

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

S. AUREUS WITH REDUCED SUSCEPTIBILITY TO VANCOMYCIN
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 74

REMINDER to Local Health Department staff: 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.

Table with 8 columns: Specimen Date, Specimen #, Specimen Source, Type of Test, Test Result(s), Description (comments), Result Date, Lab Name—City/State

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease?
If yes, symptom onset date (mm/dd/yyyy):
CHECK ALL THAT APPLY:
Septicemia/sepsis
Specimen Source
Specimen collection date:
Laboratory performing initial susceptibility test:

Was patient hospitalized for this illness >24 hours?
Hospital name:
City, State:
Hospital contact name:
Telephone:
Admit date (mm/dd/yyyy):
Discharge date (mm/dd/yyyy):
Discharge/final diagnosis:

Minimum inhibitory concentration (MIC):
Test Method:
Was additional testing performed by NC State Laboratory of Public Health?

Minimum inhibitory concentration (MIC):
Test Method:
Was additional testing performed at CDC?

Minimum inhibitory concentration (MIC):
Test Method:

PREDISPOSING CONDITIONS

Any immunosuppressive conditions..
Please specify:
Autoimmune disease
Diabetes
Malignancy
Other malignancy (ies)
Cardiovascular/heart disease
Liver disease
Kidney disease
Patient on dialysis
Chronic lung disease
Injury/Wound/Break in skin
Recent/Acute injury(ies) or wound(s)
Date:
Anatomic site:
Principal wound type
Preexisting injury or wound
Date:

PREDISPOSING CONDITIONS (continued)

Did patient have other condition potentially affecting skin integrity?
Specify condition(s):
Other underlying illness
Receiving treatment/medications (at the time of initial culture)
Antibiotics
Chemotherapy
Immunosuppressive therapy, including anti-rejection therapy
Radiotherapy
Systemic steroids/corticosteroids, including steroids taken by mouth or injection
Receive vancomycin in 12 months prior to diagnosis
Number of course of vancomycin treatments
Treatment start date (mm/dd/yyyy):
End date (mm/dd/yyyy):
Prior history of vancomycin-resistant enterococci (VRE)
Date of most recent culture:
Site of culture:
Prior history of methicillin-resistant staphylococcus aureus (MRSA)
Date of most recent culture:
Site of culture:

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

REASON FOR TESTING

Why was the patient tested for this condition?

Symptomatic of disease

Screening of asymptomatic person with reported risk factor(s)

Exposed to organism causing this disease (asymptomatic)

Household / close contact to a person reported with this disease

Other

Unknown

TREATMENT

Did the patient take an antibiotic for this illness? Y N U

Specify antibiotic name: _____

Date antibiotic began (mm/dd/yyyy): ___/___/___

Date antibiotic ended (mm/dd/yyyy): ___/___/___

Is the number of days medication was taken known? Y N

Number of days taken: _____

CLINICAL OUTCOMES

Survived? Y N U

Died? Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): ___/___/___

TRAVEL/IMMIGRATION

The patient is:

Resident of NC

Resident of another state or US territory

None of the above

Did patient have a travel history during the one year 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:

Additional travel/residency information:

BEHAVIORAL RISK & CONGREGATE LIVING

In what setting was the patient most likely exposed?

Restaurant

Home

Work

Child Care

School

University/College

Camp

Doctor's office/ Outpatient clinic

Hospital In-patient

Hospital Emergency Department

Laboratory

Long-term care facility /Rest Home

Military

Prison/Jail/Detention Center

Place of Worship

Outdoors, including woods or wilderness

Athletics

Farm

Pool or spa

Pond, lake, river or other body of water

Hotel / motel

Social gathering, other than listed above

Travel conveyance (airplane, ship, etc.)

International

Community

Other (specify) _____

Unknown

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the one year prior to onset of symptoms, did the patient have any of the following health care exposures:

Dialysis Y N U

Facility name _____

City _____

State _____

Country _____

Hospital

Visit / admit date (mm/dd/yyyy): ___/___/___

Facility name _____

Has patient been discharged? Y N U

Discharge date (mm/dd/yyyy): _____

Was facility notified regarding ill patient?

Yes No Unknown Not applicable

Name of person notified _____

Date notified (mm/dd/yyyy): ___/___/___

Long term care facility - resident (e.g. nursing home, rest home, rehab)

Visit / admit date (mm/dd/yyyy): ___/___/___

Facility name _____

City _____ State _____

Country _____

Has patient been discharged? Y N U

Discharge date (mm/dd/yyyy): _____

Was facility notified regarding ill patient?

Yes No Unknown Not applicable

Name of person notified _____

Date notified (mm/dd/yyyy): ___/___/___

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:

S. aureus, reduced susceptibility to vancomycin

2007 CDC Case Definition

Clinical Description

S. aureus can produce a variety of syndromes with clinical manifestations including skin and soft tissue infections, empyema, bloodstream infection, pneumonia, osteomyelitis, septic arthritis, endocarditis, sepsis, and meningitis. *S. aureus* may also colonize individuals who remain asymptomatic. The most frequent site of *S. aureus* colonization is the nares.

Laboratory criteria for diagnosis

- Isolation of *S. aureus* from any body site.

AND

- Intermediate or resistance of the *S. aureus* isolate to vancomycin, detected and defined according to Clinical and Laboratory Standards Institute (CLSI, formerly NCCLS) approved standards and recommendations (Minimum Inhibitory Concentration [MIC]=4-8 µg/ml for VISA and MIC≥16 µg/ml for VRSA).

Case Classification

Confirmed: A case of vancomycin-intermediate or vancomycin-resistant *S. aureus* that is laboratory-confirmed (MIC=4-8 µg/ml for VISA and MIC≥16 µg/ml for VRSA).

Reference

Clinical and Laboratory Standards Institute/NCCLS. Performance Standards for Antimicrobial Susceptibility Testing. Sixteenth informational supplement. M100-S16. Wayne, PA: CLSI, 2006.