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

Why Early and Accurate CIDP Diagnosis Matters: The Role of Standardized Tools

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Dr. Silvestri:
Hi, this is CME on ReachMD. I'm Dr. Nick Silvestri, and joining me today is Dr. Jeff Allen.

Jeff, what are the standardized CIDP diagnostic tools we can use to reach an early and accurate diagnosis of CIDP?

Dr. Allen:
Sure. Thanks for that question, Nick. One of the most important early tools is, of course, nerve conduction test. For nerve conduction tests, we're really looking to define the demyelination in CIDP, which is really important for that diagnosis.

So when one looks at the guidelines, the EAN/PNS guidelines, the specific things that we want to see meet demyelinating criteria are outlined in that guideline. The guideline can be very complex, but essentially to meet minimum diagnostic criteria in order to say one has a demyelinating neuropathy, we're looking for one prespecified change in one nerve that might include conduction velocity slowing or conduction block, temporal dispersion, prolonged distal latencies, or prolonged minimum F wave latencies. So there's a lot of opportunity in order to meet those demyelinating criteria. You have one change, it's minimally supportive of debilitating; you have two changes, it's generally considered strongly supportive.

So it's a really helpful resource to have. Beyond nerve conductions, we can often see things like changes in the CSF protein, imaging changes on MRI or ultrasound where nerves can look big or bright. Nerve biopsy, we don't do so much for CIDP diagnosis anymore, but it can be helpful in some situations, especially when mimics are on the table. And then looking for responses to treatment.

So response to treatment is considered one supportive test for this diagnosis of CIDP. But when we do that, it's really important to be objective as possible about that. So we don't just ask patients how they feel, but actually measure things like a disability scale or a strength impairment scale or some other gait assessment to really see if they're improving.

Certainly, not every patient needs all of those supportive steps taken in order to make their diagnosis for CIDP, but for some patients, it can be really helpful in order to increase their confidence that we're dealing with CIDP or maybe steer us in a different direction for a different diagnosis.

Dr. Silvestri:
Yeah. No, that's a great summary, Jeff. I guess my question would be, how often do you do CSF analysis if you've got a case that sounds like CIDP, looks like CIDP on examination, and then the electrophysiology is strongly supportive?

Dr. Allen:
Yeah, it's a great question. For somebody that's got a typical phenotype and strongly supportive electrophysiology, as long as there's no

red flags that there's not anything else that might be causing those symptoms, then spinal fluid isn't often needed. The place that I find it most helpful are patients with maybe one of the phenotypes that aren't typical, electrophysiology that's maybe weakly supportive or pointing in that direction but doesn't meet some of those prespecified criteria in the guidelines. For some of those patients, the supportive data, like CSF protein, can be quite helpful. It's also really helpful when there's other things on the table. If you're thinking, for example, about malignancy infiltration or sarcoid or some sort of infectious process, really helpful in that setting as well.

I guess one final comment on that is that, although we often think about this testing as being supportive of the diagnosis, it's important to always approach the supportive data with a little element of skepticism, especially for changes that are mild or moderate and the wrong clinical scenario. Certainly, a high CSF protein by itself is not diagnostics of CIDP, nor is imaging or how patients feel after you put them on steroids or IVIG. So keeping those considerations in mind is really important as well.

Dr. Silvestri:
Yeah, I have to agree with you. I think the times when I typically consider doing a lumbar puncture for CSF analysis in CIDP are those variants or are situations where I'm curious or wondering if there's something else going on, like POEMS syndrome or something like that, where there can be some diagnostic clues in the CSF, or if I think there may be an alternate diagnosis that has different treatment implications.

Well, thanks so much for condensing all that information, Jeff. I really appreciate it.

Our time is up and thanks for listening.

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