Congenital Varicella Syndrome

Australian Paediatric Surveillance Unit

If you have any questions about this form, please contact the APSU by emailing SCHN-APSU@health.nsw.gov.au

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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REPORTING CLINICIAN

1. APSU Dr Code/Name: ___ ___ ___ ___ / _____

Provide your best organizational email address: _____

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:
- ☐ Male
- ☐ Female

8. Post code: **___ ___ ___ ___**

9. Date of diagnosis: ___ ___ (month) / ___ ___ ___ ___ (year)

10. Measures at birth *(if known)*
- (a) Birth weight: _____ grams
- (b) Length: _____ cm
- (c) Head Circumference: _____ cm *(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 and could provide additional details, please write the other physician's name in the space below then complete questionnaire details above this line and return to APSU. If no other report is received for this child we will contact you for further information.

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

Instructions for questions below: Please answer each question by ticking the appropriate box or writing your response in the space provided. Y = Yes, N = No, DK= Don't Know, NA = Not applicable

DIAGNOSIS (tick all that apply)

16. Which of the following criteria were used to diagnose Congenital Varicella Syndrome (CVS)?
- ☐ Cicatricial skin lesions in a dermatomal distribution and/or pox-like scars and/or limb hypoplasia
- ☐ Development of Herpes Zoster in the first year of life
- ☐ Spontaneous abortion following varicella infection in pregnancy;
  - ☐ Termination
  - ☐ Stillbirth
  - ☐ Early death

17. If laboratory confirmed, which tests were +ve?

- ☐ Culture
- ☐ PCR
- ☐ EM
- ☐ IF
- ☐ Serology

17a. 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. Give gestation/age when abnormalities were first noted:

_____ weeks gestation; ***or***

_____ days/weeks of age

CLINICAL FEATURES

19. Did the child have any of the following features at diagnosis? *(tick all that apply)*

a) Cicatricial skin scars?

- ☐ Yes
- ☐ No
- ☐ DK

b) Pox-like lesions?

- ☐ Yes
- ☐ No
- ☐ DK

c) Limb hipoplasia?

- ☐ Yes
- ☐ No
- ☐ DK

d) Herpes Zoster (<12m of age) ?

- ☐ Yes
- ☐ No
- ☐ DK

If Yes specify age(s) at onset: _____

e) CNS abnormality?

- ☐ Yes
- ☐ No
- ☐ DK

If Yes, please specify *(e.g. microcephaly, hydrocephalus, cerebellar hypoplasia, motor or sensory defects, sphincter dysfunction, peripheral nervous system defects, muscle atrophy, encephalitis, cortical atrophy)*:

_____
_____
_____
_____

f) Eye lesions?

- ☐ Yes
- ☐ No
- ☐ DK

If Yes, please specify *(e.g. cataract, chorioretinitis, Horner's syndrome, ptosis, nystagmus, optic atrophy)*

_____
_____
_____
_____

g) Gastrointestinal abnormalities?

- ☐ Yes
- ☐ No
- ☐ DK

If Yes, please specify *(e.g. colonic atresia, hepatitis, liver failure)*:

_____
_____

h) Genito-urinary abnormalities?

☐ Yes
☐ No
☐ DK

If Yes, please specify: _____

_____

i) Cardiovascular abnormalities?

☐ Yes
☐ No
☐ DK

If Yes, please specify: _____

_____

j) Failure to thrive?

☐ Yes
☐ No
☐ DK

If yes, give measures:

Height _____ cm
Weight _____ grams
Age when measured: _____

k) Developmental delay?

☐ Yes
☐ No
☐ DK

If Yes, please specify: _____

_____

OUTCOME OF CHILD

20. Was hospitalisation after birth prolonged due to CVS?

☐ Yes
☐ No
☐ DK

Or was the child readmitted for CVS?

☐ Yes
☐ No
☐ DK

If Yes for either, number of days hospitalised due to CVS: _____ days

21. Did the child receive any treatment specifically related to CVS?

☐ Yes
☐ No
☐ DK

If Yes, please specify treatments: _____

_____

22. Did the patient undergo surgery related to CVS?

☐ Yes
☐ No
☐ DK

If Yes, please specify: _____

_____

23. What is the child's current status?

☐ Still hospitalised **GO TO Q26**
☐ Dead **GO TO Q24**
☐ Discharged alive **GO TO Q25**

24. If the child died, was varicella, or its complications a cause of death?

☐ Yes
☐ No
☐ DK

25. If the child was discharged, were there any ongoing problems related to CVS on discharge?

☐ Yes
☐ No
☐ DK

If Yes, describe: _____

_____

PREGNANCY AND MOTHER'S DETAILS for all live births

26. If you do not know the answers to the following questions, is there another medical practitioner (e.g. Mother's obstetrician or GP) from whom we could obtain this information?
If Yes, please provide contact details:

☐ Yes
☐ No
☐ DK

_____
_____

27. Mother's age when this child was born: _____ years

28. Affected child's birth order *e.g. 1/1, 2/2* : _____ /_____

29. Did the mother have an identified varicella contact during pregnancy?

☐ Yes - ***go to question 30***
☐ No - ***go to question 34***
☐ DK - ***go to question 34***

30. Gestation at time of contact in weeks from LMP: _____ weeks

31. Who was the source of exposure for mother? *if known (e.g. own child, relative):*

_____
_____

32. Was this contact living in the same household?

☐ Yes
☐ No
☐ DK

33. Had the contact been vaccinated against varicella, *(if known)*?

☐ Yes
☐ No
☐ DK

34. Did the mother have a varicella-like illness in pregnancy?

☐ Yes
☐ No - ***go to question 36***
☐ DK - ***go to question 36***

If yes, stage of pregnancy in weeks from LMP: _____ weeks

35. What treatment was provided to the mother for the varicella-like illness?

☐ Zoster immune globulin
☐ Aciclovir
☐ Famciclovir
☐ Valaciclovir
☐ None
☐ DK
☐ Other *(specify):* _____

36. Was maternal varicella infection confirmed by laboratory testing?

☐ Yes
☐ No
☐ DK

If Yes, which laboratory tests were +ve?

☐ Culture
☐ PCR
☐ EM
☐ IF
☐ Serology

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