



AMOSS Condition Form

PERIPARTUM HYSTERECTOMY

Section 1: Previous pregnancies	
1.1	Did the woman have a large PPH (>1000ml) following a prior birth? <div style="text-align: center;"> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT KNOWN <input type="checkbox"/> </div>
Section 2: Previous medical history	
Please indicate whether any of the following were present	
2.1	Did this woman have a history of anaemia, <i>prior</i> to the index pregnancy, that required treatment? YES <input type="checkbox"/> NO <input type="checkbox"/> NOT KNOWN <input type="checkbox"/>
If yes, please indicate the type of anaemia:	
	Iron deficient <input type="checkbox"/>
	B ₁₂ deficient <input type="checkbox"/>
	Other <input type="checkbox"/> Please specify _____
Section 3: This pregnancy	
3.1	Was the woman anaemic (Hb < 80g/l) during <i>this</i> pregnancy? <div style="text-align: center;"> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT KNOWN <input type="checkbox"/> </div>
	If yes, what was the lowest recorded Hb during pregnancy, prior to any acute bleeding <div style="text-align: right;"> <input type="text"/> <input type="text"/> g/L </div>
Section 4: Details of peripartum hysterectomy & treatment	
4.1	Date and time of hysterectomy <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> : <input type="text"/>
4.2	Type of hysterectomy Total <input type="checkbox"/> Sub-total <input type="checkbox"/> Not Known <input type="checkbox"/>
4.3	Was this a planned hysterectomy prior to caesarean section? <div style="text-align: center;"> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT KNOWN <input type="checkbox"/> </div>
4.4	Total estimated blood loss <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mL
4.5	Date and time of the onset of severe acute bleeding (if EBL>1000mL) <div style="text-align: right;"> <input type="text"/>/ <input type="text"/>/ <input type="text"/> <input type="text"/>: <input type="text"/> </div>
4.6	Date and time of first coagulation test following onset of acute bleeding <div style="text-align: right;"> <input type="text"/>/ <input type="text"/>/ <input type="text"/> <input type="text"/>: <input type="text"/> </div>
4.7	Did the woman receive any blood products? YES <input type="checkbox"/> NO <input type="checkbox"/>

If yes, please record the number of units received by this woman

Whole blood or packed red blood cells	□□□ units
Fresh frozen plasma	□□□ units
Platelets	□□□ units
Cryoprecipitate	□□□ units
Fibrinogen	□□□ units
Cell saver cells	□□□□□ mL

4.8 What was the primary underlying cause of haemorrhage? (please tick one only)

Uterine atony	<input type="checkbox"/>
Placenta praevia	<input type="checkbox"/>
Placenta accreta/increta/percreta	<input type="checkbox"/>
Placental abruption	<input type="checkbox"/>
Uterine infection	<input type="checkbox"/>
Uterine rupture	<input type="checkbox"/>

If yes, please specify pre-labour during labour
traumatic spontaneous

Extension of incision at time of caesarean section

Extension of previous caesarean section scar at the time of caesarean section

Genital tract trauma/tears

Other cause

If yes, please specify _____

4.9 Please indicate what treatment was used prior to hysterectomy

	<i>Tick all that apply</i>	<i>Please rank the therapies in the order in which they were first used (1,2,3...)</i>
Syntocinon infusion	<input type="checkbox"/>	□□
Ergometrine	<input type="checkbox"/>	□□
Prostaglandin F2 α	<input type="checkbox"/>	□□
Misoprostol	<input type="checkbox"/>	□□
Intra-abdominal packing	<input type="checkbox"/>	□□
Intra-uterine balloon	<input type="checkbox"/>	□□
Intra-uterine packing	<input type="checkbox"/>	□□
Recombinant Factor VIIa	<input type="checkbox"/>	□□

Vessel embolisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vessel ligation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intra-arterial balloons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B-Lynch or other brace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
suture			
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
4.10 What medical staff were present during the first theatre procedure?			
<i>Please tick all that apply</i>			
		At start of procedure	Called for during procedure
Consultant obstetrician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP (Dip Obs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trainee obstetrician – registrar level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consultant anaesthetist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP (Anaes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trainee anaesthetist – registrar level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other – please specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>			
4.11 Did a gynae-oncologist assist with the hysterectomy?			
	YES <input type="checkbox"/>	NO <input type="checkbox"/>	NOT KNOWN <input type="checkbox"/>
4.12 Please nominate any other surgical specialty involved e.g. vascular surgeon			
<hr/>			
4.13 What was the total number of surgical procedures? (including for caesarean section and operation when hysterectomy performed) <input type="checkbox"/>			
4.14 How many surgical procedures did the woman undergo after the hysterectomy was performed? <input type="checkbox"/>			
4.15 Were any of the following organs damaged during surgery			
Ovaries	YES <input type="checkbox"/>	NO <input type="checkbox"/>	NOT KNOWN <input type="checkbox"/>
Bladder	YES <input type="checkbox"/>	NO <input type="checkbox"/>	NOT KNOWN <input type="checkbox"/>
Ureter	YES <input type="checkbox"/>	NO <input type="checkbox"/>	NOT KNOWN <input type="checkbox"/>
Other	YES <input type="checkbox"/>	NO <input type="checkbox"/>	NOT KNOWN <input type="checkbox"/>
If other, please specify <hr/>			
4.16 Please indicate if ovaries were removed during surgery?			

NO ONE BOTH

Section 5: Post-operative thrombophylaxis

5.1 Was chemical thromboprophylaxis used following surgery?

YES NO NOT KNOWN

If yes, please give details below

Tick all that apply

Date & time commenced

Fractionated heparin (s/c)

Low molecular weight

heparin (s/c)

Other – please specify

5.2 Were other forms of thromboprophylaxis used following surgery?

YES NO NOT KNOWN

If yes, please give details below

Tick all that apply

Date commenced

Full leg TEDS

Half leg TEDS

Calf compression

(equipment)

Other – please specify

5.3 Please indicate whether any of the following morbidities occurred (*tick all that apply*)

Acute respiratory distress syndrome

Pulmonary oedema

Disseminated intravascular coagulopathy (DIC)

Renal failure requiring dialysis

Cardiac arrest

Pulmonary embolism

Deep vein thrombosis

Other thrombosis

If yes, please specify
