

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	Left UE	Right LE
	Prox	Dist	Prox
	Prox	Dist	Prox
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	Left UE	Right LE
	Prox	Dist	Prox
	Prox	Dist	Prox
Neck Flexors/Extens.	Respiratory muscles	Quadruplegia/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
Hyperreflexic/spastic	Reflexes not tested	Unknown	
Tone in affected body parts at time of maximal weakness:		Flaccid	Hypotonic
Hypertonic/spastic	Tone not tested	Unknown	
Sensory abnormalities present?		Yes	No
Date of sensory symptom onset: ____/____/_____		Unknown	
Description of sensory abnormalities: _____			
Pain present?		Yes	No
Date of pain onset: ____/____/_____		Unknown	
Description/location of pain: _____			
Prominent dyspnea/shortness of breath present?		Yes	No
Approximate date of dyspnea onset: ____/____/_____		Unknown	
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
Description of bowel/bladder involvement: _____			
Date of bowel/bladder involvement: ____/____/_____			
Dysarthria and/or dysphagia present?		Yes	No
Date of dysarthria/dysphagia: ____/____/_____		Unknown	
Description of dysarthria/dysphagia: _____			
15. Any other cranial nerve abnormalities present?		Yes	No
If yes, specify cranial nerve abnormality, as specifically as possible:		Unknown	
Date of onset of CN abnormality: ____/____/_____		Date of resolution of CN abnormality: ____/____/_____	
Ataxia present?		Yes	No
If yes, date ataxia noted / recorded: ____/____/_____		Unknown	
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 ____/mm ³	RBC ____/mm ³	Protein ____ mg/dL	Glucose ____ mg/dL
WBC differential: Neutrophils ____% Lymphocytes ____% Monocytes ____% Eosinophils ____%				
Date CSF 2: ____/____/____	WBC ____/mm ³	RBC ____/mm ³	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

*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