After a decade of significant strides in multiple sclerosis (MS) treatment, researchers are continuing their search for better therapies—and even a cure—on some radically new fronts.

“During the past several years, we have seen remarkable advances. We started out with no treatment options for MS. Now we have five FDA-approved therapies—glatiramer acetate, mitoxantrone, and the three interferons,” says James Bowen, MD, Assistant Professor of Neurology at the University of Washington in Seattle. “Unfortunately, our success is only partial; all of the available treatments slow but do not halt the disease. In the next few years, we are likely to see new medications or new combinations of medications that will be successively better.”

Dr. Bowen discussed what several of these new treatments might mean for MS patients in the future.

**Combination Therapies**

Bolstered by the idea that combination therapy may result in greater improvement than monotherapy, MS researchers have begun focusing on new drug combinations. Research has concentrated primarily on two approaches: pairing established MS medications with one another, and combining these medications with new therapies.

“The hope is that these combinations will be more successful than the medications used individually,” says Dr. Bowen, noting that research into the use of MS drug combinations is still relatively young—most studies are phase I or II clinical trials.

One promising area of research involves the combination of chemotherapeutic agents with drugs already approved for MS treatment. Researchers have focused on immunosuppressive drugs in an attempt to slow the proliferation and activity of immune cells believed to turn against the body in MS and attack the myelin that surrounds nerve fibers.

Of particular interest is the combination of interferons with azathioprine (AZA), a drug generally used to prevent organ transplant rejection and for cases of severe arthritis. Two research reports presented at the 54th Annual Meeting of the American Academy of Neurology in Denver illustrated the beneficial effects of this combination. One study, conducted by the National Institutes of Health, looked at six patients with relapsing-remitting MS (RRMS) who, despite treatment with interferon beta-1b, continued to develop lesions and to experience high exacerbation rates. Study participants experienced a significant reduction in lesions after adding AZA to the interferon treatment regimen. Four patients also saw a modest decrease in relapse rate.
results of an ongoing Czech study seem to point in a similar direction. The study showed that adding 50 mg of AZA to a weekly dose of 30 mcg interferon beta-1a cut relapse rates by 72% after two years.2

Other chemotherapeutic agents that are being studied in combination with existing therapies include cyclophosphamide, methotrexate, and mycophenolate.

Dr. Bowen is encouraged by these avenues of research because “most of these chemotherapeutic agents are targeted against a specific portion of the immune system that would not leave a patient generally immune-suppressed.”

**New Approaches to MS Treatment**

- Combining established MS treatments (interferons with glatiramer acetate or mitoxantrone, glatiramer acetate with mitoxantrone)
- Adding chemotherapy agents to approved MS drugs (azathioprine with interferons, other chemotherapy agents with existing treatments)
- Autologous bone marrow transplants
- Monoclonal antibodies (such as natalizumab)
- Statins (atorvastatin, lovastatin, simvastatin, mevastatin)

**Autologous Bone Marrow Transplants**

Though highly intensive and still years away from FDA approval, there are several preliminary phase I safety studies which suggest that autologous bone marrow–derived stem cell transplants may protect MS patients from the destructive effects of immunosuppressive drugs.

“These studies are based on the premise that high-dose chemotherapeutic treatments might be more effective in MS than lower doses of therapy,” Dr. Bowen explains. “The transplant is needed to rescue patients from the extreme immunosuppression that would otherwise result.” Stem cells, which manufacture blood cells and are found in greatest concentration in the bone marrow, tend to be destroyed during chemotherapy. Thus, patients are left immunocompromised and vulnerable to infection and illness unless the stem cells are replaced.

A recent study of autologous stem cell transplants from the University of Washington, Seattle, involved 26 MS patients, most with severe progressive disease refractory to other treatments. Over a median follow-up period of 12 months, six patients improved and nine remained neurologically stable. However, 10 of the study participants deteriorated, based on the definition of an Expanded Disability Status Scale score of 0.5. The researchers agreed that in future trials of autologous bone marrow transplant, treatment should be given to MS patients earlier in the course of the disease when disability is less pronounced.3
Early results of another study suggest that about 20% of MS patients who receive stem cell transplants continue to have MS exacerbations, despite aggressive treatment. However, the implications of this finding are unclear. Dr. Bowen theorizes that results may be confounded because the study participants had particularly severe MS and were not compared with untreated controls.

At least one phase II randomized study is currently in development that will compare transplant patients with a control group taking mitoxantrone.

**MONOCLONAL ANTIBODIES**

MS researchers are keenly interested in monoclonal antibodies for their ability to attack specific immune system proteins believed to play a role in MS while leaving the rest of the immune system intact and functional. Currently, monoclonal antibodies are being developed in mice with spliced-in human immunoglobulin material, so the antibodies can be given to MS patients for long-term periods without being rejected.

A leading antibody contender is natalizumab (Antegren®), an alpha-4 integrin antagonist. Alpha-4 integrin is a glycoprotein that may play a role in the pathogenesis of MS by aiding the migration of lymphocytes and monocytes to the brain, causing inflammation. Natalizumab inhibits this process.

A recent international, multicenter, double-blind phase II study published in the *New England Journal of Medicine* found that 3 or 6 mg/kg intravenous infusions of natalizumab given every 28 days for six months significantly reduced relapse rates and number of new lesions in a group of 213 patients with RRMS or secondary progressive MS, as compared with placebo. Researchers are now beginning phase III studies of natalizumab to determine its long-term effects. If these studies show the drug to be safe and effective, it could be on the market within two years, Dr. Bowen says.

Other monoclonal antibodies being studied for MS include those directed against immune-regulating proteins such as CD52, tumor necrosis factor-alpha, CD20, and interleukin-2.

“**All of the available MS treatments slow but do not halt the disease. In the next few years we are likely to see new medications or new combinations of medications that will be successively better,**” Dr. Bowen predicts.

**STATINS**

Used to control high cholesterol and reduce the risk of heart disease, statins are now regarded as a possible treatment for MS. Dr. Bowen points to recent research suggesting that the effectiveness of statins against heart disease may be due to their anti-inflammatory and immunosuppressive actions along with their cholesterol-lowering properties. A study published in *Nature* using mice with experimental autoimmune encephalomyelitis (EAE, a condition akin to mouse MS) revealed that one of these agents, atorvastatin, not only cut the rate of EAE development, but also reversed established disease in many instances.

A recent in vitro study found that three of the statins—lovastatin, simvastatin, and mevastatin—inhibit the proliferation of peripheral blood mononuclear T and B cells taken from patients with MS. Researchers also discovered that combining interferon beta-1b with a statin produced an additive inhibitory effect on the cells, suggesting that statins could eventually be used as an add-on treatment.

Dr. Bowen notes that several phase I studies now are under way to determine how effective statins may be in the treatment of MS patients, and some phase II studies are in development.

> **REFERENCES**


> **MSX**

—Sidney Stevens
Veterans of the United States Armed Forces with multiple sclerosis (MS) who seek treatment at Veterans Affairs (VA) medical centers and hospitals will soon be receiving some of the most up-to-date MS care available. The National Institutes of Health has just awarded the Multiple Sclerosis Center of Excellence East (MSCoE) in Baltimore and the Multiple Sclerosis Center of Excellence West (MSCoW) in Seattle $8 billion over the next four years to serve as a national VA consortium, coordinating and expanding MS programs across the country in clinical care, research, and education.

As explained by Christopher Bever, MD, Director of the MSCoE, both facilities will be responsible for recruiting a network of VA clinics across the United States. Jodie Haselkorn, MD, MPH will serve as Director of the MSCoW.

The purpose of this program is “to make sure veterans with MS throughout the VA system are getting excellent care and treatment that meets a unified standard,” says Dr. Bever, who is also Professor of Neurology at the University of Maryland School of Medicine in Baltimore. “The centers are responsible for looking at MS care throughout the VA system, reviewing existing clinical practice guidelines, and developing guidelines where they are lacking,” he adds.

Part of the problem is that veterans with MS are scattered around the country, says Dr. Bever. In the VA system, there are only a few medical centers that have MS subspecialists, so a lot of these patients are being treated by either general neurologists, internists, or primary care providers. “The Centers of Excellence are responsible for identifying where the MS patients are in the system, finding the nearest center to that patient, and making sure that somebody in that center works with the patient’s primary care provider so he or she has access to the latest treatments for MS,” explains Dr. Bever. Population management strategies will be implemented that use the VA’s powerful technological backbone to identify veterans with MS.

Although the centers are “in start-up mode right now,” according to Dr. Haselkorn, they will be on the cutting edge of MS treatment, education, and research. “We are excited about the broad spectrum of inpatient and outpatient care that the centers’ programs will cover,” she says. One example is the Seattle center’s home monitoring tele-medicine program. “We already have three veterans who have audio-video home monitors. We’re looking forward to dispensing text-based monitoring as a means to enhance access and improve quality of service,” notes Dr. Haselkorn, who has led an MS program at VA Puget Sound for more than 10 years and is Associate Professor of Rehabilitation Medicine at the University of Washington in Seattle. “For at least some of the veterans, the tele-medicine program may be able to delay or avert nursing home placement, help to smooth the transition to home after an exacerbation, and increase adherence to disease-modifying therapies,” she says.

In addition to traditional educational methods, distance learning methods and enhancements to the electronic medical record will be available to both veterans and providers, says Dr. Haselkorn. For instance, computer programs for health care providers that link educational materials to medical records will include “pop-up” links to Web sites, providing clinicians with further information about a particular aspect of a patient’s health status.

“This large-scale coordination of MS care is a major clinical opportunity,” notes Dr. Haselkorn. “The two centers can’t improve services by providing direct clinical services by themselves. Rather, we must work with our colleagues at other VA hospitals and with veterans themselves to improve the delivery of consistent health services across the country.”

—Rosalee L. Blumer
Rehabilitation for Gluteal Weakness in MS

By Pat Provance, PT
Kernan Rehabilitation Hospital and Maryland Center for MS

Gluteal weakness is a common problem in multiple sclerosis (MS)—and one that often is overlooked—partly because the patient is sitting on it!

Muscle weakness in MS occasionally is disease-related or may be caused by inactivity. Primary weakness, physiologic fatigue, and spasticity often are related to MS plaques in the central nervous system that slow nerve conduction. Balance problems may be related to primary weakness, cerebellar disease, visual impairment, or sensory loss.

However, several groups of muscles that are important for strength, stability, and balance frequently develop secondary weakness that may be attributed to disuse and prolonged positional stretch. People with MS commonly admit that their level of activity has gradually declined over a period of months to years. They sit to rest, watch TV, or work on computers, and many use wheelchairs or scooters for energy conservation while remaining ambulatory for short distances.

The gluteus maximus is a powerful, one-joint, hip extensor that often develops stretch and disuse weakness secondary to prolonged sitting. Adjacent to the gluteus maximus, the gluteus medius is an essential player in lateral hip and pelvic stability. The strength of these muscles is rarely tested during neurologic examinations.

Techniques for Evaluating Gluteal Strength

To properly evaluate the strength of this muscle group, the patient should be tested in prone and side-lying positions. However, because most clinicians perform their evaluations while the patient is sitting, gluteal weakness frequently is overlooked. Since the patient’s ability to maintain stability while standing on one leg relies primarily on the strength of the gluteal muscles and quadriceps, this can be a relatively simple method of screening for gluteal weakness after adequate quadriceps strength—with or without tone—has been confirmed.

To evaluate gluteal strength, the patient should be asked to stand and face the clinician, resting both hands on the clinician’s hands. The clinician should note the degree to which the arms are needed to accomplish this. Then, the patient should try to stand on one leg using one of the following methods: 1) with the opposite leg lifted into hip flexion, 2) with the opposite knee bent and hip straight, or 3) with the opposite leg extended in front. This test then should be repeated with the other leg.

If gluteal weakness is present, the patient may have difficulty maintaining balance. The pelvis will deviate forward or sideways, the trunk may sway, and pressure on the clinician’s hands may increase. Abdominal weakness, especially of the lower abdominal muscles, is part of this pattern because it may cause an anterior pelvic tilt and present an added strain on the gluteal muscles.
The typical standing posture of patients with gluteal weakness is hip flexion (as shown in the illustration on the previous page) with locked knees and a tendency to brace the body with the arms due to significant weakness and fear of falling.

The Good News
Even when significant gluteal weakness is present, disuse weakness often is reversible with appropriate corrective exercises. Behavior modification techniques can play a big part in correcting this phenomenon and in preventing further deterioration. In addition, the use of ambulation aids may help the patient sustain erect posture and stability while promoting a ‘normalized’ gait pattern. Appropriate exercises and behavior modification techniques are outlined in the sidebar.

Ambulation Aids
A qualified therapist who has knowledge, experience, and sensitivity about the challenges of MS should perform an evaluation of the patient’s ambulation needs. The most commonly prescribed assistive devices to help improve gait and balance include:
- Canes (which provide the least amount of support)
- Lightweight forearm crutches, such as those manufactured by Walk Easy Inc (www.walkeasy.com)
- Four-wheeled, rolling walkers with large swivel wheels, a flip-up seat, hand brakes, and backrest, such as those made by Dolomite Home Care Products (www.dolomitehcp.com) or Invacare (www.invacare.com)
- Ankle-foot orthoses, custom-made to correct or prevent footdrop

There is great potential for improvement in strength, function, and quality of life when disuse weakness has been identified and explained to the patient. The knowledge that noticeable strengthening is possible—because the weakness is due to sitting, not MS—can be a strong motivating factor in increasing patient compliance. In addition, the instruction to “do something corrective every 30 minutes” presents patients with an achievable alternative to performing exhausting, inappropriate calisthenics. Since progress usually is apparent after just a few weeks, this fuels the patient’s desire to continue.

Suggested Reading

Basic Corrective Exercises for Gluteal Weakness

Sit ↔ Stand: “Nose over toes,” “fold/unfold,” and so on with minimal or no use of hands and arms—except for instruction to lightly touch chair with fingers when sitting down for safety reasons.

Gluteal Sets: Isometric buttock squeeze whenever hip is straight—standing, prone, or supine. Hold for at least three breaths.

Bridging: Lie on back with knees bent. Tighten abdominal muscles and lift buttocks until hips are straight. Hold for three breaths.

Standing Weight Shifts: With hand support as needed. May be done at kitchen or bathroom counter or with back against wall and walker in front for support. Smoothly shift weight from one leg to the other without hip drop or trunk sway, consciously tightening the quadriceps and gluteal muscles on the supporting leg while keeping hips and shoulders still.

Supported Single Leg Stand: Erect posture with hand support as needed.

Abdominal Strengthening: Can be done in any position, since the abdominal muscles do not cross the hip joint.
1) External obliques: Pull up and in with lower muscle girdle.
2) Transverse abdominal muscles: With hands at waist, pull inward with the abdominal muscles to make the waistline smaller.

Hip Flexor Stretching: Adaptive shortening of the hip flexor muscles is common with prolonged sitting. Lying on back, with both legs straight, pull one knee up toward the chest to help flatten the lower back, then press the opposite leg down, tightening buttocks muscles until a stretch is felt at the front of the upper inner thigh.

Behavior Modification Strategies
- Change position or do a corrective exercise every 30 minutes; a kitchen timer or computer reminder helps. If sitting, perform sit ↔ stand and gluteal sets while maintaining erect posture.
- Rest in a horizontal position, lying on stomach with a small pillow or folded towel under waist, not hips.
- Gradually increase duration and frequency of controlled standing and walking.

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Registry Links MS Patients to Appropriate Clinical Trials

Developing more effective therapies to slow and even stop the progression of MS, improve symptomatic therapies, and enhance care services for people with this disease are some of the main objectives of the CMSC. With these goals in mind, the consortium initiated the North American Research Committee on MS (NARCOMS) Patient Registry in 1996. The registry is a recruitment database that links investigators with patients who are potential candidates for clinical studies.

According to Olympia Hadjimichael, MPH, coordinator of research for the registry, “patients with MS are strong advocates for research, want to know a great deal of information about current studies, and tend to be cooperative about collaborating on research projects.”

The NARCOMS Patient Registry is a patient-reported database in the form of a long-term study. Participants update their information every six months and respond to surveys on MS-related questions. The registry has enrolled more than 21,000 participants in the United States thus far. Registration is voluntary, confidential, and free of charge to patients.

“The registry is a recruitment database,” notes Ms. Hadjimichael. “However, due to its large size, it provides researchers with clear profiles of MS patients.” Data gathered include basic demographics such as marital status, living situation, educational level, and employment status. Patients also are presented with questions about the impact of MS on their ability to work, third-party health insurance sources, and information about family history of the disease.

Diagnostic evaluations include queries about relapse and attack frequency and past and present use of immunologic and symptomatic therapies. A self-reported disability scale (Patient Determined Disease Steps) and a handicap scale (Performance Scale) are used to describe the patient’s clinical status.

Any individual who has received a diagnosis of MS is eligible to enroll by calling (800) 253-7884, e-mailing narcoms@chw.edu, or registering online in the “MS Patients” section of the CMSC Web site at www.mscare.org.

Following is a list of some current clinical trials:

➤ CNTO 1275 Investigational Drug, Molecule that Regulates Immune Response. Contact: Yale Center for MS Treatment and Research; (203) 764-8498; email: jasmine.kenny@yale.edu.

➤ Combination Therapy with Avonex®, and Bi-Monthly High Dose IV Methotrexate. Contact: Laurie A. Dressman, RN; (816) 753-8800, ext. 124; e-mail: ldressman@cinpc.com.

➤ High Dose Chemo/Radiotherapy and Hematopoietic Stem Cell Transplant. Contact: Peggy Bates; (713) 394-6243; e-mail: mbates@tmhitmc.com.

➤ Induction Therapy With a Single High Dose Bolus of Intravenous Methotrexate With Leucovorin Rescue, Prior to Initiation of Avonex Treatment in Patients Presenting with a First Acute Demyelinating Event: Comparison with CHAMPS Results. Contact: Laurie A. Dressman, RN; (816) 753-8800, ext. 124; e-mail: ldressman@cinpc.com.

➤ Novantrone® and Avonex OR Novantrone and Copaxone®. Contact nearest center: Baltimore: (410) 328-5605; Cleveland: (216) 444-6800 New Haven, Conn: (203) 764-8498; New York City: (212) 241-4264.

➤ Novantrone Quality of Life and Cost of Illness Study. Contact: Sonna Hunsley, RN, Barrow Neurological Institute in Phoenix; (602) 406-3343; e-mail: shunsle@chw.edu.

➤ Pseudobulbar Affect in MS Patients. Contact: National Multiple Sclerosis Society at www.nationalmssociety.org or call (800) FIGHT MS (344-4867).

➤ Rolipram to Treat RRMS and SPMS. Contact: NIH Patient Recruitment and Public Liaison Office; (800) 411-1222; e-mail: prpl@mail.cc.nih.gov.

➤ Study of Oral Fampridine-SR on Walking Ability in MS. Contact: Dianne Pennington at Acorda Therapeutics; (914) 347-4300, ext. 112; e-mail: dpennington@acorda.com.

➤ Treatment of RRMS With Copaxone and Albuterol. Contact: Sandra Cook; (617) 713-2006; e-mail: scook@partners.org.

➤ Zenapax® to Treat MS. Contact: NIH Patient Recruitment and Public Liaison Office; (800) 411-1222; e-mail: prpl@mail.cc.nih.gov.
Cultural Issues in MS Nursing

“Cultural sensitivity” seems to be one of the latest catch-phrases in medicine. Although the issue appears to receive plenty of lip service, the primary goal behind a culturally sensitive approach is to improve patient care by attempting to break down some of the barriers among cultures and establish greater trust between health care providers and their patients. Since a trusting relationship is especially important in the treatment of patients with a chronic, life-altering disease like MS, how can clinicians most effectively treat all patients, regardless of cultural origin?

As a first step, health care professionals must recognize the diversity of the populations they serve, says Elida J. Greinel, RN, Clinical Coordinator for the Multiple Sclerosis Specialty Clinic of New Mexico in Albuquerque. According to Ms. Greinel, awareness of cultural differences must be created among MS nurses so they can better serve members of ethnic and cultural minority groups. Then, strategies can be implemented to ensure patients receive the best care possible while having their unique cultural viewpoints and practices respected.

Practical Considerations

One obvious obstacle to care is a possible language barrier. In a recent survey by the Robert Wood Johnson Foundation, one fifth of Spanish-speaking people living in the United States reported that they did not seek medical treatment due to such barriers. Those surveyed said that speaking a language other than English made it harder to fully explain symptoms, ask questions, and follow through with getting prescriptions filled. It also affected the level of trust patients had toward the health care system, leading them to believe that clinicians did not understand their needs.1 For such patients, Ms. Greinel suggests, “it’s helpful to use an interpreter who not only speaks the person’s language but has some kind of medical background.”

Another factor that must be taken into consideration, according to Ms. Greinel, is the special work situation that may exist for someone of another culture. Since medical clinics usually are open on weekdays during typical office hours, an immigrant field worker, for instance, may not be able to take time off from a job for medical appointments. Such people would be much better served if clinics had more flexible hours, she advises.

In addition, some individuals may be in the United States illegally and think that a medical clinic might report them to immigration services. “We have to make it clear to them that this is not our role or intention,” Ms. Greinel emphasizes.

Finding a Compromise

The ways that different cultures perceive health and illness also may create rifts between clinicians and patients. For instance, some Hispanic cultures have a predominantly spiritual view of illness and believe that if people are ill they have somehow failed God or Providence, she explains. Although the views of other cultures sometimes come into conflict with the beliefs of conventional medicine, it is crucial to take into account patients’ cultural or spiritual beliefs, especially when they are facing a chronic and unpredictable disease like MS. The traditions of a heritage or religion can create a strong foundation for patients by providing them with guidance at a time when they seem to have lost a sense of control over their lives.

“As nurses, our role is not to challenge other people’s belief systems, but to guide and educate them,” Ms. Greinel suggests. The role of the health care provider is to find some compromise by attempting to understand the patient’s point of view while explaining to him or her some of the advantages of the clinician’s approach, she adds. “Sometimes, MS patients may feel desperate, so they are more susceptible to being swayed by alternative treatment approaches and more vulnerable to quackery. So, educating the patient is extremely important.

“If dignity and respect are central to the health care provider’s approach, however, culture is not going to be a problem,” Ms. Greinel concludes. “Having and showing respect for the individual transcends any cultural, religious, or ethnic boundary.”

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GET CERTIFIED! MARK YOUR CALENDAR FOR THE NOVEMBER IOMSN CERTIFICATION EXAM

A Multiple Sclerosis Nursing International Certification Examination will be given nationally and internationally on November 1, 2003. For details on exam locations and to obtain the handbook for candidates, which includes all application materials and a list of suggested readings, visit the Professional Testing Corporation’s Web site at www.ptcny.com.

All candidates for certification must be registered nurses. It is recommended that nurses have at least two years of experience in MS or neurologic nursing. The application deadline is September 15.
New research into multiple sclerosis (MS), coupled with the rapid rise in the number of MS specialist nurses, has contributed to a growing trend of addressing the deeper needs of MS patients and adopting a “whole-person” approach to MS care. Additionally, conventional MS disease-modifying drugs may be only partially effective or may cause undesirable side effects. At the most recent MS Trust/IOMSN meeting in Harrogate, United Kingdom (UK), Thomas E. Whitmarsh, FRCP, FFHom discussed how some of these issues might be addressed through the use of complementary and alternative medicine (CAM).

What Is CAM?

CAM may be defined as “diagnosis, treatment, and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying the demand not met by orthodoxy, or by diversifying the conceptual frameworks of medicine.” According to Dr. Whitmarsh, Consultant Physician at Glasgow Homeopathic Hospital, this definition provides a good starting point for an informed discussion of MS treatment strategies because it points out that needs are not always met by the symptom-management approach of traditional medicine. It also offers “the possibility and the hope of one day combining CAM and conventional medicine, so that we can practice the best of both worlds in a truly integrated fashion.

“CAM can offer MS patients a number of interventions which may help with specific symptoms; there is even some suggestion that the rate of decline can sometimes be slowed,” says Dr. Whitmarsh. However, he cautions, no CAM methods available at this time can provide a cure for MS. This caveat is important because many MS patients are desperate for a cure and are vulnerable to false claims or unrealistic hope. They may turn to alternative modalities because conventional approaches fail to offer a cure. This may account for the widespread use of CAM among MS patients, which has been documented in several studies. For example, a Colorado study reported that one third of MS patients surveyed reported visiting a CAM practitioner in the previous six months.

Evaluating the efficacy and safety of the numerous CAM approaches can be confusing. Patients do not always obtain reliable information and sometimes use remedies that may be ineffective or unsafe. To compound the problem, many people do not tell their health care providers about their use of alternative remedies, and many providers do not ask patients if they are using them. The result is that some individuals are making decisions about CAM therapies without adequate information and without the input of their clinicians.

Which CAM Approaches Work?

Which alternative therapies are efficacious and safe? Dr. Whitmarsh points to several evidence-based CAM therapies for MS that have been supported by randomized, controlled trials; they include nutritional therapy, massage, body work, reflexology, neural therapy, imagery, and psychological counseling. Anecdotal evidence supports the efficacy of other CAM therapies, such as acupuncture, aromatherapy, yoga, and homeopathy.

Dr. Whitmarsh urges health care providers to familiarize themselves with CAM, which may help to fill the gap when conventional treatments are either insufficient for or poorly tolerated by the patient.

For example, standard drug therapies are available to address MS symptoms such as bladder and bowel dysfunction, cramps and spasms, sexual impotence, and tremor; however, some patients do not respond to these therapies or may experience adverse effects. Additionally, conventional treatments often do not adequately address symptoms such as fatigue, depression, or emotional problems, says Dr. Whitmarsh. CAM can offer a new armamentarium of remedies that can sometimes help to relieve these symptoms.

Familiarity with CAM also enables clinicians to become involved with the patient’s alternative program...
and guide him or her toward more reputable alternative therapies.

Health care providers may enhance their practices by understanding the factors that draw MS patients to CAM. According to Dr. Whitmarsh, these patients are seeking “some form of care that encompasses and respects their experience of illness in the context of the rest of their lives.” He notes that “this is the agenda of the movement for holism in medicine and this is claimed as the basis for most CAM therapies. The rise in the use of CAM by patients should help us to learn what patients need and to adopt a whole-person outlook toward care.”

Dr. Whitmarsh urges health care providers to familiarize themselves with CAM, which may help fill the gap when conventional treatments are either insufficient for or poorly tolerated by the patient.

THE HOMEOPATHIC APPROACH

According to Dr. Whitmarsh, homeopathy as it is practiced in the UK is unique among CAM therapies because it has been widely used by conventionally trained medical professionals in the National Health Service (NHS) since the agency’s inception in 1950. This gives medical homeopaths the “unique authority and vision of what a dual training and seamless, integrated use of complementary medicine can bring to their patients,” he says.

“Let like be treated by like” is the basic principle of homeopathy. “This is based on the observation that individuals who have an illness or a condition can be helped by medicines that produce similar symptoms when given to healthy individuals,” Dr. Whitmarsh explains. “Homeopathic remedies are produced from a range of natural substances. They are administered in a highly diluted form and are therefore mostly nontoxic,” he adds.

One of the most important advantages of homeopathy is that it offers an individualized treatment plan based on the entire person, rather than on disparate symptoms. “Homeopathic remedies often are based on personal characteristics and not just pathology. Thus, a true ‘constitutional prescription’ can be made only after a detailed inquiry into the minutiae of a person’s life,” he says.

When working with an MS patient, Dr. Whitmarsh often decides which homeopathic remedy to prescribe for specific symptoms or for a relapse by considering the perceived precipitating event in the person’s life. For example, some relapses seem to be triggered by depression or other emotional factors, while others may occur following a viral illness. Although each relapse may present with the same symptoms, each may be treated with different homeopathic remedies.

BEYOND SYMPTOM CONTROL

Can homeopathy prevent disease progression in MS? At present, there is no hard evidence to support that claim, says Dr. Whitmarsh. Many more randomized, controlled trials must be undertaken to study the true effects of a homeopathic approach, as well as other modalities of CAM. However, this does not mean that the benefits of homeopathy stop with symptom control. “The homeopathic approach has much to offer the person with MS, not just in the prescription of remedies or the potential reduction in conventional drugs with their attendant side effects,” notes Dr. Whitmarsh. “There is a particular quality of interaction with the individual and necessarily a whole-person approach to care.”

REFERENCES


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NEW DIAGNOSTIC CRITERIA MAY LEAD TO EARLIER DETECTION OF MS

The recently developed McDonald diagnostic criteria are more accurate than the previous Poser criteria in the early diagnosis of MS in patients with a single demyelinating episode or clinically isolated syndromes (CIS), according to a recent analysis conducted in Barcelona, Spain.

The McDonald criteria, issued in 2001 by the International Panel on the Diagnosis of MS, use MRI images to provide objective demonstration of dissemination in time and space in patients with CIS and clinical evidence of one lesion. The Poser criteria require a second clinical episode before a diagnosis of MS can be made.

The Barcelona study looked at 139 patients with CIS who had MRI scans within three months of their first attack and again 12 months later. Researchers analyzed the number and location of lesions at baseline, the development of new lesions at one year follow-up, and the results of cerebrospinal fluid examination, comparing the McDonald with the Poser criteria.

One year after symptom onset, more than three times as many patients with CIS were diagnosed with MS using the McDonald diagnostic criteria compared with the Poser criteria.

One year after symptom onset, more than three times as many patients with CIS were diagnosed with MS using the McDonald criteria, as compared with the older criteria (37% of patients vs 11%). Eighty percent of those diagnosed based on the new criteria developed a second clinical episode within an average follow-up time of 49 months.

The researchers concluded that using the McDonald criteria may lead to earlier diagnosis of MS. Early diagnosis has become increasingly important because early intervention with available therapies may delay the occurrence of a second attack and may yield long-term clinical benefits.

CONTINUING EDUCATION CONFERENCE CALENDAR

June 14–18, 2003
13th Annual Meeting of the European Neurological Society. Location: Istanbul, Turkey. Contact: ENS 2003, c/o AKM Congress Service, Clarastrasse 57, PO Box CH-4005, Basel, Switzerland; 41-61-686-77-11; fax: 41-61-686-77-88; e-mail: info@akm.ch; Web site: www.akm.ch/ens2003.

August 30–September 2, 2003
7th Congress of the European Federation of Neurological Societies. Location: Helsinki, Finland. Contact: EFNS 2003 Secretariat, 17 Rue du Cendrier, PO Box 1726, CH-1211, Geneva 1, Switzerland; 41-22-908-0488; fax: 41-22-732-2850; e-mail: efns03@kenes.com; Web site: www.kenes.com/efns2003.

September 17–20, 2003
19th Congress of the European Committee for Treatment and Research in Multiple Sclerosis. Location: Milan, Italy. Contact: ECTRIMS 2003, c/o AKM Congress Service, PO Box Clarastrasse 57, CH-4005, Basel, Switzerland; 41-61-686-77-11; fax: 41-61-686-77-88; e-mail: info@akm.ch; Web site: www.akm.ch/ectrims2003.

October 19–22, 2003
128th Annual Meeting of the American Neurological Association. Location: San Francisco. Contact: Lori Anderson, ANA, 5841 Cedar Lake Rd, Suite 204, Minneapolis, MN 55416; (952) 545-6284; fax: (952) 545-6073; e-mail: lorianderson@llmsi.com; Web site: www.aneuroa.org.

November 2–4, 2003
MS Trust 7th Annual Conference. Location: Harrogate, UK. Contact: Kelly Blaney, Multiple Sclerosis Trust, Packer Forbes Communications, 53 Cavendish Road, London, SW12 0BL; 44-0-20-8772-1551; fax: 44-0-20-8772-1552; e-mail: ms2003@packerforbes.com; Web site: www.mstrust.org.uk.

November 8–12, 2003
33rd Annual Meeting of the Society for Neuroscience. Location: New Orleans. Contact: Society for Neuroscience, 11 Dupont Circle NW, Suite 500, Washington, DC 20036; (202) 462-6688; fax: (202) 462-9740; e-mail: info@sfn.org; Web site: www.sfn.org.

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