0738

Real World Steroid Burden, Treatment Patterns, and Rheumatologists' Perceptions on Advanced Therapy in Giant Cell Arteritis

Anisha B. Dua,[1] Aditi Kadakia,[2] Patrick Zueger,[2] Simran Marwaha,[3] Nathaniel Zerad,[2] Arathi Setty,[2] William Jones,[3] Valerie Devauchelle-Pensec[4]

[1]Northwestern University Feinberg School of Medicine, Chicago, IL, USA; [2]AbbVie Inc., North Chicago, IL, USA; [3]Adelphi Real World, Bollington, UK; [4]Department of Rheumatology, Centre Hospitalier Universitaire de Brest, Brest, France

OBJECTIVE

To assess treatment patterns, glucocorticoid (GC) burden, and rheumatologists' perceptions of advanced therapies (AT) for giant cell arteritis

CONCLUSIONS

Even though most rheumatologists aimed to taper patients off GCs completely by 24 months, 75% of patients were using GCs at 4 years post-diagnosis

Both rheumatologists and patients reported several adverse events associated with GC use, and rheumatologists recognize the need for more effective steroid-sparing AT options

Most rheumatologists agreed that ATs should be given early; however, less than a quarter of patients in EU-5 have ever received an AT

Our data suggest that optimizing treatment strategies beyond GCs is critical, and greater real-world adoption of ATs could close the gap between guideline recommendation and clinical practice

To obtain a PDF of this poster

Scan QR code to download an electronic version of this presentation and other AbbVie ACR 2025 scientific presentations

QR code expiration: September 29, 2026

The design, study conduct, and financial support for the study were provided by AbbVie. AbbVie participated in the interpretation of data, review, and approval of the poster. No honoraria or payments were made for authorship. Medical writing services were provided by Kay Hallam, MSc, of Avalere Health, Ltd., and funded by AbbVie.

A.B. Dua has received consulting fees from AbbVie, Amgen, AZ, GSK, Novartis, and Sanofi; has participated in clinical trials or received grant support from Amgen, Novartis, and Rheumatology Research Foundation; and was on the Board of Directors for Vasculitis Foundation and Rheumatology Research Foundation. A. Kadakia, P. Zeuger, N. Zerad, and A. Setty are employees of AbbVie and may own stock or stock options. S. Marwaha and W. Jones are employees of Adelphi Real World. V. Devauchelle-Pensec has received grants from Fresenius and consultancy fees from AbbVie and Novartis.

References

1. Curtis J R, et al. *Rheumatol Ther.* 2025. https://doi.org/10.1007/s40744-025-00778-2
2. Boysson H, et al. *Rheumatology.* 2022;61:3567–75.
3. Castan P, et al. *J Clin Med.* 2022;11:1034.

Presented at the American College of Rheumatology (ACR) Convergence, October 24–29, 2025, Chicago, IL, USA [DV-016845]

INTRODUCTION

- Giant cell arteritis (GCA) is the most common vasculitis in patients aged 50 years and older, and is characterized by inflammation of the arteries in the head, neck and upper body[1]
- Glucocorticoids (GC) are the mainstay of treatment for GCA, but GC-use can cause significant adverse events (AEs), including infections, metabolic changes, cardiovascular morbidities, osteoporosis, cataracts, and cognitive changes[2,3]
- GC-associated AEs increase in frequency and severity with higher cumulative dose and prolonged use, meaning there is a need for steroid-sparing advanced therapies (ATs)[2,3]
- Understanding the real-world impact of GC-use and capturing physician's perceptions on ATs will assist in the development of new steroid-sparing ATs

METHODS

Study Design and Participants

- Data were from the Adelphi Real World GCA Disease Specific Programme™, a cross-sectional, retrospective survey of rheumatologists and their patients with GCA in France, Germany, Italy, Spain, and the United Kingdom (EU-5), and the United States (US) from 05/2024–10/2024
- Eligible physicians had to be qualified in rheumatology as their primary specialty, be actively involved in GCA management, and consult with ≥ 4 patients with GCA per month
- Eligible patients were aged ≥ 18 years, had a physician–confirmed GCA diagnosis, and were not currently involved in a clinical trial
- Rheumatologists completed patient record forms (PRF) for each patient to record demographics, treatment history, and clinical characteristics
- Rheumatologists were also surveyed on their patient management approach and treatment perceptions
- Patients for whom a PRF was completed were then invited to fill in a self-assessment form to capture their treatment preferences

Outcomes

- Demographics and patient histories were reported at time of data collection
- Treatment patterns were compared between patients in the EU-5 and the US
- Cumulative and daily oral GC-use was recorded by disease duration
- GC-related AEs were reported by both rheumatologists and patients, and perceptions of ATs were compared between rheumatologists in the EU-5 and the US

Statistical Analysis

- Demographics, treatment patterns, GC dose, GC-related AEs, and physician perceptions were all summarized descriptively

RESULTS

Demographics and Patient History

- Among 846 patients with GCA, 63% were female, 94% were white, mean age was 71 years and median time since diagnosis was 15.2 months **(Table 1)**

Table 1. Demographics and Patient History

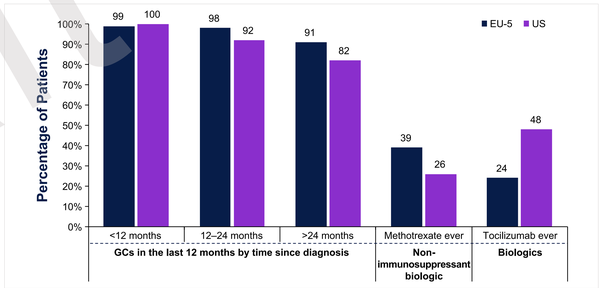
Characteristic	Total Patient Sample N = 846
Female, n (%)	530 (63)
White, n (%)	795 (94)
Age, mean (SD)	71.3 (9.6)
Country, n (%)	
France	133 (16)
Germany	120 (14)
Italy	144 (17)
Spain	120 (14)
UK	129 (15)
US	200 (24)
Time from diagnosis, median months	15.2
Patients diagnosed by a rheumatologist, n (%)	654 (77)
Test used to diagnose GCA, n (%)	
Unilateral temporal artery biopsy	460 (54)
Temporal artery ultrasound	426 (50)
Top 5 autoimmune comorbidities, n (%)	
PMR	348 (41)
Psoriasis	27 (3)
IBD	23 (3)
Rheumatoid arthritis	22 (3)
Atopic dermatitis	20 (2)
Top 5 non-autoimmune comorbidities, n (%)	
Osteoporosis	172 (20)
Diabetes with chronic complications	133 (16)
Anxiety	115 (14)
Depression	102 (12)
Obesity	80 (9)

GCA, giant cell arteritis; IBD, inflammatory bowel disease; PMR, polymyalgia rheumatica; UK, United Kingdom; US, United States.

Treatment Patterns in the EU-5 and US

- Most patients in the EU-5 and the US were using GCs in the last 12 months, regardless of time since diagnosis **(Figure 1)**
- Tocilizumab and methotrexate were the next most common treatments that were ever used; tocilizumab was more commonly used in the US (EU-5, 24%; US, 48%) and methotrexate was more commonly used in the EU-5 (EU-5, 39%; US, 26%)
- Median time from diagnosis to receiving tocilizumab was 3.8 months in US and 6 months in EU-5
- Median time from diagnosis to receiving methotrexate was approximately 5 months in both EU-5 and US

Figure 1. Treatments Received by Patients in the EU-5 and US

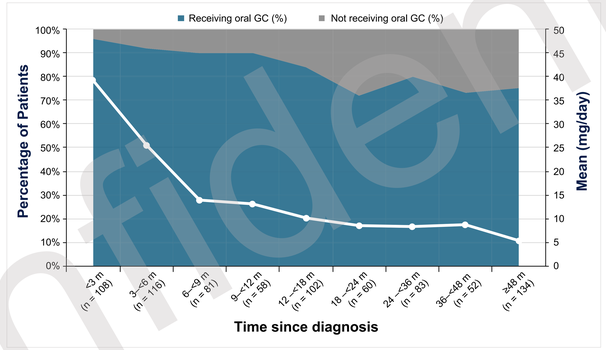


EU-5, European Union-5; GC, glucocorticoid; US, United States.

Oral GC Use by Disease Duration

- Over the last 12 months, median cumulative GC doses were 4343 mg, 5200 mg and 2196 mg for patients diagnosed < 1 year, 1–2 years, and > 2 years ago, respectively
- Most rheumatologists (87%) aimed to taper patients to low dose GCs by 12 months post-diagnosis and 81% aimed to taper patients off GCs completely by 24 months post-diagnosis
- At 24–< 36 months post-diagnosis, 80% of patients were receiving GCs and the average dose was 8.4 mg/day; at ≥ 48 months post-diagnosis, 75% of patients were receiving GCs and the average dose was 5.3 mg/day **(Figure 2)**

Figure 2. Oral GC Received by Disease Duration

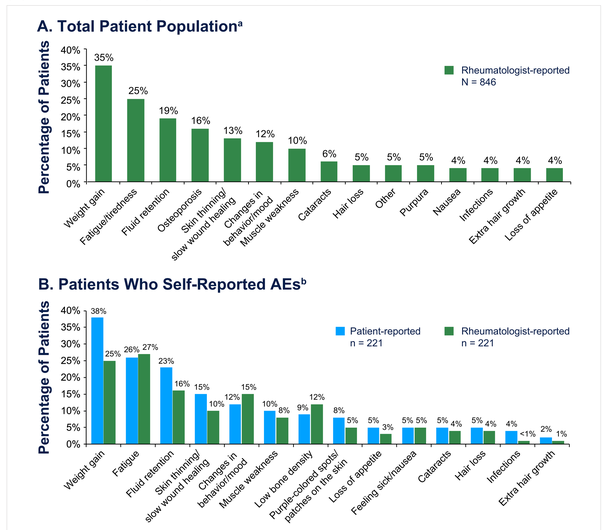


GC, glucocorticoid; m, months.
Line graph shows mean oral GC dose received per day over time.

GC-Related Adverse Events

- The number of patients experiencing ≥ 1 GC-related AEs was higher when reported by rheumatologists (74%) compared to patients (55%)
- The most frequent GC-related AEs were weight gain, fatigue/tiredness, and fluid retention, as reported by both rheumatologists and patients **(Figure 3)**
- Among patients who self-reported AEs (n = 221), more AEs were generally reported by patients than by rheumatologists

Figure 3. GC-related AEs Reported by Rheumatologists and/or Patients Among (A) All Patients and (B) Patients Who Self-Reported AEs



AE, adverse event; GC, glucocorticoids.

Rheumatologists' and Patients' Perceptions on ATs

- Among 196 rheumatologists surveyed, over 90% believed the following AT attributes were important: maintenance of remission; achievement of GC-free remission; reduction of high-dose/cumulative GC use; to allow GC cessation; and to be safe, tolerable, and patient-compliant **(Table 2)**
- Most rheumatologists (EU-5, 90%; US, 94%) agreed that ATs should be given early in GCA treatment to improve outcomes and reduce GC toxicity
- Most rheumatologists agreed that limited choices in AT administration routes are a barrier to widespread use (EU-5, 51%; US, 80%) and that convenient administration is an important attribute of ATs (EU-5, 65%; US, 84%)
- Most patients (75%) stated that they preferred receiving treatments orally rather than by injection or infusion

Table 2. Rheumatologists' Perceptions on ATs

	EU-5 N = 166	US N = 30
How important do you perceive each of the following attributes to be for an advanced treatment indicated for GCA?[a]		
Maintains remission		
Somewhat important	1 (1%)	1 (3%)
Very important	60 (36%)	10 (33%)
Extremely important	105 (63%)	19 (63%)
Maintains glucocorticoid-free remission		
Somewhat important	9 (5%)	1 (3%)
Very important	53 (32%)	12 (40%)
Extremely important	104 (63%)	17 (57%)
Reduces cumulative glucocorticoid dose		
Somewhat important	13 (8%)	1 (3%)
Very important	72 (43%)	10 (33%)
Extremely important	81 (49%)	19 (63%)
Safety/tolerability		
Somewhat important	5 (3%)	0 (0%)
Very important	68 (41%)	9 (30%)
Extremely important	93 (56%)	21 (70%)
Patient compliance		
Somewhat important	16 (10%)	2 (7%)
Very important	92 (55%)	13 (43%)
Extremely important	58 (35%)	15 (50%)
Physicians' opinions on each statement regarding the use of advanced therapies[b]		
Advanced therapies should be used early in patients with GCA to significantly improve outcomes and reduce glucocorticoid toxicity		
Disagree/strongly disagree	16 (10%)	2 (7%)
Agree/strongly agree	150 (90%)	28 (93%)
Lack of variety in advanced treatments route of administration is a barrier to more widespread use of advanced therapy		
Disagree/strongly disagree	77 (46%)	6 (20%)
Agree/strongly agree	89 (54%)	24 (80%)
The launch of new treatments results in earlier use of advanced therapy		
Disagree/strongly disagree	26 (16%)	0 (0%)
Agree/strongly agree	140 (84%)	30 (100%)
I would use advanced therapies more often if there were more options		
Disagree/strongly disagree	42 (25%)	1 (3%)
Agree/strongly agree	124 (75%)	29 (97%)

AT, advanced therapies; EU-5, European Union-5; GCA, giant cell arteritis; US, United States.
[a]No more than 1 rheumatologist answered 'of no importance' for any given question. [b]Including biologics, JAK inhibitors.

©AbbVie Inc. 2025

Draft Confidential

45102-RHM-Prepr in GCA (ePoster) — ACR 2025 — AbbVie — proof 5 — october 7, 2025
the henderson company 6020 keating avenue, chicago illinois 60646 (847) 979-8051
72 x 40.5 RGB **CREATED @ 100%**