Multiple Sclerosis-related Q & A from American Brain Foundation eNews “Ask a Neurologist”

Q. Is it possible to manage MS without hard core drugs?

A. Multiple sclerosis is felt to be an inflammatory disease of the central nervous system. Given this, one of the goals of managing MS is reducing the inflammation by using drugs that act on the immune system (disease-modifying therapies, or DMTs). It is important to recognize that these DMTs are not intended to make patients feel better but instead attempt to (1) reduce MS relapses, (2) reduce the number of new lesions on magnetic resonance imaging, or MRIs, and (3) delay the progression of disability. Interventions other than the DMTs have not been proven to accomplish these three goals.

Some of the environmental factors that are felt to cause/worsen MS include low vitamin D levels and tobacco use. Many patients with MS take vitamin D supplements, and it is advised that patients with MS stop smoking. Data is insufficient to make a specific recommendation regarding a specific diet in MS, although a well-balanced, healthy diet is probably wise. Exercise is likely also helpful in managing MS.

Q. Are there any recommended stem cell studies related to multiple sclerosis?

A. Stem cells are basic cells in our bodies that can produce multiple, more specialized cells. Stem cells that may be relevant in MS include those that lead to the production of certain immune cells, those that lead to repair after injury of the brain from MS, and cells that help protect other cells from injury or death. Stem cell research is still very early in development and is being performed at a limited number of centers. Much of the stem cell research is still focusing more on safety than effectiveness, and no stem cell therapies have been proven to work for managing MS or its symptoms.

Q. Can a person have MS even though MRIs and spinal fluid tests do not show it?

A. There are specific requirements necessary to make a diagnosis of MS. All of these diagnostic criteria require that a patient have at least one clinical attack, defined as at least 24 hours of new or worsening neurologic symptoms occurring in the absence of fever or infection and preceded by 30 days of neurologic stability. Although MRI lesions are not required to make a diagnosis of MS, the absence of abnormalities on the MRI makes a diagnosis of MS very unlikely. Most (but not all) patients with MS have a positive spinal fluid; however, contrary to popular belief, a positive spinal fluid does not make a diagnosis of MS.

Q. Can MS eventually cause symptoms of thinking disorders like over dramatization, paranoia, unreasonable thoughts, believing people are doing things they are not, or inability to reason?

A. Multiple sclerosis (MS) can cause more than just physical issues like walking; it can also cause disorders of mood and thinking. The most common mood disorders with MS include depression and anxiety; paranoia, delusions, and having unreasonable thoughts are possible, but much less common in MS. The common issues with thinking in MS include slower thought processes (information processing speed) and decreased working memory; frank dementia or inability to reason is much less common.
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Q. Is there a way to treat MS patients for psoriasis without affecting their MS?

A. MS patients are often treated with corticosteroids for other health conditions, including psoriasis, and this probably does not have any effect on MS. When selecting a medication for a patient (including a disease modifying therapy for MS), the hope is to find a drug that offers more than one potential benefit and avoid drugs that might adversely affect another condition. Interferons like Beta 1A-Injection (Avonex or Rebif) and Beta 1B (Betaseron or Extavia) can help with MS but may worsen psoriasis; conversely, a drug like dimethyl fumarate (Tecfidera) can offer a benefit in both MS and psoriasis.

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