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Characterizing Treatable Causes of Small Fiber Polyneuropathy in Gulf War Veterans

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Damage to the small nerve fibers that sense pain and regulate function of internal organs results in small-fiber polyneuropathy (SFPN). SFPN symptoms include unexplained chronic widespread pain (CWP) and chronic multisymptom illness (CMI) similar to Gulf War Illness. Our prior research demonstrated that SFPN is prevalent in such CWP and CMI syndromes and that it can have onset at a young age. Given these non-specific symptoms, objective testing is recommended for SFPN diagnosis. In the first year of this study, an Internet-based framework for developing a formal Case Definition of SFPN was developed. Global experts were invited to participate in a Delphi method process to determine the most reliable markers for SFPN (Case Definition). We also will determine if common blood tests have utility in diagnosing SFPN because some causes are treatable. We performed a preliminary retrospective study to identify blood tests with historically good predictive value.

Neuropathy, Gulf War Illness, chronic widespread pain, chronic multisymptom illness, small-fiber polyneuropathy, case definition

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INTRODUCTION:

Nerves contain motor, sensory, and autonomic axons, most of which are the small-diameter, unmyelinated C-fibers or thinly myelinated A-delta fibers that sense pain and regulate the function of internal organs and tissues. The farthest ends of these long axons easily malfunction and degenerate if their oxygen, nutrient, or energy supply is compromised, which results in small-fiber polyneuropathy (SFPN). SFPN symptoms include unexplained chronic widespread pain (CWP) and chronic multisymptom illness (CMI), including cardiovascular, gastrointestinal, microvascular, and/or disordered sweating, which contributes to heat and exercise intolerance and fatigue, similar to Gulf War Illness. Given these non-specific symptoms, objective testing is recommended for SFPN diagnosis. Our prior research suggests that SFPN is prevalent in CWP and CMI syndromes [1]. We additionally discovered SFPN that affects adolescents and adults [2]. This early-onset SFPN usually begins in adolescence or early adulthood but can linger to cause CWP and CMI for decades, like Gulf War Illness. Importantly, some causes of early-onset SFPN can be treated and even cured. Our previous preliminary data show that among 38 Gulf War veterans and 41 matched controls, 49% of veterans had objective evidence of SFPN vs. 12% of controls [3]. However, interpretation is uncertain as there is no case definition of SFPN. We propose to recruit a group of global experts and use validated methods to develop a case definition of SFPN. We will then apply this case definition in combination with clinical tests to not only look for the prevalence of SFPN among Gulf War veterans, but also to look for potentially treatable causes.

KEYWORDS:

Neuropathy, Gulf War Illness, chronic widespread pain, chronic multisymptom illness, small-fiber polyneuropathy, case definition

ACCOMPLISHMENTS:

What were the major goals of the project?

Objective/Hypothesis:
To determine the prevalence and clinical significance of undiagnosed small-fiber polyneuropathy among Gulf War veterans, and to look for potentially treatable causes of SFPN associated with Gulf War Illness.

Specific Aims:

Aim I: To develop a working Case Definition of SFPN to help physicians confirm or refute clinically suspected cases and for research use, and then to objectively diagnose the presence or absence of SFPN among Gulf War veteran using validated anatomical and physiological diagnostic tests.

Aim II: To perform blood and skin-biopsy tests for the specific treatable causes of SFPN and to compare the prevalence of identified causes in Gulf War veterans with or without SFPN to evaluate the specificity of association.

Within these Specific Aims, only Task 1 under Specific Aim I was to be accomplished largely in the first year of this study (up to month 14):
Task 1. Retrospective analysis and application of Delphi method to develop a Case Definition. A panel of Experts will contribute benchmark cases through which key health history parameters are used to build the Case Definition.

What was accomplished under these goals?

Aim I:

We accomplished the following under Aim I (Task 1):

1. We obtained IRB and HRPO approval for the study, and amended the protocol to meet the requirements of both the MGH IRB and DOD HRPO.

2. We engaged the Informatics Team in the MGH Department of Neurology to create an Internet site that serves as the entry point to a secure platform where the global panel of Experts can upload actual de-identified case reports to be used for the Delphi process of developing the Case Definition of SFPN. The public portion of the website may be accessed at http://NeuropathyCommons.org.

3. We recruited National and International experts to develop the Case Definition. They currently include:

National:

- Professor Didier Cros, MD (Massachusetts General Hospital, Boston, MA)
- Professor Roy Freeman, MD (Beth Israel Deaconess Medical Center, Boston, MA)
- Professor David Herrmann, MD (University of Rochester, Rochester, NY)
- Professor Norman Latov, MD, PhD (Weill Cornell Medical College, New York, NY)
- Professor Adam Loavenbruck, MD (Mayo Clinic, University of Minnesota, Rochester, MN)
- Professor Glenn Lopate, MD (Washington University in St. Louis, MO)

International:

- Professor Colin Chalk, MD, CM, FRCPC (McGill University, Montreal, Canada)
- Professor Catharina Faber, MD, PhD (Maastricht University Medical Centre, Maastricht, Netherlands)
- Professor Alejandra González-Duarte, MD (Instituto Nacional de Ciencias Médicas y Nutrició Salvador Zubiran, Tlalpa, Mexico)
- Professor Riadh Gouider, MD (Razi Hospital, University of Medicine of Tunis, La Manouba, Tunisia)
- Professor Sung-Tsang Hsieh, MD, PhD, MPH (National Taiwan University Hospital, Taipei, Taiwan)
- Professor Thierry Kuntzer, MD (Centre Hospitalier Universitaire Vaudois, Lausanne, Switzerland)
Professor Giuseppe Lauria, MD (Instituto Carlo Besta, Milan, Italy)
Professor Jean-Pascal Lefaucheur, MD, PhD (Hôpital Henri-Mondor, Public Hospitals of Paris, Paris-Est Créteil University, Créteil, France)
Professor Manoj Menezes, MD (University of Sydney, Children’s Hospital, Westmead, Australia)
Professor Osvaldo Nascimento, MD (Universidade Federal Fluminense, Copacabana, Rio de Janeiro, Brazil)
Professor Claudia Sommer, MD (University of Würzburg, Würzburg, Germany)
Professor Judith Spies, MBBS, FRACP, PhD (University of Sydney, Camperdown, Australia)
Professor Thirugnanam Umapathi, MBBS, MRCPE, FAMS (Neurology) (National Neuroscience Institute, Singapore)
Professor Isin Unal Cevik, MD, PhD (Hacettepe University Faculty of Medicine, Sihhiye- Ankara, Turkey)

We plan to invite additional experts from the US, Israel, Japan, Africa, South America, and the UK.

Additionally, we have assigned another group of leaders to a Scientific Advisory Board to steer the Delphi process. They currently include:

Scientific Advisory Board:

Professor Verne S. Caviness, Jr., MD, DPhil (Massachusetts General Hospital and Harvard Medical School, Boston, MA)
Professor Alain Créange, MD, PhD (Hôpital Henri Mondor, Paris Est Créteil, France)
Professor John England, MD (Louisiana State University School of Medicine, New Orleans, Louisiana)
Professor Eva Feldman, MD, PhD (University of Michigan Health System, Ann Arbor, Michigan)
Professor Riadh Gouider, MD (Razi Hospital, Tunis, Tunisia)
Professor Mary M. Reilly, MD, FRCP, FRCPI (University College London, England)

4. We hosted an International videoconference between the MGH-based Nerve Unit (Oaklander Lab) and the France-based collaborative team at the Henri Mondor Hospital (Prs. Créange and Lefaucheur). In addition to being an invited expert on neuropathy, Professor Créange is an authority on the Delphi method.

5. To advance Task 2 (Apply validated tests to veterans and diagnose SFPN) we met with Drs. Jorge Serrador and Drew Helmer of the East Orange, NJ VA Hospital and War-Related Injury and Illness Study Center (WRIISC) to develop strategies for recruiting Gulf War Veterans.
Aim II:

While awaiting completion of the secure portion of the collaborative website for developing the Case Definition, we performed preliminary retrospective studies under Aim II to identify the blood tests that may have the best predictive value for SFPN:

1. We began by focusing on the diagnostic tools remaining to be developed under Specific Aim II to help identify SFPN, specifically blood tests for markers of SFPN. To gain perspective on the relative utility of the various tests, we retrospectively examined the prevalence of abnormal blood test results among SFPN patients to see if the tests had positive predictive value for SFPN, and also considered their cost-effectiveness in light of their predictive value. The goal was to evaluate the diagnostic utility of commonly available neuropathy-related blood tests in patients with idiopathic SFPN and formulate evidence-based recommendations for testing.

To do so, we surveyed the yield and cost of all 21 commonly available blood tests reported in the literature as useful for identifying causes of SFPN (Table 1) [4,5,6]. Results from within one year before or after the test for SFPN were included. With IRB permission, we examined the records of a large cohort of patients with objectively confirmed predominantly idiopathic SFPN at MGH during calendar year 2013 and at least one blood-test result available. The objective tests were distal-leg skin biopsy, autonomic function testing (AFT) and surgical nerve biopsy [7].

We found that out of 195 qualifying patients 57% had more than one abnormal blood test result, and among those patients who had at least 10 of the recommended blood tests done, 91% had at least one abnormal result. The most prevalent blood-test abnormality was high angiotensin-converting enzyme (ACE), but no patients had sarcoidosis diagnoses or diagnostic chest imaging. High ACE may be linked to SFPN pathogenesis. 44% had blood-test abnormalities consistent with dysimmunity (ESR, ANA, C3, C4) suggesting possible associations and supporting routine testing.

We presented posters on these preliminary results at the 2015 Meeting of the Peripheral Nerve Society (PNS) [8] and the 2015 Meeting of the American Neurological Association (ANA) [9]. The posters are included as Appendices 1 and 2, respectively.

The future plan under this grant is to refine the list of blood tests and apply the ones with most utility to Gulf War Veterans who are additionally well-characterized by history, skin biopsy,
dermatopathology, and autonomic function testing, and to age‐matched controls to look for the prevalence of markers of SFPN that are indicative of causality.

What opportunities for training and professional development has the project provided? Nothing to report. This project is not intended to provide training opportunities. Nonetheless, personnel do gain additional clinical and research skills through their participation.

How were the results disseminated to communities of interest? This project so far has developed an Internet framework to increase awareness within the affected community and promote participation in this research project. The website has pages specifically dedicated to patients and their issues, providing resources for information including our research efforts. As such, it will act as an outreach and recruiting tool for Gulf War Veterans among others affected by SFPN.

We also presented preliminary results under Aim II at two scientific meetings (Peripheral Nerve Society and the American Neurological Association) as described above.

What do you plan to do during the next reporting period to accomplish the goals? During the next reporting period, we plan to engage the global experts to arrive at a consensus Case Definition of small‐fiber polyneuropathy (SFPN) via the Delphi method. This will allow us to more accurately identify verified SFPN among the research volunteers whom we will recruit in the coming year, to include Gulf War Veterans of diverse health histories and normal control volunteers.

IMPACT:

What was the impact on the development of the principal discipline(s) of the project? A goal of this project is to generate a formal Case Definition for small‐fiber polyneuropathy which is intended to guide future practice of diagnosticians. Toward that goal, we have initiated creating a website with public and private Internet pages, to raise awareness of SFPN among the general population and health care professionals through the public pages, and to allow global experts to access the private (secure) pages to add case reports to arrive at a consensus Case Definition.

What was the impact on other disciplines? Nothing to report.

What was the impact on technology transfer? Nothing to report.

What was the impact on society beyond science and technology? As described above, public awareness and attitudes toward SFPN and its sufferers should be impacted by this project.

CHANGES/PROBLEMS:
Changes in approach and reasons for change

There have been no changes in our approach, nor are any changes anticipated. We performed a preliminary study related to Aim II ahead of sequence as the development of the collaboration website took slightly longer than anticipated.

Actual or anticipated problems or delays and actions or plans to resolve them

The initial step of creating the private portion of the Internet site which is tied to the secure data collection tool REDCap was delayed as Kate O’Neil took a leave of absence. However, we then accelerated the remainder of the website by engaging the bioinformatics team of the Department of Neurology to design the public portion and to begin adding the private portion. We also proceeded to accomplish a portion of studies related to Aim II ahead of schedule.

Changes that had a significant impact on expenditures

We delayed recruiting study subjects because of the delay in arriving at the expert consensus Case Definition. However, the majority of recruitment is scheduled beyond the first year.

Significant changes in use or care of human subjects, vertebrate animals, biohazards, and/or select agents

Nothing to report.

Significant changes in use or care of human subjects

Nothing to report.

Significant changes in use or care of vertebrate animals.

Not applicable.

Significant changes in use of biohazards and/or select agents

Not applicable.

PRODUCTS:

Other publications, conference papers, and presentations.

Preliminary results of studies related to Aim II were presented in poster form at two scientific meetings:


Website(s) or other Internet site(s)
The collaboration website for developing the Case Definition is under development and is part of an overall laboratory website that describes small-fiber polyneuropathy, associated research, and resources. It will also serve as an effective recruiting tool for Veterans and patients. The site can be accessed at [http://NeuropathyCommons.org](http://NeuropathyCommons.org).

**PARTICIPANTS & OTHER COLLABORATING ORGANIZATIONS**

What individuals have worked on the project?

<table>
<thead>
<tr>
<th>Name:</th>
<th>Anne Louise Oaklander MD, PhD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Role:</td>
<td>PI</td>
</tr>
<tr>
<td>Researcher Identifier (e.g. ORCID ID):</td>
<td></td>
</tr>
<tr>
<td>Nearest person month worked:</td>
<td>2</td>
</tr>
<tr>
<td>Contribution to Project:</td>
<td>Dr. Oaklander oversaw design of the collaboration website and provided content to the website, identified and invited the International collaborators to participate in developing the case definition, and contributed the analysis of relevant blood tests for neuropathy.</td>
</tr>
<tr>
<td>Funding Support:</td>
<td>No other funding support was used to conduct the work under this award.</td>
</tr>
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<table>
<thead>
<tr>
<th>Name:</th>
<th>Max Klein PhD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Role:</td>
<td>Co-Investigator</td>
</tr>
<tr>
<td>Researcher Identifier (e.g. ORCID ID):</td>
<td></td>
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<tr>
<td>Nearest person month worked:</td>
<td>3</td>
</tr>
<tr>
<td>Contribution to Project:</td>
<td>Dr. Klein obtained IRB and HRPO approval for this project and maintained IRB compliance. He also provided content to the collaboration website, arranged videoconferences with the global network of experts, discussed the case definition development with the experts, and advised on the Delphi Method.</td>
</tr>
<tr>
<td>Funding Support:</td>
<td>No other funding support was used to conduct the work under this award.</td>
</tr>
<tr>
<td>Name:</td>
<td>Kate O’Neil BS</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------------</td>
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<tr>
<td>Project Role:</td>
<td>Clinical Studies Coordinator/Research Assistant</td>
</tr>
<tr>
<td>Researcher Identifier (e.g. ORCID ID):</td>
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<tr>
<td>Contribution to Project:</td>
<td>Ms. O’Neil assisted with maintaining IRB (and HRPO) documentation, contributed content to the collaborative website, and advised on the design of the secure portion of the collaborative website in accordance with the Delphi Method.</td>
</tr>
<tr>
<td>Funding Support:</td>
<td>No other funding support was used to conduct the work under this award.</td>
</tr>
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<table>
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<tr>
<th>Name:</th>
<th>Heather Downs BS</th>
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<td>Project Role:</td>
<td>Histotechnologist</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Nearest person month worked:</td>
<td>1</td>
</tr>
<tr>
<td>Contribution to Project:</td>
<td>Ms. Downs contributed content to the collaborative website including detailed instructions on preparing skin biopsies, and processed administrative activities related to this study.</td>
</tr>
<tr>
<td>Funding Support:</td>
<td>No other funding support was used to conduct the work under this award.</td>
</tr>
</tbody>
</table>

Has there been a change in the active other support of the PD/PI(s) or senior/key personnel since the last reporting period?

There are no changes to report that impact personnel effort on this project.

What other organizations were involved as partners?

Nothing to report.

SPECIAL REPORTING REQUIREMENTS

None.
REFERENCES


ACRONYMS AND ABBREVIATIONS

<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>DEFINITION</th>
</tr>
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<tbody>
<tr>
<td>ACE</td>
<td>Angiotensin converting enzyme</td>
</tr>
<tr>
<td>AFT</td>
<td>Autonomic function test</td>
</tr>
<tr>
<td>ANA</td>
<td>Antinuclear antibody</td>
</tr>
<tr>
<td>AST/ALT</td>
<td>aspartate transaminase/alanine transaminase</td>
</tr>
<tr>
<td>C, C3, C4</td>
<td>Complement components</td>
</tr>
<tr>
<td>CMI</td>
<td>Chronic multisymptom illness</td>
</tr>
<tr>
<td>CWP</td>
<td>Chronic widespread pain</td>
</tr>
<tr>
<td>DOD</td>
<td>Department of Defense</td>
</tr>
<tr>
<td>ESR</td>
<td>Erythrocyte sedimentation rate</td>
</tr>
<tr>
<td>GTT</td>
<td>Glucose tolerance test</td>
</tr>
<tr>
<td>Hgb</td>
<td>Hemoglobin</td>
</tr>
<tr>
<td>HRPO</td>
<td>Human Research Protection Office</td>
</tr>
<tr>
<td>IgA</td>
<td>Immunoglobulin A</td>
</tr>
<tr>
<td>IRB</td>
<td>Institutional review board</td>
</tr>
<tr>
<td>MGH</td>
<td>Massachusetts General Hospital</td>
</tr>
<tr>
<td>PI</td>
<td>Principal Investigator</td>
</tr>
<tr>
<td>REDCap</td>
<td>The Research Electronic Data Capture platform</td>
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<tr>
<td>SFPN</td>
<td>Small-fiber polyneuropathy</td>
</tr>
<tr>
<td>SPEP/IFIX</td>
<td>serum protein electrophoresis and immunofixation</td>
</tr>
<tr>
<td>SS-A, SS-B</td>
<td>Sjögren's-syndrome-related antigens A, B</td>
</tr>
<tr>
<td>TTG</td>
<td>Tissue Transglutaminase Antibodies</td>
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APPENDIX 1. Poster presented at the 2015 Meeting of the Peripheral Nerve Society

COST/BENEFIT ANALYSIS OF BLOOD TESTS FOR CAUSES OF “IDIOPATHIC” SMALL FIBER POLYNEUROPATHY (SFPN)

Magdalena Lang MD1, Roi Treister PhD1, Anne Louise Oaklander MD PhD1,2
1 Department of Neurology, Massachusetts General Hospital, Harvard Medical School, Boston, MA, 02114, USA
2 Department of Pathology (Neuropathology), Massachusetts General Hospital, Boston, MA, 02114, USA

BACKGROUND

SFPN is a common and often disabling type of polyneuropathy. The common symptoms are sensory and dysautonomic, reflecting dysfunction of small-diameter unmyelinated and thinly myelinated peripheral nerves. Objective testing for SFPN is offered to patients with symptoms but no known causes (idiopathic). For this purpose, neurological societies recommend distal-leg skin biopsy measurements of small-fiber epidermal innervation, autonomic function testing (AFT) of carotidal, adrenergic, and sudomotor small-fiber function, and nerve biopsy in select cases.1 If these confirm SFPN, blood testing is recommended to look for occult causes.3 Testing is recommended for diabetes, dyslipidemia, low vitamin B12, paraproteinemia, celiac, Sjögren’s, sarcoidosis, and autoimmunity. Potential infectious causes include HIV, hepatitis C, and leprosy and Lyme in some locations. The diagnostic utility of each specific test is unclear despite several studies,4-6 and cost has only recently been considered.7

To evaluate diagnostic utility of commonly available neuropathy-related blood tests in patients with idiopathic SFPN and formulate evidence-based recommendations for testing in this setting we surveyed yield and cost of 21 blood tests in a large cohort with objectively confirmed predominantly idiopathic SFPN in the northeastern United States (New England).

METHODS

Study design: All patients with abnormal test results that objectively confirmed the presence of SFPN at MGH during calendar year 2013 were considered for inclusion. The tests reviewed were distal-leg skin biopsy, autonomic function testing (AFT) and surgical nerve biopsies.1 Patients also had to have at least one blood-test result available. IRB permission was obtained.

Blood tests studied: All commonly available 21 blood tests reported in the literature as useful for identifying causes of SFPN were studied (Table 1). Results from within one year before or after testing for SFPN were included. For repeated tests, the result from closest to the date of neuropathy test was used.

Cohort characteristics: Data regarding the most common symptoms of SFPN were collected from medical records to further characterize this cohort. Results of electrophysiological and nerve conduction studies (EMG/NCS) were also recorded.

Statistical analyses: SPSS for Windows version 19 (Chicago, IL) was used. Relationships between age, gender, and the prevalence of abnormal results of blood tests were analyzed using the McNemar test. Patients were dichotomized as young or old using the median age of 49 as the discriminator. Given the explanatory nature of this study, no corrections were made for multiple comparisons.

RESULTS & CONCLUSIONS

- Review of 415 records yielded 185 qualifying patients referred by 29 physicians.
- Patients were 70% female, 95% Caucasian, mean age 43.0 ± 18.0 years; 147 had SFPN confirmed by skin biopsy, 42 by AFT and 6 by nerve biopsies.
- Overall, 57% of patients had ≥ 1 abnormal blood-test result, among those with ≥ 10 tests, 91% had ≥ 1 abnormal result.
- The most prevalent blood-test abnormality was high angiotensin-converting enzyme (ACE), but no patients had sarcoidosis diagnoses or diagnostic chest imaging. High ACE may be linked to SFPN pathogenesis.
- 44% had blood-test abnormalities consistent with dysimmunity (ESR, ANA, C3, C4) suggesting possible associations and supporting routine testing.
- In this idiopathic SFPN cohort, the 2% prevalence of diabetes, 17% prevalence of prediabetes, and 24% prevalence of high triglycerides were less than prevalences in the general Massachusetts population.
- We did not find age or sex effects on test outcomes other than the high triglyceride levels being more common in males (p = 0.026).
- US government (Medicare) reimbursement for all 21 blood tests was $305.73 per patient. Factoring yield and cost generated the test groups shown below. These permit cost-effective sequential testing.

Cost/benefit analysis:

<table>
<thead>
<tr>
<th>Test</th>
<th>Prevalence of abnormal</th>
<th>Prevalence of abnormal (in testing)</th>
<th>Reimbursement for test</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALT (high)</td>
<td>44.9% (185)</td>
<td>26.7% (52)</td>
<td>$13.50</td>
</tr>
<tr>
<td>AST (high)</td>
<td>33.1% (123)</td>
<td>19.4% (43)</td>
<td>$14.50</td>
</tr>
<tr>
<td>Cre (high)</td>
<td>35.1% (137)</td>
<td>21.5% (44)</td>
<td>$15.00</td>
</tr>
<tr>
<td>ESR (high)</td>
<td>25.2% (104)</td>
<td>14.9% (33)</td>
<td>$16.50</td>
</tr>
<tr>
<td>CRP (high)</td>
<td>25.2% (104)</td>
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<tr>
<td>HbA1c (high)</td>
<td>20.2% (82)</td>
<td>11.5% (24)</td>
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<tr>
<td>TSH (low)</td>
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<td>$19.50</td>
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REFERENCES

APPENDIX 2. Poster presented at the 2015 Meeting of the American Neurological Association

Cost/Benefit of Blood Tests in Idiopathic Small-fiber Polyneuropathy (SFPN)

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ABSTRACT

Effective treatment of SFPN requires detecting and treating its causes. Since diagnosis is difficult, symptomatic people without known cause (“idiopathic” cases) are referred for objective test confirmation of SFPN. Patients with confirmed SFPN diagnoses then undergo testing for cause. This IRB-approved study evaluated the yield and cost of 21 widely available, approved test panels, and sequences for neuropathy causes. Inclusion required a physician’s impression of SFPN, confirmation during 2013 by an AAN-recommended objective test (autonomic function testing, PGP9.5 distal-leg skin biopsy, sensory nerve biopsy), and ≥ 1 blood-test result. The primary outcomes were blood-test diagnostic yield (% abnormal results) and cost, as approximated by Medicare reimbursement rates. Reviewing 415 records yielded 195 qualifying and included patients. They were 70% female, 95% Caucasian, with mean age 43.0 ± 18.6 years. Tests included potentially relevant abnormalities in 57%, most common high erythrocyte sedimentation rate (ESR, in 28%), antinuclear antibodies (ANA ≥ 1:160; in 27%), hyperglycemia (in 25%), and low complement C4 (in 16%). 42% had ≥ 1 dysimmune marker (ESR/ANA/C4). The most prevalent abnormality was high angiotensin-converting enzyme (ACE, 45%), but no patients had sarcoidosis, so specificity must be considered. Per-patient reimbursement for all 21 blood tests was $305.73. We integrated each test’s yield and cost to generate recommendations for cost-efficient sequential testing in northeastern US.

BACKGROUND

Small-fiber neuropathy (SFPN) causes common, subjective, and non-specific cardiovascular, gastrointestinal, and sweating complaints plus widespread chronic pain, so confirming the diagnosis in patients without known risk factors (e.g., diabetes, chemotherapy) requires objective test confirmation. If SFPN is confirmed, multiple blood tests for occult causes are recommended, but their diagnostic value is uncertain. The aim of the current study was to evaluate the diagnostic performance of the commonly available neuropathy-related blood tests in a large cohort of patients with objectively confirmed predominantly idiopathic SFPN in the northeastern United States (New England).

RESULTS

- Reviewing 415 records yielded 195 qualifying patients of 29 physicians.
- They were 70% female, 95% Caucasian, with mean age 43.0 ± 18.6 years.
- 147 had their SFPN confirmed by skin biopsy, 42 by AFT and 8 by nerve biopsies.
- Overall, 57% had ≥ 1 abnormal cohort-level result.
- The most prevalent blood-test abnormality was high angiotensin-converting enzyme (ACE) in 44.6%.
- We found no age or sex effects on test outcomes other than high triglycerides tending to be more common in males (p = 0.017)

CONSIDERATIONS FOR CLINICAL USE

None among the patients with high ACE had sarcoidosis diagnoses or sarcoidosis revealed by chest imaging. Thus, routine testing for ACE is not necessary in this setting.

The 44% prevalence of blood-test abnormalities consistent with dysimmune/inflammation (ESR, ANA, C3, C4) suggests a possible association meriting further study.

Among these idiopathic SFPN patients, the 2% prevalence of diabetes and 17% prevalence of prediabetes were less than in the Massachusetts population (2010 census) suggesting that occult hyperglycemia is rare in this setting and costly testing for it is not necessary.

The 24% prevalence of hyperglycemia in this cohort was less than the prevalence in the census-measured Massachusetts population suggesting no specific association nor need for testing.

Diagnostic yield, cost, and specificity can be integrated for cost-effective screening for causality in patients with idiopathic SFPN.

REFERENCES


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