Hospital and required ventilation support as the hypertrophy and severity dramatically increased.

The patient’s anomaly scan was normal and a fetal echocardiography did not show any signs of congenital, valvular, or structural abnormality. Neonatal hypertrophic cardiomyopathy usually has a poor prognosis that is not secondary to a cardiac malformation with the exception of transient hypertrophic cardiomyopathy in neonates of diabetic mothers [1].

Myocardial ischaemia can develop following acute fetal distress and the common neonatal manifestations of this include cardiac failure, tricuspid or mitral insufficiency [2,3].

There is an increased risk of hypertrophic cardiomyopathy among newborns of diabetic mothers [4]. Around 1 in 5000 people are affected in the UK, but the majority are in their teenage years or early adulthood [5]. As a result, there is little literature regarding this condition and we aim to establish suitable antenatal care and heighten awareness with particular attention to the surveillance of neonates after acute fetal distress. We also recommend a multidisciplinary team approach with the maternal and fetal medicine departments.

REFERENCES

PM.01 MANAGEMENT AND OUTCOMES OF HELLP SYNDROME IN THE UK

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Objective To describe the current management and outcomes of HELLP (haemolysis, elevated liver enzymes and low platelet count) syndrome in the UK.

Methods A national descriptive study using the UK Obstetric Surveillance System, including all women diagnosed with HELLP syndrome between June 2011 and May 2012.

Results 109 women were identified with HELLP syndrome. 69 women (65%) were diagnosed with HELLP syndrome antenatally at a median gestation of 35 weeks (range 21–41). 54% (37/68) of antenatally diagnosed women had a planned management of immediate delivery and delivered a median of 5 h 37 min after diagnosis (range 35 min–21 h 26 min); 43% (29/68) had a planned management of delivery within 48 h and delivered a median of 11 h 40 min after diagnosis (range 1 h 28 min–74 h 43 min); only 2/68 had a planned attempt at expectant management, with one delivering 3 days and the other 12 days after diagnosis. Overall, 41% (45/109) of women received corticosteroids (only three for maternal indications, two of whom were diagnosed postpartum); 78% (84/109) received antihypertensive medication and 78% (85/109) were given magnesium sulphate. Severe morbidity was noted in 15% (16/109) of the women and one woman died (case fatality 0.9%, 95%CI 0.02–5.0%). Major complications were reported in 9% (10/109) of infants and there were two perinatal deaths (perinatal mortality rate 18 per 1,000 total births, 95%CI 2–62). All cases associated with major