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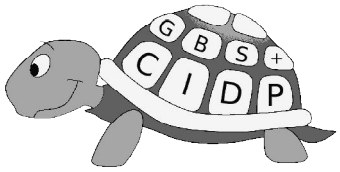

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INFORMATION

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NEWSLETTER OF THE IN GROUP: THE INFLAMMATORY NEUROPATHY SUPPORT GROUP OF VICTORIA INC. Supporting sufferers from acute Guillain-Barre Syndrome(GBS) & Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)

NEXT MEETING
SUNDAY, 15th May, 2016 AT 2.00PM
Balwyn Library Meeting Room, Whitehorse Road, Balwyn
Guest Speaker: Dr. Valerie Tay, Neurologist, St. Vincent's Hospital Melbourne
A small plate to share would be appreciated. Thank you.

Dates to Remember !!!**PLEASE NOTE THE FOLLOWING INFORMATION!!!**

Due to renovations, the following two meetings will be at Ashburton Library, 154 High St., Ashburton.

Sunday, 14th August 2.00pm Sunday, 20th November 12.00 noon

Notes from the February Meeting.

President: Margaret Lawrence. Welcome everybody. Thank you all for coming and a special welcome to Dr. Les Roberts who is going to speak to us this afternoon and also to his Research Co-ordinator, Kate McHutcheon. Thank you very much for joining us and a warm welcome from us all.

Apologies: John Burke, Dorothy Brennan and also Len and Barbara Waters who both have whooping cough.

Treasurer's Report: Doug Lawrence. This is a brief **financial report up to the end of December**. **Subs. $1,050**. **Donations to date of $3,725** which as I say every meeting is indicative of the support we are getting from our **members** with their **generous donations**. I have received a **grant from CSL of $200** to cover the cost of our **Website. We thank CSL for again supporting us** with that. **Bank Interest of $257**. We made **$906** at our **Luncheon and Dutch Auction** just **before Christmas**, which was not only **a lot of fun** but a **great result. Mid-year function of $116** and then some sundry book and cook book sales giving us a total of **$6,300 in the six months** in the way of income.

Against that was our **$10,000 donation** which we gave through **Assoc. Prof. Andrew Kornberg to the Children's Hospital.** Once again we have managed to do a tremendous effort for which **Andrew has given his thanks and our name appeared in their booklet**.

Expenses **newsletters $517**, **postage $70, miscellaneous $18** Currently **$6,917 in the bank** and on our way to **achieving our aim again this year by the end of November/December**.

Again a big thanks to all our members who have supplied funds in the form of **donations** and **attending** the few **functions** we have.

I would like to mention for the record there are is a number of members who are yet to pay their subscriptions for this current year because our year ends on the 30th of June, so those who haven't paid, we would appreciate if they were able to bring their subscriptions up to date.

Margaret: I have the **booklet from the Children's Hospital with our name in it** and I have marked where our name appears and **you can read the emails**. There is **a nice one from Andrew and the official thank you from the Children's Hospital.**

CSL. Dr. Christopher Fry who we now speak to regarding our website etc., will attend our May meeting. Following on from that, **CSL are having their 150 Anniversary** and **I received an invitation** to their **Gala Celebration**. I am going mainly because I think it is fantastic that they are recognising our group and that is why I was invited. I felt it was **important** that **The IN Group is represented.**

Talk by Dr Les Roberts, Neurologist, St. Vincent's Hospital, Melbourne.

Thank you very much for your welcome and also on behalf of Kate. It is good to have Kate here this afternoon. **If any of you have questions I can't answer, ask Kate** and she will probably know the answers and **she also knows all about neurology research trials if anybody is interested**.

I looked through the notes from when Tim Day gave a talk to you and I summarized it.

> **CIDP is known to respond to cortisone or steroids.**
> **It's response to IVIg is possibly faster**. (I am going to use the term IVIg today rather than 'Intragam', etc. because it is all in the process of change at the present time.)
>
> **Response to steroids is possibly longer lasting than it is to IVIg.**
>
> **After 6 months of treatment there may be remissions that last a variable time. Around 20-30% of people go into remission from their CIDP down the track and there is possibly, debatable, but possibly, more remissions with those on steroids.**

I thought today we would focus on some of the research we have been involved in at St.Vincent's in CIDP and Guillain-Barre` Syndrome.

The **PATH Study**, which is a **CSL Study**, (they are very active in the field of CIDP), the PATH comes from **P**olyneuropathy **A**nd **T**reatment with '**H**izentra', 'Hizentra' being the **trade name of the gamma globulin** that is used. This **is a study of the subcutaneous use** of the IG (pro 20) or 'Hizentra'. **It is now close to completing recruitment**. It has gone for 3 years now and they **now have sufficient in the trial to proceed** with it.

The aim of this trial was to use **subcutaneous infusions rather than intravenous infusions** of the **gamma globulin**. I think from our experience **it seems to be reasonably successful but our experience is very small**, so we will **wait and see what the results of that trial** are.

There is **an extension trial with that, so patients who responded well have been able to be provided with ongoing treatment for about 3 years.**

Another trial which is still going but probably **not for that much longer**, for **CIDP,** is the **Novartis Trial** using a drug called **Fingolimod**. (More about the active trials in a moment.) It comes from the term Fingolimod - oral for CIDP. The use of Fingolimod is a **treatment used for MS**.

It is **also associated with an extension trial for those who actually get the active drug and who respond well to it. It is still open to recruitment, so if any of you are interested in being involved in the trial it is still possible to be enrolled in that, if the inclusion criteria are fulfilled.**

We **at St.Vincent's**, along **with CSL** in Melbourne, have initiated **a study** called the **Biomarker Study**. This too **is open to recruitment**. This is a fairly straight forward Study. It is a bit time consuming, but not too bad. Basically, **we are looking for biomarkers or things which can indicate whether or not people respond or are going to respond to IVIg** or not and to perhaps **try and break up CIDP into different subgroups**, perhaps that might respond, or perhaps that might not. So as a search for that, we are **doing lots and lots of tests** although **from the participants' perspective there are not that many tests**.

It is not a trial to test the treatment. Patients continue on treatment. They must be on IVIg for this to work. It doesn't matter which brand of IVIg, but they must be on IVIg and have responded to that to be involved in this trial. Alternatively, patients who are just presenting and are about to start IVIg are also included in the trial.

Another project which is **in development** at the moment is **on Guillain-Barre` Syndrome in relation to diagnosis**. The **different sub-types** of this that we will look at briefly in a moment or two and **we are planning more detailed testing** than usually is the case **to try and reduce the number of tests in the longer term that patients need to have for this.**

So the **Fingolimod Trial** which **is still active, is** what we call **a Double Blind Trial**, which means the **patient doesn't know what they are getting**; the **staff who are assessing them don't know what they are getting**; somewhere **in the Cloud somebody knows** what they are getting, but not any of us. It is a **multi-centre**, so it is **a worldwide trial**. **It is placebo controlled** so there is a **possibility that subjects in this trial will have the placebo**, but there are **ways of treating them quickly if things start to go wrong**.

The trial's aim is to evaluate Fingolimod for its efficacy, its safety and compare it with Placebo. This is the **trade name 'Gilenya' or Fingolimod**. It is already available and has been for several years in Australia for treatment of MS. It is **readily used as capsules** and **much easier than IVIg**. You just pop a pill.

The **reasons for testing Fingolimod are that it works well in MS so there are a lot of similarities between MS and CIDP.** As you know **they are very different** because one, **CIDP, affects the peripheral nerves and the peripheral myelin. MS affects the central nervous system. There are a few patients who actually get both,** so they have MS and they have peripheral nerve disease. We have a couple of those patients at St. Vincent's, so it is **pretty uncommon but it does occur**. **There are similarities between the two.**

Fingolimod is relatively safe. It **does slow the pulse. When patients have it for the first time they are monitored, we just watch to make sure it is okay**. It **lowers the lymphocyte count**, so they **require blood tests to check that this is okay**.

I might say that when patients are in the trial for Fingolimod those of us involved in their treatment don't know what the results of the ECG's are when they are monitored for their pulse. We don't know what their lymphocyte counts are unless they get to dangerous levels that something needs to be done about it. A small number get macula oedema, that is inflammation or swelling in the back of the eye that is part of the central vision, so that does require treatment and withdrawal of the drug.

There is **an experimental allergic neuritis which mimics CIDP and mimics GBS and Fingolimod seems to work in animals that have these conditions.**

The primary objective in this trial is to compare it with Placebo to **find out whether Fingolimod actually works. It is measured by the measure of disability progression**. That is done in a number of ways. There are **several questionnaires**. One assessment is the **INCAT** which is the **Inflammatory Neuropathy Cause and Treatment disability scale** that basically asks you about whether there is any **worsening of the use of the hands or the arms or legs or gait** and so on, **very straight forward sort of measurements** that are done and **we confirm worsening by this scale.**

Other objectives of this trial are to assess the safety and tolerability of the Fingolimod so we are **measuring very carefully any adverse events** that are involved in that. As we said, **we don't know what happens with blood test results other than those that are important for us to assess**, but we are **not given anything that would tell us what the patient is actually getting**.

Also measured is grip strength. It is a little device that basically you **just hold in your hand and squeeze**. It's a very simple procedure to do and **it comes up with a number.** Then the fancy test called **The R-ODS Disability Scale** and again it is a very **straight forward questionnaire type**

testing that is done. So the tests for assessment and ongoing assessment in this trial are fairly straight forward.

What is **Fingolimod? Fingolimod** is used in the treatment of MS. It actually comes from fungi. It is not your average mushroom, but from fungi. It is a metabolite of them. **It actually modulates Sphingosine 1-Phosphate**. It **modulates** that. **It stops lymphocytes basically from getting out of the lymph glands.**

We have lymph glands throughout the body and **the lymphocytes originate in those, then spread through the body. Fingolimod stops them from getting out so they can't actually get to the nerves and damage the nerves by those lymphocytes. It reduces the number of circulating lymphocytes.**

Here is a little picture which is a simple diagrammatic representation of a lymphocyte and these **sphingosine 1-phosphate (S1P) activate the T cell or lymphocyte so that it can actually get out of the lymph gland. That is the normal state of affairs up the top and this picture is where it gets stuck in the lymph gland and can't get out so it can't do any damage to the nerves. (**You can always tell if a patient is taking their medication because of their white cell count.)

The inclusion Criteria for this trial is:-
There must be **a written form of consent** before anything is done so a **description is given of the type of procedures that are done and what it involves**.
A person must fulfil the EFNS criteria for diagnosis of CIDP.

Any of you heard of the EFNS criteria? NO.
The **European Federation of Neurological Societies** is where the name came from and a **group of people got together and worked out the Criteria that you use for making a diagnosis of CIDP.** They are **very complex criteria** and there are, I think, **14 different types of criteria** that are **used for diagnosis of CIDP**, but this is the **one that is now used most commonly in research trials.**

What it does, it looks **very carefully at the clinical picture of the patient**, so **the way the patient presents with their symptoms**. It looks at **the nerve conduction study results** and there are **certain criteria for slowing the conduction of the nerves**, the **blocking of nerve responses** and so there are pretty **complex criteria** that Kate and I are supposed to know. **When we do nerve conduction studies on a patient we can work out whether or not that patient fulfils those criteria to make the diagnosis of CIDP.**

Patients must either fulfil those criteria at the present time or they must have fulfilled them previously when they have had nerve conduction studies, in the setting of a presentation of symptoms which fits with CIDP.

The **patients must have either typical CIDP or pure motor CIDP** or some unusual variants. The **INCAT scores**, **questionnaires and so on are done.** The **other Criteria are that they must be receiving either IVIg or steroids and their condition is stable. There has to be some evidence that they are actually responding to medication and haven't just got better anyway**. **Some things that are excluded are different types of neuropathy** that can **look a bit like CIDP.** You have probably all heard of Lyme Disease. There is a lot of debate at the moment whether **Lyme Disease** exists in Australia or not but it certainly does in the United States, Southern America and in Europe and many other places in the world. **Lyme disease is excluded and some other conditions**.

The Exclusion Criteria, things that **keep people out** are summarized here. These are additional things that keep people out of the trial.
Plasma exchange, immunosuppressive drugs, some **particular types** that are used like '**Rituximab'** and so on. These are some of the **things that may influence the effects of the medication and the ability of it to work** and on the **rare circumstance where patients have had stem cell transfer. Histories of malignancies, poorly controlled diabetes, drug addictions** and so on and **other neurological psychiatric disease**.

Summarising, those who can't be in the trial are those who don't have typical CIDP, other causes of neuropathy, severe diabetes, recent treatment with a number of other drugs, malignancies or things that would interfere with their involvement with the trial.

This is a diagrammatic representation of the trial. This is a screening period here. **After 14 days where patients undergo appropriate tests and reassessment of their test results** and so on and **to see if they can be involved in the trial. Then somebody draws out of a hat**, (perhaps a little more technically than that), **whether they will get the fingolimod or placebo**. **It is packaged in such a way that no-one can tell the difference between the two**. They then go **into the trial**. There is a **follow-up three months after that**.

This trial is associated with an extension trial as well. **If a person actually gets Fingolimod, does well with Fingolimod, then the drug company will keep it going for 3 years after the trial.**

Summary of Fingolimod Trial - for any of you who are interested in it.

Screening drug for 45 days, then **randomisation and the double blind**. No-one knows what they are getting.

Stop the IVIg and steroids and **start Fingolimod or placebo,** then **multiple assessments** which are not too demanding in this trial.

Carry out **checks to see that everything is going along safely and nicely**. If there is **a good response, go on to the Extension Trial.**

The **Biomarker Study** that we are doing at **St. Vincent's** is to **determine if we can detect any biomarkers that will predict the response or lack of response to IVIg.** I think you are all aware **IVIG is very, very expensive**. **That is why at the moment we can't keep up with supplies in Australia and others are being imported and changed over at the present time.**
We are in the process at the present time of changing over to 'Privigen' and 'Flebgamma' which are the trade names of the two which are being used at the moment. I think they were the cheapest ones available that is why we are using those.

The idea of this is that **if you are going to treat someone with something that it not going to work it would be really nice to do a blood test or something that will tell you that before you subjected them to treating them for 3 month or so. That is the aim of the project.**

This is a complex diagram and I don't want you to try and understand it because I don't understand it but I put this up because **all of these things that you see on there are what are being tested in the biomarker study. C.S.L has biochemists, endocrinologists, immunologists and people working on this who are actually testing for all these sorts of things.** We do our routine screening blood tests and so on, but **they are testing inflammatory responses**.

As new things come along, we are looking at adding some of those new things, **e.g. recently there is a paper on line that looked at an antibody called Neurofascin 155 antibody** and that antibody seems to be **associated with patients having resistant disease that doesn't respond to IVIg**. We have been able to **add that** to the list of things we are going **to do in the biomarker study**. They will all be **done as a group at the end of the study** so we will hopefully be **able to contribute something more to the meaningful literature** on that.

The inclusion criteria for the biomarker study, is fairly straight forward. **Patients have to have CIDP that fulfils the criteria** we mentioned before **and must be being treated with IVIg.** The other practical consideration is that **patients need to be coming to St.Vincent's or St.Vincent's Private because we need to be able to get to them to take blood tests regularly.**

The study involves **having a blood test immediately prior to the infusion of IVIg; immediately after the infusion of IVIg;** then **one week later.** It also involves **nerve conduction studies** to make sure the necessary criteria are fulfilled and **questionnaires** are involved as well.

This is probably arguably **one of the easiest clinical trials** you can get into because **it involves just blood tests and some questionnaires. It doesn't involve changing the treatment other than arranging to have some of the IVIg sent to the centre involved in the study.**

The **study is for 3 months** and you must be **on treatment with IVIg** and the **blood tests** as we said. If **the patient has a new diagnosis of CIDP and if their neurologist is planning on doing a lumbar puncture and take some spinal fluid, we ask if we can have just a little bit of spinal fluid as well. The procedure is not done as part of the trial** but if it is being done for the patient's assessment, then we ask that we have a little bit of the fluid.
The study **requires nerve conduction studies and those called CSP's**. CSP's are a test we use for **small nerve fibres**. In our body we have what are called **large nerve fibres** which are the **common** ones we all know are **affected in CIDP**. We have the **autonomic nervous system**, which are **usually unmyelinated fibres**, so **no myelin sheath is around them** and they are **not affected to a great extent in CIDP.** We also have **some nerve fibres which have a thin layer of myelin around them. No-one has ever looked at this before to find out whether those nerves are being affected, so as part of this trial we are just adding one extra test when patients have nerve conduction studies which tells us about these particular nerves. So far it looks encouraging as it looks like those might be being affected.**

Question: Is this separate to the study you were talking about before?
Answer: No. **This is part of the biomarker study**.

Question: So **you have to meet the criteria for the biomarker study.**
Answer: Yes, that's right. With this one there is no direct benefit for the participants, although we may be able to tell them what different nerves may or may not be affected, I guess, but that's no real benefit. **If it is informative, then it is going to help other people in the future and that is the purpose of it, to try and find out things that would indicate you don't need IVIg because it is not going to work, or it is going to work for you. That's the ideal results that we hope for.** There are **many people worldwide looking for these sorts of things** so we shall see.

There are many tests being performed, but in fact **this involves three blood tests for the patient each time they have their infusion with IVIg over 3 months.**

This study is in development at the moment **The Guillain-Barre` Syndrome Study**. This is a complicated slide but it is meant to be complicated so I can explain what it means to you.
We **lump Guillain-Barre` Syndrome as Guillain-Barre` Syndrome but it is actually made up of a number of different conditions** and the **common one in Australia is AIDP** which is **Acute Inflammatory Demyelinating Polyneuropathy.** It is very **similar to CIDP except that it is acute**. **CIDP** is defined as having an onset to it but it has to be **progressing over at least 2 months,** whereas in **GBS it is less than 2 months. Usually 90% have progressed by 30 days, 1 month.** There are a few that go on a bit longer than that, but then **it stabilises and hopefully gets better**. Certainly **if it continues to get worse then we classify it as CIDP.**

AMAN Syndrome is **common** in some Asian countries like **China and Japan** but it is probably **much more common here than we realise**. This is where the **nerve axon is affected rather than the myelin sheath.** The actual findings on our electrical tests of nerve and muscle are **different from what we see in AIDP,** but it often **takes 3 weeks before you can actually pick the difference. You need a study at the beginning of it and at the end of it.** These **patients were originally said not to respond well to any treatment**. I'm not sure that is continuing to be the case, as **we recognise the condition a bit** more often.

AMSAN is very similar but it **is an acute motor and sensory axonal neuropathy** so it involves both the **sensory and motor nerves, not just the motor nerves**. They **all present in a similar way, but they have different outcomes in the longer term**.

Miller Fisher Syndrome is seen to be a variant of Guillain-Barre` Syndrome. Any of you heard of the Miller Fisher Syndrome? Yes. **Miller Fisher Syndrome is associated with abnormalities of the eye movements (ophthalmoplegia), unsteadiness on gait and ataxia and a loss of reflexes,** but **without weakness**. **Some of these patients actually go on to get typical GBS**. Some people who come with an **AIDP variant get some eye movement abnormality**. There

is **a bit of a cross-over, but these are associated with a particular antibody that is different from any of the others. It takes time for it to develop so you can't always pick that.**

The **reason for our study is to try and distinguish between these** and again **the reason is similar to the biomarker study**. Some **patients may respond better than others to different treatments** and **if you can sort them out in the first instance**, then it is **possibly going to help in the longer term in terms of treatment.**

Many years ago, when I was just a little younger than I am now, we used to see a lot of people with what we called **Limb Girdle Muscular Dystrophy.** There were groups of people who we called the **Lumpers** and there were those we called the **Splitters**. The **Lumpers lumped all of these into one condition** which said that **Limb Girdle Muscular Dystrophy was one condition.** The **Splitters said, "On no, it is all different.** This **person has weakening of the shoulder-blade;** this one has **weakness of the biceps**, so there are **different patterns of involvement. It turns out that both groups were right,** in that **some people have the same pattern when you look at them, but biochemically they are very different. There are 20 or 30 different Limb Girdle Dystrophies that are now recognised biochemically.**

There is **a peripheral neuropathy called Charcot-Marie-Tooth disease** which is an **inherited neuropathy**. At the **last count that I am aware of there were 78 different genetic abnormalities underlining this condition.**

So the **Splitters are 100% right** but the **Lumpers were right because they all look very similar to each other.**

The question **with Guillain-Barre` is:- Should we lump or should we split? Nobody quite knows. I like to think the Splitters are going to be right** but we will find out, I guess, with time. **Our aim in the study is to try to be able to do investigations in the first week of the condition**, so the first week of presentation, to try and distinguish which one of these it is. **Miller Fisher is easy because the eyes go every which way and people get double vision**, but the **others can be very similar and very hard to pick in the early stages** and traditionally we do a **repeat study at 2 or 3 weeks after the first nerve conduction test**.

Our aim is **to try and do more sophisticated tests of nerve function, looking at what we call blink reflexes and other sorts of things, to try to distinguish between these different groups. These are the unanswered questions or some of the unanswered questions in relation to CIDP.**

There was a **paper** in a **Journal** called **"Muscle and Nerve"** last year which looked at this and also a **Journal article in "Neurology"** another neurology Journal. A group in one of those (**a neurology article)**, **where a tertiary referral hospital**, (a hospital where you get patients who have seen somebody else, their GP has sent them on to a neurologist, then the neurologist has sent them on to another group of people who specialise in the condition) **found that almost half of patients who had a diagnosis of CIDP did not actually have CIDP. So, one of the things we have to do is improve the accuracy of diagnosis.**

Question: If that's the case, what do you do?
Answer: You have to make sure your diagnosis is right.

Question: If you are in a situation where, for example you don't go to St. Vincent's where you work but you are at a different hospital, how in the world do you know of this work?
Answer: Okay. I guess neurologists the world over are looking at this so I am not the only one, looking at the diagnosis being wrong.

There are simple things that we do in our reports for example in our nerve conduction tests. Since the paper came out last year we have made a point of **saying "This patient fulfils the EFNS Criteria" or "This patient does not fulfil the Criteria."** We have **actually been going back through all the previous nerve conduction studies those patients** have had and if they have never fulfilled it we say, **"They have never fulfilled the Criteria. Please review the diagnosis."**

I think neurologists generally are aware of this and looking very carefully for it. Patients don't like it and **we certainly don't like our patients to be getting IVIg for example for 2 years when they don't actually have CIDP.** It is something **we are all very much aware** of.

I have to stress that **this is an American Study** so you **can't just relate that back to Australia**. You can't take it from one country and say it is the same in another country. You can't even **take it from Sydney and say it is the same in Melbourne**. We all are different. **We don't know what the incidences are here, but sometimes people have diabetic neuropathy. There were a couple in that reported trial who had inherited neuropathy. Some of these can be quite difficult to distinguish** and so you have to go back to the grass roots of what you are looking at and **see if the people do actually fulfil the Criteria. We definitely need to improve accuracy of diagnosis.**

We need **biomarkers of neuronal damage** like we have been talking about **to predict whether people will respond to certain treatments or not** and some of the neuropathies we look at with CIDP, but some of the related immune neuropathies, something wrong with the immune system, we actually know that some treatments work really well and others don't. With the well defined different groups you can sometimes pick this out.

How do we determine the optimal frequency and dosage of treatment? That is very difficult. We usually give people what we call **an induction course** where they have a certain amount of IVIg over a few days. Then they go on to **ongoing treatment which is perhaps every 4 weeks apart**, but we have to keep thinking **do they need to keep going every 4 weeks** or can we **stretch that to 6** or **do they actually need it at all**. There are a **group of patients who have gone into remission** for whom it is not going to work anyway. These are things that we need to be thinking about.

One of the things that of course is very hard for us as neurologists is the patient comes in and says **"Yes. The week before I get my infusion of IVIg I feel lousy. I feel I need it."** It is a very common finding. **It doesn't necessarily mean that they need the IVIg that it is actually working**. It **can have a Placebo affect**. It can be that it **has some other effects that are not measurable in nerve function itself.** So these are difficult things to deal with.

Amongst the things we are looking at **is the level of immunoglobulin in the blood stream of the patients who have been treated**. **Is there a target level** we should be aiming at? Should we keep on **giving more to patients rather than giving a set dose**? Should we look at **how much actually gets into the blood stream and what dose is the best?** The other thing is that **people do fluctuate**. Like I said, **sometimes** those fluctuations are **genuine fluctuations**. Quite often they are and if you test the strength of patients in between the strength fluctuates and you objectively show there are changes. **We don't even know whether it helps to increase the frequency and keep a better control over a longer period of time with a more stable dosage. These are things that need to be looked at and whether there are long term effects of that.**

We come again to **CIDP. Is it one condition? Is it a group of conditions?** I think it is **probably a diverse group of conditions** where there are **different antibodies** that actually **induce the inflammation, neurofascin** being **one of the first antibodies to be shown to cover a distinct group.**

Question: Would you have to ask your neurologist if it is okay for you to do the Biomarker Study?
Answer: The **Biomarker Study is done through St.Vincent's with CSL**. It costs a lot of money for them to get Research Ethics Committee approval to do it at other hospitals. It brings in a whole lot of other logistical problems. **We have negotiated at St.Vincent's that we can actually, temporarily, with the person's neurologist's opinion, take over the infusions of the IVIg.** We have nothing to do with the treatment. **The treating neurologist would continue to be the treating neurologist**, but we have been able to make it so that the treating neurologist can say Mr.X. requires 40grams of IVIg. This is the brand that he has. Could you please arrange it and **we can do that for 3 months** and the patient can be involved in that Study.

One thing we have wondered about, and this could be done, would be **people need to actually fulfil the EFNS Criteria so as part of the trial we need to do nerve conduction studies.** One possibility is for patients to come and **we could discuss the situation with Informed Consent**. The informed consent allows people to withdraw at any stage. **It is not a commitment to anything**. We could then

do nerve conduction studies, for example, and **see whether or not the person is eligible to go in the trial**. If they are not, there is no need to pursue that further. If they are, then we would certainly **need their neurologist's consent to take over treatment and their neurologist would need to tell us what to provide the patient in terms of treatment.**

Question: Are we able to get a copy of this information? If you are about to discuss it with your neurologist at a different hospital, then obviously I don't have all the material kept in my head.
Answer: If patients want to pursue that we are happy to communicate with the treating neurologist on that level. I am happy to provide these slides. That is not an issue.

Question: I have had treatment every 2 weeks at St.Vincent's for 6 years and now my neurologist says **my sensory nerves have got worse because he can't pick them up on the nerve conduction**. He has said I should keep going on my treatment.
Answer: I am **not commenting on anyone's individual treatments** here but what I can say is that **sometimes patients don't respond as well as we would like them to respond**. We like to know there is some degree of response so we can continue treatment, because **there are alternative treatments**. **IVIg** is one of the treatments. If that just doesn't work we can use **steroids** and other **immune suppressive agents**. **Plasma exchange** is used, so there are other treatments that can be used. Your neurologist would need to sit down with you and say, "Yes it has slowed things down. It has had some positive effect". There is no point in continuing on if there is no benefit at all.

Question: If you are going back on people's previous records to see if they meet the new criteria, **have you found any that didn't meet the criteria but are responding well to IVIg?**
Answer: **Yes we have found one or two**. It was published a couple of years ago where they actually lined up **14 or maybe 16 criteria that they used and not everyone fulfilled all those** criteria. Consequently the **EFNS has come from that** and is now used. It is though a group of criteria which is very important from a research point of view **so we have a standard group of patients.** Occasionally you **see patients** whose diagnosis does not fit anything else whatsoever, but they might **just miss one or two**. These **are very complex criteria** so **if they don't fulfil all** the criteria, then we note that, but **they can still receive** it.

Question: It could mean that IVIg could also be treating other things similar to CIDP?
Answer: Yes. Quite possibly. Really what **IVIg treats is an inflammatory response** and if that's from other causes, yes it may be working on those.

Question: I was interested in what you were saying about **people who have balance problems**. **Do not all people who have CIDP have balance problems?**
Answer: Not all people do, no. Some people have **motor predominant CIDP**. Their **muscles are weak but they still get input to tell them where they are**. They can correct any balance problems and it is not really an issue. **The issue is weakness**. If balance problems are really bad, it usually implies one of two things. One is that the **sensory nerves are affected**. One of the simple ways of checking that is to say "What happens when you **close your eyes**. **Are you worse then?** Or when you are in the shower?" People close their eyes as you have water there and they become very unsteady because their **sensory input is not working properly**. The **second circumstance** when balance is a problem is where there is **a great degree of weakness, particularly around the hips** and it is very hard to maintain your balance then because of **lack of strength**.

Question: I have a **serious balance problem**. **Is there any treatment** for it?
Answer: The **treatment of balance problems is the treatment for CIDP**. Beyond that, yes the treatments are **physiotherapy and so on**. We also get some benefit from referring patients to the **Falls and Balance Clinic at the Eye and Ear Hospital**. We think of Eye and Ear because people can't see or can't hear, but that covers a wide range of issues and **they are very helpful in looking at ways to overcome balance problems.**

Question: I have had CIDP and I have been getting IVIg for 10 years. With mine **I notice I might go along and be okay for quite a while and then I have a downwards spiral**, not to any great extent that it affects me, but **then I will level out** and I go along and I might have **a slight lift and then I will level out again** and this has been going on **for the 10 years.** I asked my neurologist whether **if I went off IVIg what would happen?** She said, "If you go off it and you do go downhill, it's too hard to get you back again."

Answer: Fluctuations in CIDP are common. What you have described is something we do see. Patients feel better for a while, then a bit worse, then they feel better. We don't fully understand why that is the case. **If you do nerve conduction studies on patients during those phases, they are not a good indication of that at all. Nerve conduction studies remain the same for the 10 years, but the patients symptoms are considerably different. They are not a great indicator of what is going on, but the fluctuations are there. Sometimes it is because of other illness.** Patients get sick from something else and are not feeling so well and that knocks them off their feet and makes them a bit worse.
If you actually stop the IVIg, then yes people can get worse. Usually though if they get worse they pick it up fairly quickly as they are watched very carefully. Some times we see patients who go off treatment and they get worse, then they have an induction course where you hit them really hard with IVIg and that sometimes works.

Question: Is there any research being done on plasma exchange.
Answer: Yes there has. **Plasma Exchange is roughly the same as IVIg in its responsiveness**. There are some patients who don't respond to Plasma Exchange and some that don't respond to IVIg, so in CIDP, as distinct from Guillain-Barre` Syndrome, if one doesn't work then you can stop and try the other.

Question: The impression I am getting and please tell me if I am wrong, is okay you may be able to tell whether a **person has CIDP** or something else, but am I right in thinking **there is still yet no other magic pill or magic treatment that has been developed other than putting them on steroids, etc.?** You might be finding differences in the diagnosis but **are you finding differences in what is the treatment?**
Answer: Most of the **treatment that looks promising is anecdotal** by that I mean **someone reports something like 'Rituximab' which is an antibody which is used. There might be patients that respond to that or to other like drugs or other chemotherapy type agents, but they are not well controlled trials like plasma exchange and IVIg and steroids** are.

Question: Just out of curiosity, **I had GBS and had double vision and wonder if it is typical to have do**uble vision with CIDP?
Answer: It would be extremely unusual with CIDP. If someone with CIDP had double vision I would be looking at another cause.

Question: This question is not for me but someone else has **a lot of pain with CIDP. Is that typical?**
Answer: It is that which has **made us look for these small nerve fibres** what we talked about before. The **small nerve fibres are the ones that feel pain and temperature**. Patients with CIDP (you may correct me as a group here) often when we test temperature sensation they can pick changes fairly well. They can often pick pain pretty well so the nerves have some function but **we suspect there is some function there that is not normal and that is in fact what we are finding at the moment with the impairment of the fibres which feel pain.** When people have what we call a **small fibre neuropathy** which is what we are referring to here**, pain is the main feature – a neuralgic type of pain.**

Question: A lot of people who ring me are very distressed with pain and ask me what can I take?
Answer: The **treatment for small fibre neuropathy is very complex and difficult**. The most **common treatment we use first off is amitriptyline in a very small dose**. Amitriptyline is a very old fashioned antidepressant drug. This pain has nothing to do with depression. **We use between 10 and 50 milligram to control this type of pain.** When we used to use it as an antidepressant it was 150 milligrams. **It does seem to suppress pain**. Some of the **newer antidepressants** are used. **'Lyrica' has been shown to be the most effective agent for it**. We don't always go for the most effective first. If **we can use the simple one with the least side effects** we try that.

Question: Is it true that **CIDP is male dominant?** (Looking around the room at all the men there was a peel of laughter.)
Answer: Yes. **It is more common in males** than females, which is **curious because** most **autoimmune disorders are more common in females** than males.

Question: I was wondering if it is because men are inclined to work in areas with more chemicals?

Answer: I am not sure about that. One of the bugs that is **associated with Guillain-Barre`** and so on is **campylobacter jejuni** and that is **found in lots of things**. It is **found in the Yarra River**, it is **found in gumtrees**, it is **found in poorly cooked chicken**. You get food poisoning. It is all over the place. You can come up with lots of ideas. **Maybe men eat more uncooked chicken** than women.

Question: You just said before that people with CIDP don't get Miller Fisher Syndrome. **Is that correct?**
Answer: Yes. **If someone that looks like CIDP has double vision we look for other causes**. **There is a condition called CABINAD** for example, which is **an ataxia with abnormal eye movements and peripheral neuropathy and it doesn't fit under the usual umbrella of CIDP.**

Peter: Les we are extremely grateful that you came to talk. My judgment about these meetings and I have been coming to them for fourteen years with my wife, **you can tell whether the speaker has been successful by the range and depth of the questions** and I thought you made a **most impressive performance**. (Peter handed a gift to Les.) Les, that will not **do anything for you medically**, but it is nice to sit down and drink it.

Gwen: Someone asked me about what this is **on my wrist**. We have taken on **an alarm system** because we have so many friends now living on their own and those living together who didn't have any sort of alarm system. **We have found this one to be extremely good**. You **pay for it once**. You **don't have any on-going costs**.

The way it works is if you **press the yellow button** (which sometimes we do accidentally), **it calls the other person.** If you are **in the house or the garden** you will hear it. It is for **if you need help**.

If you are in strife, you squeeze the red button. There is not much chance of squeezing that one accidentally. If you do press the red button **you will have set up an arrangement** with four people. We have **our son's home number and his mobile, our daughter-in-law** and **a friend** and **if nobody answers the ambulance is called** and comes.

We have **used it a few times**, but the security it gives you **is absolutely great**. It is easy. You can wear it **on your wrist or you can have it around your neck if you like**. If you are interested we can tell you about them.

They were **$400 for two of them and for setting up the service**. The message that it sends to our son and contact includes the information on how to get into the house. It has been **very useful** around the home when I need help or Gwen does, it gives a blast. The product is **called Care Alert.**

It also has another function. If you are not talking to your husband you can wake him up in the night with this blast!! (Laughter) Peter: In her defence she has only done that 12 times since we have had it. (More laughter) Gwen: Look out 13 will be tonight!

We received the following note and were very touched. **Thank you for these kind words Vicki.**

"I would like to say thank you for all the work the committee and the group do. It is much appreciated.

My Dad (Percy Bruton) had CIDP for over 30 year, unfortunately he died in July. We (Mum and the family) cared for him at home. He was blind and completely disabled for the past 2-3 years but had an amazingly good humour and a very accepting attitude. There was never a "Why me?" He was a farmer in central Victoria so he had been exceedingly fit and active until his 50's. He was initially given a diagnosis of Motor Neuron Disease and after many tests he was told there was nothing that could be done for him. Expected life span 4 years. He was 56 years old, married with 6 young children and a large family farm to run!! So he stopped going to the Doctor. Eventually, 12 years later, he was retested and they said CIDP.

He was an amazing man who managed to continue to run the farm and raise his kids whilst loosing the ability to walk or care for himself.

He enjoyed getting the newsletter and took great joy in showing the fantastic District Nurses who came to help care for him over the years. The local doctors learnt a great deal about CIDP, an illness most had never heard of let alone seen. I would often read your newsletters after he had read them and it is one of the main reasons I decided to become a nurse. I still read your Newsletters with great interest.
Thank you again, Yours sincerely, Vicki Sundblom".

Another lovely note.

The Monday Embroidery Group which Margaret B (name supplied) is a very important part of would like you to accept this donation – made instead of us buying a gift for each other. Margaret would like the money to go to The 'IN' Group.

(Editor's note: Over the years Margaret and her Bridge Club and now her Embroidery Group have made many donations. Thank you to Margaret and her friends for their kind generosity. All donation to The 'IN' Group go towards research.)

Email Mailing List. If you would like to be included on The IN Group email mailing list please send an email to John Burke at the following address: **jburke@contracts.com.au**

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THE 'IN' GROUP
The Inflammatory Neuropathy Support Group of Victoria Inc.
Supporting sufferers from acute Guillain-Barre` Syndrome (GBS and
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
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