Primary Care in MS

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When people with MS visit their generalist clinicians, acute concerns can easily take up the entire primary care visit. For those living with chronic illness, however, good health care relies on comprehensive preventive services. The family physician, internist, or other primary care clinician remains the most appropriate practitioner to meet these and other primary care needs in MS.

PREVENTIVE HEALTH CARE

People with MS should receive the same preventive health interventions as other patients. Annual screening should include a medical history, physical examination, and laboratory tests as appropriate. The health maintenance visit may require special screening tests, based on age and other risk factors:

- Pelvic examination and Pap testing for women of reproductive age
- Clinical breast or testicular examination after age 20-25
- Digital rectal examination after age 40 years, including prostate examination for men
- Mammogram every one to two years for women after age 40
- Fecal occult blood testing, sigmoidoscopy or colonoscopy for men and women who are over 50 or have other risk factors
- Serum screening for dyslipidemia and thyroid abnormalities
- Bone densitometry (such as dual energy X-ray absorptiometry or DEXA) for anyone at risk for fractures or osteoporosis
Practitioners may worry that pelvic or rectal examinations may be difficult or time-consuming to perform in patients with physical disabilities. Examination tables that lower to the floor can help. If the office does not have such equipment, referral can be made to another facility that does. During examinations, the practitioner can also use adaptive equipment or techniques to increase comfort and avoid fatigue. Women with MS who have substantial leg weakness or spasticity, for instance, may better tolerate a pelvic examination if an assistant or lithotomy stirrups help support the legs. Some radiology offices offer seated mammography positioning.

**PROMOTING WELLNESS**

**Cardiovascular health:** Cardiovascular disease leads the mortality list among American adults. People with MS should protect their heart health by:

- Avoiding recreational drugs, excessive alcohol, or tobacco (Patients who want help quitting smoking can call 1-800-NO-BUTTS.)
- Maintaining a healthy body weight and lipid profile
- Following the latest USDA guidelines for diet and exercise
- Seeking periodic screening for hypertension, diabetes and obesity
- Talking with doctors about taking a daily baby aspirin (men over age 45 and women over age 55)
- Obtaining immediate medical attention for possible symptoms of myocardial infarction or stroke, since MS could alter these symptoms.

**Exercise:** A number of studies have found that regular aerobic conditioning and resistance training benefit persons with MS through improved fitness, muscle strength and quality of life. Exercise also decreases risk of cardiovascular disease, obesity, and osteoporosis in the general population. Specific exercise prescriptions often include a warm-up period, 40 minutes of aerobic training and/or resistance exercises (for instance, on alternating days), and a cool-down period. The National MS Society (1-800-344-4867) can direct people with MS to appropriate exercise programs in their communities.

**Family wellness:** Family members without MS need to focus on their own wellness too. Caregivers of people with disabilities may become so involved with MS-related demands that they neglect themselves. On the other end of the spectrum, persons with MS who are able and willing to embrace wellness may become role models who inspire similar achievements among family and friends.

**Immunizations:** The Centers for Disease Control and Prevention recommend: (1) annual influenza immunization; (2) tetanus and diphtheria (Td) booster every 10 years; (3) pneumococcal immunization after age 65 or in anyone with additional risk factors; (4) varicella immunization if there is no history of clinical varicella illness; (5) annual influenza immunization after age 50; (6) human papilloma virus (HPV) immunization up to age 26 years; and (7) any other immunizations dictated by individual risk factors. Those with MS should generally avoid live virus immunizations (such as smallpox, chickenpox, measles, mumps and rubella).
Menopause: In years past, health practitioners routinely recommended hormone replacement for postmenopausal women because preliminary, observational data suggested a benefit. More recently, large randomized trials have concluded that hormone replacement increases risk of heart disease and breast cancer. Women with osteoporosis can instead use a bisphosphonate medication (alendronate, ibandronate, risedronate or others) or another non-estrogen medication to prevent fractures.

Nutrition: The USDA’s new Dietary Guidelines for Americans 2010 (http://www.cnpp.usda.gov/DietaryGuidelines.htm; www.choosemyplate.gov) emphasize a low-fat diet rich in fresh fruits, vegetables, nuts, low-fat dairy products and whole grains. These guidelines can help reduce obesity, which if present, can magnify MS symptoms. And data from the Nurses Health Study showed that obese girls in their teens were twice as likely to develop MS as were girls with a healthy body weight. Persons with MS should also take a daily multivitamin and mineral supplement as well as 1,000 mg of calcium (1,200 mg daily for postmenopausal women and for all adults with impaired mobility). Recent data indicate that vitamin D levels may play a role in the MS disease process. Low levels early in life appear to correlate with an increased risk of developing the disease, and lower levels in someone who is already diagnosed appear to increase the risk of an MS exacerbation. How much vitamin D supplementation a person needs depends on his or her blood level. It is important to monitor these levels and not just take large amount of vitamin D because too much can be harmful.

Tobacco: Smoking, in addition to causing heart and lung disease as well as cancer, has also been associated with increased risk of developing MS and accelerated disease progression.

Safety: Like all adults, those with MS should be counseled to follow good safety practices, including seat belts, sun protection, violence prevention, and safer sex. Clinicians should notify adult protective services if they suspect abuse of a dependent adult, regardless of the adult’s age.

MANAGING MS-RELATED CONCERNS

MS exacerbations: MS exacerbations may initially present to the primary care clinician rather than to the neurologist. All clinicians should therefore be aware of factors that can confuse the clinical picture of potential MS exacerbations:

- **Hormonal changes** greatly affect MS. Menses may cause fluctuations in MS symptoms. MS often improves during pregnancy, but commonly flares during the postpartum months.

- **Pseudoexacerbations** of MS can result from various factors that raise core body temperature: heat and humidity, flu-like reactions to interferons, exercise, or infections. Urinary tract infections are common culprits that can cause fatigue, weakness or other “MS attack-like” symptoms without classic dysuria. Unlike actual MS exacerbations, such pseudoexacerbations are self-limited and rarely require intervention beyond cooling measures and treatment of any underlying infection or inflammation.
Certain **MS complications** can also mimic exacerbations: Pressure neuropathies on peripheral nerves can lead to unexplained sensory or motor deficits. Occult pressure ulcers need to be anticipated, identified and treated. Undiagnosed hypothyroidism might mimic MS-related fatigue. Primary care physicians can greatly help their patients by anticipating, recognizing and managing such complications.

In contrast to pseudoexacerbations, actual MS exacerbations are defined by new or recurrent MS symptoms that last at least 24 hours and cannot be better explained by another etiology. Exacerbations commonly respond to short-term, high-dose steroids, which are often given intravenously.

**Other MS complications:** MS is a multifaceted disease that can present myriad challenges. Complications to watch for in primary care include:

- Bladder and bowel dysfunction, including constipation and UTIs
- Cognitive changes, which can be quite subtle
- Depression, which is both common in MS and amenable to treatment
- Dysarthria and dysphagia that may cause cough or globus sensation
- Gait disorders and falls, which may need physical therapy or orthotics
- Pain (neuropathic, orthopedic, rheumatologic, or other), which should be thoroughly worked up and treated
- Visual deficits ranging from optic neuritis to visual motor abnormalities

With careful attention both to preventive care and to ongoing disease management, primary care clinicians can make indispensable contributions to the comprehensive care of their patients with MS.
RECOMMENDED READINGS


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