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Rapid control of disease activity by Tocilizumab in ten “difficult-to-treat” cases of Takayasu arteritis
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Introduction.—Interleukin 6 (IL-6) has emerged as a key cytokine in the pathogenesis of TA and its serum levels have been shown to correlate well with disease activity [1]. We aimed to assess outcome of ten TA patients treated with Tocilizumab, sIL-6R blocker in our center.

Methods.—Records of ten patients with TA on monthly Tocilizumab infusions were studied. Details regarding demography, medications, investigations, angiography and outcome were noted.

Results.—In total, ten patients were studied with median age of 24.5 (13–53) years, median disease duration of 25.5 (1.5–60) months and Indian Takayasu Arteritis Score (ITAS) of 4.5 (0–13). Nine of them had received six doses and 1 patient had taken five doses of Tocilizumab. All patients had active disease with ITAS of ≥ 1 and/or angiographically active 1A in spite of treatment with adequate immunosuppression for 27 (1.5–60) months.

Tocilizumab led to a clinical response with ITAS of 0 and reduction in inflammatory markers in 100% patients by 4th infusion. Six patients (60%) maintained clinical response with radiologically stable disease and normal acute phase reactants at last infusion. Three patients with normal acute phase reactants (APR) at last infusion were refractory to Tocilizumab at last infusion, in contrast to 86% (6/7) responders in those with baseline high APR. Tocilizumab facilitated rapid reduction in steroid dose from 24 ± 15 to 5.4 ± 4.9 mg/day (p = 0.003) in this cohort. One patient with good response till the last infusion flared 6 months after discontinuation of Tocilizumab. Only minor adverse events reported were: one patient each with transient skin rash, transient transaminitis, uncomplicated urinary tract infection and upper respiratory tract infection. There was no major adverse event or fatality.

Discussion.—Ours is the largest series of Tocilizumab therapy in TA.

Conclusion.—Tocilizumab may be an effective steroid sparing option for rapid control of refractory disease activity in patients of Takayasu arteritis with elevated levels of acute phase reactants.

Reference

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Chronic periaortitis and autoimmune thyroiditis: A novel association
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Introduction.—Chronic periaortitis (CP) is a rare disorder characterized by a fibro-inflammatory tissue that surrounds the abdominal aorta and the iliac arteries. CP is believed to have an autoimmune aetiology. Anecdotal case reports have also described an association with autoimmune thyroiditis. The aim of this study was to investigate the prevalence and clinical significance of autoimmune thyroid disease in CP.

Methods.—We enrolled 66 consecutive patients with new-onset CP, diagnosed at or referred to our Department from all over Italy between 2005 and 2011; 71 subjects recruited from the general population and matched with CP patients for age, sex and geographic origin (North, Centre and South of Italy) served as controls. All the study subjects underwent thyroid ultrasound and measurement of serum TSH, FT3, FT4 and anti-thyroglobulin (anti-Tg) and anti-thyroid peroxidase (anti-TPO) antibodies.

Results.—Sixteen CP patients (24%) and seven controls (10%) had positive anti-TPO antibodies (P = 0.039); 21 patients (32%) and 8 controls (11%) were positive for either anti-TPO or anti-Tg antibodies (P = 0.006). Ultrasound revealed a chronic thyroiditis pattern (inhomogeneous, hypoechoid gland) in 45 patients (68%) and 23 controls (32%) (P < 0.001). At the first evaluation, 11 CP patients (17%) and four controls (6%) were taking L-tiroxine for hypothyroidism. During the follow-up (median 45 months, range 3–72), five additional CP patients developed hypothyroidism requiring hormonal replacement therapy. During the whole follow-up, the prevalence of hypothyroidism requiring hormonal replacement therapy in our CP cohort was 24% (16/66 patients).

Conclusion.—This is the first large-scale study to show an association between CP and autoimmune thyroiditis, thus suggesting that these conditions have a common autoimmune background. A high proportion of patients with CP develop autoimmune hypothyroidism.

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Tocilizumab in refractory Takayasu arteritis: Case series and literature review
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Introduction.—Takayasu arteritis (TA) is a rare large vessel vasculitis, characterized by a chronic course with disease relapse. The aim of this study is to analyze the efficacy and the tolerance of the anti-interleukin-6 receptor monoclonal antibody, tocilizumab, in patients with TA.

Methods.—We retrospectively studied patients with TA (ACR and/or Ishikawa’s criteria): five French multicenter cases and nine from the literature. Clinical, biological, radiological disease activity and treatment were analyzed before tocilizumab, during the follow-up and at the last available visit.

Results.—Fourteen patients with TA (age 40 years [23–47], 12 women) were included. At initiation of tocilizumab therapy, 12 patients were treated with corticosteroids (prednisone; median dose 23 mg/day [10–34]), methotrexate (n = 9), azathioprine (n = 6) or infliximab (n = 5). Tocilizumab was used at 8 mg/kg every 4 weeks with 6 cures [5–8] and median follow-up of 9 month [7–14]. Overall response as evaluated by the physician was noted in 10/10 cases (100%), 9/11 cases (82%) and 6/9 cases (67%) at 3, 6 month and the last visit, respectively. Clinical and biological activities were significantly decreased within 3 months (P < 0.05), as was the prednisone dose (from 23 mg/day [11–34]) to baseline at 10 mg/day [6–11] at 6 months; P = 0.06. PET FDG uptake was present in 9/9 cases at baseline with SUVmax 3.8 [2–5], and persisted in only 2/9 patients at 6 months under tocilizumab. No patient was still steroid-dependent at 12 months (vs. seven cases before tocilizumab) (P < 0.05). At the last visit, tocilizumab was continued in seven patients (50%), and was discontinued in the other seven patients because of the remission (n = 5), relapse (n = 1) and the absence of tocilizumab financement (n = 1). No death related to tocilizumab treatment was noted (Supplementary data: figure S1).