

Timely action for multiple sclerosis

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MULTIPLE SCLEROSIS (MS) is the most common acquired neurological disability in young adults, affecting one in 1000. Its challenges for general practitioners (GPs) include early detection, awareness of new therapies, work with multidisciplinary teams and its long-term management as a chronic disease.

The international consensus is that early diagnosis and treatment maximise brain health and preserve the central nervous system.¹ Much more neurological damage happens in the first few years after onset than previously thought. But because MS usually begins in young adulthood, when there is high neurological reserve, the extent of initial damage may not be clinically noticeable.

Since *Australian Journal of General Practice* last focused on MS,² there have been significant improvements in diagnosis, disease-modifying therapies (DMTs), rehabilitation and research. The revised McDonald criteria are now the diagnostic standard for all types of MS. Gadolinium-enhanced magnetic resonance imaging and post-image analysis expedite diagnosis and can be prognostic in some subtypes. Over a dozen DMTs with different modes of action have been assessed for efficacy. Although the onset of MS and how it gives rise to disability are not completely understood, it is now possible to ‘treat to target’ against clinical and subclinical markers of disease activity.^{1,3,4} Almost every initial presentation, relapse or progression of MS occurs in the community. Polymorphic, enigmatic or fluctuating neurological symptoms pose a diagnostic challenge. Identifying the minority of problems that

need to be managed outside of primary care draws on core GP skills of managing uncertainty and effective problem solving. Collaboration between the GP, neurologist and radiologist is paramount for diagnosis and monitoring.

MS treatment and rehabilitation require multidisciplinary care.³⁻⁶ As medical generalists, GPs have specialised knowledge of how the parts of treatment function within the whole. Over repeated clinical encounters, the GP also builds cumulative knowledge of the person with MS. GPs select from this knowledge base first to collaboratively define the problem, and then to decide whether the task at hand is a common variant within their experience, such as affective disorders, or requires specialised help, such as when screening for ‘invisible’ impairments. This month’s focus highlights some of these parts – diagnosis and medication, walking impairment, diet, self-management, cognitive deficits, rehabilitation and the lived experience of people with MS.

Living with a chronic illness entails grief, suffering and loss. Therefore, there are many points at which patients either benefit from support or are harmed through surplus suffering. Insights from patient advocates and qualitative researchers help patients and clinicians work better together.⁷ The GP scope of practice includes close attention to the lived experience, not only as an abstraction but for that specific person. Therapeutic engagement contributes to patient empowerment, which in turn improves coping skills, disease knowledge and control.⁷

Over the course of a lifetime, the person with MS does not only seek medical help for one disease. Each clinical encounter is also an opportunity for preventive

medicine and health promotion. Specific to MS, cardiovascular fitness is closely related to brain health.¹ If MS progresses or is not optimally treated, the relational costs outside the health system – including unemployment, caregiving and disability – soar. General practices also care for entire families and are embedded within the context of local community networks and healthcare agencies.

The ideal of high-quality, patient-centred care in MS is best attainable through meaningful interdisciplinary cooperation. The GP and the MS care team working well together can offer a person with MS an individualised and tailored approach to their wellbeing.

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