

CLOSURE OF ACUTE / CRONIC LEAKAGE FORM - PART 1

Si prega di compilare tutti i campi (spuntare almeno un campo per ogni domanda) ed inserire un codice di sei cifre alfanumeriche nella casella Data record per identificare il form e completare successivamente il giudizio finale nella seconda parte.
Inviare il form al Fax n. 030 3469896 o alla e-mail r.manta@ausl.mo.it, all'attenzione del Dr. Raffaele Manta

| | | | | | |
|--|--|------------|--|--------------------|--|
| Investigator (First and last name) | | | | Data record | |
| Endoscopic unit of (Name and address) | | | | | |
| Telefono | | Fax | | email | |
| Date of compilation | | | | | |

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| Intervention | |
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| Procedure complicated by stapling line / anastomotic failure | |
| <input type="checkbox"/> | Acute stapling line / anastomotic failure after surgery |
| <input type="checkbox"/> | Chronic stapling line failure or fistula in stapling line after surgery |
| <input type="checkbox"/> | Other fistula (please specify below) |

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|-----------------------------------|----------------------|--------------------------|-------------------|--------------------------|------------------------------|
| Initial surgical procedure | | | | | |
| <input type="checkbox"/> | Esophageal resection | <input type="checkbox"/> | Gastric bypass | <input type="checkbox"/> | Vertical-Banded Gastroplasty |
| <input type="checkbox"/> | Sleeve gastrectomy | <input type="checkbox"/> | Gastric resection | <input type="checkbox"/> | Colonic resection |
| <input type="checkbox"/> | Rectal resection | | | | |

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| Date of initial surgical intervention (dd.mm.yyyy) | |
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|--|------------------------------|--------------------------|----------------------------|--------------------------|--------------|
| Location of stapling line failure | | | | | |
| <input type="checkbox"/> | Esophago-gastric anastomosis | <input type="checkbox"/> | Gastro-jejunal anastomosis | <input type="checkbox"/> | Gastric wall |
| <input type="checkbox"/> | Rectal anastomosis | cm from anus | | | |
| <input type="checkbox"/> | Other (please specify below) | | | | |

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| Size of stapling line (Please indicate cm) | |
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|----------------------------|---|------------------------------|------------|--------------------------|-----------|
| Type of OTSC system | | | | | |
| <input type="checkbox"/> | Small, endoscope diameter (9.5-11,0 mm) | <input type="checkbox"/> | Atraumatic | <input type="checkbox"/> | Traumatic |
| | | <input type="checkbox"/> | Atraumatic | <input type="checkbox"/> | Traumatic |
| <input type="checkbox"/> | Medium, endoscope diameter (10.5-12,0 mm) | Gastric Closure (GC) version | | | |
| <input type="checkbox"/> | Large, endoscope diameter (11.5-14,0 mm) | <input type="checkbox"/> | Atraumatic | <input type="checkbox"/> | Traumatic |

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| Number of clips placed | | Duration of clipping procedure (Minutes) | |
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| Technique used for OTSC application | |
| <input type="checkbox"/> | Suction with cap only |
| <input type="checkbox"/> | Conventional instrument through working channel |
| <input type="checkbox"/> | OTSC Twin Grasper and suction |
| <input type="checkbox"/> | OTSC Anchor and suction |

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| Therapeutic success of procedure, Therapeutic result (Closure) achieved? | |
| <input type="checkbox"/> | Fully achieved |
| <input type="checkbox"/> | Partially achieved |
| <input type="checkbox"/> | Not achieved (Please specify) |

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| Sign | |
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CLOSURE OF ACUTE / CRONIC LEAKAGE FORM - PART 2 FINAL JUDGEMENT

Si prega di compilare tutti i campi (spuntare almeno un campo per ogni domanda) ed inserire il codice di sei cifre alfanumeriche, scelto per la prima parte del form, nella casella Data record per poter ricollegare entrambe le parti del form .
Inviare il form al **Fax n. 030 3469896** o alla **e-mail r.manta@ausl.mo.it**, all'attenzione del Dr. Raffaele Manta

| | | | |
|--|--|--------------------|--|
| Investigator (First and last name) | | Data record | |
| Endoscopic unit of (Name and address) | | | |
| Telefono | | Fax | |
| | | email | |
| Date of compilation | | | |

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|---|--|
| Judgement of therapeutic success | |
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| Days after clips placement | |
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| Method used to determine procedural success | |
| | Clinical judgement |
| | Re-endoscopy |
| | X-ray / CT |
| | Other (please specify below) |
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|-------------------------------|--|-----|--|----|--|----------------|
| Clip still in position | | Yes | | No | | Not determined |
|-------------------------------|--|-----|--|----|--|----------------|

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|--------------------------|---------------------------|
| Closure achieved? | |
| | Yes (Fully achieved) |
| | Yes (Partially achieved) |
| | Not determined |
| | No (Please specify below) |
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| Complications observed at follow-up | |
| | No |
| | Yes (Please specify below) |
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| Sign | |
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