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:

Relapsing-remitting phase: B – *Subsequent relapse*

Progressive phase: C – *Without inaugural relapse*; D – *With inaugural relapse*; E – *Subsequent relapse*

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. IRREVERSIBLE DISABILITY since last visit

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. 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 ○ *NORMAL* ○ *ABNORMAL*										○ < 9, specify exact count: ___ ○ ≥ 9 ☐ Confluent lesions	○ 0 ○ 1 ○ 2 ○ ≥ 3	○ 0 ○ ≥ 1
Supratentorial												
Infratentorial												
SPINAL CORD										*Total* 0 1 ≥ 2	*Lesion ≥ 3 vertebral segments*	
Cervical											☐	
Thoracolumbar											☐	
OPTIC NERVE R										Images seen ○ Information from report ○	Tick if FLAIR was used: ☐	
L												

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

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 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
- 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*

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*

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)