

the 10th centile. Ten women had bipolar disease and 6 used anti-psychotics. One (16%) baby was below the 10th percentile.

In total 12 women took olanzepine and of these 8 (66%) babies had a congenital anomaly, 4 had tongue tie but 3 babies (on fluoxetine and olanzepine) had major congenital heart disease.

Conclusion Women referred to a mental health clinic had increased rates of growth restriction compared with the general population. Numbers are small but association of antenatal anti-psychotics with fetal growth restriction and congenital anomalies needs to be considered.

PM.66 WITHDRAWN BY AUTHOR

PM.67 BOWEL PERFORATION FOLLOWING SEVERE CONSTIPATION IN PREGNANCY: A CASE REPORT

doi:10.1136/archdischild-2013-303966.148

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Stercoral perforation is defined as "perforation of the bowel due to pressure from a faecal mass." This is due to an accumulation of stool that has hardened and has remained in the bowel over a long period of time causing stagnation and deformity of the large intestine.

At 25 weeks gestation a lady attended with severe constipation despite various stimulants/enemas and left sided abdominal pain. She started vomiting and felt generally unwell. She had abdominal distension and sluggish bowel sounds. Haematology and biochemistry were normal. Ultrasound showed large amounts of gas in the bowel but was otherwise unremarkable. The surgeons reviewed her, excluded any obstruction and continued conservative management with observation and laxatives. Her pain and constipation continued until she became tachycardic and tachypnoeic, her CRP began to rise. Prophylactic steroids were given. Antibiotics were commenced and urgent MRI arranged. MRI showed no obvious stricture or structural obstruction. A Naso-gastric tube was passed draining bilious fluid. Throughout the day her clinical condition deteriorated. She was transferred to delivery for critical care review and surgical input.

She eventually went to theatre for a de-functioning ileostomy. At laparotomy bowel perforation was identified with faecal peritonitis. She had a colectomy. Due to maternal condition and access and post operative considerations the baby was delivered by caesarean section.

Although constipation is common amongst pregnant women it is usually corrected by conservative measures such as stimulants/enemas and adequate hydration. Refractory cases should prompt early referral for investigation for underlying pathology.

PM.68 MANAGEMENT DILEMMAS OF CONN'S SYNDROME IN PREGNANCY

doi:10.1136/archdischild-2013-303966.149

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The most common cause of primary hyperaldosteronism is Conn's syndrome (80%), and treatment resistant hypertension with hypokalaemia in pregnancy should prompt investigation for this. There is physiological up-regulation of the rennin-angiotensin system during pregnancy, resulting in secondary hyperaldosteronism. The true incidence of Conn's syndrome in pregnancy is unknown but low, and vague presentations make diagnosis and management a dilemma.

A 25 year old primigravida presented at 26 weeks with hypertension, proteinuria and bilateral leg oedema. She had an emergency caesarean section for severe pre eclampsia. Persistent hypokalaemia lead to a subsequent diagnosis of Conn's syndrome. She had normal

adrenal imaging. She began pharmacological treatment with spironolactone. Currently she is 24/40 into her second pregnancy.

Spironolactone is contraindicated due to its teratogenic effects particularly virilisation of male fetuses. She has been commenced on low dose Aspirin and oral potassium supplements. Her renal function and Magnesium levels, along with blood pressure and urinalysis are being monitored regularly.

Studies have shown unsatisfactory hypotensive effects with methyldopa, hydralazine, labetalol, diazoxide and nifedipine. There is limited research available for eplerenone which is structurally similar to spironolactone but weaker and so does not have virilising effects, this is however unlicensed. Although the presentation of pathology can be non specific and "normal" in early pregnancy, treatment resistant hypertension requires assessment for primary hyperaldosteronism. Management has considerable difficulties due to the teratogenicity/lack of evidence on first line pharmacological treatments. So far there is supportive evidence that amiloride is safe and effective and could be used in these cases.

PM.69 HAEMATINIC EVALUATION AND SUPPLEMENTATION IN A NORMAL PREGNANCY

doi:10.1136/archdischild-2013-303966.150

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Maternal and Neonatal complications have been described in antenatal iron, folate and B12 deficiencies.¹ International recommendations have described the investigation and treatment of haematinic deficiencies.²

A prospective audit was conducted between January and April 2012. Postnatal patient charts were randomly sampled. Data was entered into a secure database. Haematinic levels were retrospectively acquired using institutional laboratory systems.

176 patients were included in our sample group, with a total of 757 investigations. 155 patients had more than 2 sets of haematological investigations during pregnancy. 39.7% had haematinic investigations performed. 48 patients had a ferritin level below 30 ug/L, of which 11 were using iron supplementation. 69.8% of patients reported folate supplementation, with 12.5% taking combined antenatal supplementation. 21% were taking a form of iron supplementation. Of the 28 people who were recorded as not taking antenatal supplementation, 6 had suboptimal ferritin levels.

Currently, there are no national guidelines on haematinic investigation in the antenatal population. This is imperative to improve patient outcomes. It is also essential to treat those who demonstrate clinical anaemia, and sub-optimal ferritin levels.

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PM.70 COMPARATIVE STUDY BETWEEN GESTATIONAL AND PREGESTATIONAL DIABETES IN RELATION TO GLYCEMIC CONTROL AS REGARDING FETAL AND NEONATAL OUTCOME

doi:10.1136/archdischild-2013-303966.151

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Background Pregnancy tends to reset the glucose homeostasis in the direction of diabetes. About 1–2% of all pregnant women

develop an abnormal glucose tolerance in pregnancy, but most often glucose tolerance returns to normal postpartum. This condition is called gestational diabetes mellitus (GDM).

Aims Comparative study between gestational and pregestational diabetes in relation to glycemic control as regarding fetal and neonatal outcome.

Methods This study was conducted in Kasralainy Maternity hospital in Egypt from september 2011 to march 2012 and it included 60 pregnant women complicated by DM attending outpatient clinic or inpatient. Patients were classified into two groups, Gestational Diabetes: 30 pregnant women complicated by DM which is diagnosed for the first time during pregnancy and Pregestational Diabetes: 30 pregnant women who have DM that has been diagnosed prior to pregnancy.

The two groups were compared according to fetal (macrosomia and intrauterine fetal death) and neonatal (respiratory distress syndrome and birth injuries) complications. All patients were 18 to 40 years old, singleton pregnancy, with time of termination after completed 37 weeks.

Results Fetal macrosomia occurred more with GDM, on the other hand birth injuries and RDS occurred more with Pre-GDM. Macrosomia and RDS were commoner among poor glycemic control in pregnant diabetic females than birth injuries and IUFD.

Conclusions Glycemic control started as early as possible (the best being preconceptional) is important to decrease the incidence of birth injuries, macrosomia, fetal mortality, the need for NICU admission (RDS).

PM.71 A CASE OF LATE ONSET POSTPARTUM ECLAMPSIA: AN EXTREME OF ECLAMPSIA?

doi:10.1136/archdischild-2013-303966.152

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Eclampsia is the onset of generalised seizures in the setting of pre-eclampsia.¹ Traditionally eclampsia occurring more than 48 hours into the postnatal period was thought rare and termed; late onset postpartum eclampsia.² Evidence shows a changing pattern of disease with eclampsia rates falling however a comparative increase in late postpartum seizures.^{3,4} These may lack classical symptoms and signs and may not be identified before seizure onset.^{1,2}

A 27 year old parous patient presented 7 days postnatally with generalised tonic-clonic seizures, severe hypertension and neurological irritability with no proteinuria. This was preceded acutely with severe headache. Previous history was uncomplicated by hypertensive disease and her partner was unchanged. There was no symptomatology of pre-eclampsia in the antenatal or immediately postnatal period. Antenatal history was uneventful showing generalised oedema only and there was concurrent and progressive fetal growth. Following routine discharge after caesarean section for failure to progress in labour this patient represented with a seizure from home. There was a normal CT of brain. This patient responded to magnesium sulphate and labetalol with no further seizures and a large diuresis. Ongoing blood pressure control proved to be difficult, requiring multispecialty input.

We conclude that the "classic" definitions of these diseases may present barriers for rapid diagnoses and treatment with late postpartum variants showing atypical symptomatology, signs and disease progression with a non-linear relationship between pre-eclampsia and eclampsia. We advocate increased vigilance and reporting in the late postpartum period.

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PM.72 HOMOCYSTEINEMIA AND PREGNANCY A DANGEROUS COMBINATION

doi:10.1136/archdischild-2013-303966.153

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Preeclampsia represents one of the most frequent complications of pregnancy. Damage of the endothelial layer lining the blood vessel wall is thought to play an important role in the pathophysiology of preeclampsia, accordingly, mild hyper homocysteinaemia has been reported to be more prevalent among pre-eclamptic women. Homocysteine is a naturally occurring sulphur containing amino acid resulting from demethylation of methionine. The accumulation of homocysteine and its metabolites is caused by a disruption of any of the required enzymes or cofactors involved in the pathways of methionine metabolism. These abnormalities could arise from genetic predisposition and/or nutritional and environmental factors. The most common cause of homocysteinemia, encompassing 95% of the patients, is a deficiency in the cystathionine B-synthase (CBS) enzyme, defective methylcobalamin synthesis, or abnormality in methylene tetrahydrofolate reductase (MTHFR). Homocysteine is responsible for endothelial cell damage leading to proatherogenic effects, thromboembolic effects, hypoperfusion of placenta, and overproduction of free radicals. In pregnancy homocysteinemia has been implicated with recurrent miscarriage, pre-eclampsia, placental abruption, IUGR, preterm delivery. We present a unique case of massive abruption and IUD. A 34 year old G4 P1 + 2 with an uneventful antenatal period presented at 36 weeks with antepartum haemorrhage, massive abruption and intrauterine demise diagnosed on admission. Postpartum investigations of note were elevated urate at 394, red cell distance width of 19.2, and Homocysteine level of 17.7 mmol/l (mild Homocysteinemia). Review of literature indicated plasma levels over 12 mol/L should be treated aggressively with vitamin supplementation. We had therefore initiated therapy with B12, B6, folic acid to normalise homocysteine levels.

PM.73 CASE REPORT: ABDOMINAL CUTANEOUS NERVE ENTRAPMENT SYNDROME IN THE PREGNANT PATIENT

doi:10.1136/archdischild-2013-303966.154

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Case Report A 25 yr para 1 (NVD) at 30 + 2 weeks gestation presented with severe right sided abdominal pain. Vital signs were stable. Tenderness was elicited in the right lumbar region with voluntary guarding. WCC, CRP and urinalysis were normal. Fetal assessment ultrasound was normal. A Surgical opinion excluded acute surgical causes. Urgent MRI was normal. There was no improvement despite IV morphine. When the patient was reassessed, clinical examination revealed an area of tactile allodynia on the lateral edge of the rectus sheath from T8 to T12 with a positive Carnett's sign. A diagnosis of ACNES was made, and the pain resolved with administration of lignocaine patches. An exacerbation three weeks later required local infiltration of the cutaneous abdominal nerves. Caesarian delivery was performed at 34+5 weeks to relieve abdominal distension and prevent risk to the fetus of opiate analgesia. The pain spontaneously resolved post-partum.