

International Collaboration on Endocarditis
Case Report Form

Site/Patient# **2** _____ - _____ Initials: _____

Fax to 919-668-7054 or **Email** to ice@endocarditis.org

Demographics

Table DEMOG

1. Date of Birth: / / (example: 12/JAN/1956) **BIRTHDT**
d d m m m y y y y

2. Gender: 1 Male 2 Female **sex**

3. Race: White or Caucasian **racewhite** Black or African American **raceblack** East Asian **raceasian** West Asian **raceasian**
 Native American / Alaskan Native **racenatamer** Native Hawaiian/ Other Pacific Islander **racenathaw** Aboriginal **raceabor**
 Other Race **raceother** Unknown/Not documented **raceunk**

4. Ethnicity: Hispanic or Latino **hispanicyes** Not Hispanic or Latino **nonhispanicyes** Unknown/Not documented **hispanicunk**

5. Height : **ht** 2 Centimeters **htce** 1 Inches **htin**

6. Weight: **wt** 2 Kilograms **wtkg** 1 Pounds **wtlb**

7. Smoking Status: **ss** Never **ssintvl** Quit <1 month **1** Quit ≥1 month **2** Current **3**

Current Infectious Endocarditis (IE) Episode

Table Current IE

8. Date of first clinical manifestation of IE: / / **req** **OR**, if Unknown , answer a.
d d m m m y y y y

a. If date is unknown, what is the approximate time since 1st clinical manifestation? **ieintvl**
 < 1 month **1**
 1 – 6 months **2**
 >6 months **3**
 Unknown **99**

9. Date of first medical contact : **contactdt** / / **req**
d d m m m y y y y

10. Date of admission at your center: **admitdt** / / **req**
d d m m m y y y y

11. Was the patient transferred to your hospital from another facility? **transfer**
 No **0** Yes, if yes, date of 1st hospitalization? **hospdt** / / **req**
d d m m m y y y y

12. Was patient on aspirin at admission when IE diagnosed? **aspnow**
 No **0** Yes **1** Unknown/Not documented **99**
↳ if yes, **aspdse**
a. Daily dose 81 **1** mg 325 mg **2** 650 **3** mg Other **4** **aspother**
b. Length of treatment: <1 month 1-6 months > 6 months **aspfen**
c. Was aspirin continued during hospitalization? **aspensp**
 No **0**
 Yes, during all of hospitalization **1**
 Yes, during part of hospitalization **2**
 Replaced with another anticoagulant **3**

13. Was patient on Warfarin/Coumadin at admission when IE diagnosed? **warfnw**
 No **0** Yes **1** Unknown/Not documented **99**
↳ if yes,
a. INR (Protime) IU **INR**
b. Length of treatment: <1 month **1** 1-6 **2** months > 6 months **3** **warfpfen**
c. Was Warfarin/Coumadin continued during hospitalization? **warfpensp**
 No **0**
 Yes, during all of hospitalization **1**
 Yes, during part of hospitalization **2**
 Replaced with another anticoagulant **3**

Table Valve Status

Valve Status at beginning of episode: *Please provide date of last repair/replacement or check if native only.*

valvename	Naton <i>Native only</i>	varepnopr <i>Valve repair- no prosthesis</i>	vareppr <i>Valve repair- with prosthesis</i>	vamere <i>Mechanical Replacement</i>	vabire <i>Bioprosthetic Replacement</i>	vahore <i>Homograft Replacement</i>	vaaure <i>Autograft Replacement</i>
14. Aortic	<input type="checkbox"/>	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y
15. Mitral	<input type="checkbox"/>	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y
16. Tricuspid	<input type="checkbox"/>	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y
17. Pulmonic	<input type="checkbox"/>	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y	<input type="checkbox"/> d d/ mmm/ y y y y

Medical History (Diagnoses/Procedures known prior to episode of IE) Table Med Hx

18. Chronic Pulmonary Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxcopd
↳ if yes, <input type="checkbox"/> Mild 1 <input type="checkbox"/> Moderate 2 <input type="checkbox"/> Severe 3			
19. Coronary Artery Disease (assessment prior to or during this episode of IE)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxcad
a. Number of vessels with significant (≥ 50%) stenosis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3 <input type="checkbox"/> Unknown/Not documented nosten
b. Left main stenosis ≥50%	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented leftsten
20. History of Myocardial Infarction	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxami
a. Most recent MI: ___/___/___	recmidt		
	d d m m m	y y y y	
21. Percutaneous Coronary Intervention	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxpci
22. Cardiac Surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxsurg
23. Prior surgical coronary bypass	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxcabg
24. Atrial fibrillation/flutter	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxflut
25. Congestive Heart Failure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxCHF
a. NYHA Class (prior to this episode of IE)	<input type="checkbox"/> I 1	<input type="checkbox"/> II 2	<input type="checkbox"/> III 3 <input type="checkbox"/> IV 4 nyhachf
26. Peripheral Vascular Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxpvD
a. Claudication	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented pvDclaud
b. Previous or planned surgery on abdominal aorta, limb arteries, or carotids	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented plansurgabd
27. Cerebrovascular Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxcvD
a. History of CVA	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxcva
b. History of TIA	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxtia
c. Carotid stenosis >50%	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented carsent
28. Endocavitary Cardiac Device	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented endocavD
29. Diabetes Mellitus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxdiab
a. End Organ damage?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented hxdend

30. Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	hxcancer
a. Leukemia/Lymphoma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	leuklymp
b. Genitourinary	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	gucan
c. Gastrointestinal	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	gican
d. Oral	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	oralcan
e. Other cancer tumor	<input type="checkbox"/> No	<input type="checkbox"/> Yes, if yes specify: <u>othtumsp</u>	<input type="checkbox"/> Unknown/Not documented	othcantum
f. Are any of these metastatic?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, if yes specify: <u>metatsp</u>	<input type="checkbox"/> Unknown/Not documented	metat

31. Lab Values

a. Baseline creatinine:	<u>basecreatvl</u> _____	<input type="checkbox"/> umol/L	bcum	<input type="checkbox"/> mg/dL	bcmg	<input type="checkbox"/> Unknown/Not documented	basecreat
b. INR	<u>inr</u> _____	<input type="checkbox"/> umol/L	<input type="checkbox"/> mg/dL	<input type="checkbox"/> umol/L	<input type="checkbox"/> mg/dL	<input type="checkbox"/> Unknown/Not documented	inrunit
32. Bilirubin	_____	<input type="checkbox"/> umol/L	<input type="checkbox"/> mg/dL	<input type="checkbox"/> umol/L	<input type="checkbox"/> mg/dL	<input type="checkbox"/> Unknown/Not documented	

33. Albumin < 2.8 g/dl 2.8-3.5 g/dl >3.5 g/dl Unknown/Not documented

34. Ascites No Ascites Ascites controlled medically Ascites poorly controlled Unknown/Not documented

35. Encephalopathy No Encephalopathy Encephalopathy controlled medically Encephalopathy poorly controlled Unknown/Not documented

36. Mild Renal Insufficiency No Yes Unknown/Not documented **reaninsf**

37. Moderate or Severe Renal Disease No Yes Unknown/Not documented **renaldz**

a. Hemodialysis Dependent? No Yes Unknown/Not documented **hxdialys**

if yes, Has the patient had dialysis at least twice in the past week? No Yes Unknown/Not documented **dialtwk**

38. Peptic Ulcer Disease No Yes Unknown/Not documented **hxpud**

39. Mild Liver Disease No Yes Unknown/Not documented **livdzmld**

40. Moderate / Severe Liver Disease No Yes Unknown/Not documented **livdzms**

↳if yes, please check if the patient has the following:

Jaundice Bleeding SBP Liver Cancer Hepatorenal Syndrome

41. Connective Tissue Disease	Idjaund	Idbleed	Idsbp	Idcanc	Idhs	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	hxctd
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42. Hemiplegia No Yes Unknown/Not documented **hxhemipl**

43. Other neurologic dysfunction severely affecting ambulation or day to day functioning No Yes Unknown/Not documented **hxneuro**

44. Dementia No Yes Unknown/Not documented **hxdement**

45. HIV No Yes Unknown/Not documented **hxhivpos**

a. Clinical diagnosis of AIDS No Yes Unknown/Not documented **hx aids**

b. CD4 count _____ (absolute) (3months) Unknown/Not documented **cd4**

c. Viral Load _____ (3months) Unknown/Not documented **virload**

d. HAART No Yes Unknown/Not documented **haart**

e. HCV (RNA+) No Yes Unknown/Not documented **hcv**

46. Intravenous drug use No Yes Unknown/Not documented **hxivdrug**

47. History of previous IE? No Yes Unknown/Not documented **previe**

if yes, patient enrolled previously in ICE? No Yes what patient number? _____ - _____ **priorpatient, priorpatientid**

		Site/Patient#	2	Initials:
48. Congenital Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	congenhd
49. Rheumatic heart disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	hxrheum
50. Native Valve Predisposition	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	natvalve
a. Aortic regurgitation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	aorregur
		↳ if yes,	<input type="checkbox"/> Mild <input type="checkbox"/> 1 <input type="checkbox"/> 2 Moderate <input type="checkbox"/> 3 Severe	aorregurm
b. Aortic stenosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	aostan
		↳ if yes,	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	aostanm
c. Mitral regurgitation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	mitregur
		↳ if yes,	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	mitregurm
d. Mitral stenosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	mitresten
		↳ if yes,	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	mitrestenm
51. Hypertension	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	hxhtn
52. Hyperlipidemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	hxlip
53. Immunosuppressive Therapy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	hximmune

Prosthesis Information: Table Prosthesis

54. Does the patient have prosthesis? **prosth**

No **0** → Go to Next section

Yes **1** → Complete Prosthesis sections 51-63 below

	Present prothprest	Date of Implantation dd/mmm/yyyy prothdt	Removed prothremove	Date Removed dd/mmm/yyyy removedate	Debrided prothdeb	Date Debrided dd/mmm/yyyy prothdebdt
Intravascular Catheter prothtype						
55. Short term central catheter (non-hemodialysis)	<input type="checkbox"/> No <input type="checkbox"/> 1 Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	
56. Long term central catheter (non- hemodialysis)	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	
57. PIC/PICC line	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Cardiac Device						
58. Pacemaker	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	
59. Combo Pacemaker/Implantable Defibrillator	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	
60. Other – Specify: carddvother _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Hemodialysis						
61. Prosthetic graft	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	
62. AV fistula	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	
63. Short Term Hemodialysis Catheter	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	
64. Long Term Hemodialysis Catheter	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Orthopedic Device						
65. Prosthetic knee	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___
66. Prosthetic hip	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___
67. Other – Specify: carddvotherother _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___	<input type="checkbox"/> No <input type="checkbox"/> Yes	___/___/___

Culture / Serology Table Culture

68. Was a blood culture drawn? No, if no, then go to Question # 65 **blddrawn**
 Yes, if yes, then complete a – b

a. Date first cultures drawn: / / / / / **blddt**

b. Did cultures show growth? **growth**

- No, if no, was the patient treated with antibiotics at the time (or within 7 days) of cultures? **antibt**
 - No → Go to Question # 65
 - Yes → Go to Question # 65

Yes, if yes, **complete Blood Culture Form (page 16)**

69. Were other cultures obtained that were related to the IE episode that helped define the cause or the extent of the IE episode? No Yes, if yes complete a-d **cultyes**

Source and organism of other culture:

cultsrc

- a. Valve **1** No Yes
- b. Joint **2** No Yes
- c. Pacemaker (device, pocket, or lead)**7** No Yes
- d. Other Sterile Site _____ **othspec** No Yes

} If yes, please complete the Other Culture Form (page 18)

Serology / PCR

• Answer “no” if serology or PCR is not documented or unknown. If titer is unknown enter “NA” in the titer field.

70. Were serologies obtained? **serolyes** No Yes **1**, if yes, were the following drawn? (answer a-e) :

- a. Bartonella **barton** No Yes, if yes, complete titer results if available- titer: 1: _____ **bartitr**
- b. Brucella **bruce** No Yes, if yes, complete titer results if available- titer: 1: _____ **bructitr**
- c. Coxiella burnetii **coxiburn** No Yes, if yes, complete titer results if available- titer: 1: _____ **asprtitr**
- d. Legionella **legion** No Yes, if yes, complete titer results if available- titer: 1: _____ **legtitr**
- e. Other _____ No Yes, if yes, complete titer results if available- titer: 1: _____ **serolitr**

(Enter bug code #) **serolspec**, if other **serolsp**

71. Was Polymerase Chain Reaction (PCR) performed? **pcyres** No Yes, if yes, were the following drawn?

- a. What was the Source? **pcrsrce** Valve **1** Blood **2**
- b. What was the Organism? _____ **if bug code not found, write in genus/species** _____ **pcrorg**
 (Enter bug code #) **pcrspec**

Presumed Source Of Acquisition **acquist**

72. For this IE episode, where was the presumed source of acquisition? (check one only)

- Community **1**
- Health Care Associated: Hospital acquired **2**
- Health Care Associated: Non-hospital acquired **3**
- Unknown/Not documented **99**

Echocardiography Table Echo

73. As part of the initial diagnostic evaluation was a transthoracic echocardiogram (TTE) performed? **tteperf**
 No Yes, if Yes, date study performed: / / / / / **ttedt**

74. As part of the initial diagnostic evaluation was a transesophageal (TEE) performed? **teeperf**
 No Yes, if Yes, date study performed: / / / / / **teedt**

75. Of the initial echocardiograms, which type provided the most diagnostic information? 1 TTE 2 TEE **echotype**

Please answer the following questions in reference to the most diagnostic echocardiogram.

Was there evidence of new moderate or severe regurgitation in the following?

- | | | | | |
|---------------|-----------------------------|------------------------------|---|--|
| 76. Aortic | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | 0 1 98 regav |
| 77. Mitral | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | regmv |
| 78. Tricuspid | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | regtv |
| 79. Pulmonic | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | regpv |

Was there evidence of Intracardiac vegetations in the following locations?

- | | | | | |
|--|-----------------------------|------------------------------|---|-----------------|
| 80. Aortic | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | vegaort |
| 81. Mitral | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | vegmit |
| 82. Tricuspid | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | vegtric |
| 83. Pulmonic | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | vegplum |
| 84. Chordae | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | vegchord |
| 85. Catheter | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | veg cath |
| 86. Myocardial wall | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | vegmyocl |
| 87. Intracardiac device pacemaker /ICD | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | vegdevi |

Was there evidence of these Intracardiac complications?

- | | | | | |
|--------------------------|-----------------------------|------------------------------|---|-----------------|
| 88. Perforation | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | paraperf |
| 89. Abscess | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | peraabs |
| 90. Intracardiac fistula | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | parafist |

For patients with prosthetic valves, was there evidence of these prosthetic paravalvular complications?

- | | | | | |
|---|-----------------------------|------------------------------|---|---------------|
| 91. Dehiscence | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | prosd |
| 92. New moderate – severe <u>para</u> valvular regurgitation | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Unknown/Not documented | prosnw |

Other findings

93. Estimated left ventricular ejection fraction **elvef** **eparvsp** EF =ef Unknown/Not documented **99**
94. Estimated pulmonary artery or right ventricular systolic pressure PASP=**pasp** Unknown/Not documented **99**
Estimated peak RV or PA systolic pressure = 4 (tricuspid jet velocity)² + est RA pressure

Regurgitation

- | | | | | | | |
|----------------------|---|--|--|--|---------------------------------------|------------------|
| 95. Mitral Regurg | 1 <input type="checkbox"/> None or trace | 2 <input type="checkbox"/> Mild | 3 <input type="checkbox"/> Moderate | 4 <input type="checkbox"/> Severe | 5 <input type="checkbox"/> N/E | rgmitral |
| 96. Aortic Regurg | <input type="checkbox"/> None or trace | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> N/E | rgaortic |
| 97. Tricuspid Regurg | <input type="checkbox"/> None or trace | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> N/E | rgtricusp |
| 98. Pulmonic Regurg | <input type="checkbox"/> None or trace | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> N/E | rgplum |

Stenosis

99. Mitral Stenosis None or trace Mild Moderate Severe N/E **stmitral**
100. Aortic Stenosis None or trace Mild Moderate Severe N/E **staortic**
101. Tricuspid Stenosis None or trace Mild Moderate Severe N/E **sttricuspid**
102. Pulmonic Stenosis None or trace Mild Moderate Severe N/E **stplump**

Largest Vegetation Size

103. Mitral **szmitralx** _____mm X **szmitraly** _____mm OR N/A **szmitralna**
104. Aortic **szaorticx** _____mm X **szaorticy** _____mm OR N/A **szaorticna**
105. Tricuspid **sztricuspx** _____mm X **sztricuspy** _____mm OR N/A **sztricuspna**
106. Pulmonic **szpulmonicx** _____mm X **szpulmonicy** _____mm OR N/A **szpulmonicna**
107. IC Device: **szicdx** _____mm X **szicdy** _____mm OR N/A **szicdna**
108. IC Catheter: **szcathx** _____mm X **szcathy** _____mm OR N/A **szcathic**
109. Other: **szothersp** _____ **szotherspx** _____mm X **szothery** _____mm OR N/A **szotherna**

Clinical Course Table Clinic

Were any of the following markers of IE present during this episode?

110. Fever >38°C No **0** Yes **1** **99** Unknown/Not documented **fever**
111. Osler's Nodes No Yes Unknown/Not documented **osler**
112. Conjunctival hemorrhages No Yes Unknown/Not documented **conjhemr**
113. Roth Spots No Yes Unknown/Not documented **roth**
114. Splenomegaly No Yes Unknown/Not documented **spleno**
115. Janeway lesion No Yes Unknown/Not documented **janeway**
116. Splinter Hemorrhage No Yes Unknown/Not documented **splnhemo**
117. Vascular embolic event No Yes Unknown/Not documented **othembol**
118. Presence of new murmur No Yes Unknown/Not documented **murmnew**
119. Worsening of pre-existing murmur No Yes Unknown/Not documented **murmold**
120. Elevated Rheumatoid factor No Yes Unknown/Not documented **erf**
121. Elevated C-reactive protein No Yes Unknown/Not documented **crp**
122. Elevated sedimentation rate No Yes Unknown/Not documented **esr**
123. Hematuria No Yes Unknown/Not documented **hemat**

Development of Complications Table Complications

124. New or worsening heart failure secondary to aortic or mitral valvular insufficiency **newchf**
 No **0** Yes **1** Unknown/Not documented **99**
 ↳ if yes, answer a-b
 a. NYHA Class I **1** II **2** III **3** IV **4** **99** Unknown/Not documented **newchfclass**
 b. Occurred before decision was made for surgery? No Yes, **if yes, answer 1** **newchfbefore**
 i. Was this a factor in the decision for surgery? No Yes **newchfdec**

125. New or worsening heart failure secondary to other cause? **chfother**
- No Yes **1** Unknown/Not documented **2**
- ↳ if yes, answer a-c
- a. NYHA Class I **1** II **2** III **3** IV **4** 99 Unknown/Not documented **chfotherclass**
- b. Specify other cause _____ **chfotherspe**
- c. Occurred before decision was made for surgery? No Yes, **if yes, answer I** **chfotherbefore**
- i. Was this a factor in the decision for surgery? No Yes **chfotherdec**
-
126. Myocardial infarction (during this episode) **amidurep**
- No Yes Unknown/Not documented
- ↳ if yes, answer a-b
- a. Date first present: _____ / _____ / _____ **amidurepdt**
d d m m m y y y y
- b. Occurred before decision was made for surgery? No Yes, **if yes, answer I** **amidurepbefore**
- i. Was this a factor in the decision for surgery? No Yes **amidurepdec**
-
127. Evidence of myocardial or paravalvular abscess, paravalvular leak/fistula, perforation, or prosthetic dehiscence?
- No Yes Unknown/Not documented **evidmi**
- a. Specify complication and location
- evidmiia** i. intracardiac abscess: 0 Aortic **1** Mitral **2** Tricuspid **3** Pulmonic **4** Myocardial
- evidmipl** ii. paravalvular leak: 0 Aortic **1** Mitral **2** Tricuspid **3** Pulmonic
- evidmift** iii. fistula: **evidorg** origin _____ **evidend** end _____
- evidmipe** iv. perforation: 0 Aortic **1** Mitral **2** Tricuspid **3** Pulmonic
- evidmiph** v. prosthetic dehiscence: 0 Aortic **1** Mitral **2** Tricuspid **3** Pulmonic
- b. Occurred before decision was made for surgery? No Yes, **if yes, answer I** **evidmibefore**
- i. Was this a factor in the decision for surgery? No Yes **evidmiddec**
-
128. Evidence of extra cardiac mycotic aneurysm? **evidcard**
- No Yes Unknown/Not documented
- ↳ if yes, answer a-b **evidcardloc**
- a. Intracerebral **1** Intrabdominal **2** Other specify _____ **evidcardsp**
- b. Occurred before decision was made for surgery? No Yes, **if yes, answer I** **evidcardbefore**
- i. Was this a factor in the decision for surgery? No Yes **evidcarddec**
-
129. Was there evidence of persistent bacteremia? **evidbact**
- No Yes Unknown/Not documented
- ↳ if yes, answer a
- a. Occurred before decision was made for surgery? No Yes, **if yes, answer I** **evidbactbefore**
- i. Was this a factor in the decision for surgery? No Yes **evidbactdec**
-
130. Evidence of persistent infection after beginning appropriate antibiotic therapy:
- a. Number of days of fever (T>38C) *after beginning appropriate antibiotic therapy* _____ **bactfeverdays**
- b. Number of days leukocytosis (WBC>10) *after beginning appropriate antibiotic therapy* _____ **bactleukdays**
- c. Date of last *positive* culture _____ / _____ / _____ **lasposcultdt**
d d m m m y y y y
- d. Date of first *negative* culture _____ / _____ / _____ **firngcultdt**
d d m m m y y y y
-
131. Central Nervous System (CNS) event? **strk**
- No Yes Unknown/Not documented
- ↳ if yes, answer a-b
- a. Type (check one): Embolic without hemorrhage **3**
 Embolic with hemorrhagic **4**
 Intracranial hemorrhage (ICH) **5**
- b. Occurred before decision was made for surgery? No Yes, **if yes, answer I** **strkbefore**
- i. Was this a factor in the decision for surgery? No Yes **strkdec**

132. Embolization (other than stroke) **emboli**
 No Yes Unknown/Not documented
 ↳ if yes, answer a-b
 a. Location: **0 1**
 i. Vascular periphery No Yes **vascperi**
 ii. Spleen No Yes **spleen**
 iii. Liver No Yes **liver**
 iv. Pulmonary No Yes **pulmon**
 v. Other No Yes, specify: **emboloth _____ emblist**
 b. Occurred before decision was made for surgery? No Yes, **if yes, answer I embolibefore**
 i. Was this a factor in the decision for surgery? No Yes **embolidec**
-
133. Recurrent emboli after appropriate antibiotic therapy? **embolirec**
 No Yes Unknown/Not documented
 ↳ if yes, answer a-c
 a. Number of emboli? **embolinum** 1 **1** 2-4 **2** >4 **3 emboliveg**
 b. Was vegetation still present after last documented embolus? No Yes Unknown
 c. Occurred before decision was made for surgery? No Yes, **if yes, answer I embolirecbefore**
 i. Was this a factor in the decision for surgery? No Yes **embolirecdec**
-
134. New conduction abnormality? **newabnor**
 No Yes Unknown/Not documented
 ↳ if yes, answer a-b
 a. Location : (check all that apply) Left bundle block **lbbabn**
 Right bundle block **rbbbabn**
 LAFB **lafbabn**
 Heart Block ↳ **hbabn**
 Highest Degree 1st **1** 2nd **2** 3rd 98Unknown
 b. Occurred before decision was made for surgery? No Yes, **if yes, answer i newabnorbefore**
 i. Was this a factor in the decision for surgery? No Yes **newabnordec**
-
135. New renal insufficiency? **newrenal**
 No Yes Unknown/Not documented
 ↳ if yes, answer a-b
 a. Highest Creatinine level before surgical decision **hcl** **I hclmg** mg/dL OR **I** **μmol/L hclum**
 b. Occurred before decision was made for surgery? No Yes, **if yes, answer i hclbefore**
 i. Was this a factor in the decision for surgery? No Yes **hcldec**
-
136. Ventricular tachycardia, ventricular fibrillation or aborted sudden cardiac death? **vent**
 No Yes Unknown/Not documented
 ↳ if yes, answer a
 a. Occurred before decision was made for surgery? No Yes, **if yes, answer i ventbefore**
 i. Was this a factor in the decision for surgery? No Yes **ventdec**
-
137. Cardiopulmonary resuscitation (CPR) or cardiac massage? **cpr**
 No Yes Unknown/Not documented
 ↳ if yes, answer a
 a. Occurred before decision was made for surgery? No Yes, **if yes, answer I cprbefore**
 i. Was this a factor in the decision for surgery? No Yes **cprdec**

138. Mechanical ventilation (before initiation of anesthesia for surgery)? **mechvent**
 No Yes Unknown/Not documented
 ↳ if yes, answer a
 a. Occurred before decision was made for surgery? No Yes, **if yes, answer I mechventbefore**
 i. Was this a factor in the decision for surgery? No Yes **mechventdec**

139. Inotropic support?
 No Yes Unknown/Not documented **intopic**
 ↳ if yes, answer a
 a. Occurred before decision was made for surgery? No Yes, **if yes, answer I intopicbefore**
 i. Was this a factor in the decision for surgery? No Yes **intopicdec**

140. Intra-aortic balloon pump or other ventricular assist device **intraaortic**
 No Yes Unknown/Not documented
 ↳ if yes, answer a
 a. Occurred before decision was made for surgery? No Yes, **if yes, answer i intraaorticbefore**
 i. Was this a factor in the decision for surgery? No Yes **intraaorticdec**

141. Unstable angina (rest angina requiring IV nitrates) **unstableang**
 No Yes Unknown/Not documented
 ↳ if yes, answer a
 a. Occurred before decision was made for surgery? No Yes, **if yes, answer i unstableangbefore**
 i. Was this a factor in the decision for surgery? No Yes **unstableangdec**

Treatment Table Treatment

Treatment questions are relevant to the IE episode.

142. Date of first dose of antibiotic therapy to which the bacteria was **sensitive** : ^{therdt} / / / / / / /
 143. Total planned length of treatment _____ days **tmtdays**
 144. Predominant Antibiotic Used

Antibiotic		
a. Penicillin txpen	0 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes
b. Ampicillin/Amoxicillin txamp	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Penicillinase-Resistant penicillin txpenr	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d. Cefazolin/Cephalothin txcef	<input type="checkbox"/> No	<input type="checkbox"/> Yes
e. Ceftriaxone txcefr	<input type="checkbox"/> No	<input type="checkbox"/> Yes
f. Vancomycin txvanc	<input type="checkbox"/> No	<input type="checkbox"/> Yes
g. Daptomycin txdapto	<input type="checkbox"/> No	<input type="checkbox"/> Yes
h. Other: _____ txtoth,tmtlist	<input type="checkbox"/> No	<input type="checkbox"/> Yes
i. Other: _____ txoth2,tmtlist2	<input type="checkbox"/> No	<input type="checkbox"/> Yes

145. Other antibiotics used:
 a. Aminoglycoside No **0** Yes **1** **99** Unknown/Not documented Indicate # days: _____ **txamino**
 b. Rifampin No Yes Unknown/Not documented Indicate # days: _____ **txrif**

Table Surgery

146. Was there an indication for **cardiovascular** surgery? (whether or not this patient was an appropriate candidate for surgery or actually underwent surgery) **surgind**

- No⁰ Yes¹ 99Unknown/Not documented

↳ if yes, answer a and b

a. What was the first date an indication existed? _____ / _____ / _____ **surgindt**
d d m m m y y y y

b. What were the indications for surgery?

Check all that apply:

- Heart failure **indhf**
- Emboli **indemb**
- Persistent bacteremia **indbact**
- Myocardial abscess **indabsc**
- Severe or worsening valvular regurgitation **indregur**
- Vegetation size, mobility **indveg**
- Organism **indorg**
- Other (specify) _____ **indoth, indothlist**

147. Was a cardiac/cardiothoracic surgeon consulted on this case? **consult**

- No Yes Unknown/Not documented

↳ if yes, answer a-b

a. Did surgeon recommend surgery? No Yes **recsurg**

b. Date of initial consultation _____ / _____ / _____ **consultdt**
d d m m m y y y y

148. Did the patient undergo **cardiovascular** surgery? **surgthis**
 No, (if no **AND** if there was an indication for surgery then complete **Non-Surgery Form, page 15**)
 Yes → if yes complete a – p

- a. Date of surgery: / / / / / **surgdt**
d d m m m y y y y
- b. Was there evidence of endocarditis at the time of surgery or in the surgical specimens?
 No Yes Unknown/Not documented **endosurg**
- c. Was this demonstrated by vegetation or intracardiac abscess? **surgveg**
 No Yes Unknown/Not documented
- d. Was this confirmed by histology, showing active endocarditis? **surghist**
 No Yes Unknown/Not documented
- e. Was surgery performed? Electively Urgently Emergently **surgperf**
- f. Results of Surgery: *Check all the apply:*
 No Complications **nosurgcomp**
 Stroke **strkcomp**
 Death **deathcomp**
 Other Complications _____ **othercomp,othercomplist**
- g. Length of effective therapy after surgery? ___ days **lengther**

Type of Surgery - Valvular

	<u>No Surgery</u>	<u>Valve repair- no prosthesis</u>	<u>Valve repair- with prosthesis</u>	<u>Mechanical Replacement</u>	<u>Bioprosthetic Replacement</u>	<u>Homograft Replacement</u>	<u>Autograft Replacement</u>
h. Aortic surga	<input type="checkbox"/> 0	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
i. Mitral surgmv	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Tricuspid surgtv	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Pulmonic surgpv	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Type of Surgery -Non-valvular

- | | | | |
|--|-----------------------------|--|--------------------------------|
| | 0 | 1 | |
| l. Pacemaker / ICD removal | <input type="checkbox"/> No | <input type="checkbox"/> Yes | surgpm |
| m. Coronary artery bypass | <input type="checkbox"/> No | <input type="checkbox"/> Yes | surgcabg |
| n. Thoracic aorta surgery | <input type="checkbox"/> No | <input type="checkbox"/> Yes | surgar |
| o. Repair of fistula or ventricular septal rupture | <input type="checkbox"/> No | <input type="checkbox"/> Yes | surgrepair |
| p. Other cardiac surgery | <input type="checkbox"/> No | <input type="checkbox"/> Yes, if yes, specify: _____ | surgother,surgotherlist |

Table Metastatic Sites

Metastatic Sites of Infection Type of infect	infect	Confirmed by: check all that apply confirmedinfect				Specify Location speclocinfect
		Culture 1	Radiology 2	Exam 3	Other: specify otherconfirmspec,otherconfirmspec list	
149. Non-articular prosthesis: specify _____ nonprothspec	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
150. Abscess: specify _____ abscessspe	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
151. Vertebral osteomyelitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
152. Epidural abscess	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
153. Psoas abscess	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
154. Non-vertebral osteomyelitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
155. Septic emboli (non-cutaneous)	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
156. Septic thrombophlebitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
Visceral Abscess						
157. Kidney	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
158. Liver	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
159. Spleen	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
160. Meningitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
161. Pacemaker/ICD	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____
162. Other: specify _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	_____

Metastatic Sites of Infection-Septic Arthritis

Confirmed by: check all that apply **confirmedsepinfect**

Type of septicinfect		Prosthesis typeprost	Culture 1	Radiology 2	Exam 3	Other: specify confirmedsepinfectlist
163. Hip	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
164. Knee	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
165. Shoulder	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
166. Elbow	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
167. Ankle	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
168. Other: specify _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

End of Episode Table EOE

169. What was the patient's Discharge Status: **dischst**

Dead

↳ **deathdt**

a. Date of Death: / / / / / → **DONE; SIGN CRF**
d d m m m y y y y

Alive

↳

b. Date of Discharge from your hospital? / / / / / **dischdt**
d d m m m y y y y

c. Where was the patient discharged to? **discloc**

Home

Hospice/Palliative Care

Transfer to another hospital

Nursing Home

Rehabilitation Center

Other: (specify) _____ **dischspec, dischsplist**

d. Was the patient discharged on antibiotics (OPAT therapy) **dischopat**

No

Yes

Unknown/Not documented

SIGNATURE

I have reviewed all the data recorded on these CRF pages for this patient and certify that they are accurate and complete to the best of my knowledge.

Study Coordinator or PI: _____ Date: / / / / /
d d m m m y y y y

Check List for Completion

1. Non-Surgery Form (page 15) →→→→Complete this form if you answered "No" to question 144 on page 12
 Completed Not Applicable

2. Blood Culture Form (page 16) → Complete this form if you answered "Yes" to question 64b on page 5
 Completed Not Applicable

3. Poly Culture Form (page 17)→→Complete this form if you answered "Yes" to question 6 on page 16
 Completed Not Applicable

4. Other Culture Form(page 18) →→Complete this form if you answered "Yes" to question 65a-d on page 5
Use separate forms for each source checked as yes
 Completed Not Applicable

5. Micro Isolate to be sent: Yes No →→ when will this be shipped?
 / / / / /
d d m m m y y y y

6. Reminder: Please keep the echo tapes for this episode for any possible quality control checks in the future.
Review the CRF for blank fields. Answer all questions to your best ability.

Contact the ICE Coordinating Center for any questions.

Fax : 919-668-7054

Email: ICE@endocarditis.org

Non-Surgery Form Table NonSurg

Complete this form if you answered "no" to question 144 on page 12.

Please complete the following questions if the patient had an indication for surgery, but did not receive surgery.

What were the reasons the patient did not have surgery and an indication existed?

1. Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrgstrk
2. Intracranial hemorrhage	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrgih
3. Heart failure -secondary to valvular insufficiency	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrgchf
4. Heart failure- secondary to other causes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrgchfoth
5. Sepsis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrgseps
6. Hemodynamic instability-secondary to sepsis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrghisep
7. Hemodynamic instability-secondary to other causes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrghioth
8. Prognosis poor regardless of treatment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrgpoor
9. Prognosis good without surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrggood
10. Surgery not consistent with overall goals of care	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	ssrgcaregoal
11. Patient refused	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrgrefuse
12. Patient died before surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrgdied
13. Resources (personnel, facilities, equipment) not available?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrgresource
14. Surgeon declined to operate	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrgdecl
15. Other contraindications to surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown/Not documented	nsrgcontr
If, yes Specify _____				nsrgcontsp, nsrgcontsplist

16. If cardiac surgery is not performed during index hospitalization, will surgery be anticipated and scheduled in the future?
schfut No Yes Unknown/Not documented

↳ If, yes specify reason for late surgery:

<input type="checkbox"/> Heart failure	schfutdhf
<input type="checkbox"/> Emboli	schfutemb
<input type="checkbox"/> Persistent bacteremia	schfutbact
<input type="checkbox"/> Myocardial abscess	schfutabsc
<input type="checkbox"/> Severe or worsening valvular regurgitation	schfutregur
<input type="checkbox"/> Vegetation size, mobility	schfutveg
<input type="checkbox"/> Organism	schfutorg
<input type="checkbox"/> Other (specify) _____	schfutoth, schfutothlist

Blood Culture Form Table bloodcult

Complete this form if you answered "yes" to question 64b on the Culture / Serology form (page 5).

1. Number of positive cultures: _____ **poscult**
2. Number of total cultures: _____ (1 intravenous stick = 1 culture) **totcult**
3. Days of bacteremia: _____ 1 2 3 4 5 6 7 8 9 10 >10 **daysbact**
4. Were at least two positive cultures from blood samples drawn more than 12 hours apart? No Yes **samplos**
5. Were there at least three positive blood cultures from at least 3 blood samples (or the majority of positive cultures if there are four or more blood samples)? No Yes **samplmaj**
6. Was this episode a polymicrobial infection? **polymicr** No Yes → **complete Poly Blood Culture Form (page 17)**
7. Genus and/or species of the likely **primary infecting organism** :

Genus and/or Species of Organism: _____ **bugspec** _____ (Enter Bug Code #)

Refer to the complete Bug Code list available on the ICE website. If code not found, write in genus/species of "other" organism.
if other bloodoth

Common Bug Code List (Complete List available on the ICE website)

Genus/Species	Code
Abiotrophia defectiva	73.01
Candida albicans	37.01
Candida parapsilosis	37.05
Chlamydia pneumoniae	7.02
Enterobacter cloacae	9.01
Enterococcus faecalis	28.01
Enterococcus faecium	28.03
Escherichia coli	10.01
Haemophilus parainfluenzae	23.02

Genus/Species	Code
Klebsiella pneumonia	16.01
Mycoplasma pneumoniae	78.01
Pseudomonas aeruginosa	12.01
Staphylococcus aureus	17.10
Staphylococcus epidermidis	17.04
Staphylococcus lugdunensis	17.07
Streptococcus anginosus	25.01
Streptococcus bovis	25.13
Streptococcus gallolyticus	25.14

Genus/Species	Code
Streptococcus gordonii	25.06
Streptococcus Group B/agalactiae	25.15
Streptococcus Group C/G	25.16
Streptococcus mitis	25.08
Streptococcus mutans	25.09
Streptococcus oralis	25.10
Streptococcus pneumoniae	25.18
Streptococcus salivarius	25.11
Streptococcus sanguis	25.12

Organism Sensitivities (S= Susceptible, I= Intermediate, R= Resistant, U = Unknown)

Antibiotics	S	I	R	U	MIC
8. Aminoglycoside bldamino	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	99 <input type="checkbox"/>	
9. Penicillin bldpen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ penmic <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2mcg/L
10. Ampicillin/amoxicillin bldamp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	penmicmg, penmicmcg
11. Penicillinase-Resistant Penicillin bldpenr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ penrmic <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2mcg/L
12. Cefazolin / Cephalothin bldcefa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	penrmicmg, penrmicmcg
13. Ceftriaxone bldcefr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Vancomycin bldvanc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ vancmic <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2mcg/L vancmicmg, vancmicmcg
15. Daptomycin blddapto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ daptomic <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2 mcg/L
16. Other: bldoth _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	daptomicmg, daptomicmcg
17. Other: bldoth2 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Enterococcus

18. High Level Streptomycin histrib	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. High Level Gentamicin higentb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Poly Blood Culture Form Table Polycult

Complete this form if you answered "yes" to question 6 on the Blood Culture form (page 16).

- Genus and/or species of the likely **secondary infecting organism** (check one):
Genus and/or Species of Organism: _____ **(Enter Bug Code #) bugspec_, if other bloodoth**
Refer to the complete Bug Code list available on the ICE website. If code not found, write in genus/species of "other" organism.
- Number of positive blood cultures for secondary infecting organisms: _____ **poscultsec**
- Number of total cultures: _____ *(1 intravenous stick = 1culture)* **totcultsec**

Common Bug Code List (Complete List available on the ICE website)

Genus/Species	Code
Abiotrophia defectiva	73.01
Candida albicans	37.01
Candida parapsilosis	37.05
Chlamydia pneumoniae	7.02
Enterobacter cloacae	9.01
Enterococcus faecalis	28.01
Enterococcus faecium	28.03
Escherichia coli	10.01
Haemophilus parainfluenzae	23.02

Genus/Species	Code
Klebsiella pneumonia	16.01
Mycoplasma pneumoniae	78.01
Pseudomonas aeruginosa	12.01
Staphylococcus aureus	17.10
Staphylococcus epidermidis	17.04
Staphylococcus lugdunensis	17.07
Streptococcus anginosus	25.01
Streptococcus bovis	25.13
Streptococcus gallolyticus	25.14

Genus/Species	Code
Streptococcus gordonii	25.06
Streptococcus Group B/agalactiae	25.15
Streptococcus Group C/G	25.16
Streptococcus mitis	25.08
Streptococcus mutans	25.09
Streptococcus oralis	25.10
Streptococcus pneumoniae	25.18
Streptococcus salivarius	25.11
Streptococcus sanguis	25.12

Organism Sensitivities (S= Susceptible, I= Intermediate, R= Resistant, U = Unknown)

Antibiotics	S	I	R	U	MIC
4. Aminoglycoside bld2amino	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	99 <input type="checkbox"/>	
5. Penicillin bld2pen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ pen2mic <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2mcg/L pen2micmg, pen2mcgl
6. Ampicillin/amoxicillin bld2amp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Penicillinase-Resistant Penicillin bld2penr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ penr2mic <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2mcg/L penr2micmg, penr2mcg
8. Cefazolin / Cephalothin bld2cefa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Ceftriaxone bld2ceftr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Vancomycin bld2vanc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ vanc2mic <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2mcg/L vanc2micmg, vanc2micmcg
11. Daptomycin bld2dapto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ dapto2mic <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2mcg/L dapto2micmg, dapto2micmcg
12. Other: _____ bld2oth, bld2othlist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Other: _____ bld2oth2, bld2oth2list	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For Enterococcus

14. High Level Streptomycin histrepb2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. High Level Gentamicin higentb2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Other Culture Form Table Othcult

**Complete this form if you answered "yes" to 65 a-d on the Culture / Serology form (page 5).
Use separate sheets for each source checked as "yes."**

othsource

1. What was the source? Valve **1**
 Joint **2**
 Pacemaker (device, pocket, or lead) **7**
 Other Sterile Site _____ **otherspec, othspeclist**

2. What is the **Genus and/or Species of Organism:** _____ **(Enter Bug Code #)**
 Refer to the complete Bug Code list available on the ICE website. If code not found, write in genus/species of "other" organism.
bugspec_, if other bloodoth

Common Bug Code List (Complete List available on the ICE website)

<u>Genus/Species</u>	<u>Code</u>
Abiotrophia defectiva	73.01
Candida albicans	37.01
Candida parapsilosis	37.05
Chlamydia pneumoniae	7.02
Enterobacter cloacae	9.01
Enterococcus faecalis	28.01
Enterococcus faecium	28.03
Escherichia coli	10.01
Haemophilus parainfluenzae	23.02

<u>Genus/Species</u>	<u>Code</u>
Klebsiella pneumonia	16.01
Mycoplasma pneumoniae	78.01
Pseudomonas aeruginosa	12.01
Staphylococcus aureus	17.10
Staphylococcus epidermidis	17.04
Staphylococcus lugdunensis	17.07
Streptococcus anginosus	25.01
Streptococcus bovis	25.13
Streptococcus gallolyticus	25.14

<u>Genus/Species</u>	<u>Code</u>
Streptococcus gordonii	25.06
Streptococcus Group B/agalactiae	25.15
Streptococcus Group C/G	25.16
Streptococcus mitis	25.08
Streptococcus mutans	25.09
Streptococcus oralis	25.10
Streptococcus pneumoniae	25.18
Streptococcus salivarius	25.11
Streptococcus sanguis	25.12

Organism Sensitivities (S= Susceptible, I= Intermediate, R= Resistant, U = Unknown)

<u>Antibiotics</u>		<u>S</u>	<u>I</u>	<u>R</u>	<u>U</u>	<u>MIC</u>
3. Aminoglycoside	bldvmino	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Penicillin	bldvpen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ penvmic_ <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2mcg/L
5. Ampicillin/amoxicillin	bldvamp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	penvmicmg, penvmicmcg
6. Penicillinase-Resistant Penicillin	bldvpenr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ penvmic <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2mcg/L
7. Cefazolin / Cephalothin	bldvcefa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	penvmicmg, penvmicmcg
8. Ceftriaxone	bldvceft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Vancomycin	bldvvanc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ vancvmic <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2mcg/L
10. Daptomycin	bldvdapto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vancvmicmg, vancvmcg _____ daptovmic <input type="checkbox"/> 1mg/L <input type="checkbox"/> 2 mcg/L daptovicmg, daptovicmcg
11. Other: _____	bldvoth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Other: _____	bldvoth2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
For Enterococcus						
13. High Level Streptomycin	histrepv	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
14. High Level Gentamicin	higentbv	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	