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

An audit of neonatal respiratory morbidity following elective caesarean section at term. Nicoll Black C, Princess Royal Maternity Hospital, 16 Alexandra Parade, Glasgow.


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: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 profiles1. 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