Cholera Diagnosis and Case Management Summary

11 January 2024

Healthcare workers throughout the country should be on high alert for suspected cholera cases.

Cholera case definitions:

A suspected case of cholera:

- A person of any age with or dying from acute watery diarrhoea with or without vomiting

A confirmed case of cholera:

- Isolation of toxigenic *Vibrio cholerae* O1 or O139 from a specimen collected from any patient with diarrhoea.

Transmission of cholera

Cholera is transmitted through contaminated water or food, or less commonly person-to-person. Healthcare workers attending to persons with suspected or confirmed cholera should observe strict contact precautions and hand hygiene.

Laboratory confirmation of cholera

1. Obtain specimen collection material from the laboratory (universal specimen container, swab etc.).
2. If the laboratory is on-site, collect stool specimen in universal specimen container and submit immediately.
3. If a delay of >2 hours between specimen collection and processing at the laboratory is likely, obtain transport media from the laboratory (Cary-Blair transport media is recommended). Dip a swab into the stool specimen and place the swab into the bottle of Cary-Blair transport medium. Leave the swab in the bottle, close, and submit the bottle and original stool specimen to the lab. Refrigerate both if there is a delay in transport to the laboratory.
4. Mark specimen clearly: 'suspected cholera'.

Cholera treatment guidelines, specimen collection guidance and updates are available at www.nicd.ac.za under the 'Diseases A-Z' tab.

Response to a suspected case of cholera:

1. Establish that the patient meets the case definition for a suspected case of cholera.
2. Observe appropriate **infection control procedures** (standard and contact precautions, including isolation where possible; see national guidelines on NICD website).
3. **Assess the patient's level of hydration and manage fluid losses as appropriate** (see national guidelines on NICD website).
4. Submit a **stool specimen** to the laboratory and label the specimen as 'suspected cholera'.
5. **Notify** the case as "suspected" cholera immediately – do not wait for lab confirmation.
6. All laboratories should send any *Vibrio cholerae* isolates to the NICD Centre for Enteric Diseases for further testing.

Managing a suspected cholera case

Rehydration is the mainstay of treatment.

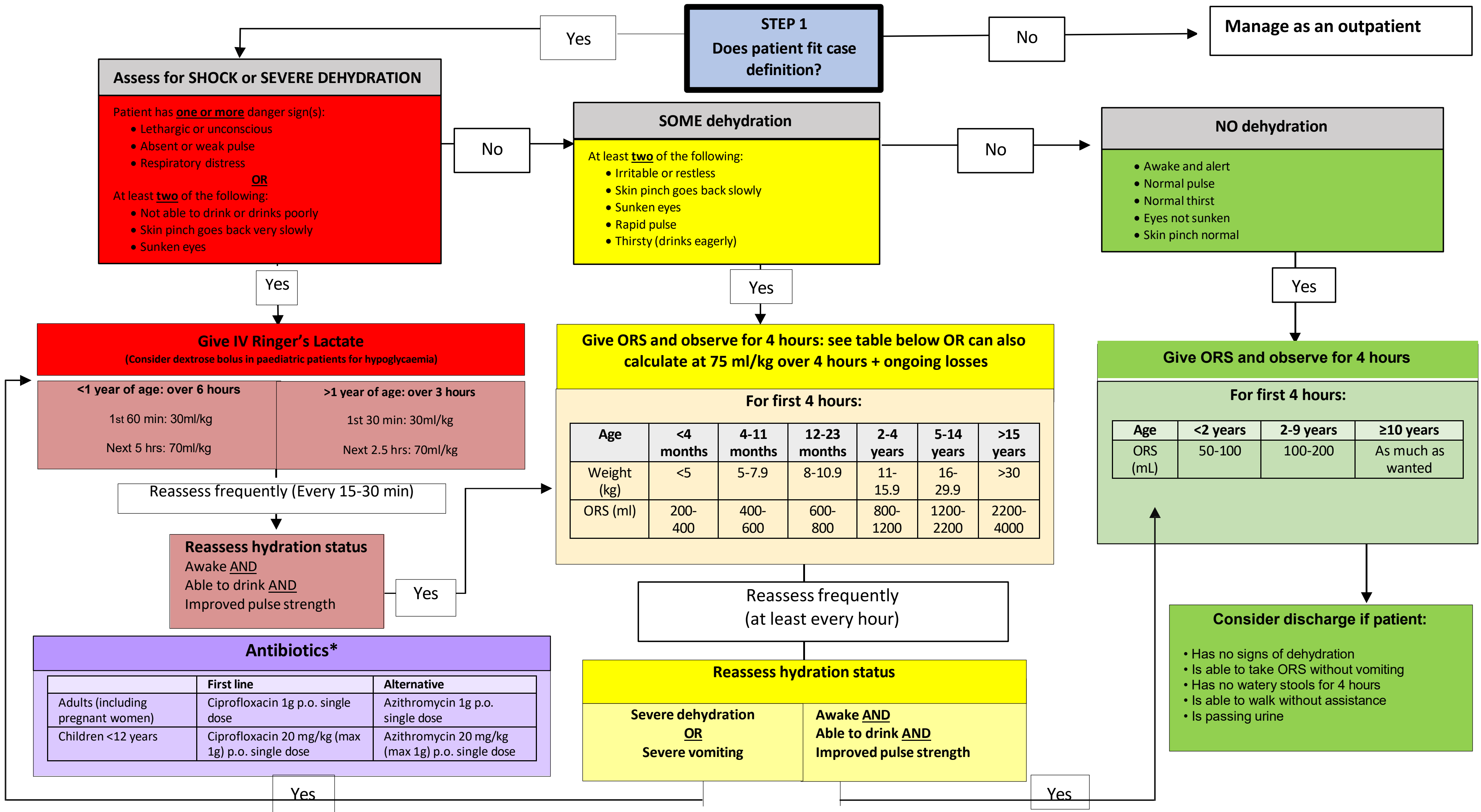
1. Assess and reassess the degree of dehydration frequently.
2. Replace fluid and maintain hydration status based on the degree of dehydration (see next page)
3. Antibiotic therapy is recommended for hospitalised patients. Ciprofloxacin is currently the antibiotic of choice:

Paediatric dose:	Adult dose:
20 mg/kg (max 1g) po stat	1g po stat

4. Children <5 years of age should be given zinc supplementation.
5. Patients should be fed as soon as they can tolerate food
6. Patients who are no longer dehydrated, can take ORS, and have decreased frequency of diarrhoea may be discharged.
7. Don't prescribe anti-motility drugs (e.g. loperamide)
8. Isolate patient if possible and apply contact precautions

Treatment Flowchart for Cholera Cases

Adapted from the Global Task Force on Cholera Control Cholera Outbreak Response Field Manual, October 2019



Age	<4 months	4-11 months	12-23 months	2-4 years	5-14 years	>15 years
Weight (kg)	<5	5-7.9	8-10.9	11-15.9	16-29.9	>30
ORS (ml)	200-400	400-600	600-800	800-1200	1200-2200	2200-4000

Age	<2 years	2-9 years	≥10 years
ORS (mL)	50-100	100-200	As much as wanted

	First line	Alternative
Adults (including pregnant women)	Ciprofloxacin 1g p.o. single dose	Azithromycin 1g p.o. single dose
Children <12 years	Ciprofloxacin 20 mg/kg (max 1g) p.o. single dose	Azithromycin 20 mg/kg (max 1g) p.o. single dose

*Antibiotics are indicated for: all patients with severe dehydration; all patients requiring hospitalisation; patients with coexisting conditions (including pregnancy) or comorbidities (including HIV and SAM) regardless of degree of dehydration; and patients with high purging (at least one stool per hour during the first 4 hours of treatment) or treatment failure (the patient is still dehydrated after completing the initial 4 hours of rehydration therapy), regardless of the degree of dehydration.