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Real-World Adaptation of Trial Protocols

Dr. Goldberg:
We all want the longest dosing interval possible for our patients. So how do we get there with second-generation agents? I'm Roger Goldberg, and joining me today is Dr. Ehsan Rahimy.

Dr. Rahimy:
Roger, thank you. It's great to be here. I think that's a great question. At least in my real-world clinical experience, I've been able to extend patients out at various intervals, out to as far as 16 weeks.

Here's a nice example I'd like to share in a patient with retinal vein occlusion. This gentleman initially presented to me, he had several bevacizumab injections. He was subsequently transitioned to aflibercept. The aflibercept worked quite well for him. This is 2 mg of aflibercept. However, I could really never extend beyond a 6-week interval here. Here's an example of his recurrence of fluid. He'd get intraretinal fluid and a little bit of subfoveal fluid if he even went 7 weeks or 8 weeks. And his visual acuity would drop to 20/80 at least at this particular visit. And then you can see that when he at least stayed in his 6-week interval, his visual acuity is relatively well preserved at 20/30. However, this particular patient was just increasingly frustrated with the injection burden and really wanted to find a way to extend out his treatment interval.

So at one visit, I gave him an intravitreal injection of a dexamethasone implant, and two things happened. Number one, he had a pronounced steroid response. His pressure went as high as 45 mm Hg, and subsequently required IOP drop-lowering therapy, and he subsequently did not want further treatment with this. Number two is he was only actually able to extend out as far as 10 weeks, and then you saw a really pronounced rebound effect with fluid, worse than I had even seen in that presentation. So once faricimab came available, he was quite excited to try this option. And here he is after the very first dose of faricimab. I had him come back in 4 weeks. He was completely dry. And we've been able to gradually extend this patient out now to a 12-week dosing interval. So he is particularly pleased. His visual acuity is preserved at 20/25 and we've reduced injection burden by basically half over an annual course.

Dr. Goldberg:
That's really a phenomenal case, and great to talk about retinal vein occlusion, which I think is often kind of the neglected stepchild of retinal vascular disease, as we spend so much time talking about wet AMD and DME so thanks for including an RVO case.

This is an interesting case of a patient of mine who I'd been following for intermediate AMD. They came in for their routine 6-month follow-up and really had no symptoms. Visual acuity was excellent. And I noticed on the OCT that there was a small amount of subretinal fluid, again, nonfoveal, not affecting the central subfield thickness. And again, because the patient was asymptomatic, I said, let's just keep an eye on it. I wasn't ready to treat this patient. And lo and behold, they came back 3 months later, and the fluid had spontaneously resolved. And I felt
pretty good about myself. But I knew, like to me, this was a little bit of a red flag that this is definitely a patient who's at high risk of developing true exudative wet macular degeneration. And lo and behold, they came in, it ended up being 2 years later, with true wet AMD here, with serous PED, a fibrovascular PED, intraretinal fluid. And this patient ended up going on therapy.

But I just thought it was a neat case that really highlights kind of thinking about when we start treatment, whether it's a patient with nonexudative macular neovascularization or a little bit of subretinal fluid at the edge of a PED. And I still find either OCT angiography or traditional fluorescein angiography can be helpful in these cases.

Dr. Rahimy:
I think that's a wonderful case to show. And I think you did the right thing, which was the moment you saw that initial fluid, you flagged it. It's important to continue to monitor that patient, whether or not you decide to treat in the first place.

Dr. Goldberg:
Yeah, and I shorten the interval of follow-up. I kind of reviewed Amsler very closely.

Well, our time is up today. Thank you, Ehsan, for being here, and thank you to our audience for listening.

Dr. Rahimy:
Thanks for having me, Roger.