161 NON-CLOSURE OF THE PERITONEUM DURING CESAREAN SECTION: LONG-TERM FOLLOW-UP OF A RANDOMIZED CONTROLLED TRIAL

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OBJECTIVE: To compare long term morbidity of non-closure and closure of the peritoneum at cesarean section.

STUDY DESIGN: Participants to a randomized controlled trial, conducted in the Department of Obstetrics and Gynecology of Geneva University Hospital, were contacted 7 years later. Main outcome measures included subsequent fertility, abdominal pain and urinary symptoms after the cesarean section, assessed by a postal questionnaire. Reports of subsequent operations were retrieved to assess the presence of peritoneal adhesions.

RESULTS: We were able to contact 226 of the 280 women recruited initially, and 144 responded to the questionnaire. Sixty-nine had been allocated to non-closure of the peritoneum and 75 to closure. Baseline characteristics at randomization were comparable both between the respondents and the non-respondents, and between originally allocated groups. No statistically significant difference was found between the two groups regarding fertility, abdominal pain, and urinary symptoms. Among 29 reports of subsequent abdominal surgery, 14 mentioned the presence of adhesions (8 in the non-closure and 6 in the closure group; $P = .47$). The number of women reporting at least one significant morbidity was similar between groups (24 in the non-closure and 19 in the closure group; $P = .72$). The power of the study was sufficient to demonstrate statistical significance if differences were large (30% to 10%, power = 80%), but not if differences were smaller (30% to 15%, power = 48%; 30% to 20%, power 22%).

CONCLUSION: Non-closure and closure of the peritoneum seem to result in similar long term morbidity. Other follow-up studies should be conducted to evaluate the safety of not closing the peritoneum at cesarean section.

163 WITHDRAWN

162 DELIVERY OUTCOME AFTER SUCCESSFUL EXTERNAL CEPHALIC VERSION LOUIS

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OBJECTIVE: The aim of this study was to investigate the delivery outcome after successful external cephalic version (ECV).

STUDY DESIGN: We performed a case-control study involving 279 women delivered after successful ECV from 1995 to 2000. The delivery outcomes were compared between women with successful ECV and those with spontaneous cephalic presentation delivered during the same period (n = 28447).

RESULTS: The risk of instrumental delivery and emergency cesarean section is higher in the ECV group (14.3% Vs 12.8%; OR 1.4; 95% CI 1.0 to 2.0, and 23.3% Vs 9.4%; OR 3.1; 95% CI 2.3 to 4.1 respectively). The higher cesarean rate is due to an increase in all major indications, namely non-reassuring fetal heart tracing, failure to progress of labor and failed induction. The higher incidence of instrumental delivery is mainly due to an increase in prolonged second stage. The odds ratio for operative delivery remained significant after controlling for potential confounding variables, including maternal age, height, parity, maturity, birth weight, labor induction and augmentation, and duration of labor. There were also significantly greater frequencies of labor induction (24.0% Vs 13.4%; OR 2.0; 95% CI 1.5 to 2.7) and use of epidural analgesia (20.4% Vs 12.4%; OR 1.8; 95% CI 1.4 to 2.4) by women in the ECV group. The higher induction rate is mainly due to induction for postdates, abnormal nonstress test and antepartum hemorrhage of unknown origin.

CONCLUSION: The incidence of operative delivery and other obstetric interventions are higher in pregnancies after successful ECV. Women undergoing ECV should be informed concerning this higher risk of intervention.

164 RISK FACTORS FOR BLOOD TRANSFUSION IN PREGNANT WOMEN WITH AT LEAST ONE PRIOR CESAREAN SECTION

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OBJECTIVE: To assess the risk factors for a blood transfusion in pregnant women with a history of at least one Cesarean section (C/S).

STUDY DESIGN: We performed a multicenter retrospective cohort study reviewing the medical records of 14,309 women who had a prior C/S and a subsequent delivery. These subjects were identified by an ICD code based search at 17 tertiary and community hospitals from 1995-1999. Data were collected from medical records by nurse abstractors and included information on sociodemographic factors, obstetrical history, antenatal complications, and labor characteristics. Risk factors for transfusions were assessed by using univariate analysis, stratified analysis, and multiple logistic regression.

RESULTS: The incidence of transfusion in our entire cohort was 148/14,309 (1.03%). Women who had a successful vaginal birth after Cesarean section (VBAC) had the lowest rate of transfusion. Using successful VBAC as the referent, women who had a failed VBAC and women who had an elective repeat C/S had approximately the same increased risk for a transfusion (AOR = 2.7, 95%CI 1.6-4.6 vs. AOR = 2.8, 95%CI 1.9-4.2). The results of our univariate and multivariate analyses are presented in the Table.

CONCLUSION: Our study demonstrates that in terms of a blood transfusion, a successful VBAC is protective while an elective C/S and a failed VBAC confer the same increased risk.

Table

Transfusion risk factors

	UNIVARIATE OR (95%CI)	MULTIVARIATE OR (95%CI)
African American race	1.85 (1.32-2.57)	1.59 (1.09-2.30)
Tertiary care hospital	1.48 (1.07-2.04)	1.38 (0.97-1.95)
Preeclampsia	2.49 (1.28-4.84)	1.74 (0.79-3.81)
Successful VBAC	0.51 (0.36-0.71)	0.35 (0.23-0.54)
Abruption	6.52 (3.59-11.83)	5.31 (2.67-10.55)
Uterine rupture	10.89 (6.33-18.73)	10.11 (5.04-20.29)
Operative injury	14.19 (7.57-26.60)	10.05 (4.37-23.14)