FIRST LINE THERAPY IN CIDP: A CASE FOR STEROIDS

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Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) is a chronic progressive or relapsing neuropathy leading in at least 50% of the patients to temporary severe disability in the course of the disease while approximately 10% of them eventually become persistently disabled or die because of the illness. Even if the cause of the disease remains largely unknown, there is a general consensus that CIDP is an autoimmune disease. A few randomized controlled trials (RCT) have shown a comparable efficacy of steroids [1], plasma exchange (PE) [2] and high dose intravenous immunoglobulin (IVIg) [3] as initial treatment in CIDP with approximately two third of the patients improving after each of these treatments. It is however common experience that the majority of these patients need to be treated for several years if not indefinitely so that when starting one of these therapies in a patient with CIDP not only their short-term but also their long-term efficacy and side effects should be considered. Unfortunately with the only exceptions of a recently published RCT showing that IVIg may retain its safety and efficacy up to 48 weeks, there are no other data from RCT supporting the long-term efficacy of these therapies in CIDP or providing information on which of them has the best cost benefit-ratio so that it remain unclear which of these treatments should be first considered in the initial treatment of CIDP. In the recently published EFNS/PNS guidelines on the management of CIDP [4], the authors concluded that in the absence of contraindications to individual drugs or specific clinical presentation such as motor CIDP, that may worsen under steroid, either steroid or IVIg should be equally considered for the initial therapy of CIDP, whereas PE was considered a valuable option for unresponsive patients. These conclusions were based not so much on differences in their efficacy in CIDP but on their suitability and tolerability for long-term use. The authors considered indeed PE a less desirable option considering its relatively short effect usually lasting only a few weeks therefore requiring periodic exchanges to maintain the improvement as well as the not so uncommon occurrence of adverse events including severe hypotension, electrolytic unbalance, thrombophlebitis as well as difficulty with venous access which often become a major problem in the chronically treated patients. Even if the efficacy of steroids in CIDP has been so far demonstrated in a single, randomized placebo-controlled study on 35 patients, the evidence of their efficacy in CIDP is sustained by several uncontrolled or retrospective studies on larger series of patients showing that this therapy is effective in 60-70% of patients either when given orally or at high-dose intravenously. The disadvantage of this therapy is that, similarly to all other therapies for CIDP, in most responsive patients it has to be continued for several years with the consequent risks associated with its protracted use, including osteoporosis and consequent risk of bone fractures, cataract, diabetes, peptic ulcer, hypertension, mood disorders, gain of weight and hirsutism. On the other hand steroids are an inexpensive therapy that can be easily taken orally at home making the patient less dependent on the repeated hospitalization which is required by PE o IVIg. IVIg are also effective in over 60% of patients treated in small uncontrolled series and its efficacy has been confirmed in four RCT. Two additional RCT comparing IVIg with PE or with oral prednisolone, have shown an identical effect of IVIg, steroids and PE as initial, short-term treatment for CIDP. As in the case of PE, the effects of IVIg usually last only a few weeks so that most patients require periodic infusions to maintain improvement, even if this transient effect, almost invariably observed in patients with chronic relapsing forms, is not constant in those with chronic progressive disease, some of whom may have a durable response. IVIg are often preferred to steroids because of their rapid effect which often becomes manifest within one week, infrequent contraindications (IgA deficiency, renal failure, congestive heart failure or a recent history or increased risk of thromboembolism), and relatively minor side effects associated even with their prolonged use. Their disadvantage mainly consists however in their considerably higher cost (approximately 3,000 and 6,000 € per month at the usual dose of 1-2g/kg/month) making them unaffordable for the non-wealthy patients or countries, and by the fact that in most countries it requires repeated accesses to the Hospital for their infusions further increasing not only the cost of this therapy but also the time the patients have to dedicate to the treatment of their disease. In conclusion the more frequent and severe adverse events associated with steroids than with IVIg may be balanced by their easier oral assumption and inexpensiveness compared to IVIg and by the fact that the patient is less dependent on the repeated hospitalization which are required by chronic PE or IVIg therapy [5]. Whether however this balance holds true especially for the long-term treatment of this disease remains a matter of personal opinion at least until this will be properly analyzed in a RCT comparing the long term efficacy and safety of these two treatments in CIDP, like the one is currently in progress in Italy. Until then the pro and cons of each of these treatments should be clearly presented to the patients who, in the absence of medical contraindications or financial restraints, should be involved in the final therapeutical decision.

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