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

Navigating CIDP Treatments: IVIg and Steroid Advantages and Limitations

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

Nick, please tell us some pros and cons about first-line CIDP treatments.

Dr. Silvestri:
Yeah. Thanks, Jeff. I mean, when I think of first-line treatments in CIDP, I really think of 3 potential therapies. I think of intravenous immunoglobulin, IVIG; steroids, usually prednisone, but there can be IV methylprednisolone, for example; and plasma exchange. And those are generally the order I kind of consider using them as first line.

Thinking first about IVIG, I mean, the pros are that if patients have CIDP, the vast majority of people are going to respond well to IVIG. Probably about 90%, give or take, of patients with CIDP will respond to it and will do well. It's generally a safe medication. Ig actually can be given intravenously or subq. We generally think of first giving people intravenous immunoglobulin and then transitioning to subq overtime if necessary. So, again, the pros typically are efficacy and general safety.

The cons are, well, with IVIG, it requires good venous access and repeated infusions. The length of infusion can vary from patient to patient depending on how well they tolerate it, and that's really one of the major cons, too, is tolerability. I think that significant percentage of patients that receive IVIG, unfortunately, experience side effects with it. Those side effects can be during the infusion, such as headaches, flu-like symptoms, myalgias, etc. There can be some more serious consequences, safety issues with IVIG, like thrombosis, kidney issues, and the like. Thankfully, with newer-generation IVIG formulations, those tend to be less common, but there are still safety concerns notwithstanding.

If I shift to corticosteroids, I've once heard it said that corticosteroids are the best and the worst drug we have. They're very effective at treating most autoimmune disorders, including CIDP, but the doses and the length of therapy that we often need to use to treat a disease like CIDP are too high and too long, and that leads to significant risk in terms of side effects, both in the short term and the long term. And so, frankly, I reserve corticosteroid use for patients with CIDP towards the bottom. I don't like to use it. That being said, some people, you just have to use it because they don't respond to other forms of therapy. But certainly, it's not my first choice.

When it comes to plasma exchange, I mean, there's no doubt plasma exchange is effective in CIDP. I think considering it as a first-line therapy, I mean, it technically is, but I don't use it in that way. It can be very cumbersome. It requires, in most centers, the placement of a central venous catheter. It can be onerous for patients. It can lead to problems with salt and water shifts, which can be problematic in people with underlying cardiac disease, for example.

So I generally reserve plasma exchange for refractory cases or cases where patients present quite, quite sick. And I use it as kind of an acute, aggressive therapy before I move on to another agent like IVIG.

Not a lot of data in CIDP on other agents, such as oral immunosuppressants, that we commonly use in other autoimmune disorders in the neuromuscular world. But there are certainly cases where those agents can be used, particularly in patients who are on corticosteroids, in order to try to be able to reduce those doses.

Dr. Allen:
That's a great summary of first-line of therapies. I think it's really important when we're starting treatment with CIDP to always start with something that's evidence-based and proven effective before moving on to somethings that’s off-label and not proven effective. My paradigm is much like yours. IVIG, if that doesn't work, reassess the diagnosis. Still CIDP, then steroids, and then maybe move on to something like plasma exchange.

Can you talk to me just a little bit about subcutaneous Ig? Do you ever start that first line, or what's a good patient for that?

Dr. Silvestri:
Yeah. So to be fair, I’ve not tried subq Ig from the get-go. I've definitely had patients with CIDP where I'll start them on IVIG, I'll determine that they respond to it, so that, as you point out, it can give me a little shot in the arm of confidence to make sure they have CIDP. And then I'll transition them to subq Ig.

I think that the right patients for subq Ig are those that perhaps have venous access issues as time goes on, where some of those side effects that I mentioned before, headaches, flu-like symptoms, myalgias, those seem to be less common with the subcutaneous versions. And then, finally, people that have busy lives that maybe are working full-time or have a lot of obligations, that maybe don't have the time to get to the infusion center or do the intravenous IVIG, but maybe can do subq Ig over the weekend, in the evening, that sort of thing.

Dr. Allen:
Thanks, Nick. That's a great discussion. Hopefully some of these points, we can put into practice. Thanks so much for listening.

Announcer:
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