YSOA NEWSLETTER

EDITOR: Dr Kay Robins

YORKSHIRE SOCIETY OBSTETRIC ANAESTHETISTS

Issue 24/ January 2024

Presidents Message

Happy new year and congratulations on navigating through another year of challenges!

Out with the old, in with the new, and this year it's the introduction of PSIRF (Patient Safety Incident Response Framework). For those of you not directly involved in Governance, this is the new way in which NHS England have asked us to investigate our patient safety incidents. Those of you who attended the YSOA ASM 2023 will recall Rebecca Allen's presentation on preparing for Coroner and Health Safety Investigation Branch (HSIB) investigations – HSIB now renamed as MNSI- Maternity and Newborn Safety Investigations. PSIRF will be the structure Maternity will follow for all investigations apart from those referred to MNSI (maternal death, intrapartum stillbirth, early neonatal death and severe brain injury in babies).

Once you get your head around all the new acronyms, the changes introduced encourage a focus on understanding how incidents happen, including the factors that contribute to them, rather than focusing on which member of staff was deemed to have failed somewhere. We know ourselves that a blame culture stifles open and transparent investigation and learning, and we also know that incidents are very rarely as a result of one single person's failure in a moment of time. Within maternity (and obstetric anaesthesia by association) there have been several high-profile reports commissioned to uncover systems, cultures and behaviours that collectively have led to patient harm. Dr Bill Kirkup's report on the NHS Trusts Morecambe Bay and then East Kent, and Donna Okenden FRSA, was commissioned to report on Shrewsbury and Telford, and her current investigation at Nottingham.

The YSOA is delighted to announce that **Donna Okenden** will be presenting at our 2024 YSOA ASM at Lazaat Hotel and Conference Centre, Cottingham, Hull on the 30th April! She will be outlining her tips on how to implement her report into our maternity units.

Not only are we privileged to have Donna speaking to us, but we also have a wonderful line-up of local, national and international speakers, covering a wealth and breadth of topics to capture your interest and learning. As always, the YSOA offers great value for money for CPD and the opportunity to catch up with your colleagues in Yorkshire, over delicious food. See the full line-up and how to book later in the newsletter!

I look forward to seeing you there!

Dr Sarah Radbourne: YSOA President

Dr Sarah Radbourne—President of YSOA

Lazaat Hotel, Cottingham, Annual Scientific Meeting, Tuesday 30th September 2024

Dates for your diary

YSOA Annual Scientific Meeting 2023

Lazaat Hotel, Cottingham, Tuesday 30th April 2024.

Contact: Wayne Sheedy at

obstetricday@hotmail.co.uk or wayne.sheedy@talktalk.net

YSOA Anniversary Meeting

Friday September 20th 2024

Refundable Fee £25, includes Dinner

Contact: Wayne Sheedy at

obstetricday@hotmail.co.uk or wayne.sheedy@talktalk.net

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

Yorkshire Society of Obstetric Anaesthetists Annual Scientific Meeting
Lazaat Hotel, Cottingham, 30th April 2024

Time	Session
0830 – 0915	Registration
0915 – 0920	Welcome / Introduction Dr Aseem Tufchi, Consultant Anaesthetist Dr Sarah Radbourne, Consultant Anaesthetist, Mid Yorkshire. President YSOA
Session 1 – Chair: Anju Raina	
0920 – 1000	High Risk anaesthetic clinic: Challenges and interesting cases *Dr Ann-Mair Hammond Jones*
1000 – 1040	Time to listen, learn and act: Tips on how to implement the report in maternity units *Miss Donna Ockenden*
1040 – 1110	Tea / Coffee
Session 2 – Chair: Sarah Radbourne	
1110-1150	Update on the role on Interventional Radiology in Obstetrics *Dr Raghuram Laxminarayan*
1150– 1230	Proficiency based programme in labour epidural training *Dr Hassan Ahmad*
	LUNCH 1230-1330
Session 3 – Chair: Amanda Vipond	
1330 – 1410	Topic to be confirmed related to GMC *Dr Iftikhar Ahmed*
1410 – 1440	Trainee presentations
1440 – 1510	Pro-Con Debate: TBC *Pro-side: TBC* *Con-side: TBC*
1510 – 1540	Tea / Coffee
Session 4 – Chair: TBC	
1540 – 1610	Controversies in Obstetric Anaesthesia: Perspectives from the Developing World *Prof Kundra VIRTUAL SESSION*
1610 – 1640	Management of maternal sepsis in critical care *Dr Rebecca Lathey*
1640 – 1700	Prizes / Close

Lazaat Hotel, Cottingham

Essential Information

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

Meeting Fee (members):

- Consultants £130 (£120)
- SAS/Trainee £80 (£75)
- ODPs/midwives £25 (£25)

Payment by BACS to following Account (Yorkshire Society of Obstetric Anaesthetists Ltd):

Acc No:60660963

Sort Code:30-98-97

Bank: Lloyds TSB

Email remittance: wayne.sheedy@talktalk.net

Abstract Prizes

- Oral Presentation £100
- Poster £50

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

http://ysoa.org.uk

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 17th April 2024

Bradford tbc

For more information please go to the Yorkshire and Humberside Deanery Website (hyp-tr.clinical.courses@nhs,net)

TOAASTY Advanced Obstetric Course

for senior trainees and consultants

Hull Clinical Skills Facility 15th October 2024

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

Yorkshire Difficult Airway Course

tbc

YSOA 2023 Anniversary Meeting Review

Hinsley Hall, Leeds, 22nd September 2023

HInsley Hall September 2023 was a superb evening of extremely thought-provoking case studies from our Yorkshire units. We came away slightly unnerved at the complexities of the cases described to us, but also reflecting on what a huge pool of talent there is in Yorkshire, of our obstetric anaesthetic colleagues!

Dr Tamer Abouzied and Dr Dileep Wijeratne gave us a slightly anxiety-inducing presentation on the management of placenta percreta with massive neovascularisation. Placenta accreta occurs in ~ 1:2500 pregnancies. Only 5% of this number are Percreta, but Placenta Percreta carries an 800 x higher maternal mortality, due to placental invasion through the entirety of the myometrium and into extrauterine tissues- bladder, internal iliac artery, inferior vena cava even. The centralised MRI reporting service for accreta is at Sheffield, with specialist tertiary centres for Accreta surgery at Sheffield and Leeds.

The presenters described the pathophysiology of accreta, arising generally at the site of a previous uterine scar. Angiogenic factors leak from the placenta bed, causing neorevascularisation, with very small, fragile vessels. At the presenters hospital, they manage surgery for women with Percreta every two to three weeks. Each case requires significant pre-operative planning with an experienced MDT. The speakers described the use of REBOA -resuscitative Endovascular Balloon Occlusion of the Aorta as an adjunct to gain supported haemorrhagic control where there has been invasion into vasculature, such as the rare case they described of involvement of the internal iliac artery. The presenters described the tense situation where despite the use of REBOA, at one point the woman's blood loss was 5 litres in just a 10-minute period.

Dr Ella Bilson then took us through her case presentation of a patient presenting with Brugada Syndrome. Brugada Syndrome is a rare and potentially-life threatening cardiac rhythm condition. This syndrome been recognised as an important cause of sudden cardiac death at a young age. Brugada syndrome carries a familial link, but 50% of cases arise spontaneously. The woman, of Ethiopian heritage required careful antenatal planning for her birth, due to the restricted number of anaesthetic agents that are considered safe, as many drugs induce ventricular tachyarrythmias. Brugadadrugs.org gives a comprehensive guide for the anaesthetist on which drugs are absolutely contra-indicated (including bupivacaine, propofol, procaine), those that should preferably be avoided (lignocaine, amiodarone, ketamine, tramadol, metoclopramide) and isoprenaline being a relatively safe antiarrhythmic of choice. After that list there were little options left, but thankfully the woman delivered vaginally without needing any anaesthetic intervention. Phew!

Dr Liz Lowis presented a case of a woman who re-presented to hospital several days later following her discharge from home after having an emergency caesarean section. At the caesarean, the woman had had a 2.5 litre PPH, due to bleeding from a venous sinus. When the woman re-presented, she was unwell with symptoms and signs of sepsis and underwent emergency laparotomy; 2.5 litres of purulent fluid was drained. Unfortunately, her condition rapidly deteriorated and she was treated in ICU for Streptococcus Toxic Shock Syndrome, requiring intravenous immunoglobulin therapy. She went on to develop necrotising fasciitis of her uterus necessitating uterine necrosectomy. At her second laparotomy, she required insertion of REBOA to support her circulation. Her continued ICU care remained stormy – she developed sub-cortical haemorrhage demonstrated on CT of her head, and soft tissue necrosis, requiring debridement and amputation. She was stable enough to be extubated after 18 days, and required a long in-patient stay for rehabilitation.
The husband of the woman remarked to the surgical team that her could hear fluid sloshing around in her abdomen, when she turned over in bed. Dr Lowis reminded us of the need to "Think Sepsis" and of the higher rates of invasive group A strep (iGAS) currently being observed in the Yorkshire and Humber region.

Contact Us

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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)

Dr Sam Doyle presented a case of a parturient with Ehlers Danlos III and PoTS (Postural tachycardia Syndrome). EDS III is characterised by joint hypermobility; lax connective tissues increase the risk of hyperextension, dislocation and easy bruising. The obstetric anaesthetist will be aware that patients with EDS III have a higher risk of bleeding due to their friable tissues, increased risk of accidental dural puncture due to the boggy feel of the ligaments and regional anaesthesia failure, linked to local anaesthetic resistance. The local anaesthetic resistance can be variable – some patients may have failed epidural analgesia, but reasonable spinal anaesthesia., or spinal anaesthesia which wears off more quickly than usual. The cause of local anaesthetic resistance is not understood, but may well be due to the more rapid dispersion of the local anaesthetic due to the abnormal structure and synthesis of connective tissue. 80% of people with EDS have PoTS; most people with PoTS have EDS III. PoTS is a form of dyautonomia causing low blood pressure, digestive and bladder problems, temperature and sweating dysregulation, as well as the tachycardia. There is a link with EDS III with PoTS with depressive disorders.
The presenter discussed the pros and cons of spinal, CSE and GA – the take home message was to carefully assess the anaesthetic block and listen to the woman's concerns of pain and inadequate block.

Dr Stephy Jose presented a case of a parturient with TAR syndrome- if you haven't come across it before, it stands for Thrombocytopenia Absent Radius syndrome. I would encourage you to look at some photos online to see the challenges the anatomy of this syndrome can create for the anaesthetic team. The syndrome is autosomal recessive, which also has a 30% chance of congenital heart defects, micrognathia and poses many dilemmas for the obstetric anaesthetist in establishing intravenous access due to the limb abnormalities, blood pressure monitoring for the same reason, as well as options for analgesia and anaesthesia in view of the thrombocytopenia and potentially challenging airway. The patient described to us had previously undergone ASD repair and was also being treated for Pregnancy Induced Hypertension. Her platelet count hovered around 77 antenatally. Unfortunately, the patient required an internal jugular central line for IV access, induction of labour followed by spinal anaesthesia for a category I caesarean- but as a result of extensive planning the was woman delivered safely, with the baby in good condition.

Lastly, **Dr Megan Oldbury** described another complex post-partum presentation. The woman had presented to ED 4 weeks post- partum with a history of fever/rigors, dysuria and frequency for 10 days. She had been seen at a walk-in centre one week prior with abdominal pain, and at that time had been advised it was most likely of muscular origin.
Following assessment in ED, she was commenced on IV antibiotics and transferred to labour ward in view of her NEWS 2. Within 12 hours her MEWS score increased to 7. She complained of pain in her abdomen and right hip, chest pain, shortness of breath, nausea and diarrhoea. Pelvic ultrasound did not reveal anything suspicious, but a CT abdomen performed 24 hours after admission revealed a right psoas collection- likely an abscess with thrombosis of right sided venous system. There was multifocal lung consolidation possibly due to septic emboli. Auscultation of the chest revealed a pan-systolic murmur, triggering a bedside echo request. The report described global hypokinesis and moderate systolic impairment, with peripartum cardiomyopathy (PPCM) being suspected.
An MDT was requested with Cardiology, Interventional Radiology, Anaesthesia and Obstetrics and it was agreed that the woman would be transferred to CCU for cardiovascular support, undergo CT angio (which identified thrombosis of the right common iliac, right internal external iliacs, and multiple emboli within the lungs) and radiological drainage of the psoas abscess.
Whilst the woman remained on CCU, her case was discussed at the infective endocarditis MDT. The opinion was that the LV impairment may well have been due to sepsis, as there was no valvular pathology. She was eventually discharged home with plan for OP Echo and follow up with cardiology. If the diagnosis remained as PPCM- contraception was advised.
Dr Oldbury then gave us a brief recap on the pathophysiology of PPCM. The majority of pregnant women who die of heart disease have not been identified as being 'at risk' before labour. We also heard current guidance on the treatment of PPCM, the anaesthetic considerations for labour and delivery and the longer-term prognosis (around 50% of patients will regain normal systolic function). On reflection of the case, it was unclear when the onset of the cardiomyopathy was and the formation of the abscess – whether there was evidence that the cardiomyopathy was present antenatally.