

Buruli ulcer clinical and treatment form – Recurrence

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| Health facility: _____ | Date of clinical diagnosis or admission (dd/mm/yy): ____/____/____ |
| Name of health worker treating patient: _____ | Date of complete healing (dd/mm/yy): ____/____/____ |
| Name of patient: _____ ID#: _____ | Age (years): _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address (village or town): _____ District: _____ | Weight (kg): _____ Profession: _____ |
| Region/Province/State: _____ Country: _____ | REFERRED BY: <input type="checkbox"/> Self -referral <input type="checkbox"/> Family member <input type="checkbox"/> Village health worker <input type="checkbox"/> Health worker <input type="checkbox"/> Former patient <input type="checkbox"/> Schoolteacher <input type="checkbox"/> Other (specify) _____ |

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| CLINICAL HISTORY OF PREVIOUS ILLNESS Health facility of previous treatment: _____ Clinical form(s): _____ Location: _____ Rifampicin + streptomycin treatment (total doses received): _____ End of last treatment (approximate date/month): _____ Treatment outcome(s): _____ | CLINICAL HISTORY OF PRESENT ILLNESS Approximate date/month of onset of recurrent lesion: _____ Duration of illness before seeking care (weeks): _____ Use of traditional treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Limitation of movement at any joint: <input type="checkbox"/> Yes <input type="checkbox"/> No | CLINICAL FORMS <input type="checkbox"/> Nodule (N) <input type="checkbox"/> Plaque (Q) <input type="checkbox"/> Oedema (E) <input type="checkbox"/> Ulcer (U) <input type="checkbox"/> Osteomyelitis (O) <input type="checkbox"/> Papule (P) |
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| CATEGORIES | <input type="checkbox"/> Category I: A single lesion ≤ 5 cm in diameter | <input type="checkbox"/> Category II: A single lesion 5–15 cm in diameter | <input type="checkbox"/> Category III: A single lesion >15 cm in diameter , multiple lesions, lesions at critical sites, osteomyelitis |
| LOCATION OF LESION(S) | <input type="checkbox"/> Upper limb (UL) <input type="checkbox"/> Lower limb (LL) | <input type="checkbox"/> Abdomen (AB) <input type="checkbox"/> Back (BK) | <input type="checkbox"/> Buttocks and perineum (BP) <input type="checkbox"/> Thorax (TH) <input type="checkbox"/> Head and neck (HN) CRITICAL SITES <input type="checkbox"/> Eye <input type="checkbox"/> Breast <input type="checkbox"/> Genitalia |

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| LABORATORY CONFIRMATION | | | | |
| Specimen(s) collected: <input type="checkbox"/> Yes <input type="checkbox"/> No Date <u>first</u> specimen taken: ____/____/____ | Results | <input type="checkbox"/> ZN: | <input type="checkbox"/> Positive <input type="checkbox"/> Negative | <input type="checkbox"/> Positive <input type="checkbox"/> Negative |
| Specimen(s) type(s): <input type="checkbox"/> Swab <input type="checkbox"/> Fine needle aspiration (FNA) <input type="checkbox"/> Biopsy | | <input type="checkbox"/> PCR: | <input type="checkbox"/> Positive <input type="checkbox"/> Negative | <input type="checkbox"/> Positive <input type="checkbox"/> Negative |
| | | <input type="checkbox"/> Histo: | <input type="checkbox"/> Positive <input type="checkbox"/> Negative | <input type="checkbox"/> Positive <input type="checkbox"/> Negative |

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| TREATMENT TYPE (Tick all applicable) <input type="checkbox"/> Dressings <input type="checkbox"/> Antibiotics <input type="checkbox"/> Surgery (Date: ____/____/____) <input type="checkbox"/> POD (prevention of disability) |
| DOSAGES Rifampicin: _____ (mg) Streptomycin: _____ (g) - Total doses : 90 - ____ = ____ Other (name): _____: _____ (mg) |

Cross out each day (X) after administering both antibiotics: if antibiotics are not taken, indicate with the symbol Ø

| Day Month | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | Total doses | | |
|--------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-------------|--|--|
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| <input type="checkbox"/> 1a: Antibiotic treatment completed | <input type="checkbox"/> 2a: Healed without surgery | <input type="checkbox"/> 3a: Healed without limitation of movement at any joint | <input type="checkbox"/> 4: Referred for further treatment |
| <input type="checkbox"/> 1b: Antibiotic treatment not completed | <input type="checkbox"/> 2b: Healed with surgery | <input type="checkbox"/> 3b: Healed with limitation of movement at any joint | <input type="checkbox"/> 5: Lost to follow up <input type="checkbox"/> Died |

