Disseminated Gonococcal Infection Case Report Form (Version 2 September 2023)

REDCap Case ID (Generated by REDCap): _____

REPORTER INFORMATION

Date Form Completed (MM/DD/YYYY): _____

Name of Person Completing Form: _____ Phone No: _____

Agency: _____ Email: _____

CASE INFORMATION

1a. Was case sent to CDC's NNDSS as a gonorrhea case?

☐ Yes (Answer 1b)
☐ No
☐ Unknown

1b. If yes, was the case sent via: ☐ NETSS ☐ MMG

If case sent via NETSS:
State: _____
MMWR Year: _____
Case Report ID: _____
Site Code: _____

If case sent via MMG:
National Reporting Jurisdiction (77968-6): _____
Local record ID (N/A: OBR-3): _____

2. How was this case identified? (Check all that apply):
☐ Provider report
☐ Laboratory report
☐ Other, specify _____

3. Case classification* for disseminated infection:
☐ Verified
☐ Likely

***Case Classification**
https://doh.wa.gov/sites/default/files/legacy/Documents/5000/347-653-GonorrheaReportingGuidelines.pdf?uid=6424a22c7b895

4. Date first reported to health department:
(MM/DD/YYYY): _____

CASE INFORMATION: DEMOGRAPHIC INFORMATION

1. State of Residence
_____
☐ Not a US resident
☐ Unknown

2. County of Residence:
_____
☐ Not applicable
☐ Unknown

3. Age (In years):
_____ ☐ Unknown

4. Sex Assigned at Birth:
☐ Male
☐ Female
☐ Unknown

5. Current Gender:
☐ Male gender
☐ Female gender
☐ Transgender male
☐ Transgender female
☐ Gender diverse or non-binary
☐ Other gender identity
☐ Unknown

6. Race (Check all that apply):
☐ White
☐ Black
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ Other race
☐ Unknown

7. Hispanic Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

CASE INFORMATION: PREGNANCY STATUS

1. At time of DGI diagnosis, patient was:
☐ Pregnant (Answer 2, 3)
☐ Postpartum* (Answer 2, 3)
☐ Neither
☐ Unknown

2a. If pregnant or postpartum, what is the estimated due date?
(MM/DD/YYYY): _____

Postpartum = up to one year

2b. If pregnant or postpartum, what is the date of the pregnancy outcome?
(MM/DD/YYYY):
_____

3a. If pregnant or postpartum, what was the outcome of the fetus?
☐ Live birth, no apparent illness
☐ Live birth, clinical infection with *N. gonorrhoeae* (Answer 3b)
☐ Live birth with neonatal death before 30 days
☐ Still birth (Gestational age ≥ 20 weeks)
☐ Spontaneous abortion/miscarriage (Gestational age < 20 weeks)
☐ Termination
☐ Still pregnant
☐ Unknown

3b. If live birth with clinical infection with *N. gonorrhoeae*, what were the signs/symptoms?
Signs/Symptoms: _____

PAST MEDICAL HISTORY (Check all that apply; include ANY known past medical history ever during lifetime)

1. Condition/Diagnosis	Yes / No / Unknown			
Complement deficiency	☐ Yes	☐ No	☐ Unknown	
Previous disseminated gonococcal infection (DGI)	☐ Yes	☐ No	☐ Unknown	
Previous meningococcal infection	☐ Yes	☐ No	☐ Unknown	
HIV infection	☐ Yes	☐ No	☐ Unknown	
Atypical hemolytic uremic syndrome (aHUS)	☐ Yes	☐ No	☐ Unknown	
Generalized myasthenia gravis (GMG)	☐ Yes	☐ No	☐ Unknown	
Paroxysmal nocturnal hemoglobinuria (PNH)	☐ Yes	☐ No	☐ Unknown	
Immunosuppressive therapy (e.g. steroids, chemotherapy, radiation)	☐ Yes	☐ No	☐ Unknown	
Systemic lupus erythematosus (SLE)	☐ Yes	☐ No	☐ Unknown	
Diabetes mellitus	☐ Yes	☐ No	☐ Unknown	
Hepatitis C infection	☐ Yes	☐ No	☐ Unknown	
Hepatitis B infection	☐ Yes	☐ No	☐ Unknown	
Malignancy	☐ Yes	☐ No	☐ Unknown	If yes, specify _____
Other	☐ Yes	☐ No	☐ Unknown	If yes, specify _____

PAST MEDICAL HISTORY CONTINUED | **REDCap ID:**_____

2a. Did the patient receive any antibiotics in the 1 month prior to the current DGI diagnosis? ☐ Yes (Answer 2b) ☐ No ☐ Unknown

2b. If yes:

Antibiotic	Dose (mg)	Route (IV, IM, PO)	Frequency (Every ___ hours)	Duration (Days)	Date Started (MM/DD/YYYY)

3a. Prior to this gonococcal infection, did the patient receive or have history of receiving the medication Eculizumab (or other biologic agents that inhibit the complement cascade)? ☐ Yes (Answer 3b) ☐ No ☐ Unknown

3b. If yes:

If not receiving Eculizumab, what complement-inhibiting biologic agent did the patient receive? _____

What was the date of the last dose in which Eculizumab (or other complement-inhibiting biologic agent) was administered (MM/DD/YYYY)? _____

Did the patient receive antibiotic prophylaxis as a result of the receipt of this medication? ☐ Yes ☐ No ☐ Unknown

If yes, please specify which antibiotic (name and dose) they received? _____

DGI CLINICAL COURSE: UROGENITAL, PHARYNGEAL, AND RECTAL SYMPTOMS

1a. Was the patient experiencing symptoms of urogenital, pharyngeal, or rectal gonorrhea at the time of or within a month prior to DGI presentation?

☐ Yes (Answer 1b) ☐ No ☐ Unknown

1b. If yes, when did the patient first seek medical care for the symptoms of urogenital, pharyngeal, or rectal gonococcal infection (MM/DD/YYYY)?

_____

Symptom	Yes / No / Unknown			Date of Onset (MM/DD/YYYY)
Penile/Vaginal discharge	☐ Yes	☐ No	☐ Unknown	_____
Dysuria	☐ Yes	☐ No	☐ Unknown	_____
Sore throat	☐ Yes	☐ No	☐ Unknown	_____
Rectal bleeding, discharge, and/or pain	☐ Yes	☐ No	☐ Unknown	_____
Abdominal or pelvic pain	☐ Yes	☐ No	☐ Unknown	_____
Testicular pain or swelling	☐ Yes	☐ No	☐ Unknown	_____
Other, specify: _____	☐ Yes	☐ No	☐ Unknown	_____

DGI CLINICAL COURSE: DGI CLINICAL PRESENTATION, MANAGEMENT, AND OUTCOME

1. When did the patient first develop DGI symptoms (e.g., fever, chills, malaise, rash, joint pain or swelling) (MM/DD/YYYY)? _____

2. When did the patient first seek medical care for the DGI symptoms (MM/DD/YYYY)? _____

3. In what types of medical facilities was the patient evaluated or treated for DGI symptoms, even if a diagnosis was not made (Check all that apply)?

☐ Emergency Department
☐ Urgent care clinic
☐ Primary care clinic (e.g., Family Practice, Internal Medicine, Pediatrics)
☐ STD specialty clinic
☐ Other specialty clinic (e.g., Sports Medicine/Orthopedics, Rheumatology, Infectious Diseases, OB/GYN)
☐ Inpatient hospital service(s)
☐ Other, specify: _____
☐ Unknown

4a. Clinical Manifestations of DGI (Check all that apply):

☐ Fever
☐ Bacteremia
☐ Endocarditis
☐ Hepatitis
☐ Meningitis
☐ Myocarditis
☐ Skin lesions; if yes, please describe:

_____

☐ Polyarthralgia
☐ Septic arthritis
☐ Tenosynovitis
☐ Osteomyelitis
☐ Other, specify _____
☐ Unknown

4b. If the patient was diagnosed with septic arthritis, what anatomic sites were involved? (Check all that apply)

☐ Knee ☐ Ankle
☐ Wrist ☐ Spine
☐ Other, please specify:

_____

☐ Unknown

4c. If the patient was diagnosed with osteomyelitis, what anatomic sites were involved? (Check all that apply)

☐ Knee ☐ Ankle
☐ Wrist ☐ Spine
☐ Other, please specify:

_____

☐ Unknown

5a. Was the patient admitted to a hospital for DGI management (i.e., hospitalized as inpatient)?

☐ Yes (Answer 5b)
☐ No
☐ Unknown

5b. If yes:

Total Number of Days Hospitalized

_____

6a. Did the patient have any procedures (inpatient or outpatient) related to DGI?

☐ Yes (Answer 6b) ☐ No ☐ Unknown

6b. If yes, check all that apply:

☐ Joint aspiration
☐ Lumbar puncture
☐ Skin biopsy
☐ Transesophageal echocardiogram
☐ Joint washout, debridement, or operative incision and drainage
☐ Heart valve replacement surgery
☐ Other

If other, please describe:

_____

DGI CLINICAL COURSE: DGI CLINICAL PRESENTATION, MANAGEMENT, AND OUTCOME CONTINUED **REDCap ID:**____________________

7a. What was the clinical outcome of the DGI case? ☐ Survived ☐ Died ☐ Unknown

7b. If the patient died, what was the cause(s) of death:____________________

7c. Date of Death (MM/DD/YYYY): ____________________

DGI TREATMENT (*After* DGI diagnosis was made)

Medication	Dose (mg)	Route (IV, IM, PO)	Frequency (Every ___ hours)	Duration (Days)	Date Started (MM/DD/YYYY)
1a. Ceftriaxone					
1b. Cefixime					

1c. During the clinical course, did the patient receive additional antimicrobial treatment not already described above? ☐ No ☐ Yes ☐ Unknown

If yes, which antimicrobials? (Check all that apply)	Duration of treatment (days)	Date started (MM/DD/YYYY)
☐ Vancomycin IV		
☐ Piperacillin/tazobactam (Zosyn)		
☐ Cefepime		
☐ Meropenem		
☐ Doxycycline (IV or PO)		
☐ Ciprofloxacin (IV or PO)		
☐ Amoxicillin/clavulanic acid (Augmentin)		
☐ Other, please specify: ____________________		
☐ Unknown		

2a. Did the patient complete the prescribed treatment for DGI? ☐ No ☐ Yes ☐ Unknown

2b. If no: why was the prescribed treatment not completed?

☐ Patient left against medical advice ☐ Other reason, specify ____________________
☐ Patient was discharged before diagnosis was received ☐ Unknown

LABORATORY RESULTS (*Use a separate line for each specimen tested*)

Was *N. gonorrhoeae* testing performed at *disseminated sites* of infection during the current DGI presentation? ☐ Yes (Complete table) ☐ No ☐ Unknown

Date of Specimen Collection (MM/DD/YYYY)	Specimen Type (Select one)		Diagnostic Test Type (Select one)	Result (Select one)
____________	☐ Blood ☐ Synovial fluid ☐ CSF*	☐ Skin lesion ☐ Other, specify: ________ ☐ Unknown	☐ NAAT* ☐ Culture ☐ Other, specify: ________ ☐ Unknown	☐ Positive ☐ Negative ☐ Indeterminant ☐ Unknown
____________	☐ Blood ☐ Synovial fluid ☐ CSF*	☐ Skin lesion ☐ Other, specify: ________ ☐ Unknown	☐ NAAT* ☐ Culture ☐ Other, specify: ________ ☐ Unknown	☐ Positive ☐ Negative ☐ Indeterminant ☐ Unknown
____________	☐ Blood ☐ Synovial fluid ☐ CSF*	☐ Skin lesion ☐ Other, specify: ________ ☐ Unknown	☐ NAAT* ☐ Culture ☐ Other, specify: ________ ☐ Unknown	☐ Positive ☐ Negative ☐ Indeterminant ☐ Unknown

Please provide details for any other *N. gonorrhoeae* testing performed at *disseminated sites* of infection.

**CSF=cerebrospinal fluid; NAAT=nucleic acid amplification test*

LABORATORY RESULTS (Use a separate line for each specimen tested) | **REDCap ID: ____________________**

Was *N. gonorrhoeae* testing performed at urogenital, pharyngeal, and rectal sites in the 3 months prior to or associated with the current DGI presentation/diagnosis?

☐ Yes (Complete table) ☐ No ☐ Unknown

Date of Specimen Collection (MM/DD/YYYY)	Specimen Type (Select one)		Diagnostic Test Type (Select one)	Result (Select one)
________________	☐ Urine ☐ Endocervical ☐ Vaginal ☐ Urethral	☐ Pharyngeal ☐ Rectal ☐ Other, specify: ________________ ☐ Unknown	☐ NAAT* ☐ Culture ☐ Other, specify: ______________ ☐ Unknown	☐ Positive ☐ Negative ☐ Indeterminant ☐ Unknown
________________	☐ Urine ☐ Endocervical ☐ Vaginal ☐ Urethral	☐ Pharyngeal ☐ Rectal ☐ Other, specify: ________________ ☐ Unknown	☐ NAAT* ☐ Culture ☐ Other, specify: ______________ ☐ Unknown	☐ Positive ☐ Negative ☐ Indeterminant ☐ Unknown
________________	☐ Urine ☐ Endocervical ☐ Vaginal ☐ Urethral	☐ Pharyngeal ☐ Rectal ☐ Other, specify: ________________ ☐ Unknown	☐ NAAT* ☐ Culture ☐ Other, specify: ______________ ☐ Unknown	☐ Positive ☐ Negative ☐ Indeterminant ☐ Unknown

Please include any additional *N. gonorrhoeae* testing performed at urogenital, pharyngeal and rectal sites in the 3 months prior to and including the current DGI presentation.

** NAAT=nucleic acid amplification test*

Were any available *N. gonorrhoeae* isolates sent to CDC for further testing? ☐ Yes ☐ No ☐ Unknown
If yes: what was the date of shipment to CDC? (MM/DD/YYYY) __________________

ADDITONAL COMMENTS (e.g., additional patient history, clinical course, etc.):

FOR CDC USE ONLY: CDC LRRB Assigned ID: ______________________________

BEHAVIORAL AND PARTNER INFORMATION (Collected from medical chart review and/or patient interview)

1. Gender of sex partners in the past 12 months (Check all that apply):
☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Gender diverse or non-binary ☐ Other gender identity ☐ Unknown

2. Exchanged money, food/lodging, or drugs for sex in the past 12 months: ☐ Yes ☐ No ☐ Unknown

3. Homelessness (e.g., living on the street, in a shelter/a single-room occupancy hotel, in a car) at any time during the past 12 months:
☐ Yes ☐ No ☐ Unknown

4. Incarcerated in the past 12 months: ☐ Yes ☐ No ☐ Unknown

5. Reports using the drug in the past 12 months (or positive drug test)

Drug		**If used in past 12 months, was it injected?**
5a. Methamphetamine	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
5b. Heroin	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
5c. Other opioid, excluding prescription painkillers	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
5d. Prescription painkillers	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
5e. Cocaine/Crack	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
5f. Other:________________________________	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

BEHAVIORAL AND PARTNER INFORMATION: PARTNER SERVICES INFORMATION (Using a 60-day interview period)	**REDCap ID: ____________________**

6a. Was the patient interviewed by a Disease Intervention Specialist (DIS) or other public health staff? ☐ Yes (Answer 6b) ☐ No ☐ Unknown

If yes:

6b. Did the patient report any sex or needle sharing partners or associates: ☐ Yes ☐ No ☐ Unknown

If partner information available, complete the table below.

Partner	**Partner Gender (Select one)**	**Partner Type (Select one)**	**Locating Information Provided (Select one)**	**Interview Performed (Select one)**	**Gonorrhea Case (Select one)**	**DGI Case (Select one)**	**Isolate Sent to CDC for Additional Testing (Select one)**
________	☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Gender diverse or non-binary ☐ Other gender identity ☐ Unknown	☐ Sex ☐ Needle sharing ☐ Sex *AND* needle sharing ☐ Associate	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
________	☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Gender diverse or non-binary ☐ Other gender identity ☐ Unknown	☐ Sex ☐ Needle sharing ☐ Sex *AND* needle sharing ☐ Associate	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
________	☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Gender diverse or non-binary ☐ Other gender identity ☐ Unknown	☐ Sex ☐ Needle sharing ☐ Sex *AND* needle sharing ☐ Associate	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
________	☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Gender diverse or non-binary ☐ Other gender identity ☐ Unknown	☐ Sex ☐ Needle sharing ☐ Sex *AND* needle sharing ☐ Associate	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
________	☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Gender diverse or non-binary ☐ Other gender identity ☐ Unknown	☐ Sex ☐ Needle sharing ☐ Sex *AND* needle sharing ☐ Associate	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
________	☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Gender diverse or non-binary ☐ Other gender identity ☐ Unknown	☐ Sex ☐ Needle sharing ☐ Sex *AND* needle sharing ☐ Associate	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Include information on any additional partners.

FOR CDC USE ONLY

If partner isolate was sent to CDC for additional testing:

CDC LRRB Assigned ID: ___________________________