Diagnosis of symptomatic neuroma is based on a history of (suspected) nerve injury, symptoms in a defined neural anatomic distribution and most importantly pain. In combination with a positive Tinel sign, positive response to a diagnostic local anesthetic injection, or US or MRI confirmation of neuroma, these criteria form the basis of diagnosis of symptomatic neuroma.

**1. Introduction**

- Neurams occur in 5-10% of patients sustaining a nerve injury, especially after amputation. They are often difficult to treat and may cause significant morbidity.
- Diagnosis has traditionally been made based on patient history, symptoms, physical examination, and location and distribution of pain, sometimes supported by a Tinel sign, imaging, and response to a nerve block.
- There are no established or formally accepted diagnostic criteria for symptomatic neuroma.

**Design:**
- Systematic review following the 2009 PRISMA guidelines.
- Pubmed, Embase, Cochrane Library
- Screening by title and abstract
- Eligibility assessed by full article

**Inclusion:**
- All articles addressing neuroma after nerve injury and amputation
- Languages: English, Dutch, German

**Exclusion:**
- Duplicates
- Non-human studies
- Non-extremity neumras
- Morton’s neuroma, bowler’s thumb

**Diagnostic Criteria for Symptomatic Neuroma**

**Must have all 3:**
1. Pain with at least 3 of the following characteristics: burning, sharp, shooting, electric, or similar, numbness, cold intolerance
2. Symptoms in a defined neural anatomic distribution
3. History of nerve injury or suspected nerve injury

**Must have at least 1:**
1. Positive Tinel sign (for cutaneous nerve)
2. Positive response to local anesthetic injection
3. US or MRI confirmation of neuroma