Acute flaccid paralysis (AFP)

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM
2305 St. Laurent Blvd.
Ottawa, ON K1G 4J8
Tel: 613-526-9397, ext . 239
Fax: 613-526-3332
cpsp@cps.ca
www.cpsp.cps.ca

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: British Columbia, 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 <u>all</u> 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.

Public Health Agency of Canada | Agence de la santé publique du Canada

Canada

Protected B when complete

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):

The National Microbiology Laboratory (NML) of the Public Health Agency of Canada (PHAC) provides reference diagnostic services free of charge. The Client and NML agree that this requisition acts as an agreement for the NML to provide testing, as described in the Guide to Services, for the above requested tests.

November 2016