Consultative Council on Obstetric and Paediatric Mortality and Morbidity
Victorian Perinatal Data Collection Unit

Victorian Perinatal News Bulletin

No. 2 June 2007

Welcome to the second edition of the Victorian Perinatal News Bulletin. This Bulletin has been designed to keep you up to date with information from the Victorian Perinatal Data Collection Unit (VPDCU).
Sonia Palma
HIM, VPDCU.

VPDCU Staff News

Gemma Wills has been appointed the new VPDCU Research and Liaison Midwife. She commenced working at the Unit on May 7th. One of Gemma's first priorities is to reduce the number of queries. She can be contacted on (03) 9096 0380 on Mondays, Tuesdays and Wednesdays.

Common queries we ask you

1. Ultrasound <13 weeks, 13-26 weeks

We generally query information on ultrasounds only if there is another query on the same perinatal form. For some reason there seems to be a problem with collecting this data item at some hospitals. Please be aware that if the number of ultrasounds is not known, "99" should be placed in the ultrasound field and not "00" as this is a valid response. Where the number of ultrasounds is left blank we insert "99" because we can not assume that there were no ultrasounds.

2. Talipes

A number of queries could be eliminated if "Talipes" was qualified with "structural" or "positional". For hospitals generating perinatal forms from computer systems, this could be achieved by adding these to the reference table for midwives to choose.

3. Neonatal Morbidity

Neonatal morbidity is a very important determinant of outcome of pregnancy and duration of hospital stay. It is important to include any neonatal morbidity up to the time of discharge of the baby on the perinatal form. This will reduce the number of queries especially for very premature babies.
Babies admitted to SCN or NICU without neonatal morbidity documented on the perinatal form will be followed up for the reason for admission.

Electronic Transfer of Data (ETOD) and Revision of the Perinatal form

As reported in the last Perinatal News Bulletin, work is currently underway on the ETOD project and revision of the perinatal form.

There will be a number of new data items for the new perinatal form, most of which midwives are already collecting, and changes to some existing data items making them more consistent with the National Health Data Dictionary format.

The new data items will need to be approved internally by the Data Management Advisory Committee and then legislated before they will be released for collection.

Sara Scalzo is working on the ETOD project and can be contacted on (03) 9096 2695. Currently the business process and requirements are being fleshed out.

We will keep you informed of our progress and the proposed implementation timelines once they are available.

Midwives Study Day 2007

The next Midwives Study Day will be held on Friday November 30th 2007. Details will be provided soon. Watch this space and mark the date in your diaries. The study day is a great opportunity to hear about how perinatal data is used for research and surveillance purposes. This year we are celebrating 25 years since the VPDCU began.

Feedback

The following email address, perinatal.data@dhs.vic.gov.au, is for you to communicate with us, whether it is for perinatal information, comments or concerns. We would appreciate your feedback on this bulletin. The next bulletin is scheduled for December 2007.

An audit on developmental dysplasia of the hip in Victoria, Australia, 2007

Developmental dysplasia of the hip (DDH) is a very important abnormality of the musculoskeletal system. Originally referred to as congenital dislocation of the hip (CDH), DDH is the 5th most common defect reported to the Victorian Birth Defects Register (VBDR).

Reporting of DDH to the Victorian Birth Defects Register

Many terms are used to describe aspects of this condition: developmental dysplasia of the hip, congenital dislocation of the hip, subluxed hip, unstable hip, dislocatable hip, clicky hip, clickable hip and so on. Usually only those cases described specifically as DDH/CDH are included in the VBDR. If any other terminology is used, the case is excluded, unless further investigation is required.

Over the past few years there has been an increase in the reporting of "clicky hips for investigation" on the Perinatal Morbidity Statistics form. The VBDR usually follows up the outcomes of these cases with the clinician. This has created more work not only for the VBDR but also for attending doctors/midwives.

Pilot follow-up of "clicky hips for investigation"

In 2005 a small pilot was conducted to determine how many cases of "clicky hip for investigation" resulted in the positive diagnosis of DDH. The outcomes are shown below:

Outcome	Number	%
No abnormality	22	84.6
DDH/CDH	1	3.8
Mild hip dysplasia	2	7.6
Other	1	3.8
Total	**26**	**100**

Of the 26 cases, 3 (11.4%) were eligible for inclusion in the VBDR. Therefore cases of "clicky hips for investigation" reported on the Perinatal Morbidity Statistics form cannot be ignored, as this would result in missing over 10% of cases.

The current study –

It has been decided to conduct a statewide study to follow-up all cases of hip abnormality reported to the VBDR within a six month period. In collaboration with the Orthopaedic Department at the Royal Children's Hospital, we aim to:

1. improve reporting and classification of hip anomalies.
2. determine the prevalence of DDH/CDH in Victoria over a six month period.
3. analyse the terminology used to report DDH/CDH.

<u>Methodology – How you may be involved</u>

1. VBDR will collect details of all cases of any hip abnormalities reported on the Perinatal Morbidity Statistics forms for children born between January 1, 2007 and June 30, 2007.

2. Each hospital will be contacted with a list of all babies reported for this period with any hip abnormality to obtain contact details of the treating paediatrician/general practitioner (GP) /Outpatient Department (OPD).

3. Letters will be sent to all treating clinicians requesting information on each case: diagnosis, age at diagnosis, investigations undertaken, and treatment if any.

4. For hip abnormalities that are reported through either Maternal & Child Health Nurses or private paediatricians similar follow-up and confirmation procedures will be adopted.

5. All cases of DDH reported via the hospital inpatient/outpatient listings obtained from each of the tertiary paediatric hospitals will be treated as a confirmed diagnosis.

Reporting of birth defects on the Perinatal Morbidity Statistics (PMS) Form

The reporting of birth defects on the PMS is a mandatory requirement. Nearly 50% of all notifications to the Victorian Birth Defects Register (VBDR) come from the PMS forms. It is important that midwives report all birth defects noted at birth to the VBDR to ensure that the data in the Register is complete.

Health Information Managers (HIMs) are also encouraged to notify the VBDR of any birth defects by using the electronic BDR form which can be found at www.health.vic.gov.au/perinatal/, otherwise Notification forms can be requested from the VPDCU directly.

The general rule for reporting to the VBDR is that if in doubt report the birth defect anyway. The VBDR can receive several notifications from different sources about the one child. Multiple notifications are encouraged.