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Managing Patients With AAV in the Rheumatology Clinic

Announcer:
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Dr. Kronbichler:
This is CME on ReachMD, and I am Dr. Andreas Kronbichler. And here with me is Professor Bernhard Hellmich.

As a rheumatologist, Bernhard, what's your perspective on AAV induction and maintenance treatment, and is it different from a nephrologist's view?

Dr. Hellmich:
Yeah. Thanks, Andreas. So, yeah, it shouldn't be that different.

So what we have advocated in the recent guidelines is an interdisciplinary approach. So people with ANCA-associated vasculitis can present with a variety of different organ manifestations and problems, so it's always advised to send these people to dedicated vasculitis centers where experts from different disciplines are working together.

And that's the concept we are running in our clinic. Although it's a rheumatology-dominated department of internal medicine, we have divisions of respiratory medicine and nephrology created, so we have colleagues from all different specialties together. We have other departments around. And what we are doing in clinical practice, first, we do a complete check. So we check for different potential manifestations of vasculitis, of ANCA-associated vasculitis in a patient who presents with the suspicion of AAV in order to not miss anything.

And what is a good guide in clinical practice, in fact, is the BVAS score sheet. It's not important really in practice to check the exact values, but not to miss any organ manifestations. So that can give you some advice what you should check and what you should talk with your patients, not to miss anything.

And while we are evaluating these organ manifestations, we are just collecting all the different things that are active, things that may present comorbidities or organ damage from previous treatment, and then we make a treatment plan, and this we discuss with the patient.

So we make an individualized treatment plan and we, today, have good recommendations from the societies made by KDIGO or the EULAR recommendations, where we have different options for induction therapy to get the patient quickly in remission to avoid damage, and then to a choice of maintenance therapy regimen that prevents further damage caused by relapses. And that is also considering the comorbidities and potential side effects of medications. And this can differ quite differently between different patients depending on

disease severity, on affected organ manifestations, on previous side effects of the medications, and on comorbidities.

So how do we monitor treatment responses? So once we have made the complete assessment of the patients, we know which manifestations are active and we are just repeating the examinations we have done to find the active organ manifestations. So, for example, in the patients with pulmonary disease, we check respiration. If the patient has alveolar hemorrhage, we check the oxygen saturation. We are checking the respiration. We even may try to repeat the imaging in order to see if the infiltrates are going down. We check the hemoglobin for other manifestations, like the kidney. We check, of course, the creatinine, if it's improving or not. We are checking the urine, or our nephrologists do this, and see if there are still red blood cells around. And for other organ manifestations, for example, for ENT, we are asking the patients if there's still nose bleeding or are there nasal crusts? We may repeat the imaging of the ENT section. For arthritis or for musculoskeletal manifestations, we are just asking the patient if the pain improves, if the mobility of the joints is getting better. For skin manifestations, we are checking if these are resolving or if there are any residuals left that need to be treated. And for neurologic manifestations, for example, we check if the patient's improving with his motor functions, if certain paresis may improve or if they represent damage if it has been damaged for some time.

Of course, we are also checking, in parallel treatment, complications like blood sugar values, if the patient develops the diabetes, which is quite frequent during induction treatment. We are looking for other comorbidities due to the treatment. So we are doing an osteoporosis assessment down the line. We are looking for cardiovascular manifestations or risk factors like cholesterol, LDL importantly. And we treat them if they are abnormal because these patients really have a high cardiovascular risk. And we also consider measures for protecting from infections.

So, Andreas, you have done some great work in this area. So all our patients with high-dose induction therapy, they get co-trimoxazole. We are looking for vaccinations, and we try to keep the patients out of infections as good as we can.

So that's the way we are doing from a rheumatology perspective, but I think this holistic approach is what is done in most vasculitis centers.

Dr. Kronbichler:
Well, thank you, Bernhard. That's excellent, and I think it also shows us that this is a disease group where we really need a lot of different specialists, actually, for the optimized care. And also, especially shared decision-making with the patient as we have already talked about before, is also very relevant, actually, I think, to improve patient satisfaction, but also to have an optimized treatment strategy for each and every patient.

So that was a great session again. And our time is unfortunately up. And thanks for listening, everyone.

Dr. Hellmich:
Thanks. Bye-bye.

Announcer:
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