

INVASIVE HAEMOPHILUS INFLUENZAE DISEASE CASE REPORT

County	Case number
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Patient name—last	first	middle initial	Date of birth (mm/dd/yy) ____/____/____	Age ____ months or ____ years (if ≥ 2 years)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (number/P.O. box, street)			City	State	ZIP code
County of residence of patient			Parent/guardian name		Telephone number ()
Onset date (mm/dd/yy) ____/____/____	Date reported to Health Department (mm/dd/yy) ____/____/____	Physician/source of report name			Telephone number ()

RACE (check one) African-American/Black <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____	ETHNICITY (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino
Asian—Please also check one box below: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian (Non-Hmong) <input type="checkbox"/> Chinese <input type="checkbox"/> Thai <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian (Non-Hmong) <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian <input type="checkbox"/> Hmong <input type="checkbox"/> Vietnamese (Non-Hmong) <input type="checkbox"/> Korean	<input type="checkbox"/> Pacific Islander—Please also check one box below: <input type="checkbox"/> Guamanian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan Hawaiian

If < 6 years old, is patient in day care (supervised group of ≥ 2 children for > 4 hours per week)? Yes No Unknown

Hib vaccination: *If* < age 10 and serotype is “b” only, see Hib Vaccine History on reverse.

CLINICAL DATA	
Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Admit date (mm/dd/yy) ____/____/____
Hospital name	
Type of Infection (check all that apply) <input type="checkbox"/> Meningitis <input type="checkbox"/> Otitis media <input type="checkbox"/> Pneumonia <input type="checkbox"/> Peritonitis <input type="checkbox"/> Bacteremia <input type="checkbox"/> Other: _____ <input type="checkbox"/> Septic Arthritis <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Epiglottitis <input type="checkbox"/> Pericarditis <input type="checkbox"/> Cellulitis _____	Outcome of case <input type="checkbox"/> Recovered <input type="checkbox"/> Died, date: _____

LABORATORY DATA	
<i>Include cultures from normally sterile body sites only; do not include throat, sputum, or conjunctival swab.</i>	
Source of Specimen <input type="checkbox"/> Blood <input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Placenta <input type="checkbox"/> Joint <input type="checkbox"/> Pleural fluid <input type="checkbox"/> No <i>H influenzae</i> isolated from normally sterile site <input type="checkbox"/> CSF <input type="checkbox"/> Pericardial fluid <input type="checkbox"/> Other _____	
Serotype of Isolate (Please make every effort to get serotype test result at least on cases under age 15 years.) <input type="checkbox"/> Type b <input type="checkbox"/> Unable to type (e.g., unencapsulated) <input type="checkbox"/> Not tested or unknown <input type="checkbox"/> Other type (specify) _____	CSF Bacterial Antigen Screen (<i>Do not include serum or urine bacterial antigen screen.</i>) <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown

Is isolate resistant to:		
Ampicillin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Chloramphenicol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Rifampin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

MISCELLANEOUS		
Long-term effects: If case survived, is long-term damage likely? Yes (specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Medical history: Patient has preexisting underlying medical conditions? <input type="checkbox"/> Yes (specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Source of infection: Exposed to confirmed/suspected Hib case? <input type="checkbox"/> Yes (specify) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown

CASE CLASSIFICATION	
Case definition	
Confirmed: Clinically compatible illness and <i>H. influenzae</i> cultured from a normally sterile body site. (Note: sputum, throat swab and conjunctival swab are not normally sterile sites).	
Probable: Clinically compatible illness with <i>H. influenzae</i> type b antigen detected in CSF.	
Possible: Any suspected case not meeting above criteria.	
Check one: <input type="checkbox"/> Confirmed <i>H. influenzae</i> disease <input type="checkbox"/> Probable <i>H. influenzae</i> disease <input type="checkbox"/> Possible <i>H. influenzae</i> disease (Sending report on possible cases is optional.)	

PROTECTION OF CONTACTS OF A CASE OF INVASIVE HAEMOPHILUS INFLUENZA TYPE B DISEASE

Use of these guidelines is optional. The guidelines represent suggestions only, since contact management varies with individual situations. Consultation available from Immunization Branch, (510) 540-2065.

Case

1. Respiratory isolation for 24 hours after start of antibacterial treatment.
2. If he/she will be returning to household with other children under age four years or to child care center with children under age four years, start case on rifampin just before discharge from hospital to eliminate upper respiratory tract carriage of organism.

Household (with Hib case in past month)

1. Give rifampin to **all** household members in these situations: (a) immunocompromised child, or infant under age 12 months, regardless of immunization status; or (b) child 1 through 3 years of age who has not completed the Hib immunization series.
2. Inform household that any child who develops possible invasive Hib disease signs, e.g., fever, headache, sore throat, lethargy, within this 30-day period should be evaluated by a physician as soon as possible.

Child Care Facility (with Hib case in past two months and with children under age four years in same classroom as case.)

1. Inform parents of other children who were in same classroom as case that an Hib disease case has occurred, that the risk to their child is very low, but if he/she develops possible invasive Hib disease signs, e.g., fever, headache, sore throat, lethargy, within this two-month period, they should consult a physician as soon as possible.
2. Rifampin prophylaxis—If there are no classroom contacts under two years old, prophylaxis is not needed. Non-room contacts do not need prophylaxis even if under two years old. If there **are** room/classroom contacts under two years old, two recommendations exist:
 - a. CDC/ACIP:
 - (1) If children under two years old were in same room as the case **and**
 - (2) If authorities can achieve at least 75 percent compliance, then **strongly consider** concurrent rifampin prophylaxis for **all** staff and children in that room, regardless of age or Hib immunization status of recipients. If prophylaxis is chosen, do it promptly. If more than 14 days since case was last in classroom, rifampin benefit is likely decreased.
 - b. APHA 1990 Control of Communicable Disease in Man: Under the circumstances outlined in “Household” section, part 1(b) above, **can consider** rifampin prophylaxis.
3. AAP/PHA: If **2** cases in facility less than 60 days apart and children under 2 years old in same classroom(s) as case(s), give rifampin prophylaxis concurrently to all children and staff in this room(s).

Rifampin Prophylaxis

1. **Dose:** 20 mg/kg, once daily, to maximum of 600 mg/day. Dose for infant under 1 month old is 10 mg/kg/day. Comes in 150 mg and 300 mg capsules. Package insert has instructions for making one percent syrup suspension for those too young to take capsules, or can mix contents of capsules with several teaspoons of applesauce. **Duration:** 4 days.
2. **Notes:** Can stain soft contact lenses and turn urine orange. Can interfere with oral contraceptives during current cycle. Not generally recommended for pregnant women or for persons with liver disease.

HIB Vaccine History Complete only for cases under age ten years known to be due to serotype b.

Dose Number	Date (Month/Day/Year)	Manufacturer	Lot Number	If manufacturer and/or lot number unknown, give vaccine provider name and address or phone number, if known.

Investigator name (print)	Date	Telephone number ()
Agency name		