

deliveries, with 3 post-partum haemorrhages. Birth weights ranged from 2.37 kg to 4.9 kg. 155 patients had more than 2 sets of haematological investigations during pregnancy, with 83 patients having more than 5 measurements. 39.7% had haematinic investigations performed, with 48 of these patients had sub-optimal ferritin levels. Only 3 patients were defined as anaemic before 12 weeks gestation.

There are currently no national guidelines regarding appropriate haematological investigations in pregnancy. This study demonstrates the demographics and frequency of haematological investigation in our population. We have also identified the proportion of anaemia demonstrated at varying gestations.

PM.92 FACILITATION OF VAGINAL DELIVERY IN AN INFANT WITH COMPLETE HEART BLOCK (CHB) SECONDARY TO MATERNAL ANTI RO ANTIBODIES

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A 36-year-old, G4P4 presented at 7 weeks gestation, with known Sjogren's Syndrome (Lupus anticoagulant and Anti Ro antibody positive) and previous deep vein thrombosis. At 20 weeks gestation both anomaly and fetal echocardiogram were undertaken and confirmed as normal. However 10 days later repeat echocardiogram confirmed congenital heart block (CHB), ventricular rate 60 bpm. There was no evidence of either fetal hydrops or heart failure. The couple was counselled regarding the potentially poor outcome.

The pregnancy continued; the fetus remained healthy albeit with CHB. Options for delivery were regularly discussed. Given both her parity and history of quick labours she was keen, if possible, to avoid surgery. Serial growth scans confirmed good growth velocity. Comprehensive evaluation of heart function and fetal circulation (CVP score) and fetal well being (Biophysical Score) was assessed and shown to be maintained throughout pregnancy and at term when she presented in early labour. Labour progressed rapidly to delivery of a female infant, in excellent condition (Apgars of 9 at 1 and 5 minutes), birth weight 3.02 kg. The newborn was transferred to SCBU and an echocardiogram re affirmed CHB with good cardiac function. She established demand feeding over the next 48 – 72 hours without compromise and was discharged home with mum within the week. She remains well and has not yet required pacing (age 1 year).

Discussion The strategy of close fetal surveillance using both biophysical profile (BPP) and cardiovascular profile (CVP) scoring during both pregnancy and early labour facilitated a spontaneous vaginal delivery at term.(1)

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PM.93 A COMPLICATED CASE OF GIANT VULVAL CONDYLOMATA IN PREGNANCY

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Anogenital warts are one of the most common sexually transmitted diseases in the UK caused by HPV infection.^{1,2} The condition is not purely benign with significant symptoms present in some patients related to severity and site of disease with an increased risk of cervical and other anogenital cancers.^{2,3} HPV infection is higher in

pregnant women with rapid growth of warts observed which is thought to be related to immunological factors.⁴ Treatment, even in non-pregnant individuals is difficult and cure elusive.⁵ Treatment options are limited in pregnancy to conservative, non-teratogenic medical management and surgery.^{4,5} We present a case of massive condylomata in a pregnant patient complicated by brittle diabetes and mental health issues.

A 30 year old parous patient presented in early pregnancy with hyperemesis, poorly controlled type1 diabetes and a massive growth of vulval warts causing severe pain and difficulty mobilising. This large exophytic mass covered the vulvae and would preclude vaginal delivery. Genito-urinary medicine suggested a conservative course of treatment. Subsequently the patient had several admissions with hyperemesis and poor glycaemic control. The patient disclosed suicidal ideation related to the vulval warts and desire to not continue pregnancy. A termination of pregnancy was requested on this basis. Psychiatry review documented a depressive episode and suicide risk. In view of these factors a surgical resection was performed. This was complicated by significant blood loss requiring return to theatre, blood transfusion and HDU admission. Currently the pregnancy is ongoing.

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PM.94 THE MANAGEMENT OF A TWIN PREGNANCY IN A PATIENT WITH MAGIC SYNDROME

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In 1985 Firestein *et al*, first described patients with co-existent relapsing polychondritis and Behçet's Disease. They proposed the acronym MAGIC syndrome (Mouth And Genital ulcers with Inflamed Cartilage).

This is a rare condition with no more than twenty cases described in the literature to date.

This case is the first to report the management of a pregnancy in a patient with MAGIC syndrome.

The autoimmune pathogenesis can potentially damage cartilage anywhere in the body, including cardiac valves and tracheal cartilage. Therefore a multidisciplinary approach to the management of this pregnancy was paramount.

We describe her antenatal, intrapartum and post-partum management specific to this condition and demonstrate how this led to a safe delivery of her twins.

PM.95 SYSTEMIC LUPUS ERYTHEMATOSUS, IMMUNOSUPPRESSION AND SQUAMOUS CELL CARCINOMA OF THE TONGUE DURING PREGNANCY

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This case describes a 29 year old cigarette smoker with underlying Systemic Lupus Erythematosus (SLE) treated aggressively with