UNIVERSITY OF SASKATCHEWAN
College of Medicine
OFFICE OF THE SASKATCHEWAN MULTIPLE SCLEROSIS CLINICAL RESEARCH CHAIR
RESEARCH-GROUPS.USASK.CA/SKMS-OFFICE

Revised: July 6, 2021

Automatic Extension of EDS Coverage

The Ministry of Health will be providing an automatic Extension of EDS of six months for those on an MS Drug with prior EDS renewal dates between March 1st, 2020 and September 30th, 2021:

https://formulary.drugplan.ehealthsask.ca/PDFs/July%201%202021-EDS%20Auto-Extension%20bulletin%20203.pdf

NeuroSask: Active and Connected

Beginning April 23rd, 2020, USask physiotherapist Dr. Sarah Donkers (PhD) and physical medicine and rehabilitation expert Dr. Katherine Knox (MD) started the program NeuroSask: Active and Connected, a twice-weekly videoconference program consisting of a physiotherapist-guided movement class, followed by an interactive session with a guest medical or wellness expert or a social activity.

Due to popular demand, the "NeuroSask: Active and Connected" program will continue to run until the end of December. The "active" movement portion of the program runs on Tuesdays and Thursdays from 2:00 p.m -2:30pm. On Thursdays, the "connect" portion of the program will follow from 2:30- 3:00 p.m.

To register for the NeuroSask: Active and Connected program please visit: https://rehabscience.usask.ca/neurosask/

Q and A for People Living with MS during COVID-9 Pandemic- Canadian Network of MS Clinics (CNMSC)

Below are the recommendations of a number of key MS opinion leaders in Canada. These are general guidelines, and your MS healthcare provider may suggest alternative strategies on an individual basis. There is no specific research to guide management of MS as it relates to COVID- 19. These recommendations are based on available information, known mechanisms of action of medications and experience with other similar infections / epidemics (ie influenza).

Q: Since MS is a chronic illness, is it a risk for COVID-19?

A: Your risk of getting COVID-19 is the same as everyone else's in our community. The risk is increasing with more reported cases. Having MS, or neuromyelitis optica, does not put you at greater risk of getting COVID-19. Most people have mild disease and the younger a person is, the better.

We do not believe MS puts you at greater risk of severe disease if you get COVID-19, however, the impact of having a viral infection may be greater for you. Any virus can cause a relapse, or it can cause a pseudo-relapse. Relapses and pseudo-relapses can be hard to tell apart. Usually a pseudo-relapse has the same symptoms that you have had before, typically, symptoms that might come and go at times of fatigue, stress or illness.

People with MS who are severely disabled (ie. having arm weakness and therefore possibly chest muscle weakness) may be at greater risk of more severe respiratory disease).

Some of the Disease Modifying Therapies (DMTs) may also increase risk (see below).

Q: How do I avoid COVID-19 infection?

A: Wash your hands frequently. Avoid touching your face. Avoid shaking hands or fist bumps (if you must shake hands - clean with hand sanitizer afterwards). Avoid going out in crowded public places especially if you are of higher risk and maintain social distancing (approximately 2 meters).

Q: Should I stop my DMT?

A: No. If you do not have COVID-19, you should not stop your DMT. Stopping your DMT may lead to relapses unnecessarily. In particular, there is no evidence to stop or hold first line DMTs including beta-interferons (Avonex, Betaseron, Rebif, Plegridy, or Extavia), glatiramer acetate (Copaxone, Glatect), teriflunomide (Aubagio), and minocycline as they are not immune- suppressive. Dimethyl fumarate (Tecfidera), and natalizumab (Tysabri) are also not immune-suppressive or only mildly immune-suppressive. (For DMF there may be increased immune- suppression if lymphocytes are below 0.5).

Fingolimod and natalizumab are associated with rebound MS activity and should not be stopped abruptly or without medical supervision. Fingolimod is being studied as a treatment for COVID-19, however it is also immune suppressing.

If you have distinct symptoms of COVID-19 or have tested positive and are taking fingolimod it will most likely be continued but you should contact your MS healthcare provider for an individual evaluation.

Q: Should I delay my infusion with ocrelizumab or rituximab?

A: No, not unless you have COVID-19, or a close contact has it. In this case a decision between yourself and your MS healthcare provider may result in a delay. There are no rebound relapses with these cell depleting therapies, and they are often a have a treatment effect that persists well beyond the 6 months - therefore a delay is possible.

Q. I have been on cladribine (Mavenclad) or alemtuzamab (Lemtrada) recently. Am I immune compromised and likely have severe disease with COVID-19?

A. This depends on how recently you completed the treatment course and what your lymphocyte count is. If your treatment was recently completed and you have lymphocytes below 0.5, then you are at an increased risk and should consider increased measures to avoid infection such as limiting public outings and maintaining social distancing. There is nothing that can be done, except the passage of time, to improve your lymphocyte count.

Q: I am about to start on a therapy. Should I delay starting?

A: If you are about to start a cell depleting therapy (alemtuzumab, ocrelizumab, rituximab or cladribine) you may want to consider a delay until we are past the threat of a large pandemic, particularly for cladribine and alemtuzumab, where there can be significant immune suppression for several months. However, the level of activity of your MS needs to be considered as an MS relapse also poses a significant risk. This should be discussed with your MS health professional.

Summary of specific DMT recommendations below:

Disease Modifying Therapies (DMTs) summary:

- Glatiramer (Copaxone, Glatect): no need to stop even with COVID infection
- Interferon –beta (Avonex, Betaseron, Rebif, Plegridy, or Extavia): no need to stop even with COVID infection
- Teriflunomide (Aubagio): no need to stop even with COVID infection
- Minocylcline: no need to stop even with COVID infection
- Dimethyl fumarate (Tecfidera): no need to stop even with COVID infection, except if lymphocytes are .5 or below- if below, should hold until lymphocytes are above 0.7
- Natalizumab (Tysabri): no need to stop even with COVID infection
- Fingolimod (Gilenya): no need to stop, call MS healthcare provider if you have symptoms of COVID or have tested positive
- Cladribine (Mavenclad): extra precautions if lymphocytes below 0.5; consider delaying start oftreatment. Discuss with MS healthcare provider
- Alemtuzumab (Lemtrada): extra precautions if lymphocytes are below 0.5; consider delaying start of treatment.Discuss with MS healthcare provider
- Rituximab/Ocrelizumab (Ocrevus): no need to stop therapy; can discuss with MS healthcare provider re delaying infusion beyond 6 months particularly if there has been a close contact or you are COVID positive or have symptoms