CONGENITAL CYTOMEGALOVIRUS INFECTION (CMV)

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM

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REPORTING INFORMATION
(To be completed by the CPSP Senior Coordinator)

Report number:	
Month of reporting:	
Province:	
Today's date:	

Please complete the following sections for the case identified above.
Strict confidentiality of information will be assured.

CASE DEFINITION FOR CONGENITAL CYTOMEGALOVIRUS (CMV) INFECTION

Report all newborns with CMV infection confirmed in the **first three weeks of life** by any of the following laboratory methods:

- Culture of CMV from an appropriate clinical specimen*
- Polymerase chain reaction (PCR) positive for CMV from an appropriate clinical specimen*
- Presence of CMV-specific IgM in the neonatal or cord blood†

* Urine, throat, blood, CSF or tissue biopsy

† Please note that serology (i.e., TORCH screen) is a very poor way of making the diagnosis. Many newborns with congenital CMV do not produce detectable IgM. Viral isolation or identification is the most reliable diagnostic method.

SECTION 1 – DEMOGRAPHIC INFORMATION

1.1 Date of birth: ____ /_____ /_______ (DD MM YYYY) 1.2 Sex: Male ___ Female ___

1.3 Province/Territory of residence: ____________________

Urban ____ Rural (population <1,000) ____ Unknown ____

1.4 Biological mother:

1.4.1 Ethnicity: First Nations _____ Innu _____ Inuit _____ Métis _____

Asian _____ Black _____ Caucasian _____ Latin American _____ Middle Eastern _____

Other (specify): ________________________________ Unknown _____

1.4.2 Country of birth: Canada ____ Other (specify):______________________. Unknown ____

If other, specify number of years since immigration: <1 ____ 1 – 5 ____ >5 ____

1.4.3 Education (highest level completed):

Primary School ____ High School ____ Community College/Technical School ____

University ____ Professional degree and/or graduate school ____

Other (specify): __________________________________ Unknown ____

1.4.4 Employment: Full-time ____ Part-time ____ Unknown ____

If known, specify type of work: ____

1.4.5 Daycare exposure:

- Daycare work six months before or while pregnant:
  Yes ____ No ____ Unknown ____
- Household exposure to preschool children attending daycare while pregnant:
  Yes ____ No ____ Unknown ____

1.4.6 HIV serostatus: Negative ___ Positive ___ Unknown ___

SECTION 2 – BIRTH INFORMATION

2.1 **Mother** — Age: ______ years   Parity: G ___ P ___ A ___

2.2 **Newborn** — Gestational age: ______ weeks   Birth weight: ______ grams   Length: ______cm

Head circumference: ______ cm

2.3 Clinical signs and symptoms:

		No	Yes	Unknown
2.3.1	Small for gestional age	___	___	___
2.3.2	Microcephaly	___	___	___
2.3.3	Jaundice	___	___	___
2.3.4	Hepatomegaly	___	___	___
2.3.5	Splenomegaly	___	___	___
2.3.6	Rash	___	___	___
2.3.7	Congenital anomalies	___	___	___

If yes, please specify:____

SECTION 3 – INVESTIGATIONS AT PRESENTATION

3.1 Reason for CMV testing of the newborn:

3.1.1 Mother diagnosed during pregnancy ____

3.1.2 Fetal intrauterine growth delay ____

3.1.3 Other reason, please specify: ____

3.2 Blood tests in the first week of life:

		No	Yes	Not done	Unknown
3.2.1	HgB < 120 g/dL – anemia	___	___	___	___
3.2.2	Platelets < 100,000 – thrombocytopenia	___	___	___	___
3.2.3	Total bilirubine > 200 μmol/L – jaundice	___	___	___	___
3.2.4	ALT or AST twice normal – hepatitis	___	___	___	___

3.3 CMV confirmed by:

			Pos	Neg	Not done	Unknown	Date first positive DD MM YYYY
3.3.1	Viral culture:	Throat	___	___	___	___	____/____/______
		Urine	___	___	___	___	____/____/______
		Blood	___	___	___	___	____/____/______
		CSF	___	___	___	___	____/____/______
3.3.2	Serology: CMV-IgM		___	___	___	___	____/____/______
3.3.3	Polymerase chain reaction: CMV-PCR						
		Throat	___	___	___	___	____/____/______
		Urine	___	___	___	___	____/____/______
		Blood	___	___	___	___	____/____/______
		CSF	___	___	___	___	____/____/______

3.4 Other investigations:

		Done	Not Done	Normal	Abnormal	Results
3.4.1	Head ultrasounds	___	___	___	___	______________________
3.4.2	Cranial CT scan	___	___	___	___	______________________
3.4.3	Hearing assessment	___	___	___	___	______________________
3.4.4	Ophthalmology	___	___	___	___	______________________

SECTION 4 – MANAGEMENT

4.1 Public health report: Done ____ Not done ____ Unknown ____
If done, please specify by whom: yourself ____ someone else ____

4.2 Antiviral therapy: No ____ Yes ____ If yes, specify drug: ____________________

4.3 Hospital stay: Total number of days ______ Days in intensive care unit: ______

SECTION 5 – OUTCOME

5.1 Child still in hospital: No ___ Yes ___ Unknown ___

5.2 Child transferred to another facility: No ___ Yes ___ Unknown ___
If yes, please specify: ____________________

5.3 Child discharged home: No ___ Yes ___ Unknown ___

5.4 Child is deceased: No ___ Yes ___ Unknown ___
If yes, age at time of death _____ (weeks / months) Cause of death: ____________________

5.5 Lost to follow-up _____

SECTION 6 – REPORTING PHYSICIAN

First name____________________ Surname____________________

Address____________________

City____________________ Province____________________ Postal code____________________

Telephone number____________________ Fax number____________________

E-mail____________________ Date completed____________________

Thank you for completing this form.

(CMV 2005-03)