respectively, p=0.034). We used the ratio between the pelvic EEC and HC to express a proportion score (PS) for CPD. The PS was significantly smaller in ID and CS-CPD, in comparison to NVD, in all pelvic levels: inlet (1.08±0.1 and 1.09±0.1 VS 1.15±0.08, p=0.006); mid (0.92±0.09 and 0.97±0.1 VS 1.03±0.08, p=0.0003); and outlet (0.77±0.04 and 0.81±0.07 VS 0.84±0.08 p=0.011). ROC analysis showed that a mid pelvis PS of 1 had a 68% sensitivity, 58% specificity and a positive predictive value of 89% for CS-CPD.
CONCLUSION: Low proportion score of maternal pelvic parameters and neonate head circumference, is highly correlated with ID and CS-CPD.

115 Placental abruption as a marker for long term cardiovascular mortality: a follow up period of more than a decade

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OBJECTIVE: To investigate the risk for subsequent cardiovascular events in women having placental abruption, during a follow-up period of more than 10 years.
STUDY DESIGN: A population-based study comparing consecutive pregnancies of women with and without placental abruption was conducted. Deliveries occurred during the years 1988-1999 and had a follow up until the year 2010. Associations between placental abruption and maternal long-term cardiovascular hospitalizations, morbidity and mortality were investigated. Multivariable analysis was used to control for confounders.
RESULTS: During the study period, there were 47,909 deliveries who met the inclusion criteria, of these 1.4% (n=653) occurred in patients with placental abruption. No significant differences were noted regarding subsequent long term hospitalizations due to cardiovascular causes during at least a decade of follow-up (OR= 1.2, 95% CI 0.8-1.8, P=0.314), as well as regarding invasive procedures (OR=1.5 95% CI 0.7-3.3, P=0.312; table). However, placental abruption was noted as a risk factor for long term cardiovascular mortality (OR= 6.6, 95% CI 2.3-18.4, P=0.004). The case fatality rate for placental abruption was 13.0% vs. 2.5% in the comparison group. (P<0.001). In a multivariate logistic regression model, after controlling for confounders such as ethnicity and maternal age, placental abruption was noted as an independent risk factor for maternal long-term cardiovascular mortality (adjusted OR= 4.5; 95% CI-1.1-19.1, P = 0.041).
CONCLUSION: Placental abruption is a significant risk factor for long-term cardiovascular mortality in a follow-up period of more than a decade.

Subsequent cardiovascular events in women having placental abruption

	Placental abruption (n= 653)	No abruption (n= 47265)	P value
Cardiovascular hospitalizations	4.4%	3.7%	0.314
Invasive cardiovascular procedures	0.9%	0.6%	0.312
Cardiovascular mortality	0.6%	0.1%	0.004

116 Giving birth to a small for gestational age infant is a risk factor for long-term maternal cardiovascular morbidity

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OBJECTIVE: To investigate whether women with a prior occurrence of small-for-gestational-age (SGA) are at an increased risk for subsequent long term maternal cardiovascular morbidity.
STUDY DESIGN: A population-based study comparing consecutive pregnancies of women with and without a previous delivery of a SGA neonate was conducted. Deliveries occurred during the years 1988-1999, with a follow-up period until 2010. Incidence of long-term cardiovascular morbidity was compared between women with SGA neonate and women who gave birth at the same period to an appropriate for gestational age neonate. Logistic regression was conducted to obtain adjusted odds ratios (AOR) and 95 % confidence intervals (CI) for the association between SGA and subsequent cardiovascular morbidity.
RESULTS: During the study period 47612 deliveries met the inclusion criteria; 9.3% (n=4411) occurred in patients with a prior occurrence of SGA. Women with a prior occurrence of SGA had higher rates of long term complex cardiovascular events such as congestive heart failure, cardiac arrest etc. (OR=2.3; 95% CI 1.3-4.4, P=0.006) and long term cardiovascular mortality (OR= 3.4; 95% CI 1.5-7.6, P=0.006; table). Using a multivariable logistic regression model, controlling for confounders such as maternal age and ethnicity, having delivered a SGA neonate was noted as an independent risk factor for long-term maternal cardiovascular hospitalizations (AOR= 1.4; 95% CI-1.1-1.6, P < 0.001).
CONCLUSION: Delivery of a previous SGA infant is an important predictor of long-term maternal cardiovascular morbidity during a follow-up period of more than a decade.

Long term cardiovascular morbidity and mortality in patients with and without a prior occurrence of SGA

	Delivered SGA (n= 4411)	No SGA (n= 47,612)	OR	95% CI	P value
Complex cardiovascular events	0.3%	0.1%	2.3	1.3-4.4	0.006
Cardiovascular mortality	0.2%	0.1%	3.4	1.5-7.6	0.006
Invasive cardiovascular procedures	0.5%	0.4%	1.2	0.8-1.9	0.329

117 Misoprostol for treatment of intrauterine fetal death at 14-28 weeks of pregnancy

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OBJECTIVE: To systematically assess whether misoprostol has high safety and effectiveness for the treatment of intrauterine fetal death at 14-28 weeks of pregnancy and to help establish the best dose of misoprostol for this purpose.
STUDY DESIGN: This double-blind trial randomized 153 women, 14-28 weeks gestation, into two groups. Women received either 100mcg buccal misoprostol (Group 1) or 200 mcg buccal misoprostol (Group 2) every 6h for a maximum of 8 doses. The primary outcome was successful evacuation within 48h.
RESULTS: The 200mcg dose was significantly more effective than the 100 mcg dose at evacuating the uterus within 48h (Group 1: 66.7%; Group 2: 84.2% (RR 0.79 (95%CI: 0.65-0.95). The mean time to evacuation was significantly shorter in Group 2 (18.9h +11.9h) than Group 1 (24.0 +12.4h) (p=0.03). The side effect profile was similar in the two groups. Few women reported nausea (Group 1: 19%; Group 2: 24%), vomiting (Group 1: 10%; Group 2: 16%), chills (Group 1: 24%; Group 2:21%) or headache (Group 1: 16%; Group 2: 21%). However, significantly more women in the 200mcg group reported diarrhea