PULMONARY AIDS CLINICAL STUDY
FORM R - CHEST RADIOGRAPH EVALUATION

Version Date: The version date of the form, located in the upper right corner of the form, should be checked by the interviewer to insure that the correct version of the form is being used.

1. **Patient ID:** The patient's ID label should be affixed here. If a label is not available, the ID should be printed neatly in the space provided.

2. **Clinic:** Enter the two digit clinic-specific ID number in the boxes provided. For all clinics that are composed of only one primary center, a '01' should be entered. If there is more than one clinic at a particular center, the investigator at the center should assign each clinic a different clinic ID number beginning with '01' and going in sequence. A list of the assigned clinic numbers should then be sent to the Coordinating Center.

3. a. **Date of Procedure:** Enter the date the procedure was performed. Remember to use the complete date format described earlier in this document.

   b. **Time of Procedure:** Record military time procedure was performed or 00:00.

4. **Type of Study:** Check the appropriate boxes indicating the type of studies that were performed.

5. **Normal:** Indicate whether or not the radiograph is <u>entirely</u> normal. If ***yes***, skip to question 12. If ***no***, proceed with Question 6.

6. **Cardiomegaly:** Indicate in the boxes provided whether the patient has an enlarged heart.

7. **Pleural Fluid:** Note for each side of the lungs, if pleural fluid is present. Indicate *yes* if there is likely to be pleural fluid present. Documentation of free fluid by decubitus views need not be pursued.

8. **Pleural Thickening:** Note for each side the presence or absence of any pleural thickening other than fluid.

   a. **Basilar:** Any thickening on the diaphragmatic surface or the lower 1/3 of a lung's surface.

   b. **Apical:** Any thickening of the pleural surface involving the upper third of a lung's surface.

   c. **Lateral:**

9. **Adenopathy:**

   a. **Hilar:** Indicate the presence of adenopathy involving either or both hilar areas seen of any radiographic view.

   b. **Mediastinum:** Indicate any adenopathy exclusive of hilar area but including azygous, paratracheal and aortopulmonary window involvement.

10. **Infiltrate:** Answer each portion of this question. Note multiple areas or types of infiltrates may be present.

    a-c. Indicate the presence of **any type of parenchymal infiltrate** in the upper 1/3, middle 1/3, or lower 1/3 of either the right and/or left lung.

    d. **Interstitial:** Any infiltrate involving the alveolar wall and presenting as a reticular infiltrate.

e. **Nodular: Any infiltrate involving the alveolar wall and presenting as a nodular infiltrate.**

f. **Alveolar:** Involving the alveolar surface and presenting as a fluffy or ***ground glass*** appearance with or without air bronchograms.

g. **Cavitary:** Any size of cavitation larger than 0.5 cm in greatest diameter with or without the presence of fluid.

h. **Nodule:** Note any discrete nodular or mass density present within a lung. Then note the size if a nodule exists.

i. **Multiple Nodules:** Indicate if multiple nodules are present within a lung. Then indicate, in centimeters, the largest diameter of the largest nodular density.

11. **Pneumothorax:** Indicate whether pneumothorax is present in either side.

12. **Change in Films:** Indicate if current film(s) have changed since most recent available prior radiographs. If all films normal, indicate ***no*** change. Enter date of most recent prior film used for comparison. If current film has changed, indicate whether general appearance is improving (i.e., normalizing) or deteriorating.

13. **Narrative:** (optional) Describe any findings not described above including heart size/contour abnormalities and boney abnormalities.

14. ***Visit Type:*** *Indicate the visit type by checking the appropriate box. If* ***Baseline*** *or* ***Scheduled Follow-up*** *visit, skip to Question 16.*

15. ***Qualify as Scheduled Visit:*** *Indicate Yes or No if the symptom generated or one month follow-up visit qualifies by protocol definition as a scheduled visit. If the visit does not qualify as a scheduled visit, skip to Question 17.*

16. ***Scheduled Follow-up Month:*** *If baseline visit, enter ØØ in the boxes provided. Otherwise, indicate which scheduled follow-up visit the form is being completed for. For routine patients, these should be the 06, 12, 18, 24, 30, 36, 42 and 48 month visits. For intense patients, these should be the 03, 06, 09, 12, 15, 18, etc. month visits.*

17. ***Date of Associated Intake, Interval, or Hospital Form:*** *Indicate the date of the Intake, Interval, or Hospital form that was completed at the visit in which this form is also being completed. If no Interval, Intake or Hospital form is associated with this form, the date should be left blank and keyed as a -1 in the Day boxes.*

Films Read By: Indicate the name of the individual who read the films that were used to complete the form.

Form Reviewer/Date: The individual, other than the interviewer, that reviews the form for completeness and correctness should print their name and the date the form was reviewed in a legible manner in the space provided.

Form Keyer/Date: The individual that keys the form using the RTIDE screen entry package should print their name and the date the form was keyed in a legible manner in the space provided.

FORM R Version: 01 NOV 89

PULMONARY COMPLICATIONS OF HIV INFECTION
CHEST RADIOGRAPH EVALUATION

1. Patient ID .....

2. Clinic .....

3. A. Date of Radiograph ..... Day Month Year

   B. Time (military) ..... :

	PA Yes	PA No	LAT Yes	LAT No	AP Yes	AP No
4. Type of Study	y	n	y	n	y	n

	Yes	No
5. Normal	y	n

(If YES, skip to question 12)

	Yes	No
6. Cardiomegaly (enlarged heart)	y	n

	Right Yes	Right No	Left Yes	Left No
7. Pleural Fluid	y	n	y	n

8. Pleura Thickened:

	Right Yes	Right No	Left Yes	Left No
A. Basilar	y	n	y	n
B. Apical	y	n	y	n
C. Lateral	y	n	y	n

FORM R Version: 01 NOV 89

9. Adenopathy:

	RIGHT Yes	RIGHT No	RIGHT Suspicious	LEFT Yes	LEFT No	LEFT Suspicious
A. Hilar	☐ y	☐ n	☐ u	☐ y	☐ n	☐ u
B. Mediastinum	☐ y	☐ n	☐ u	☐ y	☐ n	☐ u

10. Infiltrate:

	Right Yes	Right No	Left Yes	Left No
A. Upper 1/3	☐ y	☐ n	☐ y	☐ n
B. Middle 1/3	☐ y	☐ n	☐ y	☐ n
C. Lower 1/3	☐ y	☐ n	☐ y	☐ n
D. Interstitial type	☐ y	☐ n	☐ y	☐ n
E. Nodular type	☐ y	☐ n	☐ y	☐ n
F. Alveolar type	☐ y	☐ n	☐ y	☐ n
G. Cavitary	☐ y	☐ n	☐ y	☐ n
H. Nodule	☐ y	☐ n	☐ y	☐ n
1. If YES, Largest Nodule ..	☐☐ • ☐			
I. Multiple Nodules	☐ y	☐ n	☐ y	☐ n

J. If YES, Size of Largest Found

☐☐ • ☐ cm (largest diameter)

	RIGHT Yes	RIGHT No	LEFT Yes	LEFT N
11. Pneumothorax	☐ y	☐ n	☐ y	☐ n

	Yes	No	Prior Film Unavailable
12. Change since prior film?	☐ y	☐ n	☐ u

	Day	Month	Year
A. Date(s) of prior film(s)			

	Yes	No
Improving	☐ y	☐ n
Deteriorating	☐ y	☐ n

	Day	Month	Year
B. Date(s) of prior film(s)			

	Yes	No
Improving	☐ y	☐ n
Deteriorating	☐ y	☐ n

	Day	Month	Year
C. Date(s) of prior film(s)			

	Yes	No
Improving.....	☐ y	☐ n
Deteriorating	☐ y	☐ n

13. Narrative (Optional):

14. Visit Type: ☐* 0 Baseline ☐* 1 Scheduled Follow-up ☐ 2 Symptom Generated
☐ 3 One Month Follow-up ☐ 4 Hospital

*** If Baseline or Scheduled Follow-up, skip to 16.**

	Yes	No
15. Does this visit qualify as a scheduled visit?	☐ y	☐ n

If No, skip to 17.

16. For which scheduled follow-up visit does this qualify? .... ☐☐ month
(00=Baseline; 03 month, 06 month, 09 month, etc.)

17. Date of Intake, Interval, or Hospital Form associated with this form:

Day	Month	Year
☐☐	☐☐☐	☐☐

Film Read By: _____

Form Reviewed By: _____ Date _____
(please print)

Form Keyed By: _____ Date: _____
(please print)