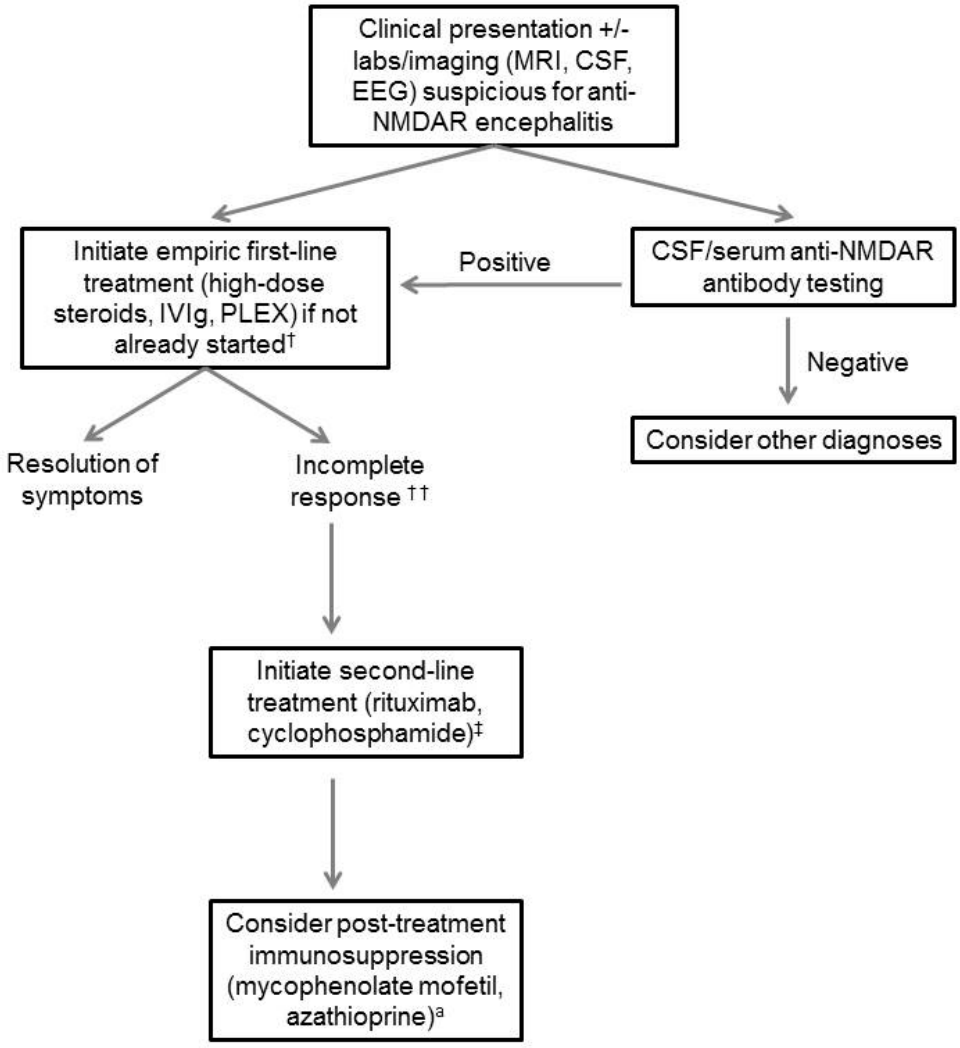
Figure e-1. Treatment of anti-NMDAR encephalitis.



Footnote:

† One group has advocated concurrent IVIg (0.4 g/kg/day for 5 days) and methylprednisolone (1 g/day for 5 days) for first-line treatment.[a] A slow taper of methylprednisolone over several weeks following the 5-day course may also be considered.[b] Some patients may benefit from PLEX before rather than after IVIg.[c]

†† The exact timing of when to proceed to second-line agents is not clear. Some groups advocate waiting 10-14 days[a,d] to allow for first-line therapies to work, although other groups

proceed more quickly to second-line immunotherapy.[b] In general, aggressive treatment is advocated, as shorter time to treatment is significantly associated with lower modified Rankin scores at 24 months.[e]

‡ Rituximab or cyclosphophamide may be used for second-line therapy. One protocol has proposed concurrent rituximab and cyclophosphamide administration.[a] The benefits of concurrent administration should be weighed against the highly toxic side effects of cyclophosphamide, involving up to 40% risk of ovarian failure, especially in women of reproductive age.[f]

References: [a]Dalmau et al., Lancet Neurol 10(1):63-74; [b]Lancaster, J Clin Neurol 12(1):1-13; [c]Pham et al., J Clin Apheresis 26(6):320-325; [d]Way et al., Neurology 86(16 Supplement): P3.245; [e]Titulaer et al., Lancet Neurol 12(2):157-165; [f]Clowse et al., J Women's Health 18(3):311-319.