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Clinical Conundrums in ARIA: Triage and Imaging in the Emergency Setting for Patients Prescribed Anti-Aβ mAbs

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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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 Jerry Barakos and Danya Khoujah. Let's dive into our case.

Dr. Khoujah:
So Lisa is a 76-year-old patient with mild cognitive impairment due to Alzheimer's disease. And she presents to the emergency department with confusion in the headache. She has been receiving lecanemab and underwent her most recent dose 2 weeks ago. The team must determine the next steps for her triage and management.

Dr. Bateman:
Lisa's presentation highlights the need for robust triage strategies and emergency department protocols tailored to ARIA management. Let's explore best practices for prioritizing treatment and imaging in such scenarios.

Dr. Khoujah:
So the first thing that we need to do is recognize the she’s on an anti-amyloid monoclonal antibody through an accurate medication reconciliation. And we all know that that's not always the easiest task, so sometimes we just need to be creative. We need to ask patients if they use any injectable medications that they don't have with them in their little brown bag, or if there are any special medications that need a lot of monitoring that they're on.

The other thing is we need to be able to identify the signs and symptoms of ARIA so that we can have a comprehensive differential diagnosis. So if patients are coming in with a headache, altered mental status, dizziness, gait disturbance, visual disturbance, and sometimes rarely, thankfully, a seizure. If those are the symptoms they're coming in with, then we need to think of ARIA as one of our differentials. The other common ones, of course, are strokes, whether ischemic or hemorrhagic, stress, delirium, and a CNS infection.

Dr. Barakos:
From an imaging point of view, as a radiologist, what tools do we typically employ? Well, we want to use the standard tools we would employ in any emergency room setting. So if the patient is coming in with symptomatology that is quite suggestive of a stroke, obviously we would initiate our standard stroke protocol, typically consisting of CT, CT perfusion, and CT angiography.

However, if the symptomatology is more indescript and we may be concerned about a wide variety of different conditions, CT still remains the imaging modality of choice as a first-line evaluation of the entire spectrum of possibilities in the emergency room setting.

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Obviously, MRI serves kind of a secondary role to further characterize or better define more nuanced abnormalities. So in other words, obviously our routine serial imaging of these patients who are on anti-amyloid agents consists of MRI. However, in the emergency room setting, we're going to stick to our typical paradigm of CT/CT stroke analysis initially.

So it really depends on the clinical history as to what imaging modality we'll use. And at the same time, we have to be cognizant of the fact that the patient, if they're being treated with anti-amyloid agents, and if they're having ARIA, these changes may be very hard to identify on CT. And in that setting, the MRI affords us to increase conspicuity to evaluate and identify the more subtle changes of ARIA.

So at the end of the day, it requires a bit of reasoning to determine what do we think the most probable abnormality is in this emergency room setting, and then choose the appropriate imaging tool.

Dr. Bateman:
So it sounds like one of the things that's going to be really important for this triangulation between the dementia specialist or the neurologist who's consulting the emergency department physician and the radiologist, is to make sure that we're communicating clearly between the three of us so that the imaging findings are communicated back to both of those individuals so that we can make appropriate decisions about: Does this person need to be admitted to the hospital? Or are they okay to leave the emergency department and continue following up with their dementia specialist, who may be very different and may be a different person from the neurological consultant in the emergency room?

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

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