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I am not an early adopter of new technologies. I only abandoned my flip phone with its 2 x 2-cm screen 2 years ago, when it expired after countless years of faithful service. Admittedly, the concept and practical applications of artificial intelligence (AI) remain largely foreign to me. I did create a ChatGPT account; I launched 1 search for fun, and I haven't touched it since then. I am not particularly proud of this inertia, although I am less and less apologetic about it, having reached my mature years. Worries about being replaced by AI do not torment me because only I can crack dad jokes all day long, despite the many eyerolls they elicit. I do acknowledge that the prospects afforded to us by the versatility of AI in medicine are fascinating, although the enthusiasm is mixed with legitimate concerns. As a rehabilitation professional, I can see how AI may make rehabilitation technology "smarter" and help our patients with MS who have activity limitations as well as their loved ones who care for them. Nevertheless, in the world of scholarly publishing, AI engenders many debates. I invite you to browse the documents and resources posted by the Committee on Publication Ethics (<https://publicationethics.org/>), of which this journal is a member.

In this issue, we are proud to contribute to the growing body of literature on the use of AI in the diagnosis, monitoring, and management of multiple sclerosis (MS). Stoll and colleagues report on the use of machine learning to derive scores on the Expanded Disability Status Scale from assessments conducted on a mobile application, compared to scores that are derived via a neurologist's examination. While not a perfect match, the results are encouraging.

Cognitive difficulties occur frequently in MS, yet there are few strategies to improve cognitive function and they do not always yield significant results, as illustrated in the recently published results of the CogEx (NCT03679468) multicenter, randomized, sham-controlled trial of cognitive rehabilitation combined with exercise. Addressing factors that may contribute to cognitive impairment remains an important management strategy. While anecdotally observed, the detrimental effects of pharmacological agents on cognitive function in MS have not been thoroughly studied, which contrasts with the large body of evidence on these effects for the general population of individuals aged 65 years and older. Huebner and colleagues found associations between lower performance on a short battery of cognitive tests and the number of medications prescribed, as well as the burden of anticholinergic medications. In individuals with MS participating in a dietary intervention study, Saxby and colleagues observed a concomitant improvement of performance on a test of cognitive processing speed with an improvement in serum fatty acid profiles. While the associations reported in both studies do not establish causality, they are intriguing.

Several articles propose new strategies to identify, evaluate, and manage various symptoms and comorbidities associated with MS, such as using the Capability-Opportunity-Motivation-Behavior model to better understand factors associated with physical activity behavior (Huyhn and colleagues); exploring the correlates of sleep efficiency, ie, the percentage of time in bed actually spent sleeping as measured by polysomnography (Queisi and colleagues); seeking a better understanding of experiences related to spasticity, which are not reflected in the commonly used clinical measures (Thrower and colleagues); and critically analyzing the evidence on the outcomes of reflexology on various MS symptoms (Deenadayalan and colleagues).

I am constantly humbled by the empathy, tireless energy, inquisitiveness, and willingness to innovate exhibited by clinicians and care providers in the field of MS. It is my sincere hope that the contents of this March/April 2024 issue will add its modest contribution to their mission.

—**Francois Bethoux, MD**
Editor in Chief