in the Wales Deanery (UK). Grounded theory was used to analyse the responses, including free text.

While 8% of respondents cited lack of knowledge of or disagreement with the practise, 87% of obstetricians and trainees admitted that as the surgical sequence involved in a delivery is automatic, they sometimes or often forgot to incorporate a delay before clamping. This automaticity is adaptive, arising from a need to reduce cognitive load during complex motor tasks.

Where visuospatial skills are sufficiently refined (task mastery), cognitive attentional skills are engaged only at key points. These are used as landmarks in expert sequences such as playing a musical instrument, using a gaming controller or surgery. During an abdominal delivery, clamping of the cord is unlikely to be a key landmark. This applies particularly for the experienced obstetrician in contrast to the novice.

The hypothesis that there would be an inverse relationship between the experience of the surgeon and the ease of incorporation of a new element to the operation was supported. Simple aide memoires facilitated incorporation of the new process, shown at reaudit.

PL.66 VAGINAL BREECH DELIVERY – 12 YEARS AFTER THE TERM BREECH TRIAL ARE THE RISKS AS HIGH AS SUGGESTED? AUDIT OF PRACTISE WITHIN THE SETTING OF A HIGH RISK LABOUR WARD

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The publication of the Term Breech Trial 12 years ago caused an almost universal change in UK practise towards offering elective caesarean section to women with breech presentation at term. These results have entered the public psyche to such an extent that women no longer have confidence undergoing vaginal breech deliveries (VBD) and experience has been eroded such that clinicians no longer maintain their skills. This has implications for women wishing to undergo VBD as well as morbidity and mortality from increasing numbers of caesarean sections (CS). We sought to answer the question of whether it was suitable and safe to offer VBD to women presenting in labour rather than carrying out emergency CS.

Between 2002–2011, 502 women with breech presentation at term attended in labour. 77 (15%) had normal vaginal delivery, 219 (44%) had emergency CS and 206 (41%) had urgent CS. In the CS group, 51 (12%) required CS anyway; therefore 78% were suitable to consider VBD.

Only 47% of this group attempted VBD. The majority chose CS due to personal preference or recommendation from doctors, highlighting lack of confidence in VBD by both doctors and women.

5-minute Apgar scores were comparable between groups but morbidity from blood loss was higher in women undergoing emergency CS vs. VBD. (1250 ml vs. 686 ml).

We believe these results show that VBD can be safe in selected cases and the time has come for clinicians to regain their experience so that more women can be offered this birth option with confidence.

PL.67 EFFECT OF DIFFERENT PROSTAGLANDIN PREPARATIONS FOR INDUCTION ON ADMISSION TO DELIVERY TIME

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Background Around 20% of labours are induced with the current recommended method being prostaglandin for cervical priming. The 2 commonly used preparations are a prostaglandin gel administered 6 hourly, or a prostaglandin pessary, administered over 24 hours. Following a change in protocol from gel to pessary, we aimed to look at the effect on admission to delivery time (ADT).

Methods The notes of 395 women who had labour induced within a large tertiary unit in the North West between August 2009 and May 2012 were studied, excluding those induced for prelabour ruptured membranes. Data was collected retrospectively using a standard proforma.

Results 93 women received prostaglandin gel and 302 received the pessary (28 also needed gel). The median ADT for women induced using gel was significantly shorter at 26.37 hours (interquartile range 15.87–42.96) than with the pessary at 31.83 hours (20.73–46.54 hours $p = 0.002$ non-parametric testing). There was no difference in parity or oxytocin use between the 2 groups. Outcomes between the 2 groups were the same, with no difference in postpartum haemorrhage rate or vaginal delivery ($p > 0.05$).

Conclusions The prostaglandin pessary was associated with a longer ADT, which is perhaps unsurprising given its longer duration of use prior to assessment for amniotomy. This is probably because the predicted increase in labour commencing in the pessary group without further oxytocin did not occur, reflected in no difference in oxytocin use between the 2 groups. This has implications for bed occupancy, patient flows and NHS costs.

PL.68 WHEN SHOULD TWIN INDUCTION OF LABOUR START TO INCREASE THE CHANCES OF DAYTIME DELIVERY?

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Background Vaginal twin deliveries can be complicated and senior obstetrician presence may be advisable. Our unit has consultant on-site presence between 08:30 and 20:30, so we sought to determine when inductions should be commenced to maximise deliveries during these "daytime" hours.

Methods Women having prostaglandin induction after 36 weeks, resulting in at least one vaginal delivery and where no delays to normal care occurred were selected. Nulliparous and parous women were considered separately and the percentage of "daytime" deliveries calculated for inductions commenced in the morning (06:00 – 11:59), afternoon (12:00 – 17:59) and evening (18:00 – 23:59). (Inductions commenced 00:00 – 05:59 were excluded due to infrequency.) Analysis of length of labour (defined from start time to delivery of first twin) was performed.

Results The majority of inductions were commenced in the morning. For nulliparous women, 71% of morning-commenced inductions resulted in "daytime" deliveries, compared with 50% and 67% of afternoon-commenced and evening-commenced procedures. Labour length was normally distributed with mean of 21.8 hours (SD 7.9 hours). For parous women, afternoon-commenced induction produced a higher percentage of "daytime" deliveries; 85% compared with 50% and 67% for morning-commenced and evening-commenced inductions. Labour length was normally distributed with mean of 15.0 hours (SD 7.0 hours).

Conclusions For nulliparous women, commencing induction in the morning provides a high likelihood of "daytime" delivery. For parous women, analysis of inductions by start time and mean length of labour suggests a trial of commencing induction later in the day might increase the proportion of "daytime" deliveries.

PL.69 DELIVERY OUTCOMES AND EVENTS IN SUBSEQUENT PREGNANCIES AFTER PREVIOUS ANAL SPHINCTER INJURY

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Introduction Few recent studies have examined outcome in pregnancies following previous third degree perineal tears and results are

conflicting. One study found that although anal sphincter injury was increased five-fold at next delivery compared with all multiparae, 95% of women delivering vaginally after a previous third degree tear did not sustain further overt sphincter damage. (1).

In this institution it is recommended that all women with a prior history of ASI are seen at a perineal clinic in the third trimester in subsequent pregnancies.

Objective To assess the mode of delivery following a previous anal sphincter injury (ASI) and to evaluate perineal outcome following vaginal birth.

Methods A retrospective search of the hospital PAS systems was conducted on patients who had a delivery following an ASI from 2010 – 2012. Variables were described by counts and percentages and analysed using SPSS version 20.

Results Between January 2010 and July 2012, 147 women with previous ASI were assessed in the third trimester regarding mode of delivery. The results highlight risk factors for ASI and summarise factors which influence decision for subsequent mode of delivery. Perineal outcomes are documented for those who delivered vaginally.

Conclusion This paper highlights the importance of individualised antenatal assessment in patients who have previously sustained ASI. Patients who have prior ASI may have a personal preference when considering mode of delivery, but a specialist clinic affords them opportunity for detailed discussion. Many women went on to have uncomplicated vaginal deliveries after previous ASI.

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PL.70 OUT-PATIENT PROPESS USE (CONTROLLED RELEASE PGE2 PESSARY) – AUDIT OF USE IN DISTRICT GENERAL HOSPITAL

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Background Propess is a controlled release pessary which releases 0.3 mg of Dinoprostone per hour. As there is constant release rate, this would ensure steady Progesterone concentration and reduce the risk of hyperstimulation. Also, the need for one vaginal examination as opposed to one every 6 hrs improves patient acceptability.

Aim The aim of the audit was to look at the practise of using the first Propess on an out-patient basis with informed consent. We looked at the pregnancy outcomes after the Outpatient use of first Propess.

Method Prospective audit was done looking at the practise of using the first Propess.

Only low risk patients were given an option for Out-patient Propess. Informed verbal consent was obtained and open access to ward was given after Propess insertion. **If anyone needed any further Propess, this was carried out as an in-patient.** Initial proforma was filled in by the midwife and the notes were reviewed after delivery.

Results We looked the patients between the time period of 15/5/10 to 31/12/10. 57 women opted for Out-patient management.

67% of women who laboured with Propess alone were Nulliparous
There were no adverse outcomes.
APGARs at 5 min were >9 for all babies
No admissions to neonatal unit
Avg. blood loss at delivery 388 ml

Conclusion Outpatient use of first Propess does not alter pregnancy outcomes and does not increase the risks to baby.

When used selectively, the out-patient IOL is safe and effective alternative to patient admission.

Out patient use of Propess has decreased hospital stay.

20/57 women did not need a review prior to 24 hrs equalling 480 hours of saved in-patient care.

PL.71 PAIN IN LABOUR: COMPARATIVE STUDY BETWEEN WOMEN UNPREPARED AND PREPARED BY THE PSYCHOPROPHYLACTIC METHOD

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Background Pain relief is associated to biological, sociocultural and psychological factors. Supporters of preparation for childbirth claim that the main causes of pain result from the triad fear, tension and pain.

Objectives To determine if mothers using the psychoprophylactic method of childbirth perceive less pain than those not prepared, and analyse the influence of age and self-concept in the perception of pain in labour.

Methods This was a comparative, cross-sectional study with a sample of 103 mothers (50 prepared, 53 unprepared). The data collection instruments include a questionnaire with a socio demographic and obstetric characterization and scale of self-concept of Vaz Serra. Pain was assessed with a numerical scale, on three occasions (beginning of labour, active phase and postpartum).

Results The unprepared mothers perceive more pain in early labour and active phase. The prepared mothers reveal more pain in the immediate postpartum, with statistically significant differences in the onset and active phase of labour. The age of the prepared mothers does not influence the perception of pain at the beginning of labour and in the immediate postpartum; in the unprepared mothers it does not influence the active and post-partum phases. In prepared parturients, increase in self-concept decreases the perception of pain, while unprepared mothers do not reveal statistically significant differences.

Conclusions As a preparation for childbirth decreases the perception of pain, we recommend this method to be implemented in services monitoring the health of pregnant women.

PL.72 RISK FACTORS FOR MANUAL REMOVAL OF PLACENTA ACROSS PARITY

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Background Retained placenta is a complication of the third stage of labour that is associated with increased rates of post-partum haemorrhage. Previous research identified risk factors related to maternal demographics and delivery related variables, but both clinical practises and patient variables have since changed. This study re-examines risk factors for manual removal of placenta (MROP) across parity.

Method This case-control study was conducted at the National Maternity Hospital in Dublin Ireland from January 2011 to Dec 2011. A chart review of all liveborn, singleton, vaginal deliveries was conducted to investigate maternal and delivery related variables in relation to retained placenta. Women were grouped based on the need for MROP as well as by parity. Statistical analysis was performed using chi square tests and odds ratios.

Results 7163 deliveries met the study criteria and 190 (2.65%) required MROP. Risk factors that were identified were parity, two or more miscarriages, previous ERPC, gestation at delivery, and oxytocin to accelerate labour. When divided based on parity, increased