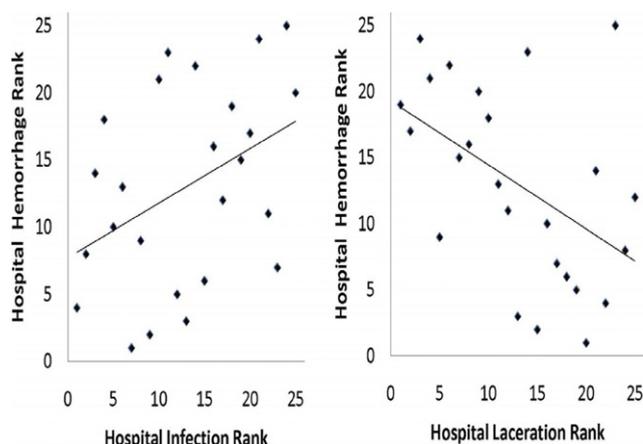


CONCLUSION: Quality measures for different obstetric outcomes are poorly correlated, and may be inversely correlated in some cases. Therefore, performance based on a single outcome quality measure cannot be generalized. Multiple quality measures should be assessed to gain a better understanding of overall hospital performance.



31 Trial of labor after previous cesarean section versus repeat cesarean section: are patients making an informed decision?

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OBJECTIVE: Although trial of labor after cesarean (TOLAC) is considered a reasonable option for most women, with an overall rate of success of 60-80%, the majority of women who would be eligible for a TOLAC undergo an elective repeat c-section (ERCS). We hypothesized that this is due, in large part, to poor education of patients on the risks and benefits of both options.

STUDY DESIGN: We conducted an IRB approved, prospective observational study of women who presented to our hospital for delivery between November 2010 and July 2011 with a history of one prior c-section and no contraindications for TOLAC. Consenting women were asked to fill out a questionnaire upon presentation to labor and delivery, either prior to their scheduled ERCS or upon admission for their TOLAC. Chi-Square and t-test were used, as appropriate, with Bonferroni correction for multiple comparisons.

RESULTS: The study included a total of 155 women, 87 that presented for TOLAC and 68 that presented for ERCS. There were no differences in age, level of education, ethnicity and provider type between the groups. Women in both groups demonstrated lack of knowledge on the risks and benefits of TOLAC and ERCS, particularly women in the ERCS group. Specifically, patients were not familiar with the chances of a successful TOLAC, the effect of indication for previous CS on success, the risk of uterine rupture, and the increase in risk with each successive CS. Only 13% of TOLAC patients and 4% of ERCS patients knew the chances for a successful TOLAC, while the majority in both groups stated that they "did not know". The majority (64%) of ERCS patients did not know the risk of uterine rupture during TOLAC and 52% did not know which delivery mode had a faster recovery time. When patients perceived their providers as having a preference for ERCS, only 4% chose TOLAC. Conversely, 43% chose TOLAC when they thought that was their provider's preference.

CONCLUSION: Candidates for TOLAC appear to have little knowledge of the risks and benefits associated with their choice for mode of delivery and provider preference affects this choice, either directly or indirectly.

	TOLAC (total=87)	ERCS (total=68)	P Value
Chances of successful TOLAC: Answered Correctly	11 (13%)	3 (4%)	0.511
Chances of successful TOLAC: Answered "Do not know"	46(54%)	49 (73%)	0.112
Risk of rupture: Answered "Do not know"	37 (45%)	42 (64%)	0.014
Faster recovery time: Answered "Do not know"	18 (21%)	34 (52.3%)	0.00056
Risk of complications increases with each cesarean: Answered Correctly	54 (66%)	31 (46%)	0.182
Patient perceived provider preferred ERCS	3 (4%)	19 (29%)	0.000077
Patient perceived provider preferred TOLAC	36 (43%)	10 (15%)	0.021

32 Velamentous cord insertion: does it affect perinatal outcomes?

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OBJECTIVE: Velamentous cord insertion can be readily identified on prenatal ultrasound and carries an incidence of 1%. We set out to identify any associations between this finding and perinatal outcomes.

STUDY DESIGN: This was a retrospective cohort study of 529,249 singleton pregnancies using the California Birth Registry of which 2,789 (0.52%) were complicated by velamentous cord insertion. Outcomes examined included intrauterine fetal demise (IUFD), small for gestational age (SGA), preterm delivery <37 weeks, manual removal of the placenta and cesarean rate. Chi squared tests and multivariable logistic regression analyses were used for statistical analysis.

RESULTS: Velamentous cord insertion was statistically significantly associated with an increased risk of IUFD, SGA, preterm delivery <37 weeks and need for manual removal of placenta (Table 1). When confounders such as parity, maternal age, ethnicity and gestational age were controlled for, the AOR for IUFD remained high at 8.19 (95% CI, 5.66-11.85) for velamentous cord insertion.

CONCLUSION: Velamentous cord insertion is associated with an increased risk of adverse perinatal outcomes such as IUFD, SGA, preterm delivery < 37 weeks and need for manual removal of placenta. Routine identification of the placental cord insertion site should be considered. Close surveillance of these pregnancies could include serial ultrasounds for growth as well as antenatal testing. Future research should focus on the optimal management including the gestational age for delivery of these pregnancies.

Table 1. Perinatal outcomes by presence or absence of velamentous cord insertion

	Velam. (%)	Non-Velam. (%)	p-value
IUFD	2.59	0.29	0.001
SGA	16.93	10.17	0.001
PTD < 37 wks	13.57	9.54	0.001
Man Plac Remov	14.47	0.76	0.001
C/S (Nullip)	30.69	30.23	0.723
C/S (Multip)	28.45	32.17	0.002