Conclusions

Test, 6 have serology pending (not yet 8 months) and 2 were lost were not infected, 8 left the country prior to the 8-month serology

2.33–4.72 kg). All babies received HBV IgG and the first dose of

delivery, 9/33 had a C section, 2 delivered elsewhere and one

17/33 had a normal vaginal delivery, 5/33 had an instrumental
treatment.

Uganda Maternal and Newborn Hub, formed in 2011 seeks to

growth in professional volunteering in developing countries. The

This paper presents the results of an interim evaluation of an initia-
tive of acute infection. Where tested, the predominant genotypes
were B and C, occurring in 16/32 and 11/32 respectively. Genotype
D was noted in 4/32 women. One woman was co-infected with Hepatitis C.

Mean viral load (VL) pre-treatment was >1 x 10^8 IU/ml, mean
VL closest to delivery was 6.5 x 10^6 IU/ml (P < 0.001). No resis-
tance to LAM was identified in the 70% who were tested post
treatment.

Median delivery gestation was 39 weeks (range 37–41 weeks);
17/33 had a normal vaginal delivery, 5/33 had an instrumental
delivery, 9/33 had a C section, 2 delivered elsewhere and one
patient is still pregnant. Median birth weight was 3.49 kg (range
2.33–4.72 kg). All babies received HBV IgG and the first dose of vaccine within the first 24 hours of life. Of 33 live born infants, 17
were not infected, 8 left the country prior to the 8-month serology
test, 6 had serology pending (not yet 8 months) and 2 were lost to follow up.

Conclusions

Treatment with LAM is a safe and effective. No vertical transmission of HBV was noted, and no adverse maternal or fetal effects were reported.

PM.63 INTERNATIONAL VOLUNTEERING TO PROMOTE MATERNAL AND NEWBORN HEALTH: OPTIMISING IMPACT
doi:10.1136/archdischild-2013-303966.145

J Ackers, K Macleod, E Lewis, J Ackers-Johnson. Liverpool Mulago Partnership, Liverpool, UK

This paper presents the results of an interim evaluation of an initiative funded by the Tropical Health Education Trust (THET) and
hosted by the Liverpool-Mulago-Partnership. Internationalisation is becoming an essential dimension of clinical careers resulting in a

growth in professional volunteering in developing countries. The Ugandan Maternal and Newborn Hub, formed in 2011 seeks to

reduce maternal and newborn mortality in Uganda through improved partnership.

In 2012 the HUB was awarded funding through THET’s Health Partnership Scheme to set up the ‘Sustainable Volunteering Project’
(SVP). The SVP is responsible for the recruitment, deployment and evaluation of professional volunteers across the HUB. It aims to:

- Reduce Maternal and Newborn Mortality in Uganda through the placement of professional volunteers.
- Develop, promote and evaluate a model for sustainable and effective professional voluntarism

Working in close partnership with the Association of Anaesthe-
tists of Great Britain and Ireland, the Royal College of Obstetri-
cians and Gynaecologists, the Royal College of Paediatrics and
Child Health and the Royal College of Midwives the SVP aims to
provide a more supportive and effective environment for clinical volunteering.

The paper presents results of the interim evaluation outlining key areas of intervention including the reduction of caesarean-
section rates through instrumental (vacuum) delivery; the promo-
tion of Early Warning Scoring Systems; Infection Control and High
Dependency Maternal/Neo-natal Care. It assesses the role of clinical volunteers in promoting sustainable change in development set-
tings and in terms of the acquisition of clinical skills and experience for early career clinicians returning to the UK.

PM.64 PREGNANCY OUTCOMES IN WOMEN WITH SICKLE CELL DISEASE AT A LONDON HOSPITAL (2006–2012)
doi:10.1136/archdischild-2013-303966.146

M Panisai, E Dorman, K Erskine, T Ahmed, R Amos. Homerton University Hospital
NHS Foundation Trust, London, UK

Introduction

SCD is associated with both maternal and fetal compl-
ications including pre-eclampsia, growth restriction and stillbirth together with an increased frequency of acute painful crises.

Method This was a 6-year retrospective audit of 56 pregnancies women with SCD. 22 HbSS & HbS-beta(0); 27 HbSC, 7 HbS-beta(+)

Setting

The women were all managed by the same multidisci-

plinary team, which included haematologists, obstetricians and a specialist SCD midwife.

Results

There were few obstetric antepartum complications (2%
pre-eclampsia, 2% antepartum haemorrhage). However, 55% were admitted with acute painful crises. 7 women underwent regular exchange transfusions for severe pre-existing maternal disease and significant obstetric history. There were no maternal deaths in this cohort.

9% of women with SCD were delivered before 34 weeks. 64% of women were delivered by caesarean section (61% emergency, major-
ity of which were for failure to progress).

Out of the 56 pregnancies, there were 54 live births, 2 stillbirths
(one unexplained at 40 weeks, one with severe growth restriction at 27 weeks), and 1 neonatal death (day 8 secondary to disseminated herpes simplex).

Discussion

The Green-top Guideline (No.61, 2011) suggests all those with SCD should be on low dose aspirin from 12 weeks, have appropriate management of painful crisis and undergo extra scanning with uterine artery dopplers.

Most of these pregnancies predate this RCOG guideline. It would be interesting to note if further improvements in outcome will follow recent recommendations. SCD is the commonest and fastest growing single gene genetic disorder in the UK and these women benefit from specialised multidisciplinary care.