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Reconsidering the Algorithm: DME

Announcer:
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Dr. Weng:
We've been discussing clinical trial and real-world data around more durable treatments for diabetic macular edema. So let's take a closer look at efficacy with some actual patient cases.

This is CME on ReachMD, and I'm Dr. Christina Weng.

Dr. Borkar:
I'm Dr. Durga Borkar, and I've got a case here.

This is a 65-year-old phakic woman with moderate NPDR [non-proliferative diabetic retinopathy] with diabetic macular edema in the right eye. Her past ocular history is significant for cataract and ocular hypertension in both eyes. At presentation, she is 20/50, and you can see that she has significant center-involving diabetic macular edema, including some subretinal fluid as well.

I initially tried to treat her with aflibercept every 4 weeks for 4 injections, and you can see that there was a marginal improvement in her center-involving DME and visual acuity. She went from 20/50 to 20/40, but still with pretty significant, persistent edema. At that point, faricimab was not available yet – I may have considered it earlier. So I decided to transition her to intravitreal triamcinolone, just to see how she would do with steroids, although we know that not all patients respond to each steroid the same way in terms of their IOP response. I decided to try this before a longer-acting implant and started her at a 2-mg dose, because there is some data to suggest a slightly lower incidence of ocular hypertension in these patients. So after I tried that for 2 injections, I saw that she did improve, but she still had an incomplete response. At that point, faricimab became available, and what was great to see was that her center-involving DME significantly improved, and I was able to extend her to Q6-week treatment before her initial 4 loading doses. Her vision improved from 20/40 to 20/25, and her CST improved significantly.

I would say some of the key points here are that I would consider switching to faricimab early, if patient is not responsive, and really it would be wonderful to be able to start some of these patients initially on faricimab, which is now more of an option, given that it's readily available at multiple academic centers as well. And it may be a helpful option to avoid steroids in phakic patients or patients with glaucoma. We know that some of the patients with glaucoma do tolerate steroids well, with just additional topical treatment, but it is still a risk to take. So it's nice to have this additional option in our armamentarium.

It's also interesting to just think about how quickly we are able to extend some of these patients. You know, typically, on-label use would require four Q4-week loading doses, but what we saw in FARETINA and what I am seeing in my practice is that we're not necessarily doing that all the time.

Dr. Weng:

Great case, Durga. I think there's really 2 points that are highlighted by your case. First, this eye did have a response, but not a complete response, as you said, to an anti-VEGF and a steroid, and a switch to faricimab was able to finally get the retina dry. You know, while it's impossible to tease out the anti-VEGF component from the anti-angiopoietin 2 component of this bispecific molecule, this case certainly suggests that the additional blockade of Ang2 may be beneficial. And second, I noticed that you did load the patient with 4 monthly faricimab injections, and this is really less of a statement than it is a point of discussion, but it will be interesting to learn how treatment regimens are adopted in the real world, not only in terms of loading, but also in the increments and thresholds used in extending and contracting intervals.

Dr. Borkar:
Those are great points, Christina. I think one of the challenges with evaluating durability in the real world is balancing physician intention and patient follow-up patterns. In my patient case, I had initially tried to load them and treated them Q4 weeks for the first 2 injections. But with the third injection, she came back after 6 weeks. She looked good at that point, and so I continued her on Q6-week treatment. But it just reflects how, in the real world, durability is not always measured according to strict re-treatment criteria.

Dr. Weng:
Yeah, you're absolutely right, Durga. I'm so glad you brought up that point, because I recently actually presented, on behalf of our study group, a paper that we've been working on, looking at that very question. And just bottom line, we looked at patients who were treated with anti-VEGF injections and looked at the delta, or difference, between the intended follow-up versus the actual follow-up. We were very surprised to find that almost a quarter of injections were given at least 7 days later than intended, so it's really important that we continue to focus on this very important issue.

Dr. Borkar:
Those are all excellent points, Christina. We'll be talking more about treatment-resistant DME in our next episode, so stay tuned.

Dr. Weng:
See you soon.

Announcer:
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