

UK ITP REGISTRY PREGNANCY STATUS AND OUTCOME SHEET (2.0)



Date of Data Collection:

Registry Identification Code (RIC):

General Information	
Date of day 1 of last menstruation:	Final estimated delivery date:
Is this a multiple pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many fetuses?
Was ITP diagnosed during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date:
Anthropometric and Lifestyle Information	
Booking weight (kg):	Date recorded:
Smoking Status: <input type="checkbox"/> Never <input type="checkbox"/> Gave up before pregnancy <input type="checkbox"/> Gave up during pregnancy <input type="checkbox"/> Current <input type="checkbox"/> No data	Date smoking status was recorded:
Alcohol consumption before pregnancy <input type="checkbox"/> None <input type="checkbox"/> Occasional <input type="checkbox"/> < 10 units per week <input type="checkbox"/> 11 to 20 units per week <input type="checkbox"/> 21 to 40 units per week <input type="checkbox"/> 40 units per week <input type="checkbox"/> Yes, but amount not available	Alcohol consumption during pregnancy <input type="checkbox"/> None <input type="checkbox"/> Occasional <input type="checkbox"/> < 10 units per week <input type="checkbox"/> 11 to 20 units per week <input type="checkbox"/> 21 to 40 units per week <input type="checkbox"/> 40 units per week <input type="checkbox"/> Yes, but amount not available
Date recorded:	Date recorded:

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Current Pregnancy (beginning of pregnancy to 3 months post-partum)	
Bleeding events	
Bleed Type/Site	
Skin	Date of Bleed
Bruise Severity (number of bruises): <input type="checkbox"/> 1-5 <input type="checkbox"/> >5 <input type="checkbox"/> Unknown	
Petechiae Severity (number of petechiae): <input type="checkbox"/> ≤ 10 <input type="checkbox"/> >10 <input type="checkbox"/> >50 <input type="checkbox"/> Unknown	
Subcutaneous Haematoma Severity: <input type="checkbox"/> ≤2 <input type="checkbox"/> >2 <input type="checkbox"/> Unknown	
Bleed from minor wounds Severity: <input type="checkbox"/> ≤5mins <input type="checkbox"/> >5mins <input type="checkbox"/> Unknown	
Other (please specify)	
Mucosal	Date of Bleed
Epistaxis Severity: <input type="checkbox"/> Whilst blowing nose <input type="checkbox"/> Spontaneous and lasting <5mins <input type="checkbox"/> Spontaneous and lasting >5mins <input type="checkbox"/> Required packing/cauterisation <input type="checkbox"/> Unknown Transfusion required?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Oral cavity Severity: <input type="checkbox"/> Gum bleeding <input type="checkbox"/> Bullae or blisters <input type="checkbox"/> Bleeding from bites to lip and tongue <input type="checkbox"/> Unknown	
Subconjunctival bleeds	

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Other (please specify)	
Organ	Date of Bleed
Gastrointestinal bleed (e.g. rectal bleed, haematemesis and malaena) Type: <input type="checkbox"/> Occult blood <input type="checkbox"/> Lower GI bleed <input type="checkbox"/> Haematemesis and/or malaena <input type="checkbox"/> Other	
Gynaecological bleed Type: <input type="checkbox"/> Spotting (in between periods) <input type="checkbox"/> Menorrhagia <input type="checkbox"/> Post-menopausal bleeding <input type="checkbox"/> Pregnancy-related bleed <input type="checkbox"/> Other	
Haemarthrosis Transfusion required?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Intracranial bleed Severity: <input type="checkbox"/> Traumatic <input type="checkbox"/> Non-traumatic	
Intramuscular haematoma Transfusion required?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ocular haemorrhage Type: <input type="checkbox"/> Retinal bleeds <input type="checkbox"/> Vitreous bleeds <input type="checkbox"/> Other	
Pulmonary haemorrhage (e.g. haemoptysis, bleed into the lungs) Transfusion required?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Urinary (haematuria) Type: <input type="checkbox"/> Microscopic <input type="checkbox"/> Macroscopic Transfusion required?: <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Other internal bleed (please specify)				
Other				
Post-procedural bleed				
Other (please specify)				
ITP Treatments given during pregnancy				
Treatment	Dose	Indication to treat	Date of treatment initiation	Length of treatment (days)
Anti-D Azathioprine Cyclophosphamide Cyclosporine Danazol Dapsone Dexamethasone Eltrombopag IVIg Methylprednisolone Mycophenolate Prednisolone Rituximab Romiplostim Splenectomy Vinca alkaloids Other (please specify)	µg mg/day mg/day mg/week mg/day mg mg/day mg/day g/day mg/day mg/day mg/ day mg/m ² /week µg/kg/week mg/week	Prophylactic to prevent bleeding due to platelet count. Symptoms: bruising/ bleeding Asymptomatic but treated to reach a target platelet count for other non- delivery surgical procedures. Asymptomatic treated to reach target for vaginal delivery. Asymptomatic treated to reach target for elective Caesarean section. Other (please specify)		
e.g. Prednisolone	60 (mg/day)	Symptoms: bruising/ bleeding	01/10/2015	14

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Supportive Therapies- did the participant receive any of the below during pregnancy?				
Supportive Therapy	Yes/ No	Start date	End date	
Red blood cell transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Platelet transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Fresh frozen plasma transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Cryoprecipitate transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Tranexamic acid	<input type="checkbox"/> Yes <input type="checkbox"/> No			
H. pylori H. Pylori treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Plasmapheresis	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Protein A-Immunoadsorption	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Delivery and post-partum				
Anaesthesia Method at Delivery	Yes/ No	Date		
Did the participant receive regional anaesthesia during delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Was regional anaesthesia withheld due to platelet count or coagulation abnormalities at time of delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Haematological Values/Blood Results				
Blood Test	Earliest FBC available during pregnancy	FBC with lowest platelet count during pregnancy	FBC at delivery	FBC post-partum (up to 3 months post pregnancy)
Platelet ($\times 10^9/L$)				
Hb				
WBC ($\times 10^9/L$)				
Neutrophil ($\times 10^9/L$)				
RBC ($\times 10^{12}/L$)				
MPV				
Date of results				
Coagulation results at delivery				

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Prothrombin time (PT): INR (if PT not available):	Activated partial thromboplastin time (APTT): Activated partial thromboplastin ratio (if APTT time not available):	Fibrinogen:
Date of results:		
Details of Delivery		
Did this participant have a miscarriage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	
Did this participant have a termination of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	
Was delivery induced? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of being induced:	Indication to induce:
Did the participant labour? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Type of Delivery	Yes/ No	Date
Vaginal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Caesarean	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Indication for Caesarean Section <input type="checkbox"/> Maternal comorbidity/ complication <input type="checkbox"/> Previous Caesarean delivery/ uterine surgery <input type="checkbox"/> Failure to progress in first stage <input type="checkbox"/> Failure to progress in second stage <input type="checkbox"/> Suspected Foetal distress <input type="checkbox"/> Failed instrumental delivery <input type="checkbox"/> Patient choice	Grade of urgency for Caesarean section <input type="checkbox"/> Immediate threat to life- mother or foetus <input type="checkbox"/> Maternal or foetal compromise which is not immediately life threatening <input type="checkbox"/> Needing early delivery but no maternal or foetal compromise <input type="checkbox"/> At a time to suit the mother and maternity team	
Were Ventouse forceps use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Were Lift out forceps used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Were rotational forceps used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was it a breech delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Approximately how much blood was lost during delivery? (ml) (C-section or vaginal delivery)	ml	
Maternal Outcomes		
Did any of these bleed events occur?	Yes/ No	Date
Caesarean section wound haematoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neuroaxial anaesthesia haematoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Perineal haematoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Post-partum haemorrhage	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Red Blood cells transfusion required	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Co-morbid conditions during pregnancy or up to 3 months post-partum		
Co-morbidity	Yes/ No	Date of Diagnosis
Pregnancy induced hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Preeclampsia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eclampsia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Haemolysis, elevated liver function, low platelets (HELLP)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gestational Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Thrombosis (venous)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Thrombosis (arterial)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Infection requiring hospitalisation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Renal Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cerebrovascular accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Disseminated Intravascular Coagulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Adult respiratory distress syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Required Ventilation	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Cardiac arrest		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other (please specify):			
Did the participant die? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary cause of death:	Secondary cause of death:	
Infant Outcome			
Infant Details			
Date of Birth:		Birth weight (grams): g	
Was the infant stillborn?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	
Was the infant admitted to the neonatal unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	
Infant Morbidities			
Did the infant experience any of the follow?	Yes/ No	Date	
Lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Exchange transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Intraventricular haemorrhage	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Haemorrhage in any other organ (please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Jaundice requiring phototherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Major congenital abnormalities	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Necrotising enterocolitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Neonatal encephalopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Respiratory distress	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Severe infection	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other (Please Specify):			
Did the infant have cranial imaging? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, was there evidence of a cranial haemorrhage? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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Did this infant pass away? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary cause of death	Secondary cause of death
Infant Platelet Counts		
Is a delivery cord or neonatal platelet count available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Plt count:	Date:
Is a separate nadir platelet count available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Plt count:	Date:
Infant Thrombocytopenia Treatments		
Did the infant receive the following treatments for the thrombocytopenia?	Yes/ No	Date
Platelets	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Immunoglobulins	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the infant receive different treatment for thrombocytopenia? If yes, please specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Breastfeeding		
Was the infant breast-fed during the first 3 months after birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If the infant was breast fed for less than 3 months, how many weeks was the infant breast fed for?	Weeks	