SEVERE ACUTE HEPATITIS IN CHILDREN < 17 YEARS OF AGE

Australian Paediatric Surveillance Unit

Please contact the APSU at email SCHN-APSU@health.nsw.gov.au if you have any questions about this form

APSU Office Use Only	
Study ID #:	

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.

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Date: 10.12.2025

REPORTING CLINICIAN'S DETAILS:

1. APSU Dr Code/Name: ☐☐☐☐/_____

Provide your best organisational email address: _____

2. Date case report form completed: __ __/__ __/__ __ __ __ *(dd/mm/yyyy)*

PATIENT DETAILS:

3. First 2 letters of first name: ☐☐

4. First 2 letters of surname: ☐☐

5. Date of Birth: __ __/__ __/__ __ __ __ *(dd/mm/yyyy)*

6. Sex: ☐ Male ☐ Female ☐ Indeterminate

7. Postcode of family: ☐☐☐☐

8. Child's ethnicity: ☐ Aboriginal ☐ Torres-Strait Islander
☐ Both Aboriginal & Torres Strait Islander ☐ Other *(specify)*:_____

9. Child's country of birth: ☐ Australia ☐ Other *(please specify):* _____ ☐ DK

10. Recent travel overseas in past SIX months? ☐ Yes ☐ No ☐ Not known
If yes:
1. Country: _____ Date from: ___/___/___ Date to: ___/___/___
2. Country: _____ Date from: ___/___/___ Date to: ___/___/___
3. Country: _____ Date from: ___/___/___ Date to: ___/___/___

11. Age-appropriate routine immunisations: ☐ Yes ☐ No ☐ Not known

SEVERE ACUTE HEPATITIS CASE DEFINITION (<17 YEARS OF AGE):

I. Symptoms and signs at presentation

Fever	☐ Yes	☐ No	☐ DK	Itch	☐ Yes	☐ No	☐ DK
Jaundice	☐ Yes	☐ No	☐ DK	Joint or muscle pain	☐ Yes	☐ No	☐ DK
Abdominal pain	☐ Yes	☐ No	☐ DK	Dark urine	☐ Yes	☐ No	☐ DK
Fatigue	☐ Yes	☐ No	☐ DK	Pale coloured stools	☐ Yes	☐ No	☐ DK
Loss of appetite	☐ Yes	☐ No	☐ DK	Nausea	☐ Yes	☐ No	☐ DK
Rash	☐ Yes	☐ No	☐ DK	Vomiting	☐ Yes	☐ No	☐ DK
Other	☐ Yes	☐ No	☐ DK *If other*, please specify: _____				

AND

II. An elevated serum alanine aminotransferase (ALT) level (>500 U/L) ☐ Yes ☐ No ☐ DK

OR

An aspartate aminotransferase (AST) levels (>500 U/L) ☐ Yes ☐ No ☐ DK

If this patient is primarily cared for by another physician who you believe will report the case, please complete the details above this line and return to the APSU. Please keep the patient's name and other details in your records.

If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.

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

PRESENTATION:

12. Hospital admission: ☐ Yes ☐ No ☐ DK ***If yes***, date admitted: ___/___/_____

13. Pre-existing medical condition: ☐ Yes ☐ No ☐ DK

If yes, list underlying conditions (including if known chronic Hepatitis B or C carrier): _____

14. Any medications PRECEDING onset of illness: ☐ Yes ☐ No ☐ DK

***If yes*,** list: _____

15. Date of onset of symptoms: __ __/ __ __/ __ __ __ __

COVID:

16. SARS-CoV-2 test on admission: ☐ Positive ☐ Negative ☐ Not performed

17. SARS-CoV-2 test in the previous 2 weeks before hospitalisation: ☐ Positive ☐ Negative ☐ Not performed

Date of test: __ __/ __ __/ __ __ __ __

18. SARS-Cov-2 test positive in the past 12 months ☐ Yes ☐ No ☐ DK

Date of test: __ __/ __ __/ __ __ __ __

If SARS-CoV-2 positive, was it: ☐ Rapid Antigen ☐ PCR

19. COVID-19 Vaccine? ☐ Yes ☐ No ☐ DK

If Yes, 1st dose: __ __/ __ __/ __ __ __ __ 2nd dose: __ __/ __ __/ __ __ __ __

INVESTIGATIONS AT THE TIME OF DIAGNOSIS:

20. Laboratory bloods: (tick if performed and state results)

A. FBC	Results	B. LIVER	Results
☐ Hb	……g/L	☐ Bilirubin	……µmol/L
☐ WBC	……x10^9/L	☐ Alanine Transaminase (ALT)	……U/L
☐ Neutrophils	……x10^9/L	☐ Aspartate Transaminase (AST)	……U/L
☐ Lymphocytes	……x10^9/L	☐ Alkaline phosphatase (ALP)	……U/L
☐ Platelets	……x10^9/L	☐ Gamma-glutamyl Transaminase (GGT)	……U/L

C. RENAL	Results	D. CLOTTING	Results
☐ Urea	……mmol/L	☐ APTT	……seconds
☐ Creatine	…… µmol/L	☐ INR	……

E. OTHER	Results
☐ CRP	……mg/L

21. Maximum values:

Max Bili …… µmol/L Date: __ __/ __ __/ __ __ __ __

Max ALT ……U/L Date: __ __/ __ __/ __ __ __ __

Max INR …… Date: __ __/ __ __/ __ __ __ __

Max CRP ……mg/L Date: __ __/ __ __/ __ __ __ __

22. Virology: *(tick if tested and result)*

Test	Result	Test	Result
☐ Hep A	☐ pos ☐ neg ☐ not tested	☐ CMV	☐ pos ☐ neg ☐ not tested
☐ Hep B	☐ pos ☐ neg ☐ not tested	☐ HSV	☐ pos ☐ neg ☐ not tested
☐ Hep C	☐ pos ☐ neg ☐ not tested	☐ EBV	☐ pos ☐ neg ☐ not tested
☐ Hep E	☐ pos ☐ neg ☐ not tested	☐ HHV6	☐ pos ☐ neg ☐ not tested
☐ Adenovirus	☐ pos ☐ neg (if pos complete A)	☐ HHV7	☐ pos ☐ neg ☐ not tested
☐ SARS-CoV-2	☐ pos ☐ neg ☐ not tested	☐ HHV8	☐ pos ☐ neg ☐ not tested
☐ Other *(state):*	☐ pos ☐ neg (if pos complete B)	☐ HIV	☐ pos ☐ neg ☐ not tested

A. If Adenovirus Positive, was it from: ☐ Blood PCR ☐ Throat swab ☐ Stool ☐ Other, state: _____

B. Other virus: _____, was it from: ☐ Blood PCR ☐ Throat swab ☐ Stool ☐ Other, state: _____

23. Any significant positive bacterial cultures? ☐ Yes ☐ No ☐ Not done

If yes, Date of culture: __ __/ __ __/ __ __ __ __ Organism: _____

Site: _____ Specimen type: _____

24. Was testing done for:

Leptospirosis?	☐ Yes	☐ No	☐ DK ***If yes,*** result: _____
ASOT?	☐ Yes	☐ No	☐ DK ***If yes,*** result: _____
25. Was testing done for autoimmune hepatitis?	☐ Yes	☐ No	☐ DK
ANA (Anti-nuclear antibody):	☐ Yes	☐ No	☐ DK ***If yes,*** result: _____
SMA (Smooth muscle antibody):	☐ Yes	☐ No	☐ DK ***If yes,*** result: _____
LKMA1 (Liver kidney microsome type 1 antibody):	☐ Yes	☐ No	☐ DK ***If yes,*** result: _____
Other (specify): _____	☐ Yes	☐ No	☐ DK ***If yes,*** result: _____
26. Was abdominal imaging performed?	☐ Yes	☐ No	☐ DK ***If Yes,*** Date: __ __/ __ __/ __ __ __ __
If yes, state investigation and main findings:	_____		
27. Was a liver biopsy performed?	☐ Yes	☐ No	☐ DK ***If Yes,*** Date: __ __/ __ __/ __ __ __ __
If yes, main findings:	_____		
28. Other investigations performed?	☐ Yes	☐ No	☐ DK ***If Yes,*** Date: __ __/ __ __/ __ __ __ __
If yes, main findings:	_____		
29. Did the child receive antiviral medication?	☐ Yes	☐ No	☐ DK
If yes, describe:	_____		
30. Was the cause of hepatitis drug induced?	☐ Yes	☐ No	☐ DK

If yes, which type of drug:

- ☐ Antibiotic *(please specify)*: _____
- ☐ Anti-epileptic *(please specify)*: _____
- ☐ Anti-Tuberculosis treatment *(please specify)*: _____
- ☐ Paracetamol
- ☐ Vaping / e-cigarette: _____
- ☐ Non-prescription drugs *(please specify)*: _____
- ☐ Complementary Therapies *(please specify)*: _____
- ☐ Other *(please specify)*: _____

OUTCOMES:

31. Child's status At the time of questionnaire completion: *(tick **all** that apply)*

- ☐ Discharged; date of discharge: __ __/ __ __/ __ __ __ __
- ☐ Still inpatient
- ☐ On-going hepatitis (ALT >500 U/L)
- ☐ Liver failure
- ☐ Liver dysfunction
- ☐ End stage liver disease
- ☐ Liver transplant
- ☐ Died

If died, date of death: __ __/ __ __/ __ __ __ __

Cause of death: _____

_____

32. Indicate the Final diagnosis if known when completing the questionnaire: *(tick all that apply)*

- ☐ Viral hepatitis, state which virus: _____
- ☐ Autoimmune hepatitis, type: _____
- ☐ Drug-induced hepatitis, which drug: _____
- ☐ Acute hepatitis of unknown origin
- ☐ Other diagnosis, state diagnosis: _____

33. Any other comments: _____

Thank you for your help with this research project.

Please return this case report form to the APSU via email to SCHN-APSU@health.nsw.gov.au or fax to 02 9845 3082, or mail to Australian Paediatric Surveillance Unit, Kids Research, Locked Bag 4001, Westmead NSW 2145 - even if you don't complete all items.

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