Primary Care Advice and Guidance
Sensory Symptoms

Sensory symptoms are very common in the general population, are often benign and most patients do not require a neurological consultation to deal with them.

Initial Primary Care Assessment

- Patients should have general physical and neurological examination with deep tendon reflexes.
- Ask about alcohol intake, medications, illicit drugs (including nitrous oxide balloons) and vascular risk factors.
- Please also check the following blood tests:
  FBC, B12*, Folate*, U&Es, TFTs*, LFTs, Calcium/albumin, Random glucose & HbA1C
  *(TFT, Vitamin B12 and folate do not need to be repeated if done within 3 months prior to referral)

Intermittent Sensory Symptoms

If symptoms come and go, they are likely to be **benign**.

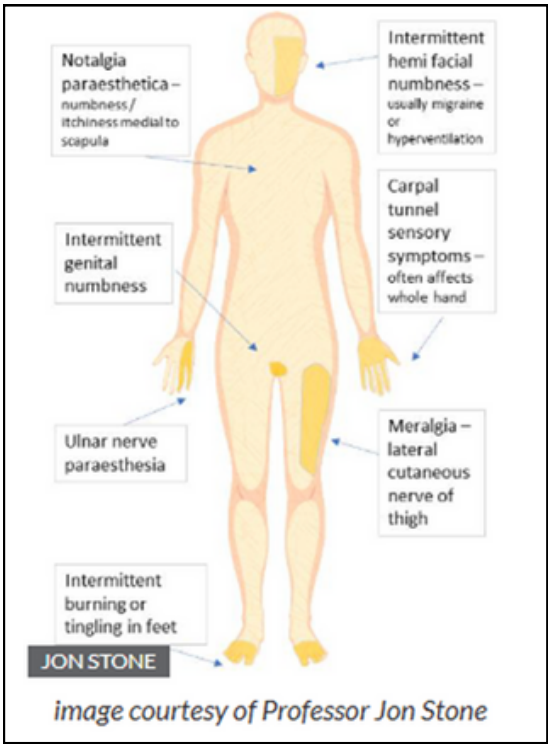

image courtesy of Professor Jon Stone

Paraesthesia (a burning or 'pins and needles' sensation) due to peripheral neuropathy is usually persistent (although variable) and if related to Multiple Sclerosis (MS) tends to worsen over a few days and plateau for several weeks before improving. If related to MS, it will also rarely be in the distributions shown in the diagram and upper motor neurone findings are typically found on examination.

Are they related to posture or time of day?

Hand symptoms occurring at night or in the morning are usually carpal tunnel or ulnar compression, regardless of the distribution (which often doesn't follow textbook descriptions). Tingling or burning in the feet mostly at night is common as part of restless legs syndrome. Meralgia may be worse after driving or with tight clothing.

Facial numbness – Intermittent facial numbness is common with migraine, also in hyperventilation (where there may be perioral or tongue numbness also).
The hyperventilation may not be noticeable to patient.

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Sensory Symptoms

Notalgia Paraesthetica – describes an area of paraesthesia, which is sometimes itchy, in the medial scapula. It is benign but annoying and there is no investigation or treatment required

Carpal tunnel and ulnar sensory symptoms – are common in the population. Advise a wrist splint to be worn at night for 12 weeks in suspected carpal tunnel syndrome. Advise avoid leaning on elbows, prolonged elbow flexion, especially at night for ulnar nerve symptoms.

Intermittent genital numbness – is nearly always benign and commonly goes with chronic pelvic pain. Think about cauda equina/neurosurgical referral if there is clear sphincter dysfunction, erectile dysfunction, sciatica or leg weakness.

Meralgia paraesthetica – is really common especially as the population becomes more obese. The patient will characteristically be able to draw an area with their finger around their anterolateral thigh which is numb or paraesthetic. The management is explanation, weight loss where appropriate and avoiding tight clothes in the inguinal region.

Who to refer?

- Patients developing limb weakness or unsteadiness (sensory ataxia).
- Neurological examination consistent with a peripheral neuropathy (if reflexes are present, it is very unlikely to be a peripheral neuropathy and neurophysiology is likely to be normal).

Who to refer urgently?

- Patients with rapidly evolving or significant motor weakness - ***consider hospital admission via local acute medical admission pathways.***
- Patients with myelopathic features on examination (hyperreflexia, ankle clonus or a sensory level.
- Patients with associated sphincter disturbance - ***consider referral to spinal surgeons.***

Patients Who May Be Managed in Primary Care/Unlikely to Benefit from Specialist

- Patients with symptoms lasting seconds or minutes - suggest a watch and wait policy.
- Patients with intermittent sensory disturbance in toes or burning sensations in feet with normal examination including ankle reflexes - suggest watch and wait.
- Patients with a previously confirmed genetic neuropathy e.g. Charcot Marie Tooth Disease, with clinical progression due to natural history of the neuropathy, but no available active therapies. Travel to hospital for reassessment is unlikely to add further in such patients. It could be useful to discuss the case with the responsible consultant in case referrals to other services may be helpful. (e.g. rehabilitation medicine, physiotherapy etc)
- Diabetic neuropathy. Patients with a history of diabetes mellitus with gradual onset symmetrical distal sensory neuropathy do not typically need further assessment in neurology. Blood tests as recommended above may be useful.