cerclage of 0.15% in the subsequent pregnancy, which is similar to the baseline rate in the 1st pregnancy (table 1).

Conclusions: Women with a prior preterm birth at 34–36 weeks have very low risk of cerclage in the subsequent pregnancy compared to women who delivered at <34 weeks. Although current guidelines recommend serial transvaginal ultrasounds in all women with a prior preterm birth, this group may need less surveillance.

VP52.29  
Using celecoxib for the suppression of preterm labour instead of magnesium sulfate
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Objectives: We aimed to use celecoxib to suppress preterm labour instead magnesium sulfate (MgSO4) to prevent preterm labour.

Methods: It was a randomised clinical trial study, which was done on 600 pregnant women. All subjects were divided into two groups by simple random sampling. One group was given 4 grams of MgSO4 intravenously and second group was given 100 mg celecoxib orally every 12 hours for at least 2 days. The data were entered and analysed using SPSS 11 and performed using t-test and chi-square test.

Results: The finding of this study has shown that preterm labour may be prevented in 75.7% of subjects who had received celecoxib and there were no significant difference between two groups in frequency of history of preterm labour (p = 0.1), frequencies of nulliparity (p = 0.99), duration of drug use and arrest contraction (p = 29), delivery before 48 hours (p = 20), and mean gestational age in lack of response to treatment (p = 24).

Conclusions: Result has shown that celecoxib was similar to MgSO4 as a medication to prevent preterm labour; it was recommended to be prescribe to prevent preterm labour, because it was cheaper than magnesium sulfate.

VP52.30  
Preterm birth screening using routine transvaginal ultrasound: a retrospective study
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Objectives: Determination of second trimester TUCL usefulness and application for the prediction of PTB in a cohort of Portuguese pregnant women.

Methods: Retrospective cross-sectional cohort study that included all singleton pregnant women who performed second trimester ultrasound (18 to 22+6 weeks) in Centro Hospitalar Universitário São João, between January of 2013 and October of 2017.

Results: Our cohort included 4,481 women, with 4% spontaneous PTB. Within premature labours, 0.7% occur before the 34th week of gestation. TUCL mean was 33.8mm and TUCLs of 25.0mm, 27.0mm and 29.0mm represented percentiles 3, 5 and 10, respectively. Confounders, like maternal age, previous PTB and cervical surgery were included in a multiple logistic regression analysis that showed a significant association between shorter TUCL and PTB. The best cut-off for PTB prediction in this cohort of pregnant women was 20mm and not the most used value of 25mm.

Conclusions: Our study supports the usefulness of TUCL for predicting PTB and emphasised that the cut-off to define short cervix can differ according to the population.

VP53: STILLBIRTH

VP53.01  
Reduction of stillbirths in England according to uptake of the Growth Assessment Protocol 2008–2017
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Objectives: Antenatal detection of SGA can significantly reduce the risk of stillbirths. The Growth Assessment Protocol (GAP) was developed to address the problem that most SGA fetuses are missed. We set out to analyse the effect that the GAP program had on stillbirth rates in England.
VP53.02
Risk of stillbirth increases in serially scanned pregnancies with an SGA fetus not detected antenatally
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Objectives: The small-for-gestational-age (SGA) fetus has a substantially increased risk of adverse perinatal outcome. We previously reported that pregnancies designated at risk but not receiving serial scans had a significantly higher rate of stillbirth. We now wanted to ascertain the effect of a false-negative assessment, i.e. where scan estimation of fetal weights (EFW) showed average size for gestation (AGA) and SGA was missed.

Methods: The study cohort consisted of an anonymised database of 1,351,788 deliveries in the GAP program, 2016–19. It included 262,478 pregnancies that were assessed at booking as being at increased risk of growth restriction and received serial scans in the third trimester. SGA was defined as fetal or neonatal weight <10th centile. Data regarding the progress of labour, mode of delivery, and indications for operative vaginal delivery or Caesarean section were collected from the records of the labour ward after delivery, and indications for operative vaginal delivery or Caesarean section were collected from the records of the labour ward after birth. Occurrence of non-reassuring fetal heart tracing (NRFHT) was defined as any need for intervention due to abnormal tracing.

Results: The SGA detection rate within this population was 66.6% and the false-negative rate (fetus scanned AGA but birthweight SGA) was 33.4%. The stillbirth rate (9/1000) was 4.2 in AGA pregnancies and 10.0 in SGA pregnancies detected by scan, but rose to 12.8 in pregnancies where SGA failed to be detected antenatally (risk relative to SGA detected cases: 1.5 [CI 1.3–1.7]; relative to AGA pregnancies: 3.0 [CI 2.6–3.4]). The median length of gestation in this high-risk cohort was 275 days for AGA pregnancies, 274 days for undetected SGA, and 264 days when SGA was detected antenatally.

Conclusions: A false-negative assessment of EFW in high-risk pregnancies results in a significant increase in stillbirth risk. Protocols for serial scanning need to be accompanied by quality assurance of ultrasound biometry.

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