

Neonatal Varicella Infection

Australian Paediatric Surveillance Unit

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

APSU Office Use Only

Study ID #:

Month/Year

Report:

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

Version: 2.0_27.02.2021

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 (if known): _____ grams
11. Gestational age at birth (if known): _____ weeks
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 of neonatal varicella infection

16. How was varicella infection diagnosed in the infant? Clinical Laboratory Both
17. If laboratory, which tests were +ve?
(tick all that apply) Culture PCR EM IF Serology
- xx. 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. a. Give age when illness commenced: _____
- b. Approximate duration of illness: _____ days

c. Did the infant spend time in hospital due to varicella?

Yes No DK

If yes, number of days in hospital:

_____ days

e. Was the infant admitted to ICU/HDU?

Yes No DK

If yes, number of days in ICU/HDU

_____ days

Section B: Clinical Features that can be attributed to varicella

19. Did the child have any of the following: (tick all that apply)

- a. Skin lesions consistent with varicella Yes No DK
- b. Bacteraemia / septic shock Yes No DK
- c. Toxic shock / toxin mediated disease Yes No DK
- d. Necrotising fasciitis Yes No DK
- e. Encephalitis Yes No DK
- f. Purpura fulminans Yes No DK
- g. Disseminated coagulopathy Yes No DK
- h. X-Ray evidence of pneumonia Yes No DK
- i. Fulminant varicella (multi-organ involvement) Yes No DK
- j. Reye's Syndrome Yes No DK
- k. Hepatitis Yes No DK
- l. Other _____

20. If there is/was concurrent or secondary infection state site of infection, sample type and organism:

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

Section C. Underlying medical conditions

21. Is the patient immunocompromised?

Yes No DK

If yes, specify:

22. Has the patient any other significant underlying illness?

Yes No DK

If yes, specify:

Section D. Management

23. Did the child receive any specific treatment?

Yes No DK **If No/DK, go to section E**

24. Antiviral agent?

Yes No DK

Aciclovir Date of first dose: _____ Dose: _____ Date ceased: _____

Famiciclovir Date of first dose: _____ Dose: _____ Date ceased: _____

Valaciclovir Date of first dose: _____ Dose: _____ Date ceased: _____

25. Zoster Immune Globulin?

Yes No DK Date: _____

26. Other treatments?

Yes No DK

If yes, describe:

Section E. Outcome

27. What is the patient's current status? Still hospitalised **GO TO Q28**
 Dead **GO TO Q27a**
 Discharged alive **GO TO Q27b**

(a) If the child died, 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: _____

Section F. About Exposure to Varicella of Mother and Infant

28. Was there a history of varicella exposure for the infant? Intrauterine Postnatal No DK
If intrauterine, go to question 29.
If postnatal, go to Question 34.
If No/DK, questionnaire is finished.

29. During pregnancy, did the mother have contact with someone infected with varicella? Yes No DK
If Yes, gestation in weeks from LMP: _____ weeks

30. Was maternal varicella infection confirmed by laboratory testing? Yes No DK
If Yes, which laboratory tests were +ve? Culture PCR EM IF Serology

31. Did the mother have a varicella-like illness in Pregnancy? Yes No DK
(a) If yes, stage of pregnancy in weeks from LMP: _____ weeks
(b) What treatment was provided to the mother for the varicella-like illness?
 Zoster immune globulin Aciclovir Famciclovir
 Valaciclovir None DK
 Other (specify): _____

32. Who was the contact? (eg. friend, relative) _____
If Contact was a child please give age: _____ or DK

33. Was this contact living in the same household as the mother or affected infant? Yes No DK

34. Was the contact vaccinated against varicella? Yes No DK

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*