

Acute flaccid paralysis (AFP)

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM

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REPORTING INFORMATION

(To be completed by the CPSP)

Report number: _____

Month of reporting: _____

Province: _____

Today's date: _____

Please complete the following sections for the case identified above. Refer to the user manual for assistance:

www.cpsp.cps.ca/uploads/studies/acute-flaccid-paralysis-questionnaire-user-manual.pdf

Confidentiality of information is assured.

NOTE: Please report all AFP cases to local public health authorities if legislatively required in your jurisdiction:

Alberta, Saskatchewan, Ontario, Quebec, Newfoundland and Labrador, New Brunswick, Nova Scotia,
Prince Edward Island, and the Northwest Territories.

CASE DEFINITION FOR ACUTE FLACCID PARALYSIS

Acute onset of focal weakness or paralysis characterized as flaccid (reduced tone) without other obvious cause (e.g., trauma) in children less than 15 years old. Transient weakness (e.g., post-ictal weakness) should not be reported.

Month first seen _____

SECTION 1 – DEMOGRAPHIC INFORMATION

1.1 Date of birth: ____/____/____ 1.2 Sex: Male___ Female___ Unknown___
DD MM YYYY

1.3 Postal code – first three digits only: __ __ __

SECTION 2 – RELEVANT MEDICAL HISTORY

2.1 Is the child immunocompromised? Yes___ No___ Unknown___

If yes, briefly state condition(s): _____

2.2 Does the child have any abnormal neurological history? Yes___ No___ Unknown___

If yes, briefly state condition(s): _____

SECTION 3 – TRAVEL AND IMMUNIZATION HISTORY

3.1 Has the child travelled to another country in the 30 days prior to illness onset? Yes___ No___ Unknown___

If yes, specify country or countries and approximate dates of travel: _____

3.2 Has a close contact travelled to another country in the 90 days prior to illness onset? Yes___ No___ Unknown___

If yes, specify country or countries and approximate dates of travel: _____

3.3 Did the child receive any vaccines in the 6 weeks prior to paralysis/weakness onset? Yes___ No___ Unknown___

3.4 Record below all vaccines the child has received in the 6 weeks (42 days) prior to paralysis/weakness onset.

Vaccine	Dose number in series	Date of vaccination (DD/MM/YYYY)
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

SECTION 3 – TRAVEL AND IMMUNIZATION HISTORY (cont'd)

3.5 Record below all polio immunizations using inactivated polio vaccine (IPV) or oral polio vaccine (OPV) ever received by this child. *Note: OPV is still being used in countries outside of Canada.*

Vaccine (IPV or OPV)	Dose number in series	Date of vaccination (DD/MM/YYYY)	Vaccine (IPV or OPV)	Dose number in series	Date of vaccination (DD/MM/YYYY)
_____	_____	___/___/_____	_____	_____	___/___/_____
_____	_____	___/___/_____	_____	_____	___/___/_____
_____	_____	___/___/_____	_____	_____	___/___/_____
_____	_____	___/___/_____	_____	_____	___/___/_____

3.6 Are the child's immunizations up-to-date? Yes__ No__ Unknown__

3.7 Has any household member or close contact received OPV within 90 days prior to onset of the child's illness?
Yes__ No__ Unknown__

SECTION 4 – CLINICAL FEATURES AND RECENT INFECTION HISTORY

4.1 Date of paralysis/weakness onset: ___/___/_____
DD MM YYYY

4.2 Date paralysis/weakness reached full extent or maximal weakness: ___/___/_____
DD MM YYYY

4.3 Was fever present at paralysis/weakness onset? Yes__ No__ Unknown__

4.4 Grade maximal weakness in affected limbs using the numeric codes:
Right leg _____ Left leg _____ Right arm _____ Left arm _____ ←

1 = Total paralysis
2 = Flicker of movement only
3 = Able to move but not against gravity
4 = Reduced active strength but able to move against gravity
777 = Not applicable
999 = Unknown

4.5 Were respiratory muscles affected by paralysis/weakness?
Yes__ No__ Unknown__

4.6 Were cranial nerves affected by paralysis/weakness?
Yes__ No__ Unknown__

If yes, indicate affected nerve(s): _____

4.7 Were there symptoms of a current or recent (≤ 6 weeks before onset) infection? Yes__ No__ Unknown__

If yes:

4.7.1 Describe the type of infection: __Respiratory tract __Gastrointestinal __Other: _____

4.7.2 Was there a positive laboratory test (e.g., microbiological or serological) confirming an infection?
Yes__ No__ Unknown__

If yes, specify the organism or infection identified: _____

SECTION 5 – INVESTIGATIONS

5.1 Please indicate which of the following procedures were conducted and describe the results in the space provided.

Diagnostic procedure	Body part imaged	Result*	Describe
EMG/NCS: Yes__ No__ Unk__	_____	Abn__ N__ Unk__	_____
MRI Yes__ No__ Unk__	_____	Abn__ N__ Unk__	_____
CT Yes__ No__ Unk__	_____	Abn__ N__ Unk__	_____

*Abn = Abnormal; N = Normal; Unk = Unknown

SECTION 5 – INVESTIGATIONS (cont'd)

5.2 Please indicate which of the following laboratory tests were conducted and provide details in the space provided.

Laboratory test	Date (DD/MM/YYYY)	Result*	Organism	Laboratory†
Stool sample 1 (viral testing):	Yes__ No__ Unk__ ___/___/___	Pos__ Neg__ Unk__	_____	_____
Stool sample 1 (bacterial culture):	Yes__ No__ Unk__ ___/___/___	Pos__ Neg__ Unk__	_____	_____
Throat swab (viral testing):	Yes__ No__ Unk__ ___/___/___	Pos__ Neg__ Unk__	_____	_____
Other‡ (viral testing):	Yes__ No__ Unk__ ___/___/___	Pos__ Neg__ Unk__	_____	_____

* Pos=Positive; Neg=Negative; Unk=Unknown. † Include laboratory name and city.

‡ If other, specify test: _____

Every case of AFP should have **one stool sample obtained within 14 days of paralysis onset**. The sample should be submitted to the **National Microbiology Laboratory (NML)** with a completed requisition form, which can be found at the end of this questionnaire or at <http://open.cnphi-rcrsp.ca/gts/faces/public/laboratory.xhtml?labId=1012&lang=en>. **Data contained in the requisition form will remain with the NML and not shared with the Canadian Paediatric Surveillance Program.**

All that is needed for stool sampling is a suitable container (such as one would use for a urine specimen). This can be stored safely in a standard freezer until it can be shipped. The specimen does not have to be shipped frozen. Contact the NML when you are ready to ship the specimen. They will provide you with a shipping account number so that shipping expenses will be covered by the NML. The NML can be contacted at:

Enteroviruses and Enteric Viruses, National Microbiology Laboratory
 1015 Arlington Street, Winnipeg, MB R3E 3R2
 Telephone: 204-789-2022 / 204-789-2082
 Email: NML.Enteroviruses@phac-aspc.gc.ca

5.3 a) Please indicate if a CSF examination was conducted and provide details in the space provided.

Laboratory test	Date (DD/MM/YYYY)	Result*	Organism	Laboratory†
CSF examination:	Yes__ No__ Unk__ ___/___/___	Pos__ Neg__ Unk__	See Q. 5.3 b)	_____
CSF (viral testing):	Yes__ No__ Unk__ ___/___/___	Pos__ Neg__ Unk__	_____	_____

b) If CSF examination results were abnormal, indicate which parameters were abnormal and provide exact values:

Abnormal	Value	Units	Abnormal	Value	Units
Protein:	Yes__ No__ Unk__	_____	Neutrophils:	Yes__ No__ Unk__	_____
Glucose:	Yes__ No__ Unk__	_____	Lymphocytes:	Yes__ No__ Unk__	_____
WBC:	Yes__ No__ Unk__	_____	RBC:	Yes__ No__ Unk__	_____

* Pos=Positive; Neg=Negative; Unk=Unknown. † Include laboratory name and city.

SECTION 6 – DIAGNOSIS AND OUTCOME

6.1 Was the child hospitalized? Yes__ No__ Unknown

If yes, duration of hospitalization: ___days ___weeks ___months

6.2 Indicate the outcome using the appropriate numeric code provided:

6.2.1 Outcome at time of initial report: _____

Date that outcome was initially assessed: ___/___/___
 DD MM YYYY

6.2.2 Outcome at least 60 days after onset of paralysis/weakness: _____

- 1 = Fully recovered
- 2 = Partial recovery with residual paralysis/weakness
- 3 = Outcome pending (not recovered, condition progressive)
- 4 = Fatal
- 5 = Other
- 777 = Not applicable
- 999 = Unknown

SECTION 6 – DIAGNOSIS AND OUTCOME (cont'd)

6.3 Please indicate the final diagnosis:

- Guillain-Barré syndrome
- Guillain-Barré syndrome (Miller-Fisher Variant)
- Transverse myelitis
- Acute disseminated encephalomyelitis (ADEM)
- Acute poliomyelitis
- Vaccine-association poliomyelitis
- Other, specify : _____

All cases of poliomyelitis should be IMMEDIATELY reported to your public health unit.



6.4 Please indicate the level of certainty associated with the final diagnosis:

Probable___ Definite___

6.5 Is there any suspicion at all that this might be related to infection with poliovirus? Yes___ No___ Unknown___

If yes, describe: _____

SECTION 7 – COMMENTS

7.1 Please provide any comments you wish to include that may help with case classification:

SECTION 8 – REPORTING PHYSICIAN / IMPACT CENTRE

8.1 Date completed: ___/___/___
DD MM YYYY

8.2 IMPACT Centre: Yes___ No___

- I agree to be contacted by the CPSP for further information.
- I do not wish to be contacted by the CPSP for further information.

First name _____ Surname _____

Address _____

City _____ Province _____ Postal code _____

Telephone number _____ Fax number _____

E-mail _____

Thank you for completing this form.



REQUISITION FOR ENTEROVIRUSES AND ENTERIC VIRUSES

Enteroviruses and Enteric Viruses

National Microbiology Laboratory
1015 Arlington Street, Winnipeg, MB R3E 3R2
Telephone: (204) 789-2022 / (204) 789-2082
Email: Tim.Booth@phac-aspc.gc.ca or Elsie.Grudeski@phac-aspc.gc.ca

SENDER INFORMATION

NAME: _____
ADDRESS: _____
CITY: _____
PROVINCE: _____ POSTAL CODE: _____
TELEPHONE: _____ FAX: _____

PATIENT INFORMATION

NAME-CODE: _____
DATE OF BIRTH (YYYY-MM-DD): _____
SEX M F
CITY: _____ PROVINCE: _____

OTHER INFORMATION:

SPECIMEN INFORMATION

FOR PRIMARY SPECIMENS:

SPECIMEN REF #: _____
DATE TAKEN (YYYY-MM-DD): _____
 STOOL
 OTHER (SPECIFY): _____

FOR VIRAL ISOLATES:

SPECIMEN REF #: _____
DATE TAKEN (YYYY-MM-DD): _____

PASSAGE HISTORY OF ISOLATE:

ORIGINAL SPECIMEN (EG. STOOL): _____
CELL LINE USED (EG. MONKEY KIDNEY): _____
PASSAGE NUMBER OF ISOLATE: _____
OTHER TESTING RESULTS
(EG. IFA; NEUTRALIZATION): _____

SUSPECTED VIRUS

ENTEROVIRUS PARECHOVIRUS
 POLIOVIRUS NOROVIRUS
 OTHER (SPECIFY): _____

TEST REQUESTED

ENTEROVIRUS AND HUMAN PARECHOVIRUS DETECTION/
TYPING
 POLIOVIRUS DETECTION AND MOLECULAR
CHARACTERIZATION
 NOROVIRUS MOLECULAR DETECTION/TYPING

CLINICAL HISTORY

PARALYSIS VOMITING MYOCARDITIS
 ASEPTIC MENINGITIS HAND-FOOT-MOUTH DISEASE
 DIARRHEA PERICARDITIS HERPANGINA
 EPIDEMIC PLEURODYNIA ACUTE HEMORRHAGIC
CONJUNCTIVITIS
 OTHER (SPECIFY): _____
EXPOSURE TO POLIO VACCINE:
 RECIPIENT CONTACT
HOSPITALISATION? YES NO

TRAVEL HISTORY

LOCATION: _____
DATE (YYYY-MM-DD): _____
LOCATION: _____
DATE (YYYY-MM-DD): _____