



AMOSS Case Form

AMNIOTIC FLUID EMBOLISM

Section 1 Diagnosis of amniotic fluid embolism

1.1 Please indicate if any of the following features were present at or immediately preceding diagnosis

	Tick all that apply	Please rank the features in order of occurrence (1,2,3, etc.)
Acute fetal compromise	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac arrest	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac rhythm problems	<input type="checkbox"/>	<input type="checkbox"/>
Coagulopathy	<input type="checkbox"/>	<input type="checkbox"/>
Hypotension	<input type="checkbox"/>	<input type="checkbox"/>
Maternal haemorrhage	<input type="checkbox"/>	<input type="checkbox"/>
Premonitory symptoms e.g. restlessness, agitation, tingling	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>

Laboratory test results

1.2 Please record the blood levels of the following at diagnosis and at their most abnormal level (fill with 999 if not known)

Marker	Level at diagnosis	Worst recorded level
Platelet count (x10 ⁹ /l)	□□□	□□□
Fibrinogen level (mg/dL)	□□□	□□□
Haemoglobin (g/L)	□□□	□□□
Activated partial thromboplastin time (APPT) (secs)	□□□	□□□
INR	□□□	□□□
Creatinine (µmol/l)	□□□	□□□

1.3 Was a mast cell tryptase performed? YES NO UNKNOWN

Maternal event

2.1 Date and time of event / / :

2.2 Date and time of diagnosis of AFE / / :

2.3 At what location did the woman collapse/develop severe symptoms?

Home GP/doctor's clinic Operating suite Birth Suite

Other Please specify _____

2.4 Had the membranes ruptured prior to event?

YES NO NOT KNOWN

If yes, please state date and time of rupture / / :

Was rupture of membranes artificial OR spontaneous

2.5 Meconium staining of liquor fresh old none

2.6 Was there fetal distress before maternal collapse?

YES NO NOT KNOWN

If yes, please specify

2.7 At the time of collapse/event, was the woman: pre-labour first stage
second stage post-delivery

2.8 Contraction frequency at time of event (number in 10 minutes)

2.9 Anaesthetic/analgesia at time of collapse

spinal epidural combined spinal GA none

2.10 Were any clinical staff present at collapse? YES NO

If yes, please specify professional group e.g. midwife _____

2.11 Time woman was first seen by an obstetrician after collapse :

2.12 Time woman was first seen by an anaesthetist after collapse :

Therapy

3.1 Please indicate if any of following therapies were used and when

	Please tick all that apply	Date	Time
Hysterectomy	<input type="checkbox"/>	□□/□□/□□	□□:□□
Plasmaphoresis	<input type="checkbox"/>	□□/□□/□□	□□:□□
Recombinant Factor VIIa	<input type="checkbox"/>	□□/□□/□□	□□:□□
Intubation and ventilation (additional to that needed for GA)	<input type="checkbox"/>	□□/□□/□□	□□:□□
ECMO	<input type="checkbox"/>	□□/□□/□□	□□:□□
CPR	<input type="checkbox"/>	□□/□□/□□	□□:□□
Other	<input type="checkbox"/>	□□/□□/□□	□□:□□

If other, please specify

3.2 Did the woman receive any blood products?

YES NO NOT KNOWN

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

Volume infused of cell saver cells (mls) mls

Section 4: Labour and birth details

4.1 Was uterine hyperstimulation used?

YES NO NOT KNOWN

If yes, for how many minutes?

Section 5: Maternal outcome

5.1 If the woman died and a post-mortem examination was done, were fetal squames or debris found in the pulmonary circulation?

YES NO NOT KNOWN

Any other information?

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