

CARDIAC FORMS

P²C² HIV
CARDIAC ASSESSMENT
FORM # 71

INSTRUCTIONS

This assessment is not intended to reflect the complete history and physical examination, but is a collection of important data items required for this study.

Each center must perform a complete history and physical to assess the health status. The final impression will be documented on this form.

Routine Schedule:

- Group I - Complete this form at the initial cardiology visit and at months 4, 8, 12, 16, 20, 24, 28, 32, 36, 40, 44, 48, 52, 56, 60, 64, 68, 72 and 76.
- Group II - Testing will be performed at the baseline visit and at month 4. HIV status will be determined at month 6 and the schedule of testing will be determined by whether the child is a Group IIa or IIb.
- Group IIa - Testing will be performed at months 8, 12, 16, 20, 24, 28, 32, 36, 40, 44, 48, 52, 56, 60, 64, 68, 72 and 76.
- Group IIb - Testing will be performed at months 12, 18, 24, 30, 36, 42, 48, 54, 60, 66, 72 and 78.
 (controls)

Intercurrent Illness:

- Groups I and II - Complete this form at the time of an evaluation of an intercurrent illness.

ITEM # INSTRUCTIONS/NOTES

- 1 Indicate the reason for the cardiac assessment whether routine or due to intercurrent illness (unscheduled inpatient or outpatient).
- 7a - 7c Nine blood pressure measurements are to be taken at the time of the visit (includes: three pressures in the right arm, three in the left arm, and three in the right or left leg). The state of the patient should be the same for each blood pressure reading taken. If the pressures are taken but are felt to be unreliable, enter F5 (unknown). If the pressures are not done, enter F7. Leg BP should be taken in the thigh just above the popliteal fossa.
- 8a - 8i Respond to each medication listed. If response to 8h or 8i is "1" (yes), specify the drug. More than one medication may be entered in the "specify" field.
- 9b - 9k If cardiac abnormalities are identified during the examination, the anomalies are documented here. Use as many lines as needed. All items in a line must be completed.

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CARDIAC ASSESSMENT
FORM # 71

ITEM# INSTRUCTIONS/NOTES

9b - 9k
 (continued)

Complete each line of information as needed and enter "F6" in the first field immediately following the last entry. The "F6" designates that entry is complete, and additional fields are not applicable. It is not necessary to write "F6" in each space shown.

DIAGNOSIS NARRATIVE:

Write out the diagnosis.

SITE CODE:

Code the site of the disease. Use the SNOMED 5 digit topography codes (codes with a "T" prefix). The prefix has already been provided on the form. Enter the five digit code number.

If the site is not found in the SNOMED Indices or a site cannot be assigned (see general instructions), use the following conventions:

- T-00001 = Code not found/unable to code
- T-00002 = Site code not applicable

DIAGNOSIS CODE:

Code the diagnosis. Use the SNOMED Function (prefix F), Disease (prefix D) or Morphology (prefix M) codes. The prefix must precede the code number. Refer to the alphabetic index, Volume II, for the complete listing of diagnoses.

Some disease code numbers are four digits in length. Use as many spaces as needed. Begin the entry from the far left and leave the last space blank.

Example: Myocarditis (newborn); code D-7135 enter:

 D - 7 1 3 5

If the diagnosis cannot be found in the SNOMED Indices, enter "D-00001".

CODING EXAMPLE

Example: Final diagnosis - tachycardia and mitral regurgitation

b. <u> Tachycardia </u>	<u> T </u> - <u> 3 </u> <u> 2 </u> <u> 0 </u> <u> 0 </u> <u> 0 </u>	<u> F </u> - <u> 7 </u> <u> 3 </u> <u> 1 </u> <u> 4 </u> <u> 0 </u>
c. <u> Mitral regurgitation </u>	<u> T </u> - <u> 3 </u> <u> 8 </u> <u> 0 </u> <u> 0 </u> <u> 0 </u>	<u> F </u> - <u> 7 </u> <u> 0 </u> <u> 5 </u> <u> 0 </u> <u> 0 </u>
d. <u> F6 </u>	<u> T </u> - <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>	<u> </u> - <u> </u> <u> </u> <u> </u> <u> </u> <u> </u>

P²C² STUDY
CARDIAC ASSESSMENT

GROUPS I AND II PATIENTS

Patient's ID #: I D N O

Form #: 7 1

Completed by: _____
(print name)

Date Completed: DT-FORM
(mm/dd/yy)

Visit: Month V I S I T H

Code missing data items as follows:

F5 = Unknown F6 = Not applicable F7 = Not done

- 1. Indication IN
 - 1 - routine
 - 2 - unscheduled outpatient
 - 3 - unscheduled inpatient

- 2. Date of visit (mm/dd/yy) DT-CA

- 3. Patient state STATECA
 - 1 - relaxed
 - 2 - tense
 - 3 - unmanageable

- 4. a. Temperature (°C) TEMPCA
- b. Thermometer placement THERMCA
 - 1 - axillary
 - 2 - oral
 - 3 - rectal

- 5. Heart rate (beats/min) HTRATECA

- 6. Respiratory rate (breaths/min) RR-CA

P²C² STUDY
CARDIAC ASSESSMENT

7. Blood Pressure: *Three pressures are to be taken in the right arm, left arm, and right or left leg. The state of the patient should be the same for each blood pressure reading taken. If the pressures are taken but are felt to be unreliable, enter F5 (unknown). If the pressures are not done, enter F7.*

	<u>First Reading</u> systolic/diastolic	<u>Second Reading</u> systolic/diastolic	<u>Third Reading</u> systolic/diastolic
a. Right arm	BPRARMS1 / BPAARMΔ1	BPRARMS2 / BFRARMΔ2	BPRARMS3 / BPAARMΔ3
b. Left arm	BPLARMS1 / BPLARMΔ1	BPLARMS2 / BPLARMΔ2	BPLARMS3 / BPLARMΔ3
c. Right or left leg	BPLEGS1 / BPLEGΔ1	BPLEGS2 / BPLEGΔ2	BPLEGS3 / BPLEGΔ3
(Leg BP should be taken in the thigh just above the popliteal fossa)			
d. Method			<u>CAPMETH</u>
1 = Dinamap			
2 = Doppler			
3 = auscultation			
4 = palpation			

CURRENT CARDIAC MEDICATIONS

8. Indicate current cardiac medications (respond to each item 8a - 8i):

0 = no
1 = yes

- a. Digoxin DIGOXIN
- b. Furosemide FUROSEM
- c. Hydrodiuril HYDRODIU
- d. Spirolactone SPIROL
- e. Enalapril ENALAP
- f. Captopril CAPTOPR
- g. Hydralazine HYDRALAZ
- h. Antiarrhythmic ANTIARR
(Specify: OTHANTI)
- i. Other OTHMEDCA
(Specify: OTHMEDSP)

If yes to any one of the above items, complete item 8j:

j. Specify the reason for the medication:

CAREASMD

P²C² STUDY
CARDIAC ASSESSMENT

IMPRESSION AT CONCLUSION OF HISTORY AND PHYSICAL

9. a. Cardiac abnormalities identified

ABNORCA

- 0 - no
- 1 - yes

If yes, complete 9b - 9k as needed: (SNOMED codes with prefix M, F or D are applicable in the diagnosis field.)

	<u>Diagnosis</u> (narrative)	<u>Site code</u> (SNOMED)	<u>Diagnosis code</u> (SNOMED)
b.	<u>CANARR1</u>	<u>T- CASITE1</u>	<u>- CADIAG1</u>
c.	<u>CANARR2</u>	<u>T- CASITE2</u>	<u>- CADIAG2</u>
d.	<u>CANARR3</u>	<u>T- CASITE3</u>	<u>- CADIAG3</u>
e.	<u>CANARR4</u>	<u>T- CASITE4</u>	<u>- CADIAG4</u>
f.	<u>CANARR5</u>	<u>T- CASITE5</u>	<u>- CADIAG5</u>
g.	<u>CANARR6</u>	<u>T- CASITE6</u>	<u>- CADIAG6</u>
h.	<u>CANARR7</u>	<u>T- CASITE7</u>	<u>- CADIAG7</u>
i.	<u>CANARR8</u>	<u>T- CASITE8</u>	<u>- CADIAG8</u>
j.	<u>CANARR9</u>	<u>T- CASITE9</u>	<u>- CADIAG9</u>
k.	<u>CANARR10</u>	<u>T- CASITE10</u>	<u>- CADIAG10</u>

Entered by: CERT-ND
(cert. #)

Date entered: DT-FMENT
(mm/dd/yy)

P²C² HIV
FETAL ECHOCARDIOGRAM
FORM # 72

INSTRUCTIONS

FETAL ECHO STUDIES DISCONTINUED AS OF 12/19/92

**P²C² HIV
FETAL ECHOCARDIOGRAM**

GROUP II PRENATAL ENROLLMENT

Patient's ID #: JW0

Form #: 72

Completed by: _____
(print name)

Date Completed: DT-FORM
(mm/dd/yy)

Code missing data items as follows:

F5 - Unknown F6 - Not applicable F7 - Not done

- 1. Date of procedure (mm/dd/yy) DT-FE
- 2. Tape Number (5 digits)..... TAPFEFE
- 3. Tape start time (min. : sec.) STARTFE FESTSEC
- 4. Tape end time (min. : sec.) ENDFE FEEKSEC
- 5. a. LMP date (last menstrual period date)..... DT-LMP
- b. Menstrual age (weeks) MENAGE

Fetal Measurements

- 6. a. Biparietal diameter (mm) BI PARJET
- b. Femur length (mm) FEMUR
- [Estimated gestational age (weeks) GSTAGEFE]
- 7. Umbilical arterial Doppler systolic flow rate SYSTOLFL
- 8. Umbilical arterial Doppler diastolic flow rate DIASTOLFL

P²C² HIV
FETAL ECHOCARDIOGRAM

Cardiac Studies

9.	Left ventricular cavity in diastole (mm).....	<u>LCAVDIA</u>
10.	Right ventricular cavity in diastole (mm).....	<u>RCAVDIA</u>
11.	Left ventricular cavity in systole (mm).....	<u>LCAVSYS</u>
12.	Right ventricular cavity in systole (mm).....	<u>RCAVSYS</u>
13.	Mitral annulus diameter (mm).....	<u>MITRALD</u>
14.	Tricuspid annulus diameter (mm).....	<u>TRICUSPD</u>
15.	Left ventricular wall thickness (mm)	<u>LVENTW</u>
16.	Right ventricular wall thickness (mm)	<u>RVENTW</u>
17.	Ventricular septal wall thickness (mm).....	<u>VENTWALL</u>
18.	Systolic aortic root (mm)	<u>AORTICRT</u>
19.	Systolic pulmonary root (mm)	<u>PULMRT</u>
20.	Peak aortic velocity (meters/sec).....	<u>PKAVEL</u>
21.	Peak pulmonary velocity (meters/sec).....	<u>PKPVEL</u>
22.	Aortic velocity time integral (meters)	<u>AVEL</u>
23.	Pulmonary velocity time integral (meters)	<u>PVEL</u>
24.	Heart rate by Doppler (beats/min)	<u>MEANHR</u>
25.	Peak mitral E velocity (meters/sec)	<u>MITRALE</u>
26.	Peak mitral A velocity (meters/sec)	<u>MITRALA</u>
27.	Peak tricuspid E velocity (meters/sec)	<u>TRICUSPE</u>
28.	Peak tricuspid A velocity (meters/sec)	<u>TRICUSPA</u>
29.	Mitral velocity time integral (meters)	<u>MITVTI</u>
30.	Tricuspid velocity time integral (meters)	<u>TRIVTI</u>

P²C² HIV

FETAL ECHOCARDIOGRAM

- 31. Mitral regurgitation NITREGUR
 - 0 - none
 - 1 - regurgitant jet < halfway into the atrium
 - 2 - regurgitant jet extends to the mid-atrium
 - 3 - regurgitant jet extends to the posterior atrial wall

- 32. Tricuspid regurgitation TRIREGUR
 - 0 - none
 - 1 - regurgitant jet < halfway into the atrium
 - 2 - regurgitant jet extends to the mid-atrium
 - 3 - regurgitant jet extends to the posterior atrial wall

- 33. Pleural effusion:
 - 0 - no
 - 1 - yes
 - a. Right PLEFFUSR
 - b. Left PLEFFUSL

- 34. Pericardial effusion PERIEFF
 - 0 - no
 - 1 - yes

- 35. Ascites ASCITES
 - 0 - no
 - 1 - yes

- 36. Scalp skin thickness SCALPSK
 - 1 - < 2 mm
 - 2 - 2 - 4 mm
 - 3 - > 4 mm

Patient #: _____

**P²C² HIV
FETAL ECHOCARDIOGRAM**

37. a. Cardiac abnormalities identified

ABNOREFE

- 0 - no
- 1 - yes

If yes, complete 37b - 37g as needed: (SNOMED codes with prefix M, F or D are applicable in the diagnosis field.)

	<u>Diagnosis</u> (narrative)	<u>Site code</u> (SNOMED)	<u>Diagnosis code</u> (SNOMED)
b.	<u>FENARR1</u>	<u>T- FESITE1</u>	<u>- FEDIAG1</u>
c.	<u>FENARR2</u>	<u>T- FESITE2</u>	<u>- FEDIAG2</u>
d.	<u>FENARR3</u>	<u>T- FESITE3</u>	<u>- FEDIAG3</u>
e.	<u>FENARR4</u>	<u>T- FESITE4</u>	<u>- FEDIAG4</u>
f.	<u>FENARR5</u>	<u>T- FESITE5</u>	<u>- FEDIAG5</u>
g.	<u>FENARR6</u>	<u>T- FESITE6</u>	<u>- FEDIAG6</u>

Entered by: CERT-ND
(cert. #)

Date entered: DT-FMENT
(mm/dd/yy)

P²C² STUDY**POSTNATAL ECHOCARDIOGRAM PART I**

FORM # 73

INSTRUCTIONS

Data collected on this form will be used to complete Form #74 (Postnatal Echocardiogram Part II: Off Line Analysis). A copy of this form, along with the M-mode tracing, is to be sent to Boston for each echocardiogram performed.

Routine Schedule:

- Group I - Complete this form at the initial cardiology visit and at month 4, 8, 12, 16, 20, 24, 28, 32, 36, 40, 44, 48, 52, 56, 60, 64, 68, 72 and 76.
- Group II - Testing will be performed at the baseline visit and at month 4. HIV status will be determined at month 6 and the schedule of testing will be determined by whether the child is a Group IIa or IIb.
- Group IIa - Testing will be performed at months 8, 12, 16, 20, 24, 28, 32, 36, 40, 44, 48, 52, 56, 60, 64, 68, 72 and 76.
- Group IIb controls - Testing will be performed at months 12, 18, 24, 30, 36, 42, 48, 54, 60, 66, 72 and 78.

Intercurrent Illness:

- Groups I and II - Complete this form when indicated for a cardiac intercurrent illness.

ITEM # **INSTRUCTIONS/NOTES**

- 4 & 5 The tape start time corresponds to the start time as identified on the echocardiograph tape. The time is to be recorded in minutes and seconds. The tape end time should be recorded in the same manner.
- 14 Aortic regurgitation: The jet diameter is measured in parasternal long and short axis views as the regurgitant jet crosses the valve or at the earliest point when it can be detected.
- 20 & 23 Mitral and tricuspid regurgitation: Based on the diameter of the color Doppler jet at the valve.
- 29a - 29g Record all structural abnormalities observed at the time of the echo. (NOTE: If a structural abnormality is documented in a previous question on the form, the diagnosis should not be recorded, again, under this item.)

Complete each line of information as needed and enter "F6" in the first field immediately following the last entry.

DIAGNOSIS NARRATIVE:

Write out the diagnosis.

P²C² STUDY
POSTNATAL ECHOCARDIOGRAM PART I
FORM # 73

ITEM # INSTRUCTIONS/NOTES

29b - 29g **SITE CODE:**
 (cont.)

Code the site of the disease. Use the SNOMED 5 digit topography codes. The prefix has already been provided on the form. Enter the five digit code number.

If the site is not found in the SNOMED Indices or a site cannot be assigned (see general instructions), use the following conventions:

- T-00001 = Code not found/unable to code
- T-00002 = Site code not applicable

DIAGNOSIS CODE:

Code the diagnosis. SNOMED codes with an M, F or D prefix are applicable. The prefix must precede the code number. Refer to the alphabetic index, Volume II, for the complete listing of diagnoses. If the diagnosis cannot be found in the SNOMED Indices, enter "D-00001".

STATUS:

Enter the appropriate code to indicate if the abnormality is either new (not seen on last echo) or persistent (previously observed and recorded). Missing codes will not be accepted in this field. Previous echos must be reviewed.

Coding Example: Ventricular septal defect (seen previously) and left coronary artery dilatation (new condition)

b. <u>Ventricular septal defect</u>	<u>T - 3 2 4 1 0</u>	<u>M - 2 4 4 0 0</u>	<u>2</u>
c. <u>Left coronary artery dilatation</u>	<u>T - 4 3 1 0 0</u>	<u>M - 3 2 1 0 0</u>	<u>1</u>
d. <u>F6</u>	<u>T - - - - -</u>	<u>M - - - - -</u>	<u>-</u>

30a - 30g Investigators/technicians are required to review the last echo study performed on the patient prior to completing this form (preferably prior to performing the echo study). Abnormalities observed at the last echo should be specifically noted and evaluated. If the abnormality is present, record the condition in item 29. (See above). However, if the condition is no longer present, enter "1" (yes) in item 30a. Describe and code the resolved abnormality in items 30b - 30g. (See above for coding instructions).

If a structural abnormality seen on the previous echo could not be adequately examine due to poor viewing position, and the status of the abnormality is unknown, item 30a should be completed with an F5 ("unknown"). The details should be summarized in the narrative and codes T-99999 and D-99999 entered in the field provided.

Example - PFO was seen on the last echo, but cannot be adequately evaluated due to poor position for viewing:

30b. PFO unobservable (poor position) T - 9 9 9 9 9 D - 9 9 9 9 9

P²C² STUDY
POSTNATAL ECHOCARDIOGRAM
PART I: DIRECT INTERPRETATION

GROUPS I AND II PATIENTS

Patient's ID #: INDO - - - -

Form #: 73

Completed by: _____
(print name)

Date Completed: DT-FORM
____/____/____
(mm/dd/yy)

Visit: Month VJSMTH

Code missing data items as follows:

F5 - Unknown F6 - Not applicable F7 - Not done

- 1. Indication INDPE
 1 - routine
 2 - unscheduled outpatient
 3 - unscheduled inpatient
- 2. Date of postnatal echocardiogram (mm/dd/yy) DT-PE
 ____/____/____
- 3. Tape number TAPEPE

- 4. Tape start time (min. : sec.) STARTPE : PESECC

- 5. Tape end time (min. : sec.) ENDPE : PEENSEC

- 6. Sedation SEDATION
 0 - no
 1 - yes
- 7. Height (cm) HT-PE

- 8. Weight (kg) WT-PE

- 9. Body surface area (m²) BSA

- Blood Pressure
- 10. Peak systolic blood pressure (mm Hg) PKBP
- 11. Diastolic blood pressure (mm Hg) DIASTBP
- Pericardium
- 12. Pericardial effusion EFFUSION
 0 - none
 1 - localized with < 5 mm maximum thickness
 2 - localized or circumferential with 5 - 10 mm maximal diam.
 3 - circumferential with 11 - 15 mm maximal diameter
 4 - circumferential with > 15 mm maximal diameter

P²C² STUDY
POSTNATAL ECHOCARDIOGRAM
PART I: DIRECT INTERPRETATION

Aortic Valve

- 13. Aortic valve maximum velocity (m/sec)
- 14. Aortic regurgitation

 - 0 = none
 - 1 = jet diameter < 3 mm
 - 2 = 3 - 5 mm
 - 3 = 6 - 8 mm
 - 4 = > 8

ATVELPE
ATREGRUG

- 15. Aortic vegetation

 - 0 = negative
 - 1 = positive

ATVEG

Pulmonic Valve

- 16. Pulmonic valve maximum velocity (m/sec)
- 17. Pulmonic regurgitation

 - 0 = no
 - 1 = yes (do not use this code, no longer applicable)
 - 2 = yes, physiologic
 - 3 = yes, pathologic

PLVELPE
PLREGRUG

- 18. Pulmonic vegetation

 - 0 = negative
 - 1 = positive

PLVEG

Mitral Valve

- 19. Mitral valve maximum velocity (m/sec)
- 20. Mitral regurgitation

 - 0 = none
 - 1 = < 3 mm
 - 2 = 3 - 5 mm
 - 3 = 6 - 8 mm
 - 4 = > 8 mm

MITVELPE
MITREGR

- 21. Mitral vegetation

 - 0 = negative
 - 1 = positive

MITVEG

Tricuspid Valve

- 22. Tricuspid valve maximum velocity (m/sec)

TRIVELPE

P²C² STUDY

POSTNATAL ECHOCARDIOGRAM PART I: DIRECT INTERPRETATION

23. a. Tricuspid regurgitation
- 0 = none
 - 1 = < 3 mm
 - 2 = 3 - 5 mm
 - 3 = 6 - 8 mm
 - 4 = > 8 mm

TRI REG RG

If response to 23a is "0" (none) skip to item 24.

- b. Tricuspid regurgitation (maximum velocity, m/sec)

TRI REG GD

24. Tricuspid vegetation
- 0 = negative
 - 1 = positive

TRI VEG

25. Atrial enlargement:
- 0 = no
 - 1 = yes

- a. Right atrial enlargement

RA ENLARG

- b. Left atrial enlargement

LA ENLARG

26. Interventricular septal position in late systole
- 1 = convex towards right ventricle
 - 2 = straight
 - 3 = convex towards left ventricle

SEPT POS

27. Diastolic septal flattening
- 0 = not present
 - 1 = present

SEPTAL F

28. Regional wall motion abnormalities
- 0 = negative
 - 1 = positive

WALL MOT

29. a. Additional structural abnormalities identified ...
- (Note: If a structural abnormality is documented in a previous question on this form, the diagnosis should not be repeated again here.)
- 0 = no
 - 1 = yes

ABNOR PE

If yes, complete 29b - 29g as needed: (Use SNOMED codes. SNOMED codes with prefix M, F or D are applicable in the diagnosis field.)

Status: 1 = new (not seen on last echo); 2 = persistent (previously seen and documented).

Patient #: _____

P²C² STUDY
POSTNATAL ECHOCARDIOGRAM
PART I: DIRECT INTERPRETATION

	<u>Diagnosis</u> (narrative)	<u>Site code</u> (SNOMED)	<u>Diagnosis code</u> (SNOMED)	<u>Status</u> 1 = new 2 = persistent
b.	<u>PENARR1</u>	<u>T - PESITE1</u>	<u>- PEDIAG1</u>	<u>ABSTAT1</u>
c.	<u>PENARR2</u>	<u>T - PESITE2</u>	<u>- PEDIAG2</u>	<u>ABSTAT2</u>
d.	<u>PENARR3</u>	<u>T - PESITE3</u>	<u>- PEDIAG3</u>	<u>ABSTAT3</u>
e.	<u>PENARR4</u>	<u>T - PESITE4</u>	<u>- PEDIAG4</u>	<u>ABSTAT4</u>
f.	<u>PENARR5</u>	<u>T - PESITE5</u>	<u>- PEDIAG5</u>	<u>ABSTAT5</u>
g.	<u>PENARR6</u>	<u>T - PESITE6</u>	<u>- PEDIAG6</u>	<u>ABSTAT6</u>

30. a. Are there any structural abnormalities that were identified on the last echo that are no longer present?
 0 = no
 1 = yes

REABNDR

If yes, list and code the resolved diagnoses in 30b - 30g:

	<u>Diagnosis</u> (narrative)	<u>Site code</u> (SNOMED)	<u>Diagnosis code</u> (SNOMED)
b.	<u>RENAR1</u>	<u>T - RESITE1</u>	<u>- REDJAG1</u>
c.	<u>RENAR2</u>	<u>T - RESITE2</u>	<u>- REDJAG2</u>
d.	<u>RENAR3</u>	<u>T - RESITE3</u>	<u>- REDJAG3</u>
e.	<u>RENAR4</u>	<u>T - RESITE4</u>	<u>- REDJAG4</u>
f.	<u>RENAR5</u>	<u>T - RESITE5</u>	<u>- REDJAG5</u>
g.	<u>RENAR6</u>	<u>T - RESITE6</u>	<u>- REDJAG6</u>

Entered by: CERT-NO
(cert. #)

Date entered: DT-FMENT
(mm/dd/yy)

 * A copy of this form is to be sent along
 * with the M-mode tracing to:
 *
 *

P²C² HIV
POSTNATAL ECHOCARDIOGRAM PART II
FORM # 74

INSTRUCTIONS

An offline analysis of echocardiographic data (collected in Part I - form #73) will be performed by each center and captured on this form. A separate analysis will be performed by the Boston group on each patient in the study.

Routine Schedule:

- Group I - Complete this form at the initial cardiology visit and at month 4, 8, 12, 16, 20, 24, 28, 32, 36, 40, 44, 48, 52, 56, 60, 64, 68, 72 and 76.
- Group II - Testing will be performed at the baseline visit and at month 4. HIV status will be determined at month 6 and the schedule of testing will be determined by whether the child is a Group IIa or IIb.
- Group IIa - Testing will be performed at months 8, 12, 16, 20, 24, 28, 32, 36, 40, 44, 48, 52, 56, 60, 64, 68, 72 and 76.
- Group IIb controls - Testing will be performed at months 12, 18, 24, 30, 36, 42, 48, 54, 60, 66, 72 and 78.

Intercurrent Illness:

- Groups I and II - Complete this form when indicated for a cardiac intercurrent illness.

P²C² HIV
POSTNATAL ECHOCARDIOGRAM
PART II: OFF LINE ANALYSIS

GROUPS I AND II PATIENTS

Patient's ID #: IDNO

Form #: 74

DT-FORM

Completed by: _____
 (print name)

Date Completed: / /
 (mm/dd/yy)

Visit: Month VISMTH

Code missing data items as follows:

F5 = Unknown

F7 = Not done

- | | | | | |
|--|-----|---|-----|-----------|
| 1. Date of echocardiogram (mm/dd/yy) | --- | / | --- | DT-PE2 |
| 2. R-R interval (msec) | --- | | | RAINTER |
| 3. Ejection time (msec) | --- | | | EJECTX |
| <u>Dimension</u> | | | | |
| 4. End diastolic dimension (cm) | --- | | | EDD |
| 5. End systolic dimension (cm) | --- | | | ESD |
| <u>Thickness</u> | | | | |
| 6. End diastolic posterior wall thickness (cm) | --- | | | ENDPTHICK |
| 7. End systolic posterior wall thickness (cm) | --- | | | ESPTHICK |
| 8. End diastolic septal thickness (cm) | --- | | | DSEPTTH |
| 9. End systolic septal thickness (cm) | --- | | | SSEPTTH |
| <u>Shortening</u> | | | | |
| 10. Fractional Shortening (%) | --- | | | FS |
| <u>Velocity</u> | | | | |
| 11. Mitral valve peak early velocity (m/sec) | --- | | | MVA |
| 12. Mitral valve peak atrial velocity (m/sec) | --- | | | MVE |
| <u>Aortic Measurements</u> | | | | |
| 13. Aortic annulus diameter (cm) | --- | | | PEANAD |
| 14. Sinuses of Valsalva (cm) | --- | | | PEAMSV |
| 15. Sino-tubular junction (cm) | --- | | | PEAMSTJ |

Entered by: _____
 (cert. #)

Date entered: / /
 (mm/dd/yy)

P²C² HIV
STANDARD ECG
FORM # 75

INSTRUCTIONS

Routine Schedule:

Group I and II - Complete this form at the initial cardiology visit and at month 12, 24, 36 48, 60 and 72.

Intercurrent Illness:

Groups I and II - Complete this form when an ECG is performed for the evaluation of a cardiac intercurrent illness.

ITEM # **INSTRUCTIONS/NOTES**

- 1 Indicate the reason for testing. Testing may be routine or due to illness (unscheduled inpatient or outpatient).
- 4b Bradycardia is defined as any heart rate which is below the 2nd percentile of the Davignon Tables. (See Appendix 10, Figure 1 and Appendix 15 in the Manual of Operations.)
- 4c Tachycardia is defined as any heart rate which exceeds the 98th percentile of the Davignon Tables. (See Appendix 10, Figure 1 and Appendix 15 in the Manual of Operations.)
- 6b Record the axis in degrees. Negative numbers are acceptable.
- 6c (See Appendix 10, Figure 2 in the Manual of Operations for reference.)
- 18 - 40 10 millivolts = 1 ml.
- 35 - 40 Indicate if the measurement for each P and T amplitude is available in the first column. If available, enter the measurement in the second column. (Note: These questions are in two parts to allow for the negative measurements. Negative entries in the second column are actual measurements, not "missing data".)
- 41 This field should be used to document abnormal findings only. If an abnormality has already been documented in a previous question on this form, it should not be repeated here.

P²C² STUDY STANDARD ECG

GROUPS I AND II PATIENTS

Patient's ID #: I D N O - - - -

Form #: 7 5

Completed by: _____
(print name)

Date Completed: DT-FORM / /
(mm/dd/yy)

Visit: Month V J S M T H

Code missing data items as follows:

F5 = Unknown

F7 = Not done

- 1. Indication INDECG
 - 1 - routine
 - 2 - unscheduled outpatient
 - 3 - unscheduled inpatient
- 2. Date of ECG (mm/dd/yy) DT-ECG
- 3. a. Atrial rate (beats/min.) HRATRIAL
- b. Ventricular rate (beats/min.) HRVENT
- 4. Rhythm (respond to each item):
 - 0 - not present
 - 1 - present, predominant rhythm
 - 2 - present, other rhythm
 - a. Sinus rhythm SINRHY
 - b. Sinus bradycardia SINBRAD
(rate below the 2nd percentile of the Davignon Tables)
 - c. Sinus tachycardia SINTACHY
(rate which exceeds the 98th percentile of the Davignon Tables)
 - d. Junctional rhythm JUNRHY
 - e. First degree AV Block AVBLOCK
 - f. Second degree AV Block I AVBLK1
 - g. Second degree AV Block II AVBLK2
 - h. Third degree AV Block THDAVB
 - i. Premature atrial contraction ATCONT
 - j. Premature junctional contraction JUNCTCON
 - k. Premature ventricular contraction VENTCON

P²C² STUDY STANDARD ECG

Rhythm continued

- l. Supraventricular tachycardia
- m. Ventricular tachycardia
- n. Atrial flutter
- o. Atrial fibrillation
- p. Other (Specify: SOTHRHY)

SVTACHY
VTACHY
FLUTTER
AFIB
OTHRHY

5. Atrial enlargement: Right atrial enlargement - P wave in any lead > 2.5 mm.
Left atrial enlargement - P terminal forces in lead V₁ > 1 mm.

0 - no
1 - yes

- a. Right atrial enlargement
- b. Left atrial enlargement

RAE
LAE

6. a. Frontal plane QRS axis available

0 - no
1 - yes

QRS
AVAILABLE

If response is "1" (yes), complete 6b and 6c:

- b. Frontal plane QRS, axis (degrees) [negative numbers accepted]
 - c. QRS deviation
- 0 - normal
1 - left axis deviation
2 - right axis deviation
3 - indeterminate

QRS
QRS DEVI A

7. a. Right ventricular hypertrophy

0 - no
1 - yes

RVHYPER

- 1) qR in V_{4R}, V_{3R}, or V₁
- 2) Positive T wave in V₁ over the age of 1 week
- 3) R wave in V₁ > 98th percentile for age in absence of a biphasic QRS complex (RS ratio > mean for age)
- 4) S wave in V₆ (SV₆) > 98th percentile for age in absence of a biphasic QRS complex.

If response is "1" (yes), complete 7b and 7c:

- b. R wave amplitude in V₁ (RV₁) (mm).....
- c. Depth of SV₆ wave (mm)

RVWAVE
RVS WAVE

Patient #: _____

P²C² STUDY
STANDARD ECG

- 8. a. Left ventricular hypertrophy
- 0 = no
- 1 = yes

LVHYPER

- 1) R V₆ > 98th percentile for age in absence of a biphasic QRS complex.
- 2) S V₁ > 98th percentile for age in absence of a biphasic QRS complex.

If response is "1" (yes), complete 8b and 8c:

- b. Height of R V₆ wave (mm)
- c. Depth of S V₁ wave (mm)

LVHGH

LVDEPTH

- 9. a. Biventricular hypertrophy
- 0 = no
- 1 = yes

BVHYPER

- 1) Independent criteria for right and left ventricular hypertrophy
- 2) Any biphasic QRS complex > 60 mm (i.e. R+S)

If response is "1" (yes), complete 9b:

- b. R + S (mm)

BVRS

- 10. Low voltage (< 5 mm all frontal plane leads).....
- 0 = no
- 1 = yes

LOWVOLT

- 11. a. Conduction defect
- 0 = none
- 1 = complete right bundle branch block
- 2 = complete left bundle branch block
- 3 = intraventricular conduction delay

CDEFECT

- b. QT_c interval

QTINTER

Patient #: _____

P²C² STUDY
STANDARD ECG

12. Q greater than .035 width in lead (respond to each):

0 = no
1 = yes

- a. I or L or V₆
- b. II or III or F
- c. V₁ or V₂ or V₃

QLEAD1
QLEAD2
QLEAD3

13. ST depression greater than 2 mm (respond to each):

0 = no
1 = yes

- a. I, V₅ or V₆
- b. AVF only
- c. All leads
- d. Any other leads

STDEPI
STDEPF
STDEPA
STDEPO

Specify: STDEPS

14. Non-specific ST depression ≤ 2 mm (respond to each):

0 = no
1 = yes

- a. I, V₅ or V₆
- b. AVF only
- c. All leads
- d. Any other leads

STDEPLI
STDEPLF
STDEPLA
STDEPLO

Specify: STDEPLSP

15. ST elevation greater than 1 mm (respond to each):

0 = no
1 = yes

- a. I, V₅ or V₆
- b. AVF only
- c. All leads
- d. Any other leads

STELVI
STELVF
STELVA
STELVO

Specify: STELFS

Patient #: _____

P²C² STUDY STANDARD ECG

16.	PR duration in lead II (milliseconds)	.....	<u>PRDURI I</u>
17.	QT duration in lead V5 (milliseconds)	.....	<u>QT DUR V5</u>
18.	Q amplitude in lead III (millivolts)	.....	<u>QAMP III</u>
19.	Q amplitude in lead AVF (millivolts)	.....	<u>QAMP AVF</u>
20.	Q amplitude in lead V5 (millivolts)	.....	<u>QAMP V5</u>
21.	Q amplitude in lead V6 (millivolts)	.....	<u>QAMP V6</u>
22.	R amplitude in lead AVR (millivolts)	.....	<u>RAMP AVR</u>
23.	R amplitude in lead V3R (millivolts)	.....	<u>RAMP V3R</u>
24.	R amplitude in lead V1 (millivolts)	.....	<u>RAMP V1</u>
25.	R amplitude in lead V2 (millivolts)	.....	<u>RAMP V2</u>
26.	R amplitude in lead V4 (millivolts)	.....	<u>RAMP V4</u>
27.	R amplitude in lead V5 (millivolts)	.....	<u>RAMP V5</u>
28.	R amplitude in lead V6 (millivolts)	.....	<u>RAMP V6</u>
29.	S amplitude in lead V3R (millivolts)	.....	<u>SAMP V3R</u>
30.	S amplitude in lead V1 (millivolts)	.....	<u>SAMP V1</u>
31.	S amplitude in lead V2 (millivolts)	.....	<u>SAMP V2</u>
32.	S amplitude in lead V4 (millivolts)	.....	<u>SAMP V4</u>
33.	S amplitude in lead V5 (millivolts)	.....	<u>SAMP V5</u>
34.	S amplitude in lead V6 (millivolts)	.....	<u>SAMP V6</u>

P and T Amplitudes (Items 35 - 40) - Record if measurements are available in the first column using codes provided. Enter the measurement in the second column if available (values may be negative):

	<u>Measurement Available</u>	<u>Amplitude</u>
	0 = no 1 = yes	
35.	<u>NAPAMP II</u>	<u>PAHP II</u>
36.	<u>NATAMP V3</u>	<u>TAMP V3R</u>
37.	<u>NATAMP V1</u>	<u>TAMP V1</u>
38.	<u>NATAMP V2</u>	<u>TAMP V2</u>
39.	<u>NATAMP V5</u>	<u>TAMP V5</u>
40.	<u>NATAMP V6</u>	<u>TAMP V6</u>
41.	Other abnormal findings	<u>EKGOTH</u>
	0 = no 1 = yes Specify: _____	<u>EKGOTHSP</u>

Entered by: CERT-NO
(cert. #)

Date entered: 1 DT, FMENT
(mm/dd/yy)

P²C² HIV
HOLTER MONITOR
FORM # 76

INSTRUCTIONS

Routine Schedule:

Group I and II - Complete this form at the initial cardiology visit and at month 12, 24, 36, 48, 60 and 72.

Non-Routine Testing:

Groups I and II - Refer to section 5.3.7 and 5.3.8 in the Protocol for indications for non-routine testing.

Tests Under 18 hours:

Studies entered under 18 hours should be entered in the normal fashion (do not enter as missing). If the Holter test is performed more than one time (in order to achieve a good study) during any one visit window, all attempts are to be entered. The duration and use of the Holter vest must be documented. If more than one study is submitted within any one visit window, the study with a duration of 18 hours or more should be submitted for the visit month (month entered into the visit month field). All other attempted studies in the same period should be entered with a visit month of "F6" (-2).

<u>ITEM #</u>	<u>INSTRUCTIONS/NOTES</u>	
1	Indicate the reason for testing. Testing may be routine or due to illness (unscheduled inpatient or outpatient). Choose the appropriate response.	
3	Enter the total number of USABLE hours.	
5a - 5c 7a - 7c	Using the example report on the following page, items 5a - 5c and 7a - 7c would be completed as follows:	
5.	How many hours during the recording was the minimum heart rate at each of the following levels:	
	a. Less than 60	— 0
	b. 60 - 100	— 5
	c. Greater than 100	<u>2</u> 0
7.	How many hours during the recording was the maximum heart rate at each of the following levels:	
	a. Less than 180	— 1
	b. 180 - 220	<u>2</u> 2
	c. Greater than 220	<u>2</u> 2

P²C² HIV
HOLTER MONITOR
FORM # 76

(EXAMPLE)

Holter Monitor Hourly Summary

<u>HOUR</u>	<u>DUR</u>	<u>HEART RATE</u>		
		<u>MIN</u>	<u>AVERAGE</u>	<u>MAX</u>
14	18	150	196	225
15	60	92	166	182
16	60	130	153	174
17	60	87	163	219
18	59	137	187	225
19	60	130	174	192
20	59	94	182	219
21	60	116	174	192
22	59	139	178	207
23	60	156	178	213
0	60	134	170	192
1	60	153	166	207
2	59	109	178	207
3	58	132	178	213
4	60	118	160	196
5	59	96	163	196
6	60	128	156	182
7	58	84	174	207
8	59	147	166	196
9	60	142	163	196
10	59	150	187	207
11	60	150	174	207
12	59	134	174	207
13	59	102	163	207
14	59	137	166	202

P²C² STUDY HOLTER MONITOR

GROUPS I AND II PATIENTS

Patient's ID #: IDNO

Form #: 7 6

Completed by: _____
(print name)

Date Completed: DT-FORM
(mm/dd/yy)

Visit: Month JSMTH

Code missing data items as follows:
F5 = Unknown F7 = Not done

1. Indication INDHM
 - 1 = routine
 - 2 = unscheduled outpatient
 - 3 = unscheduled inpatient
2. a. Date of Holter (mm/dd/yy) DT-HM
- b. Was the Holter vest used ("Teddi Top") TEDDI TOP
 - 0 = no
 - 1 = yes
3. Duration (hours/minutes) HMHOURS / HMMIN
4. Minimum heart rate MINHR
5. How many hours during the recording was the minimum heart rate at each of the following levels:
 - a. Less than 60 MIN<60
 - b. 60 - 100 MIN60100
 - c. Greater than 100 MIN>100
6. Maximum sinus rate MAXSINUS
7. How many hours during the recording was the maximum heart rate at each of the following levels:
 - a. Less than 180 MAX<180
 - b. 180 - 220 MAX180220
 - c. Greater than 220 MAX>220
8. Average heart rate HMAVGHR
9. Longest pause (sec) PAUSE
10. Rhythm (respond to each item):
 - 0 = no
 - 1 = yes
 - a. Sinus rhythm HMSINRHY
 - b. Junctional rhythm HMJUNCT
 - c. First degree AV Block HMAVB

P²C² STUDY HOLTER MONITOR

Rhythm continued

- d. Second degree AV Block I
- e. Second degree AV Block II
- f. Third degree AV Block

HMAV1
HMAV2
HMTDAV

11. Arrhythmia present
- 0 = no
 - 1 = yes

ARRYTH

If arrhythmia is present, complete items 12 and 13.

12. Arrhythmia - Complete 12a - 12e (respond to each):
- 0 = none
 - 1 = rare (less than 10 per day)
 - 2 = moderate (10 per day - 1 per hour)
 - 3 = frequent (more than 1 per hour)

- a. Premature atrial contractions
- b. Premature junctional contractions.....
- c. Premature ventricular contractions
- d. Atrial flutter
- e. Atrial fibrillation

HMATRIAL
HMJUNCTC
HMVENT
HMFLUT
HMFIB

13. Other arrhythmias - If response in first column is yes, complete remaining items in that row:

	<u>Present</u> (0 = no 1 = yes)	<u>Number of</u>	<u>Longest Duration</u> (sec.)	<u>Most Rapid Rate</u> (beats/min.)
a. Supraventricular tachycardia	SVT	SVTNUMB	SVTDUR	SVTRATE
b. Ventricular tachycardia	VENTT	VENTNUM	VENTDUR	VENTTRAT

14. Other observations
- 0 = no
 - 1 = yes

HMOTHOB

If yes, please describe below:

HMOTHSP

Entered by: BERT-NO
(cert. #)

Date entered: 11-15-94
(mm/dd/yy)

P²C² HIV
ENDOMYOCARDIAL BIOPSY
FORM # 77

INSTRUCTIONS

Intercurrent Illness:

Groups I and II - The endomyocardial biopsy is performed when clinically indicated. Complete this form as needed.

ITEM # INSTRUCTIONS/NOTES

5 If the response to this item is "0" (no), STOP at this point. If the response to this item is "1" (yes), proceed and complete the remaining items on this form.

6b - 6f If a histologic abnormality is identified, complete 6b - 6f as needed. Inflammation, fibrosis and degeneration must be specified as to the type. The specifics will be documented under "Additional Codes".

Complete each line of information as needed and enter "F6" in the first field immediately following the last line of entry.

Examples:

- a. Moderate inflammation of the endocardium with neutrophils and eosinophils
- b. Severe myocardial fibrosis, diffuse
- c. Slight degeneration of the myocardium, granular

The above would be entered in the following manner:

	<u>Site</u>	<u>Abnormality</u>	<u>Degree</u>	<u>* Additional Codes</u>		
				---	---	---
a.	<u>1</u>	<u>1</u>	<u>2</u>	<u> 3</u>	<u> 4</u>	<u> F6</u>
b.	<u>2</u>	<u>3</u>	<u>3</u>	<u> 1</u>	<u> 2</u>	<u> F6</u> <u> F6</u>
c.	<u>2</u>	<u>7</u>	<u>1</u>	<u> 2</u>	<u> 2</u>	<u> F6</u> <u> F6</u>
d.	<u>F6</u>	---	---	---	---	---

P²C² HIV
ENDOMYOCARDIAL BIOPSY
FORM # 77

ITEM # **INSTRUCTIONS/NOTES**

7b - 7c If an infectious disease is identified, complete 7b - 7c as needed. Use one line per organism identified. All items in a line must be completed.

Enter "F6" in the first field immediately following the last entry.

ORGANISM NARRATIVE:

Write out the organism identified in the biopsy.

ORGANISM CODE:

Code the organism using the four digit SNOMED Etiology codes. The prefix has already been provided on the form. Enter the four digit code number.

If the appropriate code cannot be found in the SNOMED Indices, enter "E-0001".

METHOD IDENTIFIED:

Applicable codes are listed. If the diagnostic method used is not listed, enter "9" (other) and specify in the field provided.

CODING EXAMPLE

Example: CMV cultured from biopsy and cryptococcus found in tissue stain.

	<u>Organism Narrative</u>	<u>Organism Code</u>	<u>Method</u>
b.	<u>Cytomegalovirus</u>	E- <u>3</u> <u>2</u> <u>2</u> <u>2</u>	<u>1</u>
c.	<u>Cryptococcus</u>	E- <u>4</u> <u>1</u> <u>2</u> <u>0</u>	<u>2</u>
d.	<u>F6</u>	E- <u> </u> <u> </u> <u> </u> <u> </u>	<u> </u>

8b - 8c If a non-infectious disease (other than histologic abnormality documented in 6b - 6f) is identified, complete 8b - 8c as needed. Use one line per disease. Each narrative must be accompanied by a SNOMED code for that disease.

If the diagnosis cannot be found in the SNOMED Indices, enter "D-00001"

P²C² HIV ENDOMYOCARDIAL BIOPSY

GROUPS I AND II PATIENTS

Patient's ID #: INDO

Form #: 77

Completed by: _____
(print name)

Date Completed: DT-FORM
(mm/dd/yy)

Code missing data items as follows:

F5 - Unknown

F6 - Not applicable

1. Indication INSEB
 - 1 - congestive heart failure with abnormalities
in systolic ventriular performance
 - 2 - other (Specify: _____)
2. Date of endomyocardial biopsy (mm/dd/yy) DT-EB
3. Specimen number EBSPEC
4. Site of biopsy SITEEB
 - 1 - right ventricle
 - 2 - left ventricle
 - 3 - both
 - 9 - other (specify: _____)
5. Abnormalities identified on biopsy? ABNOREB
 - 0 - no
 - 1 - yes

IF NO ABNORMALITIES WERE SEEN IN THE BIOPSY SPECIMEN,
STOP HERE.

IF ABNORMALITIES WERE IDENTIFIED DURING THE BIOPSY
COMPLETE THE REMAINING ITEMS ON THIS FORM.

Patient #: _____

P²C² HIV
ENDOMYOCARDIAL BIOPSY
HISTOLOGIC ABNORMALITIES

HISTOABN

6. a. Histologic abnormalities identified ?
- 0 = no
- 1 = yes

If yes, complete 6b - 6f as needed:

<u>Site codes</u>	<u>Abnormality codes</u>	<u>Degree codes</u>
1 = Endocardium	1 = Inflammation *	1 = slight
2 = Myocardium	2 = Thrombosis	2 = moderate
3 = Intima (vascular)	3 = Fibrosis *	3 = severe
4 = Media (vascular)	4 = Elastosis	
5 = Adventitia (vascular)	5 = Hypertrophy	
6 = Capillaries	6 = Atrophy	
	7 = Degeneration *	
	8 = Necrosis	
	9 = Interstitial hypercellularity (non-inflammatory)	

* Additional codes are required for the following abnormalities (Space is provided if more than one code is applicable.):

<u>Inflammation</u> (cell types)	<u>Fibrosis</u>	<u>Degeneration</u>
1 = cell not specified	11 = focal interstitial	21 = vacuolar
2 = lymphocytes	12 = diffuse	22 = granular
3 = neutrophils	13 = focal replacement	23 = myocytolysis
4 = eosinophils		
5 = macrophages		
6 = plasma cells		

<u>Site</u>	<u>Abnormality</u>	<u>Degree</u>	<u>* Additional Codes</u>		
b. <u>HASITE1</u>	<u>HABNORM1</u>	<u>HADEG1</u>	<u>EBAAC11</u>	<u>EBAAC12</u>	<u>EBAAC13</u>
c. <u>HASITE2</u>	<u>HABNORM2</u>	<u>HADEG2</u>	<u>EBAAC21</u>	<u>EBAAC22</u>	<u>EBAAC23</u>
d. <u>HASITE3</u>	<u>HABNORM3</u>	<u>HADEG3</u>	<u>EBAAC31</u>	<u>EBAAC32</u>	<u>EBAAC33</u>
e. <u>HASITE4</u>	<u>HABNORM4</u>	<u>HADEG4</u>	<u>EBAAC41</u>	<u>EBAAC42</u>	<u>EBAAC43</u>
f. <u>HASITE5</u>	<u>HABNORM5</u>	<u>HADEG5</u>	<u>EBAAC51</u>	<u>EBAAC52</u>	<u>EBAAC53</u>

P²C² HIV
ENDOMYOCARDIAL BIOPSY

INFECTIOUS DISEASE

7. a. Infectious disease identified?
0 = no
1 = yes

INFDISFB

If yes, complete 7b - 7e as needed:

Method Codes (If more than one code applies,
1 = culture enter the most definitive method.)
2 = stain/histologic
9 = other (Specify: EBMETH01)

	<u>Organism</u> (narrative)	<u>Organism Code</u> (SNOMED)	<u>Method Identified</u> (See above codes)
b.	<u>EBNAR1</u>	E- <u>EBORG1</u>	<u>EBMETH1</u>
c.	<u>EBNAR2</u>	E- <u>EBORG2</u>	<u>EBMETH2</u>
d.	<u>EBNAR3</u>	E- <u>EBORG3</u>	<u>EBMETH3</u>
e.	<u>EBNAR4</u>	E- <u>EBORG4</u>	<u>EBMETH4</u>

NON-INFECTIOUS DISEASE

8. a. Other diseases identified?
0 = no
1 = yes

NONINFEB

If yes, complete 8b - 8e as needed (Use SNOMED codes.
Codes with a D prefix are applicable. Codes with and F
or M prefix will be rare, but may occur.)

	<u>Disease</u> (narrative)	<u>Disease code</u> (SNOMED)
b.	<u>EBDIS1</u>	- - <u>EBDISCD1</u>
c.	<u>EBDIS2</u>	- - <u>EBDISCD2</u>
d.	<u>EBDIS3</u>	- - <u>EBDISCD3</u>
f.	<u>EBDIS4</u>	- - <u>EBDISCD4</u>

Patient #: _____

**P²C² HIV
ENDOMYOCARDIAL BIOPSY**

- 9. a. Non-diagnostic abnormality identified
 0 - no
 1 - yes

NONDIAG

If yes, complete 9b:

b. Specify: NONDIAG

- 10. a. Electron microscopy performed
 0 - no
 1 - yes

EMEB

If performed, complete 10b:

- b. Findings
 0 - normal
 1 - abnormal

EMFIND

If abnormal, complete 10c:

c. Specify: EMNARREB

- 11. Frozen tissue available
 0 - no
 1 - yes

FLTISSEB

Entered by: CERT-NO
(cert. #)

Date entered: DT-FM-ENT
(mm/dd/yy)

P²C² HIV
CARDIAC CATHETERIZATION REPORT
FORM # 78

INSTRUCTIONS

Intercurrent Illness:

Groups I and II - The cardiac catheterization is performed when clinically indicated. Complete this form as needed.

ITEM # **INSTRUCTIONS/NOTES**

8 - 37 An entry must be made in each field. If a measurement was not done, enter "F7".

46b - 46g If cardiac abnormalities are identified from the catheterization, the anomalies are documented here. Use as many lines as needed. All items in a line must be completed.

Enter "F6" in the first field immediately following the last entry.

DIAGNOSIS NARRATIVE:

Write out the diagnosis.

SITE CODE:

Code the site of the disease. Use the SNOMED 5 digit topography codes. The prefix has already been provided on the form. Enter the five digit code number.

If the site is not found in the SNOMED Indices or a site cannot be assigned (see general instructions), use the following conventions:

- T-00001 = Code not found/unable to code
- T-00002 = Site code not applicable

P²C² HIV
CARDIAC CATHETERIZATION REPORT
FORM # 78

ITEM # **INSTRUCTIONS/NOTES**

46b - 46g **DIAGNOSIS CODE:**
(continued) Code the diagnosis. Use the SNOMED Function (prefix F),
Disease (prefix D) or Morphology (prefix M) codes. The
prefix must precede the code number. Refer to the alphabetic
index, Volume II, for the complete listing of diagnoses.

If the diagnosis cannot be found in the SNOMED Indices, enter
"D-00001".

P²C² HIV
CARDIAC CATHETERIZATION REPORT

PRESSURES

<u>Site</u>	<u>a-wave</u> (mm Hg)	<u>v-wave</u> (mm Hg)	<u>Mean</u> (mm Hg)
8. Right atrium	a) <u>AWAVERA</u>	b) <u>VWAVERA</u>	c) <u>MEANRA</u>
9. Left atrium	a) <u>AWAVELA</u>	b) <u>VWAVELA</u>	c) <u>MEANLA</u>
10. Right Pulmonary veins/PA wedge	a) <u>AWAVERP</u>	b) <u>VWAVERP</u>	c) <u>MEANRPV</u>
11. Left Pulmonary veins/PA wedge	a) <u>AWAVELPV</u>	b) <u>VWAVELPV</u>	c) <u>MEANLPV</u>

<u>Site</u>	<u>Systolic</u> (mm Hg)	<u>Diastolic</u> (mm Hg)	<u>Mean</u> (mm Hg)
12. Main pulmonary artery	a) <u>SYSMPA</u>	b) <u>DIASTMPA</u>	c) <u>MEANMPA</u>
13. Right pulmonary artery	a) <u>SYSPA</u>	b) <u>DIASTPA</u>	c) <u>MEANRPA</u>
14. Left pulmonary artery	a) <u>SYSLPA</u>	b) <u>DIASTLPA</u>	c) <u>MEANLPA</u>
15. Systemic artery	a) <u>SYSSA</u>	b) <u>DIASTSA</u>	c) <u>MEANSA</u>
16. Ascending aorta	a) <u>SYSA</u>	b) <u>DIASTAA</u>	c) <u>MEANAA</u>
17. Descending aorta	a) <u>SYSDA</u>	b) <u>DIASTDA</u>	c) <u>MEANDA</u>
18. Right ventricle; body	a) <u>SYSDRV</u>	b) <u>DIABDRV</u>	
19. Right ventricle; outflow	a) <u>SYSDTRV</u>	b) <u>DIADTRV</u>	
20. Left ventricle; body	a) <u>SYSDLV</u>	b) <u>DIABDLV</u>	
21. Left ventricle; outflow	a) <u>SYSDTLV</u>	b) <u>DIADTLV</u>	

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CARDIAC CATHETERIZATION REPORT

O₂ SATURATION AND BLOOD GAS MEASUREMENTS

<u>Site</u>	<u>O₂ SAT (%)</u>	<u>PO₂ (mm Hg)</u>
22. Right atrium	a) <u> OXYRA </u>	b) <u> PORA </u>
23. Left atrium	a) <u> OXYLA </u>	b) <u> POLA </u>
24. Inferior vena cava	a) <u> OXYINF </u>	b) <u> POINF </u>
25. Superior vena cava	a) <u> OXYSUP </u>	b) <u> POSUP </u>
26. Left pulmonary veins/PA wedge	a) <u> OXYLPV </u>	b) <u> POLPV </u>
27. Right pulmonary veins/PA wedge	a) <u> OXYRPV </u>	b) <u> PORPV </u>
28. Main pulmonary artery	a) <u> OXYMPA </u>	b) <u> POMPA </u>
29. Right pulmonary artery	a) <u> OXYRPA </u>	b) <u> PORPA </u>
30. Left pulmonary artery	a) <u> OXYLPA </u>	b) <u> POLPA </u>
31. Systemic artery	a) <u> OXYSYS </u>	b) <u> PWSYS </u>
32. Ascending aorta	a) <u> OXYASC </u>	b) <u> POASC </u>
33. Descending aorta	a) <u> OXYDESC </u>	b) <u> PODESC </u>
34. Right ventricle body	a) <u> OXYRVBD </u>	b) <u> PORVBD </u>
35. Right ventricle outflow	a) <u> OXYRVOUT </u>	b) <u> PORVOUT </u>
36. Left ventricle body	a) <u> OXYLVBD </u>	b) <u> POLVBD </u>
37. Left ventricle outflow	a) <u> OXYLVOUT </u>	b) <u> POLVOUT </u>

Patient #: _____

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CARDIAC CATHETERIZATION REPORT

- 38. Oxygen Consumption (ml/min/m²)
- 39. Oxygen Capacity (ml/L)

O₂ CONSUM

O₂ CAP.

CALCULATIONS

- 40. Blood Flow (L/min/m²):
 - a. Pulmonary
 - b. Systemic
 - c. Effective Pulmonary

PULMBF

SYSTEMBF

EFFECTBF

PSRATIO

- 41. Pulmonary to systemic flow ratio

- 42. Shunts (L/m/m²):
 - a. Left to Right
 - b. Right to Left

SHUNTLR

SHUNTRL

- 43. Resistances (mm Hg/L/min.)
 - a. Systemic
 - b. Pulmonary arteriolar

RESIST

RESISTPA

ANGIOGRAPHY

- 44. Left ventricular:
 - a. End diastolic volume (ml)
 - b. End systolic volume (ml)
 - c. Ejection fraction (%)

LFTEDVOL

LFTESVOL

LFTEF

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CARDIAC CATHETERIZATION REPORT

45. Right ventricular:

- a. End diastolic volume (ml) RGTEDEVOL
- b. End systolic volume (ml) RGTESVOL
- c. Ejection fraction (%) RGTEF

46. a. Cardiac abnormalities identified

ABNOR CC

- 0 = no
- 1 = yes

If yes, complete 46b - 46g as needed: (SNOMED codes with prefix M, F or D are applicable in the diagnosis field.)

	<u>Diagnosis</u> (narrative)	<u>Site code</u> (SNOMED)	<u>Diagnosis code</u> (SNOMED)
b.	<u>CCNAR1</u>	<u>T- CCSITE1</u>	<u>- CCDIAG1</u>
c.	<u>CCNAR2</u>	<u>T- CCSITE2</u>	<u>- CCDIAG2</u>
d.	<u>CCNAR3</u>	<u>T- CCSITE3</u>	<u>- CCDIAG3</u>
e.	<u>CCNAR4</u>	<u>T- CCSITE4</u>	<u>- CCDIAG4</u>
f.	<u>CCNAR5</u>	<u>T- CCSITE5</u>	<u>- CCDIAG5</u>
g.	<u>CCNAR6</u>	<u>T- CCSITE6</u>	<u>- CCDIAG6</u>

Entered by: CERT-NO
(cert. #)

Date entered: DT-FMENT
(mm/dd/yy)

P²C² HIV
CARDIAC PHYSICAL EXAMINATION
FORM # 79

INSTRUCTIONS

This form is to be completed for the evaluation of a cardiac abnormality. The evaluation should ideally be performed on the same day of the new finding, or at the latest, two weeks of the initial finding. Evaluation of persistent structural abnormalities will be left up to the discretion of the cardiologist.

PART I can be completed by the nurse coordinator, however PART II must be completed by a cardiologist.

<u>ITEM #</u>	<u>INSTRUCTIONS / NOTES</u>
4b	Fractional shortening (FS) % change = $\frac{\text{Current FS} - \text{Previous FS}}{\text{Previous FS}} \times 100$

P²C² STUDY CARDIAC PHYSICAL EXAMINATION

GROUP I and II PATIENTS

Patient's ID #: ILNO - - - -

Form #: 79

Completed by: _____
(print name)

Date Completed: DT-FORM
____/____/____
(mm/dd/yy)

Code missing data items as follows:

F5 = Unknown F6 = Not applicable F8 = Date unknown

1. Date of cardiac evaluation (mm/dd/yy) DT-CEXAM
____/____/____
2. Cardiologist performing examination CARDIOL

Part I: REASON FOR CARDIAC PHYSICAL EXAMINATION

3. Indicate signs or symptoms which triggered the cardiac physical examination. Respond to each of the following:
 0 = no
 1 = yes
 - a. Unexpected or unresponsive respiratory symptoms >7 days not thought to be due to lung disease REASRESP
 - b. Persistent respiratory symptoms > 2 weeks in conjunction with documented pulmonary illness REASPI
 - c. Signs and/or symptoms of pericardial effusion or endocarditis REASKEFFU
 - d. Signs and/or symptoms suggestive of congestive heart failure REASCHF
 - e. Presence of frequent ectopy or unexplained "blue spells", unexplained seizures, unexplained syncope or significant autonomic dysfunction REASECTO
4. Are there echocardiogram findings which triggered this cardiac evaluation? REASECHO
 0 = no
 1 = yes

If yes, respond to each of the following:

 - a. Date of echocardiogram (mm/dd/yy) DT-ECHO
____/____/____
 - b. Fractional shortening less than 20% or change in fractional shortening of 25% ECHOFS
 - c. Pericardial effusion ECHOPE
 1 = none
 2 = localized or circumferential with 5-10 mm maximal diameter
 3 = circumferential with > 11 mm maximal diameter

P²C² STUDY

CARDIAC PHYSICAL EXAMINATION

0 = no
1 = yes

- d. Aortic regurgitation, jet diameter \geq 3 mm ECHOAR
 - e. Mitral regurgitation, jet diameter \geq 3 mm ECHOMR
 - f. Tricuspid regurgitation, jet diameter \geq 3 mm ECHOTR
 - g. Pulmonic regurgitation, pathologic ECHO PR
 - h. VSD ECHOVSD
 - i. ASD ECHOASD
 - j. PDA (> 2 months of age) ECHOPDA
 - k. Pulmonic valve stenosis ECHOPVS
 - l. Other significant structural abnormality ECHOSA
- (Specify: ECHOSASP)

5. Are there ECG findings which triggered this cardiac examination? REASECG
- 0 = no
1 = yes

If yes, respond to each of the following:

- a. Date of ECG (mm/dd/yy) DT-ECGE
_____ / _____ / _____
- b. 2nd degree heart block ECG2BLK
- c. 3rd degree heart block ECG3BLK
- d. Supraventricular tachycardia ECGSTACH
- e. Atrial fibrillation ECGAF
- f. Atrial flutter ECGFLUT
- g. Ventricular tachycardia ECGVTACH
- h. Ventricular fibrillation ECGVF
- i. "Q" wave > 0.35 seconds, any leads ECGQW
- j. ST depression > 2 mm, any lead ECGSTDP

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CARDIAC PHYSICAL EXAMINATION

6. Are there Holter monitor findings which triggered this cardiac examination?

REASHOLT

- 0 = no
- 1 = yes

If yes, respond to each of the following:

- a. Date of Holter monitor (mm/dd/yy) / / / DT-HOLT
- b. 2nd degree heart block HOL2BLK
- c. 3rd degree heart block HOL3BLK
- d. Supraventricular tachycardia HOLSTACH
- e. Atrial fibrillation HOLAF
- f. Atrial flutter HOLFLUT
- g. Ventricular tachycardia HOLVTACH

Part II: CARDIAC PHYSICAL EXAMINATION

7. Patient condition:

- 0 = no
- 1 = yes

- a. Feeding difficulties PCFEED
- b. Excessive perspiration PCEXPER
- c. Inappropriate weight gain PCWTGAIN
- d. Fatigue PCFATIG
- e. Exertional dyspnea PCEXDYS
- f. Chest pain PCCPAIN
- g. Syncope or presyncope PCSYNCO
- h. Shock PCSHOCK

8. Findings:

- 0 = no
- 1 = yes

- a. Cyanosis FINDCYN
- b. Rales FINDRAL
- c. Hepatomegaly FINDHEP
- d. Peripheral edema FINDDEM

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CARDIAC PHYSICAL EXAMINATION

0 - no
1 - yes

- e. Decreased pulse volume FINDPUS
- f. Poorly perfused extremities FINDPERF
- g. Cardiomegaly FINDCARD
- h. Thrill FINDTHRI
- i. S₃ FINDS3
- j. S₄ FINDS4
- k. Increased P² FINDP2
- l. Rub FINDRUB
- m. Tachycardia FINDTACH
- If yes, enter maximum heart rate FINDMXHR
- n. Bradycardia FINDBRAD
- If yes, enter minimum heart rate FINDMNHR
- o. Arrhythmia FINDARR
- p. Systolic murmur FINDSMUR
- If yes, enter Grade 1-6 FINDSGRA
- If yes, regurgitation = 1
 ejection = 2 FINDREG
- q. Diastolic murmur FINDDMUR
- If yes, enter Grade 1-6 FINDDGRA
- r. Congestive heart failure FINDCHF

9. Comments:

CPE COMM

Entered by: CERT-NO
(cert. #)

Date entered: DT-FHENT
(mm/dd/yy)