Instructions for Congenital Syphilis THISIS Data Entry

TEXAS Health and Human Services
Texas Department of State Health Services

Contents

Step 1: Find birth parent through search

1. Search for an event with associated syphilis morbidity (hint: cross-product notifier – 700 event in **green text**)
2. If the person has multiple morbidities for syphilis, select the **most recent morbidity**
    a. Review all syphilis events:
        i. Verify maternal syphilis history
        ii. Verify maternal labs
            1. Are there reactive labs within the event that indicate a syphilis diagnosis?
            2. Has there ever been an untreated two-dilution titer rise? Is there a potential unreported syphilis morbidity?
        iii. Verify morbidity question package
            1. Does maternal case meet surveillance criteria?
            2. Is maternal morbidity staged correctly?
            3. Does a new maternal morbidity need to be added?
    b. Review treatment within events
        i. Did mother receive adequate treatment for their most recent surveillance stage of syphilis?
            1. 710, 720, and 730 –
                a. 2.4 MU of Bicillin x 1
                b. 100 mg Doxycycline BID x 14 days
                *NOT ACCEPTABLE DURING PREGNANCY
            2. 740, 745, or 755
                a. 2.4 mu Bicillin x 3
                    i. 7 day intervals during pregnancy
                    ii. 6-10 day intervals outside of pregnancy
                b. 100 mg Doxycycline BID x 28 days
                *NOT ACCEPTABLE DURING PREGNANCY
3. **Dates of treatment should be individually entered**
        i. Was adequate treatment *initiated* at least 30 days prior to delivery?
4. Update maternal information as needed
    a. Document changes in event notes
    b. Send a task to STD Data manager group if morbidity is changed to 755 but the diagnosis year is prior to 2018.
        i. Set the priority to Low
        ii. Use the subject "Notification of historical morbidity modification"
    c. Send a task to STD Data manager group if a morbidity is added.
        i. Set the priority to Low
        ii. Use the subject "Notification of historical morbidity"

Step 2: Find/Select Infant Event

1. In the search screen, use date of birth (DOB) of the infant and disease 700
2. If infant event does not exist, create and infant event
3. If creating an infant record
    a. Enter Name
        i. If birthname is not known, use the following naming standards:
            1. First Name "Baby Boy"
            2. Middle Name "Jane"(Mother's First Name)
            3. Last Name "Smith" (Mother's Last Name)
    b. Enter Sex Assigned at birth
    c. Enter current gender identity as sex assigned at birth. This is to avoid a concern that is generated in the event if gender identity is not entered.
    d. Enter race and ethnicity (if no race or ethnicity is available, use the maternal information)
    e. Address – use maternal address with city and county
4. If infant is in CPS custody, use only city, zip, and county and not the street address.
5. If infant is a stillborn: street 'DECEASED', City, County, ZIP
6. Enter phone number under person, "Additional Demographics", phone number type "Relative/friend"
    a. These naming standards are to reduce the risk of merging
7. Select infant event
    a. Add/update lab results for the infant in the lab results tab
        i. Treponemal and Non-treponemal tests including non-reactive lab results
        ii. Cerebral Spinal Fluid (CSF) lab results including CSF protein and WBC counts using a different specimen type
8. Do not modify imported labs with manually reported lab results
    a. Update the Clinical QP with treatment information
        i. Enter symptoms = none
            1. No CS symptoms are available in the Clinical QP
            2. Update Treatment:
                a. Aqueous Penicillin IV 50,000 u/kg for 10 days
                    i. Do not put frequency
                    ii. Add in notes: "Given Q12 for days 1-7, given Q8 for days 8-10" (when/if that was the dosing)
                b. Benzathine Penicillin IM 50,000 u/kg x 1 if the

infant received a single dose of treatment
c. No Treatment and select a reason
i. MD chose not treatment
ii. Select other if treatment was not indicated

ii. Update pregnancy status

Step 3: Completing the CS Question Package

Congenital Syphilis Reporting information

1. "Date Reported to Health Department" =
   i. Date labs were faxed or reported by phone to HD
   ii. Date labs were imported (infant lab results or maternal delivery labs)
   iii. Date HD was notified about Vital Statistics match
2. Reporting jurisdiction = Select program HD
3. Worker = You ☺

Demographics

1. No need to fill out "Legacy" information
2. Link Mother's Event
   i. "Mother's Event linked to this Event?" = Yes
   ii. Search for mother's **MOST RECENT** morbidity event **(See Step 1)**
3. City, State, Zip, County, and Country need to be filled out
4. Complete insurance status and marital status to the best of your ability. If you have questions, please contact Central Office
5. Complete "Did mom reside outside of Texas during pregnancy?" This allows for the appropriate assignment of morbidity.

Labor and Delivery

1. Type of Birth = Singleton unless the mother delivered twins or multi-gestation (e.g. - Triplets)
2. Select location of birth
3. Delivering facility
   a. If infant was not delivered at a hospital, select evaluating provider/hospital
4. Add the Medical Record Number from the mother's hospital records

Maternal Clinical

1. Add or calculate last menstrual period (LMP)
    a. LMP can be calculating by subtracting the gestational age of the infant from the infant's DOB. **timeanddate.com/date/dateadd.html**
2. Gravida (number of pregnancies)
    a. Equal to the sum of para, stillbirths, and abortions/miscarriages
3. Para (number of children)
    a. Including current birth
4. "Number of stillbirths prior to this pregnancy" and "number miscarriages and abortions prior to this pregnancy"
    a. Only include the number of stillbirths, miscarriages, or abortions that occurred prior to the current pregnancy.
    b. If the mother had abortions/miscarriages, but the actual number is unknown, enter "99"

Prenatal Care

1. Contact the prenatal care (PNC) provider directly to obtain:
    a. Date of first visit
    b. Number of visits
    c. Trimesters that care was received
2. Sometimes the prenatal care records or information can be obtained from or the hospitalization records.
3. Prenatal care information can also be initially identified by the maternal lab history in THISIS
    a. Review if the mother has multiple labs during pregnancy from a medical provider
    - Date of first PNC visit must be entered.
    - If number of PNC visits is unknown, enter "99"
    - If you cannot confirm PNC, select "Unknown"
5. Mother's **clinical stage** of syphilis during pregnancy is the stage of syphilis that was diagnosed during the current pregnancy by the provider.
    a. If Mother was diagnosed prior to pregnancy select "Previously Treated, Serofast"
    b. If the provider said the client was early syphilis, but PHFU staged as unknown, late duration select "Early Syphilis"
6. Mother's **surveillance stage** of syphilis during pregnancy is the stage of syphilis that was reported in THISIS during the current pregnancy.
    a. If Mother was diagnosed prior to pregnancy, select "Not

infected/No case"

b. This may be different than the clinical stage
    i. If mother's morbidity was **reclassified** **(See Section 1C)** select the corrected morbidity.

Maternal Testing

Add both the non-treponemal and the treponemal after answering "Mother tested during pregnancy/delivery = YES":

Answer the following with "YES", "NO", or "UNKNOWN":

- Non-treponemal or treponemal tests at first prenatal visit
- Non-treponemal or treponemal tests at 28-32 weeks gestation
- Non-treponemal or treponemal tests at delivery

Minimally, the client will have delivery labs (no PNC). Refer to **Texas Health and Safety Code 81.090** for the Laws and Requirements regarding syphilis testing during pregnancy.

Then add lab results (most recent first) from the following time points by clicking Add New:

1. Labor and delivery
2. 28-32 weeks gestation
3. First prenatal care visit
4. Syphilis diagnosis lab
    a. If this lab is the same as any of the above time points it does not need to be re-entered
5. Any non-reactive labs relevant to this diagnosis or pregnancy
6. Update Mother's HIV status during pregnancy
    a. If negative, add mother's most recent HIV test *during* pregnancy (date is required).

Maternal Treatment

1. This is auto-populated by the system and the drop-down selection cannot be changed
2. Select the treatment that the mother received prior to, during pregnancy, or at labor and delivery.
    a) If the mother received more than one dose of Bicillin, only select the dosage received in a series.

Child Clinical

1. Add estimated gestational age.
    a. Round up at the 5d mark (38wk 5d = 39 wks)

    b. Use '999' for unknown.
2. Add birth weight in grams.
    a. If birth weight is unknown, enter '9999'
3. Symptoms of Congenital Syphilis:
    a. If no physical s/s of CS are observed, select "Yes, the child was asymptomatic"
    b. If s/s of CS "No- the child had classic congenital symptoms"
        i. Select all the symptoms that apply

Child testing

1. "Did the child have a reactive non-treponemal test" and select "Yes", "No", "Unknown", or "No Test"
    a. If "Yes", add the reactive non-treponemal lab result with the date of test.
2. "Did the child have a reactive treponemal test" and select "Yes", "No", "Unknown", or "No Test"
    a. If "Yes", add the reactive treponemal lab result with the date of test.
    b. Infants with mothers with a history of syphilis will always have a reactive treponemal test when it is drawn due to the maternal antibodies.
        i. Be sure to select "No Test" and not "No" if the infant did **NOT** have a treponemal test completed.
3. Confirmatory testing:
    a. "darkfield or DFA-TP"
        i. This is unlikely to have been performed.
    b. "PCR"
        i. This is unlikely to have been performed.
    c. "IHC"
        i. Immunohistochemistry exam: performed on placentas, umbilical cords, lesions present on the infant, and autopsy material.
    d. "special stain"
        i. Sometimes referred to as a 'silver stain": performed on placentas, umbilical cords, lesions present on the infant, and autopsy material.

Add lab dates if the following labs were performed. It is unlikely these labs were performed in the absence of infant symptoms; be sure to select "No Test" and not "unknown" if these lab results are not present on the pathology report.

4. "Did the child have long bone x-rays?" select "Yes", "No", "Unknown", or "No Test"

a. Select "Yes" when the long bone (radius, homers, ulna, femur, tibia, fibula) x-ray report, sometimes called the radiologist report, radiographs, or skeletal survey has the following phrases:
    i. "lucent bands"
    ii. "focal lesions"
    iii. "metaphyseal destruction and/or abnormalities (metaphysitis)"
        - "transverse metaphyseal lucencies"
    iv. "Wimberger Sign"
    v. "periostitis"
    vi. diffuse osteitis
b. For selection "Yes" or "No", add the date performed.

5. "Did child have a CSF-VDRL?" select "Yes, Reactive", "Yes, Non-reactive", "No Test", or "Unknown".
    a. For responses "Yes, Reactive" and "Yes, Non-reactive", add the date the lumbar puncture was performed.
        i. For the response: "Yes, Reactive" be sure to update the lab results tab in the infant event with the CSF-VDRL lab result.
6. "Did child have a CSF cell count or CSF protein test?" select "Yes, CSF WBC Elevated", "Yes, CSF Protein Elevated", "Yes, Both Test Elevated", "Yes, Neither Test Elevated", "No Test" or "Unknown".
    a. For responses ""Yes, CSF WBC Elevated", "Yes, CSF Protein Elevated", "Yes, Both Test Elevated", "Yes, Neither Test Elevated", "add the date the lumbar puncture was performed.
        i. For the responses: "Yes, CSF WBC Elevated", "Yes, CSF Protein Elevated", "Yes, Both Test Elevated", "Yes, Neither Test Elevated", be sure to update the lab results tab in the infant event with the CSF WBC and CSF protein counts.

Definitions for elevated counts can be found here:
cdc.gov/nndss/conditions/syphilis/case-definition/2018/

Child Treatment

1. "Was the child treated"
    a. Yes- with aqueous PCN for ≥ 10 days
    b. Yes- with ampicillin followed by aqueous/procaine PCN ≥ 10 days (DO NOT CHOOSE)
    c. Yes- with benzathine penicillin x1
    d. Yes- with other treatment
        i. Specify other treatment
            1. Ex: infant started on IV Aq. PCN and medication was

discontinued.
2. Ex. Infant received the alternate treatment of 10 days of Procaine PCN IM

e. No Treatment. Select one of the following reasons:
   i. Lost to follow-up
   ii. MD chose to treat
   * Most common choice
   iii. Patient deceased (chose for stillbirths)
   iv. Unknown
   v. Other
      1. Select for infants who have NR RPRs whose mothers were diagnosed **and** adequately treated *prior to current pregnancy*
         a. Answer: "treatment not indicated"

2. Outpatient pediatric facility
   a. Update with infant's pediatrician information

Finalize QP

7. Verify all *required questions are answered
8. Save and stay
   a. See if a **Congenital Investigation ID** is generated and if a congenital syphilis case classification is triggered in the CS QP
      i. If you received Not Applicable, a required field is missing and needs to be populated
9. Submit to FLS for approval.

Step 4: Verifying Morbidity Reporting

Once a case classification is generated, determine if morbidity is needed (Probable, Stillbirth, Confirmed).

1. Validate/Add morbidity if applicable
2. If there are no labs for the infant, to add morbidity:
3. Select diagnosis code 790
4. "Facility of first test"
   a. Search for facility of birth and select the hospital/pediatrician
5. Select Address for morbidity
   a. "Case address source= Provider"
   b. Select the address for this morbidity
   c. Verify that the address has **county** and **zip code** populated
6. Enter the Method of case detection as "Screening"
   a. Select "Neuro-syphilis" as "No"
   b. Select "Ocular manifestation" as "No"

c. Select "Otic manifestation" as "No"
d. Select "Late clinical manifestation" as "No"

7. Save and Stay

8. VALIDATE

a. Validate that a "Case number" has been generated
b. Validate that "Report to CDC" = "Yes"

9. If this event is **not a case** and morbidity is reporting:
    a. Manually remove morbidity using the following steps:
        i. "Is this a new case?" = NO"
        ii. "Unreport to CDC" = "Yes"

Step 5: Log in CS Spreadsheet