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Clinical Conundrums in ARIA: How to Interpret and Manage ARIA-H

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Dr. Bateman:
Welcome to Clinical Conundrums: Navigating Case Scenarios in Your Own Practice Setting, where we will cover quick and challenging cases related to amyloid-related imaging abnormalities, or ARIA, management. I'm Dr. Trey Bateman, and here with me today are doctors Jerry Barakos and Joy Snider. Let's dive into our case.

Dr. Snider:
Yeah, thanks, Trey. This case is Sarah, who's a 73-year-old lady who's on lecanemab, and she was diagnosed with moderate ARIA-H, so ARIA with hemorrhage, on a routine MRI. The question now is whether to suspend, continue, or permanently stop dosing with lecanemab.

Dr. Bateman:
So let's talk about this decision-making process. Jerry, can you walk us through the imaging findings that define ARIA-H severity?

Dr. Barakos:
Yes. So for ARIA-H, of course we're using our blood sensitive sequence, whether it's the GRE T2 star, or the susceptibility weighted sequence. Again, we're using a rule of 5s for microhemorrhages. What we're talking about here when we're talking about the ARIA-H findings, these are incident findings. In other words, the patient has been enrolled, and they may have up to four lobar microhemorrhages to begin with. But as radiologists, when we're doing these follow-up scans, when we're counting microhemorrhages or reporting siderosis, etc., these are incident findings; they have developed in the interim when compared to the baseline scan.

Now, when talking about new lobar microhemorrhages, again, the rule of 5s. So if you're between 1 and 4, we'll consider that mild, between 5 and 9 that will be moderate, and 10 or more that will be severe. So that will be a very simple manner to state whether we have mild, moderate, or severe ARIA-H, as reflected in parenchymal microhemorrhages.

Now, we also look for superficial siderosis. Now, if we have one zone of superficial siderosis, we refer to that as mild. If there are two, we'll refer that as moderate. And if there are more than two, that will be severe. So in brief, that is the severity scale employed.

Dr. Bateman:
So Joy, once this imaging diagnosis has been made, how do you decide the next steps for the patient's anti-amyloid therapy management?

Dr. Snider:
So this is based on a couple of things. One is the radiographic severity that we just heard about from Jerry, and the other is if there are any clinical symptoms. So we always want to check with patients once we get these findings and ascertain if there are symptoms. And

as we talked about in other episodes, this could be challenging too. Is it a mild headache they've always had? Is it something different? But we do try to look for symptoms that have some clinical significance.

So in this case, if we accept that the patient is clinically asymptomatic, if the ARIA is mild, so less than 4 new microhemorrhages, we would proceed with dosing. We would probably let the patient know, make sure they were okay with that, but we would proceed with dosing and reassess in about 4 weeks to see if the microhemorrhages were stable. If it's more moderate, if there's 5 to 9, or even more than 10 microhemorrhages, then we would suspend dosing. If it's moderate, we would probably offer the patient the option of continuing. And again, we'd want to reassess with repeat imaging in 4 to 8 weeks to make sure things were stable. If it's severe, generally, we would not continue dosing.

So these are things that we talk about with our patients. We weigh the pros and cons. We have to look at our comfort with using these medications, realizing that these things are often asymptomatic. So I certainly have patients in clinic and in clinical trials, who we dose through 10 to 12, I think I have one with 18 microhemorrhages. It does start to get you a little excited. In some of our patients with autosomal dominant Alzheimer disease, the microhemorrhages are more common, so we're comfortable with a few more than we might be in sporadic. But understanding that microhemorrhages particularly are worrisome, but they can be part of the natural disease process, so we kind of have to add that in too. So it gets very difficult, but it does involve talking to your radiologist, understanding what we know is incidents or new and what we think is baseline. And then being very transparent with the patients about what we're seeing, what we think the risks are, and also how much we actually don't know.

So this is one point where I put in a plug for continuing to use registries. The CMS registry, the ALZ-NET registry and others. So as we go over time, we will all learn more about what is safe to do and what we should avoid doing with these patients.

Dr. Bateman:
So the key takeaway that I'm hearing for making decisions with management here in ARIA-H, really the same as it is with ARIA-E, is that you've got to consider the clinical presentation separately from the radiographic presentation, and then combine those together to understand what the next best steps are for your patient, because somebody who might have moderate ARIA-H with no symptoms is quite different from somebody who has moderate ARIA-H with some increase in confusion or dizziness. And so really taking both of those into account is really important.

And then the topic that comes up time and time again in most of these videos is the importance of shared decision-making and good communication between our colleagues in radiology.

So thank you all for this insightful discussion. To our viewers, be sure to explore our other episodes for more in-depth insights into the nuance of ARIA management. Thank you for joining us.

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