Conclusion: Analysis of the burden of disease and the use of medical resources in newly identified EGPA patients revealed that EGPA patients require hospitalizations and AHV, in addition to exposure to high doses of OCS. The appropriate medication for the treatment of EGPA to reduce burden on patients may need consider the pathophysiological state of EGPA patients.

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FRI0219

MEPOLIZUMAB FOR EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS IN REAL WORLD DATA

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Objectives: To investigate the treatments of eosinophilic granulomatosis with polyangiitis (EGPA) and evaluate the usage of mepolizumab in clinical settings.

Methods: The subjects were consecutive EGPA patients who were hospitalized and treated at our department and the Rheumatology, Department of Internal Medicine IV, Osaka Medical College between 2002 and 2018. Their clinical data, treatments, and courses were examined, and the usage of mepolizumab was evaluated.

Results: Of 49 EGPA patients, 41 could be analyzed (14 males and 27 females, mean age of onset: 56.4 years). The percentage of positive ANCA was 31.7%, and affected sites were peripheral nerve (92%), central nervous system (17%), skin (51%), ENT (39%), lungs (29%), heart (22%), digestive organs (12%), and kidneys (15%). Remission induction therapy was performed with PSL (41 cases, 100%), PSL pulse (16 cases, 39%), IVCY (17 cases, 41%), RTX (4 cases, 10%), IVIG (22 cases, 54%), AZA (22 cases, 54%), MTX (4 cases, 10%), MMF (2 cases, 5%), MIZ (1 case, 2%), and MEPO (1 case, 2%). Maintenance therapy was performed with PSL (41 cases, 100%), AZA (21 cases, 51%), MTX (6 cases, 15%), MMF (2 cases, 5%), MIZ (3 cases, 7%), and MEPO (10 cases, 24%). In 10 patients who received mepolizumab, the percentage of positive ANCA was 40%, and the median dose of PSL was reduced from 9.5mg to 5.5mg after administration. Neither relapses nor adverse events occurred in patients who had received mepolizumab.

Conclusion: Mepolizumab reduced the dose of steroids and improved tolerability in EGPA patients with or without ANCA.

Disclosure of Interests: None declared

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FRI0220

EFFICACY OF ADJUNCTIVE METHOTREXATE IN PATIENTS WITH GIANT CELL ARTERITIS TREATED WITH TOCILIZUMAB PLUS PREDNISONE TAPERING: SUBANALYSIS OF THE GIACIA TRIAL

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Background: There is conflicting evidence regarding the efficacy of methotrexate (MTX) in giant cell arteritis (GCA).^{1,2} The benefit of adjunctive treatment with MTX remains to be determined in these patients. Data are presented from a subanalysis of the 52-week, double-blind, randomized controlled GiACTA trial in a subgroup of patients with GCA who received MTX in addition to tocilizumab (TCZ) or placebo (PBO) in combination with prednisone tapering.

Objectives: Assess the efficacy of adjunctive MTX in patients with GCA.

Methods: In part 1 of GiACTA, patients were randomly assigned to TCZ administered subcutaneously every week (QW) or every other week (Q2W) plus 26-week prednisone tapering or PBO plus 26-week (PBO+26) or 52-week (PBO+52) prednisone tapering.³ MTX could be initiated at a stable dose during screening, continued during the double-blind period, and reduced or discontinued at the investigator's discretion according to disease status. Efficacy was determined as the achievement of sustained remission (absence of GCA flare and C-reactive protein <1mg/dL from weeks 12 to 52 and adherence to the prednisone taper).³

Results: During part 1 of GiACTA, 28 of 250 (11%) treated patients received adjunctive MTX for a median duration of 52.1 weeks: 14 of 149 (9%) TCZ-treated patients received MTX for a median of 52.1 weeks, and 14 of 101

(14%) PBO-treated patients received MTX for a median of 51.9 weeks. Baseline characteristics (Table 1) were balanced between patients who received and did not receive MTX, except for longer disease duration and a higher proportion of patients with relapsing GCA among those who received MTX. The MTX-treated patients tended to have lower prednisone doses at baseline. The median cumulative glucocorticoid dose received over 52 weeks was similar between PBO-treated patients who received MTX and those who did not (3033 mg and 3672 mg, respectively) and between TCZ-treated patients who received MTX and those who did not (1339 mg and 1862 mg, respectively). Sustained remission was achieved by 6 of 14 (43%) patients treated with TCZ + MTX and by 76 of 135 (56%) patients treated with TCZ without MTX (Figure 1). None of the 14 PBO + MTX-treated patients achieved sustained remission, whereas 16 of 87 (18%) patients who received PBO without MTX achieved sustained remission (among all patients in the primary analysis,³ 82 of 149 [55%] in the TCZ groups and 16 of 101 [16%] in the PBO groups achieved sustained remission). The mean annualized relapse rate at 52 weeks was not different between the MTX-treated and MTX-untreated groups for the TCZ (0.76 with MTX vs 0.47 without MTX; $p = 0.2549$) or PBO (1.89 vs 1.46; $p = 0.4611$) groups (p values based on t tests). Rates of adverse events per 100 patient-years were numerically higher in MTX-treated than MTX-untreated patients: 1267 and 858, respectively, in the TCZ groups and 1331 and 952, respectively, in the PBO groups.

Conclusion: Preliminary data from a small subgroup of patients suggest that adjunctive MTX does not increase the likelihood of sustained remission, reduce disease relapse rate, or improve steroid sparing in patients with GCA. Response rates in TCZ-treated patients appear to be independent of treatment with MTX. The results from this post hoc analysis in a small sample of GCA patients treated with MTX should be confirmed in larger studies.

References:

- [1] Hoffman GS et al. *Arthritis Rheum* 2002;46:1309-18. 2. Mahr AD et al. *Arthritis Rheum* 2007;56:2789-97. 3. Stone JH et al. *N Engl J Med* 2017;377:317-28.

Baseline Demographics and Disease Characteristics

	PBO+Pred		TCZ+Pred	
	MTX n=14	No MTX n=87	MTX n=14	No MTX n=135
Age, y, median	71.5	68.0	63.0	71.0
Female, %	93	71	71	76
White, %	100	98	100	96
Body mass index, kg/m ² , median	27.5	24.8	25.6	25.5
GCA duration, days, median	303.0	42.0	306.5	42.0
Relapsing GCA, %	93	48	79	48
Pred dose ≤30 mg/day, %	71	49	86	47
CRP, mg/L, median	5.8	3.4	3.7	4.1
ESR, mm/h, median	16.0	20.0	15.5	17.5
Pred, prednisone.

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