Acute Flaccid Paralysis (AFP) Notification & Investigation Form

Health Protection Agency

Male' Maldives

Form003
HPA/2015

HPA USE	Case No:MAV/	Year:

1. Notification Information

Notifying health facility: (Name/ Island/ Atoll/ Region)		
Notified by (person):	Title:	
Received by (person):	Title:	
Date case notified to HPA:	Date received by HPA:	

2. Case Identification

Patient's Name:	Sex:	Date of Birth:	ID/PP No:	
Legal guardian's name:		Atoll & Island:	Contact No:	
Current Address:		Atoll & Island:		
Permanent Address:		Atoll & Island:	Nationality	

3. Immunization History (To be confirmed from immunization card)

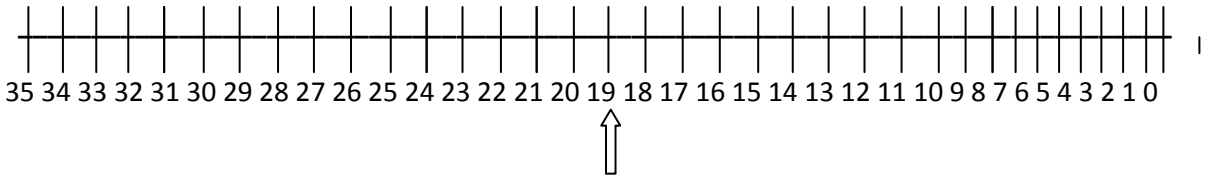
OPV Doses received through routine EPI:	☐Yes	☐No	Total Routine OPV doses:	
OPV doses received through SIA	☐Yes	☐No	Total OPV Doses through SIA:	

Date of last dose of OPV:
To be completed by HPA

4. Travel History

Travel of child within 35 days prior to onset of paralysis *(Indicate dates and place of travel with arrows on date line)*

Write travel dates ⇩ **Day of onset** ⇩



Write here places visited corresponding to the travel dates

Requires cross notification? Yes☐/ No☐/ Not applicable☐		
If yes, date of cross notification:	Place notified by	Place of residence

5. Hospitalization:

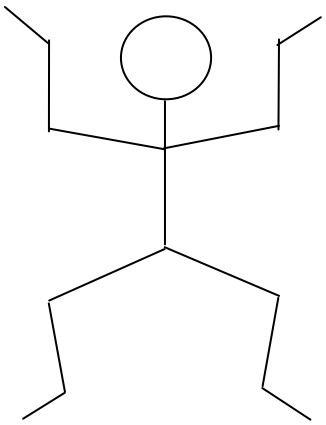
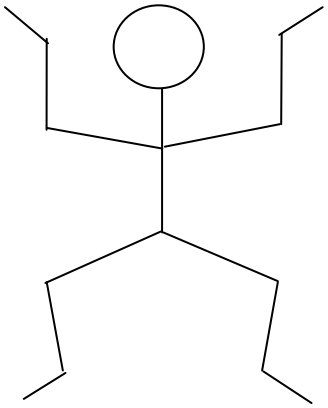
Date of hospitalization (initial):	Hospital Record No:
Name of Hospital:	
Date of hospitalization (referral):	Hospital Record No:
Name of Hospital:	

6. Clinical History:

Onset of signs and symptoms:	Onset of paralysis:

✓ *Tick where appropriate*

Signs and symptoms	Yes	No	Unknown	Paralysis/ Paresis	Yes	No	Unknown
Fever				**Sudden**			
Nausea/vomiting				**Flaccid**			
Diarrhea				**Paralysis progressed more than three days of onset**			
Constipation				**Ascending**			
Sore throat				**Descending**			
Muscular pain				**Asymmetric**			
Headache							
Stiff neck							
Sensation loss							
Respiratory involvement							
Bulbar involvement							
Gait							
Bladder/Bowel							
Injections 30days-				**If yes- side and site of injection**			

7. Clinical examination:				
Clinical examination	Initial case investigation Date: Examined by :		60-day follow-up Date: Examined by:	
Tone(normal/↑/↓	UL :Right left	LL :Right left	UL :Right left	LL :Right left
Power (Grade 0 to 5) **0-No contraction** **1-Flicker of contraction** **2- Active movement with gravity eliminated** **3-Active movement against gravity but no resistance** **4-Active movement against resistance** **5-Normal**				
Reflexes:	**N/↑/↓/absent/uncooperative child**	**N/↑/↓/absent/uncooperative child**	**N/↑/↓/absent/uncooperative child**	**N/↑/↓/absent/uncooperative child**
Biceps	Right	Left	Right	Left
Triceps	Right	Left	Right	Left
Supinator	Right	Left	Right	Left
Knee Jerk	Right	Left	Right	Left
Ankle Jerk	Right	Left	Right	Left
Plantar	Right: flexor/ extensor/uncooperative child	Left: flexor/ extensor/uncooperative child	Right: flexor/ extensor/uncooperative child	Left: flexor/ extensor/uncooperative child
Circumference:	Right	Left	Right	Left
Mid-arm	Right	Left	Right	Left
Fore-arm	Right	Left	Right	Left
Mid-thigh	Right	Left	Right	Left
Mid-calf	Right	Left	Right	Left
Cranial nerves affected	Right	Left	Right	Left
Additional comments				

8. Stool specimen

	Date collected	Date sent	Date of result	Laboratory result (P1, P2, P3, Wild, Vax, NPEV, Negative)
Stool sample 1				
Stool sample 2				

*If stool not collected in 14 days why?

☐Late investigation ☐ Delay in stool collection ☐Late notification ☐Constipation ☐Lost

☐Others._____

9. Final Classification:

☐Confirmed Polio ☐Compatible ☐Discarded:

If compatible, why?

If discarded, final diagnosis:

☐Gullain-Barre Syndrome ☐Meningitis

☐Transverse Myelitis ☐Non-polio enterovirus

☐traumatic neuritis ☐Tumors

☐viral myositis, encephalitis ☐Hypokalemic paralysis or weakness.

☐Other (Specify) : _____

10. Case closed by: (Expert Committee)

Name:	**Name:**
Designation:	**Designation:**
Signature:	**Signature:**
Date:	**Date:**

For further information or inquiries, please contact:
Communicable Disease Division/Surveillance
Health Protection Agency
Roshanee Building, Sosun Magu, Male'.

Telephone: +960-3014 496, Hotline: +960-3014 333
Fax: +960-3014 484 email: hpa@health.gov.mv

Forms and case definition booklet are available on **http://www.health.gov.mv , www.hpa.gov.mv**

Appendix 1-AFP surveillance reporting Procedures

(1) REPORTING INSTRUCTIONS FOR ALL AFP CASES (all ages)

1. **Telephone reporting:** Report all cases, *immediately by telephone during working hours(8:00am to 3:00pm, Sunday to Thursday)* to the Health Protection Agency (HPA) via 3014496 or 3014333

    - Out of working hours Head of Communicable Disease Surveillance may be contacted on **(+960) 7512240**

2. **Collection of stool specimens from cases of AFP for viral culture:** Due to intermittent shedding, collect **2 stool specimens.**

    - First sample must be collected within 24 hours of diagnosis
    - Second sample must be collected 24 hours after the collection of first sample.

All stool samples must be collected within 2 weeks of onset of paralysis. Stool should be collected in a sterile container at the Health Facilities and sent to IGMH laboratory with the guidance and assistance of HPA.

Note: All costs for transport and analysis will be borne by the HPA. Coordinating specimen transport will be carried out by HPA. All Stool samples are transported via DHL to WHO reference laboratory, MRI in Sri Lanka.

3. **AFP Case investigation form** form must be completed after collecting stool samples send to HPA immediately.

4. **Lab results:** All results must be communicated to HPA Surveillance by MRI Lab via email. All results will be attached to the case investigation form.

5. **Clinical Evaluation:** All AFP cases must undergo clinical evaluation 60 days after the onset of paralysis by a pediatrician or physician to determine the outcome of the patient regardless of the adequacy of the stool sample. All patient documentations relevant to diagnosis must be attached at follow-up by HPA.

6. **Expert review:** All cases should be submitted by HPA surveillance to the expert review committee for final diagnosis and case closure.

Case Definition for ACUTE FLACCID PARALYSIS (AFP)

Maldives recorded its last indigenous case of poliomyelitis in 1981 (Last case of poliomyelitis due to wild poliovirus was recorded in 1994. This is a 6 years old boy who had received 1 dose of OPV, who has been living in India for 2 years. The case was reviewed by a WHO STC, which included an active search for other cases. The case was determined to be an imported case) and since then no case of wild polio has been detected in the country. Poliomyelitis is a disease under the national elimination/eradication programme and the country is working for certification of eradication of the disease. According to WHO Acute Flaccid Paralysis (AFP) surveillance criterion would be of "certification standard" if the following three performance criteria are to be achieved.

a) The system should detect at least Two case of non-polio AFP for every 100 000 children under 15 years of age.
b) Two adequate diagnostic specimens should be collected from at least 80% of detected AFP cases
c) All specimens should be processed at a WHO accredited laboratory.

Therefore, in addition to the passive case reporting system that exists in the country a specific active case finding system operates for poliomyelitis. Moreover, strong routine immunization programme and special efforts to ensure "reaching the unreached children" with OPV vaccine are the interventions for Maldives to stop the wild polio virus circulation.

Strategies of Poliomyelitis Eradication

- Strong Routine Immunization Programme
- Acute Flaccid Paralysis (AFP) Surveillance
- National Immunization Days (NIDs)
- Mopping-up immunization

AFP Surveillance Case Definition:

Any child under 15 years of age with acute onset flaccid paralysis*

OR

Any person at any age with paralytic illness if when polio is suspected

- **Acute:** Rapid progression from weakness to paralysis (Sudden onset- as opposed to chronic)
- **Flaccid:** Loss of muscle tone, "floppy" (as opposed to spastic or rigid)
- **Paralysis:** Inability to move the affected part (Weakness, loss of voluntary movement) **AND** the paralysis is ***not*** from birth or is ***not*** a result of an injury

Suspected Polio: Case which meets the case definition of Acute Flaccid Paralysis

*All AFPs should be reported irrespective of diagnosis.

The classification of "suspected case" is temporary. and within 10 weeks of onset the case should be reclassified as "confirmed", "compatible", "vaccine-associated" or "discarded. Confirmation of cases will be done by the expert committee according to the low-chart in Figure 2 below.

Confirmed case of Polio:

A case with acute paralytic illness with or without residual paralysis, and isolation of wild poliovirus from the stools of either the case or his/her contacts, tested from a WHO accredited laboratory.

All confirmed or compatible cases should be reported within 24 hours to WHO under the International Health Regulations (IHR 2005).

Role of Physicians, Nurses and Health Workers:

- All suspected cases of AFP from the hospitals and health care facilities should be identified and notified and investigated.
- All physicians/Nurses of hospitals or health facilities (resident physicians, pediatricians, neurologists, Consultants, medical officers and Nurses) should be encouraged to identify and notify immediately any suspected AFP case.
- All community health workers should identify and immediately notify any suspected AFP case to nearby health facility or hospital
- The clinicians of the hospital or health care facility need to collect information and investigate the patients and complete the "AFP Notification Form" and send to the DSFP.

Differential Diagnosis of AFP:

The most common differential diagnosis of Acute Flaccid Paralysis includes:

- paralytic poliomyelitis
- Guillain-Barré syndrome
- transverse myelitis

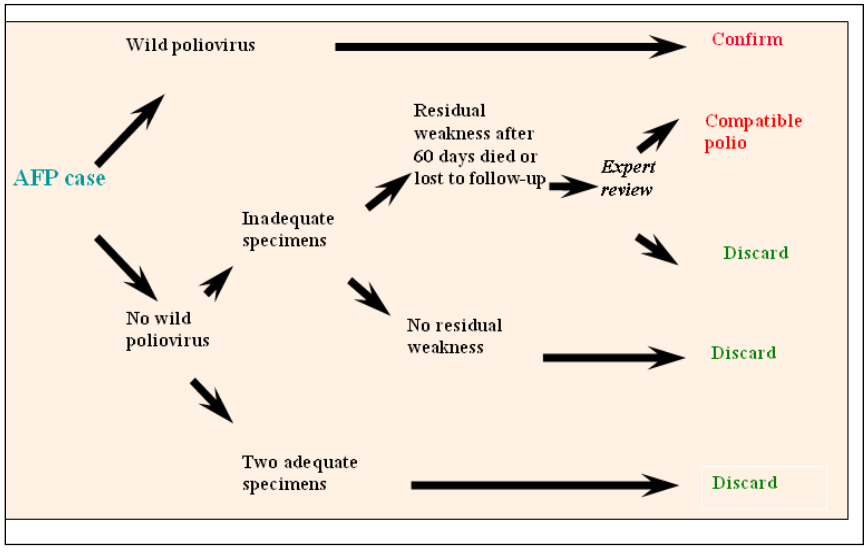
Less common etiologies are traumatic neuritis, viral myositis, encephalitis, meningitis, non polio enteroviruses (like Coxsackieviruses A and B, echovirus, enterovirus 70 and enterovirus 71), tumors, and hypokalemic periodic paralysis.

Classification of AFP cases

Final classification of AFP cases includes three possibilities:

1. Confirmed Polio,
2. Non Polio AFP and
3. Compatible with Polio.

Figure 2: Virological Classification scheme of AFP Case



Non-Polio AFP:

A **non-polio AFP** case is an AFP case with no wild poliovirus isolated from any of the two adequate stool samples by any WHO accredited reference laboratory or absence of residual paralysis during the 60+ days follow-up investigation of an AFP case with inadequate stool samples.

Compatible with Polio:

An AFP case is **compatible with polio** from whom adequate stool samples could not be collected and there was either residual paralysis on 60+ days follow-up or 60+ follow up could not be done either due to death or loss to follow-up; and after reviewing history, clinical features and necessary investigation reports, the National committee for Immunization Practices (NCIP) / National Expert Review Committee (ERC) could not rule out possibility of poliomyelitis

Laboratory criteria for diagnosis

Isolation of wild polio virus from 2 adequate stool samples collected within 14 days of onset of paralysis, from a suspected case of acute flaccid paralysis.

SPECIAL ASPECTS:

Surveillance performance should meet the following criteria:

1. At least 2 children under 15 years of age should be detected in Maldives (based on 2006 population data)
2. Two adequate specimens* collected from detected AFP cases.
   **Adequate specimens—mean 2 specimens collected 24-48 hours apart and within 14 days of onset of paralysis.*
3. AFP cases must be reported to DPH immediately, be investigated within 48 hours of notification, and stool specimens must be collected within 14 days of paralysis onset.
4. *The specimen arriving at the* WHO reference laboratory within 3 days after collection *and must be of adequate volume (approximately 8-10 grams), have appropriate documentation (i.e. laboratory request form) and be in "good condition" (no leakage, no desiccation, and evidence that the reverse cold chain was maintained).*