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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P222

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 (84%) 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
was lower than that seen following a single RTX course for relapsing GPA, and relapses were rapidly controlled by further RTX. A switch from ANCA negativity to positivity was a relapse predictor but ANCA was negative in one half of the relapses.

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P224
Re-treatment with rituximab in ANCA-associated vasculitis only in the presence of clinical relapse: A single centre experience
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Introduction.— How to use Rituximab (RTX) after RTX induced remission is still a matter of debate. Two main strategies, both preemptive, have been proposed so far:
– re-treatment at fixed intervals (at different times);
– re-treatment after the reconstitution of B lymphocytes.
We report on our experience based on:
– maintaining pts under low-dose steroids and MTX or AZA after RTX-induced remission;
– re-treating pts with RTX only in the presence of clinical relapse.

Methods.— We included all pts with ANCA-associated vasculitis (AAV) treated with RTX at the onset of disease or at a clinical relapse from Jan 2006 to Jan 2013.
RTX was initially administered with 4 weekly intravenous (i.v.) infusions, each at a dose of 375 mg/m² of BSA; more recently, a regimen with 2 i.v. doses of 1 g each, administered 2 weeks apart, was adopted.

Results.— Over a 7-year period, 56 pts with AAV were treated with RTX. Thirty-eight pts were affected by granulomatosis with polyangiitis (GPA), 16 by microscopic polyangiitis (MPA) and 2 by Churg-Strauss syndrome (CSS).
AAV was positive in 56/58 pts (37 anti-PR3 and 17 anti-MPO). Seventeen pts were treated at the onset of disease (11 MPA, 5 GPA, 1 CSS), while 39 pts (33 GPA, 5 MPA, 1 CSS) were treated at relapse. All pts obtained remission.
After a mean follow-up of 30.1 months (SD 21.4, range 6–84), 39 pts (69.6%) didn’t relapse: 15 of 17 pts treated at the onset of AAV, 24 of 39 pts treated at relapse.
Only 17 pts relapsed (13 GPA, 4 MPA), after a mean follow-up time of 21.9 months (SD 11.3, range 12–60): 2 of 17 pts treated at the onset, 15 of 39 pts treated at relapse.
Only four pts, all affected by GPA, had more than one relapse (two relapses in two pts and three in two pts).

Conclusion.— So far, the majority of pts did not relapse after the first RTX treatment. In pts who had relapses, the mean time to relapse was much longer than the times reported in the literature. Our results could depend on the effect of low-dose steroid/immunosuppressive maintenance therapy in prolonging the RTX action.

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P225
Gestational rituximab exposure in women with vasculitis
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Introduction.— Historically, cyclophosphamide (CYC) has been the mainstay of therapy for ANCA vasculitis. Rituximab (RTX) has proven to be an effective alternative to CYC in women of child-bearing age, but little is known about fetal effects of RTX exposure during pregnancy.

Methods.— While being treated with RTX, women were counselled to avoid or plan pregnancy. Urine hCG was checked before each dose. Among pregnancies, patients and fetuses were monitored for recurrent disease and complications associated with RTX and immunosuppression. Where possible, maternal and fetal cord blood was tested for CYC and rituximab and their offspring

Characteristics of women with autoimmune vasculitis exposed to rituximab and their offspring

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age</th>
<th>DX</th>
<th>Medications at delivery</th>
<th>Antenatal RTX exposure (months)</th>
<th>Weeks gestation</th>
<th>Child sex</th>
<th>APGAR</th>
<th>Child’s weight (g)</th>
<th>Maternal B cells (%) at delivery</th>
<th>Fetal B cells (%)</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>31</td>
<td>PAN Azathioprine, prednisone</td>
<td>8</td>
<td>31</td>
<td>M/8.9</td>
<td>1625</td>
<td>&lt; 0.01%</td>
<td>NR</td>
<td>0.01%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2a</td>
<td>25</td>
<td>GPA None</td>
<td>7.5</td>
<td>15</td>
<td>N/A</td>
<td>N/A</td>
<td>&lt; 0.01%</td>
<td>N/A</td>
<td>0.01%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2b</td>
<td>27</td>
<td>GPA None</td>
<td>7.5</td>
<td>15</td>
<td>N/A</td>
<td>N/A</td>
<td>&lt; 0.01%</td>
<td>N/A</td>
<td>0.01%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td>20</td>
<td>GPA Prednisone</td>
<td>0.25</td>
<td>40</td>
<td>M/9.9</td>
<td>2945</td>
<td>&lt; 0.01%</td>
<td>3</td>
<td>0.01%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3b</td>
<td>22</td>
<td>GPA Prednisone</td>
<td>0.5</td>
<td>41</td>
<td>F/8.9</td>
<td>3500</td>
<td>0.54</td>
<td>NR</td>
<td>0.01%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>29</td>
<td>GPA Prednisone</td>
<td>13.5</td>
<td>38</td>
<td>F/8.9</td>
<td>3270</td>
<td>&lt; 0.01%</td>
<td>5</td>
<td>0.01%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>39</td>
<td>MPA None</td>
<td>0.25</td>
<td>38</td>
<td>M/8.10</td>
<td>3515</td>
<td>&lt; 0.01%</td>
<td>NR</td>
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<td></td>
</tr>
<tr>
<td>6</td>
<td>32</td>
<td>GPA None</td>
<td>2.8</td>
<td>40</td>
<td>M/9.9</td>
<td>2693</td>
<td>&lt; 0.01%</td>
<td>7</td>
<td>0.01%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DX: diagnosis; RTX: rituximab; g: grams; NR: not recorded at time of delivery; N/A: not applicable; M: male; F: female; PAN: polyarteritis nodosa; GPA: granulomatosis with polyangiitis (formerly Wegener’s); MPA: microscopic polyangiitis.