ACUTE FLACCID PARALYSIS QUESTIONNAIRE

CIDR ID

PATIENT DETAILS

Surname | **Forename**

Address

County | **Sex** M ☐ F ☐ | **Date of Birth**

Ethnic groups (see note on page 3)

☐ Irish	☐ African	☐ Any other White background	☐ Any other Black background	☐ Other
☐ Irish Traveller	☐ Chinese	☐ Any other Asian background	☐ Roma	Other, please specify

Country of infection

REPORTING CLINICIAN'S DETAILS

Hospital		**Referring Hospital**	
Consultant			
Email		**Referring Consultant**	
Hospital Chart Number			
Date of Hospital Admission		**Date of Discharge (if known)**	

GP DETAILS

GP Name		GP Address	
GP Tel			

CLINICAL FEATURES AND INVESTIGATIONS

Date of onset of paralysis (dd/mm/yy)

	Yes	No
Fever at onset of paralysis?	☐	☐
Rapid paralysis progression (within 14 days)?	☐	☐
Asymmetric paralysis?	☐	☐
Patient hospitalised?	☐	☐
Patient immunosuppressed?	☐	☐
Sensory level detected on examination?	☐	☐
Cranial nerve involvement?	☐	☐
Bladder or bowel involvement? (incl. urinary retention/incontinence)	☐	☐
Respiratory illness/symptoms?	☐	☐
Rash?	☐	☐

Site of paralysis?

- Facial paralysis only ☐
- Limb ☐
- Limbs & resp. muscles (bulbar) ☐
- Bulbar only ☐
- Limb plus facial paralysis ☐
- Unknown ☐

Please specify additional details, if any

BIOMED INVESTIGATIONS & RESULTS

Please indicate of any of the following have been performed

	Yes	No			Yes	No
EMG?	☐	☐		**Spinal MRI?**	☐	☐
Date:				Date:		
Brain MRI?	☐	☐		**CXR?**	☐	☐
Date:						

Please specify additional details, if any

VIROLOGY TESTING by NVRL (National Virus Reference Laboratory)

Please send specimens to NVRL as soon as possible

Stool Specimen 1
Date collected

Second stool specimen should be taken >=24 hours after first specimen and both specimens taken within 14 days of onset of paralysis

Stool Specimen 2
Date collected

Lab Result Stool Specimen 1

Lab Result Stool Specimen 2

Respiratory Specimens

	Yes	No	Date collected
Throat swab?	☐	☐	
Nasopharyngeal swab/aspirate?	☐	☐	

Results:

Feidhmeannacht na Seirbhíse Sláinte Health Service Executive

hpsc

ACUTE FLACCID PARALYSIS QUESTIONNAIRE

NATIONAL VIRUS REFERENCE LABORATORY

Patient Name

VIROLOGY TESTING by NVRL (National Virus Reference Laboratory) (continued)

Please send specimens to NVRL

	Yes	No	Date collected		Yes	No	Date collected
Lumbar puncture (LP)/CSF?	☐	☐		**Serology?**	☐	☐	

CSF Results:

No. of PMN		Glucose mmol/L	
No. of Lymphocytes		protein g/L	
No. of RBCs			

Serology Results:

PATIENT VACCINATION HISTORY

Has patient ever been immunised against polio? Yes ☐ No ☐ Unknown ☐

If YES, date of most recent polio vaccination?

Vaccine Type	Oral:	IPV:	Vaccination Date
1st dose	☐	☐	
2nd dose	☐	☐	
3rd dose	☐	☐	
4th dose	☐	☐	

Comment/Other Details e.g. vaccine brand and batch number

RISK FACTORS

Has patient been in contact with someone who received oral polio vaccine within 6 weeks prior to onset of symptoms?	Yes ☐	No ☐		
Has patient travelled overseas in the last 3 months?	Yes ☐	No ☐	Country	
Respiratory illness in 4 weeks before onset?	Yes ☐	No ☐	Onset date	
Gastrointestinal illness in 4 weeks before onset?	Yes ☐	No ☐	Onset date	
Rash in 4 weeks before onset?	Yes ☐	No ☐	Onset date	
Any underlying illness in 4 weeks before onset?	Yes ☐	No ☐		

If YES, describe

DIAGNOSIS (Please indicate if any of the following have been diagnosed in light of current available evidence)

Peripheral neuropathy
- ☐ Guillain-Barre syndrome (acute post-infectious polyneuropathy)

Anterior horn cell disease
- ☐ Acute poliomyelitis
- ☐ Vaccine-associated poliomyelitis
- ☐ Other neurotropic viruses
- ☐ Hopkins' syndrome

Systemic disease
- ☐ Acute porphyria
- ☐ Critical illness neuropathy/myopathy
- ☐ Conversion disorder

Disorders of neuromuscular transmission
- ☐ Botulism
- ☐ Insecticide *e.g. organophosphate poisoning*
- ☐ Tick bite paralysis
- ☐ Other

Acute myelopathy
- ☐ Transverse myelitis
- ☐ Acute disseminated encephalomyelitis (ADEM)
- ☐ Spinal cord ischaemia
- ☐ Spinal cord injury including trauma
- ☐ Peri-operative complication
- ☐ Other

Muscle disorders
- ☐ Periodic paralyses
- ☐ Mitochondrial diseases (infantile type)
- ☐ Viral myositis
- ☐ Other

Other clinical information

OUTCOME AT TIME OF REPORTING

Date Follow-up?

	Yes	No		
Did the patient survive the illness?	☐	☐	If NO, date of death	If NO, duration of paralysis? ☐ days
Does the patient have any residual paralysis?	☐	☐	If YES, specify Sensory ☐ Motor ☐ Both ☐	

If YES, describe

PLEASE USE THE BACK OF THIS QUESTIONNAIRE IF YOU HAVE ANY FURTHER INFORMATION THAT MAY HELP US

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

ACUTE FLACCID PARALYSIS QUESTIONNAIRE

Patient Name

COMMENTS Including other diagnosis not included on page 2

CASE DEFINITION: Acute anterior poliomyelitis (Polio virus)

Clinical criteria
Any person <15 years of age with acute flaccid paralysis (AFP)
OR
Any person in whom polio is suspected by a physician

Laboratory criteria
At least one of the following three:

- Isolation of a polio virus and intratypic differentiation– Wild polio virus (WPV)
- Vaccine derived poliovirus (VDPV) (for the VDPV at least 85% similarity with vaccine virus in the nucleotide sequences in the VP1 section)
- Sabin-like poliovirus: intratypic differentiation performed by a WHO-accredited polio laboratory (for the VDPV a >1% up to 15% VP1 sequence difference compared with vaccine virus of the same serotype)

Epidemiological criteria
At least one of the following two epidemiological links:

- Human to human transmission
- A history of travel to a polio-endemic area or an area with suspected or confirmed circulation of poliovirus

Case classification
A. **Possible case**
Any person meeting the clinical criteria (in the absence of any alternative diagnosis)

B. **Probable case**
Any person meeting the clinical criteria and with an epidemiological link

C. **Confirmed case**
Any person meeting the clinical and the laboratory criteria

Current as of: 01/03/2023

Note regarding ethic identifier: This should be self-reported and is that to which the individual case identifies him or herself. It should not be 'given' by investigator.

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Form completed by:____

Contact telephone number:____

Email:____

Date of Completion

Clinicians should notify AFP cases meeting case definition to the Medical Officer of Health for the area of residence of the patient. Further information is available at https://www.hpsc.ie/notifiablediseases/whotonotify/