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<https://reachmd.com/programs/cme/cidp-monitoring-challenges-suboptimal-responses-in-cidp-treatment/29775/>

Released: 12/17/2024

Valid until: 12/17/2025

Time needed to complete: 57m

ReachMD

www.reachmd.com

info@reachmd.com

(866) 423-7849

CIDP Monitoring Challenges: Suboptimal Responses in CIDP Treatment

Announcer:

Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Silvestri:

This is CME on ReachMD and I'm Dr. Nick Silvestri. Joining me today is Dr. Jeff Allen.

Jeff, what are some of the challenges in monitoring the response to treatment for CIDP?

Dr. Allen:

Thanks for that question. It can be really tricky but a really important thing to try to work out. We treat patients with different therapies, IVIG or steroids, and sometimes they get better. They're not walking, and now they're walking, and it's easy to know if they're improving. But often, it's not so easy. But the implication of really understanding if the treatments are doing what we think they're doing is really, really important. In many ways, it drives the diagnosis that we think people have. If we think they have CIDP and they get better, then we presume that that diagnosis was correct. It also drives long-term treatment. So somebody's put on a treatment and we think it's working, and it often continues to perpetuate the use of that treatment. So it's really important to get that right.

In my practice, I always like to use more objective outcome measures whenever possible in order to quantify improvements or to really understand if patients are improving. Some of the big areas that I like to assess are evidence of improvement in disability, evidence of improvement in some impairment, like walking or sensory function or strength. And then sometimes quality of life measures can be helpful as well.

When we're talking about improvements in disability, one skill I like to use in clinical practice is called the I-RODS, which is a Rasch-built or statistically modeled disability scale developed specifically for patients with CIDP. It's a list of 24 questions. Patients are asked if they can do their eat tasks, or do they do it with difficulty or if they can't do it at all. And it takes about 5 minutes to do. It starts with fairly simple tasks, like reading or getting dressed or washing, and then ends with more difficult tasks, like standing for hours or running. And based on that, you can kind of quantify some disability that a lot of patients with CIDP or related neuropathy struggle with. Another outcome measure that assesses disability is the INCAT, which is often used in clinical trials, which is a good one as well.

When it comes to strength impairment, of course, doing an MRC-sum score or MRC muscle testing is something every neurologist does, which is great. Another tool I like to use is just handheld grip strength with a Jamar dynamometer or Martin-Vigorimeter. Very, very easy to do. It gives you an immediately available, quantifiable assessment of grip strength, which takes about 30 seconds to do, and it's easy to compare. Patients actually really like to do this. They really find it interesting to follow their grip strength over time.

We also know the grip strength is not just the reflection of hand function, but also is a representative of overall functionality in somebody with CIDP, so it gives us a lot of really important information.

When it comes to assessing walking and gait, obviously, gait is often affected in those with CIDP. Some of the tools I like to use are the

Timed Up and Go with the TUG test. Patients are seated in a chair, has to stand up, walk 3 meters, turn around, and sit back down. So, obviously, super easy to do and it doesn't take a lot of space. A lot of our clinics don't have a lot of space. All you need is a chair and a 3-meter hallway and a stopwatch. And so it's very, very easy to do. We don't have a full understanding of what a meaningful change in the TUG score for patients with CIDP is, but I think we're understanding that as well. Other people like to do a 10-meter walk, or 6-minute walk, which is okay, as well.

But those are some of the ways that I do on patients at every visit in order to kind of quantify some improvements or worsening in patients with CIDP.

Dr. Silvestri:

Yeah, I mean those are all, I mean, great ideas. I think that in the context of a busy clinical practice, it's probably not practical to do all of those measures. I mean, certainly in the context of a clinical trial, that makes a lot of sense, and in practice it might be a good idea to kind of pick up one or two of those outcome measures to do in addition to your history and your exam, really to help you understand how a patient is doing, especially if they say they're not doing great. Right? I think that some objective evidence to add on to that sentiment is really important to be able to know if it's time to make a shift in therapy, for example.

Dr. Allen:

Yeah, I think you're right. Instead of doing everything, it's important to pick your battles, and it can be specific to a specific patient. So if one patient, you think they can really capture disability on the I-RODS or grip strength, that's important. But maybe another patient, a walking test is better. But something objective, I think, is really, really helpful to quantify getting better or getting worse.

Dr. Silvestri:

That's a great point. Yeah, individualizing is important.

Well, this has been a great, brief discussion. I hope you find this information useful. And thanks for tuning in.

Announcer:

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