

# Clinical checklist Cadasil

## CEREBRAL AUTOSOMAL DOMINANT ARTERIOPATHY WITH SUBCORTICAL INFARCTS AND LEUKOENCEPHALOPATHY

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CENTRUM MEDISCHE GENETICA UZ GENT

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### 1. Patient information

Name: \_\_\_\_\_

First name(s): \_\_\_\_\_

Sex:  Male  Female

Date of Birth: \_\_\_\_\_

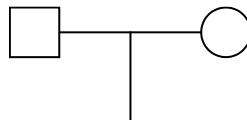
Address: \_\_\_\_\_

Referring physician: \_\_\_\_\_

Referring center: \_\_\_\_\_

Date: \_\_\_\_\_

### 2. Pedigree



### 3. Checklist for CADASIL

Please indicate the clinical characteristics for CADASIL present/absent in your patient.

	present	absent
Migraine without aura	<input type="checkbox"/>	<input type="checkbox"/>
Migraine with aura	<input type="checkbox"/>	<input type="checkbox"/>
TIA or CVA > 50 years	<input type="checkbox"/>	<input type="checkbox"/>
TIA/CVA onset < 50years	<input type="checkbox"/>	<input type="checkbox"/>
Mood and anxiety disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Alterations in attention and memory	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive decline	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Leukoencephalopathy	<input type="checkbox"/>	<input type="checkbox"/>
Leukoencephalopathy extended to temporal pole	<input type="checkbox"/>	<input type="checkbox"/>
Leukoencephalopathy extended to external capsule	<input type="checkbox"/>	<input type="checkbox"/>
Subcortical infarcts	<input type="checkbox"/>	<input type="checkbox"/>
Family history* in at least 1 generation	<input type="checkbox"/>	<input type="checkbox"/>
Family history* in at least 2 generations	<input type="checkbox"/>	<input type="checkbox"/>

\*For at least one of the typical features (headache, transient ischemic attack/stroke, cognitive decline, psychiatric disturbances)

### 4. Other relevant clinical manifestations

- |   |  |
|---|--|
| <input type="checkbox"/> seizures                   | <input type="checkbox"/> acute reversible encephalopathy |
| <input type="checkbox"/> intracerebral haemorrhages | <input type="checkbox"/> vertigo (dizziness)             |
| <input type="checkbox"/> myocardial infarction      | <input type="checkbox"/> other: _____                    |
| <input type="checkbox"/> visual abnormalities       |  |