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Letter to the Editor

From patient viewpoint: a perspective on new therapeutic options

What a 60-year-old "guy" with hemophilia today possibly ask for, after having survived a decade without any treatment, and then going through the gloomy years of plasma derivatives tainted with deadly blood-borne viruses like HIV, HBV and HCV, the most appalling drug-induced catastrophe of modern medicine?

After the marketing of recombinant products in the mid '90s, the next 20 years were marked by 2nd and 3rd generation rFVIII and rIX with little, if any, perceived improvement by patients. In the last few years new significantly innovative drugs have been developed, offering an increased efficacy in terms of half-life, which means a higher protection against bleedings and/or less frequent injections. The onset of non-replacement therapy that can be administered subcutaneously has been warmly welcomed by patients. Meanwhile, the ever-receding gene therapy, something we have been hearing about since the '90s, has made great steps forward, some of them no longer in company pipelines but ready to start the registration process, even if its therapeutic scope so far is not curing hemophilia for good but providing a temporary mitigation, and many issues are still open (long term safety, possibility to repeat it, among others).

We are undeniably facing a change of paradigm, requiring and fostering adjustments by both patients and physicians. The most important indicator of the efficacy of hemostatic therapy is the frequency of bleeding, state WFH Guidelines for the Management of Hemophilia. Though FVIII/IX levels have a direct impact on clinical response and can be easily gauged, providing an insight on treatment effectiveness, it's by now well known that microbleeds, that is bleedings that are not apparent, can actually occur, impacting joint health in the long run. While with replacement therapy FVIII/IX levels can be considered a good efficacy metrics, there is so far no direct lab test showing how well non-replacement therapy is working. Here more than ever, we must rely on clinical response. Needless to say, from a patient perspective subcutaneous vs intravenous injection is much easier, and more so, if infusion frequency is once a week instead of 2/3 times a week. It's generally agreed that the choice of treatment should be shared with patients, who in Italy are required to sign an ad hoc informed consent. Given the picture, patient involvement in the decision making process is paramount. After considering the patient's lifestyle, age, and general conditions, including musculoskeletal and vein access, provided no clinical issue advises against non-replacement therapy, what else can guide drug choice if not the patient's preference? This way, a major pharmaceutical innovation is likely to make the difference in the relationship between physician and patient, giving the latter a greater edge in a choice which is now less technically-driven than it used to be. We are living a time of significant advance, the most relevant of which, non-replacement therapy and gene therapy, can probably be seen as a bridge between traditional treatments and a new era where a cure for hemophilia is finally looming. Meanwhile, the above mentioned 60 year-old patient can weigh up the pros and cons of different innovative therapeutic options, including gene therapy, a choice far less predictable than it was only 10 years ago. Which is, in itself, a good sign of the huge progress that has been made.

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