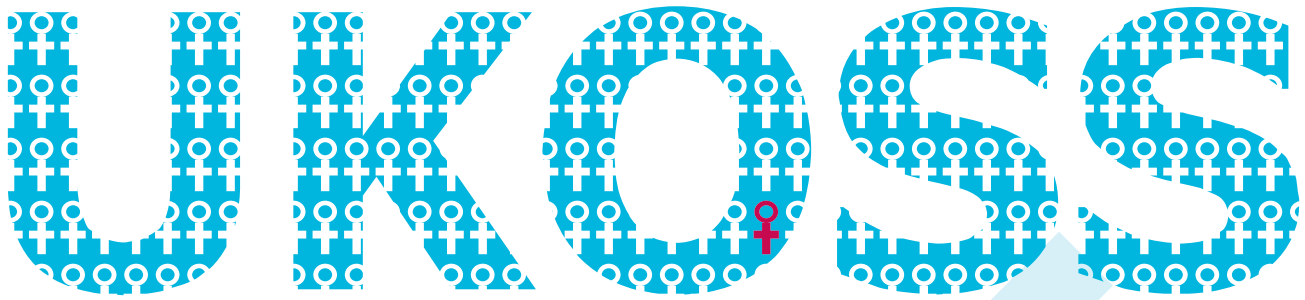


ID Number:



UK Obstetric Surveillance System

## Epidural Haematoma or Abscess after an Anaesthetic Regional Technique Study 01/14

Data Collection Form - CASE

Please report any woman delivering on or after 01/01/2014 and  
before 01/01/2018

### Case Definition:

All pregnant women identified as having an epidural haematoma or abscess after a regional anaesthetic technique or attempt at technique.



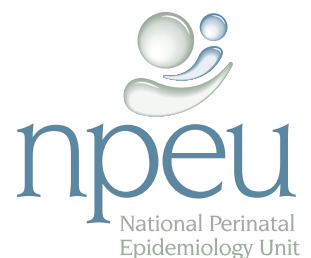
Royal College of  
Obstetricians  
and Gynaecologists

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: \_\_\_\_\_



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<sup>1\*</sup>** (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 Pregnancies

- 2.1 Number**  
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 Did the woman have any previous pregnancy problems?<sup>2\*</sup>** Yes  No   
If Yes, please specify \_\_\_\_\_

### Section 3: Previous Medical History

- 3.1 Does the woman have a known bleeding disorder?** Yes  No   
If Yes, please give details \_\_\_\_\_
- 3.2 Did the woman have any other pre-existing medical problems?<sup>3\*</sup>** Yes  No   
If Yes, please give details \_\_\_\_\_

\*For guidance please see back cover

## Section 4: This Pregnancy

4.1 Final Estimated Date of Delivery (EDD)<sup>4\*</sup>

 DD /  MM /  YY

4.2 Was this a multiple pregnancy?

 Yes  No 

If Yes, specify number of fetuses

4.3 Did the woman have any of the following?

 Yes  No 

Pre-eclampsia  Intrauterine death  Antepartum haemorrhage requiring transfusion

Postpartum haemorrhage requiring transfusion  HELLP Syndrome  Immunodeficiency

Any other condition associated with coagulopathy  (please specify) \_\_\_\_\_

4.4 Was the woman diagnosed with a systemic infection in pregnancy?

 Yes  No 

If Yes, please specify \_\_\_\_\_

4.5 Did the woman receive any anti-platelet drugs (e.g. aspirin), anticoagulants (e.g. heparin) or anticoagulant herbal remedies (e.g. garlic, ginseng, giroka) during this pregnancy?

 Yes  No 

If Yes, please complete the table below:

Agent	Dose	Units	Date started	Duration
_____	_____	_____	<input type="text"/> DD <input type="text"/> MM <input type="text"/> YY	_____
_____	_____	_____	<input type="text"/> DD / <input type="text"/> MM <input type="text"/> YY	_____
_____	_____	_____	<input type="text"/> DD <input type="text"/> MM <input type="text"/> YY	_____

4.6 Were there any other problems in this pregnancy?<sup>2\*</sup>

 Yes  No 

If Yes, please specify \_\_\_\_\_

## Section 5: Diagnosis and Delivery

### Section 5a: Epidural Haematoma or Abscess

5a.1 Was this woman diagnosed with: (tick one only) Epidural haematoma  Epidural abscess

5a.2 What was the date and time of diagnosis?

 DD /  MM /  YY  hh :  mm 24hr

5a.3 Which of the following features were present at diagnosis?

(tick all that apply and indicate date/time of onset)

Feature		Date of onset	Time of onset
Pain at site of regional	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> DD <input type="text"/> MM <input type="text"/> YY	<input type="text"/> hh <input type="text"/> mm
Tenderness at site of regional	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> DD / <input type="text"/> MM / <input type="text"/> YY	<input type="text"/> hh : <input type="text"/> mm <small>24hr</small>
Lower limb motor block	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> DD <input type="text"/> MM <input type="text"/> YY	<input type="text"/> hh <input type="text"/> mm
Sphincter dysfunction	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> DD / <input type="text"/> MM / <input type="text"/> YY	<input type="text"/> hh : <input type="text"/> mm <small>24hr</small>
Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> DD <input type="text"/> MM <input type="text"/> YY	<input type="text"/> hh <input type="text"/> mm
Other (please specify) _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="text"/> DD / <input type="text"/> MM / <input type="text"/> YY	<input type="text"/> hh : <input type="text"/> mm <small>24hr</small>

**5a.4 How was the diagnosis confirmed?** (tick all that apply and note findings)

Ultrasound  CT  MRI  Clinical diagnosis only   
 Other  (please specify) \_\_\_\_\_

What date and time was the diagnosis confirmed?   /   /   :   24hr

Findings:  
 \_\_\_\_\_  
 \_\_\_\_\_

**Section 5b: Details of associated regional procedure**

**5b.1 What was the indication for regional anaesthesia?** (tick all that apply)

Labour  Caesarean section  Instrumental delivery   
 Other  (please specify) \_\_\_\_\_

**5b.2 Which of the following aseptic precautions were used?** (tick all that apply)

	Gloves	Gown	Mask	None	Not known
By Anaesthetist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
By person assisting anaesthetist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5b.3 Was chlorhexidine used?**

Yes  No

If Yes, what strength was used (tick one only)

0.5%  2%  Other  (please specify) \_\_\_\_\_

If No, please specify what was used \_\_\_\_\_

**5b.4 Please list the drugs used for the epidural/spinal/CSE, with doses OR concentrations / volumes as appropriate:**

Agent	Total dose (include units)	Concentration	Volume
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**5b.5 Was a mixture used for the epidural/spinal/CSE?**

Yes  No

If Yes, was it premixed in pharmacy?

Yes  No

If No, what date and time was it made up?

/   /   :   24hr

**5b.6 Was the regional abandoned?**

Yes  No

If Yes, what date and time was it abandoned?

/   /   :   24hr

If No, what date and time was the catheter successfully placed?

/   /   :   24hr

**5b.7 What technique was used?** (tick one only)

Spinal   
 Epidural   
 CSE

If CSE or epidural, what date and time was the catheter removed?

/   /   :   24hr

5b.8 How many attempts at the procedure were made? □□

5b.9 What was the needle gauge and type?

Please list below and include needles used for all attempts (successful and unsuccessful)

Gauge	Type	Successful
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

5b.10 Was there a bloody tap with either needle or catheter? Yes  No

5b.11 Was a resite required? Yes  No

If Yes, please indicate reason (tick one only)

Block failure  Displaced catheter  Other

If Other, please specify \_\_\_\_\_

5b.12 Did the woman have any abnormal clotting indices at the time of the regional procedure? Yes  No  Not known

If Yes, please indicate what tests were performed to investigate this and whether they were normal or abnormal:

	Performed?	Abnormal?
Coagulation screen	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Thromboelastography	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Platelet Function Studies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other (please specify) _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

5b.13 Did this woman receive low molecular weight heparin in the 12 hours prior to or the 12 hours after her regional anaesthesia? Yes  No

If Yes, please list agent, dose, indication and time given below:

Agent	Dose (include units)	Date given	Time given	Prophylactic (P) or Therapeutic (T)?
_____	_____	DD MM YY	hh mm	_____
_____	_____	DD / MM / YY	hh : mm <small>24hr</small>	_____
_____	_____	DD MM YY	hh mm	_____

### Section 5c: Management of epidural haematoma/abscess

5c.1 Was an inter-hospital transfer required? Yes  No

5c.2 Was surgery performed? Yes  No

If Yes, what date and time was surgery performed?

DD / MM / YY hh : mm  
24hr

**5c.3 Was any other specific management given?**

Yes  No

If Yes, please specify: \_\_\_\_\_

## Section 5d: Delivery

**5d.1 Did this woman have a miscarriage?**

Yes  No

If Yes, please specify date

/   /

**5d.2 Did this woman have a termination of pregnancy?**

Yes  No

If Yes, please specify date

/   /

If Yes to 5d.1 or 5d.2, please now complete sections 6a, 7 and 8

**5d.3 Is this woman still undelivered?**

Yes  No

If Yes, what date was she discharged after her epidural haematoma and before delivery?

/   /

Will she be receiving the rest of her antenatal care from 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 then, complete sections 6a, 7 and 8

\_\_\_\_\_

**5d.4 Was delivery induced?**

Yes  No

If Yes, please state indication \_\_\_\_\_

Was vaginal prostaglandin used?

Yes  No

**5d.5 Did the woman labour?**

Yes  No

**5d.6 Was delivery by caesarean section?**

Yes  No

If Yes, please state:

Grade of urgency<sup>5\*</sup>

Indication for caesarean section: \_\_\_\_\_

Method of anaesthesia: (tick one only)

Spinal

CSE

Epidural top-up

De-novo epidural

General anaesthetic

General for failed regional technique

## 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?<sup>6\*</sup>**

Yes  No

If Yes, please specify \_\_\_\_\_

**6a.3 Did the woman die?**

Yes  No

If Yes, please specify date and time of death

/   /    :   :

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

(Please state if not known) \_\_\_\_\_

\*For guidance please see back cover

## 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](http://www.npeu.ox.ac.uk/ukoss)

### 6b.1 Date and time of delivery

/   /     :

### 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, what date was the intrauterine death confirmed?

Ante-partum  Intra-partum

If Yes, go to section 7

### 6b.6 5 min Apgar

### 6b.7 Was the infant admitted to the neonatal unit?

Yes  No

### 6b.8 Did any major infant complications occur?\*

Yes  No

If Yes, please specify \_\_\_\_\_

### 6b.9 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?

(Please state if not known) \_\_\_\_\_

## Section 7:

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

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## Section 8:

Name of person completing the form \_\_\_\_\_

Designation \_\_\_\_\_

Today's date

/   /

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

\*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. 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