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Implementing the SOC Induction Therapies in AAV

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Dr. Brix:
This is a CME on ReachMD, and my name is Silke Brix. And here with me today is Bernhard Hellmich. Bernhard is professor of rheumatology and the lead of the Departments for Internal Medicine, Rheumatology and Immunology at Kirchheim Hospital, and he's the co-director of the Vasculitis Centre for Tübingen-Kirchheim. And importantly, the senior author of our new EULAR and ERA combined recommendations on ANCA vasculitis. So it's a great pleasure to have him here explaining in the next minutes how he himself implements our latest guidelines for standard of care therapy in practice and uses them to personalize the induction phase to optimize his patient's care. Bernhard?

Dr. Hellmich:
Thank you, Silke. That’s a great introduction. So given all the different options for treatment for patients with AAV, we in fact are able to personalize our treatment today, and there are some factors you can consider in your daily practice when you face a patient with active ANCA-associated vasculitis.

So first of all, you should consider is this a patient with new-onset disease or relapsing disease? Let’s stay with a patient who has a new-onset disease. In this case, you first should have a look if this is a patient with a severe organ manifestation, which is organ- or life-threatening. That's the case in most patients, especially if they have renal disease and severe pulmonary disease.

And then it's first important to consider your treatment goals and to discuss them with the patient.

So the biggest impact of AAV is the deterioration of organ function and the induction of organ damage that may last. So your treatment goal is certainly to get into remission very fast and to avoid damage. And to do so, we have quite a good variety of treatment options today.

We have recent guidelines from KDIGO and the EULAR recommendations, which have been published both in print this year. And for induction of remission in a new-onset patient with severe disease, both societies recommend to use high-dose glucocorticoids together with either rituximab or cyclophosphamide for induction of remission. If you choose rituximab or cyclophosphamide, it depends on certain patient factors. And here we are with the personalization.

So cyclophosphamide is preferred by some people if the patient has very severe renal disease with a creatinine above 4. Some colleagues even use combined treatment with rituximab and cyclophosphamide because data for just rituximab are not that broad. There aren’t so many studies on that. So cyclophosphamide may have a benefit there.

On the other hand, rituximab may be preferable, especially in patients who have childbearing potential, males and females, or young patients, it could be preferred. Another reason to prefer rituximab could be that it is also given as a standard of care for maintenance, and you don't have to switch for another agent.

So usually you induce a remission with the induction protocols that are outlined in the guidelines, you taper your glucocorticoids to around 5 mg after 4 to 5 months, and then you continue your treatment.

A new development is inclusion for induction of remission of avacopan, which is a C5 receptor antagonist. There was a randomized, controlled clinical trial that led to the approval of this agent and the data showed that, with avacopan, it's possible to taper your glucocorticoids much faster, to avoid glucocorticoids mostly, and reduce glucocorticoid toxicity.

There were also data showing that avacopan, the addition of avacopan improves the recovery of renal function in patients with kidney involvement, especially if there is a significant involvement or severe involvement of the kidney and impaired renal function.

So usually the guidelines recommend to add avacopan to spare glucocorticoids in patients where this is desirable, and it's also considered in patients with severe renal disease.

So once you have tapered your glucocorticoids, usually continue the induction glucocorticoids for some time and your avacopan usually for one year. That's the approved dosage and time of treatment. And later on, you will switch to a maintenance therapy

Dr. Brix:
Well, thank you, Bernhard. That's was a great talk through the whole of the induction. And to summarize, so you would say your treatment goal is to control disease activity and aim for minimal organ damage and minimize toxicity, right?

And perhaps I'd just like to add in that advising people that do not regularly see vasculitis patients to then, early, contact an expert center if it doesn't go your way so that, early on, to try to minimize any damage causing because you're not on top of the game.

So I'd like to thank the audience for the attention, and I hope this was useful.

Announcer:
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