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Creutzfeldt-Jakob disease surveillance in Australia: update to 31 December 2022

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Creutzfeldt-Jakob disease surveillance in Australia: update to 31 December 2022

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Abstract

Nationwide surveillance of Creutzfeldt-Jakob disease (CJD) and other human prion diseases is performed by the Australian National Creutzfeldt-Jakob Disease Registry (ANCJDR). National surveillance encompasses the period since 1 January 1970, with prospective surveillance occurring from 1 October 1993. Over this prospective surveillance period, considerable developments have occurred in pre-mortem diagnostics; in the delineation of new disease subtypes; and in a heightened awareness of prion diseases in healthcare settings. Surveillance practices of the ANCJDR have evolved and adapted accordingly. This report summarises the activities of the ANCJDR during 2022.

Since the ANCJDR began offering diagnostic cerebrospinal fluid (CSF) 14-3-3 protein testing in Australia in September 1997, the annual number of referrals has steadily increased. In 2022, a total of 599 domestic CSF specimens were referred for diagnostic testing and 79 persons with suspected human prion disease were formally added to the national register. As of 31 December 2022, just under half of the 79 suspect case notifications (36/79) remain classified as 'incomplete'; 15 cases were classified as 'definite' and 23 as 'probable' prion disease; five cases were excluded through neuropathological examination. For 2022, fifty-five percent of all suspected human-prion-disease-related deaths in Australia underwent neuropathological examination. No cases of variant or iatrogenic CJD were identified. The SARS-CoV-2 pandemic did not affect prion disease surveillance outcomes in Australia during 2022.

Keywords: Creutzfeldt-Jakob disease; prion disease; transmissible spongiform encephalopathy; disease surveillance

Introduction

Of the human prion diseases (also known as transmissible spongiform encephalopathies), the most common is Creutzfeldt-Jakob disease (CJD). As described previously,¹ human prion disease mostly arises sporadically, but can occur through person-to-person transmission or from a genetic aetiology. The Australian National Creutzfeldt-Jakob Disease Registry (ANCJDR) was established in 1993 as part of the response to four people dying from CJD related to fertility treatment utilising cadaveric pituitary hormones. In the following year,² the Allars inquiry released its findings into the use

of cadaver-derived pituitary hormones under the Australian Human Pituitary Hormone Program and the association with four medically-acquired (iatrogenic) CJD (iCJD) deaths, recommending a broadening of the responsibilities of the then nascent ANCJDR. In addition to monitoring for further cases of iCJD in Australia, related to cadaveric pituitary hormone treatment for infertility or short stature and contaminated dura mater grafts, the ANCJDR's activities have evolved to encompass the surveillance of all types of CJD, including sporadic, genetic and variant CJD (vCJD: the zoonosis related to bovine spongiform encephalopathy [BSE]), as well as other prion diseases

such as Gerstmann-Sträussler-Scheinker syndrome and fatal sporadic or familial insomnia. Human prion disease became a notifiable disease in all states and territories of Australia as of June 2006.

Initial case awareness at the ANCJDR mostly arises through diagnostic testing requests made to the ANCJDR. After a preliminary review of referred cases, those deemed to be genuine suspected human prion disease undergo further detailed evaluation and addition to the national surveillance register, to determine whether a case can be excluded from suspicion or can be classified as a 'definite', 'probable' or 'possible' prion disease case according to diagnostic criteria endorsed by the Creutzfeldt-Jakob Disease International Surveillance Network (colloquially EUROCJD) and to determine the aetiology of the illness.³

The incidence of sporadic CJD (sCJD) is commonly reported to be approximately one case per million per year; however, in most countries with longstanding surveillance systems in place, annual incidence rates have been consistently reported above this quoted figure.⁴ Multi-national collaborative studies show that intensity of surveillance correlates with reported incidence rates.⁵ Temporally, human prion disease incidence rates have increased in most countries, including Australia, as surveillance mechanisms have been optimised and diagnostic testing capabilities improved, in parallel with a generally greater awareness of this rare disease in the healthcare setting.

In this report, updated national surveillance figures to 31 December 2022 are provided for all retrospective (to 1970) and prospective (from 1993) cases ascertained, including a discussion on case notifications, classifications and overall incidence.

Surveillance methods

Patients with suspected human prion disease have been prospectively notified to the ANCJDR since October 1993. From 1997 onwards, suspected cases have been increasingly notified through referral for cerebrospinal fluid (CSF) 14-3-3 protein western blot testing, which has over time become the predominant source of initial ANCJDR awareness of suspected CJD cases. Other ascertainment mechanisms include, or have included, personal communications from clinicians, families, hospitals and CJD-related groups, as well as health record searches through hospitals and health departments.

Once referred to the ANCJDR, referrals undergo a *prima facie* assessment and, if the suspicion of prion disease is supported, the case is notified to the appropriate health department and added to the ANCJDR register as a formal 'suspected case' for continued surveillance and evaluation with the aim of exclusion or classification according to EUROCJD-endorsed diagnostic criteria. Evaluation of registered cases can be prolonged, as the ANCJDR requires next-of-kin consent to access and compile the appropriate clinical information from various health information sources to facilitate a comprehensive review. Response times can vary, as the information can be extensive or sources numerous. Medico-demographic questionnaires are offered and forwarded to families, if they are willing to contribute, providing valuable information for analysis and evaluation.

Classification of registered cases remains as 'incomplete' until all known available information is gathered and reviewed, or until a definitive result from neuropathological assessment is obtained. Cases may be excluded from the register based on neuropathological examination or after thorough clinical evaluation. A 'definite' classification requires brain neuropathological examination, including immunochemical analysis; 'probable' and 'possible' cases are reliant on a specific clinical profile and diagnostic test outcomes being met as previously described.³ As of 1 January 2017, the diagnostic criteria

were amended to include a positive result in the real-time quaking-induced conversion (RT-QuIC) assay using CSF or other tissues in a person with a progressive neurological syndrome. The updated EUROCD diagnostic criteria for surveillance of sporadic CJD are listed in Appendix A. In keeping with previous reports, the total number of confirmed prion disease cases for 2022, including for statistical analyses, are those that have been classified as 'definite' or 'probable' cases.

To support surveillance responsibilities, the ANCJDR provides diagnostic platforms for ante- and post-mortem testing for human prion diseases. The testing of CSF for the presence of a family of low-molecular-weight proteins (14-3-3) has been performed weekly by the ANCJDR since 1997. This accredited test has been readily utilised by clinicians. In 2017, the ANCJDR formally added estimation of CSF total-tau protein concentrations, which is also National Association of Testing Authorities/International Laboratory Accreditation Cooperation (NATA/ILAC) accredited, for the diagnosis of human prion disease. The concentration of total-tau protein in CSF is measured by Roche Elecsys® technology.ⁱ Since January 2021, the RT-QuIC assay is performed routinely on all CSF specimens referred for diagnostic testing with sufficient sample volume. The ANCJDR also undertakes western blot analysis for misfolded, protease-resistant prion protein in brain and tonsil tissue from biopsies or autopsies as supplementary immunohistochemical assessments, as required for diagnostic and sub-classification purposes. Prion protein gene (*PRNP*) testing for sequence variations in the open reading frame, particularly for proven disease-causing mutations, is performed by an external independent provider as appropriate. Upon request, the ANCJDR performs deoxyribonucleic acid (DNA) extractions from frozen post-mortem

brain tissue, which can be used for *PRNP* testing. The ANCJDR actively promotes all diagnostic tests to clinicians and families to achieve the most accurate diagnosis and classification of persons suspected to suffer from prion disease.

Annual human prion disease incidence rates are calculated using direct age-standardisation, based on the 1970–2022 Australian Bureau of Statistics estimated resident population data for Australia and for each state and territory.ⁱⁱ Health information is collected through a combination of public health and surveillance responsibilities, based on the national notification of communicable diseases in observance of the *National Health Security Act 2007* and *Privacy Act 1988* (Cth) 16B. ANCJDR surveillance activities for 2022 were approved by the University of Melbourne Human Research Ethics Committee (#20361).

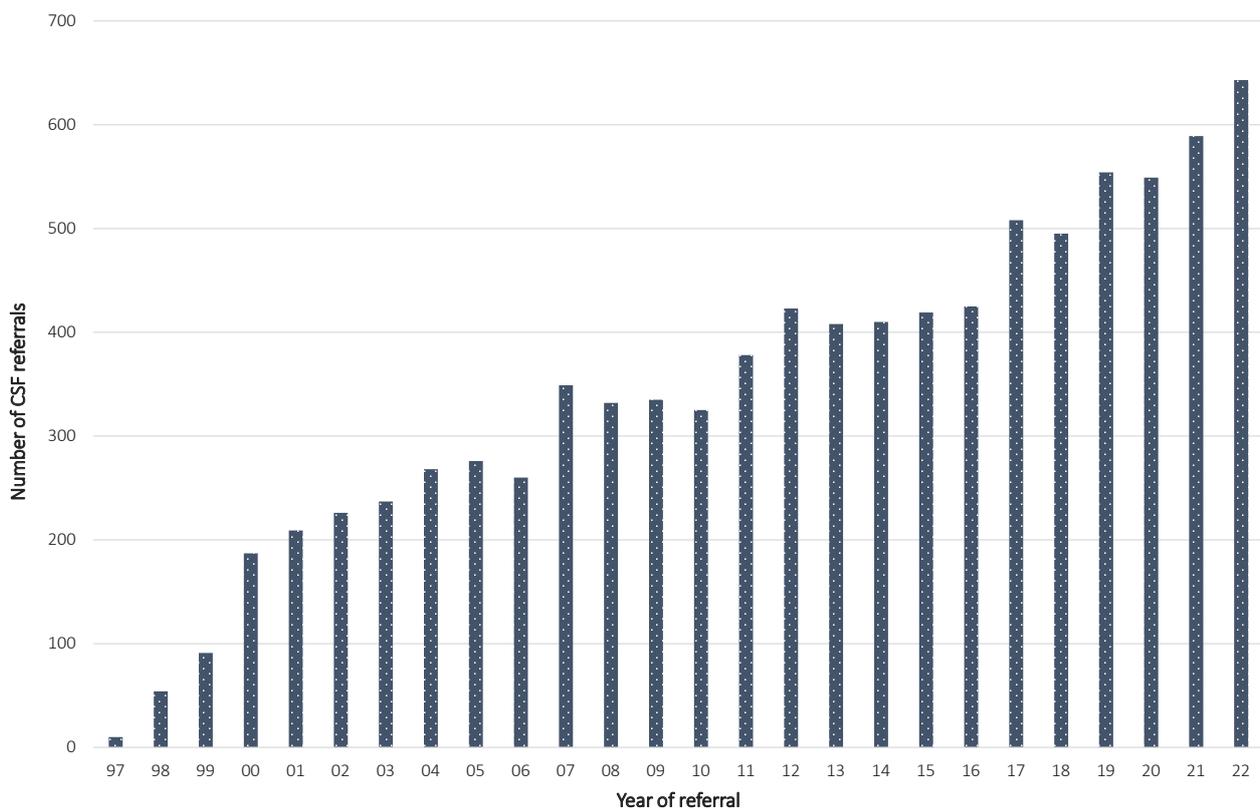
Results

In 2022, the ANCJDR received 599 domestic CSF specimens for diagnostic testing. This number reflects a continuing positive trend in annual CSF referral numbers and represents an increased awareness and perceived utility of CSF diagnostic testing by clinicians (Figure 1). In 2022, non-domestic CSF referrals made up 7% of the total CSF specimens received by the ANCJDR. The majority of domestic CSF referrals come from the most populous states, in which there has been a noticeable steady increase in test referrals, while CSF referrals from the Australian Capital Territory, the Northern Territory and Tasmania have remained relatively unchanged. Notably, diagnostic test referrals from New South Wales have increased more rapidly over the last decade than those from all other states, increasing from an average referral rate of 12 referrals per million population per year (1997–2012) to 23 referrals per

i Roche Diagnostics. The power of Elecsys® in Alzheimer's disease. [Internet.] Basel: Roche Diagnostics; 2022. Available from: <https://diagnostics.roche.com/global/en/article-listing/health-topics/neurology/the-power-of-elecsys-in-alzheimers-disease.html>.

ii Australian Bureau of Statistics. 3101.0 National, state and territory population – June 2022. Tables 51–59. Accessed on 1 February 2023. Available from: <https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release#data-download>.

Figure 1: Annual number of CSF specimens referred to the ANCJDR for diagnostic testing, from 1997 to 2022



million population per year (2013–2022). The national average CSF referral rate for the period of 1997–2022 is 14 referrals per million per year; the Northern Territory has the lowest rate of CSF referrals (4 referrals per million per year), while all other states range between 10 referrals per million per year (Western Australia) to 17 referrals per million per year (Tasmania).

During 2022, seventy-nine persons with suspected human prion disease were added to the national CJD surveillance register following *prima facie* review. Of these, six cases were known to the ANCJDR prior to 2022 through CSF referrals (3), genetic counselling services (2) and neuropathology services (1). At the time of their initial notification in 2021, these cases were not added to the register due to a low level of suspicion for prion disease after initial case review. Further information ascertained in 2022 increased the likelihood of prion disease, resulting in formal notification and addition of the cases to the register. These six cases therefore contribute to the total numbers of suspect case notifications arising in 2021.

The remaining 73 suspected cases for 2022 were initially notified via: request for CSF diagnostic testing (52 cases); communications from clinicians (13 cases); neuropathology services (5 cases); the CJD Support Group Network (2 cases); and health departments (1 case). In 13 suspected cases, no CSF specimen was received by the ANCJDR for diagnostic testing; these cases were notified by the treating doctor (6 cases); neuropathologists (5 cases); health departments (1 case); and the CJD Support Group Network (1 case). While there is still a predominance of initial case awareness through referrals for CSF diagnostic testing, there has been in recent years a noticeable increase in case notifications through treating clinicians, neuropathologists, health departments and families seeking expert advice and guidance from the ANCJDR. Some previous proactive ANCJDR surveillance mechanisms (e.g. mortality database searches and reply-paid mailouts to clinicians) have been discontinued over time due to human resource constraints.

The number of suspected cases added to the ANCJDR register in 2022 follows the trend of increasing rates and was not significantly affected through the SARS-CoV-2 pandemic. The average annual number of prospective, formal suspect prion disease cases notified to the ANCJDR for the period 1997–2022 (i.e. since the introduction of diagnostic testing of CSF) is 73. States and territories exhibited modest fluctuations in the annual number of suspect case notifications for 2022, compared to both the previous year and the longer-term average.

Of the 79 formal suspect case notifications received in 2022, 15 cases were confirmed as ‘definite’ by neuropathological examination and 23 cases were classified as ‘probable’ following detailed review of clinical information. Five cases were confirmed as non-prion disease following neuropathological assessment, while 17 cases were still alive and considered ‘incomplete’ at the end of 2022; neuropathology reports were pending for 19 deceased suspected cases. It

is typical for several months to elapse between performance of a post-mortem and completion of the neuropathology report.

Since 1993, there has been a positive trend in the annual number of suspected cases of human prion disease undergoing post-mortem brain examination, or less commonly brain biopsies (albeit with relative plateauing over the last 15 years), beginning with twelve such cases in 1993 and increasing to between 30 and 50 brain autopsy referrals per year for the period from 2005 to 2022 (Figure 2). In 2022, of the 67 suspected CJD case deaths, 37 were referred for a brain post-mortem examination, with one additional patient undergoing a pre-mortem brain biopsy.

The average annual proportion of suspected prion disease cases on the register between 1993 and 2022 undergoing post-mortem brain examination is 61% (range 38–78%); the provisional proportion for 2022 is 55%. Annual

Figure 2: Number of brain-only post-mortem (PM) examinations and brain biopsies (BBx) completed relative to suspect case deaths from 1993 to 2022, by year

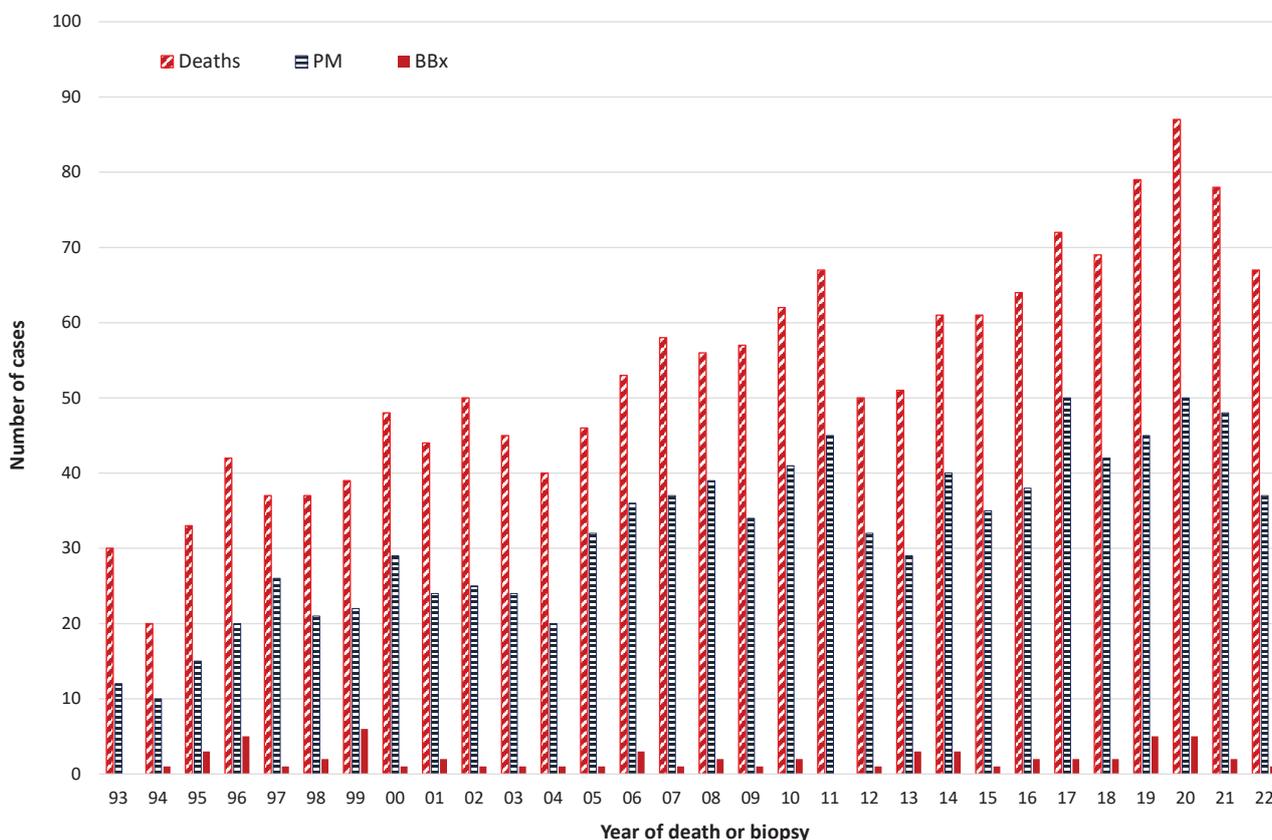


Table 1: Overall summary of Australian human prion disease, 1 January 1970 to 31 December 2022

Classification	Sporadic	Familial	Iatrogenic	Variant CJD	Unclassified	Total
Definite	721	66	5 ^a	0	0	791
Probable	436	35	4	0	0	475
Possible	14	2	1	0	0	17
Incomplete	0	7	0	0	220	227
Total	1,171	110	9	0	220	1510

a Includes one definite iatrogenic case who received pituitary hormone treatment in Australia, but disease onset and death occurred while a resident of the United Kingdom. This case is not included in statistical analysis since morbidity and mortality did not occur within Australia.

suspected prion disease brain autopsy referrals by states and territories over the period 1993–2022 display considerable fluctuation in each jurisdiction. In the more populous states, there has generally been an overall temporal increase in brain autopsy referrals. In regions with smaller populations this positive trend is also present but less robust due to the relative impact of variation in the annual brain autopsy referrals caused by small population sizes and case numbers.

As of 31 December 2022, there were 1,510 cases on the ANCJDR register with 1,266 of these classified as ‘probable’ or ‘definite’ prion disease cases. An additional ‘definite’ iatrogenic case, who was treated in Australia but died in the UK, is included in Table 1; this case is not classified as an Australian case due to their location at death and is thereby excluded from the overall statistical analysis of Australian prion disease cases. Since the start of prospective surveillance in 1993, a total of 859 suspected prion disease cases have been excluded from the register after detailed follow-up.

In 2022, thirty-one cases were re-classified from ‘incomplete’ to ‘definite’ prion disease and forty-one cases to ‘probable’ prion disease. One ‘possible’ case of a likely genetic form of prion disease (unspecified insert mutation present in family) was classified in 2022. In 2022, the total number of ‘incomplete’ cases under evaluation was slightly lower than in 2021.

The age-standardised mortality rate (ASMR) for prion disease for 2022 is 1.3 deaths per million per year. This figure is provisional and almost certainly an underestimate, as 19 neuropathology reports are pending and one case who died in 2022 remains under investigation. Annual ASMR values for human prion disease in Australia during the period of 1970 to 2022 have generally increased. The mean annual ASMR during the period from 1970 to 2022 is 1.11 deaths per million (range 0.1–2.3). For the prospective surveillance period of 1993 to 2022, the annual mean ASMR is 1.45 deaths per million (range 0.7–2.3). By state and territory, most regions in Australia have an annual mean ASMR equivalent to or above one case per million per year between 1993 and 2022 (Table 2) with the exception of the Northern Territory. The lower rates of ascertainment in the Northern Territory may be explained by its small population and therefore vulnerability to variations and the impact of a missed case. Proximity to specialised health care and post-mortem services may also play a role in case under-ascertainment, as demonstrated in CSF diagnostic test referral rates and autopsy referral rates well below the national average.

A breakdown of annual case numbers and mortality rates is shown in Figure 3 and Table 2. The highest annual number of ‘probable’ and ‘definite’ prion disease cases reported, since surveillance commenced in 1993, was 73 in 2020, resulting in an annual ASMR of 2.28 deaths per million. Higher mortality rates, ranging between 1.6 and 2.3 deaths per million per year,

Table 2: ‘Definite’ and ‘probable’ cases of human prion disease from 1993 to 2022, by year and state or territory

Jurisdiction ^b	2022 ^a		1993–2022		
	Cases	ASMR ^c (deaths/million/ yr)	Total cases	Long term average cases	Average ASMR (deaths/million/ yr)
ACT	1	1.34	16	0.5	1.28
NSW	12	1.17	335	11.2	1.42
NT	1	3.66	7	0.2	0.77
Qld	8	1.14	167	5.6	1.14
SA	2	0.83	88	2.9	1.60
Tas.	2	2.34	23	0.8	1.15
Vic.	9	1.14	279	9.3	1.60
WA	7	2.09	137	4.6	1.78
Australia	42	1.30	1,052	35.1	1.45

- a The figures for 2022 are provisional and almost certainly an underestimate, as 19 neuropathology reports are pending and one case who died in 2022 remains under investigation.
- b ACT: Australian Capital Territory; NSW: New South Wales; NT: Northern Territory; Qld: Queensland; SA: South Australia; Tas.: Tasmania; Vic.: Victoria; WA: Western Australia.
- c ASMR: age-standardised mortality rate, in deaths per million population per year.

Figure 3: Human prion disease in Australia from 1993 to 2022; number of cases and age-standardised mortality rates (ASMR), by year

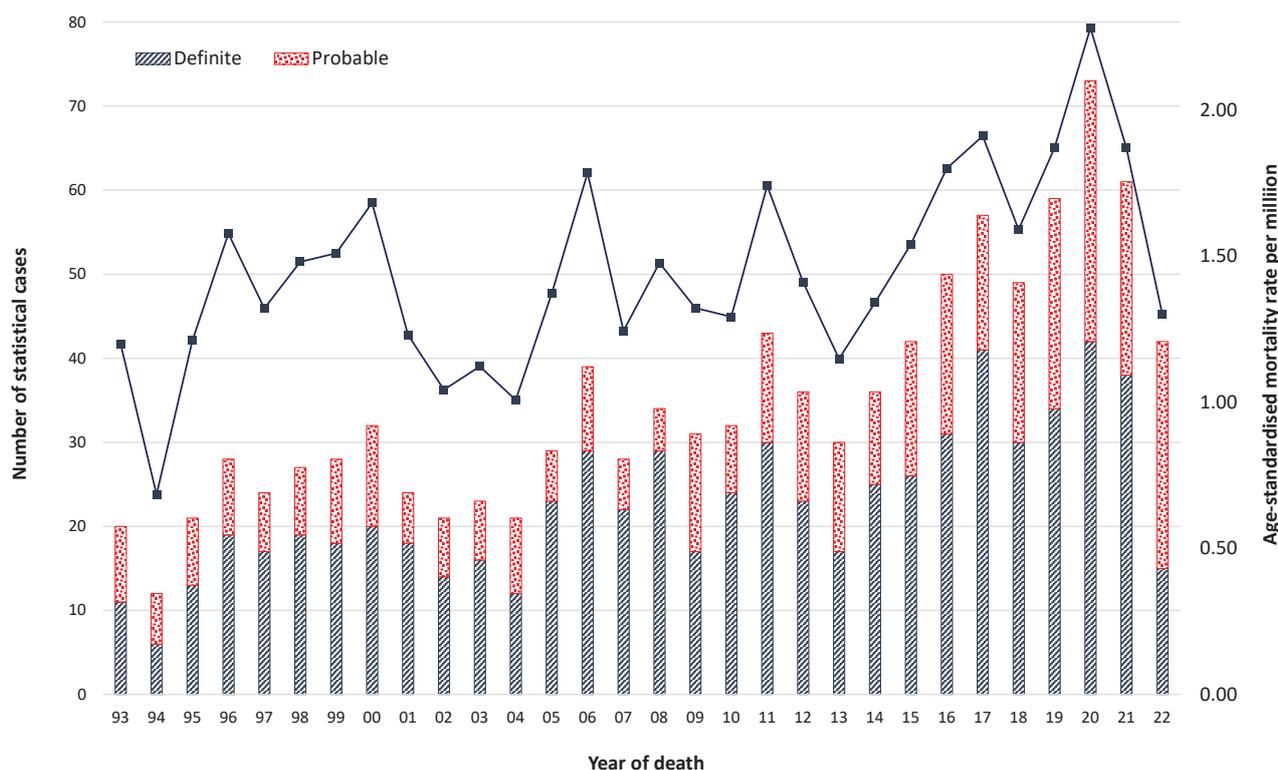
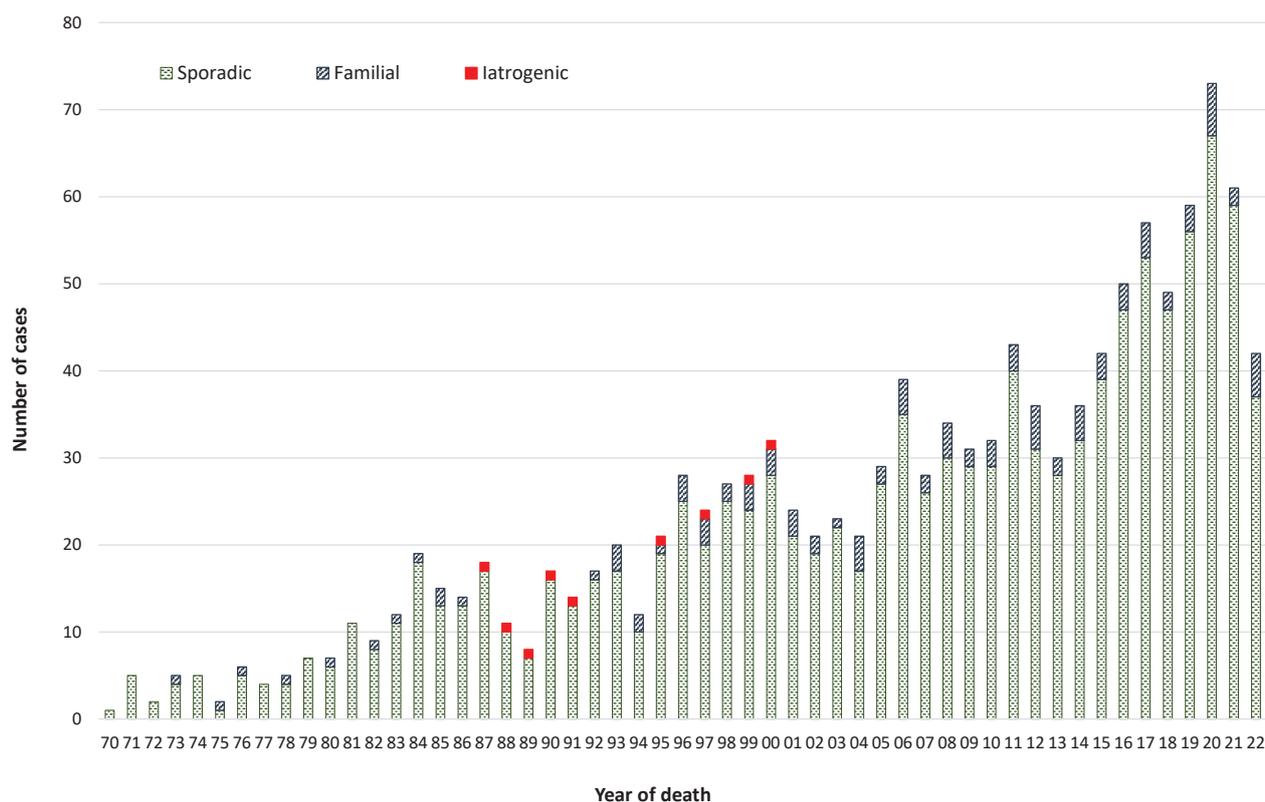


Figure 4: ‘Definite’ and ‘probable’ human prion disease cases 1970 to 2022,^a by year and aetiology



a Includes one definite iatrogenic case who received pituitary hormone treatment in Australia but disease onset and death occurred while a resident of the United Kingdom.

have been recorded since 2016; this coincides with the introduction of new diagnostic tools, such as CSF tau estimation, the RT-QUIC assay and improved MR brain imaging.

The proportions of human prion disease aetiologies on the ANCJDR register for 2022 remained similar to previous years (Figure 4); the vast majority of the 1,266 statistical cases of human prion disease are ‘sporadic’ (91%), while genetic and iatrogenic cases represent 9% and < 1%, respectively, of all ‘definite’ and ‘probable’ cases. No case of vCJD has yet been confirmed, including during 2022.

There are currently 1,157 ‘definite’ and ‘probable’ sporadic prion disease cases on the ANCJDR register. The distribution is almost equal between males (49%) and females (51%), with the slight predominance in females reflecting their longer life expectancy. The average age at death is 67 years, with a median of 68 years,

ranging in age from 19 to 91 years. The average duration of illness is 6.3 months, with a median of 4 months, ranging from 0.9 to 60 months.

There are currently 64 families affected by genetic prion disease on the ANCJDR register, comprising 101 individuals (66 ‘definite’ and 35 ‘probable’ cases) with a confirmed genetic aetiology, 57% of whom were female. The average age at death for genetic prion disease is approximately a decade younger than in sporadic prion disease, at 57.9 years, with a median of 60 years, ranging from 18 to 83 years; the average duration of illness is approximately 7 months longer than in sporadic prion disease, at 13.7 months, with a median of 5.6 months, ranging from 1.3 to 192 months. The average age of death is 58.5 years in females and 57.2 years in males ($p = 0.61$) while the average duration is 14.1 months in females and 13.1 months in males ($p = 0.82$).

To date, three prion protein gene (*PRNP*) mutation carriers have been excluded from the register after brain autopsy. They died aged 70, 88 and 91 years old, well above the average age at death of their pedigrees. Seven incomplete cases remain under investigation on the register without a neuropathological or clinical case classification outcome; however, there is documented concern for genetic prion disease. Six families are of unspecified *PRNP* status, although there is a recorded family history of prion disease. The range of *PRNP* mutations in Australian genetic prion disease cases is shown in Table 3. In 2022, six cases of genetic prion disease were confirmed neuropathologically or by clinical case evaluation; two novel mutations were identified: R208H (the patient is currently alive) and E211D (neuropathologically confirmed). The utility of diagnostic biomarkers for genetic prion disease, especially those found in CSF, continues to be defined.⁶

Discussion

In 2022, the number of suspected prion disease referrals and confirmed cases broadly matched the long-term average (1997–2022). Australia continued to be free of vCJD and no further cases of iCJD were detected. By state and territory, the numbers of suspected case referrals showed generally only modest fluctuations

during 2022 compared to previous years; the fluctuations seen in 2022 are within previously observed ranges.

Long-term national surveillance units report differing annual prion disease mortality rates, ranging from 0.24 to 4.56 per million population.⁴ Higher rates of human prion disease over short time frames have also been recognised and investigated in various global settings with inconclusive outcomes.⁷ The underlying basis for fluctuations and differences in national mortality rates is uncertain, although variation in case ascertainment is one potentially contributing factor.⁵ Spatio-temporal clustering of CJD has previously been recognised in New South Wales and Victoria.^{8,9} Detailed epidemiological assessment by the ANCJDR did not disclose any likely horizontal transmission event, but instead uncovered a heightened intensity of surveillance. This more intense level of surveillance was reflected by the significantly higher rates of referrals of suspect prion disease cases for evaluation and diagnostic testing to the ANCJDR, as well as higher neuropathological examination rates in suspected patients. Monitoring of the geographical distribution of suspected case referrals and confirmed cases remains an important facet of ANCJDR national surveillance. An overall increase in sporadic CJD cases has also been observed in Australia and is most

Table 3: Prion protein gene (*PRNP*) sequence variations/mutations identified in Australian cases

Mutation/polymorphism	Definite/probable cases	Cases PM proven not CJD
E200K	46	3
D178N	17	0
V210I	8	0
P105T	6	0
P102L	6	0
Insert mutations/OPRI ^a	4	0
Other mutations ^b	8	0
Not determined	6	0
Total	101	3

a OPRI: octapeptide repeat insertion.

b A133V, E200D, E211D, G131V, T188A, V176G, V180I, V189I.

likely due to a combination of an ageing population, improved case ascertainment and diagnostic methodologies, and greater awareness of prion disease in the healthcare sector. The gradual but notable increase in the incidence of sCJD, but not that of genetic forms of prion disease, has also been reported in other countries with longstanding prion disease surveillance and supports the notion that it is a result of the globally ageing population.^{10,11}

Ascertainment mechanisms in 2022 were unchanged compared to recent years, with the majority of initial referrals coming through requests for diagnostic CSF testing. Some proactive ascertainment mechanisms (such as jurisdictional health department and tertiary hospital mortality database searches) have ceased, while other case detection methods have increased. The number of CSF referrals to the ANCJDR for diagnostic testing remained high for 2022. A 20% increase in diagnostic test referrals coincided with the introduction of CSF total-tau protein estimation and the identification of misfolded prion protein in CSF by real time conversion assays (such as RT-QuIC) in 2017.

The proportion of post-mortem examinations being performed in suspect prion disease cases remains high and aligns with the long-term mean brain autopsy percentage of approximately 61% (of suspected case deaths) from 1993 onward. This contrasts with the findings of an Australian healthcare setting survey where the national hospital post-mortem rate was 12% in 2002–2003;¹² more recently, a major Australian tertiary centre audit of hospital autopsy data has described an autopsy rate of 6.6% in 2011–2013.¹³ The high suspected prion disease-related post-mortem rate underpins the high and consistent number of confirmed Australian human prion disease cases recorded over the more recent prospective surveillance time period, and provides confident understanding of the cause of death in suspected cases ultimately determined as non-prion disease. The consistent use of diagnostic RT-QuIC technology on CSF, with high specificity and good sensitivity, may be

contributing to a modest decline in autopsy referral rates from a long-term average (1993–2021) of over 61% to 55% in 2022. This trend has also been observed in other international prion surveillance units.^{iii,iv}

A recent study by the ANCJDR of prion disease in Indigenous Australians has confirmed that sCJD occurs in Indigenous Australians throughout Australia with a phenotype and incidence rate equivalent to non-Indigenous Australians, supporting the adequacy of national human prion disease surveillance.¹⁴

No further iCJD cases were confirmed in Australia during 2022. The most recent human cadaveric pituitary gonadotrophin-related CJD death occurred in 1991, while the most recent Lyodura-related CJD death occurred in 2000. In 2021, Japan reported two iCJD cases, associated with dura mater transplants.^v

Since vCJD was first reported in 1996, a total of 233 patients, from 12 countries, have been identified with this disease. Case 178 from the United Kingdom (UK) was methionine-valine heterozygous at codon 129 of the *PRNP* gene;¹⁵ all cases previously had been methionine homozygous at codon 129. The patient was 36 years old when he presented with psychiatric symptoms prior to onset of neurological features that included cognitive decline, ataxia and myoclonus, dying after an illness of 20 months. CSF 14-3-3 and RT-QuIC were negative. Brain magnetic resonance imaging (MRI) revealed features more typical of sCJD (bilateral high signal in basal ganglia) without any posterior thalamic high signal ('pulvinar sign'). The patient did not meet the epidemiologic diagnostic surveillance criteria for 'probable' or 'possible' vCJD, although he fulfilled criteria

iii Personal communication, National Prion Disease Pathology Surveillance Center, Case Western Reserve University, Ohio, United States of America.

iv Personal communication, National CJD Research & Surveillance Unit, University of Edinburgh, Scotland, United Kingdom.

v Personal communication, Japanese prion surveillance unit.

for ‘probable’ sCJD; neuropathology, including western blot glycotyping, was typical of vCJD. It remains uncertain whether this case marks the start of a second wave of vCJD affecting those heterozygous for methionine-valine at codon 129. This case also underscores the importance of performing suspect CJD brain autopsy examinations and the benefits of maintaining high-level surveillance within Australia. The most recent three vCJD cases, who died in France in 2019 and 2021 and Italy in 2016, are plausibly related to accidental occupational exposure incidents in laboratory settings.^{11,16}

The horizontal transmission of amyloid beta (A β) peptides associated with Alzheimer’s disease, through contaminated pituitary hormone treatments and dura mater grafts, is essentially proven,^{17–19} with the likelihood that contaminated neurosurgical instruments may also be a source of transmission.²⁰ It is also becoming increasingly accepted that such inadvertent inoculation can eventuate many years later in a disease phenotype.²¹ Prion protein and A β protein share similar properties, such as prion-like mechanisms of template-directed protein propagation, as well as inter-cellular spread of the misfolded protein isoforms and formation of larger fibrils. The slow propagation is associated with prolonged incubation periods before these proteins result in overt clinical and pathological evidence of disease following inoculation. In 2021, a comprehensive database search at the Royal Melbourne Hospital identified three young adult patients presenting with spontaneous intra-cranial haemorrhage due to early-onset CAA (confirmed pathologically in two). All three had undergone childhood neurosurgery with use of Lyodura (dura mater) grafts confirmed in two and likely to have been used in the third patient, supporting the likelihood of early-onset CAA due to transmission A β peptides from contaminated Lyodura, with the findings recently published.²²

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Appendix A

EUROCID diagnostic criteria for surveillance of sporadic CJD from 1 January 2017

Definite:

Progressive neurological syndrome AND Neuropathologically or immunohistochemically or biochemically confirmed

Probable:

I + two of II and typical EEG^a

OR

1.2.2 I + two of II and typical MRI brain scan^b

OR

1.2.3 I + two of II and positive CSF 14-3-3

OR

1.2.4 Progressive neurological syndrome and positive RT-QuIC in CSF or other tissues

Possible:

I + two of II + duration < 2 years

I Rapid progressive cognitive impairment

II A Myoclonus

B Visual or cerebellar problems

C Pyramidal or extrapyramidal features

D Akinetic mutism

a Generalised periodic complexes.

b High signal in caudate/putamen and MRI brain scan or at least two cortical regions (temporal, parietal, occipital) either on diffusion-weighted imaging (DWI) or fluid-attenuated inversion recovery (FLAIR)