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.

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PL.70 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 proforma 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
There were no adverse outcomes.
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 equalling 480 hours of saved in-patient care.

PL.71 PAIN IN LABOUR: COMPARATIVE STUDY BETWEEN WOMEN UNPREPARED AND PREPARED BY THE PSYCHOPROPHYLACTIC METHOD

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Background Pain relief is associated to biological, sociocultural and psychological factors. Supporters of preparation for childbirth claim that the main causes of pain result from the triad fear, tension and pain.

Objectives To determine if mothers using the psychoprophylactic method of childbirth perceive less pain than those not prepared, and analyse the influence of age and self-concept in the perception of pain in labour.

Methods This was a comparative, cross-sectional study with a sample of 103 mothers (50 prepared, 53 unprepared). The data collection instruments include a questionnaire with a socio demographic and obstetric characterization and scale of self-concept of Vaz Serra. Pain was assessed with a numerical scale, on three occasions (beginning of labour, active phase and postpartum).

Results The unprepared mothers perceive more pain in early labour and active phase. The prepared mothers reveal more pain in the immediate postpartum, with statistically significant differences in the onset and active phase of labour. The age of the prepared mothers does not influence the perception of pain at the beginning of labour and in the immediate postpartum; in the unprepared mothers it does not influence the active and post-partum phases. In prepared parturients, increase in self-concept decreases the perception of pain, while unprepared mothers do not reveal statistically significant differences.

Conclusions As a preparation for childbirth decreases the perception of pain, we recommend this method to be implemented in services monitoring the health of pregnant women.

PL.72 RISK FACTORS FOR MANUAL REMOVAL OF PLACENTA ACROSS PARITY

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Background Retained placenta is a complication of the third stage of labour that is associated with increased rates of post-partum haemorrhage. Previous research identified risk factors related to maternal demographics and delivery related variables, but both clinical practises and patient variables have since changed. This study re-examines risk factors for manual removal of placenta (MROP) across parity.

Method This case-control study was conducted at the National Maternity Hospital in Dublin Ireland from January 2011 to Dec 2011. A chart review of all liveborn, singleton, vaginal deliveries was conducted to investigate maternal and delivery related variables in relation to retained placenta. Women were grouped based on the need for MROP as well as by parity. Statistical analysis was performed using chi square tests and odds ratios.

Results 7163 deliveries met the study criteria and 190 (2.65%) required MROP. Risk factors that were identified were parity, two or more miscarriages, previous ERPC, gestation at delivery, and oxytocin to accelerate labour. When divided based on parity, increased

maternal age was a significant risk factor for primiparous patients. For both groups, MROP was associated with greater blood loss.

Conclusion These results show an increase in the rate of MROP as compared to earlier studies and identifies similar risk factors. Of note, maternal age in primiparous women and use of oxytocin are factors that have undergone change since earlier studies and may be contributing to the rise in the rates of MROP in the industrialised world.

PL.73 DOES WHO WALKS INTO THEATRE MAKE A DIFFERENCE FOR SECOND STAGE DELIVERIES AND SHOULD IT?

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Detailed statistics on individual acchouchers have been kept from 2009 at JCUH. This paper is based on that data. It considers the influence of individual acchouchers on the success rate of second stage delivery in theatre.

Consultant attendance is currently 92%. Before the introduction of 98 hour cover attendance was 74%.

There was considerable variation in the success rates of individual achouchers from 20–78%. If instrumentation was attempted then rates varied from 40–87%.

Complication rates of the successful trials were compared. The consultants were split into three groups:

Success rate of ≤ 40%
Success rate of 41–70%
Success rate of > 70%

The least maternal complications (third/fourth degree tear and PPH > 1.5 l) occurred in the group with the highest success rate.

The number of neonatal complications (NNU admission of a baby > 37 weeks, apgar < 7 at 5 mins, cord ph < 7.1 and shoulder dystocia) were very small but they did not increase in the group with the higher delivery rate.

Conclusions there is considerable variation in success rates in women taken to theatre in the second stage dependant on the acchoucher. If we are to lower the caesarean section rate we need to look at the skills of individuals. A higher success rate does not appear to be associated with a higher complication rate. Further assessment is required looking at the complications of caesareans in the second stage. Data collection has commenced in 2012 to try and look at this further.

PL.74 INDUCTION OF LABOUR WITH PROPESS®

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Introduction Propess® is a vaginal delivery system that consists of a non-biodegradable polymeric drug delivery device containing 10 mg dinoprostone (Prostaglandin E_2) dispersed throughout its matrix. Introduction in most units as a method of induction of labour is largely due to reported benefits which include effectiveness and better patient experience.

Objective To evaluate the use of Propess® for induction of labour and the pregnancy outcome of the recipients.

Method A retrospective review of all induction of labour undertaken with Propess® over 4 months. Data was extracted from Euro king database unto excel for analysis.

Result 66 patients, with parity not more than 3, were induced with Propess® at term. The commonest indication for induction was post maturity (74%) however 4 (6%) high risk patients were induced with Propess®. 93% of patients who achieved spontaneous vaginal delivery received single dose Propess®. Patients delivered through caesarean section had slightly bigger babies (SVD 3.666 kg: CS 3.713 kg), were more likely to receive additional agents (prostin) to ripen the cervix and syntocinon to augment labour. Overall 55 patients (83%) achieved vaginal birth (spontaneous and assisted) and 17% via emergency caesarean section.

Conclusion Propess® is a cost effective agent for induction of labour as over 80% of patients achieved vaginal birth after single dose. However further studies are required to determine choice and/or dosage of additional cervical ripening agents suitable for use when single dose Propess® fails. This will help to reduce the number of caesarean sections performed for 'failed induction' after single dose Propess®.

PL.75 AN AUDIT OF LOWER URINARY TRACT INJURIES IN A LARGE OBSTETRIC UNIT – 2 YEAR OUTCOME

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Objective The main objective of this audit was to investigate the number of bladder injuries after delivery and compare it to the existent incidence in literature.

Method Retrospective medical record review of patients in Kingston Hospital's Obstetric department who had suffered from either ureteric or bladder injury between January 2011 and November 2012. A record of all these patients was recovered from the Obstetric electronic database.

Results There were a total of 11,246 deliveries between January 2011 and November 2012. Out of these 6,356 were normal vaginal deliveries, 1,684 were instrumental deliveries and 3,206 were caesarean sections. There were 6 cases of bladder injury found, all during caesarean section. 3 out of the 6 cases had caesarean section before the index pregnancy. 3 others had placenta praevia. Of these 3 previous caesarean section patients, 2 were unsuccessful at vaginal birth after caesarean section. One of them had a scar dehiscence extending to the bladder. Subsequent repair in all 6 cases was successful as indicated by normal imaging and a successful trial without catheter following 2 weeks of being catheterised.

Conclusion The rate of bladder injury found was 6/11,246 deliveries between January 2011 and November 2012. The incidence of bladder injury following caesarean delivery, 6/3,206 is comparable to the literature. This study also found that having a previous caesarean delivery increased the likelihood of having a bladder injury after caesarean delivery. Subsequent repair of bladder injury demonstrated good success rates.

PL.76 FAILURE TO IDENTIFY THE NEW ONSET OF INTRAPARTUM RISK FACTORS IN LOW RISK PREGNANCIES: A MISSED OPPORTUNITY FOR BETTER NEONATAL OUTCOME

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Objective Evaluate the risk factors and immediate outcome of term neonates born with Apgar Score (AS) of <7 at 5 minutes.

Methods Retrospective review of maternity database to identify 187 live born neonates with AS <7 @ 5 minutes, during a 2 year period, in a large tertiary care unit in N.Ireland. Excluding multiple pregnancies and neonates born preterm or with congenital malformations, a sample of 57 term neonates were identified for analysis of case notes.

Results 63% of mothers were primigravida, at 37 weeks or more, with 54% of them being forty weeks or more at delivery. Only 28% of pregnancies were known to be high risk at the onset of labour