

3rd IPOPI Clinical Care Webinar IG Therapies: From good to best practice

by Prof Troy Torgerson

SEPTEMBER 26 2019— 14.00H WET



Q&A 3rd IPOPI Clinical Care Webinar

IG Therapies: From good to best practice

by Professor Troy Torgerson and with participation of Dr Nizar Mahlaoui

Question 1

Colleen Brock:

What are your thoughts about getting the meningitis vaccine? Have heard that it is recommended because there is not enough protection in the plasma donors.

Prof Torgerson: It certainly would not hurt to receive the meningitis vaccine but if a person is antibody deficient, there is a good chance that they may not make any significant antibody response to it so there may be no benefit. As a result, we do not routinely recommend it. We do however recommend that patients receive the yearly influenza vaccine (killed virus) and we are now recommending that patients over the age of 50 receive the new Shingles vaccine that is a killed virus as well (goes by the name of Shingrix in the U.S.). The reason for recommending these is that even if patients are not able to generate an antibody response to the vaccine, there may still be benefit because it can educate and stimulate their T cells to be able to attack and manage the virus better.

Question 2

Vera Polyakova:

Is there any blood test or any test done to show what type of product will be the right and better fit? I have been using the same product for over a year and I am always tired before and after infusion. Thank you.

Prof Torgerson: Unfortunately, there are no tests that can predict which IgG product is more likely to be tolerated or cause fewer side effects. One of the things that I have observed to be most helpful with the fatigue and headaches surrounding infusions is aggressive hydration starting a day before the infusion and continuing for about a day after. In patients receiving SCIG, I tell them to drink a lot of liquids. In patients on IVIG, we often give 0.5-2 liters of saline as a bolus before the infusion and that seems to help mitigate some of these side effects.

Question 3

Leire Solis:

How do doctors know which administration route is preferable from the get-go if I have a relatively "normal & quiet" life?

Prof Torgerson: We don't always know. Some of the major considerations include the following: 1) We know that IVIG is often associated with headaches and fatigue around the time of infusion and that this is less common with SCIG so in patients who already have a lot of headaches, fatigue, etc. I often recommend starting with SCIG. 2) Lifestyle is a big factor. For instance, if a patient travels a lot either for work or pleasure, I often recommend SCIG so it can be taken with them and done wherever the patient happens to be at the moment. Alternatively, if patients are

very phobic of needles, I usually recommend IVIG infusions once per month to limit the number of needle sticks required.

Question 4

Amalia Rizqi:

In limited resources countries when Ig replacement therapy is not covered by national health insurance, what is the minimal dose of IVIg that could be given for children with predominantly antibody deficiencies that still could prevent serious bacterial infections?

Dr Mahlaoui:

Targeting a trough IgG plasma level of at least 4g/L is safest to prevent serious bacterial infections such as septicemia, meningitis or acute pneumonia

Question 5

Amalia Rizqi:

Very hard for us, physician in Indonesia to achieved 4g/L of IgG through plasma level for our PID patients due to national health insurance constraint. Some expert said that 100 mg/kg BW IVIG every month is better than occasional IVIG replacement. Is it OK?

Dr Mahlaoui:

Yes in order to avoid septicemia or meningitis (which are the most severe infections), but it is very unfortunate not to be able to achieve higher IgG through levels or higher doses of IgG

Question 6

Leire Solis:

If in a country only IVIG is reimbursed but a patient deals badly with the peaks and troughs of intravenous administration. Can an IVIG be administered subcutaneously?

Dr Mahlaoui:

Technically this is feasible but lower concentrations of IVIG vs. SCIG would require several infusions per week which would also be painful and come with potential skin issues.

Prof Torgerson: Yes, before the 20% IgG products were available for SCIG infusion, we used the 10% IVIG solutions and had patients administer them subcutaneously. Most of the time they were tolerated just fine but as Dr. Mahlaoui points out, the volume of infusion using a 10% solution is twice as much as for a 20% solution so that can be an issue. There were also some anecdotal reports of skin atrophy or scarring at infusion sites, but we never saw that in our clinic and I told patients that if the subcutaneous infusions became painful then they probably shouldn't do them.

Question 7

Amalia Rizqi:

In CVID children with bronchiectasis that could have regular Ig supplementation, is there any specific IgG trough level that could safely guide us to stop his/ her antibiotic prophylaxis due to bronchiectasis?

Dr Mahlaoui:

This decision is based on the clinical status and not only on the blood tests. Stopping the antibiotics would be based on a good trough IgG plasma level AND good clinical testing (+ respiratory testing).