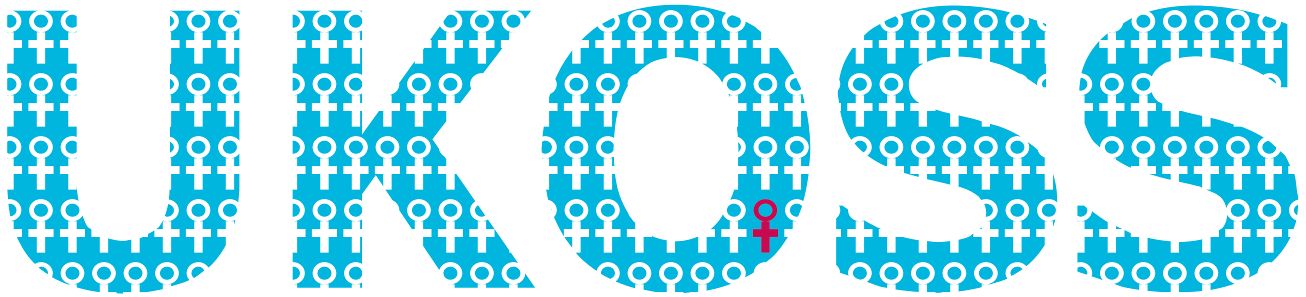
ID Number:



Gastroschisis Study 03/06

Data Collection Form - CASE

Please report all women delivering or due to deliver between 1st September 2006 and 31st October 2007

Case Definition:

A congenital malformation characterized by visceral herniation through an abdominal wall defect lateral to an intact umbilical cord and not covered by a membrane.

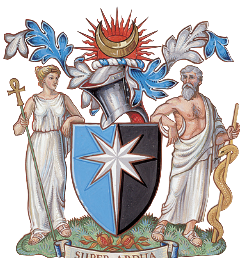
Excluded: Aplasia or hypoplasia of abdominal muscles, skin-covered umbilical hernia, exomphalos or omphalocele.

Please return the completed form to:

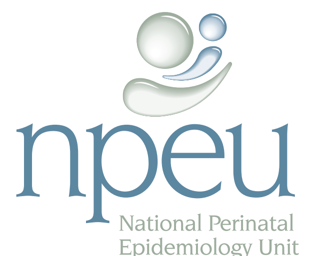
UKOSS
National Perinatal Epidemiology Unit
University of Oxford
Old Road Campus
Oxford
OX3 7LF

Fax: 01865 289701
Phone: 01865 289714

Case reported in: ______________



Royal College of Obstetricians and Gynaecologists



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.

SAMPLE CASE

Section 1: Woman's Details

1.1 Year of birth ☐☐☐☐ (YYYY)

1.2 County of residence ____________________

1.3 Ethnic group[1]* ☐☐

1.4 Marital status single ☐ married ☐ cohabiting ☐

1.5 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

____

1.6 Height at Booking (cm) ☐☐☐

1.7 Weight at Booking (kg) ☐☐☐.☐

1.8 Smoking status Never ☐ Gave up prior to pregnancy ☐

Current ☐ Gave up during pregnancy ☐

Section 2: Previous Obstetric History

2.1 Gravidity

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 Pregnancy problems[2]* Yes ☐ No ☐

If Yes, please specify ____________________

2.3 Previous infant with gastroschisis Yes ☐ No ☐

Section 3: Previous Medical History

Please indicate whether any of the following were present:

3.1 Previous or pre-existing medical problems[3]* Yes ☐ No ☐

If Yes, please specify ____________________

3.2 Was recreational/illegal drug use declared at booking? Yes ☐ No ☐

If Yes, were recreational/illegal drugs used in early pregnancy? Yes ☐ No ☐

If Yes, please specify drugs used (if known) ____________________

*For guidance please see back cover

SAMPLE CASE

Section 4: This Pregnancy

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

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

If Yes, please specify number of fetuses ☐

4.3 Were there problems in this pregnancy[2]*? Yes ☐ No ☐

If Yes, please specify ______

4.4 Did the woman conceive on the oral contraceptive pill? Yes ☐ No ☐

If Yes, was it: combined oral contraceptive pill ☐ progesterone only pill ☐

4.5 Did the woman have documented influenza in early pregnancy? Yes ☐ No ☐

If Yes, was any drug treatment given? Yes ☐ No ☐

If Yes, please specify drugs used ______

4.6 Did the woman have any other infection in early pregnancy Yes ☐ No ☐

If Yes, please specify ______

4.7 Was this woman prescribed regular aspirin treatment in pregnancy? Yes ☐ No ☐

If Yes, specify date started D D / M M / Y Y

4.8 Was any other regular medication prescribed in early pregnancy? Yes ☐ No ☐

If Yes, please list *(if more than 3 please continue in section 7)*

Medications used	Date started	Dose	Date stopped
	D D / M M / Y Y		D D / M M / Y Y
	D D / M M / Y Y		D D / M M / Y Y
	D D / M M / Y Y		D D / M M / Y Y

4.9 Before diagnosis of gastroschisis, was this woman booked for delivery at a different hospital? Yes ☐ No ☐

If Yes, please indicate name of booking unit ______

4.10 Will this woman receive all her antenatal care at your hospital? Yes ☐ No ☐

If No, please indicate name of hospital ______

Diagnosis of Gastroschisis

4.11 Date of Diagnosis D D / M M / Y Y

4.12 Was an ultrasound diagnosis made? Yes ☐ No ☐

If Yes, please indicate the anomalies found (tick one)

Isolated gastroschisis ☐

Gastroschisis with other abnormality ☐

Please specify additional abnormalities ______

Other anomaly ☐

Please specify ______

4.13 Did the woman have an AFP measurement in early pregnancy? Yes ☐ No ☐

If Yes, please give date of test D D / M M / Y Y

And result ☐.☐ MoM

*For guidance please see back cover

SAMPLE CASE

Antenatal Management

4.14 Were antenatal steroids given? Yes ☐ No ☐

If Yes, please indicate date of first course D D / M M / Y Y

And number of courses given ☐

4.15 Please indicate whether any of the following were performed and the frequency with which they were performed

Biophysical profile Yes ☐ No ☐ No. of times performed ☐

CTG Yes ☐ No ☐ No. of times performed ☐

Growth scan Yes ☐ No ☐ No. of times performed ☐

Umbilical artery doppler Yes ☐ No ☐ No. of times performed ☐

4.16 Were bowel or growth measurements made antenatally? Yes ☐ No ☐

If Yes, please indicate findings in table below *(if more than 3 measurements were made, please continue results in section 7)*

Scan Number	1	2	3
Date	D D / M M / Y Y	D D / M M / Y Y	D D / M M / Y Y
Maximum Stomach Diameter (mm)	☐☐	☐☐	☐☐
Maximum Bowel Wall Thickness (mm)	☐☐	☐☐	☐☐
Minimum Bowel Wall Thickness (mm)	☐☐	☐☐	☐☐
Maximum Bowel Dilatation (mm)	☐☐	☐☐	☐☐
Minimum Bowel Dilatation (mm)	☐☐	☐☐	☐☐
Polyhydramnios (Tick if yes)	☐	☐	☐
Oligohydramnios (Tick if yes)	☐	☐	☐
IUGR (Tick if yes)	☐	☐	☐

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 D D / M M / Y Y

5.3 Did this woman have a termination of pregnancy? Yes ☐ No ☐

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

*For guidance please see back cover

SAMPLE CASE

5.4 Was delivery induced? Yes ☐ No ☐
If Yes, was prostaglandin used Yes ☐ No ☐
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]* ☐
Grade of operator ______________________
Indication for caesarean section ______________________

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 DD/MM/YY
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 DD/MM/YY hh:mm (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 or paediatric surgical unit? Yes ☐ No ☐
If Yes, duration of stay *(days)* ☐☐
Or Tick if infant is still in NICU/SCBU/Paediatric surgical unit ☐
Or Tick if infant was transferred to another hospital ☐

6b.7 Was gastroschisis confirmed postnatally? Yes ☐ No ☐

6b.8 Did any other major infant complications occur?[7]* Yes ☐ No ☐
If Yes, please specify ______________________

*For guidance please see back cover

SAMPLE CASE

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?

____

Section 7

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

____

SAMPLE CASE

Section 8

Name of person completing the form ________________________

Designation ________________________

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.

If you are unable to make a copy please tick the box ☐

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

SAMPLE CASE