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Reviewing Individualized Therapy in CIDP Patients

Announcer:
You're listening to *Clinician's Roundtable* on ReachMD. On this episode, brought to you by CSL Behring, we'll hear from Dr. Michael Pulley, who's a Professor of Neurology at the University of Florida in Jacksonville. He's also a neurologist at the UF Health Neuroscience Institute specializing in clinical neurophysiology, and neuromuscular medicine. Today, he'll provide best practices for individualizing therapy for chronic inflammatory demyelinating polyneuropathy, or CIDP, patients who are transitioning from IVIg to SCIg therapy. Here's Dr. Pulley now.

Dr. Pulley:
The reason that it's important to individualize therapy in CIDP care is that no two patients are exactly alike in terms of how much they need. And this has been demonstrated in some clinical trials of intravenous immunoglobulin where depending on the dose used, the response rates varied from 70 to 80 to 90% depending on which dose of intravenous immunoglobulin they were getting.

And we think the same principles will apply to subcutaneous immunoglobulin, and that's been demonstrated in the study. Although there wasn't a statistically significant difference in the rates of preventing relapse, there was a numerical trend that looked like the higher dose of subcutaneous immunoglobulin was more effective at preventing relapse than the lower dose. And so again, that's just an indication that it's not one-size-fits-all, we need to be able to adjust the dose for an individual patient.

One of the reasons that we consider subcutaneous immunoglobulin is that patients may notice at the end of their treatment cycle that they have a wearing-off of the affect. So when you receive intravenous medication, it starts off with a very high level in the bloodstream, and then by three weeks later, which is usually the standard of care time for the next dose, the level has dropped significantly, and that may allow some symptoms to return. With subcutaneous immunoglobulin, the levels are much more consistent throughout the course of treatment, so there's not as much likelihood of having wearing-off in between treatments.

So patients do have fears about sticking needles in themselves. One of the biggest misconceptions is that they're better off with smaller needles, or shorter needles, and we try to make sure that they understand that we want the drug to go under the skin and not into the skin. An injection site reaction is significantly higher if the drug is infused into the skin instead of under the skin. So I tell people that you're better off with a long needle than a short needle. And I also encourage them that the training by the nurse is very simple, and almost always can be completed in one or two training sessions, and then the patient can be self-sufficient in doing their own treatment.

So it's important to have the patient let us know if they notice there's any deterioration in their condition as a result of transitioning because there's a conversion factor that had been proposed based on reduced absorption of the drug from a subcutaneous route. 100% is absorbed into the bloodstream when it's given intravenously, but a slightly smaller percentage eventually gets into the bloodstream when it's subcutaneous. So I think it's important for patients that they are monitoring that.

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