improvements in outcome over the last decade for women with CHT managed in our unit. Underlying mechanisms for adverse events in women with CHT should be studied and racial differences explored.

**PM.45 INCREASED NT – A RETROSPECTIVE AUDIT FROM A UNIVERSITY HOSPITAL**

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The Aim of this audit was to ensure that our teaching hospital was continuing to provide good quality care for women who were screened and presented with increased nuchal translucency (NT) >3.5 mm. We had initial difficulty identifying these women.

We identified 54 women with an NT greater than 3.5 mm. The NT mean ± SD was 5.5 ± 1.9. Of these 46/54 (85%) agreed to an invasive test. Two women were referred to the regional fetal medicine department. Therefore 44 women underwent invasive testing within our department. Mean gestation age was 13 weeks for chorionic villous sampling and 17 weeks for amniocentesis.

All 44 were performed using ultrasound guidance using a 19 or 20 G needle. There was one failed attempt in those undergoing CVS and one with amniocentesis. There were no miscarriages in these women undergoing invasive testing. Five women required anti D and all received it. None of those undergoing testing had a bloody tap or post procedure infection.

Twelve fetuses had abnormal karotypes with trisomy 13 (n = 2), trisomy 18 (n = 4), trisomy 21 (n = 4) and Turner’s (n = 2). Of these 8 underwent termination of pregnancy, with 3 women going to term with trisomy 21 and 1 with trisomy 13.

Despite our unit achieving 100% compliance with the standards set by the Green-top guideline No8 Amniocentesis and CVS, there was initial difficulty in identifying those with abnormal screening results. As a result of this audit, a computerised logbook of all procedures has been created to help with future auditing.

Sixty two (95%) would take thromboprophylaxis if indicated in a future pregnancy.

Conclusions Reported patient compliance with 7 days of postnatal thromboprophylaxis is high. Most patients are prepared to self-inject although a substantial number required help to administer the injections. The majority would accept the medication if required in a future pregnancy. Some did not feel they had adequate information and this could be addressed in our unit.

**REFERENCES**


**PM.47 LIFESTYLE HABITS IN OBSE PREGNANCY: A CASE-CONTROL STUDY**

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Introduction Obesity is rapidly becoming prevalent amongst the obstetric population and has been linked to many complications such as gestational diabetes mellitus, preeclampsia and thrombembolism(1). There is a paucity of literature examining the lifestyle habits of obese pregnant women, which may be contributing to such complications.

Methods Sixty-two obese pregnant women (body mass index (BMI) 30.0–39.9 kg/m²; mean = 34 kg/m²) were matched by age and ethnicity to 124 non-obese pregnant women (BMI 20.0–29.9 kg/m²; mean = 25 kg/m²). A structured questionnaire was used to assess self-reported lifestyle habits.

Results Based on self-reported walking and other activities, 39% of the obese group and 35% of the control group met current guidelines for exercise in pregnancy(2) (P = 0.589). The obese group were more aware of calories on food labels (63% vs 38%; P = 0.003) and were more likely to drink low fat milk (53% vs 28%; P = 0.005). Prior to pregnancy, the recommended upper limit for alcohol intake of 11 units or more per week was exceeded by a greater percentage of obese women (18% vs 4%; P = 0.004). Smoking during pregnancy was also more prevalent in the obese group (10% vs 1%; P = 0.003).

Conclusion While obese women appeared to be more aware of certain healthier lifestyle choices, their alcohol intake exceeded that of the control group prior to pregnancy, which may have contributed to a greater calorie intake. Further research is needed into possible causes of maternal obesity, such as actual dietary intakes and food portion sizes. This could aid the development of more effective lifestyle interventions for pregnancy.

**REFERENCES**


**PM.48 A CASE OF HAEMOGLOBIN SUN PRAIRIE IN PREGNANCY**

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Introduction Hemoglobin Sun Prairie (HbSP) is an alpha chain hemoglobinopathy with a prevalence of around 1:10,000 and is found predominantly in the African American population. It is caused by a single base pair substitution in the alpha gene which results in the replacement of an aspartic acid residue at position 146 with a valine residue (Δ146Val).

Several questions remain regarding HbSP, including whether the patients with the more severe phenotype have a different mutation than those with the clinical silent phenotype. The overall impact of this condition on pregnancy is unclear.

Case Report A 30 year old African American female was referred to the genetics clinic for her first pregnancy. She had no history of similar illnesses or of problems with other pregnancies. She had previously been told that she was heterozygous for HbSP but was not sure what this meant.

She was 14 weeks pregnant and had been referred due to a family history of sickle cell disease. She had no symptoms but had a number of concerns regarding her pregnancy and the potential impact of her HbSP. She was referred to genetics where she had a confirmed diagnosis of HbSP. She had no alpha thalassemia so was classified as HbSP-α+.

She was counselled regarding her pregnancy and those of her children. She had no family members affected with sickle cell disease or thalassemia. She was given the option of prenatal diagnosis which she declined.

She was referred to a hematologist who performed a full blood count which revealed a slight decrease in her hemoglobin level. She was also referred for continued pregnancy surveillance.

Conclusion HbSP is a hemoglobinopathy that can be difficult to diagnose. There is limited information available regarding the impact it may have during pregnancy. The majority of affected women have normal pregnancies but there are reports of increased fetal loss and stillbirths. This case highlights the importance of genetic counseling and the need for further research into the impact of HbSP during pregnancy.