Center for Policy, Planning and Evaluation Administration
Division of Epidemiology–Disease Surveillance and Investigation

August 7, 2020

Health Notice for District of Columbia Health Care Providers
Acute Flaccid Myelitis Recommendations and Reporting — 2020

SUMMARY

Acute Flaccid Myelitis (AFM) is a condition that affects the nervous system, causing a sudden onset of arm or leg weakness and loss of muscle tone and reflexes. Enteroviruses, particularly EV-D68, are likely responsible for the increase in cases every two years since 2014. From January 1 through June 30, 2020, the Centers for Disease Control and Prevention (CDC) have received 33 reports of patients under investigation (PUIs) for AFM; 13 AFM cases have been confirmed in 10 states and the District of Columbia (DC) thus far. Two patients with confirmed AFM died in the acute phase of their illness, one in 2017 and one in 2020. There have been 630 confirmed cases since the CDC started tracking AFM in August of 2014. To date, one confirmed case of AFM has been reported to the DC Department of Health (DC Health).This health notice provides recommendations, reporting guidelines in DC, and resources on AFM. Clinicians are encouraged to maintain vigilance for AFM among all age groups and to report patients with acute onset of flaccid limb weakness to DC Health. Reporting of cases will help states and CDC monitor the occurrence of AFM and better understand factors associated with this illness.

BACKGROUND

CDC recently published a Vital Signs press release (https://www.cdc.gov/media/releases/2020/p0803-acute-flaccid-myelitis-outbreak.html) alerting healthcare providers of the possibility of an increased number of AFM cases in 2020. AFM is an uncommon, but life-threatening neurologic condition that affects mostly children and can lead to permanent paralysis or disability. AFM is a medical emergency and patients must be hospitalized and monitored in case they progress to respiratory failure. Prompt recognition and immediate action by pediatricians, and emergency department and urgent care providers are critical to achieving the best possible outcomes. AFM typically presents with sudden limb weakness, and most patients report having respiratory illness or fever before onset. Patient health can decline quickly, resulting in paralysis or the need for a ventilator. Patients who tested positive for EV-D68 typically had more severe AFM illness, requiring hospitalized intensive care and ventilation. Most cases occur between August and November.

RECOMMENDATIONS

- CASE REPORTING: An emerging infectious disease or an unusual occurrence of any disease is reportable in the District of Columbia. Cases of AFM must be reported immediately by submitting a Notifiable Disease and Condition Case Report Form online using the DC Reporting and Surveillance Center (DCRC), which can be found on our Infectious Diseases website: (https://dchealth.dc.gov/service/infectious-diseases).
    - Clinicians should send the following information about all patients that meet the clinical criterion for AFM. If this information is not available at the time of reporting, DC Health Epidemiologist will reach out to you to complete the AFM patient summary form and obtain any additional information.
        - AFM patient summary form (https://www.cdc.gov/acute-flaccid-myelitis/hcp/data.html)
        - Admission and discharge notes
        - Neurology and infectious disease consult notes
        - Magnetic resonance imaging (MRI) reports AND images

- Complete vaccination history, and
- Laboratory test results.

If you suspect a case that meets the clinical criterion of AFM, please notify DC Health immediately as you wait for pending clinical notes, or laboratory or MRI results.

- LABORATORY TESTING: Clinicians should collect specimens from patients under investigation for AFM as early as possible in the course of illness, **preferably on the day of onset of limb weakness**, and coordinate with DC Health to submit specimens to CDC through the DC Public Health Laboratory for testing. Specimens to collect include:
  - CSF;
  - Serum; and
  - A nasopharyngeal (NP) or oropharyngeal (OP) swab; and
  - Stool
    - Please note: **Collection of stool is required for AFM surveillance**. Two stool specimens should be collected at least 24 hours apart early during the course of illness to rule out poliovirus infection.
- Pathogen-specific testing for diagnostic purposes should continue at hospital or DC Public Health Laboratories.
- AFM testing at CDC includes:
  - Routine enterovirus/rhinovirus (EV/RV) testing and typing of CSF, respiratory, and stool specimens and poliovirus testing of stool specimens to rule out the presence of poliovirus. Results will be provided to the submitter once testing is completed.
  - Additional testing of CSF and serum to look for etiology/mechanism for AFM. Patient-level results for the additional testing will not be provided since the testing protocols are not performed under the Clinical Laboratory Improvement Amendments (CLIA) nor intended for clinical diagnosis.
- Please note test results and case classification may take up to four weeks.

ADDITIONAL RESOURCES

- Acute Flaccid Myelitis: https://www.cdc.gov/acute-flaccid-myelitis/references.html
- AFM Investigation Form: https://www.cdc.gov/acute-flaccid-myelitis/afm-surveillance.html
- CSTE standardized case definition for AFM: https://cdn.ymaws.com/www.cste.org/resource/resmgr/2019ps/final/19-ID-05_AFM_final_7.31.19.pdf
- For Clinicians and Health Departments: https://www.cdc.gov/acute-flaccid-myelitis/hcp/index.html

Please contact the DC Health Division of Epidemiology–Disease Surveillance and Investigation at:
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