that of the population as a whole. Children born following ICSI had fewer total hospital admissions than their IVF peers, the difference did not persist when first admissions were analysed. Different-sex twins, but not twins overall, had lower total hospital admissions than singletons.

Abstract PF.46 Table

	All hospital admissions		First hospital admission	
ART cohort	O (E)	SAR# (95% CI)	O (E)	SAR# (95% CI)
All ART children	1378 (1795.3)	77 (73, 81)	634 (855.3)	74 (68, 80)
Type of ART	928 (1141.7)	81 (76, 87)	413 (542.0)	76 (69, 84)
-IVF treatment	450 (653.6)	69 (62, 75)*	221 (313.3)	71 (61, 80)
-ICSI treatment				
Type of embryo transfer	1153 (1458.5)	79 (74, 84)	512 (697.6)	73 (67, 80)
-Fresh embryo transfer	225 (336.8)	67 (58, 76)*	122 (157.7)	77 (64, 91)
-Frozen embryo transfer				
Plurality	888 (1172.7)	76 (71, 81)	425 (558.1)	76 (69, 83)
-Singleton	189 (293.4)	64 (55, 74)*	113 (139.6)	81 (66, 96)
-Different-sex twins	472 (599.3)	79 (72, 86)	200 (286.6)	70 (60, 79)
-Twins				
Gender	753 (1009.0)	75 (69, 80)	357 (463.4)	77 (69, 85)
-Male	625 (781.7)	80 (74, 86)	277 (390.3)	71 (63, 79)
-Female				

*denotes statistically significantly different to the value directly above
Standardized for age-group, gender and calendar period

PF.47 ROUTINE CERVICAL ASSESSMENT AT ANOMALY SCAN MAY REDUCE NEONATAL MORBIDITY AND MORTALITY ASSOCIATED WITH PRETERM BIRTH

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A recent metaanalysis has suggested that measurement of the cervical length should be performed in conjunction with the anomaly scan (1). We decided to investigate if this recommendation is justifiable in a population where the risk of preterm birth is low.

Methods We reviewed 11 years of obstetric data from the Coombe Women and Infants University Hospital. Relative risks of adverse outcomes from the metanalysis were applied and we extrapolated the possible numbers of women requiring intervention.

Results Over the 11 years from 1999 to 2010, there were 94,646 singleton deliveries.

There were 881 births (0.93%) as a result of spontaneous labour from 19–34 weeks, of which 805 were livebirths. Applying the figures from the metaanalysis 1609 women who had a singleton pregnancy could be expected to have a cervical measurement <15 mm. If none of these women received progesterone we could expect 515 women (32.1%) to deliver at <34 weeks. If we gave progesterone to all these women we would prevent 281 births at less than 34 weeks (17.5%). Therefore we would reduce the delivery rate before 34 weeks by 234 pregnancies, which is 21 babies a year.

Conclusion In units where the spontaneous preterm rate is low it is difficult to suggest that routine cervical measurement is justified. Each individual hospital should evaluate the possible benefits of universal screening for a short cervix prior to instigating a policy of performing a transvaginal ultrasound assessment of cervical length at the time of the anomaly scan.

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PF.48 PRENATAL DIAGNOSIS OF MODERATE AND SEVERE CEREBRAL VENTRICULOMEGALY – OUR EXPERIENCE AN A SINGLE TERTIARY REFERRAL CENTRE

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The diagnosis of fetuses with cerebral ventriculomegaly >1.2 mm prenatally is challenging due the number of possible etiologies and variable prognoses. Recommended investigations include ultrasonographic assessment, TORCH screening, MRI evaluation along with specialised paediatric postnatal follow-up. There is limited data about the antenatal course and obstetric outcomes of affected pregnancies managed expectantly. We sought to evaluate all cases of prenatally diagnosed moderate to severe ventriculomegaly managed in our centre. We performed a retrospective cohort study of patients attending/referred to the Rotunda FAU from 2006–2011. Cases were identified from the FAU database and included for evaluation if ultrasonographic measurements >1.2 mm in either/both cerebral ventricles were documented. During this six year period, there were 71 cases identified that met study criteria with pregnancy outcome data available for 65 cases. Of these 83.1% (54/65) elected to continue the pregnancy following diagnosis with 44/54 continuing their care in the Rotunda Hospital. The mean gestation at time of ultrasonographic diagnosis was 24 + 3 weeks (14 + 4 – 39 + 4). Other prenatal investigations performed included 23 amniocenteses, 17 TORCH screens and 12 fetal MRIs. Vaginal delivery was achieved in 33.3% of women (n = 13) (mean HC 325.9 mm) with the remaining 66.7% (n = 26) undergoing caesarean section (mean HC 347.9 mm). The majority of cases with ventriculomegaly >12 mm were managed expectantly within our unit. We found that this finding had a significant impact on the mode of delivery. Overall less than 50% cases had a definitive aetiology prior to delivery which highlights importance of thorough paediatric follow-up postnatally.

PF.49 TERM ADMISSIONS TO THE NEONATAL UNIT; ARE THEY AVOIDABLE?

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Introduction Approximately 10% of all babies born require admission to the neonatal unit and term infant represent a significant percentage of NICU admission and are major contributors to workload.

Aim To identify potentially avoidable admissions of term babies to neonatal unit and common avoidable factors.

Background Neonatal intensive care and special care nurseries provide a level of care that is both high in cost and low in volume. Term infant represent a significant percentage of NICU admission and are major contributors to workload.

Methods Retrospective audit from 01/01/2011 to 31/12/2011, patient list obtained from SCBU data base.

Results Total number of deliveries was 3882. Total admissions to SCBU were 316. Term baby admissions (>37 wks) were 117 (37%). 55% of babies stayed 3 to 5 days in SCBU. 19% babies required respiratory support. Readmission needed in 4 cases. External transfer was done in 8% (9) cases for reasons like cooling, surgical opinion and severe jaundice. No perinatal mortality was noted in these series.

Maternal profile 70% of the mothers were without any obstetric or medical risk factors. 50% mothers came in spontaneous labour. 50% of these mothers were delivered by vaginal delivery.

In RDS group –50% (vaginal delivery) and 20% (Elective LSCS).

In hypoglycaemic group-39% were diabetic mothers and 33% had good intrapartum blood sugar control.

Conclusions 70% of mothers were low risk and 50% of them were admitted in spontaneous labour. There were no major avoidable factors in the mothers to reduce term neonatal admissions.

Recommendations To set up a transitional care unit where babies needing intermediate care can be managed and this will reduce the cost of admissions to SCBU.

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PF.50 TERMINATION OF PREGNANCY FOR FETAL ANOMALY – ARE WE PROVIDING A WOMAN CENTRED SERVICE?

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Background With improved antenatal testing, more women face the possibility of termination of pregnancy for fetal anomaly (TOPFA). Choice of medical or surgical TOPFA method is advocated by the RCOG based on similar risk profiles[1]. We investigated women's experiences of TOPFA by surveying members of Antenatal Results and Choices (ARC) - a national charity supporting parents throughout antenatal testing.

Methods A link to an online questionnaire with structured and open-ended questions was emailed to 600 members and publicised on the ARC website. The survey was open from 20/1/12 – 7/3/12. Responses were downloaded, cleaned, coded, and analysed using SPSS and Microsoft Excel. TOPFAs after 24 weeks gestation and selective reductions were excluded.

Results 351 responses were analysed. Indications for termination were categorised as chromosomal/genetic (56%), structural (42%), and other (2%). Mean gestation at TOPFA was 17 weeks. Overall, 74% were only offered medical TOPFA; 14% were offered a choice. At ≤15 weeks gestation, 31% were offered choice vs. 5% at 16–24 weeks ($p < 0.001$). 16% with a chromosomal/genetic indication were offered choice vs. 12% with a structural/other indication ($p = 0.25$). Overall, 78% underwent medical TOPFA; 88% indicating it was the only method offered. Of those offered choice, 60% chose surgical. Women who had surgical TOP were more likely to feel it was right for them.

Conclusion Accepting the limited survey sample, our survey suggests women are not offered a choice of method for TOPFA, impacting on satisfaction. Service delivery needs improvement to meet national guidance and women's needs.

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PF.51 EXPECTANT MANAGEMENT OF PRENATALLY DIAGNOSED FETAL ANEUPLOIDY

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It is essential to counsel patients about all options following the prenatal diagnosis of fetal aneuploidy (FA). We sought to ascertain the prenatal course and pregnancy outcomes in those with a prenatal diagnosis of fetal aneuploidy and were managed expectantly.

Prenatally diagnosed cases of FA were identified from the anomaly register between 2005 and 2011. The indication for diagnostic testing, the ultrasound findings and subsequent pregnancy outcomes were analysed.

There were 212 cases of prenatally diagnosed FA registered on the database during the study time period. There were 84 (39%) cases of expectant management. The indication for invasive testing included; markers at fetal anatomical survey (n = 49); cystic hygroma (n = 21); high risk FTS (n = 11) and maternal request (n = 3). Second trimester ultrasound abnormalities detected included; Multiple abnormalities 36%, cardiovascular 19%, central nervous system 19%, cystic hygroma 9% and others 17%. Cases of Trisomy 18 and 13 were more likely to be managed expectantly than T21, OR 0.14 (95% CI 0.08–0.25 $p < 0.0001$). Intra-uterine death (IUD) occurred in 40 (48%) cases, late miscarriage in 13 (15%), early neonatal death in 14 (17%) and 17 (20%) infants were alive at six week follow up. The mean gestational age at delivery was 31 weeks.

This study provides much needed data about the expectant management of affected pregnancies. Important information includes the high rate of IUD and preterm delivery. We found that patients in our cohort were more likely to continue the pregnancy with a lethal diagnoses of T13 and 18 compared to T21.

PF.52 THE NATURAL HISTORY OF TRISOMY 18 AND TRISOMY 13

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Objective Trisomy 18 (T18) and trisomy 13 (T13) are the second and third commonest aneuploidy syndromes, with prevalences of approximately 4:10,000 (T18) and 2:10,000 (T13) births. We aimed to examine the natural history (including diagnosis, pregnancy outcome, complications and survival) of these pregnancies in a setting where termination of pregnancy for fetal abnormality is illegal.

Study design A retrospective review was performed of confirmed cases of trisomies 18 and 13 from 2001 to 2012. Following case identification, individual charts were examined.

Results 46 trisomy 18 and 24 trisomy 13 pregnancies were identified. Median maternal age was 38 years (T18) and 35 years (T13). Most T18 cases (74%) were diagnosed prenatally, however, less than half (45%) of T13 cases were prenatally diagnosed. 36% (T18) and 18% (T13) of live born fetuses were delivered by emergency Caesarean section, the commonest indication being distress in undiagnosed fetuses. All but three T18 pregnancies and one T13 pregnancy continued to a natural outcome. 48% (T18) and 46% (T13) survived following birth, for a median of 1.5 days (T18) and 7 days (T13). A significantly longer survival time was found in T18 female infants compared with males. One T13 infant is alive at over one year of age.

Conclusions This study provides information for professionals and patients regarding the natural histories of trisomies 18 and 13