

My prog-MS ezine

For people with progressive MS and other interested people

Issue 62, September-October 2025

Hello and welcome to the 62nd edition of my ezine about progressive Multiple Sclerosis and MS progression in general. My name is Ian Cook. I'm a non-active secondary progressive MSer from Birmingham, UK. My EDSS is 6, well 6.5 and going up, and my age is 67.

The ezine is now in its 11th year and as ever there is just a little progress in the world of progressive MS research although still sadly still no cure. In issue 61 there are eight pages of prog-MS news stories, lots on T cells, B cells and stem cells. There are also two features. One feature, on page 5, looks at Tolebrutinib, a new drug for naSPMS and PPMS. The drug seems effective but will cash be there to fund it in the UK?

There's another feature on page 10 looking at my life with MS. I recently celebrated my 67th birthday and half of my life has been spent with MS and half without. Because I have never met the eligibility criteria for any disease modifying drug my MS is untreated. But with the arrival of Tolebrutinib things may be changing so, assuming I live long enough I may be able to tell a very different tale soon. Here's hoping.

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News

Neural stem cell grafts show promise for myelin repair in prog-MS

A study led by Cambridge researchers has shed light on how neural stem cell grafts could help restore myelin in the central nervous system. The findings suggest neural stem cell-based therapies might hold greater promise as a potential treatment for progressive MS than other existing stem cell treatments.

The study, published in the journal Brain, was spearheaded by University of Cambridge scientist Dr. Luca Peruzzotti-Jametti and offers crucial insights into the potential of neural stem cell transplantation in progressive MS, offering a more targeted approach.

The research showed, for the first time, that neural stem cells grafts can mature directly into oligodendrocytes, the cells responsible for producing myelin. More importantly, the study provided evidence supporting the safety of human induced neural stem cell transplantation.

The study focused on using induced neural stem cells (iNSCs) in a mouse model to evaluate their ability to promote remyelination. The research provides critical evidence that induced neural stem cell grafts can effectively turn into myelin-producing cells within the damaged central nervous system, suggesting a potential new way to treat progressive MS.

The research team is now investigating the underlying mechanisms of MS in the central nervous system and exploring how neural stem cell-based treatments can influence neuroprotective and anti-inflammatory processes. The goal of this research is to see how these therapies may slow brain atrophy or brain shrinkage and also slow the progression of MS.

This new compelling research has been described as demonstrating the ability of neural stem cell grafts to generate new myelin in laboratory animals exhibiting MS-like lesions and thus carries significant implications for ongoing research and the development of clinical trials in an area of stem cell research that, until now has been largely overshadowed by haematopoietic stem cell transplantation (HSCT), also known as bone marrow transplant, and mesenchymal stem cell therapy (MSCT) which focuses on repairing damaged nerve tissue.

For details of sources for all news stories go to page 14

Walking gains seen in prog-MS after new CAR-T cell therapy

A new type of 'immunotherapy' – a therapy which works on the immune system – is showing great promise in treating prog-MS with clinical trials presently taking place in the UK and US. There have been improvements in walking among those treated. There is even talk of a 'cure'.

The new therapy called 'CAR T-cell therapy', is a treatment that has been used for several years to treat blood cancers. CAR-T cell therapy involves modifying a patient's T cells to target and eliminate specific cells. In MS this would be ''autoreactive B cells that are believed to play a major role in the autoimmune attacks on myelin which characterise MS.

CAR-T -cell therapy works by extracting T cells from the patient's blood and genetically modifying the cells in a lab to produce cells designed to recognize specific triggers for an immune response, in this case, it would be B cells expressing a marker called CD19 which is believed may be involved in MS's characteristic auto-immunity.

CD19 has been linked to various cancers - notably B cell lymphomas, acute lymphoblastic leukaemia, and chronic lymphocytic leukaemia. The majority of these B cell malignancies express normal to high levels of CD19.

Following the extraction of T cells, the genetically modified cells would then be infused back into the patient, where they would seek out and destroy problematic B cells. This process aims to "reset" the immune system by eliminating the autoreactive B cells that contribute to the autoimmune attack on the central nervous system seen in MS. Several clinical trials are presently investigating the use of CAR T-cells in MS, including trials focusing on B-cell depletion and potentially resetting the immune system.

One study reported on the first use of CD19 CAR T-cells in two patients with progressive MS, and found the therapy to be generally safe with promising effects in infiltrating immune cells according to the journal 'ScienceDirect'. Other trials are exploring the use of CAR T-cells to target Epstein-Barr virus (EBV)-infected B

Overall, researchers believe CAR T-cell therapy represents a potential new way to target and eliminate autoreactive B cells and potentially reset the immune system. One trial presented at the 11th Congress of the European Academy of Neurology (EAN) in the presentation "Anti-BCMA CAR T cell therapy in patients with multiple sclerosis." reported that three progressive MS patients had seen less disability with CAR T-cell therapy. Improvements included gains in walking, hand function seen, along with oligoclonal band resolution.

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New global trial testing oral therapy for MS spasticity

A global clinical trial has been launched to test out a new 'oral therapy' called BMS-986368 to treat spasticity — muscle stiffness and spasms — in MS. 'Oral theraopy' usually means pills, capsules, and liquid medications.

The Phase 2 study (NCT06782490), called BALANCE-MSS-1, is enrolling 200 adults with MS who have had spasticity for at least six months. The planned trial sites are in the U.S., Australia, Canada, Puerto Rico, and across Europe; several sites (sadly none in the UK) are already recruiting. The trial is sponsored by bio-pharma Celgene and operated by Bristol Myers Squib, which acquired the biopharma company in 2019.

As many as 90% of people with MS experience spasticity, which can range from mildly uncomfortable to very painful. Spasticity can have a substantial impact on a person's ability to go about daily life. There are oral and injectable medications available to ease spasticity, but patients may also rely on strategies like stretching and physical therapy.

Some medications used for spasticity, such as botulinum toxin, require injections and, data has shown, may lead to serious side effects. Oral options, including certain muscle relaxants and anti-anxiety medications, can have tolerability issues.

Another strategy that's been explored for MS spasticity is the use of cannabis-based therapies such as nabiximols,(Sativex) a mouth spray that is approved in some countries for MS, but is not cleared in the U.S. The compounds in these products mimic the function of a class of naturally occurring molecules in the body called 'endocannabinoids'. Endocannabinoids regulate a wide range of bodily functions, including mood, pain, and sleep, and are also involved in helping muscles relax.

In the past 20 to 30 years, there has not been a major development of new effective oral medications to treat spasticity and the majority of the currently available oral medications have side effects like drowsiness, which limits their usefulness during the daytime.

BMS-986368 is designed to increase levels of the body's own naturally occurring endocannabinoids by inhibiting two enzymes that would normally break them down. By boosting endocannabinoid signalling, the therapy is expected to help promote muscle relaxation and ease spasticity.

The Phase 2 trial of BMS-986368 is expected to enrol 200 MS patients, ages 18-70, with spasticity. The participants will be randomly assigned to receive one of three doses of the therapy or a placebo daily for six weeks. The trial is expected to report its final results in 2027.**For details of all news stories go to page 14**



New SPMS drug. Will it be funded in the UK? It's all about the money.

While non-active SPMSers like me wait for US authorities to license Tolebrutinib, interest turns to how much the drug will cost when it crosses 'The Pond'.

The question is: ' Will it be affordable/ available over here?' Traditionally MS disease modifying drugs come with a hefty price tag. Annual costs are often higher than $70,000 in the US. The price is often cheaper in the UK. Here 'bulk buying' through NICE (National Institute for Care and Clinical Excellence) means the drugs can be provided more cheaply to MS patients on the NHS. It's the tax payer not the patient footing the bill.

The question is whether Tolebrutinib will be affordable even for bodies like NICE. It's all about the money. Two quite contrasting views have emerged about the price Sanofi will charge for their new prog-MS drug, which may also be offered to PPMS patients when clinical trials complete later this year. According to 'Mouse Doctor', writing on the Barts MS Blog, the price will be an uncomfortably high one, making it one of the more expensive drugs around. He says as follows: "Tolebrutinib has slowed clinical progression we will see what they charge in the US it will possibly be North of $100,000 so now add another $100,000 for the relapsing DMT and you will have NICE frothing at the mouth with fear.

'However as patents on the Relapsing drugs perspire then the price could drop and make the combination better….Alemtuzumab + tolebrutinib….teriflunomide + tolebrutinib…..Biogen RR drug + Biogen BTK, Novartis RR drug…they haven't done progressive trial so you could have Roche Ocrelizumab + Roche BTK or maybe Roche BTK does all, Watch this space…or should we say ECTRIMS next year."In plain English I think Mouse Doctor is saying tolebrutinib will be a pricey drug, although where it is used in combination with other MS drugs the price could come down. He's also saying we may hear more at the big MS experts' meeting ECTRIMS next year.

A contrasting view on tolebrutinib pricing is taken by the Institute for Clinical and Economic Review (ICER). This US-based body is an independent, non-profit research institute that conducts evidence-based reviews of 'health care interventions'.

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Continued from page 5 ICER analyses evidence on the benefits and risks of these so-called 'interventions' to measure their value and suggest a fair price. So, what does ICER think is a fair price for tolebrutinib? Is their figure the same as Dr. Mouse? Erm, no, not by a long chalk. They say: 'ICER has calculated a health benefit price benchmark (HBPB) to be between $3,250 and $5,900 per year. ICER's HBPB is a price range suggesting the highest US price a manufacturer should charge for a treatment based on the amount of improvement in overall health patients receive from that treatment'

One of the reasons for ICER not putting a higher price tag on Tolebrutinib is that while it recorded some impressive improvements in certain areas, in other areas its improvements were less clear cut. The drug is also potentially toxic and requires patients to be tested for this toxicity on a regular basis

ICER says: 'There was a lack of improvement in some additional outcomes, such as brain atrophy and the nine-hole peg test, a measure of upper extremity function. Additionally, there is a small but non-trivial risk of severe liver toxicity with tolebrutininb; though this risk may be mitigated by weekly monitoring of liver function tests, such intensive monitoring may not be a realistic expectation in clinical practice.'

Given the above uncertainties, ICER rated the current evidence on tolebrutinib as 'promising but inconclusive' ("P/I") for individuals with non-relapsing SPMS. Basically, ICER thinks the drug is good, but not that good when you consider all those weekly liver tests and other issues. This sort of observation may be a useful stick for NICE to beat Sanofi with, in the hope that the drug's lack of effect on some key measures like brain atrophy and the nine hole peg test means that tolebrutinib should not have a top dollar price tag. My own view is that NICE will get a price somewhere between ICER's and that of Mouse Doctor, say $50,000 pa or South of that (to use Mouse Doctor's expression).

If there is a stand-off between NICE and Sanofi there is also the wild card option of a 'risk sharing' scheme where Sanofi gets money based on how effective tolebrutinib proves to be. The original risk sharing scheme was brokered by an MS charity about 20 years ago when the first drugs for relapsing remitting MS arrived. The scheme, which had many critics, did at least get these 'first generation' disease modifying drugs over the line. It has never been repeated but if Sanofi hold out for a high price it might be a way of beating them down, It's what Donald Trump calls 'the art of the deal'.

Photo p1 and p5 by Alexander Grey on Unsplash. For further details of sources for feature see page 14

Foralumab nose spray trial starts dosing patients in US

A multicentre Phase 2a clinical trial testing foralumab nasal spray in people with nonactive secondary progressive multiple sclerosis (SPMS) has begun dosing patients at Weill Cornell Medicine Multiple Sclerosis Centre in New York.

The Phase 2a study (NCT06292923) is assessing the safety and efficacy of Tiziana Life Sciences' therapy, and aims to enrol up to 54 participants. Dosing began in late 2023 at Brigham and Women's Hospital in Boston. The company announced last year that the trial was expanding to other U.S. sites, including Weill Cornell in New York. The addition of Weill Cornell "further strengthens our Phase 2 clinical trial, which aims to address the significant unmet medical need in MS treatment," a company spokesman said in a press release.

Foralumab is an antibody therapy designed to reduce inflammation in the brain and spinal cord. It binds to the CD3 receptor on T cells, key immune cells involved in the inflammatory attacks that drive MS and other neurodegenerative diseases. By doing so, it is thought to suppress pro-inflammatory T cells while enhancing regulatory T cells, which help control excessive immune responses.

In a Phase 1 trial, foralumab nasal spray was found to be generally safe and well tolerated in healthy individuals and to modulate the immune system towards a more anti-inflammatory profile. This Phase 2a trial is testing the treatment in people with non-active SPMS.

Patients in the trial are randomly assigned to receive nasal foralumab at a dose of 50 or 100 micrograms per dose, or a placebo, in three-week cycles – three times a week for two weeks followed by a week of pause – for a total of four cycles, or about three months.

The study's main goal is to assess the treatment's safety and efficacy in reducing the activity of microglia, the brain's resident immune cells that contribute to neuroinflammation and MS progression. Secondary goals include changes in standard measures of motor and cognitive disability, fatigue, and quality of life, as well as changes in inflammatory brain lesions and brain volume. Following the completion of the placebo part of the trial, expected by the end of the year, all patients may enter an open-label extension study, in which all will receive foralumab for six months. The goal is to assess the treatment's long-term safety and efficacy.

For further details of all news and features go to page 14

No MS disability progression for over 60% after stem cell transplant

Nearly two-thirds of people with MS who had a stem cell transplant showed no signs of confirmed disability progression five years later, according to a study tracking MS patients in the U.K.

The results were generally better for people with relapsing-remitting MS (RRMS), but nearly half of individuals with progressive MS also remained free of disability progression after five years, the data showed.

While some safety issues were reported, these were generally more common in people with more advanced disease or those who had received higher chemotherapy dosages before the transplant. Those findings, the researchers noted, highlight the critical importance of carefully selecting patients for stem cell transplant and optimizing treatment protocols to maximize safety and long-term benefits.

The study, "Autologous haematopoietic stem cell transplantation for multiple sclerosis in the UK: A 20- year retrospective analysis of activity and haematological outcomes from the British Society of Blood and Marrow Transplantation and Cellular Therapy (BSBMTCT)," was published in the journal Transplantation & Cellular Therapy.

Autologous hematopoietic stem cell transplant (aHSCT), also referred to as stem cell therapy, is a procedure designed to reset the immune system and reduce the excessive inflammation that drives MS, but the procedure carries risks and is thus not widely available. In the U.K., for example, aHSCT has been available for MS patients since 2013 through the NHS. However, fewer than 0.3% of potentially eligible patients have undergone the procedure. Also, comprehensive national data on outcomes are lacking, the team noted.

To better understand the U.K. patient experience with aHSCT in real-world practice, the research team examined data from 364 people with MS who received a transplant in one of 14 UK centres from 2002 to 2023. Slightly more than half of the patients (58%) had RRMS, while 36% had either primary progressive MS (PPMS) or secondary progressive MS (SPMS).

In the first 100 days after aHSCT, five patients (1.4%) died, mostly due to conditioning-related toxicity. A few other safety issues were also reported after treatment with aHSCT. These included new cancers (1.6%), new new autoimmune conditions (7.9%), and viral reactivations (76%), particularly of the Epstein-Barr virus (EBV).

Regarding efficacy, 62% of patients remained free from confirmed disability progression five years post-transplant. Outcomes were best in RRMS, with 68% of patients experiencing no sustained progression of EDSS scores compared with 59% of those with SPMS and 46% of PPMS patients. **For details of all news stories go to page 14**

News

Experimental MS Drug Nearly Eliminates Disease Activity

Frexalimab, a new drug in clinical trials that blocks a protein which immune cells use 'to talk to each other' but which also contributes to MS inflammation and damage is being trialled in progressive MS with results expected in 2028 .

By blocking cells called CD40L, frexalimab aims to reduce inflammation in the brain and spinal cord. Research so far suggests it could protect nerves from damage to slow progression of MS.

The drug, which is given as an injection under the skin, provides extended tight control of MS whether measured by relapse or brain imaging at 2-year follow-up, results of an open-label extension (OLE) of a phase 2 trial showed.

"At week 96, there was almost complete suppression of new gadolinium-enhancing lesions with very similar pattern seen with new or enhancing T2 lesions," said study investigator Stephen Krieger, MD, professor of neurology, Icahn School of Medicine at Mount Sinai, New York City.

"Part of the interest in frexalimab and anti-CD40 therapies is the idea that both B- and T-cell activity can be modulated without cell depletion," explained Krieger, who presented the long-term open-label data on May 29 at the Consortium of Multiple Sclerosis Centers (CMSC) 2025 Annual Meeting.

The latest data suggest frexalimab is fulfilling its promise. Over follow-up to date, there has been nearly complete suppression of gadolinium-enhancing (Gd+) lesions on MRI among those taking the dose now being tested in the phase 3 trials. At 2 years, with an annualized relapse rate of 0.08%, 92% of patients were relapse-free.

Although the research into the drug has been taking place for longer in relapsing remitting MS phase III clinical trials are also taking place involving patients with progressive MS. One of the trials called FREVIVA is enrolling patients with progressive MS and will report in 2028.

The randomized portion of an earlier phase 2 trial attracted attention when it was published a year ago in The New England Journal of Medicine, but the 2-year results published more recently showed that the efficacy and safety observed at 12 weeks persist**.**

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Sixty-seven, not quite out

When I celebrated my sixty seventh birthday recently, I marked a significant 'MS milestone'. My MS diagnosis was shortly before my 34th birthday, so my 68 years (yes, I have started year 68) can be roughly divided in two halves. I've spent 34 years with MS and more or less the same number without, that's roughly half and half.

Looking back on the second half of my life, the half with MS, I have one major regret – that I have never been eligible for any disease modifying drugs. The reason is because I was diagnosed at the wrong time, annoyingly 5-10 years too early. Let me explain.

When I was diagnosed in 1993 there were no disease modifying drugs so I was given the proverbial 'pat on the back' and no more. Then, about five years later the ABC drugs (Avonex, Beta Interferon, Copaxone) were introduced, hoorah. However, at the time there were guidelines about who was eligible for these new drugs. I was told you had to have a relapse every year or so. Given that my relapse rate was one relapse in five years I was clearly never going to meet this criterion. I was ineligible.

So, back in the 1990s my MS was untreated but at the time it didn't worry me. My MS was stable, my level of disability was minimal. 'Watchful waiting' which I believe was the recommended intervention - or non-intervention- seemed a sensible course of action. The neurologist would just carry on 'watching and waiting'.

With hindsight 'watchful waiting' was a disaster because watchful waiting involved a lot of waiting and very little watching. Year after year my neurologist refused to give me an MRI, saying he preferred to rely on a 'physical examination'. While physical examinations can be helpful, they don't show you what's going on 'under the bonnet' so to speak.

As the 1990s turned into the millennium I was aware that my condition was getting worse and I was still ineligible for those ABC drugs as my relapse rate was unchanged.

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Continued from p10 The next generation of MS drugs, things like Tysabri, which are highly effective, were still five years away from being available, and the relapse rate rules were still in place for the ABC drugs. I still wasn't getting an MRI .

So, when my MS transitioned to secondary progressive in 2003 I was ineligible for the new generation of more effective DMDs like Tysabri which, when they finally did arrive, were restricted to those with relapsing remitting MS which I had transitioned from, a few years earlier. More than a decade later when siponimod a drug for secondary progressive MS was finally approved, it was only available for 'active' secondary progressive MS whose disease was 'active'. Given that my MS is inactive I was once again ineligible.

Fast forwards to 2025 and as someone with non-active Secondary Progressive MS I think I am a member of the last group to be treated. However, all hope is not lost. A new drug for non-active SPMS called Tolebrutinib is awaiting approval by the FDA in the US. If all goes to plan Tolebrutinib should be available in the UK next year and I am hopeful that NICE will agree to foot the bill meaning I will be eligible for my first DMD 35 years after diagnosis.

Looking back on my 'MS history' I regret that I didn't push harder to get on one of the ABC drugs back in the 1990s. But I ask myself 'would it have made any difference?'. I have a friend about my age who was diagnosed roughly when I was. He paid for DMDs for at least a decade and he is the one in the wheelchair, not me, so who knows?

When Tolebrutinib does arrive in the UK next year I will have an opportunity to find out if a DMD does work for me, and I will make every effort to go on this new MS drug. The figures from Phase 3 trials show Tolebrutinib stopping disease progression, even reversing it in a few cases. I hope I am one of the lucky ones and I won't be shutting the stable door after the MS horse has long since bolted. That's my hope. Life with MS is all about hope. Here's hoping.

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News

Cancer drug can promote re-myelination

A new analysis of data from a small clinical trial testing an anti-cancer therapy called bexarotene for use in MS has shown that the drug can promote the repair of the myelin sheath and may also help limit nerve damage in MS.

The analysis, titled "Serum neurofilament light chain levels suggest neuroprotection following bexarotene-induced remyelination in people with relapsing remitting multiple sclerosis," was published in the journal Multiple Sclerosis and Related Disorders.

Bexarotene is a compound approved under the brand name Targretin as a treatment for cutaneous T-cell lymphoma, a type of blood cancer. Preclinical research suggested that bexarotene may be able to promote remyelination in MS. In the mid-2010s, a team led by scientists in the U.K. conducted a small Phase 2a clinical trial, called CCMR-One (ISRCTN14265371), testing bexarotene against a placebo in people with relapsing-remitting MS (RRMS).

Although the study showed that bexarotene was associated with substantial side effects that made it ill-suited for use as a routine MS treatment, it also indicated that treatment with the cancer therapy reduced visual evoked potential (VEP) latency — a sign of remyelination based on how quickly nerve signals travel from the eyes to the brain.

In theory, increasing remyelination is expected to help limit nerve fibre damage in people with MS. However, there's not much hard data to support this idea. To help fill this gap, a research team from the University of Cambridge in the U.K. and the University of Basel and University Hospital Basel in Switzerland looked at data from the CCMR-One study.

Specifically, the team examined whether bexarotene treatment affected biomarkers of nerve damage, Their findings did suggest that remyelination in response to bexarotene treatment may be associated with neuroprotection in people with relapsing-remitting MS. There are hopes this improvement may also be seen in progressive MS.

For details of all stories go to page 14

News

Cold sore virus may play role in MS, mouse study finds

A common herpes virus that causes cold sores, called herpes simplex virus type 1 (HSV-1), may contribute to multiple sclerosis (MS). That's according to a study by researchers at the University of Illinois Chicago (UIC).

In mice lacking a protein that helps control HSV-1, infection led to the degrading of the myelin sheath, the protective coating on nerve fibres that's damaged in MS, triggering MS-like symptoms. When these mice were treated with a molecule that blocks MLKL, a protein that boosts HSV-1 infection, myelin was preserved.

"Our findings enhance our understanding of how viruses develop and offer potential avenues for mitigating viral-induced [nerve cell] damage," Deepak Shukla, PhD, a professor at UIC and the study's lead, said in a university news story.

The study, "MLKL–OPTN axis regulates herpesvirus-induced neurological sequelae," was published in the journal 'Clinical and Translational Medicine'.

In MS, a mistaken immune attack on the myelin sheath also damages nerve cells and oligodendrocytes (the cells that produce myelin), giving rise to various neurological MS symptoms. One of the strongest risk factors for MS is a history of infection with the Epstein-Barr virus, a type of herpes virus, which raises the risk of developing the autoimmune disorder by more than 30 times. Other herpes viruses, including the varicella-zoster virus that causes chickenpox and shingles, and human herpes virus 6, have also been linked to MS onset and progression.

HSV-1 causes cold sores, and is carried by two of every three adults. While most people with HSV-1 have no symptoms, the virus, which infects through the eyes and mouth, can stay in the body for life. It poses a particular risk to people with weakened immune systems.

In previous work, Shukla's team discovered a link between HSV-1 and a heightened immune response in the brains of mice, leading to cognitive impairment, lack of coordination, and anxiety. The researchers also identified a protein, optineurin (OPTN), as an antiviral factor that restricts HSV-1 replication and spread. Cells without optineurin were more susceptible to programmed cell death after HSV-1 infection**.**

For details of all news stories see page 14

References further details, etc

Page 2 Neural stem cell grafts show promise in prog-MS

https://www.news-medical.net/news/20250707/Neural-stem-cell-grafts-show-promise-for-myelin-repair-in-multiple-sclerosis.aspx

Page 3 CAR-T cell therapy may be breakthrough in prog-MS

https://multiplesclerosisnewstoday.com/news-posts/2025/06/25/3-progressive-ms-patients-see-lowered-disability-car-t-cell-therapy/?utm_source=MS&utm_campaign=3bd174ee40-Email_ENL_NON-US_MS&utm_medium=email&utm_term=0_b5fb7a3dae-3bd174ee40-71290133

Page 4 New cannabis type drug being trialled.

https://multiplesclerosisnewstoday.com/news-posts/2025/07/18/new-global-trial-testing-oral-therapy-bms-986368-ms-spasticity/

https://clinicaltrials.gov/study/NCT06782490

https://multiplesclerosisnewstoday.com/news-posts/2016/10/07/abide-and-celgene-partner-develop-abx-1431-as-cannabis-like-treatment-for-ms-neurological-diseases/

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https://mstrust.org.uk/a-z/tolebrutinib

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https://multiplesclerosisnewstoday.com/news-posts/2025/06/20/foralumab-nasal-spray-trial-starts-dosing-patients-weill-cornell/?utm_source=MS&utm_campaign=efa1c520f2-Email_ENL_NON-US_MS&utm_medium=email&utm_term=0_b5fb7a3dae-efa1c520f2-71290133

https://www.tizianalifesciences.com/tiziana-life-sciences-expands-phase-2-clinical-trial-of-intranasal-foralumab-with-commencement-of-first-patient-dosing-at-weill-cornell-multiple-sclerosis-center/

Page 8: Benefits of stem cells for MS patients

https://multiplesclerosisnewstoday.com/news-posts/2025/07/08/stem-cell-transplant-shows-long-term-benefits-ms-patients-study/?utm_source=MS&utm_campaign=4cf1ba7066-Email_ENL_NON-US_MS&utm_medium=email&utm_term=0_b5fb7a3dae-4cf1ba7066-71290133

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https://www.medscape.com/viewarticle/experimental-ms-drug-nearly-eliminates-disease-activity-2025a1000f9u?ecd=mkm_ret_250625_mscpmrk_neuro_topcontent_etid7522616&uac=223883BY&impID=7522616

https://clinicaltrials.gov/study/NCT06141486

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As this is a feature about me the best reference is myself. If you have any queries email me iancookjournalist@yahoo.co.uk

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https://multiplesclerosisnewstoday.com/news-posts/2025/08/0528/medications-myelin-sheath-repair-help-limit-ms-nerve-damage/?utm_source=MS&utm_campaign=98156ee333-Email_ENL_NON-US_MS&utm_medium=email&utm_term=0_b5fb7a3dae-98156ee333-71290133

Page 13 Cold sore virus may play role in MS

https://multiplesclerosisnewstoday.com/news-posts/2025/07/21/cold-sore-virus-play-role-ms-mouse-study-finds/

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