progression of disability in most patients leads to permanent disablement and inability do live independently.

e course of MS mainly depends on the patient's age at onset and the type of the disease - prognosis is worse for patients with primary-progressive MS. According to Deggenhardt et al., in the relapsing-remitting (RRMS) and primary-progressive types of MS (PPMS) the negative prognostic factors include: occurrence of progression, higher number of bouts, greater disability within the rst 5 years, shorter interval before the second bout and involvement of a larger number of systems [13]. Other negative factors include: shorter time to progression in the primary-progressive type and more quickly progressing disability during the rst two years and ve years in the primary progressing type [13]. Weinshenker et al. observed that up to 50% of patients will require devices helping them to walk within 15 years from the onset of MS [14]. In one of their last reports Tutuncu et al. published the results of a study of two cohorts of patients: with relapsing-remitting MS and with progressive clinical course (primary or secondary) [15]. Progression occurred before the patient's age of 75 years in 99% of patients with diagnosed progressive course of the disease, while in 38% of patients with RRMS progression did not develop before the age of 75 years. On both cohorts, only 2% of patients reached EDSS=6 (Expanded Disability Status Scale by Kurtzke) before progression. us the conclusion that the RRMS form of MS must not necessarily transform into a progressive one. e

functioning. In recent years there have been many studies carried out which showed that the quality of patients' life is a ected not only by the physical disability but also the psychological and psychosocial factors [18-22].

Symptomatic treatment and rehabilitation constitute a very important element of palliative care in patients with multiple sclerosis. e main focus of neurorehabilitation management is not to restore the motor functions or compensate them, but to take care of the patient's condition, maintain his/her body's e c]encm and prevent symptoms such as pain, bedsores, sphincters and mood disturbances in the best possible way.

Qual] cat]on for palliative treatment, including initiation of rehabilitation and palliative care, is a d] cult decision, which should be made by a specialist team and based on clear criteria. It should not be treated as a verdict closing one's door to management aimed at improving the quality of life in terminal patients. In all cases it should be the patient's condition and the general qual] cat]on criteria that should be taken into consideration, though the criteria still remain

3. Edmonds P, Hart S, Gao W, Vivat B, Burman R, et al. (2010) Palliative care for people severely a ected by multiple sclerosis: evaluation of a novel palliative care service. Mult Scler 16: 627-636.
4. Voltz R (2010) Palliative care for multiple sclerosis: a counter-intuitive approach? Mult Scler 16: 515-517.
5. Rosati G (2001) e prevalence of multiple sclerosis in the world: an update. Neurol Sci 22: 117-139.
6. Potemkowski A (2009) Multiple sclerosis in Poland and worldwide – epidemiological considerations. Aktualn Neurol 9: 91-97.
7. http://www.emsp.org/media/ms-barometer-2013/.
8. Sepúlveda C, Marlin A, Yoshida T, Ullrich A (2002) Palliative Care: the World Health Organization's global perspective. J Pain Symptom Manage 24: 91-96.
9. Cialkowska-Rysz A (2009) e situation and challenges of palliative care in Poland. Medycyna Paliatywna 1: 22-26.
10. Stenager EN, Stenager E, Koch-Henriksen N, Brønnum-Hansen H, Hyllested K, et al. (1992) Suicide and multiple sclerosis: an epidemiological investigation. J Neurol Neurosurg Psychiatry 55: 542-545.
11. Fredrikson S, Cheng Q, Jiang GX, Wasserman D (2003) Elevated suicide risk among patients with multiple sclerosis in Sweden. Neuroepidemiology 22: 146-152.
12. Goldman Consensus Group (2005) e Goldman Consensus statement on depression in multiple sclerosis. Mult Scler 11: 328-337.
13. Degenhardt A, Ramagopalan SV, Scalfari A, Ebers GC (2009) Clinical prognostic factors in multiple sclerosis: a natural history review. Nat Rev Neurol 5: 672-682.
14. Weinshenker BG, Bass B, Rice GP, Noseworthy J, Carriere W, et al. (1989) e