ID Number:

British Association of Paediatric Surgeons Congenital Anomalies Surveillance System

Oesophageal Atresia Data Collection Form

Please report all infants born on or after 1st April 2008.

Data Collection Form - CASE

Case Definition:

A congenital malformation comprising an interruption of the continuity of the oesophagus with or without a persistent communication with the trachea.

Please return the completed form to:

BAPS-CASS
National Perinatal Epidemiology Unit
University of Oxford
Old Road Campus
Oxford
OX3 7LF

Fax: 01865 289701
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 8.

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 8.

7. If you encounter any problems with completing the form please contact the Study Administrator or use the space in section 8 to describe the problem.

Section 1: Perinatal Details

Antenatal data

1.1 Was OA suspected antenatally? Yes ☐ No ☐

If No, *please go to 1.3*

If Yes, at what gestational age *(completed weeks)*? ☐☐

1.2 Which feature suggested diagnosis *(please tick any that apply)*

Absent stomach ☐ Small stomach ☐ Dilated upper oesophagus ☐ Other ☐

If Other, please specify _____

1.3 Was polyhydramnios present? Yes ☐ No ☐

If Yes, what was the maximum amniotic fluid index? ☐☐

1.4 What was the mother's year of birth? ☐☐☐☐ (Y Y Y Y)

Birth data

1.5 Ethnic group[1]* ☐☐

1.6 Gestational age at birth *(completed weeks)* ☐☐

1.7 Age at presentation Days ☐☐ Hours ☐☐

1.8 Gender Male ☐ Female ☐

1.9 Birth weight *(g)* ☐☐☐☐

1.10 Was the infant transferred from another hospital after delivery? Yes ☐ No ☐

If Yes, please specify hospital infant was born in _____

*For guidance please see back cover

1.11 **Were there any associated anomalies diagnosed or suspected?** Yes ☐ No ☐

If Yes, please complete table below

Anomaly	Susupected antenatally *(Tick if Yes)*	Confirmed postnatally *(Tick if Yes)*
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

Section 2: Pre-Operative Investigations and Management

2.1 **Was a chest x-ray performed?** Yes ☐ No ☐

2.2 **Was an abdominal x-ray performed?** Yes ☐ No ☐

2.3 **Was the upper pouch decompressed?** Yes ☐ No ☐

If Yes, please indicate method

Replogle tube ☐ NG tube ☐ Other ☐ please specify _____

2.4 **Was the side of the aortic arch known pre-operatively?** Yes ☐ No ☐

2.5 **Did the infant need ventilator support pre-operatively?** Yes ☐ No ☐

If Yes, please state type Intubation ☐ CPAP ☐

and indication: (eg prematurity, pneumonitis, complications of TOF, etc)

_____

2.6 **Were antibiotics given at induction/peri-operatively?** Yes ☐ No ☐

Section 3: Management of OA - gross classification type (a) or (b)

Answer this section only if the infant had type (a) or (b), else go to section 4

3.1 **Did the infant have** *(please tick one)*

(a) OA without fistula ☐ (b) OA with upper pouch fistula only ☐

3.2 **Length of the gap (number of vertebral bodies)** ☐☐

Initial surgery *Answer this section only if the infant had type (a) or (b), else go to section 4*

3.3 **Date of initial surgery** D D / M M / Y Y

3.4 **Age of infant at first operation** *(Day of birth = Day 0)* Days ☐☐

3.5 **Operation type**

Gastrostomy and cervical oesophagostomy ☐

Gastrostomy alone ☐ Primary anastomosis ☐ Focker operation ☐

Other ☐ please specify _____

Secondary surgery

3.6 **Has secondary surgery been performed?** Yes ☐ No ☐

If Yes, please give: Date of secondary surgery D D / M M / Y Y

Operation type

Delayed primary anastomosis ☐

Oesophageal replacement with: Colon ☐ Gastric transposition ☐

Gastric tube ☐ Small bowel ☐

Other ☐ please specify _____

Please continue to section 5

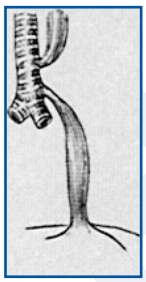
Section 4: Management of OA - gross classification type (c), (d) or (e)

Answer this section only if the infant had type (c), (d) or (e)

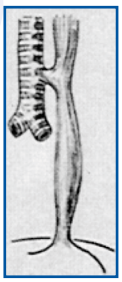
4.1 **Did the infant have** *(please tick one)*

c) OA with lower pouch fistula ☐

(d) OA with upper and lower pouch fistulae ☐



(e) H–type trachea-oesophageal fistula ☐



4.2 **Was the first surgical procedure** TOF ligation only ☐ Primary repair ☐

If TOF ligation only, please give date and time of procedure

D D / M M / Y Y h h : m m (24hr)

What material was used for the fistula ligation?

Absorbable ☐ Non-absorbable ☐ Clip ☐ Other ☐

If Other, please specify _____

Has the infant now had an anastomosis? Yes ☐ No ☐

If YES, please continue, if NO go to section 5

4.3 **Date and time of anastomosis** D D / M M / Y Y h h : m m (24hr)

4.4 **Age of infant at anastomosis** *(Day of birth = Day 0)* Days ☐☐ Hours ☐☐

4.5 **Was a bronchoscopy performed?** Yes ☐ No ☐

4.6 **Was an oesophagoscopy performed?** Yes ☐ No ☐

4.7 **Surgical approach**: Thoracotomy: Left ☐ Right ☐ Neither ☐

Approach: Extrapleural ☐ Transpleural ☐

Thoracoscopic procedure? Yes ☐ No ☐

If Yes, was operation converted to open Yes ☐ No ☐

4.8 **Was an additional lengthening procedure required?** Yes ☐ No ☐

If Yes, was it: Anterior upper pouch flap ☐ Upper pouch myotomy ☐

Other ☐ please specify _____

4.9 **What type of suture was used for the oesophageal anastomosis?**

Absorbable ☐ Non-absorbable ☐

4.10 **What side was the aortic arch?** Left ☐ Right ☐ Not documented ☐

4.11 **Was a trans-anastomotic (TA) tube placed?** Yes ☐ No ☐

4.12 **Was a gastrostomy placed?** Yes ☐ No ☐

4.13 **Was a chest drain placed at surgery?** Yes ☐ No ☐

4.14 **What was the grade of primary operator?** Consultant ☐ Trainee ☐

If Trainee, what was their grade of training? ST ☐

4.15 **Were further surgical procedures necessary?** Yes ☐ No ☐

If Yes, please give date D D / M M / Y Y

and details of surgery: _____

Section 5: **Post-operative care**

Respiratory

5.1 **Was the infant electively ventilated post-operatively?** Yes ☐ No ☐

If Yes, please state indication? _____

How many days was this for? ☐☐☐

If less than 24 hours, please give number of hours ☐☐.☐

5.2 **Was the infant ventilated post-operatively as an emergency?** Yes ☐ No ☐

If Yes, please state indication? _____

How many days was this for? ☐☐☐

Feeding

5.3 **Was feeding started by TA tube?** Yes ☐ No ☐

If Yes, please give date TA feeds started D D / M M / Y Y

and date full TA feeds established D D / M M / Y Y

5.4 **Has oral feeding started?** Yes ☐ No ☐

If Yes, please give date oral feeds started D D / M M / Y Y

and date full oral feeds established D D / M M / Y Y

Investigations

5.5 **Was a cardiac echo performed?** Yes ☐ No ☐

If Yes, was this Pre-operatively ☐ Post-operatively ☐

5.6 **Was a spinal x-ray and/or ultrasound performed?** Yes ☐ No ☐

5.7 **Was a renal ultrasound performed?** Yes ☐ No ☐

5.8 **Was a contrast swallow performed?** Yes ☐ No ☐

If Yes, was this: As a routine procedure ☐ Because of symptoms ☐

Section 6: Complications during primary admission

Anastomotic Leak

6.1 **Did an anastomotic leak occur?** Yes ☐ No ☐

If Yes,

Date leak detected D D / M M / Y Y

Mechanism of leak detection *(please tick all that apply)*

Pneumothorax ☐

Routine post-op contrast study ☐

Contrast study because leak suspected ☐

Other ☐

If Other, please specify _____

Treatment of leak *(please tick all that apply)*

Conservative without antibiotics ☐

Conservative with antibiotics ☐

Original chest drain alone ☐

New chest drain alone ☐

Surgical repair ☐

Oesophageal diversion (oesophagostomy) ☐

Other ☐

If Other, please specify _____

Anastomotic Stricture

6.2 **Was a stricture diagnosed during primary admission?** Yes ☐ No ☐

If Yes,

Date stricture diagnosed D D / M M / Y Y

Treatment of stricture:

Balloon dilatation ☐

Bougie dilatation ☐

Other ☐

If Other, please specify _____

Gastro-oesophageal reflux (GOR)

6.3 Was prophylactic medical therapy given? Yes ☐ No ☐

If Yes, please specify drugs used _____

6.4 Was GOR diagnosed? Yes ☐ No ☐

If **Yes**, please indicate

Date of diagnosis D D / M M / Y Y

Method of diagnosis *(please tick all that apply)*

Clinical ☐
Contrast swallow - routine ☐
Contrast swallow - for symptoms ☐
pH probe – routine ☐
pH probe – for symptoms ☐
Other ☐

If Other, please specify _____

Was medical therapy given? Yes ☐ No ☐

If Yes, please specify drugs used _____

Was fundoplication performed? Yes ☐ No ☐

If Yes, was it open ☐ laparoscopic ☐

Date of procedure: D D / M M / Y Y

Other complications

6.5 Did the infant require *(please tick)*

Bronchoscopy for airway obstruction ☐
Aortopexy ☐ please give date D D / M M / Y Y
Tracheostomy ☐ please give date D D / M M / Y Y

6.6 Did the infant develop a recurrent fistula? Yes ☐ No ☐

If Yes, please give date detected D D / M M / Y Y

6.7 Did the infant have any other complications? Yes ☐ No ☐

If Yes, please specify _____

Section 7: Outcome

7.1 Has the infant been transferred to another hospital? Yes ☐ No ☐

If Yes, please give name of hospital _____
name of responsible consultant _____
and date of transfer D D / M M / Y Y

7.2 Has the infant been discharged home? Yes ☐ No ☐

If Yes, please specify date of discharge D D / M M / Y Y

7.3 Did this infant die? Yes ☐ No ☐

If Yes, please specify date of death D D / M M / Y Y

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

(*please state if not known*) _____

7.4 Were the parents given any of the following support information? Yes ☐ No ☐

If Yes, *please tick all that apply*

Contact details for the TOFs support group ☐

TOFs group book/ leaflets ☐

In-house information leaflets ☐

Section 8:

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

Section 9:

Name of person completing the form _____

Designation _____

Today's date D D / M M / Y Y

You may find it useful in the case of queries to keep a copy of this form.

Definitions

1. UK Census Coding for ethnic group

WHITE
- 01. British
- 02. Irish
- 03. Any other white background

MIXED
- 04. White and black Caribbean
- 05. White and black African
- 06. White and Asian
- 07. Any other mixed background

ASIAN OR ASIAN BRITISH
- 08. Indian
- 09. Pakistani
- 10. Bangladeshi
- 11. Any other Asian background

BLACK OR BLACK BRITISH
- 12. Caribbean
- 13. African
- 14. Any other black background

CHINESE OR OTHER ETHNIC GROUP
- 15. Chinese
- 16. Any other ethnic group