

Uterine rupture

DATA COLLECTION FORM-CASE

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

**Hospital name **

**Hospital case number **

**BACKGROUND INFORMATION on uterine rupture**

Uterine rupture is a rare complication of pregnancy that is life-threatening to mother, fetus, or both. Whereas a uterine scar, mostly from a previous caesarean section, is the most common predisposing risk factor, it is well recognized that a rupture of an unscarred uterus is a far more dramatic event.

Rupture of an unscarred uterus is more common in low income countries in the presence of an obstructed labour. Yet, the last four CEMD reports in UK each includes at least one case of uterine rupture in a parous woman following induction of labour

According to the WHO, a uterine rupture occurs in 5 women for every 10,000 births. The incidence is lower in high income countries, the incidence being 3 for every 10,000 births. Moreover in Western countries the chance of the rupture to occur in an unscarred uterus is much lower being 0.6 for every 10,000 births (i.e. 1 in 6 cases of uterine rupture).

The definition used by UKOSS was rather restricted. The use of the LEMMoN definition allows the study of clinical symptoms preceeding uterine rupture.

As we aim at comparing the results obtained in Belgium with the results of the UK, as well as those found in the Netherlands, we decided to use the definition set by the LEMMON study in the Netherlands

***Definition uterine rupture***

The purpose in Belgium is to use a definition including all uterine rupture cases as defined by UKOSS, but also to consider all other forms of uterine rupture as defined by the LEMMoN study in the Netherlands.

**LEMMoN defined “uterine rupture”** as the occurrence of clinical symptoms (abdominal pain, abnormal fetal heart rate pattern, acute loss of contractions, vaginal blood loss), leading to an emergency caesarean delivery, at which the presumed diagnosis of uterine rupture was confirmed; or peripartum hysterectomy or laparotomy for uterine rupture after vaginal birth.

LEMMoN **excluded cases of scar dehiscence** found during elective caesarean section without preceding clinical symptoms.

**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**

* 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

- 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 10

- **Si vous ne pouvez pas répondre à une question, nous vous invitons à le mentionner dans la section 10**

- 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

**SECTION 1 : WOMAN’S DETAILS**

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

 

 

 

 









* 1. **Marital status**







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





If yes, please enter her occupation



If not, please enter the occupation of the partner



* 1. **Height at 1st visit cm**
	2. **Weight at 1st visit kg**
	3. **Calculate BMI **
	4. **Smoking status**







 

**1.9 Language skills:**

   

 

 

 

 

 

 



 

 

 

 

 

 

 

 

**SECTION 2: PREVIOUS PREGNANCIES**

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

Duration of the previous pregnancies Alive born Birthweight(g) 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 at 12 weeks gestation

 🡪 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  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 4: CURRENT PREGNANCY**

* 1. **Beginning of pregnancy**

 

 ****

If assisted, please specify 

* 1. **Final estimated date of delivery** day month  year
	2. **Was this pregnancy a multiple pregnancy at 12 weeks gestation ?**

  If yes, please specify number of fetuses 
 

* 1. **Were there any problems/complications in this pregnancy**



If yes, please specify 

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





* 1. **Pregnancy follow-up = during pregnancy** (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 Group Practice outside a hospital

**SECTION 5A: LABOUR, DELIVERY and UTERINE RUPTURE**

* 1. **Date and Time of admission of the patient**

day month hour minutes

* 1. **Was the patient in spontaneous labour?**



* 1. **Was labour induced/pre-induced?**


If yes, please state indication



What was the Bishop score ad admission/prior to induction: Bishop score 

|  |  |
| --- | --- |
| **CERVIX** | **SCORE - maximum is 13** |
| **0** | **1** | **2** | **3** |
| **Position cervix** | Posterior | Midline | Anterior | - |
| **Consistency** | Firm | Medium | Soft | - |
| **Effacement** | 0-30%3-4cm longnot-effaced | 40-50%2cm½ effaced  | 60-70%1 cm or less ¾ effaced  | >80%Fully effaced |
| **Dilatation** | Closed | 1-2cm | 3-4cm | 5cm |
| **Head: station** | Hodge 1spine -3 | Hodge 2spine -2,-1 | Hodge 3spine 0 | Hodge 4spine +1,+2 |

Was prostaglandin used for induction/pre-induction?



If yes, please specify type of prostaglandin (name) given, dose and date & time:

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

Other methods used for induction / pre-induction

* Mechanical



 

 

 

 day month hour minutes

* Amniotomy to induce or pre-induce



day month hour minutes

Aspect of amniotic fluid



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

* 1. **Did the woman labour ?**

 

If yes, please state date and time of diagnosis of labour

(i.e. 3cm dilatation and regular contractions)

day month hour minutes

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

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

  

 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

* 1. **Date and time of suspicion of uterine rupture**

day month hour minutes

* 1. **Dilatation at the moment of suspicion of uterine rupture (cm)** 
	2. **Fetal presentation at the moment of suspicion of uterine rupture**

Fetal stage at the moment of suspicion of uterine rupture



* 1. **Please indicate what symptoms and signs were noted prior to diagnosis of rupture** (thick all that apply)













If ticked please specify abnormality noted

 

 Time first noticed (hh:mm) 

 

 Time first noticed (hh:mm) 

 

 Time first noticed (hh:mm) 

 

 Time first noticed (hh:mm) 

 

 Time first noticed (hh:mm) 

 

 

 Time first noticed (hh:mm) 

* 1. **Was acute tocolysis administered because of suspicion of fetal distress**

 ****



|  |  |  |  |
| --- | --- | --- | --- |
| **Preparation NAME (dilution used)** | **Maximum flow rate** | **Start time(hh:mm)** | **Time of discontinuation** |
|  |  |  |  |

* 1. **Findings during laparotomy**





* 1. **Was rupture diagnosed before or during laparotomy**





* 1. **Date and time of diagnosis**

day month hour minutes

* 1. **Position of rupture**









* 1. **Position of fetus at time of laparotomy**









**SECTION 5B: MANAGEMENT OF UTERINE RUPTURE**

* 1. **Indicate how the uterine damage was repaired**





If ticked, please specify date and time

 day month hour minutes





* 1. **How was the rupture closed**









* 1. **Where any of the following organs damaged at rupture of removed during surgery?** (thick all that apply)

Parametrium  

Ovaries  

Bladder  

Ureter  

Bowel  

* 1. **Estimated blood loss**  ml
	2. **Did the woman refuse blood products**





If no, were blood products given





If yes, please state total units of each

Whole blood of packed red cells 

Fresh Frozen Plasma 

Platelets 

Cryoprecipitate 

Call salvaged blood  ml

* 1. **Were there signs of DIC / clotting problems**





**SECTION 6: OUTCOME MOTHER**

* 1. **Was the mother transferred to another 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 the woman have fever after the delivery**

 



If yes, enter diagnosis



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





If yes, enter please



**SECTION 7: OUTCOME 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. **Mode of delivery**

VAGINAL











C-SECTION







Reason for intervention



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

Arterial  Base excess 

Venous  Base excess 

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





If yes, please specify





* 1. **Was the infant stillborn**



 

 



*If yes, please go to section 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 complication occur**





Please specify





* 1. **Was the infant transferred to another 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





**SECTION 8: DELIVERY OF THE PLACENTA**

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

day month hour minutes

Measure taken to enhance third stage





If yes, please indicate method(s) used:









**SECTION 9: POST MORTEM EXAMINATION**

* 1. **Was a maternal post mortem examination performed?**




If yes, please summarize the report







* 1. **Was a post mortem examination performed on the fetus/infant?**




If yes, please summarize the report







**SECTION 10: PLEASE USE THIS SPACE TO ENTER ANY OTHER INFORMATION YOU FEEL MAY BE IMPORTANT**

























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

**Signature**