**Results** The average monthly deliveries increased from 6.1 to 22.8 before and after the intervention respectively. The number of women attending for antenatal care increased from 11.5 to 33.6 per week before and after the intervention respectively.

**Discussion** Community health education empowers women, gives them a greater understanding of their health needs and has been successful at increasing the number of deliveries at Kabubbu HC. Community health education can be used alongside other interventions as a means to reduce maternal mortality.

## PL.59 FACTORS TO OVERCOME DELAYED DISCHARGE FOLLOWING CAESAREAN SECTION WITH AN ENHANCED RECOVERY PATHWAY

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Enhanced recovery (ER) pathways improve clinical outcomes, the Department of Health (DoH) suggesting several applications. Current published data within obstetrics is limited. Increased pressure on maternity beds; 39% of maternity units in England closing to admissions on one or more occasions in the year to 31 March 2007 [2], highlights a pivotal throughput parameter to benefit from an ER pathway.

**Methods** Survey of patients following elective caesarean section (CS) over a five-month period. Questionnaire designed against DoH guidelines [1].

**Results** 50 surveys completed.

100% of patients were awake in recovery with regular analgesia prescribed. Mean pain score was 0.1/10. 28% of respondents were nauseated or vomited in recovery. Mean time until discharge criteria were met was 153 minutes. Mean time for actual discharge from recovery was 213 minutes. 15% of patients were eating before discharge. 97% had a motor block on discharge. Urinary catheter remained in situ after 12 hours in 79% of patients. 100% of patients remained in hospital after 36 hours.

**Discussion** Patients delayed from returning to the ward may follow delayed discharges on the receiving ward, staff requirements to permit safe transfer and prolonged presence of an epidural (7%) and urinary catheters (79% after 12 hours). Promoting urinary catheter removal at 6 hours on a dedicated 'receiving bay' may reduce length of stay.

DoH suggests a change of culture may accompany discharges at 24 hours (providing all recovery factors have been cleared). We plan to implement a formal ER programme and re-audit in six months.

## PL.60 CONSEQUENCES OF FAILED INSTRUMENTAL DELIVERIES- HOW BAD IS IT?

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**Background** Unsuccessful instrumental delivery (ID) is typically associated with increased risks of adverse outcomes. We aimed to investigate the fetal and maternal consequences of failed instrumental deliveries in our unit.

**Methods** Data was collected prospectively as part of ongoing audit of all IDs performed in our unit between October 2008 and March 2012.

**Results** Complete records were available for 2664 IDs. Delivery was unsuccessful in 75 (2.8%). There was 1 maternal bladder injury and 1 hysterectomy. Unsuccessful ID was associated with increased blood loss (EBL), increased decision to delivery interval (DDI) and lower fetal Ph ($p < 0.001$ Mann-Whitney-U, table).

**Abstract PL.60 Table 1**

| Table | Unsuccessful | | Successful | |
|---|---|---|---|---|
| | Median | Interquartile range (IQR) | Median | IQR |
| Arterial Ph | 7.17 | 7.13–7.20 | 7.21 | 7.16–7.26 |
| Venous Ph | 7.22 | 7.17–7.26 | 7.29 | 7.24–7.33 |
| DDI (mins) | 47 | 32–62 | 18 | 10–37 |
| EBL (mls) | 650 | 500–900 | 400 | 300–600 |

Sequential instruments were used in 189 (7%), and were successful in 182/189 cases (96%). Compared with successful use, unsuccessful sequential instruments were associated with higher blood loss, increased DDI and lower fetal Ph (p£0.06, Mann Whitney-U). Two fetal injuries occurred where sequential instruments failed compared to 3 injuries out of 68 unsuccessful deliveries where only 1 instrument was used ($p = 0.07$ fishers exact test).

**Conclusions** ID was associated with a low risk of failure, but failure was associated with worse outcomes. Although sequential instrument use was associated with the poorest outcomes, outcomes were better if vaginal delivery was achieved in this situation. This highlights the need for careful and competent use of instruments in the presence of experienced operators.

## PL.61 PERIPARTUM HYSTERECTOMY – ANTICIPATED VERSUS UNANTICIPATED

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**Background** Peripartum Hysterectomy (PH) is a rare complication of pregnancy[1]. This study sought to determine the rate of PH in our population and compare aetiology and clinical outcomes in cases of PH that are anticipated and unanticipated.

**Method** Cases of PH for obstetric haemorrhage between 2006 and 2011 were identified from an MOH database. Data included maternal demographics, subspecialty of operator, aetiology for PH, estimated blood loss(EBL), RCC units transfused, surgical complications and length of hospital stay.

**Results** 26 cases of PH (0.6/1000) were identified; 17 anticipated and 9 unanticipated. Placenta accreta (PA) was the indication for PH in 15/17 anticipated and 4/9 unanticipated cases. The remaining cases were attributed to uterine rupture (3/9), placenta previa, cervical ectopic and atony.

**Abstract PL.61 Table 1**

| | Anticipated n = 17 | Unanticipated n = 9 | p value |
|---|---|---|---|
| Mean Age (yrs) | 34 +/-5 | 36 +/-3 | |
| Mean Parity | 3 | 2 | |
| Mean EBL(L)<br>Range | 5.5 +/-3.6<br>1.3–12.0 | 6.6 +/-3.9<br>2.8–14.3 | 0.89 |
| RCC units transfused | 7.2 +/- 5.2 | 9.4 +/- 4.8 | 0.4 |
| Intraoperative Complications | 41.1% | 33.3% | |
| Mean Operating time(mins) | 136 +/-63 | 190 +/-95 | 0.11 |
| Gynae Oncologist | 88% | 33% | |

**Discussion** The majority of cases of PH are anticipated because of prenatal diagnosis of placenta accreta and are more likely to undergo elective delivery by a gynae-oncologist. Despite this EBL, RCC transfusion and postoperative complications are not significantly different from unanticipated cases of PH, possibly reflecting the severity of cases diagnosed antenatally. Continuing research is required to improve the prenatal diagnosis of placenta accreta and to reduce perioperative blood loss with measures such as interventional radiology[2].