Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/a-closer-look-at-real-world-strategies-for-treatment-resistant-dme/15856/

Released: 08/31/2023
Valid until: 08/31/2024
Time needed to complete: 23m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

A Closer Look at Real-World Strategies for Treatment-Resistant DME

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

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Borkar:
Anti-VEGF therapy is a mainstay of treating DME, but a notable proportion of patients fail to achieve a sufficient response despite monthly injection. How should we be managing these patients now that a new anti-VEGF, anti-Ang2 treatment is available?

This is CME on ReachMD, and I'm Dr. Durga Borkar.

Dr. Weng:
I'm Dr. Christina Weng.

We know from trials like PROTOCOL-T from the DRCR [Diabetic Retinopathy Clinical Research] Retina Network that despite the effectiveness of anti-VEGF therapy, a substantial proportion of patients will have persistent fluid. And until recently, the options were either to pursue an intraclass switch to a different anti-VEGF drug or an interclass switch which typically meant turning to intravitreal steroids. However, faricimab, which was FDA-approved in 2022, now represents another option. Based on the YOSEMITE and RHINE phase 3 studies, which did include treatment-experienced DME patients as approximately a quarter of the cohort, faricimab demonstrated noninferior visual and anatomic outcomes compared to aflibercept, given on a Q8 week basis, but with some impressive durability results, with over 75% of eyes reaching at least a quarterly dosing interval. That being said, we also saw that there was a small proportion that still required Q4-week dosing of faricimab, speaking to the heterogeneous nature of DME.

Durga, what's your approach to patients with difficult-to-treat DME?

Dr. Borkar:
That's a great question. I think, as you've mentioned, we now have a broader array of agents, and the fact that faricimab has an expanded mechanism of action makes me think about this a little earlier and maybe instead of an initial switch to steroids. If I've treated with another anti-VEGF agent for 3-6 injections every 4 weeks, and there's still persistent center-involving macular edema, I consider switching earlier rather than later. And what we saw in FARETINA was that, you know, almost 90% of patient eyes were treatment-experienced in the FARETINA-DME study, and most were aflibercept switchers. Even in this group of presumably somewhat refractory cases, more than 60% of patient eyes were able to be extended beyond 6 weeks after just 1-2 injections, which speaks to some observed effect by physicians even though we don't currently have anatomic data. But I think there's a subgroup of patients who really have a more inflammatory component to their DME, as you mentioned, and those patients maybe need steroids earlier.

So I also think about steroids not just for patients who are not responsive to anti-VEGF or faricimab treatment, but also for those patients who need Q4-week injections with the hope that a transition to steroids will give them a more durable option. And a few studies have really highlighted that impact on durability. Those are the REINFORCE and USER studies. What we saw in REINFORCE, which was a

study evaluating the dexamethasone implant with or without anti-VEGF treatment – it was a prospective, phase 4, observational study of 180 eyes – was that there was a very durable treatment effect. The mean treatment interval was approximately 5 months. And the safety signals were typical to what we expect with steroid treatment. Approximately 23% required IOP-lowering medication, and 8% had cataract surgery during the study period.

When we look at the USER study – this was a retrospective chart review of 160 eyes treated with the fluocinolone acetonide, 0.19-mg implant – what we saw was that the mean treatment interval was over 14 months, which is excellent in terms of durability. And again, safety was very similar to what we've seen with other steroid studies. About 30% required IOP-lowering medication, and 23% who were phakic at baseline, so patients are getting steroid treatment who are phakic. I think that's important to remember when we think about when and where to use steroids.

Dr. Weng:
Well, thanks for providing those insights. I think if I had to summarize all the terrific information that you've shared, it really comes down to 3 points. First, as effective as they may be, these first-generation anti-VEGF agents have limitations in DME which is a complex, multifactorial, and heterogeneous disease, and a substantial proportion of eyes may not respond completely. The second point is for treatment-resistant eyes, there are several approaches to consider, including increasing the treatment frequency or switching within a treatment class, switching to a different treatment class, as you alluded to, or even using combined treatment. And finally, the third takeaway is that the choice of which approach to take should really be individualized to the specific patient and their needs. Some of the considerations that you may think about include age, phakic status, ocular comorbidities, DME duration, prior response, and of course anatomic characteristics. But bottom line, we don't treat averages or images. We treat the patient sitting in front of us in the chair.

Dr. Borkar:
I couldn't have said it better, Christina. Well, that's all the time we have for today. Stick around as we take a look at some patient cases.

Dr. Weng:
Stay tuned!

Announcer:
You have been listening to CME on ReachMD. This activity is provided by Prova Education and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/Prova. Thank you for listening.