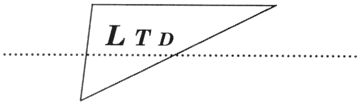
IS



NIDDK

Liver Transplantation Database

INTRA-OPERATIVE SURGEON ASSESSMENT FORM

01/30/1991

DONOR ID ________________________________

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. ________

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INTRA-OPERATIVE SURGEON ASSESSMENT FORM
NIDDK Liver Transplantation Database

PATIENT ID ___________-___________________________

TRANSPLANT NO. ______

DATE OF TRANSPLANT (at time of closure) _____/_____/_____ MM DD YY

I. SURGEON ASSESSMENT OF DONOR LIVER

1. ASSESSMENT OF LIVER

	AT END (after biliary reconstruction) Yes	No
1.1 Consistency/texture: normal	____	____
1.2 Perfusion/color: well perfused	____	____
1.3 Injury/trauma	____	____

2. OVERALL QUALITY OF LIVER (check one) 1. Good __ 2. Fair __ 3. Poor __

3. BILE PRODUCTION (check one) 1. Good __ 2. Fair __ 3. Poor __

II. TYPE OF ARTERIAL ANASTOMOSIS (Final)

1. **Donor** (check one)

__ 1. Celiac axis with aortic patch

__ 2. Celiac axis

__ 3. Common hepatic artery

__ 4. Superior mesenteric artery single vessel

__ 5. SMA with composite SMA - celiac patch

__ 6. Aortic conduit

__ 7. Other ____
specify (30 char)

2. **Recipient** (check one)

__ 1. Celiac axis

__ 2. Common hepatic artery

__ 3. Proper hepatic artery

__ 4. SMA hepatic artery

__ 5. Aorta

__ 6. Splenic

__ 7. Other ____
specify (30 char)

3. Was iliac interposition graft done? Yes__ No__

4. Anastomosis redone? Yes__ No__

IF YES, reason

__ 4.1 Poor blood flow

__ 4.2 Other ____
specify (30 char)

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III. TYPE OF PORTAL VEIN RECONSTRUCTION (Final)

1. **Donor portal vein** to: (check one)

__ 1. Recipient portal vein

__ 2. Recipient portal vein with interposition graft

__ 3. SMV with interposition graft

__ 4. Other ____
specify (30 char)

2. REDONE? Yes__ No__

IF YES

2.1 Reason ____ specify (30 char)

IV. BILIARY ANASTOMOSIS PERFORMED (check one)

__ 1. Choledochocholedochostomy with T tube

__ 2. Choledochojejunostomy

__ 3. Other ____
specify (30 char)

V. INTRAOPERATIVE SURGICAL PROCEDURES Yes__ No__

IF YES, check all that apply

__ 1. Bowel perforation/resection

__ 2. Splenectomy

__ 3. Ligate splenic artery

__ 4. Graft size reduction

IF YES, check segments transplanted (see diagram on opposite page)

__ 1.	__ 5.
__ 2.	__ 6.
__ 3.	__ 7.
__ 4.	__ 8.

__ 5. Umbilical hernia repair

__ 6. Ligation of prior portosystemic shunt

__ 7. Other ____

__ 8. Other ____
specify (30 char)

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VI. PREVIOUS ABDOMINAL/SHUNT SURGERIES Yes__ No__
IF YES, check all that apply

__ 1. Biliary enterostomy
__ 2. Portosystemic shunts IF YES — Taken down during surgery? Yes__ No__
__ 3. Peritoneal (LeVeen, Denver) shunts
__ 4. Proctocolectomy
__ 5. Cholecystectomy
__ 6. Previous ulcer surgery, specify type ______________________________ (30 char)
__ 7. Splenectomy
__ 8. Gynecological surgery
__ 9. Other ______________________________
__10. Other ______________________________
specify (30 char)

VII. MISCELLANEOUS INFORMATION ITEMS

1. ASCITES at time of initial opening Yes__ No__

   IF YES — 1.1 Specify quantity removed ________ liters

2. OTHER ORGAN TRANSPLANT DONE? Yes__ No__
   IF YES, check all that apply

__ 2.1 Bowel	__ 2.4 Heart
__ 2.2 Pancreas	__ 2.5 Heart/lung
__ 2.3 Kidney	__ 2.6 Other ______________________ specify (30 char)

VIII. PATIENT'S CONDITION AT THE END OF SURGERY (check one)

__ 1. Did not survive surgery
__ 2. Unstable blood pressure requiring vasopressors
__ 3. Stable blood pressure but urine output less than or equal to 1 ml/kg/hr
__ 4. Stable blood pressure and urine output greater than 1 ml/kg/hr

IX. SURGEON OF RECORD __________-____________________
Center # (2 char) Initials (3 char)

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PATIENT ID __________-________________________

X. COMMENTS: Yes__ No__

IF YES

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____
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____
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(60 char/line)

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