

ANNUAL BALI INTERNATIONAL COMBINED CLINICAL MEETING

Prof. John Svigos AM,

**Consultant Obstetrician and Gynaecologist, Maternal Fetal Medicine Service, Women's and
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Background: This valuable collaboration between Adelaide and Bali was first convened by Prof. I G. Surya, the late Prof. Made Kornia and Associate Prof. John Svigos in May 2011 at Sanglah General Hospital, Bali-Indonesia. This is a three day clinical meeting consisting of a daily Plenary Session for formal presentations running along with a Concurrent Session predominantly for "hands on" and interactive teaching. The meeting has a multidisciplinary focus which is in tune with contemporary Maternal Fetal Medicine practice and consists of obstetricians, midwives, neonatologists and obstetric anaesthetists from both cities sharing their respective experiences. From an initial modest meeting with 80 registrants this has now grown to over 300 registrants in 2015. A fourth day was trialed in 2014 in which a Field Day was incorporated into the program and enabled the overseas participants to gain some first hand experience in the workings of an orphanage (Anak Anak Bali Kids), a midwife obstetric unit (Bumi Sehat) and a level two hospital (Sanjiwani Hospital, Gianyar). Further Field Days are anticipated at future meetings. The Visiting Faculty from Australia are predominantly from the Women's and Children's Hospital with input from The Lyell McEwin Hospital both in Adelaide, The Royal North Shore Hospital and the Royal Prince Alfred Hospital in Sydney and the King Edward Memorial Hospital in Perth. The broader strategic aspects of the collaboration have seen the rotation of three MFM Trainees from the Trigonum (Denpasar, Surabaya and Malang) through Adelaide for two months in 2011 and 2012 as part of their MFM training. Unfortunately AusAID funding has not been forthcoming for further rotations to occur but in 2016 a multidisciplinary group from Sanglah General Hospital will be making a one week visit to the Women's and Children's Hospital as a forerunner to further visits. Meantime the collaborations with the Dr. Soetomo Hospital, Surabaya and the Saiful Anwar Hospital, Malang are being further strengthened with members of the Visiting Faculty also visiting the MFM units at these hospitals prior to the BICCM. The Convenors for the 2016 BICCM meeting in May will be Dr. Ryan Mulyana assisted by Dr Jaya Kusuma, Feto Maternal Division, Sanglah General Hospital and Dr Rosalie Grivell assisted by Associate Prof John Svigos, MFM Service, Women's and Children's Hospital.

Keywords: clinical meeting; multidisciplinary; orphanage; trigonum; feto maternal

SYNOPSIS OF PAPERS PRESENTED AT PLENARY SESSIONS OF THE FIFTH ANNUAL BALI COMBINED CLINICAL MEETING MAY 21ST – 23RD 2015 THEME: CONTEMPORARY LABOUR WARD MANAGEMENT

INTRATHECAL LABOUR ANALGESIA IN LOW RESOURCE AREAS

Prof. Made Wiryana,

Dept Anaesthesiology and Intensive Therapy, Sanglah General Hospital

A descriptive study of neuroaxial analgesia used during labour at Sanglah Hospital was presented including not only the more standard parenteral and epidural analgesia but the more contemporary alternative of a single shot spinal (intrathecal) block using a mixture of bupivacaine/morphine/fentanyl and adjuvant clonidine to prolong its action to achieve 4 hours pain relief for the laboring mother.

THE PLACE OF PARACERVICAL, PUDENDAL, CAUDAL AND TAP BLOCKS IN ASSISTED BIRTH

Dr. Anu Raju,

Consultant, Dept Anaesthesia, Women's and Children's Hospital, Adelaide, South Australia

A descriptive study of paracervical, pudendal and caudal anaesthesia was presented with a commentary on their decreased use in the obstetric population due to the more widespread use of neuroaxial anaesthesia for assisted vaginal birth. However each technique offers the unique advantage for regional anaesthesia when central neuroaxial blockade is contraindicated or simply not available. The Transversus Abdominis Plane (TAP) Block which blocks the intercostal nerves T6 – L1 is not intended for assisted vaginal birth but is an effective method of providing post operative analgesia for lower abdominal surgery and caesarean section.

CAESAREAN SECTION AUDIT USING ROBSON'S CLASSIFICATION AT SANJIWANI HOSPITAL, GIANYAR, BALI-INDONESIA

Dr. Raka Budayasa,

Consultant Obstetrician and Gynaecologist

Caesarean section rates have been increasing world wide including Indonesia where the overall CS rate is 7.3% (IDHS data 2007) varying between 16.8% with the highest wealth and 1.8% for the poorest. However CS rates in tertiary referral hospitals are of the order of 30 – 50%. In 2011 the CS rate was 23.1% in Sanglah Hospital and in Sanjiwani Hospital it was 23.4%. This may be due to effective triage and referral but there remains the possibility that CS is being performed inappropriately or for nonstandard indications. In 2014 a CS audit was performed of the previous three years in Sanjiwani Hospital using the Robson's Classification of 10 Groups of CS Indications. These Groups are exclusive, truly inclusive, clinically relevant and can be used prospectively for determining policy. The audit identified that Group 5 (Previous CS), although forming only 13.8% of the obstetric population at the hospital, contributed 26.8% of the total CS rate with a successful Trial Of Labour After Caesarean section (TOLAC) rate of 59.1%. An active policy of TOLAC was instituted at the hospital with a successful vaginal birth rate after previous caesarean section in 102 /111 women (91.8%). The audit also identified a disproportionate percentage of failed induction or caesarean section in Groups 2 and 4 which has now led to a change in clinical practice with regard to cervical score and cervical ripening prior to induction of labour with the results to be collated at the end of 2015.

CAESAREAN SECTION AT FULL DILATATION

A/ Prof John Svigos AM,

Consultant Obstetrician and Gynaecologist, Maternal Fetal Medicine Service, Women's and Children's Hospital, Adelaide, South Australia

CS at full dilatation includes prolonged second stage in which the fetal head can be deeply impacted in the pelvis and this may be difficult to perform with associated greater maternal and fetal morbidity. The incidence has increased over the past two decades and now forms 5% of the indications for CS. Variability in case mix, individual obstetric practice and senior support, skills and training will influence the rates and make comparisons locally, nationally and internationally difficult. Failed operative vaginal delivery and failed attempt at operative delivery (principally occipito posterior position) along with higher maternal and expected fetal weight and the presence of fetal distress, the experience of the obstetrician, the fear of malpractice may all play a role in the increased incidence of CS at full dilatation. Strategies to reduce CS include appropriate management of labour, judicious use of syntocinon infusion, correction of fetal malposition by manual rotation to the occipito anterior position early in the second stage (the POP OUT Trial), Kielland's forceps, vacuum rotation cup. To reduce morbidity at CS then attention must be paid to surgical technique and dis-impaction of the fetal head including manual and passive methods (Fetal Pillow) along with structured protocols and specific drills utilizing simulators.

**THE PARTOGRAM REVISITED – IS 6 CM THE NEW 4 CM?
IS PASSIVE DESCENT AND A PROLONGED SECOND STAGE ACCEPTABLE?**

Dr Kate Andrewartha,

Registrar in Obstetrics and Gynaecology

RM Erin Kore,

Senior Intrapartum Midwife Women’s and Children’s Hospital, Adelaide, South Australia

Zhang et al (2010) after examination of 62,000 women in labour changed the longstanding Friedman’s calculations (1955) for expected progress in the first and second stages of labour after noting that the median and 95th percentile rates of cervical dilatation up to 6 cm were the same for multiparous and nulliparous but after 6 cm, multiparous entered the accelerated phase of labour while there was no clear accelerative point for nulliparous women. ie prior to that they were deemed to be in the latent phase of labour and managed accordingly. The management and length of the second stage of labour may be affected by parity, regional anaesthesia and position of the fetal head. Passive descent until there is an urge to push or the head is visible at the introitus may be suitable in women with regional analgesia but in theory has the potential for maternal and neonatal complications. Meta analyses (Brancanto et al 2007, Fitzpatrick et al 2002, Simpson et al 2002) found increased rates of spontaneous vaginal delivery, decreased assisted vaginal delivery rates, no difference in rates of sphincter injury and equivalent neonatal outcomes with passive descent. However passive descent may not be applicable in settings where the use of regional anaesthesia is low

**REVIEW OF MATERNAL MORTALITY AT SANGLAH GENERAL HOSPITAL, BALI-INDONESIA
– ARE WE MAKING A DIFFERENCE?**

Prof. I G. Putu Surya,

Feto Maternal Division, Sanglah General Hospital, Bali-Indonesia

An analysis of the Maternal Mortality Rate (MMR) was conducted 2010 – 2014 in relation to the MDG target of 100 / 100,000 live births. Bali Province consistently met the target varying between 58.1 and 71.5 / 100,000 live births. Obstetric Causes of MMR were Preeclampsia –Eclampsia, Post Partum Haemorrhage, Infection and Non Obstetric Causes of MMR were Rheumatic Heart Disease, Renal infection, Lung infection with HIV/AIDS starting to achieve prominence. Location of MMR revealed that 14.7% of women died at home, 5.39% died in transit and 79.9% died in hospital. A number of 39.9% of MMR was associated with CS. Whilst the MMR in Bali has achieved the MDG target set by the WHO and it will be lowered even further by regular audit which will improve safety and quality of care with risk management, targeted community strategies, perinatal practice guidelines and protocols of management and improved skills and training of the medical and midwifery staff