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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 = 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 post-partum haemorrhage is rare for 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?

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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 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

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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 PPRM. 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

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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 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 take up 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 disagreement with the practise, 87% 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 clamping. 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 abdominal 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 aide memoires facilitated incorporation of the new process, shown at reaudit.

PL.66 VAGINAL BREECH DELIVERY – 12 YEARS AFTER THE TERM BREECH TRIAL ARE THE RISKS AS HIGH AS SUGGESTED? AUDIT OF PRACTISE WITHIN THE SETTING OF A HIGH RISK LABOUR WARD

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The publication of the Term Breech Trial 12 years ago caused an almost universal change in UK practise towards offering elective caesarean section to women with breech presentation at term. These results have entered the public psyche to such an extent that women no longer have confidence undergoing vaginal breech deliveries (VBD) and experience has been eroded such that clinicians no longer maintain their skills. This has implications for women wishing to undergo VBD as well as morbidity and mortality from increasing numbers of caesarean sections (CS). We sought to answer the question of whether it was suitable and safe to offer VBD to women presenting in labour rather than carrying out emergency CS.

Between 2002–2011, 502 women with breech presentation at term attended in labour. 77 (15%) had normal vaginal delivery, 219 (44%) had emergency CS and 206 (41%) had urgent CS. In the CS group, 51 (12%) required CS anyway; therefore 78% were suitable to consider VBD.

Only 47% of this group attempted VBD. The majority chose CS due to personal preference or recommendation from doctors, highlighting lack of confidence in VBD by both doctors and women.

5-minute Apgar scores were comparable between groups but morbidity from blood loss was higher in women undergoing emergency CS vs. VBD. (1250 ml vs. 686 ml).

We believe these results show that VBD can be safe in selected cases and the time has come for clinicians to regain their experience so that more women can be offered this birth option with confidence.

PL.67 EFFECT OF DIFFERENT PROSTAGLANDIN PREPARATIONS FOR INDUCTION ON ADMISSION TO DELIVERY TIME

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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 administered 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).

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 ruptured membranes. Data was collected retrospectively using a standard proforma.

Results 93 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 26.37 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 difference in parity or oxytocin use between the 2 groups. Outcomes between the 2 groups were the same, with no difference in postpartum 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.

PL.68 WHEN SHOULD TWIN INDUCTION OF LABOUR START TO INCREASE THE CHANCES OF DAYTIME DELIVERY?

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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 determine 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” deliveries 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 infrequency.) 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 morning. For nulliparous women, 71% of morning-commenced inductions 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 induction 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.

PL.69 DELIVERY OUTCOMES AND EVENTS IN SUBSEQUENT PREGNANCIES AFTER PREVIOUS ANAL SPHINCTER INJURY

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Introduction Few recent studies have examined outcome in pregnancies following previous third degree perineal tears and results are