Country: Town:

Hospital:

Doctor:

**DATE:**

**ELEFANT NUMBER:**

**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. Inclusion criteria**

**Age 18 to 80 years** : YES NO
**Diagnosed acute pancreatitis**\*: YES NO
**TG level is at least** 1000 mg/dl (11.3 mmol/L) : YES NO
**Signed informed consent** : YES NO
One „NO” is present = DO NOT INCLUDE!

**Pregnancy or breast feeding** : YES NO
**Abdominal pain > 48 hours** : YES NO
**Coma** : YES NO
**Malignancy** : YES NO
**Early ARDS** : YES NO
**Renal failure** : YES NO
**Allergy to insulin or heparin** : YES NO

**Any reasons contraindicating plasmapheresis\*\*** : YES NO

One „YES” is present = EXCLUDE!

\*\*severe active bleeding or disseminated intravascular coagulation (htc level <20%), other forms of coagulopathy; hemodynamic instability; potassium plasma levels < 3.5 mEq/L, sepsis, allergy to albumin, serum calcium levels < 2.1 mmol/L (corrected calcium or ionized calcium); chronic heart failure (grade II or more of the NYHA or ejection fraction lower than 50%) or symptoms od fluid overload at recruitment, long QT syndrome.

**3. Details from the medical history**

* **Lipid metabolism disorder**: yes / no

if yes: type: ………………………………………………. since when (year):……………………………………….. Medications taken regulary for this condition: yes/no

if yes:

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

* **Alcohol consumption**: yes / no

if yes: frequency: occasionally/monthly/weekly/dayly

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):……………………………

* **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: ……………………………………………………………
* **Other illnesses**: yes / no

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

* **Family medical history:**

**Pancreas diseases in family:**  yes /no /no data

acute pancreatitis:                  yes /no /no data if yes, which relative:……………….…\*

chronic pancreatitis:             yes /no /no data if yes, which relative:……………….…\*

autoimmune pancreatitis:      yes /no /no data     if yes, which relative:………………….\*

pankreatic tumor:                   yes /no /no data      if yes, which relative:……………….…\*

other:…………………   yes /no /no data if yes, which relative:.............................\*

* **Medications taken regularly**: 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) 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) type of administration:………………………………………………..other notes: ………………………………………

**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**:………………………………………………..

**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):**……………………………………….

Eye response:
4 points: Spointsaneous eye opening
3 points: Eye opening in response any speech
2 points: Opening to response to pain
1 points: 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 points: No verbal response

Verbal Response:
5 points: Oriented
4 points: Confused conversation
3 points: Inappropriate speech
2 points: Incomprehensible speech
1 points: No verbal response.

**9. Randomization**

The patient will be randomized by an internet randomization module in the following 2 groups:

Randomization:
**A**. plasmapheresis

**B**. insulin and heparin treatment

**C**. no additional specific treatment

Please circle the relevant group after randomization:

If the patient is randomized into group A, B1 form should be filled 6,12,24,48 and 72 hours after randomization.

If the patient is randomized into group B, B2 form should be filled 6,12,24,48 and 72 hours after randomization.

A or B or C

If the patient is randomized into group C, B3 form should be filled 6,12,24,48 and 72 hours after randomization.

DATE:

YEAR: ……………… MONTH: ……………. DAY: ……………… HOUR …………………. MIN: ……………………………………