between the healthcare provider and the woman’, ‘enabling autonomy’ and ‘avoiding a paternalistic relationship’. Greater information for OVD in antenatal classes was suggested in order to counteract a common theme of negative perceptions of an operative delivery.

**Conclusion** Vulnerability of the women’s feelings highlights the importance of non technical skills in ensuring a woman feels trust, is empowered and in control. These non-technical skills need to be taught, learnt and practised to ensure a woman’s experience if safe, positive and pays justice to the delight of having a child.

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**Abstracts**

A **TWO YEARS AUDIT OF INCIDENCE, RISK FACTOR, MATERNAL AND NEONATAL OUTCOME OF UMBILICAL CORD PROLAPSE AT AL CORNICHIE HOSPITAL ABU DHABI UAE**

To determine the incidence, risk factors, obstetric management, maternal and neonatal outcome of umbilical cord prolapse (UCP) in order to improve the obstetric services

**Methodology** This is retrospective audit of all the cases of Umbilical cord prolapsed at Corniche Hospital during January 2009 and December 2010.

**Results** Twenty three cases diagnosed as umbilical cord prolapse. The hospital based incidence of cord prolapse was 1:760. The mean Dignoses-Delivery Interval (DDI) was 18.5 Minutes. Eleven mothers (47.8%) were delivered within this period of time. Eighty two percent women were multiparous. 86.9% were singleton pregnancies while 13.1% were (three sets) of twin gestations. Fifteen pregnancies (65.2%) were of more than 37 weeks of gestation. 26.15% (n=6) cases, fetuses were presented as breech. In majority of the case (n=17) general anaesthesia was given (74%) for emergency caesarean section (LSCS) and in 4 cases (17%) spinal anaesthesia was chosen for caesarean delivery. Twenty two (95.65%) women were delivered by LSCS and in 4 cases (17%) general anaesthesia was given (74%) for emergency caesarean section (LSCS) and in 4 cases (17%) spinal anaesthesia was chosen for caesarean delivery. Twenty two (95.65%) women were delivered by LSCS and in 4 cases (17%) spinal anaesthesia was chosen for caesarean delivery.

**Conclusion** Cord prolapse is a rare but true obstetric emergency associated with high perinatal morbidity and mortality but with quick diagnosis and prompt multidisciplinary team management the outcome can be improved.

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**PL.35 OUTCOMES FOLLOWING INDUCTION OF LABOUR(IOL) IN THE EAST OF SCOTLAND**

**Objectives** To review delivery outcomes for IOL at Term in Ninewells Hospital Dundee and to determine whether maternal factors, indications and gestational age influence outcomes.

**Methods** Data were collected from all IOL at Term between 01/01/11–31/08/12. Information on outcomes was collected from the local maternity database (Torex Protos Evolution).

**Results** 1802/7499 (24%) had IOL. Median age was 29 years (Range = 15–48 years) and median BMI was 25.7 kg/m² (Range = 15–66 kg/m²). 1020/1802 (56.6%) were primiparous. Median gestational age was 40 weeks (Range 37–43 weeks).

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**PL.36 CATEGORY 1 CAESAREAN SECTIONS AND DECISION TO DELIVERY INTERVAL: ARE WE MISSING TARGET?**

**Background** NICE guidelines recommend decision-to-delivery interval (DDI) of 30 minutes for all category 1 Caesarean Sections (Cat1 CS).

**Methods** A retrospective analysis of 50 Cat1 CS carried out in a busy district hospital.

**Results** 44% of all Cat1 CS were done for suspected fetal compromise on CTG, followed by 30% for persistent fetal bradycardia > 6 minutes. 64% deliveries happened during night shift and 54% were undertaken by junior registrars. Decision to perform Cat1 CS was directly taken by consultant in 36% of cases with consultant being first surgeon in 78% of these cases mostly as resident on-call during nights. Mean decision-to-delivery interval was 18.8 minutes with 87% deliveries performed within targeted 30 minutes. 42% of Cat1 CS were performed under general anaesthetic with shortest mean DDI of 14.5 minutes compared to spinal anaesthesia (25 minutes) and epidural top-up (16.7 minutes). 16% had massive FFP > 1.5 litres however average hospital stay was 3 days. 26% babies were admitted to SCBU with 61% being severely acidotic with cord pH < 7.0 or base excess > 12. Mean DDI in these babies was 24 minutes.

**Conclusion** Targeted DDI of 30 minutes is difficult to achieve in 100% of cases. Use of General anaesthesia shortens the DDI interval but has its own implications. Resident on-call consultant night shifts increase direct consultant input and may influence outcomes. A significant number of babies required admission to SCBU with proportion of acidotic babies remaining high. Further measures are required to improve Decision-to-Delivery interval to improve perinatal outcomes.

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**PL.37 MATERNAL ADIPOSITY AND CAESAREAN SECTION**

**Objectives** To examine the association of maternal obesity and rising caesarean section (CS) rates with increased risk of medical conditions outside pregnancy and gestational diabetes mellitus. The purpose of the study was to assess risk.