Letters


In Reply We thank Piazza et al for their interest and commentary on our report. This case holds a unique position in the amyloid-related imaging abnormality (ARIA) management discussion in that there were a record number of 6 recurrent ARIA episodes despite an unusually aggressive ARIA management strategy. The dose reductions and suspension implemented after the final 3 ARIA episodes were precautions that went beyond those required by protocol. Trial protocol and clinical appropriate-use criteria, in turn, use a more aggressive strategy than those put forth on the US Food and Drug Administration package insert. Thus, this case could be highlighted to advocate for an even more aggressive ARIA management strategy, such as the use of intravenous corticosteroid pulse therapy followed by an oral taper.

On the contrary, this case could also be highlighted to advocate for a more relaxed ARIA management strategy. All ARIA episodes were asymptomatic, the participant remained clinically stable with unchanged Mini-Mental State Examination and Clinical Dementia Rating Scale Sum of Boxes scores, and he voiced a strong desire to continue receiving aducanumab through future trials. More broadly, approximately 74% of aducanumab-induced ARIA episodes are asymptomatic, and 25% cause mild to moderate symptoms. Thus, in this particular case, and perhaps across the spectrum of treatment-related ARIA, it remains very unclear at what point the risks of an ARIA management strategy begin to outweigh the risks of ARIA itself.

Overall, we agree with Piazza et al that there is a growing need to develop evidence-driven, standardized guidelines to manage ARIA. We support the use of large registries to better understand treatment-related ARIA as we move into the disease-modifying era in Alzheimer treatment.