

ID Number:

Date of operation:

Date of Transfer to Your Hospital:

# **British Association of Paediatric Surgeons Congenital Anomalies Surveillance System (BAPS-CASS)**

## **Congenital Diaphragmatic Hernia**

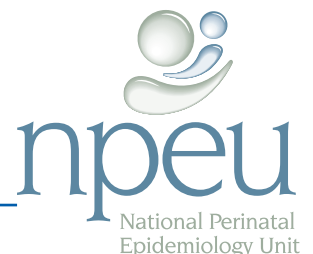
**Data Collection Form - CASE OUTCOMES ONE YEAR**

Please return the completed form to:

**BAPS-CASS**  
**National Perinatal Epidemiology Unit**  
**University of Oxford**  
**Old Road Campus**  
**Oxford**  
**OX3 7LF**  
**Fax: 01865 617775**  
**Phone: 01865 289714**



Case reported in: \_\_\_\_\_



## Instructions

1. Please do not enter any personally identifiable information (e.g. name, address or hospital number) on this form.
2. Please record the ID number from the front of this form against the infant's name on the Clinician's Section of the blue card retained in the BAPS folder.
3. Fill in the form using the information available in the infant's case notes.
4. Tick the boxes as appropriate. If you require any additional space to answer a question please use the space provided in section 7.
5. Please complete all dates in the format DD/MM/YY, and all times using the 24hr clock e.g. 18:37
- 6. If you do not know the answers to some questions, please indicate this in section 7.**
7. If you encounter any problems with completing the form please contact the Study Administrator or use the space in section 7 to describe the problem.

### Section 1: Survival data

#### 1.1 Did this infant survive?

Yes  No 

If No, please specify date of death

DD / MM / YY

What was the primary cause of death as stated on the death certificate?  
(Please state if not known.) \_\_\_\_\_

Was a post mortem examination performed?

Yes  No 

#### 1.2 Was the infant transferred to another hospital before discharge?

Yes  No 

If Yes, please give name of hospital \_\_\_\_\_

name of responsible consultant \_\_\_\_\_

and date of initial transfer

DD / MM / YY

#### 1.3 Was the infant discharged home after initial surgery?

Yes  No 

If Yes, please give date of first discharge home

DD / MM / YY

### Section 2: Morbidity during the 1st year following birth

#### 2.1 Did a chylothorax develop at any stage?

Yes  No 

If Yes, how was this managed? (please tick all that apply)

TPN Octreotide Other 

If Other, please specify \_\_\_\_\_

#### 2.2 Was a recurrent hernia present?

Yes  No 

If Yes, please specify

Method of repair \_\_\_\_\_

Date of repair

DD / MM / YY

#### 2.3 Were there any neurological sequelae?

Yes  No 

If Yes, please specify problem \_\_\_\_\_

**2.4 Is the infant now fully orally fed?** Yes  No

If No, please indicate how the child is currently being fed:

NG tube feeding

PEG gastrostomy

TPN as an inpatient

TPN at home

**2.5 Was prophylactic medical therapy given for gastro-oesophageal reflux?** Yes  No

If Yes, please specify drugs used \_\_\_\_\_

**2.6 Has gastro-oesophageal reflux been diagnosed?** Yes  No

If Yes, was medical therapy given? Yes  No

If Yes, please specify drugs used \_\_\_\_\_

Was fundoplication performed? Yes  No

If Yes, was this Open  Laparoscopic

Date of procedure DD / MM / YY

What type of fundoplication was performed?

Nissen

Thal

Toupet

Watson

Other

If Other, please specify type \_\_\_\_\_

Was a feeding gastrostomy placed? Yes  No

**2.7 Was any other late morbidity diagnosed?** Yes  No

If Yes, please tick all that were diagnosed

Adhesive bowel obstruction

Oxygen dependency

Orthopaedic

If Yes, was there a pectus chest wall deformity? Yes  No

Other

If Yes, please specify \_\_\_\_\_

**2.8 Is the infant currently on any medication?** Yes  No

If Yes, please tick all that were prescribed

Diuretics

Bronchodilators

Steroids

Inotropes

Vasodilators

Other

If Other, please specify \_\_\_\_\_

**2.9 Have the family/infant been referred or are they going to be referred to a Medical Genetics Service?** Yes  No

