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.

**Abstracts**

**PL.34**

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

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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 a 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. 80% were less than 37 weeks of gestations. 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 (95.69%) women were delivered by LSCS and one women had successful vaginal delivery after UCP.

Twenty three babies (80.7%) had apgar score at 5 minutes >7. Umbilical cord PH was done in 65.2% (n = 15) of the cases. Arterial cord pH was recorded as less than 7.2 in 53.5% (n = 8) of the neonates. Sixteen babies required admission to NICU. We had 5 early neonatal deaths (19.2%) in our case series.However, there was no case of stillbirth or HIE directly related to cord prolapse.

**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.

**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 01/01/11–31/08/12. 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.
- 194/1802 (10.7%) were for hypertensive disease, 132/1802 (7.3%) were for suspected fetal growth restriction (FGR), 106/1802 (5.8%) were for diabetes. 1057/1802 (58.6%) had spontaneous vertex delivery, 360/1802 (19.9%) had operative vaginal delivery (OVD) and 385/1802 (21.3%) had caesarean section (CS).
- 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 (OVD) and 385/1802 (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 low rates of OVD (RR = 0.57, 95%CI = 0.43–0.76, p < 0.0001).

**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.

**PL.36**

CATEGORY 1 CAESAREAN SECTIONS AND DECISION TO DELIVERY INTERVAL: ARE WE MISSING TARGET?

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**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 34% 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 night shifts. Mean decision-to-delivery interval was 18.8 minutes with 87% > 12 minutes. Mean DDI in these babies was 24.3 minutes. 16% had massive PPH (> 1 1400 ml) and 12% required cross matching of blood. 10% of cases were for suspected fetal growth restriction (FGR) and 8% were for suspected fetal distress (F D D). 12.5% of these cases were managed by consultant in direct delivery and 36% of cases were managed by consultant in indirect delivery.

**Conclusion** Targeted DDI of 30 minutes is difficult to achieve in 100% of cases. Use of General anaesthesia shortens the DDI interval but it 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 acidic babies remaining high. Further measures are required to improve Decision-to-Delivery interval to improve perinatal outcomes.

**PL.37**

MATERNAL ADIPOSITY AND CAESAREAN SECTION

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Maternal obesity and rising caesarean section (CS) rates are important obstetric issues. High visceral fat (VF) is associated with an increased risk of medical conditions outside pregnancy and gestational diabetes mellitus. The purpose of the study was to assess risk