State of California—Health and Human Services Agency

Local ID Number: _____

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

# SHIGELLOSIS
# CASE REPORT

*Please complete this form for confirmed and probable cases of shigellosis. For case definitions, see pages 7 and 8.* ***Completion of this form is not required*** *but encouraged to improve surveillance of this disease. Jurisdictions not participating in CalREDIE should mail the completed form to IDB-SSS at the address above. Jurisdictions participating in CalREDIE should create a CalREDIE incident and enter the information directly into the CalREDIE system.*

## PATIENT INFORMATION

| *Last Name* | *First Name* | *Middle Name* | *Suffix* |
|---|---|---|---|
| | | | |

| *Social Security Number (9 digits)* | *DOB (mm/dd/yyyy)* | *Age* | |
|---|---|---|---|
| Unknown | | | ☐ Years ☐ Months ☐ Days |

| *Address Number & Street – Residence* | *Apartment / Unit Number* |
|---|---|
| | |

| *City / Town* | *State* | *Zip Code* |
|---|---|---|
| | | |

| *Census Tract* | *County of Residence* | *Country of Residence* |
|---|---|---|
| | Los Angeles | USA |

| *Country of Birth* | *If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)* |
|---|---|
| | |

| *Home Telephone* | *Cellular Phone / Pager* | *Work / School Telephone* |
|---|---|---|
| | | |

| *E-mail Address* | *Other Electronic Contact Information* |
|---|---|
| | |

| *Work / School Location* | *Work / School Contact* |
|---|---|
| | |

*Gender*
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male / transman ☐ Identity not listed ☐ Declined to answer

| *Pregnant?* ☐ Yes ☐ No ☐ Unknown | *If Yes, Est. Delivery Date (mm/dd/yyyy)* |
|---|---|
| | |

| *Medical Record Number* | *Patient's Parent/Guardian Name* |
|---|---|
| | |

| *Occupation Setting (see list on page 9)* | *Other Describe/Specify* |
|---|---|
| | |

| *Occupation (see list on page 9)* | *Other Describe/Specify* |
|---|---|
| | |

*Gender(s) of Sex Partners (check all that apply)*
☐ Male ☐ Female ☐ Transgender (M to F) ☐ Transgender (F to M) ☐ Unknown ☐ Refused

*Primary Language*
☐ English
☐ Spanish
☐ Other: _____

*Ethnicity (check one)*
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

*Race(s)*
*(check all that apply, race descriptions on page 8)*

*The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.*

☐ American Indian or Alaska Native

☐ Asian *(check all that apply, see list on page 8)*
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African-American

☐ Native Hawaiian or Other Pacific Islander *(check all that apply, see list on page 8)*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Fijian
- ☐ Tongan
- ☐ Guamanian
- ☐ Other: _____

☐ White

☐ Other: _____

☐ Unknown

## ADDITIONAL PATIENT DEMOGRAPHICS

*Sex Assigned at Birth*
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

*Sexual Orientation*
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

First three letters of patient's last name: | | | |

## CLINICAL INFORMATION

| *Physician Name - Last Name* | *First Name* | *Telephone Number* |
|---|---|---|
| | | |

### *SIGNS AND SYMPTOMS*

| *Symptomatic?* ☐ Yes ☐ No ☐ Unknown | *Onset Date (mm/dd/yyyy)* | *Onset Time (hh:mm)* | *Specify AM/PM* ☐ AM ☐ PM | *Duration of Acute Symptoms (days)* |
|---|---|---|---|---|
| | | | | |

| Signs and Symptoms | Yes | No | Unk | If Yes, Specify as Noted | |
|---|---|---|---|---|---|
| Diarrhea | ☐ | ☐ | ☐ | *Max. number of stools in 24-hr period* | *Onset date of diarrhea (mm/dd/yyyy)* |
| Bloody diarrhea | ☐ | ☐ | ☐ | | |
| Fever | ☐ | ☐ | ☐ | *Highest temperature (specify °F/°C)* | |
| Nausea | ☐ | ☐ | ☐ | | |
| Vomiting | ☐ | ☐ | ☐ | | |
| Abdominal cramps | ☐ | ☐ | ☐ | | |

*Other signs, symptoms, or complications, including reactive arthritis (specify)*

### *HEMOLYTIC UREMIC SYNDROME (HUS)*

In order for a patient to be counted as a confirmed case of post-diarrheal HUS, the patient must have had an acute illness diagnosed as HUS or thrombotic thrombocytopenic purpura (TTP) that began within 3 weeks after onset of an episode of acute or bloody diarrhea.

| *Did patient have HUS?* *(See case definition, includes both anemia with microangiopathic changes and renal injury [hematuria, proteinuria, or elevated creatinine])* ☐ Yes ☐ No ☐ Unknown | *Onset Date of HUS (mm/dd/yyyy)* | If patient had HUS, please obtain and attach medical records or upload to electronic filing cabinet. |
|---|---|---|
| | | |

### *PAST MEDICAL HISTORY*

| *Did the patient take antibiotics in the month prior to onset?* ☐ Yes ☐ No ☐ Unknown | *If Yes, specify antibiotic(s)* |
|---|---|
| | |
| *Did the patient have other underlying conditions relevant to present illness?* ☐ Yes ☐ No ☐ Unknown | *If Yes, specify type of condition(s)* |
| | |

### *HOSPITALIZATION*

*Did patient visit the emergency room for illness?* ☐ Yes ☐ No ☐ Unknown

| *Was patient hospitalized?* ☐ Yes ☐ No ☐ Unknown | *If Yes, how many total hospital nights?* | *During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)?* ☐ Yes ☐ No ☐ Unknown |
|---|---|---|
| | | |

*If there were any ER or hospital stays related to this illness, specify details in the Hospitalization – Details section below.*

### *HOSPITALIZATION – DETAILS*

| | | | | | |
|---|---|---|---|---|---|
| *Hospital Name 1* | *Street Address* | | | *Admit Date (mm/dd/yyyy)* | |
| | *City* | | | *Discharge / Transfer Date (mm/dd/yyyy)* | |
| | *State* | *Zip Code* | *Telephone Number* | *Medical Record Number* | *Discharge Diagnosis* |
| | | | | | |
| *Hospital Name 2* | *Street Address* | | | *Admit Date (mm/dd/yyyy)* | |
| | *City* | | | *Discharge / Transfer Date (mm/dd/yyyy)* | |
| | *State* | *Zip Code* | *Telephone Number* | *Medical Record Number* | *Discharge Diagnosis* |
| | | | | | |

First three letters of patient's last name: | | | |

## TREATMENT / MANAGEMENT

| Received treatment? ☐ Yes ☐ No ☐ Unknown | If Yes, specify the treatments below. |
|---|---|

## TREATMENT / MANAGEMENT – DETAILS

| Treatment Type 1 ☐ Antibiotic ☐ Other | Treatment Name | Date Started (mm/dd/yyyy) | Date Ended (mm/dd/yyyy) |
|---|---|---|---|
| Treatment Type 2 ☐ Antibiotic ☐ Other | Treatment Name | Date Started (mm/dd/yyyy) | Date Ended (mm/dd/yyyy) |

## OUTCOME

| Outcome? ☐ Survived ☐ Died ☐ Unknown | If Survived, Survived as of _____(mm/dd/yyyy) | Date of Death (mm/dd/yyyy) |
|---|---|---|

## LABORATORY INFORMATION

### CLINICAL LABORATORY RESULTS – Culture and Culture Independent Diagnostic Testing [CIDT], including Shiga Toxin

| Specimen Type ☐ Stool ☐ Blood ☐ Urine ☐ Other (specify):_____ | Collection Date (mm/dd/yyyy) |
|---|---|

| Clinical laboratory Shigella culture completed? ☐ Yes ☐ No ☐ Unknown | If culture completed, specify species (serogroup) ☐ *S. dysenteriae* (Group A) ☐ *S. boydii* (Group C) ☐ Unspecified ☐ *S. flexneri* (Group B) ☐ *S. sonnei* (Group D) ☐ Negative for *Shigella* |
|---|---|
| Shigella CIDT identification completed? ☐ Yes ☐ No ☐ Unknown | If CIDT completed, specify result(s) ☐ *Shigella* spp. ☐ *Shigella* / Enteroinvasive *E. coli* (EIEC) ☐ Other (specify):_____ ☐ Negative for *Shigella* |

| Shiga toxin test completed? ☐ Yes ☐ No ☐ Unknown | Type of Test ☐ Enzyme immunoassay (EIA) ☐ PCR ☐ Vero cell assay ☐ Unknown ☐ Other (specify):_____ | |
|---|---|---|
| | Shiga toxin test result ☐ Stx positive ☐ Stx negative ☐ Unknown | If Stx positive, specify type of toxin(s) ☐ Stx 1 ☐ Stx 2 ☐ Stx 1 and Stx 2 ☐ Unknown ☐ Other:_____ |

| Laboratory Name | Laboratory CLIA Number | Telephone Number |
|---|---|---|
| | | |

### ANTIMICROBIAL SUSCEPTIBILITY TESTING

| Antimicrobial susceptibility testing completed? ☐ Yes ☐ No ☐ Unknown<br>Attach additional results or upload to CalREDIE electronic filing cabinet. | | | | | |
|---|---|---|---|---|---|
| | Ampicillin: | ☐ Susceptible | ☐ Intermediate | ☐ Resistant | ☐ Not done |
| | Azithromycin: | ☐ Susceptible | ☐ Intermediate | ☐ Resistant | ☐ Not done |
| | Ciprofloxacin: | ☐ Susceptible | ☐ Intermediate | ☐ Resistant | ☐ Not done |
| | TMP-SMX: | ☐ Susceptible | ☐ Intermediate | ☐ Resistant | ☐ Not done |
| | Third-generation cephalosporin (specify): _____ | ☐ Susceptible | ☐ Intermediate | ☐ Resistant | ☐ Not done |

### CDPH MICROBIAL DISEASES LABORATORY (MDL) OR OTHER REFERENCE PUBLIC HEALTH LABORATORY RESULTS

***Please enter final results if available***

| Specimen Type ☐ Stool ☐ Blood ☐ Urine ☐ Other (specify):_____ | | Collection Date (mm/dd/yyyy) | |
|---|---|---|---|
| Was Shigella isolate forwarded to a local public health lab? ☐ Yes ☐ No ☐ Unknown | Local Lab ID Number | Was isolate forwarded to MDL? ☐ Yes ☐ No ☐ Unknown | State Lab ID Number |

| Shigella culture completed? ☐ Yes ☐ No ☐ Unknown | If culture completed, specify species (serogroup) ☐ *S. dysenteriae* (Group A) ☐ *S. boydii* (Group C) ☐ Unspecified ☐ *S. flexneri* (Group B) ☐ *S. sonnei* (Group D) ☐ Negative for *Shigella* |
|---|---|
| | If serotyping completed, specify serotype ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ Other (specify):_____ ☐ Untypeable ☐ Unknown |

### SHIGA TOXIN TESTS – SHIGELLA ISOLATE

| Was Shigella isolate tested for Shiga toxin? ☐ Yes ☐ No ☐ Unknown | Type of Test (check all that apply) ☐ Enzyme immunoassay (EIA) ☐ PCR ☐ Vero cell assay ☐ Unknown ☐ Other:_____ | |
|---|---|---|
| Shiga Toxin Test Result ☐ Stx positive ☐ Stx negative ☐ Unknown | If Stx positive, specify type of toxin(s) ☐ Stx 1 ☐ Stx 2 ☐ Stx 1 and Stx 2 ☐ Unknown ☐ Other:_____ | Laboratory Name ☐ MDL ☐ PHL:_____ |

First three letters of patient's last name: | | | |

## *CDPH MICROBIAL DISEASES LABORATORY (MDL) OR OTHER REFERENCE PUBLIC HEALTH LABORATORY RESULTS (continued)*

***Please enter final results if available.***

### *MOLECULAR DIAGNOSTICS*

| *Was PFGE completed?* ☐ Yes ☐ No ☐ Unknown | *Pattern 1 #* | *Pattern 2 #* | *CDC Cluster ID #* |
|---|---|---|---|
| *Was whole genome sequencing (WGS) completed?* ☐ Yes ☐ No ☐ Unknown | *If Yes, specify results* | | *Laboratory Name* ☐ MDL ☐ Reference PHL:_____ |

## EPIDEMIOLOGIC INFORMATION

**INCUBATION PERIOD: 7 DAYS PRIOR TO ILLNESS ONSET**

_____ **to** _____
***(onset date minus 7 days)*** ***(onset date)***

### *TRAVEL HISTORY*

| *Did patient travel **outside county of residence** during the **incubation period**?* ☐ Yes ☐ No ☐ Unknown | *If Yes, specify all locations and dates below.* |
|---|---|

### *TRAVEL HISTORY – DETAILS*

| Travel Type | State | Country | Other location details (city, resort, etc.) | Date Travel Started *(mm/dd/yyyy)* | Date Travel Ended *(mm/dd/yyyy)* |
|---|---|---|---|---|---|
| ☐ Domestic ☐ Unknown ☐ International | | | | | |
| ☐ Domestic ☐ Unknown ☐ International | | | | | |
| ☐ Domestic ☐ Unknown ☐ International | | | | | |

| GROUP SETTINGS & OTHER EXPOSURES | Yes | No | Unk | If Yes, Specify as Noted | |
|---|---|---|---|---|---|
| Exposure to a confirmed or probable shigellosis case | ☐ | ☐ | ☐ | *Provide details in the Ill Contacts section below.* | |
| Attended or worked in daycare | ☐ | ☐ | ☐ | *Location* | |
| Contact with a diapered child or adult | ☐ | ☐ | ☐ | *Location* | |
| Lived in congregate setting (e.g., dorm, residential care facility, corrections, etc.) | ☐ | ☐ | ☐ | *Location* | |
| Homeless | ☐ | ☐ | ☐ | *Specify location(s) and/or shelter(s)* | |
| Sexual activity | ☐ | ☐ | ☐ | *Sexual partner(s)* ☐ Male ☐ Female ☐ Refused | *Engaged in oral-anal sex* ☐ Yes ☐ No ☐ Refused |
| ***EVENTS OR ACTIVITIES*** | **Yes** | **No** | **Unk** | ***If Yes*, Specify as Noted** | |
| Exposure to sewage or human excreta | ☐ | ☐ | ☐ | *Location* | |
| Attend any group activities or events (e.g., parties, shared meals, etc.) | ☐ | ☐ | ☐ | *Describe* | |
| Other activities or exposures of interest | ☐ | ☐ | ☐ | *Describe* | |
| ***WATER EXPOSURES*** | **Yes** | **No** | **Unk** | ***If Yes*, Specify as Noted** | |
| Natural recreational water (rivers, lakes, oceans, etc.) | ☐ | ☐ | ☐ | *Location* | |
| Artificial recreational water (swimming pools, water parks, fountains, etc.) | ☐ | ☐ | ☐ | *Location* | |
| Drank untreated water | ☐ | ☐ | ☐ | *Source(s)* | |

*Source(s) of drinking water (check all that apply)*
☐ Public ☐ Individual well ☐ Shared well ☐ Bottled ☐ Other: _____ ☐ Unknown

First three letters of patient's last name: | | | |

## FOOD HISTORY – OUTSIDE HOME

| Did patient consume food or drink prepared outside the home? ☐ Yes ☐ No ☐ Unknown | If Yes, specify name of place (e.g., restaurant, concession stand, friend's house, etc.), location, date, and items consumed on the below. |
|---|---|

## FOOD HISTORY – OUTSIDE HOME – DETAILS

| | | |
|---|---|---|
| Name of Place 1 | Location (city, state) | Date (mm/dd/yyyy) |
| | Items Consumed | |
| Name of Place 2 | Location (city, state) | Date (mm/dd/yyyy) |
| | Items Consumed | |
| Name of Place 3 | Location (city, state) | Date (mm/dd/yyyy) |
| | Items Consumed | |
| Name of Place 4 | Location (city, state) | Date (mm/dd/yyyy) |
| | Items Consumed | |

## PATIENT CLEARANCE INFORMATION

| Did this patient require clearance to return to daycare, school, or work? ☐ Yes ☐ No ☐ Unknown | If Yes, please provide details below. |
|---|---|

## PATIENT CLEARANCE INFORMATION – DETAILS

| | | | |
|---|---|---|---|
| Employer/Situation (place of employment, daycare name, etc.) | | | Telephone Number |
| Street Address | City | State | Zip Code |

| | | |
|---|---|---|
| Was clearance completed? ☐ Yes ☐ No | If Yes, Date of First Clearance Specimen (mm/dd/yyyy) | Date of Final Clearance Specimen (mm/dd/yyyy) |
| | If No, specify reason | |

Clearance Issues (including use of antibiotics to facilitate clearance, etc.) / Comments

## HOUSEHOLD CONTACTS

| How many people besides the case, live in the household? | Please provide details below. |
|---|---|

## HOUSEHOLD CONTACTS – DETAILS (If more than 4 household contacts, list additional contacts on page 10.)

| | | | | | |
|---|---|---|---|---|---|
| Name 1 | Relationship | Age | Gender | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| | Telephone Number | Similar illness? ☐ Yes ☐ No ☐ Unknown | | Onset Date & Time | Comment |
| Name 2 | Relationship | Age | Gender | Occupation | Sensitive occupation situation? ☐ Yes ☐ No ☐ Unknown |
| | Telephone Number | Similar illness? ☐ Yes ☐ No ☐ Unknown | | Onset Date & Time | Comment |
| Name 3 | Relationship | Age | Gender | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| | Telephone Number | Similar illness? ☐ Yes ☐ No ☐ Unknown | | Onset Date & Time | Comment |
| Name 4 | Relationship | Age | Gender | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| | Telephone Number | Similar illness? ☐ Yes ☐ No ☐ Unknown | | Onset Date & Time | Comment |

First three letters of patient's last name: | | | |

## ILL CONTACTS

| Any contacts with similar illness (including household contacts)? ☐ Yes ☐ No ☐ Unknown | If Yes, specify details below. |
|---|---|

## ILL CONTACTS – DETAILS (If more than 3 ill contacts, list additional contacts on page 10.)

| | | | | | |
|---|---|---|---|---|---|
| Name 1 | Age | Gender | Telephone Number | Type of Contact / Relationship | Date of Contact (mm/dd/yyyy) |
| | Street Address | | | Exposure Event | Illness Onset Date (mm/dd/yyyy) |
| | City | State | Zip Code | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| Name 2 | Age | Gender | Telephone Number | Type of Contact / Relationship | Date of Contact (mm/dd/yyyy) |
| | Street Address | | | Exposure Event | Illness Onset Date (mm/dd/yyyy) |
| | City | State | Zip Code | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| Name 3 | Age | Gender | Telephone Number | Type of Contact / Relationship | Date of Contact (mm/dd/yyyy) |
| | Street Address | | | Exposure Event | Illness Onset Date (mm/dd/yyyy) |
| | City | State | Zip Code | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |

## NOTES / REMARKS

## REPORTING AGENCY

| Investigator Name | Local Health Jurisdiction | Telephone Number | Date (mm/dd/yyyy) |
|---|---|---|---|
| | Los Angeles County | | |

| First Reported By | Health education provided? |
|---|---|
| ☐ Clinician ☐ Laboratory ☐ Other (specify):_____ | ☐ Yes ☐ No ☐ Unknown |

## EPIDEMIOLOGICAL LINKAGE

| Epi-linked to known case? ☐ Yes ☐ No ☐ Unknown | Contact Name / Case Number |
|---|---|

## DISEASE CASE CLASSIFICATION

Case Classification (see case definition on page 7)
☐ Confirmed ☐ Probable

## OUTBREAK

| Part of known outbreak? ☐ Yes ☐ No ☐ Unknown | If Yes, extent of outbreak: ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other: _____ |
|---|---|

| Mode of Transmission ☐ Point source ☐ Person-to-person ☐ Unknown ☐ Other: _____ | Vehicle of Outbreak | Pattern 1 ID number | Pattern 2 ID number |
|---|---|---|---|
| | | | |

## STATE USE ONLY

State Case Classification
☐ Confirmed ☐ Probable ☐ Not a case ☐ Need additional information

First three letters of patient's last name: | | | |

## CASE DEFINITION

**SHIGELLOSIS (2017)**

**CLINICAL CRITERIA**

An illness of variable severity commonly manifested by diarrhea, fever, nausea, cramps, and tenesmus. Asymptomatic infections may occur.

**LABORATORY CRITERIA**

**Confirmatory**

Isolation of *Shigella spp.* from a clinical specimen.

**Supportive**

Detection of *Shigella spp*. or *Shigella*/EIEC in a clinical specimen using a CIDT.

**EPIDEMIOLOGIC LINKAGE**

A clinically compatible case that is epidemiologically linked to a case that meets the supportive or confirmatory laboratory criteria for diagnosis.

**CASE CLASSIFICATION**

**Confirmed**

A case that meets the confirmed laboratory criteria for diagnosis.

**Probable**

- A case that meets the supportive laboratory criteria for diagnosis, OR
- A clinically compatible case that is epidemiologically linked to a case that meets the supportive or confirmatory laboratory criteria for diagnosis.

**Criteria to distinguish a new case of this disease or condition from reports or notifications which should not be enumerated as a new case for surveillance:**

- A case should not be counted as a new case if laboratory results were reported within 90 days of a previously reported infection in the same individual.
- When two or more different serotypes are identified in one or more specimens from the same individual, each should be reported as a separate case.

**COMMENT**

The use of CIDTs as stand-alone tests for the direct detection of *Shigella*/EIEC in stool is increasing. EIEC is genetically very similar to *Shigella* and will be detected in CIDTs that detect *Shigella*. Specific performance characteristics such as sensitivity, specificity, and positive predictive value of these assays likely depend on the manufacturer and are currently unknown. It is therefore useful to collect information on the type(s) of testing performed for reported shigellosis cases. When a specimen is positive using a CIDT, it is also helpful to collect information on all culture results for the specimen, even if those results are negative.

Culture confirmation of CIDT-positive specimens is ideal, although it might not be practical in all instances. State and local public health agencies should make efforts to encourage reflexive culturing by clinical laboratories that adopt culture-independent methods, should facilitate submission of isolates/clinical material to state public health laboratories, and should be prepared to perform reflexive culture when not performed at the clinical laboratory. Isolates are currently necessary for molecular typing (PFGE and whole genome sequencing) that are essential for outbreak detection and for antimicrobial susceptibility testing, which is increasingly important because of substantial multidrug resistance among *Shigella*.

**HEMOLYTIC UREMIC SYNDROME, POST-DIARRHEAL (2010)**

**CLINICAL DESCRIPTION**

Hemolytic uremic syndrome (HUS) is characterized by the acute onset of microangiopathic hemolytic anemia, renal injury, and low platelet count. Thrombotic thrombocytopenic purpura (TTP) also is characterized by these features but can include central nervous system (CNS) involvement and fever and may have a more gradual onset. Most cases of HUS (but few cases of TTP) occur after an acute gastrointestinal illness (usually diarrheal).

**LABORATORY CRITERIA**

The following are both present at some time during the illness: Anemia (acute onset) with microangiopathic changes (i.e., schistocytes, burr cells, or helmet cells) on peripheral blood smear and renal injury (acute onset) evidenced by either hematuria, proteinuria, or elevated creatinine level (i.e., greater than or equal to 1.0 mg/dL in a child aged less than 13 years or greater than or equal to 1.5 mg/dL in a person aged greater than or equal to 13 years, or greater than or equal to 50% increase over baseline).

Note: A low platelet count can usually, but not always, be detected early in the illness, but it may then become normal or even high. If a platelet count obtained within 7 days after onset of the acute gastrointestinal illness is not less than 150,000/$mm^3$, other diagnoses should be considered.

*(continued on page 8)*

## CASE DEFINITION (continued)

**CASE CLASSIFICATION**

**Confirmed**

An acute illness diagnosed as HUS or TTP that both meets the laboratory criteria and began within 3 weeks after onset of an episode of acute or bloody diarrhea

**Probable**

- An acute illness diagnosed as HUS or TTP that meets the laboratory criteria in a patient who does not have a clear history of acute or bloody diarrhea in preceding 3 weeks, OR
- An acute illness diagnosed as HUS or TTP, that a) has onset within 3 weeks after onset of an acute or bloody diarrhea and b) meets the laboratory criteria except that microangiopathic changes are not confirmed

**COMMENT**

Some investigators consider HUS and TTP to be part of a continuum of disease. Therefore, criteria for diagnosing TTP on the basis of CNS involvement and fever are not provided because cases diagnosed clinically as post-diarrheal TTP also should meet the criteria for HUS. These cases are reported as post-diarrheal HUS.

## RACE DESCRIPTIONS

| Race | Description |
|---|---|
| American Indian or Alaska Native | Patient has origins in **any** of the original peoples of North and South America (including Central America). |
| Asian | Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam). |
| Black or African American | Patient has origins in **any** of the black racial groups of Africa. |
| Native Hawaiian or Other Pacific Islander | Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands. |
| White | Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa. |

## ASIAN GROUPS

- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Chinese
- Filipino
- Hmong
- Indian
- Indonesian
- Iwo Jiman
- Japanese
- Korean
- Laotian
- Madagascar
- Malaysian
- Maldivian
- Nepalese
- Okinawan
- Pakistani
- Singaporean
- Sri Lankan
- Taiwanese
- Thai
- Vietnamese

## NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

- Carolinian
- Chamorro
- Chuukese
- Fijian
- Guamanian
- Kiribati
- Kosraean
- Mariana Islander
- Marshallese
- Melanesian
- Micronesian
- Native Hawaiian
- New Hebrides
- Palauan
- Papua New Guinean
- Pohnpeian
- Polynesian
- Saipanese
- Samoan
- Solomon Islander
- Tahitian
- Tokelauan
- Tongan
- Yapese

First three letters of patient's last name: | | | |

## OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

## OCCUPATION

- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory/seasonal worker
- Agriculture - other/unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other/unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - waiter or waitress
- Food service - other/unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - registered nurse
- Medical - other/unknown
- Military - officer
- Military - recruit or trainee
- Protective service - police officer
- Protective service - other
- Professional, technical, or related profession
- Retired
- Sex worker
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high (secondary) school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high (secondary) school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Other
- Refused
- Unknown

First three letters of patient's last name: | | | |

## HOUSEHOLD CONTACTS – DETAILS (continued from page 5)

| | | | | | |
|---|---|---|---|---|---|
| Name 5 | Relationship | Age | Gender | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| | Telephone Number | Similar illness? ☐ Yes ☐ No ☐ Unknown | | Onset Date (mm/dd/yyyy) | Comment |
| Name 6 | Relationship | Age | Gender | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| | Telephone Number | Similar illness? ☐ Yes ☐ No ☐ Unknown | | Onset Date (mm/dd/yyyy) | Comment |
| Name 7 | Relationship | Age | Gender | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| | Telephone Number | Similar illness? ☐ Yes ☐ No ☐ Unknown | | Onset Date (mm/dd/yyyy) | Comment |
| Name 8 | Relationship | Age | Gender | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| | Telephone Number | Similar illness? ☐ Yes ☐ No ☐ Unknown | | Onset Date (mm/dd/yyyy) | Comment |
| Name 9 | Relationship | Age | Gender | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| | Telephone Number | Similar illness? ☐ Yes ☐ No ☐ Unknown | | Onset Date (mm/dd/yyyy) | Comment |
| Name 10 | Relationship | Age | Gender | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| | Telephone Number | Similar illness? ☐ Yes ☐ No ☐ Unknown | | Onset Date (mm/dd/yyyy) | Comment |

## ILL CONTACTS – DETAILS (continued from page 6)

| | | | | | |
|---|---|---|---|---|---|
| Name 4 | Age | Gender | Telephone Number | Type of Contact / Relationship | Date of Contact (mm/dd/yyyy) |
| | Street Address | | | Exposure Event | Illness Onset Date (mm/dd/yyyy) |
| | City | State | Zip Code | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| Name 5 | Age | Gender | Telephone Number | Type of Contact / Relationship | Date of Contact (mm/dd/yyyy) |
| | Street Address | | | Exposure Event | Illness Onset Date (mm/dd/yyyy) |
| | City | State | Zip Code | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |
| Name 6 | Age | Gender | Telephone Number | Type of Contact / Relationship | Date of Contact (mm/dd/yyyy) |
| | Street Address | | | Exposure Event | Illness Onset Date (mm/dd/yyyy) |
| | City | State | Zip Code | Occupation | Sensitive occupation / situation? ☐ Yes ☐ No ☐ Unknown |