

2. DACH ANCA VASKULITIS FORUM 2024

22. & 23. NOVEMBER 2024 | MÜNCHEN

CSL Vifor

**Patient mit AAV
nach Entlassung:
Wie geht's weiter?**

Dr. Johannes Trachsler



Zürich





2. DACH AAV Meeting München 11.2024

Patient mit AAV nach Entlassung- wie geht's weiter?

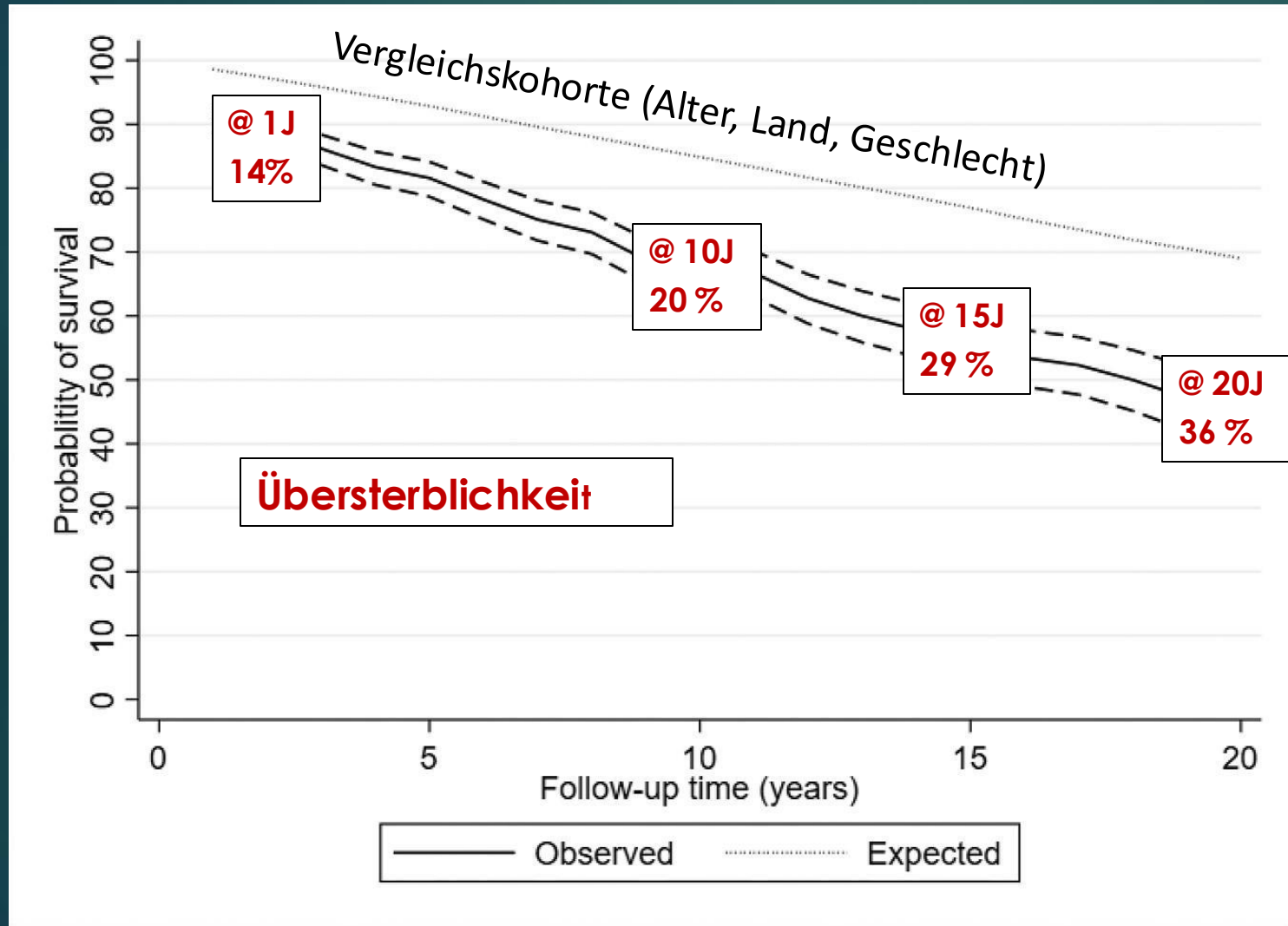
Langzeitverlauf

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Stadtspital Zürich

Weniger lang, als es sollte



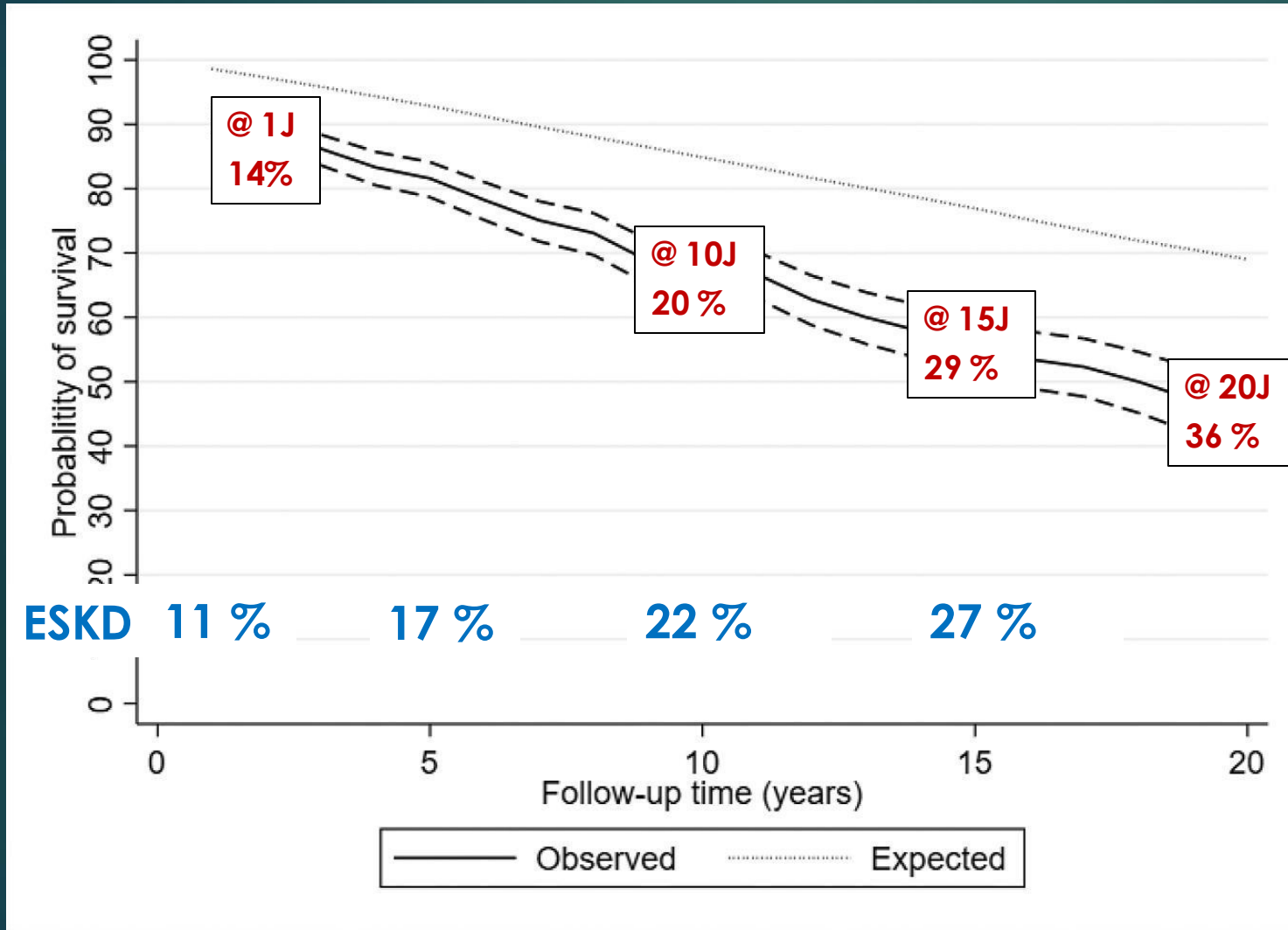
7 EUVAS-Trials, N 848
57 J, GFR 42, $\frac{3}{4}$ CYC

Trend für besseres
Überleben 2000-2012
vs 1995-2000

Survival bei i.v. CYC
besser als po CYC

Das CKD-Risiko nimmt laufend zu

CKD/-Stadium korreliert mit Mortalität



Todesursachen:

Infekte 26%

CV 14%

Malignome 13%

- < 54J: 19% -> > 65 J: 28%

Todesursachen im Langzeitverlauf FU > 5 J

Infekte 19%

Malignome 15%

CV 14%

Vaskulitis: Todesursache in 0-8%

Und die Lebensqualität?

Systematic Review of PROM's in Patients with AAV

30 Studien

- vorwiegend im Verlauf bei stabilen Pat. in Remission (22/30)

Floyd et al Rheumatology 2024

Die Health related QoL bei AAV ist

Schlechter als Normalbevölkerung, v.a. bei Jüngeren/Frauen

Depression und Angststörung 5-6x häufiger

Kein Zusammenhang (in 13/15 Studien=86%) mit

- BVAS, VDI, **Krankheitsdauer**

Zusammenhang u.a. mit

- Fatigue (partielle Besserung im Verlauf)
- Sozio-ökonomische Faktoren: Job/Finanzen, Beziehungen, ED
- Prednison

Fatigue ist sehr häufig- und kann persistieren

Schottische Case-Control-Studie (74 AAV-Pat vs 781 Kontrollen)

- KH-Dauer 6 J; 85% BVAS 0

- Fatigue insgesamt 78.5 vs. 48.9%

- Keine Abnahme im Verlauf:

KH-Dauer:	1 J	1-10 J	> 10J
mod./schwer	47%	33%	40%

Fall 1 : Lange scheint alles ruhig

Herr B. 1946

2012 ED GPA

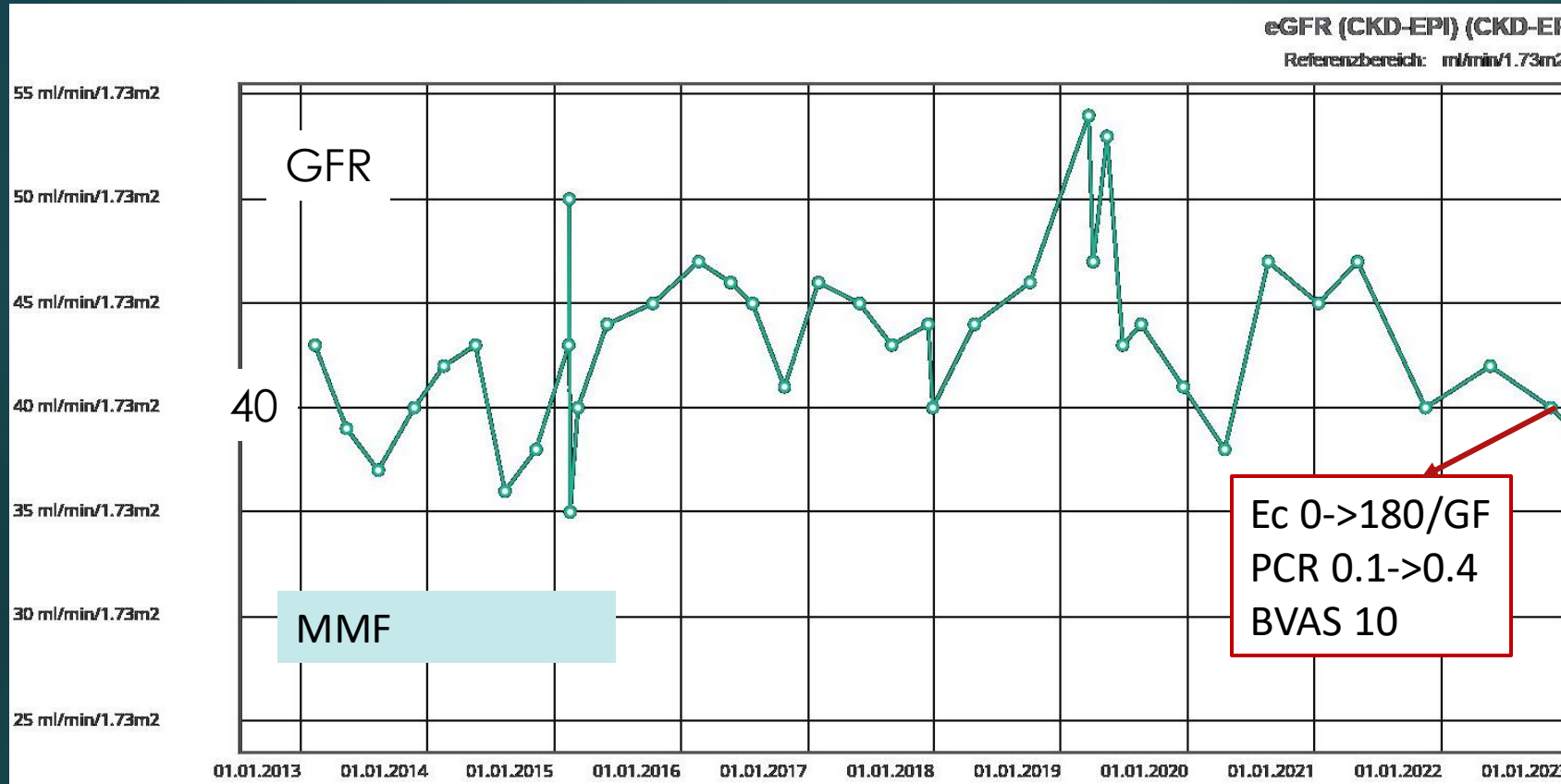
- PR3-ANCA +
- Rhinitis, pulmonale Noduli
- GN (crescentic class); Dialysepflicht-> Erholung auf GFR 40 ml/min.
- Therapie
 - Solumedrol 3x1g-> PDN po
 - 7x PEX
 - Cyclophosphamid i.v. kumulativ 7 g
 - AZA (Unverträglichkeit)-> MMF

10 Jahre mit stabilem Verlauf



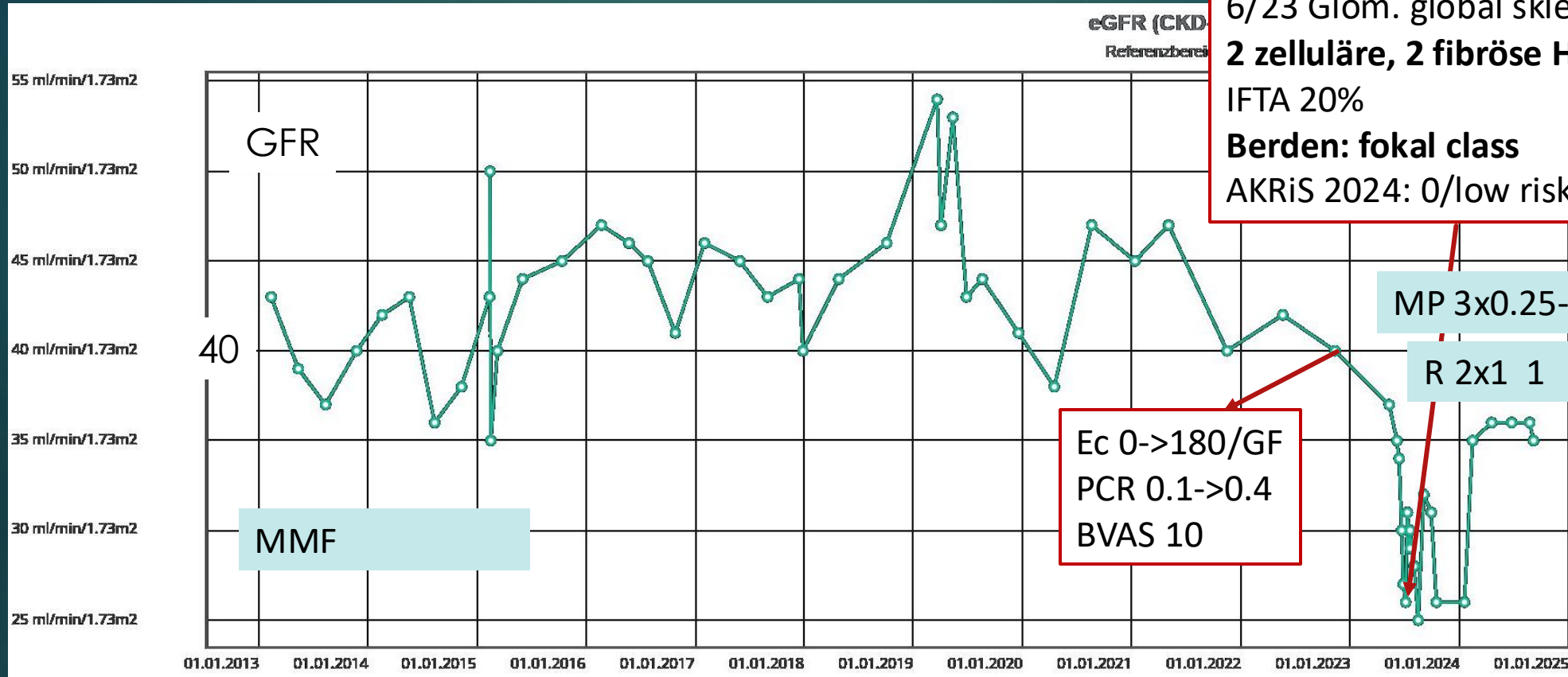
PR3 U/ml: 174	neg	neg	neg	neg	neg	neg	5 (<3)	neg
Ec/GF		bland		bland		bland		
PCR g/g		0.1		0.1		0.1		

10 Jahre mit stabilem Verlauf



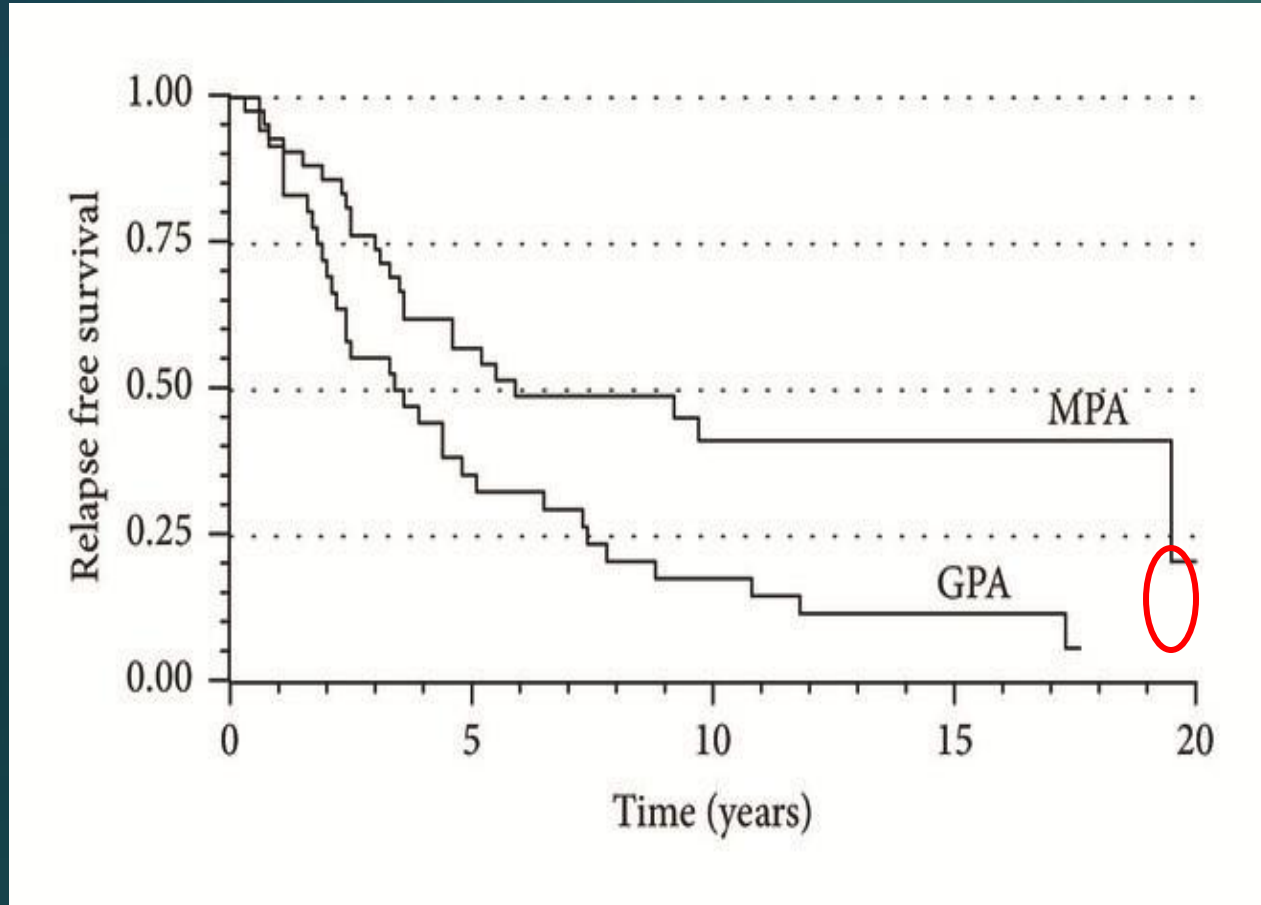
PR3 U/ml: 174	neg	neg	neg	neg	neg	neg	5 (<3)	neg
Ec/GF		bland		bland		bland		
PCR g/g		0.1		0.1		0.1		

10 Jahre mit stabilem Verlauf



PR3 U/ml: 174	neg	neg	neg	neg	neg	neg	5 (<3)	neg	132	neg
Ec/GF		bland	bland	bland	bland	bland		180		
PCR g/g		0.1	0.1	0.1	0.1	0.4				

Relaps im Langzeitverlauf: Jeder?



n 85, Helsinki, FU 16 J

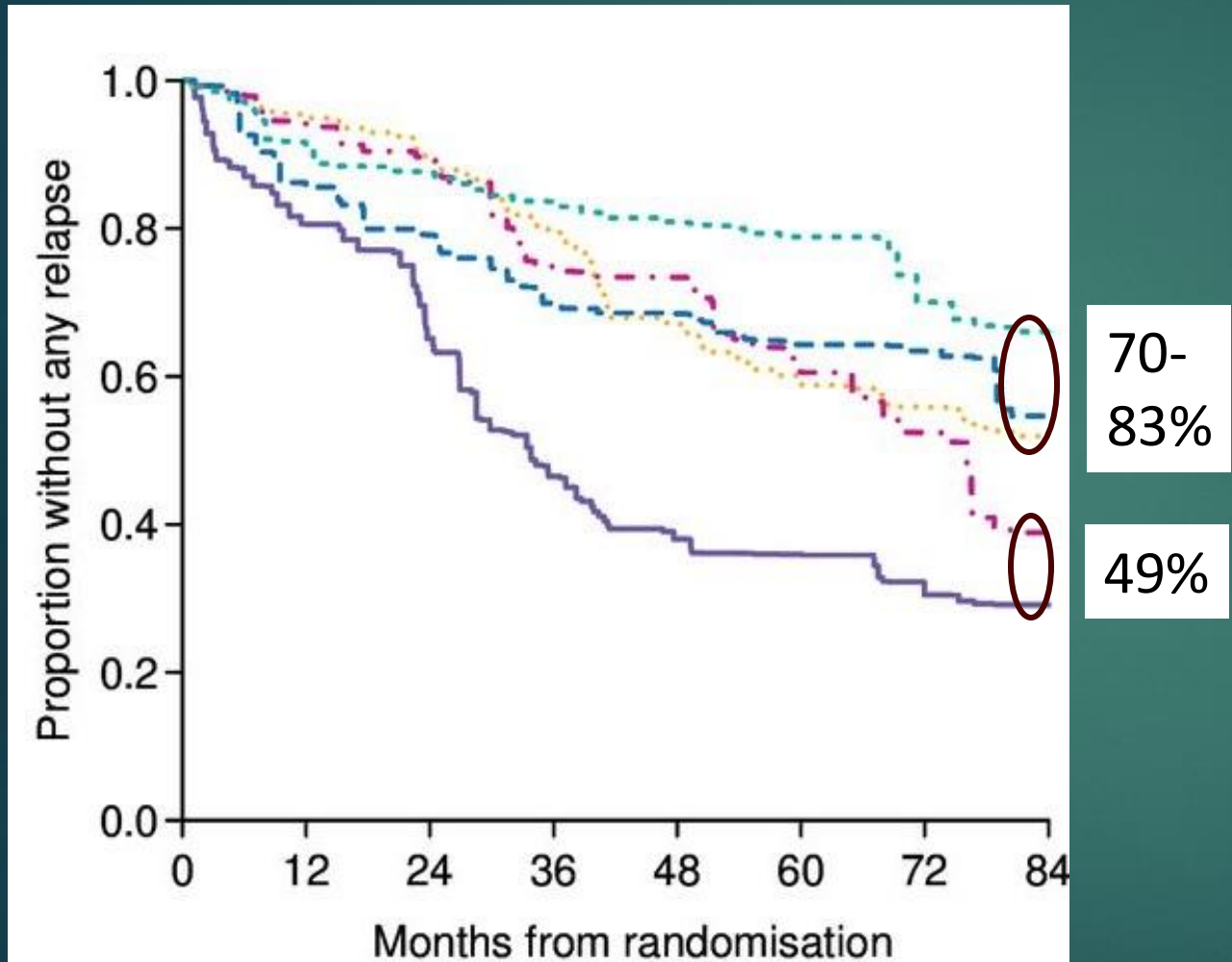
58J, eGFR 24

80%.: CYC-> **AZA**

@ 20 J

- Relaps free survival 10%

Relaps im Langzeitverlauf: Rituximab besser (bis 7 J)?



N 277, MAINRITSAN 1-3
FU 7 J

Induktion: 78% CYC, 22% RTX
Remissionserhalt:

- Azathioprine
- ⋯ 18-mo. fixed-schedule RTX
- - 18-mo. individually-tailored RTX
- - 36-mo. tailored/fixed RTX
- ⋯ 36-mo. fixed/fixed RTX

RF: St.n. Relaps; ENT; GFR↑;
MPO->neg HR 0.21; **PR3 ns**

Survival @7 J.: 85-94% ns

Prognose-Scores für Relaps (Therapie-abhängig?)

FRS (Relaps-Rate @5 J)

- Je 1 Punkte für: PR3, GFR > 30, Alter < 75
- 0-1-2-3 Punkte: 8% - 30% - 48% - 76%
- Remissionserhalt: AZA 39%, RTX 40%

Samson et al RMD Open 2023

McClure 2021 (FU 5 J)

- RTX->RTX über max. 2 Jahre
- Score 1 J nach letzter RTX-Gabe
 - ANCA pos, ENT, Relaps, tieferes Krea; weniger PDN @RTX-Stop; ohne PR3
- Hoch- vs. Tiefrisikogruppe: Relaps nach 22 vs. 70 Monaten
- Für individuelle Prognose ungenügend

McClure et al Rheumatology 2021

Fall 2 Steter Tropfen höhlt den Stein

Herr S. 1973

2002 ED GPA mit PR3-ANCA

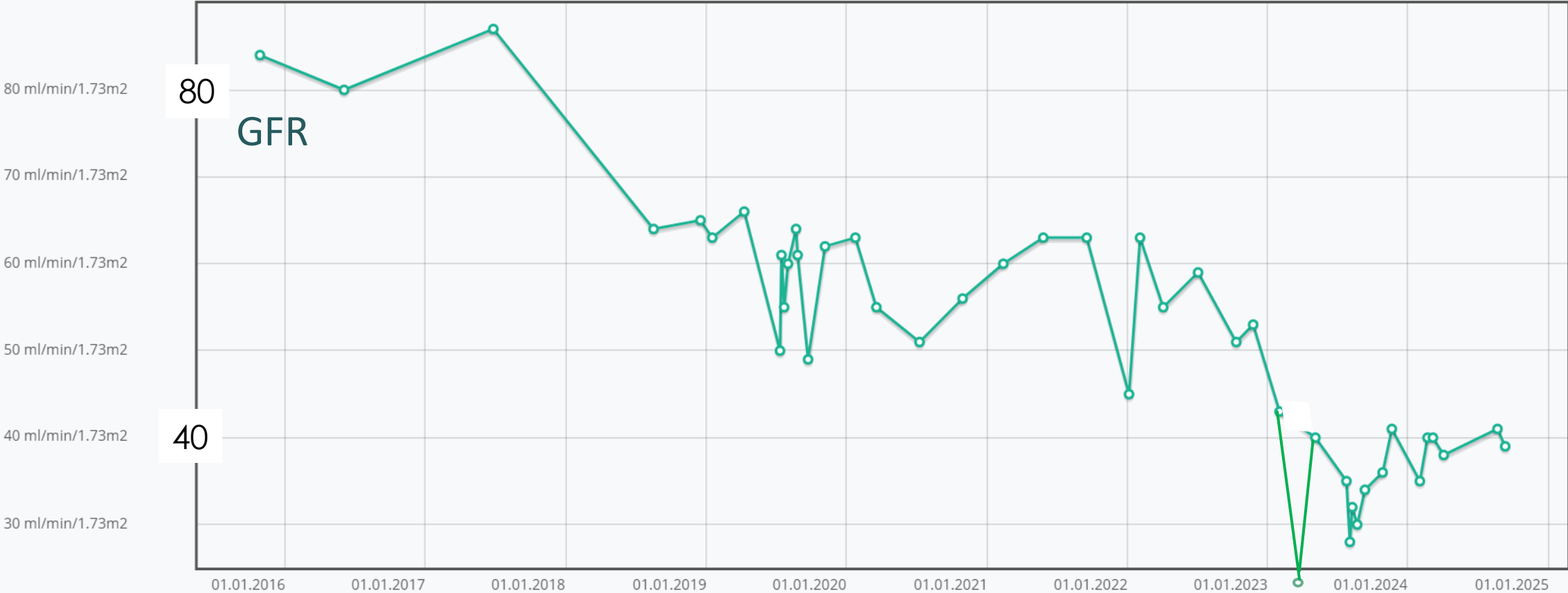
- fokale GN, Epistaxis, GI-Befall
- Cyclophosphamid i.v. x10; Methotrexat 2 Jahre

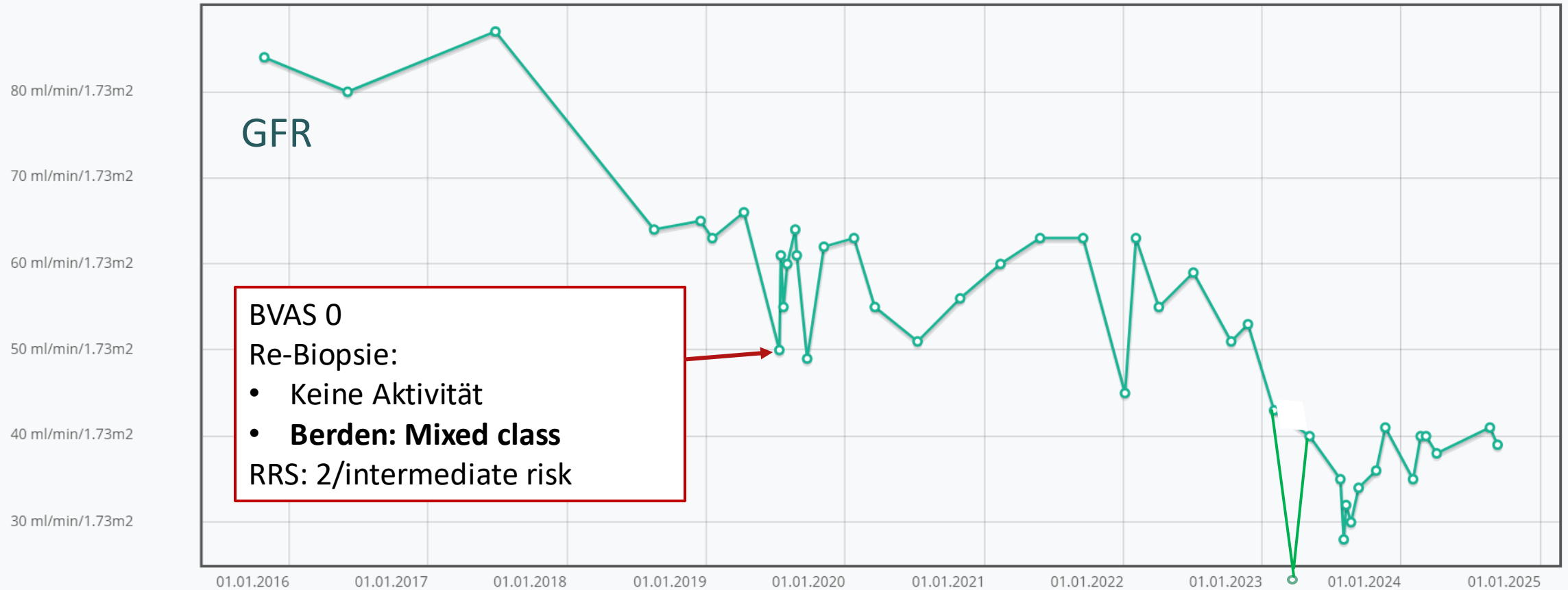
2003 Re-Biopsie (persistierender Proteinurie) ohne Aktivität

Uebernahme Behandlung Ende 2015

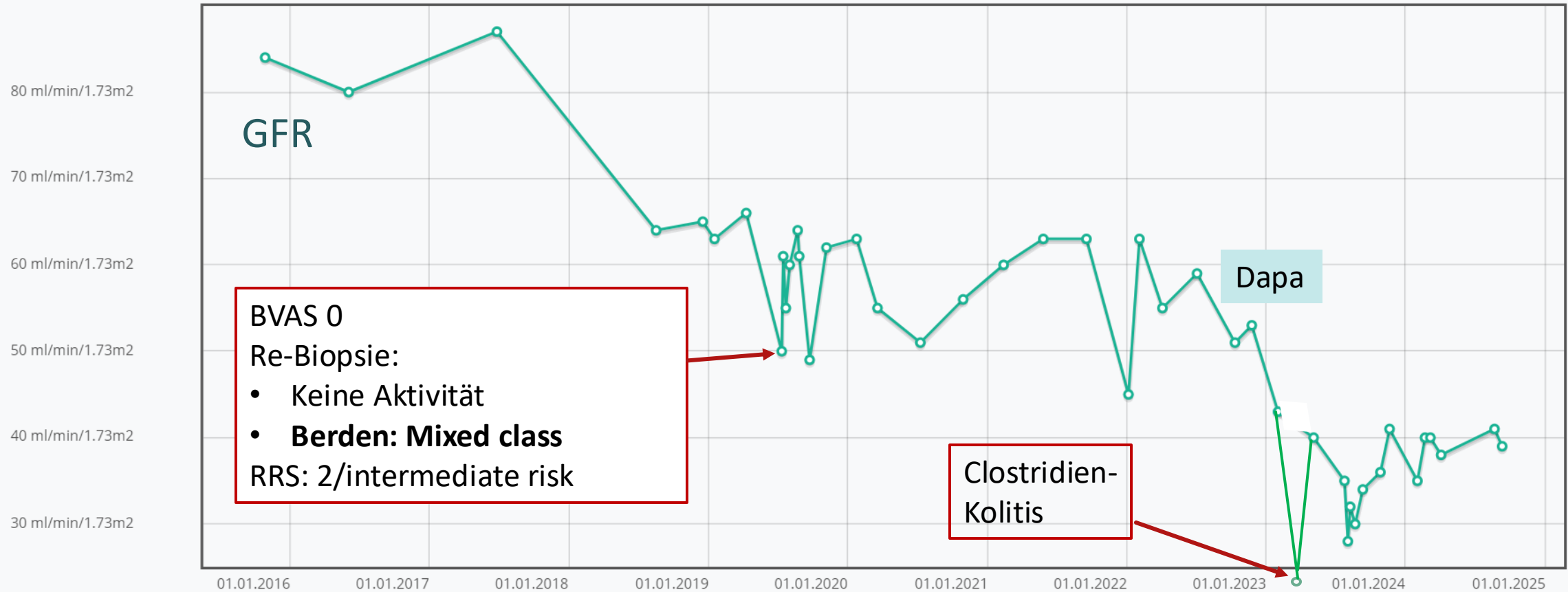
- GFR 85 ml/min.
- Sediment intermittierend Ec
- Proteinurie um 1 g/g
- PR3-ANCA 4 U/mL (<3)

Referenzbereich: ml/min/1.73m²

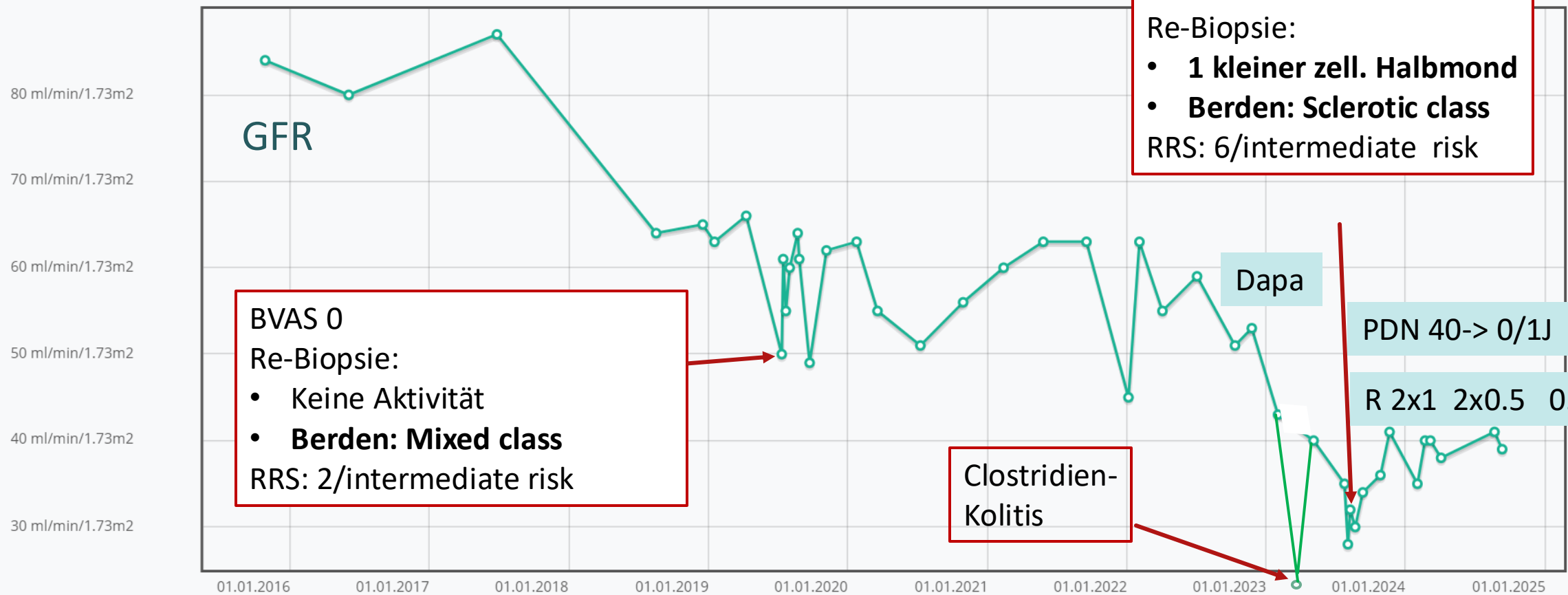




PR3 U/ml:	4 (<3)	11	13
Ec/GF	1-15		8-15
PCR (g/g)	1		



PR3 U/ml:	4 (<3)	11	13	11	33(<7)	28	23 (<3)
Ec/GF	1-15		8-15				6-14
PCR (g/g)	1			2			



PR3 U/ml:	4 (<3)	11	13	11	33(<7)	28	23 (<3)	59	6	2
Ec/GF	1-15		8-15				6-14			
PCR (g/g)	1			2			3			

Was ist ein renaler Relaps mit Therapie-Bedarf?

KDIGO 2024/EULAR 2022

- Relapse is defined as the occurrence of increased disease activity after a period of partial or complete remission.

BVAS: renale Befunde (< 4 Wochen bzw. 3 Monate)

- PCR > 0.2 g/g
- Ec-urie \geq 10/GF
- Kreatininanstieg \geq 30% oder CCL-Abfall \geq 25%

Neue Marker? Noch nicht in der Klinik

- sCD163, MCP-1 i.U., ...

Odler, .., Kronbichler, CKJ 2023

Hilft die Biopsie?

Studie mit Re-Biopsien

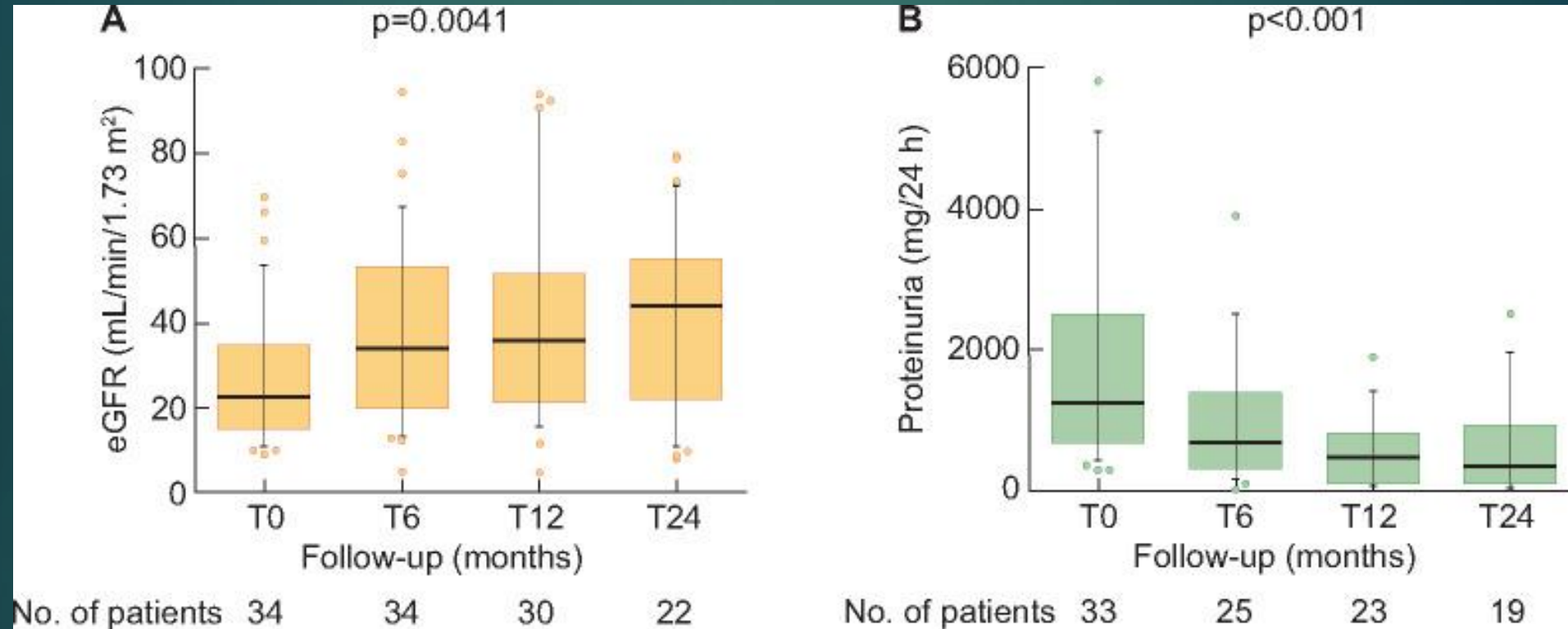
- n=59
- im Schnitt 4 Monate nach 1. Biopsie
- Von 24 klinisch aktiven Patienten zeigen nur 42% histologische Aktivität
- Hämaturie nicht diskriminierend
 - Klinische Aktivität ≠ histologische Aktivität

Subakuter Verlauf ohne histologische Aktivität: Therapie?

Serie mit «slowly progressive» renaler AAV

- Definition: GFR-Verlust 25-50% in den 6 Mt. vor Dx
- 5% von 856 Patienten
- Alle MPA mit MPO-/p-ANCA
- Renal limited: 61%
- Nierenbiopsie
 - Vorwiegend chronische Läsionen: Sclerotic class 43%, 78% rein fibröse Halbmonde
 - 20% aktive Läsionen

IS in 90%, mit Erfolg



Zusammenfassung Langzeitverlauf, Diskussion

Überleben/ESKD-Raten/QoL suboptimal: Durch AAV, Therapie, CKD?

Zeitlich unlimitierter Follow up nötig

- Hohe Relapsrate im Langzeitverlauf
- Impfungen, CV-Prävention/-Therapie, Tumorscreening, CKD-Therapie

Relaps-Diagnose im Einzelfall schwierig

- Wann biopsieren (Dx, Prognose)?
- Subakuter Verlauf: Immunsuppression?

Wer braucht eine prolongierte Remissionserhaltung?



Besten Dank

Diskussion

Probleme im Langzeitverlauf

Dauer Erhaltungs-Rx?

Studien bis 4 J

- REMAIN
- MAINRITSAN 3

KDIGO: 18-48 Mt

EULAR: 24-48 Mt

(Relaps, R-Risiko ↑ länger?)

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Gekürzte Verschreibungsinformationen

Schweiz:

Tavneos®. Z: Avacopan. **I:** Tavneos, als ergänzende Therapie zu einer immunsuppressiven Standardbehandlung auf Basis von Rituximab oder Cyclophosphamid mit Glukokortikoiden, ist für die Behandlung erwachsener Patienten mit schwerer aktiver ANCA Vaskulitis (GPA/MPA) indiziert. **D:** Orale Einnahme morgens und abends 2x täglich 30 mg (3 Kapseln zu je 10 mg) mit Nahrung. **KI:** Überempfindlichkeit gegen den Wirkstoff oder einen der Hilfsstoffe. **VM:** Hepatotoxizität; Angioödem; Überwachung des Blutbildes (weisse Blutkörperchen); Schwere Infektionen; Reaktivierung des Hepatitis-B-Virus; Herzbeschwerden; Bösartige Tumore; Macroglycerinhydroxystearat. **S/S:** Eine Anwendung während der Schwangerschaft und bei Frauen im gebärfähigen Alter, die keine Verhütungsmethode anwenden, ist nicht empfohlen. Es ist nicht bekannt, ob Avacopan in die Muttermilch ausgeschieden wird. Der Nutzen des Stillens für das Kind sollte gegen den Nutzen der Behandlung für die Patientin abgewogen werden. **UW:** Sehr häufig: Infektion der oberen Atemwege, Nasopharyngitis; Kopfschmerzen; Erbrechen, Durchfall, Übelkeit; erhöhter Lebertest; verminderte Anzahl weisser Blutkörperchen. Häufig: Lungenentzündung, Infektion der unteren Atemwege, Influenza, Bronchitis, Zellulitis, Infektion der Harnwege, Herpes zoster, Sinusitis, orale Candidose, Herpes im Mundbereich, Otitis media, Rhinitis, Gastroenteritis; Neutropenie; Oberbauchschmerzen; Anstieg der Kreatinphosphokinase im Blut. Gelegentlich: Angioödeme. **IA:** Avacopan ist ein Substrat von CYP3A4. Die gleichzeitige Verabreichung von Induktoren oder Inhibitoren dieses Enzyms kann die Pharmakokinetik von Avacopan beeinflussen. Siehe Fachinformation. **P:** Tavneos 10 mg: 30 und 180 Hartkapseln. **Liste B.** Detaillierte Informationen: www.swissmedicinfo.ch. Stand der Information: Januar 2024. **Zulassungsinhaberin:** Vifor Fresenius Medical Care Renal Pharma Ltd., St. Gallen. **Vertrieb:** Vifor Pharma Switzerland AG, CH-1752 Villars-sur-Glâne |

▼Dieses Arzneimittel unterliegt einer zusätzlichen Überwachung. Für weitere Informationen, siehe Fachinformation TAVNEOS® auf www.swissmedicinfo.ch.

Gekürzte Verschreibungsinformationen

Österreich:

Tavneos® Fachkurzinformation

Tavneos®10mg Hartkapsel

Zusammensetzung: Jede Hartkapsel enthält 10 mg Avacopan. Sonstige Bestandteile mit bekannter Wirkung: 245 mg Macrogolglycerolhydroxystearat(Ph.Eur). **Anwendungsgebiete:** Tavneos® ist in Kombination mit einem Rituximab- oder Cyclophopamid-Dosierungsschema indiziert zur Behandlung erwachsener Patienten mit schwerer aktiver Granulomatose mit Polyangiitis (GPA) oder mikroskopischer Polyangiitis (MPA). **Gegenanzeigen:** Überempfindlichkeit gegen den Wirkstoff oder einen der sonstigen Bestandteile. **Pharmakotherapeutische Gruppe:** Komplement-Inhibitoren **ATC- Code:** L04AJ05 **Inhaber der Zulassung:** Vifor France, 100-101 Terrasse Boieldieu Tour Franklin La Defense 8 92042 Paris La Defense Cedex, Frankreich. Rezept- und apothekenpflichtig. Weitere Angaben zu Warnhinweisen und Vorsichtsmaßnahmen für die Anwendung, Wechselwirkungen mit anderen Arzneimitteln oder sonstigen Wechselwirkungen, Schwangerschaft und Stillzeit und Nebenwirkungen sowie Gewöhnungseffekten sind der veröffentlichten Fachinformation zu entnehmen. Stand der Information: Mai 2023

▼ Dieses Arzneimittel unterliegt einer zusätzlichen Überwachung. Dies ermöglicht eine schnelle Identifizierung neuer Sicherheitsdaten. Angehörige der Gesundheitsberufe werden gebeten, alle Verdachtsfälle von unerwünschten Wirkungen zu melden.