The challenge of managing patients with multiple sclerosis

recognised. However, many neurologists will be reluctant to give a prediction about the future course of MS to a person who is newly diagnosed, preferring to ‘watch, wait and see’ over the next few years.

Treatment and nursing management

Although there is no cure for MS at present, there are treatments available to reduce the number of relapses, to prevent or reduce progression of the disease, to treat an acute relapse and for ongoing management of symptoms. Common symptoms are listed in Box 2.

The nurse, as part of the multidisciplinary team, can play a major role in the ongoing support of the patient, as well as in the prevention and management of symptoms (Box 3, p44). In many centres around the country, there are now MS specialist nurses who provide information, support and advice about the condition from the time of diagnosis and throughout the disease process. The role also involves acting as a consultant and educational resource for staff (UK Multiple Sclerosis Specialist Nurse Association et al, 2001). Competencies have been developed to ensure best practice (UK Multiple Sclerosis Specialist Nurse Association et al, 2003). The MS specialist nurse is often the main source of advice and support for the patient.

Many people will have difficulty coming to terms with the diagnosis, and will be uncertain of the future, and worried about the prospect of disability. All members of the multidisciplinary team can be involved in suggesting relaxation and coping strategies, but sometimes referral to a neuropsychologist or counsellor is beneficial.

Many symptoms of MS can be treated with drugs commonly used in other disorders, for example, drugs used in the treatment of epilepsy are often used to treat neurological pain experienced in MS, and antidepressants may be used to treat sensory disturbances.

In an acute relapse, corticosteroids are commonly used to reduce inflammation and shorten the duration of any new symptoms (Barnes, 2000). The first person to be made aware of a relapse is often the MS specialist nurse, who will first ensure that there is no prodromal infection. The nurse will advise on the side-effects of steroid treatment and their management. If an infection is present, many patients experience new symptoms or a flare-up of old ones. This is known as a pseudo-relapse and the symptoms usually disappear when the infection has been treated. Steroids will not be given at this time.

Alternative therapies

Many patients try complementary therapies, ‘alternative’ treatments and diets, although there is little or no evidence to support their use in MS. In the absence of a cure, many people will admit to trying anything treatment options, irrespective of current evidence. The nurse can advise on their use, giving information as available.

Some symptoms, such as pressure ulcers, urinary tract infections and contractures can be prevented using good management and nursing care.

A holistic assessment can alert the nurse to any signs or symptoms, and appropriate action can be taken, such as the provision of pressure-relieving equipment and referral to other professionals, including the continence nurse adviser and physiotherapist. Physiotherapy can help prevent problems and aid mobility, as well as treat symptoms such as spasms and altered tone.

Fatigue is the most commonly reported symptom in MS and is considered by many patients to be the most debilitating symptom (Krupp, 2003; MS Society, 1997). MS specialist nurses, physiotherapists and occupational therapists can suggest fatigue management strategies to try to reduce its overwhelming effects.

As well as fatigue, there are other symptoms that are silent or hidden, such as pain, altered sensation, bladder, bowel and sexual dysfunction, and cognitive problems. It is important that the nurse inquires about them during the patient’s assessment and that appropriate intervention is carried out in a sympathetic and understanding manner. Many people, professionals included, find it difficult to discuss sexual dysfunction, which is a very real problem for many patients with MS, although treatment options are available (Betts, 1999).

Drug therapies

So-called ‘disease-modifying’ treatments, such as beta-interferons and glatiramer acetate, are now available under the Department of Health’s risk-sharing scheme. These drugs are of benefit only in relapsing types of MS and do not work for everyone. On average, they will cut down by one-third the number of relapses, and will slow down the accumulation of disability.

Some people with an aggressive or progressive "

### BOX 1. COMMON SYMPTOMS OF MS ON INITIAL PRESENTATION

- Optic neuritis/visual disturbance
- Limb weakness
- Sensory disturbance
- Vertigo
- Bladder problems/disturbance of micturition

USEFUL CONTACTS

MS National Centre
Tel: 020 8438 0700
Helpline: 0808 800 8000
(Mon–Fri, 9am–9pm)
www.mssociety.org.uk

MS Society Scotland
Tel: 0131 335 4050
www.mssocietyscotland.org.uk

MS Society Northern Ireland
Tel: 02890 802 802
www.mssociety.org.uk

MS Trust
Tel: 01462 476 700
www.mstrust.org.uk

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Multiple sclerosis (MS) is the most common cause of neurological disability in young adults in the UK. It is variable in presentation and progression. Although there is no cure, there are many symptomatic treatments available. Nurses have a vital role in the ongoing assessment and management of people with MS.

Multiple sclerosis (MS) is the most common disabling neurological condition in young adults in the UK (Perkin and Wolinsky, 2000). It occurs all around the world, but is more common in countries with temperate climates. The UK, Scandinavia and Iceland have the highest rates of MS in the world.

MS is usually diagnosed in adults aged 20-40 years. It is more common in women than in men, at a ratio of 3:2 (MS Society, 2003).

The cause of MS is unknown. Current opinion is that it is an autoimmune disease that occurs in a genetically susceptible individual. Scientists remain unsure of what causes the disease process to start. Many different theories have been proposed and investigated, without success. These include viruses, trauma and environmental factors (Ebers and Sadovnick, 1998a).

**What is MS?**

MS is a common neurological disease, affecting about 85,000 people in the UK (MS Society, 2003). It is a progressive disease, although the rate of progression is variable. It is characterised by episodes of demyelination in the brain and/or spinal cord. These episodes are disseminated/ separated both in terms of time of occurrence and area affected and can be recognised as plaques on a magnetic resonance imaging (MRI) scan. During an acute attack, there is inflammation, oedema, breakdown of the blood-brain barrier and demyelination of the nerve. There is still a lot to be learned and understood about the importance of all these factors. Plaques (lesions) may be seen on MRI, showing that an attack has occurred, without the person’s experiencing any difficulties or having any symptoms. There is uncertainty as to whether inflammation and blood-brain barrier breakdown always result in demyelination. Some demyelinated fibres can still conduct current and sometimes remyelination can occur. If the axon itself is damaged, remyelination does not occur and disability will eventually result (Hawkins, 2000; Compston, 1999a; Hartung, 1997).

Studies of specific racial groups have shown that MS is rare in certain races. For example, the Inuit in Canada have a much lower prevalence rate than other Canadians, and it is extremely rare in black Africans (Kurtzke and Wallin, 2000; Compston, 1999b).

Migration studies have shown that the age at which a person emigrates to another country will have an impact on whether the person’s age of onset reflects the prevalence rate of the country of origin or the rate of the new country (Compston, 1999b; Ebers and Sadovnick, 1998a).

MS is not a hereditary disease, although there are families in which more than one member have the condition. This knowledge, plus twin, sibling and adoptee studies, has generated much research into genetic susceptibility (Compston, 1999c; Ebers and Sadovnick, 1998a; 1998b; McFarland et al, 1997).

**References**


**Box 2. Commonly occurring symptoms in patients with multiple sclerosis**

All the symptoms listed in Box 1 plus:

- Ataxia;
- Bowel dysfunction;
- Cognitive dysfunction;
- Fatigue;
- Pain;
- Sexual dysfunction;
- Spasticity;
- Speech/swallowing difficulties;
- Tremor;
- Trigeminal neuralgia.

**Abstract**


Multiple sclerosis (MS) is the most common cause of neurological disability in young adults in the UK. It is variable in presentation and progression. Although there is no cure, there are many symptomatic treatments available. Nurses have a vital role in the ongoing assessment and management of people with MS.
**REFERENCES**


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**BOX 3. TREATMENTS AND MANAGEMENT OPTIONS FOR MULTIPLE SCLEROSIS**

**Relapse management using corticosteroids**

Oral or IV methylprednisolone is commonly used to reduce inflammation and prevent damage to the blood-brain barrier (Barnes, 2000).

**Symptom management using traditional medications/interventions**

These include drug treatments for altered sensation, fatigue, spasticity, pain, tremor, bladder, bowel and sexual dysfunction.

**Disease-modifying treatments**

These drugs, for example, interferon beta-1a, interferon beta-1b, and glatiramer acetate alter the course of the disease by reducing the number of relapses and slowing down the time taken to accrue disability as a result of the relapse. They do not stop the disease activity.

**Immunosuppressant and immunomodulatory drugs**

Examples are azathioprine, cyclophosphamide, methotrexate, mitoxantrone, immunoglobulin, but they are not used routinely and are not licensed for use in the treatment of MS in the UK, although mitoxantrone is now licensed in the US for use in MS.

**Physiotherapy**

This helps to maintain mobility and good posture; it prevents contractures, and reduces spasms.

**Occupational therapy**

This helps a patient achieve maximum independence in the activities of daily living, and advice can be given on aids and adaptations.

**Fatigue management**

Advice is given on rest, relaxation, exercise and medication; for example, amantadine or modafinil may be prescribed.

**Complementary/alternative therapies**

Aromatherapy, multivitamins, acupuncture, homoeopathy and hyperbaric oxygen therapy may be helpful. Many people with MS try different therapies to relieve symptoms. There is often little evidence to support their use, but this does not necessarily mean that there is no benefit from using them.

**Dietary**

There is no evidence to support the use of special diets or the need for vitamin supplements in MS, but many people try gluten-free or very low fat diets.

**Psychological help**

This assists patients to come to terms with their diagnosis, new symptoms and any deterioration in their condition, as well as with cognitive problems and mood disorders.

immunomodulatory drugs such as mitoxantrone or immunoglobulin. These drugs are not currently licensed for the treatment of MS in the UK.

**Pregnancy and birth**

There is no evidence to suggest that pregnancy, labour, birth or the baby will be affected by a parent having MS. Pregnancy reduces the risk of a woman having a relapse, although there is an increased risk of a relapse in the three months post-partum. Many parents are worried about when and when to tell their children about MS. Information on this issue is available from the MS Society.

**Lifestyle**

Every aspect of a person’s life can be affected by a diagnosis of MS. It is up to the individual who to inform. It can sometimes be beneficial to inform employers to ensure that potential issues relating to work can be addressed. The nurse can advise on what information to give, and when. Drivers should notify the Driver and Vehicle Licensing Agency (DVLA) and their motor insurance company of their diagnosis. If new insurances are to be taken out, the diagnosis should be divulged. If a current policy has critical illness cover, a claim can be made.

The nurse is an important member of the multidisciplinary team in the ongoing care and support of the patient with MS. It is vital that nurses keep up to date with information and research on MS, linking whenever possible with the MS specialist nurse to help the patient come to terms with having the disease and keep control over his or her life.

**Current research**

The MS Society and the MS Trust both fund research into all aspects of MS and its management. They are also involved in the funding and education/training of MS specialist nurses. Most current research into treatment options is funded by the pharmaceutical industry. These trials often involve thousands of people across the world and it may take many years before results are available. Guidelines for the management of MS were published in the autumn of 2003 by the National Institute for Clinical Excellence (NICE, 2003). They outline good practice and bring together evidence and guidance for care and treatment, which should help towards ending the lottery of health care for people with MS. National Service Framework guidelines for chronic diseases are awaited.

**Conclusion**

MS is a common, progressive neurological disease that affects about 85,000 people in the UK. Because it is variable in presentation, diagnosis is not always straightforward. There is no cure at present, although treatments are available to reduce the number of relapses and reduce progression of the disease. Nurses are important members of the multidisciplinary team and can help patients come to terms with having the disease and to keep control over their lives. The MS specialist nurse is