

PL.49 REDUCING THE CAESAREAN SECTION (CS) RATE IN A RURAL HOSPITAL IN SOUTH-WEST UGANDA

doi:10.1136/archdischild-2013-303966.231

R Lon, H Allatt. *Royal Berkshire Hospital, Reading, UK*

Background The fertility rate in Uganda is 6.1.¹ The significance of repeated CS and the risks of labour after caesarean section are well-documented. Often CS is the most appropriate mode of delivery but the decision to operate should be made judiciously to reduce maternal morbidity and mortality.

The CS rate in Kisizii Hospital, previously around 23% (2009–2010), had increased steadily to 41% in July 2012. Retrospective case note examination indicated frequent poor decision-making in labour leading to unnecessary CS. Decisions were often made by very junior staff.

Method The following were implemented in early August:

1. Tutorials on diagnosing & managing progress in labour and fetal distress
2. Tutorials on vacuum deliveries
3. Algorithms to aid decision-making processes
4. Updated induction of labour guidelines

Results**Abstract PL.49 Table 1**

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
CS rate (% del)	39.4	41.8	33.5	34.0	36.0	41.1	26.2	23.5	31.5
Fresh SB rate*	1.1	1.6	2.1	2.8	0.5	2.1	2.7	2.3	2.7
Birth asphyxia rate*	0.6	5.4	1.0	14.9	6.3	1.1	2.0	5.1	3.4

*percentage of live births

The CS rate for August to October was statistically significantly less than for January to July ($p < 0.05$, Fisher's exact test). There were no significant differences observed in the fresh stillbirth or birth asphyxia rates.

Conclusion Simple algorithms with timely tutorials can help junior staff to improve their decision-making processes where the preferable alternative of continual senior support is not feasible.

PL.50 AN AUDIT EXPLORING THE IMPACT OF NICE CAESAREAN SECTION GUIDANCE ON ELECTIVE CAESAREAN SECTION RATES AT THE COUNTESS OF CHESTER HOSPITAL (COCH)

doi:10.1136/archdischild-2013-303966.232

²J Gent, ¹S Brigham. *Countess of Chester Hospital, Chester, UK*; ²University of Liverpool, Liverpool, UK

Background In November 2011, NICE released new guidance for Caesarean Sections in the UK. The new guidance stated that "for women requesting a CS, if after discussion and offer of support, a vaginal birth is still not an acceptable option, offer a planned CS"¹. This audit will look into whether this has increased CS rates at COCH.

Method 40 sets of patients notes were selected to represent a snapshot of elective CS from January 1st 2012 to June 30th 2012. Data collected included documented indication for delivery, actual indication for delivery as well as elective CS rates for 2010, 2011 and 2012.

Results The overall elective CS rate for the hospital increased by 2% between Jan–June 2011 and 2012 compared to only a 1% rise between 2009–2011. The overall maternal request rate has increased from 0.5% of total deliveries in 2010 and 2011 to 1.4% in Jan–September 2012. Within the cohort the maternal request rate was 7.5% for Jan to

¹UNICEF 2010

June 2012 compared to 5.5% in 2010. There was a large disparity between documented and actual indication for delivery of 30%.

Conclusion From the results of this audit we can see that elective CS rates due to maternal request are on the increase. This suggests that the NICE guidance released in November 2011 has had an impact, to what degree is difficult to say however we can better substantiate this with annual figures.

REFERENCE

1. NICE. *CG132 Caesarean section: full guideline*. 23 November 2011 [Online]. Available from: <http://guidance.nice.org.uk/CG132/Guidance/pdf/English>

PL.51 SEVEN IN ONE YEAR: LESSONS LEARNED FROM A REVIEW OF PERIPARTUM HYSTERECTOMY IN A DISTRICT GENERAL HOSPITAL

doi:10.1136/archdischild-2013-303966.233

M Latibeaudiere, I Babarinsa. *Gloucestershire Hospitals NHS Foundation Trust, Gloucester, UK*

Following an unusual number of peripartum hysterectomies performed in the calendar year August 2011 to August 2012 in our district general hospital, we undertook a detailed review of the seven cases in which caesarean hysterectomies were necessitated by major obstetric haemorrhage, an incidence of about 12 per 10,000 deliveries, approximately three times the incidence quoted in UKOSS data.

Comparing these with the available national data regarding pathophysiology, we noted that the higher than expected incidence of placental implantation abnormalities were likely the causative factor (4 of 7 (57%) cases reviewed compared to 39% in national evidence). Evidence of good clinical practise was noted with respect to consent, appropriate staffing and involvement of senior clinicians. A range of measures were used prior to hysterectomy, including pharmacological treatments, haematological correction of coagulopathy, haemostatic brace sutures and uterine compression balloons.

While it is hoped that the number of cases represents a statistical 'blip' rather than an on-going trend, our experience emphasises the challenges faced by a busy district general hospital dealing with rising birth rates and increasing case complexity. We discuss the lessons learned from this case review, including the role of clinical governance and the benefit of open professional discussion.

REFERENCES

1. Knight M on behalf of UKOSS. Peripartum hysterectomy in the UK: management and outcomes of the associated haemorrhage. *BJOG* 2007;114:1380–1387.
2. Prevention and management of postpartum haemorrhage. RCOG Green Top Guideline No. 52. May 2009. RCOG.
3. Placenta praevia, placenta praevia accrete and vasa praevia: diagnosis and management. RCOG Green Top Guideline No 27. RCOG 2011.

PL.52 PLACENTA ACRETA IN ST VINCENTS UNIVERSITY HOSPITAL 2008–2011

doi:10.1136/archdischild-2013-303966.234

S Elsayed, G Ryan, P Lenehan. *St. Vincent University Hospital, Dublin, Ireland*

This is a retrospective review of all the patients who had a caesarean section for suspected placenta accreta in St Vincent's Hospital (SVH) from December 2008 to October 2011.

The study includes all women who were referred to SVH for caesarean section with an antenatal diagnosis of placenta accreta/percreta. The review included patient's age, parity and previous caesarean sections, antenatal diagnosis with ultrasound and MRI, hysterectomies performed, conservative management, ICU/HDU admissions after the procedure and radiological input. The review excludes women who had caesarean sections in SVH for other indications.

Results During the period 11 women had caesarean sections in SVH, 6 of these women had a caesarean section for suspected

placenta accreta. The average age was 35.6 years. All 6 had antenatal ultrasound and 5 had MRI.¹ 3 were diagnosed with placenta percreta and required bladder repair. 5 women had a caesarean hysterectomy. 4 women required ICU admission, 2 were admitted to HDU. 1 had conservative management with uterine artery embolization day 2 post operatively followed by manual removal of placenta at 8 weeks.² 2 women had a blood loss greater than 4 litres. All 6 women had female infants. All 6 had a history of previous caesarean section. 1 woman had 4 previous D&Cs for recurrent miscarriage. 3 had uterine artery embolization.³

Conclusion This review looks at the diagnosis and management of placenta accreta in a large tertiary centre and reviews the role of a multidisciplinary approach to its management.⁴

REFERENCES

1. LA McLean, ME Heilbrun, PJ Woodward. Assessing the role of magnetic resonance imaging in the management of gravid patients at risk for placenta accreta. *Acad Radiol* 2011;18:1175–1180.
2. BC Chan, HS Lam, CP Lee. Conservative management of placenta praevia with accreta. *Hong Kong Med J* 2008;14:479–84.
3. AP Rao, H Bojahr, I Renfrew. Role of interventional radiology in the management of morbidly adherent placenta. *J Obstet Gynaecol* 2010;30:687–9.
4. E Hayes, G Ayida, A Crocker. The morbidly adherent placenta: diagnosis and management options. *Curr Opin Obstet Gynaecol* 2011 Oct 14.

PL.53 A RETROSPECTIVE ANALYSIS ON COMPLICATIONS AND MANAGEMENT OF MACROSOMIC BABIES

doi:10.1136/archdischild-2013-303966.235

RN Pillai, T Davidson, T Singhal, A Matiluko. *University Hospitals of Leicester NHS Trust, Leicester, UK*

Introduction Considerable disparity has been noticed in macrosomic deliveries due to lack of recognised guideline in the management of macrosomia. In this study, we determined risk factors predicting macrosomia and associated complications. We analysed variations in management of macrosomia in a large teaching hospital.

Method This study was done by retrospective analysis of case notes of 45 women who delivered macrosomic babies from January 2010 to June 2010 in university hospitals of Leicester NHS trust.

Results Incidence of macrosomia was highest in the age group 30–40 years (46%). About 71% of babies with macrosomia in our analysis occurred in women with BMI < 30. Eighty % of macrosomic babies were born to non-diabetic mothers. Prior incidence of macrosomia occurred in 17.9% of multiparous women in our sample. Our analysis highlighted the variations in management of macrosomia, typically in mode of delivery (Table 1).

Conclusion In our analysis, we concluded that it is difficult to anticipate macrosomia based on risk factors. Also, there is a high incidence of complications associated with macrosomic deliveries. This highlights need for regular obstetric emergency 'skills and drills'. There is a need for standardised guidelines on management of macrosomia.

Abstract PL.53 Table 1 Antenatal care/delivery/complications associated with macrosomia

Factor	Incidence
Antenatal clinical suspicion	40%
Macrosomia missed on scan	16.6%
Spontaneous Vaginal Deliveries	48.8%
Induction of Labour	33.3%
Elective Caesarean section	17.7%
Postpartum haemorrhage	44.4%
Anal Sphincter Injury	6.6%
Shoulder Dystocia	0.49%
Poor Apgar score/NNU admission	0%

PL.54 THE FETAL PILLOW (FP): A NOVEL INTERVENTION TO REDUCE MATERNAL AND FETAL COMPLICATIONS IN CAESAREAN SECTIONS AT FULL DILATATION (CSFD)

doi:10.1136/archdischild-2013-303966.236

¹NM Mufti, ¹TT Thomas, ¹SS Sircar. ¹University of Glasgow, Glasgow, UK, UK; ²Wishaw General Hospital, Lanarkshire, ML2 ODP, UK

CSFD have an increase in maternal and fetal complications. There is an increase in post-partum haemorrhage, blood transfusions, and increase in hospital stay for mothers and NICU admissions. One method of reducing morbidity relating to CSFD is the FP, a silicone balloon inserted vaginally prior to CSFD resulting in a 3–4 cm upward displacement of the fetal head.

A retrospective study was performed analysing FP use in 16 patients undergoing CSFD, compared to 18 patients undergoing CSFD without FP use. The aim was to establish whether the FP reduces complications in CSFD.

Average operating time using FP was 41.6 minutes, and 70 minutes without. Average blood loss using FP was 698 mls, and 829 mls without. Uterine extensions were 31% in FP, and 33% without. The group without the use of FP saw 2 cases of blood transfusion, one had bladder damage intraoperatively, another required HDU admission, two had maternal pyrexia, and one required re-admission. This group also had two NICU admissions. 6% of surgeons reported fetal head delivery difficult using FP, and 39% without. 50% of surgeons said delivery of fetal head was easy using FP, and 39% without.

The FP seems to aid delivery of the impacted fetal head at CSFD. In the FP group there was reduction in average operating time, intra-operative trauma, need for transfusions, and blood loss. There was no maternal pyrexia, no maternal admissions to HDU, and no NICU admissions. These results are very encouraging to assess the routine use of fetal pillow in CSFD.

PL.55 TESTING SALIVA FOR THE PREDICTION OF PRETERM BIRTH: HOW ACCEPTABLE IS THIS METHOD TO WOMEN AT RISK?

doi:10.1136/archdischild-2013-303966.237

J Carter, R Cate, A Briley, L Poston. *Division of Women's Health KCL, Women's Health Academic Centre KHP, London, UK*

Background Despite extensive work to prevent preterm birth (PTB) it is still not possible to accurately predict those women at risk. Previous research¹ has suggested that salivary progesterone may be useful as an indicator of risk. Saliva tests are relatively uninvasive, but the acceptability of this method has not yet been investigated in pregnant women.

Aim The POPPY study aims to investigate salivary progesterone in a large cohort of women (n = >1000) at risk of PTB to support the development a predictive test and to assess acceptability.

Method In addition to providing at least one 5 ml sample of saliva between 20 and 28 weeks' gestation, women at risk of PTB are asked to complete a short acceptability questionnaire (adapted from Sy et al²).

Results To date, 1042 questionnaires have been completed. Interim results reveal the number of women agreed or strongly agreed that: 1. They liked the test because it was: a) easy/simple to use, n = 816 (78%); b) better than having blood taken, n = 701 (67%); c) convenient, n = 672 (64%); d) quick, n = 600 (58%); 2. They disliked the test because of: a) mouth dryness, n = 300 (29%); b) time taken, n = 234 (22%); c) embarrassment, n = 89 (9%); d) feelings of gagging, n = 73 (7%). 3. 84% of respondents (n = 880) would recommend it to other pregnant women.

Conclusion Although the majority of women found providing saliva for testing acceptable, this was not universal. Consideration