

# 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

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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.

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**MOTOR**



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.

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## Early detection of motor severity



**CONDITIONAL RECOMMENDATION** based on LOW QUALITY evidence

**HINE 40–60**



### Ambulant more likely

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

**HINE <40**



### 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.

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ABNORMAL  
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