Patients.– Case notes from ninety-eight patients with Takayasu arteritis were reviewed retrospectively. Drug treatment, laboratory and imaging data were analysed, and disease activity further assessed using the Indian Takayasu arteritis (ITAS) and damage scores (TADs).

Results.– Nine patients were treated with biologics, all had previously received high dose prednisolone and ≥ 1 immunosuppressant drug, and five patients had failed cyclophosphamide. Three patients received more than one agent and eight remain on biologics. The patients prescribed biologics had more extensive arterial disease than the rest of the cohort (5–9 arteries involved, TADs 3–11), with active disease prior to the initiation of biologics (ITAS 2–9 and CRP 12–206 mg/L). The mean duration of treatment was 2.6 years, and one patient suffered a significant adverse event. Eight patients were prescribed anti-TNFα therapy, three anti-IL-6R blockade. One patient developed new arterial stenoses while receiving anti-TNFα and subsequently responded to tocilizumab. Two patients received the IL-6R antagonist as a first-line biologic. Biologic therapy resulted in a clinically relevant improvement.

Discussion.– Although anti-TNFα therapy is effective in refractory Takayasu’s, up to 30% do not respond or relapse. While tocilizumab offers an alternative in these cases, suppression of constitutional symptoms and CRP complicates disease monitoring, and regular imaging is required.

Conclusion.– In refractory Takayasu arteritis, TNFα and IL6R blockade proved an effective option. In light of their efficacy in cyclophosphamide non-responders, we propose to use biologics ahead of cyclophosphamide in these young patients.

http://dx.doi.org/10.1016/j.lpm.2013.02.065

A64
Assessment of patients with Takayasu’s arteritis in a routine clinical follow-up with Indian Takayasu Clinical Activity Score (ITAS2010)

F. Alibaz-Onen, H. Direkseneli
Marmara University, School of Medicine, Istanbul, Turkey

Introduction.– ITAS2010 is a new composite index developed to assess clinical activity in Takayasu’s arteritis (1A), which is weighted for vascular items. We aimed to investigate the effectiveness of ITAS2010 in the routine clinical follow-up of 1A.

Patients.– Patients (n = 33, mean age: 40.9 ± 12 years, F/M: 30/3) classified according to ACR criteria for 1A were enrolled. ITAS2010 forms were filled cross-sectionally for baseline, two follow-up visits prospectively, with intervals of at least 4–6 months, by including only new or worsening symptoms within the past 3 months.

Results.– ITAS2010 was similar at baseline for both active and inactive patient (12/5–20) vs.10 (0–19), respectively). There was no correlation between ITAS2010 and acute phase reactants (APRs). Similarly, change according to PGA was not reflected in ITAS in the second visit (1.15 (0–6) vs. 1.4 (0–3), respectively). Only three visit ITAS2010 score was observed to be significantly higher in active [1.62 (0–7)] patients compared to inactives [0.45 (0–3)] (P = 0.001). The total agreement between ITAS2010 and PGA was 60% (kappa: 0.096, P = 0.43) and between ITAS2010 and Kerr et al. [1] was 74% (kappa: 0.18, P = 0.035). The total agreement between PGA and Kerr et al. was 71% (kappa: 0.26, P = 0.005). Twelve patients were evaluated with imaging in the follow-up (four with PET, eight with MR-Angiography). When we added an extra-score on ITAS2010 for high APRs or positive imaging (vascular progression with radiology or increased uptake on vascular structures with PET), the total agreement between ITAS2010 and PGA increased to 74% (kappa: 0.499, P < 0.001), whereas ITAS2010 and Kerr et al. decreased to 51% (kappa: 0.102, P = 0.06).

Conclusion.– The agreement between PGA and ITAS2010 was observed to be limited. However, when we combined ITAS2010 with APR or imaging, our results improved. ITAS2010 had a significant discriminatory value according to disease activity in only the third visit in our routine follow-up. These results suggest that ITAS2010 may be valuable in the long-term follow-up, especially if combined with biomarkers and imaging.

Reference

http://dx.doi.org/10.1016/j.lpm.2013.02.066

A65
A randomized trial of mycophenolate mofetil versus cyclophosphamide for remission induction of ANCA-associated vasculitis: “MYCYC”. On behalf of the European vasculitis study group

R. Jones1, L. Harper2, J. Ballarin3, D. Blockmans4, P. Brogan5, A. Bruchfeld6, M. Cid7, K. Dahlsvleen1, J. Dezoyas8, P. Lanyon9, C.A. Poh10, V. Tesar11, A. Vaglio12, M. Walsh13, D. Walsh1, G. Walters14, D. Jayne1

1. Addenbrooke’s Hospital, Cambridge, United Kingdom
2. University of Birmingham, Birmingham, United Kingdom
3. Fundació Puigvert, Barcelona, Spain
4. University of Leuven, Leuven, Belgium
5. Great Ormond Street Hospital, London, United Kingdom
6. Karolinska University Hospital, Karolinska, Sweden
7. Hospital Clinic, Barcelona, Spain
8. Auckland City Hospital, Auckland, New Zealand
9. Nottingham University Hospital, Nottingham, United Kingdom
10. Royal Adelaide Hospital, Adelaide, Australia
11. Charles University, Prague, Czech Republic
12. University Hospital of Parma, Parma, Italy
13. McMaster University, Hamilton, Canada
14. Canberra Hospital, Canberra, Australia

Introduction.– Cyclophosphamide (CYC) induction regimens are standard therapy for ANCA-associated vasculitis (AAV) with major organ involvement. However CYC is associated with considerable toxicity. Mycophenolate mofetil (MMF) is a potential alternative to CYC. We performed an international, non-inferiority randomised trial comparing MMF to CYC for remission induction of AAV.

Patients.– Eligible patients had newly diagnosed AAV and were randomised to receive up to 6 months of induction with either MMF 2-3 g/day (n = 70) or 6–10 pulses of IV CYC 15 mg/kg (n = 70). Both groups received the same tapering oral prednisolone regimen and azathioprine maintenance therapy. The primary outcome was remission (absence of disease activity for ≥ 4 weeks while adhering to the glucocorticoid regimen). We hypothesized that MMF treatment would result in no more than 12% fewer remissions.

Results.– The groups were similar at trial entry. The primary remission endpoint occurred in 46/70 (66%) MMF vs. 48/70 (69%) CYC [risk difference (RD) = −3%, 90% CI −16 to 10%; P = 0.06 for non-inferiority]. Remission induction irrespective of steroid compliance occurred in 61/70 (87%) MMF vs. 54/70 (77%) CYC (RD 10%, 90% CI −1 to 21%; P = 0.01 for non-inferiority). However, glucocorticoid dosing did not differ significantly between groups overall (P = 0.96). Key safety out-
comes did not differ significantly; serious adverse events MMF 32/70 (46%) vs. CYC 27/70 (39%) (RD 7%, 95%CI –9 to 23%), serious infections MMF 18/70 (26%) vs. CYC 11/70 (16%) (RD 10%, 95%CI –3 to 23%), dialysis MMF 2/70 (3%) vs. CYC 3/70 (4%) (RD –1%, 95%CI –8 to 5%), death MMF 5/70 (7%) vs. CYC 4/70 (6%) (RD 1%, 95%CI –7 to 10%).

Conclusion.– In the primary analysis we were unable to demonstrate that MMF is non-inferior to IV CYC for remission induction at six months in newly diagnosed AAV. How, glucocorticoid treatment affects remission induction with MMF requires further study. Longer term safety outcomes and relapse data are required to fully understand the role of MMF as induction therapy for severe AAV.

http://dx.doi.org/10.1016/j.lpm.2013.02.067

A66 Rituximab versus azathioprine for maintenance in ANCA-associated vasculitis. A prospective study in 117 patients

Introduction.– Once ANCA-associated vasculitis (AAV) remission has been achieved with CS and cyclophosphamide (CYC), maintenance therapy usually relies on azathioprine (AZA) or methotrexate. However, 28-month relapse rate remains of 28%. Although rituximab (RTX) has been demonstrated to be as effective as CYC for induction of complete remission by 6 months, some studies showed that half of the patients without maintenance relapsed within 2 years. The results of a prospective, randomized TRIAL of RTX vs. AZA to maintain AAV remission are reported.

Patients.– Once remission was obtained with a conventional regimen, patients with newly diagnosed or relapsing AAV were randomly assigned to receive a 500-mg RTX infusion on D1, D15, 5.5 months later, then every 6 months for a total of five infusions over 18 months, or AZA 283 mg/m²/d for 28 months. Other outcome measures were the severe adverse event (SAE) rate associated with maintenance regimen.

Results.– Among the 117 patients (66 men/51 women; mean age, 55 ± 13 years; 93 newly diagnosed and 24 relapsers) participating in the study (59 in the AZA arm, 58 in the RTX arm); 89 had GPA, 23 MPA and five kidney-limited diseases. The main clinical manifestations at diagnosis or relapse included ENT involvement in 88 (77.2%), lung in 69 (60.5%) and kidney in 82 (71.9%). Creatininemia was 185 ± 184 μmol/L. All patients have completed their follow-up. Major relapses have occurred in 18 (15.7%) patients: three (5.4%) in the RTX arm and 15 (25.4%) in the AZA arm, with two AZA-arm deaths (one sepsis, one pancreatic cancer). Thirty-three experienced SAE: 18 related to AZA, 15 to RTX. In the AZA arm, 12 infections (one fatal) and one skin cancer were observed vs. 11 infections (none fatal) in the RTX arm.

Conclusion.– This study demonstrated that 500 mg of RTX every 6 months was superior to AZA to maintain AAV remission. The infection frequencies were comparable in the two arms, and other SAE were infrequent and resolved in most patients.

http://dx.doi.org/10.1016/j.lpm.2013.02.068

A67 Treatment of systemic necrotizing vasculitides in patients > 65 years old: Results of the multicenter randomized CORTAGE trial

Introduction.– With increasing life expectancy, the number of patients older than 65 years with newly diagnosed AAV is growing. However, the specific treatment of AAV in patients older than 65 years is still under debate.

Methods.– Multicenter RCT on patients > 65 yo with newly diagnosed SNV to compare conventional therapy (based on FFS; for all, ~28 mo of CS alone, combined with 500-mg/m² CYC IV pulses every 2–3 wk