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Evidence-based Discussion of the New and Emerging Treatment Strategies for Idiopathic Hypersomnia

Announcer:
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Dr. Davis:
Hi, I'm Matt Davis. I'm a Neurologist and Sleep Specialist in solo private practice in New Jersey. And we're going to be talking about new and emerging therapies in idiopathic hypersomnia. I'm here with Dr. Logan Schneider.

Dr. Schneider:
Thanks. Thanks for having me. I'm a Sleep and Cognitive Neurologist out here in Stanford area, and happy to chat about the therapies that are here, and maybe in the future, what will be coming down the pipeline.

Dr. Davis:
So, yeah. So you know, idiopathic hypersomnia is such a sometimes nebulous disorder, and there have been very few approved, in fact, almost no approved medications for it. So, what can you - let's talk about, you know, first what the, you know, previous treatments were before we had a new FDA approved medicine recently in low-sodium oxybate. What are your thoughts on some of the older therapies we were using?

Dr. Schneider:
Yeah, well, I mean, my thoughts are somewhat mixed. I think it was really just trying anything you could from the menu. They were intuitive, at least some of the main ones that were supported by the AASM's recent guideline, including wake-promoting agents and stimulants. They did have benefits in some, and not middling benefits in others, typically didn't resolve the underlying condition. Obviously, it's like putting a Band-Aid on something without actually solving the underlying issue. But they made sense, right? You're stimulating somebody to more wakefulness.

Then there were some of those more fringe therapies that, at least in certain trials may have demonstrated some benefits that were unexpected, but you know, really supported by some of the work that was coming out of Emory, suggesting maybe there's some substance floating around in the brain making you sleepier, and so if we can block that substance action, maybe that is actually a way to promote wakefulness. And I think this is, you know, informed pipelines of therapies that ultimately are going to try and stop that sedating type of brain signaling. So yeah, it was anything that we could try to try and figure it out. And as you mentioned, we don't know what one individual's idiopathic hypersomnia is caused by, and so it's hard to create a tailor therapy that appropriately addresses it. And so, it was really just trying what's on the menu.

Dr. Davis:
Yeah, no. I totally agree. And, you know, my strategy was always to start with modafinil or armodafinil, because there seems to be a little bit more evidence for that. And I think the AASM has that on the top of their list for treatment guidelines. But yeah, it's always been a challenge, because we aren't exactly quite sure what we are treating here, so it's just a matter of treating it symptomatically.

And yeah, I kind of always stuck with, you know, our experience with wake-promoting medicines, and not some of those more fringe therapies. But there are those patients who respond to some of these more unusual medicines unexpectedly. But then, of course, the FDA approved low-sodium oxybate a few years ago for idiopathic hypersomnia. I found it to be very effective, you know, the theory being that it's treating some of the underlying sleep dysfunction, particularly helpful for these patients with, you know, their unique symptoms of like sleep inertia, for example, which it's really, in my opinion, the only thing that's really, really treating that in these patients. What are your thoughts and what has been your experience over the past couple of years using that?

Dr. Schneider:
Yeah, I have a similar experience also, is I've been trying to rationalize the mechanism by which it's working in my mind, since we don't have a good answer on that.

Dr. Davis:
Yeah.

Dr. Schneider:
We have a lot of decades of data of its usage in folks with narcolepsy. And in those individuals, one of the hallmark pathologies, or I guess symptoms of the pathology, is the disruptive nocturnal sleep. And so presumably, if you're improving the sleep itself, then you might see the improvements in daytime function as well. And I think the thing that felt quite intuitive about that is if you look at Bogan's data from 2015, that the accrual of benefits in sleepiness and cataplexy management accrue over time. And that's kind of like the intuition that we have when you pay off debt slowly from a sleep deficiency standpoint. So, I started to, you know, analogize that to the practice here in idiopathic hypersomnia management, as well as when we treat with CPAP and when we resolve the sleep fragmentation, you're less sleepy during the day. And so, I looked at it more as like effective sleep. And I do see that in patients generally, is that they have less of the inertia, less of a desire to sleep during the day, and in fact, need less sleep.

In fact, in the clinical trial, that got the FDA approval, essentially those folks who started on once nightly because they couldn't wake up and take that second dose ultimately ended up being - as many of them ultimately ended up being able to take that second dose. And in fact, one of the side effects of this medication can be insomnia. So, I look at that and say, well, maybe over time, it eventually is resolving that sleep dysfunction so that they can function during the day.

Dr. Davis:
Yeah, that's exactly how I'm looking at it. I totally agree with that. Just in our last few moments here, you're more attuned to some of the emerging therapies than I am because you're in kind of this academic environment that I'm not, what are your thoughts about where things might go?

Dr. Schneider:
I'm actually hopeful for the orexin agonists working on various things. It's becoming much more sleep medicine-specific, knowing how the sleep-wake mechanisms work.

Dr. Davis:
Cool. Very cool. Well, thank you for your attention and I hope this was meaningful for people watching. Thank you.

Announcer:
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