Annex II

European physical and mental disability rating scale for medical purposes

Contents

I. Nervous system

I. Nervous system

Situations not described are to be assessed by comparison with clinical situations which are described and quantified.

Where the Scale envisages complete deficit only, partial sequelae should be assessed on the basis of the deficit observed, with reference to the rating for total loss.

A) Neurology

Article 1

Motor and sensorimotor sequelae of central or medullary origin

Article 1-1 Complete tetraplegia, depending on level C2 to C6 below C6	 95% 85%
Article 1-2 Complete hemiplegia with aphasia without aphasia	 90% 75%
Article 1-3 Complete paraplegia, depending on level	70 to 75%
Article 1-4 Complete cauda equina impairment, depending on level	25 to 50%

B) Sensorimotor deficits

Article 2

Motor and sensorimotor sequelae of peripheral origin

Damage to the nervous system entails paralysis (total lesion) or paresis. It should be assessed in terms of its objectively measured clinical and technical repercussions.

Article 2-1

Face

Article 2-1-a Paralysis of the trigeminal nerve	
• unilateral	15%
• bilateral	30%
Article 2-1-b Paralysis of the facial nerve	
• unilateral	20%
• bilateral	45%
Article 2-1-c Paralysis of the glossopharyngeal nerve	
• unilateral	8%
Article 2-1-d Paralysis of the hypoglossal nerve	
• unilateral	10%

Article 2-2

Upper limb

	D *	ND **
Article 2-2-a Total paralysis (complete lesion of the brachial plexus)	65%	60%
Article 2-2-b Paralysis of the median-ulnar nerve	45%	40%
Article 2-2-c Paralysis of the radial nerve		
• above the tricipital branch	40%	35%
• below the tricipital branch	30%	25%
Article 2-2-b Paralysis of the median nerve		
• arm	35%	30%
• wrist	25%	20%
Article 2-2-e Paralysis of the ulnar nerve	20%	15%
Article 2-2-f Paralysis of the circumflex nerve	15%	12%
Article 2-2-g Paralysis of the musculocutaneous nerve	10%	8%

* dominant side

** non-dominant side

Given their implications for the upper limb, the following impairments have been included in this chapter:

	D *	ND **
Article 2-2-h Paralysis of the spinal nerve	12%	10%
Article 2-2-i Paralysis of the superior thoracic nerve	5%	4%

Article 2-3

Lower limb

Article 2-3-a Total paralysis of the sciatic nerve (complete lesion)	
• high truncal form (with paralysis of the gluteal nerves)	45%
• low form, below the knee	35%
Article 2-3-b Paralysis of the femoral nerve	35%
Article 2-3-c Paralysis of the fibular nerve	22%
Article 2-3-d Paralysis of the tibial nerve	22%
Article 2-3-e Paralysis of the obturator nerve	5%

* dominant side
** non-dominant side

Article 3

Cognitive disorders

Analysis of neuropsychological deficit syndromes has to refer to precise signs and concepts. So-called "frontal" syndrome corresponds in fact to entities which are now well defined and whose associated deficits of varying severity produce extremely polymorphic clinical pictures.

It is thus essential that assessment of the rate of disability should be based on precise specialist medical reports which correlate the initial lesions with the data from clinical and paraclinical examinations.

Article 3-1

True frontal syndrome

Article 3-1-a Major form with apragmatism with serious impairment of ability to form and sustain social and family relationships	60 to 85%
Article 3-1-b Severe form with changes in instinctual behaviour, loss of initiative, mood disorders, precarious social and family relationships	35 to 60%
Article 3-1-c Moderate form with relative bradypsychia, memorisation difficulty, mood disorders and repercussions on social and family relationships	20 to 35%
Article 3-1-d Minor form with distractibility, slowness, difficulty in memorisation and grasping complex ideas. Little or no impairment of ability to sustain social and family relationships	10 to 20%

Article 3-2

Communication disorders

Article 3-2-a Major aphasia with jargonaphasia, alexia, disturbances of comprehension	70%
Article 3-2-b Minor form: disturbances of naming and repetition, paraphasia. Comprehension is retained	10 to 30%

Article 3-3

Memory disorders

Article 3-3-a Full Korsakoff's syndrome	60%
Article 3-3-b Associated disorders: frequent forgetfulness, a handicap in everyday living requiring the subject to use aides-mémoire, perceptual distortion, possibly confabulation, difficulty in mastering new tasks, problems with recall	10 to 60%
Article 3-3-c Total or partial loss of didactically acquired knowledge: Ratings for this should be assessed using the same scale as for memory disorders.	

Article 3-4

Minor cognitive disorders

Where there is no true frontal syndrome or isolated impairment of a cognitive function, certain cranial traumas of varying severity may give rise to objectively measurable symptoms which constitute a syndrome different from postconcussion syndrome, with:

Short attention span, slowness of thought, memorisation difficulty, rapid mental tiredness, intolerance to noise, mood swings, lasting longer than 2 years	5 to 10%

Article 3-5

Dementia

Trauma has not been proved to trigger dementia. Alzheimer's disease and senile dementia are never the result of trauma.

Article 4

Mixed cognitive and sensorimotor deficits

These mixed deficits are typical sequelae of severe cranial trauma. In most cases they combine frontal dysfunctions with cognitive deficits, behavioural disturbances, pyramidal and/or cerebellar syndromes or sensory disturbances (hemianopsia, oculomotor paralysis, etc.) consistent with the lesions visualised by medical imaging.

These associations produce clinical pictures which differ from one subject to another, to the point where one cannot suggest precise ratings in the way one can for fully personalised sequelae. These deficits will be assessed on an overall basis.

It is possible, however, in the context of medico-legal assessment, to identify several levels of severity in relation to the overall deficit.

Article 4-1 Loss of all useful voluntary activity, loss of all identifiable relational abilities	100%
Article 4-2 Major sensorimotor deficits seriously limiting independence, in conjunction with cognitive deficits incompatible with a reasonable relational life	85 to 95%
Article 4-3 Major cognitive disorders comprising primarily lack of inhibition and severe behavioural disorders which compromise all social interactions, with sensorimotor deficits compatible with independence in the essential actions of everyday living	60 to 85%
Article 4-4 Cognitive disorders in conjunction with permanent disturbance of attention and memory, relative or total loss of initiative and/or self-criticism, inability to manage complex situations, with sensorimotor deficits which are patent but compatible with independence in the actions of everyday living	40 to 60%
Article 4-5 Cognitive disorders which combine obvious slowness of thought, patent memory deficit, difficulty in grasping complex ideas with minor sensorimotor deficits	20 to 40%

Article 5

Epilepsy

One cannot suggest a disability rating until cranioencephalic trauma and epileptic seizures have been confirmed, and until the necessary time has elapsed to stabilise the condition's spontaneous progression and render the patient suitable for treatment.

Article 5-1

Epilepsy with loss of consciousness

(Generalised epilepsy and complex partial epilepsy)

Article 5-1-a Epilepsy which is not controllable despite appropriate drug treatment and followed by established, almost daily seizures	35 to 70%
Article 5-1-b Epilepsy which is hard to control, with frequent seizures (several a month), and secondary effects from treatment	15 to 35%
Article 5-1-c Epilepsy which is well controlled by treatment which is well tolerated	10 to 15%

Article 5-2

Epilepsy without loss of onsciousness

Epilepsy which is partial and simple, authenticated as such by type and frequency of seizures and the secondary effects of treatment	10 to 30%

Isolated EEG abnormalities, in the absence of established seizures, do not allow a diagnosis of post-traumatic epilepsy to be postulated.

Article 6

Postconcussion syndrome

Symptoms reported but not confirmed objectively following an established loss of consciousness	2%

Article 7

Deafferent pain

This is pain linked to a lesion of the peripheral nervous system, which is felt without any nociceptive stimulation and may be one of several clinical types:

anaesthesia dolorosa, severe acute pain, hyperpathia (e.g. phantom limb pain or trigeminal neuralgia).

These are types of 'exceptional pain' which are not part of the customary post-traumatic picture and so are not included in the disability ratings. They are a secondary form of damage.

Nevertheless there would seem to be a case for assessing them by increasing the disability rating for the deficit concerned by a further 5 to 10%.

***

Article 8

Neuralgia

Following impairment of a cranial or peripheral nerve, where the pain reported by the patient is supported by objective clinical or technical evidence but a definite diagnosis requires the opinion of a specialist, the assessment should take account of the frequency of attacks and the efficacy of drug treatment.

Article 8-1 Trigeminal	Up to 25%
Article 8-2 Facial	Up to 8%
Article 8-3 Cervico-brachial	Up to 12%
Article 8-4 Intercostal	Up to 3%
Article 8-5 Femorocutaneous	Up to 3%
Article 8-6 Femoral	Up to 8%
Article 8-7 Sciatic	Up to 15%

C. Psychiatry

(By reference to ICD-X and DSM-IV)

Article 9

Persistent mood disorders

In the case of post-traumatic physical lesions requiring complex and protracted treatment with severe sequelae, there may be permanent mental suffering in the form of persistent mood disorders (depressive state):

Article 9-1 Frequent medical monitoring by a specialist, major drug treatment required with or without hospitalisation	10 to 20%
Article 9-2 Regular medical monitoring by a specialist with sporadic specific drug treatment	3 to 10%
Article 9-3 Necessitating medical monitoring at irregular intervals with intermittent treatment	Up to 3%

Article 10

Traumatic neurosis

(post-traumatic stress syndrome, fright neurosis)

These follow mental symptoms triggered by the sudden, unexpected and brutal occurrence of a traumatic event with which the individual is unable to cope

The stress factor must be intense and/or protracted.

The event must have been memorised.

The body of symptoms includes phobic anxiety, avoidance behaviour, obsessive-compulsive disorder and personality change. Even if treated very early, this cannot be assessed earlier than two years or so after the event.

Article 10-1 Full-blown phobia syndrome	12 to 20%
Article 10-2 Phobic anxiety with panic attacks, avoidance behaviour and obsessive- compulsive disorder	8 to 12%
Article 10-3 Phobic anxiety symptoms with avoidance behaviour and obsessive- compulsive disorder	3 to 8%
Article 10-4 Minor phobic anxiety symptoms	Up to 3%

Article 11

Psychotic disorders

These are not considered further in the Scale since they have hardly ever been shown to be the result of trauma.

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II. Sensory system and Stomatology

II. Sensory system and stomatology

1) Ophthalmology

Situations not described are to be assessed by comparison with clinical situations which *are* described and quantified.

Visual acuity

Article 12

Total loss of vision

Article 12-1 Loss of vision in both eyes (blindness)	85%
Article 12-2 Loss of vision in one eye	25%

Article 13

Loss of visual acuity in both eyes, distance and near vision

	10/10	9/10	8/10	7/10	6/10	5/10	4/10	3/10	2/10	1/10	1/20	<1/20	Blindness
10/10	0	0	0	1	2	3	4	7	12	16	20	23	25
9/10	0	0	0	2	3	4	5	8	14	18	21	24	26
8/10	0	0	0	3	4	5	6	9	15	20	23	25	28
7/10	1	2	3	4	5	6	7	10	16	22	25	28	30
6/10	2	3	4	5	6	7	9	12	18	25	29	32	35
5/10	3	4	5	6	7	8	10	15	20	30	33	35	40
4/10	4	5	6	7	9	10	11	18	23	35	38	40	45
3/10	7	8	9	10	12	15	18	20	30	40	45	50	55
2/10	12	14	15	16	18	20	23	30	40	50	55	60	65
1/10	16	18	20	22	25	30	35	40	50	65	68	70	78
1/20	20	21	23	25	29	33	38	45	55	68	75	78	80
<1/20	23	24	25	28	32	35	40	50	60	70	78	80	82
Blindness	25	26	28	30	35	40	45	55	65	78	80	82	85

Table I

Distance vision.

	P 1.5	P2	P3	P4	P5	P6	P8	P10	P14	P20	< P20	Blindness
P 1.5	0	0	2	3	6	8	10	13	16	20	23	25
P 2	0	0	4	5	8	10	14	16	18	22	25	28
P 3	2	4	8	9	12	16	20	22	25	28	32	35
P 4	3	5	9	11	15	20	25	27	30	36	40	42
P 5	6	8	12	15	20	26	30	33	36	42	46	50
P 6	8	10	16	20	26	30	32	37	42	46	50	55
P 8	10	14	20	25	30	32	40	46	52	58	62	65
P 10	13	16	22	27	33	37	46	50	58	64	67	70
P 14	16	18	25	30	36	42	52	58	65	70	72	76
P 20	20	22	28	36	42	46	58	64	70	75	78	80
< P 20	23	25	32	40	46	50	62	67	72	78	80	82
Blindness	25	28	35	42	50	55	65	70	76	80	82	85

Table II

Near vision.

Table II should be used only where there is sizeable distortion between close and distance vision. In that case calculate the arithmetical mean of the 2 ratings.

Article 14

Visual field

Article 14-1 Hemianopsia • depending on type, extent and whether or not central vision is impaired	up to 85%
Article 14-2 Quadranopsia • depending on type	up to 30%
Article 14-3 Central scotoma • bilateral • unilateral	up to 70% up to 20%
Article 14-4 Juxta-central or paracentral scotoma • depending on whether it is uni- or bilateral with visual acuity preserved	up to 15%

Article 15

Eye movement

Article 15-1 Diplopia • depending on direction of gaze, whether or not the condition is permanent, whether or not one eye needs to be covered at all times	up to 25%
Article 15-2 Oculomotor paralysis • depending on type	up to 15%
Article 15-3 Intrinsic movement • depending on type (maximum total aniridia)	up to 10%
Article 15-4 Heterophoria; total paralysis of convergence	5%

Article 16

Lens

Article 16-1 Loss (aphakia) corrected by spectacles or contact lenses • bilateral • unilateral To which should be added the rating for the corrected loss of visual acuity, without exceeding 25% for a unilateral lesion and 85% if both eyes are affected.	20% 10%
Article 16-2 Loss corrected by a lens implant (pseudophakia): add 5% for each pseudophakic eye to the ratings for loss of visual acuity	

Article 17

Adnexa of the eye

Depends on the impairment, the most serious being ptosis with campimetric deficit and bilateral alacrimia	up to 10%

***

2) ENT

Situations not described are to be assessed by comparison with clinical situations which *are* described and quantified.

A) Hearing

Article 18

Auditory acuity

Article 18-1

Total deafness

Article 18-1-a Bilateral	60%
Article 18-1-b Unilateral	14%

Article 18-2

Partial deafness

Assessment is in 2 stages:

Article 18-2-a

Mean hearing loss

This is assessed by reference to the air conduction tonal deficit measured in decibels at 500, 1000, 2000 and 4000 hertz, applying weightings of 2, 4, 3 and 1 respectively. The sum is divided by 10.

Refer to the table below.

Mean hearing loss in dB	0 - 19	20 - 29	30 -39	40 - 49	50 - 59	60 - 69	70 - 79	80 +
0 - 19	0	2	4	6	8	10	12	14
20 - 29	2	4	6	8	10	12	14	18
30 - 39	4	6	8	10	12	15	20	25
40 - 49	6	8	10	12	15	20	25	30
50 - 59	8	10	12	15	20	25	30	35
60 - 69	10	12	15	20	25	30	40	45
70 - 79	12	14	20	25	30	40	50	55
80 +	14	18	25	30	35	45	55	60

Article 18-2-b

Auditory distortion

Assessment should compare this crude rating with the results of speech audiometry to assess any auditory distortions (recruitment in particular) which makes the functional impairment worse.

The table below suggests increased ratings which might be considered in the light of the results of pure tone threshold audiometry:

% discrimination	100%	90%	80%	70%	60%	< 50%
100%	0	0	1	2	3	4
90%	0	0	1	2	3	4
80%	1	1	2	3	4	5
70%	2	2	3	4	5	6
60%	3	3	4	5	6	7
< 50%	4	4	5	6	7	8

Where a hearing aid is worn, the improvement should be determined by comparing the auditory curves obtained with and without the hearing aid in place; it enables the rating to be reduced, but account must be taken of the nuisance value of the prosthesis, especially in a noisy environment.

Article 19

Isolated tinnitus

If confirmed as imputable to trauma	up to 3%

B) Balance

Article 20 Bilateral vestibular impairment, with objectively confirmed destruction, depending on severity	10 to 25%
Article 21 Unilateral vestibular impairment	4 to 10%
Article 22 Benign paroxysmal vertigo	up to 4%

C) Nasal breathing

Article 23 Untreatable obstruction	
• bilateral	up to 8%
• unilateral	up to 3%

D) Olfactory sense

(including altered sense of taste)

Article 24 Anosmia	8%
Article 25 Hyposmia	Up to 3%

E) Speech

Article 26 Aphonia	30%
Article 27 Isolated dysphonia	up to 10%

***

3) STOMATOLOGY

Situations not described are to be assessed by comparison with clinical situations which are described and quantified.

For a removable prosthesis reduce by 1/2; for a fixed prosthesis reduce by 3/4. Where an implant is fitted there is deemed to be no disability.

Article 28 Loss of all teeth where it is clear that prosthetic replacement is not possible bearing in mind the implications for general health	28%
Article 29 Loss of a tooth, prosthetic replacement not possible • incisor or canine • premolar or molar	1% 1,5%
Article 30 Mandibular dysfunction • mouth can open no wider than 10 mm • mouth can open no wider than 10 to 30 mm	25 to 28% 5 to 25%
Article 31 Post-traumatic misalignment of teeth, depending on its effect on the ability to chew	2 to 10%
Article 32 Amputation of the mobile part of the tongue, bearing in mind its effect on speech, chewing and swallowing, depending on the severity of dysfunction.	3 to 30%

***

III. Osteoarticular system

III. Osteoarticular system

Situations not described are to be assessed by comparison with clinical situations which *are* described and quantified.

In the case of a joint or the limb itself, the overall rating is not the sum of the separate ratings but the result of their synergy, and the sum of the ratings for ankylosis of all the joints of a limb in a good position may not be higher than the value for total anatomical or functional loss of the limb.

Ratings justified by very severe stiffness not systematically provided for should be based on the rating for ankylosis of the relevant joint.

As regards endoprostheses for the major joints, it must be acknowledged that none of them restores proprioception and all of them impose certain restrictions on the lifestyle of the person concerned. Consequently, the presence of an endoprosthesis justifies a rating in principle of 5%.

Where the objective functional result is not satisfactory, these inconveniences in principle of the endoprosthesis are automatically included with those of the functional deficit, and this additional rating is not then justified.

A) Upper limb

(excluding hand and fingers)

Article 33

Amputations

Current possibilities for prosthetic replacement of the upper limbs do not generally speaking restore true function to the patient, since he cannot regain sensation. Where there is an improvement, the expert should take specific account of this and make a reasonable reduction in the rating suggested below.

	D *	ND **
Article 33-1 Total amputation of upper limb	65%	60%
Article 33-2 Amputation of arm (shoulder mobile)	60%	55%
Article 33-3 Amputation of forearm	50%	45%

* dominant side

** non-dominant side

Article 34

Ankylosis and stiffness

Article 34-1

Shoulder

There are 6 pure shoulder movements which, together, enable the joint to function. Each of these movements has its own relative importance in the actions of everyday living.

The 3 essential movements are anterior elevation, abduction and internal rotation followed by external rotation, retropulsion and adduction. Impairments of retropulsion and adduction justify ratings so minimal that they are not included in the table below. They serve to weight the rating calculated for limitations of the other movements.

Article 34-1-a

Ankylosis

	D *	ND **
Arthrodesis or ankylosis in functional position		
• shoulder blade fixed	30%	25%
• shoulder blade mobile	25%	20%

* dominant side

** non-dominant side

Article 34-1-b

Stiffness

	D *	ND **
Elevation and abduction limited to 60° • with total loss of rotation • other movements fully possible	 22% 18%	 20% 16%
Elevation and abduction limited to 90° • with total loss of rotation • other movements fully possible	 16% 10%	 14% 8%
Elevation and abduction limited to 130° • other movements fully possible	 3%	 2%
Isolated loss of internal rotation	6%	5%
Isolated loss of external rotation	3%	2%

Article 34-2

Elbow

Only mobility between 20 and 120 degrees of flexion is of any practical use. Movements outside this useful range have only very minimal relevance for everyday life.

Thus the ratings below apply only to deficits within this range.

The expert should take account of the extension deficit and flexion deficit, the ratings for these being necessarily considered together though not added together. The rating for any pronosupination deficit may be added.

* dominant side

** non-dominant side

Article 34-2-a

Ankylosis

	D *	ND **
Arthrodesis or ankylosis in functional position		
• pronosupination preserved	24%	20%
• pronosupination lost	34%	30%

Article 34-2-b

Stiffness

	D *	ND **
Full flexion, and extension		
• limited beyond 90°	15%	12%
• limited to 90°	12%	10%
• limited to 20°	2%	1%
Full extension, and flexion		
• up to 120°	2%	1 %
• up to 90°	12%	10%
• beyond	15%	12%

Article 34-3

Isolated impairment of pronosupination

* dominant side

** non-dominant side

Article 34-3-a

Ankylosis

	D *	ND **
Ankylosis in functional position	10%	8%

Article 34-3-b

Stiffness

	D *	ND **
Stiffness in pronation range	0 to 6%	0 to 5%
Stiffness in supination range	0 to 4%	0 to 3%

Article 34-4

Wrist

The useful range extends from 0 to 45 degrees for both flexion and extension. Movements outside this useful range have only very minimal relevance for everyday life. The same is true of radial deviation.

Article 34-4-a

Ankylosis

	D *	ND **
Arthrodesis or ankylosis in functional position • pronosupination preserved • pronosupination lost	 10% 20%	 8% 16%

* dominant side

** non-dominant side

Article 34-4-b

Stiffness

	D *	ND **
Stiffness in useful range • flexion deficit	0 to 4%	0 to 3%
• extension deficit	0 to 6%	0 to 5%
Loss of ulnar deviation	1,5%	1%

Hand

The essential function of the hand is prehension, determined by the efficient performance of grasping and gripping movements. These require the possession of fingers of adequate length, mobility and sensitivity.

The expert will primarily need to make an analytical examination of the hand.

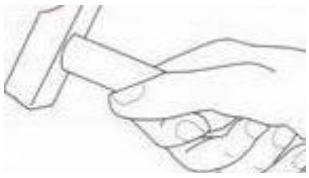
He will then have to check that his findings on examination are borne out by the patient's ability to perform the six basic grasping and gripping actions (see figure).

Any discrepancy should prompt careful investigation of its causes and a possible adjustment to the disability rating envisaged, the absolute limit being the loss of value of the fingers concerned.

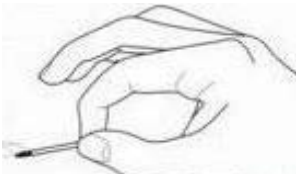
* dominant side

** non-dominant side

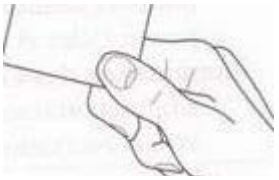
Principal grasping and gripping actions



Power grip, palmar



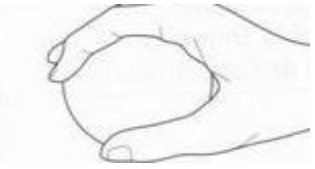
Precision grip, (sub)terminal opposition



Precision grip, subtermino-lateral

Dynamic tripod

Hook grip



Power ball grip

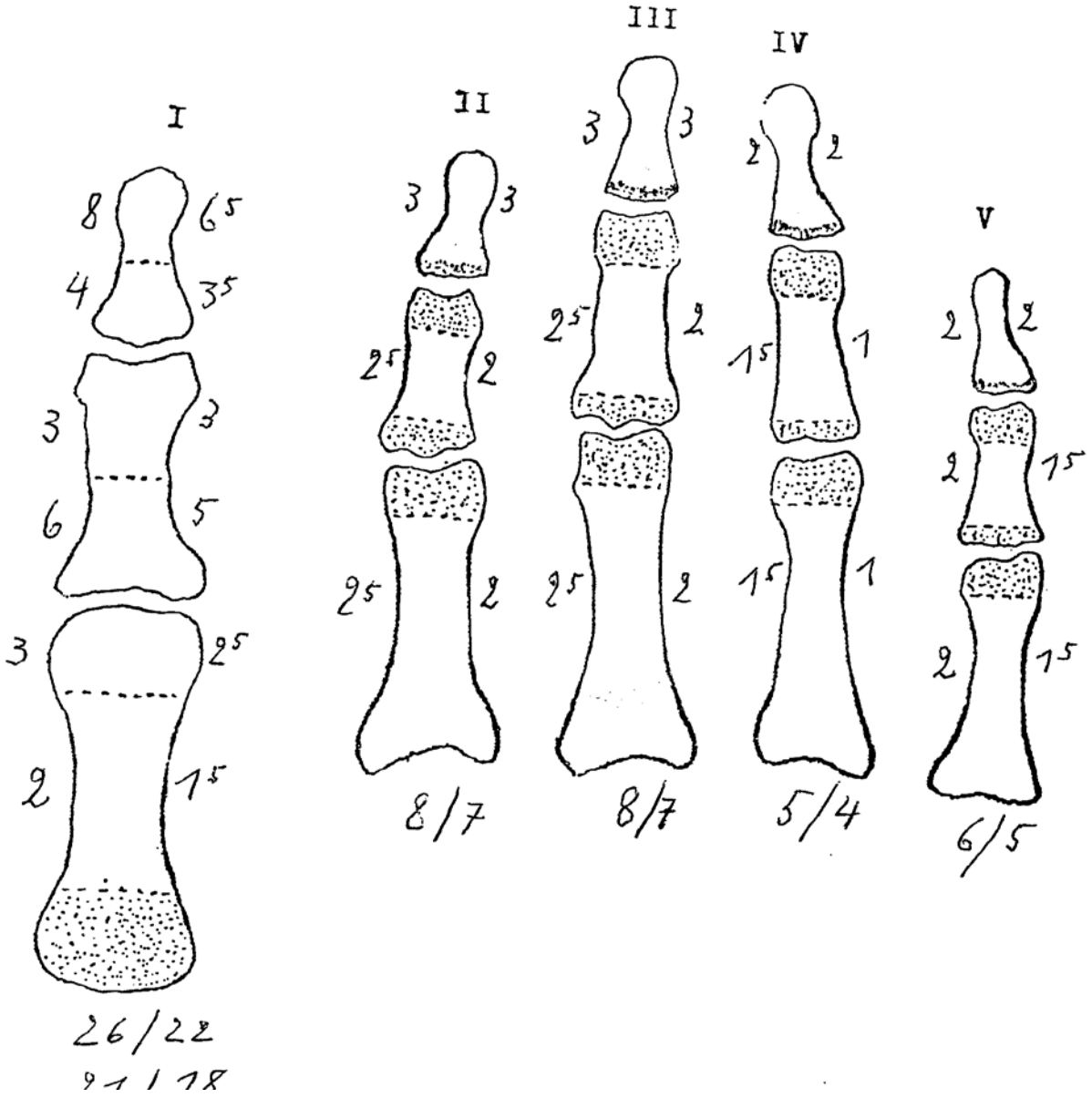

I
II
III
IV
V
8
6⁵
4
3⁵
3
3
6
5
3
2⁵
2
1⁵
3
3
2⁵
2
2⁵
2
2⁵
2
3
3
2
2
1⁵
1
1⁵
1
2
2
2
1⁵
2
1⁵
26/22
8/7
8/7
5/4
6/5

Diagram of the hand

(see Article 35-2: Amputation of the fingers)

In this diagram:

- the dotted areas are valued at nil
- the rating attributed to each segment covers the whole of that segment
- partial loss of a segment is calculated pro rata as a proportion of the rating for total loss
- the ratings suggested take account of the minor changes in sensitivity, blood supply and shape which the practitioner knows to be usual with finger amputations

Article 35

Amputations

Article 35-1

Total amputation of the hand

	D *	ND **
Total amputation of the	50%	45%

Article 35-2

Amputation of the fingers

See diagram on previous page

* dominant side

** non-dominant side

Article 35-2-a

Amputation of the thumb (and its metacarpal) or long fingers: see diagram of hand

Example for amputation of the thumb	D *	ND **
Loss of MC + P1 + P2	26%	22%
Loss of P1 + P2	21%	18%
Loss of P2	12%	10%

Article 35-2-b

Amputation of a long finger (total or partial): see rating on diagram.

Article 35-2-c

Amputation of several long fingers (combined losses): simply adding together the calculated ratings for single fingers does not take account of the interaction of the long fingers. This synergy is different depending on the number of fingers involved:

- loss of 2 long fingers: increase the simple total by 45% of the rating calculated
- loss of 3 long fingers: increase the simple total by 65% of the rating calculated
- loss of 4 long fingers: increase the simple total by 45% of the rating calculated

Article 35-2-d

Amputation of the thumb and one or more of the long fingers: here the term "thumb" refers only to P1 + P2.

* dominant side

** non-dominant side

Simply adding together the ratings for the thumb and all the long fingers lost (calculation of this latter rating takes account of the interaction of the long fingers) would give an overall rating which was too high. The value attributed to the thumb in the diagram of the hand only applies if the long fingers are intact. If they are not, the thumb loses part of its usefulness in the synergistic action of all 5 digits.

Thus, the following reducing factors should be applied to the rating arrived at by simply adding together the rating for the thumb + the rating for the long fingers increased for their synergistic action:

- loss of thumb and 1 finger: 0% (impairment too minor to count in the calculation)
- loss of thumb and 2 fingers: -5%
- loss of thumb and 3 fingers: -10%
- loss of thumb and 4 fingers: -20%

Thus the rating for the loss of the four long fingers on the dominant side is 27% (8 + 8 + 5 + 6), to which should be added, to take account of synergy, 45% of 27% = 12%. The total rating is therefore 39%.

If, in addition, the thumb is lost (the thumb on its own being rated at 21%), from the total for the thumb and four long fingers (39 + 21) = 60% a figure of 20% of 60%, i.e. 12% should be deducted to take account of the loss of usefulness in the grip function.

The rating for the amputation of the thumb (P1 et P2) and the four long fingers is therefore 60 – 12 = 48%.

Since the rating for the total loss of the dominant hand is 50%, there remains a rating of 2% for the metacarpus, which is of little use.

On the same basis, the rating for the loss of the thumb and the four long fingers on the non-dominant side is 44%.

Loss of the first metacarpal as well will have little effect on the final rating: the first metacarpal on its own is of little value.

The effect on the final rating for the other metacarpals is modest but variable since, depending on the case, resection of them will be desirable or slightly counterproductive.

Article 36

Ankylosis, arthrodesis and stiffness

Where there is combined impairment of several fingers, the proposed factors should be applied to take account first of the synergy between the long fingers and, second, of impairment affecting both the thumb and one or more of the long fingers: see earlier text.

Article 36-1

Ankylosis

By convention the trapezometacarpal joint of the thumb is called A0; for all the fingers A1 is the metacarpophalangeal joint, A2 the proximal interphalangeal joint, and A3 the distal interphalangeal joint.

The functional position for the long fingers is flexion of 20 to 30°.

The functional position for the thumb is abduction and antepulsion of A0 and slight flexion of A1 and A2.

Article 36-1-a

Ankylosis of the thumb in the functional position

Ankylosis of A0, A1 and A2 gives a rating of less than 75% of the value of the finger used for ankylosis of the long fingers, taking into account the special function of the thumb. Even with this ankylosis a degree of opposing force can still be exerted.

	D *	ND **
A0 + A1 +A2	16%	14%
A0	8%	7%
A1	4%	3,5%
A2	4%	3,5%
A1 + A2	8%	7%

Article 36-1-b

Ankylosis of all the joints of a long finger

Article 36-1-b1

In the functional position: equivalent to 75% of the value of the finger's loss, given that sensation is retained and limited use of the finger is still possible

	D *	ND **
Index finger	6%	5%
Middle finger	6%	5%
Ring finger	4%	3%
Little finger	4,5%	4%

* dominant side

** non-dominant side

Article 36-1-b2

In a poor position

Overflexed	D *	ND **
Index finger	8%	7%
Middle finger	8%	7%
Ring finger	8%	4%
Little finger	6%	5%

Overextended	D *	ND **
Index finger	7%	6%
Middle finger	7%	6%
Ring finger	4,5%	3,5%
Little finger	5%	4%

Article 36-1-c

Ankylosis of one or more joints of a long finger

The expert should use the rating for total ankylosis of the finger concerned less 1/3 or 2/3.

Article 36-2

Stiffness

The rating given for stiffness is a proportion of the rating for ankylosis, taking into account the normal range of mobility of each joint.

The normal range of mobility for the long fingers is:

- A1 and A2: index and middle finger: 20 to 80°; ring finger and little finger: 30 to 90°
- A3: 20 to 70°

* dominant side

** non-dominant side

The normal range of mobility for the joints of the thumb lies on either side of their functional position.

Article 37

Disorders of palmar sensitivity

Disordered sensitivity of the back of the hand has no implications for function, so it does not justify a disability rating.

The ratings proposed cover slight paraesthesia and discrete abnormalities of shape which the doctor knows to be normal in minor neuromas following resection of a nerve.

Where several fingers are involved, the factors for synergy of the long fingers and for loss of both thumb and one or more of the long fingers should be applied: see earlier text.

Article 37-1

Anaesthesia

The rating given is 75% of the rating for anatomical loss of the segment(s) of the finger(s) in question.

Article 37-2

Hypoaesthesia

The rating given is 50% to 75% of the rating for anatomical loss of the segment(s) of the finger(s) in question, depending on the severity and localised extent of hypoaesthesia and the finger affected (ability to grip).

B) Lower limb

Article 38

Amputations

Amputation of a lower limb, unless it is the foot, renders the patient unable to walk or stand. The suggested ratings are for a patient correctly fitted with a prosthesis. If the prosthesis is not all that satisfactory the expert will assess the rating on the basis of how well it is tolerated and how effective it is. The rating may not be higher than for amputation of the whole limb.

Article 38-1 Disarticulation of the hip or high-level transfemoral amputation where a prosthesis cannot be fitted	65%
Article 38-2 Unilateral disarticulation of the hip or high-level transfemoral amputation without ischial support	60%
Article 38-3 Femoral amputation	50%
Article 38-4 Disarticulation of the knee	40%
Article 38-5 Amputation of the leg	30%
Article 38-6 Tibiotarsal amputation	25%
Article 38-7 Mid- or transmetatarsal amputation	20%
Article 38-8 Amputation of the 5 toes and 1st metatarsal	12%
Article 38-9 Amputation of the big toe and 1st metatarsal	10%
Article 38-10 Amputation of both phalanges of the big toe	6%

Article 39

Ankylosis and stiffness

Article 39-1

Hip

Flexion: 90° allows most actions of everyday living; 70° allows the patient to sit and negotiate stairs; 30° allows him to walk.

Abduction: 20° allows virtually all actions of everyday living.

Adduction: of minimal practical importance.

External rotation: only the first 30° range is useful.

Internal rotation: 10° is enough for most actions of everyday living. Extension: 20° is used in walking and negotiating stairs.

Pain is an essential factor determining use of the hip in everyday life (walking and standing): the suggested ratings take account of this.

Article 39-1-a

Ankylosis

Hip • in good position	30%

Article 39-1-b

Stiffness

Article 39-1-b1

Extreme stiffness of several movements

with accompanying signs (radiological signs, amyotrophy, etc.), this is a more severe condition than ankylosis	Up to 40%

Article 39-1-b2

Assuming full movement otherwise

Total loss of flexion	17%
Flexion • limited to 30° • limited to 70° • limited to 90°	 13% 7% 4%
Total loss of extension	2%
Permanent irreducible flexion of 20°	4%
Total loss of abduction	6%
Total loss of adduction	1%
Total loss of external rotation	3%
Total loss of internal rotation	1%

Article 39-2

Knee

Flexion: 90° allows half and, above all, the most important actions of everyday living (walking, sitting down, using stairs); 110° allows 3/4 of everyday actions and 135° allows all of them.

Extension: an extension deficit of less than 10° is compatible with 3/4 of everyday actions.

Article 39-2-a

Ankylosis

Knee • in good position	 25%

Article 39-2-b

Stiffness

Flexion • limited to 30° • limited to 50° • limited to 70° • limited to 90° • limited to 110°	 20% 15% 10% 5% 2%
Extension deficit • less than 10° • 10° • 15° • 20° • 30°	 0% 3% 5% 10% 20%

Article 39-2-c

Laxity (no prosthesis fitted)

Lateral • less than 10° • more than 10°	 0 to 5% 5 to 10%
Anterior • isolated • rotational	 2 to 5% 5 to 10%
Posterior • isolated • rotational	 3 to 7% 7 to 12%
Complex rotational	10 to 17%

Article 39-2-d

Axial deviation

Genu valgum • less than 10° • 10 to 20° • more than 20°	 0 to 3% 3 to 10% 10 to 20%
Genu varum • less than 10° • 10 to 20° • more than 20°	 0 to 4% 4 to 10% 10 to 20%

Article 39-2-e

Femoropatellar syndromes

Femoropatellar syndromes	0 to 8%

Article 39-2-f

Sequelae of meniscus lesions

Sequelae of meniscus lesions	0 to 5%

Article 39-3

Ankle and foot

Article 39-3-a

Tibiotalar joint

With 20° plantar flexion one can perform over half the actions of everyday living; with 35° one can perform all of them.

With 10° dorsiflexion one can perform virtually all everyday actions.

Loss of a few degrees of dorsiflexion is more of a handicap than an equivalent loss of plantar flexion given the restricted range of dorsiflexion.

Article 39-3-a1

Ankylosis

• In functional position with forefoot supple	10%

Article 39-3-a2

Stiffness

Total loss of plantar flexion	5%
Total loss of dorsiflexion	5%
Plantar flexion • from 0 to 10° • from 0 to 20° • from 0 to 30°	 5% 4% 2%
Dorsiflexion • from 0 to 5° • from 0 to 10° • from 0 to 15°	 5% 3% 1%
Irreducible talipes equinus	Up to 15%

Article 39-3-a3

Laxity

Laxity	2 to 6%

Article 39-3-b

Subtalar joint

Valgus: with 5° one can perform virtually all actions of everyday living;

Varus: with 5° one can perform over half the actions of everyday living and with 15° one can perform all of them.

Loss of varus carries a higher disability rating than loss of valgus because varus ankylosis is less well tolerated than valgus ankylosis.

Article 39-3-b1

Ankylosis

• in good position	7%
• varus	9%
• valgus	8%

Article 39-3-b2

Stiffness

Limitation by half	3%
Limitation by one third	2%

Article 39-3-c

Midtarsal joint (Chopart's joint) and tarsometatarsal joint (Lisfranc's joint)

Article 39-3-c1

Ankylosis

Midtarsal (Chopart)	2%
Tarsometatarsal (Lisfranc)	4%

Article 39-3-c2

Stiffness

Limitation by half	3%

Article 39-3-d

Metatarsophalangeal joints - toes

Article 39-3-d1

Ankylosis

Metatarsophalangeal of the big toe, depending on position	2 to 3%
Ankylosis of toes 2 to 5, in good position	0 to 2%

Article 39-3-d2

Stiffness

The expert should set the rating for stiffness on the basis of the suggested ratings for ankylosis.

Article 39-3-e

Combined ankylosis

• tibiotalar and subtalar joints, midtarsal joint and forefoot supple	17%
• tibiotalar and subtalar joints with reduced mobility of the midtarsal joint and forefoot	20%
• subtalar and midtarsal joints in good position, other joints free	9%
• tibiotalar, subtalar and midtarsal joints, forefoot supple	19%
• tibiotalar, subtalar, midtarsal and tarsometatarsal joints	23%
• idem with ankylosis of the toes	25%

Article 40

Uncompensated shortening

Up to 5 cm	8%
Up to 4 cm	6%
Up to 2 cm	2%
Up to 1 cm	0%

C) Spine

Situations not described are to be assessed by comparison with clinical situations which are described and quantified.

Article 41

Cervical spine

Article 41-1

Without documented lesions of bones, discs or ligaments

Intermittent pain triggered by precise causes which are always the same, requiring pain relieving and/or anti-inflammatory drugs on demand, with minimal reduction of movement	up to 3%

Article 41-2

With documented lesions of bones, discs or ligaments

Article 41-2-a Very frequent pain with permanent functional impairment requiring caution in all movements, established vertigo and associated posterior headache, • with multi-stage, very extreme stiffness, depending on number of levels • some remaining neck movement	 15 to 25% 10 to 15%
Article 41-2-b Frequent pain with clinically confirmed limitation of the range of motion, real but intermittent need for drug treatment	3 to 10%
Article 41-2-c Arthrodesis or ankylosis without accompanying symptoms, depending on number of levels	3 to 10%

Article 42

Thoracic spine, lumbar spine and lumbosacral junction

Article 42-1

Without documented lesions of bones, discs or ligaments

Intermittent pain triggered by precise causes, requiring appropriate drug treatment on demand and the avoidance of major and/or protracted effort, associated with discrete segmental stiffness	up to 3%

Article 42-2

With documented lesions of bones, discs or ligaments

Article 42-2-a Thoracic spine: • active stiffness and pain in all movements and in all positions, requiring regular drug treatment • permanent discomfort with pain between the shoulder blades, problems with weight-bearing capacity, hollow back, loss of radiological thoracic kyphosis, drug treatment required	 3 to 10% 10 to 15%
Article 42-2-b Lumbar spine and thoracolumbar and lumbosacral junctions: • active stiffness and discomfort or pain in all movements and in all positions, requiring regular drug treatment • very frequent pain with permanent discomfort requiring caution in all movements, with major segmental stiffness in movements, clinically confirmed limitation • exceptionally severe clinical and radiological findings	 3 to 10% 10 to 15% up to 25%

Article 43

Coccyx

Coccygodynies	up to 3%

D) Pelvis

Article 44 Post-fracture pain in one ischiopubic ramus	Up to 2%
Article 45 Pain and/or instability in the pubic symphysis	2 to 5%
Article 46 Pain after dislocation or fracture of the sacroiliac joint	2 to 5%
Article 47 Associated pain and instability in the pubic symphysis and sacroiliac joint • without reduction in weight-bearing capacity of pelvis or gait impairment • with reduction in weight-bearing capacity of pelvis and gait impairment	 5 to 8% 8 to 18%

***

IV. Cardiorespiratory system

IV. Cardiorespiratory system

Situations not described are to be assessed by comparison with clinical situations which are described and quantified.

I) Heart

The expert should refer to the classification below, which is modelled on that of the New York Heart Association (NYHA), taking account of the functional symptoms reported by the patient, his clinical examination and a range of complementary tests (ECG, Doppler, exercise tolerance test, transoesophageal echocardiography, catheterisation, etc.).

Among the technical data, the ejection fraction is of primary importance for objectively quantifying sequelae.

The expert should also take account of the need for medical drugs and the consequent need to monitor the patient.

Article 48

Cardiological sequelae

Article 48-1 Functional symptoms even at rest confirmed by clinical data (effort of getting undressed, clinical examination) and paraclinical data. Major drug treatment and frequent hospitalisation required Ejection fraction < 20%	55% +
Article 48-2 Functional limitation on mild exertion with signs of myocardial incompetence (pulmonary oedema) or associated with peripheral vascular complications or complex arrhythmias. Serious drug treatment and close monitoring of the patient required Ejection fraction 20% to 25%	45 to 55%
Article 48-3 Idem with significant drug requirement and/or in the event of associated arrhythmias Ejection fraction 25% to 30%	40 to 45%
Article 48-4 Functional limitation hampering ordinary activity (walking quickly), clear worsening of echography or Doppler parameters. Intolerance of effort with exertional ECG abnormalities, drug treatment required. Ejection fraction 30% to 35%	35 to 40%
Article 48-5 Patient reports functional limitation on ordinary exertion (2 stages), confirmed by exertional ECG or the existence of signs of myocardial dysfunction. Physical exertion contraindicated, and drug treatment required with close cardiological monitoring Ejection fraction 35% to 40%	25 to 35%
Article 48-6 Patient reports functional limitation on patent (significant) exertion with signs of myocardial dysfunction (Doppler, catheterisation, etc.) with drug treatment and close monitoring required Ejection fraction 40% to 50%	15 to 25%

Article 48-7 Patient reports functional limitation on substantial exertion (sport) without signs of myocardial dysfunction or ischaemia, with drug treatment and regular monitoring required Ejection fraction 50% to 60%	8 to 15%
Article 48-8 No functional limitation. Good tolerance of effort; depending on the case, drug treatment and/or regular monitoring required Ejection fraction > 60%	up to 8%

Article 49

Transplantation

The possibility of a transplant takes into account the fact that these patients need serious amounts of medical drugs and especially close monitoring

Depending on functional outcome and tolerance of immunosuppressants	25 to 30 %

2) Lungs

Whatever the origin of the lung damage, assessment must be based on the degree of chronic respiratory insufficiency, measured in terms of:

- severity of breathlessness, graded by reference to Sadoul's clinical scale of dyspnoea:

Stage or class	Description
1	Dyspnoea on major exertion greater than in stage 2
2	Dyspnoea when walking up a gentle incline, walking quickly, or stage 1
3	Dyspnoea when walking normally on the level
4	Dyspnoea when walking slowly
5	Dyspnoea even on mild exertion

- clinical examination performed by a lung specialist,

- complementary tests already performed or requested for the purposes of the insurance claim report. These tests must be non-invasive.

Examples include imaging, endoscopy, respiratory gas measurement, spirometry, lung function tests and blood tests such as FEV_1/FVC, MMEF, SaO_2, TLC, FVC, TLCO/AV, PaO_2 , $PaCO_2$:

FVC: forced vital capacity; TLC: total lung capacity; FEV_1: forced expiratory volume in 1 second; MMEF: maximum mid-expiratory flow; PaO_2: arterial oxygen tension; $PaCO_2$: arterial carbon dioxide tension; SaO_2: arterial haemoglobin oxygen saturation; TLCO/AV: carbon monoxide transfer factor/alveolar volume.

Article 50

Anatomical loss of all or part of a lung

Total loss	15%
Loss of one lobe	5%

These ratings may be added together with the disability ratings for any associated respiratory insufficiency.

Article 51

Chronic respiratory insufficiency

Article 51-1 Dyspnoea on the slightest exertion (getting undressed) with • either FVC or TLC less than 50% • or FEV1 less than 40% • or resting hypoxaemia (PaO2) less than 60 mm Hg, with or without hypercapnoea (PaCo2), possibly necessitating lengthy oxygen therapy (> 16 h/day) or tracheotomy or intermittent mechanical ventilation	50% +
Article 51-2 Dyspnoea whilst walking on the level at one's own pace, with • either FVC or TLC between 50 and 60% • or FEV1 between 40 and 60% • or resting hypoxaemia (PaO2) between 60 and 70 mm Hg	30 to 50%
Article 51-3 Dyspnoea whilst walking normally on the level, with • either FVC or TLC between 60 and 70% • or FEV1 between 60 and 70% • or TLCO/AV less than 60%	15 to 30%
Article 51-4 Dyspnoea whilst walking quickly upstairs or up a gentle incline, with • either FVC or TLC between 70 and 80% • or FEV1 between 70 and 80% • or TLCO/AV between 60 and 70%	5 to 15%
Article 51-5 Dyspnoea on major exertion with minor deterioration of lung function test scores	2 to 5%

Article 52

Persistent painful sequelae of thoracotomy

Up to 5%

V. Vascular system

V. Vascular system

Situations not described are to be assessed by comparison with clinical situations which are described and quantified.

Article 53

Sequelae affecting arteries, veins and lymph vessels

The rating should take account of any need for medical drugs and/or medical monitoring, e.g. in the case of a prosthesis which does not in itself justify a disability rating.

Article 53-1

Arteries

Article 53-1-a Lower limb • Discomfort on exertion (established intermittent claudication) • Discomfort at rest (established spontaneous ischaemic pain) • Idem with tissue necrosis which may be serious enough to warrant amputation	 5 to 15% 15 to 25% 25% +
Article 53-1-b Upper limb Depending on functional impairment (e.g. loss of strength, hypothermia, etc.)	 5 to 10%

Article 53-2

Veins

Sequelae of manifest phlebitis, which must be assessed bearing in mind any pre-existing condition

Article 53-2-a Discomfort on walking for any length of time, permanent measurable oedema requiring the patient to wear support stockings at all times; recurrent stasis dermatitis and ulcers	10 to 15%
Article 53-2-b Discomfort on walking for any length of time, permanent measurable oedema requiring the patient to wear support stockings at all times; stasis dermatitis	4 to 10%
Article 53-2-c Feeling of 'heavy leg' with verifiable oedema in the evenings	Up to 4%

Article 53-3

Lymph vessels (lymphoedema)

Article 53-3-a Upper limb	Up to 10%
Article 53-3-b Lower limb	see Veins above

Article 54

Total splenectomy

Article 54-1 Drug treatment strictly required	15%
Article 54-2 Asymptomatic	5%

***

VI. Digestive system

VI. Digestive system

Situations not described are to be assessed by comparison with clinical situations which are described and quantified.

Article 55

Permanent cutaneous ostomies and total incontinence

Article 55-1

Ostomies with pouching system

Colostomy, ileostomy	30%

Article 55-2

Faecal incontinence

Uncontrollable	45%

Article 56

Problems common to various impairments of the digestive system

The rating includes that inherent in loss of the organ.

Article 56-1 Full-blown malabsorption syndrome	60%
Article 56-2 Necessitating frequent medical check-ups, constant treatment and adherence to a strict diet, with effects on the patient's general health	30%
Article 56-3 Necessitating regular medical check-ups, virtually permanent treatment and adherence to a strict diet, with implications for the patient's social life	20%
Article 56-4 Necessitating periodic medical check-ups, intermittent treatment and dietary precautions, without effects on the patient's general health	10%

Article 57

Hepatitis

Article 57-1

Without cirrhosis

Ratings are based on the Metavir score which has the virtue of having been designed specifically for hepatitis.

This is based on 2 parameters, the activity score and the fibrosis score:

Activity score	Fibrosis score
A0: none	F0: no fibrosis
A1: minimal	F1: fibrosis, expansion of portal tracts without septa formation
A2: moderate	F2: enlargement of portal tracts with rare septa formation
A3: marked	F3: numerous septa without cirrhosis
	F4: cirrhosis

The ratings proposed are thus as follows:

Article 57-1-a Persistent (chronic active) hepatitis	20%
Article 57-1-b Metavir score higher than A1 F1, lower than F4	10%
Article 57-1-c Metavir score A1 F1 or lower	5%

Article 57-2

With cirrhosis (i.e. Metavir score higher than F4)

Ratings are based on the Child-Pugh scoring system:

Group	A	B	C
Serum bilirubin (µmol/l)	< 34,2	34,2 to 51,3	> 51,3
Serum albumin (g/l)	> 35	30 to 35	< 30
Ascites	Absent	Easily controlled	Poorly controlled
Neurological	Absent	Transient or mild	Hepatic coma
Nutritional status	Excellent	Good	Mediocre, loss of muscle mass

The ratings proposed are as follows:

Article 57-2-a Class 3: advanced hepatic insufficiency Child-Pugh C	70% +
Article 57-2-b Class 2: Child-Pugh B	40%
Article 57-2-c Class 1: Child-Pugh A	20%

VII. Urinary system

VII. Urinary system

Situations not described are to be assessed by comparison with clinical situations which are described and quantified.

Article 58

Loss of a kidney, not replaced, renal function normal or as before

Rating for loss of an internal organ, against the specific psychological and cultural background of the case	15%

Article 59

Renal insufficiency

Article 59-1 Creatinine clearance less than 10 ml/min. Need for dialysis at a dialysis centre or at home; depending on complications	35 to 65%
Article 59-2 Creatinine clearance between 10 and 30 ml/min. Deterioration in general health. Very strict diet and serious drug treatment required	25 to 35%
Article 59-3 Creatinine clearance between 30 and 60 ml/min. Minimum BP less than 12. Asthenia, need for strict diet and medical treatment	15 to 25%
Article 59-4 Creatinine clearance between 60 and 80 ml/min with BP 16/9 or less, depending on diet, deterioration in general health and treatments	5 to 15%

In the specific case where renal function has worsened in a patient who has lost one kidney, the rating for the anatomical loss may not be added, but the minimum proposed rating for deterioration in kidney function is 15%.

Article 60

Transplantation

Depending on tolerance to treatment with corticosteroids and immunodepressants	10 to 20%
If there is also renal insufficiency which is imputable, refer to the table above	

Article 61

Incontinence

Uncontrollable	30%

Article 62

Ostomy

With pouching system	15%

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VIII. Reproductive system

VIII. Reproductive system

Situations not described are to be assessed by comparison with clinical situations which are described and quantified.

Ratings do not take account of any endocrine effects.

They do not include repercussions on sexual differentiation where the damage is sustained before puberty.

Some of these ratings reflect sociocultural attitudes to loss of the organ concerned.

1) Females

Article 63

Organ loss

Article 63-1 Hysterectomy	6%
Article 63-2 Ovariectomy • bilateral • unilateral	 12% 6%
Article 63-3 Mastectomy • bilateral • unilateral	 25% 10%

Article 64

Sterility

Definitive inability of all medical methods of intervention to assist procreation in a previously fertile subject; rating includes loss of organs	25%

2) Males

Article 65

Organ loss

Article 65-1 Orchidectomy • bilateral • unilateral	 15% 6%
Article 65-2 Loss of the penis	40%

Article 66

Sterility

In a previously fertile subject, the rating includes loss of the testicles	25%

If the penis is also lost, the combined rating for organ loss and sterility is 45%.

***

IX. Endocrine system

IX. Endocrine system

Situations not described are to be assessed by comparison with clinical situations which are described and quantified.

Problems of imputability in this area are some of the most difficult. It is extremely rare, in the work of assessment, to see physical damage represented solely by an isolated endocrine deficit.

Here more than in any of the other chapters, decisions must be reached on the basis of clinical examinations and complementary tests done by a specialist.

Assessment should be based on suitability for treatment, monitoring of treatment and the efficacy of treatment.

Article 67

Pituitary gland

Article 67-1 Panhypopituitarism (represented by total functional deficit of the anterior and posterior pituitary), necessitating replacement therapy and regular clinical and biological monitoring, depending on the efficacy of treatment	20 to 45%
Article 67-2 Diabetes insipidus, assessed in terms of the efficacy of medical drugs in controlling polyuria	5 to 20%

Article 68

Thyroid gland

Article 68-1 Hyperthyroidism, with deterioration in biological constants, tremor, exophthalmos without effects on vision Idem, with repercussions on other organs and/or functions	 5 to 8% 8 to 30%
Article 68-2 Hypothyroidism (exceptional after trauma)	 Up to 5%

Article 69

Parathyroid glands

Hypoactive parathyroid gland, depends essentially on abnormal biomeasurements (blood calcium, blood phosphorus, parathyroid hormone) and the discomfort caused by persistent clinical signs	5 to 15%

Article 70

Pancreas – Diabetes

Article 70-1 Non-insulin-dependent diabetes • This is never a direct result of trauma. • Where imputability is established, depends on the nature of the clinical signs, need for monitoring and	5 to 10%
Article 70-2 Insulin-dependent diabetes • Onset of this type of diabetes often poses problems of imputability, except where it is the result of major pancreatic lesions. • The rating will be assessed in terms of the stability of the condition, its effects on the patient's social life and the need for medical drugs and monitoring	20 to 40%
- Article 70-2-a Poorly controlled diabetes, with malaise and repercussions for general health, necessitating close biological monitoring	15 to 20%
- Article 70-2-b Well controlled diabetes using simple insulin treatment, depending on the need for monitoring	
In the event of complications which leave permanent sequelae, refer to the specialist areas concerned.	

Article 71

Adrenal cortex

Insufficiency of the adrenal cortex: depends on the need for drug treatment and monitoring	10 to 25%

Article 72

Gonads

Depends on the outcome of replacement therapy	10 to 25%

***

X. Skin

X. Skin

Deep burns or pathological scarring

Situations not described are to be assessed by comparison with clinical situations which are described and quantified.

Article 73

Sequelae affecting the skin

(The ratings do not include aesthetic consequences and restrictions on movement)

Depending on the percentage of the body surface affected by the lesions

Article 73-1 Less than 10%	5%
Article 73-2 10 to 20%	10%
Article 73-3 20 to 60%	10 to 25%
Article 73-4 More than 60%	25 to 50%

***

Practical rules for the use of the european permanent disabilities rating scale

Principles

The assessing doctor is to quantify disabilities, i.e. physical or mental impairments which can be detected medically and are therefore measurable, by reference to the European scale.

Some types of sequela (e.g. ophthalmological, ENT, stomatological, etc.) will require recourse to a specialist in the appropriate field. The specialist's report must provide the assessing doctor with all the necessary technical data and considerations which will enable him to draw a conclusion on attributing and quantifying the sequelae.

Regardless of the function involved (locomotion, hearing, sight, etc.), if a prosthesis, orthosis or technical aid supplied to patients improves their functional problems, assessment of those problems must take account of such benefits.

Definitions

For the purposes of applying the European scale, permanent disability is defined as:

> irreversible reduction on physical and/or mental potential as detected by medical means or explicable in medical terms, added to which are the pain and mental consequences known by the doctor to be normally associated with the sequela and the impact on everyday life customarily and objectively associated with that sequela.

The degree of disability is:

> the degree of difficulty, in relation to a theoretical maximum of 100%, experienced by any patient whose sequelae are thus quantified, in performing the normal movements and acts of everyday life.

General

The degrees proposed for the scale should relate to the individual as a whole. The degree should not therefore quantify a loss of function or of an organ in relation to physical integrity, rated at 0%, of that function or organ.

The degrees concern sequelae assessed in isolation.

Total loss of function is deemed equivalent to loss of the limb or organ in question. Situations not described are to be assessed by comparison and analogy with described and quantified sequelae.

Mandatory nature of the scale

Application of the European scale is mandatory.

It is binding where it sets a predetermined degree; where it sets a range, the expert must stay within the minimum and maximum degrees.

Partial anatomical and/or functional sequelae must be assessed on the basis of the loss observed, taking account of the scale's degree for total loss, in cases where the scale does not set precise degrees.

Also mandatory are the rules set out for using certain sections of the scale (for example, to calculate the synergy of the fingers of one hand).

For a left-handed person, the degrees applied to the right upper limb are to be applied to the left limb, and vice versa.

Multiple sequelae

In the event of multiple sequelae deriving from one accident, calculation of the overall degree is by simple addition,

- without exceeding the degree for total loss of the limb or organ in the event of multiple lesions of that limb or organ;

- without exceeding 100%.

Special cases

Polymorphic symptoms

For example, the scale does not provide a degree for a laryngectomy: the assessing doctor must make an overall quantification of the impact on everyday life of dyspnoea and aphonia or dysphonia (there is a degree in the scale for each of these sequelae).

Pre-existing conditions

A pre-existing condition is defined as an established condition which prior to the accident caused a clinical condition which was perceptible in the everyday life of the patient.

Latent pre-existing condition or predisposition

A latent pre-existing condition without a perceptible clinical effect or impact on the everyday life of the patient is deemed equivalent to a pathological predisposition or susceptibility.

In either case the patient is deemed not to have possessed a pre-existing condition and no subtraction may be effected from the final assessment.