Clinical report of the Rotunda Hospital, 1st January 1981 to 31st December 1981 (520 KB)

ROTUNDA HOSPITAL

DUBLIN

CLINICAL REPORT

1981

CLINICAL REPORT
of the
ROTUNDA
HOSPITAL

1st January, 1981

to 31st December, 1981

Master:

GEORGE R. HENRY, M.D., M.A.O., F.R.C.O.G.
(elected November 1980)

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GLOSSARY

BOOKED PATIENT (B): Any patient seen at the Antenatal Clinic or in a Consultant's Rooms prior to admission.

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

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

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

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

INTRODUCTION

In introducing my first Clinical Report, I wish to pay tribute to my predecessor, Dr. Ian Dalrymple, who completed his seven year Mastership on 31st December 1980. During these seven years the Perinatal Mortality rate for the Hospital dropped from 23-3 to 14 8. The main factor contributing to this decline was Dr. Dalrymple's initiative in developing Neonatal Intensive Care with the purchase of very expensive equipment. The wisdom of this course has been amply vindicated by the results that have been achieved.

On repeated occasions Dr. Dalrymple referred to the inadequate Labour Ward and Operating Theatre accommodation, and I know that he was greatly disappointed that this situation had not been rectified before he completed his Mastership. The Department of Health are undoubtedly sympathetic to our pleas to get our building extension started but, at present, are bound by severe financial constraints due to the economic recession besetting the country at the present time. I sincerely hope that the Department of Health will allow us to commence our development programme without delay. This programme involves centralising our storage space in the old kitchen area of the Students' residence, enlarging the Out Patient Department by taking over the Mortuary area and relocating the Mortuary in the lower storey of the Paediatric Unit.

A definitive decision was taken during the year to develop the Old Pillar Room under the Gate Theatre as a Teaching Centre and I am extremely grateful to the Friends of the Rotunda for agreeing to undertake the £•} million fund-raising campaign necessary to complete this project.

It is natural to review the objectives of an Annual Clinical Report at the beginning of a Mastership as it is often said that the work involved in producing this Report is not justified. It is my intention to use the Annual Clinical Report as a medium for reviewing the contemporary work which the Hospital is undertaking. Bald statistics are unreadable by anyone other than those most intimately involved. On the other hand, an annual account of the philosophy and clinical approach of those working in a large maternity unit may be of interest to a wider audience. I envisage that during the next seven years the recent revolutionary advances of neonatal intensive care will come under increasing scrutiny with regard to long-term follow-up of infants. The fact that obstetricians now have the opportunity to deliver less mature babies, entirely in the fetal interest, is bound to make a re-appraisal of conventional antenatal care mandatory.

The technological advances in obstetrics in recent years have changed the whole outlook of obstetricians and for this reason I do not propose to present my Clinical Report in a stereo-typed fashion. In my first report I have tried to lay a foundation upon which the next six years will be built.

During the year Mr. Graham Alford retired from his post of Dental Surgeon to the Hospital. Mr. Alford had given very many years of loyal service to the Rotunda and had witnessed great changes in the dental state of the community resident on the north side of Dublin.

Mr. Peter McLean joined the staff as an occasional consultant for Special Purposes. This formalised the situation under which Mr. McLean gives a most efficient service for patients requiring urological surgery in the Rotunda.

Dr. D. Bohn who had been a Consultant Anaesthetist to the Hospital for a short period resigned his appointment to return to Canada.

During the year Dr. Eamonn McGuinness resigned as Senior Registrar to take up a Consultant post in Cork. We wish him every success.

Dr. Michael Darling joined the staff from the Hammersmith Hospital, London, in October as Senior Registrar in Obstetrics and Gynaecology. Dr. Darling now undertakes the Microsurgery in the Rotunda.

In order to alleviate the overcrowding in our single temporary operating theatre a small emergency operating theatre was developed in the Labour Ward.

This theatre is used for procedures requiring general anaesthesia in the Labour Ward and to prevent "doubling-up" of cases in the main operating theatre.

It is regrettable to have to end this introduction on a note of caution. Maternity care is now considered a worthwhile "consumer product" by the media and consumers alike; both demanding an active role in its provision. In principle this is a healthy development, but too often it develops into a litigation witch-hunt and this makes critical review of perinatal mortality and morbidity a hazardous procedure.

This Report is the combined work of many people, including those whose names appear at the head of each section. To them, and especially to Miss Mildred Aherne, our Medical Records Officer, and her Assistant Miss Mary Gregg, I offer my sincere thanks.

G. R. HENRY, Master.

TEACHING:

The full teaching programme continued during the year. Fifty-six Royal College of Surgeons in Ireland undergraduate students underwent their two month Obstetrics and Gynaecology course in the Hospital during the months January to April and November and December.

During May, June and September, October, 47 undergraduates from Trinity College went through the hospital.

During the months of July and August we welcomed 10 students from America and the U.K. who were undertaking elective periods of study.

Between October 1980 and March 1981 we had 19 postgraduate students in residence undertaking the D.G.O. (Diploma of Obstetrics and Gynaecology, Trinity College Dublin) course.

38 doctors were successful in obtaining the L.M. (Rotunda) Diploma during the year.

A major development was the conversion of the old Students' Dining Room in the Students' Residence to a Library. This project was financed by the Friends of the Rotunda and has been of enormous benefit to all members of the Hospital staff.

LECTURES:

The 1981 Bartholomew Mosse Memorial Lecture was given by Professor John Davis, Professor of Paediatrics at the University of Cambridge. His lecture entitled "Survival of the Fittest" was particularly appropriate for the International Year of the Disabled and was a broadly based justification for neonatal intensive care.

Two Ninian Falkiner Memorial Lectures were given during 1981. In February Professor Harold Fox, Professor of Pathology at the University of Manchester, gave an immensely enjoyable lecture on the subject of "Placental Insufficiency". In October Professor Norman Nevin, Professor of Medical Genetics at the Queen's University of Belfast, gave a wide-reaching lecture on the subject "Prevention of Handicap through Antenatal Care".

We were also pleased to welcome Mr. T. L. T. Lewis from Guy's Hospital who lectured on "Vulval Dystrophy".

RESEARCH

An active programme of research has continued in the Hospital during the year and the following is a list of the ongoing projects:

(1) Effects of Bleeding in Pregnancy —Dr. M.Walzman, Prof. J. Bonnar.

(2) Data Collection Project —Prof. A. D. H. Browne.

(3) Perinatal Outcome and Maternal Hazards of Antepartum Haemorrhage —Dr. Oluitan, Prof. J. Bonnar.

(4) Determination of Blood and Tissue levels of Ascorbic Acid, Histamine and Prostaglandins E_2, F_2 and I_2 (6 Keto PGF_2) in 3rd Trimester normal pregnancy and in pregnancy complicated by Antepartum Haemorrhage —Dr. Sharma, Prof. Bonnar.

(5) Neural Tube Defect Study —Dr. Dalrymple.

(6) An Investigation of the Efficacy and Toxicity of Caffeine in the Treatment of Apnoea of Infancy —Dr. Matthews.

(7) Use of Exogenous H. C. G. Therapy in the Management of early threatened Abortion and the use of H.C.G. in the Prevention of Abortion —Prof. R. Harrison

(8) Ultrasound Diagnosis of Intracranial Haemorrhage in Premature Newborns —Dr. Matthews.

(9) Metoclopramide as an Effective Drug for Gastric emptying in Caesarean Section —Dr. J. Gardiner.

(10) Alfentanyl in Gynaecological Anaesthesia —Dr. J. Gardiner.

I am extremely grateful to the Friends of the Rotunda who have supplied the funds for the majority of these projects.

SUMMARY

Total Deliveries	6,841
Booked	6,210
Unbooked (total includes 527 cases before 28 weeks maturity)	631
Deliveries before 28 weeks maturity (755)	
Abortions	679
Miscarriages (21 born alive)	73
Moles	3
Deliveries 28 weeks maturity and over:	
Total patients delivered	6,086
Total Births	6,142
Maternal results:	
Maternal mortality	1
Incidence (per cent)	0.01
Multiple pregnancies:	
Twins	56
Fetal Results:	
Total live births 28 weeks maturity and over	6,087
Deadborn	55
1st week N.N.D.'s	27
Late N.N.D.'s	6
Perinatal mortality rate	13.3
Corrected Perinatal Mortality Rate (excluding congenital anomalies)	8.8
W.H.O. perinatal mortality rate (Weight 1,000+ grams)	13.5
Miscellaneous Maternal Complications: *(not detailed elsewhere in the Report)*	
Anaemia	379
Phlebitis	24
Breast abscess	3
Hyperemesis Gravidarum	13
Pulmonary embolus	2
Tumours	16
Cardiac disease *	15

STATISTICAL ANALYSIS OF HOSPITAL POPULATION

THE MASTEH

Age	*Number*	*Percentage*
< 20 years	348	5
20-24 „	1,260	18
25-29 „	2,855	42
30-34 „	1,502	22
35-39 „	672	10
40+ „	204	3
Total	6,841	100
Parity		
0	2,616	38
1,2,3,	3,701	54
4 +	524	7
Total	6,841	100
Socio-Economic Group		
1	435	6
2	1,191	18
3	833	12
4	1,345	20
5	795	12
6	803	12
7 Unemployed	507	7
8 Unmarried or Unsupported	635	9
9	291	4
Total	6,841	100

COMMENT

This is the first time a statistical analysis of patients attending the Rotunda has been included in the Clinical Report.

The Socio-Economic Classification used is the same as that used by Dowding (Br.MedJ. 1981 Vol. 282, 683-686).

The fathers' occupation was classified according to the British Registrar General's social classes I, II, IIIN, IIIM, IV and V referred to in this report as Groups 1 to 6. The unemployed were classified separately (Group 7), as were the never married and unsupported mothers (Group 8). Defence forces personnel were classified as Group 9.

MATERNAL MORTALITY

THE MASTER

Number of Cases : 1

S.E. Group 8. Age 17. Height 160.5 cms. Primigravida. Gestation 16 weeks.

This patient attended the Antenatal Clinic on 12/2/1981 for her first visit when she was noted to be 16 weeks pregnant.

On 14/2/1981 she was tragically burnt to death in the Stardust disaster.

FETAL LOSS

THE MASTER

Summary

Total Births 28 weeks maturity and over	6.142
Total Stillbirths	55
Stillbirth Rate	8.9 per 1.000
Total 1st week Neonatal Deaths	27
Total late Neonatal Deaths	6
Postmortem Rate	75 per cent
Perinatal Mortality Rate	13.3
W.H.O. Perinatal Mortality Rate (Weight 1.000 or more grams.)	13.5
Perinatal Mortality Rate (Weight 500 or more grams.)	18.4
Corrected Perinatal Mortality Rate (Excluding Congenital anomalies)	8.8
BookedCases	81
Unbooked Cases	1

CLASSIFACTION OF PERINATAL MORTALITY

	S/B	1st Week NND's	Late NND's
1. Antepartum Death with maceration only	11	—	–
2. Antepartum Asphyxia	29	—	—
3. Intrapartum Asphyxia	4	4	—
4. Birth Trauma			
5. Pulmonary Syndrome etc.	—	2	
6. Intraventricular Haemorrhage		2	1
7. Pneumonia			
8. Haemolytic Disease			
9. Previable/Prematurity			
10. Miscellaneous	—	1	2
11. (a) Congenital Malformations	3	13	1
(b) Anencephalus	7	5	-
Total	55	27	6

FETAL LOSS/BIRTH WEIGHT

(Excluding Congenital Malformations but including late Neonatal Deaths.)

TABLE 1.

Weight	*Number*		*Percentage*
	SIB	*N.N.D.*	
< 500 grms.	1		*2*
501 - 1000 grms.	2	5	12
1001 - 1500 grms.	10	2	20
1501 -2000 grms.	6	2	13
2001 -2500 grms.	5	2	12
2501 -3000 grms.	10	1	19
3001 -3500 grms.	7	2	15
3501 + grms.	4	—	7
Total	45	14	100

FETAL LOSS/GESTATION

(Excluding Congenital Abnormalities but including late Neonatal deaths.)

TABLE II

Gestation in weeks	*Number*		*Percentage*
	S/B	*N.N.D.*	
28-30	3	6	15
31-32	8	1	15
33-34	3	1	7
35-36	3	-	5
37-38	13	2	25
39-40	8	2	18
41 +	7	2	15
Total	45	14	100

COMMENT

There were 82 Perinatal deaths during the year and 6 late Neonatal Deaths. In 29 cases congenital abnormalities were present (35 per cent).

Forty of the forty five stillborn normally developed fetuses died before the onset of labour. In 5 cases the antenatal care could be criticised. In an additional 7 cases the fetus was small for dates and in 4 of these cases no action was taken. In 2 cases the only avoidable factor appeared to be heavy cigarette smoking by the mother.

Table I shows that 57 per cent of the fetal loss in normally formed babies occurred in those weighing 2000 grams or more.

Table II shows that 63 per cent of the fetal loss in normal babies occurred in those born after 35 weeks gestation.

These results suggest that we have a long way to go before eliminating avoidable fetal loss. During the year we relied upon monitoring of daily fetal movements with the back-up of antepartum cardiotocography to detect the fetus at risk in utero before the onset of labour. This policy has obvious limitations; the two most obvious being (a) the subjective element in the mother recording fetal movements and (b) doubt as to which cases should be subjected to cardiotocography. It is our intention to make greater use of ultrasonic assessment of fetal growth and combine this with a more energetic policy of establishing fetal lung maturity by amniocentesis.

It is disappointing to record that 8 babies died as a result of intrapartum asphyxia. In 2 cases continuous -intrapartum fetal heart monitoring failed to diagnose a fetus in distress while in a third case the tracing on the monitor was ignored. One case should have had an earlier Caesarean section and in two cases earlier induction of labour might have prevented the intrapartum asphyxia.

Four of the first week Neonatal deaths were the result of asphyxia during labour. Table I shows that 9 of the 14 normally formed babies which died during the neonatal period weighed less than 2000 grams. Table II shows that 8 of these babies were less than 34 weeks gestation.

AN ANALYSIS OF THE CONGENITAL MALFORMATIONS SHOWS THE FOLLOWING:

Central Nervous System Abnormality	17
Congenital Heart Disease	3
Multiple Congenital Anomalies?Chromosomal	4
Renal anomaly (Potter's Syndrome)	1
Miscellaneous:	4
Achondrophlasia	
Congenital Myotonia	
Toxaopasmosis	
Congenital Fibroelastosis	
Total	29

Six of the 12 Anencephalics were diagnosed early in pregnancy by means of routine ultrasound examination. It is interesting to note that only one case (No. 171744) would have qualified for amniocentesis under conventional selection procedures for this investigation in early pregnancy. It is not our policy to offer amniocentesis to patients in early pregnancy as termination of pregnancy before 28 weeks gestation is not considered.

ANTEPARTUM DEATHS

ANTEPARTUM DEATH WITH MACERATION ONLY

(1) 165955 B. Age 27. Para 3 $^{+0}$. Gestation 34 weeks. Hydramnios. Intrauterine death at 34 weeks. Macerated fetus weighing 1,430 grams. Assisted breech delivery. Post-Mortem: Multiloculated cyst in lower lobe of left lung.
(2) 166863 B. Age 32. Para 5 $^{+0}$. Gestation 32 weeks. Booked at 17 + weeks gestation. Three antenatal visits. Last seen at 32 + weeks gestation and noted to be 28 weeks in size with marked weight loss. Diagnosis considered to be intrauterine death. Not confirmed by X-Ray. Eventually admitted at 38 weeks gestation with some bleeding. Subsequently delivered of a macerated stillborn male infant weighing 1,200 grams. Post-Mortem permission refused. Antenatal factors: Smoked 30-40 cigarettes per day.
(3) 166969 B. Age 36. Para 2 $^{+1}$. Gestation 37 weeks. Booked at 14 + weeks gestation. History of a threatened abortion at 10 weeks. Smoker. Failure to gain weight from 33 weeks. Last seen at 36 + weeks. Fundus 31 weeks in size. Fetal movement chart satisfactory. Admitted in labour the following day with no fetal heart present and fully dilated. Normal delivery macerated female infant weighing 1,610 grams. Post-Mortem: Normal macerated fetus. Antenatal Factors: Small for dates fetus where earlier admission to hospital might have allowed earlier detection of fetal compromise.
(4) 168527 B. Age 29. Para 1 $^{+1}$. Gestation at delivery 39 weeks. Previously Caesarean section for failed trial of labour. Family history of Diabetes Mellitus. Booked at 8 weeks. Intrauterine death diagnosed at 28 weeks. Glucose Tolerance test at 35 weeks normal. Spontaneous onset of labour at 39 weeks. Normal delivery of macerated female infant weighing 1,320 grams. Post-Mortem: Maceration only. No structural anomalies noted.
(5) 169123 B. Age 45. Para 6 $^{+3}$. Gestation at delivery 37 weeks. Booked early. Noticed decrease in fetal movements at 36 weeks. Seen again at 37 weeks when no fetal heart was picked up. Normal delivery macerated male infant. Weight: 2,130 grams. Post-Mortem: Macerated fetus. No structural anomalies. Antenatal Factors: Undetected small for dates fetus. Patient not advised regarding necessity to report decrease in fetal movements.
(6) 169256 B. Age 20. Para 0 $^{+0}$. Inupta. Booked at 11 weeks and attended regularly. Fetal movements not felt at 30 weeks. Heavy smoker. Breech delivery of macerated female infant at 31 weeks. Weight 680 grams. Post-Mortem: Macerated fetus. No structural anomalies.
(7) 169446 B. Age 35. Para 3 $^{+1}$. Gestation at delivery 32 weeks. Past history of 2 stillbirths. Booked early and attended regularly. Noticed to be small for dates at 28 weeks and also had pre-eclamptic toxaemia. Fetal heart not heard 4 days after admission. Three weeks later normal delivery of macerated female infant. Weight: 760 grams. Post-Mortem: Maceration only. Antenatal Factors: Earlier admission for bed rest indicated.
(8) 169784 B. Age 25. Para 1 $^{+0}$. Gestation at delivery 29 weeks. Admitted with spontaneous rupture of membranes at 29 weeks. Breech extraction of stillborn second twin weighing 200 grams. Post-Mortem: Not done.
(9) 171182 B. Age 35. Para 0 $^{+0}$. Unbooked. 14 years Infertility. Transferred from Monaghan County Hospital at 37 weeks gestation with a twin pregnancy, small for dates, hypertension and in early labour. First twin was a footling breech presentation and there was some doubt about the second twin's heart beat. Caesarean section performed. 1st Twin weighed 2,175 grams. 2nd Twin macerated female infant weighing 1,520 grams. Post-Mortem: Maceration only.
(10) 171274 B. Age 42. Para 8 $^{+0}$. Admitted at 19 weeks gestation with history of low back pain since October 1980. Lost power in her legs and transferred to St. Vincent's Hospital. Myelogram showed block at T 11 and immediate decompression surgery was performed. Malignant lymphoma diagnosed and

transferred to St. Luke's Hospital for Radiotherapy. Spontaneous vaginal delivery of stillborn infant weighing 1,020 grams at 31 weeks gestation. Post-Mortem: Maceration only.
(11) 171393 B. Age 25. Para 1 $^{+0}$. Booked at 9 weeks gestation. Attended antenatal clinic at 34 weeks with history of no fetal movements for 2 days. Fetal heart not heart. Normal delivery of macerated female infant weighing 1,260 grams. Post-Mortem: Maceration only.

ANTEPARTUM ASPHYXIA

(1) 165501 B. Age 31. Para 4 $^{+0}$. Gestation at delivery 35 weeks. Previous Caesarean section. Blood Group AB Rhesus negative. Antibodies present. Normal antenatal care. Admitted at 35 weeks gestation with a severe abruptio placentae. Labour induced with Syntocinon. Normal delivery of stillborn female infant 2,520 grams. Retroplacental clot of 750 mis. Post-Mortem: Not done.
(2) 165505 B. Age 22. Para 0 $^{+0}$. Gestation: Term + 11 days. No fetal heart heard on admission in labour. Normal delivery. Male infant covered in meconium. Weight 3,210 grams. Post-Mortem: Early maceration. Antenatal Factors: Bleeding in early pregnancy. Weight loss in late pregnancy. Fetal movement chart not satisfactory.
(3) 165712 B. Age 20. Para 0 $^{+0}$. Gestation 30 weeks. Admitted in labour having had spontaneous rupture of membranes. Breech presentation. No fetal heart heard on admission. Breech extraction. Male infant. Weight 1,380 grams. Post-Mortem: Large subcapsular haematoma of right lobe of liver.
(4) 165898 B. Age 31. Para 3 $^{+1}$. Gestation 39 weeks. Admitted with significant APH. Fetal heart 88 beats per minute. Immediate Caesarean section. Stillborn male infant delivered. Weight 2,540 grams. Post-Mortem: Intra-uterine anoxia.
(5) 166174 B. Age 42. Para 3 $^{+1}$. Gestation 40 weeks. Admitted in labour with spontaneous rupture of membranes. Fetal heart recorded as dropping to 100 beats per minute. Grade 2-3 meconium. Cervix 3 cms. dilated. Caesarean section performed. Macerated male infant. Weight 3,290 grams. Post-Mortem: Maceration. Normal fetus. Antenatal factors: Mild hypertension and weight loss.
(6) 166270 B. Age 26. Para 3 $^{+0}$. Gestation 37 weeks. Abruptio placentae. Labour induced. Stillborn female infant. Weight 2,330 grams. Post-Mortem: Antepartum anoxia.
(7) 166370 B. Age 19. Para 0 $^{+0}$. Gestation 31 weeks. Hypertension at 28 weeks. In-patient for three weeks. Very poor cardiotocograph. Fundus only 22 weeks. Fetus assessed at less than 500 grams. Intrauterine death at 30 weeks. Macerated female infant. Weight 1,100 grams. Post-Mortem: Not done.
(8) 166908 B. Age 25. Para 1 $^{+0}$. Gestation 32 weeks. Booked at 15 weeks gestation. Admitted in labour at 32 weeks gestation with hyperemesis, haematemesis and malaena. Haemoglobin 6-8. On admission no fetal heart heard. Subsequently went into labour and was delivered of a fresh stillborn female infant weighing 1,700 grams. Subsequent investigation showed acute duodenal ulceration. Post-Mortem: Antepartum anoxia.
(9) 166989 B. Age 37. Para 7 $^{+1}$. Gestation 37 weeks. Booked with uncertain dates. Poor antenatal attender. Admitted at 38 + weeks by ultrasound assessment of gestation, fully dilated with no fetal heart. Lift-out forceps delivery of stillborn infant, covered in meconium and weighing 2,700 grams. Post-Mortem: Permission refused.
(10) 167587 B. Age 40. Para 1 $^{+3}$. Gestation 40 weeks. Booked at 8 weeks gestation. Static weight from 38 weeks. C.T.G. at 38 weeks satisfactory. Admitted in labour at Term + 2 days. No fetal heart heard on admission. Normal delivery. Slightly macerated male infant. Weight 2,320 grams. Post-Mortem: Intra-uterine anoxia. Antenatal Factors: Failure to gain weight. Undetected small for dates fetus.

(11) 168422 B. Age 34. Para 0^{+0}. Innupta. Unknown gestation. Booked when fundus equal to 22 weeks in size. B.P. 120/90 at booking. One week later scan equivalent to 24 weeks gestation. Regular antenatal care. Admitted at 39 weeks gestation by scan complaining of low back pain. Allowed home the next day. Last seen in antenatal clinic at term +8 days by scan. Fetal movements recorded as satisfactory. Admitted at term + 15 days by scan in early labour. Fetal heart not heard on admission. Thick meconium on rupturing membranes. Normal delivery of fresh stillborn female infant weighing 3,050 grams. Post-Mortem: Normal infant. Antenatal Factors: Admitted with spurious labour.

(12) 168425 B. Age 21. Para 0^{+0}. Innupta. Booked at 25 weeks gestation. Fundus equal to 28 weeks in size. No further antenatal care. Admitted at 37 weeks gestation in labour with no fetal heart present. Normal delivery of macerated female infant weight 3,200 grams. Post-Mortem: Maceration only. No structural anomalies.

(13) 169202 B. Age 35. Para 0^{+0}. Booked early. Family history of diabetes. Seven years infertility. Fetal heart not heard at 37 weeks. Normal delivery of macerated female infant. Weight 2,560 grams. Post-Mortem: Early maceration. No structural anomalies.

(14) 169264 B. Age 29. Para 0^{+0}. Transferred from Letterkenny Hospital with fulminating pre-eclamptic toxaemia at 32 weeks gestation. Caesarean section performed on day after admission. Fresh stillborn male infant. Weight 1,500 grams. Post-Mortem: Anoxic changes.

(15) 169500 B. Age 19. Para 0^{+0}. Gestation at delivery 42 weeks. Uneventful antenatal care. Admitted at term + 17 days with no fetal heart, in labour. Normal delivery of female infant weighing 3,270 grams. Post-Mortem: Early maceration.

(16) 169925 B. Age 29. Para 0^{+0}. Gestation at delivery 42 weeks. Family history of diabetes. Admitted in labour at Term + 14 days. Normal delivery of male infant weighing 4,870 grams. Post-Mortem: Early maceration. Antenatal Factors: Despite family history of diabetes screening tests not performed.

(17) 170013 B. Age 26. Para 2^{+0}. Gestation at delivery 38 weeks. Normal antenatal career. Admitted five days after last visit to antenatal clinic with history of contractions and vaginal bleeding. Fetal heart not heard on admission. Normal delivery of fresh stillborn infant weighing 2,720 grams. Post-Mortem: Not performed. Vilamentous insertion of cord noted. Suspected cause of death vasa praevia.

(18) 170213 B. Age 34. Para 0^{+0}. Gestation at delivery 37 weeks. Booked at six weeks. Regular antenatal attender. Patient reported diminished fetal movements at 36 weeks and fetal heart not detected by ultrasonic scan. Labour induced with Quinine followed by normal delivery of macerated infant weighing 1,300 grams. Post-Mortem: Normal infant with maceration. Antenatal Factors: Small for dates fetus not detected.

(19) 170377 B. Age 27. Para 0^{+0}. Gestation at delivery 38 weeks. Booked at 9 weeks. Twin pregnancy diagnosed at 11 weeks. Serial biparietal diameters by ultrasound showed fall off in growth of second twin from 26 weeks. Admitted with hypertension at 33 weeks and again at 37 weeks. Spontaneous onset of labour at 38 weeks. First twin weighed 3,210 grams. Second twin breech delivery of macerated stillborn infant weighing 1,770 grams. Antenatal Factors: The compromised condition of second twin was recognised early. One abnormal cardiotocograph tracing was obtained but when repeated was normal, (in retrospect obviously tracing of first twin). Earlier intervention could have prevented stillbirth of second twin.

(20) 170427 B. Age 46. Para 1^{+2}. Gestation at delivery 41 weeks. Booked at 18 weeks. Dates uncertain. Ultrasonic scan suggested maturity 4 weeks less than dates. Admitted at 38 weeks by dates (34 weeks by scan) on account of age, poor obstetrical history and geographical distance from the Hospital. Fetal cardiotocography satisfactory 4 days before onset of irregular contractions.

Attempt to get labour established with Syntocinon unsuccessful. Fetal cardiotocography again normal one day before fetal heart disappeared. Labour induced subsequently with Prostaglandin pessaries. Normal delivery of slightly macerated infant weighing 2,650 grams. Two true knots in cord. Post-Mortem: Not done. Antenatal Factors: Fetal Cardiotocography failed to detect imminent fetal death. Earlier establishment of fetal maturity by amniocentesis and elective Caesarean section possibly indicated.

(21) 170515 B. Age 28. Para 0^{+0}. Gestation at delivery 29 weeks. Regular antenatal attender admitted at 29 weeks following small antepartum haemorrhage. Fetal heart not heard on admission. Spontaneous onset of labour and breech delivery of stillborn infant weighing 1,330 grams with retroplacental clot of 800 mis. Post-Mortem: Intra-uterine anoxia.

(22) 170937 B. Age 28. Para 0^{+0}. Gestation at delivery 34 weeks. History of 8 years primary infertility. Treated with Clomid. Booked at 8 weeks gestation. Admitted at term + 2 days with absent fetal movements. Fetal heart not heard. Prostin induction followed by normal delivery of macerated female infant weighing 3,420 grams. Post-Mortem: Anoxic changes.

(23) 170964 B. Age 43. Para 1^{+0}. Uncertain dates. Attended antenatal clinic at term by ultrasonic assessment of gestation with history of no fetal movements for 2 days. Normal delivery male infant weighing 2,890 grams. Post-Mortem: Anoxic changes.

(24) 171555 B. Age 26. Para 0^{+0}. Gestation at delivery 42 weeks. Regular antenatal attender. Fetal heart not heard in clinic. Admitted 6 days later in spontaneous labour. Normal delivery of macerated female infant weighing 2,710 grams. Post-Mortem: Permission refused. Antenatal Factors: Smoked 30 cigarettes per day.

(25) 171670 B. Age 19. Para 0^{+0}. Gestation at delivery 38 weeks. Booked at 13 weeks. Regular antenatal attender. Last seen in Clinic at 38 weeks. No fetal movements felt on the following day. Admitted 2 days later in spontaneous labour. Normal delivery of macerated female infant weighing 3,740 grams. Post-Mortem: Maceration only. No fetal abnormality.

(26) 171780 B. Age 29. Para 1^{+0}. Gestation at delivery 38 weeks. Booked at 12 weeks. Regular antenatal attender. No fetal movements felt for one week before last attendance at Clinic. Labour induced with Prostin. Normal delivery of macerated female infant weighing 2,230 grams. Post-Mortem: Maceration only. Antenatal Factors: Noted to be small for dates but no action taken.

(27) 171812 B. Age 37. Para 4^{+1}. Gestation at delivery 40 weeks. Booked at 9 weeks. Regular antenatal attender. Last seen in Clinic at 39 weeks with history of no fetal movements for 3 days. Spontaneous onset of labour and normal delivery of macerated female infant weighing 1,790 grams. Cord x 2 tightly around neck. Post-Mortem: Maceration only. Antenatal Factors: Known to be small for dates and admitted to hospital but discharged home.

(28) 171903 B. Age 28. Para 0^{+0}. Gestation at delivery 40 weeks. Booked at 7 weeks. Regualr antenatal attender. Admitted in spontaneous labour at term + 4 days. Unable to hear fetal heart on admission due to very tense abdomen. Cervix 3 cms. dilated. Membranes ruptured and grade 3 meconium obtained. Fetal heart thought to be heard. Emergency Caesarean section performed and macerated female infant delivered weighing 3,690 grams. Cord tightly around neck x 4. Post-Mortem: Early maceration. Normal infant.

(29) 171523 B. Age 26. Para 0^{+0}. Gestation at delivery 35 weeks. Innupta. First seen at 34 weeks gestation. No previous antenatal care. One week after first visit to Antenatal clinic admitted in labour. No fetal heart heard on admission. Normal delivery of male infant weighing 2,890 grams. Post-Mortem: Anoxic changes.

INTRAPARTUM ASPHYXIA

(1) 165479. B. Age 29. Para 1^{+0}. Gestation: Term + 12 days. Spontaneous onset of labour. Head free. Cervix 3 - 4 cms. dilated. Artificial rupture of

membranes. Meconium Grade 1 - 2. Four and a half hours after admission started on Syntocinon drip. Cervix progressed to 8 cms. dilatation. Decision to perform Caesarean section on account of failure to progress and fetal distress. On transfer to theatre found to be fully dilated with fetal heart 90 beats per minute. Easy Barton's forceps delivery. Male stillborn infant. Weight 3,350 grams. Post-Mortem: Intrapartum anoxia. Intrapartum Factors: Continuous fetal heart monitoring and fetal blood sampling failed to diagnose severe intrauterine hypoxia.

(2) 165900 B. Age 20. Para 2^{+0}. Gestation 31 weeks. Small for dates. Last seen at 30 weeks. Admitted in? premature labour. Breech presentation. Spontaneous rupture of membranes. Two days later started contracting. Started on Duvadilin and Ampicillin. Fetal heart not heard and cervix 3-4 cms. dilated. Developed pyrexia. Assisted breech delivery fresh stillborn male infant. Weight 2,000 grams. Post-Mortem: Intra-uterine pneumonia. Intrapartum Factors: Earlier Caesarean section in view of maternal pyrexia.

(3) 169307 B. Age 31. Para 4^{+0}. Gestation at delivery 39 weeks. Admitted in spontaneous labour with no fetal heart heard. Draining Grade 3 meconium. Normal delivery fresh stillborn male infant. Weight 4,700 grams. Post-Mortem: Anoxic changes.

(4) 172272 B. Age 17. Para 0^{+0}. Gestation at delivery 38 weeks. Booked at 14 weeks. Regular Antenatal attender. Admitted with spontaneous onset of labour. Cervix 1 cm. dilated and considered unsuitable for artificial rupture of membranes. One hour later difficulty in hearing fetal heart. Membranes ruptured and grade 3 meconium obtained. No fetal heart heard. Normal vaginal delivery of fresh stillborn male infant weighing 2,850 grams. Cord 48 inches long and wrapped around body and arms. Post-Mortem: Permission refused. Antenatal factors: Weight loss noted in late pregnancy. Consideration of induction might have changed events.

HAEMOLYTIC DISEASE

(1) 166441 B. Age 36. Para 3^{+2}. Gestation at delivery 36 weeks. Previous intrauterine death from hydrops fetalis at 38 weeks; also previous Neonatal deaths of twins at 29 weeks - probable cause of death prematurity rather than hydrops fetalis. Husband heterozygous. A Rhesus negative with antibodies. Booked at 13 weeks, fundus 22 weeks in size. First amniocentesis done at 16 weeks. At 26 weeks gestation fundus equalled 32 weeks in size. Plasma Exchange commenced at 28 weeks gestation. Had a total of five exchanges but patient decided not to continue. Patient failed to attend for repeat amniocentesis at 32 weeks gestation. Intrauterine death at 34 weeks. Spontaneous onset of labour. Normal delivery of macerated male infant. Weight 2,460 grams. Post-Mortem: Grossly macerated. Minimal hydrops.

CONGENITAL MALFORMATIONS

(1) 168385 B. Age 29. Para 2^{+0}. Gestation at delivery 40 weeks. Elective Caesarean section on account of 2 previous sections. Macerated female infant known to be achondroplastic since 31 weeks. Weight 1,290 grams. Post-Mortem: Achondroplasia.

(2) 169181 B. Age 33. Para 0^{+0}. Gestation at delivery 40 weeks. Assisted breech delivery of male infant weighing 3,230 grams with Hydrocephalus. Post-Mortem: Permission refused.

(3) 169642 B. Age 26. Para 1^{+0}. Gestation at delivery 41 weeks. Assisted Breech delivery of female infant weighing 3,400 grams. Post-Mortem: Hydrocephalus with Lumbo-thoracic myelocele.

NEONATAL DEATHS

Intrapartum Anoxia

(1) 165500 B. Age 21. Para 0^{+0}. Gestation at delivery 39 weeks. N.N.D. at 2 days. Admitted in labour following spontaneous rupture of membranes. Breech presentation. Grade 3 meconium noted three hours after admission. Also irregular fetal heart. Cervix 4 cms. dilated. Decision to perform Caesarean section. Live male infant delivered. Weight 2,000 grams. Apgars 1 and 4. Baby intubated. Post-Mortem: Right Pneumothorax.

(2) 166926 B. Age 28. Para 0^{+0}. Gestation at delivery term + 7 days. N.N.D. at 2 days. Booked at 10 weeks. Regular and normal antenatal care. Admitted at term + 7 days with a history of show and irregular contractions. Cervix 1 cm. dilated and 50% effaced. Four hours later considered to be in labour. Cervix fully effaced and 2 cms. dilated. Membranes ruptured and blood stained liquor noted. Two hours later still only 2 cms. dilated. Started on intravenous Syntocinon and 2 hours later was 4 cms. dilated with clear liquor. Epidural given and was fully dilated 1 hour later. Fetal scalp electrode removed. Fully dilated for 2 hours. Fetal heart considered to be 70 beats per minute just before forceps applied on account of delay in second stage of labour. Easy lift-out forceps of male infant weighing 3,430 grams. Apgar 0 at 1 minute. Successfully resuscitated with cajdiac massage and intubation. N.N.D. at 2 days. Post-Mortem: Congestive cardiac failure with functional dilatation of tricuspid valve. Intrapartum Factors: Undetected intrapartum asphyxia.

(3) 168764 B. Age 26. Para 1^{+0}. Gestation at delivery 40 weeks. Previous premature labour at 13 weeks gestation. Booked at 12 weeks gestation. Regular antenatal care. Blood pressure 150/90 at 18 weeks gestation and 160/90 at 23 weeks gestation. Cervical incompetence excluded at 18 and 22 weeks. Admitted in spontaneous labour at term. Scanty clear liquor at artificial rupture of membranes. Fetal scalp electrode applied. Normal delivery of female infant weighing 2,470 grams after 3| hour labour. Cord around neck. Baby flat at birth. Apgar 8 at 5 minutes. N.N.D. at 3 days. Post-Mortem: Poorly expanded lungs. Right basal consolidation. Intrapartum Factors: Unsatisfactory monitoring of fetal heart.

(4) 169684 B. Age 19. Innupta. Gestation at delivery 41 weeks. Good antenatal attender. Admitted with poor fetal movement record at 41 weeks. Spontaneous rupture of membranes suspected. Allowed home and re-admitted two days later. Poor cardiotocograph tracing in labour for two hours. Easy forceps delivery of very flat baby covered in meconium weighing 3,300 grams. N.N.D. at 2 days. Post-Mortem: Anoxic changes. Antepartum Factors: Patient sent home with ruptured membranes and draining meconium. Antepartum asphyxia not detected.

Pulmonary Syndrome etc. .

(1) 168436 B. Age 35. Para 5^{+1}. Gestation at delivery 29 weeks. Booked at 14 weeks gestation. Noted to be 16 weeks in size. Admitted at 20 weeks gestation with vaginal bleeding. Scan showed twins and a placenta praevia. Allowed home and again re-admitted at 22+ weeks gestation with further bleeding. Remained in hospital with persistant slight vaginal bleeding. Caesarean section carried out at 29 weeks on account of heavier bleeding. 1st Twin male infant weighing 1,100 grams. 2nd Twin Male infant weighing 1,450 grams. N.N.D. at 40 hours with severe Respiratory Distress Syndrome. Post-Mortem: Refused.

(2) 169784 B. Age 25. Para 1^{+0}. Gestation at delivery 29 weeks. Twin pregnancy. Admitted with spontaneous rupture of membranes at 29 weeks gestation by ultrasound. Fetal heart of second twin not heard. Breech extraction of first twin weighing 900 grams. N.N.D. at 2 days. Post-Mortem: Massive intrapulmonary haemorrhage. Intrapartum Factors: Caesarean section might have been a preferable way to deliver.

INTRAVENTRICULAR HAEMORRHAGE

(1) 170873 B. Age 19. Para 0 $^{+1}$. Booked at 24 weeks gestation. Several episodes of urinary tract infection. Admitted at 29 weeks gestation in premature labour. Intravenous Duvadilan ineffective. Assisted breech delivery of male infant. Weight 1,000 grams. N.N.D. at 11 hours. Clinical diagnosis of massive intraventricular haemorrhage (ultrasound diagnosis). Post-Mortem: Not done.
(2) 171179 B. Age 25. Para 0 $^{+0}$. Booked at 10 weeks gestation. Admitted at 27 weeks with vaginal bleeding. Bleeding continued and spontaneous onset of labour at 28 weeks. Normal delivery of male infant. Weight 825 grams. N.N.D. at 5 days. Post-Mortem: Small peri-ventricular haemorrhages.

Miscellaneous

(1) 168246 UnB. Age 30. Para 0 $^{+0}$. Transferred from Monaghan County Hospital with severe P.E.T. at 32 weeks gestation. Ten days after admission developed severe abruptio placentae. Caesarean section performed. Female infant. Weight 1,880 grams. Apgars 5 and 8. Treated with Priscoline. Developed acute erosion of stomach and died on 4th day. Post-Mortem: Acute erosion of stomach and left Pneumothorax.

Congenital Malformations

(1) 166029 B. Age 31. Para 1 $^{+0}$. Normal delivery. Weight 3,410 grams. N.N.D. at 4 days. Post-Mortem: Congential Myotonia.
(2) 166079 B. Age 23. Para 0 $^{+0}$. Normal delivery. Weight 2,770 grams. N.N.D. at 48 hours. Post-Mortem: Congenital Heart Disease. Hypoplastic left ventricle.
(3) 165627 B. Age 18. Para 0 $^{+0}$. Assisted breech delivery. Weight 2,650 grams. N.N.D. at *j* hour. Post-Mortem: Severe Spina-Bifida and Hydrocephalus.
(4) 165962 B. Age 27. Para 4 $^{+1}$. Normal delivery. Weight 4,290 grams. N.N.D. at 7 days. Post-Mortem: Congenital Fibro-elastosis.
(5) 166498 B. Age 37. Para 4 $^{+0}$. Twin pregnancy. Second twin. Normal delivery. Weight 1,580. N.N.D. at 1 hour. Post-Mortem: Multiple congenital abnormalities.
(6) 168260 B. Age 35. Para 1 $^{+0}$. Previous section. Placenta praevia and Hydrocephalus. Elective Caesarean section. Inverted-T incision. Male infant. Weight 3,970 grams. N.N.D. at 1 day. Post-Mortem: Hydrocephalus.
(7) 168373 B. Age 35. Para 5 $^{+0}$. Gestation at delivery 41 weeks. Booked at 21 weeks gestation. Admitted at 37 weeks gestation as noted to be small for dates. Allowed home but re-admitted at term + 10 days as still small for dates. Poor cardiotocograph tracing and elective Caesarean section performed. Female infant weighing 2,100 grams. N.N.D. at 4 days. Post-Mortem: Single cardiac ventricle.
(8) 169275 B. Age 23. Para 0 $^{+0}$. Gestation at delivery 39 weeks. Assisted breech delivery female infant weighing 2,480 grams. N.N.D. at 1_T hours. Post-Mortem: Hypoplastic Kidneys — Potter's syndrome.
(9) 169505 B. Age 19. Innupta. Para 1 $^{+0}$. Gestation at delivery 28 weeks. Admitted with threatened abortion at 26 weeks. Premature labour. Normal delivery of female infant weighing 1,000 grams. N.N.D. at 23 hours. Post-Mortem: Meningo-cerebritis. Toxoplasmosis infection.
(10) 169810 B. Age 25. Para 2 $^{+1}$. Gestation at delivery 32 weeks. Admitted at 32 weeks with spontaneous rupture of membranes. Normal delivery of female infant weighing 1,510 grams. N.N.D. at 35 minutes. Post-Mortem: Multiple congenital abnormalities.
(11)170043 B. Age 21. Para 0 $^{+0}$. Gestation at delivery 34 weeks. Admitted at 34 weeks with polyhydramnios. Spontaneous rupture of membranes. Fetal distress in second stage of labour. Forceps delivery of female infant weighing 1,370 grams. N.N.D. at 30 minutes. Post-Mortem: Not performed but multiple

congenital abnormalities noted including dextrocardia, low set ears, oesophageal atresia and mongoloid facies suggestive of Edward's Syndrome.
(12) 171159 B. Age 27. Para 2^{+0}. X-Ray at term + 10 days showed gross microcephaly. Prostin induction. Normal delivery of female infant. Weight 3,180 grams. N.N.D. at 10 hours. Post-Mortem: Microcephaly and encephalocele.
(13) 171744 B. Age 41. Para 3^{+1}. Booked at 13 weeks gestation. Spontaneous rupture of membranes at 37 weeks. Normal delivery of female infant. Weight 2,600 grams. N.N.D. at 40 hours. Clinical diagnosis of Microcephaly and multiple congenital abnormalities. Post-Mortem: Not done.

Late Neonatal Deaths

(1) 166069 B. Age 22. Para 1^{+1}. Gestation at delivery 40 seeks. Antepartum haemorrhage at 36 weeks. Prostoglandin induction at term. Normal delivery of female infant weighing 2,740 grams. Apgar scores 9 at 1 minute ant 10 at 5 minutes. Died at age 19 days. Post-Mortem: Severe congenital heart disease.
(2) 168350 B. Age 29. Para 6^{+1}. Gestation at delivery 28 weeks. Threatened miscarriage and premature onset of labour with spontaneous rupture of membranes. Normal delivery of male infant weighing 750 grams. Died at age 8 days. Post-Mortem: Normal premature infant.
(3) 168950 B. Age 28. Para 1^{+0}. Gestation at delivery 37 weeks. Booked at 14 weeks. Twins diagnosed by ultrasound at first visit. Admitted at 35 weeks gestation with moderately severe pre-eclamptic toxaemia. Serial biparietal diameter measurements by ultrasound showed fall-off in growth of first twin at 36 weeks gestation. Amniocentesis performed showed mature Lecithin/Syngomyelin ratio. Spontaneous onset of labour two days later. Labour lasted 5 hours. Assisted breech delivery of first twin weight 2,150 grams. Apgar scores 8 at 1 minute and 9 at 5 minutes. First twin developed Proteus Meningitis and died at 9 days of age.
(4) 169157 B. Age 35. Para 4^{+0}. Gestation at delivery 38 weeks. Booked at 11 weeks. Previous Rhesus Incompatibility history. Last two pregnancies terminated by Caesarean section. Homozygous husband. Repeat elective Caesarean section performed at 38 weeks. Female infant weighing 2,990 grams. Three exchange transfusions required in the first 60 hours. Discharged home 6 days after delivery. Re-admitted for top-up transfusion 20 days later and collapsed and died during the blood transfusion.
(5) 169464 B. Age 36. Para 9^{+0}. Gestation at delivery 30 weeks. Mild hypertension at booking at 11 weeks. Noted to be large for dates at 26 weeks. Admitted in premature labour at 30 weeks with undiagnosed twin pregnancy. Both twins normal deliveries. First twin weighing 1,450 grams. Second twin weighing 1,150 grams. Second twin N.N.D. at 15 days. Post-Mortem: Inhalation of vomitus. Antenatal factors: Twin pregnancy not diagnosed.
(6) 169744 B. Age 32. Para 2^{+0}. Gestation at delivery 32 weeks. Emergency Caesarean section performed for fetal distress resulting from severe abruptio placentae. Female infant weighing 1,000 grams delivered. N.N.D. at 8 days. Post-Mortem: Intraventricular Haemorrhage.

DELIVERIES LESS THAN 28 WEEKS AND GREATER THAN 500 GRAMS

DR. MICHAEL DARLING

Summary:

Total number of infants born	34	(3 sets of twins) (1 set of triplets)
Deadborn	13	
Live born	21	
Survived	2	
Weight 500-1,000 grams	27	
1,000 + grams	7	
> 1,000 grams —Stillborn	2	
— Liveborn	5	

COMMENT

Twenty-eight mothers delivered of a total of 34 babies, 27 of whom weighed between 500 and 1,000 grams, and 7 weighed more than 1,000 grams.

Twenty-one babies were liveborn, 5 of whom weighed > 1,000 grams. Of these 5, 4 died of respiratory distress syndrome (2 of these were twins), and the fifth survived. The other baby to survive weighed 700 grams.

It is notable that of the larger babies (> 1,000 grams) all were born by the vaginal route for presenting by the breech. One of these breech deliveries survived and the other 4 babies all died of respiratory distress syndrome. Traumatic intracranial haemorrhage was not a problem.

NEONATAL INTENSIVE CARE UNIT

DR. T. MATTHEWS

Seven hundred and seventy-three babies were admitted to the Neonatal Intensive Care Unit (N.I.C.U.) during the year. Table 1 shows a breakdown of these infants by fetal maturity with the outcome. Of the 59 babies delivered at 30 weeks gestation or less 32 survived (54-2%). Of the 186 babies delivered between 31 and 36 weeks gestation 183 survived (98-4%).

Table II shows a breakdown of the infants admitted to the N.I.C.U. by weight. This table shows that 30 babies were delivered weighing less than 1,000 grams and 12 of these survived (40%). Between 1,001 gms. and 2,000 gms. there were 94 babies with 84 survivors (87-2%).

It must be stressed that these figures have not been corrected for congenital abnormalities. Some babies with major congenital heart disease were transferred to other hospitals and their subsequent course is unknown. Nevertheless it can be said that these results are a useful yardstick against which to judge obstetric intervention in pregnancies where severe fetal compromise is involved. With a survival rate of 98% for fetal maturity between 31-36 weeks it is our policy to deliver these babies if the obstetric complications are severe.

With increased experience in ultrasound the accurate estimation of fetal weight in utero is becoming a reality and as many of our problems are associated with premature labour the decision to treat actively is helped by an assurance that the fetus weighs in excess of 1,000 grms.

TABLE I

Fetal Maturity weeks	*No. of babies*	*Died*	*Survived*	*% Survival*
27 or <	20	17	3	15.0
28-30	39	10	29	74.4
31-33	34	1	33	97.0
34-36	152	2	150	98.7
37-39	212	6	206	96.7
40 and >	316	4	312	98.8
Total	773	40	733	94.7

TABLE II

Fetal Weight (grms.)	*No. of babies*	*Died*	*Survived*	*% Survival*
< 500 grms	2	1	1	50.0
501- 750	8	5	3	37.0
751-1,000	20	12	8	40.0
1,001-1,500	35	10	25	71.0
1,501-2,000	59	2	57	96.7
2,001-2,500	162	4	158	97.5
2,501-2,750	72	1	71	98.6
2,751-3,000	93	1	92	98.9
3,001-4,000	249	4	245	98.4
> 4,001 grms	73		73	100
Total	773	40	733	94.8

During 1981 thirteen normally formed infants weighing > 999 g. born in the Rotunda died during the first post natal week. This group comprises 8 of very low birth weight (< 1,500 g.), 4 term infants dying from asphyxia, and one infant (Case No. 168246) Birth weight 1,880 g. with very severe R.D.S., pneumothoraces and requiring I.P.P.V. and Tolazoline, who died at 42 hours of age from a massive gastric haemorrhage.

The V.L.B.W. group (Case Nos. 169943, 165985, 166447, 166078, 171928, 170873, 170629, 168436) had a mean birth weight of 1,112 g. and gestational age of 27 weeks. Table 1 illustrates some relevant data.

	Birth Weight	*Gest. Age*	*Mode of Delivery*	*Apgar Score*	*Survived (Hours)*	*P.M.*
169943	1,000 g.	27	C.S.	1	1	Normal
170629	1,150 g.	27	Breech	1	11	Normal
165985	1,020 g.	26	2nd Twin Footling Breech	8	11	Cerebral Oedema + + +
170873	1,000 g.	28	Breech	5	10	I.V.H.
166078	1,175 g.	25	Vertex 1st Twin	2	13	I.V.H.
166447	1,050 g.	25	Footling Breech	1	23	I.V.H.
168436	1,450 g.	29	Vertex 2nd Twin	1	41	Moribund from birth
171928	1,050 g.	26	Breech	7	144	-

As can be seen only 2 out of these 8 infants survived longer than 24 hours. In the main these infants were shocked and compromised from birth requiring I.P.P.V. etc. to keep them alive for a few hours. The last infant was the only infant whose condition was reasonably stable on I.P.P.V. until day 5 when clinical signs of I.V.H. occurred.

The four remaining cases in this group (Numbers 165500, 166926, 169684, 168764) were cases of severe intrapartum asphyxia requiring resuscitation at birth and dying from asphyxial damage.

Note: 1 of the 8 above V.L.B.W. deaths were of < 28 completed weeks gestation leaving 6 normally formed infants > 28/52 gestation dying during the year.

PREECLAMPTIC TOXAEMIA

DR. P. KIR WAN

Summary:

(a) Total number of cases ..... Booked = 108, Unbooked = 5

Incidence against total deliveries at all periods of pregnancy (6,841) ..... 1.6 percent

(b) Maternal Mortality ..... Nil

(c) Gross fetal loss ..... Before 28 weeks = 2, Stillbirths = 4, 1st week N.N.D. = 2

Perinatal mortality rate 50.4

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

FETAL LOSS

Stillbirths:

Case No. 166370 — Antepartum Anoxia.
Case No. 168392 — anencephalic.
Case No. 169446 — Antepartum death with maceration only.
Case No. 171182 — Antepartum death with maceration only.

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

Case No. 166498 — Congenital malformations.
Case No. 168246 — Miscellaneous. Acute erosion of stomach and left pneumathorax.

Deliveries 20—28 weeks:

Case No. 166146
Case No. 167049

COMMENT

This table has been considerably altered from previous years. Only those cases where hypertension was associated with proteinuria are included. The reason for this was to concentrate on maternal morbidity as this group comprises the majority of patients requiring hospitalization and treatment. Labour was induced in 46 cases (41%) and 8 of these patients had caesarean sections. 33 patients were delivered by caesarean section (29%). 28 patients required antihypertensive therapy and the standard drug used was hydralazine. There were 9 amniocentesis, including 2 failed attempts. The only special test used to monitor fetal well-being is antenatal cardiotocography. Delivery is expedited only where the C.T.G. indicates imminent fetal demise or a significant risk of maternal eclampsia or C.V.A. exists. Considering the 4 stillbirths, there was one anencephalic and one macerated twin, birth weight 1570 grams, transferred in labour from a county hospital. The two stillbirths which occurred while the patients were under our care weighed 760 grams and 1100 grams and are considered unavoidable. One of the neonatal deaths had multiple congenital abnormalities and the other baby weighed 1750 grams, was delivered bv caesarean section because of an abruptio placenta, apgar score 8 at birth, N.N.D. day 4 from a pneumothorax. One of the two deliveries between 20-28 weeks was a fetus passed in association with a molar pregnancy and the other was a 500 gram macerated fetus.

ECLAMPSIA

DR. P. KIRWAN

(a) Total number of cases 4
(b) Maternal mortality ..... Nil
(c) Fetal loss 1

Case No. 165963. Primigravida. Age 24. Innupta. Uncertain dates. Admitted, 36 weeks. B.P. 150/100. 200 mgs protein/100 mis. Headache and vomiting. I.V. Apresaline 50 mgs given. Eclamptic fit following admission x 2. Fits controlled with Apresaline, Valium and Heminevrin. Spontaneous onset of labour 6 hours later. ARM at 2-3 cms. Thick meconium staining of liquor. Immediate L.S.C.S. Apgars 4 and 7. Baby required intubation. Post-operative progress uneventful. Both mother and baby were well at 6 weeks check.

Case No. 168963. Primigravida. Age 24. Innupta. Untertain dates. Antenatal care uneventful. Admitted at term in labour — duration of labour three hours. B.P. normal during labour. Normal delivery, twelve hours later had an eclamptic fit in postnatal ward. B.P. 120/85. No protein. Further fit five hours later. B.P. 120/85. No protein. Treated with Heminevrin. Uneventful recovery. Referred for neurological opinion. Mother and baby were well at 6 weeks check.

Case No. 169264. Primigravida. Age 29. Dates certain gestation 31 weeks. Transferred from County Hospital with fulminating P.E.T. B.P. 150/110 complaining of headache. Proteinuria 1000 mgm/100 mis. Given 10 mgs Apresaline I.V. Following morning B.P. 180/116 complaining of severe headache, 20 mgs Apresaline I.V. stat. Immediate L.S.C.S. Fresh stillborn infant delivered. Birth weight 1500 grms. Fetal heart present immediately prior to delivery. Post operatively patient had an eclamptic fit, and obstructed airway. B.P. controlled with Apresaline and Eudemine. Post operative recovery normal. Discharged on tenth postnatal day. P.M. Intrauterine anoxia.

Case No. 169966. Primigravida. Age 34. Innupta. Booked at 26 weeks. Uneventful antenatal course until 32 weeks. B.P. 162/95. No protein. Admitted for rest and assessment. At 39 weeks B.P. 230/125. 300 mgs of protein. Headache and visual disturbance. I.V. Apresaline 20 mgs given. L.S.C.S. Baby flat at birth. Apgar 4 & 7. Birthweight 2210 grms. Eclamptic fit three hours post delivery, controlled with Apresoline/Heminevrin and Valium. B.P. 120/90 on discharge. Mother and baby were well at 6 weeks check.

COMMENT

Case No. 1 was a classical eclamptic patient and the timing of delivery in such cases is always difficult. With good anaesthetic and paediatric back up facilities, early rather than late delivery is desirable in order to minimise the risks of hypoxia to the fetus.

Case Nos. 2 & 4 were postnatal eclamptic fits. The low apgar in case No. 4 is difficult to explain as the patient had received no sedation prior to caesarean section.

Case No. 3 must be considered an avoidable stillbirth. Had delivery been effected the night of admission instead of the following morning the outcome might have been different. However the delay was considered justifiable as the patient had undergone a long journey from the country.

PLACENTA PRAEVIA

DR. B. GAUGHAN

Summary:

(a) Total number of cases 36
Incidence against total deliveries
28 weeks maturity and over ..... 0 6 per cent

(b) Maternal mortality 0

(c) Gross fetal loss ..... 1 1 st week N.N.D.

Perinatal Mortality Rate 28

Treatment
Vaginal delivery 1
Caesarean section 35

FETAL LOSS

1st week Neonatal death 168436 2nd twin — Pulmonary Syndrome.

COMMENT

The incidence is relatively constant from year to year but the perinatal mortality has decreased markedly this year.

ANTE PARTUM HAEMORRHAGE EXCLUDING PLACENTA PRAEVIA

DR. B. GAUGHAN

Summary:

(a) Total number of cases ..... 277 — Booked = 263, Unbooked = 14

Incidence against total deliveries
28 weeks maturity and over (6142) ..... 4.5 percent

(b) Maternal mortality ..... Nil

(c) Gross fetal loss ..... 10 — stillbirths = 5, N N D 's =5

""includes two late neonatal deaths.
Perinatal mortality 29

(d) Multiple pregnancies ..... 4 sets of twins
Number delivered by Caesarean Section 50

CLASSIFICATION OF HAEMORRHAGE

	Total	S/B	N.N.D.
Accidental abruption	54	4	4
Accidental unclassified	223	1	1

FETAL LOSS:

Stillbirths 5

165501 — Antepartum Anoxia.
165898 — Antepartum Anoxia.
166270 — Antepartum Anoxia.
170515 — Antepartum Anoxia.
171812 — Antepartum Anoxia.

Neonatal deaths ..... 5 (including late N.N.D.'s)

166069 — Congenital malformation. Late N.N.D.
168246 — Miscellaneous — Left pneumothorax and acute erosion of stomach.
169505 — Congenital malformation — toxoplasmois.
169744 — Intraventricular haemorrhage — Late N.N.D.
170043 — Congenital malformation.

COMMENT

Cases of antepartum haemorrhage in which evidence of retroplacental clot is found following delivery are classified as haemorrhage due to abruptio placenta. All other cases are regarded as unclassified accidental haemorrhage (having excluded placenta praevia and local causes). The incidence has increased again this year. However, it is gratifying to note the marked reduction in perinatal mortality.

MULTIPLE PREGNANCY

IAN J. DALRYMPLE

Summary:

(a)	Total number of cases	56	All twins Booked: 52 Unbooked: 4
	Incidence against total deliveries 28 weeks maturity and over (6086)	0.9 per cent	
(b)	Maternal mortality	Nil	
(c)	Gross fetal loss	12	Stillborn =2 lstweekNND's =3 Late NND's = 2 20-28 weeks = 5
	Perinatal Mortality rate	107	
(d)	Diagnosed antenatally	46	
(e)	Primigravidae	13	
	Multigravidae	43	

FETAL LOSS

STILLBORN = 2

170377 — Antepartum Asphyxia
171182 — Antepartum Death with maceration only.

NEONATAL DEATHS = 3

166498 — Congenital Malformations
168436 — Pulmonary Syndrome
169784 — Pulmonary Syndrome

LATE NEONATAL DEATHS =

168950 — Proteus Meningitis
169464 — Inhalation of Vomitus

20 — 28 weeks maturity = 5

166895 — 370 grams.
169784 — 200 grams.
165985 — 1,020 gram, maturity 26 weeks.
166078 — 1,175 grams and 800 grams, maturity 25 weeks.

COMMENT

The incidence of multiple pregnancy is lower than previous years when it varied between 1 and 1-5 per cent. Perinatal mortality is higher than average being 107 per thousand.

Five of the fetuses lost were considered to be so small or so immature that they have not been included in the Perinatal mortality statistics. In two cases, (166895 and 169784) intrauterine death obviously occurred very early in pregnancy.

On two occasions a macerated twin was delivered at home. Both these patients were unbooked and only admitted to hospital following delivery and, consequently, have not been included in the perinatal statistics.

In case 171182 delivery was achieved by Caesarean section because of recurrent antepartum haemorrhage and hypertension. There was doubt about the fetal heart in this case prior to delivery. In case 170377 an abnormal cardiotocograph was recorded at 37 weeks. When repeated it appeared to be normal but that baby was dead at the time of delivery. Obviously, the second cardiotocograph had not been centred on the affected baby.

There were three first week neonatal deaths in babies of greater than 28 weeks maturity. Multiple congenital abnormalities were present in case 166498 and severe respiratory distress in case 168436. In case 169784 the baby delivered at 29 weeks and died on the second day from a massive intrapulmonary haemorrhage. This baby weighed 900 grams. In case 166078, maturity was thought to be 25 weeks, the babies weighing 1,175 and 800 grams.

Management of multiple pregnancy has remained the same as in the previous year apart from the increase in use of ultrasound in assessment of fetal growth.

INDUCTION OF LABOUR

THE MASTER

Summary:

(a) Total number of cases 482
Incidence against total number of deliveries
28 weeks maturity and over—6086 . . . . . 7.9 per cent.

(b) Gross fetal loss — stillborn = 1; 1st week N.N.D. = 1

(c) Surgical induction of labour 278
Incidence against total number of deliveries . . . . .
28 week maturity and over—6086 4.6 per cent
. . . . . .

Method of Induction

Vaginal Prostin only		200
Vaginal Prostin & Artificial Rupture of Membranes	18	
Artificial Rupture of Membranes only	37	278
Artificial Rupture of Membranes and Intravenous Syntocinon	175	
Vaginal Prostin and Artificial Rupture of Membranes and Intravenous Syntocinon	48	
Oral Prostin only		4
	TOTAL	482

FETAL LOSS

STILLBORN = 1

170427 Antepartum Anoxia

1st WEEK N.N.D. = 1

169684 Intrapartum Anoxia

Indications for Induction:

Postmaturity	173
Psychiatric	2
Small for dates fetus	8
Spurious labour	23
Static or Falling Maternal Weight	19
Maternal Age	26
Poor Obstetric History	15
Hypertension	80
Pre-eclamptic Toxaemia	30
Minor Antepartum Haemorrhage	23
Multiple Pregnancy	10
Patients' Convenience/Geographical	40
Diabetes	4
Abnormal Cardiotocography	2
History of Threatened Abortion	5
History of Infertility	1
Fetal Abnormality	2
Poor Fetal Movements	10
Rhesus Disease	6
Chronic Renal Disease	1
Intrauterine Death	1
Unknown	1
TOTAL :	482

INDUCTION OF LABOUR

COMMENT

Induction of labour is defined as the artificial initiation of labour by means of drugs, artificial rupture of the membranes, or a combination of both. The advent of Prostoglandins has brought a new dimension to the consideration of this problem. Oral or intravenous prostoglandins have, in our experience, unpleasant side-effects but the use of vaginal tablets has proved both effective and acceptable during the past year. The exact dosage used varies between 2-4 mgms. This has led to a relaxation in our strict policy of restricting induction of labour to cases where it is considered that there is a distinct risk of fetal compromise in utero.

Artificial rupture of the membranes was performed on 278 occasions to induce labour, giving a surgical induction rate of 4-6 per cent. Two of the 482 patients who had labour induced lost their babies subsequent to the induction. In case No. 170427 there was confusion about the maturity and an attempt to induce labour with intravenous Syntocinon (as there appeared to be spurious labour) was unsuccessful. This patient was a 46 year old multipara. Case No. 169684 was a 19 year old unmarried girl who was admitted on account of poor fetal movements at 41 weeks and draining a brown discharge per vaginam. She was allowed home and re-admitted 2 days later on account of a poor cardiotocograph tracing. The baby died 2 days following delivery having been born very flat and covered in meconium.

Twelve of the 482 inductions failed to get labour established (2-5 per cent) — one case of oral Prostin; 6 cases of vaginal Prostin and 4 cases of vaginal Prostin accompanied by surgical rupture of the membranes and intravenous Syntocinon. In one case oral Prostin was associated with Abruption of the Placenta. In one other case surgical rupture of the membranes failed to initiate labour in a patient with a previous Caesarean section scar and a repeat section was carried out after the membranes had been ruptured for 24 hours.

VAGINAL BREECH DELIVERY

THE MASTER/DR. B. GILL

Summary:

(a) Total number of cases..... 146
Incidence against births 28 weeks maturity
and over (6,142)..... 2.3 per cent

(b) Gross Fetal Loss 16
Stillborn = 6
1st Week N.N.D. = 5
Late N.N.D. = 1
20-28 Weeks = 4

Total Perinatal Deaths..... 11
Perinatal Mortality Rate..... 75

VAGINAL BREECH DELIVERY

(excluding Breech Extraction)

PARITY	NUMBER	STILLBORN	N.N.D.
PRIMIPARAE -	31	2	3
MULTIPARAE	104	3	1
TOTAL	135	5	4

1 set of twins delivered as breech in this table.

BREECH EXTRACTION

PARITY	NUMBER	STILLBORN	N.N.D.
PRIMIPARAE	3	**1**	-
MULTIPARAE	8	0	2
TOTAL	12	1	**2**

1 set of twins delivered as breech extractions in this table.

FETAL LOSS

VAGINAL BREECH DELIVERY (Excluding Breech Extraction)

STILLBORN

165900 — Intrapartum Asphyxia
169642 — Congenital Malformation
170377 — Antepartum Asphyxia
170458 — Anencephalus
171274 — Antepartum Death with Maceration.

NEONATAL DEATHS = 4

165627 — Congenital Malformations
168950 — Proteus Meningitis — Late N.N.D.
169275 — Congenital Malformation
170873 — Intraventricular Haemorrhage.

20 - 28 WEEKS MATURITY

169256 — Intrauterine death at 28 weeks. Weight 680 grams
165985 — Second twin. 26 weeks maturity. N.N.D. at 1 day. Weight 700 gms.
171928 — N.N.D. at 6 days. 26 weeks maturity. Weight 1050 grams.

BREECH EXTRACTION

STILLBORN = 1

165712 — Antepartum Asphyxia

NEONATAL DEATHS = 2

166498 — Congenital Malformations
169784 — Pulmonary Syndrome

20 — 28 WEEKS MATURITY

169784 - 2nd Twin. Weight 200 grams.

COMMENT

Breech delivery is increasingly coming under scrutiny as a potential cause of perinatal morbidity. The main area of controversy at present is the role of vaginal breech delivery in the management of the small baby — both premature and dysmature.

In Case no. 165900, resort to Caesarean section earlier would have been a preferable management than going for a vaginal delivery in a patient with pyrexia during labour.

In Case No. 170873 the cause of death was a massive intraventricular haemorrhage in a baby weighing 1,000 grams at 29 weeks gestation. It is impossible to be dogmatic about the role of vaginal breech delivery in this case.

Forty of the 146 breech deliveries were managed under epidural analgesia. It is our impression that epidural analgesia facilitates the late first stage and second stage of labour in breech presentation.

FACE AND BROW PRESENTATION

DR. P. KIRWAN

Summary:

(a) Total number of cases ____ 10 — Booked = 9; Unbooked = 1

Incidence against total births
28 weeks maturity and over (6142) . . . . . 0.1 per cent

(b) Brow presentations . . . . . 4 — Primiparae = 2; Multiparae = 2

(c) Face presentations . . . . . 6 — all multiparae

(d) Maternal mortality . . . . . Nil

(e) Gross fetal loss . . . . . Nil

Methods of delivery:

BROW PRESENTATION = 4
Caesarean sections 4

FACE PRESENTATION = 6
Caesarean sections 3
Spontaneous 3

COMMENT

Eight of the patients in this table started labour spontaneously. Two of the brow presentations had labour induced with prostoglandin. Three of the babies had apgar scores of six or less, but in none of the cases was the duration of labour greater than 4 hours. All babies were normal at follow up. The incidence of Face and Brow presentation continues to fall. There were no congenital abnormalities and it is gratifying to be able to report no perinatal loss.

TRANSVERSE AND OBLIQUE LIE IN LABOUR

DR. M. DARLING.

Summary:

Total number of cases..... 7

COMMENT

Five of these 7 cases were delivered by Caesarean section and the other 2 babies were both second twins and had vaginal breech deliveries. One of these babies succumbed having multiple congenital abnormalities.

DISPROPORTION

DR. E. W. LILLIE.

Summary:

(a) Total number of cases 62
Incidence against total deliveries
28 weeks maturity and over (6,086) . . . . . 1.01 percent

(b) Maternal mortality . . . . . Nil

(c) Gross fetal loss . . . . . Nil

(d) Ruptured uterus . . . . . Nil

COMMENT

It is of interest to compare the results shown in this table with those of 10 years ago. In the Rotunda Hospital report for the year 1971, the incidence of cephalo-pelvic disproportion was quoted as 2-4%, more than twice the present figure. Although there was no maternal mortality nor ruptured uterus in 1971, 6 babies were lost giving a perinatal mortality rate of 50. Thus, on first appearances, it might seem that the incidence of disproportion had been halved during the past decade and the outcome for all such cases improved to such an extent that it could not be bettered. However a more complete breakdown of the above figures indicates that all stated cases of disproportion in 1981 were delivered by Caesarean section; 37 cases electively and 25 following various periods of labour. No case of stated disproportion in 1981 was delivered per vaginam; while in 1971, 35 cases (29%) had a vaginal delivery.

The only explanation that can be given to this situation is that a new generation of Obstetricians seldom bothers to detect cephalo-pelvic disproportion during the antenatal period; frequently overcomes it, often inadvertently, with Oxytocin in labour and fails to note it when occasionally heavy traction is required to complete an operative vaginal delivery.

For this table, it means that a comparison of todays statistics with those of yesteryear is practically valueless. In spite of these observations, one can not find fault with the results for the year under review.

In recent years, some writers have suggested that this table might be deleted from hospital reports. There is some justification for this statement as so many cases must remain undetected while others may be incorrectly classified, being delivered by Caesarean section for multiple indications.

The tendency to forego clinical pelvic assessments in the antenatal period must be deplored as many budding obstetricians have little experience in the detection of pelvic abnormalities and associated disproportion. To them disproportion is either absolute or non-existent. Some of them may eventually practice in developing countries where the condition is more common and the panacea of Caesarean section not so readily available, I trust we shall see a return to good clinical teaching in this respect.

PROLAPSE AND PRESENTATION OF THE CORD

DR. P. MCKENNA

Total number of cases	17
Incidence	0.3 per cent
Perinatal deaths	0

Management

Caesarean section	14
Assisted breech	2
Forceps delivery	1

Three of the patients were primiparae

COMMENT

The incidence of cord prolapse has remained constant over the last few years. We are fortunate in not having any perinatal mortality associated with cord prolapse this year.

HAEMOLYTIC DISEASE

DR. P. MCKENNA

Number of cases	24	
Incidence per cent	0.4	
Perinatal deaths	2	
Perinatal mortality rate	83:	1000
Stillbirths	2	
Neonatal deaths	Nil	
Late neonatal deaths	1	
Infants affected	21	
Infants requiring exchange	9	
Number of Mothers under 30 years of age	3	

PERINATAL DEATHS

165501 — Antepartum anoxia
166441 — Haemolytic Disease
169157-(late N.N.D.)

COMMENT

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

There were only three Mothers under thirty with Rhesus antibodies and one of these developed the antibodies during her first pregnancy.

One of the stillbirths was due to abruption and the other, although macerated did not appear hydrophic. The late neonatal death was due to collapse of the baby at 21 days during a top up transfusion.

PROLONGED LABOUR

THE MASTER

Definition: Labour lasting in excess of 12 hours.

Total No. of patients	8	
Incidence	0.1	per cent.
Primigravidae	7	
Multiparae	1	
Fetal Loss	0	
Perinatal Morbidity	0	

166060 B. Age 21. Para 0 $^{+0}$. Failure to progress in labour with breech presentation. Caesarean section performed after 14 hours. Labour managed under epidural analgesia. Birth weight of baby 3,520 grams.
166073 B. Age 22. Para 0 $^{+0}$. Head not engaged after 12 hours labour. Deflexed occipito-posterior position. Labour managed under epidural analgesia. Caesarean section. Birth weight of baby 3,820 grams.
167317 B. Age 24. Para 0 $^{+0}$. Labour induced with Prostin. Rotational forceps delivery after 16 hours labour. Labour managed under epidural analgesia. Birth weight of baby 3,460 grams.
169833 B. Age 19. Para 0 $^{+0}$. Trial of labour. Caesarean section for failure to progress after 17 hours of labour. Labour managed under epidural analgesia. Birth weight of baby 3,620 grams.
170958 B. Age 26. Para 0 $^{+0}$. Failed trial of Vacuum Extractor and forceps after 12 hours labour. Labour managed under epidural analgesia. Caesarean section. Birth weight of baby 4,140 grams.
170963 B. Age 22. Para 0 $^{+0}$. Vacuum extraction delivery after 20 hours labour. Labour managed under epidural analgesia. Birth weight of baby 3,840 grams.
171797 B. Age 30. Para 2 $^{+2}$. Severe shoulder dystocia after 12 j hours labour. Birth weight 5,860 grams.
171946 B. Age 24. Para 0 $^{+0}$. Rotational forceps delivery for deep transverse arrest after 14 hours labour. Labour managed under epidural analgesia. Birth weight of baby 3,760 grams.

COMMENT

Labour was considered to last in excess of 12 hours in eight cases. Seven of these patients were primigravidae while the eighth was a multipara who delivered a 13 lb. baby. All 8 cases were managed under epidural analgesia. The effectiveness of the epidural in relieving the "maternal stress" of labour often lulls the Obstetrician and Midwife into a sense of false security by delaying the decision to accelerate labour. In the 8 cases reported here there was no indication of neonatal morbidity.

FORCEPS

THE MASTER / DR. MICHAEL DARLING

Summary:

(a) Total number of cases 777
Incidence per cent ..... 12.7 per cent

(b) Maternal mortality ..... Nil

(c) Gross fetal loss ..... 7 — Deadborn = 4, 1st week N.N.D.'s = 3

Perinatal mortality rate 9.0

CAUSES OF FETAL LOSS:

STILLBORN

165479 — Intrapartum anoxia.
165922 — Anencephalus.
166989 — Antepartum anoxia.
171276 — Anencephalus.

NEONATAL DEATHS

166926 — Intrapartum anoxia.
169684 — Intrapartum anoxia.
170043 — Congenital malformation.

COMMENT

During the last seven years the incidence of forceps delivery has increased steadily to 18.2% in 1980. The main reason for this was thought to be the increased use of epidural anaesthesia. However, this year sees a dramatic fall by 50 per cent to 12.7 per cent, the lowest since 1970. 3 of the Perinatal deaths were associated with the mode of delivery. In Case No. 165479 continuous fetal heart monitoring and fetal blood sampling failed to diagnose intrauterine hypoxia. While the patient was being transferred to the theatre for a caesarean section on account of failure to progress in labour the fetal heart disappeared. In case No. 166926 earlier resort to forceps delivery was indicated. In case No. 169684 antepartum hypoxia was undetected. Following a rapid labour a very hypoxic baby was delivered. In retrospect this patient should have had labour induced at the time for her initial admission to hospital.

VACUUM EXTRACTOR

DR. B. GAUGHAN

Summary:

(a) Total number of cases ..... 127 — Primiparae = 34; Multiparae = 93; Booked = 127; Unbooked = 0

Ihcidence against total births 28 weeks maturity and over (6142) ..... 2.1 per cent

(b) Gross fetal loss ..... Nil

Indication for Vacuum Extractor:

First Stage of labour-

Fetal distress	7
Failure to advance	3
Maternal distress	1
Total	11

Second stage of labour-

Delay in second stage	92
Fetal distress	20
Maternal distress	3
Hypertension	1
Total	116

COMMENT

The incidence in use of the vacuum extractor has increased markedly this year. This is mainly due to its replacing the use of the obstetric forceps in cases of delay in the second stage of labour.

CAESAREAN SECTION

DR. P. MCKENNA

Total number of cases	419
Incidence per cent	6.9 per cent
Maternal mortality	0
Perinatal deaths	10
Perinatal mortality rate	23.9
Stillbirths	5
Neonatal deaths	5
Primary Caesarean Sections	258
Repeat Caesarean Section	161
Classical Caesarean Section	3

INDICATIONS FOR PRIMARY CAESAREAN SECTIONS

Fetal distress	64
Breech	36
Failure to progress in labour	25
Placenta praevia	19
Pre-eclampsia	18
Abruption	18
Abnormal antepartum cardiocography	15
Prolapse/presentation of cord	12
Transverse lie	10
Cephlopelvic disproportion	7
Infertility/bad obstetric history	6
Face/brow presentation	5
Pelvic tumour	4
Failed induction	3
Twins	3
Rhesus	3
Previous repair	3
Compound presentation	2
Previous myomectomy	2
Failed instrumental delivery	2
Fractured pelvis	1
TOTAL	2

INDICATIONS FOR REPEAT CAESAREAN SECTIONS

Routine repeat	91
Disproportion	17
Failed trial of labour	13
Fetal distress	9
Breech	6
Abruption	6
Toxaemia	4
Abnormal ante-partum values	3
Rhesus disease	3
Bad obstetric history	3
Cord prolapse	2
Brow presentation	1
Failed induction	1
Transverse lie	1
Placenta praevia	1

CLASSICAL CAESAREAN SECTION

There were three classical caesarean sections. Two were done because of prematurity and one because of a transverse lie. In two of the cases it was the patients first caesarean section.

STILLBIRTHS

Primary	165898 — Antepartum anoxia.
	166174 — Antepartum anoxia.
	169264 — Antepartum anoxia.
	171903 — Antepartum anoxia.
Repeat	168385 — Congenital malformation.

NEONATAL DEATHS

Primary	165500 — Intrapartum anoxia.
	168373 — Congenital malformation.
	168436 — Pulmonary Syndrome.
	169744 — Intraventricular Haemorrhage.

Incidence of Caesarean section for the last 8 years

	1974	1975	1976	1977	1978	1979	1980	1981
Incidence	7.0%	7.1%	8.1%	7.7%	8.9%	8.9%	8.1%	6.9%
P.N.M.	27.3	26.2	42.7	35.2	41.3	32.5	33.8	23.9

COMMENT

The incidence of caesarean section has fallen to 6.9%: the perinatal mortality rate associated with caesarean section has also fallen.

Any perinatal death associated with caesarean section is particularly unfortunate. Neonatal deaths associated with prematurity (169744, 168436) or fetal abnormality (168373) are almost inevitable if one is to attempt to salvage any viable fetus. Stillbirths associated with caesarean section may represent a difficult decision knowing the fetus is dead (168385) as it may represent a decision taken in haste due to pressure of immediate circumstances (165898, 169264, 171903).

HYSTERECTOMY ASSOCIATED WITH PREGNANCY

DR. H. MCVEY

170658. Mrs. M. C. Age 35.

This patient had had twelve previous normal confinements apart from a deep venous thrombosis and pulmonary embolus following an abortion in 1973. Subsequent to this she had four normal confinements.

On this pregnancy she first attented the Antenatal Department on the 18th March 1981, her last period being the 3rd January 1981 and the expected date of delivery the 10th October 1981. Ultrasound scan confirmed the expected date of delivery was accurate and the patient was started immediately on Heparin in view of her previous history. Several appointments were made with her for follow up by the Physician but due to domestic difficulties, she failed to attend.

She was admitted on the 20th June 1981 at approximately 28 weeks gestation with right chest pain. A venogram and lung scan proved normal and she was discharged on continuing Heparin therapy. She was re-admitted on the 20th July 1981 with query rupture of membranes but no contractions were preserir. She admitted that she had not been taking the Heparin and she was discharged with arrangements made for this to be done in hospital. On the 28th September 1981 she was re-admitted with a hypertension of 150/90 and on the 2nd October 1981 there was a spontaneous rupture of the membranes with slight contractions. Labour progressed normally and on the 3rd October 1981 at 11.45 hours a male alive weighing 4500 grms was born without incident. At 13.05 hours on that date there was a substantial post partum haemorrhage with collapse and no recordable blood pressure. No suggestion of pulmonary embolus existed and blood transfusion was started immediately. At 03.15 hours on the 4th October 1981 8 units of blood had been run in and clinical condition improved slightly but vaginal loss persisted. Vaginal examination and exploration showed no cause for the loss and immediate laparotomy was decided upon. The laparotomy showed no free blood in the peritoneal cavity and the uterus was found to be very bulky and extremely atonic. A total abdominal hysterectomy and left salpingo-oophorectomy was performed.

By 22.00 hours on the 4th October 1981 her condition had much improved, haemoglobin being 10.8grms, blood pressure 110/80 and the output satisfactory. The patient was started on Wafarin. Her condition slowly improved although her convalescence was stormy but she was found fit for discharge and well on the 2nd November 1981. Both she and baby were in good condition on discharge.

HYSTERECTOMY ASSOCIATED WITH RUPTURED UTERUS

DR. H. MCVEY

169992. M.P. Age 28 years.

This patient had four previous uncomplicated confinements but the last confinement on 12th August 1974 resulted in a classical section at 31 weeks for severe antepartum haemorrhage due to placenta praecia and a transverse lie. On this occasion her last period was on 29th December 1980 and the expected date of delivery 5th October 1981. She was admitted on 31st August at approximately 35 weeks gestation getting regular contractions and extremely tender over the lower uterine segment. In view of her previous history an immediate caesarean section was decided upon. On laparotomy it was found that the bladder stretched almost to the fundus of the uterus with a long haemotoma underneath. On disecting of the bladder it was found that the old classic scar had ruptured and a live male infant could easily be delivered through this. In view of the extremely poor condition of the upper uterine segment, it was decided that it would be impossible to repair this and a hysterectomy was performed. The patient had an uneventful convalescence and was discharged well on 10th post-operative day.

UTERINE RUPTURE

DR. H. MCVEY

165640. M.F. Age 36 years.

This patient first attended the Antenatal Clinic on 9th October 1980. She had had four previous uncomplicated pregnancies of big babies and her final pregnancy was an ectopic in November 1979. She was seen on three occasions at the Antenatal Clinic and when her gestation was 22 weeks it was noticed that the uterus was not palpable and there had been a decrease in weight. Intrauterine death was confirmed by ultrasound. On 10th January 1981 at 15.00 hrs a routine evacuation of products of conception was performed. The cervix was dilated with difficulty and the placental tissue found extremely adherent to the postero-lateral wall. A large amount of placental tissue was removed and there was excessive bleeding. Eventually the evacuation was considered complete and there was no bleeding at the end of the procedure.

At 20.00 hrs the patient's condition had deteriorated and by 22.00 hrs her blood pressure was 80/50 and pulse 135 and she was complaining of some shoulder-tip pain. By this time she had had four units of blood and laparotomy was decided upon as soon as her condition improved. This was done at 00.15 hrs on 11th January 1981 when laparotomy revealed a small well-defined perforation on the back of the uterus. The abdomen was distended and there was approximately 3| litres of blood in the abdominal cavity. At the site of perforation a small well-defined artery was bleeding profusely. This was sewn over with catgut and good haemostasis obtained. At 12.30 hrs on the same day her condition was very much better, blood pressure being 130/95 and electrolyte balance satisfactory. Apart from one days post-operative pyrexia she made an uneventful recovery and was discharged from hospital on 19th January 1981.

167978. P.M. Age 35 years.

This patient's first pregnancy was an incomplete abortion followed by a curettage. Her second pregnancy was a spontaneous delivery of a breech at 31 weeks gestation complicated by a marked hypertension. The third pregnancy was an emergency lower segment caesarean section at 34 weeks, again because of hypertension and C.T.G. showing Type II dips. On this occasion she first presented to the Antenatal Clinic on 5th November 1980. She progressed reasonably satisfactorily until 22nd January 1981 when she developed a hypertension of 170/100 and in view of her previous history it was decided to admit her for rest and fetal monitoring. On 12th May 1981, when the patient was approximately 39 weeks gestation, there was spontaneous rupture of the membranes. On examination clear liquor was draining, the cervix admitted one finger, was long and uneffaced. It was decided to await spontaneous onset of labour. On 13th May 1981 at 10.00 hrs examination to assess progress showed the cervix to be 4 cms dilated and very posterior. The liquor was clear and contractions were getting stronger. At 16.30 hrs the same day the contractions had decreased, dilation of the cervix remained the same and the cervix was almost sacral. Immediate lower segment section was decided upon. A laparotomy revealed the liquor visible through a small window in the old scar approximately 2 inches in length. The scar had undergone dehiscence but the membranes were intact. A male child, weighing 81bs lOoz. was delivered successfully and the ruptured scar sutured with Dexon. The patient made an uneventful recovery and was discharged home on 22nd May 1981.

168527. A.O. Age 29 years.

This patient first presented for Antenatal Care on 29th October 1980, her **expected date** of delivery being 11th June 1981. Her previous history was of a lower segment caesarean section in February 1979 at 43 weeks gestation. The

indication for the section was a failed trial labour, the baby weighing lOlbs 12oz. On 22nd May 1981 no fetal movements were reported and on examination the cervix was closed. On 5th June again no fetal movements were felt by the patient and she was admitted to hospital with a diagnosis of intrauterine death. At 10.00 hrs on 10th June 1981 she fell into spontaneous labour. At 11.43 hrs on 10th June she had a spontaneous delivery of a macerated female infant weighing 1268 grams. Following delivery she continued to bleed and examination under anaesthesia showed that the previous scar had ruptured. Laparotomy showed that the left side of the previous scar had ruptured extending into the vagina for 4 inches. This was repaired in layers and a drain left in the retrovesical pouch. A large intravaginal pack was inserted and this was removed under anaesthesia on 12th June when there was only slight bleeding from the posterior vaginal wall. Another pack was inserted which was removed two days later with no recurrence of haemorrhage. Post mortem examination showed a severely macerated female infant but no congenital abnormalities were present. The patient was discharged home well on 22nd June 1981, 12 days after operation.

171276. A.A. Age 27 years.

This patient's expected date of delivery was 5th October 1981 but as it was an immediate post-pill conception an ultrasound was done. This concluded the expected date of delivery was early in November 1981. Her previous obstetrical history was an elective caesarean section in 1977, the indication being a primiparous breech presentation with pre-eclamptic toxaemia. She first attended the Antenatal Clinic on 4th March 1981, but as she was very much bigger than her dates, an X-ray was performed on 20th August 1981 and the presence of an Anencephalic fetus confirmed. Quinine induction as an out-patient was attempted but this failed and it was decided to leave her alone. On 29th October she developed hypertension and she was admitted to hospital on 2nd November 1981. Prostin induction, allied with Quinine was attempted on 3rd November but there was no success. On 5th November there was a spontaneous rupture of membranes and the following day labour ensued. On 7th November 1981 there was a difficult delivery of an Anencephalic head shoulders following a right cleidotomy. Following delivery omentum was felt in the vagina and immediate laparotomy undertaken. On this there was complete dehiscence of the old uterine scar with extension of the tear down to the left side into the vagina and around the left broad ligament posteriorly. The uterus was repaired in layers and some excision of the omentum performed.

On 8th November 1981 the patient's temperatue was 104, pulse 160 but minimal P.V. loss. A blood culture was done and this subsequently proved negative. On 10th November, again there was a minimal P.V. loss but rigors developed and the question of damage to the left ureter was raised. It was decided to do retrograde catheterisation which was performed on 14th November combined with laparotomy. This showed that the left ureter had been ligated in the base of the broad ligament which was completely disrupted. The left ureter was re-implanted into the fundus of the bladder and the patient put on Septrum, Gentamicin and Flagyl. She went through a rather stormy convalescence but was discharged well on 14th day post-operatively.

POSTPARTUM HAEMORRHAGE

PROF. R. HARRISON

Summary:

(a) Total number of cases (all booked) 275
Incidence against total deliveries

28 weeks maturity and over (6,086) . . . . . 4.5 per cent

(b) Maternal mortality . . . . . Nil

(c) Number of patients transfused 47

Type of haemorrhage and estimated cause:

PRIMARY HAEMORRHAGE (134)

Atonic	52
Adherent placenta	13
Trauma	4
Retained products	4
Unknown	61

SECONDARY HAEMORRHAGE (66)

Retained products	60
Atonic	5
Trauma	1

Unknown Unanalysazied Classifiable 75

COMMENT

The total incidence of Postpartum haemorrhage is approximately the same, the large number of cases whose data classification is negligible precludes further comments but indicate the urgent need for the introduction of proper data collection method in this the most important area of obstetrics.

MANUAL REMOVAL OF PLACENTA

PROF. R. HARRISON

Summary:

(a) Total number of cases (all booked) ... 102

Incidence against total deliveries
28 weeks maturity and over (6086) ... 1.6 per cent

(b) Maternal mortality ... Nil

Indications for manual removal:
Adherent placenta ... 58
"Retained" placenta ... 9
Postpartum haemorrhage ... 3
Detached cord ... 10
Failed ergometrine technique ... 3
Vaginal Septum ... 1
Unknown ... 18

A ssociatedfactors:
(1) Epidural ... 31
(2) Personal patients ... 34

COMMENT

There is a slight decrease in the incidence of manual removal with adherent placenta again the major cause. The high incidence of epidurals suggest as in 1979 that there may be some who in the presence of analgesia such as this do not wait the awful longer time for the natural process of separation to be completed. This may also be a factor in the high numbers involving personal patients of experienced obstetricians.

OUT-PATIENT DEPARTMENT

THE MASTER

	1981	1980
Antenatal	39,941	42,311
Postnatal	2,944	3,830
Gynaecological	5,276	4,686
Dental	*61	193
Varicose Veins	530	685
Minor Operations and Amnioscopy	201	213
Post Operative Attendances	438	619
Medical Attendances	166	364
Family Planning	31	94
Hypertension and Nephrology	272	317
TOTAL	49,860	50,312

Man, Feb, March, April only.

COMMENT

The heavy workload in the Out Patient Department is reflected in the above figures.

Antenatal Clinics are also conducted in Finglas, Ballymun, Kilbarrack and Coolock. There has been a significant increase in the attendances at the Gynaecological Out Patients' Department.

With Mr. Alford's retirement the Dental Clinic has been suspended until such time as a replacement for Mr. Alford is appointed.

It is hoped to establish a Family Planning service in the Hospital in the near future.

DIABETES

DR. M. I. DRURY

Only one clinical diabetic was delivered in 1981.

147492 Age 25. Para 1^{+1}. Diabetic for one year. The patient developed P.E.T. She was induced by rupture of the membranes at 38y weeks and delivered of a living female infant weighing 3,490 grams. The infant was normal.

COMMENT

Our policy is to achieve strict control of diabetes and in the absence of complications to aim for vaginal delivery at term.

THROMBO EMBOLIC CLINIC

DR. EOIN O'BRIEN DR. MARY HENRY

Last year thirty-one patients were seen in the Thrombo-embolic clinic. Of these six were acute cases of deep vein thrombosis and twenty-five patients had a previous history of deep vein thrombosis or pulmonary embolism.

Acute cases of Deep Vein Thrombosis:-

Six cases were seen with signs and symptoms of deep vein thrombosis. Four of these patients were pregnant and the duration of gestation ranged from eight weeks in one case to thirty-four in another. There were no obvious reasons why these women developed deep vein thrombosis. Two patients were post-partum. In one case the symptoms developed on the fourth day after delivery but in the other case the patient was trouble free until six weeks post-partum.

Patients seen for Prophyllactic Treatment:-

Twenty-five patients were treated for prophylactic reasons. All were given subcutaneous heparin, self administered, in doses ranging from 5,000 I.U. b.d. to 10,000 I.U. b.d. Six patients had had deep vein thrombosis during a previous pregnancy. In two cases there had been episodes of thrombosis during two and three pregnancies respectively. In eleven patients the episode had occurred in the post-partum period, again in some cases on more than one delivery.

The remaining five patients had interesting histories. One patient had a Deep Vein thrombosis while on the "pill". She was only 21 at the time, did not smoke but her blood group was A positive.

The next case was a woman of forty-five, Gravida nine who had developed a deep vein thrombosis in her right leg seven years before while in hospital for treatment of pulmonary tuberculosis. She was a non-smoker and her blood group was A positive.

The third case, age thirty-six, Gravida seven, said she had a deep vein thrombosis during treatment for a giant cell tumour nine years before. Unfortunately, we were unable to confirm this with the hospital in question. She was a non-smoker and blood group A.

The fourth patient, age thirty-five, Gravida six, developed a deep vein thrombosis five years before when in hospital for investigation of rectal bleeding. Her blood group was O positive and she was a non-smoker.

The last case, a patient, aged thirty-eight, Gravida four had had a pulmonary embolus twenty years before following an accident while playing hockey. She had had some oedema in her left leg for many years. She had smoked twenty cigarettes daily, but had stopped when she became pregnant. Her blood group was B positive.

All acute cases were satisfactorily treated and those on prophylactic treatment did not have a recurrence of thrombosis.

We would like to thank Sister Nealon and her staff for their help in the Clinic, the Master and his staff for referring cases early to the Clinic, Sister Walsh and the ante-natal staff for instructing patients in self administration of heparin and the Radiology Department in the Mater Hospital for their continued co-operation.

VARICOSE VEIN CLINIC

DR. MARY HENRY

As in recent previous years the most remarkable feature of the patients attending the varicose vein clinic has been that their venous insufficiency is much less serious than some years ago. The fact that so many patients attending the hospital are younger and of lower parity* is probably the reason for this improvement.

Two hundred and fifty-six patients with varicose veins attended the clinic. Of these only thirteen were over forty years of age and one third were on their fifth or subsequent pregnancy. Most of the patients were in their late twenties or early thirties and on their third or fourth pregnancies. One hundred and fifty-two patients with uncomplicated varicose veins attended. One patient had a varicose ulcer which was present before she became pregnant and two had varicose eczema. All were satisfactorily treated before delivery.

Superficial phlebitis was a problem both before and after delivery. This year there were twenty-two cases. Thirteen of these cases were post partum and only one of these patients had been referred to the varicose vein clinic before delivery even though all had varicose veins, some quite extensive.

Painful vulval varices were the presenting problem with fourteen patients. These were treated symptomatically. Patients were advised to wear a panty girdle and to avoid standing. All reported a considerable improvement in symptoms with this advice.

Seven patients with lymphoedema to a lesser or greater extent were seen and advised to wear elastic stockings. All these patients had a problem with oedema before pregnancy but it had increased during the pregnancy. Painful angiectatids were the main complaint in four cases. Reassurance that these would improve greatly on delivery and would be helped in the meantime by wearing elastic stockings sufficed in all cases. One patient with a pain in her leg for which no reason could be found was seen and one woman had a lipoma in her thigh.

It is very encouraging to see the improvement in the general condition of the patients but it would be very helpful to see all patients with varicose veins early in pregnancy to try to prevent the development of phlebitis and other complications.

May I once again thank Sister Nealon and her staff for their co-operation and help, the Master and his staff for referring the cases and Mrs. Daly for her help and cheerfulness in the clinic.

PSYCHIATRIC CLINIC

DR. MARY MARTIN

During the year 1981 there were 416 attendances at the Out-Patient Clinic of whom 47 were new referrals. In 1980 the figures were 425 and 58. In addition 156 patients were seen in the wards of whom 49 were new referrals. The corresponding figures for 1980 were 108 and 33.

The pattern of illness does not alter much from year to year. Depression associated with anxiety, i.e. neurotic, atypical or reactive depression, was the commonest diagnosis. Pure endogenous depression, mania, and schizophrenia all occurred occasionally Quite a number of patients presented with anxiety states often with phobic features. Other patients were seen because of personality disorders or mental handicap.

Many patients had marital problems and there was a high incidence of social stress.

The highest proportion of patients were referred during pregnancy directly from the Antenatal Clinics. In some of these, their General Practitioner had requested psychiatric consultation. In other patients symptoms started during the puerperium. A small proportion of patients were referred directly from the Gynaecological Clinics.

Treatment of psychiatric illness obviously varies according to diagnosis. An important part of it with every patient, however, is providing adequate time to take a reasonable history (including family background, early years and upbringing, stressful life events, quality of marriage, social problems, basic personality). She is encouraged to discuss any worries or problems. Such an interview is time-consuming but often has a beneficial effect before any other specific treatment has been suggested.

Ideally the Antenatal Clinics should afford the same time for the Obstetrician to assess the psychological status of his patient. This, combined with reasonable privacy for the interview, and continuity of care from one Obstetrician, would add considerably to the quality of antenatal care given to each patient.

SEXUALLY TRANSMISSIBLE DISEASES

DIAGNOSTIC CLINIC

DR. W. H. VERLING

Admissions to the Diagnostic Clinic 1981

No Infection	3
Herpes	1
Gonorrhoea	1
Trichomonal	1
Chlamydia	1
Warts	3
B.F.P.	6
Total	14

Notes:

1. B.F.P. = "Biological False Positive" serology for Syphilis.
2. The total is 14 as the same patient had Gonorrhoea and Trichomonal.

There was no case of Syphilis admitted to the clinic during the year, which is very gratifying, as is also the fact that there was only one case of Gonorrhoea. This gives a total of one case of Venereal Disease as all the rest of the infections are classified as Non Venereal.

This case of Gonorrhoea, and the single case of Chlamydial infection were both diagnosed in ante-natal patients. For this reason it was especially advantageous that the diagnoses were made.

The lone patient with Herpes was from the Gynaecology clinic and the infection was not on the cervix.

Of the 3 patients with Papilloma Accuminate one was from the Ante-natal clinic and was not treated until after delivery, as the warts did not recede after delivery.

Contact tracing was carried out in all cases. Only one contact being found to be infected and that was in the case of Chlamydia infection.

ULTRA SOUND DEPARTMENT

DR. G. MCCARTHY

Total number of Scans	7,026
Total number of Patients	6,037
Diagnosis of pregnancy	127
Prior Shriodkar Suture	25
Miscellaneous	394
Blighted Ovum	38
Foetal Heart	92
Retained Products	263
Ectopic Pregnancy	13
Fibroid	42
Cyst	91
Hydatidiform Mole	12
Foetal Abnormality	15
Serial B.P.D.	57
Maturity B.P.D.	4,658
Multiple	56
Presentation	20
Placental Localization	865
Intra-Uterine Death	36
Amniocentesis	62
Abdominal Ratio	10
I.U.C.D.	16
Liquor Content	98
Hydramnios	25
Double Uterus	1
B.O.H.	3
Kidney	1
Cord Presentation	1

COMMENT

The number of Ultra-Sound examinations continue to increase annually with at present, no increase in staff. While there is pride in the service given by the staff, we feel that unnecessary scans are requested by many doctors — thus increasing our numbers while not increasing our efficiency. Ideally, the department wishes to employ more time on specialized scanning i.e. Ovarian, Neo-Natal Brain, Anomalies, etc.

We have had many interesting cases this year of which the following act as illustration;

(1) A patient presented with bleeding which had persisted despite two recent curettings at another hospital.
The scan showed a double uterus, one section full of retained products. This showed that the wrong cavity had been curetted.

(2) Cystic lung anomolies in two second trimester foeti.

(3) The outlining of a patient's kidney which had been thought to be absent following retrograde pyelogram. It was subsequently realized that a ureter had been severed during an emergency operation.

(4) A cord presentation was noted on routine scanning at 38 weeks. The patient was admitted immediately, spontaneously ruptured her membranes 12 hours later - and the baby was saved as a section was performed without delay, due to previous knowledge of the cord presentation.

We hope (1) To have more machines in 1982 and have already reviewed Real-Time and Sector scanners both in Ireland and Scotland with this in view.

(2) To have more fully trained personnel so that specialised sessions may be possible in the foreseeable future.

I would like to take this opportunity to thank Staff Nurse O' Keeffe for her continued excellent work and support, also our new secretary Mary Mohan who is an efficient and pleasant colleague - and finally to the Master for his interest and efforts to advance the Department.

BLOOD TRANSFUSIONS

(Maternity Patients only)

PROF. ALAN D. H. BROWNE

(1) CONDITIONS FOR WHICH BLOOD TRANSFUSION WAS GIVEN 1981

Indication for Transfusion	*No. of patients transfused*	*Total stored units*	*Total packed cells*	*Single unit transfusions*
C-Section	52	116	4	9
PPH	54	117	4	7
Anaemia	34	27	59	0
Abortion	17	37	4	1
APH (not sectioned)	6	20	0	0
Caesarean Hyst.	1	15	0	0
Ruptured Uterus	3	18	0	0
Vulva Haematoma	1	0	3	0
Hydatidiform Mole	1	2	0	0
Total	169	352	74	17

TABLE 2

Indication for transfusion	*Patients Transfused*		
	1979	1980	1981
PPH	60	72	54
Abortion	19	26	17
Anaemia	32	31	34
C-Section	73	64	52

TABLE 3

Indication for transfusion	*Stored Units*			*Packed Cells*		
	1979	1980	1981	1979	1980	1981
PPH	129	178	117	5	4	4
Abortion	52	65	37	2	0	4
Anaemia	18	25	27	60	45	59
C-Section	206	153	116	2	0	4

TABLE 4

Year	*Patients transfused*	*Stored units*	*Packed cells*	*Single units*	*Deliveries before and after 28 weeks*
1979	203	464	69	16	7,064
1980	213	514	56	14	7,196
1981	169	352	74	17	6,841

COMMENT

(1) The excellent services of the NBTSB was unfailingly satisfactory, for which their Director Dr. J. P. O'Riordan and his staff are to be thanked and congratulated.

(2) There has been a satisfying reduction in the number of patients requiring blood transfusions in the management of PPH, Abortion, and Caesarean Section. The number of Anaemia cases stands about the same. The use of stored blood for such cases has remained about the same, and there is a satisfactory increase in the use of packed cells.

(3) Single unit transfusions have slighly increased, mainly in connection with Caesarean Section and its management.

(4) C-Section, PPH, and Anaemia head the list of indications for blood transfusions, and its use in management of abortions is declining. Talk of return to domiciliary delivery should take full account of the continuing occurrence of PPH, which in such circumstances would almost certainly take a toll of maternal lives, in the absence *of* promptly available blood transfusions. Too little is heard of the facets of the problem.

PATHOLOGY DEPARTMENT

DR. D. E. MELLON

Haematology:

Haemoglobin	25,872
P.C.V.	1,348
White Cell Counts	1,152
Differentials	756
Platelet Counts	156
E.S.R.	384
Reticulocyte Counts	36
Prothrombin Times	108
Partial Thromboplastin Times	48
F.D.P.'s	12
Fibrinogen Titres	12
Heparin Levels	132
Total	30,016

Serology:

A.B.O. Groups	12,675
Rh. Groups	12,675
Antibody Screens	11,301
Direct Coombs Test	1,374
Kleihauer	954
Antibody Investigation	631
Titres	116
Genotypes	94
A.B.O. Antibody Screen	230
A.B.O. Immune Antibody Investigation	70
Du. Investigations	2,052
Investigation of Febrile Transfusion Reaction	7
Total	42,179

Two of the Febrile Transfusion Reactions were due to White Cell Antibodies. No cause was found for the remainder.

Transfusion Service:

No. of Units received from Blood Bank	1,045
No. of Units returned to Blood Bank	157
"Wastage"	15%
No. of patients X-Matched 3,	240
No. of X-Matches performed	6,447
No. of Anti D Gamma Globulin issued	990

The reduction in the "wastage" of blood was due to the introduction of improved Serological techniques which enabled us to introduce a "group and hold" procedure for certain catagories of patients and so reduce the number of units held for emergency use.

Cytology:

Total No. of Smears received	6,521
No. diagnosed as malignant	30(0.46%)
No. diagnosed as dyskaryotic	58(0.89%)
Details of malignant smears:	
Age: Youngest:	27 years
Oldest:	72 years
Marital Status: Single:	2
Married:	28

Of the 30 women with malignant smears 3 were treated without further Laboratory investigation and 4 are still under consideration, and of the remainder, histological examination confirmed that:

4 had severe dysplasia of the Cervix.
17 had carcinoma-in-situ.
1 had an adenocarcinoma.
1 had an invasive squamous carcinoma.

Histology:

Autopsies: Infants	99
No. of Paraffin Blocks (Autopsies)	299
Surgical specimens	2,488
No. ofParafin Blocks (surgical)	4,704
No. of Carcinomas diagnosed	35
(a) Endometrium	12
(b) Cervix	16
(c) Vulva	2
(d) Ovary	1
(e) Vagina	
(0 Others	2

There were 8 patients with dysplasia and 9 patients with hyperplasia during 1981.

Biochemistry:

Total No. of specimens received	7,140
Total No. of Biochemical Tests carried out	12,590

These numbers are marginally increased over 1980. 40% increase was seen in electrolytes, sugars and bilirubins while oestrogens and L/S Ratios decreased by 50%. In the last 5 months of 1981 the numbers of Calcium and Magnesium performed increased slightly.

Bacteriology:

Routine Specimens cultured	6,754
Routine Sensitivity tests	876
Routine Urinanalysis	6,624
Routine Urinanalysis — Cultures	2,347
Routine Urinanalysis — Sensitivities	608
O.P.D. Bacteruria Tests	4,669
Semen Analysis	398
Pregnancy Tests	6,754
Total	29,030

Application was made during the year for extra staff to deal with increased demand for Cytological screening. When it was rejected it became necessary to cease examining specimens from certain categories of patients. This has controlled the work load but at the risk that an early cancer will be missed in one of our patients.

Once again the laboratory staff are to be thanked for their cooperation in maintaining the service and particularly for their willingness to operate the voluntary "on-call" system after normal working hours.

ANAESTHETIC DEPARTMENT

DR. J. GARDINER

	General Anaesthesia				
	197.7	1978	1979	1980	1981
Total	3,659	3489	3,570	3,476	3,308
Between 21.00 - 07.00 hrs.	620	414	485	449	628

During the year Dr. W. P. Blunnie was appointed from Belfast to replace Dr. D. Bohn. We are delighted to welcome him and wish him every success.

We were very happy to have Drs. P. J. Breen, C. Bacon, D. Murphy, B. Nally, and M. O'Nolan rotate through our Department and wish them all well.

This year we record a more comprehensive breakdown of our epidural service, specifically the mode of delivery and maternal complications.

	Epidural							
	1974	1975	1976	1977	1978	1979	1980	1981
Total	64	164	594	1010	877	1128	1243	894

Total = 894

428Primiparous(48%)
466 Muciparous (52%)

Mode of Delivery	*Primiparous*	*Multiparous*
Spontaneous	134(31%)	263 (56%)
Wrigleys Forceps	194(40%)	146(31%)
Rotation Forceps	.42(10%)	14(3%)
Vacuum Extraction	18(4%)	22 (5%)
L.S.C.S.	40(9%)	21 (4%)
Breech	14 (3%)	24(5%)
Twins	2 (0.5%)	6(1.3%)
Stillbirths	5(1%)	2 (0.4%)
N.N.D.	2 (0.4%)	1 (0.2%)
Admitted to Paediatric Unit	28 (6.5%)	30 (6%)

The stillbirth and N.N.D. babies are detailed in the fetal loss section.

Reference: 171393 — Antepartum death with maceration only.
171276 — Anencephalus.
165922 — Anencephalus.
167754 — Anencephalus.
168422 — Antepartum asphyxia.
170937 — Antepartum asphyxia.
170458 — Anencephalus.
166926 — Intrapartum asphyxia.
165870 — Anencephalus.
165627 — Congenital malformations.

Of the babies admitted to the Paediatric Unit, one was subsequently transferred to Our Lady's Hospital, Crumlin, one subsequently a cot death; one in each group admitted was a rotational forceps, one in each was a vacuum extraction. There were four from the L.S.C.S. group and 19 had spontaneous vertex deliveries. All are reported doing well.

Maternal Complications

Three mothers had urinary problems. All were primips. One needed suprapubic cathetherisation. It is impossible to know who is going to get problems but there is no doubt that proper bladder emptying is a major factor in preventing its occurence. All were completely satisfactory on discharge.

Five mothers had headache after inadvertent dural puncture. Four needed a blood patch, before the headache was completely relieved.

There were a few mothers who perhaps has some slight regrets about having the epidural when they had time to reflect afterwards. There really is no way of recognising this type of patient beforehand and even if there were it is difficult to imagine explaining this as a contra indication to a mother in strong labour that might be getting out of hand.

There were no cases of prolonged effect of the epidural. Complications were minimal and I believe benefits were maximal.

SOCIAL WORK DEPARTMENT

During the year 1981, six thousand nine hundred and eleven interviews with patients and their relatives were carried out by our staff.

With the increasing caseload of single mothers and of extra-maritally pregnant patients, less time was available for those with other social difficulties.

Patients having illegitimate pregnancies numbered 1,122, of whom 60 had no ante-natal care and were admitted to hospital unbooked; there were 353 late bookings, leaving 1,062 who attended before the 20th week of pregnancy. The majority (813) originated from Dublin city and precincts; the remainder were from Irish rural areas (272); Northern Ireland (12); Great Britain (16); other European countries (7); United States (1); Asia (1). One or both parents were aware of the pregnancy at the time of first antenatal attendance for 66.5% of the patients seen.

The following three tables illustrate some of the statistics enumerated:-

Table I *Socio-economic groups*

	Professional/ Managerial	White Collar	Skilled Manual	Semi-skilled Manual	Unskilled	Never worked	Ex School	Nil known/ elicited
Patient	27	315	146	222	361	24	18	9
Putative Father	32	165	253	173	291	15	5	188

Table II *Civil Status*

	Single	Married	Married & Apart	Widowed	Not known 1 or elicited
Patient	1,043	1	68	10	
Putative Father	911	12	69	3	127

Table III

Ages			Gravida (relating to illegitimate pregnancies only)			Relationship with Putative Father					
oo c o	Oldest	No. Teenage	One	Two	Three +	Stable	Unstable	Casual	Co-habitee	Engaged	Nil known
>*14	47	**450 (40.15%)**	877	159	85	304	3	62	158	217	39

Whilst the number of patients already engaged at the first visit showed little increase on last year, known co-habitations increased from 11% to 14% of the total. Many such liaisons existed because one of the parties had a failed marriage and in the absence of civil divorce could not legalize their situations and their main reason to see the social worker was to clarify the situation about birth registration. Heretofore, it had been obligatory for a married woman extra-maritally pregnant to register her husband's name as the father of her child, unless a High Court Order ruled otherwise; it became possible in 1981 for

the mother to leave blank the column of the entry which provides for the father's particulars without reference to the Courts. However, in these situations a Court Order was still necessary if the natural father wished his name to go on the register.

The outcome of the 1,122 illegitimate pregnancies was as follows:—

Live illegitimate births in 1981	608
Confinements in 1981, patient having married during pregnancy	107
Abortions/miscarriages in 1981	37
Stillbirths in 1981	10
Transferred elsewhere for confinement	21
Not pregnant	2
Did not return to Rotunda	36
Undelivered 1981	300*
Patient died in fire, antenatally	1
Total	1,122

*Of the 300 undelivered in 1981, at least 65 married subsequent to their initial attendance at the hospital.

Of the 608 illegitimate live births there were 12 neo-natal deaths. The outcome of the remaining 596 was as follows:-

Kept by patient	505
Placed for adoption	71
Uncertain	20
Total	596

The rate of illegitimacy in the hospital further increased with the percentage of illegitimate live births known to our department being 10. (The rate for the entire country is only available for the first three quarters of 1981 (i.e. 4 9, 5 4 and 5-7).

The proportion of girls and women keeping their babies was 85% of the total live births, 12% opted for adoption (i.e.71 babies), 3% were ambivalent and temporary care became necessary, a matter causing social workers here and in the community much concern, for it ill-befits an infant not to be bonded early and permanently.

Publicity and pressure came to the fore in the establishment of three groups concerned with the trail for termination of pregnancies to other countries - "Life" an off-shoot of the British group, "Prolife" and the "Society for the Protection of the Unborn Child". It is a cause for concern that despite the activity of these organizations, the real needs of single pregnant mothers are being so poorly met and little has been achieved in understanding or getting to underlying factors exacerbating the problem. Society's attitudes continue to be hypocritical and regressive, sex being isolated from deep and loving human relationships, so often parental attitudes driving girls to seek to have their pregnancies terminated. In practice, the lack of housing and other basic living needs and of counselling services, is grave. Most agencies offering such services are short-staffed. Witness the organization, Cherish, having, on financial grounds, to halve its professional social work staff. Practical helping measures, making it possible for all parents to stand by their daughters without fear, could do much more to preserve the lives of the unborn than constitutional and legal exercises which will not reduce the flight for terminations.

The continuing worsening of the country's economic situation, with real output decreasing and losses in competitiveness with E.E.C. countries gave rise to serious recession, yet with a rising standard of living. Higher taxes impinged

on those working, whilst higher prices affected everyone, especially the dependent population. The percentage of insurable workers registered as unemployed in the Dublin and Dun Laoghaire area was 10 5 (8 5 in 1980). Due to cut-backs and a resultant slowing down on the provision of municipal houses, as well as to spiralling interest rates, many young cpuples had to commence married life sharing with relatives, thus making them even more vulnerable to marital and relationship stresses. In the private sector there was discrimination against couples with children; rents, too, were exorbitant, hence the pressure on local authority waiting lists became greater than need be.

The Task Force on Child Care Services, established in 1974, published its final main and supplementary reports on the improvement in services, children's legal rights and administrative structures. A completely new approach was evident based upon considerations and principles which will mean a radical reorganization of services for children in Ireland. The Department of Health commenced the draft of a Children's Bill which when enacted will supercede the present Children's Act (1908).

During the year there was a steady stream of enquiries from people born out of wedlock in this hospital prior to the operation of the Adoption Act 1952. Most of these spent their early life in institutions or with a series of foster parents and had no secure base for development. The common request was to trace their mothers. The assurance of confidentiality by the hospital to their mothers made the disclosing of definite information impossible. It was necessary to give much time to those making such requests. One could not fail to consider more sympathetically the rights of the illegitimate child or adult to have information about his or her natural parents. The dilemma has continued to exert our minds as to a wise solution.

A new and additional Maternity Allowance Scheme connected with Maternity Leave under the Maternity Protection of Employment Act came to operate in April 1981. In effect, the 14 weeks benefit is based on 80% of the woman's previous year's taxable pay. Whilst advantageous for a minority of patients, this was an extravagant political measure and would seem to have augured poorly for the infant, the employer, and the revenue. For those women who did not wish to return to work post-natally the 12 weeks Pay-Related Maternity Allowance still existed. The new legislation also gave entitlement to time off from work for ante-'and post-natal appointments.

Useful constructive criticism and concern was voiced in the media about maternity services, especially those pertaining to hospitals. Bearing in mind that pregnancy is a period of crisis, of susceptibility to upsets for many women, the importance of having their apprehensions and curiosities dealt with in relaxed, homely and unhurried surroundings should be planned for in any new complex. Perhaps the environment of most maternity hospitals is too clinical and seemingly unfriendly, the production-line element being apparent. The Rotunda has suffered more than most in the shortage of space, and with archaic conditions in many areas and yearly postponement of the building of a new complex.

A conference "Death, a Part of Life" held in St. James' Hospital in June, gave us much food for thought in the management and care of the bereaved, be this through miscarriage, stillbirth, neo-natal death, physical or mental handicap, or the giving of a child for adoption. The practice of transferring mothers, who miscarried or had stillbirths, to an isolation ward or to the Gynaecological Section, although well-meant, would appear to emphasize the feeling of failure and preclude the healthier expression and working through of grief in a maternity ward. The need not to be over-protected is vital. The importance of having the opportunity to see the infant, bearing in mind the difficulties in grieving for someone never seen, the involvement in burial arrangements, of helping the father and other children were all vital facets in bereavement counselling. It is appropriate here to voice our appreciation of Messrs. Fanagan, our Undertakers for the sensitive and kindly service that

they provide. Counselling in the post-termination of pregnancy period took place in a few instances during the year. The circumstances surrounding the often-panic procedure hastily carried out makes counselling a vital part of the maternity social workers role when such post-termination patients came under the hospital's care.

Many of our patients from the Rotunda catchment area were bereaved or affected by the Stardust Disco fire in February. One ante-natal patient was amongst the 48 who died.

As well as our work relating to Obstetric, Paediatric, Gynaecological, and Psychiatric patients in the hospital, we liaised more often by telephone than personally with the Drumcondra Annexe. A special word of thanks goes to Sister Thornton and her Staff Nurses there for their forbearance when we could not visit as regularly as we would have wished.

Within the hospital, Dr. G. R. Henry commenced his term of office as Master. His understanding of, and ready help with, many difficult social situations has been greatly appreciated.

The launching of the long-requested hospital information booklet took place in June. This has proved to be a most valuable adjunct to the hospital service.

We became involved in Parenteral groups, giving brief talks to the patients on benefits, registration of births, etc. with an invitation to any patient to call and see us privately regarding any more personal problems. This has been a useful opportunity for patients to get to know of our existence as part of the hospital team, particularly because for many years it has not been possible to see every ante-natal patient on her first visit to the hospital.

From time to time, we have received gifts of adult and children's clothing and footwear; whereas this was occasionally required in emergency situations, it was inappropriate that we should store large supplies, primarily on account of putting emphasis on "hand-outs" to entire families, also because of absence of storage space. We have been, thus, most grateful to the Social Aid Centre of the Dublin Central Mission, where an extremely well organized clothing depot exists, for taking our surplus donations and in turn acting as an agent to help those who are referred.

Our supply of infant clothing at base continues to be necessary. Our Infant Clothing Fund and Samaritan Fund Committees met these needs. To the latter Committee we have appreciated the opportunity to consult with them when difficult economic situations made quite substantial financial aid necessary as a temporary and rehabilitative measure. To both Committees I, or one of my colleagues, report at regular meetings.

The financial backing of the Friends of the Rotunda has kept both our charitable committees solvent. We are greatly indebted too, to the Council of the Hospital Saturday Fund for a donation of IR£360 which was divided equally between the Infant Clothing Fund and the Samaritan Fund. The trustees of the Glorney Fund donated IR£ 1,000 to be used in particular cases recommended by the Medical Social Workers. All these kind financial backings have greatly aided our working, particularly when there was need for prompt action, thus long bureaucratic decision-making delays have been avoided.

Teaching

Lectures/Tutorials were given to medical students, post-graduates, pupil-midwives, public health nurses and physiotherapy students. Two social studies undergraduates (from Trinity College and University College, Dublin, respectively) carried out field-work placements in the Department. We were involved in regular meetings of the National Association of Practice Teachers.

There were no changes of staff within the Department. In organizing and providing a social work service for patients under this hospital's care, I have greatly appreciated the skill and support of my two colleagues, our two secretarial assistants and the helpful collaboration from other members of hospital staff, as well as the many statutory and voluntary agencies that we liaise with in the community.

Eleanor A. Holmes.

PHYSIOTHERAPY DEPARTMENT

During the month of March we moved to our new Department on the ground floor, more spacious and more convenient for our Mums. Improved facilities coupled with this move allowed us to put into practise a more comprehensive programme of education. This programme is run jointly by Midwife and Physiotherapist. It is very satisfactory to report that these joint classes are running smoothly. We are appreciative of the contribution by the Medical Social Worker, Dietician and Hospital Consultant. In spite of the extra curriculum it is some what disappointing to record that our percentage of primigravida attending our classes (income less than 9j thousand pounds) is lower than the year 1980, 44% in 1981 as compared with 50% in 1980. This can be explained by the fact that the turnover of classes is less — period of course prior to 1981 was 6 weeks, our new course i*8 weeks. It is also sad to record that the percentage of fall-out is higher. Of course, it is too early to draw any conclusion yet but might it be that our new programme is too ambitious? Areas we will have to give some thought to in the future are:-

(a) Number of visits to classes during pregnancy.
(b) What are the mothers actual needs and expectations during pregnancy and labour.

Expectant mums are concerned only with pregnancy and labour. They find it difficult and almost impossible to relate to "after the baby". This is a natural phenomenon of living:- "sufficient unto-the-day". Added to this natural phenomenon is the increasing number of expectant mums continuing with their career or study — their career or study absorbing so much of their energies, emotions and time. They cannot afford the luxury of relaxing into or indeed allowing themselves to be absorbed by the moods and emotions in one of the most important times in their lives. This is very sad. They miss a time of looking forward, a time of mentally tuning into their baby in-utero, a time to understand the natural swing of mood and emotion, a time for growth. Important dates now are: — finishing work, — time off, — going back to work. The role of woman is being diminished by this "Rat Race" or "New Liberation" and not enhanced as many feminists would wish us to believe.

The relationship of mother and child is surely affected. Society frequently deplores the effect on the child and tends to forget that the mother equally suffers. Very few mothers are so career orientated that they would prefer to return to work. Most have no choice. Society has created this false emphasis on material commodities, has created much demands and set such unrealistic high expectations on our youth. These are now as millstones rather than what one would have hoped gems of freedom. Only society can change this trend by demonstrating that the most important unit for stability and emotional security is the family.

Community Physiotherapy

It is satisfactory to record an expansion of our services in the community. Classes'commenced in conjunction with the respective Public Health Nurse in the Health Centres, Coolock - Kilbarrack. We are indebted to the Director of Community Care Dr. Brian O'Herlihy and also to the Health Education Co-ordinator Miss Nora Sheehan for their co-operation and support. Hopefully classes will be introduced into the Health Centre — Ballymun 1982. This is an aspect of our work we enjoy co-operating closely with the health team and meeting the young mum in her own environment. Finglas classes continue to flourish and the department wish to thank Mrs. Helen Brophy-Macken Health Education Co-ordinator in this area for her support and vast experience.

Paediatrics — Mrs. Anne Murphy M.C.S.P.

Total number of treatments

	Chests	Torticollis	Feet	Erbs	Neuro
1980	291	58	143	1	99=592 Total
1981	595	52	186	1	73 = 907 Total

We are happy to note an increased awareness in the role of the physiotherapist in the treatment of neonatal conditions. This is demonstrated most markedly in number of referrals of chest physiotherapy which has virtually doubled since last year but there is also an increase in the number of minor congenital feet deformities attending the physiotherapy department. The number of treatments given for torticollis has slightly decreased since last year, however we feel that this is due to the fact that these babies are being referred to us at an earlier age and are thus responding quicker to treatment. However, for the second year running there has been a large decrease in the number of babies 'at risk' receiving physiotherapy, 1980 was down 29% on 1979 and 1981 down a further 26% on 1980. These figures are causing us some concern as early treatment of these babies is vitally important to prevent abnormal patterns of movement developing. Physiotherapy treatment for the baby the best way to perform all normal activities, i.e., dressing, feeding, sleeping positions, etc., to facilitate development of normal movement patterns.

Gynaecological Department

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

Pre-Natal Department

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

Post-Natal Rehabilitation

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

Dr. George Henry commenced his Mastership at the beginning of the year. This department extends a very warm welcome to him, his wife Hilary and his two children Rachel and Jonathan. We wish him every happiness and success in his new role.

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

Teaching Lecturers:-

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

Kathleen Marshall M.C.S.P.

PARENTCRAFT EDUCATION

Parentcraft Education is not new but has always been taught informally within the home. Although the close knit community and extended family is fading by the time we see our clients many have already established opinions and attitudes about labour and child care, especially feeding but with rapid changes in society we as professionals must accept responsibility to prepare couples for their future role.

Childbirth is unique to each woman but it is a sequence of events rather than a single experience — this sequence includes the periods of development as well as delivery and postnatal adjustments. We as educators must participate in all aspects with our prospective parents and achieve the aims of Parentcraft Education which are:-

1. To prepare the woman physically, emotionally and psychologically for the birth of "her baby".
2. To improve standards of hygiene and health within the community.
3. To improve standards of infant and child care.
4. To ensure that every baby is a Wanted Baby.
5. To help reduce
    1. Perinatal Mortality
    2. Neonatal Mortality
    3. Infant Mortality
    4. Non accidental injury and cot deaths
6. To help improve family life.

To achieve those aims we must teach prospective parents what they want to know and in their own language. The programme must be flexible to meet needs of individual groups. The teacher must be skilful and sensitive to adapt to suit the individuals who attend her class and be convinced of the need of this service as there is usually no immediate feedback but it is a long term preventative medicine.

The basic programme which we teach and discuss is as follows.

Programme

First Thursday every month 20.00 hrs — 21.00 hrs. Ideally all couples should attend this session early in pregnancy. There is a brief talk by Doctor, Dietician, Midwife and Physiotherapist. Information is given about classes and bookings accepted.

Classes to commence at 28 weeks gestation.

CLASS I

Development of Fetus to date.
Effect of pregnancy on body — i.e. minor disorders of pregnancy — nausea, heartburn, constipation etc., and discussion re: Management.
Advice re: Smoking, Alcohol, travel, sexual relationships, exercise, drugs i.e. (self medication), support tights, rest, hygiene and diet in pregnancy, dental health and maternity clothes.
List of clothes to take into Hospital.

CLASS II

Physiological changes towards term — i.e. Oedema, Braxton Hicks Contractions etc. Explanation of onset of normal labour and how to recognise labour has started. When to go to Hospital, Admission procedure in Labour Ward.
Explanation of Induction of Labour — its indications and methods. Brief talk by Social Worker.

CLASS III

Detailed explanation of physiology of 1st Stage of Labour. Care by midwife in labour i.e. routine observations and vaginal examinations. Why such care is necessary. Machinery used in monitoring — during 1st stage. Analgesia available in 1st stage and demonstration of inhalational analgesia.

CLASS IV

Detailed explanation of physiology of 2nd and 3rd stages. Explanation (briefly) re: Possible need for Forceps Delivery, or Caesarean Section.
Episiotomy — Indications and technique, reassurance on use of local Anaesthesia. Repair of Episiotomy. Stress importance of perineal hygiene in puerperium and on return home.
Immediate care of baby at birth — i.e. Naso-Pharyngeal, Suction and possibility of resuscitation being necessary. Clamping and cutting of umbilical cord.
Labelling of Infant. Tour of the Labour Ward.

CLASS V

Breast feeding in detail. Advantages of Breast feeding.
Breast changes and care during pregnancy.
Preparation for Breast feeding.
Feeding technique and maintenance of Lactation promoting "Demand Feeding.
Early problems i.e. Full Breasts, Engorgement, Sore/Cracked nipples, and how to overcome these.
Expressing Breast Milk.
Importance of good diet to maintain lactation.
Suitable film or slides on Breast Feeding. Physical demonstration by mother who is breast feeding if possible.
Breast feeding and returning to work.

CLASS VI

Artificial feeding — demonstration of reconstitution of artificial feeds. Importance of Hygiene when handling baby feeding equipment. Sterilization technique and equipment. Range of Artificial Milks available.

Importance of correct/accurate re-constitution and number of feeds per 24 hours. Avoidance of early weaning, and the practice of giving honey on soothers (dental health), Suitable film on artificial feeding.

CLASS VII

Care of Baby after birth.
Screeding tests in hospital.
Demonstration of baby bathing and daily toilet of baby.
Different methods of applying nappies, suitable layette for baby and other baby equipment i.e. Carry cots, prams, etc.
Establishing a home routine with baby.
Importance of follow-up clinics and vaccinations.
Promotion of good health habits.

CLASS VIII

Changes in emotions of new mother and how to cope. Resumption of Sexual relationships, family planning — all methods explained and times of such clinics given. Importance of 6 week Post Natal examination. Help on return home if problems arise.

Importance of rest on return home and continuation of Post Natal Exercises.
Fathers Evening 20.00 hrs. — 21.00 hrs.
Film "Your Baby's Birth".
Fathers role in Labour Ward.
Re-cap on when to come into Hospital and onset of Labour.
Requirements to take into Hospital with you for baby and self.
Visiting times.
Who to contact when you have a problem on return home. List of phone numbers of Public Health Nurses.
Questions/Discussions.
This programme is only a guide and allows for flexibility according to needs of various Clinics, or to meet the requirements of individual groups of patients. All classes are held in conjunction with the Physiotherapy Department.

Our audience is not captive but induced to attend and unfortunately those in most need will not attend classes unless pressurised by medical attendants. An ideal opportunity for doing this is at the clients "first booking visit" in the antenatal clinic when doctors, midwives and social workers should make the prospective parents aware of our service. If outside employers became more aware of hospital and community services then they too could encourage many couples to attend classes as nowadays most women work late into pregnancy and are afraid to ask for time off to attend classes in the hospital or at community clinics.

Our community clinics of Coolock, Kilbarrack and Finglas teach our basic parentcraft programme and the women attending those classes visit the Labour Ward here in the Rotunda during the session. For many this is their very first introduction to a hospital environment. At the community clinic there is a better opportunity to teach that section of the community in most need, social class 4, 5; who would not attend hospital based classes.

Since the introduction of this present parentcraft programme in April 1981 hospital based classes had the following attendances during 1981:

MONTH	Public Patients ATTENDANCES	Private Patients ATTENDANCES
April	148	35
May	263	30
June	234	50
July	246	44
August	262	39
September	348	45
October	222	55
November	262	52
December	116	35
	2.101	385
Grand Total	April 1981 - December 1981 = 2.486	

All Class attenders are followed up by Parentcraft Staff during their post natal stay. There is also a family planning lecture for all in-patients every week. This has laid the foundation for the newly organised Family Planning Clinic.

Mrs. Carmel Daisley
Parentcraft Tutor

THE MIDWIFERY NURSING STAFF

Miss M. A. KELLY, MATRON.

Senior Members of Nursing Staff:-

Miss M. A. Kelly, Matron.
Miss H. C. Feeney, Assistant Matron.
Miss K. O'Hora, Assistant Matron.
Miss M. Carroll, Administration Sister.
Miss K. Maguire, Labour Ward Sister.
Miss M. Thornton, Unit Nursing Officer.

Midwife Teaching Staff

Miss A. Monaghan
Miss M. Beirne

In the Rotunda Hospital we have a complement of 14 Sisters and 114 permanent Staff Midwives. We also have one Staff Midwife working full time in the Ultrasound Department.

Midwifery School

Up until this year we had only two Tutors and the Tutor/Student ratio was 1:58. In March, we appointed a Staff Midwife, Mrs. C. Daisley, who had obtained the M.T.D. to teach Student Midwives in the clinical area, pending approval by the Department of Health of a third Tutor. In July, we were fortunate to have a third Tutor approved by the Department.

A sincere thanks is due to Miss A. Monaghan Principal Midwife Teacher and Miss M Beirne Midwife Teacher for their hard work and dedication.

Midwifery Training

There were 800 enquiries from Nurses interested in Midwifery Training during 1981. 116 Students commenced Midwifery Training and seven Students withdrew from the Course before completion of their Training. 109 Students completed their full Course, 102 were successful at the first attempt of the An Bord Altranais examination and 6 passed their final examination at the second attempt. Twenty Nurses joined the Staff at the end of their Training.

Prizewinners

The Raymond Cross Gold Medal for the best Student Midwife in Theory was awarded to:-

Miss Felicity Kelliher,
The Old Schoolhouse,
Willistown,
Dunleer,
Co. Louth.

Silver Medal was awarded tor-

Miss Bernadette Gannon,
4, Old Market Street,
Sligo.

Bronze Medal was awarded to:-

Miss Margaret Garvey, Syngefield, Birr, Co. Offaly.

Solomon's Gold Medal for the best Practical Nurse of the Year was awarded to:-

Miss Jean Burke,
Derravari,
Ballincarrig Park,
Douglas Road,
Cork.

We congratulate them on their achievement and we wish them every success in the future.

We would also like to congratulate the Nurses who did not win prizes. Unfortunately, only a few can be prizewinners and we wish them all every success in the future.

Par enter aft

The new Parenteral Department was opened in April 1981. Before this time the Unit of Mothercraft was situated in the Private Clinic and this arrangement was inadequate and inaccessible and as a result of this many of the mothers got lost getting from Physiotherapy to Mothercraft and vice versa. The Mothercraft teacher, Miss E. O'Neill, S.R.N., S.C.M., at the time and later Mrs. E. Lynch, with Miss O'Neill welcomed the union of the two units physically. Mrs. Lynch, R.G.N., S.C.M., M.T.D., was appointed to the Staff in March, financed by the Friends of the Rotunda for nine months. To the Friends I say a most sincere thanks for their generosity.

Shortly after the opening of the new Department and the union of the two units it became evident with the increased attendance and the increase in the number of classes, that the newly developed Parentcraft area was insufficient to meet the needs. The Mothercraft Staff moved out to the old library (once it became vacant and the new library opened), which was situated in the centre of patient care and established the unit of Mothercraft there. This arrangement worked very well. It gives the two disciplines the opportunity to discuss mutual problems and plan the programmes according to the needs of the Ante-Natal patients, be they in-patients or out-patients. The Mothercraft Staff have a good liasion with the Community Staff and talks are programmed so that patients attending the Hospital or Community receive the same standard, also patients attending the Community Clinic attend the Hospital for a tour of the Labour Ward and communicate with the Labour Ward and Parentcraft Staff.

Neo-Natal Intensive Care Unit

We are pleased to report an addition of 6 Staff Midwives to this establishment, bringing the total number of trained Midwives to 1 Sister and 18 Staff Midwives. This gives a Nurse-Infant ratio of 1:6. We implemented the three shift system to give an equal standard of care day and night. However, even now the Midwife/Infant ratio is far from ideal and would be considered inadequate if a scientific study were carried out. In 1981, the Royal College of Midwives recommended that the complement should be increased to 1-5 Midwives for Special Care Cot and a 5-1 for each Intensive Care Cot. I would like to congratulate Sr. Fallon and her Staff for their hard work and dedication to Nursing.

Clinical Procedure Manual

Work has begun on compiling a Nursing Procedure Manual. It will enable the Midwives to standardise the Nursing techniques and eliminate some of the problems of conflicting advice to patients. We hope that it will become the Student Midwive's bible.

Ward Furniture

We are happy to report that we were able to budget for two new couches for the Labour Ward and 30 new beds with adjustable height and tilt for the Ward

area. We have also provided 70 baby-cots by the mothers bed-sides. This should encourage better bonding and mother/baby contact.

In the Labour Ward there was a great need for mother and baby to remain together during those very precious moments following delivery and to encourage bonding, and we have ordered slimline cots for this purpose.

C.S.S.D.

This year we budgeted for the setting up of a C.S.S.D. Department for Theatre and, in particular, the Labour Ward. We have already ordered delivery instruments costing IR£ 10,000. Pre-packed instruments in the Labour ward will improve the standard of sterile techniques and will relieve the Midwife from non-nursing duties, allowing her more time for patient care, teaching of Students and planning orientation of new staff.

Retirements

Miss M. O'Connell S/N Neonatal Intensive Care Unit retired early from the staff after 16 years service to the hospital. We will all miss her and we wish her success and happiness.

Staff Turnover

44 Staff Midwives resigned from the Staff giving a Staff turnover of 30% approximately, this year.

Upgrading of Staff

The Department of Health approved the upgrading of Miss K. O'Hora from that of Home Sister to Assistant Matron in July, and Miss M. Thornton from Sister-in-charge (Rotunda Annexe) to that of Unit Nursing Officer.

My sincere congratulations to them both.

I would like to welcome Dr. G. R. Henry, and to thank him for his loyal support throughout the year. We also thank the Medical Staff, both senior and junior, for their co-coperation and communication. We thank the Para-Medical and supporting Staff for their help and guidance. Thanks is also due to Mr. I. Gault, and the Administrative Staff, whom we work so closely with, for their kindness and assistance.

Finally I would like to say a special word of thanks to the Nursing Staff for their hard work and dedication to duty.

To my senior nursing colleagues in the office a special word of thanks for* their loyal support, guidance and constant hard work.

GYNAECOLOGICAL DEPARTMENT

DR. MICHAEL DARLING.

Operations (Gynaecological only)	1,776
GENITAL PROLAPSE:	
Manchester Repair	15
Vaginal Hysterectomy	73
Anterior and Posterior Repair	18
Anterior repair	13
Posterior repair	8
STRESS INCONTINENCE OF URINE:	
Urethroplasty	6
Target Colporrhaphy	3
ABDOMINAL OPERATIONS OF THE UTERUS:	
Hysterectomy	178
Myomectomy	15
Gilliam suspension	22
OPERATIONS ON THE TUBES AND OVARIES:	
Tubal surgery	24
Ovarian Cystectomy	38
OPERATIONS ON THE VULVA AND VAGINA:	
Vulvectomy	2
Vaginectomy	1
Stretching of introitus	7
Fenton's operation	9
Repair of fistula	2
Bartholin's cyst	17
MISCELLANEOUS OPERATIONS:	
Diagnostic D/C	854,
D & C Cautery or Cautery alone	4
Cystoscopy	42
Cone biopsy of cervix	14
Punch biopsy of Cervix	25
Laparotomy	38
Laparotomy (Appendix)	
Laparoscopy	147
Laparoscopy with ovarian biopsy	58
Repair incisional hernia	2
Resuture abdominal wound	2

COMMENT

The Gynaecological work load continues to increase placing a great strain on the one hospital operating theatre. Limiting factors are lack of theatre operating time and the pressure of Gynaecological bed space.

As well as the routine general Gynaecological service more specialised services have evolved including infertility, colposcopy and oncology.

ONCOLOGY

During the year there were 30 "positive" cervical smears seen, with ages ranging from 27 to 72 years. Sixteen of these were picked up from the various

hospital clinics at routine screening, only 14 had symptoms and 4 patients were pregnant.

Colposcopy, selective cervical biopsy, cone biopsy or a combination of these procedures was used in follow-up. Cone biopsy of the cervix was performed on 14 occasions and 7 of these revealed carcinoma in situ. In total, carcinoma in situ was seen on 10 occasions. Nine squamous carcinomas were invasive, with ages ranging from 32 to 83 years (3 under 40 years).

Adenocarcinoma of the body of the uterus was seen on 12 occasions, (29 to 85 years), but ovarian carcinoma only twice.

Infertility

Sub-fertile couples are seen at the general Gynaecological clinics, but there is also a specific Infertility Clinic held weekly. At this clinic in 1981, at least 125 new couples joined the patients already attending. Twenty-seven of these couples were secondary referrals.

In all cases the aim was initially to complete an infertility profile based upon semen analysis, post coital test, Hysterosalpingography and sympto-thermic charts with laparoscopy and a sex hormone profile also performed in selected cases. Further in depth investigations and therapy followed from this.

During the year at least 73 pregnancies were reported by patients, 8 of these aborted and there were 2 ectopics. The therapy for these pregnancies was as follows:

Treatment at Time Pregnancy Achieved = 73

Male			
Tubal Surgery			
Ovulation Induction	41	Clomid	5
		H.C.G.	1
		Novaldex	5
		Parlodel	5
		Clomid & Parlodel	9
		Placebo	1
Nil	22		

COMMENT

The Fertility Clinic continues weekly at the Hospital. Difficulties are great, but despite that all investigations and therapeutic procedures concomitant with a full service are ofTered to the patients. However, this service to the couples could be greatly improved if the Clinic was separated from the general Gynaecological service, if a proper system of medical record was introduced and if specific staff at all levels interested in the problem were allocated to service a Clinic each week.

VABRA

During the year 23 patients had out patient endometrial biopsies using the Vabra aspirator. Careful patient selection has shown this to be an acceptable alternative for obtaining samples of endometria. There were no complications and all patients were able to leave hospital within 90 minutes.

COLPOSCOPY CLINIC

During the year, 28 new patients were seen at the Colposcopy clinic. All patients were referred from the Hospital clinics, the reason for referral being abnormal cytology or an abnormal looking cervix. The present method *of* treating cervical intra-epithelial neoplasia is cone biopsy.

X-RAY DEPARTMENT 1981

DR. J. G. MCNULTY

Number of Examinations
Adults (Obstetrics & Gynaecology)

Abdomen in Pregnancy	208
Chest	283
Pelvimetry	139
Hysterosalpingograms	444
I.V. Urography	160
Cystograms	11
Others	214
Total	1459

Infants (Paediatric Radiology)

Chest	1249
Hips	1133
Barium Studies	19
Acute Abdomen	178
Skeletal System	143
Others	55
Total	2777
Total Examinations	4236

COMMENT

More than 60 per cent of the work of the Department is now concerned with Neonatal Radiology especially Chest Radiography in the Neonatal Intensive Care Unit. Since many of these babies are very ill and require immediate x-ray examinations often multiple, and during unsocial hours the Radiographers - Mrs O Carroll and Mrs Doris deserve special credit and thanks for their magnificent efforts to cope during the night both on working days and at weekends as well as during the working day. The close cooperation of the consultant Neonatologist - Dr. T. Matthews - is much appreciated. While the number of examinations in pregnancy has decreased a little the numbers remain high for other x-ray examinations during pregnancy (Chest complications etc.).

The use of our modern Television Fluoroscopy Unit for investigation of infertility continues to increase weekly and we have this year the highest numbers ever for Hysterosalpingography.

During the year Miss Mary Mohan joined the staff of the department and has rendered valuable clerical assistance.

Dr. J. G. McNulty.

GENETIC COUNSELLING CLINIC.

DR. SUSAN P. MCMANUS, M.D. M.SC.

There were 46 new referrals to the Genetic Counselling Clinic this year, two requiring second visits. Two sets of parents seen in 1979 re-attended, as did one mother seen in 1978.

In 37 cases consultations related to the presence of a genetic disorder in a living or deceased offspring. Four couples with a history of habitual abortion with no identified gynaecological aetiology were investigated for the possibility of genetic cause for same. An increase was noted in the number of requests for counselling because of the presence of a genetic condition in a parent or potential parent - 4 cases this year as compared with 1 case in 1980. A small - 4 cases - but important new group of referrals was noted. These persons - unaffected themselves - wanted counselling because of a family history for a genetic disease.

Both parents attended in 33 out of the 37 cases where referral related to the birth of an affected offspring. This paternal attendance in 89% of such cases was the best experienced since the Genetic Counselling Clinic commenced. The birth orders of offspring necessitating the referral were first born 30%, second born 20%, third born 20%, fourth born 20%, fifth born and higher 10%.

As in previous years the largest group of referrals related to the presence of neural tube malformations in offspring - 14 cases (37%). Five couples who had had Down's Syndrome infants were seen - in all cases Trisomy 21 was the karyotype. Two sets of parents with Edward's Syndrome offspring - Trisomy 18 - were also seen. Thus chromosomal anomalies formed the second largest group (17%) of genetic problems seen. Other conditions necessitating referral included adrenogenital syndrome, renal agenesis, osteogenesis imperfecta, hare lip, cleidocranial dysostosis, achondrogenesis syndrome and congenital dislocation of the hip.

Forty-two percent of parents were given a low recurrence risk for their problem (less than 1 in 20), 38% an intermediate risk (1 in 10 to 1 in 20), and 20% a high recurrence risk (greater than 1 in 10). This last group showed a considerable increase over 1980's figures - 8%.

One male partner in the 4 couples investigated for recurrent abortions was found to have a balanced chromosomal translocation which had given rise to the reproductive problems. The abnormality detected implied a high risk for further spontaneous abortions, and also for physically and mentally abnormal offspring.

Two females with spina bifida were seen at the clinic, genetically they were low risk persons, but both had severe clinical complications which implied potential obstetrical hazards. One mother with a hare lip was seen also with a low risk potential. One male, karyotyped before referral, because of the presence of a chromosomal anomaly in a sister who had had a grossly abnormal offspring was seen. This man also had a balanced translocation with high risk genetic implications as in the case mentioned above.

In the final group of referrals - one potential mother came because her husband's mother had Huntingtons Chorea; two other females - both intending to marry in the near future - came because both had nieces with cystic fibrosis; and one mother wanted to know the implications for her children aged 4 and 2 following the diagnosis of retinitis pigmentosa in a sister's son. A high risk situation existed in the first case, and a low risk one. in the other 3.

May I once again express my thanks to the Nursing and Secretarial Staff of the Paediatric Out-Patient Department, especially Miss Audrey Dixon, all of whom help me so much with the efficient running of this clinic.

PAEDIATRIC DEPARTMENT

PROF. P. C. D. MACCLANCY AND DR. T. MATTHEWS

Total number of live births over 28 weeks maturity	6,087
Additional live births under 28 weeks maturity	21
Total admissions to Paediatric Unit and Nursery (Intensive Care Unit)	1,677
Total Extern admissions to Paediatric Unit and Nursery (Babies born outside Rotunda Services)	42
Total number of attendances to O.P.D. Clinics	14,417
Initial attendances at O.P.D. Clinics	5,515
First week Neonatal Deaths (Intern)	27
Deaths in I.C. Unit, Labour Ward, and Paediatric Unit	57
Intern	54
Extern	3
Late Neonatal Deaths (Intern)	6
First week Neonatal Deaths (Extern)	1
Late Neonatal Deaths (Extern)	Nil

LOW BIRTH WEIGHT INTERN

(includes babies under 28 weeks)

	1980			1981		
	Survived	Died	Total	Survived	Died	Total
Under 1,000 grams	7	19	26	6	21	27
1,000-1,500 grams	17	8	25	23	14	37
1,500-2,000 grams	46	7	53	52	4	56
2,000-2,500 grams	194	3	197	186	6	192
Total	264	37	301	267	45	312

LOW BIRTH WEIGHT EXTERN

Under 1,000 grams	-	1	1	1	2	3
1,000-1,500 grams	-	1	1	1	-	1
1,500-2,000 grams						
2,000-2,500 grams	1		1	1	1	2
Total	1	2	3	3	3	6

JAUNDICE

Type	*Total*		*No Treatment*		*Phototherapy*		*Exchange Transfusion*	
INTERN	1980	1981	1980	1981	1980	1981	1980	1981
Rhesus	30	23	4	5	26	18	16	10
ABO	14	11	1	1	13	10	1	—
Hyperbilirubinaemia (Miscellaneous)	360	370	134	140	225	230	1	3
Total	404	404	139	146	264	258	18	13
EXTERN								
Rhesus			–	–				
ABO			–	–				
Hyperbitirubinaemia (Miscellaneous)	1	1	–	–	1	1		
			–	–			—	—
Total	1	1	–	–	1	1		
			–	–				

CEREBRAL DYSFUNCTION

	Hypoxic Ischaemic Encephalopathy (H.I.E.)				*Metabolic*		*Miscellaneous*		*Obstetrical Trauma*	
	Ante! Intrapartum		*Postpartum*							
	1980	1981	1980	1981	1980	1981	1980	1981	1980	1981
INTERN										
Total	18	12	I		62	56	10	3	1	
Low Birth Weight	1	4			19	28				
Less than 1,500 grams					6	6				
Alive	13	8	I		61	55	8	3		
Deaths	5	4			1	1	2		1	
Seizures	10	11				2	8	2	1	
EXTERN										
Total	-	2		1	1	1			—	—
Low Birth Weight					1	1	—	—		
Less than 1,500 grams						1				
Alive		2		1	1	1				
Deaths										
Seizures		2		1						

RESPIRATORY DISTRESS

	Idiopathic Respiratory Distress Syndrome		*Transient Tachypnaea of the Newborn*		*Meconium Aspiration Syndrome*		*Pneumonia*		*Respiratory Distress Secondary to Congenital Abnormality*		*Persistent Foetal Circulation*	
INTERN	1980	19S!	1980	1981	1980	1981	1980	1981	1980	1981	1980	1981
Total	69 '	84	70	58	6	3	6	10	3	1	*1*	I
Alive	56	77	70	58	6	3	6	10	1		4	
Deaths	13	7							2	1	3	1
C.P.A.P.	35	32									6	
l.P.P.V.	36	15	- '	1	1				2		J	1
Associated with congenital abnormality	1	1					2		3	1	1	
Weight 1,000-1,499 grams	18	18		1								
Weight less than I.OOOg.	9	9					1					
EXTERN												
Total	2	2	-	1		1						
Alive	1	1	-	1	-	1					-	-
Deaths	1	1					-	-	-	-		
C.P.A.P.												
l.P.P.V.		2				]						
Associated with congenital abnormality												
Weight 1,000-1,499 grams	-	I										
Weight less than I.OOOg.		1		1								

CONGENITAL ABNORMALITIES

	C.V.S.	*C.N.S.*	*G.I.T.*	*G. U. T.*	*Chromosomal*	*Miscellaneous*
INTERN						
Total	34	12	8	16	11	273
Ative	26	4	8	15	9	268
Deaths	8	8		1	2	5
Major	34	12	7	1	11	8
Minor			1	15		265
EXTERN						
Total	1	1	1	—	—	
Alive		1	1			
Deaths	1		1			—
Major	1		1			
Minor		1				

PAEDIATRIC ASSESSMENT CLINIC 1981

DR. NESSA JOYCE

Following the Two Year Rotunda Research Study conducted at the Rotunda Hospital in 1979/80, in collaboration with the Department of Statistics, Trinity College Dublin, paediatric assessment clinics were commenced during 1980/81. The assessment clinics were concerned with the follow-up of infants who suffered from a morbid condition during the perinatal period and were considered to be at risk of mental or physical handicap. In this context it would be of inestimable value to the hospital if we were informed of any previously undiagnosed major condition found in any Rotunda born infant by any medical colleague. In some cases there is no apparent obstetrical or neonatal cause. This important information is presently being supplied by one of the area Directors of Community Care in the Eastern Health Board.

Infants born in 1980 were recalled to the clinic at the approximate age of 9 months. Attendance at the clinic was by appointment, the parents were notified by post. In the event of non attendance after a maximum of three letters, information was sought from the Directors of Community Care for Dublin city and county. For rural areas information was also sought from the appropriate Director of Community Care or the general practitioner. When the infant was attending a specialist a progress report was requested. Each infant who attended the Rotunda was given a physical examination, assessment of growth, measurement of head circumference and assessment of physical and behavioural development.

A total of 364 infants were recalled for paediatric assessment. In each case the paediatric chart containing details of maternal and neonatal record was available and provided an excellent opportunity for co-relating events in pregnancy and delivery with the outcome in the infant.

Results of follow-up were as follows:- 284 infants — seen at paediatric assessment clinic, Rotunda Hospital. 51 infants — information from outside source.

1. Normal Development 247
2. Further Observation Required 42
3. Further Observation Required and Attending Specialist 46
4. Failed Appointment or Untraced 23
5. Died 6

Congenital Anomalies

A total of 39 infants presented with major congenital abnormalities which included 5 infants with cleft lip and/or palate, 19 infants who had Down's Syndrome (3 died), 2 cases of Spina bifida and hydrocephalus, 2 cases of meningocele, 4 cases of congenital abnormality of cardio vascular system (one died at 3/12). A further 5 infants had abnormalities of the gastro intestinal tract which included a case of gastro oesophageal fistula in a dysmature baby who had grossly delayed development, hearing defect, and suspected microcephalus at 10/12. There was one case of Gorlin's syndrome, one case of congenital rubella who later presented with a hearing defect and bilateral cataracts. There were 3 cases of major congenital abnormality of genitalia.

Cerebral Dysfunction

A total of 17 infants presented with evidence of neuromotor dysfunction in the neonatal period, which varied from cerebral irritation or depression, hypotonia or hypertonia to generalised seizures. Three infants who showed symptoms of cerebral depression had delayed motor milestones and hypotonia at paediatric assessment during the first year. One infant who showed signs of cerebral irritation and hypertonia on day 1, was deaf at 11 months, with normal motor development. One infant who had generalised convulsions (following

maternal pyrexia in labour) was diagnosed as cerebral palsy at 5/12 and is attending the Central Remedial Clinic. One infant who suffered apnoeic spells, severe asphyxia and seizures presented with a hearing defect and delayed gross and fine motor development at approximately 9 months and is attending for physiotheraphy in a rural area and has been assessed for hearing and wears a hearing aid.

Prematurity

Premature infants were divided into three groups on the basis of birth weight:-

Group I 1500 grams or less — 24
Group II 2000 grams or less — 31 (2 untraced)
Group III 2001 grams or over — 81 (4 untraced)

Group I In the very low birth weight group (1500 grams or less) all were assessed between 9-11 months. Nine infants were assessed as having normal development in view of low birth weight and prematurity. Six infants were assessed as having normal development but were on or below the 3rd weight centile. Seven infants had delayed motor development, one with major hypospadius and one with strabismus. One infant had delayed motor development at 9 months and was later referred to the Central Remedial Clinic, diagnosed as a mild to moderate spastic diplegia. One infant suffers from cerebral palsy with mental handicap, epilepsy and visual defect and is attending the Central Remedial Clinic.

Group II In this group one infant died from sudden infant death syndrome at 4 months. One infant had delayed motor development at paediatric assessment. One infant had retarded growth and marked delayed gross and fine motor development, and was later diagnosed as having absent corpus callosum.

Group III In this group five infants had delayed motor development at paediatric assessment. One infant who was a slow feeder in the neonatal period was grossly under weight and had suspected coeliac disease. One infant developed infantile spasms at 4 months followed by developmental delay and is attending the Central Remedial Clinic for neur©developmental training.

Dys maturity

A total of 107 infants were considered to be dysmature or small for dates at birth. Seven of these were untraced or did not attend any paediatric assessment centre. One infant died from sudden infant death syndrome at 4/12. One infant died from cystic fibrosis. Two infants had delayed motor development. Twenty infants were on or under the 3rd weight per centile. One infant developed infantile spasms, at 4/12 (aetiology unknown) and is attending the Central Remedial Clinic for gross neuro developmental delay. One infant developed infantile spasms at 8/12 (aetiology unknown) and is blind with suspected optic nerve damage.

Haemolytic Disease of Newborn

A total of 27 infants had haemolytic disease of the newborn, nineteen due to rhesus isoimmunisation and eight due to ABO incompatability (one rhesus infant did not attend any paediatric assessment clinic). All these infants were considered to have normal development with the exception of one infant who was well below the 3rd weight per centile due to adverse social conditions and one infant had delayed motor development.

Hypoglycaemia

Sixteen infants suffered from hypoglycaemia in the first week of life. Two infants did not attend for paediatric assessment. The fourteen infants who did attend were considered to have normal development.

Endocrine Disorders

One infant who had thyroid deficiency with a positive Guthrie test in the neonatal period was developing normally at 10 months.

Metabolic Disorders

One infant had phenylketonuria at birth and was developing normally at 10 months. Sibling was also developing normally.

This project was made possible by generous financial support from the Friends of the Rotunda under the direction of Professor A. D. H. Browne.

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