National Institute for Health and Care Excellence

Final

Multiple sclerosis in adults: management

Committee discussion for diagnostic criteria for multiple sclerosis; possible multiple sclerosis; neuromyelitis optica and clinically isolated syndrome

NICE guideline NG220

Committee discussion underpinning recommendations 1.1.1 to 1.1.9 and research recommendations in the NICE guideline

June 2022

Final

National Institute for Health and Care Excellence

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1 Diagnostic criteria

1.1 Review question:

What are the key diagnostic criteria for the following: multiple sclerosis; possible multiple sclerosis; neuromyelitis optica and clinically isolated syndrome?

The committee agreed that the recommendations for the diagnosis of multiple sclerosis should be based on McDonald criteria. These criteria are well established and accepted across the multiple sclerosis community. The McDonald criteria are widely accepted as the gold standard for the diagnosis of MS. They were used as the basis for the recommendations in the 2014 version of the guideline and these recommendations were therefore updated in accordance with the revised 2017 criteria. An evidence review looking at the diagnostic accuracy of different diagnostic criteria was therefore not thought to be helpful in informing recommendations. Committee consensus opinion was used to word the recommendations that would be useful for clinicians in practice (by informal consensus methods).

1.1.1 The committee's discussion and interpretation of the evidence

1.1.1.1 The outcomes that matter most

An accurate diagnosis of multiple sclerosis will help direct appropriate management and treatment.

1.1.1.2 The quality of the evidence

The recommendations for diagnosis are based on agreed international criteria for diagnosis of Multiple Sclerosis. The committee used informal consensus to agree the wording of the recommendations, adapting the most up to date McDonald criteria for use by non-MS specialists.

1.1.1.3 Benefits and harms

A prompt and accurate diagnosis will ensure that people have timely access to interventions to manage their symptoms. Clinical harms include delay in diagnosis and misdiagnosis. If non-specialists have a clearer idea of the clinical presentation of MS, they may refer at an earlier stage. The committee therefore highlighted common symptoms of MS as well as those which are not suggestive of the condition. The committee added the importance of excluding fever and infection as these can mimic the symptoms of MS. The committee removed the recommendation on performing blood tests to exclude alternative diagnosis. They highlighted that these need to be tailored to the individual and their presenting symptoms. Providing information as to which patients are unlikely to have MS is also of benefit to non-specialists and people with symptoms. The committee emphasised the importance of a review for people who had symptoms but did not meet the McDonald criteria for diagnosis. Information and support should also be provided. The committee discussed the impact of a diagnosis of MS and the importance of providing information on support groups and reliable internet sources. This is further supported by the recommendations on information and support.

1.1.1.4 Cost effectiveness and resource use

Considering specific characteristics for the diagnosis of multiple sclerosis does not have any economic implications. The recommendations reflect current clinical practice and are not expected to increase the number of referrals or the cost of making a diagnosis.

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1.1.1.5 Other factors the committee took into account

The committee considered that the diagnosis of MS is complex but diagnostic criteria are a guide to who should be referred to a specialist. MS occurs primarily in people between ages of 20 and 50 years. The pathology of MS is of an inflammatory process and the time course can help differentiate symptoms from those caused for example, by TIA or stroke where the symptoms occur suddenly or over a time course of minutes to hours. The committee considered it useful to identify common patterns of presentation, but the list is not exhaustive. Fatigue, depression, and dizziness are non-specific symptoms and would not usually suggest a diagnosis of MS if a person does not have accompanying neurological symptoms and signs.

The committee discussed how it may be difficult for people living in rural areas to access a consultant neurologist and they may have to travel long distances. However, the committee confirmed that due to the importance of obtaining an accurate diagnosis a referral to a consultant neurologist is essential.

The committee noted that a copy of the clinic letter detailing the discussion and diagnosis is typically sent to the GP. They expect this to be sent quickly (as often the patient will contact the GP shortly after the diagnosis) and include the contact details and resources that the patient has been signposted to, including legal requirements and rights.

The committee were aware of the NICE guideline on suspected neurological conditions: recognition and referral (NG127) and made a cross reference to this.

1.1.2 Recommendations supported by this evidence review

This evidence review supports recommendations 1.1.1 to 1.1.9.

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