



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, E¹) 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.

¹If 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: _____	Home phone: _____
City/Town: _____	Work phone: _____
Postal Code: _____	Cell phone: _____

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Date reported to PHAC (dd/mm/yyyy):		Initial report Updated report	<input type="checkbox"/> <input type="checkbox"/>
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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 <input type="checkbox"/> Male Other
Ethnicity/ Race* (check all that apply):	<input type="checkbox"/> Black (e.g. African, Afro-Caribbean, African Canadian descent) <input type="checkbox"/> East/Southeast Asian (e.g. Chinese, Korean, Japanese, Taiwanese descent or Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian descent) <input type="checkbox"/> Indigenous (e.g. First Nations, Inuk/Inuit, Métis descent) <input type="checkbox"/> Latino (e.g. Latin American, Hispanic descent) <input type="checkbox"/> Middle Eastern (e.g. Arab, Persian, West Asian descent – i.e. Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish) <input type="checkbox"/> South Asian (e.g. South Asian descent – i.e. East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean) <input type="checkbox"/> White (e.g. European descent) <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not asked <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Unknown		
*Indicates the population group to which the case most closely identifies			
If Indigenous, indicate which Indigenous identity the case self-identifies as:	<input type="checkbox"/> First Nations <input type="checkbox"/> Métis (includes member of a Métis organization or Settlement) <input type="checkbox"/> Inuk/Inuit <input type="checkbox"/> Other Indigenous, specify: <input type="checkbox"/> Not asked <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Unknown		

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

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 <input type="checkbox"/> No <input type="checkbox"/>	
Nausea	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Abdominal pain/ cramping	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Diarrhea	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Bloody stool	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Pale stool	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Dark urine	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Rash	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Vomiting	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Respiratory Symptoms – shortness of breath, cough	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Upper Respiratory Symptoms – runny nose, congestion, sore throat	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Malaise/ tiredness	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Conjunctivitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other (please specify below):	Yes <input type="checkbox"/> No <input type="checkbox"/>	

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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 <input type="checkbox"/> No <input type="checkbox"/>	
Visited ER	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Admission to hospital (for at least 1 night)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
ICU/CCU admission	Yes <input type="checkbox"/> No <input type="checkbox"/>	

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)
	Result	Not tested	Pending	
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	
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 <input type="checkbox"/> No <input type="checkbox"/>				
Abdominal ultrasound scan	Yes <input type="checkbox"/> No <input type="checkbox"/>				
CT scan	Yes <input type="checkbox"/> No <input type="checkbox"/>				
Liver biopsy (summarise histopathology report, including whether damage starting at portal tracts or diffuse)	Yes <input type="checkbox"/> No <input type="checkbox"/>				
List immunohistochemistry stains performed (adenovirus/CMV/EBV etc)	Yes <input type="checkbox"/> No <input type="checkbox"/>				

Section 6: Case medical and health history				
Did the case have COVID-19? Yes <input type="checkbox"/> Suspected <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> If yes, was it confirmed by a test? Yes <input type="checkbox"/> [PCR <input type="checkbox"/> ; Rapid test <input type="checkbox"/>] No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>		
If yes, details: (diagnosis, date of diagnosis, medication)				
Is the case immunosuppressed?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
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 <input type="checkbox"/> No <input type="checkbox"/>		
If yes, details: (product, dose and frequency, where purchased)				
Has the patient received any vaccine in the 5 months prior to diagnosis?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, details: (type, date of administration)				
Has the patient received a COVID-19 vaccine?		Yes <input type="checkbox"/> No <input type="checkbox"/> Date:		
Does the patient have autoimmune hepatitis? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		If yes, details:		
Does the patient have HLH (Hemophagocytic Lymphohistiocytosis)? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		If yes, details:		

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