

Claims Case Study 1

Gender: Female

Age: 32

Policy Definition:

A definite diagnosis by a consultant neurologist of Multiple Sclerosis. There must be current clinical impairment of motor or sensory function which must have persisted for a continuous period of at least 6 months.

GP report:

Presented to GP in August 2014 with 2 periods of visual disturbance and facial/left sided numbness. Was also seen in 2010 with some blurring of vision and pins and needles. Spontaneously resolved so thought to be viral and not investigated.

Referral made when seen with a week's symptoms in view of previous viral problem and also reporting periods of nausea in between these periods.

Referred for MRI, lumbar puncture and VERs.

Neurologist report:

MRI of brain showed multiple white matter lesions indicative of demyelination. MRI of spine also showed lesions consistent with demyelination. Lumber puncture showed oligloclonal bands to be present in spinal fluid and VER's showed clear delay, both strong indicators of MS.

Diagnosis made as above (MRI and other MS specific tests). Also she has now had two episodes of visual and motor disturbance of three weeks duration.

To date she has only had short periods so far. Diagnosis made of classic relapsing/remitting MS. Currently in a period of remission. Only minor symptom is slight pins and needles twice a day lasting no longer than 5 minutes. Continues to work at present so no treatment as yet but has been referred to the MS nurses.

Questions:	
	☐ Are you happy with the diagnosis of MS?
	☐ Are you satisfied the claimant has had symptoms for 6 months?
	☐ Would you seek any additional evidence?
	☐ Would you seek a CMO opinion on this case?