

**Varicella complications requiring hospitalisation  
Australian Paediatric Surveillance Unit**

Please ring Prof Robert Booy on 02 9845 1415 if you wish to discuss this questionnaire.

**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 .....grams (if Known)  
11. Gestational age at birth .....weeks (if Known)  
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 and History**

16. How was varicella diagnosed? Clinical  Laboratory  Both   
17. If laboratory which tests were +ve? (tick all that apply)  
Culture  PCR  EM  IF  Serology   
18. Were vesicle samples collected and sent to your local virology lab? Yes  No  DK   
If Yes, which laboratory?  
.....  
19. a. Give age when varicella illness commenced .....  
b. Approximate duration of illness .....days  
c. Was there a history of varicella exposure? Yes  No  DK   
d. Describe source of exposure if known (give details eg. younger unimmunised sibling; outbreak at school etc.)  
.....

**Section B: Clinical Features**

20. Which complications of varicella infection were present? (tick all that apply)
- |  |                              |                             |                             |                      |
|--|------------------------------|-----------------------------|-----------------------------|----------------------|
| a. Bacteraemia / septic shock                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| b. Toxic shock / toxin mediated disease          | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| c. Necrotising fasciitis                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| d. Septic arthritis                              | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| e. Other focal purulent collection               | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> | If Yes, specify..... |
| f. Encephalitis                                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| g. Ataxia  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| h. Purpura fulminans                             | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| i. Disseminated coagulopathy                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| j. X-Ray evidence of pneumonia                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| k. Fulminant varicella (multi-organ involvement) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| l. Reye's Syndrome                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| m. Hepatitis                                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> | DK <input type="checkbox"/> |                      |
| n. Other .....                                   |                              |                             |                             |                      |

21. Is/was there concurrent or secondary infection? Yes  No  DK

If Yes, state site of infection, sample type and organism for all:

Site	Sample Type	Organism
<i>e.g. brain</i>	<i>e.g. CSF</i>	<i>e.g. Staphylococcus Aureus</i>
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

22. What specific treatments related to varicella did the child receive?

a. Antiviral Treatment Yes  No  DK

If yes which one? Aciclovir  Famciclovir  Valaciclovir  DK  Other , Specify.....

b. Other Yes  No  DK

If yes, please describe.....

**Section C. Underlying medical conditions and history**

23. Is the child immunocompromised? Yes  No  DK

Specify.....

24. Does the child have an underlying skin disorder? (eg eczema) Yes  No  DK

Specify .....

25. Has the child any chronic illness that might increase the risk of varicella complications? (eg. Asthma, malnutrition)

Yes  No  DK

If yes specify disease and current treatment.....

.....

26. Does the child smoke? Yes  No  DK

27. Had the child been vaccinated against varicella (live attenuated varicella vaccine)? Yes  No  DK

If yes, when? \_\_\_/\_\_\_/\_\_\_

28. Is there a history of varicella illness (other than this episode) for this child? Yes  No  DK

If Yes, describe.....

29. Has the child ever received varicella zoster immunoglobulin? Yes  No  DK

If yes, when? .....

30. Affected child's birth order eg. 1/2, 2/4, ...../.....

**Section D. Severity and Outcome**

31. How much time did the child spend in hospital? .....days/weeks

32. Was the child admitted to ICU/HDU? Yes  No  DK  If yes, number of days in ICU/HDU.....

33. What is the patient's current status? Still hospitalised  **Questionnaire is finished**

Dead  **GO TO Q33a** Discharged alive  **GO TO Q33b**

a. If dead, 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.....

**Please return this questionnaire in the addressed reply-paid envelope to  
Dr Yvonne Zurynski, Australian Paediatric Surveillance Unit, Locked Bag 4001, Westmead, 2145, NSW**

*Thank you for your assistance with this study, which has been approved by a Human Ethics Committee. The APSU is a Unit of the Royal Australasian College of Physicians (Division of Paediatrics and Child Health) and is funded by the NHMRC (Enabling Grant No. 402784), the Department of Health and Ageing, and the Faculty of Medicine at the University of Sydney.*