

Table 1- Peroneal Evidence Table/Chief Methodological Characteristics

Ref. #		Diagnosis: Clinical/ EDX/ Clinical+EDX	# of Patients	Number / type of control subjects	Patients Mean Age, Years (Range)	Assembly Method	Assessment Time	Conclusion
1	Compared negative area to EDB and AL, affected/ unaffected limb and across. FH segment III. Needle EMG IV. Superficial peroneal (6) III	Clinical. *	11, 7 for contralateral comparison	25 normal volunteers + 10 control subjects for side-to-side normative data	49 (15-82)	Consecutive referrals with acute PN	1.5 to 10 weeks post symptom onset	Reduced CMAP at all sites more common in EDB Conduction block more often to AL muscles. MCV distal to FH to EDB unaffected
3	MNC to EDB III. Superficial peroneal SNC III Needle EMG IV	Clinical *	30	25 healthy volunteers	27.6 (14-54)	Referrals with common PN after weight loss	1-4 weeks Follow-up: 3 weeks to 7 months	Conduction block of the deep peroneal nerve was the most consistent finding
5	MCS to EDB utilizing 2 cm segments across FH region compared to MCV across 10 cm segment III	Clinical*	18	28 healthy volunteers enrolled for study	52 (24-77)	Referrals with suspected PN	Not Reported	Short segment stimulation was more often abnormal
6	MCS to EDB, AT, IV Needle EMG IV	Clinical +EDX	103 116 nerves	References by others. Implicit, not reported: laboratory's own normal values.	53 (9-83)	Those with PN on neurophysiologic tests. Those with concomitant neurologic diagnoses and PN were excluded.	Acute 57 Gradual 35 Indeterminate 11	In 43% diagnosis was not suspected clinically pre-study. Localized to FH by conduction block at FH
7	Superficial peroneal recording at ankle/knee stimulating 14 cm proximal to ankle electrode III	Clinical	11	35 normal subjects recruited for the study	Not Reported	Referrals with clinical diagnosis of PN	<1 month: 4 subjects	Knee responses absent in all subjects. Normal subjects: 6% of limbs no response
8	Orthodromic and antidromic superficial peroneal SNCs of the 4 branches to the toes III	Clinical*	7	21 healthy, paid volunteers	48 (26-73)	Subjects with sensory symptoms in the superficial peroneal distribution and abnormal superficial peroneal NCS	Not Reported	Obtained in at least one branch in all normal subjects. Absent or reduced SNAP in the distribution of sensory loss in all cases
9	MCS to EDB stimulating at the fibular neck and PF IV	EDX diagnosis of peroneal nerve lesion at the knee, by NE	36 38 nerves	186 without peroneal nerve lesion. 48 with polyneuropathy	45	EMG studies indicating PN at the knee	Not Reported	Fall in motor amplitude between the popliteal stimulation and FH stimulation compared to control values was seen in 61.6% of cases
10	MCS to AL and EDB with stimulation	EDX: abnormal NE	23	39 healthy subjects	Not Reported	Abnormal EMG of anterior leg muscles	2 days to 6 months	CV to the AT was more often abnormal than the

	above/below the FH IV	of underlying muscles					post- onset	EDB
11	Orthodromic sensory studies above and below the FH III. MCS to EDB, PL and AT with stimulation at ankle, above and below FH III	Clinical only	77 referrals:23 definite 24 suggestive; 18 other 12 fracture (excluded)	74 subjects without neuromuscular disease	50%: 40-60 25%: 20-40 25%: >60	Referrals for investigation of PN Classified based on history, lab studies, and PE findings	50% > 6 months	Slowing of sensory fibers across the FH was most often abnormal. MCV also useful for localization of site
12	MCS to EDB with needle recording V EMG of PL, AT IV. Orthodromic SNC to above and below FH with near nerve electrodes IV	EDX	14	Referenced criteria for abnormality Implicit, not reported: laboratory's own normal values.	(21-73)	Abnormal MCS across the FH	Initial evaluation: 1 mo-1 year post symptom onset. Follow up: 5 mo-3 years	Normal sensory CV distal to FH was predictive of clinical recovery. All patients who recovered clinically had normal MCV distal to the compression site
13	MCS to AT, PB and EDB above, below and at the FH IV. Superficial peroneal sensory conduction IV. EMG of CP muscles IV	Inclusion: Clinical Exclusion: Abnormal NE of SHBF; single sensory CP branch abnormal.	22	12 control subjects	51 (17-77)	Consecutive referrals with clinical findings of unilateral common PN	Mean: 2 months, 2 indeterminate	Muscles supplied by the deep peroneal nerve were more frequently involved