Feto-Maternal Alloimmune Thrombocytopenia (FMAIT) Study 02/06

Data Collection Form - CASE

Report only women delivered after 1st August 2006

Case Definition:

Any infant newly-diagnosed with fetomaternal alloimmune thrombocytopenia (FMAIT) (thrombocytopenia secondary to proven fetomaternal platelet alloantigen incompatibility).

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: ________________
**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

1.2 Ethnic group

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 Pregnancies

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 Previous infant with FMAIT
   Yes ☐ No ☐
   If Yes, please indicate whether sibling was:
   Severe Intracranial haemorrhage or platelet count <50 x 10⁹/L ☐
   Mildly affected (Bruising or petechiae, platelet count 50-150 x 10⁹/L) ☐

2.3 Pregnancy problems
   Yes ☐ No ☐
   If Yes, please specify ________________________________

Section 3: Previous Medical History

3.1 Were there any previous or pre-existing medical problems?
   Yes ☐ No ☐
   If Yes, please specify ________________________________

*For guidance please see back cover
Section 4: This Pregnancy

4.1 Final Estimated Date of Delivery (EDD)*

4.2 Was this pregnancy a multiple pregnancy?
   If Yes, please specify number of fetuses

4.3 Before diagnosis was this woman booked for delivery at a different hospital?
   If Yes, please indicate name of booking unit

4.4 Will this woman receive all her antenatal care at your hospital?
   If No, please indicate name of hospital

4.5 Were there problems in this pregnancy\(^2\)?
   If Yes, please specify

4.6 What was the date of diagnosis of FMAIT?

4.7 What maternal-fetal platelet antigen incompatibility was found?
   If Other, please specify

Fetus

4.8 Please record below the results of all fetal blood samples performed (if known):
   (Continue in section 7 if necessary)

<table>
<thead>
<tr>
<th>Date of Sample</th>
<th>Fetal Platelet count (x 10^9/L)</th>
<th>List any complications of procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before transfusion</td>
<td>After transfusion</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

4.9 Please indicate whether any of the following treatments were used and the dates when they were first given

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Number of treatments</th>
<th>Date of first treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steroids e.g. dexamethasone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Intravenous immunoglobulin (IVIg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrauterine transfusion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*For guidance please see back cover
## Section 5: This Delivery

### 5.1 Is this woman still undelivered?  
If Yes, will she be delivered at your hospital?  
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?  
If Yes, please specify date

### 5.3 Did this woman have a termination of pregnancy?  
If Yes, please specify date

### 5.4 Was delivery induced?  
If Yes, please state indication

### 5.5 Did the woman labour?

### 5.6 Was delivery by caesarean section?  
If Yes, please state whether elective or emergency  
and give indication for caesarean section  
Method of anaesthesia:  

## Section 6: Outcomes

**Section 6a: Woman**

### 6a.1 Did any major maternal morbidity occur?  
If Yes, please specify

### 6a.2 Did the woman die?  
If Yes, please specify date of death  
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

### 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?  
If Yes, please go to section 7

*For guidance please see back cover*
6b.5 5 min Apgar

6b.6 Was the infant admitted to the neonatal unit?
   Yes ☐ No ☐
   If Yes, duration of stay (days)
   Or Tick if infant is still in NICU/SCBU
   Or Tick if infant was transferred to another hospital

6b.7 What was the infant's platelet count at birth? (x 10^9/L) (if known)

6b.8 Did this child develop any haemorrhagic complications?
   Yes ☐ No ☐
   If Yes, please indicate below which complications occurred (tick all that apply)
   Intracranial haemorrhage
   Gastrointestinal bleed
   Bruising/petechiae
   Other
   If Other, please specify ____________________________

6b.9 Did any other major infant complications occur? ☐
   Yes ☐ No ☐
   If Yes, please specify ____________________________

6b.10 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?
   ____________________________

*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. 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