



Form 3: Late-Onset Invasive Infection



Use this form:

To report each episode of **microbiologically-confirmed** (*Section A*) or **clinically-suspected** (*Section B, overleaf*) late-onset invasive infection

Infant's surname: _____

Infant's first name: (*enter unknown if applicable*) _____

Infant's date of birth: / /

Name of hospital: _____

Section A: Microbiologically-confirmed late-onset invasive infection

A.1 Details of samples showing positive culture:

Site (blood or CSF)	Name of organism	Date of sample
		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>

A.2 How many days was this infant treated with antibiotics for this episode?
(*please state the intended number of days if this infant died during treatment*)

A.3 Date antibiotics started: / /

A.4 Date antibiotics stopped: / /

If available, please provide a copy of the microbiology report

A.5 How many days was this infant treated with antifungals for this episode?
(*State the intended number of days if this infant died during treatment, do not include prophylactic doses*)

A.6 Date antifungals started: / /

A.7 Date antifungals stopped: / /

Definitions:

Microbiologically-confirmed Late-onset Invasive Infection

Microbiological culture from blood or CSF sampled aseptically more than 72 hours after birth of any of the following
- potentially pathogenic bacteria (including coagulase-negative Staphylococci species but excluding probable skin contaminants such as diphtheroids, micrococci, propionibacteria or a mixed flora)
- fungi

AND

Treatment for 5 or more days with intravenous antibiotics after the above investigation was undertaken. If the infant died, was discharged, or was transferred prior to the completion of 5 days of intravenous antibiotics, this condition would still be met if the intention was to treat for 5 or more days.

There is no need to report urinary tract infection unless there is also a positive blood culture.

Section B: Clinically-suspected late-onset invasive infection

Definitions:

Either - Absence of positive microbiological culture, OR - culture of a mixed microbial flora or of likely skin contaminants (diphtheroids, micrococci, propionibacteria) only.

AND

Clinician intent to administer antibiotic treatment or intravenous antifungals for 5 or more days (excluding antimicrobial prophylaxis) for an infant who demonstrates 3 or more of the following clinical or laboratory features of invasive infection:

B.1 Please specify reasons for antibiotic treatment (tick all boxes that apply)

- Increase in oxygen requirement or ventilatory support
- Increase in frequency of episodes of bradycardia or apnoea
- Temperature instability
- Ileus or enteral feeds intolerance and/or abdominal distention
- Reduced urine output to <1 ml/kg/hour
- Impaired peripheral perfusion (capillary refill time >3 seconds, skin mottling or core-peripheral temperature gap >2°C)
- Hypotension (clinician defined as needing volume or inotrope support)
- Irritability, lethargy or hypotonia (clinician-defined)
- Increase in serum C-reactive protein levels to >15 mg/l or procalcitonin ≥2 ng/ml;
- White blood cells count <4 or >20 × 10⁹ cells/l or platelet count <100 × 10⁹/l
- Glucose intolerance (blood glucose <2.2 mmol/l or >10 mmol/l)
- Metabolic acidosis (base excess <-10 mmol/l or lactate >2 mmol/l)

B.2 How many days was this infant treated with antibiotics for this episode? (please state the intended number of days if this infant died during treatment)

B.3 Date antibiotics started:

 / /

B.4 Date antibiotics stopped:

 / /

B.5 How many days was this infant treated with antifungals for this episode? (State the intended number of days if this infant died during treatment, do not include prophylactic doses)

B.6 Date antifungals started:

 / /

B.7 Date antifungals stopped:

 / /

Section C: Form details



Details of person completing form

Name: _____ Role: _____

Date: / / Signature: _____

Principal Investigator Signature: _____

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