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| The Influence of Comorbidity on Health Related Quality of Life in Multiple Sclerosis |
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| The aim of the project was to determine how the presence of co-existing health conditions affects quality of life in MS. The project took place from July 2010 to July 2014 and we were successful in enrolling 949 individuals from four provinces across Canada: Alberta, British Columbia, Manitoba and Nova Scotia.  In this newsletter you will find some of the major findings from the project, which have been presented or published in scientific journals. |
| What is Comorbidity? |
| Comorbidity is the co-existence of two or more health conditions. As physical and psychiatric comorbidities are very common in MS, it is important to understand how they affect quality of life, disease progression, and your ability to take medications as prescribed. |
| Pain |
| Pain is one of the most common symptoms of MS, and while pain is a concern for all persons with MS, it is more so for those with comorbidities.  We found that:   * Over the course of two years, 31% of people in the study developed levels of pain that disrupted normal activities in their life.1 * Fibromyalgia, rheumatoid arthritis, Irritable Bowel Syndrome, migraine, chronic lung disease, depression, anxiety, hypertension, and high cholesterol were all associated with disruptive levels of pain.1 * Monitoring and treating these conditions may be an effective way of improving pain in MS, which is why it is important to communicate about these conditions at each doctor’s visit.1 |
| Mental Health |
| We found that:   * A significant number of study participants suffered from mental health problems: 29% reported depression, 12% anxiety, 1.5% bipolar disorder, and 0.1% schizophrenia.9 * Depression, anxiety, and bipolar disorder were more common among women, while schizophrenia was more common in men.6 * At time of MS diagnosis, the most common comorbidity was depression.8 |
| Fibromyalgia and Thyroid Disease |
| We found that:   * 7% of people living with MS also suffer from fibromyalgia and there were 124 (per 100,000) new diagnoses of fibromyalgia every year.3 * 10% of people with MS were also diagnosed with thyroid disease.4 * These numbers were higher than for people who don’t have MS.3 |
| Smoking and Alcohol Dependence |
| **FACT: MS disability progresses more quickly in people who smoke.**  **MYTH: Quitting smoking will increase anxiety and depression.**  **FACT: Alcohol dependence and/or smoking increase the likelihood that someone will develop depression in the future.5** |
| Medications |
| * The higher number of comorbidities, the less likely a person is to initiate disease-modifying treatment for MS.7 * People with heart disease were 28% less likely to start disease-modifying treatment. * People with anxiety were 22% less likely to initiate treatment. Anxiety can impair communication between patients and doctors, and interfere with a person’s ability to manage their prescribed medications.7 |
| Quality of Life |
| * MS has a strong influence on quality of life, but it’s not just neurologic disability that is responsible for this.9 * Other medical conditions, particularly anxiety and depression, have significant effects as well. These conditions often work together and have an impact on important symptoms, like fatigue, which in turn affect quality of life.9 * We need to think about treating all these together to obtain meaningful improvements in the quality of life of people with MS.9 |
| Publications |
| 1.Fiest, K. M. *et al.* Comorbidity is associated with pain-related activity limitations in multiple sclerosis. *Mult. Scler. Relat. Disord.* 4, 470–476 (2015). 2. Marrie, R. A. *et al.* Mental comorbidity and multiple sclerosis: validating administrative data to support population-based surveillance. *BMC Neurol.* 13, 16 (2013). 3. Marrie, R. A. *et al.* The incidence and prevalence of fibromyalgia are higher in multiple sclerosis than the general population : A population-based study. *Mult. Scler. Relat. Disord.* 1, 162–167 (2012). 4. Marrie, R. A. *et al.* The incidence and prevalence of thyroid disease do not differ in the multiple sclerosis and general populations: A validation study using administrative data. *Neuroepidemiology* 39, 135–142 (2012). 5. McKay, K. A. *et al.* Adverse health behaviours are associated with depression and anxiety in multiple sclerosis: A prospective multisite study. *Mult. Scler. J.* 22, 685–693 (2015). 6. Marrie, R. A. *et al.* Differences in the burden of psychiatric comorbidity in MS vs the general population. *Neurology* 85, 1972–1979 (2015). 7. Zhang, T. *et al.* Examining the effects of comorbidities on disease-modifying therapy use in multiple sclerosis. *Neurology* 86 (14), 1287-1295 (2016). 8. Marrie, R. A. *et al.* Sex differences in comorbidity at diagnosis of multiple sclerosis: A population-based study. *Neurology* 86(14), 1279-1286 (2016). 9. Berrigan, L. I. *et al.* Health-related quality of life in multiple sclerosis: Direct and indirect effects of comorbidity. *Neurology* 86(15),1417-1424 (2016). |
| If you have any questions about the study, please contact: Karen Stadnyk, Study Coordinator, 902-473-5734  *N*ewsletter Version 1.0 Dated May 4, 2016 REB ROMEO # 1000328 (formerly REB # CDHA-RS/2011-027) |