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Implementing CIDP Clinical Guidelines: Optimizing Therapy

Announcer:
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Dr. Allen:
This is CME on ReachMD. I'm Dr. Jeffrey Allen. Joining me today is Dr. Nicholas Silvestri.

Nick, how can we use the CIDP clinical guidelines to optimize our therapies for CIDP?

Dr. Silvestri:
Yeah. Thanks, Jeff. I mean, I think clinical guidelines are incredibly important as a good framework for us to understand how to treat our patients. There are guidelines in multiple disorders that we treat, obviously including CIDP. And I think what's helpful from these guidelines are to think about how to approach a patient in general, but I think what's also important, really, is to understand when it's important to individualize therapies to a patient. So, for example, as we've previously discussed, I think we both typically use IVIG as our first-line therapy before thinking of others. But there may be instances where using IVIG isn't appropriate because of patients', maybe, past experiences with the medication or, more likely, comorbidities. And the same can be true for corticosteroids. I mean, I can think of many patients where I hesitate to use corticosteroids because of preexisting comorbidities or risks. I'm worried about risks of developing side effects. And so while guidelines, I think, in general can be very helpful as a framework, it's important always to put your individual patient in the context of those guidelines to make individualized choices.

I think another important point to bring up, and I think you touched on this as well in a previous episode, is that frequently, we'll have patients who are diagnosed with CIDP who are put on a therapy like IVIG, and they're just not responding or not responding optimally. And I think that is a great time to really stop and think, is this diagnosis correct? Maybe it means going back and taking the history and doing a more thorough exam. Maybe it's repeating the electrolyte diagnostic studies. Maybe it's doing some of the ancillary studies we talked about before. But I think that if you have a patient who's not responding optimally, the options are either they don't have CIDP or they have a severe and refractory case, in which case you might have to think about using other agents, potentially using something like plasma exchange or other agents as well.

Dr. Allen:
You know, those are some great points we often use. As you said, guidelines are response to treatment to support a diagnosis of CIDP. And if we use that improvement with treatment to say you do have CIDP, then the opposite should also be true, right? So if you don't respond to treatment, it probably makes it less likely.

And the guidelines really hit this point hard where, if you're starting treatment and it doesn't work, objectively, before charging into something else, rethink about the diagnosis and then move on to something that's evidence-based.

The other thing I really like about the guidelines from the treatment perspective is how they help us think about long-term utilization of

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some of the immunotherapies, where the first objective is to see if patients are getting better. Say we start IVIG, objectively see if somebody's getting better. If they do get better, always think about how often or how long they might need that therapy for and how much therapy they might need. All of our patients are a little bit different; the requirement of one with IVIG might not be the same than another. And the guidelines can help us really optimize and personalize therapy. If we think about doing some dose reductions or interval lengthening in the case of IVIG, or in some cases, the opposite might be true where in order to give more out of it, increasing that treatment.

In terms of looking at some of the off-label treatments for the guidelines, can you comment on how the guidelines might help us think about when to use other non-evidence-based therapies in practice?

Dr. Silvestri:
Yeah. I mean, I think that really boils down to a couple of instances, right? So one instance would be suboptimal responses to conventional therapies or intolerance of those therapies. Or as a measure in those corticosteroid-dependent patients, to be able to reduce those doses. Certainly, these aren't things that should be thought of as first-line agents, and I think that their use should be probably the exception rather than the rule. But there are some helpful hints in the guidelines about those agents as well.

Dr. Allen:
Yeah, it's always tricky to balance unknown risks and unknown benefits in someone with some of these therapies. So hopefully the guidelines can help us make a little bit more sense out of that.

Well, thank you so much for this brief discussion. It's giving me something to think about. Thanks for listening.

Announcer:
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