conflicting. One study found that although anal sphincter injury was increased five-fold at next delivery compared with all multiparae, 95% of women delivering vaginally after a previous third degree tear did not sustain further overt sphincter damage. (1).

In this institution it is recommended that all women with a prior history of ASI are seen at a perineal clinic in the third trimester in subsequent pregnancies.

**Objective** To assess the mode of delivery following a previous anal sphincter injury (ASI) and to evaluate perineal outcome following vaginal birth.

**Methods** A retrospective search of the hospital PAS systems was conducted on patients who had a delivery following an ASI from 2010 – 2012. Variables were described by counts and percentages and analysed using SPSS version 20.

**Results** Between January 2010 and July 2012, 147 women with previous ASI were assessed in the third trimester regarding mode of delivery. The results highlight risk factors for ASI and summarise factors which influence decision for subsequent mode of delivery. Perineal outcomes are documented for those who delivered vaginally.

**Conclusion** This paper highlights the importance of individualised antenatal assessment in patients who have previously sustained ASI. Patients who have prior ASI may have a personal preference when considering mode of delivery, but a specialist clinic affords them opportunity for detailed discussion. Many women went on to have uncomplicated vaginal deliveries after previous ASI.

**REFERENCE**


**PL.71**

**OUT-PATIENT PROPESS USE (CONTROLLED RELEASE PGE2 PESSARY) – AUDIT OF USE IN DISTRICT GENERAL HOSPITAL**

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**Background** Propess is a controlled release pessary which releases 0.3 mg of Dinoprostone per hour. As there is constant release rate, this would ensure steady Progesterone concentration and reduce the risk of hyperstimulation. Also, the need for one vaginal examination as opposed to one every 6 hrs improves patient acceptability.

**Aim** The aim of the audit was to look at the practise of using the first Propess on an out-patient basis with informed consent. We looked at the pregnancy outcomes after the Outpatient use of first Propess.

**Method** Prospective audit was done looking at the practise of using the first Propess.

Only low risk patients were given an option for Out-patient Propess. Informed verbal consent was obtained and open access to ward was given after Propess insertion. *If anyone needed any further Propess, this was carried out as an in-patient.* Initial pro-forma was filled in by the midwife and the notes were reviewed after delivery.

**Results** We looked the patients between the time period of 15/5/10 to 31/12/10. 57 women opted for Out-patient management.

67% of women who laboured with Propess alone were Nulliparous

APGARs at 5 min were >9 for all babies

No admissions to neonatal unit

Avg. blood loss at delivery 388 ml

**Conclusion** Outpatient use of first Propess does not alter pregnancy outcomes and does not increase the risks to baby.

When used selectively, the out-patient IOL is safe and effective alternative to patient admission.

Out patient use of Propess has decreased hospital stay. 20/57 women did not need a review prior to 24 hrs equaling 480 hours of saved in-patient care.