CASE BASED CONSIDERATIONS IN CLINICAL PRACTICE FOR MULTIPLE SCLEROSIS

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Case Discussion #1: Radiologically Isolated Syndrome

Radiologically Isolated Syndrome (RIS) was first described in the literature in 2009 by Okuda, et.al. Since that time, there have been subsequent publications that have improved our understanding of the prognostic implications, clinical importance, and therapeutic considerations for these cases. We will review real-world cases of RIS and use audience response system (ARS) to determine current approaches and thoughts about these cases. We will provide a summary review of the literature to date regarding the risk factors for MS conversion; cognitive impact/testing results in these patients – touching on the clinical significance of these findings; and considerations for initiating treatment in those that have dynamic MRI activity or other evidence to support clinical deficits[1-4].

Case Discussion #2: Fulminant Presentation and First-Line Therapy Selection

We will present 1-2 patients with fulminant/aggressive presentation based on clinical disability and MRI activity. Using ARS we will survey current practice approaches that would be taken in this case. There is currently a lack of formal criteria for fulminant presentation or treatment strategies. We will discuss current practice among the participants based on ARS system. We will then review the literature available to guide these choices[5-10]. Discussion will include induction vs. escalation approaches.

Case Discussion #3: Measuring DMT Response and Deciding When to Switch

We will present a case of treatment failure (clinical and/or radiographic). Using ARS we will survey the audience for current definitions for treatment switch. There remains a lack of consensus in everyday practice – of treatment failure and when to switch therapy. Some of this is related to differences in the acquisition and utilization of MRIs in managing MS patients[11]. We will review available guides for DMT "response" vs. "failure" to help providers make decisions about when and who to switch therapies.[12, 13] We will also define NEDA (no evidence of disease activity) and discuss the application of these guidelines in MS treatment management[14].

References

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