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Balancing Risk and Benefit: Traditional MG Treatments and Medications to Avoid

Announcer:
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Dr. Howard:
This is CME on ReachMD, and I'm Dr. James Howard. Here with me today is Dr. Nicholas Silvestri. Let's begin our discussion on treatments utilized in the management of generalized MG by focusing on the historically more traditional approaches.

Nick, could you review our conventional approaches to treating myasthenia gravis and, further, how we balance their risk-benefit ratios?

Dr. Silvestri:
Of course, Chip. Thanks for asking. So I think, first, we'll start with symptomatic therapies, the cholinesterase inhibitors, the most frequently used being pyridostigmine. Generally speaking, good for mild symptoms, good for symptomatic therapy, but not effective at treating the underlying disease. Moreover, these therapies don't work in everyone. And they can come with side effects, most likely muscarinic side effects, which, in my experience, tend to be more gastrointestinal in nature, such as abdominal cramping, diarrhea, and the like.

When it comes to therapy that really addresses the underlying immunopathogenesis of the disease, the traditional therapies have been relatively nonspecific in nature. And perhaps the most long-used therapy are corticosteroids, which I think we can agree are probably the best and the worse treatment for myasthenia gravis. Specifically, we know they're effective. Sometimes, unfortunately, the only effect can be quite high doses, but they work quickly and they're inexpensive. Those are certainly some pluses, but unfortunately, the minuses outweigh the pluses, particularly in the long term.

If you can think of a side effect, corticosteroids will cause it, but the ones that are the most concerning are weight gain, high blood pressure, osteoporosis, dysglycemia, gastrointestinal disorders, and the like. And so it's really important that if we use corticosteroids in our patients with myasthenia gravis, we use them for the least amount of time possible and with the lowest possible dose, hopefully transitioning to other agents that may be more safe in the long term.

If we think about oral immunosuppressive therapy, there have been a number of different medications that have been used. I think here in the States, we more often use azathioprine and mycophenolate. Both have been shown to be effective in MG but can take sometimes a year or more to become effective and lead to problems like chronic infections, increased risk of malignancy. In the case of azathioprine, it can cause pancreatic issues. Mycophenolate can cause gastrointestinal issues.

And there are other what are being called steroid-sparing agents that are less frequently used in the States, like tacrolimus, which can be more often used in Japan. Methotrexate tends to be used in developing countries because of its relatively low expense. But these also come with side effects such as the risk for immunosuppression as well as malignancy.

And then, finally, just touching on IVIg. IVIg can be used as a chronic or an acute therapy. Acutely mostly from exacerbation in crisis, but some centers like to use it chronically, but it's really a burden to patients. It's an intravenous method of delivery, can lead to renal problems, thrombosis, can cause infusion reactions, and it tends to be not convenient for our patients.

And, finally, before I pass it to you, Chip, I'll just touch on plasma exchange. Again, most often used in the acute phase in the context of myasthenic crisis but can be used chronically when other methods fail. But it's really burdensome to patients in terms of having to have a chronic line and having to really go for treatments repetitively over the course of one's life.

Dr. Howard:
Well, thanks Nick. That was an excellent overview of our current standard of care. Our culture's changing. Clinicians now want minimal symptomatology from the patient with minimal adverse event profiles. And, clearly, while many of our standards of care have been quite beneficial, their adverse event profiles have been quite limiting and hence the search for new targeted therapies.

Well, that was a great but brief discussion. We hope that this treatment review was helpful. Thank you for listening.