Multiple Sclerosis

The GP's Perspective

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The GP's role

Hmmm.....

Depending on your point of view, it may be:

How they see what we do

- Emergency service
- Counsellor
- Social service
- Information provider for insurer
- Lazy overpaid fat cat (Daily Mail readers only)
- Referrer of heartsinks (NHS)
- Referrer of charming eccentrics (private)

How we see what we do

- Diagnosis
- Filter
  - Disease from non disease
  - Trivial from serious
- Long term holistic management and care
- Management of the patient as well as the disease

How we differ....

Generalist

- Sees all patients
- Has a broad knowledge of all specialities
- Sees unselected patients
- Has limited access to investigations

Specialist

- Sees patients within their own specialty
- Has an in depth knowledge of their subject
- Sees patients referred to them
- Has access to more investigations

How we differ....

Generalist

- In general, sees patients and their families over the long term
- Sees the same patients for many different conditions
- DOES NOT have a provisional diagnosis before the patient enters

Specialist

- In general, sees patients for relatively brief periods
- Sees patients for a narrow range of conditions
- Has been offered a provisional diagnosis by the GP

Case 1: Mrs LD
History

- Female, 23, previous TOP nil else
- 1 month – altered sensation in different regions. Currently LEFT arm and perineum
- Has been stumbling
- Bowels and bladder normal
- Vision normal
- Higher function normal

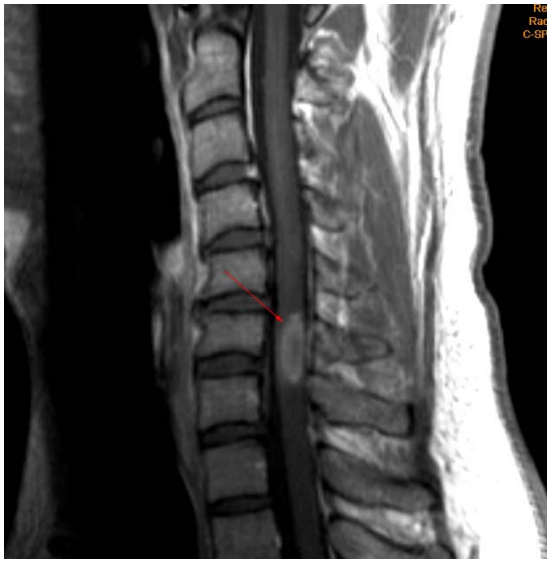
Case 1: Mrs LD
Examination

- Cranial nerves and cerebellum normal
- LEFT C6, C7, T7 and RIGHT S4 sensory change
- LEFT L1 and L2 muscular weakness

Provisional Diagnosis: Demyelination

Case 1: Mrs LD
Consultant's findings

- Progression of symptoms with RIGHT optic neuritis and transverse myelitis
- VEPs: delayed RIGHT eye response
- CSF: oligoclonal band
- MRI: plaques seen in spinal cord



Diagnosis Confirmed: Multiple Sclerosis

Case 1: Mrs LD
Progress

Generalist

- Incidental vitamin B12 deficiency treated
- Development of severe cystic acne:
  - Initial GP treatment unsuccessful
  - Referred to dermatology for oral retinoids
- Discussion re pregnancy and associated risks
- 51 appointments

Specialist

- Initial treatment with methylprednisolone
- Progression of symptoms: Copaxone started
- Progression of symptoms: changed to Avonex
- Clinical improvement
- 30 appointments

Cae 2: Mrs KA
History

- Female, 45, nurse. Husband consultant physician
- PMH: 1 x ectopic , 2 x pulmonary embolus, polycystic ovaries, hypothyroidism

Jan 2011

- Dysaesthesia RIGHT hand
- Weak triceps reflex
- Referred and investigated
- MRI non-contributory

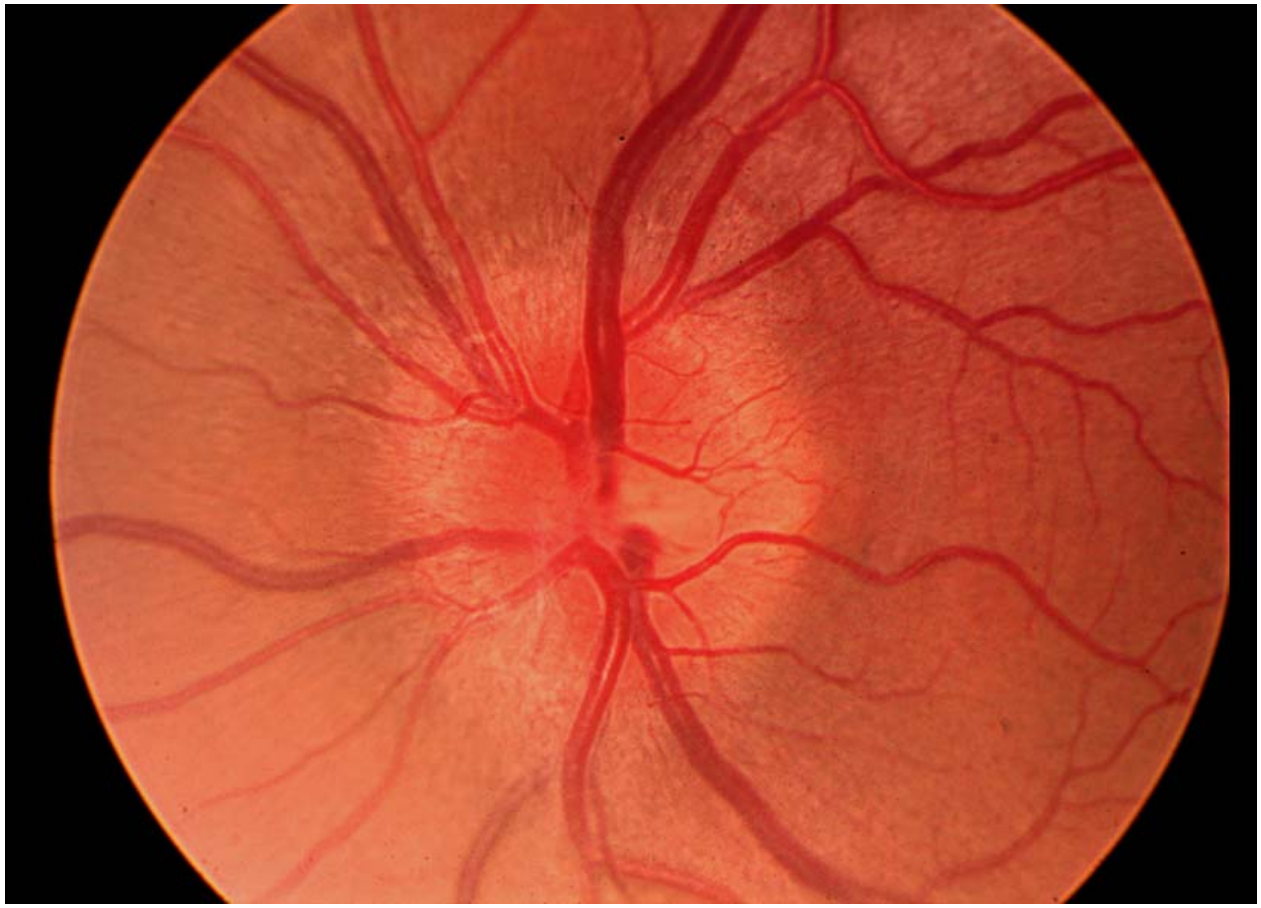
Nov 2011

- Acute transient unilateral visual loss
- Investigated: no evidence of a vascular event
- Ophthalmologist quoted as saying “optic neuritis” but no supporting letter

Aug 2012

- Dysaesthesia LEFT lower leg
- Pain RIGHT arm
- Responded to amitriptyline prescribed by another partner
- Falls x 2

Optic Neuritis



Case 2: Mrs KA
Examination

- Reduced sensation to pinprick LEFT L3 & L4
- Brisk RIGHT ankle reflex, depressed LEFT ankle reflex
- Referred

Case 2: Mrs KA
Consultant's findings

- MRI: normal
- Nerve conduction: normal
- VEPs: normal

Diagnosis: GOK
Action: Discharge to GP

Case 2: Mrs KA
Progress

Generalist

- Seen regarding thyroid status and adoption proceedings
- 4 appointments since referral

Specialist

- Not seen since

Case 3: Mrs VW
History

- Female, 47
- Episodic mild/moderate anxiety, mild hypochondriasis

Jan 2005

- Bilateral leg weakness
- Brisk reflexes
- MRI: transverse myelitis

May 2009

- Easy fatigability in right lower leg and foot
- Slight clumsiness
- Examination normal

June 2009

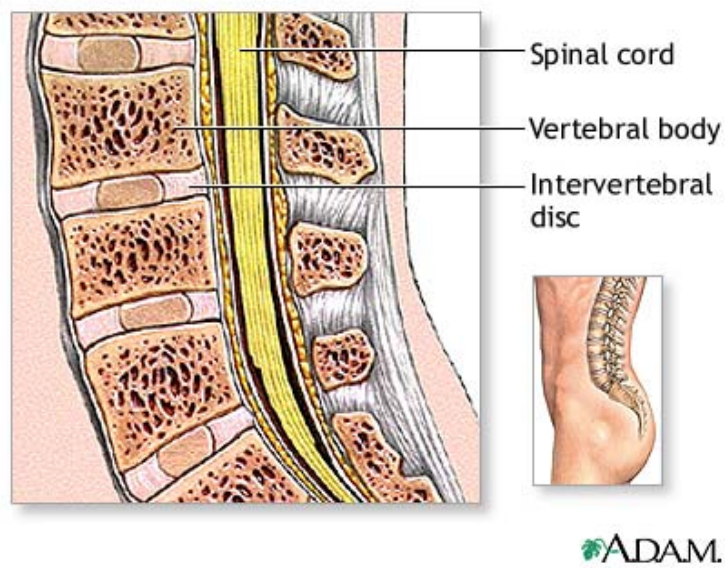
- Marked weakness
- Difficulty getting up from chair

Case 3: Mrs VW
Examination

- RIGHT hip adduction and abduction weak
- RIGHT ankle reflex spastic
- Referred

Case 3: Mrs VW
Consultant's findings

- MRI: cervical and lumbar demyelination
- Good response to iv methylprednisolone
- Further treatment declined



Case 3: Mrs VW

Generalist

- No progression
- 34 appointments since 2009
- Multiple vague symptoms
- Benign breast cyst
- Eczema
- Persuading patient that she should not follow homeopath advice to get fillings removed because of “mercury toxicity”

Specialist

- No progression
- 4 further appointments since 2009

Summary

- The roles of GP and specialist are different but complementary
- Big things start small
- The diagnosis of multiple sclerosis is rarely clear at the first attendance
- Holistic care of the patient is more than management of the disease
- Specialists and GPs together usually get the best outcome for the patient

somewhat different

Thank you

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