

**Peripartum Hysterectomy**

**or embolisation**

DATA COLLECTION FORM-CASE

STUDY - IDENTIFICATION NUMBER: \_\_\_\_\_\_\_\_\_

**Hospital name **

**Hospital case number **

**BACKGROUND INFORMATION on peripartum hysterectomy and/or embolization of the uterine arteries**

Peripartum hysterectomy and/or embolization of the uterine arteries are usually carried out in the context of a life-threatening obstetric haemorrhage. From the UKOSS report on the the subject of peripartum hysterectomy it is observed that to control hemorrhage was the reason for performing a hystectomy in 315 of 318 cases.

Since embolization of the uterine arteries is becoming more and more common for that purpose, we decided we could not omit the evaluation of that tool in controlling hemorrhage. There will be overlap in some cases.

It is clear from the CEMCD report 2003-2005 that, at least in the United Kingdom, maternal deaths due to hemorrhage had increased. Study of the ‘near-miss’ events is not only useful in defining risk factors but also helps to study appropriate management and preventative measures.

A nationwide observational study in the U.K. in 2005 revealed that for each woman that died of hemorrhage 150 women survived. There were only 87 attempts to solve the hemorrhage with a more conservative approach such as embolization of the uterine arteries.

Two women died (case fatality rate of 0.6%) following peripartum hysterectomy, whereas many more had bladder damage (7-23% depending on the cause of post partum hemorrhage) and some 20% required further surgery either to control hemorrhage or to repair damage to other organs. There also was a strong correlation with the presence of a uterine scar from caesarean section(s) in previous pregnancies.

We do not know how many of the uterine arterial embolization procedures are successful and how many are deemed to be followed by hysterectomy.

***Definition of “peripartum hysterectomy” cfr the UKOSS definition***

Any woman giving birth to a fetus or infant and undergoing a hysterectomy in the same clinical episode/ during the same hospitalisation.

Similarly ***“peripartum embolization of the uterine arteries”***will be considered when occurring in the same clinical episode.

**Instructies**

**Deze vragenlijst is zodanig opgemaakt dat u het formulier niet hoeft uit te printen : u kunt de vragen rechtstreeks op de computer beantwoorden. U moet de vragenlijst wel eerst opslaan alvorens deze ingevuld, als bijlage, te kunnen electronisch terugsturen naar** [**B.OSSVlaanderen@gmail.com**](mailto:B.OSSVlaanderen@gmail.com)

**Mocht u de vragenlijst niet rechtstreeks kunnen aanvullen, gelieve deze eerst uit te printen en manueel in te vullen; de ingevulde vragenlijst kan dan per post, per fax, of ingescant electronisch worden teruggestuurd**

**Fax nr 016 344205**

**e-mail zie hierboven vermeld adres**

* Gelieve geen namen, noch adressen in te vullen op dit formulier.
* Gelieve alle data te noteren als dd/mm/jj en voor alle tijden de 24uurs notatie te gebruiken.
* Vink de hokjes aan , aan de hand van het dossier. **Wil er op letten niet beide “yes” en”no” op dezelfde vraag te antwoorden**
* Indien er te weinig plaats voorzien is bij een vraag kan u verder aanvullen in section 9.
* **Indien een vraag niet beantwoord kan worden, gelieve dit te vermelden in SECTION 9.**
* Indien U problemen ondervindt bij het invullen van dit formulier, aarzel dan niet om ons te contacteren.
* Wil rekening houden met de betekenis van volgende afkortingen :

N.A. betekent “Not Applicable” = not relevant

N.R. betekent “Not Reported” = not registred

0 betekent “none”

U betekent “Unknown” – zou eigenlijk nooit mogen voorkomen

**Instructions**

**Ce questionnaire a été élaboré de sorte que vous ne devez pas l’imprimer. Vous pouvez répondre aux questions directement sur l'ordinateur. Vous devez tout d’abord sauvegarder le questionnaire avant de l’envoyer électroniquement une fois rempli à** [B.OSSVlaanderen@gmail.com](mailto:B.OSSVlaanderen@gmail.com)

**Si vous n'êtes pas en mesure de remplir le questionnaire, vous pouvez l’imprimer et le remplir manuellement. Le questionnaire peut alors être envoyé par courrier, par fax, ou scanné et renvoyé par voie électronique**

**N° de Fax : 016 344205**

**email voir adresse ci-dessus**

- Veuillez remplir les noms et adresses sur ce formulaire.

- S’il vous plaît, notez toutes les dates comme ceci: jj / mm / aa et utilisez le format de 24 heures pour les heures.

- Cochez la case, selon le type de dossier. **Vous ne pouvez pas, à la fois, cocher «oui» et «non» à la même question**

- S’il y a peu de place pour répondre à la question, vous pouvez ajouter la suite de vos commentaires à la section 9

- **Si vous ne pouvez pas répondre à une question, nous vous invitons à le mentionner dans la section 9**

- Si vous avez des difficultés à remplir ce formulaire, n’hésitez pas à nous contacter.

- Veuillez prendre en compte la signification des abréviations suivantes:

N.A. signifie “Not Applicable” = not relevant

N. R. signifie “Not Reported” = not registred

0 signifie "none"

Vous voulez dire "Unknown" - inconnu

**SECTION1: WOMAN’S DETAILS**

* 1. **Year of birth**: 
  2. **Ethnic group**

















* 1. **Marital status**







* 1. **Was the woman in paid employment at the start of pregnancy?**





If yes, please enter her occupation 

If no, please enter the occupation of the partner



**1.5 Height at 1st visit: cm**

**1.6 Weight at 1st visit: kg**

**1.7** **Calculate BMI**: **kg/m2**

**1.8 Smoking status:**









**1.9 Language skills:**



































**SECTION 2: PREVIOUS PREGNANCIES**

* 1. **Gravidity** ** excluding the present pregnancy**

Duration of the previous pregnancies Alive born Birthweight in gr Still alive

1st weeks days   

2nd weeks days   

3th weeks days   

4th  weeks days   

5th weeks days   

6th weeks days   

*Please take care not to indicate both “yes” and “no”*

*If no previous pregnancies, please go to section 3*

* 1. **Did the woman have any previous pregnancy problems/complications**





Please specify each complication







****

* 1. **Has the woman had previous caesarean sections**

Was the immediately preceding delivery by caesarean section ?





If yes, please specify number in total 

Please indicate the following for each **previous caesarean section**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of c-section (mm/yy) | |  |  |  |  |
| Gestation at delivery (weeks + days) | |  |  |  |  |
| Indication for c- section | |  |  |  |  |
| In labour at time of C-section | Yes |  |  |  |  |
| No |  |  |  |  |
| Type of uterine incision (low transverse/ corporal/other) | |  |  |  |  |
| Type of uterine closure (single layer/double layer/not known) | |  |  |  |  |
| Recorded postpartum Endometritis/ woundinfection/other | |  |  |  |  |

* 1. Give date of **the last vaginal delivery** : day month year

Give date of **the last caesarean section**: day month year

* 1. Multiple **pregnancies:**

🡪 number: 

 🡪 number: 

🡪number: 

* 1. **Date of last delivery**

day month  year

**SECTION 3 PREVIOUS MEDICAL HISTORY**

* 1. **Previous or pre-existing medical problems**





If any please specify







* 1. **Previous or pre-existing gynecological problems**





If any please specify







* 1. **Previous uterine surgery**





**** 

Number of interventions [[1]](#endnote-1)  Total Number of fibroids 

If yes, was the cavity breached?



Number 



Number 



Number 

****

Number 

****



* 1. **Did the woman have a previous uterine perforation (e.g. in case of D&C)**





If yes, was any treatment given for the perforation, and specify







**SECTION 4a: CURRENT PREGNANCY**

**4.1 Beginning of pregnancy**

 

If assisted, please specify: 

**4.2. Final estimated date of delivery**: day month years

**4.3. Was this pregnancy a multiple pregnancy at 12 weeks gestation ?**





If yes, please specify number of fetuses: 

**4.4. Were there any problems/complications in this pregnancy?**





If yes, please specify: 

**4.5. What was the planned mode of delivery for this pregnancy?**





**4.6. Were there some complications of the pregnancy that may predict the hysterectomy?**





If yes, please specify: 

Date or gestational age at time of complication:

Date: day month year

Gestational age: weeks days

**4.7. Placenta localization**:









COMMENTS on placenta localization:



**4.8. Pregnancy follow-up**

**Where was the first visit ?**



**Where was the follow-up ?** (please indicate principle place where woman was seen by any type of caregiver / several caregivers are possible)

**By Midwife**



  

**By Family Doctor**



  

**By Specialist**



 

\*= any place organized by a third party e.g. O.N.E / K&G / or a Group Practice outside a hospital



**SECTION 5a : Labour**

5.1 Was labour induced/pre-induced ?

 

If yes, please state indication: 

What was the Bishop score prior to induction? 

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CERVIX** | **SCORE - maximum is 13** | | | |
| **0** | **1** | **2** | **3** |
| **Position cervix** | Posterior | Midline | Anterior | - |
| **Consistency** | Firm | Medium | Soft | - |
| **Effacement** | 0-30%  3-4cm  not-effaced | 40-50%  2cm ½ effaced | 60-70%  1 cm or less  ¾ effaced | >80% Fully effaced |
| **Dilatation** | Closed | 1-2cm | 3-4cm | 5cm |
| **Head: station** | Hodge 1 spine -3 | Hodge 2 spine -2,-1 | Hodge 3 spine 0 | Hodge 4 spine +1,+2 |

**Was prostaglandin used to induce or pre-induce labour?**

 

* If yes, please specify type of prostaglandin given, dose and date of time administered:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Agent** | **Administration route** | **Dose (mg) in case of IV:  max dose** | **Date (dd/mm/yy)** | **Time (hh:mm)** |
|  |  |  |  |  |
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|  |  |  |  |  |

**Were mechanical methods used to induce or pre-induce labour?**

 

If Yes, please specify:







day month hour minutes

**Was an amniotomy realized to induce/pre-induce labour?**

 

If yes, please specify:

day month hour minutes

Aspect of amniotic fluid: 

**Did the woman receive syntocinon/oxytocin as part of the induction?**

 

If yes, please specify **start** of syntocinon infusion:

day month hour minutes

If yes, please specify **stop** of syntocinon infusion:

day month hour minutes

-Duration of syntocinon: hours-min

-Maximal flow rate of syntocinon:  mL/min

-Dilution of syntocinon:  U/L

-Total dose of syntocinon:  to be calculated

5.2 Did the woman labour?

 

Please state date and time of diagnosis of labour

(=3 cm dilatation + regular contractions):

Date: day month year

Time: hours-min

What was the maximum contraction frequency (number of contractions in 10

minutes)? 

**Did the woman receive syntocinon/oxytocin to augment labour ?**

 

If yes, please specify start of syntocinon infusion:

day month hour minutes

If yes, please specify stop of syntocinon infusion:

day month hour minutes

-Duration of syntocinon: hours-min

-Maximal flow rate of syntocinon:  mL/min

-Dilution of syntocinon:  U/L

-Total dose of syntocinon:  to be calculated

**SECTION 5.b. Complications of labour and delivery**

**5.3 Bleeding problems**

Estimated blood loss:







Shock:

 

If yes, please indicate which clinical symptoms were present:

 



 

**Atony of the uterus**:

 

**Placental retention:**

 

**5.4. Delivery Trauma**













Surgical damage to other organs:

 

If yes, please specify: 

**Clotting disorders:**

 

If yes, please specify: 

Infection:

 

If yes, specify location: 

If reported, specify kind of micro-organism: 

**SECTION 5. c.**  **HYSTERECTOMY EMBOLISATION of the UTERINE/ILIAC ARTERIES or**

**EMBOLISATION**

TOTAL NUMBER OF MAJOR INTERVENTIONS

Please use a the same page again for every major intervention being laparotomy/embolisation

MAJOR INTERVENTION – hysterectomie/embolisation/other ORDER OF INTERVENTION

 

5.5. Was the intervention planned or unplanned?

 



5.6. What was the immediate reason?









5.7. What were the other measures taken?









 











\*Intra-uterine:







\*Other, please specify: 



**SECTION 5d. CLINICAL OUTCOMES - RESULT of INTERVENTION(s)**

7.1.Total amount estimated blood loss (mL): 

7.2.Method(s) used to estimate (e.g. clinical, weight of compresses,…):



7.3 Transfusion:





If yes:



If yes, number of units 



If yes, number of units: 



If yes, number of units 



If yes, number of units 



If yes, number of units 



If yes, number of units 

7.4. Lowest blood count Hgb - Hcrt: 

🡪 Date: day month year

Time: hours min

7.5. Renal function: 

7.6. Liver tests: 

7.7. Temperature: 

**SECTION 6: OUTCOME MOTHER**

* 1. **Was the mother transferred to another hospital**



If yes, please enter the name of the hospital



Was the mother admitted to an ICU (Intensive Care Unit)



If yes,

Enter name Unit



Duration of stay of ICU (days)

 days



Total duration of hospital stay (including on the maternity ward)

 days

* 1. **What method of transport was used ?**







* 1. **Did the woman die**



If yes

Specify date of death

day month hour minutes

What was the primary cause of death



* 1. **Did any other major maternal morbidity occur ?**















And please give further details on any other complication







**SECTION 7a: DELIVERY and OUTCOME of the CHILD**

If more than one infant: please photocopy this section of the form and attach an extra filled in sheet to the form.

* 1. **Date & time of delivery**

day month hour minutes

 weeks days

* 1. **Birth weight** g
  2. **Induction of labour**

****

* 1. **Mode of delivery**

VAGINAL

****





C-SECTION

****





Reason for planning / reason for executing intervention



* 1. **Give 5 minute Apgar score** 
  2. **Give umbilical cord pH**

Arterial pH  Base excess 

Venous pH  Base excess 

* 1. **Was the infant stillborn**









*If yes, please go to section 7b and 8*

* 1. **Did the infant die after birth**

   
 Date and time

day month hour minutes

What was the primary cause



Was there a postmortem examination



Was primary cause of death confirmed



* 1. **Did any major fetal complication occur**



Please specify





* 1. **Fetal well-being assessment during labour**



Please specify





* 1. **Was the infant transferred to another hospital ?**



If yes, please specify the hospital



Was the infant admitted to a neonatal unit (N\* or NICU)



If yes, please specify the unit



Admission –date & time

day month hour minutes

Discharge –date & time

day month hour minutes



Admission –date & time

day month hour minutes

Discharge –date & time

day month hour minutes

Was the infant retransferred to hospital of birth



* 1. **Which interventions were performed**

Intubation/ventilation



Cooling



Transfusion



Other, specify



* 1. **Which imaging techniques were performed**

Ultrasound



MRI



Findings





Other





**SECTION 7b: DELIVERY OF THE PLACENTA**

* 1. **Date & time of delivery of the placenta**

day month hour minutes

Measured taken to enhance third stage:



If yes, please indicate the method(s) used









**SECTION 8 – POST MORTEM EXAMINATIONS**

**8.a. maternal**

**8.1. Was a maternal post-mortem examination performed ?**

****

**If yes, please summarise the result**

****

****

****

****

**8.2. Was a post-mortem examination performed of the fetus/infant ?**

****

**If yes, please summarise the result**

****

****

****

****

**SECTION 9: PLEASE USE THIS SPACE TO ENTER ANY OTHER INFORMATION YOU FEEL MAY BE IMPORTANT**

























**Name of person completing the form**   
**Date** 

**Signature**

1. [↑](#endnote-ref-1)