XIPERE InXights

XIPERE Patient Case Study Series

TREATMENT OF CYSTOID MACULAR EDEMA AND FOCAL CHORIORETINAL INFLAMMATION ASSOCIATED WITH CHRONIC IDIOPATHIC UVEITIS

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A mainstay of treatment of noninfectious uveitis is systemic and/or local immunosuppression using corticosteroids.[1] Systemic corticosteroids provide sustained control of ocular inflammation while avoiding the risks of peri- or intraocular corticosteroid injections and implants, but are associated with an increased risk of systemic side effects including increased blood sugars, infections, and other systemic adverse events.[1,2] By contrast, local corticosteroids deliver more rapid control of inflammation without systemic immunosuppression, but are associated with ocular adverse events, including intraocular pressure elevation and cataract formation.[1]

LANA RIFKIN, MD
Ophthalmic Consultants of Boston
Boston, MA

Lana Rifkin, MD, is a paid consultant of Bausch + Lomb.

Here, I describe a case of bilateral cystoid macular edema (CME) associated with focal chorioretinal inflammation and chronic idiopathic uveitis. The patient refused systemic immunosuppressive therapy and preferred a treatment option that did not involve intravitreal corticosteroid implants. To optimally address this patient's needs, she was treated with injections of XIPERE® (triamcinolone acetonide injectable suspension) 40 mg/mL bilaterally.

XIPERE delivers triamcinolone acetonide via the suprachoroidal route, specifically depositing the corticosteroid in the compartment between the choroid and sclera,[3] maximizing corticosteroid exposure in target tissues and minimizing drug exposure to non-target tissues. Following XIPERE treatment, the patient's uveitic CME resolved at 2-week and 6-week follow-ups in the right and left eye, respectively. This case exemplifies the attributes of patients for whom I believe XIPERE represents an excellent treatment option.

INDICATION

XIPERE® (triamcinolone acetonide injectable suspension) for suprachoroidal use is a corticosteroid indicated for the treatment of macular edema associated with uveitis.

IMPORTANT SAFETY INFORMATION

Patients should be monitored following injection for elevated intraocular pressure. See Dosage and Administration instructions in full Prescribing Information.

Please see additional Important Safety Information throughout and full Prescribing Information here.

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Case Report: A Patient With Macular Edema Associated With Chronic Idiopathic Uveitis and Focal Chorioretinal Inflammation

BACKGROUND: The patient was a 74-year-old White female. Her general medical history included mitral valve prolapse, paroxysmal atrial fibrillation, pneumothorax, and most recently, a multitrauma bicycle accident leading to a stay in intensive care. Her ocular medical history included cataracts. The patient also had a history of chronic bilateral noninfectious uveitis with focal chorioretinal inflammation and secondary cystoid macular edema, which had been treated with a combination of prednisolone acetate eye drops, difluprednate eye drops, posterior sub-Tenon triamcinolone acetonide injections, and dexamethasone intravitreal implants.

DIAGNOSIS: The patient presented to my practice with decreased vision bilaterally, macular and optic nerve leakage on fluorescein angiography in both eyes, but no evidence of vasculitis. CME was present on spectral-domain optical coherence tomography (SD-OCT) in both eyes (**Figure**), elevated central subfield thickness were measured in both eyes (**Table**). A thorough work-up was done and was found to be negative. Based on the patient's medical history and these clinical findings, a diagnosis of bilateral chronic idiopathic uveitis with focal chorioretinal inflammation and recurrent cystoid macular edema was made.

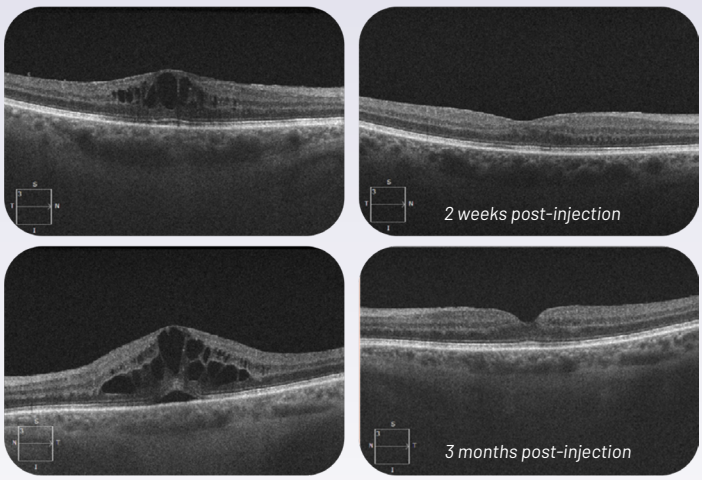

Figure. SD-OCT imaging of patient eyes on the day of XIPERE injection and 2 weeks after XIPERE injection. Note the presence of CME before injection, which was absent after XIPERE injection.

		Pre-XIPERE	1 month post-XIPERE
Best corrected visual acuity	OD	20/60	20/25
	OS	20/60	20/30
Central subfield thickness	OD	458 µm	276 µm
	OS	642 µm	308 µm
Intraocular pressure	OD	12 mmHg	11 mmHg
	OS	12 mmHg	14 mmHg

Table. Measurements of best corrected visual acuity, central subfield thickness, and intraocular pressure before and after XIPERE injection.

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TREATMENT: I discussed more long-term treatment options—which included systemic therapy, dexamethasone implants, fluocinolone acetonide intravitreal implants, and XIPERE®—with the patient. The patient adamantly refused systemic therapy, and she did not wish to proceed with intravitreal implants, as she reported her previous intravitreal implants to be "very distracting." The patient already had cataracts and acknowledged that she would need cataract surgery in the future, so the risk of corticosteroid-induced cataract was not a concern for her. In addition, her intraocular pressure had always been normal, and her optic nerves were healthy. Based on these considerations, we felt that XIPERE suprachoroidal injections would be the ideal next logical step for her, with the treatment goals of improving vision and resolving her recurrent uveitic CME.

The patient was administered XIPERE in both eyes. Uveitic CME resolved 2 weeks after the first injection in the right eye and was resolved at 6-week follow-up after injection in the left eye (**Figure**). Quantifiable improvements in both visual function and central subfield thickness were observed in both eyes 1 month after the first injection (**Table**). The first injection lasted approximately 7 months in the left eye and 5.5 months in the right eye, after which a second XIPERE injection was administered. The patient's CME remained resolved for an additional 7 months in the right eye, at which point she elected to have a third XIPERE injection as the edema recurred. Her left eye has remained stable with no recurrence of CME for 1 year after 2 XIPERE injections. The patient underwent cataract surgery in the interval between the first and second injections in both eyes.

WHY XIPERE?

I recommend this product as a treatment option to my patients who: 1) have persistent or recurrent uveitic macular edema; 2) decline, or are poor candidates for, systemic immunosuppressive or immunomodulatory therapy; and/or 3) find intravitreal corticosteroid implants uncomfortable or distracting. This patient had macular edema associated with chronic uveitis that was resistant to multiple ocular corticosteroid therapies. This patient filled all 3 of the aforementioned criteria and, in my view, was an excellent candidate for suprachoroidal corticosteroid therapy with XIPERE.

The efficacy of XIPERE was assessed in a 6-month, randomized, multicenter, double-masked, sham-controlled study in patients with macular edema associated with anterior, intermediate, or posterior uveitis, or panuveitis (PEACHTREE); patients were treated at baseline and Week 12.[3,4] In PEACHTREE, a statistically significantly greater proportion of patients treated with XIPERE achieved a ≥15-letter improvement in best-corrected visual acuity than control patients at Week 24 (47% vs 16%, respectively; P<0.01).[3] In a noninterventional extension study of PEACHTREE, called MAGNOLIA, XIPERE was shown to provide durable efficacy with the potential to last up to a year following 1 or 2 injections.[5] The most common adverse reactions reported by ≥10% of patients and at a rate greater than control included elevated intraocular pressure and eye pain.[3]

MY APPROACH TO SUPRACHOROIDAL INJECTION OF XIPERE

1. Administer subconjunctival lidocaine injection near the area to be injected
2. Prepare a sterile field using a lid speculum
3. Begin administration using XIPERE's 900-µm needle; the 1100-µm needle may be used at the discretion of the treating physician[3]

Tip: Inject XIPERE at the site of best exposure, with no large blood vessels present.

IMPORTANT SAFETY INFORMATION (CONT'D)

- XIPERE® is contraindicated in patients with **active or suspected ocular or periocular infections** including most viral diseases of the cornea and conjunctiva, including active epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, varicella, mycobacterial infections, and fungal diseases.

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IMPORTANT SAFETY INFORMATION (CONT'D)

- XIPERE® is contraindicated in patients with known **hypersensitivity to triamcinolone acetonide** or any other components of this product.
- Use of corticosteroids may produce cataracts, increased intraocular pressure, and glaucoma. Use of corticosteroids may enhance the establishment of secondary ocular infections due to bacteria, fungi, or viruses, and should be used cautiously in patients with a history of ocular herpes simplex.
- Hypothalamic-pituitary-adrenal (HPA) axis suppression, Cushing's syndrome, and hyperglycemia can occur following administration of a corticosteroid. Monitor patients for these conditions with chronic use.
- In controlled studies, the most common ocular adverse reactions were increased ocular pressure, non-acute (14%), eye pain, non-acute (12%), cataract (7%), increased intraocular pressure, acute (6%), vitreous detachment (5%), injection site pain (4%), conjunctival hemorrhage (4%), visual acuity reduced (4%), dry eye (3%), eye pain, acute (3%), photophobia (3%), and vitreous floaters (3%), and in 2% of patients: uveitis, conjunctival hyperaemia, punctate keratitis, conjunctival oedema, meibomianitis, anterior capsule contraction, chalazion, eye irritation, eye pruritus, eyelid ptosis, photopsia, and vision blurred.

  The most common non-ocular adverse event was headache (5%).
- Corticosteroids should be used during pregnancy or nursing only if the potential benefit justifies the potential risk to the fetus or nursing infant.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088

Please see additional Important Safety Information throughout and full Prescribing Information here.

References: 1. Mehta NS, Emami-Naeini P. A review of systemic biologics and local immunosuppressive medications in uveitis. *J Ophthalmic Vis Res*. 2022;17(2):276-289. **2.** Tamez-Pérez HE, Quintanilla-Flores DL, Rodríguez-Gutiérrez R, González-González JG, Tamez-Peña AL. Steroid hyperglycemia: prevalence, early detection and therapeutic recommendations: a narrative review. *World J Diabetes*. 2015;6(8):1073-1081. **3.** XIPERE® [prescribing information]. Alpharetta, GA: Clearside Biomedical, Inc. **4.** Yeh S, Khurana RN, Shah M, et al. Efficacy and safety of suprachoroidal CLS-TA for macular edema secondary to noninfectious uveitis: phase 3 randomized trial. *Ophthalmology*. 2020;127(7):948-955. **5.** Khurana RN, Merrill P, Yeh S, et al. Extension study of the safety and efficacy of CLS-TA for treatment of macular oedema associated with non-infectious uveitis (MAGNOLIA). *Br J Ophthalmol*. 2022;106(8):1139-1144.

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