

Giant-Aneurysm-Registry

Basic Module (page 1)

Please fax to:

++49- 30- 450 560 900 (Dengler)

Patienten ID: _____ age: _____ sex: m f

date of admission to the ward:

in case of out-patients: date of first contact

____ . ____ . ____
day month year

reason for presentation (current event):

- SAH - *if yes:* WFNS
 epileptic seizure
 effects of local compression by the aneurysm
 secondary ischemic stroke caused by the aneurysm
 asymptomatic or incidental finding

health condition before to current event:

mRS

Has this aneurysm been diagnosed prior to the current event or presentation?

yes no If "yes": date of first diagnosis:

____ . ____ . ____
day month year

risk factors:

hypertension yes no
if „yes“: treated untreated
myocardial infarction yes no
additional aneurysms yes no
if „yes“:
 intracranial? bled before? yes no
 extracranial? bled before? yes no
smoker yes no
if „yes“: current former smoker

alcohol abuse yes no
polycystic kidney disease yes no
arterio-venous malformation yes no
Ehlers-Danlos-syndrome yes no
Marfan-syndrome yes no
aortic coarctation yes no
family history of aneurysms (1. generation) yes no

previous treatment:

surgical yes no
endovascular yes no
antihypertensive meds yes no
aspirin yes no
coumarines yes no
clopidogrel yes no
other anti-platelets yes no
statins yes no

Giant-Aneurysm-Registry

Basic Module (page 2)

health condition at current presentation:

GCS mRS

asymptomatic yes no
if "no":

cranial nerve palsy yes no
motor deficit (arm/leg) yes no
aphasia yes no

radiologic diagnosis at current presentation:

SAH yes no
ICH yes no
SDH yes no
edema yes no
ischemia yes no
aneurysm without additional pathology yes no

characterization of the aneurysm:

diagnostic mode:

CT-A
 MR-A
 DSA

localisation:

ICA right left
 MCA right left
 ACA / AcomA right left
 post. circulation right left

shape:

saccular
 fusiform

structure:

completely thromosed
 partially thromosed
 calcified
 none of the above

largest diameter :

mm

aneurysm therapy:

conservative yes no

if „no“:

date of intervention: ____ . ____ . ____
day month year

direct aneurysm occlusion:

no direct aneurysm occlusion
 endovascular → coil others
 surgical → clip others

vessel occlusion: (e.g. proximal or distal or trapping)

no vessel occlusion
 endovascular
 surgical

vessel reconstruction:

no vessel reconstruction
 endovascular → regular stent
→ flow-diversion stent
→ others
 surgical

ventriculo-peritoneal or –atrial shunt: yes no

decompressive hemikraniectomy: yes no

bypass surgery: yes no

complications:

a) caused by therapy:

none
 intracranial bleeding
 secondary ischemic stroke
 others

b) occurred during therapy:

none
 vasospasm
 hydrocephalus
 others

radiologic result after therapy:

aneurysm
 completely occluded
 not completely occluded

in case of bypass surgery:
flow reversal successful?
 yes no

Giant-Aneurysm-Registry

Basic Module (page 3)

<p>health condition at discharge:</p> <p>mRS <input type="checkbox"/></p> <p>asymptomatic <input type="checkbox"/> yes <input type="checkbox"/> no <i>if "no":</i></p> <p>cranial nerve palsy <input type="checkbox"/> yes <input type="checkbox"/> no motor deficit (arm/leg) <input type="checkbox"/> yes <input type="checkbox"/> no aphasia <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p>patient discharged to:</p> <p><input type="checkbox"/> home <input type="checkbox"/> rehabilitation <input type="checkbox"/> nursing home <input type="checkbox"/> other clinic <input type="checkbox"/> other department <input type="checkbox"/> dead</p> <p>medication at discharge:</p> <p><input type="checkbox"/> antihypertensive meds <input type="checkbox"/> aspirin <input type="checkbox"/> coumarines <input type="checkbox"/> clopidogrel <input type="checkbox"/> other anti-platelets <input type="checkbox"/> heparin</p> <p>date of discharge:</p> <p>____ . ____ . ____ day / month / year</p>
<p>Was further intervention needed regarding the same aneurysm?</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><i>if "yes":</i> when? date ____ . ____ . ____ day / month / year</p> <p><i>Why was further intervention needed?</i></p> <p><input type="checkbox"/> aneurysm rupture <input type="checkbox"/> residual aneurysm lumen <input type="checkbox"/> hydrocephalus <input type="checkbox"/> leakage from bypass anastomosis <input type="checkbox"/> others</p> <p><i>What kind of further intervention?</i></p> <p><input type="checkbox"/> surgical aneurysm treatment <input type="checkbox"/> endovascular aneurysm treatment <input type="checkbox"/> others</p>	