ROTUNDA HOSPITAL
DUBLIN

CLINICAL REPORT
1997

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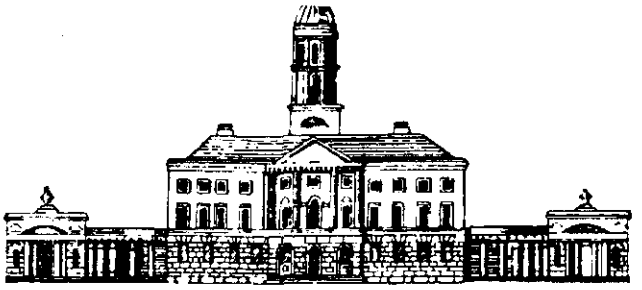

THE ROTUNDA HOSPITAL

Clinical Report

1st January 1997 - 31st December 1997

MASTER

Peter McKenna

F.R.C.O.G., F.R.C.P.I.

Elected November 1994

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1. INTRODUCTION

1997 was a busy year in the Rotunda. We delivered 6,223 babies, the largest number of deliveries for approximately 20 years. The perinatal mortality fell to a figure of 7.1 the lowest figure in the hospital's history. The proportion of babies less than 2,500 grams also continues to rise and in 1997 was 7.4 per cent. It is of course particularly gratifying that against this back drop of the rising proportion of problematic deliveries and increased workload that such good results were achieved.

Every year appears to bring new challenges in our attempts to provide a service that lives up to our patients expectations, and one that our staff can be proud of. One new difficulty that is appearing and has every indication of becoming worse is the difficulty in recruiting qualified midwifery staff. In a relatively short period of time we have gone from a situation of over-supply of midwives to a shortage, bordering on occasion to a crisis. If this problem is not acknowledged and urgently addressed it will have a negative impact on patient care and staff morale. Another new development in our obstetric practice arrived during 1997 with the increasing number of refugees and emigrants. During 1997 we delivered approximately 250 refugees, coming from Africa, the Far East and Eastern Europe. Communication is the largest single difficulty, and with the refugees coming from so many countries, this is likely to remain a significant problem for the foreseeable future.

During the year we had several significant physical developments in the Hospital. The first was the opening of the extension to the Human Assisted Reproduction Unit. Due to the success of Professor Harrison's I.V.F. Unit the workload continues to expand and the extra space, mostly consisting of laboratory, theatres and offices will provide the faclilties to cope with the increased demand. Also during 1997 we opened a new lecture theatre, which having been partially funded by the estate of Dr. Dalrymple has been named after him.

During the year the hospital was involved in the preparation of a report on the Dubin Maternity Services. This report was prepared by Mr. David Kennedy. With the National Maternity Hospital and The Coombe Women's Hospital we helped prepare the document that was submitted to the Department of Health in December 1997. Whereas no immediate fundamental changes are envisaged, it is hoped that the report will lead to greater co-operation between maternity hospitals, the rationalisation of some sub-specialities and a more integrated approach to gynaecological services in each of the three Eastern Health Board regions. One very positive and immediate outcome of the report has been an understanding and acceptance of the fact that the current increase in activity in the three maternity hospitals does not appear to be an unsustained blip, but more likely part of a trend of increasing numbers in the eastern area.

During the year we were sorry to lose the services of Vanessa Kelly, the Hospital Accountant and Sr. Clarke (through early retirement) of the Lower Corridor. In different ways both are significant losses to the hospital. We wish Sr. Clarke every happiness in retirement and Vanessa Kelly in her new and demanding role.

In 1997 the Bartholomew Mosse Lecture was given by Mr. Peter McLean, President of the Royal College of Surgeons in Ireland. He spoke on the changes that are currently taking place in postgraduate training and how these changes are being implemented in Ireland. It was an honour and a great hospital to entertain Mr. McLean representing an Institution with whom the hospital has had along and harmonious relationship. The spring Ninian Falkiner Lecture was delivered by Dr. Aidan Halligan, he spoke on 'Teaching Old Docs New Tricks: the Implementation of Evidence Based Care in Obstetrics and Gynaecology'; and the autumn Ninian Falkiner Lecture was given by Dr. Andrew Greene who spoke on 'Genetics in Obstetrics and Gynaecology'. Both lectures were thought provoking and stimulating, being pitched at precisely the right level.

During 1997 it cost £19.2 million to run the Rotunda Hospital of which £15.6 was received from the Department of Health. The hospital was extremely gratified and indeed relieved when at the end of 1997 the considerably increased workload was recognised and a sum of money, additional to our original allocation, was given to the hospital to cope with the increased birth rate. Assuming that Ireland continues to prosper in the foreseeable future - an assumption with which everybody appears to be comfortable, there is every reason to believe that the number of births will continue to increase.

Our overall perinatal mortality of 7.1 and the corrected perinatal mortality of 4.8 are both gratifying figures. To achieve these requires an enormous amount of hard work on the part of all the staff and for this I am very grateful. I think, that at this time, a particular word of thanks should go to the nursing staff who have to work under particular pressures due to the shortage of midwives. Our caesarean rate has risen slightly this year to 21.9%. There seems little doubt to me that part of the rise in our caesarean section rate is meeting the patient request and against a background of good results and proven safety for the procedure it is difficult not to accede to these requests.

The Hospital looks forward to 1998 with optimism and anticipates a busy year. We hope to eventually begin construction of both the Paediatric Unit and improvements to the standard of accomodiation on our post - natal ward on the third floor. Both of these developments are seen as necessary and significant for the hospital and must be started shortly to ensure our continued role as a major force in Irish Obstetrics.

2. OBSTETRICAL SUMMARIES AND TABLES

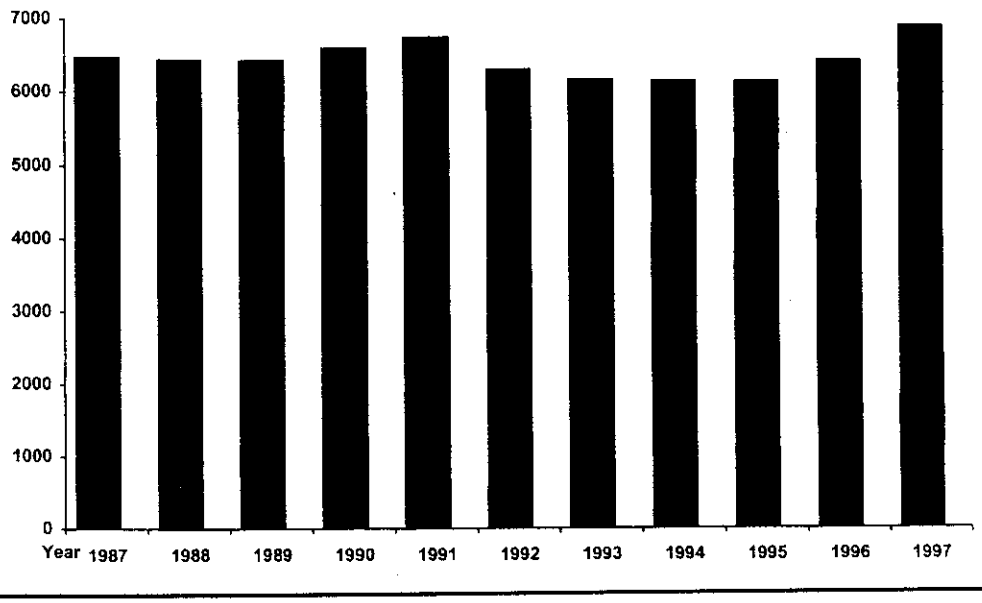
2.1 STATISTICAL ANALYSIS OF MATERNITY POPULATION

	1997		1987	
AGE	TOTAL	%	TOTAL	%
< 20 Years	580	8.4%	442	6.8%
20 - 24 Years	1,190	17.3%	1,695	26.2%
25 - 29 Years	1,823	26.5%	2,280	35.2%
30 - 34 Years	2,056	29.9%	1,367	21.1%
35 - 39 Years	995	14.5%	531	8.3%
> 40 Years	236	3.4%	158	2.4%
Total	**6,880**	**100.0%**	**6,473**	**100.0%**
PARITY:				
0	3,019	43.9%	2,465	38.1%
1,2 3	3,573	51.9%	3,486	53.9%
>4	288	4.2%	522	8.0%
TOTAL	**6,880**	**100.0%**	**6,473**	**100.0%**
SOCIO-ECONOMIC GROUP:				
1	255	3.7%	288	3.5%
2	724	10.5%	856	13.2%
3	942	13.7%	616	9.5%
4	867	12.6%	1,657	25.6%
5	624	9.1%	400	6.4%
6	141	2.0%	352	5.4%
7 (Never Worked)	1,515	22.0%	772	11.9%
8	1,744	25.3%	1,220	18.8%
9	68	1.0%	120	1.8%
UNKNOWN	0	0%	252	3.9%
TOTAL	**6,880**	**100.0%**	**6,473**	**100.0%**
GESTATION:				
< 18 Weeks	625	9.2%	698	10.8%
18 - 23 Weeks	22	0.3%	20	0.3%
24 - 27 Weeks	30	0.4%	24	0.4%
28 - 31 Weeks	54	0.8%	40	0.6%
32 - 36 Weeks	333	4.9%	197	3.0%
37 - 41 Weeks	5,418	78.5%	4,958	76.6%
> 42 Weeks	398	5.9%	536	8.3%
Unknown	-		-	-
TOTAL	**6,880**	**100.0%**	**6,473**	**100.0%**
BIRTH WEIGHT:				
500 - 999 Grams	40	0.6%	33	0.6%
1,000 - 1,499 Grams	67	1.1%	34	0.6%
1,500 - 1,999 Grams	94	1.5%	67	1.2%
2,000 - 2,499 Grams	260	4.2%	175	3.1%
2,500 - 2,999 Grams	889	14.3%	735	13.1%
>3,000 (1986 figures)	4,873		4,587	81.4%
3,000 - 3,499 Grams	2115	34.0%	-	-
3,500 - 3,999 Grams	1908	30.7%	-	-
4,000 - 4,499 Grams	703	11.3%	-	-
4,500 - 4,999 Grams	131	2.1%	-	-
> 5,000 Grams	16	0.2%	-	-
TOTAL	**6223**	**100.0%**	**5631**	**100.0%**

2.2 MATERNITY SUMMARY

	1997	1987
SUMMARY		
TOTAL BIRTHS	6,984	-
TOTAL MOTHERS DELIVERED:	6,880	6,473
Births	6,223	
Miscarriages	761	
Booked	6,288	
Unbooked	592	
Unknown	0	
Mothers Delivering > 500 grams	6,119	
Births > 500 grams	6,223	5,631
Births > 1000 grams	6,183	5,598
MATERNAL RESULTS:		
Maternal Mortality	0	0
MULTIPLE PREGNANCIES:		
Twins	86	65
Triplets	8	-
Quadruplets	1	-
FETAL RESULTS:		
Total Live Births > 500 grams or more	6190	5605
Stillbirths	29	26
1st. Week N.N.Ds	15	27
Late N.N.Ds	-	6
Perinatal Mortality Rate (500 grams or more)	7.1	9.4
Perinatal Mortality Rate (1000 grams or more)	-	8.0
(excluding congenital anomolies)	5.2	6.9

NUMBER OF MOTHERS DELIVERED



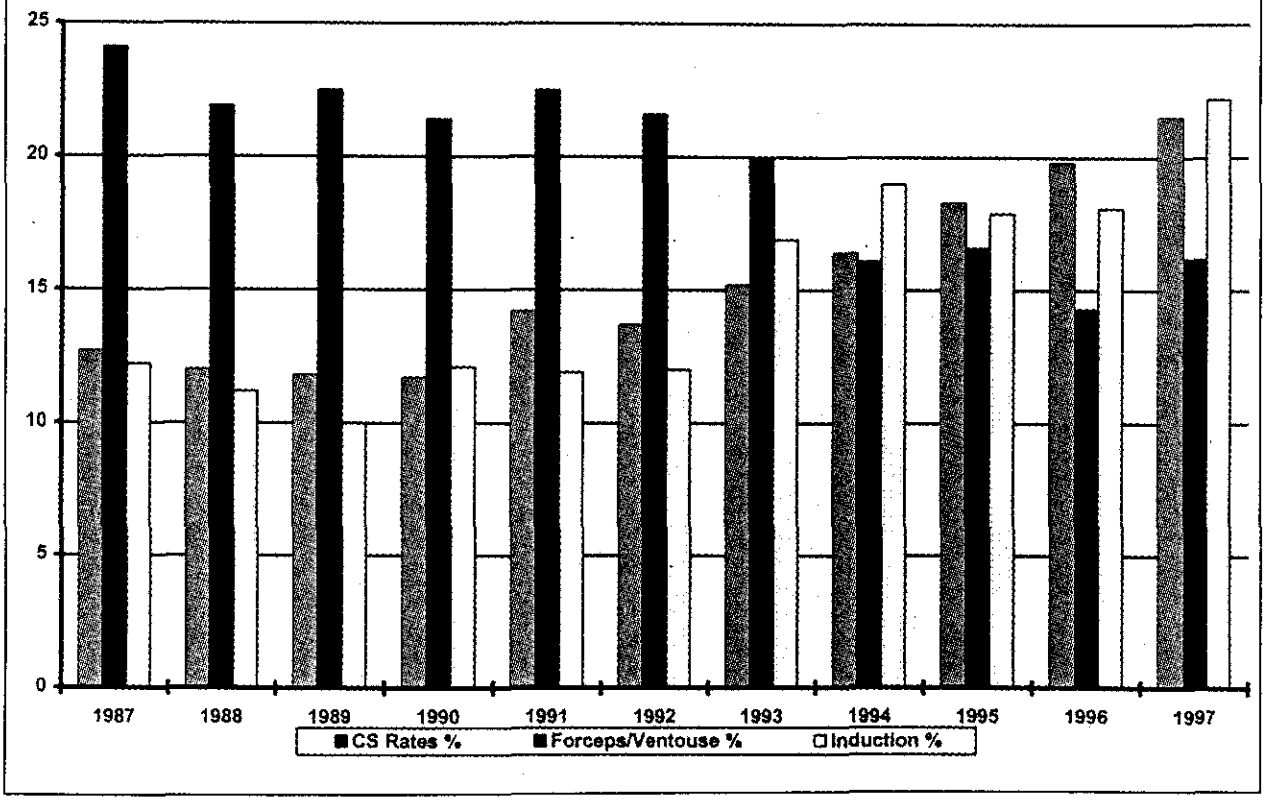
2.3 COMPARATIVE TABLE FOR TEN YEARS

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
BABIES BORN	5,910	5,631	5,804	5,893	5,923	6,129	5,692	5,563	5,576	5,595	5,857	6223
PERINATAL DEATHS	73	53	54	58	64	54	58	48	66	52	60	44
PERINATAL MORTALITY RATE	12.4	9.4	9.3	9.8	10.8	8.8	10.2	8.4	11.8	9.5	10.2	7.1
MOTHERS DELIVERED	6,582	6,473	6,439	6,422	6,596	6,739	6,294	6,144	6,129	6,132	6,414	6880
MATERNAL DEATHS	2	0	0	1	0	0	0	1	0	1	0	1
CAESAREAN SECTION %	11.7	12.7	12	11.8	11.7	14.2	13.7	15.2	16.4	18.3	19.8	21.9
FORCEPS/VENTOUSE%	21.9	24.1	21.9	22.5	21.4	22.5	21.6	20	16.1	16.6	14.3	16.2
EPIDURAL%	37.2	38.5	40.7	44.1	46.6	51.4	54	56	64.1	66.7	67.1	70.8
INDUCTION%	14.4	12.2	11.2	10	12.1	11.9	12	16.9	19	17.9	18.1	22.2

2.4 FOETAL LOSS

Total Births > 500 grams or more	6,223
Total Stillbirths	29
Stillbirth Rate (per 1,000 births)	-
Total 1st Week Neonatal Deaths	15
Total Late Neonatal Deaths	-
Post-mortem Rate	
Perinatal Mortality Rate (500 grams or more)	7.1
Congenital Malformations	11
Corrected Perinatal Mortality Rate	4.8
(Excl. Congenital Malformations)	
Booked Cases	6,288
Unbooked Cases	592
Total Mothers Delivered	**6,880**

TEN YEAR COMPARISON RATES



2.4 FOETAL LOSS
The Master

STILL BIRTHS 1997

During the year there were 29 stillbirths

Abruption	9
Hypoxia	7
Congenital Malformations	6
Infection	3
Cord Accident	2
Twin to Twin Transfusion	2

ABRUPTION (9)

1. Age 28, one previous spontaneous vaginal delivery at 37weeks. Uneventful antenatal care until presented at 36 weeks with clinical signs of an abruption. Fetal heartbeat was absent at ultrasound examination. Patient established in labour and a female foetus weighing 2304g was delivered vaginally. The mother required transfusion of 3 units of blood. Post-mortem confirmed death due to placental abruption.
2. Age 18, Primigravida, uneventful antenatal care until presented at 31 weeks with a history of vaginal bleeding, abdominal pain and decreased fetal movements. A clinical diagnosis of placental abruption was made. Fetal heartbeat was absent at ultrasound examination. Patient delivered a stillborn male foetus weighing 1766g. Post-mortem confirmed acute hypoxia secondary to placental abruption.
3. Age 32, primigravida, uneventful antenatal care until presented at 30 weeks with abdominal pain and decreased fetal movements. Fetal heartbeat was absent at ultrasound examination but a retroplacental blood clot was noted. Labour was induced and patient delivered a stillborn female infant weighing 1184g. Post-mortem: widespread placental infarction and retroplacental haemorrhage.
4. Age 24, mother has systematic lupus erythematosis, medication: aspirin 75mg a day. One previous vaginal delivery of 2300g. Normal antenatal care until 34 weeks when reported a small painless vaginal bleed. Ultrasound examination was normal. Presented one week later with irregular pains and a prolonged bradycardia was noted on heart rate

tracing. Unfortunately no fetal heartbeat was seen at ultrasound examination. Patient had a spontaneous vaginal delivery of a stillborn infant weighing 2605g. Post-mortem: permission was refused, but placental examination showed recent retroplacental haemorrhage of forty per cent of the placental surface.

5. Age 31, one previous vaginal delivery of a baby weighing 2000g at 39 weeks. Uneventful antenatal care until admitted to hospital at 38 weeks with abdominal pain. Fetal heartbeat was absent at ultrasound examination. A clinical diagnosis of abruption was made. A stillborn male infant weighing 2906g was delivered. Post-mortem excluded congenital malfunctions and confirmed fetal anoxia to retroplacental haemorrhage.
6. Age 31, past maternal history of Sarcoidosis. Previous vaginal delivery of male infant weighing 2580g. Normal antenatal care until presented with a clinical abruption at 36 weeks. The fetal heart was not heard. Subsequent vaginal delivery of fresh stillborn male infant weighing 2740g. Post-mortem confirmed abruptio placenta as the cause of death.
7. Age 42, previous classical caesarean section at 25 weeks for severe pre-eclampsia - neonatal death. Mild hypertension, gestational diabetes and a small vaginal bleed complicated this pregnancy. Patient retained in hospital. At 35 weeks, the fetal heart could not be detected. A stillborn male infant weighing 2800g was delivered by caesarean section because of previous classical caesarean section. Permission for post-mortem was refused, but examination of placenta confirmed operative findings of retroplacental haemorrhage.
8. Age 18, primigravida, presented in spontaneous labour with ruptured membranes and prolapsed cord at 24 weeks. Although the cord was pulsating at the time of presentation the mother was managed conservatively because of the gestation. A fresh stillborn female infant weighing 718g was delivered. Post-mortem: no malfunctions but hypoxia due to retroplacemental haemorrhage.
9. Age 31, patient unbooked in the Rotunda. Transferred in labour at 24 weeks. Vaginal breech delivery of stillborn infant weighing 615g. Permission for post-mortem refused but clinical course suggested intrauterine death secondary to antepartum haemorrhage.

HYPOXIA (7)

1. Age 41, primigravida, routine antenatal care until antenatal visit at 32 weeks - no fetal movements and no fetal heart detected. Labour was induced and a stillborn female foetus weighing 1612g was delivered spontaneously. Post-mortem: pointed to hypoxia in an appropriately grown infant.

2. Age 32, previous obstetric history - one ectopic pregnancy and two vaginal deliveries of normal female infants. No fetal heart was detected when the patient booked at 32 weeks, having arrived in the country three weeks previously. Labour was induced and a stillborn infant weighing 1850g was delivered. Post-mortem: death because of intrauterine hypoxia secondary to utero-placental dysfunction. No congenital abnormalities were detected.
3. Age 33, primigravida twin pregnancy diagnosed early by ultrasound. Regular fetal assessment showed good growth until 30 weeks when a divergence of fetal weighs began. Because of this divergence, the mother was admitted for elective caesarean section at 38 weeks. On admission, however, ultrasound scan could not detect the fetal heart in twin two. At caesarean section, twin one was a live female weighing 3420g and twin two was stillborn weighing 2180g. Post-mortem excluded congenital malformation and showed the cause of death to be intrauterine hypoxia.
4. Age 32, this woman, with an uncomplicated antenatal history, presented in her fourth pregnancy at 32 weeks in labour with an intrauterine death. She had an assisted breech delivery of a baby girl weighing 1256g. Post-mortem confirmed the death was due to hypoxia.
5. Age 19, primigravida, was admitted to a General Hospital for treatment of a respiratory infection when 24 weeks. At 29 weeks she was noted to be slightly hypertensive. Biophysical score was normal. She presented two days later with abdominal pain and no fetal movements. No fetal heartbeat was detected. The patient established in labour and delivered a stillborn female infant weighing 1210g. Post-mortem excluded congenital malformations and showed the cause of death to be hypoxia secondary to placental infarction.
6. Age 21, primigravida, booked at 29 weeks. Uneventful antenatal care until admitted at 38 weeks complaining of lower abdominal pain and decreased fetal movements. Scan showed no fetal heartbeat. Spontaneous labour progressed to delivery of a stillborn male weighing 2430g. Post-mortem: features of hypoxia were identified in this macerated foetus. No congenital malformations were seen.
7. Age 40, primigravida, booked late at 32 weeks. Presented at 36 weeks with decreased fetal movements. Scan showed no fetal heartbeat. Patient was admitted and labour was induced. A stillborn female infant weighing 2028g was delivered. Post-mortem: no congenital malformation but evidence of protracted hypoxia.

CONGENITAL (6)

1. Age 33, one previous baby delivered by caesarean section in labour, for failure to progress. Pregnancy uneventful until 29 weeks, when patient

presented with decreased fetal movements. Ultrasound examination showed pleural effusions and ascites. A cardiac scan suggested a hypoplastic left heart with ventricular septal defect. After review by a paediatric cardiologist it was decided that this lesion was not amenable to surgery and therefore no active intervention was undertaken. The mother presented in spontaneous labour at 34 weeks and delivered a stillborn female weighing 2130g. Post-mortem: Tetralogy of Fallot.

2. Age 21, primigravida, uneventful antenatal care until 31 weeks when patient presented with abdominal pain and premature rupture of the membranes. The liquor was blood stained. No fetal heart was recorded. Patient progressed in labour to an assisted breech delivery of a stillborn male infant weighing 540g with obvious congenital malformations. Post-mortem: Edward's Syndrome, cytogenetics confirmed Trisomy 18.

3. Age 17, primigravida, ultrasound scan at 24 weeks showed a large left diaphragmatic hernia and ascites. Repeat ultrasound scan at 28 weeks confirmed this and suggested cystadenomatous malformation type one or type two. Chromosome analysis performed at 28 weeks was normal. Patient presented at 34 weeks with an antepartum haemorrhage. No fetal heart was detected. Patient established in labour and delivered a stillborn male infant weighing 1916g. Permission for post-mortem was refused, however external examination of the foetus confirmed abdominal distension in keeping with hydrops. Cause of death diaphragmatic hernia or cystadenomatous malformation.

4. Age 37, one previous twin delivery at 34 weeks and one normal delivery at term. Anencephaly diagnosed at ultrasound examination. Patient had spontaneous labour and delivery of stillborn female infant, weighing 1838g. Post-mortem: anencephaly.

5. Age 31, primigravida, family history of neural tube defect. Antenatal ultrasound did not detect any fetal abnormality. Intrauterine death at 39 weeks. Spontaneous labour, vaginal delivery of female foetus weighing 3580g with hydrocephalus. Post-mortem showed Hydrocephalus and Spina Bifida.

6. Age 28, previous delivery of male infant weighing 2520g at 36 weeks. Uncomplicated antenatal course until 39 weeks when patient presented with no fetal movements. Intrauterine death was discovered at ultrasound. Labour was induced and patient delivered a stillborn male infant weighing 3770g. Post-mortem: Congestive cardiac failure secondary to a large ventricular septal defect. Baby had features of Downs syndrome. Cytogenetics: confirmed Trisomy 21.

INFECTION (3)

1. Age 20, primigravida, uneventful antenatal course until 30 weeks when patient presented with no fetal movements. Scan showed no fetal heartbeat. Spontaneous vaginal delivery of a stillborn female infant, weighing 1180g, at 30 weeks. Post-mortem showed intrauterine infection with acute chorioamnionitis and necrotising funicitis, ureaplasma urealyticum was isolated.
2. Age 32, primigravida, admitted to hospital at 24 weeks with premature rupture of membranes. The white cell count was elevated but conservative management was adopted. Intrauterine death occurred two days later. A stillborn male foetus weighing 544g was delivered spontaneously. Post-mortem showed purulent chorioamnionitis, E. coli was cultured.
3. Age 36, three previous term vaginal deliveries. Uneventful antenatal care until 36 weeks, when reported flu like illness. Intrauterine death occurred one week later and labour was induced. A stillborn female infant weighing 2644g was delivered. Post-mortem showed congenital infection probably due to cytomegalovirus.

CORD ACCIDENT (2)

1. Age 27, past obstetric history - two vaginal deliveries of normal children, preceded by an emergency caesarean section at 34 weeks of a male weighing 1800g. Normal antenatal care until presented at 40 weeks with decreased fetal movements. Normal CTG. Five days later presented with no fetal movements and no fetal heart was heard. Subsequent vaginal delivery of a stillborn male infant weighing 2952g. Post-mortem excluded congenital malformations and showed evidence of prolonged hypoxia probably due to the presence of a nuchal cord.
2. Age 38, two previous deliveries, one at 39 weeks and one at 35 weeks. Both infants had a metabolic disorder of fatty oxidation, which responded to a high carbohydrate diet. Uneventful antenatal care until presented at 28 weeks with no fetal movements and no fetal heart. Subsequent spontaneous delivery at home of baby weighing 520g. Post-mortem excluded major congenital malfunctions. Death was because of hypoxia secondary to torsion of the umbilical cord.

TWIN TO TWIN TRANSFUSION (2)

1/2 Age 21, one previous vaginal delivery of a live born infant weighing 3490g. Patient booked at 20 weeks and ultrasound showed a twin pregnancy. Both sacs however contained reduced liquor. Patient was admitted to hospital where liquor continued to drain intermittently. At 26 weeks there was difficulty in auscultating one of the fetal hearts. Ultrasound could only detect one fetal heartbeat. A CTG showed

decelerations of the surviving twin's heart rate. Emergency caesarean section was carried out and two female stillborn twins were delivered, one weighing 1120g, the second 1100g. Post-mortem showed evidence of twin to twin transfusion i.e. one twin being pale and the other plethoric, and vascular anastamoses in the placental site.

NEONATAL DEATHS

There were 15 neonatal deaths:

Prematurity	5
Congenital Malformations	5
Abruption	2
Cord Accident	1
Infection	1
Twin to Twin Transfusion	1

PREMATURITY (5)

1. Age 37, previous delivery of healthy infant. Twins diagnosed at 13 weeks. At 23 weeks, premature rupture of the membranes was followed by spontaneous delivery. Twin one, cephalic, birth weight was 630g, Apgar scores 7 and 9. Twin two weighed 655g, Apgar scores were 5 and 8. Twin two developed an electrolyte imbalance with metabolic acidosis, coliform septicaemia and died at three days of age. Permission for post-mortem was refused, but cause of death sepsis and prematurity.
2. Age 35, previous delivery of healthy male at 36 weeks. Mother booked in at 19 weeks and was admitted to hospital at 26 weeks in labour. Breech delivery of male infant weighing 550g, Apgar scores of 5 at 5. Eye lids fused, baby died at several hours of age, because of extreme prematurity. Permission for post-mortem was refused.
3. Age 24, primigravida, presented at 22 weeks with a small vaginal bleed and was admitted. Established in labour and delivered a liveborn male infant weighing 550g. The baby died at 30 minutes of age. Post-mortem showed extreme prematurity and choriomnionitis.
4. Age 27, Primigravida, admitted at 22 weeks with vaginal bleeding and at 23 weeks had ruptured membranes. Treated with antibiotics because of a high white cell count. Spontaneous labour established and patient delivered a liveborn male infant weight 560g, Apgar scores were two and one. Because of weight and gestation there were no active resuscitation. Baby died after one hour. Permission for post-mortem was refused. Examination of placenta showed marked chorioamnionitis. Cause of death was prematurity and septicaemis.

5. Age 31, primigravida, on replacement therapy for Addison's disease. Booked at 10 weeks and scan showed twin pregnancy. At 24 weeks there was evidence of twin to twin transfusion with polyhydramnios of sac one and polyhydramnois of sac two at ultrasound examination - twin one weighed 900g and twin two 670g. At caesarean section twin one weighed 780g with good Apgar scores. Twin two weighed 545g and was asphyxiated. A difficult resuscitation ensued. Twin two died at 13 minutes. Post-mortem showed a monozygotic (monochorionic diamniotic) placenta with twin-to-twin arterio-venous vascular anastomoses. Twin two had borderline pulmonary hypoplasia and associated intra-pulmonary haemorrhage. Death was because of prematurity, twin-to-twin transfusion and pulmonary haemorrhage.

CONGENITAL (5)

1. Age 27, one previous delivery by caesarean section. Ultrasound at 28 weeks showed bilateral pleural effusions and pulmonary collapse with other signs of hydrops. At 29 weeks pleural tap was performed. A female infant weighing 1940g, with Apgar scores of 3, 5 and 6 was delivered at 33 weeks by caesarean section because of reaccumulation of fluid and difficulty in tapping pleura. The infant died at six hours of age. Post-mortem: pulmonary hypoplasia secondary to non-immune hydrops. A possible but not certain cause of the hydrops is ectasia of the lymphatic drainage with leakage into the pleural space. Karotype was normal and there was no evidence of neuromusclar abnormalities or central nervous system abnormalities.
2. Age 32, primigravida, with a family history of neural tube defect. Patient was transferred to the Rotunda at 33 weeks with probable hydrocephalus. Ultrasound confirmed hydrocephalus and showed additional hydronephrosis and an umbilical hernia. Spontaneous rupture of the membranes occurred. A caesarean section was performed because of a failed induction. A liveborn male infant weighing 2360g with hydrocephalus was delivered. The baby survived less than one day. Post-mortem confirmed the ultrasound findings. Cytogenetics diagnosed Trisomy 18.
3. Aged 29, two previous normal infants. Admitted in labour when 37 weeks and proceeded to spontaneous vaginal delivery of a liveborn female infant weighing 2380g. Apgar scores were 2 and 3. Resuscitation was abandoned at 25 minutes. Post-mortem: Potters Syndrome due to obstructive uropathy.
4. Age 35, previous normal vaginal delivery at term. Uneventful antenatal care until 34 weeks when noticed to be small for dates and a breech presentation. Scan showed decreased liquor volume and CTG showed

decelerations. A female infant weighing 1615g was delivered by an emergency caesarean section. The infant had clinical features of Potter's Syndrome. Ultrasound showed no renal tissue and the infant died on day three. Post-mortem confirmed renal agenesis and pulmonary hypoplasia i.e. Potters Syndrome.

5. Age 19, primigravida. Uneventful antenatal care until 35 weeks when patient presented with a small antepartum haemorrhage. Delivered by elective caesarean section on account of breech presentation and poor biophysical score. A dysmorphic male infant weighing 2660g was delivered. The baby was difficult to ventilate. Renal ultrasound showed small kidneys. Clinical course suggested Potter's Syndrome and the infant died at 30 hours of age. Post-mortem confirmed Potter's syndrome with small dysplastic kidneys and hypoplastic lungs.

ABRUPTION (2)

1. Age 31, previous 37 week delivery, followed by stillborn male infant at 29 weeks due to placental abruption. Uneventful antenatal care until 28 weeks when patient presented with abdominal pain. On examination the uterus was tender and there was a fetal bradycardia. Clinical diagnosis was of placental abruption. An emergency caesarean section was carried out delivering a baby weighing 1060g with Apgar scores of 1 and 3; cord pH was 6.75. The infant required ventilation and showed cerebral hypoxia. The infant died on day 3. Permission for post-mortem was refused but clinically death was due to placental separation/abruption.
2. Age 25. Past history of four uneventful vaginal deliveries at term. Uneventful antenatal care, apart from urinary tract infection. Mother admitted to hospital at 26 weeks with signs of placental abruption. An emergency caesarean section was performed. A liveborn female infant weighing 970g was delivered with Apgar scores of 2, 2 and 5. Despite resuscitation baby died at 12 hours of age. Post-mortem showed hypoxia with hyaline membrane disease and intraventricular haemorrhage.

CORD (1)

1. Age 40, Primigravida, uneventful antenatal care, admitted to hospital with abdominal pain at 39 weeks. A fetal tachycardia was noted on CTG. An emergency caesarean section was preformed because patient was not in labour. A female infant weighing 3020g was delivered. The Apgar scores were 1 and 6. Meconium grade three, a nuchal cord and true knot in the cord were noted. Ventilation was necessary because of extreme birth asphyxia. Due to extremely poor prognosis ventilation was stopped. Post-mortem: Widespread neuronal necrosis indicative of severe hypoxia of at least twelve to eighteen hours duration, probably related to cord accident.

INFECTION (1)

1. Age 21, previous premature labour and neonatal death at 25 weeks. Mother presented at 16 weeks with premature rupture of the membranes and was admitted to hospital. She stayed in hospital for the next 11 weeks, and had occasional episodes of vaginal bleeding. Labour established prematurely at 27 weeks. A liveborn male infant weighing 1082g was delivered by caesarean section because of breech presentation. The baby, although in reasonable condition at birth, deteriorated rapidly and died at 5 hours despite active intervention. Post-mortem showed severe congenital pneumonia.

TWIN TO TWIN TRANSFUSION (1)

1. Age 29, Four previous term vaginal deliveries. Twin pregnancy diagnosed at 16 weeks gestation. Pre-eclampsia developed at 29 weeks gestation. Decelerations noted on antenatal CTG at 29 weeks and delivery by caesarean. Twin 1 weighed 1130g with apgar scores of 8 and 9. Twin II weighed 670g with apgar scores of 4 and 7. Twin II anaemic and transfused, however presistent bradycardia at 13 hours and died at 14 hours of age. Post-mortem showed no malformation or no structural cause of death. Clinical diagnosis of twin to twin transfusion was confirmed. It was felt that bradycardia was the result of metabolic imbalance resulting from the twin to twin transfusion.

MATERNAL DEATH (1)

1. Age 22, insulin dependent diabetes since the age of 7. Did not have a booking visit at the Rotunda but was referred as an emergency at 7 weeks, from a Casulty Department of a General Hospital with hypoglycaemia. Out-patient blood sugars were under good control, but was admitted moribund to a General Hospital Casulty at 8 weeks amenorrhoea. The patient was last seen alive at 4 am and was found dead the following morning. Post-mortem showed aspiration and a Coroner's Enquiry concluded that the patient died of natural causes.

2.5 HYPERTENSION WITH PROTEINURIA/PET

TOTAL NUMBER OF CASES	205
Booked	199
Unbooked	6
Incidence Against Delivery at all Periods of Pregnancy	3.0%
Maternal Mortality	0
Gross Fetal Loss	0
Stillbirths	0
Neonatal Deaths	0
Multiple Pregnancy	3
Parity of Patients:	**205**
0	133
1	33
2	22
3	7
4+	10
Gestation of Patients:	**205**
< 28 Weeks	2
28 - 29 Weeks	5
30 - 31 Weeks	5
32 - 33 Weeks	5
34 - 35 Weeks	10
36 Weeks +	178

2.6 MULTIPLE PREGNANCY

Total Number of Cases	**95**
Twins	86
Triplets	8
Quadruplets	1
Incidence against Total Deliveries	1.4%
Maternal Loss	0

2.7 INDUCTION OF LABOUR

Total Number of Cases	**1,362**
Incidence Total No. of Dels. > 500 Grams	22.2%
Number of Caesarean Sections for Induced Cases	0
Stillbirths	4
Neonatal Deaths	0
Methods of Induction:	
A.R.M.	239
A.R.M. and Syntocinon	429
Prostin and A.R.M. and Syntocinon	194
Prostin and A.R.M.	118
Prostin	215
Prostin and Syntocinon	12
Syntocinon	151
Others	4
Total	**1,362**

2.8 VACUUM EXTRACTOR

Total Number of Cases	**608**
Primiparous	445
Multiparous	163
Fetal Loss	0

2.9 FORCEPS

Total Number of Cases	**386**
Primiparous	256
Multiparous	130
Forceps Rate	-
Fetal Loss	0

2.10 CAESAREAN SECTION

Total Number of Cases	**1,343**
Incidence Against total Deliveries > 500 grams	21.9%
Maternal Mortality	0
Stillbirths	4
Neonatal Deaths	6
Primary Caesarean Sections	988
Repeat Caesarean Sections	355
Classical Caesarean Sections	6

INDICATIONS FOR PRIMARY SECTIONS:	
Fetal Distress	317
Failure to Progress	110
Breech	166
Abruption	9
A.P. Fetal Distress	9
A.P.H.	21
P.E.T.	43
Oblique / Transverse Lie	15
Pyrexia	6
Placenta Praevia	20
Bad Obstetric History	11
Cord Prolapse etx.	10
C.P.D.	20
Failed Forceps / Vacuum	6
Brow Presentation	8
Multiple Pregnancy	15
Failed Induction	36
Prematurity	7
Hypertension	18
Deep Transverse Arrest	2
Misc.	139
TOTAL	**988**

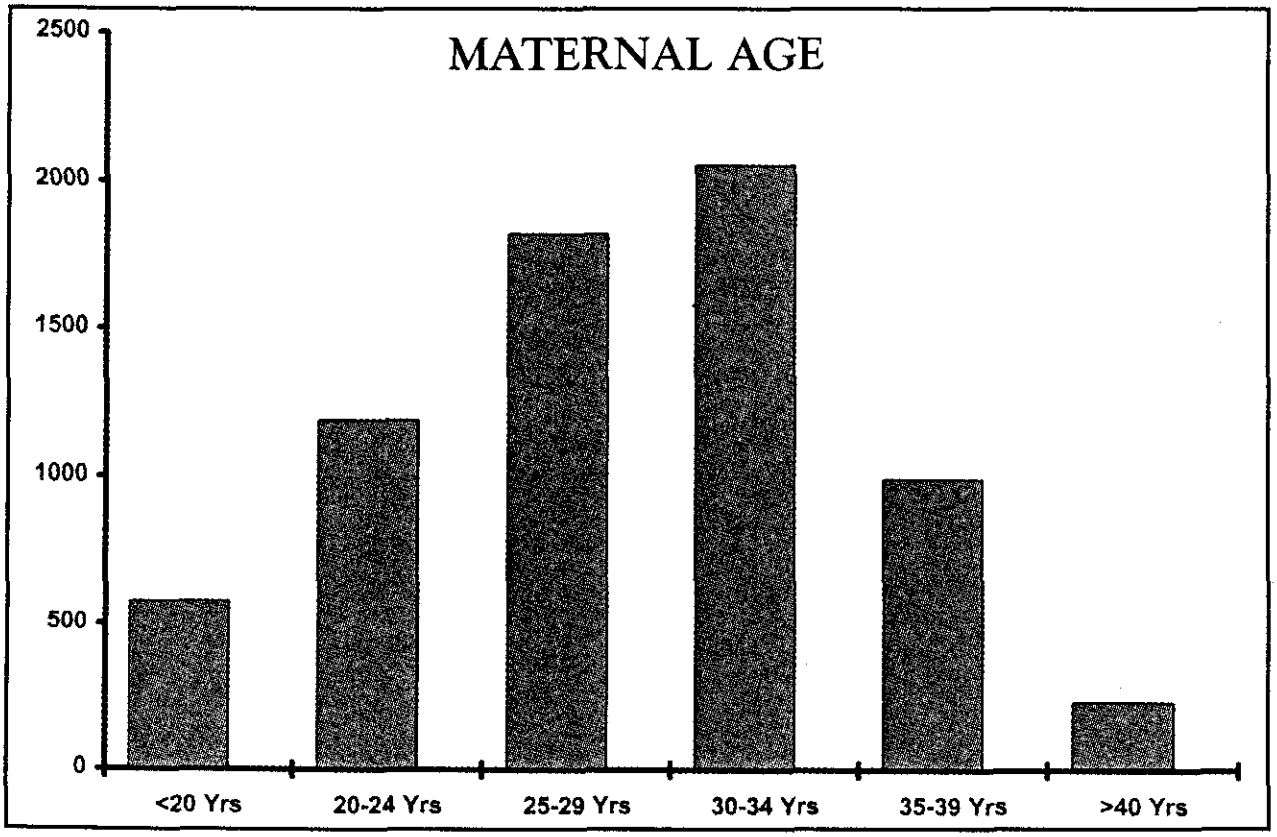
INDICATIONS FOR REPEAT SECTIONS:	
Failure to Progress	15
Fetal Distress	50
Disproportion	11
Unstable Lie	12
Breech	20
Hypertension	2
Placents Praevia	8
A.P.H.	6
P.E.T.	2
Poor Obstetric History	11
Previous Section History	218
Multiple Birth	2
Abruption	1
Failed Induction	2
Misc.	25
TOTAL	**385**

2.11 BREECH PRESENTATION AND DELIVERY

SUMMARY	
Total Number of Cases	**297**
Vaginal Breech Delivery	26
Delivery by Caesarean Section	256
Incidence against Total Deliveries > 500 grams	4.8%
Caesarean Section Incidence for Breech Presentations	86%
Gross Fetal Loss	2
Vaginal Breech Delivery/Maturity:	
< 28 Weeks	4
28 - 30 Weeks	2
31 - 33 Weeks	2
34 - 36 Weeks	6
37 - 40 Weeks	11
> 40 Weeks	1
Vaginal Delivery/Birth Weight:	
< 1,000 grams	4
1,000 - 1,499 grams	3
1,500 - 1,999 grams	4
2,000 - 2,499 grams	4
2,500 - 2,999 grams	7
> 3,000 grams	3
Unknown	1
Vaginal Breech Delivery/Parity:	
Primiparae	12
Para 1	9
Para 2	4
Para 3	0
Para 4	0
Para 5 or more	1
Vaginal Breech/Delivery:	
Primiparae	4
Para 1	6
Para 2	3
Para 3	-
Para 4	-
Para 5 or more	-

2.12 OUT-PATIENT ACTIVITY DATA

CLINIC	NO. OF SESSIONS	ATTENDANCE		
		New	Return	Total
Ante-Natal	1,092	4,438	18,731	23,169
Post-Natal	200	0	1,189	1,189
Psychiatry	86	96	236	332
Endocrinology	62	120	478	598
Varicose Veins	34	84	187	271
Thrombosis	38	15	109	124
Rhesus	47	1	7	8
Medical	46	132	446	578
Fetal Loss	23	46	84	130
Anaesthetic	43	71	6	77
Total	**1,671**	**5,003**	**21,473**	**26,476**



3. DEPARTMENTAL REPORTS

3.1 DEPARTMENT OF PAEDIATRICS

Professor T.A. Clarke (Director) Professor T.G. Matthews and Dr. M.D. King

The physical facilities that exist in the NICU at the Rotunda Hospital remain seriously substandard. Plans for a new combined Paediatric Department, on the site of the old Labour Ward and the Present NICU, have been submitted to the Department of Health and it is hoped that these will be improved as soon as possible

Nursing numbers remain inadequate. The workload has increased due to a combination of the increased survival of VLBW infants, an increase in the number of multiple pregnancies associated with assisted reproduction treatment, a lower threshold at which obstetricians deliver the at-risk pregnancy earlier, and an increase in social problems including maternal drug abuse. There was greater than 100% occupancy in the NICU during 1997. This places enormous stress on the staff working in crowded heated conditions. There is a need for an increase in nursing staff in the NICU and Paediatric Unit to cope with the increased workload and to maintain satisfactory nurse to baby ratios. It has been impossible to deliver high risk mothers for much of the year with the consequent transfer of high risk mothers to other maternity hospitals including transfer to country obstetric units of mothers already transferred from the country to Dublin.

DEATHS

There were 18 neonatal deaths in 1997, including three pateneonatal deaths. Three first week neonatal deaths occurred in normally formed infants with birthweight greater than one kilogram: one term infant born with the umbilical cord around the neck and evidence of chronic prenatal asphyxia. An infant born at 28 weeks gestation following placental abruption with a pH of 6.88 and Apgar score of 1 and 3 and another 28 weeks gestation infant born following prolonged premature rupture of membranes who died at age of four hours due to overwhelming Group B streptococcal fulminant sepsis. Two late deaths were due to Sudden Infant Death Syndrome and a late neonatal death was associated with polycythaemia, E. Coli sepsis and purpura fulminans.

VERY LOW BIRTHWEIGHT INFANTS

10 normally formed VLBW infants died including the two 28 weeks gestation infants noted above. Seven of the other eight were <600 grams birthweight and five of these were 22 to 24 weeks gestation. Two of these were not resuscitated. Four of the seven were twins or triplets; three of these four had signs of twin transfusion syndrome.

There were 92 infants born with birthweight less than 1500 grams; another five

VLBW infants were transferred from other hospitals. The average total length of stay for all infants with birthweight 501-1500 grams was 51 days. Sixty eight of these required assisted ventilation including six who received high frequency ventilation. Sixty three infants required surfactant for treatment of RDS.

Deciding whether or not to resuscitate the very immature infant remains problematic. As tiny infants survive in greater numbers, there is a need for prolonged follow-up of these infants, in a properly resourced comprehensive developmental clinic. Greater emphasis needs to be directed at identifying preventable handicap, including attempting to define the lower limit of gestation at which it is appropriate to attempt resuscitation. As we have noted in recent years, we agree generally with the statement by Allen Etal that, considering current mortality and morbidity, "aggressive resuscitation of infants born at 25 weeks gestation is indicated, but not those born at 22 weeks." (New England Journal of Medicine 1993; 329; 1597-1601).

There is a need for improved audit and quality assurance and the appointment of an audit assistant is essential to coordinate use of resources and patient outcome data.

VERY LOW BIRTHWEIGHT SURVIVAL 1986 - 1986

BIRTHWEIGHT (Grams)	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996 1*	1997	1997 Survival	TOTAL	ROTUNDA CORRECTED SURVIVAL
500 - 749 Birth	10	6	5	4	10	6	9	3	9	15	9	16	56%	67	(to 28 days)
Deaths	8	4	3	3	6	3	6	1	8	11	7	7		43	35%
(Lethal Malformation)				1	1						1			1	
750 - 999 Births	10	13	9	10	14	16	10	13	18	13	16	17	94%	103	88%
Deaths	6	9	5	3	5	3	2	5	4	1	2	1		18	
(Lethal Malformation)	1	2	1		2	2	1	1	1	1				6	
1000-1249 Births	14	13	23	21	14	24	14	17	22	16	19	34	94%	146	
Deaths	3	3	6	6	3	1	4	0	2	3	1	2		13	
(Lethal Malformation)		1	3	1	3	1	3		2	3	1			10	
1250 - 1499 Births	25	26	17	23	22	29	15	19	32	26	25		100%	168	99%
Deaths	1	3	2	6	1	4	0	1	1	1	3	0		10	
(Lethal Malformation)	1		2	2		3		1	1	1	2			8	

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Births <1500 grams	60	58	54	58	60	75	48	52	81	70	67	92
Normal Deaths	17	16	10	14	9	5	8	5	11	11	9	10
Lethal Abnomalities	1	3	6	4	6	6	4	2	4	4	4	0
Corrected Survival%(to 28 days)	71.2	70.9	79.2	74.1	83.3	92.8	81.8	90	85.7	83.3	85.7	89.1
						(Neonatal Deaths Mulitples)				5	5	4
VLBW Survivors 28 days	42	39	38	40	35	64	36	45	66	55	54	82
1500-1999 Births	78	67	67	72	62	68	59	74	73	93	80	
1500-1999 Deaths	2	6	1	1	1	4	3	2	2	2	3	2
Lethal Abnormalities	1	5	1	1	1	4	2	2	1	1	3	2
2000-2499 Births	237	175	223	201	206	220	191	193	218	213	228	
≥ 1Kg birthwt.,early deaths normal infants		3	3	10	4	4	0	2	1	3	3	

NEONATAL MORTALITY 1997

Birth Weight	Gestation	Sex	Mode Delivery	APGAR 1	APGAR 5	Age Death	Cause Death
DEATH VERY LOW BIRTHWEIGHT IN BORN INFANT							
520	26	M	LSCS	1	2	15 mins	Twin-twin perforated oesophagus, pericardiac haemorrhage, immature
550	22	M	SVD	NR	NR	28 mins	Previable, acute chorioamnionitis
555	23	M	Breech	5	5	24 hours	Immature, RDS, electrolyte imbalance, hyperkalaemia, grade 2 IVH, (no PM)
560	23	M	Spont	NR	NR	1 minute	Immature
655	24	M	SVD	5	8	4 days	Immature, twin, surfactant, enterobacter sepsis (no PM)
670	29	F	LSCS	4	7	14 hours	Twin-twin transfusion, haematocrit 0.19, large blood transfusion, age 12 hours in 25% oxygen on IPPV, hypocalcaemia, age 14 hours in 3.5% oxygen on IPPV, sudden bradycardia, not respond resuscitation
970	26	F	LSCS	2	2	12 hours	Admitted with abruption, immediate delivery, cord ph 7.00, ET adrenaline, RDS, Right IVH
1070	28	F	LSCS	1	3	66 hours	Placental abruption, cord ph 6.88, RDS, seizure age 2 hours, IVH, coma-unresponsive, (no PM)
1100	28	M	LSCS	7	8	4 hours	PPROM at 16 weeks, choriamnionitis, pneumonia, septic shock, group B streptococcus grown from placenta.
DEATHS INFANTS BIRTHWEIGHT >1500 GRAMS NORMALLY FORMED							
2075	35	F	SVD	9	10	22 days	Sudden infant death syndrome
3020	39	F	LSCS	1	6	36 hours	Cord around neck, evidence chronic asphyxia
3220	39	M	SVD	9	10	16 days	Sudden infant death syndrome
LETHAL MALFORMATIONS							
1615	34	F	LSCS	1	7	3 days	Potters syndrome, no renal tissue.
1940	33	M	LSCS	3	5	6 hours	Non-imune hydrops, congenital chylothorax
2360	39	F	LSCS	2	2	1 hour	Trisomy 18, left diaphragmatic hernia, pulmonary hypoplasia, dysplastic urethral valves, congenital hydrocephalus
2380	36	F	SVD	2	3	23 minutes	Posterior urethral valves, Potters syndrome, complete obstructive uropathy, urethral-vaginal dysplasia, borderline pulmonary hypoplasia
2400	37	M	LSCS	9	10	26 days	Twin, polycythaemia, partial exchange, thrombophlebitis, E.Coli sepsis, purpura fulminans, renal failure, Candida septicaemia
2660	35	M	LSCS	3	6	30 hours	Bilateral pneumothoraces, dysplastic kidneys, hypoplastic lungs.

1995 VERY LOW BIRTH WEIGHT FOLLOW UP.

There was a total of 56 VLBW surviving children born in 1995 to be reviewed at the age of two years in 1997.
All children were sent an appointment for neuro development assessment at corrected age of two years. Information was obtained regarding 42 children following attendance or from their local paediatricians where long distance was a factor via Cork (1). Waterford (1).
Fourteen children did not attend despite telephone contact before the appointments were made and despite two appointments being sent.
The majority of non-attenders (11/14) live in Dublin and nine are male. Eight were born by caesarean section. However a review of a random selection of attenders indicates that mode of delivery is not a significant contributory factor in their non attendance.
Of the remaining three non-attenders, one lives in Kildare, another in Co. Laois and one in Co. Sligo. All are female and two were born by caesarean section.
The following tables indicate the gestational age and weight distribution of the cohort.

Table 1.

Gestational Age	<26wks	>26<28 wks	>28 <30wks
Male	2	6	4
Female	1 =3	5 =11	9 =13
	>30 <32 wks	>32 <34 wks	>34 <36 wks
Male	2	2	1
Female	5 =7	2 =4	2 =3
	36 + wks		
Male			
Female	1 =1		n=42

Table 2.

Birth Weight	<500grms	>500 <750 grms	>750 <1.0kg
Male		2	6
Female		2 =4	4 =10
	>1.0 <1.25Kg	>1.25 <1.5Kg	
Male	4	5	
Female	4 =8	15 =20	n=42

OUTCOME

The majority did well from the developmental and neurological point of view. There were two documented cases of cerebral palsy and one child had significant developmental delay. These require closer examination.

Case1: Female with birth weight 1340 grams at 28 weeks gestation born by forceps delivery and had a grade two intraventicular haemorrhage. She has a spastic diplegia. However at two years she is walking independently with age appropriate language skills.

Case 2 + 3: These are surviving twins of a triplet pregnancy.

Case2: Male with birth weight 835 grams at 25+4 weeks gestation has evidence of probable mild dipegia with learning ability at the upper end of mild mental handicap.

Case 3: Male with birth weight 610 grams at 25+4 weeks gestation has significant learning difficulties - probably moderate - upper severe. His motor ability is not significantly impaired.

Three children have definite syndrome diagnosis i.e. Russell Silver, Ehlers Danlos and Prader-Willi. Two are functioning within the normal range, the third is not by virtue of her underlying condition.

Five children, four (male) were identified with particular areas of delay i.e. eye, hand co-ordination and speech. These children have been referred to appropriate services. However they would benefit from repeat psychological assessment before school entry.

In order to validate our initial findings there is need for further follow up of approximately 15% of our annual very low birth weight population at ages 3 years and 4 years. This would require the services of a psychologist and Occupational Therapist as well as paediatricians in the first instance.

A retrospective review of non-attenders over 3-5 year period will be carried out to confirm suspected risk factors for non-attendance and in an attempt to improve uptake.

3.2 DEPARTMENT OF GYNAECOLOGY

Out-Patients:	1997
No. of Clinics	556
No. of New Patients	3,226
Total No. of Patients	8,135

In-Patients:	
Bed Complement	35
No. of Admissions	1,975
Major Operations	728
Minor Operations	3,066
Total Operations	3,794

THEATRE WORKLOAD: DEPARTMENT OF GYNAECOLOGY

	Rotunda
Vaginal Surgery:	
Vaginal hysterectomy	67
Manchester Repair	9
Pelvic Floor Repair	79
Urethroplasty	1
Smear	78
Removal of IUCD	17
Insertion of IUCD	5
Other	234
Total	**279**

Abdominal operations of the Uterus:	
Total Abdominal Hysterectomy	179
Wertheims Hysterectomy	0
Myomectomy	51
Gillians Suspension	1
Bilateral Salpingo-oopherectomy	113
Other	0
Total	**344**

Surgery on the Tubes and Ovaries:	
Tubal Surgery	49
Tubal Ligation	513
Salpingectomy	8
Ovarian Cystectomy	63
Oopherectomy	13
Ovarian Biopsy	59
Salpingo-oopherectomy	7
Other	1
Total	**713**
Other Procedures	
Laparascopy	280
Laparascopy & Dye	749
Hysteroscopy	258
D&C	660
EUA	10
Total	**1,957**
Cystoscopy	20
Laparotomy (including Ectopics)	47
Appendicectomy	1
Excision Bartholins Cyst	9
Fentons	1
Diathermy Vulaval Warts	12
TCRE	19
Laparoscopic Division of Adhesions	30
Polypectomy	33
Punch Biopsy of Cervix	6
LLETZ	25
Cautery to Cervix	38
Endocoagulation	87
Other Gynae Surgery	173
Total	**2,458**
Grand Total	**3,794**

3.3 DEPARTMENT OF PATHOLOGY

Dr. J.E. Gillian (Director), Dr. Mary Cafferkey, Dr Phillip Mayne,
Dr. Deirdre Devaney, Dr Eoin Smith
Mrs Gwen O'Connor (Chief Technologist)
Registrars; Dr Niamh Birmingham, Dr Vourneen Healy

INTRODUCTION:

There was a significant increase in the workload for the laboratory in 1997 compared to the previous year. The number of specimens referred to the laboratory increased by almost one third. A break down of the numbers of specimens received by each department and the numbers of tests are stated in Table 1.

Table 1: Department workloads for 1997 compared to 1996

Department	Number of Specimens	% + over 1994	Number of Tests	%+ over 1994
Haematology	29701	-4.2	37177	-1
Blood Group Serology	13731	+7.4	41327	+5.2
Transfusion	5682	+26	6225	+17
Microbiology	25917	-0.4	60719	+8
Microbiology Serology	6283	+1	125668	+1
Biochemistry Histopathology	26519	+11	85283	+18
Surgicals	4141	+11	17085	+15
Autopsies	99	-3	2432	-12
Cytology	13688	+20	113726	+29

HISTOPATHOLOGY:

Staff: Technologist:Ms Carmel Curran.
Technicians: Ms Dympna Sheehan; Ms Philomena Bateson; Ms Anne Kennedy.
Pathology Technician: Bill O'Neill. Laboratory aid: Brid Beglin; Niamh O'Shea

There was an overall increase of 7% in the numbers of surgical specimens compared to the previous year. This was due to a 15% increase in the numbers of placentas, 2% increase in the numbers of routine surgical specimens. The number of slides examined, i.e. specimen:test ratio was unaltered from the previous year (i.e. routine surgicals 2.23; placentas 6.97).

Table 2: Analysis of Autopsies for the Year 1997

Birth Weight Category	Stillbirth CA*(SA)**	Early NND CA (SA)	Post NND CA (SA)	Refered CA (SA)	Total Cases CA (SA)
≥ 500 grams	30 (4)	11 (3)	3 (0)	8 (0)	52 (7)
< 500grams	47 (31)	-	-	1	47 (31)
Autopsy Death occured elsewhere		2	2		

* CA, Complete Autopsy; ** SA, Superficial Autopsy

A total of 99 autopsies were performed. These comprised 91 hospital cases and 2 cases, which were referred from outside. Permission for autopsy was refused in a further 38 cases, on which superficial autopsy examination were performed. A breakdown in the number of autopsy numbers is stated in Table 2. An analysis of perinatal death, i.e. > 500 grams is reviewed elsewhere in this report. Our findings are summarised in Table 3 according to the Wigglesworth classification. In addition to these infant deaths examined in the department of pathology there were four other infants who died outside the hospital. Two of these deaths occurred during the early neonatal period, while a further two were post neonatal deaths. The overall autopsy rate for these cases was 88%.

Table 3: Autopsy Findings in 59 cases with birth weight ≥ 500 grams

Wigglesworth Category	IUD CA* (SA)**	Early NND CA (SA)	Post NND CA (SA)	Referred CA (SA)
IUD Normally formed	21 (2)	- -	- -	0 (0)
Malformation	5 (1)	4 (0)	1 (0)	2 (0)
Prematurity	- -	3 (3)	1 (0)	1 (0)
Birth Asphyxia	1 (1)	1 -	- -	1 (0)
Specific Cause	3 -	3 -	1 (0)	4 (0)
Total	30 (4)	11(3)	3 (0)	8 (0)

CA* Complete Autopsy; SA ** Superficial Autopsy

There were 78 cases weighing < 500 grams. Full autopsies were performed in 47 of these cases, i.e. autopsy rate of 60%. The diagnoses obtained from these investigations are summarised in Table 4. Significant pathological findings were found in 75% in those with full autopsies while significant autopsy diagnoses were identified in 25% of those where superficial autopsies were performed.

Table 4: Autopsy Findings in 78 fetuses < 500 grams

Diagnosis	Complete Autopsy Number	(%)	Superficial Autopsy Number	(%)
Major Malformations	5	(10)	2	(6.5)
Chronic Uteroplacental Insufficiency	3	(8)	0	(0)
Retroplacental Haemorrhage	6	(13)	0	(0)
Retroplacental Haemorrhage with Infection	4	(8)	2	(6.5)
Unexplained	12	(25)	22	(71)
Twin-to-Twin Transfusion	7**	(15)	0	
Other	1	(2)	1	(3)
No examination*			1	(3)
Total	**47**		**31**	

* Body of fetus removed before examination was performed
** This includes one triplet, the other triplets were > 500 grams at birth

CYTOLOGY:

Staff: Senior Technician:- Ms Maria Tobin.
Technicians: Ms Tokiko Kumasako; Ms Olive Sweeney; Ms Maeve Whelan

A total of 13,400 cervical smears were examined during 1997. This represented a 20% increase over 1996. The growth in numbers was due to increased accession from hospital work and also from General Practioners in the Dublin area.

The number of patients with positive smears was 411. These included 406 cases of CIN, 2 cases of squamous carcinoma of cervix; 1 case of endocervical adenocarcinoma, and 2 cases of endometrial adenocarcinoma. This represents a positive rate of 3%, which is increased compared to the rate for 1996. The increase in this rate is in some degree related to cervical smears taken at colposcopy from patients referred from other centres/practices. The overall ratios between CIN grades I, II, III described in Table 5 is not significantly different from that seen in 1996. A total of 772 cases of borderline smears were reported, representing an incidence of 5.76% the combined incidence of CIN I and borderline change was 6.6% (expected 'achievable benchmark criteria' (ABC) is 5.5 ± 1.5%). The combined incidence of CIN II and III was 1.89% (ABC expected level 1.6 ± 0.4%). There has been a noticeable trend for CIN II to occur in progressively

younger age groups. Over the past three years over 50% of CIN I and II occur in the age group categories of 0-20 and 21-30 years.

The number of fluid aspirations for Cytology was 288, which is the same as in the previous year. These were mainly ovarian cyst aspirates from infertility investigations and from IVF patients.

Table 5: Analysis of patients with positive smears by age and grade of CIN

Grade of Neoplasia	Number of Patients	Patients ages (years)					
		0-20	21-30	31-40	41-50	51-60	60+
CIN I	145	12	66	38	23	6	-
CIN II	93	5	48	26	13	1	-
CIN III/CIS	168	2	59	69	30	7	1

BIOCHEMISTRY:

Staff: Senior Biochemist: Peter Browne. Senior Technician: Ms Bernie Jackson. Technician: Ms Maria Phelan

During the past few years the staff were experiencing considerable difficulty with ageing equipment used for the analysis of routine biochemistry specimens. This caused considerable analyser downtime and poor analytical performance, which was reflected in deterioration in external quality assurance. This analyser was replaced during the year with a Roche Integra. Staff attended a number of training sessions and the instrument was implemented successfully within a very short period of time. Overall performance improved considerably with a marked improvement in the overall mean running variance index score (OMRVIS) rising from 60 to 43, below the mean of 46 for laboratories of comparable size. This new instrument has enabled us to increase the repertoire of investigations performed in-house thus further reducing the turn-around time for some analytes. During the year the workload activity for 'routine' and specialised biochemical investigations continued to increase by a further 18% although the number of specimens received rose by only 11%.

In collaboration with the Children's Hospital, Temple Street a number of research projects were initiated. The Group was able to demonstrate that a metabolite identified in the urine by GCMS and associated with a rare inherited metabolic disorder in children was in fact a normal constituent in urine from pregnant women. This original finding, which was published in the Lancet, suggests a source of the metabolite in an alternative metabolic pathway involving branch chain

amino acids. Further work is underway to confirm our working hypothesis. Another study is also underway to establish a sensitive method to measure homocystine in plasma and to determine changes in the metabolism of the amino acid, methionine, and its metabolite homocystine during pregnancy and their relationship with early pregnancy loss.

HAEMATOLOGY:

Staff: Senior Technicians: Ms Catherine Robinson; Ms Jane Halligan.
Technicians: Ms Patricia Gough; Ms Janet Tierney; Ms Catherine Keany.

While there was a small decrease of 1 % in the total number of tests over 1996, this decrease was not significant. Some tests were slightly decreased (FBC –5.7%) while others, such as coagulation studies and differential white cell counts, continued the trend for 1996 and increased by 19% and 33% respectively. The number of tests referred to outside laboratories rose by 65% (1197 tests in 1996 compared to 1986 tests in 1997). The majority of these tests were for cytogenetics, specialised coagulation studies and haemoglobin electrophoresis. It is expected that the demand for the latter will continue to increase, reflecting changes in the ethnic background in our patient population.

Table 6: Analysis of Haematology Workload

TEST	NUMBERS	% INCREASE 1996
FBC	27298	-5.7%
DIF	2818	-1%
Cord Hb's	5	-50%
ESR'S	56	-16.4%
Kleihaur	93	+29%
Prothrombin time	2224	+19%
APTT	2245	+18.6%
Fibrinogen	22	+37%
FDP	7	-50%
Lupus A/B	60	-27%
HbS	80	+100%
Retic	269	-50%
Total tests	**37177**	**-1%**
Total specimens	**29701**	**-4.2%**
(Send outs)	1986	+65%

SEROLOGY:

Table 7: Analysis of Serology Workload

TEST	NUMBERS	% INCREASE 1996
ABO group	13293	+7.2%
Rh group	13293	+7.2%
Antibody Sc	12454	+6%
DCT	1162	-15%
Du	488	+15%
Immune (ABO)	71	+144%
A.B Investigations	281	-39%
Titres	110	+44%
Genotypes	175	-52%
Total tests	**41327**	**+5.2%**
Total specimens	**13731**	**+7.4%**
received		

The increase experienced in 1996 continued in 1997 with a 7.4% rise in specimens. This caused a further increase of 11.4% in tests (1996 saw in 9.3% increase in specimens and 11% increase in tests over 1995). The antenatal referrals remained at 1996 levels but the specimens referred for 'group and save' increased dramatically (30%) contributing significantly to the overall increases in work load.

There was quite a selection of clinically significant antibodies encountered of which only 3 were new anti-D's. Previous trends of multiple antibody detection continued. There were two babies with haemolytic disease of the newborn due to anti-c+E and anti-E. Both infants required exchange transfusions.

TRANSFUSION:

Table 8: Analysis of Transfusion Workload

TEST	NUMBERS	% INCREASE 1996
No. of cross matches	935	-26.6%
No. of units transfused	233	-6%
No. of patients X/matched	392	-5.5%
Tx:Xm ratio	1:4	1:3.08
Average wastage	17%	-
No. of group and holds	5290	+30.7%
Quads issued	772	+15.6%
Total tests	**6225**	**+17%**
Specimens received	**5682**	**+26%**

The demand for cross match blood continued to decline with a 5.5% reduction in patients cross matched and a 60% reduction in the units transfused. Despite the 26% reduction in the number of units cross-matched our cross-match: transfusion ratio was too high at 4:1. Ideally it should have been 2:1. The effect of the fall in the number of cross-matches was however countered by a 30% rise in 'group and saves'. It is here that the transfusion policy needs to be re addressed. From the cross-match figures it is obvious that few of the group and saves were subsequently converted to cross-matches.

The demand for neonatal transfusion rose by 15.6%. It is hoped in the near future to reduce donor exposure by eliminating the sharing of quad packs. This has been made possible by the extension of the expiry date of the quad packs to 35 days after validation by the blood transfusion service board.

The percentage wastage appeared high at 17% but in reality this amounted to 8 units per month. The 35 day expiry date allowed a smaller stock to be held but there was a minimum stock level below which it is unsafe. The reduction in transfusion levels has led to a certain number of unused units of blood.

CLINICAL MICROBIOLOGY:

Staff: Technologist: John Mc Morrow.
Technicians: Ms Susan Luke; Ms Patricia Baynes; Ms Bernadette Lennon; Ms Ann Lamont; Ms Ita Cahill

The number of specimens processed in the Microbiology laboratory remained

approximately the same as in 1996 and there was an increase of 8.3% in the number of tests performed on these specimens. The number of specimens and the number of tests performed in 1996 and 1997 are summarised below.

	1996	1997
Number of microbiology Specimens	26009	25917
Number of serology specimens	6219	6283
Number of Tests	56082	60719

The principal changes were a large increase in the number of swabs for microbiology (21%), and a 32% increase in the number of requests for Mycoplasma/Ureaplasma culture. These increases were attributable mainly to the introduction of routine screening for carriage or infection with Group B streptococci or Mycoplasma/Ureaplasma in antenatal patients with suspected or confirmed premature labour or premature pre-labour rupture of the membranes. There was also an increase of 6% in the number of urine specimens

A total of 9,421 specimens were referred for tests to other laboratories. Of these 7,635 referrals were for antenatal screening performed at dedicated reference centres (rubella and syphilis serology). The remaining referrals were for viral serology.

The anonymous Hepatitis B screening programme continued and revealed an increase from 4 positive in 1996 to 11 positive in 1997 (See **Table** below). Vertical transmission of hepatitis B (from carrier mother to infant) may be reduced by active and passive immunisation of the infant at birth; however the present voluntary screening programme is identifying only half of all positive mothers.

Time period	Number tested	Number positive for hepatitis B surface antigen	Known positive
Jul-Dec 1995	2718	1 (0.03%) one in 2,700	0
1996	6219	4 (0.06%) one in 1,550	1
1997	6283	11 (0.18%) one in 570	6

The anonymous HIV screening programme continued and there were 6 positives detected by this programme throughout 1997. The voluntary testing system identified only 4 of the 6 infected women.

The semi-automated continuous-monitoring blood culture system installed in 1995 continued to prove itself a valuable addition to the laboratory equipment. Use of this system has facilitated early detection of positive cultures (in some cases in as little as 6 hours of specimen collection) and rapid identification of infecting organisms. However, culture will not detect all episodes of sepsis; pre-administration of antibiotics may render a specimen sterile despite ongoing infection and some bacteria are extremely fastidious in their growth requirements and may not survive in artificial culture conditions. A pilot project using non-culture methods to detect invasive bacterial infection in the newborn commenced in August 1997 at the Rotunda. This study which is funded in part by the Friends of the Rotunda, is using the molecular biology technique, the Polymerase Chain Reaction (PCR) to detect a small piece of nucleic acid (DNA) which is unique to bacteria. A subsequent PCR step will be used to identify the specific bacterial species involved. Preliminary results are very encouraging.

There is limited information on the prevalence of congenital infection in the Republic of Ireland. One organism, which may cause congenital infection is the protozoan parasite, *Toxoplasma gondii*. A national study of the seroprevalence of antibody to *Toxoplasma gondii*, in women of child-bearing age was completed at this laboratory in 1997. This work was performed in collaboration with the National Newborn Screening Laboratory at the Children's Hospital, Temple Street. Overall, 24.8% of the 16,035 specimens tested were positive for *Toxoplasma* antibody. There was considerable variation in *Toxoplasma* seroprevalence with the rate in Dublin (20.3%) significantly below the mean. This is the first phase of a project to determine the incidence of congenital toxoplasmosis in this country.

MANAGEMENT ADMINISTRATION & SECRETARIAT:

Staff: Chief Technologist:- Ms Gwen O'Connor
Secretarial Staff: Ms Jacinta Core; Ms Anna Farley; Ms Maura Whelan
Porter: Don Allen

The laboratory secretarial staff are an important two-way operational interface between laboratory personnel and the medical and nursing hospital staff. The work involves not only transmitting laboratory results to clinics and wards but also specimen accession and communication, including patient reception. The progressive increase in laboratory work load, noted in this and previous reports, has necessitated the appointment of a third member to the existing two permanent staff. This was facilitated in part by a funding allocation from the Department of Health for the development of the cervical cytology screening services.

It deserves mention that not only is the pace of laboratory clerical work intense,

but also requires significant special training. This entails both specific areas in computer skills and also acquisition and understanding of pathology procedures and vocabulary. This training is required not only by our permanent clerical staff but also any locum staff who provide cover during holidays etc. from the general secretarial 'pool' within the hospital. A significant facilitating relationship concerning this area has been developed with the hospital administration over a considerable number of years.

The role of the Chief Technologist is central to contemporary laboratory management. The role has evolved considerably embracing not only day-to-day organisation of duty rotas, and multi-disciplinary on-call service, but also financial monitoring, medical informatics, scientific development and future planning. This requires liaison, not only with other hospital departments but also outside agencies. A specific area of concern during 1997 and continuing in the present year has been the upgrading of the computer program.

3.4 DEPARTMENT OF ANAESTHESIA
Dr. J. Gardiner

Our thanks again must go to our junior staff whose workload in the HARI unit, the Gynaecology Dept., the HDU, and the Obstetric Department continues to increase.

Congratulations are due to Dr. B. Blunnie who has become the Dean of the Faculty of Anaesthetics RCSI. President Mary McAleese will inaugurate the College of Anaesthetics on Wednesday 23rd September 1998 with Dr. Blunnie becoming the first President of the newly formed College.

DELIVERIES UNDER EPIDURAL:	
Total	**3,598**
Total (inc. Spinals)	**4,335**
Primparous	
Mode of Delivery:	1,881
Normal	913
Forceps	178
Vacuum	488
L.S.C.S	302
Breech	0
Multiparous	
Mode of Delivery	1,717
Normal	1,293
Forceps	67
Vacuum	176
L.S.C.S	177
Breech	4

HIGH DEPENDENCY UNIT
Dr Mary Bowen

The High Dependency Unit was introduced in July 1996. It is a 2 bedded unit covering an area of 35 square meters. Since its introduction the number of admissions there until December 1997 was 152.

The majority of patients admitted were obstetrical (80%) and 20% patients admitted were gynaecological.

In the obstetrical group 42% were admitted with pre-eclampsia; 13% with haemorrhage and 45% with medical problems of pregnancy. Occupancy rate was approximately 50%.

3.5 ROYAL COLLEGE OF SURGEONS IN IRELAND ROTUNDA UNIT

Head of Department.
Robert F. Harrison. MA., MD., FRCS., FRCOG., FRCP.

Senior Lecturer.
Paul Byrne. ND., FRCOG., FRCPI.

Lecturers.
Geraldine Connolly. MRCOG.
Melwyn D'Mello. MRCOG.
Mary McCaffrey. MRCOG.

Laboratory Scientist.
Louise Drudy. PhD.

Secretarial.
Marie-Louise Redmond. MBA.
Suzanne Naughton. MMIII. Grad.

1. Service.
The unit continues as part of Team B's hospital requirements for Obstetrics and Gynaecology. Personnel are supplied to specialist clinics concerned with menopause, vaginal health, obstetric day care, hypertension and renal clinic, infertility and pregnancy loss.

2. Teaching.
2.1. Undergraduates.
165 students attended the introductory course held in September 1996 in the Pillar Room. Eighty-four students attended the practical modules in November/December 1996, January/February and March/April 1997 respectively. In the Final Examinations the Gold Medal was obtained by Mary Browne and second place by Aishling Wallace. Of the students attending the Rotunda Hospital eight were awarded an honours mark and ten failed the first time.

3. Research.
R.F. Harrison
a. Infertility/Assisted Reproduction

P. Byrne

a. An audit of day care in the management of hypertension in pregnancy.
b. H Pylori in pregnancy study (with Geraldine Connolly)
c. Multicentre randomised trial comparing oxybutynin and tolteridine in the management of detrusor instability.
d. An evaluation of periurethral Macroplastique injection in the management of stress incontinence of urine.

L. Drudy.

a. Aspects of male infertility.
b. Recombinant Follitrophin Beta (Puregon under ordinary clinical conditions).
c. Assessment of the Safety and Efficacy of recombinant human luteinizing hormone.M. McCaffery.
a. Vaginal discharge.
b. Pregnancy Loss.

G. Connolly.

a. Pregnancy Loss.
b. Operative Therapy for Fibroids.
c. Menopause.
d. H. Pylori in Pregnancy and Neonates.

Suzanne Naughton.

a. Exploring the possibility of gaining ISO 9002.

Student Fellowships.

a. A simplified and CD Rom for the Obstetric and Gynaecology Undergraduate Course. J. Sheehan and Sean McBrinn.
b. Teenage pregnancy in the Rotunda Hospital. A Review. S. Conneely

Certificates Awarded

Louise Drudy

Molecular Genetics. Trinity College Dublin.

Quality Assurance in Health Care Institutions: A training course for healthcare providers. Maastricht University the Netherlands.

Genetics/Paramedical Course European Society for Reproductive Biology Goteborg Sweden.

3.6 HUMAN ASSISTED REPRODUCTION IRELAND (HARI)

Director.
Robert F. Harrison. MD., MD., FRSCS., FRCOG., FRCP.

Sub-Specialist Trainee Senior Registrar.
Tom Barrett. MRCOG>

Clinicians
Miriam Doyle. MRCOG.
Eimear Mallon. MRCGP.
Helen Spillane. MRCOG.
Saji Jacob. MRCOG.

Laboratory.
Aidan McMahon MSc.
Evelyn Cottell PhD.
Declan Keane MSc.
Barbara Hughes MSc.
Ciara Hughes MSc.
Kathleen Waite BSc.
Adrianne Pope Phd

Nurses.
Benny Hennelly SRN. SCM. Sr.
Teresa Woods SRN. SCM. Staff Nurse.
Kitty Lowery SRN. SCM. Staff Nurse.
Joan Kelly SRN. SCM. Staff Nurse.
Bronagh Murphy SRN. SCM. Staff Nurse.

Counsellors.
Ann Davy BA., Dip. Soc. Admin. Dip. Counselling.
Eileen Conway B.Soc.Sc. CQSW
Roisin Venables.

Sex & Marital Therapist.
Caroline Harrison. MSc. BSS. CQSW.

Secretarial.
Sue Ryan
Natasha O'Sullivan.

Housekeeping.
Maureen O'Rourke.

1997 saw considerable changes in the HARI unit at the Rotunda Hospital. Because of overcrowding an ambitious building project was commenced at the beginning of January and completed by 24th October 1997. This was behind the anticipated date which meant no cases were performed between 13th August and the 10th October when necessity demanded restart. This was initially in the Hospital theatre for 13 days.

During the period of time the unit was being built a number of original facilities had to be knocked down giving rise to tremendous overcrowding. However both staff and patients showed great forbearance in what were very difficult circumstances indeed. The unit was officially opened on 4th December 1997 by Professor Harrison.

During 1997, 659 patients had zygotes transferred and 132 clinical pregnancies ensured. There were 370 new patients undergoing IVF and 106 undergoing ICSI. Because of the severe disruption it is not valid to consider these results in isolation from other years. Indeed it is perhaps apposite at this stage of change to consider the figures in both IVF and ICSI that have been achieved throughout the time when using the original HARI facilities.

This data is shown in Table 1.

In overall terms of take home baby rates which can only be collated up to 1996 of the 1,717 patients 34% conceived who commenced the programme and 28% took home babies.

Plans for the future in HARI include further consideration by the Hospital Board of a request for zygote freezing and the provision of a sperm freezing programme for cancer victims. Through liaison with urological colleagues there will be an increase in artificial insemination for electro ejaculation paraplegic patients and testicular aspiration will commence prior to ICSI.

In line with clinical activities which have increased so to has counselling both in general terms for those distressed at being infertile, those wishing to avail of IVF or ICSI and those identified as having a sexual or marital problem.

Research.

Tom Barrett.
The Genetics of Azoospermia.

David Bailey
The Genetics of Azoospermia.

R.F. Harrison withM. Fawzy
Inhibin B and its use in Infertility.

Saji Jacob
Analysis of recombinant verses urinary FSH.

Eimear Mallon
Audit of IVF/ICSI outcome.

Evelyn Cottell
Infection of male infertility. PhD>

Aidan McMahon
Male Infertility. Msc.

Table 1.

Results HARI IVF 1989-97 +ICSI 1995-97 Clinical Pregnancy Rates (n=751)		
Per Patient	2193	34%
Per No. of Cycles	3718	20%
Per No. of Cycles where oocytes retrieved	3191	24%
Per No. of Cycles where zygotes replaced	2817	27%

3.7 DEPARTMENT OF MIDWIFERY
Miss M.A. Kelly, Matron

SENIOR STAFF
Miss M. Cunningham (Deputy Matron)
Miss E. Archibald (Assistant Matron)
Miss M. Thornton (Unit Nursing Officer)
Ms. A. Keenan (Unit Nursing Officer)
Mrs. K. Ruddy (Acting Assistant Matron)

SISTER MIDWIVES:
Ms. G. Birrane
Ms. M. Cahill
Ms. K. Clarke (until Nov.1997)
Ms. B. D'Arcy
Ms. J. Dillon
Ms. M. Duggan
Ms. E. Early
Ms. M. Gannon
Ms. G. Gorman (from April 1997)
Ms. S. Graham
Ms. C. McDermott
Ms. M. McGovern
Ms. M. McNally
Ms. F. O'Carroll
Ms. M. Philbin
Ms. M. Quinn
Ms. A. Redman
Ms. A. Reid
Ms. M. Williams
Ms. P. Williamson

SCHOOL OF MIDWIFERY STAFF
Midwife Teachers: Ms A. Monaghan, Principal Midwife Teacher
Ms M. Carroll, Midwife Teacher
Ms M. McNelis, Midwife Teacher
Ms. D. Daly, Midwife Teacher

TOTAL STAFF
Total Midwifery Staff (including 72 Student Midwives) for 1997 = 256

MIDWIFERY TRAINING PROGRAMME

36 Student Midwives commenced the Higher Diploma in Midwifery Education Programme in 1997.

43 Student Midwives completed their Midwifery Education Programme and passed their Final State Examinations.

21 Student Midwives joined the Staff during the year following completion of training.

Congratulations to all our Student Midwives on their success.

Obstetric Secondment

Student Nurses attend from Beaumont Hospital, Our Lady's Hospital for Sick Children Crumlin, and James Connolly Memorial Hospital Blanchardstown, for a three week module in obstetrics during their General Training. A total of 15 such courses were held throughout the year and 160 Student Nurses attended.

English Student Midwives

Student Midwives completing their Bachelor and Masters in Midwifery Degree in England completed a four week elective module at the Rotunda Hospital observing the modern management in Obstetrics and Neonatology.

Visiting Midwives

Midwives from U.S.A., England, Finland, Wales, and Tasmania visited the Hospital to observe modern management in Obstetrics and Neonatology.

Presentation of Awards 1997

Due to the introduction of the Postgraduate Diploma in Midwifery which started in September 1996 there were no Awards held in 1997.

History - The End of and Era

April 1996 saw the end of the midwifery programme leading to certification.
The Rotunda Hospital can be justly proud of its long history of teaching Midwives right from the beginning. In 1755, ten years after the opening of the first lying-in hospital, Mosse petitioned the Irish Parliament for financial assistance for the building of a new lying-in hospital, and identified the training of Midwives as being one of the anticipated benefits. When the Royal Charter was granted in 1756, it provided that ... "*all students in physic, surgeons, or apprentices to surgeons, and all others whether men or women as intended to practise midwifery, and shall be approved by the Master, shall and may have full liberty to attend the hospital and be instructed under the said Master and his two assistants*" This provision put formal midwifery training on the medical map.
Mosse had, in 1757, proposed an idea for fund-raising by which Grand Juries of counties supporting the work of the hospital could nominate a trainee midwife who would be trained in the hospital, and return and work in the county which had nominated. This had not succeeded, but in 1770, William Bury, a governor of the hospital submitted a scheme which was essentially the same. The Board approved it, and plans for a lecture theatre were drawn up. The Master, Dr. Collum, recommended Dr. David MacBride for the post of lecturer. Six counties were drawn by lot, and the Grand Juries of the selected counties were invited to nominate a trainee who would be employed as a nurse-tender, and instructed in midwifery by the Master and his assistants. When qualified, the nominee would return to practise midwifery in her county. Grand Juries were invited to make a

contribution to cover the maintenance of these women during their period of residence in the lying-in hospital. Counties Kildare, Dublin, Roscommon, Antrim, Sligo, and Wexford were drawn by lot in 1771.
Instruction was provided by practical means and although records of the early years were poor there were students in residence. The employment of female students as Nurse Tenders was discontinued in 1773, but they were allowed to "assist" in the care of patients. This term, "Nurse Tender", was included on Hospital Certificates up until 1983.
The introduction of a course of lectures was finally achieved by Clark (Master 1786 to 1793) who also arranged for the provision of Certificates. Subsequent Masters - Atthill and Smyly - improved conditions for nurses.
Hospital records indicate that there was growth in importance of the Rotunda Training School as an institution. Female Pupils refers to Female Pupil Midwives which are as follows:

Years	*Number of Female Pupils*
1787 - 1796	11
1797 - 1806	117
1807 - 1816	93
1817 - 1820	126
1821 - 1826	-
1827 - 1832	84
1833 - 1842	159
1843 -1852	139
1853 - 1861	146
1862 - 1897	383

Smyly appointed the first Lady Superintendent of the Hospital and a trained nurse, Miss Sarah Hampson, in 1891. The Lady Superintendent had responsibility for the Housekeeper and Nursing Staff.
Education of students was developed further with the introduction of the District or Extern Service by Purefoy during his Mastership. Further improvement in the conditions for students and nurses was made by Tweedy during his Mastership.
The Rotunda Hospital continued to provide midwifery training and issue Certificates to successful students. State control of midwifery training and practice commenced with the passage the Midwives Act of 1918 which set up the Central Midwives Board for Ireland. This Board was established on 13th September 1918, with the first meeting on 1st October 1918. Midwifery training for medical and surgical nurses was of four months duration and of six months duration for all others. A Roll of Midwives was set up and enrolment was by virtue of holding a Certificate issued by a maternity hospital. A period of grace was allowed during which holders of Certificates issued by maternity hospitals could apply for

enrolment. This period of grace was set to expire on 6th February 1920. This Roll of Midwives commenced on 17th February 1919 and the first entry on the Roll is that of a Rotunda trained Midwife who trained in 1905. Furthermore, the last entry on the Roll is also that of a Rotunda trained Midwife who trained in 1889.
The Midwives Act of 1918 required hospitals to be approved as training hospitals for Midwives; approval was granted to the Rotunda on 17th December 1918. Up to this point examinations had been conducted by the individual hospitals. The Central Midwives Board proceeded to draw up an Examination Scheme which was submitted to the Privy Council and General Medical Council for approval. This was granted and the first State Examination was held on 8th July 1920. 73 candidates entered - 62 passed.
On 6th May 1920 the Central Midwives Board approved rules which set out the period of training as follows:

> 3 years General Training entitled a candidate to a reduction of 2 months of the six months training. If the General Hospital had separate Children's Wards or Gynaecological Wards and if the candidate had spent not less than 3 months or her General Training in such wards, she would be exempt from 3 of the 6 months' training.

The Government of Ireland Act was passed in 1920. On 1st December 1921 the Government of Ireland (Adaptation of Enactments) No. 2 Order 1922 set up a Midwives Board for Northern Ireland. The Central Midwives Board, Saorstat Eireann, which had its first meeting on 14th March 1924 now regulated midwifery training in the "Free State".
A further increase in the length of midwifery training was proposed by the Central Midwives Board for England on 25th June 1924. Six months training was required for General Trained Nurses and twelve months for others. This alteration came into effect on 1st January 1926 in England. The Central Midwives Board, Saorstat Eireann, approved this and introduced it in Ireland in May 1926.
The Midwives Act 1931 authorised the issue of badges to Registered Midwives.
The Midwives Act 1938 increased midwifery training to twelve months for General Trained Nurses and two years for others. Changes in the Examination System were also introduced - Part One Examination was taken after six months for General Trained Nurses and after eighteen months for others. The first Part One Examination was held in March 1959 and later that year the Clinical Examination was introduced.
The Central Midwives Board elected its Chairman annually from amongst its members. In 1946 Ninian Falkiner (Master 1940 - 1947) was elected Chairman and during his term as Chairman he directed the Revision of the Rules of Practice (1946) and incorporated into the Rules of Practice regulations controlling the use

of Drugs and Gas and Air (1946). He suggested that Midwives should be involved in the examination of pupil midwives. A Certificate of Competence in the Administration of Inhalation Analgesia was required by Midwives from 1947 onwards. Mrs. K. Clarke (widow of Tom Clarke 1916) was also a member of the Central Midwives Board at this time.

The Nurses' Bill introduced in 1947 aimed to dissolve the Central Midwives Board and allow for the setting up of An Bord Altranais. As Chairman of the Central Midwives Board, Ninian Falkiner was very strongly opposed to this and stated: "*The dissolution of the Central Midwives Board is not satisfactory and will reduce the Midwife to the role of Maternity Nurse*".

The Nurses' Bill became the Nurses Act and was signed by Dr. Noel Brown, Minister for Health in 1949. An Bord Altranais did have a Midwives Committee but it did not have the power or independence of The Central Midwives Board. In 1959 the last group of Direct Entry into midwifery of two years duration was commenced.

Distinguished members of the Rotunda staff who served on this Committee were Miss Egan, Matron of the Rotunda Hospital up until 1970, and her successor Miss Grey. In addition, the first Education Officer of An Bord Altranais was Miss R. Cunningham - a Rotunda Midwife.

In 1970 midwifery training was altered - training was of one continuous years duration with Part One and Part Two eliminated. Professor A. Browne (Master 1961 - 1967) was elected Chairman of the Midwives Committee and was instrumental in introducing the practice of Midwifery Tutors suggested by the Midwifery Examination. This had been suggested by Falkiner in 1946 and it was fitting that his goal was achieved under the Chairmanship of Professor Browne. Lectures were given to pupil Midwives (Student Midwives from 1970 onwards) by Obstetricians approved by the Central Midwives Board and from 1949 onwards An Bord Altranais. Ninian Falkiner appointed a Sister Tutor in 1940 whose duties were the instruction of pupil Nurse Midwives and the part-time care of six semi-private maternity patients. In 1969 a second Midwife Teacher was appointed. With the introduction of the Obstetrics Module for students in General Nursing in 1982 the number of staff increased to four. The Inspection of Training Schools was re-introduced and carried out in 1973.

With Ireland's entry into the European Community and the issue of Midwifery Directives, midwifery training was further altered. The Midwives Directives signed in January 1980 came into effect in January 1983 and with this commenced two years midwifery training. The first training of two years duration commenced in the Rotunda Hospital on 14th February 1983.

Midwives are currently legislated for under the Nurses Act, 1985 which repealed the remainder of the Midwives Act, 1944 and the Nurses Act, 1950, and EU Directives which specify educational requirements and the activities of the midwife (Council Directives 80/154/EEC[4], 80/155/EEC).[5]

Our present Matron, Miss Mary Kelly, was happy to have the first male Student Midwife in Ireland commence training in the Rotunda Hospital in 1985, and by a happy coincidence in which the wheel seemed to turn the full circle, he chose to attend the Rotunda which an earlier man midwife, Bartholomew Mosse, had founded as the first institution of its kind 240 years earlier. To date three men have undertaken Midwifery Training at the Hospital.

During this century 5,783 undertook midwifery training - see table below

Years	*Number of Female Pupils*
1904 - 1907	-
1908 - 1920	737
1921 - 1930	517
1931 - 1940	588
1941 - 1950	407
1951 - 1960	594
1961 - 1970	1020
1971 - 1980	1079
1981 - 1994	841

The nationality of Pupil Student Midwives is extremely varied. They come from America, Arabian Gulf, Australia, British Guyana, Burma, Canada, Holland, England, Federated Malay State, Gibraltar, Grenada, India, Ireland, Isle of Man, Jamaica, Jersey, Kenya, Lebanon. Namibia, New Zealand, Nigeria, Norway, Rhodesia, Scotland, Siam, Solomon Islands, South Africa and Wales.

CONTINUING EDUCATION

Continuing Education is the key to achieving excellence in professional standards and is approached in the Rotunda Hospital by means of internal and external courses.

(a) **In-House Education Programme 1997**

1. Milton Seminar. "*Teenage pregnancy. The effects of substance abuse on the baby*".
2. C.P.R.
3. Current Perspectives in Patient Services Management.
4. Dublin Maternity Hospitals Sisters Study Day.
5. Epidural Lectures for Delivery Suite Midwives.
6. Fire lectures.
7. Health and Safety Lectures.
8. Healthcare computing in the 1990's.

9. Infant nutrition.
10. Joint Maternity Hospitals Seminar. "*New developments in midwifery education*" and "*Risk management*"
11. Management Development Workshops for Sisters and Staff Midwives. "*Standards audit and quality in midwifery*", "*Budgeting knowledge and skills*", "*Staff appraisals*", "*Communication and interpersonal skills for Midwives*", *Teaching midwifery students in the clinical area*", "*Legal issues relating to care planning*", and "*Recap and strategy for the way forward*".
12. Management of rape and sexual assault.
13. Manual handling and lifting lectures.
14. Medical record keeping.
15. Ninian Falkiner Memorial Lecture. "*Teaching old docs new tricks: The implementation of evidence based care in obstetrics and gynaecology*".
16. Promotion, Management and Support of Breast Feeding Courses (UNICEF and WHO 18 hour course).
17. Research Appreciation Courses.
18. Sexual Assault Treatment Unit Seminar.
19. Symposium for Healthcare Professionals. "*Death and grieving in a maternity and neonatal paediatric setting (miscarriage, stillbirth, neonatal death)*".

(b) **External Courses/Conferences attended during 1997**

1. Irish Refugee Council. "*Asylum - an opportunity for Ireland*".
2. The Infection Control Nurses Association Conference. "*Balancing the old with the new*".
3. 3rd Annual Conference of the Irish Society for Quality in Healthcare. "*Changing for Quality*".
4. Irish Association of Sterile Services Managers Annual Conference. "*Coping with change*".
5. Joint Maternity Hospitals Seminars. "*New developments in midwifery education*" and "*Risk management*".
6. National Conference of An Bord Altranais. "*On-going developments in nurse education and training*".
7. An Bord Altranais National Conference. "*Towards the future: nursing trends*".
8. 15th Annual Conference of Home Birth Centre of Ireland.
9. 16th Annual Nursing and Research Conference 1997 (R.C.S.I.).
10. Advanced Neonatal Nurse Practitioner. Current educational developments - implications of role for practice.
11. Basic Cardiac Life Support (BCLS) Provider Courses.

12. Building a memory for the future.
13. Facilitating reflective practice in nursing.
14. Foetal monitoring in practice.
15. Health & Safety Training Seminar.
16. Hepatitis C Conference - A Current Perspective.
17. Infection Control Nurses Association Meeting.
18. Irish Network for Smoking Prevention.
19. Living with loss.
20. Management Development Programme.
21. Midwifery Seminar.
22. Prostitution - A European Perspective.
23. Quality and acute healthcare services - attainment of certification.
24. Supporting breast feeding in disadvantaged areas.
25. The 2nd Annual Conference and Scientific Symposium of Healthcare Informatics Society of Ireland.
26. The current management and implications of drug abuse on mothers and babies.
27. The world of work in rapidly changing society.

(c) **External Courses/Conferences attended during 1997**
In addition to the above 9 midwifery staff undertook external courses (1 Diploma Course, 7 Degree Courses and 1 Masters in Education).

Appointment
Ms. Gemma Gorman was appointed Sister Midwife, Neonatal Intensive Care Unit in April 1997.

Retirement
Ms. Kathleen Clarke who joined the staff of the Rotunda Hospital in July 1964 retired in November 1997 after giving a total of 33 years loyal service to the Rotunda Hospital. During these thirty three years she saw many changes in patient care, and training and education of Student Midwives. She met change as a great challenge, and we were on the wave of great change when she decided to leave us. She always worked hard to the good of patient care and the setting of standards, and she always showed a great interest in whatever plans and events the Rotunda took part in. We wish her well in her retirement.

Deaths
Miss Gabriel Gogarty who commenced employment as Staff Nurse on 30th June 1953 was appointed Sister in the Gynaecological Department in May 1962. She retired after 34 years service in 1987, during which time she was respected and

loved by all whom she came in contact with. We are sorry to note that she died in April 1997 following a short illness.

Ms. Audrey Kelly joined the staff in Theatre on 18th September 1973. Audrey was a very efficient Theatre Nurse and Midwife. She was loved by all the staff. Audrey's health was poor for about ten years, and despite that she continued to work and hold down her job on a full-time basis until her untimely death in March 1997.

CHAPLAINS

A special word of thanks to our Chaplains Reverend W. Stewart (Church of Ireland) and Reverend Father C. Sheridan (Roman Catholic) for all their help throughout the year, particularly their input into ongoing counselling of all grades of staff, taking part in Student Midwife education talks, the management of patient care and particularly their input into the whole area of bereavement.

In 1997, there were a total of 127 funeral services for 134 babies. The statistics are as follows:

Under 500 grms.	=		88
Over 500 grms. Stillbirths	=	29	
Neonatal	=	16	
Cot Death	=	1	46
	Total:		**134**

CONCLUSION

I wish to thank all the Midwives and supporting staff for their co-operation and team work during the year, especially at times when staff have been under great pressure with the increase in the birth rate and the changing trends in midwifery and neonatology.

Sincere thanks to our Hospital Secretary, Mr. Noel Nelson, whom I work so closely with, to my senior midwifery staff and to all our supporting staff for their help and encouragement.

I would like to thank Mary and Frances, my secretaries, for their loyalty, hard work and dedication during 1997.

My sincere thanks to the Master, Dr. Peter McKenna, for his willingness to listen, his co-operation, understanding and unstinting support.

3.8 PHYSIOTHERAPY DEPARTMENT
Mrs. Kay Marshall/ Ms. Ann Murphy

This year marks the end of a long and fruitful era in the physiotherapy department. I refer to the retirement from hospital life of Kaye Marshall. Kaye has worked in the Rotunda since 1961 and has been Head of Physiotherapy since the mid 1960s. During these years she has challenged and confronted many issues, she has not been afraid to be controversial and always, she has had the needs of our mums close to her heart.

In earlier years she campaigned for greater education and preparation for labour. In more recent years she has stressed the importance and need for greater care of the perineum during childbirth and the puerperium. She has highlighted through research the levels of both urinary and faecal incontinence post partum. Thus recognised she pushed out and reviewed the various parameters used in treatment of incontinence - Kaye has therefore left a great legacy to the physiotherapy department, one which we will endeavour to develop and nurture. We wish her well in her further research and studies and hope she has many years of good health.

OBSTETRIC PHYSIOTHERAPY

(a) **Preparation for parenthood.** The antenatal classes were very well attended throughout the year. A total of 1078 primiparous women attended classes, many accompanied by partners/friends/mothers.

The refresher classes for multiparous mums continue to be well attended, as are the dads classes.

Individual tuition was provided in special situations and for patients with hearing or language difficulties.

(b) **Pregnancy related disorders**

Back (S.I.) pain	- 128 patients
Public symphisis pain	- 18 patients
Carpel Tunnel Syndrome	- 9 patients

There continues to be an increase in the number of referrals with sacroiliac strain.

These patients are instructed in good postural habits, gentle back exercises and in most cases are fitted with a support.

(c) **Postnatal physiotherapy**

We endeavour to see all postnatal patients once or twice prior to discharge. Particular emphasis is placed on pelvic floor re-education, back-care, and of

circulatory disorders. Patients are encouraged to attend for fallow-up if they have any symptoms of incontinence.

PHYSIOTHERAPY IN GYNAECOLOGY

(a) Inpatients-

All patients admitted for major surgery were seen pre and post-operatively. Where patients had developed wound infections or haematoma, these were treated with pulsed short wave.

(b) Outpatients-

The treatment of both urinary and faecal incontinence to be a major part of the departments workload.

The use of biofeedback in conjunction with other treatment modalities both encourages and motivates the patient with their exercise programme as they can see for themselves the steady gradual increase in muscle strength.

PAEDIATRIC PHYSIOTHERAPY

Neurodevelopmental	-39 babies
Torticollis	-50 babies
Chest physiotherapy	-15 babies
Minor feet deformities	-15 babies
Erbs palsy	-10 babies

Most of these babies had numerous treatments with Mum and Dad being instructed as to how to continue treatment while at home.

In conclusion I would like to thank all the hospital staff who have welcomed me back to the Rotunda especially my colleagues in physiotherapy whose support has been invaluable.

3.9 DEPARTMENT OF RADIOLOGY
Professor James G. McNulty

ADULTS

Abdomen in Pregnancy	:	0
Chests	:	223
Pelvimetries	:	26
Hysterosalpingograms	:	216
I.V. Urography	:	34
Venograms	:	54
Others	:	155

BABIES

Chests	:	1,442
Hips	:	852
Barium Studies	:	34
Acute Abdomen	:	297
Skeletal Survey	:	15
Others	:	265
Babies Total	:	2,903
Adults Total	:	708
T O T A L	**:**	**3,611**

3.10 ULTRASOUND DEPARTMENT
Dr. R. Gleeson

The demand for scans continues to increase, the number of booked scans is higher than in 1995. The amniocentesis service in particular continued to develop.
Scanning machines are in use in the clinics and the labour ward and the number of informal and out -of -hours scans is increasing as more staff become familiar with scanning techniques.
Twenty seven structural abnormalities were detected during the year:

Skeletal dysplasis	1	Anencephalus	3
Renal dysplasia	5	Hydrocephalus	6
Diaphraghmatic hernia	1	Cystic Hygroma	2
Gastroscesis	1	Bowel atresia	1
Body stalk abnormality	1	Hydronephrosis	1
Thoracic cyst	1	Multiple abnormalities	2
Encephalocoele	2		

STATISTICS FOR 1997

GENERAL ULTRASOUND		FETAL ASSESSMENT UNIT	
TOTAL SCANS	24027	TOTAL SCANS	2039
Early pregnancy complications & booking scans	13914	BPS	748
Serial growth & biophysical scoring	4797	Post Dates	443
General obstetrical	3313	Multiple Pregnancy	163
		Amniocentesis	125
GYNAECOLOGY		PET	153
		IUGR / SFD's	94
Fibroids	223	Large for Dates	40
Ovarian cysts	278	APH/pain	81
Follicle tracking	1483	Prelabour SROM	102
Abdominal viscera (incl. renal)	172	Anomaly	44
Misc.	47	Misc.	47

3.11 PARENTCRAFT AND FAMILY PLANNING DEPARTMENT

Ms. Carmel Kearns

FATHER'S ROLE

At long last our society has broken away from its traditional view that fathers have only an indirect involvement with childbirth and parenthood. Fathers are now recognised as equal to mothers in the role of parenting. We have always encouraged this viewpoint in our classes and therefore fathers are more actively involved during pregnancy, delivery, and baby care. Pregnancy can be a time of great emotional change for most men - with both positive and negative feelings . We provide discussion about "fathers role' and accurate information on all aspects of pregnancy, on the emotional side of parenthood and post natal depression with discussion about life after delivery.

Not many future parents have a realisation of what to expect of themselves in terms of baby's sleep needs, physical changes and new responsibilities. Our classes are very much based on the realities of parenthood. This provides the foundation for other healthcare professionals to build on.

1997 Attendances at Formal Classes = 280

Deaf / Hard of Hearing Couples

Deaf / Hard of Hearing Classes continues as requested and when necessary with the aid of sign language interpreter.

ISPCC / Hospital Project

ISPCC / Hospital "Positive Parenting" Courses continued antenatally and postnatally

1997 Attendances = 60

Dental Students

Dental Students from Trinity College continue to be facilitated by us to give a presentation on dental hygiene as part of their Diploma Course.

Individual Education Sessions

Individual Parentcraft Sessions are provided for those with special needs or language problems - there was a high increase in this in 1997 due to more varied clinical groups attending the hospital.

Attendances for 1997 = 200

"Sit In"

"Sit In" Sessions for obstetric, physiotherapy and mediacal students as well as for refresher nurses, visiting midwives and public health nurses are an ongoing part of our education.

Womens Health Lecture
Womens Health Lecture by Ms Margaret Merrigan-Feenan to female inmates of St. Patrick's Institution.

Transition Year Student for Secondary Schools = 50

Travellers Group - Community based education relevant to Travellers was organised by the Eastern Health Board and sessions were given by Ms. Margaret Merrigan-Feenan.

Civil Defence - 2 Lectures given to Trainees by Carmel Kearns during 1997.

Out Reach - Youth groups from Coolock attended for 1/2 day in March hosted by Carmel Kearns.

BREAST FEEDING

Breastfeeding is by far the best way to feed a baby. Most women know this but breastfeeding is not always easy for women who live in societies where it is hidden, and don't get a chance to learn how to do it. Some women find that breastfeeding is easy and satisfying right from the start but many find it difficult to do without help. In its effort to promote breastfeeding and support the Rotunda Hospital offers these women:

1. *Antenatal support*
   a) Breastfeeding class
   b) Breastfeeding information on an individual basis.

2. *Postnatal support*
   a) In Hospital
   - Breastfeeding groups at ward level
   - Individual assistance and support with common breastfeeding problems in the early days
     e.g. - sore /cracked nipples
     - babies who refuse the breast
     - low birthweight babies

   b) Following Discharge
   - Drop-in service in hospital for crisis calls
   - Phone service for questions or queries or simply reassurance

The Breastfeeding Committee met three times during the year witha member of the voluntary groups attending two of the meetings.

18 Hour UNICEF Breasfeeding Course

Two courses for staff midwives were held in the School of Midwifery in 1997. These were held from 5-7p.m. over a three week period. Certificates were presented on completion of the course.

World Breastfeeding Week 1-7th August

This was again celebrated with an information stand in the reception area. Representatives from hospital staff, voluntary groups, community mothers groups, PHNs were available to give people information about breastfeeding services on offer in the hospital and in the community.

September Study Day

Again the Irish Lactation Consultants Association held a very successful study day in the Rotunda Hospital Pillar Room.

Topic:	Breastfeeding in Disadvantaged Areas
Speakers:	Moya Bolger, Family Development Nurse, Coolock
	Teresa Keegan FDN, Finglas
	Cathy Donnelly, Community Mother, Tallaght.

STAFF: Staff Midwife A. Wilson
Staff Midwife M. Lavery

Number of new patients seen in year	-	560
Number of outpatients seen in year	-	74
Number of external phone calls received	-	175

FAMILY PLANNING

The Rotunda Family Planning Clinic operates on Thursday mornings and is a walk in service. It is open to women who have attended this hospital or who are referred by their G.P., Social Worker or Special Clinics around the city.

Contraception, sexual and reproductive health, more than any other branch of medicine is an area where a partnership between the patient and professionals is vital. The provision of full, accurate and objective information contributes to that partnership and through such information truly informed choices and decisions can be made.

Our services provides access to contraception, sterlilisation, pre-conceptual care and help with conception, as in the Natural Methods - Individual instruction is given on the Natural Methods of Family Planning by Margaret Merrigan-Feenan both to patients and doctors who are completing their Family Planning Course. The 4th Year Medical Students also benefited from a lecture delivered by her. Planned Parenthood provides benefits for the health of individuals, families and communities.

3.12 SEXUAL ASSAULT TREATMENT UNIT
Dr. M. Holohan

In 1997, 253 clients were seen at the Sexual Assault Treatment Unit; 234 females and 19 males. Three clients attended on two separate occasions with two different incidents. Evaluation of long-term sexual abuse was required for 16 cases, the remainder being seen after an acute incident. Of these 240 attendances, 200 were seen within 72 hours, with essentially no delay on the part of the Unit in responding to the case. The Gardai were involved in 88 per cent of these recent cases. Three assaults had occurred in another country and each of these had been reported to the relevant police force.

The ages of female clients seen after a recent incident is shown in Figure (1). the majority of these 223 clients were less than 30 years old with 33 attending secondary school at the time of the assault.
Only 15 per cent of the acute assaults in females were between 09.00 and 21.00 hours and 40 per cent of these assaults occurred in May to August inclusive. Two clients were hospitalised as a result of the assault. In this group 223 clients, 14 were married or co-habiting; 73 (33 per cent) were unemployed; 33 were in second-level and 20 were in third-level education. There were 13 attendees who worked in the sex industry. An active psychiatric disorder was present in 6 cases and 8 attendees were in special schools or workshops.

In a recent incident in males and females the alleged assault occurred in either the victim's (50) or assailant's (50) home in 100 of these 240 attendances and the assailant was a stranger in 64 cases or an acquaintance of less than 8 hours in 59 cases. There were two assailants in nine cases, three assailants in six cases and four assailants on one occasion.

Post-coital contraception was given to 99 (52 per cent) of 190 females seen within 72 hours of the assault. It was not given to 62 women seen early, because they were already using effective contraception, were post-hysterectomy, post-menopausal, had received treatment prior to attending the Unit or the nature of the assault did not require treatment. Three clients were already pregnant at the time of presentation. Treatment was refused by 26 clients.

More than two units of alcohol had been consumed by the victim in 124 of the acute cases and drug abuse occurred in a further 15 cases, with drugs and alcohol abuse in seven cases. The particular scenario associated with Rohypnol was noted in four cases.

All clients were offered screening for sexually transmitted diseases. Twenty-two refused an appointment. One hundred and thirteen did not attend for the arranged appointment. In the remaining 121 clients, anaerobes were detected in six cases, candida in nine, haemolytic strep in three and klebsiella in one. More seriously, chlamydia was detected in two cases, Hepatitis-C was determined in two cases (both drug abusers) and two clients were treated with clinical signs of pelvic inflammatory disease, although the infection screen was subsequently negative.

The role of the Unit in education continued, with lectures given by the staff members on courses for nursing and medical students, rape crisis workers, Gardai and at medical meetings. A training course in Forensic Medical Examination was held in January 1997. Liaison between the different disciplines involved in the care of the victims of sexual crime continued.

FEMALE CLIENTS TO S.A.T.U. (1997)

Age - Yrs	>16	16 - 19	20 - 29	30 - 39	40 - 49	50 - 59	>59
No	21	64	87	29	16	6	0
%	9.4	28.8	39	13	7.1	2.7	0

3.13 MEDICAL SOCIAL WORK DEPARTMENT REPORT
Eilish McDonnell-Head of Department

CELTIC TIGER VS. SOCIAL REALITY 1997

1997 can best be described as the year of change. The Celtic Tiger strolled confidently through the land - we are now a prosperous economic entity and unemployment finally seems to be coming under control. The much dreaded national debt is significantly reduced, and progress that was never thought possible has been made on the national question. Ireland has come of age as a modern society, fully prepared to accept the challenges of the next millennium.

The new-found prosperity has not impacted noticeably on the social problems that seriously affect the significant number of Irish people who find themselves living below the poverty line. Essential resources such as suitable housing, adequate childcare, sufficient weekly income are not equitably distributed. Commitment and resources must also be directed at pro-active prevention and community support to offer real choices to young people in disadvantaged areas.

Undoubtedly the forces of law and order are winning the battle with the drug barons and several successful prosecutions have been made. As the battle with the drug barons starts to affect their pockets, the cost of heroin on the streets has dropped and there is now greater access to heroin which probably accounts for an increase in the prevalence of young heroin smokers. Young heroin users feel less stigmatised because they are not injecting - However the affect of heroin on their lives will be no different. Community and treatment services are expanding and offering an excellent service to those who can avail of a programme. Priority must still be given to providing a secure drug-free environment for parents and their families. Local communities are making valiant efforts to divert young people.

The number of drug users in the MSW Department continues to increase. Sometimes an unplanned pregnancy is the catalyst which enables them to engage with a drug-treatment centre and in many cases get control over their drug use problem. It would be very helpful if more attention could be paid to this positive outcome for unplanned pregnancies for some people. Some former drug users are excellent and committed parents and the notion of all addicts as bad mothers must be challenged.

Social & Demographic Trends 1997

In 1997, births outside marriage numbered 13,892 which represents 27 per cent of all births for the year. This a small increase on 1996. It is not known how many of

these births result in the formation of new One-Parent Family - marriage may follow the birth, the couple may be cohabiting, it may be a second child to an existing lone parent. There were 2.984 births to women under the age of 20 in 1997. This is an increase of 47 births over the 1996 figure. The biggest proportion of unmarried parents receiving social welfare payments was in the age 20 - 24 category. The number of those under 20 years and unmarried receiving One-Parent-Payment was 6.3 per cent in 1996. One-Parent-Family Parent now covers unmarried, separated and prisoners spouses. 57,280 families received this benefit in 1997 of whom 2,758 were under the age of 20. In reality less than 5 per cent of the overall Social Welfare expenditure goes to one-parent families - a far cry indeed from the notion that such families are a huge drain on the national coffers.

MSW Dept.

1997 was also a year of change in the Social Work Department. There was changes in the social work personnel and clerical staff. The Department functioned for six months with Sheila McCrory and Gerardine Parkinson sharing the head of department responsibilities until a new head was appointed in September 1997. The changes within the department were also reflected in the changes in the case load seen by the social work department.

NON-MARITAL PREGNANCIES 1997

In 1997, we recorded 2,635 non-marital deliveries in the Rotunda Hospital. This represents a small increase of 340 over the previous year's figures. The busiest months for non-marital deliveries were August and September with approximately 250 in each of these months

NON-MARITAL BIRTH OUTCOMES

Patients Delivered	Twins	Neo Natal Deaths	Considered Adoption/ Foster Care at Birth
2,635	14	8	19

It is clear from these figures that only a very small proportion of our mothers did not go on to rear their children themselves. Fifteen women considered adoption and less than half of these continued through to placement. Eight of these continued to care for their babies with support from the Health Board Social Workers. Four went into foster care. These figures show a small reduction from the previous year.

There were eight neo-natal deaths, two cot deaths and four stillborn babies.

Refugees and Asylum Seekers

Throughout 1997 there was a constant increase in the number of non-nationals and asylum seekers attending the Hospital and being seen in the Medical Social Work Department. Some came late in pregnancy having been only in the country a few weeks and some only a few days before attending the Rotunda. Many came with poor or non-existent English and if was difficult to make adequate assessment of need and community support. Towards the end of the year various ad hoc groups were set up by asylum seekers e.g. The Black Women's Network. Another welcome improvement was the setting up of The Eastern Health Board Community Welfare Service - a specific welfare service for refugees and asylum seekers - at St. James Hospital in order to streamline payments of supplementary welfare entitlements. In conjunction with this service the Eastern Health Board appointed two G.P's who are available daily to see refugees. The Public Health Nursing Service also appointed two PHN's to provide a dedicated service on a daily basis for refugees.

Housing continues to be a major problem for both refugees and the indigenous population alike. Throughout 1997 housing (both the unavailability of local authority houses and the rising cost in the private rented sector) continued to cause problems for our clients.

Conferences/Seminars/Launches Attended

28 January 1997 - Dept of Health launch of booklet "When someone close dies" written by Beaumont MSW Dept.

"Violence against women - responding to woman and children at risk of male domestic violence"
Imelde C. Keogh Head Social Workers and Centre Care to convene this conference which was held in the Pillar Room of the Rotunda Hospital on the 6/7 February 1997. The conference was opened by the Minister for State at the Department of the Tanaiste Eithne Fitzgerald and many people contributed including Justice Peter Smithwich, Don Hennessy, Harry Ferguson, TCD Health Board Personnel, Dr. Mary Holohan, Celine Deane, Women's Aid staff including Monica O'Connor, Sgt Mary Delamare and Rita Fagan from Inchicore. Policy makers and Practitioners availed of this opportunity to advance our understanding of domestic violence and to explore the policy and practice of those who seek to respond to women and children at risk.

7/8 February 1997 - Dublin Corporation "Drugs in Dublin - Working together we can make a difference" - Shelia McCrory attended.

Minister For Health MIchael Noonan T.D. launched. *"A Plan for Woman's Health 1997-1999"* on the 9th of April in the Royal College of Physicians, Kildare Street, Dublin 2. Attended by Shelia McCrory.

The symposium entitled *"Death and Grieving in a Maternity and Neo-Natal Paediatrics setting (miscarriages, Stillbirth, neo-natal deaths)"* was hosted in the Pillar Room on the 8th of May 1007 by the Department of Post Graduate Education. Ms Gerardine Parkinson and Ms Sheila McCrory presented on the topic "Letting go and Moving on."

"Asylum - An opportunity for Ireland". The Irish Refugee Council hosted a one day seminar in the Pillar Room of the Rotunda Hospital on the 13th of June 1997. The opening address was by President Mary Robinson and contributors included David Norris, Ms Pauline Lukaso, Mahin Sesidvash, Derek Steward and Nadette Foley of the IRC. Topics covered included Amnesty International, advice on Individual rights in Europe (AIRE) and refugees in Ireland.
Carmona Early Services, Hospital/Order of St John of God in Glenageary launched their home and centre based programme for children from birth to 5 years of age who have or at risk of developmental delay. Gerardine Parkinson attended.

"Celebrating 25 years of Cherish". The 25th anniversary Cherish conference took place at the Pillar Room in the Rotunda Hospital on the 12th of June 1997. It was followed by a celebration lunch.

Treoir half yearly meeting attended by Gerardine Parkinson on the 13th of June 1997 at Dr. Steevens Hospital Eastern Health Board Office. Topics for the meeting included Registration of Birth Act 1996,, Children's Bill 1997, Principals in relation to Family Relations and Identity.

Treoir Special Members Meeting 17th September 1997 in 36 Upper Rathmines Road, Dublin 6. *"Key Issues for Unmarried Parents"* Information gathered at this meeting was used to inform Treoir's submissions to the Government Departments *in coming months. Interestingly, al the issues raised were currently being addressed* at one level or another by Treoir. The session was useful in that priorities were established in the area of research, housing, child care, legal issues, economic issues and social and personal support.

14 October / 18 November - Two day training workshop with Hilda Loughran (UCD) - Training group consisting of MSW from all three Dublin Maternity Hospitals.

"*A Portrait of Family Grief*",ISLANDS and Bereavement Trust (UK) hosted a one day conference in November 1997 and it was followed by training day facilitated by Jenny Thomas and Julia Samual of the Child Bereavement Trust, UK. The conference was held in the Ardilaun House Hotel, Galway and Tainiste Mary Harney was present.

21 November - "*HIV Strategies for Communication*" - to mark World AIDS Day 1997.

22 November - "*Young People and Drugs - Critical issues for policy*" - Trinity College Addiction Studies Course and Children's Research Centre - Attended by Shelia McCrory.

Treoir A.G.M. 1 December 1997 in the Board Room of Dr. Steeven's Hospital. Apresentation was made on new birth registration legislation and in particular the difficulties being experienced by parents and workers in the area.

Teaching/Lectures
~DGOS Lectures - Shelia McCrory & Gerardine Parkinson
~Lectures to physiotherapy, midwifery and medical students
~MSW input to weekly ante-natal classes

Acknowledgements

As stated earlier 1997 was a period of great change not just socially but within the context of the social work department. I would like to take this opportunity to thank colleagues in MSW Department and throughout the hospital for the co-operation and support I have received since my appointment in September 1997. The assistance given to us by the Infant Clothing and Samaritan Fund Committee is greatly appreciated by the families.

3.14 ROTUNDA MENTAL HEALTH SERVICE
Dr. John Sheehan

The Mental Health Service provided by Dr. John Sheehan at the Rotunda Hospital enjoyed a busy year in 1997. There were 120 new patient appointments and almost 500 review appointments during the year. Referrals continued from both antenatal and postnatal clinics, as well as the specialist services including, the Menopause clinic and Gynaecology clinics. Over 150 in-patient consultants were also conducted, mainly on the Lower Corridor, with postnatal patients.

Lectures on Perinatal Psychiatry were provided to the Midwifery Students, as well as the Medical Students, from the Royal College of Surgeons of Ireland. Lectures were also given to the Diploma in Gynaecology and Obstetric Students, based in the Rotunda and linked to Trinity College Dublin.

Negotiations progressed with regard to the establishment of a Research Fellow post at the Rotunda Hospital, in perinatal psychiatry. It is proposed to have a joint post with St. Vincents's Hospital, Fairview. Funding will be provided from several sources including, the Friends of the Rotunda.

In 1997, increased emphasis was placed on the prevention of mental health problems. Closer links with Community Mental Health Services, insured that those women with pre-existing severe mental health problems, had proper care and support during their time in the Rotunda.

An information leaflet on postnatal depression was produced and will be brought into operation in 1998. It is proposed to give the information leaflet to those women at risk of a postnatal depression.

Dr. Sheehan continued to work closely with Medical Social Work Department.

Finally, a symposium on death and grieving in a maternity and neonatal paediatric setting was held in May 1997, at the Rotunda, for health professionals. The symposium was multidisiplinary in nature and was very well attended. It also precipitated a review of the bereavement services provided to women at the Rotunda.

4. FRIENDS OF THE ROTUNDA

4.0 FRIENDS OF THE ROTUNDA
Dr Cliona Buckley, Chairman / Mary Butler, Secretary

The Friends of the Rotunda was founded in 1971 to assist the Hospital by financing research, supporting voluntary work and improving amenities for patients and staff.

Research projects funded by the Friends in 1997 were:

*Hypertension during pregnancy - Dr. Paul Bosio
*The causes of miscarriage - Dr. John Gillan
*Stress Incontinence following childbirth - Kaye Marshall
*Diagnosis of Group B Streptococcal - Dr. Mary Cafferkey

Approximately £34,000 was spent on Research during 1997.

The Samaritan and Infant Clothing Fund Committee continued to support the work of the Social Work Department.

The Hospital Shop run by F.O.R. Trading Ltd, in the Reception area provides a service to all in the Hospital for the benefit of Friends.

Fund-raising events in 1997 included:

Autumn Art Exhibition
Bridge Evenings
Flag Days
Golf Classic
Gate Theatre Evening
Dalkey Bring & Buy
Christmas Card Sale
Tennis Tournament
Mini Marathon
Bank of Ireland Concert
Rotunda Football Challenge
Gala Flower Demonstration
Russborough House Open Day

Many of these events were held in the elegant Pillar Room, which was also leased for outside functions when not in use as a teaching centre. The Pillar Room is administered jointly by the Hospital and the Friends. Bookings are made through Anna Marie Ryan in the Friends office.
The Friends Council is greatful to all who organised and supported Friends fundraising during 1997.

5. PUBLICATIONS AND PRESENTATIONS

5. PUBLICATIONS AND PRESENTATIONS

ABSTRACTS

Cullen A, Kiberd B, Matthews T, Mayne P, O'Regan M et al. **Antimony in blood and urine of infants.** International Conference on Sudden Infant Death Syndrome (Proceedings), Dublin Castle, March 1997.

Cullen A, Kiberd B, Matthews T, Meehan M, Mc Donnell M, O'Regan M, Devaney D et al. **Cot Mattresses and SIDS. Is there a link?** International Conference of SIDS (Proceedings), Dublin Castle, March 1997.

Cullen A, Kiberd B, Matthews T, Meehan M, Mc Donald M, Devaney D et al. **A case control study of levels of antimony in SIDS.** International Conference of SIDS (Proceedings), Dublin Castle, March 1997.

Kilgallen C, Condell D, Cahalane S, Gillan J E. **Old Pulmonary Petechiae are not significantly increased in SIDS.** International Conference on SIDS, Dublin Castle, March 1997.

N. Bermingham. **Confined Placental Trisomy and Uniparental Disomy for Chromosome 16 in a Growth Retarded Infant.** Royal Academy of Medicine, Pathology Section, Registrars Prize Meeting, Cork, February 1998.

Macauley D, Toner M, Walker J, Gillan J. **Lifting the shroud from intrauterine life - dental defect in foetal and neonatal teeth; preliminary observations.** Annual Meeting of British Society of Oral Pathology, Bristol, September 1997.

Ahern N. McCaffrey M., Mallon E., Barrett T., Doyle M., Fawzy M., Harrison R. **Can bacterial vaginosis influence assisted reproduction.**
Abstract 33. Royal College of Surgeons in Ireland Study Day April1997.

Barrett T, McQuaid S, Barton D, Stallings R, Harrison R.
Is genetic screening needed before treatment with intracytoplasmic sperm injection? Irish Journal of Medical Science 1997.

Barrett T., McQuaid S., Barton D., Stallings R., Harrison R.F. **The Role of Medical Genetics in Male Factor Infertility.** Abstract 9. Royal College of Surgeons in Ireland Study Day April 1997.

Barrett T., Butler A., Barton D., Harrison R.F. **Molecular Genetic Analysis-the Y Chromosome in Male Infertility.** Blair Bell Society Jubilee Competition. RCOG. London 12th December 1997. No. 28.

Connolly G., Milner M., Byrne P., Short M., Harrison R.F., McKenna P. **Compliance with HRT in a Menopause Clinic Population.** Modern Medicine. 1997 Vol;27 Supplement. Irish Menopause Society.

Drudy L., Mccaffrey M., Mallon E., O'Dwyer H., Harrison R. **Spermatozoal DNA Flow cytometry and recurrent miscarriage.** Abstract 54. Royal College of Surgeons in Ireland Study Day April 1997.

Gordon UD., Gordon AC., Harrison R.F. **A randomised prospective study of the effect of LH on follicular growth and development.** Human Reproduction. 1997 Vol. 12. Abstract Book 1. 0108 p52.

Gordon UD., Gordon AC., Harrison R.f. **Effect of differing dosages of LH on oocyte maturation and fertilisation.** Human Reproduction. Vol. 12. 1997. Abstract Book1. 0112 p53-4.

Gordon Ud., Gordon AC., Robson WR., Harrison R.F. **A randomised prospective study of the effect of differing doses of LH on ovarian steroidogenesis.** Human Reproduction. 1997 Vol. 12. Abstract 1. p 232-233.

McCaffrey M., Verso J., Sheehan J., Harrison R., **Genital imaging psychotherapy on women attending specialist infection clinic.** Abstract 68. Royal College of Surgeons in Ireland Study Day April 1997.

Stallings R., Barton L., Hegarty A., Dunlop A., Carey A., Khokar T., Barrett T., Harrison R.**Cytogenetic screening of ICSI candidates and genetic counselling.** The American Journal of Human Genetics, supplement to Vol. 61, A14, October 1997.

PUBLICATIONS

Fogarty J, Cafferkey M, Maloney A. **The Epidemiology of Invasive Meningococcal Disease in the Republic of Ireland in 1995.** Communicable Disease Report, 1997, R5-13.

Taylor M.R.H., Lennon B, Holland CV, Cafferkey M. **Community study of toxoplasma antibodies in urban and rural school chilren aged 4 to 18 years.** Archives of Diesease in Childhood, 1997, 77, 406-409.

Cafferkey M. **Invasive Meningococcal Disease.** Infectious Disease Bulletin, Vol 5 number 1 (supplement), 1997.

Cafferkey M, Lennon B, Johnson Z, Mayne P.D., Cubitt W. D., Mc Kenna P. **Seroprevalence of antibody to *Toxoplasma gondii* in Irish women of child-bearing age.** Modern Perspectives on Zoonoses Ed., Holland C., Royal Irish Academy, Dublin, 1997, 39-44.

Cafferkey M. **Cryptisoiruduyn - An Overview.** Infectious Disease Bulletin, Vol 5 number 4, 1997.

Walsh R, Conway H, Roche G, Naughten E, Mayne PD. **3-methylglutaconic aciduria in pregnancy.** Lancet 1997; 349:776

Khan M A, Puri P, Devaney D. **Mesothelioma of Tunica Vaginalis Testis in a child.** Journal of Urology, 1997; 158:198-199

Higgins J, Darling M. **Folate and Pregnancy,** Chapter 20 198 - 208. Year Book of Obstetrics & Gynaecology 1997 Ed. Shaughan OBrien, Vol. 5.

Higgins J, Walshe J, Darling M. **Liver Function Tests in pre-eclampsia,** Brit. Journal Obstetrics & Gynaecology October 1997 Vol. 104, 1215.

Higgins J, Walshe J, Darling M. **Can 24 hour Ambulatory Blood Pressure Measurement predict the development of Hypertension in Primagravid.** British Journal Obstetrics & Gynaecology 1997 Vol. 104 356 - 362.

Darling M. **Elective or selective caesarean delivery of the small baby.** Commentary Lancet. March 7. 1997.

Bosio P, Keenan E, Gleeson R, Dorman A, Clarke T, Darling M, O'Connor J. **The Prevalence of Chemical Substance and Alcohol Abuse in an Obstetric Population in Dublin.** (1997).Ir Med J 90; 4, 149-50

HELLP syndrome continues to be a management and diagnostic dilemma. Gleeson R, Walsh JJ. (1997). Ir Med J 90; 8, 289

Pugh H.E., Gammell S.J., Bamberger E.S., Gleeson K., Coulter-Smith S.D., Ferreux E., Moseley R.P., Gatter K.C., Crow J.C., Lewis C.E., Perrett C.W. **The Expression and Regulation of VEGF and PD-ECGF/TP in Ovarian Cancer.** J. Pathol. 181 (suppl.) 1997. (published abstract)

Coulter-Smith S.D., Navenga S., Morris R.W., Rolfe K., Gleeson K., Economides D.L., McLean A.B.**Transvaginal Sonographic and Colour Dopper assessment of Adnexal Pathology: Are Traditional Indices accurate predictors of malignancy?** Acta Obstet et Gynecol. Scand. (1997) Vol 76. No 167. P54. (published abstract)

Ginsburg J., Preievic G. M., Coulter-Smith S.D., Havenga S., MacLean A.B. **The effect of Tibolone on Uterine Artery Flow Parameters.** Acta Obstet et Gynecol. Scand. (1997) Vol 76. No 167. p25 (published abstract)

Baban D.F., Liu B., Rolfe K., Coulter-Smith S.D., MacLean A.B., Lewis C., Seymour L.W., Perrett C.W. **Differential expression of vascular endothelial growth factor (VEGF) isoforms in Ovarian Cancer.** Int. J. Gynecol Cancer (1997) 7 (suppl.2) p.68 (published abstract)

Phelan D. McLean P. **Irish Board of Intensive Care Medicine.** J. Ir. Coll. Phys. Surg. 1997; 26; 319

Power M, Carey M, O'Regan R and Noriarty DC. **Epidural Clonidine does not alternate hypoxic pulmonary vasoconstriction in anaesthetised swine.** European Journal of Anaesthesiology, 1997; 14; 61-63.

Dowd NP, Taylor A, Moriarty DC and Blunnie WP, **The effects of Omeprazole on Serum Bupivacaine levels following epidural administration.** Canadian Journal of Anaesthesia, 1997: 44: 1029-1030.

McCrory C, Blunnie WP and Moriarty DC. **Elective tracheal intubation in cervical spine injuries.** Irish Medical Journal., 1997; 90: 234-236.

Colbert S, Flanagan F and Moriarty DC. **Haemodynamic changes from the laryngeal mask.** European Journal of Anaesthesiology, 1997; 14: 514-517.

Whitford A, Hone R, Magner J, Eustace P. **Intraocular pressure changes following laryngeal mask airway insertion - a comparative study.** Anaesthesia 1997; 52: 794-796.

Barton D, McCarroll M. **Advanced Cardiac Life Support Algorithms,** J. Ir. College of Physicians & Surgeons. 1997; 26: 275-282.

J. Porter, R. Page, A.E. Wood and D. Phelan. **Ventricular perforation associated with the use of introducer-dilator systems.** Canadian Journal of Anaesthesia, 1997; 44: p. 317-320.

Reinhart K, Radermacher P, Sprung CH, Phelan D, Bakker J, Steltzer H. **Pulmonary Artery Catheterization - quo vadis? do we have to change the current practice with this monitoring device?** Intensive Care Medicine, 1997; 23: 605-609. (Editorial).

O'Gorman DA, O'Connell AW, Murphy KJ, Moriarty DC, Shiotani T, Regan CM. **Nefiracctam prevents propofol-induced anterograde and retrograde amnesia in the rodent without affecting quality of anaesthesia.** Anaesthesiology (in press).

Jayaram A, Bowen M, Carp H. **Ultrasound examination of the stomach contents of women in post partum period.** Anaes. & Analg., 1997; 84: 3, 522-6.

Regan CM, O'Gorman DA, O'Connell AW, Moriarty DC. **Propofol-induced antigrade and retrograde amnesia in the rodent without compromising anaesthetic quality.** Society for Neuroscience, 1997. October. New Orleans.

C. Fagan, K. Carson, J. Hurley. **Beating Heart Bypass - "Our Experience With new Technique".** Royal Academy of Medicine in Ireland. Registrars Prize. October. 1997.

O'Gorman D, O'Connell A, Regan CM and Moriarty DC. **The effects of Cognitive Enhancing Nsotropes (?) On Propofol Induced Anterograde Amnesia.** Post Graduate Assembly Meeting, New York. December 1997.

Connolly G., Holohan M. **Should women be advised against pregnancy after breast cancer treatment.** Hospital Doctor of Ireland. 1997:3:7:37-38.

Cottell E., Barry-Kinsella C., Drudy L., Gordon A., Kondaveeti-Gordon U., Harrison R.F. **Initial and swim-up motile sperm concentration in Earles medium as a predictor of IVF.** ARTA. Vol. 9. 129-134. 1997.

Cottell E., Lennon B., McMorrow J., Barry-Kinsella C., Harrison R.F. **Processing of semen in an antibiotic rich culture medium to minimise microbial presence during in vitro fertilisation.** Fertil Steril 67: 98-103 1997.

Fawzy M., Harrison R.F., Barrett T., Mallon E. **Within range stratification improves the prognostic capability of normal day 3 follicle stimulating hormone for in vitro fertilisation down regulated gonadotrophin therapy.** ACDS. Vol 13: 276-89 1997.

Gordon AC., Harrison R.F., McMahon A., Fawzy M. **Establishing an intracytoplasmic sperm injection (ICSI) programme for the treatment of male factor infertility in Ireland.** Irish Journal of Medical Science. 166, 65-69 1997.

Harrison R.F., Gordon A.C., Kondaveeti-Gordon U., Kinsella C.B., Cottell E., Drudy L., Kelly A. **The role of IVF in the management of unexplained infertility.** ARTA Vol 9. 89-101 1997.

Harrison R.F., Barrett T., Stallings R., **Cytogenetic analysis is essential before ICSI.** Human Reproduction 1997 12. 8. 1835.

Harrison R.F., Magill P., Blackie S., Kilminister S.G. **Endometrial safety of a new formulation of 17-B oestradiol and low-dose micronised medroxyprogesterone acetate.** British Journal of Clinical Research. 8: 15-22 1997.

Milner M., Sinnott M., Gasparo D., Kelly A., Barry-Kinsella C., Harrison R.F. **Climacteric Symptoms, Gonadotrophins, Sex Steroids, and Binding Proteins with Conjugated Equine Estrogen-Progestin and Tibolone over two years.** Menopause. The journal of the North American Menopause Society. 3, 4, 208-213. 1997.

PRESENTATIONS

Cafferkey M, Johnson Z, Mayne P, Mc Kenna P. **Seroprevalence of Toxoplasmosis in women of child-bearing age.** Annual Meeting of the Irish Paediatric Association, Limerick, May 1997.

Cafferkey M, Murphy K, O'Neill C. **New Developments in the Diagnosis of Bacterial Meningitis.** Meeting of the European Monitoring Group on Maningococci, Institut Pasteur, Paris, June 1997.

Fogarty J, Cafferkey M, Maloney A. **The Epidemiology of Invasive Meningococcal Disease in the Repubilc of Ireland in 1995.** Meeting of the European Monitoring Group on Meningococci, Institut Pasteur, Paris, June 1997.

Devaney D. **Sclerosing Cholangitis in infancy.** Royal Academy of Medicine in Ireland - Pathology Section, February 1997.

Devaney D. **Langerhans Cell histoeythesis (LCH) involving the liver.** International Paediatric Pathology Association

Coulter-Smith S.D.,**The Expression and Regulation of VEGF and PD-ECGF/TP in Ovarian Cancer.** Oral Presentation: British Pathological Society meeting January 1997. Abstract published J. Pathol 181(suppl.) 1997

Coulter-Smith S.D.,**Screening for Ovarian Pathology: Are traditional Doppler indices predictors of Malignancy?** Presentation: 12th Congress of the European Association of Gynaecologists and Obstetricians. 25-28th June 1997.

Coulter-Smith S.D.,**Transvaginal Sonographic and Colour Doppler assessment of**

Adnexal Pathology; Are Traditional Indices accurate predictors of malignancy? Presentation XV FIGO World Congress of Gynaecology and Obstetrics. August 3-8th Copenhagen, Denmark. Abstract published in conference abstract book.

Coulter-Smith S.D.,**The effect of Tibolone on Uterine Artery Flow Parameters.** Presentation: XV FIGO World Congress of Gynaecology and Obstetrics. August 3-8th Copenhagen, Denmark. Abstract published in conference abstract book.

Coulter-Smith S.D.,**Differential expression of vascular endothelial growth factor (VEGF) isoforms in Ovarian Cancer.** Oral Presentation: Sixth biennial meeting of the International Gynecologic Cancer Society. Fukuoka, Japan. October 20-24, 1997.

Coulter-Smith S.D.,**Screening for ovarian cancer. Issues for the future.** Guest Lecture at the annual study day of The Institute of Obstetricians and Gynaecologists, College of Physicians. September 1997.

INVITED LECTURES:

Devaney D. **Post Mortem - Why Bother ?** International Conference on Sudden Infant Death Syndrome, Dublin.

Devaney D. **ACHEING in Constipation.** Royal Academy of Medicine in Ireland

Cafferkey M. **Meningococcal Infection in Dublin.** Academy of Medical Laboratyr Sciences Annual Conference; RDS Dublin, 23rd April 1997.

Cafferkey M. **The Epidemiology of Invasive Meningococcal Disease in the Republic of Ireland in 1995.** Meeting of the European Monitoring Group on Meningococci; Institut Pasteur, Paris, June 1997

Moriarty DC. **Intrathecal opiates. Clinical update in Anaesthesiology.** Mt. Sinai School of Medicine, Acapulco, Mexico. January, 1997.
Moriarty DC. **Training and Examination.** Northern Ireland Anaesthetic Society. March 1997.

Moriarty DC. **Simulators and Education.** Queen's University, Belfast. April 25th, 1997. Mater Hospital/UCD April, 26th, 1997.

Phelan D. **Withdrawal of futile medical interventions.** Intensive Care Medicine Diploma Course, Dublin. April 1997.

E. Carton. **IBICM Diploma, Refresher Course,** St. James Hospital. April 1997. Nutritional supports.

Biunnie WP. **The Role of the Anaesthetist as Per-operative Physician.**3rd Kelantan Congress, Malaysia. June 1997.

Dr. B. Marsh. "The PA Catheter never saved a Life". Intensive Care Society of Ireland 10 th Annual Scientific Meeting. June 1997. Pro-Con Debate.

Nutrition in the Critically Ill. 10th Anniversary Intensive Care Society of Ireland Congress. Dublin. June 1997.

Phelan D. **Perioperative tissue/splancnic hypoperfusion.** Third Anaesthesia & Critical Care Symposium, Killarney. September 1997.

Bowen M. **Combined spinal epidural,** 3rd Anaesthetic and Critical Care Symposium. Killarney. September 1997.

Carton E. **Bacterial Translocation.** RCSI/Yale/Mayo Clinic. 3rd Symposium Anaesthesia & intensive Care. Killarney. September 1997.

Robert F. Harrison **Male Infertility: Recent Advances. Assisted Reproductive Techniques and their Audit.**Membership Theoretical Course, National Hospital, Dublin. 16 - 20 June 1997

Robert F. Harrison **Genetic Abnormalities Following ICSI.** Advances in Assisted Reproduction Technologies in the Year 2000. Rome. 16 -18 September 1997.

Robert F. Harrison. **Modern developments in the treatment techniques in infertility.** Joint Hospitals Sisters Study Day. Rotunda Hospital. 29 October 1997.

Robert F. Harrison. **Stress and Infertility. The Management of Unexplained Infertility. Is there any role of treatment in male factor fertility?.** Fifth Congress of Basic Diagnosis and Treatment on Infertility and Reproductive Endocrinology. Ankara. Turkey 31 October - 2 November 1997.

Robert F. Harrison. **Irish Menopause Society. Fifth Annual Symposium.** Dublin 4 October 1997.

Robert F. Harrison. **Molecular Genetic Analysis the Y Chromosome in Male Infertility.** Blair Bell Society Jubilee Competition. RCOG. London 12 December 1997.

Dr. Paul Byrne. **The investigation and management of diabetes in pregnancy.** DRCOG Course. Coombe Womens Hospital. (December 1997).

Dr. Paul Byrne. **The medical management of urinary in continence.** Irish Continence Interest Group Annual Study Day. Coombe Womens Hospital. (June 1997).

Dr. Paul Byrne. **Health and Fitness in the Middle Years.** Beaumount Hospital Public Lecture Series. (March 1997).

Dr. Paul Byrne. **The role of surgery in the management of the infertile couple.** Theatre Nurses Course, Beaumount Hospital. (September 1997).

Dr. Paul Byrne. **Who needs colposcopy?.** Theatre nurses Course, Beaumount Hospital. (October 1997).

Dr. Paul Byrne. **Annual Academic Report for RCSI.** Four Provinces Meeting. Institute of Obstetrics and Gynaecology. (November 1997).

Dr. Louise Drudy. **Germ Cells and Fertilisation.**Dublin Institute of Technology. (January 1997).

Dr. Louise Drudy. **Quality Assurance in the Laboratory.** Maastricht, the Netherlands Quality Assurance in Health Care Institutions (July 1997).

Dr. Tom Bennett. **The Role of Medical Genetics in Male Factor Infertility.** Royal College of Surgeons, Dublin. Annual Research Day (April 1997).

Dr. Tom Bennett. **The investigation and treatment of infertility.** National Infertility Support and Information Group Meeting. Cork (April 1997).

Dr. Tom Bennett. **Screening and Cervical Cancer.** Public Health Study Day Beaumount Hospital. Dublin. (September 1997).

Dr. Tom Bennett. **Contraception and the Perimenopause.** Irish Menopause Society Workshop Meeting. Dublin . (October 1997).

Dr. Tom Bennett. **Microdeletions of the Y Chromosome in an Irish Population of Infertile Males.** Specialist Registrar Conference Royal College of Obstetricians and Gynaecologists. London. (October 1997).

Dr. Tom Bennett. **Molecular Genetic analysis of the Y Chromosome in Male Infertility.** Blair Bell Jubilee Meeting Royal College of Obstetrician and Gynaecologists. London (December 1997).

Dr. Saji Jacob. **Comparative study of sperm deoxyribo nucleic acid (DNA) content and damage between fertile and infertile men using flow cytometry and gel electrophoresis.** Fifty third Annual Meeting of the American Society for Reproductive Medicine Cincinnati, Ohio. (October 1997).

Dr. Geraldine Connolly. **A single centre prospective study of the HELLP / partial HELLP syndrome in Ireland. Presentation and outcome.** Irish Neprhology Association. Dublin (July 1997).

Dr. Geraldine Connolly. **Helicobacter Pylori in Pregnancy-preliminary findings.** British Perinatal Society Meeting. Ballinasloe. (October 1997).

Dr. Geraldine Connolly. **Teenage Pregnancy in the Rotunda Hospital - A Review.** Irish Junior Obstetrics and Gynaecology Annual Scientific Meeting. Dublin. (November 1997)

6. SUMMARY FINANCIAL POSITION 31 DECEMBER, 1997

Income: -	£, 000	£, 000
Department of Health Allocation 1997	15,588	
Patient Income	3,129	
Other	644	19,361
Pay: -		
Medical	2,200	
Nursing	6,016	
Other	4,638	12,854
Non Pay: -		
Drugs & Medicines	1,629	
Medical & Surgical Appliances	781	
Insurances	750	
Laboratory	412	
Other	2,970	6,542
Net Deficit 1997		35
Taxes paid to Revenue Commissioners Year ended 31 December, 1997		
P.A.Y.E		2,895
P.R.S.I. EE	457	
P.R.S.I. ER	693	1,150
Withholding Tax		33
Building Tax		7
		4,085

HOSPITAL STAFF

Master:
Dr. P. McKenna

Hospital Secretary:
Mr. N. Nelson

Matron:
Ms. M. A Kelly

Director of Paediatrics
Prof. T. Clarke

Director of Anaesthesia
Dr. J. Gardiner

Director of Pathology
Dr. J. Gillan

NURSING ADMINISTRATION

Senior Staff

Miss M. Cunningham (Deputy Matron)
Miss E. Archibald (Assistant Matron)
Miss M. Thornton (Unit Nursing Officer)
Mrs. K. Ruddy (Acting Assistant Matron)
Ms. A. Keenan (D/S Superintendent)

Sister Midwives

Ms. G. Birrane	Ms. M. Gannon	Ms. M. Philbin	Ms. M. Cahill
Ms. S. Graham	Ms. M. Quinn	Ms. G. Gorman	Ms. C. McDermott
Ms. A. Redman	Ms. B. D'Arcy	Ms. M. McGovern	Ms. A. Reid
Ms. J. Dillon	Ms. M. McNally	Ms. M. Williams	Ms. M. Duggan
Ms. F. O'Carroll	Ms. P. Williamson	Ms. E. Early	Ms. K. Clarke

PARAMEDICAL HEADS OF DEPARTMENT

Chief Pharmacist	*Senior Physiotherapist*	*Senior Radiographer*	*Chief Technologist*
Ms. A. Frankish	Ms. K. Marshall	Ms. V. Doris	Ms. G. O'Connor

ADMINISTRATIVE HEADS OF DEPARTMENT

Head of IT/ Patient Services
Mr. T. Carroll

Personnel Manager
Ms. M. Crowe

Accountant
Ms. V. Kelly

Patient Services Officer
Ms. P. Griffin

Supplies Officer
Mr. S. Williamson

SUPPORT STAFF DEPARTMENT HEADS

Catering Officer	*Domestic Supervisor*	*Housekeeper*	*Maintenance*
Ms. P. Ryan	Ms. M. McCarthy	Ms. Y. Herterich	Mr. R. Taplin

Head Porter
Mr. M. McGrath

Chaplains
Fr. C. Sheridan
Rev. W. Stewart

School of Midwifery Staff

Ms. A. Monaghan, Principal Midwife Teacher
Ms. M. Carroll, Midwife Teacher
Ms. M. McNelis, Midwife Teacher
Ms. D. Daly, Acting Midwife Teacher.

SENIOR REGISTRAR/ASSISTANT TO THE MASTER
Dr. M. Milner, Dr. S. Coulter-Smith, Dr. M. McCaffrey

LECTURERS (RCSI) - Dr. M. D'Mello, Dr. M. McCaffrey, Dr. G. Connolly

REGISTRARS

Dr. F. Lyons	Dr. J. Slevin	Dr. M. O'Donovan
Dr. P. Bosio (Research Reg.)	Dr. S. O'Donnell	Dr. N. Al Shabibi (Research Reg.)

CLINICAL CLERKS

Dr. S. Conroy	Dr. N. Black	Dr. M. Eogan
Dr. M. Kennelly	Dr. T. Walsh	Dr. A. Martin
Dr. I. Basit	Dr. K. Darhouse	Dr. N. Jha
Dr. R. Thorp	Dr. S. Adala	Dr. S. Ismail
Dr. M. Tarrant	Dr. A. Kilcoyne	Dr. M. Lynch
Dr. M. O'Riordan	Dr. A. Horne	

REGISTRARS IN ANAESTHETICS

Dr. B. Swanton (Senior)	Dr. P. Higgins (Senior)	Dr. Alsayouri
Dr. S. Ahmed	Dr. V. Shariff	

ANAESTHETIC HOUSE OFFICERS

Dr. N. Eustace	Dr. R. Fanning	Dr. C. Glynn
Dr. G. Ghazali	Dr. K. Rabenstein	Dr. R. O'Farrell
Dr. I. Brady	Dr. A. Sunderaj	

PAEDIATRIC REGISTRARS

Dr. D. Coughlan	Dr. C, McMahon	Dr. H. Stokes
Dr. A. Broderick	Dr. R. Philip	Dr. J. Meehan
Dr. P. Gilligan	Dr. N. Murphy (Research)	

CLINICAL TUTOR IN PAEDIATRICS
Dr. P. Murphy

PAEDIATRIC HOUSE OFFICERS

Dr. S. Harty	Dr. M. Ryan	Dr. O. Byrne
Dr. K. Johnson	Dr. N. Abid	Dr. A. Khan
Dr.V. Sahayaraj	Dr. H. Al Girim	Dr .T. Hussein
Dr. A. Broderick	Dr. C. McMahon	Dr. D. McKenna
Dr. N. Ngeh	Dr. M. Parameshwar	Dr. K. Hassan

PATHOLOGY REGISTRAR

Dr. V. Healy	Dr. M. Healy	Dr. N. Bermingham

PHARMACIST - Ms. A. Frankish

MEDICAL SOCIAL WORKERS

Ms. E. MDonnell (Head)	Ms. S. McCrory	Ms. G. Parkinson
Ms. H. Houston	Ms J. McKevitt	Ms. H. Sheeran

PHYSIOTHERAPISTS

Ms. K. Marshall (Head)	Ms. V. McConnell	Ms. T. Totterdell

RADIOGRAPHER
Mrs. V. Doris
Mrs. G. Kelly

NUTRITIONIST
Mrs. R. O'Carroll

BARTHOLOMEW MOSSE LECTURE

1997	Mr. Peter McLean	*Reforms in Surgical Training and Examinations*
1996	Dr. N. Patel	*The Work of the President*
1995	President M. Robinson	*Reflections on Maternity Care*
1994	Prof. G. Chamberlain	*"We and the Labouring World are Passing"* WBY
1993	Prof. David T. Baird	*Infertility and Contraception in an Overcrowded World*
1992	Sir Peter Froggatt	*Wakley's Lancet and Jacob's Dublin Press: Instruments for medical Reference*
1991	Hon. Mr. Justice Ronan Keane	*Medical Negligence - a question of balance*
1990	Prof. V. Tindall	*A Speciality in Distress*
1989	Prof. H. Fox	*A Symbiotic Relationship*
1988	Prof. J.S. Scott	*The Third Sex. Sociology is out of step with Biology*
1987	Prof. A.D.H. Browne	*A Magnificent Recklessness for Philantrophy*
1986	Prof. Sir Malcolm MacNaughton	*Obstetric Audit - 50 years on*
1985	Dr. R.G. Edwards	*Current Clinical, Scientific and Ethical Situation of Human In Vitro Fertilisation*
1984	Prof. Kieran O'Driscoll	*Obstetrics: Subject under siege*
1983	Prof. J.H.M. Pinkerton	*Evory Kenedy: A Master Controversial*
1982	Mr. R.M. Feroze	*The Training of a Gynaecologist*
1981	Prof. John A. Davis	*Survival of the Fittest*
1980	Prof. G.S. Dawes	*Analysis of the Human Fetal Heart Rate Antenatally*
1979	Mr. E.A.J. Alment	*Fetus and Family*
1978	Prof. P.B.B. Gatenby	*Medicine and the Third World*
1977	Prof. C.J. Dewhurst	*The Menopause*
1976	Prof. J.P.M. Tizard	*Management and Disease of Children, a Modern View of a 19th Century Text*
1975	Dame Josephine Barnes	*The Teachers and the Taught*
1974	Prof. C.A. Clarke	*The Role of Natural History in Understanding Disease*
1973	Prof. A. Ingelman-Sundberg	*Urge Incontinence in Women*