



UK Obstetric Surveillance System

Anaphylaxis in Pregnancy 03/12

Data Collection Form - CASE

Please report all pregnant women diagnosed with anaphylaxis on or after 01/10/2012 and before 01/10/2014

Case Definition:

Anaphylaxis is defined as a severe, life-threatening generalised or systemic hypersensitivity reaction. The following three criteria must be met for a diagnosis of anaphylaxis to be made:

1. A life-threatening airway problem and/or breathing problem and/or circulatory problem
2. Sudden onset and rapid progression of symptoms
3. Skin and/or mucosal changes

Women should not be reported if a diagnosis of anaphylaxis has been excluded by their senior attending obstetrician.



Royal College of
Obstetricians
and Gynaecologists

Bringing to life the best
in women's health care

Please return the completed form to:

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

Fax: 01865 617775
Phone: 01865 289714

Case reported in: _____



npeu
National Perinatal
Epidemiology Unit

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*}** (enter code, please see back cover for guidance)
- 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 Obstetric History

- 2.1 Gravidity**
Number of previous completed pregnancies beyond 24 weeks
Number of previous pregnancies less than 24 weeks
- 2.2 Did the woman have any previous pregnancy problems?^{2*}** Yes No
If Yes, please specify _____

Section 3: Previous Medical History

- 3.1 Does the woman have a previous history of anaphylaxis?** Yes No
- 3.2 Does the woman have a previous history of atopy?** Yes No
If Yes, please tick all that apply Eczema Asthma Hay fever
- 3.3 Does the woman have a history of allergic reaction to any of the following?** Yes No
If Yes, please tick all that apply Latex Food stuffs Animal fur or bird feathers
Dust mites Insect stings Pollen/spores Other
If Other, please specify _____

*For guidance please see back cover

3.4 Does the woman have a history of previous recorded allergic reaction to any drugs, including antibiotics? Yes No

If Yes, please state which drug / antibiotic _____

If Yes, please describe the reaction recorded in the notes _____

3.5 Does the woman have any other pre-existing medical problems?^{3*} Yes No

If Yes, please specify details _____

Section 4a: This Pregnancy

4a.1 Final Estimated Date of Delivery (EDD)^{4*} /

4a.2 Was this pregnancy a multiple pregnancy? Yes No

If Yes, specify number of fetuses

4a.3 Were there any other problems in this pregnancy? Yes No

If Yes, please specify _____

Section 4b: Diagnosis and management of anaphylaxis

4b.1 What was the date and time when symptoms were first experienced? / :
24hr

4b.2 What was the date and time anaphylaxis was diagnosed? / :
24hr

4b.3 Did the woman have a life threatening airway problem? Yes No

If Yes, please tick all that apply Laryngeal or pharyngeal oedema Hoarse voice
Stridor Other

If Other, please specify _____

4b.4 Did the woman have a life threatening breathing problem? Yes No

If Yes, please tick all that apply Shortness of breath and raised respiratory rate
Wheeze Decreased oxygen saturations Confusion secondary to hypoxia
Cyanosis Respiratory exhaustion or respiratory arrest Other

If Other, please specify _____

4b.5 Did the woman have a life threatening circulatory problem? Yes No

If Yes, please tick all that apply Signs of shock such as faintness, pallor or clammy skin
Tachycardia >100bpm Systolic BP <90mmHg Decreasing level of consciousness
Signs of ischaemia on ECG Cardiac arrest

4b.6 Did the woman have skin or mucosal changes (for example flushing, urticarial/nettle rash, angioedema)? Yes No

If Yes, please give details _____

4b.7 Where was the woman when anaphylaxis occurred?

Home or Community Postnatal ward Delivery suite Theatre Other

4b.8 Was there a suspected causative agent? Yes No Unknown

If Yes, please state the suspected causative agent: _____

4b.9 Did the woman have any known previous exposure to the causative agent? Yes No Unknown

If Yes, please state when _____

4b.10 Were any regular medications (including over the counter, herbal or recreational) being taken prior to the onset of anaphylaxis?

Yes No

If Yes, please list these medications _____

4b.11 Were vital observations recorded prior to anaphylaxis?

Yes No

If Yes, what were the most recent set of vital observations prior to the diagnosis of anaphylaxis

Observation	Date	Time
Blood pressure (mmHg)	DD / MM / YY	hh : mm <small>24hr</small>
Oxygen saturation (%)	DD / MM / YY	hh : mm <small>24hr</small>
Heart rate (bpm)	DD / MM / YY	hh : mm <small>24hr</small>
Respiratory rate/min	DD / MM / YY	hh : mm <small>24hr</small>

4b.12 What were the vital observations at the time of diagnosis of anaphylaxis?

Yes No

Blood pressure (mmHg)	DD / MM / YY	hh : mm <small>24hr</small>
Oxygen saturation (%)	DD / MM / YY	hh : mm <small>24hr</small>
Heart rate (bpm)	DD / MM / YY	hh : mm <small>24hr</small>
Respiratory rate/min	DD / MM / YY	hh : mm <small>24hr</small>

4b.13 Did the woman have a cardiorespiratory arrest?

Yes No

If Yes, please state the date and time at which this occurred DD / MM / YY hh : mm
24hr

4b.14 Was any fetal heart rate abnormality noted?

Yes No

If Yes,

What was the abnormal rhythm? _____

Date and time it was first noted? DD / MM / YY hh : mm
24hr

How long did it persist? _____ minutes

4b.15 Following diagnosis of anaphylaxis, was high flow oxygen given?

Yes No

4b.16 Following diagnosis of anaphylaxis, were IV fluids given?

Yes No

If Yes, please state

Name of fluid	Volume (ml)	Time started	Time stopped
_____	_____	hh : mm <small>24hr</small>	hh : mm <small>24hr</small>
_____	_____	hh : mm <small>24hr</small>	hh : mm <small>24hr</small>
_____	_____	hh : mm <small>24hr</small>	hh : mm <small>24hr</small>

4b.17 Following diagnosis of anaphylaxis, were any of the following drugs administered?

Yes No

If Yes,

Name of drug	Time given	Dose given	Route
Adrenaline	Yes <input type="checkbox"/> No <input type="checkbox"/>	hh : mm <small>24hr</small>	
Chlorphenamine	Yes <input type="checkbox"/> No <input type="checkbox"/>	hh : mm <small>24hr</small>	
Hydrocortisone	Yes <input type="checkbox"/> No <input type="checkbox"/>	hh : mm <small>24hr</small>	

4b.18 Were any other drugs given during the resuscitation period?

Yes No

If Yes, please state

Drug name	Time given	Dose given	Route	Indication
<input type="text"/>	<input type="text"/> h <input type="text"/> h : <input type="text"/> m <input type="text"/> m <small>24hr</small>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> h <input type="text"/> h : <input type="text"/> m <input type="text"/> m <small>24hr</small>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/> h <input type="text"/> h : <input type="text"/> m <input type="text"/> m <small>24hr</small>	<input type="text"/>	<input type="text"/>	<input type="text"/>

4b.19 Once resuscitation was complete, was blood taken for serum tryptase levels? Yes No

If Yes, please state the result:

Normal Raised

Section 5: 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

/ /

5.3 Is this woman still undelivered?

Yes No

If Yes, will the woman receive the remainder of her antenatal care at your hospital?

Yes No

If No, please indicate the name of the hospital providing future care

Will she be delivered at your hospital?

Yes No

If No, please indicate the name of delivery hospital

5.4 Was delivery induced?

Yes No

If Yes, please state indication

If Yes, was vaginal prostaglandin used?

Yes No

5.5 Did the woman labour?

Yes No

If Yes, what date and time was labour diagnosed?

/ / : :
24hr

Was syntocinon used?

Yes No

Did the woman have an epidural for analgesia?

Yes No

5b.1 Was delivery by caesarean section?

Yes No

If Yes, please state:

Grade of urgency^{5*}

Indication for caesarean section

Method of anaesthesia:

Spinal Epidural top-up CSE

Epidural General anaesthetic

The time between decision and delivery of the baby

:
24hr

Section 6: Outcomes

Section 6a: Woman

6a.1 Was the woman admitted to ITU (critical care level 3)?

Yes No

If Yes, please specify:

Duration of stay

days

Or Tick if woman is still in ITU

Or Tick if woman was transferred to another hospital

6a.2 Did any other major maternal morbidity occur?^{6*}

Yes No

If Yes, please specify _____

6a.3 Did the woman die?

Yes No

If Yes, please specify date and time of death

/ / : 24hr

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

(Please state if not known) _____

Section 6b: Infant

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 Sex of infant

Male

Female

Indeterminate

6b.5 Was the infant stillborn?

Yes No

If Yes, was the death ante-partum or intra-partum?

Ante-partum

Intra-partum

6b.6 Apgar

5 min

10 min

6b.7 Did the infant require resuscitation at birth?

Yes No

6b.8 Were cord gases measured?

Yes No

If Yes, please record cord gas results:

	Arterial	Venous
pH	- <input type="text"/> . <input type="text"/> <input type="text"/>	- <input type="text"/> . <input type="text"/> <input type="text"/>
Base Excess	- <input type="text"/> . <input type="text"/> <input type="text"/>	- <input type="text"/> . <input type="text"/> <input type="text"/>

6b.9 Did the infant experience any seizures?

Yes

No

Unknown

6b.10 Was an aEEG or a full EEG performed?

Yes

No

Unknown

If Yes, please state the results _____

6b.11 Did the infant have any neurological imaging?

Yes

No

Unknown

If Yes, type of imaging used _____

Date and time

/ / : 24hr

What damage was identified? _____

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. Previous or current 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)
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
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 morbidity, 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
Major congenital anomaly
Severe infection e.g. septicaemia, meningitis
Exchange transfusion