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ORAL PRESENTATIONS
Instrumental Vaginal Delivery (IVD) helps expedite delivery during the second stage of labour so as to avoid a second stage caesarean section. However, due to mechanical effects on the fetal head, vacuum and forceps may cause CTG abnormalities due to vaginal stimulation and increased intracranial pressure. Knowledge of common patterns on CTG trace after applications of instruments and their underlying pathophysiology may help reduce unnecessary interventions and improve the outcomes.

A retrospective analysis of 445 cases who had vacuum (227) and forceps delivery (218) at St. George’s University Hospitals NHS Foundation Trust during a 12 month period was performed. CTG features were analyzed at both 10 minutes prior to and immediately after the application of the chosen instrument and specific abnormalities were correlated to Apgar Score at 1 and 5 minutes and umbilical cord arterial pH.

During IVD, 90% of the CTG trace showed abnormalities. Tachycardia, baro, chemo-receptor mediated decelerations and saltatory pattern were the most common ones. Increased baseline FHR during vacuum delivery was possibly secondary to pain and resultant sympathetic over-activity. Saltatory pattern was more common in forceps due to increased intracranial pressure and resultant autonomic instability. Despite CTG abnormalities secondary to mechanical stimulation of the fetal head, outcomes were good.
Increased use of operative vaginal delivery has been advocated as a strategy to curb the rising rate of caesarean delivery, however, there is limited comparative information regarding perinatal and maternal outcomes between operative vaginal and caesarean delivery. The decision between these delivery options is most uncertain at midpelvic station. We aimed to quantify perinatal and maternal morbidity/mortality associated with midpelvic operative vaginal delivery compared with caesarean delivery.

We conducted a retrospective cohort study of all term singleton operative vaginal and caesarean deliveries in the second stage of labour in British Columbia, Canada from 2004 to 2014. The primary outcomes were severe perinatal morbidity/mortality (neonatal convulsions, assisted ventilation, severe birth trauma, 5-minute Apgar <4, and perinatal death) and severe maternal morbidity (including severe postpartum haemorrhage, shock, sepsis, and cardiac complications). Logistic regression was used to estimate adjusted odds ratios (AOR) and 95% confidence intervals (CI) after stratifying by indication (dystocia/fetal distress). Absolute effects were quantified by calculating the adjusted rate differences and number needed to treat (NNT).

Attempted midpelvic operative vaginal delivery is associated with higher rates of severe perinatal morbidity/mortality, though these associations vary by indication and instrument. Birth and obstetric trauma rates are substantially increased following attempted midpelvic operative vaginal delivery compared with caesarean delivery.
Prolonged attempts at vacuum delivery are associated with neonatal morbidity and maternal trauma, especially if the procedure is unsuccessful and cesarean is performed. There is currently no method of objectively quantifying the likelihood of a successful delivery. Our study was designed to assess if ultrasound measurements can predict duration of vacuum extractions, mode of delivery and fetal outcome in nulliparous women with slow progress in the second stage of labor.

From 2013-2016 we performed a prospective cohort study in nulliparous women at term with slow progress in the second stage of labor in seven European maternity units. Fetal head position and station was determined using transabdominal and transperineal ultrasound. The main outcome was duration of vacuum extraction in relation to ultrasound measured head-perineum distance (HPD) with a predefined cut-off of 25 mm. Secondary outcomes were delivery mode and umbilical artery cord blood samples after birth. The time interval was evaluated using survival analyses, and the outcomes of delivery were evaluated using receiver-operating characteristics curves and descriptive statistics. Results were analysed according to intention to treat.

Ultrasound can predict labor outcome in women with slow progress in second stage of labor. The information obtained with ultrasound could give us more information as whether vacuum delivery should be attempted or if cesarean were preferable, to determine whether senior staff should be in attendance and if the vacuum attempt should be performed in the operating theatre. Transperinatal ultrasound is easy to learn and perform, and can be used online in the delivery room.
TOPIC: Specific variants of labour

ABSTRACT ID: 095

TITLE: WHICH FACTORS COULD AFFECT ROTATION OF FETAL OCCIPUT POSTERIOR POSITIONS DURING THE FIRST STAGE OF LABOR?

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Fetal occiput posterior (OP) positions account for 15 to 20% of cephalic presentations and are associated with higher rates of dystocia, prolonged labor and operative delivery compared to occiput anterior (OA) positions. The aim of this study was to identify maternal, neonatal or obstetric factors affecting rotation from OP to OA position during the first stage of labor. Secondarily, we assessed obstetric and neonatal outcomes according to this rotation.

This study is a secondary analysis of a multicenter randomized controlled trial (EVADELA). Study population were women in labor with ruptured membranes and with a term fetus in OP position confirmed by ultrasound. We excluded women who underwent cesarean before full dilatation and analyzed 285 women. We compared 2 groups according to fetal head position at the end of the first stage of labor: those with and without rotation from OP to OA position. Factors associated with rotation from OP to OA position were assessed using univariate analyses and a multi-level logistic regression model. Obstetric and neonatal outcomes were compared in univariate analyses and obstetric outcomes were stratified by parity.

Oxytocin administration might be a factor affecting rotation from OP to OA position during the first stage of labor. Further studies should be performed to give a better understanding of this relation and to assess benefits and risks of its utilization for managing labor with fetal OP positions.
TOPIC: Normal birth

ABSTRACT ID: 149

TITLE: Squatting birth position? Yes, but on flat feet! Results of an innovative biomechanical study.

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Women not influenced by Western conventions adopt mainly squatting birth position during labour. Observations of women in squatting birth positions show however two slightly different posture types: with flat footed or on the tip toe. In this study we investigated with innovative biomechanical methods the impact of feet position for pregnant women in squatting position on pelvis and lumbar curve, which are fundamental from the obstetrical mechanics’ perspective.

Women over 32 weeks of gestation were eligible for study entry. We analysed 2 different squatting positions: spontaneously taken and after change of feet attitude (flat feet were imposed when not spontaneously adopted).

To quantifying the posture of the women’ body parts (including the thighs, trunk and pelvis), we employed an optoelectronic motion capture (Vicon™, Oxford Metrics). A specific body model was proposed in order to obtain the segment angles (thigh flexion and abduction; superior pelvic inlet flexion relatively to the spine) based on external markers. We also used a measure system of the lumbar curve (Epionics™ spine system).

These angles obtained for the two squatting positions were compared using a paired t-test.

Some authors described the optimal birth position as associating a minimum lordosis with a pelvic inlet plane perpendicular to the lumbar spine. According to our results, these two are better obtained in squatting position with the feet flat than on tiptoe.

The clinical benefits of such biomechanical results should nevertheless be evaluated by further studies taking into account mother, fetus, and delivery outcomes.
Delivery after a previous cesarean section (CS) has been associated with adverse outcomes in the offspring. The objective of the study was to compare offspring condition in deliveries after a previous CS (with no previous vaginal deliveries) to birth order one deliveries (primiparas).

The Medical Birth Registry of Norway (MBRN) provided data, 1989-2009. Robson 5 deliveries, “the study group” (uterine scar, singleton, cephalic, ≥37 weeks gestation); n=43597, were compared to Robson 1 and 2 deliveries, “the comparison group” (birth order one, singleton, cephalic, ≥37 weeks gestation); n=422566. The outcomes were offspring mortality (death during delivery, in the first 28 days of life, or time unknown) and reduced five-minute Apgar score (<7 and <4). For each outcome, odds ratio (OR), crude and adjusted for maternal age and education (AOR), was calculated. The outcomes were compared for all deliveries in the two groups, and for those resulting in vaginal or acute CS delivery, supposed to represent trial of labor.

In all deliveries after a previous CS, no excess risk of offspring mortality or 5-minute Apgar score <4 was observed. Adjusted for maternal age and education, the risk of 5-minute Apgar <7 was reduced. In vaginal and acute CS deliveries after a previous CS, excess risk of offspring mortality and 5-minute Apgar score <4 was observed.
Since 1985, the amount of women giving birth after the age of 40 years old has increased nine fold. In 2016 the Dutch association of obstetrics and gynaecology (NVOG) increased the age limit of receiving IVF fertility treatment from 45 to 50 years old. Almost all complications that can occur during pregnancy, are associated with an advanced maternal age. The aim of this study is to consider the evidence of advanced maternal age related risk of adverse maternal and perinatal outcomes.

In this population-based cohort study, we identified all women who gave birth in the Netherlands between 2000 and 2015. These included both hospital births and homebirths. We used international definitions of maternal age: advanced maternal age (AMA, women between 35 and 45 years old), very advanced maternal age (VAMA, women over 45 years old) and extremely advanced maternal age (EAMA, women over 50 years old). Outcome parameters were maternal mortality, hypertensive disorders, gestational diabetes, postpartum hemorrhage, placenta previa, mode of delivery, breech birth, perinatal mortality, fetal growth restriction, NICU admission, prematurity and asphyxia.

Our results show an increase in maternal and perinatal complications as maternal age rises. These results confirms the little prior research that has been done in which the chances of many complications during pregnancy increase with advanced maternal age. Obstetric caregivers should be aware of the elevated risks that accompany the advanced maternal age. Pregnancy guidelines should be modified accordingly.
MISODEL® is a 200-microgram misoprostol slow releasing vaginal insert. It is currently the only PGE1 cervical ripening agent approved by Swissmedic. Misoprostol vaginal inserts have been shown to increase rates of tachysystole, without adverse perinatal outcomes. However, literature is scarce regarding the correlation between tachysystole, as well as other obstetrical factors, and failed labor induction with such agents.

A retrospective cohort study in a Swiss tertiary maternity unit. Multivariable logistic regression was used to identify factors independently associated with unsuccessful labor induction, defined as vaginal delivery exceeding 24 hours post misoprostol administration, and Cesarean birth. Variables included tachysystole, maternal age, parity, maternal BMI, indication for labor induction, gestational age, fetal birth weight, Bishop score, maternal smoking, use of epidural anesthesia, and presence of meconium-stained amniotic fluid.

This study illustrates that the presence of tachysystole did not affect labor induction. Other maternal and obstetrical factors such as parity, early initiation of epidural anesthesia, and presence of meconium-stained amniotic fluid may predict labor induction failure with misoprostol vaginal inserts. These findings are comparable to studies involving other PGE1 and PGE2 agents. Such elements should guide the obstetrician in case’s management, following a global assessment of the patient.
In the 2000s original research about manual rotation (MROT) of the posterior occiput has been done only by the american Brian Shaffer and by the french Camille Le Ray. They showed that MROT reduces cesarean sections (CS) in case of persistent posterior occiput (POP). In 2013 at the Giannina Gaslini Hospital in Genoa, Italy, we decided to reduce the increasing number of CS for POP introducing MROT in our delivery room, following the encouraging experiences of Shaffer and Le Ray.

Digital and manual rotation (grouped as MROT) structured according to the StratOG tutorial were learned by simulation on a mannequin and assimilated to an operative vaginal delivery (OVD). From July 2013 to August 2016 we conducted a prospective open case control study on 139 women with a prolonged second stage and posterior occiput. Outcomes were: vaginal delivery (VD), OVD, CS, maternal and neonatal outcome. In 38 cases MROT was avoided (CTG abnormal and/or a worse vaginal exploration). In the remaining 101 women indications and prerequisistes allowed MROT: 40 cases were managed by obstetricians who had learned the maneuver (group A), 61 cases by the other obstetricians (group B). Each group represented the control of the other.

Our study allows us to conclude that the technique we used to perform MROT can be learned and taught by simulation and decreases CS in case of POP, with an increase of OVD.

Some issues need to be clarified: Can we be confident that StratOG’s tutorial shows the best technique? Should MROT be performed prophylactically? Is it correct to perform digital rotation in first instance, then manual rotation in second instance? OVD could be the best way to conclude vaginal delivery after MROT?
Short-term maternal morbidity of cesarean (CS) versus vaginal delivery (VD) are still controversial. The main methodological issue when studying this association is indication bias. Our objective was to test and quantify the independent association between CS and severe acute maternal morbidity (SAMM) as compared with VD, globally and according to the timing of CS, before or during labor. This analysis was conducted with a special focus on controlling confounding by indication.

Population-based cohort-nested case-control study. Data source was the EPIMOMS study, designed to study SAMM, conducted in 6 French regions in 2012-2013 i.e. source population of 182,300 deliveries. Cases were 1444 women with per/postpartum SAMM not due to a condition present before delivery. Controls were 3464 randomly selected women who delivered without SAMM in the same regions. We used propensity score (PS) to modelize for each woman the probability of having a CS based on characteristics present before delivery. We estimated odd ratios (ORs) for the association between CS and SAMM after stratification on maternal age in the PS matched population, and in the total population from models with traditional adjustment for confounders.

CS delivery is associated with a higher risk of SAMM than VD, after controlling for confounding by indication. However, the strength of this association depends on maternal age. The risk is particularly marked for women aged ≥ 35 years, for both CS before and during labor. Practitioners should consider this increased maternal risk in order to inform women, decide the mode of delivery and avoid CS performed without medical evidence, especially when the unique ‘indication’ is high maternal age.
Continuous improvement of obstetric care depends on the consistent collection of high-quality data on maternal and neonatal outcomes. A new classification for intrapartum caesarean section combines the retrospective assessment of progress in labor, use of oxytocin and indication for delivery in an objective, consistent system. We hypothesised that teaching in the concept of the classification and its practical application results in common understanding among obstetric caregivers.

Twenty-five obstetric units covering 85% of all births in Norway selected 1-3 local caregivers to become experts in the classification system. A total of 49 participants (11 midwives, 6 trainees and 32 consultants) came together for a seminar, went through 2.5 h of training (lecture, group session) and finally were asked to classify 10 cases delivered by caesarean section in labor according to the classification system. Information given included the partograph, medication and interventions during labor and the fetal monitoring trace. The degree of agreement compared to the correct classification was calculated for each participant, expressed as Cohen’s Kappa ($\kappa$). Differences between professions were assessed by independent sample t-test.

Teaching of a new classification system for intrapartum cesarean section resulted in a promising degree of agreement among obstetric staff. It is currently tested at 25 Norwegian delivery units in a large scaled study. The classification system may become a valuable tool for objective quality assessment in obstetric care in the future.
Objective:
To evaluate the effectiveness of routine induction of labour (IOL) at 41 weeks as compared to expectant management (EM) until 42 weeks in obstetrical low risk women.

Study Design:
A multicentre randomised controlled non-inferiority-trial was performed within the Dutch Research Consortium for Women’s Health. Women with an uncomplicated singleton pregnancy in cephalic position were allocated for IOL or EM. Primary outcome was a composite of perinatal mortality and morbidity (5’ Apgar score<7, umbilical cord pH<7.05, NICU admission, plexus brachialis injury and/or meconium aspiration syndrome). Secondary outcome was a composite of maternal mortality and morbidity (haemorrhage postpartum ≥1000 ml, manual removal of placenta, obstetric anal sphincter injuries, Intensive Care admission), mode of delivery and need for analgesia.

Conclusion:
No significant difference was found in adverse perinatal or maternal outcomes between induction of labour at 41 weeks or expectant management until 42 weeks in obstetric low risk women. The results of this study can be used in a process of shared decision making.
Hypoxic-ischemic encephalopathy (HIE) is an important cause of acute or subacute neurological injury at birth, occurring in about 1-2 per 1000 live births. It is associated with high risk of early neonatal death and childhood morbidity. Aneurin Bevan University Health Board (ABUHB) is one of Wales’s largest health boards with approximately 6000 deliveries per year across 2 hospitals. The study aim is to audit all HIEs across the trust to determine causation, outcome and areas for improvement.

All cases of HIE 2 and 3 were audited retrospectively from January 2014 – December 2016, from 18502 births within ABUHB. HIE was graded using the Sarnat score as moderate (HIE 2) or severe (HIE 3). We assessed whether criterion for cooling was met, identified any causative factors, associated injuries and long term implications. There were six categories for causative factors of HIE: acute intrapartum causes, sepsis, meconium, congenital problems/ slow adaption and misdiagnosed fetal distress. Perinatal information was collected from patient notes and information obtained from local risk management meetings in order to determine misdiagnosed fetal distress cases.

Over the 3 years HIE audits for ABUHB have met national rates of 1-2 per 1000 live births. There is no significant improvement in HIE rates over the 3 years. The criterion for cooling was met in all cases. There was a total of 7 misdiagnosed fetal distress emphasising need for improved knowledge of fetal physiology behind the interpretation of cardiotocography in order to improve perinatal outcomes and reduce HIE rates.
Our aim is to study the effect of advanced maternal age in late- and postterm pregnancies on composite adverse perinatal and maternal outcome in the Dutch population.

We performed a national cohort study on data from the Netherlands Perinatal Registry on singleton cephalic deliveries between 37w0d and 42w6d, without congenital anomalies, high blood pressure or diabetes from 1999-2010. We created three groups: ages ≥18-34 (n=1,321,366); 35-39 (n=286,717) and ≥40 (n=40,909). We compared a composite of adverse perinatal outcomes (perinatal death, meconium aspiration syndrome, Apgar score 5’<7, NICU admission and sepsis) and composite of maternal outcomes (maternal death, placental abruption and postpartum hemorrhage ≥1000ml (PPH)) and mode of delivery between these groups and performed a analysis on late- and postterm pregnancies. Because of multiple testing, we stated p<0.001 as significant.

In our cohort study, we showed less composite adverse perinatal and maternal outcomes at age ≥18-34 in comparison to age 35-39 and age ≥40 in pregnancies between 37w0d and 42w6d. In late- and postterm pregnancies, we found an increase in composite adverse perinatal and maternal outcomes, irrespectively of maternal age.
Fetal ST segment analysis (STAN), invented in Sweden, is used across Scandinavian countries and the UK improving intrapartum fetal monitoring. Conventional interpretation of CTGs via pattern recognition can lead to unnecessary interventions whereas understanding fetal physiology facilitates interpretation in relation to hypoxia. The aim of this project was to decrease unnecessary interventions and minimise hypoxic fetal injury via STAN monitoring and fetal physiology in the Royal Gwent Hospital.

The intention of this article is to show how appropriate introduction of new technologies can significantly improve intrapartum care. We would like to share our experiences to date, and difficulties we have encountered and overcome. We introduced STAN in stages to ease the transition process, using only the CTG function until staff were confident with the equipment before commencing ST analysis in November 2014.

We have conducted a retrospective analysis of emergency CS (emCS) deliveries in the 2 years prior to, and year of, implementation of STAN and prospectively collected emCS rates for the 2 years since. We reviewed patients’ notes, collected data and used excel to analysis data.

We present reduced rates of interventions with no significant differences in adverse maternal outcomes, rates of fetal acidosis (pH <7.0) or hypoxic ischaemic encephalopathy.

STAN monitoring with interpretation using fetal physiology has improved fetomaternal outcomes and reduce caesarean section rates in our unit. Mutual effort and dedication of the team and increasing knowledge and confidence are essential to maintain high standards of care and safety while introducing new technologies.
Successful management of Major postpartum haemorrhage (PPH) requires a multidisciplinary approach based on skilled care providers working in a collaborative team. This is achieved by training staff in simulated settings and also ensuring formal debriefing and feedback after actual PPH events. The present study aimed to develop a valid and reliable tool for assessing the clinical performance of teams managing postpartum haemorrhage (PPH).

Part 1: Delphi study.

12 obstetricians from UK, Norway, Sweden, Iceland and Denmark achieved consensus on a) the elements to include in the assessment tool, b) the weight of each element, and c) the final tool.

Part 2: Test of validity and reliability.

Two observers independently applied the TeamOBS-PPH tool to 85 real-life teams managing patients with PPH > 1000ml in two Danish hospitals.


Delphi panel consisting of 5 clinicians from US and 15 video-recordings of in-situ simulations of PPH from a US hospital, maternal care level 4. To assess the external validity, three observers independently applied the tool to the 15 video recordings.

The tool TeamOBS-PPH can be applied in three situations;

1) In education, as a feedback tool after simulation training to encourage reflective practice with the aim of improving performance and enhancing patient safety,

2) In the clinic, as a feedback tool to facilitate team debrief after real-life events and

3) To evaluate overall treatment of PPH by multidisciplinary teams in obstetric departments.
The introduction of ultrasound into the delivery room has gained much interest during the past years in the ongoing effort to assess labor process and diagnose high risk cases for complicated labor in a more accurate and quantitative method. The purpose of our study was to assess the utility of visual biofeedback using trans-perineal ultrasound (TPU) measurement of the angle of progression (AOP) during the second stage of labor on pushing efficacy, perineal tearing, and labor outcome.

Visual biofeedback using TPU was performed during the second stage of labor (n=20). AOP was measured at rest and during a single pushing effort while the patient observed the effectiveness of her pushing on the ultrasound screen. Obstetrical results were compared to a control group (n=60) who received standard coached maternal pushing by midwives.

We present the pioneering technique of visual biofeedback using trans-perineal ultrasound during the second stage of labor. At any moment during the second stage of labor, visual biofeedback using TPU served as a useful tool to push more efficiently and reduce the severity of perineal tears. When performed within the first hour following full cervical dilatation, our results demonstrate that visual biofeedback reduced the incidence of operative delivery.
POSTER PRESENTATIONS
Progestogens are vital for maintaining pregnancy and supplementation may also prevent complications such as miscarriage and preterm birth. Many trials and at least eighteen meta analyses have concluded that progestogens were effective. However recently two large trials PROMISE and OPPTIMUM concluded they were ineffective. This suggests that the results of the positive reviews may have been biased by selective publication or choice of endpoints, so called “P-hacking”.

We performed a Meta-analysis of trials testing the effect of progestogens in preventing or treating miscarriage or preterm birth. We restricted our analysis to endpoints which could not have been “P-hacked”, namely the registered primary endpoint from trials that were either registered before they started, or registered during the recruitment phase and also double blind.

When evaluated in registered double-blind trials with analysis restricted to predefined primary endpoints, progestational agents in pregnancy are ineffective. This highlights the importance of trial registration and the bias of data driven secondary analyses.
A key objective in the United Nations’ Millennium Development Goals was improving maternal health; however, maternal mortality remains a major public health issue worldwide, especially in Sub-Saharan Africa. Barriers to accessing healthcare are undoubtedly prevalent in developing countries; evidence suggests that strengthening obstetric emergency care through simulation-based training provides a promising means to improve maternal outcomes.

The aim of this study was to determine the efficacy of obstetric simulation-training for postpartum haemorrhage (PPH) and eclampsia in two rural hospitals in Uganda. The simulation-training model consisted of a half-day session, comprising two simulation scenarios adapted for a low-resource setting from the PRactical Obstetric Multi-Professional Training (PROMPT) course, followed by an interactive discussion of clinical management algorithms. Questionnaires completed before and after assessed subjective improvements in knowledge and confidence as well as participant views. Participant characteristics were also analysed.

This simulation-training programme covering PPH and eclampsia was effective in improving participants’ knowledge and confidence. Training appeared to be more successful in those with less previous training. This study adds evidence for the efficacy not only of simulation training in developing countries, but also of the benefits of a low-cost, time-efficient simulation training model.
In Sweden the diagnostic code defines prolonged latent phase > 18 hours to cervix dilation 3 cm regardless of parity. Previous studies describe the prevalence of prolonged latent phase between 5%-6.5%.

Our aim was to describe the prevalence of a prolonged latent phase, in women with spontaneous onset of labour and with the intention to give birth vaginally. Further to compare obstetric interventions and labour outcome in women with a latent phase < 18 or > 18 hours.

Descriptive and comparative study from a middle-sized hospital, in the western part of Sweden. 1445 birth records of intended vaginal births with spontaneous onset of labour and a gestational week > 34 were included in the analysis. Background characteristics, obstetric interventions, labour and neonatal outcome were compared between records from women with < 18 hours latent phase and those with > 18 hours.

The prevalence of a prolonged latent phase is more common than earlier reported. A prolonged latent phase was associated with obstetrical interventions, and operative births.
Stroke is rare in females of reproductive age, but normal physiological changes of pregnancy and pathological states related to pregnancy increase risk of stroke in this age group of women. There is a dilemma still in managing the mode of delivery for these women.

A 38-year-old, 38 weeks pregnant female presented in her third pregnancy to A&E with sudden onset left sided facial and arm weakness and subjective speech difficulty. She had 2 vaginal deliveries before. The initial symptoms improved, but residual symptoms stayed all day. CT head, Carotid, Femoral USS Doppler scans were normal. MRI Brain showed focal area of restricted diffusion in right centrum suggestive of infarct. She was started on anti-platelet agent dipyramidole 200 mg twice a day. The symptoms recovered without any residual neurological symptoms within few days. After discussing the pros and cons of vaginal delivery and caesarean section, patient chose to have a caesarean section. Due to high risk of venous thromboembolism, patient was recommended 6 weeks of postpartum prophylactic anticoagulation.

Stroke that occur in pregnant women could be either ischemic or hemorrhagic. Around 90% of strokes occur close to delivery or postpartum. Though the neurologists suggest that vaginal delivery could be safe, the problem lies if the woman had a recent ischemic or a hemorrhagic stroke. The increase in intracranial pressure during pushing may theoretically put the woman at risk. Multidisciplinary team involvement is vital when such decisions are made which should include the woman herself.
The principles of autonomy, nonmalificience, beneficience and justice are all intertwined and central to issues that are faced in women who decide to continue pregnancy with life threatening fetal anomalies. This case study is about a patient who decided to continue a pregnancy with a fetus that has agenesis of the corpus collosum with associated colpocephaly. Considering the risks associated with caesarean section for the woman, is it ethical to consider caesarean section as mode of delivery?

A 31 year primigravida presented for routine scan in pregnancy. The foetus was found to have agenesis of corpus collosum. She had an amniocentesis which excluded trisomies 13, 18,21. Discussion around significant morbidities for the baby was carried out by the obstetricians, neonatologists and the neurosurgeons. Termination of pregnancy was offered as a choice. Though she initially agreed to terminate the pregnancy, she changed her mind and continued the pregnancy. In view of increasing head circumference and ventriculomegaly the options for mode of delivery was discussed with her. Though the head circumference was less than 90th centile, the woman chose to deliver the baby by elective caesarean section at 38 weeks gestation.

This case study is about a patient with a fetus that has agenesis of the corpus collosum with associated colpocephaly. Postnatally this infant could have a spectrum of disabilities including delayed motor milestones or epilepsy. Knowing the morbidities associated with this baby, the ethical dilemma persists regarding monitoring in labour and mode of delivery. The risks in subsequent pregnancies should be discussed with the woman prior to deciding on mode of delivery.
Preterm infants are at risk for developing Respiratory Distress Syndrome (RDS) leading to alveolar collapse from surfactant deficiency. They are given oxygen support using RAM cannula continuous positive airway pressure (RCPAP) designed to keep alveoli open. Kangaroo care is a novel practice in reducing hypothermia, apnea, and bradycardia for preterm infants, by mimicking the environment in-utero.

This is a prospective, non-blinded, randomized controlled trial which was conducted in the Neonatal ICU over one year. Seventy preterm neonates weighing 1000 – 2000 grams, aged < 36 weeks with an Apgar score of > 7 at the first and fifth minute of life requiring RCPAP due to respiratory distress were included. Thirty-five subjects were randomly assigned to Kangaroo care group and thirty-five subjects to conventional care group. Maternal and neonatal characteristics were obtained. Outcomes determined were the length of RCPAP use, length of oxygen support, morbidity, mortality, sepsis, and length of hospital stay. Data were analysed using mean and standard deviation, independent sample T-test and percentage-frequency distribution.

Kangaroo mother care provided to preterm neonates on RAM cannula CPAP significantly decreases the duration of oxygen support and RCPAP. Physiologic responses such as temperature during the KMC position together with oxygen saturations before, during, and after the intervention, results revealed statistically significant differences. KMC also lowered the incidence of air leak syndromes, necrotizing enterocolitis, and late onset neonatal sepsis which were statistically significant.
Rates of Cesarean sections have been on the rise over the past three decades, despite the ideal rate of 10 to 15% that has been set by the WHO. Strikingly, these rates have reached alarming levels in the Middle East where fertility rates are quite high, such as Egypt and Jordan, where cesarean delivery rates have exceeded 50 and 30%, respectively. There is no doubt that CS is a safe procedure, however, like all other surgical procedures it is not without risks both to the mother and the newborn.

In the Middle East and many African and Asian countries women tend to have large families. There is a substantial increase in the incidence of morbidly adherent placenta and the risk of scar pregnancy. The number of previous cesarean section deliveries is directly proportional to the risk of developing morbidly adherent placenta. Morbidly adherent placenta is the most common cause of emergency postpartum hysterectomy, which is often associated with severe maternal morbidity and mortality.
Living beings when exposed to any acute stress exhibit a “fight or flight” response via the sympathetic nervous system for survival. Initial application of vacuum or forceps on the fetal head may lead to fetal pain/stress response resulting in sympathetic over-activity.

A retrospective analysis of 445 cases of vacuum (227) or forceps (218) delivery at St. George’s University Hospitals NHS Foundation Trust during a 12 month period was performed. CTG features were analyzed at both 10 minutes prior to and immediately after the application of the chosen instrument.

Similar to adults, when challenged with an acute stress/pain due to the application of vacuum or forceps, approximately 50% of fetuses exhibited the sympathetic response characterized by an immediate increase in the fetal heart rate, over 80% of which was within 1 minute, irrespective of the type of the instrument.
Croatian midwifery has changed drastically in the past few years. Most of the changes resulted from joining the EU. The structural modification intended to increase education, skill and the ability to monitor physiological birth. But is that goal accomplished? With joining the EU Croatia was obliged to open undergraduate studies. It has been a few years since the first students have graduated and the Croatian Chamber of Midwives has prepared a survey among midwife bachelors in Croatia.

We created a survey, containing 63 questions. Participating in the survey was anonymous. Questions varied in form: written answers, circle one or more answer, yes or no questions. Out of more than 2500 registered midwives in Croatia, just over 130 were midwife graduates and among them, more than half completed the survey. The respondents were employed in general or county hospitals, clinics or private gynecological clinics. The answers received were from participants from all counties in the Republic of Croatia. Due to all this, we determined that we had the representative sample. We then analyzed all the answers. Some of them were analyzed statistically and the others just by sorting and listing all the answers.

More and more studies are coming out on the importance of midwife care. Quality midwifery care is needed and it is proven that this makes women more satisfied. We hope that this analysis will serve as an indicator of the status of higher education of midwives in Croatia and become the starting point for considering the final alignment and takeover of the competences that midwives are guaranteed by the Midwifery Act so that we can finally say midwives monitor physiologic birth in Croatia.
The c-section rate has doubled in the last decade and has outreached the upper limit of 15%, which was recommended by the WHO in 1985. An internationally recognized classification system had been required to analyze the trend and its possible consequences in a standardized manner. The goal of this study was to evaluate the c-section rate and the fetal outcome using the Robson classification. This study took place at the University Hospital of Vienna in an 11-year time period (2003-2013).

This is a retrospective data-analysis of singleton and twin pregnancies in cephalic, breech, transverse or oblique presentation with a gestational age between 23 and 42 weeks. Of 30.162 occurred cases, 26,561 cases were eligible for the data analysis. These cases were then divided into 10 groups based on the Robson-criteria. The overall cesarean section rate between 2003 and 2013, main contributors to the rate and the fetal outcome as a function of mode of delivery (vaginal vs. cesarean) within each Robson category had been analyzed. The outcome parameters included: birth weight, umbilical cord arterial pH, neonatal intensive care admission, Apgar score for 1, 5, 10 minutes and cumulated. For group 1-4 and 10 superior fetal outcomes were demonstrated after vaginal birth. If the absence of maternal and fetal complications is given, a vaginal birth is recommended for these categories. In breech presentation and in twin pregnancies a c-section seems to be beneficial. Women with previous uterine scars showed the highest cesarean rate and were a main contributor to the overall c-section rate, although it was demonstrated that Apgar Scores were significant higher after vaginal birth.
The physiological changes experienced during pregnancy increase the predisposition to Urinary Tract Infection. Urinary Tract Infection is a condition which threatens both the mother’s and the fetus’s health. The symptoms of Urinary Tract Infection are repetitive unless preventive measures are taken. Therefore, it is possible to prevent the repetitive symptoms of Urinary Tract Infection with the help of the genital hygiene instruction which midwives will give.

The population of the research is comprised of pregnant women with diagnosis of Urinary Tract Infection and research sample consists of response group pregnant women and control group pregnant women. Data were collected from pregnant women that had been diagnosed with UTI. The pregnant women in response group were given personal hygiene instruction data were collected by using Introductory Properties Question Form Genital Hygiene Behaviours Inventory UTI and Genital Hygiene Information Evaluation Form. In second stage of research they waited for 21 days in total to interview pregnant women again in case possibility of symptoms of UTI can be repeated. Data were recollected via telephone interviews. In this stage symptoms were examined with UTI Follow-up Form.

As a consequence, it has been understood that in addition to the medical treatment of Urinary Tract Infection in pregnant women, the symptoms of urinary tract infection can be prevented with the hygiene instruction which will be given by all health staff, notably by midwives. Thus the healthy women will form the healthy society.
Perinatal asphyxial encephalopathy is associated with high risk of death and neurodevelopmental impairment which imposes enormous financial and emotional implications to the patient, family and society. Among the survivors cerebral palsy, functional disability and cognitive impairment often develop later in childhood. It is vital to understand the pathophysiology of HIE (Hypoxic ischaemic encephalopathy). A review and audit of cases, their management and follow up can be useful for learning.

A retrospective audit of all cases of HIE 2-3 was conducted over two hospital sites. A sample size of 15 cases over one year was included. An audit proforma was used to collect data. The audit points were APGAR scores, blood gases, CTG prior to birth, type of HIE, seizure activity, Cerebral function monitoring, cooling criteria, MRI day 10-14. Data analysis was done on a Microsoft excel sheet and the results were displayed on power point. They were presented in clinical governance meeting in an effort for improvement of care. Intrapartum information was provided to co-relate with the outcomes.

Cooling was provided to all babies with HIE 2-3. Passive cooling was initiated immediately after birth followed by active cooling. Cooling criteria was met in all the cases. The active cooling was carried on in a few cases even when the CFM was normal. All had an MRI at 10-14 days. There was one avoidable HIE where in CTG showed saltatory pattern and lessons were learnt from it. A plan for long term follow up and audit of babies with HIE 2-3 was recommended.
Our primary objective was to compare neonatal and maternal outcomes in women with twin pregnancies, beyond 32 weeks, having a planned vaginal birth or a planned caesarean section (CS).

This was a retrospective cohort study from a single tertiary centre over 9 years. 534 sets of twins ≥32+0 weeks of gestation were included. 401 sets planned vaginally and 133 sets planned by CS. We compared a composite adverse perinatal outcome (perinatal mortality or serious neonatal morbidity; five minute APGAR score ≤4, neurological abnormality and need for intubation) and a composite maternal adverse outcome (major hemorrhage, trauma, or infection) between the groups.

Given the similarity of these results with several other larger studies of twin birth, we sought to look at reasons why there is still a rising rate of CS for twin births. We further make suggestions for keeping this rate to a sensible minimum.
Persistent posterior varieties (PPV) represent about 5% of deliveries and typically have a maternal-fetal prognosis more reserved than anterior varieties. The vacuum extractor seems particularly well suited to this situation through the cephalic flexion and rotation induced thanks to it. The aim of our study was to retrospectively evaluate the occipito-pubic (OP) extraction rate after placing a vacuum extraction on a PPV.

This is a mono-centric descriptive study, including during 4 years all patients with a term singleton fetuses born by vacuum extractor placed on a PPV.

Our results show that vacuum extraction is an effective means for rotation of the fetal head in the maternal pelvis even in a situation with high risk of dystocia that are PPV, generating an anterior occiput degagement in almost 2/3 of cases.

The ventouse can also avoid a cesarean in most cases (> 85%) and does not seem to worsen the maternal-fetal no prognosis. Vacuum extraction appears to us to be the instrument of choice in case of need of assistance at birth in cases of PPV.
Labour is about to begin in the latent phase. It can last long and can be an exhausting and discouraging for laboring women. Care in early labour is significant, because coming to hospital in that stage increases the likelihood of various interventions. It has been also shown to increase health-care costs. The aim of this scoping review was to chart broadly the relevant literature on any interventions conducted by midwives during the latent phase of labour in the care of laboring women.

The inclusion criteria were defined in the following way: 1) The study describes the care during the latent phase of labour at home or in a health care facility; 2) The study describes the interventions made by midwives during the latent phase; 3) The study produces information about the impacts of the interventions or the experiences of the woman/the healthcare professionals in regard to the interventions. Only peer reviewed original studies, which equated with the inclusion criteria, were written in English, and published during the years 1994–2014 were included in the review. No particular exclusion criteria were included in the data searches. Data (n=12) were selected and analyzed by searching for similarities and variations.

Research evidence about latent phase interventions is still rare. Based on the review it seems that desirable interventions are support, guidance and clear advice. Moreover, non-medical pain relief must be considered during latent phase.
Mechanical induction is now approved by NICE. A Cochrane review of 71 RCTs including 9722 women found mechanical methods of induction of labour (IOL) result in same rates of caesarean section with less risk of hyperstimulation. We undertook a service improvement project to introduce mechanical induction of labour to our unit. The different stakeholders were consulted from the beginning. We audited the use of both Foleys and Cooks catheters after their introduction.

Aims:
To evaluate different methods of mechanical IOL to provide safer, more efficient and cost effective care. We also assessed patient experience.

Method:
This was a prospective audit of 100 consecutive patients who accepted Cook or Foley balloon as a method for IOL. An anonymous paper questionnaire was also given to patients prior to discharge.

We are moving towards a more personalised induction route for women to provide them with the safest and most acceptable and successful method of induction. Mechanical induction of labour provides us with another safe method to offer women. It may be best reserved for multiparous women and it appears safe in VBACs.
The cesarean rate in France rose from 6.1% in the 1970s to over 20% in 2010 while WHO recommends a caesarean section (CS) rate of between 10 and 15%.

The university hospitals are largely responsible for the education of future obstetricians and thus of their obstetric practices. A good indicator of these practices is the percentage of CS in low risk pregnancies. We therefore examined cesarean rates in primipara in all of level 3 maternities in university hospitals in 2010.

This is a retrospective descriptive study concerning the year 2010 and included 37 centers. The primary endpoint was the rate of caesarean section in singleton pregnancies, primiparous women at term.

Although 80% of university hospitals in 2010 had a cesarean rates in primiparas between 15 and 25%, our study shows a wide disparity in the extreme values and results above the level recommended by the WHO. This average rate of 20% in a population considered low risk suggests an increase in the cesarean rate in the future if no corrective action is taken. It is the responsibility of university hospitals to optimize obstetric training of interns who will be the obstetricians of tomorrow.
Measuring preventable adverse events is important for health providers but also for consumers and payers of health care. The National Perinatal Information System has developed the Adverse Obstetric Index (AOI), a composite of 10 maternal and newborn adverse events that can expose an obstetric team to malpractice liability.

Retrospective review of medical records contained in the Hospital Universitari General de Catalunya from 2014 to 2016. The AOI was calculated as the number of adverse events divided by total number of deliveries. We also calculated a Weighted Adverse Score System (WAOS) – the total weights of all the adverse events divided by the total number of deliveries-, and a Severity Index (SI) - the total weights of all the adverse events divided by the number of deliveries with an adverse event. Coefficient of variation (CV) of each event was also calculated in order to detect abnormal fluctuations that could affect the scores.

Although results in our cohort were biased by improvements in data recording in the last year, the AOI demonstrated to be a feasible tool to measure adverse events. Attention should be paid on variability of some of the events. We think all Obstetric Units in Europe should monitorize adverse perinatal events in a standardized way as the AOI system.
Maternal obesity before pregnancy is usually associated with an increase in pathologies during pregnancy and maternal-fetal morbidities at childbirth. Our objective was to study the relationship between the maternal BMI on the day of delivery and the mode of delivery.

This is a mono-centric descriptive retrospective study including during 5 years all patients with a term singleton fetuses in cephalic presentation.

The increase in maternal BMI on day of delivery clearly shows an increase in the rate of caesarean and a worsening of the materno-fetal prognosis.
The aim of this study is to determine the effectiveness of using iv drotaverine versus rectal N-butylscopolammonium bromide in reducing the first stage of labor in primigravida women.

The study was carried on 112 primigravida women admitted in our ward for spontaneous labor during 2016. The inclusion criteria were: primigravida, spontaneous labor, regular contractions and no more than 3 cm dilatation on admission, no type of analgesia during labor. The patients were administrated either iv drotaverine – 40mg, either 20mg of N-butylscopolammonium – rectal administration. We measured the duration of first stage of labor and the outcomes of delivery.

Both substances are effective in reducing the first stage of labor and their use has no apparent association with adverse maternal or neonatal outcome.
Maternal training in water is an alternative to the traditional maternal education courses. The exercises in the water prepares the future mothers for the childbirth.

Water is a medium that offers a multitude of possibilities to work, even a more playful way of working.

We invite couples to attend the course as of the 5th month of pregnancy, this information is given in the consultation during pregnancy control.

The course is 1 hour in the water and another hour out of water for giving theoretical information.

Within the water you work:

Heating
Work of lower limbs
Back work
Respiratory work
Upper extremity work
Pelvic work and gynecological position
Puts
Relaxation

Throughout our professional practice and for 20 years we have introduced the preparation for childbirth in the water.

Pregnant women value it as a different and attractive way to prepare for childbirth.
Streptococcus agalactiae (GBS) colonization can lead to perinatal infection if prevention measures are not implemented. Although controversy may exist, different protocols have been developed in European countries.

This study aims to compare the vaginal-rectal culture results in the third trimester of pregnancy with culture results repeated the birth day. Objectives: GBS prevalence; microbiological agreement and changes; in positive cultures the antibiotic profile susceptibilities.

Study design: Observational, cross-sectional, ambispective.

Participants: A total pregnant women in labour assisted in the delivery ward at Germans Trias i Pujol University Hospital were included and meet the inclusion criteria assuming IC95% and 5% precision.

Data collection: data for the first culture were retrospectively at the 35-37 week of pregnancy regarding clinicla history. At thomont of the delivery the second vagino-rectal swab taken at submit to the microbiology departament once the written consent has been signed.

Sociodemographic and clinical data have been analyzed. Statistical analyse of descriptive and inferential data has been done using IBM SPSS v.20 for windows.

The analyze of 49% of participants needed to complete the sample, doesn’t bring enough information to find significant differences in the results shown.

Changes in cultures outcomes indicate excess or defect of treatment to the mother-child binomial. To have cultures closer or to have the data delivery or to have high risk pregnant profile will optimeze clinical decisions. This will reduce antibiotic consume and reduce the number of resistains, side effects and incidence of neonatal sepsis.
Betamethasone is widely used to enhance fetal lung maturation in case of threatening preterm labour. Especially in these cases, it is important to have reliable information concerning the fetal condition. Fetal heart rate variability is a promising marker for fetal distress, and spectral analysis can quantify the modulation of the autonomic nervous system. High frequency power is parasympathetically mediated, while low frequency power is both sympathetically and parasympathetically mediated.

We performed a prospective cohort study in a tertiary care teaching hospital, approved by the Ethical Committee. Patients with a gestational age from 24 weeks onwards who required antenatal betamethasone were included. Exclusion criteria were maternal age <18 years, fetal congenital malformation and fetal growth restriction. We performed daily non-invasive fetal electrocardiogram measurements, from hospitalisation until delivery, discharge or day 5. Recordings were analysed offline, and spectral analysis was performed on extracted fetal heart rates using a continuous wavelet transform. Measurements during day 1, 2 and 3 were compared to a reference measurement, which was calculated as the median of days 0, 4 and/or 5.

It seems that following betamethasone administration, fetal movements and fetal heart rate variability decrease. Furthermore, it seems that this decrease is caused by less sympathetic modulation of the autonomic nervous system. Spectral analysis of fetal heart rate variability can give us a better insight regarding the physiological mechanisms behind these observed changes.
Point-of-Care Testing of fetal scalp blood lactate is used as an alternative for pH analysis in fetal scalp blood sampling (FBS) during labor. Lactate measurements are not standardized and values vary with each device used. The aim of this study was to evaluate StatStrip Lactate (SSL) in the clinical setting in comparison to lactate (RLL) and pH (RLpH) by RapidLab.

We obtained 323 FBS samples from 139 women. Parallel sampling of SSL and RLL/RLpH was performed in 247 samples. Outcome measures were the agreement and discrepancy rates between SSL, RLL and RLpH and the failure rate of all three methods. We constructed a Bland-Altman graph to assess the variability between the measurements across the range of values. The discrepancy rates between methods were compared using previously established cut-off values for SSL indicating reassurance (7.0 mmol/L) to those for RLpH (7.25).

SSL is a reliable test to measure lactate in FBS at a low failure rate. As there are discrepancies between SSL and RLpH and the cut-off values have not yet been evaluated prospectively regarding intervention rates and neonatal outcome, we recommend using SSL in addition to pH in FBS. A clinical guideline is provided.
The assistance of labour implies detecting women who present a rigid cervix in the first stage of labour. The administration of Buscopan in the first stage of labour is an extended practice which aims to ease the labour process as well as to ease slow dilatations in which a rigid cervix has previously been detected. This review aims to highlight the evidence about cervix rigidity and the administration of Buscopan in first stage of labour as a dilatation easer.

A systematic and standardized review has been done through the following databases: BDIE (Spanish nursing research database), BVS (Spanish health virtual library), Iberoamerican Cochrane, Cochrane Library, Biomed Central, Trip Database, Pubmed. Articles have been chosen following scientific criteria as well as for specific references to the issues: presence of cervix rigidity and dilatation process during labour; use of the spasmolytic action of Buscopan related to labour. The search has been limited to the period 2005-2016. Key words were obtained from MeSH with the following descriptors: cervix, rigid/rigidity, labor stage first, buscopan, labor. 83 articles were found and only 14 were strictly related to the analysed issues.

Administration of Buscopan as a dilatation easer is controverted. Although no complications have been reported, side effects on the mother (taquicardia) can appear and, as the most of the medications, it crosses the placenta barrier. The reviewed articles use the initial hypothesis that spasmolytics could ease or shorten the dilatation process and that this fact benefits the most of pregnant women in labour but, possibly it could be limited to those cases with a real potential benefit.
Endometriosis is a chronic and dynamic disease with evolution periods versus latent periods. Affected women may suffer a wide range of symptoms. Its prevalence varies from 5% to 20% in women who suffer from chronic pelvic pain and from 20% to 40% in women who suffer infertility. This case report aims to follow the disease evolution studying a clinical case, to highlight endometriosis implications on affected women’s quality of life and to list strategies to front the disease efficiently.

CLINICAL EVOLUTION:


- March 2012: normal transvaginal ecography


- December 2013: Adenomiosis signs. Estenosis recto-sigmoidea


- 2015: Hysterectomy.

Endometriosis symptomatology highly affects the quality of life of women who suffer it. Infertility and pain during sexual intercourses are common but also daily activities result affected by continued pain and tireness. It is an emotional challenge for women and their partners to cope with it. Midwives can collaborate and learn about it in order to be able to detect the first signs, understand the disease evolution and the stadium in which a certain woman is when assisting her.
We set out to explore and quantify perceptions and experiences of women with a traumatic childbirth experience, in order to identify areas for prevention and to help obstetricians and midwives improve woman centered care.

A retrospective survey was conducted online among 2192 women with a self-reported traumatic childbirth experience. Women were recruited in March 2016 through social media, including specific parent support groups. They filled out a 35-item questionnaire of which the most important items were (1) self-reported attributions of the trauma, and how they believe the traumatic experience could have been reduced or prevented by better communication and support by their caregiver, or if they themselves had asked for or refused interventions.

Women attribute their traumatic childbirth experience primarily to lack and/or loss of control, issues of communication and practical/emotional support. They believe that in many cases their trauma could have been reduced or prevented by better communication and support by their caregiver, or if they themselves had asked for or refused interventions.
Home births in high risk pregnancies and unassisted childbirth seem to be increasing in the Netherlands. Until now there were no qualitative data on women’s motivations for these choices in the Dutch maternity care system where integrated midwifery care and home birth are regular options in low risk pregnancies.

An exploratory qualitative research design with a constructivist approach and a grounded theory method were used. In-depth interviews were performed with twenty-eight women on their motivations for going against medical advice in choosing a high risk childbirth setting. Open, axial and selective coding of the interview data was done in order to generate themes. A focus group was held for a member check of the findings.

The goal of counselling should not be to bring as many women as possible within the framework of protocols, but to prevent negative choices.

Recommendations for maternity caregivers can be summarized as: 1) Rethink risk discourse, 2) Respect a woman’s trust in the birth process and her autonomous choice, 3) Have a flexible approach to negotiating the birth plan, 4) Be aware of alternative delivery care providers and other sources of information, and 5) Provide obstetric care without fear.
Most women experience childbirth without any complications, but maternal satisfaction during that moment is not always achieved. Many studies to measure women’s satisfaction were validated in various languages, but not in Brazilian Portuguese. To do so, the Mackey Childbirth Satisfaction Rating Scale (MCSRS) Questionnaire was translated and the agreement between judges was examined. The aim was to perform the cross-cultural adaptation and face validity of MCSRS to Brazilian Portuguese.

The MCSRS was first translated to Brazilian Portuguese by a bilingual obstetrician living in the United States. This version was back-translated by a native English speaker and then compared to the original instrument. Afterwards, ten professionals (four professors of Obstetrics, one Obstetrician Doctor, four Midwifery Professors and one Psychologist Professor) were invited to assess the final version of the questionnaire in the following criteria: clarity, semantic equivalence, pertinence and relevance of the statements. All judges had experience in providing care for pregnant women. The frequency of concordance was calculated by Ubersax’s method and a multilevel analysis was performed using the lme4 package.

The judges have agreed that the items of the final translated version of MCSRS provide the assessed criteria and the negative correlation is considerably low. They are likely to agree that the items are pertinent and relevant, but slightly less consonant in agreeing on clarity. The final Brazilian Portuguese version of the MCSRS showed face validity and the instrument appears to be able to measure the outcome properly.
Scientific literature describes that is necessary to optimize vitamin D levels in the gestation period because its deficiency is related to clinical complications that may affect both mother and newborn and even effect the future life of women. It's important to know the risk factors to provide prevention or early treatment, which is a subject of controversy. In order to know the scientific evidence about the importance of vitamin D we proposed this bibliographic revision.

Articles inclusion criteria: originals, clinical practice, magazine, meta-analyses, guidelines with an available abstract in Spanish/English; referred to pregnant women; that described the function, relevance, sources, factors related to a deficit of vitamin D; that analyse complications and efficiency of the administration of supplements, published in the last 6 years. Pubmed ≥19 years added, availability in the library of inquiry. 188 items were identified and 14 were selected for review.

It is mandatory to identify pregnant women in risk of suffering a deficit of vitamin D, in order to include blood determinations of vitamin D along their pregnancy. Once the deficit has been detected, it is necessary to implement a vitamin D supply and to make an accurate following of the case in order to prevent obstetric complications in neither the actual pregnancy nor the future ones. Even in sunny countries like Spain.
Group B Streptococcus (GBS) causes major neonatal morbidity and mortality. Antenatal GBS culture is increasingly replaced by intrapartum GBS-PCR. However, PCR-based intrapartum screening is more expensive and may delay the commencement of antibiotic prophylaxis. We analysed the accuracy of antenatal enriched GBS culture in predicting intrapartum GBS colonization. We also evaluated whether the accuracy of antenatal testing is affected by the time interval between sampling and labour.

This was a prospective multicenter study comparing antenatal enriched GBS culture (AC) and intrapartum PCR (I-PCR) and culture (IC) during 5/2015 – 4/2016. Altogether 2624 women with singleton pregnancies planning a vaginal birth were recruited in the study. A vaginal-rectal GBS culture was taken antenatally at pregnancy week 35+0-37+6 and both GBS culture and GBS-PCR intrapartum. For GBS culture, a house-made selective plate (10% sheep blood agar supplemented with Oxoid SR 0126, containing colistin sulphate and oxolinic acid) was used followed by an enrichment Todd-Hewitt broth with selective supplement. Cepheid GeneXpert system XVI was used for GBS PCR.

The sensitivity of enriched antenatal culture is comparable to that of intrapartum PCR, at least when antenatal culture is performed ≤35 days before labour. Considering the high cost and possible invalid results of PCR testing, more studies on the cost-effectiveness and effect of PCR-screening on newborn morbidity and mortality are needed before comprehensive universal antenatal GBS enrichment culture can be replaced with intrapartum PCR.
Postpartum Hemorrhage (PPH) is a leading cause of major maternal morbidity. In this study we try to identify risk factors for this pathology in our population.

Retrospective case-control study of 4343 deliveries recorded in the Hospital Universitari General de Catalunya (HUGC) database during years 2015-16. Individual association with PPH was analyzed for: age >40 years, race, obesity, parity, previous cesarean section, multiple pregnancy, macrosomy (fetal weight>4000gr), risk gestation and postdate pregnancy. A multivariate analysis was carried out for variables selected in the first step. R software (R core Team, Vienna 2016) was used for statistical analysis. A critical p value inferior to 5% was set for significance.

Although maternal obesity usually has a negative impact in perinatal outcomes, in our sample it seemed to have a protective effect. Forceps delivery was related with higher rates of PPH. No significant association with PPH was observed with other variables such as previous cesarean section, fetal weight, postdate pregnancy or maternal age.
Maternal pyrexia is a common complication of labour. It can be caused by a wide range of conditions and can lead to a variety of maternal and neonatal sequel. Although maternal infection, mainly chorioamnionitis is recognized as the foremost cause, current evidence suggests that some if not most fever in labor are due to non-infective etiology. Among non-infective causes, epidural analgesia is most widely recognized and associated with a four- to five-fold increased risk for pyrexia.

This study was conducted at Cork University Maternity Hospital. Medical records of mothers that entered active labour (spontaneous or induced) that developed a systemic fever of greater than 38 degrees Celsius on one occasion or 37.5 degrees Celsius on two consecutive occasions 30 minutes apart during the time period of September 2016 to November 2016 were retrospectively reviewed. The presence or absence of the following factors were recorded in each case: parity, induction of labour, prolonged rupture of membranes, epidural analgesia, oxytocin administration, maternal tachycardia or other signs of maternal sepsis, CTG abnormalities, mode of delivery, results of microbiological investigations and neonatal admission to the neonatal unit.

Maternal pyrexia is strongly associated with iatrogenic intervention and leads to significant intervention to treat including operative delivery with all the associated complications. During the study period, the majority of patients who developed pyrexia in labour had no additional clinical signs of infection and did not meet the current diagnostic criteria for sepsis. Bacteremia wasn’t identified in any of the cases, while bacterial colonization was identified in only 22% of cases.
Pregnancy is a developmental period for women. Emergence stress during pregnancy is thought to be caused by psychosocial stress factors. It has also been determined that stress perceived during pregnancy is associated with depression and anxiety. Stress experienced during pregnancy is thought to adversely affect the self-care agency of the pregnant.

Aim: this cross-sectional study was aimed at evaluating the effects of developmental perceived stress during pregnancy on their self-care agency.

The data was collected from the pregnant women who presented to the policlinic of three city hospitals in the western region of Turkey. The sample comprised 1022 women. Data were collected using the Pregnant Information Form, Perceived Stress Scale and Exercise of Self Care Agency Scale.

For the analysis of the data, the SPSS statistical program, numbers, percentage distributions, mean values, chi-square and correlation tests were used. The independent and dependent variables of the study were the perceived stress level and the self-care agency of the pregnant women. To conduct the study, approvals were obtained from the hospitals and pregnant women participating in the study.

The study demonstrated that the developmental stress perceived by the pregnant women affected their self-care power and that the self-care power decreased as the stress increased.
Liver diseases in pregnancy are very diverse. Some of these problems are specifically associated to the gestational state, whereas others may reflect a preexisting condition that has been exacerbated by pregnancy.

The most common cause of jaundice in pregnancy is viral hepatitis. Beside this, other causes have to be take into consideration such as intrahepatic cholestasis of pregnancy, cholecystitis, pancreatitis, acute fatty liver of pregnancy, preeclampsia.

We report a case of a 36 years old woman, I G I P, addressed to our department with a 39 weeks pregnancy, live fetus in cranial presentation, uterine contractions at 6 minutes and spontaneous amniotic membrane rupture.

The patient had a poor social condition and her pregnancy was not monitored. Her last and only routine blood samples were obtained at 23 weeks of gestation. She was not aware about any medical history.

The general examination revealed only scleral and skin jaundice. She was in labor with a cervical dilatation of 3 cm, spontaneous rupture of the membranes with yellow-green amniotic fluid. The fetal heart rate was within normal values.

Emergency blood samples revealed only alterations of the liver function: total bilirubin 5.66 mg/dL, conjugated bilirubin 3.87 mg/dL, slightly elevated ALAT and ASAT enzymes, alkaline phosphatase 288 U/L and cholesterol 235 mg/dL. The viral markers for hepatitis B and C were negative.

CTG was normal. Ultrasound scan revealed a live fetus with biometry appropriate for 39 weeks of gestation. Doppler study of the umbilical artery was normal.

Despite no obvious sign of fetal distress at the moment of admission and not knowing exactly the liver disease and fetal condition due to this, we decided to extract the fetus by C-section. It was extracted a live female fetus of 3500 grams, Apgar score 8 with a good adaptation. Postpartum condition of the patient was good with lowering the total bilirubin levels to 3.6 mg/dL at discharge.

Poor socio-economic status and lack of pregnancy follow-up are the main factors that explain the difficulty of diagnosis and decision taking at the moment of admittance. Moreover, jaundice in pregnancy could reveal a very serious condition both for the mother and for the fetus. Further investigations needs to be done in order to diagnose the liver disease.

In these circumstances precaution is very important for pregnancy and birth management.
It was aimed to ensure prospective mothers to access safe, the quality and quantity of health services through mother-friendly practices. Assessment of satisfaction, detection of deficiencies in the field can be guiding for the elimination of these. The most important factor affecting the satisfaction patients are satisfaction with midwifery/nursing. This study was aimed at investigating the birth process-related satisfaction of women who gave birth in a mother-friendly hospital.

The study is an analytical, cross-sectional study. Data were collected retrospectively from the mothers who gave birth vaginally (n = 101) between March 01, 2016 and July 15, 2016 through telephone interviews. To collect the data, a questionnaire developed by the researchers and the Scale for Measuring Maternal Satisfaction at Birth were used. The scale is a five-point Likert-type scale designed to assess maternal satisfaction at birth. To analyze data, the SPSS numbers, percentages, mean scores, one way variance analysis (ANOVA) and correlations were used.

To conduct the study, approvals were obtained from the relevant institutions and the pregnant women participating in the survey.

The mother-friendly model focuses on the provision of single rooms to protect their privacy. The mother-friendly model aim to encourage normal vaginal birth and to reduce intervention rates. The mothers stated that they were satisfied with the practice in the Mother-friendly Hospitals and in the care they received from the midwives during birth.
Labor and delivery of nulliparous women are often longer and more difficult compared with those of multiparous women. But there are few reports on the subsequent labor and delivery of the women whose first labor was long and difficult. Therefore, we examined whether long and difficult labor repeats again or not.

Our clinic is a private OB/GYN one, where mainly low risk pregnancy/delivery is accepted. Vacuum extraction is used when appropriate, but forceps delivery is not done in our clinic. Women who delivered vaginally their first and second babies in our clinic from January 2004 to December 2016 were retrospectively examined. Enrolled criteria were 37 weeks gestation or more, cephalic presentation, and singleton. Patients who experienced breech presentation, cesarean delivery, fetal demise before onset of labor were excluded.

Long and difficult labor repeats infrequently. This may encourage women who have anxiety about next pregnancy and childbirth because of their long and difficult first labor.
While the association between high body mass index (BMI) and adverse fetal and infant outcomes is well known; the association with severe maternal morbidity is understudied. We carried out a study examining the effect of maternal BMI on severe maternal morbidity during delivery hospitalization.

All singleton hospital births in Washington State, USA, 2004-2013, were included (N=743,630). BMI (kg/m2) categories were: underweight (<18.5), normal (18.5-24.9), overweight (25.0-29.9), obese level I (30.0-34.9), level II (35.0-39.9), and level III (≥40). A composite outcome of maternal death/severe morbidity (SMM) included conditions based on high case-fatality (eg, sepsis), organ damage (eg, acute renal failure), and serious sequelae (eg, hysterectomy). Demographic data and SMM diagnoses (ICD-9) were obtained from linked birth certificate and delivery hospitalization files. Logistic regression was used to obtain adjusted odds ratios (AOR) and 95% confidence intervals (CI); adjusted for parity, maternal age, assisted conception, etc.

Severe maternal morbidity is elevated among underweight women and increases gradually for women with BMI above normal. Underweight women have higher risk of antepartum hemorrhage with transfusion, while women with increased BMI have elevated risk of other severe morbidity. Risk of acute renal failure is more than 2-fold in both, underweight and overweight women; and increases further to a 4-fold risk among the most obese women.
Breastfeeding is a nutritional method that has positive effects in terms of protecting and improving baby's health, providing adequate and balanced nutrition, ensuring social-psychological development, strengthening the bonding process. In order to determine level of anxiety related to the breastfeeding process of puerperal women who were admitted to the newborn unit for treatment due to a medical indication and who did not breastfeed their baby for the first 24 hours after birth.

A descriptive design was used in this research. Between August and December 2015, the size of the minimal sample was determined according to the universe specific sample formula, and the sample was randomly sampled at 164 puerperant. Data were collected using the Personal Information Form and the Hamilton Anxiety Scale. The questionnaire took approximately 15–20 min to complete. Written permissions were obtained from the Scientific Ethics Committee of Malatya. The variance analysis, Independent t test and Kruskal-Wallis was used for data.

It is recommended that health professionals who working in the presentation of pregnancy and delivery health care services should to assume an active role in support mothers, determine anxiety levels related to the breastfeeding process and ensuring that the breastfeeding process continues in a healthy manner. It is extremely important that physically and emotionally supporting puerperants, who especially can not breastfeed to baby, in breastfeeding process.
Induction of labour accounts for up to 25% of all births in developed countries and rates are slowly rising. However, the current body of evidence is largely medical and takes little account of women’s feelings and experiences. This qualitative study set out to investigate induction from the woman’s perspective. This presentation will demonstrate how conceptualising induction as a state of liminality may offer a new way of understanding induction, leading to improved care for women.

A qualitative study with full ethical approval was undertaken using a purposive sample of primiparous women recruited from a maternity unit in the south of England. All participants were low-risk at the start of pregnancy and had been induced at or close to term, mostly for uncomplicated, post-dates pregnancy. 21 consenting participants were interviewed in their homes or by telephone at 3-6 weeks postnatally, followed by a hand-search of maternity records to contextualise women’s accounts. Interview data were audio recorded, anonymously transcribed and thematically analysed by the investigator. Key themes relating to the in-patient experience were then interpreted using anthropological theories of rites of passage and liminality.

Conceptualising induction as a liminal state may enhance care providers’ understanding of women’s feelings and promote a more woman-centred approach to care. Thorough preparation for induction, including an explanation of likely delays is fundamental to enabling women to form realistic expectations. Care providers need to consider whether women undergoing induction are receiving adequate support, analgesia and comfort aids conducive to the promotion of normal labour and the reduction of stress.
Maternal obesity is one of the greatest challenges of labor care. External monitoring is compromised by the increased fatty layers, leading to suboptimal fetal and maternal surveillance. Electrohysterography (EHG) is an innovative technique which could enhance non-invasive uterine monitoring in obese parturients as the electrical currents are potentially less hampered by obesity. We want to evaluate the performance of a real-time EHG device in morbidly obese women.

During a two-hour measurement of first and/or second stage of term labor, uterine contractions of morbidly obese women were simultaneously monitored by EHG (Puretrace, Nemo Healthcare, Veldhoven, the Netherlands), external tocodynamometry (TOCO) and the intra-uterine pressure catheter (IUPC). We defined morbidity obesity as a body mass index (BMI) of >40 kg/m² during labor. Contraction detection was performed by a computer-based algorithm, with IUPC as reference and sensitivity as main outcome. Furthermore, group comparisons of non-obese, obese and morbidly obese women were performed by using data from a larger study. Additionally, the abdominal circumference during labor was correlated to the sensitivity of both external methods.

Electrohysterography performs significantly better than external tocodynamometry in morbidly obese women.
TOPIC: Improving the organization of labour care

ABSTRACT ID: 092

TITLE: The Impact Of Childbirth Specific Stereogram Cards On The Perception Of Labour Pain

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Focusing underlies the seeing technique of the stereograms which were discovered by Charles Wheatstone in 1838. Given that focusing is essential in the seeing technique of stereograms, it is considered that childbirth specific stereogram cards could be effective in reducing the perception of labour pain. This is an empirical study which was planned as randomly controlled to determine the impact of stereogram cards specifically prepared for childbirth on the perception of labour pain.

Stereogram Creating Software: Numerous software can be used to obtain stereogram images. Stereogram Creator software is one of those.

Creating Childbirth Specific Stereogram Cards: For the three-dimensional images on the background of the stereogram cards, childbirth specific (pregnant and baby) silhouette images were prepared specifically.

The impact of childbirth specific stereogram cards on the perception of labour pain during the labour process is required to be tested using randomized empirical studies.
Standard practice, before May 2015, to induce labour, in Sligo University Hospital (SUH) Ireland, was to use Prostin (dinoprostone) gel. Due to a lack of availability of 1 mg of Prostin, the alternative Propess® (dinoprostone 10mg pessary) was sourced. A guideline for its use was adapted & put into practice.

Following the introduction of Propess® in SUH, an audit was undertaken to compare the two methods of induction, looking at time from induction start, length of labour and type of birth.

A retrospective analysis of all inductions of labour in Sligo, Ireland from March to October 2015 was undertaken comparing dinoprostone gel (Prostin) and dinoprostone slow release pessary (Propess®). Inclusion criteria: 37 weeks’ gestation; cephalic presentation; singleton pregnancy, requiring induction involving the administration of dinoprostone. Exclusion criteria: previous caesarean section; uterine scarring.

Data was collected on demographics, parity, gestation and clinical outcomes.

N/A

The study in SUH, suggests Propess® to be an effective method for all inductions. Its use has resulted in a high vaginal birth rate. The lower oxytocin augmentation use, reduced electronic fetal monitoring in labour and potential problems that arise from oxytocin use, has shown it to be a safe method of induction locally in Sligo, Ireland. As a result, Propess® is now the standard treatment to induce labour in Sligo, Ireland. This audit will be repeated in 2017 to compare 2015 findings.
Labour progress is assessed by digital vaginal examinations (VE), but they are subjective and can be incomplete. Intrapartum ultrasound is an emerging non-invasive method for assessing head descent, rotation and cervical dilatation. As it is an emerging technology, there is a need to ascertain its value.

Patient and public involvement (PPI) sessions were held to assess the acceptability of the technique; capturing the views of pregnant women, an online women’s voices panel and midwives.

We organised four voluntary patient focus groups for pregnant women following antenatal sessions booked at Imperial College Healthcare NHS Trust (breastfeeding, antenatal screening and physiotherapy classes) at between 8 and 37 weeks of pregnancy. One midwifery healthcare professional session was held. A short presentation on intrapartum and transperineal ultrasound was received before completing a questionnaire modified from a validated questionnaire (W-DEQ). Values were assessed using a Likert scale; 1 being most valuable and 6 not being valuable at all. An online session with presentation, patient information and survey was emailed to the Royal College Obstetricians Gynaecologists (RCOG) Women’s Voices Involvement Panel (WVIP).

This study represents the first reported investigation of public and professional opinion of intrapartum ultrasound, a technique that is becoming widespread in delivery units throughout Europe. Most pregnant women perceive value in the technique, as do a women’s representative panel. Midwives were less positive, over half being neutral or negative to the technique. There remains some way to go in terms of education towards acceptance of ultrasound for assessing the progress of labour.
Objective: To identify risk factors associated with serious maternal outcome following complete uterine ruptures.

Methods: We studied medical records of 250 complete uterine ruptures, identified through medical birth registry of Norway (MBRN) and patient administration system (PAS), in all maternities (1967-2008) (N=2209506). Cross tabulations and logistic regressions were applied.

Conclusion: Ruptures of unscarred uteri, manipulation at delivery, and postpartum detection of rupture after vaginal delivery significantly increased serious maternal outcome, indicating delayed diagnosis, and catastrophic rupture site in these mothers.
Maternal satisfaction during childbirth is not always achieved, because many factors may influence this moment. Therefore, knowledge of women’s experience at birth is relevant to health care providers and can be an indicator of quality of maternity care. The aim of this study was to describe the factorial structure and to examine the psychometric properties of the Brazilian Portuguese version of the Mackey Childbirth Satisfaction Rating Scale (MCSRS) questionnaire.

This study was carried out in a low risk public maternity hospital with 53 postpartum women. The inclusion criteria were: postpartum period, maternal age from 18 to 40 years; term live birth and full comprehension of questionnaire. The final cross-cultural adaptation of a Brazilian Portuguese version of the MCSRS with 34 items was applied. The scale structure was obtained by performing an exploratory factorial analysis (EFA) using the fa routine and estimate of maximum likelihood and oblique rotation. To determine the dimensionality of the questionnaire, we used the chi square test based on likelihood ratio. The reliability was examined by analyzing the internal consistency of the subscales using Cronbach’s alpha and MacDonald’s omega.

The two scales showed good internal consistency and a high communality for the majority of items was found. These findings suggest that responses to the Brazilian Portuguese version of MCSRS are valid and reliable. Thus, this translation of the questionnaire can be used as an efficient tool for maternal satisfaction evaluation during childbirth.
A good experience during childbirth is important for a woman’s well-being, as well as for her planning of future pregnancies. Maternity care providers should make every effort to assure not only a satisfying birth experience for the mother, but also safety for both the mother and the baby. Maternal opinion about the care received is essential for the planning of health care actions. The aim of this study was to describe women’s experience and obstetric interventions during labor and delivery.

This study carried out at a low-risk public maternity hospital in São Paulo, Brazil. The inclusion criteria were: women aged 18-40 years who had just had a singleton live birth after a term gestation. They were asked to answer a questionnaire including sociodemographic questions and obstetric data was collected from birth records. The Brazilian Portuguese version of Mackey Childbirth Satisfaction Rating Scale (MCSRS) questionnaire was applied and two questions regarding overall maternal opinion were studied. A written informed consent for participation in the study was obtained from all participants. The study was approved by the local Human Research Ethics Committee.

The vast majority of women interviewed had a positive experience during childbirth and were satisfied with the care they were provided. A supportive health care team should be well aware about the various strategies available for intrapartum care. Careful assessment of each woman during labor and delivery is importantly related to maternal satisfaction, so assisting her wishes is essential to promote a positive experience overall.
Satisfaction with childbirth is an important health outcome, which all pregnant women should achieve, and can be an indicator of quality of maternity care. Many studies have examined this complex phenomenon comprising multiple dimensions and components. The aim of this study was to assess women’s satisfaction with childbirth at a low-risk public maternity hospital and to determine associations with selected variables.

This study was carried out at a low-risk public maternity hospital in São Paulo, Brazil. The inclusion criteria were: women aged 18-40 years who had just had a singleton live birth after a term gestation. Women were invited to answer the validated Brazilian Portuguese version of Mackey Childbirth Satisfaction Rating Scale (MCSRS) questionnaire with 34 items (5 subscales: self 11 items; partner 2 items; baby 3 items; nurse 8 items; physician 8 items; overall 2 items). The level of satisfaction with each item was scored on a Likert scale with 5 points. A total score was calculated (sum of the scores for each individual question, maximum=170). The study was approved by the local Human Research Ethics Committee.

These findings suggest that women’s childbirth satisfaction can be influenced by breastfeeding in the delivery room. It can also demonstrate the importance of providing a safe and comfortable environment, so that mother and baby are not separated immediately and are able to strengthen their bond right after birth.
Women’s satisfaction with childbirth depends mostly on expectation and perception of control. Improvement of their care is of utmost importance because the quality of the experience relates significantly to adjustment to postpartum period and bond between mother and child. Most studies assess adult women but only a few relate to adolescents’ satisfaction during labour and delivery. The aim of this study was to assess adolescents’ satisfaction with childbirth and compare it with adult women’s.

This study took place at a low-risk maternity hospital in São Paulo, Brazil. The inclusion criteria were: postpartum period, age from 14 years to 19 years; term live birth and full comprehension of questionnaire. Control group had the same inclusion criteria, except for the age range (20 to 35 years). Each participant was invited to answer a questionnaire (modified version of the Mackey Childbirth Satisfaction Rating Scale) with 18 items measuring childbirth satisfaction (5 subscales: self, 5 items; partner, 1 item; baby, 3 items; physician, 7 items; overall, 2 items). Each item was to be rated on a Likert scale with 5 points. A total score was calculated (sum of the scores for each individual question, maximum=90).

Adolescents were statistically less satisfied with their childbirth in general. Specifically regarding topics such as their baby and the care provided by doctors, they also had less satisfaction when compared to the control group. This shows that different strategies need to be developed for this specific group of women, especially regarding medical care and provision of support to adolescent mothers to be with their babies so that they experience a more positive childbirth.
Objective: To identify risk factors associated with serious perinatal outcome following complete uterine ruptures.

Methods: We studied medical records of 256 births with complete uterine ruptures after start of labour, identified through Medical Birth Registry of Norway and Patient Administration System, in all births (1967-2008) (N= 2,236,959). Cross tabulations and logistic regressions were applied.

Placental abruption, and infant expulsion into abdominal cavity increased the risk for perinatal deaths following ruptures while postpartum diagnosis of rupture after vaginal delivery is more associated with infant morbidity.
Improvement of care for women during childbirth has been studied, but less attention is paid to adolescents. High rates of teen pregnancy have been reported worldwide and their perception of childbirth is different when compared to adult women. Therefore it is relevant to describe differences among adolescent and adult women and in the care provided for them during labor and birth. The aim of this study was to compare intrapartum care and childbirth aspects between adolescents and adult women.

This study took place at a low-risk public maternity hospital in São Paulo, Brazil. The inclusion criteria were: women aged 14-19 years and 20-35 years (control group) who had just had a singleton live birth after a term gestation. They were asked to answer a questionnaire including sociodemographic questions and obstetric data was collected from birth records. A written informed consent for participation in the study was obtained from all participants or from their legal responsible person. The study was approved by the local Human Research Ethics Committee.

The intrapartum care provided for adolescents and adults was similar in the population studied. A supportive health care team should be well aware about the various strategies available for intrapartum care. It is essential for health care providers to offer appropriate care for all women during labor and childbirth, regardless of their age.
Expectation and perception of control are relevant aspects for women’s satisfaction with childbirth. Most studies assess adult women, but only a few relate to adolescents’ satisfaction during labor and delivery itself, in spite of their confirmed different perception of birth, when compared to adults. Therefore it is important to analyze the differences in these groups concerning those topics.

This study took place at a low-risk maternity hospital. The inclusion criteria were: postpartum period, maternal age from 14 to 19 years; term live birth and full comprehension of questionnaire. Control group had the same inclusion criteria, except for the age range (20 to 35 y). Each participant was invited to answer a questionnaire (a modified version of the Mackey Childbirth Satisfaction Rating Scale) with 18 items and, in the end, two other questions regarding expectation and qualitative evaluation of the experience. Each item was to be scored from 1 to 4. A written informed consent was obtained from all participants or from their legal responsible person. The study was approved by the local Human Research Ethics Committee.

The majority of adolescents had very different expectations for their childbirth, even though they found it a positive experience in the end. Efforts need to be put in improving knowledge about the perception of pregnancy and childbirth itself for this specific group of young women, so that they are not so surprised when this important moment comes.
Transperineal ultrasound is increasingly used to assess labour progress. However, a comprehensive assessment of its acceptability has not yet been conducted. We aimed to compare the acceptability of vaginal examination (VE) with intrapartum ultrasound (USS) techniques (transabdominal (TA) and transperineal (TP)) prior to delivery.

119 women 24-42 weeks’ gestation were included in a prospective observational study April 2015-July 2016. The acceptability of digital VE and transperineal ultrasound were assessed pre and post examination using the modified Wijma-Delivery Experience Questionnaire, W-DEQ. Experience scores ranged from 6-36 (6 being most and 36 being least positive) in 6 domains: positive-trust and relax, negative-harmful to baby, worrying, painful, intrusive.

This is the first study to comprehensively assess the acceptability of VE and intrapartum USS. USS assessment prior to delivery is more acceptable than VE. RA ameliorated the negative experience of the VE post assessment but had no effect on the USS scores implying that without RA, USS is preferred. These findings also have implications for women in early labour or in conditions such as vaginismus or genital mutilation where VE is poorly tolerated.
Pregnancy requires antenatal care either for the mother and her baby from the initiation of pregnancy to delivery. The main aims of antenatal care are to identify chronic undiagnosed diseases of the mother and to determine health risks which would endanger the mother and her baby.

The present descriptive and cross-sectional study has been designed and carried out between January 2008 and April 2008 to evaluate the impact of antenatal care to the mode of delivery in women living in Beşiktaş, İstanbul. The study included 366 women who have had a cesarean section or vaginal delivery in Beşiktaş during the last year before the initiation of the study. Data were collected by using a questionnaire form, which was prepared with a survey of the literature including 33 questions and performed by a single investigator through personal interviews.

We believe that midwifes and nurses should be directed to inpatient and outpatient trainings and supervision and quality control and nursing staff should be directed more towards counseling and education for quality and quality services that will be given to pregnant women during prenatal period.
Vacuum-assisted operative vaginal delivery at midpelvic is allowed in most guidelines, but should be performed by trained obstetricians. On the contrary, when a vertex presentation is not engaged, trial of operative vaginal delivery should not be performed, keeping in mind that evaluation of engagement is not obvious. The main objective of a trial of vacuum extraction is then to correct dystocia due to vertex deflexion, facilitating vaginal delivery.

Trials of flexion performed at midpelvic were collected during a four years consecutive period retrospectively. Inclusion criteria were: singleton vertex presentation at full cervical dilatation from 34 to 42 weeks of gestation. Effectiveness of vacuum-assisted operative delivery has been estimated by comparison of the two possible issues of delivery (vaginal delivery / caesarean section). Fisher’s exact test was used to detect differences in categorical variables. Factors associated with failure were analysed using a logistic regression.

Operative flexion vacuum assisted vaginal delivery could be executed in peculiar situations and performed by confirmed obstetricians. They also should be aware of the potential consequences of this technique compared to delivery by caesarean section and that a trial of vaginal flexion doesn’t always mean vaginal delivery.
Obstetric anal sphincter injuries (OASI) strongly affect women’s health. Some risk factors are known but both predictive and preventive strategies remain disappointing. An association between peripheral ligamentous laxity and pelvic floor muscles has been reported during pregnancy. We hypothesize that peripheral ligamentous laxity at term could be an indicator for the risk of OASI. Our main endpoint was to assess whether peripheral ligamentous laxity at term is associated with OASI occurrence.

This study included women above 36 weeks of gestation. We assessed ligamentous laxity between the 36th week of pregnancy and the admission in the delivery room by measuring the passive extension of the non-dominant index finger after applying 0.26N.m to the second metacarpo-phalangeal joint (MCP laxity) with a specific extensometer. Perineal tears were reported using the classification of the Royal College of Obstetricians and Gynaecologists (RCOG) and OASI was defined by a stage 3 or more. After excluding women who had undergone cesarean section, we reported perineal tears prevalence and the characteristics of our population. We investigated the association between MCP laxity and OASI using a one-way ANOVA test then a Mann-Kendall test.

Increased MCP laxity seems associated with a higher risk of OASI. These results suggest that tissues with a greater elasticity could be less resistant to the perineal trauma during childbirth. Taking into account biomechanical characteristics of pregnant women in our risk prediction for OASI occurrence could lead to an individualized risk assessment including the intrinsic women’s characteristics. This would allow for personalized information of pregnant women about their risk of OASI.
Acupressure is the application of pressure to acupuncture points. It has been used to induce labour in cases of post-maturity. Post-maturity can increase the risk of stillbirth. The acupressure points used for induction of labour have a very strong effect on the energy of the uterus, causing uterine activity and promoting a downward expulsion of the foetus.

Research has shown that acupressure is a safe technique and enhances cervical ripening and might reduce the need for using pharmacological agents.

A 36-year-old primi gravida, with an uncomplicated pregnancy, booked for home birth. Hospital induction was booked for post-maturity at 41.5 weeks of gestation.

She was very motivated to avoid medical intervention. Three days before the medical induction was due, her Bishop score was ≤ 6. I suggested that she start acupressure to help establish contractions and promote cervical dilatation.

The couple were trained, and then practiced in my presence, using pressure on four specific acupuncture points unilaterally every 2 hours and four others twice a day. The location of the points was made easier by providing them with illustrations of the points. They were using the points correctly, and before leaving the house, I told them to call me when the contractions were more frequent.

I was called after two days, as she was having contractions. The Bishop score was greater than seven.

I started using acupressure points for pain relief and also used specific points to augment labour, as the contractions were irregular.

After one hour the contractions became more regular.

On vaginal examination, the findings were that the cervix was effaced, anterior, and the os 6 cm dilated. The membranes were still intact. Cephalic presentation was confirmed, with station at the Ischia spines.

We prepared the pool, as she wanted a water birth. After 4 hours, the cervix was fully dilated, and she had a Spontaneous vertex delivery after one hour, of a male infant, born in good condition.

The woman and her partner were very satisfied with their birth experience, especially as they could have the home birth they wanted. They avoided being admitted to the hospital for a medical induction of labour.

Considering the positive effect of acupressure for cervical ripening, it can be concluded that acupressure seems to facilitate a less medicalised childbirth, preventing potential problems which may occur when using pharmacological agents for induction.
High rates of anxiety symptoms have been reported among pregnant women. During pregnancy, intense psychological, physiological, and physical changes occur in women and this fact reflects directly on maternal mental health. Some studies have attempted to understand the reflection of maternal anxiety symptoms on maternal and fetal circulation. The aim was to analyze the effects of maternal anxiety on maternal and fetal circulation assessed by Doppler velocimetry.

The inclusion criteria were a healthy woman; a singleton pregnancy; maternal age 18 to 40 years; gestational age between 34 and 40 weeks; low risk pregnancy; an understanding of the research method and an agreement to participate in the study. Each pregnant woman was evaluated by ultrasound for fetal biometry, amniotic fluid index and Doppler studies: uterine arteries (UtA), fetal middle cerebral artery (MCA), umbilical artery (UA) and umbilical vein (UV). Subsequently, the women were asked to answer the Beck Anxiety Inventory (BAI) questionnaire presenting 21 self-reported items and validated for the Brazilian population. Each item, rated from 0 to 3, describes a common symptom of anxiety and the sum represents the total score (0-63).

Maternal anxiety seems to have no effects on maternal or fetal circulation in low-risk pregnancies. However, this study involved few cases with moderate and no cases of high levels of maternal anxiety, which may be the main limiting issue in the results. Further studies are needed to better investigate the effects of anxiety on maternal and fetal hemodynamics during pregnancy.
The aim of the study was evaluation of success rate and the safety of external cephalic version after 36 weeks of gestation. The evaluation of the subjective feelings of mothers who have undergone external cephalic version.

A retrospective analysis of external cephalic version attempts performed on a group of 638 singleton breech pregnancies after 36 weeks gestation in the years 2003 – 2016 at the Department of Gynecology and Obstetrics, Masaryk University, Brno, the Czech Republic. The effectiveness, number and type of complications, mode of delivery and perinatal result were observed. Prospectively we evaluated answers from questionnaire completed by patients after completion of external cephalic version in the years 2015 - 2016.

External cephalic version is a safe procedure. External cephalic version reduce the rate of noncephalic presentations at term and thus the number of cesarean deliveries for breech presentation at term. The vast majority of women assesses external cephalic version positively.
Prolonged labour is an important cause of maternal and perinatal morbidity and mortality. Identifying the precise cause of slow labour progress can be challenging. As a result failure to progress has become a leading indication for Caesarean Section and has had a major impact on the escalating Caesarean birth rate in the United Kingdom. Robust evidence as to how best care for such women is lacking and is now a research priority for the Royal College of Obstetricians and Gynaecologists.

An audit proforma was designed based on diagnostic criteria for failure to progress in accordance with the National Institute of Clinical Excellence (NICE). Data was collected prospectively between October 1st 2016 and November the 30th 2016 following identification of suitability by staff on labour ward. Inclusion criteria included a singleton pregnancy with a cervical dilatation of greater than 4cm when delay in labour was diagnosed. Both nulliparous and multiparous patients were included. Lack of acceptable progress was treated with intravenous Syntocinon, a synthetic version of the hormone Oxytocin. A uniform concentration of 10 international units in 49 millilitres of Normal Saline was used in all circumstances.

Overall the management of failure to progress in this unit could be improved with more strict adherence to national guidance. The majority of mothers who deliver at term have no complications during pregnancy and have a single fetus with a cephalic presentation, yet it is seems these mothers are the main contributors to the increasing Caesarean section rate. The key to reversing this rise clearly lies in the diagnosis and management of labour.
Failed instrument vaginal delivery (FID) is associated with potentially serious maternal and fetal complications such as angular tears, PPH, difficulty in delivery of the fetal head, fetal ischaemic-hypoxic injuries, birth trauma and perinatal deaths.

Aims: To determine incidence of failed instrument vaginal delivery (FID) and maternal and neonatal outcomes.

To Analyse determinants of FID.

To assess usefulness of FIDS (Failed instrument vaginal delivery scoring system).

A Retrospective study of all failed instrument deliveries was carried between January 2012 to December 2016. Data was analysed using Microsoft Excel. Determinants of Failed instrument delivery, maternal and perinatal outcomes were analysed. RCOG ‘Patterns of Maternity of Care’ as well as previously published data were used to compare the FID rate with national and local data.

Our incidence of emergency Caesarean sections following FID is very low 2.1% compared to nationally reported rate 5-10%. FID is associated with significant maternal morbidity. Our scoring system showed that parity, duration of 2nd stage >4hrs, malposition and level of experience of operator are still major determinant factors. We recommend that previously published FID score should be modified to include station of presenting part instead of oxytocin use as it has been found as better predictor.
Failed instrument vaginal delivery (FID) is associated with potentially serious maternal and fetal complications such as angular tears, PH, difficulty in delivery of the fetal head, fetal ischaemic-hypoxic injuries, birth trauma and perinatal deaths. Aims: To determine incidence of failed instrument vaginal delivery (FID) and maternal and neonatal outcomes. To Analyse determinants of FID. To assess usefulness of FIDS (Failed instrument vaginal delivery scoring system).

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Our aim was to compare obstetric and neonatal outcomes of women with a low-risk pregnancy intending to give birth at the “Cocon”, an alongside midwifery-led unit, with women with a low-risk pregnancy intending to deliver on the classic delivery suite at Erasme Hospital in Brussels.

We performed a retrospective cohort study of obstetric and neonatal outcomes of women who chose to deliver at the “Cocon” (n= 558) and women who chose to deliver at the standard labour ward (n=414) for a two year period from March 1st 2014 to February 29th 2016. We proceeded with a univariate analysis to compare maternal and neonatal outcomes. A logistic univariate regression was performed in order to establish the odds-ratio with a confidence interval of 95%. We report a p-value using the Wald Chi-squared test and consider the threshold of significance at less than 0.05. An “intention to treat” approach was used in the analysis.

Maternal outcomes were significantly better for women who chose to give birth at the alongside midwifery-led unit the “Cocon” and there was no increase in neonatal morbidity in our population. In case of complications, having a close standard labour ward provides security to the mother and her baby.
A high spinal refers to a more cephalad progression of the level of anesthesia than planned when the neuraxial block was administered. It can be caused by an accidental intrathecal injection of a local anesthetic dose intended for the epidural space, and might produce cardiorespiratory compromise if a high concentration is used. The clinical presentation may be difficult to quickly differentiate from other critical events, if it occurs after the anesthesiologist has left the parturient's bedside.

A healthy 38 years old primigravida with a 39,2 weeks pregnancy is admitted in the labour ward for labour induction given the recent diagnosis of mild pre-eclampsia. She was started on Magnesium sulfate and was induced with buccal Misoprostol 50 mcg 6/6h. The blood pressure values kept stable, as the analytic parameters including magnesaemia. Once in active labour, she requested epidural anaesthesia. After the first injection of levobupivacaine and sufentanil and still in the presence of the midwife, the patient started to manifest dyspnea and quickly progressed to a loss of consciousness and pulmonary arrest. Unaware of the diagnosis, the obstetric team immediately started basic life support and at the arrival of the intensive care unit team the patient was intubated, and given supportive care with assisted ventilation using a bag valve mask (Ambu®) contributing to normal periferic saturations with no need of vasopressors and inotropes. Despite the improvement of the maternal status with the described measures, the cardiotocography kept registering fetal bradycardia leading to an emergency caesarean. A healthy girl with 2740g and an Apgar score of 9/10 was born.

The mother had a good clinical evolution during the puerperium, despite headache and cervical pain as a probable consequence of the neuroaxial analgesia. She needed nifedipine to control the blood pressure and the analytic parameters remained normal.

We present a case of high spinal causing a complete diaphragmatic paralysis and consequent pulmonary arrest. The sudden presentation associated with the epidural medication administration helped to establish the diagnosis. The high spinal outcome can be disastrous if the situation is not recognized and corrected immediately. The unresponsive obstetric patient should be managed with standard resuscitative measures while the precise diagnosis is ascertained.
Studies show that physical exercise is beneficial for the mother and the foetus: it prevents excessive weight gain and maternal adipose tissue, decreases the risk of diabetes and other obstetric complications and reduces the incidence of caesarean section.

The midwife Félix Jiménez Jaén in Spain developed this method and his work has already shown that it increased the likelihood of having a more successful delivery.

The aim of this study was to find out what kind of delivery the women had.

Types of study: observational, descriptive and prospective. Study subjects: Pregnant women between the 2nd and 3rd trimester of pregnancy who voluntarily enrolled in the method between September 2016 and January 2017. All cases were included in the study, were 24 women between 13 and 35 weeks of gestation, and did between 3 and 12 sessions of AIPAP each.

When the delivery date passed, the women were contacted by telephone to explain their birth experience. Births took place in private clinics (mostly), public hospitals, and at home. Different aspects are worked on every day: aerobic capacity, elasticity, strength and respiratory capacity. In all sessions, the common denominator is to perform pelvic movements.

The percentage of caesarean is still higher than what the WHO recommends, but lower than the average in Catalonia.

Despite all this, at the moment the number of caesareas are not significant, any caesarean section has been due to rotation dystocia, which would support the idea that the pelvis has been a facilitator.

No case of gestational diabetes has been obtained, which also confirms the fact that performing physical exercise significantly reduces the risk of developing this pathology.
The proportion of women giving birth by cesarean section (CS), especially elective, is increasing in developed countries over the past decades. It is recommended to perform an elective CS (ECS) after 39 weeks of gestation (WOG). Thus, there is no strong evidence suggesting it is better to perform an ECS after the onset of labour. We examined the outcomes of neonates born by ECS with no signs of labour compared with ECS performed after the onset of labour.

We conducted a single-center perspective study of women with a singleton pregnancy overcoming an ECS (indications: repetitive CS, breech presentation) at ≥39 WOG from January to June 2016. Women were assigned to groups: A- ECS performed at the set time, B – ECS preformed after the onset of labour. Outcome variables: newborn’s Apgar scores, termoregulation, hypoglycemia, infection, adverse respiratory outcomes, admission to neonatal intensive care unit, prolonged hospitalization and death. Potential confounder was WOG. ANCOVA was used to compare continuous variables and χ² tests were used to compare categorical variables, data was considered statistically significant if p<0.05.

Neonates born after ECS with no signs of labour compared with neonates born after ECS with onset of labour had no significant differences in neonatal outcomes. Neonates born after ECS without signs of labour had a tendency approaching significance to have hypoglycemia more frequently. There is a need to measure outcomes in later time points after birth to see how ECS with onset of labour may impact children health.
We present the evaluation of the new training method in obstetrics that was launched in Lithuania. The trainings were based on a few elements of HybridLabTM method and one element from ALSO® trainings. The aim was to analyze if participants’ knowledge and confidence increased after the trainings and whether or not the impact was long-lasting; moreover, to find a target group of the trainings participants.

Data was collected across Lithuania in 2015. Participants evaluated their knowledge and confidence on a Likert-type scale about management of urgent obstetrical situations: vacuum - assisted vaginal delivery, shoulder dystocia, postpartum haemorrhage, preeclampsia/eclampsia, early preterm labour and dystocia. We assessed how participants’ knowledge and confidence changed after the trainings (compared to before the trainings) and how long the effect lasted for. The change of knowledge and confidence was analysed according to the years of experience of the participants. Data were analyzed using factorial one-way repeated-measures ANOVA models and a linear regression model.

The new training method improved knowledge and confidence of participants and it remained heightened for up to six months after the trainings indicating that the trainings had long-lasting benefits. Moreover, the trainings were most beneficial for participants with lower work experience, which indicated that they should be the target group of similar trainings.
Introduction Induction of labour is increasing in many developed countries, however the optimal induction method with respect to time-to-delivery and mode-of-delivery has yet to be determined.


Linear regression analysis was used to estimate mean time-to-delivery with $\beta$-estimates and 95% confidence intervals (CI) with adjustments for maternal age, height, BMI, year-of-delivery, hospital, gestational age, hypertensive disease, diabetes and Bishop Score. Logistic regression analysis was used with OR and 95% CI to calculate odds of secondary outcomes; cesarean delivery, instrumental vaginal delivery, maternal and neonatal outcomes, adjusting for the same confounders as in the linear regression model.

Conclusions Balloon-catheter is the most effective induction method with respect to time-to-delivery in nulliparous women at term irrespective of cervical ripeness and without more complications in mother and infant compared with prostaglandin methods.
Failed instrument delivery (FID) is associated with potentially serious maternal and fetal complications such as angular tears, PPH, difficulty in delivery of the fetal head, fetal ischaemic-hypoxic injuries, birth trauma and perinatal deaths.

Aims: To determine incidence of failed instrument vaginal delivery (FID) and maternal and neonatal outcomes. To Analyse determinants of FID. To assess usefulness of FIDS (Failed instrument vaginal delivery scoring system).

Retrospective study of all failed instrument deliveries was carried between January 2012 to December 2016. Data was analysed using Microsoft Excel. Determinants of Failed instrument delivery, maternal and perinatal outcomes were analysed. RCOG ‘Patterns of Maternity Care’ as well as previously published data were used to compare the FID rate with national and local data.

Our incidence of emergency Caesarean section following FID is very low 2.1% compared to nationally reported rate between 5-10%. FID is associated with significant maternal morbidity. Our scoring system showed that parity, duration of 2nd stage of labour >4hrs, malposition and level of experience of operator are still major determinant factors. We recommend that previously published FID score should be modified to include station of presenting part instead of oxytocin use as a better predictor.
The Perinatal and Maternal Mortality Review Committee Neonatal Encephalopathy (NE) Working Group reviews New Zealand cases and recommends ways to reduce incidence and morbidity from NE. Using a nationwide data collection the rate of NE was determined(1) and important demographic & clinical associations were identified(2). Multidisciplinary case review ascertained contributory factors among potentially avoidable NE(3). Current work focuses on performance of children with NE at five years of age.

Cases of NE were reported monthly by paediatricians via the New Zealand Paediatric Surveillance Unit methodology. Once a case was reported the coordination service of the PMMRC contacted Lead Maternity Carers to obtain further pregnancy details. In order to study status at 5 years of age in those children identified from this NE database who were born from January 2010 to December 2011, the results of the Before School Check, a national screening programme of school readiness, were requested.

National data on NE has been used previously to document the rate of NE, demographic and clinical associations and potential avoidability. The current work reports the results of the Before School Check, (a screening programme of school readiness for all New Zealand Children at 4-5 years) in those children diagnosed perinatally with NE. This data is routinely collected and provides novel information on childhood status and services used by children following an episode of NE.
Syphilis is curable since 1928, when Penicillin was discovered. Despite this, syphilis remains a major issue. All pregnant women should be tested from the first antenatal visit. In Romania there are still plenty of pregnant women that present to the hospital, in labor, with unknown syphilis status. Labor management in TPHA positive patients is challenging because the mother can transmit the infection during passage through the birth canal by contact of the newborn with genital lesions.

In this retrospective observational study we assessed all pregnant women in labor that presented to the hospital between 1st of January 2015 and 31st of December 2016, with no prenatal care. A total of 391 patients met the criteria. A number of 19 patients were TPHA positive based on anti TP test performed on admission as a routine standard for every patient in labor with no prenatal care. The primary objective was to determine optimal management when dealing with a TPHA positive patient in labor with no prenatal care.

All patients in labor with no prenatal care should be systematically tested on admission for syphilis. All TPHA positive women require continuous fetal monitoring while in labor because it might be a higher risk of abnormalities in the fetal heart rate. TPHA positive women might have a higher incidence of cesarean section indication. C-section might be a better way to end pregnancy by avoiding contact of the newborn with genital lesions.
Arrest of postpartum hemorrhage (PPH) using a new conservative technique would reduce blood transfusions, unnecessary surgeries and maternal deaths. For cases of atonic PPH, a new device that uses vacuum force to collapse the uterus causing rapid tamponade was proposed. This may be a better alternative to balloon tamponade as it follows natural physiology, and is easy to use. Our study sought to demonstrate safety, effectiveness, and ease of use in the deployment of this new device to treat PPH.

Ten properly informed and consented women with vaginal deliveries, in a hospital setting, treated at delivery with prophylactic uterotonics, plus additional uterotonics for excessive bleeding, were the subjects of this study. When conservative medical therapy was failing and tamponade therapy was indicated for PPH, our device, that generates uniform vacuum within the entire uterine cavity, was used with a physiologic vacuum force of 70 mmHg. A shielded multi-pore loop was positioned in the uterine cavity and connected directly to a regulated vacuum source with collection canister to display all residual blood and any ongoing uterine bleeding. Vacuum forces were confined to the uterus with a seal positioned at the external cervical os.

Rapid, effective, inexpensive treatment for postpartum hemorrhage is a high priority in efforts to reduce maternal mortality and morbidity. This preliminary investigation suggests that a device designed to create vacuum-induced uterine tamponade may be a better alternative than balloon devices used to treat atonic PPH. This method for control of PPH is easy to use, provides direct visualization of blood loss, and is compatible with normal physiology. Additional study is needed and in progress.
C-section rates have been increasing in the last years, specially in developed countries. Regarding Spain, 22% of births in public hospitals occur by CS, with highest rates around 35%. In Private hospitals rates are even higher: 40%. There’s no evidence that links these higher rate areas to a high obstetric risk population. It seems to be more attached to certain clinical practices. Are CS indications standardized? Do we always perform a CS in similar clinical situations?

On this basis, in 2008, 5 public hospitals in the Balearic islands, carried out a pilot study to analyse CS rates and adequacy. Strict criteria each category had to be met for a CS to be considered properly performed. Main purpose: prevent unnecessary c-sections. Collateral effect: reduce and keep rates under control.

CS were divided in 2 groups:

Elective

1. Acute fetal distress
2. Failed Labour Induction
3. Arrest of dilatation
4. Cephalic Pelvic Disproportion
5. Miscellany

The medical implementation of really strict criteria for caesarean performance has taken us to a very important and sustained reduction of CS rates. The group overview of each individual situation and the staff concern and encouragement has brought a deep change in birth care. It’s necessary to develop an educational program directed at the general public. CS standardization needs be essential in any Maternity Ward in order to raise awareness of the total number of unnecessary CSs.
I will describe and discuss the UK dataset, which was part of an international prospective observational study that I conducted on a population of healthy pregnant women who laboured in water. The primary objective was to describe and compare maternal and neonatal characteristics, interventions and outcomes. A secondary goal was to investigate a series of hypotheses, one of which was to explore if there was an association between labouring in water and the incidence of normal birth.

A convenience sample of 8924 women who laboured in water were recruited across 26 National Health Service Hospitals in the UK, consisting of 15 obstetric units (OU), 5 alongside midwifery units (AMU), 9 freestanding midwifery units and 155 women’s homes (community), between 2000 and 2008. Descriptive analyses were stratified by maternal parity and planned place of birth. Frequency, percentage and 95% confidence interval were calculated for categorical data. Appropriate measures of central tendency (mean, median) and dispersion (SD, range) were calculated for continuous data after assessing the distribution of the data. Missing data were excluded from analysis. Univariate analyses were undertaken to test differences between care settings.

This study showed a high overall association between labouring in water and spontaneous vaginal birth. Marked differences found for nulliparae between care settings are interesting and provide new information for midwifery discussions with these women about planning place of birth. Reassuringly, adverse events were rare and newborn outcomes were similar between care settings. Labouring in water has the potential to normalise birth for healthy pregnant women.
The mental state of pregnant teenagers is not a subject that has been largely studied over the years. A lot of emphasis has been put on their pre and post-natal needs.

Aim

A retrospective study undertaken to ascertain the various experiences, expectations and psychological needs during labor in the adolescent mother included: presuppositions of the labor, mother’s experience, support system, contributions of the medical staff and improvements in psychological care.

A survey including 71 cases was conducted in Clinical Hospital of Obstetrics and Gynecology “Prof. Dr Panait Sarbu”, Bucharest between January and December 2016.

Adolescent mothers experience a range of psychological changes intrapartum including fear, excitement, anxiety, regret, guilt, loneliness, pain etc. Their mental state is influenced by their immaturity and support system. Special attention should be paid to the psychological support of this particular group of mothers in order to make labor bearable. This includes increasing their ability to interact with their support system, better pain management and having non-judgmental medical staff.
How to optimize gynecological childbirth position? Firstly by assessing the relation between hip flexion, position of pelvis inlet plane and lordosis. An innovative biomechanical study

In the developed countries of western Europe, nearly 90% of women give birth on their back. Since the 19th century, the course of labour is considered to be optimised with an adequate birth position, which should minimize lordosis and induce a pelvic inlet plane perpendicular to the lumbar spine. Now, it remains to know the biomechanical relation between hip flexion, position of pelvic inlet plane and lordosis in order to obtain this “optimal” configuration in gynecological position.

Eighteen pregnant women were assessed. To quantify the posture of the woman’s body parts (including thighs, trunk, and pelvis), an optoelectronic motion capture device was used. Lumbar curve was measured with the Epionics™ system. The subjects were positioned and recorded in 48 different combinations of hip flexion and abduction.

Ligamentous laxity was also measured at the second metacarpo-phalangeal joint with a specific extensometer.

Correlation between hip flexion, abduction, Flexion of the Pelvic Inlet Plane Over the Spine (FPIPOS), and the lumbar curve was established. Univariate and multivariate correlations were computed with multiple regression model under Stata® V14 software.

The optimal FPIPOS was reached by all the subjects conversely to the optimal lordosis. Moreover, hip flexion and hip abduction had different effect on the FPIPOS and the lordosis. More than the abduction, the hip flexion appeared to be essential to mobilize the pelvis and position it in order to induce the optimal FPIPOS. Lordosis was less influenced by the positioning of the thighs that weren’t sufficient to reach the optimal lordosis.
Obstetric anal sphincter injuries (OASIS) include third and fourth degree tears which are serious sequelae of vaginal birth. Previous study showed that Striae Gravidarum (SG), predicted first and second degree perineal tears and there was a significant association between SG severity (i.e. SG total score) and the degree of tear. Based on those results, the aim of the present study was to find out if there is an association between the severity of SG and the severity of OASIS.

This cross sectional study was conducted at four university teaching medical centers. Women who were diagnosed after a vaginal birth with OASIS were asked to participate in the study. After informed consent, the midwife interviewed the woman and assessed for SG. Severity scoring of SG was observed using the numerical scoring system of Atwal et al (2006). Subsequently, the same midwife collected all medical and demographic data from medical files. Effect size was calculated with a proportion of 0.2 (proportion of 3rd or 4th degree perineal tear in our country), using the G*Power 3 program (Faul, Erdfelder, Lang, & Buchner, 2007).

The innovation of this research is the association between SG and OASIS severity (3A, 3B). There is a difference in the anatomical compose of the anal muscles, while 3C and 3B composed of striated muscles, the 3C and 4 involve also smooth muscles. This difference may be the clue for the association between SG severity and second degree tears (2), and 3A 3B - all are striated muscles.
Induction of labour (IOL) is a frequent intervention in high income countries. Various methods for IOL are available. In Germany, Austria and Switzerland, there is a broad variety of hospital protocols for different methods, in particular with off-label medication. Midwives’ experiences and views on IOL; their perception of risk and effectiveness of different methods (including complementary and alternative methods, CAM); and on their perception of women’s experiences are evaluated.

For six months an online questionnaire with 22 closed and open questions was available for midwives in all settings in the German-speaking European countries. Open questions were analyzed with content analysis according to Mayring. Descriptive data were computed with MS Excel.

According to midwives’ views, there is a need for evidence-based guidance for IOL management in the German-speaking countries. Better communication and a stronger focus on shared decision-making are essential for sufficient quality of maternity care.
As the demand for healthcare resources continues to increase, there is pressure to improve efficiency and productivity. The increase in UK elective caesarean section (CS) rates (1.) is one example where such a predicament exists. In our organisation, elective CS occur on a dedicated operating list, within 3 fixed morning sessions across the working week. The aims of this full audit cycle were; to assess the functioning of the elective CS lists, improve productivity and theatre utilisation.

Prospective audit data collected over a 16 week period, from June - October 2014. Time of team brief, reasons for delays, anaesthetic start time for 1st, 2nd, 3rd case and number of midwifery staff allocated to the list all recorded. Presentation of findings given at combined obstetric-anaesthetic clinical governance meeting. Improvements agreed by the co-directorate included; a commitment to the allocation of 2 midwives per-list, a prompt team brief at 08:45, and provision of a dedicated operative surgeon with responsibility to the elective patients only. Impact of changes assessed by re-auditing list performance using identical data fields over an 18 week period, occurring between February-June 2015.

The nature of obstetric working is unpredictable, even within elective cases, however this is no excuse for inefficiency. Our audit revealing a 60% increase in list completion highlights how clear planning and communication can significantly improve theatre utilisation and patient flow. With all incomplete elective cases being diverted to the afternoon solo-emergency theatre, our simple interventions have resulted in a significant patient safety improvement.
Abnormal placentation (AP) or accreta spectrum disorders carry high risk for intrapartum hemorrhage. Risk factors for AP are prior cesarean section, placenta previa, uterine anomalies, uterine surgery, and multiparity. AP is reported to be the most common indication for peripartum hysterectomy and hemorrhage. An obstacle to Interventional radiology (IR) services is location away from labor and delivery. Four cases of IR/OR hybrid suite usage are reviewed in setting of suspected AP.

**Case 1:** Suspected focal accreta to submucosal fibroid

33 y.o. G2P1001, prior c/s focal area of adherent placenta at fundus with submucosal fibroid adherent to placenta. Given the concerns with bleeding at time of placental removal, patient had c/s at 37 weeks with delivery in hybrid suite with occlusion balloons. Blood loss was 800cc, uterus preserved. All did well.

**Case 2:** 35 y.o. G3P1001 C/S planned at 32 weeks given percreta, bulging lower uterine segment, and pain.

C/S performed in IR/OR hybrid suite. Occlusion balloons used and embolization performed. EBL was 4000 cc, 1135 cc in cell saver, 5 units of PRBC, 1 unit of platelets, 3 units of FFP, 3600 cc crystalloids. Hysterectomy performed. All did well.

**Case 3:** 33 y.o. G2P0010 33 weeks due to bleeding, placenta previa, and accreta.

Delivery in IR/OR hybrid suite with occlusion balloons, end embolization with gel foam. 2000 cc blood loss, preserved uterus. Next pregnancy 3 years later with previa and percreta, and urgent c/s for bleeding at 32 5/7 weeks gestation, hybrid suite was not available. C/S hysterectomy in main OR with 1200 cc blood loss and 1 liter from cell saver transfused. All did well.

**Case 4:** 35 y.o. G3P2002 with scheduled C/S at 34 weeks suspected increta, previous c/s x2, previa. C/S in IR/OR hybrid suite with balloons in place, not inflated. 3500 cc blood loss, 4 units transfused from cell saver, 1 unit of FFP, 6500 cc of crystalloid. Hysterectomy performed. All did well post op.

The OR/IR hybrid suite has significant utility in obstetrics in cases of AP and anticipated hemorrhage. Advanced interventions such as embolization are also helpful in decreasing blood loss. OR/IR hybrid suite usage in this setting for cesarean delivery in obstetric patients with AP, may also lead to uterine preservation through the combination of minimally invasive and standard surgical management.
High Australian CS rates may be contributed to by false positive diagnosis of intrapartum fetal distress using CTG alone. Metaanalyses of research on STan monitoring has not shown reductions in CS rates, although significant reduction in rates of scalp pH sampling have been shown. A pilot study was undertaken to compare STan with CTG. Since Australian practice is to perform CS rather than scalp pH, we hypothesised that with STan, significant reduction in emergency CS rate would be plausible.

Prior to STAN implementation, a comprehensive CTG and STan education program was conducted for all maternity staff in our tertiary maternity centre, followed by credentialing and retesting on a two yearly cycle.

Women were randomised to conventional CTG or STan in a 1:1 randomisation using European STan guidelines.

These non significant results do have the magnitude and direction of effect, which would give biological plausibility and support the hypothesis that that the usage of STan in Australia could reduce emergency CS rates without worsening perinatal outcomes. Our pilot findings are consistent with the reduction in emergency CS rates reported by observational studies from centres in Norway, Sweden and UK, which have implemented STan monitoring after appropriate staff training.
Rebozo is a typical Mexican shawl used by traditional midwives to massage pregnant women. An observational study designs was used to evaluate Rebozo massage effects about fetal occiput posterior position (OP) in labour. OP is the cephalic fetal malposition more frequently observed during labour and it’s responsible for most of dystocia associated with maternal and fetal morbidity.

This research evaluated successful OP rotation in two groups of pregnant women in labour (30 women in each): the experimental group received Rebozo treatment, and the control group received standard treatment (alternative maternal position). Secondary outcomes were also investigated, such as type of delivery, use of oxytocin and epidural, and time of labor.

The research was approved by the local ethical committee.

Significant differences were observed between the 2 groups: treated group showed a significant improvement in anterior fetal rotation and in spontaneous delivery after rebozo massage. No significant differences in the other outcomes.

These satisfactory results coming from small available sample size and from methodological limitations study. Future studies are required by the authors.
Epignathus is a mature benign teratoma arising from sphenoid bone, upper jaw, palate or tongue, which grows into the oral, nasal cavities or intracranially. This tumor occurs 1 in 35000 to 1 in 200000 live birth mostly in female fetuses. Intrauterine fetal and neonatal demise in up to 50% have been reported. The prognosis depends on localization and size of epignathus. The cases of epignathus in monochorionic twin have not published yet.

A 30-year-old woman (g2,p2) with prior uncomplicated medical history underwent ultrasound screening at 11w 3d, which revealed normal monochorionic diamniotic (MC DA) twin.

At 21w first fetus had no abnormalities, while second one appeared to have large mass both with solid and cystic components, protruding from mouth cavity. There were no lower jaw and no tongue visualised. The tumor size was 63x48x52 mm, with poor vascularisation. Fetal MRI scans showed proliferative mass, extending from inferior orbital wall through the facial skull to the prevertebral tissues. Despite uncertain prognosis for the affected fetus, multidisciplinary counselling agreed on pregnancy prolongation in sake of the intact MC twin.

Polyhydramnios with amniotic index 491 and 476 mm required 2 amniodrainages at 28 and 31w respectively. The estimated volume of the lesion rapidly increased from 663 to 1862 cm3 in period from 28 to 32 w and CS was performed at 32w 5d after RDS prophylaxis. The unaffected twin was delivered first weighing 1780g with Apgar 7/8. According to multidisciplinary counseling and patient informed consent, prenatal intraoperative feticide of the affected twin was performed by intraumbilical vein injection of Lidocaine with prior fetal anesthesia by fentanyl. The total weight of stillborn fetus with tumor was 3127g. Autopsy confirmed mature teratoma arising from palate. Histology showed haphazard mixture of mature tissues: neuroepithelial, lipids and heart comparable mussels cells.

The major controversy was about pregnancy management and delivery time. Serial amniodrainages were performed for pregnancy prolongation. Taking into account high risk of cotwin neuro-vascular injury, end-organ damage, fetal loss and preterm delivery in MC DA twin pregnancy, antenatal umbilical clamping and laser ablation were not agreed. Thus the intranatal feticide was successfully applied. Multidisciplinary approach allowed to provide beneficial outcomes both for mother and unaffected twin.
HELLP is an acronym that refers to a syndrome characterized by hemolysis, elevate liver enzymes and low platelet count. This pathology is cause of an important maternal morbidity and even mortality. An unusual complication of this syndrome is the rupture of liver hematoma, that happens in 1/40000-250000 cases. It is an obstetric emergency which needs an early diagnosis and multidisciplinary treatment.

We describe a case of a 32 years old term pregnant with a normal pregnancy care who arrived to the Emergency Section of our Hospital because of a rupture of membranes at term. While we were doing the basic scanning the patient referred a strong epigastric pain, nausea and vomiting. At that moment she had a limit blood pressure (140-90) and completely normal both blood and urine analysis. So we did an ultrasound examination which demonstrated the development of an hematoma beneath Glisson’s capsule. In addition the Fetal Monitoring showed us a Category II Tracing.

We made an emergency caesarean section where we noted an hemoperitoneum because of the rupture of liver hematoma. The treatment was a liver packing by the surgeon. While we were doing the caesarean section the new blood analysis showed a modestly aminotransferases elevation (GPT 255 and GOT 194), low plateled count (84.000) and hemolysis. The result of the caesarean section was a newborn with Apgar 4-7-10 and arterial cordon blood of 6.87 an venous of 6.99 (nowadays is a healthy child).

The pregnant woman was diagnosed as a HELLP Syndrome. She required Intensive Care at the Hostpital during 48 hours. While the hospital stay she was given intravenous magnesium sulfate and was support with several blood transfusion, but no antihypertensive drugs were needed. The patient had a correct evolution and she left the hospital after 6 days after the surgery.

The spontaneous rupture of a liver hematoma is an unusual complication of a HELLP Syndrome. This fact is associated with a high maternal and fetus morbility and even mortality in several reports. So if it takes place, after the diagnosis is confirmed, the multidisciplinary early management is required for a successful outcome.
Persistent fetal circulation secondary to right-to-left shunting through persistent fetal channels in the absence of structural heart disease is a syndrome characterized by pulmonary hypertension leading to severe hypoxemia. Its incidence has been reported as 1.9 per 1000 live births, with mortality rate ranging between 4–33%.

We present a case of a 28 years old woman, VG IIP, with a 35 weeks of gestation pregnancy complicated with Rh isoimmunisation. The level of anti D antibodies was in growth and the Doppler MCA was altered. It was decided to extract the premature fetus by C-section. The newborn weight was 2400 grams and the Apgar score was 7.

Consecutively, the baby developed severe respiratory distress and it was necessary supportive treatment with mechanical IPPV ventilation and Sildenafil. The hemoglobin and bilirubin from umbilical cord and peripheral blood in the first day of life revealed no pathological changes. There wasn’t necessary blood transfusion.

Infant required mechanical IPPV ventilation for 6 days and than 3 days of nasal CPAP. The evolution was slowly favorable. From day 12 it was initiated enteral nutrition. The discharge was able after 26 days.

We were in front of a case of preterm newborn SGA extracted by emergency C-section because of maternal-fetal isoimmunisation with changes in biophysical fetal profile.

The baby developed soon after birth complications of premature delivery – respiratory distress syndrome and pulmonary hypertension – but without requiring treatment for Rh isoimmunisation.
A CCSU has to be simple, easy to understand, unambiguous & objective, it needs to be easy to communicate & audit. Previous CCSU systems have not fulfilled this role. In 2015 a new CCSU was introduced in a large tertiary referral maternity unit and was subsequently audited in 2016.

The new system applied to Emergency caesarean sections (EmCS) defined as caesarean sections (CS) not on a pre-planned elective list, were categorised into: “Immediate”, “≤30 min” or “>30min”

Daily review of EmCS. Patient identifier gathered from theatre log, time theatre was informed & intended urgency of delivery gathered from emergency list record, time of baby delivery gathered from the hospital Patient Administration System. Any missing information was gathered from patient notes.

Prospective assessment by obstetrician & assigned appropriate category & recorded in the theatre emergency list. Decision to delivery interval (DDI) calculated from time of theatre notification to birth of baby

In our institution there is no dedicated obstetric theatre and no theatre in the labour ward. There is 1 unstaffed theatre & in the case of an immediate CS when normal theatre is occupied, staff are mobilised from other areas of the hospital.

This new CCSU satisfied our requirements. It was more objective & easier to communicate. It was accepted by all clinical staff. The low incidence of Immediate EmCS reflected the particular intrapartum practice possibly a high incidence of fetal blood sampling.

Remaining issues with auditing were the unspecified cases which reflect a lack of recording in theatre.

Other units could use this classification to record & compare the group sizes as a portion of the total number of deliveries.
Women diagnosed of thrombophilia undergoing prophylactic or therapeutic treatment with low molecular weight heparin (LMWH) tend to be induced at term to minimize obstetric accidents and to guarantee the possibility of use of locoregional anesthesia. Induction of labor has shown an increase of cesarean rates compared to spontaneous labor.

Our aim was to compare type of birth and perinatal outcomes in women with thrombophilia and without thrombophilia in our hospital.

We underwent a retrospective observational case-control study comparing pregnancy characteristics and perinatal outcomes in women with thrombophilia (case) and without thrombophilia (control) who gave birth in our hospital during 2015 and 2016.

In both groups we analyzed body mass index, age, duration of pregnancy, caucasian breed, nulliparity and fetal weight, cesarean and forceps rates, Apgar <7, NICU Admission, Maternal ICU Admission and postpartum hemorrhage.

Despite observing a higher rate of induction of labor in women with thrombophilia, this is not correlated to a higher rate of cesarean birth in this group neither major complications. This is probably due to a careful selection of patients before induction in daily practice, individualizing each case and undergoing strict obstetric surveillance when pregnancy is near term or at term. Furthermore, the use of prostaglandines for cervical ripening is to be considered when needed.
Female genital mutilation (FGM) consists of all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

FGM is most common in the western, eastern, and north-eastern regions of Africa, in some countries the Middle East and Asia, as well as among migrants from these areas. FGM is recognized internationally as a violation of the human rights of girls and women.

A comprehensive literature review was conducted in Pubmed and Uptodate.

Health care professionals should work with sociocultural mediators and interpreters to improve communication with women and their family. Midwives should take advantage of close relationship created with mutilated women during prenatal care, and deal with FGM showing respect, empathy, and confidentiality.
To examine how complex and irregular fetal heart rate (FHR) dynamics differ between fetuses of normal pregnancies and those of pregnancies complicated by maternal anemia (MA), and to place this in the context of high-risk pregnancies.

Our study population consisted of 97 pregnant women affected by MA, 118 affected by pregnancy-induced hypertension (PIH), 88 affected by gestational diabetes mellitus (GDM), 53 with preterm premature rupture of membranes (pPROM), and 356 normal pregnancies as controls. We calculated approximate entropy (ApEn), sample entropy (SampEn), and correlation dimension (CD) to quantify irregularity and the chaotic dynamics of each FHR time series.

The decreased complexity and/or irregularity in the FHR from pregnancies with MA may reflect abnormalities in the complex, integrated cardiovascular control. The irregularity and complexity of the FHR increased together with Hb levels in pregnancies with MA. Our data suggest that the integrity of the nervous system in the fetuses compromised by severe MA might result directly in adverse outcomes.
The reactive non-stress test (NST) notice the increase of fetal heart rate (FHR) by more than 15 beats/min for longer than 15 seconds following fetal movements, but FHR dynamics according to reactivity related to fetal movement have not yet been identified. To compare and analyze differences in antepartal FHR parameters, non-linear indices and pregnancy outcomes in fetuses proven to be normal after delivery according to the reactivity as a result of NST and fetal movement (FM).

We surveyed 3,295 NST data acquired using a computerized FHR analysis system. First, subjects were divided into two groups by the reactivity as a result of NST (reactive (R) cases, n=1720 vs non-reactive (NR) cases, n=1575). Second, each two groups were divided into three groups according to FM : group1 (NR, FM=0), group2 (NR, FM=1), group3 (NR, FM>=2) and group4 (R, FM=0), group5 (R, FM=1), group6 (R, FM>=2). Neonatal outcomes were compared, and FHR parameters analyzed using computerized fetal monitoring system. Non-linear analysis was performed using approximate entropy, ApEn; sample entropy; SampEn, and correlation dimension; CD.

The heart rate dynamics of fetuses are not affected by fetal movement and they are coincidence with fetal and perinatal outcomes.
Hypoxic ischemic encephalopathy (HIE) is a leading cause of acquired neonatal brain injury and may result in death or long-term neurodisability. Timely decisions are critical during intrapartum care and is dependent on access/input from senior professionals. However studies have not looked at the incidence and variation of HIE in relation to working hours.

Aim: To compare the incidence and variation of neonatal HIE admissions in relation to weekends and out of hours and normal working hours.

Retrospective targeted data collection was performed over a period of 5 years (Jan 2010-Dec 2015) from a busy district general hospital with approximately 6000 deliveries/year. Data obtained from the neonatal Badgernet included day and time of birth of baby and grade of HIE. Weekend was taken from Friday 17:00- Monday 9:00 and out of hours was taken as 17:00-9:00. Results were collated and analysed using STATA 9.

There appears to be a weekend/out of hours effect for babies with HIE. This has important implications for understanding and improving quality of healthcare services. The study can help develop appropriate perinatal workforce planning outside normal working hours. A larger study along with looking at timing of maternal admissions is required to confirm this effect.
Epidural rates are high in tertiary obstetric referral centers where patients with high risk pregnancies receive care. Studies show that some patients prefer birth without epidural, and that supporting them to achieve this goal is challenging in hospital obstetric units. Contextual factors, including routine intervention, may limit labour support. Studies of labour support and patient pain management preference have excluded patients with high risk pregnancies.

This study aimed to identify barriers and facilitators to birth without epidural in a tertiary obstetric referral center by exploring perspectives of health care professionals and patients. Individual semi-structured interviews were conducted with 10 health care professionals (including 5 nurses and 5 physicians) and 4 patients who intended to deliver without epidural analgesia (including 3 who delivered without epidural and one who ultimately chose to have epidural). A knowledge translation framework, the Ottawa Model of Research Use, guided development of the interview questions. Interviews were recorded, transcribed, and analysed using inductive qualitative thematic analysis.

Findings of this study can be used to improve support for patients who aim to give birth without epidural analgesia within the tertiary obstetric referral centre context. Participants identified a need for unit level support of this patient goal. This could be implemented through development of guidelines, increasing the variety of pain management options available, offering labour support training to staff, and providing information about birth without epidural to families.
Pregnancy after liver transplantation (LT) is possible but associated with increased risk of obstetrical complications. Currently there is large number of LT women of reproductive age, for instance in the USA over 14000, however, data on pregnancy outcomes after LT is limited. We report here for the first time the pregnancy outcomes after LT in Finland.

All of the 25 pregnancies ending in deliveries after LT in Finland in 1998-2015 were analyzed. The data was collected from the mothers’ medical records. The main outcome measures included pregnancy complications, mode of the delivery and status of breast feeding. Neonatal outcome measures were birth weight, 5 minute Apgar score and umbilical artery pH.

LT pregnancies in Finland result in good perinatal outcome with healthy, mostly full-term, normally grown off-springs, however, serious maternal complications related to underlying liver pathology, transplant surgery and immunosuppressive medication seem to occur relatively frequently.
Midwives have a significant impact on the clinical outcome and the birthing experience of women. However, there has been a lack of research focusing specifically on clinical midwives’ learning and development of professional competence. (1,2,3,6). The midwives profession face numerous stressors within their clinical practice including time pressures, workload, multiple roles and emotional issues and only competent midwives can make the difference in complicated situations and dilemmas. (4,6).

The aim is to describe peer group supervision if an effective method of midwifery activities on the case of East Tallinn Central Hospital Women’s Clinic. Action was held in focus group which was led by the moderator. Focus groups are suitable method for monitoring and assessing exploring the needs and improving professional development. Focus group was formed by seven midwives. Midwives were in the age between 28 up to 50. Working experience varied between 3 years to 24 years. The group received and acted six times, one time per month.

The main goal of focus group meetings was discussing about complicated situations and dilemmas in midwifery activities. The main method of the focus group work was peer group supervision method. Midwives got an overview of different approaches about peer group supervision content and conditions. Settlement of the case study as an important aspect in the work of the midwives. At subsequent meetings was based on the different possibilities of peer group supervision method: case study analysis which contained ethical dilemmas; setting up and management of emotions exercises, self-analyses, reflection and recommendations for improving personal integrity etc. In collaboration with the settlement of the cases allowed raising professional skills and effectiveness in midwifery.

Peer group supervision supports to build confidence, resilience, capacity and skills. The midwives who participated in focus group expressed a hope that the activities of a peer group will become a regular.
Our principle aim with this survey is to gain insight into staff attitudes and culture to medication management, and particularly reporting of medication incidents in order to address whether the CWIUH Medication Incident Reporting system suffers from the limitations outlined above. This will then inform the larger issue of improving systems to prevent harm to patients due to medication errors.

An anonymous survey consisting of 12 questions and 2 options for free-text opinion was developed and issued to all medical, midwifery, nursing and pharmacy staff in a tertiary level maternity hospital.

82 completed surveys were collected and responses were analysed using Microsoft Excel. Pareto analysis was performed on a number of survey questions in order to illustrate certain data relating to factors affecting reporting and perceptions of culture.

While we can’t solve the staffing crisis in our hospital the analysis shows us other ways by which we can potentially facilitate improved reporting rates e.g. more feedback, simpler forms. The survey highlights a number of issues which must be addressed at an organisational level by promoting the reporting system as a learning tool for entire organisation. Overall, the perception of the hospital’s reporting culture is positive, borne out by fact that a duty of care drives over half of reports.
Optimal management of twin deliveries is controversial. We aim to assess the factors correlated to the development of hypoxia in 2nd twin with vaginal delivery (VD) of 1st twin.

This is a retrospective observational study including di-amniotic pregnancies admitted to VD. We compared pregnancies according to 2nd twin hypoxia. Inclusion criteria: gestational age at delivery ≥35 weeks, birth weight ≥1800 gr, vaginal delivery of the 1st twin. Hypoxia was defined as at least one of Apgar Score 10 minutes < 5, neonatal resuscitation for > 10 minutes, neonatal acidosis defined as pH ≤ 7 and/or BE ≥ 12 mmol/L.

The incidence of hypoxia in twin pregnancy admitted to VD was low. It was correlated to abnormal CTG, that could be associated to intrapartum sentinel events. This emogas alteration expresses an acute fetal distress, without the development of neonatal encefalopathy. The twin to twin interval time was not an isolated influencing factor for neonatal hypoxia, but it must be reduced in case of abnormal CTG or acute intrapartum events. Therefore VD is a safe option in di-amniotic twin pregnancies.
In 2007, Lopriore first described Twin anemia-polycythemia sequence (TAPS) as a specific chronic form of complication in the twin pregnancies, and characterized it as imbalanced inter-twin blood flow without amniotic fluid discordance. In the past decade, more than 100 cases have been studied on TAPS, but still there has been limited knowledge about spontaneous TAPS. We present a case of TAPS detected at 32+6 weeks’ gestation occurred spontaneously in Korean woman.

A 34 year-old pregnant woman, gravida 1 para 0 with monochorionic-diamniotic (MCDA) twins, presented to the emergency department with a chief complaint of sudden onset abdominal pain at 32+6 weeks of gestation. At 31+2 weeks of gestation, obstetrical assessment of the patient revealed appropriate development of both twins for gestational age without significant inter-twin difference in fetal growth, and there were not intertwin discrepancies in amniotic fluid volume. Fetal nonstress test (NST) showed normal baseline heart rate with moderate variability. At presentation, the symptom began 3 hours prior to presentation and the patient also described abrupt cessation of fetal movements. Fetal heart beat was not checked, and intrauterine fetal demise of both twins was confirmed on obstetric ultrasonography. Any related findings or symptoms of premature preterm rupture of membrane or chorioamnionitis were not found. She underwent termination via vaginal delivery. The first fetus was pale and weighed 1520g, and the second fetus was plethoric and weighed 1830g.

* Macroscopic placental examination: The anemic and pale area of placenta was corresponded with first fetus side with anemic appearance. Hypervascularity of the second fetus area in placenta implied that there was hemo-dynamic discordancy between two fetuses. Velamentous umbilical cord insertion of the anemic area was found. Pathology confirmed results were same as above and supported diagnose to clarify TAPS.

In MCDA twins, especially from mid-trimester, close monitoring with regular Doppler ultrasound measurement and increasing awareness of TAPS is crucial in order to improve the detection and the optimal management.
Uterine atony is the most common cause of postpartum hemorrhage. Among several options, uterine compression sutures are simple and effective in controlling uterine atony during cesarean section; additionally, they may lead to a higher possibility of subsequent pregnancy. In this study, the outcomes of subsequent pregnancies and deliveries following the placement of Shin’s modified B-Lynch suture for uterine atony during cesarean section were compared with a control group.

A cohort of cesarean deliveries performed by a single surgeon between January 2007 and December 2014 were retrospectively analyzed. Shin’s sutures were applied in cases of uterine atony that did not respond to uterine massage and uterotonics within 5 minutes. Subsequent pregnancy and delivery outcomes were compared between patients who received and did not receive Shin’s sutures.

There was no significant difference in the outcomes of subsequent pregnancies and deliveries between groups who received and did not receive Shin’s sutures. However, there was a higher rate of pelvic adhesions in the suture group.
The research was carried out in descriptive type in order to determine the relationship between the year-end achievement score and physical activity of the midwifery department students who undergoing undergraduate education in three cities, Balıkesir, Konya and İzmir.

Research population has created 234 students in the first class of midwifery department in the provinces where Konya, Balıkesir and İzmir state universities. The data of the study were collected by using the questionnaire including the socio-demographic characteristics of the students which prepared by searching the literature and the International Physical Activity Evaluation Questionnaire Short Form.

The study was conducted in university first-year students so they were experiencing an adaptation process and thus could not exercise regularly. It is recommended to repeat the study in more numbers, different age groups and different classes.
Aromatherapy uses essential oils that are extracted from flowers, stems, plant roots and leaves. It can be used in bath, massage oil, vaporizer, burner or topical. It is a natural alternative therapy to reduce anxiety. The aromas change our moods because the olfactory bulb is in direct contact with the cells of the brain. If we have some emotional change by putting the essential oil in a burner or spreading the aroma by the environment, it will help us find the balance.

Literature review through a systematic search of the followings databases: Trip Database, Cochrane, Medline, Cinahl, Cuiden and Cuidatge. They have also been consulted documents published in organizations and societies such as: WHO, FIGO, SEGO, ACOG. We have selected articles published between 2013 and 2016.

Using aromatherapy in labor is an additional tool for the midwife, as it helps to reduce both pain and anxiety in the woman. More experimental and cohort studies are needed to evaluate the improvement in obstetric and perinatal outcomes.
Midwives from different countries and/or countries recommend pregnant women out herbal tea leaf tree raspberries to stimulate the onset of labor spontaneously and improve the quality of the contractions.

What is presented in this poster is a systematic review of existing scientific literature on the use of this phytotherapic by labor.

Literature review through a systematic search of the followings databases: Medline, CINAHL, Cochrane, care and Cuidatge. Have also been consulted documents published in organizations and societies such as: WHO, FIGO bran, ACOG.

We have selected articles published between 2012 and 2016.

Once reviewed the literature, there is a lack of conclusive studies with a sample sufficient to assess the effectiveness of the leaf of the tree of raspberries with quality scientific evidence.
The aim of the study was to investigate whether the angle of progression (AoP), as measured by transperineal ultrasound, was predictive of both the time remaining in labor and vaginal delivery.

This was a prospective observational cohort study involving 270 low-risk women with singleton pregnancies at term. The AoP, measured at the end of the first stage of labor, was used as a predictive variable of time remaining in labor and mode of delivery. The Kaplan Meier and Cox algorithms were used to evaluate the time elapsed between AoP measurement and delivery as a function of AoP. Instead, logistic regression was used to calculate the adjusted probability of vaginal delivery as a function of AoP.

The AoP was directly associated with the time remaining in labor and was predictive of a successful vaginal delivery; however, the impact on clinical practice seems low.
The rate of cesarean sections (CS) increased in last decades. In 2011, in Italy, it reached 36.7%. Repeated CS is the most significant contributor to overall CS rate. To reduce CS rate and related morbidities, vaginal birth after caesarean (VBAC) should be supported.

Nearly 25% of women with previous CS require induction of labor. In these women balloon catheters may be an appropriate alternative to prostaglandins, since prostaglandins are associated with a higher risk for uterine rupture.

We conducted a retrospective multicenter study in 9 Italian obstetric units. We collected women with singleton pregnancies at term, one previous lower transverse CS, no contraindications for VBAC, unfavourable cervix (Bishop score ≤3) and intact membranes, who underwent induction of labour with double balloon catheter between Jan 2013 and Mar 2016.

Both the uterine and vaginal balloons were inflated with 80 cc of saline solution and catheter was kept for 12-24 hours or until spontaneous expulsion or spontaneous rupture of membranes.

The primary outcome was rate of VBAC and secondary outcomes were maternal (uterine rupture, post-partum haemorrhage, visceral injury) and fetal (Apgar score < 7 at 5’, cord blood PH < 7.05, NICU admission).

This is the largest case series reported in literature about labour induction with double balloon catheters in women with previous CS.

The VBAC success rate in our study was comparable to that reported in literature (54%) for women with previous CS subjected to labour induction with balloon catheters.

Our favourable experience lends support to further research to demonstrate the safety of this method.
There is strong evidence regarding the benefits of early skin-to-skin contact. These benefits however are sometimes overlooked in the busy operating theatre. A visit to the operating theatre during labour or for an elective caesarean section is stressful for all involved. We sought to utilise a targeted patient education approach to improve awareness and provision of skin-to-skin following operative delivery, as well as reduce stress and improve experience amongst birthing-partners.

Birthing partners of women who underwent operative delivery in July 2015 were surveyed. This included both elective and emergency cases. 20 birthing partners were surveyed regarding the occurrence and awareness of skin-to-skin in theatre, their overall experience and prior-understanding. Following dissemination of survey results, a multi-disciplinary consultation process was undertaken. An information delivery poster has been produced to outline the events which occur in theatre, re-enforcing the importance of skin-to-skin. Three posters have been placed in key areas of patient contact. Following their installations a re-survey was undertaken (July 2016) to evaluate their impact on skin-to-skin and experience of birthing-partners.

Our work demonstrates a simple but effective method in improving operative skin-to-skin rates, highlighting the role of information delivery and education as a tool for reducing stress and improving overall satisfaction levels. Our posters, including pictorial examples, provide a prompt and discussion point to aid skin-to-skin initiation and are an excellent resource for the preparation of patients, family and staff regarding the events which occur in an obstetric theatre.
Female genital mutilation (FGM) is a harmful embedded practice with important impact on women’s health and quality of life. It has been estimated that 48092 girls/women, originated from countries where FGM is practiced, are living in Belgium. Studies demonstrated that Belgian gynecologists and midwives are confronted with women with or at risk for FGM. However, little is known about knowledge, attitude and practice of midwives regarding FGM. Therefore, a survey was conducted among Flemish midwives.

A quantitative descriptive study was conducted using a semi-structured questionnaire. The study population consisted of all midwives, working on labor wards, postnatal wards and maternal intensive care units (MIC).

This study indicates that Flemish midwives are confronted with FGM and its complications and highlights the gaps in knowledge on FGM. This may interfere with the provision of adequate care and prevention of FGM for the newborn daughter and underlines the need for appropriate training of (student)midwives regarding FGM as well as for the development and dissemination of clear guidelines in Flemish hospitals.
Thirteen to twenty-five percent of women with cesarean delivery (CD) scheduled at 39 weeks will present with spontaneous labor onset prior to the scheduled delivery date. We aimed to investigate if labor onset before planned CD affects the risk of neonatal admission, respiratory distress, or neonatal infectious morbidity.

Our cohort included singleton term pregnant women with intended CD who delivered at Aarhus University Hospital from 1990 to 2012. Two groups of women were identified: Women with intended CD performed prior to labor (non-labor CD) and women with intended CD performed after spontaneous labor onset (labor onset CD); in both groups there was no other medical indication for an immediate or early term CD. Data were stratified in early term (37-38 weeks) and full term (39-40 weeks) CDs. The main outcome measures were neonatal admission, respiratory distress, and infectious morbidity. We compared the risk of each adverse outcome between labor onset and non-labor groups and calculated adjusted odds ratios (aOR) using logistic regression models.

Labor onset prior to planned CD was not associated with a decrease in neonatal respiratory morbidity, but may be associated with increased risks of neonatal infection. In this observational study, non-labor CD at 39 completed weeks was associated with the lowest risk of adverse events for child and mother.
Spontaneous abortion or miscarriage occurs in 10 to 25% of all pregnancies. The midwife has a considerable role in guiding couples dealing with spontaneous abortion, and is assumed to possess sufficient knowledge and skills. This research is the first large scale Knowledge, Attitude and Practical experience (KAP) study among midwives in Flanders (Belgium) on spontaneous abortion.

A quantitative descriptive KAP study was conducted using a semi-structured questionnaire. A total of 647 midwives (54%) working on maternity, labor and gynecological wards, maternal and neonatal (intensive) care units, antenatal consultations and reproductive medicine, were included.

Flemish midwives consider themselves as a key care giver in the emotional guidance of couples with miscarriage. However, they experience several barriers, e.g. lack of knowledge. The results highlight the importance of adequate training in knowledge and communication skills during midwifery education. Further research should focus on the educational midwifery programs, current (treatment) practices, involvement and attitude of the Flemish midwife in caring for couples with spontaneous abortion.
The postpartum can be a stressful period and requires adequate coping capabilities. Sense of coherence (SOC) refers to a person’s ability to cope with stressors (i.e. psychological resilience). A strong SOC has been related to good physical and psycho-social health. Few studies, however, examined SOC during the postpartum. Therefore, this study examined whether SOC is associated with women’s perceived health status and quality of life (QoL) ≤8 weeks postpartum.

This cross-sectional study used an online survey and recruited women with term delivery, at ≤8 weeks postpartum via the maternity ward of a regional hospital, flyers and social media. SOC was measured using the valid and reliable SOC-13. Perceived health status was measured using a 4-point scale (very good to poor health). QoL was evaluated on a scale graded from 0 to 10 (worst to best imaginable QoL). Descriptive statistics, t-tests, chi-square tests and correlations were calculated.

Women seemed to cope well with early motherhood as indicated by moderate SOC scores and good scores on QoL and perceived health status. SOC seems to be associated with perceived health status, suggesting the importance of paying attention to psychological resilience during the perinatal period and underlining the need for further research in larger and more specific (e.g. vulnerable) populations.
The Internet is widely used by new mothers as an important source of health information and communication. Internet and mobile technologies offer new opportunities to convey postnatal health promotion. As part of a larger project aiming to develop a digital postnatal tool for new parents, the objective of this study was to investigate the current Internet use and access, needs and expectations on digital information and communication of women during the postpartum.

An explorative and descriptive study was performed using an online survey on IT-user-experience, general and postpartum-specific Internet use and interest in an Internet-based platform. Women at ≤12 weeks postpartum were recruited via the maternity ward of regional hospitals, flyers and social media. Descriptive statistics were applied.

This study provided particular areas for development of a mobile application based on IT-user-experience and Internet use, more specifically insight was gained into specific interest for an Internet-based platform in early motherhood. Healthcare professionals should give women links to high-quality information sites and take the opportunity to discuss web-based health promotion with new mothers.
Since the low specificity of the cardiotocogram (CTG), fetal blood sampling (FBS) and ST-analysis (STAN) have been developed as alternative methods for fetal monitoring. However, their efficiency is still under debate. Ante-and intrapartum monitoring by non-invasive fetal electrocardiogram (NI-fECG) turns out to be a possible alternative for obtaining a CTG and a fetal ECG. In this pilot study we aim to perform 250 intrapartum NI-fECG measurements, to improve the algorithm and hardware.

The measurements described in this abstract were performed in the MMC Veldhoven, a Dutch tertiary referral center. In eligible women an adhesive patch containing 8 ECG electrodes (Parides Atlantis, Nemo Healthcare BV) was placed on the maternal abdomen. We started recording at the moment of active labour and continued during both stages of labour. From the recordings a CTG and fetal ECG were extracted. Here, we report two clinical cases, in which NI-fECG may be technically more difficult.

Case 1 concerns a para 0 with a gestational age of 40 weeks and 5 days, who had an uncomplicated pregnancy. Labour was augmented with oxytocin because of insufficient uterine contractions. The CTG showed an abnormal pattern and several FBS’s had to be performed (pH 7.31, 7.32, 7.12). Because of suspicion of fetal distress a vacuum extraction was performed. A shoulder dystocia occurred, which was solved after two minutes by the manoeuvre of McRoberts and the all-fours position. A baby of 3525 grams was born with an Apgar score of 2/4/7 after 1, 5 and 10 minutes respectively. Umbilical cord gases showed an arterial pH of 7.26 with BE -8 and a venous pH of 7.29 with BE -8.

Case 2 concerns a para 2 with a gestational age of 37 weeks and 6 days and a BMI of 38.1. She had a gestational diabetes treated with insulin. Labour was induced with dinoprostone gel, after which she had a smooth progression of dilatation and delivery. Her child weighed 4295 grams, which is above the 97th percentile.

The aim of this pilot study is to improve the algorithm and hardware. Here we report the current clinical application of the NI-fECG in two intrapartum settings. For each case the fetal heart rate (FHR) signal quality and signal loss of the NI-fECG will be compared to the FHR measured by the scalp electrode or the Doppler ultrasound. If possible we will analyse the specific fetal ECG waveform characteristics. The results will be presented at the congress.
Hyperemesis gravidarum occurs in approximately 0.3% to 3% of pregnancies. Certain factors, such as multiple pregnancies, maternal age and the number of fetuses, are known to be associated with hyperemesis, but the overall picture of the associated conditions remains incomplete. We aimed at determining the incidence of hyperemesis gravidarum in Finland and to assess the conditions associated with it.

Data of women with hyperemesis gravidarum discharge diagnosis in early pregnancy between 2004 and 2011 (5,215 women, hyperemesis pregnancies N=5,795) were retrieved from Finnish Hospital Discharge Register and Finnish Medical Birth Register. Three matched controls were chosen for each case (15,645 women, pregnancies N=28,904). Incidence of hyperemesis gravidarum was calculated. The association between hyperemesis and pre-pregnancy body mass index, smoking, socioeconomic status, marital status, residence, assisted reproductive technology (ART), sex and number of fetuses was analyzed.

The incidence of hyperemesis gravidarum in Finland was comparable to that in other Nordic countries. Our results supported the multifactorial etiology of hyperemesis; the risk of hyperemesis was associated with environmental conditions and maternal characteristics, some of which have been found to be related to elevated levels of hCG, but the exact mechanisms by which these factors contribute to hyperemesis gravidarum remain to be elucidated.
Clinical pathways allow professionals to register in an agile and safe way all those activities that they perform as well as the monitoring of outcome indicators after the intervention. Using a clinical pathway to support normal labour allows to reduce variability of interventions in normal birth and labour and to unify one sole intervention criteria, to make the registering of all activities during labour easier and identify any unusual events as well as being able to assess the quality of care.

In May 2012 at Hospital Parc Taulí de Sabadell (Barcelona, Spain), a multidisciplinary team formed by obstetricians, midwives, anaesthetists and paediatricians was gathered with the purpose of creating a clinical pathway for normal labour. A bibliographic research regarding clinical pathways was carried out, more specifically on previous experiences in clinical pathways for normal labour and all findings were shared amongst all members of the team. Each member of the group concluded that it was indispensable to join clinical pathways for normal labour with an inclusion criteria of those women who could in fact follow the clinical pathway of the normal labour and birth. In the end, the contents in the clinical pathway for normal labour were the following: partogram, medical interventions, nursing care plans, time sequence of process and discharge planning and recommendations.

The development of the clinical pathway for normal labour was possible thanks to an interdisciplinary consensus and agreement amongst all members of the team. Clinical pathway for normal labour and birth has helped reduce variability of actions as well as unify intervention criteria. It has allowed for a thorough register on completed activities and has made communication among professionals easier as well as improving the continuity and quality of care during labour process.
Childbirth experience is arguably as important as measuring birth outcomes such as mode of delivery or perinatal morbidity. A robust, validated, Danish tool for evaluating childbirth experience is lacking. The Childbirth Experience Questionnaire (CEQ) was developed in Sweden in 2010 and validated in Swedish women, but never validated in a Danish setting, and population.

The purpose of our study was to validate the CEQ as a reliable tool for measuring the childbirth experience in Danish women.

First, the CEQ was translated from Swedish to Danish according to COSMIN recommendations. The face validity of the CEQ was then tested among 10 women, who recently gave birth. Later, the CEQ was sent to 77 women one month postpartum and again 2 weeks later. Demographic and delivery characteristics were used to establish construct validity of the CEQ applying the method of known-groups validation. The results of the scored CEQ sent out twice were used to measure test-retest reliability of the CEQ by calculating the quadratic weighted index of agreement between the two scores.

The Childbirth Experience Questionnaire is a valid and reliable instrument to measure childbirth experience in the Danish population.
DIC is a recognised complication of obstetric haemorrhage, placental abruption and IUD, usually associated with massive haemorrhage. Low Fibrinogen is considered to be predictive of ongoing bleeding during acute haemorrhage. Serum fibrinogen <2g/L has a 100% positive predictive value for severe haemorrhage. This case describes acute blood loss of only 12.5% of her circulating volume leading to severe DIC which did not cause ongoing haemorrhage as would have been anticipated given past research.

A 38 year old lady with BMI 43 was brought into hospital with sudden onset abdominal pain. She also had new onset headache, peripheral oedema and a firm, tender abdominal mass. She was unaware that she was pregnant, but a bedside scan revealed a 27 week pregnancy with IUD. Urgent pre-eclampsia (PET) bloods and coagulation studies were sent. Her blood pressure was borderline and proteinuria noted on urine dip. She had a 92ml antepartum haemorrhage at this time. All blood loss during her admission was weighed and measured. She delivered a fresh stillborn infant shortly thereafter and lost 566ml at the time of delivery. She was noted to be bleeding from her cannula sites hence a blood sample was sent for urgent haemostatic analysis using ROTEM®. Following delivery of the placenta, 803ml was expelled from the uterus. In spite of having only lost 12.5% of her estimated circulating volume she developed severe coagulopathy - her Fibrinogen was 0.3 and ROTEM® FIBTEM A5 was incalculable (APTT 53.9, PT>108). She required a total of 12g Fibrinogen concentrate over a period of 5 hours in order to normalise her coagulopathy. In the interim her blood pressure rose and she developed severe PET requiring MgSo4 infusion, fluid restriction and IV anti-hypertensive therapy. During her admission she only required 1 unit of packed red cells and was discharged home 3 days after admission with 6 weeks of thromboprophylaxis. Her total blood loss during her admission was 1605ml.

It is important to be vigilant for evolving DIC in the presence of risk factors such as obstetric haemorrhage, placental abruption and IUD, even in the absence of massive haemorrhage. Prompt correction of clotting abnormalities, in this case with Fibrinogen concentrate is essential in reducing further blood loss. It is clear that serum Fibrinogen <2g/L and FIBTEM A5 <10mm is not always associated with prolonged bleeding or invasive procedures as previously described.
The reduction in aspiration risk achieved through preoperative fasting must be offset against the adverse effects of prolonged starvation.(1) National guidelines highlight the administration of carbohydrate beverages (CBs) as a proven method of attenuating preoperative thirst, anxiety and postoperative nausea and vomiting.(1) CBs improve postoperative wound healing and facilitating recovery from surgery.(1) As such, CBs are an important aspect of an enhanced recovery from surgery programme. (2)

Our aims were to assess the impact of introducing CBs on maternal satisfaction, patient experience and starvation times. An initial audit (3) was conducted to assess starvation times, levels of thirst, and awareness of starvation guidance for all patients undergoing elective caesarean section (ECS) over a 6 week period (2014). Results were disseminated to the department and a re-education campaign undertaken. Repeat audit: Preload CBs were issued to non-diabetic ECS patients in the pre-operative assessment clinic, with instructions to take one at 22:00 the evening prior, and one at 06:00 on the morning of surgery. Patients identified as likely to require further fluids on day of surgery were offered a further CB.

Our re-audit reveals a clear improvement in patient experience and satisfaction through the self-administration of CBs – which were well tolerated by all. The introduction of CBs has led to increased awareness levels within our patient population, resulting in a clear reduction in patient discomfort. It has ultimately encouraged “active participation” from patients with respect to their preparation for theatre.
Statistical data on the vertical transmission prevention of road shows that only half of HIV-infected pregnant women therapy should be initiated in a timely manner. Health care professionals need to identify possible reasons why such a large proportion of HIV-infected women on preventive treatment does not commence in a timely manner. The aim of research was to explore the women`s who are living with HIV experiences about health care in the perinatal period.

Research was conducted as part qualitative phenomenological study. Upon receipt of the Riga Stradins University and one of the largest Latvian authorities obstetric ethics committee for authorization, was conducted a qualitative study. As a study tool was selected semi-structured, in-depth interview, which allows to discover not only the status quo but what have been in the other stories that reflect human behavior and beliefs diversity. It was used in a targeted selection of respondents, as there are tiny number of people who experienced the phenomenon under study, and there are difficulties to access the persons who have been experienced this phenomenon.

Diversity of experience;

women living with HIV, notes the lack of information on preventive medical measures in the succession of health care for women living with HIV and social support availability, at the same time pointing out that Latvian Infectology Center is a safe and reliable source of information;

importance of the first contact with patient;

there are still some attitude problems at work with women living with HIV, linking it with less experience in working with women living with HIV.
Nearly all women giving birth in Victoria, Australia initiate breastfeeding but early discontinuation is high.

The overall aims of this study are to describe maternal factors that are associated with early breastfeeding problems for women who give birth to term babies and who initiate breastfeeding; and to explore the extent to which the use of oxytocin infusions in labour, epidural analgesia in labour and birth by caesarean section (CS) are associated with early breastfeeding problems.

Retrospective population-based cohort study of all term livebirths to first time mothers in Victoria in 2009-2014.

Data on all births in Victoria are reported by attending midwives to the Victorian Perinatal Data Collection. Items relevant to this analysis include maternal characteristics, oxytocin infusion in labour, intrapartum analgesia, method of birth and three breastfeeding items: whether the mother attempted to breastfeed or express breastmilk at least once (initiation of breastfeeding); whether the baby was given any formula during the postnatal hospital stay; and whether the last feed prior to discharge was taken entirely and directly from the breast.

Comparison of proportions and adjusted Odds Ratios will be reported.

Our findings will help maternity care providers identify women at risk of early breastfeeding problems, and so enable them to provide additional care for women who are likely to need it.

When there is no clear clinical indication for intervention, women and caregivers who value successful breastfeeding might use the final results of this study to inform decision-making around the use of epidural analgesia, oxytocin infusions to induce or augment labour, and method of birth.
We started with AFL measurements in Tartu in 2016. Previous publications have shown a strong relation between high (≥10.0) AFL concentration and dysfunctional labour. The frequency of adverse neonatal outcome at delivery has also been associated with high level of lactate in the amniotic fluid before delivery. The aim of this paper was to analyse the results of the AFL measurements.

We analysed 49 deliveries retrospectively. The AFL concentration was collected vaginally during the delivery at bedside. 3 patients were excluded due to failed samples and 5 more patients because of not having any labour stimulation. The AFL measurements of 41 patients were taken into account. All 41 deliveries were stimulated with intra-venous oxytocin. The samples were taken 1-4 times per patient depending on the needs and length of the labour. We also determined the Apgar scores of all newborns.

The results of the AFL measurements were taken into consideration when making decisions concerning labour stimulation and the delivery method. No special inclusion criteria were used.

If 2 or more AFL measurements exceeded 10.0, there was an increased chance of ending the delivery with a Caesarean section. We also noticed high AFL values in fetopelvic disproportion and fetal distress groups. No other relations were noticed.

Further prospective studies with bigger groups should be conducted to investigate amniotic fluid lactate concentration as a predictor of dysfunctional labour and neonatal outcomes.
The reliability and efficacy of external tocography (TOCO) as an indicator of uterine activity (UA) has been a topic of discussion for decades. The introduction of electrohysterography (EHG) as an alternative method for contraction assessment has reinforced the need for a reliable comparison of signal quality of the obtained UA traces. Typical validation methods require recording the gold standard intrauterine pressure (IUP) and define the signal quality based on resemblance with the IUP.

We propose a statistical method using crowd-sourced evaluation of UA to determine signal quality and reliability using statistical methods. To this end, a web-interface was designed to collect expert evaluations, allowing for scalability of recordings, experts, and evaluation criteria. After login an accepted expert has access to a randomized 25-minute TOCO segment from a total of 235 segments recorded on 33 women at full gestation (39w5d +/- 2w) during labor. In addition, questions on the perceived quality, contractility level, and contraction pattern, frequency and duration are shown, where the last three are only shown when the patient is contracting. In total, 2,159 signal evaluations by 20 experts were made.

The presented web-interface and statistical analysis method enable crowd-sourcing of clinical evaluation of UA signal quality without the requirement of a gold standard reference signal. This method may be useful to objectively compare quality and usability of various UA signals like the TOCO, IUP, and EHG. Because the system uses an web-interface and experts can be crowd-sourced the system is very scalable, allowing for easy analysis of very large datasets.
Intrauterine Devices for contraception are popular with 168 million users worldwide. Complications associated with malpositioned or displaced IUDs include expulsion, displacement, embedment and perforation. Management depends on severity of malposition and symptoms. Incidence of uterine perforation in large studies are around 0.7-1.6/1000. Risk of perforation is associated with postpartum insertion, uterine structural abnormalities, extreme anteversion & retroversion and inexperienced operator.

Ms VM, a 31yrs nulliparous lady suffering from Inflammatory Bowel Disease presented with chronic lower abdominal discomfort. She had a copper IUCD fitted 10 yrs back.

On transvaginal scan, the uterus was found to be retroverted and mobile. The stem and left arm of the copper IUCD was found within the endometrial cavity. However, the right arm of the IUCD was found to have completely perforated the myometrium with the tip of the arm present just above the urinary bladder. No free fluid was noted within the pouch of douglas.

She was counselled regarding pros and cons of an expectant management as well as surgical removal. As copper can cause intense peritoneal irritation, the patient opted for surgical removal. She was made aware of the risk of breakage of the embedded and perforated arm whilst removal under general anaesthesia which increased likelihood of laparoscopy or a laparotomy.

A peri-operative ultrasound scan under general anaesthetic confirmed findings. The position of the coil was carefully assessed to ensure appropriate traction in the right direction. The stem of the copper IUCD was grasped with an artery forceps and gently pulled downwards.

The entire IUCD was removed and almost total breakage of the right arm was noted. A repeat transvaginal scan was performed after 10 mins of removal to exclude any evidence of haemoperitoneum or bleeding into the endometrial cavity.

This case illustrates the importance of performing a routine transvaginal ultrasound scan prior to the insertion of an intrauterine device in modern gynaecological practice to identify a retroverted retroflexed uterus so as to minimise the likelihood of uterine perforation. In this very rare case of complete perforation of a single arm of IUCD, which increases the risk of breakage of arm whilst removal necessitating a laparoscopy or laparotomy, was avoided by perioperative transvaginal scan.
Intracranial hemorrhage (ICH) in term infants is a rare but serious complication with potential for adverse neurologic outcome and mortality. Previous studies have found that infants delivered by vacuum extraction (VE) have increased risk for ICH compared with infants born by non-instrumental delivery or cesarean section but the causal relations are unknown. We hypothesized that complicated VEs, including long extraction time, multiple pulls and cup detachments, may cause ICH in the newborn.

This case-control study included all VE-delivered infants diagnosed with neonatal ICH, born in Sweden at term during 1999-2013 (n=182). The controls (n=546), matched for hospital and year of birth, were delivered by VE and were not diagnosed with ICH. Detailed information on pregnancy, labor and delivery were systematically retrieved from medical records of both cases and controls. The main exposure, complicated VE, was defined on the basis of recommendations for VE as: extraction time >15 minutes, and/or >6 pulls to deliver the infant, and/or >2 cup detachments during extraction. Information was also collected on a number of co-variates. Data was analyzed using descriptive statistics and conditional logistic regression analysis.

Preliminary results indicate that non-compliance with recommendations for safe VE increases the risk for neonatal ICH, since a higher proportion of the cases had a complicated extraction including >15 minutes duration, > six pulls and >2 cup detachments. This reinforces the importance of compliance with VE guidelines.
Early skin-to-skin contact immediately after birth is recommended, according to the Child Friendly Hospital Initiative or the National Institute for Health and Care Excellence Guide "Cesarean section pathway." However, this measure is poorly implemented in hospitals for cesarean deliveries.

The objective of this systematic review is to analyze the factors that influence the establishment of this measure after a cesarean section in healthy newborns and to describe the benefits that it produces.

This study consisted of a systematic review of the literature, which examined current evidence on early skin-to-skin contact in cesarean deliveries at hospitals in different locations. Five articles from the well-known bibliographic databases "Pubmed", "Cochrane" and "Google Academic" were selected.

Skin-to-skin contact should be established immediately after cesarean deliveries and during the first two hours of the baby's life due to the observed benefits and not having contraindications in healthy newborns, offering to the father if contact with the mother is not possible.

This contact leads to a significantly better birth experience, the couple becomes an active part of birth as well as improved breastfeeding and early mother-infant interaction.
The experience of first birth has a major impact on professional socialization of midwives. Clinical placement is of great importance for gaining the knowledge, practical skills and attitude, as it forms individual's professional identity. Student midwives in Slovenia enter the labour ward settings in their first year midwifery programme, after simulation laboratory and one week of clinical training with university teacher in the practical setting.

A qualitative descriptive design was used. Written reflections of 29 first year student midwives were collected. Students were asked to write their reflections about their first birth seen in the labour ward placement and delivered the reflections in the week after their clinical placement. Data were analysed using an inductive thematic analysis approach. Informed consent was obtained from the students and the confidentiality was assured.

This study showed a lot of midwifery students see cesarean section as their first birth. This opens an issue how to provide students with the experience of physiological birth. The research opens up also a wide range of topics connected to empathy – how to preserve individuals sensitivity to woman's needs later in study and during a career? An area that was derived from the reflections was also the importance of mentors' stance, since through mentorship also attitudes are being perpetuated.
Women with previous subfertility may have different needs for post-partum care and support than women who didn’t experience this problem. There is little quantitative research available on the experiences of early post-partum care regarding person-centred care, a personal approach, and spending enough time on the woman. We compared women who find that they had a long-awaited pregnancy (LAP-group), to women who don’t think they had a long-awaited pregnancy (NLAP-group).

A quantitative study was conducted by analysing client questionnaires about the primary maternity caregiver (the midwife). The data were collected during the DELIVER study in 2009-2011 that included 20 midwifery practices in the Netherlands (n=7901). For inclusion (n=2715), responses had to be available on the grouping variable (“I have waited too long for this pregnancy”) and the outcome variables (”Overall satisfaction with care” and “Consumer Quality Index on obstetric care”). The results of the LAP-group (n=386) and NLAP-group (n=2329) were compared. The analysis included various socio-demographic characteristics such as age, parity, descent, income and education.

Women are generally very satisfied with the maternity care provided by the midwife in the early post-partum period. Despite that the sub-questions showed small differences between the groups regarding the communicative aspects of maternity care, we recommend that the primary maternity caregiver pays more attention to communication during post-partum support and encouragement, especially in women with previous fertility problems. This includes taking enough time and having a personal approach.
Neonatal birth weight is an important factor affecting not only perinatal morbidity and mortality but also maternal morbidity. Approximately in 1-10% of pregnancies, complications of fetal macrosomia develop. Excessive fetal weight is associated with many complications such as shoulder dystocia, brachial plexus injury, neonatal asphyxia, neonatal mortality, and maternal and fetal birth trauma. The present study aimed to investigate the effects of birth weight on maternal and fetal complications.

The present study is a retrospective record study. The study data were obtained from the medical records of women who gave birth in a training research hospital in İzmir, a province in Turkey, between 2011 and 2015 (n=58826). The study data were collected from the medical records of the women by using a questionnaire including items questioning their demographic characteristics such as age, gravida, parity, and birth weight. To analyze the data, the SPSS 16.0 statistical program, numbers, percentage distributions, mean values and the chi square test were used. To conduct the study, necessary permission was obtained from the institution where the study was to be conducted.

Statistically significant difference was found in the need for intervention (episiotomy, vacuum-forceps, cesarean section) when the birth weight exceeded normal limits. It is necessary for health personnel to know that several complications such as shoulder dystocia, brachial plexus injury, neonatal asphyxia, meconium aspiration syndrome, stillbirth, neonatal mortality, maternal and fetal birth trauma can occur during and after the birth process of macrosomic infants and to act accordingly.
Postpartum haemorrhage occurs in 5% to 10% of live birth. It’s the main cause of maternal mortality in France and an important cause of preventable death.

Our maternity has the technical Platform to perform uterine arterial embolization hemodynamically stable patients.

The aim of our study was to evaluate the practice of hemostatic surgery (arterial ligation, uterine compression or hysterectomy) when the embolization of uterine arteries won’t be performed.

We performed a retrospective unicentric study from the 1st of January 2010 to the 31st of December 2015, with all of the patients who had a postpartum haemorrhage in our type III universitary maternity.

From this group, we included the patients who had a surgical management by arterial ligation and/or uterine compression suture and/or hysterectomy.

We excluded the patients who didn’t need a second line management, or who did need arterial embolization without surgical management, and those who the medical file was incomplete.

With the computerized medical file we had collected the chronology of management, blood losses, transfusion, and maternal complications after surgery.

The hypogastric arteries ligation is the surgical intervention the most undergone in our study, in association with another intervention in 76% of cases. The uterine compression suture is associated with another surgical intervention in 79.3% of cases. Finally, the Tsirulnikov’s arterial ligation was performed as a unique intervention in 17.4% of cases.

The hysterectomy was performed as the first surgical intervention in 42% of cases, and after 1.8 others interventions for the others cases.
Caesarean section rates continue to increase worldwide. There is no known ‘correct’ rate, but according to WHO once it is above 10% there is no evidence for improved maternal or neonatal mortality, and the procedure carries significant risk. The Caesarean section rate in the UK was 27.1% in 2015-2016 compared to 24.1% in 2005-2006. Our unit had a rate of 28.5% in 2015-2016. We aimed to use the Robson classification system to help us to safely reduce our Caesarean numbers.

We initially compared the Robson classification for Caesareans performed in our unit in 2015-2016 with the data available from Robson et al from the National Maternity Hospital in 2011, using our online data collection system for all deliveries. We then retrieved the case notes for all non-elective Caesarean sections in Kingston Hospital in October 2016 for a more detailed analysis, to assess which groups in the Robson classification had high rates of Caesarean section and to further sub-classify these groups into reasons for Caesarean section. We used this overview of deliveries over a year and the snapshot of non-elective Caesarean sections in a month to develop strategies for our unit to reduce the Caesarean rate.

Robson classification system is a useful way to categorise Caesarean section rates.

We found the main contributing groups to our high Caesarean rate were Group 1 (nulliparous, single cephalic, >37/40, spontaneous labour), Group 2 (nullips, single ceph, >37/40, induced/CS before labour) and Group 5 (prev CS, single cephalic, >37/40). In Group 1 this was largely due to failure to progress first stage, in Group 2 failure to progress second stage and in Group 5 40% had declined VBAC.
Latent phase of labour is a period of time not necessarily continuous when women experience painful contractions and cervical changes up to 4 cm dilatation. Hospitalization often leads to a cascade of unnecessary interventions. The primary aim of this study was to investigate the association between admission diagnosis (latent phase vs active phase) and mode of birth. Secondary aim was to explore the relationship between hospital admission diagnosis and intrapartum intervention rates.

A retrospective, correlational study was conducted in a large Italian maternity hospital. Data from January 2013 to December 2014 were collected from the hospital electronic records. 1,446 low risk women, defined with spontaneous labour at term, single fetus with cephalic presentation and maternal age within 18-45 years, were selected. Women were dichotomized in two groups based on admission diagnosis: ‘latent phase’ or ‘active phase’ of labour. Latent phase is a cervical dilatation ≤ 2 cm in the presence of regular or irregular contractions; active phase is a cervical dilatation ≥ 3 cm in the presence of regular uterine activity, according to the local protocol.

Findings contribute to raise awareness on timing of hospital admission, management of early labour and how these may be associated with intrapartum interventions. Women admitted in early labor had higher probability to experience intrapartum interventions. Maternity services should be organized around women and families’ needs, providing early labour support, which enable women to feel reassured, delay their admission to hospital, avoiding the cascade of unnecessary interventions.
The aim of our study was to assess whether the eucapnic pH, the neonatal eucapnic pH at birth and others clinical and biological parameters at birth could be predictive factors of neonatal neurologic morbidity in case of an arterial cord blood pH less than 7.00.

Retrospective study in a university hospital by including all cases of arterial cord blood pH less than 7.00 between 01/10/2012 and 30/09/2014. The eucapnic pH was calculated by adding 0.08 pH units for 10 mmHg of pCO2 above 50 mmHg. The neonatal eucapnic pH at birth was obtained by the dedicated Excel module.

Our study did not validate the eucapnic pH and the neonatal eucapnic pH at birth as being predictive factors for neonatal neurological morbidity, unlike the Apgar score. However, all of these results require validation by a larger multivariate analysis.
The aim of our study was to classify intrapartum Caesarean Delivery (CD) in Group 1 of the Ten Group Classification System at the National Maternity Hospital, Dublin from 2005–2015. Currently there is no consensus on an appropriate classification system for intrapartum CD. The purpose of this classification is to stratify groups of women delivered by CD using a common objective clinical criteria. Subjective indications are reserved for use further along the hierarchical tree within the subgroups.

Data was gathered from our hospital’s obstetric database. The classification is based on the principle that CDs in labour are performed for one of two reasons: fetal reasons or labour dystocia. It divides dystocia into 2 groups: inefficient uterine action (IUA) or efficient uterine action (EUA) depending on cervical dilatation (\(≤1\text{cm/hr or } ≥1\text{cm/hr}\)). It differentiates between suspected fetal distress without oxytocin (Fetal) and with oxytocin (IUA/Inability to treat/Fetal Intolerance) & between IUA cases treated with maximum oxytocin (Poor Response) and those where maximum oxytocin was not reached because of over contracting (ITT/OC). It also allows for IUA cases not treated with oxytocin. EUA is subdivided into CPD and persistent malposition.

The intrapartum CD rate in Group 1 was low during the time period studied, with the biggest contributor being Dystocia/IUA/ITT/Fetal Intolerance. Applying this robust, replicable system to classify intrapartum CD enhances perinatal audit and allows for comparison between units. It also helps to focus modification of management on whichever subclassification is the biggest contributor to the rate of CD.
TOPIC: Others

ABSTRACT ID: 232

TITLE: THIRD- AND FOURTH-DEGREE PERINEAL TEARS - INCIDENCE AND RISK FACTORS IN AN ITALIAN SETTING

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Third and fourth degree obstetrical tears involve damage of anal sphincter. They can produce significant long-term morbidity such as fecal incontinence, dyspareunia, fistula and abscess formation. Great effort was given in last years in attempt to identify women at risk of developing severe perineal tears. However there are conflicting data about some other risk factors. This study aimed to identify risk factors for severe perineal tears in an Italian setting.

This retrospective study analyzed deliveries from January 2011 to December 2015. Data were extracted from dedicated software for antenatal care and intrapartum monitoring of a single Italian hospital. Singleton pregnancy, cephalic presentation and vaginal delivery after 20 weeks of gestational age were inclusion criteria. Patients who developed a 3rd-4th degree tear as consequence of the delivery were included in group A, otherwise in group B. Data regarding population characteristics, antenatal care, labour and delivery characteristics and fetal parameters were analyzed. Statistical analysis was performed with JMP statistical software. Pearson chi square test and Wilcoxon test were performed. A p<0.05 was considered significant.

Our experience confirmed that operative delivery and nulliparity are risk factors for severe perineal tears. Moreover we found out that moderate/severe obesity could be an additional risk factors for III and IV degree tears.
Breech presentation occurs in 3-4% of term pregnancies. Successful external cephalic version (ECV) reduces the number of caesarean sections (CS) as breech presentation is the third most frequent indication. A meta-analysis focused on EVC-related risks concluded that the pooled success rate is 58% and the pooled complication rate 6.1%. In our department ECV is offered to all women with foetal breech presentation near term to increase the probability to achieve an uncomplicated vaginal delivery.

All women who underwent an ECV at San Gerardo Hospital in Monza from 1986 to 2014 were included. ECV was performed in scheduled session by a trained practitioner on all consenting women at 37 or more weeks of gestation in absence of contraindications such as placenta previa, vaginal bleeding, non-reassuring fetal status, fetal anomalies and ruptured membranes. Relative contraindications were IUGR, oligohydramnios, uterine anomalies and previous uterine scar. On admission, ultrasound was performed to evaluate type of breech presentation, amniotic fluid volume and placental position. Tocolytics were used to promote uterine relaxation. Fetal CTG was completed before and after the procedure. ECV success rate and complication rate were recorded.

Provided procedures are concentrated in scheduled sessions after 37 weeks of gestation and performed by skilled operators using a consistent pre-procedure protocol (timing, ultrasound, CTG, tocolytics), CVE is safe and cost-efficient. It reduces by almost two thirds the rate of breech presentation at term, thus promoting vaginal delivery. We recommend to develop and maintain clinical expertise in ECV to minimize the risks associated with the procedure and increase its success rate.
Since the beginning of assisted reproductive technology (ART), the number of pregnancies achieved with in vitro fertilisation has increased.

ART associate more obstetrical and perinatal complications; low birthweight infants, preeclampsia, preterm delivery, diabetes and perinatal mortality.

The aim of this study is to analyse the obstetrical results in a private tertiary hospital in 2016, comparing spontaneous pregnancies versus pregnancies achieved with in vitro fertilisation (IVF).

We underwent a retrospective observational case-control study comparing pregnancy characteristics and perinatal outcomes in women with spontaneous pregnancy and women with pregnancy achieved with IVF, who delivered in our hospital in 2016.

In both groups we analysed age, duration of pregnancy, percentage of nulipary, percentage of twins, percentage of previous caesarean sections, body mass index, forceps and caesarean rates, inductions, severe perineal tears, Apgar under 7, NICU admission, maternal ICU admission, and postpartum haemorrhage.

Most of the patients who achieved pregnancy with IVF were nulipara and with an average age of almost 38. The caesarean rate is 58%, and 10.48% of IVF were twins, which contributed to the high caesarean rate.

However the IVF pregnancies have a good pronostic, because the number of newborns admitted at the ICU unit is not high. If the number of twins can be reduced, we will have less obstetrical and perinatal complications in the future.
The strategy of promoting a trial of labor after cesarean (TOLAC) in the eligible women is widely envisaged by international guidelines to decrease the risks of maternal morbidities and obstetric complications in future pregnancies favored by Elective Repeated Cesarean Section (ERCS).

We herein report the results of a targeted implementation of such approach at a tertiary care Centre.

Since 2014, at the Maternity Hospital of the University of Parma an antenatal clinic for women with a history of previous caesarean section (CS) has been set up. In this context a detailed assessment of the woman, including obstetric history and clinical examination, is performed at 36 weeks by a senior obstetrician and the option of TOLAC is offered to the eligible candidates. To analyze the impact of this new project in reducing Robson’s V class CSs, a six-year cohort study has been conducted. We prospectively collected data from the introduction of the TOLAC Clinic (2014-2016), and compared the VBAC rate with a cohort of Robson V class women who delivered in our Centre in three year period before (2011-2013).

A dedicated TOLAC Clinic seems to yield significant decrease of Robson’s V class CS rates. Previous vaginal delivery, including VBAC, cervical dilation > 4 cm before the previous CS and an appropriate birthweight are the strongest predictors for a successful TOLAC.
It is estimated that 85% of women suffer some perineal trauma during vaginal delivery. There are several identified factors that can increase the risk as well as the preventive described actions.

Objective: To identify risk factors and preventive measures for third and fourth degree perineal tears based on the current literature.

A bibliographic search has been carried out in the main databases from 2010 to 2015 period using the following keywords: Perineum, Prevention and Control, Perineal Trauma and Anal Injury.

The obtained data has allowed us to know and identify different preventive and effective measures for the perineal trauma manipulation.
Most of women from our environment who use epidural analgesia during labour spend most of the time lain down, for this reason we consider the importance of knowing the risks and benefits of adopting different positions. OBJECTIVES: Know the different positions that women can adopt with epidural analgesia during the labour and its benefits.

A bibliographic research has been carried out through the following sources: PubMed, The Cochrane Library, The Cochrane Plus, CUIDEN, Tripdatabase and Scielo during 2011-2016 period using the following key words: analgesia, anaesthesia, birth position and labour positions. A total of 403 articles were obtained, which due to selection criteria appliance (5 years old and primary revision through the title and abstract) only 14 are analyzed.

The mobility of the pelvis during labour with epidural analgesia is a tool that favours the empowerment of women and increases their confidence, so we should encourage them to adopt the position they prefer.
This prospective cohort study investigated and describes a method of audit for the total oxytocin dose given over the duration of labour and its effects in terms of fetal tolerance, uterine muscle response and labour outcome in 905 spontaneously laboring single cephalic nulliparous women at term (SSCNT) in a single institution. Dystocia was diagnosed when cervical dilation was <1 cm/hr over 2hrs and in the second stage by lack of rotation and descent. The treatment was oxytocin.

There were 426 women treated using oxytocin in the 1st stage of labour. The mean cervical dilation at commencement of oxytocin was 2 cm (SD 1.58). In all cases oxytocin was commenced at a rate of 5 μU/min with a maximum of 30 μU/min. The mean dose of oxytocin given over duration of labour to women with dystocia diagnosed in the 1st stage of labor was 3661 mU (SD 2899) median 2550 mU [75 mU-18750 mU]. Mean duration of treatment was 393 mins (SD 244) [60-869]. Administration in accordance with the oxytocin regimen would allow a dose of 7680 mU over 393 mins to be given. 50% of women reached the maximum dose according to the regimen. The number who maintained treatment at max dose decreased to 9.1% (39/426) at 1 hour, 5.8% (25/426) at 2 hrs and 2.8% (12/426) at 4 hrs.

The effects of the given dose of oxytocin to any woman range from fetal compromise, uterine tachysystole to no effect. Women delivered by CS for fetal intolerance were sensitive to oxytocin at a much lower dose than those delivered for poor response. Women who were delivered by CS for over contracting did not receive the maximum dose over their labour. This method of audit could be replicated elsewhere to elicit the optimum oxytocin regimen for the treatment of dysfunctional labor in the SSCNT.
Pre-induction cervical ripening greatly influences the outcome of induction of labor (IOL). It is an artificial initiation of labor before its spontaneous onset for the purpose of delivery of the fetoplacental unit. Many factors are associated with its success in postdatism. The aim of this study is to further compare the efficacy of Laminaria sticks and Foley’s catheter for cervical ripening.

We performed a retrospective cohort study of pre-induction cervical ripening progress among of 104 women with a singleton pregnancy with the full-term period of gestation, vertex presentation, intact fetal membranes. The period of study was from 1/01/2015 to 31/12/2016 at the D.O. Ott Research Institute of Obstetrics and Gynecology, Saint-Petersburg, Russia.

All women were equally randomized into 2 groups: in 1 group (46 women) we used 3 to 9 intracervical Laminaria sticks, in 2 group (58 women)—Foley’s catheter with volume between 50ml to 80ml. There were 11 clinical cases of beginnings with the Laminaria sticks and endings with the Foley’s catheter. We included in study also women who used oral Misoprostol during pre-induction cervical ripening.

Foley’s catheter provides a significant change in Bishop’s score, greater success rate of cervical favorability, higher frequency of IOL. Both methods have been shown a good Bishop’s score dynamics of cervical ripening but the difference between Laminaria sticks and Foley’s catheter methods is: Laminaria sticks were used more with unfavorable and almost favorable cervixes (Bishop’s score<6) when Foley’s catheter is started to use mostly with favorable cervixes.
Morbidity adherent placenta (MAP) is increasingly common as caesarean section rates increase. This presents a unique set of challenges to obstetricians as morbidity from MAP is high. Increasingly they are developing techniques to minimize complications associated with MAP. The Triple P procedure is an approach which reduces operative blood loss and reduces the need for hysterectomy. Until now no subsequent pregnancies are reported in women who have undergone the Triple P procedure.

A 30 year old woman in her sixth ongoing presented to our services at 11 weeks of pregnancy. She had had five previous caesarean sections, the last of which was diagnosed as a posterior placenta accreta with documented invasion of the placenta into the right broad ligament. In that pregnancy delivery was planned and undertaken at 36 weeks in our tertiary fetal medicine unit using the Triple P procedure. During that time she declined sterilisation but was counselled extensively against future pregnancy. Eighteen months later she presented to our centre where a dating scan showed a singly intrauterine pregnancy with a posterior low placenta. The patient was counselled and risks of further MAP were discussed. Subsequent review at 16 and at 20 weeks gestation failed to show an evidence of morbidity adherent placenta. Further imaging at 32 weeks was also reassuring, but showed the estimated fetal weight to be on the 10th centile. This persisted and an elective caesarean section was planned at 38 weeks. An uncomplicated lower segment caesarean section was performed with minimal blood loss recorded.

We present the first case of pregnancy following Triple P procedure. Whilst pregnancy following previous MAP remains possible, in many cases women will have undergone hysterectomy. We await more longterm data before advocating women actively pursue pregnancy having undergone the Triple P Procedure.
Neonatal encephalopathy occurs in 3 per 1000 infants born at term and is commonly due to hypoxia–ischaemic insult around the time of delivery. The incidence has not changed in the past decade with some of the causes being unavoidable.

The objective of this study is to undertake a multidisciplinary structured review of all cases of neonatal encephalopathy to determine the proportion of potentially avoidable morbidity and mortality and to identify themes for quality improvement.

The total number of babies diagnosed with hypoxic-ischemic encephalopathy born between April 2015 and March 2016 in a 6000 delivery/year maternity in the UK was identified by cross checking the reported numbers by risk team and by ‘running’ the relevant codes from the medical coding department. A total sample population of 17 babies was identified and the risk reports, clinical notes and discharge summaries, laboratory results, scan reports and cardiotocography (CTG) traces were reviewed and discussed in a multidisciplinary team. When available the CTG traces were reviewed and classified by FIGO and type of hypoxia.

The incidence of HIE at Kingston maternity follows what is described in the literature. Neonatal encephalopathy is a brain disorder with a variety of causes, not always caused by an hypoxic-ischemic event. In the population studied in a cord pH <7.05 was present in 29% of the cases. The challenge of obstetricians remains how best to recognise those babies at risk of intrapartum hypoxic insult, with intrapartum fetal heart monitoring remaining the main focus of the potential avoidable cases.
Robson's classification system proposes a global standard for assessing, monitoring and comparing cesarean section rates. It permits comparison of rates in specific healthcare facilities during certain periods of time and between different facilities.

We observed in our maternity during 2015 that group 2 in Robson's classification was one of those with higher relevance in the increase of the cesarean global rates. Our purpose was to reduce these cesarean rates for this group during 2016.

All inductions in the Hospital Universitario General de Catalunya during 2016 were monitored in a prospective form. To that end, internal clinical meetings discussed weekly all inductions scheduled and the results on inductions made during the week before. Meetings discussed mainly whether induction was appropriate, weeks of gestation, parity and cervical maturity. Finally, obstetric results were also evaluated, mainly delivery way and perinatal results.

Robson’s classification permits to identify groups with higher contribution to the cesarean global rates. Specific measures to reduce the significance of a group can be initiated once they are identified.

Cesarean rates in group 2 have decreased significantly. In our opinion, it is due to the evaluation of all patients in this group by our medical team. However, it is necessary to continue pushing on the improvement of this indicator because we are yet above the desirable rates.
Sleep disturbances are common during pregnancy, yet underdiagnosed and under-investigated. Assessment of sleep quality is clinically relevant in view of the previous findings that sleep disturbances may be associated with an increased risk for adverse pregnancy or delivery outcomes. We investigated sleep quality during pregnancy focusing on insomnia, nocturnal breathing problems and sleepiness.

A total of 2949 pregnant women from the FinnBrain Birth Cohort Study were studied three times prospectively during pregnancy. Sleep quality was assessed in early, mid-, and late pregnancy (gestational weeks/gwks 14, 24, and 34, respectively) by using the Basic Nordic Sleep Questionnaire (BNSQ). Responses regarding insomnia symptoms, sleepiness symptoms, and breathing problems were dichotomized to represent clinically significant problems. To analyze the changes in sleep variables between the pregnancy stages, McNemar’s test was used to compare dichotomous variables.

Our study is in keeping with previous findings that general sleep quality declines as pregnancy proceeds. Using a detailed sleep questionnaire, we further suggest that sleep onset insomnia, sleep maintenance insomnia and snoring worsened as pregnancy proceeded. However, no increase in negative daytime consequences was found, presumably indicating a compensatory capacity against pregnancy-related sleep impairment.
Primary postpartum haemorrhage (PPH) is commonly defined as a blood loss of 500 ml or more within 24 hours after birth. PPH can be minor (500-1000ml) or major (more than 1000ml). PPH is the leading cause of maternal mortality in low-income countries and the primary cause of nearly one quarter of all maternal deaths globally (WHO).

The objective is to review the latest recommendations to predict and prevent PPH according to the main guidelines in this field.

A systematic review of the main databases (Cochrane Library, EMBASE, Trip, MEDLINE and PubMed) was performed, restricting the search to articles published between 2006 and 2016. Furthermore, the latest guidelines from the principal organizations were selected (WHO, RCOG, FIGO, ICM, NICE).

There is no evidence that the uterine massage (a classical maneuver after delivery) contributes to prevent PPH, according to research.

The early clamping of the umbilical cord should be avoided before than 1 minute from the delivery of the baby because of the benefits for the new-born.

Reducing the PPH incidence is possible just following a few simple recommendations and all women giving birth should be offered uterotonics during the third stage of labour.
TOPIC: Intrapartum fetal monitoring

ABSTRACT ID: 253

TITLE: Development an Obstetrics Decision Support System based on expert system approach

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Medical decision support systems have continuously received the interest of medical community because Information Technology has become very familiar and nowadays doctors and medical staff are able to have access to health data and health systems using either laptops, PDAs or their mobile phone.

In this work, we present the development of an Obstetrics Decision Support System (ODSS) to support the Obstetrician during the labor and to suggest the best decision to select between performing a CS or a ND. The ODSS has been developed using the expert systems methodology by experienced obstetricians who have described their decision making process using the rule based method: IF ‘there is Indication 1’ and “Indication 2 is medium” then “Do Action 1”.

The ODSS has been developed and tested in real cases and the results are very promising.
The majority of women associate childbirth with intense pain. Several studies suggest that maintaining vertical positions can help to make this process more bearable. Birth ball exercise, such as swiss-ball, fit-ball, can be an effective complimentary tool during the pregnancy and childbirth insomuch that it can help to keep verticality and as such, reduce pain.

The objective of this review is huge to show the birth ball exercise provides effective aid and increased wellness during childbirth.

A literary review of articles published between 2006 and 2016 in the following databases was carried out: Cochrane Library, EMBASE, Trip, MEDLINE and PubMed.

The clinical implementation of the birth ball can be an effective aid for women in childbirth.

More rigorous and randomized clinical tests are needed to consolidate the effects of the birth ball in the alleviation of pain relief.
INTRODUCTION: Overt hypothyroidism in pregnancy is associated with adverse outcomes, though the effects of subclinical hypothyroidism and isolated hypothyroxinemia on pregnancy outcomes is still controversial. Subclinical hypothyroidism might be associated with preterm delivery, low Apgar score, fetal death and miscarriages and isolated hypothyroxinemia with preterm labor, high birth weight and neurocognitive deficits in children.

METHODS: In a total of 469 pregnant women, third trimester serum was assayed for thyroid-stimulating hormone (TSH) and free thyroxine (free T4). Thyroid hypofunction was defined as 1) subclinical hypothyroidism with TSH levels above 3mIU/L for the 3rd trimester and free T4 between the 5th and 95th percentiles and 2) isolated hypothyroxinemia with TSH levels below 3mIU/L for the 3rd trimester and free T4 below the 5th percentile. The results were associated with birth weight, week of labor and history of miscarriages. Patients with thyroid hypofunction were compared with euthyroid patients (TSH and free T4 between normal limits). The results were analyzed with T test.

CONCLUSION: In our study, we did not find a link between subclinical hypothyroidism and adverse pregnancy outcomes. Similarly, hypothyroxinemia was not associated with the majority of pregnancy complications. However, it was associated with higher birth weight.
Cervical pessary placement to treat cervical shortening is controversial and multiple randomized clinical trials published in the last several years have shown conflicting results.

Pessaries’ proposed mechanism of action involves changing the uterocervical angle, in order to avoid uterine weight being directed towards the cervix. Moreover, cervical pessary placement, particularly the Arabin pessary, prevents cervical dilatation, deterioration of the mucous plug, and membrane exposure.

The purpose of this study is to present the results regarding the role of cervical pessary use to prevent preterm birth in clinical practice, based on our two-year experience. We included pregnant women with cervical shortening (<20mm) and absence of contraindications to the use of a cervical pessary, such as uterine contractions or genitourinary infection. These high-risk women were selected based on their higher probability of preterm birth, in spite of relevant obstetric background and gestational age at which cervical shortening was diagnosed. These women were admitted to the hospital, and reevaluated after a few days of bed rest. If preterm birth risk was still high, the cervical pessary was placed, if no contraindication was found.

Results show that cervical pessary placement in high-risk pregnancies, was able to extend pregnancy in most cases, reducing preterm birth and increasing gestational age at birth, thus reducing associated perinatal morbidity and mortality. As interventions aiming to reduce the risk of preterm birth in cervical shortening show conflicting results, cervical pessary use could be an option in such cases. However, more studies and larger population samples are needed to corroborate these results.
Maternity Dashboards are valuable monitoring tools for visual representation of maternal and neonatal outcome data: enabling monitoring of performance and benchmarking, providing timely feedback, guiding areas for improvement and training. Despite widespread use in high resource settings, there is minimal literature on use in low/middle resource settings, where morbidity and mortality rates are often higher.

Aim: to develop a Maternity Dashboard for the Philippines, a middle resource setting

The Philippines PROMPT Project is a feasibility study implementing multi-professional obstetric emergencies training and dashboards in seven pilot hospitals. Course facilitators from each unit attended a 2-day Maternity Dashboard Training Programme, designed to train them to develop and implement a Dashboard.

2 interactive sessions enabled the teams to develop key quality indicators. Each unit compiled a list of process and outcome indicators relevant to their clinical practice. The lists were pooled and the teams voted for the indicators they wanted to include. An iterative cycle of voting rounds was employed to select the most popular indicators.

Teams of multi-professional training facilitators developed indicators for a Maternity Dashboard for use in the Philippines. Following this training, each team will set individual targets for each indicator and implement the Dashboard into their units within six months. This will be the first Maternity Dashboard developed for use specifically in a middle resource setting. Involving local clinicians increases the likelihood of successful implementation and local ownership of this tool.
Diazepam, brand name Valium, is a benzodiazepin that is commonly used as an anxiolytic, sedative and antiepileptic drug. It is used also in obstetrics mainly during labor. When taken in late pregnancy Diazepam can cause withdrawal syndrome in the neonate and sedation. It appears in many clinical studies for the last 40 years especially in the treatment of prolonged labor. In the obstetric patient, in our country, diazepam is used off-label during the onset of labor and the active stage of labor.

We conducted a clinical analysis of the use of Diazepam in preeclamptic women in labor. All patients were primigravida, at term with gestational hypertension or mild preeclampsia, with cephalic presentation and intact membranes, with no fetopelvic disproportion and no uterine scar, with BMI < 30, with misoprostol induced labor and no epidural anesthesia. Two doses of 10 mg of Diazepam were administered intramuscular during the first stage of labor.

We assess the duration of the first stage of labor, the rate of cervical dilatation, maternal blood pressure values, neonatal outcome, adverse reactions. The potential effect of Diazepam on pain relief was not evaluated. The results were compared with a control group with the same features.

Diazepam during labor leads to faster and more effective dilatation of the cervix. Its use in the dose administered in our study is safe for both mother and infant.

The use of Diazepam during labor in women with preeclampsia is an option of active management of labor to consider in these cases.
Fetal arrhythmias are benign in most cases and occur in as many as 1% to 3% of all pregnancies. Diagnosis and fetal condition assessment are only possible based on ultrasonography and echocardiography. But in some cases, arrhythmias are first detected by cardiotocography (CTG). Careful interpretation of CTG in this cases and further evaluation with ecocardiography is required.

We present the case of a 31-year-old pregnant woman, with three previous normal deliveries of healthy children. Current pregnancy course was uneventful, with normal ultrasound at 20 and 35 weeks of pregnancy. She came to the emergency room in labour at 39 weeks of pregnancy. CTG at the beginning had normal baseline with accelerations and some ectopic beats were identified. Internal fetal monitoring was indicated and, as the patient reached full dilation, CTG become uninterpretable due to very frequent premature atrial contractions (Figure 1). It was expected prompt delivery, so ecocardiography was not possible, although no signs of major cardiac abnormalities were identified by ultrasound. The patient delivered vaginally a healthy boy, 3150 g, apgar score 9/10 (first and fifth minutes) and normal fetal cord blood pH (7.25).

At six hours of life an ecocardiography revealed atrial septal aneurysm, mild tricuspid insufficiency and patent ductus arteriosus. Frequent premature atrial contractions were observed. Follow-up was scheduled at 18 days of life, two and seven months. In this last appointment, ecocardiogram was normal and the patient was discharged to primary care pediatrician.

Cardiotocography is the "gold standard" to monitorise labour. However, in cases of fetal arrhythmia it can be difficult to identify fetal heart beats. If possible, an ecocardiography is required in case of a new detected arrhythmia, but if there is no possibility due to several causes, a basic ultrasound to rule out severe conditions is adviseable.
Labour pain is one of the most severe pains which has ever been evaluated and its fear is one of the reasons women wouldn’t go for natural delivery. Considering different factors which affect experiencing pain, this study aims to identify and analyse qualitative literature to explore women’s expectations and experiences of pain and its coping during childbirth.

It was developed by a systematic review on the principal databases (Cochrane Library, MEDLINE, EMBASE and PubMed), restricting the search to articles published between 2006 and 2016.

This review concludes that women would like to be attended by health professionals who promoted continuity of care and an acceptance of pain as part of normal childbirth. To deal with childbirth pain successfully and get greater satisfaction with the experience, antenatal educators would need to ensure that pregnant women are appropriately prepared for what might actually happen, limiting this expectation-experience gap.
Due to low specificity of the CTG, alternative methods for fetal monitoring have been developed. Antepartum fetal monitoring by non-invasive fetal electrocardiogram (NI-fECG) could be an alternative for obtaining a CTG and fetal ECG. Low signal amplitudes from the foetal heart and electrical insulation due to vernix caseosa formation are challenges to overcome. In this study we perform 100 antepartum NI-fECG measurements. Here, we report the application of antepartum NI-fECG in four cases.

The antepartum measurements described in this abstract were performed in the MMC Veldhoven, a Dutch tertiary referral center. In eligible women visiting our outpatient clinic or women admitted to our obstetrics ward an adhesive patch containing 8 ECG electrodes (Parides Atlantis, Nemo Healthcare BV) was placed on the maternal abdomen simultaneously with scheduled CTG with Doppler Ultrasound. Measurements were performed between 24 to 42 weeks of gestation. Total monitoring lasted for 30 minutes. From the recordings a CTG and fetal ECG (fECG) were extracted.

The aim of this study is to improve the algorithms of our measurements by detecting technical difficulties in several stages of gestation before labour is initiated. The known insulating effect of vernix caseosa formation between 28 to 37 weeks of gestation is one challenge we aim to overcome. Together with other technical difficulties encountered during the measurements of this new method, a pool of essential information is created towards clinical implementation.

We report four clinical cases selected in different stages of gestation, with specific difficulties to overcome each term. The selected cases have gestational ages around 25 weeks, 30 weeks, 35 weeks and 40 weeks, and will show valuable information about the development of NI-fECG measurements.

First measurements have recently been conducted and the results of the cases will be presented at the conference.

These four cases show the clinical application of NI-fECG for several stages of gestation. For each case the fetal heart rate (FHR) signal quality and signal loss of the NI-fECG will be compared to the FHR measured by the Doppler ultrasound. If possible, we will also analyse the specific fECG waveform characteristics. We continue on refining our algorithms throughout this study. The results will be presented at the congress.
Empowerment in pregnancy is defined as increasing knowledge for health decision making [1]. Despite the high prenatal care expenditure, United States ranks 33/179 countries for maternal health [2]. Empowering expectant moms is recommended to improve maternal health [3] and providing quantitative data on pregnancy could help in making informed decisions. This study investigates if Bloomlife, a pregnancy monitor tracking and counting contractions, can empower pregnant women in their 3rd trimester.

Women were recruited at Freyja Medical Clinic (Redwood City, CA) between 28 and 32 weeks gestation and were randomized into experimental (BL) or control group (CT). BL used Bloomlife from week 32 to delivery, at least once a week. All of them received standard prenatal care and signed an informed consent. They filled the Pregnancy-related Empowerment Scale (PRES, [4]) at week 32 (pre) and 36 (post), scoring each item on a 4-point Likert scale. Descriptive statistics were calculated for participant’s characteristics, PRES items and subscales (E1: Provider connectedness; E2: Skillful decision-making; E3: Peer connectedness; E4: Gaining voice) and sum score. Differences between groups were evaluated using T-test (a=0.05).

Empowerment reduces pregnancy issues and helps women to correctly approach those that may arise. This study explored if a smart pregnancy monitor automatically tracking and counting contractions, could increase body awareness. The results showed that women using Bloomlife for one month felt more respected by their healthcare provider and reported increased awareness of doing their best to have a healthy baby, while CT reported lower scores on both these aspects, consequently reducing empowerment.
Pregnancy anxiety is defined as worries and fears about pregnancy and child [1]. Many women experience it [2], especially during the third trimester[3], impacting labor outcomes. Technology can help by providing objective physiological data about pregnancy [4,5]. Bloomlife is a smart pregnancy monitor automatically tracking and counting contractions and making this information available to pregnant women. This study investigates if Bloomlife decreases pregnancy anxiety during the third trimester.

Women were recruited at Freyja Medical Clinic (Redwood City, CA) between 28 and 32 weeks gestation and were randomized into experimental (BL) or control group (CT). BL used Bloomlife from week 32 to delivery, at least once a week. All of them received standard prenatal care and signed an informed consent. They filled the pregnancy related anxiety questionnaire revised 2 (PRAQ-R2, [6]) at week 32 (pre) and 36 (post), scoring each item on a 5-point Likert scale. Descriptive statistics were calculated for participant’s characteristics, PRAQ-R2 subscales (F1: Fear of giving birth; F2: Worries about not healthy child; F3: Concerns about appearance) and sum score. Differences between groups were evaluated using T-test (a=0.05).

We investigated if Bloomlife, a smart pregnancy monitor automatically tracking and counting uterine contractions, can impact pregnancy anxiety and we found that concerns about appearance and anxiety reduced for women using it during the third trimester, while they increased in control group. This may be due to the objective information gathered through Bloomlife which increases awareness and provides reassurance to expectant moms. However, further studies are needed to validate this assumption.
Caesarean section is the major obstetric surgery, rates are increasing worldwide. The rate of caesarean section varies not only between different countries but also between different hospitals. The caesarean section rate has risen from about 3% in the 1950s to 15% in the mid-1990s. In 2015, the Health and Social Care Information Centre published NHS maternity statistics reporting that the caesarean section had risen to 26.2% for 2013–14.

OBJECTIVES

» To identify the rate of primary cesarean section

» To put forth recommendations to reduce the rate of primary cesarean section

METHODS

Settings: Al Corniche Hospital (Tertiary care Maternity Hospital), Abu Dhabi, United Arab Emirates

Population: Population consisted of pregnant women who have a singleton pregnancy with vertex presentation, at term and have not had a prior caesarean birth.

Study Design: It is a prospective study. All primary caesarean sections were reviewed on a monthly basis during the period of February 2016 till November 2016. Data collected from electronic medical records. A current version of Microsoft Excel is used to input the data.

Primary caesarean section rates decreased from 27.8% to 13.2%. In review, use of fetal blood sampling in abnormal CTG when appropriate and the use of partogram to diagnose delay in labour resulted in higher vaginal delivery. Recommendations during review were, all primary caesarean sections be discussed during grand rounds. Practice of fetal blood sampling and training to be continued. Introduced education on CTG. Bishop’s score done in induction of labour. Partogram must be activated in labour.
Relationship between pregnancy and natural course of cervical lesions is still much debated. The aim of this study is to describe the association between mode of birth and the natural course of cervical lesions defined as: regression (High Squamous Intraepithelial Lesion - H-SIL to Low Squamous Intraepithelial Lesion - L-SIL or H-SIL to negative Pap-smear or L-SIL to negative Pap-smear) or progression (L-SIL to H-SIL or H-SIL to Carcinoma In Situ), according to Bethesda classification.

A retrospective cohort study was conducted in an Italian maternity department. Data were collected from the medical records of pregnant women with abnormal cervical cytology who underwent a colposcopy between January 2006 and December 2015. A sample of 61 women, with available data on delivery and cytological exams, has been taken. Data collection included demographics, mode of birth and cervical pathology. Natural course of cervical lesions was analyzed in relation to the mode of delivery.

Childbirth process has a key-role in the natural course of lesions: spontaneous regression rate is high with non significant differences associated to the mode of delivery. Our study showed that the regression of the cervical lesions occurs more frequently in the postnatal period than in non-pregnant women: the main reason of this phenomenon could be explained with the physiological modifications of the cervix during pregnancy, labour and delivery.
Labor induction is a common practice procedure. But using pharmacological and mechanical methods for labor induction can increase complications. Complementary and alternative medicine methods could be a safe alternative option for inducing labor. The use of complementary therapies is increasing with the aim to have the most physiological labor as possible.

The objective is to review the evidence available about non-pharmacological methods for induction of labor.

It was developed by a review on the principal databases (Cochrane Library, EMBASE, Trip, MEDLINE and PubMed), restricting the search to articles published between 2006 and 2017. The latest guidelines from the principal organizations were consulted (WHO, RCOG, FIGO, ICM, NICE).

MESH: labor, induced; complementary therapies; acupuncture.

There is no studies of acceptable quality about non-pharmacological methods for induction of labor.

The evidence available suggested that acupuncture, acupressure, shiatsu, chamomile, hypnosis and breast stimulation could be useful to stimulate contractions.

Until safety issues have been fully evaluated it should not be used in high-risk women.

Evidence from randomized control trials is required to evaluate the effectiveness and safety of this non-pharmacological methods for labor induction.
The Robson Ten Group Classification System (RTGCS) is increasingly being used worldwide to compare rates of mode of delivery. It has been less used to examine perinatal outcome. The aim of this study is to suggest a method of using the RTGCS to assess perinatal mortality and morbidity. In particular, the rates of stillbirths (SB); intrapartum deaths (IPD); early neonatal deaths (NND) and rates of hypoxic-ischemic encephalopathy (HIE).

Data were retrospectively collected from contemporaneously written annual reports of a tertiary teaching maternity hospital in Dublin, Ireland for a 10 year period from 2005 to 2014 with an annual birth rate of 9000 deliveries. Rates of: stillbirths (infants born with no signs of life after 24 weeks gestation and/or weighing >500g birth), intrapartum deaths (death of an infant during labour), early neonatal deaths (death of a liveborn infant in the first 7 days of life) and rates of hypoxic ischemic encephalopathy (infants >37 weeks gestation with evidence of neonatal encephalopathy in the first week of life with evidence of metabolic acidosis in arterial blood or umbilical cord samples) for all infants during this time period are included.

As recommended by the World Health Organisation and as increasing numbers of countries worldwide implement the RTGCS to compare induction and rates of mode of delivery, it is important to remember that other perinatal outcomes can, and should, be analysed using the same system. This will allow focussed interventions on prospective groups of women to take place depending on local results.
Postpartum period goes from delivery until six weeks after it. Hospital stay after delivery usually varies according to type of delivery and peripartum complications' occurrence. Although rarely, complications may occur and they can be severe enough to motivate a new admission to the hospital. Actually, postpartum readmissions are an important quality indicator of care. Bearing that in mind, we aimed to analyze postpartum readmissions in our hospital in order to improve women’s healthcare.

We collected data from all readmissions in a period of thirty days after discharge in CMIN’s Puerperium department between January 2014 and December 2016. We excluded twin pregnancies and postpartum readmissions of deliveries outside our facility. Data collected included mother's information, pregnancy, labor and new-born characteristics as well as readmission motive and treatment performed. These data were analyzed using IBM SPSS Statistics 21 and compared with a control group of 130 women who haven’t been readmitted and which delivery took place in the same period in our facility.

Thereafter, readmissions’ incidence in our facility are comparable with others described in literature. Readmissions’ group was found to have more nulliparous women, women who had a previous caesarean section or who underwent a caesarean section, low 5th minute Apgar classifications, higher birth weight, higher percentage of episiotomies and intrapartum fever. Caesarean sections were also found to be associated with longer hospital stay on readmission.
The dynamic of maternal, perinatal and infant mortality rates is the very basic index which reflect the state and efficiency of obstetric and neonatal medical healthcare organization in any region of the world. In Russian Federation these indicators have been significantly reduced from 17,3, 9,98 and 7,4 to 10,7, 8,29, and 6,5 respectively for previous 5 years by 2016. Nevertheless, these rates in Russia are still higher than in our neighbors — Nordic countries.

In order to test a direction needed to reduce the intrapartum and neonatal mortality the retrospective study of evaluation of intrapartum deaths and neonatal near-miss cases was performed in one of the North-West Russian region. There were 229 (1,17‰) cases of the intrapartum deaths in the period from 2012 to 2014. Only 131 (57%) medical records were available for evaluation, while others were inaccessible due to court investigations. The retrospective analysis of 56 cases neonatal near-miss of term liveborn with severe asphyxia (Apgar score 5 or less on 5 minute (0,95‰), which required a hypothermia) was taken in 2015.

Prevention of intrapartum fetal losses and newborn’s near-misses are the major challenges in modern obstetrics. An accurate gestational age estimation prior to induction of labour, partogram using for detection of labor obstruction, FIGO CTG evaluation recommendation, CTG in the 2nd stage of labor, shorting the time from pathological CTG patterns to emergency delivery, training of instrumental vaginal delivery, personal and team training could be a way to achieve better outcomes in the future.
Low umbilical cord pH at birth is a measure of perinatal asphyxia, associated with mortality and morbidity in the neonatal period and beyond. Neonatal care continues to advance, with techniques such as therapeutic hypothermia now well established. In this context, an arterial pH ≤7.0 might no longer be an indicator of poor outcomes. The objective was to evaluate neonatal outcome parameters in our recent consecutive series of babies born with umbilical cord pH ≤7.0 and a base deficit (BD) ≥12.

Retrospective review of cases in Royal Gwent Hospital, Newport, approximately 4000 deliveries per annum. For 4 years from January 2012, all births with cord blood pH ≤7.0 and BD ≥12 were identified from the blood-gas analyser on the delivery suite. Cord blood was taken from a double-clamped portion of umbilical cord immediately after birth and processed. Antenatal, neonatal and paediatric clinical notes were reviewed, along with Magnetic Resonance Imaging (MRI) results and childhood follow-up. Hypoxic ischaemic encephalopathy was graded using the Sarnat score as mild (HIE 1), moderate (HIE 2), or severe (HIE 3). Six babies were excluded; 2 were stillborn, 3 died from congenital abnormalities and 1 transferred out of area.

The majority of babies born with acidosis at birth did well with >96% having no persisting neurological sequelae. Good outcome was strongly associated with the absence of or mild (Grade 1 HIE). More than half of babies with Grade 2 HIE also had a good clinical outcome. This is important and relevant information for counselling parents.
Perinatal asphyxia is a major cause of long-term childhood morbidity and has long been predicted by fetal acidosis determined by umbilical cord pH. It's thought to occur more frequently with pH≤7.0, a commonly used target by which obstetricians assess their performance. Currently existing observations are inconsistent and more evidence is needed to determine the validity of this association. This study aims to evaluate the association between umbilical cord arterial pH≤7.0 and long-term outcomes.

We retrospectively analysed all babies born from January 2012 to December 2015, at Royal Gwent Hospital, Newport with umbilical cord pH ≤7.0. All umbilical cord gases with pH ≤7.0 were obtained from the cord gas analyser on the main delivery unit via biochemistry. 7 babies were excluded; 1 who was transferred to another hospital, 2 stillbirths and 4 early neonatal deaths of which 3 were diagnosed with genetic or developmental defects and 1 who had severe perinatal asphyxia with care withdrawn on day 3 of life. In total 196 babies were included in analysis. Perinatal and paediatric clinic follow-up information was collected from online clinical portal databases.

This study does not support the claim that cerebral palsy occurs more frequently with an arterial cord pH ≤7.0 when only one (0.5%) of the babies developed cerebral palsy. This study shows that arterial cord pH ≤7.0 alone has a low association with childhood morbidity with 94.9% of the babies having normal long-term development. This highlights that we should be looking for different parameters as targets to assess our performance on labour ward.
Babies are often separated from their mothers at birth; this situation is more prevalent in women who give birth by cesarean section. Skin-to-skin contact improves breastfeeding and also the transition to the outside world for babies. Hospital of Mollet is sensitized in the promotion of humanized childbirth as well as in the promotion of breastfeeding. For this reason, this hospital offered to some women who gave birth by cesarean section to do skin-to-skin contact as soon as possible

Aim: Describe perinatal results of women who make skin-to-skin contact during caesarean section at Mollet Hospital.

Specifics: Evaluate the feasibility of the procedure in our environment.

Design: a retrospective study of a series of cases

Participants: The procedure was offered to three women attended with medical indication of caesarean section. Two of them were when the dilatation process did not evolve correctly and the other one by an elective caesarean section in December 2016.


Skin-to-skin contact in cesarean section is a safe procedure in our case, for both the mother and the newborn, and can contribute to improve in the satisfaction of women, without hindering the work of professionals. This pilot test allows us to establish a protocol for all pregnant women who meet the inclusion criteria. The future work hypothesis is that skin-to-skin contact may increase effective breastfeeding
The rising CS rate is concerning and vaginal delivery is associated with less morbidity. The CTG is also criticised as it has had little impact on the cerebral palsy rate and has increased the CS rate. The poor specificity of the CTG in detecting fetal hypoxemia and acidosis is problematic. Because of the inaccessibility of adjunctive tests in resource poor settings, it is unavoidable that the decision to perform a CS for fetal reasons is made on the CTG alone.

The aim of this study was to determine how many CS were performed on the background of normal or suspicious CTG traces. This study was conducted at Tygerberg Hospital, a referral hospital for high risk pregnancies in Cape Town, South Africa, performing 7300 deliveries per year. Ethics approval was in place.

Emergency CS performed during February 2014 were analysed where the written indication for CS was related to a CTG abnormality. Incomplete records were excluded. Demographic data were entered on Excel. A 30 minute strip of the CTG trace correlating to the time when the decision for CS was made was copied and all identifying data removed. The CTG strips were independently analysed by a professor not involved in the study.

Over half of the CS performed for fetal indications had CTGs assessed as normal or suspicious, meaning these CS may have been avoided. However, it is likely that other factors were considered in the decision for CS bearing in mind the high risk sample. The high DDI and good neonatal condition at delivery reflect the fact that many CTGs were normal. Ongoing work should be directed towards CTG interpretation in the labour ward and improving the DDI in cases of fetal compromise.
Budd Chiari Syndrome (BCS) is defined as congestive hepatopathy due to obstruction of the hepatic venous flow. BCS, which is reported rarely during pregnancy and has various diseases in its etiology; Behcet’s disease, oral contraceptive use, polycythemia, antiphospholipid or idiopathic cases. The BCS associated with the pregnancy is usually seen in the early postpartum period. In this case report, we reported a case with Budd Chiari syndrome that developed on the 6th postpartum with cesarean section.

28-year-old woman, gravida 3 parity 2 patients with recurrent cesarean section, 36 weeks 1 day pregnancy is present. An urgent cesarean decision is made on the increase of cervical dilatation on vaginal examination. Blood pressure arterial 130/60 mmHg, pulse 84 beats/min, fever 37°C, respiratory rate 20/min. None of laboratory and ultrasonography findings were special. No specific feature during cesarean section. No post-operative features in follow-up, laboratory values were normal. On the 6th day after the operation, she presented with abdominal pain and dyspnea. Laboratory findings: Hb: 6 hct: 16 plt: 245000 wbc:18000 glu:109 creatine: 0.55 Ast:458 alt:521 t.protein: 5.6 alb:3 APTT: 28.8 pt:16.8 inr:1.35 fibrinogen:402 D-dimer:3.29 Pathologic findings in abdominal ultrasonography were: In the size of 195 * 156mm, which holds a large area in the right lobe of the liver, a current lesion in the RDUS was observed. Blood and lung tomography taken on these findings: Hypodense areas in liver subcapsular hematoma?Bleeding?Pulmonary embolism was ruled out. Subcutaneous injection of 0.6 cc clexane was initiated. Emergency laparotomy was performed with a diagnosis of liver hematoma laceration due to distant vision in the abdomen, a tendency of AST / ALT to increase and exacerbation of right upper quadrant pain. In the operation which is performed with general surgery, Budd chiari syndrome was diagnosed. The patient was scheduled for intensive care unit treatment with Budd Chiari syndrome.

With this case, it is important to remind that young patients who are admitted in the early postpartum period may have rarely encountered fatal diseases under non-specific complaints and to emphasize the importance of antithrombotic therapy by calculating thromboembolic risk factors of the patient following post-cesarean postoperative period.
One of the most critical aspect in midwifery is the appropriate diagnosis of established labor. The Active phase is a cervical dilatation of $\geq 4$ cm with regular contractions. A different approach to recognise the onset of labor involves the observation of maternal signs (behaviour, posture, physical signs...). The aim of the research is to investigate the association between maternal signs and the two phases of the first stage of labor (latent vs active) before the women’s hospital admission.

A cross-sectional study was conducted in an Italian Maternity Unit on July 2016. 66 observations were collected to evaluate the onset of labor during triage assessment in women with uterine contractions, single pregnancy at term, cephalic presentation, age $\geq$ of 18 years. The evaluation was performed by a midwife using a collection form with different items: 11 variables (abdominal palpation, uterine activity, maternal behaviour, fetal movements, pain localisation...), described by few qualifiers. Every single observation involved also a vaginal examination to diagnose the active phase of labor. Chi square test was performed to associate each variable to the latent or to the active phase.

The diagnosis of active phase, due to its major importance for the childbirth process, should allows time to observe the woman and to assess both vaginal dilatation and maternal signs. We found that some of these are more predictable to be present during established labor, therefore they should be implemented into midwifery practice. Further research are planned to provide a score at the end of the collection form, to enhance the Midwife’s skills towards the diagnosis of the active phase.
Robson Ten Group Classification System (RTGCS), promoted by WHO as the ‘global standard’, has gained a wide acceptance in its use, allowing the comparison intra- and inter-institutional setting, to reduce the CS rate.

To ascertain the potential contributing role played by maternal characteristics and epidural analgesia (EA) administration on CS trend in the Groups 1 and 3 of the well-defined Robson Ten Group Classification System (RTGCS) in an Italian university hospital setting.

A secondary analysis in a previous cohort, including a total of 12 098 deliveries in four (1998, 1999, 2010, 2011) of a 13-year period was performed and directed to Groups 1 (nulliparous women with singleton cephalic full-term pregnancy, in spontaneous labour) and 3 (multiparous women with singleton cephalic full-term pregnancy, in spontaneous labour) of RTGCS. A longitudinal comparison between Period I (1998-1999) and Period II (2010-2011) for Groups 1 and 3 was accomplished in agreement with EA demanding, satisfied from 2002 by an appropriate clinical protocol.

Though RTGCS allows easy identification of the leading contributing patients groups, additional information about maternal characteristics and AE administration should be evaluated in women with singleton cephalic full-term pregnancy and in spontaneous labour.
Birth is an important turning point in the lives of many women. The delivery experience is positively perceived by some women whereas for some others it is traumatic. Supportive midwifery care which aims at actively assisting the woman delivering, meeting emotional needs and providing comfort. Supportive care in labor also includes avoid disturbing behaviors, comfortable behaviors, provide information and education.

This is a descriptive study. The participants are 325 women who had given vaginal birth in Aydin Maternity and Pediatric Hospital of the Health Ministry between March-May 2016. Data were collected in postpartum 24 hours with a form which defines the socio-demographic and obstetric features of the woman and the Scale for Perception of Supportive Care Given to Woman in Labor developed by Uludağ and Mete (2013). This scale consists of three subscales: education, comforting behaviors and disturbing behaviors.

Women who have low income and unemployment are perceive more supportive care in labor.
Non-asthmatic chronic lung diseases are uncommon and potentially harmful in pregnancy. Pregnant women have lack of adaptive respiratory capacity and higher risk of respiratory failure. Determining the most appropriate route of delivery for lung-impaired patients may be challenging, since they may present limiting dyspnea, poor abdominal muscle tone and may need supplemental oxygen. Herein, we analyze our casuistic of route of delivery for pregnant women with complex pneumopathy.

Retrospective chart review of singleton pregnant women with complex pneumopathy followed from 2005 to 2017. We collected data regarding labor onset, route of delivery, frequency of instrumental vaginal delivery, gestational age at delivery, Apgar scores, and newborn weight. All patients had at least one spirometry on the course of pregnancy. Predicted Forced Expiratory Volume in 1 second (FEV1) and Forced Vital Capacity (FVC) were considered. Patients were classified into 3 groups according to route of delivery (Normal Vaginal, Forceps, Cesarean Section). Kruskal-Wallis nonparametric test was applied for comparing spirometric results from different groups of delivery. Statistical analyses were performed using IBM SPSS software version 20.0.

Our results corroborate the feasibility of vaginal delivery for lung-impaired patients, since even women with potentially severe complex pneumopathy could achieve an uneventful vaginal delivery. Moreover, our data suggest no association between severity of spirometric lung impairment and route of delivery or instrumental vaginal delivery. Specialized clinical and obstetrical care during pregnancy and labor are pivotal to determine the safest route of delivery for chronic lung disease patients.
Pregnant women go to many ways to ease the normal birth process. Some foods can make birth easier. The date fruit (Phoenix dactylifera) is one of the birth-facilitating foods. Some studies showing that date fruit can help birth. This fruit benefits related to labor are due to the effects of herbal estrogens and oxytocin-like effects. Date fruit contains saturated and unsaturated fatty acids. Fatty acids providing and reserving energy, contribute to prostaglandin provision; therefore, it can be helpful in saving energy and strengthening uterus muscles. It also contains hormones which help the uterus contractions.
Introduction: Although splenic artery pseudoaneurysm (SAP) is a rare pathology, risk of SAP rupture is 10 times higher than with true splenic aneurysm (TSA). SAP is associated with pancreatitis, trauma & peptic ulcer. Rupture of TSA or SAP has high maternal and foetal mortality rate. Rupture occurs more often in women of childbearing age and up to 95% during pregnancy. Therefore, ruptured TSA or SAP should be considered as a differential diagnosis during pregnancy with unexplained abdominal pain.

Case description: A 36-year-old pregnant woman (gravida 2, parity 0) was referred to the emergency department after an episode of loss of consciousness with nausea, vomiting, dizziness, and mild lower abdominal pain. She was 13 weeks pregnant and mostly healthy although an episode of pancreatitis has been reported previously. On arrival, she was normotonic (120/90 mmHg) with tachycardia (135-145 x/min), SpO2 98-100% on room air. Laboratory analysis revealed haemoglobin 11.9 g/dL, platelet count 281,000 cells/mm3, leucocytosis 21,800 cells/mm3, C-reactive protein 1.6 mg/L. Eight hours later her symptoms progressed, peritoneal signs appeared and haemoglobin declined to 9.7 g/dL. Transabdominal ultrasound showed hemoperitoneum with a single intrauterine pregnancy with an active foetus. She directly underwent to an exploratory laparoscopy but the definite origin of bleeding was not found and laparoscopy was converted to open laparotomy. A ruptured SAP was found and sutured, splenectomy was not performed. Postoperatively the patient was hemodynamically stable, recovered quickly and was discharged after 6 days. Emergency caesarean section was performed at 29 weeks gestation because a risk of premature delivery, prematurely ruptured amniotic membranes, fetal distress (proved by meconial amniotic fluid and cardiotocography) and breech position. A live premature girl with Apgar scores 2 and 7 was born and admitted into neonatal intensive care unit.

Conclusions: We report a case of a successful treatment of ruptured SAP during pregnancy. Rupture of SAP should be considered during pregnancy as a life-threatening event with catastrophic prognosis for mother and child.
Maternal satisfaction is one of the most important outcome in the evaluation of quality of the maternal services. The BSS-R is a 10-item self report scale to assesses women’s perceptions of birth in order to determine women’s satisfaction with their birth experience. The primary aim of this research was to achieve the cross-cultural and conceptual equivalence of the BSS-R tool in italian.

The WHO method, which involves a forward translations and a back translation, was used to translate and adapt the BSS-R instrument in italian. According to the WHO guidelines we went through the following steps: 1) forward translation by a midwife 2) expert panel of 3 midwives experienced in health, translation and research followed by a Back-translation; 3) Pre-testing and cognitive interviewing involved 100 italian women during the postnatal period, representative of those who will be administered the questionnaire; 4) Final version in italian.

The BSS-R is the first italian tool to evaluate the maternal satisfaction of the women’s birth experience. Further researches are needed to validate the scale in the italian contest. The interviews were an opportunity for midwives to explore the maternal satisfaction with childbirth and the quality of the midwifery care.
WHO stated (1985): “the rate of cesarean section (CS) shouldn’t exceed 10-15%”. Arrested labor is one of the major contributions for increasing CS rate. Recent evidence established new labor curves. Understanding factors, which can influence normal labor progression and its outcomes, is of utmost relevance. The main purpose of this study was to relate uterine contractions (UC) frequency and duration of active and expulsive phases with type of delivery, medication, and maternal and neonatal variables.

Retrospective study in a tertiary hospital using a previously selected population of 148 women in labor with singleton vertex term pregnancy. UC frequency (average number of UC/10-min segments (UC/10m)) and duration of active (≥6 cm dilatation (Tact)) and expulsive (≥10 cm dilatation (Texp)) phases were analysed as dependent variables in multiple linear regression models. Model A: maternal (obesity, weight gain, diabetes, previous vaginal delivery) and neonatal (newborn’s gender, weight (NW) and head circumference (HC)) characteristics and type of delivery (vaginal/vacuum/CS) were considered as independent variables. Model B: previous vaginal delivery, spontaneous labour, newborn’s gender, type of delivery and intrapartum medication were analysed as independent variables.

Decrease in UC/10m among obese women may be real or a result of poor signal acquisition (no impact on labor progression/type of delivery). Positive relation between CS and greater Tact translates frequently observed but still unexplained labor progression abnormalities. The influence of salbutamol can be seen as a consequence of its use in situations of uterine hyperstimulation. Possible association between higher NW/HC and longer Tact/Texp can be further explored in the future with a larger sample.
Previous cesarean section is known to increase probability of further cesarean birth. Vaginal birth after cesarean section (VBAC) is known to be safe enough to be considered in case of spontaneous labor, but challenge comes when there is a need to terminate pregnancy in this group of women. Elective cesarean birth is an option, but it is not exempt of risk, so we want to consider if induction of labor can be a safe enough option in selected patients.

We performed a retrospective observational case-control study among women with one previous cesarean section who gave birth in our hospital during 2015 and 2016. We excluded patients undergoing elective cesarean section, and we included women admitted for induction of labor (case) and with spontaneous onset of labor (control). We compared rates of cesarean section and forceps and perinatal outcomes in both groups (NICU admission, postpartum hemorrhage, maternal intensive care, Apgar<7 and major tears).

In the case group (induction of labor) we compared type of birth between women with and without cervical ripening with dinoprostone.

Induction of labor in selected patients doesn’t increase probability of adverse perinatal outcomes more than spontaneous onset of labor without significant differences.

Despite the fact that our cohort of patients is limited, induction of labor could be a safe option for a carefully, selected patients. Probably further studies are needed.
TOPIC: Induction and augmentation of labour

ABSTRACT ID: 295

TITLE: Cervical maturation with Foley catheter after previous cesarean section - casuistic of a tertiary hospital

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Considering the cesarean rate in Portugal, it is important to discuss about labor induction in pregnant women with previous cesarean section. When cervical conditions are unfavorable, one of the possible methods for labor induction is the use of a Foley catheter.

The main purpose of this study was to evaluate the success of labor induction with Foley catheter. Secondarily, we aimed to find characteristics predictive of success.

Retrospective study that included pregnant women with previous cesarean section in whom the method chosen for induction of labor was Foley catheter. The induction of labor was between 01/01/2014 and 31/08/2015.

For the statistical analysis, STATA v12 (Stata Corp. Texas, EUA) was used, and to analyse continuous and categoric variables we used, respectively, T-student and chi-square tests.

The use of Foley catheter allowed that 37.8% of pregnant women that could have been submitted to another cesarean section had a vaginal delivery. The history of a previous vaginal delivery increased the probability of success.
Pemphigoid gestationitis is a rare pathology, with an incidence between 1/1700 and 1/50000 pregnancies, usually in the 2nd and 3rd trimesters, with a benign course.

We present a clinical case of a pregnant women that presented with pruritus associated to eritematous bullae in the abdominal region, with one month of evolution. A skin biopsy was performed and topical betamethasone was prescribed.

In the follow up study, there was positivity for rheumatoid factor, anti-nuclear antibodies and anti-SS-A antibodies. The fetal echocardiogram was normal. The skin biopsy was inconclusive and another biopsy was performed. As the lesions worsened, progressing for superior and inferior limbs, and taking into account the imunulogical results, the patient initiated oral prednisolone.

The diagnostic hypothesis considered were Pemphigoid gestationis or Subacute bullous lupus erythematosus.

At 35+1 weeks of gestational age, there was the diagnosis of intrauterine growth restriction with cerebro-placentar ratio<5th percentile, with oligohydramnios. Also, there was the suspicion of preterm premature rupture of membranes. An elective cesarean section was performed as it was a breech presentation.

After delivery, the cutaneous lesions significantly improved, and there was histological confirmation of Pemphigoid gestationis (linear expression of complement 3 at the basement membrane zone, patognomic sign of this pathology in a pregnant woman).

As in the clinical case presented, there is an association of Pemphigoid gestationis with intrauterine growth restriction and prematurity. There is a high risk or recurrency in a future pregnancy, as well as a 25% risk of flare associated with the use or oral contraception or during menses.
Cancer during pregnancy is rare and its diagnosis is difficult and sometimes delayed. The most common complication for the pregnancy itself is iatrogenic prematurity.

We present a clinical case of a 37-years-old pregnant women, without any relevant previous medical history, that went to the emergency room at 22 weeks of gestational age complaining of dry cough since two months before. Additional symptoms were progressive dyspnoea, left posterior pleuritic thoracic pain and no weight gain despite being pregnant. She had been given oral antibiotic without any improvement.

A CT scan showed a left shift of the mediastinum, a 64 mm mass in the left inferior pulmonary lobe, with air bronchogram next to the hilum and reticulum accentuation (interpreted as lymphangitic carcinomatosis), and pleural effusion. The citology of pleural effusion was positive for malignant cells (adenocarcinoma).

The patient was transfered to a tertiary hospital, where the diagnosis of stage 4 lung adenocarcinoma, Alk+, was confirmed. With the progression of the disease, pleural, subcutaneous, peritoneal and bone metastasis were identified. Due to deterioration of clinical status, an elective cesarean delivery was performed at 30+2 weeks of gestational age. During surgery, there was confirmation of intraperitoneal carcinomatosis. The anatomopathological exam of the placenta showed presence of metastasis.

In the postpartum period crizotinib was initiated but as the disease progressed, carboplatin and pemetrexed were prefered. There was a progressive deterioration of the clinical status and the patient died 4 months after initiating treatment.

It is important to reeber that for the same age and cancer stage, the prognosis is not different from the non pregnant women. Treatment can be initiated but if the prognosis doesn't change, it is acceptable to delay its begging until the postpartum period. A multidisciplinary approach is extremely important.
'PRES' is a relatively rare condition that’s commonly linked with hypertension or pre-eclampsia. Symptoms include headache, seizures, visual disturbance and cortical blindness. Its pathogenesis is thought to be due to disturbed cerebral auto-regulation leading to increase vascular permeability of the posterior circulation. This review of cases will hopefully demonstrate how this condition can manifest in different ways and the importance of early recognition in achieving a good outcome.

Case 1:

20 year old, primigravida induced at 38 weeks’ gestation for pre-eclampsia. She achieved a normal vaginal delivery and her blood pressure remained well controlled throughout. Following delivery, she complained of intermittent blurring of vision that preceded to complete loss of vision and confusion. Examination revealed total loss of vision bilaterally with normal neurology and optic fundi. MRI confirmed changes consistent with PRES. Fortunately, she regained her vision after 8 hours.

Case 2:

22 year old, primigravida was admitted 36 weeks’ gestation following a presumed eclamptic seizure in the community. Once stable a decision was made to deliver by Caesarean Section. Following delivery, the patient remained abnormally confused, irritable associated with intermittent blurring of vision. No other neurological findings were demonstrated. Later an MRI confirmed the diagnosis of PRES. She made full recovery and was discharged following a formal neurological review after 7 days.

Case 3:

A 28 year old presented 4 days following a normal delivery with symptoms suggestive of an eclamptic seizure. She continued to suffer from headache and blurring of vision 24 hours after the episode and therefore an MRI head was requested. The MRI changes seen were diagnostic of PRES.

'PRES' should be considered as a potential differential diagnosis in women presenting with the symptoms discussed. MRI imaging is diagnostic, typical findings include bilateral white matter changes in the posterior regions, mainly within the parietal and occipital lobes.

A multi-disciplinary approach is key and early recognition is important in reducing the potential development of neurological sequelae of the condition in the absence of treatment.
Intrauterine growth restriction has many possible causes and the most common is placental insufficiency. It is frequent in multiple pregnancy and can be associated with perinatal morbidity and mortality.

We present a clinical case of a 28-years-old women, primiparous, with multiple pregnancy. She had class 2 obesity and essential chronic hypertension of difficult management during pregnancy. At 22 weeks of gestation, at urinalysis, erythrocytes casts, proteinuria and leucocituria were identified, raising the diagnostic hypothesis of primary renal disease agudization. The diagnostic exams that followed did not confirm this hypothesis, so preeclampsia was considered. At 24 weeks, intrauterine growth restriction was diagnosed in both fetuses (1st and 0.4th percentiles) with umbilical artery (UA) pulsatility index (PI) > 95th percentile with intermittently absent end diastolic flow and uterine arteries PI > 95th percentile, with bilateral notch, and so the patient was hospitalized. Taking into account the poor prognosis of the clinical situation, the couple decided for an expectant management, knowing that intrauterine death could happen. There was worsening of maternal renal (nephrotic proteinuria) and hepatic function, and progressive deterioration of both fetuses, with estimated weights 95th percentile, middle cerebral artery PI < 5th percentile and oligohydramnios. One of the fetuses had ductus venosus PI > 95th percentile, with normal a-wave. There was intrauterine death of both fetuses at 28+1 weeks of gestation. After delivery, there was a gradual and significant improvement of maternal condition.

There are no established screening to identify fetuses in risk of developing intrauterine growth restriction. Beyond fundal height and weight gain, hard to evaluate in an obese pregnant women, it would be important to define a set of biomarkers that taken into account with maternal and fetal biophysical characteristics, namely fluxometry, could help us to identify fetuses at risk.
Adolescent pregnancy incidence has been declining over the past few years largely due to increasing use of contraceptive methods. However, births to adolescent mothers still represent 10% of births worldwide and account for 23% of maternal morbidity and mortality. In Portugal, data from 2015 reported an incidence of approximately 2.2% of births to teenage mothers, a significant decline since 2008 (4.2%), but still above average in Europe.

Data concerning all deliveries of women until the age of 18 (inclusive) at our medical centre between January 2015 and December 2016 were collected. In order to obtain an equal number of control cases, data from all women older than 18 years accompanied in low risk pregnancies consult and with delivery in the same period, were introduced in Excel® and randomly selected. Statistical analysis using IBM SPSS Statistics 21 was then performed considering various demographic and clinical parameters including profession, coitarche, delivery mode, need for episiotomy and risk of lacerations, maternal or foetal gestational and post-partum complications and risk of preterm labor and foetal growth restriction.

As described in literature, pregnant teens in this population were more likely to be students and unmarried, initiate intercourse sooner and have a vaginal delivery. However, we did not find an increased risk of instrumented delivery or of maternal and foetal complications. Adolescence is a unique stage in women’s development and therefore it is imperative to acknowledge the risks and needs of this population in order to obtain the best outcome for the mother and the newborn.
Pelvic floor disorders include pelvic organ prolapse, urinary incontinence, and fecal incontinence. Urinary incontinence is more common during pregnancy. Urinary incontinence symptoms resolve in many women after delivery or the postpartum period, but some will have persistent symptoms.

We present a case report of a pregnant woman, 29 years, 39 weeks, G1P0, admitted in first stage of labour. Her sister underwent surgery because of the urinary incontinence at 30 years old. Vacuum-assisted vaginal delivery with epidural anesthesia. Male newborn, weighed 3210g, Apgar score at first minute 10 and fifth minute 10. In the postpartum was diagnosed with urinary incontinence. The cystourethroscopy reveal normal coaption of the sphincter, normal bladder and ureteral meatus, without fistulous paths.

The diagnosis was stress incontinence. The case was evaluated by urology and physiatry. At the hospitalar discharge we recommended kegel exercises. An appointment was scheduled to urology, gynecology and physiatry.

After one month, the stress incontinence symptoms were present. Pelvic examination reveal a well-healed episiotomy without evidence of organ prolapse, with a positive stress test for urinary incontinence. Biofeedback was recommended. Six months after delivery there was a significant improvement of symptoms of urinary incontinence. Treatment options were discussed. Given the improvement in symptoms with conservative management, the surgery was canceled.

Pregnancy and delivery likely contribute to pelvic floor injury due to compression, stretching, or tearing of nerve, muscle, and connective tissue. Initial treatment includes lifestyle modifications and pelvic floor muscle exercises for all patients with urinary incontinence. Those that receive biofeedback are more likely to report improvement or cure of urinary incontinence. Patients without adequate relief should be referred to consider other options.
Delayed-interval delivery describes the attempt to stop labour in twin pregnancies after the birth of the first twin aiming at improving the outcome of the second twin by reaching a higher gestational age. We report two cases of diamniotic, dichorionic twin pregnancies who presented with preterm premature rupture of membranes (PPROM). After vaginal delivery of the first twin a cerclage was placed in both cases and the pregnancies were prolonged for several weeks until the second fetus was born.

Both women presented in 2016 with a PPROM of the first twin at the University Hospital in Lübeck, Germany. The first patient was a 37-year-old gravid 2 para 0 with PPROM at 18+5 weeks of gestation. Both twins were alive at admission. She was treated with antibiotics but otherwise expectant management. After a progressing cervical dilation with repeated umbilical cord prolapse, the first twin was born dead 18 days later in 21+2 weeks of gestation. On the same day a cervical cerclage was placed. Pregnancy was prolonged for 47 days with treatment of antibiotics and tocolytics. A course of corticosteroids was given for lung maturation. At 28+0 weeks a cesarean section was performed because of suspected chorioamnionitis. A boy with 1095g was delivered, who could be released from neonatology department two months later.

The second patient was a 34-year-old gravid 1 para 0 who presented with PPROM and a cervical dilation of 3cm at 22+6 weeks. We treated her with tocolytics, antibiotics and betamethasone for lung maturation. Despite tocolytic therapy the first twin was delivered vaginally ten days later at 24+2 weeks. It was a boy of 590g. A cervical cerclage was placed in his mother one day later under continued tocolytic therapy. Pregnancy was prolonged for another 33 days. A cesarean section was performed at 29+0 weeks because of suspected chorioamnionitis. A boy with 1460g was delivered. Both twin brothers were released from our neonatology department after 5 and 2 months.

Delayed-interval delivery is an option in selected cases of diamniotic, dichorionic twin pregnancies who present with PPROM or preterm labor before or around the limit of viability. This treatment option may only be chosen after intensive information and discussion with the families about risks and chances for both twins. In our two cases, pregnancy could be prolonged for 47 and 33 days after vaginal delivery of the first twin, which dramatically improved the outcome of the second twin.
Rhesus hemolytic disease in newborns is very rare nowadays due to prevention with RHOGAM in Rhesus negative women after abortion, missed abortion, early invasive genetic diagnostic procedures and delivery.

We present a baby that is conceived as second child of Rhesus negative mother whose first child suffered from severe jaundice due to Rhesus hemolytic disease but who refused to take RHOGAM after delivery for religious reasons. In second pregnancy high level of specific antibodies was detected so intrauterine exsangvinotransfusion occurred twice successfully but third attempt resulted with premature birth in 30 GA. After delivery baby got three transfusions for severe anaemia and spent a month in the neonate care unit due to intensive care and treatment with phototherapy. She was dismissed with weight 2000 g, length 47 cm and HC 32 cm and Hb 96 g/l RBC 3,14 HCT 29,8. We continued therapy of anemia with per oral therapy and succeeded in correction of anemia. On the same time the child was under early neurodevelopment treatment as severe anemia itself and prematurity together can cause delay in development.

Due to fetal monitoring and prenatal therapy of Rhesus hemolytic disease and afterbirth prompt transfusion and later on per oral therapy of anemia and early neurodevelopment treatment, we can avoid neonatal problems and
Hydronephrosis refers to distension and dilation of the renal pelvis and calyces. Structural abnormalities of the junctions between the kidney, ureter, and bladder that lead to hydronephrosis can occur during embriogenesis/first eight weeks after conception/

We have made prospective clinical study including term newborns hospitalized from different reasons after discharge home from delivery room but coming to the Institute for Children s and Youth Health Care of Vojvodina from various health problems

Our aim was to diagnose the percentage of congenital hydronephrosis in population of hospitalized newborns at our department for ill term babies during a 6 year period

From 2010 to 2016 in total 1071 newborns were hospitalized at our department due to high fever, sleepiness and poor feeding (62% male and 38% female)

Almost half of them / 439 / were diagnosed as urinal infection due to puss in urine, positive urine culture with significant number of bacteria, mostly E coli and high CRP. Ultrasound scan revealed hydronephrosis in 67% of them.

In this particularly group of neonatal patients, one third of them were not diagnosed prenatally They did prenatal ultrasound examination of fetus before 28 th week of pregnancy but two thirds were diagnosed prenatally in last four weeks of pregnancy

Unfortunately none of them got advice to check urine and urine culture after they were dismissed from delivery department but only the advice to make regular check up and control ultrasound scan at one month of age Meanwhile infection occurred and they were hospitalized as ill babies

After antibiotic treatment, they went home with advice to regularly examine urine and urine culture once a month, to repeat ultrasound scan of kidney and to do urological consultation

It is important to regularly do prenatal ultrasound scan after 32 week of pregnancy when even mild hydronephrosis can be detected, to point out the importance of postnatal ultrasound scan and laboratory test of urine and urine culture in perinatal or early neonatal age

These measures will diminish number of urine infections in this group of newborns and avoid complications as neonatal sepsis and renal failure in older age are
Postpartum hysterectomy is considered an obstetric emergency. Incidence varies between 0.13 and 5.38 per 1000 births. The most common indication is abundant hemorrhage that cannot be controlled by conservative measures. It should be noted that postpartum hemorrhage is one of the main causes of maternal mortality. Although more frequent in women with specific characteristics as abnormal placentation, fibroleiomyomas or previous cesarean, hysterectomy may be necessary after any type of delivery.

VP, 29 years old, healthy. Previous history: appendectomy, umbilical herniorrhaphy and eutocic term delivery 10 years before, without complications.

Current pregnancy monitored. Third trimester ultrasonography with fetal growth restriction led to induced labor at 38 weeks. Active phase of labor started 12 hours after beginning induction and 50 minutes later a precipitate eutocic delivery occurred, with first degree laceration. Newborn with 2195g. Procedures uneventful. After 15 minutes an abundant hemorrhage began despite medical therapy. Evaluation confirmed laceration of the right border from the cervix to the vagina. Trachelorrhaphy and laceration suture were performed, with blood loss reduction.

Puerpera evolved with paleness, hypotension, tachycardia, oliguria and hemoglobin (Hgb) 7.1g/dl. Transferred to the Intensive Care Unit, patient only allowed blood transfusion 2 hours later. Instrumental revision of the uterine cavity was performed, with extraction of clots.

After 4 hours patient was still unstable with new abundant blood loss (Hgb 3.2g/dl, 135000 platelets, coagulation time increase). Surgery revision was performed and a uterine balloon tamponade was placed.

Six hours later puerpera was in hemorrhagic shock (Hgb 7g/dl, 57000 platelets). Emergent laparotomy found a massive retroperitoneal hematoma and tearing of the vaginal, cervix and uterine posterior wall which led to a total hysterectomy.

Patient was discharged on the 9 day of puerperium, clinically stable.

This clinical case of a healthy woman with an uneventful pregnancy and a eutocic delivery without apparent immediate complications recalls that situations that lead to greater maternal morbidity and mortality, such as postpartum haemorrhage, do not happen only after dystocic delivery or delivery with surgical intervention. Therefore, we should always maintain a high state of alert in the immediate postpartum, paying attention to all possible delivery complications.
Labor induction rate has doubled for the past two decades worldwide. Most common indications for labor induction are: postterm pregnancy, preeclampsia, diabetes, premature ruptures of membranes, fetal growth restriction, Rhesus isoimmunisation, fetal demise. In some cases induction should be decided with caution: multiple pregnancy, hydramnios, grand parity, obesity, minimal pelvic distocia, post myomectomy scar, macrosomia.

We performed a retrospective study over 2 years – 7048 births, of which 3031 vaginal deliveries, of which 1031 after induced labor. The tracked parameters of the various methods of labor induction were: onset and length of labor, side effects and complications, fetal outcome, failure of induction. Methods of induction: misoprostol tablets by vaginal route, Misodel, amniotomy and oxytocin, calcium and estradiol. The modified Bishop score was used, induction was performed only at a score of 6 or greater.

Labor induction rate in our hospital was similar to international rate. Prostaglandin using method was highly effective in inducing labor and there was also a shorter time interval between latent and active phase. The rate of side effects and complications in labor induction was low and there was a good mother and infant outcome with induced labor. The C-section rate was high with the calcium-estradiol method and very low with prostaglandine released dispositives for vaginal administration.
In the world literature the numerous studies have shown the benefits of vaginal birth after cesarean (VBAC) versus repeat CS. However the frequency of VBAC in Russian Federation is only 5-8%. At the same time the number of pregnant women with an operated uterus is 8-10% and is steadily increasing. The purpose of this research was to study the clinical efficiency of labor induction (LI) in pregnancies with a uterine scar.

Retrospective study included the 367 deliveries. Spontaneous labor occured in 60 (41,7%) cases. LI was conducted in 84 (58,3%) patients at the term of 40 weeks of pregnancy. Amniotomia was performed for LI in 39 cases with the cervix ripeness ≥8 Bishop Score (BS); 5 cases (12,8%) required oxytocin infusion. Intracervical Foley catheter was used in the cases of cervix ripeness 6-7 BS for labor preinduction in 45 women (53,6%) with the "maturing" cervix, however labor began without amniotomia in 9 (20%) women. Elective repeat CS was preferred in cases with the cervix ripeness ≤5 at term.

The success of VBAC depends on the maturity of the cervix. The induction of labor by amniotomia is effective in 87% (34) women with the "mature" cervix; the further stimulation of labor by oxytocin is necessary in only 13% (5) patients. Labor began after cervical ripening using a Foley catheter in one of five women. The subsequent amniotomia in women with the "maturing" cervix is effective in 80%, however the stimulation of labor by oxytocin is necessary in one of ten women among them.
A delivery in the limit of fetal viability (between the 22 and 26 weeks) is an enormous clinical challenge due to a great fetal and maternal morbi-mortality, which in the last decades have improved significantly. The decision regarding the delivery route (vaginal or surgical) should be made in the best interest for both patients considering each clinical situation. The aim of this study is to evaluate if survival rate and neonatal morbidity are associated to delivery route in this population.

A retrospective cohort study was performed including all deliveries occurred in the limit of viability attended in a tertiary hospital in Madrid from January 2013 to December 2016. We defined “limit of viability” as any delivery occurring between the 22nd and 26th week of pregnancy. All data regarding maternal background, pregnancy follow-up and medical care offered to these patients were extracted from the digital clinical records. A $X^2$-test was used to analyse differences in the proportion of survival by the possible risk factors, delivery causes and obstetric interventions. A logistic regression test was used to find potential predictors of survival. All statistical calculations were performed using the STATA 13.1 for Windows.

Perinatal mortality was not associated to delivery route in our cohort, although it showed a clinically significant difference in multiple gestations in favour of CS. No specific cause or obstetric intervention was statistically associated to survival. The best predictor of survival was a neonatal weight >750 grs. Based on these data, obstetric management should consider fetal weight instead of gestational age, although more studies are needed to achieve the best available clinical evidence.
The purpose of our study was to determine whether meconium-stained amniotic fluid is associated with puerperal infection and whether the quality of the meconium is further associated with the severity of infection.

We designed a retrospective cohort study of all deliveries beyond 37 weeks gestational age from January 2015 till December 2015, at the University Hospital of Obstetrics and Gynecology of Tirana.

Data were collected on rates of chorioamnionitis, endomyometritis, the quality of amniotic fluid, length of labor and analyzed with bivariate and multivariate analyses.

We found that the presence and severity of meconium stained amniotic fluid during labour is associated with puerperal infection. Intra partum MSAF should be considered as a potential marker for infectious morbidity in women in labor and delivery.
Prolonged pregnancy is known to be associated with increased risks of perinatal and maternal complications, morbidity and mortality. Induction of labor is practiced to try and prevent the problems mentioned above. Several studies have shown that mifepristone can ripen the cervix or induce labor in term pregnancies. The aim of our study was to evaluate mifepristone use outcomes for cervical ripening and induction of labour versus expectant management in full-term pregnancy.

A randomized controlled trial. 149 women. 74 women randomized to induction of labor received mifepristone 200mg per os. If after 24 h the Bishop score was still less than 8, women received second dose. If the Bishop score was 8 or greater - artificial rupture of membranes. If Bishop score was 6-7 - intracervical dinoprostone gel. 75 women randomized to expectant management.

Outcomes: Gain in Bishop score within 24 and 48-h of mifepristone, Number of women going into spontaneous labor within 24, 48 and 72-h of mifepristone, Incidence of failed induction (no cervical changes or labour) or expectant management (still undelivered to 42 weeks), Enrollment-delivery interval, Mode of delivery, Oxytocin augmentation, Neonatal outcomes.

Mifepristone had moderate effect in inducing cervical ripening and labour in full-term pregnancy. There were no significant difference in main maternal and neonatal outcomes between mifepristone use and expectant management. Further research is required to assess whether mifepristone could help prevent and improve outcomes of prolonged pregnancy.
Post-term pregnancy is a risk factor for neonatal morbidity even in low-risk singleton pregnancies. Objective: To determine the association of post-term pregnancy with neonatal outcome in low-risk pregnancies.

Objective: To determine the association of post-term pregnancy with neonatal outcome in low-risk pregnancies.

Methods: Retrospective study, collecting data from January 2010 until December 2015, for all singletons delivered, after 39 weeks. Patients: All newborns of low-risk singleton pregnancies born at 39+0 to over 42 weeks gestation. Exclusion criteria: multiple gestation, maternal hypertensive disorder, diabetes or cholestasis, placental abruption or intrapartum fever, SGA and major congenital or chromosomal anomalies. Intervention: We compared the adverse outcome among three groups, based on GA at birth: post-term (≥42w), late term (41-41+6w) and full term (39-40+6w). Mean Outcome Measures: Admission to NICU, hospital length of stay, Apgar score, birth trauma, respiratory, neurological, metabolic and infectious morbidities and neonatal mortality.

Post-term pregnancy is an independent risk factor for neonatal morbidity even in low-risk singleton pregnancies.
Objective: The goal was to study whether postnatal magnesium sulfate infusion could improve neurologic outcomes at discharge for term neonates with severe perinatal asphyxia.

32 term babies (>= 37 weeks of gestation) with severe perinatal asphyxia were studied in a prospective, longitudinal, placebo-controlled trial. Patients were assigned randomly to receive either 3 doses of MgSO4 infusion at 250 mg/kg per dose (1ml/kg per dose) 24 hours apart (treatment group) or doses of normal saline infusion (1ml/kg per dose) 24 hours apart (placebo group). Both groups also received supporting care according to the unit protocol for perinatal asphyxia.

Postnatal MgSO4 treatment improves neurologic outcomes at discharge for term neonates with severe perinatal asphyxia.
INTRODUCTION: The induction of labor is a frequent situation in the practice of obstetrics, with an approximate incidence of around approximately 25% of births worldwide. The way the induction is performed is largely responsible for its success. International guidelines recommend, based on scientific evidence, the adequate and rational use of the different methods for induction. At present, there is no local guideline.

OBJECTIVES: to define characterize induction of labor in a developing country without induction protocols and to determine those possible factors that influence non-progression to vaginal delivery.

METHODS: A cross-sectional, descriptive, multicenter study was carried out, was carried out in public and private centers, including University centers, in Montevideo, Uruguay. We recruited patients at 37 and 41 weeks of gestational age, with maternal and/or fetal indication of interruption of gestation through induction of labor. A datasheet was applied by reviewing the medical history.

CONCLUSION: The inductions in the studied centers are performed in an adequate way, with a good rate of progression to vaginal delivery. However, it is necessary to have a national induction guide to correct errors such as the indication not according to the bishop’s score, to homogenize procedures and to extend the use of all possible methods of induction.
Knowledge of fetal physiology behind interpretation of cardiotocography (CTG) is paramount in order to improve perinatal outcomes. Allegations from the NHS litigation authority’s report centred on failure to recognise an abnormal CTG and act on it. The study’s aim is to evaluate whether cases of preventable hypoxic ischaemic encephalopathy (HIE) have reduced in a maternity unit where a teaching programme on physiological interpretation of CTG and ST segment analysis (STAN) has been implemented.

This study was carried out in Aneurin Bevan University Health Board (ABUHB), a large maternity unit, with an annual number of 6000 deliveries. All cases of HIE Grades 2&3 over a 3 year period from January 2013 were analysed. This period covered 18 months before and after the introduction of established teaching on physiological interpretation of CTG and use of STAN. All doctors and midwives working in ABUHB had to complete an e-learning module, pass a test and attend a training day held twice a year and led by Mr Edwin Chandaharan, an expert in the field. Funding was provided for all employees by ABUHB. Clinical neonatal data, CTGs, patient notes and local risk management meeting notes were analysed to assess outcomes and preventability.

This study provides evidence of how implementing a teaching programme on physiological interpretation of CTG and STAN in a large maternity unit has the potential to improve perinatal outcomes related to hypoxic ischaemic encephalopathy rates. Further long-term research is needed in order to determine any statistically significant improvement as well as research looking into whether the teaching programme has led to a reduction in unnecessary operative interventions.
To evaluate the fetal growth assessment associated with low APGAR score (8) score in the first and fifth minute.

The study included 21410 mother-newborn pairs from Split University Hospital Center, Croatia. Newborns body mass below 10th percentile was considered as small (SGA), above 90th percentile as large (LGA), and in-between these two values as appropriate for gestational age (AGA). Neonatal ponderal index (PI) was calculated by formula: PI (g/cm³) = birth weight (g) * 100/ birth length³ (cm³). PI below 10th percentile was considered to be low ("neonatal thinness") and above 90th percentile as high ("neonatal obesity") representing asymmetrical growth. The fetal growth charts were developed in the same institution, thus warranting evaluation quality. APGAR score was evaluated one and five minutes after delivery.

Normal fetal growth infants have greater chance for high APGAR score in the first and fifth minute. Being SGA or LGA, and especially in the low PI subgroup, is associated with low APGAR score probability. Fetal growth evaluation during pregnancy and ultrasound fetal weight estimation should be obligate antenatal care. Although not in the causal relation to APGAR score, prenatal fetal growth rating can help in parturition planning and clinical decision process during the labor.
The impact of cesarean section (CS) on maternal and neonatal outcomes has been studied extensively, and CS rate is a well-established indicator of quality in maternity care and is also related to resource use. Because of differences in patient populations between providers, it is important to risk-adjust CS rates when performing comparisons between providers. The objective of this study was to estimate case mix adjusted variation in CS rate between providers in Sweden.

In total, 139,756 deliveries in 2011 and 2012 were identified in regional administrative systems in 7 regions covering 67% of all deliveries in Sweden. Data were linked to the Medical birth register and population data. 23 different sociodemographic and clinical characteristics were used for adjustment. Analyses were performed for the entire study population as well as for two subgroups: Nulliparous, cephalic, full-term, singletons and Multiparous, cephalic, full-term, singletons, no previous CS. Logistic regression was used to calculate predicted probability of CS for each woman, to derive expected rate of CS per provider, and to analyze case mix adjusted differences between providers.

Statistically and clinically significant differences in CS rate remain between providers in Sweden after adjusting for differences in case mix. This indicates a potential for fewer interventions and lower resource use in Swedish childbirth care. Best practice sharing and continuous monitoring are important tools for improving childbirth care.
In the most recent MBRRACE report VTE is the leading cause of direct death in pregnancy and puerperium. In pregnancy the risk of PE increases and is 20 fold higher in puerperium. PE is fatal and death can occur within 30 minutes.

We reviewed the diagnosis and management of cases with PE in pregnancy in our unit. 

Our Unit

Royal Gwent Hospital is a busy district general hospital with 6000 deliveries/year. An Obstetrician with specialist interest in Haematology along with the haematologist run a very successful combined clinic.

Method

We performed an audit in our unit over a period of 24 months from Jan 2014-2016. We identified 10 patients over a period of 24 months (Jan 2014-16). Data for the review was collected retrospectively from the patient’s notes and analysed.

Results:

The study included a total of 9 patients, all under the age of 35 years. The majority were multiparous. All our patients presented with the classical symptoms of SOB and chest pain. According to our local protocol these patients were to be commenced on heparin therapeutic dose prior to arranging any further investigations. We found that this was followed through in more than 70% of cases. The investigations that are performed in our local unit are Chest X-ray and CTPA.

In conclusion, at the Royal Gwent Hospital there is a satisfactory protocol for the diagnosis and management of Pulmonary embolism. This is being reviewed regularly by the specialist team.
There is an increase in the incidence of placenta praevia due to increasing number of caesarean sections and increasing maternal age. Based on the relation of the placenta to the cervical os it is deemed major or minor. Routine ultrasound scanning at 20 weeks gestation is used for placental localisation. Placenta praevia is associated with serious complications to both mother and baby. Multidisciplinary team involvement and consultant presence is recommended due to the gravity of the situation.

A Multidisciplinary team including Obstetricians, Gynaecologists, Anaesthetists, Interventional Radiologist, Paediatricians are involved. We performed an audit over 2 years from (Jan 2013- Dec 2014) to assess the diagnosis and management of these patients.

We have, on average, 6000 deliveries in our unit per annum. We had 48 cases of Placenta Praevia over this period.

Over the course of our study we found that, our detection rate for placenta praevia at 20 weeks was good. However there was no TVS performed at this stage, we are currently liaising with the ultrasound department to introduce this practice. We did not have any mortality related to placenta praevia.
About half of all stillbirths occur in the intrapartum period, representing the greatest time of risk. Estimated proportion of stillbirths that are intrapartum varies from 10% in developed regions to 59% in south Asia [WHO, 2015]. Mortality inside the hospital is directly influenced by the quality of care in the hospital and provides a potentially powerful measure of care quality [Robert L.G. et al., 2013].

Retrospective study was handled. The sample size was limited by the total number of stillbirths at term (0 Apgar score at the first and fifth minute of life) registered in the Institute of Mother and Child (IMC) and Municipal Clinical Hospital nr.1 (MCH1) during 2013-2016. The study group included 142 cases of intrauterine fetal demise at term. In order to obtain the necessary information it has been examined the stationary patient chart (Form 096/e) and birth registers (Form 010/e). Data collection was carried out by means of a specially developed questionnaire.

The majority of mature babies die before the onset of labor. High percentage of congenital abnormalities indicates that stillbirth rate can be reduced by the timely antenatal detection of them and not always represents the care quality of particular health facility.
Repeat cesarean deliveries present an increased maternal and fetal morbidity. Risk of uterine rupture, a rare but feared complication associated with TOLAC, requires appropriate patient selection. A significant relationship between lower uterine segment thickness and uterine rupture has been reported. Our aim was to examine maternal and neonatal outcomes involving patients with previous cesarean birth, considering lower uterine segment thickness.

Retrospective study in a Swiss tertiary maternity unit between 2013 and 2016. Women with previous single cesarean section, a lower uterine thickness measurement performed by ultrasound between 35 0/7 to 38 6/7 SA and singleton pregnancy were included. Patients with a thickness measurement above 3.5 mm were orientated to trial of labor, as per our unit’s guidelines. Patients’ considerations were included in the decision. Vaginal birth was considered as a successful outcome from trial of labor. Maternal factors (age, gravidity, parity, measure of lower uterine segment) and neonatal outcomes (fetal weight, arterial pH, venous pH, Apgar at 5 min) were compared between women who had a successful or failed TOLAC.

This study illustrates that trial of labor is a safe option for women after single cesarean delivery. Rate of maternal request for repeat cesarean was high, highlighting the need for early discussion on the mode of delivery. A randomized trial investigating the appropriate threshold for the lower uterine thickness measurement is required.
To assess success rates and associated maternal and fetal risks. To determine the different methods of induction for labor at term, compare induction with Foley catheter and induction with naturally occurring prostaglandin E2 (PGE2) tablets, in women with gestational age at term.

At University Clinic of gynecology and obstetrics, two hundred and twelve women at term are included in study, one group with Foley catheter, second group with PGE2 tablets, with a maximum of two doses. The primary outcome measures were the admission-to-delivery interval and the induction-to-delivery interval. Secondary outcomes included cesarean section rate, mode of delivery, and maternal and neonatal safety outcome. Results were calculated applying Fisher’s exact test, c2-test, t-test and calculating the P-value using an alpha level of 0.05 for Type I errors.

Foley catheter is equally efficacious in labor induction and demonstrates a similar fetal and maternal safety profile to PGE2.
Urinary tract infections are relatively common problems during pregnancy. There are a number of conditions associated with an increased prevalence of asymptomatic bacteriuria in pregnancy. Low socio-economic status, sickle trait anemia, diabetes mellitus and grand multiparity have been reported; each is associated with two-fold increase in the rate of bacteriuria.

This study determine the risk factors related to the presence of such condition in pregnant women.

This is a retrospective study based on our clinical files of 504 women during 2010 – 2015 period. Files of women, which had records showing the presence of urinary infections, within the last month, others who had been under antibiotic treatment during the last week, women who had a positive anamnesis on chronic urinary tract disease and others with obstetrical complications regarding vaginal bleeding were not taken under consideration, excluded from this study’s datas.

Files of all women that were part of this retrospective study had datas of urine specimens taken by the midstream collection of urine. Risk factors related to asymptomatic bacteriuria, obstetric and demographic characteristics had also been recorded.

Among all other risk factors, of known importance, such as history of previous urinary tract infections, diabetes, anemia, the educational level, should be an important risk factor to take under consideration in following the protocols, that demand the urine culture.
Maternal obesity has a significant impact on maternal metabolism and offspring development. Insulin resistance, glucose homeostasis, fat oxidation and amino acid synthesis are all disrupted by maternal obesity and contribute to adverse outcomes. Modification of lifestyle is an effective intervention strategy for improvement of maternal metabolism and the prevention of adverse outcomes.

The aim of our study was to assess a correlation between obesity and the evolution of pregnancy complications.

This is a retrospective study of a group of 488 women, followed in our clinics during a 5 years experience. 5 were excluded because were diagnosed with Diabetes Mellitus in the first visits of pregnancy (6-12 weeks of gestation). The remaining 483 women chosen to be part of the study, had no conditions such as Diabetes or diagnosed endocrine diseases. The group was divided in 2 major categories. Considerably obese women, with BMI $\geq 35$ and women with BMI between 18.5 - 25.

The experience of our clinics, shows a strong correlation between morbid obesity and pregnancy complications. Therefore, weigh loss should seriously be considered, better before conceiving.
Pregnancy, childbirth, and their consequences are still the leading causes of death, disease and disability among women of reproductive age in developing countries.

Yet, quality of care is still an non-existent component in the majority of the maternity hospital in developing countries. Labour support, drinking and eating in labour, free positions and mobilisation, bonding, skin to skin, early breastfeeding dont exist in our projects. How can we address those?

the 'Case" would be a typical example of what happens during a childbirth in developing countries

Normal and respectful birth needs to be addressed all over the world and in developing countries where women are forces to be in bed, beaten, verbally abused, and no attention is given to her and to the newborn. This might cost women and newborn' lives.
Cesarean section (CS) carries substantial risk for maternal near miss (MNM). This study investigated the frequency, risk factors, and perinatal outcomes for MNM at three university hospitals in Tehran, Iran where CS is overused and a large number of migrants from Afghanistan also receive maternity care.

A prospective incident case-control study was conducted from March 2012 to May 2014. The WHO MNM approach was used to identify cases. A sample of 1024 women delivering at the study sites during the study period was randomly selected to represent source population named controls. MNM ratio, crude and adjusted odds ratios (AOR) with confidence intervals (CI) for risk factors were assessed.

CS overuse clearly affected the obstetric causes of MNM. A lack of health insurance had measurable impact on developing MNM. Appropriate usage of CS and financial coverage of emergency obstetric care services can improve maternal and perinatal outcomes.
In the last studies it has been described a higher risk of complications after 41 weeks gestational age for both mother and fetus. That’s the reason why in the University Hospital of Vic it has started a new protocol that pregnant can choose whether they want to be inducted or decide an expectant behavior.

The aim of this research is to know the influence of labor inductions after the 41 weeks gestation in the on obstetric and neonatal outcomes in low and medium risk pregnancies.

A quantitative study is carried out. It’s about a descriptive, observational and cross-sectional study.

The study sample is consisted of pregnant classified as low or medium risk according to the protocol of pregnancy of the Generalitat of Catalonia, which decided to finish the pregnancy by a labor induction by own decision between the 41 and the 41.6 weeks gestational age under the diagnosis of “Chronologically Prolonged Gestation” (CPG) and there si no other pathology which indicates the induction. This took place in the HUV from June to December of 2016. The information needed was collected through medical records of all pregnant included in the study. Statistical analysis was performed using SPSS versión 16.0.

In the multiparous women the obstetric results were better than primiparous. There were a high percentage of caesareans in primiparous. Also it was observed a relationship between cesarean section and star of the induction with a Bishop income under 6. Inductions increase the time of entry into the delivery room.

In future researches it must be a comparation between pregnant who decided a labor induction and those women who decided an expectant behavior.
The Robson's ten-group classification system (TGCS) is a reproducible, clinically relevant and prospective classification system proposed by the World Health Organization as a global standard for assessing, monitoring and comparing cesarean section rates. Data regarding deliveries performed over a 3-year period from 2014 to 2016 at a tertiary hospital in Portugal were recorded and all women were classified according to the TGCS. Retrospective analysis of data was performed.

As expected, groups 1, 2, 5 and 10 were the greatest contributors to the overall cesarean rate. An attempt to increase the number of vaginal deliveries in these groups, especially in groups 2 and 5, might contribute to the reduction of cesarean’s rate.
Cerebroplacental ratio (CPR) is considered a Doppler parameter indicating placental function in term pregnancies. In this study we have evaluated the relationship between CPR measured in early labor and perinatal and delivery outcomes in a cohort of uncomplicated singleton term pregnancies.

Multicentre prospective observational study involving three Tertiary Centres. Patients carrying low risk term pregnancies, as defined by the absence of any maternal morbidity and pregnancy complication, estimated fetal weight >10th centile and gestation between 37 and 42 weeks were eligible for the study. Only women with spontaneous onset of labor were included. Cases were submitted to Doppler measurement of the umbilical artery (UA), middle cerebral artery (MCA) and uterine artery (UtA) in early labor. All measurements were performed in between uterine contractions. CPR was computed by dividing MCA and UA pulsatility index. Cases were grouped based on a previously described CPR cut off of 0.6765 MoM.

Our data on a wide cohort of low risk term pregnancies have shown that a reduction in the CPR measured in early labor is associated with a higher risk of obstetric intervention for suspected intrapartum fetal distress and poorer perinatal outcomes, including a higher rate of transfer to NICU and lower birthweight. These results suggest that a closer intrapartum monitoring is warranted whenever a reduction in the CPR in early labor is detected.
The assessment of pH on the umbilical artery is considered the gold standard to diagnose neonatal acidemia at birth. More recently, the simultaneous evaluation of both arterial and venous sample has become common with the aim of correlating the duration of fetal hypoxia (acute or chronic). The purpose of this study was to assess the correlation between the Delta pH (vein - artery) on the umbilical cord and the intrapartum hypoxia CTG patterns in a group of acidemic neonates.

All non anomalous term neonates consecutively born with acidemia (pH<7.10 on the arterial cord) between 2013 and 2017 at the University Hospital of Parma were recruited. Based on the difference between vein to artery pH the study population was divided in two groups: 1) Delta pH 0.1 (larger Delta pH). Intrapartum CTG traces were collected and their characteristics were reviewed by an expert obstetrician who was aware of the arterial acidemia but was blinded to the Delta pH result. According to a formerly reported classification, CTG features were classified as chronic, slowly evolving, subacute and acute hypoxia. In the two groups the prevalence of the type of fetal intrapartum hypoxia was detected.

Within the limitation of the small sample size, our data do not confirm previous hypothesis that high Delta pH is associated with an acute hypoxic condition. Such findings need to be confirmed on wider cohorts.
We are presenting two case reports and a literature review of two cases who developed ovarian vein thrombosis secondary to their post partum sepsis.

Retrospective observational case reports

We present two cases who developed post partum sepsis after their deliveries.

The first case is a 41 years old, Para four who was readmitted to our maternity unit with post partum sepsis and severe abdominal pain two days after she has had an uneventful elective caesarean section.

A CT scan revealed bilateral ovarian vein thrombosis.

The second case is a 42 years old, Par two who was readmitted to our unit with sepsis three days after a normal vaginal delivery, and a CT scan revealed a right ovarian vein thrombosis.

Both were started on our standard sepsis protocols.

Both patients did not have any previous thromboembolic events nor any family history of such a condition. Both patients were commenced on therapeutic dose of LMWH for three months.

Ovarian vein thrombosis is a rare but potentially serious complication that may occur as one of the differential diagnosis of post partum abdominal pain and sepsis. It is most commonly seen in the puerperal period with an incidence of 1 in 3000 deliveries. The incidence increases to 1 in 800 with caesarean sections.
Controlling caesarean delivery rates is a public health priority. The World Health Organization proposes adopting the Robson classification as an internationally applicable cesarean section classification system.

Objective: to compare cesarean rates between two level 3 university hospital maternities using the Robson classification in order to explain the 10% observed difference of global cesarean rate between these two care centers and analyse its impact on neonatal health.

Population: all the deliveries and the children alive or death, after 22 weeks of gestation or above 500g, between 2012 and 2014 in two level 3 maternity units of Ile de France.

Main outcome measures: Caesarean rate for each group, its contribution to the overall caesarean rate for each group with adjustment for maternal characteristics significantly different between the two groups (maternal diseases, body mass index, tobacco, age).

Methods and indications of labor inductions for the 2A group (nulliparous women with induced labour at term). Neonatal conditions, pH, APGAR score and transfert in pediatric units for each group.

Although differences in practices of labor induction could explain differences in cesarean rate in the 2A group, the decision to perform a cesarean section remains complex and multifactorial. The Robson classification is a very interesting tool for making assumptions but remains limited to explain the observed differences.
Cervical ripening can be promoted in many ways, but mechanical methods are among the oldest.

As all the other methods this one also has its pros and cons. Disadvantages compared to pharmacological methods include some maternal discomfort upon manipulation of the cervix, a theoretical increase in the risk of maternal and neonatal infection from introduction of a foreign body, the potential for disruption of a low-lying placenta, and increase in need for oxytocin induction of labor.

Preinduction of labor was performed in term pregnancies at Sestre milosrdnice University Hospital Center.

Advantages of these technique include their low cost compared with some drugs, low risk of tachysystole, few systemic side effects, and convenient storage requirements (no refrigeration or expiration, which are issues for some drugs).
The aim of the study was to assess the correlation between the estimation of the fetal head station (FHS) by digital examination, and angle of progression (AOP) by transperineal ultrasound, during second stage of labor.

AOP and head station were assessed prospectively in pregnant woman at ≥37 weeks of gestation during the 2nd stage of labor by two different examiners who were blinded to each other results.

Reproducibility of measurements was assessed for intra- and inter-observer variability of the AOP. Statistical analysis included assessment of reproducibility of measurements by ICC, correlation between the clinical and the sonographic methods and construction of normal reference range for head station.

Our study shows that TPU measurements of the AOP is reliable, and correlates significantly with the clinical FHS. These findings offer sonographic standardization of the FHS and a valuable tool in the management of second stage of labor.
The aim of our study was to evaluate different sonographic methods for the prediction of the difficulty and the success of operative vaginal delivery (OPD).

A prospective study was performed on 45 term singleton uncomplicated pregnancies with prolonged 2nd stage of delivery with cephalic presentation. Measurements of the fetal head, relations between the fetal head and maternal pelvic parameters during rest and during maternal pushing were taken using translabial ultrasound.

Translabial ultrasound is useful in the prediction of the difficulty and the success of OPD. The higher the extent of head that passed the IPL, the less difficult the OPD and the greater the success rate of the OPD.
Reflexology is a pressure technique at the hands and feet and has different uses in the field of health. In this review, we examined the effect of reflexology on birth pain in accordance with scientific studies.

The study is a descriptive retrospective literature study. On February 21, 2013, the keywords “reflexology” and “birth pain” in the PUBMED in English and all the articles published in the last decade were examined.

Reflexology has recently been used in a limited number of complementary methods to relieve birth pain. For this reason, there is a need for randomized controlled, evidence-based studies to be done by midwives in this regard.
Literature shows inter-hospital variation in cesarean section rates, which may partially be explained by differences in maternal characteristics as well as socio-demographic factors. Thereby, nonmedical factors could play an important role in driving the decision of an obstetrician to perform a CS. The objective of the current study was to explore hospital practice variation of unplanned CS (UPCS) and analyze the contribution of patient and hospital factors to the probability of having an UPCS.

A retrospective medical chart review was performed in 21 hospitals in The Netherlands. All nulliparous women with a singleton in vertex position between 37 and 42 weeks’ gestational age and intended vaginal delivery were selected (n=708).

Patient factors (demographic and medical) and hospital factors were analyzed (teaching or non-teaching hospital, no duty following shift, planned audit on caesarean sections, time of delivery and 24 hours’ availability of micro-blood analysis or ST-analysis, epidural anaesthesia, and an operation team in hospital). A correction for known CS risk factors was performed by logistic regression. The difference between observed and expected UPCS rates and contributing factors were analyzed.

Using UPCS rates as an indicator of quality of care without correction for patient factors is questionable, since UPCS practice variation can mostly be explained by differences at patient level. Most hospital factors did not contribute to the UPCS rates, suggesting increased availability of resources does not lower the risk. However, time of day seems to have a pronounced effect, suggesting delaying or anticipating behaviour by individual caregivers.
Cerebro-umbilical (C/U) ratio (also known as cerebro-placental ratio) is increasingly being investigated for its role in the prediction of fetal distress in nulliparous labour at term. However, the data on the timing of the Doppler in relation to labour onset and its usefulness is still unclear.

Transabdominal ultrasound scans to assess fetal position and transperineal to assess head perineum distance and caput were performed in early labour in 124 low risk women in a large London hospital 2015-2016. The length of labour in those with vaginal birth was defined from 4cm in spontaneous labour and the start of syntocinon in induced and augmented labour. Labour and maternal characteristics, obstetric and immediate neonatal outcomes were obtained.

Cerebral and umbilical Doppler was more frequently measured at higher fetal head stations in early labour. C/U ratio was not associated with time to delivery overall but in deliveries for fetal compromise there was a trend towards a relationship between C/U ratio and length of labour. This still ongoing study is the first to explore the effect of length of labour on C/U ratio and delivery mode.

* Kruskal-wallis test

# Spearmans Rank Correlation Coefficient