Pregnancy in Renal Transplant Recipients
Study 01/07

Data Collection Form - CASE

Please report all women delivering after 1st January 2007 and before 1st February 2010

Case Definition:
Any pregnant woman identified as having a transplanted kidney (with or without a transplanted pancreas).

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.

2.2 Did the woman have any previous pregnancy problems?

   If Yes, please specify

### Section 3: Previous Medical History

3.1 What was the date of most recent transplant?

3.2 Was this first  | second  | third  | transplant? (please tick)

3.3 What was the source of the transplanted organ?
   - Live donor
   - Cadaveric heart-beating donor
   - Cadaveric non-heart-beating donor
   - Not known

3.4 Was a pancreas transplanted at the same time?

3.5 What was the underlying disease or condition which led to the requirement for transplant?

3.6 Were there any other previous or pre-existing medical problems?

   If Yes, please specify

*For guidance please see back cover
Immediate pre-pregnancy assessment

3.7 What was the most recent serum creatinine or eGFR prior to pregnancy?
Creatinine μmol/l [ ] eGFR ml/min [ ] or tick if not known

3.8 What was the most recent diastolic blood pressure prior to pregnancy?
mmHg [ ] or tick if not known

3.9 Was there proteinuria prior to pregnancy?
If Yes, what was the most recent, Albumin/Creatinine Ratio (ACR) [ ] OR Protein/Creatinine Ratio (PCR) [ ]

Section 4: This Pregnancy

4.1 Final Estimated Date of Delivery (**EDD**)

4.2 Was antenatal care undertaken in the usual hospital for this woman's area of residence?
If No, please indicate below reasons for care at a different hospital (tick all that apply)
- Referred to a tertiary centre because of underlying medical condition
- Patient preference
- Other
  - If Other, please specify

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

4.4 Was the woman taking any prescribed drugs at conception?
If Yes, please give details

4.5 Was the woman taking any folic acid at conception?

Immunosuppressive therapy

4.6 Please indicate whether any of the following immunosuppressive therapies were used (tick all that apply)

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Prior to pregnancy</th>
<th>During pregnancy</th>
<th>Maximum dose used during pregnancy (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azathioprine</td>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Cyclosporin</td>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Prednisolone</td>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Mycophenolate mofetil</td>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Tacrolimus</td>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other immunosuppressive</td>
<td></td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

*For guidance please see back cover*
4.7 Please indicate the number of antihypertensive drugs used:
   - Prior to pregnancy
   - First trimester
   - Second trimester
   - Third trimester

4.8 Please record the levels of the following:

<table>
<thead>
<tr>
<th></th>
<th>Highest serum creatinine (µmol/l)</th>
<th>Highest systolic blood pressure (mmHg)</th>
<th>Highest diastolic blood pressure (mmHg)</th>
<th>Highest urine protein (g/24h)</th>
<th>Lowest haemoglobin (g/dl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First trimester (up to 14 weeks)</td>
<td>[ ] [ ] [ ] [ ]</td>
<td>[ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
<td>[ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
</tr>
<tr>
<td>Second trimester (14-28 weeks)</td>
<td>[ ] [ ] [ ] [ ]</td>
<td>[ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
<td>[ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
</tr>
<tr>
<td>Third trimester (after 28 weeks)</td>
<td>[ ] [ ] [ ] [ ]</td>
<td>[ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
<td>[ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
</tr>
</tbody>
</table>

Complications

4.9 Please indicate if any episodes of renal dysfunction occurred during pregnancy. [ ] Yes [ ] No
   (Renal dysfunction is taken to mean a rise of 20% or more in serum creatinine from the lowest level recorded during pregnancy)
   If Yes, how many episodes? [ ]
   What was the cause of dysfunction? (if known) (e.g. obstruction/rejection/infection)
   Was a transplant biopsy performed? [ ] Yes [ ] No
   If Yes, what was the biopsy diagnosis? [ ]

4.10 Was pre-eclampsia diagnosed in this pregnancy? [ ] Yes [ ] No
   If Yes, please give date of diagnosis [ ] [ ] [ ] [ ] [ ]

4.11 Was gestational diabetes diagnosed in this pregnancy? [ ] Yes [ ] No
   If Yes, was it managed by (please tick)
   diet alone [ ] oral [ ] hypoglycaemics [ ] insulin [ ]
   Please give date of first diagnosis [ ] [ ] [ ] [ ] [ ] [ ]

4.12 Were there other problems in this pregnancy [ ]?
   Yes [ ] No [ ]
   If Yes, please specify ____________________________

Section 5: This 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 give reason for termination [ ] [ ] [ ] [ ] [ ]

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

#### Section 6a: Woman

6a.1 **Was the woman admitted to ITU/HDU**
- Yes [ ] No [ ]
  - If Yes, duration of stay (days) [ ]
  - Or Tick if woman is still in ITU/HDU [ ]
  - Or Tick if woman was transferred to another hospital [ ]

6a.2 **Did any major maternal morbidity occur?**
- Yes [ ] No [ ]
- If Yes, please specify

6a.3 **Did the woman die?**
- Yes [ ] No [ ]
  - 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**
- / / 
  - : 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 [ ]

*For guidance please see back cover*
6b.3 Birthweight (g)

6b.4 Did the infant have a major congenital anomaly?
   Yes ☐ No ☐
   If Yes, please specify ________________________________

6b.5 Was the infant stillborn?
   Yes ☐ No ☐
   If Yes, please go to section 7

6b.6 5 min Apgar

6b.7 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.8 Did any other major infant complications occur? ☐
   Yes ☐ No ☐
   If Yes, please specify ________________________________

6b.9 Was the infant breastfed prior to discharge home?
   Yes ☐ No ☐ Not Known ☐

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?
   ________________________________________________________________
   ________________________________________________________________

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 __________ __________ __________

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. Current or previous 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)
   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
   Severe infection e.g. septicaemia, meningitis
   Exchange transfusion