

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 _____ . _____ $10^3/\text{mm}^3$ 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

e. Escherichia coli

b. Clostridium species

f. Klebsiella species

c. Enterobacter species

g. Proteus species

d. Enterococcus

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. <input type="checkbox"/> Bacteroides species | e. <input type="checkbox"/> Escherichia coli |
| b. <input type="checkbox"/> Clostridium species | f. <input type="checkbox"/> Klebsiella species |
| c. <input type="checkbox"/> Enterobacter species | g. <input type="checkbox"/> Proteus species |
| d. <input type="checkbox"/> Enterococcus | h. <input type="checkbox"/> Pseudomonas species |
| i. <input type="checkbox"/> 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