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Multiple Sclerosis Service
Management of MS Relapses

Approved	22/06/2010	
Version	2	
Date of First Issue	2002	
Review Date	10/05/2018	
Date of Issue	01/02/2010	
EQIA	Yes	22.06.10
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Group / Committee – Final Approval	Neurology Managed Care Network	

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Consultation and Change Record

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Distribution:	MS Service Information Provision NHS Forth Valley Intranet Service Information Directory

Change Record

Date	**Author**	**Change**	**Version**
	Dr. McLeod	Author	2002
	Dr. C. Neumann	Change to oral dosing regime in line with best practice and NICE guidelines for MS No. 18	2007
	Dr. C. Neumann	Reviewed – algorithm and Appendix1 added	2010
10.05.11	Dr C. Neumann	Reviewed with no changes made. Next review date 10.05.12	2
04.07.2012	Dr C Neumann	Reviewed with no changes made.	2
19.03.2014	Dr C Neumann	Reviewed with no changes made	2
24.08.2016	Dr C Neumann	Reviewed MS Service contact details updated	2

MANAGEMENT OF MS RELAPSES

- About 15% of MS patients have relapsing remitting MS and suffer from regular relapses. Some patients with progressive MS can also have relapses.
- A relapse is defined as an acute deterioration in neurological function lasting 24 hours or more.
- Many MS relapses are mild and non-disabling such as an episode of upper limb numbness. Others are severely disabling and can result in an individual being bed bound, or unable to self-care or work.

WHAT CAUSES MS RELAPSES

- About 25% of MS relapses are related to an underlying infection such as an upper respiratory tract or urinary tract infection. Many occur for no apparent reason.
- If an MS patient has a relapse then it is important to look for the underlying infection. Often appropriate treatment of this will speed up recovery from the infection and avoid the need for steroids.
- It is important to distinguish an acute relapse from a temporary deterioration due to tiredness or stress, or from progression of the disease.
- Recent evidence has shown that there is no definite association between vaccination and an MS relapse. In addition it has been shown that relapses are less likely to occur during pregnancy but are slightly more common in the first few weeks post-partum.

STEROIDS IN MS RELAPSES

- Steroids have been shown to speed up the recovery of an MS relapse. However, they have no influence on the eventual outcome and resultant disability. (Some papers a few years ago raised the possibility that steroids in optic neuritis may influence the development of MS but this has been questioned).

- Currently there is no evidence that steroids affect the long-term course of disease in MS

- Steroids should only be used if the relapse is truly disabling and not simply progression of disease. In general steroids are not used in a purely sensory upset and are reserved for more severe episodes. This is partly because of the risk of side effects such as avascular necrosis of the hip and partly because with more frequent use of steroids the benefits appear to wear off. (This may simply reflect worsening disease).

- Steroids **SHOULD NOT** be used if there is evidence of underlying infection. All patients should be questioned about symptoms of a chest or urinary or other infection. Venous blood should be taken for FBC, U&E's, CRP and an MSSU should be processed. Treatment of the infection might avoid the need for steroids.

WHICH ROUTE

- Intravenous
  A short course e.g. intravenous methylprednisolone, 1gm daily for three days, can be given. We do not recommend a tapering dose of oral steroids.

- Oral Steroids
  Alternatively, oral high dose methylprednisolone can be given, e.g. methylprednisolone 100 mg tablets, 1g daily for 3 days.
  It is recommended to prescribe an oral proton pump inhibitor for approximately one month from treatment.

  There is no evidence that one route is better than the other and we often let the patient choose. Continued courses of steroids, or a second course if the first didn't work, are not recommended.

HOW OFTEN

- We do not recommend more than 2 courses of steroids a year. MS patients are often immobile and already at increased risk of osteoporosis. This can be made worse by steroids. In addition there is a risk of avascular femoral head necrosis and cataract with increasing use of steroids.

STEROID DEPENDENCE

- Some patients with secondary progressive MS may become steroid dependent. Steroids can often give a sense of well being without influencing disability and patients may request steroids when feeling low. They are contraindicated in this situation.

SIDE EFFECTS

- Other than those stated, in the short term patients can be at risk of steroid induced hyperglycaemia, hypertension, psychosis, reactivation of underlying infection and peptic ulceration.

FOLLOW UP

- Patients may be left with new disability following a relapse, which may or may not be helped by steroids. Consideration should be given to referral for physiotherapy, occupational therapy or speech and language therapy. In addition symptomatic management of pain, spasticity etc may be appropriate in the short or long term.

TREATMENT OF MS RELAPSES

Before treating an MS patient for a relapse have you considered:

1. Is this a disabling "true relapse" or is this progression of disease or a temporary deterioration related to low mood, fatigue, stress or other circumstances

2. Is there an underlying infection? Check infection screen and ask about symptoms of a chest infection, UTI etc.
   <u>NB:</u> PATIENTS WITH MS CAN OFTEN HAVE A SUBCLINICAL UTI OR MAY FIND THE SYMPTOMS OF A UTI DIFFICULT TO DIFFERENTIATE FROM SYMPTOMS OF MS. VENOUS BLOOD SHOULD BE TAKEN FOR FBC, U&E's, CRP AND AN MSSU SHOULD BE PROCESSED

3. Have steroids been used recently or several times in the past year? As a rule of thumb, a maximum 2 courses of steroids should be used a year

4. Have you documented clinical history and findings? This may be important if the patient is to be considered for disease modifying treatment.

5. Does the patient require follow up in the MS clinic? Do they need referral for rehabilitation in the meantime? Can they cope at home whilst suffering this relapse? Do they require symptomatic treatment during the relapse?

6. If the patient requires admission to the wards or intravenous methyl prednisolone as a day case and they have
   a. No evidence of infection
   b. A clearly disabling relapse
   c. Not had more than 2 courses this year
   d. Are suitable for day case IV Methyl prednisolone

   If the patient does not fulfill the above criteria, and does not require admission, please contact the MS team and we will fit them into a clinic slot ASAP. There are weekly MS clinics held with a slot kept free for this situation.

   IF IN DOUBT, WE ARE HAPPY TO ASSESS THE PATIENT IN THE MS CLINIC FIRST

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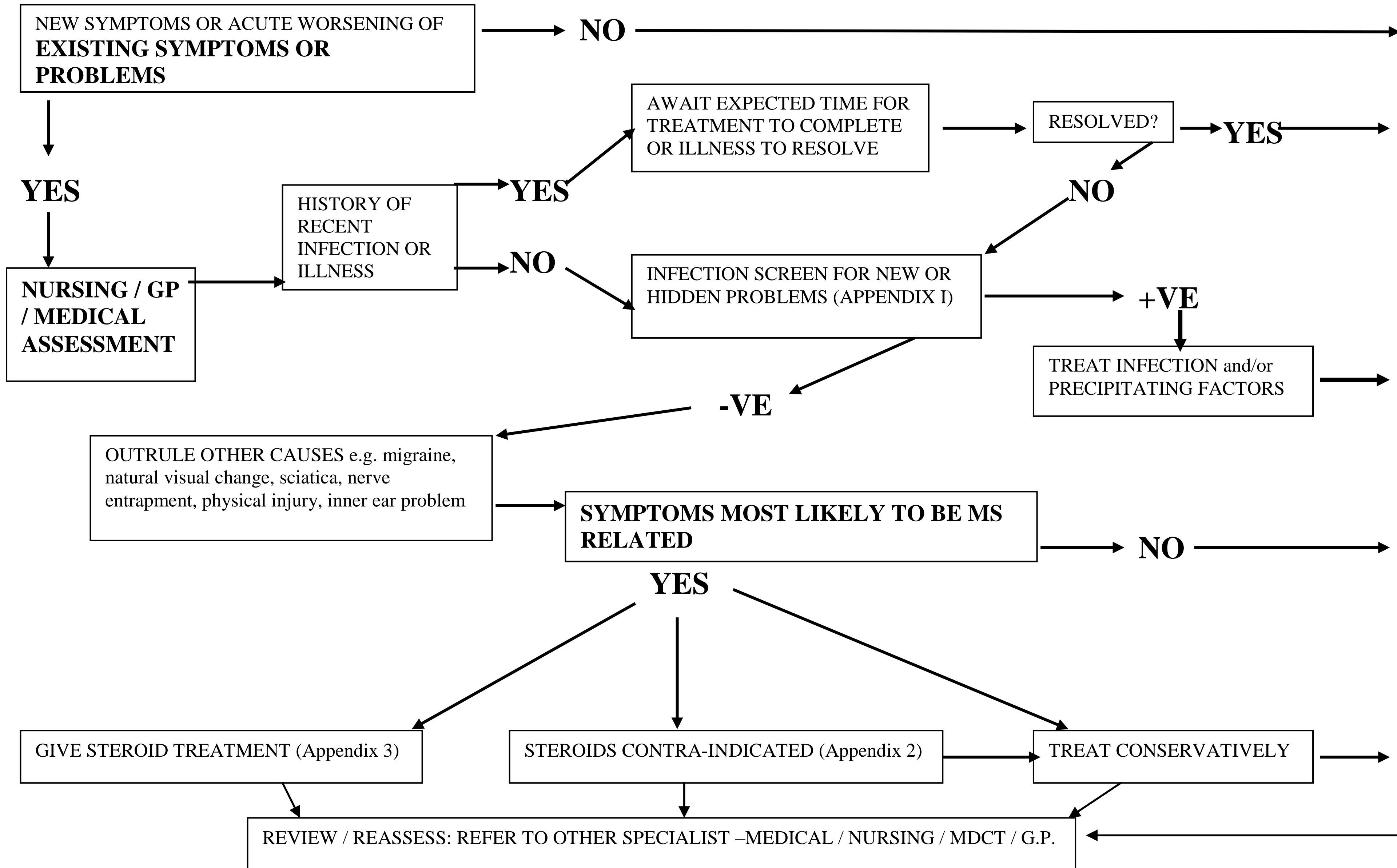
NEW SYMPTOMS OR ACUTE WORSENING OF
EXISTING SYMPTOMS OR PROBLEMS
NO
YES
NURSING / GP / MEDICAL ASSESSMENT
HISTORY OF RECENT INFECTION OR ILLNESS
YES
NO
AWAIT EXPECTED TIME FOR TREATMENT TO COMPLETE OR ILLNESS TO RESOLVE
RESOLVED?
YES
NO
INFECTION SCREEN FOR NEW OR HIDDEN PROBLEMS (APPENDIX I)
+VE
TREAT INFECTION and/or PRECIPITATING FACTORS
-VE
OUTRULE OTHER CAUSES e.g. migraine, natural visual change, sciatica, nerve entrapment, physical injury, inner ear problem
SYMPTOMS MOST LIKELY TO BE MS RELATED
NO
YES
GIVE STEROID TREATMENT (Appendix 3)
STEROIDS CONTRA-INDICATED (Appendix 2)
TREAT CONSERVATIVELY
REVIEW / REASSESS: REFER TO OTHER SPECIALIST –MEDICAL / NURSING / MDCT / G.P.

APPENDICES

APPENDIX 1	***APPENDIX 2***	***APPENDIX 3***
INFECTION SCREEN:	***CONTRA-INDICATIONS***	***STEROID PROTOCOLS***
TEMP > 37.5 deg C	HISTORY OF PSYCHOSIS	ORAL METHYL PREDNISOLONE PER LOCAL MS RELAPSE PROTOCOL
CRP >10	SEVERE DEPRESSION	
WCC >10	ACUTE OSTEOPOROSIS	IV METHYL PREDNISOLONE : AS PER LOCAL MS RELAPSE PROTOCOL AT DAY MEDICINE FDRI
+VE URINALYSIS	UNSTABLE IDDM	
SUSPECT SPUTUM	ACTIVE GASTRIC ULCERATION	
INFECTED WOUND	RECTAL BLEEDING	
ORAL / VAGINAL THRUSH		EXPLAIN RATIONALE AND SIDE EFFECTS
DIARRHOEA		GIVE INFORMATION LEAFLETS
THROAT INFECTION		GAIN INFORMED CONSENT
		GIVE STEROID CARD
ACTION		
SEND SPECIMEN TO LAB: SPUTUM / M.S.S.U. / C.S.U./ SWABS / BLOOD FBC, U&E's, CRP AWAIT RESULT		

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