Severe Obesity
Study 01/16

Sample Data Collection Form – CASE

Please report all women meeting the case definition AND admitted for labour care in the AMU on or after 1st January 2016 and before 1st January 2017

Case Definition:

Any woman with a Body Mass Index (BMI) greater than 35 kg/m\(^2\) at booking and admitted for labour care in the AMU

Instructions

This is a Sample Data Collection Form for information only. Please do not use this form to provide us with information on a case you have reported. Data should be entered using our OpenClinica system at https://openclinica.npeu.ox.ac.uk/OpenClinica

Section 1. Woman’s details

1.1 Body Mass Index (BMI) at time of booking
Should be >35 kg/m\(^2\) to meet the case definition.

_______ kg/m\(^2\)

1.2 Age at delivery (years)
_______ years

1.3 Ethnic group
Please tick one
☐ White British
☐ White Irish
☐ Any other White background
☐ Mixed White & Black Caribbean
☐ Mixed White & Black African
☐ Mixed White & Asian
☐ Any other mixed background
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Any other Asian background
1.4 Is the woman in currently in paid employment?
☐ Yes, please give woman’s occupation ________________________________
☐ No, please give partner’s occupation ________________________________

1.5 Children in Low-income Families Measure score
0.000 [Note: This is derived from the woman’s postcode ________________ You will need to click on a link in the online data collection form and enter the woman’s postcode when prompted. Then copy the number returned and paste into the form]

1.6 Height at booking (cm)
_________________________ cm [Or not recorded]

1.7 Minimum recorded weight (kg) & date measured
_________________________ kg _______________ (Date recorded) [Or not recorded]

1.8 Maximum recorded weight (kg) & date measured
_________________________ kg _______________ (Date recorded) [Or not recorded]

1.9 Smoking status at delivery
☐ Never smoked
☐ Gave up prior to pregnancy
☐ Gave up during pregnancy
☐ Current smoker
☐ Not recorded

Section 2. Pregnancy/antenatal history

2.1 Has this woman had any previous pregnancies?
☐ Yes [If Yes, go to 2.1.1]
☐ No [If no, go to 2.2]

2.1.1 Number of completed pregnancies ≥24 weeks, prior to this pregnancy
_____________

2.1.2 Number of pregnancy losses<24 weeks
_____________
2.1.3 Was this woman known to have had complications in a previous pregnancy?
For example, unexplained stillbirth/neonatal death; pre-eclampsia requiring preterm birth; primary PPH requiring treatment or transfusion; retained placenta requiring manual removal; caesarean section; shoulder dystocia.
[ ] Yes, please specify ______________________
[ ] No

2.2 Was this pregnancy conceived through assisted conception?
[ ] Yes
[ ] No

2.3 Final Estimated Date of Delivery (EDD)
Note: Use the best estimate (ultrasound or date of last menstrual period) based on a 40 week gestation ________________ (Date)

2.4 Immediately prior to the onset of labour was this woman known to have any medical conditions?
For example: confirmed cardiac disease; essential hypertension; asthma (please specify if requiring increase in treatment or hospital treatment); thromboembolic disorders; atypical antibodies; Group B Streptococcus; hyperthyroidism; epilepsy.
[ ] Yes, please specify ______________________
[ ] No

2.5 During antenatal care were any current pregnancy problems (in addition to BMI>35kg/m²) identified?
For example: pre-eclampsia or pregnancy induced hypertension; small for gestational age.
[ ] Yes, please specify ______________________
[ ] No

2.6 Did this woman have an oral glucose tolerance test during pregnancy?
[ ] Yes [If Yes, go to 2.6.1]
[ ] No [If no, go to Section 3]

2.6.1 Did this test indicate gestational diabetes?
[ ] Yes
[ ] No
Section 3. Labour and birth care

3.1 Date and time of start of labour care in the AMU

______________ (Date) ______________ (Time, 24hr clock)

3.2 Stage of labour at start of labour care

☐ Latent stage: painful contractions & some cervical change, including cervical effacement and dilatation up to 4 cm;
☐ Active 1st stage: regular painful contractions & progressive cervical dilatation from 4 cm
☐ Passive 2nd stage: full dilatation before or in absence of involuntary expulsive contractions
☐ Active 2nd stage: baby visible or expulsive contractions with findings/signs of full dilatation or active maternal effort with full dilatation in absence of expulsive contractions

3.3 On initial assessment at the start of labour care were any of the following identified?

Please tick at least one box:

☐ Maternal tachycardia (Pulse >120 beats/minute on 2 occasions, 30 minutes apart)
☐ Hypertension (Single blood pressure reading - diastolic ≥110 mmHg or systolic ≥160 mmHg OR diastolic ≥90 mmHg or systolic ≥140mmHg on 2 readings 30 minutes apart)
☐ Proteinuria (2+ of protein or more AND single reading of either diastolic blood pressure ≥90 mmHg or systolic ≥140mmHg)
☐ Maternal pyrexia (Temperature of ≥38°C on a single reading, or ≥37.5°C on 2 readings 1 hour apart)
☐ Vaginal blood loss (Other than a show)
☐ Prolonged rupture of membranes (>24 hours before onset of established labour)

If Yes, please specify duration

☐ Significant meconium (Dark green or black amniotic fluid that is thick or tenacious, or any meconium-stained amniotic fluid containing lumps of meconium)
☐ Reported pain differing from pain normally associated with contractions
☐ Abnormal presentation, including cord presentation
☐ Transverse or oblique lie
☐ High or free-floating head (4/5–5/5 palpable or free-floating head in a nulliparous woman)
☐ Suspected fetal growth restriction or macrosomia
☐ Suspected anhydramnios or polyhydramnios
☐ Fetal heart rate abnormality (<100 or >160 beats/minute)
☐ Deceleration in fetal heart rate
☐ Reduced fetal movements in the last 24 hours
☐ None of the above

3.4 Did this woman use immersion in water for pain relief at any time during labour?

☐ Yes
☐ No
3.5  Was this woman transferred to the care of an obstetrician at any time during labour care or immediately after the birth?
Note: Includes transfers for epidural/pain relief. Does NOT include postnatal transfer where baby was transferred to specialist care, but mother’s care was not transferred

☐ Yes [If Yes, go to 3.5.1]
☐ No [If no, go to 3.6]

3.5.1  Date and time of decision to transfer
_________________ (Date) _________________ (Time, 24hr clock)

3.5.2  Primary reason for transfer
☐ Hypertension
☐ Significant meconium
☐ Confirmed delay in first stage of labour
☐ Confirmed delay in second stage of labour
☐ Epidural/other pain relief request
☐ Fetal heart rate abnormalities in first stage
☐ Fetal heart rate abnormalities in second stage
☐ Retained placenta
☐ Repair of perineal trauma
☐ Other, please specify

3.5.3  Was labour augmented with syntocinon?
☐ Yes _______________ (Date) __________________ (Time, 24hr clock)
☐ No

3.5.4  Did this woman have an epidural or spinal?
☐ Yes _______________ (Date) __________________ (Time, 24hr clock)
☐ No

3.5.5  Did this woman have a general anaesthetic?
☐ Yes
☐ No

3.6  Was this a multiple birth?
☐ Yes, number of babies__________
☐ No

3.6.1  Date and time of delivery
_________________ (Date) _________________ (Time, 24hr clock)

3.7  What was the place of birth?
☐ AMU, under midwifery care
☐ AMU, under care of obstetrician
☐ Obstetric unit, under midwifery care
☐ Obstetric unit, under care of obstetrician
3.8 Did this woman give birth in water?
- Yes
- No

3.9 What was the mode of birth?
- Spontaneous vertex birth (go to 3.10)
- Vaginal breech (go to 3.10)
- Ventouse (go to 3.10)
- Forceps (go to 3.10)
- Caesarean section (got to 3.9.1)

3.9.1 Grade of urgency of Caesarean section
- Category 1: Immediate threat to life of woman or fetus
- Category 2: Maternal or fetal compromise, not immediately life-threatening
- Category 3: Needing early delivery, no maternal or fetal compromise
- Category 4: At a time to suit the woman and maternity team

3.9.2 Primary reason for Caesarean section
- Abnormal presentation
- Fetal compromise
- Maternal compromise
- Slow progress
- Other, please specify ____________________
- Not known

3.10 Was shoulder dystocia documented?
- Yes, please describe management technique used __________________________________________
- No

3.11 Did this woman receive a prophylactic oxytocic (syntocinon) in the 3rd stage?
- Yes
- No

Section 4. Maternal outcomes

4.1 Did this woman have any perineal trauma involving the anal sphincter (3rd/4th degree tear)?
- Yes
- No

4.2 Did this woman receive postnatal low molecular weight heparin (LMWH) thromboprophylaxis?
- Yes. Please say for how long ________________ days or ____________________ weeks
- No
4.3 Within the first 48 hours after giving birth was this woman admitted to a higher level of care?

☐ No (go to 4.4)
☐ Yes, High dependency unit or area (go to 4.3.1)
☐ Yes, Intensive care unit (go to 4.3.1)
☐ Yes, other (please specify) __________________________ (go to 4.3.1)

4.3.1 What was the main reason for admission to HDU/ICU:
______________________________

4.3.2 What was the total duration of stay in HDU/ICU:
__________________________ hours or ____________ days

4.4 Was this woman recorded as having a PPH of 1500ml or more?

☐ Yes
☐ No

4.5 Did this woman receive a blood transfusion within 48 hours of giving birth?

☐ Yes (go to 4.5.1)
☐ No (go to 4.6)

4.5.1 When was the first blood transfusion given?

☐ Intrapartum
☐ End of third stage – 23 hours after birth
☐ 24-48 hours after birth

4.5.2 How many units of whole blood or packed cells did this woman receive?
__________________ units

4.5.3 Was a cell saver used?

☐ Yes. Volume of patient’s blood transfused _________________ ml
☐ No

4.5.4 What was the main reason for blood transfusion?

☐ Uterine atony
☐ Genital tract trauma
☐ Retained products/morbidly adherent placenta
☐ Other, please specify __________________________

4.6 Was there any other maternal morbidity?

☐ Yes, please specify ___________________________________________
☐ No

4.7 Did this woman die?

☐ Yes (go to 4.7.1)
☐ No (go to 4.8)
4.7.1  Date and time of maternal death
        __________ (Date) ______________ (Time, 24hr clock)

4.7.2  What was the underlying cause of maternal death?
        Please describe ____________________________

        □  Not yet known

4.8  What was the date of maternal discharge?
        __________ (Date)

Section 5.  Baby outcomes
Please repeat this section if more than one baby

5.1  What was the birthweight?
        __________ g

5.2  Sex of baby

        □  Male
        □  Female
        □  Indeterminate

5.3  Was the baby stillborn?

        □  Yes (go to 5.3.1)
        □  No (go to 5.4)

5.3.1  When did the baby die?

        □  Before the start of care in labour
        □  After the start of care in labour

5.4  What was the Apgar score at 5 minutes?

        ____

5.5  Was the baby breastfed at least once?

        □  Yes
        □  No

5.6  Was the baby admitted to a neonatal unit or any other paediatric high level care within 48 hours of birth?

        □  Yes (go to 5.6.1)
        □  No (go to 5.7)

5.6.1  What was the duration of stay in the neonatal unit?

        ____________________________ hours or _____________ days
5.6.2 What was the main reason for admission to the neonatal unit?

- [ ] Hypoxic-ischaemic encephalopathy
- [ ] Hypoglycaemia
- [ ] Birth trauma
- [ ] Feeding problems
- [ ] Other, please specify ________________________________

5.7 Was there any other neonatal morbidity?

- [ ] Yes, please specify ________________________________
- [ ] No

5.8 Did this baby die after birth?

- [ ] Yes (go to 5.8.1)
- [ ] No (go to 5.9)

5.8.1 Date and time of neonatal death

___________ (Date) ________________ (Time, 24hr clock)

5.8.2 Primary cause of neonatal death

- [ ] Congenital anomaly
- [ ] Antepartum infection
- [ ] Immaturity related conditions
- [ ] Intrapartum asphyxia, anoxia or trauma
- [ ] Infection
- [ ] Other, please specify ________________________________
- [ ] Not yet known

5.9 Date of neonatal discharge

___________ (Date)

Section 6. Any other information

6.1 Please enter any other information you feel may be important