A total of 48 patients were identified from 20 publications (51 including our patients). Indications for insertion included extensive deep vein thrombosis (DVT) (39), PE (7), recurrent thrombosis (1), contraindication to anticoagulation (1) and unknown (3). Complications at insertion occurred in 2 patients. Two philtres were not removed, one philtre was repositioned and outcome was unclear in 5. Therefore 37/40 were retrieved successfully (81%). Retrieval failed in 8 women because of failure to snare (2), tilting (4), fracture and migration of the device(1) and occlusion of the philtre with thrombus (1).

The incidence of failed retrieval of IVC philtres in pregnancy (18%) is at the higher end of the spectrum reported in the general population (0 – 22%). Careful consideration of the benefits and risks of IVC philtre placement in pregnancy is paramount and the patient needs to be informed that almost one in five philtres remain in situ with subsequent increased risk of post thrombotic syndrome.

PM.81 THE IMPACT OF AN OBSTETRIC ANAESTHETIC ANTENATAL CLINIC FOR THE MORBIDLY OBESE, A RETROSPECTIVE STUDY

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The CMACE/RCOG joint guideline recommend in their management of women with obesity in pregnancy guideline that pregnant women with a booking BMI > 40 should have an antenatal consultation with an obstetric anaesthetist. We compare the pregnancy outcome data in our morbidly obese population from both before and after the introduction of our specialist obesity obstetric anaesthetic clinic.

We performed a retrospective audit, comparing pregnancy outcomes in the first six months of 2009 pre-clinic, and the first six months of 2011 post clinic establishment, in the morbidly obese, looking at; anaesthetic type, estimated blood loss, cord pH < 7.1, cord pH < 7.0, and APGARs at 1, 5 and 10 minutes. The results are reviewed in the context of mode of delivery, induction, preterm delivery and birth weight.

Results The type of anaesthetic for elective section was 12/12 (100%) spinal in 2009 v 10/11 (90.9%) spinal +1/11 (9.1%) epidural in 2011. For emergency section the type of anaesthetic was 3/12 (25%) epidural + 9/12 (75%) spinal in 2009 v 10/15 (66.7%) epidural with one conversion to general anaesthetic (6.7%) +5/15 (33.3%) spinal in 2011. Estimated blood loss in 2011 appeared higher than in 2009, but was not significantly so. Comparing EBL in 2009 v 2011; 23/46 (50%) v35/70 (50%) had <500 ml, 20/46 (43.3%) v25/70 (35.7%) had 500–999 ml, 1/46 (2.1%) v 4/70 (5.7%) lost 1000–1499 ml, 2/46 (4.3%) v 5/70 (7.1%) lost >1500 ml. Cord pH below 7.0 occurred in 1/46 (2.1%) in 2009 v 1/70 (1.4%) in 2011. APGARS below 8 at 1, 5 and 10 minutes were 3/46 (6.5%), 1/46 (2.1%) and 1/46 (2.1%) respectively in 2009 and 13/70 (18.6%), 2/70 (2.8%) and 0/70 (0%) respectively in 2011.

There were no obvious improvements in our outcome measures following the introduction of a consultant obstetric anaesthetist clinic for those with morbid obesity.

PM.82 ACUTE HYPONATRAEMIA IN LABOUR – THE OBSTETRIC MARATHON?

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Maternal hyponatraemia during labour can affect both mother and baby. As a result, standard intrapartum care includes administration of oxytocin in sodium-containing fluids, limitation of oral intake and use of isotonic sports drinks. There is no strict guidance on best practise and local protocols vary.

We present a case report of acute severe hyponatraemia following spontaneous vaginal delivery at 38^{+5} weeks gestation in a 34-year-old primiparous woman. This previously well woman spent 4.5 hours in the birthing pool and drank approximately 6 litres of water/lucozade in that time. After delivery, she suffered a seizure and acute confusion. The plasma sodium was 117 mmol/L (135–145 mmol/l). This was corrected with hypertonic saline to 130 mol/L within 4 hours. She was admitted to intensive care and required sedation and ventilation. Endocrine investigations revealed no underlying cause. Differential diagnoses included atypical eclampsia and posterior-reversible encephalopathy syndrome. She was discharged on day 6 with a Mini-mental State Examination score of 30/30.

Isotonic drinks prevent urinary ketosis, maintain plasma glucose and electrolytes, thereby preventing the 'starvation effect' of labour, also seen in marathon runners. Review of the literature relating to the effect of water immersion and oral fluid intake on plasma sodium levels during labour suggests that a 40-minute bath may cause increased naturiesis and plasma volume expansion. Water tolerance appears diminished in labour and thus intoxication may be possible with relatively moderate volumes.

We recommend that in labour a) women do not drink excessively, b) hypotonic fluid administration is avoided, c) fluid-balance charts become mandatory.

PM.83 TESTING FOR FETOMATERNAL HAEMORRHAGE BY ACID ELUTION CAN YIELD FALSE POSITIVE RESULTS IN THE PRESENCE OF ELEVATED MATERNAL FETAL HAEMOGLOBIN

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Appropriate testing for fetomaternal haemorrhage (FMH) is critical in the prevention of morbidity and mortality due to haemolytic disease of the fetus and newborn (HDFN) in RhD negative women. The Kleihauer or acid elution (AE) test is widely used to assess the size of fetomaternal haemorrhage and to determine whether sufficient Anti-D immunoglobulin has been administered to prevent HDFN. This test is based on the principle that adult haemoglobin (HbA) is eluted from red cells in an acidic solution while the fetal haemoglobin (HbF) is not. However, in the presence of an elevated level of HbF of maternal origin, the AE test may be "positive" in the absence of a true FMH. We report two cases in which this situation arose antenatally, leading to difficulties in clinical interpretation. In both cases, specialised flow cytometry revealed the presence of elevated levels of HbF of maternal origin. While awaiting completion of specialised investigations, Anti-D was administered but was later found to have been unnecessary. Early awareness of the possibility of elevated maternal F cells ensures that samples can be sent to appropriate reference laboratories early to limit unnecessary Anti-D administration. The true prevalence of "false positive" AE tests due to elevated maternal HbF is unknown and is the subject of ongoing work in our laboratory, but should be considered in the differential diagnosis of an AE test remaining positive despite appropriate Anti-D administration.

PM.84 THE ASSOCIATION BETWEEN SEVERITY OF IMPAIRED GLUCOSE TOLERANCE IN GESTATIONAL DIABETES WITH AGE, BMI AND ETHNICITY

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Introduction Gestational diabetes (GDM) has been shown to cause adverse fetal outcomes including macrosomia, shoulder dystocia and stillbirth. The multinational Hyperglycaemia and Pregnancy Outcome (HAPO) Study has shown there is a linear relationship between oGTT result and fetal growth. Investigating epidemiological risk factors is essential to ensure appropriate high-risk groups are being screened.

Methods and Materials A retrospective case note review was undertaken of all patients with newly diagnosed GDM ($n = 321$) over a 2-year period at the West Middlesex University Hospital. The 75 g oGTT results were recorded with relevant demographic data including parity, age, BMI and ethnicity.

Results Asian ethnicity had the highest fasting plasma glucose ($\mu = 5.49$; $n = 208$), and 2-hour plasma glucose ($\mu = 9.32$; $n = 208$). One-way Anova revealed a statistically significant difference between Caucasian, Black, Asian and Oriental ethnicities with fasting glucose ($p = 0.008$) and at 2 hours ($p = 0.046$). Regression analysis revealed a significant direct association between BMI and fasting glucose ($p = 0.002$; $R = 0.169$). On simple scatter plot analysis, an inverse correlation was evident between age and fasting plasma glucose level, although this was not significant on regression analysis.

Discussion This study highlights the variation in glucose tolerance between different ethnicities. It also substantiates the known relationship between BMI and fasting plasma glucose. Historically increasing age has been associated with insulin resistance and is a known risk factor for GDM. Interestingly, this study suggests that fasting glucose amongst GDM patients is inversely related to age, perhaps owing to lifestyle factors and differing perceptions amongst younger patients.

PM.85 DIAGNOSING PE IN MATERNITY PATIENTS. AN AUDIT OF RADIOLOGICAL INVESTIGATIONS AND CLINICAL INTERPRETATION

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VTE is an important cause of maternal mortality but signs and symptoms are unreliable. Ionising radiation has hazards for the fetus and mother. Current American Thoracic Society guidelines recommend VQ scans in preference to CTPA if chest x-ray and lower limb Doppler are negative but clinical suspicion remains.

VQ scans are not diagnostic, results are given as a probability of PE, i.e. none, low, intermediate or high which can be difficult for the clinician to interpret.

We undertook an audit to compare practise with guidelines and assess clinical interpretation of VQ scans. Results were compared with CTPA. All maternity patients, between 8 weeks gestation and 6 weeks post-partum, undergoing VQ or CTPA were identified from a radiology database. Clinical information was obtained from notes and computerised records. Data was analysed with excel and 2 × 2 tables.

78 maternity patients were identified, 5 had PE identified on CTPA. Chest x-ray was performed in 92% patients and lower limb Doppler in 68% (audit standard 100%). VQ scans were performed in 59% women and CTPA in 56%. 60% patients with low/intermediate and intermediate VQ scans underwent CTPA and 2 (33%) were found to have PE. In the 12 patients who underwent both CTPA and VQ scanning, the sensitivity of VQ was 33% and specificity was 60%.

Clinicians need to be aware of the high probability of PE in patients with intermediate results, and in many cases even a low probability result should prompt consideration of CTPA.

PM.86 MELANOMA IN PREGNANCY: A CASE REPORT

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A 36 year old presented at 20 weeks gestation with an abnormal mole. Biopsy revealed a non-ulcerated Stage 1B malignant melanoma with 1.3 mm Breslow thickness and 3.5 mitosis/mm^2 (T2a). Lymphoscintigram identified an inguinal sentinel node. She underwent sentinel node biopsy (SNB), wide local excision (WLE) and exicision of the melanoma biopsy scar. She delivered a healthy female infant at 38 weeks with no placental or fetal metastasis. Follow up of the patient over the next 10 months has shown no disease recurrence.

The challenges surrounding melanoma in pregnancy lie in the timing and mode of investigation and treatment. Studies comparing localised melanoma in pregnant and non- pregnant individuals have not identified any differences in stage, tumour thickness, lymph node metastases or survival[1]. The management of this patient is more aggressive that that advocated in a recent case series in which WLE under local anaesthetic, with SNB postpartum is advocated for second trimester T1b-2b patients.[2] No adverse effects to the fetus have been identified following lymphoscintigram[3]. In conclusion, our data support the use of lymphoscintigram with SNB during pregnancy.

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PM.87 UNPLANNED PREGNANCY IN A WOMAN WITH HUNTINGTON'S CHOREA

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A 35 year old hospital worker was diagnosed with Huntington's disease in the previous year after following a personality change.

Her main symptoms reported was that of choriform movements and anxiety which was managed with 150 mg of Venlafaxine. Her mother also suffers from the condition. The pregnancy was unplanned and booked at 24 weeks. The couple were aware of the 50% risk of inheritance to the baby, but declined prenatal testing as they would not have undergone a termination should the result be positive. Antenatally, her choriform movements increased causing her to fall and fracture her right humerus. She required help with activities of daily living and subsequently social workers and occupational therapists were involved in her care. There was evidence of good clinical growth, although at 34 weeks gestation scan demonstrated evidence of an enlarged heart for which all investigations were normal.

The plan was to aim for a vaginal delivery, however she presented with SROM of thick meconium in early labour. She progressed to 4 cm dilatation, developed a bradycardia and subsequently had a CS. The apgars were normal and the patient made a straightforward post op recovery. The enlarged heart was not confirmed postnatally.

This report focuses on the issues involved in reproductive decision making and prenatal testing in parents at risk of Huntington's disease. Both deciding to abstain from having children or to pursue prenatal testing, with a 50% chance of a positive result, reflect complex problems.

PM.88 SEPSIS – KEEPING AN OPEN MIND!

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