ID Number:

British Association of Paediatric Surgeons Congenital Anomalies Surveillance System

Gastroschisis

Data Collection Form - CASE

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:

BAPS Congenital Anomalies Surveillance System
National Perinatal Epidemiology Unit
University of Oxford
Old Road Campus
Oxford
OX3 7LF

Fax: 01865 289701
Phone: 01865 289700

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 infant's name on the Clinician's Section of the blue card retained in the BAPS folder.

3. Fill in the form using the information available in the infant'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 5.

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 you do not know the answers to some questions, please indicate this in section 5.

8. If you encounter any problems with completing the form please contact the Study Administrator or use the space in section 5 to describe the problem.

Section 1: **Infant's details**

1.1 **Ethnic group**[1]* ☐☐

1.2 **Gender** Male ☐ Female ☐

1.3 **Gestational age at birth** *(completed weeks)* ☐☐

1.4 **Mode of delivery**

spontaneous vaginal ☐
ventouse ☐
lift-out forceps ☐
rotational forceps ☐
breech ☐
pre-labour caesarean section ☐
caesarean section after onset of labour ☐

1.5 **Birthweight (g)** ☐☐☐☐

1.6 **Head Circumference (cm)** ☐☐.☐

1.7 **5 min Apgar** ☐☐

1.8 **Was gastroschisis diagnosed antenatally?** Yes ☐ No ☐

1.9 **Did the postnatal diagnosis agree with the antenatal diagnosis?** Yes ☐ No ☐

1.10 **Were there any associated anomalies (either structural or chromosomal)?** Yes ☐ No ☐

If Yes, please specify _____

1.11 **Was the infant transferred from a different hospital after delivery?** Yes ☐ No ☐

If Yes, please specify hospital where infant was born _____

1.12 **Mother's year of birth** Y Y Y Y

1.13 **Father's occupation** (*if known*) _____

1.14 **Sibling with gastroschisis** Yes ☐ No ☐

*For guidance please see back cover

Section 2: **Macroscopic appearance of bowel at delivery**

2.1 Was the gastroschisis closed or vanished at birth? Yes ☐ No ☐

If Yes, *go to section 3*

If No, please continue

2.2 Was the defect measured? Yes ☐ No ☐

If Yes, size of defect (cm) ☐.☐

2.3 Position Right of umbilicus ☐ Left of Umbilicus ☐

2.4 Eviscerated organs *(please tick all that apply)*

stomach ☐
small bowel ☐
large bowel ☐
spleen ☐
bladder ☐
liver ☐
gonads ☐
gall bladder ☐

2.5 Please circle the boxes from each of the five categories (CATAP) that best describe the macroscopic appearance of the bowel at delivery:

CHARACTER	BOWEL DESCRIPTION			
Colour	Pink/Healthy (normal)	Meconium stained/ Healthy	Dusky/ Ischaemic	Black/Necrotic
Adhesions	Bowel Loops Separate with No Adhesions	≤50% of Bowel Loops Adherent	>50% of Bowel Loops Adherent	Undefined Adherent Mass
Thickening	None (normal)	Minimal Thickening	Moderate Thickening	Severe Thickening
Atresia	Not Visible	Single	Multiple†	Small Bowel AND / OR Large Bowel
Perforation	Not Visible	Single	Multiple†	Small Bowel AND / OR Large Bowel

† If multiple atresias, how many sections were atretic? ☐

† If multiple perforations, how many sections were perforated? ☐

2.6 Was the bowel length measured? Yes ☐ No ☐

If Yes, what was the total length? (cm) ☐☐.☐

Section 3: **Operative management**

3.1 Was reduction and closure attempted? Yes ☐ No ☐

If Yes, please continue. If No, *go to section 4*

3.2 Date and time of first procedure D D / M M / Y Y h h : m m (24hr)

3.3 Where was the first procedure performed?

Delivery suite ☐ Elsewhere in hospital of birth ☐ Other hospital ☐

3.4 Please specify the surgical sequence at first closure *(tick all that apply)*:

Procedure	Attempted	Successful	Unsuccessful	Please indicate the order in which procedures were attempted (1,2,3 etc)
Operative fascial closure	☐	☐	☐	☐
Ward reduction (Bianchi)	☐	☐	☐	☐
Custom Silo†	☐	☐	☐	☐
Preformed silo	☐	☐	☐	☐
Patch‡	☐	☐	☐	☐
Other primary reduction and closure	☐	☐	☐	☐
Other staged closure	☐	☐	☐	☐

If Other primary or staged closure, please specify technique _____

† Custom silo = silo constructed by surgeon

If custom silo used, please specify material used _____

‡ If Patch used, please specify material used _____

3.5 Was a second closure procedure performed? Yes ☐ No ☐

If Yes, please continue. If No, *go to section 4*

3.6 Date of second procedure D D / M M / Y Y

3.7 Please specify the surgical sequence of the second closure *(tick all that apply)*:

Procedure	Attempted	Successful	Unsuccessful	Please indicate the order in which procedures were attempted (1,2,3 etc)
Operative fascial closure	☐	☐	☐	☐
Patch‡	☐	☐	☐	☐
Other closure	☐	☐	☐	☐

If Other closure, please specify technique _____

‡ If Patch used, please specify material used _____

Section 4: **Outcomes**

4.1 Was the infant ventilated? Yes ☐ No ☐

If Yes, please state duration of ventilation (days) ☐☐

Or Tick if infant is still ventilated ☐

4.2 Was the infant fed parenterally? Yes ☐ No ☐

If Yes, please state duration of parenteral nutrition (days) ☐☐

Or Tick if infant is still receiving TPN ☐

4.3 Is the infant now fully orally fed? Yes ☐ No ☐

If Yes, please state days to full oral feeding ☐☐

4.4 Has the infant been discharged home? Yes ☐ No ☐

If Yes, please state days to discharge ☐☐

4.5 Has the infant been transferred to another hospital? Yes ☐ No ☐

If Yes, please give name of hospital _____

name of responsible consultant _____

and date of transfer D D / M M / Y Y

4.6 Did the infant have any of the following complications?

Intestinal necrosis/perforation Yes ☐ No ☐

Wound dehiscence Yes ☐ No ☐

NEC Yes ☐ No ☐

Missed atresia Yes ☐ No ☐

Reoperation Yes ☐ No ☐

If Yes, please specify _____

_____

Other major complications[2]* Yes ☐ No ☐

If Yes, please specify _____

_____

4.7 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) _____

*For guidance please see back cover

Section 5

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

Section 6:

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. Fetal/infant complications, including:

Respiratory distress syndrome
Intraventricular haemorrhage
Neonatal encephalopathy
Chronic lung disease
Severe jaundice requiring phototherapy/transfusion
Severe infection e.g. septicaemia, meningitis
Exchange transfusion
TPN cholestasis
Short gut