CASE REPORT FORM

Multiple Sclerosis and Covid-19

STUDY CODE: MuSC-19

PATIENT ID: ☐☐ — ☐☐

Site code - Patient code

CONFIDENTIAL

UNIVERSITÀ DEGLI STUDI DI GENOVA — SCLEROSI MULTIPLA associazione italiana — Sin SOCIETÀ ITALIANA DI NEUROLOGIA

PATIENT ID: | | | — | | |

DEMOGRAPHY AND BASELINE DATA

COUNTRY SITE: _____

TYPE OF CONTACT:
☐ HOSPITAL VISIT
☐ TELEPHONE CONTACT
☐ COMPLETED BY EMAIL

DATE OF VISIT (OR TELEPHONE CONTACT)
|__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

DATE OF WRITTEN INFORMED CONSENT: |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

SEX ☐ Male ☐ Female

AGE |___|___|___| years

HEIGHT |___|___|___|,|___| cm

WEIGHT |___|___|___|,|___| Kg

ETHNICITY
☐ Caucasian
☐ Black or African-American
☐ Asian
☐ Other_____

PREGNANCY ☐ No ☐ Yes ☐ N.A. (male)

EMPLOYMENT
☐ Any/Not employed
☐ Office clerk
☐ Workman
☐ Unfit for work
☐ Student
☐ Retired
☐ Other _____

NUMBER OF COHABITANTS |___|___|

How many of these are school-age children?
|___|___|

NUMBER OF COVID⁺ COHABITANTS |___|___|

WORK IN THE HEALTHCARE SECTOR Physician ☐ Nurse ☐ Healthcare assistant ☐

SMOKER HISTORY
☐ Never smoked
☐ Former smoker
☐ Current smoker → Vaping ☐ Cigarettes ☐

ALCOHOL
☐ Never used alcohol
☐ Occasional consumption
☐ Regular consumption

SUBSTANCE ABUSE Any history of alcohol/drug abuse within the last year? ☐ No ☐ Yes

MS HISTORY

MS-TYPE
☐ Relapsing remitting MS (RRMS)
☐ Secondary progressive MS (SPMS)
☐ Primary progressive MS (PPMS)

DATE OF MS DIAGNOSIS
|__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

Last available EDSS |___|___| **Date of EDSS assessment** |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

IN TREATMENT AT THE TIME OF THE FIRST SIGNS/SYMPTOMS OF INFECTION ☐ No ☐ Yes

IF YES, TYPE OF DMD ☐ I LINE ☐ II LINE

IF YES, NAME OF DMD

☐ Alemtuzumab	☐ Methotrexate	☐ Fingolimod
☐ Azatioprina	☐ Mitoxantrone	☐ Rituximab
☐ Copaxone	☐ Natalizumab	☐ Teriflunomide
☐ Daclizumab	☐ Ocrelizumab	☐ Other
☐ Dimethyl fumarate	☐ Interferon	_____

START DATE OF LAST DMD |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

STOP DATE OF LAST DMD |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y ☐ **ONGOING**

IF STOPPED, REASON FOR DMD INTERRUPTION

☐ For COVID infection	☐ Pregnancy or pregnancy planning
☐ End of the therapeutic cycle	☐ Adverse event / Side Effect
☐ Lack of efficacy	☐ Other_____
☐ Patient's decision	

ANY CYCLE OF METHYLPREDNISOLONE OR OTHER GLUCOCORTICOID WITHIN LAST 3 MONTHS?
☐ No ☐ Yes
If YES:
Start date |__|__| |__|__| |__|__|__|__| **Stop date** |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y D D M M Y Y Y Y

LAST WHITE BLOOD CELL COUNT *(prior this visit)*
Date of assessment:
|__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y
Results:
☐ NORMAL OR NCS
☐ ABNORMAL AND CS → **Value**: _____

LYMPHOCYTE COUNT *(prior this visit)*
Date of assessment:
|__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y
Results:
☐ NORMAL OR NCS
☐ ABNORMAL AND CS → **Value**: _____

PATIENT ID: |__|__| — |__|__|

COMORBIDITIES, TREATMENTS AND SURGERY

ONGOING COMORBIDITIES: ☐ No ☐ Yes → **If YES, please details below**

	Disease	**Diagnosis date** (DD MM YYYY)	**If treated, name of treatment**
☐	Cerebrovascular disease	|__|__| |__|__| |__|__|__|__|	____________
☐	Haematological disease	|__|__| |__|__| |__|__|__|__|	____________
☐	Coronary heart disease	|__|__| |__|__| |__|__|__|__|	____________
☐	Hypertension	|__|__| |__|__| |__|__|__|__|	____________
☐	Diabetes	|__|__| |__|__| |__|__|__|__|	____________
☐	Chronic liver disease	|__|__| |__|__| |__|__|__|__|	____________
☐	Chronic kidney disease	|__|__| |__|__| |__|__|__|__|	____________
☐	Malignant tumor	|__|__| |__|__| |__|__|__|__|	____________
☐	HBV	|__|__| |__|__| |__|__|__|__|	____________
☐	HIV	|__|__| |__|__| |__|__|__|__|	____________
☐	Major depressive disorder	|__|__| |__|__| |__|__|__|__|	____________
☐	Other ____________	|__|__| |__|__| |__|__|__|__|	____________

SURGERY IN THE LAST YEAR: ☐ No ☐ Yes → **If YES, please details below**

Surgery	**Surgery date** (DD MM YYYY)
____________	|__|__| |__|__| |__|__|__|__|
____________	|__|__| |__|__| |__|__|__|__|
____________	|__|__| |__|__| |__|__|__|__|
____________	|__|__| |__|__| |__|__|__|__|

COVID19 – SIGNS, SYMPTOMS AND SOURCE OF INFECTION

DATE OF FIRST SYMPTOMS:

|__|__| |__|__| |__|__|__|__|

D D M M Y Y Y Y

FEVER AT ADMISSION: ☐ No ☐ Yes

↓

IF YES

Date of fever onset:

|__|__| |__|__| |__|__|__|__|

D D M M Y Y Y Y

Temperature: |___|___| °C

OTHER SYMPTOMS:

☐ COUGH
☐ FATIGUE
☐ SPUTUM PRODUCTION
☐ SORE THROAT
☐ HEADACHE
☐ BONE OR JOINT PAIN
☐ SHORTNESS OF BREATH
☐ NASAL CONGESTION
☐ CHILLS
☐ LOSS OF TASTE
☐ LOSS OF SMELL
☐ OTHER _____

SIGNS OF INFECTION:

☐ LYMPH NODES ENLARGED
☐ TONSILS SWELLING
☐ THROAT CONGESTION
☐ RASH
☐ OTHER _____

POTENTIAL EXPOSURE TO SOURCE OF TRANSMISSION WITHIN PAST TWO WEEKS?

☐ No ☐ Yes

IF YES, PLEASE DETAIL _____

_____

SUPPOSED GEOGRAPHICAL AREA OF INFECTION: _____

COVID19 – LABORATORY AND RADIOLOGICAL DATA

DATE OF LABORATORY DATA:

|__|__| |__|__| |__|__|__|__|

D D M M Y Y Y Y

NOT EXECUTED ☐

WHITE BLOOD CELL COUNT: (Not done ☐)
☐ NORMAL OR NCS
☐ ABNORMAL AND CS → **Value**: _____

RED BLOOD CELL COUNT: (Not done ☐)
☐ NORMAL OR NCS
☐ ABNORMAL AND CS → **Value**: _____

LYMPHOCYTE COUNT: (Not done ☐)
☐ NORMAL OR NCS
☐ ABNORMAL AND CS → **Value**: _____

PLATELET COUNT: (Not done ☐)
☐ NORMAL OR NCS
☐ ABNORMAL AND CS → **Value**: _____

HEMOGLOBIN: (Not done ☐)
☐ NORMAL OR NCS
☐ ABNORMAL AND CS → **Value**: _____

PaO2/FiO2 RATIO: (Not done ☐)
☐ NORMAL OR NCS
☐ ABNORMAL AND CS → **Value**: _____

CHEST RADIOGRAPH:

|__|__| |__|__| |__|__|__|__|

D D M M Y Y Y Y

NOT EXECUTED ☐

FINDING: ☐ NORMAL ☐ ABNORMAL

CHEST CT:

|__|__| |__|__| |__|__|__|__|

D D M M Y Y Y Y

NOT EXECUTED ☐

FINDING: ☐ NORMAL ☐ ABNORMAL

CHEST ULTRASOUND:

|__|__| |__|__| |__|__|__|__|

D D M M Y Y Y Y

NOT EXECUTED ☐

FINDING: ☐ NORMAL ☐ ABNORMAL

LOCATION: ☐ UNILATERAL ☐ BILATERAL

DISTRIBUTION: ☐ CENTRAL ☐ PERIPHERAL ☐ ALL

LESION INVOLVMENT: ☐ SINGLE LESION ☐ MULTIPLE LESIONS ☐ DIFFUSE

CHECK ALL ABNORMALITIES REVEALED:

☐ GROUND GLASS OPACITY ☐ CONSOLIDATION ☐ PATCHY SHADOWING

☐ INTERSTITIAL ABNORMALITIES ☐ OTHER _____

PRESENCE OF PNEUMONIA ☐ No ☐ Yes

PLEASE, BRIEFLY REPORT ANY FURTHER SIGNIFICANT FINDINGS:

_____

_____

COVID19 – DIAGNOSIS AND TREATMENTS

FIRST STREP THROAT: ☐ Negative ☐ Positive ☐ Not executed

SECOND STREP THROAT: ☐ Negative ☐ Positive ☐ Not executed

DATE OF COVID DIAGNOSIS:

|__|__| |__|__| |__|__|__|__|

D D M M Y Y Y Y

TREATMENTS:
☐ ANTIVIRAL
☐ CHLOROQUINE
☐ HYDROXYCHLOROQUINE
☐ INTRAVENOUS ANTIBIOTICS
☐ SYSTEMIC GLUCOCORTICOIDS
☐ OXYGEN THERAPY
☐ INTRAVENUS IMMUNE GLOBULIN
☐ OTHER

PLEASE SPECIFY ALL DETAILS RELATED TREATMENTS FOR COVID IN THE DEDICATED SECTION OF THE CRF

MECHANICAL VENTILATION: ☐ No ☐ Yes → **IF YES:** ☐ INVASIVE ☐ NOT INVASIVE

SEVERITY, IF COVID POSITIVE: ☐ MILD ☐ SEVERE ☐ CRITICAL

Critical cases: *Critical cases include patients who suffered respiratory failure, septic shock, and/or multiple organ dysfunction/failure.*
Severe cases*: This includes patients suffer from shortness of breath, respiratory frequency ≥ 30/minute, blood oxygen saturation ≤93%, PaO2/FiO2 ratio <300,28 and/or lung infiltrates >50% within 24–48 hours.*
Mild cases: *Mild cases include all patients without pneumonia or cases of mild pneumonia.*

HOSPITALIZATION: ☐ No ☐ Yes

IF YES, DATE OF HOSPITALIZATION:

|__|__| |__|__| |__|__|__|__|

D D M M Y Y Y Y

COVID19 – DETAILED TREATMENTS FOR COVID19

1.

Trade Name: _____

Start date: |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y) **Stop date:** |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y)

☐ Ongoing

Total daily dose and unit: _____ **Route of administration:** _____

Indication: _____

2.

Trade Name: _____

Start date: |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y) **Stop date:** |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y)

☐ Ongoing

Total daily dose and unit: _____ **Route of administration:** _____

Indication: _____

3.

Trade Name: _____

Start date: |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y) **Stop date:** |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y)

☐ Ongoing

Total daily dose and unit: _____ **Route of administration:** _____

Indication: _____

4.

Trade Name: _____

Start date: |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y) **Stop date:** |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y)

☐ Ongoing

Total daily dose and unit: _____ **Route of administration:** _____

Indication: _____

COVID19 – FOLLOW UP 1 [+ 1 week]

DATE OF VISIT: |__|__| |__|__| |__|__|__|__|
(OR TELEPHONE CONTACT) D D M M Y Y Y Y

OUTCOME:

☐ STABLE

☐ RECOVERED |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

☐ RECOVERING

☐ WORSENING *Please, details occurred complications in the dedicated section*

☐ DEATH |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

Cause of death: _____

HOSPITALIZATION SINCE PREVIOUS CONTACT:

☐ HOSPITALIZED |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

☐ DISCHARGED FROM HOSPITAL |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

COVID19 – FOLLOW UP 2 [+ 2 weeks]

DATE OF VISIT: |__|__| |__|__| |__|__|__|__|
(OR TELEPHONE CONTACT) D D M M Y Y Y Y

OUTCOME:

☐ STABLE

☐ RECOVERED |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

☐ RECOVERING

☐ WORSENING *Please, details occurred complications in the dedicated section*

☐ DEATH |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

Cause of death: _____

HOSPITALIZATION SINCE PREVIOUS CONTACT:

☐ HOSPITALIZED |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

☐ DISCHARGED FROM HOSPITAL |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

COVID19 – FOLLOW UP 3 [+ 3 weeks]

DATE OF VISIT: |__|__| |__|__| |__|__|__|__|
(OR TELEPHONE CONTACT) D D M M Y Y Y Y

OUTCOME:

☐ STABLE

☐ RECOVERED |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

☐ RECOVERING

☐ WORSENING *Please, details occurred complications in the dedicated section*

☐ DEATH |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

Cause of death: _____

HOSPITALIZATION SINCE PREVIOUS CONTACT:

☐ HOSPITALIZED |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

☐ DISCHARGED FROM HOSPITAL |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

COVID19 – FOLLOW UP 4 [+ 4 weeks]

DATE OF VISIT: |__|__| |__|__| |__|__|__|__|
(OR TELEPHONE CONTACT) D D M M Y Y Y Y

OUTCOME:

☐ STABLE

☐ RECOVERED |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

☐ RECOVERING

☐ WORSENING *Please, details occurred complications in the dedicated section*

☐ DEATH |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

Cause of death: _____

HOSPITALIZATION SINCE PREVIOUS CONTACT:

☐ HOSPITALIZED |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

☐ DISCHARGED FROM HOSPITAL |__|__| |__|__| |__|__|__|__|
D D M M Y Y Y Y

COVID19 – COMPLICATIONS AND COMMENTS

1.

COMPLICATION, DESCRIPTION: _____

_____

_____

Start date: |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y) **End date:** |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y)

☐ Ongoing

2.

COMPLICATION, DESCRIPTION: _____

_____

_____

Start date: |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y) **End date:** |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y)

☐ Ongoing

3.

COMPLICATION, DESCRIPTION: _____

_____

_____

Start date: |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y) **End date:** |__|__| |__|__| |__|__|__|__| (D D M M Y Y Y Y)

☐ Ongoing

Any other relevant COMMENT_____

_____

_____

_____