Continued from page 32

ical studies more than 50% of plasma cells in the lesion stained for IgG4. The patient's IgG4 levels were elevated nearly 10-fold, and reevaluation of a lymph node biopsy performed 4 years earlier showed previously undetected IgG4-related systemic disease (Arthritis Rheum. 2009;60:3139-45).

Dr. Stone and his colleagues concluded that IgG4-related systemic disease should be considered in all patients with aortitis of unknown etiology, and noted that treatment might prevent progression of the systemic disease to other organs.

At the ACR symposium, where he spoke on "odd types of vasculitis," Dr. Stone said it is intriguing that this condition hadn't been previously identified given the number of other diagnoses known to be related to IgG4.

The findings prompted a review of prior cases of aortitis at Massachusetts General Hospital, where a large number of aortic surgeries are performed, and it was found that 5.2% of 638 thoracic aorta resections performed from 2003 through 2008 were inflammatory, and about 12% stained intensely for IgG4, he said.

"So we think [IgG4-related systemic disease] accounts for about 12% of cases of inflammatory aortitis," he added, noting that in a 2008 study from Japan, 4 of 10 cases involving the descending aorta stained intensely for IgG4.

The findings demand that the classification of aortitis be revisited, and that lymphoplasmacytic IgG4-related disease be included as a type of isolated aortitis, Dr. Stone concluded.

Dr. Stone said that he had no relevant financial disclosures. ■

Prolonged Glucocorticoid Use May Prevent Vasculitis Relapse

BY AMY ROTHMAN SCHONFELD

FROM A RHEUMATOLOGY MEETING SPONSORED BY NEW YORK UNIVERSITY

NEW YORK – Early discontinuation of glucocorticoid therapy may greatly increase the risk of relapse in antineutrophil cytoplasmic antibody–associated vasculitis, said Dr. Yusuf Yazici.

He discussed a study that addressed the controversial question of whether low-dose glucocorticoids contribute to maintaining remission of the disease.

Patients successfully treated for antineutrophil cytoplasmic antibody–associated vasculitis (AAV) face high rates of relapse, up to 38% at 30 months. Although glucocorticoids are often used to prevent relapse in AAV, high-quality evidence to guide treatment is lacking, Dr. Yazici said.

"Our aim is always to get patients off steroid therapy, but maybe that is a misguided aim," said Dr. Yazici, director of the Seligman Center for Advanced Therapeutics and Behçet's Syndrome Evaluation, Treatment and Research Center at the New York University Hospital for Joint Diseases.

Dr. Yazici cited findings from a meta-analysis of studies investigating the treatment of AAV that included a predefined glucocorticoid dose and protocol for tapering (Arthritis Care Res. 2010;62:1166-73). Thirteen studies involving 983 patients were identified for inclusion, including five observational and eight randomized controlled trials. None of the studies directly compared glucocorticoid regimens.

To elucidate the role of glucocorticoid therapy in relapse, the authors divided the studies into those that had a zero glucocorticoid target dose (aimed to get patients completely off glucocorticoid therapy, n = 695) and those having a nonzero glucocorticoid target dose (low glucocorticoid maintenance dose allowed, n = 288).

The investigators found that 36% of the overall group relapsed. Upon further examination, the relapse rate was 43% for those in the zero glucocorticoid target dose group, compared with 14% in those allowed to continue glucocorticoids – approximately a threefold increase.

Even for those who discontinue glucocorticoids, timing is important. When the investigators divided patients in the zero target dose into those who had to reach zero within 12 months (the early zero group) and those who were allowed to reach zero after 12 months (the late zero group), there was a 48% relapse rate for the early zero group, compared with a 29% rate for the late zero group. While the early zero glucocorticoid target dose group had significantly more relapses than the nonzero group (*P* less than .001), the late zero glucocorticoid target dose group was similar to the nonzero group. By grouping the late zero and nonzero groups, the authors concluded that early discontinuation of glucocorticoid was associated with a 20% increased risk of relapse (28% vs. 48%).

The results suggest that glucocorticoid dose should be monitored, and that patients with AAV should be kept on 5.0-7.5 mg of glucocorticoids for at least a year after reaching remission, said Dr. Yazici. ■

VITALS

Major finding: The relapse rate for patients with antineutrophil cytoplasmic antibody–associated vasculitis was 43% in a pooled analysis of studies in which patients were tapered completely from glucocorticoids, compared with 14% in studies of patients allowed to continue glucocorticoid therapy. Early discontinuation was associated with a higher relapse rate than was later discontinuation.

Data Source: Meta-analysis of 13 studies involving 983 patients investigating the treatment of AAV that included a predefined glucocorticoid dose and protocol for tapering.

Disclosures: Dr. Yazici has served as a consultant or speaker for, or has received research support from, BMS, Celgene, Centocor, Genentech, Merck, Novartis, Roche, and UCB.

Use Topicals for Less Severe Cutaneous Lupus

BY SHARON WORCESTER

EXPERT ANALYSIS FROM A SYMPOSIUM SPONSORED BY THE AMERICAN COLLEGE OF RHEUMATOLOGY

CHICAGO – A number of treatments can be considered for cutaneous lupus erythematosus.

"Topicals are certainly a good way to start for a less severe patient," Dr. Victoria P. Werth said at the meeting.

Topical steroids can be used, she said, noting that she often starts with a potent class 1 drug.

A class 1 drug, however, would be impossible to use on the face for more than a few days, added Dr. Werth, a dermatologist and immunologist at the University of Pennsylvania, Philadelphia.

"Often on the face we use Cortaid or something like a Synalar [fluocinolone] or Lidex [fluocinonide] for a short period of time and then taper down to hydrocortisone," she said.

The more recently available topical nonsteroidal T-cell inhibitors, tacrolimus and pimecrolimus, can be used as adjunctive therapy. These agents aren't perfect, but they may be worth trying in a patient in whom one does not want to use steroids long term, she said.

Intralesional steroids are another treatment option and are particularly useful for scalp lesions and isolated lesions.

Vitamin D replacement also may be helpful. A study published last year showed that cutaneous lupus patients, like many people, had very low vitamin D levels in winter, but levels didn't rise much during the summer as they do in others – likely because patients are following advice about sun avoidance.

As for systemic therapy, data from prospective randomized controlled trials are lacking, and most guidance comes from retrospective case series. But antimalarials are considered first-line treatment in those who can't use topical therapy.

Specifically, hydroxychloroquine is typically given at 6.5 mg/kg per day or less for 6-8 weeks, and quinacrine can be added at 100 mg/day for an additional 6-8 weeks in those who fail to respond to hydroxychloroquine monotherapy.

Not everyone needs the combination, but it is very beneficial in some patients, Dr. Werth noted.

Chloroquine at 3.5 mg/kg per day can be used in those who fail to respond to that combination. Although there are more concerns about toxicity, there are patients who will do better on chloroquine, she said.

Other therapies beyond the topicals and antimalarials include dapsone, retinoids, thalidomide, methotrexate, mycophenolate mofetil, azathioprine, corticosteroids, and cyclophosphamide.

"We use dapsone predominantly for bullous lupus, and in some patients – if they're not too sick with their SLE, and their bullous lupus is not terrible – it's worth trying," she said, noting that "it's very good on neutrophilic infiltrates, and it can work."

Retinoids are on the list only because one trial compared them with antimalarials. Retinoids aren't very effective, they have a lot of toxicity, and they're not easy to use, she said.

In contrast, thalidomide can be very effective and is used in refractory patients. Its use is associated with rapid clinical response at 100 mg/day for 2 weeks, with full clinical response in 2-3 months. About 75% of patients who are refractory to antimalarials will respond.

Maintenance doses also can be effective (25-50 mg/day), but rapid relapse can occur on discontinuation.

Thalidomide does not have much effect on systemic lupus. Its use is associated with the risk for serious toxicity, including teratogenicity, neurotoxicity, premature ovarian failure, and hypercoagulable state.

Methotrexate, mycophenolate mofetil, and azathioprine have been shown to be equivalent to thalidomide in many ways, and because they aren't associated with the neurotoxicity that can occur with thalidomide, Dr. Werth said she often uses one of these first.

"I don't really have a preference for one over another," she added.

She noted, however, that it is important to consider what else may be going on with patients, because those with renal involvement can be treated with mycophenolate mofetil or cyclophosphamide, and both may also help with cutaneous disease.

In addition to medical therapies, patients with cutaneous disease should be advised to avoid heat and drug exacerbations of their condition. It is critical that they use a high SPF sunscreen with good UVA and UVB coverage. Many sunscreens will say they offer both, but most don't have great UVA coverage, Dr. Werth said.

Tell patients to look for a product that has the highest SPF they can find (at least 30), and to ensure that the product contains ecamsule (Mexoryl) or avobenzone/oxybenzone (Helioplex) to provide good UVA protection, she advised.

Dr. Werth disclosed that she has received grants from Celgene Corporation and Amgen, and has served as a consultant to MedImmune, Genentech, Novartis, Pfizer, and Cephalon. She also developed an outcome measure for lupus. ■