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https://reachmd.com/programs/cme/So-You-Think-You-Want-a-TKI/54102/

Released: 03/04/2026
Valid until: 03/04/2027
Time needed to complete: 35m

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So You Think You Want a TKI?

Announcer:
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Dr. Weng:
Welcome to CE on ReachMD. I'm Dr. Christina Weng, and here with me today is Dr. Katherine Talcott. Our focus today is on tyrosine kinase inhibitors, or TKIs, which represent a new class of investigational therapies to treat exudative retinal diseases.

Dr. Talcott, welcome. You have a busy practice at Cole. Which patients come to mind that potentially might be good candidates for treatment with a TKI?

Dr. Talcott:
Thanks so much for the kind introduction and for having me. As you mentioned in a prior episode, really all of the patients that we take care of might be considered to be good candidates for TKIs, but I just thought about a couple of patients who I had seen recently who I thought might make particularly good candidates.

So one of the patients I saw recently is a 79-year-old man. He has neovascular AMD and, unfortunately, he's had a recurrence of fluid on one of the second-generations, on faricimab. So before treatment, his vision in the right eye was 20/50. And if I look at his OCT, he had subretinal fluid as well as subretinal hyper-reflective material that was there.

After I gave him 3 faricimab injections, his vision improved to 20/30. There's no fluid at all. But like most retina specialists, I utilize a treat-and-extend approach. So I tried to extend him out, first going to 6 weeks and then going to 8 weeks. Unfortunately, when I got up to 8 weeks, the fluid came back, mostly in the form of subretinal fluid, but vision also dropped down to 20/40. So, this is a patient who can't have his fluid and vision controlled while being on one of these second-generation agents. But really, our goal is to try and minimize treatment burden for patients, and so I was unable to extend him. So I think he might be a good candidate for something that provides a little bit better control.

Another example of someone with neovascular AMD that I had seen recently is a 68-year-old patient who was controlled on aflibercept every 4 to 6 weeks. This is someone I actually inherited from one of my colleagues and has been getting injections for, I think, about 6 or 7 years now. Every time we try and extend him past 6 weeks, he has a recurrence of fluid, and so he's just more comfortable staying on that 4-to-6-week regimen. We've tried him on different agents other than aflibercept before, but he really feels most comfortable on that agent and would rather stay at 4 to 6 weeks. When we've tried him on second generation agents before, we haven't really been able to get him past 7 to 8 weeks.

He is a patient who I'm very keenly aware of sort of the impact of frequent treatment because he is someone who's actively working. So that means he has to take a day off of work, maybe even a second day off of work if his eye is pretty irritated after the injection every 4

to 6 weeks.

I also can think about DME patients for whom TKIs might be beneficial. I have an example of a DME patient who has persistent fluid despite getting monthly injections. I started off treating his intraretinal fluid due to diabetic macular edema with bevacizumab injections for 3. He still had persistent fluid. I switched him over to aflibercept. He received 2 of those injections, and while the fluid is less, there is still persistent fluid there. And I've really continued him on monthly aflibercept injections, but he still has residual fluid.

So those are, in general, patients who I think might be good candidates for TKIs, but I'm interested to hear how you would recommend that retina specialists in general monitor or consider patients who they're thinking about starting TKIs on when they become available.

Dr. Weng:
Well, I love those examples that you shared, Kat, because I think we all, as listening to these real-life cases, can think of patients in our own practices that are exactly the same, right? And so the first 2 examples I especially appreciate, because those are patients that actually do respond to treatment, but they just need so many injections so frequently. And that treatment burden shouldn't be underestimated because we all know that over longer periods of time, it's very hard to sustain those treatment burdens. And what ends up happening is that they end up missing visits or going longer than they should, and that can result in subpar visual acuity outcomes.

To answer your question, there's so much to think about when it comes to potentially integrating this novel class of drugs into our treatment algorithms. And a lot of this, of course, is going to hinge on the pivotal trials that are underway. But I'll mention three things in terms of integrating into our algorithms. The first is that it seems that these could be great options for both treatment-naïve and treatment-experienced patients. You talked about patients, obviously, who are already on current agents, and those patients can all potentially benefit from switching or integrating into this TKI class when and if they are approved. But we also have to remember treatment-naïve patients might be excellent candidates too, and that's what we're learning from some of these pivotals.

The second thing is I think these drugs will really expand on the concept of combination therapy in our field, especially with wet macular degeneration. That's sort of a novel concept and while it might not apply to all, some patients may require supplementation with anti-VEGFs as we've seen.

And then the third is this is not unique to TKIs and really applies to all longer durability drugs, but I truly believe that remote monitoring will be increasingly valuable the more we extend patients' treatment intervals.

Well, that's all the time that we have today. Thanks for joining me again, Dr. Talcott, and thank you for tuning in to our listeners who are on this event. I hope this discussion will be helpful in your clinical practice.

Dr. Talcott:
Thanks for having me.

Announcer:
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