To be considered a probable or confirmed case, the patient must have a highest recorded temperature greater than 100.4 °F. Otherwise, the patient is not a surveillance case and should be assigned as “not a case” in WVEDSS. Additionally, if the patient has a fever that may be caused by a more likely clinical explanation (e.g. another infection), then the patient is “not a case.”

Central or peripheral neurologic dysfunction may include meningitis, encephalitis, acute flaccid paralysis or other acute signs such as myelitis, peripheral neuritis, and nerve palsies and abnormal reflexes or movements.

Assays for detection of IgM and IgG antibodies such as enzyme-linked immunosorbent assay (ELISA), microsphere assay (MIA), and immunofluorescence assay (IFA) provide a presumptive diagnosis and should have confirmatory testing performed. Confirmatory testing involves detection of arboviral-specific neutralizing antibodies utilizing such assays as the plaque reduction neutralization test (PRNT).

Note: Vaccination history, detailed travel history, date of onset of symptoms, and knowledge of potentially cross-reactive arboviruses known to circulate in the region of exposure should be considered when interpreting results.
Virus-specific IgM antibodies in serum with confirmatory virus-specific neutralizing antibodies in the same or a later specimen

-OR-

Four-fold or greater change in virus-specific quantitative antibody titers in paired sera

-OR-

Virus-specific IgM antibodies in CSF and a negative result for other IgM antibodies in CSF for arbovirus endemic to the region of exposure

-OR-

Isolation of virus, or demonstration of specific viral antigen or nucleic acid in, tissue, blood, CSF, or other body fluid

Patient had a fever $\geq 100.4^{\circ}F$

Physician-documented central or peripheral neurologic dysfunction

Absence of neuroinvasive disease – AND – absence of a more likely clinical explanation

Neuroinvasive

Non-Neuroinvasive

Patient had a fever $\geq 100.4^{\circ}F$

Physician-documented central or peripheral neurologic dysfunction

Absence of neuroinvasive disease – AND – absence of a more likely clinical explanation

Neuroinvasive

Non-Neuroinvasive

Virus-specific IgM antibodies in CSF or serum with no other testing done

Physician-documented central or peripheral neurologic dysfunction

Absence of neuroinvasive disease – AND – absence of a more likely clinical explanation

Non-Neuroinvasive

Probable

1To be considered a probable or confirmed case, the patient must have a highest recorded temperature greater than 100.4 $^{\circ}F$. Otherwise, the patient is not a surveillance case and should be assigned as “not a case” in WVEDSS. Additionally, if the patient has a fever that may be caused by a more likely clinical explanation (e.g. another infection), then the patient is “not a case.”

2Central or peripheral neurologic dysfunction may include meningitis, encephalitis, acute flaccid paralysis or other acute signs such as myelitis, peripheral neuritis, and nerve palsies and abnormal reflexes or movements.

3Assays for detection of IgM and IgG antibodies such as enzyme-linked immunosorbent assay (ELISA), microsphere assay (MIA), and immunofluorescence assay (IFA) provide a presumptive diagnosis and should have confirmatory testing performed. Confirmatory testing involves detection of arboviral-specific neutralizing antibodies utilizing such assays as the plaque reduction neutralization test (PRNT).

Note: Vaccination history, detailed travel history, date of onset of symptoms, and knowledge of potentially cross-reactive arboviruses known to circulate in the region of exposure should be considered when interpreting results.