

key points

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In around 85% of cases, multiple sclerosis (MS) starts with an acute neurological episode, a clinically isolated syndrome, which is considered to be the first clinical episode of relapsing-remitting MS (RRMS). It is characterised by the presence of acute relapses, after which there is normally good functional recovery. About 15-20 years after symptom onset, most patients develop secondary progressive MS, characterised by a gradual and irreversible neurological decline.

MS affects women more frequently than men, with a ratio of 2-3:1. Age at disease onset varies depending on the type of MS. In RRMS the disease generally starts in the late 20s. Symptom onset in those with primary progressive MS occurs around the age of 40.

The cause of MS is unknown. It is believed that a combination of risk factors can trigger an autoimmune response against the CNS leading to the development of MS. Risk factors can be either genetic or environmental and include: a past history of infection by Epstein-Barr virus; high latitude/low solar exposure and low vitamin D levels; smoking; and obesity in adolescence.

Clinical relapses in RRMS reflect acute inflammation in the CNS, resulting in specific clinical syndromes including optic neuritis, myelitis, brainstem/cerebellum syndrome and supratentorial syndrome. In progressive MS, progression generally presents with gradual loss of power in the lower limbs, which may be asymmetric. It is often accompanied by sensory disturbances in the lower limbs, bladder and bowel symptoms.

Investigations need to rule out conditions that can mimic an inflammatory-demyelinating disease of the CNS and determine the presence of dissemination in space and dissemination in time of the inflammatory-demyelinating disease. There is no confirmatory test for MS and it remains essentially a clinical diagnosis.

Management is based on education, prevention, a multidisciplinary approach and self-management. Preventing worsening in MS includes strategies to change the disease course, i.e. disease modifying drugs, which should be preceded by an accurate and early diagnosis.

If a patient with MS presents to a GP with symptoms suggestive of a relapse, it is important to check for the concomitant presence of an infection, such as urinary tract infection or chest infection, and treat it if necessary. Steroid treatment may be administered when there is a disabling clinical relapse.