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SATURDAY, 15 JUNE 2019

09:00:00 – 10:30:00

Current treatment of vasculitis

SP0181 TREATMENT OF GCA

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The treatment of giant cell arteritis (GCA) has taken a dramatic leap forward over the past 18 months, with the start of the era of interleukin-6 inhibition for the treatment of this disease. For the first time in 70 years, rheumatologists now have a highly-effective alternative to continuous therapy with doses of glucocorticoids that are often unacceptably high, leading inevitably to steroid-related toxicity. Clinicians now have many questions about the optimal approach to treatment in this new era: When should IL-6 inhibition begin? How quickly should glucocorticoids be tapered? Should prednisone be stopped completely? Can tocilizumab ever be discontinued? How does one monitor for the possibility of disease flare? This session will address all of these questions using a data-driven approach, with reference to new data from the GACTA trial

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SP0182 TREATMENT OF AAV

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Background: ANCA associated vasculitis is an autoimmune disease classified by clinical phenotype and serology. A genetic predisposition has been determined which differs between PR3-ANCA and MPO-ANCA patients. Experimental models have confirmed the pathogenicity of ANCA for certain aspects of pathology and have defined a role for alternative complement pathway activation but have failed to explain granuloma formation or gain insights into the origin of breakdown of tolerance. Therapy has emerged empirically to include the combination of high dose glucocorticoids and immunosuppression with B cell depletion, Rituximab, emerging as an alternative immunomodulator over the last 20 years. Studies have evaluated the role of Rituximab in induction, in refractory and relapsing disease and in the prevention of relapse and have explored the role of biomarkers in monitoring therapy. AAV patients continue to suffer poor outcomes especially if renal, cardiac or gastrointestinal features are present at diagnosis. Adverse event rates remain high and the majority of patients pursue a relapsing course. Inhibition of the alternative complement component C5a is emerging as a new therapeutic opportunity.

Objectives: To define the outcomes and predictors for adverse outcomes in AAV. To review recent clinical trial data in the context of established guideline statements and to discuss the treatment of more complex clinical scenarios.

Methods: A description of current approaches to classification and subgrouping by severity. Review of recent clinical trial data and guidelines and application of learned knowledge to clinical scenarios.

Conclusion: AAV remains a disease with poor outcomes. There is a need for further understanding of the barriers to early diagnosis and access to specialist care. Treatment decisions are now well supported by evidence from clinical trials. Rituximab has had a major influence on current management strategies and is leading to improved outcomes and reduced glucocorticoid exposure. Complement inhibition is a potential new therapy for AAV.

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SP0183 DIAGNOSIS AND TREATMENT OF HCV RELATED VASCULITIS

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Chronic hepatitis C virus (HCV) infection is the most common cause of cryoglobulinemic vasculitis. In contrast, non-cryoglobulinemic vasculitis is rare in chronic HCV infection. Cryoglobulinemic vasculitis is a systemic immune complex-mediated vasculitis predominantly affecting small vessels and associated with the presence of serum cryoglobulins, i.e. cold-precipitable immunoglobulins. HCV is a hepato- and lymphotropic virus. Notably, secondary transition from benign lymphoproliferative disease to malignant non-Hodgkin lymphoma (NHL) as well as primary co-manifestation of cryoglobulinemic vasculitis and NHL has been reported in chronic hepatitis C. While cryoglobulinemia is detected in 50% or more of the patients with chronic hepatitis C, less than 5% develop related vasculitis. In this disorder, HCV induces clonal proliferation of memory phenotype marginal zone-like B-lymphocytes with restricted Ig heavy chain variable (V_H) 1-69 gene expression encoding for the IgM rheumatoid factor (RF) WA idiotype. Monoclonal IgM RF binding to the Fc region of polyclonal IgG with anti-HCV reactivity facilitate the formation of cryoprecipitable multi-molecular immune-complexes. Cryoglobulins are preferentially deposited in tissues with high blood flow per unit mass of tissues, e.g. skin, synovium, choroid plexus and glomerulus, where they bind to endothelial cells via the C1q receptor.

Endothelial cryoglobulin deposition induces the activation and recruitment of circulating neutrophil granulocytes and other immune cells to the endothelial lesion eventually resulting in complement-consuming vasculitis.

The histopathologic changes in HCV-related vasculitis range from cutaneous leukocytoclastic vasculitis to severe necrotizing arteritis. Type I membranoproliferative glomerulonephritis is frequently found in patients with renal involvement. Clinical features of HCV-associated vasculitis comprise purpura, Meltzer's triad (purpura, arthralgia, asthenia), polyneuropathy, renal involvement and Raynaud's