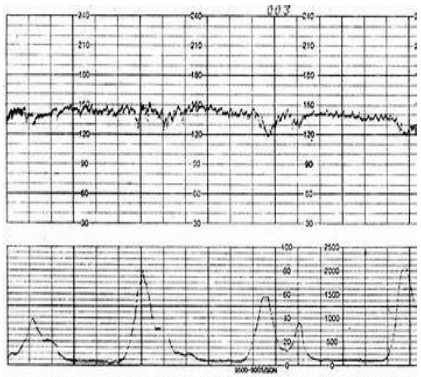
Saving babies' lives – Care bundle (element 3)

Reduced fetal movements

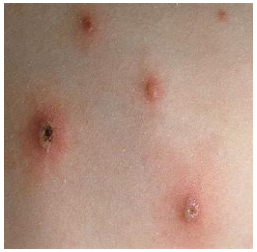
- Aspiration
  - Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage RFM
- Interventions
  - Information and advice leaflet on reduced fetal movement (RFM), based on current evidence, best practice and clinical guidelines, to be provided to all pregnant women by, at the latest, the 24th week of pregnancy and RFM discussed at every subsequent contact
  - Use provided checklist to manage care of pregnant women who report reduced fetal movement, in line with RCOG Green-top Guideline 57

NHS England "High quality care for all, now and for future generations."

THE NHS CONSTITUTION
the NHS belongs to us all



Infections

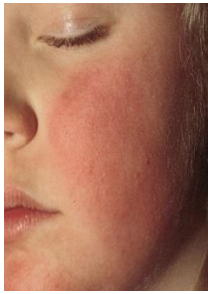


Diarrhoea and vomiting

- Usually self-limiting and resolves with conservative measures
- Please refer if persistent vomiting, unable to tolerate oral fluids, or at risk of ketoacidosis (diabetics)

Varicella zoster exposure or infection

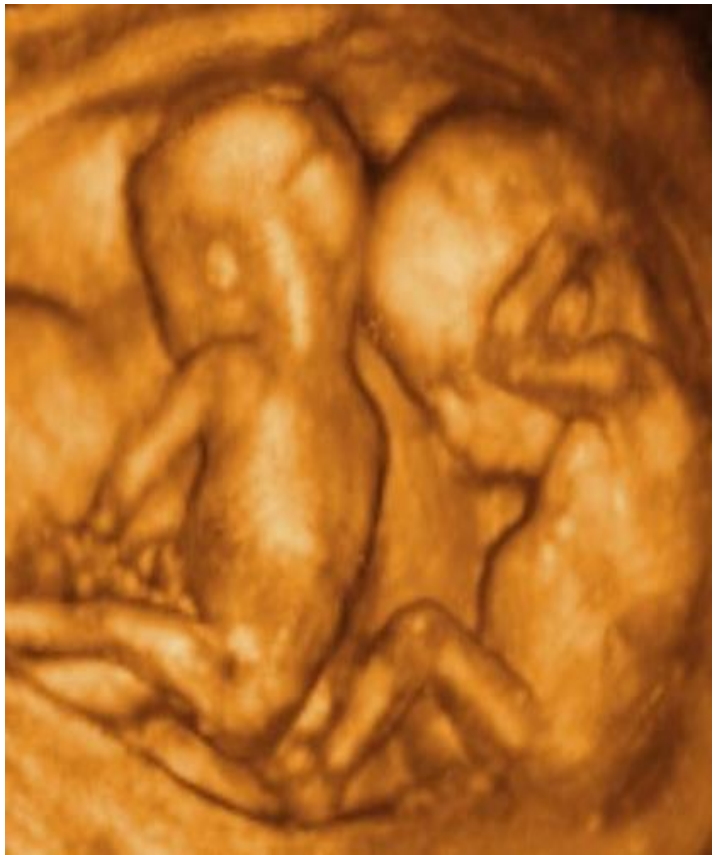
- Should ideally not attend maternity due to risk to other non-immune pregnant women
- If woman is unsure if previous VZV infection, we can arrange testing of booking viral blood sample without woman attending. Please contact on-call SpR via switchboard
- If non-immune and requires VZIG, please liaise with on-call SpR to arrange suitable place for us to administer VZIG (usually in UCC / A&E but needs prior agreement)
- If woman infected with VZV, please refer ONLY if acutely unwell and at risk of pneumonitis etc.



Parvovirus exposure or infection

- Should ideally not attend maternity due to risk to other non-immune pregnant women
- We can arrange testing of booking viral blood sample for parvovirus without woman attending. Please

  contact on-call O&G SpR via switchboard to arrange
- If non-immune (IgG and IgM negative), would need serial parvovirus serology testing to determine if IgM subsequently becomes positive. Please liaise with on-call O&G SpR via switchboard
- If antenatal parvovirus infection confirmed, will require fetal medicine surveillance scans to identify signs of fetal anaemia / hydrops.



Early Pregnancy & Acute Gynaecology Unit (EPAU)

Queen Charlotte's & Chelsea Hospital
Imperial College Healthcare NHS Trust

Miss Christine Ekechi

Consultant Gynaecologist

EPAU

What is the rationale for Early Pregnancy Units?

- Maternal mortality rate from ectopic pregnancies is estimated at 0.2 per 1000
  - 2009 – 2014 9 women died directly from an ectopic pregnancy. 3 died from complications following attempts to terminate a pregnancy
- Murray, Baakdah et al (2005) found the prevalence of ectopic pregnancy was 6–16% among women who attend an Emergency Department with first trimester bleeding or pain or both
- Many more women (22) died from thrombosis or thromboembolisim
- 58% of early pregnancy deaths – “improvements in care may have made a difference to the outcome.”
- National Confidential Enquiry into Patient Outcome and Death (2007) suggests that prompt clinical assessment in a dedicated emergency assessment unit:

1. Improve patient outcomes – morbidity and mortality
2. Improve patient satisfaction
3. Reduce Emergency Department workload
4. Reduce hospital length of stay

Early Pregnancy & Acute Gynaecology Unit - QCCH

- Imperial College Healthcare NHS Trust: Queen Charlotte's Hospital (EPAU) and St Mary's Hospital, Paddington (GER)

  - Open Monday - Friday 09:00 – 16:30
  - Daily Consultant cover
  - Approximately 4500 cases per year
  - In patient beds on Gynaecology Wards at St Marys and Queen Charlotte's Hospitals

Multidisciplinary Team

Miss Catriona Stalder
Lead Consultant
Rapid Access Clinic Lead

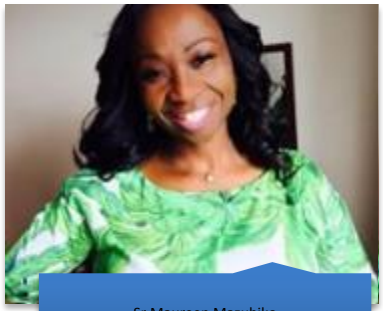
Miss Christine Ekechi
Consultant
Lead for USS Training

Professor Tom Bourne
Consultant
Research Professor
Ovarian Cyst Clinic

Miss Veronica Djapardy
Consultant

Miss Shyamaly Sur
Consultant

Sr Maeve Tuomey
Lead Scanning Sister



Sr Maureen Mazubiko
Scanning Sister

Renata Dziubinska
Scanning Nurse

Mr Joseph Yazbeck
Consultant
Rapid Access Clinic Lead
Ovarian Cyst Clinic

Clinical Research Fellows

Facilities

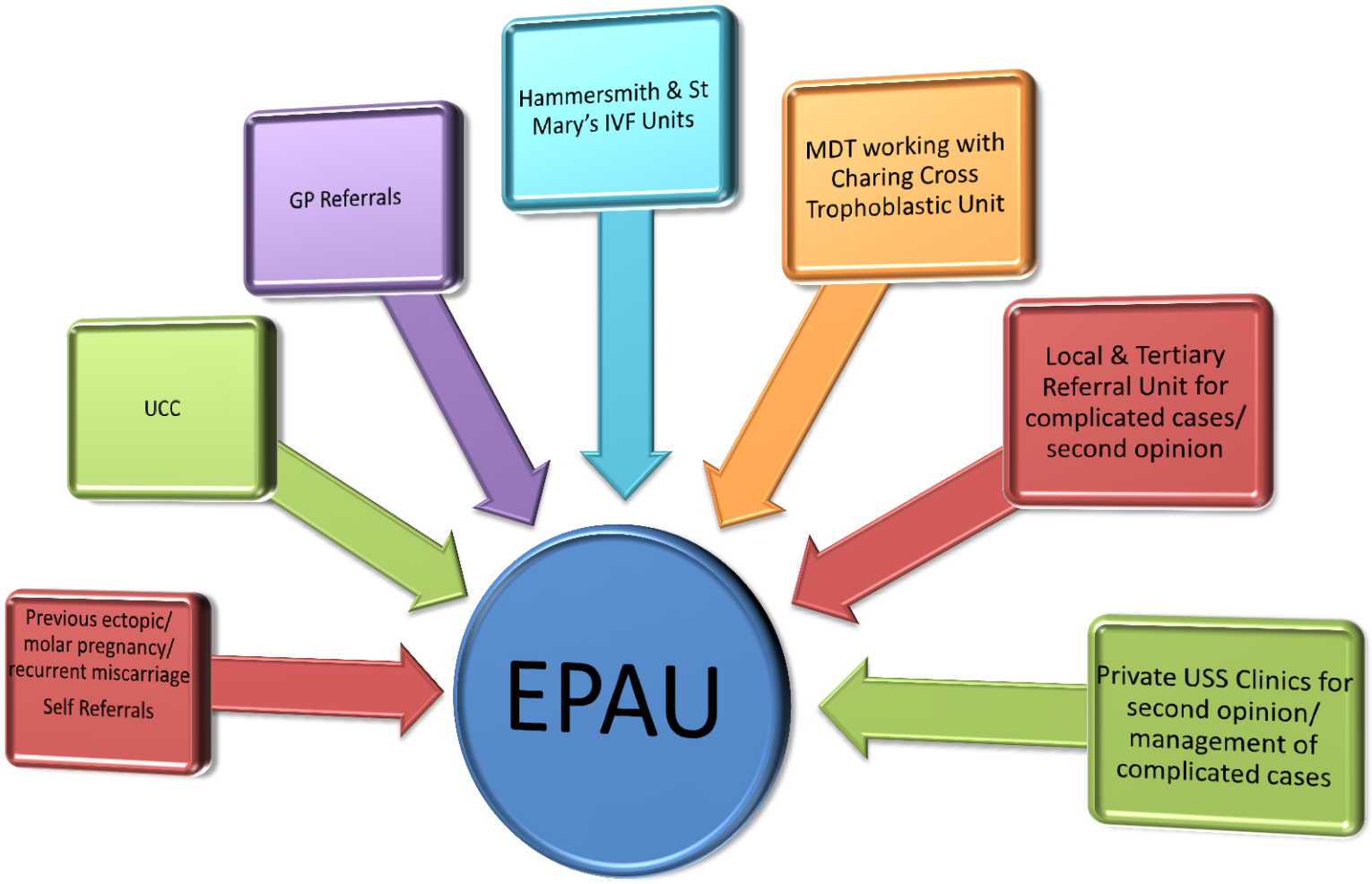
Comfortable waiting room

Up to date scanning facilities

Private counseling room

Research Space/ Meeting Rooms

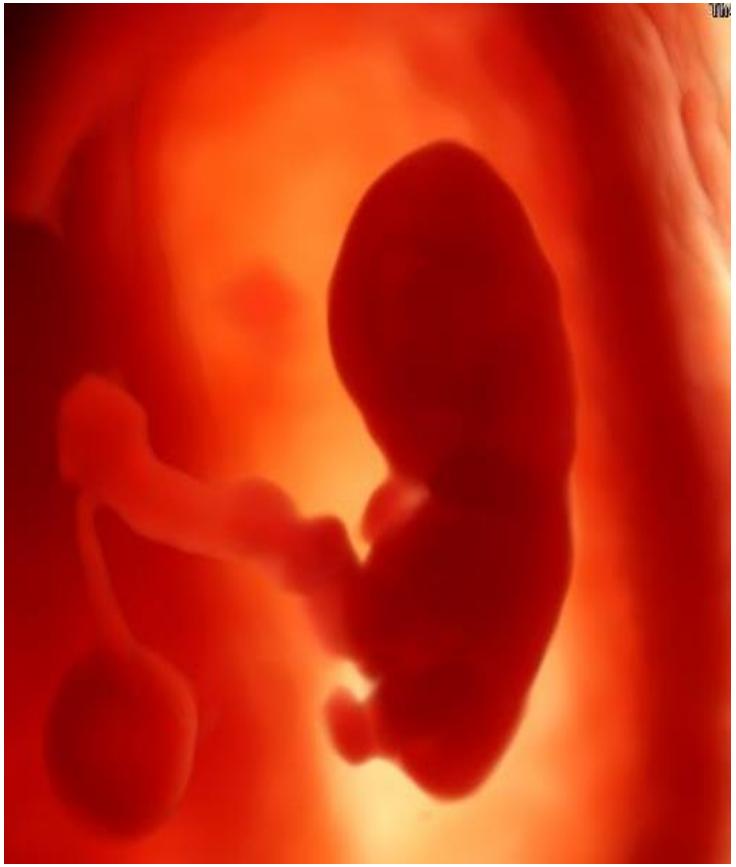
Referral pathways



Important to establish and maintain strong community links with GPs and other community services

Services

Early Pregnancy Ultrasound



Assess women with pain +/- bleeding with a positive pregnancy test

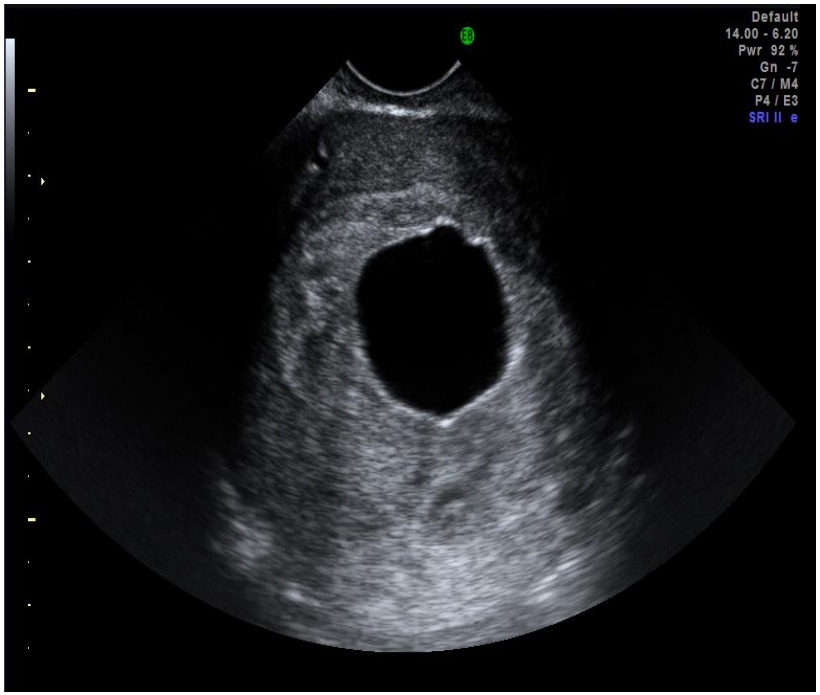
Confirm viable pregnancy/ies

Diagnose ectopic pregnancy

Diagnose miscarriage

Services

Management of Miscarriage



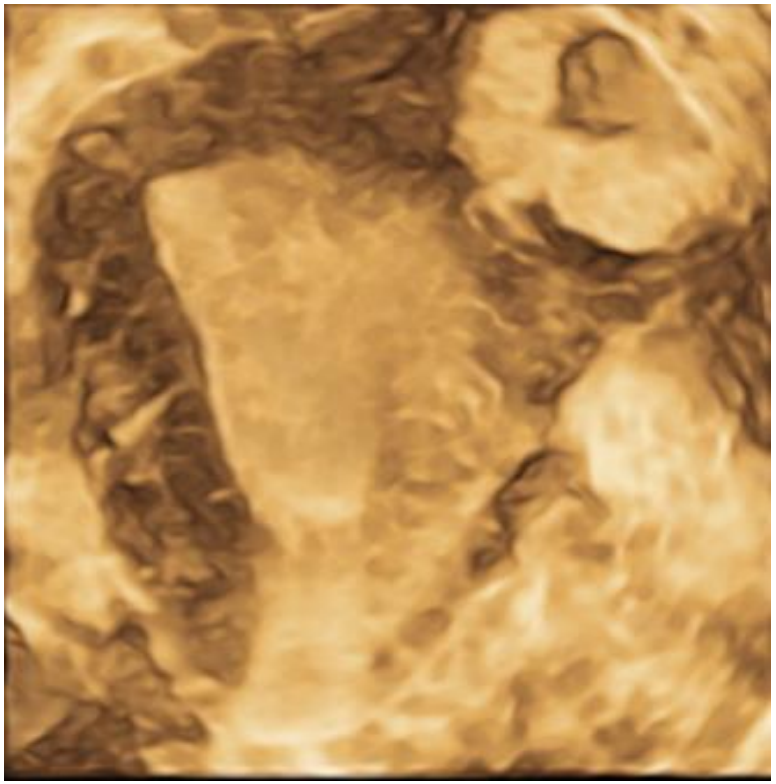
Conservative management of miscarriage

Medical management of miscarriage

Surgical management of miscarriage (Evacuation of Retained Products of Conception (ERPC))

Manual Vacuum Aspiration (MVA)

Services



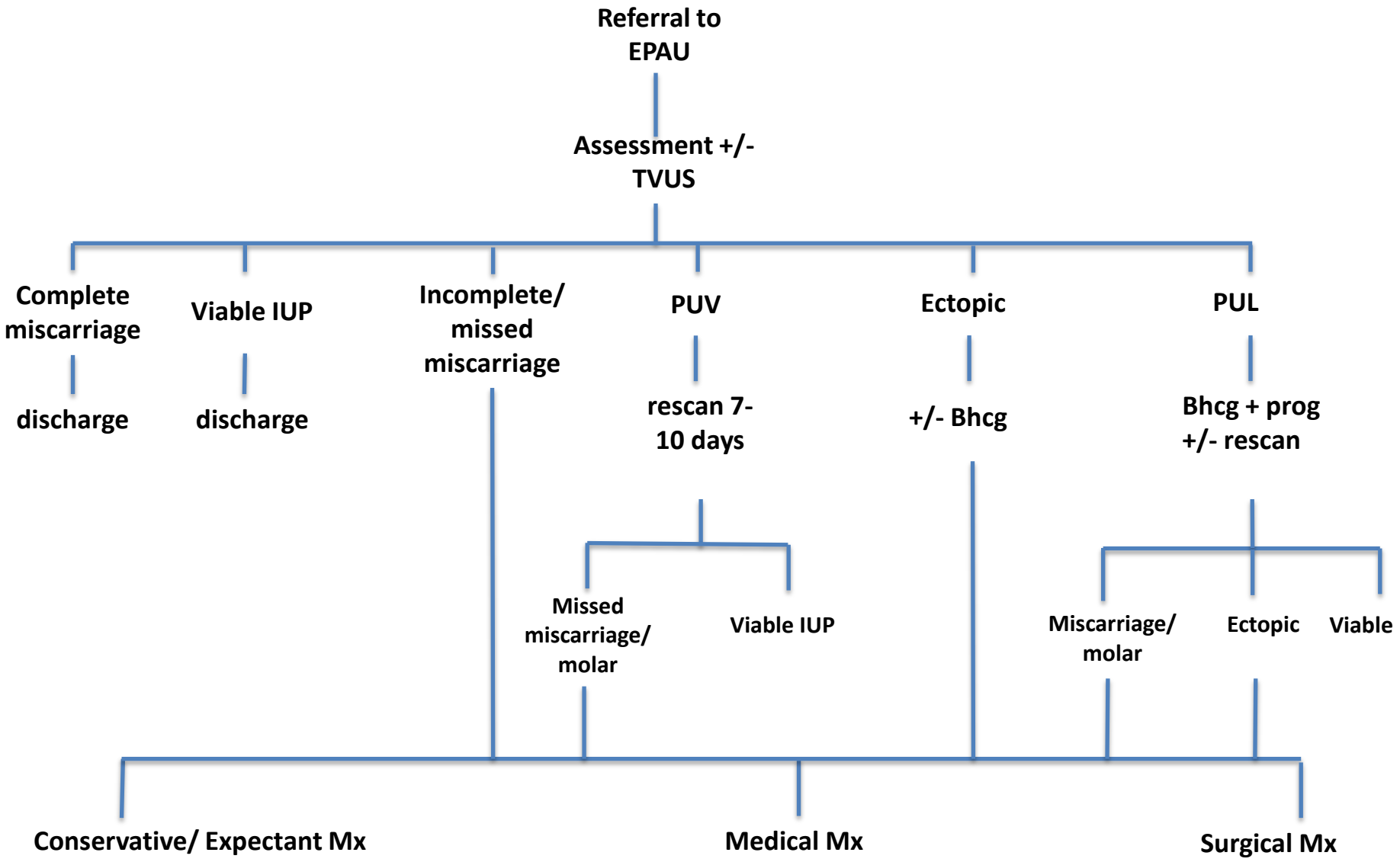
Conservative management of ectopic pregnancy

Medical management of ectopic pregnancy with methotrexate

Surgical management of ectopic pregnancy

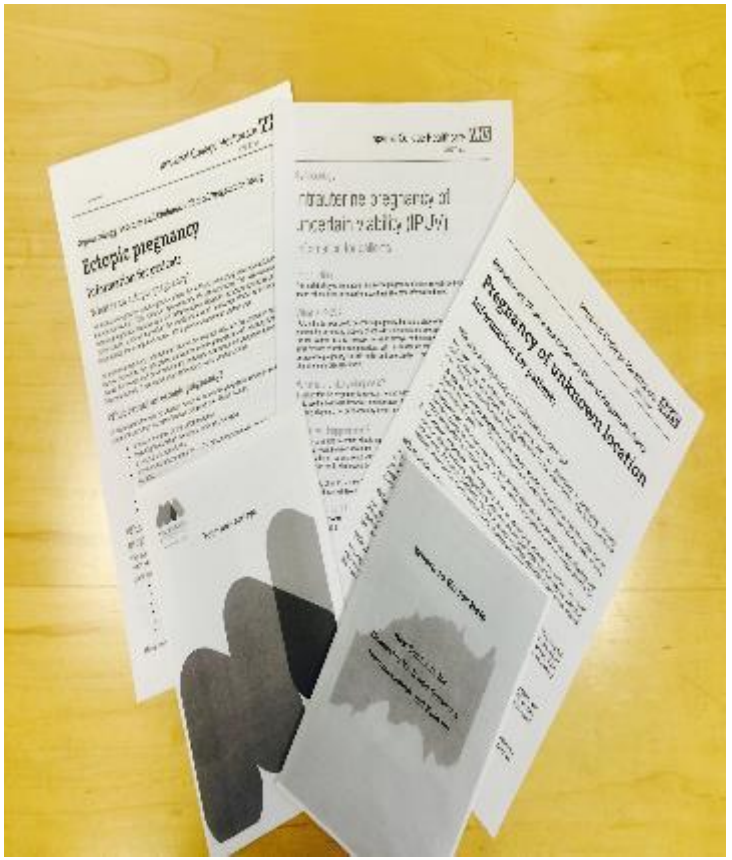
- Salpingotomy
- Salpingectomy

Management Algorithms



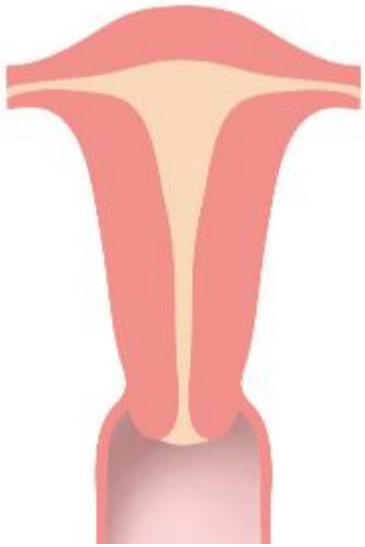
Services


Pregnancy Loss
Support
Group
Have you recently suffered a pregnancy loss?
Would you like to talk to others who have also experienced miscarriage and can relate to what you're going through?
The Early Pregnancy Unit at Queen Charlotte's & Chelsea Hospital is now holding a support group for women and their partners who may wish to talk and connect with others with similar experiences. This group is facilitated by Flora Saxby, a trained psychotherapist and specialist gynaecology and early pregnancy nurse, along with others from the EPAU team.
The support group will meet on the following dates: 7PM to 9PM
Thursday 14/12/2017
Thursday 18/01/2018
Thursday 08/02/2018
Thursday 15/03/2018
Thursday 12/04/2018
Thursday 10/05/2018
The Duke of Sussex Room
2nd Floor, Queen Charlotte's & Chelsea Hospital
Du Cane Road, London W12 0HS
If you are interested in attending our group and wish to book your place and/or require further information, please contact us by email.
Email: miscarriagegroupqcch@gmail.com
We apologise that in order to be sensitive to the group, we are unable to accommodate children.


Ectopic pregnancy
Pregnancy of unknown location

Services

Gynaecology Assessment

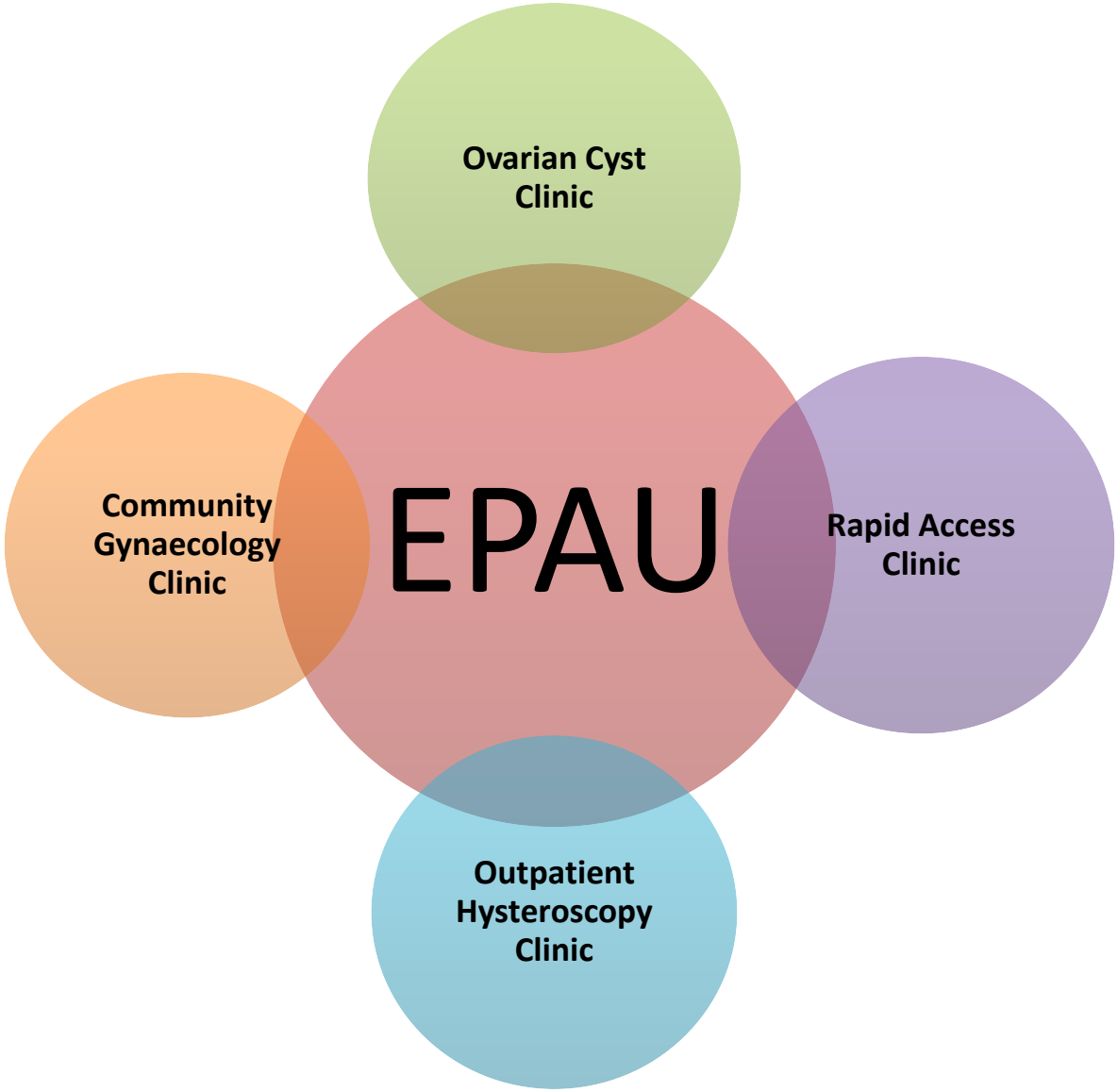


Assess women with pain +/- bleeding with a negative pregnancy test

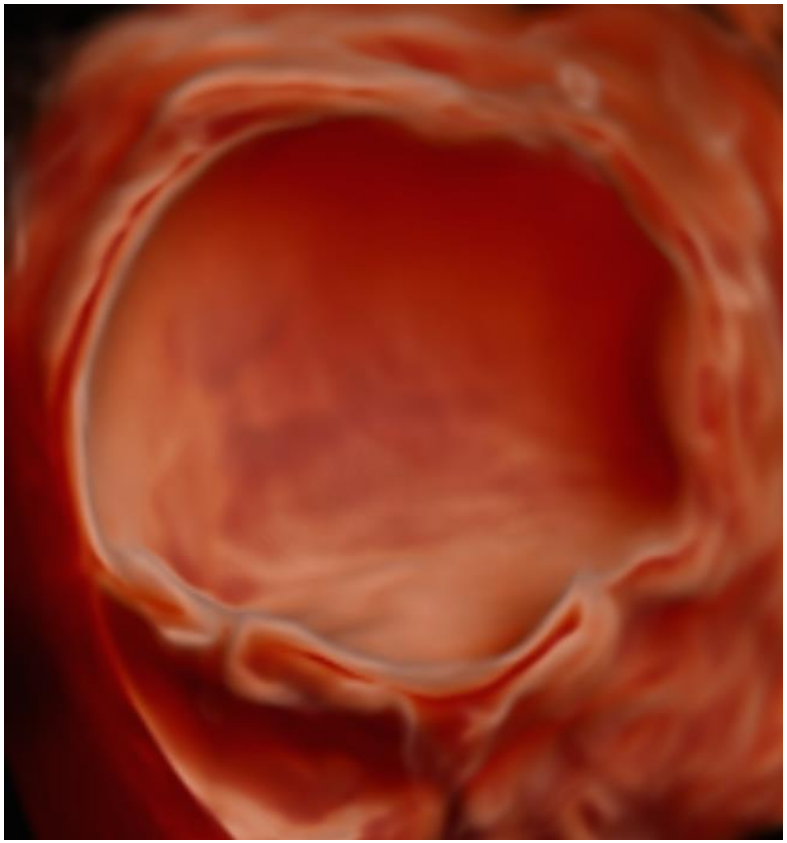
Assessment and treatment of bartholins cysts/ labial abscesses

Inpatient management of PID/ pelvic abscesses

Adjunct Services



Ovarian Cyst Clinic



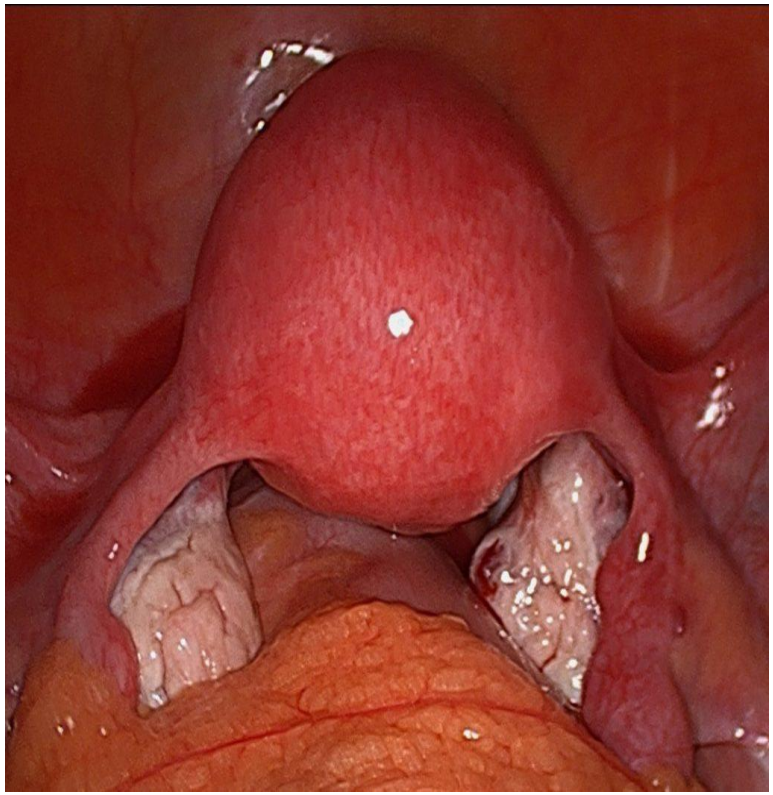
Lead by Professor Tom Bourne & Mr Joseph Yazbek - Gynaeoncologist

Wednesday AM. Friday AM.

Ultrasound assessment of pelvic masses.

Referrals to GOPD – Ovarian Cyst Clinic

Rapid Access Clinic



Lead by Mr Joseph Yazbek – Gynaeoncologist and Miss Catriona Stalder

Tuesday. Thursday PM

2WW referrals. PMB. Abnormal pelvic masses. Abnormal bleeding
? cancer

Clinical and ultrasound assessments

Referrals to GOPD

Outpatient Hysteroscopy Clinic

Lead by Miss Christine Ekechi

4 clinics per week. 3 Consultant outpatient hysteroscopists. 1 nurse hysteroscopist

Diagnostic & therapeutic procedures

Well tolerated by patients with excellent patient feedback

Referrals to GOPD

Community Gynaecology Clinic

Lead by Miss Catriona Stalder

Parkview Medical Centre

Friday AM

Research Unit

Lead by Prof Tom Bourne

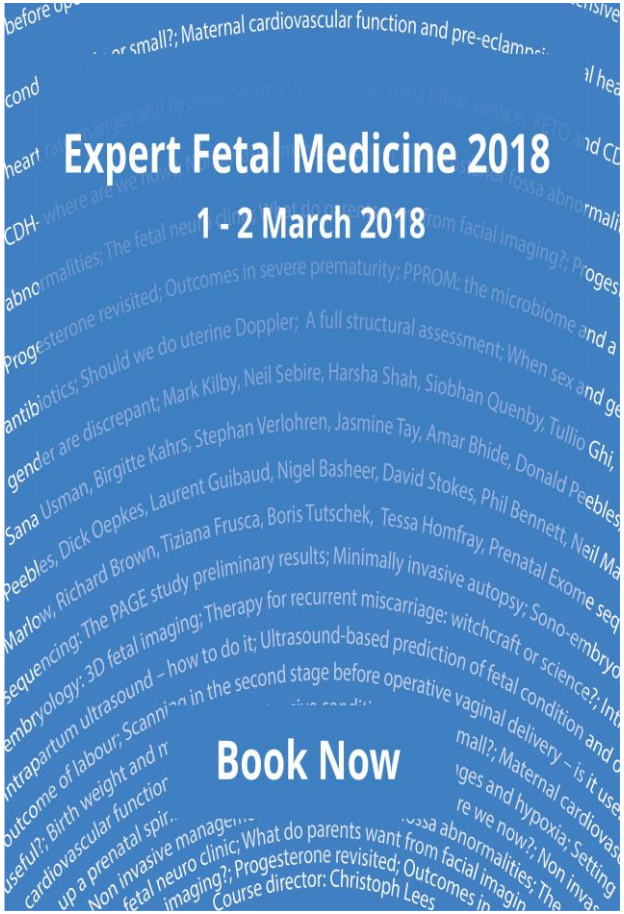
Tommy's National Centre for Miscarriage

4 Clinical Research Fellows & 3 Research Nurses

Associated with KU Leuven, Belgium, The Centre for Fetal Care (CFC) and the Institute for Reproductive and Developmental Biology (IRDB) Hammersmith

EPOS, PRECISE

Education



Study evenings for clinicians and GPs in early pregnancy & fetal medicine

USS training for trainees

Contact Us

Tel: 0203 313 5131

Fax/ Email: 0203 313 5115

Quality Improvement – Induction of Labour

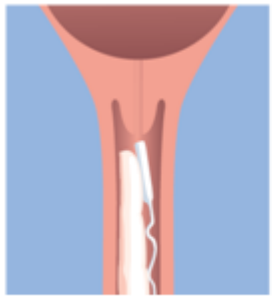


Figure a.

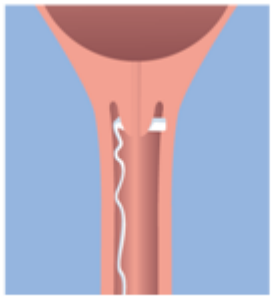
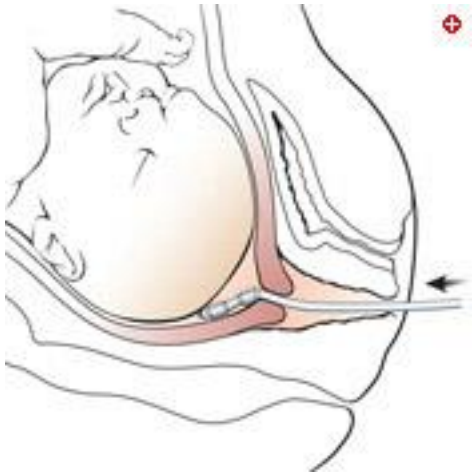


Figure b.

Figure c.



	Median
Baseline (Nov '16- Feb '17)	1d 19h 5min
Propess/Prostin (Feb '17-Jul '17) 172 women	1d 5h 50min
Mysodelle (Jul '17 – Nov '17) 207 women	22h 06min

https://www.imperial.nhs.uk/our-services/maternity-and-obstetrics/labour-and-birth

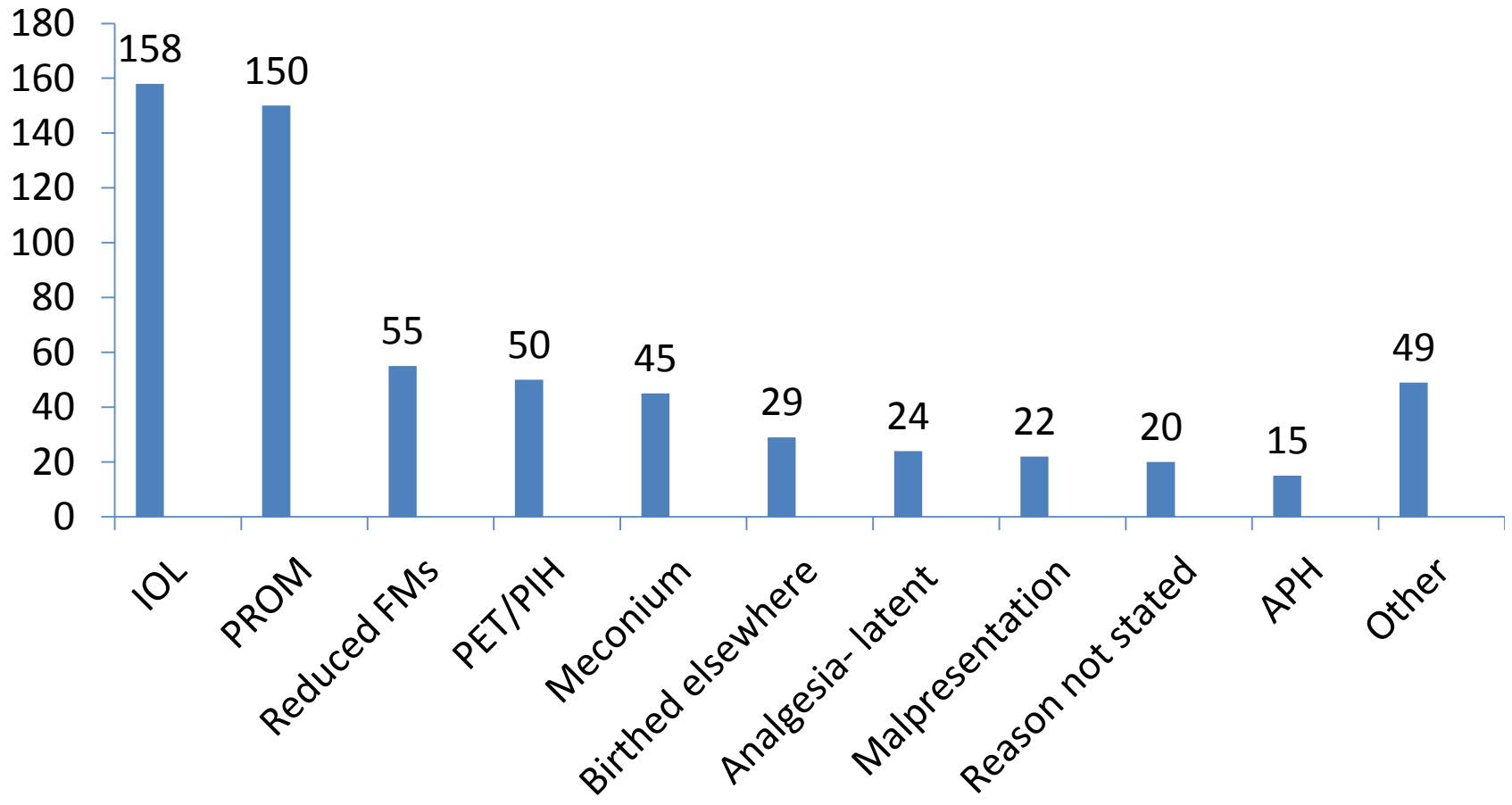
Activities and Outcomes for the Birth Centres: April 2016- March 2017.

Pauline Cooke Dec 2017

Background

- QCH BC opened in April 2001 and SMH opened in June 2008
- QCH has 7 rooms with 3 pools and SMH has 5 rooms with 2 pools
- Referrals by 34 weeks
- Birth preparation at 36 weeks
- Antenatal appointments at 38, 40 and 41 weeks
- Follow NICE criteria

Antenatal transfers SMH n= 617(rate of 50%)



Intrapartum

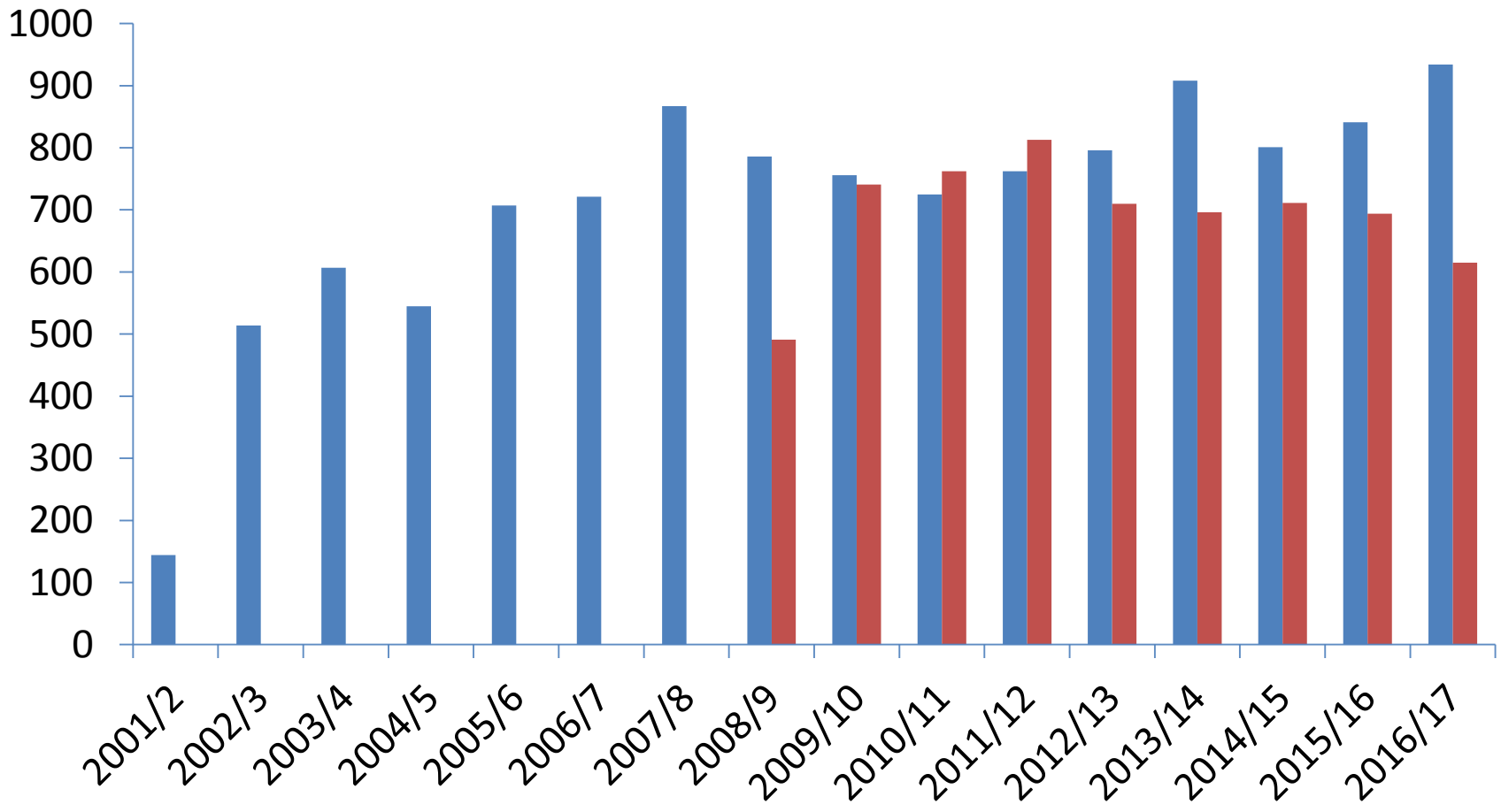
- No of births: QCH 934
  SMH 615
- No of women cared for in labour: QCH 1155
  SMH 731
- QCH: primips 45%
  multips 55%
- SMH: primips 43%
  multips 57%

Use of water: QCH 65%
SMH 71%

Water births: QCH 35%
SMH 38%

Transfers: QCH 19%
SMH 15.8%

Births per year



Intrapartum Transfers

- QCH: n= 221 or **19%**

  89% primips, rate of 32%

  11% multips, rate of 4.4%

- SMH: n= 116 or **15.8%**

  89% primips, rate of 28%

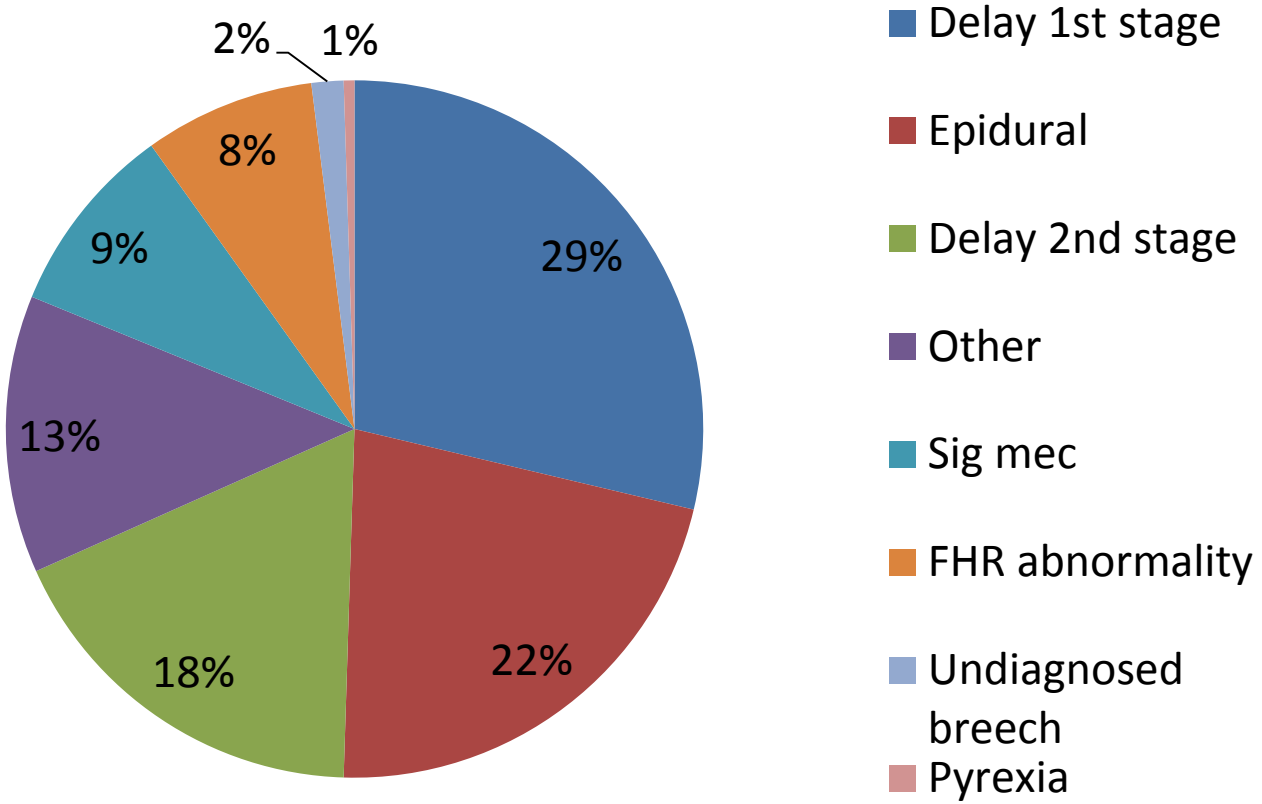
  11% multips, rate of 3.5%

- Birthplace (2011)transfer rate: **26.4%**

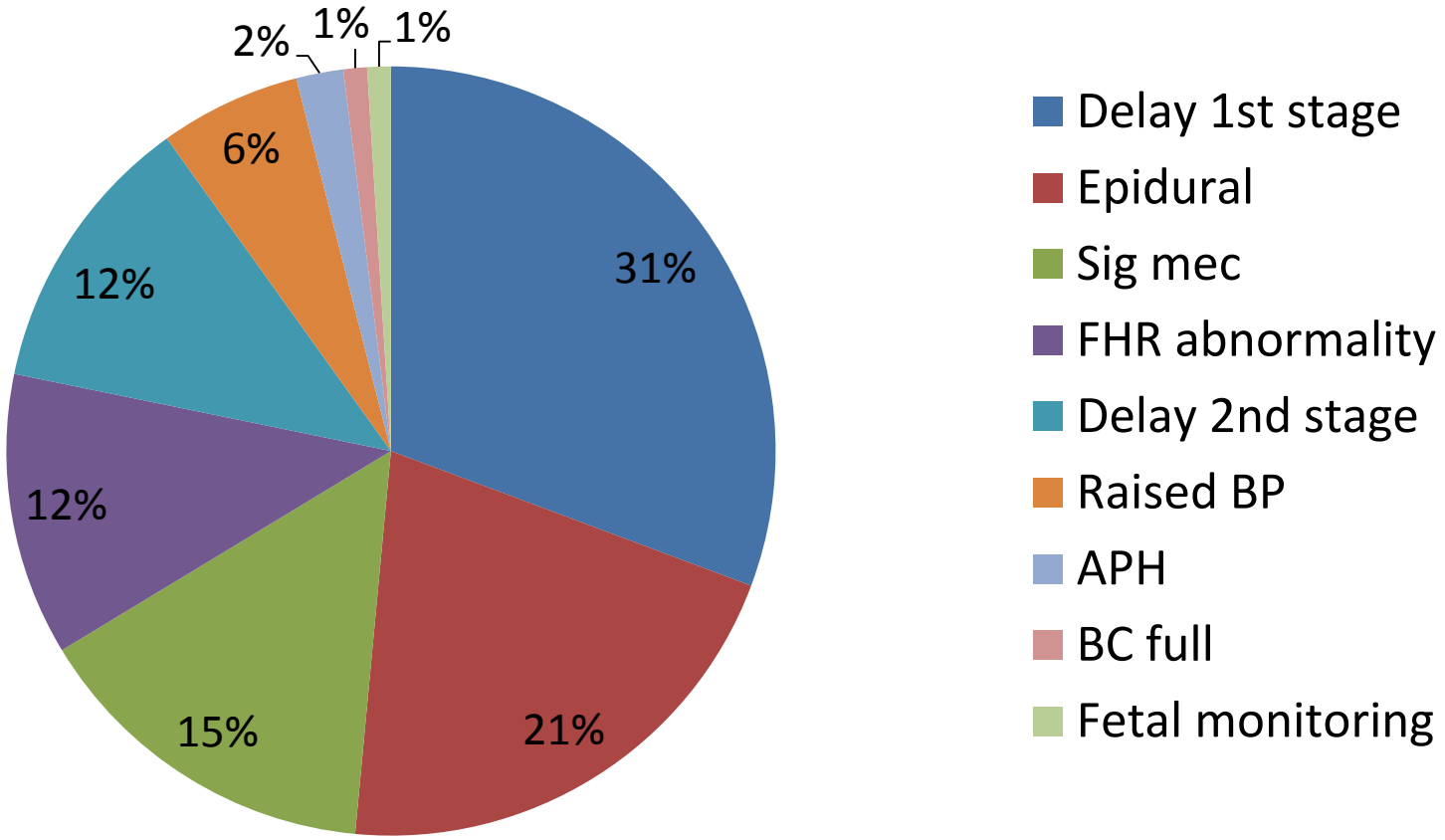
  primips 40.2%

  multips 12.5%

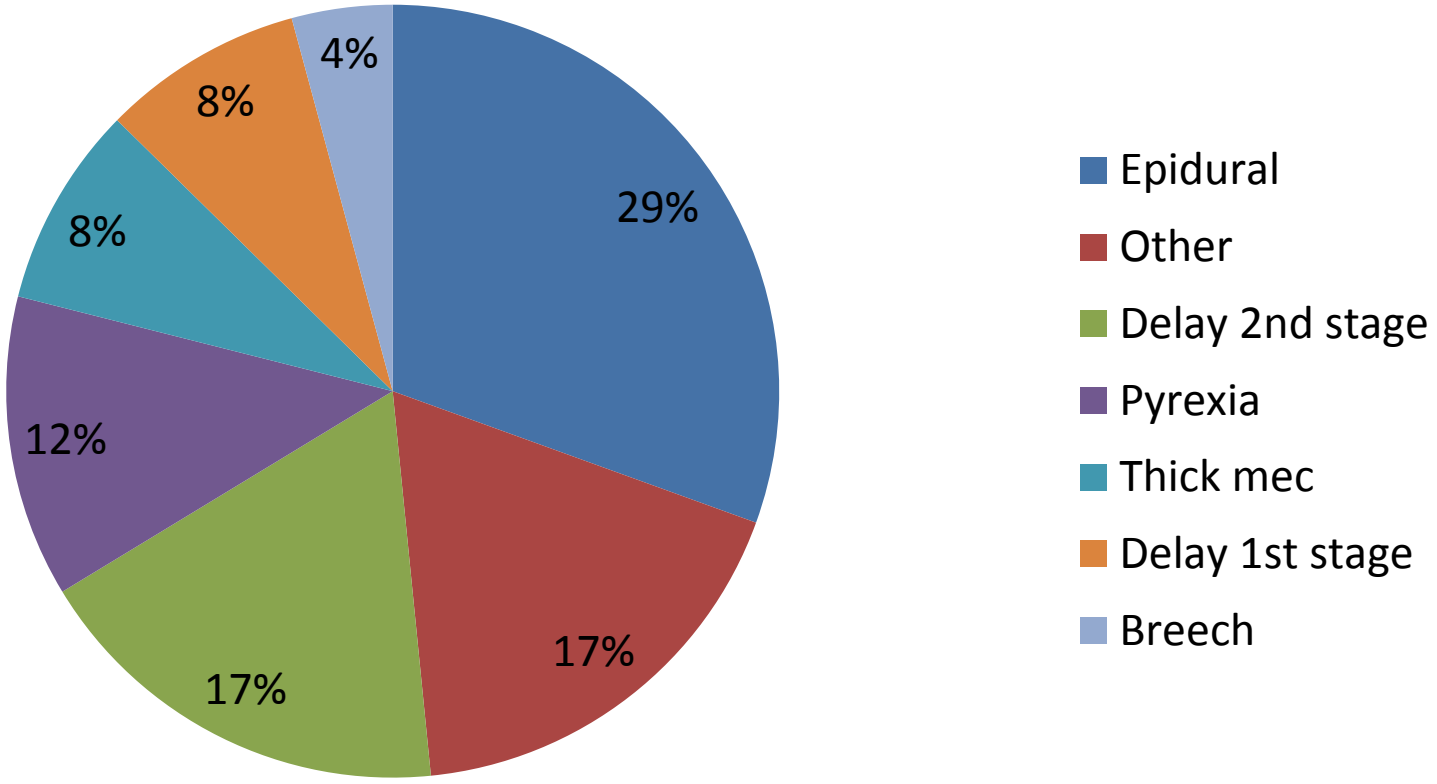
Reasons for intrapartum transfers QCH primips (n =197 or 32%)



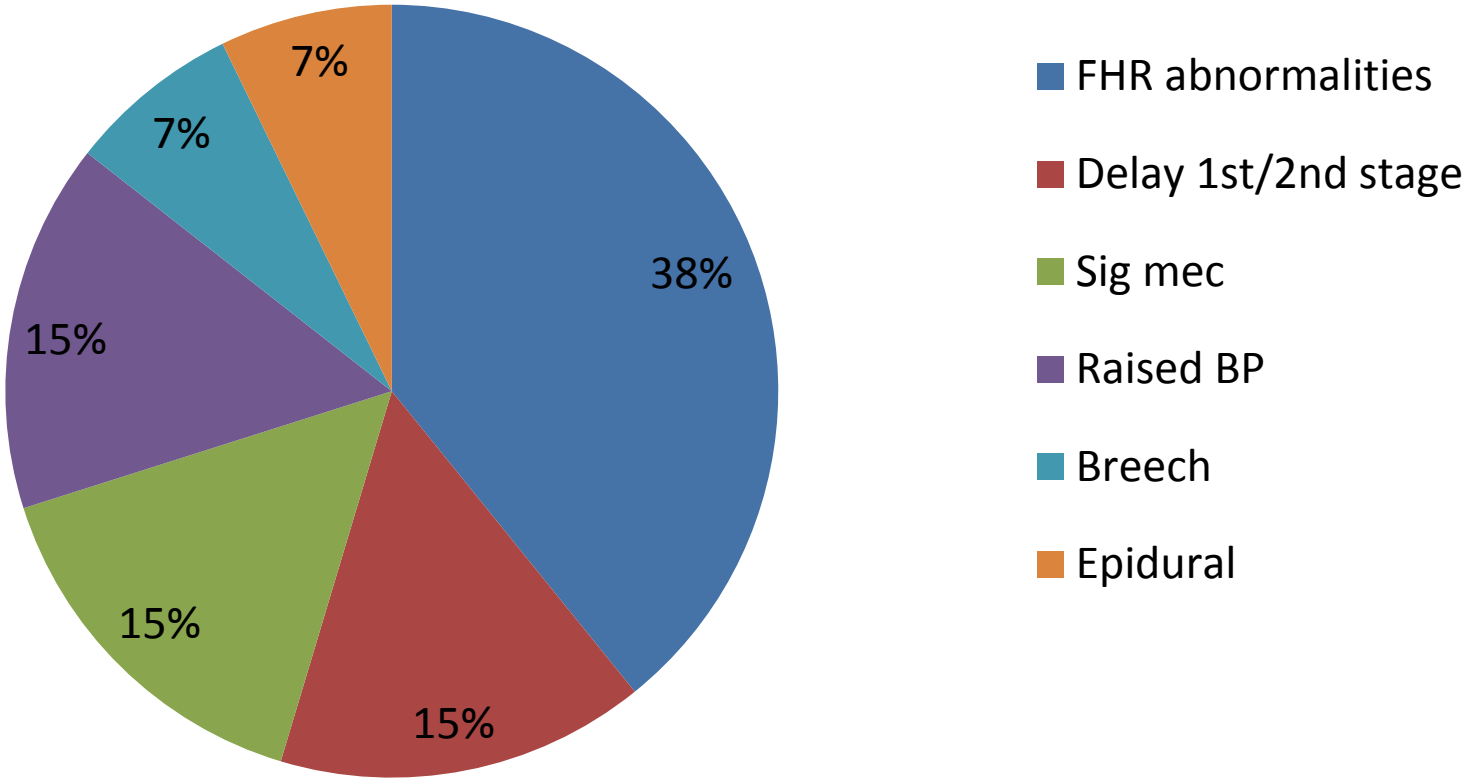
Reasons for intrapartum transfers SMH primips (n =103 or 28%)



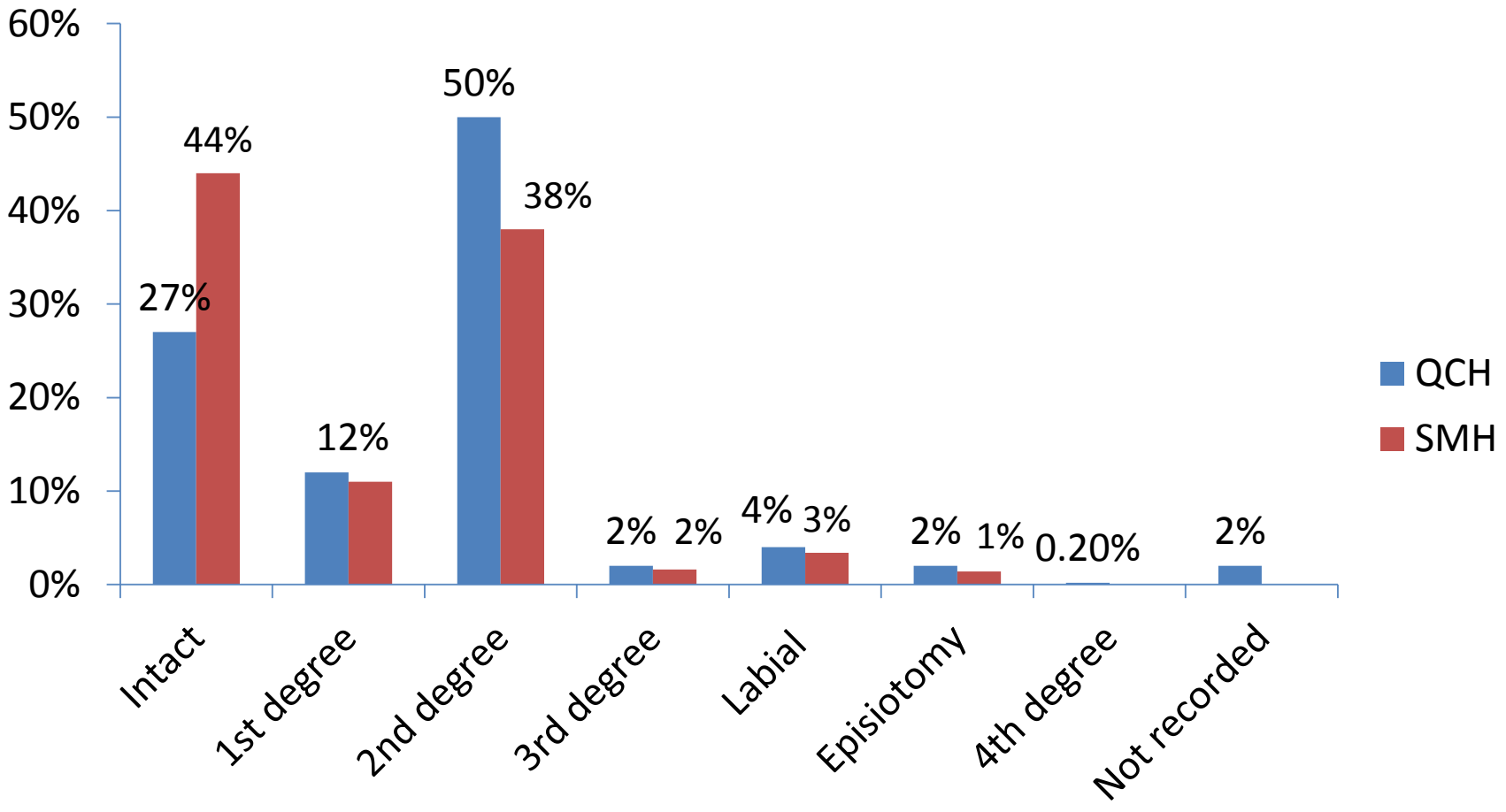
Reasons for intrapartum transfers QCH multips (n =24 or 4.4%)



Reasons for intrapartum transfers SMH multips (n =13 or 3.5%)



Perineal trauma



Postnatal transfers

QCH 70 (7.4%) SMH 32 (5.2%)

- **PPH:** QCH = 37 (3.9%)
  - <1500mls= 27
  - 1500-2000mls= 7
  - 2000- 3000mls= 3

  SMH = 13 (2.1%)
  - <1500mls= 8
  - 1500-2500mls =4
  - >3000= 1
- **3rd/4th degree tears:**

  QCH = 20 (2.1%)

  SMH = 10 (1.6%)
- **MROP:** QCH = 31 (3.3%)

  SMH = 6 (0.9%)

Neonatal unit transfers

- QCH: 4 (0.42%)
- SMH: 3 (0.48%)

Percentage of BC births

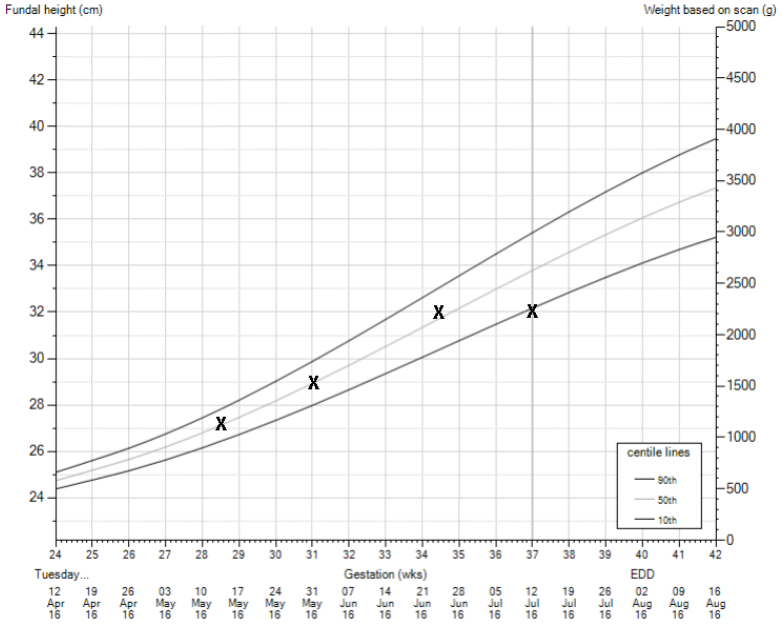
- BC births as a % of all maternities:
  - QCH: 16.4%
  - SMH: 17.8%
  - Total BC births (1549) 16.9%

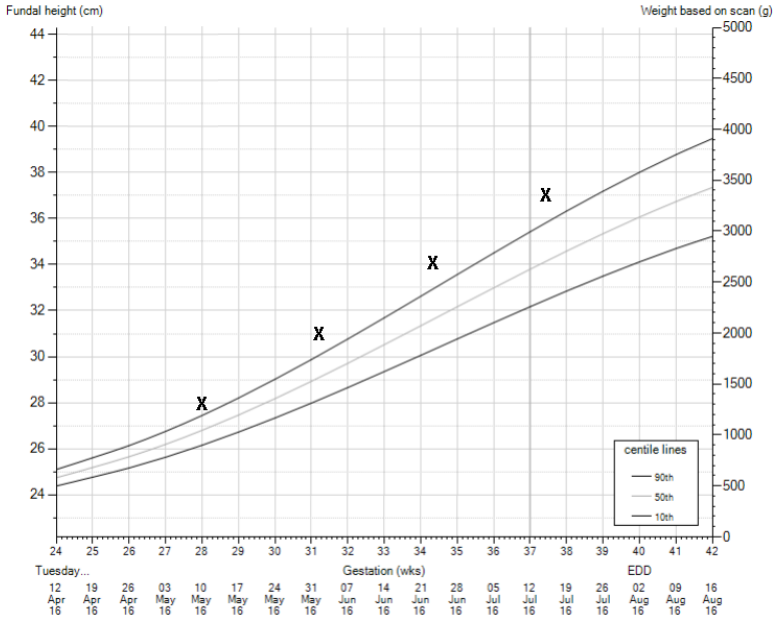
Acknowledgements

- Susan Barry (QCH)
- Sarah Cryan (SMH)
- The teams of midwives and MSWs

DESIGN Study

- Implementation of the GAP/GROW protocol
- Use of customised growth charts to detect small for gestational age fetuses
- Reducing stillbirths





Growth **A**ssessment **P**rotocol (GAP)
DEtection of **S**mall for **G**estatio**N**al Age Fetus (DESiGN Trial)

Place sticker here

Patient name

MRN Number

Ultrasound request Form to be used in Conjunction with Departmental Guideline

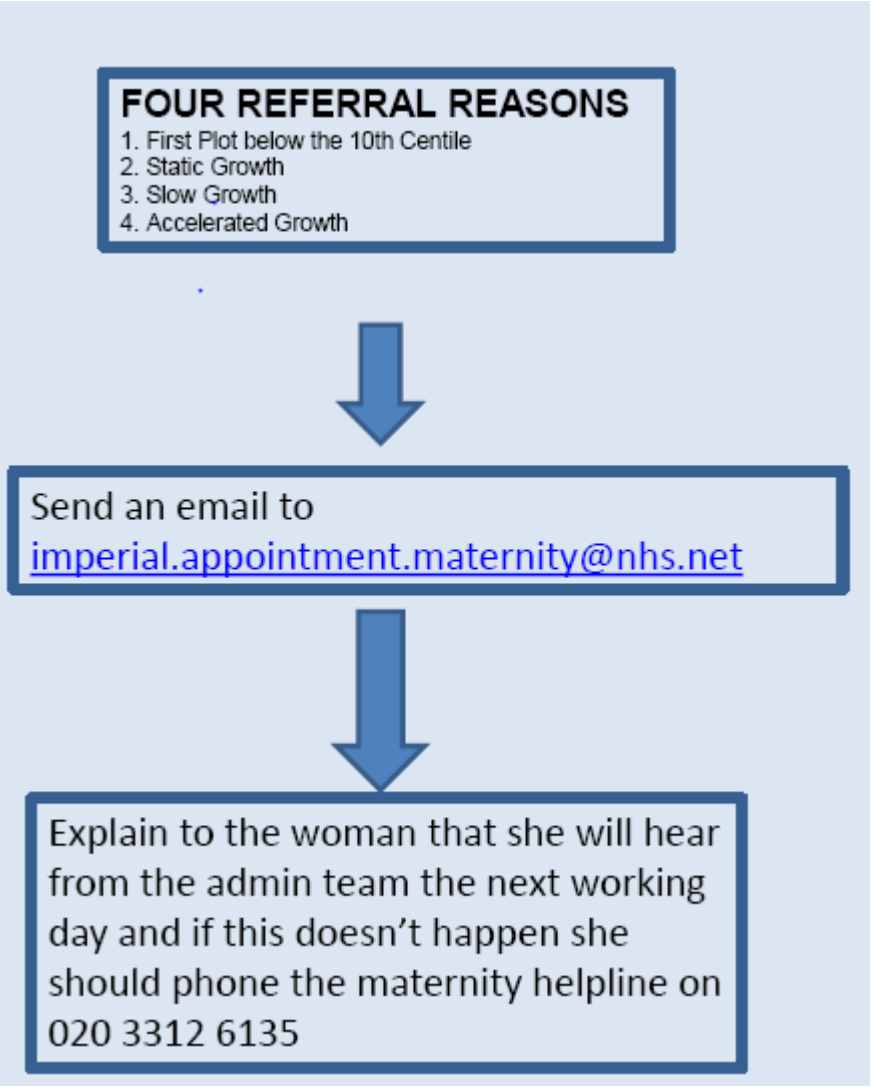
Imperial College Healthcare NHS Trust

Consultant

				Requester			Receptionist ONLY		
	Reason	**Please tick √**	**Any Comments**	**Printed Name**	**Signature**	**Date**	**28weeks**	**32 weeks**	**36 weeks**
Examination	**Within 3 working days - refer to SGA policy; discuss with CFC/FMU if urgent and no capacity in ultrasound department**			**MW / GP / Obstetrician to Request**			**Appointment date and time**		
	First SFH <10th centile								
	SFH static/slow growth								
	SFH excessive growth								
	Appointment to be booked at:			**MW / Obstetrician to Request**			**28 weeks**	**32 weeks**	**36 weeks**
Clinical History:	Smoker 10 + cigarettes per day								
	Current illicit drug user								
	BMI <18kg/m^2 or >40 kg/m^2								
	Heavy bleeding in 1st trimester similar to menses								
	Low PAPP-A <0.3MoM								
	Maternal age >40 years								
	Previous SGA baby (birth weight below 10th centile)								
	Previous stillbirth								
	Previous early-onset pre-eclampsia or IUGR requiring delivery <34 weeks		**Refer to FMU/CFC**						
	Previous late-onset pre-eclampsia >34 weeks								
	Chronic hypertension								
	Other medical conditions eg. Pre-existing diabetes, APS, SLE, chronic kidney disease, inflammatory bowel disease, gastric bypass, congenital cardiac disease, sickle cell disease, on anti-psychotic meds, etc…		**Obstetric Medicine or PNMH Consultants ONLY**						

- Patient Information: Growth Charts and Screening for Small Babies
  - https://www.imperial.nhs.uk/our-services/maternity-and-obstetrics/antenatal-care/patient-information

- Perinatal Institute
  - www.perinatal.org.uk
  - Examples of Growth Chart patterns



St Mary's Maternity Services

Jayne Terry
Consultant Obstetrician
Head of Maternity
Intrapartum lead
Jayne.terry@nhs.net


ST MARY'S


St Mary's Hospital Guide
alamy stock photo


ST. MARYS HOSPITAL
CLARENCE
MEMORIAL WING


ST MARY'S HOSPITAL
© Ray Tang/REX/Shutterstock

St Mary's Hospital

- The major acute hospital for north west London
- Runs one of four major trauma centres in London
- 24/7 A&E department
- Maternity unit and Co-located Birth centre
- Antenatal clinic, FMU, Maternity Day Assessment unit, Triage, 24/7 anaesthetics
- Level 2 Neonatology

Caring for our women and families

- GP or self referral
- Community clinics

Antenatal care commu...

2,520 views

SHARE

Community clinics

- Edward Wilson Primary School
- Bayswater Children's Centre
- Park Medical Centre
- Cathnor Park Childrens Centre
- Flora Gardens Primary School
- Queen's Park Children's Centre
- Holmfield House
- St Quintin Children's Centre
- Randolph Beresford Early Years Centre
- Old Oak Community & Children's Centre
- The Portman Early Childhood Centre
- Hungry Caterpillar Day Nurseries
- Maples Children's Centre
- Grange Children's Centre
- Hathaway Children's Centre
- Windmill Lane Children's Centre
- Ealing Hub
- Acton Health Centre
- Hanwell Children's Centre
- Mattock Lane Health Centre
- Granville Children's Centre
- Harmony Children Centre

Caring for our women and families

- 60% of women have all appointments in community
- Out of area and high risk women will be seen in antenatal clinic

- Core team of 8 obstetricians. Gynaecology on site
  - Fetal medicine specialists
  - Maternal medicine specialists – HIV/infectious diseases (Jefferiss Wing), Diabetes (Endocrinology team), Neurology, Haematology
  - Preterm labour clinic
  - Multiple pregnancy

- Perinatal mental health team
  - Perinatal psychiatrist, perinatal mental health midwife, Lead obstetrician

- Bereavement clinic – specialist midwives and consultant lead

- Postnatal follow up clinic

- 'Blue team' – small group of midwives looking after women with additional social, emotional needs.

Caring for our women and families

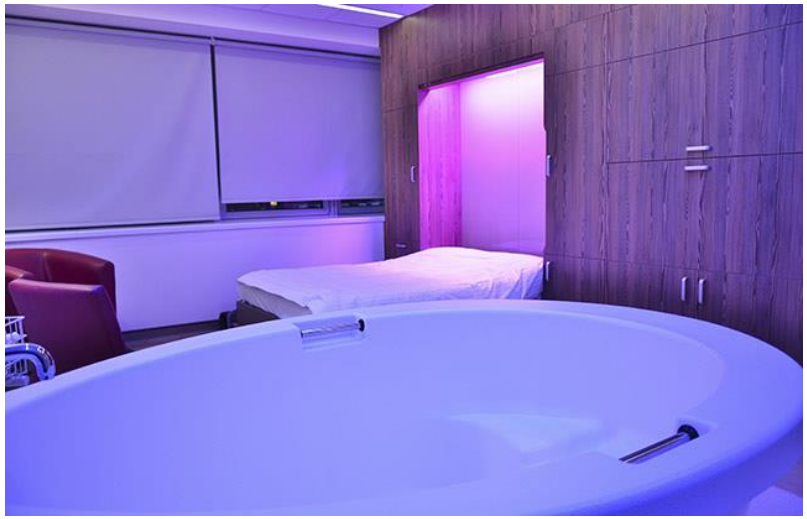
- **Antenatal education classes**
  - Parent Education Centre at St Mary's
    - Birth and Parenthood Preparation Classes
    - Breastfeeding
    - Infant massage

- King's midwifery students and Imperial College medical students
- GP trainees, clinical fellows, subspecialty trainees and specialty trainees

- **Maternity Day Assessment Unit** (0203 312 7707)
  - 8am-8pm Mon-Fri. Reduced fetal movements, Itching, BP checks,
- **Triage** – on LW
  - A&E for pregnancy. 24/7. ?Waters broken, early labour

Place of Birth

- Birthplace study
- Home birth – community teams
- 20% women deliver in Birth centre
  - Birth preparation classes from 36 weeks
  - Fewer interventions, personal, smaller group of midwives



Place of Birth

- Labour ward
  - Obstetricians, anaesthetists
  - 2 pools
  - Telemetry
  - 2 theatres
  - Recovery area and HDU
  - Bereavement room

Postnatal

- Enhanced Recovery
- Discharge talk every day 11am
- Partners/support can stay
- Breastfeeding specialists
- Discharge summaries
- PICO dressings

Obstetrics-Stmarys@nhs.net

- Email for non urgent queries for St Mary's patients
- Consultant Obstetrician response within 2 working days

Jayne.terry@nhs.net

Imperial College Healthcare NHS
NHS Trust

Enhanced Recovery

Charity Khoo

What is it?

- A programme designed to optimise and speed up recovery after Caesarean Section
- Reduced postoperative complications and readmission rates
- Specifically tailored to the individual
- Discharge 24 – 36 hours after birth

How do we do it?

- Antenatal
  - Cases identified and option offered to woman
  - breast feeding classes - 2 hrs run by AN clinic
  - Link to breast feeding support worker
- Preoperatively
  - Physiotherapist education – moving, exercises, bladder care
  - Obstetric – preoperative clerking, questions answered
  - Anaesthetist – recovery following epidural/spinal, analgesia post operatively

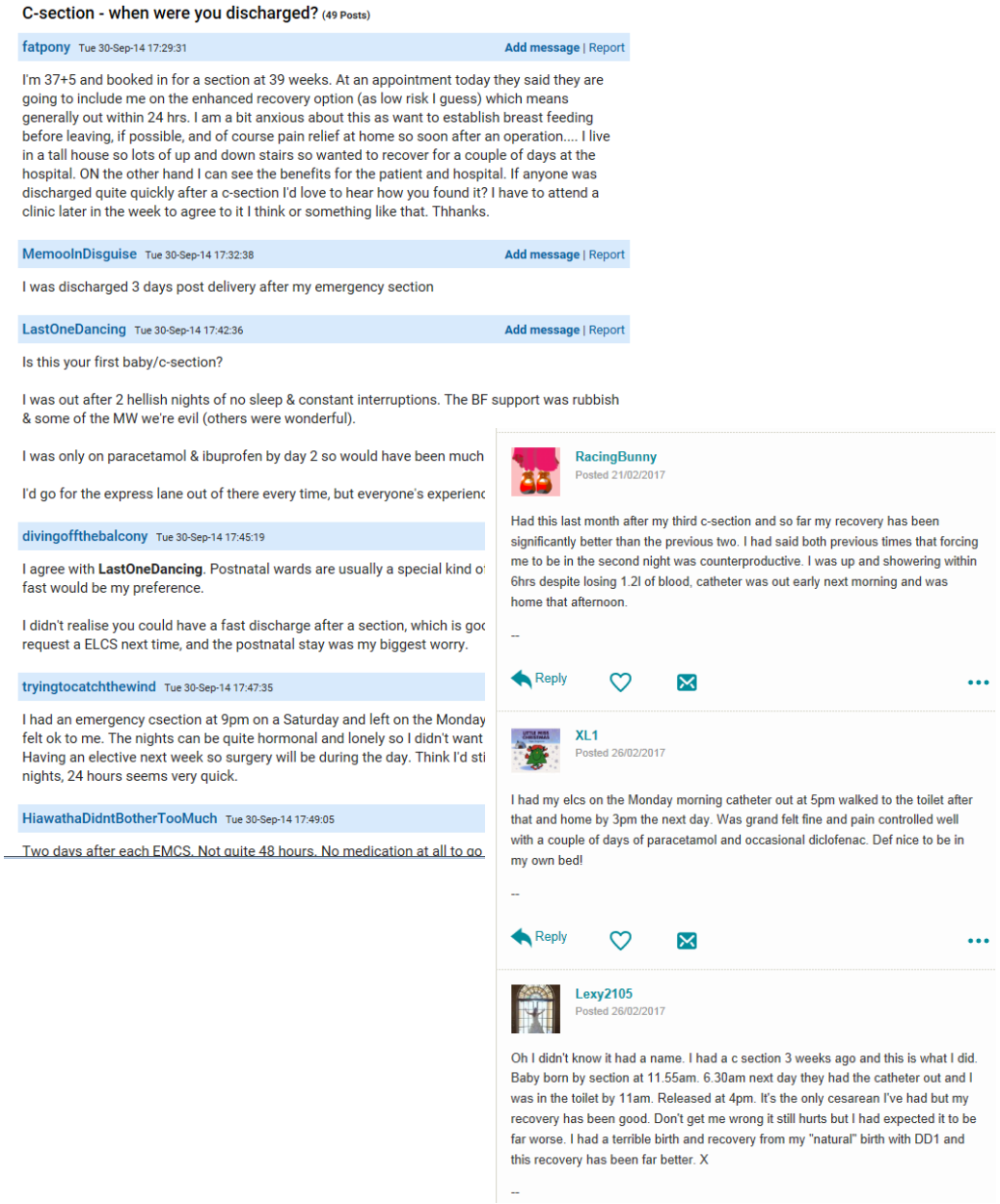
On the day

- Intrapartum
  - Skin to skin
- After the operation
  - Breastfeeding
  - Food offered within 1 hour after surgery
  - Catheter out 6 hours (if feasible)
  - Encouraged to sit in the chair

Discharge Day

- Shower in the morning
- Physio, obstetrician and anaesthetic review
- Breastfeeding check, including voluntary attendance at breastfeeding ward talk
- Baby check
- Contact details given
  - Breastfeeding support
  - Triage / maternity helpline
  - Where to come
- Home
  - Midwifery review within 3 days

What does Mumsnet say?



C-section - when were you discharged? (49 Posts)

fatpony Tue 30-Sep-14 17:29:31 — Add message | Report

I'm 37+5 and booked in for a section at 39 weeks. At an appointment today they said they are going to include me on the enhanced recovery option (as low risk I guess) which means generally out within 24 hrs. I am a bit anxious about this as want to establish breast feeding before leaving, if possible, and of course pain relief at home so soon after an operation.... I live in a tall house so lots of up and down stairs so wanted to recover for a couple of days at the hospital. ON the other hand I can see the benefits for the patient and hospital. If anyone was discharged quite quickly after a c-section I'd love to hear how you found it? I have to attend a clinic later in the week to agree to it I think or something like that. Thhanks.

MemooInDisguise Tue 30-Sep-14 17:32:38 — Add message | Report

I was discharged 3 days post delivery after my emergency section

LastOneDancing Tue 30-Sep-14 17:42:36 — Add message | Report

Is this your first baby/c-section?

I was out after 2 hellish nights of no sleep & constant interruptions. The BF support was rubbish & some of the MW we're evil (others were wonderful).

I was only on paracetamol & ibuprofen by day 2 so would have been much

I'd go for the express lane out of there every time, but everyone's experienc

divingoffthebalcony Tue 30-Sep-14 17:45:19

I agree with **LastOneDancing**. Postnatal wards are usually a special kind o fast would be my preference.

I didn't realise you could have a fast discharge after a section, which is goc request a ELCS next time, and the postnatal stay was my biggest worry.

tryingtocatchthewind Tue 30-Sep-14 17:47:35

I had an emergency csection at 9pm on a Saturday and left on the Monday felt ok to me. The nights can be quite hormonal and lonely so I didn't want Having an elective next week so surgery will be during the day. Think I'd sti nights, 24 hours seems very quick.

HiawathaDidntBotherTooMuch Tue 30-Sep-14 17:49:05

Two days after each EMCS. Not quite 48 hours. No medication at all to go

RacingBunny
Posted 21/02/2017

Had this last month after my third c-section and so far my recovery has been significantly better than the previous two. I had said both previous times that forcing me to be in the second night was counterproductive. I was up and showering within 6hrs despite losing 1.2l of blood, catheter was out early next morning and was home that afternoon.

--

Reply

XL1
Posted 26/02/2017

I had my elcs on the Monday morning catheter out at 5pm walked to the toilet after that and home by 3pm the next day. Was grand felt fine and pain controlled well with a couple of days of paracetamol and occasional diclofenac. Def nice to be in my own bed!

--

Reply

Lexy2105
Posted 26/02/2017

Oh I didn't know it had a name. I had a c section 3 weeks ago and this is what I did. Baby born by section at 11.55am. 6.30am next day they had the catheter out and I was in the toilet by 11am. Released at 4pm. It's the only cesarean I've had but my recovery has been good. Don't get me wrong it still hurts but I had expected it to be far worse. I had a terrible birth and recovery from my "natural" birth with DD1 and this recovery has been far better. X

--

- Nicer at home
- Main concern – at home analgesia
- Had at last deilivery – its great!
- ‘seems very quick’

Bereavement Clinic

Bryony Jones
Bryony.jones2@nhs.net

Bereavement Clinic Aims

- Support parents who have suffered pregnancy loss or death of their baby following late miscarriage, stillbirth, neonatal death and termination of pregnancy for fetal abnormality.
- Offer a dedicated appointment for a couple to discuss their pregnancy loss
- Clear communication to couples, referring clinicians and primary care and advice regarding referral to other relevant healthcare professionals as needed.
- Classification of pregnancy loss.
- Contribute to the audit of perinatal loss at Imperial NHS Trust

Who do we see?

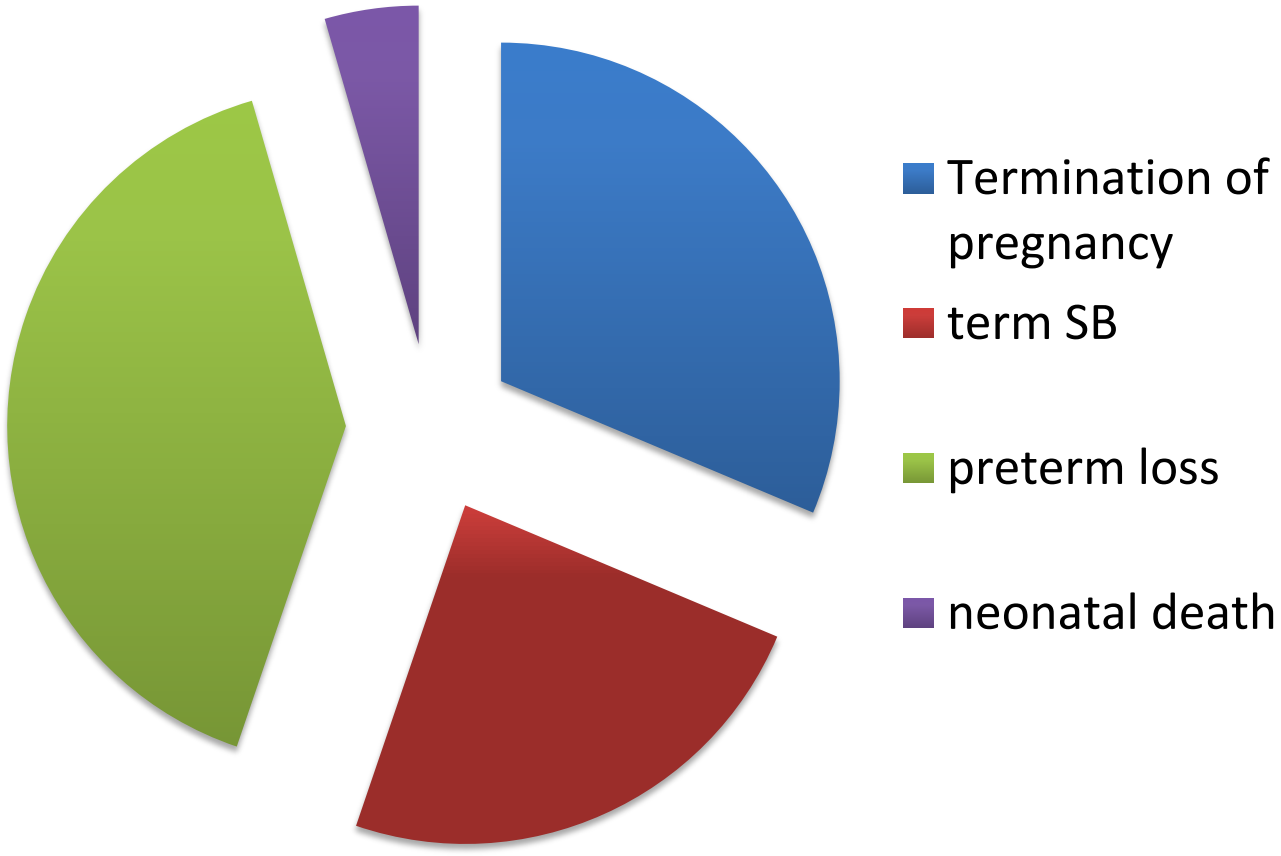
The bereavement clinic has been designed to see women/couples who have had;

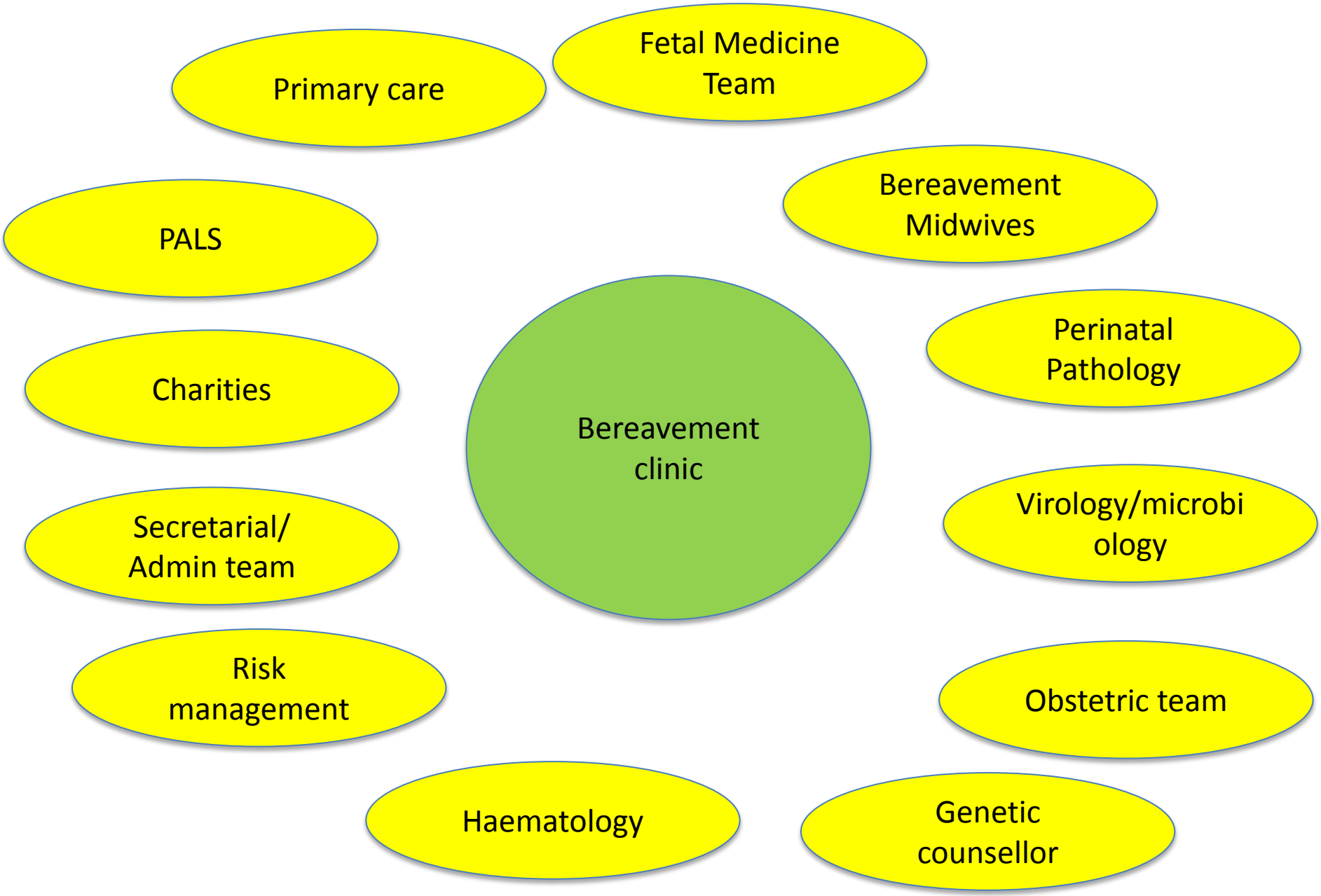
- ✓ Stillbirth
- ✓ late miscarriage/pregnancy loss 20-24 weeks gestation
- ✓ termination of pregnancy for fetal abnormality
- ✓ early neonatal death

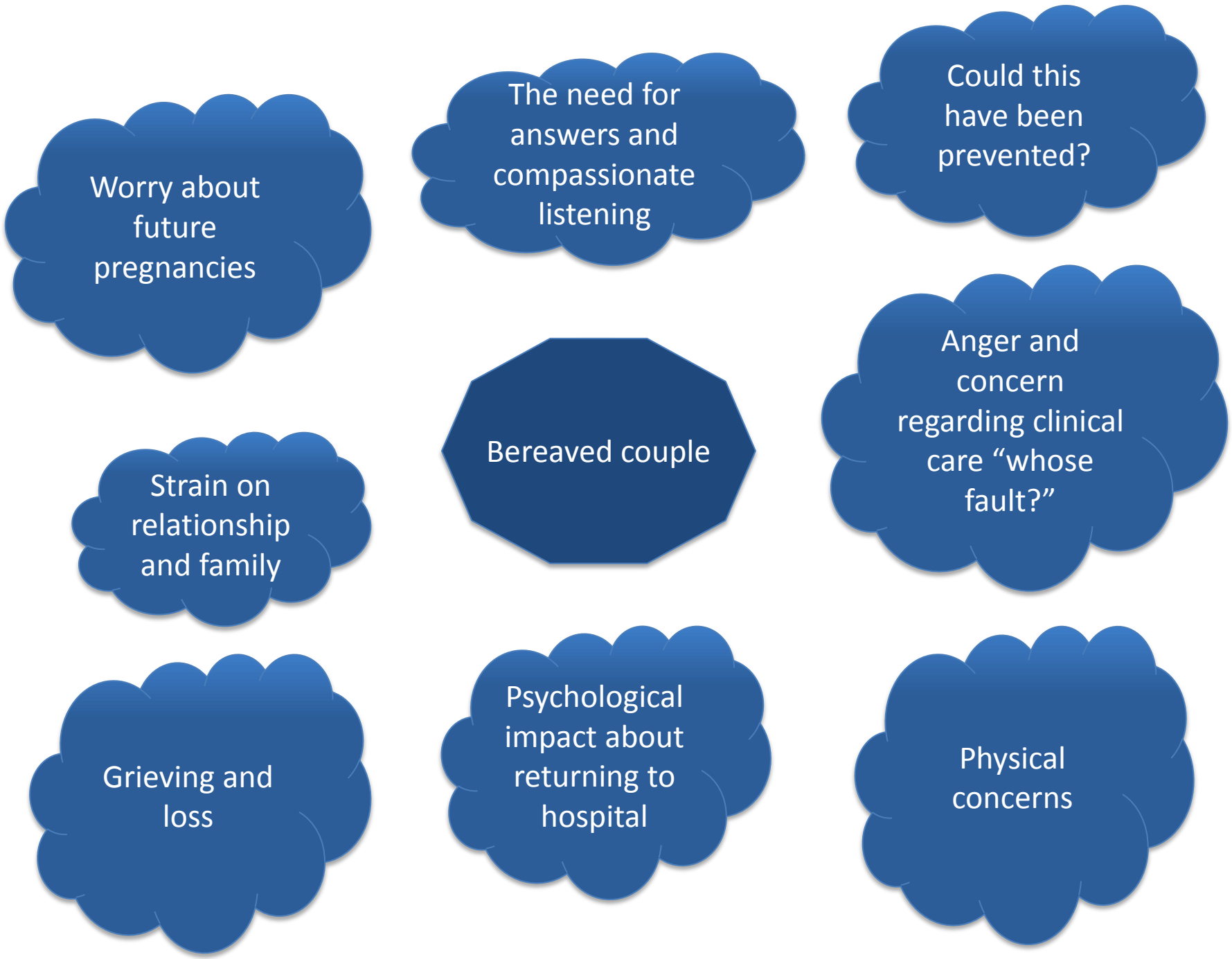
People who refer to the clinic are;

* Bereavement midwives
* Post natal staff
* Primary care

Who do we see?


Termination of pregnancy
term SB
preterm loss
neonatal death


Primary care
Fetal Medicine Team
PALS
Bereavement Midwives
Charities
Bereavement clinic
Perinatal Pathology
Secretarial/ Admin team
Virology/microbiology
Risk management
Obstetric team
Haematology
Genetic counsellor


Worry about future pregnancies
The need for answers and compassionate listening
Could this have been prevented?
Bereaved couple
Anger and concern regarding clinical care “whose fault?”
Strain on relationship and family
Grieving and loss
Psychological impact about returning to hospital
Physical concerns

The consultation

- Listen - patient led
- Discuss pregnancy and identify risk factors
- Physical recovery
- Emotional recovery
- Review of serology and bacteriology investigations
- Review of genetic/postmortem results
- Identify further investigations
- Identify if further support needed
- Communication

+/- Future pregnancy planning

Referral

- Centre for Fetal Care
  Second floor
  Queen Charlotte's & Chelsea Hospital
  Du Cane Road
  London W12 0HS

Contact information

Phone: 020 3313 3998

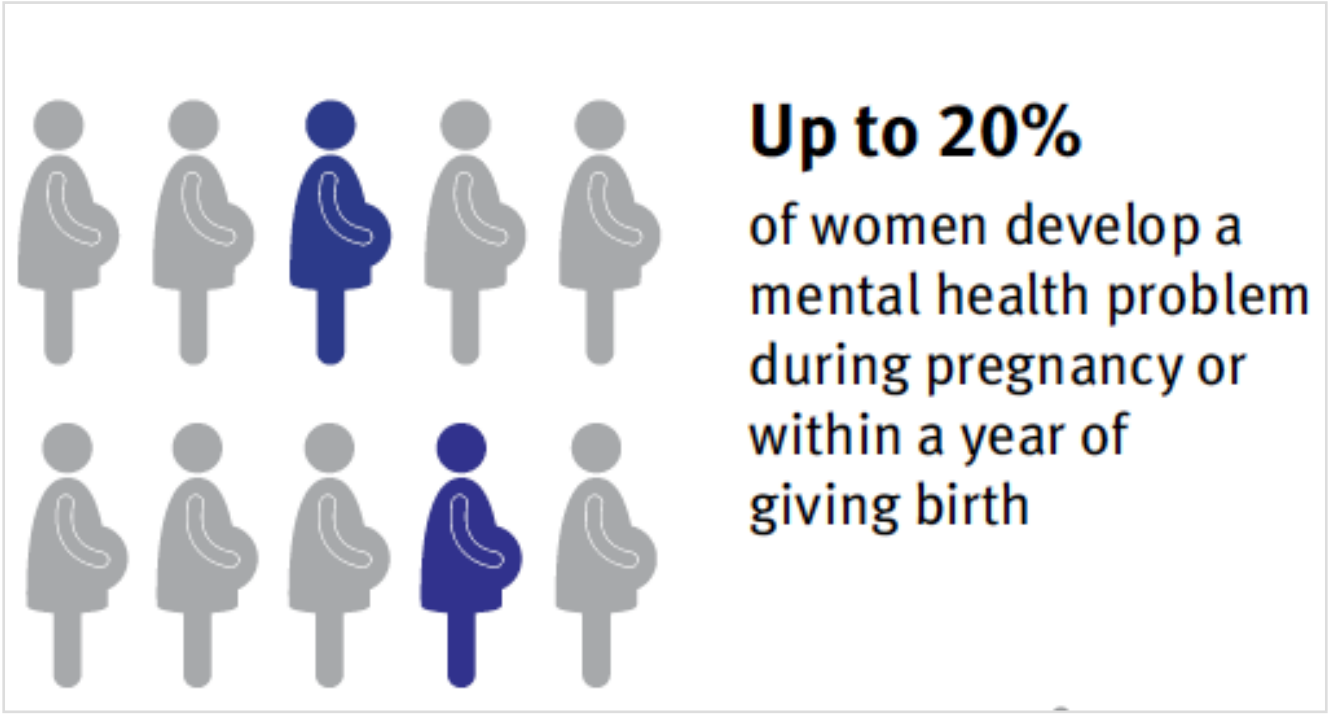
Fax: 020 3383 3507

Perinatal Mental Heath

Ms Karen Joash – MRCOG

Consultant Obstetrican and Gynaecologist

Burden of illness



Perinatal Mental Health

- Affects 15-20% of women
- Hx Severe postnatal depression or puerperal psychosis
- Anxiety disorder
- Depression on medication
- Psychosis
- Eating disorders
- Self-harm

Spectrum of disorders

MILD
- Depression
- Anxiety
- Baby Blues

MODERATE
- Depression
- Anxiety
- Tokophobia
- PTSD
- OCD
- Sub Misuse
- Personality Disorder

SEVERE & ENDURING
- Bipolar Affective Disorder
- Schizophrenia
- Schizoaffective Disorder
- Severe depression +/- psychosis
- Postpartum Psychosis

Adverse outcomes

- Suicide
- Fetal & infant death
- Obstetric complications
- Attachment & bonding problems
- Accidents, neglect, abuse
- Developmental /cognitive delay
- Emotional & behavioural problems

Scope of the Problem

Perinatal Mental health team

Role of the Obstetrician/PNM team

Role of the obstetrician/GP

Perinatal Mental Health – the figures

- In 2015 MBRRACE reported that 22% of women who died had mental health risk factors.
- **This annual review of deaths in London has an even higher rate of 27%.**
- Of note 10% of women will develop a new mental illness during pregnancy or during the first year post delivery.
- Mental health problems are relatively common at a time of significant change in life.
- **Depression and anxiety affect 15-20% of women in the first year after childbirth, but about half of all cases of perinatal depression and anxiety go undetected.**

National Maternal Review –

What is the antenatal provision?

- Almost **one in five women said that they had not been asked** about their emotional and mental health state at the time of booking, or about past mental health problems and family history.

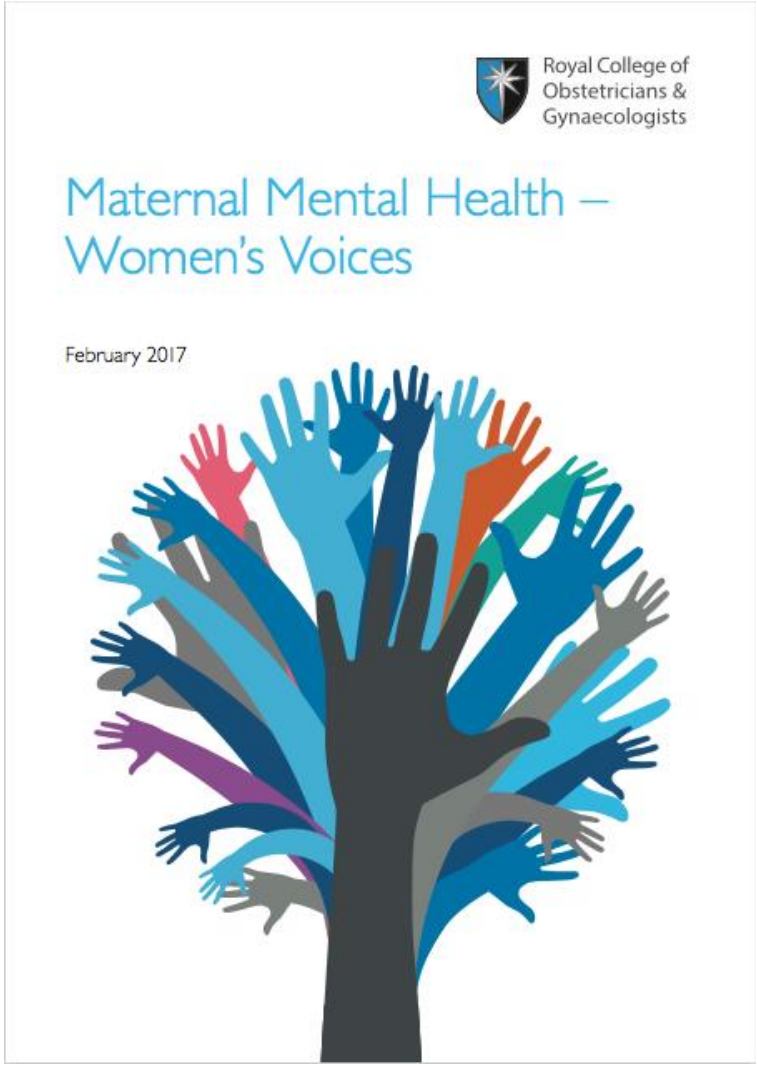
- Many of those with mental health problems that are detected **do not receive evidence-based treatment.**

- There is a large geographical variation in service provision: an estimated 40% of women in England lack access to specialist perinatal mental health services.

- Given the contribution of mental health causes to late maternal mortality, this is a significant concern, as also set out in NHS England's recently published Mental Health Taskforce report.

RCOG report

- Women's voices



What are women saying or not saying?

Boots family Trust report 2015

- 22% said they had suicidal thoughts
- 50% are feel isolated
- 14% considered that a history of mental health problems was the primary cause of their perinatal illness
- 40% had suffered a traumatic birth
- 28%of mothers with mental health problems admit to have trouble bonding with their child
- 30% never tell a health professional Many women are reluctant to discuss the type and depth of their feelings
- 34% of those who admitted they had hidden their feelings said they had done so because they were concerned their baby might be taken away

Role – Caring

- “Patients don’t care how much you know until they know how much you care”

- *Quote – barefoot whispers*

Role - Detection

- ***Understanding/seeing/noticing***
- ***32% did not realise that a healthcare professional could help (women's voices RCOG 2017)***
- ***23% thought it was normal***
- ***23% thought their healthcare professional was unapproachable***

Detection - Mood questions

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

- Also consider asking about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):

- During the past month, have you been feeling nervous, anxious or on edge?[7]

- During the past month have you not been able to stop or control worrying?[7][new 2014]

Detection

- Just ask!!!!!!

- **Current or Past Psychiatric medication**
- *(and date stopped if not current)*

- **Has your mother, sister or daughter** had a severe mental illness after having a baby?
- **If yes discuss with Perinatal Mental Health Team (and refer if this was definitely Postpartum Psychosis)**

Role - destigmatize

- ‘It is an odd paradox that a society, which can now speak openly and unabashedly about topics that were once unspeakable, still remains largely silent when it comes to mental illness’

- *Glenn close*

Medication

- If unsure seek advice
- UKTIS – good source of information
- Do not stop medication abruptly
- Citalopram, sertraline all safe

Common themes

•Drug prescribing

- Drug prescribing had been delayed in early pregnancy in two cases due to a lack of understanding by healthcare providers with regard to drug safety in pregnancy.

- In addition, there had been a delay in starting treatment after birth. It is important that clinicians' awareness of which medicines are appropriate for use in pregnancy and the postnatal period is regularly updated.

Communication

•Common themes

- Communication could have been improved in three of the four cases.
- Challenges included poor sharing of timely and adequate information between different multidisciplinary teams as well as between acute and community providers, private and NHS services.
- A continuing challenge, particularly to services across London include different electronic data capture systems used across psychiatric and maternity services, a major barrier to communication and sharing of information on women who may be very vulnerable.

- **There were some good examples of practice and risk assessments being conducted, as well as appropriate referrals made to children and adult social care services by both A&E and psychiatric ward staff**.

Common Themes

- Difficult relationships

- In three cases there was evidence of difficult family relationships which exacerbated already deteriorating mental health.
- These relate to partners as well as extended family members.
- In two cases, relationship problems were identified on discussion with the women, which exacerbated the deterioration. There was no evidence in any of the cases that these relationship issues had been explored further, or whether there had been any enquiries to determine whether domestic violence or abuse had been experienced.

- **Women who experience psychological abuse during pregnancy, even in the absence of physical and/or sexual violence, report significantly poorer mental health related quality of life compared to women without a history of psychological abuse (Tiwari *et al*, 2008).**
- **Staff need to be mindful that opportunities should be initiated to enable women to be seen alone, without any family or partner present.**

The Team

- Dr Sarah Taha, consultant Perinatal Psychiatrist at QCCH
- Dr Maddalena Miele, Consultant Perinatal Psychiatrist at SMH
- Ms Karen Joash, Consultant Obstetrician at QCCH
- Ms Shankari Arulkumaran, Consultant Obstetrician at SMH

- Fungai Zhuwawu, Psychiatric Nurse at QCCH
- Dionne Levy, Perinatal Mental Health Midwife at QCCH & SMH

Role – Service Leads

•Tertiary unit

- Joint psychiatric clinic with psychiatrist
- Routine ANC alongside specialist midwife
- Dedicated perinatal mental health midwife

- CASE 1 – Bipolar disorder medication stopped. Private care.
- CASE 2 – Requesting debrief on delivery having panic attacks.
- CASE 3 – Asylum seeker severe anxiety

Referral

For advice or guidance about referral pathways, please call one of the numbers below. The phone lines are answered 09.00 to 17.00, Monday through Friday.
St Mary's Hospital Perinatal Mental Health Team contact: Mary Locket
Phone: 020 3312 1582

Queen Charlotte's & Chelsea Hospital Perinatal Mental Health Team contact:
Phone: 020 3313 3033

Perinatal Mental Health Midwife: Dionne Levy
Phone: 078 1079 4709

Self-referrals

While patients cannot self-refer to our Trust's perinatal mental health service, other mental health resources may be accessed via IAPT at iapt.nhs.uk [LINK: http://www.iapt.nhs.uk/].

Final quote

- ‘The human body experiences a powerful gravitational pull in the direction of hope. That is why the patient’s hopes are the physicians secret weapon. They are the hidden ingredients in any prescription’

Norman Cousins