**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

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| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
| There are several causes of paralysis. In the context of NMC, acute flaccid paralysis is used to identify poliomyelitis cases (see polio). | * Health care practitioner *(nurse or doctor making the clinical diagnosis)*
* Laboratory making the diagnosis
 | Any child under 15 years of age with AFP (acute flaccid paralysis, or sudden onset of hypotonic weakness, including Guillian Barre syndrome) or any person of any age with paralytic illness if polio is suspectedDisease incubation period is 7-21 days | Any child under 15 years of age with AFP (acute flaccid paralysis, or sudden onset of hypotonic weakness, including Guillian Barre syndrome) or any person of any age with paralytic illness if polio is suspected |  A case is confirmed as a polio caseSee polio case definition |

 **AGRICULTURAL OR STOCK REMEDY POISONING**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
|  | * Health care practitioner *(nurse or doctor receiving the laboratory result)*
* Laboratory making the diagnosis
 |  |  |  |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**BILHARZIA (schistosomiasis)**

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| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
| Parasitic fluke (schistosome) infection, acquired by skin exposure to surface water inhabited by infected intermediate host snails. Two species of schistosome produce urogenital and intestinal infections, respectively, with both shared and organ-specific clinical features. | * Health care practitioner *(nurse or doctor receiving the laboratory result)*
* Laboratory making the diagnosis
 | A person with compatible clinical features of acute infection (fever, hepatosplenomegaly, urticaria, diarrhoea, etc), or intermediate infection (haematuria, cervicitis, etc) or late infection (hydronephrosis, portal hypertension, etc), and history of exposure in an endemic area. | A person with compatible clinical features and history of exposure in an endemic area, plus a single positive serological or antigen test, and/or haematuria, and/or raised eosinophil count (>0.45 x 109/L). | Schistosome eggs reported in urine or faeces, or on histopathology in biopsy samples; or ≥4-fold rise in titre of serological test over 2 weeks; or repeatedly positive antigen test |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**BRUCELLOSIS**

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| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
| Brucellosis is an infectious disease caused by Brucella bacteria (melitensis and abortus). People can get the disease when they are in contact with infected animals or animal products contaminated (unpasteurised milk/dairy products) with the Brucella bacteria. Animals that are most commonly infected include sheep, cattle, goats. Pig, and dog brucellosis have not occurred in South Africa. Initial symptoms can include: fever, sweats, malaise, anorexia, headache, pain in muscles, joint, and/or back, fatigue. Some signs and symptoms may persist for longer periods of time. Others may never go away or reoccur and include recurrent fevers, arthritis, swelling of the testicle and scrotum area, swelling of the heart (endocarditis), neurologic symptoms (in up to 5% of all cases), chronic fatigue, depression, swelling of the liver and/or spleen. There is a vaccine available for prevention in animals and reduce risk of exposure to humans. Treatment of human brucellosis requires longterm multiple antibiotic course. Brucellosis is rarely fatal if treated; in untreated persons, estimates of the case fatality rate vary from less than 2% to 5%. Deaths are usually caused by endocarditis or meningitis. | * Health care practitioner *(nurse or doctor receiving the laboratory result)*
* Laboratory making the diagnosis
 | A person with acute or insidious onset of intermittent or irregular fever of variable duration, night sweats, undue fatigue, anorexia, weight loss, headache, and arthralgia. Local infection of organs may occur AND having relevant epidemiological exposure (e.g Occupational contact with infected ruminants or birth excretions or fetuses; or by eating or drinking unpasteurized/raw dairy products or undercooked meat; or breathing brucella bacteria in slaughterhouses or laboratory).  | A probable case is a suspected case with a. laboratory Gram-ve Bacillus culture; OR b. A single high agglutination titre to Brucella; OR c. Detection of Brucella species by PCR testing from a normally sterile site other than blood. | A confirmed case is a person with laboratory evidence of Brucella infection by (a. Culture isolation of Brucella species; OR b.Detection of Brucella species by PCR testing from a blood sample; OR c.IgG seroconversion or a significant increase in IgG antibody level (e.g. fourfold or greater rise) to Brucella). |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**CONGENITAL RUBELLA SYNDROME**

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| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
| Clinical syndrome consisting of birth defects occurring in an infant whose mother had rubella infection in pregnancy. | * Health care practitioner *(nurse or doctor receiving the laboratory result)*
* Laboratory making the diagnosis
 | A child less than 12 months of age with at least one of the following: cataracts, glaucoma, congenital heart disease, hearing impairment, pigmentary retinopathy, purpura, hepatosplenomegaly, jaundice, microcephaly, developmental delay, meningoencephalitis, radioluscent bone disease | 1)An infant with no laboratory confirmation of rubella infection but at least two of the following without a more plausible etiology:-cataracts or congenital glaucoma, -congenital heart disease -hearing impairment,-pigmentary retinopathy;2)An infant with no laboratory confirmation of rubella infection but at least one of the following without a more plausible etiology;-cataracts or congenital glaucoma, -congenital heart disease -hearing impairment,-pigmentary retinopathy;**AND**one or more of the following: -purpura, -hepatosplenomegaly, -jaundice, -microcephaly, -developmental delay, -meningoencephalitis,-radiolucent bone disease. | A suspected case with at least one of the following: detection of rubella-specific immunoglobulin M antibody OR positive rubella-specific immunoglobulin G antibodies whose titre does not drop by at least two fold within a 4 week period OR a specimen that is PCR-positive for rubella virus  |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**CONGENITAL SYPHILIS**

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| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
| A condition affecting an infant or child (< 2 years) whose mother had untreated or inadequately treated syphilis.**Early Congenital Syphilis**: may present anytime in infancy or early childhood (< 2 years).An infected infant may be asymptomatic at birth and develop signs 4-8 weeks after birth. | * Health care practitioner *(nurse or doctor receiving the laboratory result)*
 | Any case meeting the following criteria will be considered a case of congenital syphilis: [1] A live birth or fetal death at more than 20 weeks of gestation or >500 g (including stillbirth) born to a woman with positive syphilis serology **AND** without adequate syphilis treatment. Adequate maternal treatment is defined as at least one injection/dose of 2.4 million units of intramuscular benzathine benzylpenicillin at least 30 days prior to delivery.**OR**[2] A live birth, stillbirth or child aged <2 years born to a woman with positive syphilis serology or with unknown serostatus, and with **laboratory evidence** of syphilis infection (regardless of the timing or adequacy of maternal treatment). *The following constitutes acceptable laboratory evidence* • Demonstration by dark-field microscopy or fluorescent antibody detection of Treponema pallidum in the umbilical cord, placenta, nasal discharge or skin lesion material or autopsy material of a neonate or stillborn infant; * Treponema pallidum PCR positive on umbilical cord, placenta, nasal discharge or skin lesion material or autops material of a neonate or stillborn infant

• Analysis of cerebrospinal fluid (CSF) is reactive for Venereal Disease Research Laboratory (VDRL) test, or elevated CSF cell count or protein; • Infant with a reactive non-treponemal (RPR) serology titre fourfold or more than that of the mother; • Infant with a reactive non-treponemal (RPR) serology titre < fourfold more than that of the mother but that remains reactive ≥6 months after delivery;• Infant with a reactive non-treponemal serology test (RPR or VDRL) of any titre **AND** any of the clinical signs listed below born to a mother with positive or unknown serology, independent of treatment • Any stillborn infant with a reactive maternal test should be considered a congenital syphilis case (i.e. a syphilitic stillbirth).**AND/OR**[3] A live birth, stillbirth or child aged <2 years born to a woman with positive syphilis serology or with unknown serostatus, and with radiographic clinical evidence of syphilis infection (regardless of the timing or adequacy of maternal treatment). *Acceptable radiological evidence refers to:*• Long bone radiographs suggestive of congenital syphilis (e.g. osteochondritis, diaphyseal osteomyelitis, periostitis); **AND/OR**[4] A live birth, stillbirth or child aged <2 years born to a woman with positive syphilis serology or with unknown serostatus, and with clinical evidence of syphilis infection (regardless of the timing or adequacy of maternal treatment). *Acceptable clinical evidence* * In settings where a non-treponemal (RPR) titre is not available, an infant born to a mother with reactive or unknown serology, independent of treatment, and whose 6-month examination demonstrates any of the early clinical signs listed below;

o Early clinical signs that may be present in an infant with congenital syphilis include non-immune hydrops, hepatosplenomegaly, rhinitis (snuffles), and skin rash, pseudoparalysis of an extremity or failure to thrive or achieve developmental milestones. o An older infant or child may develop additional signs or symptoms such as frontal bossing, notched and pegged teeth (Hutchinson teeth), clouding of the cornea, blindness, bone pain, decreased hearing or deafness, joint swelling, sabre shins, and scarring of the skin around the mouth, genitals and anus. |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**HAEMOPHILUS INFLUENZAE TYPE B**

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| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
| *Haemophilus influenzae* type b (Hib) causes pneumonia, septicaemia, meningitis, epiglottitis, septic arthritis, cellulitis, otitis media, and purulent pericarditis, as well as less common invasive infections such as endocarditis, osteomyelitis, and peritonitis. Infections are clinically indistinguishable from infections caused by other bacteria. Spread by droplets or direct contact with respiratory tract secretions. Asymptomatic carriage occurs. | * Health care practitioner *(nurse or doctor receiving the laboratory result)*
* Laboratory making the diagnosis
 | Cannot be notified as a clinically suspected case | Invasive disease such as bacteremia, meningitis, epiglottitis, cellulitis, septic arthritis, pneumonia, empyema, pericarditis or osteomyelitis where the public health physician, in consultation with the physician and microbiologist, considers that Hib disease is the most likely diagnosis | The isolation of *Haemophilus influenzae* type b from a normally sterile site specimen (e.g., blood; cerebrospinal, pericardial or synovial fluid), or a positive Gram stain and latex result, or a positive PCR result. |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**HEPATITIS A**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
|  | * Health care practitioner *(nurse or doctor receiving the laboratory result)*
* Laboratory making the diagnosis
 | This condition cannot be notified clinically, as it mimics any other cause of jaundice. |  | The presence of Hepatitis A-specific IgM antibodies(Anti-HAV IgM). |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**HEPATITIS B**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
| Viral infection of the liver. Modes of transmission include perinatal, blood borne (e.g.health-care setting) and Sexual. | * Health care practitioner *(nurse or doctor receiving the laboratory result)*
* Laboratory making the diagnosis
 | -Acute: discrete onset of an acute illness with signs/symptoms of (i) acute infectious illness(e.g. fever, malaise, fatigue) and (ii) liver damage (e.g. anorexia, nausea, jaundice,dark urine, right upper quadrant tenderness, AND/OR raised alanine aminotransferase(ALT) levels more than ten times the upper limit of normal)- Chronic: person not meeting the case definition for acute hepatitis(e.g. person tested in the context of the evaluation of a chronic liver disease,a check-up or a survey) | N/A | 1)Acute: -IgM anti-HBc positive, or- IgM anti-HBc +ve AND HBsAg positive2)Chronic:- HBsAg +ve OR-Dual positive for total anti-HBc AND HBsAg For 6 months or longer |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**HEPATITIS C**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
| Viral infection of the liver. Main route of transmission is blood borne (e.g. health-care setting),perinatal and Sexual transmission rare. | * Health care practitioner (nurse or doctor receiving the laboratory result)
* Laboratory making the diagnosis
 | -Discrete onset of an acute illness with signs/symptoms of (i) acute infectious illness(e.g. fever, malaise, fatigue) and (ii) liver damage (e.g. anorexia, nausea, jaundice,dark urine, right upper quadrant tenderness, AND/OR raised alanine aminotransferase(ALT) levels more than ten times the upper limit of normal)- Chronic: person not meeting the case definition for acute hepatitis(e.g. person tested in the context of the evaluation of a chronic liver disease,a check-up or a survey) | N/A | 1)Acute:HCV RNA +ve and anti-HCV –veORSeroconversion to anti-HCV positive2)Chronic: HCV RNA +ve for 6 months or longer |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**HEPATITIS E**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
|  | * Health care practitioner (nurse or doctor receiving the laboratory result)
* Laboratory making the diagnosis
 | This condition cannot be notified cbased on clinical suspiscion  |  | The presence of Hepatitis E-specific IgM antibodies (Anti-HEV IgM). |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**LEAD POISONING**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
|  | * Health care practitioner (nurse or doctor receiving the laboratory result)
* Laboratory making the diagnosis
 |  |  |  |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**LEGIONELLOSIS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
| Disease caused by bacteria from the genus *Legionella* commonly presents with a spectrum of illness ranging from asymptomatic, to severe pneumonia (Legionnaire’s Disease), often requiring hospitalisation. Acquired from inhalation of contaminated aerosols. | * Health care practitioner (nurse or doctor receiving the laboratory result)
* Laboratory making the diagnosis
 | Any person with clinical/radiological evidence of pneumonia where the public health physician, in consultation with the physician and microbiologist, considers that Legionnaire’s disease as the most likely diagnosis. | Any person with clinical/radiological evidence of pneumonia with: 1) *Legionella pneumophila* non-serogroup 1 or other *Legionella* spp. specific antibody response (fourfold or greater rise in specific serum antibody titer). | Any person with clinical/radiological evidence of pneumonia and at least one of the following: 1) Isolation of *Legionella* spp. from a respiratory specimen or any normally sterile site2) Detection of *Legionella pneumophila* serogroup 1 antigen in urine3) Detection of *Legionella* spp. nucleic acid in a clinical specimen4) *Legionella* pneumophila serogroup 1 specific antibody response (fourfold or greater rise in specific serum antibody titer). |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**LEPROSY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
|  | * Health care practitioner (nurse or doctor receiving the laboratory result)
* Laboratory making the diagnosis
 | A case of leprosy is defined as any person having one or more of the following* Hypo-pigmented or reddish skin lesion(s) with definitive loss of sensation;
* Damage to the peripheral nerves, as demonstrated by loss of sensation and weakness or morbidity of the muscles of hands, feet or face; and
 |  | A positive skin-smear for acid-fast bacilli or positive biopsy. (But where laboratory test cannot be conducted, diagnosis is often established from patient ‘s clinical signs and symptoms). |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**MATERNAL DEATH (PREGNANCY, CHILDBIRTH AND PUERPERIUM)**

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| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
|  | * Health care practitioner (nurse or doctor receiving the laboratory result)
 |  |  | No laboratory based confirmation |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**MERCURY POISONING**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
|  | * Health care practitioner (nurse or doctor receiving the laboratory result)
* Laboratory making the diagnosis
 |  |  |  |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**SOIL TRANSMITTED HELMINTHS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
|  | * Health care practitioner (nurse or doctor receiving the laboratory result)
* Laboratory making the diagnosis
 |  |  |  |

**Category 2: Written or electronic notification within 7days of diagnosing a case.**

**TETANUS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
| Caused by the bacteria *Clostridium tetani*, the incubation period for neonatal tetanus is 3 to 21 days but diseases can be up to 178 days following infection.The WHO estimated that there were about 34019 deaths from neonatal tetanus in 2015. In children and adults, there are three possible types: localised tetanus in which musces around injusry site have spasms, cephalic tetanus in which there is cranial nerve palsy following ear infection or head lesion and finally generalised tetanus which all voluntary skeletal muscles of the body. Laboratory evidence is by isolation of *Clostridium tetani* from a wound in a compatible clinical setting and prevention of positive tetanospasm in mouse test from such an isolate using specific tetanus antitoxin. However, this is not performed in South Africa. | * Health care practitioner (nurse or doctor making the diagnosis)

**NB: Only confirmed cases should be notified.** | There is no case definition of a suspected tetanus case.  |  In the absence of a more likely diagnosis, an acute illness with muscle spasms or hypertonia. | * Neonatal tetanus: An infant with normal feeding and crying in first two days of life who subsequently losses these abilities between 3 and 28 days of life with onset of rigidity and spasms.
* Children and adults: a patient with one of the following; rismus; or risus sardonicus (sartirical smile); or painful muscle contractions.
 |

**Category 2: Written or electronic notification within 7days of diagnosing a case. The case must be notified following laboratory confirmation**

**Tuberculosis: pulmonary**

**Tuberculosis: extra-pulmonary**

**Tuberculosis: multidrug-resistant (MDR-TB)**

**Tuberculosis: extensively drug-resistant (XDR-TB)**

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| --- | --- | --- | --- | --- |
| **Disease epidemiology** | **Who must notify** | **Clinical case definition**(Suspected case) | **Probable case definition** | **Confirmed case definition** |
|  |  |  |  |  |
|  | * Health care practitioner (nurse or doctor receiving the laboratory result)
* Laboratory making the diagnosis
 |  Refer to the TB national treatment guidelines for South Africa | Refer to the TB national treatment guidelines for South Africa | Refer to the TB national treatment guidelines for South Africa |