MEDICAL SERVICES

PROVIDED ON BEHALF OF THE DEPARTMENT FOR WORK AND PENSIONS

Training & Development

Neurological and Infections Key Points and Analytical Guidance

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Foreword

This guidance has been produced as part of a Continuing Medical Education programme for practitioners approved by the Department for Work and Pensions Chief Medical Adviser to carry out medical assessments.

All practitioners undertaking medical assessments must be registered medical or nursing practitioners who in addition, have undergone training in disability assessment medicine. The training includes theory training in a classroom setting, supervised practical training, and a demonstration of understanding as assessed by quality audit.

This guidance must be read with the understanding that, as experienced disability analysts, the practitioner will have detailed knowledge of the principles and practice of diagnostic techniques, and therefore such information is not contained in this guidance.

In addition, the guidance is not a stand-alone document, and forms only a part of the training and written documentation that a practitioner receives. As disability assessment is a practical occupation, much of the training also involves verbal information and coaching.

Thus, although the guidance may be of interest to non-medical readers, it must be remembered that some of the information may not be readily understood without background medical knowledge and an awareness of the other training given to disability analysts.

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Section 1.4

CFS and Medically Unexplained Symptoms

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Contents

Part A - Key Points

Introduction

These evidence-based protocols are the result of extensive research by Atos Healthcare Medical Services. They contain key points on the aetiology, diagnosis, treatment, prognosis, and main disabling features of the neurological and infection conditions that are most commonly encountered in the field of Disability Assessment Medicine.

These key points are intended to be particularly useful as a quick reference guide. The full text of the protocols is available on a CD.

The key points that are presented in this section are complemented by the other parts of this module, which incorporate original analytical guidance and advice on the most relevant assessment techniques.

1. Multiple Sclerosis

1.1 Description

- Multiple sclerosis is a chronic inflammatory disease of the central nervous system.
- Diagnosis requires evidence of lesions that are separated in time and space.
- The cause is unknown but an immunological abnormality is suspected.
- It has been linked to the geographical area where the individual spent their first 15 years.
- In Europe and North America MS is the most common cause of neurological disability in young adults.

1.2 Diagnosis

- The disease is characterised by various symptoms and signs of CNS dysfunction.
- The most common presenting symptoms are:-
  - Parasthesiae in one or more extremities, in the trunk, or on one side of the face.
  - weakness or clumsiness of a leg or hand
  - Visual disturbances, e.g., partial blindness and pain in one eye (retrobulbar optic neuritis), dimness of vision, or scotomas.
- Mental symptoms include:-
  - Apathy, lack of judgment, or inattention may occur.
  - Emotional lability is common and may suggest an incorrect initial impression of hysteria. Euphoria occurs in some patients.
  - Reactive depression, in others.
- Magnetic resonance imaging (MRI) is the most sensitive diagnostic imaging technique.
- MS lesions may also be visible on contrast-enhanced CT scans.
- CSF is abnormal in the majority of patients.

1.3 Management

- Spontaneous remissions and fluctuating symptoms make treatments difficult to evaluate.
- Corticosteroids are the main form of therapy
- Immunomodulatory therapy with interferon-β reduces the frequency of relapses in relapsing remitting MS.
- Intravenous gamma globulins given monthly may help control relapsing MS refractory to conventional therapies.
- In debilitated patients prevention of bed sores and urinary tract infections is essential. The need for self catheterisation has to be carefully evaluated.
- The treatment of mental health problems and depression are strongly indicated in the clinical management of multiple sclerosis.
- The evidence base for the effectiveness of multidisciplinary rehabilitation in patients with multiple sclerosis (MS) is not yet established.

1.4 Prognosis

- Studies indicate that the rate of progress through disability milestones is time related.
- Neurological relapses in multiple sclerosis (MS) are the clinical counterpart of acute focal inflammation of the central nervous system (CNS)
- Neurological progression is that of chronic diffuse neurodegeneration.
- After a relapse or exacerbation there may be return to the pre-relapse level of problem but there will not be an improvement from that baseline and some functional reduction is much more likely.

1.5 Disabling Effects

- Weakness of one or more limbs, spasticity, muscle fatigue, unsteadiness of gait and difficulties with speech.
- Difficulty in bladder control is common.
- As the disease progresses mobility problems become apparent.
- Visual problems may also increase mobility problems.
- With further progression these manifestations will give rise to difficulty with self care.

- It is now considered that if symptoms resulting from a relapse do not remit within 6 months they are likely to be permanent.

2. Parkinson's Disease

2.1 Description

Parkinson's disease is characterised by impairment of movement, muscle rigidity, and tremor.

Idiopathic Parkinson's disease (PD) is a progressive neurodegenerative condition.

Parkinson's disease affects about 1% of people ≥ 60 years and 0.4% of those > 40 years.

2.2 Aetiology

The aetiology of Parkinson's disease is unknown, however, a number of factors have been implicated.

- Environmental insult
- Genetic factors
- Ageing

2.3 Diagnosis

The diagnosis is primarily clinical based on history and examination.

The three key features are tremor, rigidity and bradykinesia.

The tremor is slow and coarse and maximal at rest (pill rolling).

Rigidity is the raised resistance noted during passive joint movement.

As rigidity progresses, movement becomes slow (bradykinesia), decreased (hypokinesia), and difficult to initiate (akinesia).

2.4 Treatment

Treatment should be started when symptoms start to cause disability.

Definitive treatment of early PD is with levodopa or a dopamine agonist.

In the elderly, L-dopa is the first line choice as it is better tolerated.

As a result of autonomic dysfunction, anti-parkinsonian drugs' patients can have problems with constipation, urinary symptoms and postural hypotension.

Maximizing activity is a goal.

Patients should perform daily activities to the extent possible.

Physiotherapy should be available for people with PD.

Occupational therapy should be available.

Speech and language therapy should be available.

Currently three surgical options are available for PD.

2.5 Prognosis

Parkinson's disease is a progressive disorder which starts with mild unilateral involvement and progresses to complete dependency.

2.6 Main Disabling Effects

Patients have difficulty starting to walk, turning, and stopping.

There is a tendency to fall forward (propulsion) or backward (retropulsion) known as postural instability.

Dementia and depression are common.

Some patients have difficulty swallowing and are at risk of aspiration.

3. Epilepsy

3.1 Description

- Epilepsy is a group of disorders rather than a single disease.
- Seizures can be classified as partial or generalised.
- A person is considered to have epilepsy if they have had two or more unprovoked seizures.
- Epilepsy is common, with an estimated prevalence in the developed world of 500-1000/100 000 population.
- The causes/risk factors include birth/neonatal injuries, congenital or metabolic disorders, head injuries, tumours, infections of the brain or meninges, genetic defects, degenerative disease of the brain, cerebrovascular disease, or demyelinating disease.

3.2 Diagnosis

- A clear history from the individual and an eyewitness to the attack give the most important diagnostic information, and should be the mainstay of diagnosis.
- Investigations

  EEG - NICE guidelines for diagnosis and management of the epilepsies in adults and children recommend that an EEG should be performed to support a diagnosis of epilepsy in adults in whom the clinical history suggests the seizure is likely to be epileptic in origin. In children, EEG is recommended after the second or subsequent seizure.

  Magnetic Resonance Imaging (MRI) scanning is the current standard of reference in the investigation of patients with epilepsy.

  Computed Tomography (CT) scanning has a role in the urgent assessment of seizures, or when MRI is contraindicated (e.g. in patients who have pacemakers or metallic implants).

3.3 Management

- Antiepileptic drug (AED) therapy is long term, usually for at least three years and, depending on circumstances, sometimes for life.
- Treatment is usually started with a single drug at a small dose.

- Full adherence to the drug regimen is essential for the treatment to be successful.
- The goal of AED therapy should be maintenance of a normal lifestyle by complete seizure control without drug-related side effects.
- Drugs are usually chosen according to seizure type**.**

3.4 Prognosis

- Outcome for the newly diagnosed patient on carefully monitored monotherapy is good, with 70 - 80% entering prolonged remission.
- Factors that contribute to poor prognosis are the presence of structural lesions and associated neuropsychiatric handicaps.
- Important factors influencing a decision about AED withdrawal in adults include:-

  Driving

  Employment

  Fear of further seizures

  Risks of injury or death with further seizures

  Concerns about prolonged AED

3.5 Disabling Effects

- **Mild**
  A person with mild epilepsy would normally have a fit frequency of less than monthly. He/she may have brief absence seizures or infrequent generalised seizures with useful warning and no dangerous post-fit behaviour.

  He/she would normally be able to carry out all self-care activities for most of the time.
  The risk of falling would normally be very small.

  A person with mild epilepsy, is physically fit, and would normally be capable of walking an unlimited distance.
  He/she would normally be safe outdoors and could find their way around. They may be permitted to hold a driving licence.

- **Moderate**
  A person with moderate epilepsy would have a fit frequency of around one to two a month.
  He/she would normally have useful warning of a seizure, but may have

post seizure manifestations such as confusion and drowsiness.
For the majority of the time a person with moderate epilepsy would be able to safely self care.
Normally the person would have adequate warning of a fit, and be able to remove themselves from danger.
A person with moderate epilepsy, is physically fit, and would normally be capable of walking an unlimited distance.
He/she would normally be safe outdoors and could find their way around.
They are unlikely to be permitted a driving licence.

- **Severe**

A person with a severe degree of epilepsy would normally have frequent grand mal attacks, (at least more than twice a month), without warning which are manifest with severe convulsions, in which injury may often be sustained and which might require hospital care.

Because of the absence of useful warning, he /she would normally require the presence of another person for the majority of the time, to safely carry out activities of daily living (for example when bathing).
The person would not normally be able to safely prepare and cook a meal without supervision.
A person with epilepsy, which is not complicated by any other disabling condition, is physically fit, and would normally be capable of walking an unlimited distance.
They would not be permitted to hold a driving licence.

4. HIV and Aids

4.1 Description

- HIV infection refers to infection with the human immunodeficiency virus (HIV) type 1 or type 2. Initial infection may produce non-specific febrile illness.
- Asymptomatic carriage of human immunodeficiency virus may continue for 8 to 10 years.
- Current treatments interrupt the life cycle of the virus but without affecting a cure.

4.2 Epidemiology

- Worldwide estimates suggest that by December 2005 about 38.6 million people were living with HIV. In 2005, there were estimated to be 4.1 million new cases of HIV infection and 3.3 million deaths from AIDS.
- The major risk factor for transmission of HIV is unprotected heterosexual or homosexual intercourse.
- **Primary or acute HIV infection** is a condition that occurs 2-4 weeks after infection with the human immunodeficiency virus (HIV).
- After an infection with HIV, antibodies to the virus can be detected in the blood. This (seroconversion) usually takes 3 months but can take 1 year.
- **Asymptomatic HIV infection** is a phase during chronic infection with HIV during which there are no overt symptoms of HIV infection.
- In some individuals the asymptomatic phase can last 10 years or more.
- **Acquired Immune Deficiency Syndrome** death rate has shown a marked drop between 1995 and 1998 and a slower but continuing decrease since.
- About 25 million people worldwide have died from this infection since the start of the epidemic, and 40.3 million people are currently living with HIV/AIDS globally.

4.3 Diagnosis

- The standard test is an HIV antibody test which becomes positive about 6-12 weeks after infection.
- **The HIV viral load** is measured since this has prognostic importance.
- Increasingly tests for HIV drug resistance are carried out before therapy is initiated.
- Test are also indicated to exclude other important infections such as Hepatitis B and C, Sexually transmitted diseases (STDs) and Tuberculosis.
- AIDS may present with symptoms of opportunistic infections that do not normally develop in individuals with healthy immune systems.

As HIV infection progresses towards AIDS common symptoms may include

- fevers,
- increasing sweats (particularly at night),
- swollen glands and splenomegaly
- oral symptoms such as thrush or ulcers
- weakness,
- weight loss

- Those with HIV infection require regular monitoring of CD4 count, HIV RNA load (viral load), as well as basic screening lab tests.
- Different AIDS illnesses tend to emerge at different degrees of CD4 cell destruction resulting in increasing compromise of the immune system.

4.4 Management

- Intervention aims to reduce transmission of HIV, to prevent or delay the onset of AIDS, (as manifested by opportunistic infections and cancers), increase survival and minimise loss of quality of life, with minimal adverse effects.
- Without treatment, about 50% of infected people will die of AIDS over 10 years.

- With treatment, prognosis depends on age, CD4 cell count and initial viral load.
- Antiretroviral therapy is recommended for all patients with a history of HIV infection and an opportunistic illness which meets the definition of AIDS, or severe symptoms of HIV regardless of CD4+T cell count.
- There are currently four classes of antiretroviral drugs in use but several new classes are in advanced development, whilst a second generation of established classes is emerging.
- For routine use 3 drugs (in abbreviation :HAART) are used in combination.
- A number of factors may influence the safety and efficacy of antiretroviral therapy
  - Non adherence to therapy
  - Adverse drug reactions
  - Drug/drug interactions
  - Development of drug resistance.

4.5 Prognosis

- At the present time, there is no cure for AIDS.
- Without treatment, about 50% of people infected with HIV will become ill and die from AIDS over about 10 years.
- HAART has dramatically increased the time from diagnosis to death.
- Other independent predictors of poorer outcome were advanced age and infection through injection drug use.

Other poorer prognostic factors include

- Liver disease
- Cardiovascular disease
- Diabetes
- The development of non-AIDS related cancers especially lung or pancreatic.

4.6 Main Disabling Effects

- HIV infected individuals under care can typically be expected to remain generally well for a long number of years after infection.
- Those who have developed one or indeed several severe AIDS illnesses may be left with general or neurological damage, including cognitive impairment. This group is likely to require special support.

Care needs may arise from features such as:

- Dementia
- Neurological damage including neuropathy
- Endocrine upset
- General debility
- Night sweats (severe)
- Altered bowel habit (severe diarrhoea)
- Muscle weakness
- Poor balance
- Psychological sequelae such as depression, anxiety, substance abuse and alcoholism

The need for attention and supervision will increase and may become substantial if severe manifestations ensue such as:

- Infection with opportunistic infections such as cytomegalovirus or toxoplasmosis
- Malignant disease

In advanced HIV or AIDS the ability to walk can be severely affected by a number of factors:

- Dyspnoea due to respiratory infection (PJP or TB) - though this has the potential to improve with appropriate treatment.
- Peripheral neuropathy or muscle weakness
- Severe debility

- Visual impairment can arise as a result of especially cytomegaloviral infection or brain involvement.

If significant, then this can affect the ability to get around independently.

5. Chronic Fatigue Syndrome / M.E.

5.1 Description

- A long standing disabling fatigue without demonstrable muscle weakness.
- Substantial reduction of previous levels of occupational, educational, social, or personal activities
- Little evidence that inflammation of the brain and spinal cord occurs.

5.2 Aetiology

- the composite term CFS/ME best describes this condition and that it is a spectrum of disease
- Infective agents have been implicated but no clear link with serology indicating past viral infection.
- Environmental factors, abnormal physiological pathways and genetic pre-disposition are all likely to contribute
- stressful life events or difficulties may precede development of CFS/ME

5.3 Diagnosis

- a diagnosis of “exclusion”
- Fatigue with specific features and one or more of a defined list of symptoms.

5.4 Treatment

- There is no specific treatment for CFS.
- Most people do recover to some extent, if not completely, or adjust their lifestyle to improve their symptoms
- In CFS/ME management may be a more appropriate term than treatment.
- Cognitive Behavioural Therapy (CBT) and Graded ExerciseTherapy (GET) are the currently advocated preferred treatment modalities.
- If chronic pain is a predominant feature, referral to a pain management clinic is appropriate.

5.5 Prognosis

The prognosis is highly variable in this unpredictable condition.

- People with mild illness may recover spontaneously, or with some general advice or a limited treatment programme over a six month period.
- People with established CFS/ME of moderate severity are likely to need a more extensive management programme.
- Some people will recover fully, but others will not achieve their previous level of functioning. Some may not improve.
- Recovery rates for CFS/ME are unclear as studies have tended to be on those attending specialist units and thus being in the moderate or severe categories.
- A median of 40% (in some studies 65%) who do not report full recovery do show improvement.
- Some indicators of a good prognosis and some of a poorer outcome have been identified.

5.6 Main Disabling Effects

The disabling effects of CFS/ME in individuals are variable.

- In mild cases the person is likely to be able to walk short distances on an unrestricted basis most of the time.
- Cognition such as judgment, thought processes and communication are not affected.
- With moderate CFS/ME mobility is likely to be restricted with difficulty walking more than 100 metres consistently but severe restriction of walking is unlikely. Judgment, thought processes and means of communicating are not affected to the extent that they would be unable to find their way around in familiar and unfamiliar places.
- The ability to maintain personal hygiene and nutrition is likely to be unimpaired.
- 75% of those with CFS/ME are in the mild or moderate category.
- Those with severe functional restrictions may exhibit problems with mobility, cognition, particularly tasks requiring concentration and self care, and they may only manage minimal tasks such as face washing or cleaning teeth.
- They may be severely restricted in their ability to walk.

6. Medically Unexplained Symptoms

6.1 Description

- The common factor among all the syndromes is the lack of a satisfactory medical explanation. Common symptoms include, for example, headache, muscle and joint pain, low back pain, non-cardiac chest pain, and bowel discomfort.
- Somatoform disorders is recognised in both DSM IV where the bodily symptoms or concerns also have to result in clinically significant distress or impairment in functioning, and in the WHO ICD 10 which has a similar description but is more detailed in its exclusions.
- Somatoform syndromes are quite prevalent in all countries. According to a cross-cultural study by the WHO, nearly 20% of primary care patients are affected by multiple somatoform symptoms.

6.2 Aetiology

- Evidence supports an interaction of physiological, psychological and interpersonal factors.
- Although the lack of organic pathology is the central feature of the 'medically unexplained syndromes', current models of somatization consider benign psycho-physiological processes to be relevant

6.3 Diagnosis

There are specific diagnostic criteria.

A history of many physical complaints beginning before age 30 years.

Each of the following criteria must have been met

- four pain symptoms
- two gastrointestinal symptoms
- one sexual symptom
- one pseudo-neurological symptom

AND Either (1) or (2):

1. after appropriate investigation, each of the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)

2. when there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings.

Definitions and descriptions of various sub-types of somatoform disorder are detailed in Section 3 – Diagnosis in the full protocol.
(Not all are recognised by ICD – 10)

6.4 Treatment

Treatment can be difficult as many do not accept that they have a mental component.

Many people who have somatoform disease also have other mental health problems such as anxiety, depression or substance abuse. Treatment of the coexisting condition may improve their somatoform disorder.

CBT is the best established treatment for a variety of somatoform disorders.

6.5 Prognosis

- Short symptom duration and changed marital status are associated with a better prognosis.

- Pending litigation appears to indicate poor prognosis as does an unidentified or untreated psychiatric disorder.

6.6 Main Disabling Effects

- In a study patients with somatization had substantially greater functional disability and role impairment than non-somatizing patients. The degree of disability was equal to or greater than that associated with many major, chronic medical disorders.

- Patients who have anxiety or depressive disorders are particularly limited in social functioning, role functioning because of emotional problems and subjective health.

- In patients with comorbidity the impairments are summated.

7. Part C - Analytical Guidance

The tables in this section are for guidance only, they are not prescriptive and each claimant has to be considered on an individual basis.

7.1 Multiple Sclerosis

	Significant disability unlikely	Significant disability likely	Severe disability likely
History & Symptoms	Fully continent or can manage incontinence independently	Occasional bowel or bladder incontinence requiring help	Regularly incontinent and requiring help
	Feeds independently (with aids if needed)	Some help needed (e.g. cutting food) Feeds in reasonable time	Unable to feed self at all Unable to eat or swallow
	Sits and rises independently	Sits without support. Needs use of aid to rise	Cannot rise without support of another person
			Restricted to bed or chair
	Walks independently (reasonable distance and time)	Use of aids for reasonable distance in reasonable time	Cannot walk at all
			Wheelchair use
	Dresses independently	Help in some areas or uses aids	Cannot dress independently
	Can toilet independently (with or without aids)	Requires help in some areas	Cannot toilet independently
	No problem on stairs or uses handrail	Requires supervision from another person	Cannot use stairs even with supervision or Support
Typical day	Independent day to day living and full social interaction	Some restrictions on ADLs and reduced social interaction	Requires help with most ADLs and severe restriction of social interaction

	Significant disability unlikely	Significant disability likely	Severe disability likely
Observations	Informal movements within normal limits	Some restriction in upper or lower limb function and gait	Static or intention tremor Stiff imbalanced gait Hemiplegia
	No speech problem	Can communicate	Unable to communicate
	Normal mental health features	Mild to moderate depression features	Significant features of depression and/or anxiety
Clinical findings	Paraesthesia of one extremity or one side of the face	Muscular weakness and spasticity	Major neurological deficits Bilateral signs
	Increased deep reflexes	Vertigo	Increased fatiguability
	Normal vision	Partial blindness or dimness of vision	Diplopia

7.1.1 Overall analysis

In relapsing remitting MS spontaneous remission is common in the early stages of the disease and indeed may be lifelong.

However, if symptoms resulting from relapse do not remit within 6 months they are likely to be permanent.

If features suggest there is a mental health component it is essential to carry out the standard Mental Health Assessment.

7.2 Parkinson's Disease

	Significant disability unlikely	Significant disability likely	Severe disability likely
History & Symptoms	Feeds independently (with aids if needed)	Some help needed (e.g. cutting food) Feeds in reasonable time	Feeding (and writing) impossible
	Sits and rises independently	Sits without support. Needs use of aid to rise	Cannot rise without support of another person
	Steps out well Normal stride	Stride moderately shortened	Shuffling gait. Difficulty turning
	Turns safely	Difficulty initiating walking Help in some areas or uses aids	Tendency to fall forwards or backwards
	Dresses independently	Requires help in some areas	Cannot dress independently
	Can toilet independently (with or without aids)	Requires supervision from another person	Cannot toilet independently
	No problem on stairs	Requires to use handrail or has had aids installed	Can only use stairs with supervision or support
Typical day	Independent day to day living and full social interaction	Some restrictions on ADLs and reduced social interaction	Requires help with most ADLs and severe restriction of social interaction
Observations	Pill rolling tremor 2 cm of tremor movement in limbs or head	Severe tremor but not constant Some hand control retained	Tremor constant and severe Full loss of hand control

	Significant disability unlikely	Significant disability likely	Severe disability likely
	No speech problem or slight hoarseness with good volume and easily understood Normal expression Full animation Normal mental health features	Moderate hoarseness Monotone Difficult to understand Marked immobility of expression Mouth remains closed Mild to moderate depression features	Marked weakness Very difficult to understand Frozen expression Drooling present Significant features of depression and/or anxiety
Clinical findings	No significant clinical findings	Detectable cog-wheel rigidity Detectable slowing of pronation / supination rate	Sever rigidity particularly neck and shoulders Severe slowing of pronation / supination rate

7.2.1 Overall Consideration

If features suggest there is a mental health component it is essential to carry out the standard Mental Health Assessment.

7.3 Epilepsy

For a majority of people with epilepsy, seizures can be substantially reduced or completely controlled, enabling people to live normal or close to normal lives. For the remaining 20 percent, epilepsy is disabling, marked by frequent seizures, other impairments, memory and other cognitive effects, and a highly compromised standard of living.

	Significant disability unlikely	Significant disability likely	Severe disability likely
History & Symptoms	Children and adults in this category will ▪ have gained control of seizures fairly rapidly ▪ have no or very infrequent seizures ▪ experience limited if any side effects from medication ▪ be cognitively intact ▪ have no additional physical or mental impairments.	Children and adults in this category will ▪ be more likely to experience side effects from medication ▪ take higher doses to maintain control ▪ experience a greater level of social, emotional, and educational/ employment problems	Children and adults in this category will ▪ have epilepsy as a result of brain disease or injury ▪ be poorly controlled despite the use of multiple medications and combinations of medications ▪ have impairment of learning, memory, attention, and motor and emotional function ▪ experience some retardation or slowing
Typical day	No difficulty with self care. Manages routine tasks including washing, dressing and cooking. May hold a driving licence. Usually aura or warning so injury unlikely.	likely to experience a greater level of social, emotional, and educational/ employment problems Post seizure confusion and drowsiness. Unlikely to hold a driving licence.	require help in everyday living have difficulty in maintaining family support and social relationships report bouts of continuous seizure activity (flurries) and status epilepticus
Observations	Likely to be normal	Likely to be normal	May appear depressed and withdrawn. May exhibit confusion or aggression particular in post-ictal phase.

Clinical findings	Likely to be normal	Possibly mild depression	Depression likely Bruising or other injuries Other manifestations of brain injury or congenital problems

7.4 HIV and Aids

	Significant disability unlikely	Significant disability likely	Severe disability likely
History & Symptoms	Positive HIV test Disease duration <8yrs CD4 count >200µL No history of opportunistic infections	Disease duration >10yrs CD4 count <200µL Therapy problems • Non adherence to therapy • Adverse drug reactions • Drug/drug interactions • Development of drug resistance. Anaemia Diarrhoea Night sweats Hyperlipidaemia, liver disease or diabetes	Disease duration >10yrs CD4 count <100µL Kaposi's Sarcoma Lymphoma Lung or pancreatic carcinoma Repeated respiratory infections (incl. T.B.) Uncontrollable diarrhoea Visual impairment Severe opportunistic infections
Typical day	Independent day to day living and full social interaction	Bowel urgency and frequency. Help with medication Walking distance < 800m	Help with most activities of daily living Walking distance < 50m
Observations		Unsteadiness Hairy leukoplakia Facial lipodystrophy	Breathlessness Muscle wasting
Clinical findings	No significant clinical findings	Muscle weakness Peripheral neuropathy Cognitive impairment, depression, anxiety	General debility Reduced visual acuity Peripheral neuropathy Dementia

7.5 CFS / ME

	Significant disability unlikely	Significant disability likely	Severe disability likely
History & Symptoms	Mild illness and recovery over six months. Specialist referral unlikely. No history of setbacks or replapses.	History of 1 – 2 years. Specialist referral and management programme but likely to have been able to attend hospital.	Long clinical course with severe and unremitting symptoms. Little or no response to a range of interventions. Continuing setbacks and relapses.
Typical day	Can wash, dress, bathe. Mobility generally unrestricted. Cognition and communication not affected. Fatigue countered by avoidance of leisure and social pursuits and sometimes rest.	Mobility restricted to 100m. but more severe restriction unlikely. Afternoon rests may be a feature. This may have affected work or education. Normal tasks may require rest after completion. Personal hygiene and nutrition unimpaired. Cognition and judgement can be affected but insight of precautions remains good.	Severe mobility restriction. Only minimal self care tasks (teeth, face washing) may be managed. May require supervision due to cognitive impairment and require meal preparation. Light and noise sensitivity. May be bed or wheelchair bound.
Observations	No limitations	Mild cognitive, concentration and affect changes may be noted.	Cognition and concentration problems may be evident.
Clinical findings	Normal (unless co-morbid conditions).	No specific findings on examination.	Muscle weakness and loss of muscle bulk, particularly in lower limbs may be evident.

7.6 Medically Unexplained Symptoms

Because this covers a huge range of conditions with widely varying clinical features and effects, each claimant has to be considered on their own merit.

Observation form

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