

NIDDK
Liver Transplantation Database
COMPLICATIONS - CMV INFECTION FORM

03/14/1990

COMPLETION LOG

Data Collector ID _____ - _____
Center Initials

DATE

Data Collection _____ / _____ / _____

Data Entry _____ / _____ / _____

Sysid _____

Verification _____ / _____ / _____

Cleaned _____ / _____ / _____

Transfer _____ / _____ / _____
MM DD YY

FORM KEYS

Patient ID _____

Transplant No. _____

Date of Outcome Evaluation ____ / ____ / ____

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PATIENT ID _____

TRANSPLANT NUMBER _____

*** To be completed for EACH EPISODE OF CMV, whether treated or untreated. Outcome evaluation to be done: 1) at 6 weeks after onset of the infection; 2) again at 4 months for those not resolved at 6 weeks.

I. 1. Is this episode of CMV infection

__ 1. New

__ 2. Relapse IF RELAPSE Relapse no. _____

__ 3. Persistent CMV (CMV (+) prior to this transplant)

__ 4. Persistent CMV (CMV (+) since this transplant)

__ 5. Unresolved at 6 weeks but currently not present

IF 5Go to VIII. Outcome on p.4

2. From time of first transplant, were only CMV (-) blood products given? Yes__ No__ Unk__

3. Was prophylactic CMV therapy given within 30 days after the most recent transplant? Yes__ No__

IF YES, specify type (30 char)

II. 1. Date of diagnosis (first positive culture and/or histology) of CMV infection MM DD YY

2. What triggered suspicion of CMV infection (check all that apply) DATE

__ 2.1 CMV serology conversion

__ 2.2 Positive cultures/histology

__ 2.3 Elevated LFT's

__ 2.4 Clinical symptoms

MM DD YY

IF YES, check all that apply

__ 1. Arthralgias __ 2. Fever __ 3. GI symptoms
__ 4. Pneumonia __ 5. Other specify (30 char)

3. Was diagnosis based on CMV serology conversion alone? Yes__ No__

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III. Was patient symptomatic during this episode?

Yes__ No__

IF YES, check all that apply

	Date of Onset
<input type="checkbox"/> 1. Arthralgias	____/____/____
<input type="checkbox"/> 2. Fever (Duration _____ days)	____/____/____
<input type="checkbox"/> 3. Jaundice	____/____/____
<input type="checkbox"/> 4. GI symptoms	____/____/____
<input type="checkbox"/> 5. Pneumonitis	____/____/____
<input type="checkbox"/> 6. Retinitis	____/____/____
<input type="checkbox"/> 7. Other _____ specify (30 char)	____/____/____ MM DD YY

IV. SEVERITY INDEX during this episode

Specify worst (check one)

- 1. Asymptomatic, outpatient/at home
- 2. Asymptomatic, in hospital
- 3. Symptomatic, outpatient/at home
- 4. Symptomatic, in hospital/admitted for other reasons
- 5. Symptomatic, in hospital/admitted for CMV
- 6. Symptomatic, in hospital ICU

V. BIOCHEMICAL PARAMETERS during this episode

		DATE OF SAMPLE
1. Alkaline phosphatase (U/L):	highest value _____	____/____/____
2. SGPT (ALT) (U/L):	highest value _____	____/____/____
3. Gamma GTP (U/L):	highest value _____	____/____/____
4. Total bilirubin (mg/dl):	highest value _____	____/____/____
5. Platelet Count x10 ³ (cells/mm ³):	lowest value _____	____/____/____
6. WBC x10 ³ (cells/mm ³):	lowest value _____	____/____/____ MM DD YY

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VI. Were cultures/tests done during this episode? Yes__ No__

IF YES, check all that apply

	RESULTS		DATE OF SAMPLE*
	Pos	Neg	
<input type="checkbox"/> 1. Blood culture	_____	_____	____/____/____
<input type="checkbox"/> 2. BAL culture			
<input type="checkbox"/> 2.1 Culture	_____	_____	____/____/____
<input type="checkbox"/> 2.2 Inclusion bodies	_____	_____	____/____/____
<input type="checkbox"/> 2.3 Immunoperoxidase monoclonal	_____	_____	____/____/____
<input type="checkbox"/> 2.4 Immunoperoxidase polyclonal	_____	_____	____/____/____
<input type="checkbox"/> 2.5 CMV DNA probing	_____	_____	____/____/____
<input type="checkbox"/> 3. CMV serology conversion	_____	_____	____/____/____
<input type="checkbox"/> 4. Urine culture	_____	_____	____/____/____
<input type="checkbox"/> 5. Liver biopsy			
<input type="checkbox"/> 5.1 Culture	_____	_____	____/____/____
<input type="checkbox"/> 5.2 Inclusion bodies	_____	_____	____/____/____
<input type="checkbox"/> 5.3 Immunoperoxidase monoclonal	_____	_____	____/____/____
<input type="checkbox"/> 5.4 Immunoperoxidase polyclonal	_____	_____	____/____/____
<input type="checkbox"/> 5.5 CMV DNA probing	_____	_____	____/____/____
<input type="checkbox"/> 6. Open lung biopsy			
<input type="checkbox"/> 6.1 Culture	_____	_____	____/____/____
<input type="checkbox"/> 6.2 Inclusion bodies	_____	_____	____/____/____
<input type="checkbox"/> 6.3 Immunoperoxidase monoclonal	_____	_____	____/____/____
<input type="checkbox"/> 6.4 Immunoperoxidase polyclonal	_____	_____	____/____/____
<input type="checkbox"/> 6.5 CMV DNA probing	_____	_____	____/____/____
<input type="checkbox"/> 7. GI biopsy			
<input type="checkbox"/> 7.1 Culture	_____	_____	____/____/____
<input type="checkbox"/> 7.2 Inclusion bodies	_____	_____	____/____/____
<input type="checkbox"/> 7.3 Immunoperoxidase monoclonal	_____	_____	____/____/____
<input type="checkbox"/> 7.4 Immunoperoxidase polyclonal	_____	_____	____/____/____
<input type="checkbox"/> 7.5 CMV DNA probing	_____	_____	____/____/____
<input type="checkbox"/> 8. Other _____ specify (30 char)	_____	_____	____/____/____ MM DD YY

* For first positive culture; or if always negative, date of most recent sample.

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VII. Was treatment given? Yes__ No__

IF YES, check all that apply

<input type="checkbox"/> 1. Gancyclovir	Dates: from	____/____/____	to	____/____/____
		MM DD YY		MM DD YY
Total dose _____ mg				
<input type="checkbox"/> 2. Reduce protocol immunosuppressive medications				
<input type="checkbox"/> 3. Other _____				
specify (30 char)				

VIII. Outcome (check one)

Date of evaluation

____/____/____
MM DD YY

1. Not evaluated; no cultures done

2. Persistent CMV

IF YES, check all that apply

<input type="checkbox"/> 2.1 Viuria
<input type="checkbox"/> 2.2 Viremia
<input type="checkbox"/> 2.3 Other _____
specify (30 char)

3. Cure

Date ____/____/____

4. Retransplant

Date ____/____/____

5. Death from CMV

Date ____/____/____

6. Death from other causes

Date ____/____/____
MM DD YY

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