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Early Fluid Resolution – A Key to Long-Term Success

Dr. Rahimy:
What is the best way to use second-generation agents in the real world to best benefit our patients? I'm Ehsan Rahimy, and joining me today is Roger Goldberg. Welcome, Roger.

Dr. Goldberg:
Thanks for having me, Ehsan. I want to show you a case here of a patient I switched from 2 mg aflibercept to 8 mg aflibercept as I think sometimes having a real-world example shows the benefit of these second-generation agents. So this is a patient of mine who had received 48 2-mg aflibercept injections. They've been doing well. I was very happy here. The patient is 20/40, and you can see there's a fibrovascular EPD, there's some serous component to that as well; it's not all fibrovascular tissue. And then a little bit of subretinal fluid. And as we've talked about, hey, maybe a little bit of subretinal fluid at the edge of the pigment epithelial detachment you can tolerate. But I decided to switch this patient to 8 mg aflibercept when that became available to us. And what you see here is not only a resolution of the subretinal fluid, but a dramatic reduction in the height of the pigment epithelial detachment, which I think reflects resolution of the serous component of the PED. And amazingly, the vision had improved, actually, from 20/40 to 20/25, and the patient noticed it. And so to me, this is always just a reminder that, hey, maybe we can do better for our patients, even though I thought I'd been doing really well with this case.

Dr. Rahimy:
That's a wonderful case. Thank you for sharing that. I think we both agree we've seen better fluid resolution overall with these second-generation agents that are more durable.

Here's a case I'd like to share as well, too. This is a gentleman well known to me. He had exudative AMD in the right eye, presenting visual acuity of 20/50, starting with some intraretinal fluid/subretinal fluid. And as we can see here, he was initially maintained on bevacizumab for over a year. His visual acuity stayed roughly the same. And then we started to see a lack of control at 8-week intervals. It got worse after having cataract surgery. We saw quite a bit of subretinal fluid. And then the fluid was essentially well controlled after switching to faricimab therapy.

And number one, we're having better control of the exudative process. His visual acuity actually improved. But more importantly, I think, to this particular individual, is that his treatment interval has been substantially extended, initially out to 12 weeks, and now out to every 16 weeks.

Dr. Rahimy:
So Roger, a question for you, if the improvements in vision are similar between these second-generation agents and their predecessors, ultimately, what's the value proposition for a patient to use these agents?

Dr. Goldberg:

It's a great question, and I think it's almost a little deceiving, because yes, the clinical trials are designed to show a noninferiority, but we're not treating the average of 1,000 patients. We're treating the individual patient in front of us. And at least my goal, and I suspect your goal, and most every other retina specialist's goal out there, is to try to achieve the best outcomes as possible, as quickly as possible for them. And that includes early resolution of the fluid, as rapid improvement in the vision as possible, and then trying to maintain those gains with as few injections as possible. And I think that's really what these next-generation agents are offering us.

Dr. Rahimy:
Yeah, I wholeheartedly agree. Well stated.

Dr. Goldberg:
One question I had on this is, do you have any worry or concern? Fascinatingly, the left eye has turned out to be the worst-seeing eye. The right eye, you've extended out to 16-week intervals on faricimab. Any concern about extending that far in what's now essentially a monocular patient?

Dr. Rahimy:
That's a wonderful question. I do have this concern, I think actually potentially more for my diabetic patients than my new vascular AMD patients. And you nicely pointed out when we have some of our patients where this is their monocular eye getting treatment and it's their better-seeing eye, I have to try to encourage them to extend.

So while our patients appreciate the availability of these next-generation agents with the opportunity to extend, I've been quite surprised at just how many patients don't necessarily want to go out that far in some cases, especially if it's their monocular or better-seeing eye.

Unfortunately, this is all the time we have for today. Thank you, Roger, for joining me, and thank you to our audience for listening.

Dr. Goldberg:
Thank you.