MULTIPLE SCLEROSIS REFERRAL GUIDELINE

MAINE MEDICAL PARTNERS - NEUROLOGY •92 CAMPUS DRIVE, SUITE B, SCARBOROUGH, ME • (207) 883-1414

HIGH RISK

SUGGESTED EMERGENT CONSULTATION

SYMPTOMS AND LABS

Hemiparesis/plegia, paraparesis/plegia, hemisensory paresthesia/numbness, diplopia with ataxia, vertigo and/or unilateral or bilateral visual loss

EXAM:
Examples: hemiparesis/plegia, paraparesis/plegia, hemisensory deficits, optic neuritis dx by ophthalmologist, hyperreflexia, spasticity

SUGGESTED PREVISIT WORKUP

Send to ER or call REMIS if:

Disabling and/or acute onset of one or more of above symptoms unable to bve managed or evaluated as outpatient (paraplegia, hemiplegia, dysphagia, severe visual loss, severe ataxia) OR alternative diagnosis considered (CVA)

Request urgent neurology consultation for:

New, persistent, subacute symptoms suspected to be due to MS

MODERATE RISK

SUGGESTED CONSULTATION OR CO-MANAGEMENT

SYMPTOMS AND LABS

History of focal CNS symptoms: (paresthesias, numbness, weakness, ataxia, diplopia, history of optic neuritis) which lasted for days or weeks but resolved or improved

History of recurrent episodes of one or more of above symptoms in the past with recent reoccurrence

Progressive LE weakness, numbness, ataxia with onset of symptoms in late 40s or 50s

Existing MS diagnosis:
- need for transfer of care
- second opinion on management
- 2nd opinion for suspected MS dx

EXAM:
unilateral upper/lower OR bilateral lower limb motor or sensory deficits, ataxia, hyperreflexia
MRI:
suggestive or diagnostic of MS

SUGGESTED WORKUP

Request more urgent MS evaluation (less than 4 weeks) for recent new symptoms improved or resolved if patient w/o current neurologist OR patient is transferring care from out of state and needs medication management (ex. infusions)

LABS to r/o mimickers:
CBC, CMP, TSH, B12, ANA, RF, SSA/B, ACE, Lyme, RPR

Routine scheduling for transfer of care/second opinion

LOW RISK

SUGGESTED ROUTINE CARE

SYMPTOMS AND LABS

Less than 48 hours symptom duration, non-localizing symptoms, alternative diagnosis considered that would require more acute evaluation (stroke, cord compression, malignancy)

Patients seeking more than a 3rd opinion after negative neurological work ups

EXAM:
Normal or alternate diagnosis more likely

MRI:
Brain and cervical spine negative

SUGGESTED MANAGEMENT

Consider general neurology referral if still concerned about a neurological etiology

CLINICAL PEARLS

- Common Neurologic Symptoms of Multiple Sclerosis:
- Optic Neuritis (decreased acuity and color saturation, scotoma, pain w/eye movements)
- Partial Transverse Myelitis (weak legs, numbness, neurogenic bladder, Lhermitte's phenomenon)
- Cerebellar/Brainstem (imbalance, dysarthria, diplopia, dysphagia, tremor, vertigo)

Maine Medical
PARTNERS

These clinical practice guidelines describe generally recommended evidence-based interventions for the evaluation, diagnosis and treatment of specific diseases or conditions. The guidelines are: (i) not considered to be entirely inclusive or exclusive of all methods of reasonable care that can obtain or produce the same results, and are not a statement of the standard of medical care; (ii) based on information available at the time and may not reflect the most current evidenced-based literature available at subsequent times; and (iii) not intended to substitute for the independent professional judgment of the responsible clinician(s). No set of guidelines can address the individual variation among patients or their unique needs, nor the combination of resources available to a particular community, provider or healthcare professional. Deviations from clinical practice guidelines thus may be appropriate based upon the specific patient circumstances.

V1.1 7/21