



## Complete Summary

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### GUIDELINE TITLE

European Federation of Neurological Societies/Peripheral Nerve Society guideline on management of chronic inflammatory demyelinating polyradiculoneuropathy: report of a joint task force of the European Federation of Neurological Societies and the Peripheral Nerve Society.

### BIBLIOGRAPHIC SOURCE(S)

Hughes RA, Bouche P, Cornblath DR, Evers E, Hadden RD, Hahn A, Illa I, Koski CL, Leger JM, Nobile-Orazio E, Pollard J, Sommer C, Van den Bergh P, van Doorn PA, van Schaik IN. European Federation of Neurological Societies/Peripheral Nerve Society guideline on management of chronic inflammatory demyelinating polyradiculoneuropathy: report of a joint task force of the EFNS and PNS. *Eur J Neurol* 2006 Apr;13(4):326-32. [27 references] [PubMed](#)

Joint Task Force of the EFNS and the PNS. European Federation of Neurological Societies/Peripheral Nerve Society Guideline on management of chronic inflammatory demyelinating polyradiculoneuropathy. *J Peripher Nerv Syst* 2005 Sep;10(3):220-8. [PubMed](#)

### GUIDELINE STATUS

This is the current release of the guideline.

## \*\* REGULATORY ALERT \*\*

### FDA WARNING/REGULATORY ALERT

**Note from the National Guideline Clearinghouse:** This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [May 23, 2007, Gadolinium-based Contrast Agents](#): The addition of a boxed warning and new warnings about the risk of nephrogenic systemic fibrosis (NSF) to the full prescribing information for all gadolinium-based contrast agents (GBCAs).

## COMPLETE SUMMARY CONTENT

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## SCOPE

### **DISEASE/CONDITION(S)**

Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)

### **GUIDELINE CATEGORY**

Diagnosis  
Evaluation  
Management  
Treatment

### **CLINICAL SPECIALTY**

Family Practice  
Internal Medicine  
Neurology

### **INTENDED USERS**

Physicians

### **GUIDELINE OBJECTIVE(S)**

To construct guidelines for the definition, diagnosis and treatment of chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) based on the available evidence and, where adequate evidence was not available, consensus

### **TARGET POPULATION**

Patients with chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)

### **INTERVENTIONS AND PRACTICES CONSIDERED**

#### **Diagnosis**

1. Assessment of signs and symptoms
2. Electrodiagnostic tests including nerve conduction studies
3. Cerebrospinal fluid (CSF) examination
4. Magnetic resonance imaging (MRI) of spinal roots, brachial plexus and lumbosacral plexus

5. Nerve biopsy
6. Assessment of concomitant diseases

### **Treatment**

1. Intravenous immunoglobulin (IVIg) or corticosteroids
2. Plasma exchange (PE)
3. Immunosuppressant or immunomodulatory drugs
4. Advice about foot care, exercise, diet, driving, and lifestyle management
5. Treatment of neuropathic pain
6. Physiotherapy if indicated
7. Psychological support
8. Referral to a rehabilitation specialist

### **MAJOR OUTCOMES CONSIDERED**

Effectiveness of treatment

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

The Task Force members searched MEDLINE from 1980 onwards on July 24, 2004 for articles (on "chronic inflammatory demyelinating polyradiculoneuropathy" and "diagnosis" or "treatment" or "guideline") but found that the personal databases of Task Force members were more useful. The Task Force members also searched the Cochrane Library in September 2004.

### **NUMBER OF SOURCE DOCUMENTS**

Not stated

### **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Weighting According to a Rating Scheme (Scheme Given)

### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

#### **Evidence Classification Scheme for a Diagnostic Measure**

**Class I:** A prospective study in a broad spectrum of persons with the suspected condition, using a "gold standard" for case definition, where the test is applied in a blinded evaluation, and enabling the assessment of appropriate tests of diagnostic accuracy

**Class II:** A prospective study of a narrow spectrum of persons with the suspected condition, or a well-designed retrospective study of a broad spectrum of persons with an established condition (by "gold standard") compared to a broad spectrum of controls, where test is applied in a blinded evaluation, and enabling the assessment of appropriate tests of diagnostic accuracy

**Class III:** Evidence provided by a retrospective study where either persons with the established condition or controls are of a narrow spectrum, and where test is applied in a blinded evaluation

**Class IV:** Any design where test is not applied in blinded evaluation OR evidence provided by expert opinion alone or in descriptive case series (without controls)

### **Evidence Classification Scheme for a Therapeutic Intervention**

**Class I:** An adequately powered prospective, randomized, controlled clinical trial with masked outcome assessment in a representative population or an adequately powered systematic review of prospective randomized controlled clinical trials with masked outcome assessment in representative populations. The following are required:

- a. Randomization concealment
- b. Primary outcome(s) is/are clearly defined
- c. Exclusion/inclusion criteria are clearly defined
- d. Adequate accounting for dropouts and crossovers with numbers sufficiently low to have minimal potential for bias
- e. Relevant baseline characteristics are presented and substantially equivalent among treatment groups or there is appropriate statistical adjustment for differences

**Class II:** Prospective matched-group cohort study in a representative population with masked outcome assessment that meets a–e above or a randomized, controlled trial in a representative population that lacks one criteria a–e

**Class III:** All other controlled trials (including well-defined natural history controls or patients serving as own controls) in a representative population, where outcome assessment is independent of patient treatment

**Class IV:** Evidence from uncontrolled studies, case series, case reports, or expert opinion

### **METHODS USED TO ANALYZE THE EVIDENCE**

Review of Published Meta-Analyses  
Systematic Review

### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not stated

### **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Pairs of task force members prepared draft statements about definition, diagnosis and treatment which were considered at a meeting at the European Federation of Neurological Societies (EFNS) congress in September 2004. Evidence was classified as class I–IV and recommendations as level A–C according to the scheme agreed for EFNS guidelines (See the "Rating Scheme for the Strength of the Evidence" and the "Rating Scheme for the Strength of the Recommendations" fields; for EFNS guideline standards, see "Availability of Companion Documents" field in this summary). When only class IV evidence was available but consensus could be reached the Task Force offered advice as good practice points. The statements were revised and collated into a single document which was then revised iteratively until consensus was reached.

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

### **Rating of Recommendations for a Diagnostic Measure**

**Level A rating** (established as useful/predictive or not useful/predictive) requires at least one convincing class I study or at least two consistent, convincing class II studies.

**Level B rating** (established as probably useful/predictive or not useful/predictive) requires at least one convincing class II study or overwhelming class III evidence.

**Level C rating** (established as possibly useful/predictive or not useful/predictive) requires at least two convincing class III studies.

### **Rating of Recommendations for a Therapeutic Intervention**

**Level A rating** (established as effective, ineffective, or harmful) requires at least one convincing class I study or at least two consistent, convincing class II studies.

**Level B rating** (probably effective, ineffective, or harmful) requires at least one convincing class II study or overwhelming class III evidence.

**Level C rating** (possibly effective, ineffective, or harmful) requires at least two convincing class III studies.

**Good Practice Point** When only class IV evidence was available but consensus could be reached the Task Force offered advice as good practice points.

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guidelines were validated according to the European Federation of Neurological Societies (EFNS) criteria (See "Availability of Companion Documents" field).

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

The levels of evidence (class I-IV) supporting the recommendations and ratings of recommendations (A-C, Good Practice Point) are defined at the end of the "Major Recommendations" field.

#### **Diagnostic Criteria for Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)**

**Good Practice Points** for defining diagnostic criteria for CIDP:

1. Clinical: typical and atypical CIDP (see Table 1 below)
2. Electrodiagnostic: definite, probable and possible CIDP (see Table 2 below)
3. Supportive: including cerebrospinal fluid (CSF), magnetic resonance imaging (MRI), nerve biopsy and treatment response (see Table 3 below)
4. CIDP in association with concomitant diseases (see Table 4 in the original guideline document)
5. Categories: definite, probable, and possible CIDP with or without concomitant diseases (see Table 5 below)

**Good Practice Points** for diagnostic tests:

1. Electrodiagnostic tests are recommended in all patients (**Good Practice Point**)
2. CSF, MRI and nerve biopsy should be considered in selected patients (**Good Practice Point**)
3. Concomitant diseases should be considered in all patients but the choice of tests will depend on the clinical circumstances (see Table 6 in the original guideline document).

#### **Table 1. Clinical Diagnostic Criteria**

- |   |
|---|
| I. <i>Inclusion criteria</i><br>A. Typical CIDP |
|---|

Chronically progressive, stepwise, or recurrent symmetric proximal and distal weakness and sensory dysfunction of all extremities, developing over at least 2 months; cranial nerves may be affected, and

Absent or reduced tendon reflexes in all extremities

B. Atypical CIDP

One of the following, but otherwise as in A (tendon reflexes may be normal in unaffected limbs)

Predominantly distal weakness (distal acquired demyelinating sensory [DADS])

Pure motor or sensory presentations, including chronic sensory immune polyradiculoneuropathy affecting the central process of the primary sensory neuron

Asymmetric presentations (multifocal acquired demyelinating sensory and motor [MADSAM] Lewis–Sumner syndrome Focal presentations (e.g. involvement of the brachial plexus or of one or more peripheral nerves in one upper limb)

Central nervous system involvement (may occur with otherwise typical or other forms of atypical CIDP)

II. *Exclusion criteria*

Diphtheria, drug or toxin exposure likely to have caused the neuropathy

Hereditary demyelinating neuropathy, known or likely because of family history, foot deformity, mutilation of hands or feet, retinitis pigmentosa, ichthyosis, liability to pressure palsy

Presence of sphincter disturbance

Multifocal motor neuropathy

Antibodies to myelin-associated glycoprotein

**Table 2. Electrodiagnostic Criteria**

- I. Definite: at least one of the following
- A. At least 50% prolongation of motor distal latency above the upper limit of normal values in two nerves, or
  - B. At least 30% reduction of motor conduction velocity below the lower limit of normal values in two nerves, or
  - C. At least 20% prolongation of F-wave latency above the upper limit of normal values in two nerves (>50% if amplitude of distal negative peak compound muscle action potential [CMAP] <80% of lower limit of normal values), or
  - D. Absence of F-waves in two nerves if these nerves have amplitudes of distal negative peak CMAPs at least 20% of lower limit of normal values + at least one other demyelinating parameter<sup>a</sup> in at least one

<p>E. Partial motor conduction block: at least 50% amplitude reduction of the proximal negative peak CMAP relative to distal, if distal negative peak CMAP at least 20% of lower limit of normal values, in two nerves, or in one nerve + at least one other demyelinating parameter<sup>a</sup> in at least one other nerve, or</p> <p>F. Abnormal temporal dispersion (&gt;30% duration increase between the proximal and distal negative peak CMAP) in at least two nerves, or</p> <p>G. Distal CMAP duration (interval between onset of the first negative peak and return to baseline of the last negative peak) of at least 9 ms in at least one nerve + at least one other demyelinating parameter<sup>a</sup> in at least one other nerve</p>	<p>other nerve, or</p>
<p>II. Probable</p> <p>At least 30% amplitude reduction of the proximal negative peak CMAP relative to distal, excluding the posterior tibial nerve, if distal negative peak CMAP at least 20% of lower</p> <p style="padding-left: 40px;">limit of normal values, in two nerves, or in one nerve + at least one other demyelinating parameter<sup>a</sup> in at least one other nerve</p>	
<p>III. Possible</p> <p>As in 'I' but in only one nerve</p>	

To apply these criteria the median, ulnar (stimulated below the elbow), peroneal (stimulated below the fibular head), and tibial nerves on one side are tested. Temperatures should be maintained to at least 33 degrees C at the palm and 30 degrees C at the external malleolus (**Good Practice Points**). Further technical details are given in the accompanying web document (<http://www.efns.org>) and see van den Bergh and Pieret, *Electrodiagnostic criteria for acute and chronic inflammatory demyelinating polyradiculoneuropathy. Muscle and Nerve* 2004; 29: 565-574.

<sup>a</sup>Any nerve meeting any of the criteria A-G.

**Table 3. Supportive Criteria**

<p>A. Elevated cerebrospinal fluid protein with leucocyte count &lt;10/mm<sup>3</sup> (<b>level A recommendation</b>)</p> <p>B. Magnetic Resonance Imaging showing gadolinium enhancement and/or hypertrophy of the cauda equina, lumbosacral or cervical nerve roots, or the brachial or lumbosacral plexuses (<b>level C recommendation</b>)</p> <p>C. Nerve biopsy showing unequivocal evidence of demyelination and/or remyelination in ≥5 fibres by electron microscopy or in &gt;6 of 50 teased fibres</p> <p>D. Clinical improvement following immunomodulatory treatment (<b>level A recommendation</b>)</p>
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**Table 5. Diagnostic Categories**

Definite CIDP
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Clinical criteria I A or B and II with Electrodiagnostic criteria I; or Probable CIDP + at least one Supportive criterion; or Possible CIDP + at least two Supportive criteria

#### Probable CIDP

Clinical criteria I A or B and II with Electrodiagnostic criteria II; or Possible CIDP + at least one Supportive criterion

#### Possible CIDP

Clinical criteria I A or B and II with Electrodiagnostic criteria III CIDP (definite, probable, possible) associated with concomitant diseases

### **Treatment of CIDP**

For induction of treatment:

1. Intravenous immunoglobulin (IVIg) or corticosteroids should be considered in sensory and motor CIDP in the presence of troublesome symptoms (**level B recommendation**). The presence of relative contraindications to either treatment should influence the choice (**Good Practice Point**).
2. The advantages and disadvantages should be explained to the patient who should be involved in the decision making (**Good Practice Point**).
3. In pure motor CIDP IVIg should be considered as the initial treatment (**Good Practice Point**).
4. If IVIg and corticosteroids are ineffective plasma exchange (PE) should be considered (**level A recommendation**).

For maintenance treatment:

1. If the first-line treatment is effective continuation should be considered until the maximum benefit has been achieved and then the dose reduced to find the lowest effective maintenance dose (**Good Practice Point**).
2. If the response is inadequate or the maintenance doses of the initial treatment are high, combination treatments or adding an immunosuppressant or immunomodulatory drug may be considered (see Table 7 in the original guideline document) (**Good Practice Point**).
3. Advice about foot care, exercise, diet, driving, and lifestyle management should be considered. Neuropathic pain should be treated with drugs according to EFNS guideline on treatment of neuropathic pain. Depending on the needs of the patient, orthoses, physiotherapy, occupational therapy, psychological support and referral to a rehabilitation specialist should be considered (**Good Practice Points**).
4. Information about patient support groups should be offered to those who would like it (**Good Practice Point**).

### **Definitions:**

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**Class I:** A prospective study in a broad spectrum of persons with the suspected condition, using a "gold standard" for case definition, where the test is applied in a blinded evaluation, and enabling the assessment of appropriate tests of diagnostic accuracy

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**Level C rating** (possibly effective, ineffective, or harmful) requires at least two convincing class III studies.

**Good Practice Point** When only class IV evidence was available but consensus could be reached the Task Force offered advice as good practice points.

### **CLINICAL ALGORITHM(S)**

None provided

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations").

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

Appropriate diagnosis and treatment of chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)

### **POTENTIAL HARMS**

Because adverse events related to difficulty with venous access, use of citrate and haemodynamic changes are not uncommon in plasma exchange, either corticosteroids or intravenous immunoglobulin (IVIg) should be considered first.

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

- This guideline provides the view of an expert task force appointed by the Scientific Committee of the European Federation of Neurological Societies (EFNS). It represents a peer-reviewed statement of minimum desirable standards for the guidance of practice based on the best available evidence. It is not intended to have legally binding implications in individual cases.
- There is a dearth of evidence concerning general aspects of treatment for symptoms of chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) such as pain and fatigue. There is also a lack of research into the value of exercise and physiotherapy and the advice which should be offered concerning immunizations. International and national support groups offer information and support and physicians may consider putting patients in touch with these organizations at <http://www.guillian-barre.com/> or <http://www.gbs.org.uk>.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

The European Federation of Neurological Societies has a mailing list and all guideline papers go to national societies, national ministries of health, World Health Organisation, European Union, and a number of other destinations. Corporate support is recruited to buy large numbers of reprints of the guideline papers and permission is given to sponsoring companies to distribute the guideline papers from their commercial channels, provided there is no advertising attached.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better  
Living with Illness

### IOM DOMAIN

Effectiveness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Hughes RA, Bouche P, Cornblath DR, Evers E, Hadden RD, Hahn A, Illa I, Koski CL, Leger JM, Nobile-Orazio E, Pollard J, Sommer C, Van den Bergh P, van Doorn PA, van Schaik IN. European Federation of Neurological Societies/Peripheral Nerve Society guideline on management of chronic inflammatory demyelinating polyradiculoneuropathy: report of a joint task force of the EFNS and PNS. *Eur J Neurol* 2006 Apr;13(4):326-32. [27 references] [PubMed](#)

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## **ADAPTATION**

Not applicable: The guideline was not adapted from another source.

## **DATE RELEASED**

2006 Apr

## **GUIDELINE DEVELOPER(S)**

European Federation of Neurological Societies - Medical Specialty Society  
Peripheral Nerve Society - Disease Specific Society

## **SOURCE(S) OF FUNDING**

European Federation of Neurological Societies

## **GUIDELINE COMMITTEE**

Joint Task Force of the European Federation of Neurological Societies and the Peripheral Nerve Society

## **COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

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## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

The following authors have reported conflicts of interest as follows:

R. Hughes, personal none, departmental research grants or honoraria from Bayer, Biogen-Idec, Schering-LFB and Kedrion

D. Cornblath, personal honoraria from Aventis Behring and Baxter

A Hahn, personal honoraria from Baxter, Bayer, Biogen-Idec

C. Koski, personal honoraria from American Red Cross, Baxter, Bayer, ZLB-Behring

J.M. Leger, personal none, departmental research grants or honoraria from Biogen-Idec, Baxter, Laboratoire Francais du Biofractionnement (LFB), Octapharma

E. Nobile-Orazio, personal from Kedrion, Grifols, Baxter, LFB (and he has been commissioned by Kedrion and Baxter to give expert opinions to the Italian Ministry of Health on the use of IVIg in dysimmune neuropathies)

J. Pollard, departmental research grants from Biogen-Idec, Schering

P. van Doorn, personal none, departmental research grants or honoraria from Baxter and Bayer

The other authors have nothing to declare.

## **GUIDELINE STATUS**

This is the current release of the guideline.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available to registered users from the [European Federation of Neurological Societies Web site](#).

Print copies: Available from RAC Hughes, Department of Clinical Neuroscience, Guy's Campus, King's College, London, UK; Phone: +44 20 7848 6125; Fax: +44 20 7848 6123; Email: [richard.a.hughes@kcl.ac.uk](mailto:richard.a.hughes@kcl.ac.uk)

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

- Brainin M, Barnes M, Baron JC, Gilhus NE, Hughes R, Selmaj K, Waldemar G; Guideline Standards Subcommittee of the EFNS Scientific Committee. Guidance for the preparation of neurological management guidelines by EFNS scientific task forces – revised recommendations 2004. Eur J Neurol. 2004 Sep;11(9):577-81. Electronic copies: Available in Portable Document Format (PDF) from the [European Federation of Neurological Societies Web site](#).
- Guideline papers. European Federation of Neurological Societies. Electronic copies: Available from the [European Federation of Neurological Societies Web site](#).

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

This NGC summary was completed by ECRI on March 22, 2007. The information was verified by the guideline developer on May 3, 2007. This summary was updated by ECRI Institute on June 20, 2007 following the U.S. Food and Drug Administration (FDA) advisory on gadolinium-based contrast agents.

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