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P305 -Variable response to induction therapy and significant burden of treatment adverse events over the first 12 months of remission induction treatment in ANCA Associated Vasculitis (AAV) Patients – a study of routine clinical practice

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Background: Aims of therapy in AAV patients who require induction treatment include assessment of comorbidity, disease activity, and vasculitis damage before commencing treatment with a combination of high dose glucocorticoids (GC) with rituximab (RTX) or cyclophosphamide (CYC). It is believed to be important to achieve control of the vasculitis as soon as possible but also to avoid acute treatment-related morbidity as well as prevention of long term GC damage. This study aimed to examine clinical outcomes and adverse events in AAV patients receiving remission induction treatment in routine clinical practice in the UK.
Methods: This was a retrospective clinical review of 297 UK AAV (granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA)) patients who were diagnosed between 2014-17. 79.5% were incident patients and 20.5% relapsing. Clinical data were reviewed at baseline, 1, 3, 6 and 12 months following commencement of induction therapy.
Results: 37.0% of patients had GPA, 63% MPA and mean age was 58.17 years (SD 15.6) with 49.5% male. Birmingham vasculitis activity score (BVAS) was used in under 10% of cases, but physicians reported 9.1% as mild/localized, 52.5% as moderate systemic and 38.4% as severe, life threatening. Comorbidities were common, with hypertension (37.0%), diabetes (15.5%), COPD/asthma (13.1%) and coronary arterial disease (9.8%) among the most frequently reported. Only 41.8% reported no comorbidities. Induction therapy varied with 63.3% receiving CYC, 22.9% RTX whilst 83.5% received GCs. As BVAS was not assessed in routine practice, clinical response was assessed as full (no vasculitis activity and GC taper on track), partial (reduction in vasculitis activity and major organ damage arrested) and no response (no improvement in vasculitis). Response rate varied and therapy-related adverse events were common.
At the last consultation (median 20 months from diagnosis) 73.1 % had no signs of active vasculitis whereas others had varying activity including 5.6% with moderate to severe systemic AAV. 9.1% were receiving renal replacement therapy and 41.4% still took GCs (32.5% < 5mg/day, 61.1% 5-10mg, > 10-20mg/day 5.1%, >20 mg/day 1.3%).
Conclusions: AAV patients frequently have comorbidity at time of induction therapy and vasculitis was rarely assessed using BVAS. Response to remission therapy was variable with many patients still not responding fully at 12 months. Therapy-related adverse events and infections are common, especially in the first 3 months. There is an unmet medical need for better response rates and reduction in toxicity of existing therapy.