

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.

#### REFERENCES

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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<sup>1</sup>. 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.

#### REFERENCE

1. Termination of Pregnancy for Fetal abnormality in England, Scotland and Wales Report of a Working Party (May 2010) RCOG.

#### 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