



UK Obstetric Surveillance System

Pregnancy in Renal Transplant Recipients Study 01/07

Data Collection Form - CASE

**Please report all women delivering after 1st January 2007
and before 1st February 2010**

Case Definition:

Any pregnant woman identified as having a transplanted kidney (with or without a transplanted pancreas).

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**
- | | Before Transplant | After Transplant |
|---|---|---|
| Number of completed pregnancies beyond 24 weeks | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
| Number of pregnancy losses less than 24 weeks | <input type="text"/> <input type="text"/> | <input type="text"/> <input type="text"/> |
- If no previous pregnancies *please go to section 3.*
- 2.2 Did the woman have any previous pregnancy problems^{2*}** Yes No
If Yes, please specify _____

Section 3: Previous Medical History

- 3.1 What was the date of most recent transplant?** / /
- 3.2 Was this first** **second** **third** **transplant? (please tick)**
- 3.3 What was the source of the transplanted organ?** Live donor
cadaveric heart-beating donor
cadaveric non-heart-beating donor
not known
- 3.4 Was a pancreas transplanted at the same time?** Yes No
- 3.5 What was the underlying disease or condition which led to the requirement for transplant?** _____
- 3.6 Were there any other previous or pre-existing medical problems^{3*}** Yes No
If Yes, please specify _____

Immediate pre-pregnancy assessment

3.7 What was the most recent serum creatinine or eGFR prior to pregnancy?

Creatinine $\mu\text{mol/l}$ eGFR ml/min or tick if not known

3.8 What was the most recent diastolic blood pressure prior to pregnancy?

mmHg or tick if not known

3.9 Was there proteinuria prior to pregnancy?

Yes No

If Yes, what was the most recent, Albumin/Creatinine Ratio (ACR)

OR Protein/Creatinine Ratio (PCR)?

Section 4: This Pregnancy

4.1 Final Estimated Date of Delivery (EDD)^{4*}

/ /

4.2 Was antenatal care undertaken in the usual hospital for this woman's area of residence?

Yes No

If No, please indicate below reasons for care at a different hospital (*tick all that apply*)

Referred to a tertiary centre because of underlying medical condition

Patient preference

Other

If Other, please specify _____

4.3 Was this pregnancy a multiple pregnancy?

Yes No

If Yes, specify number of fetuses

4.4 Was the woman taking any prescribed drugs at conception?

Yes No

If Yes, please give details _____

4.5 Was the woman taking any folic acid at conception?

Yes No

Immunosuppressive therapy

4.6 Please indicate whether any of the following immunosuppressive therapies were used (*tick all that apply*)

	Prior to pregnancy	During pregnancy	Maximum dose used during pregnancy (mg)
Azathioprine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Cyclosporin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Prednisolone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Mycophenolate mofetil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Tacrolimus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Other immunosuppressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/>
If Other please specify	_____		

*For guidance please see back cover

4.7 Please indicate the number of antihypertensive drugs used:

- Prior to pregnancy
- First trimester
- Second trimester
- Third trimester

4.8 Please record the levels of the following:

	Highest serum creatinine (µmol/l)	Highest systolic blood pressure (mmHg)	Highest diastolic blood pressure (mmHg)	Highest urine protein (g/24h)	Lowest haemoglobin (g/dl)
First trimester (up to 14 weeks)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
Second trimester (14-28 weeks)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
Third trimester (after 28 weeks)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>

Complications

4.9 Please indicate if any episodes of renal dysfunction occurred during pregnancy.

Yes No

(Renal dysfunction is taken to mean a rise of 20% or more in serum creatinine from the lowest level recorded during pregnancy)

If Yes, how many episodes?

What was the cause of dysfunction? (if known) (e.g. obstruction/rejection/infection)

Was a transplant biopsy performed?

Yes No

If Yes, what was the biopsy diagnosis?

4.10 Was pre-eclampsia diagnosed in this pregnancy?

Yes No

If Yes, please give date of diagnosis

//

4.11 Was gestational diabetes diagnosed in this pregnancy?

Yes No

If Yes, was it managed by (please tick)

diet alone oral hypoglycaemics insulin

Please give date of first diagnosis

//

4.12 Were there other problems in this pregnancy^{2*}?

Yes No

If Yes, please specify _____

Section 5: This Delivery

5.1 Did this woman have a miscarriage?

Yes No

If Yes, please specify date

//

5.2 Did this woman have a termination of pregnancy?

Yes No

If Yes, please specify date and give reason for termination

//

*For guidance please see back cover

5.3 Is this woman still undelivered? Yes No

If No, please *continue*

If Yes, will this woman receive all her antenatal care at your hospital? Yes No

If No, please indicate name of hospital

Will she be delivered at your hospital? Yes No

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

5.4 Was labour 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 Was the woman admitted to ITU/HDU Yes No

If Yes, duration of stay (*days*)

Or Tick if woman is still in ITU/HDU

Or Tick if woman was transferred to another hospital

6a.2 Did any major maternal morbidity occur^{6*}? Yes No

If Yes, please specify _____

6a.3 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

*For guidance please see back cover

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:

Thrombotic event
Amniotic fluid embolism
Eclampsia
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
Surgical procedure in pregnancy
Hyperemesis requiring admission
Dehydration requiring admission
Ovarian hyperstimulation syndrome
Severe infection e.g. pyelonephritis

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

Cardiac disease (congenital or acquired)
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
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
HELLP
Pulmonary oedema
Mendleson's syndrome
Renal failure
Thrombotic event
Septicaemia
Required ventilation

7. Fetal/infant complications, including:

Respiratory distress syndrome
Intraventricular haemorrhage
Necrotising enterocolitis
Neonatal encephalopathy
Chronic lung disease
Severe jaundice requiring phototherapy
Severe infection e.g. septicaemia, meningitis
Exchange transfusion