Fresh Approaches to MS Care

New treatment options encourage a fresh approach to patients.

A Q&A WITH JOHN CORBOY, MD, FAAN AND PATRICIA COYLE, MD, FAAN

After years of status quo, the treatment landscape for multiple sclerosis has rapidly and undeniably changed. The growth of the field of MS therapies—now with three oral therapies on the market—creates new decisions for physicians and patients when it comes to treatment selection. While the influence of factors like insurance coverage and therapy cost should be minimal, according to the National Clinical Advisory Board of the National Multiple Sclerosis Society (See Sidebar) and many other experts, the reality of these factors is inescapable in actual practice.

To get a better sense of the decision-making process for specialists, we asked MS experts to share thoughts on their current strategies for patient management.

Q. The field of disease-modifying therapies has certainly grown in recent months. Could you briefly describe your general approach to treatment selection for the newly diagnosed, treatment-naive patient with MS or suspected MS?

John R. Corboy, MD, FAAN: Take no prisoners. Treat aggressively from the outset, so as to maximize reduction in inflammatory disease activity.

Exceptions might be patients diagnosed after a long benign course, who likely will do well no matter what we treat them with (maybe even with nothing).

Patricia K. Coyle, MD, FAAN: Drug selection is based on drug, disease, and patient factors, influenced by practical availability and personal experience. I briefly discuss all options, then narrow down to recommend specific choices and their pros and cons.

Q: In the new treatment environment, how do you approach the established patient who is already on a therapy?

Dr. Corboy: If the patient is stable for a significant period of time on whatever drug, and tolerating it well, I leave them on that drug. I have a very low threshold to move to best available therapy.

Q. What factors do you believe justify considering a therapeutic switch?

Dr. Coyle: Any relapse while on therapy should be investigated for possible switch. Worsening on exam or surveillance MRI, in the setting of someone who feels well and reports no change, should be verified with alternative testing, or lead to a second unacceptable MRI before switching on neuroimaging criteria alone.

Dr. Corboy: I look for new disease activity on scan or exam (i.e., attack or change in EDSS), or intolerance, especially if it affects compliance.

Q. Is patient interest in oral therapy sufficient reason to initiate an oral agent over an injectable DMT?

Dr. Corboy: If patients have been putting up with the pain and inconvenience of injections for a period of time, and developing "shot burnout," switching to a more effective drug that

FDA-APPROVED MS DISEASE-MODIFYING THERAPIES

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone (glatiramer acetate)
- Extavia (interferon beta-1b)
- Gilenya (fingolimod)
- Novantrone (mitoxantrone)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Tysabri (natalizumab)

Exhibit
Exhibit No.: 2065

happens to be oral makes very good sense, from a compliance and patient satisfaction point of view.

Q. What factors (insurance coverage/costs, convenience, trial data, experience) would you say are most relevant to you in your therapeutic decision-making?

Dr. Coyle: Trial data and experience are most important to me. It is a sad commentary when cost/coverage becomes the deciding factor.

Dr. Corboy: Efficacy. Efficacy. Risk. Compliance (convenience and side effects). Insurance/costs never play a role in philosophical choice, but often play a practical role in what we can actually get for the patient.

Q: The media, patient groups, drug marketers, and even neurologists sometimes seem to view the available therapies according to their delivery method—injectable versus oral. Do you think this is a meaningful distinction, or, more importantly, how would you recommend that your colleagues treating MS conceptualize the field?

Dr. Corboy: To paraphrase James Carville, "It's the efficacy, stupid." When you explain to patients that the goal is to maintain their neurological function at their present state for as long as possible, they clearly agree that is most important. If you waffle around, talking about number of injections per week, oral vs. injectable vs. infusion, the discussion is way off track.

Dr. Coyle: I think this is a meaningful distinction. I think of MS options in three buckets: first line parenterals, second line parenterals, and oral options.

Q. Several agents are new or relatively new to market. What are you looking to learn about newer agents as experience with them increases?

Dr. Coyle: Over time I am looking at long-term efficacy and safety, and that there are no late surprises. Over time, a sense of the true tolerability and effectiveness of a new agent compared to interferons and glatiramer acetate will become apparent.

Dr. Corboy: What is the true side effect profile, are there long-term risk issues? Does the efficacy remain intact over time? How can we manage the risk?

Q. Can we still learn more about the interferons or glatiramer acetate in light of these new therapies?

Dr. Corboy: Although there is a general perception, and some data that the "old" drugs are inferior, we likely still need some comparative trials. It is, however, getting very difficult to convince people to enter trials with injectables as the comparator. I would favor trials comparing the higher efficacy medications to each other. This will never be sponsored by pharma, and needs alternative techniques to accomplish.

PRINCIPLES OF CARE: NMSS.ORG

- Patients' access to medication should not be limited by the frequency of relapses, age, or level of disability.
- Treatment is not to be stopped while insurers evaluate for continuing coverage of treatment, as this would put patients at increased risk for recurrent disease activity.
- Therapy is to be continued indefinitely, except for the following circumstances: there is clear lack of benefit; there are intolerable side effects; better therapy becomes available.
- All of these FDA-approved agents should be included in formularies and covered by third party payers so that physicians and patients can determine the most appropriate agent on an individual basis; failure to do so is unethical and discriminatory.
- Movement from one disease-modifying medication to another should occur only for medically appropriate reasons.
- None of the therapies has been approved for use by women who are trying to become pregnant, are pregnant, or are nursing mothers.

— *National Clinical Advisory Board of the National Multiple Sclerosis Society (2008)*

Q. When does it make sense to discontinue medication? How can the neurology community develop a consensus around this?

Dr. Corboy: I consider discontinuation of DMTs under the following circumstances

1. Intolerance
2. In a patient with apparent diminished risk of new inflammatory disease activity

a. "Benign MS," likely around 60, with onset at least 15-20 years prior, no attack in the last five years, no enhancing MRI lesion for 5-plus years, and on DMT for at least 5-10 years, or

b. Same as above, but has more significant disability, but appears to have "burned out," or

c. SPMS, with similar characteristics as above (i.e. age, duration of disease, no new lesions, no attacks, etc.)

We need a study to give us some guidance. Anyone who says they know what to do in these contexts is making it up. Data trumps all. ■

John R. Corboy, MD, FAAN is Professor, Neurology, University of Colorado School of Medicine and Co-Director, Rocky Mountain MS Center at Anschutz Medical Campus.

Patricia K. Coyle, MD, FAAN is Professor and Vice Chair (Clinical Affairs), Department of Neurology, Stony Brook University in Stony Brook, NY.