Immune-system therapy appears safe for people with progressive forms of multiple sclerosis. And it may ease symptoms in some people.
Multiple sclerosis is caused by a misguided immune system attack on the protective sheath around nerve fibers in the spine and brain. Depending on where the damage occurs, symptoms can include vision problems, muscle weakness, numbness and difficulty with balance and coordination.

Most people with MS are initially diagnosed with the "relapsing-remitting" form, which means that symptoms flare up for a time and then ease.

The new study involved patients with progressive MS, where the disease steadily worsens without periods of recovery.

Most had the "secondary" progressive form -- which means they initially had relapsing-remitting MS, but it worsened. One patient had progressive MS from the start, which is known as "primary" progressive MS.

The patients agreed to try a treatment studied in MS, said study co-author Rajiv Khanna, of the QIMR Berghofer Medical Research Institute in Brisbane, Australia.

The approach is known as "adoptive" immunotherapy, where a patient's own immune system T cells are genetically tweaked to fight an enemy -- such as cancer cells.

Khanna's team took samples of the MS patients' T cells, then altered the cells to boost their ability to recognize and attack the Epstein-Barr virus. Those T cells were infused back into the patients' blood, at gradually escalating doses over six weeks. Epstein-Barr is a common virus that infects most people at some point. But researchers suspect it plays a role in MS in some people.

According to Khanna, there is also evidence that MS progression correlates with Epstein-Barr "activation" in the body. The aim of the T-cell therapy is to "clear out" B cells -- another type of immune system cell -- that are infected with Epstein-Barr.
Complementary approaches to taking care of yourself

**Food and diet** — Although various diets have been promoted to cure or control MS, no diet has been proven to modify the course of MS. MS specialists recommend that people follow the same high fiber, low fat diet that is recommended for all adults.

**Exercise** — Exercise offers many benefits for people with MS. In addition to improving your overall health, aerobic exercise reduces fatigue and improves bladder and bowel function, strength, and mood. Stretching exercises reduce stiffness and increase mobility. The physical therapist can recommend an exercise plan to fit your abilities and limitations.

**Stress management** (.pdf) — The relationship between stress and the onset or worsening of MS is far from clear — and different types of stress appear to affect different people in different ways. But none of us feel our best when we’re stressed, so it’s important to find the stress management strategies that work best for you.

**Acupuncture** — Acupuncture is finding its way into Western medicine, with studies suggesting possible benefits for a wide range of problems.

Over six months, the researchers said, none of the patients suffered serious side effects from the treatment.

In addition, three showed symptom improvements within two to eight weeks of their first T-cell infusion.

The findings are scheduled for presentation at the annual meeting of the American Academy of Neurology, April 22-28, in Boston.

The biology behind the T-cell therapy is not fully clear, Bebo said. Although Epstein-Barr is suspected as one factor in driving the initial development of MS, even that is not established, he said.

Bebo said he suspects that if the experimental T-cell therapy has benefits in MS, it might be because it clears out B cells.
Even if the approach proves effective, there are practical hurdles in delivering a therapy like that, Bebo pointed out.

"This is one of many approaches being tested," Bebo said. "We're learning more about MS progression all the time. So the future looks bright."

Study results presented at meetings are usually considered preliminary until published in a peer-reviewed medical journal.

**Summary**

Results from a small pilot study suggested that high-dose biotin 300mg/day (MD1003) might be an effective treatment for secondary and primary progressive MS. To test this further, French researchers carried out a clinical trial to see if treatment with high-dose biotin could reduce disability.

154 people with progressive multiple sclerosis with an initial EDSS of 4.5 - 7, took capsules containing either placebo or high-dose biotin three times a day for 12 months. 13 out of 103 people (12.6%) taking high-dose biotin had reduced disability at month 9 which was maintained at month 12, compared to none of the 51 people taking placebo.

After the first 12 months, all participants took high-dose biotin for a further 12 months. At the end of the second 12 months, 19 of 133 people had reduced disability, which included 10 of the 13 people who had responded in the first year and others who had initially been taking placebo.

The study also looked at how many people had increased disability. At the end of the first 12 months, 4 out of 103 people (4.2%) taking high-dose biotin had increased EDSS, compared to 6
of 51 (13.6%) people taking placebo. At the end of the second 12 months, EDSS had increased in 9.9% of those in the biotin>biotin group compared to 31.7% in the placebo>biotin group. The researchers conclude that high-dose biotin causes a reversal of MS-related disability in a subset of people with progressive MS.

Background

MD1003 is a highly concentrated formulation of biotin under investigation as a treatment for secondary and primary progressive multiple sclerosis (MS). It is thought that very high doses of biotin may be effective in MS by promoting myelin repair through activation of an enzyme involved in myelin synthesis and by enhancing energy production in demyelinated nerves. A small pilot study of 23 people (link is external) with primary and secondary progressive MS provided initial evidence of effectiveness and safety of high doses of biotin. This was an open study - in other words both the people with MS and their doctors knew what treatment they were receiving; this can bias the results.

To investigate high-dose biotin further, researchers carried out a clinical trial to see if treatment with high-dose biotin could reverse, that is improve, levels of disability. This is a more ambitious target than previous studies in progressive MS where the main aim of a study is to prevent further disability.

Topline results from this clinical trial were presented at a scientific meeting in 2015. Full details of the study have now been published and are summarised in this Research Update.

How this study was carried out

154 people with secondary and primary progressive MS with EDSS of 4.5 - 7 and evidence of disease worsening in the previous 2 years were recruited at study centres in France.

Participants took either high-dose biotin (300mg each day) or placebo capsules three times a day for the first 12 months, then all participants took high-dose biotin for a further 12 months. Throughout both parts of the study, neither participants nor investigators knew which treatment they had taken during the first 12 months.

Participants continued with any medications or other treatments they were already taking. Approximately half of the people in each group were taking fampridine, and approximately 40% in each group were taking a disease modifying drug.

Participants visited their study centres every three months for assessments. The main measure of the study was an improvement in disability after 9 months which was still evident 3 months later at the 12 month assessment. Improvement in disability was defined as either a reduction in EDSS of 0.5 to 1 point (depending on starting level) or a 20% reduction in the time to walk 25 feet.
What was found
At the end of the first 12 months, 13 out of 103 people (12.6%) taking high-dose biotin had reduced disability, compared to none of the 51 people taking placebo. Of those whose disability improved, just 2 had an improvement in both EDSS and walking time; 8 had an improvement in EDSS only, and 3 had an improvement in walking time only.

At the end of the second 12 months, 19 out of the 133 people who had continued in the study had reduced disability, which included 10 of the 13 people who had responded in the first year and a further 9 who had initially been taking placebo.

A secondary measure was the number of people with worsening disability (increase in EDSS). The proportion of participants with increased EDSS at month 9 (and maintained at month 12) was 13.6% in the placebo group and 4.2% in the high-dose biotin group. At month 18 (maintained at month 24) the proportion increased to 31.7% in the placebo>biotin group and 9.9% in the biotin>biotin group.

There were no serious side effects although five participants taking high-dose biotin had “apparent hyperthyroidism” which had been caused by high levels of biotin in samples interfering with thyroid hormone blood tests. Mild to moderate side effects included urinary tract infections and headache and were reported for both placebo and biotin groups, suggesting that side effects were not caused by biotin.

What does it mean?
The results suggest that high-dose biotin may cause a reversal of MS-related disability in a subset of people with progressive MS. However, the numbers of people involved in the study are relatively low, making it difficult to draw firm conclusions. The data are complex and will require more detailed analysis to draw further conclusions or identify those most likely to benefit.

Medical EXPOSE
http://www.medicalexpose.com/
Living with Multiple Sclerosis: 7 Best Exercises

Exercise is an essential component of managing symptoms and even slowing the progression of multiple sclerosis (MS). Before starting an exercise plan, consult a physical therapist to get a sound evaluation of your strengths and weaknesses and what moves are right for you.

Here are some of the most recommended exercises for those living with MS to aid strength, coordination, balance, and weight management:

1. Focusing on strengthening the core is very important for overall strength. Planks are an efficient way to target all core muscles including the obliques, abdominals, and back muscles. Try to hold the pose for 10 to 15 seconds, and gradually build up to your time.

2. The half-bridge pose is a gentle posterior muscle conditioning exercise that strengthens the glutes, legs, lower back, and abdominals. Gently flow in and out of this pose while deeply inhaling and exhaling. Work your way up to 10 repetitions.

3. The modified plank is a less intense, yet effective core strengthening exercise. Severe MS may make the plank pose especially difficult, making this a safer option. Try to hold the pose for 10 to 20 seconds and repeat between 3 and 5 times.

4. Introductory aerobic classes like step or marching in place are good for maintaining and improving balance.

5. Practice squats to increase lower body strength. Make sure to sit backwards so that your knees don’t bend over your foot. If this is too difficult, try squating against a wall. Aim to complete 10-12 repetitions. If this becomes too easy, try adding some light weights.

6. Improve stretching ability and circulation with seated back extensions. Start by sitting as tall as possible and then reach high while inhaling and then bring your arms back down with the exhale. Maintaining perfect posture is key. Repeat 5 to 10 times.

7. Lunges are an effective way to build strength in your quads, hamstrings, and ankle while also increasing circulation and improving balance. Make sure to keep both knees at about a 90-degree angle to protect your knees. Repeat 10 times on each leg.
Complementary and alternative medicine for the treatment of multiple sclerosis

Vijayshree Yadav, Lynne Shinto, and Dennis Bourdette

Abstract

Multiple sclerosis (MS) is a chronic disabling disease of the CNS that affects approximately 500,000 people in the USA [1]. Most patients initially have a form of MS referred to as relapsing–remitting MS (RRMS). This type of MS is characterized by periods of clinical stability that are interrupted by relapses or attacks of MS during which patients experience clinical worsening. Patients may or may not have complete recovery from these relapses. Approximately 50% of patients with RRMS eventually enter a phase of the illness referred to as secondary progressive MS (SPMS), in which there is progressive worsening of their disease. Patients with SPMS often cease to have clinical relapses of MS. Approximately 10–15% of people with MS have primary progressive MS (PPMS), in which there is progressive worsening of the neurologic symptoms from the onset of disease.

Multiple sclerosis pathogenesis is believed to involve an autoimmune response within the CNS, resulting in multifocal demyelination with varying axonal injury [1]. Inflammation and demyelination seem to be the primary pathology in the relapsing forms of MS, whereas neurodegeneration causing axonal degeneration seems to dominate the pathology in progressive forms of the disease [2]. The immune dysregulation in MS is primarily mediated by activated T cells, B cells and macrophages, as well as soluble mediators of inflammation such as antibodies, cytokines, free radicals and proteases. Transmigration of activated T cells across the blood–brain barrier is critical to the development of new inflammatory lesions in MS [1,3,4]. Several factors that facilitate T-cell migration across the blood–brain barrier include binding between integrins and their counter-ligands, such as ICAM-1 on endothelial cells and leukocyte function-associated antigen 1 on T cells and proteases produced by activated T cells, such as matrix metalloproteinase (MMP)-9 [5–13]. Several studies have reported higher MMP-9 levels in MS subjects compared with control subjects [14,15]. MS subjects with a relapsing–remitting disease course have been reported to have elevated MMP-9 mRNA levels expressed in immune cells compared with healthy controls [16]. Similarly, previous studies have correlated changes in serum MMP-9 activity with relapses of MS [17]. Cytokines also play important role as mediators of MS pathogenesis. Correlations exist between the expression of pro-inflammatory cytokines,
such as TNF-α, IFN-γ and IL-2, during periods of clinical worsening and that of regulatory cytokines, such as IL-4 and IL-10, during periods of remission [18–24]. The currently available US FDA-approved disease-modifying therapies (DMTs) for MS, such as human recombinant IFN-β and glatiramer acetate, work partly by shifting cytokine production from a proinflammatory to an anti-inflammatory profile [25–28]. In addition, IFN-β also inhibits the MMP-9 levels and activity from the T cells [14,29,30].

Treatments for MS are divided into two large categories: those that are intended to control the disease process and those that help to manage symptoms. Pharmacological agents that intend to control the disease process besides human recombinant IFN-β and glatiramer acetate include a monoclonal antibody against α-4 integrin, natalizumab and a chemotherapy agent, mitoxantrone. These therapies reduce the frequency of relapses and new lesion formation in the brain and reduce the risk of increased disability among patients with relapsing MS. However, these therapies are ineffective in progressive forms of MS, only partially effective in relapsing MS, only available in injectable forms, have significant side effects and are very costly.

Common symptoms that MS patients suffer from include fatigue, depression, cognitive impairment, spasticity, pain and imbalance. These symptoms can have a significant negative impact on the patient’s quality of life; hence, treatment targeting these is critical. Pharmacologic or rehabilitative treatments can help with these symptoms to a variable extent but care is still not optimal; therefore, the development of more effective and affordable symptomatic therapies remains a critical goal of MS care.

Go to:

Prevalence of complementary & alternative medicine use in MS

There have been a number of studies reporting the prevalence of complementary and alternative medicine (CAM) use by MS patients, and the range of prevalence is quite broad, at 33–70% [31–39]. A conservative estimate from this range is that at least a third of MS patients have used CAM. Patient characteristics that are predictive of CAM use in MS are reported to be similar to those reported in the general population and include being female, being more highly educated and patient reports of poor health status [31,33,34,36,40].

Most MS patients who use CAM report benefit from the commonly used therapies, which include diet, omega-3 fatty acids (FAs) and antioxidants [31,34,35,38,39]. In addition to the perceived benefit, reasons for CAM use include desire to use holistic health-care, patient empowerment, improving general health, and relief from physical and psychological symptoms [31,32,34,41]. The majority of MS patients use CAM as an adjunct to conventional therapies, rather than as an alternative to conventional MS therapies, and perceive both conventional and CAM therapies as being beneficial [31,32,34–37,39].

There is a paucity of well-designed clinical trials assessing the benefit of CAM therapies for treating MS. High-use therapies, which include diet, omega 3 FAs and antioxidants, may have potential benefit in MS as they have immunomodulatory and neuroprotective properties when evaluated in animal models, MS patients and in other chronic disease conditions. Diet, omega-3 FAs and antioxidants also appear to have a high safety profile when used at recommended doses. Table 1 provides a summary of CAM clinical trials in MS.
Dietary supplements in MS

Omega-3 FAs

Omega-3 FAs are a family of polyunsaturated FAs (PUFAs) that contain a common carbon–
carbon double bond at the third carbon from the terminal methyl end of the molecule. The parent
omega-3 FA is linolenic acid. It is an ‘essential fatty acid’ and cannot be synthesized in humans
and therefore must be supplied in the diet. Sources high in linolenic acid are plant-based and
include flaxseeds and flaxseed oil, soy and soybean oil, and canola oil. Eicosapentanoic acid
(EPA) and docosahexanoic acid (DHA) are two omega-3 FAs that are synthesized from linolenic
acid through a series of enzymatic steps [42]. While EPA and DHA can be synthesized from
linolenic acid in humans, a rate-limiting enzymatic conversation from linolenic acid to EPA and
DHA results in a very low conversion rate to EPA and DHA [43].

Unlike plant oils, which contain no EPA and DHA, fish and fish oils contain high levels of EPA
and DHA, particularly coldwater fish (e.g., salmon and mackerel). DHA can cross the blood–
brain barrier and, along with arachidonic acid, is a major component of neuronal cell membranes
[44,45]. EPA can be converted to prostaglandin I₃ and E₃, thromboxane A₃ and leukotriene B₅,
and therefore has immunomodulatory capacity, acting as an anti-inflammatory agent [42,46].

Although there are numerous studies reporting the immunomodulatory effects of omega-3 FAs,
there are few studies evaluating omega-3 FAs in MS. Gallai et al. reported a significant decrease
from baseline in the levels of the proinflammatory cytokines secreted from peripheral blood
mononuclear cells (PBMCs) of MS subjects and healthy controls supplemented with fish oil
[47]. Overall, 20 subjects with MS and 15 age-matched healthy controls were supplemented with
6 g per day of fish oil containing 3.0 g EPA and 1.8 g DHA for 3 months; the study also included
a 2-month wash-out period. The significant decrease in PBMC-secreted cytokines was observed
after 3 months of supplementation. All MS subjects had a stable course of MS for at least 3
months prior to enrollment, had not modified their diet as a consequence of developing MS and
were not on any MS disease-modifying therapies. No differences were demonstrated in
baseline ex vivo cytokine levels between MS subjects and controls. Cytokine levels were
reported to have returned to baseline values in both groups after a 3-month wash-out period.
Matrix metalloproteinase-9 appears to be important for T-cell migration into the CNS in MS and animal models of MS, and in vitro studies suggest that omega-3 FA supplementation can decrease MMP-9 production [48,49]. In an open-label pilot study, our group reported a significant decrease in MMP-9 levels secreted from unstimulated PBMCs [48]. Ten RRMS patients received fish oil concentrate at 8 g per day (containing 2.9 g EPA and 1.9 g DHA) for 3 months. All subjects showed a decrease in MMP-9 levels, whether or not they were on MS disease-modifying medication [48].

It is still not known exactly how omega-3 FAs decrease levels of MMP-9 and inflammatory cytokines. Omega-3 FAs have been reported to decrease NF-κB and activator protein-1 binding activity, both of which may alter gene transcription of MMP-9 and some proinflammatory cytokines [49–51]. Therefore, modulating gene expression may be a mechanism by which omega-3 FAs might induce immunomodulation in MS. Future studies warrant evaluating the effects of EPA and DHA on MMP-9 mRNA levels.

There has been only one study evaluating the effects of omega-3 FA on MS disease activity [52]. This was a double-blind placebo-controlled trial in which MS patients (n = 312) were randomized to receive either 20 capsules per day of either omega-3 FA (from fish oil) or an olive oil placebo for 2 years. The olive oil placebo contained 72% oleic acid and the fish oil contained a dose of EPA 1.71 g per day and DHA 1.41 g per day. This study reported a trend in improvement in the omega-3-treated subjects compared with controls in disease severity (measured by Expanded Disability Status Score [EDSS]) over 2 years (p = 0.07). While the results did not achieve statistical significance favoring omega-3 FA supplementation, the study was not optimally designed. Both groups in the study were advised to follow a diet low in animal fat and high in omega-6 FAs. Importantly, both groups developed changes in serum FA content over the 2 years of the study, which may indicate a diet effect in the placebo group.

Omega-3 FAs appear to be safe. The Bates study did not report adverse effects of omega-3 or placebo oil supplementation over 2 years [52]. The published pilot studies conducted by our group support the safety of omega-3 FAs combined with MS disease-modifying therapies at a daily dose range of 2–8 g for 3–6 months [48,53]. No serious adverse effects were reported in either of these studies; any adverse events were mild. The Physician’s Desk Reference for Nutritional Supplements reports no serious adverse events in those taking fish oil supplements up to 15 g/day [54]. The most common side effects are mild and include ‘fishy burps’ and mild gastrointestinal effects (e.g., stomach upset, loose stools/diarrhea and stomach bloating).

**Lipoic acid**

Lipoic acid (LA) is an antioxidant and dietary supplement that has a variety of biologic effects. LA is available in both oral and intravenous forms and is prescribed as a treatment for diabetic neuropathy in Germany. While some LA is derived from the diet, LA synthase can catalyze the generation of LA in mammals. Under normal circumstances, essentially no free LA is detectable within the blood. However, following oral or parenteral administration, free LA appears within the blood and a variety of tissues, including the CNS [55–57].

Lipoic acid and its reduced form, dihydrolipoic acid (DHLA), form a redox couple that functions as a cofactor for several mitochondrial dehydrogenases (Figure 1) [58]. In vitro, a number of anti-oxidant activities have been associated with LA/DHLA, including free radical scavenging,
metallic ion chelation, regeneration of intracellular glutathione and repair of oxidative damage to macromolecules \[59\]. Extracellular LA enters the cell via the sodium-dependent multivitamin transport system and by diffusion across cell membranes. Intracellularly, LA is reduced to DHLA within mitochondria by dihydrolipoyl dehydrogenase and in the cytoplasm by glutathione reductase and thioredoxin \[58,60,61\].

**Figure 1**

Lipoic acid and its reduced form, dihydrolipoic acid.

Several laboratories have shown that LA is an effective therapy in the animal model of MS, experimental autoimmune encephalomyelitis (EAE). EAE has provided important insights into the immunopathogenesis of MS and has led to the development of new therapeutic approaches for the treatment of MS \[62,63\]. LA has been shown to be an effective therapy for EAE \[64–66\]. LA suppresses EAE by interfering with trafficking of encephalitogenic T cells into the spinal cord. Immunomodulatory effects of LA involve several related mechanisms of action, including inhibition of MMP-9 production by T cells at the mRNA level and inhibition of the expression of the adhesion molecules ICAM-1 and VCAM-1 by CNS endothelial cells \[64,65,67\]. Importantly, LA is able to stimulate production of cAMP via the prostaglandin receptors EP2 and EP4 \[68,69\]. cAMP is an important second messenger that activates protein kinase A, initiating a cascade of effects that result in immunomodulation. This effect may be central to the therapeutic effect of LA in EAE.

We conducted a double-blind, placebo-controlled, dose-finding trial of orally administered LA in MS, which is the first reported trial of LA in MS and the first trial in humans to relate serum LA concentrations to changes in serum markers of inflammation \[70\]. This was a 2-week study with 37 subjects that, despite its short duration and small sample size, found that a dose of 1200 mg was significantly better than 600 mg in producing measurable serum LA concentrations and was generally well tolerated. We also found that there was considerable inter-subject variability in peak serum LA concentrations determined by high-performance liquid chromatography (range 0–17 μg/ml with a 1200 mg oral dose). In this study, we also explored the effect of oral LA administration on serum soluble ICAM-1 (sICAM-1) and MMP-9. A significant dose–response effect on serum sICAM-1 level also was observed with increasing doses of LA associated with decreasing levels of serum sICAM-1. We also found a statistically significant negative correlation between peak LA concentrations and changes in serum MMP-9 levels in this study, which considering the small sample size of the trial and the inter-subject variability in absorption of LA, supports the role of LA as potential anti-inflammatory agent. These observations provide the rationale for studying LA as a potential treatment for MS.

Lipoic acid appears to be safe and has been shown in randomized controlled trials to be effective for treating symptoms of diabetic polyneuropathy \[71–77\]. In these trials, the most common adverse reactions to LA included gastrointestinal intolerance, nausea and headache.
Ginkgo biloba

Ginkgo biloba (GB) is one of the traditional Chinese medicine treatments that has been used for centuries in China but has only recently gained popularity in the Western world. Standardized extracts of GB leaves are available as supplement over the counter in the USA. GB extracts have a number of pharmacologic properties that suggest they may alter neural function and enhance cognitive performance. Flavonoids, which are primarily flavon-o-glycosides, and terpenoids are the two major classes of compounds considered to be pharmacologically important in GB extracts. Standardized GB extracts typically contain approximately 24% flavonoids, 4–6% terpenoids and multiple other compounds in smaller quantities. The terpenoids are unique compounds only found in the Ginkgo tree and include bilobalide and the ginkgolides A, B, C, M and J. The flavon-o-glycosides are glycoside derivatives of quercetin, kaempferol and isorhamnetin [78].

Cognitive impairment can be a significant cause of morbidity and disability and can affect 40–50% of people with MS [79,80]. Currently, there are no effective symptomatic therapies for cognitive dysfunction in MS. GB has been suggested to improve cognitive performance in Alzheimer’s disease, as seen in clinical trials and several other studies [81–86]. However, more recently, there have been negative trials on the effect of GB in dementia [87–90], which makes the issues of clinical efficacy of GB on cognition improvement somewhat more controversial. More recent systematic reviews that included results of these negative trials suggest that GB is safe but that the improvement on cognitive improvement appears to be inconsistent [91,92], which contrasts with earlier systematic reviews [93].

Our group conducted a randomized placebo-controlled pilot study evaluating the effects of treatment with a standardized GB extract on cognitive performance in 43 subjects with MS [94]. Subjects received GB 120 mg or placebo twice daily for 12 weeks. The outcomes of the study included several neuropsychological tests, including the Stroop test, which is a measure of attention and executive function. Subjects receiving GB showed improved performance on the Stroop test as well as improvement in subjective reports of cognitive deficits. This pilot study also showed that GB was safe and well tolerated. Based on these results, a double-blind placebo-controlled trial involving 100 subjects is underway to further assess the effects of GB on cognitive function in people with MS.

Ginseng

Fatigue is reported in 75–95% of people with MS, and 50–60% of people with MS report that fatigue is their worst problem [95,96]. Treatment options for MS fatigue include the off-label use of CNS stimulants and amantadine. These medications are of limited efficacy, are often poorly tolerated and can be expensive. Ginseng may represent a novel approach to treating MS-related fatigue.

Ginseng is a herbal product that has been used in China for more than 2000 years. This compound is one of the most extensively studied herbal products in the scientific literature [97,98]. The known active constituents in American ginseng are the ginsenosides [99–102], which are reported to have a wide range of biological effects, including antioxidant activity with increased oxygen radical scavenging and decreased lipid peroxidation, stimulation of the hypothalamic–pituitary–adrenal system with a corticosteroidal effect, increased antitumor
activity, improved cardiovascular function through vasodilation and reduced platelet aggregation, and hypoglycemic activity [103–110].

Despite uncertainty about its mechanism of action, a limited number of placebo-controlled trials have suggested that ginseng is capable of decreasing fatigue. Of particular interest, one placebo-controlled trial of 501 healthy adults with complaints of stress and fatigue demonstrated an overall improved quality of life after a 12-week treatment trial with an Asian ginseng extract [109]. Another large placebo-controlled trial of ginseng in 384 postmenopausal women with complaints of stress and fatigue demonstrated improved general wellbeing after 16 weeks of treatment [110].

Because ginseng appeared to be useful for fatigue in other populations, Kim et al. conducted a double-blind placebo-controlled crossover pilot trial of American ginseng extract using an escalating daily dose of 100 mg, 200 mg and 400 mg for the first 3 weeks of a 6-week intervention period in subjects with MS to determine its effects on fatigue [111]. However, this study failed to show any benefit of American ginseng extract on fatigue in these subjects with MS [Kim E, Pers. Comm.]. Some subjects experienced insomnia while on American ginseng, suggesting that higher doses might not be tolerated. Thus, American ginseng does not appear to be a promising treatment for fatigue in MS.

Ginseng extracts appear to be safe, although large doses can cause side effects. Ginseng extracts have been used at doses of up to 2 g per day without adverse effects [108,109]. Excessive intake of ginseng (with dosing at 3–15 g per day) has been associated with hypertension, nervousness, irritability, insomnia, rash and diarrhea [112]. Five different animal models using conventional toxicological methods reported no acute or chronic toxicity of the extract [97,113].

### Green tea polyphenols (epigallocatechin-3-gallate)

Epigallocatechin-3-gallate (EGCG) is one of the active constituents in green tea that has been reported to have immunomodulatory and neuroprotective effects in limited rodent models. In mouse models, EGCG has been reported to decrease TNF-α [114] and have neuroprotective effects in models of amyotrophic lateral sclerosis [115], Parkinson’s disease [116] and transient ischemic artery occlusion [117].

One report evaluating EGCG in EAE found that to prevent disease, an oral dose of 300 μg twice daily per mouse significantly reduced disease severity (p < 0.05), while to treat disease, an effective dose was achieved at 60 μg twice daily per mouse (p < 0.05) [118].

Although there are no reports evaluating EGCG in MS patients, anti-inflammatory and neuroprotective effects in animal models of a variety of neurologic disorders warrant evaluation of EGCG for neuroprotection in MS. A clinical trial evaluating the safety and neuroprotective effects of EGCG in MS patients is currently underway at Louisiana State University (LA, USA) [Lovera J, Pers. Comm.]. EGCG will be given at a dose of 400 mg twice daily for 2 years. The primary goal is to assess dose safety and to assess neuroprotection via MRI measures.

While EGCG is generally safe, there are reports of rare serious side effects. Daily doses between 400 and 2000 mg have been evaluated in cancer studies [119,120] and in obesity studies [121,122]; in these studies, EGCG has been reported to be well tolerated. Rare cases of liver failure have been reported with green tea extracts [123–125]. This side effect occurred within the
first 50 days of starting the product and was reversible in most cases. The most commonly reported side effects are mild and include nausea, abdominal pain, headache and fatigue.

**Vitamin D**

Vitamin D is a group of fat-soluble prohormones, the two major forms of which are vitamin D₂ (or ergocalciferol) and vitamin D₃ (or cholecalciferol). In vertebrates, vitamin D₃ is produced in the skin from exposure to UV radiation \[^{126}\]. Vitamin D₃ is converted into 25-hydroxyvitamin D₃ in the liver and 1,25-dihydroxyvitamin D₃ in the kidney \[^{127}\]. 1,25-dihydroxyvitamin D₃, which is the bioactive form of vitamin D, is important for regulating the calcium and phosphorus levels in the blood by promoting their absorption from food and helping normal bone mineralization, growth and remodeling \[^{128–130}\]. Vitamin D also regulates immune function (reviewed in \[^{131,132}\]). There are emerging data that support the notion that vitamin D may have a potential immunomodulatory role in MS \[^{133,134}\].

Epidemiologic studies have found that low vitamin D intake and low serum vitamin D levels may increase the risk of MS \[^{135,136}\]. Earlier studies looking at serum vitamin D levels in MS and in healthy controls showed mixed results; however, more recent data support a high prevalence of vitamin D deficiency in people with MS. Barnes et al. reported no difference between MS matched controls in either serum vitamin D₂ or D₃ levels \[^{137}\]. Van der Mei et al. found no mean difference in serum vitamin D₃ levels between MS patients and matched controls, but did find a significant correlation between increasing MS disability and low vitamin D₂ levels \[^{138}\]. Soilu-Hanninen et al. found no mean difference in serum vitamin D₂ levels between MS subjects and controls during the winter months but found that MS subjects had significantly lower serum vitamin D₂ levels than controls during the summer months \[^{139}\]. This study also found that MS subjects had lower serum vitamin D₂ levels during relapses compared with remission states. A recent study looked at the serum vitamin D levels in people with MS (n = 199) and found 84% of them to be vitamin D-deficient \[^{140}\]. These authors also examined the change in serum vitamin D levels in 40 MS patients who took either low-dose vitamin D₂ (<800 IU/day) or high-dose vitamin D₃ (50,000 IU/day for 7–10 days, followed by 50,000 IU weekly or biweekly) and found that subjects in the high-dose vitamin D₃ group had significantly elevated serum vitamin D levels compared with the low-dose vitamin D₂ group. In an open-label study, oral calcitrol at a target dose of 2.5 μm/dl was found to be safe and tolerable in 16 MS patient for up to 1 year of supplementation \[^{141}\]. Another recent study examined the seasonal variation in the serum vitamin D levels in people with MS (n = 103) and healthy controls (n = 110) and found these levels to be significantly higher in summer than in winter in both people with MS and the healthy controls \[^{142}\]. This study also suggested that women with higher circulating levels of vitamin D had a lower incidence of MS and MS-related disability.

One interesting study that examined whether vitamin D has any effect on genetic susceptibility in MS found that the expression of the MS-associated MHC class II allele **HLA-DRB1*1501** appears to be regulated by vitamin D \[^{143}\]. This discovery may be an important clue towards the relationship between vitamin D and MS.

Studies of vitamin D in EAE, the animal model of MS, have shown that vitamin D inhibits inflammation. A low-calcium diet in conjunction with injection of 1,25-dihydroxy-vitamin D₃ prolonged the survival of mice with severe EAE \[^{144}\]. Cantorna et al. showed that 1,25-dihydroxy-vitamin D₃ completely eliminated signs of EAE in mice \[^{145}\]. Subsequent studies
indicated that 1,25-dihydroxy-vitamin D₃ treatment resulted in a diminished presence of inflammatory macrophages in the inflamed CNS, suggesting that vitamin D may influence inflammatory cell trafficking or apoptosis [146].

Clinical trials looking at effects of vitamin D supplementation in people with MS are being conducted. One recent small study that included 29 people with RRMS correlated the levels of serum vitamin D with cytokines, IFN-γ (considered proinflammatory) and IL-4 (considered anti-inflammatory) [147]. This study found that people with high serum vitamin D levels had an improved anti-inflammatory profile, thus suggesting a potential role of vitamin D in regulatory T-cell function in people with MS.

There are emerging data from both animal and small clinical trials that vitamin D may have potential beneficial effects in MS. The more specific role of vitamin D in MS management needs to be clarified in larger clinical trials.

**Cost of dietary supplements**

The costs of the dietary supplements discussed will vary depending on dose and brand, and in the USA, dietary supplements are not covered by insurance and therefore it is an out-of-pocket cost for patients. The cost of each individual supplement is relatively inexpensive, ranging from US$20 to 40 per month.

**Cannabis**

There have been a number of studies evaluating the use cannabinoids in people with MS. As the majority of controlled studies have evaluated cannabinoids for spasticity in MS, we will focus on these studies.

The major psychoactive constituent in cannabis is δ-9-tetrahydrocannabinol (THC). THC binds to cannabinoid receptors (CBs) in the CNS and acts as a partial agonist to both CB₁ and CB₂ receptors. In MS, the mechanism of action of THC is unknown, although there is limited evidence that it has anti-inflammatory and neuroprotective properties [148].

Cannabidol (CBD) is a non-psychoactive constituent in cannabis and is the major constituent in the plant. It is thought to decrease the clearance of THC by affecting liver metabolism. It binds to both CB₁ and CB₂ receptors in the CNS, with a higher affinity to the CB₂ receptor.

In a review of six controlled studies evaluating a combination of THC and CBD for spasticity in MS, it was found that THC–CBD was well tolerated and improved patient self-reports of spasticity [149–155]. Objective measures did not show significant improvement compared with placebo [149]. Three of the six studies were placebo-controlled; the sample size range was 12–295 MS patients; the dose range was less than 10 mg/day to 120 mg/day; and the intervention range was 2–15 weeks [152,153,155]. Only one study reported a significant improvement in Ashworth score [154] and none of the studies reported a significant improvement in timed walk. The authors noted that side effects were mild and reported in both treatment and placebo groups. The authors concluded that there was significant improvement in patient-reported spasticity.
combined and that the combination of THC and CBD was well tolerated in MS. They noted that objective measures of spasticity showed no significant improvement.

Unlike the dietary supplements discussed, THC is a controlled substance (requiring a prescription in the USA) and is sold under the trade name of Marinol® (Solvay Pharmaceuticals, IL, USA).

MS & diet

The role of diet in both causing and ameliorating the severity of MS has intrigued people with MS and researchers alike. The relationship between dietary habits and MS has been explored most famously by Roy Swank, a US neurologist in the 1950s–1980s who advocated significant dietary modification in people with MS. The ‘Swank diet’ he devised is characterized by intake of a very low amount of saturated fats (no more than 10–15 g/day). In addition, people are advised to take cod liver (fish) oil supplementation, a major source of omega-3 FAs. Before the introduction of disease-modifying therapies in the mid-to-late 1990s, the ‘Swank diet’ was widely used by MS patients and is still followed by many patients today [156]. Observational studies published between 1953 and 2003 by Swank suggested that patients who follow a diet low in total fats and saturated fats have reduced MS disease activity and disability progression compared with those not following a low-fat diet [157–161]. The 50-year study that began in 1953 looked at the effects of the Swank diet in MS and provided follow-up information for 144 MS patients and demonstrated their survival [160]. In this study, MS patients were divided into two groups: ‘good dieters’ (n = 70) and ‘bad dieters’ (n = 74). The good dieters strictly followed a low-fat diet by consuming less than 20 g/day of fat and bad dieters consumed more than 20 g/day of fat. After 34 years, there had been 23 deaths in the good dieters group as compared with 58 deaths in the bad dieters group. After a period of 15 years during which subjects were not followed, investigators contacted the subjects again in the year 2000 and found only 15 survivors, all of which were from the good dieters group. Most of these patients (13 out of 15) were still ambulatory and found to be otherwise healthy MS patients. This study, although it is a unique long-term follow-up of an intervention for MS, has been criticized for the lack of a control group for comparison [162].

A small, 1-year, partially blinded randomized trial studied the effect of low-fat dietary intervention with omega-3 FA supplementation in 31 RRMS subjects [163]. Subjects were randomized into one of two groups: the ‘fish oil’ group and the ‘olive oil’ group. The ‘fish oil’ group was given a low-fat diet consisting of FAs from fish oil supplementation intake, not exceeding 15% of total daily calories. These subjects also took six fish oil capsules (equivalent to 1 g of fish oil; containing 65% omega-3 FAs; EPA 1.98 g/day and DHA 1.32 g/day). The ‘olive oil’ group received olive oil supplements (six capsules of 1 g of olive oil per day) and followed the American Heart Association Step I diet (total fat ≤30% of total daily calories and saturated fats <10% of total daily calories). The primary outcome of the study was the Physical Component Scale of the Short-Form Health Survey Questionnaire. Secondary outcomes were the Modified Fatigue Impact Scale and Mental Health Inventory. The subjects were followed for an average of 11 ± 2.9 months and the fish oil group maintained higher Physical Component Scale scores than the olive oil supplementation group (although this was not statistically significant). The MHI scores were similar in the two intervention groups. At the 6-month time point, the olive
oil group reported reduced fatigue as compared with the fish oil group (p = 0.035), which continued for 12 months. For both intervention groups, relapse rates were reduced compared with the year prior to entering the study. This study therefore suggested that a low saturated fat diet with fish oil supplementation might promote better physical and mental health for people with MS.

Another 2-year, open-label uncontrolled study examined the effects of dietary advice along with fish oil and vitamin supplementation in 16 newly diagnosed MS patients (four men and 12 women; mean age: 32 years; mean duration of MS: 1.6 years) [164]. The outcomes of the study included annual MS exacerbation rate and disability as measured by EDSS [164]. The intervention included increased fish intake (up to three to four times per week) along with vegetables and fruits daily, while reducing saturated fat intake from meats and dairy products, as well as sugar-containing products. The subjects received a vitamin B complex and 200 mg of vitamin C supplementation in addition to 5 ml of fish oil (containing 0.4 g of EPA, 0.5 g of DHA, 1.0 mg of vitamin A, 10 μg of vitamin D and 5.5 mg of vitamin E). After 2 years of the study intervention, there was a significant reduction in the mean annual exacerbation rate (pre-study rate: 1.39, decreased to 0.06; p < 0.001) and EDSS (pre-study score: 2.16, decreased to 1.63; p < 0.01). There was also a significant change in the blood lipid profile as evident by an increase in the plasma total phospholipid omega-3 FA levels and decrease in the omega-6 FA levels. Even though the reduction in relapse rate and improvement in EDSS were remarkable for an open-label study, the trial is limited by the lack of a control group and not being randomized or blinded. The positive study results are also criticized as possibly being due to physiologic placebo effects and that results could represent ‘regression towards the mean.’

A case-controlled 4-year study of 197 MS patients and 202 matched-control subjects examined the association between different dietary factors and the risk of MS [165]. This study shows support for a possible protective function against MS risk of the components frequently found in plants, such as vegetable protein and dietary fiber (especially from cereals), vitamin C, thiamine, riboflavin, calcium and potassium. This study also showed a significant positive relationship of a high-energy-intake diet and high animal fat consumption with the possibility of developing MS. At least two other researchers have examined the connection between nutrition and MS and found a significant prevalence of malnutrition in the disease. These authors recommend initiating healthy eating habits after diagnosis of MS [166,167].

These publications on the potential therapeutic effects of a low-fat diet and omega-3 FA supplementation certainly have methodological problems and are not definitive. However, given the low cost and safety of a low-fat diet and fish oil supplementation, these studies provide additional impetus for performing larger and better-designed trials. However, this approach to treating MS has never been subjected to a well-controlled clinical trial and consequently most physicians are unlikely to make dietary recommendations to people with MS.

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**Expert commentary**

There is a great divide between people with MS and most conventional physicians over the issue of CAM therapies. Most people with MS try CAM approaches and many continue to use them in an effort to improve the quality of their lives. For certain CAM therapies, MS patients report
benefit, enough so to continue taking them and to pay for them themselves. However, most conventional physicians discourage patients from pursuing CAM therapies, partly owing to the absence of scientific evidence of their benefit and partly owing to concerns over patients pursuing costly and potentially risky therapies. Most CAM therapies have not been studied in well-designed clinical trials and as a known limitation of small pilot studies, most clinical trials published thus far are not adequately powered to assess the desired outcome. However, the absence of evidence does not mean absence of benefit. In addition, surveys reveal that most people with MS are trying safe and relatively low-cost CAM therapies. The challenge is to identify CAM therapies that have some rationale for benefit and to conduct well-designed clinical trials to determine what works and what does not.

We believe that certain CAM therapies, particularly dietary supplements, have sufficient evidence from in vitro and animal studies to warrant investigation. As outlined in this review, there is ample evidence to justify investigations of omega-3 FAs and LA as disease-modifying therapies for MS. Other supplements, such as GB, might prove useful as symptomatic therapies for MS. Cannabis shows evidence from patient self-reports to improve spasticity, although this is not a dietary supplement and requires a prescription in the USA. Dietary supplements have the advantage of being amenable to double-blind placebo-controlled trials, which allows for screening of these therapies in pilot trials. The negative pilot trial of American ginseng extract for fatigue in MS and the positive pilot trial of GB for cognitive impairment in MS have allowed investigators to pursue one, GB, in a larger trial and conclude that the other, American ginseng, is not effective.

Dietary supplements that prove beneficial in MS offer opportunities for development and improvement for the pharmaceutical industry. LA is highly effective in the animal model of MS; however, it is erratically absorbed when taken orally by humans and this may prove to be a significant obstacle to its use as a treatment for MS. Developing formulations or derivatives of LA that are reliably absorbed from the GI tract would help in the development of LA as a treatment for MS and other disorders. Botanical extracts, such as GB, contain a variety of biologically active compounds. Should GB prove to be effective as a symptomatic therapy for cognitive impairment in MS, identifying the chemical constituents that are responsible for the positive effects could lead to further drug development.

In general, we recommend that healthcare providers have an open-minded approach to people with MS using CAM therapies. People with MS who use CAM therapies are generally well-informed and use CAM therapies that are safe. In our MS clinics, we encourage the use of disease-modifying agents as the first-line therapy for relapsing MS management, but emphasize an overall wellness approach for all MS patients. This wellness approach includes the use of CAM therapies such as a low-fat diet, supplementation with omega 3-FAs and vitamin D, as well as the use of mind and body techniques such as yoga, tai’chi and prayer. We also work closely with an MS-trained naturopath physician and acupuncturist to offer additional guidance to patients who are more inclined towards a holistic approach towards their disease. In our experience, most people who have adopted this wellness approach to their MS care report improvement in their sense of wellbeing and quality of life. It is of course uncertain whether these approaches alter disease activity. We strongly discourage people with MS to indulge in expensive CAM therapies without clear benefit or those that may potentially be toxic. Health professionals can also educate themselves as well as counsel their patients by utilizing information about CAM therapies from resources such as the National MS Society and the NIH.
especially the National Center of Complementary and Alternative Medicine websites and publications.

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Five-year view

Assessing the effectiveness of any therapy for MS takes several years. For CAM therapies that might alter the disease course, screening therapies in the animal model of MS, EAE, is a cost-effective way of determining whether a CAM therapy is worth pursuing in clinical trials. CAM therapies might be useful as symptomatic therapies, however, will require the conduction of well-designed double-blind placebo-controlled pilot trials. We anticipate that over the next 5 years we will see more trials of CAM therapies, both in EAE and in pilot trials in MS.

At present, the approaches that appear to hold the most promise and warrant further investigation in MS are:

- The effectiveness of a low-fat diet in relapsing MS
- The effectiveness of omega-3 FA and LA supplementation as anti-inflammatory and neuroprotective agents in both relapsing and progressive forms of MS
- The role of vitamin D as an anti-inflammatory and neuroprotective agent in MS

Within 5 years, large double-blind placebo-controlled trials of GB for cognitive impairment in MS will have been completed and we will know whether or not this is effective.

Key issues

- Conservative estimates are that at least a third of multiple sclerosis (MS) patients use complementary and alternative medicine (CAM) therapies.
- While the majority of MS patients who use CAM report benefit from diet, omega-3 fatty acids (FAs) and antioxidant supplements, these treatments have not been investigated with the rigor required to determine whether or not they are effective.
- There is evidence to support investigating the effectiveness of omega-3 FAs as an anti-inflammatory and neuroprotective therapy for MS.
- Lipoic acid (LA) is an antioxidant that has been shown to be effective in treating the animal model of MS, experimental autoimmune encephalomyelitis. Early clinical trials of LA in MS suggest that it can modulate some immunologic markers associated with disease activity, however, LA is erratically absorbed when taken orally. Further studies in MS are warranted.
- Ginkgo biloba may improve cognitive performance in MS but a larger clinical trial, which is currently underway, needs to be completed to prove its efficacy.
- American ginseng extract is ineffective in treating fatigue in MS.
- Vitamin D deficiency appears to increase the risk of developing MS. Results from large clinical trials are needed to determine whether vitamin D supplementation is a potential treatment for MS.
- Cannabis may improve spasticity in MS, although most trials show improvements in patient self-report and not in objective measures of spasticity (Ashworth).
- A low-fat diet deserves investigation as an adjunctive therapy for the control of relapsing MS.
Footnotes

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