

10/10/2018



## Increase in suspected cases of Acute Flaccid Myelitis in Washington State since August 2018

### Current situation in Washington (WA)

- A cluster of suspected acute flaccid myelitis (AFM) has been reported among Washington residents.
- As of October 9<sup>th</sup>, five WA cases are being evaluated by CDC neurologists and other AFM experts.
- All cases are among **children between 7 months and 5 years of age** who presented with acute paralysis of one or more limbs. All had a prodrome that included respiratory symptoms in the week prior to presentation with symptoms of AFM. Four of the five had fever of 100.4 F or greater.
- The earliest onset of limb weakness was on August 28, 2018 and the most recent on October 5<sup>th</sup>.
- The cases are residents of King County (2), Pierce County (1), Lewis County (1), and Snohomish County (1).

### Actions requested

**Report suspected cases of AFM promptly** (see case definition below) to your Local Health Jurisdiction, Jefferson County Public Health (JCPH), 360-385-9400. JCPH will provide assistance with the following:

- **Complete the AFM patient summary form** when reporting patients to JCPH: (<https://www.cdc.gov/acute-flaccid-myelitis/downloads/patient-summary-form.pdf>)
- **Collect surveillance specimens** from patients suspected of having AFM as early as possible in the course of illness (see details below)\*.
- **Provide the following information:** 1) brain and spinal MRI images on a disc 2) MRI reports, 3) H&P notes, 4) neurology consult notes, 5) infectious disease consult notes, and 6) diagnostic laboratory reports
- **Order viral respiratory and viral stool cultures to be performed locally** if not already done.

Also, please notify JCPH if you are aware of patients of any age that previously presented to your facility and fit the case definition (please have CSF results or MRI report available).

### Background

From January 1<sup>st</sup> to September 30<sup>th</sup>, 2018 a total of 38 people in 16 states across the United States have been confirmed to have AFM. Most of these have been in children. More information about national surveillance for suspected AFM cases, which started in 2014, can be found [here](#). No etiology for AFM has been established although potential associations with enteroviruses (including EVD68 and EVA71), adenovirus, herpes viruses, arboviruses including West Nile virus, and other viruses have been reported. Non-infectious causes have not been ruled out.

## Resources

### CSTE case definition

Clinicians should be vigilant and consider AFM in patients presenting with:

*Onset of acute limb weakness*

**AND**

*A magnetic resonance image (MRI) showing spinal cord lesion largely restricted to gray matter and spanning one or more spinal segments*

**OR**

*Cerebrospinal fluid (CSF) showing pleocytosis (white blood cell count >5 cells/mm<sup>3</sup>)*

### Specimen collection guidance

Collect specimens from patients suspected of having **AFM as early as possible in the course of illness** including:

- Cerebrospinal fluid (collected within 24 hours of the serum)
- Serum (collected within 24 hours of the CSF)
- Two stool specimens separated by 24 hours (whole stool)
- Upper respiratory tract sample nasopharyngeal swap or oropharyngeal swab
- Oropharyngeal swab should always be collected in addition to the nasopharyngeal specimen on any patient suspected to have polio.
- **Order a viral respiratory and a viral stool culture to be performed locally** if not already done.

**Please contact JCPH Communicable Disease staff at 360-385-9400, for questions, sampling and shipping details.**