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

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

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
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

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

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

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): ____/____/____

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? ☐Y ☐N

If yes, specify: _____

_____

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: _____

Source of death information (select all that apply):

- ☐ Death certificate
- ☐ Autopsy report final conclusions
- ☐ Hospital/discharge physician summary
- ☐ Other

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:

_____

_____

_____

Additional travel/residency information:

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:

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: _____

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
- ☐ 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 7 days prior to onset of symptoms, did the patient work in a laboratory? ☐Y ☐N ☐U

If yes, specify and give details:

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 _____

_____

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:

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:

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:

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

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 wildlfe _____

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:

Anthrax (*Bacillus anthracis*)

2010 Case Definition

CSTE Position Statement Number: 09-ID-10

Clinical description

- Cutaneous Anthrax: An acute illness, or post-mortem examination revealing a painless skin lesion developing over 2 to 6 days from a papular through a vesicular stage into a depressed black eschar with surrounding edema. Fever, malaise and lymphadenopathy may accompany the lesion.

- Inhalation Anthrax: An acute illness, or post-mortem examination revealing a prodrome resembling a viral respiratory illness, followed by hypoxia, dyspnea or acute respiratory distress with resulting cyanosis and shock. Radiological evidence of mediastinal widening or pleural effusion is common.

- Gastrointestinal Anthrax: An acute illness, or post-mortem examination revealing severe abdominal pain and tenderness, nausea, vomiting, hematemesis, bloody diarrhea, anorexia, fever, abdominal swelling and septicemia.

- Oropharyngeal Anthrax: An acute illness, or post-mortem examination revealing a painless mucosal lesion in the oral cavity or oropharynx, with cervical adenopathy, edema, pharyngitis, fever, and possibly septicemia.

- Meningeal Anthrax: An acute illness, or post-mortem examination revealing fever, convulsions, coma, or meningeal signs. Signs of another form will likely be evident as this syndrome is usually secondary to the above syndromes.

Case classification

Suspected: An illness suggestive of one of the known anthrax clinical forms. No definitive, presumptive, or suggestive laboratory evidence of B. anthracis, or epidemiologic evidence relating it to anthrax.

Probable:
A clinically compatible illness that does not meet the confirmed case definition, but with one of the following:
- Epidemiological link to a documented anthrax environmental exposure;
- Evidence of B. anthracis DNA (for example, by LRN-validated polymerase chain reaction) in clinical specimens collected from a normally sterile site (such as blood or CSF) or lesion of other affected tissue (skin, pulmonary, reticuloendothelial, or gastrointestinal);
- Positive result on testing of clinical serum specimens using the Quick ELISA Anthrax-PA kit;
- Detection of Lethal Factor (LF) in clinical serum specimens by LF mass spectrometry
- Positive result on testing of culture from clinical specimens with the RedLine Alert test.

Confirmed:
A clinically compatible illness with one of the following:
- Culture and identification of B. anthracis from clinical specimens by the Laboratory Response Network (LRN);
- Demonstration of B. anthracis antigens in tissues by immunohistochemical staining using both B. anthracis cell wall and capsule monoclonal antibodies;
- Evidence of a four-fold rise in antibodies to protective antigen between acute and convalescent sera or a four-fold change in antibodies to protective antigen in paired convalescent sera using Centers for Disease Control and Prevention (CDC) quantitative anti-PA IgG ELISA testing;
- Documented anthrax environmental exposure AND evidence of B. anthracis DNA (for example, by LRN-validated polymerase chain reaction) in clinical specimens collected from a normally sterile site (such as blood or CSF) or lesion of other affected tissue (skin, pulmonary, reticuloendothelial, or gastrointestinal).