

# Practice points from international guidelines

## Early detection in infants >5 months (corrected)



**CONDITIONAL RECOMMENDATION** based on MODERATE QUALITY evidence of test psychometrics in high risk populations

STANDARDISED  
**NEURO  
EXAM**



In contexts where MRI is not safe or affordable (e.g. in low to middle income countries): Early detection of cerebral palsy is still possible in those with 'infant detectable risks' between 5–24 months corrected age and should be carried out to enable access to early intervention.



with history taking about risk factors

**TEST:** Hammersmith Infant Neurological Examination (HINE) [90% predictive of cerebral palsy]. HINE scores <73 (at 6, 9 or 12 months) should be considered at high-risk of cerebral palsy. HINE scores <40 (at 6, 9 or 12 months) almost always indicate non-ambulant cerebral palsy.



## Early detection of motor severity



**CONDITIONAL RECOMMENDATION** based on LOW QUALITY evidence



### Ambulant more likely

Unilateral lesions (Grade IV haemorrhage, perinatal arterial ischemic stroke), periventricular leukomalacia (PVL), (non-cystic) moderate/severe white matter injury.



### Non-ambulant more likely

Bilateral parenchymal haemorrhages (Grade IV), bilateral cystic periventricular leukomalacia (cPVL) (Grade III), brain maldevelopment, basal ganglia injury.

In infants less than 2 years old, prognosis of motor severity predictions should be made cautiously. **Always** use standardised tools, since incomplete development of voluntary motor skills and/or abnormal tone might confound clinical observations. Motor severity is most accurately predicted using standardised neurological exams and neurological imaging.

