**Suspected Myasthenia Gravis following administration of COVID-19 vaccine\***

Local Identification Number: Adverse Event Reference Number:

Patient Initials: Patient Age: Patient Sex:

Ethnicity:

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| **Source of information** | | | |
| Name of the person reporting |  | Position (e.g. specialty and grade) |  |
| Hospital / Practice |  | Email address |  |

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| **Patient Background** | |
| Past Medical History: | |
| Regular and recent medications: | |
| Infectious illness in the last six weeks: | Yes/ No/ Unsure |
| Other vaccination received in the last six weeks: | Yes/ No/ Unsure |
| Previous adverse neurological reaction to a vaccine: | Yes/ No/ Unsure |
| History of neurological disease (previous or current): | Yes/ No/ Unsure |
| Immunosupression at the time of vaccination: | Yes/ No/ Unsure |
| If Yes to any above, please provide details: | |

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| **Patient’s Covid-19 Status** | |
| Previous diagnosis of Covid-19: | Yes, once/  Yes, more than once/ No/ Unsure |
| If Yes, date of onset: | Date: |
| If Yes, means of diagnosis: | PCR/ Antibody / Clinical |

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| **Vaccination Details** | |
| 1st vaccination: Pfizer-BioNTech/ Oxford- AstraZeneca/ Moderna/ Sinopharm/ Sinovac/ Sputnik V/ Other- specify:  Lot number: \_\_\_\_\_ Dose: \_\_\_\_ Route of administration: | Date: |
| 2nd vaccination: Pfizer-BioNTech/ Oxford- AstraZeneca/ Moderna/ Sinopharm/ Sinovac/ Sputnik V/ Other- specify:  Lot number: \_\_\_\_\_ Dose: \_\_\_\_ Route of administration: | Date: |
| Date of neurological symptoms onset | Date: |

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| **Case Definition** | |
| Abnormal, fatigueable weakness affecting skeletal muscles | Yes/No/ Unsure |
| PLUS No evidence of upper and lower motor neuron impairment | Yes/No/ Unsure |
| PLUS Unknown Aetiology | Yes/No/ Unsure |

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| **Clinical Features** | |
| Time from onset to peak symptoms (hrs/days): | |
| Ptosis | Yes/ No/ Unknown |
| Diplopia | Yes/ No/ Unknown |
| Dysphagia | Yes/ No/ Unknown |
| Dysarthria | Yes/ No/ Unknown |
| Dyspnoea | Yes/ No/ Unknown |
| Neuromuscular respiratory failure | Yes/ No/ Unknown |
| Upper limb weakness | Unilateral / Bilateral / None / Unknown |
| Lower limb weakness | Unilateral / Bilateral / None / Unknown |
| Other relevant symptoms and signs, including neurological and systemic features: | |
| Has the patient experienced a similar neurological event before? Yes/No/Unsure  If Yes, please provide details, including the date and suspected triggers: | |

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| **Assessment and investigations to exclude other causes** (please indicate which of the following have been considered, and give details at the bottom) | |
| **Clinical assessment** (give details at the bottom) | |
| Is there:   * Family history of muscle disease? * Use of medications that may exacerbate myasthenia? | Yes/ No/ Unknown  Yes/ No/ Unknown |
| **Laboratory investigations** | |
| * Anti-AChR * Anti-MUSK * Anti-LRK4 * Anti-VGCC * CK * COVID-19 serology/ PCR | Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal |
| Any other relevant laboratory results: | |
| **Radiological studies** | |
| * Chest radiograph * CT Chest * CT Head * MRI Head | Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal  Normal/ Unknown/ Not Done/ Abnormal |
| **Electrophysiology studies** | Normal/ Unknown/ Not Done/ Abnormal |
| **Muscle biopsy** | Normal/ Unknown/ Not Done/ Abnormal |
| **Genetic Testing** | Normal/ Unknown/ Not Done/ Abnormal |
| **Details of any abnormal findings:** | |
| **Please describe if any of the findings could explain the aetiology of the event:** | |

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| **Treatment** (including dose and duration) |
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| **Patient Outcome** |
| Date of last follow-up (if none, write none): |
| Maximum level of care required:  Outpatient/ Medical Inpatient/ High Dependency Unit/ Intensive Care Unit |
| Patient alive at last follow-up: Yes/ No  If No, was Myasthenia Gravis included on the death certificate: Yes/ No/ Unknown  If relevant, date of death: |
| Nutritional Support: Yes- please provide details/ No/ Unkown  Ventilation: Yes- please provide details/ No/ Unknown |
| Outcome at the last follow up (circle):  Complete resolution / Incomplete resolution / No improvement / Re-occurrence / Other sequalae  If relevant, time to complete resolution: \_\_\_\_\_\_\_\_\_ |
| Modified Ranking Scale: Before adverse event:\_\_\_\_\_\_\_ At the last follow-up: \_\_\_\_\_\_ |
| Details: |

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| **Subsequent COVID-19 Vaccinations** | |
| Has this patient received any further COVID-19 vaccines after the development of the neurological adverse event? | Yes/ No/ Unsure |
| If Yes: Pfizer-BioNTech/ Oxford- AstraZeneca/ Moderna/ Sinopharm/ Sinovac/ Sputnik V/ Other- specify:  Lot number: \_\_\_\_\_ Dose: \_\_\_\_ Route of administration: | Date: |
| If Yes, Outcome: No adverse event/ Re-occurrence of the same adverse event/ Development of another neurological adverse event/ Worsening of previously unresolved neurological adverse event/ Other sequelae  Date the outcome was last known: | |
| Other details: | |