Information on Fibromyalgia –Searchable Repository

Overview

This is a common condition, presenting frequently in both the GP setting and rheumatology outpatient clinics. In the past it was sometimes called fibrositis. Exact aetiology remains unknown, but current theories include the following:

- A central disorder of pain perception
- Abnormal levels of substance P
- Abnormal levels of serotonin (a pain control chemical that also regulates sleep)
- Viral infection
- A preceding trauma or illness

Fibromyalgia is one of several common 'medically unexplained conditions'. There is a degree of overlap with other conditions including chronic fatigue syndrome and major depressive disorder.
There are nearly 15,000 new cases annually in the UK. 9 out of 10 cases are known to be in women, with the age of onset usually between 30 and 60 years.

Care considerations

Severity of the condition varies, but in general the ability to self care and attend to nutritional and hygiene needs independently will be retained.

Mobility Considerations

Walking ability may be reduced due to the symptoms but will not usually be severely restricted. Falls are not a feature of the condition.

Prognosis

This is a chronic but non-progressive condition. There can be long periods of time when the individual is asymptomatic, but full recovery is uncommon. It is not life threatening and does not have any effect on life expectancy.

Signs and Symptoms

These include:

- Muscle stiffness
- Diffuse pain (felt primarily in the muscles)
- Fatigue
- Abnormal sleep pattern
- Impaired concentration
- Other somatic symptoms

Pain

Severity of pain can range from moderate discomfort to an intensity such that everyday tasks are interfered with. Pain may be felt all over and can also change location, varying in the individual.
There may be localised 'tender' spots at the following common sites:

- Elbows
- Scapulae
- Shoulder girdle
- Neck
- Front of knees
- Hip joints
- Back

Fatigue

May range from:

- Mild tiredness
- Severe exhaustion (similar to a flu-like illness)
- Unrefreshing sleep may be a feature

Other Somatic Symptoms

- Headache and facial pain
- Numbness and parasthesia
- Poor concentration or memory
- Anxiety or depression

Other Symptom Features

- May fluctuate with the weather
- May fluctuate with stress
- None are outwardly visible

Investigations and Treatment

There are no specific tests for fibromyalgia. Certain conditions need to be excluded such as:

- Thyroid disease
- Multiple sclerosis
- Rheumatoid arthritis
- SLE
- Chronic Fatigue Syndrome

Treatment
Likely to include the following:

- Patient education (rest and managing stress levels)
- Cognitive behaviour therapy
- Regular aerobic training -low impact graded exercise
- Low dose tricyclic antidepressants

- Analgesics

WFHRA Information

The following may assist a return to work:

- Improved understanding of the condition
- Health interventions
- Expert patient programme

On resuming work:

- May need shorter hours, for example, to avoid rush hour travel
- Define the period over which hours will be gradually increased
- Supervised and gradually increasing physical activity has been found to be effective

ESA examination

Both the physical part of the test and the Mental Function Assessment may need to be applied. The clinical history and level of therapeutic intervention should be recorded in sufficient detail to assist consideration of the apparent severity of the condition. Information about the use of any aids and appliances, or adaptations to the home environment is also useful. Careful attention should be paid to gathering sufficient information about both variability and a full range of typical day activities covering the whole day.

Clinical Examination

This may be normal .A full musculoskeletal overview is usually required.General deconditoning of muscle groups may be evident if activity levels have been reduced for a prolonged period.The sensation experienced by those suffering from fibromyalgia on palpation of tender spots is more akin to 'pain' than 'tenderness'. Often, there will be a disparity between the clinical findings and the claimed level of disability. It is important to note that this disparity is a feature of the condition.

Sources – Oxford Textbook of Medicine (online version), CCM, Atos Healthcare distance learning module in Fibromyalgia.

Depression – Information from Searchable Repository

Overview

Prolonged lowering of mood, which is out of proportion to circumstances is termed depression and is recognised as a disease entity.
Various patterns of depression are seen. There may be:

- A single episode
- Recurrent episodes
- Chronic illness with sustained depression
- Mixed anxiety and depressive disorder

Depression brought on by a specific cause such as a life event tends to be less severe.
Severe depression may be called psychotic depression if it is associated with psychotic symptoms. There is often no apparent cause for the illness. It can occur in women in the post-natal period and is known as puerperal psychosis.

Categories of depression

- Mild
- Moderate
- Severe
- Severe with psychotic features
- Agitated - a form of severe depression with marked physical restlessness and severe anxiety features
- Masked - a form of depression where the person may not appear depressed due to the absence of some of the usual clinical features.
- Post natal depression - can be mild, moderate or severe (with puerperal psychosis diagnosed if there are psychotic features.
- Seasonal Affective Disorder (SAD) - more correctly termed seasonal mood disorder, is depression usually starting in the autumn or winter which ends in the spring or summer as daylight hours increase.

Care Needs

The risk of suicide and attempted suicide may increase in the early stages of treatment of depression (as apathy and physical inertia lessen but mood is still depressed).
The severely depressed may show evidence of self-neglect and be unable to attend to their own nutritional or hygiene needs. This may only be of short duration (weeks rather than months) before treatment improves their condition.
Those with mild or moderate depression are likely to be able to cope independently day to day.

Mobility Considerations

Depression does not usually generate a need for guidance or supervision outdoors, though encouragement may be necessary.
The physical ability to walk is only affected in those rare cases of depressive stupor (hospitalisation and early response to treatment would be expected).

Prognosis

The overall prognosis for improvement in depression is good. On average a bout of depression will last 6 months.
About 70% with moderate to severe illness begin to respond to treatment within 6 weeks; without treatment, the majority can expect to recover eventually, although the natural course tends to be about 1-2 years.
A response to treatment, even in severe depression, is to be expected. The time taken for recovery can vary between individuals, and some will be subject to longer periods of illness or recurrent episodes.
There may be chronic residual symptoms (which are typical of depression).
Up to 20% of those with depression will develop a chronic illness.

Signs and Symptoms

In severe depression there can be psychotic features such as delusions or hallucinations, but these do not always occur.
The core symptoms of major depression include:

- Negative beliefs
- Loss of self esteem
- Inappropriate guilt

Other symptoms may include feelings of pessimism, worthlessness and hopelessness. There may be a slowing down, both physical and mental. The usual sense of enjoyment from interests or social activities is lost (anhedonia).

Physical symptoms may occur such as:

- Lethargy,
- Loss of energy
- Loss of appetite
- Reduced libido
- Weight loss
- Constipation
- Sleep disturbance

These symptoms can be present in those with severe depression but may also be present to a lesser degree in those with mild to moderate depression.

There may be a marked hypochondriasis and suicidal ideation may be evident.
In those with mild to moderate depression often a mixed picture with features of anxiety is seen.

Treatment/ Investigation

There are various options. In severe depression hospitalisation may be necessary. Choice of treatment depends on factors such as severity, duration, suicidal risk, co-existing medical conditions and the views of the affected individual.
Treatment methods include psychotherapy, medication and other methods. Often a combination of methods will be used.

Psychotherapy
Various techniques are used, both group and individual. In mild depression counselling may be helpful, with no other treatment required. In mild to moderate depression cognitive behavioural therapy (CBT) can be very effective.

Phototherapy
Treatment with high-intensity light can be beneficial for individuals with SAD, where the onset of depression is in the autumn or winter.

Medication
A range of different drugs is now available. An individual’s response to a particular drug is not predictable.

For some, trial and error with more than one preparation is needed. The newer drugs tend to have fewer side effects and are safer if taken in overdose.
Combinations of drugs are to be avoided but may be used to good effect by hospital specialists in resistant cases.
There is often a lag period (2 to 3 weeks) before the drug starts to take effect.
Continuing treatment for a 6 to 12 month period after symptoms have improved is recommended, as this may prevent relapse.
Maintenance medication for 5 yrs or longer should be considered if there have been:

- Three or more episodes of major depression in the last 5 years
- More than 5 episodes altogether of major depression
- Fewer recurrent episodes with persistent risk factors for relapse/recurrence.

The main groups of drugs are:

- Tricyclic antidepressants (amitriptyline, amoxapine, clomipramine, dosulepin, doxepin, imipramine, lofepramine, nortriptyline and trimipramine)
- Drugs related to trycyclics (maprotiline, mianserin and trazodone)
- Monoamine-oxidase inhibitors or MAOIs (phenelzine,isocarboxazid, tranylcypromine and moclobemide)
- Selective serotonin re-uptake inhibitors (citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine and sertraline)
- Other drugs (flupentixol, mirtazapine, duloxetine, reboxetine, tryptophan and venlafaxine)
- Mood stabilisers such as lithium may be added to other drugs in resistant depression

Other treatments
Electroconvulsive therapy (ECT) is used in severe depression and is also considered the treatment of choice in certain clinical situations such as puerperal psychosis and in resistant depression.
In very rare cases of chronic disabling depression, when all other treatments have failed, psychosurgery may be considered.

WFHRA Key Areas To Explore

The following health and workplace interventions that may assist a return to work include

- Improved understanding of the condition
- Health interventions
- Expert patient programme
- Psychological support
- Phased return to work with part-time and family-friendly hours
- Supportive mentoring and buddying
- Workload monitoring to avoid unexpected, uneven or excessive demands.

Exam Key areas to Explore – ESA

On applying the Mental Function assessment the areas that may be affected include:

- Memory and concentration
- Initiating and sustaining activities
- Awareness of hazards
- Coping with social situations
- Execution of tasks

The level of severity of depression may vary.
If the condition is mild then there is unlikely to be significant disability.

Significant disability likely
If there are features of diurnal variation of mood, early morning wakening, anhedonia, loss of appetite, loss of weight, downcast eye gaze and poor eye contact, hopelessness, unreasonable guilt, impaired concentration and memory, avoidance of social interaction then significant disabilty may be likely. Consider whether the typical day, medication taken and level of clinical input are consistent with the examination findings.

Severe disability likely
If there is evidence of psychosis, paranoia, delusions, self neglect, lack of insight, recent self harm or attempted suicide (within the last 6 months), with the client on medication and requiring a high level of clinical input then this suggests that severe disability is likely.

If there is evidence of severe mental illness then support group criteria may be met.

Clinical Examination

On mental state examination findings may vary depending on the level of severity of the client's depression.
If severe there may be:

- Unkempt appearance
- Poverty of speech
- Severe mood disturbance
- Psychotic symptoms
- Psychomotor retardation
- Active suicidal thoughts

Other features of depression may include:

- Downcast eye gaze and poor eye contact
- Reduced facial expression
- Impaired memory and concentration
- Weight loss
- Depressive thinking with hopelessness and guilt

Sources – British National Formulary, Oxford Textbook of Psychiatry (online version), CCM, Atos Healthcare EBM protocol on Depression.

Bipolar Disorder – Information from Searchable Repository

Overview

One of the more severe forms of mental illness (psychosis). A disorder of mood, in the past it was termed manic-depressive psychosis. There can be acute episodes of mood disturbance or chronic mental illness.

Types of bipolar affective disorder

These include the following:

- Hypomania
- Mania (with or without psychotic features)
- Bipolar type I disorder (episodes of major depression and mania)
- Bipolar type II disorder (episodes of major depression and hypomania)
- Rapid cycling disorder (4 bouts of major depression, hypomania, mania or mixed mood disorder experienced in the past year)
- Chronic bipolar major depression (major depression symptoms continuously for at least the previous 2 yrs)
- Cyclothymia (subsyndromal mood swings with a third developing frank bipolar disorder at some point)

For a manic episode to be diagnosed, duration of the condition must have been for at least a week.

Co-morbidity with other mental health conditions is common and can include:

- Substance related disorders (drugs and/or alcohol)
- Personality disorders
- Anxiety disorder
- ADHD
- Conduct disorder

Care Needs

Those who have mood swings from mania to depression may be at greater risk of self-harm (and may need hospitalisation as a result).
The severely depressed may show evidence of self-neglect and be unable to attend to their own nutritional or hygiene needs. This may be of short duration

(weeks rather than months) before treatment improves their condition.
Episodes of mania with very disturbed behaviour may warrant the person being watched over, though urgent treatment (often in hospital) would be likely to improve the condition within a few weeks.

Mobility Considerations

Depression does not usually generate a need for guidance or supervision outdoors, though encouragement may be necessary.
The physical ability to walk is only affected in those rare cases of depressive stupor (hospitalisation and early response to treatment would be expected).

Prognosis

There is no cure for bipolar disorder.
Effective treatment can substantially reduce the morbidity and the mortality from the condition (there is a high suicide rate).

Various patterns of recovery and relapse are seen. There may be full recovery from a single episode or between episodes of illness.
Severe disability may become a chronic feature for some individuals.

Long-term outcome for those with bipolar disorder is less satisfactory than for those with depression (in terms of relapse and chronicity).

Of those diagnosed with Bipolar type II disorder , between 25 and 50% will attempt suicide.The number who complete suicide is about 10% (usually during a depressed phase).

Signs and Symptoms

Symptoms and presentation may vary widely between individuals. Account should be taken of the number of episodes, some of which may have been sub clinical. Information from third parties may be of value in helping to establish the diagnosis.

Symptoms may include the following:

Depression

- Can be severe depression with delusions or hallucinations
- Suicidal intent (increased risk with rapid mood cycling)

Hypomania

- Intense well being
- Irritability

Mania

- Abnormal elation
- Overactivity or restlessness
- Grandiose ideas
- Decreased need for sleep
- Pressured speech
- Increased libido
- Reckless behaviour without regard for consequences
- Disinhibition
- Intrusive or argumentative behaviour
- Hostility

For a manic episode to be diagnosed, the condition must have been present for at least a week.

Treatment/ Investigation

Treatment aims to decrease the frequency, severity and impact on daily living of episodes, and to improve overall function between episodes.
Hospital treatment may need to be on a compulsory basis.

Drug Treatment

Depression may be treated with a mood stabiliser such as lithium. Carbamazepine is also used. An anti-depressant may also be required (choice of drug depends on a range of factors).
Drugs used in acute mania include lithium and sodium valproate (after an initial period of treatment with antipsychotic medication).
A range of drugs are used as maintenance therapy (which may be life-long). Occasionally this may be administered in depot form (neuroleptics).

Psychotherapeutic Treatments

May include:

- CBT (will be time limited)
- Family therapy
- Support groups

- Interpersonal and social rhythym therapy (to help establish a regular pattern of daily activities

Other Treatments

Electro-convulsive therapy or ECT may be indicated, as a treatment for severe depression. ECT may be used for mania (where pharmacological treatment is contraindicated or the illness has been refractory to medication).

WFHRA Key Areas To Explore

The following health and workplace interventions that may assist a return to work include:

- Improved understanding of the condition
- Health interventions
- Expert patient programme
- Psychological support
- Phased return to work with part-time hours
- Supportive mentoring and buddying
- Workload monitoring to avoid unexpected, uneven or excessive demands.

Exam Key areas to Explore – ESA

The history should address the pattern of the condition in terms of relapse and remission.Variability needs to be carefully recorded highlighting the level of function during both relapses, and the periods between episodes of illness. Important factors such as hospitalisation (particularly if frequent or prolonged) or compulsory treatment must be noted. Pointers to a more severe condition include a high level of management input (hospital or CMHT supervision), poor compliance and lack of insight.

The Mental Function Assessment may indicate difficulty with:

- Memory and concentration
- Coping with change
- Execution of tasks
- Initiating and sustaining daily activites
- Propriety of behaviour with other people
- Dealing with other people
- Coping with social situations

In some instances the severity of the condition will mean support group criteria are met.

Clinical Examination

Mental state examination should cover all the usual aspects including:

- Appearance (looking for any signs of self neglect)
- Speech
- Behaviour
- Orientation
- Affect
- Mood
- Cognitive function
- Abnormal thoughts
- Abnormal perceptions
- Signs of addiction
- Insight (judgement may be impaired)

Mood-This is a pervasive and sustained emotion.
Affect-This differs from mood in that it is much less sustained, often varying in the short term.

Sources – British National Formulary, Oxford Textbook of Psychiatry (online version), Oxford Handbook of Psychiatry (2005), CCM, Atos Healthcare EBM protocol on Bipolar Disorder.

Migraine – Information from Searchable Repository

Overview

Episodic headache, which may be accompanied by other symptoms. The pattern in terms of severity and frequency is variable.
Basilar-type migraine is a rare subtype of migraine with aura. An important feature of this type of migraine is that impaired consciousness or coma has been reported.

Care Needs

Care needs will not arise from this condition.

Mobility Considerations

There will be no impact on the ability to walk.

Prognosis

It is not a life threatening condition or associated with serious illness.

Signs and Symptoms

Migraine without aura

Common symptoms include:

- Unilateral headache of pulsating quality
- Nausea and/or vomiting
- Photophobia

Pain from the headache is usually moderate to severe in intensity.

Basilar-type migraine with aura

The aura will include at least two of the following symptoms. These are fully reversible. Basilar-type migraine is uncommon. The possible aura symptoms are:

- Dysarthria
- Vertigo
- Tinnitus

- Hypacusia
- Diplopia
- Ataxia
- Reduced level of consciousness
- Bilateral visual symptoms
- Bilateral paraesthesias

Motor weakness is **not** a feature of this variant of migraine.

Treatment/ Investigation

Can be very effective, and likely to include medication and advice on lifestyle adjustments.

Anti-migraine drugs
Simple analgesics
Analgesic with anti-emetic
5HT1 agonist (such as sumatriptan)
Prophylactic drugs (such as pizotifen)

Sources – British National Formulary, Oxford Handbook of Clinical Medicine (2007), International Headache Classification (ICHD-2)

Irritable Bowel Syndrome – Information from Searchable Repository

Overview

Irritable Bowel Syndrome (IBS) is a chronic non-inflammatory condition. It is characterised by abdominal pain, bloating and altered bowel habit. It affects one fifth of the UK population (to some degree) and is more common in women than in men. The cause of IBS is not known and it is not associated with any structural or biochemical disorders. Overactivity of the bowel, intolerance of specific foods or infection may result in symptoms of IBS.
It is often associated with psychosocial factors such as anxiety, depression and stress, and also features as one of the conditions often seen in association with chronic fatigue syndrome (CFS).

Unfortunately it is sometimes referred to by the misnomer of "Irritable Bowel Disease" and abbreviated to IBD, causing confusion with the far more serious inflammatory bowel conditions.

Care Needs

It is not a serious or debilitating illness, and does not give rise to care needs, except perhaps when present alongside other conditions. IBS would not normally affect a person's ability to carry out day to day self care tasks.

Mobility Considerations

It would not be expected to make any significant contribution to mobility needs.

Prognosis

IBS is a chronic condition which does not lead to bowel cancer or any other intestinal disorders. It occurs periodically with relapsing and remitting symptoms. Clients may have long periods without any symptoms and for the minority, symptoms will resolve indefinitely.

Signs and Symptoms

Symptoms include:

- Abdominal pain and discomfort
- Abdominal bloating
- Altered bowel habit, diarrhoea and constipation

- Nausea
- Poor appetite
- Lethargy

Abdominal tenderness is common. For some, symptoms are triggered by certain foods and generally abdominal pain is linked to constipation.

Treatment/ Investigation

Investigations may be performed to exclude organic bowel disease if symptoms are atypical or appear in those over the age of 45 years. Rectal examination, sigmoidoscopy, colonoscopy and barium enema may be performed in this instance.

Treatment
There is no specific treatment or cure for this condition. Management of the condition is focused upon alleviation of symptoms:

- Loperamide to treat diarrhoea
- Laxatives
- Antispasmodics e.g. mebeverine
- Soluble fibre supplementation may improve constipation
- Tricyclic antidepressants can be beneficial if pain and diarrhoea are the main symptoms
- Cognitive behavioural therapy may reduce symptoms in the short term
- Avoidance of certain foods to which there may be intolerance

WFHRA Key Areas To Explore

Those with IBS are normally able to be in full time employment.

- Self help techniques can be adopted to manage symptoms
- Physical activity can aid digestion and reduce stress, which in turn relieves symptoms

Exam Key areas to Explore – ESA

Although the client may have an altered bowel habit or urgency, continence is not normally affected.
Consider the mental function assessment as anxiety is commonly associated with IBS.

Clinical Examination

Physical examination is often normal. There may be abdominal tenderness. The client may appear anxious and tense.

Sources – Oxford Textbook of Medicine (online version), CCM.

Asthma – Information from Searchable Repository

Overview

Asthma is characterised by reversible airflow limitation, airway hyper responsiveness and inflammation of the bronchi. Most cases are **atopic** as asthma symptoms are largely caused by exposure to certain stimuli, such as tobacco smoke, grass pollen, house - dust mites, occupational pollutants and respiratory viral infections.

It is a common condition affecting people of all ages. The condition is variable and there are a range of patterns possible.
Both the frequency and duration of attacks can vary widely. **Chronic Asthma** is defined as asthma requiring maintenance treatment, whereas **acute asthma** is an exacerbation of asthmatic symptoms over a number of hours or days requiring urgent treatment.

Brittle asthma
This refers to those who are prone to very severe exacerbations of sudden onset (requiring hospitalisation) or to those who have a variable Peak Flow which fluctuates greatly over a 24 hour period.

Care Needs

Most people with asthma will be able to live independently and lead a normal life.
Exacerbations may necessitate additional treatment, but it is usual for this to be both self-administered and quickly effective.
Even where other conditions affect the ability to self-administer medication (regular or emergency) any help needed is unlikely to be required frequently or for a sustained period of time.
A few individuals may have severe and constant symptoms affecting their ability to cope with daily or self-care tasks.

Mobility Considerations

In general asthma will not usually give rise to significant mobility problems.
Walking ability may be severely restricted during severe acute exacerbations, but this is likely to be for short periods only.
A few individuals may have severe and constant symptoms affecting their walking ability.

Prognosis

Asthma is a chronic condition. It can affect individuals for many years without adversely affecting overall respiratory function.
Severe cases with significant ongoing disability are rare.
Those with brittle asthma may have life-threatening exacerbations needing urgent measures such as artificial ventilation.

Signs and Symptoms

Symptoms include cough, wheeze, breathlessness and chest tightness. These symptoms are usually episodic in nature, worse at night and provoked by triggers such as exercise. Many individuals are largely symptom free for much of the time and have one or two attacks per year, others may have chronic symptoms.

One useful indicator of severity is frequency of emergency treatment or admission to hospital.

Treatment/ Investigation

Initially **non-pharmacological** treatment methods can be adopted to facilitate the management of asthma e.g. avoidance of allergens and pollutants, dietary modification and breathing exercises. Immunotherapy has been found to be beneficial (during trials) in reducing asthma symptoms, however it is not as yet a recommended treatment.

The **pharmacological** treatments available are usually very effective at controlling symptoms, alongside education, self management plans and regular checks of inhaler technique. There are a range of drugs which can be prescribed to prevent attacks and relieve symptoms which can be administered using an inhaler device, nebuliser or orally.

The main medication groups are:

- Inhaled short-acting bronchodilators (beta-2 agonists) such as salbutamol and longer-acting beta-2 agonists such as salmeterol
- Inhaled steroids such as beclomethasone
- Leukotriene receptor antagonists such as montelukast
- Oral bronchodilators (Theophylline)
- Oral steroids (Prednisolone)

British Thoracic Society (BTS) Asthma Treatment Guidelines

Stepwise management in adults

Step 1 - Mild intermittent asthma

- Inhaled short-acting beta-2 agonists
- Inhaled ipratropium bromide
- Beta-2 agonist tablets or syrups
- Theophyllines

Step 2 - Regular Preventer Therapy

- Add inhaled steroids - starting dose 400mcg per day.

Step 3 - Add on therapy

- Add inhaled long-acting beta-2 agonist (LABA)
- If the response is poor inhaled steroids should be increased to 800 micrograms per day.
- If control remains inadequate, a trial of other therapies should be considered e.g. leukotriene receptor antagonists, theophyllines and slow release beta-2 agonist tablets.

Step 4 - Persistent poor control

- Inhaled steroids can be increased to 2000 micrograms per day
- Addition of fourth drug (e.g. leukotriene receptor antagonist, slow release theophyllines, beta-2 agonist tablets)

Step 5 - Continuous or frequent use of oral steroids

- Use daily steroid tablet in lowest possible dose to achieve adequate control.
- Inhaled steroids are the most effective drug for decreasing the need for long term oral steroids, therefore high doses of inhaled steroids (2000 micrograms per day) should be prescribed.
- Consider other treatments to minimise the use of steroid tablets
- Immunosuppressants may be prescribed once other treatments have proven unsuccessful. The client would be under specialist care to receive such treatment
- Continuous terbutaline subcutaneous infusions can be administered in cases of severe asthma.

Investigations

Peak flow measurements
Asthma produces a decrease in peak expiratory flow (PEFR) and forced expiratory volume (FEV1). These measurements may fluctuate given the

variability of the disease and may be normal if measured between episodes of bronchospasm. They are most useful when looked at as serial readings and can convey effectiveness of different therapies.

A significant drop in an individual's peak flow reading may be used as an indicator for the need for additional treatment of an exacerbation.

Lung function tests
The measurement of PEFR and FEV1 post inhaled bronchodilator demonstrates reversibility.

Chest x ray
Performed at diagnosis and in cases where a client presents with atypical symptoms.

Aspergillus antibody titres
Serum Immunoglobulin E (IgE) should be measured in cases where there is transient shadowing on x ray or with a marked blood eosinophilia.

WFHRA Key Areas To Explore

On resuming work:

- Reduced exercise tolerance may preclude heavy, manual work
- Avoidance of occupational pollutants e.g. dusts and chemicals will be necessary, and this may prevent the return to a previous occupation
- Self management education plan

For occupational asthma, BTS guidelines stipulate that relocation away from exposure should occur as soon as the diagnosis is confirmed. Ideally this should occur within 12 months of the intitial onset of work related symptoms.

Exam Key areas to Explore – ESA

Cough, breathlessness, wheeze and chest tightness are the commonest symptoms.

Consider the client's likely level of exercise tolerance from information in the history and typical day. Consider whether this is consistent with the level of medication and also the level of clinical input. Consider how often the client experiences an exacerbation of symptoms and how often they require emergency treatment or hospital admission.

Consider support group status for those with acute severe and brittle disease on maximal therapy.

Clinical Examination

On physical examination there may be no abnormalities detected. If examined during an exacerbation the client will have an expiratory wheeze and reduced chest expansion. Those with chronic asthma may have signs of hyperinflation with or without wheeze. Measure the client's expiratory peak flow, using an EU Peak flow meter, this will detect the degree of airflow limitation but is only a reflection of their condition on the day of examination. The peak flow measurement should be performed three times, recording the highest reading. Ensure the correct technique is used as poor technique will result in an inaccurate reading. The measurement must be considered alongside all other evidence. The normal values vary depending on the age, height and sex of the client.

Sources – British National Formulary, Oxford Textbook of Medicine (online version), CCM, Atos Healthcare EBM protocol on Asthma, www.brit-thoracic.org.uk

CFS/ ME – Information from Searchable Repository

Overview

Chronic Fatigue Syndrome has been recognised as a disease entity for centuries and was initially diagnosed as neurasthenia, a diagnosis which is no longer used. It is an idiopathic syndrome characterised by fatigue after minimal exertion. There are several biological and psychological features thought to precipitate and perpetuate the condition:

- Infection
- Immune abnormalities
- Endocrine dysfunction
- Psychological and behavioural factors
- Sleep disorders
- Inactivity
- Social factors

The cause remains poorly understood despite much research. Epstein-Barr virus, Q fever and viral meningitis are associated with an increased risk of developing CFS, however many people have no evidence of viral infection.
It is more common in women than men and usually presents in the 25 - 50 year age range but can affect younger people, and rarely children.
The usual ability to engage in occupational, social and daily activities is reduced from the normal level. The condition may also restrict the normal ability to be able to repeat a daily task more than once or so, without undue fatigue resulting, either at the time or more usually shortly after.

The pattern of illness may be one of relapse and remission, or unremitting symptoms. There is also a frequent association with other syndromes such as migraine, irritable bowel syndrome, atypical facial pain and fibromyalgia.

Care Needs

Day to day symptoms can vary widely in an individual. The usual pattern of variability (and severity of features) will help establish an individual's ability to self care.
The majority will be able to complete tasks independently, but at a slower pace than usual. In rare cases prolonged immobility may give rise to deconditioning or disuse atrophy.
Severe cases may be bed or wheelchair bound and unable to self care independently.

Mobility Considerations

Inability to walk is not usually a feature. Walking pace may be reduced. Walking ability may be affected by fatigue, altered balance, muscle symptoms or psychological state. In most cases walking ability will not be severely affected.

Prognosis

Those who remain under GP care have a good prognosis and full functional recovery can be achieved. In mild cases recovery can take 6 - 12 months, whereas those with severe symptoms may be symptomatic for years.

Poor prognostic features include

- No clear precipitating factor
- Duration of more than 4 years, along with severe and unremitting symptoms
- Adverse social and psychological factors
- Delayed diagnosis (or self belief in single cause)
- Rigid or unrealistic management regime
- Older age group
- Anxiety and depression
- Under care of specialist clinics.

Signs and Symptoms

Both physical and mental functioning can be affected.

Main Symptoms include:

- Physical and mental fatigue
- Post-exertional fatigue
- Muscle pains
- Altered balance
- Sleep disturbance
- Reduced concentration
- Headaches
- Altered mood

Symptoms are predominantly subjective.

Typically there are no physical signs, however in rare cases, there may be evidence of muscle wasting or deconditioning due to prolonged periods of inactivity.

Treatment/ Investigation
There are no specific clinical or laboratory tests available for diagnostic purposes.
Diagnosis relies on the overall clinical picture and exclusion of other conditions.

Fukuda criteria
These diagnostic criteria are widely used and include two components.
Presence of fatigue lasting 6 months or longer **and** 4 or more of the following:

- Impaired memory or concentration
- Sore throat
- Tender cervical or axillary lymph glands
- Muscle pain
- Multi-joint pain
- New headaches
- Unrefreshing sleep
- Post-exertion malaise

Treatment
There is no specific drug treatment. An approach that takes all factors into account works best. Advice on appropriate pacing of physical activity is needed. Anti-depressants may help both physical symptoms and depression. Cognitive behavioural therapy has been found to be more effective than convential management. Rehabilitation services are also effective in aiding recovery.

WFHRA Key Areas To Explore

On resuming work:

- May need a phased return to work or shorter hours, for example, to avoid rush hour travel
- Define the period over which hours will be gradually increased
- Supervised and gradually increasing physical activity has been found to be effective
- Recent NICE guidelines suggest that cognitive behavioural therapy is most beneficial for CFS

Exam Key areas to Explore – ESA

The commonest symptom is an abnormal level of fatigue post exertion which is persistent and associated with impaired function.

Consider the client's likely level of exercise tolerance from information in the history and typical day. Consider whether this is consistent with the level of medication and also the level of clinical input.

Anxiety, depression and impaired cognition are common features of CFS therefore the **mental function assessment should be applied** in the majority of cases.

Clinical Examination

There are usually no abnormal clinical signs on physical examination. Prolonged immobility or inactivity may give rise to muscle deconditioning or wasting.

Sources – Oxford Textbook of Medicine (online version), CCM, Atos Healthcare EBM protocol on CFS and Fibromyalgia.

Narcolepsy (Sleep Apnoea section) – Information from Searchable Repository

Overview

Obstructive sleep apnoea-hypopnoea syndrome (OSAHS) (also known as Pickwickian syndrome) is a sleep disorder in which a person has irregular breathing at night and is excessively sleepy during the day. Overweight middle-aged men are the most commonly affected group, with individuals affected often having an average obesity index over 30kg/m2. An enlarged neck circumference is also a common associated feature.
In sleep apnoea, the upper airway (pharynx) collapses repeatedly, at irregular intervals during sleep. Apnoea is when the airway collapses and is blocked completely and hypopnoea is when the collapse is partial.
The apnoea/hypopnoea index (AHI) is the number of times per hour that apnoea occurs, this is also known as the respiratory disturbance index (RDI).

Sleep apnoea is categorised as:

- Mild - with an AHI of 5 to 14 in an hour.
- Moderate - with an AHI between 15 and 30.
- Severe - if he AHI is more than 30.

Excess daytime sleepiness can occur whilst not in bed and the Epworth Sleepiness Scale (ESS) is used to measure how likely a person is to fall asleep in various situations. There is an increased risk of falling asleep in monotonous situations when the sensory stimulation is low and an increased risk of road traffic accidents has also been reported.
Although sleep apnoea can cause excess daytime sleepiness, this can also be caused by conditions such as depression, **narcolepsy**, drugs, lack of sleep due to shift work/inadequate time in bed etc.

An increased risk of heart disease and stroke is also associated and there may also be evidence of Type II respiratory failure if the individual affected also has COPD.
Alcohol and sedatives predispose to snoring and apnoea.

Eczema (Skin Problem section)– Information from Searchable Repository

Overview

The skin is frequently affected by disease, whether as primary disease of the skin itself or as a secondary effect of other conditions. There are an enormous number of different skin diseases and their classification is complex but this is not important in this context as the effects of skin disease often follow similar patterns whatever the cause.

The severity of skin conditions varies enormously. At one extreme there may be nothing more than a small patch of redness on a finger resulting from a sensitivity to a particular metal in a ring. At the other extreme weeping blisters may cover an individual from head to foot, resulting in fluid loss to a degree which may be life threatening.

Some conditions resolve, never to return, when the cause is discovered and removed, as in the case of specific allergy, whilst others follow a relapsing course throughout life requiring long-term treatment.

Care Needs

Even when skin disease is widespread and severe, in the absence of complications an affected adult should, to a very large extent, be able to cope with any necessary treatment unaided. Local treatment of the skin itself may require the application of lotions, creams, ointments, sprays, powders, or dressings. Only when the disease affects areas of skin which the individual cannot reach or when the hands are affected is there likely to be a need for attention. Even then, this may be brief and confined to mornings and evenings only. There is unlikely to be a need to treat the skin condition during the night hours.

If skin disease is secondary to other conditions there may be additional problems that make treatment more difficult. There may also be secondary problems caused by the skin disease, or by general treatments, particularly when oral steroid preparations are used. Such additional problems may have an effect on the overall disability.

Mobility Considerations

Mobility needs may arise when the soles of the feet are badly affected, and in those rare instances where the lower limbs have to be extensively bandaged. In addition, some skin diseases, particularly psoriasis, may be associated with a widespread form of arthritis. Involvement of the joints of the lower limbs in such cases might well give rise to mobility needs.

Prognosis

By the time adult life is reached the skin disease may be long-standing and all available avenues of treatment may well have been explored. However, it is unusual for skin disease to be so serious that an adult is severely disabled by it for any length of time.

Eczema (Skin Problem in children section) – Information from Searchable Repository

Overview

Common skin conditions such as eczema and dermatitis affect children as well as adults.
As in adults severity can vary widely, but the majority of cases are not associated with significant problems.

One important difference with respect to management is that treatment cannot be self-administered by young children. Both topical and oral treatments will need to be applied or given by an adult.

More severe cases are likely to have been seen by a specialist at a dermatology clinic.

Care Needs

Severe and widespread skin conditions may mean more frequent bathing and nappy changing is necessary.
As well as application of topical treatments the hands may have to be bandaged to prevent the child scratching or pulling off dressings.

The amount of time needed for administering treatment will vary from case to case, but may be substantial if the affected areas are very widespread and frequent applications of treatment have been advised.

Although actual treatment of the skin condition during the night hours is unlikely to be necessary, itching may disturb sleep and give rise to a need for settling or comforting. Nappies may also need to be changed more frequently at night in order to protect the damaged skin.

Skin diseases do not give rise to any serious danger so there will be no need for additional supervision.

Mobility Considerations

In the vast majority of cases there will be no mobility needs.
Rarely, if the soles of the feet are badly affected or there is extensive lower limb bandaging walking ability may be reduced for a short period (unlikely to be more than a few weeks).

Prognosis

Skin conditions in children often respond well to treatment, and may also improve spontaneously as they get older.
By the age of about 12 years a child is likely to be able to cope independently with their skin treatment.

Signs and Symptoms

A rash of some form is the usual mode of presentation. Itching can be a particular problem for children and can both aggravate the condition through scratching and cause sleep disturbance.

Treatment/ Investigation

Management will include avoidance of factors that have contributed to onset or aggravation of the condition.
More potent preparations such as topical steroids will be prescribed for the shortest possible period, and in the weakest effective strength.
Soothing or hydrating emollient preparations are beneficial long-term, even when the acute condition has settled.

Topical preparations are usually applied up to 3 or 4 times daily.
Severe or widespread conditions may need wet dressings. This treatment would usually require hospital admission, though localised areas might be treated at home for a few days with this method.

Sources – Oxford Textbook of Medicine (online version), CCM.