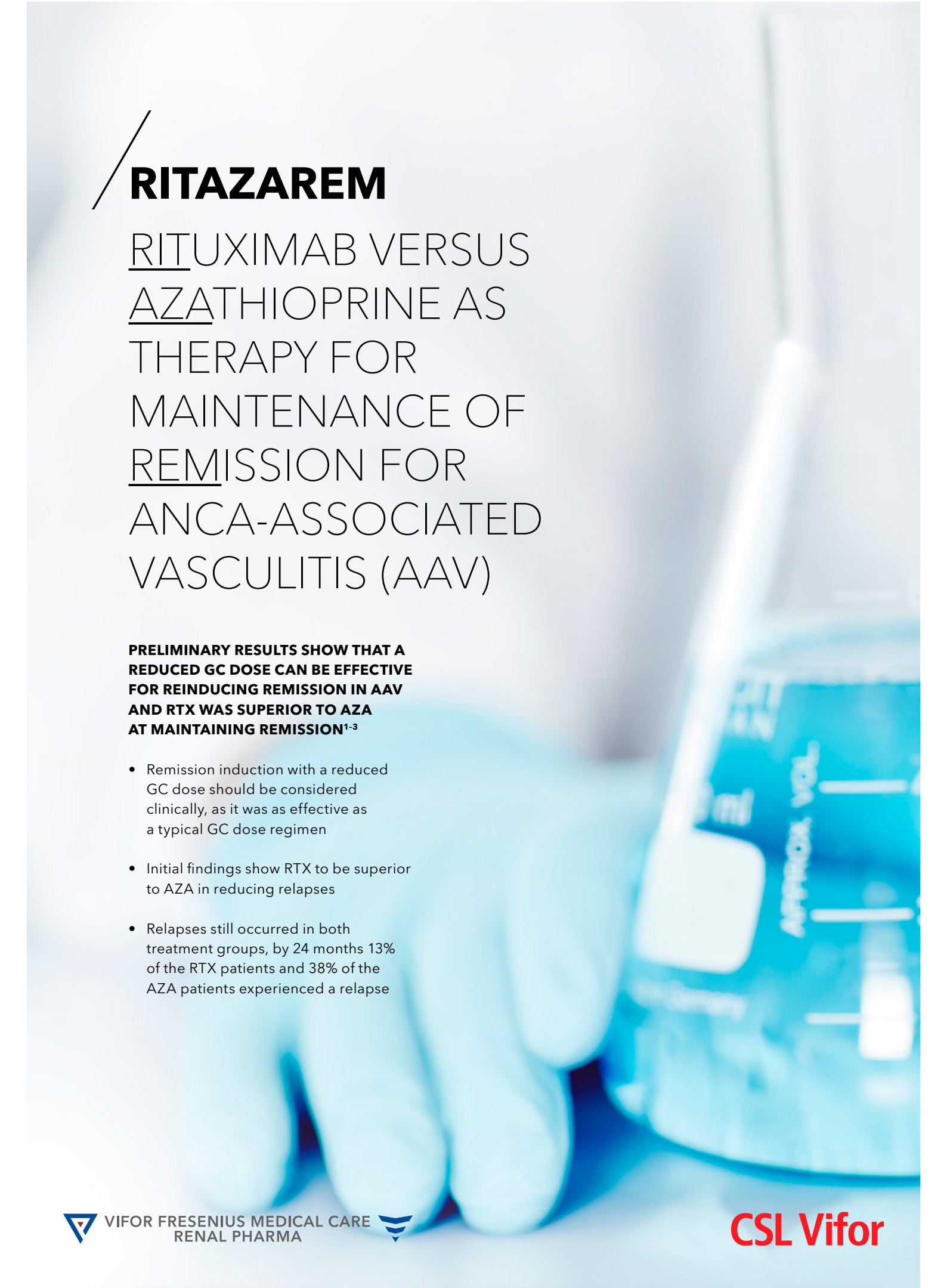
RITAZAREM

RITUXIMAB VERSUS AZATHIOPRINE AS THERAPY FOR MAINTENANCE OF REMISSION FOR ANCA-ASSOCIATED VASCULITIS (AAV)



PRELIMINARY RESULTS SHOW THAT A REDUCED GC DOSE CAN BE EFFECTIVE FOR REINDUCING REMISSION IN AAV AND RTX WAS SUPERIOR TO AZA AT MAINTAINING REMISSION[1-3]

- Remission induction with a reduced GC dose should be considered clinically, as it was as effective as a typical GC dose regimen
- Initial findings show RTX to be superior to AZA in reducing relapses
- Relapses still occurred in both treatment groups, by 24 months 13% of the RTX patients and 38% of the AZA patients experienced a relapse

VIFOR FRESENIUS MEDICAL CARE RENAL PHARMA

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INTRODUCTION

RITAZAREM assessed the superiority of RTX + GCs to induce and maintain remission compared to AZA, in relapsing patients.[1-3] The optimal RTX treatment strategy for the maintenance of remission is currently not known and warrants further investigation, especially in patients with a history of relapse.[2,3]

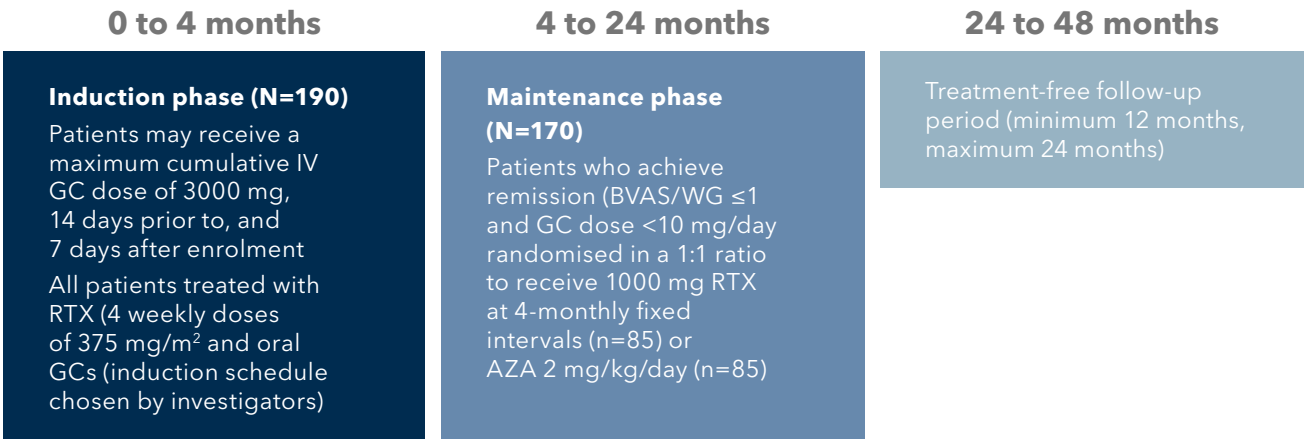
STUDY AIM

Demonstrate the superiority of repeated IV RTX doses to prevent relapses vs AZA in patients with relapsing AAV.[1-3]

The sponsor of this study was:
Cambridge University Hospitals NHS Foundation Trust

STUDY DESIGN

Randomised, open-label, multicentre, controlled trial[1-3]*



GC INDUCTION DOSING SCHEDULE

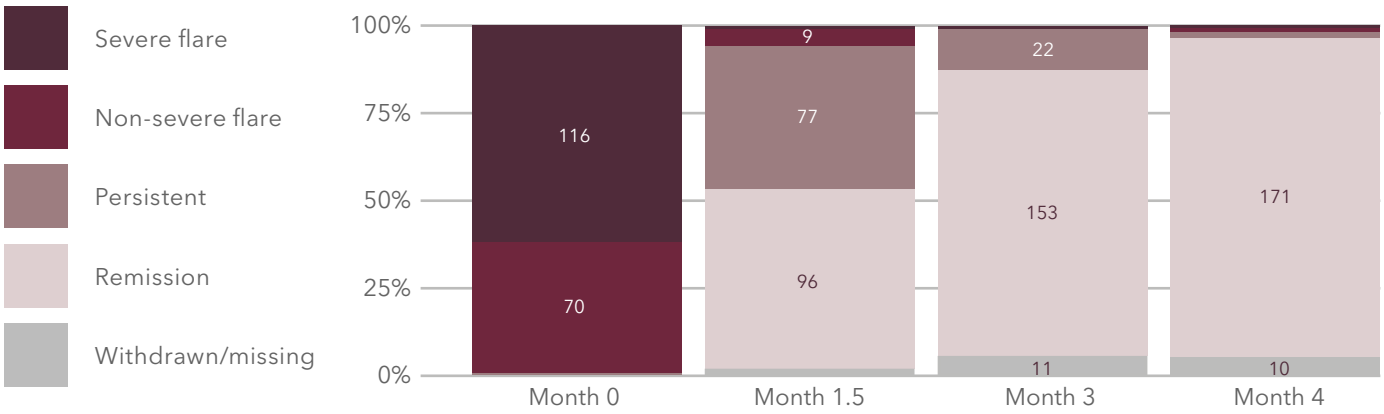
	Induction schedule A (1 mg/kg group)		Induction schedule B (0.5 mg/kg group)	
Week	<60 kg	≥60 kg	<60 kg	≥60 kg
0	50 mg/day	60 mg/day	25 mg/day	30 mg/day
2	35 mg/day	45 mg/day	20 mg/day	25 mg/day
4	25 mg/day	35 mg/day	17.5 mg/day	20 mg/day
6	20 mg/day	25 mg/day	15 mg/day	17.5 mg/day
8	15 mg/day	17.5 mg/day	12.5 mg/day	17 mg/day
10	12.5 mg/day		12.5 mg/day	
12	10 mg/day		10 mg/day	

PRIMARY OUTCOME: TIME TO RELAPSE (EITHER MINOR OR MAJOR), REPORTED AT 24 MONTHS[1]

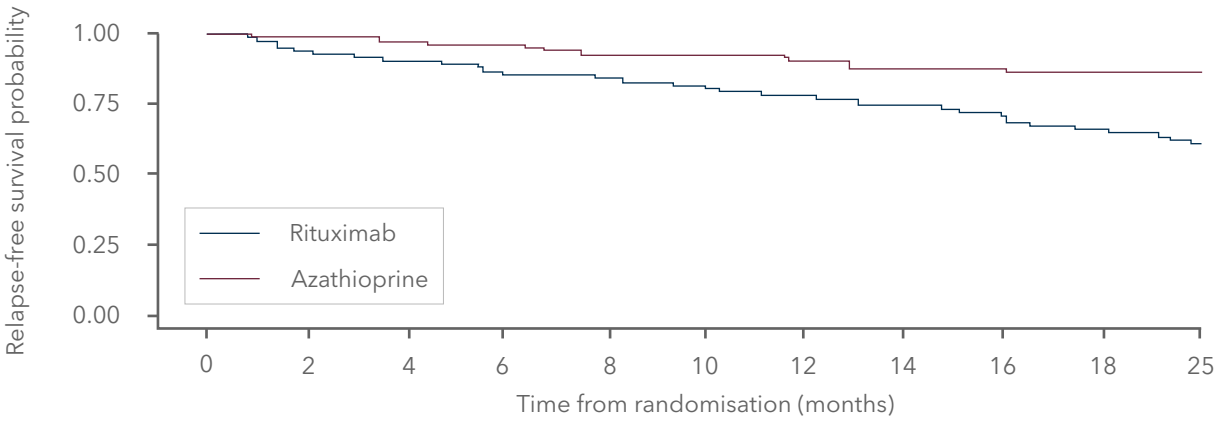
PRELIMINARY RESULTS

RTX + GCs are effective in reinducing remission with 90% of patients achieving remission by month 4 and allowing them to be randomised for the maintenance treatment comparison, 71% of all patients received the low dose GC induction regimen.[2] RTX was superior to AZA in the maintenance phase of treatment at preventing relapse: preliminary overall HR estimate of 0.36 (95% CI, 0.23–0.57, P<0.001); during treatment HR estimate of 0.30 (95% CI, 0.15–0.60, P<0.001). At month 24 the RTX group experienced fewer relapses than the AZA group, 13% vs 38%, and fewer severe AEs, 22% vs 36%.[3]

Disease response according to baseline BVAS/WG score



Relapse-free survival



Numbers at risk

Rituximab	55	52	60	72	76	76	71	71	70	69	80
Azathioprine	85	19	15	71	63	51	64	80	57	53	49

CONCLUSION

RTX is effective in reinducing remission in relapsing patients, even when used in combination with a reduced GC dose.[2] In the maintenance phase of treatment, RTX is superior to AZA at maintaining remission in patients with a history of relapse.[3]

In summary, RTX in combination with glucocorticoids is effective in both reinducing remission and preventing relapses in relapsing AAV patients.[2,3]

RTX WAS SUPERIOR TO AZA IN PREVENTING RELAPSE IN AAV PATIENTS WITH A PRIOR HISTORY OF RELAPSE[3]

References & footnotes

AAV, ANCA-associated vasculitis; AEs, adverse events; ANCA, anti-neutrophil cytoplasmic antibody; AZA, azathioprine; BVAS/WG, Birmingham Vasculitis Activity Score for Wegener's granulomatosis; CI, confidence interval; GC, glucocorticoid; HR, hazard ratio; IV, intravenous; RTX, rituximab

*Enrolled patients, median age: 59 years (range 19–89); male: 51%; anti-PR3 ANCA positive patients: 61%. Data complete for all patients up to 24 months.[2,3]

1. Gopaluni S, et al. *Trials* 2017;18(1):112. doi: 10.1186/s13063-017-1857-z.
2. Smith RM, et al. *Ann Rheum Dis* 2020;79(9):1243–96.
3. Smith RM, et al. *J Am Soc Nephrol* 2019:30.