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 is safe, positive and pays justice to the delight of having a child.

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**PL.34**

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

T Perveen

**Abstract** 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%) 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 and beyond. In 26.15% (n = 6) cases, fetuses were presented as breech. In majority of the cases (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 one woman had successful vaginal delivery after UCP.

**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**

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**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 01/01/11–31/05/12. 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).

664/1802 (36.8%) of IOL were for post-dates pregnancy, 280/1802 (15.5%) were for prolonged pre-labour rupture of membranes (PROM), 194/1802 (10.7%) were for hypertensive disease, 132/1802 (7.3%) were for suspected fetal growth restriction (FGR) and 106/1802 (5.8%) were for diabetes. 1057/1802 (58.6%) had spontaneous vertex delivery, 360/1802 (19.9%) had operative vaginal delivery, 864/1802 (21.3%) had caesarean section (CS). BMI > 30 kg/m² was associated with increased risk of CS (RR = 1.23.95%CI = 1.01–1.50, p = 0.03), and this was independent of gestational age and indication. Women who had IOL for post dates pregnancy had higher rates of CS (RR = 1.25.95%CI = 1.05–1.50, p = 0.01) and OVD (RR = 1.28.95%CI = 1.06–1.54, p = 0.01). Women who had IOL for suspected SGA fetus had lower rates of CS (RR = 0.51, 95%CI = 0.31–0.83, p = 0.003) Women who had IOL for PROM had lower rates of OVD (RR = 0.57, 95%CI = 0.43–0.76, p < 0.001).

**Conclusion** The majority of women who have IOL at Term will have a vaginal delivery. Nevertheless the risk of operative intervention increases significantly in women who have IOL at 41 weeks gestation and beyond. due to IOL for post dates pregnancy. This data will be useful in counselling women requiring IOL at Term.