NEUROLOGY

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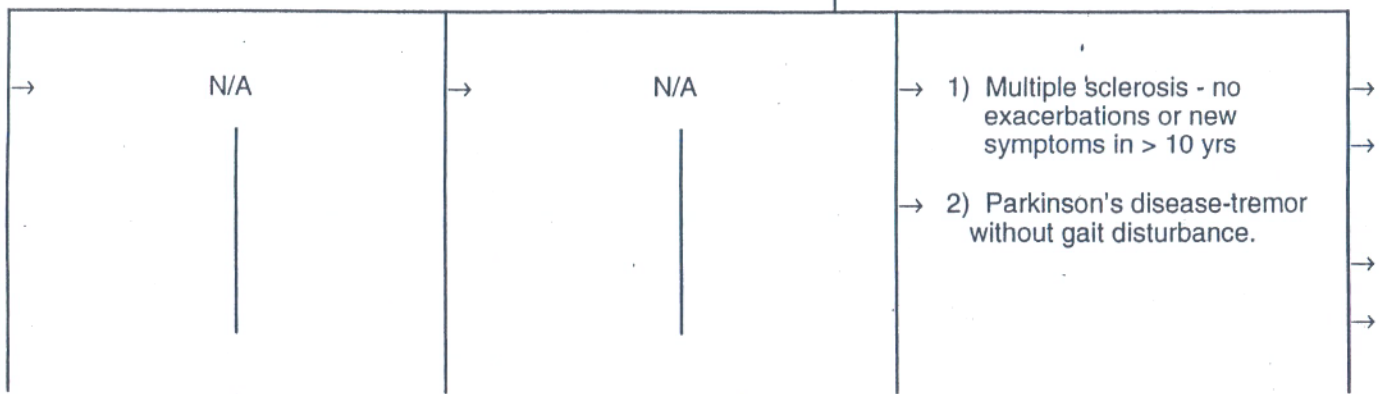
AMYOTROPHIC LATERAL SCLEROSIS (335.20), MULTIPLE SCLEROSIS (340), PARKINSON'S DISEASE (332), MYASTHENIA GRAVIS (358.0)

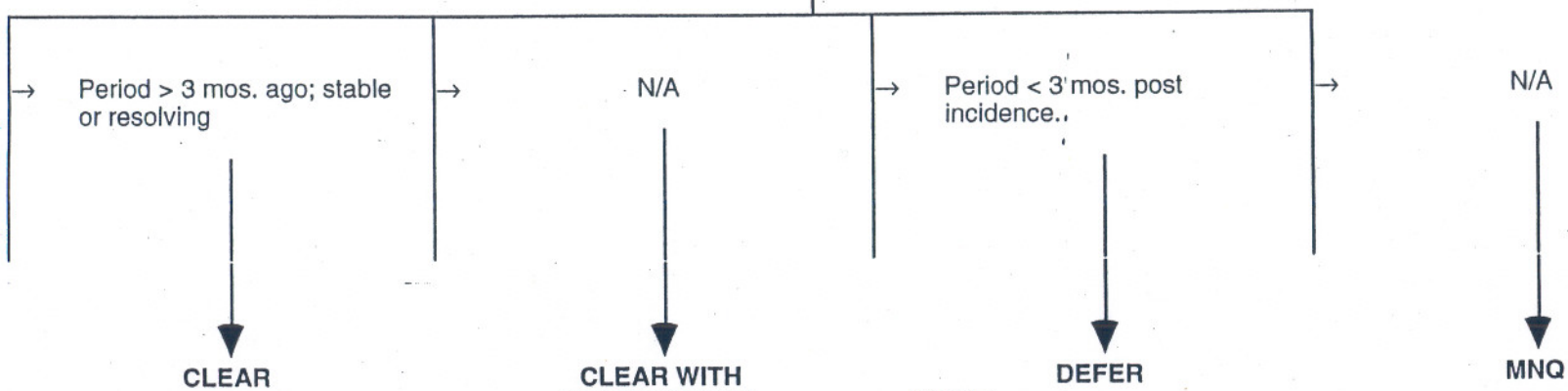


CRITERIA	→ N/A	→ N/A	→ 1) Multiple sclerosis - no exacerbations or new symptoms in > 10 yrs → 2) Parkinson's disease-tremor without gait disturbance.	→ 1) ALS → 2) Multiple Sclerosis - exacerbation or new symptom within 10 yrs. → 3) Parkinson's Disease → 4) Myasthenia gravis
ACTION	**CLEAR**	**CLEAR WITH RESTRICTIONS**	**MRB/MED ADVISOR**	**MED**
RESTRICTIONS/ DEFER			1) Note: Patients are often heat intolerant - consider country restriction 2) See below	
RATIONALE				1-3) Progressive neurological disease. 4) Recurrent, unpredictable exacerbations.

MEDICAL INFORMATION NEEDED:

Stated diagnosis.
Current Neurologist evaluation if considering clearance for stable multiple sclerosis
Parkinson's disease without gait disturbance:
Current neurological evaluation to include, current activity limitations; estimate of progression over next 3 yrs; need for medication over next 3 yrs; likelihood of exacerbation overseas due to stress, other medications, environmental or nutritional factors.

BELL'S PALSY (351.0)



RESTRIC-TIONS/ DEFER

UNTIL:

Period of 3 mos. post episode; stable or resolving.

RATIONALE Most cases resolve with little or no sequellae, within 3 mos., no need for F/U.

MEDICAL INFORMATION NEEDED: Generic information

5/4/93

HEADACHE, CLASSICAL MIGRAINE (346.0), COMMON MIGRAINE (346.1), TENSION (307.81), OTHER OR CLUSTER (346.2)

CRITERIA	→ Successfully self-manageD, not interfering with function (OTC, ISAID, analgesic, or ergotamines, prophylactic beta blockers, calcium blockers or low dose tricyclic). No transient neurologic deficits.	→ N/A	→ 1) Unsuccessful self-management or interferes with function. → 2) Periodic treatment with injected narcotic, ER visit.	→ Assoc. with transient neuro deficits.
ACTION	**CLEAR**	**CLEAR WITH RESTRICTIONS**	**DEFER**	**MNQ**
RESTRICTIONS/ DEFER			UNTIL: 1) Self-managed, no longer interferes with function. 2) Less severe, self-managed	
RATIONALE	Tension or Migraine headaches can be idiopathic or caused by Hydrocephalus, tumors, trauma. Classic migraine may have a visual aura at onset. Transient neurologic deficits (aphasic, weakness, slowed speech) occurring during or after the headache, may result in complications.			Too incapacitating, interferes with PCV's ability to function.

MEDICAL INFORMATION NEEDED: Generic information

Need for additional testing management plan.

5/4/93

MALIGNANCIES OF THE NERVOUS SYSTEM, BRAIN (191), OTHER (192)

CRITERIA

For all malignancies of the nervous system: Applicant must be free for 5 years from recurrence, without neurological abnormalities that would interfere with functioning; current evaluation by neurosurgeon and/or oncologist, and current status and prognosis reviewed by MRB.

ACTION	CLEAR	CLEAR WITH RESTRICTIONS	DEFER	MNQ
RESTRICTIONS/ DEFER				
RATIONALE				

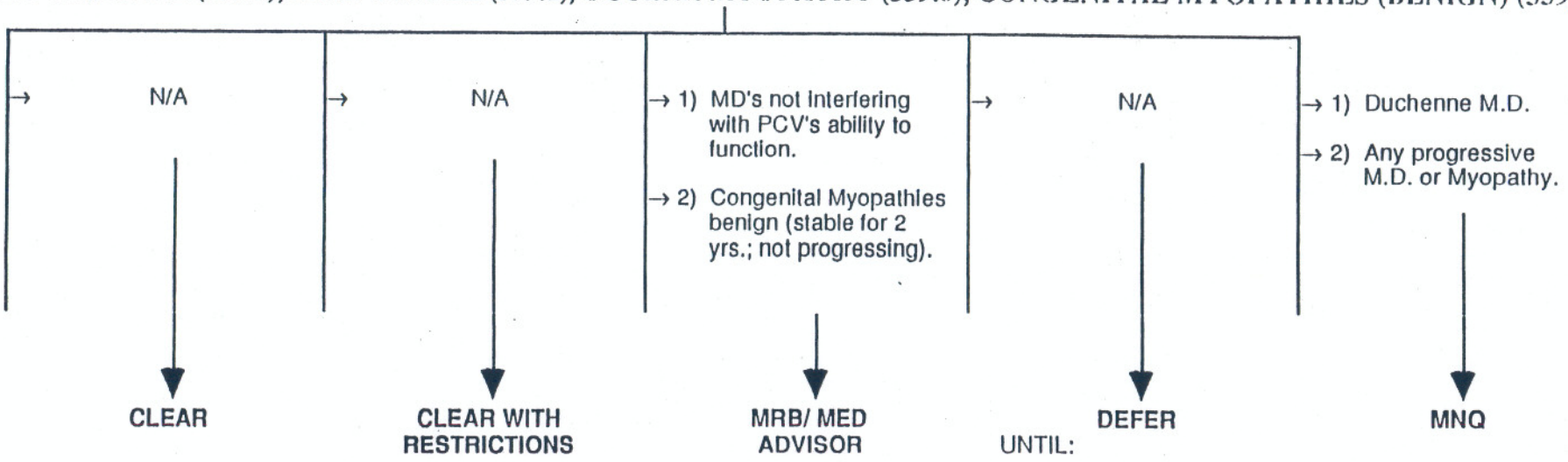
MEDICAL INFORMATION NEEDED:

Generic Information

Neurological evaluation or report.

5/4/93

MUSCULAR DYSTROPHY (MD) (359.1) AND CONGENITAL MYOPATHIES (359), DUCHENNE MD (359.1), LANDOUZY-DEJERINE (359.1), LIMB-GIRDLE (359.1), OCULAR MYOPATHY (359.0), CONGENITAL MYOPATHIES (BENIGN) (359)



RESTRICTIONS/ DEFER

1&2) PCMO concurrence; restrictions specific to functional ability.

RATIONALE

The Muscular Dystrophies are a group of progressive muscle disorders. However, different types progress at varying rates, and marked differences in functioning.

1) Duchenne MD: most common and most severe (MNQ). All other MD's need to be assessed on an individual basis.

2) Landouzy-Dejerine: weakness of facial muscles and shoulder girdles - usually ambulates without difficulty progression variables; life expectancy is normal.

3) Limb-Girdle MD: weakness of the pelvis and shoulder.

4) Ocular myopathy: ptosis and ophthalmoplegia.

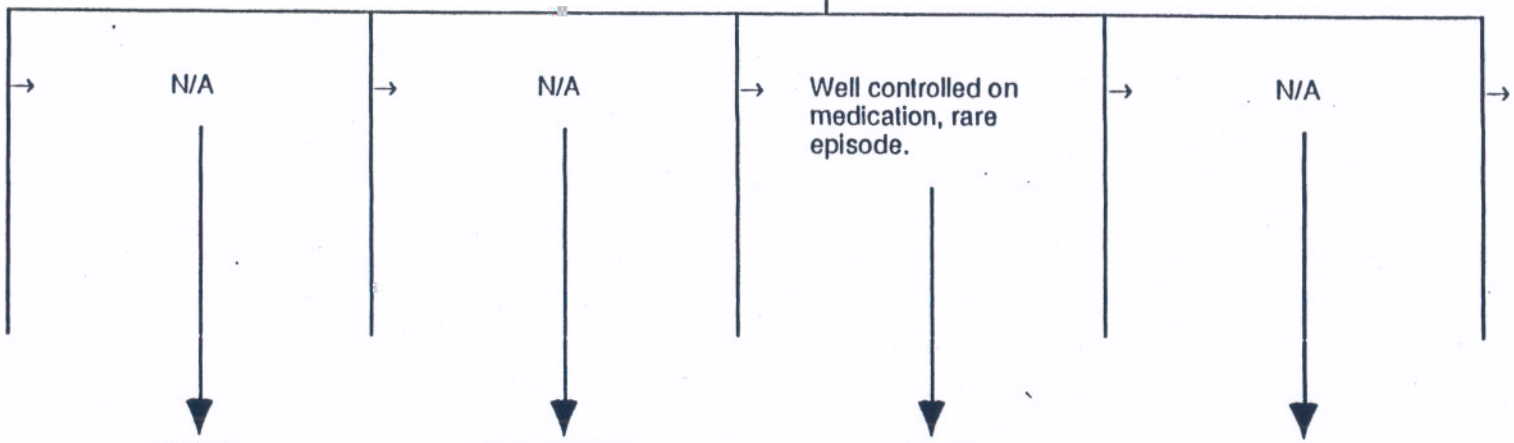
MEDICAL INFORMATION NEEDED:

Generic information; Neurologist evaluation

Rate of progression; activity, ambulation limitation; EMG's; muscle biopsies results.

5/4/93

NARCOLEPSY (347)



RESTRIC-TIONS/ DEFER

RATIONALE

Narcolepsy can be fairly easily controlled with meds: Amphetamines, Ritalin, MAO inhibitors, Imipramine, and ephedrine. Individuals with Narcolepsy can drive. They know when they're falling asleep. Ritalin and Amphetamines have some abuse potential.

Interferes with PCV's ability to function. Places PCV at risk for injury.

MEDICAL INFORMATION NEEDED:

Generic Information; Neurologist evaluation

Treatment needed next 3 yrs.; F/U needed for meds.; Activity limitations.

5/4/93

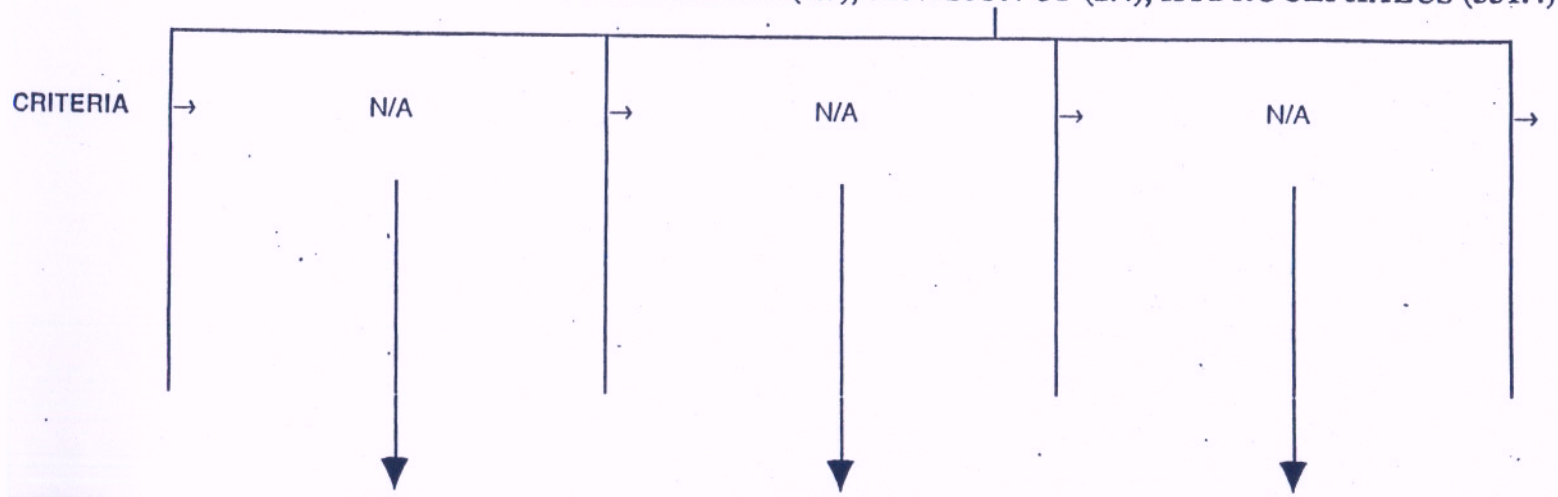
SEIZURE DISORDER, CONVULSIVE (345.1), NON-CONVULSIVE (PETIT MAL) (345.0)

	CLEAR	CLEAR WITH RESTRICTIONS	DEFER	MNQ
CRITERIA	→ 1) Hx of febrile seizures of infancy; no adult seizure. → 2) Anoxic seizure (vasovagal episode, hypotension, non-recurrent) → 3) Single seizure; seizure free without meds, for period > 2 yrs., normal EEG. → 4) Hx of multiple seizures; period > 5 yrs. med free without seizures.	→ 1) Currently on medication, one year seizure free and on same dosage for 1 yr. → 2) Single seizure: period of 1 yr. free without meds; NORMAL EEG. → 3) Hx of multiple seizures 2 yrs. seizure free without meds. Normal EEG.	→ 1) Seizure within last year. → 2) Change in meds. in last year. → 3) Meds. DC'd in last year. → 4) Abnormal EEG, not currently on medication	→ History of status epilepticus.
ACTION			UNTIL:	
RESTRICTIONS/ DEFER		1-3) PCMO concurrence list 3 countries: 4 - 6 hrs. from medical care.	1-3) See CLEAR or CLEAR WITH RESTRICTIONS. 4) stable on medication > 1 yr	
RATIONALE	Idiopathic seizures are usually fully controllable with proper med regime. Some individuals present with status epilepticus but can also be well controlled on meds. After 1 yr. seizure free, it is unlikely more seizures will recur. However, individuals are at added risk for seizures during febrile illnesses. Medication drug levels are not significant if the individuals is seizure free, except to R/O toxicity.		Still at risk for seizures. Places PCV at risk for injury or life threatening episode. Seizure Disorder: Multiple seizure episodes or abnormal EEG.	At risk for severe seizures.

MEDICAL INFORMATION NEEDED: Generic Information; Neurological evaluation.
Neurologist evaluation.
EEG results for adult , non-anoxic seizures, only if not currently on medication.

2/28/94

VENTRICULAR SHUNT (2.3), REVISION OF (2.4), HYDROCEPHALUS (331.4)



RESTRIC-TIONS/ DEFER

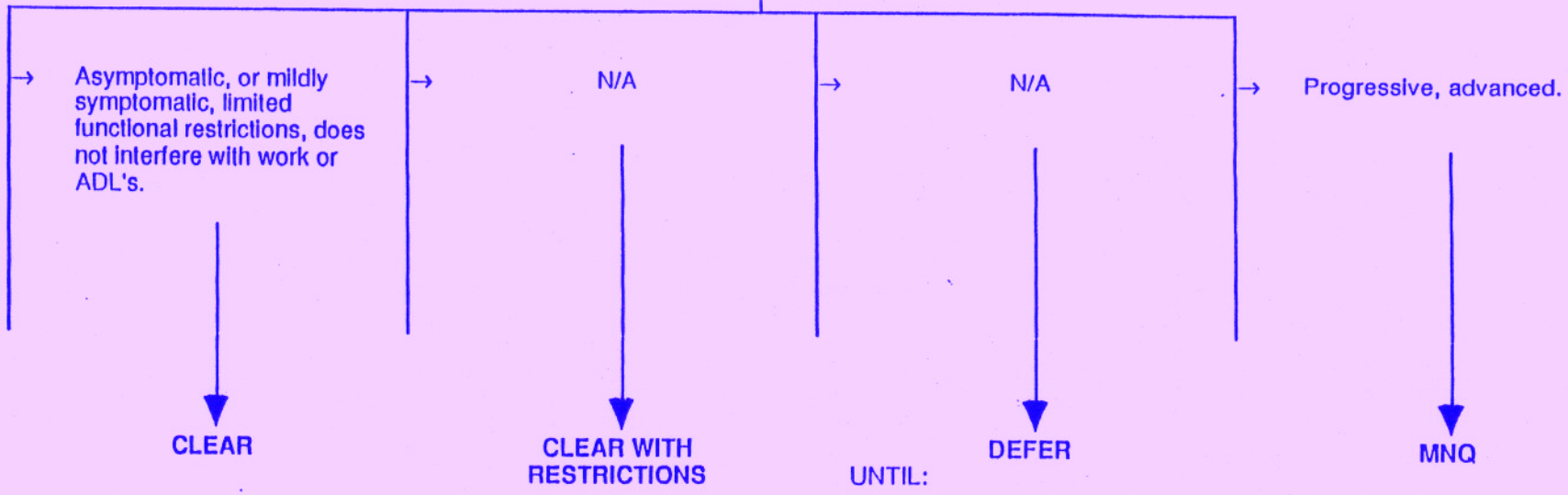
RATIONALE

Treatment cannot be supplied in developing countries.

At risk for infection and malfunction.

MEDICAL INFORMATION NEEDED: Stated diagnosis.

POST-POLIO SYNDROME (138)



RESTRICTIONS/ DEFER

Restrictions based on individual's specific requirements. Usually requires sedentary job placement.

RATIONALE

Post-Polio Syndrome is an unpredictable, recurrent syndrome affected by stress and fatigue.

MEDICAL INFORMATION NEEDED:

Generic information; Neurologist evaluation;

F/U next 3 yrs.; functional limitations.

5/4/93

NEUROLOGY

Ventricular Shunt: The opinion of the length of time
Individuals with shunts are at
problems, or blurred vision. T
to one. If the shunt has not ne

Any progressive neurological disease (Amyotrophic Lateral Sclerosis, Multiple Sclerosis, and Myasthenia Gravis) is difficult to assess because of variable progression rates. Individuals with a progressive Neurological Disorder are at risk for developing severe problems overseas.

Cerebral Palsy: Is a non-progressive disorder. The individual will require an evaluation to assess the degree of limitation. The individual may need a special placement due to the applicant's individual limitations. They are at risk for injury from falls.

Encephalitis/ Meningitis: If treated promptly, recovery is usually complete. However, seizures from the illness can develop up to one year post episode. Seizures will usually develop in individuals with other complications from the diseases.

Headache: Is a common problem. Serious disease such as neoplasm or hydrocephalus must be r/o'd with MRI or CT scan before initiation of treatment. For debilitating headaches, many effective medications now exist: Cafergot, Inderal, Ca channel blockers, tricyclic antidepressants, and Methysergide. Methysergide is given for < 3 months because it constricts the blood vessels indiscriminately; it is not appropriate for overseas administration. The other listed medications do not require any special F/U or blood work. One headache every 2 months is considered well controlled.

Muscular Dystrophies: Is a progressive disorder and in many cases is very severe. However, some benign Dystrophies do occur. If the applicant is stable and functional, they could be considered for clearance. The applicant would require a Neurological evaluation.

Narcolepsy: Is a fairly benign condition that can be well controlled with medications. Most Narcoleptics drive and operate machinery. Narcoleptics know when they are falling asleep and can take safety precautions. Meds (see guidelines) need no special lab work done. They are usually seen for f/u q 3-4 months if on Ritalin or amphetamines, because these medications have abuse potential. If on different medications, they are seen q 4-6 mos. Optimal control should be approximately <10 episodes per week of <5 minutes each on or off medications.

Parkinson's Disease: Is a slowly progressive disorder with variable rates of progression of from 5-20 years. Any applicant with a history of Parkinson's must have a Neurological evaluation. One year after diagnosis should be an adequate length of time to assess the individual's progression. Medications for treatment of Parkinson's do not require any special F/U. The individual needs evaluation q 6 months.

Seizure Disorder: Standard practice considers a seizure disorder one year on the same medication(s) and dosage without seizure activity as well controlled. The effectiveness of the meds has been established by then. However, an underlying neurological disorder must first be r/o'd. Individuals with seizure disorder need to be within a short distance of medical care. They are more susceptible to seizures during a febrile illness. Blood levels are not necessary if seizure free for 1 year. The effectiveness of the medication has already been demonstrated in the individual's response. They require follow-up every six months. Some individuals present in status epilepticus; they may become well controlled with proper medications.

Neurology

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September 17, 1997

TO WHOM IT MAY CONCERN

RE: [redacted]

I have evaluated [redacted] in the Sleep Disorders Clinic for the problem of severe excessive daytime sleepiness. The degree of sleepiness was such that [redacted] had extreme difficulty in coping with [redacted] educational and social responsibilities. Our evaluation resulted in a diagnosis of probable narcolepsy and mild obstructive sleep apnea. [redacted] has responded reasonably well to treatment with stimulant medications (methylphenidate), and is now able to perform adequately.

Narcolepsy is a disorder characterized by two different but related phenomena-that of pathological sleepiness and REM (dream) sleep disorganization. The former term refers to the inability to stay awake in situations that would cause (if you do fall asleep) social or medical harm. Examples would include while driving, talking over the telephone, examinations, classes, important meetings and in the presence of guests. Frequently this cannot be prevented in spite of the individual's best efforts, even if they think that they are in control. Objective measures of this are tests that determine how quickly they can fall asleep (the Multiple Sleep Latency Test) and the ability to stay awake under quiet conditions (the Maintainance of Wakefulness Test-not in general use), but they do not always correlate well with what the individual patient may experience in terms of sleepiness.

The requirement for treatment is lifelong, and requirements tend to be stable over time. Naps frequently make narcoleptics feel better, and they learn to use them in a strategic manner, such as before an anticipated need to maintain optimal alertness. Employers and teachers need to recognize this continuing need (for naps) in patients with narcolepsy, and often make small but special and very useful concessions (allowing naps).

Normal rapid eye movement (REM) sleep (dream sleep) is characterized by loss of muscle tone (paralysis), dreaming, eye movements and variable heart rate and respiration. REM sleep tends to occur at odd times in a narcoleptic, such as at sleep onset and during naps. They may start dreaming as soon as they fall asleep or even during short naps. They may dream while waking. Sleep-onset dreams can be at times very vivid and frightening. Untreated narcoleptics may also perform automatic acts with no recollection, due to a mix of sleep and waking behaviors.

Sleep paralysis is the condition where the loss of muscle tone seen NORMALLY in REM sleep occurs while narcoleptics are just falling asleep or awakening. It can be initially quite disturbing, but most get used to it. They last for a few seconds to several minutes, and essentially thay are awake but cannot speak/move, and may feel suffocated. Some younger narcoleptics actually become afraid to go to sleep because of the fear of frightning dreams or sleep paralysis.

Cataplexy is an emotion-linked muscle weakness. It represents the normal paralysis seen in REM sleep that is trigerred by emotion while awake. It can be induced by laughter (most common) anger, fear, startle, sex or other emotions. It may be as mimimal as a wave of subjective weakness running through the body, or complete collapse to the ground. Jaw weakness and a slumping shoulder are typical, and the kness feel like "jelly". This may happen so frequently that it itself needs treatment. It is of great diagnostic help, and is practically diagnostic of narcolepsy. REM sleep phenomena can be treated with drugs such as prozac and tricyclic antidepressants, which suppress REM sleep even in normals. If severe, such individuals may be seen as behaving "abnormally".

Every narcoleptic will have "attention deficit". No one who is sleepy can sustain attention and perform optimally in tasks that need continuous monitoring of performance or those that need focussed concentration for more than a few minutes. Examples include being attentive during meetings and lectures. Every narcoleptic may feel depressed-they may live constantly in a "twilight zone" of drowsiness and cognitive fatigue. It is very difficult to prove the absence of depression, as drugs like prozac may help narcoleptics by a related mechanism.

It is important that techers, educators in general and employers understand this disease to some extent, to enable them to appreciate the unique nature of the individuals with this disorder. They are not stupid or lazy, just uncontrollably sleepy. Some highly successful individuals today are treated narcoleptics.

Special allowances may have to be requested and made for individual narcoleptics during school / college and regular work, often on an individual basis. Examples include no shift-work (which is very poorly tolerated by narcoleptics), use of naps and allowing extra time for examinations. Academic results prior to accurate diagnosis and treatment are often very poor and may be marked for the purpose of providing an explanation for the record.

I hope this information is useful in dealing with the issues raised by individuals such as [redacted]. If I can be of any