Form for Delayed Splenic Rupture After Non-Operative Management of Blunt Splenic Injury

**Standard Study Questions**

 Is this patient ONLY on the Western Trauma Association study? **Yes, No**

 Admit Date This field is required.

 Admit Time (24 hr) This field is required.

 Age (years) Only integer values This field is required.

 Gender **Male, Female**

 Race **White, African-American, Asian, Other**

 Ethnicity **Hispanic, Non-Hispanic**

 Height (cm) Only integer values

 Weight (kg) Only integer values

 Charlson Comorbidity Index Only integer values

 Has the Patient Had Any of the Following

 At Least One Dose of Coumadin Within 7 Days of Admission **Yes, No, Unknown**

 At Least One Dose of Aspirin Within 7 Days of Admission **Yes, No, Unknown**

 At Least One Dose of Clopidrogrel Within 7 Days of Admission **Yes, No, Unknown**

 At Least One Dose of Any Other Anti-Platelet Drug Within 7 Days of Admission **Yes, No, Unknown**

 Is the Patient A Smoker **Yes, No, Unknown**

 If Yes, How Many Pack-Years This field is required.

Has the Patient Had Previous Abdominal Surgery **Yes, No**

 If Yes, Is The Only Surgery Patient Has Had Laproscopic **Yes, No This field is required.**

**Case Information**

 **Mechanism of initial injury**

 Blunt

**MVC**

**Auto vs. Peds**

**Fall**

**Assault**

**MCC**

**Machinery**

**Other**

 Date of Injury

 AIS Head Only integer values

 AIS Chest Only integer values

 AIS Abdomen Only integer values

 AIS Extremity Only integer values

 ISS Only integer values

Spinal Cord Injury **Yes, No**

 If Yes, At What Level This field is required.

 Admission GCS Only integer values

 Best 24 hour GCS Only integer values

 **Associated Intra-Abdominal Injuries**

 **Liver**

 **Right Kidney**

 **Left Kidney**

 **Stomach**

 **Small Bowel**

 **Large Bowel**

 **Admission Vital Signs**

 Admission Systolic Blood Pressure (mmHg) Integer values only

 Hospital Date

 Time (24 hr)

 Lowest SBP Within 1 Hour of Admission (mmHg)

 Hospital Date

 Time (24 hr)

 Highest SBP Within 1 Hour of Admission (mmHg)

 Hospital Date

 Time : (24 hr)

 Admission Heart Rate (BPM) Integer Values Only

 Hospital Date

 Time (24 hr)

 Lowest Heart Rate Within 1 Hour of Admission (BPM)

 Hospital Date

 Time (24 hr)

 Highest Heart Rate Within 1 Hour of Admission (BPM) Integer values only

 Hospital Date

 Time (24 hr)

 **Admission Lab Values**

 pH Decimal values only

 Base Deficit Decimal values only

 Lactate mg/DL Decimal values only

 HCT % Integer values only

 Hemoglobin Decimal values only

 PLT (x1000) Decimal values only

 INR Decimal values only

 PTT (Seconds) Decimal values only

 **Splenic Injury Grade**

 AAST Spleen Injury Grade **I, II, III, IV, V** This field is required.

Diagnosed By **Laparotomy, Abdominal CT with IV Contrast, Abdominal CT without IV Contrast**

 **Note: if diagnosis was made using CT, base AAST Injury Grade on official reading by attending radiologist at your institution and submit electronic copy of CT scan. If diagnosis was made at surgery, please have attending surgeon grade the spleen injury**

 **Admission Diagnosis and Management**

 If CT Used Was It A Multi-Detector Scanner **Yes, No** This field is required.

 If Yes, How Many Detectors Does the CT Scanner Have **4, 8, 16, 32, 64, > 64** This field is required.

 Date of Initial CT

 Time of Initial CT (24 hr)

 Splenic Pseudoaneurysm on Admission CT **Yes, No** This field is required.

 Any Intervention Performed **Yes, No** This field is required.

 If Yes, Did Patient Have **Splenectomy, Splenorrhaphy, Splenic Angiogram without EMBO, Splenic Angiogram with EMBO** This field is required.

 Location of Splenic Angiogram With EMBO **Main Splenic Atery, Selective, Both** This field is required.

 Method **Coils, Particles, Both** This field is required.

 Contrast Blush on Admission CT **Yes, No** This field is required.

 Any Intervention Performed **Yes, No** This field is required.

 If Yes, Did Patient Have **Splenectomy, Splenorrhaphy, Splenic Angiogram without EMBO, Splenic Angiogram with EMBO** This field is required.

 Location of Splenic Angiogram With EMBO **Main Splenic Atery, Selective, Both** This field is required.

 Method **Coils, Particles, Both** This field is required.

 Other Indication for Embolization (choose all that apply) At least one of these is required.

 **Prophylactic Due to Injury Grade**

 **Vessel Cut off**

 **Other**

 Other Indication for Splenic Angiogram (choose all that apply) At least one of these is required.

 **Hemodynamic Instability**

 **Precipitous Drop in HCT**

 **Need for Transfusion**

 **Other**

**Additional Management After Initial Treatment**

 Repeat Splenic Angiogram **Yes, No**

 Date This field is required.

 Indication At least one of these is required.

 **Hemodynamic Instability**

 **Precipitous Drop in HCT**

 **Splenic Pseudoaneurysm**

 **Splenic Cyst**

 **Need for Transfusion**

 **Other**

 Any Intervention Performed **Yes, No**

 If Yes, Did Patient Have **Splenic Angiogram with EMBO, Splenic Angiogram without EMBO** This field is required.

 Location of Splenic Angiogram with EMBO **Main Splenic Artery, Selective, Both** This field is required.

 Method **Coils, Particles, Both** This field is required.

 Indication for Embolization At least one of these is required.

 **Splenic Pseudoaneurysm**

 **Contrast Blush/Extravasation**

 **Vessel Cut Off**

 **Other**

 Splenectomy **Yes, No**

 Date This field is required.

 Indication At least one of these is required.

 **Hemodynamic Instability**

 **Precipitous Drop in HCT**

 **Abdominal Pain**

 **Peritonitis**

 **Splenic Pseudoaneurysm**

 **Splenic Cyst**

 **Splenic Abscess**

 **Need for Transfusion**

 **Other**

 Drainage of a Splenic Cyst **Yes, No**

 Date This field is required.

 **Discharge Data**

 Discharge Date

 ICU LOS (days) Integer values only

 Hospital LOS (days) Integer values only

 Discharge Disposition **Home, Rehabilitation, Skilled Nursing Facility, Other Hospital, Other, Dead** This field is required.

 **Out-Patient follow-up Data - 30 Days After Injury**

 Follow-up Date

 Death **Yes, No**

 If Yes, Reason This field is required.

 Date of Death This field is required.

 Returned to Full Activity Without Restrictions **Yes, No**

 Date This field is required.

 Splenic Angiogram Post Discharge **Yes, No**

 Date Invalid Date Format This field is required.

 Indication At least one of these is required.

 **Hemodynamic Instability**

 **Precipitous Drop in HCT**

 **Splenic Pseudoaneurysm**

 **Splenic Cyst**

 **Need for Transfusion**

 **Other**

Splenectomy Post Discharge **Yes, No**

 Date This field is required.

 Indication At least one of these is required.

 **Hemodynamic Instability**

 **Precipitous Drop in HCT**

 **Abdominal Pain**

 **Peritonitis**

 **Splenic Pseudoaneurysm**

 **Splenic Cyst**

 **Splenic Abscess**

 **Need for Transfusion**

 **Other**

Drainage of a Splenic Cyst Post Discharge **Yes, No**

 Date This field is required.

 **Out-Patient Follow-Up Data - 90 days After Injury**

 Follow-up Date

 Death **Yes No**

 If Yes, Reason This field is required.

 Date of Death This field is required.

 Returned to Full Activity Without Restrictions **Yes, No**

 Date This field is required.

 Splenic Angiogram Post Discharge **Yes, No**

 Date This field is required.

 Indication At least one of these is required.

 **Hemodynamic Instability**

 **Precipitous Drop in HCT**

 **Splenic Pseudoaneurysm**

 **Splenic Cyst**

 **Need for Transfusion**

 **Other**

Splenectomy Post Discharge **Yes, No**

 Date This field is required.

 Indication At least one of these is required.

 **Hemodynamic Instability**

 **Precipitous Drop in HCT**

 **Abdominal Pain**

 **Peritonitis**

 **Splenic Pseudoaneurysm**

 **Splenic Cyst**

 **Splenic Abscess**

 **Need for Transfusion**

 **Other**

Drainage of a Splenic Cyst Post Discharge **Yes, No**

 Date This field is required.

 **Out-Patient Follow-Up Data - 180 days After Injury**

 Follow-up Date

 Death **Yes, No**

 If Yes, Reason This field is required.

 Date of Death This field is required.

 Returned to Full Activity Without Restrictions **Yes, No**

 Date This field is required.

 Splenic Angiogram Post Discharge **Yes, No**

 Date This field is required.

 Indication At least one of these is required.

 **Hemodynamic Instability**

 **Precipitous Drop in HCT**

 **Splenic Pseudoaneurysm**

 **Splenic Cyst**

 **Need for Transfusion**

 **Other**

Splenectomy Post Discharge **Yes, No**

 Date This field is required.

 Indication At least one of these is required.

 **Hemodynamic Instability**

 **Precipitous Drop in HCT**

 **Abdominal Pain**

 **Peritonitis**

 **Splenic Pseudoaneurysm**

 **Splenic Cyst**

 **Splenic Abscess**

 **Need for Transfusion**

 **Other**

Drainage of a Splenic Cyst Post Discharge **Yes, No**

 Date This field is required.

 Comments