

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

**ANTHRAX
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 3**

**ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease.
Enter all information from this form into the NC EDSS question packages.**

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? Y N U
Specify _____

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? Y N U
If yes, symptom onset date (mm/dd/yyyy): ____/____/____

Fever Y N U
 Yes, subjective No
 Yes, measured Unknown
 Highest measured temperature _____
 Fever onset date (mm/dd/yyyy): ____/____/____

Fatigue or malaise or weakness Y N U

Shock Y N U
 Was systolic BP <90mm Hg Y N U
 Shock was Septic Hypovolemic

Swollen lymph nodes (lymphadenopathy or lymphadenitis) Y N U
 Distribution Regional Unilateral Bilateral Unknown
 Location Preauricular Inguinal Cervical Femoral Axillary

Altered mental status Y N U
 Patient displayed (select all that apply)
 Confusion Coma Disorientation

Headache Y N U
Stiff neck Y N U
Meningitis Y N U

(continued)

CLINICAL FINDINGS (continued)

Elevated CSF protein Y N U
Elevated CSF cell count Y N U
Encephalomyelitis/meningoencephalitis Y N U
Joint pains (arthralgias) Y N U
Muscle aches / pains (myalgias) Y N U
Skin lesions Y N U
 Please describe (check all that apply)
 Papule Pustule Vesicle Bulla(e) Ulcer

Skin lesion characterized by coal black scab surrounded by non-tender swollen rim (black eschar) Y N U

Oropharyngeal/mucosal lesion(s) (stomatitis) Y N U
Cough Y N U
 Onset date (mm/dd/yyyy): ____/____/____
 Productive Y N U
 Describe (check all that apply)
 Clear Purulent Bloody (hemoptysis)

Shortness of breath/difficulty breathing/respiratory distress Y N U
Acute Respiratory Distress Syndrome (ARDS) Y N U
Pneumonia Y N U
Did the patient have a chest x-ray? Y N U
 If yes, describe (check all that apply):
 Normal Infiltrate Diffuse infiltrates/findings suggestive of ARDS Mediastinal widening Pleural effusion Hilar adenopathy Other

Chest CT scan performed Y N U
 Describe (check all that apply)
 Infiltrate Normal Pleural effusion Hilar Adenopathy Mediastinal adenopathy Other

Hemorrhagic pleural effusion Y N U
Chest pain Y N U
Nausea Y N U
Vomiting Y N U
Abdominal pain or cramps Y N U
Diarrhea Y N U
 Describe (select all that apply)
 Bloody Non-bloody Watery Other
 Maximum number of stools in a 24-hour period: _____

Bacteremia Y N U
 Date of positive blood culture (mm/dd/yyyy) ____/____/____

Septicemia / sepsis Y N U
Other symptoms, signs, clinical findings, or complications consistent with this illness Y N U
 Please specify: _____

Clinical classification
 Cutaneous Inhalational Gastrointestinal Unknown Oropharyngeal Meningitis/meningoencephalitis

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TREATMENT

Did the patient take an antibiotic for this illness? Y N U
If yes, specify antibiotic name: _____

Were antibiotics taken before culture specimen collected? Y N U
Specify culture site(s) _____

Were antibiotics given in the 24 hours before culture? Y N U

Was antibiotic prophylaxis given prior to illness onset? Y N U

TRAVEL/IMMIGRATION

The patient is:
 Resident of NC
 Resident of another state or US territory
 Foreign Visitor
 Refugee
 Recent Immigrant
 Foreign Adoptee
 None of the above

Did patient travel during the 7 days prior to onset of symptoms? Y N U
List travel dates and destinations:
From ___/___/___ to ___/___/___

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U
List persons and contact information:

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 7 days prior to onset of symptoms, did the patient work in a laboratory? Y N U
If yes, specify and give details: _____

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? Y N U
Hospital name: _____
City, State: _____
Hospital contact name: _____
Telephone: (____) _____
Admit date (mm/dd/yyyy): ___/___/___
Discharge date (mm/dd/yyyy): ___/___/___

Additional travel/residency information:

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
If yes, specify: _____

During the 7 days prior to onset of symptoms, did the patient:
 Work in a post office or handle mail or packages? Y N U
 Name of facility _____
 Street address _____
 City _____ State _____
 Zip code _____ County _____
 Date(s) of work at this facility:
 From ___/___/___ to ___/___/___
 Specify any dates not present at work _____

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? Y N
If yes, specify: _____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U
 Patient a child care worker or volunteer in child care? Y N U
 Patient a parent or primary caregiver of a child in child care? Y N U
 Is patient a student? Y N U
 Is patient a school WORKER/VOLUNTEER in NC school setting? Y N U
 Give details: _____

Visit a post office, mail, or package facility? Y N U
 Name of facility _____
 Street address _____
 City _____ State _____
 Zip code _____ County _____
 Date(s) of visit(s) at this facility:
 From ___/___/___ to ___/___/___

During the 7 days prior to onset of symptoms, did the patient serve in the US Military? Y N U
If yes, specify where and give dates of service: _____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U
 Died? Y N U
 Died from this illness? Y N U
 Date of death (mm/dd/yyyy): ___/___/___

Autopsy performed? Y N U
 Patient autopsied in NC? Y N U
 County of autopsy: _____
 Autopsied outside NC, specify where: _____

BEHAVIORAL RISK & CONGREGATE LIVING

During the 7 days prior to onset of symptoms, did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? Y N U
 Name of facility: _____
 Dates of contact: _____

FOOD RISK AND EXPOSURE

Note: For GI Anthrax Only
 During the 7 days prior to onset of symptoms did the patient do any of the following:
 Handle raw meat other than poultry? Y N U
 If yes, specify: _____

Source of death information (select all that apply):
 Death certificate
 Autopsy report final conclusions
 Hospital/discharge physician summary
 Other

During the 7 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? Y N U
 If yes, specify: _____

In what setting was the patient most likely exposed?
 Restaurant Place of Worship
 Home Outdoors, including woods or wilderness
 Work Athletics
 Child Care Farm
 School Pool or spa
 University/College Pond, lake, river or other body of water
 Camp Hotel / motel
 Doctor's office/ Outpatient clinic Social gathering, other than listed above
 Hospital In-patient Travel conveyance (airplane, ship, etc.)
 Hospital Emergency Department International
 Laboratory Community
 Long-term care facility /Rest Home Other (specify) _____
 Military Unknown
 Prison/Jail/Detention Center

Eat ground beef/hamburger? Y N U
If yes, specify: _____

Eat pork/pork products? Y N U
If yes, specify: _____

Eat wild game meat (bear, buffalo, deer, wild boar, etc.)? Y N U
If yes, specify: _____

Eat other meat/meat products
If yes, specify: _____

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OUTDOOR EXPOSURE

During the 7 days prior to onset of illness:
Did the patient participate in any outdoor activities? Y N U
 If yes, specify: _____

Was patient exposed to wild animals? . Y N U
 If yes, specify type of animal and dates of exposure: _____

What was location of the exposure?
 North Carolina
 County _____
 US (not North Carolina)
 State _____
 Foreign
 Country _____

Did patient skin/eviscerate (gut) wild animal or have contact with wild animal carcass? Y N U
 Specify animal(s): _____
 Specify exposure(s) (contact with) (check all that apply):
 Hide Bone Blood
 Hair Raw meat Excreta

Did patient work in wildlife law enforcement? Y N U
Did patient work in wildlife rehabilitation? Y N U
 If yes, specify type of wildlife _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U
 Date of interview (mm/dd/yyyy): ____/____/____
Were interviews conducted with others? Y N U
 Who was interviewed? _____

Were health care providers consulted? Y N U
 Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U
Specify reason if medical records were not reviewed: _____

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?
 Specify location:
 In NC
 City _____
 County _____
 Outside NC, but within US
 City _____
 State _____
 County _____
 Outside US
 City _____
 Country _____
 Unknown

Is the patient part of an outbreak of this disease? Y N

Notes:

ANIMAL EXPOSURE

During the 7 days prior to onset of symptoms, did the patient have exposure to animals (includes animal tissues, animal products, or animal excreta)? Y N U
 If yes, specify and give details: _____

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder/wholesaler/distributor? Y N U
 If yes, specify and give details: _____

Did patient work with animal importation? Y N U
 If yes, specify and give details: _____

Did patient / household contact work at, live on, or visit a farm, ranch, or dairy? Y N U
 If yes, specify and give details: _____

Was patient exposed to animals associated with agriculture or aviculture (domestic/semi-domestic animals)? Y N U
 If yes, specify and give details: _____

Did patient have contact with commercial animal products (i.e. wool, hair, hides, fur, raw/smoked meat, bones, bone meal)? Y N U
 If yes, specify and give details: _____

Did patient work at or visit a slaughterhouse (abattoir), meat-packing plant, poultry or wild game processing facility? Y N U
 If yes, specify and give details: _____

Has patient otherwise slaughtered animals or been a butcher, meat cutter, or meat processor? Y N U
 If yes, specify and give details: _____

Did the patient work at or visit a fair with livestock or a petting zoo? Y N U
 If yes, specify and give details: _____

Did the patient work at or visit a zoo, zoological park, or aquarium? Y N U
 If yes, specify and give details: _____

Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? Y N U
 If yes, specify and give details: _____

Did patient work with anthrax vaccines? Y N U
 If yes, specify and give details: _____

Did patient necropsy animals? Y N U
 If yes, specify and give details: _____

Did patient work with B. anthracis? Y N U
 If yes, specify and give details: _____

Notes:

VACCINE

Has patient/contact ever received anthrax vaccine? Y N U
 If yes, provide the vaccine name, the source of the vaccine, date of vaccination, and source of the vaccine information: _____

Notes:

Anthrax (*Bacillus anthracis*)

1996 CDC Case Definition

Clinical description

An illness with acute onset characterized by several distinct clinical forms, including the following:

- Cutaneous: a skin lesion evolving during a period of 2-6 days from a papule, through a vesicular stage, to a depressed black eschar
- Inhalation: a brief prodrome resembling a viral respiratory illness, followed by development of hypoxia and dyspnea, with radiographic evidence of mediastinal widening
- Intestinal: severe abdominal distress followed by fever and signs of septicemia
- Oropharyngeal: mucosal lesion in the oral cavity or oropharynx, cervical adenopathy and edema, and fever

Laboratory criteria for diagnosis

- Isolation of *Bacillus anthracis* from a clinical specimen, or
- Anthrax electrophoretic immunotransblot (EITB) reaction to the protective antigen and/or lethal factor bands in one or more serum samples obtained after onset of symptoms, or
- Demonstration of *B. anthracis* in a clinical specimen by immunofluorescence

Case classification

Confirmed: a clinically compatible case that is laboratory confirmed