

WEDNESDAY, 12 JUNE 2019

14:15:00 – 15:45:00

How to maintain remission in vasculitis

SP0005

CASE 1 DISCUSSANT: LONG TERM EFFICACY OF REMISSION-MAINTENANCE REGIMENS FOR AAV

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ANCA-associated vasculitides (AAVs) are a group of diseases with frequent relapses that can sometimes be severe. Treatment comprises an induction-remission phase followed by a maintenance regimen. Induction-remission therapy is effective and now well-established, mainly based on the combination of corticosteroids (CS) and cyclophosphamide or rituximab. For decades, maintenance therapy was compulsory and consisted of azathioprine or methotrexate, combined or not with low-dose CS. That regimen was prescribed for at least 18 months but was sometimes taken for several years. Criteria for stopping treatment have never been codified. Since rituximab has been widely prescribed for induction, the indication for azathioprine maintenance has been challenged because its relapse rate at 18 months (29%) was comparable to that of placebo (32%) given in its stead. However, we considered those relapse rates unacceptably high and have tried to devise a different therapeutic approach to maintenance, with semestrial evaluation of the indication of rituximab infusion over 18 months. MAINRITSAN1-trial results demonstrated the superiority of rituximab to maintain remission with a 5% relapse rate at 28 months vs 29% for azathioprine recipients. The 60-month follow-up of that trial confirmed the superiority of rituximab over azathioprine (37% vs 57%), even though rituximab did not abrogate relapses. Since the publication of those results, it is now clear that AAV remission-maintenance therapy should be rituximab—and not azathioprine or another equally effective immunosuppressant like methotrexate.

Maintaining remission should now also be based on other factors predictive of relapse: vasculitis type, ANCA subtype and/or ANCA presence or absence at the end of the induction regimen. Granulomatosis with polyangiitis relapses more frequently than microscopic polyangiitis or eosinophilic granulomatosis with polyangiitis. Relapse rates of the former two are probably linked mainly to ANCA type, anti-PR3 or anti-MPO, with the latter relapsing less frequently. The long-term MAINRITSAN1-trial results identified anti-PR3 presence 1 year after ending induction treatment and/or their persistence were predictor(s) of relapse.

We also designed a study comparing fixed-schedule rituximab infusions to re-infusions [JJ1] guided by ANCA titer and/or CD19+ circulating B lymphocytes. Results of that prospective study demonstrated that fewer rituximab infusions should be given but that ANCA titer and the circulating CD19+ B-cell level are not good predictors of relapse. ANCA presence—independently of their titer—is more frequently associated with relapse.

The optimal rituximab-administration duration has not yet been established. Our group is now awaiting the imminent results of a prospective trial comparing 4 vs 8 rituximab infusions at 6-month intervals after obtaining remission.

Conclusions: Major advances have been made in the therapeutic strategy for AAVs. After remission is obtained: 1) AAVs require maintenance therapy, 2) rituximab is superior to immunosuppressants, 3) the presence, persistence and/or reoccurrence of anti-PR3 ANCA predict relapses, 4) the 500-mg rituximab dose/infusion seems well-adapted. The optimal treatment duration remains to be elucidated.

Tailoring maintenance therapy is now the main therapeutic objective for AAV management. Future trials will attempt to evaluate very long-term maintenance treatment of AAVs with the goal of eradicating relapses.

Disclosure of Interests: None declared

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SP0006

CASE 2 DISCUSSANT: LONG TERM EFFICACY OF REMISSION-MAINTENANCE REGIMENS FOR GPA

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Background: A case of Giant Cell Arteritis with different visual symptoms and delayed diagnosis will be presented. This 74 year-old patient was pulsed with Glucocorticoids (GC) and thereafter treated with Tocilizumab (TCZ). She rapidly achieved full and lasting remission. After 12 months of treatment with TCZ, infusions were stopped. The patient suffered minor relapse 4 months after treatment discontinuation and again responded to TCZ. The case raises several questions such as: How to dose and how long to treat with TCZ? How to reduce dose and when to stop GC? Are there variables to quantify subclinical diseases activity as CRP and ESR are unreliable under TCZ treatment? Are there predictive factors

for relapse after treatment discontinuation? How to control development of disease damage over time?

Disclosure of Interests: None declared

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CPPD – a forgotten disease that requires more attention?!!!!

SP0007

IS ULTRASOUND A GOOD TOOL TO EVALUATE CPPD?

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CPPD is an arthropathy with high prevalence among the elderly and a multitude of clinical manifestations that can easily bring to misdiagnosis and therapeutic errors. The possibility to assess different aspects of the disease with only one tool can be of great help for clinicians.

Ultrasound (US) can help to address both the diagnosis and the inflammatory assessment of the disease. In the last years a lot of research has been carried out regarding the applications of US in CPPD. The special OMERACT US sub-task force that is working in CPPD has produced new definitions for identification of CPPD by US and has tested their reliability demonstrating that US can be used reliably at the knees and wrists for assessing CPPD [1,2]. Further, US has been tested also for assessment of inflammatory and structural changes in osteoarthritis demonstrating to be reliable also for this purpose [3].

During the lecture the potential of US in diagnosis and follow-up of patients with CPPD will be presented. Further, a deeper insight into possible pathogenetic mechanisms, based on observations made at US imaging, will be discussed.

REFERENCES:

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SP0008

MANAGEMENT OF CPPD DISEASE

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Background: Calcium pyrophosphate deposition (CPPD) is a common cause of arthritis. Its prevalence increases with ageing, and it manifests with asymptomatic chondrocalcinosis, acute crystal synovitis, and chronic arthritis.

Objectives: The objectives of this talk are to summarize the treatment options for the management of CPPD, and, to review the evidence base supporting them.

Methods: A systematic literature search was performed to identify all studies published in the English language, and, reporting on the treatment of acute and chronic manifestations of CPPD. All published studies were included with the exception of case reports and conference abstracts. Similarly, a literature search was performed to identify the metabolic and hereditary risk-factors of CPPD. The findings of the systematic literature search are described in a narrative manner. Interventions for which there is no published data are recommended based on clinical experience and expert opinion.

Results: Based on clinical experience, oral or intra-articular corticosteroids are recommended for the management of CPPD. Colchicine and interleukin-1 antagonists are effective and recommended for the management of acute CPP crystal arthritis. Interleukin-1 antagonists should be reserved for use in refractory cases. Oral NSAIDs should be avoided as people with CPPD are frequently elderly. Low-