

CLOSURE OF PERFORATION 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					

Intervention leading to organ wall injury and location of organ wall injury

Snare Polypectomy

Caecum		Jejunal	
Ascending colon		Transverse colon	Descending colon
Sigmoid colon		Rectum (intraperitoneal)	Rectum (extraperitoneal)
Esophagus		Stomach	Duodenum

EMR (Endoscopic Mucosal Resection)

Caecum		Jejunal	
Ascending colon		Transverse colon	Descending colon
Sigmoid colon		Rectum (intraperitoneal)	Rectum (extraperitoneal)
Esophagus		Stomach	Duodenum

ESD (Endoscopic Submucosal Dissection)

Caecum		Jejunal	
Ascending colon		Transverse colon	Descending colon
Sigmoid colon		Rectum (intraperitoneal)	Rectum (extraperitoneal)
Esophagus		Stomach	Duodenum

Other (please specify also the location of organ wall injury)	
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Date of intervention (dd.mm.yyyy)	
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Indication for OTSC application

Covered organ wall perforation	Full thickness organ wall perforation	Bleeding from organ wall lesion
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Size of injury (Maximal length mm)	
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Type of OTSC system

Small, endoscope diameter (9.5-11,0 mm)	Atraumatic	Traumatic
	Gastric Closure (GC) version	
Medium, endoscope diameter (10.5-12,0 mm)	Atraumatic	Traumatic
Large, endoscope diameter (11.5-14,0 mm)	Atraumatic	Traumatic

Number of clips placed		Duration of clipping procedure (Minutes)	
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Technique used for OTSC application

Suction with cap only
Conventional instrument through working channel
OTSC Twin Grasper and suction
OTSC Anchor and suction

Therapeutic success of procedure

A) In case of organ wall injury, Closure of perforation achieved?	
Yes	
No (Please specify)	
B) In case of bleeding, Hemostasis achieved?	
Yes	
No (Please specify)	

Sign	
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CLOSURE OF PERFORATION FORM - PART 2 FINAL JUDGEMENT

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			

Judgement of procedural 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)

Clip still in position		Yes		No		Not determined
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A) In case of perforation, Perforation successfully closed?	
	Yes
	Not determined
	No (Please specify)
B) In case of bleeding, Bleeding successfully stopped?	
	Yes
	Not determined
	No (Please specify below)
	No bleeding
Closure achieved?	
	Yes (Fully achieved)
	Yes (Partially achieved)
	Not determined
	No (Please specify below)

Complications observed at follow-up	
	No
	Yes (Please specify below)

Sign	
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