

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>Bloody stool</u> Yes No Unk <u>Rash</u> Yes No Unk | |
| <u>Fever</u> Yes No Unk <u>Cough</u> Yes No Unk <u>Headache</u> Yes No Unk <u>Abdominal Pain</u> Yes No Unk | |
| <u>Sore Throat</u> Yes No Unk <u>Joint pains/aches</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? Unk | Yes No What date of onset?: ___/___/_____ |

| | | | | |
|--|---------------------|-----------------------------------|---|----------------|
| 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 | |
| Check all that apply: | Right UE | Left UE | Right LE | Left LE |
| | Prox Dist | Prox Dist | Prox Dist | Prox Dist |
| Neck Flexors/Extens. | Respiratory muscles | Quadriplegia/whole body paralysis | | Facial muscles |
| Describe weakness distribution: _____ | | | | |
| Nature of weakness onset: | Ascending | Descending | Acute/whole limb | Unknown |
| Approximate time interval to maximal weakness: _____ | | | | |
| <u>Distribution</u> of weakness at maximal weakness | Symmetric | | Asymmetric | |
| Check all that apply: | Right UE | Left UE | Right LE | Left LE |
| | Prox Dist | Prox Dist | Prox Dist | Prox Dist |
| Neck Flexors/Extens. | Respiratory muscles | Quadriplegia/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> | Areflexic | Hyporeflexic | Reflexes normal |
| <p><u>Tone</u> in affected body parts at time of maximal weakness:</p> <p>Hypertonic/spastic Tone not tested</p> | Flaccid | Hypotonic | Tone normal |
| <p><u>Sensory</u> abnormalities present?</p> <p>Date of sensory symptom onset: ____/____/____</p> <p>Description of sensory abnormalities: _____</p> | Yes | No | Unknown |
| <p><u>Pain</u> present?</p> <p>Date of pain onset: ____/____/____</p> <p>Description/location of pain: _____</p> | Yes | No | Unknown |
| <p>Prominent dyspnea/shortness of breath present?</p> <p>Approximate date of dyspnea onset: ____/____/____</p> | Yes | No | Unknown |
| <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> | Yes | No | Unknown |
| <p>Dysarthria and/or dysphagia present?</p> <p>Date of dysarthria/dysphagia: ____/____/____</p> <p>Description of dysarthria/dysphagia: _____</p> | Yes | No | Unknown |
| <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: ____/____/____</p> | Yes | No | Unknown |
| <p>Ataxia present?</p> <p>If yes, date ataxia noted / recorded: ____/____/____</p> | Yes | No | Unknown |
| <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 |
|----------------|------|----------------|---------|----------------|------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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