CONCLUSION: Almost 20% of women with previa but no accreta had hemorrhagic morbidity. 3% had severe morbidity and 2% required hysterectomy. These data are useful in counseling women with placenta previa.

Table 1. Maternal morbidity in women undergoing cesarean delivery with and without placenta previa.

Variable	Placenta Previa N=501	No Placenta Previa N=53957	RR (95% CI)	aRR* (95% CI)
Emergent delivery	119 (23.8)	4712 (12.5)	1.90 (1.62-2.23)	1.15 (0.85-1.53)
Maternal hemorrhagic morbidity	94 (18.8)	2798 (5.2)	3.62 (3.00-4.36)	2.91 (2.16-3.90)
Severe maternal morbidity	13 (2.6)	599 (1.1)	2.34 (1.36-4.02)	1.75 (0.68-4.49)
Maternal Mortality	1 (0)	32 (0)	3.16 (0.45-22.04)	---
Atony requiring uterotonics	53 (10.6)	2372 (4.4)	2.41 (1.86-3.11)	3.59 (2.31-5.58)
Red Blood Cell Transfusion	65 (13.0)	1266 (2.4)	5.53 (4.38-6.98)	3.98 (2.71-5.82)
Uterine Artery Ligation	14 (2.8)	355 (0.7)	4.20 (2.51-7.19)	2.19 (0.88-5.45)
Unplanned Exploratory Laparotomy	2 (10)	119 (5.9)	1.70 (0.45-6.41)	1.53 (0.37-6.37)
Hysterectomy	10 (2)	131 (0.24)	8.22 (4.35-15.54)	4.93 (1.89-12.90)
Venous Thromboembolic Disease	3 (0.6)	238 (0.44)	1.36 (0.44-4.22)	---
Endometritis	24 (4.8)	3111 (5.8)	0.83 (0.56-1.23)	0.42 (0.18-1.01)
Sepsis	0 (0)	82 (0.15)	---	---
Pulmonary Edema	1 (0.2)	247 (0.46)	0.44 (0.06-3.10)	---
ICU Admission	2 (0.4)	384 (0.71)	0.56 (0.14-2.24)	---

*Adjusted for maternal age, years of schooling, parity, prior vaginal delivery, pre-conception BMI, diabetes, chorioamnionitis, number of fetuses, meconium, pre-delivery hematocrit, preterm labor, placental abruption, gestational age at delivery, neonatal weight

27 Evaluation of failed induction of labor

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OBJECTIVE: Data are limited for determining the definition of failed induction. We evaluated maternal and neonatal morbidity according to duration of oxytocin administration in latent labor after rupture of membranes (ROM).

STUDY DESIGN: In the Consortium of Safe Labor study (2002-2008), we included 9,772 nulliparas and 8,698 multiparas with singleton deliveries ≥37 weeks undergoing induction with cervix ≤ 2 cm dilation. Latent labor was defined as last cervical examination <6 cm in nulliparas and <5 cm in multiparas. Vaginal delivery (VD) rates, maternal morbidity (chorioamnionitis, endometritis, and postpartum hemorrhage [PPH]) and neonatal morbidity (neonatal intensive care unit [NICU] admission, NICU stay longer than 72 hours (hrs), continuous positive airway pressure, and neonatal sepsis) were evaluated for women who were in latent labor after 6, 9, 12, and 18+ hrs of oxytocin and ROM.

RESULTS: After 6 hrs, 54% of nulliparas and 85% of multiparas entered active labor. Duration of latent labor was associated with lower VD rates (Figure 1). Only 6.5% of nulliparas and 1.1% of multiparas remained in latent labor after 12 hrs; among them, 36.7% of nulliparous and 57.4% of multiparous delivered vaginally. Only 1.4% of nulliparas and 0.3% of multiparas remained in latent labor after 18+ hrs. Maternal morbidity increased regardless of parity with longer latent phase (Figure 2). Chorioamnionitis was significantly higher in both nulliparas and multiparas after 6, 9, 12, and 18+ hrs. Endometritis was significantly higher in nulliparas after 6, 9, and 12 hrs. PPH was significantly higher in nulliparas after 6 and 9 hrs, and in multiparas after 12 hrs. Neonatal morbidity was not associated with duration of oxytocin and ROM in latent labor.

CONCLUSION: After 18 hours of oxytocin and ROM, 98.6% of nulliparas and 99.7% of multiparas delivered. Although maternal morbidity was associated with duration, neonatal morbidity was not increased. Our data support oxytocin administration after ROM for at least 12-18 hrs before considering an induction as failed as long as maternal and fetal condition allows.

Figure 1. Vaginal delivery rate in women with latent labor.

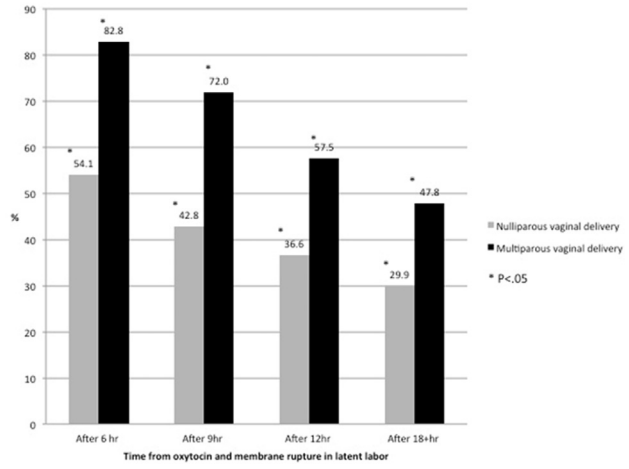
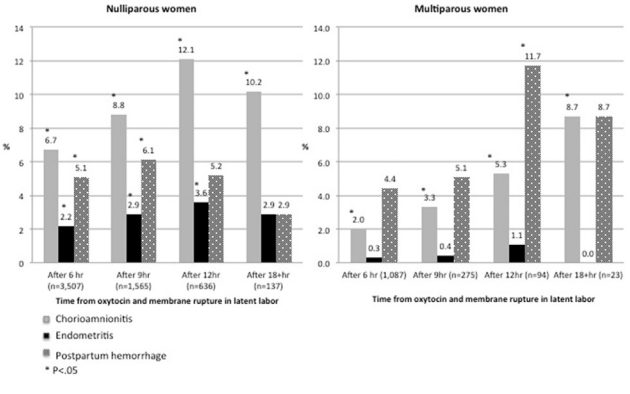


Figure 2. Maternal outcomes in women with latent labor.



28 Variation in primary cesarean delivery rates by individual physicians within a single hospital laborist model

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OBJECTIVE: Laborist practice models are associated with lower cesarean delivery (CD) rates than private practice models. Our objective is to evaluate the degree of variation in primary CD rates by