## PL.49 REDUCING THE CAESAREAN SECTION (CS) RATE IN A RURAL HOSPITAL IN SOUTH-WEST UGANDA

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**Background** The fertility rate in Uganda is 6.1.[1] The significance of repeated CS and the risks of labour after caesarean section are well-documented. Often CS is the most appropriate mode of delivery but the decision to operate should be made judiciously to reduce maternal morbidity and mortality.

The CS rate in Kisizii Hospital, previously around 23% (2009–2010), had increased steadily to 41% in July 2012. Retrospective case note examination indicated frequent poor decision-making in labour leading to unnecessary CS. Decisions were often made by very junior staff.

**Method** The following were implemented in early August:

1. Tutorials on diagnosing & managing progress in labour and fetal distress
2. Tutorials on vacuum deliveries
3. Algorithms to aid decision-making processes
4. Updated induction of labour guidelines

**Results**

**Abstract PL.49 Table 1**

| | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct |
|---|---|---|---|---|---|---|---|---|---|
| CS rate (% del) | 39.4 | 41.8 | 33.5 | 34.0 | 36.0 | 41.1 | 26.2 | 23.5 | 31.5 |
| Fresh SB rate* | 1.1 | 1.6 | 2.1 | 2.8 | 0.5 | 2.1 | 2.7 | 2.3 | 2.7 |
| Birth asphyxia rate* | 0.6 | 5.4 | 1.0 | 14.9 | 6.3 | 1.1 | 2.0 | 5.1 | 3.4 |

*percentage of live births

The CS rate for August to October was statistically significantly less than for January to July ($p < 0.05$, Fisher's exact test). There were no significant differences observed in the fresh stillbirth or birth asphyxia rates.

**Conclusion** Simple algorithms with timely tutorials can help junior staff to improve their decision-making processes where the preferable alternative of continual senior support is not feasible.

## PL.50 AN AUDIT EXPLORING THE IMPACT OF NICE CAESAREAN SECTION GUIDANCE ON ELECTIVE CAESAREAN SECTION RATES AT THE COUNTESS OF CHESTER HOSPITAL (COCH)

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**Background** In November 2011, NICE released new guidance for Caesarean Sections in the UK. The new guidance stated that "for women requesting a CS, if after discussion and offer of support, a vaginal birth is still not an acceptable option, offer a planned CS"[1]. This audit will look into whether this has increased CS rates at COCH.

**Method** 40 sets of patients notes were selected to represent a snapshot of elective CS from January 1st 2012 to June 30th 2012. Data collected included documented indication for delivery, actual indication for delivery as well as elective CS rates for 2010, 2011 and 2012.

**Results** The overall elective CS rate for the hospital increased by 2% between Jan–June 2011 and 2012 compared to only a 1% rise between 2009–2011. The overall maternal request rate has increased from 0.5% of total deliveries in 2010 and 2011 to 1.4% in Jan- September 2012. Within the cohort the maternal request rate was 7.5% for Jan to June 2012 compared to 5.5% in 2010. There was a large disparity between documented and actual indication for delivery of 30%.

**Conclusion** From the results of this audit we can see that elective CS rates due to maternal request are on the increase. This suggests that the NICE guidance released in November 2011 has had an impact, to what degree is difficult to say however we can better substantiate this with annual figures.

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[1]UNICEF 2010

## PL.51 SEVEN IN ONE YEAR: LESSONS LEARNED FROM A REVIEW OF PERIPARTUM HYSTERECTOMY IN A DISTRICT GENERAL HOSPITAL

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Following an unusual number of peripartum hysterectomies performed in the calendar year August 2011 to August 2012 in our district general hospital, we undertook a detailed review of the seven cases in which caesarean hysterectomies were necessitated by major obstetric haemorrhage, an incidence of about 12 per 10,000 deliveries, approximately three times the incidence quoted in UKOSS data.

Comparing these with the available national data regarding pathophysiology, we noted that the higher than expected incidence of placental implantation abnormalities were likely the causative factor (4 of 7 (57%) cases reviewed compared to 39% in national evidence). Evidence of good clinical practise was noted with respect to consent, appropriate staffing and involvement of senior clinicians. A range of measures were used prior to hysterectomy, including pharmacological treatments, haematological correction of coagulopathy, haemostatic brace sutures and uterine compression balloons.

While it is hoped that the number of cases represents a statistical 'blip' rather than an on-going trend, our experience emphasises the challenges faced by a busy district general hospital dealing with rising birth rates and increasing case complexity. We discuss the lessons learned from this case review, including the role of clinical governance and the benefit of open professional discussion.

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## PL.52 PLACENTA ACRETA IN ST VINCENTS UNIVERSITY HOSPITAL 2008–2011

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This is a retrospective review of all the patients who had a caesarean section for suspected placenta acreta in St Vincent's Hospital (SVH) from December 2008 to October 2011.

The study includes all women who were referred to SVH for caesarean section with an antenatal diagnosis of placenta acreta/percreta. The review included patient's age, parity and previous caesarean sections, antenatal diagnosis with ultrasound and MRI, hysterectomies performed, conservative management, ICU/HDU admissions after the procedure and radiological input. The review excludes women who had caesarean sections in SVH for other indications.

**Results** During the period 11 women had caesareans sections in SVH, 6 of these women had a caesarean section for suspected

placenta acreta. The average age was 35.6 years. All 6 had antenatal ultrasound and 5 had MRI.[1] 3 were diagnosed with placenta percreta and required bladder repair. 5 women had a caesarean hysterectomy. 4 women required ICU admission, 2 were admitted to HDU. 1 had conservative management with uterine artery embolization day 2 post operatively followed by manual removal of placenta at 8 weeks.[2] 2 women had a blood loss greater than 4 litres. All 6 women had female infants. All 6 had a history of previous caesarean section. 1 woman had 4 previous D&Cs for recurrent miscarriage. 3 had uterine artery embolization.[3]

**Conclusion** This review looks at the diagnosis and management of placenta acreta in a large tertiary centre and reviews the role of a multidisciplinary approach to its management.[4]

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## PL.53 A RETROSPECTIVE ANALYSIS ON COMPLICATIONS AND MANAGEMENT OF MACROSOMIC BABIES

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**Introduction** Considerable disparity has been noticed in macrosomic deliveries due to lack of recognised guideline in the management of macrosomia. In this study, we determined risk factors predicting macrosomia and associated complications. We analysed variations in management of macrosomia in a large teaching hospital.

**Method** This study was done by retrospective analysis of case notes of 45 women who delivered macrosomic babies from January 2010 to June 2010 in university hospitals of Leicester NHS trust.

**Results** Incidence of macrosomia was highest in the age group 30–40 years (46%). About 71% of babies with macrosomia in our analysis occurred in women with BMI < 30. Eighty % of macrosomic babies were born to non-diabetic mothers. Prior incidence of macrosomia occured in 17.9% of multiparous women in our sample. Our analysis highlighted the variations in management of macrosomia, typically in mode of delivery (Table 1).

**Conclusion** In our analysis, we concluded that it is difficult to anticipate macrosomia based on risk factors. Also, there is a high incidence of complications associated with macrosomic deliveries. This highlights need for regular obstetric emergency 'skills and drills'. There is a need for standardised guidelines on management of macrosomia.

**Abstract PL.53 Table 1** Antenatal care/delivery/complications associated with macrosomia

| Factor | Incidence |
|---|---|
| Antenatal clinical suspicion | 40% |
| Macrosomia missed on scan | 16.6% |
| Spontaneous Vaginal Deliveries | 48.8% |
| Induction of Labour | 33.3% |
| Elective Caesarean section | 17.7% |
| Postpartum haemorrhage | 44.4% |
| Anal Sphincter Injury | 6.6% |
| Shoulder Dystocia | 0.49% |
| Poor Apgar score/NNU admission | 0% |

## PL.54 THE FETAL PILLOW (FP): A NOVEL INTERVENTION TO REDUCE MATERNAL AND FETAL COMPLICATIONS IN CAESAREAN SECTIONS AT FULL DILATATION (CSFD)

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CSFD have an increase in maternal and fetal complications. There is an increase in post-partum haemorrhage, blood transfusions, and increase in hospital stay for mothers and NICU admissions. One method of reducing morbidity relating to CSFD is the FP, a silicone balloon inserted vaginally prior to CSFD resulting in a 3–4 cm upward displacement of the fetal head.

A retrospective study was performed analysing FP use in 16 patients undergoing CSFD, compared to 18 patients undergoing CSFD without FP use. The aim was to establish whether the FP reduces complications in CSFD.

Average operating time using FP was 41.6 minutes, and 70 minutes without. Average blood loss using FP was 698 mls, and 829 mls without. Uterine extensions were 31% in FP, and 33% without. The group without the use of FP saw 2 cases of blood transfusion, one had bladder damage intraoperatively, another required HDU admission, two had maternal pyrexia, and one required re-admission. This group also had two NICU admissions. 6% of surgeons reported fetal head delivery difficult using FP, and 39% without. 50% of surgeons said delivery of fetal head was easy using FP, and 39% without.

The FP seems to aid delivery of the impacted fetal head at CSFD. In the FP group there was reduction in average operating time, intra-operative trauma, need for transfusions, and blood loss. There was no maternal pyrexia, no maternal admissions to HDU, and no NICU admissions. These results are very encouraging to assess the routine use of fetal pillow in CSFD.

## PL.55 TESTING SALIVA FOR THE PREDICTION OF PRETERM BIRTH: HOW ACCEPTABLE IS THIS METHOD TO WOMEN AT RISK?

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**Background** Despite extensive work to prevent preterm birth (PTB) it is still not possible to accurately predict those women at risk. Previous research[1] has suggested that salivary progesterone may be useful as an indicator of risk. Saliva tests are relatively uninvasive, but the acceptability of this method has not yet been investigated in pregnant women.

**Aim** The POPPY study aims to investigate salivary progesterone in a large cohort of women (n = >1000) at risk of PTB to support the development a predictive test and to assess acceptability.

**Method** In addition to providing at least one 5 ml sample of saliva between 20 and 28 weeks' gestation, women at risk of PTB are asked to complete a short acceptability questionnaire (adapted from Sy *et al*[2]).

**Results** To date, 1042 questionnaires have been completed. Interim results reveal the number of women agreed or strongly agreed that: 1. They liked the test because it was: a) easy/simple to use, n = 816 (78%); b) better than having blood taken, n = 701 (67%); c) convenient, n = 672 (64%); d) quick, n = 600 (58%); 2. They disliked the test because of: a) mouth dryness, n = 300 (29%); b) time taken, n = 234 (22%); c) embarrassment, n = 89 (9%); d) feelings of gagging, n = 73 (7%). 3. 84% of respondents (n = 880) would recommend it to other pregnant women.

**Conclusion** Although the majority of women found providing saliva for testing acceptable, this was not universal. Consideration