



Slowly but surely, the world's attitude toward the COVID-19 pandemic is shifting from that of "getting rid of the virus and returning to normal life" to that of "learning to live with the virus" (and its seemingly endless variants). One illustration of these adjustments is the hybrid format of the upcoming Consortium of Multiple Sclerosis Centers (CMSC) Annual Meeting, which will be held on October 25-28. While some will enjoy socializing and networking in person (with adequate precautions) under the blue skies of Orlando, Florida, others will join from the comfort of their workplace or home. In a previous editorial, I have touched on the parallels that can be drawn between this shared experience, filled with uncertainty and disappointments, and the challenges and necessary adjustments faced by our patients. On a more positive note, I also see a similar desire to let one's personality and sense of humor shine through in the face of adversity in the elaborate and funny designs on cloth masks or mobility aids.

The present issue of *IJMSC* is not conceived as a theme issue, yet a common thread unravels through the articles: that of wellness and avoidance of comorbid complications stemming from neurogenic alterations of body functions. As a first example, lower urinary tract dysfunction, a common consequence of MS, may be associated with urinary tract infections (UTIs), which may in turn cause worsening of urinary symptoms or of other MS symptoms, and at times result in pseudo-exacerbations. It is, therefore, customary to have a low threshold for ordering urine testing in our patients. The retrospective study reported in the continuous education article by Griffith and colleagues suggests that some patients with MS may be treated for a UTI when they have asymptomatic bacteriuria. Yet, an untreated UTI may lead to urosepsis and hospitalization, often accompanied by loss of function and a prolonged recovery. The authors point out the need for UTI treatment guidelines specific to MS, as the general population guidelines are difficult to apply.

Dysphagia is another example of neurogenic dysfunction that can lead to severe medical complications such as aspiration pneumonia. Prevention of these complications relies on the strict application of recommendations from speech language pathologists regarding the preparation and ingestion of liquids and solid food. Noë and colleagues were successful in improving the compliance of kitchen staff and caregivers with dysphagia recommendations in an inpatient MS rehabilitation center,

after conducting a quality improvement project involving staff and patients.

A common concern among health care providers is the paucity of evidence to support and guide the management of many consequences of MS, including sexual dysfunction. In their literature review, Gopal and colleagues describe interventions for sexual dysfunction that fall within the physical therapy scope of practice and report encouraging efficacy results from within-group pooled analyses.

Two articles allude to differences in metabolism between individuals with MS and healthy adults. Bertapelli and colleagues report that the equations based on body mass index used in the general population to estimate percent body fat may not be as accurate in persons with MS due to differences in body composition. These authors propose a simple equation based on body mass index and sex to estimate percent body fat in MS, which they validated against the gold standard of dual-energy x-ray absorptiometry. In a randomized controlled crossover trial comparing a high-carbohydrate diet versus a high-triglyceride diet over a 3-day period, Bromley and colleagues observed differences in fatigue level and substrate utilization in healthy controls, but not in individuals with MS, and the MS group had a significantly lower rate of fat oxidation during exercise. Altogether, these findings suggest that wellness assessments and interventions specific to MS should be developed.

There is a general consensus on the need to encourage increased physical activity (PA) in persons with MS, yet several barriers to PA have been identified, including fatigue. Abonie and colleagues suggest activity pacing as a strategy to increase PA without significantly increasing fatigue, leading to improved quality of life. However, they found no association between self-driven activity pacing and PA or quality of life after rehabilitation. Would an intervention designed to facilitate activity pacing be more effective? We hope that these or other investigators will help answer this question.

Finally, Abbatemarco and colleagues report encouraging results from a pilot program of shared medical visits focused on wellness, even though some participants only attended one visit. The program was completed before the pandemic, and nowadays would face similar challenges to those of scientific conferences. However, group interventions are also more direly needed, given the social isolation that has disproportionately affected our patients.

—Francois Bethoux, MD
Editor in Chief