ACUTE FLACCID PARALYSIS INITIAL QUESTIONNAIRE (Revised October 2016)

Australian Paediatric Surveillance Unit – Victorian Infectious Diseases Reference Laboratory

Please keep a record of the child's unit number in your APSU folder.

Enquires Dr Bruce Thorley at VIDRL ph: (03) 9342 9607 to discuss this questionnaire or Prof Elizabeth Elliott on (02) 9845 3005 for clinical queries.

Please return questionnaire in the addressed reply-paid envelope to: AFP Surveillance, Victorian Infectious Diseases Reference Laboratory, The Doherty Institute, 792 Elizabeth Street, Melbourne, Victoria 3000 fax: (03) 9342 9665 email: enterovirus@mh.org.au

FOR INFORMATION REGARDING REFERRAL OF SPECIMENS TO VIDRL PLEASE SEE http://www.vidrl.org.au/surveillance/afp-surveillance1/

If this patient is primarily cared for by another physician who you believe will report the case, please complete the reporting clinician and patient details only and return to VIDRL. If no other report is received for this child we will contact you for information requested in the remainder of the questionnaire.

The primary clinician caring for this child is: Name: *Hospital:*

REPORTING CLINICIAN'S DETAILS

1. APSU Dr Code ☐☐☐☐ 2.Month/Year of Report ..... / .....
3. Dr Name_____ 4. Dr Address_____
5. Dr Telephone: (0)_____ Fax: (0)_____ Email_____

PATIENT DETAILS

6. First 2 letters of Surname ☐☐ 7. First 2 letters of Given Name ☐☐ 8.Hospital Of Admission _____
9. Date of Birth: ☐☐ / ☐☐ / ☐☐ 10. Sex ☐ M ☐ F
11. Postcode ☐☐☐☐ 12. Of Aboriginal/Torres Strait Islander descent? ☐ Yes ☐ No ☐ Unsure

PATIENT VACCINATION HISTORY

13. Has the patient ever been immunised with a vaccine including polio? ☐ Yes ACIR/written record; ☐ Yes self-report; ☐ No ☐ Unknown
14. Number of doses? _____ If known, date of last dose? Date /……/……/……. ☐ Unknown
15. Has the patient been in contact with someone who received oral polio vaccine within the 6 weeks prior to onset of symptoms? ☐ Yes ☐ No ☐ Unsure
16. Has the child travelled overseas in the last 3 months? ☐ Yes ☐ No ☐ Unsure. IF YES, specify where _____
17. Has the patient had contact with anyone who has travelled overseas OR visited from overseas in the last 3 months? ☐ Yes ☐ No ☐ Unsure.
    IF YES, specify country of travel or origin and relationship to patient_____
18. In the 6 weeks prior to presentation did the child;
    a) receive influenza vaccine? ☐ Yes ☐ No ☐ Unsure IF YES, type of vaccine:_____Date given……/……/……..
    b) receive any other vaccine? ☐ Yes ☐ No ☐ Unsure IF YES, which vaccine(s) 1:_____Date given……/……/……..
    2:_____Date given……/……/……..

CLINICAL FEATURES & INVESTIGATIONS

19. Date of onset of paralysis (dd/mm/yy) ☐☐ / ☐☐ / ☐☐
20. Site of paralysis _____
21. In the 6 weeks prior to presentation did the child
    a) have an influenza-like illness? ☐ Yes ☐ No ☐ Unsure IF YES, please describe symptoms:_____
    b) was the child tested for influenza? ☐ Yes ☐ No ☐ Unsure IF YES, result:_____ IF POSITIVE Date of positive specimen……/……/……..
22. In the 6 weeks prior to presentation did the child have any other infective illness ☐ Yes ☐ No ☐ Unsure IF YES,
    a) please describe symptoms:_____
    b) did the child have laboratory testing? ☐ Yes ☐ No ☐ Unsure IF YES, result:_____IF POSITIVE Date of positive specimen……/……/……..
23. Was the patient hospitalised? ☐ Yes ☐ No ☐ Unsure
24. Was the patient immunosuppressed? ☐ Yes ☐ No ☐ Unsure IF YES, specify_____
25. Was a sensory level detected on examination? ☐ Yes ☐ No ☐ Unsure IF YES, specify_____
26. Was there cranial nerve involvement? ☐ Yes ☐ No ☐ Unsure IF YES, specify_____
27. Was there bladder and/or bowel involvement? (eg. Urinary retention/incontinence) ☐ Yes ☐ No ☐ Unsure IF YES, specify_____
28. Was a lumbar puncture done? ☐ Yes ☐ No ☐ Unsure
29. IF YES, CSF: protein _____g/L glucose _____mmol/L Number of PMN_____ Lymphocyte_____ RBC_____ other_____
30. Were nerve conduction studies and/or EMG performed? ☐ Yes ☐ No ☐ Unsure IF YES, specify results _____
31. Was an MRI done? ☐ Yes ☐ No ☐ Unsure IF YES, brain ☐ or spinal ☐
    If YES, specify findings_____
32. How many faecal specimens were sent for viral culture? ☐ None ☐ One ☐ Two ☐ Unsure

OUTCOME

33. Did the patient survive the illness? ☐ Yes ☐ No ☐ Unsure IF NO, please give number of days between onset of paralysis and death ☐☐ days
34. Does the patient have any residual paralysis? ☐ Yes ☐ No ☐ Unsure IF NO, duration of paralysis? ☐☐ days
35. If YES, specify level sensory_____ motor _____
36. Is there residual sphincter dysfunction? ☐ Yes ☐ No ☐ Unsure

DIAGNOSIS

Please turn to PAGE 2 to complete the questionnaire.

Thank you for contributing to AFP surveillance and the WHO polio eradication program

PLEASE USE PAGE 2 OF THIS QUESTIONNAIRE IF YOU HAVE ANY FURTHER INFORMATION THAT MAY HELP US

PATIENT DETAILS

First 2 letters of Surname ☐☐ First 2 letters of Given Name ☐☐

Date of Birth: ☐☐ / ☐☐ / ☐☐

Sex M ☐ F ☐

DIAGNOSIS

37. In light of currently available evidence, what is the patient's diagnosis?

Peripheral neuropathy	Acute myelopathy	Systemic disease
❑ Guillain-Barré syndrome (acute post- infectious polyneuropathy)	❑ Transverse myelitis	❑ Acute porphyria
❑ Acute axonal neuropathy	❑ Acute disseminated encephalomyelitis (ADEM)	❑ Critical illness neuropathy/ myopathy
❑ Neuropathies of infectious diseases	❑ Spinal cord ischaemia	❑ Conversion disorder
❑ Acute toxic neuropathies(heavy metals)	❑ Spinal cord injury or compression eg.Tumour, trauma	Disorders of neuromuscular transmission
❑ Focal mononeuropathy	❑ Peri-operative complication	❑ Botulism
Anterior horn cell disease	Muscle disorders	❑ Insecticide *e.g: organophosphate poisoning*
❑ Acute poliomyelitis	❑ Polymyositis, dermatomyositis	❑ Tick bite paralysis
❑ Vaccine-associated poliomyelitis	❑ Periodic paralyses	❑ Myasthenia gravis
❑ Other neurotropic viruses	❑ Mitochondrial diseases (infantile type)	❑ Snake bite
	❑ Viral myositis	Other
	❑ Drug-induced paralysis (specify)_____	(specify)_____