

Hospitalization Flowsheet

DATA SECTION	COMPLETION INSTRUCTIONS
GENERAL INFORMATION	<p>The Hospitalization Flowsheet records daily in-hospital laboratory, procedural, treatment, and event information from up to 5 days prior to enrollment in the PALF registry through up to 7 (or 8) days after enrollment in the PALF registry or NAC trial (until the first of successful hospital discharge, transplantation, or death).</p> <p>The flowsheet is setup as an Excel spreadsheet and may be accessed via the project website.</p> <p>Enter the Patient ID, <b>initial</b> hospital admission date, PALF registry enrollment date, and NAC trial enrollment date, if applicable. Select “Y” (yes) or “N “ (no) from the dropdown box to indicate whether or not the first daily sample was collected on the day of registry enrollment. The spreadsheet will calculate and display the assessment dates according to the information entered. If the first sample was obtained on the day of enrollment, the spreadsheet will generate a 7-day study period. If the first sample was obtained on the day after study enrollment, the spreadsheet will generate an 8-day study period. Print the spreadsheet and use for data collection.</p> <p>The last column of the spreadsheet is dedicated to the day of discharge, transplant, or death, provided the first of these events occurs after the 7 (or 8) day assessment period. Record information in this column only if the first of these events occur after the daily assessments are complete. If the first of these events occur during the 7(or 8) day period, record the information in the appropriate column and do not use the ‘discharge’ column of the spreadsheet.</p>
LABORATORY RESULTS	<p><b>GENERAL INSTRUCTIONS:</b></p> <p>Record the results from samples drawn for laboratory tests within each 24 hour calendar day (midnight to 11:59PM) according to the units specified.</p> <p>If a specific test is performed more than once in a given day, record the result from the first test performed that day.</p> <p>If a test was not performed on a given day, record ND (not done).</p>
MEASUREMENTS, TREATMENTS, AND EVENTS	<p><b>GENERAL INSTRUCTIONS:</b></p> <p>Record the appropriate measurement or circle “Y” (yes) or “N” (no) to indicate whether the specified event, treatment, or procedure occurred, was present, or was performed for each 24 hour calendar day.</p> <p>If an event, treatment, or procedure occurs over the course of the assessment period, circle “Y” (yes) only when the event, treatment, or procedure applies to the specific 24 hour interval, otherwise circle “N” (no). For example, a patient who receives hemodialysis every other day – circle “Y” on the dates that dialysis was performed, and “N” on the dates that dialysis was not performed.</p>

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	<p><b>SPECIFIC INSTRUCTIONS:</b></p> <p><u>BP (blood pressure):</u> record the first measurement obtained on each assessment date. Record systolic/diastolic blood pressure in mmHg.</p> <p><u>Coma grade:</u> record the maximum coma grade for each assessment date.</p> <p>For patients ranging from 3 to 10 years of age, use the standard clinical scales to assess encephalopathy. For younger patients use the Peter Whittington scale.</p> <p>If the coma grade cannot be assessed, check "not assessable". Standard Clinical Scales:</p> <table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr> <th>Stage</th> <th>Clinical</th> <th>Asterixis/Reflexes</th> <th>Neurological signs</th> <th>EEG changes</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>None</td> <td>None/normal</td> <td>Psych testing only</td> <td>Normal</td> </tr> <tr> <td>I</td> <td>Confused, mood changes, altered sleep habits, loss of spatial orientation, forgetful</td> <td>None/normal</td> <td>Tremor, apraxia, impaired handwriting</td> <td>Normal or diffuse slowing to theta rhythm, triphasic waves</td> </tr> <tr> <td>II</td> <td>Drowsy, inappropriate behavior, decreased inhibitions</td> <td>None/ hyperreflexic</td> <td>Dysarthria, ataxia</td> <td>Abnormal generalized slowing, triphasic waves</td> </tr> <tr> <td>III</td> <td>Stuporous, obeys simple commands</td> <td>None/hyperreflexia, up-going toes (+ Babinski)</td> <td>Rigidity</td> <td>Abnormal generalized slowing, triphasic waves</td> </tr> <tr> <td>IV</td> <td>Comatose, arouses with painful stimuli (IVa), or no response (IVb)</td> <td>Absent</td> <td>Decerebrate or decorticate</td> <td>Abnormal, very slow delta activity</td> </tr> </tbody> </table> <p><b>Peter Whittington Scale:</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Stage</th> <th>Clinical</th> <th>Asterixis/Reflexes</th> <th>Neurological signs</th> </tr> </thead> <tbody> <tr> <td>Early (I and II)</td> <td>Inconsolable crying, sleep reversal, inattention to task</td> <td>Unreliable/ normal or hyperreflexic</td> <td>Untestable</td> </tr> <tr> <td>Mid (III)</td> <td>Somnolence, stupor, combativeness</td> <td>Unreliable/hyperreflexic</td> <td>Most likely untestable</td> </tr> <tr> <td>Late (IV)</td> <td>Comatose, arouses with painful stimuli (IVa) or no response (IVb)</td> <td>Absent</td> <td>Decerebrate or decorticate</td> </tr> </tbody> </table>	Stage	Clinical	Asterixis/Reflexes	Neurological signs	EEG changes	0	None	None/normal	Psych testing only	Normal	I	Confused, mood changes, altered sleep habits, loss of spatial orientation, forgetful	None/normal	Tremor, apraxia, impaired handwriting	Normal or diffuse slowing to theta rhythm, triphasic waves	II	Drowsy, inappropriate behavior, decreased inhibitions	None/ hyperreflexic	Dysarthria, ataxia	Abnormal generalized slowing, triphasic waves	III	Stuporous, obeys simple commands	None/hyperreflexia, up-going toes (+ Babinski)	Rigidity	Abnormal generalized slowing, triphasic waves	IV	Comatose, arouses with painful stimuli (IVa), or no response (IVb)	Absent	Decerebrate or decorticate	Abnormal, very slow delta activity	Stage	Clinical	Asterixis/Reflexes	Neurological signs	Early (I and II)	Inconsolable crying, sleep reversal, inattention to task	Unreliable/ normal or hyperreflexic	Untestable	Mid (III)	Somnolence, stupor, combativeness	Unreliable/hyperreflexic	Most likely untestable	Late (IV)	Comatose, arouses with painful stimuli (IVa) or no response (IVb)	Absent	Decerebrate or decorticate
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	<p><u>Seizures</u>: clinical evidence of focal myoclonic and generalized tonic-clonic seizure with or without EEG confirmation.</p> <p><u>GI bleed</u>: intestinal blood loss requiring blood products for resuscitation.</p> <p><u>Cardiac arrhythmias</u>: confirmed by 12-lead EKG</p> <p><u>Acute renal failure</u>: defined as serum creatinine &gt; 2 times the upper limit of normal for age and urine output less than 0.5cc/kg/hour.</p> <p><u>PCWP</u>: Pulmonary capillary wedge pressure</p> <p><u>NAC route of administration</u>: For each day, indicate whether NAC was given via an IV, by mouth (PO) or not at all, by circling IV, PO, or n/a (not applicable). Record NAC use regardless of whether or not it was given for acetaminophen toxicity.</p> <p><u>External liver support</u>: Record whether any type of external liver support was provided, including but not limited to ELAD or BAL.</p> <p><u>Blood products</u>: record whether red blood cells, fresh frozen plasma, or platelets were given on each assessment date and the cumulative amount given, in cc's, throughout the assessment period.</p> <p><u>Antioxidant cocktail</u>: For each day, indicate whether an antioxidant cocktail was given by circling the components given or n/a (not applicable). Include only components ordered or prescribed as treatment. Do not include antioxidants that may have been taken or ingested by the patient (example – blueberries for breakfast).  D = desferrioxamine  L = liqui-E  N = N-acetylcysteine  P = prostaglandins  S = selenium  n/a = not applicable (none of the components given)</p> <p><u>Other treatments</u>: record whether any other treatment, not included in the list, was given.</p> <p><u>Comments</u>: Record other relevant information not collected on the daily flowsheet.</p> <p><u>Plasma collected</u>: A plasma sample is to be collected on the day of enrollment into the registry or as soon as possible following enrollment into the registry. Circle "Y" (yes) on the day plasma is collected. Circle "N" (no) on the days plasma is not collected.</p>