YSOA NEWSLETTER

EDITOR: Dr Kay Robins

Issue 20/ January 2022

Presidents Message

Happy 2022!

In January we get to embrace the new coming year- set our plans and resolutions out in front of us, reflect on all that has passed in the previous year. The Roman god Janus (from which January is derived) was depicted to have two faces, on the front and back of his head, allowing him to forward and backward at the same time. He was known as the god of doorways. Alas, the last two years have been hard work for anaesthetists, and disappointingly we were unable to hold our ASMs as face-to-face meetings.

But wait – there may be light coming through that doorway! The YSOA committee and I are hoping we will, this year, be able to invite you to come through the door at the Principal Hotel in York, and join us at the Annual Scientific Meeting on Tuesday 26th April 2022. We have already got a number of fantastic speakers lined up, including a senior barrister Queen's Counsel from London, who will be exploring the most up-to-date recommendations on capacity and consent in obstetrics. I hope you have booked your study leave; you can reserve your place for the April ASM through the YSOA website. Also, we hope our Yorkshire trainee obstetric anaesthetists are getting their abstracts ready to submit in February.

We were able, however, to hold our Anniversary meeting last September as a face-to-face meeting, at Hinsley Hall in Headingley. We were treated to some engrossing presentations- who'd have thought an ENT surgeon would have cause to present at an obstetric anaesthetic meeting! If you weren't able to join us, you sadly missed out on some great food and really good discussions. Summaries of the presentations can be found a little later on in the newsletter.

So, I wish you all a very happy and healthy new year and I really hope you can join us in April in York. Happy new year to you all!

Dr Sarah Radbourne: YSOA President

Dr Sarah Radbourne—President of YSOA

Principle Hotel, York, Annual Scientific Meeting, Tuesday 26th April 2022

Dates for your diary

YSOA Annual Scientific Meeting 2022

The Principal Hotel, York , Tuesday 26th April 2022.

Contact: Wayne Sheedy at

obstetricday@hotmail.co.uk

YSOA Anniversary Meeting

Friday September 30th 2022

Fee £25 refundable deposit includes Dinner

Contact: Wayne Sheedy at

obstetricday@hotmail.co.uk

Membership details

Membership is free to all trainees and consultants in the Yorkshire and Humber region. Membership ensures you receive information regarding upcoming events and this amazing newsletter!

If you wish to become a member please forward the following information to:

obstetricday@hotmail.co.uk

Name:

Grade:

Employing Trust:

Locality if in a training post (East/South/ West)

A reliable contact email address:

Yorkshire Society of Obstetric Anaesthetists

Annual Scientific Meeting

26 April 2022, Principal Hotel, York

Confirmed Speakers:

Miss Nageena Khalique QC—Capacity and Court of Protection in the pregnant patient

Dr Deborah Horner, Bradford NHS Trust—Yorkshire and Humber MEACC Update

Other Speakers to follow:

Principal Hotel , York

Essential Information

- 5 CPD points apapplied for from the Royal College of Anaesthetists

Meeting Fee (members):

- Consultants £120 (£110)
- SAS/Trainee £70 (£65)
- ODPs/midwives £25 (£25)

Abstract Prizes

- Oral Presentation £100
- Poster £50

For full programme, bookings, abstract submission guidelines and further details see meeting website:

http://ysoa.org.uk/Contactus/

YSOA YORKSHIRE SOCIETY OBSTETRIC ANAESTHETISTS

YSOA website and Podcasts

Podcasts from the ASM 19 are available to download from our website www.ysoa.org.uk

Username:

Admin

ysoa@gmail.com

Password:
Green42Carwash
%$*ysoahull@$)

Dates of courses

Obstetric Anaesthetic Emergency Course for CT2s

Hull Clinical Skills Facility	tbc
York	tbc
Bradford	tbc

For more information please go to the Yorkshire and Humberside Deanery Website

TOAASTY Advanced Obstetric Course

for senior trainees and consultants

Hull Clinical Skills Facility	Tuesday 18th October 2022

Contact: anju.raina@nhs.net or Claire.pick@nhs.net

Yorkshire Difficult Airway Course

tbc

YSOA 2021 Anniversary Meeting - Review

24th September 2021

We were absolutely delighted that our YSOA anniversary meeting at Hinsley Hall was able to go ahead, and as a face-to-face meeting. We were treated to a fantastic evening of engrossing presentations, a delicious supper and the ability (finally!) to enjoy catching up with friends in person.

Miss Hannah Wright, Consultant Obstetrician, and Dr Hytham Shoeib, Specialty Doctor from Mid Yorkshire Hospitals, presented a rare cause of Major Obstetric Haemorrhage. A 33-year-old multiparous woman (3 previous SVDs), known to have ovarian cysts but otherwise fit, presented to A+E at 35 weeks gestation with severe left-sided abdominal pain. She was initially hypotensive on arrival, and a fast scan of her abdomen revealed a haemoperitoneum; the fetal heartbeat was present. On transfer to labour ward, the CTG was pathological, so a Cat 1 section was called. The patient was also consented for oophorectomy, as ovarian torsion was suspected. A consultant gynaecologist was called in to assist. On commencing the surgery there was substantial intra-abdominal bleeding. The foetus was delivered in good condition, but then aortic compression was needed to be applied to stem the haemorrhage. A general surgeon and vascular surgeon were called to assist. A ruptured splenic artery aneurysm was diagnosed, and splenectomy was performed. Total blood loss was 9000ml. The woman recovered quickly on ICU. A post-discharge abdominal ultrasound reported imaging in keeping with a splenunculus, accessory spleen.

The presenters explained to us that splenic artery aneurysm rupture is a rare (incidence 0.01%) and extremely life-threatening complication of pregnancy (75% maternal mortality, 95% foetal mortality). There were 3 deaths reported in the 2009-12 Saving Mothers' lives and 9 deaths in 2013-17, attributed to splenic artery aneurysm. Prompt fast scan and escalation to surgical and anaesthetic teams, and control of haemorrhage through aortic compression prior to general surgical attendance contributed to a happy outcome for all.

Contact Us

YSOA Administrator:

Mr Wayne Sheedy

01482 624069

w.sheedy@hull.ac.uk

Visit us on the web at www.ysoa.org.uk

Please email any comments or feedback regarding this newsletter to W Sheedy as above.

Please forward this newsletter to your obstetric anaesthetic colleagues and trainees to let them all know all the news – thank you.

Kay Robins , Editor (York)

Mr Aristotelis Poulios, Consultant ENT Surgeon from Mid Yorkshire Hospitals, presented a case of sudden onset hearing loss by the patient, during an elective caesarean section under spinal anaesthesia. The woman had no previous complications related to anaesthesia. She had a straightforward spinal anaesthetic, her blood pressure was maintained, total blood loss was 365 ml.

Towards the end of the procedure the patient complained of bilateral deafness and associated dizziness. She denied headache, tinnitus or any visual disturbance. Her symptoms persisted despite cessation of phenylephrine and return of full motor function. At six hours post procedure, her hearing loss was discussed with an ENT specialist who advised prednisolone 50 mg immediately and organised review with tympanogram and audiometry the next day. Her dizziness receded overnight. However, subjectively her hearing improved only partially. Her tympanogram was normal, suggesting that there was no middle ear effusion, but her pure tone audiogram showed a mild conductive overlay on the right side.

At two month follow up she reported having ongoing right sided hearing impairment and intermittent tinnitus, though denied dizziness. Her gross otoneurological examination was normal and a repeated tympanogram confirmed normal middle ear function. A repeated pure tone audiogram (PTA) showed improvement to within normal limits with closure of the conductive overlay gap on the right side, although a small one persisted with the air conduction threshold returning to normally accepted limits. A MRI scan excluded acoustic neuroma and did not identify any other structural abnormality. The patient had a temporal bone CT scan, which showed anatomical variation and a dehiscence between the vestibular aqueduct and the right jugular foramen. This patient had typical symptoms of a third window lesion which were mostly resolved over time but not to complete resolution. The sudden fluctuation in CSF pressure at spinal anaesthesia may have caused hyperosmolar reflux into the cochlear duct.

It is hypothesized that the patient may have suffered an initial trauma to the inner ear due to this abnormal communication and dehiscence and the initial hearing loss may have been mixed. High dose steroids are the most widely accepted management of inner ear trauma.

Dehiscence of the jugular bulb with the vestibular aqueduct is found in 11.5% of patients referred for CT scans with suspected pathology, with 4.3% being bilateral. 75% occur on the right side. Imaging of the petrous bones by CT is more sensitive than MRI for identifying anatomical variation. Although in some cases patients may be asymptomatic, they may also suffer from conductive or sensorineural hearing loss, pulsatile tinnitus and vertigo. Little is known about the possible consequences of bony dehiscence and so this remains conservatively managed at present. It may, however, be another mechanism by which anaesthesia may cause hearing loss. Hearing impairment following neuraxial anaesthesia is a poorly recognised complication. A high level of suspicion is required to ensure these patients are appropriately investigated and managed. Hearing loss post-anaesthesia should be investigated with audiometry in the first instance.

Dr Abdelgawad, Specialty Doctor at Mid Yorkshire, presented a case of atypical presentation of PDPH. A 25-year-old multiparous woman requested an epidural for labour. Her BMI was 25. Risks and benefits of epidural analgesia were discussed with the woman, and she was given an epidural information leaflet. Unfortunately, a spinal tap occurred during epidural siting; the catheter would not thread into the intrathecal space. The anaesthetist re-sited the epidural at another level and there appeared to be good analgesia from the first anaesthetic bolus, without any heavy motor block. The woman was apologised to and counselled for a PDPH. Four hours after the epidural placement the woman complained of severe neck pain and occipital headache. The woman became agitated due to the neck pain and complained of difficulty raising her arms. Block assessment showed an epidural block height of T1-T6 to cold.

Advice was sought from the consultant on-call and the epidural stopped. An alfentanil PCAS was offered, and she delivered by venteuse three hours later. The patient wished to go home following her delivery and continue with conservative management of her PDPH but was readmitted two days later, with PDPH and muscular neck spasms. She had an uneventful blood patch which improved her headache, but not her neck pain. Her neck pain and neck muscle spasm took several weeks to settle. We heard that rarely, acute loss of CSF following dural puncture can cause central traction on cranial or cervical nerves, more commonly the trigeminal nerve, vagus nerve or the C2-5 cervical fibres, causing neck and arm pain. The few cases that have been reported have noted that the muscular spasm or nerve traction can occur as early as 4-6 hours post-tap (Carlos et al, Anaesthesiology, 2002). When dural puncture has occurred with loss of resistance to air, the patient may exhibit symptoms of severe neck pain or headache due to travel of the air up the spinal column to the ventricles – a pneumocephalus. Again, this can occur within 4-6 hours of the tap.

Dr Rebecca Mortimer Specialist Registrar presented a case from Hull of a 25 year old G3 P0 woman who had underlying chronic kidney disease, BMI 49, hypertension, Caroli's disease (a congenital hepatic disease which predisposes to cholangitis and portal hypertension) and a previous ICU admission with COVID-19 in 2020, with possible residual lung fibrosis. The woman had an emergency caesarean for failure to progress, following two failed epidurals and a difficult spinal placement. She was discharged two days after her delivery but was readmitted four days after delivery with headache and breathlessness. Investigations showed a deteriorating renal function, deteriorating respiratory function, raised CRP and she was severely hypertensive-BP 215/100 mmHg. A CTPA showed evidence of an infective process- no PE. Her hypertension persisted despite labetolol, nifedipine, amlodipine, methyldopa and clonidine, but was finally controlled with nicardipine, doxazocin, labetolol and methyldopa. She was treated for pre-eclampsia and required intubation for type 1 respiratory failure for four days.

Her cardiac echo showed good left ventricular systolic function but dilated pulmonary arteries. The patient self-discharged a day later but was readmitted with severe hypertension and type 1 respiratory failure. She was reintubated the following day, required support for cardiac failure, but was able to be extubated again three days following. Dr Mortimer then went on to describe the diagnosis and management of hypertensive acute pulmonary oedema and reflect on the challenges of managing a very high-risk patient, who also exhibited anxiety and personality behavioural issues.

We received fantastic feedback from those who were able to attend – please make a note in your diaries to come along this September!

Regards

Drs Sarah Radbourne,

YSOA President