

European Pediatric Surgical Audit - 2026



* = required, ** = required by validation

2025-12-17 - Version: 1.0.3 (Internal code: epsa-2026)
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Patient data

Patient identification

Hospital *	<input type="checkbox"/> UMC Groningen <input type="checkbox"/> VU Medisch Centrum Amsterdam <input type="checkbox"/> UMCU <input type="checkbox"/> St. Radboud Nijmegen <input type="checkbox"/> Antoni van Leeuwenhoek, Amsterdam <input type="checkbox"/> Rigshospitalet, Hillerod <input type="checkbox"/> Helsinki University Hospital, Helsinki <input type="checkbox"/> Universitätsmedizin Mannheim <input type="checkbox"/> Skåne University Hospital <input type="checkbox"/> A.O. SS. Antonio e Biagio e Cesare Arrigo di Alessandria <input type="checkbox"/> Ospedale Pediatrico Bambino Gesù <input type="checkbox"/> Regina Margherita Children's Hospital, Torino <input type="checkbox"/> N. I. Pirogov, Sofia <input type="checkbox"/> Hospital Sant Joan de Déu <input type="checkbox"/> Kepler University Hospital Linz <input type="checkbox"/> University Children's Hospital Belgrade <input type="checkbox"/> Southampton Children's Hospital <input type="checkbox"/> Universitätsklinikum Leipzig <input type="checkbox"/> University Hospital Wroclaw <input type="checkbox"/> Odense University Hospital <input type="checkbox"/> Hospital of Lithuanian University of Health Sciences Kauno klinikos	<input type="checkbox"/> AMC <input type="checkbox"/> LUMC <input type="checkbox"/> Erasmus Medisch Centrum Rotterdam <input type="checkbox"/> Academisch Ziekenhuis Maastricht <input type="checkbox"/> Amsterdam UMC <input type="checkbox"/> Hannover Medical School <input type="checkbox"/> Karolinska University Hospital, Stockholm <input type="checkbox"/> Oslo University Hospital <input type="checkbox"/> Universitaire Ziekenhuizen Leuven <input type="checkbox"/> Spitalul Clinic de Urgenta pentru Copii "Louis Turcanu" Timisoara <input type="checkbox"/> National Institute of Children's Diseases, NUDCH <input type="checkbox"/> Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Milano <input type="checkbox"/> Children's University Hospital Latvia <input type="checkbox"/> Hospital Universitario La Paz <input type="checkbox"/> Universitair Ziekenhuis Gent <input type="checkbox"/> Hacettepe University <input type="checkbox"/> University Medical Center Hamburg-Eppendorf <input type="checkbox"/> Universitätsklinikum Frankfurt <input type="checkbox"/> Universitätsklinikum Bonn <input type="checkbox"/> Motol University Hospital Czech Republic <input type="checkbox"/> DEMO
Local patient identification number *		
Country idcode *	<input type="checkbox"/> the Netherlands <input type="checkbox"/> Belgium <input type="checkbox"/> Other/Unknown/no idcode	<input type="checkbox"/> Germany <input type="checkbox"/> Sweden
Social security number *		

Name details

Initials *	
Prefix	
Surname *	

Personal data

Date of birth *	
Sex *	<input type="checkbox"/> Male <input type="checkbox"/> Undetermined <input type="checkbox"/> Female <input type="checkbox"/> Foetus (unknown)
Country of residence *	
Postal code *	
Date of death (if applicable)	
Cause of death	<input type="checkbox"/> Due to anomaly <input type="checkbox"/> Other <input type="checkbox"/> Due to comorbidity

Prenatal data

Prenatal diagnostics

Prenatal ultrasound	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatal MRI	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected diagnosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatal genetic testing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Type of prenatal genetic testing	<input type="checkbox"/> Karyotyping		<input type="checkbox"/> Microarray
	<input type="checkbox"/> Whole Exome Sequencing (WES)		<input type="checkbox"/> Whole Genome Sequencing
	<input type="checkbox"/> Unknown		
Prenatal genetic abnormality diagnosed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatal suspect diagnosis (weeks)	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		

Prenatal anomalies on prenatal ultrasound

Polyhydramnios	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected cardiac anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected gastrointestinal anomalies.	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected anomalies of the central nervous system.	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected limb anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected urogenital anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected other anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Prenatal anomalies on MRI

Prenatal anomalies on MRI	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected cardiac anomalies on MRI	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected urogenital anomalies on MRI	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected other anomalies on MRI	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected gastrointestinal anomalies on MRI	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected anomalies of the central nervous system on MRI	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Prenatally suspected limb anomalies on MRI	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Perinatal data

Perinatal information

Place of delivery	<input type="checkbox"/> Home	<input type="checkbox"/> Regional hospital
	<input type="checkbox"/> Pediatric surgical center	<input type="checkbox"/> Unknown
Type of delivery	<input type="checkbox"/> Vaginal	<input type="checkbox"/> Elective cesarean section
	<input type="checkbox"/> Emergency cesarean section	<input type="checkbox"/> Unknown
Gestational age (weeks)	<input type="checkbox"/>	
	<input type="checkbox"/> Unknown	
Gestational age (days)	<input type="checkbox"/>	
	<input type="checkbox"/> Unknown	
Birth weight (grams) *	<input type="checkbox"/>	
	<input type="checkbox"/> Unknown	

Malformation

Add a malformation ('create'), e.g. * Anorectal malformation * Hirschsprung's disease * Congenital diaphragmatic hernia (Bochdalek) * Omphalocele * Esophageal atresia * Gastroschisis * Biliary atresia * Malrotation If a child has more than one malformation, add ('create') multiple malformations.

Anorectal malformation

Type of malformation

Age at onset **	<input type="checkbox"/> Antenatal <input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> At birth <input type="checkbox"/> Undetermined
Date of onset **		
Age at diagnosis **	<input type="checkbox"/> Antenatal <input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> At birth <input type="checkbox"/> Undetermined
Date of diagnosis **		
Date of admission tertiary paediatric surgical centre *		

Diagnostics

Type of anorectal malformation *	<input type="checkbox"/> Perineal fistula <input type="checkbox"/> Rectobladderneck fistula <input type="checkbox"/> Persistent cloaca <input type="checkbox"/> Rare type	<input type="checkbox"/> Rectourethral fistula <input type="checkbox"/> Vestibular fistula <input type="checkbox"/> Imperforate anus without fistula
Type of rectourethral fistula	<input type="checkbox"/> Bulbar	<input type="checkbox"/> Prostatic
Rare type	<input type="checkbox"/> Anterior ectopic syndrome <input type="checkbox"/> Cloacal extrophy <input type="checkbox"/> Rectal stenosis <input type="checkbox"/> H fistula <input type="checkbox"/> Other	<input type="checkbox"/> Urogenital sinus <input type="checkbox"/> Rectal atresia <input type="checkbox"/> Rectovaginal fistula <input type="checkbox"/> Pouch colon

Diagnosed spinal cord anomalies

X-ray lumbosacral vertebrae **	<input type="checkbox"/> Not performed <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal
Lumbosacral vertebrae	<input type="checkbox"/> Partial/complete lumbosacral agenesis <input type="checkbox"/> Asymmetric sacrum <input type="checkbox"/> Agenesis of os coccyx	<input type="checkbox"/> Hemisacrum or scimitar sacrum <input type="checkbox"/> Posterior sacral extension <input type="checkbox"/> Sacrum underdevelopment
Sacral ratio AP		
Sacral ratio LAT		
Ultrasound spinal cord	<input type="checkbox"/> Not performed <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal
MRI lumbosacral vertebrae	<input type="checkbox"/> Not performed <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal

Spinalcord malformations

Low conus medullaris	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Thickened filum terminale	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Intraspinal lipoma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tethered cord	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Stenosis of dural sack	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Narowed spinal canal	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other spinal cord anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Diagnosed UG anomalies

Pelvic MRI	<input type="checkbox"/> Performed	<input type="checkbox"/> Not performed
Ultrasound urogenital tract	<input type="checkbox"/> Not performed <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal

Voiding cysto-urethrography	<input type="checkbox"/> Not performed <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal
Renography (DTPA-, MAG 3-, DMSA-scan) **	<input type="checkbox"/> Not performed <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal
Urodynamic assesment	<input type="checkbox"/> Not performed <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal

Diagnosed urologic anomalies

Unilateral renal agenesis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Vesicoureteral reflux	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Neurogenic bladder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Renal dysplasia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Renal ectopia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Megaureter	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ectopic ureter	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Hydronephrosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Obstruction of distal ureter	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other urologic anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Classification of vesicoureteral reflux	<input type="checkbox"/> Grade I	<input type="checkbox"/> Grade II	
	<input type="checkbox"/> Grade III	<input type="checkbox"/> Grade IV	
	<input type="checkbox"/> Grade V		
Diagnosed genital malformations	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Type of genital malformation

Vaginal agenesis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Vaginal duplication/septum	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Bicornuate uterus/uterus duplex	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Mullerian remnants/atresia uterus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Hydrocolpos	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Cryptorchism one sided	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Cryptorchism two sided	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Hypospadias	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other genital malformation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other UG anomalies			
Chromosomal investigation postpartum **	<input type="checkbox"/> Not performed	<input type="checkbox"/> Normal	
	<input type="checkbox"/> Abnormal		

Diagnosed cardiac, bone and GI anomalies

Diagnosed anomalies of the bones	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Bone anomalies

Hemivertebrae	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Agenesis thoracic vertebrae	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Scoliosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Limb deformities	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other bone anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Diagnosed gastrointestinal or cardiac anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Gastrointestinal or cardiac anomalies

Esophageal atresia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Duodenal atresia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
VSD / ASD	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Fallot Tetralogy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Coarctatio aortae	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Patent ductus arteriosus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other GI / cardiac anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Surgery

Temporary enterostomy *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date temporary enterostomy *			
Location temporary enterostomy	<input type="checkbox"/> Transverse colon	<input type="checkbox"/> Sigmoid	
	<input type="checkbox"/> Ileum	<input type="checkbox"/> Colon descendens	
	<input type="checkbox"/> Jejunum	<input type="checkbox"/> Colon ascendens	
Type of temporary enterostomy *	<input type="checkbox"/> Single end enterostomy	<input type="checkbox"/> Loop enterostomy	
	<input type="checkbox"/> Split enterostomy		
Complications enterostomy *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Type of complication

Infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Stomal prolapse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Stomal stenosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Patient died before definitive repair?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Patient has died before definitive repair? If yes, go to 'Patientdata' to register the date of death.

Date of ARM repair *			
Surgical procedure ARM repair *	<input type="checkbox"/> Anoplasty	<input type="checkbox"/> PSARP - without abdominal phase	
	<input type="checkbox"/> PSARP - with abdominal phase	<input type="checkbox"/> ASARP	
	<input type="checkbox"/> PSARVUP / TUM	<input type="checkbox"/> None, definite enterostomy	
	<input type="checkbox"/> Other		
Enterostomy during ARM repair	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Abdominal approach ARM repair	<input type="checkbox"/> Laparotomy assisted	<input type="checkbox"/> Laparoscopy assisted	
	<input type="checkbox"/> Only transanal		
Date of closure			
Date enterostomy closure *			
Date of discharge			

Complications

Complications of surgical repair (within 30 days of surgery) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Type of complication

Wound infection (grade 3-4) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Wound dehiscence *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anal stenosis (< H10 at age 6 months) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Persistent / recurrent fistula *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Urethral injury *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Reintervention due to complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of reintervention *			
Death (within 30 days of surgery) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Patient has died within 30 days after surgery? If yes, go to 'Patientdata' to register the date of death.

Hirschsprung's disease

Family history

Age at onset **	<input type="checkbox"/> Antenatal	<input type="checkbox"/> At birth
	<input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> Undetermined

Date of onset **			
Age at diagnosis **	<input type="checkbox"/> Antenatal	<input type="checkbox"/> At birth	
	<input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> Undetermined	
Date of diagnosis **			
Date of admission tertiary paediatric surgical centre *			
Relevant family history	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Family history

Hirschsprung's disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Waardenburg syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
MEN II A, II B	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Neonatal mortality of unknown abdominal cause	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Clinical presentation

First meconium stool *	<input type="checkbox"/> < 24 hours	<input type="checkbox"/> 24-48 hours
	<input type="checkbox"/> > 48 hours	<input type="checkbox"/> Unknown

Clinical presentation

Bowel obstruction/ileus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Enterocolitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Constipation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Failure to thrive	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Diagnostics

Diagnostics

Abdominal X-ray	<input type="checkbox"/> Not performed	<input type="checkbox"/> Performed	
Results suspected for Hirschsprung's disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Abdominal X-ray with contrast enema	<input type="checkbox"/> Not performed	<input type="checkbox"/> Performed	
Results suspected for Hirschsprung's disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anorectal manometry *	<input type="checkbox"/> Not performed	<input type="checkbox"/> Performed	
Results suspected for Hirschsprung's disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Rectal suction biopsies *	<input type="checkbox"/> Not performed	<input type="checkbox"/> Performed	
Results suspected for Hirschsprung's disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Full thickness biopsies *	<input type="checkbox"/> Not performed	<input type="checkbox"/> Performed	
Results suspected for Hirschsprung's disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Genetic counseling by geneticist	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Chromosomal investigation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Genetic abnormalities diagnosed	<input type="checkbox"/> None	<input type="checkbox"/> Down's syndrome	
	<input type="checkbox"/> Waardenburg syndrome	<input type="checkbox"/> Other	

Associated congenital disorders

Other disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Surgery

Primary treatment *	<input type="checkbox"/> Rectal washouts	<input type="checkbox"/> Temporary enterostomy
	<input type="checkbox"/> Rectal washouts + temporary enterostomy	
Date temporary enterostomy *		

Location temporary enterostomy	<input type="checkbox"/> Transverse colon	<input type="checkbox"/> Sigmoid
	<input type="checkbox"/> Ileum	<input type="checkbox"/> Colon descendens
	<input type="checkbox"/> Jejunum	<input type="checkbox"/> Colon ascendens
Type of temporary enterostomy *	<input type="checkbox"/> Single end enterostomy	<input type="checkbox"/> Loop enterostomy
	<input type="checkbox"/> Split enterostomy	
Patient died before definitive repair?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Patient has died before definitive repair? If yes, go to 'Patientdata' to register the date of death.

Date elective reconstruction *	
Surgical technique *	<input type="checkbox"/> Transanal endorectal pull through (Soave Like) <input type="checkbox"/> Transanal endorectal pull through (Swenson Like) <input type="checkbox"/> Duhamel <input type="checkbox"/> None, definite enterostomy <input type="checkbox"/> Other
Approach elective reconstruction	<input type="checkbox"/> Laparotomy assisted <input type="checkbox"/> Laparoscopy assisted <input type="checkbox"/> Only transanal
Resected specimen	<input type="checkbox"/> Rectosigmoid <input type="checkbox"/> Long segment colon <input type="checkbox"/> Total colon <input type="checkbox"/> Total colon and distal ileum <input type="checkbox"/> Total colon and complete small bowel
Pathology: proximal resection side normal *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Enterostomy performed during surgical repair **	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Date enterostomy closure *	

Complications

Complications of surgical repair (within 30 days of surgery)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Type of complication

Anal stenosis (< H10 at age 6 months) **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Woundinfection **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anastomotic leakage **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anastomotic stenosis **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Enterostomy complications **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Urologic complications **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Death (within 30 days after surgery) **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Patient has died within 30 days after surgery? If yes, go to 'Patientdata' to register the date of death.

Other **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Unplanned reoperation(< 30 days) *	<input type="checkbox"/> None	<input type="checkbox"/> Relaparotomy	
	<input type="checkbox"/> Other surgery		
Date reoperation *			
Date of discharge after definitive repair			
Enterostomy at discharge	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Congenital diaphragmatic hernia

Diagnosis

Age at onset **	<input type="checkbox"/> Antenatal <input type="checkbox"/> At birth <input type="checkbox"/> Date (to be specified below) <input type="checkbox"/> Undetermined
Date of onset **	
Age at diagnosis **	<input type="checkbox"/> Antenatal <input type="checkbox"/> At birth <input type="checkbox"/> Date (to be specified below) <input type="checkbox"/> Undetermined
Date of diagnosis **	
Date of admission tertiary paediatric surgical centre *	

Antenatal steroids	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Familial predisposition	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Side of defect *	<input type="checkbox"/> Left		<input type="checkbox"/> Right
	<input type="checkbox"/> Both sides		
Type of hernia **	<input type="checkbox"/> Bochdalek		<input type="checkbox"/> Morgagni
	<input type="checkbox"/> Eventration		
Postnatal diagnosis	<input type="checkbox"/> <6 hours postpartum		<input type="checkbox"/> 6-24 hours postpartum
	<input type="checkbox"/> >24 hours postpartum		

Additional anomalies

Initial clinical symptoms

Pulmonal hypertension	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Anomalies detected by prenatal ultrasound

Stomach in thorax	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Liver in thorax	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Congenital cardiac anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Foetoscopic endoluminal tracheal occlusion	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Observed to expected lung to head ratio	<input type="checkbox"/> Smaller than 25%		<input type="checkbox"/> 25% - 40%
	<input type="checkbox"/> Larger than 40%		<input type="checkbox"/> Unknown

Associated congenital anomalies

Cardial	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Omphalocele	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Pulmonary	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other associated anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Ventilation

Mechanical ventilation	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Initial mode of ventilation	<input type="checkbox"/> Conventional	
	<input type="checkbox"/> High frequency oscillation	
	<input type="checkbox"/> Unknown	
Date of start mechanical ventilation *		
Date extubation		
(Preoperative) pneumothorax	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	<input type="checkbox"/> Unknown	

ECMO

Transfer to ECMO centre *	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No	
	<input type="checkbox"/> No, already in ECMO center	
Date of transfer to ECMO centre *		
ECMO treatment *	<input type="checkbox"/> arteriovenous	
	<input type="checkbox"/> venovenous	
	<input type="checkbox"/> no ECMO treatment	
Need for reconstruction of vessels at decannulation?	<input type="checkbox"/> No	
	<input type="checkbox"/> Yes	
Technique	<input type="checkbox"/> Ligation	
	<input type="checkbox"/> Reconstruction	
Startdate ECMO *		
Stopdate ECMO *		

Surgery

Patient died before definitive repair?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Patient has died before definitive repair? If yes, go to 'Patientdata' to register the date of death.

Date of surgery *		
Surgical approach	<input type="checkbox"/> Abdominal	
	<input type="checkbox"/> Thoracic	

Surgical technique	<input type="checkbox"/> Open	<input type="checkbox"/> Scopic
Abdominal approach	<input type="checkbox"/> Median laparotomy	<input type="checkbox"/> Subcostal incision
	<input type="checkbox"/> Transverse laparotomy	
Conversion	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Size of anomaly	<input type="checkbox"/> Boston scale A (<1/4)	<input type="checkbox"/> Boston scale B (1/4-1/2)
	<input type="checkbox"/> Boston scale C (1/2-3/4)	<input type="checkbox"/> Boston scale D (>3/4)
Hernial sac	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Closure of the defect	<input type="checkbox"/> Primary	<input type="checkbox"/> Patch
	<input type="checkbox"/> Primary with Onlay patch	
Material	<input type="checkbox"/> PTFE	<input type="checkbox"/> Permacol
	<input type="checkbox"/> Surgisis	<input type="checkbox"/> Stratice
	<input type="checkbox"/> Other	
Resection pulmonary sequestration	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nonrotation procedure (in case of malrotation)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Closure of the abdominal wall *	<input type="checkbox"/> Primary	<input type="checkbox"/> Patch
	<input type="checkbox"/> Silo	<input type="checkbox"/> Only skin closure
Date removal patch/silo and closure abdominal wall		
Chesttube	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Complications

Complications during first admission *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Type of complication

Postoperative bleeding **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Surgical wound dehiscence **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Bowel obstruction / ileus **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Sepsis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Bleeding *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
DIC *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Cerebral bleeding *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Convulsions *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Brain death *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
BPD *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Pneumonia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Chylothorax **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Pneumothorax *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Lung bleeding *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Circulatory arrest *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Arythmia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Hypotensia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Catheter-related thrombosis **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Wound infection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Renal failure *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Metabolic disorders *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Gastroesophageal reflux (GER) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
GER treatment *	<input type="checkbox"/> Medication	<input type="checkbox"/> Surgical	
	<input type="checkbox"/> Both medication and surgical		
Serothorax	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Postoperative chest tube	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Duration chest tube (days)			
Recurrence CDH (within 1 year) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Redo surgery and other surgical interventions (within 1 year) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Type of redo surgery

Select type of redo surgery. Multiple types are possible

Gastrostomy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Laparotomy for bowel obstruction / ileus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anti-reflux surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Correction recurrence CDH	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Repair incisional hernia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of redo surgery *			
Death after first admission *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Patient has died after first admission? If yes, go to 'Patientdata' to register the date of death.

Discharge

Transfer from ECMO centre *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of transfer from ECMO centre *			
Date of discharge *			
Discharge to	<input type="checkbox"/> Pediatric surgical center <input type="checkbox"/> Home	<input type="checkbox"/> Periferal hospital <input type="checkbox"/> Other	
Weight at time of discharge (grams) *			

At time of discharge

Additional oxygen	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tube feeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Antireflux medication	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Omphalocele

Diagnostics and treatment I

Age at onset **	<input type="checkbox"/> Antenatal <input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> At birth <input type="checkbox"/> Undetermined
Date of onset **		
Age at diagnosis **	<input type="checkbox"/> Antenatal <input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> At birth <input type="checkbox"/> Undetermined
Date of diagnosis **		
Date of admission tertiary paediatric surgical centre *		

Prenatal diagnostics (20 weeks)

Diameter abdominal wall defect (cm)	
Abdomen diameter (cm)	
Circumference cele (cm)	

At time of birth

Rupture of omhalocele sac	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Stomach included	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Liver included	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Type of omphalocele (Giant=> 5cm)	<input type="checkbox"/> Normal	<input type="checkbox"/> Giant
Date start enteral feeding		
Date full enteral feeding		
Ultrasound kidney	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown

Conclusion ultrasound kidney

Enlarged pyelum	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Cysts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Abnormal location kidney	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Renal agenesis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ultrasound heart and aortic arch	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Conclusion ultrasound heart

Ventricular septal defect	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Atrial septal defect	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Fallot tetralogy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Patent ductus arteriosus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Conclusion ultrasound aorta

Right side descending aorta	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
DNA diagnostics	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Conclusion DNA diagnostics	<input type="checkbox"/> No abnormalities		<input type="checkbox"/> Full trisomies (x, 13, 18, 21)
	<input type="checkbox"/> Deletions (13q, 17q, 16q24)		<input type="checkbox"/> Single gene disorders
	<input type="checkbox"/> Other genetic abnormalities		
Genetic counseling *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Conclusion genetic counseling	<input type="checkbox"/> Normal	<input type="checkbox"/> Syndromal	<input type="checkbox"/> Other

Additional defects

Gastrointestinal defects	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other defects	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Diagnosics and treatment II

Respiratory failure

Oxygen	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Ventilator	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Duration of mechanical ventilation		
Lung hypoplasia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Suspension of omphalocele	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Type of surface cover	<input type="checkbox"/> Dry (only bandage)	<input type="checkbox"/> Flammazine
	<input type="checkbox"/> Wound dressing	<input type="checkbox"/> Other
Complication of suspension	<input type="checkbox"/> No	<input type="checkbox"/> Yes (omphalitus)
Surgical treatment *	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Type of treatment (surgical) *	<input type="checkbox"/> Primary closure	<input type="checkbox"/> Staged closure
	<input type="checkbox"/> Delayed closure	
Discharge before surgical procedure?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Herniated organs

Small bowel	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Colon	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Stomach	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Liver	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Gondads	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Bladder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Malrotation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Non rotation treatment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Appendectomy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Discharge

Date of discharge

If the patient died during the initial hospital admission, please enter the date of death.

Discharge to	<input type="checkbox"/> Pediatric surgical center	<input type="checkbox"/> Periferal hospital
	<input type="checkbox"/> Home	<input type="checkbox"/> Other

If the patient died during hospital admission please choose other.

Death during hospital admission or within 30 days after surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Patient has died within 30 days after surgery? If yes, go to 'Patientdata' to register the date of death.

Re admission	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Date of readmission

Urgency of readmission	<input type="checkbox"/> Elective surgery	<input type="checkbox"/> Acute surgery
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Reason of readmission

Wound infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Wound dehiscence	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Parenteral feeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Other reasons	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Procedure

Date of surgery *

Closure skin	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Closure abdominal wall	<input type="checkbox"/> (Primary) Closure	<input type="checkbox"/> Open
	<input type="checkbox"/> Silo	<input type="checkbox"/> Patch
	<input type="checkbox"/> Plasty	<input type="checkbox"/> Plasty and patch

Operative complications	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Type of operative complication

Bleeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Bowel perforation	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Postoperative complications	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Type of postoperative complication

Abdominal compartment syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Respiratory failure (mechanical ventilation)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Respiratory tract infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Wound dehiscence	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Renal failure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Bowel obstruction / ileus	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Line sepsis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Gastro oesophageal reflux	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Discharge

Discharge

Was the patient discharged after surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Date of discharge

If the patient died during the initial hospital admission, please enter the date of death.

Discharge to	<input type="checkbox"/> Pediatric surgical center	<input type="checkbox"/> Periferal hospital
	<input type="checkbox"/> Home	<input type="checkbox"/> Other

If the patient died during hospital admission please choose other.

Death during hospital admission or within 30 days after surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Patient has died during hospital admission or within 30 days after surgery? If yes, go to 'Patientdata' to register the date of death.

Readmission (within the first year)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Date of readmission		

Reason of readmission

Elective surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Acute surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Wound infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Wound dehiscence	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Parenteral feeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other reasons	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Esophageal atresia

Diagnostics for EA

Onset and admission

Age at onset **	<input type="checkbox"/> Antenatal	<input type="checkbox"/> At birth	
	<input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> Undetermined	
Date of onset **			
Age at diagnosis **	<input type="checkbox"/> Antenatal	<input type="checkbox"/> At birth	
	<input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> Undetermined	
Date of diagnosis **			
Date of admission tertiary paediatric surgical centre *			
Discharge before primary repair? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of admission for primary repair **			

Diagnostic testing

Replogle tube *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
X-ray of thorax/abdomen with nasoesophageal tube in situ	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
X-ray of thorax/abdomen with contrast	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Gross classification

Classification of esophageal atresia *	<input type="checkbox"/> A	<input type="checkbox"/> B
	<input type="checkbox"/> C	<input type="checkbox"/> D
	<input type="checkbox"/> E	

Tracheobronchoscopy

Tracheobronchoscopy performed? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of tracheobronchoscopy *			
Sedation during tracheobronchoscopy? **	<input type="checkbox"/> Spontaneously breathing	<input type="checkbox"/> Fully sedated	
	<input type="checkbox"/> Unknown		
Location lower fistula **	<input type="checkbox"/> Carina	<input type="checkbox"/> Above the carina	
	<input type="checkbox"/> Unknown		
Tracheomalacia on first tracheobronchoscopy? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Other abnormalities on first tracheobronchoscopy? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Associated anomalies

Cardiac anomalies and anomalies of the large vessels

Echocardiography **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Done in other hospital	<input type="checkbox"/> Unknown	
Date of echocardiography **	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Cardiac anomalies or anomalies of the large vessels diagnosed? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Diagnosed cardiac anomalies

Ventricular septal defect	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Atrial septal defect	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tetralogy of Fallot	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Patent ductus arteriosus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other cardiac anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Diagnosed vessel anomalies

Right side descending aorta	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Coarctatio aortae	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other anomalies of the large vessels	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Cardiac interventions

Cardiac interventions?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of first cardiac intervention			

Renal anomalies

Ultrasound of kidneys performed? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Done in other hospital	<input type="checkbox"/> Unknown	
Date of kidney ultrasound **	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Renal anomalies diagnosed? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Diagnosed renal anomalies

Enlarged pyelum	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Renal cysts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Abnormal location of the kidney	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Renal agenesis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Duplicature	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other renal anomalies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Other VACTERL anomalies

Anorectal malformation? **	<input type="checkbox"/> No anorectal malformation	<input type="checkbox"/> Anus atresia/imperforate anus without fistula	
	<input type="checkbox"/> Perineal fistula	<input type="checkbox"/> Rectourethral fistula	
	<input type="checkbox"/> Rectobladderneck fistula	<input type="checkbox"/> Vestibular fistula	
	<input type="checkbox"/> Persistent cloaca	<input type="checkbox"/> Other	
Vertebral anomalies **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Limb anomalies **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Genetics and DNA

Genetic counseling during primary hospital stay **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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DNA diagnostics performed within the first year? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Conclusion DNA diagnostics	<input type="checkbox"/> No abnormalities		<input type="checkbox"/> Full trisomies (x, 13, 18, 21)
	<input type="checkbox"/> Deletions (13q, 17q, 16q24)		<input type="checkbox"/> Single gene disorders
	<input type="checkbox"/> Other genetic abnormalities		
Syndrome associated with EA? **	<input type="checkbox"/> No associated syndrome		<input type="checkbox"/> VACTERL syndrome
	<input type="checkbox"/> CHARGE syndrome		<input type="checkbox"/> Trisomy 21 (Down)
	<input type="checkbox"/> Other		

Other anomalies

Laryngeal anomalies? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Laryngotracheoesophageal cleft	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Neurologic anomalies? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Pulmonary anomalies? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other intestinal anomalies? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Duodenal atresia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Abdominal wall defects? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Genital anomalies? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Any other congenital anomalies? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Surgery

Previous attempt at esophageal anastomosis (only if in other hospital) **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Did the patient die before the continuity repair? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Did the patient die due to (complications related to) the esophageal atresia?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Patient has died before definitive repair? If yes, go to 'Patientdata' to register the date of death.

Primary repair

Date of esophageal reconstruction *		
Type of repair **	<input type="checkbox"/> Primary anastomosis	<input type="checkbox"/> Delayed primary anastomosis
	<input type="checkbox"/> Secondary anastomosis	
Type of secondary anastomosis **	<input type="checkbox"/> Gastric pull-up	<input type="checkbox"/> Gastric sleeve
	<input type="checkbox"/> Jejunal interposition	<input type="checkbox"/> Colonic interposition
Location of tracheoesophageal fistula *	<input type="checkbox"/> Proximal	<input type="checkbox"/> Distal
	<input type="checkbox"/> Proximal and distal	
Fistula closure approach	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracoscopy
	<input type="checkbox"/> Thoracotomy	<input type="checkbox"/> Endoscopic

Traction

Was traction performed? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Traction method	<input type="checkbox"/> External		<input type="checkbox"/> Internal
	<input type="checkbox"/> Kimura		<input type="checkbox"/> Other
	<input type="checkbox"/> Unknown		
Number of traction surgeries	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Peroperative tracheobronchoscopy *	<input type="checkbox"/> No		<input type="checkbox"/> Yes, no abnormalities
	<input type="checkbox"/> Yes, tracheomalacia		<input type="checkbox"/> Yes, extra fistula
	<input type="checkbox"/> Yes, extra fistula and tracheomalacia		<input type="checkbox"/> Yes, other abnormalities

Gastrostomy

Gastrostomy *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of gastrostomy *			

Esophageal repair: surgical details

Intended and initiated surgical approach *	<input type="checkbox"/> Thoracotomy	<input type="checkbox"/> Thoracoscopy	
Conversion *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Surgical approach	<input type="checkbox"/> Posterolateral, classic <input type="checkbox"/> Unknown	<input type="checkbox"/> Posterolateral, muscle sparing	
Intercostal or rib resection	<input type="checkbox"/> Intercostal <input type="checkbox"/> Unknown	<input type="checkbox"/> Rib resection	
Pleural approach	<input type="checkbox"/> Extrapleural <input type="checkbox"/> Thoracoscopy with conversion	<input type="checkbox"/> Intrapleural <input type="checkbox"/> Unknown	
Transection azygos vein	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Suture method used for anastomosis	<input type="checkbox"/> Interrupted sutures <input type="checkbox"/> Combination	<input type="checkbox"/> Running sutures	
Transanastomotic tube left during surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Type of surgery *	<input type="checkbox"/> Primary anastomosis <input type="checkbox"/> Jejunum interposition <input type="checkbox"/> Gastric pull-up	<input type="checkbox"/> Esophageal traction technique <input type="checkbox"/> Colon interposition <input type="checkbox"/> Gastric sleeve	

Traction

Date of start traction *			
Thoracic tube left during surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Number of days of transanastomotic tube *			

Intraoperative complications

Were there any intraoperative complications? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tube complications	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tube complications - Clavien-Madadi **	<input type="checkbox"/> Ia <input type="checkbox"/> II <input type="checkbox"/> IIIb <input type="checkbox"/> V	<input type="checkbox"/> Ib <input type="checkbox"/> IIIa <input type="checkbox"/> IV	
Bleeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Bleeding - Clavien-Madadi **	<input type="checkbox"/> Ia <input type="checkbox"/> II <input type="checkbox"/> IIIb <input type="checkbox"/> V	<input type="checkbox"/> Ib <input type="checkbox"/> IIIa <input type="checkbox"/> IV	
Blood transfusion **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Iatrogenic damage	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Iatrogenic nerve damage	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Nerve damage - Clavien-Madadi **	<input type="checkbox"/> Ia <input type="checkbox"/> II <input type="checkbox"/> IIIb <input type="checkbox"/> V	<input type="checkbox"/> Ib <input type="checkbox"/> IIIa <input type="checkbox"/> IV	
Iatrogenic tracheal damage	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tracheal damage - Clavien-Madadi **	<input type="checkbox"/> Ia <input type="checkbox"/> II <input type="checkbox"/> IIIb <input type="checkbox"/> V	<input type="checkbox"/> Ib <input type="checkbox"/> IIIa <input type="checkbox"/> IV	
Iatrogenic airway/lung damage	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Airway/lung damage - Clavien-Madadi **	<input type="checkbox"/> Ia <input type="checkbox"/> II <input type="checkbox"/> IIIb <input type="checkbox"/> V	<input type="checkbox"/> Ib <input type="checkbox"/> IIIa <input type="checkbox"/> IV	
Iatrogenic major vessel damage	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Major vessels - Clavien-Madadi **	<input type="checkbox"/> Ia <input type="checkbox"/> II <input type="checkbox"/> IIIb <input type="checkbox"/> V	<input type="checkbox"/> Ib <input type="checkbox"/> IIIa <input type="checkbox"/> IV	

Other iatrogenic damage	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other - Clavien-Madadi **	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Hemodynamic complications	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Hemodynamic complications - Clavien-Madadi **	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Pulmonary complications	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Pulmonary complications - Clavien-Madadi **	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Other intraoperative complications	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other intraoperative complications - Clavien-Madadi **	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		

End of primary hospitalization

Ventilation

Preoperative intubation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Mode of ventilation	<input type="checkbox"/> Conventional	<input type="checkbox"/> High frequency oscillation	
	<input type="checkbox"/> Unknown		
Date of preoperative intubation			
Preoperative extubation or extubation on date of surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of preoperative extubation			
Respiratory support after preoperative extubation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Postoperative intubation (not if the patient was only intubated during surgery)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Mode of ventilation	<input type="checkbox"/> Conventional	<input type="checkbox"/> High frequency oscillation	
	<input type="checkbox"/> Unknown		
Date of postoperative intubation			
Date of postoperative extubation			
Respiratory support after postoperative extubation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Reintubation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Day of last extubation			

Mortality

Death before discharge *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Did the patient die due to (complications related to) the esophageal atresia?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Patient has died before discharge? If yes, go to 'Patientdata' to register the date of death.

Discharge

Date of discharge *			
Destination of discharge	<input type="checkbox"/> Home	<input type="checkbox"/> Regional hospital	
	<input type="checkbox"/> Center with pediatric surgical unit	<input type="checkbox"/> Other care facility	
	<input type="checkbox"/> Unknown		
Anti-reflux medications at discharge	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Reason for starting anti-reflux meds	<input type="checkbox"/> Standard of care	<input type="checkbox"/> Symptomatic	
	<input type="checkbox"/> Both	<input type="checkbox"/> Unknown	

30-day complications

30-day complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anastomotic leakage *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Symptoms of leakage? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Radiologic proof of leakage? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anastomotic leakage - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Redo continuity repair within 30 days? *	<input type="checkbox"/> No reoperation was performed	<input type="checkbox"/> Reanastomosis of the esophagus	
	<input type="checkbox"/> Gastric pull-up	<input type="checkbox"/> Gastric sleeve	
	<input type="checkbox"/> Jejunal interposition	<input type="checkbox"/> Colonic interposition	
Date of redo continuity repair *			
Postoperative infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Wound infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Wound infection - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Pneumonia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Pneumonia - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
UTI	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
UTI - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Line sepsis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Line sepsis - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Infection of other known source	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Infection of other known source - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Infection of unknown origin	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Infection of unknown origin - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Chylothorax **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Chylothorax - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Other 30-day complications **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other 30-day complications - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		

One-year follow-up

One-year complications

One-year complications (between 30 days and one year postop) **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Complication of the esophageal anastomosis? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anastomotic complication - Clavien-Madadi *	<input type="checkbox"/> Ia		<input type="checkbox"/> Ib
	<input type="checkbox"/> II		<input type="checkbox"/> IIIa
	<input type="checkbox"/> IIIb		<input type="checkbox"/> IV
	<input type="checkbox"/> V		
Redo continuity repair within one year? *	<input type="checkbox"/> No reoperation was performed		<input type="checkbox"/> Reanastomosis of the esophagus
	<input type="checkbox"/> Gastric pull-up		<input type="checkbox"/> Gastric sleeve
	<input type="checkbox"/> Jejunal interposition		<input type="checkbox"/> Colonic interposition
Date of redo continuity repair			
Anastomotic stricture **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anastomotic stricture - Clavien-Madadi *	<input type="checkbox"/> Ia		<input type="checkbox"/> Ib
	<input type="checkbox"/> II		<input type="checkbox"/> IIIa
	<input type="checkbox"/> IIIb		<input type="checkbox"/> IV
	<input type="checkbox"/> V		
Date of first dilatation			
Technique of dilatation	<input type="checkbox"/> Bougienage		<input type="checkbox"/> Balloon
Additional treatments during dilatation procedure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Number of dilatations during the first year *			
Recurrent fistula **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Recurrent fistula - Clavien-Madadi *	<input type="checkbox"/> Ia		<input type="checkbox"/> Ib
	<input type="checkbox"/> II		<input type="checkbox"/> IIIa
	<input type="checkbox"/> IIIb		<input type="checkbox"/> IV
	<input type="checkbox"/> V		
Date recurrent fistula repair			
Location recurrent fistula	<input type="checkbox"/> Proximal		<input type="checkbox"/> Distal
	<input type="checkbox"/> Proximal and distal		
Recurrent fistula closure approach	<input type="checkbox"/> Cervical		<input type="checkbox"/> Thoracoscopy
	<input type="checkbox"/> Thoracotomy		<input type="checkbox"/> Endoscopic
Gastroesophageal reflux disease **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Gastroesophageal reflux disease - Clavien-Madadi **	<input type="checkbox"/> Ia		<input type="checkbox"/> Ib
	<input type="checkbox"/> II		<input type="checkbox"/> IIIa
	<input type="checkbox"/> IIIb		<input type="checkbox"/> IV
	<input type="checkbox"/> V		
Anti-reflux medication	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anti-reflux procedure *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of anti-reflux procedure			
Type of anti-reflux procedure	<input type="checkbox"/> Nissen, laparotomy		<input type="checkbox"/> Nissen, laparoscopy
	<input type="checkbox"/> Thal, laparotomy		<input type="checkbox"/> Thal, laparoscopy
	<input type="checkbox"/> Other, laparotomy		<input type="checkbox"/> Other, laparoscopy
Redo anti-reflux procedure during first year	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of redo anti-reflux procedure			
Type of redo anti-reflux procedure	<input type="checkbox"/> Nissen, laparotomy		<input type="checkbox"/> Nissen, laparoscopy
	<input type="checkbox"/> Thal, laparotomy		<input type="checkbox"/> Thal, laparoscopy
	<input type="checkbox"/> Other, laparotomy		<input type="checkbox"/> Other, laparoscopy
Frequency of cyanotic episodes (ALTE / Dying spells) **	<input type="checkbox"/> Never/rare		<input type="checkbox"/> Once per month or less
	<input type="checkbox"/> Once per week or less		<input type="checkbox"/> 2-6 times per week
	<input type="checkbox"/> At least once per day		
Tracheomalacia (postoperative) **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tracheomalacia - Clavien-Madadi * **	<input type="checkbox"/> Ia		<input type="checkbox"/> Ib
	<input type="checkbox"/> II		<input type="checkbox"/> IIIa
	<input type="checkbox"/> IIIb		<input type="checkbox"/> IV
	<input type="checkbox"/> V		
Surgery for tracheomalacia *	<input type="checkbox"/> No		<input type="checkbox"/> Yes, aortopexy
	<input type="checkbox"/> Yes, posterior tracheopexy		<input type="checkbox"/> Yes, other procedure
Date of anti-tracheomalacia procedure			
Surgical approach of anti-tracheomalacia procedure	<input type="checkbox"/> Thoracotomy		<input type="checkbox"/> Thoracoscopy
	<input type="checkbox"/> Thoracoscopy, converted to thoracotomy		<input type="checkbox"/> Sternotomy
Vocal cord paresis or paralysis that developed after surgery **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Vocal cord paresis - Clavien-Madadi * **	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV
	<input type="checkbox"/> V	
Unilateral or bilateral	<input type="checkbox"/> Unilateral	<input type="checkbox"/> Bilateral

Surgeries and readmissions

Other surgeries during the first year **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Total number of surgeries during the first year **			
Readmission for other reasons than reoperation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Total number of admissions during the first year **			

Feeding

Start enteral feeding (tube)			
Start oral feeding	<input type="checkbox"/>		
	<input type="checkbox"/> Oral feeding not started at 1 year		
Full oral feeding	<input type="checkbox"/>		
	<input type="checkbox"/> Full oral feeding not achieved at 1 year		
Oral feeding issues / Oral aversion at one year **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Need for feeding supplements	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Visit SLT specialist	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Growth and ability to maintain weight

Weight at 1 year (in g) **	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Date of weight measurement			
Length at 1 year (in cm) **	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Date of length measurement			

Mortality

Mortality at 1 year **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Did the patient die due to (complications related to) the esophageal atresia?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Patient has died due to (complications related to) the esophageal atresia? If yes, go to 'Patientdata' to register the date of death.

Two-year follow-up

Multidisciplinary team

Multidisciplinary team **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Two-year complications

Two-year complications (between one year and two years postop) **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Complication of the esophageal anastomosis? **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anastomotic complication - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Redo continuity repair within two years *	<input type="checkbox"/> No reoperation was performed	<input type="checkbox"/> Reanastomosis of the esophagus	
	<input type="checkbox"/> Gastric pull-up	<input type="checkbox"/> Gastric sleeve	
	<input type="checkbox"/> Jejunal interposition	<input type="checkbox"/> Colonic interposition	

Date of redo continuity repair			
Anastomotic stricture **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anastomotic stricture - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Date of first dilatation			
Technique of dilatation	<input type="checkbox"/> Bougienage	<input type="checkbox"/> Balloon	
Additional treatments during dilatation procedure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Number of dilatations during the second year *			
Recurrent fistula during the second year **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Recurrent fistula - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Date recurrent fistula repair			
Location recurrent fistula	<input type="checkbox"/> Proximal	<input type="checkbox"/> Distal	
	<input type="checkbox"/> Proximal and distal		
Recurrent fistula closure approach	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracoscopy	
	<input type="checkbox"/> Thoracotomy	<input type="checkbox"/> Endoscopic	
Gastroesophageal reflux disease **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Gastroesophageal reflux disease - Clavien-Madadi **	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Anti-reflux medication	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anti-reflux procedure *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of anti-reflux procedure			
Type of anti-reflux procedure	<input type="checkbox"/> Nissen, laparotomy	<input type="checkbox"/> Nissen, laparoscopy	
	<input type="checkbox"/> Thal, laparotomy	<input type="checkbox"/> Thal, laparoscopy	
	<input type="checkbox"/> Other, laparotomy	<input type="checkbox"/> Other, laparoscopy	
Redo anti-reflux procedure during first year	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of redo anti-reflux procedure			
Type of redo anti-reflux procedure	<input type="checkbox"/> Nissen, laparotomy	<input type="checkbox"/> Nissen, laparoscopy	
	<input type="checkbox"/> Thal, laparotomy	<input type="checkbox"/> Thal, laparoscopy	
	<input type="checkbox"/> Other, laparotomy	<input type="checkbox"/> Other, laparoscopy	
Frequency of cyanotic episodes (ALTE / Dying spells) **	<input type="checkbox"/> Never/rare	<input type="checkbox"/> Once per month or less	
	<input type="checkbox"/> Once per week or less	<input type="checkbox"/> 2-6 times per week	
	<input type="checkbox"/> At least once per day		
Tracheomalacia **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tracheomalacia - Clavien-Madadi * **	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Surgery for tracheomalacia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes, aortopexy	
	<input type="checkbox"/> Yes, posterior tracheopexy	<input type="checkbox"/> Yes, other procedure	
Date of anti-tracheomalacia procedure			
Surgical approach of anti-tracheomalacia procedure	<input type="checkbox"/> Thoracotomy	<input type="checkbox"/> Thoracoscopy	
	<input type="checkbox"/> Thoracoscopy, converted to thoracotomy	<input type="checkbox"/> Sternotomy	

Surgeries and readmissions

Other surgeries during the second year **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Total number of surgeries during the second year **			
Readmission for other reasons than reoperation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Total number of admissions during the second year **			

Feeding

Oral feeding issues / Oral aversion at two years **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Difficulties in swallowing / Dysphagia **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Visit SLT specialist	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Need for tube feeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Full oral feeding	<input type="checkbox"/>		
	<input type="checkbox"/> Full oral feeding not achieved after 2 years		
Need for feeding supplements	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Growth and ability to maintain weight

Weight at 2 years (in g) **	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Date of weight measurement			
Length at 2 year (in cm) **	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Date of length measurement			

Other EA-associated morbidity

Oesophagitis **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Number of acute lower respiratory infections **	<input type="checkbox"/>		
	<input type="checkbox"/> No acute lower respiratory infections	<input type="checkbox"/> Unknown	
Chronic respiratory complications or symptoms **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Musculoskeletal sequelae **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Chronic use of medications	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Mortality

Mortality at 2 year **	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Did the patient die due to (complications related to) the esophageal atresia?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Patient has died due to (complications related to) the esophageal atresia? If yes, go to 'Patientdata' to register the date of death.

Complications

Complications

Diagnosis anastomotic leakage *	<input type="checkbox"/> Clinical symptoms		<input type="checkbox"/> Contrast study
Anastomotic stenosis (during first admission) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tracheomalacia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Diagnosis tracheomalacia *	<input type="checkbox"/> Clinical symptoms		<input type="checkbox"/> Bronchoscopy
Other complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Other complications

Cardiac complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Pulmonary complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Urogenital complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Gastrointestinal complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Redo surgery first admission

Redo surgery during first admission *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of redo surgery *			

Type of surgery

Anastomotic dilatation *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Discharge

Re-admission *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Reason of re-admission *	<input type="checkbox"/> Stenosis	<input type="checkbox"/> ALTE	
	<input type="checkbox"/> Gastro esophageal reflux	<input type="checkbox"/> Pulmonal	
	<input type="checkbox"/> Cardial	<input type="checkbox"/> Other	

Redo surgery first year

Redo surgery first year *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of redo surgery *			

Type of surgery

Anastomotic dilatation (secondary) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Technique of dilatation (secondary) *	<input type="checkbox"/> Dilatation with tube	<input type="checkbox"/> Dilatation during gastroscopy	
	<input type="checkbox"/> Radiological balloon dilatation		

Complications redo surgery

Complications after redo surgery *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Type of complication

Pneumonia (secondary) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anastomotic leakage (secondary) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Diagnosis anastomotic leakage (secondary) *	<input type="checkbox"/> Clinical symptoms	<input type="checkbox"/> Contrast study	
Gastro-esophageal reflux (secondary) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Diagnosis gastro-esophageal reflux (secondary) *	<input type="checkbox"/> Clinical symptoms	<input type="checkbox"/> Contrast study	
	<input type="checkbox"/> 24 h pH measurement		
Anastomotic stenosis (secondary) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tracheomalacia (secondary) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other complications (secondary) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Other complications

Cardiac complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Pulmonal complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Urogenital complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Gastrointestinal complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Gastroschisis

Diagnostics and treatment

Age at onset **	<input type="checkbox"/> Antenatal	<input type="checkbox"/> At birth
	<input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> Undetermined
Date of onset **		
Age at diagnosis **	<input type="checkbox"/> Antenatal	<input type="checkbox"/> At birth
	<input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> Undetermined
Date of diagnosis **		
Date of admission tertiary paediatric surgical centre *		

Pre repair size of defect

AP diameter (mm)	
LR diameter (mm)	

Bowel injury score

Matting	<input type="checkbox"/> None	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Necrosis	<input type="checkbox"/> Absent	<input type="checkbox"/> Focal	<input type="checkbox"/> Diffuse
Atresia	<input type="checkbox"/> Absent	<input type="checkbox"/> Suspected	
	<input type="checkbox"/> Present	<input type="checkbox"/> Unknown	
Preoperative perforation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Volvulus	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Other abnormalities and defects

DNA diagnostics	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Conclusion DNA diagnostics	<input type="checkbox"/> No abnormalities	<input type="checkbox"/> Full trisomies (x, 13, 18, 21)	
	<input type="checkbox"/> Deletions (13q, 17q, 16q24)	<input type="checkbox"/> Single gene disorders	
	<input type="checkbox"/> Other genetic abnormalities		
Other defects	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Other defects

Cardiac defects	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Defects kidney	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Testicular defects	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other defects	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
If other, describe			
Surgery *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Surgery

Patient died before definitive repair?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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Patient has died before definitive repair? If yes, go to 'Patientdata' to register the date of death.

Type of repair	<input type="checkbox"/> Primary closure, sedation (Bianchi)	<input type="checkbox"/> Primary closure, general anaesthesia	
	<input type="checkbox"/> Closure with patch	<input type="checkbox"/> Closure with silo	
	<input type="checkbox"/> Closure with silo, then patch	<input type="checkbox"/> Closure with silo, general anaesthesia	
Date of repair *			
Size of silo			
Duration of silo (days)			
Malrotation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Non rotation treatment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Appendectomy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Herniated organs

Small bowel	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Colon	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Stomach	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Liver	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Gonads	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bladder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Perioperative antibiotics	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Peroperative complications	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Peroperative complications

Bleeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bowel perforation	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Postoperative complications **	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Type of postoperative complication

Respiratory failure (mechanical ventilation)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Respiratory tract infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Wound dehiscence	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Wound/patch infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Renal failure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bowel obstruction / ileus	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Line sepsis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Gastro oesophageal reflux	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Abdominal compartment syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Discharge

Date start enteral feeding	
Date full enteral feeding **	

Discharge

Date of discharge	
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If the patient died during the initial hospital admission, please enter the date of death.

Discharge to	<input type="checkbox"/> Pediatric surgical center	<input type="checkbox"/> Periferal hospital
	<input type="checkbox"/> Home	<input type="checkbox"/> Other

If the patient died during hospital admission please choose other.

Death during hospital admission or within 30 days after surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Patient has died during hospital admission or within 30 days after surgery? If yes, go to 'Patientdata' to register the date of death.

Readmission (within the first year)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Date of readmission		

Reason of readmission

Acute surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Elective surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Wound infection	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Wound dehiscence	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Parenteral feeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other reasons	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Biliary atresia

Diagnosis and surgery

Age at onset **	<input type="checkbox"/> Antenatal	<input type="checkbox"/> At birth
	<input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> Undetermined
Date of onset **		
Age at diagnosis **	<input type="checkbox"/> Antenatal	<input type="checkbox"/> At birth
	<input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> Undetermined
Date of diagnosis **		
Date of admission tertiary paediatric surgical centre *		
Patient died before definitive repair?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Patient has died before definitive repair? If yes, go to 'Patientdata' to register the date of death.

Kasai procedure *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date Kasai procedure *			
Type of biliary atresia	<input type="checkbox"/> Isolated biliary atresia	<input type="checkbox"/> Biliary atresia with splenic malformation (BASM)	
	<input type="checkbox"/> Cystic biliary atresia (CBA)		

1-year follow up

Clearance of jaundice < 6 months *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Screening OLT within the first year *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Liver transplantation (OLT) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of liver transplantation			
Death	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Patient has died? If the answer is yes, go to 'Patientdata' to register the date of death.

Malrotation

Diagnostics for malrotation

Onset and admission

Date of admission tertiary paediatric surgical centre *			
Age at onset *	<input type="checkbox"/> Antenatal	<input type="checkbox"/> At birth	
	<input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> Undetermined	
Date of onset *			
Age at diagnosis *	<input type="checkbox"/> Antenatal	<input type="checkbox"/> At birth	
	<input type="checkbox"/> Date (to be specified below)	<input type="checkbox"/> Undetermined	
Date of onset *			
Symptoms at diagnosis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Incidental finding **	<input type="checkbox"/> Yes, before surgery	<input type="checkbox"/> Yes, during surgery	
	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Acute intestinal obstruction *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Volvolus *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Chronic or recurrent abdominal symptoms *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Cardiac intervention *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date cardiac intervention *			

Diagnostic testing

Was an upper gastrointestinal contrast study performed? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of upper gastrointestinal contrast study *			
The diagnosis of malrotation was based on: *	<input type="checkbox"/> Upper gastrointestinal contrast study	<input type="checkbox"/> Intraoperative findings	
	<input type="checkbox"/> Ultrasound		
Whirlpool sign on ultrasound *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Type of malrotation **	<input type="checkbox"/> Typical	<input type="checkbox"/> Atypical	
Echocardiography *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of echocardiography *			
Persistent ductus arteriosus *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ventricular septal defect *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Atrial septal defect *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Tetralogy of Fallot *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Right descending aorta *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Coarctatio Aortae *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other cardiac anomalies *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Ultrasound of the urogenital system *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of the ultrasound of the urogenital system *			
Cysts *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Enlarged pyelum *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Abnormal location *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Urogenital duplication *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Renal agenesis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other urogenital malformation *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Associated anomalies

Situs inversus *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Isomerism *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Form of isomerism *	<input type="checkbox"/> Left isomerism	<input type="checkbox"/> Right isomerism	
Duodenal Atresia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Jejunioileal Atresia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Congenital diaphragmatic hernia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Gastroschisis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anorectal malformation *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Hirschsprung's disease *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Treatment

Management of malrotation *	<input type="checkbox"/> Surgical management	<input type="checkbox"/> Non-surgical treatment	
Date of primary surgery *			
Prophylactic surgical procedure *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Approach of surgical procedure *	<input type="checkbox"/> Laparoscopy	<input type="checkbox"/> Laparotomy	
	<input type="checkbox"/> Laparoscopy converted to laparotomy	<input type="checkbox"/> Unknown	
Technique of surgical procedure *	<input type="checkbox"/> Ladd's procedure	<input type="checkbox"/> Other	
Bowel resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Jejunum resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ileum resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Terminal ileum resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ileocecal valve *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ascending colon *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Transverse colon resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Descending colon resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Sigmoid colon resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Length of remaining small bowel (in cm) *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Length of remaining colon (in cm) *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Postoperative parenteral nutrition *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of start parenteral nutrition *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Parenteral nutrition stop before discharge *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of stop parenteral nutrition *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Date of discharge *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		

One-year follow-up (surgical)

Was the patient readmitted? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Date of readmission *	<input type="checkbox"/>
	<input type="checkbox"/> Unknown

Complications after surgical management

Wound complication *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Wound complication - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Bowel obstruction/volvulus *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Bowel obstruction/volvulus - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Management of bowel obstruction/volvulus *	<input type="checkbox"/> Surgical management		<input type="checkbox"/> Non-surgical treatment
Date of reoperation *			
Approach of surgical procedure *	<input type="checkbox"/> Laparoscopy		<input type="checkbox"/> Laparotomy
	<input type="checkbox"/> Laparoscopy converted to laparotomy		<input type="checkbox"/> Unknown
Technique of surgical procedure *	<input type="checkbox"/> Ladd's procedure		<input type="checkbox"/> Other
Bowel resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Jejunal resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ileum resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Terminal ileum resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ileocecal valve *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ascending colon *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Transverse colon resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Descending colon resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Sigmoid colon resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Length of remaining small bowel (in cm) *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Length of remaining colon (in cm) *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Postoperative parenteral nutrition *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of start parenteral nutrition *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Parenteral nutrition stop before discharge *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of stop parenteral nutrition *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Other complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other complications - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Date of discharge *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		

One-year follow-up (non-surgical)

Bowel obstruction/volvulus *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Bowel obstruction/volvulus - Clavien-Madadi *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Management of bowel obstruction/volvulus *	<input type="checkbox"/> Surgical management		<input type="checkbox"/> Non-surgical treatment
Date of readmission *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Intraoperative finding: malrotation *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Intraoperative finding: bowel obstruction/volvulus *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Intraoperative finding: bowel ischemia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Intraoperative finding: other complication *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of surgery *			
Approach of surgical procedure *	<input type="checkbox"/> Laparoscopy		<input type="checkbox"/> Laparotomy
	<input type="checkbox"/> Laparoscopy converted to laparotomy		<input type="checkbox"/> Unknown
Technique of surgical procedure *	<input type="checkbox"/> Ladd's procedure		<input type="checkbox"/> Other
Bowel resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Jejunum resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ileum resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Terminal ileum resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ileocecal valve *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ascending colon *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Transverse colon resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Descending colon resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Sigmoid colon resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Length of remaining small bowel (in cm) *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Length of remaining colon (in cm) *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Postoperative parenteral nutrition *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of start parenteral nutrition *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Parenteral nutrition stop before discharge *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of stop parenteral nutrition *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Hospital admission *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Other complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of discharge *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		

One-year postoperative general

Reoperation or other surgeries *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Number of surgeries due to malrotation *			
Number of surgeries due to other causes *			
Parenteral nutrition at 1 year postoperatively *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Death during first year *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Death related to malrotation *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Necrotizing enterocolitis

Diagnostics

Onset and diagnosis/admission

Date at diagnosis	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Date of admission treating paediatric surgical center *			
Where was the patient referred from?	<input type="checkbox"/> Another internal department		<input type="checkbox"/> Another healthcare centre
	<input type="checkbox"/> Home		

Date of consult paediatric surgeon *	<input type="checkbox"/>	
	<input type="checkbox"/> Unknown	
Weight at NEC diagnosis (grams) *		
Type of NEC (Bell's stage) *	<input type="checkbox"/> 1A	<input type="checkbox"/> 1B
	<input type="checkbox"/> 2A	<input type="checkbox"/> 2B
	<input type="checkbox"/> 3A	<input type="checkbox"/> 3B

Feeding

Enteral feeding received prior to NEC diagnosis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Type of enteral feeding *	<input type="checkbox"/> Mother's own milk	<input type="checkbox"/> Human donor milk	
	<input type="checkbox"/> Artificial formula	<input type="checkbox"/> Combination of human milk and formula	
Enteral feeding received 24 hours prior to NEC diagnosis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Type of enteral feeding *	<input type="checkbox"/> Mother's own milk	<input type="checkbox"/> Human donor milk	
	<input type="checkbox"/> Artificial formula	<input type="checkbox"/> Combination of human milk and formula	

Diagnostics and disease signs

During the active course of disease, please specify systematic signs

Temperature instability *	<input type="checkbox"/> Hypothermia (< 36 degrees Celsius)	<input type="checkbox"/> Normothermia	
	<input type="checkbox"/> Hyperthermia/fever (> 38.5 degrees Celsius)		
Bradycardia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Metabolic acidosis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Thrombocytopenia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Neutropenia *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Hypotension (requiring fluid, vasopressor or inotropic support) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ventilated prior to NEC diagnosis? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Apnea *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Please specify abdominal signs, during active course of disease

Gastric retention *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Bilious aspirates *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Abdominal distension *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Abdominal tenderness *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Abdominal discoloration *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Fecal blood *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Signs of peritonitis (requiring fluid, vasopressor or inotropic support) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
How were radiographic disease signs assessed? *	<input type="checkbox"/> X-ray of abdomen	<input type="checkbox"/> Ultra sound of abdomen	
	<input type="checkbox"/> Both	<input type="checkbox"/> None	

Please specify radiographic disease signs, during active course of disease

Intestinal dilation *	<input type="checkbox"/> Yes, on X-ray	<input type="checkbox"/> Yes, on ultrasound	
	<input type="checkbox"/> Yes, both	<input type="checkbox"/> No	
	<input type="checkbox"/> Unknown		
Ileus *	<input type="checkbox"/> Yes, on X-ray	<input type="checkbox"/> Yes, on ultrasound	
	<input type="checkbox"/> Yes, both	<input type="checkbox"/> No	
	<input type="checkbox"/> Unknown		
Pneumatosis intestinalis *	<input type="checkbox"/> Yes, on X-ray	<input type="checkbox"/> Yes, on ultrasound	
	<input type="checkbox"/> Yes, both	<input type="checkbox"/> No	
	<input type="checkbox"/> Unknown		
Ascites *	<input type="checkbox"/> Yes, on X-ray	<input type="checkbox"/> Yes, on ultrasound	
	<input type="checkbox"/> Yes, both	<input type="checkbox"/> No	
	<input type="checkbox"/> Unknown		
Portal venous gas *	<input type="checkbox"/> Yes, on X-ray	<input type="checkbox"/> Yes, on ultrasound	
	<input type="checkbox"/> Yes, both	<input type="checkbox"/> No	
	<input type="checkbox"/> Unknown		

Pneumoperitoneum *	<input type="checkbox"/> Yes, on X-ray <input type="checkbox"/> Yes, both <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes, on ultrasound <input type="checkbox"/> No
Fixed bowel loop >24 hours (at repeated X-Ray) *	<input type="checkbox"/> Yes, on X-ray <input type="checkbox"/> Yes, both <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes, on ultrasound <input type="checkbox"/> No
Cerebral neonatal ultrasound and/or MRI at NEC diagnosis *	<input type="checkbox"/> No <input type="checkbox"/> Yes, MRI	<input type="checkbox"/> Yes, ultrasound <input type="checkbox"/> Unknown

Please specify findings on ultrasound

Please specify findings on MRI

Intracranial hemorrhage *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Most severe 'Papile' grade *	<input type="checkbox"/> I <input type="checkbox"/> III	<input type="checkbox"/> II <input type="checkbox"/> IV	
Venous cerebral infarction *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Side of lesions *	<input type="checkbox"/> Unilateral	<input type="checkbox"/> Bilateral	
Periventricular leucomalacia grade 2 or higher *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Associated anomalies

Cardiac and large vessels anomalies

Echocardiography *	<input type="checkbox"/> No <input type="checkbox"/> Done in another hospital	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Date of echocardiography *	<input type="checkbox"/> <input type="checkbox"/> Unknown	
Major cardiac defects *	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Patent ductus arteriosus *	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Management of PDA *	<input type="checkbox"/> Medical treatment <input type="checkbox"/> Not yet treated at time of NEC diagnosis	<input type="checkbox"/> Surgical treatment
Cardiac interventions *	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Date of first cardiac intervention *	<input type="checkbox"/> <input type="checkbox"/> Unknown	
Type of cardiac intervention *	<input type="checkbox"/> Surgical treatment <input type="checkbox"/> Conservative treatment	<input type="checkbox"/> Percutane cardiac treatment
Did the patient pass away prior to the cardiac intervention? *	<input type="checkbox"/> Yes, due to cardiac anomaly <input type="checkbox"/> Yes, reason unknown	<input type="checkbox"/> Yes, NEC related <input type="checkbox"/> No

Surgery

Indication for surgery

Pneumoperitoneum *	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Clinical deterioration despite maximal non-surgical treatment for 24 hours *	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fixed loop for 24 hours *	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Surgical intervention

Surgical intervention for NEC *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of surgical intervention *	<input type="checkbox"/> <input type="checkbox"/> Unknown		
Time to surgery from diagnosis of NEC (hours) *			
Type of surgical intervention *	<input type="checkbox"/> Peritoneal drainage <input type="checkbox"/> Both (drainage as a bridge to surgery/transport)	<input type="checkbox"/> Laparotomy	
Open close procedure *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of death *	<input type="checkbox"/> <input type="checkbox"/> Unknown		

Bowel resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Stoma, primary anastomosis or clip and drop *	<input type="checkbox"/> Enterostomy/colostomy		<input type="checkbox"/> Primary anastomosis
	<input type="checkbox"/> Clip and drop		<input type="checkbox"/> Both (enterostomy/colostomy and primary anastomosis due to multiple resections)
	<input type="checkbox"/> Other		
Place of stoma *	<input type="checkbox"/> Jejunum		<input type="checkbox"/> Ileum
	<input type="checkbox"/> Colon ascendens		<input type="checkbox"/> Transvers colon
	<input type="checkbox"/> Colon descendens		<input type="checkbox"/> Sigmoid
Number of anastomoses *			

Which part of the bowel has been removed?

Jejunum *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ileum *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Terminal ileum/coecum *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Colon ascendens *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Transvers colon *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Colon descendens *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Sigmoid Transverse colon *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Sigmoid *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Length of small bowel after resection (cm) *			
Length of colon after resection (cm) *			
Was the ileocecal valve resected *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Location of NEC

Jejunum *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ileum *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Terminal ileum/coecum *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Colon ascendens *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Transvers colon *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Colon descendens *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Sigmoid *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
NEC totalis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Secondary laparotomy

A planned second-look laparotomy *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Open close procedure *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of death *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Bowel resection *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Stoma, primary anastomosis or clip and drop *	<input type="checkbox"/> Enterostomy/colostomy		<input type="checkbox"/> Primary anastomosis
	<input type="checkbox"/> Clip and drop		<input type="checkbox"/> Both (enterostomy/colostomy and primary anastomosis due to multiple resections)
	<input type="checkbox"/> Other		
Place of stoma *	<input type="checkbox"/> Jejunum		<input type="checkbox"/> Ileum
	<input type="checkbox"/> Colon ascendens		<input type="checkbox"/> Transvers colon
	<input type="checkbox"/> Colon descendens		<input type="checkbox"/> Sigmoid
Number of anastomoses *			

Which part of the bowel has been removed?

Jejunum *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Ileum *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Terminal ileum/coecum *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Colon ascendens *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Transvers colon *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Colon descendens *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Sigmoid Transverse colon *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Sigmoid *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Length of small bowel after resection (cm) *	
Length of colon after resection (cm) *	
Was the ileocecal valve resected *	<input type="checkbox"/> No <input type="checkbox"/> Yes

End of primary hospitalization

Refeeding after NEC diagnosis

Reinitiation of minimal enteral feeding after NEC diagnosis (MEF) *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Date of start MEF *	<input type="checkbox"/> <input type="checkbox"/> Unknown
Reinitiation enteral feeding after NEC diagnosis *	<input type="checkbox"/> <input type="checkbox"/> Unknown
Type of enteral feeding after NEC episode *	<input type="checkbox"/> Mother's own milk <input type="checkbox"/> Human donor milk <input type="checkbox"/> Artificial formula <input type="checkbox"/> Combination of human milk and formula
If combination, please specify more or less than 50% human *	<input type="checkbox"/> >50% human <input type="checkbox"/> < 50% human
Distal refeeding via mucous fistula before closing the stoma *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Full enteral feeding after NEC diagnosis *	<input type="checkbox"/> <input type="checkbox"/> Unknown

30 day complications

30 day complications *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Clinical sepsis (not central line associated) *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Clinical sepsis - Clavien Madadi severity score *	<input type="checkbox"/> Ia <input type="checkbox"/> Ib <input type="checkbox"/> II <input type="checkbox"/> IIIa <input type="checkbox"/> IIIb <input type="checkbox"/> IV <input type="checkbox"/> V
Stoma related complications *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Stoma related complications - Clavien Madadi severity score *	<input type="checkbox"/> Ia <input type="checkbox"/> Ib <input type="checkbox"/> II <input type="checkbox"/> IIIa <input type="checkbox"/> IIIb <input type="checkbox"/> IV <input type="checkbox"/> V
High output stoma *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Dermatitis *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Stoma prolapse *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Anastomotic leakage *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Anastomotic leakage - Clavien Madadi severity score *	<input type="checkbox"/> Ia <input type="checkbox"/> Ib <input type="checkbox"/> II <input type="checkbox"/> IIIa <input type="checkbox"/> IIIb <input type="checkbox"/> IV <input type="checkbox"/> V
Abdominal compartment syndrome *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Abdominal compartment syndrome - Clavien Madadi severity score *	<input type="checkbox"/> Ia <input type="checkbox"/> Ib <input type="checkbox"/> II <input type="checkbox"/> IIIa <input type="checkbox"/> IIIb <input type="checkbox"/> IV <input type="checkbox"/> V
Wound complication (including wound dehiscence and wound infection) *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Wound complication - Clavien Madadi severity score *	<input type="checkbox"/> Ia <input type="checkbox"/> Ib <input type="checkbox"/> II <input type="checkbox"/> IIIa <input type="checkbox"/> IIIb <input type="checkbox"/> IV <input type="checkbox"/> V
Fascial dehiscence (Platzbauch) *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Fascial dehiscence (Platzbauch) - Clavien Madadi severity score *	<input type="checkbox"/> Ia <input type="checkbox"/> Ib <input type="checkbox"/> II <input type="checkbox"/> IIIa <input type="checkbox"/> IIIb <input type="checkbox"/> IV <input type="checkbox"/> V
Anastomotic stricture *	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown

Anastomotic stricture - Clavien Madadi severity score *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Post NEC stenosis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Post NEC stenosis -Clavien Madadi severity score *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Adhesive bowel obstruction for which surgery is performed *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Adhesive bowel obstruction - Clavien Madadi severity score *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Central line-associated complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Central line-associated complications - Clavien Madadi severity score *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		

Discharge

Date of discharge *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Destination of discharge *	<input type="checkbox"/> Home	<input type="checkbox"/> Regional hospital	
	<input type="checkbox"/> Center with pediatric surgical unit	<input type="checkbox"/> Other care facility	
	<input type="checkbox"/> Unknown		
Diversion to palliative care post-operative *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Did the patient die? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of death *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Did the patient die due to (complications related to) NEC *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Enterostomy closure

Has enterostomy closure already taken place? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of closure *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		

One-year follow-up

Short bowel syndrome

Presence of short bowel syndrome - associated intestinal failure (Short bowel syndrome - Intestinal failure)? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
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Enterostomy closure

Has enterostomy closure already taken place? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of closure *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		

1 year complications

1 year complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Clinical sepsis (not central line associated) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Clinical sepsis - Clavien Madadi severity score *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Stoma related complications *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Stoma related complications - Clavien Madadi severity score *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
High output stoma *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Dermatitis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Stoma prolapse *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Stoma prolapse - Wound complication (including wound dehiscence and wound infection) *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Wound complication - Clavien Madadi severity score *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Anastomotic stricture *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Anastomotic stricture - Clavien Madadi severity score *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Post NEC stenosis *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Post NEC stenosis - Clavien Madadi severity score *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		
Adhesive bowel obstruction for which surgery is performed *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Adhesive bowel obstruction - Clavien Madadi severity score *	<input type="checkbox"/> Ia	<input type="checkbox"/> Ib	
	<input type="checkbox"/> II	<input type="checkbox"/> IIIa	
	<input type="checkbox"/> IIIb	<input type="checkbox"/> IV	
	<input type="checkbox"/> V		

Mortality

Did the patient die? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of death *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Did the patient die due to (complications related to) NEC *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Two-year follow-up

Follow up 2 year

Neurodevelopment within 2 years *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Neurodevelopment is monitored using validated scales. *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Presence of neurodevelopmental impairment *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Please specify the domain(s) in which neurodevelopmental impairment is present

Motor *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Cognitive *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Sensory *	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Vision loss	
	<input type="checkbox"/> Both	<input type="checkbox"/> No	
	<input type="checkbox"/> Unknown		
Developmental *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Reoperation

Unplanned NEC-related abdominal reoperation within 2 years *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
If yes, please specify the number of reoperations. *			
Unplanned NEC-related non-abdominal reoperation within 2 years *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
If yes, please specify the number of reoperations. *			

Mortality

Did the patient die? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of death *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		
Did the patient die due to (complications related to) NEC *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown

Enterostomy closure

Has enterostomy closure already taken place? *	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
Date of closure *	<input type="checkbox"/>		
	<input type="checkbox"/> Unknown		