Severe microcephaly (SM)

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM
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REPORTING INFORMATION
(To be completed by the CPSP)

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 SEVERE MICROCEPHALY

Report any new patient less than 12 months of age, with a head circumference measurement less than three standard deviations below the mean (0.13th centile) for gestational age and sex, based on the sex-specific World Health Organization growth parameters:

- Female term infant with a head circumference of less than 30.3 cm.
- Male term infant with a head circumference of less than 30.7 cm.
- Preterm infant (less than 38 weeks' gestation), as per appended INTERGROWTH-21st study standards.

Date of first visit: ____ /____ /_____
DD MM YYYY

SECTION 1 – INFANT INFORMATION

1.1 Date of birth: ____ /____ /_____ 1.2 Sex: Male ___ Female ___ Ambiguous genitalia ___
DD MM YYYY

1.3 Gestational age at birth: _____ weeks

1.4 Birth type: Singleton ___ Twin___ Higher order multiple ___ Order of birth: _____ N/A ___

1.5

Length (cm)	**Weight (g)**	**Head circumference (cm)**
At birth: _____	At birth: _____	At birth: _____
At visit: _____	At visit: _____	At visit: _____

1.6 Ethnicity (select all that apply):
First Nations ___ Innu ___ Inuit ___ Métis ___ Chinese ___ Japanese ___ Other Oriental ___
East Indian ___ Black ___ Caucasian ___ Latin American ___ Middle Eastern ___
Other, specify: _____ Unknown ___

1.7 Confirmed diagnosis (known cause of microcephaly): _____

1.8 If a diagnosis has not yet been confirmed, is there a leading suspected cause?
Infection ___ Genetic ___ Ischemic ___ Unknown ___ Other: _____

SECTION 2 – CLINICAL INFORMATION

2.1

Clinical features	**Yes**	**No**	**Unknown**	**Date/age of diagnosis**
Dysmorphology	___	___	___	_____
If yes, specify: _____				
Intracranial abnormalities	___	___	___	_____
If yes, specify: Calcifications ___ Simplified gyral patterns ___ Brain malformation ___ Other: _____				
Specify testing: US ____ CT ____ MRI ___ Other:_____				
Seizures	___	___	___	_____
Craniofacial disproportion	___	___	___	_____
Eye abnormalities	___	___	___	_____
If yes, specify: _____				

SECTION 2 – CLINICAL INFORMATION (cont'd)

2.1 **Clinical features** (cont'd)

	Yes	No	Unknown	Date/age of diagnosis
Hearing impairment	___	___	___	_____
If yes, specify degree: _____				
Spasticity	___	___	___	_____
Hypotonia	___	___	___	_____
Rash	___	___	___	_____
Hepatosplenomegaly	___	___	___	_____
Joint contractures	___	___	___	_____
Unusual hair patterning	___	___	___	_____

Other abnormal clinical features: _____

2.2 Has the patient achieved developmental milestones, in the following domains, appropriate for age / corrected gestational age?

Gross motor	Yes ___	No ___	N/A ___ (specify below)	Unknown ___
Fine motor	Yes ___	No ___	N/A ___ (specify below)	Unknown ___
Social	Yes ___	No ___	N/A ___ (specify below)	Unknown ___
Language	Yes ___	No ___	N/A ___	

Please specify: _____

_____

2.3 **Pregnancy information**

Prior pregnancy information: P ____ G ____

	Yes	No	Unknown	Date/age of diagnosis
Hypertension	___	___	___	_____
Gestational diabetes mellitus	___	___	___	_____
If yes, maternal GDM was: well controlled ___ poorly controlled ___ diet-controlled only ___ insulin-controlled ___				
Pre-gestational diabetes	___	___	___	_____
Abdominal injury	___	___	___	_____
Elevated maternal PKU	___	___	___	_____
Severe malnutrition	___	___	___	_____
Abnormal ultrasound findings	___	___	___	_____
Placental insufficiency	___	___	___	_____
Rhesus disease	___	___	___	_____
Other pregnancy complications	___	___	___	_____

Please specify any chronic conditions of the mother:

_____

_____

Specify any medications (prescribed, OTC) used during pregnancy: _____

Specify any medications (prescribed, OTC) used three months prior to pregnancy: _____

2.3.1 **Pregnancy exposures**

Is there a history of smoking during pregnancy? Yes ___ No ___ Unknown ___

If yes, report specific consumption: _____

Is there a history of alcohol use during pregnancy? Yes ___ No ___ Unknown ___

If yes, report specific consumption: _____

Is there a history of illicit drug use during pregnancy? Yes ___ No ___ Unknown ___

If yes, report specific illicit drug and consumption: _____

Is there a history of known teratogen exposure during pregnancy? Yes ___ No ___ Unknown ___

If yes, specify teratogen and exposure quantity: _____

SECTION 2 – CLINICAL INFORMATION (cont'd)

2.4 Delivery information

Maternal age at delivery: _____ years

Mode of delivery: SVD ____ AVD ____ C/S ____

If C/S, explain indication: _____

APGAR scores: 1 minute _____ 5 minute _____ 10 minutes _____

2.5 Diagnostic work-up

Karyotype: Yes ___ No ___ Result: _____ [ ] if pending

DNA microarray: Yes ___ No ___ Result: _____ [ ] if pending

Specific gene testing: Yes ___ No ___ Result: _____ [ ] if pending

Brain imaging: US ___ CT ___ MRI ___ Results/major findings: _____

EEG: Yes ___ No ___ Result: _____ [ ] if pending

TORCH screen: Yes ___ No ___

If positive, specify infection: Toxo ___ Rubella ___ CMV ___ Herpes ___ VZV ___ Zika ___
Syphilis ___ Other, specify: _____

Laboratory investigations (non-syphilis):

	Not done	Normal	Result	Date of test: MM / YYYY
PCR	___	___	_____	_____
IgM	___	___	_____	_____
IgG	___	___	_____	_____
PRNT	___	___	_____	_____
Other: _____	___	___	_____	_____

Other basis for diagnosis: _____

Laboratory investigations (syphilis only)

Treponemal test (specify): _____ Not done ___ Positive ___ Negative ___

Treponemal test (specify): _____ Not done ___ Positive ___ Negative ___

Treponemal test (specify): _____ Not done ___ Positive ___ Negative ___

Non-treponemal test: Not done ___ Positive ___ If positive, titer: _____ Negative ___

Trimester of TORCH infection: 1st ___ 2nd ___ 3rd ___ Unknown ___

Other diagnostic work-up, specify: _____

2.6 Travel history

Did mother or father travel to other countries during pregnancy or three months prior to conception?

Mother: Yes ___ No ___ Unknown ___

If yes,

Country: _____ Approx. date arrived: _____ Approx. date departed: _____

Country: _____ Approx. date arrived: _____ Approx. date departed: _____

Country: _____ Approx. date arrived: _____ Approx. date departed: _____

Illness presented during travel? Yes ___ No ___ Unknown ___

Specific diagnosis: _____ Diagnosis made by: _____

Specify: Fever ___ Rash ___ Arthralgia/arthritis ___ Conjunctivitis ___ Myalgia ___ Headache ___
Retro-orbital pain ___ Pruritus ___ Other, specify: _____

Father: Yes ___ No ___ Unknown ___

If yes,

Country: _____ Approx. date arrived: _____ Approx. date departed: _____

Country: _____ Approx. date arrived: _____ Approx. date departed: _____

Country: _____ Approx. date arrived: _____ Approx. date departed: _____

SECTION 2 – CLINICAL INFORMATION (cont'd)

2.6 **Travel history** (cont'd)

Illness presented during travel? Yes ___ No ___ Unknown ___

Specific diagnosis (if any): _____ Diagnosis made by: _____

Specify: Fever ___ Rash ___ Arthralgia/arthritis ___ Conjunctivitis ___ Myalgia ___ Headache ___

Retro-orbital pain ___ Pruritus ___ Other, specify: _____

2.7 Was Zika virus infection ever considered as a possible cause of microcephaly in this case? Yes ___ No ___

If yes, was the **mother** tested for evidence of past/current Zika virus infection? Yes ___ No ___

If yes, what was the testing performed? _____ Result _____ Timing of test _____

If yes, was the **infant** tested for evidence of past/current Zika virus infection? Yes ___ No ___ [ ] if pending

If yes, what was the testing performed? _____ Result _____ Timing of test _____

SECTION 3 – FAMILY HISTORY

3.1 **Consanguinity of parents**

Degree of relationship: None ___ 1st ___ 2nd ___ 3rd ___ >3rd ___

3.2 Family history of microcephaly: Yes ___ No ___ Unknown ___

Family history of other congenital anomalies: None ___ Unknown ___ Specify:_____

Family history of developmental delays: Yes ___ No ___ *If yes,* specify: _____

Previous pregnancy with congenital anomaly(ies): Yes ___ No ___ Unknown ___

History of miscarriage: Yes ___ No ___ Unknown ___

History of stillbirth: Yes ___ No ___ Unknown ___

___ **I agree to be contacted by the CPSP for further information.**

___ **I do not wish to be contacted by the CPSP for further information.**

SECTION 4 – REPORTING PHYSICIAN

First name_____ Surname_____

Address_____

City_____ Province/Territory_____ Postal code_____

Telephone number_____ Fax number_____

E-mail_____ Date completed_____

Thank you for completing this form.