Neonatal and Young Infant HSV Infection Questionnaire

Australian Paediatric Surveillance Unit (V1- 2017)

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

APSU Office Use Only	
Study ID #:	
Month/Year Report:	
Version 1.0: Date 11//11/2016	

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;

REPORTING CLINICIAN'S DETAILS **1.** APSU Dr Code/Name: __ __ ___ __ /_____ **2**. Date questionnaire completed: __ _/__ __/__ __ __ __

PATIENT DETAILS

3. First 2 letters of first name: __ __ **4.** First 2 letters of surname: __ __ **5.** Date of Birth: __ __ / __ __ / __ __ __ __

6. Sex: ☐ Male ☐ Female **7.** Postcode of family: __ __ __ __ **8.** Racial Background *(select all that apply)*: ☐ Aboriginal ☐ Caucasian ☐ Pacific Islander ☐ Torres Strait Islander ☐ African ☐ Asian ☐ DK ☐ Other *(specify):* _____

9. Country of birth of the child: ☐ Australia ☐ Other *(specify)*: _____

10. Did you make the diagnosis of primary HSV infection? ☐ Yes ***(please go to Q11)*** ☐ No – if this patient is primarily cared for by another physician who you believe could provide additional details, please write their name below and return this form to the APSU. If no other report is received for this child we will contact you for further information. Physician's
Name:_____
Clinic/hospital:_____

11. Date patient first seen by you__ __ / __ __ / __ __ __ __

MATERNAL

12. Mother's age in years ☐☐ 13. Mother's country of birth ☐ Australia ☐ Other: .....
14. Number of previous pregnancies: ..... 15. Number of previous deliveries: .....

Birth details

16. Birth weight (grams) ☐☐☐☐ 17. Gestational age at birth ☐☐ completed weeks
18. Multiple Birth? ☐ Yes ☐ No If yes, specify birth order (e.g. Twin 2) .....
19. Delivery: ☐ Vaginal - no instruments ☐ Instrumental vaginal ☐ Caesarean
20. Time between membrane rupture and delivery ☐☐ hours ☐ DK 21. Was a scalp monitor applied? ☐ Yes ☐ No ☐ DK
22. Age baby first saw a doctor with manifestations of possible HSV infection ? ☐☐ months or ☐☐ days

Clinical Manifestations in the Infant

23. Please indicate where (in which system) clinical signs were noted and age (in days) when these first manifested

			Age of onset (months or days)	
(a)Skin, or Mouth	☐ Yes	☐ No	☐☐ months	☐☐ days
(a) Eyes	☐ Yes	☐ No	☐☐ months	☐☐ days
(bi) Seizures,	☐ Yes	☐ No	☐☐ months	☐☐ days
(bii) Irritability	☐ Yes	☐ No	☐☐ months	☐☐ days
(biii) Lethargy	☐ Yes	☐ No	☐☐ months	☐☐ days
(biv) Apnoea	☐ Yes	☐ No	☐☐ months	☐☐ days
(c)Respiratory (e.g. pneumonitis)	☐ Yes	☐ No	☐☐ months	☐☐ days
(d)Hepatic (i.e. Elevated liver function tests, jaundice)	☐ Yes	☐ No	☐☐ months	☐☐ days
(e)Bleeding or DIC	☐ Yes	☐ No	☐☐ months	☐☐ days
(f)Cardiac (e.g. hypotension, poor perfusion)	☐ Yes	☐ No	☐☐ months	☐☐ days
(g)Fever (>37°C)	☐ Yes	☐ No	☐☐ months	☐☐ days
(h)Other (specify)	☐ Yes	☐ No	☐☐ months	☐☐ days

Investigations on Infant

If these specimens were sent please complete the results (or write "ND" for Not Done or DK FOR Don't know)

24. HSV typing (on any sample)?	☐ HSV 1	☐ HSV 2	☐ Not done	☐ DK	
25. HSV PCR positive surface swab or respiratory?	☐ Yes	☐ No	☐ Not done	☐ DK	Site(s). .....
26. HSV CSF PCR positive?	☐ Yes	☐ No	☐ Not done	☐ DK	Site(s) .....
27. HSV Blood PCR positive?	☐ Yes	☐ No	☐ Not done	☐ DK	Site(s) .....
28. HSV Immunofluorescence positive?	☐ Yes	☐ No	☐ Not done	☐ DK	Site(s) .....
29. HSV Isolated on Viral culture?	☐ Yes	☐ No	☐ Not done	☐ DK	Site(s) .....

Other CSF Examination Results?

30. Was a lumbar puncture performed at diagnosis? ☐ Yes ☐ No ☐ DK If YES, Date ...../...../.....

31. If YES, Number of CSF white cells/mm^3 ☐☐☐☐☐ Number of CSF red cells/mm^3 ☐☐☐☐☐

Treatment, follow up investigations, and prophylaxis of the Infant

32. Was the baby treated for HSV infection? ☐ Yes ☐ No ☐ DK If YES please provide details

DRUG Used	Age when started		Dose mg/ kg/ per/ day	Route	Duration (days)
	months	days			

33. Were antiviral drugs given as prophylaxis to prevent recurrence after treatment course completed? ☐ Yes ☐ No ☐ DK If YES please provide details:

DRUG Used	Age when started		Dose mg/ kg/ per/ day	Route	Duration (days)
	months	days			

34. Was a lumbar puncture performed at the end of antiviral therapy? ☐ Yes ☐ No ☐ DK If YES, Date ……/……/……..

35. If YES, Number of CSF white cells/mm^3 ☐☐☐☐☐ Number of CSF red cells/mm^3 ☐☐☐☐☐

CSF HSV PCR result: ☐ Positive ☐ Negative Not Done ☐

36. Convalescent CSF HSV IgG and IgM: (specify result) …… Date ……/……/……..

Cerebral imaging /EEG on Infant

37. CNS imaging performed? ☐ Yes ☐ No

38. IF Yes, CNS Imaging modality ☐ Ultrasound ☐ CT scan ☐ MRI scan ☐ Other (Specify)……

39. CNS Imaging result ☐ Normal ☐ Abnormal ☐ Not Done Date of scan ☐☐/☐☐/☐☐

Please specify result ……

40. EEG performed? ☐ Yes ☐ No

41. IF Yes, EEG Results ☐ Normal ☐ Abnormal Date of scan ☐☐/☐☐/☐☐

Please specify result ……

Outcome at this presentation

42. Infant: survived? YES ☐ NO ☐ 43. If died, Date of death ☐☐/☐☐/☐☐

44. If survived, were there obvious sequelae at discharge: ☐ Yes ☐ No ☐ DK

If yes, please specify ……

Source of infection

Genital Herpes	**Mother**	**Father**	**Other maternal sexual partner**
45. No known genital herpes at any time	☐	☐	☐
46. Genital herpes before (& during) this pregnancy	☐	☐	☐
47. Genital herpes during this pregnancy for first time	☐	☐	☐
48. Genital herpes diagnosed first time after delivery	☐	☐	☐
49. Other ……	☐	☐	☐

Non-Genital Herpes	**Mother**	**Father**	***Other (please specify)**
50. Past history of non genital herpes (oral or whitlow)	☐	☐	☐ ……
51. Oral herpes at or soon after delivery	☐	☐	☐ ……
52. Herpetic whitlow at or soon after delivery	☐	☐	☐ ……

**other = contact other than parent eg; Hospital staff /Sibling/Relative.*

53. Was Maternal antiviral therapy given during pregnancy? ☐ Yes ☐ No ☐ DK

54. If YES, please provide details

DRUG Used	Dose mg/ kg/ per/ day	Route	Duration (days)

Maternal Investigations:

55. Was the mother's HSV type specific antibody status tested? Yes ☐ No ☐

IF YES a) HSV-1 IgM Positive ☐ Negative ☐ Indeterminate ☐ Date ……/……/……..

b) HSV-1 IgG Positive ☐ Negative ☐ Indeterminate ☐ Date ……/……/……..

c) HSV-2 IgM Positive ☐ Negative ☐ Indeterminate ☐ Date ……/……/……..

d) HSV-2 IgG Positive ☐ Negative ☐ Indeterminate ☐ Date ……/……/……..

Thank you for your help with this research project. Please return this questionnaire to the APSU in the reply-paid envelope or fax to 02 9845 3082. Australian Paediatric Surveillance Unit, Kids Research Institute, Locked Bag 4001, Westmead NSW 2145. This study is supported by a grant from the Australian Department of Health. This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines.