MS CLINIC NEWSLETTER

London Health Sciences Centre - University Hospital

www.lhsc.on.ca/programs/msclinic Winter 2007

In this issue...

New Treatments Under Investigation at the MS Clinic

The TERIFLUNOMIDE Study

This is a drug with immunomodulatory effects (an agent that may modulate T cells, which drive the immune attack in MS) which has shown some promise 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. Even better news for patients is that this treatment is administered in the form of a pill. Drug side effects appeared to be tolerable.

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.

The BEYOND Study

When we treat patients with interferons or glatiramer acetate, we generally use the same dose, regardless of the patient's size.

There has been some enthusiasm to push the dosage of interferons, in this case Betaseron®, to a much higher level. A large study has been launched to identify whether double dose Betaseron® is more beneficial compared to the single-dose, commonly-used preparation. These

results will be compared to a third group of patients treated with glatiramer acetate.

We expect these results in the next two years.

The BENEFIT Study

It has been hoped that interferon treatment of multiple sclerosis, after the very first attack, might confer a better treatment advantage, compared to initiation of treatment in the later, active phase of the disease. We have completed a study in which patients, seen after their very first attack, were treated with either Betaseron®, in conventional doses, or placebo. For the conversion to clinically definite MS, treatment with Betaseron®, reduced the risk to reach clinically diagnosed multiple sclerosis by 50% over the two study years. Overall 45% of placebo patients developed clinically diagnosed multiple sclerosis compared to 28% in the Betaseron® treated patients. Therefore, the first event suggestive of MS has to be taken seriously.

The CHOICE Study

Immunomodulatory therapies including corticosteroids, interferon-beta, Copaxone® and mitoxantrone are currently available but are only partially effective in managing clinical relapses and accumulation of disability. Daclizumab (Zenapax®) is a genetically engineered humanized monoclonal antibody. This drug provides partial immunosuppression by reducing pathological T lymphocyte responses like those seen in diseases such as MS.

Results from two open-label studies of daclizumab in patients with relapsing forms of MS, with partial or failed response to interferon-beta therapy, showed a reduction in the number of new brain MRI lesions and the drug was well tolerated. Daclizumab shows promise to patients only partially responsive to interferon-beta therapy and the addition of daclizumab shows promise as a therapeutic treatment.

FREEDOMS (FTY720 Research Evaluating Effects of Daily Oral therapy in MS) Study

This study is a Phase III study scheduled to start enrollment in January 2007 as an oral treatment for relapse remitting multiple sclerosis.

The study is designed to provide the effectiveness, safety and tolerability data of this oral treatment. There are two different doses of study drug compared to a placebo. The oral capsule is taken once a day. The study will run approximately two years.

The study drug is an orally active synthetic small molecule. It functions as a “super agonist” within the autoimmune process. It acts on certain types of white blood cells responsible for immune reaction (lymphocytes). It makes these cells move away from sites of inflammation and redirects them to other places in the body where they rest. These cells are also believed to play an important role in the inflammation process associated with MS.

The BIO MS (MBP8298) Study

This is a new Phase II/III study that started in November 2006 for the treatment of secondary progressive MS.

In this two-year study, the drug MBP8298 will be injected into the blood via intravenous push. The treatment is once every six months. A total of four doses will be given.

MBP8298 is a small protein called a peptide that is a part of a much larger protein called myelin. Myelin is found in large quantities in the brain of all people. There is evidence to suggest that MBP8298 may significantly delay the further

worsening of disability in patients with secondary progressive MS (SPMS).

MBP8298 has been given to patients with MS and has been well tolerated. The adverse events that could be related to MBP8298 administration include facial flushing, blood pressure effects and burning sensation at the injection site that occurred during or immediately after MBP8298 was injected.

Jane Lesaux
Anne Howley
Ineke Lazar
Clinical Research Coordinators

Health Canada Grants Approval Of Tysabri™ (Natalizumab)

Following a priority review process, on 4 October 2006 Health Canada has granted approval to natalizumab (formerly Antegren, now Tysabri™) for the treatment of very active forms of relapsing MS. This drug is the first in a new therapeutic class called selective adhesion molecule inhibitors and has been shown to reduce relapse rates as well as disability progression, as reported in two two-year, randomized, multi-centre, double-blind studies published in 2006 (a placebo-controlled trial called AFFIRM in which London patients participated, and an add-on trial called SENTINEL done elsewhere). This approval represents an important step forward for Canadians living with this disease, as it is really good news to have another approved treatment option for Canadians with relapsing-remitting MS.

This new treatment administered by IV once every four weeks was voluntarily suspended from the US market and trials in 2005 when three study participants were diagnosed with a rare, often deadly, brain infection called progressive multifocal leukoencephalopathy (PML). After a comprehensive worldwide independent safety evaluation of more than 3,000 treated patients was completed, there were no new cases of PML; this safety evaluation was published in the March 2006 issue of the *New England Journal of Medicine.* A deep and clear understanding of the benefit-risk profile of this drug is an important step towards bringing this medicine to Canadians living with MS. Any treatment decision should be carefully evaluated by patients and their physicians. The drug works by preventing the body's affected immune cells from migrating into the brain where they can damage nerve fibers and their insulation, and should only be used as monotherapy (i.e. only one drug at a time). It is generally recommended for patients with very active forms of the relapsing type of MS with inadequate response to, or unable to tolerate other therapies.

Treated patients will be enrolled in a registry, a comprehensive program that will support the safe and effective use of this drug by ensuring that physicians and infusion centres are able to prescribe or infuse the product on an ongoing basis. This will optimize treatment through improved compliance, education and rigorous on-going surveillance.

AFFIRM and SENTINEL: clinical trials results in a glance
AFFIRM is a two-year, randomized, multi-center, placebo-controlled, double-blind study of 942 patients conducted in 99 sites worldwide (101 MS patients from ten Canadian sites including London, ON), evaluating relapse rates and the progression of disability. Participants were randomized to receive either the drug (627 patients) or placebo (315 patients).

SENTINEL is a two-year, randomized, multi-center, double-blind study in 123 sites outside Canada involving 1,171 patients who continued to experience disease activity despite treatment

with Avonex®. They were randomized to add Tysabri (589 patients) or placebo (582 patients) to their standard regimen.

The two-year adverse event profile in these trials was consistent with previously reported results. Common events included headache, fatigue, urinary or lower respiratory tract infection, depression, joint pain. The rate and incidence of infections in treated patients were similar to placebo. Serious infections occurred in 3.2 percent patients treated and 2.6 percent placebo. Two cases of PML were observed in 1,869 MS patients who were treated with Tysabri for over an 18-month period; the third case occurred among 1,043 Crohn's patients. Remarkably, PML only happened to patients who were concomitantly treated with interferon or were immunocompromised (i.e. due to treatment with immunosuppressants such as azathioprine). Other side effects (hypersensitivity reactions, including serious systemic reactions) occurred at an incidence of less than 1 percent of patients.

Dr. Marcelo Kremenchutzky
Neurologist

From the Research Bench

The Canadian Collaborative Project on Genetic Susceptibility in Multiple Sclerosis (CCPGSMS) Study continues to contact patients to seek their ongoing participation and active involvement in this groundbreaking initiative. The Study, a cross country project involving 15 MS Clinics, their patients and the patients family members, has a primary goal to look at the possible genetic and non-genetic factors that play a potential role in the development of multiple sclerosis.

The possible genetic factors of the Study are determined through the evaluation and testing of patient blood samples and in cases in which more than one individual in a family are affected by multiple sclerosis, the evaluation and testing of blood samples from the patient's other family members. Specific criteria related to the genetic requirements of the Study are provided in detail to the patient once participation is confirmed.

The non-genetic portion of the Study is comprised of a series of questionnaires regarding the patient's general health, family history, geographic location and other influential environmental factors.

At this time, 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 would also like to 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

Information Needs Research

Thank you to the seventy-five clinic patients and fifty-one family members/friends who participated in the clinic's research project on the information needs of people recently diagnosed (within the previous two years) with MS and of family members/friends of people recently

diagnosed with MS. Our study was driven by three questions:

1. What are the information needs of newly diagnosed MS patients and families/friends?
2. According to newly diagnosed MS patients and families/friends who would benefit from receiving information at diagnosis?
3. What method(s) of information delivery would best meet the needs of newly diagnosed MS patients and families/friends?

Respondents were asked to:

1. Identify the symptoms they experienced at diagnosis.
2. Rate the impact of these symptoms.
3. Rank the top five topics of information they required at diagnosis.
4. Identify who should receive information at diagnosis.
5. Rank their top five methods of receiving information.

Information categories were ranked by the people who completed the questionnaires. These categories were:

1. General information about MS (cause, types)
2. Treatment/Management of MS (drug therapies)
3. Symptoms of MS (fatigue, pain)
4. Psychosocial Issues (effect on family, employment)
5. Wellness (exercise, complementary/alternative treatments)

The information need ranked consistently high by both people with MS and families/friends was information on Psychosocial Issues. The information need ranked low by people with MS and families/friends was information on Wellness.

People with MS and families/friends identified family members as in need of information at time of diagnosis, Close to half of the respondents also indicated that friends and the employer should receive information at diagnosis.

Published materials were ranked as the number one and number two method of information delivery that best met the information needs of recently diagnosed patients and families/friends. People also ranked the interpersonal approach to information sharing high.

The results of our clinic study replicated results found by Wollin et al. in an Australian study of information needs of newly diagnosed patients in 2000. We presented our study in a poster at the Annual Meeting of the Consortium of MS Centres in Phoenix this past June.

It has been said that research does not mean anything unless it informs practice. These results have validated our current approach to information sharing with the recently diagnosed patient/family/friends. Currently we offer a package of published materials, a one to one education session at diagnosis, as well as, an annual education day for people recently diagnosed with MS. We do need to review our package as to how it addresses information needs in respect to psychosocial issues. Although some information on these issues is present in our recently diagnosed education resources we do need to seek out other sources of information that could be of benefit to our patients and their families/friends.

Research on one topic often takes you in an even more interesting direction and that has happened for us here at the clinic. Our clinic has established a multidisciplinary committee that now is looking at education resources for all our patients. Once again thank you to those who

took the time to help us begin this journey by completing the questionnaires.

Cathy-Lee Benbow
Coordinator/Social Worker

Managing Progressive MS

Progressive MS could be defined as a gradual worsening of neurological deficit for at least one year in the absence of clinical exacerbations. There are some patients who have a progressive course from onset, primary progressive MS (PPMS) or who develop secondary progressive MS (SPMS) after years of having relapsing remitting MS (RRMS). It is independent of relapses and it may take many months to appreciate if someone is slowly progressing or having a long smoldering attack. Generally progressive MS could remain stable but does not get better, like attacks do.

Unfortunately there is no proven therapy to slow the progression. Therefore the treatment goal of Progressive Multiple Sclerosis should be directed towards management of problematic symptoms and improvement of quality of life. The common belief ***" since there is no cure for progressive MS, there's nothing that can be done for me"*** is totally misleading and should be eradicated from both patients and physicians's vocabulary.

The ideal symptomatic management should:

-Encourage self-management and provide the patient with a sense of control over their disease.
-Be tailored to meet individual needs.
-Be closely monitored and include periodic reassessment.
-Be aimed to maximize patient's comfort, maintain function and prevent unnecessary complications if possible and in spite of any progression.

There are different strategies for management:

Rehabilitation: the input and expertise from disciplines such as physiotherapists, occupational therapists, speech and language pathologists, neuropsychologists, urologists is crucial in treating MS symptoms. It should be flexible to respond to the changing pattern of need and not be restricted to significantly disabled patients.

Wellness interventions: such as a well balanced diet and proper hydration, regular physical activity and stress management strategies contribute in a fundamental way to general health and wellbeing.

Psychosocial support: education about the disease and counselling to promote effective coping strategies, problem solving and personal or familial readjustment are very important tools too. Emotional and spiritual health practices should be encouraged to try to reduce stress and increase self-esteem.

Drug therapy: there are many medications that are useful in the management of the most frequent MS symptoms like fatigue, bladder dysfunction, spasticity, pain, etc. The impact of these in everyday life and the association of other medical problems should be carefully assessed and treated accordingly.

There is no scientifically proven specific treatment targeted to slow the progression of MS. There are some drugs being used but without enough evidence to support their use and with severe side effects. There are some trials being conducted at the present time that hopefully will bring more light about progressive disease.

Positive attitude and sense of humour : They may be the most important strategies, not only for MS patients but for anyone, healthy or sick. Enjoying small things everyday will in the long term fill our lives with good energy and not with sorrow.

Try this site: www.shof.msrcsites.co.uk

Dr. M. Rush
Clinical Fellow in Neurology

Another Common MS Symptom: Spasticity

What is spasticity?

Spasticity is a common symptom of MS, occurring in about 40 to 60% of patients. Spasticity is defined as increased resistance to passive movement of muscles. The amount of resistance is related to the speed of movement. If passive movement is slow then resistance may not be felt, but if movement is rapid then resistance can occur. This is why you can experience increased spasticity with movement such as rising from a chair or changing position. Spastic muscles have an elastic or spring-like quality that is abruptly terminated when they are stretched beyond a certain point. The degree of spasticity can be as subtle as a brisk reflex to severe rigidity of a joint or limb. Spasticity can restrict limb movement, interfere with walking, cause pain and disrupt one's sleep. Conversely, spasticity can benefit function by maintaining ability to stand and walk.

Why does this happen?

Our muscles require a certain degree of tone to maintain an upright posture and perform movement. The motor pathways of the central nervous system control muscle strength and tone. Coordinated muscle movement is somewhat of a Ying and Yang phenomenon. As one muscle contracts the opposing muscle must relax. This balance between contraction and relaxation is controlled by excitatory and inhibitory influences on the motor pathway. Damage to motor pathways can result in exaggerated muscle tone or spasticity due to loss of inhibition of excitatory influences, disrupting muscle relaxation.

Multiple Sclerosis lesions can occur anywhere along the motor pathway from the motor cortex, brainstem or spinal cord. Individuals who experience weakness of a limb or limbs are most likely to have symptoms of spasticity. There are also several factors that can increase spasticity. Sensory fibers provide feedback to regulate the amount of stimulation to muscles. Therefore, problems such as urinary tract infection, distended bladder from urinary retention or distended bowel due to constipation, tight fitting clothing/shoes, a fever, cold temperature, skin sores, pain or arthritic joints can contribute to worsening of spasticity. Even patients on Beta-interferons can experience increased spasticity with flu-like symptoms or injection site reactions.

How do you evaluate spasticity?

Before determining how to best manage spasticity, one first needs to assess the severity, functional impact and any factors that may exacerbate the symptom.

Symptom severity can be the level of pain associated with spasticity, frequency of spasms and the degree of stiffness. There is an assessment tool called the Ashworth Scale that practitioners use to measure spasticity. You may recall during one of your assessments the practitioner or physiotherapist shaking your leg or quickly bending and straightening your hip, knee and ankle. There is actually a purpose to this strange behaviour, in that we are trying to determine the degree of limb stiffness or rigidity.

Next we need to determine how spasticity is impacting on your function. Does it impair your ability to walk, stand, turn over in bed or transfer out of a chair? Then we need to identify how

much you rely on your spasticity or increased tone to carry out these activities. As some of you may already have experienced, when we treated your spasticity we may have inadvertently caused more weakness.

Lastly, it is important to recognize any other MS-related symptoms or factors that can exacerbate spasticity. This is important when there is a sudden worsening of spacticity. Often just eliminating or treating contributing factors such as a urinary tract infection or constipation, spasticity will improve.

How is spasticity managed?

Management of spasticity can range from physical measures to medications and in more severe cases surgery.

Physical measures consist of maintaining good posture to reduce muscle strain and contractures. Technical devices of orthotics or braces help to support weak limbs and reduce muscle strain. Ensuring proper seating with appropriate footrest height to maintain flexed hip, knee and ankle is important. Stretching and range of motion exercises are probably the most important interventions in managing spasticity. These exercises can be taught to you or someone who assists with your care. The key is maintaining a regular routine, often more than once a day. The application of heat to the affected area prior to stretching may help reduce the degree of resistance. Yoga has also been found to be beneficial as it incorporates breathing exercises and relaxation with stretching.

When physical measures are not enough then medications can be added, especially for those who experience painful spasms. The most effective medication is baclofen, thought to suppress excitatory transmission. Other oral medications include Tizanidine, diazepam, gabapentin and dantrolene. The key to these medications is dosing. It is important to start on a low dose and very gradually increase to allow for drug tolerance and to achieve a dose that will be beneficial. It may take a few attempts to find the right medication or combination of medications and therapeutic dose. For spasticity in specific muscles, injection of botulinum toxin can provide temporary relief for 8 to 12 weeks.

In cases of severe leg spasticity, surgical intervention with implantation of an intrathecal pump can be used to deliver baclofen directly to the thecal space around the spinal cord. The advantage of this treatment is the ability to provide higher doses of baclofen without the sedating side effects. This procedure is generally used in individuals who are no longer walking or need to rely on leg stiffness to transfer, as it is difficult to find the balance between treating the spasticity and maintaining ability to bear weight.

Spasticity is a common symptom of MS and like other common symptoms the exact cause is not fully understood. However, we do know what can make it worse and the importance of eliminating those factors. As well, the use of physical measures help to maintain proper posture and reduce muscle strain and spasticity. Medications can be beneficial but one needs to find the right treatment and dose that will work for them.

As with many MS treatments, it is finding the right therapy for that individual based on one's defined goals.

Lynn McEwan
NP/CNS

(Editors Note: **The following article is reprinted from our 2000 newsletter. Cindy Gutierrez our MS Clinic physiotherapist left us in December to pursue an exciting adventure in the north. On her way out the door, literally, she commented on how she should have written something for the**

newsletter! She then recalled that this article had appeared to be very beneficial to patients based on the feedback she received..and it does follow nicely with the previous article on spasticity! Thanks Cindy! We will miss you!)

Loosen Up Through Physiotherapy

Spasticity ranges in severity from very mild to severe. Some people only experience slight muscle stiffness during physical activity or rare nighttime spasms whereas others may have permanent muscle stiffness causing immobility and pain. In either case, physiotherapy can be helpful. Spasticity can have several detrimental effects. It can lead to permanent shortening of the affected muscles and to deformities. Spasticity can make activities such as walking, sitting in a wheelchair or moving around in bed very difficult. Spasms can also be quite painful for some people.

Stretching is the fundamental physiotherapy treatment for spasticity. It is the most common treatment that I prescribe. Everyone (yes that means you too!) should stretch their muscles regularly. The earlier you start, the better. Regular, prolonged stretches of affected muscles (most often the legs and torso) can help to maintain the length of the muscles, maintain range of motion in affected joints and relieve the stiffness so often complained of by patients with muscle spasticity. In addition, walking is less tiring and easier if the legs are stretched out. Stretching should be done once to twice daily, holding the stretch for a minimum of 10 seconds. Some studies have shown that very long stretches (i.e. held for up to 10 minutes or more) are more effective in MS. Stretching can be done alone or in combination with antispasticity medications such as Baclofen. Some people will be able to perform their stretches on their own, while others may need another person to help. Typical muscle groups that need stretching are the calf muscles, back thigh muscles, inner thigh muscles, front thigh muscle and trunk. Lying on your stomach for a few minutes each day will stretch the muscles on the front of the legs. Some patients will also benefit from arm stretches. Stretching is even more important for those who are less mobile, and must be done daily to prevent deformities.

For information regarding specific stretches that would be beneficial for you as an individual to do, consult a physiotherapist. Aside from stretching, there are many other physiotherapy treatments which may help to control spasticity in certain patients. These include the application of cold (in the form of ice packs) to the affected muscles, electrical stimulation, biofeedback and vibration. Proper positioning is another important technique for improving a patient's comfort and decreasing spasticity. It is also often beneficial to do strengthening exercises as spasticity can lead to reduced strength in the affected muscle and surrounding ones. Sometimes orthotics, such as foot-drop splints, or casts are used to keep a limb in the appropriate position and control spasticity.

There are several suggestions which may help you to deal with spasticity on a day-today basis. Having another person passively and rhythmically move the affected limb can be helpful in maintaining range of motion. The movement should be smooth. Never try to force through a spasm as fighting spasticity increases it. It is also helpful to avoid quick or abrupt movements, which may bring on spasms.

Certain positions can make spasticity worse, such as lying on your back with legs straight, and should be avoided. There are many other suggestions which may be helpful for controlling spasticity during activities such as sitting, getting in and out of bed or a chair, side-lying and moving around in bed. For example, when

transferring a very stiff person from a chair, it often helps to bend the trunk forward at the hips first or to prepare the person for the transfer by doing some rhythmical trunk rotations before standing up.

Unfortunately, I am unable to go into all of the techniques in this article. For more information, consult a physiotherapist. Physiotherapy offers a wide variety of techniques which can be used alone or in combination with drug treatment to reduce spasticity and prevent secondary effects. At a very minimum, everyone should be stretching their legs daily.

Cindy Gutierrez
Physiotherapist

The London Health Science Centre MS Clinic and the MS Society of Canada, Ontario Division

Partners in the Fight Against MS

For approximately two decades, the MS Society of Canada, Ontario Division has provided funding to numerous clinics across the province to support the important care that the clinics provide to our clients and their families who live with MS. The funding arrangement in Ontario is particularly significant as Ontario's commitment to clinic funding represents 70% of the total clinic funding across the country. This has always been an area of spending that the MS Society is proud of and we know these dollars are well spent in support of our clients and the services they receive in return.

For years there were five clinics that received funding from the MS Society: London, Hamilton, Toronto, Kingston and Ottawa. In recent years two additional clinics have received funding as well: the Elkie Adler MS Clinic at Sunnybrook Hospital in Toronto and the Pediatric MS Clinic at Toronto's Sick Kids Hospital.

Understandably, there has always been concern from these clinics about the sustainability of clinic funding from the MS Society, which is not surprising as hospitals continue to struggle with limited resources from government funding. This is also a significant concern for the MS Society. The Society does not receive direct funding from the government and is almost entirely self-funded. We know first hand that clients who have been directly affected by government cutbacks to home care, for example, look to the MS Society for additional support.

The MS Society has been very successful in annually increasing our fundraising dollars. That said, it is more and more challenging to increase revenue with increased competition for charitable dollars. We have great faith in the mission of the MS Society and the tremendous support that our loyal event participants and donors provide to the MS Society to continue to support and expand the services we offer to our clients and their families living with MS.

The mission of the MS Society is to be a leader in finding a cure for multiple sclerosis and enabling people affected by MS to enhance their quality of life. The clinics are a vital component of that mission. We couldn't conduct collaborative research and we couldn't enhance the quality of life of our clients to the extent we do without the vital partnership that exists with our clinic network.

In 2007, we enter an exciting new era of partnership with all the clinics in Ontario. As we have been able to increase our commitment to research in recent years, we are now looking for opportunities to provide additional resources to

all areas of support for our clients, including our financial support of the clinics.

Prior to 2007 the amount of funding available to all of the clinics had been frozen for a number of years as we balanced spending on both sides of our mission statement. In 2007 we have entered into a new partnership where 10% of the MS Society's unrestricted net revenue will be directed to the pool of funding available to the clinics.

What does this mean for clinics? Provided the historical success of the MS Society's fundraising activities repeats itself, this would mean additional funding for all clinics over time. However, more importantly, it solidifies the true partnership between the MS Society and the clinics in our joint support of those living with MS. We now have the opportunity to work even closer together and clinics have the opportunity to further support the work of the MS Society by helping us to increase the awareness of our fundraising events and how those dollars support people living with MS so that we can continue to increase the dollars raised to provide greater support to those who rely upon all of us in the fight against MS.

Jamie Hall
National Vice-President and
Chief Financial Officer
MS Society of Canada

WELCOME TO:

Dr Chris Hyson, Neurologist

Dr Hyson joined our MS Clinic team in January of last year initially with a year commitment. We are pleased to announce that Dr Hyson will continue to work in the clinic on a permanent basis.

Anne Howley, Clinical Research Coordinator

Anne returns from working in the United States for a number of years coordinating clinical trials in many diseases including multiple sclerosis. Welcome back home Anne!

Anu Sawant, Physiotherapist

Anu joined our team in mid January after working previously in the medicine service.

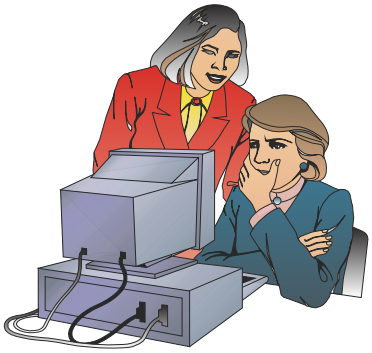
CLINIC NOTES:

- ✓ When you receive a questionnaire notifying you of an upcoming clinic 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 time if required.
- ✓ **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 blue hospital card and your health 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 24 hours notice of appointment cancellations
- ✓ If calling for a prescription renewal, please provide us with the name of the medication, the current dose you are taking, the name and telephone number of your pharmacy, and the prescription number if you have it. Please allow 24-48 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 clinic appointment by bringing with you a list of your current medications and any specific MS-related questions or concerns you 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, contact the MS Clinic office at (519) 663-3697. If you have not been seen in the clinic in over a year, we will require a referral note from your family physician.

Remember to visit us on our website:

www.lhsc.on.ca/programs/msclinic



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