

LGA infant), prepregnancy obesity and preexisting diabetes mellitus (an almost twofold higher risk to give birth to a LGA infant), gestational diabetes mellitus, and multiparity.

**Conclusions:** The results of this study identified predictive factors for LGA births in the studied population. Data collected support the planning of population-based interventions aimed both at prevention of this morbidity.

1191

### ACCURACY OF SCALES USED TO WEIGH NEWBORN INFANTS

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**Background:** Newborn infants who receive medical care are repeatedly weighed in hospital. These weights are used to determine adequacy of fluid balance, feeding and growth; and to determine appropriate drug doses.

**Objective:** To determine the accuracy of the scales used to weigh newborns in our hospital.

**Design/Methods:** All scales used to weigh infants in our hospital were checked with 3 standard weights: 500g, 1000g and 3500g. All weights were placed on each scales on 3 occasions (i.e. total 9 measurements) by one of two investigators. The order in which the weights were placed on the scales and the investigator who placed the weights on the scales were chosen randomly.

**Results:** We studied 28 infant scales (seca, Gremany. Models 335, 835-2, 376, 727, 375). Eleven (39%) scales measured the weights correctly on all occasions. Seventeen (61%) scales gave inaccurate results on 80 occasions in total, mean (SD) of 52 (29) % of occasions each. When inaccurate, the scales most frequently underestimated the true weight [63/80 (79)%]. Inaccurate measurements occurred increasingly frequently with heavier weights [19/84 (23%) measurements with the 500g weight; 24/84 (29%) with the 1000g; 37/84 (44%) with the 3500g]. The errors ranged from an underestimate of 40g to an overestimate of 220g. The mean (SD) error in absolute weight was 27 (33) g and in proportion of weight was 2 (3) %.

**Conclusions:** Scales used to weigh newborns are frequently inaccurate. While the errors we found were relatively small we speculate that they may be greater in clinical practice.

1192

### APGAR: CESAREAN SECTION AND VAGINAL DELIVERY

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One of the special problems in obstetric is extra ordinary increase of the Cesarean Section (C/S) rate.

**Aims:** To compare: A) APGAR score of C/S with V/D. B) Time of C/S with V/D.

**Materials & Methods:** This is a case-control study (retrospective), which compared 289 C/S case notes with 301 V/D. (Randomly selected from entire case notes of one of the non-educational hospitals of Iran University of Medical Sciences. The descriptive and inferential statistics (X<sup>2</sup>, T test, and mann-witny) were used.

**Results:** Average of first APGAR score in V/D group was 8.15 (SD= +\_ 1.6) and in C/S was 7.78 (SD= +\_ 0.9). Average of APGAR score after 5 minutes in V/D group was 9.34 (SD= +\_ 1.2) and in C/S was 8.86 (SD= +\_ 0.7). Rate of C/S Section at 10AM was 7.2%, at 3 PM was 7.2%, and during 12 MN till 5 AM was 6.5%. 7% of C/S did not have acceptable or clear reasons such as Tubectomy (8 cases) etc.

**Conclusions:** There was significant difference between minute one and minute five APGAR scores of the two groups. (P= 0.000) Therefore it is not acceptable that with C/S baby will have better APGAR score. There was correlation between time and type of delivery. (P=0.000) It might be due to convenience factors. This study indicates that some operations were not done for medical reasons, such as clients' demands because of fear from pain of V/D, therefore with respect to patient rights; obstetricians must offer more counseling about side effects of C/S.