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## DCVAS SCREENING

Screening Date	<table border="1"><tr><td>D</td><td>D</td><td>/</td><td>M</td><td>M</td><td>M</td><td>/</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	/	M	M	M	/	Y	Y	Y	Y
D	D	/	M	M	M	/	Y	Y	Y	Y		
Screening ID	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>											
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female											
Date of birth:	<table border="1"><tr><td>D</td><td>D</td><td>/</td><td>M</td><td>M</td><td>M</td><td>/</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	/	M	M	M	/	Y	Y	Y	Y
D	D	/	M	M	M	/	Y	Y	Y	Y		

### Inclusion criteria

	Yes	No
1. Is the patient over the age of 18 years?	<input type="checkbox"/>	<input type="checkbox"/>
2. <b>OR</b> Does the patient have a diagnosis of vasculitis? Is vasculitis a potential diagnosis for their current illness?	<input type="checkbox"/>	<input type="checkbox"/>
3. <b>OR</b> Has the patient given informed consent? The patient does not have capacity to provide informed consent but a 'consultee' ("surrogate") has declared that the patient would want to participate in the study?	<input type="checkbox"/>	<input type="checkbox"/>

If "No" is ticked for any of the inclusion criteria, then patient is NOT eligible for the study.

I confirm that the patient:

Meets **ALL** the inclusion criteria for the study: ☐

**Or**

Does not meet the inclusion criteria for the study ☐

Signature of investigator : \_\_\_\_\_

Print name: \_\_\_\_\_

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## Clinical scenarios

Tick all that applies for this subject for their current illness:

<input type="checkbox"/>	1. Referred to secondary or tertiary care with a suspicion of vasculitis
<input type="checkbox"/>	2. Multi-system disease (presentation of disease with at least 2 organs involved)
<input type="checkbox"/>	3. Fever
<input type="checkbox"/>	4. Chronic signs and/or symptoms of upper airway disease
<input type="checkbox"/>	5. Haemoptysis/pulmonary haemorrhage
<input type="checkbox"/>	6. Acute respiratory distress, exacerbation of asthma, or unexplained pulmonary fibrosis
<input type="checkbox"/>	7. Acute or progressive renal impairment and/or failure
<input type="checkbox"/>	8. Acral ischaemia/necrosis
<input type="checkbox"/>	9. Ischaemic jaw or tongue pain
<input type="checkbox"/>	10. Limb claudication
<input type="checkbox"/>	11. Aortic aneurysm (>5cm, thoracic or abdominal)
<input type="checkbox"/>	12. New-onset hypertension associated with other systemic features
<input type="checkbox"/>	13. Acute or chronic abdominal pain
<input type="checkbox"/>	14. New-onset headache
<input type="checkbox"/>	15. Sudden visual loss
<input type="checkbox"/>	16. Other signs or symptoms of ocular disease (unexplained keratitis, scleritis, uveitis, orbital disease, other)
<input type="checkbox"/>	17. Stroke
<input type="checkbox"/>	18. Chronic headache
<input type="checkbox"/>	19. Peripheral neuropathy (either sensory or motor)
<input type="checkbox"/>	20. Inflammatory polyarthritis
<input type="checkbox"/>	21. Inflammatory shoulder and/or hip girdle symptoms (Polymyalgia-like symptoms)
<input type="checkbox"/>	22. Rash/skin abnormalities (including nodules and ulcers)
<input type="checkbox"/>	23. Peripheral blood eosinophilia
<input type="checkbox"/>	24. Positive serologic test for autoimmune disease (ANCA, ANA, other)
<input type="checkbox"/>	25. Biopsy specimen consistent with vasculitis
<input type="checkbox"/>	26. Other (please specify):
	<div></div>

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## DCVAS STUDY VISIT 1

Visit date:	<table border="1"><tr><td>D</td><td>D</td><td>/</td><td>M</td><td>M</td><td>M</td><td>/</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	/	M	M	M	/	Y	Y	Y	Y
D	D	/	M	M	M	/	Y	Y	Y	Y		
Date of onset of symptoms of current illness:	<table border="1"><tr><td>D</td><td>D</td><td>/</td><td>M</td><td>M</td><td>M</td><td>/</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	/	M	M	M	/	Y	Y	Y	Y
D	D	/	M	M	M	/	Y	Y	Y	Y		
Date of diagnosis of current illness:	<table border="1"><tr><td>D</td><td>D</td><td>/</td><td>M</td><td>M</td><td>M</td><td>/</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	/	M	M	M	/	Y	Y	Y	Y
D	D	/	M	M	M	/	Y	Y	Y	Y		
Date of first assessment of this patient by you :	<table border="1"><tr><td>D</td><td>D</td><td>/</td><td>M</td><td>M</td><td>M</td><td>/</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	/	M	M	M	/	Y	Y	Y	Y
D	D	/	M	M	M	/	Y	Y	Y	Y		

## Tobacco smoking status

<input type="checkbox"/>	Current smoker
<input type="checkbox"/>	Previous smoker
<input type="checkbox"/>	Never smoked

## Pre- existing co-morbidity

Present before the onset of current illness (please tick **all** that apply):

<input type="checkbox"/>	Coronary heart disease		
<input type="checkbox"/>	Heart failure		
<input type="checkbox"/>	Peripheral vascular disease		
<input type="checkbox"/>	Hypertension requiring treatment		
<input type="checkbox"/>	Chronic obstructive pulmonary disease (not including late onset asthma)		
<input type="checkbox"/>	Asthma		
<input type="checkbox"/>	Diabetes mellitus		
<input type="checkbox"/>	Cerebrovascular accident (stroke)		
<input type="checkbox"/>	Dyslipidaemia		
<input type="checkbox"/>	Malignancy (please specify):	<table border="1"><tr><td></td></tr></table>	
<input type="checkbox"/>	Other (please specify):	<table border="1"><tr><td></td></tr></table>	

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## Ethnicity

Tick the appropriate box to indicate ethnic background. If mixed ethnicity more than 1 box may be ticked.

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | African North  |
| <input type="checkbox"/> | African Sub Saharan  |
| <input type="checkbox"/> | African-American   |
| <input type="checkbox"/> | Black Caribbean  |
| <input type="checkbox"/> | Chinese Han  |
| <input type="checkbox"/> | Chinese Other  |
| <input type="checkbox"/> | European North   |
| <input type="checkbox"/> | European South (Italian, Spanish, Portuguese, Greek, Balkan) |
| <input type="checkbox"/> | Indian (Indian/Pakistani/Bangladeshi)                        |
| <input type="checkbox"/> | Japanese   |
| <input type="checkbox"/> | Korean   |
| <input type="checkbox"/> | Latin American - Native                                      |
| <input type="checkbox"/> | Latin American - Mestizo                                     |
| <input type="checkbox"/> | Middle Eastern   |
| <input type="checkbox"/> | Pacific Islander   |
| <input type="checkbox"/> | Turkish  |
| <input type="checkbox"/> | White Caucasian American                                     |
| <input type="checkbox"/> | Other (please specify):                                      |

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## Clinical Features

### 1. General

Is this the patients 1<sup>st</sup> presentation for this illness?

Yes ☐

No ☐

Current height

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 cm

Current weight

--	--	--

 Kg

Systolic blood pressure left arm

--	--	--

 mmHg

Systolic blood pressure right arm

--	--	--

 mmHg

**Present at any time since the onset of the current illness** = Tick this box if symptoms or sign were present during the current illness. The current illness includes the whole period from when you think the vasculitis or mimic disease started till present day. This includes items that may have occurred and disappeared in the course of this illness.

Please tick if present at any time since the onset of the current illness

#### SYMPTOMS

- ☐ Light-headedness
- ☐ Syncope / Fainting
- ☐ Fatigue
- ☐ Night sweats
- ☐ Rigors

#### CLINICAL FEATURES

- ☐ Fever  $\geq 38^{\circ}\text{C}$  ( $\geq 100.4^{\circ}\text{F}$ )
- ☐ Lymphadenopathy in more than one anatomic chain
- ☐ Scalp tenderness

Weight loss this illness:

0Kg	$\leq 2\text{Kg}$	2-5Kg	$\geq 5\text{kg}$

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**2. Musculoskeletal****Not involved** ☐

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**Please tick if present at any time since the onset of the current illness**

**SYMPTOMS**

- ☐ Arthralgia (Joint pain)
- ☐ Morning stiffness  $\geq 1$  hour
- ☐ Myalgia (muscle pain) or muscle cramps
- ☐ Other (please specify):

**CLINICAL FEATURES**

- ☐ Swollen or inflamed joint(s)
- ☐ Muscle tenderness
- ☐ Muscle weakness
- ☐ Other (please specify):

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### 3. Skin

**Not involved** ☐

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**Please tick if present at any time since the onset of the current illness**

#### SYMPTOMS

- ☐ Pruritus
- ☐ Painful skin lesions of any type
- ☐ Other (please specify):

#### CLINICAL FEATURES

- ☐ Petechiae or Purpura (subcutaneous or dermal haemorrhage of any size )
- ☐ Maculopapular or papular rash (exanthema of macules and papules)
- ☐ Livedo reticularis (mottled cyanotic discoloration of the skin, with characteristic network pattern)
- ☐ Livedo racemosa ('broken' livedo - mottled cyanotic discoloration of the skin, with characteristic open network in the shape of lightening)
- ☐ Non tender skin nodules
- ☐ Tender skin nodules
- ☐ Gangrene (necrosis of tissue, usually due to loss of blood supply)
- ☐ Splinter haemorrhage (thin longitudinal lines of blood extravasation in the nail bed)
- ☐ Ulcer (defect in which the epidermis and upper part of dermis are lacking)
- ☐ Urticaria/Wheals/ Hives
- ☐ Other (please specify):

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**4. Eyes****Not involved** ☐

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**Please tick if present at any time since the onset of the current illness**

**SYMPTOMS**

- ☐ Amaurosis fugax (transient/temporary loss of vision )
- ☐ Sudden visual loss - ongoing
- ☐ Blurred vision in either eye
- ☐ Painful eye(s)
- ☐ Other (please specify):

**CLINICAL FEATURES**

- ☐ Conjunctivitis
- ☐ Watery eyes or lacrimal gland enlargement
- ☐ Proptosis / Exophthalmos (bulging out of one or both of the eyes)
- ☐ Ischaemic Optic Neuritis (confirmed by ophthalmologist)

**Ocular inflammation** (confirmed by an ophthalmologist)

- ☐ • Keratitis (inflammation of the cornea)
- ☐ • Scleritis or episcleritis (inflammation of the sclera)
- ☐ • Uveitis (inflammation of any of the following: iris, anterior chamber, vitreous cavity, retina or choroid)

**Retinal pathology** (confirmed by an ophthalmologist)

- ☐ • Retinal exudates (e.g. cotton wool spots)
- ☐ • Retinal aneurysms
- ☐ • Retinal haemorrhages (including flame haemorrhages)
- ☐ • Retinal vessel thrombosis
- ☐ Other (please specify):



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**5. Ear Nose and Throat****Not involved** ☐

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**Please tick if present at any time since the onset of the current illness**

**SYMPTOMS**

- ☐ Jaw claudication
- ☐ Hearing loss or reduction
- ☐ Bloody nasal discharge
- ☐ Non blood stained nasal discharge
- ☐ Sino nasal congestion or blockage
- ☐ Loss of smell (anosmia)
- ☐ Loss of taste (ageusia)
- ☐ Other (please specify):

**CLINICAL FEATURES**

- ☐ Inflamed ear or nose cartilage
- ☐ Saddle nose deformity (nasal bridge collapse)
- ☐ Conductive hearing loss
- ☐ Sensorineural hearing loss
- ☐ Nasal polyps
- ☐ Nasal ulcers, mucosal abnormalities or crusting
- ☐ Nasal septal defect / perforation
- ☐ Hoarse voice/stridor
- ☐ Salivary gland enlargement
- ☐ Subglottic stenosis with no previous surgery
- ☐ Subglottic stenosis with prior surgery or intubation
- ☐ Other (please specify):

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## 6. Chest / Pulmonary

Not involved ☐

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Please tick if present at any time since the onset of the current illness

### SYMPTOMS

- ☐ Dyspnoea / Shortness of Breath
- ☐ Dry cough
- ☐ Moist cough but unable to expectorate sputum
- ☐ Productive cough with purulent sputum
- ☐ Minor haemoptysis (few streaks of blood only)
- ☐ Major haemoptysis (> 1 teaspoon of blood in a day)
- ☐ Sharp chest pain on inspiration
- ☐ Other (please specify):

### CLINICAL FEATURES

- ☐ Chest wall tenderness
- ☐ Crackles / râles on auscultation
- ☐ Wheeze or evidence of obstructive airways disease
- ☐ Respiratory compromise requiring oxygen
- ☐ Respiratory failure requiring intubation
- ☐ Other (please specify):

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**Lung Function****Not performed** ☐**Please tick if present on lung function testing at any time since the onset of the current illness**

- ☐ Restrictive airways disease
- ☐ Obstructive airways disease
- ☐ Reduced DLCO or KCO
- ☐ Increased KCO
- ☐ Other (specify):

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**Bronchoscopy****Not performed** ☐**Please tick if present on bronchoscopy at any time since the onset of the current illness**

- ☐ Mass or tumour
- ☐ Bronchitic changes or mucosal injury
- ☐ Friable mucosa
- ☐ Evidence of alveolar haemorrhage
- ☐ Blood stained broncho alveolar lavage
- ☐ Purulent or muco-purulent secretions
- ☐ Other (specify):

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## 7. Cardiovascular

**Not involved** ☐

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**Please tick if present at any time since the onset of the current illness**

### SYMPTOMS

- ☐ Angina / ischaemic cardiac pain
- ☐ Arm claudication
- ☐ Leg claudication
- ☐ Carotodynia (neck pain in the region of the carotid artery)
- ☐ Raynaud's phenomenon
- ☐ Other (please specify):

### CLINICAL FEATURES

- ☐ Any cardiac murmur
- ☐ Congestive cardiac failure / Cardiomyopathy
- ☐ Myocardial infarction confirmed by ECG or blood test results
- ☐ Other (please specify):

**Vascular Examination****No abnormality on vascular examination** ☐

Artery	Left					Right				
	Pulse		Tenderness	Bruit	Hard 'cord-like'	Pulse		Tenderness	Bruit	Hard 'cord-like'
	Diminished	Absent				Diminished	Absent			
<b>Temporal</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
<b>Carotid</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Subclavian</b>			<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	
<b>Axillary</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Brachial</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Radial</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Abdominal Aorta</b>			<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	
<b>Renal</b>				<input type="checkbox"/>					<input type="checkbox"/>	
<b>Femoral</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Popliteal</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Posterior tibial</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Dorsalis pedis</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

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## 8. Gastrointestinal

**Not involved** ☐

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**Please tick if present at any time since the onset of the current illness**

### SYMPTOMS

- ☐ Abdominal pain (any)
- ☐ Postprandial abdominal pain
- ☐ Claudication of tongue
- ☐ Diarrhoea
- ☐ Dysphagia (difficulty swallowing)
- ☐ Symptoms of GI blood loss (e.g. history of malena)
- ☐ Other (please specify):

### CLINICAL FEATURES

- ☐ Mouth ulcers
- ☐ Jaundice
- ☐ Peritonism (rigid abdomen with rebound tenderness)
- ☐ Acute pancreatitis confirmed by elevated amylase
- ☐ Chronic pancreatitis confirmed on blood tests and/or imaging
- ☐ Colitis confirmed by endoscopy
- ☐ Other (please specify):

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## 9. Genitourinary

**Not involved** ☐

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**Please tick if present at any time since the onset of the current illness**

### SYMPTOMS

- ☐ Macroscopic haematuria (blood visible in urine)
- ☐ Dysuria (pain with passing urine)
- ☐ Difficulty passing urine (e.g. due to urinary obstruction)
- ☐ Passing renal stone / calculi
- ☐ Flank Pain
- ☐ Testicular pain
- ☐ Other (please specify):

### CLINICAL FEATURES

- ☐ Testicular tenderness
- ☐ Testicular swelling
- ☐ Genital ulcers
- ☐ Other (please specify):

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**10. Neurologic****Not involved** ☐

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**Please tick if present at any time since the onset of the current illness**

**SYMPTOMS**

- ☐ Seizures
- ☐ Transient ischaemic attack (neurological symptoms consistent with brain ischaemia lasting less than 24 hours)
- ☐ Photophobia
- ☐ **New persistent headache (tick all that apply)**
  - ☐ Frontal
  - ☐ Occipital or cervical
  - ☐ Temporal
- ☐ Other (please specify):

**CLINICAL FEATURES**

- ☐ Cranial nerve palsy
- ☐ Relative afferent pupillary defect
- ☐ Meningism
- ☐ Motor neuropathy (not due to radiculopathy)
- ☐ Sensory neuropathy (not due to radiculopathy)
- ☐ Hemiparesis or hemiplegia
- ☐ Paraparesis or paraplegia
- ☐ Psychosis
- ☐ Other (please specify):



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**Vaccinations, Medications and Other Drugs****None apply** ☐**Please tick if recently used (current or less than 12 months before onset of illness)****VACCINATION**

- ☐ Influenza vaccine
- ☐ H1N1 (swine flu) vaccine
- ☐ Pneumococcal vaccine
- ☐ Hepatitis B vaccine
- ☐ Other Vaccine (specify):

--

**SPECIFIC MEDICATIONS (known to be associated with systemic vasculitis)**

- ☐ Allopurinol
- ☐ Carbimazole
- ☐ Clozapine
- ☐ Ergot derivative
- ☐ Hydralazine
- ☐ Methysergide
- ☐ Phenytoin
- ☐ Propylthiouracil (PTU)
- ☐ Sulfasalazine
- ☐ Leukotriene antagonist
- ☐ Any other specific medication(s) that you think may be causing patients **systemic** symptoms (not just skin vasculitis):

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**OTHER DRUGS**

- ☐ Cocaine
- ☐ Amphetamine or Methamphetamine
- ☐ Other sympathomimetics (e.g. ephedrine or pseudoephedrine)

**Biopsy****No biopsies were done** ☐

Please write down the number which corresponds to site/organ biopsied and indicate ALL findings that apply.

Site of biopsy Finding(s): Site of biopsy Finding(s): Site of biopsy Finding(s): Site of biopsy Finding(s): 

Site of biopsy	Findings	
1. None 2. Skin 3. Kidney 4. Temporal artery 5. ENT 6. Nerve 7. Muscle 8. Liver 9. Gut 10. Lung parenchyma 11. Bronchial 12. Heart 13. Brain/meningeal 14. Aorta 15. Bladder 16. Prostate 17. Bone marrow 18. Lymph node 19. Other	<b>General</b> 1. Not done 2. Normal 3. Non diagnostic 4. Biopsy consistent with vasculitis but not definite 5. Definite vasculitis  <b>Other findings</b> 6. Benign tumour 7. Malignant tumour 8. Abscess 9. Organisms seen on microscopy 10. Culture of microorganism from biopsy specimen 11. Unspecified tissue inflammation 12. Tissue fibrosis (e.g. liver or lung fibrosis) 13. Amyloid 14. Age related vascular changes  <b>Vascular specific findings</b> 15. Arteritis of any artery in a needle, punch or other small biopsy; or of the smallest arteries in a surgical specimen 16. Arteritis in medium sized arteries in a surgical specimen ( <u>excluding</u> needle and other small biopsies) 17. Arteritis of a large artery in a surgical specimen ( <u>excluding</u> needle and other small biopsies but including arterial segment biopsies, e.g. temporal artery) 18. Aortitis in a surgically removed aortic segment 19. Necrotizing arteritis with fibrinoid necrosis 20. Inflammatory arterial aneurysm 21. Necrotizing or leukocytoclastic arteriolitis 22. Necrotizing or leukocytoclastic venulitis 23. Perivascular inflammation <u>only</u> without vessel wall involvement in a specimen	24. Immune complex deposits in vessels other than glomeruli <u>with</u> prominent IgA 25. Immune complex deposits in vessels other than glomeruli <u>without</u> prominent IgA 26. Absence or paucity of immune complex deposits in vessels other than glomeruli 27. Granulomatous vasculitis 28. Giant cells in vasculitis 29. Prominent neutrophils in vasculitis 30. Prominent eosinophils in vasculitis 31. Predominantly mononuclear leukocytes in vasculitis 32. Vascular scarring consistent with vasculitis but no active inflammation 33. Fragmentation of the internal elastic lamina 34. Intimal thickening 35. Vascular thrombosis  <b>Organ Specific findings</b> 36. Pulmonary capillaritis or haemorrhage 37. Pauci-immune (≤2+ immunoglobulin) glomerulonephritis 38. Anti-GBM glomerulonephritis 39. Immune complex (>2+ immunoglobulin) glomerulonephritis 40. IgA-dominant Immune complex glomerulonephritis 41. Myelofibrosis or myelodysplasia  <b>Extra vascular findings</b> 42. <u>Extravascular</u> granulomatous inflammation 43. <u>Extravascular</u> eosinophil-predominant inflammation 44. <u>Extravascular</u> non granulomatous acute or chronic inflammation

**Laboratory tests – most representative of this illness & prior to treatment**

	Present	Absent	Not done
<b>HAEMATOLOGY</b>			
Significant anaemia (Haemoglobin < 10g/dL or 100 g/L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant thrombocytopenia (platelets <100 x 10 <sup>9</sup> /L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant thrombocythaemia (platelets >500 x 10 <sup>9</sup> /L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant leukopenia (Total WBC < 3.0 x 10 <sup>9</sup> /L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant elevation of WBC (Total WBC >15.0x10 <sup>9</sup> /L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant neutropenia (PMN <1.5x10 <sup>9</sup> /L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant neutrophilia (PMN >10x10 <sup>9</sup> /L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maximum eosinophil count ( x10 <sup>9</sup> /L) <input type="text"/>			<input type="checkbox"/>
Maximum ESR mm/hr <input type="text"/>			<input type="checkbox"/>
<b>BIOCHEMISTRY</b>			
Maximum CRP <input type="text"/> Units <input type="text"/>			<input type="checkbox"/>
Significant elevation of creatinine kinase (>500 IU/L)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AST (SGOT) or ALT (SGPT) >2x upper limit of normal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alkaline phosphatase >2x upper limit of normal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperglycaemia (glucose > 15 mmol/L or 270 mg/dL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maximum creatinine: <input type="text"/> Units <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Albumin below 30g/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Monoclonal gammopathy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**URINE TESTS**Not done ☐

	Present	Absent	Not done
Protein on urine dipstick*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood on urine dipstick*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
leucocytes or nitrites on urine dipstick*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red cell casts in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24 hour urine protein >1g/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Please tick <b>present</b> if there is $\geq$ a trace amount			

**CRYOGLOBULINS AND COMPLEMENT**Not done ☐

	Present	Absent	Not done
Cryoglobulins (please specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type I (monoclonal immunoglobulin)	<input type="checkbox"/>		
Type II (monoclonal RF (IgM) and polyclonal IgG)	<input type="checkbox"/>		
Type III (polyclonal RF (IgM) and polyclonal IgG)	<input type="checkbox"/>		
Low C3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low C4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**AUTOANTIBODIES**Not done ☐

	Present	Absent	Not done
cANCA on immunofluorescence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pANCA on immunofluorescence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PR3 ANCA (ELISA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MPO ANCA (ELISA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other ANCA (specify): <table border="1" style="display: inline-table; vertical-align: middle; width: 150px; height: 25px;"></table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti GBM antibodies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RF (Rheumatoid factor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ACPA (Anti CCP antibody)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANA (Anti nuclear antibody)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti dsDNA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENA (extractable nuclear antigen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ro (SS-A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
La (SS-B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RNP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scl-70	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jo 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-cardiolipin IgG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-cardiolipin IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti Beta- 2- glycoprotein 1 (B2GP1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**INFECTION SCREEN**Not done ☐

		Positive	Negative	Not done
Blood culture (organism):		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine culture (organism):		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sputum culture (organism):		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSF culture (organism):		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV test		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A (evidence of acute infection only)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B (evidence of acute or chronic infection)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C (evidence of acute or chronic infection)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CMV (evidence of acute or chronic infection)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EBV (evidence of acute or chronic infection)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lyme disease ( <i>Borrelia burgdorferi</i> )		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**OTHER LABORATORY INVESTIGATIONS**Not done ☐

		Present	Not done
CSF: elevated protein		<input type="checkbox"/>	<input type="checkbox"/>
CSF: oligoclonal bands		<input type="checkbox"/>	<input type="checkbox"/>
CSF: pleocytosis (increased white cell count in CSF)		<input type="checkbox"/>	<input type="checkbox"/>
CSF: xanthochromia (degraded blood in CSF indicating previous bleed)		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):		<input type="checkbox"/>	
Other (specify):		<input type="checkbox"/>	
Other (specify):		<input type="checkbox"/>	

**Vascular imaging (most representative for this illness)      Not done ☐**

Please write down the number which corresponds to modality of imaging used, vessel imaged and findings based on imaging. More than one abnormal finding is possible, please indicate ALL that apply. Circle the side imaging was performed. L=Left, R=Right, NA=Not applicable.

Imaging Modality:  Vessel:  Side: L/R/NA Finding(s):

Imaging Modality:  Vessel:  Side: L/R/NA Finding(s):

Imaging Modality:  Vessel:  Side: L/R/NA Finding(s):

Imaging Modality:  Vessel:  Side: L/R/NA Finding(s):

Imaging Modality	Vessel imaged		Findings
1. None	1. None	21. Pulmonary artery	1. Not done
2. CT	2. Temporal artery	22. Coronary arteries	2. Vessel narrowing
3. CT angiogram	3. Intracranial artery	23. Coronary sinus	3. Vessel occlusion
4. MRI	4. Retinal artery	24. Renal artery	4. Wall thickening
5. MR angiogram	5. Sagittal sinus or veins	25. Splenic artery	5. Delayed contrast enhancement
6. FDG-PET	6. Ascending thoracic aorta	26. Superior mesenteric artery	6. Enhanced FDG uptake
7. Digital Subtraction Angiogram (DSA)	7. Descending thoracic aorta	27. Inferior mesenteric artery	7. Aneurysm
8. Ultrasound	8. Abdominal aorta	28. Popliteal vein	8. Dissection
9. Fluorescein angiogram	9. Subclavian artery	29. Femoral vein	9. Beading or micro aneurysms
10. Echocardiogram	10. Axillary artery	30. Iliac vein	10. Calcification of vessel
	11. Carotid artery	31. Inferior vena cava	11. Thrombus present
	12. Radial artery	32. Superior vena cava	12. Halo sign positive
	13. Ulnar artery	33. Axillary vein	13. Normal
	14. Iliac artery	34. Other	14. Other
	15. Femoral artery		
	16. Popliteal artery		
	17. Posterior tibial artery		
	18. Dorsalis pedis artery		
	19. Distal hand artery		
	20. Distal foot artery		



**Other imaging (most representative for this illness) Not done ☐**

Please write down the number which corresponds to modality of imaging used, site imaged and imaging finding(s). More than one finding is possible, please indicate ALL that apply. (List is on opposite page) Use as many or as few boxes as required.

Imaging Modality: ☐ Site imaged: ☐ Finding(s): ☐ ☐ ☐ ☐

Imaging Modality: ☐ Site imaged: ☐ Finding(s): ☐ ☐ ☐ ☐

Imaging Modality: ☐ Site imaged: ☐ Finding(s): ☐ ☐ ☐ ☐

Imaging Modality: ☐ Site imaged: ☐ Finding(s): ☐ ☐ ☐ ☐

Imaging Modality: ☐ Site imaged: ☐ Finding(s): ☐ ☐ ☐ ☐

Imaging Modality: ☐ Site imaged: ☐ Finding(s): ☐ ☐ ☐ ☐

Imaging Modality: ☐ Site imaged: ☐ Finding(s): ☐ ☐ ☐ ☐

Imaging Modality: ☐ Site imaged: ☐ Finding(s): ☐ ☐ ☐ ☐

Imaging Modality: ☐ Site imaged: ☐ Finding(s): ☐ ☐ ☐ ☐

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## Other imaging (most representative for this illness)

Imaging Modality	Site imaged	Findings	
1. None	1. None	<b>General</b>	<b>Respiratory</b>
2. Plain radiograph	2. Whole body	1. Not done	33. Pulmonary infiltrate
3. CT	3. Brain	2. Normal	34. Airspace / Pulmonary consolidation
4. MRI	4. Head/Neck	3. Mass /tumour	35. Pleural effusion
5. MRCP	5. Whole spine	4. Metastasis	36. Pleural calcification
6. ERCP	6. Cervical spine	5. Abscess	37. Pulmonary nodules
7. FDG-PET	7. Thoracic spine	6. Haematoma	38. Pulmonary cavities
8. PET CT	8. Lumbar/sacral spine	7. Bony abnormality	39. Pericardial effusion
9. Isotope Bone scan	9. Chest	8. Enlarged lymph nodes (localised)	40. Alveolar haemorrhage
10. Ventilation/Perfusion scan	10. Heart	9. Enlarged lymph nodes (widespread)	41. Lung infarction
11. Echocardiogram	11. Abdomen	10. Soft tissue abnormality	42. Pulmonary hypertension
12. Ultrasound	a. Liver	<b>Head and neck</b>	<b>Heart</b>
13. Vascular Doppler	b. Gallbladder	11. Para nasal sinus inflammation	43. Myocardial infarction
14. Labelled white cell scan	c. Bowel	12. Other Para nasal sinus abnormality	44. Heart valve stenosis
	d. Spleen	13. Pachymeningitis	45. Heart valve incompetence
	e. Kidney	14. Brain haemorrhage	46. Heart valve vegetations or mass
	f. Retro peritoneum	15. Brain infarct	47. Cardiomegaly
	12. Pelvis	16. Brain patchy white matter ischaemia	48. Ventilation/Perfusion mismatch
	13. Arms / Hands	17. Spinal cord abnormality	49. Other soft tissue abnormality
	14. Legs /Feet	18. Orbital wall destruction	50. Other
		<b>Abdomen</b>	<b>Musculoskeletal</b>
		19. Bowel infarction	51. Joint space narrowing
		20. Thickened bowel wall (target sign)	52. Joint erosion
		21. Renal infarction	53. Skeletal muscle infarction
		22. Shrunken kidney	54. Muscle oedema
		23. Swollen/large kidney	55. Other Muscle abnormality
		24. Hydronephrosis	
		25. Splenomegaly	
		26. Enlarged liver	
		27. Shrunken liver	
		28. Liver infarction	
		29. Splenic infarction	
		30. Gallstones	
		31. Bile duct obstruction	
		32. Pancreatitis	

**BVAS v3 (Please tick all that apply for this illness, irrespective of aetiology)**

General? <input type="checkbox"/> Yes <input type="checkbox"/> No	ENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes:</b> <input type="checkbox"/> Myalgia <input type="checkbox"/> Arthralgia / arthritis <input type="checkbox"/> Fever $\geq 38^{\circ}\text{C}$ <input type="checkbox"/> Weight loss $\geq 2\text{kg}$	<b>If yes:</b> <input type="checkbox"/> Bloody nasal discharge / crusts / ulcers / granulomata <input type="checkbox"/> Paranasal sinus involvement <input type="checkbox"/> Subglottic stenosis <input type="checkbox"/> Conductive hearing loss <input type="checkbox"/> Sensorineural hearing loss	<b>If yes:</b> <input type="checkbox"/> Hypertension <input type="checkbox"/> Proteinuria $> 1+$ <input type="checkbox"/> Haematuria $\geq 10$ RBCs/hpf <input type="checkbox"/> Serum creatinine 125-249 $\mu\text{mol/L}^*$ <input type="checkbox"/> Serum creatinine 250-499 $\mu\text{mol/L}^*$ <input type="checkbox"/> Serum creatinine $\geq 500$ $\mu\text{mol/L}^*$ <input type="checkbox"/> Rise in serum creatinine $>30\%$ or fall in creatinine clearance $>25\%$ <small>* Can only be scored on the first assessment</small>
<b>Cutaneous? <input type="checkbox"/> Yes <input type="checkbox"/> No</b> <b>If yes:</b> <input type="checkbox"/> Infarct <input type="checkbox"/> Purpura <input type="checkbox"/> Ulcer <input type="checkbox"/> Gangrene <input type="checkbox"/> Other skin vasculitis	<b>Chest? <input type="checkbox"/> Yes <input type="checkbox"/> No</b> <b>If yes:</b> <input type="checkbox"/> Wheeze <input type="checkbox"/> Nodules or cavities <input type="checkbox"/> Pleural effusion / pleurisy <input type="checkbox"/> Infiltrate <input type="checkbox"/> Endobronchial involvement <input type="checkbox"/> Massive haemoptysis / alveolar haemorrhage <input type="checkbox"/> Respiratory failure	<b>Nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No</b> <b>If yes:</b> <input type="checkbox"/> Headache <input type="checkbox"/> Meningitis <input type="checkbox"/> Organic confusion <input type="checkbox"/> Seizures (not hypertensive) <input type="checkbox"/> Cerebrovascular accident <input type="checkbox"/> Spinal cord lesion <input type="checkbox"/> Cranial nerve palsy <input type="checkbox"/> Sensory peripheral neuropathy <input type="checkbox"/> Mononeuritis multiplex
<b>Mucous membranes / eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No</b> <b>If yes:</b> <input type="checkbox"/> Mouth ulcers <input type="checkbox"/> Genital ulcers <input type="checkbox"/> Adnexal inflammation <input type="checkbox"/> Significant proptosis <input type="checkbox"/> Scleritis / Episcleritis <input type="checkbox"/> Conjunctivitis / Blepharitis / Keratitis <input type="checkbox"/> Blurred vision <input type="checkbox"/> Sudden visual loss <input type="checkbox"/> Uveitis <input type="checkbox"/> Retinal changes (vasculitis / thrombosis / exudate / haemorrhage)	<b>Cardiovascular? <input type="checkbox"/> Yes <input type="checkbox"/> No</b> <b>If yes:</b> <input type="checkbox"/> Loss of pulses <input type="checkbox"/> Vascular heart disease <input type="checkbox"/> Pericarditis <input type="checkbox"/> Ischaemic cardiac pain <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Congestive cardiac failure	<b>Other? <input type="checkbox"/> Yes <input type="checkbox"/> No</b> <b>If yes, specify:</b> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Abdominal? <input type="checkbox"/> Yes <input type="checkbox"/> No</b> <b>If yes:</b> <input type="checkbox"/> Peritonitis <input type="checkbox"/> Bloody diarrhoea <input type="checkbox"/> Ischaemic abdominal pain	<b>PERSISTENT DISEASE ONLY*</b> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; vertical-align: middle;"></div> <div style="display: inline-block; vertical-align: middle; margin-left: 10px;">             Tick if ALL abnormalities are due to persistent disease.           </div>

**VDI (Please tick all that apply for this illness, irrespective of aetiology)**

Musculoskeletal? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes:</b> <input type="checkbox"/> Significant muscle atrophy or weakness <input type="checkbox"/> Deforming/erosive arthritis <input type="checkbox"/> Osteoporosis/vertebral collapse <input type="checkbox"/> Avascular necrosis <input type="checkbox"/> Osteomyelitis	<b>If yes:</b> <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Pulmonary fibrosis <input type="checkbox"/> Pulmonary infarction <input type="checkbox"/> Pleural fibrosis <input type="checkbox"/> Chronic asthma <input type="checkbox"/> Chronic breathlessness <input type="checkbox"/> Impaired lung function	<b>If yes:</b> <input type="checkbox"/> Gut infarction/resection <input type="checkbox"/> Mesenteric insufficiency / pancreatitis <input type="checkbox"/> Chronic peritonitis <input type="checkbox"/> Oesophageal stricture/surgery
Skin/Mucous membranes? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes:</b> <input type="checkbox"/> Alopecia <input type="checkbox"/> Cutaneous ulcers <input type="checkbox"/> Mouth ulcers	Cardiovascular? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes:</b> <input type="checkbox"/> Angina/angioplasty <input type="checkbox"/> Myocardial infarction <input type="checkbox"/> Subsequent myocardial infarction <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Valvular disease <input type="checkbox"/> Pericarditis $\geq$ 3 mths or pericardectomy <input type="checkbox"/> Diastolic BP $\geq$ 95 or requiring antihypertensives	Renal? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes:</b> <input type="checkbox"/> Estimated/measured GFR < 50% <input type="checkbox"/> Proteinuria > 0.5g/24hr <input type="checkbox"/> End stage renal disease
Ocular? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes:</b> <input type="checkbox"/> Cataract <input type="checkbox"/> Retinal change <input type="checkbox"/> Optic atrophy <input type="checkbox"/> Visual impairment/diplopia <input type="checkbox"/> Blindness in one eye <input type="checkbox"/> Blindness in second eye <input type="checkbox"/> Orbital wall destruction	Peripheral vascular disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes:</b> <input type="checkbox"/> Absent pulses in one limb <input type="checkbox"/> 2 <sup>nd</sup> episode of absent pulses in one limb <input type="checkbox"/> Major vessel stenosis <input type="checkbox"/> Claudication >3 mths <input type="checkbox"/> Minor tissue loss <input type="checkbox"/> Major tissue loss <input type="checkbox"/> Subsequent major tissue loss <input type="checkbox"/> Complicated venous thrombosis	Neuropsychiatric? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes:</b> <input type="checkbox"/> Cognitive impairment <input type="checkbox"/> Major psychosis <input type="checkbox"/> Seizures <input type="checkbox"/> Cerebrovascular accident <input type="checkbox"/> 2nd cerebrovascular accident <input type="checkbox"/> Cranial nerve lesion <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Transverse myelitis
ENT? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes:</b> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Nasal blockage/chronic discharge/crusting <input type="checkbox"/> Nasal bridge collapse/septal perforation <input type="checkbox"/> Chronic sinusitis/radiological damage <input type="checkbox"/> Subglottic stenosis (no surgery) <input type="checkbox"/> Subglottic stenosis (with surgery)		Other? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes:</b> <input type="checkbox"/> Gonadal failure <input type="checkbox"/> Chemical cystitis <input type="checkbox"/> Marrow failure <input type="checkbox"/> Malignancy <input type="checkbox"/> Diabetes <input type="checkbox"/> Other
		<b>Total VDI Score*</b> <input type="checkbox"/> Record the number of positive items (1 point for each).

## Working Diagnosis – Baseline

**Do you think that the patient's current illness is due to:**

- |                                    |                          |                                     |
|------------------------------------|--------------------------|-------------------------------------|
| <b>Primary systemic vasculitis</b> | <input type="checkbox"/> | Please answer section A and B       |
| <b>Secondary vasculitis</b>        | <input type="checkbox"/> | Please answer section C (next page) |
| <b>Other illness</b>               | <input type="checkbox"/> | Please answer section C (next page) |

**A. In your opinion, what is this patient's diagnosis?**

<input type="checkbox"/> Takayasu arteritis  <input type="checkbox"/> Giant cell arteritis  <input type="checkbox"/> Isolated Aortitis  <input type="checkbox"/> Other large vessel vasculitis  <input type="checkbox"/> Single organ vasculitis: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Systemic granulomatous vasculitis (Wegener's granulomatosis)  <input type="checkbox"/> Microscopic polyangiitis  <input type="checkbox"/> Churg- Strauss syndrome  <input type="checkbox"/> Polyarteritis nodosa  <input type="checkbox"/> Other small vessel vasculitis : <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Behçet's disease  <input type="checkbox"/> Other primary vasculitis with no specific vessel size  <input type="checkbox"/> Henoch-Schönlein purpura  <input type="checkbox"/> Cryoglobulinaemic vasculitis
---	---	---

**B. How confident are you about the diagnosis? (tick one box only)**

- |                          |                                |
|--------------------------|--------------------------------|
| <input type="checkbox"/> | Very certain (75% or more)     |
| <input type="checkbox"/> | Moderately certain (50%-74%)   |
| <input type="checkbox"/> | Uncertain (25%-49%)            |
| <input type="checkbox"/> | Very uncertain (less than 25%) |



**C. If not primary systemic vasculitis, what is underlying diagnosis for this illness?**

<b>Dermatologic</b> <input type="checkbox"/> Livedoid vasculopathy <input type="checkbox"/> Ischaemic skin lesion not due to vasculitis* <input type="checkbox"/> Non-ischaemic skin lesion <input type="checkbox"/> Other dermatologic*	<b>Infectious Disease</b> <input type="checkbox"/> Bacterial endocarditis / bacteraemia <input type="checkbox"/> Bacterial or viral pneumonia <input type="checkbox"/> Eosinophilic pneumonia <input type="checkbox"/> Upper respiratory tract infection <input type="checkbox"/> Urinary tract Infection <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other infection*	<b>Respiratory</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Airway stenosis not due to vasculitis* <input type="checkbox"/> Cavitary lung lesion not due to vasculitis* <input type="checkbox"/> Chronic obstructive pulmonary disease <input type="checkbox"/> Other respiratory*
<b>Endocrine/Metabolic</b> <input type="checkbox"/> Calciophylaxis <input type="checkbox"/> Scurvy <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Other endocrine/metabolic*	<b>Malignancy</b> <input type="checkbox"/> Solid malignancy* <input type="checkbox"/> Hematologic malignancy*	<b>Rheumatologic</b> <input type="checkbox"/> Antiphospholipid antibody syndrome <input type="checkbox"/> Polymyositis/Dermatomyositis <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Systemic lupus erythematosus <input type="checkbox"/> Sjögren's syndrome <input type="checkbox"/> Other Connective Tissue *
<b>Gastrointestinal</b> <input type="checkbox"/> Mesenteric ischaemia <input type="checkbox"/> Other gastrointestinal*	<b>Neurologic</b> <input type="checkbox"/> Guillain-Barre syndrome <input type="checkbox"/> Hearing loss not due to vasculitis* <input type="checkbox"/> Migraine or other headache syndrome <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Myasthenia gravis <input type="checkbox"/> Neurodegenerative disorder <input type="checkbox"/> Neuropathy not due to vasculitis* <input type="checkbox"/> Stroke not due to vasculitis* <input type="checkbox"/> Other neurologic*	<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other inflammatory arthritis* <input type="checkbox"/> Periodic fever syndrome <input type="checkbox"/> Other rheumatologic*
<b>Genitourinary</b> <input type="checkbox"/> Nephrolithiasis <input type="checkbox"/> Nephritic / nephrotic syndrome (non-vasculitic)* <input type="checkbox"/> Other genitourinary*	<input type="checkbox"/> Ophthalmologic <input type="checkbox"/> Vision loss not due to vasculitis* <input type="checkbox"/> Other ophthalmologic*	<b>Vascular</b> <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Fibromuscular Dysplasia <input type="checkbox"/> Thromboangiitis obliterans (Buerger's disease) <input type="checkbox"/> Other vascular*
<b>Haematology</b> <input type="checkbox"/> Coagulopathy / Thrombosis <input type="checkbox"/> Hypereosinophilic Syndrome <input type="checkbox"/> Multiple myeloma /paraproteinemia <input type="checkbox"/> Systemic amyloidosis <input type="checkbox"/> Thrombotic thrombocytopenic purpura <input type="checkbox"/> Other haematologic*	<input type="checkbox"/> Other *	<input type="checkbox"/> <b>Toxic</b> <input type="checkbox"/> Cocaine-induced disease <input type="checkbox"/> Other drug-induced disease*

\*Please provide as precise a diagnosis as you can:

## DCVAS STUDY 6 MONTH UPDATE

Today's date:

D	D	/	M	M	M	/	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---	---

Is the patient still alive?

Yes

☐

Please answer section 2 and 3

No

☐

Please answer section 1, 2 and 3

Don't know

☐

What was the date of last follow up?

D	D	/	M	M	M	/	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---	---

Please answer section 2 and 3

### Section 1: Date and cause of death

Date of death:

D	D	/	M	M	M	/	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---	---

Cause of Death:

☐ Pulmonary Haemorrhage☐ Renal Failure☐ Myocardial infarction☐ Stroke☐ Malignancy (please specify):☐ Infection (please specify):☐ Unknown☐ Other (please specify):

## Section 2:      Diagnosis at 6 months

**Do you think that the patient's current illness is due to:**

- |                                    |                          |                                     |
|------------------------------------|--------------------------|-------------------------------------|
| <b>Primary systemic vasculitis</b> | <input type="checkbox"/> | Please answer section A and B       |
| <b>Secondary vasculitis</b>        | <input type="checkbox"/> | Please answer section C (next page) |
| <b>Other illness</b>               | <input type="checkbox"/> | Please answer section C (next page) |

### A. In your opinion, what is this patient's diagnosis?

<input type="checkbox"/> Takayasu arteritis  <input type="checkbox"/> Giant cell arteritis  <input type="checkbox"/> Isolated Aortitis  <input type="checkbox"/> Other large vessel vasculitis  <input type="checkbox"/> Single organ vasculitis: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Systemic granulomatous vasculitis (Wegener's granulomatosis)  <input type="checkbox"/> Microscopic polyangiitis  <input type="checkbox"/> Churg- Strauss syndrome  <input type="checkbox"/> Polyarteritis nodosa  <input type="checkbox"/> Other small vessel vasculitis : <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Behçet's disease  <input type="checkbox"/> Other primary vasculitis with no specific vessel size  <input type="checkbox"/> Henoch-Schönlein purpura  <input type="checkbox"/> Cryoglobulinaemic vasculitis
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### B. How confident are you about the diagnosis? (tick one box only)

- |                          |                                |
|--------------------------|--------------------------------|
| <input type="checkbox"/> | Very certain (75% or more)     |
| <input type="checkbox"/> | Moderately certain (50%-74%)   |
| <input type="checkbox"/> | Uncertain (25%-49%)            |
| <input type="checkbox"/> | Very uncertain (less than 25%) |

**If the diagnosis has changed from baseline, please answer section 3**



**C. If not primary systemic vasculitis, what is underlying diagnosis for this illness?**

<b>Dermatologic</b> <input type="checkbox"/> Livedoid vasculopathy <input type="checkbox"/> Ischaemic skin lesion not due to vasculitis* <input type="checkbox"/> Non-ischaemic skin lesion <input type="checkbox"/> Other dermatologic*	<b>Infectious Disease</b> <input type="checkbox"/> Bacterial endocarditis / bacteraemia <input type="checkbox"/> Bacterial or viral pneumonia <input type="checkbox"/> Eosinophilic pneumonia <input type="checkbox"/> Upper respiratory tract infection <input type="checkbox"/> Urinary tract Infection <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other infection*	<b>Respiratory</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Airway stenosis not due to vasculitis* <input type="checkbox"/> Cavitory lung lesion not due to vasculitis* <input type="checkbox"/> Chronic obstructive pulmonary disease <input type="checkbox"/> Other respiratory*
<b>Endocrine/Metabolic</b> <input type="checkbox"/> Calciphylaxis <input type="checkbox"/> Scurvy <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Other endocrine/metabolic*	<b>Malignancy</b> <input type="checkbox"/> Solid malignancy* <input type="checkbox"/> Hematologic malignancy*	<b>Rheumatologic</b> <input type="checkbox"/> Antiphospholipid antibody syndrome <input type="checkbox"/> Polymyositis/Dermatomyositis <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Systemic lupus erythematosus <input type="checkbox"/> Sjögren's syndrome <input type="checkbox"/> Other Connective Tissue *
<b>Gastrointestinal</b> <input type="checkbox"/> Mesenteric ischaemia <input type="checkbox"/> Other gastrointestinal*	<b>Neurologic</b> <input type="checkbox"/> Guillain-Barre syndrome <input type="checkbox"/> Hearing loss not due to vasculitis* <input type="checkbox"/> Migraine or other headache syndrome <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Myasthenia gravis <input type="checkbox"/> Neurodegenerative disorder <input type="checkbox"/> Neuropathy not due to vasculitis* <input type="checkbox"/> Stroke not due to vasculitis* <input type="checkbox"/> Other neurologic*	<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other inflammatory arthritis* <input type="checkbox"/> Periodic fever syndrome <input type="checkbox"/> Other rheumatologic*
<b>Genitourinary</b> <input type="checkbox"/> Nephrolithiasis <input type="checkbox"/> Nephritic / nephrotic syndrome (non-vasculitic)* <input type="checkbox"/> Other genitourinary*	<input type="checkbox"/> Ophthalmologic <input type="checkbox"/> Vision loss not due to vasculitis* <input type="checkbox"/> Other ophthalmologic*	<b>Vascular</b> <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Fibromuscular Dysplasia <input type="checkbox"/> Thromboangiitis obliterans (Buerger's disease) <input type="checkbox"/> Other vascular*
<b>Haematology</b> <input type="checkbox"/> Coagulopathy / Thrombosis <input type="checkbox"/> Hypereosinophilic Syndrome <input type="checkbox"/> Multiple myeloma /paraproteinemia <input type="checkbox"/> Systemic amyloidosis <input type="checkbox"/> Thrombotic thrombocytopenic purpura <input type="checkbox"/> Other haematologic*	<input type="checkbox"/> Other *	<b>Toxic</b> <input type="checkbox"/> Cocaine-induced disease <input type="checkbox"/> Other drug-induced disease*

\*Please provide as precise a diagnosis as you can:

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### Section 3: Reasons for change in diagnosis

(Only answer this section if diagnosis has changed from baseline)

**What factors influenced the change in diagnosis? (please tick all that apply)**

☐ Evolution of patients symptoms or signs

☐ Radiology result(s)

☐ Biopsy result(s)

☐ Laboratory test result(s)

☐ Post mortem examination

☐ Other (please specify):

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