Multiple Sclerosis Trust

MS

Multiple sclerosis information

for health and social care professionals

Fourth Edition

Section 2

Relapse

Approximately 85% of people diagnosed with MS will have relapsing remitting MS. Relapsing remitting MS is characterised by a series of relapses (also referred to as an attack, a flare up, an episode or exacerbation), interspersed with periods of remission.

A relapse is defined as a sudden episode of symptoms or disability, in the absence of fever or infection, which lasts at least 24 hours, and is a neurological disturbance typical of MS[1]. A relapse must occur at least 30 days since the start of a previous episode.

Relapses occur spontaneously and are thought to be due to an episode of acute inflammation within the CNS. Frequency of relapses is very variable, some people will experience several in a year whilst others will be relapse free for many years. In one retrospective study in a population of 2,477 relapsing remitting patients, over three quarters experienced a five year relapse-free period[2]. On average, people will experience approximately 0.6 relapses per year with frequency gradually decreasing during the course of the condition[3].

People with secondary progressive MS may also experience superimposed relapses and relapses have been reported in people with primary progressive MS[4].

The symptoms experienced depend on the area of the brain or spinal cord affected. Typically, a relapse evolves over a few days, reaches a plateau, and then remits to a variable degree over a few weeks or months. Some relapses are relatively mild while others may cause more serious problems; most relapses do not require hospitalisation.

Relapses can have a significant impact not only on physical symptoms but also on social, financial and psychological well-being of those affected[5,6]. They may provoke fresh feelings of bereavement or fear.

People may recover completely in episodes of remission or may have residual disability. Incomplete recovery has been found to range from 20 to 60% in different studies[7].

Managing relapses

Different centres have different approaches to managing relapses. For many people, their MS nurse will be the first point of contact, for others it could be their neurologist or GP. Following diagnosis, an MS nurse or other health professional should explain the procedure to follow if the patient thinks they may be having a relapse.

A number of UK MS specialist centres have audited their relapse management services and developed protocols to ensure that anyone experiencing a relapse is assessed and offered appropriate treatment as soon as possible[3,8-11].

Symptoms similar to those of a relapse can occur when there is an infection, often a urinary or respiratory infection. It is important to differentiate a relapse from a 'pseudo-relapse', which is a temporary worsening of pre-existing symptoms due to concurrent fever, illness or infection. Pseudo-relapses never present with new symptoms, often last only a few hours, and management should be aimed at treating the underlying infection. Urinary tract infections may be asymptomatic so routine screening is recommended[3]. It is important to rule out infection before commencing treatment with steroids.

Steroids

If the symptoms of the relapse are not due to infection and are affecting day to day function, treatment with a short course of high dose steroids is recommended. Studies have shown that steroids are effective in speeding up recovery from relapses but make no difference either to the degree of recovery or to the long-term progression of the condition[4].

The NICE Clinical Guideline[12] recommends that any individual who experiences an acute episode sufficient to cause distressing symptoms or an increased limitation on activities should be offered a short course of high-dose corticosteroids. The course should be started as soon as possible after onset of the relapse and should be either:

- intravenous methylprednisolone, 500mg-1g daily, for between 3-5 days or
- high-dose oral methylprednisolone, 500mg-2g daily, for between 3-5 days.

Frequent (more than three times a year) or prolonged (longer than three weeks) use of corticosteroids should be avoided.

A comparison of oral and intravenous corticosteroid treatments in MS shows that there are no major differences in clinical outcomes and both treatments appear to be equally effective and safe[13].

In the short-term, the side effects of methylprednisolone are usually minor and transient, but may include:

- indigestion
- mood changes/mood swings

- altered sleep pattern
- increased appetite
- metallic taste
- flushing of the face.

Special care is needed for people who have diabetes, and for those with previous gastric problems who may need medication to protect the stomach. Long-term treatment should normally be avoided due to side effects including, weight gain, acne, cataracts, osteoporosis (thinning of the bones, particularly the head of the thigh bone), and diabetes.

Other treatments

There are many other management considerations apart from possible treatment with steroids. Depending on the symptoms, their severity and how they are affecting daily life, various adjustments and equipment may be necessary. For example, a mother with sensory symptoms in her hands might require help to care for her young baby and to cook. Someone experiencing problems with walking may benefit from a walking stick. It may be necessary to take time off work and/or temporarily reduce activities.

There is evidence that recovery from relapse is improved if neurorehabilitation is provided at the same time as steroids are prescribed[14]. When someone experiences a sudden increase in disability or dependence, the NICE Clinical Guideline[12] recommends the individual should be:

- given support, as required and as soon as practical, both in terms of equipment and personal care
- referred to a specialist neurological rehabilitation service.

The urgency of the referral should be judged at the time, and this referral should be in parallel with any other medical treatment required.

Experiencing a relapse is often a very stressful time for both people with MS and their families who typically have a lot of unanswerable questions about when their symptoms will resolve, whether they will make a full recovery, the likelihood of further relapses or if the relapse is the start of a more progressive phase. At this time the need for reassurance is high. Health professionals sensitive to these issues can provide the communication and counselling skills needed.

Reducing the risk of relapses

Disease modifying therapies reduce the number and severity of relapses. See p24 *Disease modifying drug therapies*.

Life style issues may be important in reducing the risk of relapses. A well-balanced diet and regular exercise will promote good health and can help reduce the risk of relapse triggers such as infections. Strong evidence suggests that relapses can be triggered by infections, during the three month period after giving birth and stressful life events[15]. Vaccinations against influenza, hepatitis B and tetanus appear to be safe. Surgery, general and epidural anaesthesia and physical trauma are not associated with an increased risk of relapses.

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MS Trust resources

Key steps to delivery of a person-centred relapse service.
www.mstrust.org.uk/downloads/key_steps.pdf.

We hope you find the information in this book helpful. If you would like to speak with someone about any aspect of MS, contact the MS Trust information team and they will help find answers to your questions.

This book has been provided free by the Multiple Sclerosis Trust, a small UK charity which works to improve the lives of people affected by MS. We rely on donations, fundraising and gifts in wills to be able to fund our services and are extremely grateful for every donation received, no matter what size.

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MS Trust
Multiple sclerosis information for health and social care professionals. Fourth edition.
ISBN 1-904 156-24-X

Registered charity no. 1088353