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Prognostic value of spinal cord MRI in Multiple Sclerosis patients

Soizig Leguy^{1,2}, Benoit Combès², Elise Bannier^{2,3}, Anne Kerbrat^{1,2,*}

1 CHU Rennes, Neurology department, 2 Rue Henri le Guilloux, 35000 Rennes, France

2 Univ Rennes, Inria, CNRS, Inserm, IRISA UMR 6074, Empenn U1228, Rennes, France

3 CHU Rennes, Radiology department, Rennes, France

*Corresponding author

nne.KERBRAT@chu-rennes.fr

Abstract

Multiple sclerosis (MS) is a common inflammatory, demyelinating and neurodegenerative disease of the central nervous system that affects both the brain and the spinal cord. In clinical practice, spinal cord MRI is performed far less frequently than brain MRI, mainly owing to technical limitations and time constraints. However, improvements of acquisition techniques, combined with a strong diagnosis and prognostic value, suggest an increasing use of spinal cord MRI in the near future. This review summarizes the current data from the literature on the prognostic value of spinal cord MRI in MS patients in the early and later stages of their disease. Both conventional and quantitative MRI techniques are discussed. The prognostic value of spinal cord lesions is clearly established at the onset of disease, underlining the interest of spinal cord conventional MRI at this stage. However, studies are currently lacking to affirm the prognostic role of spinal cord lesions later in the disease, and therefore the added value of regular follow-up with spinal cord MRI in addition to brain MRI. Besides, spinal cord atrophy, as measured by the loss of cervical spinal cord area, is also associated with disability progression, independently of other clinical and MRI factors including spinal cord lesions. Although potentially interesting, this measurement is not currently performed as a routine clinical procedure. Finally, other measures extracted from quantitative MRI have been established as valuable for a better understanding of the physiopathology of MS, but still remain a field of research.

Keywords: multiple sclerosis; spinal cord; MRI; prognosis

Introduction

Multiple sclerosis (MS) is a common inflammatory, demyelinating and degenerative disease of the central nervous system that affects both the brain and the spinal cord. While the brain damage has been extensively explored since the development of MRI, spinal cord damage has been less studied, mainly due to MR acquisition challenges. These challenges are due to the geometry and the anatomical location of the spinal cord, which is a very thin and mobile structure surrounded by cerebrospinal fluid and bones, responsible for spatial inhomogeneity of the magnetic field strength. Moreover, intrinsic motion caused by cardiac and respiratory cycles can interfere and create artefacts [1]. The past few years have seen substantial improvements in spinal cord imaging, both qualitative (increased detection of focal lesions on conventional MRI sequences) and quantitative (atrophy measurement, quantitative metrics extracted from magnetization transfer and diffusion imaging, MR spectroscopy, functional MRI). Despite these developments, the use of spinal cord MRI in clinical routine remains limited compared to brain MRI, and quantitative techniques remain in the field of research.

Nonetheless, spinal cord damage is common in MS and the presence of spinal cord lesions has been demonstrated in up to 90% of patients with early relapsing-remitting multiple sclerosis (RRMS) [2–5]. The spinal cord involvement is sometimes even predominant in the clinical course of the disease [6–10]. In addition, spinal cord lesions are relatively specific to MS and have therefore been included in the diagnostic criteria for MS since their first version [11]. In the last version published in 2017, the spinal cord is one of the four localizations considered as eloquent and prone to fulfill conditions of dissemination in space, whether the lesion is symptomatic or not [12]. Spinal cord imaging is particularly useful when brain imaging does not meet diagnostic criteria. Finally, the spinal cord is a small and compact structure containing all sensory and motor nerve pathways for the limbs. A strong prognostic value of spinal cord damage on physical disability worsening can therefore be suspected.

In this review, we aim to expose the current data from the literature on the prognostic value of spinal cord MRI in MS patients. The first part will focus on the description of spinal cord pathology in MS patients, from the anatomopathological and the radiological point of view. The second part will focus on the prognostic value of spinal cord MRI, in the early and

later stages of the disease. Both conventional and quantitative MRI techniques will be discussed.

Spinal cord pathology in MS

Histopathological data

In post-mortem studies, spinal cord lesions are highly prevalent and affect the entire spinal cord from the cervical to the lumbar portion [13–16]. In the axial plane, their predominant location are the posterior and lateral columns of the white matter, while the anterior columns are less affected. Grey matter is also affected by demyelination [17], and even more importantly than white matter, especially at the thoracic level [18]. Axonal loss is the other essential histopathological feature of MS. In particular, a loss of 57 to 62% across all levels of the spinal cord, independently from axonal size and spinal cord level have been observed in patients with well established MS (mean disease duration=29 years, sd=11 years) [18]. The association between axonal loss and demyelination in chronic MS remains unclear [18,19].

Radiological data

Two different types of MRI signal abnormalities have been observed in the spinal cord of MS patients : focal lesions and diffuse abnormalities [20,2]. On T2 weighted images, focal lesions are typically described as areas of hyperintensity of small size (less than two vertebral segments and half of the cross section), with a cigar-like shape on sagittal plane and wedge-shaped in axial images, seen along the entire spinal cord (cervical, thoracic or lumbar levels) but with a predominance in the cervical portion. Diffuse abnormalities are defined as areas without sharp edge, with increase of signal intensity but not as brightly as focal lesions. They are best detected on PD-weighted sequences. They are found mostly in primary progressive patients, less frequently in secondary progressive patients and rarely in relapsing–remitting patients [21, 2, 16, 22].

Various MRI sequences to evaluate spinal cord lesions

Specific MRI sequences have been developed and evaluated for years for the detection of lesions of MS. T2-FSE (Fast Spin Echo) is the most commonly used T2-weighted sequence. It could be used in combination with a Short Tau Inversion Recovery

(STIR) sequence which has been shown to be more sensitive than T2-weighted sequence in detecting spinal cord lesions but is more susceptible to flow-related artefacts [23–25]. More recently, the T1-weighted phase-sensitive inversion recovery (PSIR) [26] sequence has been proposed, and allows a better delineation of lesions. The sensitivity of these sequences varies according to the imaged level: in cervical cord, STIR and PSIR have a higher sensitivity than T2-FSE whereas in thoracic cord STIR has a higher sensitivity than T2-FSE, itself more sensitive than PSIR [27,28]. The 3D-T1-weighted MPRAGE sequence, in which MS lesions appear as hyposignals compared to the surrounding spinal cord, has also been evaluated, revealing lesions with a better contrast as compared to T2-FSE or STIR [29]. Finally, lesions located in the lateral part of the spinal cord are often missed on sagittal scans [30] and the combination of axial and sagittal acquisition improves lesion detection, compared to sagittal scans alone [30–32].

An optimum imaging protocol for spinal cord lesion identification has been recently defined, comprising at least two sagittal sequences (STIR, T2-FSE, PD-FSE, PSIR or 3DT1 MPRAGE) or two different planes (i.e. sagittal + axial) to be confident that the identified spinal cord lesions are not artefacts [33]. These acquisitions should cover both the cervical and thoracic levels. Concerning magnetic field strengths, if 3T MRI is the preferred magnet strength in the current MAGNIMS criteria, both 1,5T and 3T can be used. Figure 1 illustrates the visualization of spinal cord MS lesions using different conventional sequences available in clinical practice.

Correlation between histopathological and radiological data

Several post-mortem studies have assessed the correlation between histopathological damages observed in the spinal cord of MS patients and the abnormalities visualized on the corresponding MR images. They have shown a good correlation when focusing on white matter demyelination [14,34]. However, grey matter lesions are not visualized as well as those in white matter [27,35], and the number of lesions in the spinal cord is underestimated by using sagittal view alone [15]. In addition, axonal damage and loss correlate poorly with abnormal signals on T2-weighted images [34,36]. This could be one of the explanations for the « clinico-radiological paradox in MS » [37], described as the surprisingly poor relationship between clinical status and radiological abnormalities. Interestingly, the correlation between axonal density in the spinal cord and spinal cord cross sectional area is low [18]. It is also important to note that if a high correlation between white matter

demyelination and signal intensity changes was reported in post-mortem studies, these results have to be moderated by the fact that MRI protocols used higher resolution MRI than in clinical routine and were not disturbed by motions artefacts encountered with *in-vivo* MRI imaging.

Prognostic value of conventional spinal cord MRI

Two main markers of spinal cord pathology are explored using conventional MRI: focal lesions and atrophy. Many of the studies using these metrics are cross-sectional and therefore seek to link the level of disability of patients at a given time to the spinal cord injury at the same time. There are fewer prognostic studies, i.e. longitudinal studies whose main objective is to link the initial spinal cord lesion load or atrophy to the progression of disability several years later. Furthermore, MS evolves over several decades, and the majority of prognostic studies involving spinal cord MRI propose a short (2 years) or medium-term (5 years) follow-up. In this section we will highlight - when available - longitudinal studies proposing long-term follow-up, as they are particularly informative. Nonetheless, it is important to bear in mind that prognostic studies with longer follow-up, do not take into account recent technical developments to better visualize and quantify the initial lesion load. The prognostic role of spinal cord MRI can therefore probably be further improved.

Focal lesions

For a long time, a relationship between MS focal lesion load and disability has been hypothesized. However, results were disappointing with poor to moderate correlation when brain MRI was used alone, and a predominant involvement of the spinal cord in physical disability was suggested. Several studies have been led since the early 2000s and their findings were concordant with a correlation between spinal cord lesion load and disability at each stage of the disease, even in the earliest time. In addition, longitudinal studies have demonstrated the prognostic role of spinal cord MRI at the onset of disease, whereas it is less well evaluated later in the disease. These studies, grouped by disease phenotypes, are detailed below.

Radiologically isolated syndrome

In radiologically isolated syndrome (RIS), spinal cord lesions are associated with an increased risk of conversion to MS. In a recent meta-analysis, the spinal cord T2 lesions

number was the most predictive factor of early clinical conversion to MS [38]. This result was reported in 9 studies, including a total of 1193 RIS patients [39–47]. Moreover, the presence of spinal cord lesions was associated with an increased risk of developing primary progressive MS (PPMS) in RIS patients [45]. In particular, 100% of the 15 RIS patients who went on to develop PPMS had spinal cord lesions prior to the progressive phase, compared with 64% of the 113 who converted to clinically isolated syndrome (CIS) or RRMS, and 23% of the 324 who remained asymptomatic. Other MRI characteristics in the pre-progressive phase of PPMS were observed to be indistinguishable from CIS/MS.

Clinically isolated syndrome

In CIS patients, the spinal cord lesion load has been consistently associated with an increased risk of conversion to MS and of disability progression [48–55]. Similar results were obtained in the presence of infratentorial lesions [56]. The risk of developing MS in presence of spinal cord lesions has been specifically evaluated in a cohort of 207 CIS patients who were followed for two years [54]. The risk of conversion to MS (McDonald 2010) [11] was increased from 2.0 to 2.6 times in case of spinal cord lesions, independently of factors like brain lesions, and was associated with the number of spinal cord lesions (1.6 to 2.1 for one lesion ; 2.4 to 3.3 for 2 lesions or more). Moreover, the risk of short-term disability progression (EDSS = 3 or more at 2 years) was observed to be 5 times higher in presence of spinal cord lesions. These results have been confirmed recently in a cohort of 178 patients with a follow-up of 15 years [55]. Patients were recruited prospectively and underwent MRI scans of the brain and spinal cord at baseline and after 1 and 3 years. They were followed clinically over 15 years. Both baseline brain gadolinium-enhancing lesion number and spinal cord lesion number were significantly associated with EDSS progression at 15 years. The analysis of MRI metrics at baseline, 1 and 3 years revealed that both new spinal cord lesions over time and baseline spinal cord lesions were associated with conversion to secondary progressive multiple sclerosis (SPMS). These results support the assumption that early focal inflammatory disease activity and spinal cord lesions are suitable predictors of very long-term disease outcomes in CIS patients.

Relapsing remitting patients

Although fewer studies - essentially cross-sectional - have been conducted in RRMS patients, results are concordant and indicate an association between spinal cord lesion load

and disability [21,57–63]. Moreover, lesion location seems to contribute to disease course. In a recent cross sectional study including 642 patients with a majority of RRMS patients, lesions in central and lateral cervical spine regions were associated with a more severe EDSS score [64]. In a subgroup of the same cohort followed at 2 years, spinal cord motor tracts lesions were the only factor associated with disability progression [65]. Interestingly, a longitudinal study including 103 RRMS patients assessed the relevance of spinal cord MRI in asymptomatic patients [66]. One-quarter of clinically stable RRMS presented a new asymptomatic spinal cord lesions. The presence of at least one asymptomatic lesion in the brain or the spinal cord, was significantly predictive of an increased risk of future relapses with a Hazard Ratio of 2.31 (95% CI = 1.13-4.72, $p = 0.02$). Another longitudinal study, involving 239 early RRMS patients (disease duration of less than 2 years) followed for at least 7 years, evaluated the impact of spinal cord injury on the development of severe disability [67]. The presence of spinal cord lesions at baseline was the best predictor for reaching EDSS 4.0 during follow-up, compared to other predictors such as the number of brain T2 lesions.

Primary progressive MS patients

Cross sectional studies have consistently shown a higher correlation between spinal cord lesion load and disability scored by the EDSS compared to brain lesion load in PPMS patients [21,68–74]. Furthermore, a specific profile of lesion location in spinal cord for progressive MS patients was described, with more frequent damages in central and lateral column as well as spinal cord grey matter involvement [62,64,75]. A key role of spinal cord lesions in disability progression is also suggested by the recent description of progressive solitary sclerosis. Thus, patients with a solitary demyelinating lesion in the corticospinal tract, mainly in the spinal cord lateral columns, can develop progressive motor impairment, clinically very similar to progressive multiple sclerosis [8,10]. Similar observations were reported in progressive multiple sclerosis patients with few (i.e. 2-5) lesions [76].

Atrophy

Spinal cord atrophy can be investigated from MR images using two different approaches. A first approach consists in using a baseline and a follow-up acquisition and in estimating the loss of spinal cord volume or cross sectional area (CSA) from one session to

the other [77,78]. A second and widely used approach consists in using a single acquisition, in computing the patient spinal cord volume or CSA and in comparing this value to a reference value (or in comparing the values measured from different populations) [79]. While this second approach is simple, its ability to detect subtle changes is limited due to the high natural inter-subject variability of spinal cord volumes and cross sectional areas. The anatomopathological substrate of spinal cord atrophy measured on MRI remains uncertain. Indeed, in recent histological studies, no significant correlation was found between the spinal cord CSA and the axonal loss [18]. Despite this lack of specificity, spinal cord atrophy has been consistently described in MS patients after a few years of disease duration and is related with disability. Its prognostic value has been demonstrated in short and medium term studies. However, longitudinal studies with a long follow-up duration are limited. Despite these results at the population level, the measurement of spinal cord atrophy is not currently used in clinical routine. Standardization of the acquisition protocols and the methods to measure spinal cord atrophy could contribute to the definition of pathological thresholds that could be used at the individual level.

Association between spinal cord atrophy and disability

At the onset of the disease, i.e. in CIS and early RRMS patients, the existence of spinal cord atrophy remains unclear [53,77,78,80–86]. These inconsistent results are probably related to different measurement methodologies and patient inclusion criteria. In addition, edema is associated with acute MS lesions, which may mask atrophy. On the contrary, the occurrence of spinal cord atrophy has been consistently demonstrated in latter stage of the disease, in RRMS [82,87], SPMS [70,88,89] as well as PPMS patients [68,70,71,90]. Similarly, numerous studies have consistently reported an association between spinal cord atrophy and physical disability [75,83,91–98]. In particular, spinal cord gray matter atrophy is more pronounced in progressive MS patients and more associated with disability than spinal cord white matter atrophy or brain gray matter atrophy [99]. These results were confirmed in a meta-analysis across 94 studies in 2018 [100]. The magnitude of spinal cord atrophy was greater in progressive MS patients compared to RRMS patients, correlated with disability, and was greater than reported rates of brain atrophy (–1.78% versus –0.5% per year).

Prognostic value of spinal cord atrophy

The prognostic value of spinal cord atrophy on conversion to definite MS was evaluated in a cohort of 131 non-spinal CIS patients followed over 5 years [53]. The annualized rate of spinal cord atrophy was significantly higher in patients who developed MS compared to those who remained CIS. The change in the upper cervical cord CSA was independently associated with EDSS at follow-up. The prognostic value of spinal cord atrophy on subsequent disability was also evaluated in a cohort of 352 patients across different MS phenotypes (RRMS: 256, SPMS: 73, PPMS: 23) with clinical and MRI evaluations at baseline, 12 months and 24 months [95]. Baseline upper cervical cord CSA and the number of spinal cord segments presenting lesions at baseline were found to be relevant contributors of disease progression at 2 years. A progressive upper cervical cord atrophy was found in all MS subtypes at 24 months, but a higher rate of cervical spinal cord volume loss was observed in patients with disease progression after 24 months (-2.3% per year) compared to stable patients (-1.2% per year). In another study including 231 MS patients with 5 years follow-up, the cervical spinal cord volume was found to be the strongest MRI predictor for EDSS score change. An increase of 1% of the annual spinal cord volume loss rate was associated with an increase of 28% of the risk progression in the following year [101].

Quantitative MRI techniques

Different quantitative MRI techniques have been applied to the spinal cord in MS patients, in order to assess the microstructure (demyelination, axonal loss) inside and outside focal lesions. These techniques include diffusion imaging, magnetization transfer imaging (MTI), magnetic resonance spectroscopy and functional MRI. They remain technically challenging, and limited to a research context. Their general principles and the components being evaluated are summarized in Table 1. To date, only a limited number of studies have used these techniques for prognostic purposes. These are summarized in Table 2.

Conclusion

Spinal cord MRI is performed far less frequently than brain MRI in MS patients mainly owing to technical limitations. Recent improvements in MRI acquisition protocols should lead to the growing use of spinal cord MRI in clinical practice in the near future [114, 115].

Spinal cord involvement is frequently observed in patients with MS, and has a clear diagnostic and prognostic value. In particular, the prognostic value of spinal cord lesions is clearly established at the onset of disease, in RIS, CIS and early RRMS patients. Spinal cord

lesions are associated with an increased risk of conversion to MS, aggravation of disability and conversion to progressive phenotype. Later in the disease, studies are lacking to affirm the prognostic role of spinal cord lesions and therefore the added value of regular follow-up with spinal cord MRI. Spinal cord atrophy, as measured by loss of cervical spinal cord area, is also associated with disability progression, independently of other clinical and MRI factors including spinal cord lesions. Although potentially interesting, this measurement is not currently performed as a routine clinical procedure. Finally, other measures extracted from quantitative MRI have been established as valuable for a better understanding of the pathophysiology of MS, but remain a field of research.

Disclosures of interest

S Leguy, B Combès, E Bannier and A Kerbrat have nothing to disclose

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Table 1 : Quantitative MRI techniques

Technique	Principle – Based on	Parameter	Association with the microstructure
DTI	Molecular diffusion of water, constrained by the anatomy, i.e. white matter bundles. Voxel-based information about the orientation and anisotropy of WM bundles in the brain or spinal cord, and thus about their integrity.	MD: mean water diffusivity	Post-mortem evidence of association with gliosis [100]
		FA: fractional (degree of) anisotropy of the diffusion directions (zero : isotropic diffusion, increases when anisotropic)	Association with axonal pathology [100]
		AD: axial diffusivity : diffusion along the principal axis of diffusion	Association with acute axonal loss in experimental model of MS [101,102]
		RD: radial diffusivity, orthogonal to the principal axis of diffusion	Association with demyelination in ex vivo spinal cords [103]
MTI	Proton mobility, depending on environment (free water ¹ H/rotationally-restricted ¹ H linked within macromolecules i.e with myelin in WM). Application of a magnetization transfer (MT) radiofrequency pulse to saturate the magnetization of linked ¹ H then transferred to free water ¹ H, reducing the measured signal intensity.	MTR: magnetization transfer ratio	Association with demyelination [16] and with inflammation [104]

¹ H-MRS	Quantify metabolite relative concentrations reflecting specific pathological processes	NAA: marker for neuronal metabolism	Reduced NAA level correlates with axonal loss [105]
fMRI	T2* signal changes reflecting the local blood flow and oxygenation changes with neuronal activity	BOLD contrast	Provides an indirect mapping of neuronal activity [106]

AD (axial diffusivity); BOLD (Blood Oxygen Level Dependent); DTI (diffusion tensor imaging); fMRI (functional MRI); ¹H-MRS (proton magnetic resonance spectroscopy); MD (mean diffusivity); MTI (magnetization transfer imaging); MTR (magnetization transfer ratio); NAA (N-acetylaspartate); RD (radial diffusivity)

Table 2: Quantitative spinal cord MRI and prognostic studies

Study	Patients	Longitudinal	Main results
MTR			
<u>Charil and al., 2006</u> Cervical cord magnetization transfer ratio and clinical changes over 18 months in patients with RRMS: a preliminary study. [107]	14 RRMS	<u>18 months</u> - At baseline: MRI, EDSS - At 18 months: EDSS, relapses	Baseline average cervical cord MTR was correlated with relapse rate during follow-up.
<u>Oh and al., 2020</u> Five-year longitudinal changes in quantitative spinal cord MRI in MS [108]	75 MS - 45 RRMS - 30 PMS	<u>5 years</u> At baseline, 1.8 year, 5 years : clinical data (EDSS), MRI	At 2 years, MTR decreased ($p = 0.04$) and at 5 years, both MTR ($p = 0.03$) and spinal cord CSA ($p = 0.009$) decreased. Robust correlations were found between the 2-year trajectories of change in quantitative spinal cord MRI measures and 5-year trajectories of change.
DTI			
<u>Agosta and al., 2007</u> In vivo assessment of spinal cord damage in MS patients: a longitudinal DT MRI study [22]	42 MS - 13 RRMS - 14 SPMS - 15 PPMS 9 HCs	<u>2.4 years</u> At baseline and after a mean follow-up of 2.4years : clinical data (EDSS), MRI	Baseline spinal cord cross-sectional area ($r = -0.40$, $p = 0.01$) and FA ($r = -0.40$, $p = 0.03$) was correlated with increase in disability at follow-up.
<u>Freund and al., 2010</u> Recovery after spinal cord relapse in MS is predicted by radial diffusivity [109]	14 MS with acute lesion 13 HCs	<u>6 months</u> At baseline, 1, 3, 6 months: clinical data (EDSS, 9HPT, TWT), MRI	Lower radial diffusivity of the spinal cord corticospinal tract at onset of spinal cord relapse was associated with better clinical outcome.
<u>Théaudin and al., 2012</u> Short-term evolution of spinal cord damage in MS: a DT MRI study [110]	16 RRMS with acute lesion	<u>3 months</u> At baseline and 3 months : clinical data (EDSS, ASIA), MRI	A baseline less marked decrease in FA value and more marked decrease in radial diffusivity inside the inflammatory lesion were associated with better clinical outcome.

<u>Oh and al., 2020</u> Five-year longitudinal changes in quantitative spinal cord MRI in MS [108]	75 MS - 45 RRMS - 30 PMS	<u>5 years</u> At baseline, 1.8 year, 5 years : clinical data (EDSS, MSFC), MRI	Results found a limited correlation between changes in DTI metrics and disability, not statistically significant, but robust correlations between the 2-year trajectories of change of quantitative spinal cord MRI measures and 5-year trajectories of change ($r = 0.97$ ($p < 0.001$) for FA; $r = 0.75$ ($p < 0.001$) for mean diffusivity; $r = 0.97$ ($p < 0.001$) for axial diffusivity).
MR spectroscopy			
<u>Ciccarelli and al., 2010</u> Spinal cord repair in MS: does mitochondrial metabolism play a role? [111]	14 MS - 13 RRMS - 1 SPMS 13 HCs	<u>6 months</u> At baseline and at 1, 3, and 6 months : clinical data (EDSS), MRI	Patients who recovered showed a sustained increase in NAA after 1 month. In the whole patient group, a greater increase of NAA after 1 month was associated with greater clinical recovery.
<u>Bellenberg and al., 2013</u> 1H-MR spectroscopy in diffuse and focal cervical cord lesions in MS [112]	22 MS patients with persistent spinal cord symptoms. 17 HCs	<u>24 months</u> - MS: At baseline and 12 months, +/- 24 months if available : clinical data (EDSS, TWT and 9HPT), MR (MRS) - HC : baseline and 6 months : MRI/S	NAA/Cr at baseline was associated significantly with cord atrophy and with disability progression during follow-up.
<u>Yetkin and al., 2016</u> Monitoring interferon β treatment response with MRS in RRMS [113]	36 RRMS recently diagnosed, never treated with interferon β . 15 HCs	<u>12 months</u> - MS : Before, at 6 and 12 months after the initiation of treatment : clinical data (EDSS), MRS - HCs : MRS	In patients treated with interferon β NAA/Cr ratios remained stable. No significant correlation between EDSS scores and MRS metabolite ratios at baseline or during follow-up
fMRI			
No longitudinal study found			

DTI (diffusion tensor imaging); EDSS (Expanded Disability Status Scale); MRS (magnetic resonance spectroscopy); MTI (magnetization transfer imaging); MTR (magnetization transfer ratio); NAA/Cr (N-acetylaspartate/Creatinine); PPMS (primary progressive MS); RRMS (relapsing remitting MS); SPMS (secondary progressive MS); TWT (Timed 25-Foot Walk test); 9HPT= (9-Hole Peg Test).

Legend of figure 1

Figure 1: Visualization of spinal cord MS lesions using different conventional sequences available in clinical practice. A : sagittal T2 TSE ; B : sagittal T1 MPRAGE ; C : sagittal PSIR; D : axial T2 TSE ; E : axial T1+ GADOLINIUM; F : sagittal STIR

