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Released: 03/25/2025
Valid until: 03/25/2026
Time needed to complete: 1h 17m

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Clinical Conundrums in ARIA: When is a Headache Concerning in Patients Prescribed Anti-Aβ mAbs?

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Dr. Bateman:
Welcome to Clinical Conundrums: Navigating Case Scenarios in Your Own Practice Setting, where we will cover quick and challenging cases related to amyloid-related imaging abnormalities, or ARIA, management. I'm Dr. Trey Bateman, and here with me today are doctors Joy Snider and Charles Vega. Let's dive into our case.

Dr. Vega:
So I'm going to present a case of Jean. Now, Jean is 75 years old on donanemab for 2 months now, and presents with a headache that she rates at a 3 out of 10 in terms of its severity. Now, she did have an MRI just 2 weeks ago, routine MRI, and showed no signs of ARIA. And her most recent dose of donanemab was administered 1 week prior.

Dr. Bateman:
This case will help us identify key symptoms that might or might not warrant out-of-sequence MRIs or emergency cares. Joy, to start us off, could you discuss how we determine whether symptoms like mild headache should prompt an out-of-sequence MRI? Or if reassurance and monitoring are more appropriate?

Dr. Snider:
It really is on a case-by-case basis, and this is one of the big challenges of managing patients on these medications. So if this is a patient who has headaches typically, and this is a pretty standard headache, responds to the usual treatment, pretty mild headache sounds like, 3 out of 10, I might have a lower index of suspicion. If this is a person who never has headaches, I might be more concerned, and particularly if there any other symptoms, if they're dizzy. It also depends on the timing relative to the infusion, because headaches are a pretty common infusion reaction. So if it happens within 24 to 48 hours of an infusion, you might be more suspicious of an infusion reaction than of ARIA. But particularly early on, when patients are in that first five- to seven-dose period when ARIA is most common, we do take these things very seriously. And if it's a new headache, very different, more severe, really a high index of clinical suspicion, then we do go ahead and get an MRI. And many times these are going to be negative. But I think it's important to know we're going to have some negative MRIs, because we do want to pick up ARIA before we start giving additional doses of medication.

Dr. Vega:
I think those are incredibly valid points, Joy. And I agree. I think we want to be judicious with our use of imaging and certainly the use of emergency services as well. But at the same time, we have to be quite vigilant here. I think for primary care, because we're often going to be the ones who get presented with these complaints, and also, if you're in an urgent care, I think that's another place you're going to see complaints, so recognizing that the patient is receiving treatment with an antibody for Alzheimer's disease is important. And then

also realizing that symptomatic ARIA occurs in less than 10% of folks in clinical trials. So it is more rare.

It's wonderful I think that when I have a relationship with a patient I know over time, I not only know their history of, say, headaches, but I also know their cognitive status, especially if they're in those early stage of dementia. So if you see a significant step-off in confusion acutely, that's certainly going to be one that's going to raise a flag for me. And I'm going to think about getting the patient neuroimaging right away.

And I think it is important to communicate as well. So I'll send a message along to the treating clinician who's actually employing the antibody as well, just to let them know what's going on and get some feedback. So a quick phone call can go a long ways in terms of getting the patient the right care, but also helping you feel more reassured as a treating clinician.

Dr. Snider:
Yeah, I would just add one thing to what Chuck said. The other big red flag is if there's focal findings. So if they have any weakness or numbness, worsened gait, and one of the most common things we have seen in practice is this increase in confusion, and that's pretty common, and can be symptomatic ARIA. So really important to try to tease that out.

Dr. Vega:
And I'll just bring up one other important thing that is important in my practice, but I think it's become common for a lot of practices, I fit in a lot of cases with acute issues via telehealth. I would say this is not a great choice for telehealth exactly because Joy is right, we want to look for focal findings so a neurologic exam should be part of this evaluation.

Dr. Bateman:
Great points from both of you.

And one of the things that you said, Joy, that I think rings very true in my practice, is that if I'm not getting some negative MRIs, I'm probably not ordering enough MRIs. My index of suspicion probably isn't quite high enough. And I think that over time, we'll probably all balancing our own barometers for understanding how aggressively to address this, and we'll see our practices change over time.

So thank you both for this insightful discussion. To our viewers, be sure to check out our other episodes for more in-depth insights into the nuances of ARIA management. Thank you for joining us.

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