

**University of Utah  
Central Data Management Coordinating Center**

**ANNOTATED ECRF FOR PUBLIC USE DATASETS**

**The CRISIS Prevention Trial**

**The Critical Illness Stress-Induced Immune  
Suppression Prevention Trial**

**CPCCRN Protocol Number 003**

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Children's Hospital of Pittsburgh**

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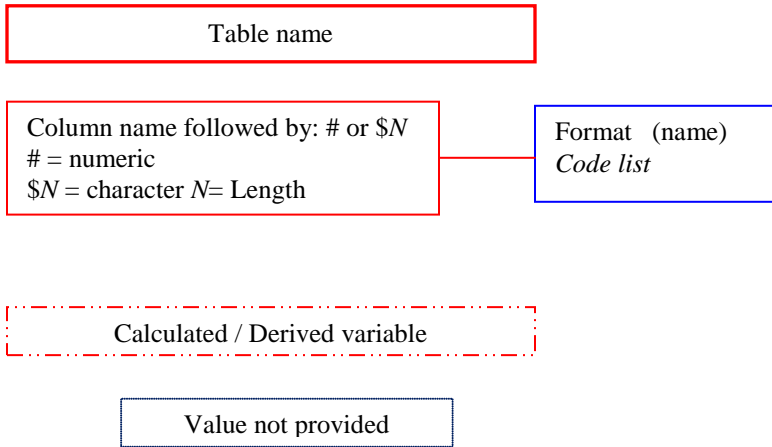
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**Annotations key:**



**Notes:**

All dates have been recoded to reflect the number of calendar days from randomization.

Sensitive and/or identifying information entered in free text fields has been removed from the public use datasets.

**studyForm Format:**

VALUE	LABEL
0	Demographics
1	Randomization
2	Baseline and Pre-dosing
2.1	Physical Examination
2.2	PRISM III
3	Study Day 1
4	Study Day 2
5	Study Day 3
6	Study Day 4
7	Study Day 5
8	Study Day 6
9	Study Day 7
10	Study Day 8
11	Study Day 9
12	Study Day 10
13	Study Day 11
14	Study Day 12
15	Study Day 13
16	Study Day 14
17	Study Day 15
18	Study Day 16
19	Study Day 17
20	Study Day 18
21	Study Day 19
22	Study Day 20
23	Study Day 21
24	Study Day 22
25	Study Day 23
26	Study Day 24
27	Study Day 25
28	Study Day 26
29	Study Day 27
30	Study Day 28
30.1	Follow Up Day 1
30.2	Follow Up Day 2
30.3	Follow Up Day 3
30.4	Follow Up Day 4
30.5	Follow Up Day 5
31	Final Patient Summary
32	Withdrawal of Consent
38	Logs
40	Early Exit
42	Endpoint Summary

CRISIS Annotated PUD eCRF

DEMOGRAPHICS (1 of 1)

**Demographics**

*Unique ID = subjectID*

subjectID #      studyForm #

<b>*DOB (MM/DD/YYYY)</b>	08	ageInYears #	SEX 1 = Female 2 = Male
<b>*Sex</b>	F	sex #	
<b>*Race</b>	Ar	race #	
<b>Ethnicity</b>	H	HISPANIC_ETHNICITY #	

**Race**  
1 = American Indian or Alaska Native  
2 = Asian  
3 = Black or African American  
4 = Native Hawaiian or Other Pacific Islander\*  
5 = White  
6 = Stated as Unknown  
7 = Other  
  
\*Combined with 7 = Other, for RACE format

DV6484G  
-1 = Hispanic or Latino  
0 = Not Hispanic or Latino  
1 = Unknown

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RANDOMIZATION (1 of 1)

**Randomization**

*Unique ID = subjectID*

subjectID #      studyForm #

Randomization	
Immune Status	2 ImmuneStatus #
If immunocompromised, provide reason	immunCompReason #
Provide "Other" immunocompromised reason	Value not provided
Date patient was randomized into the study	M randDay #
Time patient was randomized into the study (HHMM)	15 TimeOfRand \$5

DV6618G  
1 = Immune Competent  
2 = Immune Compromised

370 (ImmunCompChoices)  
1 = Bone Marrow Transplant Recipient  
2 = Other Organ Transplant Recipient  
3 = Cancer Patient \*  
4 = Human Immunodeficiency Virus \*  
5 = Other  
  
\*Combined with 5 = Other, for IMMUNCOMPCHOICES format in PUD

**Variables from analysis dataset included in the RANDOMIZATION dataset:**

Variable	Format	Type	Label	Algorithm / Notes
itt	YESNO.	#	Intent-to-treat Population	=1 if randomized, =0 if not randomized
safe	YESNO.	#	Safety Population	=1 if patient received any study drug, =0 otherwise
trtRand	TRT.	#	Randomized Treatment Group	Treatment assigned by randomization
trtRec	TRT.	#	Treatment Received	Actual treatment received by patient

YESNO  
0 = No  
1 = Yes

TRT  
1 = WHEY  
2 = ZSGM

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BASELINE (1 of 2)

**Baseline and Pre-Dosing**

*Unique ID = subjectID*

subjectID #      studyForm #

Admission Information	
Date of hospital admission	hospAdmitDay #
Time of hospital admission	HospAdmitTime \$5
Date of PICU admission	PICUAdmitDay #
Time of PICU admission	PICUAdmitTime \$5
Height (cm)	HeightCM #
Weight (kg)	WeightKG #
Chronic Ventilator Support	ChronicVentSupp #
Operative Status	OperativeStatus #
Postoperative type	PostOpType2 #
Other Surgery please describe	Value not provided
Endotracheal tube present at randomization?	EndoTubeAtRand #
Central venous catheter at randomization?	CVCathAtRand #
Urinary catheter at randomization?	UrinCatAtRand #

DV6032G 1 = Yes 2 = No	DV6478G 0 = Not postoperative 1 = Postoperative
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DV1532G 1 = Not Present 2 = Present	DV6479G 0 = Cardiac surgery 1 = Neurosurgery 2 = Orthopedic surgery 3 = Transplant surgery* 4 = Trauma surgery 5 = Other surgery  *Combined with 5 = Other, for OPERATIVE_STATUS format in PUD
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BASELINE (2 of 2)

Primary Diagnostic Category

Primary Diagnostic Category  (options of seizure therapy)

Other primary diagnostic category

Secondary Diagnostic Category

Secondary Diagnostic Category  (SecDiagCat #) (itis)

Other secondary diagnostic category

- DV6624G
- 1 = Asthma (reactive airway disease)
  - 2 = Cancer\*\*
  - 3 = Cardiac arrest w/in 24 hours (closed heart compressions)
  - 4 = Chromosomal abnormality (not hereditary)
  - 5 = Diabetes\*\*
  - 6 = Drug overdose (e.g. ingestion, toxicity)\*, \*\*
  - 7 = Gastroesophageal reflux \*\*
  - 8 = Cardiovascular disease – acquired\*\*
  - 9 = Cardiovascular disease – congenital
  - 10 = HIV infection\*
  - 11 = Hypoxic-ischemic encephalopathy (acute, not static)\*, \*\*
  - 12 = Medical device malfunction
  - 13 = Meningitis\*, \*\*
  - 14 = Pneumonia/bronchiolitis
  - 15 = Seizures (includes complications of seizure therapy)
  - 16 = Sepsis
  - 17 = Shock
  - 18 = Suicide attempt (includes intentional drug overdose)
  - 19 = Transplant\*, \*\*
  - 20 = Trauma\*\*
  - 21 = None
  - 22 = Other
- \*Combined with 22 = Other, for PRIDIAGNOSTICCAT format in PUD
- \*\* Combined with 22 = Other, for SECIDIAGNOSTICCAT format in PUD

Variables from analysis dataset included in the BASELINE dataset:

Variable	Format	Type	Label	Algorithm / Notes
PRISMIICalcS	11.	#	Baseline PRISM III Total Score	Based on the first 12 hours of PICU admission

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BASELINE\_CHRONICDIAG (1 of 1)

**Baseline – Chronic Diagnoses**

*Unique ID = subjectID, Repeat\_instance*

subjectID #

studyForm #

Repeat\_instance #

Chronic diagnoses

ChronDiagnoses #
16 : Other
16 : Other

Add record Delete record

- DV581G
- 1 = Bronchopulmonary dysplasia (BPD)\*
  - 2 = Cancer (oncologic disease)
  - 3 = Cerebral palsy
  - 4 = Chromosomal abnormality (not hereditary conditions)
  - 5 = Congenital heart disease
  - 6 = Diabetes\*
  - 7 = HIV infection
  - 8 = Hydrocephalus
  - 9 = Intraventricular hemorrhage (from perinatal period)
  - 10 = Mental retardation
  - 11 = Meningomyelocele/spina bifida\*
  - 12 = Short gut syndrome\*
  - 13 = Static encephalopathy
  - 14 = Transplant
  - 15 = None
  - 16 = Other
- \*Combined with 16 = Other, for CHRONICDIAGNOSES format in PUD

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PHYSICAL\_EXAMINATION (1of 1)

**Physical Examination**

*Unique ID = subjectID*

subjectID #

studyForm #

Physical Examination

Date of Physical Exam

Body System	Select Normal, Abnormal or Not Assessed	Comment
HEENT	<input type="text" value="HEENTPE #"/>	
Cardiovascular	<input type="text" value="CardioPE #"/>	
Lungs	<input type="text" value="LungsPE #"/>	
Abdomen/GI	<input type="text" value="AbdGIPE #"/>	
Extremities	<input type="text" value="ExtremitiesPE #"/>	DV428G 1 = Normal 2 = Abnormal 3 = Not Assessed
Neurological	<input type="text" value="NeurologicalPE #"/>	
Skin	<input type="text" value="SkinPE #"/>	
Lymph Nodes/Hematology	<input type="text" value="LymphHemPE #"/>	

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DAILYDATA (1of 3)

Daily Data / Follow Up

Unique ID = subjectID, studyForm

subjectID #

studyForm #

Study Date

Study Date:

Daily Infection Status

Does the patient exhibit any signs or symptoms of clinical infection?  **InfcnPresence #**

Does investigator believe this is a continuing event from the previous day?  **InfcnCont #**

Were any diagnostic test ordered?

**DV6032G**  
1 = Yes  
2 = No

Daily Sepsis Status

Does the patient exhibit any signs or symptoms of sepsis?  **SepsisPresence #**

Does investigator believe this is a continuing event from previous day?  **SepsisCont #**

Were any new antibiotics ordered?

**DV6032G**  
1 = Yes  
2 = No

Daily Patient Review

Endotracheal Tube  **EndoTube #**

Central Venous Catheter  **CVCath #**

Urinary Catheter  **UrinCath #**

Ventilator Support  **VentSupport #**

Additional invasive therapies or catheters present during study day  **AddlTherOrCath #**

**DV1378G**  
1 = Not present during this day  
2 = Present during this day (continuous)  
3 = Inserted/re-inserted during this day  
4 = Removed during this day

**DV6032G**  
1 = Yes  
2 = No

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DAILYDATA (2 of 3)

Additional therapies or catheters

Type of additional therapies or catheters present	Other (please describe)
4:0	Daily Data - Additional Therapies on page 15
4:0	

Add record Delete record

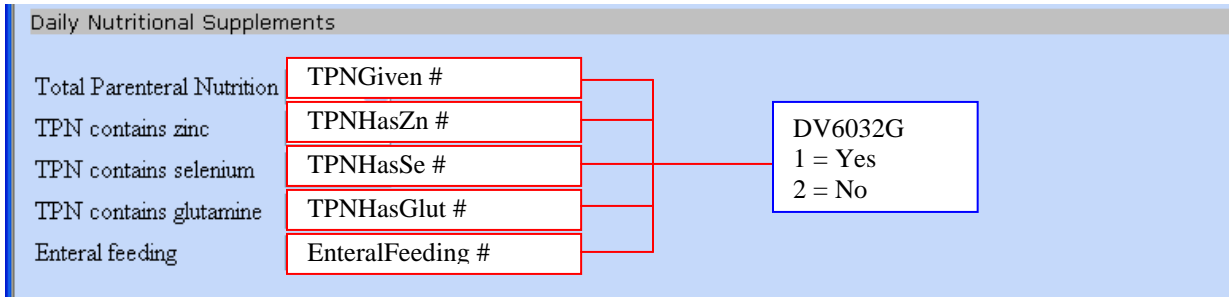
Daily medication questions

Steroids	SteroidsGiven #
Dopamine	DopamineGiven #
Calcineurin Inhibitors	CalcInhibGiven #
Intravenous gamma globulin (IVIG)	IVIGGiven #
Granulocyte colony-stimulating factor (G-CSF)	GCSFGiven #
Granulocyte-monocyte colony-stimulating factor (GM-CSF)	GMCSFGiven #
Other Immunosuppressant Therapy	OthImmunTherapy #
Non-study related Metoclopramide given	MetoclopGiven #
Supplemental zinc	SuppZnGiven #
Supplemental selenium	SuppSeGiven #
Supplemental Glutamine	SuppGlutGiven #

DV6032G  
1 = Yes  
2 = No

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DAILYDATA (3 of 3)



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DAILYDATA\_ADDITIONALTHERAPIES (1 of 1)

**Daily Data – Additional Therapies**

*Unique ID = subjectID, studyForm, Repeat\_instance*

subjectID #

studyForm #

Repeat\_instance #

Type of additional therapies or catheters present	Other (please describe)
4: Open mediastinum	
4: Open mediastinum	Value not provided

Add record    Delete record

- DV661G
- 1 = Arterial catheter
- 2 = Tracheostomy
- 3 = Chest tube
- 4 = Open mediastinum
- 5 = ECMO
- 6 = Hemodialysis
- 7 = Peritoneal dialysis
- 8 = LVAD or BIVAD
- 9 = ICP monitor
- 10 = Epidural catheter
- 11 = None
- 12 = Other

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PELOD (1 of 1)

**Pediatric Logistic Organ Dysfunction (PELOD) Score**

*Unique ID = subjectID, studyForm*

subjectID #

studyForm #

**Note:** Sites were instructed to collect PELOD scores on study day 1, 7, 14, 21 and 28 of PICU admission

PELOD

Recompute

Date of Assessment PELODDay #

Total Score

PELOD Total Score PELOD #



CRISIS Annotated PUD eCRF

OFI (1 of 1)

**Organ Failure Index (OFI)**

*Unique ID = subjectID, studyForm*

subjectID #

studyForm #

**Note:** Sites were instructed to collect OFI scores on study day 1, 7, 14, 21 and 28 of PICU admission

OFI

Recompute

Date of assessment: OFIDay #

Organ Failure Index: 0 OFI #

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HEMATOLOGY (1 of 1)

Daily Hematology Results

Unique ID = subjectID, Repeat\_instance

subjectID #      studyForm #      Repeat\_instance #

Date of Hematology Labs

Date of Lab Result(s)

Hematology

Time of Lab	Hematocrit (%)	Hemoglobin (g/100ml)	Leukocyte ( $\times 10^3/\text{mm}^3$ )	Platelets ( $\times 10^3/\text{mm}^3$ )	Seg. Neutrophils (%)	Eosinophils (%)	Basophils (%)	Lymphocytes (%)	Monocytes (%)	Abs Lymphocyte Count ( $\times 10^3/\text{mm}^3$ )	Abs Neutrophil Count ( $\times 10^3/\text{mm}^3$ )
<input type="text" value="TimeOfLab \$5"/>	<input type="text" value="Hematocrit #"/>	<input type="text" value="Hemoglobin #"/>	<input type="text" value="Leukocyte #"/>	<input type="text" value="Platelets #"/>	<input type="text" value="Neutrophils #"/>	<input type="text" value="Eosinophils #"/>	<input type="text" value="Basophils #"/>	<input type="text" value="Lymphocytes #"/>	<input type="text" value="Monocytes #"/>	<input type="text" value="AbsLymph #"/>	<input type="text" value="AbsNeut #"/>

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SERUMCHEM (1of 1)

**Daily Serum Chemistry Results**

*Unique ID = subjectID, Repeat\_instance*

subjectID #

studyForm #

Repeat\_instance #

Date of Chemistry Labs

Date of Lab Result(s)

Serum Chemistries

Time of Lab	Glucose	Creatinine	Aspartate aminotransferase	Alanine aminotransferase	Alkaline Phosphatase	Total Bilirubin
<input type="text" value="TimeOfLab \$5"/>	<input type="text" value="Glucose #"/>	<input type="text" value="Creatinine #"/>	<input type="text" value="AST2 #"/>	<input type="text" value="ALT2 #"/>	<input type="text" value="AlkPhosphatase #"/>	<input type="text" value="TIBilirubin #"/>

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MISCLABS (1of 1)

**Miscellaneous Laboratory Values**

*Unique ID = subjectID, Repeat\_instance*

**Note:** Sites were instructed to enter all other non-study required laboratory values where the investigator had determined the abnormal value was clinically significant.

subjectID #      studyForm #      Repeat\_instance #

Date Of Miscellaneous Labs

Date of Lab Result(s)      dayOfLab #

Miscellaneous Labs

Time of Lab	Lab Name	Lab Value	Unit of Measurement	Status
TimeOfLab \$5	LabName \$50	LabValue #	LabUnit \$10	LabStatus #

Add record      Delete record

DV2281G  
1 = High  
2 = Low

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FINALSTATUS (1 of 2)

**Final Status (includes Day 28 mortality information)**

*Unique ID = subjectID*

subjectID #

studyForm #

Study Summary

Date patient was last evaluated finalContactDay #

Were any study medication(s) permanently discontinued prior to Day 28? StudyMedDiscont #

DV6942G  
1 = Yes  
2 = No  
3 = Patient never received any study drugs

Provide the final status of the patient on the day of last evaluation

Patient Status PatientStatus #

If yes, please provide the primary cause of death PriCauseDeath \$255

DV623G  
1 = Alive  
2 = Dead  
3 = Could not determine

CRISIS Annotated PUD eCRF

FINALSTATUS (2 of 2)

**Variables from analysis dataset included in the FINALSTATUS dataset:**

Variable	Format	Type	Label	Algorithm / Notes
PICUDCTime	\$5.	\$	Time of PICU discharge (HHMM)	PICU discharge time for the current PICU admission OR death time if PICU discharge time was not provided
HospDCTime	\$5.	\$	Hospital discharge time (HHMM)	PICU discharge time for the current PICU admission OR death time if PICU discharge time was not provided
studyDay28Death	YESNOUK.	#	Dead on Study Day 28	= 1 if death date is on or before Study Day 28 = 0 if (death date is after Study Day 28) OR (patient is confirmed alive as of Study Day 28 AND NO death date is provided) = -1 if patient is NOT confirmed alive as of Study Day 28 AND patient withdrew from data collection prior to Study Day 28
PICUDCDay		#	Day of PICU discharge (relative to randomization)	(PICU discharge date for the current PICU admission OR death date if PICU discharge date was not provided) – randomization date
hospDCDay		#	Day of hospital discharge (relative to randomization)	(Hospital discharge date for the current hospital admission OR death date if hospital discharge date was not provided) – randomization date
studyDay28		#	Day of Study Day 28 (relative to randomization)	studyDay28: = (Date of Study Day 1 + 27) – randomization date
deathDay		#	Day of death (relative to randomization)	= (date of death, as of the final status evaluation OR Study Day 28 follow up) – randomization date
deathTime	\$5.	\$5	Time of Death (HHMM)	= time of death, as of the final status evaluation OR Study Day 28 follow up

YESNOUK  
-1 = Unknown  
0 = No  
1 = Yes

CRISIS Annotated PUD eCRF

FINALSTATUS\_STUDYMEDDISC (1of 1)

**Final Status – Discontinued Study Medications**

*Unique ID = subjectID, Repeat\_instance*

subjectID #      studyForm #      Repeat\_instance #

Discontinued study medications	
Choose study medication (s) discontinued	Reason for discontinuation
StudyMedsDisc #	DiscontReason #
<input type="button" value="Add record"/>	<input type="button" value="Delete record"/>

- DV6627G
- 1 = Metoclopramide/Placebo
  - 2 = Zinc/Placebo
  - 3 = Selenium/Placebo
  - 4 = Glutamine/Placebo
  - 5 = All study medications discontinued

- DV998G
- 1 = Adverse Event
  - 2 = Failure to tolerate study medication
  - 3 = Development of exclusion criteria
  - 4 = Removal of enteral feeding tube
  - 5 = No IV available
  - 6 = Discharged from PICU
  - 7 = Patient died
  - 8 = Parent withdrew permission for patient to continue on study medication
  - 9 = Other

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WITHDRAWALOFCONSENT (1 of 1)

**Withdrawal of Consent**

*Unique ID = subjectID*

subjectID #

studyForm #

Withdrawal of Consent	
What elements of consent were withdrawn	WDType #
Date consent was withdrawn	WDCTime #
Time consent was withdrawn	WDCTime \$5

DV6943G  
1 = Parent withdrew permission to continue on study medication, data collection can continue  
2 = Parent withdrew permission for study medication and data collection to continue, except AEs and 28 Day follow-up  
3 = Parent withdrew permission for study medication, data collection and any contact or follow-up



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ADVERSEEVENTLOG (1 of 2)

**Adverse Events Log**

*Unique ID = subjectID, Repeat\_instance*

**Note:** Adverse events were coded to the lower level term (LLT) in MedDRA version 13.0. The lower level code (MedDRALLTID) and LLT (MEDRALLT) are included in this dataset. We are including sepsis and infection events in the dataset even though these event types were excluded from the summary of AEs provided for the primary manuscript since they overlap with the outcome reporting for this study.

Adverse Event Log					
subjectID #		studyForm #		Repeat_instance #	
MedDra ID	Adverse Event Name	MedDra Code	Start Date	Resolution Date	Outcome
MedDraLLT \$100	Value not provided	MedDraLLTID #			AEOOutcome #
Add record		Delete record		AEStartDay #	AEStopDay #

DV5306G  
1 = Death  
2 = Recovered, patient returned to baseline  
3 = Recovered with sequelae  
4 = Symptoms continue

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ADVERSEEVENTLOG (2 of 2)

Intensity	Study Drug Action Taken	Study Drug Relationship	Treatment or Action Taken for this AE	Other AE Treatment
AEIntensity #	StDrugAction #	Value not provided	AETreatment1 #	AETreatOther \$1024

DV1904G  
1 = Mild  
2 = Moderate  
3 = Severe

DV13G  
1 = None  
2 = Dose reduced  
3 = Study drug interrupted/restarted  
4 = Study drug discontinued

DV6311G  
1 = None  
2 = Intervention: Surgery or Procedure  
3 = Medication initiation, change or discontinuation  
4 = Other Treatment

DV4348G  
1 = Not Serious  
2 = Moderately Serious  
3 = Serious

**Adverse Event Severity**

AESeverity #

CMEDLOG (1 of 2)

**Concomitant Medications Log**

*Unique ID = subjectID, Repeat\_instance*

**Note:** Medications were coded in RxNorm version 2010.2.1, and the code (RxNormCode) and medication name (CodedMedName) are included in this dataset. 107 records have been removed from the dataset because they could not be coded.

subjectID #   
 studyForm #   
 Repeat\_instance #

Medication Name	Medication Name (coded)	Unit Dose	Frequency
CodedMedName \$255	RxNormCode \$100	MedDose \$20	MedFrequency #
<input type="button" value="Add record"/> <input type="button" value="Delete record"/>			

Other medication frequency	Route	Other medication route	
MedFreqOther \$1024	MedRoute #	OtherRoute \$20	MedStartDay #

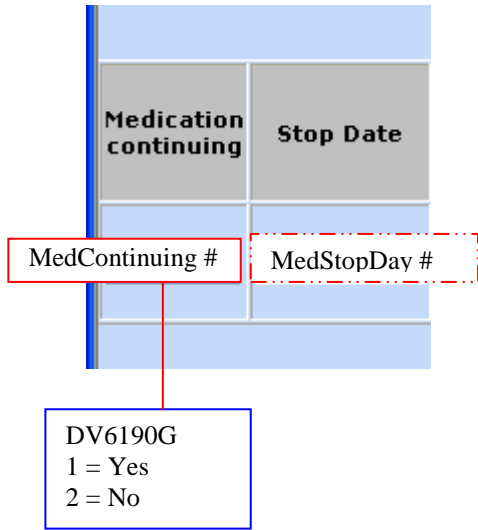
DV2159G  
 1 = QD            6 = q4h  
 2 = BID          7 = q6h  
 3 = TID          8 = q8h  
 4 = QID          9 = q12h  
 5 = qh            10 = PRN  
                   11 = Other

DV6515G  
 1 = PO            8 = IH  
 2 = IV            9 = TD  
 3 = IM            10 = VA  
 4 = PR            11 = IA  
 5 = SC            12 = NA  
 6 = SL            13 = TO  
 7 = IT            14 = ID  
                   15 = Other

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CMEDLOG (2 of 2)



INFECTIONLOG (1 of 1)

**Diagnostic Testing for Infections Log**

*Unique ID = subjectID, Repeat\_instance*

**Note:** Sites were instructed to enter all information regarding bacterial culture, antigen, PCR or antibody testing for an infection occurring within 48 hours prior to PICU admission through the last day the patient participated in the study.

Date diagnostic specimen/test obtained	Time diagnostic specimen/test obtained	Specimen Type	If Other, please specify	Organism Type	Presumed site of infection
DaySpecObtained #	TmSpecObtained \$5	SpecimenType #	OthSpecimenType \$1024	OrganismType \$255	SiteOfInfection #

Results of diagnostic specimen/test

DiagSpecResults #

DV6401G

- 1 = Positive
- 2 = Negative
- 3 = Pending

DV4106G

1 = Urine	5 = Blood
2 = Feces	6 = Skin
3 = Cerebrospinal fluid	7 = Tissues
4 = Sputum	8 = Other

DV159G

- 1 = Urinary tract
- 2 = Surgical wound
- 3 = Pneumonia
- 4 = LRTI other than pneumonia
- 5 = Bloodstream (primary)
- 6 = Bone or joint
- 7 = CNS
- 8 = Cardiovascular
- 9 = ENT
- 10 = GI tract
- 11 = Reproductive tract
- 12 = Skin or soft tissue
- 13 = Systemic
- 14 = Unknown

CRISIS Annotated PUD eCRF

PARENTERALADMIN (1 of 1)

**Parenteral Study Drug Administration**

*Unique ID = subjectID*

subjectID #

studyForm #

Calculated recommended dose

Metoclopramide or Placebo Study Drug Administration

Calculated dose (tl. mgs) - based on patients weight at admission

CalcDose #

CRISIS Annotated PUD eCRF

PARENTERALADMIN\_METOCLOPRAMIDE (1 of 1)

**Metoclopramide or Placebo Study Drug Administration Log**

*Unique ID = subjectID, Repeat\_instance*

subjectID #

studyForm #

Repeat\_instance #

Metoclopramide or Placebo Study Drug Details						
Administration Date	Administration time	Study drug dose administered (total mgs)	Dose modified?	Reason dose modified	If Other, provide reason	Dose Adjustment
adminDay #	AdminTm \$5	MetPlaceboDose #	DoseModified #	DoseModReason #	Value not provided	AdjustedDose #

DV6032G  
1 = Yes  
2 = No

DV6625G  
1 = Creatinine clearance 40-50 ml/min  
2 = Creatinine clearance 10-40 ml/min  
3 = Creatinine clearance <10 ml/min  
4 = Other

DV6397G  
1 = 75% of recommended dose  
2 = 50% of recommended dose  
3 = 25% of recommended dose  
4 = Other

CRISIS Annotated PUD eCRF

ENTERALADMIN (1 of 1)

**Enteral Study Drug Administration**

*Unique ID = subjectID*

subjectID #

studyForm #

Calculated recommended dose

Zinc or Placebo Study Drug Administration

Calculated dose (tl. mgs) - based on patients age at admission CalcDose2 #

Calculated recommended dose

Selenium or Placebo study Drug Administration

Calculated dose (tl. mcgs) - based on patients age at admission CalcDose3 #

Calculated recommended dose

Glutamine or Placebo Study Drug Administration

Calculated dose (tl. gms) - based on patients weight at admission CalcDose4 #



CRISIS Annotated PUD eCRF

ENTERALADMIN\_ZINC (1 of 1)

**Zinc or Placebo Study Drug Administration Log**

*Unique ID = subjectID, Repeat\_instance*

subjectID #

studyForm #

Repeat\_instance #

Zinc Or Placebo Details

Administration Date	Administration time	Study Drug dose administered (total mg/day)	Study Drug or Placebo Route
adminDay #	AdminTm2 \$5	DrugDose2 #	StudyDrugRoute2 #

Add record    Delete record

DV180G  
1 = NG  
2 = ND  
3 = NJ  
4 = GT

CRISIS Annotated PUD eCRF

ENTERALADMIN\_SELENIUM (1 of 1)

**Selenium or Placebo Study Drug Administration Log**

*Unique ID = subjectID, Repeat\_instance*

subjectID #

studyForm #

Repeat\_instance #

Selenium or Placebo Details

Administration Date	Administration time	Study Drug dose administered (total mcg/day)	Study Drug or Placebo Route
adminDay #	AdminTm3 \$5	DrugDose3 #	StudyDrugRoute3 #

Add record    Delete record

DV180G  
1 = NG  
2 = ND  
3 = NJ  
4 = GT

CRISIS Annotated PUD eCRF

ENTERALADMIN\_GlutAMINE (1 of 1)

**Glutamine or Placebo Study Drug Administration Log**

*Unique ID = subjectID, Repeat\_instance*

subjectID #

studyForm #

Repeat\_instance #

Glutamine or Placebo Details

Administration Date	Administration time	Study Drug dose administered (total gms/day)	Study Drug or Placebo Route
adminDay #	AdminTm4 \$5	DrugDose4 #	StudyDrugRoute4 #

Add record    Delete record

DV180G  
1 = NG  
2 = ND  
3 = NJ  
4 = GT

CRISIS Annotated PUD eCRF

ANTIBIOTICLOG (1 of 1)

**Antibiotic Log**

*Unique ID = subjectID, Repeat\_instance*

**Note:** Medications were coded in RxNorm version 2010.2.1, and the code (RxNormCode) and medication name (CodedMedName) are included in this dataset. One record has been removed from the dataset because it could not be coded.

subjectID #      studyForm #      Repeat\_instance #

Date Ordered	Time Ordered	Medication Name	Medication Name (coded)	Unit Dose	Frequency	Other medication frequency
DayAbOrdered #	200	CodedMedName \$255	RxNormCode \$100		MedFrequency #	OtherFreq \$20
	TmAbOrdered \$5			MedDose \$10		

- DV2159G
- 1 = QD
  - 2 = BID
  - 3 = TID
  - 4 = QID
  - 5 = qh
  - 6 = q4h
  - 7 = q6h
  - 8 = q8h
  - 9 = q12h
  - 10 = PRN
  - 11 = Other

Route	Other medication route	Start Date	Medication continuing	Stop Date	Presumed site of infection
MedRoute #	OtherRoute \$20	MedStartDay #	1 : Yes	MedStopDay #	SiteSepsisInfcn #
			MedContinuing #		

- DV6515G
- 1 = PO
  - 2 = IV
  - 3 = IM
  - 4 = PR
  - 5 = SC
  - 6 = SL
  - 7 = IT
  - 8 = IH
  - 9 = TD
  - 10 = VA
  - 11 = IA
  - 12 = NA
  - 13 = TO
  - 14 = ID
  - 15 = Other

- DV6190G
- 1 = Yes
  - 2 = No

- DV159G
- 1 = Urinary tract
  - 2 = Surgical wound
  - 3 = Pneumonia
  - 4 = LRTI other than pneumonia
  - 5 = Bloodstream (primary)
  - 6 = Bone or joint
  - 7 = CNS
  - 8 = Cardiovascular
  - 9 = ENT
  - 10 = GI tract
  - 11 = Reproductive tract
  - 12 = Skin or soft tissue
  - 13 = Systemic
  - 14 = Unknown

ENDPTSUM (1 of 3)

**Endpoint Summary**

*Unique ID = subjectID*

subjectID #      studyForm #

Endpoint Status

Existing Sepsis	ExistSepEpSum #	DV6032G 1 = Yes 2 = No
Existing Infection	ExistInfcnEpSum #	
Nosocomial Clinical Sepsis	NosoClinSep #	
Number of Sepsis Events	NumSepEvents #	

**Date of Nosocomial Clinical Sepsis**      **Time of Nosocomial Clinical Sepsis**

Endpoint Summary – Nosocomial Sepsis Events Log on page 41

Nosocomial Clinical Infection	NosoClinInfcn #	DV6032G 1 = Yes 2 = No
Number of Infection Events	NumInfcnEvents #	

**Date of Nosocomial Clinical Infection**      **Time of Nosocomial Clinical Infection**

Endpoint Summary – Nosocomial Infection Events Log on page 40

Incidence of Lymphopenia

Did this patient have moderate lymphopenia (absolute lymphocyte count <= 1,000 cells/ $\mu$ L for >= 3 days)	ModLym #	DV6190G 1 = Yes 2 = No
Did this patient have prolonged lymphopenia (absolute lymphocyte count <= 1,000 cells/ $\mu$ L for >= 7 days)	ProLym #	

CRISIS Annotated PUD eCRF

ENDPTSUM (2 of 3)

Variables from analysis dataset include in the ENDPTSUM dataset:

Variable	Format	Type	Label	Algorithm / Notes
Time1stHrs		#	Time to first nosocomial infection/sepsis event/censor time (hours)	<ul style="list-style-type: none"> <li>• If patient had any nosocomial sepsis/infection events then = Ceiling of [(date/time of earliest event – PICU admission date/time) / (60*60)]</li> <li>• Else if patient had no nosocomial sepsis/infection events AND did NOT withdraw from data collection then = Ceiling of {[minimum of (hospital discharge date/time, death date/time, 23:59 and 59 seconds on the day patient was last evaluated) – PICU admission date/time] / (60*60)}</li> <li>• Else if patient had no nosocomial sepsis/infection events AND withdrew from data collection then = Ceiling of [(date/time of withdrawal from data collection – PICU admission date/time) / (60*60)]</li> </ul>
censor	YESNO.	#	Censored for survival analysis of time to first nosocomial infection/sepsis event	=1 if patient had any nosocomial sepsis/infection events =0 if patient had no any nosocomial sepsis/infection events
NumEvent		#	Number of nosocomial events (infection or sepsis)	=Number of nosocomial clinical sepsis events + number of nosocomial clinical infection events
AntiFreeDay		#	Antibiotic free days in PICU	= Number of days from PICU admission to earliest of PICU discharge, death, final study evaluation Note: for continuing antibiotics with missing antibiotic stop days, assume the antibiotic stop date is the earliest date of (PICU discharge, death, final study evaluation)
pctantifreeDAY		#	Proportion of antibiotic free days in PICU	antiFreeDay / PICUDay
PICUDAY		#	Days in PICU	=earliest of (PICU discharge date, death date, date patient was last evaluated) – PICU admission date + 1
studydayMOD		#	Time from PICU admission to final study evaluation (days)	<ul style="list-style-type: none"> <li>• If patient did NOT withdraw from data collection then =Ceiling of {[minimum of (hospital discharge date/time, death date/time, 23:59 and 59 seconds on the day patient was last evaluated) – PICU admission date/time] / (60*60*24)}</li> <li>• Else if withdrew from data collection then =Ceiling of [(date/time of withdrawal from data collection – PICU admission date/time) / (60*60*24)]</li> </ul>

CRISIS Annotated PUD eCRF

ENDPTSUM (3 of 3)

EXISTINFSEPSG	SEPINF.	#	Existing Infection or Sepsis Subgroup	=0 if Existing Sepsis=No AND Existing Infection=No =1 if Existing Sepsis=Yes AND Existing Infection=No =2 if Existing Sepsis=No AND Existing Infection=Yes
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**SEPINF**  
 0 = No Pre-existing Sepsis/Infection  
 1 = Pre-existing Sepsis  
 2 = Pre-existing Infection  
 3 = Not Adjudicated

**YESNO**  
 0 = No  
 1 = Yes

**Endpoint Summary – Nosocomial Infection Events Log**

*Unique ID = subjectID, Repeat\_instance, organismID*

**Note:** It is possible to have multiple organisms per infection; each organism is on a separate row.

subjectID #

studyForm #

Repeat\_instance #

<b>Date of Nosocomial Clinical Infection</b>	<b>Time of Nosocomial Clinical Infection</b>
NosoClinInfcnDay #	NosoClinInfcnTm \$5

Add record

Delete record

**Variables from analysis dataset include in the ENDPTSUM\_NOSOCLININFC dataset:**

Variable	Format	Type	Label	Algorithm / Notes
organism		\$96		Abstracted from the lab report
organism_category		\$22		Categorized organism
specimen_location		\$50		Abstracted from the lab report
specimen_type		\$96		Categorized specimen location
organismID		#	Organism identifier (per infection)	



**Endpoint Summary – Nosocomial Sepsis Events Log**

*Unique ID = subjectID, Repeat\_instance*

subjectID #

studyForm #

Repeat\_instance #

<b>Date of Nosocomial Clinical Sepsis</b>	<b>Time of Nosocomial Clinical Sepsis</b>
NosoClinSepDay #	NosoClinSepTm \$5
<input type="button" value="Add record"/> <input type="button" value="Delete record"/>	

CRISIS Annotated PUD eCRF

MAYOLABS (1 of 1)

**Mayo Laboratory Data**

*Unique ID = subjectID, studyForm, lab*

**Note:** Sites were instructed to collect samples for Mayo Laboratory on Study Day 1 and Study Day 7/Early Exit.

subjectID #

studyForm #

**Variables from Mayo laboratory dataset and Daily Data forms:**

Variable	Format	Type	Label	Algorithm / Notes
lab	MAYOLABF.	#	Analyte	Provided by Mayo laboratory
labvc	\$50.	\$50	Lab Value	Provided by Mayo laboratory CANCELLED indicates specimen was hemolyzed, quantity not sufficient, specimen received at ambient temp, or interfering substance present in sample. Lab was unable to process.
LabDay		#	Lab Day (relative to randomization)	Sample date – randomization date
labtm	TIME5.	\$5	Lab Time	Sample time

MAYOLABF  
 1 = Prolactin (ng/mL)  
 2 = Selenium (ng/mL)  
 3 = Zinc (mcg/mL)