

LAST NAME, First name: _____

Date of birth: Day Month Year

NOMADMUS Study – Follow-up form

Date of the follow-up visit: Day Month Year

1. NEUROLOGICAL EPISODES since last visit

Did a new relapse or the onset of the progressive phase occur since last visit?

Yes No

If yes, please fill up the following table:

	<div style="border: 1px solid black; padding: 2px; display: inline-block;"> </div> Subsequent relapse	Progressive phase			<div style="border: 1px solid black; padding: 2px; display: inline-block;"> </div> Without inaugural relapse	<div style="border: 1px solid black; padding: 2px; display: inline-block;"> </div> With inaugural relapse	<div style="border: 1px solid black; padding: 2px; display: inline-block;"> </div> Subsequent relapse
Date of episode onset: Day / Month							
Year							
Episode type (according to classification above):							
Episode semiology							
Walking difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower extremity dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper extremity dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory symptoms (pain, paresthesia...)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder/bowel dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oculomotor impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo, hypoacusia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech/swallowing impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental deterioration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paroxystic symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: if yes, specify							
Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical syndrome							
TRANSVERSE MYELITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Extensive / Non extensive</i>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>
OPTIC NEURITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Unilateral: Right - Left / Bilateral</i>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>
OTHER: if yes, specify							
Episode features							
Maximal motor score (Kurtzke DSS / EDMUS GS)							
Maximal visual score (Visual Scale) RE/LE							
Recovery <i>Complete / Incomplete / None</i>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>
Corticosteroid treatment <i>No / Yes</i>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>
<i>If yes: i.v. / i.m. / per os</i>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/> — <input type="checkbox"/>
Plasma exchange <i>No / Yes</i>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>
Immunoglobulins i.v. <i>No / Yes</i>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>
Immunosuppressive drug <i>No / Yes</i>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>	<input type="checkbox"/> — <input type="checkbox"/>
<i>If yes, specify</i>							

2. IRREVERSIBLE DISABILITY since last visit

Motor disability (Kurtzke DSS / EDMUS GS)	Visual disability
Month Year	RE Year LE Year
3 Unlimited walking distance (WD) without rest but unable to run; or a significant not ambulation-related disability	1 Amblyopia, VA ≥ 7/10
4 Walks without aid; limited WD, but > 500 meters without rest	2 Amblyopia, VA ≥ 3/10 and ≤ 6/10
6 Walks with permanent uni- or bilateral support; WD < 100 meters without rest	3 Amblyopia, VA = 2/10
7 Home restricted; a few steps with wall or furniture assistance; WD < 20 meters without rest	4 Amblyopia, VA ≤ 1/10
8 Chair restricted; unable to take a step; some effective use of arms	7 No light perception
10 Death	

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

3. PARACLINICAL ASSESSMENT since last visit

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
BRAIN <input type="radio"/> NORMAL <input type="radio"/> ABNORMAL Supratentorial Infratentorial				Total <input type="radio"/> < 9, specify exact count: _____ <input type="radio"/> ≥ 9 <input type="checkbox"/> Confluent lesions	Peri-ventricular <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> ≥ 3	Juxta-cortical <input type="radio"/> 0 <input type="radio"/> ≥ 1
SPINAL CORD Cervical Thoracolumbar				Total <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> ≥ 2 	Lesion ≥ 3 vertebral segments <input type="checkbox"/>	
OPTIC NERVE R L				Images seen <input type="radio"/> Information from report <input type="radio"/>	Tick if FLAIR was used: <input type="checkbox"/>	

Evoked potentials

Date: Day _____ Month _____ Year _____

	Not done Negative Positive	RIGHT	LEFT	Not done Negative Positive
Visual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Cerebro-spinal fluid

Date: Day _____ Month _____ Year _____

Leucocytes	<input type="checkbox"/> Not done	Exact count: _____	Neutrophils, exact count: _____
Biochemistry		LCR (mg/l)	Sérum (g/l)
		Total proteins: _____	
		Albumin: _____	
		IgG: _____	IgG index: _____
Oligoclonal bands	<input type="radio"/> Not done	<input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> Equivocal

Anti-DNMO antibodies

Date of sampling: Day _____ Month _____ Year _____

Was a search for anti-DNMO antibodies performed?	<input type="radio"/> Yes — If yes:	Result: <input type="radio"/> Negative <input type="radio"/> Positive
	<input type="radio"/> No	Laboratory: _____
		Technique: IIF / CBA / FIPA / other / unknown <input type="radio"/>
		If other, specify: _____

4. ONGOING DISEASE-MODIFYING TREATMENT AND MODIFICATION OF TREATMENT since last visit

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

5. CLINICAL EVALUATION OF THE DISEASE at the time of the follow-up 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	6.0 Walks with permanent unilateral support; WD < 100 meters without rest
1.0 No disability; minimal signs on neurological examination	6.5 Walks with permanent bilateral support; WD < 100 meters without rest
2.0 Minimal and not ambulation-related disability; able to run	7.0 Home restricted; a few steps with wall or furniture assistance; WD < 20 meters without rest
3.0 Unlimited walking distance (WD) without rest but unable to run; or a significant not ambulation-related disability	8.0 Chair restricted; unable to take a step; some effective use of arms
4.0 Walks without aid; limited WD, but > 500 meters without rest	9.0 Bedridden and totally helpless
5.0 Walks without aid; WD < 500 meters without rest	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist/Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BMRC SCALE (British Medical Research Council)

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

Sensory

SUPERFICIAL TOUCH Impairment: None / Mild / Moderate / Severe

Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand/Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thigh	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper trunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower trunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand/Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thigh	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot/Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper trunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower trunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VIBRATORY SENSATION Impairment: None / Mild / Moderate / Severe

Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist/Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

POSITION SENSE Impairment: None / Mild / Moderate / Severe

Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist/Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sphincter

BLADDER

Pollakiuria	<input type="checkbox"/>	None / Mild / Severe
Urgency	<input type="checkbox"/>	None / Mild / Severe
Incontinence	<input type="checkbox"/>	None / Rare / Frequent (>1/week)
Hesitancy	<input type="checkbox"/>	None / Mild / Severe
Retention	<input type="checkbox"/>	None / Mild / Severe
Catheterization	<input type="checkbox"/>	None / Intermittent / Constante (≥3/day)

BOWEL

<input type="checkbox"/> Constipation	<input type="checkbox"/> Symptomatic
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Requiring treatment
<input type="checkbox"/> Bowel incontinence	

Please fax this form to the NOMADMUS Coordination Center at +33 4 72 12 97 14

Professional stamp (or neurologist's address)