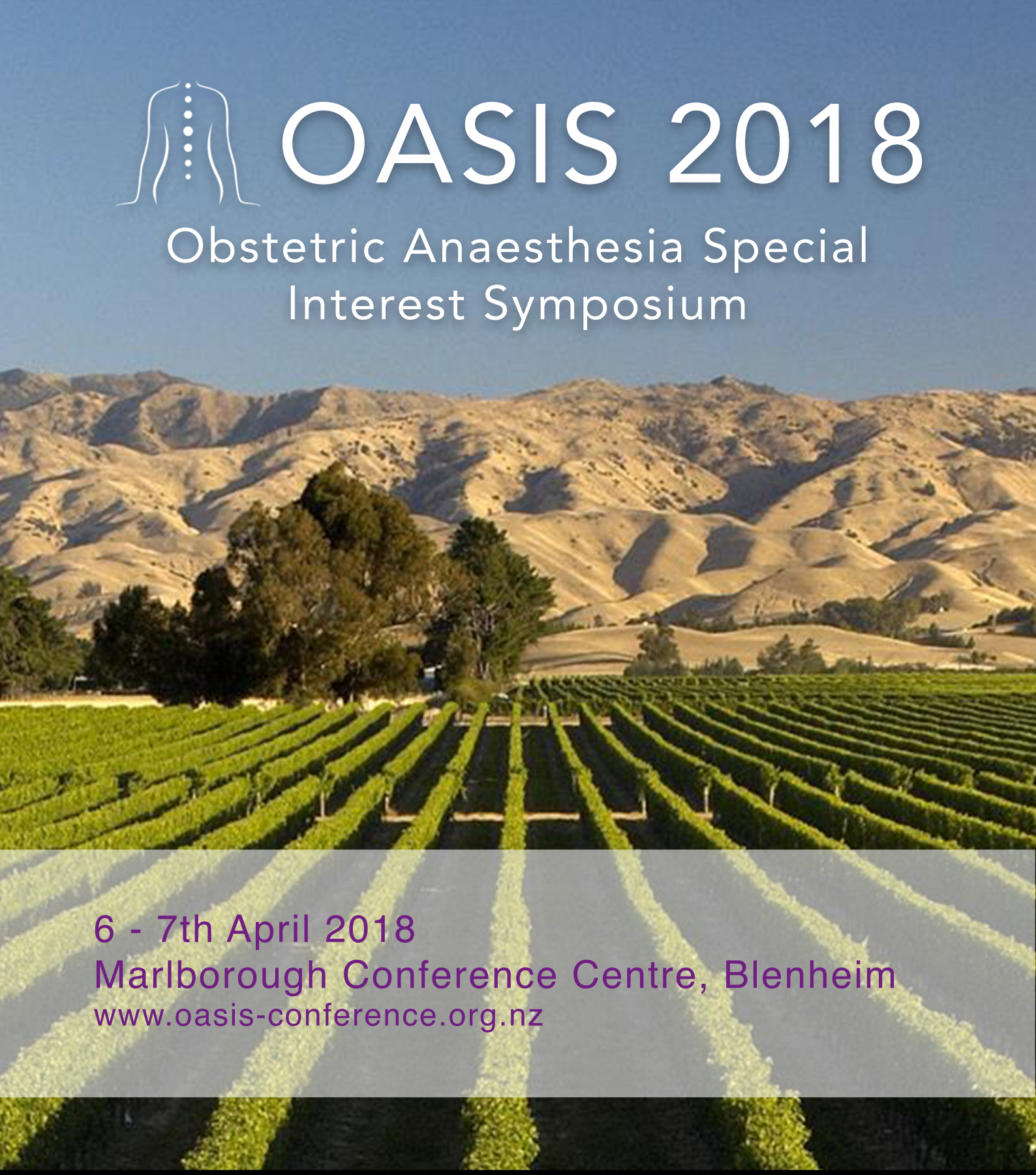

OASIS 2018

Obstetric Anaesthesia Special Interest Symposium

6 - 7th April 2018
Marlborough Conference Centre, Blenheim
www.oasis-conference.org.nz

Program and Abstract

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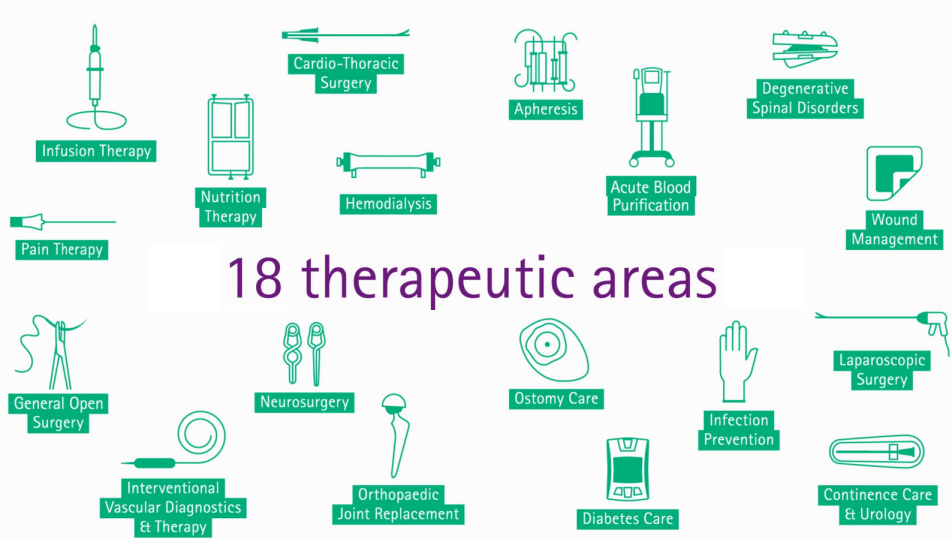

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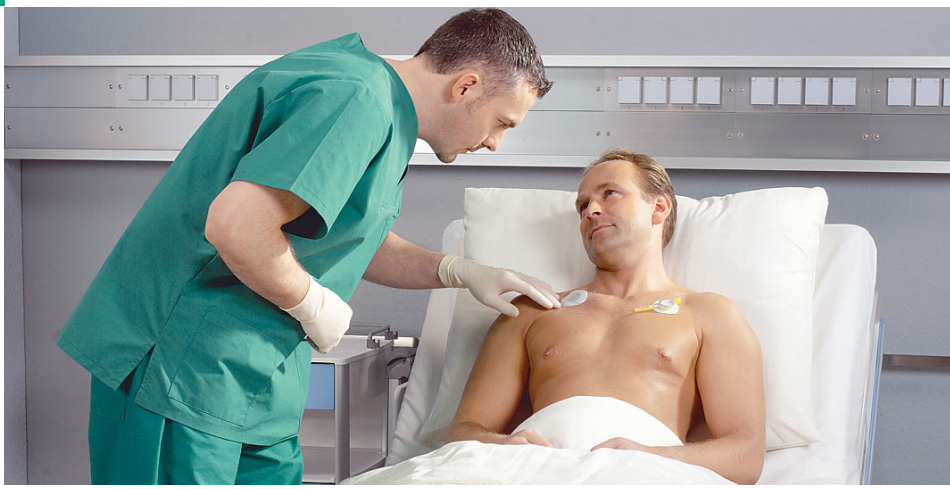

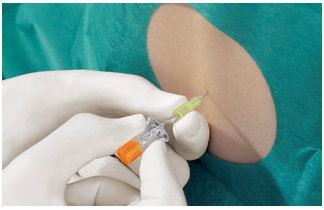

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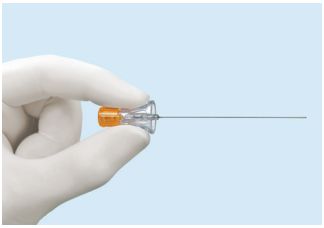

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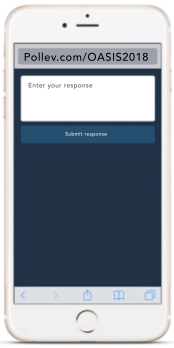
During our sessions we will be asking you to participate in the polls by responding via the Poll Everywhere webpage. There is no need to download any app. You can vote by:



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Continuing Professional Development

Participants in the 2018 ANZCA and FPM CPD program may claim this event under the Knowledge and skills activity: Learning sessions at 1 credit per hour.

Your certificate of attendance can be collected from the registration desk from afternoon tea onwards.

Toilets

The toilets are located off the common foyer area, which can be found though the double set of doors to the left of the auditorium.

Special Dietary Requirements

If you noted a dietary requirement during registration, please see the venue staff who will be able to guide you to meals that meet your requirements.

Environmental Commitment

We're proud to have been doing everything we can to increase our environmental efficiency by using environmentally friendly materials and focusing on the ideals of reduce, reuse and recycle.

Photography at OASIS 2018

Please be advised that promotional photos may be taken during the symposium for use in future advertising. Should you not wish for your photo to be taken please inform the team at registration.

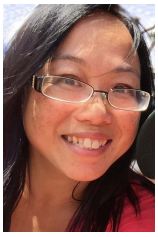
OASIS 2018 Organising Committee

Dr Joanna Doa (Convenor)
Dr Matthew Drake (Scientific Convenor)
Dr Catherine Meer (Workshop Convenor)
Dr Anna Petrocelli
Dr Andrew Reid
Dr John Walker
Dr Andrew Warmington

Conference Secretariat

Chris Peak (Conference Manager)
The Conference Company
31C Normanby Road
Mount Eden
Auckland 1024

Welcome from the Convenor



On behalf of the Organising Committee and the Department of Anaesthesia, National Women's Health, Auckland City Hospital, it is with great pleasure that I welcome you to Blenheim and to the Obstetric Anaesthesia Special Interest Symposium (OASIS) 2018 and to an inspiring, educational and enjoyable program. I hope that you will enjoy the meeting and that the opportunity to network with colleagues will stimulate a creative exchange of ideas.

I would like to thank our speakers, workshop facilitators and session chairs for their invaluable contribution. The organisation of a conference like OASIS 2018 is very much a team effort and I am grateful to the members of the organising committee, who have carried the additional workload with dedication and humour, and to acknowledge the significant contribution by our scientific convenor, Dr Matthew Drake. Thank you also to Dr Andrew Reid for his amazing work in his new skill as web developer. Finally I would like to thank B.Braun for their generous support and for hosting Friday's Welcome Reception, to The Conference Company for their excellent arrangements and to our colleagues and families for their untiring support and help in planning this meeting.

For those of you joining us at the Gala Dinner at the Omaka Aviation Heritage Centre - wining and dining in this spectacular setting will certainly finish the conference on a high note. After you have been treated to pre-dinner drinks, you will be able to watch the moving and powerful Stalingrad Experience, before making your way through the Eastern Front space to dine among the amazing aircraft in the WWII display.

All that is left to say is I hope you have a wonderful conference and enjoy your stay!

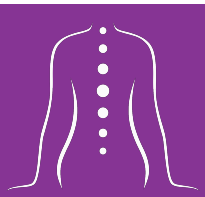
Dr Jo Doa
Convenor OASIS 2018

Welcome from the Scientific Convenor

On behalf of the National Women's Department of Anaesthesia it gives me great pleasure to welcome you to the Obstetric Anaesthesia Special Interest Symposium 2018.

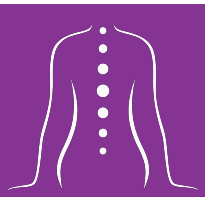
We have gathered experts in obstetrics, anaesthetics and cardiology from National Women's and beyond to bring you an engaging and thought-provoking program. Whether you work in women's health on a daily basis or part time, our aim is to renew your interest and enthusiasm for making obstetric anaesthesia care in your institution the best it can be.

Dr Matthew Drake
Scientific Convenor



Program

8.00am	**Registration and coffee**
	Session 1 **Chair: Andrew Warmington** - *Specialist Anaesthetist and Clinical Director, National Women's Health*
8.30am	**Welcome** Andrew Warmington - *Specialist Anaesthetist and Clinical Director, National Women's Health*
	What's new in obstetric anaesthesia Matthew Drake - *Specialist Anaesthetist, National Women's Health*
9.30am	**Why does the Category 1 caesarean baby never seem compromised?** Monique Stravens - *Specialist Obstetrician, Wairau Hospital, Blenheim*
10.00am	**Morning tea**
	Session 2 **Chair: John Walker** - *Specialist Anaesthetist, National Women's Health*
10.30am	**Pain in obstetric patients** **Management of antenatal pain** Glyn Richards - *Specialist Anaesthetist, National Women's Health* **Acute post-caesarean pain** Francesca Storr - *Pain Nurse Specialist, National Women's Health* **Getting the right message about pain relief options** Morgan Edwards - *Specialist Anaesthetist, North Shore Hospital*
11.45am	**We've trialled it so you don't have to … new ideas put into practice at the National Women's** Matthew Drake - *Specialist Anaesthetist, National Women's Health*



Program

12.30pm	**Lunch**
	Session 3 **Chair: Mei Soo** - *Specialist Anaesthetist, National Women's Health*
1.30pm	**Cardiac disease in pregnancy: whom you could deliver locally and whom you should refer to a tertiary cardiac unit** Fiona Stewart - *Specialist Cardiologist, National Women's Health*
2.10pm	**The day you wish you'd booked annual leave: interactive real-life case discussions from the National Women's** Kaveh Djamali – *Anaesthesia Fellow, National Women's Health* Matthew Drake - *Specialist Anaesthetist, National Women's Health* Andy Wong - *Anaesthesia Fellow, National Women's Health*
3.00pm	**Afternoon tea**
	Session 4 **Chair: Matthew Drake** - *Specialist Anaesthetist, National Women's Health*
3.30pm	**Possible placenta percreta: are you prepared?** Sue Belgrave - *Specialist Obstetrician and Chair PMMRC, North Shore Hospital* David Perry – *Specialist Radiologist, National Women's Health*
4.10pm	**Controversies in obstetric anaesthesia with interactive voting** **Cell salvage should be available 24/7 for all obstetric patients** Pro: Andy Wong - *Anaesthesia Fellow, National Women's Health* Con: Katie Ben - *Specialist Anaesthetist, Nelson Hospital* **All women with a BMI above 50 should be delivered by elective caesarean section** Pro: Monique Stravens - *Specialist Obstetrician, Wairau Hospital, Blenheim* Con: Sue Belgrave - *Specialist Obstetrician and Chair PMMRC, North Shore Hospital*
5.00pm	**Close of scientific program** Andrew Warmington - *Specialist Anaesthetist and Clinical Director, National Women's Health*

Matthew Drake

Matthew originally planned to train as an obstetrician, however some enthusiastic obstetric anaesthetists persuaded him that he could combine his interest in obstetrics with a career in anaesthesia. Originally from the United Kingdom, he is a full-time Obstetric Anaesthetist at the National Women's Hospital in Auckland. He is the ANZCA Supervisor of Training and Provisional Fellowship Supervisor at the National Women's and has been involved in various quality improvement projects there, including the introduction of Enhanced Recovery after Obstetric Surgery, Anaesthesia for External Cephalic Version of Breech presentation, and development of an obstetric-specific observations chart with appropriate physiological parameters for pregnant women.

Matthew is the Obstetric Anaesthesia representative on the Perinatal and Maternal Mortality Review Committee's Maternal Morbidity Working Group, and is the secretary of the ANZCA/NZSA National Obstetric Anaesthesia Leads Network. He has a keen interest in multidisciplinary obstetric anaesthesia education, lecturing on the midwifery course at the Auckland University of Technology, and as an instructor on the PROMPT (Practical Obstetric Multi-Professional Training) and MOET (Managing Obstetric Emergencies and Trauma) courses.

Monique Stravens

Monique is a Specialist Obstetrician & Gynaecologist at Wairau Hospital in Blenheim. She attained fellowship to RANZCOG in 2016 following completion of her training in New Zealand. She has worked at 5 different hospitals across New Zealand ranging from Tertiary Units to Provincial Hospitals. Having originally planned to subspecialise in Gynaecologic Oncology, Monique has given up the hectic pace of the big towns for life in the provinces where she can be a true Generalist and find the perfect work-life balance as she juggles her burgeoning career and young family.

Monique is a keen teacher and is a Honorary Clinical Lecturer for the University of Otago. She is a Trainee Intern Supervisor and oversees and instructs on the PROMPT course at Wairau and Nelson Hospitals.

Glyn Richards

Growing up during the war years, my earliest career aspiration was to be a Spitfire pilot. This being chronologically impossible I became fascinated by the world of medicine, duly qualifying MB.BS. from Durham University in 1966. I soon became interested in a career in anaesthetics, being an interesting balance of medical theory and practicality I thought. Post-Fellowship I worked as sole anaesthetist for several months in Sweden.

It came as a bit of a shock that I was expected to do nerve blocks for chronic pain conditions as well as general anaesthetic duties and intensive care. This however sparked an interest in pain medicine and on my return to New Zealand, in 1973, I was delighted to be invited to join Dr Bob Boas in the Pain Clinic he was developing. After many years I transferred my interest to pain in the Womens Health Discipline.

Fran Storr

My role as Clinical Nurse Specialist in Pain Management at the National Women's began in 1996. Previous to this role I held several different positions - as a theatre/anaesthetic nurse in National Women's Theatre, DCCM and Clinical Nurse Advisor and Supervisor roles. At that time there was no pain management service set up within Women's Health to review post-operative patients and I was given the role to set this service up in conjunction with the Anaesthetic Department. This is the role that I have found to be the most interesting and fulfilling aspect of my whole nursing career.

As a nurse entering the midwifery domain, it was very difficult to change practice initially. Analgesia was rarely given and any opiates were intramuscular, if you were lucky enough to receive any. Setting up interdisciplinary support took many years and the teaching load was huge – both for the service delivery, but also with the anaesthetic registrars who were seconded to the round.

I completed my Master of Nursing 2007 and since then have forged strong links with the University of Auckland supporting postgraduate teaching in Pain Management and Pharmacology papers for nurses. I belong to the New Zealand Pain Society, have provided fact sheets for IASP in the Global Year Against Pain In Women (2007 – 2008) and regularly present at local meetings.

My highlight this year was to be one of the top 200 crossfitters worldwide in my age group.

Morgan Edwards

Morgan completed medical school at Griffith University in Queensland and subsequently undertook anaesthetic training under the Auckland Regional Training Scheme. In 2017 she completed a Fellowship at National Women's Health before starting as a Specialist Anaesthetist at Waitemata District Health Board. Following the birth of her son Morgan identified a real need for readily available, factual and unemotive information for pregnant women on their pain relief choices in labour, as well as what to expect when having a caesarean section. She subsequently self-taught animation and infographic design skills and developed a series of animated infographics in conjunction with National Women's Health. In her "spare time" Morgan enjoys family time, photography and dreaming of future travel.

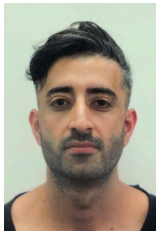
Speakers

Fiona Stewart

Fiona spent time as a Senior House Officer in Obstetrics at National Women's Hospital before competing her physician training in Auckland. Her intention was to train in Obstetric Medicine with an interest in Cardiology but realised that she would be more effective as a fully trained Cardiologist with an interest in Obstetric Medicine. She has worked as Senior Lecturer in Obstetric Medicine and for many years worked in the Medical Clinic at National Women's Hospital and for the Obstetric Medicine on call service. Her main specialist interest is in the care of women with heart disease in pregnancy.

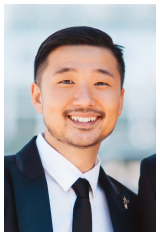
Fiona now works mainly in Cardiology for the Greenlane Cardiovascular Service and Auckland Heart Group. She maintains an active interest in Women's Cardiology and works closely with the Women's Health Anaesthetic service doing a Gynaecology Preoperative Cardiac clinic. She works closely with Cardiology colleagues around the country helping with their management of complex patients with heart disease in pregnancy. She has written invited reviews for the Obstetric Medicine Journal and is a reviewer on heart disease in pregnancy for the Obstetric Medicine Journal and Heart, Lung and Circulation Journal.

Kaveh Djamali



Kaveh works currently as a Fellow at National Women's Health Department of Anaesthesia. His interest in audit and research is aimed at improving delivery of care and patient outcome metrics. At the National Women's he is involved with a trial looking at ultra-low dose epidurals with a view to setting up a mobile epidural protocol for women in labour.
Kaveh also has had recent experience as a satisfied National Women's consumer having had his baby boy delivered there earlier this year.

Andy Wong



Andy is an Auckland trained anaesthetist. He is currently completing his Fellowship at National Women's Health Department of Anaesthesia. Andy has a passion for teaching and has been involved in-hospital house officer, anaesthetic technician and nurse teaching programs. He specialises in crisis management and is an instructor for the Certificate of Resuscitation and Emergency Care (ACLS CORE) and the Acute Life Threatening Events Recognition and Treatment (ALERT) courses.

Speakers

Sue Belgrave

Early in my medical career I knew that I wanted to be an Obstetrician. I was one of those doctors who attracted difficult cases and as part of my training in Obstetrics and Gynaecology I chose to spend time as an ICU registrar at Waikato. My training in Obstetrics and Gynaecology was predominantly in Auckland and London. As a Specialist I developed an interest in women with medical complications of pregnancy and childbirth. I worked as a consultant in the High Risk Obstetrics team at National Women's Hospital for 6 years before moving to the North Shore to take on the role of Clinical Director of Obstetrics at Waitemata DHB. I am involved in review of serious outcomes in obstetrics and have a strong interest in Quality.

My current role is an Obstetrician and Gynaecologist at North Shore Hospital and I work in ultrasound at National Women's, Waitemata DHB and for a private group reporting on Obstetric and Gynaecology ultrasound.

I am the current chair of the Perinatal and Maternal Mortality committee that also reviews cases of babies with Neonatal encephalopathy and more recently serious maternal morbidity. As part of my role in the PMMRC I am a Quality lead in HQSC and am a member of the National Maternity Monitoring Group.

David Perry

Dr David Perry is an Obstetric and Paediatric Radiologist at National Women's and Starship Children's health in Auckland. He has subspecialty interests in fetal and neonatal imaging including imaging of placental adhesive disorders and fetal MRI.

Katie Ben

Katie is an anaesthetist at Nelson Hospital and the department clinical lead for obstetric anaesthesia. After completing her anaesthetic training in the UK (Bristol, Bath and Cheltenham) she moved to New Zealand in 2009 for a one year fixed term contract and decided to stay. Katie is the New Zealand representative on the Obstetric Anaesthesia SIG Executive Committee and a member of the National Obstetric Anaesthesia Leads Network.

What's new in obstetric anaesthesia

Dr Matthew Drake
Specialist Anaesthetist, National Women's Health

The first UK confidential enquiry into maternal deaths held anaesthesia responsible in 49 of the deaths; the following triennium (1955-7), which included an anaesthetic assessor on the panel for the first time, reported only 31. Over the following 50 years obstetric anaesthesia has evolved such that there were only two anaesthetic-related maternal deaths in the 2012-5 triennium – this has been more or less stable for many years. It could be argued that quality care and safety in the subspecialty has evolved to such a point that there isn't anything that is truly "new" in obstetric anaesthesia.

However, if you speak to any new mother who has had anaesthetic input in her labour, delivery or postpartum period (quoted at 60% of all pregnant women) you will quickly appreciate there is much scope for improvement in the care we as anaesthetists deliver – labour epidurals that fail, are partially effective or result in immobility and instrumental delivery; accidental dural puncture with its associated morbidity at a critical time for motherhood; insufficient anaesthesia for operative delivery; acute postoperative pain and side effects from its treatment – the list goes on. Women's perception of satisfaction may differ from our own as anaesthesia professionals – a suboptimal epidural that permitted sufficient sensation for a spontaneous vaginal delivery may in fact be preferable despite our personal "failure"; and most of us will have experienced a dense block to T1 for an elective caesarean section that had to be converted to a general anaesthetic because of the perception of pain after surgery commences.

I have hand-searched several eminent international journals from the last 2 years for articles relevant to the practising obstetric anaesthetist and will present a brief summary of the findings from a selection of these today. In many cases they serve to confirm what we have already suspected from clinical experience or suggest incremental improvements to tried-and-tested methods, but nonetheless provide pointers towards an even better anaesthetic intervention in the peripartum period.

The presentation will follow the order of the reference list, provided separately, so you can read and review papers of interest at your leisure, and possibly incorporate some of the ideas in your own practice.

Why does the Category 1 Caesarean baby never seem compromised?

Dr Monique Stravens
Specialist Obstetrician, Wairau Hospital, Blenheim

The Category 1 Caesarean section is not an uncommon occurrence on an obstetric unit, neither is the baby who is delivered in a better than expected condition when a Category 1 caesarean section is called. This talk will review some of the literature around the Category 1 caesarean section and why there doesn't appear to be a positive relationship between neonatal outcome and a short Decision to Delivery Interval (DDI). A brief review of fetal physiology and compensatory mechanisms in the face of increased requirement will conclude the presentation.

Management of antenatal pain

Dr Glyn Richards
Specialist Anaesthetist, National Women's Health

Pain at various sites may arise during pregnancy and may become very debilitating and disheartening. This is stated to be a problem in 26% of pregnancies. The Royal College of midwives recently decided to drop the term 'normal childbirth' to describe a spontaneous vaginal delivery[1]. However the attitudes pertaining to the use of that phrase may well pervade attitudes to the whole pregnancy process and perhaps explain why some women are denied adequate pain relief or made to feel guilty or inadequate for seeking it. Likewise they may accentuate any anxieties women may have about the use of medication in pregnancy. The thalidomide disaster coloured many peoples' attitudes to medication and caused decades of suffering for many.

The overall incidence of lumbopelvic pain arising during pregnancy is between 26 and 56%[2] and may interfere with work, daily activities and sleep. 8% of these are severely disabled. Some of the difficulty in treating these patients lies in the lack of understanding of the underlying mechanism[3]. Recent studies on whiplash may be pertinent.

We will discuss the wider picture of pain syndromes arising in pregnancy, the problems this causes for the mother and, not forgetting the other interested party, the risks to the foetus[4]. Strategies for care will be discussed as well as 'risk minimising' strategies. Multidisciplinary collaboration is a major key to success in managing the more complex cases. Windows of opportunity for interested anaesthetists to use their skills to help these women will be discussed.

By avoiding any significant analgesic medication in the first trimester we would be reasonably sure of avoiding physical developmental abnormalities. What is becoming clearer is that we must be aware of what possible influence our medication regime may have on the plasticity of the developing brain. Conclusions from statistical analyses[5] and drug studies on animals[6] will write the next page in this saga.

References:

1. *Bogod, D. F.R.C.A. Bulletin 2018; 107, 28-29*
2. *Mogren, I. Pohjanen,A. (2005) Spine; 30, 983-991*
3. *Wu et al (2004) European Spine Journal; 13, 575-589*
4. *Sharpe, C. Kuschel,C. (2004). British Medical Journal; 89, F33-F36*
5. *Sorensen, E.L. (2004), British Journal of Psychiatry; 185, 366-371*
6. *Cagla Eroglu et al (2009), Cell; 139, 1-13*

Acute post-Caesarean pain

Francesca Storr
Pain Nurse Specialist, National Women's Health

The National Women's Pain Service has been actively involved in the peri-operative pain management of acute and elective surgery for obstetric and gynaecology patients since 1996. Over the subsequent years we have developed into a team of five consultants and four nurse specialists supported by clinical psychology and physiotherapy. With this our service has expanded into in-patient management of women with complex antenatal and post-partum pain supported by a weekly out-patient clinic by our multi-disciplinary team.

As a nurse entering the midwifery domain, it was very difficult to change practice initially. Analgesia was rarely given and any opiates were intramuscular, if you were lucky enough to receive any. Setting up interdisciplinary support took many years and the teaching load was huge – both for the service delivery, but also with the anaesthetic registrars who were seconded to the round.

It had been been an important goal to establish and to continue to evolve effective multimodal pain and anti-emetic management strategies for our post-operative caesarean section women. More recently our service has embraced the concept of Early Recovery following Obstetric Surgery (EROS) for our elective caesarean section patients and we have further evolved to encourage this ideology. I shall explore our journey in my presentation.

Getting the right message about pain relief options

Dr Morgan Edwards
Specialist Anaesthetist, North Shore Hospital

Antenatal education, recognised as an essential component of antenatal care, has traditionally been labour and birth focused, developed individually by local antenatal providers and restricted to programs offered in the final weeks of pregnancy. In New Zealand public access to antenatal education varies widely. Many but not all DHBs provide free classes, with other expectant parents choosing private providers. There is no national 'curriculum' – instead the content of each class is determined by the provider, often varying greatly between classes, cohorts and regions.

The aims of antenatal education programs vary, but according to the literature usually encompass:

- building confidence in ability to give birth
- preparing parents for childbirth
- preparing for parenthood
- developing support networks
- promoting confidence
- contribute to reducing perinatal morbidity and mortality

I believe in NZ we aren't always getting this right. In April 2016 a New Zealand Herald article "Dangerous advice at antenatal classes" highlighted an issue that had come to my attention in my role as a new mother. My personal experiences also led me to appreciate the degree of misunderstanding and fear surrounding childbirth and associated medical interventions amongst expectant women. As an Anaesthetic Fellow at the National Women's I have seen first-hand the impact this misunderstanding has on individual mothers' mental health and postnatal experience. I have gone on to take part in conversations in the wider medical community both domestically and internationally about the enormity of the issue.

In August 2016 I formed a focus group of 118 NZ mothers utilising social media which allowed me to identify several key areas in which expectant mothers would greatly benefit from clearly communicated and accurate information on antenatal pain relief choices. On reviewing the literature, I identified that an animated infographic would be an easily digestible and effective way of conveying information. Digital visual mediums have been shown to have the highest comprehension and retention of all forms of patient education. I sought multidisciplinary opinions to produce a balanced and encompasing presentation, "Your labour, your way".

My hope is that my infographic will become part of routine antenatal education and that it will help to bridge the gap between anaesthetist and midwifery opinions on pain relief choices in labour.

www.yourlabouryourway.co.nz

We've trialled it so you don't have to...new ideas put into practice at the National Women's

Dr Matthew Drake
Specialist Anaesthetist, National Women's Health

Innovation, or challenging the status quo, is essential if the quality and safety of obstetric anaesthetic care is to continue to improve. However, results seen in clinical trials are often hard to replicate in the "real world". Probably more than in any other area of anaesthesia, Obstetric anaesthetists collaborate with many professional disciplines – which puts them in an excellent position to view the woman's whole peripartum journey and develop innovative solutions to problems. Whilst we all strive to give our women the very best outcomes, many professionals will be reluctant to change practice until a clear benefit has already been demonstrated; influencing change across the many disciplines that comprise peripartum care can in itself discourage innovation.

Good ideas can only become widely adopted clinical practice with significant effort, unwavering enthusiasm and a dogged belief that the final destination is worth the journey. This session will discuss the evidence behind several new ideas which are being trialled or put into practice at the National Women's, and our experience of implementing them. Hopefully you will be inspired to try out one or more in your own unit.

Cardiac disease in pregnancy: whom you could deliver locally and whom you should refer to a tertiary cardiac unit

Dr Fiona Stewart
Specialist Cardiologist, National Women's Health

Maternal heart disease is the leading indirect cause of maternal death in the developed world. More women with pre-existing heart disease are embarking on pregnancies with improved survival of women with congenital heart disease and increasing maternal age leading to an increase in rates of myocardial infarction in pregnancy. In New Zealand, the Pacific and parts of Australia rates of rheumatic heart disease remain high.

The goal of good pregnancy care is the delivery of a healthy baby without compromising the mother's health. Careful assessment of the pregnant woman and well documented planning for the pregnancy and delivery care can significantly improve this outcome.

Risk at delivery is determined by:

1. The mother:
   - What is her underlying cardiac condition, is it stable, progressive, improving or unpredictable. This requires a careful cardiac assessment early in pregnancy and throughout the pregnancy.
   - Any additional complications that may change her cardiac status – the development of gestational hypertension, pre-eclampsia or a condition such as placenta praevia where there is an increased risk of haemorrhage.
2. The local hospital environment:
   - The availability of cardiac reviews and imaging where necessary
   - Anaesthetic and obstetric care available 24/7
   - The availability of peri and post delivery monitoring
   - Cardiac surgery back up

Understanding the physiological changes in pregnancy, labour and the puerperium can help predict potential complications along with an understanding of the woman's underlying cardiac condition, its severity and the effect that a sudden change in preload (PPH) or afterload (epidural, gestational hypertension, pre-eclampsia) might have.

Careful documented plans are critical for managing high risk women. These should be multidisciplinary, discussed with the woman and available 24/7 in case of emergencies.

Colleagues are always happy to discuss women whom you might be concerned about.

References:

1. *ESC Guidelines on the management of cardiovascular diseases during pregnancy. Eur Ht J 2011; 32j: 3147-97. An update of this is expected early 2018.*
2. *Canobbio et al. Management of pregnancy in patients with complex congenital heart disease. Circulation 2017; 135*
3. *Stewart FM. Marfan's syndrome and other aortopathies in pregnancy. Obstetric Medicine 2013; 6 (3): 112-119.*

The day you wish you'd booked annual leave: interactive real-life case discussions from the National Women's

Dr Kaveh Djamali
Anaesthesia Fellow, National Women's Health

Dr Matthew Drake
Specialist Anaesthetist, National Women's Health

Dr Andrew Wong
Anaesthesia Fellow, National Women's Health

Having a backstage pass to one of the most significant events of a woman's life must be the most rewarding part of any anaesthetist's professional work. Society has come to expect an excellent experience and outcome for both mother and baby in the peripartum period. However, occasionally the unexpected can crop up, usually at 2am when staffing and cognitive function are at their lowest – these are the times you wish you'd booked that last minute trip to Fiji instead of being rostered to the birthing suite.

This session will present three cases from the National Women's where the unexpected has surfaced with limited time to prepare or consult a colleague, or events have taken an unexpected turn and there is no one single "best" course of action. We invite you to take an active part in these presentations using your devices to vote for your opinion on the best course of action as the cases unfold, before finding out what actually happened.

We are very grateful to all three women for giving consent for their cases to be discussed in this forum.

Interactive polling instructions

This session will be an interactive session. We will be asking you to participate in the polls by responding via the Poll Everywhere webpage.

- Visit pollev.com/OASIS2018
- Wait for the poll to appear and respond with a click

Poll Everywhere

Possible placenta percreta: are you prepared?

Dr Sue Belgrave
Specialist Obstetrician and Chair PMMRC, North Shore Hospital

Dr David Perry
Specialist Radiologist, National Women's Health

Dr Sue Belgrave

I will start with a personal journey about early experiences with catastrophic bleeding following unrecognised placenta accreta/increta/percreta. I developed an interest in antenatal diagnosis on ultrasound and by virtue of my interest inherited the clinical responsibility for a number of women with accreta and percreta. Over the intervening time awareness of the condition and publications on the topic have increased dramatically. Expert opinion however continues to be important in both diagnosis and management. There are different approaches to surgery and conservative options. What everyone agrees on is the necessity of a multidisciplinary approach and planning for both elective and emergency delivery.

On behalf of the Anaesthestists of National Women's Health, Auckland City Hospital, we cordially invite you to join us at

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