Acute Intussusception Study Questionnaire
Australian Paediatric Surveillance Unit
Please ring Dr Margie Danchin on (03) 8341 6445 if you have any questions about this form

REPORTING CLINICIANS

1. APSU Dr Code/Name: ☐☐☐☐/……. **2.** Month/Year of Report: ……../……..

PATIENT DETAILS

3. First 2 letters of first name: ☐☐ **4.** First 2 letters of surname: ☐☐
5. Date of Birth: ☐☐/☐☐/☐☐ **6.** Sex: ☐ M ☐ F
7. Postcode of family: ☐☐☐☐

If this patient is primarily cared for by another physician who you believe will report the case, please complete the questionnaire details above this line and return to APSU. Please keep the patient's name and other details in your records. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.
The primary clinician caring for this child is: ***Name:*** ***Hospital:***

Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided.
DK= Don't Know, NA = Not applicable

Patient History

8. Birth Weight: _____(kg)
9. Term ☐ / Pre-term (<37 weeks) ☐ DK ☐
10. Is the patient of Indigenous Australian origin? Yes ☐ No ☐ DK ☐
11. Date of admission for the current episode of Intussusception: ☐☐/☐☐/☐☐
12. Has the patient had intussusception before? Yes ☐ No ☐ DK ☐
12a. If yes, how many previous episodes? _____ **12b.** At what age(s) (months)?_____
13. Is there any known history of intussusception in the family? Yes ☐ No ☐ DK ☐
14. Has the patient had any previous significant illnesses/hospitalisations/operations? Yes ☐ No ☐ DK ☐
14a. If yes, specify age at which illness took place _____ months
14b. and specify type of illness/operation:……..
……
15. According to the current Immunisation Schedule is the patient up to date? Yes ☐ No ☐ DK ☐
16. Have you previously reported this case as an adverse event to ADRAC? Yes ☐ No ☐ DK ☐
17. Has the child received a rotavirus vaccine? Yes ☐ No ☐ DK ☐
17a. If yes, specify type of vaccine and manufacturer ☐ Rotarix®, GSK ☐ Rotateq®, Merck
17b. If yes, specify date: Dose 1: ☐☐/☐☐/☐☐ Dose 2: ☐☐/☐☐/☐☐ Dose 3: ☐☐/☐☐/☐☐
18. Did the child receive any other vaccines within the last two weeks? Yes ☐ No ☐ DK ☐
18a. If yes, which one(s)?
☐ HepB ☐ DTPa ☐ Polio ☐ Hib ☐ Pneum ☐ MMR ☐ Mening C ☐ Varicella ☐ Other:_____
18b. Date of last immunisation: ☐☐/☐☐/☐☐ DK ☐ NA ☐

Medications/Traditional Medicines

19. Is the child currently receiving treatment? Yes ☐ No ☐ DK ☐
If yes, please list all medications received within the last week and currently

Date	Medication	Dose

Feeding History

20. What is the patient currently fed? (*Tick as many as apply*) Breast milk ☐ Formula ☐ Solids ☐ Other ☐
If other, please specify……
21. If breast-fed, until what age was the patient exclusively breast-fed? ____ months **Please indicate:** :Still feeding ☐ N/A ☐
22. Has there been any change to the patients' diet in the last week? Yes ☐ No ☐ DK ☐
If yes, specify……..
23. Has the patient had any feeding intolerance/food sensitivities? Yes ☐ No ☐ DK ☐ **If yes,** please describe (eg. egg - rash) ……

Clinical Details of Intussusception Episode

24. How was the diagnosis of intussusception made? (*tick >1 if relevant*)

Enema ☐ Ultrasound ☐ Abdominal X-ray ☐ Other ☐ Surgery ☐

Site of IS (eg. Ascending colon)……

Type of IS (eg. Ileocaeal)……

25. What was the duration of symptoms prior to diagnosis?

<12 hours ☐ 12-23hours ☐ 24-48 hours ☐ 49-72 hours ☐ >72hours ☐ Unknown ☐

26. Please indicate which of the following symptoms or signs were present at the time of diagnosis or in the week prior to diagnosis (*tick as many as apply*).

☐ Intestinal Obstruction ⇒	**Please specify:** ☐ Bile Stained Vomiting ☐ Acute Abdominal Distension ☐ Abnormal or absent bowel sounds ☐ Abnormal XR: Fluid level + dilated loops
☐ Features of Intestinal invagination⇒	**Please specify:** ☐ Intestinal mass ☐ Rectal mass ☐ Intestine prolapse ☐ Plain abdominal XR showing IS ☐ CT showing IS
☐ Intestinal vascular compromise or venous congestion ⇒	**Please specify:** ☐ Passage of blood per rectum ☐ Passage of "red current jelly" stool ☐ Blood on rectal examination

Other symptoms (Please specify)

☐ Abdominal pain	☐ Irritability
☐ Vomiting	☐ Shortness of breath or ☐ Abnormal breath sounds
☐ Lethargy	☐ Rash
☐ Pallor	☐ Urticaria
☐ Hypovolaemic shock	☐ Headache
☐ Plain XR abnormal – non specific, bowel gas	☐ Focal neurological signs
☐ Fever – temp:_____ ^{o}C	☐ Paralysis
☐ Diarrhoea	☐ Seizures
	☐ Other

Treatment and Outcome

27. What was the successful method of treatment?

Air/hydrostatic Enema ☐ ⇒ Specify if Ultrasound guided ☐ Fluoroscopy guided ☐

Surgery ☐ ⇒ Resection ☐ ⇒ Length of bowel resected _____cm

Other ☐ Specify……

27a. Lead point or other pathology identified? Yes ☐ No ☐ DK ☐

If Yes, describe……

28. What was the outcome for this patient? Discharged alive ☐ Still in hospital ☐ Died ☐ DK ☐

28a. What was the date of discharge/death? ☐☐ / ☐☐ / ☐☐

Samples

Approximately 40% of IS cases have stool samples +ve for adenovirus - please collect a stool sample and send for analysis in your local laboratory.

29. Was faeces sample collected? Yes ☐ No ☐ DK ☐ **If yes**, please give date collected: ☐☐ / ☐☐ / ☐☐

29a. What was the result?.....

29b.Are the results attached to this questionnaire? Yes ☐ No ☐ or will be forwarded at a later date? Yes ☐ No ☐

Please return this questionnaire in the addressed reply-paid envelope or fax to 03 8341 6449: Att Dr Margie Danchin.

Thank you for your help with this research project