

194 INTIMATE PARTNER VIOLENCE AND POSTPARTUM DEPRESSION MATTHEW GARABEDIAN¹, KRISTINE LAIN¹, WENDY HANSEN², LISANDRA GARCIA³, ANN COKER², LESLIE CROFFORD³, ¹University of Kentucky, Lexington, Kentucky, ²University of Kentucky, Obstetrics and Gynecology, Lexington, Kentucky, ³University of Kentucky, Department of OB/GYN, Lexington, Kentucky

OBJECTIVE: To evaluate the association between intimate partner violence (IPV) by type experienced (sexual, physical, or stalking) and postpartum depression.

STUDY DESIGN: This is a cross-sectional study of parous women in the Kentucky Women's Health Registry who indicated a history of IPV (n=3331). History of postpartum depression was identified from a self-report questionnaire. Multivariate analysis controlled for age, education, race, and gravidity.

RESULTS: A history of any IPV was associated with postpartum depression (aRR 1.4; 95% CI 1.2-1.7). Women experiencing sexual IPV were 50% more likely to have reported postpartum depression (1.5; 1.2-1.8). Both childhood physical and sexual abuse were associated with a 40% increase in postpartum depression rate relative to women not abused as children (1.4; 1.2-1.6; 1.4:1.1-1.7). Experiencing sexual IPV with or without other forms of IPV (stalking or physical) was associated with a 70% increase in postpartum depression (1.7; 1.4-2.2) compared with women never experiencing any type of abuse. The prevalence of postpartum depression increased in a dose dependent pattern (p for trend <0.0001) with increasing number of types of abuse experienced.

CONCLUSION: This cross-sectional study shows significant associations between a history of intimate partner violence or child abuse and postpartum depression. We cannot comment on whether the intimate partner violence was antecedent to the pregnancy. Our data highlight the need to screen for all types of abuse among pregnant women and, when found, provide surveillance in the postpartum period.

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195 LATE PRETERM BIRTHS: ARE THEY NEARLY TERM? YVONNE W. CHENG¹, ANJALI J KAIMAL¹, TIM A. BRUCKNER², J. M. NICHOLSON³, DONNA R. HALLARON⁴, AARON CAUGHEY¹, ¹University of California, San Francisco, San Francisco, California, ²University of California, Berkeley, California, ³University of Pennsylvania, Department of Family Medicine, University of Pennsylvania, California, ⁴St. Louis University, Missouri

OBJECTIVE: To estimate the risk of short-term complications in neonates born between 34 and 36 weeks by weeks of gestation.

STUDY DESIGN: This is a retrospective cohort study of singleton pregnancies delivered in the U.S. in 2003 between 34 and 36 weeks. Gestational age was subgrouped into 34, 35, and 36 completed weeks. Statistical comparison was performed using chi-square test and multivariable logistic regression models, with 37 weeks as the referent.

RESULTS: There were 249,070 births meeting study criteria: 15.4% at 34 weeks, 27.1% at 35 weeks, and 57.5% at 36 weeks. The frequency of undesirable neonatal outcomes decreases with increasing gestational age, and neonates born at 34-36 weeks had higher odds of complications compared to deliveries at 37 weeks (see Table).

(%) OR 95% CI	34 wks (n=38,513)	35 wks (n=67,415)	36 wks (n=143,142)
5m Apgar <7	4.11 % 4.05 3.73-4.39	2.68 % 2.68 2.48-2.89	1.73 % 1.75 1.63-1.87
Hyaline membr. dz	4.90 % 10.2 9.43-11.1	3.50 % 6.81 6.32-7.35	1.52 % 2.84 2.63-3.06
Ventilation >30m	5.47 % 8.65 8.02-9.32	3.40% 5.05 4.70-5.43	1.61 % 2.33 2.17-2.50
Neo seizure	0.14 % 2.45 1.68-3.57	0.05 % 1.05 0.69-1.60	0.06 % 1.14 0.85-1.54

CONCLUSION: While the risk of undesirable neonatal outcomes decrease with increasing gestational age, complication remains higher in late preterm births compared to deliveries at 37 weeks.

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196 THE EFFECT OF MATERNAL WEIGHT ON POSTTERM DELIVERY DONNA HALLORAN¹, YVONNE CHENG², NAOMI STOTLAND², AARON CAUGHEY², ¹Saint Louis University, St Louis, Missouri, ²University of California, San Francisco, San Francisco, California

OBJECTIVE: To assess the effect of prepregnancy BMI and weight gain on post-term delivery.

STUDY DESIGN: This is a retrospective cohort study utilizing birth records linked to hospital discharge data for all term, singleton infants > 37 weeks gestation born to Missouri residents (1993-1999), excluding infants born to mothers with diabetes or chronic hypertension or a history of previous cesarean section. The primary outcome was delivery at 42 weeks gestation. Pre-pregnancy BMI was categorized as follows: normal (referent), overweight, and obese. Maternal weight gain based on Institute of Medicine (IOM) guidelines adjusted for pre-pregnancy weight.

RESULTS: There were 416,358 births meeting study criteria. 8542 infants (2%) were born at 42 weeks gestation. Multivariable analysis was performed that controlled for maternal ethnicity, age, education, parity, tobacco history, Medicaid status, and infant sex. Being underweight and gaining less than the weight recommended by the IOM decreased the risk of postterm delivery. Being overweight and gaining more than the recommended weight increased the risk of postterm delivery.

Characteristic	aOR (95% CI)
Weight gain	
Less than IOM rec	0.8 (0.8, 0.9)
More than IOM rec	1.4 (1.3, 1.4)
Prepregnancy weight	
Underweight	0.8 (0.7, 0.9)
Overweight	1.2 (1.1, 1.2)
Obese	1.4 (1.3, 1.5)

CONCLUSION: Elevated weight gain and pre-pregnancy weight increase the risk of a postterm delivery while low weight gain and pre-pregnancy weight decrease the risk of a postterm delivery. While most women do not get preconceptional care, our findings suggest that restricting weight gain to the normal range can reduce the risk of postterm pregnancy.

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197 OPPORTUNITIES FOR IMPROVEMENT: INCIDENCE AND RISK FACTORS FOR MATERNAL MORTALITY FROM POSTPARTUM HEMORRHAGE IN CALIFORNIA ALEX FONG¹, DOTUN OGUNYEMI¹, JAMILA LEAKE², ¹Cedars-Sinai Medical Center, Los Angeles, California, ²Charles R. Drew University of Medicine and Science, California

OBJECTIVE: To identify trends and risk factors for postpartum hemorrhage (PPH) and associated mortality in California.

STUDY DESIGN: There were 138,316 cases of PPH from 1991 to 2000 identified in the California Health Discharge Database. Data analyzed included demographic information (age, race, geographic region) and clinical risk factors. Student's t-test, chi-square test, ANOVA and logistic regression were used as indicated. Significance was set at p<0.01.

RESULTS: The incidence of PPH in California increased from 1.7% to 2.4% (1992-2000). The rate of mortality remained generally unchanged over time. The incidence of PPH was higher in Northern California (3.4%) vs. Southern California (1.9%) and Central California (1.7%). The Los Angeles, Orange County, and Inland Empire regions had increased mortality, while the Bay Area was associated with decreased mortality. Women aged 30 years or more had increased mortality. Caucasians were about 40% less likely to die from PPH when compared to other ethnicities. The presence of hypertensive disorders (OR: 2.6), abruption (OR: 2.4), low transverse cesarean delivery (OR: 1.6), classical cesarean delivery (OR: 3.6), and hysterectomy (OR: 6.9), were all independently associated with an increased risk for PPH mortality. Manual placental extraction (OR: 0.495), episiotomy (OR: 0.285), and laceration repairs (OR: 0.376) were independently associated with a decreased risk of mortality. The mean length of stay and hospital charges were 9 days and \$79,438 for cases with maternal mortality, compared to 2.6 days and \$8,580 for those without, respectively.

CONCLUSION: The incidence of PPH increased throughout the study period. There appears to be variation in PPH incidence and mortality based on geographical region and presence of various risk factors. This information can potentially identify patients at risk and initiate strategies for prevention.

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