ID Number:

UKOSS

UK Obstetric Surveillance System

Management of Pregnancy following Gastric Bypass Surgery Study 02/14

Data Collection Form - CASE

Please report any woman delivering on or after 1st March 2014 and before 1st March 2015

Case Definition:

Any woman with a confirmed on-going pregnancy following gastric bypass surgery.

Exclude:

Any woman who had a gastric band.

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 Y Y Y Y

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 completed pregnancies beyond 24 weeks

Before gastric bypass surgery ☐☐

After gastric bypass surgery ☐☐

Number of pregnancies less than 24 weeks

Before gastric bypass surgery ☐☐

After gastric bypass surgery ☐☐

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

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

If Yes, please specify _____

*For guidance please see back cover

Section 3: Previous Medical History

3.1 **What was the date the gastric bypass surgery was performed?** D D / M M / Y Y

3.2 **What type of surgery was performed?** *(tick one only)*

Roux-en-Y ☐ Duodenal switch ☐ Gastric sleeve ☐ Other ☐ Not known ☐

If Other, please specify _____

3.3 **What weight was the woman at the time of her bypass?** *(Or tick if not known)* ☐☐☐.☐ kg

Not known ☐

3.4 **Were any of the following present before this pregnancy?** Yes ☐ No ☐

If Yes, please tick all that apply

Diabetes ☐ Hypertension ☐ Heart disease ☐ Renal disease ☐

3.5 **Did the woman have any other pre-existing medical problem3*** Yes ☐ No ☐

If Yes, please give details _____

Section 4: This Pregnancy

Section 4a: Epidural Haematoma or Abscess

4a.1 **Final Estimated Date of Delivery (EDD)[4]*** D D / M M / Y Y

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

If Yes, specify number of fetuses ☐

4a.3 **Was this pregnancy conceived following assisted conception?** Yes ☐ No ☐

If Yes, did the woman have IVF/ICSI? Yes ☐ No ☐

4a.4 **Was dietary advice given during this pregnancy?** Yes ☐ No ☐ Not known ☐

If Yes, please complete table below

Clinician giving advice	Date advice given
	D D / M M / Y Y
	D D / M M / Y Y

4a.5 **Were any of the following blood levels checked in pregnancy?** Yes ☐ No ☐

If Yes, please complete the following table:

	Result (Low/High/Normal/ X not done)	Result (Low/High/Normal/ X not done)	Result (Low/High/Normal/ X not done)	Result (Low/High/Normal/ X not done)
Date				
Ferritin				
Folate				
Vit A				
B12				
Calcium				

*For guidance please see back cover

4a.6 Was nutritional supplementation given? Yes ☐ No ☐

If Yes, please complete the following table:

				Dose	Dose units	Dose not known	Oral (O) or Parenteral (P)
Iron	Yes ☐	No ☐	Not known ☐				
Folic acid	Yes ☐	No ☐	Not known ☐				
Vitamin A	Yes ☐	No ☐	Not known ☐				
Vitamin B1	Yes ☐	No ☐	Not known ☐				
Vitamin B12	Yes ☐	No ☐	Not known ☐				
Vitamin D	Yes ☐	No ☐	Not known ☐				
Vitamin K	Yes ☐	No ☐	Not known ☐				
Calcium	Yes ☐	No ☐	Not known ☐				
Copper	Yes ☐	No ☐	Not known ☐				
Zinc	Yes ☐	No ☐	Not known ☐				
Selenium	Yes ☐	No ☐	Not known ☐				
Magnesium	Yes ☐	No ☐	Not known ☐				
Multivitamin	Yes ☐	No ☐	Not known ☐				

If Multivitamin taken, please state which one _____

4a.7 Was the woman screened for gestational diabetes? Yes ☐ No ☐

If Yes,

Date screened D D / M M / Y Y

What test was performed? *(tick one only)*

- Fasting glucose test ☐
- Post prandial glucose test ☐
- Random glucose test ☐
- Oral glucose tolerance test ☐

If Yes, did the woman develop hypoglycaemia (Dumping syndrome) following OGTT? Yes ☐ No ☐

4a.8 Was the woman treated for gestational diabetes in this pregnancy? Yes ☐ No ☐

If Yes, was this *(tick one only)*

- Diet ☐
- Oral hypoglycaemics ☐
- Insulin ☐

4a.9 Did the woman become anaemic during this pregnancy? Yes ☐ No ☐

4a.10 Was the woman treated for high blood pressure during this pregnancy? Yes ☐ No ☐

4a.11 Did the woman develop pre-eclampsia during this pregnancy? Yes ☐ No ☐

If Yes, what was the date of diagnosis? D D / M M / Y Y

4a.12 Did the woman develop thromboembolic disease during pregnancy or in the first 14 days postpartum? Yes ☐ No ☐

If Yes, what was the date of the first thromboembolic event? D D / M M / Y Y

4a.13 Which of the following clinicians were involved in the care of the woman? *(Please tick all that apply)*

Obstetrician ☐

Endocrinologist ☐

Dietician ☐

4a.14 Did the woman have a third trimester ultrasound examination? Yes ☐ No ☐

If Yes, did the scan show any evidence of the fetus being small for gestational age? Yes ☐ No ☐

If Yes, please specify (e.g. abdominal circumference <10th centile)

_____

4a.15 Were any of the following surgical complications encountered during pregnancy? *(Please tick all that apply)* Yes ☐ No ☐

Gastric dumping syndrome ☐ Incisional hernia ☐ Bowel obstruction ☐

Anastomotic leakage ☐ Anastomotic stricture ☐ Anastomotic ulcer ☐ Other ☐

If Other, please specify _____

4a.16 Were there any other problems in this pregnancy?[2]* Yes ☐ No ☐

If Yes, please specify _____

Section 4b: Weight Changes During Pregnancy

4b.1 Is the woman's pre-pregnancy weight known? Yes ☐ No ☐

If Yes, what was the

Weight ☐☐☐.☐ kg

BMI ☐☐☐

Date recorded D D / M M / Y Y

4b.2 What was the first recorded (booking) weight in pregnancy?

Weight ☐☐☐.☐ kg

BMI ☐☐☐

Date recorded D D / M M / Y Y

4b.3 What was the last recorded weight in pregnancy?

Weight ☐☐☐.☐ kg

BMI ☐☐☐

Date recorded D D / M M / Y Y

Section 5: Delivery

5.1 **Did this woman have a miscarriage?** Yes ☐ No ☐

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

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

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

If Yes to 5.1 or 5.2, please now complete sections 6a, 7 and 8

5.3 **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

_____

Will she be delivered at your hospital? Yes ☐ No ☐

If No, please indicate name of delivery hospital, then go to Section 7

_____

5.4 **Was delivery induced?** Yes ☐ No ☐

If Yes, please state indication _____

Was vaginal prostaglandin used? Yes ☐ No ☐

5.5 **Did the woman labour?** Yes ☐ No ☐

5.6 **Was delivery by caesarean section?** Yes ☐ No ☐

If Yes, please state

Grade of urgency[5]* ☐

Indication for caesarean section _____

Method of anaesthesia: *(tick one only)* 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, please specify:

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 the woman report any problems with wound or perineal healing in the first two weeks post partum?** Yes ☐ No ☐

If Yes, please specify the ASEPSIS tool category[6]* ☐

6a.3 **Did any other major maternal morbidity occur?[7]*** Yes ☐ No ☐

If Yes, please specify _____

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?

Yes ☐ No ☐ 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

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 ☐ 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, when did this occur? 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 ☐

If Yes, what was the indication for admission? _____

6b.8 Was any congenital abnormality detected? Yes ☐ No ☐

If Yes, was this detected antenatally? Yes ☐ No ☐

Please specify abnormality _____

6b.9 Did any major infant complications occur?[7*] Yes ☐ No ☐

If Yes, please specify _____

6b.10 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:

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

_____

_____

_____

_____

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.

*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. ASEPSIS tool categories:

1. Additional treatment for infection
2. Serous discharge
3. Erythema
4. Purulent exudate
5. Separation of deep tissue
6. Isolation of bacteria
7. Inpatient stay for more than 14 days

7. 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

8. 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