cytotoxic immunosuppression (cyclophosphamide and mesna). Five years later and at approximately 12 weeks pregnant she is confirmed as having squamous cell carcinoma of the right lateral border of the tongue with early local invasion. Not wishing to consider termination of her pregnancy, she underwent surgical resection; which included tracheostomy, right functional/selective neck dissection, manibulotomy, partial glossectomy and oral reconstruction using left radial forearm flap with microvascular reconstruction. Good oral function (speech and swallowing) was restored within two weeks. Potential complications include thrombosis of the microvascular reconstruction secondary to the hypercoagulable state associated with SLE and pregnancy and the complications of surgery itself on the pregnancy, namely miscarriage. The pregnancy proceeded relatively uneventfully to 37 weeks gestation when proteinuric hypertension necessitated induction of labour. The patient remains well, however, some of the scars have healed with hypertrophic/keloid scar formation. There is currently no evidence of recurrence but surveillance is essential and continues.

PM.96 EARLY ONSET SEVERE PRE-ECLAMPSIA AND HELLP SYNDROME AT 21 WEEKS GESTATION

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HELLP syndrome; haemolysis, elevated liver enzymes and low platelets may be regarded as a variant or complication of severe pre-eclampsia occurring in 0.5–0.9% of all pregnancies and in 10–20% of cases of severe pre-eclampsia[1]. It is associated with increased maternal morbidity and mortality.[2] Onset earlier than 28 weeks is rare and there is little published data on maternal and perinatal outcome.[1 3] We present a case of severe pre-eclampsia complicated by HELLP syndrome at only 21 weeks gestation.

A 38 year old primiparous patient presented at 21 weeks gestation with headache, visual disturbance and generalised oedema. She was severely hypertensive with significant proteinuria. Following admission she developed haematological and biochemical features of HELLP syndrome with a normal glucose level.

Due to her worsening clinical and haematological condition she was commenced on magnesium sulphate infusion, methyldopa and her pregnancy was terminated with misoprostol therapy. Following 2 cycles of treatment she progressed to a normal vaginal delivery of an 18 week size stillborn male.

After delivery there was marked improvement in blood pressure and haematological markers. Postnatally labetolol controlled blood pressure well. Investigations for underlying pathology included; anti-phospholipid screen, homocysteine, anticardiolipin antibodies, lupus anticoagulant and renal artery and Doppler ultrasound. These were normal. The patient was discharged to primary care on postnatal day 6 and has expressed a keen desire for subsequent pregnancy. As this patients recurrence risk is high[4] she required counselling for future pregnancy.

REFERENCES

1. Sibai BM. HELLP Syndrome, UpToDate (Sept 2012), http://www.uptodate.com/contents/hellp-syndrome (accessed October 2012).
2. Paruk F and Moodley J. Maternal and neonatal outcome in early- and late-onset pre-eclampsia. *Seminars in Neonatology* 2000;5:197-207.
3. Sibai BM. Evaluation and management of severe preeclampsia before 34 weeks' gestation. *American Journal of Obstetrics and Gynecology* 2011;205:191-198.
4. August P, Sibai BM. Preeclampsia: Clinical features and diagnosis, UpToDate (Sept 2012), http://www.uptodate.com/contents/preeclampsia-clinical-features-and-diagnosis (accessed October 2012).

PM.97 NEURAL TUBE DEFECTS (NTDS) IN 21ST CENTURY IRELAND: A TERTIARY REFERRAL CENTRE'S EXPERIENCE

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The incidence of NTDs in Ireland has declined over the past two decades from 4.8/1000 births in 1980 to 0.8–1.5/1000 births in 2001[1] Preconceptual folic acid is accepted to reduce the incidence of NTDs however, 50% of pregnancies are unplanned.[2] We reviewed the cases over the past three years, their gestation at diagnosis and outcome in conjunction with EUROCAT reporting.

All cases of NTDS were identified from the Fetal Assessment Unit records between 2009 –2011. Maternal notes were reviewed to assess demographics and pregnancy outcome.

In total 45 cases of NTD were detected. The overall incidence in our population 1.44/1000 births. Table 1 illustrates the subcategories of NTD diagnosed with the continuation rates. 53.3% (n = 24) delivered in the Rotunda, a further 42.2% (n = 19) didn't re attend for antenatal care and 4.4% (n = 2) returned to other units. Those women who didn't attend for subsequent care were statistically more likely to have diagnosis earlier in the second trimester (16 +3) than those who delivered in the Rotunda (23 +1) p value <0.0001.

There was a significant difference in the average gestation of diagnosis between the group of women who chose to not continue their pregnancies compared to those who do continue. This suggests that early diagnosis affords more options to women of infants with NTD and suggests that second trimester scanning may be warranted, particularly in high-risk groups.[3] The high incidence of NTD and the poor obstetric outcome again raises the argument for food fortification in Ireland.

Abstract PM.97 Table 1 Neural Tube Defects

Neural Tube Defects	N (%)	% that continued pregnancy
Anencephaly	21 (47)	38.1
Enencephaly	2 (4)	0
Exencephaly	4 (9)	50
Encephalocoele	0 (0)	0
Myelomeningocoele	18 (40)	88.9

REFERENCES

1. Ward M *et al*. Folic acid supplements to prevent neural tube defects: trends in East of Ireland 1996–2002. *Ir Med J* 2004:274–6.
2. Report of the Implementation group on folic acid food fortification to the Department of Health and Children 2008.
3. McAuliffe *et al*. Ultrasound detection of fetal anomalies in conjunction with first-trimester nuchal translucency screening: A feasibility study. *Am J Obstet Gynecol* 2005;193:1260–5.

PM.98 MATERNAL RENAL OUTCOMES FOLLOWING PREGNANCY COMPLICATED BY CHRONIC KIDNEY DISEASE STAGES 3–5

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Objectives To establish the effect of pregnancy on deterioration of renal function in women with Chronic Kidney Disease (CKD) stages 3–5 attending the renal antenatal clinic.

Methods All women with excretory renal dysfunction (creatinine >110 μmol/L or eGFR < 60 ml/min) prior to pregnancy were identified from the Obstetric-Renal database. Outcomes assessed

included; decline in renal function during pregnancy (defined as 25% increase in serum creatinine), persistent decline in renal function six months post-partum and time to renal replacement therapy.
Results 49 women (57 pregnancies) with CKD stages 3–5 were identified with sufficient data for analysis. Diabetes mellitus was the underlying diagnosis in nine (16%) pregnancies. 18 (32%) pregnancies were complicated by chronic hypertension. 11 (19%) pregnancies occurred in women with previous renal transplant. 21% of women had >1 g/day proteinuria prior to pregnancy.

11 (22%) women had a decline in renal function in pregnancy. Decline in renal function at 6 months post-partum was present in a total of 16 (33%) women. Predictors of significant decline in renal function included; pre-pregnancy creatinine mean 222 μmol/L in those with decline in function and 138 μmol/L in those without ($p = 0.0015$), and significant proteinuria >1 g/day present in 87.5% ($p = 0.02$).

Nine (18%) women went on to need renal replacement therapy (RRT), four within a year of delivery. Mean time to RRT was 23 months.
Conclusions Pregnant women with CKD 3–5 are at high risk of deterioration in renal function during and after pregnancy. Level of creatinine prior to pregnancy and significant proteinuria are risk factors for decline in function.

PM.99 SYPHILIS SEROLOGY IN PREGNANT WOMEN OVER A PERIOD OF 7 YEARS (2005–2011) IN A LARGE MATERNITY HOSPITAL IN DUBLIN, IRELAND

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Nearly 1.5 million pregnant women are infected with probable active syphilis each year, and approximately half of infected pregnant women who are untreated, will experience adverse outcomes due to syphilis, such as early fetal loss and stillbirth, neonatal death, low-birth-weight infants, and infants with clinical evidence of infection.

Data for all patients with positive treponemal serology at booking visit from 2005 to 2011 was gathered.

Between 2005 and 2011, 179/64349 women had positive syphilis serology representing 0.28% of the patient population. These women were between the age of 19 and 41 with a higher prevalence among women of East European origin. In the 7 year period, 1 case of congenital syphilis was recorded. This patient was a DCDA twin pregnancy who booked late at 22 weeks and delivered prematurely at 23 weeks. Hence, syphilis treatment was not commenced.

This study highlights the continued prevalence of positive syphilis serology in our pregnant population. Our combined obstetric and infectious disease clinic optimises opportunities for appropriate treatment and follow-up. Contact tracing and screening for other sexually transmitted infections are also vital components of this service.

In the current economic climate, with continued emphasis on provision of cost-effective healthcare it is important to justify the cost of screening 67921 women to identify 179 cases. Untreated syphilis has a range of antenatal and paediatricsequelae and thus we recommend that screening for syphilis continues, particularly considering frequent migration of women from Eastern Europe to this country.

PM.100 A RARE CASE OF ANTI-NMDA RECEPTOR ENCEPHALITIS IN PREGNANCY

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Anti-NMDA receptor encephalitis is a distinct disorder characterised by the predictable sequential development of symptoms; prodromal symptoms are initially noted, followed by prominent psychiatric symptoms, seizures, an unresponsive/catatonic state, hypoventilation, and involuntary orofacial-limb movements. This disorder usually affects young women with ovarian teratoma but may also affect women of any age or even men.

We report the case of a 32 year old primigravid woman who developed psychosis with associated catatonia and autonomic dysfunction at 8 weeks gestation. Cranial imaging in the form of CT and MRI was normal. EEG showed slow waves and anti-NMDA receptor encephalitis was suspected. This was confirmed by the finding of serum anti-NMDA antibodies. Transvaginal Ultrasound and pelvic MRI suggested normal ovaries. She required admission to the High Dependency Unit for several weeks but eventually responded to plasma exchange, steroids, azathioprine, Intravenous immunoglobulin and antipsychotics.

She had an Emergency LSCS at 32 weeks gestation for PPROM and delivered a healthy male infant. A mature cystic teratoma was found at caesarean section which was excised.

Although being rare in pregnancy, anti NMDA encephalitis can respond to aggressive treatment and can be associated with good maternal and fetal outcomes. An awareness of this 'new disease' (first described in 2005) can lead to an occasional but dramatic surgical treatment of a psychotic illness.

PM.101 LOCALLY INVASIVE OESOPHAGEAL ADENOCARCINOMA DIAGNOSED IN THE SECOND TRIMESTER, THE OPTIONS

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Oesophageal cancer is a rare malignancy to present during pregnancy. Standard treatment outside of pregnancy involves three cycles of Cisplatin, Epirubacin and 5 Flurouracil, a combination rarely used in pregnancy, followed by oesophagectomy in week 15 of treatment. We aim to highlight the management dilemmas posed by such cases, balancing the risk of treatment options in trying to achieve the best outcome for both mother and baby.

We present the case of a 31 year old primiparous woman diagnosed at 23 weeks gestation with locally invasive oesophageal adenocarcinoma.

Delay in chemotherapy treatment with early delivery by Caesarean section risked disease progression to an inoperable stage for mum, and the risk of prematurity for baby.

We elected to start three cycles of the standard chemotherapy regime without delay, with increased fetal surveillance. Maternal anaemia developed. Prostaglandin induction took place at 37 + 2 weeks gestation, resulting in a forceps delivery of a live 2050 g male infant with Apgars of 9 and 9 at one and 5 minutes. Neonatal full blood count was normal at 12 hours of age. Postnatal staging confirmed the lesion was still operable and oesophagectomy took place at the usual chemotherapy surgery time interval. Good tumour margins were achieved and the patient returned home on day ten.

We discuss our rational not to delay treatment with early delivery by Caesarean section, accepting the risk of chemotherapy in pregnancy. We review the literature surrounding this cocktail of chemotherapeutic agents and discuss the dilemmas surrounding the treatment of her anaemia.

PM.102 THE EFFECT OF INTRODUCING A VENOUS THROMBOEMBOLISM RISK ASSESSMENT TOOL ON THE WORKLOAD OF A COMBINED OBSTETRIC-HAEMATOLOGY CLINIC

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