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Personalizing Treatment for gMG: On the Ground at AANEM

Announcer:

You're listening to *Neurofrontiers* on ReachMD. This episode is sponsored by UCB. Here's your host, Dr. Mimi Maeusli.

Dr. Maeusli:

Welcome to *NeuroFrontiers* on ReachMD. Today, we'll hear from clinicians who attended the Annual Meeting for the American Association of Neuromuscular and Electromyographic Medicine, which took place in San Francisco in October 2025. They'll be discussing personalized management for patients with generalized myasthenia gravis, or gMG.

Given the growing range of targeted therapies for gMG, how are you approaching treatment selection? What patient- or disease-specific factors are guiding your choices?

Dr. Rodriguez:

Given that there's a lot of choices for therapy these days, including the old standbys, such as anticholinesterase inhibitors, prednisone, Imuran, and now complement inhibitors, and now also FCRN inhibitors, I explain to the patient all the different choices that are out there. But I also look at their disease process. For those who have very aggressive conditions and who we want quick relief of their symptoms, I may opt for a complement inhibitor initially. Why? Because some believe, and the data does show, that our onset or efficacy might be a bit quicker than the FCRN inhibitors or the older medicines. Although it varies from patient to patient.

If you have a patient who's had the condition for an extended length of time and you're trying to be a little bit less aggressive, then you may go ahead and initiate therapy with the FCRN inhibitor. But we have to remember that every patient's different, and so you might have a different response with each different therapy from patient to patient.

Dr. Shroff:

So it is exciting times for myasthenia, as there are so many FDA-approved options available there. And this is something which the patient and physician, we have to come to a decision together, a shared decision, on what treatment suits best for this patient—whether it could be in the form of their lifestyle or their work schedule. So depending on even the side effect profile of some of these medications and how soon or how immediately these medications bear effect, the patients start to see the improvement. So all of these factors play a role in deciding which treatment am I going to choose for patients with MG.

Dr. Alpers:

There are a variety of factors that are going to go into this, and it depends on patient's medical comorbidities. If they're a diabetic, that's going to limit our ability to use steroids. I do feel like there's still a central role for a low dose steroid and it can still be a very effective thing to use, but if a patient has, for example, difficulty swallowing, I'm going to be more aggressive a little bit earlier. Vaccination status definitely impacts my choice as far as which biological therapy to go to. And ultimately, it's always, again, a conversation with the patient. For the most part, I don't like to pick therapies for my patients. I like for it to always be a conversation. Here are the risks, here are the benefits, here's the logistical consideration for it. It's dosed every eight weeks, it's subq daily—find what fits the patient best for their lifestyle.

Dr. Maeusli:

When considering FcRn-targeted therapies, how do you differentiate between them in your practice? And what clinical factors—such as mode of delivery, dosing frequency, or efficacy—matter most when you're making those decisions?

Dr. Shroff:

So, as a clinician, yes, I want the highly effective medication for my patients so that their symptoms are well controlled. I mean, yes, ideally, I want that minimal symptom expression to reach that, and efficacy does play a huge role in achieving that. And also, we want to use the least pausable medication to achieve that minimal symptom expression. So the fewer cycles, or if I can space out the cycles, then that would be ideal for me because not every patient might need a four-week cycle. There might be some patients who can wait eight weeks in between. So that individualized treatment in these FCRN plays a crucial role for me to select which one the patient might respond to.

Dr. Alpers:

Ultimately, we don't have any head-to-head data, so efficacy I can't entirely comment on. I do believe that the degree of IgG reduction is going to correlate loosely both with the efficacy—greater reduction, greater efficacy—as well as the potential risk for infection. And so, that being said—and I'll discuss this with patients—it ultimately, again, comes down to their comfort level with a subcutaneous medication versus an IV.

Dr. Rodriguez:

A lot of patients do not like receiving intravenous therapies, even if it's on a weekly basis. So the subcutaneous formulations are quite appealing to patients. So I usually try to use the subcutaneous formulation over the intravenous formulations. That is always patient-driven. Some patients are quite comfortable with intravenous; they don't like self-delivering their medication. But by and large, most patients want a more easy delivery access, and so the subcutaneous formulations seem to be more appealing to patients.

Dr. Maeusli:

How have your conversations with patients changed when it comes to treatment logistics? Are you seeing more interest in things like flexibility, self-management, or fewer infusion visits?

Dr. Shroff:

So patients do like flexibility, especially if they're working. Based on their work schedule, they do like their flexibility. Now, previously, the infusion center visits used to be like four or six hours or half-day visits, when it was IVIG infusions and things like that. But now, with the newer treatments available, from what I hear from patients, they're not worried about these infusion day visits. It's usually 15 to 30 minutes, and they kind of add this as like, okay, I'm running another errand in a day and just squeeze in that 15, 30 minutes to their day, and then it doesn't interfere with their day. So that's the way some of these patients have described it. And of course, with self-management and self-administered medications, they have the control over it, regarding the self-administration. So yes, patients do like that option. So it primarily boils down to that shared decision between the patient and the physicians, and that's how we kind of come to a decision on what treatment to initiate.

Dr. Alpers:

It's all over the place and it depends on the patients. Some of my elderly patients that have had IVIG, they've got an infusion center they go to, and they like their infusion nurse, they might like an IV therapy and they may want it to be a little bit more frequently so they can get in, and that's something that they enjoy having.

My younger, more active patients are going to want either dosing less frequently or something that they can have their own autonomy with—some form of a self-injectable.

Dr. Rodriguez:

I take a lot of time when I first receive a patient who is suffering with generalized myasthenia, and for that matter, also ocular myasthenia. I indicate to the patient that no longer do they have to take the quote-unquote older medications, which have a lot of collateral side effects. And I indicate to the patient that honestly, we should be striving for being quite mobile and being able to do most activities that other folks are doing.

So, we shouldn't just accept that, well, you're going to be tired. Well, you're going to have droopy eyelids on and off. No. The medications that we now have can really achieve quite good success. And we use the term minimal symptom expression, and what we mean by that is that you can actually maintain a very active life and actually feel fulfilled that your therapy is working.

Dr. Maeusli:

When starting complement inhibition therapy in gMG, how do you handle the meningococcal vaccination requirements? What steps do you take to ensure patients are vaccinated appropriately before initiating treatment?

Dr. Rodriguez:

Well, handling the risk of being infected with meningococcal infection with complement inhibitor use is really something to be aware of. However, in practice, it's very rare that this occurs. But you do have to state the data to the patients, and there has to be a clear

understanding that this is still a risk. And so I quite slowly and very deliberately explain the statistics. I indicate that the vaccinations are trivial, and what I mean by that is that there's no adverse side effects from the vaccinations. And if need be, we'll introduce antibiotic therapy because, again, the risk of an infection is far less than the benefit. And, basically, the vaccinations are easy to absorb, and the antibiotics are easy to take as well.

Dr. Shroff:

So I do discuss with the patients about the risk of this meningococcal infection with complement inhibitors and the need for vaccination. So if I see a myasthenia patient early on, then I do tell them it might be worthwhile to get vaccinated and that one might need this treatment in future, so we are not waiting on a patient being vaccinated.

Now, some patients are open to that, and they do get vaccinated. Some of them are not. Now, again, it's all that decision made by the patient: an informed decision after discussing these things with them. And at times, we have started the complement inhibitor and started patients on antibiotic prophylaxis until they get vaccinated. So those options are available there, as long as we discuss with the patients and then they are aware of it and we inform them appropriately.

And I have had patients who have gotten vaccinated and we have started, versus when I had to start antibiotics and then get them started even before vaccination, as well.

So, I think the bottom line is that patients making an informed decision and a shared decision with their neurologist would be the way I would go.

Announcer:

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