ETTAA

End of Study

Patient Initials ☐☐☐ Patient Study Number ☐☐☐☐

Date CRF completed D D / M M / Y Y Y Y

Patient Status on Date above

- Alive ☐
- Withdrawn ☐
- Dead ☐
- Other ☐

If Other:

Please specify

If Withdrawn:

Date withdrawn D D / M M / Y Y Y Y

If Dead:

Date of death D D / M M / Y Y Y Y

Cause of death

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ETTAA

EURO QOL

EQ-5D5L

Health Questionnaire

Patient Initials ☐☐☐ Patient Study Number ☐☐☐☐

Time Period

Baseline	☐	*3 Month Pre Procedure	☐
* 6 Month Pre Procedure	☐	1 Month Post Procedure	☐
3 Month	☐	3 Month Post Procedure	☐
6 Month	☐	6 Month Post Procedure	☐
12 Month	☐	12 Month Post Procedure	☐
18 Month	☐	18 Month Post Procedure	☐
24 Month	☐	24 Month Post Procedure	☐
36 Month	☐	36 Month Post Procedure	☐
48 Month	☐	48 Month Post Procedure	☐
60 Month	☐	60 Month Post Procedure	☐

* Only applicable for patients in the OSR and ESG cohort arms if they are waiting longer than 3 or 6 months for their procedure from date of consent or date of reassignment

Date ☐☐ / ☐☐ / ☐☐☐☐

CONFIDENTIAL

Please indicate which statements best describe your health state, **today**, by marking one box in each group.

MOBILITY

- I have no problems in walking about ☐
- I have slight problems in walking about ☐
- I have moderate problems in walking about ☐
- I have severe problems in walking about ☐
- I am unable to walk about ☐

SELF-CARE

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

USUAL ACTIVITIES
(eg work, study, housework, family or leisure activities)

- I have no problems doing my usual activities ☐
- I have slight problems doing my usual activities ☐
- I have moderate problems doing my usual activities ☐
- I have severe problems doing my usual activities ☐
- I am unable to do my usual activities ☐

PAIN / DISCOMFORT

- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

ANXIETY / DEPRESSION

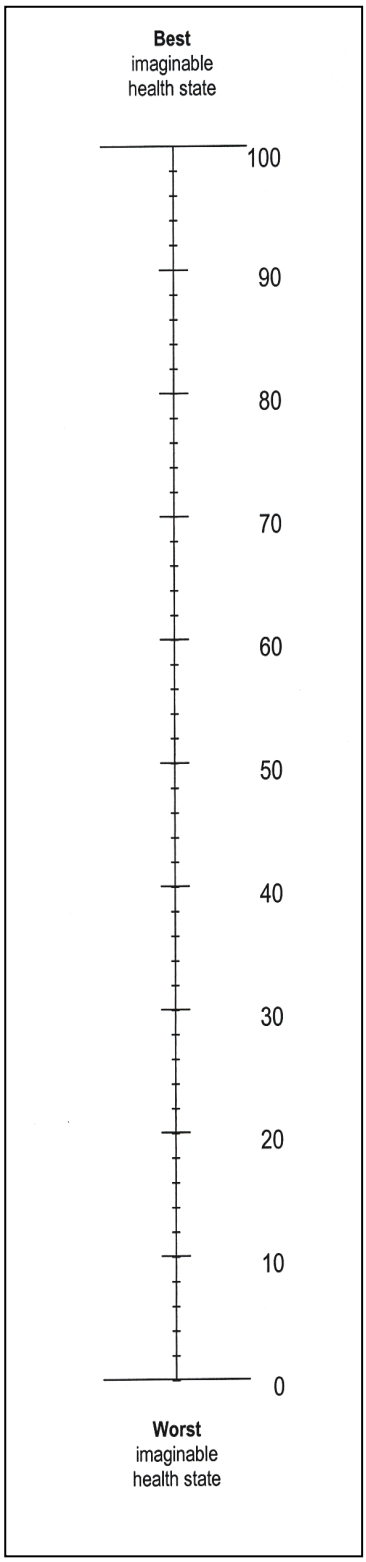
- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

To help people say how good or bad a health state is , we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked by 100 and worst state you can imagine is marked by 0.

We would like you to indicate on the scale how good or bad is your health today, in your opinion.

Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad you current health state is.

Please make sure your line crosses over the thermometer scale.



Your own health state today

To be completed by the Research Nurse | | | |

I have reviewed and approved all the information on this form (PI or designee to provide initials, signature and date)

_____

D D / M M / Y Y Y Y

		/			/				

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ETTAA

Follow Up

Patient Initials ☐☐☐ Patient Study Number ☐☐☐☐

Time Period *3 Month Pre Procedure ☐ * 6 Month Pre Procedure ☐

1 Month Post Procedure ☐
(See note below)

3 Month ☐ 3 Month Post Procedure ☐

6 Month ☐ 6 Month Post Procedure ☐

12 Month ☐ 12 Month Post Procedure ☐

18 Month ☐ 18 Month Post Procedure ☐

24 Month ☐ 24 Month Post Procedure ☐

36 Month ☐ 36 Month Post Procedure ☐

48 Month ☐ 48 Month Post Procedure ☐

60 Month ☐ 60 Month Post Procedure ☐

* Only applicable for patients in the OSR and ESG cohort arms if they are waiting longer than 3 or 6 months for their procedure from date of consent or date of reassignment

At **1 Month Post Procedure** has the patient been discharged Yes ☐ No ☐

If No, only complete the EURO QOL EQ-5D5L if able, and only complete the Study group and Was the follow up done questions on page 2.

Date ☐☐ / ☐☐ / ☐☐☐☐

Study group: WW ☐ CM ☐ OSR ☐ ESG ☐ tba ☐

Was the Follow up done? Yes ☐ No ☐

If Yes: Date D D / M M / Y Y Y Y

If No: Patient died ☐ Patient lost to follow up ☐ Patient withdrawal ☐ Other ☐

If Other please specify:

If Death: Date D D / M M / Y Y Y Y

Cause of death:

NYHA: I ☐ II ☐ III ☐ IV ☐

Class I (Mild) = No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations or dyspnoea (shortness of breath)

Class II (Mild) = Slight limitation of physical activity, comfortable at rest, but ordinary physical activity results in fatigue, palpitations or dyspnoea

Class III (Moderate) = Marked limitation of physical activity, comfortable at rest, but less than ordinary physical activity results in fatigue, palpitations or dyspnoea

Class IV (Severe) = Unable to carry out any physical activity without discomfort, symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased

Usual place of residence:

- At home ☐
- At home with **formal care** ☐ **Formal care**: They receive help from community or social services staff
- At home with **informal care** ☐ **Informal care**: They receive help with their daily activities from a relative or friend
- Residential home ☐
- Nursing home ☐
- Other ☐

If Other please specify:

Patient Initials ☐☐☐ Patient Study Number ☐☐☐☐

Did the patient receive any formal care since last point of contact: Yes ☐ No ☐

If the patient received/receives formal care:

What type of help did you receive e.g Social worker, Home care worker, Care attendant etc.	Hours/week

Did the patient receive any informal care since last point of contact: Yes ☐ No ☐

If the patient received/receives informal care:

On average how much time in terms of hours per week, did they spend ☐☐ Hours per week

What would that person have been doing as their main activity if they had not been helping and/or caring for you.(Tick all that apply)

Housework ☐ Childcare ☐ Caring for another relative ☐

Voluntary work ☐ Leisure activities ☐ Attending School or University ☐

On sick-leave ☐ Paid work ☐ Other ☐

Other or paid work please specify

Is the patient currently participating in any other clinical trials: Yes ☐ No ☐

Medications

Anticoagulant/antiplatelet: None ☐ Antiplatelet ☐ Oral anticoagulant ☐ Other ☐

If Other please state:

Hypertension: Yes ☐ No ☐

Antihypertensive Medication:

None ☐ Beta Blockers ☐ Angiotensin Converting Enzyme Inhibitors ☐

Angiotensin Receptor Blocker ☐ Calcium Channel Blocker ☐ Other ☐

If Other please specify:

Statin: Yes ☐ No ☐

Any days off work due to sickness: Yes ☐ No ☐ N/A ☐

If Yes, please state reason, number of days off and was it aneurysm related for each sickness:

Patient Initials ☐☐☐ Patient Study Number ☐☐☐☐

Number of appointments since last follow-up visit:

Nurse visit (surgery):	Yes ☐	No ☐	Number of visits: ☐☐
GP visit (surgery):	Yes ☐	No ☐	Number of visits: ☐☐
Nurse Home visit:	Yes ☐	No ☐	Number of visits: ☐☐
GP Home visit:	Yes ☐	No ☐	Number of visits: ☐☐
Physio/Occupational Health appointment:	Yes ☐	No ☐	Number of visits: ☐☐
A&E visit:	Yes ☐	No ☐	Number of visits: ☐☐
Hospital admission(s):	Yes ☐	No ☐	Number of visits: ☐☐

If Yes to Hospital admission(s), please complete the Hospital Admissions CRF

Outpatient appointment: Yes ☐ No ☐

If Yes:

Name of Clinic	Number of visits:	Aneurysm related:
_____	☐☐	Yes ☐ No ☐
_____	☐☐	Yes ☐ No ☐
_____	☐☐	Yes ☐ No ☐
_____	☐☐	Yes ☐ No ☐

Name of Clinic	Number of visits:	Aneurysm related:
_____	☐☐	Yes ☐ No ☐
_____	☐☐	Yes ☐ No ☐
_____	☐☐	Yes ☐ No ☐
_____	☐☐	Yes ☐ No ☐

Has the patient had any aneurysm related imaging done since last point of contact:

Yes ☐ No ☐

If Yes please send the images to: ETTAA Team
R&D CTBI Building
Papworth Hospital NHS Foundation Trust
Papworth Everard
Cambridge
CB23 3RE

Circle of Willis imaging: No ☐ MRI ☐ CT ☐
Angiography ☐ Other ☐

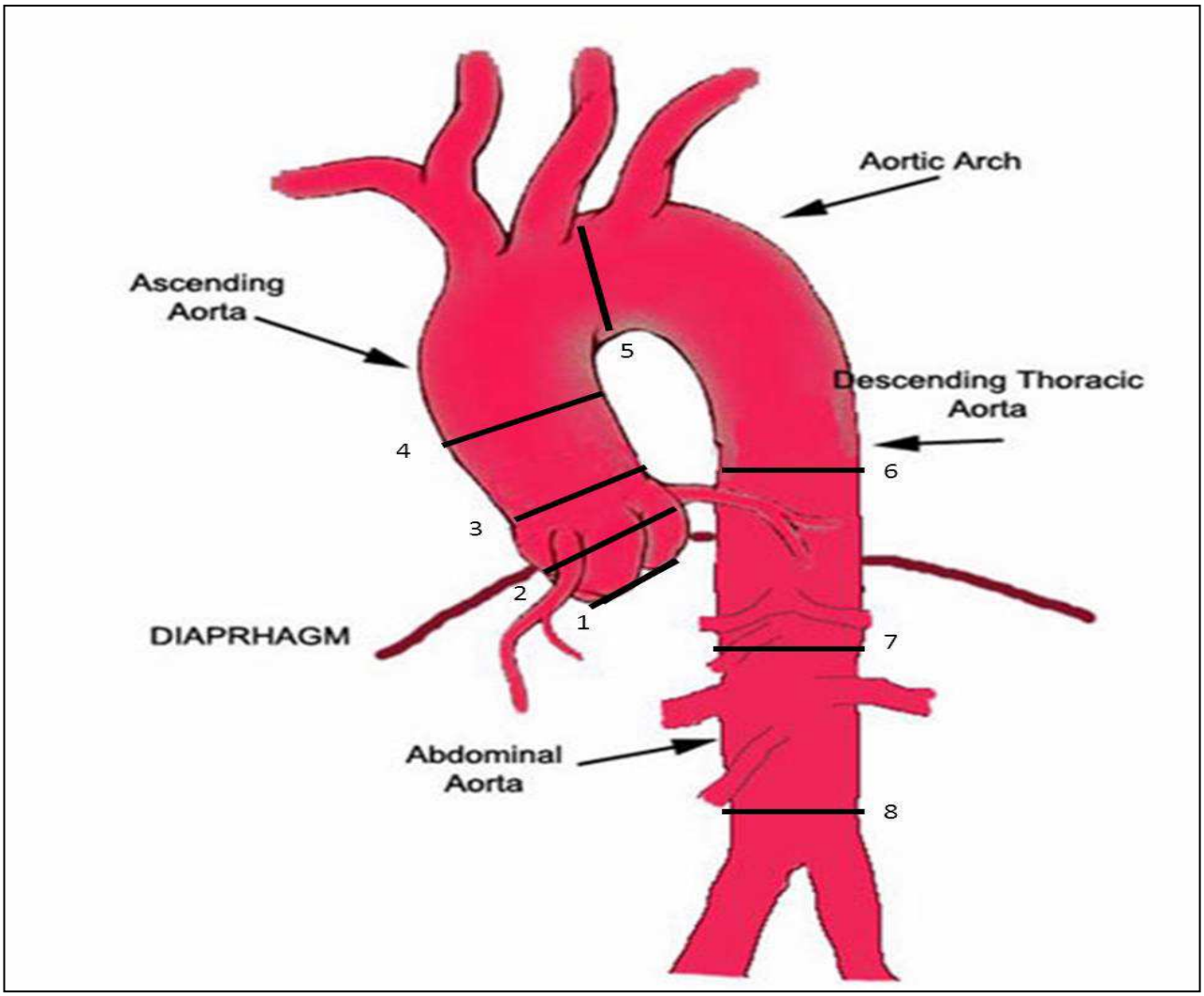
If Other please state: ☐

Thoracic Aorta imaging: CT ☐ MRI ☐ Other ☐ No ☐

If Other please state: ☐

If Yes, date of imaging: D D / M M / Y Y Y Y ☐☐/☐☐/☐☐☐☐

Patient Initials | | | | Patient Study Number | | | | |



1. Aortic annulus **2. Sinuses of valsalva** **3. Sinotubular junction**

4. Ascending aorta **5. Aortic arch** **6. Descending aorta**

7. Suprarenal abdominal aorta **8. Infrarenal abdominal aorta**

If the patient has undergone Thoracic Aortic imaging on more than one occassion please record the measurements from the most recent report:

Aortic annulus: | | . | | cm Sinuses of valsalva: | | . | | cm

Sinotubular junction: | | . | | cm Ascending aorta: | | . | | cm

Descending aorta: | | . | | cm Aortic arch: | | . | | cm

Suprarenal abdominal aorta: | | . | | cm Infrarenal abdominal aorta: | | . | | cm

Has the patient been reassigned to a different cohort arm since last point of contact: Yes ☐ No ☐

If Yes, which arm? WW ☐ CM ☐ ESG ☐ OSR ☐

Please contact the ETTAA Study Team at Papworth (01480 364890) to complete a Study Reassignment Sheet:

Has the patient experienced any new medical problems since last follow up? Yes ☐ No ☐

If Yes, please specify

I have reviewed and approved all the information on this form (PI or designee to provide initials, signature and date)

☐☐☐ _____

D D / M M / Y Y Y Y

ETTAA

Hospital Admissions CRF

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Name of Hospital admitted to: ☐

Date of admission: D D / M M / Y Y Y Y ☐☐/☐☐/☐☐☐☐

Date of discharge: D D / M M / Y Y Y Y ☐☐/☐☐/☐☐☐☐

ICU: ☐☐ days HDU: ☐☐ days Ward: ☐☐ days

Reason for admission: ☐

Was this admission related to the patients aneurysm:

- Not related ☐
- Unlikely ☐
- Possibly related ☐
- Probably related ☐
- Definitely related ☐

If the admission was probably/definitely related what were their presenting symptoms:

Asymptomatic	☐	Thoracic pain	☐
Abdominal pain	☐	Neurogical symptoms	☐
Leg ischaemia	☐	Hoarseness	☐
Other	☐		

If Other or Asymptomatic please state:

Was this admission a complication of the initial treatment:

Not related	☐
Unlikely	☐
Possibly related	☐
Probably related	☐
Definitely related	☐

I have reviewed and approved all the information on this form (PI or designee to provide initials and signature)

☐☐☐ _____

D D / M M / Y Y Y Y

☐☐ / ☐☐ / ☐☐☐☐

ETTAA
Inclusion/Exclusion Criteria

Patient Initials: ☐☐☐

Inclusion Criteria:

Chronic **arch** or **descending** aortic aneurysm = or >4cm* Yes ☐ No ☐

Age > or = to 18 years Yes ☐ No ☐

Able to give informed consent Yes ☐ No ☐

* Patients with a long standing arch or descending aneurysm may still be included as long as they have not had intervention for this particular aneurysm. If a patient has already received treatment for an aneurysm on a different part of the aorta (e.g. ascending / abdominal) then the patient is still eligible.

Exclusion Criteria:

Acute dissection or malperfusion syndromes (such as myocardial infarction, acute stroke or limb ischaemia) Yes ☐ No ☐

Is the patient eligible Yes ☐ No ☐

I have reviewed and approved all the information on this form (PI or designee to provide initials, signature and date)

☐☐☐ _____

D D / M M / Y Y Y Y

☐☐ / ☐☐ / ☐☐☐☐

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ETTAA
Medical History CRF

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Baseline Data

Method of consent: In person ☐ Postal ☐

If Postal:

Date consent form signed by patient: D D / M M / Y Y Y Y

Date consent form received back and signed by researcher: D D / M M / Y Y Y Y

Date of consent if consented in person: D D / M M / Y Y Y Y

Date of diagnosis: D D / M M / Y Y Y Y Date of first scan with CTAA>4cm

Height: ☐☐☐ cm (round to the nearest cm)

Weight: ☐☐☐ kg (round to the nearest kg)

Current employment:

- Not in paid work due to health condition ☐
- Retired ☐
- Now in paid work - full time ☐
- Now in paid work - part time ☐
- Unemployed but looking for work ☐
- Looking after home and family ☐
- In full time education ☐
- In part time education ☐
- Volunteer work or work experience ☐
- Other ☐

If Other please specify:

What was/is your main occupation (main means the one you spent the most time doing):

What is the highest level of qualification you have:

- No formal qualification ☐
- CSE or equivalent ☐
- GCSE, O-level or equivalent ☐
- A level or equivalent ☐
- Teaching certificate, HND or equivalent ☐
- Degree level or higher ☐

What is approximately your net (take home pay after taxes) family income?

- Less than £100 per week (£5200 per year) ☐
- £100 to £199 per week (£5200 to £10,399 per year) ☐
- £200 to £299 per week (£10,400 to £15,599 per year) ☐
- £300 to £499 per week (£15,600 to £25,999 per year) ☐
- £500 to £699 per week (£26,000 to £36,399 per year) ☐
- £700 to £949 per week (£36,400 to £49,399 per year) ☐
- £950 to £1,199 per week (£49,400 to £62,399 per year) ☐
- £1,200 to £1,499 per week (£62,400 to £77,999 per year) ☐
- £1,500 to £1,799 per week (£78,000 to £93,599 per year) ☐
- £1,800 to £2,199 per week (£93,600 to £114,399 per year) ☐
- £2,200 to £2,599 per week (£114,400 to £135,199 per year) ☐
- £2,600 to £2,999 per week (£135,200 to £155,999 per year) ☐
- £3,000 or more per week (£156,000 per year) ☐
- Prefer not to say ☐
- Don't know ☐

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Usual place of residence:

- At home ☐
- At home with **formal care** ☐
- At home with **informal care** ☐
- Residential home ☐
- Nursing home ☐
- Other ☐

Formal care: They receive help from community or social services staff
Informal care: They receive help with their daily activities from a relative or friend

If Other please specify: ☐

If the patient receives formal care:

What type of help did you receive e.g Social worker, Home care worker, Care attendant etc.	Hours/week

If the patient receives informal care:

On average how much time in terms of hours per week, did they spend ☐☐ Hours per week

What would that person have been doing as their main activity if they had not been helping and/or caring for you.

Housework ☐	Childcare ☐	Caring for another relative ☐
Voluntary work ☐	Leisure activities ☐	Attending School or University ☐
On sick-leave ☐	Paid work ☐	Other ☐

Other or paid work please specify ☐

Is the patient currrently participating in any other clinical trials: Yes ☐ No ☐

History of Myocardial Infarction: Yes ☐ No ☐

Diabetes mellitus: No ☐ NIDDM ☐ IDDM ☐

Smoking history: Never ☐ Ex-smoker ☐ Current smoker ☐

Pack years: ☐ One pack year is equivalent to smoking **20** per day for one calender year

NYHA: I ☐ II ☐ III ☐ IV ☐

Class I (Mild) = No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations or dyspnoea (shortness of breath)

Class II (Mild) = Slight limitation of physical activity, comfortable at rest, but ordinary physical activity results in fatigue, palpitations or dyspnoea

Class III (Moderate) = Marked limitation of physical activity, comfortable at rest, but less than ordinary physical activity results in fatigue, palpitations or dyspnoea

Class IV (Severe) = Unable to carry out any physical activity without discomfort, symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased

Medications

Anticoagulant/antiplatelet: None ☐ Antiplatelet ☐ Oral anticoagulant ☐ Other ☐

If Other please state:

Hypertension: Yes ☐ No ☐

Antihypertensive Medication:

None ☐ Beta Blockers ☐ Angiotensin Converting Enzyme Inhibitors ☐

Angiotensin Receptor Blocker ☐ Calcium Channel Blocker ☐ Other ☐

If Other please specify:

Statin: Yes ☐ No ☐

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Baseline Organ Function

Cardiovascular Previous History

LV function: Good LV>50% ☐ Moderate LV 31%-50% ☐ Poor LV<=30% ☐ Not measured ☐

Coronary artery disease: No ☐ Medication ☐ PCI ☐ CABG ☐

Previous aortic intervention: None ☐ Root ☐ Ascending ☐

Arch ☐ Descending ☐ Abdominal ☐

Prior neurovascular injury: Yes ☐ No ☐ (Has patient had a stroke or spinal cord injury?)

Extracardiac arteriopathy: Yes ☐ No ☐ **Any one or more of the following:** Claudication; Carotid occlusion or >50% stenosis; Previous or planned intervention on the abdominal aorta, limb arteries or carotids.

Current status

Valvular heart disease: None ☐ Aortic stenosis ☐ Aortic regurgitation ☐ Other ☐

Heart rhythm: Sinus rhythm ☐ Atrial fibrillation ☐ Pacemaker ☐ Other ☐

Has Hb been done in last 3 months: Yes ☐ No ☐ If Yes, Hb: ☐☐☐ g/L

Lung

COPD: Yes ☐ No ☐

FEV_1 taken in last 3 months: Yes ☐ No ☐ If Yes, FEV_1 ☐.☐☐ L

Kidney

Has Creatinine been done in last 3 months: Yes ☐ No ☐ If Yes, Creatinine: ☐☐☐ umol/L

Dialysis dependent: Yes ☐ No ☐

Aneurysm

Date of first specialist consultation regarding this aneurysm: D D / M M / Y Y Y Y

Presenting symptoms: Asymptomatic ☐ Thoracic pain ☐ Abdominal pain ☐

Neurogical symptoms ☐ Leg ischaemia ☐ Hoarseness ☐

Other ☐

If Other or Asymptomatic please state:

Connective tissue disorder: Yes ☐ No ☐

If Yes please select: Marfans ☐ Loeys-Dietz ☐ Ehlers-Danlos ☐

Degenerative disease ☐ Other ☐

If Other please state:

Family history of aneurysm: (1st degree relative, <65 years old) Yes ☐ No ☐

Circle of Willis imaging: No ☐ MRI ☐ CT ☐

Angiography ☐ Other ☐

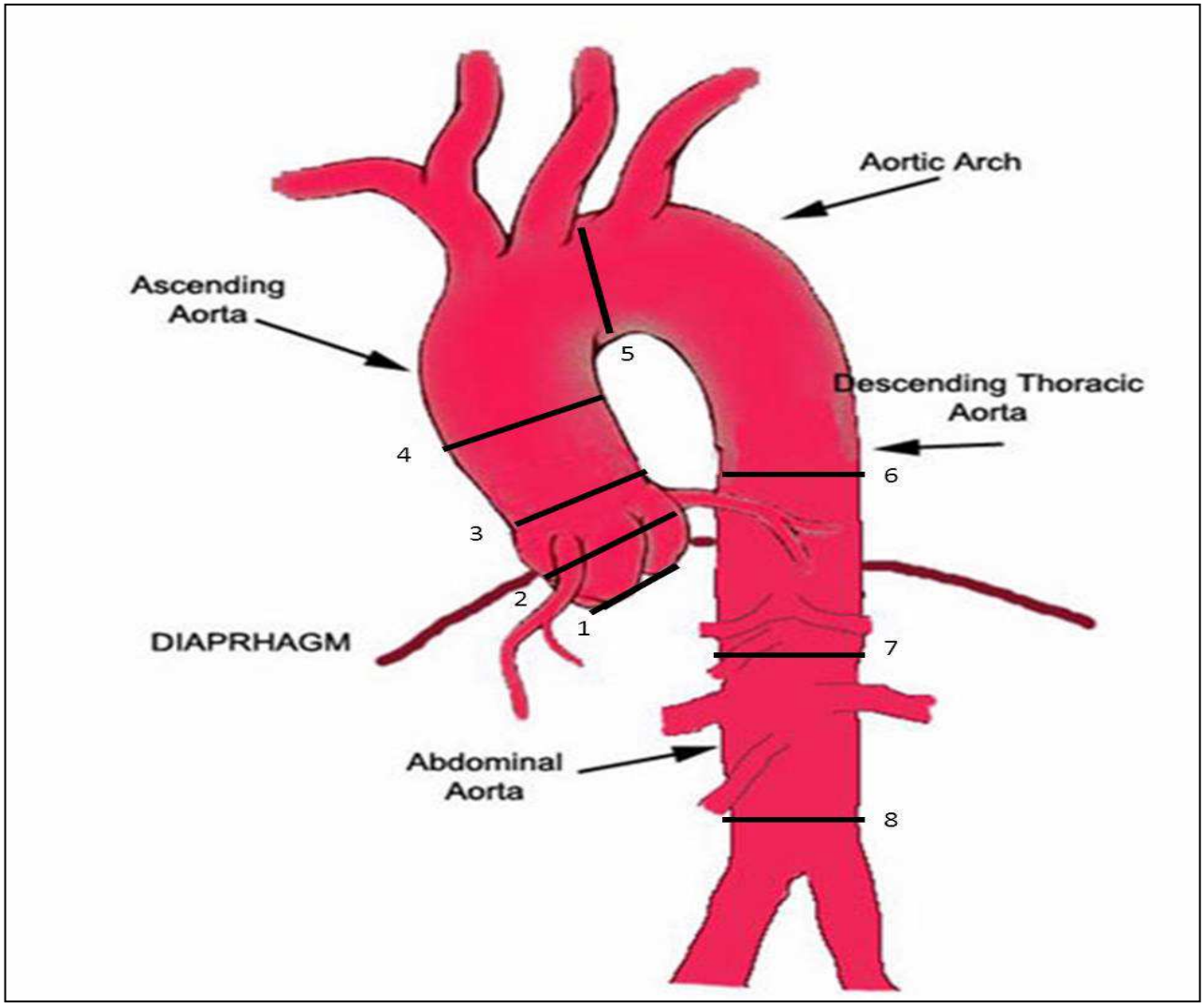
If Other please state:

Thoracic Aorta imaging: CT ☐ MRI ☐ Other ☐

If Other please state:

Date of imaging: D D / M M / Y Y Y Y

Patient Initials: | | | | Patient Study Number: | | | | | |



1. Aortic annulus **2. Sinuses of valsalva** **3. Sinotubular junction**

4. Ascending aorta **5. Aortic arch** **6. Descending aorta**

7. Suprarenal abdominal aorta **8. Infrarenal abdominal aorta**

Please note: the measurements below should be taken from the imaging results nearest (but prior) to consent

Aortic annulus: | | . | | cm Sinuses of valsalva: | | . | | cm

Sinotubular junction: | | . | | cm Ascending aorta: | | . | | cm

Descending aorta: | | . | | cm Aortic arch: | | . | | cm

Suprarenal abdominal aorta: | | . | | cm Infrarenal abdominal aorta: | | . | | cm

Was patient discussed at MDT: Yes ☐ No ☐

Date of aortic MDT:
Please note, this should be the date when the patient was first discussed by the MDT

D D / M M / Y Y Y Y

What cohort arm has this patient been assigned to

WW ☐ CM ☐ ESG ☐ OSR ☐ tba ☐

I have reviewed and approved all the information on this form (PI or designee to provide initials, signature and date)

☐☐☐ _____

D D / M M / Y Y Y Y

ETTAA
Medical History CRF

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Baseline Data

Method of consent: In person ☐ Postal ☐

If Postal:

Date consent form signed by patient: D D / M M / Y Y Y Y

Date consent form received back and signed by researcher: D D / M M / Y Y Y Y

Date of consent if consented in person: D D / M M / Y Y Y Y

Date of diagnosis: D D / M M / Y Y Y Y Date of first scan with CTAA>4cm

Height: ☐☐☐ cm (round to the nearest cm)

Weight: ☐☐☐ kg (round to the nearest kg)

Current employment:

- Not in paid work due to health condition ☐
- Retired ☐
- Now in paid work - full time ☐
- Now in paid work - part time ☐
- Unemployed but looking for work ☐
- Looking after home and family ☐
- In full time education ☐
- In part time education ☐
- Volunteer work or work experience ☐
- Other ☐

If Other please specify:

What was/is your main occupation (main means the one you spent the most time doing):

What is the highest level of qualification you have:

- No formal qualification ☐
- CSE or equivalent ☐
- GCSE, O-level or equivalent ☐
- A level or equivalent ☐
- Teaching certificate, HND or equivalent ☐
- Degree level or higher ☐

What is approximately your net (take home pay after taxes) family income?

- Less than £100 per week (£5200 per year) ☐
- £100 to £199 per week (£5200 to £10,399 per year) ☐
- £200 to £299 per week (£10,400 to £15,599 per year) ☐
- £300 to £499 per week (£15,600 to £25,999 per year) ☐
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- £1,800 to £2,199 per week (£93,600 to £114,399 per year) ☐
- £2,200 to £2,599 per week (£114,400 to £135,199 per year) ☐
- £2,600 to £2,999 per week (£135,200 to £155,999 per year) ☐
- £3,000 or more per week (£156,000 per year) ☐
- Prefer not to say ☐
- Don't know ☐

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Usual place of residence:

- At home ☐
- At home with **formal care** ☐
- At home with **informal care** ☐
- Residential home ☐
- Nursing home ☐
- Other ☐

Formal care: They receive help from community or social services staff
Informal care: They receive help with their daily activities from a relative or friend

If Other please specify: ☐

If the patient receives formal care:

What type of help did you receive e.g Social worker, Home care worker, Care attendant etc.	Hours/week

If the patient receives informal care:

On average how much time in terms of hours per week, did they spend ☐☐ Hours per week

What would that person have been doing as their main activity if they had not been helping and/or caring for you.

Housework ☐	Childcare ☐	Caring for another relative ☐
Voluntary work ☐	Leisure activities ☐	Attending School or University ☐
On sick-leave ☐	Paid work ☐	Other ☐

Other or paid work please specify ☐

Is the patient currrently participating in any other clinical trials: Yes ☐ No ☐

History of Myocardial Infarction: Yes ☐ No ☐

Diabetes mellitus: No ☐ NIDDM ☐ IDDM ☐

Smoking history: Never ☐ Ex-smoker ☐ Current smoker ☐

Pack years: ☐ One pack year is equivalent to smoking **20** per day for one calender year

NYHA: I ☐ II ☐ III ☐ IV ☐

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Class IV (Severe) = Unable to carry out any physical activity without discomfort, symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased

Medications

Anticoagulant/antiplatelet: None ☐ Antiplatelet ☐ Oral anticoagulant ☐ Other ☐

If Other please state:

Hypertension: Yes ☐ No ☐

Antihypertensive Medication:

None ☐ Beta Blockers ☐ Angiotensin Converting Enzyme Inhibitors ☐

Angiotensin Receptor Blocker ☐ Calcium Channel Blocker ☐ Other ☐

If Other please specify:

Statin: Yes ☐ No ☐

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Baseline Organ Function

Cardiovascular Previous History

LV function: Good LV>50% ☐ Moderate LV 31%-50% ☐ Poor LV<=30% ☐ Not measured ☐

Coronary artery disease: No ☐ Medication ☐ PCI ☐ CABG ☐

Previous aortic intervention: None ☐ Root ☐ Ascending ☐

Arch ☐ Descending ☐ Abdominal ☐

Prior neurovascular injury: Yes ☐ No ☐ (Has patient had a stroke or spinal cord injury?)

Extracardiac arteriopathy: Yes ☐ No ☐ **Any one or more of the following:** Claudication; Carotid occlusion or >50% stenosis; Previous or planned intervention on the abdominal aorta, limb arteries or carotids.

Current status

Valvular heart disease: None ☐ Aortic stenosis ☐ Aortic regurgitation ☐ Other ☐

Heart rhythm: Sinus rhythm ☐ Atrial fibrillation ☐ Pacemaker ☐ Other ☐

Has Hb been done in last 3 months: Yes ☐ No ☐ If Yes, Hb: ☐☐☐ g/L

Lung

COPD: Yes ☐ No ☐

FEV_1 taken in last 3 months: Yes ☐ No ☐ If Yes, FEV_1 ☐.☐☐ L

Kidney

Has Creatinine been done in last 3 months: Yes ☐ No ☐ If Yes, Creatinine: ☐☐☐ umol/L

Dialysis dependent: Yes ☐ No ☐

Aneurysm

Date of first specialist consultation regarding this aneurysm: D D / M M / Y Y Y Y

Presenting symptoms: Asymptomatic ☐ Thoracic pain ☐ Abdominal pain ☐

Neurogical symptoms ☐ Leg ischaemia ☐ Hoarseness ☐

Other ☐

If Other or Asymptomatic please state:

Connective tissue disorder: Yes ☐ No ☐

If Yes please select: Marfans ☐ Loeys-Dietz ☐ Ehlers-Danlos ☐

Degenerative disease ☐ Other ☐

If Other please state:

Family history of aneurysm: (1st degree relative, <65 years old) Yes ☐ No ☐

Circle of Willis imaging: No ☐ MRI ☐ CT ☐

Angiography ☐ Other ☐

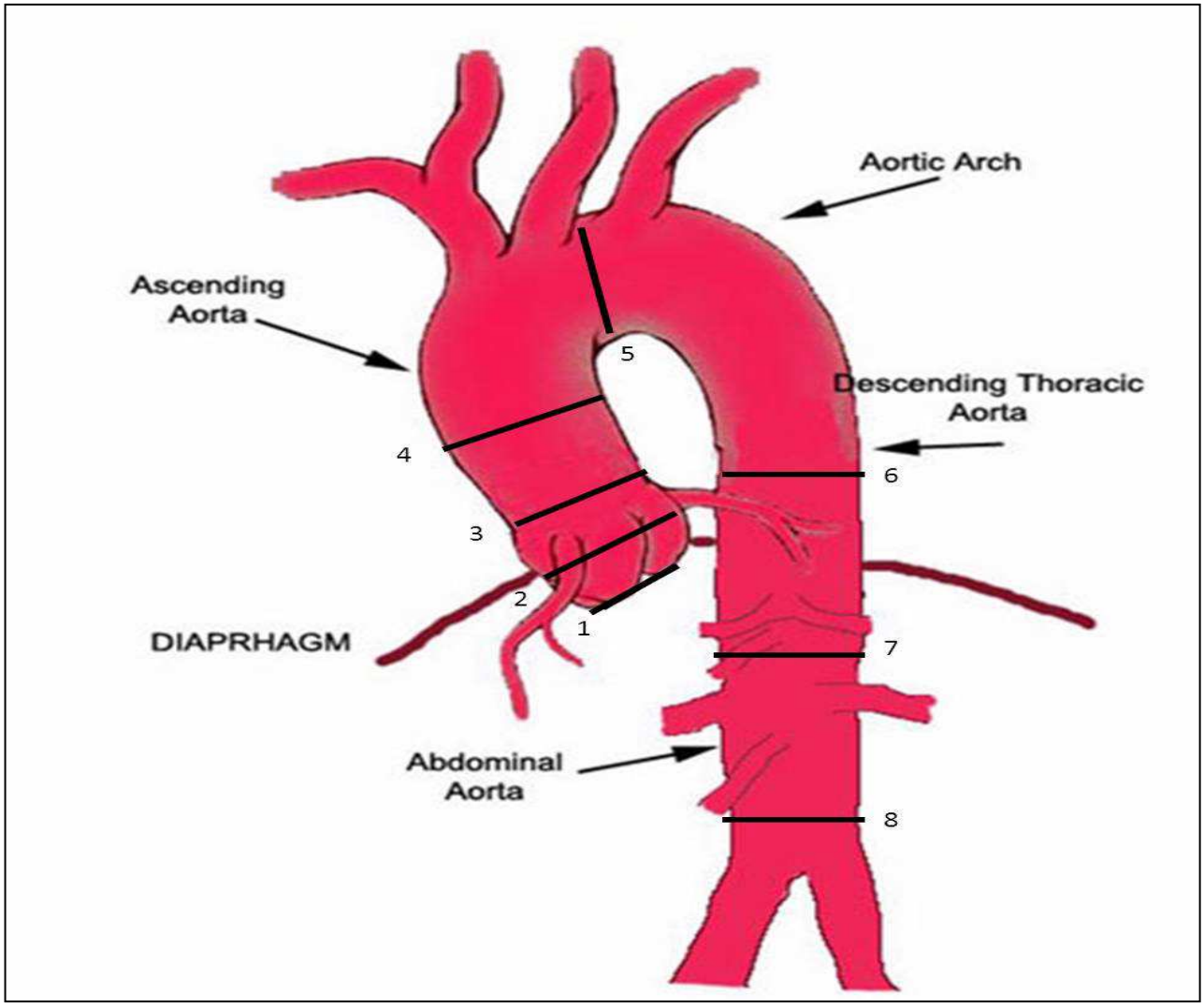
If Other please state:

Thoracic Aorta imaging: CT ☐ MRI ☐ Other ☐

If Other please state:

Date of imaging: D D / M M / Y Y Y Y

Patient Initials: | | | | Patient Study Number: | | | | | |



1. Aortic annulus **2. Sinuses of valsalva** **3. Sinotubular junction**

4. Ascending aorta **5. Aortic arch** **6. Descending aorta**

7. Suprarenal abdominal aorta **8. Infrarenal abdominal aorta**

Please note: the measurements below should be taken from the imaging results nearest (but prior) to consent

Aortic annulus: | | . | | cm Sinuses of valsalva: | | . | | cm

Sinotubular junction: | | . | | cm Ascending aorta: | | . | | cm

Descending aorta: | | . | | cm Aortic arch: | | . | | cm

Suprarenal abdominal aorta: | | . | | cm Infrarenal abdominal aorta: | | . | | cm

Was patient discussed at MDT: Yes ☐ No ☐

Date of aortic MDT:
Please note, this should be the date when the patient was first discussed by the MDT

D D / M M / Y Y Y Y

What cohort arm has this patient been assigned to

WW ☐ CM ☐ ESG ☐ OSR ☐ tba ☐

I have reviewed and approved all the information on this form (PI or designee to provide initials, signature and date)

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ETTAA
Post Procedure and Discharge CRF

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Length of Hospital Stay

Was this a staged procedure: Yes ☐ No ☐

Stage of procedure: 1st Stage ☐ 2nd Stage ☐ 3rd Stage ☐ N/A ☐

Date of admission: D D / M M / Y Y Y Y

Date of discharge: D D / M M / Y Y Y Y

ICU: ☐☐ days HDU: ☐☐ days Ward: ☐☐ days

Histology finding of explored aorta:

Marfans ☐ Loeys-Dietz ☐ Ehlers-Danlos ☐ Degenerative Disease ☐

Other ☐ No Abnormality Detected ☐ N/A ☐

Please state other:

Discharge destination:

- At home ☐
- At home with **formal care** ☐
- At home with **informal care** ☐
- Residential home ☐
- Nursing home ☐
- DGH ☐
- Community hospital ☐
- Other ☐

Formal care: They receive help from community or social services staff
Informal care: They receive help with their daily activities from a relative or friend

Please state other:

If discharged to DGH or Community hospital: Length of stay: ☐☐ days

Adverse Events During Hospital Admission

Myocardial infarction: Yes ☐ No ☐

Cardiac support: None ☐ Inotropes ☐ IABP ☐

Prolonged ventilation >48hrs: Yes ☐ No ☐

Renal support: None ☐ Temporary (pre-discharge) ☐ Permanent (post-discharge) ☐
Please note, this refers to patients who needed haemofiltration

Renal support days in hospital: ☐☐ days

GI Complications: None ☐ Bleeding ☐ Ischaemia ☐

Stoma ☐ Other ☐

Neurological injury: None ☐ TIA ☐ CVA ☐

Spinal cord injury: None ☐ Paraparesis ☐ Paraplegia ☐

Thromboembolic event: Yes ☐ No ☐

If Yes, DVT/PE: DVT ☐ PE ☐

Vocal cord palsy: Yes ☐ No ☐

Infection: No ☐ Prosthesis ☐ Wound ☐ Access site ☐ Other ☐

If Other please specify: ☐

Return to theatre: Yes ☐ No ☐

Number of returns to theatre: ☐ Please complete a Return to Theatre CRF for each episode

Alive at discharge: Yes ☐ No ☐

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Date of death: D D / M M / Y Y Y Y

Cause of death: ☐

Post-operative blood product usage

Red Cells: Yes ☐ No ☐

Units of Red Cells: ☐☐

Platelets: Yes ☐ No ☐

Units of Platelets: ☐☐

FFP: Yes ☐ No ☐

Units of FFP: ☐☐

Cryoprecipitate: Yes ☐ No ☐

Units of Cryoprecipitate: ☐☐

Other: Yes ☐ No ☐

Name: ☐ Units ☐☐☐

Name: ☐ Units ☐☐☐

Name: ☐ Units ☐☐☐

Name: ☐ Units ☐☐☐

Number of Investigations during hospital stay

CT: Yes ☐ No ☐ Number of CTs: ☐☐

MRI: Yes ☐ No ☐ Number of MRIs: ☐☐

Please note if the patient has had a CT or MRI please send the images to: ETTAA team, Papworth Hospital.

CXR: Yes ☐ No ☐ Number of CXRs: ☐☐

TOE: Yes ☐ No ☐ Number of TOEs: ☐☐

TTE: Yes ☐ No ☐ Number of TTEs: ☐☐

Other: ☐ Number: ☐☐☐

Other: ☐ Number: ☐☐☐

Other: ☐ Number: ☐☐☐

Other: ☐ Number: ☐☐☐

I have reviewed and approved all the information on this form (PI or designee to provide initials, signature and date)

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ETTAA

Procedure CRF

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Pre procedure test results:

*Has the patient had any of the following investigations done **since** completion of the Medical History Form or since discharge if the patient is having a staged procedure:*

Echo: Yes ☐ No ☐

If Yes:

LV function: Good LV>50% ☐ Moderate LV 31%-50% ☐ Poor LV<=30% ☐

Creatinine: Yes ☐ No ☐

If Yes:

Creatinine: ☐☐☐ umol/L

Hb: Yes ☐ No ☐

If Yes:

Hb: ☐☐☐ g/L

Procedure date: D D / M M / Y Y Y Y

Type of Procedure: OSR ☐ ESG ☐ Hybrid ☐

Please use 24hr clock

Theatre start time: (*Anaesthetic start time*) H H : M M

Theatre finish time: (*Time patient leaves theatre*) H H : M M

Priority: Elective ☐ Urgent ☐ Emergency ☐

Procedure Site: (The n*ame of hospital where the procedure has taken place)*

Operating Surgeon: ☐☐☐ *initials*

Staged procedure: Yes ☐ No ☐

Stage of procedure: 1st stage ☐ 2nd stage ☐ 3rd stage ☐ N/A ☐

ASA class: I ☐ II ☐ III ☐ IV ☐ V ☐

I = Healthy person

II = Mild systemic disease

III = Severe systemic disease

IV = Severe systemic disease that is a constant threat to life

V = A moribund person who is not expected to survive without the operation

Anaesthetic strategy: General ☐ Regional ☐ Local ☐

Operating facilities: OR ☐ OR with C arm ☐ Hybrid theatre ☐ CATH LAB ☐

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Aortic arch: N/A ☐ Repair ☐ Replace ☐

Prosthesis: (*manufacturer*) ☐ Size: ☐☐☐ mm

Ascending aorta: N/A ☐ Repair ☐ Replace ☐

Prosthesis: (*manufacturer*) ☐ Size: ☐☐☐ mm

Descending aorta: N/A ☐ Repair ☐ Replace ☐

Prosthesis: (*manufacturer*) ☐ Size: ☐☐☐ mm

Abdominal aorta: N/A ☐ Repair ☐ Replace ☐

Prosthesis: (*manufacturer*) ☐ Size: ☐☐☐ mm

Intra-operative blood product usage

Red Cells: Yes ☐ No ☐ Units of Red Cells: ☐☐

Platelets: Yes ☐ No ☐ Units of Platelets: ☐☐

FFP: Yes ☐ No ☐ Units of FFP: ☐☐

Cryoprecipitate: Yes ☐ No ☐ Units of Cryoprecipitate: ☐☐

Other: Yes ☐ No ☐

Name: ☐ Units ☐☐☐

Name: ☐ Units ☐☐☐

OSR Only

Surgical Incision: Sternotomy ☐ Thoracotomy ☐ Thoracolaparotomy ☐

Trap-door ☐ Clam-shell ☐ Other ☐

Please state other:

Bypass technique: None ☐ Gott shunt (axillo-fem) ☐ Partial ☐ Total ☐

Arterial cannulation:

Asc ☐	Arch ☐	BCT ☐	RSCA ☐
AxA ☐	RCCA ☐	LCCA ☐	Desc ☐
Iliac ☐	Femoral ☐	LV apex ☐	Previous vascular graft ☐

Asc = ascending Arch = Arch BCT = brachiocephalic trunk RSCA = right subclavian artery

AxA = axillary artery RCCA = right common carotid artery LCCA = left common carotid artery

Desc = descending thoracic aorta Iliac = Iliac artery Femoral = femoral artery

LV apex = left ventricular apex

Venous cannulation: Femoral ☐ RA ☐ LA ☐ Bicaval ☐

CPB time: ☐☐☐ mins Myocardial ischaemia: ☐☐☐ mins Spinal cord ischaemia: ☐☐☐ mins

Cerebral ischaemia: ☐☐☐ mins Renal/Gut ischaemia: ☐☐☐ mins

Was DHCA used: Yes ☐ No ☐ DHCA time: ☐☐☐ mins DHCA temp: ☐☐☐ ^{o}C

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Cerebral perfusion: None ☐ Retrograde ☐ Axillary Artery ☐

Brachiocephalic Trunk ☐ Left Common Carotid Artery ☐

Cerebral monitoring: None ☐ Electroencephalography ☐ Near-Infrared Spectroscopy ☐

Transcranial doppler ☐ Jugular Venous Saturations ☐ Other ☐

Please state other:

Myocardial protection: Antegrade ☐ Retrograde ☐ Warm ☐

Cold ☐ Blood ☐ Crystalloid ☐

n/a ☐

CSF drainage: Yes ☐ No ☐

CSF drainage at: Preop ☐ Intraop ☐ Postop ☐

If patient had CSF drainage please insert duration: ☐☐ days

Were intercostal arteries re-implanted: Yes ☐ No ☐ n/a ☐

If Yes, number of intercostal arteries re-implanted: ☐☐

Reimplantation technique: Individual ☐ Patch ☐ Vein graft ☐ Dacron ☐

Spinal cord monitoring: None ☐ MEP ☐ SSEP ☐ Other ☐

Please state other:

Cardiac procedures: AVR ☐ MVS ☐ CABG ☐ Other ☐ None ☐

Please state other:

Did the patient have any additional adjuvant procedures: Yes ☐ No ☐

If Yes, was the Adjuvant procedure caused by:

1. Aneurysm complication ☐ 2. Fistulae ☐ Other ☐

Please state other:

1. If Aneurysm Complication was it due to: Rupture ☐ Dissection ☐

False aneurysm ☐ Other ☐

Please state other:

2. If Fistulae: Aorto-esophageal ☐ Aorto-bronchial ☐

ESG Only

Number of stents deployed: ☐

Type of stent:

Left subclavian artery: Patent ☐ Covered by stent (with bypass) ☐ Covered by stent (without bypass) ☐

ESG vascular access: N/A ☐ Femoral ☐ Iliac ☐ Other ☐

Other:

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Did the patient have any additional adjuvant procedures: Yes ☐ No ☐

If Yes, was the Adjuvant procedure caused by:

1. Access vessel injury ☐ 2. Stent graft complication ☐
3. Endoleak ☐ 4. Fistulae ☐
Other ☐

Please state other: ☐

1. If Access vessel injury was it due to:

Bleeding ☐ Dissection ☐
Pseudoaneurysm ☐ Other ☐

Please state other: ☐

Treatment: Local repair ☐ Stent ☐ Surgery ☐

2. If Stent Graft Complication was it due to:

Conversion to open ☐ Migration ☐ Dislocation ☐
Thrombus ☐ Other ☐

Please state other: ☐

3. If Endoleak: I ☐ II ☐ III ☐ IV ☐

Treatment: Conservative ☐ Re-ballooning ☐ Additional stent ☐ Surgery ☐ Gel ☐

4. If Fistulae: Aorto-esophageal ☐ Aorto-bronchial ☐

I have reviewed and approved all the information on this form (PI or designee to provide initials, signature and date)

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ETTAA
Return to Theatre CRF

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Reason for return:

1. Access vessel injury ☐
2. Endoleak ☐
3. Aneurysm complication ☐
4. Stent graft complication ☐
5. Fistulae ☐
6. Reintervention ☐

Other ☐

If Other please state: ☐

Return to theatre: D D / M M / Y Y Y Y ☐☐ / ☐☐ / ☐☐☐☐

Please use 24hr clock

Theatre start time: (*Anaesthetic start time*) H H ☐☐ : M M ☐☐

Theatre finish time: (*Time patient leaves theatre*) H H ☐☐ : M M ☐☐

Was this related to the procedure:

- Not related ☐
- Unlikely ☐
- Possibly related ☐
- Probably related ☐
- Definitely related ☐

1. If Access vessel injury was it due to: Bleeding ☐
Dissection ☐
Pseudoaneurysm ☐
Other ☐

Please state other: ☐

Treatment: Local repair ☐ Stent ☐ Surgery ☐

2. If Endoleak: I ☐ II ☐ III ☐ IV ☐

Treatment: Conservative ☐ Re-ballooning ☐ Additional stent ☐
Surgery ☐ Gel ☐

3. If Aneurysm Complication was it due to: Rupture ☐
Dissection ☐
False aneurysm ☐
Other ☐

Please state other: ☐

4. If Stent Graft Complication was it due to: Conversion to open ☐
Migration ☐
Thrombus ☐
Dislocation ☐
Other ☐

Please state other: ☐

5. If Fistulae: Aorto-esophageal ☐ Aorto-bronchial ☐

6. If Reintervention: Re-ballooning ☐ Additional stent ☐ Surgery ☐

Patient Initials: ☐☐☐ Patient Study Number: ☐☐☐☐

Intra-operative blood product usage

Red Cells: Yes ☐ No ☐

Units of Red Cells: ☐☐

Platelets: Yes ☐ No ☐

Units of Platelets: ☐☐

FFP: Yes ☐ No ☐

Units of FFP: ☐☐

Cryoprecipitate: Yes ☐ No ☐

Units of Cryoprecipitate: ☐☐

Other: Yes ☐ No ☐

Name: _____ Units ☐☐☐

Name: _____ Units ☐☐☐

Name: _____ Units ☐☐☐

Name: _____ Units ☐☐☐

I have reviewed and approved all the information on this form (PI or designee to provide initials, signature and date)

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