

Invasive Bacterial Disease

Group A Streptococcus (*Streptococcus pyogenes*) and Streptococcal Toxic Shock Syndrome

West Virginia Electronic Disease Surveillance System
Division of Surveillance and Disease Control
Infectious Disease Epidemiology Program
Phone: 304-558-5358 or 800-423-1271 in West Virginia
Fax: 304-558-8736

Disease Under Investigation

* indicates required fields

Group A Streptococcus (*Streptococcus pyogenes*) Streptococcal Toxic Shock Syndrome (STSS)

Investigation Status*

Closed Open Regional Review State Review Superseded Unassigned

Case Status*

Confirmed Not a Case Probable Suspect Unknown

Patient Information

* indicates required fields

Last Name*

First Name*

Middle Initial

Street Address

City

County

State

West Virginia

Zip

Is the patient's residence a:

Correctional Facility (Specify) _____ Long Term Care Facility (Specify) _____
 Shelter or Group Home (Specify) _____ None of the above

Home Phone

###-###-####

Ext.

Other Phone

###-###-####

Ext.

Report Date

mm/dd/yyyy

Parent / Guardian Information

Last Name

First Name

Middle Initial

Relationship to Patient

Check if address is same as above; otherwise complete guardian contact information below

Guardian Street Address

City

County

State

West Virginia

Zip

Home Phone

###-###-####

Ext.

Other Phone

###-###-####

Ext.

Patient Demographic Information

* indicates required fields

Sex

Male Female Transsexual Unknown Failure to report sex/missing sex Other (Specify) _____

Date of Birth*

mm/dd/yyyy

Age

Age Units

Days Weeks Months Years

Ethnicity

Hispanic or Latino Not Hispanic or Latino Unknown Failure to report ethnicity/missing ethnicity

Race

(Check all that apply)

American Indian or Alaska Native Asian
 Black or African American Native Hawaiian or Other Pacific Islander _____
 White Unknown
 Failure to report race/missing race Some Other Race _____

Outcome and Clinical Information

Date of onset of symptoms

mm/dd/yyyy

Date of diagnosis

mm/dd/yyyy

Was patient hospitalized for this disease?

Yes No Unknown

Name of Hospital

Date of Admission

mm/dd/yyyy

Patient outcome from this disease:

Died Survived Unknown

Date of Death

mm/dd/yyyy

Types of infection caused by organism

(Check all that apply)

Abscess (not skin) Bacteremia without focus Cellulitis Chorioamnionitis Endometritis
 Epiglottitis Hemolytic Uremic Syndrome (HUS) Meningitis Necrotizing fasciitis Osteomyelitis
 Otitis media Pericarditis Peritonitis Pneumonia Puerperal sepsis
 Septic abortion Septic arthritis STSS Other (specify) _____

Complete for patients with Invasive Group A Streptococcus Infection and STSS

For the following questions, refer to the first 48 hours of hospitalization. For a nosocomial (hospital-acquired) case, refer to the first 48 hours of illness.

ADULTS (age 16 and older): Did systolic blood pressure fall to 90 or below during the first 48 hours?

Yes No

CHILDREN (< age 16): Did blood pressure fall below the 5th percentile for age?

Yes No

If Yes to either question above for patient, please specify:

Note: If hypotension was not documented during the first 48 hours after the first positive culture for IGAS, skip the organ involvement section below and proceed to 'Laboratory Results.'

Organ Involvement:

For all of the following questions, refer to the 48-hour interval after hospitalization or onset of illness. Did the patient have:

RENAL IMPAIRMENT: Creatinine > 2mg/dL (>177 umol/L) for adults or greater than or equal to twice the upper limit of normal for age. In patients with pre-existing renal disease, a greater than two-fold elevation over the baseline level.

Yes No

COAGULOPATHY: Platelets < 100,000/mm³ (<100 X 10⁶/L) or disseminated intravascular coagulation, defined by prolonged clotting times, low fibrinogen level, and the presence of fibrin degradation products.

Yes No

LIVER INVOLVEMENT: Alanine aminotransferase, aspartate aminotransferase, or total bilirubin levels greater than or equal to twice the upper level of normal for the patient's age. In patients with pre-existing liver disease, a greater than two-fold increase over the baseline level.

Yes No

ACUTE RESPIRATORY DISTRESS SYNDROME: Acute onset of diffuse pulmonary infiltrates and hypoxemia in the absence of cardiac failure or by evidence of diffuse capillary leak manifested by acute onset of generalized edema, or pleural or peritoneal effusions with hypoalbumenemia.

Yes No

GENERALIZED ERYTHEMATOUS MACULAR RASH WITH OR WITHOUT DESQUAMATION

Yes No

SOFT TISSUE NECROSIS: Includes necrotizing fasciitis or myositis or gangrene.

Yes No

Note: Patients with hypotension AND involvement of two or more organs AND a positive culture for Group A Streptococcus are defined as having streptococcal toxic shock syndrome (STSS) for surveillance purposes.

Laboratory Results

Sterile sites from which the organism was isolated:

(Check all that apply)

Blood Bone CSF Internal body site: Joint
 Muscle Pericardial fluid Peritoneal fluid Pleural fluid Other normally sterile site: _____

Date first positive culture obtained

mm/dd/yyyy

Other sites from which organism isolated:

(Check all that apply)

Amniotic fluid Middle ear Placenta Sinus Wound Other: _____

Laboratory Results cont.

Laboratory Name	Phone ###-###-####	Ext.	Fax Number ###-###-####
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Address

State: West Virginia	Zip:
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Reporting Source

Last Name	First Name
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Phone ###-###-####	Ext.	Fax ###-###-####
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Facility

Address

City	State West Virginia	Zip
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E-mail

Provider with Further Patient Information

Last Name	First Name
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Phone ###-###-####	Ext.	Fax ###-###-####
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Address

City	State West Virginia	Zip
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Public Health Investigation

Name of Person Interviewed	Relationship to Patient	Date reported to public health mm/dd/yyyy
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Investigator	Date public health investigation began mm/dd/yyyy	Health Department	Phone ###-###-####
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Ext.	
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Investigation ID	Part of an Outbreak? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Outbreak Name	Lost to follow-up? <input type="radio"/> Yes <input type="radio"/> No
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Public Health Investigation cont.

Check if epi-linked to another case and complete information below

Last Name of Epi-linked Case	First Name	DOB mm/dd/yyyy
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County	Onset Date mm/dd/yyyy
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Indicate underlying causes or prior illness

If none or information not available, check here:
 None Unknown

(Check all that apply)

<input type="checkbox"/> AIDS or CD4 count < 200	<input type="checkbox"/> Hodgkin's disease
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Immunoglobulin deficiency
<input type="checkbox"/> Asthma	<input type="checkbox"/> Immunosuppressive therapy (steroids, chemotherapy, radiation)
<input type="checkbox"/> Atherosclerotic cardiovascular disease (ASCVD)/CAD	<input type="checkbox"/> IVDU
<input type="checkbox"/> Burns	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Cerebral Vascular Accident (CVA)/Stroke	<input type="checkbox"/> Multiple myeloma
<input type="checkbox"/> Cirrhosis/Liver failure	<input type="checkbox"/> Nephrotic syndrome
<input type="checkbox"/> Cochlear implant	<input type="checkbox"/> Renal failure / renal dialysis
<input type="checkbox"/> CSF leak (2 deg trauma/surgery)	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Current smoker	<input type="checkbox"/> Splenectomy / asplenia
<input type="checkbox"/> Deaf/Profound hearing loss	<input type="checkbox"/> Systemic lupus erythematosus (SLE)
<input type="checkbox"/> Diabetes mellitus	<input type="checkbox"/> Transplant (specify): _____
<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Other malignancy (specify): _____
<input type="checkbox"/> Heart failure/CHF	<input type="checkbox"/> Other prior illness (specify): _____
<input type="checkbox"/> HIV infection	

Complete for patients with invasive Group A Streptococcus Infection and STSS

In the seven days prior to the first positive culture:

Did the patient have surgery? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes, date of surgery? mm/dd/yyyy	Did the patient deliver a baby? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If Yes, Vagina or C-section <input type="radio"/> Vagina <input type="radio"/> C-section
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If Yes, date of delivery: mm/dd/yyyy	
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Did the patient have:
 Varicella Penetrating trauma Blunt trauma Surgical wound (post operative) None of these Unknown

Public Health Action Taken

Describe public health action taken:

