Polio Survivors' Page

PROGRAM OPERATIONS MANUAL SYSTEM

Part 04 - Disability

Chapter 245 - Medical Evaluation

Subchapter 80 - Evaluation of Specific Issues/Neurological

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ACTION NOTE

DI 24501--Add DI 24580.000 and subchapter title to the chapter Table of Contents.

Background

This transmittal discusses the late effects of anterior poliomyelitis (polio) which may occur many years after the acute illness. It introduces guides concerning the documentation and evaluation of the new functional problems being experienced by some polio survivors. These new functional limitations are causing increased impairment for some individuals in the performance of usual daily activities including work activities.

Explanation of Manual Changes

24580.010 Evaluation of Late Effects of Poliomyelitis

Subsection A defines acute anterior poliomyelites which is now generally considered to be conquered in most industrialized countries because of vaccines developed in the mid-1950's. Also defined are late effects of polio which, for program purposes, encompass those new functional problems which may occur in an individual with a prior history of acute poliomyelitis who has had a long period (generally 20-40 years) of stability.

Subsection B describes the signs and symptoms of late effects of polio. The include fatigue, loss of endurance, weakness and pain.

Documentation is discussed in subsection C. This section provides guidance on developing cases where late effects of polio are alleged. The importance of a description of the initial illness (early records are not required) and the types of current evidence needed are discussed.

Meeting or equaling Listing 11.11 criteria, and determining residual functional capacity are discussed in subsection D. Subsections E-H consider fatigue of specific muscle groups from repeated activity and overall loss of endurance, weakness, common areas of pain problems and the vocational implications of exposure to cold, which, for some postpolio individuals, significantly impairs their ability to function.

Other program issues (onset, diagnosis coding, medical diaries and work despite a severe impairment) are discussed in subsections I-L.

24580.010 Evaluation of Late Effects of Poliomyelitis

A. Definition

1. GENERAL

Anterior poliomyelitis (polio) is caused predominantly by three types of polio viruses and occasionally by other viruses which may destroy motor nerve cells in the spinal cord and medulla. Permanent paralysis may result. The extent of permanent paralysis, if any, depends upon how many nerve cells were destroyed.

2. LATE EFFECTS OF POLIO

For the purposes of evaluation under the disability programs, the late effects of polio refer to new symptoms and neuromuscular manifestations which result in new functional loss in an individual with a prior history of acute polio. This functional loss typically occurs after a long period (more than 10 years and generally 20-40 years) of stability. The etiology of these problems is not yet known and not all polio survivors experience these late effects. Precise data are not yet available, but it may be that about 25 percent of the estimated 300,000 or more surviving individuals who had polio are experiencing new problems affecting their ability to carry out accustomed activities. These late neuromuscular effects are permanent and usually slowly progressive. There is no known treatment.

B. Signs and Symptoms

The late effects of polio (also referred to as postpolio syndrome or sequalae) include fatigue, weakness, joint and muscle pain, breathing difficulty, and intolerance of cold. There may be increasing weakness or pain in a muscle already paralyzed or in muscles not know to be previously affected. The severity of problems may range from a modest worsening to a progressive postpolio muscular atrophy.

The late effects of polio are causing increasing problems in activities such as lifting, bending, prolonged standing, walking, climbing stairs, pushing a wheelchair, transfers (e.g., from wheelchair to toilet) sleeping, swallowing, dressing, and any activity requiring repetition and endurance.

Many polio survivors who thought they were in stable condition have had to start using or add to previous use of bracing, canes, crutches, wheelchairs or breathing aids. Ability to continue with

customary activity, including work, has been curtailed for many of these individuals. Functional abilities which may have been limited, but stable for many years, are now being lost.

C. Documentation

1. GENERAL

Careful development of the history to include a description of the original diagnosis (old records are not required), degree of original paralysis and residual paralysis, the types of new functional restrictions encountered, onset of these problems, and accommodations made in activities of daily living because of them are important. Detailed medical records from the treating source should be sought first.

In selected cases, where severity of the impairment is unclear, an examination by a physiatrist (specialist in physical medicine and rehabilitation) who is knowledgeable about polio, is appropriate, if one is available. (While most cases can be resolved without a physiatrist's involvement, a physiatrist is, at present the best source for information concerning the overall functional limitations in individuals with postpolio problems.) If a physiatrist is not available for difficult cases, an evaluation by a neurologist, knowledgeable about late effects of polio, should be sought.

2. SPECIAL STUDIES

Electromyogram (EMG) and nerve conduction studies may be helpful in defining the cause and extent of neuromuscular impairment. If these studies are available as evidence of record, they should be considered along with all other evidence of record. These studies should not be purchased, except in rare, difficult cases where the examining physiatrist or neurologist, in concurrence with the DDS physician, finds these tests essential to establishing current functional status.

D. Evaluation

1. MEETING OR EQUALING THE LISTING

The listing criteria for polio (11.11) may be applied both to cases of static polio (where there has been no reported worsening after initial recovery), and cases where late effects of polio are manifested. Evaluation of the overall impairment severity is the primary consideration. It is possible to meet or equal Listing 11.11 on the basis of the late effects of polio even though medical science has not yet fully defined the etiology of these late effects.

2. RESIDUAL FUNCTIONAL CAPACITY (RFC)

In determining RFC when Listing 11.11 is neither met nor equaled, the guides in DI 24510.000ff. should be followed. Careful consideration should be given to all factors, particularly those factors critical to determining functional status in postpolio cases (see E-H below).

E. Fatigue and Loss of Endurance

1. GENERAL

Fatigue or loss of endurance may be experienced as a tiredness after using a specific muscle or group of muscles (e.g., the individual can produce one or two forceful contractions in manual muscle testing, but cannot produce 5 or 10 contractions), or may be reported as an overall unaccustomed tiredness. Fatigue should always be evaluated within the context of demonstrable abnormal organic residual neurological deficits present.

2. TESTING FOR FATIGUE

In selected cases, where fatigue is a critical factor to adjudication, a simple repetitive activity test, performed by a physiatrist or neurologist knowledgeable about late effects of polio, may be needed to demonstrate the fatigue.

3. FATIGUE IN POLIO VERSUS OTHER NEUROLOGICAL DISORDERS

The reason for the fatigue and loss of endurance in polio survivors is not yet entirely clear but may be due to the fact that postpolio individuals are using their muscles at intensities much above normal and there is insufficient time for the muscle fibers to relax and chemically restore themselves.

The fatigue for a polio survivor is not identical to the fatigue experienced by other neurologically impaired individuals. It is not, therefore, appropriate to cite the listing criteria for multiple sclerosis (11.09C) or for myasthenia gravis (11.12) when adjudication polio cases.

F. Weakness

In evaluating weakness, special attention should be paid to allegations of spinal problems related to lower extremity weakness, with secondary degeneration of the lumbosacral joints on the side of the paralysis. These leg/spinal problems are commonly seen in postpolio survivors and in combination can be severe enough to equal the intent of 11.11C Weakness in the neck and shoulder muscles is also common. This may interfere with proper support of the head or use of the arms.

G. Pain

Pain symptoms should be evaluated under DI 24515.060 (Evaluation of Pain and Other Symptoms). They types of pain syndromes often occurring in individuals with post polio problems include bursitis and tendonitis around the shoulders, myofacial pain in the neck and should and low back, postural pain problems throughout the spine that are frequently associated with scoliosis and leg length discrepancies and joint pain in the lower extremities, especially the knee.

H. Cold Intolerance

Changes in environmental temperature can at times significantly alter muscle strength and dexterity and produce pain in postpolio individuals. The intolerance of cold may prevent a postpolio individual from engaging in jobs where exposure to cold is unavoidable.

I. Onset

Onset in cases involving late effects of polio should be set based on allegations, work history and other evidence concerning impairment severity in accordance with DI 25501.001ff. Generally, the new problems are gradual and nontraumatic, but acute injuries or events (e.g., herniated discs, broken bones from falls) may be the markers of onset of disability.

J. Diagnosis Coding

If late effects of acute polio is the primary diagnosis, use code 1380 to record the diagnosis.

K. Medical Diaries

Where the primary diagnosis is polio, a medical improvement not expected diary, code 036, is appropriate per DI 26525.040C, impairment number 21.

L. Work Despite a Severe Impairment

Many individuals with severe polio residuals have accommodated to their limitations and have worked despite them. They are now experiencing new functional problems which they allege are preventing their continuing to pursue their present work. In evaluating such cases under DI 24005.005, careful consideration should be given to evidence of worsening of the impairment. A new, minor weakening in muscles critical to certain activities (e.G., walking, standing, using arms or hands) may effectively alter ability to continue to function at the same level as was maintained for may years after the initial recovery from polio.

These are pages 59 and 60, dealing with polio, from SSA's booklet DISABILITY EVALUATION UNDER SOCIAL SECURITY. Show this to your doctors before they write their letters so that they can see how these impairments are categorized by SSA and so that they will couch their responses to SSA's questions in SSA's terms:

11.01 CATEGORY OF IMPAIRMENTS, NEUROLOGICAL

11.04 Central nervous system vascular accident. With one of the following more than 3 months post-vascular accident:

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

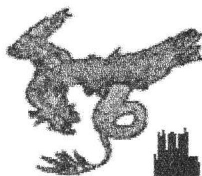
B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station. (see 11.00C).

11.11 Anterior poliomyelitis. With:

A. Persistent difficulty with swallowing or breathing; or

B. Unintelligible speech; or

C. Disorganization of motor function as described in 11.04B.



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