We present an unusual case of sepsis in a 23 year old lady of 14 weeks gestation (para 1 + 1) who presented with epigatric pain. Initial presentation was with bilious vomiting which became blood stained. She reported not opening bowels for 2 days however had passed flatus. There was no significant past medical history with only appendicectomy performed 5 years previously. On examination abdomen was slightly distended with tenderness in the epigastric region. Bloods were: WCC 2.5, Neut 1.5. Other bloods including amylase were normal. She was reviewed by the surgical team 'biliary colic' and an abdominal ultrasound performed, was normal. She was reviewed by medical, surgical, obstetric and gastroenterology teams and finally the diagnosis was of hyperemesis gravidarum.

She was readmitted 48 hours later with pyrexia, tachycardia and hypotension. An ultrasound was performed which demonstrated increased free fluid and an emergency laparotomy was performed. Findings were that of a perforated distal ileum. A resection of the ascending colon and terminal ileum was performed with an ileostomy. Unfortunately, 3 days post operatively she miscarried despite the fetal heart being present immediately post operatively.

During recovery she admitted that her sister in law had contracted tuberculosis and she herself had not been vaccinated. Investigations for TB are currently ongoing. Intra-abdominal fluid samples have confirmed the presence of ESBL.

Although an unusual presentation, this case highlights the importance of maintaining a high suspicion of sepsis. This is especially true where blood results suggest this, in the absence of other features and ongoing symptoms.

PM.89 SEVERE HEADACHES IN PREGNANCY. FIRST PRESENTATION OF ARNOLD CHIARI MALFORMATION TYPE 1

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Arnold Chiari malformation is a malformation of the brain which consists of a downward displacement of the cerebellar tonsils through the foramen magnum. Type 1 Arnold Chiari is generally asymptomatic during childhood. It can typically present in women during early adulthood and can be a cause of unexplained headaches and cerebellar symptoms.

We present a case of 32 year old primigravida with severe headache and visual loss for the first time in pregnancy. She had a twin pregnancy after successful IVF. She also developed gestational diabetes. Magnetic resonance imaging of the brain showed Arnold Chiari malformation type 1. We describe the management of this case during the antenatal and intrapartum period. She was delivered by emergency caesarean section under general anaesthetic.

Her visual loss was thought to be secondary to optic neuropathy with an unknown cause and it remains a clinical dilemma until now.

We discuss multidisciplinary team management and careful anaesthetic assessment in such cases.

PM.90 INCIDENTAL PHAEOCHROMOCYTOMA IN PREGNANCY

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Introduction Phaeochromocytoma, a catecholamine-producing endocrine tumour, is a life-threatening condition to the mother and fetus. The incidence of phaeochromocytoma in pregnancy is extremely rare, 1 in 54 000 pregnancies[1]. If it remains undiagnosed and untreated, maternal and fetal mortality amounts to 40–50%[2 3]. Classically, physicians search for the tumour in hypertensive patients with paroxysmal symptoms such as headache, sweating or palpitations. However, our patient presented atypically and would have been left undiagnosed.

Case presentation A 21-year-old presented after a fall at 24 weeks gestation, with loin pain on the contralateral side to the fall. This prompted an ultrasound scan that demonstrated a 9 cm 'haematoma' above the right kidney. As she was claustrophobic, she declined magnetic resonance imaging (MRI). A repeat ultrasound was performed which showed the mass to be unchanged. Suspicion arose and an MRI under sedation was performed (as recommended to look for adrenal/renal mass in pregnancy[4]). This confirmed an 8 cm × 7 cm mass superior to the right kidney. An endocrinologist reviewed her and serum and urine biochemistry investigations were performed.

Her urinary 3-methoxytyramine and serum dopamine levels were raised[5 6] indicating possible phaechromocytoma. She did not need α-adrenoceptor blockade, as she remained asymptomatic throughout her pregnancy. She was referred to a tertiary hospital where an elective Caesarean section and surgical tumour removal were performed simultaneously.

Conclusion Diagnosing phaeochromocytoma in an asymptomatic pregnant patient is challenging. However, when diagnosed, a multidisciplinary team approach (obstetrician, surgeon and endocrinologist) is vital in the management of this rare disorder.

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PM.91 HAEMATOLOGICAL INDICES IN PREGNANCY: AN IRISH TERTIARY CENTRE EXPERIENCE

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Many haematological changes occur during pregnancy to accommodate maternal and fetal needs. Thus, monitoring of this patient groups' haematological indices are imperative. International guidelines recommend minimum haematological sampling at booking and 28 weeks.

A prospective audit was conducted between January and April 2012. Postnatal patient charts were randomly sampled, and relevant data extracted. This was entered into a secure database. Haematological indices from throughout pregnancy and within 1 week of the postnatal period were extracted from institutional laboratory systems retrospectively.

176 patients were included in our sample group, with a total of 757 samples taken. The average age of patients was 31. Within this sample, there were 100 vaginal deliveries and 76 caesarean