**Introduction.**—The objective of this study was to evaluate the impact of using rituximab in an inception cohort of patients treated since 2003.

**Methods.**—One hundred and twenty-two patients diagnosed with AAV treated with at least one dose of rituximab from 3/15/03-8/17/12 were included. Information was collected on why rituximab was administered, time to remission on or off therapy and relapse. Time to remission and relapse were plotted using Kaplan-Meier Curves.

**Results.**—Eighty-four percent of the included patients had biopsy proven AAV. Median age of patients at the time of first rituximab treatment was 53 years IQR (38,62), with 53% female, 82% Caucasian, 46% categorized as GPA, and 53% PR3 positive. 13% of the patients were ANCA negative by ELISA and 4% of the patients were ANCA negative by immunofluorescence. Mean total follow up time of the cohort was 7.0 ± 5.5 years and mean follow up after first rituximab infusion was 4.5 ± 4.5 years.

Thirty-eight (19%) of the courses of rituximab were given for new diagnosis of AAV. One hundred and thirty-three (66%) of the courses were given for relapse and 22 (11%) of the courses were for remission maintenance. Following the first course of rituximab 23 (19%) of patients achieved remission off all therapy in 12 ± 11 months and 65% achieved remission on therapy in 4 ± 4 months. Time to relapse or date of last follow up was 20 ± 19 months following first course of rituximab. Rituximab courses were given without cyclophosphamide (CYC) in 18%, with distant prior history of exposure to CYC in 49% and concurrently with CYC in 33%. Time to relapse was shorter for patients not exposed to CYC either concurrently or historically (100% relapsed by 12 months compared to 25%) (P = < 0.0001). At 12 months 75% of ELISA negative patients had relapsed while 25% of PR3 ANCA positive patients had relapsed (P = 0.027).

**Conclusion.**—Time to relapse was shorter for patients never exposed to cyclophosphamide and those who were ANCA negative.

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Introduction

CAM has been explored in managing various chronic diseases. Our objective was to evaluate CAM use in patients with ANCA associate vasculitis (AAV) and consider the impact of CAM on disease management. Methods – Structured CAM questionnaires were administered at medical appointments (7/11–4/12). CAM treatments (acupuncture, massage, reflexology, etc.) and self-help practices (meditation, yoga, qigong, etc.) were reported. Self-help practices were classified into Mind (meditation, guided imagery, relaxation techniques) and Mind-Body (M-B) (yoga, qigong, tai chi, pilates) categories.

Results – Of 107 patients surveyed, 86% were white and 62% were female. Within the last year, 81% had a CAM practice. Top CAM treatments and practices included prayer (n = 68, 64%), exercise promotion (n = 29, 27%), massage therapy (n = 20, 19%), chiropractic services (n = 14, 13%) and acupuncture (n = 7, 7%). Reason for use was to improve well-being: for prayer n = 36/68, 53%; exercise promotion n = 25/29, 86%; massage therapy n = 14/20, 70%; and relaxation techniques n = 15/22, 68%. Each of these were found to be helpful: prayer n = 46/68, 68%; exercise promotion n = 20/29, 69%; massage therapy n = 17/20, 85%, and relaxation techniques n = 13/22, 59%.

Those who used either Mind (n = 30, 28%) or M-B (n = 15, 14%) CAM were on average a decade younger than non-users (45 vs. 56, P = 0.0016). Mind and M-B users were also more likely to be in the highest income category (60% vs. 35%, P = 0.028) and less likely to be married/partnered/widowed (35% vs 8%, P = 0.002). Of CAM users, 24% said their physician had talked to them about CAM. Under half said they would like to talk with their physician regarding CAM and 88% were comfortable sharing their CAM practices with their physician. 48% of patients would recommend CAM to other vasculitis patients. Recommendations included exercise, yoga, massage and meditation.

Conclusion – AAV patients commonly report some form of CAM practices and find benefit from the practices. Discussion of CAM with physicians is limited.

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Long term follow up of patients who received repeat dose rituximab as maintenance therapy for ANCA associated vasculitis (AAV)

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Introduction – Rituximab (RTX) is an established induction agent in AAV. We have previously shown that repeat dose RTX for two years is a potential maintenance strategy. Relapse risk after repeat dose RTX discontinuation is not known.

Methods – We report long term follow up of patients who received a two year repeat dose RTX regimen for relapsing/refractory AAV (1 g × 2, then 1 g/6 months × 4).

Results – Sixty-nine patients completed the two years RTX course. Ninety percent had GPA with prior disease duration of 60 months (IQR 21–120). During the treatment course 9/69 (13%) relapsed but completed the RTX course.

Median post-treatment follow-up was 22.7 months (IQR 12.5–38.6). 58/69 (84%) have at least 6 months of follow-up after the last RTX dose. 25/58 (43%) relapsed after a median of 15.5 months. For treatment of relapse, 10 received RTX only; 10 RTX plus glucocorticoids and five other agents. By 6 months, 21/25 (88%) had regained remission. 54/69 were ANCA negative at the end of the RTX course. 12/54 (22%) became ANCA positive during follow-up, of which nine (75%) relapsed a median of 1.6 months (0.5–4.6) after ANCA return. 15 remained ANCA positive after the RTX course, of which three (20%) relapsed. Thus, 12/25 (48%) had detectable ANCA at relapse.

Of 56 patients (81%) with available B-cell counts, 42/56 (75%) had B-cell return a median of 11 months (IQR 9–13) after the RTX course. 17/25 (68%) had detectable B cells at relapse, and in 11/17 (65%) B cells had returned in the 6 months preceding relapse.

Conclusion – Following a two years RTX re-treatment course, relapses occurred in 43% after a further follow-up of 22.5 months. Relapse risk