



AMOSS Case Form

ANTENATAL PULMONARY EMBOLISM

Section 1: Previous medical history

Please indicate whether any of the following were present

- 1.1 Previous or pre-existing medical problems YES NO
 If yes, please specify _____
- 1.2 History of thrombosis in first degree relative YES NO
 If yes, please specify _____
- 1.3 Known history of thrombophilia YES NO
 If yes, please specify _____
- 1.4 Known history of connective tissue disorder or auto-immune disease e.g. SLE YES NO
 If yes, please specify _____

Section 2: Past history of thrombosis prior to current pregnancy

- 2.1 Past history of thrombosis YES NO NOT KNOWN
 If no or not known, please go to Section 5

2.2a Details of most recent thrombotic event

2.2b Date of occurrence / /

2.2c Site (e.g. DVT, PE, axillary thrombosis, cerebral thrombosis)

2.3 Please indicate the risk factors present around the time of the thrombosis development (please tick all that apply)

- Pregnancy
- Surgery
- Combined oral contraceptive pill
- Fracture/trauma/injury
- Long haul air travel (>8hours)

Other, please specify

- 2.4 Did the woman have any other prior thrombotic events?
YES NO UNKNOWN If yes, how many?

Section 3: This pregnancy

- 3.1 History of long haul travel during this pregnancy (≥ 8 hours)
YES NO UNKNOWN
If yes, please specify duration and date/s hrs /
hrs /
- 3.2 Period of immobility/bed rest during this pregnancy (≥ 4 days) YES NO
If yes, please specify duration of immobility days /
and dates of first day of immobility days /
- 3.3 Was thromboprophylaxis used? YES NO UNKNOWN
If yes, please indicate below all measures used (tick all that apply)
TED stockings FULL LEG HALF LEG NOT USED
- 3.4 Did this woman have a thrombotic event (e.g. DVT) in this pregnancy diagnosed prior to her PE? YES NO UNKNOWN
If yes, specify date of diagnosis /
- 3.5 Please specify anticoagulant treatment for this prior thrombotic event

Warfarin YES

Other YES

If more than one event, please add details in Section 7.

Section 4 Diagnosis of pulmonary embolism

4.1 Date of pulmonary embolism / /

4.2 What site was the PE?
 left right basal apical saddle

4.3 Did the woman have symptoms and signs consistent with PE? YES NO
 If yes, please briefly describe

4.4 Please indicate if and when the following investigations were conducted

	Tick all that apply	Date	Did the result support the diagnosis?		
			Yes	No	Inconclusive
Chest x-ray	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VQ scan	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CT scan	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Echocardiogram	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MRI scan	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary angiogram	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.5 Was anticoagulation used? YES NO
 If yes, please specify

	YES <input type="checkbox"/>	Name of drug	Dose	Schedule
Low molecular weight heparin	<input type="checkbox"/>			
Unfractionated heparin	<input type="checkbox"/>			
Warfarin	<input type="checkbox"/>			
Other	<input type="checkbox"/>			

4.6 Did the therapy last for more than 7 days? YES NO UNKNOWN

4.7 Was any other treatment used e.g. Thrombolytic therapy, ECMO, interventional cardiology (basket insertion) YES NO UNKNOWN
 If yes, please specify _____

4.8 Was surgery performed as a treatment of PE? YES NO UNKNOWN
 If yes, please specify type of surgery and operative findings

Section 5: Outcomes

5a: Woman

5.1 Is this woman still pregnant? YES NO
 If yes, will she be receiving the rest of her antenatal care from the current hospital?
 YES NO
 If care will be provided at a different hospital, please indicate name of hospital providing future care, then go to next section.

5.2 Did this woman have a miscarriage? YES NO
 If yes, please specify date / /

5.3 Did this woman have a termination of pregnancy? YES NO
 If yes, please specify date / /

5.4 Was a thrombophilia diagnosed during or after this pregnancy?
 YES NO
 If yes, please specify _____
 If no, are investigations for thrombophilia to be conducted postpartum?
 YES NO UNKNOWN

5.5 If the woman died and a postmortem undertaken, did the examination confirm the diagnosis of pulmonary embolism? YES NO UNKNOWN

Any other information?

Please use this space to enter any other information you feel may be important

