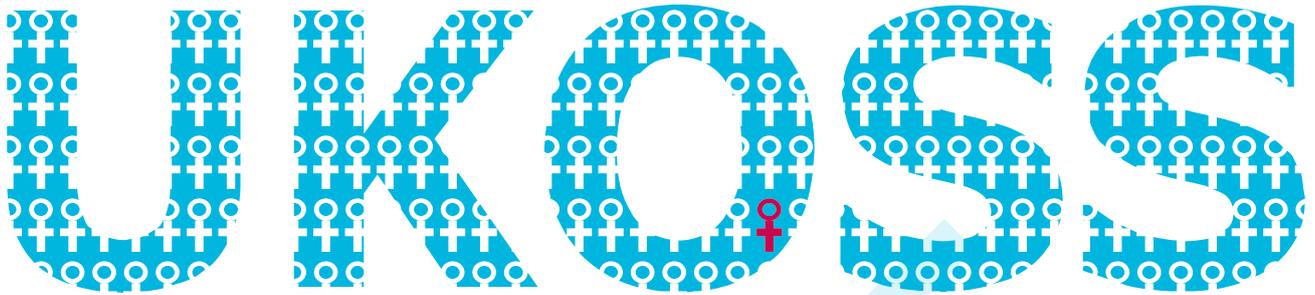


ID Number: _____



UK Obstetric Surveillance System

Feto-Maternal Alloimmune Thrombocytopenia (FMAIT) Study 02/06

Data Collection Form - CASE

Report only women delivered after 1st August 2006

Case Definition:

Any infant newly-diagnosed with fetomaternal alloimmune thrombocytopenia (FMAIT) (thrombocytopenia secondary to proven fetomaternal platelet alloantigen incompatibility).

Please return the completed form to:

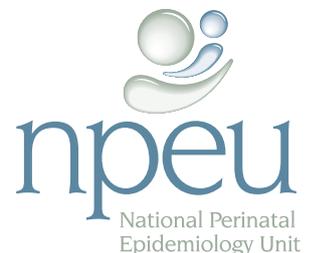
UKOSS
National Perinatal Epidemiology Unit
University of Oxford
Old Road Campus
Oxford
OX3 7LF

Fax: 01865 289701
Phone: 01865 289714



Royal College of
Obstetricians and
Gynaecologists

Case reported in: _____



Instructions

1. Please do not enter any personally identifiable information (e.g. name, address or hospital number) on this form.
2. Please record the ID number from the front of this form against the woman's name on the Clinician's Section of the blue card retained in the UKOSS folder.
3. Fill in the form using the information available in the woman's case notes.
4. Tick the boxes as appropriate. If you require any additional space to answer a question please use the space provided in section 7.
5. Please complete all dates in the format DD/MM/YY, and all times using the 24hr clock e.g. 18.37
6. If codes or examples are required, some lists (not exhaustive) are included on the back page of the form.
7. If the woman has not yet delivered, please complete the form as far as you are able, excluding delivery and outcome information, and return to the UKOSS Administrator. We will send these sections again for you to complete two weeks after the woman's expected date of delivery.
8. If you do not know the answers to some questions, please indicate this in section 7.
9. If you encounter any problems with completing the form please contact the UKOSS Administrator or use the space in section 7 to describe the problem.

Section 1: Woman's details

- 1.1 Year of birth**
- 1.2 Ethnic group^{1*}**
- 1.3 Marital status** single married cohabiting
- 1.4 Was the woman in paid employment at booking?** Yes No
If Yes, what is her occupation _____
If No, what is her partner's (if any) occupation _____
- 1.5 Height at Booking (cm)**
- 1.6 Weight at Booking (kg)** .
- 1.7 Smoking status** Never Gave up prior to pregnancy
Current Gave up during pregnancy

Section 2: Previous Pregnancies

- 2.1 Gravity**
Number of completed pregnancies beyond 24 weeks
Number of pregnancy losses less than 24 weeks
- If no previous pregnancies please go to section 3.**
If the woman has had previous pregnancies please indicate whether any of the following were present:
- 2.2 Previous infant with FMAIT** Yes No
If Yes, please indicate whether sibling was:
Severely affected (*Intracranial haemorrhage or platelet count <50 x 10⁹/L*)
Mildly affected (*Bruising or petechiae, platelet count 50-150 x 10⁹/L*)
- 2.3 Pregnancy problems^{2*}** Yes No
If Yes, please specify _____

Section 3: Previous Medical History

- 3.1 Were there any previous or pre-existing medical problems?^{3*}** Yes No
If Yes, please specify _____

*For guidance please see back cover

Section 4: This Pregnancy

- 4.1 Final Estimated Date of Delivery (EDD)^{4*}** DD / MM / YY
- 4.2 Was this pregnancy a multiple pregnancy?** Yes No
If Yes, please specify number of fetuses
- 4.3 Before diagnosis was this woman booked for delivery at a different hospital?** Yes No
If Yes, please indicate name of booking unit _____
- 4.4 Will this woman receive all her antenatal care at your hospital?** Yes No
If No, please indicate name of hospital _____
- 4.5 Were there problems in this pregnancy^{2*}?** Yes No
If Yes, please specify _____
- 4.6 What was the date of diagnosis of FMAIT?** DD / MM / YY
- 4.7 What maternal-fetal platelet antigen incompatibility was found?**
HPA-1a HPA-5b Other
If Other, please specify _____

Fetus

- 4.8 Please record below the results of all fetal blood samples performed (if known):**
(Continue in section 7 if necessary)

Date of Sample	Fetal Platelet count ($\times 10^9/L$)		List any complications of procedure
	Before transfusion	After transfusion	
DD / MM / YY			
DD / MM / YY			
DD / MM / YY			
DD / MM / YY			
DD / MM / YY			
DD / MM / YY			

- 4.9 Please indicate whether any of the following treatments were used and the dates when they were first given**

	Number of treatments	Date of first treatment
Steroids e.g. dexamethasone		DD / MM / YY
Maternal Intravenous immunoglobulin (IVIg)		DD / MM / YY
Intrauterine transfusion		DD / MM / YY

*For guidance please see back cover

Section 5: This Delivery

5.1 Is this woman still undelivered?

Yes No

If Yes, will she be delivered at your hospital?

Yes No If No, please indicate name of delivery hospital, then *go to section 7*If No, please *continue*

5.2 Did this woman have a miscarriage?

Yes No

If Yes, please specify date

 / /

5.3 Did this woman have a termination of pregnancy?

Yes No

If Yes, please specify date

 / /

5.4 Was delivery induced?

Yes No

If Yes, please state indication _____

5.5 Did the woman labour?

Yes No

5.6 Was delivery by caesarean section?

Yes No

If Yes:

Please state whether

elective or emergency Please state grade of urgency^{5*}

and give indication for caesarean section _____

Method of anaesthesia:

regional general anaesthetic

Section 6: Outcomes

Section 6a: Woman

6a.1 Did any major maternal morbidity occur^{6*}?

Yes No

If Yes, please specify _____

6a.2 Did the woman die?

Yes No

If Yes, please specify date of death

 / / What was the primary cause of death as stated on the death certificate?

Section 6b: Infant 1

NB: **If more than one infant**, for each additional infant, please photocopy the infant section of the form (**before filling it in**) and attach extra sheet(s) or download additional forms from the website: www.npeu.ox.ac.uk/ukoss

6b.1 Date and time of delivery

 / / :
24hr

6b.2 Mode of delivery

Spontaneous vaginal ventouse lift-out forceps rotational forceps breech pre-labour caesarean section caesarean section after onset of labour

6b.3 Birthweight (g)

6b.4 Was the infant stillborn?

Yes No If Yes, please *go to section 7*

6b.5 5 min Apgar

6b.6 Was the infant admitted to the neonatal unit?

Yes No

If Yes, duration of stay (*days*)

Or Tick if infant is still in NICU/SCBU

Or Tick if infant was transferred to another hospital

6b.7 What was the infant's platelet count at birth? ($\times 10^9/L$) (if known)

6b.8 Did this child develop any haemorrhagic complications?

Yes No

If Yes, please indicate below which complications occurred (*tick all that apply*)

Intracranial haemorrhage

Gastrointestinal bleed

Bruising/petechiae

Other

If Other, please specify _____

6b.9 Did any other major infant complications occur?^{7*}

Yes No

If Yes, please specify _____

6b.10 Did this infant die?

Yes No

If Yes, please specify date of death

 / /

What was the primary cause of death as stated on the death certificate?

Definitions

1. UK Census Coding for ethnic group

WHITE

01. British
02. Irish
03. Any other white background

MIXED

04. White and black Caribbean
05. White and black African
06. White and Asian
07. Any other mixed background

ASIAN OR ASIAN BRITISH

08. Indian
09. Pakistani
10. Bangladeshi
11. Any other Asian background

BLACK OR BLACK BRITISH

12. Caribbean
13. African
14. Any other black background

CHINESE OR OTHER ETHNIC GROUP

15. Chinese
16. Any other ethnic group

2. Current or previous pregnancy problems, including:

Pre-eclampsia (hypertension and proteinuria)

Eclampsia

Amniotic fluid embolism

3 or more miscarriages

Preterm birth or mid trimester loss

Neonatal death

Stillbirth

Baby with a major congenital abnormality

Small for gestational age (SGA) infant

Large for gestational age (LGA) infant

Infant requiring intensive care

Puerperal psychosis

Placenta praevia

Gestational diabetes

Significant placental abruption

Post-partum haemorrhage requiring transfusion

3. Previous or pre-existing maternal medical problems, including:

Essential hypertension

Cardiac disease (congenital or acquired)

Renal disease

Endocrine disorders e.g. hypo or hyperthyroidism

Psychiatric disorders

Haematological disorders e.g. sickle cell

disease, diagnosed thrombophilia

Inflammatory disorders e.g. inflammatory bowel disease

Epilepsy

Diabetes

Autoimmune diseases

Cancer

HIV

4. Estimated date of delivery (EDD): Use the best estimate (ultrasound scan or date of last menstrual period) based on a 40 week gestation

5. RCA/RCOG/CEMACH/CNST Classification for urgency of caesarean section:

1. Immediate threat to life of woman or fetus
2. Maternal or fetal compromise which is not immediately life-threatening
3. Needing early delivery but no maternal or fetal compromise
4. At a time to suit the woman and maternity team

6. Major maternal medical complications, including:

Persistent vegetative state

Cardiac arrest

Cerebrovascular accident

Adult respiratory distress syndrome

Disseminated intravascular coagulopathy

Pulmonary oedema

Mendleson's syndrome

Renal failure

Septicaemia

Required ventilation

7. Fetal/infant complications, including:

Respiratory distress syndrome

Intraventricular haemorrhage

Necrotising enterocolitis

Neonatal encephalopathy

Chronic lung disease

Severe jaundice requiring phototherapy

Major congenital anomaly

Severe infection e.g. septicaemia, meningitis

Exchange transfusion