

Patient Case Report Form - PSP-Study

Patient Baseline Data

Patient Study Number

Birth date (dd/mm/yyyy)

Gender

Male Female

Ethnicity

Caucasian

Asian

African

Other/mix _____

Height (m)

Weight (kg)

BMI (body-mass-index kg/m²)

Underlying Disease / Reason for Admission

Malignant

Yes

No

Admission Date (dd/mm/yyyy)

Patient Case Report Form - PSP-Study

Operation Data

Operation Date (dd/mm/yyyy)

Operation Type

- General Surgery
- Emergency Abdominal Surgery
- (Major) Endocrine Surgery
- Upper-Gastrointestinal Surgery
- Lower-Gastrointestinal Surgery
- Hepato-Pancreato-Biliary Surgery
- Transplantation
- Undefined

Operation (Text description)

Postoperative SIRS

Yes

No

Postoperative Sepsis

Yes

No

Blood Cultures Positive

Yes

No

Type of Microbiota

Gram positive

Gram negative

Fungi

Viral

Please specify microbiota type: _____

Preoperative Antibiotics (AB)?

Yes

No

Preoperative AB-Type

Co-Amoxicillin (or similar)

(multiple choices possible)

Cephalosporin

Chinolone (Ciproxin and similar)

Metronidazole

Piperacillin/Tazobactam

Carbapenem

Vancomycin/Daptomycin

Other, please indicate: _____

| | | |
|---|------------------------------------|--------------------------|
| Postoperative AB-Prophylaxis? | Yes | <input type="checkbox"/> |
| | No | <input type="checkbox"/> |
| Postoperative Prophylaxis AB-Type (multiple choices possible) | Co-Amoxicillin (or similar) | <input type="checkbox"/> |
| | Cephalosporin | <input type="checkbox"/> |
| | Chinolone (Ciproxin and similar) | <input type="checkbox"/> |
| | Metronidazole | <input type="checkbox"/> |
| | Piperacillin/Tazobactam | <input type="checkbox"/> |
| | Carbapenem | <input type="checkbox"/> |
| | Vancomycin/Daptomycin | <input type="checkbox"/> |
| Other, please indicate: _____ | <input type="checkbox"/> | |
| Postoperative AB-Therapy? | Yes | <input type="checkbox"/> |
| | No | <input type="checkbox"/> |
| Indication for Start of Postoperative AB | Fever | <input type="checkbox"/> |
| | Increasing inflammatory parameters | <input type="checkbox"/> |
| | SIRS (empirical) | <input type="checkbox"/> |
| | Sepsis (empirical) | <input type="checkbox"/> |
| | Sepsis (directed therapy) | <input type="checkbox"/> |
| | Other, please indicate: _____ | <input type="checkbox"/> |
| Date Start of Postoperative AB-Therapy? (= postoperative Day X); (dd/mm/yyyy) | | |
| Postoperative AB-Therapy Type (multiple choices possible) | Co-Amoxicillin (or similar) | <input type="checkbox"/> |
| | Cephalosporin | <input type="checkbox"/> |
| | Chinolone (Ciproxin and similar) | <input type="checkbox"/> |
| | Metronidazole | <input type="checkbox"/> |

| | | |
|---|---|--------------------------|
| | Piperacillin/Tazobactam | <input type="checkbox"/> |
| | Carbapenem | <input type="checkbox"/> |
| | Vancomycin/Daptomycin | <input type="checkbox"/> |
| | Other, please indicate: _____ | <input type="checkbox"/> |
| AB Change / Escalation | Yes | <input type="checkbox"/> |
| | No | <input type="checkbox"/> |
| Date AB Change / Escalation (= postoperative Day X); (dd/mm/yyyy) | | |
| Indication for AB Change/Escalation | Fever | <input type="checkbox"/> |
| | Increasing inflammatory parameters | <input type="checkbox"/> |
| | SIRS (empirical) | <input type="checkbox"/> |
| | Sepsis (empirical) | <input type="checkbox"/> |
| | Sepsis (directed therapy) | <input type="checkbox"/> |
| | Microbiology Report with AB-Resistogram | <input type="checkbox"/> |
| | Other, please indicate: _____ | <input type="checkbox"/> |
| Date AB STOP (regardless of indication) (= postoperative Day X); (dd/mm/yyyy) | | |
| Antifungal Therapy | Yes | <input type="checkbox"/> |
| | No | <input type="checkbox"/> |
| Preoperative Antifungal Therapy | Yes | <input type="checkbox"/> |
| | No | <input type="checkbox"/> |

| | | |
|---|-------------------------------|--------------------------|
| Preoperative Antifungal Therapy Type | Fluconazole | <input type="checkbox"/> |
| | Itraconazole | <input type="checkbox"/> |
| | Voriconazole | <input type="checkbox"/> |
| | Caspofungin | <input type="checkbox"/> |
| | Ampho B | <input type="checkbox"/> |
| | Other, please indicate: _____ | <input type="checkbox"/> |
| Postoperative Antifungal Prophylaxis | Yes | <input type="checkbox"/> |
| | No | <input type="checkbox"/> |
| Postoperative Antifungal Prophylaxis Type | Fluconazole | <input type="checkbox"/> |
| | Itraconazole | <input type="checkbox"/> |
| | Voriconazole | <input type="checkbox"/> |
| | Caspofungin | <input type="checkbox"/> |
| | Ampho B | <input type="checkbox"/> |
| | Other, please indicate: _____ | <input type="checkbox"/> |
| Postoperative Antifungal Therapy | Yes | <input type="checkbox"/> |
| | No | <input type="checkbox"/> |
| Postoperative Antifungal Therapy Type | Fluconazole | <input type="checkbox"/> |
| | Itraconazole | <input type="checkbox"/> |
| | Voriconazole | <input type="checkbox"/> |
| | Caspofungin | <input type="checkbox"/> |
| | Ampho B | <input type="checkbox"/> |
| | Other, please indicate: _____ | <input type="checkbox"/> |
| Postoperative Antifungal Change/Escalation | Yes | <input type="checkbox"/> |
| | No | <input type="checkbox"/> |

**Indication for Antifungal
Change/Escalation**

- Fever
- Increasing inflammatory parameters
- SIRS (empirical)
- Sepsis (empirical)
- Sepsis (directed therapy)
- Microbiology Report with AB-Resistogram
- Other, please indicate: _____

**Date Antifungal Therapy Change/Escalation
(dd/mm/yyyy)**

**Date Antifungals STOP
(= postoperative Day X); (dd/mm/yyyy)**

Re-Operation?

- Yes
- No

**Re-Operation Date (dd/mm/yyyy)
(= postoperative Day X)**

Re-Operation Type (text)

Re-Operation times

- 1
- 2
- 3
- 4
- 5
- >5

Pre-Reoperation Diagnostics?

Yes

No

Pre-Reoperation Diagnostisc Type

Conventional X-ray

CT-Scan

Other, please indicate: _____

**Postoperative Intervention (e.g. drain-
placement through radiologist etc.)**

Yes

No

**Postoperative Intervention Date
(= postoperative Day X); (dd/mm/yyyy)**

Postoperative Intervention Type (text)

Postoperative Intervention Times

1

2

3

4

5

>5

ICU-Readmission

Yes

No

ICU-Readmission Date (dd/mm/yyyy)

ICU-Readmission LOS

Hospital Discharge

Yes

No

If no, please indicate if

a) in hospital death

b) other reason

Hospital Discharge Date (dd/mm/yyyy)

Hospital Total Length of Stay (LOS)

Patient Case Report Form - PSP-Study

Laboratory Values

White Blood Cell Count (WBC)

WBO 0 (Baseline)

WBC 1 (Day 1)

WBC 2

.....

WBC XY (Day of discharge)

C-Reactive Protein

CRP 0 (Baseline)

CRP 1

CRP 2

....

CRP XY

Procalcitonin

PCT 0

PCT 1

PCT 2

...

PCT XY

Thrombocytes

TC 0

TC 1

TC 2

...

TC XY

Pancreatic Stone Protein

PSP 0

PSP 1

PSP 2

...

PSP XY

Pancreatitis-associated Protein

PAP 0

PAP 1

PAP 2

...

PAP XY