NOMADMUS Study – Inclusion form

Date of first visit: ___ ___ (Day) ___ ___ (Month) ___ ___ ___ ___ (Year)

PATIENT'S IDENTITY

LAST NAME: _____ Date of birth: ___ ___ (Day) ___ ___ (Month) ___ ___ ___ ___ (Year)
First name: _____
Birth name: _____ ○ Male ○ Female

PHYSICIAN'S IDENTITY

LAST NAME: _____ Phone/Fax: _____
First name: _____ E-mail: _____
Postal address: _____

Patient's background

The patient is caucasian: ○ Yes ○ No ... If no, specify: _____
Auto-immune disease: ○ No ○ Yes ... If yes, specify: _____
Tumor : ○ No ○ Yes ... If yes, specify: _____

1. HISTORICAL OVERVIEW OF NEUROLOGICAL ÉPISODES

Relapsing-remitting phase: A (1st relapse), B (Subsequent relapse)
Progressive phase: C (Without inaugural relapse), D (With inaugural relapse), E (Subsequent relapse)

Disease onset

	Episode 1	Episode 2	Episode 3	Episode 4	Episode 5
Date of episode onset: Day / Month	___ ___	___ ___	___ ___	___ ___	___ ___
Year	___ ___ ___ ___	___ ___ ___ ___	___ ___ ___ ___	___ ___ ___ ___	___ ___ ___ ___
Episode type (according to classification above):	___	___	___	___	___
Episode semiology					
Walking difficulties	☐	☐	☐	☐	☐
Lower extremity dysfunction	☐	☐	☐	☐	☐
Upper extremity dysfunction	☐	☐	☐	☐	☐
Sensory symptoms (pain, paresthesia...)	☐	☐	☐	☐	☐
Bladder/bowel dysfunction	☐	☐	☐	☐	☐
Sexual dysfunction	☐	☐	☐	☐	☐
Oculomotor impairment	☐	☐	☐	☐	☐
Facial motor	☐	☐	☐	☐	☐
Facial sensory	☐	☐	☐	☐	☐
Vertigo, hypoacousia	☐	☐	☐	☐	☐
Speech/swallowing impairment	☐	☐	☐	☐	☐
Mental deterioration	☐	☐	☐	☐	☐
Psychiatric symptoms	☐	☐	☐	☐	☐
Paroxystic symptoms	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐
Other: if yes, specify	___	___	___	___	___
Unknown	☐	☐	☐	☐	☐
Clinical syndrome					
TRANSVERSE MYELITIS	☐	☐	☐	☐	☐
Extensive / Non extensive	○–○	○–○	○–○	○–○	○–○
OPTIC NEURITIS	☐	☐	☐	☐	☐
Unilateral: Right - Left / Bilateral	○–□–□ ○	○–□–□ ○	○–□–□ ○	○–□–□ ○	○–□–□ ○
OTHER: if yes, specify	___	___	___	___	___
Episode features					
Maximal motor score (Kurtzke DSS / EDMUS GS)	___	___	___	___	___
Maximal visual score (Visual Scale) *RE/LE*	___ ___	___ ___	___ ___	___ ___	___ ___
Recovery *Complete / Incomplete / None*	○–○–○	○–○–○	○–○–○	○–○–○	○–○–○
Corticosteroid treatment *No / Yes*	○–○	○–○	○–○	○–○	○–○
If yes: i.v. / i.m. / per os	○–○–○	○–○–○	○–○–○	○–○–○	○–○–○
Plasma exchange *No / Yes*	○–○	○–○	○–○	○–○	○–○
Immunoglobulins i.v. *No / Yes*	○–○	○–○	○–○	○–○	○–○
Immunosuppressive drug *No / Yes*	○–○	○–○	○–○	○–○	○–○
If yes, specify	___	___	___	___	___

2. HISTORICAL OVERVIEW OF IRREVERSIBLE DISABILITY

Motor disability (Kurtzke DSS / EDMUS GS)

	Month	Year
3 Unlimited walking distance (WD) without rest but unable to run; or a significant not ambulation-related disability	___ ___	___ ___ ___ ___
4 Walks without aid; limited WD, but > 500 meters without rest	___ ___	___ ___ ___ ___
6 Walks with permanent uni- or bilateral support; WD < 100 meters without rest	___ ___	___ ___ ___ ___
7 Home restricted; a few steps with wall or furniture assistance; WD < 20 meters without rest	___ ___	___ ___ ___ ___
8 Chair restricted; unable to take a step; some effective use of arms	___ ___	___ ___ ___ ___
10 Death	___ ___	___ ___ ___ ___

Visual disability

	RE Year	LE Year
1 Amblyopia, VA ≥ 7/10	___ ___ ___ ___	___ ___ ___ ___
2 Amblyopia, VA ≥ 3/10 and ≤ 6/10	___ ___ ___ ___	___ ___ ___ ___
3 Amblyopia, VA = 2/10	___ ___ ___ ___	___ ___ ___ ___
4 Amblyopia, VA ≤ 1/10	___ ___ ___ ___	___ ___ ___ ___
7 No light perception	___ ___ ___ ___	___ ___ ___ ___

(Visual score according to Kurtzke, 1983 & Wingerchuk *et al.*, 1999)

LAST NAME, First name: _____ Date of birth: Day ___ Month ___ Year ____

3. HISTORICAL OVERVIEW OF PARACLINICAL EXAMS

M R I

Date: Day ___ Month ___ Year ____

	T1	T1/Gado	T2/PD/FLAIR	Number of lesions		
	Not done / Negative / Positive	Not done / Negative / Positive	Not done / Negative / Positive	Total	Peri-ventricular	Juxta-cortical
INITIAL BRAIN MRI ○ *NORMAL* ○ *ABNORMAL*				○ < 9, specify exact count: ___ ○ ≥ 9 ☐ Confluent lesions	○ 0 ○ 1 ○ 2 ○ ≥ 3	○ 0 ○ ≥ 1
Supratentorial						
Infratentorial						
MOST PATHOLOGICAL SPINAL CORD MRI				*Total* 0 1 ≥ 2	*Lesion ≥ 3 vertebral segments*	
Cervical					☐	
Thoracolumbar					☐	
OPTIC NERVE R				Images seen ○	Tick if FLAIR was used: ☐	
L				Information from report ○		

Evoked potentials

Date: Day ___ Month ___ Year ____

	Not done	Negative	Positive	RIGHT / LEFT	Not done	Negative	Positive
Visual	○	○	○		○	○	○

Cerebro-spinal fluid

Date: Day ___ Month ___ Year ____

Leucocytes

☐ Not done Exact count: ___ Neutrophils, exact count: ___

Biochemistry

	LCR (mg/l)	Sérum (g/l)
Total proteins:		
Albumin:		
IgG:		

IgG index: ___

Oligoclonal bands

○ Not done ○ No ○ Yes ○ Equivocal

Anti-DNMO antibodies

Date of sampling: Day ___ Month ___ Year ____

Was a search for anti-DNMO antibodies performed? ○ Yes — If yes: ○ No

Result: ○ Negative ○ Positive

Laboratory: ___

Technique: IIF / CBA / FIPA / other / unknown ○ ○ ○ ○ ○

If other, specify: ___

4. HISTORICAL OVERVIEW OF IMMUNOACTIVE TREATMENTS

Drug name	Date of start (Day / Month / Year)	Date of stopping (Day / Month / Year)	Reasons for stopping: Scheduled stop; Local intolerance; General intolerance; Biological intolerance; Inefficacy; Patient's convenience; Serious Adverse Event; Desire for pregnancy/Pregnancy; Other	Comment

LAST NAME, First name: _____ Date of birth: Day ___ Month ___ Year _____

5. CLINICAL EVALUATION OF THE DISEASE at the time of the inclusion visit

Date of exam: Day ___ Month ___ Year _____

Ambulation

Able to run: Yes / No

Walking distance without rest: ☐ Unlimited — >500 m — 300-500 — 200-300 — 100-200 — 20-100 — <20 m

Assistance required:
None / unilateral / bilateral / wheelchair (transfers alone) / wheelchair (help for transfer)

Kurtzke Functional Systems

Pyramidal		Brainstem	
Cerebellar	☐	Visual	☐
Sensory		Mental	
Sphincter		Other	

Kurtzke DSS and EDSS

Kurtzke DSS / EDMUS GS _____ **Kurtzke EDSS** _____

MOTOR DISABILITY SCALE : Kurtzke DSS / EDMUS GS

- 0 Normal findings on neurological examination
- 1.0 No disability; minimal signs on neurological examination
- 2.0 Minimal and not ambulation-related disability; able to run
- 3.0 Unlimited walking distance (WD) without rest but unable to run; or a significant not ambulation-related disability
- 4.0 Walks without aid; limited WD, but > 500 meters without rest
- 5.0 Walks without aid; WD < 500 meters without rest
- 6.0 Walks with permanent unilateral support; WD < 100 meters without rest
- 6.5 Walks with permanent bilateral support; WD < 100 meters without rest
- 7.0 Home restricted; a few steps with wall or furniture assistance; WD < 20 meters without rest
- 8.0 Chair restricted; unable to take a step; some effective use of arms
- 9.0 Bedridden and totally helpless
- 10 Death

Visual acuity

OD _____ OG _____

VISUAL SCALE
(according to Kurtzke, 1983 & Wingerchuk et al., 1999)

- 0 Normal exam
- 1 Amblyopia, VA ≥ 7/10
- 2 Amblyopia, VA ≥ 3/10 and ≤ 6/10
- 3 Amblyopia, VA = 2/10
- 4 Amblyopia, VA ≤ 1 /10
- 5 Counting fingers
- 6 Light perception only
- 7 No light perception

Motor

STRENGTH ***5*** *4 3 2 1 0* — ***5*** *4 3 2 1 0*

Shoulder
Elbow
Wrist/Fingers
Hip
Knee
Ankle/Toes

BMRC SCALE (British Medical Research Council)

- 5 Active motion, against full resistance
- 4 Active motion, against resistance
- 3 Active motion, against gravity
- 2 Active motion, if gravity is removed
- 1 Palpable muscle contraction only
- 0 No movement

Sensory

SUPERFICIAL TOUCH *Impairment:* ***None*** */ Mild / Moderate / Severe*

Arm
Forearm
Hand/Fingers
Thigh
Calf
Foot/Toes
Upper trunk
Lower trunk

PINPRICK / TEMPERATURE *Impairment:* ***None*** */ Mild / Moderate / Severe*

Arm
Forearm
Hand/Fingers
Thigh
Calf
Foot/Toes
Upper trunk
Lower trunk

VIBRATORY SENSATION *Impairment:* ***None*** */ Mild / Moderate / Severe*

Shoulder
Elbow
Wrist/Fingers
Hip
Knee
Ankle/Toes

POSITION SENSE *Impairment:* ***None*** */ Mild / Moderate / Severe*

Shoulder
Elbow
Wrist/Fingers
Hip
Knee
Ankle/Toes

Sphincter

BLADDER

- Pollakiuria — ***None*** */ Mild / Severe*
- Urgency — ***None*** */ Mild / Severe*
- Incontinence — ***None*** */ Rare / Frequent (>1/week)*
- Hesitancy — ***None*** */ Mild / Severe*
- Retention — ***None*** */ Mild / Severe*
- Catheterization — ***None*** */ Intermittent / Constante (≥3/day)*

BOWEL

- ☐ Constipation — ○ Symptomatic / ○ Requiring treatment
- ☐ Diarrhea
- ☐ Bowel incontinence

Please fax this form to the NOMADMUS Coordination Center at +33 4 72 68 49 03

Professional stamp (or neurologist's address)