Any women delivering on or after 01/07/2013 and before 01/07/2014

Case Definition:

Please report any pregnant woman:

1. who has been diagnosed with thrombocytopenia with a platelet count of <50 x 10^9/l at any point in her pregnancy prior to delivery where obstetric and hereditary causes for thrombocytopenia have been excluded (ie. Pre-eclampsia, HELLP syndrome, acute fatty liver of pregnancy, known antiphospholipid antibody syndrome or other hereditary thrombocytopenias)

OR

2. Any pregnant woman diagnosed with an isolated thrombocytopenia where a clinical decision to treat the thrombocytopenia prior to delivery of the infant has been made.

EXCLUDE

Women with secondary immune thrombocytopenia to systemic lupus erythematosus (SLE) Hepatitis C, CMV, HIV and HAART therapy or any condition where treatment of thrombocytopenia is focused on treatment of the causative disease are excluded from the study.

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: ____________________________
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* (enter code, please see back cover for guidance)

1.3 Marital status

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

1.7 Smoking status

   never give up prior to pregnancy
gave up during pregnancy

current

1.8 Blood group

1.9 Rhesus D status

   Positive  Negative

Section 2: Previous Obstetric History

2.1 Gravidity

   Number of previous completed pregnancies beyond 24 weeks
   Number of previous pregnancies less than 24 weeks

   If no previous pregnancies, please go to section 3

2.2 Did the woman have any previous caesarean section(s)

   If Yes, how many previous Caesarean Sections has this woman had?
### Section 3: Previous Medical History

#### Section 3a: ITP related

3a.1 Was the woman known to have ITP prior to pregnancy?  
Yes [ ] No [ ]  
If No, please go to section 3c

3a.2 What year was Immune Thrombocytopenia diagnosed?  
[ ]  
[ ]  
[ ]  
[ ]  
[ ]

3a.3 What type of ITP was diagnosed?  
Primary (idiopathic) [ ]  
Secondary (associated with other autoimmune condition) [ ]

#### Section 3b: Treatment of ITP prior to pregnancy

3b.1 Has the woman ever been hospitalized due to ITP?  
Yes [ ] No [ ] Unknown [ ]

3b.2 Did the woman receive treatment for ITP at any point prior to this pregnancy?  
Yes [ ] No [ ] Unknown [ ]

If Yes, please give details of any treatments ever received prior to this pregnancy:

<table>
<thead>
<tr>
<th>Prior to conception</th>
<th>At conception</th>
<th>Neither</th>
<th>Not known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corticosteroid therapy</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Intravenous immunoglobulin</td>
<td>[ ]</td>
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<tr>
<td>IV anti-D</td>
<td>[ ]</td>
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<tr>
<td>Azathioprine</td>
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<tr>
<td>Cyclosporin A</td>
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<tr>
<td>Cyclophosphamide</td>
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<tr>
<td>Danazol</td>
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<tr>
<td>Dapsone</td>
<td>[ ]</td>
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<tr>
<td>Mycophenolate mofetil</td>
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<tr>
<td>Rituximab</td>
<td>[ ]</td>
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<tr>
<td>TPO receptor agonists (eg eltrombopag/romiplostin)</td>
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<tr>
<td>Vinka alkaloid regimen (eg. Vincristine / vinblastine)</td>
<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Platelet transfusion</td>
<td>[ ]</td>
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<td>[ ]</td>
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</tbody>
</table>

3b.3 Did the woman have a splenectomy to treat this condition?  
Yes [ ] No [ ] Unknown [ ]

3b.4 What is the lowest recorded platelet count prior to pregnancy:  
[ ] x 10^9/l

Or please tick if unknown [ ]

#### Section 3c: Pre-existing Medical Disorders

3c.1 Did the woman have any other pre-existing medical problems?  
Yes [ ] No [ ]

If Yes, please specify ________________________________

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

Section 4a:

4a.1 Final Estimated Date of Delivery (EDD)*)

4a.2 Was this pregnancy a multiple pregnancy?
   If Yes, please specify number of fetuses

Section 4b: Diagnosis of ITP

4b.1 Was ITP first diagnosed during this pregnancy?
   If No, please go to 4b.2
   If Yes, what date was ITP diagnosed?

What investigations were performed to exclude other causes of thrombocytopenia:

- Full Blood Count
- Liver Function Tests
- Urea and Electrolytes
- Coagulation
- C-reactive protein
- Peripheral Blood Film
- Antiphospholipid antibodies

If Other tests done, please specify which (e.g. bone marrow, anti-platelet antibodies):

4b.2 Did this woman suffer with maternal symptoms of ITP during this pregnancy?
   If Yes, please specify
   - Bruising
   - Purpura
   - Epistaxis
   - Intracranial haemorrhage
   - Melaena
   - Frank Haematuria
   - Intra-abdominal bleeding
   - Gingival bleeding
   - Other

If Other, please specify:

4b.3 Was the woman hospitalized for symptoms of major bleeding?
   If Yes, number of admissions:
   Total number of days as inpatient:

4b.4 What was the lowest recorded platelet count this pregnancy?

4b.5 Were there other problems in this pregnancy?*
   If Yes, please specify:

Section 4c: Treatment of ITP during pregnancy

4c.1 Did this patient require treatment antenatally for low platelets?
   If No, please go to section 5

4c.2 What was the primary clinical reason for starting treatment? (please tick only one)
   - Symptoms of bruising/bleeding?
   - Prophylactic treatment to prevent bleeding due to platelet count?
   - Asymptomatic but treated to reach a target platelet count for normal vaginal delivery?
   - Asymptomatic but treated to reach a target platelet count for planned caesarean section?
   - Asymptomatic but treated to reach a target platelet count for other non-delivery surgical procedure?
   - Other reason

*For guidance please see back cover
### 4c.3 What treatments were given?

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<thead>
<tr>
<th></th>
<th>First line</th>
<th>Second line</th>
<th>Date started</th>
<th>Date stopped</th>
<th>Responded?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard dose</td>
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<tr>
<td>corticosteroids</td>
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<td>IVIg</td>
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<td>IV anti-D</td>
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<td>High dose methyl</td>
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<tr>
<td>prednisolone (HDMP)</td>
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<tr>
<td>Splenectomy</td>
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<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Date format:** D D / M M / Y Y

**Responded?** (tick if yes)

### 4c.4 Were there any reported maternal side effects to any treatment?  
**Yes** [ ]  **No** [ ]

*If Yes,* please give specify the name of treatment and symptoms noted

### 4c.5 Was any further treatment required?  
**Yes** [ ]  **No** [ ]

*If Yes,* please give details?

---

### 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

**5.3 Is this woman still undelivered?**  
**Yes** [ ]  **No** [ ]

*If Yes,* will the woman receive the remainder of her antenatal care at your hospital?  
**Yes** [ ]  **No** [ ]

*If No,* please indicate the name of the hospital providing future care: __________________________

**Will she be delivered at your hospital?**  
**Yes** [ ]  **No** [ ]

*If No,* please indicate the name of delivery hospital: __________________________

**5.4 Did the woman labour?**  
**Yes** [ ]  **No** [ ]

*If Yes,* what was the onset of labour? *(please tick only one)*

- Spontaneous [ ]
- Induced [ ]

*Did the woman have an epidural during labour?*

**Yes** [ ]  **No** [ ]

**5.5 Was a fetal blood sample (FBS) performed in labour?**  
**Yes** [ ]  **No** [ ]

*If Yes,* how many FBS’s were performed in labour?

*If No,* what was the reason *(please tick only one)*

- No indication for FBS [ ]
- Concern about low fetal platelets [ ]
- Other [ ]

*If Other,* please specify: __________________________

**5.6 Was the platelet count recorded during labour/at time of delivery?**  
**Yes** [ ]  **No** [ ]

*If Yes,* What was the platelet count

[ ] x 10⁹/l

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

Section 6a: Woman

6a.1 Did the woman have a postpartum haemorrhage? Primary ☐ Secondary ☐ No ☐

6a.2 Did the woman have a caesarean section wound haematoma? Yes ☐ No ☐ Unknown ☐

6a.3 Did the woman have a perineal haematoma? Yes ☐ No ☐ Unknown ☐

6a.4 Did the woman have a diagnosed epidural haematoma? Yes ☐ No ☐ Unknown ☐

6a.5 Did any other major maternal morbidity occur?* Yes ☐ No ☐

If Yes, please specify ____________________________

6a.6 Was the woman admitted to ITU (critical care level 3)? Yes ☐ No ☐

If Yes, please specify indication: ____________________________

Duration of stay ☐ days

Or Tick if woman is still in ITU ☐

Or Tick if woman was transferred to another hospital ☐

6a.7 Did the woman die? Yes ☐ No ☐

If Yes, please specify date of death DD / MM / YYYY

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 diagnosis? Yes ☐ No ☐ Not known ☐

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 DD / MM / YYYY hh:mm

6b.2 Birthweight ☐ g
<table>
<thead>
<tr>
<th>6b.3 Mode of delivery</th>
<th>Spontaneous vaginal</th>
<th>Ventouse</th>
<th>Lift-out forceps</th>
<th>Rotational forceps</th>
<th>Breech</th>
<th>Pre-labour caesarean section</th>
<th>Caesarean section after onset of labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>6b.4 Sex of infant</td>
<td>Male</td>
<td>Female</td>
<td>Indeterminate</td>
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<td>6b.5 Was the infant stillborn?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>If Yes, go to section 7</td>
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<tr>
<td>6b.6 5 min Apgar</td>
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<tr>
<td>6b.7 Was the infant admitted to the neonatal unit?</td>
<td>Yes</td>
<td>No</td>
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<td>6b.8 Did any other major infant complications occur?*</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>If Yes, please specify</td>
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<td>6b.9 Was the cord blood platelet count measured?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>If Yes, What was the cord blood platelet count at birth?</td>
<td>x 10^9/l</td>
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<td>6b.10 Did neonatal thrombocytopenia subsequently develop or worsen?</td>
<td>Yes</td>
<td>Not known</td>
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<tr>
<td>If Yes, please give details</td>
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<tr>
<td>Was there evidence of neonatal sepsis or other cause for thrombocytopenia?</td>
<td>Yes</td>
<td>No</td>
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<td>If Yes, please give details</td>
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<tr>
<td>Was any treatment administered for neonatal thrombocytopenia?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
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<td>If Yes, please give name of drugs used (e.g. IVIg or platelet transfusion combined with IVIg)</td>
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<td>6b.11 Was a transcranial USS performed?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>If Yes, was there any evidence of intracranial haemorrhage?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>6b.12 Did this infant die?</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>If Yes, please specify date of death</td>
<td>DD/MM/YYYY</td>
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<tr>
<td>What was the primary cause of death as stated on the death certificate?</td>
<td>(Please state if not known)</td>
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<td>Section 7:</td>
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<td>Please use this space to enter any other information you feel may be important</td>
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<td>Section 8:</td>
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<td>Name of person completing the form</td>
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<td>Designation</td>
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<td>Today’s date</td>
<td>DD/MM/YYYY</td>
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</table>

*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. Major maternal morbidity, 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

Version 5, May 2013