**Reader:** I receive 10 grams of intravenous immune globulin (IVIG) every two weeks. At 94 pounds, I was told the proper dose is 20 grams, but I found this was too much for me. The problem is that in 2007, I tested positive for Lyme disease and I’m wondering if I should still be treated for this? Is it recommended to take antibiotics for long periods of time for infections if needed when prescribed IVIG? Do the antibiotics lower the white blood cell count (WBC)? In the past when I was treated with antibiotics for mycoplasma and other parasitic infections, my WBC would decrease to 2 before IVIG.

**Michelle:** In primary immunodeficiency (PIDD), IVIG is used as replacement therapy. Enough IVIG is given to maintain proper IgG levels to protect you from infection. If you are receiving IVIG and still require antibiotics for long periods of time for infection, it could be because your IgG levels are not high enough to provide this protection. Your physician should monitor this level by drawing your blood immediately prior to an IVIG infusion to see what that level is at its lowest point (known as the IgG trough level). Also, usually with infections, the WBC count goes up, but with PIDD this may or may not occur. I would again attribute this to possibly not having a high enough dose of IVIG to assist your immune system to fight infections.

**Reader:** I have a 29-year-old daughter who was diagnosed 10 years ago with myasthenia gravis (MG). She suffered and was misdiagnosed for a year and a half before she was diagnosed, at which time she was in myasthenic crisis and hospitalized in the ICU. Her neurologist treated her with high-dose prednisone and five days of intravenous immune globulin (IVIG) that ultimately brought her out of the crisis. For the past 10 years, she has had her ups and downs, but she has basically been able to function at a pretty good level on 10 mg of prednisone daily and one infusion of IVIG every three to five weeks. She was treated with Imuran for several years without much benefit, and it made her feel sick, so she stopped it. She has not been hospitalized once since her initial hospital stay.

Recently, my daughter’s insurance company issued a denial of IVIG. Her doctor conducted a peer-to-peer review that resulted in a partial denial to allow for infusions for three more months, at which time the infusions will stop. The denial states that IVIG treatment is not medically necessary. The denial letter cited a recent review article in *Muscle Nerve* (2010; 41;370-4) that said of all standard treatments, IVIG is the least favorable. Instead, the best clinical response is to corticosteroids and plasmapheresis. My daughter was not able to tolerate plasmapheresis because she faints and the results only lasted for two weeks; it also is more invasive and risky and most costly. Is there anything we can do other than appealing to the state?

**Michelle:** It’s not that IVIG is not the best treatment for MG; it’s that there is no literature supporting the use of IVIG as a long-term/maintenance treatment of MG. The literature currently supports only the use of IVIG for MG exacerbations. Since your daughter has never been without IVIG for 10 years, it’s hard to know if she might actually be OK if she went off of it and just stayed on prednisone; most MG patients are. However, if your daughter’s doctor believes she absolutely cannot be without IVIG, payer policies generally state that IVIG is covered for exacerbation or if standard treatments have been tried and failed or not tolerated. You said she was sick on Imuran and plasmapheresis didn’t work, and long-term high-dose steroids have negative side effects and are not a reasonable option. Your daughter’s physician probably covered this in the peer-to-peer, but I would make sure he or she did. I would also contact your local MG foundation chapter to see if they have had a similar scenario and might offer some assistance.

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**Have a question?**

*Email us at editor@IGLiving.com.*

*Your information will remain confidential unless permission is given.*