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Precision Medicine for gMG: Tailoring Treatments Based on Patient Profiles

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Dr. Bril:
This is CME on ReachMD, and I'm Dr. Vera Bril. Here with me today is Dr. Nicholas Silvestri.

Dr. Silvestri, we have reviewed both traditional and new and emerging agents for managing gMG. With this as background, how do we match a therapeutic approach to a given patient? Better yet, how do we develop a sequential treatment plan for each patient, considering the typical patient journey with gMG?

Dr. Silvestri:
Thanks, Dr. Brll. These are great questions. I think, first and foremost, when we think about how to design a treatment plan, it goes back to one of our previous episodes when I talked about the importance of understanding the patient's serological status, right? Because I think what's available to us and what we know works well, for example, in patients with acetylcholine receptor-positive disease is very different from what works in a patient with MuSK disease.

If I just briefly talk about MuSK-positive disease first, again, we know that B cell therapy is very effective in MuSK disease. And often after making that initial diagnosis and stabilizing a patient out on, let's say, corticosteroids, I'll often go to B cell therapies early on in order to get control of the disease, but also allow me to taper a patient off of steroids. And sometimes the effect of B cell therapy is quick, and sometimes it's very long-lasting.

And another aspect of it that's important to know is that patients with MuSK myasthenia may not respond well or may worsen with drugs like pyridostigmine or IVIG. So it's important to make these diagnoses serologically.

When it comes to acetylcholine receptor-positive patients, it's a little bit more difficult, because I think that, as you well know, myasthenia gravis is considered the snowflake disease, or called the snowflake disease, whereas no patient presents very similarly. And I would say that gives us a little bit of a run for our money when it comes to developing treatment plans, at least on an algorithmic approach. That being said, generally speaking, I think the traditional approach is to stabilize a patient on the lowest possible dose of steroid and then transition them to another agent. Traditionally, those agents have been oral immunosuppressants. But over time, we could think about transitioning patients to some of the newer targeted therapies such as FcRn antagonists or complement inhibitors.

I think it's important to take certain patient characteristics into consideration when coming up with our treatment regimen, such as the severity of disease. In other words, which patients do we need to get control of faster? Have patients had frequent myasthenic crises? What are patients' medical comorbidities? And are there relative contraindications to certain agents that we can use? These are all things that I take into account when tailoring therapies to patients so that I come up with the right treatment regimen for them.

So I think that an important point that I'll make is though we have guidelines, and though we have a number of agents available to treat

patients, again, based on characteristics like their serotype, based on their disease severity, based on their medical comorbidities, there really isn't an algorithmic approach to every patient with myasthenia. You have to take these considerations into mind when you're coming up with the right therapeutic approach for each individual patient.

Dr. Bril:
Thank you, Dr. Silvestri. I would agree very much.

And I think it is so important in this disease, which is so heterogeneous and different from patient to patient, that we have to gradually establish that relationship with the patient, and trust, so that they understand what we're suggesting they do and why we're suggesting it, that they understand the risks and benefits of each therapy. And the expectations of the outcomes, because not every patient will respond to the same therapy or the same drug, so that there's not 100% response rate to any treatment. So we have to be cognizant of these concerns in the patient. And also take our time over several visits to establish that trust and that knowledge base with the patient who may never have heard of this disease before you make the diagnosis in the clinic.

With that, our time is up. Thanks for a great discussion, Dr. Silvestri. And thanks to our audience for tuning in.

Announcer:
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