

Background Shoulder dystocia remains a common cause of litigation in obstetrics.

The RCOG Shoulder Dystocia Guideline (2005) recommends auditing all cases of shoulder dystocia to improve training and patient care.

Aim This retrospective cohort study reviewed maternal and fetal complications for all cases of shoulder dystocia from July 1, 2008–Dec 31, 2010 at a large University Teaching Hospital in the UK.

Method Cases were collected from the Operating Theatre, Special Care Baby Unit, Delivery Suite and Risk Management Registries.

Results There were 292 cases (~1%) of shoulder dystocia [primigravida (n = 100), and multiparous (n = 192)]. The overall total [Group 1] (n = 292 mean birth-weight 3.979 kg \pm 0.475; the Instrumental Delivery [Group 2] (n = 94) mean birth-weight 3.937 kg \pm 0.486; and the Instrumental Delivery in Theatre [Group 3] (n = 28) mean birth-weight 4.036 kg \pm 0.577. In group 3, a Consultant was present in theatre 19/28 (67.86%).

FETAL COMPLICATIONS

SCBU Admission (n = 17) – 5.82%

Macrosomia > 4.5 kg (n = 33) – 11.30%

Erbs Palsy & Bone Fracture (n = 6) – 2.05%

Stillbirth (n = 1)

MATERNAL COMPLICATIONS

Postpartum Haemorrhage >1000 mls (n = 20) – 6.85%

3rd Degree Tear (n = 22) – 7.53% & [4th degree Tear (n = 1)]

Severe Shoulder Dystocia

Delivery head-to-body interval \geq 5 mins (n = 12) – 4.10%

Delivery Required \geq 3 Manoeuvres (n = 34) – 11.64%

Conclusion

1. The Risk Management team had a robust proforma with standardise documentation to identify, investigate (Serious Incident Reporting) and include all shoulder dystocia cases in the monthly maternity dashboard.
2. All Erbs palsy/fractures cases had outpatient Paediatric and Physiotherapy followed-up.
3. All staff must attend mandatory training involving shoulder dystocia drills.

PP64 IMPACT OF ORAL HEALTH OF THE MOTHER DURING PREGNANCY ON ORAL HEALTH OF CHILDREN

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Introduction Dental caries is a major chronic disease in children justifying investigate the effect of oral health of the mother during pregnancy on oral health status of the child. Thus, surveillance of oral health of the mother during pregnancy is essential for the promotion of child health.

Objectives To characterise the oral health of the mother during pregnancy and its effect on oral health status of the children.

Methods Observational and cross study conducted on a random sample of 653 mothers and their respective descendants living in the central region of Portugal.

Material Data collection was conducted through a questionnaire on Oral Health in Pregnancy. It is further preceded to the evaluation index of Decayed, Missing and Filled Teeth (DMFT), through the observation of the oral cavity of the children.

Results Most mothers held health monitoring during pregnancy (84.1%), while only 72.8% had six or more appointments, considering that way with a monitored pregnancy. The most frequent problems during pregnancy were oral pathology in 18.5% of mothers, 15.9% of these showed decayed teeth, 2.4% gingivitis and 0.3% periodontitis.

The DMFT of the children varied between 0 and 17 (mean = 2.23; SD = 2.484). The children whose mothers had decayed teeth during pregnancy had a higher DMFT index when compared with those

whose mothers had no oral problems (OM = 354.54 vs OM = 300.40), (U = 20965.5; Z = -2.828; p = 0.005).

Conclusion The results suggest that on the maternal health consultation and monitoring of pregnancy, health professionals should monitor the oral problems of the pregnant.

PP65 STUDY OF FACTORS ASSOCIATED WITH LOW BIRTH WEIGHT

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Background Low birth weight is a significant risk factor for neonatal morbidity and mortality as well as a general indicator of the health status of a population. Objectives: To determine the influence of socio-demographic, obstetric and prenatal care variables in low birth weight.

Methods This is a cross-sectional, descriptive, correlational and prospective study. The sample is probabilistic intentional, consisting of 1846 mothers, of which 161 had newborns with low birth weight. A questionnaire was used to collect data between March 2010 and May 2012 in 26 Portuguese public health institutions.

Results In this study, low birth weight was associated to: absence of pathologies during pregnancy, absence of gestational age risk, absence of obstetric risk, maternal age considered of risk or not/absence of gestational age risk (p = 0.000), low education/monthly income level \leq 1000 €, low education/unemployment, number of children of risk/absence of gestational age risk, no consumption of alcohol and tobacco/absence of pathologies during pregnancy, no consumption of alcohol and tobacco/absence of gestational age risk pathologies during pregnancy/absence of gestational age risk, presence of previous pathologies/absence of gestational age risk, twin pregnancy/absence of gestational age risk, and with an error of 10% to low education level, unplanned pregnancy, late onset of prenatal surveillance, and absence of previous pathologies.

Conclusion The determination of the factors that favour the development of low birth weight is of fundamental importance to the understanding, planning and development of actions within mother-child health.

PP66 AN AUDIT OF REDUCED FETAL MOVEMENTS IN A DISTRICT GENERAL HOSPITAL IN LANARKSHIRE

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Background Fetal movements are perceived as a sign of a fetal well-being, with reduced fetal movements (RFM) associated with poor perinatal outcome. Antenatal investigation of RFM aims to exclude fetal death and identify pregnancies at risk of adverse outcomes. Wishaw General does not currently have a local RFM guideline.

Aims To audit the management of women presenting to Wishaw General Maternity Unit (WGMU) with RFM, compare with RCOG guidance and devise a local RFM guideline.

Method A retrospective case note review of 23 patients presenting to WGMU.

Results 13 primigravid and 10 parous women, with a mean gestation of 37 weeks (24–41), were included.

Based on KCND 11 were high risk and 12 low risk.

All women received CTG investigation, 100% were normal. There was no documentation of risk factors for IUFD or of fundal height measurement at presentation.

4% of women were booked for USS within 24 hours of presenting with RFM. Induction of labour for RFM occurred in 4% of patients presenting at term.

All had live births with no NNU admissions. There were no infants <2.5 kg.

Conclusion 82% (14) of women were not scanned who met criteria for referral. 35% (8) of women had no form of follow up arranged.

Currently our unit is failing to meet the RCOG recommendations of Greentop Guideline 57. We have developed a local guideline to improve management of women with RFM and re-audit is underway.

REFERENCE

RCOG Greentop Guideline 57; Reduced Fetal Movements. February 2011.

PP.67 SURVEY OF CURRENT MANAGEMENT OF REDUCED FETAL MOVEMENTS IN SCOTLAND

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Maternal perception of fetal movements is the oldest and most commonly used method to evaluate fetal wellbeing. The investigation and management of reduced fetal movements (RFM) is complicated by a wide variation in the amount perceived by individual mothers and the paucity of good evidence to guide clinicians.

This survey was designed in line with the RCOG Green-top Guideline on Reduced Fetal Movements (February 2011) using www.surveymonkey.com and was distributed to all trainee and consultant obstetricians and all midwifery staff across Scotland.

200 responses were collected; 68% from midwives and 32% from obstetric trainees or consultants. 63% of responders were aware of the RCOG guideline on RFM; of these, 79% had read this guideline. Despite this, only 69% work in a unit which has a policy detailing investigations and management of women presenting with RFM. 80% of responders accepted "maternal perception of decreased fetal movements" as a definition of RFM and an indication to seek advice. Over 90% of responders routinely perform CTG (if greater than 28 weeks), blood pressure and urinalysis on women presenting with RFM. Less than 5% would routinely refer women with RFM for ultrasound examination without additional risk factors and only 67% of responders have access to this within 24 hrs or during the next working day. Surprisingly, 23% would never offer induction for RFM.

The results reveal the huge variation across Scotland when investigating and managing women presenting with RFM, highlighting the importance of further research into the issue and the development of nationally agreed policy.

PP.68 'TAKE CARE OF THE POUNDS AND THE PENNIES WILL TAKE CARE OF THEMSELVES' – THE COST OF OBESITY IN OBSTETRICS

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Objectives The literature contains little information on the economic effect of obesity on maternity services. We aimed to assess the cost impact of obesity on antenatal, intrapartum and postpartum care.

Methods Retrospective cohort study. Study group: BMI > 30 (n = 72). Control group: BMI 18.5 – 25 (n = 68). Exclusion criteria: breech, pre-existing hypertension/diabetes, multiple pregnancy, late bookers. Costing information from NI Database of Healthcare Resource Group Costs. Outcomes recorded and statistical analysis performed.

Results Overall cost of maternity care in the obese group (£11699) was significantly higher than the normal BMI group (£10643)

(p = 0.026, power 73%). Further analysis revealed the greatest cost difference was with antenatal care (p = 0.005, power 89%) from increased appointments and admissions due to increased rates of PIH, PET and GDM. There was no significant difference in the cost of intrapartum care (Normal BMI £2424, Obese £2355, p = 0.669) or postpartum care (Normal BMI £1097, Obese £1052, p = 0.627). The obese group had a higher rate of NVD (61% versus 47%), and Caesarean delivery (18% versus 13%) and lower rate of instrumental delivery (21% versus 40%). The incidences of PPH were similar, with a higher rate of 3rd degree tears in the normal BMI group. Birthweights and SCBU admissions were similar with a higher rate of breastfeeding in the normal BMI group (60% versus 53%).

Conclusion Obesity significantly increases the cost of maternity care by over £1000 per patient. This study highlights the importance of investment in maternity services and weight management programmes to cope with the evolving obesity epidemic.

PP.69 FACTORS THAT INFLUENCE CLINICIANS IN THEIR CARE OF FAMILIES WHO EXPERIENCE STILLBIRTH

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Objective Surveys of clinicians are important in Health Service research. Previous surveys have noticed a strong reluctance of doctors to know, notice or remember anything about patients who have experienced a stillbirth. Are attitudes of clinicians to stillbirth created by lack of training, education, personal experience or clinical experience? We wanted to find out what influences clinicians in their care of women and their families at the time of stillbirth.

Study design Clinicians, including junior and senior trainees, consultants and specialists were surveyed. We asked questions to elicit in-depth information on their knowledge of factual details of stillbirth cases and bereavement services available. We also questioned their personal experiences and feelings when dealing with bereaved families. Finally, we examined the impact caring for this patient group had on clinicians. Anonymised data was analysed.

Results Clinicians (90%), whether senior or junior, agreed that caring for women who experience stillbirth takes an emotional toll personally. Talking to senior colleagues or friends/family was used to cope with the impact. Only 71% could remember details of a patient who experienced stillbirth in the last year, and many were unclear on details of routine hospital bereavement care. Of the group surveyed, 14% strongly agreed that they had received adequate training to cope with stillbirth. Half had personal experience of perinatal death, while a third were parents themselves.

Conclusion Clinicians feel this patient group are challenging and should have support in this area of work. There is a continual need for staff education and training.

PP.70 PROVISION OF CARE AT THE TIME OF STILLBIRTH

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Objective The multi-disciplinary bereavement team focuses on all aspects of care including emotional, medical and spiritual, in accordance with international evidence-based practise. While there are universal commonalities in the pain of grief involved in stillbirth, we wished to refine our practise based on the needs of our specific patient group. We surveyed bereaved parents from 2011 to discover how they felt about the care they received and to look for their views on the bereavement team.