to understand the effect this new technology (and the uncertainty it can create) is having on couples. Previous qualitative work in this field is limited to women’s experience of prenatal genetic testing or women’s experience of having an abnormal ultrasound scan.

We present qualitative research from 25 semi-structured interviews with women (and their partners) whose babies have fetal anomalies after CMA testing. Data was analysed using framework analysis. A thematic framework was then identified by recognising emerging themes. Five themes were identified: diagnosis, genetic testing, family and support, reflections of the treatment received and emotions.

Our results show that women recall being told about common trisomies but often no further testing. Women expected the conventional karyotyping and CMA result would be normal following a normal QFPCR result. There were frequent misconceptions by couples regarding aspects of counselling/testing. Communication of variants of unknown (clinical) significance (VOUS) presents a particularly difficult challenge. Good clear communication by health care professionals is paramount. Couples should have literature to take home summarising scan anomalies and reinforcing information about genetic testing.

**Conclusion**

Methods : Retrospective review of all new referrals to the recurrent miscarriage clinic at the Rotunda Hospital Dublin. Vitamin B12 and folate levels were assessed at the initial consultation.

Results : National B12 levels and folate levels were accepted as 6% based on new nutritional data. We evaluated the folate and coabalan status in 98 non-pregnant women with a history of recurrent spontaneous abortion (three or more consecutive) of unknown aetiology. Low Vitamin B12 was defined as serum value less than 190 ng/l, and serum folate values less than 4.5 ug/l were considered deficient.

In total 7.1% (n = 7) patients were Vitamin B12 deficient and only one patient was folate deficient. This compares with a national incidence of 6%. These levels were not statistically different.

**Conclusion**

Introduction The importance of preconceptual folic acid has been established. However the metabolism of folate and Vitamin B12 is interlinked. Weak association has been described between Vitamin B12 deficiency and recurrent pregnancy loss. This has led to the implementation in some centres of routine B12 levels in patients with recurrent pregnancy loss. Our goal is to determine the value of such testing and its role in the management of these cases.

To determine whether the incidence of folate and/or Vitamin B12 deficiency is higher in patients with recurrent pregnancy loss than the reported national incidence of deficiency.

Methods : Retrospective review of all new referrals to the recurrent miscarriage clinic at the Rotunda Hospital Dublin. Vitamin B12 and folate levels were assessed at the initial consultation.

Results : National B12 levels and folate levels were accepted as 6% based on new nutritional data. We evaluated the folate and coabalan status in 98 non-pregnant women with a history of recurrent spontaneous abortion (three or more consecutive) of unknown aetiology. Low Vitamin B12 was defined as serum value less than 190 ng/l, and serum folate values less than 4.5 ug/l were considered deficient.

In total 7.1% (n = 7) patients were Vitamin B12 deficient and only one patient was folate deficient. This compares with a national incidence of 6%. These levels were not statistically different.

**Conclusion**

Serum concentrations of folic acid and Vitamin B12 are not significantly altered in women with unexplained recurrent miscarriage and we propose that routine testing is not warranted.