Public Health Agency of Canada | Agence de la santé publique du Canada

Acute hepatitis (non hepatitis A-E) case report form

Introduction

This is a case report form being used to report cases with unexplained acute hepatitis (non hepatitis A to E). The case definitions, which will evolve based on ongoing investigations, are:

- **Confirmed:** N/A at present

- **Probable:**
    - A person who is 16 years and younger presenting with severe acute hepatitis since 1 October 2021 and requiring hospitalization,
    AND
    - With elevated serum transaminase >500 IU/L (AST or ALT),
    AND
    - Excluding hepatitis caused or attributed to a hepatitis virus (A, B, C, D, E[1]) or a known or expected presentation of a drug or medication; a genetic, congenital, or metabolic condition; an oncologic, vascular, or ischemia related condition; or an acute worsening of chronic hepatitis.

[1]If hepatitis D or E serology results are pending or test was not done, but other criteria met, these can be reported as probable cases.

This case report form will require information from both the clinical team and the parent/guardian of the case.

FOR LOCAL USE ONLY – PLEASE REMOVE THIS PAGE IF SENDING TO PHAC	
Case information	
Case name:	Proxy name:
Personal health identifier:	
Street Address: ______________ City/Town: ______________ Postal Code: ______________	Home phone: ______________ Work phone: ______________ Cell phone: ______________

Date reported to PHAC *(dd/mm/yyyy):*		Initial report Updated report	☐ ☐

Section 1: Reporter details			
Public health authority			
Name:		Title:	
Cell phone:		Email address:	
Province or Territory:			
Clinician			
Name:		Title:	
Cell phone:		Email address:	
Organization:		Date of interview *(dd/mm/yyyy):*	

Section 2: Case information			
Month and Year of birth *(mm/yyyy):*		Sex:	Female ☐ Male Other
Ethnicity/ Race* (check all that apply): *Indicates the population group to which the case most closely identifies	☐ Black (e.g. African, Afro-Caribbean, African Canadian descent) ☐ East/Southeast Asian (e.g. Chinese, Korean, Japanese, Taiwanese descent or Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian descent) ☐ Indigenous (e.g. First Nations, Inuk/Inuit, Métis descent) ☐ Latino (e.g. Latin American, Hispanic descent) ☐ Middle Eastern (e.g. Arab, Persian, West Asian descent – i.e. Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish) ☐ South Asian (e.g. South Asian descent – i.e. East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean) ☐ White (e.g. European descent) ☐ Other, specify: ____________ ☐ Not asked ☐ Prefer not to answer ☐ Unknown		
If Indigenous, indicate which Indigenous identity the case self-identifies as:	☐ First Nations ☐ Métis (includes member of a Métis organization or Settlement) ☐ Inuk/Inuit ☐ Other Indigenous, specify: ☐ Not asked ☐ Prefer not to answer ☐ Unknown		

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Section 3: Current case status			
Alive, recovered and discharged		☐	
Alive, discharged and recovering		☐	
Alive, in hospital		☐	
Alive, in intensive care (ICU/CCU)		☐	
Deceased		☐	
Unknown		☐	
More information:			
Name of hospital where diagnosis of acute hepatitis was made:		________________________ Unknown ☐	
Was liver transplant required?	Yes ☐ No ☐ Unknown ☐	Name of hospital and date of liver transplant if applicable:	Hospital ________________ Unknown ☐ Date ________________ Unknown ☐

Section 4: Presenting illness of case		
Please provide a summary of the symptoms and signs of the presenting illness (including prodromal symptoms) and dates of onset if known:		
Symptom	Symptom present	Symptom onset date *(dd/mm/yyyy)*
Jaundice	Yes ☐ No ☐	
Nausea	Yes ☐ No ☐	
Abdominal pain/ cramping	Yes ☐ No ☐	
Diarrhea	Yes ☐ No ☐	
Bloody stool	Yes ☐ No ☐	
Pale stool	Yes ☐ No ☐	
Dark urine	Yes ☐ No ☐	
Rash	Yes ☐ No ☐	
Vomiting	Yes ☐ No ☐	
Respiratory Symptoms – shortness of breath, cough	Yes ☐ No ☐	
Upper Respiratory Symptoms – runny nose, congestion, sore throat	Yes ☐ No ☐	
Fever	Yes ☐ No ☐	
Malaise/ tiredness	Yes ☐ No ☐	
Conjunctivitis	Yes ☐ No ☐	
Other (please specify below):	Yes ☐ No ☐	

Please provide clinical contact details of this presentation:		
Clinical contact	Clinical contacts during this presentation	Admission date – Discharge date *(dd/mm/yyyy)*
Visited Family doctor or pediatrician	Yes ☐ No ☐	
Visited ER	Yes ☐ No ☐	
Admission to hospital (for at least 1 night)	Yes ☐ No ☐	
ICU/CCU admission	Yes ☐ No ☐	

Section 5: Laboratory results / Toxicology / Investigations

NOTE: Note: please follow provincial guidelines/directives for laboratory testing. Please provide results of all tests performed.

	Result	Not tested	Pending	Date sample collected *(dd/mm/yyyy)*
Laboratory marker				
Highest ALT				
Highest AST				
Highest ALP				
Highest Bilirubin				
Highest INR				
PT				
Highest Fibrinogen				
Highest Ferritin				
D-dimer				
Lowest Albumin				
Peak LDH				
Peak GGT				
Peak CRP				
Peak WBC				

	Result				Date sample collected *(dd/mm/yyyy)*
	Detected	Not detected	Not tested	Pending	
Infectious diseases					
CMV PCR in blood (indicate viral load if available)					
CMV Serology (IgG or IgM)					
EBV PCR in blood (indicate viral load if available)					
EBV Serology (IgG or IgM)					

Section 5: Laboratory results / Toxicology / Investigations

NOTE: Note: please follow provincial guidelines/directives for laboratory testing. Please provide results of all tests performed.

	Result				Date sample collected *(dd/mm/yyyy)*
	Detected	Not detected	Not tested	Pending	
Enterovirus PCR in blood (indicate viral load if available					
HSV – 1 PCR in blood (indicate viral load if available)					
HSV – 2 PCR in blood (indicate viral load if available)					
HHV-6					
HAV: PCR in blood if done, or stool, please specify: ________________________					
HAV: IgG					
HAV: IgM					
HBV (HBsAg)					
HBV DNA					
Hepatitis B antibody tests, please specify: ________________________________					
HCV (Ab)					
HCV RNA					
HEV: IgM					
HEV: IgG					
HEV PCR in blood (or stool), please specify: ________________________					
Adenovirus – stool sample					
Adenovirus – respiratory sample					
Adenovirus – blood sample (indicate viral load)					
Adenovirus – other sample					
Adenovirus genotyping, indicate sample used: ___________________________					
SARS-CoV-2 PCR – respiratory sample					
SARS-CoV-2 anti-spike and/or anti-N antibody					
RSV PCR – respiratory sample					
Influenza PCR – respiratory sample					
Enterovirus PCR – respiratory sample					
Varicella PCR in blood					
Parvovirus B19 IgM or IgG or PCR, please specify: _________________________					
HIV serology					

Section 5: Laboratory results / Toxicology / Investigations

NOTE: Note: please follow provincial guidelines/directives for laboratory testing. Please provide results of all tests performed.

	Result				Date sample collected *(dd/mm/yyyy)*
	Detected	Not detected	Not tested	Pending	
ASOT					
Throat swab for bacterial culture					
Stool for bacterial culture					
Stool PCR for norovirus and/or enterovirus (select those included if not all available)					
Other, please specify:_______________					
Toxicology					
Heavy metal screen: Lead					
Heavy metal screen: Arsenic					
Heavy metal screen: Mercury					
Drug screen: Peak acetaminophen concentration					
Urine toxicology, please provide details of any positive tox results: ______________					
Investigations	Performed	If yes, please summarise findings:			Date of test
Radiology:					
X-rays	Yes ☐ No ☐				
Abdominal ultrasound scan	Yes ☐ No ☐				
CT scan	Yes ☐ No ☐				
Liver biopsy (summarise histopathology report, including whether damage starting at portal tracts or diffuse)	Yes ☐ No ☐				
List immunohistochemistry stains performed (adenovirus/CMV/EBV etc)	Yes ☐ No ☐				

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Section 6: Case medical and health history

Did the case have COVID-19? Yes ☐ Suspected ☐ Unknown ☐ No ☐

If yes, was it confirmed by a test? Yes ☐ [PCR ☐; Rapid test ☐] No ☐

Date of COVID-19 onset (most recent episode) *(dd/mm/yyyy)*:

Please summarize any other previous illnesses requiring treatment/care in the 5 months prior to diagnosis:

Illness type (e.g. gastrointestinal illness, injury)	Hospitalisation required (yes/no)	Date of onset/ days to resolution	Primary Symptoms	Over the counter or prescribed medication taken

Please describe any other medication the case has been prescribed in the 5 months prior to diagnosis	
Does the case have any underlying medical condition? Including liver related/metabolic/autoimmune/ischaemic	Yes ☐ No ☐
If yes, details: (diagnosis, date of diagnosis, medication)	
Is the case immunosuppressed?	Yes ☐ No ☐
If yes, details: (condition (include if primary, secondary, medication related), date of diagnosis, medication)	
Does or has the case take(n) any supplements or medicines acquired, over the counter, purchased over the internet or accessed by any other methods? (Including herbal, alternative medicines, vitamins or other supplements); specifically, prompt acetaminophen/ anti-inflammatory drugs (e.g. aspirin, ibuprofen)/anticonvulsants in the 5 months prior to diagnosis?	Yes ☐ No ☐
If yes, details: (product, dose and frequency, where purchased)	
Has the patient received any vaccine in the 5 months prior to diagnosis?	Yes ☐ No ☐
If yes, details: (type, date of administration)	
Has the patient received a COVID-19 vaccine?	Yes ☐ No ☐ Date:
Does the patient have autoimmune hepatitis? Yes ☐ No ☐ Unknown ☐	If yes, details:
Does the patient have HLH (Hemophagocytic Lymphohistiocytosis)? Yes ☐ No ☐ Unknown ☐	If yes, details:

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Section 7: Travel History	
In the 5 months prior to diagnosis of acute hepatitis, has the case travelled outside of Canada?	Yes ☐ No ☐ If yes, please specify location and date of travel: ____

Section 8: Any other information	
Comments:	

END OF QUESTIONNAIRE