



FORM-A

Acute Pancreatitis

The physical examination has to be done ON ADMISSION!
The blood for laboratory parameters has to be drawn ON ADMISSION!
This form has to be filled ON ADMISSION!

Questionnaire

1. Patient personal details

Insurance number:.....
 First name:.....
 Last name:,
 Date of birth:.....
 Gender: female male
 Ethnicity/Race: White / Black / Asian-Indian Not known

2. Details from the medical history

Alcohol consumption: yes / no
 if yes: frequency: occasionally/monthly/weekly/daily
 amount (g/day):.....
 since when? (years):.....
 Alcohol consumption in the last 2 weeks:

if not:
 Did you drink alcohol earlier? yes/no
 if yes: frequency: occasionally/monthly/weekly/daily
 amount (g/occasion):.....
 For how many years?.....
 How long ago did you stop drinking alcohol?.....

Guide for estimation of the amount:
 1 dl beer (4.5 vol. %) = ~3.5 g alcohol
 1 dl wine (12.5 vol. %) = ~10 g alcohol
 1 dl hard drink (50 vol. %) = ~40 g alcohol

Smoking: yes / no
 if yes: amount (cigarettes/day):.....
 For how many years?

if not:
 Did you smoke earlier? yes/no
 if yes: amount (pcs/occasion):.....
 For how many years?.....
 How long ago did you stop smoking?

Drug abuse: yes / no *Prescribed medication should not be included here.*
 if yes: type of drug:..... amount:.....
 since when (year):.....
 (if there are more drugs, please describe them in the NOTES section at the end)

Diabetes mellitus: yes / no
 if yes: type: Type I. / Type II./Type III. c / MODY
 since when (year):.....

Country:
Town:
Hospital:
Doctor:
Patient No:

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Lipid metabolism disorder: yes / no

if yes: type: since when (year):.....

Any disease of the pancreas: yes / no

Not counting the current episode.

if yes: acute pancreatitis/ chronic pancreatitis/ autoimmune pancreatitis/ tumor/ other

if other: please describe:.....

If the patient had ACUTE PANCREATITIS in the history:

How many times did the patient have acute episodes before this episode:.....

When did the patient have the first acute episode (year):.....

If the patient has CHRONIC/AUTOIMMUNE PANCREATITIS:

When was it diagnosed?.....

How many times did the patient have acute episodes before this episode:.....

When did the patient have the first acute episode (year):.....

If the patient has PANCREATIC CANCER::

When was it diagnosed?.....

Was the patient diagnosed with chronic pancreatitis? yes / no

If yes, when was it diagnosed?.....

How many times did the patient have acute episodes before this episode?:.....

When did the patient have the first acute episode (year):.....

Other information:

.....

Pancreas disorders in family history:

acute pancreatitis: yes / no if yes: relationship to patient:.....

chronic pancreatitis yes / no if yes: relationship to patient:.....

autoimmune pancreatitis: yes / no if yes: relationship to patient:.....

pancreas tumor: yes / no if yes: relationship to patient:.....

other (please describe):.....relationship to patient:.....

.....

Congenital Anatomical Malformation of the pancreas: yes / no / no data

if yes: please describe:.....

Other illnesses: yes / no

if yes: please list/describe them:.....

Medications taken regularly: yes / no *Please specify the name of the active substance (e.g. "acetylsalicylic acid"). Please specify the amount using the International System of Units –SI (e.g. milligram, gram)*

if yes:

name:.....active substance:.....dose(gram,milligram, etc.).....

if fluid, concentration (e.g. 10%, 1g/2ml, etc.).....how many times per day (e.g. 3)

type of administration:.....other notes:

name:.....active substance:.....dose(gram,milligram, etc.).....

if fluid, concentration (e.g. 10%, 1g/2ml, etc.).....how many times per day (e.g. 3)

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 type of administration:.....other notes:

Diet: yes / no
 if yes: please describe:.....

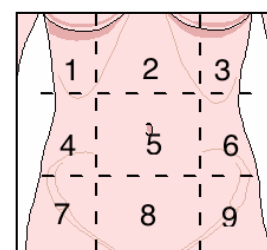
3. Etiology *The answer is “yes” if the etiological factor is proved, the answer is “no” if the etiological factor can be ruled out, the answer is “no data” if the etiological factor was not examined. Please answer “yes” to “Idiopathic” if etiological factor was not identified.*

Biliary	yes	no	no data
Alcohol	yes	no	no data
Virus infection	yes	no	no data
Trauma	yes	no	no data
Drug-induced	yes	no	no data
Congenital anatomical malformation	yes	no	no data
Cystic fibrosis	yes	no	no data
Gluten-sensitive enteropathy	yes	no	no data
Hypertriglyceridaemia	yes	no	no data
Genetic	yes	no	has not been tested yet
Idiopathic	yes	no	
Other	yes	no	

if yes: please describe:.....

4. Complains, symptoms

Abdominal pain: yes / no
 if yes: since when (hours):.....
 type: cramping / dull / sharp
 intensity (1-10):.....
 location: diffuse / localized
 Please mark the location!
 radiation:.....



Nausea: yes / no

Vomiting: yes / no
 if yes: how many times:.....
 contents of cast:.....



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Subfebrility/fever: yes / no

if yes: since when:.....
degree (°C):.....

Appetite: good / retained / bad

Weight loss: yes / no

if yes: how much (kg):.....
How long did it take? (weeks):.....

Jaundice: yes / no

if yes: for how long:.....

Stool: normal / diarrhea / constipation / fatty / putrid / undigested food/bloody/mucus

Please refer to the period just before your symptoms has started.

5. Admission details and state

Blood pressure (Hgmm):.....

Heart rate (/minute):.....

Body weight (kg):.....

Body height (cm):.....

Respiratory rate (/minute):.....

Body temperature (°C):

axillary/rectal

Oxygen saturation (%):

Previous O2 therapy: yes/no

Abdominal tenderness : yes / no

Abdominal guarding: yes / no

Jaundice: yes / no

Glasgow Coma Scale (GCS):.....

Glasgow Coma Scale:

Eye response

- 4 points: Spontaneous eye opening
- 3 points: Eye opening in response any speech
- 2 points: Opening to response to pain
- 1 point: No eye opening

Motor Response

- 6 points: Obeying command
- 5 points: Localizing response to pain
- 4 points: Withdraws to pain
- 3 points: Decorticate posture
- 2 points: Decerebrate posture
- 1 point: No response to pain

Verbal Response

- 5 points: Orientated
- 4 points: Confused conversation
- 3 points: Inappropriate speech
- 2 points: Incomprehensible speech
- 1 point: No verbal response.



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6. Laboratory parameters on admission

OBLIGATORY PARAMETERS:

Amylase (U/l)	
Lipase (U/l) <i>Obligatory if amylase is not measured. Please put 0 (zero) for amylase in this case)</i>	
White blood cell (WBC) count (G/l)	
Red blood cell (RBC) count (T/l)	
Hemoglobin (g/l)	
Hematocrit (%)	
Thrombocyte (G/l)	
Serum glucose (mmol/l)	
Blood urea nitrogen (mmol/l)	
Creatinine (umol/l)	
eGFR	
C-reactive protein (mg/l)	
ASAT/GOT (U/l)	
Lactate dehydrogenase LDH (U/l)	
Calcium (mmol/l)	

OTHER PARAMETERS (if measured):

Only arterial blood gas parameters should be registered.

Please indicate the measuring condition of blood gas parameters: Previous O2 therapy: yes/no

Sodium (mmol/l)	
Potassium (mmol/l)	
Total protein (g/l)	
Albumin (g/l)	
Cholesterol (mmol/l)	
Triglyceride (mmol/l)	
ALAT/GPT (U/l)	
Gamma GT (U/l)	
Total bilirubin (umol/l)	
Direct/Conjugated bilirubin (umol/l)	
Alkaline phosphatase (U/l)	
Erythrocyte sedimentation rate(ESR)/Westergren (mm/h)	
Procalcitonin (ng/ml)	
IgA (g/l)	
IgM (g/l)	
IgG (g/l)	
IgG4 (g/l)	
CA 19-9 (U/ml)	
PaO ₂ (Hgmm)	
HCO ₃ (mmol/l)	
sO ₂ (%)	
sweat chloride (mmol/l)	
urine amylase	
urine lipase	
urine creatinine	
(other)	

Virus serology: yes / no Which viruses? results:.....

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7. Imaging examinations on admission

Does the patient have pleural fluid? yes no N/A

Does the patient have lung infiltrate? yes no N/A

Does the patient have abnormal pancreatic structure? yes no N/A

If yes: hypoechoic/hyperechoic/peripancreatic fluid/irregular and blurred contours/Wirsung dilatation (above 1mm)/ascites/calcification/cyst

Abdominal ultrasonography: yes no

Description:

.....

.....

Abdominal X-ray: yes no

Description:

.....

.....

Chest X-ray: yes no

Description:

.....

.....

Chest Computed Tomography: yes no

Description:

.....

.....

Abdominal Computed Tomography: yes no

Description:

.....

.....

8. Genetic testing

Has it been performed earlier? yes no

if yes: please describe:

.....

.....

.....

9.a Intravenous fluid in the first 24 hours

Intravenous fluid in the first 24 hours.....ml

To be counted from the first moment until the end of the first 24 hours of medical treatment including ANY KIND of intravenous fluid (e.g. i.v. antibiotics) given by the ambulance, emergency unit and inpatient department.

9.b Immediate therapy on the day of admission

Intravenous fluid **yes** **no**
if yes: type of fluid.....
 amount (ml).....

The therapy questions refer to the day of admission from here.

Enteral feeding **yes** **no**
if yes: naso-gastric / naso-jejunal
 formula:
 amount:..... (ml)
 dilution: **yes** **no**

Pain management: **yes** **no**
if yes:
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if fluid, concentration (e.g. 10%, 1g/2ml, etc.).....how many times per day (e.g. 3)
type of administration:.....other notes:

Antibiotic therapy: **yes** **no**
if yes:
name:.....active substance:.....dose(gram,milligram, etc.).....
if fluid, concentration (e.g. 10%, 1g/2ml, etc.).....how many times per day (e.g. 3)
type of administration:.....other notes:

name:.....active substance:.....dose(gram,milligram, etc.).....
if fluid, concentration (e.g. 10%, 1g/2ml, etc.).....how many times per day (e.g. 3)
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if fluid, concentration (e.g. 10%, 1g/2ml, etc.).....how many times per day (e.g. 3)
type of administration:.....other notes:

Insulin: **yes** **no**
if yes: name of the medication:.....
 total dose of medication:.....

Intensive care: **yes** **no**
if yes: namely (ventilation, vasopressor therapy):.....

Other:
if yes: please describe:.....

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10. Interventions, endoscopic treatment:

		yes	no
if yes:	ERCP-EST/endobiliary stent/Wirsung stent/cysta drainage		
Stent:	1 plastic stent/more plastic stents/uncovered metal stent/covered metal stent		
Early complications:	none/bleeding/perforation		

ERCP:		yes	no
if yes:			
Successful biliary cannulation:	yes no		if yes: notes:
Precut:	yes no		if yes: needleknife/precut papillotomy
EST:	yes no		if yes: biliary/pancreatic
Stone extraction:	yes no		
Stent:	yes no		if yes: metal/plastic How many pcs? diameter(Fr)? length(cm)?
Pancreatic duct filling:	yes no		if yes: notes:

11. Complications *Please register pancreatic complication of fluid collection/pseudocyst/necrosis only if you had imaging proof on the day of admission, otherwise, please mark "no data".*

Pancreatic:		yes	no	no data
if yes:	fluid collections /pseudocyst / necrosis / diabetes			

Organ failure:		yes	no
if yes,:	lung /heart / kidney /other		

Death:		yes	no
	if yes: the exact time of death:		e.g. 10.25 or 22.45

12. Epicrisis *A short summary of the hospitalization (how the patient got to medical care, diagnosis, most important facts and events of the hospitalization, what happened with the patient after the hospitalization, any recommended control examinations, surgery).*

.....

.....

NOTES

.....

.....

DATE:

YEAR: MONTH: DAY: HOUR MIN:

NAME OF THE DOCTOR: **SIGNATURE:**