

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?

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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

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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

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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.

Conclusion ACNES is an uncommon cause of abdominal pain in the pregnant patient.

The fibrous ring in the rectus muscle, through which the medial cutaneous nerve travels, causes nerve ischemia when compressed. Risk factors include abdominal distension, subcutaneous oedema, and previous surgery especially Pfannenstiel incision. The syndrome, commonly affecting the 7th–12th intercostal nerves, causes unilateral pain, hypoesthesia/hyperesthesia and a positive Carnett's sign. Management with local anaesthetic injection relieves symptoms and confirms the diagnosis.

This diagnosis should be considered in cases of severe abdominal pain when investigations are normal. The advantages of early diagnosis are relief of maternal pain and avoidance of delivering a preterm fetus.

PM.74 PLACENTAL ABRUPTION SECONDARY TO ACUTE PANCREATITIS CAUSED BY HYPERTRIGLYCERIDAEMIA

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Introduction Placental abruption secondary to pancreatitis is rare. There are two cases in the literature. There are no previous reported cases of placental abruption secondary to pancreatitis caused by hypertriglyceridaemia.

Case We present the case of a 30 year old low risk primigravida who presented at 39 weeks and 6 days gestation with severe epigastric pain. Her bedside observations revealed tachypnoea but were otherwise normal. Urinalysis revealed proteinuria (++) . Vaginal examination was consistent with early labour. Initial differential diagnosis included a surgical emergency, pre-eclampsia, labour and placental abruption. Initial CTG was normal but became pathological and she went on to have emergency caesarean section within two hours of arrival. Operative findings included milky white ascitic fluid on opening the abdomen and a retroplacental clot. Chemical pathology telephoned to inform the team that her blood tests appeared lipaemic and she had an amylase of 1043 U/L (20–120 U/L) and triglycerides of 134 mmol/L (<1.70 mmol/L). She was transferred to intensive care and has had a complicated recovery, which included cardiac arrest on her first postoperative day. At the time of writing, she remains on intensive care (her seventh week) and is being considered for a pancreatectomy for severe haemorrhagic pancreatitis.

Conclusion Acute pancreatitis should be considered in all patients presenting with upper abdominal pain. It can be difficult to diagnose and present non-specifically, particularly in the latter stages of pregnancy. It is an important cause of abruption. Triglycerides increase in pregnancy and are a well established cause of pancreatitis.

PM.75 SAFETY OF FONDAPARINUX IN PREGNANCY- EXPERIENCE OF A NORTH WEST TERTIARY REFERRAL CLINIC

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Venous thromboembolism (VTE) is amongst the leading causes of maternal death in developed countries. Several series have confirmed the safety and efficacy of LMWHs in pregnancy and it has become the favoured anticoagulant. Adverse skin reactions to LMWHs are rare but recognised events, whereupon a particular LMWH may be successfully replaced with another one. However if the skin symptoms do not improve an alternative must be sought.

Fondaparinux is a synthetic pentasaccharide. Whilst it has been extensively studied for use both in surgical prophylaxis and

treatment of thromboembolic diseases; its use in pregnancy is less well documented.

We report 4 pregnancies in 3 women using Fondaparinux which adds to the available literature. All required thromboprophylaxis because of previous pregnancy associated VTE when they demonstrated broad cross-reactivity between several heparins and/or heparinoids.

In 3 pregnancies Fondaparinux was commenced in the first trimester and continued until 6 weeks postpartum. All continued without event resulting in vaginal delivery of well grown babies at term. There was no minor or major maternal bleeding (mean blood loss 250 mls) or thromboembolic event reported during the pregnancy or post-partum period. All babies were breastfed without effect. There was no congenital abnormality or neonatal bleeding. In a 4th pregnancy LMWH was initially deferred until 20 weeks gestation where upon recurrent allergic skin reaction led to the change to Fondaparinux. Review at 37 weeks gestation was pre-empted by a complaint of reduced fetal movements with pathological CTG necessitating emergency caesarean section at her base hospital.

PM.76 A QUESTION OF PROBITY: PHANTOM BLOOD GLUCOSE VALUE RECORDING IN A SELF-MONITORING PREGNANT DIABETIC WOMAN

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Introduction A successful doctor-patient relationship is based on perceived mutual trust. The importance of this is underscored in pregnant diabetic women where self monitoring of blood glucose (SMBG) levels by patients' informs and directs shared clinical decisions which impact significantly on their lifestyle, diet and medication adjustments so that a good pregnancy outcome is achieved.

Case Report A 29 yr old para2 woman with type 2 diabetes was booked and followed up in the combined antenatal diabetic clinic through her third pregnancy. She required metformin and subcutaneous insulin injections to control her blood glucose prior to conception. These were continued in pregnancy with an increase in the frequency of blood glucose monitoring. At 28 weeks of pregnancy, it was noted that blood glucose values recorded in her logbook over the course of 8 weeks consistently showed fasting levels <5 mmol/l and 1 hr postprandial levels <7 mmol/l despite HbA_{1c} levels of 72 mmol/mol (8.7%) and ultrasound scan showing fetal macrosomia and significant polyhydramnios. A review of her glucometer identified difference in the values stored in the memory and that recorded in her logbook. This discrepancy was brought to her notice and she divulged falsifying the values. She was delivered by emergency caesarean section for fetal compromise at 32 weeks gestation.

Conclusion Accuracy of home metres and diary logs needs to be confirmed at regular intervals, and SMBG values should not be the only criterion for diabetes management during pregnancy.

PM.77 SUSPECT THE UNEXPECTED!: A RARE CASE OF UTERINE NECROSIS AND ASYMPTOMATIC RUPTURE FOLLOWING INDUCED MISCARRIAGE AT 20 WEEKS GESTATION

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A 38 year-old parous lady with an unscarred uterus was admitted for induction of medical miscarriage following intrauterine death of