WOMEN'S INTERAGENCY HIV STUDY
PREGNANCY PROTOCOL
QUESTION BY QUESTION SPECIFICATIONS
POSTPARTUM FORM (PR02)

Visit Number:

All forms completed during the participant's regular core visit (including PRNOTI, PR01 and PR02) will be labeled with the current visit number tag (i.e., visit 11, visit 12, etc.).

SECTION A

PROMPT: REVIEW THE MEDICAL RECORD AND COMPLETE FORM PR02 AFTER PARTICIPANT HAS BEEN SEEN FOR A CORE WIHS VISIT AND AT LEAST ONE MONTH HAS ELAPSED SINCE HER DELIVERY OR PREGNANCY TERMINATION.

A2. Record whether the medical record was obtained. If no, code 2 (NO) and specify the REASON records were unobtainable. After specifying REASON, **END**.

A3. Record the date of the chart review in MM/DD/YY format. Skip to A5.

Questions A5–A8.

Stillbirth indicates a fetus born dead; intrapartum stillbirth means the fetus died during labor. Antepartum stillbirth also is known as intrauterine fetal demise, or IUFD; e.g., the patient usually complains of decreased or no fetal movement; no fetal heartbeat is detected via Doppler or ultrasound when the patient is seen.

All "spontaneous" abortions (e.g., missed, incomplete, inevitable, etc.) are included in the term "spontaneous abortion" and "other" abortions would include voluntary terminations.

A5. Record the date the pregnancy ended. The pregnancy may have ended due to a live birth, stillbirth, miscarriage, abortion or tubal/ectopic pregnancy.

A6. Record the approximate gestation in weeks at time of termination/delivery.

A7. Record the total number of fetuses terminated and/or delivered.

A8. Record the outcome of the participant's pregnancy for each fetus. The column completed should correspond to that particular fetus number out of the total number of fetuses indicated in question A6. For example, if the woman delivered one stillbirth only, then the OB Designee would record the outcome for that fetus in column a ("fetus #1"). If the participant was carrying two fetuses and one was a live birth and the other a stillbirth, antepartum, then the OB Designee would complete both column a ("fetus #1") and column b ("fetus #2"). The code corresponding to each outcome should be circled.

If code 1 or 2 ("live birth" or "stillbirth, intrapartum") has been circled, proceed to Section B.

If code 3 ("stillbirth, antepartum") has been circled, skip to Section F.

If code 4, 5, 6 or 7 ("spontaneous abortion," "other abortion," "tubal/ectopic" or "other") has been circled, **END** the form.

SECTION B. INTRAPARTUM COMPLICATIONS

PROMPT: INTRAPARTUM IS DEFINED AS THE TIME FROM ONSET OF LABOR TO DELIVERY.

PROMPT: OB DESIGNEES SHOULD CIRCLE <-8> IF THE REQUESTED INFORMATION IS NOT CONTAINED ON THE PARTICIPANT'S CHART.

B1. **Preterm, premature rupture of membranes**

Preterm, premature rupture of membranes (PROM) indicates rupture of membranes any time before 37 weeks and before the onset of labor and is associated with a high risk of chorioamnionitis (question B3). Some authorities define PROM as occurring 24 hours before delivery.

Code YES if spontaneous rupture of membranes occurred more than three weeks prior to participant due date. Diagnosis of PROM must be documented by one of the following:

- Visualizing a pool of amniotic fluid in the vagina or gross leakage of amniotic fluid from the vagina.
- Positive nitrazine paper reaction produced from the vaginal fluid that does not appear to be contaminated by blood and a fern pattern seen on microscopic examination of air-dried vaginal fluid.
- Positive peri-pad test after installation of indigo carmine dye.

B2. **Maternal fever** – Code YES if the participant had an oral temperature $\geq$ 100.4°F or 38.0°C, or a rectal temperature $\geq$ 101.4°F or 38.5°C.

B3. **Clinical diagnosis of chorioamnionitis**

Chorioamnionitis is a clinical diagnosis indicated by the presence of fever in labor with maternal and/or fetal tachycardia, ineffective contractions, history of PROM, and possibly purulent amniotic fluid. It can also be diagnosed via culture or pathological examination of the placenta and the umbilical cord.

Code YES if diagnosis AND the absence of any other cause AND any two of the following:

- Oral temp $\geq$ 100°F or 37.8°C, or rectal temperature $\geq$ 101°F or 38.3°C.
- Fetal heart rate persistently greater than 160 BPM.
- Maternal heart rate greater than 120 BPM in the absence of tocolytics or known maternal heart tachyrhythmia.
- Uterine tenderness not associated with contractions.
- Purulent cervical discharge or amniotic fluid.
- Premature labor unresponsive to tocolytic therapy and an amniotic fluid Gram stain positive for a single type of organism.

B4. **Pre-eclampsia**

Pre-eclampsia has been described in the Form PR01 QxQs with regard to pregnancy-induced hypertension (PIH). In the case of pre-eclampsia, the patient will have elevated blood pressures as described below, as well as proteinuria and edema, generally of the face and hands as well as the legs. (Most pregnant women will have some dependent edema that is not pathological.) The patient may also complain of headache, scotomata and, rarely, mid-epigastric pain. Such patients may have been induced because of pre-eclampsia, as the treatment for pre-eclampsia is delivery of the fetus. It may also present in the postpartum period; however, this question addresses intrapartum events only.

Code YES if diagnosis AND/OR blood pressure criteria AND uterine protein criteria are met. Blood pressure criteria include: intrapartum blood pressure persistently ≥ 140/90 OR rise in systolic pressure of ≥ 30 mm Hg and diastolic pressure ≥ 15 mm Hg over first trimester blood pressure. Uterine protein criteria include: intrapartum proteinuria of ≥ 1+ by dipstick OR 300 mg protein in 24 hour collection.

B5. **Eclampsia**

Seizure or coma in a pregnant woman without other explanation (e.g., history of epilepsy, or trauma) is considered to be diagnostic of eclampsia until proved otherwise. It carries with it a significant risk of mortality for both mother and fetus.

Code YES if diagnosis AND/OR participant fulfills criteria for pre-eclampsia from B4 AND participant has seizures intrapartum without any other known reason for seizures (e.g., history of seizure disorder).

Questions B6–B8.

Some patients may require a surgical procedure, such as the repair of a fourth degree laceration or the removal of a retained placenta, without being hemodynamically unstable. Some patients may receive a blood transfusion during cesarean section before hemodynamic instability has occurred. Surgical procedures that may be related to obstetric hemodynamic instability include: manual removal of placenta, curettage, repair of lacerations (vaginal, cervical, vulvar), exploratory laparotomy, hypogastric artery ligation, and emergency hysterectomy (following delivery or at the time of cesarean section).

B6. **Hemorrhage with hemodynamic instability** – Code YES if diagnosis AND/OR bleeding AND a BP less than 90/60 OR maternal heart rate greater than 120 BPM. Include only those episodes treated with fluid/volume expanders.

B7. **Hemorrhage requiring surgical procedure** – Code YES if diagnosis AND/OR bleeding that necessitates surgical intervention, such as dilation and curettage, hysterectomy or uterine artery ligation.

B8. **Hemorrhage requiring transfusion** – Code YES if diagnosis AND/OR bleeding that necessitates transfusion intrapartum to maintain hemodynamic stability as defined by one of the following:

- To correct BP < 90/60 or maternal HR > 120 BPM.
- To maintain hematocrit > 20.

B9. **Genital herpes**

Code YES if diagnosis AND/OR written clinical skin findings intrapartum, consistent with diagnosis when there is a history of genital herpes OR positive herpes culture from vesicular lesions.

B10. **Genital condyloma (warts)**

Code YES if diagnosis intrapartum AND/OR written clinical skin findings consistent with diagnosis.

B11. **Placenta praevia**

Placenta praevia is a condition in which the placenta covers the internal os of the cervix, and can cause significant hemorrhage for the mother and, to a lesser extent, the fetus. It presents with painless vaginal bleeding in third trimester, and is usually bright red. It may be diagnosed during the antepartum course by ultrasound.

Code YES if diagnosis intrapartum AND/OR bleeding after 28 weeks of pregnancy AND documentation that the placenta overlies the cervical os by one of the following:

- By ultrasound.

- At double set up.
- At time of cesarean section of the placenta covering the cervical os.

B12. **Abruptio placenta**

Abruptio placentae occurs when the placenta separates from the uterine wall before delivery. It usually causes bleeding of dark red blood with pain. It presents in the third trimester. The diagnosis of placental abruption is clinical although there are ultrasound findings which may be suggestive of abruption.

Code YES if diagnosis intrapartum AND/OR examination of the placenta at delivery reveals retroplacental clot OR clinical diagnosis in patient with two of the following:

- Vaginal bleeding.
- Uterine tenderness.
- Increased uterine tone between contractions.

B13. **Cord prolapse**

A cord prolapse is a true obstetrical emergency; the umbilical cord prolapses into the vaginal canal, causing cord compression and resultant fetal hypoxia. This may occur in cases of abnormal presentation (footling breech, etc.) in the presence of ruptured membranes. The cord must be elevated as high in the vagina as is possible with an assistant's hand to try to relieve the cord compression until the fetus is delivered by emergent cesarean section.

Code YES if diagnosis intrapartum AND/OR documentation of protrusion of the umbilical cord through the cervical os.

B14. **Other clinically-significant intrapartum problems** – Indicate if there were any other intrapartum problems that occurred during labor and delivery. Examples include polyhydramnios, oligihydramnios, uterine dystocia, retained placenta, and acute blood pressure problems. If YES, circle code 1 and SPECIFY the type of problem on the line provided. If NO, skip to Section C. Do not list complications affecting only the baby here.

SECTION C. LABOR AND DELIVERY SUMMARY

C4. **Labor Induced –** Record whether labor was induced. If YES, code 1 and proceed to C5a–h. If NO, code 2 and skip to C6.

C5. Labor may be induced for a variety of reasons. All of the possibilities from question **C5a–d** and question **C5f** have been discussed above. Some practitioners will induce labor at 41 or 42 weeks because of concern about placental insufficiency. Many women will be in specialized care after 41 weeks so that fetal testing may be performed semiweekly (a nonstress test, or NST, of the fetal heart rate, and possibly a detailed sonogram known as a biophysical profile, or BPP, consisting of the fetal movement, breathing movement, amount of amniotic fluid, and fetal tone). If there is evidence of fetal compromise, induction may be considered or undertaken.

Specify all indications that are applicable and circle "NO" or "DON'T KNOW / NOT RECORDED" for those that are not applicable.

a. Premature rupture of membranes – Spontaneous rupture of the membranes occurring more than one hour prior to the onset of regular uterine contractions.

b. Chorioamnionitis – See QxQs for question B3.

c. Hypertension complications – As defined in **pre-eclampsia (**Diagnosis AND/OR blood pressure criteria: intrapartum blood pressure persistently $\geq$ 140/90 OR rise in systolic pressure of $\geq$ 30 mm Hg and diastolic pressure $\geq$ 15 mm Hg greater than first trimester blood pressure AND uterine protein criteria: intrapartum proteinuria of $\geq$ 1+ by dipstick OR 300 mg protein in 24 hour collection.), **pregnancy induced hypertension** (Diagnosis

AND/OR blood pressure persistently ≥ 140/90 mm Hg OR rise in systolic pressure of ≥ 30 mm Hg and diastolic pressure ≥ 15 mm Hg greater than first trimester blood pressure, AND without proteinuria, AND no known hypertension prior to pregnancy.), and **chronic hypertension requiring treatment** (Diagnosis AND/OR high blood pressure > 140/90 mm Hg that began prior to pregnancy or in the first twenty weeks of pregnancy which is controlled with anti-hypertensive medication.)

d. Maternal diabetes – As defined in **pre-gestational diabetes** (hyperglycemia before pregnancy), **gestational diabetes** (diabetes during pregnancy by an abnormal three-hour glucose tolerance test. Criteria: two abnormal serum values from the following: Fasting - 105, 1 hour - 190, 2 hour - 165, 3 hour - 145 OR abnormal 1 hour post 50 gram glucose load of > 200 mg/dl. AND control of hyperglycemia with diabetic diet alone AND no history of elevated blood sugar prior to pregnancy) or **insulin therapy during pregnancy** (diagnosis of gestational diabetes AND hyperglycemia is controlled by the administration of insulin and diabetic diet).

e. Other maternal indication – Specify the maternal indication leading to the induction of labor. Examples include prolonged rupture of membranes, Rh incompatibility.

f. Fetal indication, IUGR – Diagnosis AND/OR estimated fetal weight less than the 10th percentile.

g. Fetal indication, postdate – Diagnosis AND/OR gestational age greater than 42 weeks or 294 days.

h. Other fetal indication – Specify the fetal indication leading to the induction of labor. Examples include severe isoimmunization, fetal anomalies.

C6. **Fetal distress**

Fetal distress, or uncertain fetal status, is often diagnosed in labor based on fetal heart rate patterns in and of themselves and/or relative to the uterine contraction pattern; or on results of fetal scalp electrode sampling.

Code YES if diagnosis AND/OR description to include either of the following:

- Prolonged fetal bradycardia – defined as fetal heart rate < 100 BPM for at least five minutes.
- Fetal scalp sample less than 7.2.
- Persistent late decelerations.

C10. **Delivery information –** Specify whether delivery information is available. If YES, code 1 and proceed to C10a. If no, code 2 and skip to Section D.

a. Date of delivery – Enter the month, day and year of delivery. If unknown, record <-8>.

b. Time of delivery – Enter the time of delivery. Specify AM or PM. If unknown, record <-8>.

C11. **Type of delivery** – Specify whether the delivery was vaginal or cesarean. If the delivery was vaginal, proceed to question C12. If the delivery was cesarean, skip to question C17.

C12. **Type of vaginal delivery** (CIRCLE ONLY ONE CODE)

- Vaginal cephalic spontaneous – Only include cephalic presentations that did not require assistance with forceps or vacuum.
- Vaginal cephalic assisted with forceps – Only include cephalic presentations which were assisted with forceps.
- Vaginal cephalic assisted with vacuum – Only include cephalic presentations which were assisted with vacuum.

- Vaginal cephalic assisted with both forceps and vacuum – Delivery assisted by use of both forceps and vacuum at some point in time, but not necessarily concurrently.
- Vaginal breech – Include all breech deliveries that were vaginal births regardless of forceps use.

If delivery type is unknown or not recorded, circle code <-8>.

C13. **Episiotomy or laceration** – Indicate if an episiotomy was done, or the participant's vulva or vagina tore during delivery.

C16. **Vaginal or vulvar hematoma**

Code YES if diagnosis AND documentation of a suprafacial collection of blood in either the vaginal or vulvar submucosa most often treated with incision and evacuation.

PROMPT: IF C11=1 (TO INDICATE VAGINAL DELIVERY), SKIP TO QUESTION C23 AFTER ANSWERING QUESTION C17.

C18. **Type of cesarean delivery** (CIRCLE ONLY ONE CODE)

- Cesarean, primary planned – Those cesareans that were planned (prior to labor) on patients who have not had a previous cesarean. Examples of indications are for congenital anomalies, fetal macrosomia.
- Cesarean, primary unplanned – All primary cesareans for maternal or fetal indications that arise in labor and therefore are not planned. Examples are cord prolapse, fetal distress.
- Cesarean, repeat planned – All repeat cesareans that are planned without an attempt at vaginal delivery.
- Cesarean, repeat unplanned – All trials of labor and attempts for vaginal birth after cesarean (for previous pregnancy) that fail.

If cesarean delivery type is unknown or not recorded, circle code <-8>.

C19. **Indications for cesarean**

Cephalopelvic disproportion, considered by some obstetric experts to be a diagnosis of exclusion, is present when the fetal head is too large to exit through the maternal pelvis. Failure to progress is present when the cervix fails to dilate despite oxytocin augmentation (when not contraindicated), rupture of membranes, etc. (the normal cervical dilation is one centimeter per hour in a multipara, and one centimeter per two hours in a nullipara). The other indications have been discussed above, except for breech presentation, which is self-explanatory.

Circle appropriate response code for each indication a–j.

a & b. Cephalopelvic disproportion/failure to progress – Diagnosis AND/OR arrest of labor in the active phase at >5 cm of cervical dilation or arrest of descent in spite of adequate uterine contractions.

c. Fetal distress – Diagnosis AND/OR description to include any of the following:

- Prolonged fetal bradycardia – fetal heart rate 100 BPM for five minutes.
- Fetal scalp sample < 7.2.
- Persistent late decelerations.

d. Breech or other abnormal presentation/lie – Diagnosis AND/OR description to include any of the following:

- Any breech.
- Shoulder presentation.

- Transverse lie.
- Other abnormal presentation.

NOTE: DO NOT INCLUDE CORD PROLAPSE HERE.

e. Active maternal herpes – Diagnosis AND description consistent with primary or recurrent active genital herpes.

f. Placenta previa – Diagnosis AND/OR documentation that the placenta overlies the cervical os by one of the following:

- By ultrasound.
- At double set up.
- At time of cesarean section of the placenta covering the cervical os.

g. Multiple gestation – Diagnosis of twins or more than two fetuses.

h. Prevention of HIV transmission – Diagnosis of maternal HIV infection.

i. Maternal indication – Diagnosis AND specify the indication. Examples include medical conditions like pre-eclampsia, diabetes, pelvic tumors.

j. Fetal indication – Diagnosis AND specify the indication. Examples are macrosomia, prematurity, or specific congenital anomalies like hydrocephalus or spina bifida.

k. Other indication – Specify any other condition not easily categorized above. Include patients that refuse trial of labor and cesareans done for cord prolapse.

C20. **Type of cesarean section** (CIRCLE ONLY ONE CODE)

The type of Cesarean section refers to the **uterine,** not skin, incision. A patient may have a Pfannenstiel incision (transverse or bikini cut) with a low vertical uterine incision.

- Low vertical (Kroenig) – A midline vertical incision in the lower uterine segment.
- Low transverse (Kerr) – A transverse incision in the lower uterine segment.
- Classical – A midline vertical incision in the upper uterine segment often extending to the uterine fundus.
- Other – Circle code 4 if type of cesarean section differs from any of those listed here (e.g., extraperitoneal). Please specify on the line provided.

Circle code <-8> if the type of cesarean section was not recorded.

C23. **Delivery anesthesia –** Indicate if delivery anesthesia was administered. If YES, code 1 and proceed to C23a. If NO, code 2 and skip to C24. Please indicate "YES" or "NO" for each anesthesia.

- General – Anesthesia which is administered either intravenously or by inhalation and is accompanied by loss of consciousness. Examples of anesthetic agents include thiopental sodium, nitrous oxide or halothane.
- Epidural – Dilute anesthetic solution injected by catheter in the peridural space.
- Pudendal – Anesthetic solution injected over the ischial spine to anesthetize the lower two thirds of the vagina and perineum.
- Spinal – Anesthetic solution injected through dura - also called saddle block.
- Local – Anesthetic solution infiltrated in the perineum.
- Other – Indicate whether any other type not listed above was used. If YES, specify.

C24. Record any other complications of labor and delivery not already listed (e.g., a precipitous delivery, non-sterile delivery, trauma to infant).

SECTION D. INTRAPARTUM LABS

D1. Record whether participant's (mother's) admission hematocrit was done. If YES, code 1 and SPECIFY result in D1a.

SECTION E. INTRAPARTUM MEDICATIONS

E1. **Intrapartum antibiotics** – Indicate whether participant took intrapartum antibiotics. Examples include penicillin, cefoxitin, cefazolin.

E2. **Intrapartum glucocorticoids** – Indicate whether intrapartum glucocorticoids were given to the participant. Examples include hydrocortisone, betamethasone, dexamethasone, prednisone.

E3. **Intrapartum antivirals** – Indicate whether intrapartum antivirals were given to the participant. Include FDA approved and/or any antivirals participant may have taken as part of a research study during labor and/or delivery. Examples include AZT (zidovudine, Retrovir), Dideoxycytosine (ddC), Dideoxyinosine (ddI), or recombinant CD4 (rCD4). If YES, code 1 and proceed to E3a. If NO, code 2 and skip to Section F.

a. **Intravenous zidovudine** – Record whether intravenous zidovudine was administered.

e. **Other antivirals, including oral zidovudine** – Record whether other antivirals, including oral zidovudine, were given. If YES, code 1 and specify on the lines provided. If NO, code 2 and skip to Section F.

SECTION F. POSTPARTUM HISTORY/COMPLICATIONS

PROMPT: POSTPARTUM IS DEFINED AS THE SIX-WEEK PERIOD FOLLOWING DELIVERY.

PROMPT: INFORMATION IN SECTIONS F AND G PERTAINS TO THE POSTPARTUM PERIOD THAT OCCURS DURING THE DELIVERY HOSPITALIZATION ONLY. IF THE DELIVERY HOSPITALIZATION LASTS LONGER THAN SIX WEEKS, OB DESIGNEE SHOULD ABSTRACT ONLY FOR THE SIX-WEEK POSTPARTUM PERIOD FOLLOWING DELIVERY.

Questions F1–F3.

See QxQs section **B,** questions **B6-B8.**

F1. **Maternal hemorrhage requiring surgical procedure** – Code YES if diagnosis AND/OR bleeding which required additional surgery to control the bleeding. Examples include retained placenta requiring curettage, placenta accreta requiring hysterectomy, vaginal lacerations requiring repair in an operating room.

F2. **Maternal hemorrhage requiring transfusion** – Code YES if diagnosis AND/OR bleeding that necessitated transfusion to maintain hemodynamic stability as defined by one of the following:

- To correct BP < 90/60 or HR > 120 BPM.
- To maintain hematocrit > 20.

F3. **Maternal hemorrhage postpartum with hemodynamic instability** – Code YES if BP < 90/60 or HR > 120 BPM and the participant was treated with fluid/volume expanders.

F4. **Endometritis**

Endometritis, also known as endomyometritis and parametritis, occurs in 25-75% of all women s/p cesarean section and 5% of women s/p vaginal delivery, and presents with postpartum febrile morbidity (> 100.4^{o} F), a boggy, tender uterus, slow uterine involution, and foul smelling lochia

rubra. Diagnosis may also be made based on endometrial cultures or endometrial biopsy. It is treated with gentamicin and clindamycin.

Code YES if diagnosis AND/OR oral temperature > 101°F or 38.4°C AND one of the following:

- Tender uterus to palpation.
- Foul smelling, purulent lochia.

F5. **Mastitis requiring antibiotics**

Mastitis, usually caused by *s. aureus,* most commonly occurs in breastfeeding women, and so should be a rare event among HIV+ mothers. It is characterized by fever, usually low-grade, with breast tenderness, induration, and redness. Treatment consists of ampicillin, compresses, and pumping the breast milk to enhance drainage.

Code YES if diagnosis AND/OR oral temperature > 101°F or 38.3°C, requiring treatment with antibiotics AND any two of the following:

- Unilateral breast (not nipple) pain.
- Erythema and induration in one area of the breast.
- Fluctuance of one area of the breast.

Questions F6-F7.

See QxQs for Form PR01, section **B,** questions **B8-B9.**

F6. **Cystitis requiring treatment** – Code YES if diagnosis AND/OR positive bacterial clean catch urine culture of >100,000 organisms/ml of a single type OR positive bacterial urine culture of organism in any amount from urine from sterile site (e.g., cathed specimen) OR in a patient who has symptoms of a urinary tract infection, >100 organisms/ml of a single type.

F7. **Pyelonephritis** – Code YES if diagnosis AND/OR clean catch urine culture of >100,000 organisms/ml of a single type AND maternal fever greater than 101° F of 38.3° C and costovertebral angle (CVA) tenderness.

F8. **Febrile morbidity** – For postpartum patients, febrile morbidity is defined as a temperature > 100.4^{o} F. Code YES if oral temperature ≥ 100.4°F or ≥ 38.°C after the first 24 hours post delivery or on any two occasions four hours apart in the first ten days postpartum.

F9. **Infection of cesarean incision**

Code YES if diagnosis of endometritis OR endomyometritis OR uterine wound infection.

If not applicable, circle code <-1>.

F10. **Episiotomy infection**

Code YES if diagnosis AND/OR oral temperature ≥ 100.4°F or ≥ 38°C on any two occasions four hours apart AND any one of the following:

- Pus drained from episiotomy.
- Episiotomy separates, debridement necessary.

If not applicable, circle code <-1>.

F11. **Other infection** – Code YES if diagnosis of specific infection AND/OR laboratory or diagnostic imaging confirmation. If YES, code 1 and specify on the line provided. If NO, code 2 and skip to F12. Examples include:

- Pelvic abscess – Clinical findings PLUS diagnostic imaging confirmation.
- Septic pelvic thrombophlebitis – Clinical findings AND a positive response to heparin therapy.

F12. **Postpartum tubal ligation**

Code YES only if tubal ligation is documented by operative report. Examples include Pomeroy, modified Pomeroy, Irving, Uchida, fimbriectomy.

F13. **Postpartum hysterectomy**

Code YES only if hysterectomy is documented by operative report.

F14. **Postpartum dilatation and curettage**

Code YES only if D & C is documented by operative report.

F15. **Other postpartum surgical procedure** – Specify surgery that is documented by operative report on the line provided. If no other surgical procedure, code 2 and skip to F16.

F16. **Other postpartum maternal complications** – Specify any medical or other conditions which occurred after delivery on the line provided. Examples include renal failure, pulmonary embolus, postpartum psychosis, thyroiditis. If patient required transfusion for any reason other than for hemorrhage as in F2, record it here.

SECTION G. MEDICATIONS ON DISCHARGE

G1. Indicate if any non-HIV-related medications were prescribed to the participant upon discharge. If "YES," specify the medications prescribed on the line provided. Record all non-HIV medications, including vitamins and analgesics.