

Appendix 1. Chart Abstraction Form

Patient Name: _____

CDC ID#: _____

Hospital #1: _____

MRN#: _____

Hospital #2 (if transferred): _____

MRN#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Country: _____

Telephone number: _____

Alt Telephone number: _____

Public reporting burden of this collection of information is estimated to average XX minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)

Name of person completing form: _____			
Demographic Information			
Age: _____	DOB ___ / ___ / _____		
Sex:	Male	Female	
What is your race? (Check all that apply.):	American Indian or Alaska Native	Asian	Black or African American
	Native Hawaiian or Other Pacific Islander	White	
Are you Hispanic or Latino?:	Yes	No	
Work (describe):			
Timeline and Outcome			
Date of prodrome (includes GI symptom) onset: ___ / ___ / _____		No prodrome	
Date of neuro illness onset: ___ / ___ / _____			
Date of first hospital admission: ___ / ___ / _____			
Initial or admitting diagnosis:			
Outcome of illness:	Died (Date (dd/mmm/yyyy): _____)		
	Discharged to chronic care or rehabilitation facility		(Date: _____)
	Discharged to home (Date: _____)		
	Still hospitalized		
Prodrome Illness Symptoms			
<u>Diarrhea</u>	Yes No Unk	<u>Vomiting</u>	Yes No Unk
<u>Fever</u>	Yes No Unk	<u>Cough</u>	Yes No Unk
<u>Sore Throat</u>	Yes No Unk	<u>Joint pains/aches</u>	Yes No Unk
		<u>Bloody stool</u>	Yes No Unk
		<u>Headache</u>	Yes No Unk
		<u>Rash</u>	Yes No Unk
		<u>Abdominal Pain</u>	Yes No Unk
		<u>Other</u> _____	
Duration of prodromal symptoms: _____ days			
Location of patient in 7 days before prodromal symptoms:			
Past Medical and Neurological History			
Past Medical and Neurological History (include EtOH, tobacco, drug use):			
Exposure History			
Travel History (include all places visited in prior 30 days—include dates of travel):			
Describe any agricultural or pesticide exposure in past 6 weeks:			
Any upper respiratory infection in the last 6 weeks?		Yes	No
Unk		What date of onset?: ___ / ___ / _____	

Case Data Collection Worksheet

CDC ID: _____

Any gastrointestinal infection in the last 6 weeks? Unk	Yes	No	What date of onset?: ___/___/_____
Any vaccinations received in the last 6 weeks? Unk	Yes	No	If yes, date of receipt: ___/___/_____ If yes, vaccine(s)_administered_____
Ill household contacts in the past 6 weeks? Unk	Yes	No	Nature of illness: _____

Toxic/Chemical Exposures

1. Did patient recall taking any herbal or folk remedies during 2 weeks prior to illness	Yes	No	Unknown
If YES, Remedy 1: _____ Remedy 2: _____			
3. Did patient recall eating any wild picked plants (like. buckthorn or Karwinskia Humboldt pictured below) during 2 weeks prior to illness onset?	Yes	No	Unknown
If YES, Plant 1: _____ Plant 2: _____			

Neuro Symptoms

Initial neurological signs and symptoms (describe): _____

Onset of weakness within first week of neuro illness?	Yes	No	Unknown
Concurrent symptoms:	Fever	Headache	Meningismus (nuchal rigidity, photo/phonophobia)
Altered mental status	Nausea/vomiting	Muscle pain/myalgia	Other
Specify if other: _____			

Distribution of weakness at first onset (e.g. first noted weakness)	Symmetric	Asymmetric	Unknown
Check all that apply:	Right UE Prox Dist	Left UE Prox Dist	Right LE Prox Dist
Neck Flexors/Extens.	Respiratory muscles	Quadruplegia/whole body paralysis	Facial muscles
Describe weakness distribution: _____			

Nature of weakness onset:	Ascending	Descending	Acute/whole limb	Unknown
Approximate time interval to maximal weakness: _____				

Distribution of weakness at maximal weakness	Symmetric	Asymmetric	Unknown	
Check all that apply:	Right UE Prox Dist	Left UE Prox Dist	Right LE Prox Dist	
Neck Flexors/Extens.	Respiratory muscles	Quadruplegia/whole body paralysis	Facial muscles	
Describe weakness distribution at maximum: _____				
Approximate date of maximal weakness: ___/___/_____				

<p><u>Reflexes</u> in affected body parts at time of maximal weakness:</p> <p>Hyperreflexic/spastic Reflexes not tested</p>	<p>Areflexic</p> <p>Unknown</p>	<p>Hyporeflexic</p>	<p>Reflexes normal</p>
<p><u>Tone</u> in affected body parts at time of maximal weakness:</p> <p>Hypertonic/spastic Tone not tested</p>	<p>Flaccid</p> <p>Unknown</p>	<p>Hypotonic</p>	<p>Tone normal</p>
<p><u>Sensory</u> abnormalities present?</p> <p>Date of sensory symptom onset: ____/____/____</p> <p>Description of sensory abnormalities: _____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p><u>Pain</u> present?</p> <p>Date of pain onset: ____/____/____</p> <p>Description/location of pain: _____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>Prominent dyspnea/shortness of breath present?</p> <p>Approximate date of dyspnea onset: ____/____/____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>Patient ever intubated? Yes No Unknown</p> <p>Date of extubation: _____</p>	<p>If yes, date of intubation: _____</p> <p>Tracheostomy required? Yes No Unknown</p>		
<p>Bowel/Bladder involvement present?</p> <p>Description of bowel/bladder involvement: _____</p> <p>Date of bowel/bladder involvement: ____/____/____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>Dysarthria and/or dysphagia present?</p> <p>Date of dysarthria/dysphagia: ____/____/____</p> <p>Description of dysarthria/dysphagia: _____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>15. Any other cranial nerve abnormalities present?</p> <p>If yes, specify cranial nerve abnormality, as specifically as possible:</p> <p>Date of onset of CN abnormality: ____/____/____ Date of resolution of CN abnormality: ____/____/____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>Ataxia present?</p> <p>If yes, date ataxia noted / recorded: ____/____/____</p>	<p>Yes</p>	<p>No</p>	<p>Unknown</p>
<p>Does the Neurology Consult Note attribute neurologic symptoms to a definitive diagnosis other than Guillain-Barre Syndrome? Yes No</p> <p>If yes, what was the rendered diagnosis: _____</p>			
<p>Hospital Course</p>			
<p>Please list nosocomial complications (if any):</p> 			

Laboratory Testing

Serum Potassium _____ on admission _____ most abnormal
 Serum Calcium _____ on admission _____ most abnormal

Cerebrospinal fluid

Did the patient have any lumbar punctures (LP) performed within 30 days of onset of weakness? Yes No Unknown

Date CSF 1: ___/___/___ WBC ___/mm³ RBC ___/mm³ Protein ___ mg/dL Glucose ___ mg/dL

WBC differential: Neutrophils ___% Lymphocytes ___% Monocytes ___% Eosinophils ___%

Date CSF 2: ___/___/___ WBC ___/mm³ RBC ___/mm³ Protein ___ mg/dL Glucose ___ mg/dL

WBC differential: Neutrophils ___% Lymphocytes ___% Monocytes ___% Eosinophils ___%

12. CSF Gram's Stain: Record result: _____

13. CSF VRDL: _____ 14. CSF Cryptococcal Antigen: _____

18. CSF Oligoclonal Bands: _____ 19. IgG Index: _____

20. IgG Synthesis Rate: _____ 21. Myelin Basic Protein: _____

Neurodiagnostics: Please indicate whether the following tests were performed. Record all results on accompanying worksheet.

- | | |
|----------------------------------------------|--------------------------------------|
| 1. Head computed tomography | 2. Spinal computed tomography |
| 3. Brain magnetic resonance imaging | 4. Spinal magnetic resonance imaging |
| 5. Electromyography/nerve conduction studies | 6. Pulmonary fluoroscopic studies |

Please indicate whether any of the following treatments or procedures were rendered during the course of illness:

- | | | |
|------------------------------------------------|------------------------------------|---------------------------|
| 1. Intravenous Immune Globulin (IVIG) | Date started: ___/___/___ | Date stopped: ___/___/___ |
| 2. Plasmapheresis/plasma exchange | Date started: ___/___/___ | Date stopped: ___/___/___ |
| 3. Alpha-interferon | Date started: ___/___/___ | Date stopped: ___/___/___ |
| 4. Corticosteroids | Date started: ___/___/___ | Date stopped: ___/___/___ |
| If yes, dosage used: _____ | | |
| 5. Other immunomodulating agent (Imuran, etc.) | Date started: ___/___/___ | Date stopped: ___/___/___ |
| If yes, specify: _____ | | |
| 7. Muscle biopsy | If yes, date obtained: ___/___/___ | |
| If yes, specify site of biopsy: _____ | | |
| If yes, narrative of result: _____ | | |
| _____ | | |

Lab results: Culture results

If any bacterial, viral or fungal culture results were obtained, please note the following results

Specimen type*	Date	Culture type (Check one)			Result (Check one)		If positive:		
		Bacterial	Viral	Fungal	No growth	Positive	Organism 1	Organism 2	Organism 3

*Specimen type: Blood, bronchoalveolar lavage (BAL), cerebrospinal fluid (CSF), nasopharyngeal swab/aspirate, pericardial fluid, peritoneal fluid, pleural fluid, sputum, synovial fluid, tissue (specify site), throat/oropharyngeal swab, stool or urine

Diagnostic Tests for Other Infectious Diseases (include Antibody tests/serology, antigen detection, PCR and special stains)

Specimen type*	Date	Test performed	Results	Interpretation	Laboratory

*Specimen type: Blood, bronchoalveolar lavage (BAL), cerebrospinal fluid (CSF), nasopharyngeal swab/aspirate, pericardial fluid, peritoneal fluid, pleural fluid, acute serum, convalescent serum, paired sera, sputum, synovial fluid, tissue (specify site), throat/oropharyngeal swab, stool or urine

Please attach results of all neurodiagnostics (include detailed EMG results if available):

FINAL BRIGHTON CASE DEFINITION CLASSIFICATION: (See Appendix

Guillain-Barre Syndrome

Level 1

Level 2

Level 3

Level 4

Level 5

Fisher Syndrome:

Level 1

Level 2

Level 3

Level 4

Level 5

APPENDIX I: BRIGHTON CASE DEFINITION CRITERIA**Guillain-Barré Syndrome**Level 1 (requires ALL criteria)

1. Bilateral **AND** flaccid weakness of the limbs
2. Decreased or absent deep tendon reflexes in weak limbs
3. Monophasic illness pattern **AND** interval between onset and nadir of illness between 12 hours and 28 days **AND** subsequent clinical plateau
4. Electrophysiologic findings consistent with GBS
5. Cytoalbuminologic dissociation (i.e., elevation of CSF protein level above laboratory normal value **AND** CSF total white cell count <50 cells / mm³)
6. Absence of an identified alternative diagnosis for weakness

Level 2

1. Criteria 1, 2, and 3 for Level 1 fulfilled
AND
2. CSF total white cell count <50 cells/mm³ (with or without CSF protein elevation above laboratory normal value)
OR
If CSF not collected or results not available, electrophysiologic studies consistent with GBS
3. Absence of identified alternative diagnosis for weakness

Level 3

1. Criteria 1, 2, and 3 for Level 1 fulfilled
2. Absence of identified alternative diagnosis for weakness

Level 4

1. Reported event of GBS, with insufficient evidence to meet case definition

Level 5

1. Not a case of GBS

Fisher SyndromeLevel 1 (Requires ALL Criteria)

1. Bilateral ophthalmoparesis **AND** bilateral reduced or absent tendon reflexes, **AND** ataxia
2. Absence of limb weakness

3. Monophasic illness pattern **AND** interval between onset and nadir of weakness between 12 hours and 28 days **AND** subsequent clinical plateau
4. Cytoalbuminologic dissociation (i.e., elevation of cerebrospinal protein above the laboratory normal **AND** total CSF white cell count <50 cells/mm³)
5. Nerve conduction studies are normal, **OR** indicate involvement of sensory nerves only
6. No alteration in consciousness or corticospinal tract signs
7. Absence of an identified alternative diagnosis

Level 2

1. Criteria 1, 2, and 3 for Level 1 fulfilled
AND
2. Cerebrospinal fluid (CSF) with a total white cell count <50 cells/mm³ (with or without CSF protein elevation above laboratory normal value)
OR
Nerve conduction studies are normal, **OR** indicate involvement of sensory nerves only
3. No alteration in consciousness or corticospinal tract signs
4. Absence of an identified alternative diagnosis

Level 3

1. Criteria 1, 2, 3, 6, and 7 for Level 1 fulfilled

Levels 4 and 5 as for GBS