

California Department of Public Health
 Center for Infectious Diseases
 Division of Communicable Disease Control
 Infectious Diseases Branch
 Surveillance and Statistics Section
 MS 7306, P.O. Box 997377
 Sacramento, CA 95899-7377

Local ID Number _____

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary Final

CYSTICERCOSIS / TAENIASIS CASE REPORT

Check one: Cysticercosis
 Taeniasis

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street - Residence		Apartment/Unit Number		Ethnicity (check one)	
City/Town		State	Zip Code	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unk	
Census Tract	County of Residence		Country of Residence		
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Home Telephone		Cellular Phone/Pager		Work/School Telephone	
E-mail Address		Other Electronic Contact Information			
Work/School Location		Work/School Contact			
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
Medical Record Number		Patient's Parent/Guardian Name			
Occupation Setting (see list on page 6)		Other Describe/Specify			
Occupation (see list on page 6)		Other Describe/Specify			
*Comment: self-identity or self-reporting The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.					
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

First three letters of patient's last name:

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SIGNS AND SYMPTOMS

Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset Date (mm/dd/yyyy)	Date First Sought Medical Care (mm/dd/yyyy)
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SIGNS AND SYMPTOMS

Signs and Symptoms	Yes	No	Unk	Signs and Symptoms	Yes	No	Unk
Headache				Subcutaneous lesion			
Seizures				Bone lesion			
Hydrocephalus				Eye lesion			
Meningitis				Stroke			
Dementia				Gastrointestinal symptoms (e.g., nausea, abdominal pain, diarrhea)			
Cranial nerve palsy				Other signs / symptoms (specify)			

HOSPITALIZATION

Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, how many total hospital nights?
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If there were any ER or hospital stays related to this illness, specify details below.

HOSPITALIZATION - DETAILS

Hospital Name 1	Street Address			Admit Date (mm/dd/yyyy)		
	City			Discharge / Transfer Date (mm/dd/yyyy)		
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis	
Hospital Name 2	Street Address			Admit Date (mm/dd/yyyy)		
	City			Discharge / Transfer Date (mm/dd/yyyy)		
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis	

TREATMENT / MANAGEMENT

Received treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify the treatments below.
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TREATMENT / MANAGEMENT - DETAILS

Treatment Type 1 <input type="checkbox"/> Antiparasitic <input type="checkbox"/> Steroid <input type="checkbox"/> Anticonvulsant <input type="checkbox"/> Other: _____	Treatment Name	Treatment Dose	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
Treatment Type 2 <input type="checkbox"/> Antiparasitic <input type="checkbox"/> Steroid <input type="checkbox"/> Anticonvulsant <input type="checkbox"/> Other: _____	Treatment Name	Treatment Dose		
Treatment Type 3 <input type="checkbox"/> Antiparasitic <input type="checkbox"/> Steroid <input type="checkbox"/> Anticonvulsant <input type="checkbox"/> Other: _____	Treatment Name	Treatment Dose		

SURGERY

Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Surgery Date (mm/dd/yyyy)
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First three letters of patient's last name:

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OUTCOME

Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	If Survived, Survived as of _____ (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
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LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type 1 <input type="checkbox"/> Serum <input type="checkbox"/> Stool <input type="checkbox"/> Tissue biopsy: _____ <input type="checkbox"/> Other: _____	Type of Test <input type="checkbox"/> Immunoblot <input type="checkbox"/> ELISA <input type="checkbox"/> Ova and parasite exam <input type="checkbox"/> Microscopic examination <input type="checkbox"/> Other: _____	
	Results	Interpretation <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal
	Laboratory Name	Telephone Number

Specimen Type 2 <input type="checkbox"/> Serum <input type="checkbox"/> Stool <input type="checkbox"/> Tissue biopsy: _____ <input type="checkbox"/> Other: _____	Type of Test <input type="checkbox"/> Immunoblot <input type="checkbox"/> ELISA <input type="checkbox"/> Ova and parasite exam <input type="checkbox"/> Microscopic examination <input type="checkbox"/> Other: _____	
	Results	Interpretation <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal
	Laboratory Name	Telephone Number

IMAGING SUMMARY

Anatomic Site 1	Type of Imaging <input type="checkbox"/> X-Ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other: _____	Date (mm/dd/yyyy)
	Result	Interpretation
	Facility Name	Telephone Number

Anatomic Site 2	Type of Imaging <input type="checkbox"/> X-Ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other: _____	Date (mm/dd/yyyy)
	Result	Interpretation
	Facility Name	Telephone Number

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD IS HIGHLY VARIABLE AND CAN RANGE FROM A FEW WEEKS TO 10 YEARS

FOOD HISTORY

Any raw or undercooked <u>game meat</u> eaten while in the U.S. in the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type of Game	Describe Where Acquired/Purchased	Year Eaten
Any raw or undercooked <u>pork</u> eaten while in the U.S. in the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type of Pork	Describe Where Acquired/Purchased	Year Eaten
Any raw or undercooked <u>beef</u> eaten while in the U.S. in the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type of Beef	Describe Where Acquired/Purchased	Year Eaten

First three letters of patient's last name:

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EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD IS HIGHLY VARIABLE AND CAN RANGE FROM A FEW WEEKS TO 10 YEARS

TRAVEL HISTORY

Did patient travel **out of country** during the **last 10 years**?

Yes No Unk

If Yes, specify countries and years in the Travel History - Details table.

TRAVEL HISTORY - DETAILS

Countries	Year Traveled	Ate raw or undercooked meat while traveling?	Describe Types of Meats Eaten and Other Relevant Information
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

CONTACTS / OTHER ILL PERSONS

Any contacts with known case of tapeworm or cysticercosis?

Yes No Unk

If Yes, specify details below.

ILL CONTACTS - DETAILS

Name 1	Age	Gender	Telephone Number	Type of Contact / Relationship	
	Street Address			Date of Contact (mm/dd/yyyy)	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Date First Reported to Public Health (mm/dd/yyyy)	
Name 2	Age	Gender	Telephone Number	Type of Contact / Relationship	
	Street Address			Date of Contact (mm/dd/yyyy)	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Date First Reported to Public Health (mm/dd/yyyy)	

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	Local Health Jurisdiction	Telephone Number	Date (mm/dd/yyyy)
First Reported By			
<input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____			

First three letters of
patient's last name:

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EPIDEMIOLOGICAL LINKAGE	
<i>Epi-linked to known case?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Contact Name / Case Number</i>
DISEASE CASE CLASSIFICATION	
<i>Case Classification (see case definition below)</i> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspected	
<i>Disease Classification</i> <input type="checkbox"/> Cysticercosis <input type="checkbox"/> Neurocysticercosis <input type="checkbox"/> Ocular or periocular cysticercosis <input type="checkbox"/> Other cysticercosis: _____ <input type="checkbox"/> Taeniasis	
STATE USE ONLY	
<i>State Case Classification</i> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspected <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information	
CASE DEFINITION	
<u>CYSTICERCOSIS (CDPH, working definition 2011)</u>	
CLINICAL DESCRIPTION Cysticercosis is a tissue infection with the larval stage of the pork tapeworm, <i>Taenia solium</i> . When tapeworm eggs or proglottids are swallowed, the hatching eggs release larvae which can migrate from the intestine into tissues (including muscle, organs, or central nervous system (CNS) where they form cysts or cysticerci). Cysticerci in the CNS can manifest clinically as headache, epileptiform seizures, signs of intracranial hypertension, or psychiatric disturbances.	
LABORATORY/IMAGING CRITERIA FOR DIAGNOSIS	
Confirmed: <ul style="list-style-type: none"> • <i>T. solium</i> identified in excised cysticerci from tissues by microscopic examination; OR • Identification of cysticerci by CT scan, MRI, or X-ray AND positive result on CDC immunoblot assay. Supportive: <ul style="list-style-type: none"> • Identification of calcified cystic lesions in tissue by CT scan, MRI, or X-ray; OR • Positive result on CDC immunoblot assay. 	
CASE CLASSIFICATION	
Confirmed: A clinically compatible case that is laboratory confirmed. Probable: A clinically compatible case that has supportive laboratory evidence. Suspected: A clinically compatible case without laboratory evidence that is epidemiologically associated with a Probable or Confirmed case.	
<u>TAENIASIS (CDPH, working definition 2011)</u>	
CLINICAL DESCRIPTION A parasitic disease characterized by an intestinal infection with the adult stage of large tapeworms (<i>Taenia solium</i> and <i>Taenia saginata</i>). Clinical manifestations are variable and may include nervousness, insomnia, anorexia, weight loss, abdominal pain, and digestive disturbances. Many cases are asymptomatic.	
LABORATORY CRITERIA FOR DIAGNOSIS	
Confirmed: Identification of <i>Taenia</i> scolex, proglottids, or eggs in feces.	
CASE CLASSIFICATION	
Confirmed: A case that meets the laboratory criteria for diagnosis.	

RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.
OCCUPATION SETTING	
<ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other 	<ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other
OCCUPATION	
<ul style="list-style-type: none"> • Adult film actor/actress • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory/seasonal worker • Agriculture - other/unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other/unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - server • Food service - other/unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker 	<ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - nurse • Medical - other/unknown • Military • Police officer • Professional, technical, or related profession • Retired • Sex worker • Stay at home parent/guardian • Student - preschool or kindergarten • Student - elementary or middle school • Student - high school • Student - college or university • Student - other/unknown • Teacher/employee - preschool or kindergarten • Teacher/employee - elementary or middle school • Teacher/employee - high school • Teacher/instructor/employee - college or university • Teacher/instructor/employee - other/unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other/unknown • Volunteer • Other • Refused • Unknown