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Optimizing AAV Outcomes: Maintenance Therapies

Announcer:
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Dr. Hellmich:
This is CME on ReachMD, and I'm Dr. Bernhard Hellmich from Kirchheim in Germany. Here with me today is Dr. Silke Brix.

So, Silke, how do you personalize maintenance therapy in treatment with your patients with AAV?

Dr. Brix:
It starts off with your EULAR recommendations. Well, if you're into the maintenance phase, and I think this is actually the crucial bit where we struggle the most, is do you have sustained remission? So when we want to use maintenance treatment, we need to first ensure are we in maintenance.

And I think this is when we have to look at our BVAS assessment, and I think the BVAS assessment is great for research, and a lot of my, especially kidney, colleagues would say that they used the BVAS assessment for research, but they don't use this actually in clinical settings because it would be a bit more stricter and more accurate actually when we look at the detailed parameters we're checking so that you have your patient in remission. Meaning that have I recovered enough kidney function? Have I resolved my hematoproteinuria? And these things, be very, very careful how you assess them and how you take them on a BVAS score is my message.

But if we then are saying, I have reached remission with my patient and I'm going for maintenance treatment, I think when you walk along your EULAR recommendation after the first point of making sure we are in remission and wanting now to use maintenance treatment, it' s actually getting rid of the steroids and the avacopan.

And I think the TAPIR trial results presented this year support that if you are using rituximab as a maintenance treatment, that you don't need to be afraid so much of a relapse. So you can, in remission, withdraw the steroids and the avacopan, especially when you have a patient safely on rituximab maintenance established

And then, the next step is after that, and that's the crucial next bit, is the individual decision of how long are we going to remain? And I think EULAR has this 24 to 48 months for a reason, because every patient is different.

And so I would say, what are the arguments for coming off treatment early versus what are the arguments for staying long? And I think one of the things that's probably really important is patient choice. So if your patient says, well, I really do not want to carry on a long-term maintenance treatment, you have a discussion with your patient. Are you going to be compliant attending clinic? Can we do some

close monitoring? Then patient choice of coming off treatment early, and perhaps not calling it with stopping maintenance treatment, but we're doing a drug holiday, and monitoring to see how long can we remain off drugs is one of the options in the maintenance phase.

But the maintenance on immunosuppression coming then to the maintenance off and the in-remission off drug phase is, I think, a fluid phase where you can have a look on the left side on my slide. It says kind of what speaks for feeling comfortable to stopping immunosuppression, and that might be that it's your MPA type more likely. So it's MPO or antibody-positive patient that has now become ANCA negative. That's a good sign that you are in control and could go into a drug holiday.

Or someone's been from the start of renal limited with MPO and has become negative and has no ENT involvement. So there isn't any granulomatous disease; there isn't any GPA. There wasn't any relapsing disease before.

And on the other side, for remaining on maintenance and not stopping it early and, rather, thinking about the 4 years of treatment is, yeah, do you have someone who has already had relapses before? Is there very little residual organ function? I think this is one of the key elements when you have had severe disease and have little kidney function left, you're not comfortable coming off immunosuppression early or even coming off at all because you're worried that the next relapse will cost the last bit of kidney function you have.

So little function left, having had relapses before, being officially a GPA, being PR3 positive, having ENT disease, these are all things, when you assess your patients, that will have you tend to prolong your maintenance phase before you try to come off immunosuppression, if you have multi-organ disease, if you are not able to monitor closely. But the ultimate aim should be that we actually manage drug holiday and remission off treatment at some point.

Dr. Hellmich:
Maybe a final question, but what is your opinion about biomarker-guided treatment for maintenance? Do you do that in your practice sometimes, or?

Dr. Brix:
Yeah, I think the established biomarkers in clinical practice would be, like your repopulation of B cells, would be the turn of the ANCA that definitely flow into my – and I incorporate them into my clinical practice. The more modern biomarkers I would love to use, that hopefully will be incorporated in the future, are things that are biomarkers of inflammation.

I do like CD163, but it's a, we know, macrophage-based marker, so this will be when you have already active inflammation in your kidney. That won't be the earliest marker. So ideally, we would have several biomarkers to combine to tell us when someone is successfully responding and when someone's disease is then calmed down, and then we can do a drug holiday. Yeah.

Dr. Hellmich:
Yeah. Thanks. So it looks, really, like there is a prospective for more individualized treatment in the future. I'm happy to discuss this further, but now our time is over.

Thanks for listening, and we hope to see you again.

Announcer:
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