THK1

Obinutuzumab use in rituximab-allergic glomerulonephritis patients: experience from Imperial College Healthcare NHS Trust

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction:
We present our experience with obinutuzumab in patients with documented rituximab allergy at Imperial College Healthcare NHS Trust (ICHT). Rituximab, a type I anti-CD20 monoclonal antibody, is widely used in the management of immune-mediated glomerulonephritis (GN). However, a subset of patients at Imperial College Healthcare NHS Trust (ICHT) have experienced hypersensitivity reactions that preclude further use. With ofatumumab no longer available, there is a clinical need for safe and effective alternatives. Obinutuzumab, a type II anti-CD20 monoclonal antibody, has been considered for off-label use in such patients.

Methods:
We conducted a retrospective review of patients at our centre who received obinutuzumab for GN conditions between 2023 and 2025. All patients had previously demonstrated rituximab hypersensitivity reactions. Clinical records were reviewed for indication, dosing regimen and infusion tolerance.

Results:
A total of 27 patients received obinutuzumab. All patients had a documented allergy to rituximab, predominantly presenting as Type III serum sickness; approximately 15% experienced Type I angioedema. The underlying indications included systemic lupus erythematosus (SLE n=15), ANCA-associated vasculitis (AAV, n=3), membranous nephropathy (MN, n=3), minimal change disease (MCD, n=3), focal segmental glomerulosclerosis (FSGS, n=2) and anti-glomerular basement membrane disease (anti-GBM, n=1). Dosing regimens were variable, with subsequent doses determined by the extent of B cell depletion. 22 patients received a single 1g dose, 4 patients received two 1g doses (with the second dose required between 11–16 months later) and 1 patient received four 1g doses over a 30-month period. No hypersensitivity or cross-reactivity was observed to obinutuzumab and all infusions were well tolerated.

Discussion:
This case series describes the use of obinutuzumab as a potentially safe effective alternative for GN patients with rituximab hypersensitivity. Across a range of glomerular conditions, obinutuzumab was well tolerated with no evidence of cross-sensitivity or infusion-related reactions. These findings support its use in patients requiring B-cell–depleting therapy who cannot receive rituximab. Further research is warranted to establish optimal dosing strategies and to evaluate its efficacy in rituximab-refractory cases.

THK2

Care Gaps in ANCA-Associated Vasculitis (AAV): exploring unmet needs and misalignments between patients and physicians

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction:
Current EULAR guidelines for the management of ANCA-associated vasculitis (AAV) emphasise the critical role of effective communication between healthcare professionals (HCPs) and patients for the optimal management of AAV. Given the diversity of clinical manifestations and the inherent complexities of AAV diagnosis, this study aimed to identify potential disconnects in communication and expectations between HCPs and AAV patients with a view to improving patient care and clinical outcomes.

Methods:
The study included a diverse group of patients and healthcare professionals (HCPs) who self-completed a 20–25-minute online survey from May to August 2024 across six European countries. Inclusion criteria required HCPs with 2-35 years of experience in relevant specialties who spend at least 60% of their time in direct patient care, had no affiliations to pharmaceutical companies, and managed ≥1 AAV patient. Patients had to be over 18 years old, diagnosed with AAV (specifically Granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA) by a physician at least 3 months prior. Statistical analysis included Z-tests for proportions and T-tests for means, applied to samples of ≥20. A maximum Differentiation Scaling methodology was used to quantify preferences, where respondents selected the “most important” and “least important” unmet needs in AAV management across 15 screens; results were presented as indices (mean score = 100), with higher indices indicating greater relative importance.

Results:
A total of 170 HCPs were included in this study. Of these, 33 (48%) patients reported being in remission, either with or without immunosuppressive treatment, at the time of the study. Mean time from symptom onset to AAV diagnosis was 5 months according to HCPs and 25 months according to patients. HCPs and patients agreed that fatigue, pain, and sleep disruption had the greatest impact on QoL. Neurological and ENT manifestations were reported by patients as having the greatest impact on QoL, whereas physicians tended to associate the most significant burden with renal and pulmonary involvement. (Figure 1) Perceptions of unmet needs varied between HCPs and patients (Figure 2).

Overall, 71% of patients believed they received the best treatments for AAV, while 71% of patients and 72% of HCPs had significant concerns about the impact of glucocorticoids on QoL. More patients than HCPs expressed concerns about the risk of infection (71% vs 44%), muscle weakness (54% vs 38%), and cognitive changes (53% vs 34%).

Both patients and HCPs expressed a need for more patient education. Expectations around remission differed in terms of definition suggesting potential for under-reporting of symptoms.

Discussion:

This study confirms that both HCPs and patients desire greater patient involvement in treatment decisions. It also points out key differences in perspectives: HCPs prioritise treatment efficacy and clinical outcomes, while patients focus more on long-term outlook, mental health, and functional impact. HCPs tend to expect remission to mean an absence of symptoms, whereas many patients have lower expectations and accept some symptoms during remission. This misalignment highlights the need for a more patient-centered approach to AAV management.

THK3

Impact of systemic involvement on relapse risk in renal anti-neutrophil cytoplasmic antibody-associated vasculitis: a retrospective cohort study

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Background
Anti-neutrophil cytoplasmic antibody (ANCA)-associated vasculitis (AAV) is a multisystem autoimmune vasculitis with presentations ranging from pulmonary haemorrhage to isolated glomerulonephritis. It is clinically classified into granulomatosis with polyangitis (GPA) or microscopic polyangitis (MPA), characterised serologically by anti-proteinase-3 (PR3) and myeloperoxidase (MPO) antibodies. Despite treatment, AAV has high morbidity due to frequent relapses. Current diagnostics lack relapse prediction. This can help reduce treatment burden for low-risk patients and increase monitoring for high-risk ones. Clinical scoring based on system involvement to risk-stratify relapse and balance treatment benefits and risks of treatments. While PR3 and extra-renal involvement are known risk factors for relapse, this research aims to clarify which systems, if any, are linked to an increased risk of relapse.

Methods
This retrospective study screened 160 patients diagnosed with AAV with renal involvement between 2004 and 2020. Data were extracted from electronic records in 2024, including cases with renal involvement on biopsy, excluding cases with coexisting renal or autoimmune diseases. Baseline confounding variables collected at diagnosis of 109 patients included ANCA serology, age, kidney function and Birmingham vasculitis activity score (BVAS). The primary predictor of outcome was systemic involvement at diagnosis, identified and attributed to vasculitis by radiological findings and clinical assessment. The primary outcome was relapse; secondary outcomes were death and end-stage renal disease (ESRD). Systems involved at diagnosis were binarised as present or absent, and were grouped into the following: respiratory, sinonasal and laryngotracheal, neurological, cutaneous, mucousal and ophthalmic, and gastrointestinal. Associations between system involvement and outcomes were investigated using multivariable logistic regression adjusted for confounders.

Results
The median age of the 109 patients at diagnosis was 69 years (Interquartile range: 59-75), and
62 patients (56.9%) were male. Among the cohort, 57 (52.3%) were PR3 positive, and 51 (46.8%) were MPO positive. Overall, 32 (29.4%) patients relapsed, 52 (47.7%) patients died, and 40 (36.7%) patients had ESRD. Multivariable logistic regression showed
PR3 positive disease (Odds ratio (OR) = 3.08, 95% Confidence interval (CI) = 1.12-8.46,

p = 0.029), neurological (OR: 5.23, 95% CI = 1.61-17.2, p = 0.006), cutaneous (OR: 3.86, 95% CI = 1.23-12.1, p = 0.021) and joint (OR = 3.03, 95% CI = 1.08-8.47, p = 0.035) involvement are significantly associated with higher relapse rates. No association between systemic involvement and death or ESRD was identified within this study.

Conclusion

These findings reiterate that PR3-positive disease increases relapse rates. This study identified joint, cutaneous, and neurological involvement as significant predictors of relapse in patients with renal AAV. Due to the retrospective nature of this study, a cause-and-effect relationship cannot be elucidated. This study provides valuable insight into the nature of renal AAV; however, the exclusion of non-renal AAV patients limits its generalisability to the patient population. Ongoing research aims to incorporate time-to-event into the analysis to strengthen the research. These findings underscore the importance of ANCA serology and organ involvement in relapse risk stratification to inform future research on targeted treatments and monitoring strategies.

THK4

ANCA-Associated Vasculitis Presenting with Inflammatory Myopathy and Multisystem Involvement: A Diagnostic and Therapeutic Challenge

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

INTRODUCTION

ANCA-associated vasculitis (AAV) most frequently presents with renal and/or pulmonary involvement. Skeletal muscle manifestations are rare and may mimic primary myopathy or infection, creating diagnostic uncertainty. We present a case of AAV initially manifesting with neuromuscular features, where the diagnosis was confirmed only after renal biopsy, highlighting the importance of broad differential consideration and multidisciplinary collaboration.

CASE PRESENTATION

An 80-year-old female presented with a two-week history of lethargy, fever, anorexia, weight loss, exertional dyspnoea, and progressive lower limb weakness. She was empirically treated for presumed community-acquired pneumonia; however, chest imaging showed no consolidation and antibiotics were ineffective.

Laboratory tests revealed elevated CRP, ESR, and creatine kinase. Neurological evaluation demonstrated bilateral proximal lower limb weakness with electromyography changes consistent with inflammatory myopathy. MRI of the thighs and spine demonstrated symmetrical muscle oedema. A myositis antibody panel was negative, but autoimmune screening revealed strong MPO-ANCA positivity.

During admission, she developed proteinuria and rising creatinine. Renal biopsy demonstrated necrotising glomerulonephritis consistent with AAV.

MANAGEMENT

She was commenced on high-dose corticosteroids alongside rituximab and avacopan, in line with current AAV management strategies. Initial clinical and biochemical improvement was noted. However, relapse occurred during steroid tapering, with worsening renal function and recurrent neuromuscular symptoms. Increasing the steroid dose resulted in renewed improvement.

The patient continues under joint renal and rheumatology follow-up, with gradual corticosteroid tapering and ongoing monitoring of renal and neuromuscular function.

DISCUSSION

This case presented diagnostic and therapeutic challenges due to its atypical features. The initial clinical picture mimicked infection, and the presence of inflammatory myopathy—uncommon in AAV—diverted attention from vasculitis. Negative myositis serology further

complicated the picture. However, persistent symptoms and MRI findings prompted a broader autoimmune work-up, leading to the diagnosis.

Steroid initiation provided early benefit, and the addition of rituximab and avacopan was appropriate given the renal involvement and steroid-sparing need. However, the relapse during tapering highlights the complexity of managing steroid-dependent disease in elderly patients and raises questions about optimal tapering speed and maintenance strategies.

This case underscores the importance of considering vasculitis in the differential diagnosis of unexplained myopathy, especially when accompanied by systemic symptoms. It also illustrates the value of timely renal biopsy in identifying pathology that can be masked by non-specific presentations.

Discussion points include the evolving role of avacopan in AAV management, its impact on relapse rates during tapering, and the potential overlap between inflammatory myopathy and vasculitis. This case reinforces the need for a multidisciplinary approach and highlights the benefit of early rheumatology input when classical features are absent.

CONCLUSION

AAV can present atypically with predominant neuromuscular features, preceding classic renal or pulmonary involvement. Persistent unexplained myopathy with systemic features should prompt consideration of vasculitis, even in the absence of myositis serology. Renal biopsy remains critical for diagnosis. Effective management requires careful immunosuppressive balance and close multidisciplinary collaboration.

THK5

Retrospective evaluation of the role of rituximab in management of adult- and childhood- onset minimal change disease

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Background:
Minimal change disease (MCD) is a leading cause of nephrotic syndrome in both children and adults. While many patients respond to corticosteroids, frequent relapses and steroid dependency remain major challenges, often necessitating long-term immunosuppression with associated toxicity. Rituximab, an anti-CD20 monoclonal antibody, has emerged as a potential therapy, though evidence of efficacy in adults remains limited.

Methods:
A retrospective service evaluation of patients with MCD in an adult renal clinic was conducted to assess clinical outcomes after rituximab treatment. At least one year of follow up post rituximab was required for inclusion.

Outcomes assessed were (a) maintenance treatment (prednisolone dose and immunosuppressant use) before and 2 years after first rituximab and, (b) relapses per year before and after first rituximab. Relapses occurring more than 5 years before first rituximab were not included in the data. A Mann-Whitney U test was used for analysis unless stated, with data presented as median (range).

Results:
32 patients were identified (22 male), aged 29 (17-78). Age of diagnosis and first rituximab treatment were 8.5 (1 – 64) and 17.5 (5 – 71) respectively. The time (years) from diagnosis to first rituximab was 7 (0 – 30). Follow up after first rituximab (years) was 7.5 (1 – 18). From 32 patients, 9 (28.1%) remained relapse-free. And 11 (34.4%) were able to come off all other immunosuppressive drugs.

(a) Data on maintenance treatment prior to first rituximab, and at least 2 years after was available for 27 patients: There was a significant decrease in the daily maintenance prednisolone dose (mg) required from a median of 10 (0 – 30) at the time of first rituximab administration, to 0 mg (0 – 10) ($p<0.00001$) at 2 years after rituximab. 25 patients were on at least one concomitant immunosuppressant prior to first rituximab compared to 15 at 2 years ($p<0.01$, Fischer's exact test).

(b) Data on relapses prior to first rituximab was available for 24 patients: Relapses per year reduced from 0.80 (0.20 – 2.20) to 0.17 (0 – 1.29) ($p<0.001$). There was no statistically significant correlation between age of diagnosis or age of first rituximab treatment with either reduction of maintenance prednisolone dose or relapses per year (Spearman's rank correlation test).

We characterized B-cell counts in twenty patients with data available with one or more relapses after rituximab treatment. At the time of relapse, 15 had B-cell counts in the normal range, 2 had a low B-cell count (< 100 cells/μL), 2 had undetectable B-cell counts, and 1 had mixed B-cell counts across relapses. Further analysis will explore the time between B-cell reconstitution and relapse, and this data may be presented at the meeting.

Conclusion:
Rituximab was associated with a significant reduction in corticosteroid requirements, discontinuation of concomitant immunosuppressants, and fewer nephrotic relapses per year. Age at diagnosis or the time of first rituximab did not influence outcomes. B-cell counts may help guide the timing of further doses of rituximab in some patients.

THK6

PROTECT post hoc analysis: efficacy of sparsentan vs irbesartan in patients with IgA nephropathy ≤12 months vs >12 months from kidney biopsy

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Background: Sparsentan (SPAR), a non-immunosuppressive, dual endothelin angiotensin receptor antagonist, showed superior proteinuria reduction and kidney function preservation vs maximum labelled dose irbesartan (IRB) in the phase 3, randomised, double-blind PROTECT trial. While SPAR was favoured across multiple prespecified subgroups, it is not known whether time from biopsy to informed consent affects efficacy. SPAR is licensed in the UK for the treatment of adults with primary IgAN with a urine protein excretion ≥1.0 g/day (or urine protein-to-creatinine ratio ≥0.75 g/g).
Methods: This post hoc analysis assessed the efficacy of SPAR vs IRB in patients with ≤12 months vs >12 months between biopsy and time of informed consent (ie, recent vs older biopsies). Endpoints included urine protein-to-creatinine ratio (UPCR) and estimated glomerular filtration rate (eGFR).
Results: SPAR showed greater UPCR reduction and slower rate of eGFR decline (slope) vs IRB in both groups (Table and Figure). The treatment effect of SPAR vs IRB on proteinuria was similar in both groups. However, the treatment effect on eGFR slope was greater in the ≤12 months group.
Conclusion: SPAR showed numerically better efficacy vs maximum labelled dose IRB regardless of time from biopsy, with greater kidney preservation with shorter time from biopsy. These results emphasise the value of early SPAR treatment.

THK7

Real-world Data on Voclosporin for the Treatment of Lupus Nephritis Including Use of Concomitant Biologic Therapies: An Analysis of the Enlight-LN Registry

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction:
Voclosporin is approved for the treatment of adults with active lupus nephritis (LN). In the Phase 3 AURORA studies, voclosporin plus Mycophenolate Mofetil (MMF) and low-dose glucocorticoids led to significant reductions in proteinuria while maintaining a stable eGFR for up to 3 years of follow-up. Biologic therapies are also frequently used in systemic lupus erythematosus and LN, yet information on the use of voclosporin in combination with these agents is limited. Here we describe baseline characteristics and demographics of patients enrolled in the Enlight-LN registry and detail the use of concomitant medications, specifically biologics.

Methods:
The Enlight-LN registry enrolled patients between March 2022 and January 2025 (NCT05337124). Enrolled patients were ≥18 years with biopsy-confirmed LN who initiated treatment with commercial voclosporin prior to study consent. Patients received standard of care in accordance with usual clinical practice at each site.

Results:
As of April 4, 2025, data were available on 229 patients. Median (range) patient age was 34.0 (18–78), with 36.2% of patients ≤30 years; 83.4% were female. Most patients self-identified as White (43.2%) or Black/African American (38.0%); 35.4% were Hispanic/Latino. Median (range) time since first LN diagnosis was 1.6 (0–26.2) years. The majority of patients had Class V disease (31.4%), Class IV disease (20.1%), or mixed Class IV/V disease (15.7%). Median (range) eGFR was 89.3 (6–170) mL/min/1.73 m^2; 10.4% of patients had baseline eGFR <45 mL/min/1.73 m^2. Median (range) UPCR was 2.3 (0.1–16.8) g/g; 38.2% of patients had baseline UPCR ≥3 g/g. There were 83 (36.2%) patients on voclosporin who concomitantly received treatment with a biologic including belimumab (28.4%), rituximab (4.8%), anifrolumab (3.9%) and obinutuzumab (1.3%).

Discussion:
This initial analysis portrays the use of concomitant immunosuppressive biologics in LN patients treated with voclosporin. This is notable given the unique and possibly synergistic

effects of these agents on the immune system. Additional analysis of the registry data will provide further clinical and mechanistic insights into the use of these multi-targeted therapeutic approaches.

THK8

Use of Voclosporin in Pediatric Patients: Summary of Available data from Post-Marketing Reports

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction:
Lupus nephritis (LN) is common in pediatric patients with systemic lupus erythematosus (SLE), with more than 50% developing renal manifestations, typically within the first 2 years. Treatment options for this patient population have been inadequately studied. Voclosporin is approved for use in adult patients with active LN. The Phase 3 AURORA studies showed that in patients ≥18 years, adding voclosporin to MMF and low-dose glucocorticoids yielded significant reductions in proteinuria with no unexpected safety signals associated with up to 3 years of treatment.
The safety and efficacy of voclosporin in patients < 18 years old has not been established. A study in the pediatric population is ongoing (Voclosporin in Adolescents with Lupus Nephritis [VOCAL; NCT05288855]). There have been reports of off-label voclosporin use in patients < 18 years captured in Aurinia's global safety database as part of post-marketing spontaneous safety surveillance. Our objective was to summarize the post-marketing experience with voclosporin in the pediatric population.

Methods:
Data included in this analysis were collected up until January 21, 2025, from the Aurinia Global Safety Database, which contains spontaneous, post-marketing reports of pediatric use. Post-marketing safety data are collected via a passive surveillance system with limitations, including possible underreporting, biased or incomplete reporting, and difficulties in attributing an adverse event (AE) to any specific drug. Use of voclosporin in patients < 18 years is considered an off-label use and is tracked in the safety database even in the absence of associated AEs. Data from the ongoing VOCAL study are not included in this analysis.

Results
As of January 21, 2025, 93 reports of pediatric use of voclosporin (in 70 unique patients) had been received, the majority from the US. Patients ranged in age from 7 to 17 years old and were mostly female. The most common indication for voclosporin was LN (83.8%). In most cases, the dose of voclosporin administered was the approved adult dose (23.7 mg twice daily; 57/93 reports). The duration of use of voclosporin was not consistently reported; where reported, the duration ranged from several weeks to 1 year, 9 months. In total, 44 of the 93 (47%) individual reports of pediatric use did not include any associated AEs following the initiation of voclosporin other than off-label use and other non-health-related events (ie. therapy interrupted, missed dose, insurance issue). Of the individual reports of pediatric

use with associated AEs, 18 were considered to be serious (Table 1). There were no particular trends in the AEs reported. Data on kidney biopsies and concomitant medications were not consistently available.

Discussion:
Due to the limited number of reports and incomplete nature of spontaneous reporting, the emerging safety profile of voclosporin in pediatric patients requires further investigation, although no new safety signals were detected. Additional research is needed to better characterize the use of voclosporin in this population.

THK9

Estimating the impact of sparsentan on dialysis and service capacity in the NHS: a national and local modelling analysis

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

Chronic kidney disease (CKD) represents a growing challenge for the NHS, with dialysis provision being one of the most resource-intensive aspects of renal care. In-centre haemodialysis requires substantial ongoing capacity, staffing, and financial commitment, with dialysis centres currently near maximum utilisation nationally. Approximately 14% of CKD cases result from glomerulonephritis, with primary IgA nephropathy (IgAN) being the most common. Sparsentan (FILSPARI®) is a dual endothelin and angiotensin receptor antagonist recently recommended by National Institute for Health and Care Excellence's (NICE) for the treatment of adults with primary IgAN. Sparsentan has been shown to slow decline in kidney function compared with irbesartan in the Phase 3 PROTECT study (NCT03762850). By delaying progression to end-stage kidney disease (ESKD), the introduction of sparsentan can reduce the number of people requiring dialysis and other renal replacement modalities. This analysis estimates the potential impact of sparsentan nationally and within a single Integrated Care Board (ICB), specifically Cambridgeshire and Peterborough.

Methodology

The analysis was based on NICE's preferred assumptions for estimating the health economic value of sparsentan. Patient eligibility was defined in line with NICE guidance and applied to population estimates for the UK and for the Cambridgeshire and Peterborough ICB (catchment population 928,260). The model incorporated IgAN epidemiology, efficacy data from the PROTECT trial, disease progression data from the RaDaR database and costs describing CKD management, dialysis, and transplantation sourced from published literature. Outcomes were projected over a 5-year horizon, comparing sparsentan with standard care (SOC), represented by irbesartan. Key endpoints included the number of people progressing to ESKD, the number initiating dialysis, and the corresponding reduction in dialysis sessions. Results are presented at national level, for a representative catchment of one million people, and for the Cambridgeshire and Peterborough ICB population.

Results

In England, 4,071 people are estimated to be eligible for treatment with sparsentan. Treatment is projected to result in 460 fewer people with IgAN reaching ESKD at 5 years, with 268 fewer requiring dialysis. This corresponds to approximately 82.9 thousand in-centre dialysis sessions avoided nationally over five years. For a representative catchment of one million people, sparsentan is expected to prevent dialysis initiation in 4.7 people after five years, leading to 1,451 fewer dialysis sessions. Within Cambridgeshire and Peterborough ICB, 66 people are estimated to be eligible for treatment. Over five years, sparsentan was predicted to result in four fewer people requiring dialysis compared with SOC, equating to approximately 1,350 dialysis sessions avoided, at a total cost of around £250,000.

Conclusion

Implementation of sparsentan across the NHS could substantially reduce the burden of kidney failure by delaying progression to dialysis. With dialysis services in Cambridgeshire and Peterborough ICB currently operating at 97% capacity, reducing demand may strengthen service resilience. For commissioners and providers, sparsentan offers the potential for improved patient outcomes alongside a meaningful reduction in dialysis demand, with associated cost savings and operational efficiencies. At both national and local levels, sparsentan provides an opportunity to improve capacity planning and alleviate pressure on renal services.

THK10

Use of avacopan-based therapy among adults with severe active ANCA-associated vasculitis (AAV): a cross-sectional survey of physicians in Germany and the UK

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction:
Avacopan, a selective C5aR1 inhibitor, demonstrated efficacy and safety in patients with ANCA-associated vasculitis (AAV) and is approved in combination with rituximab or cyclophosphamide for the treatment of adults with severe active granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]. Here, we describe usage patterns from clinical practice.
Methods:
A quantitative online survey was completed by physicians in Germany and the UK [April 17 to May 20, 2024] qualified in their primary specialty (nephrology, rheumatology, internal medicine with a secondary qualification in rheumatology or nephrology [Germany only], pulmonology, or ear, nose and throat [ENT] medicine) for 2 to 40 years. They spent ≥60% of their time in direct patient care; were responsible for treatment choices for adults with GPA/MPA and had personally managed ≥5 patients with AAV in the last 12 months, including ≥2 with severe active GPA/MPA. Each respondent completed patient record forms for 2-3 patients (≥18 years) with severe active disease (new-onset or relapsed) as of the most recent induction therapy. They were currently receiving induction therapy or were previously severe active now on maintenance therapy. Statistical significance used a type 1 error rate (alpha) of 5% using independent t-tests for means testing and independent p-tests for proportion testing. The survey included additional attitudinal/perceptual questions on GPA/MPA patient categorisation, 'active' definition, guidelines followed, and treatment attitudes (presented elsewhere).
Results:
Survey response rate was 51% (63% Germany; 43% UK). A total of 206 patient record forms were completed by 81 respondents (40 Germany; 41 UK), including 26 nephrologists, 39 rheumatologists, 9 pulmonologists and 7 ENT specialists. At their most recent induction, 93/206 patients (45.2%) were receiving avacopan-based therapy. Of these, 5 (5.4%) were continuing previous avacopan treatment and 88 (94.6%) were newly initiated. Significantly more patients in the avacopan group (vs. the non-avacopan group) had depression (25% vs 11%, p=0.008) or BMI >35 kg/m2 (17% vs 7%, p=0.026) at their initial AAV diagnosis (Table 1). A similar proportion of patients from each group had other pre-selected comorbidities at the time of AAV diagnosis, including hypertension, dyslipidaemia, Type 2 diabetes, and anxiety. Significantly more patients in the avacopan vs. the non-avacopan group had multiple (5+) organ involvement (25% vs 9%; p=0.004): lung (58% vs 43%, p=0.04), or skin involvement (43% vs 13%, p=0.001), and/or presented with 'general' (65% vs. 44%, p=0.004) or skin (34% vs 15%, p=0.002) symptoms at the start of their most recent induction (Table 2). Patients receiving avacopan-based therapy also had significantly higher CRP values (30

mg/dL vs 24.8 mg/dL, p=0.035) and showed a trend towards lower eGFR values (50 ml/min vs 55 ml/min, p=0.094) than those treated without avacopan.

Discussion:
Survey results suggest broad use of avacopan as part of induction therapy in adults with severe active (new-onset or relapsed) GPA/MPA in Germany and the UK. At initial AAV diagnosis, patients receiving avacopan-based therapy were significantly more likely to have depression or be overweight than non-avacopan patients. At their most recent induction, a significantly greater proportion had multiple organ involvement, and/or had higher CRP values.