MS CLINIC NEWSLETTER

London Health Sciences Centre – University Hospital

www.lhsc.on.ca/programs/msclinic Winter 2008

In this Issue….

New Treatments under Investigation at the MS Clinic

Over the last twenty years or so, the way we look at MS has changed, and for patients and doctors alike there is hope for the future: MS is now a treatable disease!

Scientists now know that MS involves the interaction of several critical factors: genetics, immunology, environment and myelin physiology, and how these factors interact to trigger an MS attack may vary in different people. Therefore, conducting research in all these areas is likely to contribute significantly to our overall understanding of MS, and it is our best hope for finding a cure. Large amounts of data from clinical trials and epidemiological surveys have been collected in recent years, showing efficacy of certain drugs in a statistical and analytical way for scientists, and also in a tangible and meaningful way for patients and their caregivers. As we better understand how the pieces all fit together, we are everyday one step closer to have the cause or the ultimate cure for this disease.

Now… Can people living with relapsing remitting MS see an end to injections soon? Possibly, with several new oral investigational drugs that are currently in advanced stages of research (i.e. Phase III studies, the last step before FDA & Health Canada approval). More information about clinical trials can be found here or you can search www.ClinicalTrials.gov

M. Kremenchutzky, MD
Neurologist

The TERIFLUNOMIDE Studies

Immunomodulatory drugs are agents that may help immune cells, which drive the immune attack in MS, 're-learn' and 're-direct' their actions. Teriflunomide has shown some promising immunomodulatory effects in other immune based disorders, such as rheumatoid arthritis. Our Phase 2 study was completed and suggests an encouraging effect on MRI activity and suppression of clinical flares of the disease. Drug side effects appeared to be tolerable. Even better news for patients is that this treatment is administered in the form of an oral pill!

Based upon the encouraging results of this pilot study, a larger study is being conducted to better evaluate the magnitude and durability of treatment benefit. In addition, Phase 2 studies are now being conducted to evaluate the safety and tolerability of teriflunomide when added to treatment with Betaseron, Rebif or Copaxone.

A trial of this pill for patients with the first symptoms suggestive of demyelination and "at risk" of developing MS will also launch soon to investigate if this oral drug can delay the time to a second attack and prevent the confirmation of a definite diagnosis of MS.

The FREEDOMS Study

Oral Fingolimod (also known as FTY720) is another potential MS drug with promising immunomodulatory effects, already in Phase III trials. Fingolimod seems to be very powerful but has some side-effects that need to be worked out. Presently, these include nausea, inflammation of the nasal passages, breathing difficulties, and/or reduction in heart rate. Recruitment for this study is complete and the trial is ongoing for at least one more year.

The BEYOND Study

This two year study was launched to identify whether double a dose of Betaseron® would be more beneficial than the commonly used single (commercially available) dose. A third group of patients treated with glatiramer acetate (Copaxone®) was also compared for outcomes. Recently finished, this study did not show any clinical superiority among the 3 groups. Further analysis of MRI data is awaited.

BENEFIT Observational Study

The primary objective of this study is to obtain further clinical data of patients with a first demyelinating event suggestive of MS enrolled in the BENEFIT Studies for up to seven years after the initial onset of the disease. One main focus is the comparison between early treatment with Betaseron® (initiated after the first event) and delayed treatment (initiated after the development of definite MS) or after two years. Other objectives are to gather observational data on safety, disease progression, quality of life, MRI parameters, long term adherence to therapy and choice of other disease modifying treatments.

The ALLEGRO Study

Another new investigational oral medication taken once daily called Laquinimod has shown promising immunomodulatory effects and good tolerance, and will be very soon further tested over at least 24 months. With monthly evaluations for safety and efficacy, and 4 MRI scans throughout the study this project aims at subjects of age 18 to 55 with 'active' MS (who have had at least one well documented relapse in the last 12 months and new lesions on MRI if an MRI had been done).

The CONFIRM Study

BG-12 is an oral fumarate also known as dimethyl fumarate or Fumaderm®. This "older" oral drug has been approved for psoriasis and other immune system disorders in Europe for years. Due to immune similarities with MS, these pills are now being further tested for efficacy and safety in people with the relapsing type of MS. This two year study is still open, and is also a "head-to-head" comparative trial of the pill versus placebo, and also versus an approved MS drug (Copaxone® or glatiramer acetate) for patients with relapses.

Spring/Summer 2008 Research Studies:

A new oral medication called Nerispirdine will be compared to placebo for people with a walking disability due to any type of MS. To enter the study the subject must be able to walk 25 feet in less than 45 seconds without an assistive device (i.e. cane).

The MINOCYCLINE Study

Minocycline is used to treat bacterial infections including acne; pneumonia and other respiratory tract infections; and infections of skin, genital, and urinary systems. Minocycline is in a class of medications called tetracycline antibiotics. It works by preventing the growth and spread of bacteria. It comes in pill format. Recent studies have demonstrated its anti-inflammatory properties, a key factor for MS researchers to look closely at the drug.

No, this is not a cure for MS and wouldn't necessarily replace current therapies, but if the research hypotheses are confirmed, minocycline may prove to be an orally effective treatment that when used at the time of the very first symptoms (even before a diagnosis of MS is given to you) can delay the full onset of MS. Every drug has side effects, however early studies have shown a reduction in activity of MS on brain MRI, meaning this treatment has the potential to slow the disease down significantly.

Minocycline is generally available as a prescription medication for acne and other bacterial infections but until it is proven to be safe and beneficial it is NOT recommended for treatment of MS. In fact, at this time, study sites will enroll people within 90 days of their first attack of "MS-like" symptoms. People who currently have MS or suspected MS are NOT eligible for this study.

Jane Lesaux, RN
Anne Howley, RN
Clinical Research Coordinators

FROM THE RESEARCH BENCH

The Canadian Collaborative Project on Genetic Susceptibility in Multiple Sclerosis (CCPGSMS) Study continues to go strong. To date, more than 30,000 Canadian MS patients from 16 sites across the country have been actively participating. A significant amount of patient data has been collected and assembled and now provides a major resource as a database for ongoing research.

Phase 4 of the CCPGSMS Study has provided important insight in a number of areas, specifically; the increasing occurrence of MS; that occurrences are higher in females; the roles of genetics and the environment on MS; the maternal influence on susceptibility to MS, to name a few.

The CCPGSMS is now entering Phase 5 of the Study and will carry on from the results of Phase 4, focusing on specific questions raised. As always, this new phase will include contacting study participants, both previous and new participants, to obtain updated as well as additional information. New questionnaires are currently under development and once the protocols for Phase 5 are determined, the information gathering process will begin.
With the continued support of the MS Society of Canada and the MS Clinics throughout Canada and with the ongoing cooperation of diagnosing and treating physicians, the CCPGSMS Study will continue to yield significant results. However, the ongoing success of the CCPGSMS Study is possible only through the continued support and involvement of the MS patients and their families. Your willingness to participate and to provide the necessary blood sampling and family information is the basis and foundation for the achievements to date.

Again, we would like to take the opportunity to thank all of the individuals that have participated in the Study. Your continued support and involvement provides much needed information. We also invite anyone that has previously provided information and that may now have additional information regarding their situation or another family member, to contact us should they wish to update any information.

For anyone that may be eligible to participate in the Study and is interested in doing so, or if you have any questions about whether or not you are eligible to participate, please contact Pamela Schoffer at (519) 435-1098, or by e-mail at p.schoffer@sympatico.ca.

We look forward to speaking with you soon.

Pamela Schoffer
Site coordinator CCPGSMS

TAKING CARE OF YOU WHILE YOU CARE FOR SOMEONE ELSE

All of us involved in personal relationships be it as a parent, child, partner or friend are caregivers. In all of these relationships we act out, with behaviours, the affect or feeling of caring we have for another. For example when concerned (emotion/feeling) about our child being home after school alone we make a point of calling them (behaviour) to check if they got home safe. All relationships are grounded in caring and caregiving. We all are caregivers to some degree. Although to care for and to provide care is a normal dynamic in all personal relationships, the ways in which you may behave as an expression of your caring for someone who is meeting the challenges of MS may ask more of you than in other relationships.

Many changes brought to a relationship by MS can pose a challenge to people who are a caregiver to someone with MS. Challenges can include the cognitive and physical limitations of the person. The loss to some degree of the relationship as it was prior to the diagnosis and its challenges can be an obstacle. Caregivers may feel they are on “duty” every day, all day and this can be stressful.

The importance of the caregiver taking care of themselves has been documented in the literature. One study found that 72% of caregivers reported that the most likely reason for being unable to continue to be a caregiver to a significant other was the deterioration in their own health. In order to be the caregiver that you want to be you will need to maintain your own health. This can be a foreign concept as in the role of caregiver you are far more focused on the needs of the person you care for not your own. However, you need to be taken care of first in order to continue to care for another. Two of the principle mediators for stress in caregivers are the quality of their coping skills and social support.

It is important to identify what helps you deal with the additional challenges as a caregiver for someone with MS. Coping strategies can be defined as the strategies you use to manage the demands of a situation that are perceived by you as taxing or that exceed your resources. Coping strategies can be action oriented, directed at the problem at hand or can be cognitive oriented, requiring you to change the way you think about or perceive a challenge. They can be problem focused or can be emotion focused. A strategy that is problem focused would involve you directly addressing the problem. For example, your significant other is now having difficulty managing the stairs outside your home. You access a list of resources available to you in your community, find out your options and arrange for a portable ramp to be delivered to your home. You may also use an emotion focused strategy in this same situation. You may need an afternoon away by yourself to process how hard it is to see your significant other struggling to enter their home. It is helpful to have a number of strategies available to you as you meet challenges in caregiving. There are times when an action oriented strategy is called for but at other times no action is possible, the challenge can not be changed and thus you need to be able to process the emotions attached to that challenge.

Gender can also play a part in coping. Research has shown that female caregivers identified their most helpful coping strategies to be: finding some space for themselves and involving themselves in physical activity. Male caregivers identified their most helpful coping strategy as being able to plan.

What helps you be the best caregiver possible to the person in your life with MS? On a day when you think that despite everything you managed well stop and ask yourself what was different about that day? Was it a day you did make sure you got a run in, asked for more help? Identify those things you do that help and make them a regular part of your life. Often caregivers are so busy caring they do not attend to what they need to do for themselves. At least one thing on the "to do" list for each day should be for you not for your significant other.

You will have your own answers to what helps you cope. Here are some helpful coping strategies that other caregivers have identified:

I make sure I understand as much about this illness as possible and have my own questions answered even if they are not the questions of my significant other.

I stay involved in activities and relationships outside of my caregiving relationship (remember how social support was a key coping strategy)

My significant other and I maintain the activities we have enjoyed in the past or if they are no longer possible we find a new activity we can share together.

I find out the help that is available out there before I even need it so when I do, for example in a crisis, all I have to do is access that list. I don't have to try to find the resources at a time when I am physically and emotionally drained.

I accept the offer for help from others.

I ask for help when I need it.

I commit to take care of me as well as my significant other.

I recognize that in many ways I have MS too and that can be hard. It is OK to feel the emotions attached to life with MS and some days I won't feel so strong. I need to take care of myself so that I can have those days but get past them so I can still be strong for my significant other.

I acknowledge that life has changed for us since MS but I work with my significant other on building the best relationship possible rather than focusing on what has changed. We have a future, perhaps not the one we had planned on but now we just need to work on the modified plan.

I am realistic about my expectations for myself and my significant other.

I use my sense of humour.

When faced with a challenge I try to focus on the solution not the problem.

When I asked the spouse of one of my clients about what helped him cope as a caregiver his response was: "I think of the need to make sure that I take care of me in terms of the safety lecture that the stewardess gives you when you first board a plane. The stewardess cautions anyone traveling with a partner who may require assistance in the event of an emergency to secure their (the person who will give assistance) face mask first. That's how I look at being as supportive to her as possible. I have to make sure that I take care of me". Identify your own oxygen masks. Take care of you, so you can continue to care for them.

Cathy-Lee Benbow
Coordinator/Social Worker

PREGNANCY AND MS

A common topic of discussion in our clinic is the impact of a diagnosis of MS on pregnancy and family planning. This is not surprising since MS affects mostly women of child-bearing age. The first important fact to realize is that MS has no effect on fertility, the rate of miscarriages, congenital malformations ("birth defects"), or stillbirths. One study documented an approximate 13% reduction in pregnancy rates among women with a diagnosis of MS, but this change was mostly due to women deciding not to have children for various reasons. Furthermore, all methods of birth control are considered safe in MS; specifically, oral contraceptive agents do not affect the incidence of MS or relapses.

In the 1950s and 60s, women with MS were discouraged from considering pregnancy, as it was thought to worsen the course of MS. Large, retrospective studies starting in the 1970s through to the 1990s described a decrease in relapse rate in the 3rd trimester of pregnancy, and an increase risk of relapse in the first 6 months post-partum. In 1998, a study was published of a registry in Europe of pregnant women with MS who were seen prior to pregnancy and then followed for 2 years after delivery. The rate of relapses before and after delivery was compared. This study reported that the rate of relapses decreased significantly in the third trimester and increased in the first 3 months post-partum, although 72% of women did not have a relapse during that time. They also found that a higher rate of relapses before pregnancy, as well a relapse during pregnancy correlated with a higher risk of post-partum relapses. They also did not record any effect of either an epidural anesthetic or breast feeding on the rate of relapse in MS, nor was there any effect of pregnancy on disability progression.

In terms of use of medication during pregnancy, most medications have limited data on whether they are safe for the fetus. Thus, most medications are avoided during pregnancy, if possible. Steroids do cross the placenta but have little effect on the developing fetus, if used in the 2nd or 3rd trimester. Steroids can be used if a severe relapse occurs during pregnancy, but should be avoided in the first trimester if possible. Interferons have been shown to cause miscarriages in animals, while glatiramer acetate has not, but neither is recommended in pregnancy.

However, it is well known that most pregnancies are not planned. There is some data on the safety of interferons in women with MS who became pregnant while on treatment. One study looked at the amniotic fluid and fetal blood of pregnant women on interferon treatment and the drug was not detected. A registry of women who became pregnant while participating in clinical trials between 1994 and 2003 found 41 women on interferons when they conceived, 22 women who had been on the drug, but had stopped it at least 2 weeks prior to conception, and 6 women in the placebo group. There was no difference found in the rate of complications for the baby or with the delivery between the 3 groups, but the number of patients may be too small to make definitive conclusions. There were more miscarriages in the interferon treated groups (16%). A Canadian study looked at all the women who had contacted the national registry regarding pregnancy while on interferons and found a decreased birth weight and a higher risk of miscarriages in women on interferons when compared to those who were not. However, there may be a reporting bias, meaning that you are more likely to report a problem if you are on a medication, limiting the ability to make a conclusion. Overall the data seems to indicate that there may be a risk, and that interferons should be stopped prior to conception if possible. However, the chances of a healthy infant are high if pregnancy does occur while using interferons. In the case of glatiramer acetate (Copaxone) the effects during pregnancy and on the fetus are not well known and it should therefore be avoided.

Steroids are known to be excreted in breast milk and should be avoided during breastfeeding. It is not known if interferons or glatimer acetate are excreted in breast milk, thus it is not recommended that they be used during breastfeeding either. Overall, a diagnosis of MS does not change your ability to have children, and there is an increased risk of a relapse just after delivery. The medications currently used for MS are not considered safe during pregnancy or breastfeeding and should be stopped as soon as you know you are pregnant. After delivery, your medication can be restarted if you are not breastfeeding, or after you have stopped. These changes can be managed with the help of the MS clinic before, during, and after pregnancy.

Dr. Sarah Morrow,
Clinical Fellow

PAIN AND MS

The symptom of pain in MS is more common than was previously noted. Studies have shown 45% to 65% of MS patients will experience some form of chronic pain. Pain in MS can be the cause of direct damage to central nervous system (CNS) pathways, the impact of MS on physical function or disorders not related to MS.

Nerve related pain or neuropathic pain is caused by damage to the CNS pathways that carry sensory information. Neuropathic pain is often described as deep aching, throbbing, burning, cold, crawling or tight sensation. Musculoskeletal pain that arises from the impact of MS may be caused from muscle weakness, spasticity or poor posture. As well, those with MS can also experience pain syndromes that are unrelated to the disease. Disorders such as migraine, degenerative disc disease, rheumatoid arthritis or traumatic injuries from sports or motor vehicle accidents can happen to anyone.

The challenge becomes trying to determine the cause of pain as this will be important in prescribing helpful treatments. More than one pain syndrome can exist or even mimic other syndromes. As well, pain can worsen or be aggravated by other MS symptoms such as fatigue, depression and anxiety. Depression and anxiety are frequently experienced by those with MS. Certainly these symptoms can be greater in patients with pain. It is difficult to determine the causal relationship between these disorders. Studies demonstrate that pain is more difficult to manage in persons with major depression and anxiety. Lastly, previous pain experiences and coping behaviours will influence how well one presently manages their pain.

The goal of pain management is not necessarily complete pain relief but improved ability to function day to day. Medications used to treat MS pain may have limited benefit and can cause unpleasant side effects. Thus various strategies should be employed. Physiotherapists can provide instruction on proper posture, strengthening and stretching to ease muscle strain and reduce injury. Regular exercise benefits not only ones physical health but can improve energy, quality of sleep and reduce pain perception. Occupational therapists can help with proper seating, reduced muscle strain and energy conservation. Psychological and behavioral therapies can address mood disorders caused by excessive worry and ineffective coping. Unfortunately we will be exposed to stressful events throughout our lives. However ignoring the problem in hopes it will go away often leads to increased stress and worry. Learning adaptive problem-solving skills and cognitive restructuring to recognize negative thoughts and behaviours will help one to focus on positive thoughts and strategies. In addition, relaxation techniques such as progressive muscle relaxation, controlled breathing and imagery have proven to reduce anxiety and pain.

Medications used to treat MS pain will be dependent upon the underlying cause. Antidepressants, mostly tricyclic antidepressants such as amitriptyline are commonly used. If depression is a contributing factor, the addition of venalafaxine (Effexor®) has been recognized to help treat not only depression and anxiety but appears to enhance the effect of other pain management therapies. Anti-epileptics such as carbamazepine and gabapentin are also frequently used. Recently Pregabilin (Lyrica® similar to gabapentin) has been found to reduce CNS neuropathic pain in persons with spinal cord injury and is now included in treatment of MS pain. Botulinum toxin injections are being used more often to treat focal pain syndromes caused by spasticity or tonic muscle spasms. There is some support for the use of oral and buccal spray cannabinoids in managing both MS neuropathic pain and spasticity. In general, it is a process of trial and error to determine which medications will be most beneficial and least harmful. The fact that pain in MS can have multiple causes may require a combination of different types of medications.

The management of pain experienced by those with MS can be challenging. However, the ability to determine the cause or causes of the symptom, set realistic treatment goals and utilize various strategies will most likely have greater success in reducing ones pain and improved daily functioning.

Lynn McEwan
Advanced Practice Nurse

ROLE OF PHYSICAL THERAPY IN PAIN MANAGEMENT

"In a national survey of more than 7,000 MS patients, 70% of them had experienced some kind of pain, and at least 50% were experiencing some kind of pain at the time of the survey," says Dr. Francois Bethoux, MD, director of rehabilitation services at the Mellen Center for Multiple Sclerosis Treatment and Research at The Cleveland Clinic. (WebMD). However pain is not considered a typical symptom of multiple sclerosis. Several factors can cause pain. Musculoskeletal injury can be a source of pain in MS. If there is an imbalance of strength, people will most often use strong muscles to compensate for the weak muscles. Over a period of time this can cause damage to the weak muscles or the joints. Such imbalance can cause abnormalities of gait and posture leading to back pain.

Spasticity is present in most patients with MS and can cause pain and inability to walk. By definition spasticity implies a prolonged state of increased tone and stiffness. Often the severity of spasticity increases as the disease progresses. Initially increased tone may manifest as extensor spasms. These are particularly likely to occur at night or on waking in the morning. Prolonged stiffness causes joint stiffness, muscle contractures etc. This can be a source of secondary pain. However not all pain is due to musculoskeletal injury. Injury to the nerve pathways within the central nervous system including brain and spinal cord can cause neuropathic pain. Neuropathic pain is usually constant and is not affected by activity or posture. Injury or involvement of the sensory nerve endings can be felt/noticed as tingling, burning, or other unusual skin sensations. Neuropathic pain can also present as severe aching or burning sensation or sharp stabbing pain. Walking bear-feet occasionally relieves this pain according to a few patients. This changes the weight-bearing distribution of the feet leading to musculoskeletal pain. Wearing a pressure stocking or glove, can convert the sensation of pain to one of pressure. Warm compresses to the skin, may convert the sensation of pain to one of warmth.

It is important to note that such pain can negatively impact the physical functioning in some patients mainly mobility. Sleep, emotions and social role playing can be affected. This ascertains the importance of adequate control of pain to achieve enhanced quality of life.

It is important to work with your doctor and physical therapist to identify the cause of pain. Musculoskeletal pain will usually respond to heat or cold. Strength training exercises will help to correct the muscle imbalance to a certain degree. Rehabilitation goals include assessment of adaptive equipment to minimize muscle imbalances and reduce the load on the weak muscles. Joint range of motion and stretching exercises benefit to maintain flexibility and reduce the deleterious effects of spasticity. Chronic neuropathic pain may respond to Transcutaneous electrical nerve stimulation (TENS).

Anu Sawant,
Physiotherapist

STAYING INVOLVED

People living with a neurological illness may find themselves participating less in activities that require going out of the house due to fatigue, weakness or concerns that "it will be too much". This may result in feelings of being housebound, loss of contact with friends or having to give up activities that were meaningful and enjoyable. With a bit of planning and some adjustments, this loss of mobility can be minimized.

Plan ahead:

Keep a large calendar somewhere where it is easily visible and make sure to record important events, appointments and things that you want to enjoy.

Try to space these occasions out throughout the week or month and plan lighter activities for the days before and after. If the event involves preparation (shopping or cleaning or travel for example) make sure to factor these activities into the overall plan.

Preparing ahead of time reduces stress on the actual day of the event and can spread the anticipation and enjoyment out so you are looking forward to the occasion rather than dreading it.

Don't hesitate to ask others to join in on the preparation. That way everyone gets to enjoy it. Don't forget to leave some room in your schedule for spontaneity or to deal with other things that can pop up unexpectedly and need to be dealt with. Avoid rush hour and peak times when planning outings. This will reduce the frustration experienced and the amount of time required. It can also make it easier for those people using mobility devices or who are worried about their balance.

Get the facts:

Many people limit their activities because they are uncertain whether a particular destination or event will be accessible to them. Rather than missing out all together, try to find out as much as you can about the particular venue before making your decision.

Accessible means different things to different people. Some hotels, restaurants etc. may meet the minimum standards for accessibility but may not meet your particular needs. Call ahead and ask specific questions if you have concerns.

The internet provides access to valuable information. Check out www.accesstotravel.gc.ca for information about Canadian destinations. Other links with valuable information include www.access-able.com , www.sath.org (click on Travel Tips and Access Information on the sidebar for information about specific airlines) and www.enablelink.org/agc/index.php . The Canadian government provides information for travelers with a disability or medical condition at http://www.voyage.gc.ca/main/before/faq/disabled_persons-en.asp.

Staying involved and active may mean modifying how or where you do activities. An occupational therapist (OT) can help with suggestions for modifications or tools that can allow you to continue to participate in the activities that are important to you. If you aren't already working with an OT you can contact one through the MS Clinic or your local CCAC.

You are the expert in knowing what will work for you so be sure to speak up. Friends and family members may initially hesitate to involve you in some activities because of uncertainty or concern about overtiring you or putting you in an "awkward" situation. You may need to take the lead in making suggestions or letting them know that you'd like to participate and any specific needs you might have.

Remember, a sense of humour can go a long way in educating others and helping them feel at ease. Although it may not always be easy, trying to find the funny side of situations can turn an unpleasant situation into an adventure to remember. Staying active and involved can contribute greatly to your health and your sense of well-being. If you have questions or concerns, be sure to talk to your Occupational Therapist.

Betty Dietrich
Occupational Therapist

CLINIC NOTES

- ✓ When you receive a questionnaire notifying you of an upcoming appointment, please complete it and return it to us promptly. This allows us to plan your visit. Additional appointments with team members may then be booked around your clinic appointment.
- ✓ **Please call to confirm your appointment and your attendance at least two weeks prior to your appointment date.** *Failure to do this will result in cancellation of your appointment.*
- ✓ Please allow yourself enough time for travel, parking and to report to Patient Registration at each visit.
- ✓ Please bring your Ontario Health Card and your hospital blue card to each visit.
- ✓ If you are traveling by ambulance you will need to be accompanied by a relative or health care professional.
- ✓ We require at least 48 hours notice of appointment cancellations.
- ✓ For prescription renewals, please ask your pharmacist to fax a request to 519 663-3744. Please allow 48 hours for prescription renewals.
- ✓ Please keep us informed of any changes to your personal information (address, telephone number, family physician, health card number, etc.)
- ✓ Since clinic time is limited please prepare for your clinical appointment by bringing a list of your current medications and any specific MS related questions or concerns your wish to address
- ✓ If you wish to be seen in the clinic and have not received an appointment within one year of your last appointment please contact your family physician to have him/her fax a referral as to why you need to be seen.
- ✓ Currently, we have clinic days on Tuesday and Thursday

THE MS CLINIC WHO'S WHO:

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Neurologist
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Liz Jackson

Senior Lab Technologist
Holly Armstrong

Lab Technician
Bev Scott

Site Coordinator CCPGSMS
Pamela Schoffer

We hope you enjoyed the newsletter.

To help us plan for next year please fill out the evaluation sheet.

To view it go to:
http://appserver.lhsc.on.ca/survey/_includes/index.php?loc=msnews