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Understanding Disease Progression: The Shift From Ocular to Generalized MG

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, James Howard. Here with me today is Dr. Nicholas Silvestri.

Nick, myasthenia gravis often progresses from ocular to generalized disease. Can you provide some background on this evolution for our learners?

Dr. Silvestri:
Yeah, of course, Chip. As you pointed out, most patients, about 80% or so, will initially present with ocular symptoms, and those ocular symptoms predominantly come in two flavors: either droopy eyelids, ptosis; or double vision, diplopia. Patients may have one or the other, and they may have both. But it's frankly the rare patient that stays ocular, right? We think about 85% of our patients that have myasthenia gravis have generalized disease.

And while that generalization is typically most likely to occur within the first 1 or 2 or perhaps 3 years after the initial symptoms, oftentimes, I find if you take a very careful history in a patient who otherwise is coming to you with ocular myasthenia, they have other symptoms. Or maybe a well-performed neurological examination will disclose weakness in areas where patients don't feel it yet because they're not frequently used muscles or perhaps they're not very physically active patients.

Now we know that about, as I said, 85% of people will progress from ocular to generalized myasthenia gravis, but I don't think we really quite understand yet why and how and when. There really haven't been a lot of great trials to demonstrate that our medications and interventions do a great job of preventing generalization after patients present with ocular disease. There may be some hint that treating patients early and aggressively will do so, but we don't have that data yet.

So there really are no clear clinical harbingers of this evolution. But certainly, when I have patients who present to me with ocular symptoms and I'm convinced they have myasthenia gravis by history, by exam, by ancillary studies, I definitely spend a lot of time counseling them, talking about what signs and symptoms to look out for, particularly potentially dangerous symptoms like dysphagia, like dyspnea, that could herald an incipient crisis.

And so I think it's really a lot about patient education, talking to people about what the disease is, what signs and symptoms to look out

for that could be potentially dangerous. Really talking with patients about medications, for example, that can worsen myasthenia gravis so that if a patient maybe has mild disease or mild ocular-predominant disease, their primary care doctor, for example, doesn't unknowingly put them on an antibiotic, for example, that may exacerbate their symptoms and land them into the hospital.

So I think communication is the key. Working with patients' other doctors so they understand their disease and pointing patients to reputable sources of information so that if they do need to look up something about their disease, if they can't get a hold of us, they have a resource to go to.

Dr. Howard:
Your points are very well taken and right on target. All too often, I see individuals who have been diagnosed with ocular MG who, indeed, do not have ocular MG and, as you pointed out, have mild or subtle weakness elsewhere outside of the eyelid or the muscles of eye movement that would classify them as generalized disease. And because they have been diagnosed with ocular MG, they're treated often with symptomatic therapy, cholinesterase inhibitors alone, rather than considering more aggressive immunotherapy to prevent the ongoing generalization of the weakness.

Trials have been attempted in the past to see if one could forestall generalization with early aggressive treatment of ocular disease. But that one didn't move forward enough because of lack of recruitment. And given the fact that we do not have a biomarker of disease course or therapeutic response, we're limited to astute clinical examinations, taking very detailed clinical histories, often looking for the nuances of weakness rather than overt weakness itself that may guide the clinician to say, "Oh, I need to think about this a bit differently."

Well, our time is up. Thank you for listening. I hope this discussion will be helpful in your clinical practice.