Database **BARC** **Form 25C Ascending Cholangitis**

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___ A2. Date: ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year) A3. Study Staff ID/Initials: ___ ___ ___

A4. Follow-up visit (month): 2 Week ☐ 1 ☐ 2 ☐ 3 ☐ 6 ☐ OR Age: ___ ___ mo/yr To DCC ☐

ASCENDING CHOLANGITIS

B1. Sequence number ___ ___

B2. Date of presentation/onset ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)

B3. Date of resolution ___ ___ / ___ ___ / ___ ___ ___ ___ OR 1. ☐ Continuing

B4. Patient was hospitalized 1. ☐ No → **Go to C1** 2. ☐ Yes

a. Date of admission ___ ___ / ___ ___ / ___ ___ ___ ___

b. Date of discharge ___ ___ / ___ ___ / ___ ___ ___ ___ OR 1. ☐ Continuing

C1. Total WBC ___ ___ . ___ $10^3/mm^3$ 8. ☐ ND→**Go to C2**

a. Date ___ ___ / ___ ___ / ___ ___ ___ ___

C2. Blood culture 1. ☐ Negative 2. ☐ Positive 8. ☐ ND→**Go to C4**

a. Date ___ ___ / ___ ___ / ___ ___ ___ ___

C3. If blood culture is positive, organism present *(check all that apply)*

a. ☐ Bacteroides species
b. ☐ Clostridium species
c. ☐ Enterobacter species
d. ☐ Enterococcus
e. ☐ Escherichia coli
f. ☐ Klebsiella species
g. ☐ Proteus species
h. ☐ Pseudomonas species
i. ☐ Other:_____

C4. Resistance to Bactrim 1. ☐ Negative 2. ☐ Positive 8. ☐ ND

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___ A2. Date:___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

ASCENDING CHOLANGITIS (continued)

C5. Liver aspirate culture 1. ☐ Negative 2. ☐ Positive 8. ☐ ND→**Go to C7**

a. Date ___ ___ / ___ ___ / ___ ___ ___ ___

C6. If liver aspirate culture is positive, organism present *(check all that apply)*

a. ☐ Bacteroides species
b. ☐ Clostridium species
c. ☐ Enterobacter species
d. ☐ Enterococcus
e. ☐ Escherichia coli
f. ☐ Klebsiella species
g. ☐ Proteus species
h. ☐ Pseudomonas species
i. ☐ Other:_____

C7. Interventions taken *(check all that apply)*

a. ☐ None
b. ☐ Antibiotics (Specify type and duration:_____)
c. ☐ Steroids
d. ☐ Reoperation
e. ☐ Other:_____

C8. Liver biopsy performed 1. ☐ No 2. ☐ Yes

C9. Data confirmed by medical record 1. ☐ No 2. ☐ Yes

Investigator/Coordinator Signature:_____ Date:___ ___/___ ___/___ ___ ___ ___
Month Day Year