Your Questions Answered

MULTIPLE SCLEROSIS

Q *Can MS cause a mood disorder such as depression organically—that is, independent of the stress of the disease?*

DR. HILLEL PANITCH RESPONDS:

A Depression is very common in MS, though it does not correlate with the degree of disability. However, people with MS are more likely to become depressed than people with ALS, spinal cord injury, or other conditions that have a comparable degree of disability. In addition, depression in MS is more likely to be associated with lesions in the brain than in the spinal cord.

All of this suggests that the depression seen in MS is partly "organic" and not simply caused by the stress of having a disabling disease. Although the exact cause hasn't been determined, it's generally believed that this type of depression is related to the presence of small proteins called cytokines and other substances released by inflammatory cells in relapsing forms of MS, or the loss of neurons that control emotions in progressive forms of MS.

Depression commonly accompanies MS exacerbations but is seldom, if ever, seen as the sole symptom. Sometimes patients report feeling depressed or fatigued, and state that they "feel like they are going to have a relapse," but other symptoms fail to materialize and the feeling goes away after a few days or weeks. This may or may not be associated with the appearance of new lesions on their MRI scans, and suggests that the depression or fatigue represents a "subclinical" exacerbation—a flare up of MS symptoms of which the patient is unaware aside from these feelings.

Hillel Panitch, M.D., is professor of neurology and director of the Multiple Sclerosis Center at the University of Vermont.

FLU AND NEUROLOGIC DISEASE

Q *My mother has had a progressive neurologic disorder with no diagnosis for 20 years. In 1946, when she was 11, she contracted the H1 Influenza B virus and was paralyzed for several days. At a recent hospital stay, a doctor said that it was a "real possibility" that her 1946 flu caused her neurologic disorder. Could it be true?*

DR. JAMES B. SEJVAR RESPONDS:

A It can be tempting for a physician to try to find an explanation for a patient's illness in the absence of a firm diagnosis. I think it's unlikely, however, that a prior history of influenza infection would be the source of your mother's current illness.

Influenza can be associated with various neurologic problems: encephalopathy (a state of confusion), seizures, neuropathy, as well as others. These complications most frequently occur in children, although cases of neurologic illness associated with adult influenza certainly occur. In most cases, the relationship of influenza-virus infection to these neurologic illnesses is not well understood: We don't know how—or in some cases if—the influenza virus causes the neurologic disease.

Progressive neurologic disease due to influenza-virus infection would be particularly unusual. However, during the 1918 influenza pandemic, there was also an outbreak of a strange illness known as encephalitis lethargica, in which people developed neurologic problems including, in some cases, features of Parkinsonism—problems with balance, slow movements, and facial masking [a symptom in which facial muscles become immobilized]. But, the relationship between the influenza pandemic and the outbreak of encephalitis lethargica remains unclear, and they were probably unrelated. People who recover from a severe case of influenza sometimes also develop features of Parkinsonism, but these generally occur shortly after the infection rather than appearing as a progressive disorder.

Although we probably cannot completely exclude some relationship between your mother's current illness and her influenza infection, it would be very important for her physicians to make sure that they are exploring other more likely reasons for her illness.

James J. Sejvar, M.D., is a neuroepidemiologist for the division of viral and Rickettsial disease, division of vector-borne infectious diseases, and the National Center for Zoonotic, Vector-Borne, and Enteric Diseases of the Centers for Disease Control and Prevention in Atlanta, GA.

MIGRAINE

Q *For migraine, are there any alternatives to triptans, which I have heard can cause gastrointestinal and cardiovascular problems? I recently read about a drug that can be inhaled.*

DR. WILLIAM B. YOUNG RESPONDS:

A In a recent clinical trial, inhaled DHE (dihydroergotamine) demonstrated effectiveness and minimal side effects for the treatment of acute migraine. [Dr. Young was a co-investigator in the clinical trial]. Patients using inhaled DHE experienced significantly greater pain relief after 30 minutes than patients taking a placebo. However, at four hours, only 65 percent of patients using inhaled DHE reported pain relief. Since the preliminary study results don't show significant long-term improvement in patients taking inhaled DHE compared to other therapies, additional studies are needed.

There are three forms of DHE: intravenous (given in an inpatient setting), intramuscular (which we teach patients to self-inject at home), and a weaker intranasal form. Inhaled DHE will make a more effective and practical option for many people, assuming it receives FDA approval.

Triptans typically don't cause gastrointestinal problems; however, like DHE, they have been known to cause chest pressure. This almost never indicates a heart problem. Nevertheless, it's scary for people to experience chest heaviness after taking medication. As is the case with triptans, inhaled DHE may not be advisable for patients with cardiac disease or risk.

Injectable DHE causes a considerable amount of nausea, but data from the clinical trial have shown that nausea is a low side effect with the inhaled form.

There are many other options for acute migraine management—NSAIDs (non-steroidal anti-inflammatory agents) and nausea medicines can be very effective for the management of the migraine attack. Neurologists are extremely careful about prescribing barbiturates and opioids (narcotics) because of the high risk of migraine worsening over time.

William B. Young, M.D., is professor of neurology and director of the inpatient program at the Jefferson Headache Center at Thomas Jefferson University, Philadelphia, PA.

DO YOU HAVE A QUESTION TO ASK THE EXPERTS?
Send it to neurologynow@lwwny.com