



**Infectious Disease Epidemiology Section**  
**Office of Public Health, Louisiana Dept of Health & Hospitals**  
**800-256-2748 (24 hr number) – (504) 568-5005**  
**[www.oph.dhh.state.la.us](http://www.oph.dhh.state.la.us)**

## **Influenza-Associated Encephalopathy Pediatric Cases**

01/15/2004

CDC would like to receive clinical, laboratory, and neuro-imaging results on all cases of influenza associated encephalopathy.

### **Influenza Viral Isolates**

If influenza viral isolates were obtained, CDC would like to receive the isolates. If a lumbar puncture was performed and CSF is available, frozen CSF should be shipped for RT-PCR testing for influenza viruses.

For any fatal cases or encephalopathy cases in which influenza viruses have been isolated, send the isolates to CDC for antigenic characterization. The attached form should be used to send isolates and any frozen CSF specimens – please indicate on the form that these are from fatal cases or encephalopathy cases.

### **Fatal influenza-associated pediatric cases**

For fatal cases, send clinical information and laboratory results. Autopsy reports should be sent with autopsy tissue specimens. Immuno-histochemical staining can be performed for influenza A and B viruses, and testing for other pathogens can also be done.

### **Fatal “unexplained” pediatric deaths (pneumonia cases, sudden deaths, or other cases suspicious for influenza with or without fever):**

Send any available clinical information and laboratory results. Autopsy reports should be sent with autopsy tissue specimens. Immuno-histochemical staining can be performed for influenza A and B viruses, and testing for other pathogens can also be done.

### **Clinical, laboratory, and neuroimaging results**

Send available clinical, laboratory results (especially with documentation of influenza virus infection) for fatal influenza-associated cases, influenza-associated encephalopathy cases, and “unexplained” pediatric deaths to the OPH central laboratory in New Orleans which will forward them to CDC.

## Influenza-associated Encephalopathy

Updated: 12.06.03    Case Reporting Form    CASE ID: \_\_\_\_\_

Demographic Information (identifiers – names – can be omitted)			
1. Patient <b>last name</b> (or initial):	2. Patient <b>first name</b> (or initial):		
3. <b>Gender</b> a. <input type="checkbox"/> male    b. <input type="checkbox"/> female	4. <b>Date of birth:</b> ____/____/____ (mm/dd/yy)		
5. <b>Race</b>	a. <input type="checkbox"/> Caucasian	b. <input type="checkbox"/> African-American	c. <input type="checkbox"/> Asian/Pacific Islander
	d. <input type="checkbox"/> American Indian/Alaska native	e. <input type="checkbox"/> Other (specify): _____	z. <input type="checkbox"/> Unknown
6. <b>Ethnicity</b>	a. <input type="checkbox"/> Hispanic	b. <input type="checkbox"/> Non-Hispanic	z. <input type="checkbox"/> Unknown
<b>Clinical Information: Hospital Name:</b> _____ <b>City:</b> _____ <b>State:</b> _____			
7. <b>Hospital Medical Record Number:</b> _____			
8. <b>Underlying conditions:</b>	a. <input type="checkbox"/> None	b. <input type="checkbox"/> Developmental delay	
c. <input type="checkbox"/> Seizure disorder	d. <input type="checkbox"/> Previous febrile seizures	e. <input type="checkbox"/> Asthma	
f. <input type="checkbox"/> Other neurologic disorder (specify): _____	g. <input type="checkbox"/> Other medical condition (specify): _____	z. <input type="checkbox"/> Unknown	
9. <b>Did patient receive influenza vaccine this season?</b>	a. <input type="checkbox"/> Yes	Number of vaccine doses received: ____	Dates of influenza vaccinations: ____/____/____    ____/____/____
	b. <input type="checkbox"/> No	c. <input type="checkbox"/> Unknown	d. <input type="checkbox"/> Injected    e. <input type="checkbox"/> Nasal spray
10. <b>Did the patient receive influenza vaccine in a previous season?</b>	a. <input type="checkbox"/> Yes	b. <input type="checkbox"/> No	c. <input type="checkbox"/> Unknown
11. <b>Date of illness onset:</b> ____/____/____	12. <b>Date of fever onset:</b> ____/____/____		
13. <b>Date of hospital admission:</b> ____/____/____	14. <b>Date of neurologic symptoms onset:</b> ____/____/____ (seizures or altered mental status)		
15. <b>Signs and symptoms associated with this illness:</b> (check all that apply)			
a. <input type="checkbox"/> fever	b. <input type="checkbox"/> chills/rigors	c. <input type="checkbox"/> rhinorrhea/congestion	
d. <input type="checkbox"/> cough	e. <input type="checkbox"/> shortness of breath	f. <input type="checkbox"/> sore throat	
g. <input type="checkbox"/> vomiting	h. <input type="checkbox"/> diarrhea	j. <input type="checkbox"/> joint pain/swelling	
i. <input type="checkbox"/> myalgia	k. <input type="checkbox"/> rash	If yes to rash, description: _____	
l. <input type="checkbox"/> altered mental status	m. <input type="checkbox"/> seizures	If yes, status epilepticus at any point? <input type="checkbox"/>	



c. <input type="checkbox"/> immunofluorescence		i. <input type="checkbox"/> Direct ( <b>DFA</b> )	ii. <input type="checkbox"/> Indirect ( <b>IFA</b> )
d. <input type="checkbox"/> Serology ( <input type="checkbox"/> paired sera)		e. <input type="checkbox"/> RT-PCR	f. <input type="checkbox"/> Other: _____
27. <b>Specimens used for influenza testing</b> (check all that apply):			
a. <input type="checkbox"/> Nasopharyngeal swab/wash/aspirate		b. <input type="checkbox"/> Nasal swab/wash	c. <input type="checkbox"/> Throat swab
d. <input type="checkbox"/> lung/respiratory tract tissue		e. <input type="checkbox"/> blood/serum	
28. <input type="checkbox"/> <b>Other specimens obtained</b> (e.g., cerebrospinal fluid (CSF), autopsy brain tissue): _____			
29. <b>Type of influenza virus</b> detected: a. <input type="checkbox"/> A subtype, (if known): _____ b. <input type="checkbox"/> B z. <input type="checkbox"/> unknown			
<b>Outcome</b>			
30. <b>Outcome of illness:</b>		a. <input type="checkbox"/> <b>Alive, no neurologic sequelae</b>	b. <input type="checkbox"/> <b>Alive, mild neurologic sequelae</b>
c. <input type="checkbox"/> <b>Alive, severe neurologic sequelae</b>		d. <input type="checkbox"/> <b>Died</b>	e. <input type="checkbox"/> <b>Unknown/other:</b> _____
31. <b>Discharge diagnosis:</b> _____			
32. <b>Date of hospital discharge:</b> ____/____/____			
33. <b>Date of death</b> (if fatal outcome): ____/____/____			
<b>Reporting Information</b>			
34. Date this form was completed: ____/____/____ (mm/dd/yyyy)			
35. <b>Name of person reporting case to CDC:</b>		Job title:	
36. <b>Contact address:</b>			
37. Phone number: ( ) -		38. Second Phone number: ( ) -	
39. Fax number: ( ) -		40. Email address:	
41. <b>Hospital name and address:</b>			