The Rationale for Neurology Subspecialization: Movement Problems

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Received: 2-Sept-2022, Manuscript No. jnn-22-79818; **Editor assigned:** 9- Sept -2022, PreQC No. jnn-22-79818 (PQ); **Reviewed**: 13- Sept -2022, QC No. jnn-22-79818 (Q); **Revised**: 19- Sept -2022, Manuscript No. jnn-22-79818 (R); **Published**: 27-Sept -2022, DOI. 10.35248/2471-268X.22.13.9.597.

Introduction

Among the various fellowships in neurology that are not authorised, movement disorders is one. 44 programmes are now listed on the AAN website as offering movement disorders fellowships in the United States and Canada (Directory for Fellowship Positions: American Academy of Neurology, 2010). 9% of residents who were entering fellowships picked movement disorders, according to the AAN resident survey . What circumstances call for a patient to be referred to a movement disorders expert by a general neurologist are being debated. Gaining specialised knowledge to provide better patient care is the goal of a fellowship. If there is any proof of this, that is the question. There are certain gaps in the literature's coverage of this topic. For instance, one study contends that internists in procedure-focused subspecialties typically performed lower on general medical knowledge tests. The impact of specialists on costs of care and the number of unneeded tests performed are similarly inconsistent. However, more recent research indicates that when comparing studies that focus on a single distinct medical problem, the majority of studies show better outcomes. Since these studies focus on the result of a single condition, the scales may be unfairly pushed in favour of the expert since many patients have numerous chronic conditions, as this research correctly points out. The following inquiry is whether primary care doctors require neurologist involvement for neurological diseases. Depending on who you ask, the answer to this ostensibly straightforward question is different The care of three neurological diseases was surveyed in this study by general internists, family practitioners, and neurologists (transient cerebrovascular event, dementia, Parkinson disease). Over 50% of internists said that the primary care doctor should handle the problem alone or beyond the neurologist's purview in the case of the temporary incident. More than 70% of people with dementia have this feeling. Only in cases with Parkinson's disease did a substantial majority advise referral.

The second concern is whether the patient should see a general neurologist or a neurology subspecialist after being referred to a neurologist. This is no longer merely an academic matter because the majority of residents are now participating in fellowships, albeit in unequal numbers. The opinions of the patients are enlightening. In one study, patients with multiple sclerosis were asked about their perceptions.There were a number of significant disparities between patients' perceptions of specialists and generalists. Patients who saw multiple sclerosis experts said they had better information about new therapies and side effects, as well as better access to research and multiple sclerosis care in particular regions. It is possible that primary care physicians value neurologist management of Parkinson disease, according to the earlier study. According to a different study, doctors are more inclined to refer patients for diagnosis confirmation and value the neurologist's management abilities equally. Given the findings of the multiple sclerosis trial, it would seem logical to anticipate better results from movement disorder specialists treating Parkinson disease, and the evidence is consistent with this expectation. In adherence to PD quality care indicators, a study of the treatment of Parkinson disease patients found statistically significant differences between neurologists and non-neurologists. It also found statistically significant advantages between movement disorder specialists and general neurologists in these same indicators.

The "correctness" of the Parkinson disease diagnosis is a crucial issue that has been looked into in numerous studies. A research in North Wales examined the 402 patients who were on anti-Parkinsonian drugs . Only 74% of these patients had any form of Parkinsonism, and the other patients were more likely to have essential tremor, gait apraxia, or dementia. According to a comparable London study, 20% of patients who are most likely suffering from Parkinson disease have already undergone evaluation and have received the wrong diagnosis, whereas 15% of those who have been given the diagnosis actually have another ailment.

The positive predictive value and sensitivity of the clinical diagnosis, on the other hand, were extraordinarily high in a study that was conducted in a movement disorders clinic with a neuropathological investigation to confirm the diagnosis . An idiopathic Parkinson disease clinical diagnosis had a 98.6% positive predictive value (72/73) and a 91.1% sensitivity (seven false negatives, 72/79). The findings for multiple system atrophy were correspondingly 85.7% (30/35) and 88.2% (30/34). The scores were 80% (16/20) and 84.2% (16/19), respectively, for progressive supranuclear palsy. The atypical Parkinson syndromes had a 71.4% overall positive predictive value. Although there is some discussion over whether the shift toward specialists is necessary, the evidence from the literature support the referral of patients with suspected movement disorders to neurologists as well as to movement disorders experts within the neurology community. However, movement disorders experts appear to be better able to recognise and treat some of the non-traditional (i.e., non-motor) symptoms of Parkinson disease than neurologists in general. The disparities in diagnosis and therapy between generalists and specialists are much more obvious in situations of patients with atypical Parkinson disease.

A option might be to have the patient visit the expert only once for diagnosis and possibly infrequently after that, with his home neurologist monitoring his condition on a "day-to-day" basis, in places with a dearth of movement disorders specialists or isolation. These recommendations would enable a speedier and more accurate diagnosis, removing the need for superfluous prescriptions and diagnostic testing, while enabling the patient to receive the right treatments more rapidly. This would result in better care at cheaper costs for the patient, as well as maybe for the entire healthcare system.

Cite this article: Green E. The Rationale for Neurology Subspecialization: Movement Problems. J Neurol Neurophysiol. 2022, 13(9), 001.