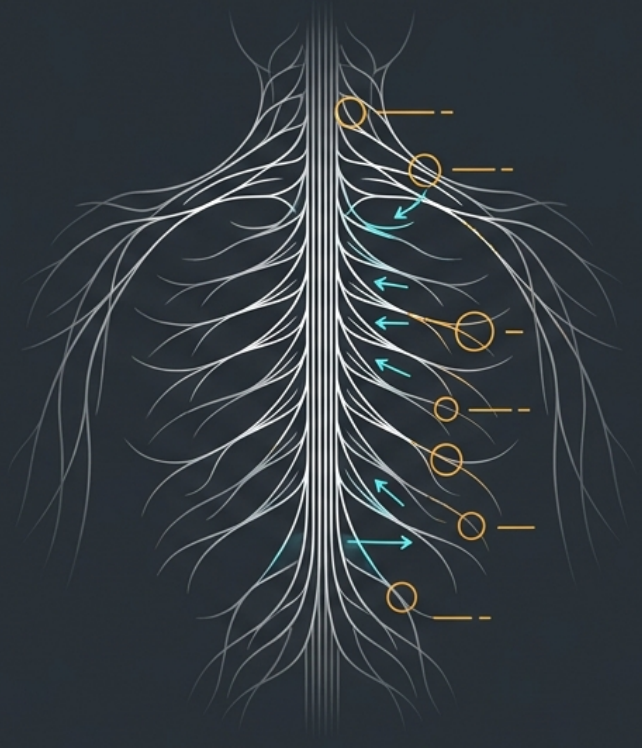


The Neuromyofascial Spectrum of MS

Re-evaluating Symptom Clusters Through the Lens of Thoracic Neuropathy, Fibro-MS, and Targeted Intervention



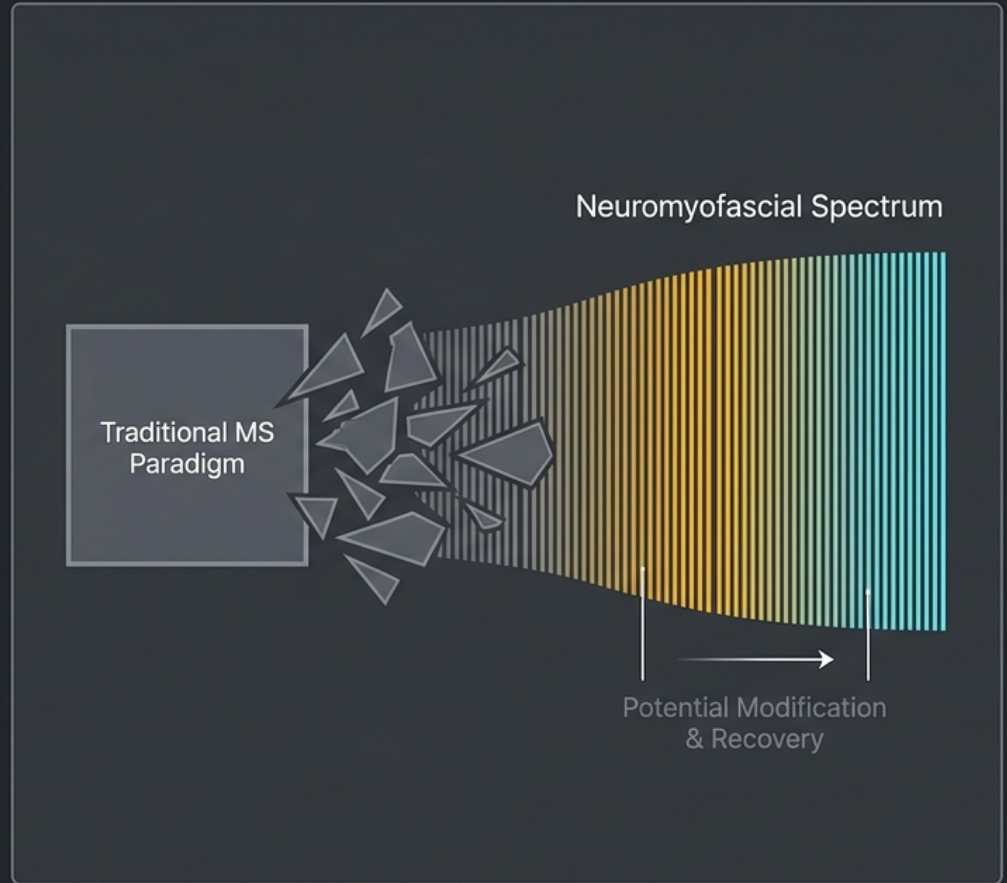
Redefining the Boundaries of MS

Core Question:

Is MS always best understood as a single, fixed autoimmune neurological disease?

The Hypothesis:

Or can specific, variable symptom clusters be interpreted—and potentially modified—within a broader neuromyofascial spectrum?

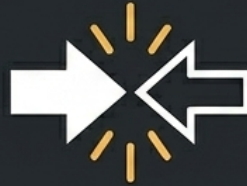


The Spectrum Model: A Conceptual Framework

The Neuromyofascial Equation



Genetics



Lifetime Injuries



Rehabilitation



Current
Neuromuscular State

Spinal Myelopathic Syndrome (SMS)

Undiagnosed partial or complete **tethering/pressure** surrounding the spinal cord (typically cervical or thoracic).

The Proposition

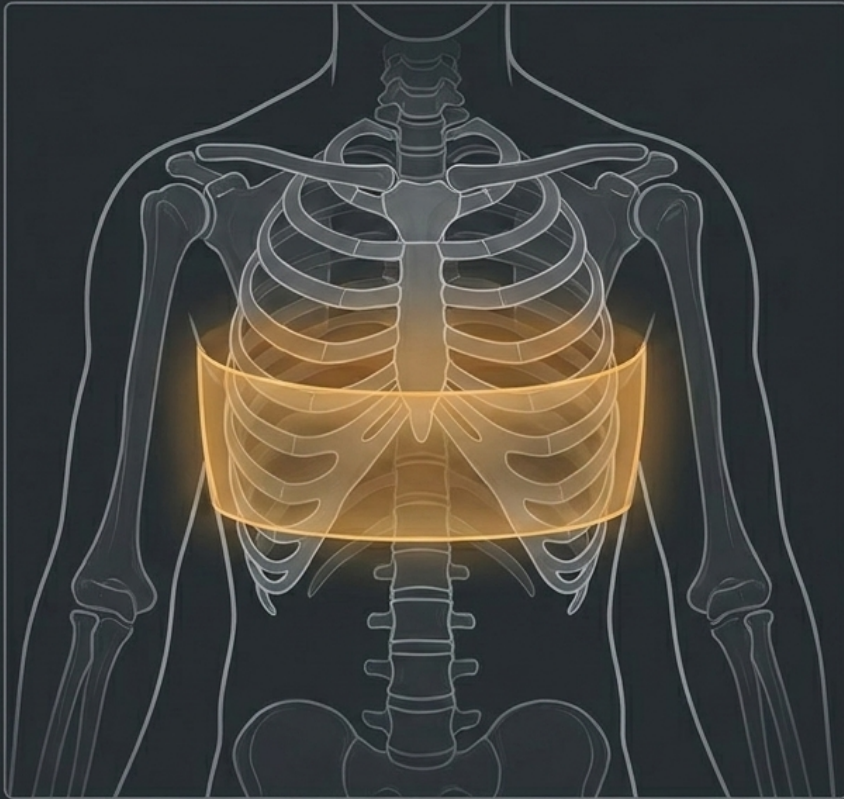
Embedded scar tissue from **trauma** (e.g., whiplash, concussions) alters spinal mechanics. This creates downstream **neuropathic and myelopathic symptoms** that clinically mimic or **exacerbate MS**.

The Shared Phenotype: Symptom Overlap

	Multiple Sclerosis	Fibromyalgia (FMS)	Post-Concussion Symussion Syndrome (PCS)	Complex Whiplash
Widespread Pain	✓	✓	✓	✓
Fatigue	✓	✓	✓	✓
Paresis / Weakness	✓	✓	✓	✓
Vision Changes	✓	✓	✓	✓
Bowel / Bladder Issues	✓	✓	✓	✓
Cognitive / Mood Changes	✓	✓	✓	✓

Key Insight: Patients with hypermobility and a history of acceleration-deceleration injuries appear to be at uniquely elevated risk across this entire spectrum.

Clinical Profile: The MS Bear Hug



Presentation

Band-like chest wall pressure, muscle pain, and severe torso constriction.

Traditional View

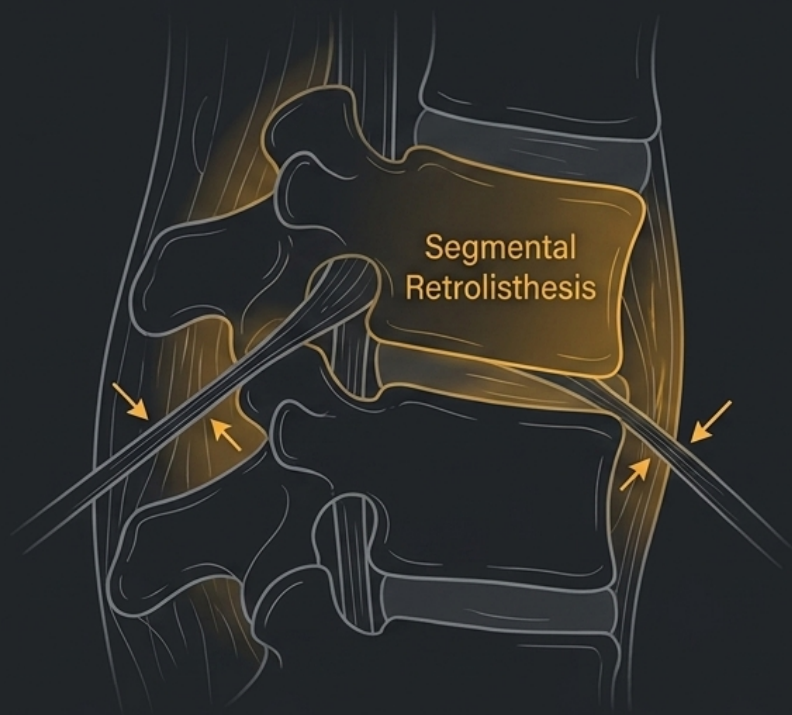
Classified primarily as dysesthesia or intercostal spasm secondary to central demyelination.

Neuromyofascial Interpretation

Frequently a symptom of underlying thoracic spine pathology and peripheral/myofascial injury. Often indicates progressive, unrecovered thoracic spinal injury—even if the patient reports zero localized upper back pain.

Mechanism of Thoracic Neuropathy

Segmental Retrolisthesis



The Pathological Cascade

Myofascial injury → Segmental retrolisthesis (vertebral backward displacement) → Nerve/Cord tethering.

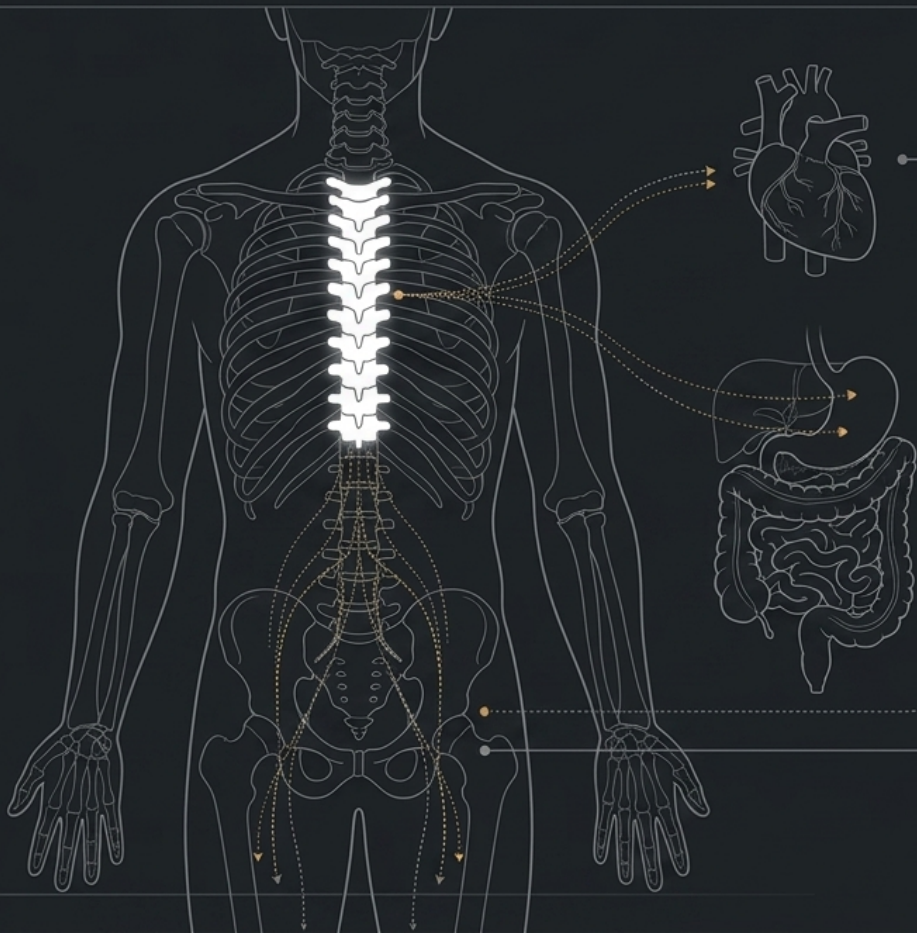
Diagnostic Challenge

Standard static MRI may fail to capture these specific, dynamic myofascial tethering effects.

Symptom Drivers

- **Unilateral Symptoms:** Driven by nerve root tethering and compromise from localized compression injuries.
- **Diffuse/Bilateral Symptoms:** Driven by mild spinal cord impingement.

The Broader Thoracic Syndrome



Cardiopulmonary-Like

Heartburn, palpitations,
costochondritis-like chest pain.

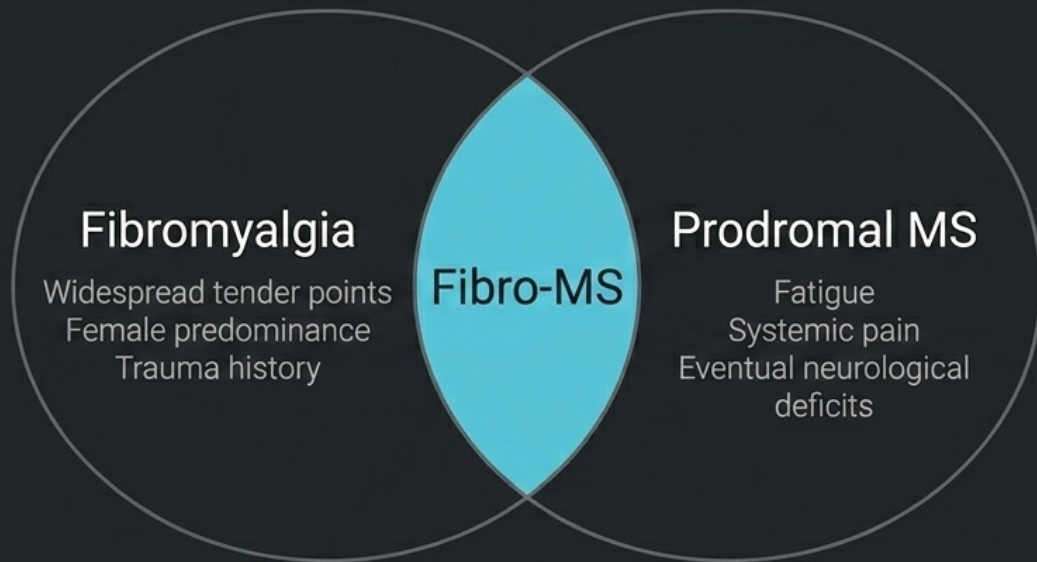
Lower Body & Autonomic

Heavy legs, difficulty walking, bladder
and bowel dysfunction.

The Biomechanical Link

Thoracic cord tethering disrupts descending
peripheral motor/sensory pathways while
simultaneously impeding autonomic outflow.

Introducing Fibro-MS



Definition

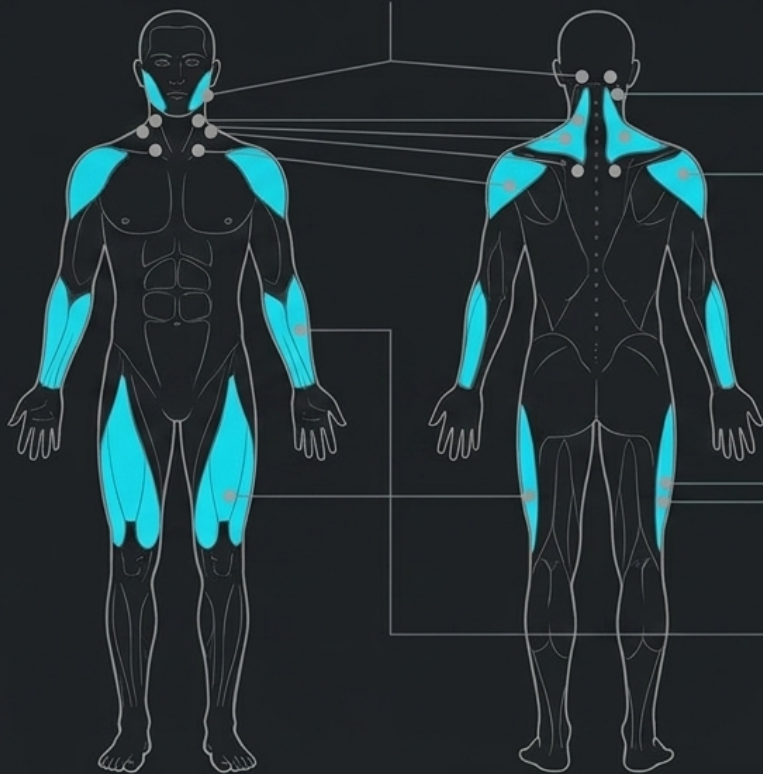
A conceptual term identifying patients diagnosed with fibromyalgia who exhibit symptom profiles highly consistent with prodromal MS.

The Proposition

Retrospective MS data often reveals mild, fibromyalgia-like pain syndromes 5–15 years prior to a formal multiple sclerosis diagnosis.

The Clinical Overlap: Fibromyalgia & Prodromal MS

Standard FMS Diagnostics: 11 of 18 tender sites (heavy upper-body emphasis)



Neuromyofascial Observations in Fibro-MS

- Chronic dystonia/spasm (deltoids, forearms, quads, IT bands)
- Migraine / Tension headaches
- TMJ disorders & Rotator cuff / Frozen shoulder
- Sciatica-like lower body pain
- Constitutional symptoms (chronic fatigue, eye pain, sleep disturbance, IBS)

The Clinical Significance of the Prodrome

“Fibromyalgia should be viewed as a potentially serious, progressive neurological condition.”

The Diagnostic Risk

Treating fibromyalgia merely as a static pain condition may miss a progressive neurological pathology.

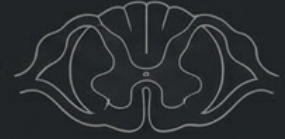
Emerging Links

Evidence suggests similarities in spinal cord changes between Fibromyalgia, Degenerative Cervical Myelopathy (DCM), and MS.

The Mandate

Fibromyalgia warrants serious neurological concern, requiring both physical and psychological rehabilitation to potentially mitigate progression.

Healthy



Slight
Compression



Severe
Tethering



Case Study: 17-Year Chronic MS

Patient Profile

42-year-old female.

History

Diagnosed with MS ~2006. Prior severe motor vehicle head-on collision. Followed regularly by tertiary MS clinic (Ocrevus, corticosteroids).

Baseline Presentation (Nov 2022)

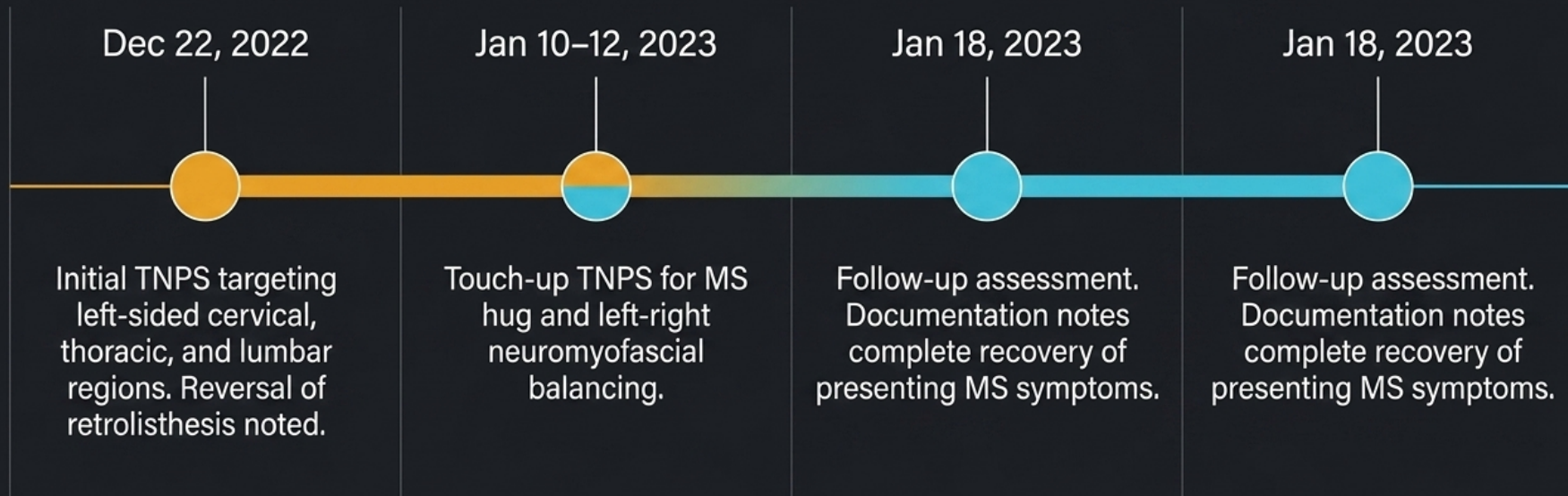
- Partial left-eye blindness & Optic Neuritis
- Constant left-sided migraine & tinnitus
- Thoracic MS Hug & bowel/bladder complications
- Palpable thoracic retrolisthesis & reduced ROM
- Left-sided paresis, paresthesia, and foot drop



Interventional Chronology (TNPS)

Intervention Audit

Transcutaneous Neuromyofascial Precision Surgery (TNPS)—tactilely guided dissection of fibrosis to mechanically decompress spinal segments.



Rapid and Durable Functional Restoration

Immediate Response (Day 1)



Sustained Outcomes (>12 Months)

Pain: 0/10

Vision: Restored / Near-Normal

Motor: Full left-side power, full ROM

Autonomic: Continence normalized

Clinical Context: Typical MS/Optic Neuritis recovery unfolds over 3–6 months; this multi-domain recovery occurred almost immediately.

The Shopping List of Discrete Injuries

Optic Neuritis & Blindness

Cranial traction originating from cervical tethering (linked to OCT retinal thinning patterns).

Lhermitte's Sign

Cervical scar tissue causing transient cord compression upon neck flexion.



MS Bear Hug & Bladder

Left thoracic cord tethering and radicular motor impairment.

Foot Drop

Lower lumbar myofascial scar tissue.

Takeaway: Neurological symptoms resolved precisely as specific anatomical mechanical blocks were released.

Academic Framing & Future Directions



Clinical Caution

Causality cannot be definitively inferred from a single, uncontrolled case report. TNPS does not imply a disease modification or cure of autoimmune MS.



The Central Implication

A **modifiable neuromyofascial pathology** may be superimposed on—or clinically masquerade as—MS in a specific subset of patients.

Closing Takeaway

Integrating neuromyofascial assessment into complex neurological and chronic pain presentations may reveal new avenues for targeted, non-pharmacological rehabilitation.