placenta acreta. 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 acreta in a large tertiary centre and reviews the role of a multidisciplinary approach to its management.[4]

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

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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 occured 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)

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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?

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Background Despite extensive work to prevent preterm birth (PTB) it is still not possible to accurately predict those women at risk. Previous research[1] 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 al*[2]).

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