CASE

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: ____________________
## Section 1: Woman’s details

1.1 Year of birth: 
1.2 Ethnic group: (*enter code, please see back cover for guidance*)
1.3 Marital status (mark one)
   - Single
   - Married
   - Cohabiting
1.4 Was the woman in paid employment at booking?
   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

## Section 2: Previous Obstetric History

2.1 Gravidity
   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 this woman’s liver function deteriorate during a previous pregnancy?
   Yes  No
2.3 Has this woman ever had any of the following: Please tick all that apply
   - A pre-term delivery (<37 weeks)
   - An infant admitted to the neonatal unit
   - A stillbirth
   None of the above
2.4 Has this woman ever had any of the following in previous pregnancies: Please tick all that apply
   - Pre-eclampsia
   - HELLP
   - Obstetric Cholestasis
   - Acute Fatty Liver of Pregnancy
   - Gestational diabetes
   - None of the above
2.5 Did the woman have any other previous pregnancy problems? (*
   If Yes, please specify: ____________________________

## Section 3: Previous Medical History

3.1 When was cirrhosis diagnosed?
3.2 What was the diagnosis of cirrhosis based on:
   a) Liver biopsy:
      Yes  No
   b) CT, MRI or Ultrasound scan:
      Yes  No
3.3 Does the woman have portal hypertension?
   If Yes, please give the date of diagnosis
      __________ / __________ / __________
   Yes  No  Not known
3.4 Which underlying liver disease does this woman have (please tick one):
   - Autoimmune Hepatitis
   - Primary Sclerosing Cholangitis
   - Primary Biliary Cirrhosis
   - Hepatitis B
   - Hepatitis C
   - Portal Vein Thrombosis
   - Other
   Not known
   If Other, please specify: ____________________________
3.5 Did the woman have oesophageal varices before this pregnancy:  
- Yes  
- No  
- Not known

If Yes, what was the size of the varices at the last pre-pregnancy endoscopy (please tick one):
- 0 - None  
- I - Small  
- II - Medium  
- III - Large  
- Not known

3.6 Has this woman ever had treatment for a variceal bleed:  
- Yes  
- No  
- Not known

If Yes, did she have:  
- Band Ligation:  
- Injection Sclerotherapy:

3.7 Has this woman had a liver transplant:  
- Yes  
- No

If Yes, please give the year of transplant:

3.8 Does the woman have any history of gallstones:  
- Yes  
- No  
- Not known

3.9 Has this woman ever had drug induced cholestasis:  
- Yes  
- No  
- Not known

If Yes, please give the name of the drug responsible:

3.10 Does this woman have any other previous / pre-existing medical conditions:  
- Yes  
- No

If Yes, please specify:

3.11 Did this woman have pre-pregnancy counselling from a doctor with a specialist knowledge of liver disease in pregnancy:  
- Yes  
- No  
- Not known

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**Section 4: This Pregnancy**

4.1 Final Estimated Date of Delivery (EDD):

4.2 Was this a multiple pregnancy?  
- Yes  
- No

If Yes, please specify number of fetuses:

4.3 Was conception?  
- Spontaneous  
- Assisted

4.4 What was the date of the first (booking) appointment in pregnancy?  

4.5 Regarding this woman’s medication, were any of the following: Please tick all that apply

<table>
<thead>
<tr>
<th></th>
<th>Taken at conception</th>
<th>Stopped prior to conception</th>
<th>Stopped following conception</th>
<th>Started during pregnancy</th>
<th>Never taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ursodeoxycholic acid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steroids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin K</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunosuppression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Immunosuppression, please specify which:

4.6 Were any other drugs not listed above taken during pregnancy for underlying liver disease?  
- Yes  
- No

If Yes, please list drugs taken
4.7 Did this woman have any of the following symptoms during pregnancy:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Tick all that apply</th>
<th>If Yes, please provide the date first noted in pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pruritus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jaundice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ascites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encephalopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.8 Were any of the following blood tests abnormal at the time of conception?

*Please tick all that apply*

<table>
<thead>
<tr>
<th>Test</th>
<th>Tick all that apply</th>
<th>Low Albumin?</th>
<th>Low Sodium?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raised ALT?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raised Bilirubin?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raised Bile Acids?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raised Creatinine?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raised Prolonged prothrombin time?</td>
<td></td>
<td>None of the above</td>
<td></td>
</tr>
</tbody>
</table>

4.9 Please give details of the worst levels of the following blood tests during pregnancy

<table>
<thead>
<tr>
<th>Test</th>
<th>Worst level</th>
<th>Or tick if not known</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilirubin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bile Acids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albumin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sodium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemoglobin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Platelets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prothrombin time</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.10 Please give details of the pre-delivery levels of the following blood tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Pre-delivery level</th>
<th>Or tick if not known</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilirubin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bile Acids</td>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Albumin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sodium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemoglobin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Platelets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prothrombin time</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.11 Did this woman have any of the following pregnancy problems: *Please tick all that apply*
- Pre-eclampsia [ ]
- Pregnancy induced hypertension [ ]
- HELLP [ ]
- Cholestasis [ ]
- AFLP [ ]
- Gestational diabetes [ ]
- None of the above [ ]

4.12 Did the woman have a post-partum haemorrhage: [ ] Yes [ ] No
If Yes, please give estimated blood loss [ ] ml

4.13 Did the woman have a diagnostic endoscopy during pregnancy: [ ] Yes [ ] No [ ] Not known
If Yes, did she have varices [ ] Yes [ ] No [ ] Not known
If Yes, what was the size of the varices *(please tick one)*:
- 0 - None [ ]
- I - Small [ ]
- II - Medium [ ]
- III - Large [ ]
- Not known [ ]

Was any treatment given during the procedure? *(please tick one)*
- None [ ]
- Sclerotherapy [ ]
- Banding [ ]
- Not known [ ]

4.14 Did the woman have a variceal bleed during pregnancy: [ ] Yes [ ] No
If Yes, please give date of bleed and treatment (indicate banding/sclerotherapy/octreotide/none)

<table>
<thead>
<tr>
<th>Date of bleed</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.15 Did this woman have a liver ultrasound scan during pregnancy: [ ] Yes [ ] No
If Yes, what was the size of the spleen [ ] cm

4.16 Did the woman have an episode of encephalopathy during pregnancy: [ ] Yes [ ] No
If Yes, what was the grade of encephalopathy:
- None [ ]
- Mild [ ]
- Moderate [ ]
- Severe [ ]
- Coma [ ]
- Not known [ ]

What treatment did she receive?

4.17 Did this woman have a liver transplant during the pregnancy: [ ] Yes [ ] No
If Yes, please give date [ ] / [ ] / [ ]

4.18 Were there any other problems in this pregnancy? [ ] Yes [ ] No
If Yes, please specify: ______________________________________

Section 5: Delivery

5.1 Did this woman have a miscarriage? [ ] Yes [ ] No
If Yes, please specify date: [ ] / [ ] / [ ]

5.2 Did this woman have a termination of pregnancy? [ ] Yes [ ] No
If Yes, please specify date: [ ] / [ ] / [ ]
and indication: ______________________________________

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

*For guidance please see back cover*
### Section 6: Outcomes

#### Section 6a: Woman

6a.1 Was the woman admitted to ITU (critical care level 3)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If Yes, duration of stay:

<table>
<thead>
<tr>
<th>days</th>
</tr>
</thead>
</table>

OR Tick if woman is still in ITU (critical care level 3):

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

OR Tick if woman was transferred to another hospital:

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

6a.2 Did any other major maternal morbidity occur?*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If Yes, please specify:


6a.3 Did the woman die?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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)*

### 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.npei.ox.ac.uk/ukoss

6b.1 Date and time of delivery:

| / | / | / | / |

6b.2 Mode of delivery:

- Spontaneous vaginal
- Ventouse or Forceps
- Vaginal Breech
- Pre-labour caesarean section
- Caesarean section after onset of labour

6b.3 Birthweight:

| g |

6b.4 Sex of infant:

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Indeterminate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6b.5 Was the infant stillborn?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If Yes, please go to section 7
6b.6 5 min Apgar

6b.7 Was meconium staining of the liquor noted at any point prior to delivery?  
Yes  No

6b.8 Was the umbilical arterial or venous pH measured?  
Yes  No

  If Yes, what was the umbilical arterial pH?
  What was the umbilical vein pH?

6b.9 Was the infant admitted to the neonatal unit?  
Yes  No

  If Yes, what was the indication?

6b.10 Did any major infant complications occur?  *

  If Yes, please specify

6b.11 Did this infant have a congenital abnormality?  
Yes  No

  If Yes, please give details

6b.12 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

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Section 8:

8.1 Name of person completing the form: ________________________________

8.2 Designation: ____________________________________________

8.3 Today’s date:  

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

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