



National
Multiple Sclerosis
Society

**MS Learn Online
Feature Presentation
Managing Your Symptoms: Numbness, Dizziness and Vertigo
Featuring Dr. Patricia Coyle**

>> **Tom** Welcome to MS Learn Online, I'm Tom Kimball.

>>**Tracey** And I'm Tracey Kimball. We continue our series on Managing Your Symptoms with Dr. Patricia Coyle a neurologist at Stony Brook University in New York.

>>**Tom** In the first episode in the series, Dr. Coyle talked about fatigue. Now she discusses numbness, dizziness and vertigo.

>>**Tracey** And just like with any MS symptom, numbness, dizziness and vertigo can range from merely a nuisance to symptoms that truly impact quality of life. They are symptoms that have been experienced by our medical correspondent, Rick Somers himself.

>>**Rick Somers:** I know that when I was diagnosed many years ago, one of my initial symptoms that presented was numbness and tingling. Talk to us about that.

>>**Patricia Coyle:** Well, numbness and tingling represent a sensory symptom abnormality, and the sensory symptom is very, very frequently involved in MS early on, and certainly during the course. The sensory abnormality may be negative or positive. Negative would be a decrease or loss of feeling, and so when people say numbness, they may be referring to a numb, dead sensation, where they really don't appreciate normal sensation. It can also be positive. It can be accentuated, and people use the term numbness for pins and needles, so-called paresthesias, which can be irritating, positive, abnormal symptomatology.

Because the sensory system is so frequently involved in MS, you are often dealing with numbness, meaning numb, dead sensation, or numbness , pins and needles paresthesias, as part of MS.

>>**Rick Somers:** Talk about the permanence and the baseline of using the term exacerbation, and getting that numbness or feeling those tingling sensations, and then trying to get back to that pre-exacerbation place.

>>**Patricia Coyle:** Well, first of all, brand-new numbness or paresthesia can clearly represent a new attack or lapse with a new lesion that's formed in the central nervous system's sensory system. Generally, we require that the abnormalities remaining for more than 24 hours to be considered a true attack and is dissociated from an active infection that the person may be having to distinguish it from a pseudo relapse. So, clearly, you can have numbness and paresthesias as part of an MS attack.

With regard to recovery, generally after an attack I tell patients the maximum recovery is in about a 12-week period, but literally can go on for up to a year. And as a general rule of thumb, and it really crosses MS to other nervous system diseases, if somebody has had a deficit remaining for a year, then I generally tell them that it is unlikely to get better, that they are probably going to remain as a permanent abnormality.

>>**Rick Somers:** A patient comes in and says, "I'm tingling, I'm numb." How do you tell them to manage? What do you suggest?

>>**Patricia Coyle:** Well, the first thing is to see whether that represents a new attack and whether I want to treat that attack with steroids or not, to speed up the time frame of recovery. And that's going to be a dialogue with the patient based on their history, their prior response, etc. If it is a new attack, then I'll be counseling the patient that there's a reasonable chance that there is going to be improvement. If the tingling, for example, remains, then I think the issue is how bothersome is it?

>>**Rick Somers:** We were talking about numbness, and let's say one of your patients who you've been seeing for a long time calls and says I'm feeling numb, I'm feeling some of those sensory issues. I want to come in and see you. How do you manage their issue?

>>**Patricia Coyle:** So, the first thing I want to determine is whether this new numbness or paresthesias is representing a new relapse or could be a pseudo-relapse. If it's a new relapse, then the issue will come up whether we wish to use steroids as an acute treatment to speed up the time frame of recovery or not. And that will be a dialogue with the patient, that we will come to that.

If I think it's a pseudo-relapse, then I want to identify any precipitating infection, and if there is specific treatment I want to do that. I want to control and increase in temperature.

If the numbness or paresthesias are remaining and are looking like they're going to be a more extended problem, then I would really dialogue with the patient very carefully.

The first issue is how bothersome is the abnormal sensation. It's not reaching the level of pain. I think when you have pain, it's very clear that that is a quality of life issue that needs to be treated. The patient is suffering. With things like pins and needles or numbness, sometimes the more the patient focuses on it, the more they actually enhance it. They're increasing their awareness of it. The more they can kind of put it out of their mind or tend to neglect it or try not to think about it, actually the less it becomes.

So, I actually have a dialogue to see whether it's significant enough that the patient wants to go on a daily medication to blunt it or not. And frequently they'll say no. If you tell me I don't have to worry about it and it's probably going to go away, I'll just give it more time.

There are specific medications that you can use to blunt abnormal sensations. None of them will take the abnormal sensation away, however.

>>**Rick Somers:** It's really a question of what you personally can manage and the choice you want to make in how you want to live.

>>**Patricia Coyle:** Absolutely. There may be some people who say, "This is so bothersome to me that anything that might relieve it is good," or, "No, if you tell me this doesn't put me in any harm's way and it may go away, then I'm not going to worry about it and I don't need to take anything."

>>**Rick Somers:** I came across the term pseudo-exacerbation, which I was not familiar with, and numbness can often be considered a pseudo-exacerbation, correct?

>>**Patricia Coyle:** Yes. Well, a pseudo-exacerbation, the MS patient has a number of lesions. These are the plaques where nerve conduction is typically normal and so they're aware of no deficit. But given certain metabolic stressors, such as raising the body temperature, as would commonly happen if the individual was fighting off an infection, that can result in a temporary failure of nerve conduction in that old damaged plaque area. That will then manifest as an abnormality, which if it's involving a sensory track, can be a return of numbness or pins and needles.

The difference is that as soon as the infection, the metabolic perturber, is taken care of or controlled, it goes away. So, it will be coincident with an overt infection or something wrong, and it will be relatively transient. As soon as that's under control or you bring the temperature down, then the deficit will go away, as opposed to a true relapse.

>>**Rick Somers:** Right. Let's talk about the dizziness and the vertigo that go with MS.

>>**Patricia Coyle:** Well, certainly the expectation is that an MS patient who has abrupt onset of dizziness, vertigo, is probably representing a central nervous system disorder related to their MS. However, MS patients can also get peripheral inner ear problems. So, I do want to do some investigation in talking to them and examining them, to make sure that I'm not misinterpreting a peripheral labyrinth inner ear issue from an MS issue.

So, putting the peripheral issue aside, if I think this is a new central nervous system problem, there's a very real possibility that that represents a new relapse, a brain stem relapse, I will investigate and certainly consider offering treatment with steroids for an acute attack to speed up the time frame of recovery.

>>**Rick Somers:** If somebody comes in and experiences -- how do you define vertigo?

>>**Patricia Coyle:** Well, vertigo by definition must have an element of the room spinning or the individual person spinning. It really does require a rotational spinning sensation. And that's a very good point, because people describe dizziness and complain about dizziness, and there are really three broad categories.

There is true vertigo, which must have a spinning sensation. Then there's the dizziness, where the person feels like they're going to pass out, a so-called presyncopal event. And then, finally, there's a much vaguer dizziness, where the person says, "I feel like my balance is off; I feel like I'm walking on a rocking boat." All three of those may be described as dizziness, but you would evaluate them a little bit differently.

>>**Rick Somers:** And there are drugs and therapies that will help people along?

>>**Patricia Coyle:** Well, absolutely. So, the first thing is to determine whether by any chance this is a peripheral and not a central problem in the MS patient. But assuming it's a central problem, first of all, in my mind, is it a central nervous system relapse and do I need to treat that? And then aside from that, there are specific medications that one may use to kind of dampen a dizzy, vertiginous sensation. There may be specific balance techniques that one will use. And, honestly, typically over time it does get better. It's very rare for dizziness to stay at the same degree as a chronic complaint.

>>**Rick Somers:** People who don't have MS and want to learn about it, I try to explain to them about the dizziness, the vertigo, the fatigue, and the best way I can liken it is by telling them, you know that feeling sometimes when you've had maybe a little too much to drink? That's for a lot of people what MS is. It is for me and I would imagine for some of the people that you deal with as well.

>>**Patricia Coyle:** Right.

>>**Rick Somers:** Thank you so much for your time. We appreciate it and look forward to learning more from you soon.

>>**Patricia Coyle:** My pleasure.

>>**Rick Somers:** Thanks.

>>**Tracey** We want to thank Dr. Patricia Coyle for sharing her time and expertise with us. And thank you for joining us on MS Learn Online.

>>**Tom** If you need additional information on this topic, stick around and we'll tell you how you can learn more.

>>**Tracey** We look forward to seeing you again.