Appendix 1. Chart Abstraction Form

**Form Approved**
**CDC ID:_____**
**OMB No. 0920-XXXX**
**Exp. Date XX/XX/XXXX**

Patient Name: _____

CDC ID#:_____

Hospital #1: _____
MRN#: _____

Hospital #2 (if transferred): _____
MRN#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Country:_____

Telephone number: _____

Alt Telephone number:_____

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**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Diarrhea | Yes No Unk | Vomiting | Yes No Unk | Bloody stool | Yes No Unk | Rash | Yes No Unk |
| Fever | Yes No Unk | Cough | Yes No Unk | Headache | Yes No Unk | Abdominal Pain | Yes No Unk |
| Sore Throat | Yes No Unk | Joint pains/aches | Yes No Unk | Other _____ | | | |

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?: ____/____/_____

Any gastrointestinal infection in the last 6 weeks? Yes No Unk
What date of onset?: ____/____/_____

Any vaccinations received in the last 6 weeks? Yes No Unk
If yes, date of receipt: __ / __/ _____
If yes, vaccine(s)_administered_____

Ill household contacts in the past 6 weeks? Yes No Unk
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 weeksprior 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 | | 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: _____

Distribution of weakness at **maximal** weakness Symmetric Asymmetric Unknown

| 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: ____/____/_____

Reflexes in affected body parts at time of maximal weakness: Areflexic Hyporeflexic Reflexes normal

Hyperreflexic/spastic Reflexes not tested Unknown

Tone in affected body parts at time of maximal weakness: Flaccid Hypotonic Tone normal

Hypertonic/spastic Tone not tested Unknown

Sensory abnormalities present? Yes No Unknown

Date of sensory symptom onset: _____/_____/_____

Description of sensory abnormalities: _____

Pain present? Yes No Unknown

Date of pain onset: ____/____/_____

Description/location of pain: _____

Prominent dyspnea/shortness of breath present? Yes No Unknown

Approximate date of dyspnnea onset: ____/____/_____

Patient ever intubated? Yes No Unknown If yes, date of intubation:

Date of extubation: Tracheostomy required? Yes No Unknown

Bowel/Bladder involvement present? Yes No Unknown

Description of bowel/bladder involvement: _____

Date of bowel/bladder involvement: ____/____/_____

Dysarthria and/or dysphagia present? Yes No Unknown

Date of dysarthria/dysphagia: ____/____/_____

Description of dysarthria/dysphagia: _____

15. Any other cranial nerve abnormalities present? Yes No Unknown

If yes, specify cranial nerve abnormality, as specifically as possible:

Date of onset of CN abnormality: ____/____/_____ Date of resolution of CN abnormality: ____/____/_____

Ataxia present? Yes No Unknown

If yes, date ataxia noted / recorded: ___/___/_____

Does the Neurology Consult Note attribute neurologic symptoms to a definitive diagnosis other than Guillain-Barre Syndrome? Yes No

If yes, what was the rendered diagnosis: _____

**Hospital Course**

Please list nosocomial complications (if any):

**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 <u>treatments</u> or <u>procedures</u> 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 |
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*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** |
|---|---|---|---|---|---|
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*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

- o Level I
- o Level 2
- o Level 3
- o Level 4
- o Level 5

Fisher Syndrome:

- o Level I
- o Level 2
- o Level 3
- o Level 4
- o Level 5

## APPENDIX I: BRIGHTON CASE DEFINITION CRITERIA

### Guillain-Barré Syndrome

Level I (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 Syndrome

Level 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