Obstetrics

Current Awareness Newsletter

March 2016
**Outreach**

Your Outreach Librarian can help facilitate evidence-based practice for all PICU staff, as well as assisting with academic study and research. We can help with literature searching, obtaining journal articles and books, and setting up individual current awareness alerts.

**Literature Searching**

We provide a literature searching service for any library member. For those embarking on their own research it is advisable to book some time with one of the librarians for a 1 to 1 session where we can guide you through the process of creating a well-focused literature research and introduce you to the health databases access via NHS Evidence.

**Critical Appraisal Training**

We also offer one-to-one or small group training in literature searching, accessing electronic journals, and critical appraisal/Statistics. These are essential courses that teach how to interpret clinical papers.

For more information, email: katie.barnard@uhbristol.nhs.uk

**Books**

Books can be searched for using SWIMS our online catalogue at www.swims.nhs.uk. Books and journals that are not available on site or electronically may be requested from other locations. Please email requests to: library@uhbristol.nhs.uk
Contents

1: Tables of Contents from March’s Gynaecology journals

2: New NICE Guidance

3: Latest relevant Systematic Reviews from the Cochrane Library

4: NHS Behind the Headlines

5: New activity in Uptodate

6: Current Awareness database articles
Tables of Contents from relevant journals

If you require full articles please email: library@uhbristol.nhs.uk

Click here Obstetrics and Gynaecology

British Journal of Obstetrics and Gynaecology

American Journal of Obstetrics and Gynecology

New Nice Guidance

Quality Standard Antenatal and postnatal mental health

Latest relevant Systematic Reviews from the Cochrane Library

Table of Contents: Issue 3, 2016

Interventions for supporting the initiation and continuation of breastfeeding among women who are overweight or obese

Hora Soltani, Frankie J Fair
Online Publication Date: February 2016

Pharmacological interventions for generalised itching (not caused by systemic disease or skin lesions) in pregnancy

Phassawan Rungsiprakarn, Malinee Laopaiboon, Ussanee S Sangkomkamhang, Pisake Lumbiganon
Online Publication Date: February 2016
Supplementation with multiple micronutrients for breastfeeding women for improving outcomes for the mother and baby
Sarah K Abe, Olukunmi O Balogun, Erika Ota, Kenzo Takahashi, Rintaro Mori
Online Publication Date: February 2016

Antenatal and intrapartum interventions for preventing cerebral palsy: an overview of Cochrane systematic reviews
Emily Shepherd, Philippa Middleton, Maria Makrides, Sarah J McIntyre, Nadia Badawi, Caroline A Crowther
Online Publication Date: February 2016

Dietary supplementation with myo-inositol in women during pregnancy for treating gestational diabetes
Tineke J Crawford, Caroline A Crowther, Jane Alsweiler, Julie Brown
Online Publication Date: February 2016

NHS Behind the Headlines

'Vaginal seeding' may put newborns at risk of infection

Wednesday Feb 24 2016

"'Vaginal seeding' of babies born by C-section could pose infection risk," The Guardian reports. The practice of exposing babies born by caesarean section to their mother’s vaginal fluid in an effort to boost their immunity...

Evidence of link between Zika virus and birth defect 'boosted'

Thursday Feb 18 2016

"Brazilian study boosts theory that Zika causes birth defect," The Guardian reports. Researchers have detected the virus in amniotic fluid surrounding two unborn babies known to have abnormally small heads (microcephaly)...

Paracetamol use in pregnancy and infancy linked to child asthma

Wednesday Feb 10 2016

"Babies given paracetamol are nearly a third more likely to develop asthma," the Mail Online reports. The study the news is based on also found a link between maternal use of the painkiller in pregnancy, and childhood asthma...
What's new in obstetrics and gynecology

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Disclosures: Kristen Eckler, MD, FACOG Nothing to disclose. Sandy J Falk, MD, FACOG Nothing to disclose. Vanessa A Barss, MD, FACOG Nothing to disclose.

Contributor disclosures are reviewed for conflicts of interest by the editorial group. When found, these are addressed by vetting through a multi-level review process, and through requirements for references to be provided to support the content. Appropriately referenced content is required of all authors and must conform to UpToDate standards of evidence.

Conflict of interest policy

All topics are updated as new evidence becomes available and our peer review process is complete. Literature review current through: Feb 2016. | This topic last updated: Mar 02, 2016.

The following represent additions to UpToDate from the past six months that were considered by the editors and authors to be of particular interest. The most recent What's New entries are at the top of each subsection.

OBSTETRICS

Pessary placement and twin pregnancies with a short cervix (February 2016)

Whether pessary placement prolongs the length of gestation in pregnancies with a short cervical length is controversial. In a multi-center randomized trial in Spain, placement of a pessary in twin pregnancies with a short cervix at 18 to 22 weeks significantly reduced the rate of spontaneous preterm birth <34 weeks, the primary study outcome [1]. However, there was no difference in a composite neonatal morbidity outcome for pessary use compared with no pessary use. Pending confirmatory data from additional studies and demonstration of improvement in neonatal outcome, we do not currently advise this intervention. (See "Twin pregnancy: Prenatal issues", section on 'Unproven interventions to prevent or delay preterm labor'.)

Antenatal steroids at 34 to 37 weeks for pregnancies at high risk of preterm birth (February 2016)

Antenatal corticosteroid therapy at 23 to 34 weeks of gestation for women at risk for preterm delivery reduces the incidence and severity of respiratory distress syndrome in offspring delivered within seven days of administration. Steroids have not been administered after 34 weeks because studies have not demonstrated a benefit, although data have been sparse. Recently, the Antenatal Late Preterm Steroids (ALPS) Trial randomly assigned women at 34.0/7ths to 36.5/7ths weeks of gestation at high risk for late preterm birth to receive a first course of antenatal betamethasone or placebo.
and found that the frequency of a composite outcome of neonatal respiratory problems was reduced in the betamethasone group \[^2\]. Based on these data, we suggest offering a course of antenatal corticosteroids to patients scheduled for cesarean delivery at 34\(^{0/7ths}\) to 36\(^{6/7ths}\) weeks. For women who have received a course of antenatal corticosteroids earlier in pregnancy or in whom delivery at 34\(^{0/7ths}\) to 36\(^{6/7ths}\) weeks is uncertain, we suggest not administering a course of steroids because of the theoretical potential for long-term neurodevelopmental harm with no benefit if the patient does not deliver preterm. We would also not administer steroids to women attempting vaginal delivery as the statistical reduction in severe respiratory complications in this trial was limited to patients undergoing scheduled cesarean delivery. (See "Antenatal corticosteroid therapy for reduction of neonatal morbidity and mortality from preterm delivery", section on 'After 34 weeks'.)

**Metformin use in nondiabetic obese pregnant women does not improve neonatal outcome (February 2016)**

It has been hypothesized that administering metformin to nondiabetic obese pregnant women might reduce gestational weight gain and, in turn, pregnancy complications associated with obesity. In the Metformin in Obese Nondiabetic Pregnant Women randomized trial, metformin use in the second and third trimesters reduced gestational weight gain compared with placebo (4.6 versus 6.3 kg) and the rate of preeclampsia (3 versus 11.3 percent), but did not reduce the frequency of large for gestational age neonates or adverse neonatal outcomes \[^3\]. Based on these and other recent data \[^4\], we believe use of metformin in pregnancy should be limited to management of hyperglycemia. (See "Weight gain and loss in pregnancy", section on 'Metformin'.)

**Chlorhexidine-alcohol for skin prep before cesarean delivery (February 2016)**

Either chlorhexidine-alcohol or iodine-alcohol is used for skin preparation before cesarean delivery. In a recent randomized trial comparing these agents for prevention of surgical-site infection (SSI) in over 11,000 women undergoing cesarean delivery, use of chlorhexidine-alcohol reduced the overall rate of SSIs and the frequency of postoperative office visits for wound concerns by about 40 percent \[^5\]. We recommend preparing the abdominal surgical site with a chlorhexidine-alcohol scrub before cesarean delivery, based on these data and previous data from adults undergoing clean-contaminated surgery \[^6\]. (See "Cesarean delivery: Preoperative issues", section on 'Skin preparation'.)

**Screening for perinatal depression (February 2016)**

Up to 15 percent of pregnant women experience depression either during pregnancy or in the postpartum period. Perinatal depression is under-recognized and associated with adverse outcomes including preterm birth, impaired fetal growth, lower birth weight, and impaired maternal-infant bonding. A systematic review, comparing usual care with a program for depression screening during
pregnancy (one trial) or postpartum (four trials), found that screening reduced the prevalence of depression at three- to five-month follow-up (absolute reduction 2.1 to 9.1 percent) [7,8]. We suggest routine screening for depression during pregnancy and at the six-week postpartum visit, with services available to ensure follow-up for diagnosis and treatment. The most widely used screening instrument is the 10-item Edinburgh Postnatal Depression Scale (figure 1A-B), which also can be used for prenatal depression. This approach is consistent with practice guidelines issued by the US Preventive Services Task Force, the American College of Obstetricians and Gynecologists, and the United Kingdom National Institute for Health and Care Excellence. (See "Unipolar major depression in pregnant women: Clinical features, consequences, assessment, and diagnosis" and "Postpartum blues and unipolar depression: Epidemiology, clinical features, assessment, and diagnosis".)

Postpartum psychosis associated with high recurrence risk (February 2016)

Postpartum psychosis is characterized by the emergence of psychotic symptoms, such as delusions and hallucinations, typically within the first weeks after delivery. Small studies have suggested that women with a history of postpartum psychosis are at increased risk of recurrence following a subsequent pregnancy. A meta-analysis of studies describing more than 5000 deliveries found that 35 percent of women with prior postpartum psychosis experienced recurrence following a subsequent pregnancy [9]. Thus, women with a history of postpartum psychosis should be educated about the increased risk of recurrence following childbirth and monitored closely in the first few weeks postpartum for early indications of psychosis. (See "Postpartum psychosis: Epidemiology, clinical manifestations, assessment, and diagnosis", section on 'Course'.)
Literature Search

Search History:
1. Medline; ("Intrapartum care" OR pre-eclampsia OR "preterm labour" OR "multiple pregnancy" OR "maternal medicine" OR "fetal abnormal**" OR "fetal growth").ti,ab; 23881 results.
4. Medline; (manage OR management).ti,ab; 813545 results.
5. Medline; 1 AND 4; 1928 results.
6. Medline; 5 [Limit to: Publication Year Current-2016 and (Language English)]; 23 results.

Title: Transabdominal ultrasound for detection of pregnancy, fetal and placental landmarks, and fetal age before Day 45 of gestation in the sheep.

Citation: Theriogenology, Mar 2016, vol. 85, no. 5, p. 939, 1879-3231 (March 15, 2016)

Author(s): Jones, Amanda K, Gately, Rachael E, McFadden, Katelyn K, Zinn, Steven A, Govoni, Kristen E, Reed, Sarah A

Abstract: Detection of pregnancy during early gestation is advantageous for flock breeding management. Transabdominal ultrasound is a practical and efficient approach for monitoring pregnancy and fetal growth in small ruminants. However, there is limited information using the transabdominal technique before Day 45 of gestation in sheep. Therefore, our objective was to determine how accurately transabdominal ultrasound could be used to detect pregnancy, to identify pregnancy landmarks, and to quantify fetal length before Day 45 in ewes. Multiparous Western White-faced ewes (n = 99) were estrus synchronized and exposed to one of four Dorset rams. The day a ewe was marked by a ram was considered Day 0 of gestation. Ewes not remarked by Day 20 were separated for ultrasonography. To detect pregnancy and landmarks, ewes were scanned three times per week between Day 26.0 ± 0.3 (mean ± standard error) and Day 40.0 ± 0.2. A single technician performed all scans in the right nonhaired abdominal pit using a real-time portable Eazi-Scan machine and a 5-MHz linear rectal transducer. All data were analyzed using the MIXED procedure in SAS (with repeated measures where appropriate). Because of rebreeding activity, 113 ultrasound periods were initiated. The specificity and positive predictive value were 100% during the entire study. The accuracy, sensitivity, and negative predictive value of ultrasound scanning were greater than 90% beginning at Day 33 ± 1. On average, pregnancy (n = 85) was detected at Day 28.7 ± 0.4 and nonpregnancy (n = 28) at Day 25.5 ± 0.6. Three early fetal losses were identified at Day 39.7 ± 0.7. In pregnant ewes (n = 82), the overall accuracy of fetal counting was 78%. The first observance of an enlarged uterus (P = 0.05) and pregnancy (P = 0.03) was detected earlier when multiple fetuses were developing compared with singletons. Placentome evagination was first observed earlier in triplets compared with twins and singletons (P = 0.02). Fetal length increased with day of gestation (P < 0.0001) but not fetal number (P = 0.72). A fetal number by day of gestation interaction (P = 0.01) indicated differences in fetal length at Day 29 ± 1 and Day 32 ± 1. These data demonstrate that a portable ultrasound using the transabdominal technique can be used to accurately determine pregnancy, identify landmarks indicative of gestation, and estimate fetal age, before Day 45 of gestation in sheep. Copyright © 2016 Elsevier Inc. All rights reserved.

Source: Medline

Title: The impact of fetal growth restriction on latency in the setting of expectant management of preeclampsia.
Abstract: Fetal growth restriction is a common complication of preeclampsia. Expectant management for qualifying patients has been found to have acceptable maternal safety while improving neonatal outcomes. Whether fetal growth restriction influences the duration of latency during expectant management of preeclampsia is unknown. The objective of the study was to determine whether fetal growth restriction is associated with a reduced interval to delivery in women with preeclampsia being expectantly managed prior to 34 weeks. We performed a retrospective cohort of singleton, live-born, nonanomalous deliveries at the University of Cincinnati Medical Center between 2008 and 2013. Patients were included in our analysis if they were diagnosed with preeclampsia prior to 34 completed weeks and if the initial management plan was to pursue expectant management beyond administration of steroids for fetal lung maturity. Two study groups were determined based on the presence or absence of fetal growth restriction. Patients were delivered when they developed persistent neurological symptoms, severe hypertension refractory to medical therapy, renal insufficiency, nonreassuring fetal status, pulmonary edema, or hemolysis elevated liver low platelet syndrome or when they reached 37 weeks if they remained stable without any other indication for delivery. Our primary outcome was the interval from diagnosis of preeclampsia to delivery, measured in days. Secondary outcomes included indications for delivery, rates of induction and cesarean delivery, development of severe morbidities of preeclampsia, and select neonatal outcomes. We performed a multivariate logistic regression analysis comparing those with fetal growth restriction with those with normally grown fetuses to determine whether there is an association between fetal growth restriction and a shortened interval to delivery, neonatal intensive care unit admission, prolonged neonatal stay, and neonatal mortality. A total of 851 patients met the criteria for preeclampsia, of which 199 met inclusion criteria, 139 (69%) with normal growth, and 60 (31%) with fetal growth restriction. Interval to delivery was significantly shorter in women with fetal growth restriction, median (interquartile range) of 3 (1.6) days vs normal growth, 5 (2.12) days, P < .001. The association between fetal growth restriction and latency less than 7 days remained significant, even after post hoc analysis controlling for confounding variables (adjusted odds ratio, 1.66 [95% confidence interval, 1.12-2.47]). There were no differences in the development of severe disease (85.9 vs 91.7%, P = .26), need for intravenous antihypertensive medications (47.1 vs 46.7%, P = .96), and the development of severe complications of preeclampsia (51.1 vs 42.9%, P = .30) in normally grown and growth-restricted fetuses, respectively. Fewer women with fetal growth restriction attained their scheduled delivery date, 3 of 60 (5.0%), compared with normally grown fetuses,12 of 139 (15.7%), P = .03. Admission to the neonatal intensive care unit, neonatal length of stay, and neonatal mortality were higher when there was fetal growth restriction; however, after a logistic regression analysis, these associations were no longer significant. Fetal growth restriction is associated with a shortened interval to delivery in women undergoing expectant management of preeclampsia when disease is diagnosed prior to 34 weeks. These data may be helpful in counseling patients regarding the expected duration of pregnancy, guiding decision making regarding administration of steroids and determining the need for maternal transport. Copyright © 2016 Elsevier Inc. All rights reserved.
Citation: Clinical obstetrics and gynecology, Mar 2016, vol. 59, no. 1, p. 119-127, 1532-5520 (March 2016)

Author(s): Ezzedine, Dima, Norwitz, Errol R

Abstract: Uterine fibroids (leiomyomas) are common in reproductive age women. Most women with fibroids have uneventful pregnancies. The most common complication is painful degeneration. Are fibroids associated with adverse pregnancy outcomes? If so, can we predict which fibroids are most likely to cause complications? And is there anything that can be done to prevent these complications, such as performing a myomectomy before pregnancy? Here we review the published literature looking at the impact of uterine fibroids on adverse pregnancy events, such as miscarriage, preterm labor, placental abruption, fetal growth restriction, and fetal malpresentation. A series of clinical recommendations for the management of pregnancy in women with uterine fibroids are included.

Source: Medline

Full Text: Available from Ovid in Clinical Obstetrics and Gynecology

Title: The ICSI procedure from past to future: a systematic review of the more controversial aspects.

Citation: Human reproduction update, Mar 2016, vol. 22, no. 2, p. 194-227, 1460-2369 (March 2016)

Author(s): Rubino, Patrizia, Viganò, Paola, Luddi, Alice, Piomboni, Paola

Abstract: ICSI is currently the most commonly used assisted reproductive technology, accounting for 70-80% of the cycles performed. This extensive use, even excessive, is partly due to the high level of standardization reached by the procedure. There are, however, some aspects that deserve attention and can still be ameliorated. The aim of this systematic review was to evaluate the results of available publications dealing with the management of specific situations during ICSI in order to support embryologists in trying to offer the best laboratory individualized treatment. This systematic review is based on material obtained by searching PUBMED between January 1996 and March 2015. We included peer-reviewed, English-language journal articles that have evaluated ICSI outcomes in the case of (i) immature oocytes, (ii) oocyte degeneration, (iii) timing of the various phases, (iv) polar body position during injection, (v) zona-free oocytes, (vi) fertilization deficiency, (vii) round-headed sperm, (viii) immotile sperm and (ix) semen samples with high DNA fragmentation. More than 1770 articles were obtained, from which only 90 were specifically related to the issues developed for female gametes and 55 for the issues developed for male gametes. The studies selected for this review were organized in order to provide a guide to overcome roadblocks. According to these studies, the injection of rescue metaphase I oocytes should be discouraged due to poor clinical outcomes and a high aneuploidy rates; laser-assisted ICSI represents an efficient method to solve the high oocyte degeneration rate; the optimal ICSI timing and the best polar body position during the injection have not been clarified; injected zona-free oocytes, if handled carefully, can develop up to blastocyst stage and implant; efficient options can be offered to patients who suffered fertilization failure in previous conventional ICSI cycles. Most controversial and inconclusive are data on the best method to select a viable spermatozoa when only immotile spermatozoa are available for ICSI and, to date, there is no reliable approach to completely filter out spermatozoa with fragmented DNA from an ejaculate. However, most of the studies do not report essential clinical outcomes, such as live birth, miscarriage and fetal abnormality rate, which are essential to establish the safety of a procedure. This review provides the current knowledge on some controversial technical aspects of
the ICSI procedures in order to improve its efficacy in specific contexts. Notwithstanding that embryologists might benefit from the approaches presented herein in order to improve ICSI outcomes, this area of expertise still demands a greater number of well-designed studies, especially in order to solve open issues about the safety of these procedures. © The Author 2015. Published by Oxford University Press on behalf of the European Society of Human Reproduction and Embryology. All rights reserved. For Permissions, please email: journals.permissions@oup.com.

Source: Medline

Title: Obstetric Complications and Management in Chronic Myeloid Leukemia.


Author(s): Rohilla, Minakshi, Rai, Rakhi, Yanamandra, Uday, Chaudhary, Neelam, Malhotra, Pankaj, Varma, Neelam, Jain, Vanita, Prasad, G R V, Kalra, Jasvinder, Varma, Subhash C

Abstract: Chronic myeloid leukaemia (CML) is amongst the most common haematological malignancies encountered in adults. The younger age of onset and increased incidence of CML in Indians leads to higher chances of encountering it in pregnancy. Pregnancy in CML is a complex situation as first line therapy with tyrosine kinase inhibitors (TKI), is fraught with multiple fetal safety issues. The fetal aspects have been elucidated in literature, but there is scarcity of information on the obstetric outcome per se in presence of CML, excluding the influence of TKI. Obstetric outcomes of 5 pregnancies in four patients with CML are being reported. Literature on interplay of CML and bleeding or thrombotic manifestations is reviewed. The major complications encountered were antepartum (APH) and postpartum haemorrhage (PPH), preterm labour, intrauterine growth retardation and intrauterine fetal death. Patients in the reproductive age group with diagnosis of CML should be carefully counseled regarding the effect of disease and TKI on the maternal-fetal health. Bleeding complications, particularly APH and PPH may be encountered in CML patients. Close coordination of the obstetrician, haematologist, and neonatologist is required in managing these cases successfully. The need for absolute contraception till the remission of disease needs to be emphasized for further pregnancies.

Source: Medline

Title: Modelling umbilical vein blood flow normograms at 14-40 weeks of gestation by quantile regression analysis.

Citation: The journal of maternal-fetal & neonatal medicine : the official journal of the European Association of Perinatal Medicine, the Federation of Asia and Oceania Perinatal Societies, the International Society of Perinatal Obstetricians, Mar 2016, vol. 29, no. 5, p. 701-706, 1476-4954 (March 2016)

Author(s): Rizzo, Giuseppe, Rizzo, Ludovica, Aiello, Elisa, Allegra, Eugenio, Arduini, Domenico

Abstract: To construct reference limits for gestation of umbilical vein blood flow (UVBF) in normal singleton pregnancies between 14 and 40 weeks of gestation using quantile regression. We ultrasonographically examined 852 fetuses from low-risk pregnancies between 16 and 40 weeks of gestation in a prospective cross-sectional study. UV diameter and time-averaged maximum velocity
(TAMXV) were measured in UV intra-abdominal portion by real time and Doppler ultrasonography. Semi-automatic measurement software was used to obtain UV diameter values. UVBF was then calculated from UV diameter and TAMXV measurements and expressed both as absolute value and as value normalized for foetal abdominal circumference (UVBF/AC). Individual centile values of the variables investigated were established by quantile regression in the gestational interval considered. In 50 cases UVBF was measured twice by the same investigator or by a second investigator and the intra- and inter-observer agreement was calculated. A significant increase in UV diameter, TAMXV, UVBF absolute value and UVBF/AC was evidenced in the gestational period considered. Growth charts were established based on these measurements. The intra- and inter-observer intraclass correlation coefficients resulted as 0.92 (0.87-0.96) and 0.89 (0.84-0.97), respectively, for UBVF. In this study we constructed UVBF charts using quantile regression in a large cohort of low-risk pregnancies. These charts offer the advantage of specific estimated regression parameters for each percentile, better defining the normal range of UVBF. This promises to be useful in the diagnosis and management of foetuses with abnormal foetal growth.

Source: Medline

**Title:** Association of admission serum laboratory parameters with new-onset atrial fibrillation after a primary percutaneous coronary intervention.

**Citation:** Coronary artery disease, Mar 2016, vol. 27, no. 2, p. 128-134, 1473-5830 (March 2016)

**Author(s):** Karataş, Mehmet Baran, Çanga, Yiğit, İpek, Göktürk, Özcan, Kazim S, Güngör, Barış, Durmuş, Gündüz, Onuk, Tolga, Öz, Ahmet, Şimşek, Barış, Bolca, Osman

**Abstract:** New-onset atrial fibrillation (NOAF) during hospitalization is considered a frequent complication associated with worse outcomes in the setting of ST-segment elevation myocardial infarction (STEMI). We aimed to investigate the association of admission serum laboratory parameters, neutrophil to lymphocyte ratio (NLR), and monocyte to high-density lipoprotein ratio (MHR) with NOAF in STEMI patients treated with a primary percutaneous coronary intervention (PCI). A total of 621 patients who were hospitalized with a diagnosis of STEMI and treated with primary PCI were retrospectively enrolled in the study. NOAF during index hospitalization and overall mortality were reported as the clinical outcomes. In our study population, 40 (6.4%) patients developed NOAF during index hospitalization. Monocyte counts, mean platelet volume (MPV), red cell distribution width (RDW), NLR, MHR, C-reactive protein (CRP), creatinine, glucose, and uric acid levels were higher in the NOAF+ group compared with the NOAF− group. In multivariate regression analysis, age, left-ventricular ejection fraction, left atrial volumes, admission heart rate, multivessel disease, increased levels of CRP, MPV, RDW, uric acid, NLR, and MHR independently predicted NOAF. In addition, NOAF was found to be an independent predictor of overall mortality in the study population. For the first time in the literature, admission serum levels of MPV, RDW, uric acid, NLR, and MHR were found to be correlated independently with NOAF after primary PCI.

Source: Medline

**Title:** Induction of labour versus expectant management at term by subgroups of maternal age: an individual patient data meta-analysis.

**Citation:** European journal of obstetrics, gynaecology, and reproductive biology, Feb 2016, vol. 197, p. 1-5, 1872-7654 (February 2016)
**Abstract:** British women are delaying childbirth. Women aged 35 years or over have a higher risk of perinatal death. There is a linear relationship between maternal age and delivery by emergency caesarean in nulliparous women. Many obstetricians induce older women at term attempting to improve perinatal outcomes; others are reluctant for fear of increasing caesarean rates. A recent systematic review of induction of labour versus expectant management in women at term, found induction was associated with a reduction in caesareans (OR 0.83, 95% CI 0.76-0.92). To identify whether induction of labour changes the risk of caesarean section in women aged 35 years or over. Available data sets from RCTs included in the Wood et al. systematic review (31 trials) and suitable RCTs published since week 23, 2012. Studies were included if they were randomised controlled trials comparing induction of labour with expectant management at term with intact membranes with a singleton or multiple pregnancy in a cephalic presentation. A quantitative meta-analysis of individual patient data (IPD) using a random-effects model to calculate odds ratios. In total 2675 women (five studies) were included in the meta-analysis and 2526 women (four studies) were included in the IPD meta-analysis. There was no statistically significant increase in caesarean section rates seen in either analysis. Induction of labour in women of advanced maternal age has no statistically significant effect on caesarean section rates. Copyright © 2015 Elsevier Ireland Ltd. All rights reserved.

**Source:** Medline

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**Title:** Surgery for gallstone disease during pregnancy does not increase fetal or maternal mortality: a meta-analysis.

**Citation:** Hepatobiliary surgery and nutrition, Feb 2016, vol. 5, no. 1, p. 53-57, 2304-3881 (February 2016)

**Author(s):** Athwal, Ruvinder, Bhogal, Ricky Harminder, Hodson, James, Ramcharan, Sean

**Abstract:** Pregnancy was traditionally considered a contraindication to cholecystectomy but is now becoming the favoured option for gallstone-related disease (GRD) during pregnancy. To assess if cholecystectomy during pregnancy increases the risk of preterm labour, fetal mortality and maternal mortality. PubMed and MEDLINE databases for the period from January 1966 through December 2013. Studies were both conservative and surgical intervention was utilised in the management of GRD were included. The results of the included studies were pooled using meta-analysis techniques. Surgical intervention for GRD in pregnancy does not increase the risk of preterm labour, fetal mortality or maternal mortality. Cholecystectomy during pregnancy for GRD is associated with low complications for the fetus and mother and should be considered in all suitable patients.

**Source:** Medline

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**Title:** Simulation Study Assessing Healthcare Provider's Knowledge of Pre-Eclampsia and Eclampsia in a Tertiary Referral Center.

**Citation:** Simulation in healthcare : journal of the Society for Simulation in Healthcare, Feb 2016, vol. 11, no. 1, p. 25-31, 1559-713X (February 2016)

**Author(s):** Hilton, Gillian, Daniels, Kay, Carvalho, Brendan
Abstract: The aim of the study was to assess knowledge of labor and delivery healthcare providers at a tertiary referral center in the management of pre-eclampsia and eclampsia. Thirteen multidisciplinary teams participated in this institutional review board-exempt study. Each group encountered the same scenario that involved a pre-eclamptic parturient who progressed to eclampsia. The participants were unaware of the scenario topic before the drill and that key interventions would be recorded and timed. Seven of 13 groups were randomized to have a cognitive aid available. Twelve of 13 groups attempted to lower the blood pressure; however, only 7 of 12 groups used the correct first-line antihypertensive medication as per the American College of Obstetricians and Gynecologists' guidelines. All groups requested and administered the correct bolus dose of magnesium (4-6 g intravenously). Only 2 of 13 groups took appropriate action to lower the blood pressure to a "safe range" before induction of general anesthesia, and 4 of the 13 anesthesiologists made drug modifications for induction of anesthesia. None of the 7 groups randomized to have a cognitive aid used it. Our results show widespread magnesium sulfate utilization; however, the use of antihypertensive medication is not universally administered in compliance with current guidelines. The importance of blood pressure management to reduce maternal morbidity and mortality in the setting of pre-eclampsia needs to be emphasized. Interestingly, availability of a cognitive aid did not ensure its utilization in this scenario. Findings suggest that for cognitive aids to be effectively used, it is essential that staff has been trained and become familiar with them before an emergent event.

Source: Medline
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The Library and Information Service provides free specialist information skills training for all UH Bristol staff and students.

To book a place, email: library@uhbristol.nhs.uk

If you’re unable to attend we also provide one-to-one or small group sessions. Contact library@uhbristol.nhs.uk or katie.barnard@uhbristol.nhs.uk to arrange a session.

**March** (1pm)
- 3rd Friday
- 11th Monday
- 14th Tuesday
- 22nd Thursday
- 30th Wednesday

**April** (12pm)
- 7th Thursday
- 15th Friday
- 18th Monday
- 26th Tuesday
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library@UHBristol.nhs.uk