PP.87 WITHDRAWN BY AUTHOR

PP.88 IDENTIFICATION OF CLINICALLY IMPORTANT COMPONENTS OF MATERNAL AND NEONATAL COMPOSITE OUTCOMES TO ASSESS THE EFFECT OF TIMING OF DELIVERY IN WOMEN WITH MILD TO MODERATE PRE-ECLAMPSIA AT 34 TO 37 WEEKS

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Background Pre-eclampsia is associated with maternal and neonatal morbidity and mortality. Delivery is often expedited to minimise maternal complications at the risk of prematurity-related complications in the baby. The important outcomes to be evaluated in the management of pregnant women with pre-eclampsia between 34 to 37 weeks gestation is unclear.
Objective To identify the clinically important components of maternal and neonatal composite outcomes in the management of women with mild to moderate pre-eclampsia between 34 to 37 weeks by a Delphi survey of experts.
Methods A two-generational Delphi method was used to prioritise the maternal and neonatal outcomes that are considered to be important in the timing of delivery in women with mild to moderate pre-eclampsia.
Results The maternal outcomes questionnaire was sent to 20 participants and the neonatal outcomes questionnaire to 24 participants. 18/20 participants (90%) responded in the first round for maternal outcomes and 18/24 participants (75%) for neonatal outcomes. In the second round 16/17 eligible participants (94%) responded for maternal outcomes and 18/18 participants (100%) for the neonatal outcomes. 21 maternal and 24 neonatal outcomes were evaluated in the first round and 17 maternal and 25 neonatal outcomes in the second round. We identified 17 and 17 components to be clinically important for development of the maternal and neonatal composite outcomes respectively. If accepted, we will be able to provide full details of the relevant outcomes.
Conclusion The composite maternal and neonatal outcomes will allow evaluation of the effect of intervention to reduce mortality and morbidity.

PP.89 PRETERM PRE-LABOUR RUPTURE OF MEMBRANES (PPROM) – WHEN CLINICIANS ASPIRE TO FIND A BALANCE

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Introduction and objectives Preterm Pre-labour Rupture of Membranes complicates 2% of all pregnancies and is related to 40% of all preterm deliveries with significant neonatal and maternal risks. Balancing the risks between prematurity and maternal/fetal infection can pose difficult dilemmas for obstetricians. This study collected data on PPROM-delivery interval, maternal and fetal outcomes and examined the impact of inter-clinician variation in practise on clinical outcomes.
Methodology This retrospective observational study included 48 women with PPROM before 36 weeks of gestation between January 2011 and April 2012 at Calderdale Royal Hospital.
Results All patients with confirmed PPROM received erythromycin and steroid. Incidence of gestation <34 weeks at PPROM was 40%; of delivery at <34 weeks was 28%. Prolongation of pregnancy of 2–7 days occurred in 52%, 7–14 days in 2% and >14 days in 13%. Timing of induction of labour (IOL) varied from 34 to 36 + 6 weeks although without any adverse outcomes. There were two neonatal deaths (NND) following spontaneous labour.
Conclusion Prolongation of pregnancy of 48 hours or more occurred in a significant percentage of patients with conservative management. Prematurity played a crucial role in the two instances of NND. It is not clear that outcomes would have been different with different clinical management. This series shows that PPROM caries significant threat to perinatal outcome even with optimum obstetric care.

PP.90 RISK FACTORS ASSOCIATED WITH INTRAUTERINE DEATHS – OUR EXPERIENCE AT DISTRICT GENERAL HOSPITAL

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Objective To identify the relationship between intrauterine death (IUD) and various demographics, medical and obstetrics risk factors relating to the local population in Ealing.
Methods There were 47 booked, singleton IUD cases amongst 7464 births in Ealing Hospital between April 2010 to September 2012. We retrospectively analysed the medical and obstetrics risk factors of IUDs (fetus ≥24/40 with absent fetal heart activity in-utero) in the local population.
Results IUD occurred in 0.63% of all birth. Females of Asian origin are at increased risk of IUD (45%) compared to other ethnicities. Lifestyle risks like smoking and alcohol posed no significant increase in risk to the Ealing population, and consanguineous relationships only accounted for 8.5% of the cases. IUD was most prevalent amongst the young (20–25) primips (59.5%) with BMI > 25 (68%), mostly occurring between 37–40 weeks (47.7%). Majority of them were booked ≤12/40 (63.8%), had Dating and Anomaly scans, (87.2%, 89.3% respectively), low risk on antenatal screening (59.5%). Interestingly, previous caesarean section (6.3%) was the most prevalent in obstetrics history. 68% had presented antenatally with reduced fetal movements, vaginal bleeding or abdominal pain. Maternal conditions like Diabetes (4.2%), Obstetrics Cholestasis (2.1%) and Preeclampsia (10%) were not strongly associated with the IUD cases, indicating robust antenatal surveillance we provide to high risk women.
Conclusion While further studies aiming to modify IUD risk factors are needed, careful planning on timing of induction of labour should be carried out specifically in young, Asian primips with BMI > 25 who present antenatally with significant episode(s).

PP.91 RUPTURE UTERUS FOLLOWING PREVIOUS CAESAREAN SECTION IN THE SECOND AND EARLY THIRD TRIMESTER OF SUBSEQUENT PREGNANCY

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Three cases of antenatal/pre-labour uterine rupture in women with scarred uterus.

Rupture uterus following lower segment caesarean section is rare occurrence.

Rupture uterus is linked with abnormal implantation of the placenta, and endometrial deficiency. In 10% there's invasive placentation where placenta invades to deeper layers increasing the risks of bleeding; prematurity; SB/NND; hysterectomy and ICU admission.

1. 34 yrs G5P3 (Cs × 2, SVD × 1, 1 miscarriage) admitted with pain and fainting at 25/40, deteriorated so needed Laparotomy, at surgery, large haemoperitoneum; left sided (5 × 8 cm) uterine rupture, male baby delivered by classical Caesarean died immediately, unable to stop bleeding so subtotal hysterectomy performed, had blood transfusion and admitted to ITU. Histology placenta percreta...
2. 27 yrs G3P1 (Cs × 1, ×1 STOP) known bicornuate uterus, anterior low lying placenta, admitted with massive APH at 29/40 needing emergency classical Caesarean, at surgery there was left sided (10 × 8 cm defect) uterine rupture, found haemoperitoneum, female fetus good condition died later. Uterus re-constructed; bleeding managed with Rusch balloon, medicines, blood transfusion. HDU care. Histology placenta Increta.
3. 39 yrs G6P3 (×3 Cs, miscarriage, 1 Top) known posterior placenta praevia, cerclage insitu, admitted with APH and fetal distress at 33/40, emergency Caesarean, uterine rupture and placenta accreta. Baby boy good condition PPH; failed conservative management; needed subtotal hysterectomy, blood transfusion and ITU Admission. Histology Placenta accrete.

Maternal and fetal morbidity and mortality from abnormal placentation could be catastrophic. Early uterine rupture is challenging diagnosis, because initial signs/symptoms are nonspecific and this delay definitive treatment.

PP.92 MANAGEMENT OF THE SECOND TWIN AFTER EXTREME PREMATURE DELIVERY OF THE FIRST

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We discuss the case of two sets of twins, with extreme premature delivery of 1st twin prolonging the gestation of the 2nd twin using close surveillance and a cervical suture.

A 36 year old Primip, IVF conception with a previous large loop excision of the transformation zone (LLETZ) attended with blood stained discharge. Vaginal examination revealed bulging membranes (cervix 3 cm dilated). Shortly after she had spontaneous ruptured membranes and delivered a 19 + 5 a SB infant. Viability of second twin was confirmed leading to a rescue Mcdonnalds suture. Cyclogest pessaries and clinidamycin PV were commenced. At 21 weeks she was re-admitted feeling generally unwell with a low grade fever. Steroids were given at 24 weeks gestation. At 30/40 she went into pre term labour. The suture was removed and she progressed rapidly to full dilatation and delivered. The baby made good progress on neonatal unit.

A 31 year old primip, IVF twins, presented with bleeding and SRM at 17 weeks gestation. She proceeded to deliver Twin 1. A rescue suture was inserted. Ante natal course was uneventful and the suture was removed at 36/40. She progressed into spontaneous labour and had a LSCS due to persistence of a pathological CTG.

Although evidence limited the cases have highlight that in some circumstances insertion of a rescue cervical suture is beneficial to prolong the gestation and viability of the second twin. Both of these sets of twins had oligohydramnios after suture insertion which then normalised throughout the rest of the antenatal course.

PP.93 PREGNANCY OF UNKNOWN LOCATION OUTCOMES IN AN EPAU SETTING

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Pregnancy of unknown location (PUL) refers to cases where there are no signs of intrauterine or extrauterine pregnancy on transvaginal ultrasound as well as no evidence of retained products of conception. The most recent report of the Confidential Enquiry into Maternal Deaths in the United Kingdom suggested that the term PUL should be abandoned and that "an early pregnancy ultrasound which fails to identify an intrauterine sac should stimulate active exclusion of tubal pregnancy".

The Early Pregnancy Assessment Unit in the Coombe Women and Infants Maternity Hospital recorded 3,900 patient visits during the study period. We examined cases of women with a diagnosis of PUL who presented between September 2011 and September 2012. Data was obtained retrospectively from routine information ascertained at the time of initial consultation and from patient records.

190 women had a diagnosis of PUL at their initial presentation to the EPAU. Mean gestation at presentation was 7.0 weeks (4.0–12.0). 158 women (83.1%) were subsequently diagnosed with complete miscarriage. 18 women (9.5%) had an ongoing intrauterine pregnancy. 14 women (7.4%) were diagnosed with an ectopic pregnancy at a subsequentvisit. The average number of samples taken for serum βhCG measurement was 2.3 and the average duration of follow-up of all women was 5.8 days. The incidence of PUL in women attending our unit was 4.8%.

Conservative management of pregnancy of unknown location is safe when carried out in a setting which enables patients to be monitored closely with rapid access to transvaginal ultrasound and serum βhCG quantification.

PP.94 DELAYED INTERVAL DELIVERY IN MULTIPLE PREGNANCY: A CASE REPORT

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We present a very unusual case of a set of twins delivering 87 days apart and with a birth weight difference of 1990 g with survival of both.

A 33 year old woman with 2 previous full term vaginal deliveries presented to the EPAU of out department at 6 weeks gestation with light PV bleeding. Ultrasound confirmed DCDA twin pregnancy. Follow-up ultrasound 10 days later confirmed an ongoing pregnancy. She had formal booking appointment at 12 weeks and an uncomplicated pregnancy with regular review until 23 + 5 gestation when she presented with brown PV watery loss. PPROM of Twin 1 was confirmed. She was afebrile with normal BP and HR. HVS was taken, oral erythromycin commenced and bethamethasone administered. She was retained for inpatient monitoring and counselled about the associated risks of preterm delivery.

24 hours following admission she began contracting and had a quick spontaneous breech vaginal delivery of twin 1, a female, at 24 + 0 weeks weighing 550 g. Twin 2 was Cephalic with normal liquor volume on ultrasound. A trial of conservative management was agreed. She was retained in hospital for 4 hourly temperature, HR and BP cheques as well as weekly HVS, CRP and FBC monitoring and ultrasound surveillance.

Her inpatient management period was uneventful and she was induced at 36 + 3 gestation with 1 mg of Prostaglandin PV and went on a few hours later to have a spontaneous vaginal delivery of Twin 2, a female, weighing 2.54 Kg as well as the retained placenta of Twin 1.