L42. Morbidity in patients with ANCA-associated vasculitis

Over the last 30 years, treatment has improved the outcome for patients with ANCA-associated vasculitis (AAV). Patient survival is reported as 45–91% at 5 years and 75–88% at 10 years compared with 80% mortality at 2 years if left untreated [1]. Despite advances in therapy, patients with AAV continue to have a substantially higher mortality than a matched background population [2] with advanced renal failure and increasing age identified as poor prognostic markers in many studies [2–4]. Infection accounts for the majority of deaths in the first year. Malignancy and cardiovascular disease are more common causes of death beyond 1 year but infection remains an important cause of death at this time [2].

**Morbidity due to disease**

Despite the improved survival, morbidity remains common and may result from damage due to disease or the adverse effects of immunosuppressive treatment. Chronic kidney disease resulting from renal vasculitis is common and occurs in up to 90% of patients with microscopic polyangiitis and 80% with granulomatosis with polyangiitis (GPA). Proteinuria often rises resulting from renal vasculitis reflecting glomerular damage, especially in those with complement deposition [5]. Patients with reduced renal function are at high risk of end-stage kidney disease (ESKD) if they have a relapse of their glomerulonephritis. End-stage kidney disease (ESKD) is not uncommon in patients with AAV; approximately 20% of those who have evidence of renal involvement will develop ESKD by 5 years [6,7]. Renal survival is best predicted by presenting serum creatinine and
percentage of normal glomeruli in the diagnostic biopsy [8,9]. However, even in those presenting with severe histological findings and very low numbers of normal glomeruli, treatment should be given as the chance of renal recovery is greater than for therapy-related death [10].

Ear, nose and throat disease in GPA has a high risk of causing irreversible damage and chronic symptomatology. Collapse of the bridge of the nose can be corrected by bone or cartilage grafts and restorative procedures should only be performed when the disease is thoroughly controlled. Damage to the nasal mucosa results in nasal crusting which provides a focus for infection as well as causing nasal obstruction. Regular nasal douching and use of a topical aseptic cream, such as, mupirocin, reduces associated symptoms and risk of infection [11]. Hearing loss is usually caused by eustachian tube obstruction and recurrent otitis media but may also result from damage to the eighth cranial nerve. Subglottic, tracheal or bronchial stenoses can be fibrotic in origin reflecting previous episodes of vasculitic damage to the airways. Physical dilatation can restore the lumen but multiple procedures may be required. The long-term outcome of alveolar haemorrhage is usually good with stable lung function but a minority of patients present with overlapping features of ANCA vasculitis and pulmonary fibrosis [12,13]. The lung fibrosis can precede or follow vasculitis and be progressive leading to respiratory failure despite control of vasculitis. This pattern is more commonly associated with the MPO-ANCA subtype. AAV is also associated with an increased risk of venous thromboembolism, especially when the disease is active [14,15]. Autoantibodies to plasminogen and tissue plasminogen activator occur in the sera of 25% and 14% of AAV patients. Their presence has been associated with more severe renal outcomes and increased risk for thromboembolic events [16]. Avoidance of classical risk factors for venous thromboembolism is important, as well as the use of prophylaxis during prolonged immobility.

Despite resolution of disease activity, poor quality of life often persists in AAV patients with fatigue described as the main contributor [17,18]. Despite many patients having significant organ damage, quality of life measures do not appear to correlate with the extent of damage [17,19]. The mechanisms of fatigue are complex, and likely to involve a balance between disease and psychosocial factors.

**Morbidity due to treatment**

Improvement in survival has resulted from improved treatment strategies; however adverse events associated with these treatments are now an important cause of death and morbidity. Infection is common. In one study, 25% of patients recruited to four EUVAS studies developed infection within the first year following diagnosis. Respiratory tract and generalised septicaemia were the most common infections [20]. Both corticosteroid and cytotoxic therapy are known to contribute to the increased risk of infection [21]. Opportunistic infections are also increased in patients with AAV treated with immunosuppression. The occurrence of Herpes Zoster Varicellae (HZV), shingles, occurs more often in AAV patients, with a frequency of 4.5 episodes of HZV/100 patient-years, than a healthy population [21,22]. *Pneumocystis jiroveci* infection (previously known as *Pneumocystis carinii*) is reported in patients with AAV with an incidence of 0.85–12% [23–25]. The presentation of *Pneumocystis* infection and HZV often occurs when immunosuppressive therapy is most intensive, although not always. The use of rituximab is increasing in patients with AAV. Infection associated with this therapy remains a concern, as there were no differences in the infection rates in the two published trials that compared cyclophosphamide to rituximab as induction therapy [26,27]. However, this may relate to glucocorticoid use as infection rates are low in RA patients treated with rituximab [28]. Predictors of infection in those receiving rituximab include low IgG before treatment, chronic lung and cardiac disease [29]. The risk of progressive multifocal leukoencephalopathy continues to cause concern [30].

Those at risk of infection should be identified and interventions undertaken to reduce risk. Factors predictive of infection include age, severity of renal dysfunction, leucopenia and intensity and duration of immunosuppression [20,31,32]. Guidelines advocate the use of prophylaxis against *P. jiroveci* in patients receiving cyclophosphamide [33]. Leucopenia is common, especially in those receiving oral cyclophosphamide [20] and should be avoided with close monitoring. Leucopenic patients can safely be treated with G-CSF [34] although a recent study in an animal model of AAV suggests G-CSF may exacerbate disease [35].

Influenza vaccinations are safe and effective in AAV without association with relapse [36]. Pneumococcal vaccination is recommended but response rates are often poor when using the polysaccharide vaccine, pneumovax. Live vaccines should be avoided in all patients taking immunosuppressives or prednisolone doses above 5 mg/d. In those AAV patients on standard maintenance therapy, maintenance of protective levels of antibody to other vaccines such as diphtheria, tetanus and polio may be shorter than in immunocompetent patients and may require more frequent booster vaccinations [37]. AAV patients who receive rituximab may be unable to respond to vaccination with new antigens although they do maintain their recall responses and respond to booster vaccination [38]. Other adverse events are specific to treatments. Glucocorticoids are known to have a broad adverse event profile, including steroid-associated diabetes, avascular necrosis and ocular cataract formation, and these should all be monitored for during treatment. Prophylaxis against osteoporosis and peptic ulceration has become routine, especially in those receiving high dose corticosteroids. Reduced bone mineral density is common in
There is considerable evidence that the risk of cardiovascular prine increases the risk of skin cancer.

The increased risk varies according to the malignancy with greater than a twofold increase on the back-

infertility, and cryopreservation of sperm and oocytes should be offered if appropriate [48].

The use of cytotoxic therapy increases the risk of malignancy. Studies with long follow-up times reveal increased incidence of malignancy with greater than a twofold increase on the background population. The increased risk varies according to the organ affected: 4.8–33-fold increase in bladder cancer rates, a 10-fold increase in non-melanoma skin cancer and 4.2–11-fold increases in lymphoma [21,49–51]. More recent publications are contradictory about the risk of malignancy using current cyclophosphamide regimens, as proposed by the EUVAS trials. At 5 years follow-up, the risk of malignancy is only increased for non-melanoma skin cancers in those patients recruited to four EUVAS trials [52] but a French study suggests that urinary tract cancer remains increased at 5 years follow-up [42]. Azathio-

significant, with many patients experiencing reduced quality of life despite successful therapy. The mortality incurred by patients suffering from AASV has fallen steadily but the chronic relapsing nature of the disease, without definitive treatments that offer cure, continues to extract a heavy toll on the health of afflicted individuals. The challenge for the future is to develop specific therapies to cure disease with improved side-effect profiles. Until then, we need to manage our current therapies more effectively with improved prevention of toxicities associated with therapy.

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References


Lectures


L43. Seropositive and negative ANCA-associated vasculitis, anti-MPO and PR3-vasculitis: Different outcomes?

Clinical definition of ANCA-associated vasculitis (AAV) and association with serotype

The AAV comprise a heterogeneous group of the three distinct forms, namely microscopic polyangiitis (MPA), granulomatosis with polyangiitis (GPA, formerly: Wegener’s granulomatosis) and eosinophilic granulomatosis with polyangiitis (EGPA, formerly Churg-Strauss syndrome) [1,2]. From the clinical point of view and according to the disease definitions and classification criteria, they share the manifestation of small- to medium-size vessel vasculitis which is strongly associated with anti-neutrophil cytoplasm antibodies (ANCA). Whereas MPA has no additional features and seems to represent a mere vasculitic disease, GPA is characterised by a granulomatous inflammatory process predominantly occurring in the upper and lower respiratory tract and asthma, eosinophilia and granulomatous inflammation are additional hallmarks of EGPA [1,2]. Interestingly, GPA and EGPA seem to follow a stage-wise course [3–6].

In GPA, the initial stage is referred to as localized GPA which is defined by upper and lower respiratory disease and no clinical signs of vasculitis [3]. Nearly half of the patients with localized disease are ANCA-negative [7]. Upon the evolvement of vasculitic symptoms (early systemic, generalized and severe disease), the vast majority of patients are ANCA-positive. Persistent localized disease in GPA is rare (5% of patients) [7]. Therefore, GPA cohorts are mainly represented by patients with systemic, ANCA-positive disease. Asthma followed by marked eosinophilia and subsequent vasculitis manifestations marks the disease course in EGPA. A predominant vasculitic phenotype with strong ANCA association can be distinguished from a phenotype with predominant eosinophil-associated organ manifestations that is usually ANCA-negative. In all, only 40% of EGPA patients are ANCA-positive [8,9].

In MPA, which is characterised by systemic vasculitis manifestations only, most patients are ANCA-positive [10]. Therefore, seronegative AAV is mainly represented by the initial stages of GPA and EGPA and the “eosinophilic” EGPA phenotype.

It is not clear why GPA has a strong association with ANCA directed against proteinase 3 (PR3-ANCA) whereas MPA and EGPA are predominantly associated with ANCA against myeloperoxidase (MPO-ANCA). Importantly, the first genome-wide association study in GPA and MPA clearly identified that GPA and MPA are genetically distinct diseases [11]. Yet, the study also revealed that the association with identified significant single nucleotide polymorphisms (SNPs) was stronger with the ANCA type (PR3-ANCA vs. MPO-ANCA) than with the clinical syndrome questioning the classification of patients on clinical and histopathological grounds. The GWAS results are supported by several recent clinical studies demonstrating that allocation to ANCA-serotype as well as specific organ involvement may also be relevant with respect to outcome [12,13].

Apart from AAV disease type and ANCA-serotype, outcome is also influenced by intensity and duration of immunosuppressive treatment, pattern of organ involvement as well as age and gender.