3T's PROTOCOL FOR GPs TREATING ACUTE RELAPSES IN A PRIMARY CARE

Protocol for the treatment of acute relapses of Multiple Sclerosis in Primary Care

MS patients having a relapse *causing distressing symptoms* or *limiting activities* of *daily living* should be offered treatment with **oral methylprednisolone** (Medrone 100 mg tablets) **500 mg daily for 5 days**, taken in the morning with food. Co-prescription of **Omeprazole** is not routinely indicated but may be a sensible precaution in patients at risk from peptic ulcer disease, gastritis or those who are taking regular NSAIDS or Warfarin.

A relapse is defined as a relatively sudden (over hours or days) increase in neurological symptoms or disability which **last for more than 24 hours.** Prior to treatment, possible precipitants, particularly infections, should be sought. Urinary tract infections may be asymptomatic and so all patients should have **Multistix tests of their urine** for protein and nitrites. When present, management should be aimed at treating the infection and steroids should not be given.

Not every relapse requires drug treatment. Steroids are given to hasten the natural recovery of a relapse. They do not alter the long term (> 6 months) outcome.

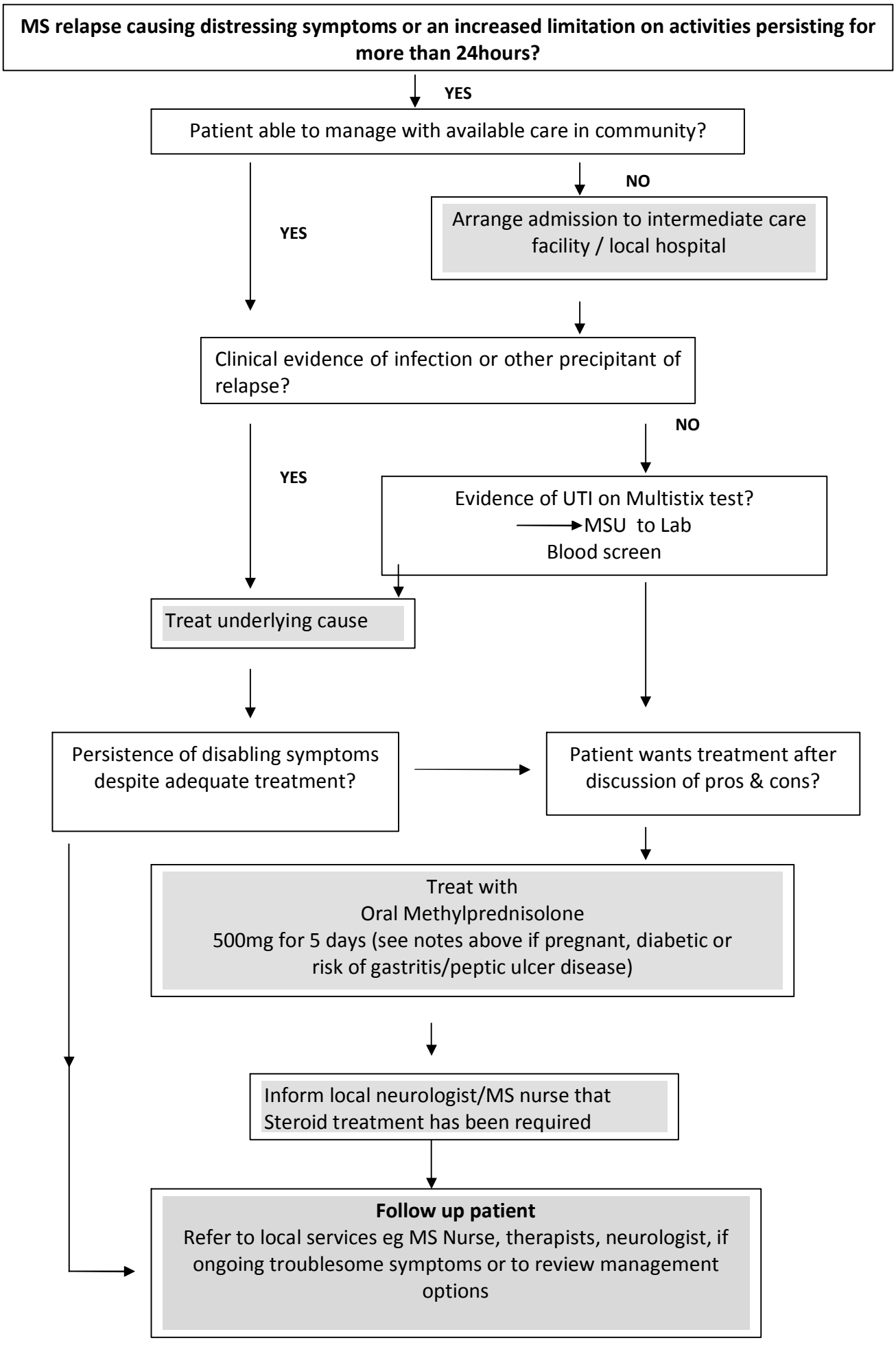
Admission to hospital is not required unless the relapse is sufficiently severe that the patient is unable to manage in the community with the maximum support available. In this situation they will need to be referred to the On-Call Medical Team and will be reviewed by the MS Nurse Specialist/Consultant Neurologist whilst an in-patient.

The local MS Nurse Specialist/Consultant Neurologist should be informed that a relapse severe enough to require treatment has occurred as this may affect the patient's eligibility for disease modifying drugs.

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 course of steroids should be avoided.** If a patient has received large, cumulative doses of steroids their risk of osteoporosis should be considered.

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

PROTOCOL FOR THE TREATMENT OF ACUTE RELAPSES OF MULTIPLE SCLEROSIS IN PRIMARY CARE



Patient Information Sheet – Treatment of MS relapse

Your Doctor/Nurse feel that you are having a relapse of your MS and that treatment with a steroid, methylprednisolone (*Medrone®*) is indicated. Relapses are a relatively sudden (over hours or days) increase in symptoms or disability lasting more than 24 hours. Infections, particularly of the chest or urinary tract, can mimic a relapse and your doctor will assess you for these, as these are best managed by treating the infection rather than giving steroids. Symptoms due to a relapse usually settle after a few weeks but can leave persisting problems. Steroids have been shown to help relapses settle more quickly but do not alter whether or not any problems will persist in the long term. **Not all relapses require treatment** and steroids are usually reserved for when symptoms are distressing or result in a limitation of your usual activities.

Steroids are not without side effects. Generally though *these do no continue for long after the treatment is completed.* You MAY experience some of the following:-

- Slight reddening or flushing of the face
- Swelling of the ankles
- Metallic taste in mouth
- Indigestion*
- Urinary tract infections, thrush or sugar in the urine.
- Mood alterations
- Altered sleep pattern
- Weight gain, increased appetite

* If you develop indigestion whilst taking the tablets you should inform your doctor as he/she may wish to give you a drug called Omeprazole to help protect the stomach lining. This should also be taken if you are taking regular anti-inflammatory drugs, e.g. Aspirin, Ibuprofen, if you are on Warfarin or if you already suffer with frequent indigestion or have a history of stomach ulcers.

Repeated courses of steroids can lead to thinning of the bones (osteoporosis) and you should not be given more than three courses of steroids a year. If your doctor is concerned about your risk of osteoporosis he may arrange a bone (DEXA) scan or give you dietary supplements of Vitamin D and Calcium.

You should also tell your doctor if you are diabetic (steroids will affect your sugar levels) or if there is a chance you may be pregnant.

If you have any further question(s) please contact the person who has prescribed the medication or speak to your local MS Nurse.

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This Guideline has been adapted from Hampshire Primary Care Trust: Protocol for GP's treating acute relapses in Primary Care.