

Probable Mild Axonal Peripheral Neuropathy

Centre for
Sustainable
Delivery



NHS
SCOTLAND

– advice for initial management in primary care

Introduction

This Fact Sheet provides information on how to treat patients with Probable Mild Axonal Peripheral Neuropathy with different symptoms, situations and circumstances.

Peripheral Neuropathy

Peripheral neuropathy has a long list of causes, some of which are treatable, such as diabetes, toxic or autoimmune disorders. Other causes, such as genetic, are useful to identify even if there is no current treatment. In practice, a large proportion of peripheral neuropathic symptoms are either not due to an identifiable peripheral neuropathy, or a consequence of axonal degeneration, especially in older people. These patients usually follow a benign course, do not become disabled and often do not need to see a neurologist. This fact sheet is aimed at providing information for this group to support their management in primary care. It is not a substitute for detailed information about peripheral neuropathy, or causes of lower limb numbness.



Is tingling in the feet usually peripheral polyneuropathy?

Sometimes, but there are many other causes. Lumbosacral radiculopathy commonly causes paraesthesia in the feet, as does compression of the peroneal nerve at the fibular head. People with restless legs syndrome commonly complain of burning feet and individuals who hyperventilate may experience intermittent paraesthesia in their feet. Neuropathies tend to cause persistent (if variable) symptoms, not intermittent. If people can identify times when their extremities are normal, a neuropathy is unlikely as intermittent sensory symptoms are common in the normal population.



Which groups of patients can be managed in primary care with suspected peripheral neuropathy without needing to see a neurologist?

Over the age of 60, around a third of people lose vibration sense at the big toe and around 20% of people lose their ankle reflexes. Approximately 13% of the UK population over the age of 80 probably have some degree of polyneuropathy – which is nearly all axonal. We cannot, and do not, need to see all of these individuals so it is a case of doing what is reasonable and providing sensible advice. Patients with the following features can usually be managed conservatively in primary care:

- Symmetrical
- Distal sensory loss only
- No gait disturbance
- Normal neurological examination or only minimal features (e.g. reduced vibration sense at toes)
- Only very slowly progressive
- Over the age of 75



This is just a guide and it is difficult to make fixed rules. Please seek our advice if unsure.

Probable Mild Axonal Peripheral Neuropathy

– advice for initial management in primary care

Centre for
Sustainable
Delivery



NHS
SCOTLAND



Which blood tests should these patients have?

- U&E, FBC, LFTs, TFTs, ESR.
- Blood Glucose. Some also suggest doing (and acting on) a glucose tolerance test as well.
- Vitamin B12.
- Protein Electrophoresis and serum immunoglobulins.
- HIV.



What should I tell my patients if I am not referring them?

In an older person with mild sensory distal symptoms as above who you have already investigated, we suggest:

- Consider treating low normal B12 with replacement therapy.
- In addition, advise the patient that disability is unlikely: e.g. 'This is common in the population. Its annoying, but is unlikely to progress and cause disability'. Most people with peripheral neuropathy present because they are worried that the problems are going to progress to cause disability and loss of independence. Studies following people for 10 years do not show disability or problems walking.
- Review for progression: e.g. 'Come back and see me if problems are worsening or causing mobility problems.'



Should I try neuropathic pain medication (e.g. tricyclics, gabapentinoids, duloxetine) for pins+needles/tingling?

Generally, the answer is no. These drugs are for neuropathic pain, not sensory symptoms and they have side effects. They may be useful in moderate to severe symptoms where pain is the issue, but they rarely help non-painful sensory symptoms.



References:

Based on UpToDate 2020 and Overell J. Practical Neurology 2011; 11:62-70