MENINGOCOCCAL DISEASE

Basis of diagnosis

Clinical criteria

Fits clinical description	Select the 'Yes' option if the case fits the clinical description as follows: *A serious invasive disease with an acute onset and may start as a mild flu-like illness and rapidly progress to fulminant septicaemia and death. Cases typically experience acute fever, malaise, nausea, myalgia, arthralgia and prostration. A rash occurs in about two thirds of cases – this may be ill defined and macular, petechial or purpuric. More severe infection leads to to shock, disseminated intra-vascular coagulation (DIC), acrocyanosis and multi-organ failure.* *Approximately 75% of cases have meningitis (typically causing headache, photophobia and neck stiffness). Infants present with less-specific features.* *Other locations of invasive disease are possible though rare, such as orbital cellulitis, septic arthritis, and pericarditis.*
Clinical features	Ideally, obtain information on all of the clinical features listed. If the feature was present, record by select the 'Yes' option. If not, select the 'No' option. If not known or unavailable then select the 'Unknown' option. Specify any other invasive illness which is not listed.

Laboratory criteria

Laboratory results	Indicate the status of laboratory confirmation. If the laboratory test results were positive select the 'Yes' option, if negative select the 'No' option. If the results of the laboratory test are not yet available, select 'Awaiting results'. If any of the laboratory tests were not carried out, select 'Not Done'. Specify the site for isolation if not listed and for the detection of meningococcal antigen. Specify any other positive test that is not listed. The laboratory confirmation requirements are given below in the 'Classification' section.

Additional laboratory results

This section will be automatically populated with data from the Invasive Pathogens Laboratory at ESR when the full typing results are available.

Group	Select the strain group identified. If strain group is not listed, select 'Other' and specify.
Type (Serotype)	Specify serotype (PorB) identified.
PorA (Subtype)	Specify PorA result identified.
ESR Updated	A flag to indicate that the laboratory results have been updated by ESR (closed to users)

Laboratory	The name of the laboratory from where the results originated (closed to users).
Date result updated	The date the result fields were updated (closed to users).
Sample Number	The laboratory sample number (closed to users).

Classification

Classification	**Under investigation** - a case which has been notified but information is not yet available to classify it as probable or confirmed. **Probable** – a clinically compatible illness. **Confirmed** – a clinically compatible illness that is laboratory confirmed. **Laboratory confirmation requires** at least one of the following: • isolation of *Neisseria meningitidis* bacteria or detection of *N. meningitidis* nucleic acid from blood, CSF or other normally sterile site (e.g. pericardial or synovial fluid) • detection of gram negative intracellular diplococci in blood, CSF or skin petechiae • detection of meningococcal antigen (i.e. latex agglutination test) in CSF. **Not a case** – a case that has been investigated, and subsequently found not to meet the case definition.

Clinical course and outcome

(in addition to the instructions for the completion of modules common to all case report forms)

Time of onset	The time of onset is the time at which the case was first aware of being ill. Values should be recorded using the 24 hour clock, e.g. 6pm = 1800hrs, and should be recorded as 18:00.
Time hospitalised	Specify the time admitted to hospital, again using the 24-hour clock as above.

Risk factors

Contact with a presumptive case	Indicate whether the case had contact with a presumptive case of meningococcal disease in the 60 days prior to disease onset. If 'Yes', whether they were offered prophylaxis, if it was taken and the type of prophylaxis. Give the name of the presumptive case and the nature of contact. You should use the categories given in the contact management section, i.e. household, childcare/ pre-school, close institutional, exposed to oral secretions or other contacts (specify). Indicate if the child was overseas during the incubation period of 2−60 days prior to the onset of disease.
Attendance at school, pre-school or childcare	Indicate whether the case attends school, pre-school or childcare. If not known or unavailable then select the 'Unknown' option.

Overseas travel	Indicate whether the case was overseas during the incubation period for meningococcal disease (range = 2-60 days). If not known or unavailable then select the 'Unknown' option.
Other risk factor for meningococcal disease	Specify any other risk factors under surveillance for meningococcal disease if they were present.

Protective factors

Was case immunised with meningococcal vaccine	Indicate whether the case had been immunised with any meningococcal vaccine at any time **before becoming ill**. If not known or unavailable, then select the 'Unknown' option.
Vaccine details	If case had been immunised (prior to becoming ill),tick the vaccine(s) checkbox (select all that apply) and provide the number of doses received, date of last dose and whether source of information was patient/caregiver recall or documented evidence.
Details of MeNZB vaccination	If case had been immunised with MeNZB, record the date dose was given or the age of the case at the time the dose was given and the documented source(s) of information (tick all that apply) for **each dose** of vaccine received. It should be noted that not all information sources are required. The NIR is sufficient. If the parent held record is viewed check the NIR or doctor's record to confirm. If there is no documented evidence of MeNZB, record how many doses the case or parent/caregiver thinks they had received. Also record the date(s) when thought to have been given.

Management

Case management	
Was case seen by a doctor	Indicate whether case was seen by a general practitioner (or other doctor in a primary care setting) prior to hospital admission. Record the date and time (use 24 hour clock as explained above) when the case was seen by the doctor. If not known or unavailable, then select the 'Unknown' option.
IV/IM antibiotics given	Indicate whether intravenous/intramuscular antibiotics were given prior to hospital admission. If 'Yes', record the date and time the antibiotics were given (use 24 hour clock). If not known or unavailable, then select the 'Unknown' option.
Contact management	
Contacts	If the case had contacts at risk of infection, describe their management. Record the number of contacts identified as listed on the case report form. Specify the type of 'Other' close contacts. If case had multiple types of contacts, specify the type below. Indicate how many of the contacts identified were counselled, offered antibiotics and offered vaccination i.e. these should be a subset of the number identified.