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Advancing MS Care: Diagnostic Clarity, Early Action, and Patient-Centered Treatment

ReachMD Announcer:
You're listening to *On the Frontlines of Multiple Sclerosis* on ReachMD. And now, here's your host, Dr. Gates Colbert.

Dr. Colbert:
Welcome to *On the Frontlines of Multiple Sclerosis* on ReachMD. I'm Dr. Gates Colbert, and joining me to discuss our evolving management approach in patients with multiple sclerosis, or MS, is Dr. Tirisham Gyang, who's a Clinical Associate Professor of Neurology at the Ohio State University Wexner Medical Center in Columbus.

Dr. Gyang, thanks for being here today. Let's dive right in. How would you describe the current state of MS management, from diagnostic to therapeutic approaches?

Dr. Gyang:
So this is a very interesting question because there have been multiple updates in the diagnosis of MS and potentially in the therapeutic approaches of MS as well. Most importantly, the McDonald criteria, which is a criteria that most physicians use to establish a diagnosis of MS, has been updated or revised. This is the 2024 revision of that criteria, the last being in 2017.

So with this revision, there are a lot of additions that will increase the sensitivity and the specificity of a diagnosis of MS. Some of these additions with the new criteria include the addition of unique or novel MRI techniques to increase the specificity of an MS diagnosis, and these include the central vein sign and also the paramagnetic rim lesions. So these are new additions that are aimed to increasing the specificity of an MS diagnosis. We also have the inclusion of the optic nerve as the fifth topographical site. In 2017, we had four topographical sites.

And then another unique aspect of this criteria is a provision for what's called a biological diagnosis of MS. From what we've known, MS is a clinical diagnosis, and you need clinical symptoms to be diagnosed with MS. However, we have seen that some patients with incidental findings of MS on an MRI, known as radiologic isolated syndrome, may benefit from treatment with a disease-modifying therapy. Two studies have been done in patients with high-risk RIS that have shown that this initiation of a disease-modifying therapy will delay the transition to MS. Therefore, with this updated criteria, high-risk RIS patients or patients with RIS who have specific metrics and additional risks can be diagnosed with MS in what's termed as a biological diagnosis.

So this 2024 criteria was just published at the end of September, and it is available for all clinicians who take care of patients with MS to utilize for diagnosing MS. We hope that this would increase the sensitivity and also the specificity of a diagnosis whereby we're capturing people who were not captured before. And in people who have been captured with MS, we're making sure these people really have MS, which is specificity.

In terms of therapeutic approaches, we have potential new treatments coming out that are still being reviewed by the FDA—tolebrutinib—studies showed a benefit for nonactive secondary progressive MS. So we're waiting on the FDA review on that, but that will potentially change the therapeutic landscape of management in MS because at this time, there is no available treatment for nonrelapsing secondary progressive MS. So that is one addition that may change the way in which we manage MS.

Dr. Colbert:
Now, we've seen a significant shift towards earlier and more aggressive intervention. What's driving that change, and how has it impacted long-term outcomes?

Dr. Gyang:
So a lot of the studies that were done within the last decade have shown that early intervention is associated with reduced long-term disability. So there's this concept of time is brain, and with things like acute stroke, that concept has been very much accepted. But a similar process is happening in MS where time is also brain. The earlier we intervene and the more aggressive interventions we take to reduce that active inflammatory process—that leads to better long-term outcomes.

And so we just talked about the diagnostic criteria, hoping that we will capture patients who were not captured before so that we can start them on very effective treatments early. And so as soon as a person is diagnosed with MS, we want to pick an intervention that would completely control the disease very early on so that they avoid this disability that sometimes doesn't set in until 15, 20, or 30 years after that diagnosis.

Then, there are actually clinical trials going on right now that are exploring the strategy to MS treatment—whether we start with what's called an escalation strategy, which is starting with a less effective but safer treatment and then escalating as needed if a patient breaks through on a treatment that's more or less classified first line or not as effective, whereas the counterpart is called induction, or early use of highly aggressive therapy or highly effective therapy. And in this model, we pick the most potent disease-modifying drug first and start that early with hopes that we could de-escalate or step down in efficacy or even discontinue therapy later. But the idea is starting with the most potent drug first, and advantage would be inflammatory activity is highest at the time of diagnosis or very early on, and you want to match that period with a very effective, disease-modifying drug.

So the DELIVER-MS and the TREAT-MS clinical studies are ongoing right now, and hopefully, we will get some data and some guidance on selecting disease-modifying therapies between an escalation model versus an induction model.

Dr. Colbert:
And there's also been a growing emphasis on personalizing treatment regimens. How do patient-specific factors influence your management approach?

Dr. Gyang:
Once that diagnosis is made, there is really no standardized protocol or algorithm on how to select a specific medication for a specific patient, and so you could go to different providers and get a recommendation of different medications. Now, a lot of factors weigh into the decision for disease-modifying therapy. From a provider's end, sometimes, we look at, how aggressive is the disease? How often is this patient having relapses? How high is the lesion burden on an MRI? We look at a lot of factors.

From the patient side, there are a lot of other things that we need to consider. For instance, if it's a woman, are they planning on having children or having a pregnancy soon? That would weigh on my decision on the kind of medication I would pick. Does this patient have other medical conditions? Do they have heart disease? Do they have diabetes? Do they have other infections? For instance, some people have chronic hepatitis. That could weigh on the type of medication that we choose.

And then there are other social factors, right? For instance, what's the work schedule of the patient? Are they able to take time off to come for an infusion, or do they prefer to do something at home? Are they compliant? Are they going to have trouble sticking with a regimen by themselves, or is it better to bring them into the infusion center so that the provider knows when they get a medication or not?

I deal with students. They live in a dorm room—do they have a refrigerator in the dorm if I'm giving them a medication that requires refrigeration? For instance, some of the self-administered injections will require refrigeration, and I have to put that into consideration. Is that something they can do in a dorm, or would I just rather have them come into the office or do something that's a pill that's a lot easier?

And so there's a lot of factors that go into that decision, and it has to be personalized with every single patient. It's a discussion between the patient and the provider, and it's picking a medication that, number one, we believe will be effective in controlling the disease, and number two, is doable based on the life of that patient. And then also, it doesn't increase the risk of other concerns that that patient may have that are unique to them.

Dr. Colbert:
For those just tuning in, you're listening to *On the Frontlines of Multiple Sclerosis* on ReachMD. I'm Dr. Gates Colbert, and I'm speaking with Dr. Tirisham Gyang about key considerations in MS management.

So, Dr. Gyang, I'd like to shift gears and ask you about how we can best support our patients in everyday practice. How does multidisciplinary collaboration play a role in MS care?

Dr. Gyang:
So this is a very important question because patients with MS present very differently and have very diverse needs. We need more than just a neurologist to take care of patients with MS. Depending on the needs of a specific patient, they may need to see a mental health provider, like a psychiatrist or a psychologist; they may need to see one of our rehabilitation specialists, for instance, a physical therapist, occupational therapist, or a speech or cognitive therapist; they may need a urologist, because bladder symptoms can be a problem with patients with MS; or they may need to see an ophthalmologist. It's a very diverse range of providers that a patient with MS may need to see.

And every single patient is different, so the needs of one patient may be completely different from the needs of another patient. Therefore, we need a lot of help from other disciplines in managing symptoms of MS or the consequence of having MS, whether it's due to MS itself or medications that we use or other factors. And so multidisciplinary care is the best approach to making sure a patient is well cared for and we're balancing all the aspects of disability or issues that may come with an MS diagnosis.

Dr. Colbert:
And how has your approach to patient communication evolved, especially in the context of shared decision-making?

Dr. Gyang:
In general, it's very important to allow patients to own or take some ownership in decision-making in MS. As I said, no two patients are alike in MS. Everybody's different, and everybody has priorities and things that they feel are most important to them. People have different approaches to risk. Some people are very risk averse, and some people are a little bit more comfortable taking risks. So I think it's very important to engage patients and also to get input for every decision, especially with, for instance, a disease-modifying therapy. It's very important and very vital to get input from the patient on what they feel is comfortable for them.

Some people may be completely comfortable with taking a specific medication, and then some people may not for one reason or another. As providers, it's very important to engage patients, provide them with adequate information that they need to understand for decisions we're trying to make, and then allow them to take some ownership in that decision and allow them to be completely comfortable with a treatment plan that has been chosen.

I always tell my patients, "I'll never do a treatment that you're not comfortable with," and I always respect that they should be very comfortable with a specific path that we're taking. I have patients who do not want to be on a disease-modifying therapy, no matter how much I try to convince them to do that, and I always have to make sure I respect their decisions, but I want to make sure they understand. And so my role is to give them all the information and all the knowledge they need and then respect their decisions.

Dr. Colbert:
And that's a great way to round out our discussion. And I want to thank my guest, Dr. Tirisham Gyang, for joining me to discuss our approach to multiple sclerosis management. Dr. Gyang, it was great having you on the program.

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