

Ohio Department of Health Invasive Group A Streptococcus (GAS) Surveillance Report

Please complete this form for each patient from whom Group A Strep (*Streptococcus pyogenes*) is isolated from a normally sterile site. If you have any questions regarding completion of this form, you may contact Infectious Disease Control (614) 466-0265. Please send the completed form to the local health department within whose jurisdiction the patient resides.

Did the patient meet the CDC clinical case definition for Streptococcal Toxic Shock Syndrome (STSS) given on the reverse side of this page? If yes, please complete the reporting form for STSS (ODH Form HEA 3823 (rev. 6/98)) instead of this form.

Demographic data

1. Last Name		2. First Name		Local Case ID (ODH use only)	
3. Address				Telephone	
4. City		5. County	6. State	7. ZIP	
8. Date of birth		month	day	year	
9. Age		_____ years	_____ months		
10. Race		<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown	11. Ethnicity		
12. Sex		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown	13. Specimen collection date		*Status (ODH use only)

Specimen data

A. Group A streptococcus was isolated from the following normally sterile site: <input type="checkbox"/> blood <input type="checkbox"/> CSF <input type="checkbox"/> pleural fluid <input type="checkbox"/> pericardial fluid <input type="checkbox"/> bone <input type="checkbox"/> synovial fluid <input type="checkbox"/> other (please thoroughly describe the site from which the specimen was obtained and how the specimen was obtained) <hr/>
B. Date of onset of symptoms <div style="text-align: center;">/ /</div>

Person completing this form:

Name		Title			
Facility Name				Phone Number	
Address					
City		State	ZIP	Date	

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Note: This form is for worksheet purposes only--do not send to ODH

Bureau of Disease Investigation and Surveillance 1-614-995-5599

Streptococcal Toxic Shock Syndrome (CDC, Revised 9/96)

Clinical Description

Streptococcal toxic-shock syndrome (STSS) is a severe illness associated with invasive or noninvasive group A streptococcal (*Streptococcus pyogenes*) infection [group A strep isolated from a sterile or non-sterile site]. STSS may occur with infection at any site but most often occurs in association with infection of a cutaneous lesion. Signs of toxicity and a rapidly progressive clinical course are characteristic, and the case-fatality rate may exceed 50%.

Clinical Case Definition

An illness with the following clinical manifestations occurring within the first 48 hours of hospitalization or, for a nosocomial case, within the first 48 hours of illness:

- Hypotension defined by a systolic blood pressure ≤ 90 mm Hg for adults or less than the fifth percentile by age for children aged < 16 years, **and**
- Multi-organ involvement characterized by **two or more** of the following:
 1. Renal impairment: Creatinine ≥ 2 mg/dL (≥ 177 μ mol/L) for adults or greater than or equal to twice the upper limit of normal for age. In patients with preexisting renal disease, a greater than twofold elevation over the baseline level
 2. Coagulopathy: Platelets $\leq 100,000/\text{mm}^3$ ($\leq 100 \times 10^6/\text{L}$) or disseminated intravascular coagulation, defined by prolonged clotting times, low fibrinogen level, and the presence of fibrin degradation products
 3. Liver involvement: Alanine aminotransferase, aspartate aminotransferase, or total bilirubin levels greater than or equal to twice the upper limit of normal for the patient's age. In patients with preexisting liver disease, a greater than two-fold increase over the baseline level
 4. Acute respiratory distress syndrome: defined by 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 hypoalbuminemia
 5. A generalized erythematous macular rash that may desquamate
 6. Soft tissue necrosis, including necrotizing fasciitis or myositis, or gangrene

Laboratory criteria for diagnosis

Isolation of group A *Streptococcus*

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Guide to completion of the Invasive GAS form

(ODH form HEA3820, revised 6/98)

Only specimens from normally sterile sites should be reported on this form.

- Specimens isolated from sites that are not normally sterile, such as skin, are not considered invasive GAS, even if they produce fulminant or fatal disease.
 - If GAS was isolated from a site which is not normally sterile and was associated with the clinical entity STSS, please complete the form STSS Surveillance Report (ODH form HEA3823 revised 6/98).
 - If an invasive GAS (from a normally sterile site) is isolated in association with the clinical entity STSS, please complete the form STSS Surveillance Report (ODH form HEA3823 revised 6/98) instead of this form.
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- INVASIVE GAS IS A CLASS A(3) REPORTABLE DISEASE, WHICH MEANS "CASE REPORTS AND REPORTS OF POSITIVE LABORATORY RESULTS . . . SHALL BE PROVIDED BY THE CLOSE OF EACH WORKING WEEK AFTER THE EXISTENCE OF SUCH CASE, SUSPECTED CASE, OR POSITIVE LABORATORY RESULT IS KNOWN" (OAC 3701-3-02, 3701-3-05, REVISED JULY 1998).
 - IF YOU COMPLETE AND SUBMIT THIS FORM, YOU DO NOT NEED TO COMPLETE AND SUBMIT A MORBIDITY CARD (ODH form 3812.11 Rev. 12/81).
 - WHEN YOU HAVE COMPLETED THIS FORM, SEND IT TO THE LOCAL HEALTH DEPARTMENT OF THE JURISDICTION IN WHICH THE PATIENT LIVES, WHICH WILL FORWARD IT TO ODH IN COLUMBUS.

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HOW TO COMPLETE SPECIFIC FIELDS

Demographic data

1. Last name

The patient's last name

2. First name

The patient's first name

Local case ID (for ODH use only)

The ODH clerk who enters the data from this form into the National Electronic Telecommunications Surveillance System (NETSS) database for transmission to CDC will assign an Ohio identification number to this case report.

3. Patient address

This should be the address where the patient resides. If the patient is a resident in a long-term care facility at the time of onset of illness, the address (city, county, zip code) of that facility should be listed here.

Telephone

The patient's home telephone number (please include the area code).

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4. City

Of the patient's residence (as in item #3)

5. County

Of the patient's residence (as in item #3)

6. State

Of the patient's residence (as in item #3)

7. Zip code

Of the patient's residence (as in item #3)

Data in fields 3, 4, 5, 6, and 7 allow

a. determination of duplicates

b. analysis by geographic location, most often at the county level, but also at city and zip code levels

8. Date of birth

Please provide the date of birth in the format: month/date/year. *Data in this field are used to describe the distribution of disease by age.*

9. Age

If the patient is over 12 months, please indicate the age with the label "year(s)." If the patient is from 1 through 12 months of age, please indicate age with the label "month(s)." If the patient is less than 1 month old, please indicate the age as "0 months."

10. Race

Please complete.

11. Ethnicity

Please complete.

12. Sex

Please complete.

Data in fields 9, 10, 11, and 12 are used to describe the distribution of disease and to provide clues as to possible risk factors for disease.

13. Specimen collection date

Please complete in the month/date/year format. *We use this date to detect seasonal trends in the type of infection and patterns of drug resistance.*

Status (ODH use only)

ODH epidemiologists will complete this field when the status of the case has been determined as confirmed, probable, or suspected.

Basic clinical data

A. Specimen source

This field **MUST** be completed. In order to qualify as invasive Group A *streptococcus*, the organism must have been isolated from blood, csf, or other normally sterile site, such as pleural or pericardial fluid, bone, synovial fluid, or other. If the site from which the specimen was obtained is not listed, i.e., you are selecting "other," please thoroughly describe the site. Information from this field will be used to confirm that this case meets the case definition.

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B. Date of onset of symptoms

This date might be different from the collection of specimen date (#13) and will *provide some measure of how rapidly these infections progress.*

Person completing this form

Please complete this section in its entirety. *This will allow state and local health department personnel to contact you in case there are any questions about the form, if any additional information is required from you, if any clusters or regional outbreaks need to be investigated, or to notify you of conclusions from the data you and your colleagues have provided.*

Thank you very much. If you have any questions, please call the Infectious Disease Investigation Section, 614-466-0265.

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