Early-onset neonatal sepsis and meningitis (NSM)

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.
Confidentiality of information will be assured.

CASE DEFINITION FOR EARLY-ONSET NEONATAL SEPSIS AND MENINGITIS

Report any neonate less than seven days of age presenting with one of the following:

- Positive blood culture*

  AND/OR
- Positive cerebrospinal fluid (CSF) culture* from a lumbar puncture (LP)

Neonates with possible nosocomial infections should also be reported.

* Culture growth includes bacterial or fungal pathogens.

Exclusion criteria

1) Neonates who are asymptomatic with positive culture, such as coagulase-negative Staphylococcus, Diphtheroids, Corynebacterium spp., Bacillus spp., Propionibacterium spp., Aerococcus spp., Micrococcus spp.
2) Positive CSF from a drain, reservoir, shunt, or intracranial surgical procedure.

Month first seen ___________________

SECTION 1 – DEMOGRAPHIC INFORMATION

A) Neonate

1.1 Date of birth: _____ /_____ /________ (DD MM YYYY) Time of birth: _________ 1.2 Sex: Male ___ Female ___

B) Mother

1.3 Place of residence (province/territory): ______________________

1.4 Age at delivery (years): ___________

1.5 Ethnicity (check all that apply):

Arab ___ Black ___ Chinese ___ Filipino ___ Japanese ___ Korean ___ Latin American ___

South Asian (e.g., Bangladeshi, Punjabi, Sri Lankan) ___ Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian) ___ West Asian (e.g., Afghan, Assyrian, Iranian) ___ White ___

First Nations ___ Inuit ___ Métis ___ Other (specify) ___________________________ Unknown ___

1.6 Gravida ___ Para ___ Abortions – Spontaneous: Yes ___ No ___ Unknown ___ Number(s) _____

– Therapeutic: Yes ___ No ___ Unknown ___ Number(s) _____

SECTION 2 – MATERNAL FACTORS PREDISPOSING TO NEWBORN INFECTIONS

2.1 Maternal GBS status: Positive___ Negative___ Unknown ___ Gestational age tested ______________

	Yes	No	Unknown
2.2 Maternal urinary tract infection during pregnancy:	___	___	___
If yes, specify GBS bacteriuria ___ Other, specify: ________________________			
2.3 Prolonged rupture of membranes (PROM >18 hours prior to delivery)	___	___	___
If yes, specify duration of ROM: ______ hours			

SECTION 2 – MATERNAL FACTORS PREDISPOSING TO NEWBORN INFECTIONS (cont'd)

			Yes	No	Unknown
2.4	Premature PROM If yes, specify gestational age at rupture _____ weeks		___	___	___
2.5	Elevated maternal temperature > 38ºC (after onset of labour)		___	___	___
2.6	Elevated maternal white blood count (WBC >10,000; after onset of labour)		___	___	___
2.7	Clinical diagnosis of chorioamnionitis		___	___	___
2.8	Maternal antibiotics (GBS prophylaxis given) If yes, specify: Type of antibiotic _______________ Duration: _______________	N/A ___	___	___	___

SECTION 3 – FAMILY HISTORY

3.1 Previous sibling with neonatal death(s) ___ ___ ___

If yes, specify reason: ____

3.2 Previous sibling with neonatal sepsis ___ ___ ___

If yes, specify type: ____

SECTION 4 – MEDICAL HISTORY

4.1 Gestational age at birth: _____ weeks completed

4.2 Type of delivery: Vaginal ___ Instrumental – Forceps ___ Vacuum ___ Cesarean section ___

4.3 APGAR score at 1 minute _____ 5 minutes _____ 10 minutes _____

4.4 Birth weight: ______ grams Height: _____ cm Head circumference: _____ cm

4.5 Date of presentation: _____ /_____ /________ (DD MM YYYY) Age at presentation: ____ hours (if < 24) or ____ days

4.6 If readmitted, date of readmission: _____ /_____ /________ (DD MM YYYY) Weight on readmission: _____ grams

Feeding: Breast ___ Formula ___ NPO ___

4.7 Clinical signs of sepsis:

	Yes	No	Unknown		Yes	No	Unknown
Lethargy				Hypotonia			
Jaundice				Hypertonia			
DIC*				Shock			
Hyperthermia/ Hypothermia				Hypoperfusion			
Seizures				Neutropenia			
Apnea				Neutrophilia			
Feeding Intolerance				Thrombocytopenia			

* Disseminated intravascular coagulopathy

4.8 Congenital anomalies: Yes ___ No ___ Unknown ___

If yes, specify: ____

4.9 Surgical or other invasive procedures before sepsis: Yes ___ No ___ Unknown ___

If yes, specify: ____

4.10 Did the infant have a central line (peripherally inserted central catheter line, umbilical line, central venous line) prior to infection: Yes ___ No ___ Unknown ___

SECTION 5 – LABORATORY INVESTIGATIONS

5.1 Check all that apply. If a copy of the de-identified microbiology report is attached, this table does not need to be completed.

Culture	Date drawn DD / MM / YYYY	Date of first reported positive result DD / MM / YYYY	Organism(s)	Antibiotic resistance Yes No
Blood 1	____ /____ /________	____ /____ /________		___ ___ (If yes, specify)
Blood 2	____ /____ /________	____ /____ /________		___ ___ (If yes, specify)
CSF	____ /____ /________	____ /____ /________		___ ___ (If yes, specify)
Urine	____ /____ /________	____ /____ /________		___ ___ (If yes, specify)
Other	____ /____ /________	____ /____ /________		___ ___ (If yes, specify)

5.2 Complete blood count at the time of presentation:

HB _______ HCT _______ WBC _______ Total neutrophils _______ Platelets __________

Smear ____

Are results compatible with disseminated intravascular coagulopathy (DIC)? Yes ___ No ___

5.3 Biochemistry at the time of presentation:

Serum sodium _____ BUN _____ Creatinine _____

Bilirubin _____ μmol/L Conjugated bilirubin ______ μmol/L Unconjugated bilirubin _____ μmol/L

SECTION 6 – TREATMENT AND OUTCOME

		Yes	No	Unknown
6.1	Transfusion	___	___	___
6.2	Intubation	___	___	___
6.3	Ionotropes	___	___	___
6.4	Seizures	___	___	___
6.5	Still in hospital	___	___	___
	If yes, total length of stay: ________ days/weeks			
6.6	Discharged home	___	___	___
6.7	Death	___	___	___
	If yes, was the infection the cause?	___	___	___

6.8 Neurological status at discharge: Normal ___ Unknown ___

Hearing loss ___ Vision loss ___ Motor impairment ___ Seizures ___

___ I agree to be contacted for further information.

___ I do not wish to be contacted for further information.

SECTION 7 – REPORTING PHYSICIAN

First name______________________________ Surname____

Address____

City____________________________________ Province______________________ Postal code___________________

Telephone number_________________________________ Fax number_______________________________________

E-mail____ Date completed____________________________________

Thank you for completing this form.

(NSM 2011-01)