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EDITORIAL

The relationship between multiple sclerosis and neuropsychiatric syndromes

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An academic appreciation of the link between multiple sclerosis (MS) and psychiatric illness has existed for almost one hundred years,[1] with a marked increase in the prevalence of affective, anxiety and psychotic disorders occurring in MS.[2]

The update article by Chalah & Ayache[3] comprehensively examines the existing literature on the concept of a ''psychiatric attack'' preceding an initial presentation of MS. Even though psychiatric disorders usually present subsequent to a diagnosis of MS, up to 2% of individuals experience a first presentation of MS consisting solely of psychiatric symptoms.[4] As described by Chalah & Ayache, there are a number of reports of even higher prevalence rates of psychiatric symptoms or diagnoses prior to the onset of MS. Disentangling when psychiatric episodes may actually herald a diagnosis of MS is challenging, and the authors in this article provide insights based on clinical presentations where clinicians should consider MS as a differential diagnosis of a psychiatric episode. Such insights derive from case studies, case series or underpowered retrospective cohort studies – by no means is this note a critique of the authors, but rather a recognition of the dearth of literature on the topic, to date.

The authors discuss the highly practical suggestion of using ''red flags'' or atypical psychiatric presentations as a prompt for clinicians to actively consider MS as a differential diagnosis. These red flags include an atypical late onset of psychiatric symptoms or a negative family history of the presenting psychiatric episode. In addition, the authors suggest that a lack of therapeutic efficacy of appropriate psychotropic interventions should prompt clinicians to reappraise the psychiatric diagnosis and consider an organic etiology such as MS. In these cases, undertaking a full clinical work-up inclusive of neuroimaging is suggested, with the potential of imaging findings helping determine the etiology of an individual's symptomatology. The association between depressive symptoms with an abnormal affect and frontal lobe pathology in a first presentation of MS is discussed by the authors. Of course, the counter-argument of brain magnetic resonance imaging providing incidental findings, confusing the clinical picture, also requires consideration.[5]

An earlier detection of MS in individuals could lead to more appropriate pharmacotherapeutic interventions and reduce morbidity. Consequently, a greater awareness of when psychiatric symptoms relate to an organic disorder such as MS rather than to a primary psychiatric disorder is optimal, and thus, this article by Chalah & Ayache is timely and of considerable clinical relevance.

Neuropsychiatric signs and symptoms occur frequently in individuals with MS and may, as stated, be an initial presenting complaint prior to a definitive diagnosis of MS – although they more commonly occur with disease progression. Whilst it remains difficult to elucidate if neuropsychiatric symptoms are indicative of MS severity,[6] earlier detection of either or both neurological and psychiatric disorders can reduce morbidity for patients. Additional research in larger cohorts of individuals with MS may allow for the development of appropriate evidence-based guidelines for clinicians to follow and thus help differentiate when a psychiatric episode may indeed be heralding a diagnosis of MS. In the interim, the ''red flags,'' as described by Chalah & Ayache, provide a pragmatic guideline for clinicians.

Disclosure

The authors report no conflicts of interest.

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