Neonatal Varicella Infection

Australian Paediatric Surveillance Unit

If you have any questions about this form, please contact the APSU (02) 9845 3005
or email SCHN-APSU@health.nsw.gov.au

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

APSU Office Use Only

Study ID #:

Month/Year Report:

Version: 2.1 17-08-2022

REPORTING CLINICIAN

1. APSU Dr Code/Name: ☐☐☐☐ / _____

2. Month/Year of Report: _____ / ___ ___ ___ ___

3. Date questionnaire completed: ___ ___ / ___ ___ / ___ ___ ___ ___

PATIENT

4. First 2 letters of first name: ☐☐

5. First 2 letters of surname: ☐☐

6. Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

7. Sex: ☐ M ☐ F

8. Post code: ☐☐☐☐

9. Date of diagnosis: ☐☐ month / ☐☐ year

10. Birth weight *(if known):* _____ grams

11. Gestational age at birth *(if known):* _____ weeks

12. Country of Birth: ☐ Australia ☐ Other, specify: _____ ☐ DK

13. Mother's country of birth: ☐ Australia ☐ Other, specify: _____ ☐ DK

14. Father's country of birth: ☐ Australia ☐ Other, specify: _____ ☐ DK

15. Is the child of Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No ☐ DK

If this patient is primarily cared for by another physician whom you believe will report the case, please write the other physician's name and complete questionnaire details above this line and return.

If no other report is received for this child we will contact you for further information.

Please keep the patient's name and other details on your APSU file.

The primary clinician caring for this child is: ***Name:*** ***Hospital:***

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

Section A: Diagnosis of neonatal varicella infection

16. How was varicella infection diagnosed in the infant? ☐ Clinical ☐ Laboratory ☐ Both

17. If laboratory, which tests were +ve? *(tick all that apply)* ☐ Culture ☐ PCR ☐ EM ☐ IF ☐ Serology

xx. Has varicella genotyping being performed ☐ Yes ☐ No ☐ DK

If Yes, Type: _____

If NOT, is there any leftover specimen available for Genotyping? ☐ Yes ☐ No ☐ DK

18. a. Give age when illness commenced: _____

b. Approximate duration of illness: _____ days

c. Did the infant spend time in hospital due to varicella? ☐ Yes ☐ No ☐ DK

If yes, number of days in hospital: _____ days

e. Was the infant admitted to ICU/HDU? ☐ Yes ☐ No ☐ DK

If yes, number of days in ICU/HDU _____ days

Section B: Clinical Features that can be attributed to varicella

19. Did the child have any of the following: *(tick all that apply)*

a. Skin lesions consistent with varicella	☐ Yes	☐ No	☐ DK
b. Bacteraemia / septic shock	☐ Yes	☐ No	☐ DK
c. Toxic shock / toxin mediated disease	☐ Yes	☐ No	☐ DK
d. Necrotising fasciitis	☐ Yes	☐ No	☐ DK
e. Encephalitis	☐ Yes	☐ No	☐ DK
f. Purpura fulminans	☐ Yes	☐ No	☐ DK
g. Disseminated coagulopathy	☐ Yes	☐ No	☐ DK
h. X-Ray evidence of pneumonia	☐ Yes	☐ No	☐ DK
i. Fulminant varicella (multi-organ involvement)	☐ Yes	☐ No	☐ DK
j. Reye's Syndrome	☐ Yes	☐ No	☐ DK
k. Hepatitis	☐ Yes	☐ No	☐ DK
l. Other	_____		

20. If there is/was concurrent or secondary infection state site of infection, sample type and organism:

Site	Sample Type	Organism
e.g. brain	*e.g. CSF*	*e.g. Staphylococcus Aureus*

Section C. Underlying medical conditions

21. Is the patient immunocompromised? ☐ Yes ☐ No ☐ DK

If yes, specify: _____

22. Has the patient any other significant underlying illness? ☐ Yes ☐ No ☐ DK

If yes, specify: _____

Section D. Management

23. Did the child receive any specific treatment? ☐ Yes ☐ No ☐ DK

If No/DK, go to section E

24. Antiviral agent? ☐ Yes ☐ No ☐ DK

☐ Aciclovir	Date of first dose: _____	Dose: _____	Date ceased: _____
☐ Famiciclovir	Date of first dose: _____	Dose: _____	Date ceased: _____
☐ Valaciclovir	Date of first dose: _____	Dose: _____	Date ceased: _____

25. Zoster Immune Globulin? ☐ Yes ☐ No ☐ DK Date: _____

26. Other treatments? ☐ Yes ☐ No ☐ DK

If yes, describe: _____

_____

Section E. Outcome

27. What is the patient's current status?

☐ Still hospitalised **GO TO Q28**

☐ Dead **GO TO Q27a**

☐ Discharged alive **GO TO Q27b**

(a) If the child died, was varicella, or its complications, a cause of death? ☐ Yes ☐ No ☐ DK

(b) If the child was discharged, were there any ongoing problems on discharge? ☐ Yes ☐ No ☐ DK

Specify: _____

Section F. About Exposure to Varicella of Mother and Infant

28. Was there a history of varicella exposure for the infant? ☐ Intrauterine ☐ Postnatal ☐ No ☐ DK

If intrauterine, go to question 29.
If postnatal, go to Question 32.
If No/DK, questionnaire is finished.

29. During pregnancy, did the mother have contact with someone infected with varicella? ☐ Yes ☐ No ☐ DK
If Yes, gestation in weeks from LMP: _____ weeks

30. Was maternal varicella infection confirmed by laboratory testing? ☐ Yes ☐ No ☐ DK
If Yes, which laboratory tests were +ve? ☐ Culture ☐ PCR ☐ EM ☐ IF ☐ Serology

31. Did the mother have a varicella-like illness in Pregnancy? ☐ Yes ☐ No ☐ DK
(a) ***If yes***, stage of pregnancy in weeks from LMP: _____ weeks
(b) What treatment was provided to the mother for the varicella-like illness?
☐ Zoster immune globulin ☐ Aciclovir
☐ Famciclovir ☐ Valaciclovir
☐ None ☐ DK
☐ Other *(specify):* _____

32. Who was the contact? (eg. friend, relative) _____
If Contact was a child please give age: _____ or ☐ DK

33. Was this contact living in the same household as the mother or affected infant? ☐ Yes ☐ No ☐ DK

34. Was the contact vaccinated against varicella? ☐ Yes ☐ No ☐ DK

Thank you for your assistance with this research project

Please return this questionnaire to the APSU via email to SCHN-APSU@health.nsw.gov.au
or by mail to: Australian Paediatric Surveillance Unit, Kids Research, Locked Bag 4001, Westmead NSW 2145
or via Fax: (02) 9845 3082

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This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines