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

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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 = 13) 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 placentaion. Where hysterectomy was performed, the underlying pathologies were uterine atony (n = 6) and invasive placentaion (accreta and percreta, n = 4).

Conclusion Surgical intervention for management of severe post-partum 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 placentaion. Obstetric training should reflect this accordingly.

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

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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 5 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

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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 Retrospective 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


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

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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 anae mia, interventricular haemorrhage and necrotising enterocolitis. Midwives colleagues use the practise routinely but obstetricians, involved mostly in operative and surgical deliveries, have inconsistently adopted deferred cord clamping.

Triggered by inconsistent uptake at audit, an online survey was circulated to Consultants and trainees in obstetrics and gynaecology
in the Wales Deanery (UK). Grounded theory was used to analyse
the responses, including free text.

While 8% of respondents cited lack of knowledge of or disagree-
ment with the practise, 57% of obstetricians and trainees admitted
that as the surgical sequence involved in a delivery is automatic,
they sometimes or often forgot to incorporate a delay before clamp-
ing. This automaticity is adaptive, arising from a need to reduce
cognitive load during complex motor tasks.

Where visuospatial skills are sufficiently refined (task mastery),

cognitive attentional skills are engaged only at key points. These are
used as landmarks in expert sequences such as playing a musical
instrument, using a gaming controller or surgery. During an abdom-
inal delivery, clamping of the cord is unlikely to be a key landmark.
This applies particularly for the experienced obstetrician in contrast
to the novice.

The hypothesis that there would be an inverse relationship
between the experience of the surgeon and the ease of incorporation
of a new element to the operation was supported. Simple aids mem-
oires facilitated incorporation of the new process, shown at reaudit.

Methods The notes of 395 women who had labour induced within
a large tertiary unit in the North West between August 2009 and
May 2012 were studied, excluding those induced for prelabour rup-
tured membranes. Data was collected retrospectively using a stan-
dard proforma.

Results 95 women received prostaglandin gel and 302 received the
pessary (28 also needed gel). The median ADT for women induced
using gel was significantly shorter at 26.57 hours (interquartile
range 15.87–42.96) than with the pessary at 31.83 hours (20.73–
46.54 hours p = 0.002 non-parametric testing). There was no differ-
ence in parity or oxytocin use between the 2 groups. Outcomes
between the 2 groups were the same, with no difference in post-
partum haemorrhage rate or vaginal delivery (p > 0.05).

Conclusions The prostaglandin pessary was associated with a
longer ADT, which is perhaps unsurprising given its longer duration
of use prior to assessment for amniotomy. This is probably because
the predicted increase in labour commencing in the pessary group
without further oxytocin did not occur, reflected in no difference
in oxytocin use between the 2 groups. This has implications for bed
occupancy, patient flows and NHS costs.

Background Vaginal twin deliveries can be complicated and senior
obstetrician presence may be advisable. Our unit has consultant
on-site presence between 08.30 and 20.30, so we sought to deter-
mine when inductions should be commenced to maximise deliveries
during these “daytime” hours.

Methods Women having prostaglandin induction after 36 weeks,
resulting in at least one vaginal delivery and where no delays to
normal care occurred were selected. Nulliparous and parous women
were considered separately and the percentage of “daytime” deliver-
ies calculated for inductions commenced in the morning (06:00 –
11.59), afternoon (12.00 – 17.59) and evening (18.00 – 23.59).
(Inductions commenced 00.00 – 05.59 were excluded due to infre-
quency.) Analysis of length of labour (defined from start time to
delivery of first twin) was performed.

Results The majority of inductions were commenced in the morn-
ing. For nulliparous women, 71% of morning-commenced induc-
tions resulted in “daytime” deliveries, compared with 50% and 67%
of afternoon-commenced and evening-commenced procedures.
Labour length was normally distributed with mean of 21.8 hours
(SD 7.9 hours). For parous women, afternoon-commenced induc-
tion produced a higher percentage of “daytime” deliveries; 85%
compared with 50% and 67% for morning-commenced and evening-
commenced inductions. Labour length was normally distributed
with mean of 15.0 hours (SD 7.0 hours).

Conclusions For nulliparous women, commencing induction in
the morning provides a high likelihood of “daytime” delivery. For
parous women, analysis of inductions by start time and mean
length of labour suggests a trial of commencing induction later in
the day might increase the proportion of “daytime” deliveries.

Background Around 20% of labours are induced with the current
recommended method being prostaglandin for cervical priming.
The 2 commonly used preparations are a prostaglandin gel admin-
istered 6 hourly, or a prostaglandin pessary, administered over
24 hours. Following a change in protocol from gel to pessary, we
aimed to look at the effect on admission to delivery time (ADT).

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