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by CME OUTFITTERS

CIDP in Focus



Advancing Precision Across the Patient Journey from Early Recognition to Downstream Management

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Jeffrey Allen, MD

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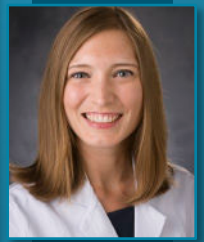
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PATIENT ADVOCATE

Disclosures

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All identified conflicts of interest have been mitigated.

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LEARNING OBJECTIVES

1. Apply current understanding of chronic inflammatory demyelinating polyneuropathy (CIDP) heterogeneity and underlying disease pathology to inform clinical assessment and management
2. Integrate current guideline-concordant diagnostic criteria to support accurate and timely identification of CIDP across its widespread constellation of clinical presentations
3. Evaluate current and emerging therapeutic strategies for CIDP, integrating interprofessional team perspectives to inform individualized treatment optimization, including appropriate patient selection and transition from conventional therapies within the context of long-term disease management

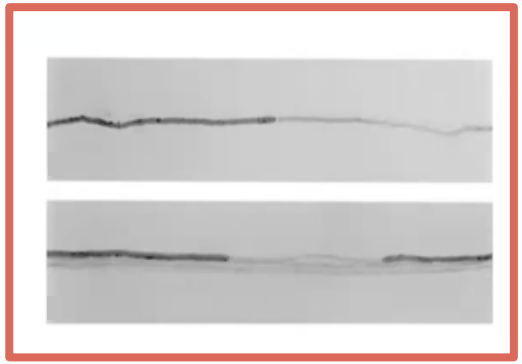
CIDP in Focus

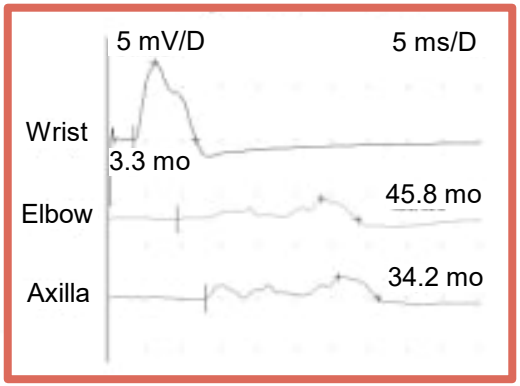
What Is CIDP? Differential Diagnosis

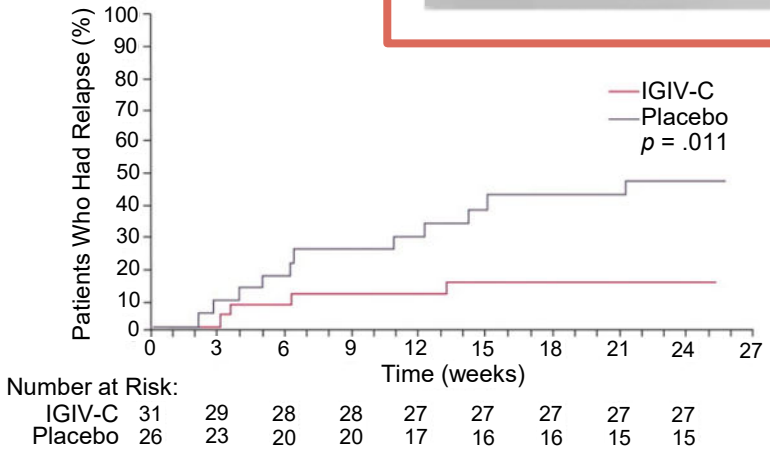
Luis Querol, MD, PhD

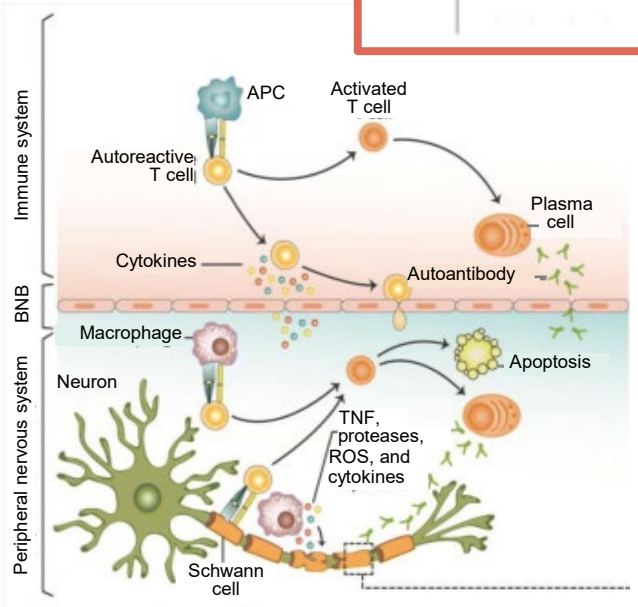


What Is CIDP?







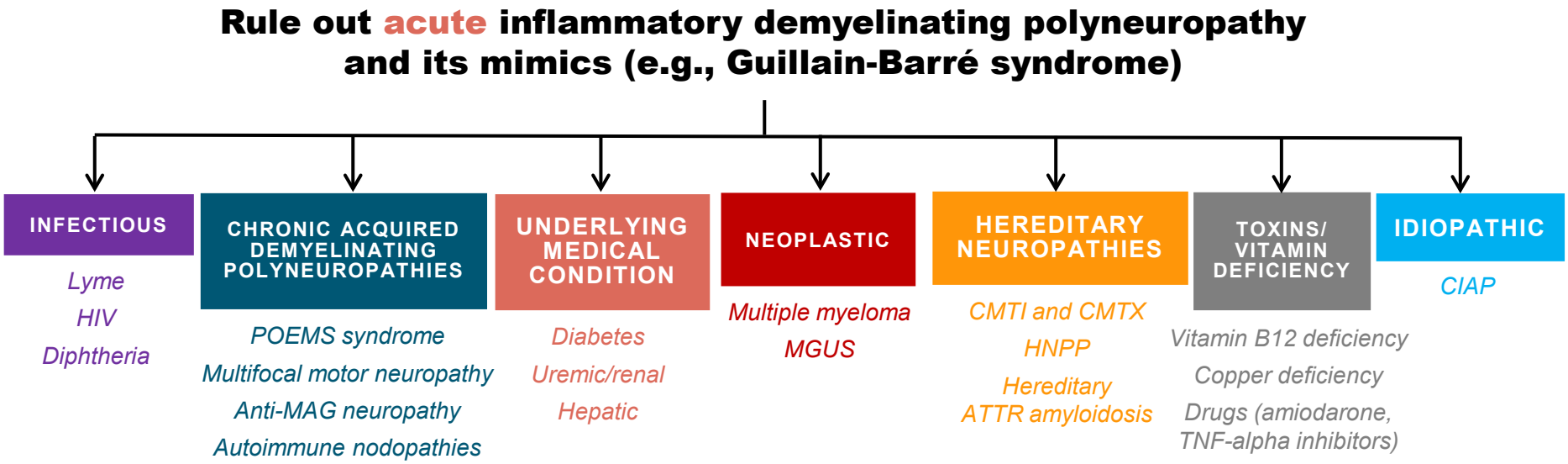


ADP = antigen-presenting cell; IGIV-C = 10% caprylate-chromatography purified immune globulin intravenous; ms/D = milliseconds per division; mV/D = millivols per division; ROS = reactive oxygen species; TNF = tumor necrosis factor.

Bosboom WM, et al. *Brain.* 2001;124(Pt 12):2427-2438. Hughes RAC, et al. *Neurology*. 2008;7(2):136-144. Kieseier BC, et al. *Nat Rev Dis Primers*. 2018;4(1):31.

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Differential Diagnosis



ATTR = amyloid transthyretin; CIAP = chronic idiopathic axonal polyneuropathy; CMTI = Charcot-Marie-Tooth Type 1; CMTX = Charcot-Marie-Tooth X-linked; HIV = human immunodeficiency virus; NCPP = hereditary neuropathy with liability to pressure palsies; MAG = myelin-associated glycoprotein; MGUS = monoclonal gammopathy of undetermined significance; NCPP = hereditary neuropathy with liability to pressure palsies; POEMS = polyneuropathy, organomegaly, endocrinopathy, monoclonal plasma cell disorder, skin changes.

Eftimov F, et al. *Brain*. 2020;143(11):3214-3224.Van den Berg PYK, et al. *J Periph Never Syst*. 2021;26:242-268.

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Patient Case 1: What Would You Do?

Audience, Community Clinician, KOL, AI, and Faculty Responses to Two Patients





PATIENT CASE 1: History

Victor S. – 52-year-old warehouse supervisor

- Evaluated for progressive weakness, numbness, and unsteadiness
- Symptoms progressed without plateau or relapsing pattern
- No antecedent illness, diarrheal episode, or vaccination
- Initially, difficulty rising from chair and climbing stairs; now also tripping on uneven ground
- Past 3 weeks: trouble with buttons and turning a key; numbness in both feet has ascended to mid-calf

- Does not describe prominent pain
- No autonomic symptoms, orthostatic lightheadedness, change in bowel or bladder function, abnormal sweating
- No dyspnea, diplopia, dysarthria, or dysphagia
- No weight loss, rash, or arthralgia
- No family history of neuropathy, no diabetes, minimal alcohol use, no relevant medication or toxin exposure
- Evaluated twice already and told each time “probably a pinched nerve”
- Worried about keeping his job



PATIENT CASE 1: Neurologic Examination

Victor S. – 52 years old

- MRC strength: shoulder abduction 4/5, hip flexion 4/5, ankle dorsiflexion 4/5, finger abduction 4+/5
- Sensation: reduced vibration and proprioception to mid-calf; pinprick reduced to the ankles
- Reflexes: absent at the ankles, reduced at the knees and biceps
- Gait: wide-based, unable to tandem walk; Romberg positive
- No tremor, no cranial nerve involvement
- Respiratory examination normal

MRC = Medical Research Council scale.



PATIENT CASE 1: Objective Baseline Measures

Victor S. – 52 years old

- aINCAT disability score: 3
- I-RODS: 42nd centile
- Grip strength: 18 kg right, 20 kg left

aINCAT = adjusted Inflammatory Neuropathy Cause and Treatment; I-RODS = Inflammatory Rasch-built Overall Disability Scale.



PATIENT CASE 1: Electrodiagnostic Studies

Victor S. – 52 years old

- Study performed with limb temperature controlled and adequate distal stimulation
- Left ulnar nerve: distal motor latency > 50% above ULN — meets one 2021 EAN/PNS demyelinating criterion
- No conduction block and no abnormal temporal dispersion in any nerve tested
- Absent F-waves in both peroneal nerves – suggestive of demyelination, ***but does not meet EAN/PNS F-wave criterion (peroneal distal CMAP amplitudes <20% of LLN)***
- ↓ sensory responses in both sural and both median nerves
- Net result: one nerve meets one demyelinating criterion

CMAP = compound muscle action potential; EAN = European Academy of Neurology; LLN = lower limit of normal; PNS = Peripheral Nerve Society; ULN = upper limit of normal.



PATIENT CASE 1: Laboratory/Supportive Testing

Victor S. – 52 years old

- SPEP with immunofixation: negative — no paraprotein
- HbA1c 5.4%; vitamin B12, TSH, and creatinine within normal limits
- ANA and extractable nuclear antigens: negative
- CSF not yet obtained; nodal and paranodal antibody panel not yet sent

ANA = antinuclear antibody; CSF = cerebrospinal fluid; HbA2c = hemoglobin A1c; SPEP = serum protein electrophoresis; TSH = thyroid-stimulating hormone.



PATIENT CASE 1: Classification

Victor S. – 52 years old

- Clinical criteria for typical CIDP are met; one nerve meets one demyelinating criterion
- Under the 2021 EAN/PNS framework this patient is classified as "*possible* CIDP"

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AUDIENCE POLLING: Case 1

This patient's clinical picture fits CIDP but the electrodiagnostic study is only weakly supportive. Which ONE would you do FIRST?

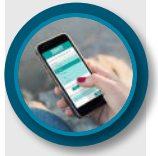
A. Repeat or extend the nerve conduction studies, including proximal and additional nerve sites
B. Order a nodal and paranodal antibody panel
C. Obtain nerve ultrasound or magnetic resonance imaging (MRI) of the roots and plexus
D. Begin empiric intravenous immunoglobulin (IVIg) and judge the diagnosis by treatment response
E. Refer to or consult a neuromuscular specialist
F. I don't know



KOL: Karissa Gable, MD

Patient Case 1 (Victor S.)









C Obtain nerve ultrasound or MRI of the roots and plexus

- **Clinical phenotype suggests CIDP** but electrodiagnostic testing is weakly supportive
- **Employ supportive testing** (e.g., spinal fluid imaging, empiric treatment)
- **Start first with imaging:** obtain nerve ultrasound or MRA of the roots or plexus to potentially:
  - Detect focal enlargement and non-compressive sites (cross-sectional area in the ultrasound)
  - Nerve root enlargement or enhancement with the imaging on MRI

MRA = magnetic resonance angiography

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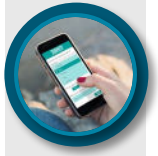
KOL: Ariel Marks, MD

Patient Case 1 (Victor S.)



D Empiric IVIg (+ **A** Repeat or extend NCS)









- **Challenging case:** one nerve (a prolonged distal latency) is atypical in CIDP
  - Can be patchy and often more proximal
  - What can compress the ulnar serve at this site?
- **Consider empiric IVIg**
  - Patient is having progressive symptoms
  - Important to address further progression and potential secondary axonal loss: **treat demyelinating process quickly**
- **Suggest simultaneous repeat of nerve conduction studies**
  - Include other less-sampled nerves

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NCS = nerve conduction study.

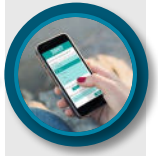
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Practicing Neurologist: 5 Years in Practice

Avatar Delivering Verbatim
Practicing Clinician Response









D **Begin empiric treatment with IVIg**

- The patient has a **non-length dependent neuropathy** involving symmetric, proximal, and distal **arm and leg weakness and hyporeflexia progressing >10 weeks**
- Clinically, this is likely CIDP
  - Progression could continue with **risk of permanent axonal damage** if not treated promptly
  - Treatment should not be delayed while awaiting repeat EMG
- Would not send nodal and paranodal antibodies

EMG = electromyography.

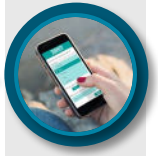
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Community Neurologist: 30 Years in Practice

Avatar Delivering Verbatim
Practicing Clinician Response









D Begin empiric treatment with IVIg

- **2021 EAN/PNS Guidelines say "possible CIDP"** – this is where many patients in community practice sit
- Testing toward certainty while **patient keeps losing function** can be detrimental
- Guidelines say an **objective response** to IVIg, PLEX, or corticosteroids **supports the clinical diagnosis**
  - **Begin empiric IVIG** and let treatment response do the diagnostic work

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PLEX = plasma exchange.

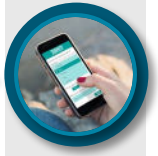
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Rural Neurologist: 45 Years in Practice

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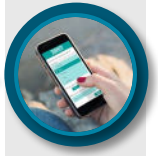
A **Repeat or extend NCS, including proximal & additional nerve sites**

- Entire electrodiagnostic **case for demyelination rests on one measurement in one nerve**
  - A one-time abnormality can be an error
- Prudent to **extend electrodiagnostic testing** to proximal sites, additional nerves
- **Document that limb temperature was controlled** and distal stimulation was adequate
- **In a small practice** you see few of these patients; **the patients you see "rarely read like the textbook"**

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Additional Community Neurologist Responses for Case 1

RESPONDENT 1	A Repeat/extend NCS
RESPONDENT 2	A Repeat/extend NCS
RESPONDENT 3	A Repeat/extend NCS
RESPONDENT 4	A Repeat/extend NCS

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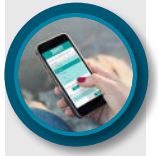
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AI: ChatGPT 5.6 Response

Patient Case 1









A **Repeat or extend NCS, including proximal & additional nerve sites**

- Convincing clinical phenotype for typical CIDP but **only one motor nerve currently fulfills a demyelinating criterion**
- **Strengthen the electrodiagnostic evidence** before jumping to a treatment response as a diagnostic test
- **EAN/PNS guideline** specifically notes **examining additional nerves and proximal sites**
- **CSF and imaging** may subsequently provide **supportive evidence**
- **Reserve nodal/paranodal antibody testing** for situations with clinical features suggesting an autoimmune nodopathy

AI = artificial intelligence.

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Angela Parris

CIDP Patient Advocate

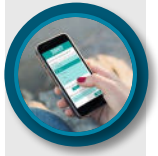
Active Volunteer,
GBS/CIDP Foundation



EXPERT FACULTY

Responses and Discussion









Decision Point

Patient Case: Victor S.

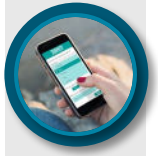
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Case Perspective Summary

Patient Case 1









	COMMUNITY/RURAL	KOLs	AI
A. Repeat or extend the nerve conduction studies, including proximal and additional nerve sites	5	1	1
B. Order a nodal and paranodal antibody panel	—	—	—
C. Obtain nerve ultrasound or MRI of the roots and plexus		1	
D. Begin empiric IVIg and judge the diagnosis by treatment response	2	1	—
E. Refer to or consult a neuromuscular specialist	—	—	—

CIDP in Focus

Clinical Criteria
Red Flags
Electrodiagnostic Criteria

Jeffrey Allen, MD
Chafic Karam, MD



CIDP Clinical Criteria

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Identifying Clinical Red Flags

TO AVOID UNDERDIAGNOSIS

- Consider CIDP on the differential for patients with proximal muscle weakness
- Duration of symptoms helps differentiate CIDP from Guillain-Barré syndrome (GBS)
  - *Progression 8 or more weeks after symptom onset strongly indicates CIDP over GBS*

TO AVOID OVERDIAGNOSIS

Look for clinical red flags

- **Pain predominance**
- Autonomic features
- Dyspnea
- Cranial nerve involvement
- Systemic features
- Family history
- Subacute, low-frequency tremor, marked ataxia, distal predominance
- Lean on EAN/PNS criteria



Lehmann HC, et al. *J Neurol Neurosurg Psychiatry*. 2019;90(9):981-987. Bjelica B, et al. *J Peripher Nerv Syst*. 2019;24(2):180-186. Van den Bergh PYK, et al. *J Peripher Nerv Syst*. 2021;26(3):242-268. Broers MC, et al. *Eur J Neurol*. 2021;28(6):2065-2073. Chaudhary UJ, et al. *J Neurol*. 2021;268(4):1366-1373. van Doorn PA, et al. *Eur J Neurol*. 2023;30(12):3646-3674.

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Electrodiagnostic Criteria

CIDP

- Clinical criteria + motor criteria ≥ 2 nerves + sensory abnormalities in ≥ 2 nerves, **or**
- Possible CIDP + ≥ supportive criteria

POSSIBLE CIDP

- Clinical criteria + motor criteria in 1 nerve + sensory abnormalities in ≥ 2 nerves, **or**
- Clinical criteria + motor abnormalities in 1 nerve + sensory criteria *not meeting motor criteria* + sensory abnormalities in ≥ 2 nerves + objective treatment response + 1 other supportive criteria

MOTOR ABNORMALITIES	
Motor distal latency prolongation	Absence of F-waves
Motor conduction block	Distal CMAP duration prolongation
Conduction slowing	F-wave latency prolongation
Temporal dispersion	

SENSORY ABNORMALITIES
Prolonged distal latency
Reduced SNAP amplitude
Slowed conduction velocity

SNAP = sensory nerve action potential.

Van den Bergh PYK, et al. *J Peripher Nerv Syst.* 2021;26(3):242-268. Allen JA, et al. *Muscle Nerve.* 2018;57(4):542-549.

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Supportive Studies

Supportive criteria for those with possible CIDP (need at least 2)

OBJECTIVE RESPONSE TO TREATMENT

- Improvement after IVIg, PLEX, or steroids
- Needs improvement on at least 1 disability scale and 1 impairment scale
- Patient-reported improvement alone does not count

IMAGING

- MRI can add value in assessing proximal nerves and the brachial and lumbosacral plexuses
- Ultrasound can evaluate focal areas of cross-sectional area enlargement

CSF

- Albuminocytologic dissociation in CSF (normal leukocytes, < 10 cells/μL, with elevated protein) is often seen in CIDP
- For individuals age > 50, consider values up to 0.6 g/L as acceptable

NERVE BIOPSY

- Rarely needed
- May help in complex cases by identifying demyelinating features and evidence of inflammation

Additional information

SEROLOGY TESTING
(not supportive for diagnosis)

- Serum monoclonal proteins using serum protein electrophoresis with immunofixation should be performed in every individual with suspected CIDP
- Anti-MAG (myelin-associated glycoprotein) antibodies should be tested in distal CIDP

Van den Bergh PYK, et al. *J Peripher Nerv Syst.* 2021;26(3):242-268. Allen JA, et al. *Muscle Nerve*. 2018;57(4):542-549.

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AUDIENCE POLLING: Case 1 – Revisited

This patient's clinical picture fits CIDP but the electrodiagnostic study is only weakly supportive. Now, which ONE would you do FIRST?

A. Repeat or extend the nerve conduction studies, including proximal and additional nerve sites
B. Order a nodal and paranodal antibody panel
C. Obtain nerve ultrasound or MRI of the roots and plexus
D. Begin empiric IVIg and judge the diagnosis by treatment response
E. Refer to or consult a neuromuscular specialist
F. I don't know



PATIENT CASE 1: 8-Week Follow-up

Victor S. – 52-year-old warehouse supervisor

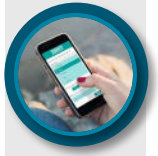
- **Started on IVIg** 2 g/kg as a loading dose, then 1 g/kg every 3 weeks
- He **returns at 8 weeks** and reports "**maybe he has a little more energy**"
- When asked, he **cannot identify a specific task that has become easier** (his family has not noticed a change)
- He has t**olerated the infusions** without adverse events

- **Neurologic examination**: unchanged from baseline
- **aINCAT** disability score: 3 (unchanged)
- **I-RODS:** 44th centile (baseline 42nd)
- **Grip strength**: 18 kg right, 21 kg left (baseline 18 kg / 20 kg)
- **No infusion-related adverse events**; doses given on schedule at target dose

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FACULTY DISCUSSION

Eight weeks in, Victor S. feels marginally better but nothing objective has changed. What would you do now?

A. Continue IVIg at the same dose and interval and reassess at 24 weeks – the trial has not yet been long enough

B. Increase the dose or shorten the interval before concluding non-response

C. Call this an objective non-response, stop IVIg, and return to the diagnostic workup – imaging, CSF, nodal and paranodal antibodies

D. Accept the patient's subjective report as a treatment response, consider CIDP confirmed, and continue indefinitely

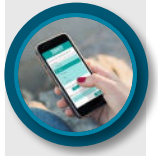
E. Refer to a neuromuscular center



FACULTY DISCUSSION

What if?



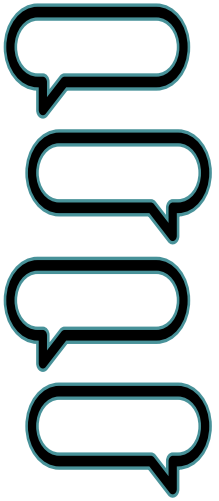






What if this same patient had a prominent postural tremor of the hands and the weakness had been distal-predominant rather than both distal and proximal?

How would that change your workup, and what would a positive vs a negative nodal or paranodal antibody result obligate you to do?



Patient Case 2: What Would You Do?

Audience, Community Clinician, KOL, AI, and Faculty Responses to Two Patients





PATIENT CASE 2: History

Diane W. – 45-year-old high school teacher

- 45-year-old high school teacher with CIDP diagnosed 18 months ago presents for routine maintenance follow-up
- Has been on IVIg since diagnosis; describes herself as "better than I was, but stuck"
- Walks without an aid but cannot run, drops small objects, unsteady in the dark or on uneven ground
- Able to keep working full time but raises the treatment schedule unprompted
- Infusion days consume most of a working day; she travels 90 minutes each way to the infusion center
- Has a predictable headache after infusions
- Uses PTO for infusions (running short)
- Asks whether there is anything that would not require organizing her life around infusion days

PTO – paid time off.



PATIENT CASE 2: Neurologic Examination

Diane W.

- MRC strength: ankle dorsiflexion 4+/5, finger abduction 4+/5; proximal strength full
- Sensation: reduced vibration and proprioception in the feet
- Gait: sensory ataxia evident on tandem gait; no aid required
- Reflexes: absent at the ankles
- No tremor; no cranial nerve involvement



PATIENT CASE 2: Objective Baseline Measures

Diane W.

- aINCAT disability score: 2 – unchanged across the past 12 months
- I-RODS: 58th centile
- Grip strength: 22 kg right, 24 kg left



PATIENT CASE 2: Current Regimen

Diane W.

- IVIg 1 g/kg every 3 weeks, administered at an infusion center
- Premedication for post-infusion headache
- No corticosteroid, no immunosuppressant



AUDIENCE POLLING: Case 2

What is your most appropriate NEXT step?

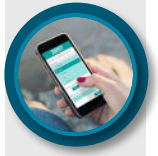
A. Re-confirm the diagnosis and reassess for a mimic or a variant phenotype
B. Verify that dose and interval are adequate before changing anything
C. Order nodal and paranodal antibody testing
D. Reduce or stop IVIg and monitor for clinical change
E. Maintain the current regimen because the patient is stable
F. Transition to a different maintenance therapy with a defined monitoring plan
G. Refer to or co-manage with a specialized center
H. I don’t know



KOL: Karissa Gable, MD

Patient Case 2 (Diane W.)









E **Maintain IG (but switch from IVIg to subcutaneous Ig [SCIg])**

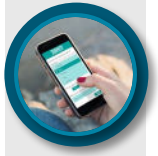
- Because **there is a response** to immunoglobulin, **stay with immunoglobulin**
  - Offer a **weekly or monthly subcutaneous Ig** therapy (SCIg or facilitated SCIg) to:
    - Reduce burden of treatment
    - Minimize side effects
- **Implement shared decision-making** with the patient to determine best regimen



KOL: Ariel Marks, MD

Patient Case 2 (Diane W.)









A Re-confirm the diagnosis and reassess for a mimic or a variant phenotype

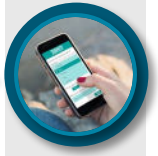
- **Prioritize re-confirming the diagnosis**
  - Repeat nerve conduction study
- **Avoid secondary axonal loss**
  - Patients may not respond to IVIg therapy or other immunomodulatory therapies because they were diagnosed late or have aggressive disease that has injured the axons
  - Once axons are injured, difficult to recover function



Practicing Neurologist: 5 Years in Practice

Avatar Delivering Verbatim Clinician Response









E **Maintain IG (but switch from IVIg to subcutaneous Ig [SCIg])**

- Patient is clinically stable and able to work
  - But…treatment poses major barriers to her lifestyle
- Suggest switching from IVIg to SCIg
  - Less likely to cause side effects
  - Could be administered at home
  - Possible to increase dose of IG, which may be beneficial
- Would not transition now to efgartigimod because patient is not considered *completely* stable given her INCAT score

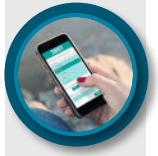
WC-157 Healthcare Provider Survey. CME Outfitters. September 2026.



Community Neurologist: 30 Years in Practice

Avatar Delivering Verbatim Clinician Response









B Verify that dose & interval are adequate before changing anything

- Don’t change anything – but verify current dose, interval, and whether the patient is actually receiving what is written in the chart
- Shared decision-making comes next
  - Discuss relevant social drivers of health (e.g., work, transportation, neighborhood)

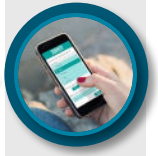
WC-157 Healthcare Provider Survey. CME Outfitters. September 2026.



Rural Neurologist: 45 Years in Practice

Avatar Delivering Verbatim Clinician Response









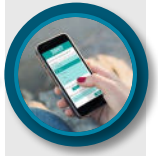
C Order nodal and paranodal antibody testing

- Diane has been on infusions for a long stretch: confirm we are not treating the wrong disease
- Autoimmune nodopathy does not behave like CIDP or respond to Ig the way CIDP does
  - If not previously done, I would order these tests before proceeding with anything else
- Other question: does she still need infusions at all?
  - Pull back therapy and “see what happens”



Additional Community Neurologist Responses for Case 2









RESPONDENT 1	E Maintain Ig, but switch to SCIg
RESPONDENT 2	E Maintain Ig, but switch to SCIg
RESPONDENT 3	F Transition to new Tx (FcRn)
RESPONDENT 4	E Maintain Ig, but switch to SCIg

WC-157 Healthcare Provider Survey. CME Outfitters. September 2026.

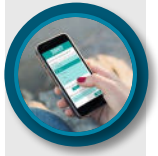


AI: ChatGPT 5.6 Response

Patient Case 2: Avatar delivers ChatGPT response











D **Reduce or stop IVIg and monitor for clinical change**

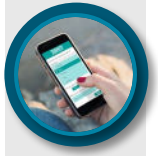
- Diane is stable, but stability does not necessarily indicate whether her disease is still active or if she remains treatment-dependent
- IVIg has been administered for 18 months; aINCAT unchanged for a year
- EAN/PNS guideline recommends periodically testing the ongoing need for IVIg by:
  - Reducing the dose
  - Lengthening the treatment interval
  - Discontinuing treatment with objective monitoring
- ChatGPT would perform a structured de-escalation before committing to another long-term therapy



EXPERT FACULTY

Live Discussion









Decision Point

Patient Case: Diane W.

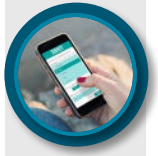
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Case Perspective Summary

Patient Case 2









	COMMUNITY/ RURAL	KOLs	AI
A. Reconfirm diagnosis and reassess for mimic or variant phenotype	—	1	—
B. Verify dose and interval are adequate before changing anything	1	1	—
C. Order nodal and paranodal antibody testing	1	—	—
D. Reduce or stop IVIg and monitor for clinical change	—	—	1
E. Maintain the current regimen because the patient is stable (but switch from IVIg to SCIg)	4	1	—
F. Transition to different maintenance therapy with a defined monitoring plan	1	—	—
G. Refer to or co-manage with a specialized center	—	—	—

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PATIENT CASE 2: Re-assessment

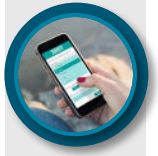
Diane W.

- Definite CIDP (2021 EAN/PNS)
- Nodal and paranodal antibody panel negative; SPEP with immunofixation negative; no alternative explanation
- Objective response to IVIg at initiation: aINCAT improved 4 to 2; I-RODS 31st to 58th centile
- Regimen already optimized at 1 g/kg q3w. Two prior attempts to extend the interval to q4w each produced objective worsening (aINCAT 2 to 3), with recovery on return to q3w
- Increasingly difficult peripheral venous access – typically 2 or more attempts per infusion
- 5- to 6-hour infusion days; consistent post-infusion headache requiring premedication; 90 minutes travel each way; 4 missed workdays per treatment cycle
- Patient's stated goal: keep working and stop organizing her life around infusion days
- Residual distal weakness and sensory ataxia unchanged over 12 months and attributed to axonal loss

q3w = every 3 weeks; q4w = every 4 weeks.











Faculty Case 2 Discussion

Dose and interval are confirmed adequate, the diagnosis is secure, the disease is active and IVIg-dependent, and the burden is the problem. What is your next step?

A. Continue IVIg unchanged and address the burden with logistics alone – home infusion, port placement

B. Transition to conventional or hyaluronidase-facilitated subcutaneous immunoglobulin

C. Transition to an approved FcRn antagonist with a defined overlap, monitoring schedule, and rescue plan

D. Add or substitute a corticosteroid regimen

E. Taper and discontinue IVIg to establish whether the patient still needs treatment



Angela Parris

CIDP Patient Advocate

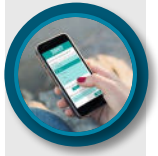
Active Volunteer,
GBS/CIDP Foundation



FACULTY DISCUSSION

What if?









What if this patient's nodal and paranodal antibodies had come back positive?

How would your treatment plan change?



CIDP in Focus

Conventional, New, and Emerging Treatments

Jeffrey Allen, MD
Chafic Karam, MD



CIDP Conventional Treatments

FIRST-LINE THERAPIES

INITIAL

- IVIg
- Plasma exchange (PLEX)
- Corticosteroids

MAINTENANCE

- IVIg
- Subcutaneous Ig (SCIg)
- Facilitated SCIg (fSCIg)
- Glucocorticoids

LIMITATIONS

GENERAL: Approximately 10%-15% of patients remain refractory to first-line therapies

SPECIFIC

- **Corticosteroids – side effects and safety concerns** *(e.g., immunosuppression, diabetes, osteoporosis)*
- **IVIg – wearing-off effects**
- **PLEX and IVIg – logistical and adherence challenges** *(i.e., due to travel to infusion centers)*

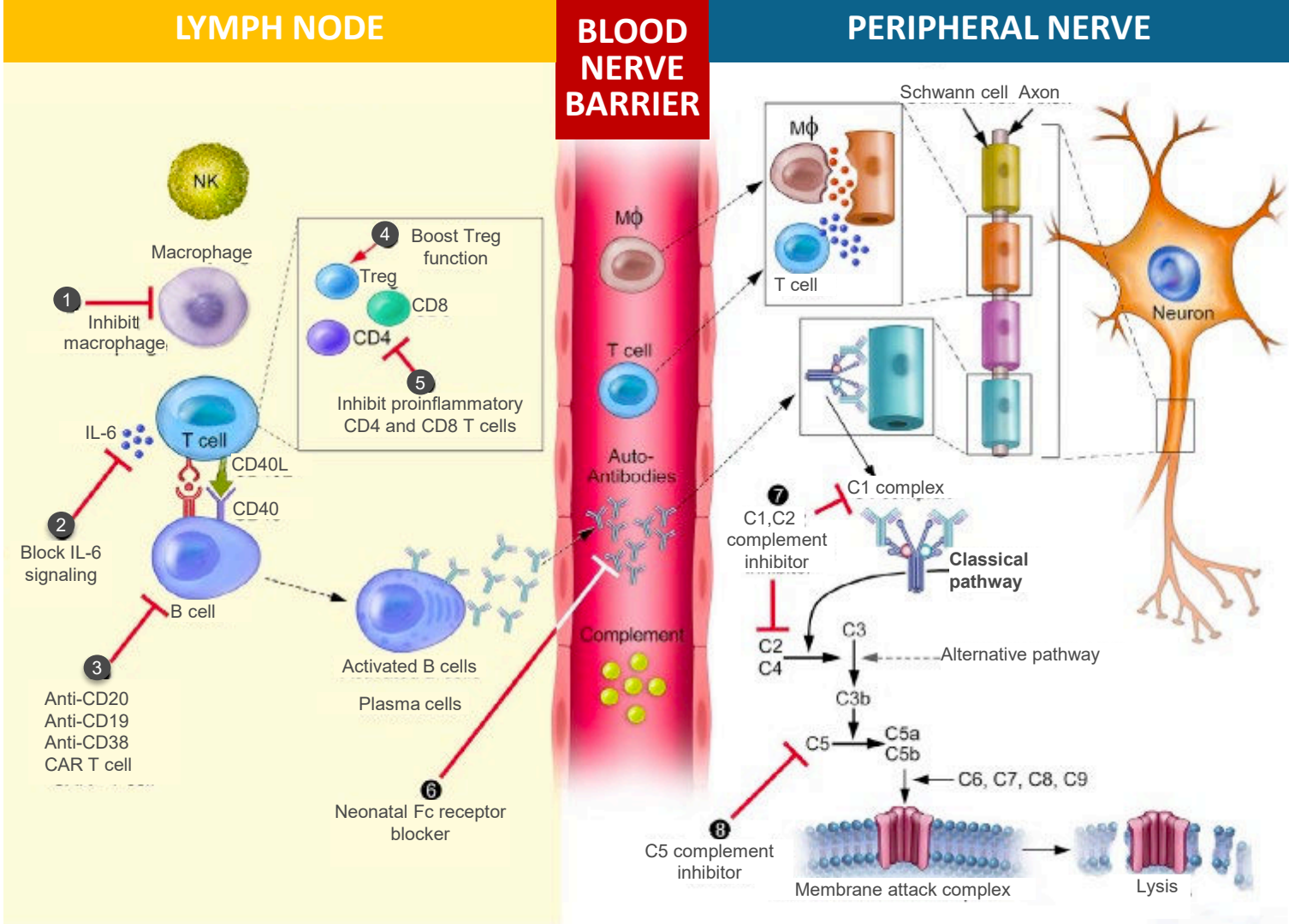
Trial Efficacy/Safety Highlights

- **SCIg – PATH** (phase 3, n = 172): relapse or withdrawal in 33% (0.4 g/kg/wk) and 39% (0.2 g/kg/wk) vs 63% on placebo over 24 weeks; adverse events were mostly mild local infusion-site reactions
- **fSCIg – ADVANCE-CIDP 1** (phase 3, n = 132): relapse in 9.7% vs 31.4% on placebo (absolute reduction 21.7 points; $p = .0045$)
- **ADVANCE-CIDP 3** (extension, n = 85, ~220 patient-years): annualized relapse rate 4.5%, no new safety signals

Doneddu PE, et al. *J Neurol Neurosurg Psychiatry*. 2019;90(2):125-132. Oaklander AL, et al. *Cochrane Database Syst Rev*. 2017;1(1):CD010369. Beydoun SR, et al. *Front Neurol*. 2021;12:638816. Querol L, et al. *J Neurol*. 2021;268(10):3706-3716. Van den Bergh PYK, et al. *J Peripher Nerv Syst*. 2021;26(3):242-268. van Schaik IN, et al. *Lancet Neurol*. 2018;17(1):35-46. Bril V, et al. *J Peripher Nerv Syst*. 2023;28(3):436-449. Hadden RDM, et al. *J Peripher Nerv Syst*. 2024;29(4):441-452.

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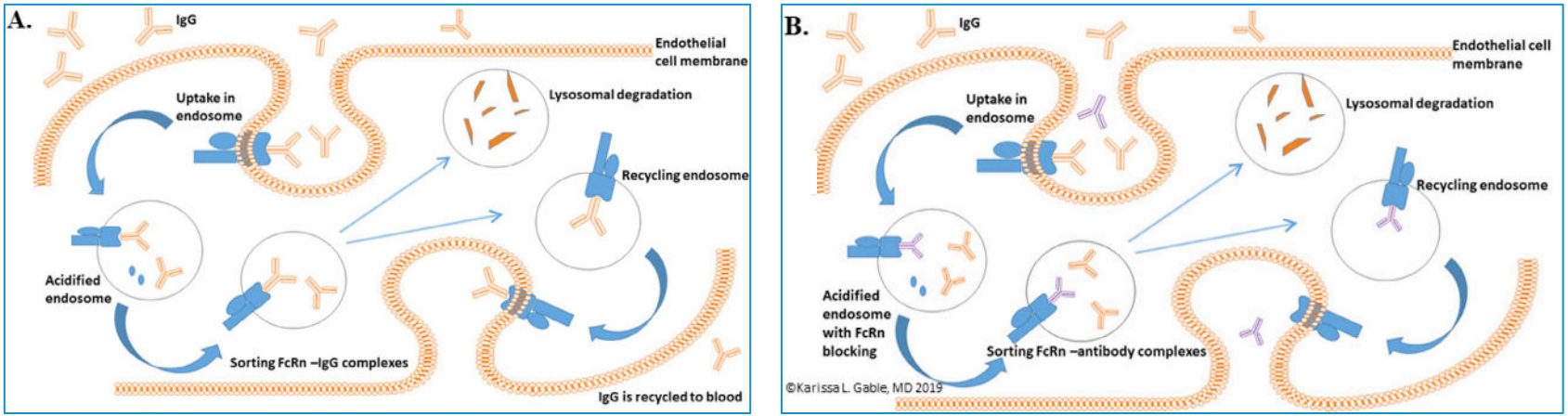
New and Emerging Targets in CIDP



CAR T cell = chimeric antigen receptor T cell.

Gable KL, Li Y. *Muscle Nerve*. 2025;72(2):201-211.

FcRn-Mediated Recycling of IgG



Binding to the FcRn receptor leaves unbound IgG in the endosome which undergoes lysosomal degradation and reduces circulating IgG levels

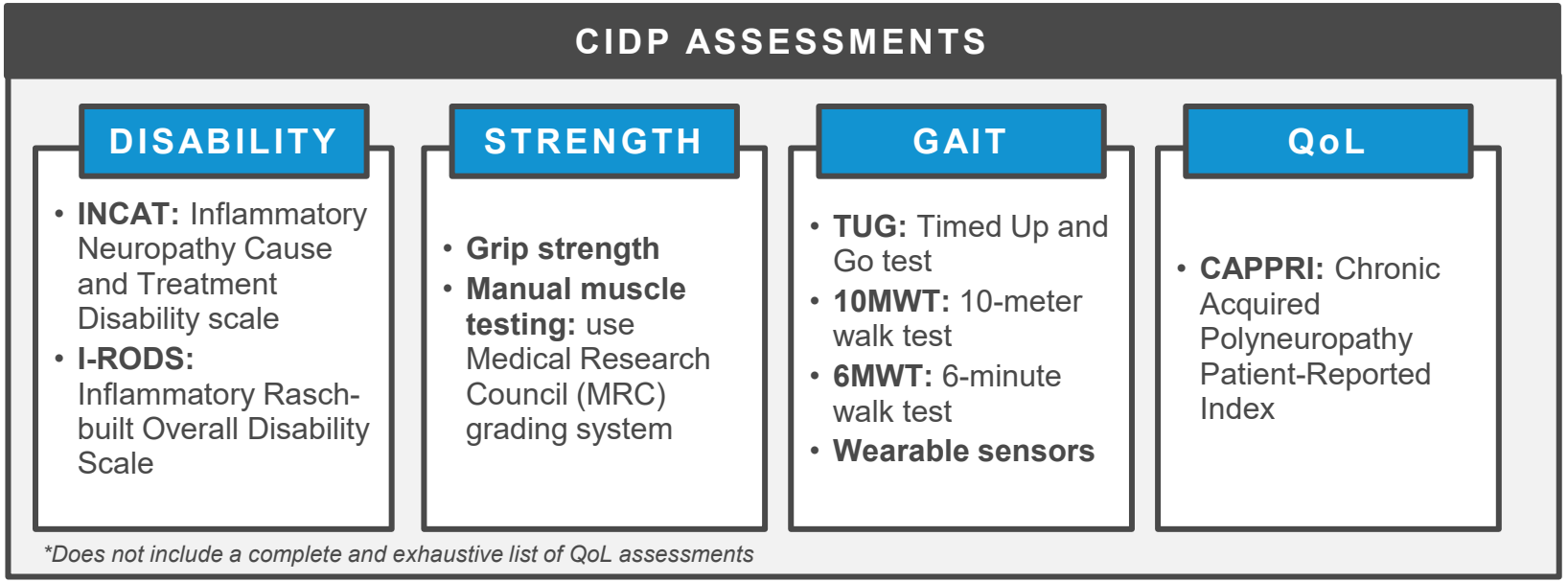
Trial Efficacy/Safety Highlights

- **ADHERE** (phase 2, randomized withdrawal; efgartigimod PH20 SC) Open-label stage (n=322): **66%** had confirmed clinical improvement
- Randomized stage (n=221): relapse in **27.9% vs 53.6%** on placebo (HR 0.39; 95% CI 0.25–0.61; P<.0001)
- AEs: **64% vs 56%**; serious adverse events **5% in each arm**. Most common: infections, injection-site reactions headache
- **ADHERE+** (long-term extension): no new safety signals with up to ~3.6 years of exposure

Gable KL, Li Y. *Muscle Nerve*. 2025;72(2):201-211. Allen JA, et al. *Lancet Neurol.* 2024;23(10):1013-1024. Allen JA, et al. *J Peripher Nerv Syst.* 2026;31(3):e70140.

Objective Assessments

Objective indicators may improve the effective and appropriate utilization of treatment



QoL = quality of life.

Allen JA, et al. *Neurology*. 2015;85(6):498-504. Allen JA, et al. *JAMA Neurol*. 2020;77(9):1159-1166. Gwathmey KG, et al. *Muscle Nerve*. 2016;54(1):9-17.

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AUDIENCE POLLING: Case 2 — Revisited

Now, what is your most appropriate NEXT step?

A. Re-confirm the diagnosis and reassess for a mimic or a variant phenotype

B. Verify that dose and interval are adequate before changing anything

C. Order nodal and paranodal antibody testing

D. Reduce or stop IVIg and monitor for clinical change

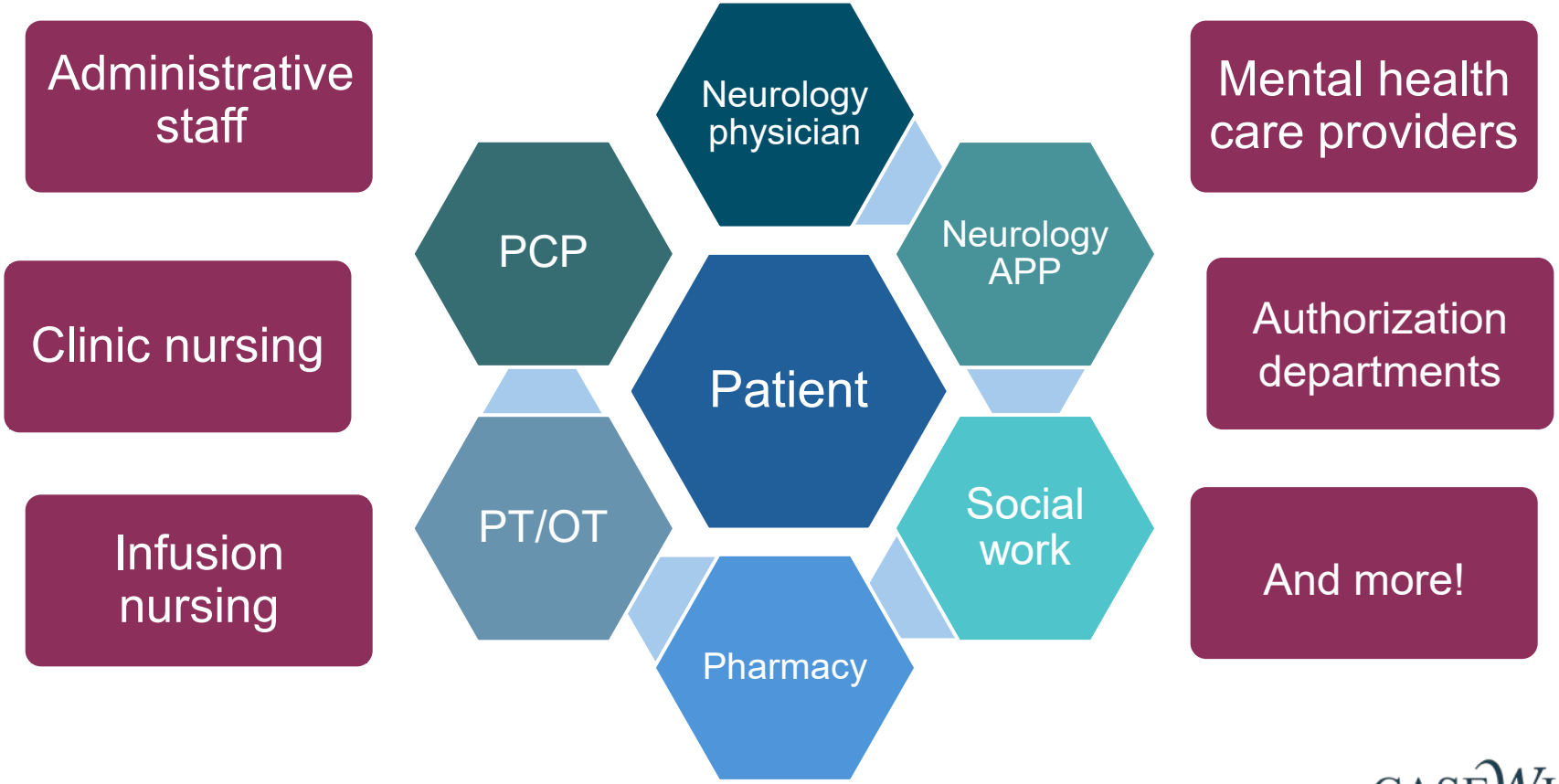
E. Maintain the current regimen because the patient is stable

F. Transition to a different maintenance therapy with a defined monitoring plan

G. Refer to or co-manage with a specialized center

H. I don’t know

Team-Based Approach for CIDP



Gogia B, et al. Chronic inflammatory demyelinating polyradiculoneuropathy. In: *StatPearls [Internet]*. 2024. https://www.ncbi.nlm.nih.gov/sites/books/NBK563249/. Howard I, et al. *Curr Treat Options Neurol.* 2019;21(8):35.

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QUESTIONS & ANSWERS



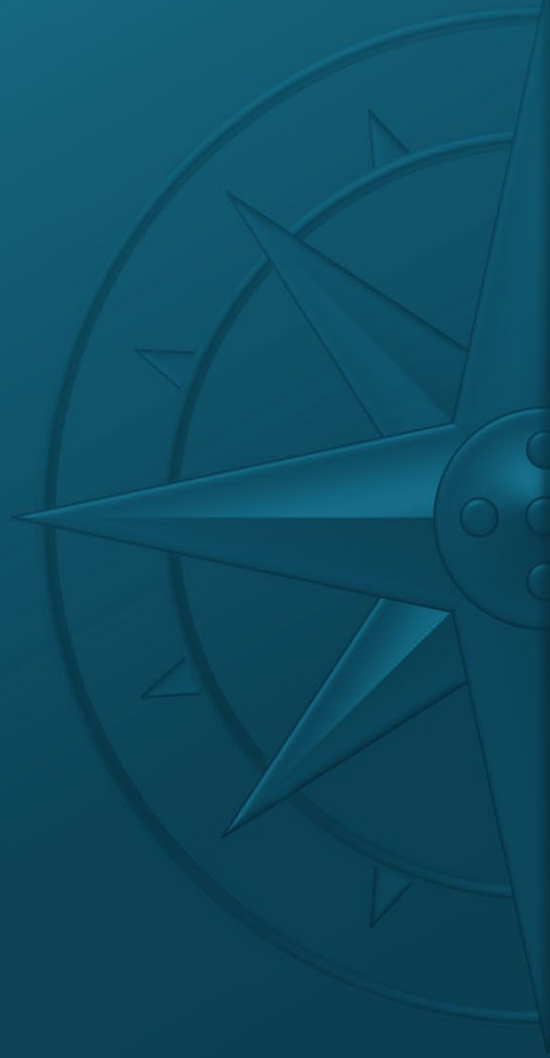
Put information into action!

Takeaways from this program can be implemented into your practice to improve patient care.

- Apply the 2021 EAN/PNS criteria to classify a patient as CIDP versus possible CIDP based on the number of nerves and criteria met, and select the supportive testing needed to raise diagnostic certainty
- Verify adequacy of IVIg dose and interval, and distinguish residual deficit attributable to axonal loss from ongoing demyelinating activity, before modifying or escalating therapy in a patient established as having CIDP
- Elicit patient-stated functional goals and incorporate treatment burden (e.g., venous access, infusion time, travel, missed work) into regimen decisions

Additional Resources

Visit www.cmeoutfitters.com for clinical information and certified educational activities



CME OUTFITTERS

Visit the Rare Diseases Hub

Free resources and education to educate health care professionals and patients

https://www.cmeoutfitters.com/practice/rare-diseases/

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3. Enter your **ABIM ID number** and **DOB** (MM/DD) on the evaluation, so credit can be submitted to ABIM

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- In approximately 3 months, complete the follow-up survey from CME Outfitters

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CMEO will send you confirmation of your participation to submit to CMS attesting to your completion of a CME for MIPS Improvement Activity.

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CIDP in Focus



Advancing Precision Across the Patient Journey from Early Recognition to Downstream Management

Supported through an independent educational grant from argenx.