

a fetus with Edwards syndrome. She was asymptomatic post administration of mifepristone 48 hours prior to admission. As an inpatient she was given 5 doses of misoprostol (400 micrograms) vaginally. Lack of progress necessitated 4 further doses after 24 hours break. The patient had a persistent pyrexia of above 38 degrees following 4<sup>th</sup> dose of misoprostol which was attributed to prostaglandin administration. Investigations revealed a CRP of 226 and a white cell count of 19.1. She was haemodynamically stable and used a remifentanil PCA for analgesia. In view of lack of response to Misoprostol she was rescanned revealing a bulky uterus with the fetus lying intraperitoneally with an intact amniotic sac. CT scan revealed a 6.3 cm defect in the anterior uterine wall with an intact sac projecting beyond normal uterine contour. There was no free fluid. In view of this patient had a laparotomy revealing a 6 by 5 cm defect in the anterior uterine wall lined by necrotic tissue. In view of significant amount of necrosis a decision was made to proceed with subtotal hysterectomy. We wish to highlight this rare case wherein uterine rupture occurred due to infection and uterine wall necrosis possibly secondary to amniocentesis and fetal demise. All the classical features of uterine rupture like haemodynamic instability and intraperitoneal bleeding were absent. Only a high index of suspicion leading on to further imaging helped establish the diagnosis.

**PM.78 USE OF INTRAVENOUS IRON SUCROSE INJECTIONS IN THE TREATMENT OF IRON DEFICIENCY ANAEMIA IN PREGNANCY**

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**Background** Iron deficiency anaemia (IDA) is the commonest cause of anaemia in pregnancy affecting 19% of the Leeds pregnant population<sup>1</sup>. It is associated with maternal morbidity including fatigue and postpartum depression<sup>2</sup>. It is also linked to adverse pregnancy outcomes including preterm delivery and intrauterine growth restriction.<sup>3</sup>

**Aim** To assess the use of intravenous iron sucrose antenatally in women with iron deficiency anaemia who were intolerant to oral treatment and its efficacy in increasing haemoglobin levels.

**Method** There were 23 patients who received iron sucrose injections in the antenatal period, identified retrospectively from the antenatal day records in the Leeds Teaching Hospitals.

**Results** Out of 23 patients in our cohort, 9 (39%) were given iron sucrose injections after 37 weeks gestation. 2 women (9%) received the injections between 20–30 weeks. The remaining 12 patients (52%) had their injections between 31–36 weeks. The mean gestation for commencing treatment was 34 weeks. The mean cohort haemoglobin level before treatment was 8.5 g/dl which improved to 9.9 g/dl after treatment. The maximum number of doses of iron sucrose injections used was 4. None of the patients required blood transfusion post-delivery. 2 patients (9%) delivered preterm between 31–37 weeks. 20 babies (87%) were born with an average birth weight between 2.5 kg–4.0 kg.

**Conclusion** Iron sucrose injections are very effective in increasing the haemoglobin level antenatally in women who can't tolerate the oral preparation or very severely anaemic.

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**PM.79 A REVIEW OF PREGNANT WOMEN ON TACROLIMUS AND PREGNANCY OUTCOMES IN LIVERPOOL**

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**Background** Fertility is usually restored in women with renal transplants, one series noting pregnancy occurring in 12% of women at childbearing age.<sup>(1)</sup>

Tacrolimus is the primary immunosuppressant in renal transplant patients. Improved transplant outcome correlates with increasing antenatal population receiving immunosuppressive therapy<sup>(2)</sup>. As pregnancy progresses, hepatic P450 cytochrome may be inhibited which thought to lead to increased serum Tacrolimus levels. We think circulating plasma volume increases and this would drop Tacrolimus levels by a dilutional effect.

**Methods** Retrospective analysis of notes from 2000–2012 from Renal-Obstetric clinic.

**Results** 15 pregnancies in 11 women on Tacrolimus recorded. Mean maternal age 30.1. Mean transplantation age 23.9 years. 5 patients had multiple renal transplants.

6 patients were primiparous (40%) and 9 multiparous (60%). Only 5 women received pre-pregnancy counselling.

10 pregnancies required increasing antenatal Tacrolimus dosing. 3 patients developed worsening renal function.

Mean gestation reached 30 weeks, with 80% of deliveries occurring <37 weeks. Live birth rate was 73.3%. 4 patients (26.7%) entered spontaneous labour, 5 (33.3%) required induction (33.3%) and 6 caesarean section deliveries (40%). Only 3 patients (20%) attended post natal follow-up within 6 weeks post-delivery.

**Conclusions** Our findings suggest dropping Tacrolimus levels in the late first and early second trimester, but then levels appear to gradually increase. Our live birth, IUGR and emergency caesarean rate were in consistence with rates noted in previous studies<sup>(3)</sup>. More research needed looking at the effect of fluctuant Tacrolimus levels and if a drop in first trimester is associated with adverse pregnancy outcome.

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**PM.80 RETRIEVABLE INFERIOR VENA CAVA (IVC) PHILTRES IN PREGNANCY – A CASE SERIES AND REVIEW OF THE LITERATURE**

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We report 3 cases of retrievable IVC philtres in pregnancy and performed a systematic review of the literature to determine the indications, success and complications rates for these devices in pregnancy.

A literature search of PubMed and Medline was conducted using the terms IVC philtre and pregnancy.

In our unit, 2 women had peripartum pulmonary emboli (PE) and the third woman had an iliac vein thrombosis and recurrent antepartum haemorrhage. Insertion of philtres was uncomplicated but only one was retrieved post delivery.