ID Number:

UKOSS

UK Obstetric Surveillance System

Extremely Preterm Prelabour Rupture of the Membranes Study

Study 04/19

Data Collection Form - CASE

Please report any woman delivering on or after the 01/09/19 and before 31/08/20

Case Definition:

Women who have experienced prelabour rupture of membranes between 16^{+0} to 22^{+6} weeks gestation

Exclusion criteria:

- Cases in which membranes ruptured before 16^{+0} but were only diagnosed in the 16^{+0} to 22^{+6} period.
- Elective induction of labour for known intrauterine death diagnosed before ruptured membranes.

Instructions

1. Please do not enter any personally identifiable information (e.g. name, address or hospital number) on this form.
2. Fill in the form using the information available in the woman's case notes.
3. Tick the boxes as appropriate. If you require any additional space to answer a question please use the space provided in section 7
4. Please complete all dates in the format DD/MM/YY, and all times using the 24hr clock e.g. 18:37
5. If codes or examples are required, some lists (not exhaustive) are included on the back page of the form.
6. If you do not know the answers to some questions, please indicate this in section 7
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 coordinator or use the space in section 10 to describe the problem.

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

Section 1: Woman's details

1.1 **Year of birth:** Y Y Y Y

1.2 **Ethnic group:**[1]* *(enter code, please see back cover for guidance)*

1.3 **Height at booking:** *cm*

1.4 **Weight at booking:** . *kg*

1.5 **What is the woman's smoking status?**

Never ☐ Current ☐ Gave up prior to pregnancy ☐ Gave up during pregnancy ☐

Section 2: Previous Obstetric History

2.1 **Gravidity**

Number of completed pregnancies beyond 24 weeks:

Number of pregnancies less than 24 weeks:

If no previous pregnancies, *please go to section 3*

2.2 **Has the woman had any of the following in a previous pregnancy?** *(please tick all that apply)*

	Yes/No	If Yes, how many pregnancies?	If Yes, earliest gestation that it occurred
EPPROM at 16^{+0}-22^{+6} weeks	Yes ☐ No ☐		weeks days
PPROM at at 23^{+0}-33^{+6} weeks	Yes ☐ No ☐		weeks days
Spontaneous midtrimester loss (without EPPROM) at 16^{+0} to 22^{+6} weeks gestation	Yes ☐ No ☐		weeks days
Spontaneous preterm birth (without EPPROM) at 23^{+0} to 36^{+6} weeks	Yes ☐ No ☐		weeks days

2.3 **Did the woman have any other previous pregnancy problems?**[2]* Yes ☐ No ☐

If Yes, please specify: _____

Section 3: Previous Medical History

3.1 **Did the woman have any previous or pre-existing medical problems?**[3]* Yes ☐ No ☐

If Yes, please give details: _____

Section 4: This Pregnancy

4.1 **Final Estimated Date of Delivery (EDD):**[4]* D D / M M / Y Y

4.2 **Was this a multiple pregnancy?** Yes ☐ No ☐

If Yes, please specify number of fetuses:

And state chorionicity _____

4.3 **Did this woman have an invasive procedure in this pregnancy?** Yes ☐ No ☐

If Yes, please tick all that apply and give date performed:

	Yes/No	Date performed
Amniocentesis	Yes ☐ No ☐	D D / M M / Y Y
CVS	Yes ☐ No ☐	D D / M M / Y Y
Other *(please specify)* _____	Yes ☐ No ☐	D D / M M / Y Y

4.4 **Did this woman have a cervical cerclage inserted before or during this pregnancy?** Yes ☐ No ☐

If Yes, please give date of most recent cerlage: D D / M M / Y Y

Was the cerclage elective or emergency? *(please tick one)* Elective ☐ Emergency ☐

Was the cerclage abdominal or vaginal? *(please tick one)* Abdominal ☐ Vaginal ☐

4.5 **Were there any other problems in this pregnancy before EPPROM?[2]*** Yes ☐ No ☐

If Yes, please specify: _____

Section 5:

Section 5a: Diagnosis of EPPROM

5a.1 **When did EPPROM occur?** *(based on history)* D D / M M / Y Y h h : m m (24hr)

5a.2 **When was EPPROM diagnosed?** D D / M M / Y Y h h : m m (24hr)

5a.3 **How was PROM diagnosed?** *(please tick all that apply)*

Clinical History ☐ Speculum *(pooling of amniotic fluid)* ☐

Bedside Test *(e.g. Amnisure, Actim EPPROM)* ☐ Monitoring sanitary pads ☐ Ultrasound scan ☐

5a.4 **Were there any complications of EPPROM at presentation?** *(please tick all that apply)*

None ☐ Vaginal bleeding ☐ Maternal pyrexia ☐ Contractions ☐ Abdominal pain ☐

Other ☐ **If Other**, please specify: _____

Section 5b: Management of EPPROM

5b.1 **Were antibiotics administered following the diagnosis of EPPROM?** Yes ☐ No ☐

If Yes, please complete for each course, including antibiotics given in labour.
Please continue in section 7 if necessary

Antibiotic given	Dose	Frequency	Date and time of first dose	Date and time of last dose
			D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)
			D D / M M / Y Y h h : m m (24hr)	D D / M M / Y Y h h : m m (24hr)

5b.2 Were corticosteroids for fetal lung maturity administered at any point in the pregnancy? Yes ☐ No ☐

If Yes, please complete for each course. Please continue in section 7 if necessary

Type of Corticosteroid given	Dose	Date and time first dose given	Date and time second dose given
		D D / M M / Y Y h h : m m 24hr	D D / M M / Y Y h h : m m 24hr
		D D / M M / Y Y h h : m m 24hr	D D / M M / Y Y h h : m m 24hr

5b.3 Was magnesium sulphate administered at any point in the pregnancy for neuroprotection? Yes ☐ No ☐

If Yes, please complete for each course. Please continue in section 7 if necessary

Dose	Date and time course started	Date and time course stopped
	D D / M M / Y Y h h : m m 24hr	D D / M M / Y Y h h : m m 24hr
	D D / M M / Y Y h h : m m 24hr	D D / M M / Y Y h h : m m 24hr

5b.4 Were tocolytics administered following the diagnosis of EPPROM? Yes ☐ No ☐

If Yes, please complete for each course. Please continue in section 7 if necessary

Type of Tocolytic	Dose	Frequency	Date and time first dose given	Date and time second dose given
			D D / M M / Y Y h h : m m 24hr	D D / M M / Y Y h h : m m 24hr
			D D / M M / Y Y h h : m m 24hr	D D / M M / Y Y h h : m m 24hr

5b.5 What was the amniotic fluid volume at the first scan after diagnosis?

AFI _____ Vertical pool depth _____

5b.6 What was the planned management strategy at presentation? *(please tick one only)*

Termination ☐ expectant management ☐

If Termination, *please go to section 5*

5b.7 Did this woman receive <u>outpatient</u> management at any point following EPPROM? Yes ☐ No ☐

If Yes, what was the date of her first discharge home following EPPROM diagnosis? D D / M M / Y Y

If Yes, was the woman managed as an outpatient for 7 or more consecutive days between EPPROM and birth? Yes ☐ No ☐

If Yes, what health monitoring interventions were performed during this period? *(please tick all that apply)*

Monitoring intervention	Yes/No	Frequency (times per week)
Temperature	Yes ☐ No ☐	
Observations (pulse/BP)	Yes ☐ No ☐	
High Vaginal Swab (HVS)	Yes ☐ No ☐	
Maternal Full Blood Count (FBC)	Yes ☐ No ☐	
Maternal CRP	Yes ☐ No ☐	
Ultrasound Scan for fetal growth	Yes ☐ No ☐	
Ultrasound Scan for fetal umbilical artery dopplers	Yes ☐ No ☐	
Ultrasound Scan for amniotic fluid volume	Yes ☐ No ☐	
Fetal Heart Rate (FHR) monitoring	Yes ☐ No ☐	
Face to face clinical assessment by midwife or doctor	Yes ☐ No ☐	
Other *(please specify)* _____	Yes ☐ No ☐	

Section 5c: Antenatal complications in pregnancy

5c.1 Did any of the following antenatal complications occur? *(please tick all that apply)*

Diagnosis	Yes/No	Date first diagnosed
Antepartum haemorrhage	Yes ☐ No ☐	D D / M M / Y Y
Evidence of intrauterine infection	Yes ☐ No ☐	D D / M M / Y Y
Cord prolapse	Yes ☐ No ☐	D D / M M / Y Y
Maternal sepsis	Yes ☐ No ☐	D D / M M / Y Y
Placental abruption	Yes ☐ No ☐	D D / M M / Y Y

Section 5d: Delivery

5d.1 Is this woman still undelivered? Yes ☐ No ☐

If Yes, will she be receiving the rest of her antenatal care from your hospital? Yes ☐ No ☐

If No, please indicate name of hospital providing future care: _____

5d.2 Will she be delivered at your hospital? Yes ☐ No ☐

If No, please indicate name of delivery hospital: _____

5d.3 Did this woman have a spontaneous miscarriage? Yes ☐ No ☐

If Yes, please specify date and time D D / M M / Y Y h h : m m (24hr)

5d.4 Did this woman have a termination of pregnancy? Yes ☐ No ☐

If Yes, date and time of delivery of fetus: D D / M M / Y Y h h : m m (24hr)

Method *(please tick all that apply)*: Surgical TOP ☐ Medical TOP ☐ Feticide ☐

Indication (if known) *(please tick all that apply)*:

Patient choice - based on likelihood of poor maternal and neonatal outcomes ☐

Clinician advised based on severe chorioamnionitis or sepsis ☐ Other ☐

If Other, please state: _____

If Yes to 5d.3 or 5d.4, please now complete sections 6a, 7 and 8

5d.5 Was delivery induced? Yes ☐ No ☐

If Yes, please state indication _____

5d.6 Did the woman go into labour spontaneously? Yes ☐ No ☐

5d.7 Was delivery by caesarean section? Yes ☐ No ☐

If Yes, please state:

Grade of urgency:[5]* ☐

Indication for caesarean section: _____

Method of anaesthesia: Regional ☐ General anaesthetic ☐

Section 6: Outcomes

Section 6a: Woman

6a.1 Was the woman admitted to ITU (critical care level 3)? Yes ☐ No ☐

If Yes, duration of stay: ☐☐ *days*

OR Tick if woman is still in ITU (critical care level 3): ☐

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 women require a surgical procedure to remove placental tissue in the post partum period? Yes ☐ No ☐

If Yes, date of procedure D D / M M / Y Y

6a.4 Did the woman die? Yes ☐ No ☐

If Yes, please specify date and time of death D D / M M / Y Y h h : m m (24hr)

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

(Please state if not known) _____

Was a post mortem examination undertaken? Yes ☐ No ☐

If Yes, did the examination confirm the certified cause of death/diagnosis?

Yes ☐ No ☐ Not known ☐

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: D D / M M / Y Y h h : m m (24hr)

6b.2 Mode of delivery: Spontaneous vaginal ☐ Assisted vaginal ☐ 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 diagnosed antenatally or during labour?
Antenatal stillbirth ☐ Intrapartum stillbirth ☐

If Yes, *please go to section 7*

6b.6 5 min Apgar ☐☐

6b.7 Please detail any of the following major infant complications that occurred:

Please specify	Yes/No	If Yes
Lung disease	Yes ☐ No ☐	Were any ot these treatments required? *(please tick)*: High frequency oscillatory ventilation ☐ Inhaled nitric oxide ☐ Supplemental oxygen therapy at 36 weeks postmenstrual age ☐
Limb contractures	Yes ☐ No ☐	Type: Fixed ☐ Postural ☐ Both fixed and postural ☐ Not known ☐ Number of limbs affected: ☐☐
Intraventricular haemorrhage	Yes ☐ No ☐	Highest grade *(please tick)*: 1 ☐ 2 ☐ 3 ☐ 4 ☐ Not known ☐
Neonatal encephalopathy	Yes ☐ No ☐	Highest grade *(please tick)*: Mild ☐ Moderate ☐ Severe ☐ Not known ☐
Treated seizures	Yes ☐ No ☐	*Please specify* _____
Major congenital anomaly	Yes ☐ No ☐	*Please specify* _____
Other	Yes ☐ No ☐	*Please specify* _____

6.8 Was the baby discharged home? Yes ☐ No ☐

If Yes, please specify date of discharge D D / M M / Y Y

6b.9 Did this infant die? Yes ☐ No ☐

If Yes, please specify date of death D D / M M / Y Y

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

(Please state if not known) _____

Section 7: Further information

Please use this space to enter any other information you feel may be important.

Section 8: Your details

8.1 Name of person completing the form: _____

8.2 Designation: _____

8.3 Today's date: D D / M M / Y Y

You may find it useful in the case of queries to keep a copy of this form.

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
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 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