Last modified at 14/06/2018 11:31 by [redacted]

Page Rating ☆☆☆☆☆ |0

Categories
No categories were selected

Scheduled and non-scheduled conditions

Ankyloses in optimum positions

In assessing the incapacity resulting from the complete fixation of joints, consideration should be given to the position in which the joint is fixed. These are the usually accepted optimum positions for ankylosed joints:

1	Shoulder	Arm abducted to about 20 degrees with the elbow slightly in front of the body and with free movement of the shoulder girdle
2	Elbow	The angle between humerus and forearm should be rather more than a right angle, at about 110 degrees. The forearm should be supinated, so that the palm is slightly upwards
3	Wrist	In the neutral position, i.e. in line with the forearm and with slight or no loss of pronation or supination
4	Hip	Thigh flexed 10 degrees with a slight abduction and slight external rotation
5	Knee	In 5 degrees of flexion
6	Ankle	5-10 degrees plantar flexion of the foot

The table below gives the type of assessment for ankyloses in the optimum position which has been given by UK Medical Appeal Tribunals. It is, however, for the medical board to determine, in accordance with the statutory provisions, the appropriate assessment in the circumstances of the individual customer.

Area	Per cent
Shoulder	40
Elbow	40
Wrist	30
Hip	60
Knee	30
Ankle	20

Last modified at 26/01/2016 11:04 by [redacted]

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Categories

No categories were selected

Scheduled and non-scheduled conditions

Assessment for conditions affecting the eyes

It is important that the medical board record the visual findings for both eyes showing visual acuity figures both before and after correction.

Should the customer attend for examination without spectacles which are normally worn or have been prescribed, the medical board has discretion either to adjourn or to decide the assessment on the balance of probability, after considering the customer's statement on the efficacy of any spectacles and their own clinical findings.

Visual impairment

Blindness, the loss of one eye and the loss of vision in one eye are conditions covered by the prescribed degrees of incapacity.

Otherwise, the affects of diminished;

- visual acuity: central vision, the vision you use to see detail
- visual field: how much you can see around the edge of your vision, while looking straight ahead.

are assessed as follows.

Visual acuity

This is customarily assessed using the Snellen Scale and comparing the finding to the table reproduced on the following page to determine the resulting percentage loss of faculty.

This table is customarily used by medical boards and Medical Appeal Tribunals to assess corrected visual acuity.

	6/6	**5/6**	**6/9**	**5/9**	**6/12**	**6/18**	**6/24**	**6/36**	**6/60**	**4/60**	**3/60**	**NPL**
6/6	0	0	2	3	4	6	9	12	20	23	25	30
5/6	0	0	3	4	5	7	10	14	22	24	26	32
6/9	2	3	4	5	6	8	12	16	24	26	28	34
5/9	3	4	5	6	7	10	14	19	26	29	32	37
6/12	4	5	6	7	8	12	17	22	28	32	36	41
6/18	6	7	8	10	12	16	20	25	31	35	40	45
6/24	9	10	12	14	17	20	25	33	42	47	52	57
6/36	12	14	16	19	22	25	33	47	60	67	75	80
6/60	20	22	24	26	28	31	42	60	80	85	90	95
4/60	23	24	26	29	32	35	47	67	85	92	95	97
3/60	25	26	28	32	36	40	52	75	90	95	100	100
NPL	30	32	34	37	41	45	57	80	95	97	100	100

Note 1: NPL = No perception of light

Note 2: These assessments are for defective vision without special features and are based on the visual defect as measured, after correction with glasses.

Visual acuity is measured using the 'Snellen scale'. A Snellen test usually consists of a number of rows of letters which get smaller as they are read down the chart.

On the Snellen scale, normal visual acuity is called 6 / 6, which corresponds to the bottom or second bottom line of the chart. If a person can only read the top line of the chart then this would be written as 6 / 60. This means they can see at 6 metres what someone with standard vision could see from 60 metres away.

The figures 6 / 60 or 3 / 60 are how the result of a Snellen test are written. The first number given is the distance in metres from the chart the person sits when they read it.

Usually this is a 6 (for 6 metres) but would be 3 if they were to sit closer to the chart, i.e. 3 metres away.

The second number corresponds to the number of lines that the person is able to read on the chart. The biggest letters, on the top line, correspond to 60. As they read down the chart, the numbers that correspond to the lines get smaller, i.e. 36, 18, 12, 9 and 6. The bottom line of the chart corresponds to the number 6. Someone with standard vision who can read to the bottom of the chart would have vision of 6 / 6.

See Example 4.

Sometimes visual acuity is recorded in other notations e.g. logMAR or cycles per degree. These other notations can (with care) be converted to a Snellen fraction for comparison.

If acuity has been recorded using logMAR or cycles per degree the tables below can be used to approximate the Snellen fraction. Also available in the tables is a conversion from metric (UK standard) to Imperial (US standard) recording.

Note: tests which use logMARf or cycles per degree to record acuity may not be measuring the same type of visual acuity as a Snellenormat change test and conversions must be treated with caution.

Snellen equivalent	LogMAR	Cycles per degree (cpd)
6/12 (20/40)	0.3	15.0
6/18 (20/60)	0.5	10.0
6/24 (20/80)	0.6	7.5
6/36 (20/120)	0.8	5.0
6/48 (20/160)	0.9	3.75
6/60 (10/200)	1.0	3.0
6/72 (10/240)	1.1	2.5
6/90 (20/300)	1.2	2.0
6/120 (20/400)	1.3	1.5
6/150 (20/500)	1.4	1.2
6/180 (20/600)	1.5	1.0
6/240 (20/800)	1.6	0.75
6/360 (20/1200)	1.8	0.50
6/480 (20/1600)	1.9	0.28

Measurement

Visual acuity is typically measured monocularly rather than binocularly with the aid of an optotype chart for distant vision, an optotype chart for near vision, and an occluder to cover the eye not being tested.

The medical board may also occlude an eye by sliding a tissue behind the patient's eyeglasses, or instructing the patient to use his or her hand. This latter method is typically avoided in professional settings as it may inadvertently allow the patient to peek through his or her fingers, or press the eye and alter the measurement when that eye is evaluated.

1. Place the chart at 6 meters and illuminate to 480 lux at that distance.
2. If the patient uses glasses, then the test is performed using them. If they do not have their glasses with them then the test using a pinhole should be done.
3. Place the occluder in front of the eye that is not being evaluated. The first evaluated eye is the one that is believed to see less or the one the patient says that is seeing less.
4. Start first with the big optotypes and proceed to the smaller ones. The patient has to identify everyone on the line being presented and communicate it to the medical board doctor.
5. If the measurement is reduced (below 20/20) then the test using a pinhole should be done and register the visual acuity using the pinhole. Both measures should be registered, with and without using pinhole.
6. Change the occluder to the other eye and proceed again from the 4th step.
7. After both eyes have been evaluated in distant visual acuity, proceed to evaluate near visual acuity using a near vision chart at normal reading distance.

In some cases, binocular visual acuity will be measured, because usually binocular visual acuity is slightly better than monocular visual acuity.

Visual field

The normal horizontal visual field using both eyes is 170 degrees. Restriction in this is called tunnel vision. Possible causes of tunnel vision include:

- glaucoma

- some types of optic atrophy, e.g. tabes dorsalis
-
- a
- retinal abnormalities, e.g. retinitis pigmentosa, choroido-retinitis
- acute ischaemia, e.g. migraine
- bilateral lesions of the anterior calcarine cortex
- laser photocoagulation for diabetic retinopathy

For the purposes of driving a private vehicle a field of 120 degrees is required so restriction to this degree would only attract a small percentage (2 to 5%). However those with severe tunnel vision restricted to around 20 degrees would attract an assessment of around 60 to 80%. These should be added to any assessment for decreased visual acuity.

Specific visual field defects

In homonymous hemianopia - literally, a loss of vision on the same side in both eyes - the field loss is usually the result of a lesion in the optic radiation or tract on one side. The visual defect is dependent on the site of the lesion:

- right-hand sided lesions lead to left temporal and right nasal field loss
- left-hand sided lesions lead to right temporal and left nasal field loss
- Macular vision is usually lost in lesions arising in the optic tract; it is usually spared in lesions arising in the more posterior optic radiation.
- Causes of homonymous hemianopia include vascular disease, head injury or cerebral tumours.
- Bitemporal hemianopia is a loss of temporal field vision in both eyes. This may be caused by a lesion that affects the centre of the optic chiasm and damages fibres from the nasal halves of the retina as they decu
- ssate.

Possible causes of this condition include:

- pituitary tumour
- craniopharyngioma
- suprasellar meningioma

Homonymous quadrantanopia describes the loss of the same quadrant of the visual field in both eyes. An example might be a "left homonymous upper quadrantanopia" suggestive of a lesion in the right temporal lobe.

There are

two types:

- Upper quadrant - Loss of vision in both upper temporal quadrants is suggestive of an early lesion at the optic chiasm
- .
- Lower quadrant - Loss of the same upper quadrant from each visual field. Usually caused by damage to the optic radiation as it passes through the parietal lobes.

An assessment of between 30 to 50% would be reasonable for these field defects. These are in addition to the assessment for the loss of visual acuity.

Aphakia

This is where a person has an absence of the internal lens to the eye which causes the eye to be severely out of focus.

Although an eye into which an artificial lens has been implanted is not, strictly speaking, aphakic, it must be remembered that accommodation is impossible. An assessment in the lower part of the range usually accepted for aphakia may be appropriate.

Medical Appeal Tribunals have normally taken account of the degree of tolerance and sensitivity to the wearing of a contact lens in assessing the degree of incapacity - see the table below.

Conditi	on	Per cent
Unilateral aphakia with reasonable correction by a contact lens	15 - 24	
Bilateral aphakia with reasonable correction by contact lens(es)	25 - 30	

Last modified at 19/08/2014 12:26 by [redacted]

Scheduled and non-scheduled conditions

Assessment for loss of tissue

Splenectomy

The removal of the spleen lowers natural resistance to certain infections in addition to loss of tissue. UK Medical Appeals Tribunals, having taken these factors into account, have usually assessed the ensuing degree of incapacity at between two per cent and five per cent.

Orchidectomy

The removal of a testis involves both tissue loss and a loss of reserve useful function which constitutes a small permanent loss of faculty. Medical Appeals Tribunals have assessed the degree of incapacity resulting from a single orchidectomy at between two per cent and five per cent.

Nephrectomy

The Commissioner held in decision R(I) 14/66 that where a person loses a kidney then as a matter of law it must necessarily mean that there is a loss of faculty. The extent of incapacity is for the medical authorities to determine, having regard to the loss of reserve useful function. Where the other kidney is functioning normally, Medical Appeals Tribunals have usually assessed the degree of incapacity at between five per cent and ten per cent.

Appendicectomy

The incapacity resulting from uncomplicated appendicectomy has usually been assessed by Tribunals at less than 1 per cent.

Last modified at 19/08/2014 13:49 by [redacted]

Page Rating ☆☆☆☆☆ |0

Categories
No categories were selected

Medical assessment

Completing the Medical Board report form

It is important when writing medical board reports (currently the S305 report) to bear in mind who will be the recipients. The report will always be seen by a lay determining officer and may also be read by members of a Medical Appeal Tribunal and the claimant and their representative.

Legibility is of paramount importance. A report which is difficult or impossible to read may be valueless to the determining officer.

You should also remember that determining officers are not medically qualified, and your report must be clear enough for them and other non-medical readers.

The report must provide an objective and fair assessment of the claimant's disabilities and relevant loss of faculty. Your conclusions must be supported by appropriate medical evidence.

Without a clear, consistent and well-presented report, the determining officer may find it difficult to explain the medical board decision and award to the claimant. Equally a Medical Appeal Tribunal may have difficulty understanding the reasons for the award given. The requirement is for a report which is:

- Legible
- Consistent and without contradictions
- Is clear, concise, relevant and positive
- Contains sufficient detail to justify the conclusions reached
- Explains why the medical opinion may in some circumstances differ from the claimant's own view of their disability
- Avoids unnecessary medical terminology
- In keeping with a consensus of medical opinion.

Doctors will develop their own style in completing the report. However, the following general guidance is based on practical experience. That part of the report relating to diagnosis, medication, treatment and clinical history can be completed while interviewing the claimant.

This is particularly important when seeing a claimant with one of the medical conditions covered in Appendices 5 onwards that require an additional report to be completed as part of the assessment process.

The remainder should be completed when the claimant has left.

Medical terminology

The use of medical terminology should be avoided. When there is no alternative to the use of a medical expression, it should be clearly explained. For example, "Aortic stenosis (a defective heart valve)".

Some terms have passed into general use, and will be generally understood, such as angina, asthma, migraine, and schizophrenia. However, it is good practice to explain briefly the nature and effects of an unfamiliar condition.

Certain expressions should never be used, such as "Functional overlay". If you think that the disability is less than claimed, you must say so explicitly, supporting your opinion by the medical evidence.

Abbreviations

Do not use technical abbreviations in your reports, such as "LBP"; "IHD". However, abbreviations in common usage are acceptable, for example "etc". and "e.g.". "R" and "L" may be used for right and left, so long as the meaning is clear from the context. If you need to use a medical term frequently, you can abbreviate it once it has been first explained and defined. For example, Non-insulin Dependent Diabetes Mellitus (NIDDM) can then be referred to as NIDDM in the rest of the report.

Harmful Information

This is information which has not been disclosed to the claimant by their medical attendant and of which they are unaware. It is information which would be considered as seriously harmful to their health if divulged to them and is the only type of information which may be withheld from the claimant in the event of a review or appeal.

Examples are details of:

- Malignancy

- Progressive neurological conditions
- Major mental illness.

Try to avoid writing Harmful Information in your reports. If, however, it is unavoidable, it should be entered on a separate page to the report headed Harmful Information with the name of the person and the date of the report to which they refer.

So you should write down the harmful information clearly identifying it as such and, if omitting an entry from the body of the report would leave a gap, write a "harmless synonym" at the relevant place. For example:

On the report:

> "*Bronchial trouble and persistent headache*".

On the harmful information page:

> "*HARMFUL INFORMATION*
>
> *True Diagnosis: Bronchial carcinoma with cerebral metastases.*"

Embarrassing Information

This is information which could not be considered harmful to the claimant's health, but which may well upset or anger them and embarrass you and the Department. If recorded in a report such information may not be withheld from the claimant.

Examples of this type of sensitive information include:

- Criticism of treatment given elsewhere
- Suspicion of malingering which you cannot substantiate
- Reference to any conviction

Last modified at 31/03/2015 13:03 by [redacted]

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Categories
No categories were selected

Scheduled and non-scheduled conditions

Deafness

The medical board doctor should assess hearing loss clinically with the person using hearing aids if normally worn. Absolute deafness is covered by the prescribed degrees of incapacity.

If there is conflicting evidence on the degree of deafness, then it is advisable that the medical board should state the reason for its preference of that on which its assessment is based.

Standing 5 metres behind the person they should talk in a normal voice and ask whether the person can hear. If not move to 2 metre and repeat the test. If still cannot hear go to 30 cm and repeat the test. If still not able to hear shout at 1 metre.

It is important that the test is in keeping with the informal observations of the claimant's hearing.

Degree of hearing attained with both ears used together with average assessments for the degree of deafness which have been given by UK Medical Appeal Tribunals(figures in percentages):

Test	Per cent
Shout not beyond 1 metre	80
Conversational voice not over 30 centimetres	60
Conversational voice not over 1 metres	40
Conversational voice not over 2 metres	20
Conversational voice not over 5 metre	10
Otherwise	0

Notes on the assessment of deafness

> Where the hearing in one ear is normal and there is significant deafness in the other ear the shout test as described above will show normal hearing and on this basis there is no loss of faculty. However the person may have difficulty detecting the direction of a shout so an assessment of around 5% would be appropriate.
>
> The assessments given above apply to deafness only. Any additional features such as vertigo, tinnitus or chronic suppuration may warrant an addition to the assessment. When such additions are made, the reasons should be made clear in the report.

Last modified at 19/08/2014 12:24 by [redacted]

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Categories
No categories were selected

Scheduled and non-scheduled conditions

Disfigurement

In assessing conditions of the face and scalp the factor of disfigurement is important.

Last modified at 19/08/2014 13:49 by [redacted]

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Categories
No categories were selected

Medical assessment

Examining the claimant

Before the examination

You should seek the claimant's express permission before proceeding to carry out any physical examination that you deem to be necessary. It is vitally important that all doctors should understand that they must not assume consent.

Explicit consent to the examination and its different parts must be obtained verbally from the claimant, and the fact that this has been done should be noted in the report.
A suitable form of words would be along the lines of, "The details of the physical examination were explained to the claimant, who gave consent for the process to proceed."

However if a claimant refuses consent or for any other reason an examination is not possible this must be fully recorded in the report.

The precise extent and nature of the examination will depend entirely on the circumstances of each individual case. You must use your medical professional judgement to decide what examination is indicated, and also whether the claimant should be asked to remove any clothing in order to complete this assessment effectively. Full general examinations are inappropriate in the LTIA assessment and should be avoided.

A further important thing to remember when recording your clinical examination findings is to interpret them by explaining in plain English the significance of the findings, e.g. "Forward flexion of L shoulder restricted to 90 degrees (about half the normal range) and this means that the claimant cannot reach upwards above shoulder level with the L arm."

Conclusion of the examination

After the interview and examination, the claimant should be invited to ask any questions regarding the procedure. It is appropriate to advise that the social security department will be in touch with the claimant as soon as possible but a specific period of time in which this will happen should not be given. No indication should be given of the likely outcome of the claim.

Questions regarding their treatment should be politely evaded. Most claimants will understand if they are told that without the results of tests, X-rays, etc., it would be impossible to venture an opinion on treatment or management and they should be advised to consult their GP on any medical issue. No criticism of the claimant's medical management, overt or implied, should ever be made.

Do not enter into discussions about entitlement to other benefits. If questions about benefits arise during the assessment, then at the end of the assessment, either take the claimant to the appropriate zone where further information can be provided or contact the Health zone who will send an officer to assist the claimant.

Do not enter into any debate about the details of the assessment or respond to criticisms of the administrative process.

If, during examination, a condition is identified which may be unknown to the claimant or his medical adviser, the GP should be notified. This process has ethical implications and requires a fuller outline which is given below.

Dealing with unexpected findings at the examination

Situations arise when doctors carrying out disability assessments may come across information that they feel should be reported to the claimant's General Practitioner. The procedures for the release of unexpected findings to a claimant's General Practitioner is as follows:

GMC Guidelines have made it clear that doctors who have contractual obligations to third parties should not pass on information to the claimant's GP without claimant consent for such action, unless there were exceptional circumstances. The GMC recommend that doctors make every effort to explain to patients why information should be passed on to those responsible for their medical care.

There may be rare occasions when despite the claimant's inability or refusal to give informed consent, the doctor may in his/her professional judgement pass on information about that individual.

This discretion must be exercised within the GMC guidelines, and doctors must be prepared to justify their decision to take such action. The types of circumstances when unauthorised disclosure by Medical Advisers would be justified include:

- when the release of that information is necessary to protect others from risk of death or serious harm;
- when the claimant requires urgent medical treatment, but cannot be contacted within a suitably rapid period of time.
- when the individual is not competent to give consent.

All doctors are strongly advised to read these guidance notes from the GMC. If any doctor does not have a copy then he/she should contact the GMC at 178 Great Portland St, London W1 W5JE (tel. 020 7580 7642)

When a Medical Adviser identifies a need to pass information about a claimant to the GP then he/she must provide a reasonable explanation to the individual. The discussion should deal with:

- the nature of the information to be passed to the GP
- the reasons for wanting to disclose this information and
- a request for consent to release of the information

The doctor should record relevant details of their discussion with the claimant and informed written consent from the claimant should be obtained. The GP should be contacted by telephone or in writing as appropriate.

Last modified at 14/06/2018 11:31 by [redacted]

Scheduled and non-scheduled conditions

Flail joints

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Categories
No categories were selected

Where there is abnormal mobility, the assessment given by Medical Appeal Tribunals for the lower limb has usually been at a higher rate than for the ankylosed joint.

Improved function may be achieved in both flail and partially ankylosed joints by skilled orthopaedic treatment, and the prospect of such treatment may affect the medical board's decision on the forward period of assessment.

Last modified at 16/05/2016 12:25 by [redacted]

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Categories
No categories were selected

Assessment guides

General guide to assessments

Assessment	Degree of loss of faculty
Less than 1%	Virtually no disablement
1 - 4%	Minimal disablement (loss of toe through metatarsal – phalangeal joint)
5 - 10%	Very mild disablement (loss of 2 phalanges middle finger)
11 - 20%	Mild (loss of index finger)
21 - 30%	Mild/moderate disablement (loss of vision in one eye)
31 - 50%	Moderate disablement (below knee amputation)
51 - 80%	Moderately severe (upper thigh amputation)
81% +	Severe disablement (loss of both hands)

Last modified at 18/05/2016 15:32 by [redacted]

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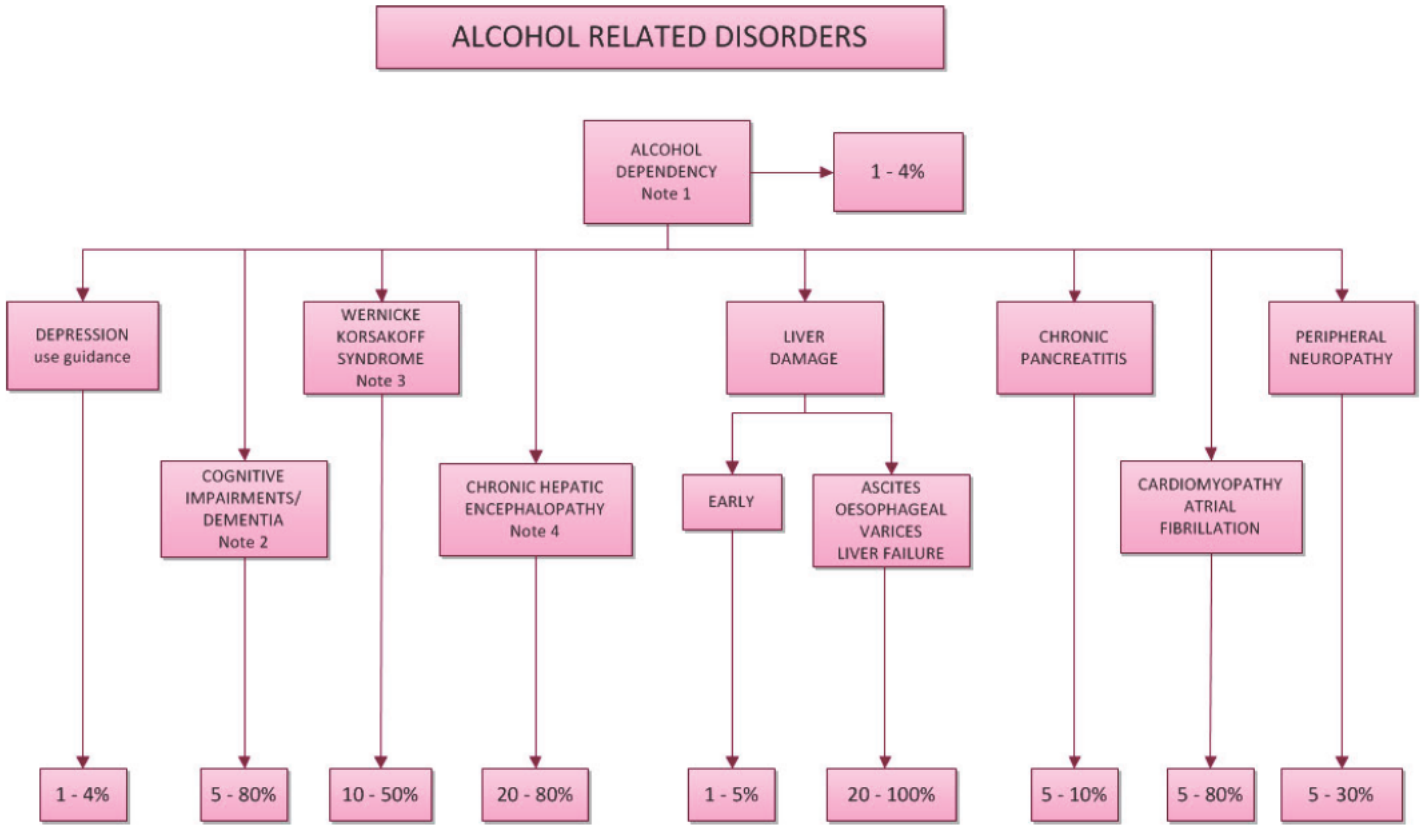
Categories
No categories were selected

Assessment guides

Guide to alcohol abuse assessments



Note 1 – Alcohol dependency

The symptoms of alcohol dependence include:

- Unable to keep a drink limit.
- Increased tolerance to alcohol. However, in the later stages of alcohol dependence, there may be a decreased tolerance to alcohol as a result of liver and central nervous system damage.
- Difficulty in getting drunk.
- Spending a considerable time drinking.
- Organising the day around drinking.
- Missing meals.

Note 2 - Cognitive impairment and dementia

- Damage to the brain occurs, especially the frontal lobe. This results in loss of memory, deterioration of personality and loss of intellectual ability. Interpersonal skills, attendance to usual interests and responsibilities may deteriorate and self-neglect may result.
- Depression caused by a direct effect of alcohol on the brain and exacerbated by social problems that include unemployment, divorce and debt. There is an increased incidence of deliberate self-harm. The suicide rate is increased six fold in people who are dependent upon alcohol.
- Anxiety. People often use alcohol to relieve symptoms of stress and anxiety. However, anxiety symptoms increase during periods of withdrawal, leading to a cycle of increased consumption.
- Psychosis. Alcoholic hallucinosis is a rare condition that is not due to alcohol withdrawal. Auditory hallucinations, often derogatory, develop in an otherwise clear consciousness. The condition usually lasts for a few days, but can persist after several months of abstinence.

Note 3 - Wernicke Korsakoff syndrome

- This is caused by vitamin B deficiency, which may persist after abstinence from alcohol and vitamin replacement.
- Wernicke's Disease results in unsteadiness, paralysis of eye movement and confusion.

- Korsakoff Syndrome resulting in severe amnesia for recent events with confabulation

Note 4 - Hepatic encephalopathy

- This can be acute or chronic.
- Acute - There is sudden onset of drowsiness and coma, usually with a precipitating cause [examples include constipation or infection].
- Chronic - There is disorder of personality, mood and intellect. The course may be fluctuating. The person is irritable, confused, disorientated and has slow slurred speech.

Last modified at 14/07/2016 09:30 by [redacted]

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Categories
No categories were selected

Assessment guides

Guide to back pain assessments

Disablement	Functional Restriction	Symptoms	Signs
Virtually none	Mild	Very mild occasional local discomfort	No objective clinical findings
Minimal (1-4%)	Mild	Mild local discomfort	Minimal objective clinical findings. On flexion fingertips reach to mid-shin or more. Full lateral flexion. Straight leg raising 40 degrees or more.
Very mild (5-10%)	Mild/Moderate	Moderate background local discomfort with some limitation of spinal movements.	Objective clinical findings present. On flexion fingertips reach to tibial tuberosity. Lateral flexion to with 4cm of popliteal crease. Straight leg raising 25 degrees – 40 degrees
Mild (11-20%)	Moderate	Moderate discomfort with intermittent exacerbations involving more acute pain.	On flexion fingertips reach upper patellar border. Lateral flexion to within 8cm of popliteal crease. Straight leg raising 10 degrees – 25 degrees. Muscle spasm may be present.
Mild/Moderate (21-30%)	Moderate/Severe	Severe discomfort with few remissions. Surgery may be under consideration. These cases tend to be rare and this level of severity short-lived.	On flexion fingertips fail to meet upper patellar border. Lateral flexion fails to reach popliteal crease by more than 8cm. SLR very restricted. Likelihood of significant neurosurgical signs in most cases. Marked muscle spasm often present.
Moderate (31-50%)	Severe	Severe discomfort with few remissions. May be incontinence and foot drop Surgery under consideration. These cases are rare and this level of severity short lived (unless permanent neurological damage).	On flexion fingertips fail to meet upper patellar border. Lateral flexion fails to reach popliteal crease by more than 8cm. SLR very restricted. Significant neurosurgical signs (including foot drop and incontinence). Marked muscle spasm often present.

Last modified at 18/05/2016 10:09 by [redacted]

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Categories
No categories were selected

Assessment guides

Guide to chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME) assessments

What is CFS/ME?

The term chronic fatigue syndrome (CFS) is used to describe an illness that is characterised by physical and mental fatigue and fatigability. A characteristic feature is fatigue/malaise that follows minimal exertion. People with CFS often describe the fatigue as being of a type and a scale beyond any other they have experienced. The illness may affect both physical and mental functioning, including cognitive function. Accompanying symptoms may include poor sleep, pain, poor concentration and memory, although this list is not exhaustive.

Chronic fatigue syndrome (CFS) is also known as myalgic encephalomyelitis (ME) and post-viral fatigue syndrome. There is some difference of opinion over whether ME is different from CFS; however, most authorities refer to the condition as CFS/ME.

The symptom of fatigue is a feeling that can sometimes be difficult to describe and to measure. It is a feeling of exceptional or abnormal tiredness or lack of energy in excess of that anticipated in response to current activity. Fatigability in CFS/ME is the overwhelming feeling of exceptional tiredness exacerbated by exertion. CFS/ME is identified by its symptoms and disabling effects, and by excluding other medical conditions that could explain them. There are no confirmatory abnormal findings on physical examination, nor is there any specific investigation such as an abnormal blood test that is diagnostic. This does not mean that CFS/ME is not a real illness, and all medical authorities now accept the illness as being a severe and valid condition.

A consensus definition of CFS/ME has been agreed by international experts for the purposes of research and includes the following:

- A complaint of persistent or relapsing fatigue for 6 months or more that is:
  - Of new or definite onset,
  - Not the result of ongoing exertion,
  - Not substantially alleviated by rest,
  - Results in a substantial reduction in previous levels of occupational, education and social or personal activities.
- Four or more of the following symptoms for 6 months or more:
  - Impaired short-term memory or concentration
  - Sore throat,
  - Tender lymph nodes (neck or armpits),
  - Muscle pain,
  - Pains in a number of joints (without arthritis),
  - New headache,
  - Un-refreshing sleep,
  - Malaise lasting more than 24 hours after exercise
- Other physical causes of fatigue such as anaemia, thyroid disease, sleep apnoea, malignancy, liver disease etc. are excluded.
- Major mental health disorders are excluded, although as with other chronic conditions, people with CFS/ME may have conditions such as depression and generalised anxiety disorder occurring at the same time.

A number of other medical conditions such as fibromyalgia, irritable bowel disease and migraine may also occur in people with CFS/ME. These have some symptoms in common with those described in CFS/ME.

It is estimated that around 1 in 200 of the UK population have CFS/ME. It is predominantly a disease of young adults (commonest incidence between 25 to 50 years) and occurs in all socio-economic groups. It appears to be more common in women [female: male 2:1 or 3:2].

Causes of CFS/ME

A specific cause of CFS/ME has not as yet been identified. Possible causes of the condition have been the subject of much debate. It is likely that the term CFS/ME describes a spectrum of disorders in which physical and mental functioning are affected. In some cases infectious illnesses like glandular fever may trigger the onset of the condition. There is no evidence however that persistent infection is responsible for the continuation of the illness. Although the cause is not fully understood, changes associated with CFS/ME may include an altered stress hormone response, altered immune response, altered gene expression, sleep problems, alterations of mood, and coping strategies. Different factors are likely to be important in different people at different times.

There has previously been much debate as to whether CFS/ME is a physical illness or not. Some researchers have put forward the argument that it is a purely psychological disorder, citing in evidence the high rate of co-morbid depression. Others are equally sure that it is purely physical, citing the abnormal hormonal tests found in some or the triggering of the illness by certain infections. Both views are oversimplifications. The reality is that the disability of CFS/ME involves both physical and mental incapacity.

Risk of developing and maintaining CFS/ME

Although the cause of CFS/ME is unclear, certain factors may be important in its development. These are usefully divided into predisposing, triggering and maintaining factors. Some people may be predisposed to the condition, for example because of their genetic makeup, or gender. For example the condition is commoner in young women.

An infectious disease such as glandular fever (infectious mononucleosis) or a major physical illness may trigger the condition. Other stressful life events or difficulties may precede development of CFS/ME, particularly if the stress is ongoing. Finally some other factors may help to keep the illness going. For example, poor sleep, poor nutritional uptake, or a concurrent mood disorder.

Clinical features

The main symptoms are persistent mental and physical fatigue, tiredness or exhaustion that are characteristically made worse by activity. People often do not sleep well and find that sleep fails to refresh them. Often they feel symptoms more after physical or mental activity, even minor exertion within the home environment, and this effect is characteristically delayed until the next day or so, and is prolonged. Muscles and joints ache and are painful. Headaches, sore throat and tender lymph glands in the neck and armpits are described. People with the condition also report short-term memory loss and poor concentration. Their mood may fluctuate and they may be prone to feelings of anxiety. Hypersensitivity to everyday levels of noise and light are reported.

People with CFS/ME often describe variation in the level of symptoms and disability. Symptoms of fatigue and pain may vary in their severity during the course of the day, or may be considerably worse for several days after undertaking unaccustomed levels of physical or mental activities, even if these involve relatively simple tasks. Patients may be able to undertake a task for a short period of time, but then be unable to sustain or repeat it.

Those whose symptoms are mild may continue to undertake a range of normal daily activities. Some people will be able to carry out their occupation but have to reduce their social activities. Those with more severe forms of the condition are unlikely to be able to continue at work or in education. Daily living activities, hobbies, interests and social interaction are also likely to be considerably reduced. In the most severe cases the individual may spend almost all of the day resting, or be bed-ridden. Some people may use a wheelchair outside to minimise the fatigue and symptoms such as joint/muscle pain, or problems with dizziness/balance, engendered by walking.
Between, a quarter and a half of people with CFS/ME are in part-time or full time employment or education. When compared to people with other diseases like diabetes mellitus or arthritis seen in hospital clinics many people with CFS/ME are on average more disabled.

Physical examination is normal in most cases. Some people may have postural hypotension. (Normally blood pressure is lower when sitting or lying in bed, on standing up it rises. In some people, in particular the elderly, there is a lag phase - a time interval - during which the pressure rises to the higher level. This may be experienced as a sensation of dizziness or light-headedness, and sometimes in the elderly leads to falls). Those who are the most chronically and severely disabled may have some observable generalised muscle wasting, most likely to be found in the lower limbs, although this is unusual.

Treatment / Management

Medication

Antidepressants may be very helpful in treatment of co-morbid conditions such as depression or insomnia. They can elevate mood or relieve anxiety in standard doses (e.g. sertraline, citalopram) or improve sleep and relieve pain in low doses (e.g. amitriptyline, trimipramine). However, antidepressants can have side effects when used at the standard dose required to treat depression; and these side effects may need to be taken into account. Simple analgesics and non-steroidal anti-inflammatory drugs (NSAIDs) are also used to alleviate persistent pain.

Management

Several different approaches have been used to manage this condition. There is no cure and treatment is aimed at managing the effects of the illness to improve both physical and mental function. No single approach is effective in all cases.

Management starts with the diagnosis and an explanation of why a patient is still ill. An explanation that CFS/ME may be progressive in some patients but is not life threatening is an important initial step. No specific drug treatments are available. A collaborative and concordant approach to managing the condition is used where doctor and patient discuss the different options with a view to reducing symptoms and disability. The aim of management is to enable the person to improve their quality of life by returning in a gradual way to usual daily activities, education or work. It is helpful to address both the physical and mental effects of the illness, and to minimise the results of over exertion or prolonged inactivity, and revise a “boom and bust” pattern of activity. A variety of forms of management as described below may be tried, either individually or in combination. All involve establishing a sustainable baseline of activity as the first step.

Graded exercise therapy and graded activity therapy

Supervised and gradually increasing physical and cognitive activity will enable the majority of people to improve, and some to return to a normal level of functioning. This is likely to be undertaken with the help of an appropriately trained physiotherapist (using graded exercise therapy) or an occupational therapist (using life style management) often within a hospital or clinic setting. Caution is required since over-activity, or increasing at too fast a rate, may lead

to relapses. Unsupervised or inappropriately supervised therapy can sometimes also cause relapses. Research suggests that this approach is helpful in the majority of adult ambulant patients.

Cognitive behavioural therapy

Cognitive behaviour therapy (CBT) is used in CFS/ME to help people to examine their interpretation of symptoms such as fatigue or muscle pain, which they may perceive as damaging to their bodies, and as a result avoid activities that appear to precipitate them. People are encouraged to view such symptoms as reversible physical and psychological processes rather than evidence of a fixed or progressive disease process, by trying out a mutually agreed programme of graded activities, which help to challenge these beliefs. Understanding the illness, addressing fears and where appropriate reinterpreting the disabling symptoms allows the person to make a gradual improvement in their level of functioning and well-being. Sleep is improved and mutually agreed graded increases in activity become possible over some weeks or months. Research suggests that this approach is helpful in the majority of adult and adolescent outpatients.

Pacing

Pacing is a lifestyle management approach in which the person with CFS/ME is encouraged to live within the limits of their illness and energy levels carefully balancing their activity and rest, as well as balancing different activities. When possible, activity is increased gradually, but readjusted in the event of symptom exacerbation. Patient group feedback is favourable and a research study is underway to look at the efficiency of the treatment.

Prognosis and duration of disabling effects

People with mild illness may recover spontaneously, or with some general advice or a limited treatment programme over the course of the following six months. These people are likely to be treated in a general practice setting.

People with established CFS/ME of moderate severity lasting one to two years or more are likely to need a more extensive management programme, as described above, lasting 6 to 12 months or more. Most people who are able to attend hospital for treatment are likely to make a significant improvement with appropriate management. Some people will recover fully, but others will not achieve their previous level of functioning. Some may not improve. Those who recover may be at risk of recurrence. Those who improve are at risk of relapse. In many patients, disability and quality of life can be improved, sometimes to a significant extent.

Severe cases are less likely to recover completely or benefit substantially from a management programme.

Indicators of a good prognosis are:

- Male sex,
- A definite history of an acute viral illness like glandular fever at the onset,
- Mild disability and few symptoms,
- Clinical features showing a pattern of evolution towards functional recovery,
- Early diagnosis aimed at eliminating associated physical disorders and/or identifying psychiatric illness along with other complicating psychological or social factors,
- A management approach which may encompass physical, psychological and social elements that allows a stepwise approach to functional improvement using rehabilitation.

Indicators of a poor prognosis are:

- Onset of symptoms without any clear precipitating factor,
- Clinical features characterised by severe and unremitting symptoms,
- Severe and persistent disability,
- A management approach that overemphasises the importance of either complete rest or which advocates a rapid return to pre-illness levels of physical activity,
- Those with co-morbid significant medical conditions or mood disorders,
- A complex background of adverse psychological and social factors.

It is important to ensure that there is a correct diagnosis of CFS by an appropriate health care professional.

Where there is a clear mental health illness such as depression this should be assessed separately using guidelines. There is much overlap in the symptoms/signs so the overall disablement is likely to be less than the sum of the 2 impairments.

Disablement	Symptoms/Signs

Virtually none Less than 1%	Able to work and engage in social activities Near normal exercise tolerance No cognitive impairment Under care of GP
Minimal 1-4%	Able to work and engage social activities Able to walk long distances may be reduced No cognitive impairment Under care of GP
Very Mild 5-10%	Able to work and engage social activities but fatigue may limit attendance at times Ability to walk long distances reduced Usually under care of GP
Mild 11-20%	Difficulty with work attendance due to fatigue Able to manage personal care Able to walk 100 to 200 metres Tasks may take longer than normal and may need to be followed by a period of rest
Mild/Moderate 21-30%	Unlikely to work due to fatigue and some cognitive impairment Able to walk around 100 metres but fatigued after Usually able to manage personal care although slowly and followed by a period of rest May have received specialist input
Moderate 31-50%	Unable to work due to fatigue and cognitive impairment Able to walk around 50 metres but may be followed by a period of fatigue Prescribed wheelchair for outdoor use Specialist input at some time during illness
Moderate/Severe 51 - 80%	Unable to work or engage in social activities Spends most of time in bed Poor attention/concentration Cognitive impairment Severe fatigue after mild physical/mental exertion Prescribed wheelchair – use indoors and out Prescribed environmental adaptations Generalised muscle wasting particularly lower limbs

Last modified at 18/05/2016 15:30 by [redacted]

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Assessment guides

Guide to Chronic Obstructive Pulmonary Disease (COPD) assessments

What is COPD?

Chronic obstructive pulmonary disease (COPD) is an umbrella term for a group of disorders, which are progressive, long term and characterised by difficulty in breathing. This is due to airflow obstruction, which is progressive, not fully reversible and does not change markedly over several months.

COPD is the term encompassing chronic bronchitis and emphysema. In most people, there is considerable overlap in the two conditions although each condition may exist by itself. COPD does not include other obstructive lung diseases such as asthma.

COPD develops gradually over many years and usually is symptomatic, from middle age, (commonly the 5th decade) onwards, when the diagnosis is usually made.
While it is present in 18% of male smokers in the UK, it is present in 14% of female smokers and is a significant reason for hospital admissions and lost working days.

It is one of the greatest causes of death in the world, being the 4th leading cause of death in the USA, was 4th in the year 2000 global mortality table and is currently rated 6th leading cause of death in the UK.

> *"Fifty percent of patients with severe breathlessness due to COPD die within 5 years."*
>
> *"At least 25,000 people die each year in the UK from the end stages of COPD."*
>
> *"A recent American Lung Association survey revealed that 51% of all COPD patients say that their condition limits their ability to work. 70% are limited in normal physical exertion, 56% in household chores, 53% in social activities, 50% in sleeping and 46% in family activities."*

The statistics are gradually changing as smoking is decreasing in wealthy countries and increasing in poorer countries and as more women are smoking and at an early age.

There are two separate processes occurring; the process involved in chronic bronchitis and that involved in emphysema.

What is Chronic Bronchitis?

Chronic bronchitis is defined clinically as "a cough productive of sputum on most days, for at least three months of each year, in more than one consecutive year".

It is characterised by a persistent inflammation of the bronchial walls with oedema of the lining and an increased production of mucus, causing cough and sputum most of the time. This tends to "clog up" the airways, and the process can lead to the eventual scarring of the lining of the bronchial tubes, and resultant airways narrowing. In advanced disease, the bronchi and bronchioles are infected with pus and inflammation leading to narrowing of both sets of airways. Early in the disease, the inflammation of the small airways is reversible if smoking is stopped early.

COPD is the term encompassing chronic bronchitis and emphysema. In most people, there is considerable overlap in the two conditions although each condition may exist by itself. COPD does not include other obstructive lung diseases such as asthma.

What is Emphysema?

Emphysema is a lung condition in which the small air sacs (or air spaces) in the lungs are affected.

The primary function of the lungs is to exchange gas, between air and the bloodstream, and this is done in the 300 million thin- walled, distensible sacs (alveoli) in the lungs. From the trachea to the alveoli are many divisions of air passages that get smaller and smaller, (the bronchi and bronchioles) and it is only the final centimetre (in the respiratory bronchioles, alveolar ducts and alveoli) that oxygen is passed into the blood, and carbon dioxide is passed out.

Emphysema is defined (histo-pathologically), as the irreversible dilatation of air spaces, caused by destruction of their walls.

It is caused by loss of elasticity of the lung tissue, both of the airways and the alveoli and the walls between many of the air sacs are gradually destroyed. This results in permanent "holes" in the lung tissue. Because the structure of the tiny airways is lost, the ability of the lungs to get rid of CO2 and absorb O2 efficiently is lost. Thus, less O2 is able to get into the blood, and to vital organs, and less CO2 can be got rid of, causing a rise in blood levels of the latter.

Also, the small airways collapse, during expiration instead of remaining open, thus causing air to be trapped in the lungs. This is because the natural elasticity of the lungs [which enables the airways to stay open] is reduced, and because there is destruction of the alveolar wall attachments, which normally hold the walls of the small airways open.

The lungs become over inflated because of this difficulty in breathing out, and this is obvious in emphysema sufferers, in an increased diameter of the chest antero - posteriorly relative to the lateral diameter.

A bulla is a locally over-distended area of emphysema. It is a thin- walled airspace caused by alveolar wall rupture. They may be any size, and may exist alone or in a collection. Rupture of a bulla may cause a pneumothorax.

COPD is the term encompassing chronic bronchitis and emphysema. In most people, there is considerable overlap in the two conditions although each condition may exist by itself. COPD does not include other obstructive lung diseases such as asthma.

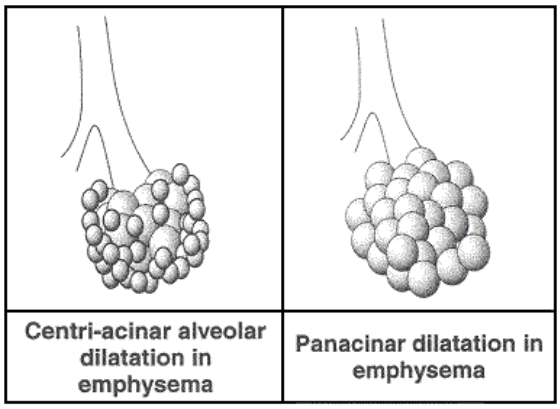
Types of Emphysema

There are two main types of emphysema:

- Centriacinar (centrilobular) where the damage mainly occurs around the respiratory bronchioles); affecting the upper parts of the lungs occurring in coal-miners and smokers.
- Panacinar (panlobular) where tissue loss and damage occurs throughout the acinus particularly affecting the lower half of the lungs. It may occur with ageing to a mild degree and the severe form is associated with alpha1- antitrypsin deficiency.

Other types of Emphysema:

- Paraseptal, where bullae occur on the lung edges, rupture of these could cause a pneumothorax.
- Irregular e.g. related to scarring, such as with tuberculosis.



What is the difference between Asthma and COPD?

Asthma is reversible

The mechanism, which causes asthma, is inflammation and constriction of the muscles around the airways. The symptoms "come and go" and treatment usually works well, reversing the effects of the irritation. However, asthma often progresses into COPD. There are usually daily variations in peak flow readings and a good response to bronchodilators. However, chronic asthma may progress to COPD.

COPD is poorly reversible or irreversible

COPD sufferers have a chronic cough with sputum, and the disease is slowly progressive. They are usually diagnosed in middle age and have a smoking history. Many patients with COPD show some response to bronchodilators but not to the extent that asthmatics do. However, bronchodilators in the form of inhalers or through a nebulizer may help with symptoms to some degree. This is because the narrowing of the airways in COPD is "fixed", and the symptoms are persistent (chronic). Also, because the condition is chronic and not very variable, peak flow testing over the course of a week will show little variation.

Table 3 Clinical features differentiating COPD and asthma

	COPD	Asthma
Smoker or ex-smoker	Nearly all	Possibly
Symptoms under age 35	Rare	Often
Chronic productive cough	Common	Uncommon
Breathlessness	Persistent and progressive	Variable
Night time waking with breathlessness and/or wheeze	Uncommon	Common
Significant diurnal or day-to-day variability of symptoms	Uncommon	Common

Clinical features in COPD

Symptoms

Initially, there may be few symptoms except for a "smoker's cough" with sputum (productive cough). The frequency of the cough and the amount of sputum steadily increases as the disease progresses. At first, the attacks of productive cough occur in the winter after colds, but eventually, with increasing severity of the disease the cough is ever- present.

With progression of the disease, breathlessness on exertion occurs with morning cough, recurrent respiratory infections and a now constant "smoker's cough".
The person becomes increasingly disabled by exertional breathlessness, and eventually in severe cases may become breathless at rest. People with COPD are more susceptible to bacterial infections and breathlessness may be exacerbated by smoke, atmospheric pollutants and respiratory tract infections.

In severe cases the heart failure occurs.

Signs

In the early stages there may be no abnormal signs, but rhonchi on breathing in and breathing out may be heard, as well as crackles in the lower zones of the lungs.

In a person with severe disease, there will be the signs of breathlessness at rest, leaning forward, using extra muscles in the neck, abdomen and chest to breathe, reduced chest expansion and a hyper-inflated chest. Loss of weight is common and there may be cyanosis (blueness) and oedema (swelling) suggesting right heart failure.

The "Blue bloater" is often representative of a person with COPD

Poor respiratory drive with the following features evident:

- Relatively mild breathlessness (dyspnoea)
- Obese and plethoric (high colour)
- Oedema (swelling) and congestive heart failure
- Large volume sputum (productive cough)
- Hypoxia (low O2) and hypercapnia (raised CO2)
- Polycythaemia
- Sleep apnoea
- Unexpectedly well- preserved lung function
- No emphysema on X-Ray
- Poor prognosis with 70% 5-year mortality.

Clinical features of Emphysema

Symptoms

- Emphysema develops gradually over a period of years.

- People with emphysema have great difficulty in exhaling (breathing out). Symptoms such as shortness of breath (sometimes associated with wheeze) occur initially on exertion and then as the disease progresses, with little exertion and ultimately at rest. The person eventually may not be able to carry out basic activities in a normal fashion. At end-stage disease the person may be dependent on oxygen for several hours a day.
- Weight loss caused by reduced eating and interest in eating because of poor breathing ability
- Feeling of tiredness because of chronic lack of oxygen in the body. Other symptoms may be impaired memory and concentration, irritability and excessive daytime sleepiness.

Signs

A barrel-shaped chest, which is a sign of over-inflation of the lungs and trapped air in the lungs. Horizontal ribs with prominent sternal angle and increased diameter from front to back. The liver may be displaced downwards.

The "Pink Puffer" is often representative of a person with emphysema.

Respiratory drive is preserved, and the following features are evident:

- Severe breathlessness with pursed-lip breathing
- Thin, and often elderly
- Heart failure uncommon but is usually terminal
- Near normal blood gas (O2 and CO2) values
- Very severe airways obstruction
- Reduced gas transfer factor
- Increased total lung capacity
- Absence of cyanosis (blue lips)
- Tachypnoea (fast breathing)
- Over-inflated chest
- Reduced breath sounds especially over bullae

Investigations in COPD

Lung function tests which demonstrate:

- Increased total lung capacity
- FEV1/ FVC Ratio usually less than 70%, an “obstructive” picture. This is demonstrated in Spirometry. The volume of air blown out in one second is divided by the total amount of air blown out, until all air is expired. This is expressed as a percentage value and a value of less than 70% indicates COPD.
- Reduced gas transfer at alveolar level

Chest x-rays/ CT Scans - These can be often normal, however an X- ray is useful in excluding other pathology (e.g. lung cancer). In moderate and severe disease there may be visible on x-ray over-inflated lungs and disorganisation of blood vessel markings with a narrow, long heart shadow and a low, flat diaphragm. There may be an abnormally increased chest diameter. Bullae (locally over-distended skin lesions usually to greater than 1 centimetre in size) may be visible.

Blood tests – There may be an increase in the count of red blood cells, which is known as “polycythaemia”, as a result of low oxygenation.

Arterial blood Gases –which demonstrate mild reduction in blood oxygen levels, and normal carbon dioxide levels.

Heart Function Tests – Echocardiogram shows the function of the heart, and ECG will demonstrate changes of right heart strain or heart failure (cor pulmonale).

Additional investigations in Emphysema

Alpha- Antitrypsin levels – This is important in emphysema; though it accounts for only around 2% of emphysema it accounts for severe emphysema at a young age and early death, especially in cigarette smokers.

Forced Expiratory Volume and Forced Vital Capacity reading

Forced Expiratory Volume (FEV1)

This is the volume of air expired into a spirometer in the first second.

In COPD, the following values are indicative of the severity of the disease:

Mild disease	Males – 2.5 litres or more
	Females – 2.0 litres or more

Moderate disease	Males – 1.5 litres to 2.49 litres
	Females – 1.0 litres to 1.99 litres
Severe disease	Males – less than 1.5 litres
	Females – less than 1.0 litre

Forced Vital Capacity (FVC)

This is the total volume of air breathed out by the person after a full inspiration (breath in) into a spirometer. This is not generally used as a diagnostic test in COPD.

The FEV1 / FVC Ratio

This is a useful diagnostic aid and is a measure of airflow limitation.

Normally, the FEV1 / FVC ratio is approximately 75%.

A value of below 70% is indicative of airflow obstruction (obstructive airways disease). This could be either asthma or COPD. The difference is that asthma is reversed when a short-acting beta agonist such as salbutamol or terbutaline are used (this is known as reversibility), whereas COPD is not reversible.

A value of between 70% and 75% is indicative of restrictive lung disease such as lung fibrosis, asbestosis etc.

Treatment / management of COPD

The following principles of treatment apply to both COPD and Emphysema:

- Stopping smoking prevents progression of the disease.
- Bronchodilators maximise lung function, and short-acting bronchodilators are used for immediate reversal.
- Inhaled steroids and beta- agonists are used to reduce exacerbations (but inhaled steroids can increase osteoporosis and pneumonia).
- Oxygen therapy reduces the risk of pulmonary hypertension and nocturnal falls in oxygen concentration.
- Pulmonary Rehabilitation increases muscle fitness and improves (mental) outlook. It is not used just for improving lung function

Stopping Smoking

The acceleration of COPD & Emphysema can be reduced by stopping smoking.

The most important management factor is stopping smoking. This will help slow the rate of deterioration but will not reverse existing damage to the lungs.

However, it will extend life expectancy. The patient should try all strategies to stop and if they stop sufficiently early, this will prevent the continuing accelerated decline in lung function. Strategies include:

- Support and encouragement from the GP and Chest Clinic.
- Nicotine replacement in the form of chewing gum or patches absorbed through the skin.
- Bupropion tablets (to aid the cessation of smoking).

Bronchodilator Medication

"The effectiveness of bronchodilator therapy should not be assessed by lung function alone but should include a variety of other measures such as improvement in symptoms, activities of daily living, exercise capacity and rapidity of symptom relief."

Therefore, the continuing use of bronchodilators depends on both the subjective feedback from the patient (i.e. that the symptoms have eased) and objective assessment.

Types of bronchodilators used are:

- Beta agonist inhalers such as Salbutamol (Ventolin), Terbutaline (Bricanyl), which are short- acting, Salmeterol (Serevent), Formoterol (Oxis or Foradil) which are long- acting
- Anti-cholinergic or anti-muscarinic inhalers (such as Ipratropium (Atrovent or Respontin), which are short-acting) and Tiotropium (Spiriva), which is long- acting.

However, the two drugs may be taken in combination and this has been shown to be effective in some patients. Such combinations are combivent (salbutamol and ipratropium) and Duovent (fenoterol and ipratropium).

- For mild disease, short- acting bronchodilators should be the initial treatment for the relief of breathlessness and exercise limitation.
- Patients who remain symptomatic should have their inhaled treatment intensified to include long- acting bronchodilators or combined therapy with a short- acting beta2 – agonist, and a short- acting anticholinergic. (Long-acting bronchodilators should be used in patients who do

not respond to short-acting bronchodilators, because they appear to have additional benefits over combinations of short-acting drugs).
- Long-acting bronchodilators should also be used in patients who have 2 or more exacerbations a year.

Theophylline (in slow- release formulations)

Theophylline should only be used after a trial of short-acting bronchodilators and long-acting bronchodilators or in persons who are unable to use inhaled therapy. There is a need to monitor plasma levels and interactions with this drug.

Corticosteroids

Inhaled corticosteroids are mainly used for reducing the frequency of exacerbations (relapses) and to slow the decline in health status - not to improve lung function.

Inhaled corticosteroids should be used in patients:

- Who have an FEV1 of less than, or equal to, 50% of predicted
- Who are having 2 or more exacerbations requiring treatment with antibiotics or oral corticosteroids in a 12- month period.

There is a potential risk of developing osteoporosis and increased susceptibility to pneumonia in patients treated with high dose inhaled steroids.
Maintenance use of oral corticosteroid treatment in COPD is not normally recommended.

Combination Therapy

If a patient still has symptoms on monotherapy, combination therapy may be tried, and these may include:

- Beta2 agonist and anticholinergic (Salbutamol and Ipratropium known as Combivent).
- Beta2agonist and theophylline.
- Anticholinergic and theophylline.
- Long-acting beta2agonist and inhaled corticosteroid (Seretide).

Again, the clinical effectiveness of combined treatments is assessed by:

- Symptoms,
- Activities of daily living,
- Exercise capacity,
- Lung function.

Antibiotics

When a bacterial infection is suspected by the GP, antibiotics should be used. There are many antibiotics to choose from and newer antibiotics may be used for more severe or resistant infections.

Pulmonary Rehabilitation

Most patients are middle-aged to elderly with associated problems of increasing age. Pulmonary rehabilitation should be considered for those with moderate to severe disease.

The aim is to counteract the effects of enforced immobility or reduced mobility, which occurs as a result of breathlessness due to the disease. Exercise programmes are devised, which are tailor-made for the person. These are multidisciplinary with the aim of increasing cardio-respiratory fitness and /or mobility so that general fitness, symptoms, quality of life, social performance and independence may be improved.

Rehabilitation should address the physical, psychological, nutritional, and educational needs of the patient.

Vaccination and Antiviral therapy

Annual influenza vaccination and vaccination against Pneumococcus should be offered to all patients. Antiviral medication is recommended for, and may be used in adults who are at risk and who present with a flu-like illness. They reduce the severity of the symptoms.

Oxygen therapy

Long-term oxygen therapy (LTOT) is used in patients who have been proved to have low oxygen levels in the blood. LTOT is delivered at a specific rate (4%) to increase O2 saturation most efficiently, while not causing the patient to drift into CO2 retention. This is called "Controlled O2 Therapy".

It is generally safe at this level. However, before this treatment is implemented, the patient is assessed to ensure that:

- They benefit sufficiently from this regime
- They do not drift into CO2 retention.

Therefore, anyone on LTOT should have been properly vetted first and so CO2 retention (excess levels of carbon dioxide in the blood tissues) is not relevant in people on controlled O2 Therapy.

LTOT is therefore beneficial to a selected patient group, normally those who no longer smoke and who have an FEV1 reading of less than 1.5 litres. It has beneficial effects on oxygen levels in the blood and on reducing the rise of the number of red blood cells, which occurs in response to low oxygen levels in the blood (known as hypoxia).

LTOT should be used for several hours a day (15 to 19). It is an indicator of severe disease. People on oxygen often have an oxygen concentrator in the home. This is a large, electronically operated machine, which is set up in the home for permanent use. It uses the oxygen present in the air, concentrating it and the person breathes it in through nasal cannulae (tubes which fit inside the nostrils) or a mask. It is fairly noisy and the tube may be very long, allowing the person to move about in the house. Cylinders of oxygen are sometimes used. They may be very large and heavy requiring special delivery and removal, set up by the bed or chair, or they may be small, for use while away from home even on aircraft.

Palliative Care

For those with end-stage disease, the full range of services available from Palliative Care Teams should be made available.

The patient should eat well or lose weight, if overweight. As the normal BMI (Body mass Index) is 25 to less than 20 there may be considerable variations from this norm. Advice from a dietician may be necessary. Nutritional supplements may be necessary if the person is very underweight.

Anxiety and depression, if present should be treated.

Air pollutants such as cigarette smoke should be avoided as much as possible.

Management / Treatment of Emphysema

The medical management of COPD and Emphysema is largely the same, but the following are specific to emphysema:

- Bullectomy (removal of emphysematous bullae)
- Lung volume reduction surgery
- Lung transplantation

Bullectomy and Lung Volume Reduction Surgery is used in persons with advanced emphysema.

Breathless people with a single large bulla, and an FEV1 of less than 50% should be considered for bullectomy.

Parts of affected (i.e. very expanded) lung are removed to reduce volume and improve efficiency of the remaining lung in persons in whom maximal medical therapy is not effective, as long as strict criteria are met.

Lung Transplantation should be considered in those with advanced emphysema, whose activities of daily living and quality of life are greatly restricted despite maximal medical therapy.

One source states that a very small group of persons are eligible for this and is mainly young people with severe disease suffering from Alpha1 Antitrypsin deficiency. Transplantation is usually of one lung.

Disablement	Treatment	Symptoms	Signs/Investigations (See guidance)
Virtually none	No regular treatment	Very mild shortness of breath made worse by a chest infection	No objective clinical findings most of the time
Minimal (1-4%)	Short-acting inhaled beta-2 agonist (eg: Salbutamol/ Terbutaline) or Short-acting inhaled antimuscarinic (anticholinergic) bronchodilators (eg: Ipratropium)	Shortness of breath on severe exertion e.g. running up a flight of steps stairs	Insignificant changes
Very mild (5-10%)	Short-acting inhaled beta-2 agonist (eg: Salbutamol/ Terbutaline) or Short-acting inhaled antimuscarinic (anticholinergic) bronchodilators (eg: Ipratropium)	Shortness of breath on moderate exertion e.g. Walking briskly. Able to climb a flight of stairs at normal pace	Early X Ray changes may be present Loss lung function 5-10%

Mild (11-20%)	Regular antimuscarinic bronchodilator (short or long-acting) (eg Ipratropium (short acting) Tiotropium (Spiriva) (long acting) plus • Long- acting Beta2 agonist • Salmeterol (Serevent) or • Formoterol Oxis (Foradil) or In combination Combivent (Salbutamol and Ipratropium and Duovent (Fenoterol and Ipratropium) or Inhaled Steroids (for those with frequent exacerbations and reversibility)	May have difficulty walking with peers. Can walk several hundred metres at own pace without stopping	Early X Ray changes present Loss lung function 10-20%
Mild/Moderate (21-30%)	Regular antimuscarinic bronchodilator (short or long- acting) (eg Ipratropium (short acting) Tiotropium (Spiriva) (long acting) plus • Long- acting Beta2 agonist • Salmeterol (Serevent) or • Formoterol Oxis (Foradil) or In combination Combivent (Salbutamol and Ipratropium and Duovent (Fenoterol and Ipratropium) or Inhaled Steroids (for those with frequent exacerbations and reversibility)	Can walk 500metrs on the flat at own pace without stopping	Established X-Ray changes. Loss of lung function 25-40%
Moderate (31-50%)	This may include: • Inhaled short-acting beta agonist, or antimuscarinic bronchodilator – Regular treatment (such as three times a day) • Inhaled steroids • Nebulized bronchodilator • Short course of oral steroids • Antibacterial treatment (antibiotics) • Combination of long-acting beta2 agonist, and inhaled corticosteroid (Seretide) • Theophylline (often used when other treatments have failed to adequately control symptoms) (Nuelin, Slophyllin, Uniphyllin) • Combinations of Salbutamol and Ipratropium (Combivent)	Manages 50 to 100 metres on the flat without stopping. Short of breath at the top of house stairs Likely to be under specialist care	Moderate X Ray changes Loss lung function 45-50%
Moderate/ Severe 51-80%	• Inhaled short-acting beta agonist, or antimuscarinic bronchodilator – Regular treatment (such as three times a day) • Inhaled steroids • Occasional oxygen • Nebulized bronchodilator • Short course of oral steroids • Antibacterial treatment (antibiotics) • Combination of long-acting beta2 agonist, and inhaled corticosteroid (Seretide)	Able to walk 20-50 metres slowly on the flat. Stops on stairs due to breathlessness Under specialist care	Major X Ray changes Lung function 55 to 60%

	• Theophylline (often used when other treatments have failed to adequately control symptoms) (Nuelin, Slophyllin, Uniphyllin) • Combinations of Salbutamol and Ipratropium (Combivent)		
Severe 81+%	• Inhaled short-acting beta agonist, or antimuscarinic bronchodilator – Regular treatment (such as three times a day) • Inhaled steroids • Nebulized bronchodilator • Short course of oral steroids • Antibacterial treatment (antibiotics) • Combination of long-acting beta2 agonist, and inhaled corticosteroid (Seretide) • Oxygen therapy (may have concentrator) • Theophylline (often used when other treatments have failed to adequately control symptoms (Nuelin, Slophyllin, Uniphyllin) • Combinations of Salbutamol and Ipratropium (Combivent)	Short of breath at rest Unable to manage stairs (stair lift or sleeps downstairs)	Severe X Ray changes Loss lung function 70+%

Last modified at 26/04/2016 10:56 by [redacted]

Page Rating ☆☆☆☆☆|0

Categories
No categories were selected

Assessment guides

Guide to depression assessments

Disablement	Symptoms/signs
Virtually none Less than 1%	Interested in wide range of activities (friends/hobbies) No more than everyday concerns Normal reaction to illness
Minimal 1-4%	Interested in wide range of activities Some mild biological symptoms Life events may cause depressed mood
Very Mild 5-10%	Some loss of interest in leisure activities Some insomnia Mild biological symptoms May have mild anxiety and irritability
Mild 11-20%	Loss interest in some leisure activities Sleep problems (early morning waking/initial insomnia. Some concentration problems Reactive mood (responds to good news) Moderate biological symptoms (loss appetite, reduced libido) Anxiety, irritable, tense
Mild/Moderate 21-30%	No interest in leisure activities Moderate/Severe biological symptoms Non-reactive mood Persistently low mood Some morbid pessimistic thoughts Problems concentration/attention Reduced gestures/eye contact/downward gaze/tearfulness
Moderate 31-50%	Severe biological symptoms Social withdrawal Moderate depressed appearance Tearful in interview Poor attention/concentration Some morbid pessimistic thoughts Slow, hesitant monotone speech Impairment judgement
Moderate / Severe 51 - 80%	Social withdrawal Severe depressed appearance

	Slow, hesitant monotone speech Psychomotor retardation Serious impairment judgement Morbid pessimistic thoughts Suicidal preoccupations Self neglect Poor attention/concentration Psychotic feature (consider 70-80% if present)

Last modified at 24/08/2015 11:33 by [redacted]

Page Rating ☆☆☆☆☆ |0

Categories
No categories were selected

Scheduled and non-scheduled conditions

Hysterical conditions

Where there is no organic explanation for symptoms, the cause may well be a mental loss of faculty, and it is for the medical board to decide whether such a loss of faculty is a conscious or deliberate mental state or whether it is an unconscious or uncontrollable functional condition.

Where it is unconscious or uncontrollable (a true hysterical condition), it should be assessed.

Last modified at 14/06/2018 11:32 by [redacted]

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Categories
No categories were selected

Scheduled and non-scheduled conditions

Injuries and conditions of hands

In considering injuries and condition of hands it is particularly important to remember that it is the resulting overall loss of ability to do what a normal person of the same age and sex would be able to do which falls to be assessed and that where a customer has sustained two or more injuries or conditions, specified separately in the Schedule, incapacity is not required to be assessed as the aggregate of specific figures in the Schedule.

To avoid confusion resulting from the use of 'first, second, third, etc' when referring to fingers in medical reports, the terminology, 'thumb, index, middle, ring and little finger' should always be used.

Last modified at 19/08/2014 13:49 by [redacted]

Page Rating ☆☆☆☆☆ 0

Categories
No categories were selected

Medical assessment

Interviewing the claimant

The nature of the interview

The interview differs materially from the traditional consultation in medical practice. The aim of the traditional interview is to arrive at a diagnosis and plan future medical management of a patient. In the assessment interview, you are gathering information which will be used to assess a claimant's loss of faculty due to the relevant disability.

Detailed medical history taking is time-wasting and unnecessary. The essential medical details which impinge on present loss of faculty are all that is required.

Interview technique

It is important that the interview is carried out in a friendly, professional and non-confrontational way. If possible, you should meet the claimant and accompany them from the waiting room. This positive initial point of contact will help put the claimant at ease. From your point of view, it provides an opportunity to observe the claimant outside the examination room, and extends the time spent in contact with them. Most importantly, it initiates the rapport between doctor and claimant which is so essential to an effective interview.

The claimant may be apprehensive, and it is good practice to explain the process and purpose of the interview and examination. Allow time for the claimant to settle down before beginning the interview. This is time well spent as it allows the interview to proceed more smoothly and productively thereafter. It is also useful to explain that the clinical examination is not in any way a general "check up", but will be focused on the way in which the overall loss of faculty affects the claimant in their everyday life. This explanation may forestall any criticism that the medical examination was not thorough.

Claimant accompanied by relative, friend, carer or other person

Claimants may often feel more at ease when accompanied, and indeed this may be a prerequisite to enable them to come to the medical board.
Companions may be able to give useful information, particularly in cases where the claimant has mental health problems, learning difficulties, or communication problems, or people who stoically understate their problems.

Occasionally, a companion may wish to give too forcefully their own opinion on the claimant's disability, perhaps giving a biased view.

You will use your own judgement in weighing the companion's evidence. If the companion is too intrusive, then you should point out that the claimant must be allowed to express their view. If this strategy is unsuccessful the companion should be asked to leave.

The actual physical examination is not normally done in the presence of the companion, but strictly with the claimant's consent, and if it appears a reasonable request, then the companion should be allowed to be present.

The decision whether to allow anyone to be present with the claimant during the medical board rests solely with the medical board. The relevant legislation, Article 4(2) of the Social Security (Determination of Disablement Questions) (Jersey) Order 1974 states;

> *'No person shall be entitled to be present during the consideration of any question by a medical board other than the claimant and any other person whom the medical board may, with the consent of the claimant, allow to be present as being a person who, in its opinion, is likely to assist it in the determination of that question'*

Recording the interview

The time of start of examination is when you first make contact with the claimant. The time the examination ends is the time when the claimant leaves you. You should also add the time at which the form was finally completed.

List all the current diagnoses. Ensure that all conditions entered in the claimant's claim form and GP medical report are included. Previously unidentified conditions which are revealed during the assessment should also be added.

In many instances the entries will be symptoms rather than exact diagnoses. Your role is to assess disability and for that reason precise diagnoses do not add to the determining officers understanding of the report. Only be specific if you have good evidence of the diagnosis. If you write "Lumbar disc protrusion" rather than "Low back pain" and it transpires at an appeal that investigations revealed spondylolisthesis then the whole value of the evidence you have provided for the Department may be undermined.

Medication

Record all regular medication whether prescribed or bought over the counter. Record the dose, if known, without using shorthand or abbreviations.

It is helpful to comment on any analgesics being taken. This may give an insight into the variability of the condition as most people take them when required rather than on a regular basis. "He takes an average of 12 paracetamol (painkillers) a week, usually over three days" provides a picture for the determining officer that will support your description of variability and pain later in the report. It is also useful to comment on the potency of the analgesic.

Note also any side-effects of medication reported by the claimant and explain any additional medication used to ameliorate them; e.g. the use of cimetidine in dyspepsia related to the use of NSAIDs.

It is also helpful to explain the purpose of any medication if known.

Details of any hospital treatment or investigations within the last 12 months

Details of any hospital treatment or investigations within the last 12 months should be recorded. It is most important to keep this information brief, concise and relevant to the present disabilities. Note whether the claimant continues to attend hospital, and the likely date of any proposed treatment procedure or investigation; for example "Is being admitted for lumbar spine operation within the next 6 weeks"; "Due to have a scan in 2 weeks' time".

Details of specific therapy for mental health problems and of mental health professional

It is important that details of therapy relating to a mental health problem are recorded. The name of the person providing such treatment should also be recorded.

Clinical history

A good history is the basis of the assessment medical examination, and the following structure should be used:

- Brief clinical history.
- Brief details of the claimant's domestic situation, for example; "Lives in a 2-storey house with husband and two children aged 10 and 12".
- A brief outline of the claimant's problems and the limitations imposed by the loss of faculty due to them, for example "Variable pain both elbows which the claimant states restricts his/her ability to lift and reach".
- Most important is an outline of how a typical day is spent in the light of the reported limitations.

The typical day

Although not always easy to elicit, a careful and well-focused history of a typical day will greatly help you in completing the rest of the report. If you obtain and record appropriate information at this stage, it will provide you with factual evidence of the effects of the claimant's loss of faculty, which you can then use to support your choice of percentage award.

You must write this section in the third person. It is a record of the claimant's everyday life, without interpretation by the medical examiner. You should make it clear that this is the claimant's account of his disabilities and not your opinion. It is also a factual description of how the claimant's condition affects them in day to day life as elicited by careful interview, using the recommended techniques referred to in the relevant section of this handbook.

The account of the "Typical day" should be particularly focused on the areas of activity which the claimant claims are affected by their medical conditions, and areas likely to be so affected.

You should give specific examples of activities, e.g. "says she enjoys watching television sitting in an armchair for 30 minutes at a time".

Avoid making a statement such as "Can only walk 50 metres" as this may well be taken as fact by the determining officer or the Medical Appeal Tribunal. Better would be; "Says he only walks 50 metres", then give an example of what the claimant actually does, as far as walking is concerned, on an average day: "Walks to the shops and back (about 200 metres in all) but says he has to stop at least twice due to back pain".

Do not feel confined by the space restrictions on the report. If necessary, use an extra blank sheet and afterwards date and sign it and attach it to the report form.

Last modified at 19/08/2014 13:49 by [redacted]

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Categories
No categories were selected

Medical assessment

Introduction to the medical assessment

The medical assessment process as a whole differs in many respects from the traditional history taking and examination in the general practice and hospital setting. It entails bringing together information gained from observation, questionnaire, medical evidence and examination in order to reach an accurate assessment of the disability of a claimant and to provide the information which the departments determining officers require to explain the assessment to the claimant.

It is a complex procedure, involving careful consideration, structured interviewing, lateral thinking and accurate observation, as well as the application of medical skills. There are four stages in performing the LTIA assessment. These are:

- Reading the documents
- Interviewing the claimant
- Examining the claimant
- Completing the medical board report form

Last modified at 14/06/2018 11:30 by [redacted]

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Categories
No categories were selected

Scheduled and non-scheduled conditions

Limb amputation cases

A certificate of stump measurement issued by an Artificial Limb and Appliance Centre (ALAC) may be available, but medical boards usually make their own stump measurements. The level of amputation should be indicated as accurately as possible.

The first points of measurement are:

1	Upper	The tip of the acromion with the stump pendant
2	Forearm	The tip of the olecranon, which is best found when the forearm or stump is flexed to a right angle
3	Above knee	The tip of the great trochanter
4	Below knee	The antero-medial edge of the upper articular surface of the tibia when the knee is flexed

The second point of measurement is in all cases:

Over the end of the bone as palpated through the skin or scar tissue. In a below knee case this will be the end of the tibia and not the end of the fibula. The measurement will be taken on the inner aspect of the stump and not, as in above knee amputations, on the outer aspect.

Assessment

> The prescribed degrees of incapacity set out in the scheduled assessments (see Appendix 1) relate to stabilised degrees of incapacity and it may be necessary for an medical board to modify the assessment where an artificial limb is to be worn, but has not yet been fitted.
>
> UK Medical Appeal Tribunals have generally accepted that a scheduled assessment is not appropriate unless a satisfactory artificial limb has been fitted, and that the assessment should be provisional and at a higher rate than the scheduled degree until the claimant has been fitted with an artificial limb and has been allowed a reasonable time to get used to wearing it.

Last modified at 16/05/2016 12:32 by [redacted]

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Categories

No categories were selected

Scheduled and non-scheduled conditions

Prescribed degrees of incapacity

	Loss of faculty	Degree of incapacity (%)
1	Loss of both hands or amputation at higher sites	100
2	Loss of a hand and a foot	100
3	Double amputation through leg or thigh, or amputation through leg or thigh on one side and loss of other foot	100
4	Loss of sight to such an extent as to render the claimant unable to perform any work for which eyesight is essential	100
5	Very severe facial disfigurement	100
6	Absolute deafness	100
	Amputation cases - upper limbs (either arm)	
7	Amputation through shoulder joint	90
8	Amputation below shoulder with stump less than 20.5 centimetres from tip of acromion	80
9	Amputation from 20.5 centimetres from tip of acromion to less than 11.5 centimetres below tip of olecranon	70
10	Loss of hand or of the thumb and four fingers of one hand or amputation from 11.5 centimetres below tip of olecranon	60
11	Loss of thumb	30
12	Loss of thumb and its metacarpal bone	40
13	Loss of four fingers of one hand	50
14	Loss of three fingers of one hand	30
15	Loss of two fingers of one hand	20
16	Loss of terminal phalanx of thumb	20
	Amputation cases - lower limbs	
17	Amputation of both feet resulting in end-bearing stumps	90
18	Amputation through both feet proximal to the metatarso-phalangeal joint	80
19	Loss of all toes of both feet through the metatarso-phalangeal joint	40
20	Loss of all toes of both feet proximal to the proximal inter-phalangeal joint	30
21	Loss of all toes of both feet distal to the proximal inter-phalangeal joint	30
22	Amputation at hip	90
23	Amputation below hip with stump not exceeding 13 centimetres in length measured from tip of great trochanter	80
24	Amputation below hip and above knee with stump exceeding 13 centimetres in length measured from tip of great trochanter, or at knee not resulting in end-bearing stump	70
25	Amputation at knee resulting in end-bearing stump or below knee with stump not exceeding 9 centimetres	60

26	Amputation below knee with stump exceeding 9 centimetres but not exceeding 13 centimetres	50
27	Amputation below knee with stump exceeding 13 centimetres	40
28	Amputation of one foot resulting in end-bearing stump	30
29	Amputation through one foot proximal to the metatarso-phalangeal joint	30
30	Loss of all toes of one foot through the metatarso-phalangeal joint	20
	Other losses of faculty	
31	Loss of one eye, without complications, the other being normal	40
32	Loss of vision of one eye, without complications or disfigurement of eyeball, the other being normal	30
A	**Fingers of right or left hand**	
	Index finger	
33	Whole	14
34	Two phalanges	11
35	One phalanx	9
36	Guillotine amputation of tip without loss of bone	5
	Middle finger	
37	Whole	12
38	Two phalanges	9
39	One phalanx	7
40	Guillotine amputation of tip without loss of bone	4
	Ring or little finger	
41	Whole	7
42	Two phalanges	6
43	One phalanx	5
44	Guillotine amputation of tip without loss of bone	2
B	**Toes of right or left foot**	
	Great toe	
45	Through metatarso-phalangeal joint	14
46	Part, with some loss of bone	3
	Any other toe	
47	Through metatarso-phalangeal joint	3
48	Part, with some loss of bone	1
	Two toes of one foot, excluding great toe	
49	Through metatarso-phalangeal joint	5
50	Part, with some loss of bone	2
	Three toes of one foot, excluding great toe	

51	Through metatarso-phalangeal joint	6
52	Part, with some loss of bone	3
	Four toes of one foot, excluding great toe	
53	Through metatarso-phalangeal joint	9
54	Part, with some loss of bone	3

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Categories
No categories were selected

Medical assessment

Reading the documents

In preparation for the interview, you should read carefully the documents in the file.

All the medical evidence should be considered. Particular attention must be paid to the GP medical report and where applicable previous medical board reports.