HEALTH ADVISORY #205
Acute Flaccid Myelitis (AFM)

TO: **West Virginia Healthcare Providers, Hospitals and Other Healthcare Facilities**

FROM: **Ayne Amjad, MD, MPH - Commissioner and State Health Officer**
West Virginia Department of Health and Human Resources, Bureau for Public Health

DATE: **September 13, 2022**

LOCAL HEALTH DEPARTMENTS: Please distribute to community health providers, hospital-based physicians, infection control preventionists, laboratory directors and other applicable partners.

OTHER RECIPIENTS: Please distribute to association members, staff, etc.

Acute Flaccid Myelitis (AFM) is a reportable condition in West Virginia. Suspected cases should be reported to the local health department (LHD) per the West Virginia Reportable Disease Rule (64 CSR7). AFM is an illness characterized by:

- acute onset of limb weakness (low muscle tone, limp, hanging loosely, not spastic or contracted), AND
- magnetic resonance imaging (MRI) showing lesions in the gray matter of the spial cord.

Surveillance has shown that AFM cases generally peak in the months of September and October. A biennial pattern has been observed with a larger number of cases reported in 2014, 2016, and 2018. In 2020, cases did not increase likely due to pandemic mitigation measures. Health officials are unsure what to expect in 2022. Public health partners and healthcare providers should be aware of the symptoms of AFM and the related resources to assist with identifying, reporting, and collecting specimens of suspected AFM cases at any time.

As of September 2, 2022, there have been 13 confirmed cases of AFM for 2022 in the United States; out of 33 reports of patients under investigation. There has been a total of 692 confirmed cases in the United States since the Centers for Disease Control and Prevention (CDC) began tracking AFM in August 2014. In West Virginia, 3 cases have been reported during the same time frame.

AFM is a known complication of certain viral infections, such as enteroviruses, West Nile Virus, Japanese Encephalitis virus, herpesvirus, and adenovirus. Coxsackie A16, EV-A71, and EV-D68 have been found in the spinal fluid of some patients with AFM. In July 2022, the New York State Department of Health reported identification of a case of vaccine-derived paralytic poliomyelitis (VDPV) in an immunocompetent adult with no related travel history who was unvaccinated. This is the first VDPV poliomyelitis case in the United States since 2013. VDPV was also found in wastewater sampling in New York. VDPV is a strain related to the weakened live poliovirus. When the VDPV circulates in under or unimmunized populations or replicates in immunodeficient individuals, the virus can revert to a form that can cause illness and paralysis.

Since no specific etiology of AFM has been identified, the West Virginia Department of Health and Human Resources, Bureau for Public Health continues to assist the CDC in looking for possible risk factors and causes.

This message was directly distributed by the West Virginia Bureau for Public Health to local health departments and professional associations. Receiving entities are responsible for further disseminating the information as appropriate to the target audience.
Categories of Health Alert messages:
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Symptoms of AFM include:

- sudden onset of arm or leg weakness and loss of muscle tone and reflexes
- facial droop/weakness
- difficult moving the eyes
- drooping eyelids
- difficulty swallowing or slurred speech

Recommendations for Healthcare Providers:

1. Clinicians should be on alert for identifying acute flaccid limb weakness and consider AFM on the differential diagnosis. Strongly consider AFM in patients with acute flaccid limb weakness, especially after respiratory illness or fever, and between the months of August and November 2022. Given the recent events in New York, it is also important to rule out polio when considering AFM diagnosis in patients.

2. Clinicians should ensure the case meets case reporting criteria (acute flaccid limb weakness, and MRI with at least some gray matter lesions in the spina cord).

3. If AFM is suspected, the LHD will need to collect the following information from the clinician for submission to CDC for case review:
   - *Patient Summary Form:* https://www.cdc.gov/acute-flaccid-myelitis/downloads/patient-summary-form.pdf. A form that has pending information should still be sent. Pending results can be provided when they become available.
   - MRI report (spine and brain with and without contrast)
   - Laboratory results
   - Neurology consult notes and images. Hospitals will be provided a link once a suspect case is reported to facilitate timely transmission of these images to CDC.

4. Assess the patient for risk of poliomyelitis (polio). Is the patient unvaccinated or under-vaccinated against polio? Did the patient recently travel to or had contact with anyone who recently traveled to areas at-risk for polio transmission? If yes to any of the questions, obtain stool samples (two stool specimens 24 hours apart) as soon as possible for poliomyelitis testing at CDC and notify the LHD.

5. Collect cerebrospinal fluid (CSF), blood, stool, and respiratory specimens from patients **as soon as possible** in the course of the illness, preferably the **day of onset of limb weakness** (two specimens taken at least 24 hours apart within 14 days of onset of limb weakness). For instructions on specimen collection, see the *Job Aid for Clinicians* at https://www.cdc.gov/acute-flaccid-myelitis/downloads/job-aid-for-clinicians-508.pdf.

6. Notify the LHD to coordinate shipment of specimens. The LHD will help coordinate specimen shipment to the CDC via the West Virginia Office of Laboratory Services.

For more information about AFM, visit https://www.cdc.gov/acute-flaccid-myelitis/index.html.

For questions about this advisory, contact the Office of Epidemiology and Prevention Services (OEPS) at 304-558-5358, ext. 2; or the 24/7 answering service at 304-342-5151.

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