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Retina Case Review: Translating the Data Into Care

Announcer:
Welcome to CE on ReachMD. This activity, titled Retina Case Review: Translating the Data Into Care is provided by Prova Education.

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Dr. Borkar:
Second-generation anti-VEGF agents and devices are becoming integral to our practice as retina specialists. Which patients should we consider for these treatments, and when? This is CE on ReachMD, and I'm Dr. Durga Borkar.

Dr. Sheth:
And I'm Dr. Veeral Sheth. That's a great question, Durga. Often, I like to start using these agents in treatment-experienced patients. How have you been using aflibercept 8 mg?

Dr. Borkar:
Very similarly, actually. So I'll show you a case. This is a patient of mine, a 77-year-old phakic woman who comes in with 2 weeks of increased distortion and decreased vision in the right eye. She does have cataracts that are becoming visually significant and is a glaucoma suspect. Other than knowing that she had early dry AMD, that it's been about 2 years since her last exam, she's been doing fairly well. So she comes in and her initial presentation, she's 20/60 in the right eye, and you can see that she has this fibrovascular PED, with quite a bit of subretinal fluid there that explains the symptoms that we're seeing. And then her visual acuity in the left eye is 20/25 and has dry AMD.

So for her initial treatment, because of an insurance mandate for at least 1 bevacizumab injection, I started her on bevacizumab. Brought her in 4 weeks later, her vision's the same. Subretinal fluid is a little bit better, but not much—certainly not acceptable or what we'd consider control. So at this point, I could continue her on the bevacizumab, but I am able to actually switch her to aflibercept 2 mg.

And so for these patients where I see kind of an incomplete response with that first injection, I do tend to load these patients when I'm able to switch. So I switched her to aflibercept 2 mg, and gave her 3 injections every 4 weeks. And you can see she's doing a lot better. She's dry. Her vision's improved to 20/50, the height of that PED has gone down.

Now I've gotten her to about a 6-week interval. She's 20/50, she's looking pretty good on aflibercept 2 mg, and now she really wants to go ahead with both cataract surgery and MIGS. What do you do at this point, Veeral? Do you tend to continue to try to extend these patients? Kind of hold the status quo until they're done with their surgery? What's the best way to manage this?

Dr. Sheth:
Yeah, I don't like to change too many variables at the same time, so here I would feel more comfortable just keeping that interval intact.

Dr. Borkar:
Yeah, and that's exactly what I did here. So I kept her at 6 weeks. She got her injection and came back 6 weeks later. She had cataract surgery, had the MIGS procedure, and it's interesting, her vision is a little better, of course. Now she's pseudophakic. She's 20/40, but you see that there's quite a bit of subretinal fluid that has recurred, which I didn't see before. At this point, I know sometimes we tolerate a little bit of subretinal fluid. This is a little bit more than what I would tolerate, and I certainly feel like I can't extend her at this point. What are your thoughts, Veeral, on what I could do next?

Dr. Sheth:
Yeah. I mean, you have kind of 2 thoughts or 2 options. You can shorten the interval, which the patient doesn't want to do, or you could switch to one of the newer-generation agents. In this case, she's doing pretty well with 2 mg, so maybe switching to 8 mg.

Dr. Borkar:
Yeah, I think that's a great point. And I think that's often how I'm deciding. There's a lot of 2 mg patients who are doing okay, but the durability is not quite there, and so I will switch them over.

And for this patient, she started at 20/40. When I switched her over to aflibercept 8 mg, I did do 3 loading doses. I think in the trial setting, we think of that as every 4 weeks. In the real world, that usually ends up being every 4 to 6 weeks because of scheduling. And so I did the 3 loading doses, and she comes back. She's 20/30, and dry. You can see that she's looking pretty good.

So at this point, I'm able to extend by 2 weeks and maintain a treat-and-extend regimen. And her current interval is 12 weeks, which is pretty good given where she started with that initial bevacizumab injection coming in 4 weeks later with still a lot of subretinal fluid present. She's 20/30, dry. And I think at this point, I can continue to extend her, especially in the context of what we see in some of the clinical trials in terms of how far out some of these patients can get. So, I think she did really well.

Dr. Sheth:
Yeah, it's a great outcome. I mean, just from a quality-of-life standpoint, to get that extension in intervals and not having to come see you as often, I think is a big benefit to the patient.

Dr. Borkar:
Absolutely. She's been really happy with it. A majority of patients in clinical trials are treatment-naïve. Have you been initiating treatment with any second-generation agents with your patients?

Dr. Sheth:
Yeah, I have been. So I can give you an example of a diabetic macular edema patient of mine. This is a patient with DME. The DME was diagnosed a couple of years before I show you these initial pictures. Has had a 10-year history of type 2 diabetes, like many of our patients. And you'll see, I kind of offer her treatment at her initial diagnosis, and she declines—unlike many of our diabetic patients who are younger, don't have a lot of time to come in for repeated treatments. And so this patient, in particular, gets lost to follow-up for 10 months. And I'll show you what happens here.

So, Durga, here she is. She's, on presentation, 20/50. And you can see lots of intraretinal fluid. So this is a patient that I certainly offer treatment to, but like I said, she just didn't want to proceed at that point and is gone for 10 months. And she comes back. And you can see on the right here, she's now 20/80, having much more difficulty at work. She's a paralegal and on the computer a lot, and she's having much more difficulty and having more difficulty driving. And so again, like many of our patients, this is what really kind of gets them back into our offices and more motivated for treatment.

And so at this visit, because of how much fluid there is, because of the hyperreflective foci, I know some of these later-generation agents—in this case, faricimab—might have been the best fit for her, and that's what I started with. And you can see almost immediately some improvement in her intraretinal fluid. This is 4 weeks after her first injection. Some improvement in vision—it was 20/80 and now it's 20/60. You see some improvement in CST. And so we decided to kind of continue on the path. This patient is now kind of buying in, is seeing that she's seeing better and happy with the treatment.

So we give her another faricimab. You can see she's 20/50 after that second one. CST is coming down, much less fluid, still quite a few

hyperreflective foci, as you can see.

And then we treat her again. So she's kind of in that loading phase. She's at 20/40 now, CST has come down quite a bit. She's at 369.

And then I give her her fourth faricimab, and at this point I extend her out. Now, I may not have extended her out, but there's a little bit of debate going on with this patient, as you know, and I'm sure you have experienced. And she does pretty well. And she comes back 8 weeks later, and you can see she's continuing to improve, less fluid, and now she's at 20/25 vision. And so, there's still some back-and-forth negotiation.

I do give her another faricimab. I see her after 8 weeks, and at that time, she's 20/25, she's got some fluid. I offer treatment, but she says, 'Look, Doc, I don't want to have an injection today. I feel like I'm doing pretty well.' So I let her go another 8 weeks, and you can see on the right she comes back. So now 16 weeks after her most recent injection, still maintaining good vision, 20/25, she's got some fluid, so I offer treatment again. And she does take that treatment because she knows it's been about 4 months and she doesn't want to go backwards. And she does well. So she's at 16 weeks after faricimab number 6—20/25 still, so maintaining good vision. CST is coming down.

And then I give her another faricimab, have her come back in 16 weeks again. And she's doing quite well at that interval. And so we kind of march along, and she's now, I can tell you, 20/25 and at a 6-month interval between her injections.

And so just shows you that you get kind of rapid reduction in fluid, and you can extend pretty quickly in these patients and still get good results. You can see here at the end, she's at a 6-month interval, but she's also got no intraretinal fluid and no hyperreflective foci. So, a good result.

For those just tuning in, you're listening to CE on ReachMD. I'm Dr. Durga Borkar, and here with me today is Dr. Veeral Sheth. Today, we're discussing how to individualize management plans using second-generation retinal treatments.

Durga, I got a question. I extended her pretty rapidly, not on purpose, after a little bit of negotiation. How do you feel these days about extending patients quickly once they've started the medications like faricimab?

Dr. Borkar:
Yeah, I mean, I think a couple things here. Looking at those CST values and the vision, certainly by clinical trial standards, she would meet extension criteria for a lot of the trials with those CST values and that good vision. And so I think that makes a lot of sense. I know a lot of our DRCR studies have also suggested the vision's 20/25, it's okay to extend.

I also think you're having very different conversations sometimes with these DME patients compared to AMD. She's 45, she's working, that treatment interval really matters to her, so much so that she came in initially with a CST of 379, and she really didn't want an injection. I mean, I've had that conversation so many times. And so you kind of know what her focus is on, and I think it's reasonable to try to extend as much as possible. Which, I mean, she had a great outcome and is doing well with an extended treatment interval. So that's great. Really great outcome for severe case of DME.

And the port delivery system is now approved for DME as well. Would you consider using it in a patient who struggles with follow-up?

Dr. Sheth:
Yeah, absolutely. So I mean, to tie into this last patient, quality of life—you mentioned it—she's not coming in as often. And I think that kind of concept really holds true with port delivery system. Because if you can extend patient's interval out and they're coming in for refills at 6 months, I think those patients really benefit.

So I have a woman in my clinic that I saw pretty recently, she's pseudophakic, she's been treated for neovascular AMD for a while. She's got a little bit of GA—geographic atrophy—in the right eye as well, and she's kind of needing quite a few treatments. So her treatment burden is pretty high. She's getting faricimab in both eyes every 6 to 8 weeks for over 2 years. And anytime you try to extend her, you see some fluid. I'll show you a little bit of that here, too. And she's also getting pegcetacoplan every 8 weeks for her right eye GA. She's very motivated.

And the biggest kicker, she splits time between Illinois and Connecticut. She's got a son here in Illinois, where I practice, and a son in Connecticut, and she splits time. And so she's having more and more difficulty coming in every 3 or 4 weeks, whether it's for her neovascular AMD injection of faricimab or GA treatment, and she's finding it difficult. She feels like she's becoming a burden on her kids. And so she's very motivated to really decrease the treatment burden.

So I'll kind of walk you through it here. This is her initial presentation to me. So those 2 years of faricimab and pegcetacoplan injections were at an outside clinic. So she comes to me, and you can see her right eye, which is her better-seeing eye at 20/40, also has GA, which is why she wants both treatments for neovascular AMD and GA. And you can see in the left eye there's some subretinal fibrosis. She's about 20/120. And her last injections were about 5 weeks ago, and so you can kind of see what stable is for her.

She comes back a few weeks later. So that was my first visit with her. I said, come back in a couple weeks, let's take a look and see. And you can see, just 2 weeks later, she's got subretinal and intraretinal fluid in that right eye—again, that's her better-seeing eye. And I treat her. So I treat her right there with faricimab, and we start planning for the left eye for port delivery. Again, now we're kind of going into that, like, let's decrease your treatment burden mode. So we treat her in the right eye. We start planning for the left eye.

You can see a couple weeks later, the right eye is doing much better. So it responds very well to the faricimab. And so moving forward with the left eye, we implant the port delivery system with the ranibizumab. She receives it. The surgery went well, and she gets refilled 7 months later. Now, if you remember that vision in that eye was 20/120, and I can tell you that looking at that eye, I thought that was probably the best she was going to do, because there was some subretinal fibrosis there. But she actually improves vision.

So I think that says something about continuous delivery of medication to these patients and really suppressing the disease, because she improves to 20/80 and she notices that the vision is better. And so, I was able to refill her.

And really along that same time, we're talking about now doing the same treatment in the right eye, because she's seeing the benefits. She hasn't had to come in as often for that left eye treatment. We've really been focusing on the faricimab and GA therapy in the right eye. So she says, ‘Doc, if you think we can do the right eye, let's go ahead and do the right eye.’ And so we go ahead and move forward with that right eye as well.

And she does very well. So this is 6 weeks after her right eye implantation. So she's 20/40, CST is 199, and it's dry, I guess, more importantly. And the left eye is kind of maintaining good vision at 20/80. So this patient does really well.

And really at the end of the day, instead of coming in every 2 or 3 weeks, which is what she had done prior to the port delivery implantation, now that she has it in both eyes, she's really getting refills every 6 months in each eye, and she's coming in twice a year. And that's really kind of helped from a quality-of-life standpoint.

So that's the kind of thing where I think port delivery system is tough. It's a surgical approach, but certainly for patients like this, it can make a difference.

Dr. Borkar:
Yeah. I mean, this is a great outcome, and I can really see how a sustained-delivery device is a good option for this patient. And really nice to see how it also allows her to leverage some of the other newer geographic atrophy treatments that are out there, because otherwise it becomes a lot—even just in terms of tracking the schedule of alternating these injections for the patient. And so this is nice for her for multiple reasons, I think.

Dr. Sheth:
Yeah, absolutely. And I didn't even mention the GA therapy. So this is kind of freeing her up to also treat that aspect of it, right? And so there was a point where she felt like she had to choose, and now she's kind of able to really kind of treat all aspects of her macular degeneration. So that's good to see.

Dr. Borkar:
Well, that's all the time we have for today. Thank you to our audience for joining us, and thank you, Veeral, for being here.

Dr. Sheth:

Thanks for having me.

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