



COVID-19 during pregnancy

DATA COLLECTION FORM

STUDY - IDENTIFICATION NUMBER: **COVID**

**BACKGROUND INFORMATION**

Covid-19 is an infectious disease caused by a new strain of coronavirus. Before the outbreak in December 2019 in Wuhan, China, it has not been identified in humans. Covid-19 knows an increasing global transmission. It is a respiratory illness that usually include following symptoms: cough, high temperature and feeling short of breath. The impact of the virus on certain groups of people is not known, as for pregnant women and their babies. Single case reports of Covid-19 infection in pregnant women, with vertical transmission of infection to infants, are emerging. SARS-CoV and MERS-CoV have shown adverse pregnancy outcomes (1). Therefore a rapid study on Covid-19 infection in pregnancy is important to inform prevention and treatment.

The College of physicians of Mother and Newborn decided to initiate the registry of COVID-19 and pregnancy in Belgium and to participate in the international study organized by the INOSS (International Network of Obstetric Survey Systems). The B.OSS (Belgian Obstetric Surveillance System) will be used to determine the incidence of hospitalization in Belgium with Covid-19 infection in pregnancy and to assess the outcomes for mother and infant.

A data collection form has been put together based upon the form of the UKOSS. This form will gather information on:

* the outcomes of Covid-19 infection in pregnancy for both mother and infant,
* the characteristics of women who are hospitalised with pandemic Covid-19 infection in pregnancy and whether these characteristics influence disease outcome
* whether the treatment of pandemic Covid-19 infection in pregnancy influence outcomes for mother and infant

1. Favre G et al. 2019-nCoV epidemic: what about pregnancies? The Lancet 2020. Published online 6 Feb

**CASE DEFINITION**

Any pregnant woman or postpartum up till 42 days after the end of pregnancy

with diagnosis of COVID-19 infection

admitted to hospital

on or after 1st March 2020 and before 1st March 2021

**DATA COLLECTION FORM**

### Section 1. Woman’s details and previous medical history

* 1. Year of birth: (YYYY)
  2. Country in which patient was born
  3. Citizenship in Belgium

Yes

No

* 1. Is the mother single?

Yes

No

Not known

* 1. Did the patient or her partner have a steady income during pregnancy (excluding social security)

Yes

No

Not known

* 1. Height at 1st visit:      cm
  2. Weight at 1st visit:      kg
  3. Did the patient smoke during pregnancy? (answer yes, even if she quit during pregnancy)

Yes

No

Not known

* 1. Gravidity.
     1. Number of current pregnancy (number)
     2. Number of completed pregnancies of ≥ 22 weeks (number)
  2. Did the woman have any other previous pregnancy problems?

Yes

No

If yes, please specify:

*(For example: 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, …)*

* 1. Does the woman have asthma requiring regular inhaled or oral steroids?

Yes

No

Not known

* 1. Has the woman had any other previous or pre-existing medical problems?

Yes

No

Not known

If yes, please specify:

*For example: 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, …)*

* 1. Has the woman been immunised against influenza?

Yes

No

Not known

### Section 2: This pregnancy , Diagnosis of COVID-19 , Therapy

* 1. Final Estimated Date of Delivery (EDD): (DD/MM/YY)
  2. Was this pregnancy a multiple pregnancy?

Yes

No

If yes, specify number of fetuses:

* 1. Were there problems in this pregnancy (besides COVID19 infection)?

Yes

No

If yes, please specify:

*(For example: 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, …)*

* 1. Please specify reason for admission

Symptomatic COVID-19 infection: specify date of admission (DD/MM/YY)

Other obstetric issues: specify date of admission (DD/MM/YY)

Delivery: specify date of admission (DD/MM/YY)

* 1. Please indicate presenting symptoms of COVID-19 and date of onset in the table below:

|  |  |  |
| --- | --- | --- |
| Symptom | Tick if Yes | If Yes, give date of onset  (DD/MM/YY) |
| None |  | |
| Fever |  |  |
| Cough |  |  |
| Sore Throat |  |  |
| Headache |  |  |
| Tiredness/lethargy |  |  |
| Limb or joint pain |  |  |
| Diarrhoea |  |  |
| Breathlessness |  |  |
| Vomiting |  |  |
| Rhinorrhoea |  |  |
| Flu-like symptoms |  |  |

* 1. Has testing for COVID-19 been carried out?

No

Yes

If yes, please specify:

virological / PCR :

Sample source:

Date of first positive test: (DD/MM/YY)

Note: Please indicate in section 6 if there was (previous) negative testing for COVID-19 (Sample source and date of test).

CT scan:

Date of test: (DD/MM/YY)

Was test positive?

Yes

No

other type of screening:

Date of test: (DD/MM/YY)

Please specify type of screening with findings:

* 1. Was this a clinical diagnosis only?

Yes

No

* 1. Were any of the following samples tested? *(tick all that apply)*

|  |  |  |  |
| --- | --- | --- | --- |
| Sample type | Tested? | If Yes, what was the test type *e.g. PCR, IgG?* | If Yes, what was the test result? |
| Amniotic fluid | Yes  No |  |  |
| Placenta | Yes  No |  |  |
| Cord Blood | Yes  No |  |  |
| High vaginal swab | Yes  No |  |  |
| Faeces | Yes  No |  |  |
| Other pregnancy tissue | Yes  No |  |  |

* 1. Did the women have confirmed pneumonia on imaging?

Yes

No

If yes, please specify:

Type of imaging used (RX thorax, CT thorax):

Please specify findings

* 1. Were anti-viral drugs used?

Yes

No

|  |  |  |
| --- | --- | --- |
| If Yes, please specify | First Agent | Second Agent |
| Agent used |  |  |
| Date treatment started | (DD/MM/YY) | (DD/MM/YY) |
| Date treatment stopped | (DD/MM/YY) | (DD/MM/YY) |
| Dose |  |  |
| Route |  |  |
| Adverse effects |  |  |

* 1. Were other drugs used during pregnancy?

Yes

No

If yes, please specify:

* 1. Were steroids given to enhance fetal lung maturation?

Yes

No

If yes, please specify:

Agent used:

Date given:

Dose:

### Section 3. Delivery

* 1. Did this woman have a miscarriage?

Yes

No

If yes,

Please specify date: (DD/MM/YY)

Was miscarriage products tested for COVID-19?

Yes

No

If yes, please specify in question 2.8 (other pregnancy tissue)

* 1. Did this woman have a termination of pregnancy?

Yes

No

If yes,

Please specify date: (DD/MM/YY)

Please specify weeks of pregnancy:

Was the pregnancy terminated due to a congenital malformation?

Yes

No

If yes, please specify:

* 1. Is this woman still undelivered?

Yes

No

If yes, Will she be receiving the rest of her antenatal care from your hospital?

Yes

No

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

***If still undelivered, please complete section 4 and then go to section 6.***

***If the woman has delivered, please continue****.*

* 1. Was delivery induced?

Yes

No

If yes, please state indication:

* 1. Did the woman labour?

Yes

No

If yes, please give date of onset of labour: (DD/MM/YY)

* 1. Was delivery by caesarean section?

Yes

No

If yes, please state:

Indication for caesarean section:

Method of anaesthesia:

Regional

General anaesthetic

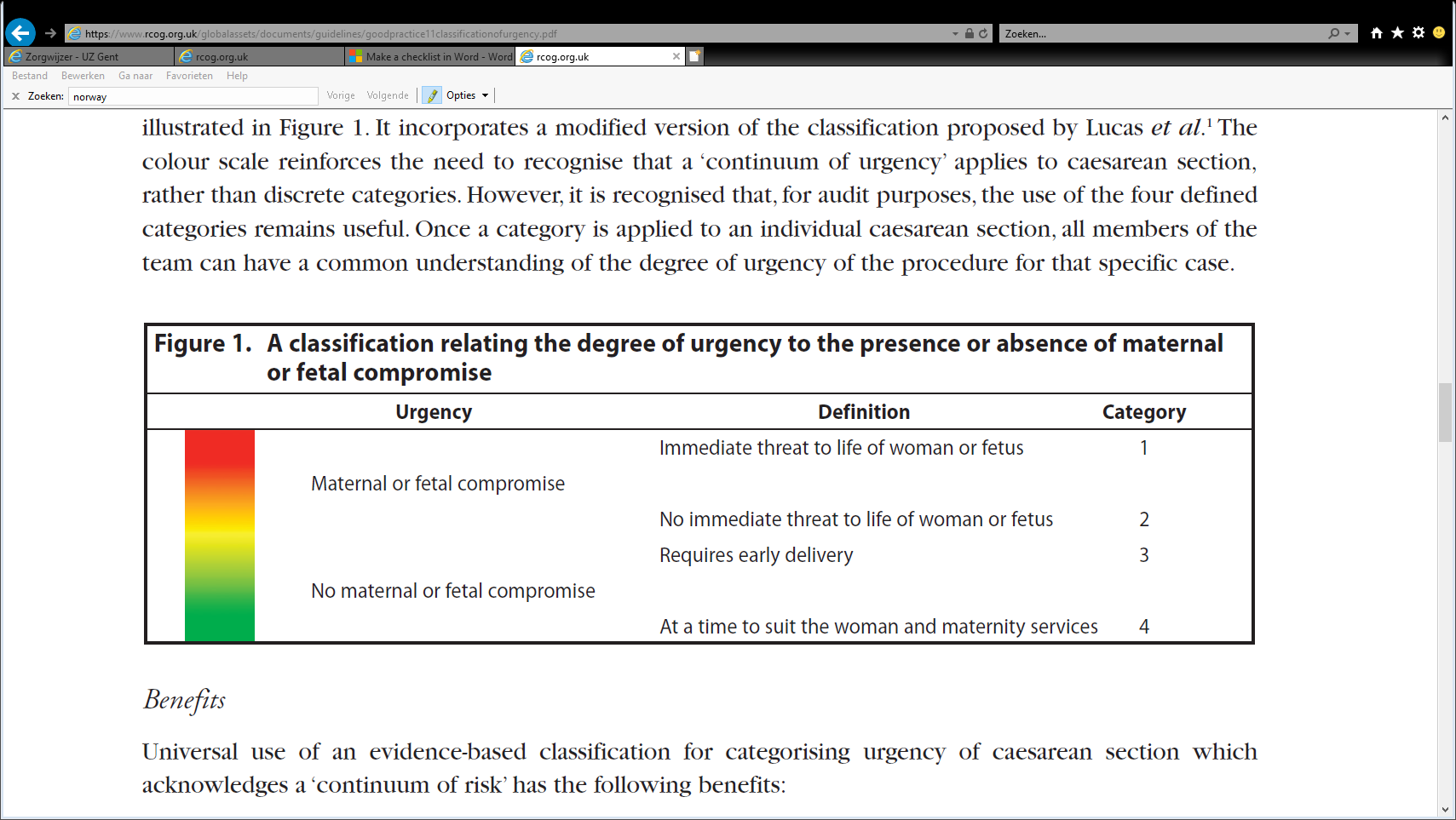
Grade of urgency:

Category I

Category II

Category III

Category IV



### Section 4. Woman’s outcome

* 1. Was the woman admitted to an Intensive Care unit?

Yes

No

If yes, please specify:

Duration of stay: (number of days)

Tick if the woman is still in Intensive Care

Tick if the woman was transferred to another hospital

If yes, please specify name of the hospital:

* 1. Did the woman require ventilation?

Yes

No

* 1. Was this woman managed with extracorporeal membrane oxygenation (ECMO)?

Yes

No

If yes,

Please indicate date ECMO commenced: (DD/MM/YY)

Name of ECMO centre:

Was this woman delivered during her ECMO treatment?

Yes

No

If yes, please give reason for delivery:

* 1. Did any other major maternal morbidity occur?

Yes

No

If yes, please specify:

* 1. What was the woman’s date of discharge after her admission for COVID-19? (DD/MM/YY):
  2. Did the woman die

Yes

No

If yes,

Please specify date and time of death: (DD/MM/YY hh:mm)

What was the primary cause of death as stated on the death certificate?

Was an autopsy performed

Yes

No

*If yes*, please specify findings

### Section 5. Infant 1 outcomes

(please complete one section for each infant)

* 1. Date of delivery: (DD/MM/YY)
  2. Mode of delivery:

Spontaneous vaginal

Ventouse or forceps

Breech

Pre-labour caesarean section

Caesarean section after onset of labour

* 1. Birthweight       grams
  2. Was the infant stillborn?

Yes

No

If yes:

Was autopsy performed?

Yes

No

If yes: please specify findings:

Was infant tested for COVID-19?

Yes

No

If yes, please specify type of test and findings:

***Please go to section 6 if the infant was stillborn.***

* 1. 5min Apgar
  2. Was the infant admitted to a neonatal unit?

Yes

No

If yes,

Type of unit:

NICU

N\*

Other unit: Please specify:

Reason for admission

Duration of stay? (number of days)

Tick if infant is still in neonatal unit

Tick if infant was transferred to another hospital

If yes, please specify name of the hospital:

* 1. Type of feeding:

Breastfeeding directly

Breastfeeding indirectly (pumping)

Bottle milk

* + 1. Reason indirect breastfeeding or bottle milk:

Prevention COVID-19 infection infant

Mother to ill

Other reason (not related to COVID 19)

* 1. Did any major infant complication occur?

Yes

No

If yes please specify:

*(For example: 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, …)*

* 1. Was the infant tested for COVID-19?

Yes

No

If yes please specify:

Sample source:

Was the test positive?

Yes

No

If yes please specify date of positive test: (DDMMYY)

* 1. Did the infant have a congenital anomaly?

Yes

No

If yes please specify:

* 1. Did this infant die?

Yes

No

If yes,

Please specify date of death: (DD/MM/YY)

What was the primary cause of death as stated on the death certificate?       Was an autopsy performed?

Yes

No

If yes: please specify findings:

### Section 6. Any other remarks

Please use this space to enter any other information you feel may be important (for example negative testing COVID-19 infection with sample source and date of test; or other information):

Finished