CLINICAL REPORT
of the
ROTUNDA HOSPITAL

1st January, 1980
to 31st December, 1980

Master:

IAN J. DALRYMPLE, M.B., M.A.O., F.R.C.P.L, F.R.C.O.G.
(elected November, 1973)

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Miss M. RYAN, M.SC.

Chemist:
T. A. McLOUGHLIN, M.P.S.L., phc.
Matron:
Miss E. M. GRAY - Retired 31st March 1980
Miss M. A. Kelly - Appointed 1st March 1980

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Mrs. R. V. DORIS, M.S.R.

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Mrs. JENNY STOREY, M.C.S.P.
Miss MICHELLE CAHILL, M.C.S.P.
Mrs. ANN MURPHY, M.C.S.P.
Mrs. VALERIE McCONNELL, M.C.S.P.

Nutritionist:
Mrs. R. O’CARROLL

Medical Records Officer:
Miss MILDRED AHERNE
GLOSSARY

BOOKED PATIENT (B): Any patient seen over at the ante-natal clinic or in a consultant’s rooms prior to admission.

STILLBIRTH (S.B.): A baby born after the end of the 28th week who shows no sign of life.

FIRST WEEK NEONATAL DEATH (N.N.D.): Death within 7 days of a live infant of 28 weeks gestation or more.

LATE NEONATAL DEATH: Death of a live born infant after 7 and before 28 days of life of an infant of 28 weeks gestation or over.

MATERNAL MORTALITY: Death of a patient for whom the hospital has accepted responsibility during pregnancy or within 6 weeks of delivery, in the hospital or elsewhere.

ABBREVIATIONS

A.N.C. Antenatal career of care.
A.P.H. Antepartum haemorrhage.
ARM/POM Puncture of membranes.
B./NB. Booked/Not booked.
B.P.D. Bi-parietal diameter.
C.A.N.C. Combined ante natal care.
C.T.G. Cardiotocography.
C.V.P. Central venous pressure.
D.I.C. Disseminated intravascular coagulation.
D.F.M.C. Daily fetal movement chart.
F.D. Forceps delivery.
F.T.N.D. Full term normal delivery.
G.T.T. Glucose tolerance test.
I.U.D. Intra-uterine death
L/S Ratio Lecithin/sphingomyelin ratio.
L.S.C.S. (L.S.S) Lower segement Caesarean Section.
M.S.U. Mid-stream specimen of urine.
N.D. Normal delivery.
P.E.T. Pre-eclamptic toxaemia.
P.N.M. Perinatal mortality — stillbirths and 1st week NND/1,000 total births.
P.P.H. Post-partum haemorrhage.
R.D.S. Respiratory distress syndrome.
S.B.I. Stillborn infant.
S.C.B.U. Special Care Baby Unit.
S.E. Socio-economic group.
U.S.S. Ultrasound scan.
U.R.T.I. Upper respiratory tract infection.
U.T.I. Urinary tract infection.
V.E. Vacuum extraction delivery.
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INTRODUCTION

During the year 1980 there were 6,444 deliveries after the 28th week of pregnancy and, unfortunately, there were two maternal deaths - one a self-administered drug overdose postpartum and a case of endotoxic shock following an abortion.

In 1974 there were 5,174 deliveries of 28 weeks maturity or more in 1980 there were 6,515 — an increase of work of over 26%. As has been emphasised in previous reports — apart from the opening of the Rotunda Annexe as a temporary measure in 1974 there has been no increase in beds to deal with this increased number of patients. I had thought when I commenced my Mastership in 1974 that the New Block would have been completed by the time I had finished — unfortunately, I have to report that this has not happened and I most sincerely hope it will be achieved in the next seven years.

During the year 97 babies were lost as stillbirths or early neonatal deaths. This is the first time less than 100 babies have been lost in the year and is the lowest perinatal mortality in the history of the hospital being 14.8. During the last seven years the perinatal mortality has fallen from 23.3. It is quite remarkable that the decrease in perinatal mortality in the last three Masterships has been approximately 30% each seven year period.

In October 1980 we were honoured by a visit from the President, Dr. Hillery who is also the President of the Hospital. We were delighted to have the opportunity to meet him and Mrs. Hillery and show them around the Hospital.

LECTURES:

The Bartholomew Mosse Lecture was delivered by Professor G. S. Dawes on "The Analysis of Human Heart Rate Antenatally." This was a most informative Lecture of particular interest because of our interest in cardiotocography. There was a large audience which thoroughly enjoyed Professor Dawes' visit.

The Ninian Falkiner Memorial Lecture in February was given by Mr. John Malvern on "The Management of the Incontinent Female" and in November by Professor Fox on "Placental Insufficiency". We were truly fortunate in both our Lecturers who gave most stimulating and informative talks on these common problems. The Lectures were thoroughly appreciated by the Post Graduate Students and also Members of the Staff.

We also had a visit from Dr. Hugh Jolly who talked on "Family central care and obstetrics." This was also a most thought provoking Lecture which was greatly appreciated by all.

ASSOCIATION OF FRIENDS OF THE ROTUNDA:

The Association continues to go from strength to strength and is remarkably successful in raising Funds for the Hospital. I would like to take the opportunity of thanking most sincerely all those on the Executive - Mr. David Dillon, Mr. Bobbie Law, Mrs. K. Marshall, Mr. Brian Overend, Professor Alan Browne, for all their hard work during the year and I was especially grateful to Mr. Hugh Hamilton who returned as Chairman and continued his hard work for the Friends.

Miss Copeland the Development Officer enthusiastically continued her Fund Raising assisted by Functions Officer, Mr. Tom Morris.

Over the past seven years the Friends have been a great help to the Hospital not only in financing Research but also they have financed the purchase of equipment and improvement in hospital conditions on a lease/lend basis until the Department of Health could find the money to pay for these improvements of patient facilities. I am truly grateful for all their help during the last seven years.
STAFF CHANGES:

It is with great regret that I record the death of Dr. Rory O’Hanlon in June 1980. Rory was a truly loyal colleague who was popular with all he met. He will be sadly missed. Also Dr. James Quinn, ex member of Staff died in July. James, who had retired for some years, was an ex Assistant Master of the Rotunda who then moved to the Meath Hospital where he gave many years of loyal service. He was succeeded on the Staff there by Dr. Rory O’Hanlon.

In March, Miss Gray, our Matron retired. She had a long association with the Hospital as she was Assistant Matron before being promoted to Matron. Having worked closely with her over the last seven years I can appreciate just how much hard work she put into the hospital. I hope she will have a long and happy retirement. I would like to welcome her successor, Miss Kelly, who came to us from Scotland and I hope she will have a long and fruitful association with the hospital.

The Rev. Sydney Lang, our Chaplain, also resigned and was replaced by the Rev. Kevin Brew, whom we welcome.

Mrs. Wilkinson, who we inherited from the Drumcondra Hospital and who continued to act as the Administrative Officer there, resigned in November.

Jack Quillinan who has been Senior Technologist in the Laboratory for many years resigned and has been succeeded by Mrs. Gwen O’Connor.

Professor Eric Doyle, who was Professor of Paediatrics in Trinity College, Dublin, resigned in September. He has given sterling service to the hospital over many years and will be sadly missed as will all those who have left us. I wish all of them well and welcome their successors.

Dr. Cyril Thornton, Lecturer to Royal College of Surgeons, Ireland, was appointed to a Consultant Post in Cork. I hope he will have a most successful career there.

NURSES’ PRIZE DAY

The Prizegiving was held in November and it was a great pleasure to welcome Miss Gray back to donate the prizes.

Raymond Cross Gold Medal: Miss Siobhan Gleeson.
Silver Medal: Miss Elizabeth Ann McCarty
Bronze Medal: Miss Deirdre Ann Elizabeth Kane
Gold Medal: Mrs. Patricia Fletcher (nee Lillie)
Long Service Medal: Sr. Mary Walsh.
Edwin Lillie Medal: Dr. Shahnaz Shah
David Gault Medal: Mr. David Knight

As this is my last Report I would like to record my heartfelt thanks to all Members of the Rotunda Hospital Staff over the seven years - my Consultant Colleagues, the Resident Medical Staff, Nursing Staff, Para-medical staff, Administrative and Secretarial Staff and all Members of the Porters and Housekeeping Staff. It would have been impossible without their help and cooperation for the hospital to have run smoothly. It is invidious to select individuals from all these people but I must mention the Registrars, Dr. Eamon McGuinness, Dr. Cyril Thornton, Dr. Patrick Kiernan, Dr. Brendan Powell and Dr. Brendan Gill because they carried the heavy clinical load and also assisted me in the compilation of this report which is really their results.

I wish to thank all those who helped in the production of the Report and a special word of thanks to Miss Mildred Aherne and her Staff in the Records Department.

Dr. Mellon as Director of the Pathology Laboratory gives a fantastic service to us all and I wish to thank him and all the Laboratory Staff for their help throughout the years.

The Blood Transfusion Service continues to give us a most efficient service for which I am truly grateful.

A special word of thanks to the Matron, Miss Gray and in the latter part of the year, Miss Kelly, the Hospital Secretary, Mr. Ian Gault, the Accountant,
Miss Learmond, who as Heads of Departments worked long and hard to keep the Hospital running efficiently during times of financial restraint.

My Secretary, Miss Marion Doyle, has also given me invaluable support over the years for which I am most grateful.

I would like to wish my successor, Dr. George Henry, a happy and successful Mastership. I am sure he will receive the same helpful co-operation and loyalty from all Members of the Hospital Staff.
## COMPARATIVE TABLE FOR 10 YEARS

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<td>24.9</td>
<td>23.3</td>
<td>20.9</td>
<td>21.2</td>
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<td>0</td>
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<tr>
<td>Caesarean Section %</td>
<td>6.3</td>
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<td>7.2</td>
<td>7.0</td>
<td>7.1</td>
<td>8.1</td>
<td>7.7</td>
<td>8.9</td>
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<td>Forceps %</td>
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<td>12.9</td>
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<td>25.3</td>
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SUMMARY

Total Deliveries ................................................................. 7,196
   Booked ................................................................. 6,566
Unbooked (total includes 507 cases before 28 weeks maturity) .............. 630
   Primigravidae ......................................................... 1,960

Deliveries before 28 weeks maturity (752)
   Abortions .............................................................. 642
   Miscarriages (17 born alive) ..................................... 108
   Moles ................................................................. 2

Deliveries 28 weeks maturity and over:
   Total patients delivered ........................................... 6,444
   Total births ........................................................... 6,515

Maternal results:
   Maternal mortality .................................................. 2
   Incidence (per cent) ................................................ 0.02

Multiple Pregnancies:
   Twins ................................................................. 69
   Triplets ............................................................... 1

Fetal Results:
   Total live births 28 weeks maturity and over ....................... 6,451
   Deadborn ............................................................. 64
   1st week N.N.D’s ..................................................... 33
   Late N.N.D’s ........................................................ 6
   Perinatal mortality rate ............................................. 14.8
   True perinatal mortality rate .................................... 14.5
   W.H.O. perinatal mortality rate (Weight 1,000+ grams) .......... 14.6

Miscellaneous Maternal Complications:
   (not detailed elsewhere in the Report)
   Anaemia ............................................................... 514
   Phlebitis .............................................................. 40
   Skin complications (dermatology) .................................. 12
   Breast abscess ..................................................... 9
   Hyperemesis Gravidarum ........................................... 11
   Pulmonary embolus ................................................ 1
   Tumours ............................................................. 22
   Cardiac disease ..................................................... 20
   Diabetes ............................................................ 25
MATERNAL MORTALITY

THE MASTER

Number of cases 2
Incidence 0.02

   This patient, who was an epileptic on Epanutin and Mysoline, was also a
   known drug addict. Her antenatal career was uneventful. The patient was
   having Physeptone therapy in the National Drug Centre. Labour commenced
   spontaneously at term resulting in the birth of a live female infant weighing 3620
   g. Apgars were 9 and 10. The patient was discharged home and was to keep in
daily contact with the Drug Centre.
   Three weeks after discharge the patient was admitted to the Richmond
Hospital with a drug overdose. Five weeks postpartum the patient was found
dead at home.
   The Coroner’s autopsy confirmed death due to asphyxia following inhalation
of vomit secondary to Palfium administration.

2. 162141 NB. S.E. Gp. 3. Age 34. Height not recorded. Para 2*1. An IUD was
inserted in February 1980. LMP 5th May 1980. Threatened abortion on the
13th July 1980 — admitted to Rotunda Hospital. Scan confirmed pregnancy
continuing with no IUCD in the uterus. Two days later spontaneous abortion
followed by curettage of retained products. Ampicillin therapy commenced in
view of history of IUD.
   On the 16th July at 0300 hours the patient bled per vaginum. Blood
transfusion commenced with Syntocinon in the drip to control the bleeding.
Four hours later the patient was found to be in extremis. BP 110/70. Peripheral
and central cyanosis. Pulse weak and thready. Diagnosis of endotoxic shock
made. Ampicillin supplemented with Flagyl and Gentamicin. No improvement
over the next hour so transferred to the Intensive Care Unit at Jervis Street
Hospital. On admission there BP unrecordable with peripheral circulatory
failure. Hyperventilation, respiration rate 45 per minute. pH 7-23. Abdominal
paracentesis revealed heavily blood stained peritoneal fluid. Started on
Ventilator. D.I.C. treated with fresh frozen plasma. Despite Dopamine and
Sodium Nitroprusside to improve hypotension the patient’s condition
deriorated and death occurred twelve hours after admission to Jervis Street
Hospital.
   Post-mortem revealed all serosal cavities contained large quantities of blood
and blood stained fluid. I.U.C.D. found in the omentum. No evidence of
damage to the uterus which showed evidence of recent pregnancy. Some
necrosis of the liver.
   Conclusion by the Pathologist — cause of death — findings were consistent
with shock and tissue under-perfusion associated with disseminated
intravascular coagulation. No perforation was found in the uterus to account
for the intra-abdominal situation of the coil, although this may have healed.
SEVEN YEAR SUMMARY

7 Maternal Deaths in 41,366 deliveries.

1974 - 1 case Cardiac Grade IV. Abruptio - Caesarean Section - disseminated intravascular coagulation - Cardiac arrest 24 hours postpartum (?Avoidable)

1975 - 1 case Epeleptic. Inhalation of vomit. Death 10th day postpartum (Unavoidable)

1976 - 1 case Astrocytoma - Death after lumber puncture elsewhere on 30th postpartum day. (Unavoidable)

1977 - 0 case.

1978 - 1 case Traumatic postpartum haemorrhage - Cardiac arrest. Death after 12 hours postpartum (Avoidable)

1979 - 1 case Portal hypertension - Haematemesis - post-operative death elsewhere on 20th postpartum day (Unavoidable)

1980 - 2 cases.
## ANALYSIS OF PERINATAL MORTALITY FOR 10 YEARS

<table>
<thead>
<tr>
<th>Year</th>
<th>Total P.N. Deaths</th>
<th>Mortality Rate</th>
<th>Antepartum Deaths</th>
<th>% of Total</th>
<th>Intrapartum Deaths</th>
<th>% of Total</th>
<th>Neonatal Deaths</th>
<th>% of Total</th>
<th>Congenital Malformations</th>
<th>% of Total</th>
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<tbody>
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<td>1971</td>
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<td>1979</td>
<td>104</td>
<td>16.4</td>
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<td>1980</td>
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<td>14.8</td>
<td>46</td>
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<td>7</td>
<td>4</td>
<td>24</td>
<td>18</td>
<td>42</td>
<td>39</td>
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</tbody>
</table>

Perinatal Mortality 500 g. or more: 20.2, 19.4, 18.6

Perinatal Mortality 1,000 g. or more: 19.1, 17.7, 16.7, 14.9, 14.6

### Perinatal Mortality by Gestational Age

- **500 g. or more: 20.2, 19.4, 18.6**
- **1,000 g. or more: 19.1, 17.7, 16.7, 14.9, 14.6**
FETAL LOSS
THE MASTER

SUMMARY

Total stillbirths ................................................. 64
Stillbirth rate ........................................... 9.8 per 1,000
Total 1st week NND’s .................................. 33
Total late NND’s ........................................ 6
Postmortem rate ........................................... 95 per cent
Perinatal mortality .................................... 14.8

True perinatal mortality rate
(excluding case where the fetus was dead before the mother
was referred to hospital = 1 case) ......................... 14.5
W.H.O. Perinatal mortality rate
(weight 1,000 or more grams) .......................... 14.6
Perinatal mortality rate of 500 grams or more .......... 18.6
Corrected P.N.M. (exclusion of congenital
abnormalities) .................................................. 10.3
Booked cases .............................................. 94
Unbooked cases ........................................... 9

ANALYSIS OF PERINATAL MORTALITY

Antepartum deaths ........................................... 46 (3 unbooked)
Intrapartum deaths ........................................... 4 (none unbooked)
Neonatal deaths .............................................. 18 (2 unbooked)
Congenital malformations .................................. 30 (4 unbooked)

CAUSES OF FETAL LOSS

<table>
<thead>
<tr>
<th>Cause</th>
<th>S/B</th>
<th>1st Week NND’s</th>
<th>Late NND’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Antepartum deaths with maceration only.</td>
<td>28</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>2. Antepartum asphyxia</td>
<td>15</td>
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<td>—</td>
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<td>3. Intrapartum asphyxia</td>
<td>2</td>
<td>2</td>
<td>—</td>
</tr>
<tr>
<td>4. Birth trauma</td>
<td>15</td>
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<tr>
<td>5. Pulmonary syndrome etc</td>
<td>15</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>6. Intraventricular Haem</td>
<td>1</td>
<td>—</td>
<td>—</td>
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<tr>
<td>7. Pneumonia</td>
<td>1</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>8. H. disease</td>
<td>1</td>
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<td>—</td>
</tr>
<tr>
<td>9. Preivable/Prematurity</td>
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<td>—</td>
<td>—</td>
</tr>
<tr>
<td>10. Miscellaneous</td>
<td>2</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>11. (a) Congenital malformations</td>
<td>6</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>(b) Anencephalus</td>
<td>10</td>
<td>2</td>
<td>—</td>
</tr>
</tbody>
</table>

It is gratifying to report an improvement in the Perinatal Mortality once more
but congenital malformations were only responsible for 30 per cent of perinatal
deaths.

The same format for presentation of results has been continued for 1980.
ANTEPARTUM DEATHS

Classification

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number</th>
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<tr>
<td>Cause unknown</td>
<td>18</td>
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<tr>
<td>Abruptio placentae</td>
<td>16</td>
</tr>
<tr>
<td>Toxaemia</td>
<td>5</td>
</tr>
<tr>
<td>Cord complications</td>
<td>6</td>
</tr>
<tr>
<td>Rhesus incompatibility</td>
<td>3</td>
</tr>
<tr>
<td>Placenta praevia</td>
<td>1</td>
</tr>
<tr>
<td>Congenital malformations</td>
<td>16</td>
</tr>
</tbody>
</table>

CAUSE UNKNOWN (15)

Less than 37 weeks (5)


37 Weeks or Over (10)


Abruptio Placentae (16)


Comment: The fact that the baby was small for dates was not diagnosed. History of previous myomectomy. High risk case.


Comment: This patient should have been delivered on admission.


Toxaemia (5)


Comment: This patient had hypertension and a small for dates baby and should have been admitted earlier.


Comment: Multiple pregnancy with mild hypertension should not have been allowed to go past term.


Comment: Hypertension, bad obstetrical history and maternal age warranted earlier admission.


Comment: This patient was admitted as soon as toxaemia presented and therefore was unavoidable.


Comment: Unavoidable.
Cord Complications (6)


Rhesus Incompatibility (3)

(1) B. 160036. S.E. Gp. 4. Age 34 Height 164 cms. Para 1 +0. Gestation 33 weeks. Homozygous husband. No live child. Plasma exchange twice weekly - total of 45. Repeat C.T.G. 24 hours after tap for lung maturity. Emergency caesarean section. S.B.I. Weight 2220 g. Post-mortem: Showed Rhesus Incompatibility. Comment: Death may have been associated with bleeding precipitated by the tap but this was never confirmed.


Placenta Praevia (1)

Congenital Malformations (16)

Central nervous system ...................................................11
Miscellaneous ...............................................................5

Central Nervous System (11)


Miscellaneous (5)

Intrapartum Deaths

There were four intrapartum deaths, two stillbirths and two early neonatal deaths.

(1) B. 162750. S.E. Gp. 2 Age 28 Height 160 cms. Para 1 +0 . Gestation 40 weeks. Completely uneventful antenatal career. Admitted with spontaneous rupture of membranes but no labour at 39 weeks and 6 days. Six hours later the patient went into labour. Fourteen hours after admission and three hours after commencement of contractions the fetal heart was not heard. The liquor was clear. The fetal heart had given rise to no anxiety prior to this. A fresh S.B.I. Weight 3310 g. was delivered. Post-mortem revealed no abnormality. Conclusion: intrapartum death of fullterm fetus - cause unknown.
Comment: This is a most unsatisfactory stillbirth as we still do not know why the baby died.

(2) B. 164195. S.E. Gp. 2. Age 29 years. Height 155 cms. Para 2 +0 . Gestation 32 weeks. Threatened abortion in early pregnancy and some scanty bleeding at 26 and 30 weeks, otherwise antenatal career uneventful. Admitted in premature labour at 32 weeks. After a total of five hours she had an easy assisted breech delivery with forceps to the aftercoming head. Just prior to delivery the fetal heart dropped. No meconium passed. F.H.N.H. on delivery. There was a small retroplacental clot weighing 80 g. Fresh S.B.I. Weight 2390 g. Failed to respond to resuscitation. Post-mortem: Intrapartum death due to antepartum haemorrhage.
Comment: A most unsatisfactory stillbirth. The patient should have been admitted earlier with the antepartum haemorrhage.

Neonatal deaths


Comment: If membranes had been ruptured on admission the meconium would have been diagnosed earlier.
NEONATAL DEATHS

Classification

Respiratory complications ......................................................... 14
Abruptio placenta ........................................................................ 1
Rhesus Incompatibility ................................................................. 1
Placenta praevia ............................................................................ 1
Haemophilia ................................................................................. 1
Congenital malformations ............................................................ 13

Respiratory Complications (14)


(11) B. 163688. S.E. Gp. 3. Age 22 Height 153 cms. Para 0 +0. Gestation 28 weeks. Spontaneous onset of premature labour. Wrigley's lift-out delivery of a 1,000 g. infant. Survived 18 hours. Post-mortem: Respiratory distress and obstruction of main bronchus.


(13) B. 164674. S.E. Gp. 2. Age 28 Height 160 cms. Para 2 +0. Gestation T + 2 days. Spontaneous delivery of healthy infant weighing 4,100 g. Sent to Ward with mother. Noted to be cyanosed when 20 hours of age. Transferred to Nursery. Died at 25y hours. Clinically thought to be a hypoplastic left ventricular - this was not confirmed by post-mortem. Post-mortem: Respiratory cardiac failure.


Abruptio Placenta (1)


Rhesus Incompatibility (1)


Placenta Praevia (1)


Haemophilia (1)

(1) B. 158634. S.E. Gp. 4. Age 34 Height 157 cms. Para 3 +0. Gestation 38 weeks. Multiple pregnancy. Second twin - assisted breech delivery. Weight 3130 g. Apgars 6 and 8. Baby well for the first five days then sudden collapse with stridor, shock, and blood in trachea. Death occurred on the sixth day. Post-mortem: Subdural haemorrhage. Comment: It was only after the death of the child we discovered the mother had two haemophiliac brothers and this was the cause of death.

Congenital Malformations (13)

Central nervous system .................................................. 5
Multiple congenital abnormalities ................................. 4
Congenital heart disease .............................................. 3
Potter's syndrome ...................................................... 1
Central Nervous System (5)


Multiple congenital abnormalities (4)


Congenital heart disease (3)

Potter's syndrome (1)


Late Neonatal Deaths (6)


SUMMARY FETAL LOSS 1974 - 1980

41,366 babies born - 791 Perinatal deaths.
P.N.M. = 19-1/1,000

791 deaths.

Congenital Malformations. . . . . 41 SB 102 N.N.D 261 = 33%
Anencephalus. . . . . . . . . . . . . . . . . 91 SB 27N.N.D.

Remainder = 530 deaths = 12-8/1,000

<table>
<thead>
<tr>
<th>S/B</th>
<th>Remainder</th>
<th>%</th>
<th>Remainder</th>
<th>N.N.D.</th>
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<tr>
<td>194</td>
<td>141</td>
<td>24-5</td>
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<tr>
<td>70</td>
<td>71</td>
<td>8-9</td>
<td></td>
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</tr>
<tr>
<td>52</td>
<td>19</td>
<td>8-5</td>
<td>180</td>
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<tr>
<td>18</td>
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<td>3-0</td>
<td>174</td>
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## SUMMARY FETAL LOSS 1974-1980

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<td>5. Pulmonary syndrome etc.</td>
<td>6</td>
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<td>16</td>
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<td>6. Intraventricular Haem,</td>
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<td>4</td>
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<td>11. (a) Congenital malformations</td>
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<td>17</td>
<td>10</td>
<td>6</td>
<td>16</td>
<td>2</td>
<td>91</td>
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<td>11. (b) Anencephalus</td>
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<td>19.7</td>
<td>18.6</td>
<td>16.4</td>
<td>14.8</td>
<td>19.1</td>
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The fetal loss averaged 19-1 per 1,000 over the seven years - the highest loss being 23-3 in 1974 and the lowest 14-8 in 1980. If one excludes congenital malformations, (which fluctuated from 29-38% of the perinatal loss, and was responsible for 33% of the loss in the seven years) - the largest cause for death was antepartum asphyxia.

Consistently over the years there have been 26-34 stillborn with maceration only and 6-15 cases of antepartum asphyxia. In many cases these were unavoidable, but an efficient screening test for diagnosis of those at risk is necessary to reduce this cause of death.

Intrapartum deaths fluctuated wildly from 10-4% of fetal loss. In many cases there are avoidable factors which can be reduced by greater emphasis on intrapartum care.

Neonatal deaths have reduced especially over the last three years - 31% of perinatal deaths in 1976 and 18-2% in 1980.

In our analysis of the P.N.M. by the Butler classification it can be seen that trauma was responsible for 1-5% of deaths - it is gratifying to report no loss from trauma in the last two years.

Pulmonary syndrome caused 11-3% of deaths and still is a problem which is of concern related to premature delivery. Intraventricular haemorrhage (4-4%) has been reduced over the last two years.

Haemolytic disease (3%) continues in our population to be a problem but many of these cases were referred for plasmapheresis which was a special interest of Dr. McGuinness.

Preivable/prematurity (2.7%) varied from year to year and was maximum (16 cases) in 1974-0 cases in 1980. It is difficult to define previability today so this classification has been avoided.

Since 1976 P.N.M. of 1,000 grams and over has fallen from 19-1 to 14 6 and since 1978 the P.N.M. of 500 grams and over from 20-2 to 18-6/1,000.
SUMMARY FOR DELIVERIES 20-28 WEEKS

THE MASTER

Summary:

Total number of infants born ........................................... 44
Deadborn ........................................................................ 23
Liveborn ........................................................................ 21
Survived ........................................................................ 1

COMMENT

Forty-one mothers delivered a total of 44 babies and all but 6 were booked for hospital delivery.

Nineteen of the babies weighed less than 500 grams; 15 were between 500 and 749 grams; 7 between 750 and 999 grams and 3 were over 1,000 grams. Only one baby (weight 1,050 grams) of 27 weeks gestation (confirmed by scan) survived. The other two over 1,000 grams weighed 1,300 grams @ 26/52 and died in labour. If its weight had been appreciated it might have done better by C.S. One infant (weight 350 grams) with hydrocephalus and spina bifida survived 9 days.

The cause of premature delivery was:

- Bleeding ................................................................. 7 cases
- No cause found ......................................................... 14
- I.U.D. ......................................................................... 13
- Spont. R.O.M ........................................................... 3
- Abruptio ................................................................. 2
- Cong. Abnormalities ................................................ 2
TOXAEMIA OF PREGNANCY

Pre-Eclamptic Toxaemia, Essential Hypertension, Chronic Essential Hypertension plus Toxaemia, and Chronic Renal Disease.

DR. P. KIRWAN

Summary:

(a) Total number of cases: 400
   Booked = 392
   Unbooked = 8

(b) Incidence against total deliveries at all periods of pregnancy (7,196):
   5.5 percent

(c) Maternal mortality:
   Before 28 weeks = 10
   Deadborn = 10
   lstweek N.N.D. = 3

(d) Gross fetal loss:
   Deadborn = 23
   lstweekN.N.D. = 3

Perinatal mortality rate: 3.28

CLASSIFICATION OF 'TOXAEMIAS'"

<table>
<thead>
<tr>
<th>Grade</th>
<th>Findings</th>
<th>Total</th>
<th>Deadborn</th>
<th>Neonatal deaths</th>
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<td>1</td>
<td>Early + late hypertension</td>
<td>288</td>
<td>9*</td>
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<tr>
<td>2</td>
<td>Late hypertension with proteinura</td>
<td>90</td>
<td>4*</td>
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<tr>
<td>3</td>
<td>Early hypertension with late proteinuria</td>
<td>22</td>
<td>7*</td>
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<tr>
<td></td>
<td>Totals</td>
<td>400</td>
<td>20</td>
<td>3</td>
</tr>
</tbody>
</table>

*includes deaths before 28 weeks maturity.

CAUSES OF FETAL LOSS:

DEADBORN = 10

I.U.D. and Maceration ............................................................ 6
Abruptio Placenta ............................................................... 3
Congenital Abnormalities ......................................................... 1

NEONATAL DEATHS = 3

Congenital Abnormalities ......................................................... 2
Intrapartum Asphyxia ............................................................... 1

FETAL LOSS:

DEADBORN = 10

breech delivery of a macerated S.B.I. Weight 1,330 g. No life for three days. Post-mortem: Maceration.

NEONATAL DEATHS = 3

1st week N.N.D.'s:

COMMENT

The Perinatal Mortality rate in this group has risen significantly over previous years. However this would appear to be due to a stricter definition of what constitutes hypertension in pregnancy. The overall incidence has fallen from 6-9% to 5 • 5% in spite of a slight increase in the total number of deliveries. The total number of patients in this group has fallen from 493 in 1979 to 400 this year.

Of the deadborn infants five occurred in babies who were small for gestational age which went unrecognised and must be considered avoidable. In three of these cases the hypertension was mild and two were associated with
proteinuria. The one avoidable N.N.D. had mild hypertension, was induced with Prostaglandin, had a seven hour labour, the liquor was clear, the foetal heart was regular until just prior to delivery when it dipped down to 90. It is difficult to see how this death could have been avoided but intrapartum monitoring might have helped.
ECLAMPSIA

DR. P. KIRWAN

(a) Total number of cases

(b) Maternal mortality

(c) Fetal loss


COMMENT

The N.N.D. was due to prematurity. However the baby must have been severely hypoxic in utero and one wonders whether the large dose of valium (100 mgs) necessary to control the eclampsia might not have contributed to the low apgar at birth.
PLACENTA PRAEVIA
DR. BRENDAN GILL

Summary:
(a) Total number of cases 40
Incidence against total deliveries 28 weeks maturity and over, (6,444) 0.6 per cent.
(b) Maternal mortality Nil
(c) Gross fetal loss 2

Perinatal mortality rate 50

GRADE 1 PLACENTA PRAEVIA:
Total number 2 (No fetal loss)
Treatment:
Caesarean section 1
Nil specific 1

GRADE II PLACENTA PRAEVIA:
Total number 12 (No fetal loss)
Treatment:
Caesarean section 12

GRADE III PLACENTA PRAEVIA:
Total number 14 (1 D/B, 1 1st week NND)
Treatment:
Caesarean section 14 1 1

GRADE IV PLACENTA PRAEVIA:
Total number 12 (No fetal loss)
Treatment:
Caesarean section 12

Fetal loss:
DEADBORN = 1


NEONATAL DEATHS = 1

1st week N.N.D.

COMMENT

The number of cases and incidence of placenta praevia has reduced this year. The perinatal mortality rate has reduced from 90/1,000 last year to 50/1,000 this year.

In one case 163432 the presence of placenta praevia had no bearing on the cause of death.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>P.N.M. Rate</td>
<td>0.6</td>
<td>0.3</td>
<td>0.6</td>
<td>0.6</td>
<td>0.7</td>
<td>0.7</td>
<td>0.6</td>
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<tr>
<td></td>
<td>29.4</td>
<td>100</td>
<td>128.2</td>
<td>105.2</td>
<td>62.5</td>
<td>83</td>
<td>50</td>
</tr>
</tbody>
</table>

The incidence is relatively constant but the P.N.M. remains higher than one would like to see.
ABRUPTIO PLACENTAE, A.P.H. OF UNKNOWN ORIGIN AND A.P.H. FROM LOCAL LESIONS OF THE GENITAL TRACT

DR. BRENDAN GILL.

Summary:

(a) Total number of cases = 245

Unbooked = 8

Incidence against total deliveries 28 weeks maturity and over, (6444) = 3.8 percent

(f) Maternal mortality = Nil

(c) Gross fetal loss = 24

Deadborn = 16

Ist week NND's = 8

Perinatal mortality rate = 97.5

(d) Multiple pregnancies = 1 set of twins.

CLASSIFICATION OF HAEMORRHAGE

<table>
<thead>
<tr>
<th>Classification</th>
<th>Total</th>
<th>D/B</th>
<th>N.N.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental-abruption</td>
<td>54</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Accidental-unclassified</td>
<td>191</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

FETAL LOSS:

DEADBORN = 16


B. 164195. S.E. Gp. 2. Age 29. Height 155 cms. Para 2 + 0. Gestation 32 weeks. Threatened abortion in early pregnancy and some scanty bleeding at 26 and 30 weeks, otherwise antenatal career uneventful. Admitted in premature labour at 32 weeks. After a total of five hours she had an easy assisted breech delivery with forceps to the aftercoming head. Just prior to delivery the fetal heart stopped. No meconium passed. F.H.N.H. on delivery. There was a small retroplacental clot weighing 80 g. Fresh S.B.I. Weight 2390 g. Failed to respond to resuscitation. Post-mortem: Intrapartum death due to antepartum haemorrhage.

Comment: A most unsatisfactory stillbirth. The patient should have been admitted earlier with the antepartum haemorrhage.


Comment: This patient should have been delivered on admission.

NEONATAL DEATHS = 8

1st week N.N.D's.


DEADBORN = 16

Intrapartum .................................................. 2
Antepartum death and maceration ......................... 1
Antepartum asphyxia ......................................... 11
Congenital abnormalities .................................... 2

NEONATAL DEATHS = 8

Prematurity. Hyaline membrane disease .................. 4
Congenital abnormalities .................................... 3
Intrapartum asphyxia ......................................... 1
COMMENT

Cases of antepartum haemorrhage in which evidence of retroplacental clot is found following delivery are classified as haemorrhage due to abruptio placenta. All other cases are regarded as unclassified accidental haemorrhage (having excluded placenta praevia and local causes). The increase in total number and incidence of cases last year has continued this year and there is a marked increase in perinatal mortality rate from 77-9 to 97-5/1000.

SUMMARY OF 7 YEARS

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1974</td>
<td>51</td>
<td>4-5</td>
<td>30</td>
<td>3-7</td>
<td>3-5</td>
<td>3-6</td>
<td>3-8</td>
</tr>
<tr>
<td>P.N.M.</td>
<td>153</td>
<td>79-8</td>
<td>160</td>
<td>106</td>
<td>86</td>
<td>77-9</td>
<td>97-5</td>
</tr>
</tbody>
</table>

The incidence has reduced over the years and the P.N.M. has been less than 100 for the last 3 years.
**HYDRAMNIOS**

**Summary:**

(a) Total number of cases .................................35  
Incidence against total deliveries at all periods of pregnancy, 7,196.........0.4 percent

(b) Gross fetal loss .................................7  
Deadborn = 6  
1st week NND = 1

Perinatal mortality rate ........................................170.7

(c) Multiple pregnancies .................................6 sets of twins

(d) Maternal mortality .................................Nil

**FETAL LOSS:**

**DEADBORN = 6**


**NEONATAL DEATHS = 1**

1st week N.N.D's

MULTIPLE PREGNANCY
MASTER

Summary:

(a) Total number of cases ........................................... 70
   Incidence against total deliveries 28 weeks
   maturity and over, (6,444) .................. 1.08 per cent

(b) Maternal mortality ............................................. Nil

(c) Gross fetal loss, ............................................. 10
   Perinatal mortality, ............................... 70.9

(d) Diagnosed antenatally, ................................. 64

(e) Primigravidae, ............................................. 13
   Multiparae, ............................................. 57

FETAL LOSS:

DEADBORN = 7

B. 159059. S.E. Gp. 4. Age 27. Height 160 cms. Para p'^1'. Gestation 36 weeks, multiple
   admission. 1,410 g. (first twin 2,150 g. alive and well). Uniovular twin pregnancy. Post-mortem:
   cause unknown.
B. 160537. S.E. Gp. 3. Age 22. Height 167 cms. Para 0'^0'. Gestation term + 1 day. Multiple
delivery of second twin. Macerated S.B.I. Weight 2,330 g. Post-mortem: maceration only.
   Comment: Multiple pregnancy with mild hypertension should not have been allowed to go past
   term.
B. 160585. S.E. Gp. 4. Age 22. Height 166 cms. Para l'^0'. Gestation 35 weeks. Multiple
   pregnancy. Premature labour at 35 weeks. F.H.N.H. on admission. Spontaneous delivery of
   second twin. Macerated S.B.I. Weight 1,500 g. Post-mortem: advanced maceration only.
   Velamentous insertion of macerated cord. Twist in cord leading to intrauterine death.
B. 161284. S.E. Gp. 2. Age 36. Height 165 cms. Para 0'^0'. Gestation 32 weeks. Multiple
   labour. Delivery by Caesarean section. First twin macerated S.B.I. Weight 2,000 g. Post-mortem:
   Maceration stillbirth.
   Comment: This patient was admitted as soon as toxaemia presented and therefore was
   unavoidable.
   Macerated S.B.I. 2,080 g. Post-mortem: Maceration.
   1,300 g. Post-mortem: Maceration only.
   admission. Multiple pregnancy. Repeat elective Caesarean section. Second twin macerated S.B.I.
   1,670 g. Post-mortem: refused.

NEONATAL DEATHS = 3

1st week N.N.D's

B. 158634. S.E. Gp. 4. Age 34. Height 157 cms. Para 3'^0'. Gestation 38 weeks. Multiple
   pregnancy. Second twin — assisted breech delivery. Weight 3,130 g. Apgars 6 and 8. Baby well
   for the first five days then sudden collapse with stridor, shock and blood in trachea. Death
   occurred on the sixth day. Post-mortem: Subdural haemorrhage.
   Comment: It was only after the death of the child we discovered the mother had two haemophiliac
   brothers and this was the cause of death.


**COMMENT**

Over the years the incidence of multiple pregnancy has varied between 1.08 (1980) and 1.5 (1977) with a P.N.M. from 13.6 (1974) to 115.6 (1976). Management consists of regular ante natal care with a vaginal examination at each visit to assess the state of the cervix. Unfortunately one of the twins had been an I.U.D. in many cases and it illustrates the difficulty of monitoring both infants.

Of the seven stillborn all were macerated — in three cases (160537, 161378 and 164687) the maturity was over 38 weeks and they might have been saved by premature delivery. There were three neonatal deaths, one (163029) due to congenital abnormality, one (160585) due to R.D.S. and clinically a persistent fetal circulation and one (158634) possibly due to brain haemorrhage from haemophilia.
SURGICAL INDUCTION OF LABOUR
MASTER

Summary:

(a) Total number of cases 281
Incidence against total number of deliveries
28 weeks maturity and over — 6,444 __ 4.3 per cent

(b) Maternal mortality ............................................. Nil

(c) Gross fetal loss ............................................. 6
Perinatal mortality rate ........................................ 17.4

(d) Multiple pregnancies ........................................... 5 sets of twins

(e) Ruptured uterus .................................................. Nil

(f) Termination by Caesarean Section ........................ 19 (6.7%)

Indications for Induction:
Postmaturity...................................................... 82
Toxaemia of pregnancy ......................................... 59
Placental insufficiency .......................................... 44
Geographical and social reasons, .............................. 32
Assorted............................................................ 29
A.P.H ............................................................. 17
Abnormal antepartum C.T.G ................................. 8
Rhesus incompatibility ......................................... 7
Multiple pregnancy ............................................. 5

FETAL LOSS:

DEADBORN = 3


NEONATAL DEATHS = 3

1st week N.N.D.’s.


Late N.N.D.
The incidence of surgical induction of labour has steadily declined from 29.5 in 1974 to 4.3 in 1980. Over the last 18 months induction of labour with vaginal prostaglandin has become popular and hence the rate of 4.3% is artificially low for induction of labour. The P.N.M. was 17.4 — of the 3 stillborn 2 were anencephalic and one (164687) was a macerated 2nd twin. The two N.N.D.'s were congenital malformations and the late N.N.D. was congenital heart disease and Downes Syndrome. None of these were related to the induction of labour. Since we reduced our surgical induction rate we have been criticized for being too conservative. This year only one case (165365) was later than T + 14 days and this baby was anencephalic.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Incidence</td>
<td>29.5</td>
<td>25.9</td>
<td>15.5</td>
<td>13</td>
<td>7.6</td>
<td>6.4</td>
<td>4.3</td>
</tr>
<tr>
<td>P.N.M.</td>
<td>11.1</td>
<td>6.1</td>
<td>12.3</td>
<td>2.4</td>
<td>4</td>
<td>2.4</td>
<td>17.4</td>
</tr>
<tr>
<td>Caesarean Section</td>
<td>4%</td>
<td>4.5%</td>
<td>5.9%</td>
<td>4.3%</td>
<td>7.9%</td>
<td>10.9%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>
PERSISTENT POSTERIOR POSITION AND TRANSVERSE POSITION OF THE OCCIPUT

MASTER

Summary:

(a) Total number of cases.........395
Incidence against total births 28 weeks
maturity and over, 6,515........................................ 6.06 per cent

(b) Maternal Mortality......................... Nil

(c) Gross fetal loss........................................ 3  Deadborn = 1

Perinatal mortality rate.........................7.5

1st week N.N.D's = 2

DEADBORN = 1

NEONATAL DEATHS = 2

1st week N.N.D's

BREECH DELIVERY
MASTER

Summary:

(a) Total number of cases (this includes 101 delivered by Caesarean section, 2 of which were 1st week neonatal deaths).............................................270
Incidence against total births 28 weeks maturity and over (6,515).............................................4.1 per cent

Deadborn = 13
1st week NND's = 6
Late NND's = 1
rennai mortality raie .......................... /U.J

UNCOMPLICATED BREECH = 99

<table>
<thead>
<tr>
<th>Parity</th>
<th>Total</th>
<th>Deadborn</th>
<th>N.N.D's</th>
<th>Gross fetal loss</th>
<th>Perinatal mortality %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primiparae</td>
<td>24</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Multiparae</td>
<td>75</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

COMPLICATED BREECH = 68

<table>
<thead>
<tr>
<th>Parity</th>
<th>Total</th>
<th>Deadborn</th>
<th>N.N.D's</th>
<th>Gross fetal loss</th>
<th>Perinatal mortality %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primiparae</td>
<td>14</td>
<td>5</td>
<td>1</td>
<td>18</td>
<td>26.4</td>
</tr>
<tr>
<td>Multiparae</td>
<td>49</td>
<td>8</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Five sets of twins delivered as Breech in this Table.

BREECH DELIVERY FOLLOWING INTERNAL VERSION IN LABOUR = 2

<table>
<thead>
<tr>
<th>Parity</th>
<th>Total</th>
<th>Deadborn</th>
<th>N.N.D's</th>
<th>Gross fetal loss</th>
<th>Perinatal mortality%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primiparae</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Multiparae</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

FETAL LOSS:

DEADBORN = 13


5 : 6. F.H.N.H. next visit. Assisted breech delivery of macerated S.B.I. Weight 1570 g. Cord tightly around neck times 1. Post-mortem: Intrauterine hypoxia and maceration. Comment: The fact that the baby was small for dates was not diagnosed.


B. 160408. S.E. Gp. 4 Age 20. Height 155 cms. Para 0\textsuperscript{10}. Gestation 38 weeks. Mild maternal hypertension. (140/90). F.H.N.H. on admission. Spontaneous breech delivery of a macerated S.B.I. Weight 1330 g. No life for three days. Post-mortem: Maceration. Comment: This patient had hypertension and a small for dates baby and should have been admitted earlier.


B. 164195. S.E. Gp. 2. Age 29. Height 155 cms. Para 2\textsuperscript{10}. Gestation 32 weeks. Threatened abortion in early pregnancy and some scanty bleeding at 26 and 30 weeks, otherwise antenatal career uneventful. Admitted in premature labour at 32 weeks. After a total of five hours she had an easy assisted breech delivery with forceps to the aftercoming head. Just prior to delivery the fetal heart dropped. No meconium passed on delivery. There was a small retroplacental clot weighing 80 g. Fresh S.B.I. Weight 2390 g. Failed to respond to resuscitation. Post-mortem: Intrapartum death due to antepartum haemorrhage. Comment: A most unsatisfactory stillbirth. The patient should have been admitted earlier with the antepartum haemorrhage.

NEONATAL DEATHS = 7

1st week N.N.D's.

B. 158634. S.E. Gp. 4. Age 34. Height 157 cms. Para 3\textsuperscript{10}. Gestation 38 weeks. Multiple pregnancy. Second twin-assisted breech delivery. Weight 3130 g. Apgars 6 and 8. Baby well for the first five days then sudden collapse with stridor, shock, and blood in trachea. Death occurred on the sixth day. Post-mortem: Subdural haemorrhage. Comment: It was only after the death of the child we discovered the mother had two haemophilic brothers and this was the cause of death.


COMMENT

The incidence of breech presentation at the onset of labour remains steady at 4-1 (1980) to 5-2 (1975). The P.N.M. rate varied from 133 (1978) to the lowest of 70.3 this year. In uncomplicated breech deliveries only 3 infants have been lost out of 586 deliveries. The Caesarean section rate remains between 31% (1974) and 38% (1980).

In 1980 there were 13 stillborn infants — eight were macerated, five were congenital malformations and one (No. 164195) was an intrapartum death due to abruptio placenta.

Of the 7 early neonatal deaths four had congenital abnormalities, No. 158634 was an assisted breech delivery of a second twin. The child, which was well for five days, collapsed and died. Post-mortem showed a subdural haemorrhage. It was only at this stage it was discovered that the mother had two haemophiliac brothers. No. 159815 was a 32 week premature assisted breech delivery which survived 14½ hours. Death due to hyaline membrane disease. One late N.N.D (No. 158559) was due to Edward’s syndrome on the 22nd day.

In none of these cases can death be associated with the mode of delivery.
FACE AND BROW PRESENTATION

DR. R.K. BRENNAN

Summary:

(a) Total number of cases ........................................15  All booked
    Incidence against total births 28 weeks maturity and over (6,515) .................................. 0.2 per cent

(b) Brow presentations ........................................... 4  Primipara = 1
    Multiparae = 3

(c) Face presentations .......................................... 11  Primiparae = 3
    Multiparae = 8

(d) Maternal mortality ........................................... Nil

(e) Gross fetal loss ............................................. 1  (Deadborn)
    Perinatal mortality rate ..................................... 66.6

Methods of delivery:

BROW PRESENTATION = 4 cases
    Caesarean section ........................................... 4 Total D/B N.N.D.
    — — —

FACE PRESENTATION = 11 cases
    Spontaneous ................................................. 6  1 —
    Caesarean section ......................................... 4 — —
    Forceps ...................................................... 1 — —

FETAL LOSS:

DEADBORN = 1

Summary:

(a) Total number of cases 17

Primiparae = 2
Multiparae= 15

Booked = 16
Unbooked - 1

Incidence against total births 28 weeks maturity and over, (515) = 0.2 per cent

(b) Maternal mortality Nil

(d) Gross fetal loss Nil

MANAGEMENT:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Total</th>
<th>D/B</th>
<th>N.N.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caesarean section</td>
<td>15</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Assisted breech</td>
<td>2</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

COMMENT

The incidence is half that of last year and it is gratifying to report no fetal loss.
### Summary:

(a) Total number of cases............ 25  
Incidence against total deliveries 28 weeks maturity and over, (6,444) .................... 0.3 per cent  
(b) Maternal mortality .................... Nil  
(c) Gross fetal loss .......................... Nil  
(d) Ruptured uterus .......................... Nil

### Comment

Where labour is efficiently accelerated with oxytocin the incidence of C.P.D. has become so rare in our practice that it should seldom be diagnosed prior to labour. In this table only those cases where a secondary arrest at greater than 4 cms occurred where labour was adequately stimulated and cases with True Conjugate less than 10 cms are included. All previous sections are excluded except where an adequate trial of labour failed to achieve a normal delivery due to arrest of labour or failure of the presenting part of descend.

All cases were delivered by Caesarean section. There were five elective sections and all other patients had an adequate trial of labour. Of the five elective sections the True conjugate was 10 cms, 9.2 cms and 9.5 cms. Pelvimetry was not done in the remaining two cases.
PROLAPSE AND PRESENTATION OF THE CORD

Summary:

(a) Total number of cases, 25 (all booked)
Incidence against total deliveries 28 weeks maturity and over, (6,444), 0.3 per cent

(b) Maternal mortality, Nil

(c) Gross fetal loss, 1 (Deadborn)
Perinatal mortality rate, 40

PROLAPSED CORD

Total number of cases, 22
Primiparae = 6
Multiparae = 16

Management:

Caesarean section, 16
Forceps, 2
Breech extraction, 2 (1 Deadborn)
Vacuum extraction, 1
Spontaneous delivery, 1

PRESENTATION OF THE CORD:

Total number of cases, 3

Management:

Caesarean section, 3 (All Multiparae)

FETAL LOSS:

DEADBORN = 1

COMMENT

The incidence over the 7 years has reduced from 0.6 in 1974 to 0.3 for the last 2 years. The P.N.M. varies from 250 (1978) to 40 (1979) — the loss of the baby usually depends on its condition on admission. The only fetus lost this year was an anencephalic.
RHESUS HAEMOLYTIC DISEASE

DR. P. MCKENNA

Number of cases .......................... 32
Incidence per cent ...................... 0.4
Perinatal deaths ......................... 4
Stillbirths ............................... 3 (1 due to abruption)
Neonatal deaths ......................... 1
Abortions before 20 weeks .......... 2
Patients married to heterozygous husbands .......................... 14
Infants affected .......................... 26
Infants not affected ...................... 6
Infants requiring exchange transfusion 14
Patients treated with plasma exchange 3
Perinatal mortality rate ............... 125:1000

Age distribution of women with antibodies:
20-24 .......................... 2
25-29 .......................... 5
30-34 .......................... 5
34 .......................... 20

Number of mothers thought to have begun their reproductive life after 1970 ....................... 11
Number of mothers with previous stillbirths or neonatal deaths as a consequence of Rhesus disease ....................... 12

PERINATAL DEATHS:

COMMENT

The management of Rhesus disease remains unchanged from last year - being based on past obstetric history, antibody titre, spectrophotometry and ultrasound. Plasma exchange was offered to several patients.

The number of patients is similar to last year and although the "pool" of affected patients is diminishing it is unlikely ever to dwindle to insignificant proportions. This is borne out by the fact that a quarter of the patients are under 30, and a third of the patients began their reproductive career after 1970 - about the time the use of Anti- D became established practice.

The severity of the disease is emphasised by the fact that no fewer than 12 of the 32 affected mothers had previous stillbirths or neonatal deaths as a consequence of Rhesus disease.

52
LABOUR FOLLOWING CAESAREAN SECTION

DR. B. GAUGHAN

Summary:

Total number of cases ......................................................... 228 (Booked = 225)
(unbooked = 3)
Incidence per cent .............................................................. 3.5
Maternal mortality ............................................................... 0
Twins ........................................................................ 4
Stillbirths ........................................................................ 4
Neonatal deaths ................................................................. 1
P.N.M. rate ................................................................ 21.5/1000
Ruptured uterus/scar ............................................................ 0

Methods of delivery:

<table>
<thead>
<tr>
<th>Delivery Method</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous</td>
<td>150</td>
</tr>
<tr>
<td>Forceps - Rotational = 10; Direct = 57</td>
<td>67</td>
</tr>
<tr>
<td>Vacuum extraction</td>
<td>5</td>
</tr>
<tr>
<td>Breech</td>
<td>6</td>
</tr>
<tr>
<td>Instrumental deliveries (forceps and vacuum)</td>
<td>72 (31%)</td>
</tr>
</tbody>
</table>

Causes of Fetal Loss:

STILLBIRTHS = 4


NEONATAL DEATHS = 1


COMMENT

The number of vaginal deliveries following Caesarean section continues to increase each year.

These cases are carefully supervised in labour and often the second stage is assisted thereby giving a high incidence of instrumental deliveries - 31% when both the forceps and vacuum extractor are counted.

The use of epidural anaesthesia is not contra-indicated in these cases and the incidence this year is much higher than last year. Interestingly, the instrumental delivery rate is lower.
Summary:

(a) Total number of cases........1,188
Incidence per cent........................................18.2
(b) Maternal mortality........................................Nil
(c) Gross fetal loss..........................................12

(Deadborn = 4)
(1stweekNND's = 7)
(LateNND's=1)

Perinatal mortality rate..................................9.2

Causes of fetal loss:

DEADBORN = 4


NEONATAL DEATHS = 8

1st week N.N.D's


B. 163688 S.E. Gp. 3. Age 22. Height 153 cms. Para 0\textsuperscript{0}. Gestation 28 weeks. Spontaneous onset of premature labour. Wrigleys lift-out delivery of a 1,000 g. infant. Survived 18 hours. Post-mortem: Respiratory distress and obstruction of main bronchus.


Late N.N.D's
COMMENT

The incidence has increased steadily from 13.9 to 18.2 in the last 7 years - the main reason for this being increased use of epidural anaesthesia. The fetal loss has fallen from 22.4 in 1974 to 9.2 this year. In some cases the baby was dead before the forceps were applied and it is not an accurate reflection on the possible danger of forceps. There were no cases of traumatic intracranial damage.
Summary:

(a) Total number of cases, 56

Incidence against total births 28 weeks maturity and over, (6515), 0.8 per cent

(b) Gross fetal loss Nil

(c) Epidurals, 29

Indications for Vacuum Extractor:

First stage of labour-
- Fetal distress, 20
- Failure to advance, 9
- Abnormal monitor values, 3
- Correction of brow presentation, 1
- Maternal distress

Total 34

Second stage of labour-
- Delay in second stage, 14
- Fetal distress, 7
- Abnormal monitor values, 1

Total 22

(Primiparae = 16)
(Multiparae = 40)
(Booked = 55)
(Unbooked = 1)

51.7%
CAESAREAN SECTION
THE MASTER

Summary:

(a) Total number of cases, 522
Booked = 508
Unbooked = 14
Incidence against total deliveries 28 weeks
maturity and over, 6,444, 8.1 per cent

(b) Maternal mortality, Nil

(c) Gross fetal loss, 19
Deadborn = 7
1st week NND = 1
Late NND's = 1

Perinatal mortality rate, 33.8

(d) Multiple pregnancies, 10 sets of twins

(e) Primary Caesarean sections, 351
Classical = 1
LLS = 168
Classical = 3

(f) Repeat Caesarean sections, 171

(g) Total Pfannensteil incisions, 417 = 79.9%

INDICATIONS FOR PRIMARY SECTIONS

<table>
<thead>
<tr>
<th>Indication</th>
<th>Total</th>
<th>DIB</th>
<th>N.N.D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal distress</td>
<td>85</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Breech</td>
<td>54</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Abnormal ante-partum values</td>
<td>36</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Disproportion</td>
<td>32</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Placenta Praevia</td>
<td>27</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Toxaemia/Eclampsia</td>
<td>24</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Failure to progress/failed trial of labour</td>
<td>21</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Prolapse/Presentation of cord</td>
<td>16</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Abruptio placenta</td>
<td>14</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Transverse/Oblique lie</td>
<td>14</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Infertility/B.O.H</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rhesus incompatibility</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Abnormal scalp sample</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Face/brow presentation</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Previous repair</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cervical dystocia</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Compound presentation</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Failed forceps</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Maternal pyrexia</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>351</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FETAL LOSS:

DEADBORN = 5


Comment: This patient was admitted as soon as toxaemia presented and death therefore was unavoidable.


Comment: The fact that the baby was small for dates was not diagnosed. History of previous myomectomy. High risk case.


NEONATAL DEATHS = 9

1st week N.N.D's


Late N.N.D's


58
INDICATIONS FOR REPEAT CAESAREAN SECTIONS

<table>
<thead>
<tr>
<th>Indication</th>
<th>Total</th>
<th>D/B</th>
<th>NND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Repeat</td>
<td>51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disproportion</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal Distress</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failed trial of labour</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placenta praevia</td>
<td>10</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>B.O.H</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transverse/Oblique lie</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toxaemia</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal antepartum values</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breech</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Abruptio placenta</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Previous repair</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical stenosis</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failed forceps</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failed induction</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspected ruptured uterus</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcerative Colitis with R.V. fistula</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>171</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

FETAL LOSS

DEADBORN = 2


1st Week NEONATAL DEATHS = 3

<table>
<thead>
<tr>
<th>1st week N.N.D's</th>
</tr>
</thead>
</table>

COMMENT

The incidence of Caesarean section is slightly reduced from 8.9% to 8.1% and the Perinatal mortality is the same 32.5% to 33.8% this year. There were only four Classical Caesarean sections the indications being: (1) Transverse lie; (2) Placenta praevia - failed induction; (3) Uterine abnormality - disproportion; (4) Obstructed labour due to cervical fibroid.

In the primary cases there were five stillborn infants - two known I.U.D. before delivery (No. 161284 - 2nd twin: No. 163218 Abruptio with fibroid obstructing delivery): two were associated with abruptio placenta resulting in fresh stillbirths (No. 158692 and No. 163714) and 160036 was a Rhesus case possibly associated with bleeding from an amniocentesis. The neonatal deaths were congenital abnormalities in four cases (No. 158402, No. 158785, No. 159840, and No. 165411): No. 161239 premature delivery at 29+ weeks for
Eclampsia: 162164 a failed trial of labour in a grand multipara: 162811 with Rhesus incompatibility. In 160980 abruptio placenta led to an intrapartum death. No. 160854 was a late N.N.D. with hydrocephalus. In the repeat cases both the stillbirths were macerated and the N.N.D's were associated with an abnormal fetus (161285), abruptio (163294) and placenta praevia (164747).

SEVEN YEAR SUMMARY

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence</td>
<td>7%</td>
<td>7.1%</td>
<td>8.1%</td>
<td>7.7%</td>
<td>8.9%</td>
<td>8.9%</td>
<td>8.1%</td>
</tr>
<tr>
<td>P.N.M.</td>
<td>27.3</td>
<td>26.2</td>
<td>42.7</td>
<td>35.2</td>
<td>41.3</td>
<td>32.5</td>
<td>33.8</td>
</tr>
<tr>
<td>Pfannenstiel</td>
<td>48%</td>
<td>67%</td>
<td>70%</td>
<td>72%</td>
<td>73%</td>
<td>80.6%</td>
<td>79.9%</td>
</tr>
</tbody>
</table>

The incidence has increased over the seven years as has the P.N.M. The Pfannenstiel incision is now the incision of choice for this operation.
HYSTERECTOMY ASSOCIATED WITH PREGNANCY
DR. H. MCVEY

160202. Mrs. E. D.
This patient first presented to the Antenatal Clinic on the 20th August 1979, expected date of delivery being the 28th March 1980. She gave a history of 4 previous normal deliveries, weighing approximately 81bs. with no complications. During her antenatal attendance she was noted to have a persistent oblique or transverse lie and she was admitted for this condition on the 10th March 1980. The transverse lie persisted and she had a Caesarean Section on the 4th April 1980. She was delivered of a boy weighing 4550 grms in weight. She was discharged on the 12th day after an uneventual convalescence, but had to be re-admitted on the 25th April 1980 with a secondary postpartum haemorrhage. The patient was quite shocked and given blood transfusions, but despite this her condition deteriorated. Examination under anaesthetic showed there were no retained products and it was decided to do a hysterectomy. There was difficulty in tying pedicles as sloughing occurred. She had a total transfusion of 11 units of blood, ran a stormy convalescence and was discharged on the 16th day, Mother and Baby being well.

162702. Mrs. K. M.
This patient first attended the Antenatal Clinic on the 12th February 1980, expected date of delivery being the 23rd August 1980. She gave a history of 2 previous Caesarean Sections, one in March 1974 for fetal distress and prolonged first stage. The second in February 1976 for cephalopelvic disproportion and failure to advance in the first stage. In view of her history she was admitted on the 11th August 1980 for Elective Repeat Caesarean Section. The operation was performed on the 12th August 1980 and proved to be very difficult technically with the bladder extremely adherent. A High Lower Segment Caesarean Section was attempted with difficult delivery of a deeply engaged head. The previous scar extended into the cervix and the bladder was extremely adherent along the scar on the uterus. It was considered that the uterus was not safe for a further pregnancy and a sub total hysterectomy was performed. The patient had a baby girl weighing 3270 grms. and was discharged without any puerperal complications on the 12th day.

163432. Mrs. S. McM.
This patient first attended the Antenatal Clinic on the 5th June 1980, the expected date of delivery being ? October 1980. This was her 10th pregnancy all previous being normal except for the last one in November 1976 which was a Classical Caesarean Section indicated by severe pre-eclamptic toxaemia. She was an extremely poor attender at the Antenatal Clinic, only having 2 visits. She was admitted for antepartum haemorrhage on the 30th July, ultrasound having diagnosed a placenta praevia. The bleeding was so severe that 6 units of blood were given and she remained in hospital with slight bleeding until September 1980. On the 18th September 1980 an Elective Caesarean Section was performed for a breech presentation with a placenta praevia. The placenta proved to be accreta and total removal of the placenta was impossible. consequently a sub total hysterectomy was decided upon and this was done. The Mother and Baby left the hospital in good condition 14 days after delivery.

164870. Mrs. B. K.
This patient aged 40 years of age first attended the Antenatal Clinic on the 23rd September 1980, the expected date of delivery being the 29th December 1980. She had 2 previous normal deliveries in 1968 and 1971. She was diagnosed as having multiple uterine myomata due to a previous examination outside our care. When she first attended it was noted she had a transverse lie and this abnormal presentation continued until the final visit to the Antenatal
Clinic on the 17th November 1980. She was admitted for this complication, but subsequently developed an accidental haemorrhage and was operated on, on the 1st December 1980 because of this condition. She had a baby boy weighing 3070 grms. Following Caesarean section inspection of the posterior aspect of the fundus and the left adnexa showed large areas of adhesions with oozing especially from a degenerating fibroid at the left side of the fundus, other smaller fibroids very soft and with friable oozing at the right posterior fundus. It was decided that a hysterectomy should be performed and a very haemorrhagic Total Hysterectomy was performed with the vault sewn open. The patient was put on Velosef and Flagyl postoperatively and appropriate transfusions were started. The patient responded and was discharged well on her 12th puerperal day.
162123. Mrs. O. D.

This patient first presented at the Antenatal Clinic on the 7th February 1980. She gave a history of having had a Lower Segment Caesarean Section on the 21st January 1972 for failed trial of labour and contracted pelvis. It was a breech presentation and it was thought on abdominal palpation that possibly a double uterus was present. At operation it was confirmed there was a bicornuate uterus and a baby boy weighing 3390 grms. was delivered.

On the 25th September 1973 she had an Elective Caesarean Section of a baby girl weighing 2640 grms. On the 2nd November 1977 a Classical Section was performed to deliver a baby boy weighing 3120 grms.

On this pregnancy the lie was unstable throughout her antenatal career and her expected date of delivery was the 24th July 1980. She was admitted on the 15th July 1980 for Elective Caesarean Section. At operation the old classical scar had disrupted at the time of delivery by breech extraction. It was confirmed at operation that a bicornuate uterus was present and the ruptured uterus was repaired in layer with good haemostasis. Unfortunately the abdominal wound brokedown and had to be re-sutured on the 5th day. After a fairly stormy convalescence the patient was discharged on the 15th day post operatively. The baby was a girl weighing 3500 grms.
POSTPARTUM HAEMORRHAGE
MASTER

Summary:

(a) Total number of cases ........................................... 279 (Booked = 271
(Unbooked = 8
Incidence against total deliveries 28 weeks
maturity and over, (6,444) ......................... 4-3 per cent
(b) Maternal mortality ............................................. Nil
(c) Number of patients transfused ............................. 63
(d) Number of patients in shock ............................... 1

Type of haemorrhage and estimated cause:
PRIMARY HAEMORRHAGE (183)
Atonic .............................. 117
Retained/Adherent Placenta ................. 44
Traumatic ........................... 22

SECONDARY HAEMORRHAGE (96)
R.P.C .................................................. 96

COMMENT
The incidence of P.P.H. varied from 2-8% in 1974 to 4-6% in 1977 and 1978 and 4-3% in 1980. Whether this is a true increase or a greater awareness of the condition is difficult to assess. It is well appreciated that the blood loss at delivery is a "guess-timate" in most cases.
MANUAL REMOVAL OF PLACENTA
DR. B. GAUGHAN

Summary:

(a) Total number of cases = 123
Booked = 122
Unbooked = 1
Primiparae = 38
Multiparae = 85

Incidence against total deliveries 28 weeks
maturity and over, (6,444), 1.9 per cent

(b) Maternal mortality = Nil

Indications for manual removal:
Adherent placenta = 90
Detached cord = 8
Failed ergometrine technique = 8
P.P.H. = 8
(including 2 cases of uterine inversion)
Retained cotyledon = 5
Exploration of genital tract = 4

COMMENT

The incidence is exactly the same as that of last year and thus follows the
trend in varying little from year to year.
However, the incidence of adherent placenta rose by almost 30% from last
year. Many of these cases had epidural anaesthesia which facilitates easy,
painless manual removal.

Maternal morbidity is not increased and only seven cases required blood
transfusion following manual removal. It is interesting to note two cases of
complete inversion of the uterus, both cases responding well to immediate
manual replacement.
The work of the out-patient department remains the same despite the increased delivery rate. This is explained by the extended use of combined antenatal care. The decrease in the number of visits to the medical clinic reflects the better health of the population.
Six patients with acute deep vein thrombosis and one with pulmonary embolism were seen in the clinic. One case of deep vein thrombosis occurred to a patient in the post-partum period. All the other patients were pregnant. In one case the patient was only eight weeks pregnant when thrombosis occurred. Two of these patients had a previous history of deep vein thrombosis. All were satisfactorily treated with heparin.

Two patients with very extensive superficial phlebitis in the thighs were also treated with subcutaneous heparin.

Twenty-nine patients with histories of previous thrombo-embolic problems were seen. Six of these patients had developed a deep vein thrombosis in the past while taking the pill and all were blood group A.

One patient had had a pulmonary embolus following a cholecystectomy some years before. Another suffered from multiple pulmonary embolism of unknown origin six years before and was on long-term Warfarin. She was treated with heparin as soon as it was discovered she was pregnant. In another case the patient was neither pregnant, post-partum, post-operative on the pill when she had a pulmonary embolus.

A patient with mitral valve disease was changed from Warfarin to heparin for the duration of her pregnancy without ill effects.

Heparin was given for prophylactic reasons during the pregnancy to ten women who had deep vein thrombosis during a previous pregnancy and to seven patients who had had post-partum thrombo-embolic disease in the past. In general treatment with self-administered subcutaneous heparin was instituted at about thirty-two weeks. Sister Nealon and the staff in the Pre-Natal Department are to be thanked and congratulated on teaching the patients to inject themselves. Two patients, one with very severe varicose veins and one with severe lymphodema were treated with prophylactic Heparin at delivery. We would like to thank the Master and the Consultants and junior staff for so conscientiously referring these patients early in pregnancy. The fact that so many high risk patients completed their pregnancies and deliveries without trouble must be a source of satisfaction to all of us. The incidence of acute DVT is also low.

We would like to thank Sister Nealon, the out-patient staff and the laboratory staff for their help and co-operation.
During 1980, 267 new patients were seen at the Varicose Vein clinic. In general patients are being referred to the clinic in early pregnancy which makes treatment more effective.

In most cases, problems associated with venous insufficiency are not as severe as in the past due to the general improvement in the patient’s health and the decrease in parity in many patients.

However 29 patients with superficial phlebitis were seen. Twenty-three of these cases were post-partum and only one of the patients had attended the veins clinic although superficial phlebitis is rarely seen in patients with normal veins. Two patients attended with varicose ulcers and in both cases these healed before delivery. Five patients with varicose eczema attended, one patient with haemorrhoids and in two patients angiectatids were the main problem. Twelve patients with vulval varices were seen and one patient with severe varicose veins in the glutal areas.

I would like to thank the Master, Consultants and junior staff for referring the patients early in pregnancy. Sister Neilan and her staff for their helpful cooperation and Mrs. Nora Daly and Mrs. Kay Ward for their assistance in the Clinic.
During the year 1980 there were 425 attendances at the Out-Patient Clinic, of whom 58 were new referrals. The corresponding figures for 1979 were 442 and 54. In addition, 108 patients were seen in the Wards of whom 33 were new referrals. (142 and 29 in 1979).

In 1980, eleven patients experienced major psychotic illness. Details are shown in the following tables.

### SEVEN PATIENTS WITH PSYCHOTIC ILLNESS IN PUERPERIUM

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Age</th>
<th>Parity</th>
<th>Period in Hospital</th>
<th>Treatment</th>
<th>Response</th>
<th>Past History of Psychiatric illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>26</td>
<td>1</td>
<td>8 days</td>
<td>ECT Chemotherapy Antidepressants</td>
<td>Excellent-8 month follow-up</td>
<td>Nil</td>
</tr>
<tr>
<td>Depression</td>
<td>46</td>
<td>4</td>
<td>6 weeks</td>
<td>ECT Chemotherapy Phenothiazines</td>
<td>Excellent</td>
<td>Puerperal depression after third child</td>
</tr>
<tr>
<td>Mania</td>
<td>28</td>
<td>2</td>
<td>6 weeks</td>
<td>ECT Chemotherapy Phenothiazines</td>
<td>Excellent-1 month follow-up</td>
<td>Puerperal mania after first child.</td>
</tr>
<tr>
<td>Mania</td>
<td>28</td>
<td>3</td>
<td>6 weeks</td>
<td>ECT Chemotherapy</td>
<td>Excellent-8 month follow-up</td>
<td>Puerperal mania after first and second children.</td>
</tr>
<tr>
<td>Hypomania</td>
<td>34</td>
<td>3</td>
<td></td>
<td>Phenothiazines</td>
<td>Symptoms settled rapidly.</td>
<td>16 year history recurrent manic/depressive illness including one puerperal episode after second child. Brief In-Patient treatment for mania in seventh month of this pregnancy*</td>
</tr>
<tr>
<td>Hypomania</td>
<td>34</td>
<td>3</td>
<td></td>
<td>Phenothiazines</td>
<td>Symptoms settled rapidly.</td>
<td>14 year history recurrent schizo-affective illness with pronounced manic element. One puerperal episode after first child.</td>
</tr>
<tr>
<td>Mania</td>
<td>32</td>
<td>3</td>
<td>4 admissions in 6 month puerperal period.</td>
<td>ECT Chemotherapy</td>
<td>Poor</td>
<td>7 year history recurrent manic/depressive illness.</td>
</tr>
</tbody>
</table>

This patient experienced psychotic episode in pregnancy as well as puerperium.
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Age</th>
<th>Parity</th>
<th>Period in Hospital</th>
<th>Treatment</th>
<th>Response</th>
<th>Past history of Psychiatric illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizo-affective</td>
<td>37</td>
<td>1</td>
<td>8 days in fifth month pregnancy for manic episode</td>
<td>Chemotherapy Phenothiazines</td>
<td>Fairly good. 2 month post-partum follow-up.</td>
<td>10 years history recurrent schizo-affective illness with pronounced manic element with several hospital admissions.</td>
</tr>
<tr>
<td>Schizo-affective</td>
<td>32</td>
<td>3</td>
<td>O.P. treatment depression 7th-9th months.</td>
<td>Chemotherapy Phenothiazines Anti-depressant</td>
<td>Good. 1 year post-partum follow-up.</td>
<td>10 years history recurrent schizo-affective illness with several hospital admissions.</td>
</tr>
<tr>
<td>Paranoid Schizophrenia</td>
<td>33</td>
<td>3</td>
<td>Continual O.P. Treatment.</td>
<td>Chemotherapy Phenothiazines</td>
<td>Poor. Remains psychotic but coping at home under supervision</td>
<td>5 years history schizophrenic thought disorder, paranoid delusions, ideas of reference and influence, aural hallucinations.</td>
</tr>
<tr>
<td>Psychotic episodes associated with Epilepsy.</td>
<td>22</td>
<td>3</td>
<td>2 weeks in 8th month of pregnancy</td>
<td>Chemotherapy. Anti-convulsives. Tranquillisers.</td>
<td>2 years history acute psychotic episodes associated with poorly controlled epilepsy and requiring LP. treatment.</td>
<td></td>
</tr>
</tbody>
</table>

The four patients with no previous history of psychiatric illness other than — in three cases — puerperal episodes, made rapid, full recoveries with treatment (depression 2; mania 2). This accords with the general belief today that puerperal psychosis has a good prognosis.

The other seven patients (schizo-affective 3; manic/depressive 2; paranoid schizophrenic 1; psychosis associated with epilepsy 1) had long histories of illness. Breakdown in the puerperium or pregnancy, was one in a series of incidents. Response to treatment was less good, and the prognosis guarded.

The incidence of puerperal psychosis is probably 1 per 1,000 confinements. Accurate figures are hard to obtain as a maternity hospital will not see all such cases, some commencing after discharge and being dealt with by the General Practitioner. The risk of relapse in subsequent pregnancies is generally thought to be 1 in 6. In the case of puerperal mania the risk is probably higher than in depression. If two successive pregnancies have resulted in puerperal psychosis, the risk of relapse in another pregnancy is high. If a patient who has had one puerperal psychosis should develop another it will be similar in type and response to treatment as the first one.

All the above factors should be considered and discussed with the patient and her husband who may seek advice about further pregnancies to help them make their decision. It is not proven that prophylactic treatment in the last weeks of pregnancy minimises the chance of puerperal breakdown, but it seems a reasonable course to follow.

It is desirable that any patient with a past history of psychotic illness be referred for psychiatric supervision during pregnancy. Firstly, her basic personality can be assessed and secondly, full details of any previous illness can
be obtained. Thirdly, simple supportive psychotherapy can be given as most such patients are very anxious throughout pregnancy lest puerperal breakdown occur again. Fourthly, prophylactic treatment may be given. This is much better total care for the patient than confronting the Psychiatrist with her for the first time in an acute psychotic state in the post-natal ward.

Another much needed step in improving care for patients with puerperal psychoses is the provision of a mother and baby unit in a Psychiatric Hospital in Dublin. There is evidence that such Units have many benefits. The bond between mother and child, which is extremely important, is fostered and strengthened. It is easier to persuade patients to agree to necessary admission to a Psychiatric Hospital if their baby can go with them. Even when acutely disturbed a mother can relate to her baby and help look after it under close nursing supervision. As she improves she can take more responsibility for the baby. And some workers believe that the mother's recovery is hastened under these circumstances. It is hoped that such a Unit will be provided before too long.
SEXUALLY TRANSMISSIBLE DISEASES CLINIC
DR. W. H. VERLING

Special Clinic

<table>
<thead>
<tr>
<th>No. of patients admitted</th>
<th>Adults</th>
<th>Babies</th>
<th>Adults + Babies Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Syphilis</td>
<td>Gonorrhoea</td>
<td>N.V.D.</td>
</tr>
<tr>
<td>1973</td>
<td>1</td>
<td></td>
<td>89</td>
</tr>
<tr>
<td>1974</td>
<td>2</td>
<td></td>
<td>77</td>
</tr>
<tr>
<td>1975</td>
<td>4</td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>1976</td>
<td>3</td>
<td></td>
<td>80</td>
</tr>
<tr>
<td>1977</td>
<td>2</td>
<td></td>
<td>52</td>
</tr>
<tr>
<td>1978</td>
<td>10</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>1979</td>
<td>10</td>
<td></td>
<td>10</td>
</tr>
</tbody>
</table>

Note: N.V.D. = Non Venereal Disease.

It is very pleasing to see that our figures show no venereal disease. This is in contrast to the reports from the rest of the world, which indicates that we must be very vigilant.

I wish to acknowledge the Service's indebtedness to the Master, his staff, to Sr. Cahill and her staff, and to the staff of the Service, Mrs. Vera Docherty and Miss M. McGuirk.

It is sad, and the end of an era, now that Mrs. Vera Docherty has retired. Mrs. Docherty who retired this year worked at the Clinic since it opened, and after years of steadfast and loyal service found it necessary to retire due to ill health. We wish her many happy years of retirement.

Diagnostic Clinic

<table>
<thead>
<tr>
<th></th>
<th>No. of patients admitted</th>
<th>S.T.D.</th>
<th>Diagnosis</th>
<th>Non-S.T.D.I</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978</td>
<td>6</td>
<td>1</td>
<td>Gonorrhoea</td>
<td>5</td>
</tr>
<tr>
<td>1979</td>
<td>6</td>
<td>2</td>
<td>1 Gonorrhoea 1 Latent Syphilis</td>
<td>4</td>
</tr>
<tr>
<td>1980</td>
<td>7</td>
<td>4</td>
<td>1 Gonorrhoea 1 Papilloma acuminate 1 N.S.G. 1T.V.</td>
<td>3</td>
</tr>
</tbody>
</table>

4 patients were found to be suffering from Sexually Transmissible Disease (S.T.D.). The case of Gonorrhoea was found, because her husband had been diagnosed as having Gonorrhoea at the Mater Clinic, and on investigating the patient the Gonococcus was isolated. The case of Papilloma acuminate was so grossly overgrown that surgical removal had to be recommended. The case of Non Specific Genital (N.S.G.) infection was successfully treated and the contact likewise.

Also the case of Tricheinouas Vaginalis (T.V.) was successfully treated and also the contact.

These figures indicate the almost absence of S.T.D. from the Rotunda population, but I wish to advise great vigilance.

I would like to thank the Master, Sister Nealon, Staff Nurses, Nurses and the Laboratory, for making the running of this Clinic so smooth.

W. H. Verling
Ultra-sound continues to hold an important place in obstetrical and Gynaecological diagnosis. Again, our figures have increased this year, and we now possess a Real Time Scanner which has been of considerable benefit.

There have been some interesting features noted under the new category "miscellaneous" including a foetal lung abscess and brain development anomaly in utero.

Doctors continue to come here from various centres around the country and abroad, to learn Ultra-sound and to start their own departments.

I wish to thank Staff Nurse Regan who regretfully left during the year, and to welcome Staff Nurse O'Keeffe who has become a proficient and excellent colleague. I also wish to thank my secretary Pamela Doherty.

My hope for the future of this department is to find added time and opportunity to include research projects both in obstetric and neo-natal fields.
BLOOD TRANSFUSIONS  
(Maternity Patients only)  
PROF. ALAN D. H. BROWNE

(1) CONDITIONS FOR WHICH BLOOD TRANSFUSION WAS GIVEN. (1980)

<table>
<thead>
<tr>
<th>Indications for Transfusion</th>
<th>No. of Patients transfused</th>
<th>Total stored units</th>
<th>Total packed cell units</th>
<th>Single unit transfused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caesarean Section</td>
<td>64</td>
<td>153</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>P.P.H.</td>
<td>72</td>
<td>178</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Anaemia</td>
<td>31</td>
<td>25</td>
<td>45</td>
<td>1</td>
</tr>
<tr>
<td>Abortion</td>
<td>26</td>
<td>65</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>APH (Vaginal delivery)</td>
<td>16</td>
<td>67</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Caesarean Hysterectomy</td>
<td>2</td>
<td>23</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Vulva Haematoma</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>213</td>
<td>514</td>
<td>56</td>
<td>14</td>
</tr>
</tbody>
</table>

(2) COMPARATIVE TABLES

<table>
<thead>
<tr>
<th>Indication for Transfusion</th>
<th>Patients transfused</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>'76</td>
</tr>
<tr>
<td>P.P.H.</td>
<td>41</td>
</tr>
<tr>
<td>Abortion</td>
<td>32</td>
</tr>
<tr>
<td>Anaemia</td>
<td>38</td>
</tr>
<tr>
<td>C. Section</td>
<td>63</td>
</tr>
</tbody>
</table>

COMPARATIVE TABLES — (2A)

<table>
<thead>
<tr>
<th>Indication for Transfusion</th>
<th>Stored Units</th>
<th>Packed Cells</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>'76</td>
<td>'77</td>
</tr>
<tr>
<td>P.P.H.</td>
<td>110</td>
<td>83</td>
</tr>
<tr>
<td>Abortion</td>
<td>68</td>
<td>74</td>
</tr>
<tr>
<td>Anaemia</td>
<td>45</td>
<td>44</td>
</tr>
<tr>
<td>C. Section</td>
<td>143</td>
<td>188</td>
</tr>
</tbody>
</table>

(3) CUMULATIVE SUMMARY OF BLOOD TRANSFUSION THERAPY

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Patients transfused</th>
<th>Stored units</th>
<th>Packed cell units</th>
<th>Single units</th>
<th>Deliveries before and after 28 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>127</td>
<td>266</td>
<td>49</td>
<td>12</td>
<td>5,987</td>
</tr>
<tr>
<td>1976</td>
<td>195</td>
<td>446</td>
<td>69</td>
<td>10</td>
<td>6,369</td>
</tr>
<tr>
<td>1977</td>
<td>226</td>
<td>436</td>
<td>36</td>
<td>17</td>
<td>6,761</td>
</tr>
<tr>
<td>1978</td>
<td>251</td>
<td>584</td>
<td>136</td>
<td>10</td>
<td>6,937</td>
</tr>
<tr>
<td>1979</td>
<td>203</td>
<td>464</td>
<td>69</td>
<td>16</td>
<td>7,064</td>
</tr>
<tr>
<td>1980</td>
<td>213</td>
<td>514</td>
<td>56</td>
<td>14</td>
<td>7,196</td>
</tr>
</tbody>
</table>

COMMENT

(1) As in previous years the Rotunda Hospital gratefully acknowledges the services provided by the National Blood Transfusion Service Board and its National Director J. P. O'Riordan and his staff. The cumulative summary of
blood transfusion therapy (obstetrical cases only) over the last six years indicates the extent to which obstetrical management relies on blood transfusion to achieve good results.

(2) In 1980 the number of patients transfused was almost the same as in 1979, but the number of stored units of blood increased considerably from 464 to 514. The number of packed cells used decreased slightly, and the single unit transfusions remained at about the same level. It is disappointing to see the decrease in the use of packed cells used in the treatment of anaemia and this is accompanied by a slight rise in the number of stored units. The number of patients transfused for anaemia was almost identical with the previous year, but it does seem as if too many escape diagnosis in the ante-natal period, and when being transfused too many are given stored units rather than packed cell units which are more appropriate for this condition.

(3) Abortion and Caesarean section continue to feature as the conditions for which the greatest number of patients are transfused and the greatest amount of blood is necessary. It cannot be over-emphasised that the frequent use of Caesarean section to the extent that it is currently being used could only be justified in terms of maternal safety when a first-class blood transfusion service is available. Likewise PPH — about which one hears very little in obstetrical gatherings nowadays — would presumably be a very much more lethal condition than it is at present unless the Blood Transfusion Service which we enjoy was instantly available.

(4) The high cost of blood transfusion and its increasing use in other fields of medicine make it mandatory that it should be used with great discrimination. It would be very gratifying if the number of transfusions for anaemia could be reduced by greater vigilance in the ante-natal period. There might be a place for its reduction in connection with the treatment of incomplete abortion. It is almost certain that its use in the treatment of post-partum haemorrhage could be reduced, and the rising generation of the medical profession should be constantly reminded by those responsible for the Blood Transfusion Service of the place of component therapy available other than stored blood.
The demands on every Department continue to increase.

**Haematology**
- Haemoglobin: 32,049
- P.C.V: 3,012
- White Cell Counts: 1,015
- Differentials: 912
- Platelet Counts: 132
- E.S.R: 208
- Prothrombin Time: 240
- Partial Thromboplastin Time: 48
- F.D.P’s: 36
- Reticulocyte Count: 24

**Total No.** 37,676

**Serology**
- A.B.O. Groups: 10,050
- Rh. Groups: 10,050
- Antibody Screens: 9,810
- Direct Coombs Test: 1,524
- Kleihauers: 836
- Antibody Investigations: 656
- Genotype Determinations: 96
- Titres: 148
- A.B.O. Immune Antibody Screens: 139
- Du. Investigations: 2,215
- Investigation of Febrile: 9
- Transfusion reactions: 35,533

Six of the "Transfusion Reactions" were due to white cell antibodies. No cause was found for the other three.

**Transfusion Service**
- No. of Units received from Blood Bank: 1,374
- No. of Units returned to Blood Bank: 321
- No. of Units transfused: 1,143
- % Wastage: 23%
- No. of patients cross-matched: 3,984
- No. of cross-matches performed: 8,202
- No. of doses of Anti D and Globulin issued: 864

**Cytology**
- Total No. of Smears: 4,555
- No. of Positive Smears: 8
- No. of Suspicious: 35

Of the eight Positive Smears, subsequent Biopsy confirmed five to be Carcinoma in situ, one invasive Carcinoma, one severe Dysplasia. In one case there was no evidence of Malignancy.

Of the thirty five suspicious smears five were severely dyskaryotic. Two of these cases subsequently progressed to Carcinoma-in-Situ and all are under active consideration.
Histology
Autopsies (Infants) ................................................. 126
Number of Paraffin Blocks (Autopsies) .................................. 550
Surgical Specimens .................................................. 2,365
No. of Paraffin Blocks (Surgical) .................................... 5,500
No. of Carcinomas diagnosed ........................................... 29
  (a) Endometrium .................................................... 6
  (b) Cervix ........................................................... 13
  (c) Ovary ............................................................ 5
  (d) Vagina ........................................................... 1
  (e) Vulva ............................................................ 3
  (f) Others ............................................................ 1

Of the 13 Cervical Carcinomas diagnosed six were initially detected by Cytological examination.

Biochemistry
Total No. of Specimens received ...................................... 6,229
Total No. of Biochemical Tests carried out .............................. 11,391

During the year a decrease was seen in the number of Urea and Uric Acid, and Pregnancy Oestrogens requested while the number of Bilirubins and Glucose Tolerance Tests increased. The Urine and Pregnancy Tests usually carried by this Department are now being done in the Bacteriology Department.

Bacteriology
Routine Specimens - Cultured ...................................... 7,008
Routine Sensitivity Tests ............................................. 980
Routine Urinanalysis ............................................... 6,102
Routine Urinanalysis Cultures ..................................... 1,769
Routine Urinanalysis Sensitivities ................................ 163
O.P.D. Bacteruria Tests .............................................. 5,059
Semen Analysis ....................................................... 368
Pregnancy Tests ...................................................... 6,833

28,282

COMMENT
As evident from the figures the work continued to expand in 1980. Over the years the range of tests being performed has increased while the Staff number has remained the same.

The Department provides a voluntary "On Call" service for emergency work and this too has shown an upward swing—Cross-Matching being the bulk of the work.

The Laboratory Staff are to be thanked for their co-operation in maintaining this service.

77
## Number of examinations

<table>
<thead>
<tr>
<th>Category</th>
<th>Adults</th>
<th>Babies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterus and Contents</td>
<td>390</td>
<td></td>
</tr>
<tr>
<td>Pelvimetry</td>
<td>190</td>
<td>980</td>
</tr>
<tr>
<td>Hysterosalpingogram</td>
<td>402</td>
<td></td>
</tr>
<tr>
<td>Erect Abdomen</td>
<td>15</td>
<td>195</td>
</tr>
<tr>
<td>I.V.P.</td>
<td>197</td>
<td>4</td>
</tr>
<tr>
<td>Chest</td>
<td>283</td>
<td>47</td>
</tr>
<tr>
<td>Misc</td>
<td>189</td>
<td>51</td>
</tr>
<tr>
<td>Mict. Cystogram</td>
<td>46</td>
<td>61</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,712</strong></td>
<td><strong>2,886</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Adults</th>
<th>Babies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest</td>
<td></td>
<td>980</td>
</tr>
<tr>
<td>Barium Meal</td>
<td>47</td>
<td>4</td>
</tr>
<tr>
<td>Barium Enema</td>
<td>4</td>
<td>51</td>
</tr>
<tr>
<td>Erect Abdomen</td>
<td>195</td>
<td>61</td>
</tr>
<tr>
<td>Long Bones</td>
<td></td>
<td>51</td>
</tr>
<tr>
<td>Skull</td>
<td>12</td>
<td>1,426</td>
</tr>
<tr>
<td>I.V.P.</td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>Congenital Abnormality</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>&quot;hips&quot;</td>
<td></td>
<td>54</td>
</tr>
<tr>
<td>Misc</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>2,886</strong></td>
</tr>
</tbody>
</table>

**Total 4,598**
In this year there were 50 new referrals seen at the Genetic Counselling Clinic, four of these required second visits. In 41 cases attendance was due to the presence of a genetic abnormality in an offspring either living or deceased. Two unmarried females were investigated for sex chromosome anomalies, five couples attended with a history of non-gynaecological habitual spontaneous abortion, and two first cousins intending to marry were seen. A father with a limb deformity also came along to discuss his genetic prognosis.

There was an improvement over previous years in the number of fathers accompanying mothers to the clinic. Where relevant both parents attended in 88% of cases. This figure was 80% in 1979. First born (32%) and second born (30%) formed the largest proportion of referrals where an affected offspring was concerned.

As always counselling for neural tube malformations was requested most - 11 cases. A large increase in referrals for counselling for Down's Syndrome - 9 cases - was noted over the previous year - 3 cases. Three parents with balanced chromosomal translocations were discovered - all were referred because they had had offspring with severe mental and physical abnormalities associated with abnormal chromosome patterns. Each had a high risk of recurrence of their offspring's problems, and illustrate the need for chromosomal investigation of parents of such offspring in all cases to detect the familial cases. None of the five couples investigated for habitual abortions had a chromosomal anomaly. Other referrals were for such conditions as congenital heart disease, haemophilia, Becker's muscular dystrophy, holoprosencephaly, and hare lip with associated cleft palate.

Recurrence risks varied from a high (greater than 1 in 10) risk in 8%, through an intermediate (1 in 10 to 1 in 20) risk in 44% to a low (less than 1 in 20) risk in 48% of the parents seen. This risk figure is based on the 1 in 40 risk every woman has at every pregnancy for an offspring with a mental or physical handicap.

My thanks are due to the Nursing and Secretarial Staff, especially Miss Audrey Dixon, of the Paediatric Out-Patients Department for their help which ensures the smooth running of this clinic.
Anaesthetic Department
Dr. J. Gardiner

During the year Dr.'s O'Fahartaigh, Butler, McDonnell and Meeke were rotated here through the Training Programme.

Dr. Bohn, our new consultant jointly appointed with the Mater Hospital, went back to Toronto. We are awaiting a replacement from the Mater. He was an excellent colleague. We wish himself and Dr. Olivia Butler every success and happiness and sincerely hope we have not seen the last of them.

Our work load has risen even further and the Board of this hospital have sanctioned a further Junior Anaesthetist. We hope the Department can sanction an expansion of the junior quota in the near future. Dr. O’Nolan was the first doctor appointed to this post.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Between 21.00-07.00</td>
<td>3,659</td>
<td>3,489</td>
<td>3,570</td>
<td>3,476</td>
</tr>
<tr>
<td>Total</td>
<td>620</td>
<td>414</td>
<td>485</td>
<td>449</td>
</tr>
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<table>
<thead>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>64</td>
<td>164</td>
<td>594</td>
<td>1,010</td>
<td>877</td>
<td>1,128</td>
<td>1,243</td>
</tr>
</tbody>
</table>
SOCIAL WORK DEPARTMENT

During 1980, our staff carried out 6,588 interviews with patients and their relatives; major social difficulties accounted for 53% of this work load. Our service was to married, widowed, deserted, separated and single patients, whose obstetric, paediatric, gynaecological and psychiatric care was complicated by social and emotional problems and included:

(1) Enabling patients and their relations to come to terms with troublesome situations, whilst negotiating and facilitating the best possible solution to any given amalgam of difficulties, especially those which would hinder the best results from other specialized care.

(2) Removal of barriers, emotional and practical, which would prevent necessary treatment.

(3) Preventive social therapy, facilitating modification of behaviour and attitudes, especially in vulnerable situations, e.g., signs of marital breakdown, the potential for non-accidental injury to children, difficulties in parenting.

(4) Dealing with hostility, hurt and bereavement.

(5) Interpreting the impact of hospitalization and appreciating the depersonalizing effect this can have on the individual.

Crisis intervention was a factor in much of the work load and normally required our instant availability and attention. Many of the more intractable problems were exacerbated by economic and environmental factors, such as rising unemployment (including increased redundancies), and scarce housing. Other problems were aggravated by emotional deprivations resulting in personality difficulties and relationship malfunctions.

The year 1980 was one of recession. The percentage of insurable workers registered as unemployed in the Dublin and Dun Laoghaire area was 8.5 (8.1 in 1979). The inflation rate had risen to 21% for the period February 1980 to February 1981 (rate had been 15% in the previous 12 months).

These two factors allied to the increasingly difficult housing situation created serious impediments in the lives of many of our patients. Some had insufficient income to keep pace with rising costs. An additional baby often put severe strain on the family budget, and, in the wider context, on the economy of the country, which had an already top-heavy dependent population. Unemployment, without hope of work, was demoralizing and had far-reaching effects on those affected; support and help in maintenance of self-respect was as vital as helping to meet the pressing material requirements.

The housing situation deteriorated with the Municipal Authorities unable to rehouse all those in need. Many newly-weds, especially, had great difficulties. They were faced with the dilemma-of sharing with relations, or renting at grossly inflated rates, which precluded saving for a home of their own. There was also the near certainty of being evicted when pregnancy was apparent. Depression, anger and frustration were commonly-found emotions in the sheer helplessness of this plight, some resorted to squatting, the delay in implementing the legal process of removal giving them temporary respite.

Marital violence and malfunction showed every indication of being on the increase. Legal redress lagged behind current family needs. Barring orders were mostly ineffectual and were usually of too short duration. Civil divorce could not be obtained, whereas church annulments were being granted in certain cases and led to blatantly anomalous situations for couples and their children.

Relationship malfunctioning was usually found to be a result of emotional deprivation and insecurity; factors, such as instability in the home, inconsistent discipline, leading to behavioural problems in young adults were likely factors in cases of illegitimacy especially the teenage group. There were many instances of over-reaction by parents who used their single pregnant daughter, in particular,
as the scape-goat, when in effect, she was the victim of certain tensions in her home and family situation.

Those having illegitimate pregnancies numbered 964, of whom 49 had no ante-natal care and were admitted to hospital unbooked. The majority, (720), originated from Dublin city and precincts; Irish rural areas (212); Northern Ireland (12); Great Britain (13); other European countries (5); United States (1); Vietnam (T). One or both ‘parents’ were aware of the pregnancy at the time of the first ante-natal visit for 72% of patients seen.

Ages ranged between 14 years and 45 years with 46% teenage pregnancies. One patient died of drug abuse, postnatally.

The following three tables illustrate some of the statistics enumerated:

**Table I**

<table>
<thead>
<tr>
<th>Socio-economic groups</th>
<th>Professional/Managerial</th>
<th>White Collar</th>
<th>Skilled Manual</th>
<th>Semi-skilled Manual</th>
<th>Unskilled</th>
<th>Never Worked</th>
<th>School child</th>
<th>Not known or elicited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>28</td>
<td>272</td>
<td>77</td>
<td>215</td>
<td>320</td>
<td>24</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Putative Father</td>
<td>50</td>
<td>86</td>
<td>232</td>
<td>115</td>
<td>278</td>
<td>9</td>
<td>4</td>
<td>190</td>
</tr>
</tbody>
</table>

**Table II**

<table>
<thead>
<tr>
<th>Civil Status</th>
<th>Single</th>
<th>Married</th>
<th>Married &amp; Apart</th>
<th>Widowed</th>
<th>Not known or elicited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>893</td>
<td>2</td>
<td>57</td>
<td>12</td>
<td>123</td>
</tr>
<tr>
<td>Putative Father</td>
<td>764</td>
<td>23</td>
<td>51</td>
<td>3</td>
<td>123</td>
</tr>
</tbody>
</table>

**Table III**

<table>
<thead>
<tr>
<th>Ages</th>
<th>Gravida (relating to illegitimate pregnancies only)</th>
<th>Relationship with Putative Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youngest</td>
<td>Oldest</td>
<td>No. Teenage</td>
</tr>
<tr>
<td>14</td>
<td>45</td>
<td>430</td>
</tr>
</tbody>
</table>

The number of patients already engaged increased, being 22% of the total. Most of those patients were content to postpone marriage till after confinement. When this happened, the child’s birth could be made legitimate without difficulty. The unsatisfactory situation regarding birth registration of children born extra-maritally, yet whose parents were stably co-habiting, was mentioned in our 1979 report. This situation continued unresolved.

82
There has been growing pressure from many organizations and individuals to have the status of illegitimacy abolished. The term is derogatory and discriminatory to the innocent subject who should have a right to have his or her paternity established and who should not have to forego succession rights. It is hoped that a solution, which will take care of all the difficult and complex aspects connected with such disparities, will be found soon.

The outcome of the 964 illegitimate pregnancies was as follows:

- Live illegitimate births in 1980: 512
- Confinements in 1980, patient having married during pregnancy: 97
- Abortions/miscarriages in 1980: 27
- Stillbirths in 1980: 7
- Transferred elsewhere for confinement: 14
- Not pregnant: 2
- Did not return to Rotunda: 23
- Undelivered 1980: 284*
- Total: 966**

* Of the 285 undelivered in 1980, 81 married subsequent to their initial attendance at the hospital.
** The total of 966 includes 2 sets of twins.

Of the 512 illegitimate live births there were 6 neo natal deaths and 1 death at 9 days (c/o Spina Bifida). The outcome of the remaining 505 was as follows:

- Kept by patient: 420
- Placed for adoption: 69
- Uncertain: 13
- Long-term fostering: 2
- Place of Safety Order: 1
- Total: 505

The proportion of girls and women keeping their babies was 83-2%; 13-7% opted for adoption (i.e. 69 babies); 2-6% were ambivalent; two babies were placed in long term fosterage due to uncertainties, one infant was placed in the care of the Health Board through a "Place of Safety" Order.

The rate of illegitimacy in the hospital further increased with the percentage of illegitimate live births known to us being 7.9. (The rate for the entire country is only available for the first two quarters of 1980 i.e. 4.9 and 5.2 respectively at time of writing, July 1981).

Due to pressures in the Maternity Section, it was not possible to maintain as close liaison with the Paediatric Unit as we would have wished. We have been much dependent on the staff of the Paediatric Department to refer socially at-risk infants, where neglect, abuse and other hazards are likely, babies who fail to thrive, children from deprived situations, as well as physically and mentally handicapped and medically vulnerable infants.

Professional workers in the Social Services, being concerned about the stresses that lead to non-accidental injury to children, have formed an organization "Parents Under Stress". Initially, two self-helps groups have been set up and further development and expansion is planned.

The Government set up two Civil Legal Aid and Advice Centres, in Dublin, with a complicated means test in operation, minimum charge being £1 for Legal Aid (i.e. solicitor) and £10 for Legal Advice (i.e. counsel). The voluntary Free Legal Aid Centres were phasing out their services by ceasing to accept new cases.

During the year, an Attachment of Earnings Order was made allowing employers to deduct maintenance from the bread-winner's wages and to send this to the District Court clerk for payment to the spouse (maximum £50 weekly
for wife and £15 for each dependent child). Separate payments were also in order from the Department of Social Welfare. These rulings, when it is possible to execute them, have eased the finances of certain mothers, particularly where alcoholism has been a factor in the non-support.

We have had close and friendly liaison with Public Health Nurses and Community Social Workers, especially in the North city area. Our colleagues in the community were sometimes already involved with certain of our patients and their families and in these instances our role was to facilitate continuance of that contact and to act as a link with services that this hospital provides. The hospital has reason to be grateful for the professional care and follow-up given by social workers and nurses, in the community.

We thank, too, the many voluntary agencies who have served our patients: the adoption societies; the organizations and homes for lone parents and their children; the hospital Saturday Fund Council which donated £300 towards the needs of certain deprived patients; our own Samaritan and Infant Clothing Fund committees, for their continued interest, support and work; the Friends of the Rotunda for their generous subvention to these two committees. Many other individuals helped with knitting as well as teaching our long-stay patients to knit and with other diversional activities. The response of so many of the needs of our clients more than equalled our demands in mobilizing their resources, sometimes most urgently.

Within the hospital, we welcomed the setting up of a new Admissions Office which provided a more welcoming, discreet and comfortable entre for patients.

A ward census scheme came into operation in June. This was a welcome and time-saving procedure; it has streamlined the administrative process in the precise recording of patients' transfers and discharges.

The opening of the new hospital restaurant in March not only provided attractive appetising food in delightful surroundings, but aided inter-disciplinary communication and therefore had an indirect beneficial effect on patients.

Miss E. M. Gray retired from her post as Matron in March. Her sensitivity, kindness and solicitude for patients and her own, as well as other, hospital staff in times of calm and crisis will not readily be forgotten.

Dr. R. H. O’Hanlon’s untimely death grieved all those who worked with him. He showed concern, in the broadest sense, for his patients. His courage, wisdom and kindness will long be remembered.

Dr. I. J. Dalrymple’s Mastership ended; his business acumen added to his professional skills and his social awareness, with his quick recognition of priorities, translating ideas and aims into practical action, made an excellent amalgam for such office.

Teaching: Lectures/Tutorials were given to postgraduates, physiotherapy students, pupil midwives, public health nurses and industrial welfare officers. Field-work training was given to one undergraduate social studies student.

Conferences and Research: Children First; The Family Experience of Adoption (May 1980); Federation of Services for Unmarried Parents and their Children; Participation in survey on housing and other factors relating to single mothers (June 1980).

Finally, I wish to thank my two colleagues, Margaret Burns and Angela Long whose wisdom in dealing with oft-times difficult situations is deeply appreciated, and our two secretaries, Deirdre Carton and Alison Colelough, whose hard work, discretion, courtesy and skill in dealing with the public is greatly valued.
Obstetric Physiotherapy was introduced into this hospital in 1958 by Mrs. Hazel Tamplin M.C.S.P. The Physiotherapy Department at that time comprised one metal locker, situated off a main corridor. This locker progressed to two very small rooms - inadequate and inaccessible to patients. It is good however to report the new department is underway. Regrettably it will not be opened until 1981. It had been hoped the department would have been completed during the mastership of Dr. Ian Dalrymple. We wish to record our very sincere thanks to the Master for his vision, sheer determination and perseverance. It was no easy task - thwarted with many difficulties. We are therefore all the more grateful to him. One other name we would wish to associate with the long struggle to establish a suitable department is Dr. Peter Denham. He is synonymous with Obstetric Physiotherapy. Dr. P. Denham became part of the 'Preparation Team' in 1963 (Master, Alan D. H. Browne, M.D., M.A.O., F.R.C.P.I., F.R.C.O.G.) together with Miss M. McCann Sister Tutor. Since then he has worked in close association with this department, giving us particular help with the making of the Glaxo film "Ready for Baby"-1968. (Master, Dr. E. W. Lillie, M.D., M.A.O., F.R.C.O.G.) Also during that time we were privileged to work with Sister Tutors, Miss E. Eames and Miss C. O'Boyle. We thank Dr. Denham for his moral support down through the years, for his encouragement and above all a sense of proportion and good humour.

We look forward to working in our new department for obvious reasons - the main one being to extend our present programme of preparation. Hither to this was not possible due to lack of facilities and the work load on our mothercraft teacher Mrs. Elaine O'Neill. We trust that with the opening of our new department all these problems will be resolved. It is good to record in the 1960's the team contributing to ante-natal education consisted of Midwife, Obstetric Physiotherapist, Dietician and Obstetrician. Like all aspects of life there is a natural movement, an evolvement, - so also with teaching programmes. In the future we hope to follow more closely a programme of preparation devised and formulated jointly by members of the Midwife Board and members of Obstetric Association of Chartered Physiotherapists Ireland. The programme was finalised in 1977 and received the approval of Bord Altranais, talks having taken place during 1975 - 1976 between the two professional bodies under the guidance of Bord Altranais. It is hoped that this will be a "blueprint" for ante-natal education throughout the country. The central theme underlying the idea behind the joint exercise is the maximum care and support of the woman during pregnancy, labour and puerperium. It is good to note this programme still involves the multi-disciplines, each discipline giving of its own particular expertise. The first National Course was held in the Rotunda on 1st and 2nd March 1979.

The working committee consisted of:-

Ms. Ita O'Dwyer, R.G.N., R.M., M.T.D.
Ms. Ena Gurhy, R.G.N., R.M., M.T.D.
Ms. Anna Managhan, R.G.N., R.M., M.T.D.
Ms. Joan Johnson, Obstetric Physiotherapist, Waterford.
Ms. Mary Johnson, Obstetric Physiotherapist, Tralee.

PREPARATION FOR PARENTHOOD

Midwife:  

Class 1.  24-26 weeks  

Development of Fetus  

Simple explanation of development of fetus and appendages. Note date of quickening.
Physiology of pregnancy and relation of these changes to the minor disorders.
Explanation of such minor disorders and instruction in their treatment stressing prevention. Maternity wear. Nutrition in pregnancy applied to development of fetus and maternal organs; the prevention of anaemia and maintenance of maternal health. Practical hints in purchasing and proper utilisation of foods to be included. Alcohol and cigarettes and drugs. Preparation for and encouragement of breast feeding is essential here - value of consuming the correct foods will be stressed.
Maternity benefits.

**Obstetric Physiotherapist:**

*Class 1. 24-26 weeks*

Fundamental aim in preventative. This is achieved by:-

1. Practical application of ergometrics in the musculoskeletal system, thereby preventing and alleviating minor disorders in pregnancy, e.g. backache, postural defects, circulatory disorders such as oedema, varicose veins. Demonstration of the effects of the developing fetus on posture. The adaptation of posture particularly in working conditions:

   (a) In the home; lifting and handling children and objects. Correct ways of carrying out household activities.

   (b) Working conditions outside of the home - e.g. office workers, etc. Correct standing, sitting etc. applied to the particular job in which she is employed.

2. Advice on adequate rest and exercise with explanation.

3. Advice on supports where necessary, such as abdominal or support stockings. Footwear.

**Midwife:**

*Class 2. 26 weeks*

**Physiology of Labour**

Simple explanation of physiological changes in labour, changes which occur in labour and their effects on mother and fetus.

Baby layette should be dealt with stressing the type of clothes not to purchase.

Purchasing of toilet requisites for the baby - cost of the and advice on minimising expense should be included.

**Obstetric Physiotherapist:**

*Class 2. 26 weeks*

Introduction and demonstration with discussion of relaxation and breathing. Illustrating how this process may be employed to cope with all the possible anxieties and fears of pregnancy, using these natural means to minimise the need of drugs. Developing sensory awareness and relating this to the early activity of the fetus. Recapitualtion of 1st class.
Midwife: **Class 3 28 weeks**

Obstetric Physiotherapist: **Class 3 28 weeks**
1st stage of Labour. Breathing and relaxation applied to the physical and emotional activities of labour - including explanation of sensations and demonstration of contracting uterus by use of visual aids. Breathing and relaxation applied to the different types of contractions. How the father can help during this stage.

Midwife: **Class 4 30 Weeks**
Induction of labour and its limitations. Equipment in use in Labour Ward, fetal monitor and the value of such equipment in the detection of complications must be simply explained in a reassuring manner. Vaginal examinations explained - why such examination is necessary.

Obstetric Physiotherapist: **Class 4 30 weeks**
Practical consideration of coping with the end of 1st stage of labour with its more frequent and powerful contractions associated with any emotional crisis that may occur. Neuro-muscular control and dissassociation. Methods of dealing with backache, thigh cramps, etc. i.e. techniques of massage; frictions, kneading, effleurage and counter pressure.

Midwife: **Class 5 31 weeks**

Obstetric Physiotherapist: **Class 5 31 weeks**
2nd Stage of Labour. Active controlled relaxation. Explanation and demonstration of technique for the expulsive stage. Importance of correct use of the diaphragm and abdominal muscles with conscious decontraction of pelvic Floor. Coping with internal and external examinations - A.R.M., rectal or vaginal examinations.

Midwife: **Class 6 32 weeks**
Breast feeding. Preparation for and care of the breasts explained. Detailed instruction is needed here in preparation of nipples, expressing colostrum. Diet again stressed.
Demonstration of preparation of artificial feed given. Stress sterilisation of equipment and cleanliness of hands. Suitable film shown here.

Obstetric Physiotherapists:  
Class 6  32 weeks  
Rehearsal for normal labour.

Midwife:  
Class 7  34 weeks  
"New mother and her Needs"  
Postnatal care elaborated on - the importance of postnatal exercises stressed. Suggestions in organisation of home routine after discharge given. Explanation given about screening tests on baby, e.g. B.M. Test, Guthrie test, immunisation and vaccination explained. Visit to post natal ward.

Obstetric Physiotherapist:  
Class 1  34 weeks  
Variations in labour with a simple explanation of the different patterns of labour. Introduction of the importance of postnatal exercises to prevent development of conditions such as stress incontinence and backache in riper years. Emphasis continued on correct posture and positioning for lifting and carrying during the post-natal period and for breast and bottle feeding. Discussion of the whole subject.

Midwife:  
Class 8  36 weeks  
Discussion on Responsible Family Planning. Diagnosis of onset of true labour. Recap on labour and on the stage at which admission to hospital is desirable. Value of post natal examination stressed.

Obstetric Physiotherapist:  
Class 8  36 weeks  
Recapitulation on positioning for relaxation:- sitting, either in a chair or cross-legged. In standing, leaning against the wall, or over furniture . . . . . . .

Midwife and Obstetric Physiotherapist:  
Optional 9th Class:  
Film evening with discussion. Father's invited. Where possible, fathers to attend physiotherapist's classes for practical demonstration of their role. Film list will be provided as aids to teaching.

A quote from the hospital report 1973. "It has become obvious that this department is training predominently the private and semi-private patient for labour", Why? During Dr. Dalrymple's term of office we were greatly concerned about this trend and gave it much serious thought. We decided to change our policy radically regarding classes. This was not appreciated by some of the Consultant staff. It is satisfying to report this year, however, that of the 1040 patients attending for ante-natal education all were in the public or 'ward' category. 1040 patients unfortunately constitutes only approx 50% of the primigravida attending the hospital. What of the other 50%?

It became obvious that the person not attending for classes or once attending but now a defaulter, was young, often single, in the lower socio-economic groups, in catchment areas of vast population — Finglas, Coolock Ballymun. When we examined the reasons why the pattern became apparent and constant
— time, busfares, less interest and fear of an institutionalised environment. The solution was obvious. We chose Finglas as a pilot project. During 1979 talks were held between the interested parties, Director of Community Care area 6, Public Health Nurses, Dr. Peter Denham and the Master. Despite the many difficulties (for example lack of funds and facilities) classes finally commenced in November 1979 in a pram shelter, a concrete floor with one ring of an electric fire in the old Finglas Clinic. I would like to express my appreciation to all the young girls who "soldiered" with us throughout the long winter months. This was the first of the ante-natal education education programme to be conducted in the community by a midwife and obstetric physiotherapist.

The ante-natal classes are now held in the new clinic in most comfortable and adequate surrounds. Here in the community we meet the young pregnant girl on a one to one basis in an atmosphere stripped of all hospital paraphenalia (white coats and authority), an atmosphere conducive to easy and frank discussion and learning. The conduct of these classes is a model for all other health centres. I wish to express my admiration and gratitude to Mrs. Helen Brophy-Macken, Health Education Co-ordinator without whose help this project could not have been launched. To my colleagues I wish also to say thank you. This community project was undertaken with no extra staff or extra remuneration. Our satisfaction is that our expectations have been fulfilled — similar clinics are planned for Coolock and Kilbarrack in 1981. This community effort should go a long way to increasing the percentage attending classes. Mrs. Jenny Storey M.C.S.P. now attends the Finglas Clinic, Thank you.

Following is a report by Mrs. Helen Brophy-Macken, Health Education Co-ordinator.

EDUCATION FOR PARENTHOOD IN THE COMMUNITY
HOSPITAL COMMUNITY LIAISON

Having assessed the Health needs of the community in which I work as a Health Education Co-ordinator it was quite evident to me that preparation for parenthood in the Community was a priority need. While working as a Public Health Nurse, prior to my present position, in the community, the number of people becoming parents without any preparation whatsoever was amazing. When we think of any job, trade, or profession, a certain amount of training and preparation is essential, if one is to carry out the work efficiently. How much more important should this training be when we are talking about "moulding and training young people for life". We only have to look at the long waiting lists of children in our Child Guidance Clinics, presenting with behavioural/developmental difficulties. Quite often one finds that it is in the quality of parenting and not in the child that the problem lies. Also I have discovered in my work as a Marriage Counsellor that a lot of clients coming for help have difficulty in parenting. Indeed one quite often notices the marital difficulty presenting itself when the first baby arrives. Also fear of pregnancy because of a previous traumatic experience in the labour ward (due to ignorance and lack of preparation for labour) puts untold strain on family relationships. So, having taken all the above into account, there was no doubt in my mind that Health Education begins in Utero.

So, as a result of consultation and liaising between the Community and the Rotunda Hospital, the first community based parentcraft education programme got under way in Finglas Health Centre on 1st November, 1979. Mrs. Kaye Marshall and myself worked as a team. The classes were attended by ladies from the Finglas area mainly. We also had ladies from the County who found the venue convenient.
Recruitment of Mothers

Mothers were recruited by the Health Education Co-ordinator attending at:

(1) The Finglas Ante-natal Clinic.
(2) The Rotunda Hospital on the 1st Thursday of each month at 8.00 p.m.
(3) Liaison with Nurse O'Neil, Mothercraft Nurse at the Hospital.
(4) Liaison with physiotherapy department.

The Ante-natal team at the Finglas clinic have been extremely helpful in encouraging mothers to attend the classes.

It was not just a matter of getting numbers into these sessions, but I honestly feel we have to:

(a) Educate our fellow professionals of the nees of preparation for parenthood as being an integral part of ante-natal care.
(b) To try and change attitudes of the future parents re their own sexuality, pregnancy, labour and parenthood.

This takes a lot of hard work. The numbers did not break down our doors to attend the classes and we literally had to "keep after" them. But it has now paid dividends and now in July, 1981 we are grossly overbooked in the Finglas Centre. Classes - January 1980 - December 1980

Attendance at the classes ranged from 11 to 16 per series. (Each series included 7 sessions, plus a trip to the hospital).

Fathers were encouraged to attend any of the sessions with a night set aside especially for them. From the March sessions onwards there was a full compliment of fathers present and this included the boyfriends as well. I found that the men were extremely interested and amazed that they should be included.

Layout of the Attendance

Mothers 90
Fathers 72 (Father's night)
Innuptas 14
"Fall outs" 10
Incompletes 8 (Delivered prior to completion of series)
Multipara 56 Breastfeeding session

When I say "fall outs" I am referring to the number of ladies who did not attend more than 2 to 3 sessions. This was due to low motivation and lack of awareness. Some of the mothers missed out on sessions due to hospitalisation and 2 got married, but these joined the following group and compensated in that way.

Progress to date

Looking back over the year there has been a marked change of attitude at the ante-natal clinic, even at local level where people are enquiring about enrolling in the classes, but we have a long way to go yet.

Finally I wish to list the number of reasons why this service should be community based.

(1) Most of the health services - general practitioners - public health nurses - social workers and ante-natal clinic etc. are also community based. Indeed the ante-natal service is incomplete without having the parentcraft classes included.
(2) It provides a social outlet for those isolated at home.
(3) It is more likely to attract those with low motivation who would not take the trouble necessary to attend hospital based classes, by the same token the menfold are also more likely to attend in the local community where they feel more secure and less inhibited.
(4) Each community because of its social structure will need an individual approach.

Gynaecological Department
All patients requiring major surgery had routine Pre and Post-operative physiotherapy. The number of treatments in this area remain constant. We are most grateful to Sister Gogarty and her staff for the co-operation and understanding of the physiotherapy needs of the patient.

Pre-Natal Department
There is need for growth and expansion for physiotherapy service in this area. Regrettably we are only able to cover the essential treatments. We are most grateful to Sister Walsh and her staff for their co-operation and understanding.

Post-Natal Rehabilitation
Most patients had the benefit of Post-Natal physiotherapy. We are convinced that the patient in the long term will derive much benefit. We would like to thank the midwives for their assistance in encouraging the patient during the day to continue with their exercises. We are most grateful to Sisters M. Dunne, M. Cunningham, M. Thornton and Staff Nurse P. Ryan for their advice and co-operation.

Paediatrics - Mrs. Valerie McConnell, M.C.S.P.
There was a marked increase in referrals with the important exception of a significant decrease in 'neuro' babies referred. Referrals of neonatal chests mainly pneumonia and bronchiolitis were up 86% on 1979. Minor congenital feet deformities referred were up an incredible 143% on 1979. Torticollis showed an increase of 48% referrals and we are glad to say we had only 1 case of Erbs Palsy in the year compared to an average of 5 every year '77 to '79. Our biggest concern however is the very large drop in referral of babies 'at risk' - 29% down since '79 but a further 50% down in the second half of 1980. It is essential to initiate treatment early for these babies to prevent abnormal patterns of movement developing. 'Treatments' consists of teaching the mother and others caring for the baby the best way to perform all normal activities, i.e., dressing, feeding sleeping positions, etc., to facilitate development of normal movement patterns.

<table>
<thead>
<tr>
<th>Total number of treatments</th>
<th>Chests</th>
<th>Torticollis</th>
<th>Feet</th>
<th>Erbs</th>
<th>Neuro</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>291</td>
<td>58</td>
<td>143</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>Total</td>
<td>592</td>
<td></td>
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</tr>
</tbody>
</table>

During the year the Matron Miss E. M. Gray retired. We said goodbye to her very reluctantly. This department has had the happiest associations with her - her qualities being manifold and varied. We remember her for her integrity, fairmindedness and sense of duty. This department has lost a dear friend. We wish her joy and fulfillment of all her expectations in the future.

This year also sees the completion of the Mastership of Dr. Ian Dalrymple. His work and dedication has laid a mark on this department and the hospital for the years to come. We will remember him as a person who secured a small niche for physiotherapy in the proud portals of the Rotunda. More importantly the populace in the large catchment areas of the Rotunda, Finglas, Coolock and Kilbarrack will remember him as the Master who introduced "Preparation for Parenthood" into the community via the health centres, thus ensuring that those
in the lower socio-economic groups are not penalised by their birth.

It was a privilege to have worked with him. All my colleagues wish to share that sentiment with me.

In conclusion may we thank Matron and the nursing staff, the labour ward staff for their co-operation and kindness for looking after the physiotherapists and students during the year; Mr. Gault and the administrative staff for all their kindness and assistance; the para-medical colleagues for their co-operation and support. I am most grateful to my colleagues for their loyalty and support during the year. A very special word of thanks from the department to Miss Imelda Farrell for the excellent and efficient manner in which she runs the department.

Teaching Lecturers:-

Pupil Midwives
Fourth Year Medical Students
Dublin School of Physiotherapy
Public Health Nurses
Post Graduates

Kathleen Marshall.
Although operating on a part-time basis, dietary advice is provided through:
The Diabetic Clinic
The Weekly Nutrition Clinic
Nutrition Classes
In Patient Advice

The Diabetic Clinic
Held weekly on Monday under the direction of Dr. I. Drury, the response to this clinic is particularly gratifying with patients numbering 15-20 each week. The success of this clinic reflects the medical importance attached to control of diet where there is a risk of diabetes in pregnancy; it is likely that virtually all of the patients in this category, together with diagnosed cases, are referred to this clinic.

The Weekly Nutrition Clinic
This clinic is primarily intended to provide dietary advice during pregnancy. In contrast to the diabetic clinic this service is sadly underutilised. Patient numbers rarely exceed 5 and are often as low as 2 each week; one would expect a much better attendance as statistically the proportion of pregnant mothers with nutritional problems is significantly greater than those with diabetes.

Practically all of the patients attending this clinic are grossly overweight. While some of these cases are sent for dietetic advice following their first antenatal clinic, the majority are not referred until the later months of pregnancy when they have experienced excessive weight gains and often exhibiting side-effects of high blood pressure or toxaemia. At this stage it is very difficult to reverse the over-weight condition. It is likely that many post-natal patients are seriously overweight and embarked on a future of chronic obesity.

Nutrition is the only branch of medicine where anybody can be an "expert" and we are bombarded with conflicting and often dangerous advice from every magazine and newspaper. In my experience, the medical profession are often as gullible as the public in their attitude to dietary advice from the most casual of sources. Perhaps, it is this debasing of the science of nutrition that leads many doctors to overlook the professional service when it is provided.

It must be realised that pregnancy is very often the start of a lifetime of obesity. Much of this subsequent misery could be avoided if patients are referred for dietary advice as soon as a potential weight problem is detected rather than sending patients away with platitudes such as "you will have to watch the weight" or "cut down on starchy foods".

Nutrition Classes
These are a part of the monthly Parentcraft meetings for new parents. In these classes, which both parents attend, the essential features of diet in pregnancy are discussed, breastfeeding is strongly encouraged emphasising the enormous benefits to baby and mother.

The very positive response of parents at these meetings is due largely to Dr. Peter Denham who pioneered this service in 1963 and under his able leadership has developed since.

In Patient Advice
There is still no adequate system for referring in-patients, particularly overweight gynaecological cases, to the Dietition. Implementing effective procedures for identifying inpatients with nutritional problems and referring them for dietary advice is a priority.
A high proportion of parents attending the Parentcraft sessions recognise the desirability of breastfeeding and the mothers seriously intend to carry it through, however, after initial attempts many are discouraged and, conceding to the mores of the "convenience food" society, turn to formula feeding. Every new mother needs support and encouragement when she starts to feed her baby in the first few days after birth. There is a real need for a full time adviser who would help and support mothers in these initial stages of breastfeeding from about 2 days after birth. The provision of such a support service would increase the proportion of breastfed babies very significantly.

My sincere thanks for the advice and support received during the year from Dr. I. Drury, Dr. P. Denham, Sr. Nealon and her staff in OPD, Mrs. K. Marshall and her staff in Physiotherapy Department, and Miss Eleanor Holmes and her staff.
GYNAECOLOGICAL DEPARTMENT—1980

MASTER

Admissions .................................................. 1,830
Operations (Gynaecological only) .................. 1,805

GENITAL PROLAPSE:
Manchester repair, ........................................... 30
Vaginal hysterectomy, ................................. 97
Anterior and posterior repair, ....................... 19
Anterior repair, ........................................... 5
Posterior repair, ......................................... 7

STRESS INCONTINENCE OF URINE:
Urethroplasty, .............................................. 13

ABDOMINAL OPERATIONS ON THE UTERUS:
Hysterectomy, ............................................. 158
Wertheim's Hysterectomy, ............................ 2
Myomectomy, ............................................. 14
Gilliam suspension, .................................... 21

OPERATIONS ON THE TUBES AND OVARIES:
Tubal surgery, ............................................. 40
Ovarian cystectomy, .................................. 41
Tubal ligation, ........................................... 5

OPERATION ON THE VULVA AND VAGINA:
Stretching of introitus ................................... 3
Bartholins cyst, .......................................... 10
Repair of fistula, ....................................... 5
Vulvectomy, .............................................. 5

MISCELLANEOUS OPERATIONS:
Diagnostic D/C, .......................................... 855
D & C Cautery or Cautery alone, ...................... 159
Laparotomy, ............................................. 48
Appendicectomy, ........................................ 9
Resuture of abdomen, .................................. 2
Fenton's operation, .................................... 7
Laparoscopy, ........................................... 112
Laparoscopy and biopsy ovary, ............... 59
Cystoscopy, ............................................. 41
Cone biopsy cervix, .................................... 14
Punch biopsy of cervix, ............................... 23
Repair Incisional Hernia, ......................... 1

Total = 1,805

The work in the Gynaecology Department has increased from 1070 operations in 1974 to 1805 in 1980. There has been no increase in beds but earlier discharge and more outpatient minor operations has achieved this.
DEPARTMENT OF PAEDIATRICS

The annual report continues to highlight the traditional major causes of perinatal mortality namely congenital abnormality, low birth weight and late foetal/early neonatal asphyxial deaths. The improved services available now, mean an improved chance of survival for the low birth weight infant and only prolonged and careful follow-up will document the handicap rate amongst this group. However because the majority of infants are normally formed and term perhaps we need to specifically examine our performance in this area. One method would be to compare the death rates amongst normally formed infants weighing 2,500 grams and over - including late foetal and neonatal asphyxia deaths. There is also an urgent need to standardise the clinical/neurological examination used in evaluating these full term, normally formed, asphyxiated infants. The introduction of the term, Hypoxic Ischaemic Encephalopathy in this report is used because it is simple and widely used throughout the world but only time will tell if it's purported prognostic implications hold up.

During the year under review Professor Eric E. Doyle retired from his post as Consultant Paediatrician to the Hospital. Professor Doyle has been associated with the Rotunda Paediatric Department for 25 years. During that time he made many major contributions to Paediatric Medicine and the administration of the Hospital. He held the Chair of Paediatrics at the University of Dublin for 9 years and has been a Governor of the Rotunda and National Children's Hospital for many years. He carries the good wishes of all his colleagues in the Rotunda for his future retirement.

Total number of live births over 28 weeks maturity 6,451
Additional live births under 28 weeks maturity 17
Total admissions to Paediatric Unit and Nursery (Intensive Care Unit) 1,878
Total Extern admissions to Paediatric Unit and Nursery (Babies born outside Rotunda Services) 16
Total number of attendances at O.P.D. Clinics 15,899
Initial attendances at O.P.D. Clinics 6,191
First Week Neonatal Deaths (Intern) 49
Deaths in I.C. Unit, Labour Ward and Paediatric Unit 59
Late Neonatal Deaths (Intern) 6
First week Neonatal Deaths (Extern) 1
Late Neonatal Deaths (Extern) 1

LOW BIRTH WEIGHT INTERN
(includes babies under 28 weeks)

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>1979 Survived</th>
<th>1979 Died</th>
<th>1980 Survived</th>
<th>1980 Died</th>
<th>Total Survived</th>
<th>Total Died</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1,000 grams</td>
<td>6</td>
<td>18</td>
<td>7</td>
<td>19</td>
<td>24</td>
<td>36</td>
</tr>
<tr>
<td>1,000-1,500 grams</td>
<td>23</td>
<td>19</td>
<td>42</td>
<td>17</td>
<td>45</td>
<td>36</td>
</tr>
<tr>
<td>1,500-2,000 grams</td>
<td>47</td>
<td>4</td>
<td>51</td>
<td>46</td>
<td>98</td>
<td>50</td>
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<tr>
<td>2,000-2,500 grams</td>
<td>192</td>
<td>14</td>
<td>206</td>
<td>194</td>
<td>398</td>
<td>340</td>
</tr>
<tr>
<td>Total</td>
<td>268</td>
<td>55</td>
<td>323</td>
<td>264</td>
<td>391</td>
<td>319</td>
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</tbody>
</table>

LOW BIRTH WEIGHT EXTERN

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>1979 Survived</th>
<th>1979 Died</th>
<th>1980 Survived</th>
<th>1980 Died</th>
<th>Total Survived</th>
<th>Total Died</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1,000 grams</td>
<td></td>
<td></td>
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<td></td>
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<td>1,500-2,000 grams</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2,000-2,500 grams</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Under 1,000 grams
1,000-1,500 grams
1,500-2,000 grams
2,000-2,500 grams

Total
# EARLY NEONATAL DEATHS

(Causes)

**Intern:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beta Haemolytic Streptococci Sepsis</td>
<td>1</td>
</tr>
<tr>
<td>Congenital Abnormalities</td>
<td>15</td>
</tr>
<tr>
<td>Extreme Prematurity (500-749 grams.)</td>
<td>10</td>
</tr>
<tr>
<td>Persistent Foetal Circulation</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory Distress Syndrome</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory Distress Syndrome/Birth Asphyxia</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory Distress Syndrome/Persistent Foetal Circulation</td>
<td>2</td>
</tr>
<tr>
<td>Respiratory Distress Syndrome/Pneumopericardium</td>
<td>2</td>
</tr>
<tr>
<td>Severe Birth Asphyxia</td>
<td>4</td>
</tr>
<tr>
<td>Severe Rhesus Disease/Hydrops</td>
<td>1</td>
</tr>
<tr>
<td>Subdural Haemorrhage/Breech Delivery/Haemophilia</td>
<td>1</td>
</tr>
<tr>
<td>Very Low Birth Weight (Less than 1,500 grams)</td>
<td>10</td>
</tr>
<tr>
<td>Very Low Birth Weight/Intraventricular Haemorrhage</td>
<td>1</td>
</tr>
<tr>
<td>Very Low Birth Weight/Respiratory Distress Syndrome/Intraventricular Haemorrhage</td>
<td>5</td>
</tr>
<tr>
<td>Very Low Birth Weight/Respiratory Distress Syndrome/Intraventricular Haemorrhage</td>
<td>4</td>
</tr>
</tbody>
</table>

**Extern:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Low Birth Weight (Less than 1,500 grams)</td>
<td>1</td>
</tr>
<tr>
<td>Very Low Birth Weight/Respiratory Distress Syndrome/Intraventricular Haemorrhage</td>
<td>1</td>
</tr>
</tbody>
</table>

# LATE NEONATAL DEATHS

**Intern:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candida Sepsis</td>
<td>1</td>
</tr>
<tr>
<td>Congenital Abnormalities</td>
<td>4</td>
</tr>
<tr>
<td>Road Traffic Accident/Cerebral Contusion</td>
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</tr>
</tbody>
</table>

**Extern:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Low Birth Weight/Beta Haemolytic Streptococci Sepsis</td>
<td>1</td>
</tr>
</tbody>
</table>

# DEATHS DUE TO CONGENITAL MALFORMATIONS

Intern:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anencephaly</td>
<td>2</td>
</tr>
<tr>
<td>Congenital Heart Disease</td>
<td>5</td>
</tr>
<tr>
<td>Down’s Syndrome</td>
<td>3</td>
</tr>
<tr>
<td>Encephalocele</td>
<td>1</td>
</tr>
<tr>
<td>Hydrocephalus/Spina Bifida</td>
<td>4</td>
</tr>
<tr>
<td>Multiple Abnormalities</td>
<td>2</td>
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<tr>
<td>Potter’s Syndrome</td>
<td>1</td>
</tr>
<tr>
<td>Trisomy 18</td>
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</table>
# RESPIRATORY DISTRESS

<table>
<thead>
<tr>
<th></th>
<th>Idiopathic Respiratory Distress Syndrome</th>
<th>Transient Tachypnoea of the Newborn</th>
<th>Meconium Aspiration Syndrome</th>
<th>Pneumonia</th>
<th>Respiratory Distress Secondary to Congenital Abnormality</th>
<th>Persistent Foetal Circulation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
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<td>70</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>7</td>
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<tr>
<td>Alive</td>
<td>56</td>
<td>70</td>
<td>6</td>
<td>6</td>
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<td>4</td>
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<tr>
<td>Deaths</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>C.P.A.P.</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>I.P.P.V.</td>
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</tr>
<tr>
<td>Associated with/</td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>abnormality, minor</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight 1,000-1,499 grams</td>
<td>18</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight less than 1,000g.</td>
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<tr>
<td></td>
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<tr>
<td><strong>EXTERN</strong></td>
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</tr>
<tr>
<td>Deaths</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.P.A.P.</td>
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<tr>
<td>I.P.P.V.</td>
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</tr>
<tr>
<td>Associated with/</td>
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</tr>
<tr>
<td>abnormality, minor</td>
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</tr>
<tr>
<td>Weight 1,000-1,499 grams</td>
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<tr>
<td>Weight less than 1,000g.</td>
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</table>
### CONGENITAL ABNORMALITIES

<table>
<thead>
<tr>
<th></th>
<th>C.V.S.</th>
<th>C.N.S.</th>
<th>G.I.T.</th>
<th>G.U.T.</th>
<th>Chromosomal</th>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>63</td>
<td>19</td>
<td>5</td>
<td>20</td>
<td>21</td>
<td>326</td>
</tr>
<tr>
<td>Alive</td>
<td>55</td>
<td>9</td>
<td>5</td>
<td>18</td>
<td>16</td>
<td>323</td>
</tr>
<tr>
<td>Deaths</td>
<td>8</td>
<td>10</td>
<td>—</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Major</td>
<td>32</td>
<td>15</td>
<td>5</td>
<td>10</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>Minor</td>
<td>31</td>
<td>4</td>
<td>—</td>
<td>10</td>
<td>—</td>
<td>311</td>
</tr>
<tr>
<td><strong>EXTERN:</strong></td>
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### CEREBRAL DYSFUNCTION

<table>
<thead>
<tr>
<th>Hypoxic Ischaemic Encephalopathy (H.I.E.)</th>
<th>Metabolic</th>
<th>Miscellaneous</th>
<th>Obstetrical Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERN</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>65</td>
<td>10</td>
</tr>
<tr>
<td>Low Birth Weight</td>
<td>18</td>
<td>65</td>
<td>10</td>
</tr>
<tr>
<td>Less than 1,500 grams</td>
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<td>61</td>
<td>8</td>
</tr>
<tr>
<td>Alive</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Deaths</td>
<td>10</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Seizures</td>
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<tr>
<td><strong>EXTERN</strong></td>
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<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Miscellaneous group — This group includes 4 normally formed full term infants with unexplained seizures, one infant with haemophilia/Cerebral Haemorrhage, and one infant of a Heroin addict.
## JAUNDICE

<table>
<thead>
<tr>
<th>Type</th>
<th>Total</th>
<th>No Treatment</th>
<th>Phototherapy</th>
<th>Exchange Transfusion</th>
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</thead>
<tbody>
<tr>
<td><strong>INTERN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABO</td>
<td>30</td>
<td>30</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Hyperbilirubinaemia (Miscellaneous)</td>
<td>15</td>
<td>14</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>335</td>
<td>360</td>
<td>138</td>
<td>134</td>
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<td><strong>EXTERN</strong></td>
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<td>Hyperbilirubinaemia (Miscellaneous)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td>1</td>
<td></td>
<td></td>
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</tbody>
</table>