Alternative Therapies for Multiple Sclerosis

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Multiple sclerosis (MS) is the most disabling neurological condition of young adults with a high prevalence in European and North American population. Heterogeneity has been observed in its pathology. Much evidence seems to confirm the old hypothesis that it is an immune-mediated disorder in genetically susceptible individuals exposed to undetermined environmental factors, resulting into inflammation, demyelination and scarring of white mater. Most patients with MS experience progressive neurological disability inspite of the use of the available modalities of treatment. Currently available drugs: IFN-B1a,[1,3] IFN –B1b,[1] Glatiramer and IFN –B1b[1] have been found to be effective in reducing the relapse and disability in relapsing-remitting multiple sclerosis but not curing the disease. PRISM (prevention of relapse and disability by interferon B-1a Subcutaneously in Multiple Sclerosis),[5] CHAMPS (controlled High risk Avonex MultiPle Sclerosis)[3] and ETOMS (early treatment of multiple sclerosis)[1] studies have all advocated the early use of disease modifying agents for decreasing the number of relapse and disability. Similarly the use of Mitoxantrone in primary progressive MS is accepted but has been restricted due to its cardio-toxicity. As there is no cure and the disabilities persist, patients look for alternative modalities of treatment.

Markelov and collegues, in their thought-provoking review, published in this issue of Nepal Journal of Neuroscience,[4] highlight the role of Bee venom therapy and low dose naltrexone for treatment of MS.

Bee venom therapy in various forms has been in practice since ancient times. As authors have stated, it is in use in certain Asian countries where fortunately the incidence of MS is low and secondly it is used for symptomic relief rather than as a disease modifying agent.

Though authors have mentioned about various mechanisms of action in favour of the Bee Venom in different form in the treatment of MS, lack of clinical evidence in the form of validated clinical trials debar this modality of treatment from being accepted as first line treatment as suggested by the authors. We need to address the prospects of this alternative and need to have trials with safe derivatives of bee venom before they can be accepted as main therapy for MS.

Similarly, low dose naltrexone in MS can give some symptomatic relief in the form of fewer spasms, improved bladder control etc. but again, to accept it as the modality of treatment in MS, we need further clinical trials.

Till cure or 'near' cure is achieved our aim should be to make patients symptom free as far as possible and here comes the role of evaluating various agents which are practiced in different communities in different part of the world.

References

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