CDC/Chicago Lymphogranuloma Venereum (LGV) Suspected Case Report Form

Case Number _____

If you have a suspected LGV case, please fax report to Chicago Department of Public Health (CDPH), STI Surveillance Unit at (312) 745-7627.

Reporting of Case

Name of Person Completing this Form _____ Phone _____

Today's Date ___/___/___ Affliiation (e.g., clinic, health department) _____ Fax _____

E-mail Address _____

Patient's Address at Time of Visit for Suspected LGV

Last Name _____ First Name _____ Middle Initial _____ Home Phone _____

Residence Street _____ (Apt No.) _____ Work Phone _____

City _____ State _____ Zip _____ Health Jurisdiction/County/State/Country of Residence _____

Patient's Demographic Information

Gender: ☐ Male ☐ Female ☐ Transgender (☐ M-to-F ☐ F-to-M)

Date of Birth: ___/___/___

Age: ____

Hispanic/Latino? Y N U

Race (check all that apply):

- ☐ White
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other: _____
- ☐ Unknown

Clinical Information

Date of Initial Health Care Visit for Suspected LGV: ___/___/___

Clinic where patient was seen for suspected LGV:

Clinic Name _____

Street _____

City _____ State _____ Zip _____

Patient's Clinic ID#: _____

Clinic Type:

- ☐ STD Clinic
- ☐ HIV/AIDS Clinic
- ☐ Primary Care
- ☐ Emergency Department
- ☐ ID Clinic
- ☐ GI Clinic
- ☐ Other: _____

Setting:

- ☐ Kaiser
- ☐ Private Practice
- ☐ University Hospital
- ☐ Emergency Department
- ☐ Public Community Clinic
- ☐ Correctional
- ☐ Other: _____

What was the patient's chief complaint(s) at the initial clinic visit for suspected LGV?
(Please list): _____

Is this patient the sex partner of a person diagnosed with proven or suspected LGV? Y N U

Does the patient report having a sex partner with symptoms consistent with LGV? Y N U

This form adpated from the California Department of Health Services, STD Control Branch.

Date Case Closed ___/___/___ **DIS** ____ **Sup** ____

CDC/Chicago Lymphogranuloma Venereum (LGV) Suspected Case Report Form

Case Number _____

Symptoms

At the initial clinic visit for suspected LGV, did the patient give a history of having any symptoms? Y N U

If "Yes", Symptom(s):	Approximate Date of Onset	Still Present at Exam?	If NO, Duration (# Days)
Y N U Anal Discharge	__/__/__	Y N U	_____
Y N U Rectal Bleeding	__/__/__	Y N U	_____
Y N U Anal Spasms (cramping)	__/__/__	Y N U	_____
Y N U Urgency with pain with bowel movement (Tenesmus)	__/__/__	Y N U	_____
Y N U Constipation	__/__/__	Y N U	_____
Y N U Lymph node enlargement in groin	__/__/__	Y N U	_____
Y N U Ulcer Painful? Y N Site: _____	__/__/__	Y N U	_____
Y N U Papule Painful? Y N Site: _____	__/__/__	Y N U	_____
Y N U Fever	__/__/__	Y N U	_____
Y N U Weight Loss	__/__/__	Y N U	_____
Y N U Malaise	__/__/__	Y N U	_____
Y N U Other *(specify)*: _____	__/__/__	Y N U	_____

Physical Exam Findings

Y N U Inguinal Lymphadenopathy *(if Yes, complete below)*
- Y N U Unilateral
- Y N U Bilateral
- Y N U Tender at Adenopathy site
- Y N U Bubo
  If Yes, is it draining? Y N U

Y N U Ulcer *(if Yes, complete below)*
Tender? Y N Site: _____

Y N U Papule *(if Yes, complete below)*
Tender? Y N Site: _____

Y N U Mucous or purulent anal discharge

Y N U Rectal bleeding

Y N U Fever

Y N U Weight Loss

Y N U Other *(specify)*:
_____
_____
_____

Clinical Procedures

	Indicate Findings	If Yes to Anoscopy, Proctoscopy or Sigmoidoscopy, biopsy done?
Y N U Rectal exam (digital) done?	_____	
Y N U Anoscopy done?	_____	Y N U
Y N U Proctoscopy done?	_____	Y N U
Y N U Sigmoidoscopy done?	_____	Y N U

Chlamydia History

	If Yes, # Infections
Did the patient **ever** have a history of chlamydia infection *(not including the current diagnosis)*? Y N U	_____
Did the patient have a history of chlamydia infection in the **past year** *(not including the current diagnosis)*? Y N U	_____

If Yes, Anatomic Site(s) of Last Infection:
☐ Urine ☐ Urethral/Cervical ☐ Rectal ☐ Pharyngeal ☐ Other: _____ ☐ Unknown

Date: __/__/__ Treatment: _____

CDC/Chicago Lymphogranuloma Venereum (LGV) Suspected Case Report Form

Case Number _____

Patient's Self-Reported HIV Status

Patient knows HIV status? [Y] [N] [U] [R]

If Yes, Status? ☐ Infected ☐ Not Infected ☐ Refused

If Infected, Date of Diagnosis (mm/yyyy) ____/____

If Not Infected, Date of Last Test (mm/yyyy) ____/____

Taken anti-retroviral therapy: Ever? [Y] [N] [U] Last 12 Months? [Y] [N] [U] Currently? [Y] [N] [U]

Chlamydia Tests Conducted

Check which chlamydia tests were conducted at visit for suspected LGV and test results, if available:

CT Specimen Type & Lab Used	CT Test Results	Test Type (if known)
[Y] [N] [U] Urine Lab Name: _____	☐ Positive ☐ Equivocal ☐ Negative ☐ Unk	☐ GenProbe Aptima ☐ Roche Amplicor ☐ Unknown ☐ BD ProbeTec ☐ Other: _____
[Y] [N] [U] Urethral Swab Lab Name: _____	☐ Positive ☐ Equivocal ☐ Negative ☐ Unk	☐ Culture ☐ GenProbe Aptima ☐ Other: _____ ☐ GenProbe PACE 2 ☐ BD ProbeTec ☐ Unknown ☐ Roche Amplicor ☐ Antigen detection (specify): _____
[Y] [N] [U] Rectal Swab If Yes: ☐ Blind Specimen ☐ Directed under Anoscopy/ Proctoscopy/Sigmoidoscopy ☐ Unknown Lab Name: _____	☐ Positive ☐ Equivocal ☐ Negative ☐ Unk	☐ Culture ☐ GenProbe Aptima ☐ Other: _____ ☐ Roche Amplicor ☐ BD ProbeTec ☐ Unknown ☐ Antigen detection (specify): _____
[Y] [N] [U] Oropharyngeal Swab Lab Name: _____	☐ Positive ☐ Equivocal ☐ Negative ☐ Unk	☐ Culture ☐ GenProbe Aptima ☐ Other: _____ ☐ Roche Amplicor ☐ BD ProbeTec ☐ Unknown ☐ Antigen detection (specify): _____
[Y] [N] [U] Serology Lab Name: _____	Titer: _____ Optical Density: _____	☐ CF ☐ MIF ☐ IFA ☐ EIA ☐ Other: _____ ☐ Unknown
[Y] [N] [U] Other: _____ Lab Name: _____	Describe Results: _____	Describe Test Type: _____

Other STD Tests Conducted

Check other STDs for which tests were conducted at the initial LGV clinic visit and test results, if available:

STD	Test Results	Test Type (if known)
[Y] [N] [U] Gonorrhea - Urine	☐ Positive ☐ Negative ☐ Unk	☐ NAATs ☐ Other: _____ ☐ Unk
[Y] [N] [U] Gonorrhea - Rectal	☐ Positive ☐ Negative ☐ Unk	☐ Culture ☐ NAATs ☐ Other: _____ ☐ Unk
[Y] [N] [U] Gonorrhea - Oropharyngeal	☐ Positive ☐ Negative ☐ Unk	☐ Culture ☐ NAATs ☐ Other: _____ ☐ Unk
[Y] [N] [U] Trichomonas	☐ Positive ☐ Negative ☐ Unk	☐ Culture ☐ Wet mount ☐ Other: _____ ☐ Unk
[Y] [N] [U] Syphilis - Non-Treponemal	☐ Reactive - Titer: 1: ____ ☐ Non-reactive ☐ Unk	Serology: ☐ RPR ☐ VDRL ☐ Other: _____ ☐ Unk
[Y] [N] [U] Syphilis - Treponemal	☐ Reactive ☐ Non-reactive ☐ Unk	Serology: ☐ FTA-abs ☐ TP-PA ☐ Other: _____ ☐ Unk
[Y] [N] [U] Syphilis Ulcer/Chancre Site #1: _____ Site #2: _____	Site #1: ☐ Positive ☐ Negative ☐ Unk Site #2: ☐ Positive ☐ Negative ☐ Unk	#1: ☐ Darkfield ☐ DFA-TP ☐ Other: _____ ☐ Unk #2: ☐ Darkfield ☐ DFA-TP ☐ Other: _____ ☐ Unk
[Y] [N] [U] Genital/Rectal Herpes Site #1: _____ Site #2: _____	Site #1: ☐ Positive ☐ Negative ☐ Unk Site #2: ☐ Positive ☐ Negative ☐ Unk	#1: ☐ Culture ☐ Other: _____ ☐ Unk #2: ☐ Culture ☐ Other: _____ ☐ Unk
[Y] [N] [U] Other: _____	☐	☐

CDC/Chicago Lymphogranuloma Venereum (LGV) Suspected Case Report Form

Case Number _____

LGV Treatment

Was treatment given for suspected LGV? [Y] [N] [U]

If Yes, Drug: _____ Dose: _____ Frequency: _____ # Days: _____

Patient's Sexual History

Number of **male sex partners** the patient had in the past **12 months**: _____

Number of **male sex partners** the patient had in the past **3 months**: _____ Of these, **# New:** _____ **# Anonymous:** _____

In the past **3 months**:

- Did the patient have sex (anal, vaginal) without a condom with any of these male partners? [Y] [N] [U]
- Did the patient have receptive anal intercourse with any of these male partners? [Y] [N] [U]
- Did the patient have receptive anal fisting with any of these male partners? [Y] [N] [U]
- **For male patients only:** Did the patient have insertive anal intercourse with any of these male partners? [Y] [N] [U]

Number of **female sex partners** the patient had in the past **12 months**: _____

Number of **female sex partners** the patient had in the past **3 months**: _____ Of these, **# New:** _____ **# Anonymous:** _____

In the past **3 months**:

For male patients only:

- Did the patient have sex (anal, vaginal) without a condom with any of these female partners? [Y] [N] [U]
- Did the patient have insertive anal intercourse with any of these female partners? [Y] [N] [U]

Risk Factors

Which of the following drugs were used in the past **12 months**?

- Marijuana [Y] [N] [U] [R]
- Crack Cocaine [Y] [N] [U] [R]
- Cocaine [Y] [N] [U] [R]
- Ecstasy [Y] [N] [U] [R]
- Heroin [Y] [N] [U] [R]
- Methamphetamine [Y] [N] [U] [R]

Other #1: [Y] [N] [U] [R]

Specify: _____

Other #2: [Y] [N] [U] [R]

Specify: _____

Other #3: [Y] [N] [U] [R]

Specify: _____

In the **12 months** before the suspected LGV diagnosis:

- Been in Jail/Juvenile Detention Center? [Y] [N] [U] [R]
- Been in Prison/Long-Term Correctional Facility? [Y] [N] [U] [R]
- Been a Member of Gang? _____ (Gang Name) [Y] [N] [U] [R]
- Gave Money/Drugs for Sex? [Y] [N] [U] [R]
- Received Money/Drugs for Sex? [Y] [N] [U] [R]
- Had any Sex Partners who have ever been in jail/prison/juvenile hall? [Y] [N] [U] [R]

Venues

In the **3 months** before this suspected LGV diagnosis, where did the patient meet any **NEW** or **ANONYMOUS** sex partners? [R]

☐ No new or anonymous partners in past 3 months

	Meeting Venue	Name(s) of Venues		Meeting Venue	Name(s) of Venues
Bars/Clubs	[Y] [N] [U] [R]		Circuit Parties	[Y] [N] [U] [R]	
Baths/Spas	[Y] [N] [U] [R]		Telephone Chat Lines	[Y] [N] [U] [R]	
Sex Clubs	[Y] [N] [U] [R]		Other #1	[Y] [N] [U] [R]	
Internet/Chat Rooms/Email	[Y] [N] [U] [R]		Other #2	[Y] [N] [U] [R]	
Private Parties	[Y] [N] [U] [R]		Other #3	[Y] [N] [U] [R]	

CDC/Chicago Lymphogranuloma Venereum (LGV) Suspected Case Report Form

Case Number _____

Patient's Travel History

Did the patient travel to Europe in the past **3 months**? [Y] [N] [U]

If Yes, please indicate location, dates, and if the patient had sex there (other than someone with whom they traveled to that location)?

		Sex There?
Location: _____	Dates: _____	[Y] [N] [U]
Location: _____	Dates: _____	[Y] [N] [U]
Location: _____	Dates: _____	[Y] [N] [U]

Did the patient travel anywhere else in the past **3 months**? [Y] [N] [U]

If Yes, please indicate location, dates, and if the patient had sex there (other than someone with whom they traveled to that location)?

		Sex There?
Location: _____	Dates: _____	[Y] [N] [U]
Location: _____	Dates: _____	[Y] [N] [U]
Location: _____	Dates: _____	[Y] [N] [U]

Additional Comments

Additional comments you may have (e.g., other history, risk factors, or behaviors of relevance for this suspected case):