Taeniasis/Cysticercosis

COUNTY

FOR STATE USE ONLY #

☐ taeniasis
☐ cysticercosis ___/___/___ case report

☐ confirmed
☐ probable ___/___/___ interstate

Date investigation initiated: ____ /____ /____

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City County Zip

e-mail address_____ language spoken _____

ALTERNATE CONTACT ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT *(check all that apply)*

☐ Lab ☐ Infection Control Practitioner
☐ Physician ☐ _____

Name _____

Phone _____ Date ___/___/___
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient? ☐

DEMOGRAPHICS

SEX
☐ female ☐ male

DATE OF BIRTH ____/____/____
m d y

or, if unknown, AGE _____

HISPANIC ☐ yes ☐ no ☐ unknown

RACE
☐ White ☐ American Indian
☐ Black ☐ Asian/Pacific Islander
☐ unknown ☐ refused to answer
☐ other _____

Worksites/school/day care center/N/A_____

_____

Occupations/grade/N/A_____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptoms of taeniasis: ☐ yes ☐ no ☐ unk

if yes, ONSET on ____/____/____
m d y

Check all that apply:

abdominal pain	☐ yes	☐ no	☐ unk
abdominal distension	☐ yes	☐ no	☐ unk
diarrhea	☐ yes	☐ no	☐ unk
saw worm segments in feces	☐ yes	☐ no	☐ unk

Symptoms of cysticercosis: ☐ yes ☐ no ☐ unk

if yes, ONSET on ____/____/____
m d y

Check all that apply:

seizure	☐ yes	☐ no	☐ unk
chronic/recurrent headaches	☐ yes	☐ no	☐ unk
acute headache	☐ yes	☐ no	☐ unk
nausea/vomiting	☐ yes	☐ no	☐ unk
focal weakness	☐ yes	☐ no	☐ unk
cognitive impairment	☐ yes	☐ no	☐ unk
psychosis	☐ yes	☐ no	☐ unk
loss of consciousness	☐ yes	☐ no	☐ unk
paresthesias	☐ yes	☐ no	☐ unk
vision changes	☐ yes	☐ no	☐ unk
subcutaneous nodules	☐ yes	☐ no	☐ unk

☐ other _____

LABORATORY DATA

☐ Fecal culture confirming *Taenia solium?* m d y

Lab _____ Date ___/___/___

☐ Fecal culture confirming *Taenia* species?

Lab _____ Date ___/___/___

☐ Coproantigen test positive?

Lab _____ Date ___/___/___

☐ Serum EITB assay positive?

Lab _____ Date ___/___/___

☐ Serum ELISA positive?

Lab _____ Date ___/___/___

☐ CT scan? CT results: ☐ confirmatory ☐ compatible ☐ suggestive

Facility where scan was performed _____ Date ___/___/___

☐ MRI scan? MRI results: ☐ confirmatory ☐ compatible ☐ suggestive

Facility where scan was performed _____ Date ___/___/___

☐ Pathologic specimen confirming *T. solium* cyst?

Lab _____ Date ___/___/___

Hospitalized: ☐ yes ☐ no ☐ unk

name of hospital _____ date of admission ____/____/____ date of discharge ____/____/____

Discharged to long-term care facility: ☐ yes ☐ no ☐ unk

Outcome: ☐ survived ☐ died ☐ unk date of death ____/____/____

PATIENT'S NAME ▸ ____________________

BASIS OF DIAGNOSIS

RISK FACTORS FOR DISEASE

Frequent or extended travel outside of US? ☐ yes ☐ no ☐ unk

If yes, specify countries ______________________________

____

____

____

____

Residence outside of US? ☐ yes ☐ no ☐ unk

If yes, specify countries ______________________________

____

____

____

Household contact with travel or resdience outside of US? ☐ yes ☐ no ☐ unk

If yes, specify countries ______________________________

____

____

____

Household contact with history of tapeworm, cysticercosis, seizures, chronic head-aches, other unexplained neurologic disease? ☐ yes ☐ no ☐ unk

Name(s) of household contacts above	Relationship
______________________	____________________
______________________	____________________
______________________	____________________
______________________	____________________

DIAGNOSTIC CRITERIA CHECKLIST (CYSTICERCOSIS)

Absolute Criteria

1. Biopsy or autopsy demonstrating parasite in tissue ☐ yes ☐ no ☐ unk
2. Cystic lesions showing the scolex on CT or MRI ☐ yes ☐ no ☐ unk
3. Direct visualization of parasites in retina ☐ yes ☐ no ☐ unk

Major Criteria

1. CT or MRI scan with highly suggestive lesions ☐ yes ☐ no ☐ unk
2. Positive EITB assay ☐ yes ☐ no ☐ unk
3. Resolution of lesions after treat-ment with praziquatel or albendazole ☐ yes ☐ no ☐ unk
4. Spontaneous resolution of small enhancing lesions seen on CT or MRI ☐ yes ☐ no ☐ unk

Minor criteria

1. CT or MRI with compatible lesions ☐ yes ☐ no ☐ unk
2. Symptoms compatible with cysticercosis ☐ yes ☐ no ☐ unk
3. Positive CSF ELISA ☐ yes ☐ no ☐ unk
4. Subcutaneous nodules ☐ yes ☐ no ☐ unk

Epidemiologic criteria

1. Household contact with evidence of *T. solium* infection ☐ yes ☐ no ☐ unk
2. Residence in endemic area ☐ yes ☐ no ☐ unk
3. Frequent or extended travel to endemic area ☐ yes ☐ no ☐ unk

INFECTION TIMELINE

Exposure period to date of onset usually <5 years, sometimes >25 years.

CASE-CONTACT MANAGEMENT AND FOLLOW-UP

HOUSEHOLD ROSTER/OTHER CONTACTS

Tapeworm carriers identified ☐ yes ☐ no ☐ unk

Name	Age	Relation to Case	Date of test	Date treated	Drug given	Education provided (yes / no / unk)
			___/___/___	___/___/___	____________	☐ ☐ ☐
			___/___/___	___/___/___	____________	☐ ☐ ☐
			___/___/___	___/___/___	____________	☐ ☐ ☐
			___/___/___	___/___/___	____________	☐ ☐ ☐
			___/___/___	___/___/___	____________	☐ ☐ ☐
			___/___/___	___/___/___	____________	☐ ☐ ☐
			___/___/___	___/___/___	____________	☐ ☐ ☐
			___/___/___	___/___/___	____________	☐ ☐ ☐
			___/___/___	___/___/___	____________	☐ ☐ ☐

A

ADMINISTRATION

Remember to copy patient's name to the top of this page.

Initial report sent to OHS on ___/___/___

Completed by ______________________ Date __________ Phone __________ Case investigation sent to OHS on ___/___/___