

British Paediatric Surveillance Unit Study

Feto-Maternal Alloimmune Thrombocytopenia (FMAIT)

Data Collection Form - BIRTH

Report only infants born after 1st October 2006

Case Definition:

Any infant born during the study period with a documented maternal/fetal platelet antigen incompatibility, usually in the presence of maternal antibodies AND **one** of the following:

Cord platelet count at birth $<50 \times 10^9/l$

Haemorrhagic complications before or after birth (e.g. intraventricular haemorrhage, GI bleed, bruising or petechiae)

Antenatal therapy with either maternal steroids, IVIg or fetal platelet transfusion

Reporting instructions:

Please report any infant born since the beginning of October 2006 in the UK with newly-diagnosed FMAIT (confirmed or suspected), seen by you for the first time in the last month.

Please return the completed form to:

**Dr Marian Knight
National Perinatal Epidemiology Unit
University of Oxford
Old Road Campus
Oxford
OX3 7LF**

Fax: 01865 289701

Phone: 01865 289714

Case reported in:

2.4 Please indicate whether any of the following treatments were used and the dates when they were first given

	Number of treatments	Date of first treatment
Steroids e.g. dexamethasone		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Maternal Intravenous immunoglobulin (IVIg)		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Intrauterine transfusion		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>

Section 3: Postnatal

3.1 What was the platelet count at birth? ($\times 10^9/L$)

3.2 Did this infant require any platelet transfusions? Yes No

If Yes:

How many transfusions?

Were they: (please tick) random platelet transfusions

HPA-1a/5b negative platelet transfusions?

Section 4: Outcomes

4.1 Time to discharge days, or tick if not yet discharged

4.2 Did this child develop any haemorrhagic complications? Yes No

If Yes, please indicate below which complications occurred (*tick all that apply*)

Intracranial haemorrhage

Gastrointestinal bleed

Bruising/petechiae

Other

If Other, please specify _____

4.3 Did any other major infant complications occur?* Yes No

If Yes, please specify _____

4.4 Did this infant have any apparent disability, delay or impairment on discharge? Yes No

If Yes, please specify _____

4.5 Did this infant die Yes No

If Yes, please specify date of death / /

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

(please state if not known) _____

*For examples please see back page

Section 5

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

Section 6

Name of person completing the form _____

Designation _____

Today's date

D	D	/	M	M	/	Y	Y
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*Examples

Fetal/infant complications, including:
Respiratory distress syndrome
Necrotising enterocolitis
Neonatal encephalopathy
Chronic lung disease
Severe jaundice requiring phototherapy
Major congenital anomaly
Severe infection e.g. septicaemia, meningitis
Exchange transfusion