Advanced Symptom Management in Multiple Sclerosis

Elizabeth Crabtree-Hartman, MD

KEYWORDS

• Symptom management • Quality of life • Pseudoexacerbation
• Nonpharmacologic treatment • Spasticity • Neuropathic pain • Neurogenic bladder
• Neurogenic bowel

KEY POINTS

- Symptom management can have a profound impact on quality of life.
- Symptom management should always begin with respectful listening and appropriate counseling/validation.
- Meaningful symptom management is time consuming, and it is imperative to develop tools and resources to maximize efficiency in the clinic.
- An increase in baseline symptoms is often a pseudoexacerbation caused by a physiologic stressor such as an infection (urologically silent urinary tract infection) or emotional stress.

INTRODUCTION

Although the armamentarium of disease-modifying therapies has expanded greatly, a more significant impact on quality of life for patients with multiple sclerosis (MS) remains via meaningful symptom management. Disease-modifying therapies have had a positive impact on disability and the neurologic symptoms therein. Historically, in the pretreatment era, longitudinal data disclosed that one-third to one-half of patients showed progressive decline 15 years after onset, with up to 54% transitioning to secondary progressive MS (SPMS) after 19 years.[1,2] More recently, longitudinal data showed only 11.3% of patients transitioning to SPMS after a median of 16.8 years.[3]Therefore, patients are incurring less disability and, by definition, fewer symptoms caused by MS. However, current disease-modifying therapies are preventive, and decrease the risk for incurring new symptoms/disability; they do not, with few exceptions, improve ongoing

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Department of Neurology, Tulane University School of Medicine, 131 S. Robertson Street, Suite 1300, New Orleans, LA 70112, USA
E-mail address: crabtreehartman@gmail.com

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symptoms. In this setting, most patients have 1 or more active symptoms caused by MS, and most are undermanaged. Thus, meaningful symptom management is one of the major means by which quality of life can be improved for patients with MS.

There are challenges to comprehensive symptom management to consider and target. Time is one of the major hurdles. Some thought can be given to who should undertake symptom management. Should this responsibility be managed by a specialist in MS, nurse practitioner [NP] MS specialist, general neurologist, and so forth, or combinations of these? Regardless of who is in charge, certain strategies can improve clinical efficiency. Predating the clinic visit, patients could respond to questionnaires on paper or digitally, and this information can be organized for the care provider before the clinic encounter and/or uploaded into the clinic note. Within the clinic visit, establish the patient's priorities and apprise the patient of reasonable expectations for the current visit, as well as the plan for continuity to address remaining items of concern. Maximize templates/smart sets/dot phrases for the electronic medical record. Internet-based visits can serve as a convenient and effective tool for symptom management follow-up visits. In addition, providing a road map for the patient regarding symptom management can reduce anxiety and interpersonal viscosity.

Other challenges to symptom management include communication barriers, polypharmacy, and the partial efficacy of many medications. Lack of access to prescribed medications caused by insurance denial occurs with regularity. Without a means for close follow-up, care providers may not learn of insurance denials for months, during which time the patients have gone undertreated. Some thought can be given to which tools may assuage these challenges in a particular practice environment.

Understanding patients' expectations is crucial for time management. It is common for patients to want to avoid medications. For any given symptom, nonpharmacologic and pharmacologic interventions can be offered, but time should be budgeted differently if the patient does not want to consider medications.

GENERAL GUIDELINES

Evaluation of an initial presentation of a neurologic symptom generates a broad differential diagnosis regarding the origin of the patient's clinical complaints: exacerbation versus pseudoexacerbation versus unrelated to MS. If the symptoms may be caused by a relapse, a distinct approach to management ensues. A pseudoexacerbation is characterized by an escalation of baseline symptoms, most frequently including, but not limited to, fatigue and spasticity. Common causes for pseudoexacerbation include urinary tract infection (UTI) (symptomatic or urologically silent), physiologic stressor caused by a medical condition (eg, thyroid, anemia, diabetes), dehydration, emotional stress, and changes in temperature/barometric pressure fronts. Appropriate history taking and laboratory inquiry can guide management of a pseudoexacerbation. Treatment of a urologically silent UTI can result in resolution of neurologic symptoms or a return to baseline severity. A presenting symptom also can be either directly MS related or indirectly MS related. For instance, low back pain or hip pain is common among patients who have experienced a partial myelitis with incomplete recovery. Because of the use of accessory muscles for ambulation, a musculoskeletal pain syndrome can develop. During history taking, it is important to consider secondary syndromes and counsel patients accordingly; avoid assuming that the condition is not caused by MS.