Guideline for the Treatment of an Acute Multiple Sclerosis (MS) Relapse

This guideline is intended for use by primary and secondary care settings: Specialists (neurology), GPs and primary care clinicians, and general medicine

An acute MS relapse is a relatively sudden (over hours or days) onset of new neurological symptoms or significant worsening of pre-existing neurological symptoms or disability lasting **for more than 24 hours, in the absence of an infection or other precipitating cause**. Often worsening symptoms of MS are not an MS relapse and do not require treatment with steroids.

Urinary tract infections (UTI) should be excluded in *all* relapsing MS patients by testing their urine for protein and nitrites using dipstick tests and, if positive a urine culture.

If UTI is excluded and a patient's condition is severe enough to require treatment, the patient's MS nurse/neurologist should be informed. The patient has contact details for the MS team and would usually make the contact where possible. The MS team will relay the recommendations back to the GP by phone/email/letter.

Not every relapse requires treatment. Steroids are given to hasten the natural recovery of a relapse but do not affect the long-term outcome**.** Mild relapses should be allowed to resolve without medical treatment. Steroids should be offered if the relapse is *causing distressing symptoms or limiting activities of daily living.*

Prior to prescribing steroids a discussion of pros and cons is advised with the patient. This should be patient centered and include:

Pros:

- Steroids can shorten relapse recovery
- Steroids can ease the acute symptoms and make the person feel better

Cons:

- Steroids make no difference to the long term course of the relapse or condition
- There is a significant risk of side effects (refer to Summary of Product Characteristics (SPC) and ensure patient centered discussion)
- The likelihood of side effects increases with increasing frequency of use

In line with NICE guideline (NG220) MS management in adults, when treatment is needed for an acute MS relapse, prescribe **oral Methylprednisolone 100mg tablets**, (off-label – **amber 1**), ***500mg daily for 5 days,*** taken in the morning with food. A tapering course of steroids is NOT required following this. Co-prescription of **medication for gastroprotection e.g. omeprazole** is not routinely indicated but may be a sensible precaution in patients at risk from peptic ulcer disease or gastritis, and those on regular NSAIDs or antithrombotic therapy. If patients have previously suffered with intolerable insomnia associated with steroid treatment then a short-term prescription for **night sedation** (such as zopiclone or zolpidem for 5-7 days in line with South East London Formulary) may also be given.

CAUTION should be taken when treating patients with diabetes and those with **mental health conditions.** Steroids can be given during **pregnancy** and to **nursing mothers,** although small amounts of steroid will pass into breast milk and breast feeding should not take place for at least two hours after taking them. Patients on **disease-modifying drugs** may require an MRI scan and / or a lumbar puncture *prior* to considering treatment with steroids and **should be discussed with the MS team.**

Admission to hospital is not required, unless the relapse is so severe that the patient is unable to manage in the community with the maximum support available. In these cases, **the MS team should be notified of the admission immediately** as intravenous methylprednisolone (1g/day for 3 days) or plasma exchange may be indicated.

A second course of steroids for a single relapse should not be given without discussion with the MS team**.** If a patient has received large cumulative doses of steroids their risk of osteoporosis should be considered. See the SEL osteoporosis treatment pathway.

Please ensure the MS team are made aware of the patient's relapse.

For patient booklets, please see Managing your relapses (booklet) | MS Society

Multiple Sclerosis Service Contact Details

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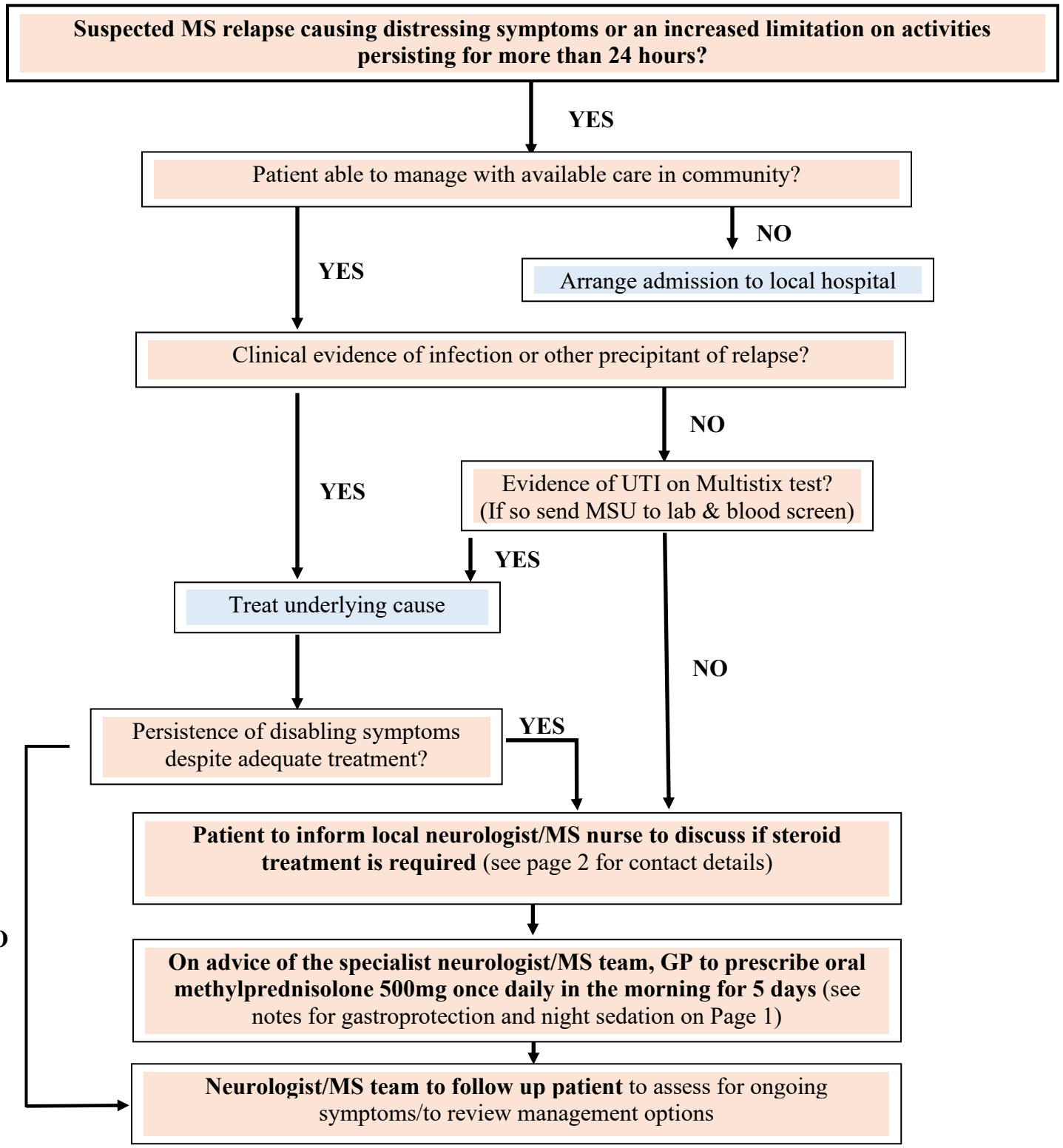
GUIDE FOR THE TREATMENT OF SUSPECTED ACUTE RELAPSES OF MULTIPLE SCLEROSIS IN PRIMARY CARE



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South East London Integrated Medicines Optimisation Committee (SEL IMOC). A partnership between NHS organisations in South East London Integrated Care System: NHS South East London (covering the boroughs of Bexley/Bromley/Greenwich/ Lambeth/Lewisham and Southwark) and GSTFT/KCH /SLaM/ Oxleas NHS Foundation Trusts and Lewisham & Greenwich NHS Trust