Association of British Neurologists

FREQUENTLY ASKED QUESTIONS NEUROLOGY ADVICE AND GUIDANCE/ ADVICE AND REFER/ ACTIVE CLINICAL REFERRAL TRIAGE

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ASSOCIATION OF BRITISH NEUROLOGISTS

FAQS NEUROLOGY ADVICE AND GUIDANCE / ADVICE AND REFER / ACTIVE CLINICAL REFERRAL TRIAGE

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Preface

The provision of specialist advice (advice and guidance, advice and refer, active clinical referral triage) is increasing. Providing early access to specialist advice supports primary care in the management of patients with neurological conditions and provides faster access to information and treatment for patients.

Aimed at neurologists, we have provided example answers to the frequently asked neurology advice and guidance questions. You may need or wish to adapt these using local knowledge and pathways. Many queries are related to headache, transient loss of consciousness, and dizziness. As many services have pathways for these symptoms, we have not included these in this document but would recommend the following resources:

1. **Headache**
    a. The British Association for the Study of Headache (BASH) guidelines
    National Headache Management System for Adults 2018
    b. NHS Scotland Headache guidelines
    National Headache Pathway | The National Centre Sustainable Delivery
2. **Transient loss of consciousness**
    a. NICE guidelines
    Overview | Transient Loss of Consciousness ('Blackouts') in Over 16s | Guidance | NICE [CG109]
3. **Dizziness/Vertigo**
    a. NHS Lothian Vertigo and Dizziness - Advice for Initial Management in Primary Care
    b. North West London's Dizziness Flowchart

We also recommend viewing Suspected Neurological Conditions: Recognition and Referral NICE guideline [NG127].

For additional resources, please see https://apps.nhslothian.scot/refhelp/guidelines/neurology/ which has useful information fact sheets on common neurology A&G queries (e.g. phantosmia, sensory symptoms). Also, Buku Medicine is a free medical education app for any clinician who refers to specialist doctors.

1. My patient has a relative who has had a sub-arachnoid bleed. Do they need an aneurysm screening?

The general recommendation for aneurysm screening is if there are two or more first-degree relatives with confirmed brain haemorrhage secondary to an intracranial aneurysm. If referral is required, refer to neurology, neurosurgery or genetics depending on local pathways.

2. Can I give a patient with epilepsy…

a. anti-depressants?

Yes. The evidence that anti-depressant medications worsen seizure control is very limited. SSRIs such as sertraline and citalopram are preferred over tricyclics. Depression and anxiety are common in people with epilepsy and should be treated appropriately.
For further information, see Scottish Intercollegiate Guidelines Network SIGN 143 guidelines (section 6.2.2).

b. medication for ADHD?

Yes. ADHD is more common in people with epilepsy than in the general population. Though ADHD medication (e.g. methylphenidate and amphetamine products) warns about the potential risk of lowering seizure threshold, a large study (Brikell et al. Epilepsia. 2019; 60: 284–293) has shown that ADHD medication does not increase seizure risk in patients with epilepsy.

3. Do patients with essential tremor need to see a neurologist?

Not all patients with essential tremor will need drug treatment; sometimes, reassurance is all that is required. Patients may find useful information at the National Tremor Foundation website (www.tremor.org.uk).

To help to reduce symptoms:
- Avoid caffeine
- Reduce stress
- Relaxation techniques
- Sufficient sleep
- Use heavier cutlery when eating
- Use a heavier cup when drinking, and drink through a straw
- Type instead of writing

Medical treatment
- Propranolol - Can be given on an intermittent basis (e.g. 10-40mg propranolol 30 min to 1 hour before a social activity) or a regular usual dose of 40mg 2-3 times per day. Start 10mg once a day, increased every 3 days to 40mg twice a day. Maintenance is usually 80-160mg daily, though doses up to 240-320mg may be required. Side effects

include light-headedness and bad dreams. Slow-acting preparations can be considered. Atenolol can be considered.

- Primidone - Commence at 25mg once a day, increasing by 25mg weekly, usually to 50mg twice a day (or stopping sooner if there is a good response). Further increases can be made in 25mg increments, up to a maximum of 250mg three times a day. Side effects may include nausea, vomiting, loss of appetite, fatigue, confusion, blurred vision, unsteadiness, and/or reduced sexual function. Side effects are typically short-lived and disappear with continued therapy. Primidone should be taken with meals to help minimise gastrointestinal effects.

Alternatives include Topiramate (contraindicated in women of childbearing potential unless the conditions of the Pregnancy Prevention Programme are fulfilled), Zonisamide or Gabapentin.

4. Do I need to refer a patient with fasciculations?

Fasciculations are common, particularly in the calves, but can occur in any muscle. They are more common in people who are fit and active. Fasciculation in the absence of weakness is not suggestive of underlying motor neurone disease, and reassurance can be given. If there is associated muscle weakness, urgent referral is recommended.

Myokymia (painless repetitive muscle fibre twitching) is commonly seen around the eye or in the first dorsal interosseous muscle. It is nearly always benign.

5. Can I refer a patient with insomnia to neurology?

Most cases of insomnia should not be referred to neurology unless thought to be secondary to a primary neurological disorder (e.g. parasomnia, narcolepsy). Neurological causes of insomnia are unusual. Pure (primary) insomnia is much more common. Psycho-social factors may contribute and should be addressed. Advice can be obtained from Insomnia - NHS (www.nhs.uk). CBT for insomnia is available (free on NHS for some) on Sleep Station. The self-help guide *'Overcoming insomnia and sleep problems'* by Professor Colin Espie is another useful aid. If obstructive sleep apnoea is suspected, please arrange pulse oximetry or refer to the local respiratory service.

6. My patient has symptoms following a head injury

Headaches and dizziness are common post-head injury. Headaches may have a migraine-like phenotype, and dizziness may be due to benign paroxysmal positional vertigo. Therefore these diagnoses are also worth considering and treating.

It is important to exclude subdural haematoma with a CT head scan if they fulfil NICE criteria.

If excluded, simple measures to help with post-head injury symptoms include:

- Ensure well rested and sleep if tired
- Avoid alcohol

- Return to usual activities gradually
- Consider relaxation techniques
- Where possible, keep stress levels reduced
- Analgesia for headache. Low dose Amitriptyline could be considered
- Medication to help with nausea symptoms if present
- An antidepressant if there are symptoms of mood-related disorders, which can sometimes be associated
- If patients have problems with memory/concentration, sometimes assistance of a psychologist or occupational therapist can be beneficial
- Cognitive behavioural therapy could also be considered

A useful patient resource is available at www.headinjurysymptoms.org. Patients can self-refer to the patient charity Headway. They also have a helpful patient information leaflet called "Mild Head Injury and Concussion".

7. My patient has incidental findings on MRI/CT brain

- **Arachnoid cyst** – These are relatively common benign lesions. Most are congenital and remain asymptomatic throughout life. A small percentage may cause symptoms due to increasing size and mass effect. If concerned symptoms are due to the mass effect of an arachnoid cyst, refer to neurosurgery.

- **Atrophy -** Brains atrophy as we age. There is a normal spectrum of atrophy. Most atrophy commented on a scan report would be part of normal ageing and within the normal spectrum. In certain neurodegenerative diseases, atrophy is more common, and the pattern may help identify the disease, but unless there are symptoms most atrophy can be ignored.

- **Colloid cyst -** Most colloid cysts are picked up incidentally. They are located in the 3rd ventricle and can cause obstructive hydrocephalus if they grow. Although the likelihood of growth is low, it is recommended that all patients with colloid cysts be referred to neurosurgery. If there are any symptoms of raised intracranial pressure (optic discs can be checked by an optician/clinician or headache with raised intracranial pressure features), this should be an urgent referral.

- **Empty sella** – In adults, this can be an incidental finding (2-38% of MRI scans) and often does not cause symptoms. It can occur in idiopathic intracranial hypertension but usually there are other associated MRI findings e.g. optic nerve sheath distension. Please check the optic discs or send to an optician to assess for papilloedema. If present, onward referral would then be required.

- **Pineal cyst -** In adults, most pineal cysts are incidental (1-10% of all MRIs) and do not cause symptoms. Incidental simple pineal cysts in adults (<10mm) do not require any monitoring or follow-up scans. If the cyst is large (>15mm, in some centres >10mm), reported as atypical (multiloculated, enhancing, solid component) or associated with hydrocephalus (usually as an emergency) or in a child, please refer to neurosurgery. For more information, please see Management of Pineal and Colloid Cysts article.

- **Meningioma -** It is quite common for meningiomas to be picked up incidentally. Almost all (except very old/frail) should be referred to the neuro-oncology MDT, and most will need monitoring for variable periods of time (whether this is by neurology or neurosurgery may vary depending on local pathways).

- **Small vessel disease -** Small vessel ischaemia (white matter hyperintensities) is a common finding on MR imaging, especially in older individuals. The mainstay of treatment is treating modifiable risk factors (hypertension, hypercholesterolaemia,

smoking, alcohol, and diabetes mellitus) and promoting a healthy lifestyle. At present, there is no evidence for anti-platelet treatment.

- **Tonsillar descent -** Tonsillar descent or low-lying tonsils (less than 5mm descent of the cerebellar tonsils through the foramen magnum). It is not pathological and is distinct from Chiari I malformations (defined as cerebellar tonsillar descent greater than 5mm below the foramen magnum in adults). It is usually asymptomatic; if so, no further treatment is required. However, it may be seen in normal and pathological circumstances (e.g. due to intracranial hypotension or hypertension) therefore, should be considered in the clinical context. Scan review with neuroradiology may be beneficial. If symptoms are present (headache, vertigo, disequilibrium) referral could be considered.

8. My patient is experiencing olfactory hallucinations. Could this be epilepsy?

Most people with olfactory hallucinations (phantosmia) report an intermittent smell of something burnt, foul or unpleasant. Cigarette smoke and petrol are common descriptions. This is usually a benign phenomenon for which no cause is identified. It may be associated with migraine or head injury.

9. My patient has sensory symptoms; could they have MS?

Sensory symptoms are very common in the general population. Most people with fleeting, intermittent or whole-body sensory disturbance will not have an identifiable underlying neurological cause. If symptoms come and go, they are likely to be benign sensory symptoms. Addressing any sleep, pain or mood issues could be helpful. Consider giving advice around hyperventilation in addition if the pattern fits (intermittent sensory symptoms around the mouth or in the extremities).
Paraesthesia related to peripheral neuropathy is usually persistent (although variable). If related to MS, symptoms develop over a few days, plateau for several weeks before then improving. Neurological sensory disturbance usually conforms to specific anatomical patterns.

Functional sensory symptoms are common in people with other persistent physical symptoms (e.g. fibromyalgia) and in people with anxiety. Objective examination is often normal. When abnormal, there is usually a non-anatomical pattern of the deficit e.g. reduced sensation on the palm of the hand only. Reassurance and signposting is usually sufficient. There is useful patient information at Functional Sensory Symptoms – Functional Neurological Disorder (FND) (neurosymptoms.org). Patients who are really disabled by functional sensory symptoms or who have other neurological symptoms may need referral for diagnosis and management of functional neurological disorder.

Note: if sensory disturbance is only in the toes, we find that we hardly ever make a diagnosis in neurology. Watch and wait. Similarly, patients with burning sensations in their feet but normal ankle jerks and no clear sensory disturbance rarely require neurological assessment.

- **Carpal tunnel syndrome -** Episodic pins and needles occurring with activity or during sleep in the distribution of the median nerve consider carpal tunnel syndrome (CTS). Advise a wrist splint to be worn at night for 12 weeks. If there is associated weakness or symptoms do not settle after 2-3 months consider nerve conduction studies or

onward referral. Referral pathways will depend on local arrangements (e.g. neurosurgery, orthopaedic, MSK).

- **Facial numbness -** Intermittent facial numbness is common with migraine and also in hyperventilation (where there also may be perioral or tongue numbness).

- **Meralgia paraesthetica -** Common and can be associated with elevated body mass index. Characteristically, the patient will be able to draw an area with their finger around their anterolateral thigh which is numb or paraesthetic. There should be no associated weakness and normal reflexes. The management is explanation, weight loss where appropriate and avoiding tight clothes in the inguinal region.

- **Multiple sclerosis -** Symptoms develop over days, and persist for days to weeks before resolving. Sensory symptoms lasting minutes to hours, particularly with variable duration, will not be caused by MS. Most commonly, if it affects the spinal cord, it will cause sensory disturbance in the legs with a sensory level on the abdomen or chest. If it affects the brain, it will cause unilateral sensory disturbance.

- **Notalgia paraesthetica -** Describes an area of paraesthesia, which is sometimes itchy, in the medial scapula (where you can't itch). It is benign but annoying, and there is no investigation or treatment required.

- **Peripheral neuropathy -** Length-dependent peripheral neuropathies begin in the toes, move proximally, and then affect hands later (glove and stocking sensory loss). Ankle jerks are usually absent. Check B12, HbA1c, thyroid function and alcohol intake. Consider referral for neurological assessment if no cause is found (30% have no identifiable cause), if it is rapidly progressive or if motor involvement occurs.

- **Restless leg syndrome -** If there are night-time symptoms and no objective sensory loss, consider restless leg syndrome, especially if associated with a need to move. For RLS, check ferritin. If less than 75 µg/l, iron replacement should be considered (once daily or alternate days if not tolerated) and consider investigation if iron deficient. Recheck ferritin in 3 months if symptoms have not improved.
  For more information, see NICE - Restless Legs Syndrome page.

- **Spinal radiculopathy –** Can cause episodic sensory symptoms. A MRI cervical / lumbar spine is not essential but if performed may show mild disc degenerative changes with foraminal narrowing. Exercises and neuropathic analgesics can be helpful. Severe pain may require review and consideration for nerve root injection. Weakness and urinary / bowel symptoms imply spinal cord involvement (myelopathy) and require urgent review.

- **Ulnar neuropathy -** Advise against leaning on elbows and prolonged elbow flexion, especially at night. Patients with only sensory symptoms can be managed conservatively. Referral pathways will depend on local arrangements (e.g. orthopaedic, MSK).

10. My patient has lost their sense of smell or taste. Could there be a neurological cause?

It would be highly unusual for a reduction in sense of smell or taste to be secondary to a primary neurological problem. Possible causes include sinusitis, viral infections (e.g. COVID-19), head injury, nutritional deficiencies (e.g. B12 deficiency), head and neck radiotherapy, ageing, drugs (e.g. antibiotics) and smoking. It can be associated with Parkinson's disease. Neurology referral is not usually required. You may wish to consider referral to the ENT department for further assessment.

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