Abstract PL.04 Table

Jan	Feb	Mar	Apr	May	Jun	Total C/S rate for first 6 months of 2010
25.8%	26.9%	24.4%	27.4%	26.0%	26.3%	26.1%
Jan	Feb	Mar	Apr	May	Jun	Total C/S rate for first 6 months of 2012
22.2%	22.2%	20.0%	23.0%	21.0%	21.0%	21.5%

Robson Group analysis of these rates demonstrate the greatest reductions in caesarean sections for term nullip women in spontaneous labour, for nulli- and multiparous women in induced labour, and for women with multiple pregnancies.

As confirmed by the Birthplace study[1], the introduction of birth centres has led to a reduction in caesarean section for low risk women. Furthermore, we postulate that the increased Consultant presence on labour ward has increased confidence in vaginal operative delivery and CTG interpretation, reducing the need for caesarean section.

PL.05 USE OF QUANTITATIVE FETAL FIBRONECTION FOR PREDICTION OF SPONTANEOUS PRETERM BIRTH IN HIGH RISK ASYMPTOMATIC WOMEN

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Introduction Prediction of spontaneous preterm birth (sPTB) remains a challenge in obstetrics. Fetal fibronectin (fFN) is a strong negative predictor of sPTB (Berghella *et al*, 2008). Quantitative measurements of fFN may provide additional discriminatory information, improve positive prediction and be more clinically useful in predicting risk and outcome. The aim of this study was to determine if risk of sPTB correlated with concentration of fFN.

Study design A prospective blinded study of cervico-vaginal fFN concentration (ng/mL) in asymptomatic women considered at high risk of spontaneous preterm birth (n = 744; 22–27^{+6} weeks') using a 10Q analyser (Hologic®). Clinicians were blinded to the result until post-delivery but the qualitative TLI_{10} (Hologic®) fFN result was made available.

Results The rate of sPTB (<34 weeks') was lowest (2%) for women with concentrations 0–9 ng/ml, and highest for those with concentrations ≥200 ng/mL (31%). Compared to <10 ng/mL fFN, the relative risk of delivery was: (10–49 ng/ml) 4.3 (95% CI 0.03 to 0.13), (50–199 ng/mL) 4.3 (95% CI 0.005 to 0.15), (≥200 ng/mL) 13 (95% CI 0.16 to 0.42). The positive predictive value for sPTB (<34 weeks') increased from 15, 19, 31% with increasing thresholds (10, 50, 200 ng/mL respectively), yet negative prediction remained >95%.

Conclusion Risk of sPTB is increased for concentrations above 10 ng/mL. Quantitative fFN provides additional thresholds (10 and 200 ng/mL) over the qualitative method (50 ng/mL) to discriminate risk of sPTB in high risk asymptomatic women.

PL.06 TREATMENT FOR PRIMARY POSTPARTUM HAEMORRHAGE – A COCHRANE SYSTEMATIC REVIEW

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Aim To assess the effectiveness and safety of interventions used for the treatment of primary postpartum haemorrhage (PPH).

Methods We searched the Cochrane Pregnancy and Childbirth Group's Trials Register for randomised and quasi-randomised controlled trials for the treatment of primary PPH.

Results Twelve randomised clinical trials (RCT) with a total of 4060 participants fulfilled our inclusion criteria and were included in this review. Four RCTs (1483 participants) compared misoprostol with placebo given in addition to conventional uterotonics. Adjunct use of misoprostol to additional uterotonics had no impact on our primary outcomes including maternal mortality (risk ratio (RR) 6.16; 95% confidence interval (CI) 0.75 to 50.85), serious maternal morbidity (RR 0.34; 95% CI 0.01 to 8.31); admission to intensive care (RR 0.79; 95% CI 0.30 to 2.11), or hysterectomy (RR 0.93; 95% CI 0.16 to 5.41).

Two RCTs (1851 participants) compared 800 mcg sublingual misoprostol to oxytocin infusion as primary PPH treatment. Primary outcomes did not differ between the two groups. Five trials examined the effectiveness of oestrogen, tranexamic acid, lower segment compression and aortic compression devices, but were too small to assess impact on primary outcomes.

Conclusion Compared with misoprostol, oxytocin infusion is more effective and causes fewer side effects when used as the first-line therapy for the treatment of primary PPH. There is no evidence to suggest that misoprostol is effective as an adjunct to uterotonic treatment for primary PPH. Misoprostol should be considered as first-line uterotonic in settings where injectable oxytocics are not available.

PL.07 MORBIDITY OF INTENDED BIRTH MODE AFTER PREVIOUS CAESAREAN SECTION

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Aim To compare clinical outcomes of two approaches to birth after primary caesarean; i) planning elective repeat caesarean section (ERCS) ii) planning to attempt vaginal birth after previous caesarean (VBAC), with outcomes of second and third pregnancies evaluated.

Methods The population of this retrospective cohort study was identified from the Aberdeen Maternity and Neonatal Databank. Those included were women and offspring of pregnancies following primary caesarean delivery between 1993 and 2007. Planned mode of delivery was ascertained using four recorded variables; gestation at delivery, induction of labour, actual mode of delivery and indication for emergency caesarean section.

Main Outcomes Mode of delivery, pre-eclampsia, antepartum haemorrhage, postpartum haemorrhage, bladder injury, scar rupture and hysterectomy in the women. Neonatal unit admission, hypoxic ischaemic encephalopathy and cerebral palsy in the offspring.

Results Of 2350 women identified, 1211 planned ERCS and 1139 planned to attempt VBAC. One in four women planning ERCS delivered by emergency caesarean section before their planned delivery date. Of those planning VBAC, 796 delivered vaginally. Women planning ERCS were less likely to experience pre-eclampsia {adjusted odds ratio (OR) 0.7 (95% confidence interval (CI) 0.6–0.9)}. antepartum haemorrhage {adjusted OR 0.7 (95% CI 0.5–0.9)} or postpartum haemorrhage {adjusted OR 0.5 (95% CI 0.4–0.7)} than those attempting VBAC. Neonatal unit admission was more likely if ERCS was planned {adjusted OR 1.3 (95% CI 1.1–1.6)}, but this was gestation-related.

Conclusion Delivery by repeat caesarean appears safer for women as the benefits of a slightly shorter duration of pregnancy include less morbidity associated with late pregnancy.

[1]Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study BMJ 2011; 343:d7400