**REFERENCES**
1. Flood *et al*. Changing trends in peripartum hysterectomy over the last four decades. *Am J Obstet Gynecol* 2009 Jun; 200(6):632.e1–6.
2. Angstmann *et al*. Surgical management of placenta accreta: a cohort series and suggested approach. *Am J Obstet Gynecol* 2010 Jan; 202(1):38.e1–9. Epub 2009 Nov 17.

## PL.62 PERI-PARTUM HYSTERECTOMY: STILL REQUIRED FOR MANAGEMENT OF POST-PARTUM HAEMORRHAGE?

doi:10.1136/archdischild-2013-303966.244

SM Barr, V Leburn, J Richmond. *NHS Greater Glasgow & Clyde, Glasgow, UK*

**Background** Postpartum haemorrhage (PPH) complicates 5–10% of all deliveries in the UK. While the use of uterotonic agents and compression devices has reduced the requirement for definitive surgical intervention, examination under anaesthetic, exploratory laparotomy and peri-partum hysterectomy remain in use to control intractable haemorrhage.
**Method** Cases of obstetric examination under anaesthetic (n = 66), exploratory laparotomy (n = 13) and peri-partum hysterectomy (n = 10) carried out in the Southern General Hospital were identified from theatre logs and the clinical risk reporting system from April 2009 to November 2012. Clinical features including estimated blood loss and interventional radiology involvement were extracted. Total births for this period was 16050.
**Findings** The incidence of return to theatre for the management of PPH was 0.41% of total deliveries over this period. Of these cases, exploratory laparotomy was performed in 20% (n = 13); peri-partum hysterectomy was required in 10.5% (n = 7) of those cases, with an overall incidence of 0.06%. A further three cases of caesarean hysterectomy were also identified; these were elective procedures for antenatally diagnosed invasive placentation. Where hysterectomy was performed, the underlying pathologies were uterine atony (n = 6) and invasive placentation (accreta and percreta, n = 4).
**Conclusion** Surgical intervention for management of severe postpartum haemorrhage is rarefor the overall obstetric population but remains necessary for management of uterine atony unresponsive to pharmacological management or compression and in cases of invasive placentation. Obstetric training should reflect this accordingly.

## PL.63 CAN WE SUSPECT SCAR DEHISCENCE OR RUPTURE AT EARLY STAGES?

doi:10.1136/archdischild-2013-303966.245

S Bhaskar, W Forson. *Royal Maternity Hospital, Belfast, UK*

**Introduction** Uterine rupture is amongst the preventable obstetric complication that carries severe risks both to mother and baby
**Aim** Critically analyse the notes of women with rupture uterus over a period of 11 years and to reflect and learn from the outcome.
**Method and Settings** Retrospective analysis of case notes of women with confirmed uterine rupture over a period of 11 years from January 2000–December 2011 at Royal Maternity Hospital, Belfast.
**Results** 17 women had confirmed uterine rupture in the study period of which 4 were preterm. All women except for one, had one or more term caesarean sections in past. The median interval between caesarean section and rupture was 3 years. Only 23% of women had induction of labour. Scar tenderness with or without suspicious CTG was the leading reason to suspect rupture. In nearly 70% of women maternal observations remained stable. Scar rupture was suspected only in 65% of women before the surgical intervention. 8 women (47%) had either scar rupture or dehiscence of varying length while remaining 53% had extensions of scar rupture. Conservative management remained the main stay of management. 35% of babies required neonatal care. The study also considered factors like uterine anomalies and surgeries, labour details including postpartum, staff involved etc.
**Conclusion** Trial of labour in previous section with successful outcome has long term implication on maternal health, while at the same time staff providing the care should be educated and trained to suspect the scar problems at early stages and intervene appropriately.

## PL.64 PYREXIA IN LABOUR: OUTCOME AND MANAGEMENT

doi:10.1136/archdischild-2013-303966.246

S Elsayed, N Bozreiba, H Khan, S Cooley, S Coulter-Smith. *Rotunda Hospital, Dublin, Ireland*

Intrapartum fever can be due to an infectious or non-infectious aetiology and can lead to a variety of maternal and neonatal sequelae. Sepsis contributes significantly to maternal morbidity and mortality. Pyrexia may be the only symptom in early sepsis.[1]
**Aim** To evaluate the incidence, management and outcome of intrapartum pyrexia in the Rotunda hospital, and to evaluate adherence to new hospital guidelines regarding septic screen and antibiotic therapy in intra-partum pyrexia.
**Method** Rretrospective audit of practise between 1 August and 30 September 2012. The presence or absence of maternal risk factors were reviewed and included: antenatal Group B Streptococcus (GBS), antenatal infections, preterm prelabour rupture of membranes (PPROM), prolonged rupture of membranes (ROM) and epidural analgesia. Intra-partum course parameters: management of pyrexia including resource to septic screen and intravenous antibiotics were evaluated.
**Results** 41 cases were selected and reviewed. The incidence of pyrexia in labour was 2.7% over the study period. The median maternal age was 29. The median gestational age at delivery was 40. 80.5% were nulliparous. 5% had PPROM. 24% had prolonged spontaneous ROM (more than 18 hr). Only one woman was positive for GBS antenatally. 5 cases had GBS on HVS detected on septic screen and 1 case had GBS on placental swab. Labour was induced in 43.9%. 27% delivered by emergency LSCS and 39% by instrumental delivery.
**Conclusion** 88% of pyrexial women had a septic screen as per protocol. There was a poor culture lead from MSU with the highest yield from placental histology. Pyrexia in labour was associated with: Nulliparity, Induced labour, Prolonged ROM, Epidural analgesia and Operative delivery

**REFERENCE**
1. Maayan-Metzger A, Mazkereth R, Shani A, *et al*. Risk factors for maternal intrapartum fever and short-term neonatal outcome. *Fetal Pediatr Pathol* 2006;25:169.

## PL.65 DEFERRED CLAMPING OF THE UMBILICAL CORD: NEURAL PROGRAMMING IN THE SURGEON AS A BARRIER TO CHANGE

doi:10.1136/archdischild-2013-303966.247

[1,2]MM Beard. [1]*Wales Deanery, Cardiff, UK;* [2]*ABM University Health Board, Swansea, UK*

Recent UK and international guidelines have advocated deferred clamping of the umbilical cord. The evidence of benefit for the neonate is robust, particularly for preterm infants at high risk of anaemia, interventricular haemorrhage and necrotising enterocolitis. Midwifery colleagues use the practise routinely but obstetricians, involved mostly in operative and surgical deliveries, have inconsistently adopted deferred cord clamping.

Triggered by inconsistent takeup at audit, an online survey was circulated to Consultants and trainees in obstetrics and gynaecology