

# IOMSN UPDATE

## The IOMSN Expands Its Reach

**T**his year, the International Organization of Multiple Sclerosis Nurses (IOMSN) was thrilled to sponsor four regional nursing updates across the United States. This project was funded through an educational grant from Biogen Idec, a staunch supporter of MS nursing. We are very grateful to Biogen Idec and our other pharmaceutical partners for their faith and support in helping to promote the importance of MS nursing.

Our goal was to reach nurses in regional areas that have not been well served by MS nursing education. All programs were accredited and we were thrilled to have record turnouts at all events, suggesting a strong interest in our continuing these programs in the future.

Each regional event was chaired and organized by regional nurse leaders who were in charge of finding an appropriate venue and selecting their faculty. A standard set of slides that fulfilled the educational goals were provided by the IOMSN



to the speakers to facilitate their preparation. We received excellent evaluations for these programs and will be using this format for future programs.

For their tireless efforts in coordinating these programs, we would like to thank our regional chairs, Elida Greinel from Albuquerque, Pat Loge from Billings, Montana, Beverly Layton from Birmingham, Alabama, and Brant Oliver from Lebanon, New Hampshire. We also want to thank our co-provider, Nurse Practitioner Alternatives, and Laurie Scudder, our brilliant liaison, for their support and input. If you are a nurse eager to facilitate this process in the future, please contact us at the IOMSN office and we will try to make this possible for you. **MS**



*Colleen Harris  
Committee Chair  
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### INTERESTED IN SHARING YOUR KNOWLEDGE WITH THE WORLD? JOIN THE IOMSN!

The IOMSN is the only organization dedicated to the education of MS nurses around the world. If you wish to join the IOMSN, contact the organization at: IOMSN, c/o MS Center at Holy Name Hospital, 718 Teaneck Road, Teaneck, NJ 07666, (201) 837-0727, [www.iomsn.org](http://www.iomsn.org).

## The Debate Over When To Start Treating MS

**A**n ongoing discussion among multiple sclerosis (MS) professionals focuses on when to treat MS. Should treatment begin at the onset of the first clinically isolated symptom (CIS), or is a watchful waiting approach more appropriate? At the meeting of the Consortium of Multiple Sclerosis Centers (CMSC) held last June, this was the subject of many presentations, with important perspectives on both sides. Here, we present an interview with Dr. Robert Shin in which he discusses whether to initiate early treatment based on an initial episode of optic neuritis. In the next article, Dr. Corey Ford, President of the CMSC, responds with a different approach.

### Optic Neuritis and MS: What Does the Connection Mean Clinically?

Current treatment for MS involves long-term therapy of self-injected drugs taken for an indefinite period of time. While some diagnosed patients may experience a relatively benign course, other patients may progress on to severe disabilities and irreversible tissue damage associated with their disease. The Medical Advisory Board of the National Multiple Sclerosis Society released a consensus statement in 2005 recommending initiating treatment with disease-modifying therapies as soon as patients are diagnosed with relapsing MS, and even in some cases of patients who are not yet diagnosed but experience a CIS and are at high risk for MS. The debate over when to treat is not a new one in MS, and the controversy continues to grow.

Optic neuritis has been strongly linked to the development of MS, presenting the dilemma of whether to treat patients with this single symptom before they have been diagnosed with clinical MS. Robert Shin, MD, Assistant Professor of Neurology and Ophthalmology at the University of Maryland, offered his perception of these same challenges relating to optic neuritis as a predictor of MS at the CMSC.

Optic neuritis is an attack of visual blurring or vision loss in one eye, almost always associated with some pain or eye discomfort on eye movements, caused by demyelination of the optic nerve. By itself, optic neuritis is usually a self-limiting condition. In most cases, the pain and discomfort will resolve and vision will improve within a few weeks to several months. Some primary care physicians, neurologists, or ophthalmologists may decide to treat with intravenous steroids. This does not improve the vision restored to the patient, but does shorten the course of the episode.

Regardless of how the clinician decides to treat the optic neuritis, Dr. Shin strongly recommends that all patients with optic neuritis be sent for a brain magnetic resonance imaging (MRI) scan, with and without contrast, to identify whether they have demyelinating lesions that can signify an increased risk for the future development of MS. Optic neuritis is not the same thing as MS, but it can commonly affect people with MS, or even be the first sign that MS is developing, especially when the initial brain MRI is abnormal.

Dr. Shin explains that it's been known for a long time that a certain percentage of people with optic neuritis will go on to develop MS, but one of the challenges has been determining the actual risk in individual patients who have had optic neuritis. "It depends on which study you look at and how long you follow the patients," says Dr. Shin. "If a patient has optic neuritis and the brain MRI shows some demyelinating lesions, then the risk of MS might be 50% to as high as 80% or 90%, depending on the study and whether you're following the patient for 5, 10, or 20 years."

Dr. Shin points out that while most clinicians agree that the opportunity to prevent irreparable damage and long-term disability suggests that MS treatment

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begin as early as possible, this approach needs to be balanced with the realities of the cost of treatment and the hazards and discomforts of injection therapy for a patient who might not need it. "If the risk of developing MS after optic neuritis in high-risk patients is between 50% and 80%, that still leaves 20% to 50% of patients with optic neuritis and an abnormal brain MRI who may not go on to develop MS," he says. "Should all patients with optic neuritis and an abnormal brain MRI be treated for MS, even when we know that at least some of them will never develop MS?"

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Counter to many MS clinicians today, Dr. Shin does not advocate treating preclinical MS on the basis of CIS or a diagnosis of optic neuritis. "I feel that we should reserve MS treatments for patients who actually have MS," he says. "If patients present with a CIS or optic neuritis as their only event then, by definition, they don't have MS, because they've only had one event." If a patient's brain MRI is abnormal, there is an increased risk that he or she will go on to develop MS, although it is not currently possible to determine

## **DON'T FORGET TO REGISTER FOR THE NEXT EXAMINATION SITTINGS!**

The application deadline for the *February 2008 Multiple Sclerosis Specialist Certification (MSCS)* exam is January 1, 2008.

Information and applications are available at [www.ptcny.com](http://www.ptcny.com).

which patient will develop MS and would therefore benefit from therapy and which patient will not.

Dr. Shin recommends careful monitoring using MRI at 3- to 6-month intervals for at least a year or two. "We know that for every clinical symptom or attack a patient may have, they can have up to 10 'invisible' events that can be detected by brain MRI. You can detect demyelinating activity even before the patient may have a second symptom on the outside," he states. "Modified McDonald criteria allow us to use this evidence of new or enhancing lesions on MRI to diagnose MS even before a patient has a second clinical attack." At that point in time, Dr. Shin suggests, clinicians can recommend starting MS treatment.

If, over time, there are no new clinical attacks and no evidence of new demyelination on brain MRI, then the clinician can refrain from starting MS treatment. "This might be one of the minorities of patients who will not go on to develop MS," he states.

"This strategy is a compromise," Dr. Shin says. "If someone presents with optic neuritis, but is going to go on to develop MS, we have a good chance of detecting that within the first year or two using the brain MRI. We haven't lost much time, but we're also not running the risk of treating someone with expensive injections that doesn't have to be on that treatment."

The alternative, treating all patients with a CIS and evidence of an abnormal brain scan, means that at least some of the patients are being given unnecessary treatment. "To have a patient who does not have MS taking a needle every week or every day for an indefinite period of time with no end point," he suggests, "does that patient a disservice." And while numerous studies of MS therapies have shown that, as a collective group, patients with CIS and an abnormal brain MRI can benefit from early intervention with immunomodulating drugs, Dr. Shin concludes, "When I'm sitting down with an individual patient and trying to determine if he or she should be on MS treatment or not, then I have to do what's best for that individual person."

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## Long-Term Data Still Needed To Prove Benefits Of Early Ms Treatment

Patients with a single clinical event and MRI or cerebrospinal spinal fluid (CSF) findings suggestive of MS present a dilemma. In the majority of these cases, a second disease-defining relapse will occur; in others, a new asymptomatic MRI lesion may appear. The clinical picture then fulfills the latest International Panel criteria for diagnosing clinically definite MS (CDMS). Whether to recommend therapy or decide to wait and repeat MRI scans at intervals is an issue of clinical judgment made with education and involvement of the patient.

Clearly, treating CIS with MRI lesions is treating MS at the earliest stage possible for most, but not all, patients. Three-year data from the BENEFIT study of interferon beta-1b shows a persistent difference in disability favoring initiating therapy at the CIS stage rather than waiting for the development of CDMS. Of course, this result applies best to groups of patients and may not apply directly to an individual. Some patients make the decision easier, either by wanting to be as aggressive as possible and having no qualms

about starting therapy, or, in contrast, being unsure of their commitment to what may be life-long treatment and needing time to adjust to the probability of MS. Those latter patients may prefer to wait for a new MRI lesion or a second clinical event before deciding that immunomodulators are a better choice than untreated MS.

In the final analysis, we have no data proving that the clinical outcome at 20, 30, or 40 years will be altered by delaying treatment of CIS. These patients will continue to look to their neurologists for advice and remind us of our responsibility to make the best possible judgments with imperfect information. **MS**



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