Please send the completed CRFs to the Data Center:

PD Dr. med. Carsten Friedrich, Universitätsklinik für Kinder- und Jugendmedizin, Klinik für Allgemeine Kinderheilkunde, Hämatologie/Onkologie, Klinikum Oldenburg AöR, Rahel-Straus-Str. 10, 26133 Oldenburg, Tel.: +49 (0)441 403707082013, Fax: +49 (0)441 4032789278

KRANIOPHARYNGEOM Registry 2019 CRF 1
Data at Diagnosis Recording Form

Patient initials | Pat.nr. | Gender | Birthdate | Malig-ID

Hospital..... City ..... … Country.....

Date of diagnosis (Imaging) ……. Date of diagnosis (Histology) ……

Anthropometric data

Examination Date: ___.___._____ Measured body height (cm): _____,____

Measured waist circumference (cm): _____,____ Measured body weight (kg): _____,____

Measured head circumference (cm): _____,____

Birth weight (g): _____,____ Gestational age (wk) _____

Pubertal (PH) stage (Tanner): _____ Pubertal (B/G) stage (Tanner) _____

Body hight father (cm): _____,____ Body weight father (kg): _____,____

Body hight mother (cm): _____,____ Body weight mother (kg): _____,____

Symptoms before diagnosis:	**CTC-grade:**	**hospitalization**		**duration in month**
Growth decline:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Weight gain:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Polyuria / Polydypsia /DI:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Neurological findings:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Headaches:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Visual disorders:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Cognitive disturbance:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Alopecia:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Skin disorder: (Hypo-/Hyperpigmentation, Ulceration, Teleangiectasia, Induration)	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Fatigue:	❍ yes ____	❍ yes	❍ no	duration: _____ mo

Incidental finding ❍ yes ❍ no

<u>Preoperative</u> endocrine findings:

Diabetes insipidus: ❍ Hypocortisolism: ❍
Hypothyroidism: ❍ Hypogonadism: ❍
Growth hormone deficiency: ❍

Puberty:

Pubertas tarda: ❍
Pubertas praecox: ❍
Normal: ❍

Behavioural abnormalities ❍ yes ❍ no

Hypothalamic syndrome ❍ yes ❍ no
(food-seeking behaviour/morbid obesity, somnolence/sleep disturbance, temperature instability)

Remarks:

Address/Fax to Data Centre within 3 months

Date Stamp Signature

KRANIOPHARYNGEOM Registry 2019 CRF 2
Neurosurgery Recording Form

Date of Birth ☐☐ ☐☐ ☐☐☐☐ Date of Diagnosis = Surgery ☐☐ ☐☐ ☐☐☐☐ Centre ID ☐☐☐ Malig-ID ☐☐☐☐☐

Male ☐ Female ☐ Initials ☐☐

Hospital..... City..... … Country.....

Date of 1st surgery: ☐☐☐☐☐☐☐ **Number of previous surgeries:** ☐

Hospital _____

Surgeon:_____

Planned OP Procedures		**Realized OP Procedures**	
Radical resection	❍	Radical resection	❍
Limited resection	❍	Limited resection	❍
Biopsy	❍	Biopsy	❍
Cyst drainage, subtotal tumor resection, relief of hydrocephalus	❍	Cyst drainage, subtotal tumor resection, relief of hydrocephalus	❍
Installation of sclerosing substances or radioisotopes into the cyst	❍	Installation of sclerosing substances or radioisotopes into the cyst	❍
Shunt (e.g. relief of hydrocephalus)	❍	Shunt (e.g. relief of hydrocephalus)	❍

Tissue sample preserved: yes ❍ no ❍

Surgical approach to tumor Open/Transcranial ❍ Transphenoidal ❍ Endoscopic ❍

Pituitary stalk (intraoperativ): cut ❍ obtained ❍ not identified ❍

Hypothalamic infiltration (intraoperativ): yes ❍ no ❍ not evaluated ❍

Second surgery intervention

Date of 2nd surgery: ☐☐☐☐☐☐☐ **Number of previous surgeries:** ☐

Planned OP Procedures		**Realized OP Procedures**	
Radical resection	❍	Radical resection	❍
Limited resection	❍	Limited resection	❍
Cyst drainage, subtotal tumor resection, relief of hydrocephalus	❍	Cyst drainage, subtotal tumor resection, relief of hydrocephalus	❍
Installation of sclerosing substances or radioisotopes into the cyst	❍	Installation of sclerosing substances or radioisotopes into the cyst	❍
Shunt (e.g. relief of hydrocephalus)	❍	Shunt (e.g. relief of hydrocephalus)	❍

Surgical approach to tumor Open/Transcranial ❍ Transphenoidal ❍ Endoscopic ❍

Pituitary stalk (intraoperativ): cut ❍ obtained ❍ not identified ❍

Hypothalamic infiltration (intraoperativ): yes ❍ no ❍ not evaluated ❍

Histology: yes ❍ no ❍

Perioperative complications (within 30 days of surgery):

Blood transfusion requirement	❍	New visual disturbance	❍	Subdural effusion	❍
CSF infection (meningitis)	❍	Severe salt and flood balance review	❍		
Strokes	❍	Paresis	❍		

Remarks:

Address/Fax to Data Centre within 3 months

Date Stamp Signature

KRANIOPHARYNGEOM Registry 2019 CRF 3
Radiotherapy Recording Form 1.0 – General Information

Date of Birth ☐☐ ☐☐ ☐☐☐☐ Date of Diagnosis=Surgery ☐☐ ☐☐ ☐☐☐☐ Centre ID ☐☐☐ Malig-ID ☐☐☐☐☐

Male ☐ Female ☐ Initials ☐☐

Hospital..... City..... … Country.....

_____ _____

Name of responsible Radiation Oncologist Department of Radiotherapy (stamp)

Date start of RT: ☐☐☐☐☐☐☐☐ **Date end of RT:** ☐☐☐☐☐☐☐☐

Time of radiotherapy
number of operations before RTX ____
postoperative radiotherapy ❍
radiotherapy after progress ❍

Radiotherapy treatment Interruption ❍ no ❍ yes
Number of Breaks ____
Total number of days/missed RT sessions ____

Break 1

dose achieved before break __.__ Gy
dose compensation ❍ no ❍ yes, with __.__ Gy

causes of treatment interruption:
❍ Toxicity Adverse Event (AE, CTCAE v5.0)
AE: _____ grade:_____
AE: _____ grade:_____
AE: _____ grade:_____
❍ Disease progression
❍ Bank holidays
❍ Other: _____

Break 2

dose achieved before break __.__ Gy
dose compensation ❍ no ❍ yes, with __.__ Gy

causes of treatment interruption:
❍ Toxicity Adverse Event (AE, CTCAE v5.0)
AE: _____ grade:_____
AE: _____ grade:_____
AE: _____ grade:_____
❍ Disease progression
❍ Bank holidays
❍ Other: _____

Early termination of RT

❍ no ❍ yes

causes of treatment interruption:
❍ Toxicity Adverse Event (AE, CTCAE v5.0)

AE: _____ grade:_____
AE: _____ grade:_____
AE: _____grade:_____

Hospitalization during radiotherapy

❍ no ❍ yes
total number of unplanned hospitalization days: ____

causes of hospitalization:
❍ Toxicity Adverse Event (AE, CTCAE v5.0)

AE: _____ grade:_____
AE: _____ grade:_____
AE: _____ grade:_____

Remarks

Please refer to the next page "Radiotherapy 1.1 - Therapy Technique. Send all completed forms to the study center in Oldenburg.

Date Stamp Signature

KRANIOPHARYNGEOM Registry 2019 CRF 3
Radiotherapy Recording Form 1.1 – Treatment Technique

Date of Birth	Date of Diagnosis=Surgery	Centre ID	Malig-ID
⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋⌊_⌋⌊_⌋	⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋⌊_⌋⌊_⌋	⌊_⌋⌊_⌋⌊_⌋	⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋

Male ☐ Female ☐ Initials ☐☐

Image fusion (MRI/CT) for treatment planning ❍ no ❍ yes

3-D treatment planning ❍ no ❍ yes

RT mode ❍ Photons ❍ Protons ❍ Other _____

RT technique
- ❍ Conventional simulation-based XRT
- ❍ 3D conformal XRT without intensity modulation
- ❍ Intensity-modulated XRT with fixed gantry agles (IMRT)
- ❍ Volumetric modulated arc therapy (VMAT)
- ❍ Tomography
- ❍ Active scanning/ pencil beam scanning (protons)
- ❍ Passive scattering/ uniform scanning (protons)
- ❍ Fractionated stereotactic radiotherapy
- ❍ Radiotheraphy
- ❍ Brachytherapy
- ❍ Daily imaging for set-up
- ❍ Other _____

Target of radiotherapy
- ❍ Residual tumor, recurrent/progressive tumor only
- ❍ Residual tumor + high risk area
- ❍ Total area with initial tumor contact (tumor bed, primary tumor/ recurrent/progressive tumor + residual tumor)

Volume GTV (residual tumor/ recurrent tumor) (cm³): _____
❍ not applicable

Volume GTV (residual tumor + tumor bed) (cm³): _____
❍ not applicable

Volume CTV (cm³): _____

Margin GTV-CTV (mm): _____

Volume PTV (cm³): _____

Margin CTV-PTV (mm): _____

Dose of prescription Total dose: __.__ Gy Number of fractions: ____

Single dose: __.__ Gy

Target volume/ risk organs	Uniform name	May (D2%) in Gy	Mean dose in Gy
GTV (residual/progressive tumor)	GTV_res/rel		
GTV (residual tumor + tumor bed)	GTV_res+tb		
CTV	CTV_XXXX (prescribed dose in cGy)		
PTV	PTV_XXXX (prescribed dose in cGy)		
Brainstem	Brainstem		
Brainstem centre (ø 2-3 mm)	Brainstem_Cent		
Spinal cord (below C1)	SpinalCord		
Cochlea (left)	Cochlea_L		
Cochlea (right)	Cochlea_R		
Eye lense (left)	Lens_L		
Eye lense (right)	Lens_R		
Hippocampus (left)	Hippocampus_L		
Hippocampus (right)	Hippocampus_R		
Hypothalamus	Hypothalamus		
Infratentorial brain (posterior fossa)	Brain^Înfratent		
Chiasma	OpticChiasm		
Nervus opticus (left)	OpticNrv_L		
Nervus opticus (right)	OpticNrv_R		
Pituitary gland	Pituitary		
Supratentorial brain	Brain^Supratent		
Temporal lobe (left)	Lobe_Temporal_L		
Temporal lobe (right)	Lobe_Temporal_R		
Thyroid gland	Glnd_Thyroid		

Remarks:

As part of quality assurance, the RT data set must be sent to Reference Radiation Therapy after the end of irradiation. The dataset should contain the following data: 1. diagnostic imaging (initial and postoperative MR), 2. planning CT, 3. RT structure set, 4. RT image, 5. RT plan for target volumes and contoured risk organs, 6. MR sequences used for contouring, 7. registration matrix of MR fusion.

Please contact the Reference Center Radiation Therapy Essen for submission of the radiation plan in DICOM format:

Westdeutsches Protonentherapiezentrum Essen (WPE)
Referenzzentrum Strahlentherapie Essen
Am Mühlenbach 1
45147 Essen
Tel.: +49 201 723-8156
FAX: 49 201 723-5978
Mail: wpe_referenzzentrum_strahlentherapie@uk-essen.de

Radiation plan sent to the Reference Center Radiation Therapy Essen?
❍ yes ❍ no

Date Stamp Signature

KRANIOPHARYNGEOM Registry 2019 CRF 4
Consignment bill for sending the radiological imaging to the Radiological Reference Center Augsburg

Date of Birth ⌊⌊⌋⌊⌋⌊⌊⌋⌊⌋⌊⌋⌋ Date of Diagnosis=Surgery ⌊⌊⌋⌊⌋⌊⌊⌋⌊⌋⌊⌋⌋ Centre ID ⌊⌊⌋⌊⌋⌋ Malig-ID ⌊⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌋

Male ☐ Female ☐ Initials ☐☐

Hospital..... City..... … Country.....

Only enclose this form when sending CDs by postal mail!

We prefer sending the images to the neurological reference center via **MDPE-Server** (https://www.mdpe-hit.de/)! If sending by postal mail, send the CD with Dicom data without viewer to the following address:

Dr. Brigitte Bison,
Diagnostische und interventionelle Radiologie und Neuroradiologie
Universitätsklinikum Augsburg, Stenglinstr. 2,
86156 Augsburg, Tel.: +49 (0)821 4002954; Fax: +49 (0)821 4003312
E-Mail: hit-nrad@uk-augsburg.de

Original images are returned to the centers as soon as possible after scanning/ documentation. The reference assessment of the neuroradical findings is sent to the centers within few working days.

Multiple answers possible

Diagnosis:		_____	Date of surgery:	⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋
Examination:		❍ at first diagnosis	Date of MRI:	⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋
		❍ during the course	Date of CT:	⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋
Imaging:	CT	❍ yes ❍ no	❍ without contrast medium (CM)	❍ with contrast medium (CM)
	MRI	❍ yes ❍ no	❍ T1-weighted ❍ T2-weighted	❍ with CM ❍ without CM
Date of shipment:		⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋		
Date of medical report:		⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋		
Images returned:		⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋		

Date Stamp Signature

KRANIOPHARYNGEOM Registry 2019 CRF 5
Follow-Up Recording Form

Date of Birth ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋⌊_⌋⌊_⌋ Date of Diagnosis=Surgery ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋⌊_⌋⌊_⌋ Centre ID ⌊_⌋⌊_⌋⌊_⌋ Malig-ID ⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋

Male ☐ Female ☐ Initials ☐☐

Hospital..... City..... … Country.....

Anthropometric data

Examination Date: ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋⌊_⌋⌊_⌋

Measured body height (cm) ⌊_⌋⌊_⌋⌊_⌋ , ⌊_⌋

Measured body weight (kg) ⌊_⌋⌊_⌋⌊_⌋ , ⌊_⌋

Measured head circumference (cm) ⌊_⌋⌊_⌋⌊_⌋ , ⌊_⌋

Pubertal (PH) stage (Tanner) ⌊_⌋

Pubertal (B/G) stage (Tanner) ⌊_⌋

Symptoms in the course:	**CTC-grade:**	**hospitalization**		**duration in month**
Growth decline:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Weight gain:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Neurological findings:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Headaches:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Visual disorders:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Cognitive disturbance:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Alopecia:	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Skin disorder: (Hypo-/Hyperpigmentation, Ulceration, Teleangiectasia, Induration)	❍ yes ____	❍ yes	❍ no	duration: _____ mo
Fatigue:	❍ yes ____	❍ yes	❍ no	duration: _____ mo

Endocrine findings:

				Puberty:	
Diabetes insipidus	❍	Hypocortisolism	❍	Pubertas praecox	❍
Hypothyroidism	❍	Hypogonadism	❍	Pubertas tarda	❍
Growth Hormone deficiency	❍			normal	❍

Behavioural abnormalities ❍ yes ❍ no

Hypothalamic syndrome ❍ yes ❍ no
(food-seeking behaviour/morbid obesity, somnolence,/sleep disturbance, temperature instability)

Medication:

Minirin/DDAVP:	❍ yes	❍ no	Sex steroids:	❍ yes	❍ no
L-Thyroxine:	❍ yes	❍ no	Psychopharmaceuticals:	❍ yes	❍ no
Growth hormone:	❍ yes	❍ no	Sleep modifying drugs	❍ yes	❍ no
Glucocorticoids:	❍ yes	❍ no	others:_____		

Remarks:

Address/Fax to Data Centre within 3 months

Date Stamp Signature

KRANIOPHARYNGEOM Registry 2019 CRF 6
Status, Relapse and Death

❍ annually, ❍ at relapse and/or death

Date of Birth ⌊⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌋ Date of Diagnosis=Surgery ⌊⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌋ Centre ID ⌊⌊⌋⌊⌋⌋ Malig-ID ⌊⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌋

Male ☐ Female ☐ Initials ☐☐

Hospital..... City..... … Country.....

Status at follow up

Date of Examination ⌊⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌋

Status of patient
- ❍ Alive - free from tumor
- ❍ Alive with post op residual tumor
- ❍ Relapse after complete resection
- ❍ Progression of residual tumor
- ❍ Dead

comments: …….

Relapse/progression treatment: Date: ⌊⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌋

- ❍ No treatment
- ❍ Surgery
  - ❍ Complete ❍ Subtotal
- ❍ Radiotherapy (XRT)
- ❍ Cyst drainage
- ❍ Ventriculo-perit. Shunt
- ❍ Instillation of radioisotopes
  - ❍ Phosporus ❍ Yttrium ❍ Radium
- ❍ Instillation of sclerosing substances (e.g. Interferon α)
- ❍ Other_____

Death: Date of death: ⌊⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌊⌋⌋

Cause:
- ❍ Primary tumor disease
- ❍ Relapse/ progression
- ❍ Treatment related mortality
- ❍ Addison's crisis
- ❍ 2nd malignancy
- ❍ cannot differentiate if tumor or treatment
- ❍ Hypopituitarism
- ❍ Cardiovascular cause (eg. strokes)
- ❍ Other cause……

Remarks:

Address/Fax to Study Centre within 3 month

Date: **Stamp:** **Signature:**

Please do not fill out this form – it will be reported by the radiological reference center Augsburg.

KRANIOPHARYNGEOM Registry 2019 CRF7
Radiological Reference Evaluation Recording Form

Date of Birth ⌊⌊ ⌊⌊ ⌊⌊⌊⌊ Date of Diagnosis=Surgery ⌊⌊ ⌊⌊ ⌊⌊⌊⌊ Centre ID ⌊⌊⌊ Malig-ID ⌊⌊⌊⌊⌊

Male ☐ Female ☐ Initials ☐☐

Hospital..... City..... … Country.....

Date of surgery: ⌊⌊ ⌊⌊ ⌊⌊⌊⌊

Examination: ❍ at first diagnosis MRI date: ⌊⌊ ⌊⌊ ⌊⌊⌊⌊

❍ during the course CT date: ⌊⌊ ⌊⌊ ⌊⌊⌊⌊

Imaging: **CT** ❍ yes ❍ no ❍ without contrast medium (CM) ❍ with contrast medium (CM)

MRI ❍ yes ❍ no ❍ T1-weighted ❍ T2-weighted ❍ with CM ❍ without CM

Tumor localization ❍ intrasellar ❍ intra-extrasellar ❍ extrasellar

Tumor structure: ❍ solid ❍ cystic ❍ mixed

Displacement/Compression of:
❍ Pituitary stalk
❍ III. Ventricle
❍ Ant. Hypothalamus
❍ Post. Hypothalamus
❍ Opt. chiasm
❍ Thalamus

Hydrocephalus ❍ yes ❍ no ❍ Lateral ventricles ❍ III. Ventricle

max. Tumor-Diameter (solid and cystic) **(mm)** based on: MRI-Finding ❍ CT-Findings ❍

Total tumor	**(mm):**	**Cystic part**	**(mm):**
Cranio-caudal	⌊⌊⌊	Cranio-caudal	⌊⌊⌊
Ant-posterior	⌊⌊⌊	Ant-posterior	⌊⌊⌊
right-left	⌊⌊⌊	right-left	⌊⌊⌊
max. midline height	⌊⌊⌊		

Cystic part > 50 %: ❍ yes ❍ no

CT evaluation:
preoperative: calcifications ❍ yes ❍ no
during the course calcifications ❍ yes ❍ no

MRI evaluation (slices <= 3 mm):
Signal T1 ❍ hypointense ❍ isointense ❍ hyperintense
Signal T2 ❍ hypointense ❍ isointense ❍ hyperintense

Overall: **Progression:** ❍ yes ❍ no **Recurrence:** ❍ yes ❍ no

Remarks:

Address/Fax to Data Centre within 3 months

Date Stamp Signature

Version 085/20242

Please send the completed CRFs to the Data Center:

PD Dr. med. Carsten Friedrich, Universitätsklinik für Kinder- und Jugendmedizin, Klinik für Allgemeine Kinderheilkunde, Hämatologie/Onkologie, Klinikum Oldenburg AöR, Rahel-Straus-Str. 10, 26133 Oldenburg, Tel.: +49 (0)441 403707082013, Fax: +49 (0)441 4032789278

KRANIOPHARYNGEOM Registry 2019 CRF 8
Report of serious adverse events Recording Form

Date of Birth ⌊⌊⌋⌊⌋⌊⌊⌋⌊⌋⌋ Date of Diagnosis=Surgery ⌊⌊⌋⌊⌋⌊⌊⌋⌊⌋⌋ Centre ID ⌊⌊⌋⌋ Malig-ID ⌊⌊⌋⌊⌋⌊⌋⌋

Male ☐ Female ☐ Initials ☐☐

Hospital..... City..... … Country.....

Reporting party / contact person / name: _____

_____

Contact phone number / fax number: _____

Hospital: Date/Signature (Stamp): _____

Adverse events (AEs) are all disturbances of well-being (subjectively perceived as well as objectively ascertainable), symptoms of illness, possibly intercurrent diseases, and impairments leading to accidents occurring during the observation period, irrespective of a possible causal relationship with the study treatment. Expected AEs related to radiotherapy (toxicities) will be recorded on CRF 3; all other AEs will be documented on this form.
Serious adverse events occurring during therapy must be documented and reported immediately, i.e. **within 24 hours**, to the study center in Oldenburg.

AEs classification is based on severity:

- ❍ Mild (symptoms that are easily tolerated and do not require a change in approach).
- ❍ Moderate (symptoms that are severe enough to limit the patient's ability to perform and require medical intervention).
- ❍ Severe (symptoms that are so severe that the patient's performance is limited and he/she cannot perform his/her usual activities, requiring medical intervention, e.g. Addison krisis)

Serious adverse events include:

- ❍ Any death, regardless of cause of death.
- ❍ Life-threatening/life-threatening medical conditions.
- ❍ Events that result in permanent severe disability.
- ❍ Overdose events that result in symptoms

Date of Event: ___.___._____

Exact description of event:
Type, onset, duration, manifestation/severity, causality, actions taken, if any.
Related signs, symptoms, and laboratory changes should be grouped into a single condition.

_____
_____
_____
_____
_____
_____