

hypoglycaemia. Lack of documentation in discharge summaries causes difficulties during audits and clinical coding and workforce planning for inpatient diabetes care. A new trust policy has been drafted to facilitate appropriate documentation of capillary blood glucose readings and insulin administration.

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Postnatal monitoring for diabetes following gestational diabetes in the UK

L Butler^{1,2}, AP McGovern¹, S de Lusignan¹, S Jones¹ and Quality Improvement in Chronic Kidney Disease (QICKD) Trial Investigators¹

¹Department of Clinical Informatics, Department of Healthcare Management and Policy, University of Surrey, Guildford, UK, ²Department of Renal Medicine, Derriford Hospital, Plymouth, UK

Aims: Current guidelines recommend fasting glucose testing at 6 weeks after delivery for all women diagnosed with gestational diabetes. Here we investigate the quality of this postnatal follow-up in primary care.

Methods: Data from the Quality Improvement in Chronic Kidney Disease (QICKD) trial was used to identify a cohort of women (n = 786) with gestational diabetes from GP practices (n = 127) across the UK. All women were followed up, using anonymised routinely recorded data, for a year after diagnosis to identify evidence of blood glucose monitoring for the development of diabetes.

Results: Follow-up was generally poor with only 102 (13.0%) women recorded as having one or more blood glucose tests during the follow-up period. Of those women attending follow-up 8% had abnormal test. One case of impaired fasting glucose was detected, three cases of impaired glucose tolerance and four new cases of diabetes. Where the type of glucose test used was recorded, fasting glucose was the most commonly used (92%).

Conclusions: Postnatal monitoring of women with gestational diabetes is markedly suboptimal despite current recommendations. For those attending follow-up the number of new diabetes cases detected is significant. The importance of improving the quality of follow-up for women following gestational diabetes is evident.

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Evaluation of metformin in gestational diabetes: systematic review and meta-analysis

MO Khin, M Vatish, S Gates and P Saravanan

Warwick Medical School, University of Warwick, Coventry, UK

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Can initiation of continuous subcutaneous insulin infusion during pregnancy cause harm?

G Morrison, S Spelman, PJ Weston and TS Purewal

Diabetes Centre, Royal Liverpool University Hospital, Liverpool, UK

Introduction: For women with diabetes, pregnancy is associated with an increased risk to both the mother and fetus. Continuous subcutaneous insulin infusion (CSII) is an approved method of maintaining target glycaemic stability during pregnancy. However, there may be concern that such a fundamental change during pregnancy may have an adverse impact.

Method: Uptake of preconception care, physiological parameters and pregnancy outcomes were compared between a cohort of established pump users and a group initiated during the antenatal period onto CSII. The cohort was 65 pregnant females with Type 1 diabetes, 35 converted onto CSII antenatally, 36 primagravidas. CSII rationale: 60 hypoglycaemia, five hyperglycaemia. Complications included 24 retinopathy, 10 hypertension, two neuropathy, two nephropathy, three gastroparesis. Established CSII: age 31.5 years \pm 4.9 (22–41) [mean, SD (range)], presentation 5.3 weeks' gestation \pm 1.77 (0–8), HbA1c 53mmol/mol \pm 7.4 (37.7–73.7), body mass index 25.4 \pm 3.34 (21–33.1), preconception care 24. CSII antenatal initiation: 14.2 weeks' gestation \pm 4.8 (4–25), age 29.7 years \pm 5 (19–40), HbA1c 54.1mmol/mol \pm 9.9 (34.4–89.1), body mass index 35.3 \pm 4.2 (17.5–38), preconception care 8, all reporting unawareness of hypoglycaemia or diabetic ketoacidosis.

Results: Established CSII: delivery 35.3 weeks' gestation \pm 2.84 (27.8–38.1). HbA1c 47.5mmol/mol \pm 4.3 (34.4–68.3), birth weight 3363kg \pm 1084 (1050–4840), caesarean section 16, special care 16. CSII antenatal initiation: delivery 36 weeks' gestation \pm 2.1 (30–38), HbA1c 48.6mmol/mol \pm 6.9 (34.4–68.3), birth weight 3132kg \pm 86.3 (1740–4500), caesarean section 25, special care 16. No severe hypos in either group.

Conclusion: Established pump patients were more likely to access preconception care. Caesarean sections were reduced and infants had a lower birth weights compared with the antenatal CSII initiation cohort. Pregnancy should not be a barrier to the initiation of CSII as severe hypoglycaemia can be eliminated.

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Measurement of pregnancy outcomes in women with Type 1 and Type 2 diabetes using a standardised data set

S James¹, K Pojak¹, E Homer¹, S Heran¹, F McKinnon¹, C Moses², N Mahadevan² and SR Mehta¹

¹Department of Diabetes and Endocrinology, Ealing Hospital NHS Trust, London, UK, ²Department of Obstetrics, Ealing Hospital NHS Trust, London, UK

Aim/objective: Pregnancy outcomes for women with pre-gestational diabetes and their babies are poor compared with those for women who do not have diabetes. In 2008 the National Institute for Health and Clinical Excellence recommended further improvements in the management of diabetes before and during pregnancy. Recently, a standardised data set was developed for measuring pregnancy outcomes in such women. We used this data set to assess our practice.

Methods: Data were obtained on 78 women with pregnancies complicated by Type 1 or Type 2 diabetes with an estimated date of delivery between 1 January 2010 and 30 June 2012 by retrospective review of case notes and clinical databases. Women were asked at booking whether their pregnancy was planned (n = 44) or unplanned (n = 34).

Results: Women with planned pregnancies had a lower HbA1c prior to conception and throughout pregnancy, although this did not reach statistical significance: 61 (49–80) vs 64 (51–81)mmol/mol prior to conception (Mann–Whitney p = 0.53) and 44 (39–46) vs 49 (40–58)mmol/mol during the third trimester (p = 0.08). They were more likely to be taking folic acid prior to conception (38.6% vs 23.6%) and less likely to be taking statins (13.6% vs 20.6%). They had lower rates of serious adverse pregnancy outcomes, a composite of stillbirth, neonatal death and major congenital malformation (4.5% vs 14.7%).

Conclusion: A standardised data set for diabetes in pregnancy allows clinicians and commissioners to have access to accurate and