scan if indicated, induction of labour (IOL) based on consultant decision) with intensive management (ultrasound scan, maternal serum hPL, IOL if either result was abnormal). Anxiety was assessed by state-trait anxiety index (STAI) before and after investigations for RFM. Rates of protocol compliance and IOL for RFM were calculated.

Results 137 women were approached, 120 (88%) participated. 2 women in the standard group did not complete the study. 20% of participants had a poor perinatal outcome. All women in the intensive group had ultrasound assessment of fetal size and liquor volume vs. 96.7% in the standard group. Although there was no difference in IOL rates overall, 50% of the intensive group had IOL for abnormal scan or low hPL after RFM vs. 25% of controls who had IOL for RFM ($p < 0.01$). STAI reduced for all women after investigations but this reduction was greater in the standard group ($p = 0.02$).

Conclusion Women are willing to participate in an RCT of management of RFM with a low rate of attrition. Investigations decrease maternal anxiety. Participants randomised to the intensive group were more likely to have IOL for RFM.

PP.36 THE IMPACT OF UNEXPLAINED RECURRENT MISCARRIAGE ON SUBSEQUENT PREGNANCY OUTCOMES

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Aim We sought to determine subsequent pregnancy outcomes in a cohort of women with a history of unexplained recurrent miscarriage (RM) as compared to healthy pregnancy controls.

Study design This was a prospective cohort study of women attending a dedicated RM clinic in the Rotunda Hospital in 2011. Inclusion criteria included women with a history of three consecutive first trimester losses that were unexplained in the past, no medical intervention and singleton pregnancies only. The inclusion criteria for the healthy controls included no history of stillbirth, intrauterine growth restriction, preeclampsia or preterm labour.

Results Of the 42 women with RM recruited to the study nine (23%) experienced further first trimester miscarriages, one molar and one ectopic pregnancy. The remaining RM cohort with ongoing pregnancies (n = 31) were compared to healthy controls (n = 31) matched for age and BMI. The only statistical difference between the two groups was the earlier mean gestational delivery of the RM group (38 + 2 vs 39 + 4 weeks, $p = 0.004$) attributed to earlier induction due to their past history. Otherwise there was no significant difference with respect to pregnancy complications, delivery and neonatal outcomes. All of RM patients achieved successful term deliveries with a 74% vaginal delivery rate and a mean birthweight of 3.23 kg.

Conclusion This study re-iterates the reassuring prognosis for women with a history of unexplained RM who undergo supportive care at a dedicated clinic. The majority delivered appropriately grown fetuses at term which was comparable to healthy controls.

PP.37 THE ANTENATAL DETECTION OF SERIOUS CARDIAC ANOMALIES – EVALUATING A DISPARATE GROUP AGAINST A TARGET

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Background In 2010, the NHS Fetal Anomaly Screening Program (FASP) issued national targets for the antenatal detection rates (ADR) of "serious cardiac anomaly" at the 18^{+0}–20^{+6} week Fetal Anomaly Scan. There is no standardised definition for reporting for this heterogeneous group of anomalies. Here we evaluate the EUROCAT "serious cardiac group" against the FASP target of 50% antenatal detection, using data for 2010–2011 from the East Midlands and South Yorkshire Congenital Anomaly Register (EMSYCAR).

Methods Births between 01/01/2010 and 31/12/2011 reported to EMSYCAR as affected by one or more of the relevant cardiac ICD-10 codes were included in this analysis; cases associated with chromosomal anomalies were excluded. Birth prevalence and detection rates with 95% confidence intervals were calculated for each anomaly and compared to the FASP target.

Results The regional birth prevalence rate for the serious cardiac group was calculated; this varied between anomaly sub-groups from 0.59 to 4.42 per 10,000 births. The ADR failed to reach the FASP target: (44.85%, *39.14%–50.66%*) though it was not significantly lower. Overall, 7 sub-groups reached the FASP target; 2 groups achieving statistical significance.

Conclusion The EUROCAT serious cardiac group of anomalies show wide ranging birth prevalence and ADR between the subgroups, highlighting problems with standardised reporting. Given problems defining the group and the requirement for producing annual FASP target data at hospital level using small case numbers, there is major statistical uncertainty, leading to problems interpreting results. Standardisation of definitions and reporting will enhance the value of FASP targets for units.

PP.38 AN AUDIT INTO THE OUTCOMES OF PREGNANCY IN PATIENTS WITH THROMBOPHILIA

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In pregnancy, patients with thrombophilia are known to have a poorer obstetric outcome. However the outcomes of pregnancy are not well defined in the literature. We did a retrospective audit looking at a cohort of women with thrombophilia. Medical records were reviewed for pregnancy events pre and post diagnosis of thrombophilia, the management and pregnancy outcomes.

Twenty-nine women had a total of 125 pregnancies, 83 pre-diagnosis and 42 with treatment. They had a mean age of 34 years with mean age at diagnosis of 29 years old. Women treated after a diagnosis of thrombophilia had significantly less miscarriages in the 1st trimester and 2nd trimester (68% vs 21%, Fisher's exact test $P = <0.0001$) than those pre-diagnosis and treatment.

The current treated pregnancy outcomes showed a mean birth weight of the babies born at term (37–40 weeks) was 3.2 kg (Range 2.43–3.95 kg). 38% had spontaneous onset of labour, whilst 55% were induced at 38–39 weeks gestation. The remaining 7% included a miscarriage and stillbirth. Only 63% achieved a vaginal delivery compared to 91.6% in the pre-diagnosis pregnancies, which was statistically significant. ($P = <0.02$ Fishers exact test). This is due to the higher number of inductions at 38–39 weeks gestation in these women.

Therefore the recommended treatment for thrombophilia in pregnancy has significant benefit to the outcome of live birth. However due to induction of labour prior to the due date to reduce the risk of stillbirth women are less likely to achieve a vaginal birth.

PP.39 TEENAGE PREGNANCY – A DECADE SINCE THE UK DEPARTMENT OF HEALTH TEENAGE PREGNANCY STRATEGY PLAN: A REVIEW IN A UNIVERSITY TEACHING HOSPITAL IN LONDON, UK

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