

**Undetermined agent, source, mode of transmission, and risk factors for Guillain-Barré
Syndrome in the setting of Zika virus transmission— Colombia, 2016**

Chart Abstraction Form

Study ID Number COL-____

Encounter level (Brighton 1-5) or not neuro (6): ____

The ID number begins with the 2 digit case number (for example COL-01). Information as documented by attending physician.

The following pages are to be abstracted from the medical records / exam:

Chart Abstractor: _____
MRN: _____

Abstraction Date: ____/____/____
MM DD YYYY

- 1. First name: _____
2. Paternal name: _____
3. Age (years): _____

Middle name: _____
Maternal name: _____
Date of birth: ____/____/____
MM DD YYYY

4. Sex: [] Male [] Female

5. Patient address: _____

6. Patient zip code: _____

7. Patient phone number: _____

8. Date of neuro symptom onset: ____/____/____ Date first sought care: ____/____/____
MM DD YYYY MM DD YYYY

Date of admission: ____/____/____
MM DD YYYY

Date of discharge/death: ____/____/____
MM DD YYYY

9. Discharged to:

- [] Home [] Rehab/skilled nursing facility [] Transferred [] Died [] Other (specify) _____

CURRENT ILLNESS

10. How long from onset until hospital admission? _____minutes/hours/days/weeks

11. What were the initial neurologic symptoms (i.e. within the three days of illness onset)? (check all that apply, signs from PE, symptoms from HPI)

- [] Leg weakness [] Arm weakness [] Diplopia/Ophthalmoplegia
[] Leg numbness/paresthesias [] Arm numbness/paresthesias [] Face numbness/paresthesias
[] SOB / respiratory distress [] Gait imbalance (not weakness)/ataxia [] Hand clumsiness/ataxia
[] Hyporeflexia/areflexia [] Face weakness [] Dysarthria [] Dysphagia [] Dysautonomia

12. What neurologic symptoms occurred AT ANY TIME during the neuro illness? (check all that apply, signs from PE, symptoms from HPI)

- [] Leg weakness [] Arm weakness [] Diplopia/Ophthalmoplegia
[] Leg numbness/paresthesias [] Arm numbness/paresthesias [] Face numbness/paresthesias
[] SOB / respiratory distress [] Gait imbalance (not weakness)/ataxia [] Hand clumsiness/ataxia
[] Hyporeflexia/areflexia [] Face weakness [] Dysarthria [] Dysphagia [] Dysautonomia

13. How long from onset until maximum/worst neuro symptoms? _____ minutes/hours/days/weeks

14. At the worst point during this neuro illness, check all that apply for the patient:

- Unable to walk without assistance (e.g. cane, walker) Unable to walk at all
 Admitted to the hospital Admitted to the ICU/CCU Intubated

15. If any blood was taken for this neurologic illness, please fill out the following for the INITIAL blood draw:

Date ____/____/____ WBC ____ HgB ____ Plts ____ Na ____ K ____
MM DD YYYY

BUN ____ Cr ____ Glucose ____ TBili ____ AST ____ ALT ____ AlkPhos ____

16. Was there documented hyporeflexia/areflexia? Yes No Unknown

17. Was there documentation of upper motor neuron signs?

- Hyperreflexia Increased tone/spasticity Babinski/Hoffman Sustained clonus

18. Was there any sensory level documented? Yes No Unknown

LABORATORY, IMAGING, AND ELECTROPHYSIOLOGIC STUDIES

19. Was a lumbar puncture (LP) done? Yes No Unknown

LP date ____/____/____ RBCS ____ WBCS ____ Protein (mg/dL) ____ Glucose (mg/dL) ____
MM DD YYYY

Differential _____ IgG index ____ Oligoclonal bands ____ IgG synthesis _____

LP date ____/____/____ RBCS ____ WBCS ____ Protein (mg/dL) ____ Glucose (mg/dL) ____
MM DD YYYY

Differential _____ IgG index ____ Oligoclonal bands ____ IgG synthesis _____

20. Did they receive any targeted treatment (IVIg/steroids/plasma exchange) for this neuro illness?

IVIg Yes No Unknown Start date ____/____/____
MM DD YYYY

Plasma exchange Yes No Unknown Start date ____/____/____
MM DD YYYY

Steroids Yes No Unknown Start date ____/____/____
MM DD YYYY

Mechanical ventilation Yes No Unknown Start date ____/____/____
MM DD YYYY

Other Yes No Unknown Start date ____/____/____
MM DD YYYY

21. Did the patient receive blood transfusion/blood products? (other than IVIg)

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Yes No Unknown which one _____ Start date ____/____/____
MM DD YYYY

22. Were any of the following diseases tested for? If so, what was the result? (including specimen and type of test)

- a. *Campylobacter jejuni* Yes No Result: _____
- b. *Mycoplasma pneumoniae* Yes No Result: _____
- c. *Haemophilus influenzae* Yes No Result: _____
- d. *Salmonella spp.* Yes No Result: _____
- e. Cytomegalovirus (CMV) Yes No Result: _____
- f. Epstein-Barr virus (EBV) Yes No Result: _____
- g. Varicella-zoster virus (VZV) Yes No Result: _____
- h. Human immunodeficiency virus (HIV) Yes No Result: _____
- i. Enterovirus / Rhinovirus Yes No Result: _____
- j. Arboviruses Yes No Result: _____
- k. Other Yes No Result: _____

23. Was neuro imaging done? If so, what was the result? (Transcribe the impression)

Yes No Result: _____
Date ____/____/____
MM DD YYYY

24. Were electro-diagnostics done (e.g. EMG)? If so, what were the results? (Transcribe the impression)

Yes No Result: _____
Date ____/____/____
MM DD YYYY

25. What was the GBS Brighton level? 1 2 3 4 5

Levels of Diagnostic Certainty

Level 1	Level 2	Level 3	Level 4*	Level 5
Absence of an alternative diagnosis for weakness				NOT a case * Lacking documentation to fulfill minimal case criteria
Acute onset of bilateral and relatively symmetric flaccid weakness of the limbs				
Decreased or absent deep tendon reflexes in affected limbs				
Monophasic illness pattern with weakness nadir between 12 hours and 28 days, followed by clinical plateau				
Albuminocytologic dissociation (elevation of CSF protein level above laboratory normal value and CSF total white cell count < 50 cells/mm ³)	CSF with a total white cell count < 50 cells/mm ³ (with or without CSF protein elevation above laboratory normal value) or if CSF not collected or results not available, and electrodiagnostic studies consistent with GBS			
Electrophysiologic findings consistent with GBS				

ANTECEDENT ILLNESS

26. a.) In the 2 months prior to neuro onset date, did the individual experience an acute illness? (other than their neuro illness)? Yes No Unknown

b.) How long from prior acute illness onset until admission for neuro illness? _____
minutes/hours/days/weeks

27. a.) What symptoms did they report having or what signs were noticed? (check all that apply)

- | | | | |
|---------------------------------------|---|---|---|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Nausea or Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Muscle pains | <input type="checkbox"/> Joint pains | <input type="checkbox"/> Skin rash | <input type="checkbox"/> Conjunctivitis |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Coughing | <input type="checkbox"/> Runny nose |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Calf pain | <input type="checkbox"/> Pruritis | |

b.) If any blood was taken for this acute illness, please fill out the following for the INITIAL blood draw:

Date ____/____/____ WBC ____ HgB ____ Plts ____ Na ____ K ____
DD MM YYYY

BUN ____ Cr ____ Glucose ____ TBili ____ AST ____ ALT ____ AlkPhos ____

c.) Were they hospitalized for this acute illness? Yes No Unknown

d.) Did they receive any blood products / IVIG for this illness? Yes No Unknown

What product? _____ Date? ____/____/____
MM DD YYYY

e.) Did they receive plasmapheresis / plasma exchange for this illness? Yes No Unknown

If yes, date? ____/____/____
MM DD YYYY

28. Is there a test result available for dengue from this medical visit? Yes No Unknown

If yes, please specify: _____

29. Is there a test result available for chikungunya from this medical visit? Yes No Unknown

If yes, please specify: _____

30. Is there a test result available for Zika from this medical visit? Yes No Unknown

If yes, please specify: _____

PAST MEDICAL, SOCIAL AND FAMILY HISTORY

31. What medical conditions are listed in the admission history and physical (H&P)?

- Hypertension Diabetes HIV Autoimmune disorder _____

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Prior GBS Hemoglobinopathy B12 deficiency Cancer _____

32. What social conditions are listed in admission H&P?

Alcohol use Drug use Tobacco Other _____

33. What conditions are listed in family history of H&P?

Autoimmune disorder (specify) _____ Cancer (specify) _____

Hemoglobinopathy (specify) _____ Neuro (specify) _____