Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/neurofrontiers/tbd/26390/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

ATTR Peripheral Neuropathy: How to Avoid Misdiagnosis

Announcer:
Welcome to *NeuroFrontiers* on ReachMD. On this episode, we'll discuss enhancing outcomes for patients with transthyretin amyloid polyneuropathy with Dr. Morie Gertz. Not only is Dr. Gertz a hematology specialist at the Mayo Clinic Comprehensive Cancer Center in Rochester, Minnesota, but he also presented a session on this exact topic at the 2024 American Association of Neuromuscular and Electrodiagnostic Medicine Annual Meeting. Let's hear from him now.

Dr. Gertz:
ATTR inherited peripheral neuropathy is a disease that's hiding in plain sight. The problem is it's an uncommon cause of neuropathy in a general neurology practice, and so it's very easy to be misdiagnosed as diabetic neuropathy, inherited neuropathy, Charcot-Marie-Tooth, alcohol-related neuropathy, or monoclonal gammopathy-related neuropathy. Yet they're there, and of course, because there is highly effective therapy available, it becomes important not to overlook the diagnosis. Studies have shown that over 18 months, patients develop irreversible progression of their neuropathy if they're not diagnosed.

But there are important clues that you can keep in your clinical practice. ATTR neuropathy, because it's axonal and demyelinating, can be painful. It's associated with autonomic features such as orthostatic hypotension or intractable diarrhea. There's weight loss, bilateral carpal tunnel syndrome, biceps tendon rupture, and a high prevalence of spinal stenosis.

Only 50 percent of these patients actually have a family history, so the absence of an autosomal dominant inheritance pattern doesn't exclude the diagnosis. But it's important for the practicing neurologist to recognize the possibility that these patients also will have amyloid cardiomyopathy, so lower extremity edema, dyspnea on exertion, atrial fibrillation, and a history of some ill-defined heart disorder all become important clues for a practicing neurologist to say this is more than just a simple axonal, symmetric, length-dependent neuropathy and start thinking about the possibility of amyloidosis—both AL, and just as importantly, ATTR neuropathy—because of our available therapies.

ATTR peripheral neuropathy is an autosomal dominant inherited disorder. And once patients are questioned, it's actually quite common to find a parent, an aunt, an uncle, a first cousin, or an older sibling who will also have peripheral neuropathy symptoms. All patients who have suspected ATTR-PN need to have genetic testing done, and it's vital both for initiation of therapy and identifying a proband who may have many first-degree relatives with symptoms consistent with peripheral neuropathy to have it. It's really quite interesting that mail-in genetic testing such as 23andMe actually test for the three most common peripheral neuropathy inherited ATTR that are available. That's the V142I, the T80A, and the V50M—those are the three most common in the United States—and those are all tested for in those testing kits.

The reason why it's critical to diagnose ATTR peripheral neuropathy, the inherited forms, is because there are available highly effective therapies that have undergone rigorous testing prior to their approval. In virtually all the studies of the gene silencers that are approved for peripheral neuropathy, they've demonstrated, compared to placebo, stabilization of Neurological Impairment Score where placebo patients show significant deterioration in neurologic function by 9 and again at 18 months, and patients who received therapy show significant stabilization. In fact, the median is about stable, but that means, of course, that half of the patients actually improve neurologic function while they're on therapy.

But just as important as the Neurological Impairment Score, quality of life studies have been performed. Usually these are neurologic questionnaires that were designed originally for diabetic neuropathy that also show significant benefit when compared to placebo. Placebo patients show a significant decline in quality of life by 9 months. Patients on therapy remain stable, median, which means again

half of the patients have improved quality of life.

Announcer:
That was Dr. More Gertz discussing his session at the 2024 American Association of Neuromuscular and Electrodiagnostic Medicine Annual Meeting that focused on enhancing outcomes for patients with transthyretin amyloid polyneuropathy. To access this and other episodes in our series, visit *NeuroFrontiers* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!