Ophthalmia neonatorum caused by *N gonorrhoeae* or *C trachomatis*

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM

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REPORTING INFORMATION
(To be completed by CPSP staff)

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

Please complete the following sections for the case identified above. If the information asked below is not readily available, please leave it blank. Strict confidentiality of information will be assured.

CASE DEFINITION FOR OPHTHALMIA NEONTORUM CAUSED BY *N GONORRHOEAE* OR *C TRACHOMATIS*

Any patient less than 28 days of age (4 weeks) at onset of symptoms, with clinical features of ophthalmia neonatorum (ON) including at least one of the following:

- Conjunctival/ocular erythema
- Conjunctival/ocular discharge
- Conjunctival and/or periocular swelling

AND

N gonorrhoeae isolated in culture or identified by nucleic acid amplification test in specimens from the eye, blood, CSF, or other sterile site

OR

C trachomatis isolated in culture or identified by nucleic acid amplification test in specimens from the eye, nasopharynx, or other respiratory tract specimen

Exclusion criteria

- Ophthalmia neonatorum associated with another microorganism

Month first seen (MM): _____

SECTION 1 – DEMOGRAPHIC INFORMATION

1.1 Date of birth: ____ /____ /_____ (DD MM YYYY)

1.2 Male____ Female____

1.3 Province/territory of permanent residence: _____

1.4 Province/territory of diagnosis: _____

1.5 Postal code (first 3 digits only): ____ ____ ____

1.6 Are you aware of the neonatal ocular prophylaxis policy in the institution where this patient was born?

Yes ___ No ___ Unknown ___ Not applicable___

If yes, is ocular prophylaxis at this institution (check one):

❍ Mandatory (as directed by legislation/regulation)
❍ Routine practice with informed consent (allowing parents to opt out if desired)
❍ For high-risk situations only

SECTION 2 – PRENATAL HISTORY

2.1 Gravida status: _____

2.2 Prenatal care received? Yes ___ No ___ Unknown ____

2.2.1 *If No or Unknown*, was mother screened for *N gonorrhoeae* and *C trachomatis* at delivery?
Yes ___ No ___ Unknown ____ *(If yes,* enter data in 2.4 and/or 2.6 below)

2.2.2 Prenatal care provider: OB-GYN _____ Family medicine _____ Midwife _____

Regarding *N gonorrhoeae:*

2.3 Known history of *N gonorrhoea*e infection prior to pregnancy? Yes ___ No ___ Unknown ____

2.3.1 Treated: Yes ___ No ___ Unknown ____

2.4 Screening for *N gonorrhoeae* in pregnancy? Yes ___ No ___ Unknown ____

2.4.1 *If yes* (check all that apply): ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐ At delivery

2.4.2 Results: Positive ___ Negative ___

2.4.3 *If positive*, antibiotic sensitivity: _____
(List drugs tested and results OR unavailable)

2.4.4 *If positive*, treated? Yes ___ No ___ Unknown ____
If treated, drug used: _____ Duration: _____ Route: _____

2.4.5 Test of cure after treatment? Yes ___ No ___ Unknown ____
If yes, result: Positive ___ Negative ___

Regarding chlamydia:

2.5 Known history of chlamydia infection prior to pregnancy? Yes ___ No ___ Unknown ____

2.5.1 Treated: Yes ___ No ___ Unknown ____

2.6 Screening for chlamydia in pregnancy? Yes ___ No ___ Unknown ____

2.6.1 *If yes* (check all that apply): ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐ At delivery

2.6.2 Results: Positive ___ Negative ___

2.6.3 *If positive*, treated? Yes ___ No ___ Unknown ____
If treated, drug used: _____ Duration: _____ Route: _____

2.6.4 Test of cure after treatment? Yes ___ No ___ Unknown ____
If yes, result: Positive ___ Negative ___

Risk factors for new acquisition of sexually transmitted infection (STI) during pregnancy:

2.7 Partner(s) with known risk factors for STI: Yes ___ No ___ Unknown ____

2.8 New sexual partner(s): Yes ___ No ___ Unknown ____

2.9 Mother treated for STI but partner(s) not treated: Yes ___ No ___ Unknown ____

SECTION 3 – BIRTH HISTORY

3.1 Gestational age (weeks completed, or term) _____ 3.2 Birth weight _____ (g)

3.3 Type of delivery: ❍Vaginal ❍ Caesarean

3.4 Prolonged rupture of membranes > 18 hours? Yes ___ No ___ Unknown ___
If yes, duration: _____ (hours or unknown)

3.5 Maternal intrapartum antibiotic given (e.g., GBS prophylaxis): Yes ___ No ___ Unknown ___

If yes, antibiotic name: _____

3.6 Place of birth: ☐ Hospital ☐ Home ☐ Birthing centre ☐ Other, specify: _____

3.7 Was ocular erythromycin ointment applied? Yes ___ No ___ Unknown ___

If yes, age when applied _____ (hour or unknown)

SECTION 4 – CLINICAL COURSE

4.1 Date of onset of first symptoms: ____ /____ /_____
DD MM YYYY

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

4.3 Date diagnosis confirmed: ____ /____ /_____
DD MM YYYY

4.4 Clinical presentation

Presentation	Yes	No	Duration of symptoms prior to presentation (days)
Conjunctival/ocular erythema			
Conjunctival/ocular discharge			
Conjunctival/periocular swelling			
Fever			
Suspected sepsis			
Suspected meningitis			
Other (list):_____			

SECTION 5 – MICROBIOLOGY INVESTIGATIONS (INFANT)

5.1

Specimen	Culture result*	Date DD/MM/YYYY	PCR/NAAT results	Date DD/MM/YYYY
Eye discharge				
Nasopharyngeal/other respiratory tract				
Blood				
Other (specify):_____				

* *N gonorrhoeae* (GC), *C trachomatis* (CT), Negative (N), or Not done (ND)

5.2 If *N gonorrhoeae* was isolated, report sensitivity: (susceptible / resistant / intermediate / not available)

Erythromycin: _____ Azithromycin: _____ Tetracycline: _____

SECTION 6 – TREATMENT

6.1 Was antibiotic treatment given? Yes ___ No ___ Unknown ___

6.2 *If yes*, list medications used in empiric or definitive treatment:

Medication	Dose per kg	Frequency per day	Route (IV, IM, oral, ocular)	Duration in days (actual or planned)

6.3 Was patient hospitalized for treatment? Yes ___ No ___ Unknown ___

If yes, duration of hospitalization: _____ (days)

6.4 Was ocular surgery required? Yes ___ No ___ Unknown ___

If yes, describe: _____

6.5 Was a microbiological test done after treatment was completed? Yes ___ No ___ Unknown ___

If yes: Specimen: _____ Test: _____ Result: ☐ Positive ☐ Negative

Specimen: _____ Test: _____ Result: ☐ Positive ☐ Negative

Specimen: _____ Test: _____ Result: ☐ Positive ☐ Negative

SECTION 7 – OUTCOME (Completion of this section may require follow-up. If treatment outcome is not yet known, please leave all entries blank)

7.1 Date of last follow-up: ____ /____ /_____
DD MM YYYY

7.2 Did the patient have persistent or recurrent symptoms after completion of the recommended course of antibiotic therapy? Yes ___ No ___ Unknown ___

If yes, specify symptoms: _____

7.3 Were microbiology tests again positive for the same microorganism? Yes ___ No ___ Unknown ____

If yes: Specimen(s): _____ Test(s): _____

7.4 Was a repeat course of antibiotic given? Yes ___ No ___ Unknown ___

If yes: Antibiotic: _____ Dose: _____ Route: _____ Duration: _____

7.5 Did the patient have any ocular sequelae: Yes ___ No ___ Unknown ___

If yes, specify: _____

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

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

SECTION 8 – REPORTING PHYSICIAN

First name _____ Surname_____

Address _____

City_____ Province _____ Postal code_____

Telephone number_____ Fax number_____

E-mail_____ Date completed_____

Specialty_____ Type of provider_____

Thank you for completing this form.