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| ***How to use this template***  *This template for information for GPs has been produced by the MS Trust to accompany ‘Eight Steps to improving your Relapse Service’ published in 2016. The text can be adapted by the local MS team to create an information sheet to send to GPs either as part of a general mailing, or appended to a letter or email asking them to assist in the treatment of MS relapse.*  *Before using it, delete this box, add your own service name and details, and highlight in the ‘Contact details section’ the most appropriate way that GPs can contact the team.* |

**[Service name and logo]**

**Information for GPs about MS relapse**

People with multiple sclerosis (MS) may present with a relapse – as their GP you may be the first point of contact for this episode. It is recommended that you discuss anyone who presents with symptoms of relapse with your local MS team (contact details overleaf) and the MS team should always be informed of people with MS who have had a relapse.

**Signs and symptoms of relapse**

A relapse is defined as *the onset of new symptoms or the worsening of pre-existing symptoms, attributable to demyelinating disease, lasting for more than 24 hours and preceded by improving or stable neurological status for at least 30 days from the onset of the previous relapse in the absence of infection, fever or significant metabolic disturbance[[1]](#footnote-1).*

Common symptoms occurring during relapse include weakness in one or more limbs, problems with vision, increased fatigue, altered sensation (which may include neuropathic pain) or cognitive problems though any other symptom which can be associated with MS may occur.

**Treating relapse**

NICE clinical guidelines[[2]](#footnote-2) recommend that people with MS who experience a relapse which causes distressing symptoms or limits activities of daily living should be offered treatment with **oral methylprednisolone (Medrone, 500mg daily for 5 days**) to be taken each morning with food. Treatment should start as soon as possible and within 14 days of the onset of symptoms. Lower doses of steroids should not be given. Co-prescription of omeprazole is not routinely indicated but may be a sensible precaution for people at risk from peptic ulcer disease, gastritis or who are taking regular NSAIDs or warfarin.

High dose steroids work to speed recovery and ease symptoms of relapse but make no long term difference to outcomes. A discussion should be had with the patient about the potential benefits of treatment with high dose methylprednisolone versus the potential problems of possible side effects.

The MS team should always be informed if you suspect one of your patients is having or has had a relapse (even if it does not require treatment) as this is an important factor in ensuring they are treated optimally with the most appropriate disease modifying drug. Disease modifying drugs can improve long term outcomes for people with MS.

**Differential diagnosis**

Differential diagnosis of relapse in MS can be difficult and it is recommended that you discuss anyone who attends your surgery with a sudden deterioration in their MS symptoms with the local MS team before treating (either the neurologist or MS nurse)[[3]](#endnote-1). This is particularly important if they are currently taking alemtuzumab (Lemtrada), dimethyl fumarate (Tecfidera), fingolimod (Gilenya) or natalizumab (Tysabri) or so that potentially serious complications can be ruled out.

Infection is a common cause of relapse-like symptoms in people with MS and **must** be excluded prior to treating with high dose methylprednisolone. Urinary tract infections are particularly common. If you find someone has an infection this should be treated and then the individual should be reassessed to determine whether they need treatment for a relapse once the infection has cleared.

**Caution with steroids**

A second course of steroids for a single relapse should not be given without discussion with the local neurologist. Frequent (more than three times a year) or prolonged courses of steroids should be avoided. If someone has received repeated doses of steroids their risk of more serious complications such as osteoporosis is heightened they should be reviewed by the MS team.

Diabetic patients should be monitored closely during steroid treatment and if the diabetes is very unstable this may be an indication for admission.

Steroid therapy should be avoided during the first trimester of pregnancy and treatment should only be initiated on the advice of a Consultant Neurologist.

**Contact details for local MS team**

MS Specialist Nurse(s) ……………………………

Consultant Neurologist ………………

Out of hours please contact (*add* *details of how to contact on-call neurology registrar or give any other instructions*)

**Further information**

* More information about managing relapse in MS for health professionals is available from the MS Trust website – www.mstrust.org.uk/relapse-guide
* Information for people with MS about relapse in MS and a wide variety of other topics is also available to download free of charge – [www.mstrust.org.uk](http://www.mstrust.org.uk)/relapse

1. NHS England. Commissioning policy: disease modifying therapies for patients with multiple sclerosis. Redditch: NHS England; 2014. Available from: www.england.nhs.uk/wp-content/uploads/2013/10/d04-p-b.pdf [↑](#footnote-ref-1)
2. National Institute for Health and Care Excellence. Multiple sclerosis: management of multiple sclerosis in primary and secondary care. (CG 186). London: NICE; 2014 [↑](#footnote-ref-2)
3. [↑](#endnote-ref-1)