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Precision Medicine in Myasthenia Gravis: Crafting Personalized Treatment Strategies

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Howard:
This is CME on ReachMD, and I'm Dr. Chip Howard. Here with me today is Dr. Nick Silvestri.

Nick, now that we've discussed the historical, traditional treatments and the novel targeted FcRn antagonists, how do we match a given patient with MG with your most safe and most effective therapeutic approach? And, looking long term, is it currently possible to develop a sequential treatment plan for each patient based on the typical journey of someone with MG?

Dr. Silvestri:
Chip, that is such a great question, and I think we still have so much to learn about myasthenia gravis in order to really answer that. I think what would be fantastic, and what I think, frankly, is our biggest unmet need in myasthenia gravis is a biomarker that would allow us to predict which patient would be best treated with which agent, whether it's a traditional agent or a targeted agent. And that would allow us then to really prevent using some of these agents that have potential deleterious effects on patients with really nothing to gain before we cycle them through treatment or treatments.

So I do believe we will see that in the course of the next few years, but right now it's purely clinical medicine. It's using our experience. It's taking into account certain factors like patient age, patient comorbidities, other medications they're on, in women, their childbearing needs or desires. There's so much that goes into it that differs from patient to patient, that one of the great things about practicing medicine in myasthenia is that it's not really algorithmic. I mean, certainly, we have frameworks that we follow; there are the international consensus guidelines.

There are other guidelines that help us provide a framework, but you really have to apply that framework to the patient in front of you and take so many variables into account. Now, to an extent, there are profiles that allow us to determine what treatments might be better than others. We talked about MuSK myasthenia gravis and how those patients tend not to respond well to pyridostigmine. They tend not to respond well to IVIg. They tend to respond very, very well to B cell therapy such as rituximab.

So when it comes to MuSK patients, it's almost a little bit easier in terms of coming up with a treatment plan in those patients because we know what works well and what doesn't work in those patients. But for the majority of patients with acetylcholine receptor-positive disease, it's really looking at all those variables that I mentioned and really trying to determine, you know, number one, what will be the

most efficacious, and number two, but not that far behind, which medication will be the safest for them.

I think that in an ideal world, in the absence of payers, we would probably try to use targeted therapies earlier on because they're efficacious, they work quickly, and they have fewer off-target side effects, as we've discussed. But we do not live in a payer-agnostic world and often have to use agents that might cause problems early on at the behest of what we're allowed to use in our armamentarium.

So long story short, great question. Definitely need a biomarker, hopefully which is in development in someone smarter than me's lab right now, to figure this out, but I do think that we will see it in the course of the next few years.

Dr. Howard:
Great discussion, Nick. I think the other critical aspect to all of this is that this has to be a clinician-patient shared decision-making process. The patient, and while we seemingly may know best, they have to have an integral role in deciding what is best for them. And does the elderly sedentary individual, do we need to go full out, if you will, to make them absolutely normal, and some would argue absolutely not. And so the shared process has to be an integral part of this whole management string.

With that, our time is up. Thanks for a great discussion, Nick. And thank you to our audience for tuning in.