



Australian Paediatric Surveillance Unit

Influenza Surveillance 1st June to 30th September 2017

The Department of Health has requested for APSU to conduct seasonal surveillance for severe complications of laboratory confirmed influenza in children aged < 15 years and admitted to hospital. This surveillance will inform future vaccination policy and improve our understanding of severe influenza disease in children.

Severe Complications of Influenza will be added to the routine monthly APSU report card. However, we ask that you report children that meet the case definition criteria as soon as possible by e-mail, fax or phone and return the case report form on the reverse of this page or complete an on-line version of the case report form.

Aim: To document the clinical features, medical and vaccination history, and outcome of children admitted to hospital with severe complications of influenza

Case Definition:

Any child aged < 15 years with laboratory confirmed influenza AND admitted to hospital AND who have at least one of the following complications:

- Pneumonia (Confirmed on X-ray or microbiology)
- Oxygen requirement
- Mechanical ventilation
- Laboratory proven secondary bacterial co infection; Bacteraemia; Septicaemia;
- Encephalitis / encephalopathy
- Seizures (including simple febrile seizure, prolonged or focal seizure or status epilepticus)
- Transverse myelitis
- Polyneuritis/ mononeuritis
- Guillain-Barré syndrome
- Reye Syndrome
- Myocarditis; Pericarditis; Cardiomyopathy
- Rhabdomyolysis
- Purpura fulminans
- Disseminated coagulopathy
- Shock (requiring >40 ml/kg fluid resuscitation)
- Acute renal failure
- Death, including death at presentation to hospital

Please do not report children hospitalized for influenza who do not have severe complications

If you have seen a case of severe hospitalized influenza please report the child to the APSU as soon as possible by **phone 02 98453005**; email schn-apsu@health.nsw.gov.au or **fax: 02 98453082**

Please use this **secure web link to an on-line case report form**
<https://redcap.sydney.edu.au/surveys/?s=XKK7X84LNX>

OR please complete the case report form overleaf and fax back to APSU: 02 98453082

Additional case report forms may be downloaded from: www.apsu.org.au

If you need assistance with this surveillance study please contact the APSU

Please turn over for the case report form...

Severe Influenza in children < 15 Years (June to September 2017)**Australian Paediatric Surveillance Unit**Please ring the APSU 02 9845 3005 if you have any questions about this questionnaire. Additional questionnaires can be downloaded www.apsu.org.au**Instructions:** Please answer each question by ticking the appropriate box or writing your response in the space provided. DK= Don't Know.....**REPORTING CLINICIANS** 1. Dr Name: _____ Ph: _____ Email: _____2. Hospital: _____ APSU code (if have one) _____ 3. Date questionnaire completed: //**PATIENT DETAILS:** 4. First 2 letters of first name: 5. First 2 letters of surname: 6. Date of Birth: //7. Sex: M F 8. Postcode of family: 9. Country of Birth: Australia Other specify _____ DK10. Ethnicity: Aboriginal Torres Strait Islander Both Aboriginal and Torres Strait Islander Caucasian
Asian Pacific Islander Middle Eastern African Other (specify) _____**SECTION A: Diagnosis, Presentation and Treatment**11. Date of onset of symptoms: // 12. Date of 1st admission to hospital: //13. Admitted to ICU? Yes No DK 13(a). If yes, specify date of admission to ICU: //14. How was influenza confirmed? Nose swab Nasopharyngeal aspirate Other (specify): _____15. Which lab tests were +ve for influenza? PCR IF Serology Rapid Antigen Test16. Results: Influenza type? A B 17. Was further sub-typing done? Yes No DK

18. If Yes, Which sub-type was present? (eg. H1N1-09, H3N2, Shanghai-like, Malaysia-like) _____

19. Which of the following symptoms were apparent on presentation to hospital?

- Fever
- Cough
- Dyspnoea
- Sore throat
- Vomiting
- Diarrhoea
- Headache
- Malaise/lethargy
- Myalgia
- Confusion/disorientation
- Seizure/unconsciousness
- Rash
- Other (specify) _____

20. Please tick all complications present during the hospital stay

- Pneumonia (X-ray confirmed) Oxygen therapy needed?
- Mechanical Ventilation? If yes, for how long? _____ Days
- Encephalitis / encephalopathy
- Seizure: (specify type): _____
- Myocarditis Pericarditis Cardiomyopathy
- Rhabdomyolysis
- Purpura fulminans Disseminated coagulopathy
- Transverse myelitis Polyneuritis mononeuritis
- Guillain-Barré syndrome
- Shock (requiring >40 ml/kg fluid resuscitation)
- Acute renal failure Reye's Syndrome
- Laboratory proven **bacterial co-infection**; Specify organism and site: _____
- Laboratory proven **viral co-infection**; Specify organism and site: _____

21. Any other complications? Yes No DK If Yes, specify: _____22. Was the child treated with: (a). Tamiflu Relenza Neither DK Date Commenced: //(b). Antibiotics If yes, which ones? _____ (c). Ibuprofen (e.g. Nurofen) Other NSAIDS Aspirin**SECTION B: Underlying medical conditions and history**23. Is the child immunocompromised (eg. HIV+ve, primary immunodeficiency, treated for malignancy)? Yes No DK

If Yes, specify _____

24. Has the child any other chronic illness that might increase the risk of influenza complications? Yes No DK If yes, which one(s)? Cystic fibrosis Congenital heart disease Neuromuscular disorder Asthma Other chronic lung disease Other (Specify) _____25. Did the child receive the Flu vaccine in the last 12 months? Yes No DK If yes, when? _____ DK 26. If yes which vaccine? _____ DK 27. Has the child been vaccinated against pneumococcus? Yes No DK If yes, when? _____ DK 28. Prior to admission did the child have contact with a person with lab confirmed influenza? Yes No DK

29. If yes, who was the contact person? (eg. Parent, sibling, friend) _____

30. Was the contact person a: Child Adult 31. Age of contact person? _____ DK 32. Did the child travel overseas in the 10 days before onset of symptoms? Yes No DK If yes, where? _____33. Has the child had close contact with farm animals in the past 10 days? Yes No DK If yes, what type? _____**SECTION C: Outcome**34. At the time of reporting, was the child In ICU Hospitalised Discharged Alive Died35. Date of Discharge or Death // 36. If died, autopsy performed? Yes No DK 37. Were there any ongoing problems on discharge? Yes No DK If yes, specify: _____

Please return this case report form ASAP via FAX: 02 9845 3082