Spotlight on postural control in patients with multiple sclerosis

Luca Prosperini¹
Letizia Castelli²
¹Department of Neurosciences, San Camillo-Forlanini Hospital, Rome, Italy; ²Department of Neurology and Psychiatry, Sapienza University, Rome, Italy

Abstract: Multiple sclerosis (MS) is a disease that heavily affects postural control, predisposing patients to accidental falls and fall-related injuries, with a relevant burden on their families, health care systems and themselves. Clinical scales aimed to assess balance are easy to administer in daily clinical setting, but suffer from several limitations including their variable execution, subjective judgment in the scoring system, poor performance in identifying patients at higher risk of falls, and statistical concerns mainly related to distribution of their scores. Today we are able to objectively and reliably assess postural control not only with laboratory-grade standard force platform, but also with low-cost systems based on commercial devices that provide acceptable comparability to gold-standard equipment. The sensitivity of measurements derived from force platforms is such that we can detect balance abnormalities even in minimally impaired patients and predict the risk of future accidental falls accurately. By manipulating sensory inputs (dynamic posturography) or by adding a concurrent cognitive task (dual-task paradigm) to the standard postural assessment, we can unmask postural control deficit even in patients at first demyelinating event or in those with a radiologic isolated syndrome. Studies on neuroanatomical correlates support the multifactorial etiology of postural control deficit in MS, with the association with balance impairment being correlated with cerebellum, spinal cord, and highly ordered processing network according to different studies. Postural control deficit can be managed by means of rehabilitation, which is the most important way to improve balance in patients with MS, but there are also suggestions of a beneficial effect of some pharmacologic interventions. On the other hand, it would be useful to pay attention to some drugs that are currently used to manage other symptoms in daily clinical setting because they can further impair postural controls of patients with MS.

Keywords: multiple sclerosis, postural control, balance, accidental falls, force platform, cognitive-motor interference

Introduction
Postural control can be defined as the ability to uphold the body’s center of gravity within the base of support while maintaining a specified posture, making a voluntary movement or reacting to an external disturbance.¹

Postural control strategies include either compensatory postural adjustments following an unpredicted disturbance or anticipatory postural adjustments that counteract any destabilizing consequences of voluntary movement or predicted disturbance.²

Postural responses cannot be considered as “reflex-like” automatic response, but rather balance control represents a complex task that is controlled by a combination of central and peripheral components including spinal reflexes, supraspinal commands,
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and the integration of afferent and/or efferent signals passing through the visual, vestibular and somatosensory systems, respectively, by the central nervous system (CNS).3 Biometric factors, physiologic functions, cognitive processing, emotional status, visual feedback and cerebellar activity have shown to influence postural sway. Consequently, numerous disorders including injuries, aging or neurologic, otologic and orthopedic pathologies can adversely affect postural sway. Deficiency in any one of the mechanisms involved in postural control can produce detrimental effects on balance, causing a sense of instability, vulnerability, as well as predisposing to accidental falls and further injury.4

Multiple sclerosis (MS) is the most common cause of nontraumatic, progressive disability in young adults.5 MS is both an inflammatory and neurodegenerative disease characterized by demyelination and several degrees of axonal loss of the brain and spinal cord.6 By affecting the ability of neurons to communicate with each other effectively, MS can also be depicted as a “disconnection syndrome” leading to a variety of neurologic and neuropsychological deficit.7 The deficient integration of neural pathways, due to the widespread and variable distribution of CNS damage in patients with MS, can also affect postural control and the ability to maintain adequate balance.8 Postural control can even be impaired by MS-driven damage to peripheral organs providing sensory inputs to CNS or involved in motor output (Figure 1).

Indeed, impaired postural control is often observed in MS, with approximately two-thirds of these patients reporting lack of balance and coordination as the main symptom affecting their mobility in daily living.9 Balance deficit reduces mobility and independence, leads to falls and injuries, and impacts upon overall quality of life.10 Fatigue, muscle weakness and spasticity further contribute to compromise adequate balance and predispose patients to accidental falls (Figure 2).8,11–14

**Accidental falls**

Overall, frequency of accidental falls in people affected by MS is greater than in general population, as indirectly suggested by case–control studies documenting an approximately twofold increased risk of fall-related fractures and/or injuries in patients with MS compared with sex/age-matched individuals without MS (Table 1).15–20

Observational studies conducted on young and middle-aged MS sample also showed that the proportion of fallers may range from 30% to 63% in a time frame of 1–12 months, with about 29%–45% being recurrent fallers.14 These proportions are quite impressive if we consider that about 30% of community-dwelling healthy adults over 65 years fall in a 12-month period, and only 10% are recurrent fallers.21 Furthermore, the number of accidental falls was collected retrospectively in most of these observational studies, thus leading to an underestimation of events occurred.

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![Figure 1 Schematic of postural control and its alterations in MS.](https://www.dovepress.com/)

**Abbreviation:** MS, multiple sclerosis.
fact, although there is a good correlation ($r=0.82$) between prospective recording and retrospective self-reporting of accidental falls, retrospective data are prone to recall bias, mainly because only falls resulting in injury are more likely to be reported by patients.22

Fall tendency may occur early in the course of the disease, even before walking and balance impairment become clinically evident and even after the first demyelinating event.23 Near-falls (i.e., a trip or stumble) occur commonly, but are underreported by patients with MS, despite the fact that near-falls and accidental falls share similar circumstances surrounding fall events, such as transferring outside the home and tripping over an obstacle; however, accidental falls can happen even indoor, especially in the kitchen or bathroom.24,25

Factors that predispose patients with MS to accidental falls are a higher level of disability, a progressive disease course, the use of assistive devices for ambulation, a worse postural control and an impaired cognition13,14,26

### Assessment of postural control

Evaluating the level of impairment in postural control is clinically relevant for several purposes, including early detection of subjects at risk of falling, understanding of underlying pathophysiology and objective documentation of therapeutic efficacy.

Balance deficit can be quantified by means of clinical scales and force platforms. Clinical scales to evaluate balance encompass physician-rated scales, stop-watch measures

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**Table 1** Case–control studies exploring the incidence of fall-related fractures and injuries in patients with multiple sclerosis

<table>
<thead>
<tr>
<th>Study</th>
<th>Average age (years)</th>
<th>Cases</th>
<th>Controls</th>
<th>Outcome</th>
<th>Risk $^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bazelier et al$^{13}$</td>
<td>44.8</td>
<td>5,565</td>
<td>33,360</td>
<td>Any fracture</td>
<td>1.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hip fractures</td>
<td>2.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Osteoporotic fractures</td>
<td>1.4</td>
</tr>
<tr>
<td>Cameron et al$^{16}$</td>
<td>60.3</td>
<td>721</td>
<td>194,696</td>
<td>Injurious falls</td>
<td>1.9</td>
</tr>
<tr>
<td>Bazelier et al$^{17}$</td>
<td>43.6</td>
<td>2,415</td>
<td>12,641</td>
<td>Any fracture</td>
<td>0.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fall-related fractures</td>
<td>2.1</td>
</tr>
<tr>
<td>Bazelier et al$^{18}$</td>
<td>36.9</td>
<td>2,963</td>
<td>15,436</td>
<td>Any fracture</td>
<td>1.0</td>
</tr>
<tr>
<td>Ramagopalan et al$^{19}$</td>
<td>~50</td>
<td>87,873</td>
<td>7,820,697</td>
<td>Femur/hip fractures</td>
<td>1.9</td>
</tr>
<tr>
<td>Bhattacharya et al$^{20}$</td>
<td>~65</td>
<td>2,631</td>
<td>1,063,773</td>
<td>Any fracture</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Notes: $^a$Values $>1$ indicate increased risk in patients with multiple sclerosis.
and even self-administered questionnaires. Although some clinical scales are easy and relatively quick to use, they are hampered by their variable execution and subjective judgment in the scoring system. Moreover, when used to predict patients at risk of falls, clinical scales have poor performance in discriminating between fallers and nonfallers, mainly due to their low sensitivity (i.e., performance in detecting fallers) and moderate–good specificity (i.e., performance in detecting nonfallers). Other limits of clinical scales are their nonlinear distribution and floor or ceiling effect, especially when evaluating patients with subtle balance deficit (Table 2). Therefore, some authors suggest that, in clinical practice, multiple tests should be administered for accurately identifying fallers. Alternatively, the Balance Evaluation Systems Test (BESTest) exhibits very good accuracy in predicting accidental falls (>90%), but it is time-consuming and requires many tools for the assessment of six different aspects of human balance, namely biomechanical constraints, stability limits, postural responses, anticipatory postural adjustments, sensory orientation and stability in gait. The use of a shorter version (mini-BESTest), with only a 10-minute administration time, could be more applicable to daily clinical setting.

To overcome all the aforementioned limitations of clinical scales, there has been an increased interest about computer-based and objective instrumented measurements of balance. Posturography is an umbrella term that indicates all the techniques used to quantify postural control in upright stance, in either static or dynamic conditions, by means of a force platform. Force platforms are instruments that measure ground reaction forces generated by a body standing on or moving across them, to quantify biomechanical parameters of human balance control. Static posturography refers to the measurement of postural sway of the body’s center of pressure (COP) during quiet standing on a fixed support surface, while dynamic posturography involves the use of induced balance perturbation, such as shifting the support surface, using an unstable support surface, moving the visual surround, applying stimuli to upper body parts or performing voluntary weight shift.

Static posturography provides objective measurements of postural control that have been shown to be not only highly reliable, but also valid in differentiating healthy controls from patients with MS. Furthermore, static standing balance measurements are more sensitive and accurate than a common clinical test (the Berg Balance Scale) in predicting accidental falls in MS. This can be also displayed by the statokinesigram, that is, layout of a line connecting the successive positions of the body's COP during a stop-watch recording (Figure 3).

All posturographic techniques provide detailed and objective measurements of a wide range of time-domain or frequency-domain features of postural control, based on the sway of COP, that is, the point of application of the resultant from the vertical force's action. These measurements consist of many different parameters, including (but not limited to) speed, range, root mean square distance, path, area and 95% confidence ellipse, and can be characterized on the anteroposterior or mediolateral axis or as the sum of the COP displacements.

However, while static posturography is performed in conditions that are somewhat away from those encountered in daily-life activities, dynamic posturography seems to be a more ecologic approach to investigate postural control. Dynamic posturography assessment provides data on the motor and sensory contribution to balance control by manipulating one or more specific inputs (visual, vestibular or proprioceptive) involved in postural control. Moreover, the measurement of postural sway of the body’s center of pressure (COP) during quiet standing on a fixed support surface, while dynamic posturography involves the use of induced balance perturbation, such as shifting the support surface, using an unstable support surface, moving the visual surround, applying stimuli to upper body parts or performing voluntary weight shift.

### Table 2 Clinical scales currently used to assess postural control and balance in multiple sclerosis

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Brief description</th>
<th>Time of administration</th>
<th>Overall score</th>
<th>Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities-Specific Balance Confidence</td>
<td>16-item self-administered questionnaire</td>
<td>15 minutes</td>
<td>0–100</td>
<td>↓</td>
</tr>
<tr>
<td>Balance Evaluation System Test</td>
<td>36-item physician-rated scale</td>
<td>30 minutes</td>
<td>0–108</td>
<td>↓</td>
</tr>
<tr>
<td>Berg Balance Scale</td>
<td>14-item physician-rated scale</td>
<td>15 minutes</td>
<td>0–56</td>
<td>↓</td>
</tr>
<tr>
<td>Dizziness Handicap Inventory</td>
<td>Multidimensional 25-item self-administered questionnaire</td>
<td>15 minutes</td>
<td>0–100</td>
<td>↑</td>
</tr>
<tr>
<td>Dynamic Gait Index</td>
<td>8-item physician-rated scale</td>
<td>10 minutes</td>
<td>0–24</td>
<td>↓</td>
</tr>
<tr>
<td>Falls Efficacy Scale International</td>
<td>16-item self-reported questionnaire</td>
<td>10 minutes</td>
<td>0–100</td>
<td>↑</td>
</tr>
<tr>
<td>Four-Square Step Test</td>
<td>Stop-watch measurement</td>
<td>≤3 minutes</td>
<td>N/A</td>
<td>↑</td>
</tr>
<tr>
<td>Mini-BES Test</td>
<td>14-item physician-rated scale</td>
<td>10–15 minutes</td>
<td>0–28</td>
<td>↓</td>
</tr>
<tr>
<td>Timed Up-and-Go Test</td>
<td>Stop-watch measurement</td>
<td>≤3 minutes</td>
<td>N/A</td>
<td>↑</td>
</tr>
<tr>
<td>Tinetti Performance-Oriented Mobility Assessment</td>
<td>16-item physician-rated scale</td>
<td>10–15 minutes</td>
<td>0–48</td>
<td>↓</td>
</tr>
</tbody>
</table>

**Note:** Worse postural control indicated by lower (↓) or higher (↑) scores.

**Abbreviation:** N/A, not applicable.
these data can be combined into composite scores, such as the equilibrium score or the postural stability index.\(^4^0\) However, it has been found that 13%–22% of patients with MS fell under the more difficult conditions of dynamic posturography, especially when forced to rely only on a single input.\(^4^1\) Therefore, dynamic posturography seems to be less suitable than static posturography to assess postural control in patients with MS. Moreover, dynamic posturography requires an administration time longer than static posturography, and a more expensive and bulky equipment with respect to standard force platform.

Recently, low-cost force platforms using commercial devices have been proposed as a solution to overcome the aforementioned limitations of an expensive and bulky equipment. The commercial Wii balance board, an off-the-shelf accessory used for playing with Wii and Wii U video game consoles (Nintendo, Kyoto, Japan), contains load cells detecting body’s weight shifts. Although less accurate than standard force platforms because of their low-resolution measurements, low-cost systems based on Wii balance board can be useful in situations where lower accuracy and precision may be acceptable, as in daily clinical setting.\(^4^2\) While excellent test–retest reliability (\(>75\%\)) was reported for Wii balance board-based low-cost systems, their agreement with standard force platform is at best adequate (40%–74%).\(^4^2\) In fact, postural measurements obtained from Wii balance board are wider than those obtained from standard force platform, especially in conditions where there is lower performance variability (e.g., assessment of postural sway with eyes opened in subjects with mild disability). By contrast, Wii balance board performs more consistently with standard force platforms where there is higher performance variability (e.g., assessment of postural sway with eyes closed in subjects with greater disability). All these considerations imply that, from a clinical standpoint, low-cost systems can be effectively used in longitudinal study to test relative change in the same individual, while they are not recommendable to test absolute difference across individuals in cross-sectional study. Therefore, the clear advantage of these low-cost systems, representing a time-/space-/money-saving alternative to bulky and expensive laboratory-grade force platform, should be balanced with their disadvantages of a lower accuracy and worse signal-to-noise ratio.

Postural control can be reliably assessed also by the visual perception computing systems enabled with the Kinect camera, a motion-sensing input device developed for playing video games running on Xbox 360, Xbox One and Windows-equipped personal computers (Microsoft, Redmond, WA, USA). The Kinect system contains an RGB color Video Graphic Accelerator camera and an infrared depth sensor that work together to detect body motion and to display a real-time physical image. Other than as a surrogate for static posturography assessment,\(^4^\) the Kinect has also been used as a surrogate for gait analysis in MS populations.\(^4^\)–\(^4^\)

**Cognitive-posture interference**

Patients with MS often exhibit deficits in both postural control and cognitive functions, and there is emerging evidence that a postural task and a cognitive task may interfere with each other when performed simultaneously,\(^5^9\) raising the hypothesis of an overlap between network subserving the postural control and some cognitive functions.\(^5^0\)–\(^5^1\) This phenomenon is generally defined as cognitive-motor interference and, in the specific case of balance, is called cognitive-posture interference.\(^5^2\)

Cognitive-posture interference can be purposely investigated by means of dual-task paradigm experiments, that is, a study procedure that requires an individual to perform two tasks simultaneously.\(^5^3\) Ideally, a dual-task experiment should assess a cognitive task and a motor task without any mutual interference (single-task condition) and while performed concurrently (dual-task condition). This framework allows...
the estimation of the so-called dual-task cost, that is, the percentage change from single-task to dual-task condition, for the cognitive and the motor task.54

To better elucidate the relationship between the cognitive task and the motor task in dual-task situations, Plummer and Eskes54 proposed a graphical representation of the cognitive-motor interference patterns. This can be applied also to cognitive-postural interference phenomenon, by calculating the dual-task cost of balance and cognition according to the following formulas:

\[
\text{DTC} (\%) = \frac{- \text{postural sway}^{\text{DT}} - \text{postural sway}^{\text{ST}}}{\text{postural sway}^{\text{ST}}} \times 100\%, \text{ when higher values indicate worse performance;}
\]

\[
\text{DTC} (\%) = \frac{\text{correct items}^{\text{DT}} - \text{correct items}^{\text{ST}}}{\text{correct items}^{\text{ST}}} \times 100\%, \text{ when lower values indicate worse performance;}
\]

where DTC is dual-task cost, DT is dual-task, and ST is single-task.

Afterwards, the two dual-task costs, that of cognition and that of balance, can be plotted against each other to identify a specific pattern among nine possible patterns: mutual interference or facilitation, balance interference or facilitation, cognitive interference or facilitation, balance-priority or cognitive-priority tradeoff, and no interference (Figure 4). Worthy of note, no literature data and specific rules are currently available to define the boundaries of the no-interference area.54

Dual-task studies aimed at exploring the cognitive-postural interference phenomenon in MS populations were mainly based on static posturography assessment while performing a concomitant cognitive test. Most of these studies suggested a predominant pattern of balance interference, that is, the dual-task condition causes deterioration of postural control.49

However, the reciprocal effect of dual-tasking on the cognitive and a static balance task is not always explored in the literature, with the changes of cognitive performance during balance testing being reported only rarely. Another unsolved issue is which concurrent cognitive task has the most detrimental effect on postural control in patients with MS. Recently, it has been reported that cognitive task exploring executive functions are the most suitable to unmask the cognitive-posture interference phenomenon, but these data require further confirmation.50

The clear advantage of dual-task paradigms is that they increase efficiently the sensitivity of a clinical test by exacerbating existing subtle deficits. Deterioration in balance when performed in conjunction with a concurrent cognitive task has been described indeed not only at the latest stage of MS, but also in patients without any overt cognitive deficit and even in subjects at the first demyelinating event or radiologically isolated syndrome, that is, asymptomatic subjects with neuroimaging findings suggestive of demyelinating disease.50,55,56 Several detrimental consequences of cognitive-postural interference have been reported in patients with MS, including an increased risk of accidental falls, a higher level of fatigue and a reduced quality of life, especially in terms of social function and physical role perception.57–60 Nonetheless, the clinical relevance of this phenomenon in MS populations needs to be investigated more deeply.

![Figure 4 Patterns of cognitive-postural interference based on the reciprocal DTC of balance and cognition.](https://www.dovepress.com/)

**Note:** The asterisk indicates no interference.

**Abbreviation:** DTC, dual-task cost.
Neuroanatomical correlates of postural control deficit

The deficit of postural control observed in patients with MS, who have a widespread, variable and sometimes extensive damage into CNS, may be due to multifactorial causes that differ from person to person. Therefore, postural balance deficit has been generally interpreted as a result of an impaired central integration of visual, vestibular and somatosensory inputs. However, it is also possible that damage in specific locations of CNS is the primary contributor to MS-related balance deficit, as suggested by magnetic resonance imaging (MRI) studies.

One preliminary study found that the presence of a greater lesion volume (as seen on T2-weighted images) at brainstem level might be considered as a risk factor for multiple accidental falls (collected in a time frame of 6 months), regardless of the patient’s disability level.

Both slowed afferent proprioceptive conduction along demyelinated dorsal columns of spinal cord and damage of proprioceptive neural pathways originating from right brain hemisphere have been proposed as important causes of impaired postural control. Another hypothesis proposes the damage of cerebellar connections as the primary contributor to the balance impairment or, more extensively, the focal and diffuse involvement of the cerebellum, its connections, and other associative regions.

The severity of balance impairment has been shown to be related with both damage along specific white matter tracts – including cerebellar peduncles, pons, thalamus and some supratentorial associative bundles – and regional atrophy of anterior lobules of the cerebellum (IV, V, VI) and lobule VIII. The remarkable disparity between the widespread abnormalities in white matter tracts and the selective grey matter damage of the cerebellum also suggests that postural control deficit is caused by a cerebellar atrophy secondary to disconnection from the cerebral cortex and the spinal cord.

Clinically relevant association between impaired postural sway and damage of cerebellar connections has been demonstrated not only with conventional and nonconventional structural MRI, but also with resting-state functional MRI techniques. Compared to healthy subjects, patients with MS exhibit abnormalities of cortico-cerebellar circuits, with decreased connectivity in caudate nuclei and thalami, and increased connectivity in the cerebellum, pons, left amygdala and orbitofrontal cortices. In particular, decreased connectivity between dentate nuclei of cerebellum and the left caudate nucleus has been related with worse postural control. This altered connectivity within the cerebellar network suggests a compensatory mechanism leading to an adaptive role in maintaining an adequate balance, as also supported by a recent study showing an association between better postural control and greater connectivity within a specific area of the anterior lobe of cerebellum belonging to the leg motor network.

However, networks involved in postural control regulation can be different in diverse situations. Consequently, damage at different levels of CNS can result in different types of balance deficit. When all sensory inputs (visual, proprioceptive and vestibular) are available, the resulting balance deficit is related mainly to cerebellar atrophy and demyelinating lesions along cerebellar connections, while spinal cord atrophy and demyelinating lesions in brainstem are the principal contributors of a worse postural control when the visual input is lacking.

The severity of cognitive-posture interference due to MS has been related with a higher probability of detecting demyelinating lesions in distinct anatomical regions – namely the superior and anterior radiate – bilaterally. Therefore, it is possible that disconnection of brain circuitry between cerebellum, thalami, striatum and prefrontal areas – connected through the anterior and superior corona radiate – can impair the higher-level postural control required to maintain an adequate balance in dual-task situations.

Interventions to improve postural control

Rehabilitation is currently the cornerstone for managing and improving postural control in patients with MS. There are a lot of strategies that have been proposed, including proprioceptive training, motor and sensory training, endurance training, step training, Pilates exercises, whole-body vibration, hippotherapy (equine-assisted therapy), balance-based torso weighting, Tai-Chi Chuan, vestibular rehabilitation, robot-assisted gait training, virtual reality and exergames. A recently published meta-analysis specifically addressing this topic revealed that gait and balance functional training interventions yielded the greatest effect on postural control, and showed that higher-intensity programs maximized effectiveness. Overall, these rehabilitative interventions promoted only a small decrease in fall risk, thus suggesting also that the magnitude of the improvements achieved was not sufficient to influence fall outcomes. However, the use of fall event as outcome measures is affected by several methodologic concerns, as discussed earlier (see also “Accidental falls” section). Furthermore, published studies suffer from a number of limitations that represent an avenue for future investigation, including small sample sizes, few data on long-term effect and retention of training-induced improvement, lack of standardized postural control outcomes, wide
variability in terms of schedule, duration, frequency and intensity of rehabilitative interventions.

Postural control impairment cannot be effectively managed with pharmacologic interventions, because there is not yet any medication with indication for improving balance. Furthermore, some drugs that are broadly used in neurologic setting may even worsen gait and balance of patients with MS, including antidepressives (selective serotonin reuptake inhibitor and serotonin and norepinephrine reuptake inhibitor), centrally acting muscle relaxants, genitourinary medications and sex hormones (Table 3). If there is also a dose-dependent effect of the aforementioned classes of medications on the risk of accidental falls is still controversial.

The potential effect of cannabinoids and its derivatives on postural control is still unclear. There are few case reports showing clinical improvement of motor coordination in patients with MS affected by ataxia. By contrast, it has also been reported that cannabis smoking further impairs posture and balance in patients with MS and, more recently, a large multicenter, postmarketing experience in Italy showed that drowsiness and dizziness are two relevant reasons for premature discontinuation of nabiximols, a plant-derived δ-9-tetrahydrocannabinol-cannabidiol oromucosal spray medicine for add-on treatment of refractory MS-related spasticity. Furthermore, an independent study conducted on a small sample of patients with MS (n=22) has suggested a detrimental effect of nabiximols on postural control (detected at static posturography), especially in dual-task condition.

Short-term improvement of postural control has been reported with prolonged-release oral dalfampridine, a voltage-gated potassium-channel blocker able to improve action potential conduction in demyelinated axons that was specifically licensed to improve walking in patients with MS. More specifically, the beneficial effect of dalfampridine on balance might be mediated by an enhanced inhibitory drive and precision of pacemaking of cerebellar Purkinje cells.

A potential efficacy of riluzole as symptomatic therapy in different forms of cerebellar ataxia, including two patients with MS, has been suggested in a double-blind randomized clinical trial. By opening small-conductance calcium-activated potassium channels, riluzole might reduce hyper-excitability of the neurons in the deep cerebellar nuclei that receive altered inhibitory input from Purkinje cells.

Finally, the suggestive theory that dopamine agonists can reduce cognitive-posture interference has been recently raised, under the hypothesis that disconnection of CNS areas innervated by dopaminergic neurons (striatum and prefrontal cortex) is responsible for an increased dual-task cost of balance in patients with MS. However, to our knowledge, there are no data available to support the use of dopamine-agonist therapy in the MS setting.

Conclusion

Postural control is impaired early in the MS course, even in patients with minimal or no disability. Balance problems result in accidental falls and reduced mobility, negatively affecting quality of life and daily living activity.

Impaired postural control has multifactorial causes in MS, given the variable and extensive damage to the CNS. The role of rehabilitation in improving postural control deficit and, to a lesser extent, in reducing the risk of accidental falls is well established. At the moment there is no pharmacologic intervention specifically indicated for balance problems, but there are promising data favoring drugs that modulate neural transmission at cerebellar and prefrontal network level.

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Table 3 List of medications potentially affecting postural control in multiple sclerosis

<table>
<thead>
<tr>
<th>Deteriorating postural control</th>
<th>Improving postural control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrally acting muscle relaxants</td>
<td>Prolonged-release fampridine</td>
</tr>
<tr>
<td>Selective serotonin reuptake inhibitor</td>
<td>Riluzole</td>
</tr>
<tr>
<td>Serotonin-norepinephrine reuptake inhibitor</td>
<td>Dopamine agonists</td>
</tr>
<tr>
<td>Genitourinary compounds</td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
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<tr>
<td>Sexual hormones</td>
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References

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