for later further thyroid ablation. In his follow-up visit, three months later, he reported no pain on ambulation.

Discussion: For each type of thyroid malignancy, several genes have been identified. However, to date, no common gene mutation responsible for the pathogenesis of the different tumor types has been determined. For instance, point mutations of the RAS oncogene are found in about 40% of thyroid neoplasms (N-RAS, H-RAS, and K-RAS, in order of decreasing frequency) including both PTC and FTC. No single theory can completely explain the pathogenesis of these tumors in all cases, and so, with the present level of understanding of the disease, a combination of theories must be accepted. Management of collision tumors of the thyroid gland is usually complex owing to the presence of dual pathology in the tumor tissues and given the fact that literature on this condition is scarce. Generally, the treatment needs to be individualized.

Conclusion: Most likely, a rare phenomenon of simultaneous mutation of different genes can give birth to contemporary different thyroidal neoplasms.

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Reproductive Endocrinology
CLINICAL STUDIES IN FEMALE REPRODUCTION I
Screening for Gestational Diabetes Mellitus: Universal or Selective Screening? Screening for Gestational Diabetes Mellitus: Universal or Selective Screening?

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SAT-012
Screening for gestational diabetes mellitus: universal or selective screening?

Introduction:
The presence or absence of risk factors is often employed in screening for Gestational Diabetes Mellitus (GDM). The risk factors for GDM includes previous delivery of macrosomic babies, family history of type 2 diabetes mellitus, previous GDM among others. The impact of selective screening is yet to be fully evaluated in our environment.

Objective
To determine the impact of selective screening on diagnosis of gestational diabetes mellitus

Methods
The study was a prospective open cohort study carried out from 1st March to 30th November 2017 at the Lagos University Teaching Hospital (LUTH), Lagos, Nigeria. Ethical approval was obtained from the Health Research Ethics Committee of Lagos University Teaching Hospital (LUTH) before commencement of the study.

All the pregnant women were categorized into either risk group or control group based on the presence or absence of clinical risk factors for GDM. All participant had 75g Oral Glucose Tolerance test (OGTT) done at 24 to 28 weeks gestation and follow up till delivery.

The data obtained were age, risk factors for GDM, fasting plasma glucose, one-hour post glucose load plasma glucose & two-hour post glucose load plasma glucose. The data were presented as mean, standard deviation, percentages & chi square. The p value ≤ 0.05 was considered significant.

Results
Ninety pregnant women were screened for GDM. Forty-four women had risk factors for GDM while 46 were non risk group. Their mean age was 32.6± 5 years. The mean age for the risk & non-risk group were similar.

The overall prevalence of GDM using the IADPSG criteria was 23.3%. The percentage of women in the risk group with GDM was 38.6% while those women in the non risk group with GDM was 8.7% which was statistically significant (p value 0.004).

Discussion
The most commonly identified risk factors for GDM in this study were family history of type 2 diabetes mellitus, history of unexplained miscarriage & previous history of delivery of macrosomic babies.

Some women in the non-risk were diagnosed, even though the prevalence was lower than that observed among women with risk factors for GDM. Approximately one in ten women would have been missed if selective screening was employed in this study.

Most of the women in the non-risk group who were diagnosed with GDM were managed with medical nutritional therapy while majority of women in the risk group had insulin therapy.

Conclusion
The findings in our study further supports the idea of universal screening for GDM in order to avoid missed diagnosis.

Keywords: gestational diabetes mellitus, Screening, oral glucose tolerance test.

Thyroid
BENIGN THYROID DISEASE AND HEALTH DISPARITIES IN THYROID I

Personalized Treatment Planning for Radioiodine Therapy of Graves’ Disease; The Collar Therapy Indicator (CoTI)

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SAT-417
Introduction Since its introduction 80 years ago, the therapeutic I-131 dosage has usually been tailored to individual patient requirements based on the uptake of a tracer radioiodine (RAI) dose. Estimated exposure has typically been extrapolated from the results of activity measurements at one or two time points, e.g., at 4 and 24 hours. We now know that treatment of hyperthyroid Graves disease with these methods lead to a 13–25% rate of failure to cure hyperthyroidism and a 46–80% rate of long-term hypothyroidism in cured patients. There is a need for a more much personalized...