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Practical Approach to Incorporation of Oxybates Into Clinical Practice

Announcer:
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Dr. Trice:
Good afternoon, I'm Dr. Kevin Trice. And I'm here with Dr. Ana Krieger to talk about Practical Approaches to Incorporating Oxybates into the Clinical Practice. Dr. Krieger, thanks for being here. Now that there are multiple medication options for narcolepsy, how do you really add oxybates into the mix for your patients?

Dr. Krieger:
Thank you so much, Dr. Trice, for having me. So, this is a very important question because not all providers know that oxybates have been available for over two decades to treat our patients. And typically, what we try to do is just to look for patients that do have either more severe disease in terms of symptoms, daytime sleepiness, or difficulty with their quality of life or performance at work or school, and also patients that have cataplexy. I think that is really a big factor that tries to figure out, can we unify the treatment with one medication and be able to both to improve their sleep and sleepiness, and at the same time, reduce cataplexy?

Dr. Trice:
That's interesting. You mentioned something really important there, I think was one, time to use monotherapy. Do you use combination therapy? Or do you - how do you titrate up different doses, if you do that?

Dr. Krieger:
I use a lot of combination therapies. Let's say if a person comes in with more mild cases, I typically start with medications like wake-promoting agents first and see how they do. And if that is sufficient, you know, we're happy to stay with that. Now, other patients do need more aggressive treatment. And sometimes you need two or even three medications in a few cases in order to be able to control their symptoms. So, the key point is really to personalize, not only to the patient's satisfaction, but also within our level of expertise and experience of treatment to offer them everything that is available in the market.

Dr. Trice:
Right. You mentioned something I think was phenomenal, and that's the cataplexy portion and kind of being specific in patients in that, but also kind of making it customizable for each patient, which I think a lot of practitioners try and do. So, do you consider for you first line or second line? Or where do you kind of add it in? What's the biggest trigger for you to kind of start an oxybate?

Dr. Krieger:
Cataplexy is definitely on the top of the list. And people have cataplexy, and most patients that come to us have significant narcolepsy already to begin with. Because most of the wake-promoting agents and other stimulants, they are not sufficient to treat cataplexy. So, that is definitely one of the first-line indications that we see in our practice.

Dr. Trice:
Absolutely. And then in those patients, do you kind of start low and kind of titrate up for effectiveness and maybe looking for side effects? Or do you have somebody who may be severe and falling asleep in school or driving or having work performance issues about to be fired, do you start those patients really high and try to get their symptoms under control and wean it down? Kind of what's the approach you do in that sense in terms of dosing?

Dr. Krieger:
I usually start slow. You know, the first dose, I think I always want to test it out and see if they tolerate well. It's a very, very safe therapy, very well tolerated. However, sometimes you do have patients that need to adjust, let's say, if you use more of a high-salt medication versus the low salt, the mixed salts oxybates, there is a difference. So, they need to acclimate and figure out their diet and water intake as well. And also watch out for potential side effects. Even if they are unusual, it's important for the patients to know.

And a big aspect of this is really education, right? You want the patient to have a partnership in us. We are lucky to have centralized pharmacies that are specialized and they understand all the aspects of the treatment, and they are able to help us educate patients. So, I typically want them to start with a lower dose. We may escalate more quickly than once a week, depending on what the needs are and the response. But I typically don't start with a very high dose to begin with.

Dr. Trice:
Good. Good. And then maybe the last question just for time, how do you manage those difficult populations, ones that may have a history or be on concomitant medications that may be contraindicated, or add a little bit more risk when you start to add oxybates, how do you manage those?

Dr. Krieger:
We educate patients. It's really, for them, you know, it is always a calculated risk. We know what are their behaviors, some of them are in college and we have to figure out how to manage that because they are young. Others may have young kids, and we need to figure out how do you manage having young kids, you know, in the area if they have this liquid, how do they maintain safety?

A big issue has been alcohol intake, to be honest. And that's where we discuss with our patients. Like what is the goal and the objective? Are they really so in need of that alcohol intake in the evening? Or can they actually scale down, or decide if there is an evening or important event that they choose to drink, maybe they should skip the medication on that evening.

So, we have to really partner with them to figure out the best way to manage their condition, knowing their social and lifestyle and personal and professional needs.

Dr. Trice:
That's very helpful. I'm going to take some of these and hopefully incorporate them into my practice. Again, Dr. Krieger, thank you so much. I think that's some great considerations in terms of how to add oxybates to your clinical practice.

Dr. Krieger:
Thank you for having me.

Announcer:
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