NMOSD UNVEILED

Optimizing Long-Term Outcomes in Neuromyelitis Optica Spectrum Disorder with Innovative Therapies

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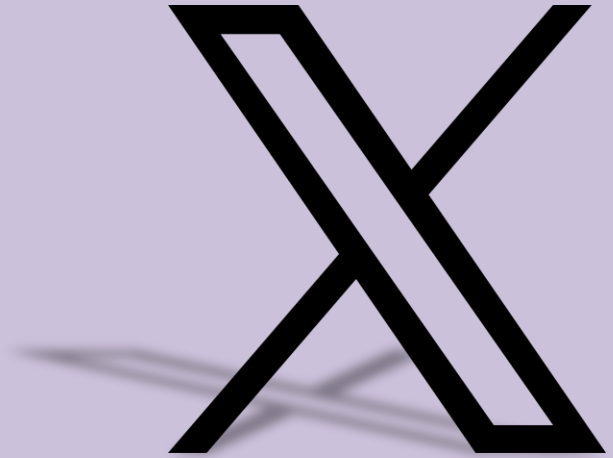
CME OUTFITTERS



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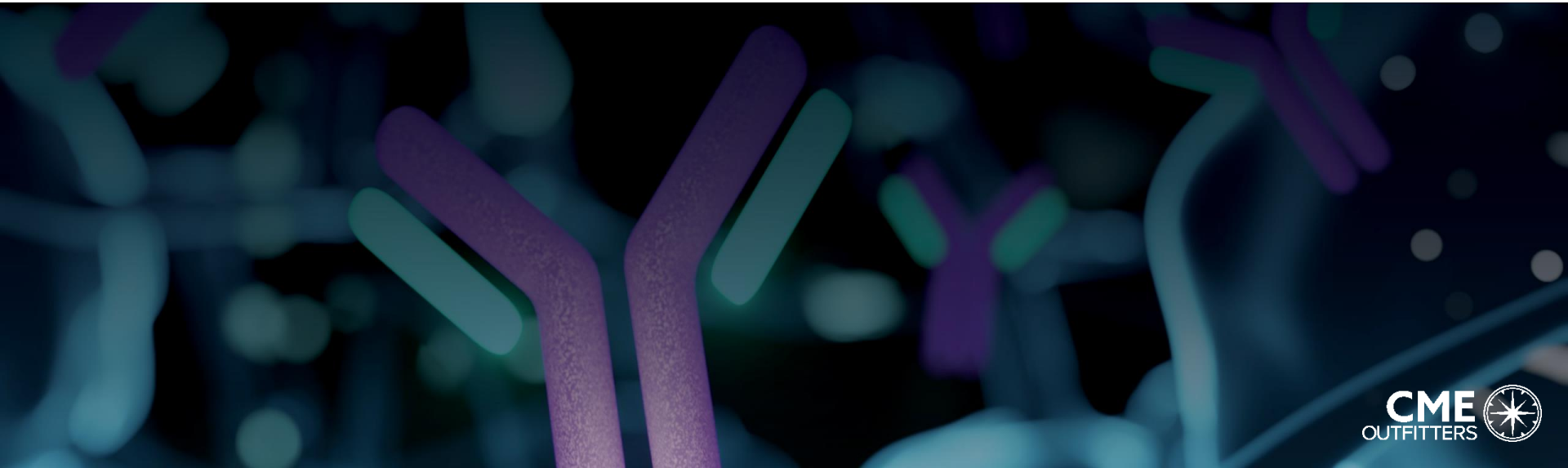
LEARNING OBJECTIVES

1. Identify the pathophysiology of NMOSD including the role of the complement mechanism in the disease state.
2. Evaluate diagnostic criteria including clinical presentation, AQP4-IgG status, and magnetic resonance imaging (MRI) findings to accurately diagnose NMOSD.
3. Utilize recently approved and emerging NMOSD therapeutic antibodies in preventing acute episodes, associated damage, and long-term disability.
4. Implement ongoing care and monitoring of patients with NMOSD to optimize long-term outcomes.

The NMOSD Patient Experience

Clinical Course and Unmet Needs

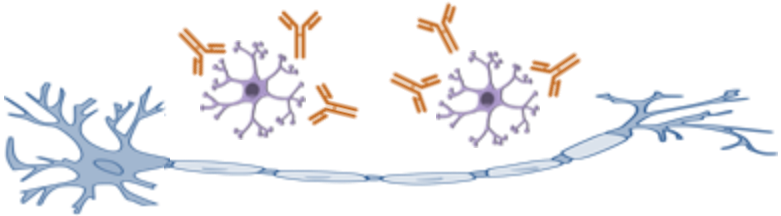


Chelsey's Story: Part 1

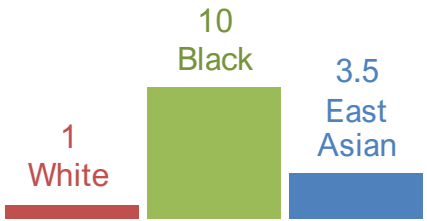
CME OUTFITTERS

NMOSD Background

Autoimmune, relapsing, demyelinating, CNS astrocytopathy



Global prevalence
per 100,000



Typical age of onset

35 to 40 years

Can present in all ages, rarely in children and older adults

Female-to-male ratio

♀ : ♂

High female predilection, up to 9:1 in seropositive

CNS = central nervous system

Kim S, et al. *Neurology.* 2018;91(22):e2089-e2099. Hor JY, et al. *Front Neurol*. 2020;11:501. Briggs FB, Shaia J. *Multiple Sclerosis Journal*. 2024;30(3):316-324.

NMOSD Clinical Course

90%

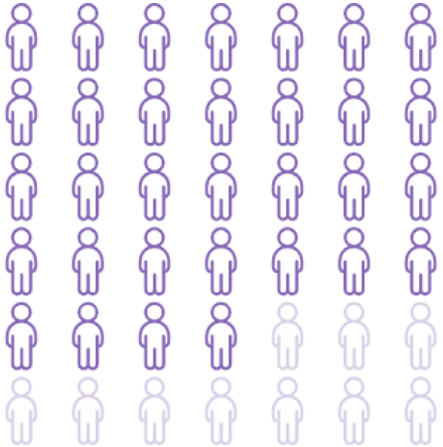
Acute relapses

90% of patients experience relapses

70% relapse within 2 years

50% relapse within 1 year

75%



Incomplete recovery

75% of attacks leave patients with residual deficits

5% have no recovery at all

60%

Cumulative disability

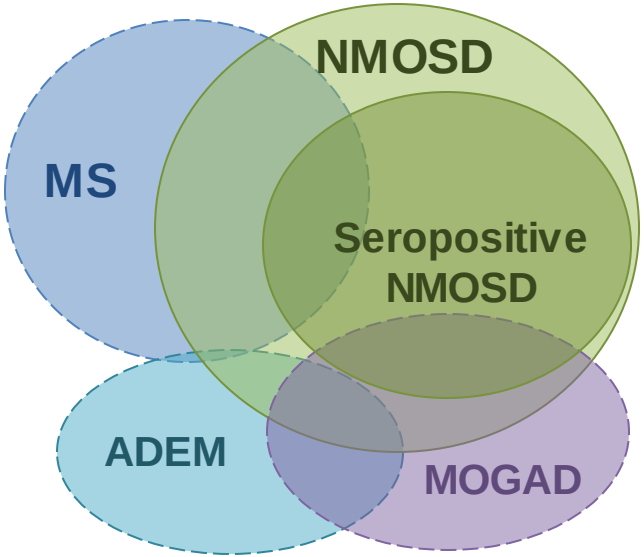
60% of patients go blind in at least one eye within 5 years

30% become severely disabled

Jiao Y, et al. *Neurology*. 2013;81(14):1197-1204. Duchow A, et al. *Ann Neurol*. 2024;95(4):720-732. Kleiter I, et al. *Ann Neurol*. 2016;79(2):206-216. Ghezzi A, et al. *J Neurol*. 2004;251(1):47-52.

NMOSD Misdiagnosis

25% to 40% of people currently living with NMOSD were initially misdiagnosed, most often with multiple sclerosis (MS).

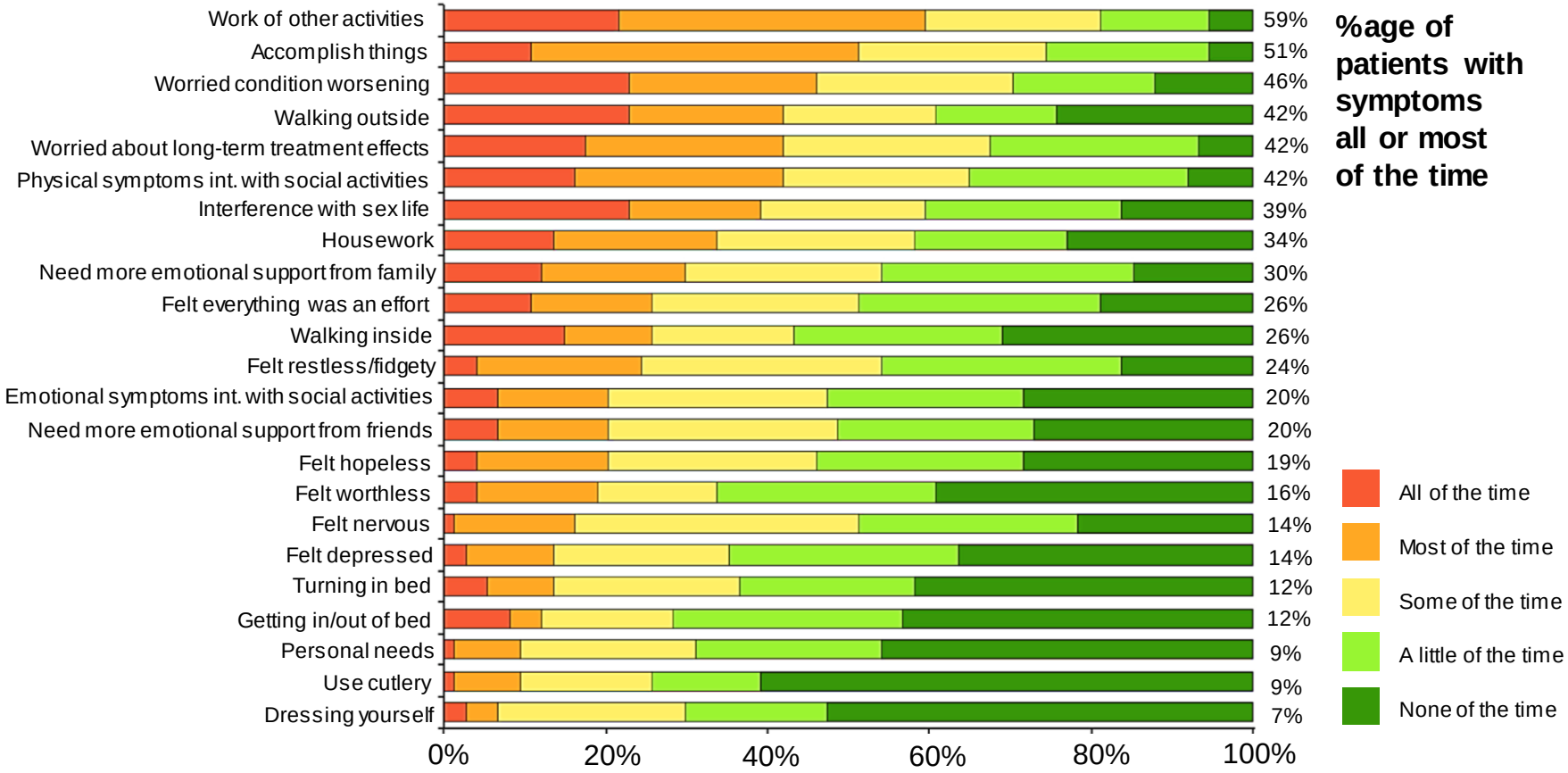


- Factors associated with misdiagnosis
  - Area postrema syndrome (APS) without neurological symptoms
  - Longer time to see neuroimmunology specialist and/or undergo MRI
  - Negative serostatus
- Consequences of misdiagnosis
  - Delay in initiating maintenance therapy
  - Inappropriate or harmful treatment
  - Greater frequency and severity of relapses
  - Increased risk of permanent disability

ADEM = acute disseminated encephalomyelitis; AQP4 = aquaporin-4 immunoglobulin; MOGAD = myelin oligodendrocyte glycoprotein antibody disease.

Min JK, et al. *Neurol Ther*. 2023;12(2):619-633. Smith AD, et al. *Mult Scler Relat Disord*. 2023;70:104498. Rotstein DL, et al. *Mult Scler Relat Disord*. 2024;83:105434.

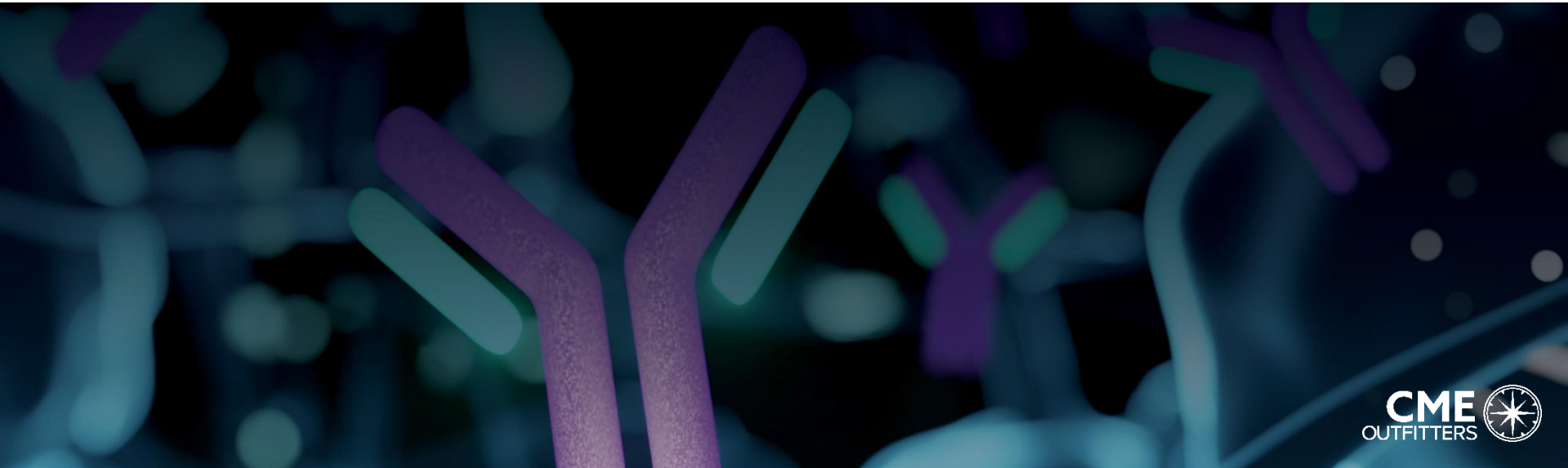
NMOSD Impacts on Quality of Life (QoL)



Eaneff S, et al. *Mult Scler Relat Disord.* 2017;17:116-122.

Inside NMOSD Pathophysiology

Autoantibodies and the Complement Cascade



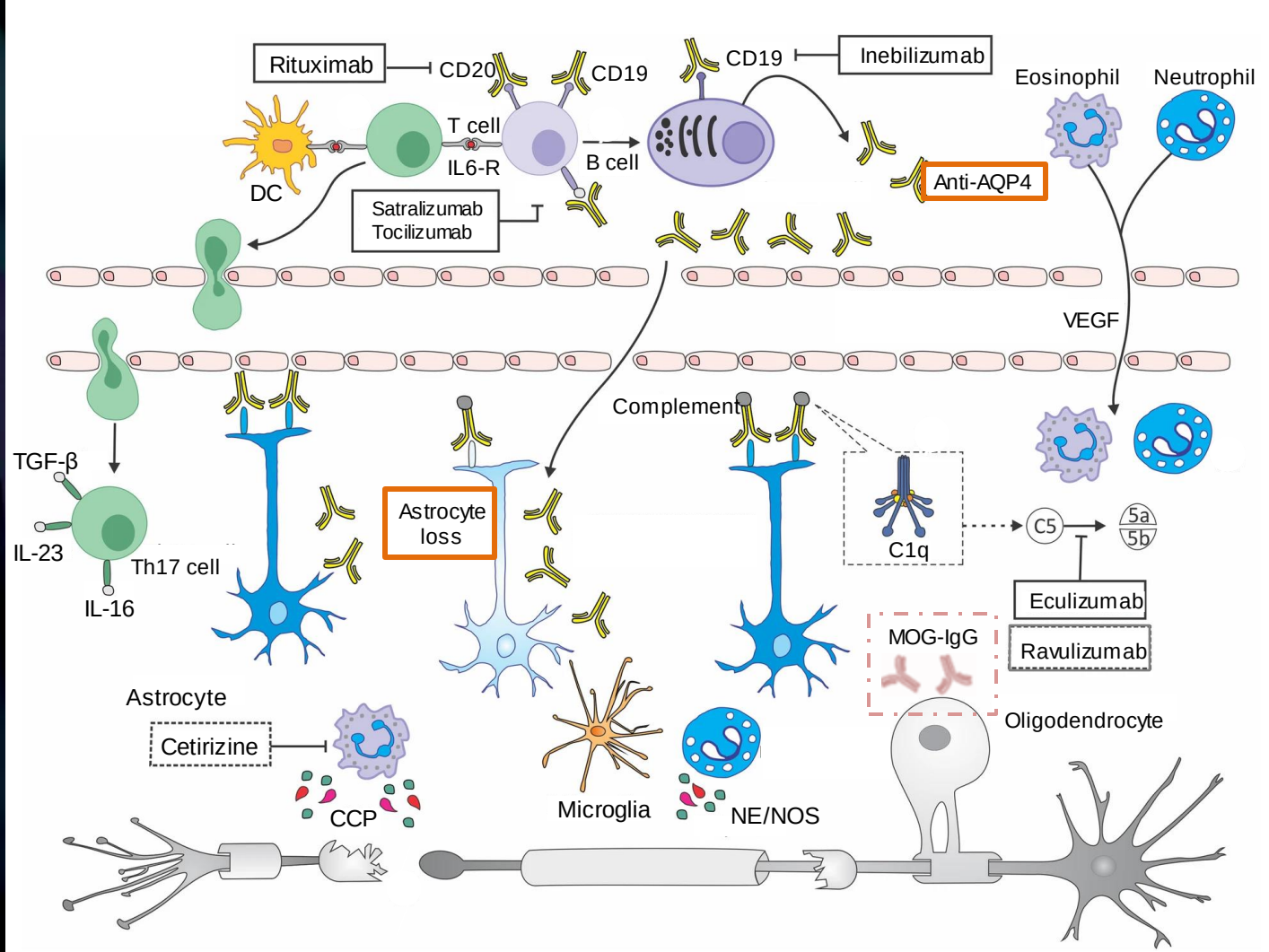
Proposed NMOSD Pathogenesis

- **Aquaporin 4 (AQP4)**
  - Water channel expressed on astrocyte end-feet
  - Regulates bidirectional flow of aqueous material across blood-brain/CSF barrier (BBB)
  - Most prevalent in optic nerve, spinal cord, and brainstem (areas of NMOSD insult)
- **AQP4-IgG autoantibody production**
  - Reactive T cells (Th17) prompt production of autoantibodies (B cells, plasmablasts, IL-6) targeting AQP4
  - AQP4-IgG near 100% specificity for NMOSD
- **Complement activation**
  - AQP4-IgG (or otherwise undiscovered NMO-antibody) binds AQP4 and activates complement
  - Complement cascade promotes neutrophil chemotaxis and MAC deposition (C5)
- **Astrocytopathy**
  - Complement-driven inflammation causes severe astrocyte necrosis (elevated GFAP)
  - Astrocyte loss compromises BBB and promotes further CNS inflammation (NMOSD attacks)
  - Secondary oligodendrogliopathy drives demyelination and axonal degeneration (lesions)

IgG = immunoglobulin G; CSF = cerebrospinal fluid; MAC = membrane attack complex; GFAP = glial fibrillary acidic protein; CNS = central nervous system

Huang TL, et al. *Int J Mol Sci.* 2022;23(14):7908. Wu Y, et al. *Mult Scler Relat Disord.* 2019;27:412-418.
Papadopoulos MC, Verkman AS. *Lancet Neurol.* 2012;11(6):535-544.

NMOSD Immuno-pathology and Therapeutic Targets



DC = dendritic cells, IL = interleukin, TGF = tumor growth factor, C = complement, CCP = cytotoxic cation proteins, NE = neutrophil elastase, NOS = nitric oxide species, VEGF = vascular endothelial growth factor

Carnero Contentti E, Corraele J. *J Neuroinflammation.* 2021;18(1):208

AQP4-IgG Antibody Testing

Frequency and distribution of positive results yielded by different AQP4-IgG assays in patients with clinical NMOSD diagnosis

	Assay type	Results					
	M1-ELISA	–	–	–	+	+	+
	M1-CBA	–	–	+	+	–	–
	M1-FACS	+	+	+	+	–	–
	M23-FACS	–	+	+	+	+	–
Group 1	Patients	1	0	3	10	0	2
N tested	388						
Positive	16 (4%)						
Group 2	Patients	0	3	3	17	1	0
N tested	615						
Positive	24 (4%)						
Group 3	Patients	2	1	2	0	0	0
N tested	31						
Positive	5 (14%)						

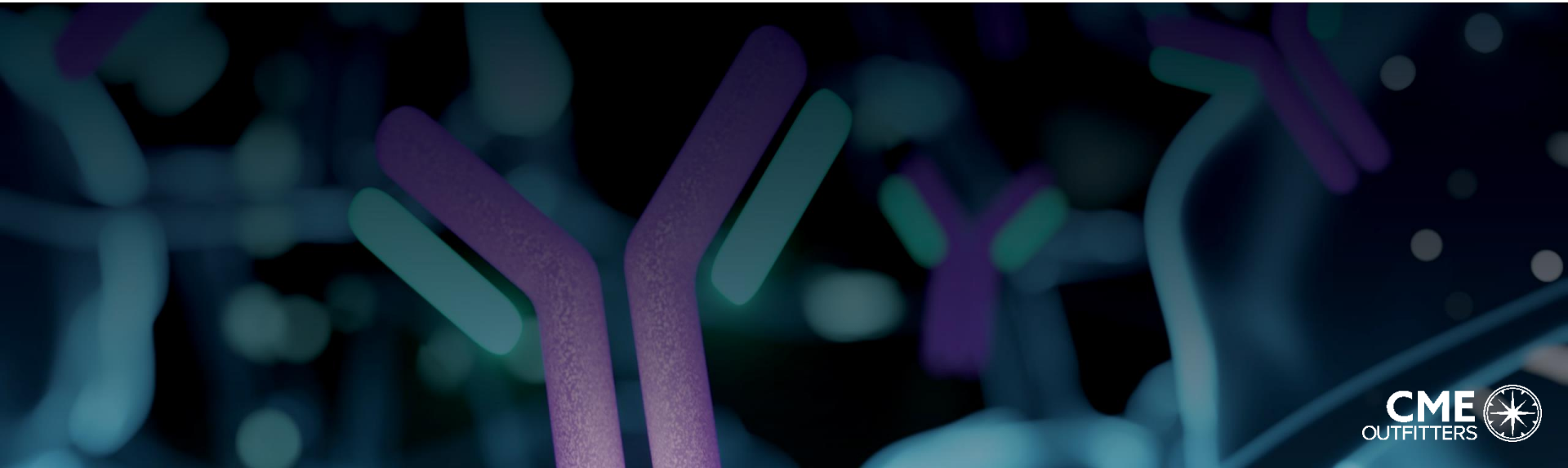
- **Cell-based assays (CBA) preferred**
  - Fluorescence-activated cell sorting (FACS) nearly 100% specific for AQP4-IgG
  - Other CBAs > 90% specific
  - 70-90% sensitivity overall
- **ELISA and immunohistochemistry assays**
  - Commercially available, but not preferred
  - Sensitivity affected by fluctuating antibody titers
  - Concern for false positives
  - Re-testing recommended if uncertain
- **Serum preferred over CSF**
  - Serum testing is more sensitive and less invasive
  - Consider CSF only if serum is inconclusive

ELISA = enzyme-linked immunosorbent assay

Fryer JP, et al. *Neurol Neuroimmunol Neuroinflamm.* 2014;1(1):e11. Alkabie S, Budhram A. *Front Neurol.* 2022;13:912050.

NMOSD Diagnosis

Clinical, Serological, and Radiological Criteria



Patient case: Angela

Angela, a 32-year-old African American female, presents to the ED with an acute onset of neurological symptoms. She reports malaise and fatigue followed by persistent nausea and vomiting for the past 2 days. Today she woke up with severe weakness and numbness in her lower extremities, leading to difficulty with walking and standing. She also reports a band-like sensation around her abdomen and urinary retention.

Assessment:

Upon examination, Angela has decreased strength in her legs (2/5 MRC), hyperreflexia, and a sensory level at T6. Cranial nerve exam reveals mild facial asymmetry and difficulty with gag reflex.

Past medical history:

Migraines (dx age 30): Accompanied by visual disturbances, nausea, and vomiting; managed with prophylactic propranolol 20 mg PO twice daily

Hypothyroidism (dx age 26): Managed with levothyroxine 175 mcg PO daily

Family history: Mother has Sjögren's Syndrome. No other significant family medical history.

MRC = Medical Research Council scale for muscle strength; PO = by mouth/oral

Which of Angela's presenting symptoms most strongly suggests brainstem involvement?

A. Malaise and fatigue

B. Persistent nausea and vomiting

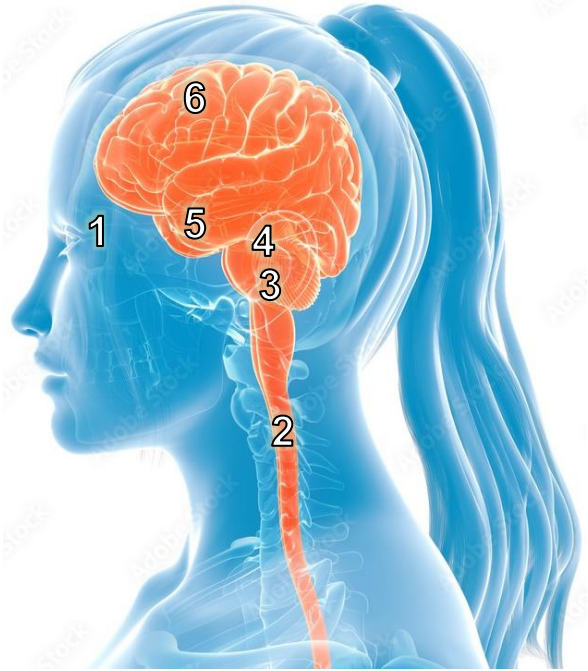
C. Severe weakness and numbness in lower extremities

D. Band-like sensation around her abdomen

E. I don't know

NMOSD Core Clinical Characteristics

1. **Optic neuritis**
2. **Acute myelitis**
3. **Area postrema syndrome (APS)**
4. Acute brainstem syndrome (ABS)
5. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
6. Symptomatic cerebral syndrome with NMOSD-typical brain lesions



Wingerchuk DM, et al. *Neurology.* 2015;85(2):177-189. Jarius S, et al. *J Neurol.* 2023;270(7):3341-3368.

NMOSD Clinical Presentation

Transverse myelitis

- Weakness/paralysis of limb, torso, +/or respiratory muscles
- Painful tonic spasms
- Sharp, shooting, radicular pain
- Pruritis, numbness, tingling, or burning sensations
- Bladder, bowel +/or sexual dysfunction

Optic neuritis

- Unilateral > bilateral partial or complete blindness
- Loss of visual acuity or color saturation
- Retrobulbar pain that worsens with eye movement
- Abnormal/asymmetrical pupillary response to light

Area postrema syndrome (APS)

- Intractable nausea, vomiting, +/- hiccups

+/-

Brainstem, diencephalic, +/or cerebral syndromes

- Symptomatic narcolepsy +/- autonomic dysfunction
- Difficulty speaking, swallowing, +/or breathing
- Facial paralysis
- Severe headache, visual disturbances, altered mental status
- Vertigo, hearing loss, tinnitus
- Encephalopathy, hydrocephaly, seizures
- Fulminant neurogenic respiratory failure

Wingerchuk DM, et al. *Neurology*. 2015;85(2):177-189. Jarius S, et al. *J Neurol*. 2023;270(7):3341-3368. Jarius S, et al. *Clin Exp Immunol*. 2014;176(2):149-164

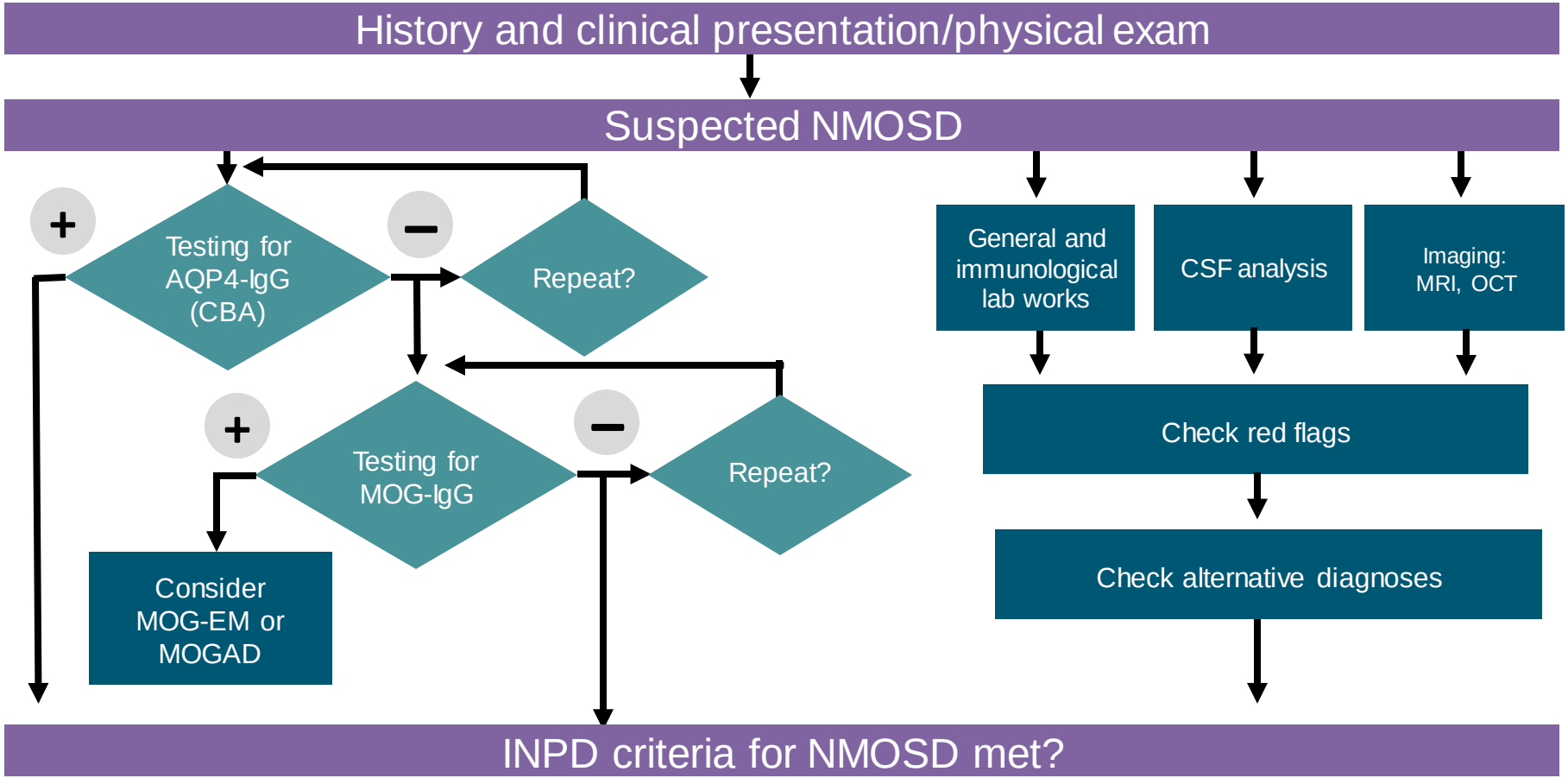
NMOSD Diagnostic Criteria

2015 International Panel for NMOSD Diagnosis (IPND)

NMOSD with AQP4-IgG	NMOSD without AQP4-IgG (or unknown)
• ≥ 1 core clinical characteristic • Positive test for AQP4-IgG using best available detection method (cell-based assay strongly recommended) • Exclusion of alternative diagnoses (i.e., sarcoidosis, neoplastic/paraneoplastic, vascular, chronic infection, etc.)	≥ 2 core clinical characteristic occurring as a result of one or more clinical attacks and meeting all of the following requirements: • ≥ 1 core clinical characteristic must be optic neuritis, acute myelitis with LETM, or APS • Dissemination in space (≥ 2 core clinical characteristics) • Fulfillment of additional MRI requirements, as applicable • Negative test for AQP4-IgG using best available detection method, or testing unavailable • Exclusion of alternative diagnoses

Wingerchuk DM, et al. *Neurology*. 2015;85(2):177-189.

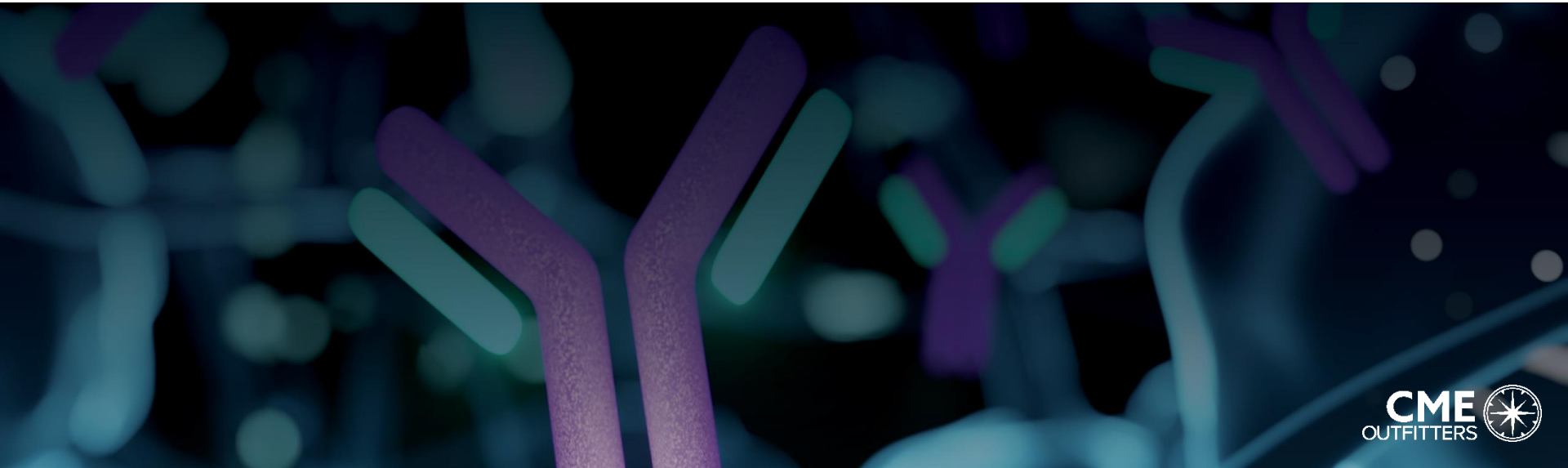
Proposed NMOSD Diagnostic Algorithm



Jarius S, et al. *J Neurol.* 2023;270(7):3341-3368. Wingerchuk DM, et al. *Neurology*. 2015;85(2):177-189.

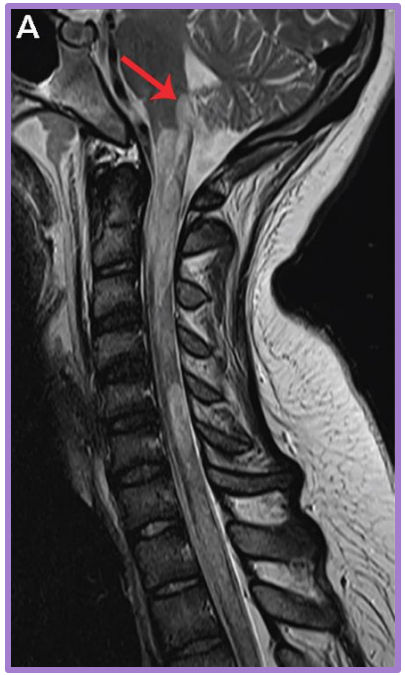
It’s Demyelinating, It’s Relapsing, but It’s Not MS

Red Flags and Clinical Pearls



Patient Case: Angela

Angela is started on high-dose corticosteroids and sent for lab work and imaging.



Laboratory analysis:

Serum

- Anti-AQP4-IgG: Positive
- Anti-MOG-IgG: Negative

CSF

- Oligoclonal bands: Absent
- Protein level: Elevated (100 mg/dL)
- WBC count: Elevated (20 cells/µL)

Additional findings:

MRI: Sagittal T2-weighted brain/spine MRI shows poorly delineated hyperintense signal changes within an enlarged spinal cord extending over 8-9 spinal segments (LETM). A hyperintense dorsal medulla/area postrema lesion is also seen.

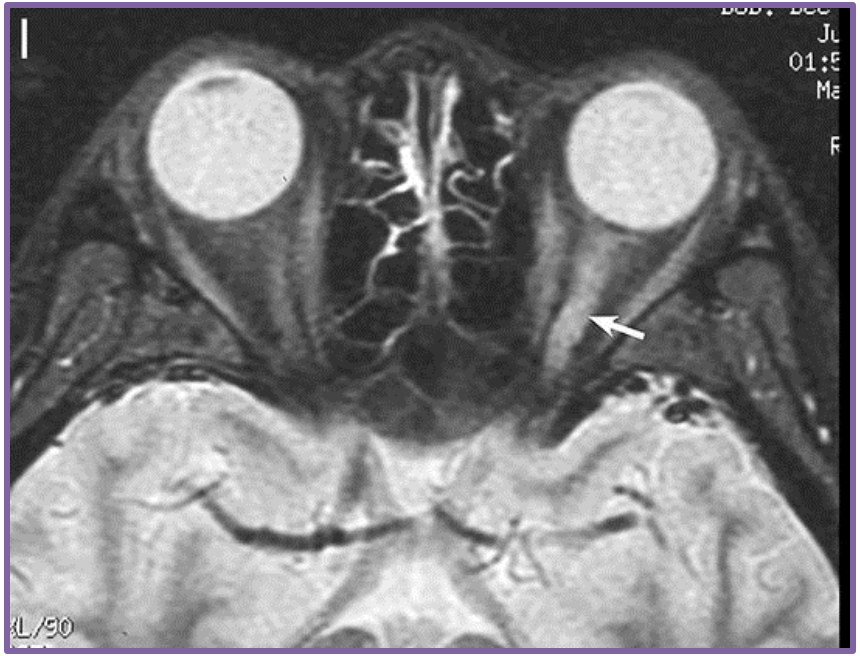
WBC = white blood cell. Costello F. *Continuum (Minneap Minn)*. 2022;28(4):1131-1170.

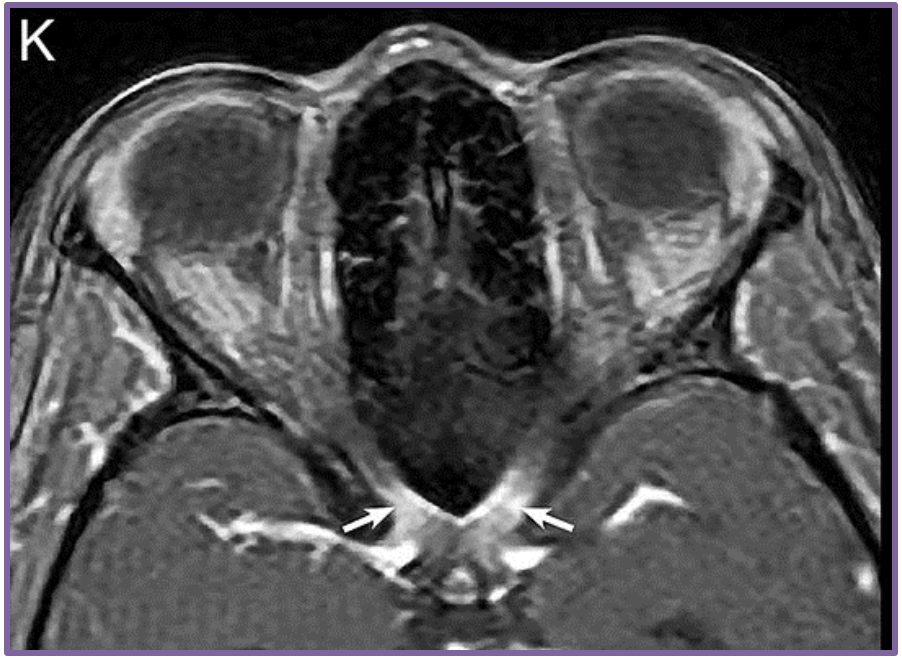
Which combination of findings in Angela's workup is *most* specific for NMOSD?

A. Anti-AQP4-IgG positive + LETM
B. Anti-AQP4-IgG positive + absent CSF oligoclonal bands
C. LETM + absent CSF oligoclonal bands
D. Anti-AQP4-IgG positive + Anti-MOG-IgG negative
E. I don't know

MRI: Acute Optic Neuritis

NMOSD requires normal findings or only nonspecific white matter lesions, *OR* optic nerve MRI with T2-hyperintense lesion or T1-weighted gadolinium-enhancing lesions ≥ half the length of the optic nerve or involving optic chiasm.

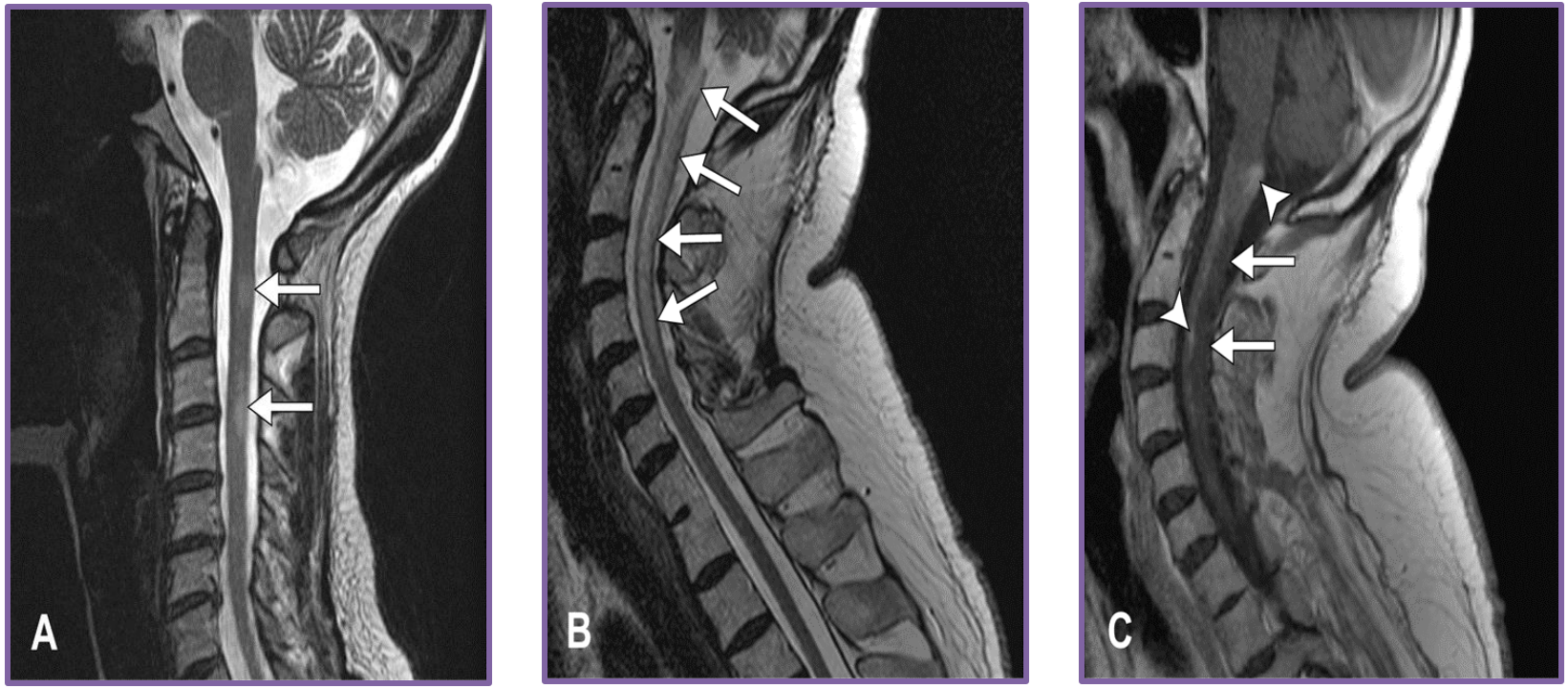




Wingerchuk DM, et al. *Lancet Neurol*. 2007;6(9):805-815.

MRI: Spinal Cord Lesion Phenotype

NMOSD myelitis requires LETM ≥ 3 contiguous segments, *OR* focal atrophy ≥ 3 contiguous segments in patients with history of acute myelitis.

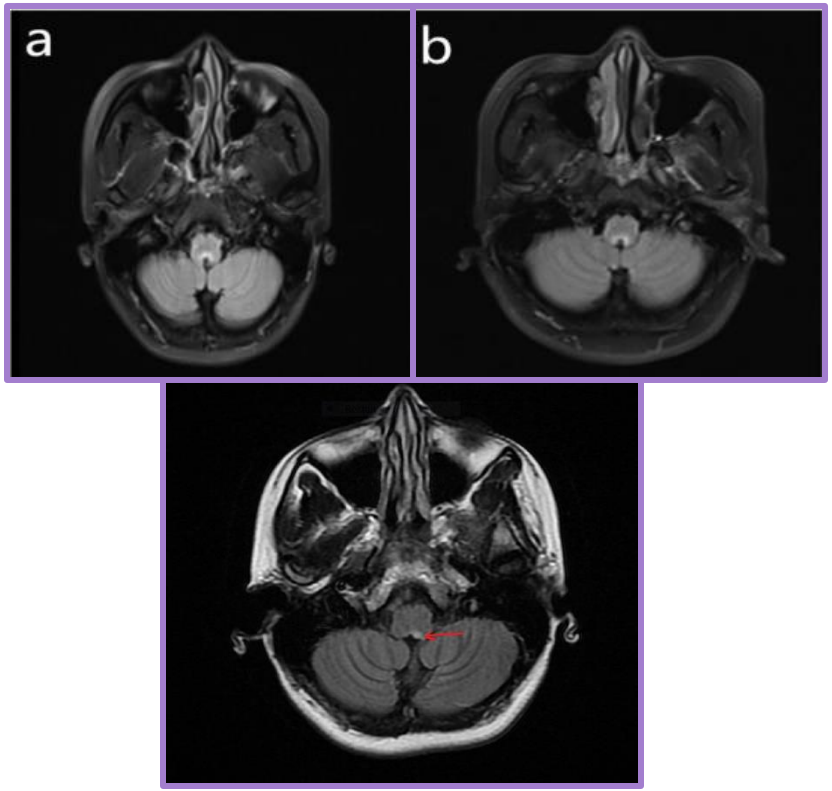


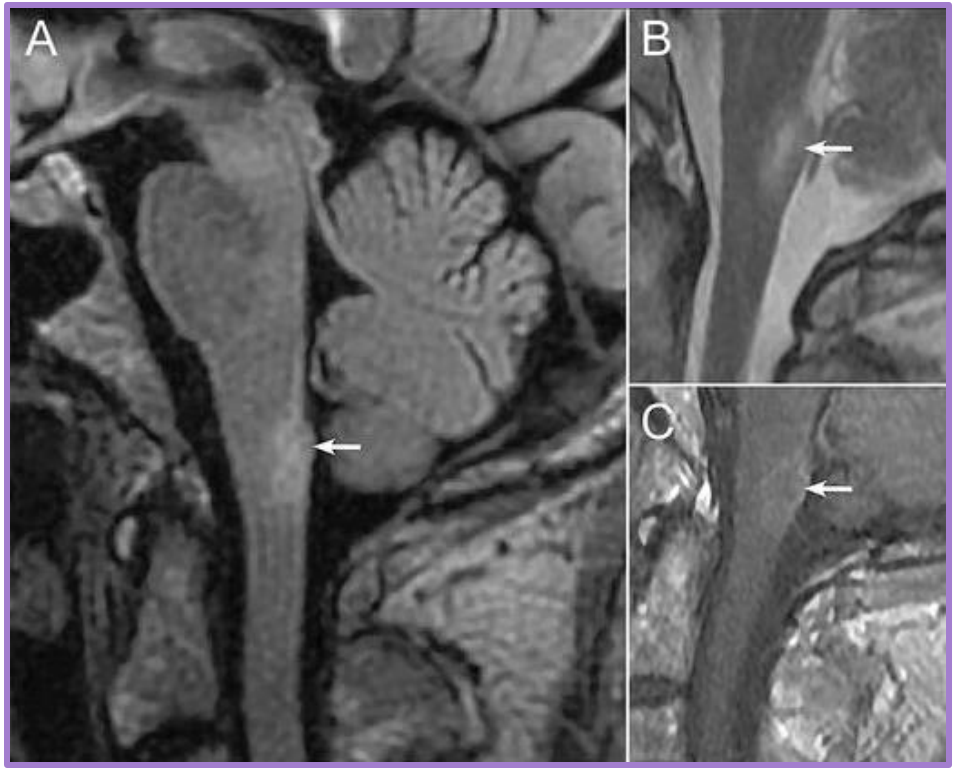
MS **NMOSD** **NMOSD**

Wingerchuk DM, et al. *Lancet Neurol*. 2007;6(9):805-815.

MRI: Area Postrema Syndrome

NMOSD requires associated dorsal medulla oblongata/area postrema lesions.

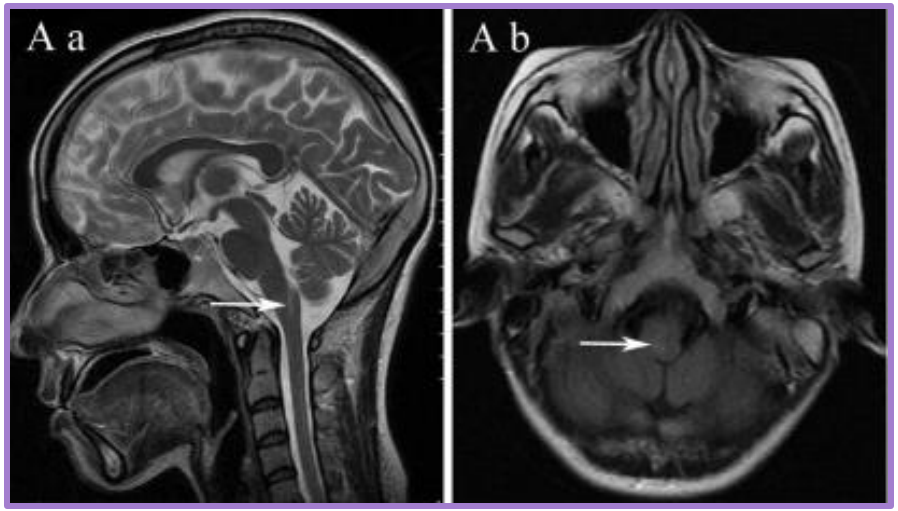


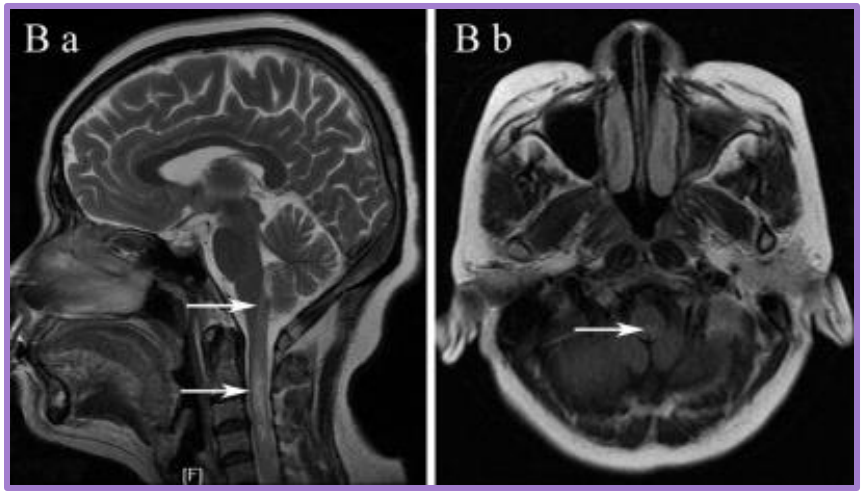


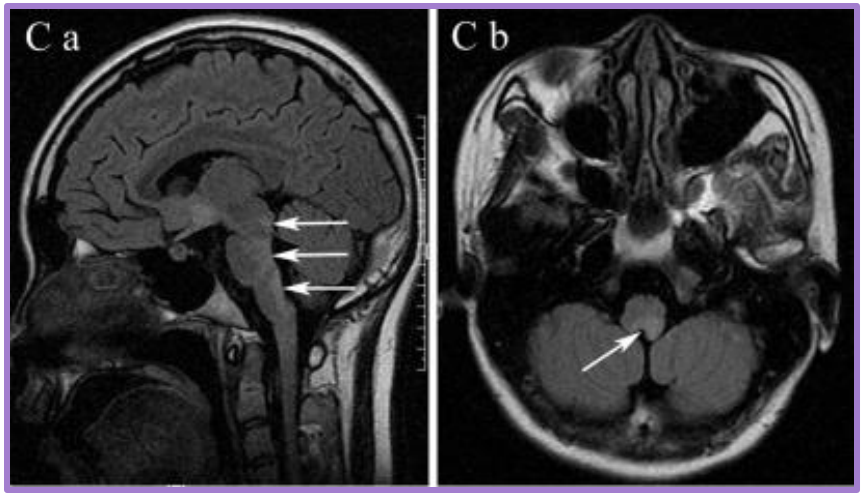
Wingerchuk DM, et al. *Neurology*. 2015;85(2):177-189. Lu Z, et al. *PLoS One.* 2011;6(8):e22766.

MRI:
Other Brainstem Syndromes

NMOSD requires associated periependymal brainstem lesions.







Wingerchuk DM, et al. *Neurology*. 2015;85(2):177-189.
Lu Z, et al. *PLoS One*. 2011;6(8):e22766.

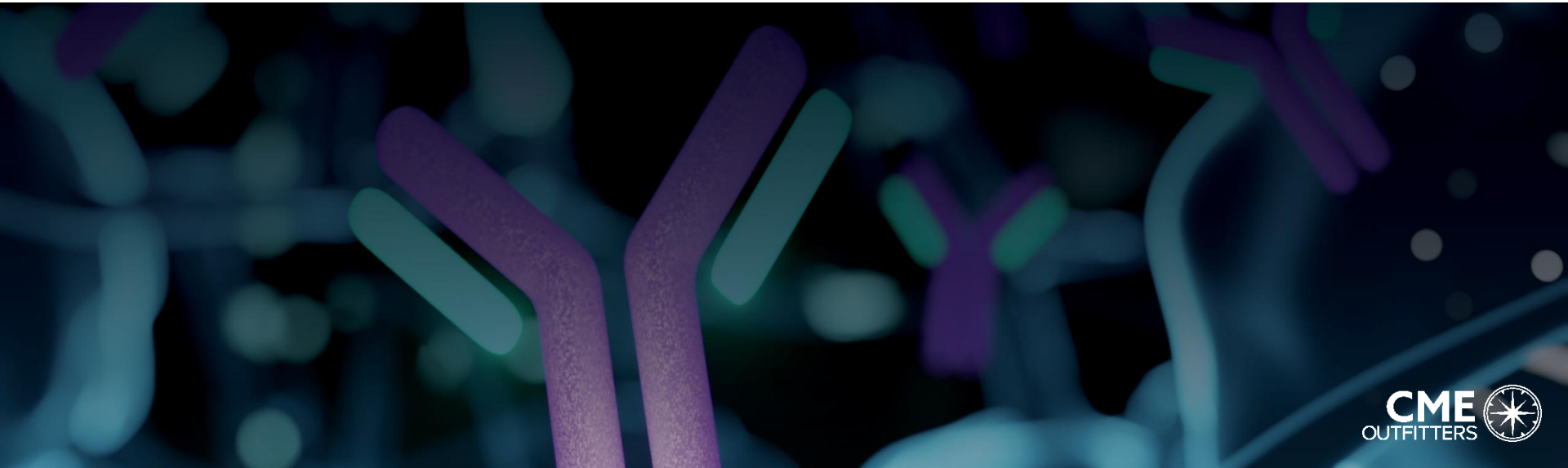
Red Flags: NMOSD vs MS vs MOGAD

	NMOSD	MS	MOGAD
AQP4-IgG seropositive	Mostly	No	No
Attack recovery	Usually incomplete	Usually complete	Incomplete (first is worst)
Secondary progressive course	Rare	Common	No
Optic neuritis presentation	Unilateral > bilateral	Unilateral	Bilateral > unilateral
ADEM presentation	Rare	Rare	Common
CSF oligoclonal bands	Rare	Common	Rare
Lesion location	Mostly central	Mostly peripheral	Mostly peripheral
Cortical or juxtacortical lesions	Rare	Common	Rare
Spinal cord lesions	Long (≥ 3 segments)	Short	Involves conus medullaris
African or Asian descent	Common	Uncommon	No predilection

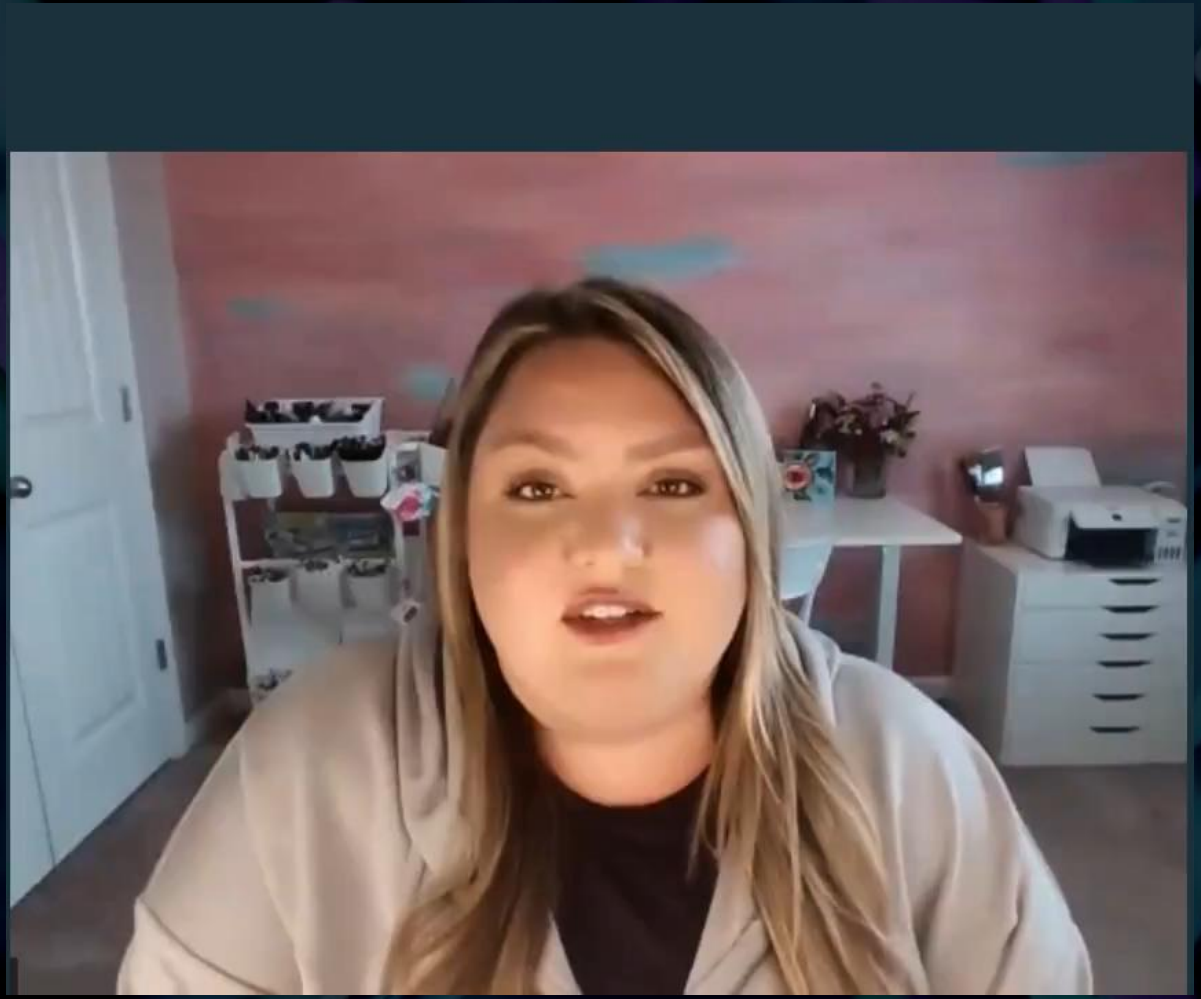
Wingerchuk DM, et al. Neurology. 2015;85(2):177-189. Jarius S, et al. *J Neurol.* 2023;270(7):3341-3368. Cortese R, et al. Neurology. 2023;100(3):e308-e323. Wildner P, et al. *Mult Scler Relat Disord.* 2020;37:101452. doi:10.1016/j.msard.2019.101452

NMOSD Treatment

Optimizing Outcomes from Acute to Chronic Management



Chelsey's Story: Part 2



CME OUTFITTERS

Importance of NMOSD Treatment

- **Recovery after attack/relapse typically poor and incomplete**
  - Attack: emergence of new NMOSD-related symptoms and/or exacerbation of pre-existing ones for > 24 hours, with or without new/enlarging or enhancing MRI lesions*
  - Pseudo-attack: worsening of pre-existing neurological symptoms attributed to non-NMOSD clinical factors, such as infections, fever, injury, comorbidities, medications, psychiatric disorders
- **Incomplete recovery leads to accumulating disability**
  - Every attack can leave residual disability and worsen quality of life
  - Subsequent attacks tend to increase in severity and duration over time
- **Inappropriate treatment worsens disease**
  - Increase in disease activity, relapse frequency, and/or relapse severity associated with initiation of many MS drugs (interferon-β, glatiramer acetate, natalizumab, alemtuzumab, fingolimod, dimethyl fumarate)
  - Mitoxantrone and cyclophosphamide not recommended due to limited effectiveness and high risk of severe adverse effects

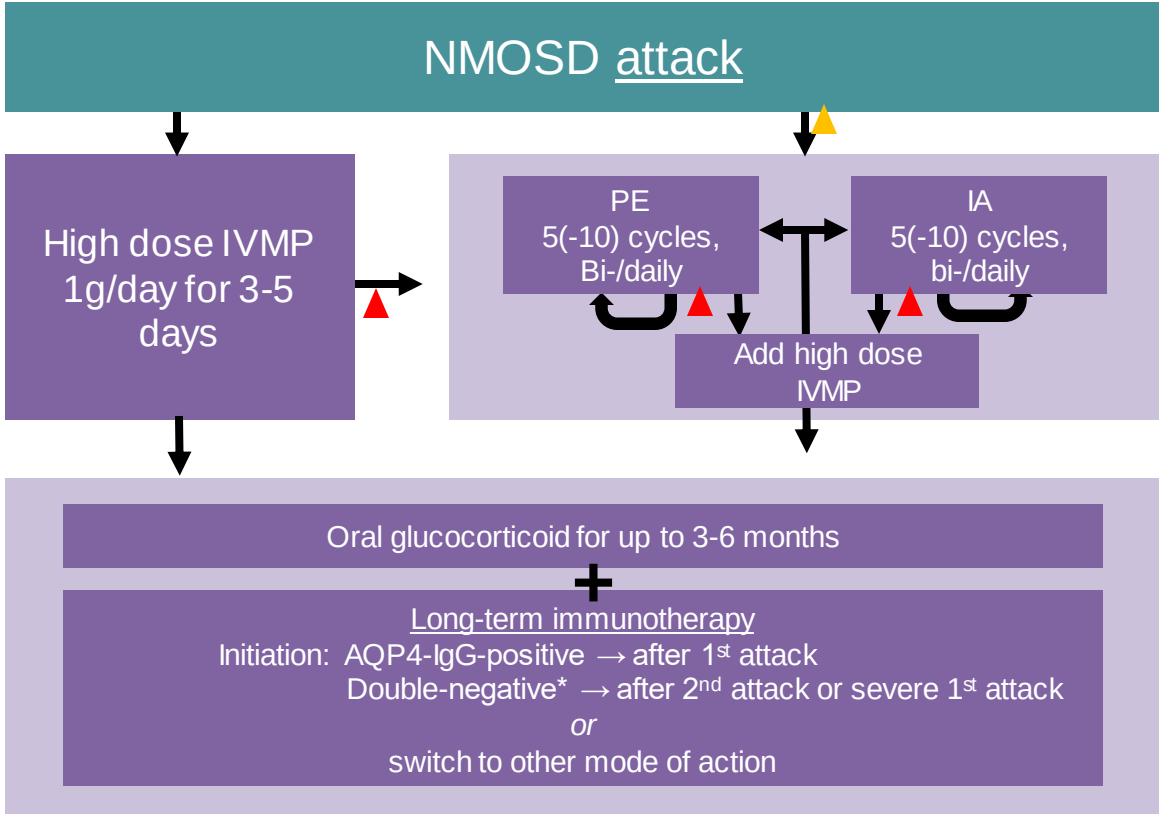
*The necessity of MRI changes to classify NMOSD attacks is widely debated with experts on both sides

Kümpfel T, et al. *J Neurol.* 2024;271(1):141-176. Kessler RA, et al. *Neurol Neuroimmunol Neuroinflamm.* 2016;3(5):e269.

NMOSD Treatment Goals and Options

- **Acute: minimize attack damage through rapid initiation and early escalation of acute therapies**
  - High-dose corticosteroids†: typically, intravenous methylprednisolone (IVMP)
  - Apheresis: therapeutic plasma exchange (PE) or immunoadsorption (IA)
- **Chronic: prevent relapses and therefore worsening disability through early initiation of long-term maintenance therapies**
  - Traditional* immunosuppressive therapy (IST): low-dose corticosteroids, azathioprine†, mycophenolate mofetil†
  - Traditional* monoclonal antibody (mAb): rituximab†
  - Approved mAb: eculizumab, inebilizumab, satralizumab, ravulizumab
- **Symptomatic: maximize quality of life**
  - Patient specific and symptom guided

*Traditional therapies are used off-label, as there were no FDA-approved therapies for NMOSD maintenance prior to 2019.
† not FDA-approved for the treatment of NMOSD
PLEX = therapeutic plasma exchange, IA = immunoadsorption
Kümpfel T, et al. *J Neurol.* 2024;271(1):141-176.



▲ Insufficient response to steroids during previous attacks or sufficient response to apheresis therapy during previous attacks or severe myelitis

▲ No sufficient recovery

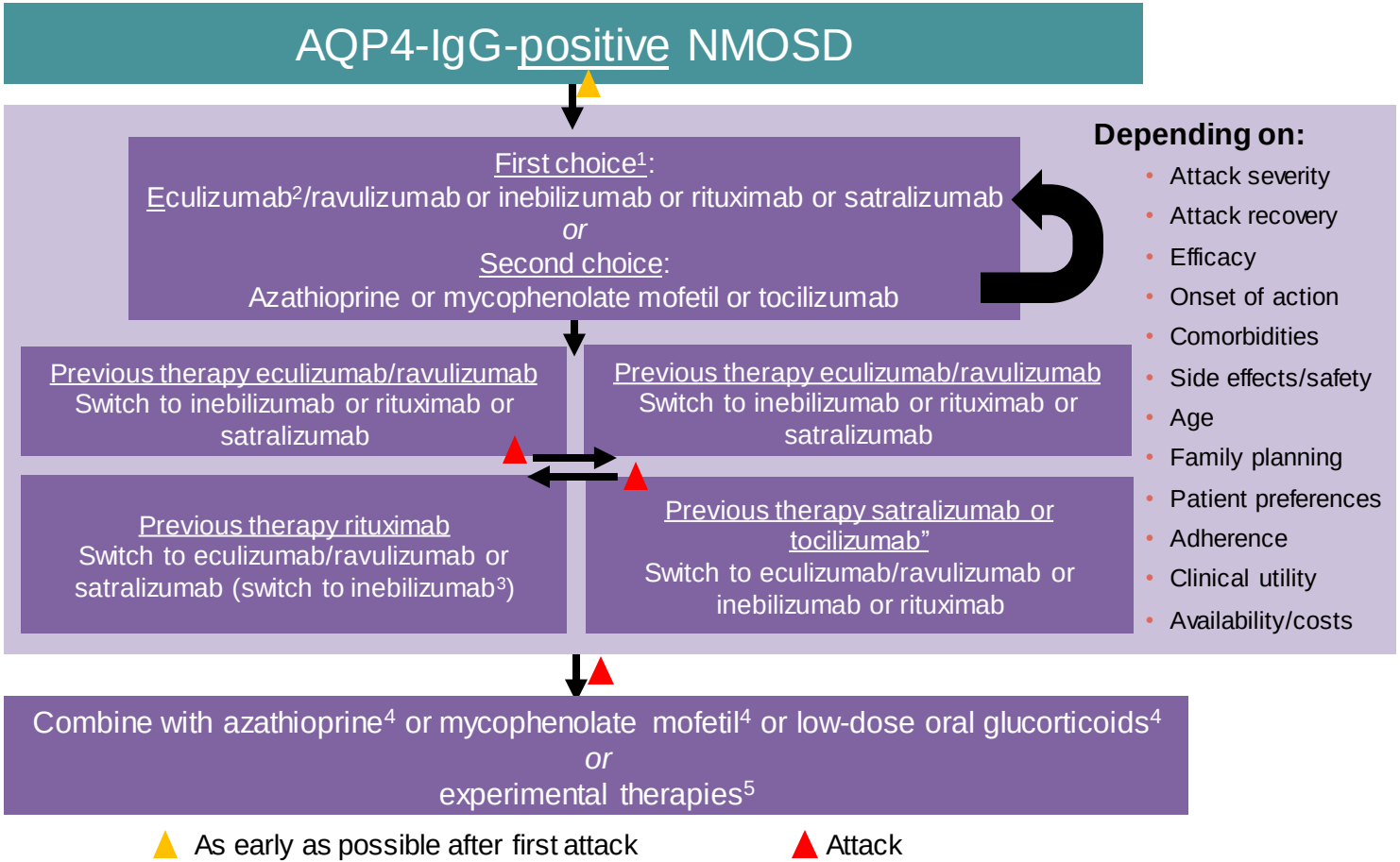
PO = oral. Kümpfel T, et al. *J Neurol.* 2024;271(1):141-176.

NMOSD Acute Attack Therapy

- Initiate immediately upon attack confirmation
- Begin apheresis early if IVMP elicits inadequate response
- Apheresis alone or adjunct with IVMP may be first-line for patients with supporting history of response or severe myelitis
- Intravenous immunoglobulins (IVIg) occasionally considered in patients with contraindications to IVMP and apheresis
- Acute therapy must be followed by PO corticosteroid taper to prevent subsequent attacks

NMOSD Maintenance Therapy

- Start immediately after first clinical attack or upon confirmed diagnosis
- Treatment choice is highly variable and patient specific, but approved mAb preferred over traditional IST whenever possible
- As no therapy is approved for seronegative NMOSD, treatment recommendations are driven by expert opinion



[1]in alphabetical order; [2]use approved only after the 2nd attack in some countries; [3]hypothetical option, no clinical data; [4]in countries where mAb are not available, a combination of azathioprine/mycophenolate mofetil and glucocorticoids may be used; [5]e.g., intermittent plasma exchange/immunoadsorption or hematopoietic stem cell transplantation. In children or in case of contraindications to other therapies intravenous immunoglobulins may be used; methotrexate and tacrolimus may be used if other therapies are not available. Kümpfel T, et al. *J Neurol.* 2024;271(1):141-176.

Traditional Immunosuppressants

All off-label therapies with modest empirical efficacy

- **Mycophenolate mofetil (CellCept®): 1000-2000 mg PO daily**
  - Takes 4-6 months for full effect; corticosteroid coverage needed in interim
  - Major safety concerns: teratogenicity, pancytopenia, hypertension, ulcers, hepatotoxicity, pulmonary toxicity, nephrotoxicity, increased risk of serious infection and malignancy
- **Azathioprine (Imuran®): 2-3 mg/kg PO daily**
  - Takes 2-6 months for full effects; corticosteroid coverage needed in interim
  - Major safety concerns: teratogenicity, hypofertility, pancytopenia, pancreatitis, hepatotoxicity, pulmonary toxicity, increased risk of serious infection and malignancy
- **Corticosteroids: low-dose (ideally ≤ 7.5 mg/day PO prednisone equivalent)**
  - Immediate effects; often used as add-on therapy
  - No controlled data on optimal dosing or tapering; low-dose desired to limit adverse effects
  - Major safety concerns: bone fractures, diabetes, dyslipidemia, cardiovascular disease, myopathy, cataracts, ulcers, skin thinning, impaired wound healing, adrenal suppression, Cushing's syndrome, psychiatric effects, increased risk of infection

PO = per os (orally, by mouth)

Kümpfel T, et al. *J Neurol.* 2024;271(1):141-176. Chan K-H, Lee C-Y. *International Journal of Molecular Sciences.* 2021; 22(16):8638.

Traditional mAb: Rituximab (RITUXAN®)

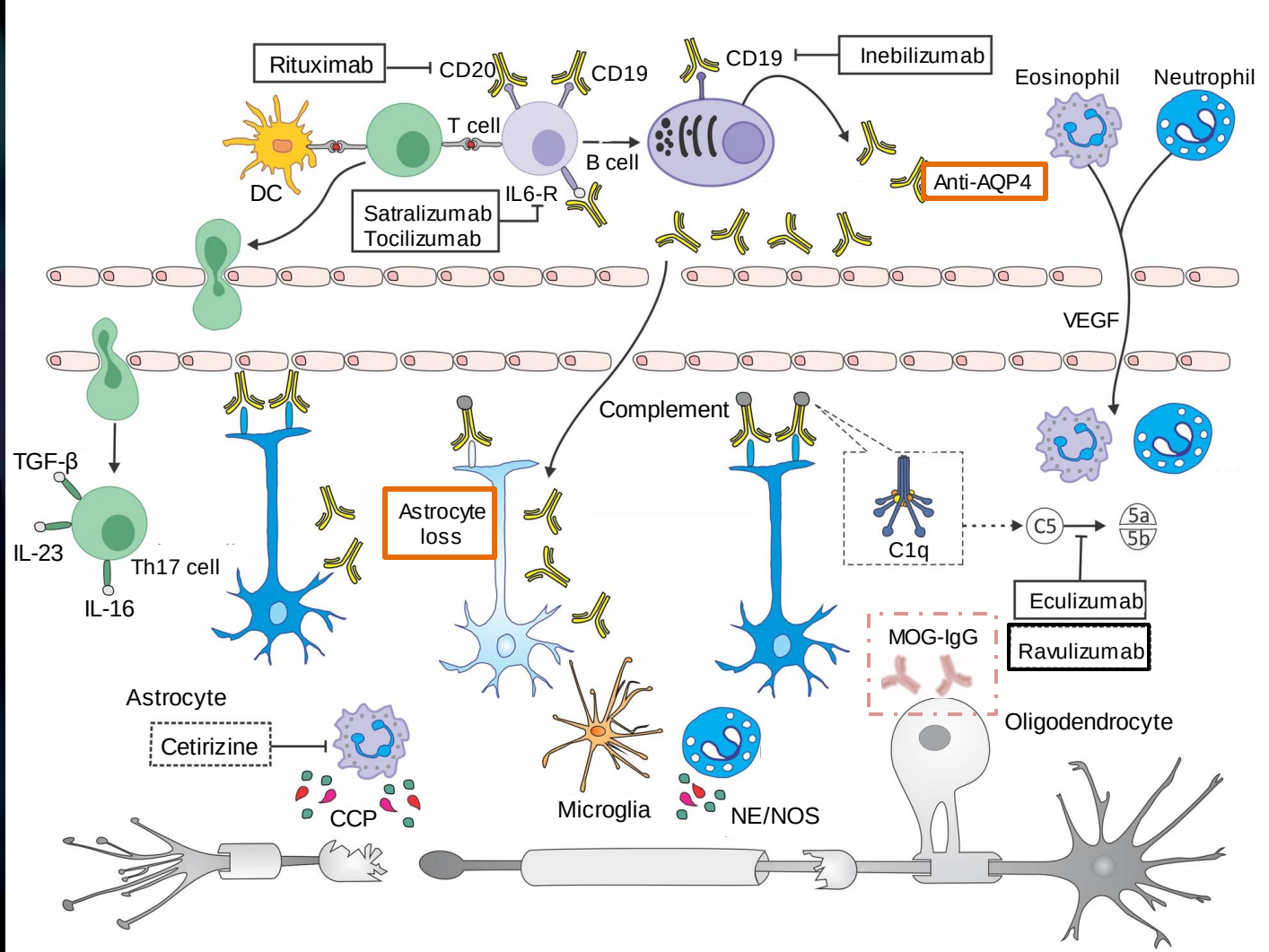
Most robust activity amongst off-label therapies

- Anti-CD20+ mAb; B-cell depletion within 4 weeks, full onset in 8-12 weeks
- Dosing: typically, 1000 mg IV on days 1 and 14, then 500-1000 mg every 6 months thereafter
- Efficacy: no adequately powered RCTs; retrospective reviews demonstrate 70-96% reduction in relapse rate
- AEs: infusion reactions, URTI, late-onset neutropenia, hypogammaglobulinemia, reactivation of viral illness
- Caution: ongoing concerns about FCGR3A-V158F polymorphism impacting efficacy and ultimately memory B-cell depletion

MOA = mechanism of action, AE = adverse effects, URTI = upper respiratory tract infection

Kümpfel T, et al. *J Neurol*. 2024;271(1):141-176. Wang Y, et al. *Mult Scler Relat Disord.* 2021;50:102843. Kim SH, et al. *JAMA Neurol*. 2015;72(9):989-995.

NMOSD Immuno-pathology and Therapeutic Targets



Carnero Contentti E, Corraele J. *J Neuroinflammation*. 2021;18(1):208

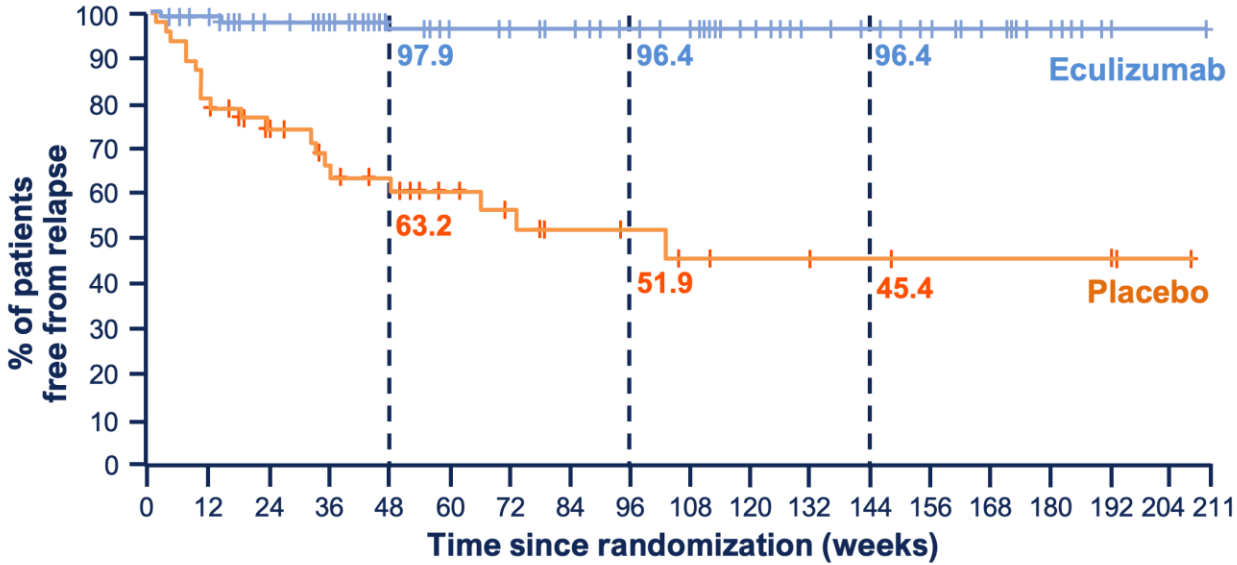
Eculizumab (SOLIRIS®): Anti-C5 mAb

90-minute IV: 900 mg/week x 4, 1200 mg/week x 1, then 1200mg every 2 weeks

Immediate onset within 1-2 weeks

PREVENT: Time-to-event double-blind RCT

- AQP4-IgG**(+)** NMOSD with 2 relapses in last year or 3 relapses in last 2 years, including ≥ 1 in last 12 months + EDSS ≤ 7 (N = 143)
- Randomized 2:1 to eculizumab or placebo (**+/- continued traditional IST**)



94% relative reduction in risk of relapse with eculizumab vs placebo (0.06 HR, p < 0.0001)

AEs: headache, URTI, arthralgias/myalgias, GI upset

Caution: anemia, leukopenia, fungal infections, allergic infusion reactions

REMS: meningococcal vaccination due to risk of encapsulated bacteria infection

EDSS = expanded disability status scale, GI = gastrointestinal

Kümpfel T, et al. *J Neurol.* 2024;271(1):141-176. Pittock SJ, et al. *N Engl J Med.* 2019;381(7):614-625.

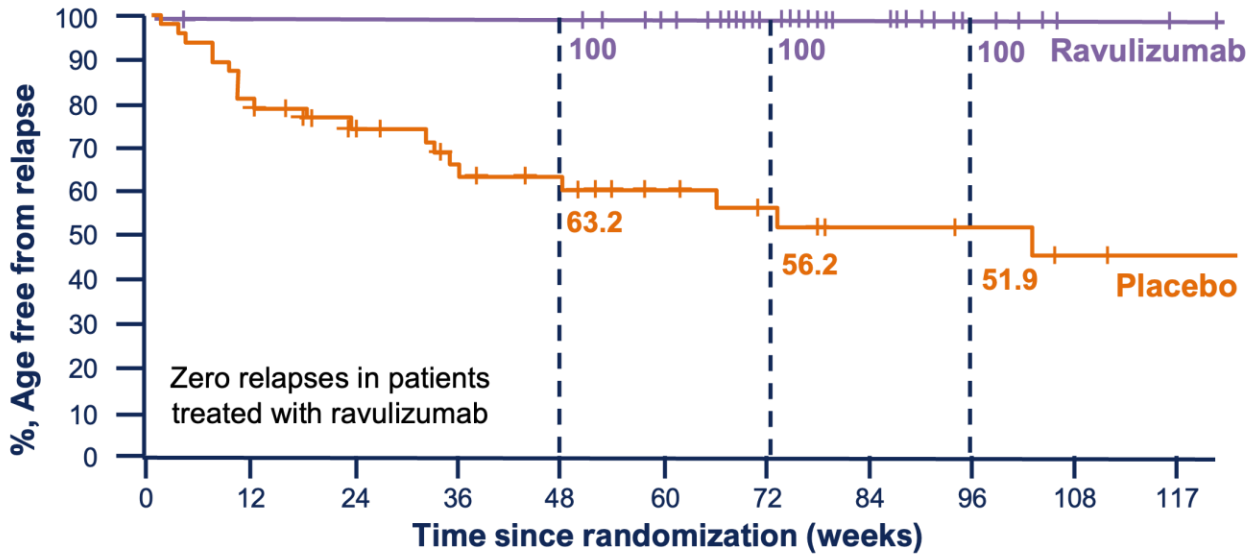
Ravulizumab (ULTOMIRIS®): Anti-C5 mAb

Weight-based IV infusion: day 1 loading dose, day 15 maintenance dose every 8 weeks

Immediate onset within 1-2 weeks

CHAMPION-NMOSD: Time-to-event external comparator RCT

- AQP4-IgG**(+)** NMOSD with ≥ 1 relapse in last 12 months + EDSS ≤ 7 (n = 58 ravulizumab, n = 47 external placebo arm from PREVENT)
- Continued IST allowed



98.6% relative reduction in risk of relapse with ravulizumab vs placebo (0.014 HR, p < 0.0001)

AEs: headache, UTI, arthralgia, myalgia, URTI

Caution: anemia, leukopenia, fungal infections, allergic infusion reactions

REMS: meningococcal vaccination due to risk of encapsulated bacteria infection

Kümpfel T, et al. *J Neurol.* 2024;271(1):141-176. Pittock SJ, et al. *Ann Neurol.* 2023;93(6):1053-1068.

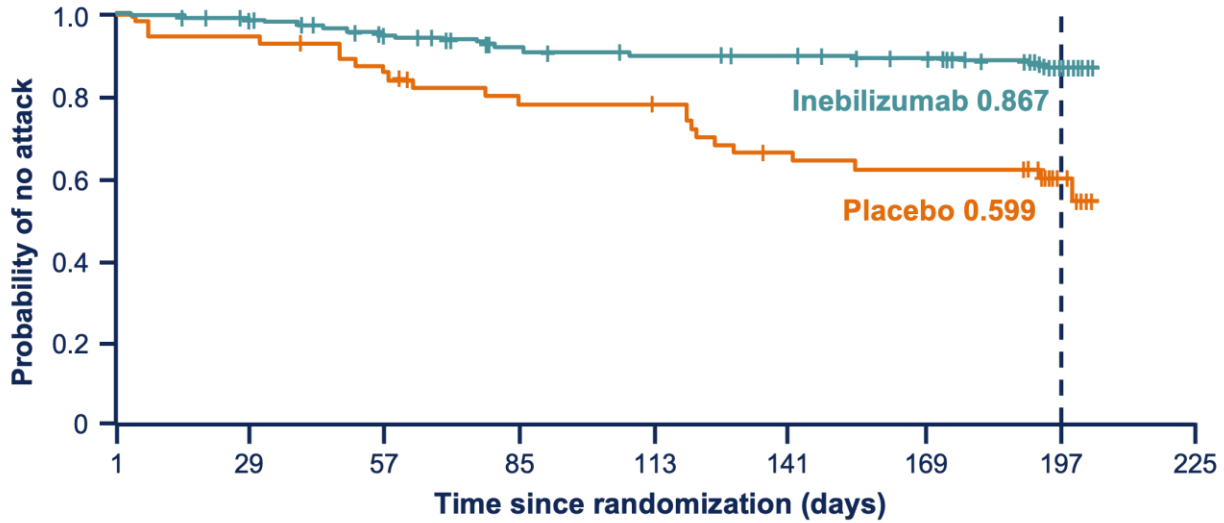
Inebilizumab (UPLIZNA®): Anti-CD19 mAb

90-minute IV with triple pre-medication: 300 mg on day 1 and 15, then every 6 months

B-cell depletion within 2 weeks, full onset in 6-8 weeks

N-MOmentum: Time-to-event double-blind RCT

- AQP4-IgG**(+/-)** with 1 relapse in last 1 year or 2 relapses in last 2 years + EDSS ≤ 8 (N = 230)
- Randomized 3:1 to inebilizumab or placebo (+ corticosteroid days 1-21 **only**)



In AQP4(+) only: 77% relative reduction in risk of relapse with inebilizumab vs placebo (0.27 HR, $p < 0.0001$)

AEs: UTI, URTI, arthralgias

Caution: life-threatening infusion reactions, opportunistic infection, viral reactivation, hypogammaglobulinemia, teratogenic

Kümpfel T, et al. *J Neurol.* 2024;271(1):141-176. Cree BAC, et al. *Lancet.* 2019;94:1352–63.

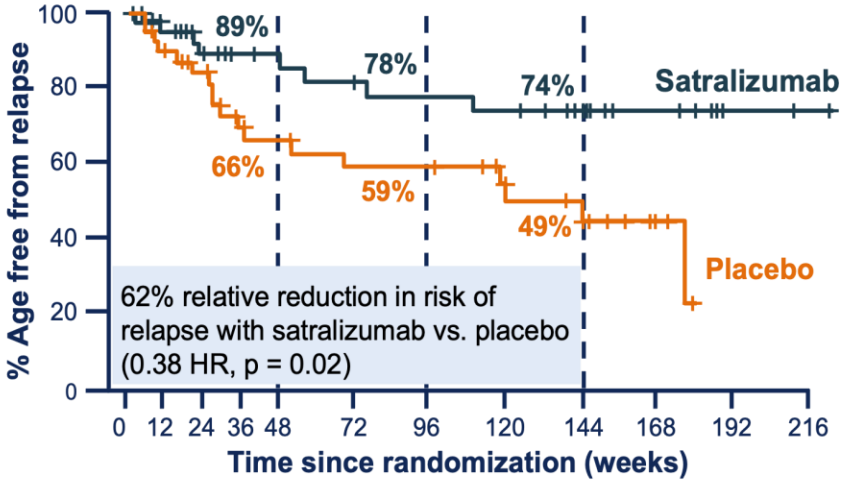
Satralizumab (ENSPRYNG®): Anti-IL-6 mAb

Ages 12+ approved

Self-administered SC: 120mg every 2 weeks x 3, then every 4 weeks; full onset in 12-24 weeks

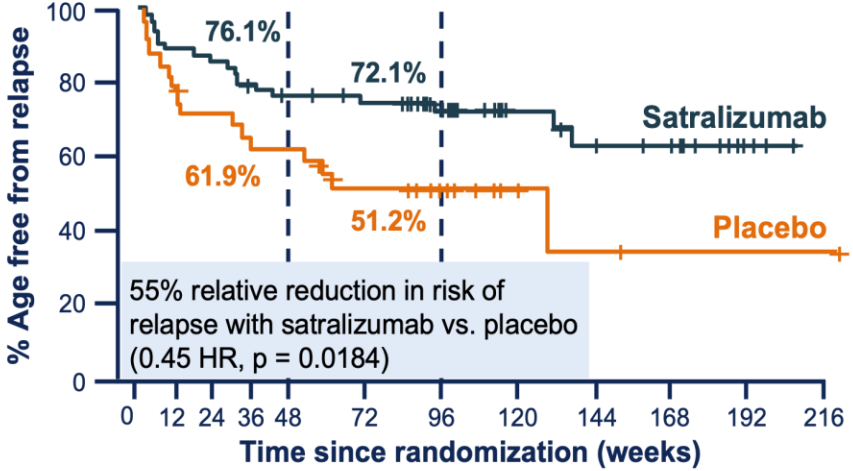
SAkuraSky: Time-to-event double-blind RCT

- AQP4-IgG**(+/-)** with ≥ 2 relapses in last 2 years including ≥ 1 in last 1 year + EDSS ≤ 6.5 (N = 83; **n = 8 aged 12-17 years**)
- Randomized 1:1 satralizumab or placebo (**+ continued IST**)



SAkuraStar: Time-to-event double-blind RCT

- AQP4-IgG**(+/-)** with ≥ 1 relapse in last year + EDSS ≤ 6.5 (N = 95)
- Randomized 2:1 satralizumab or placebo (**no IST allowed**)



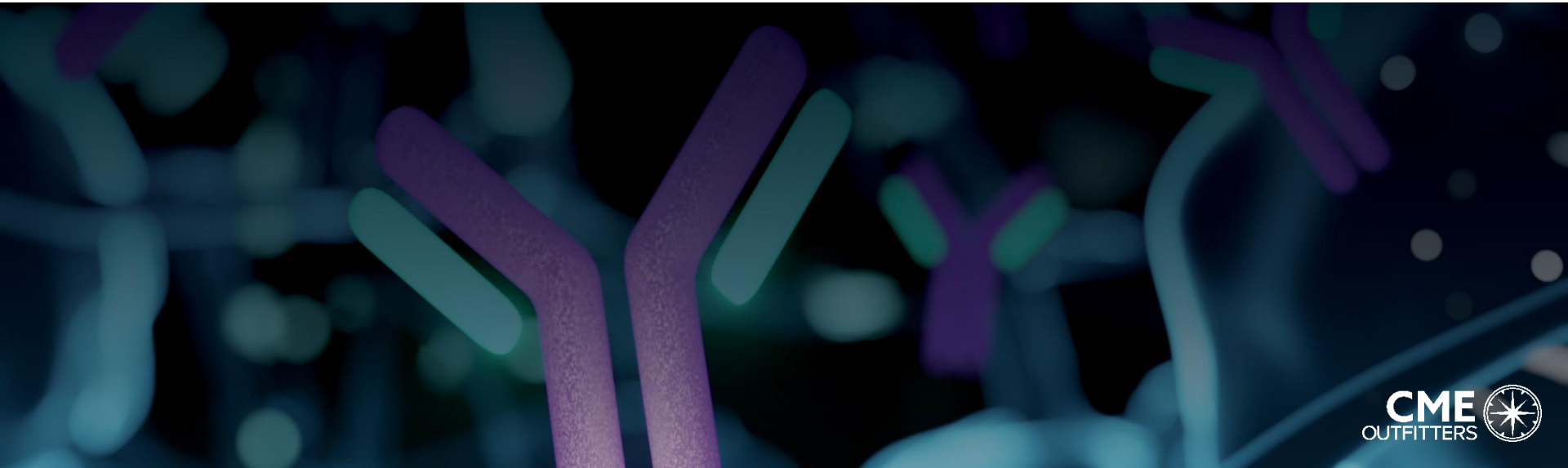
Pooled analysis: 75% risk reduction in AQP4-IgG(+), no significant difference in AQP4-IgG(-)

AEs: injection reactions, headache, arthralgia, URTI, neutropenia, thrombocytopenia, elevation in LFTs/cholesterol/triglycerides

LFTs = liver function tests. Kümpfel T, et al. *J Neurol*. 2024;271(1):141-176. Yamamura T, et al. *N Engl J Med.* 2019;381(22):2114-2124. Traboulsee A, et al. *Lancet Neurol*. 2020;19(5):402-412. Yamamura T, et al. Mult Scler Relat Disord. 2022;66:104025.

Long-Term Follow-up

Ongoing Monitoring and Supportive Patient Care



Chelsey's Story: Part 3

Ongoing Monitoring Needs

- **Neurological assessments**
  - Routinely or as clinically indicated
  - Purpose: monitor disease activity, residual symptoms, response to treatment
- **Brain and spinal cord imaging**
  - Routinely or if new symptoms occur
  - Purpose: detect new lesions, assess disease burden, guide treatment adjustments
- **Laboratory tests**
  - Antibody titers: AQP4-IgG and/or MOG-IgG periodically or as indicated
  - Labs: CBC, BMP, GFAP, others as indicated by treatment protocol
  - Purpose: monitor treatment effects, potential seroconversion, comorbidities
- **Treatment monitoring**
  - IST and mAb: regular assessment of efficacy, side effects, opportunistic infections, long-term safety concerns, QoL

Kümpfel T, et al. *J Neurol.* 2024;271(1):141-176. Abboud H, et al. *J Neurol.* 2022;269(4):1786-1801.

Symptomatic and Supportive Care

Motor dysfunction	Vision impairment	Neuropathic pain and paresthesias	Spasticity and tonic spasms
Bladder, bowel, and sexual dysfunction	Fatigue and disordered sleep	Pregnancy	Psychiatric/ cognitive impairments
Infection and vaccines	Autoimmune comorbidities	Psychosocial support	Patient/care partner education

Kümpfel T, et al. *J Neurol.* 2024;271(1):141-176. Abboud H, et al. *J Neurol.* 2022;269(4):1786-1801.

SMART Goals

- Recognize the patient experience and impacts of living with NMOSD.
- Increase the rate of accurate NMOSD diagnoses by implementing the latest diagnostic criteria and cell-based antibody testing.
- Distinguish NMOSD from MS lesions (or lack thereof) on brain and spinal cord imaging.
- Reduce time to initiation of NMOSD maintenance therapy in newly diagnosed patients.
- Implement appropriate monitoring and supportive care measures to optimize patient quality of life.

QUESTIONS

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ANSWERS

Thank you for joining us.
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