Artérite à Cellules Géantes : Quelle biothérapie pour quel patient ?

Journée de formation du GFEV

20 novembre 2026

Maxime Samson

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Centre de Référence Maladies Rares « Maladies auto-immunes et auto-inflammatoires systémiques rares de l'adulte »

INSERM UMR 1098, UBFC, équipe “Immunopathologie et Immunorégulation”

Liens d’intérêt

Symposium, boards, consulting

- ABBVIE
- ARGENX
- ASTRAZENECA
- BOEHRINGER
- CHUGAI
- CSL VIFOR
- GSK
- NOVARTIS
- FRESENIUS KABI

Invitations à des congrès

- ASTRAZENECA
- CHUGAI
- GSK
- NOVARTIS
- OTSUKA
- CSL VIFOR
- FRESENIUS KABI

Grant

- NOVARTIS

PNDS 2024

Corticothérapie*
40-80 mg/j

* Possibilité de bolus de MP (250-500 mg, 1 à 3 jours si atteinte visuelle)

Réponse ?

NON

Reconsidérer le diagnostic

OUI

ATCD d'évènement CV majeur **
Ostéoporose fracturaire
ATCD de décompensation d'une pathologie psychiatrique sous corticoïdes
Diabète compliqué
ATCD de corticothérapie prolongée (>6 mois), quelle qu'en soit la cause

infarctus du myocarde, hospitalisation pour angor instable, AVC, AOMI symptomatique, revascularisation coronarienne ou des artères des membres inférieurs, **non lié à ACG

NON

OUI

Objectif sevrage ≤ 12 mois
15 mg/j à M3
5-10 à M6
Sevrage à M12

Echec sevrage CS en moins de 12 mois
Intolérance des CS

Objectif sevrage 6 mois ***
+
Tocilizumab ou MTX

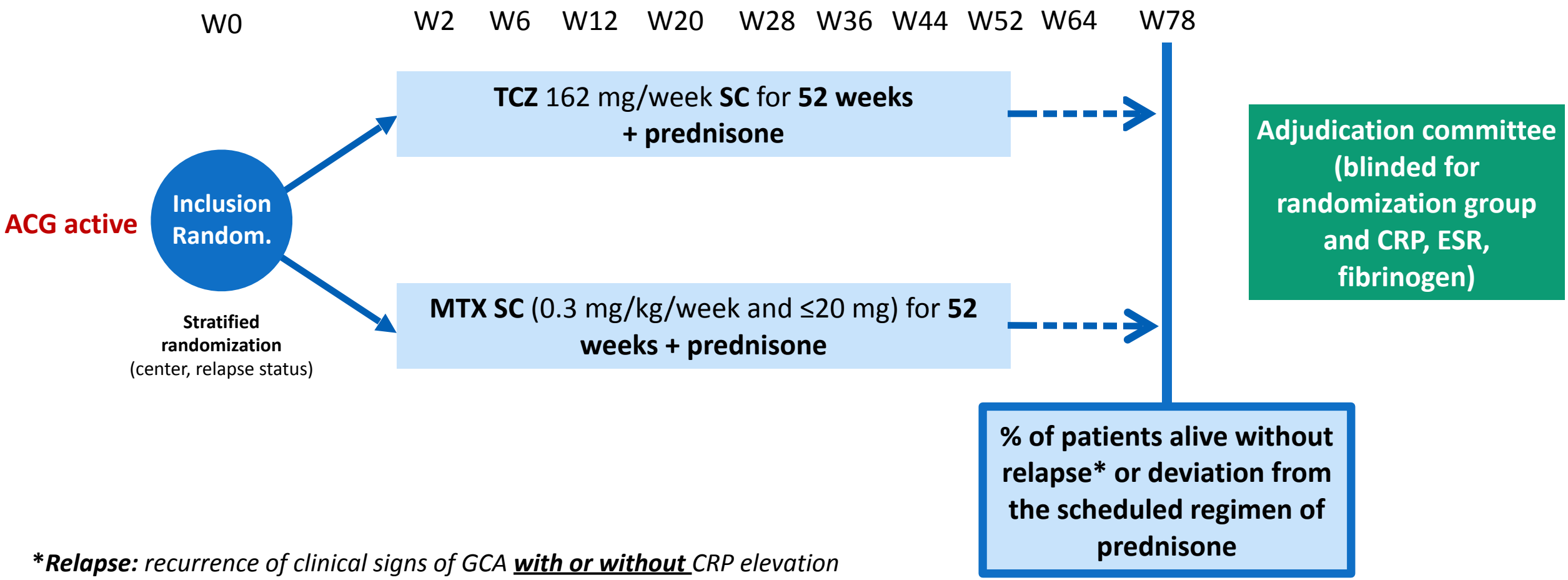
*** un délai <6 mois est même envisageable après avis d'expert

Méthotrexate ou tocilizumab ?

METOGiA: design

Prospective, open-label, multicenter RCT
Non-inferiority (**margin = 20%**)

W78
Primary endpoint



Relapse: *recurrence of clinical signs of GCA* ***with or without*** *CRP elevation*
Remission : *absence of clinical signs of GCA* ***and*** *CRP ≤10 mg/L*

Samson M et al. submitted

METOGiA: results

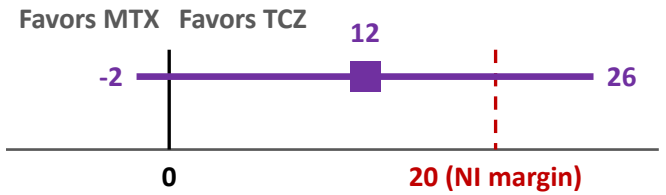
Population: 230 randomized (ITT n=218; PP n=196).

Primary endpoint at W78 (PP)

Alive without relapse or deviation from the GC tapering protocol

51% TCZ (n=103)

39% MTX (n=93)



Difference TCZ - MTX (95% CI)
PP: 12% [-2; 26] (P=0.12)
ITT: 10% [-3; 23] (P=0.07)
significant if P<0.025

Non-inferiority of MTX not demonstrated

Secondary endpoints at W52 (ITT)

P=0.003 **P=0.006** **P=0.0005** **P=0.011**

Cumulative prednisone dose: 3275 vs 3423 mg (P=0.32)

At W78 (26 wks after stopping TCZ/MTX): differences no longer significant (relapse-free 58% vs 50%, P=0.25)

Safety at W78 (ITT)

	TCZ	MTX
Deaths	1	6
Treatment-related SAE	6	12
Pneumocystis pneumonia	0	5
All SAE (patients)	86 (49)	107 (53)

AE and infectious SAE balanced between arms.

PjP: MTX arm only, mostly with lymphopenia; no anti-PjP prophylaxis in any case.

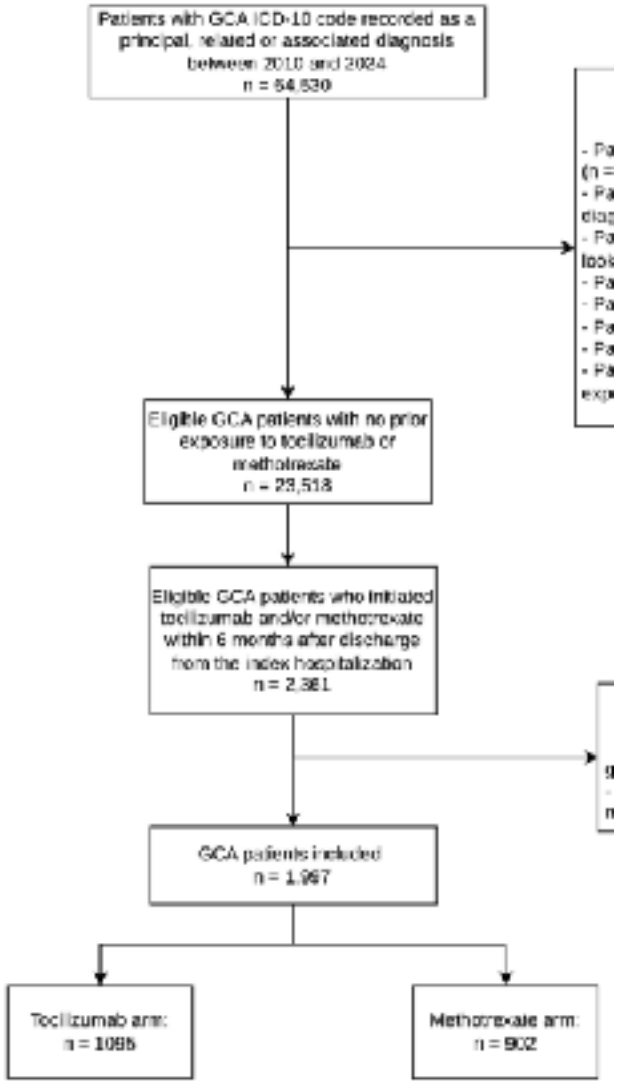
MTX was not shown to be non-inferior to TCZ at W78. TCZ was superior at W52 for most secondary endpoints, with a better safety profile.
These results support TCZ as the preferred GC-sparing agent over MTX in GCA.

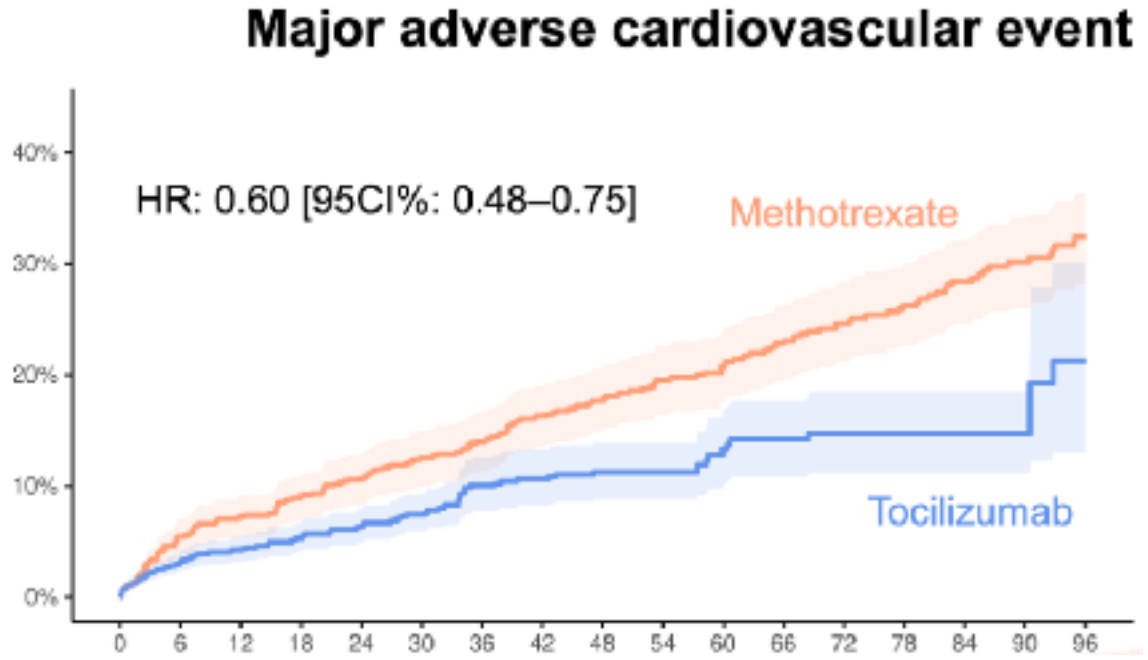
Samson M et al. submitted

Tocilizumab Is Associated With a Lower Incidence of Major Adverse Cardiovascular Events in Giant Cell Arteritis

Alexis F. Guedon, MD, MPH, PhD; Patrice Cacoub, MD, PhD; Fabrice Carrat, MD, PhD; Olivier Espitia, MD, PhD; Adrien Mirouse, MD, PhD; Etienne Ghrenassia, MD; Olivier Fain, MD, PhD; Arsène Mekinian, MD, PhD; David Saadoun, MD, PhD

Circulation 2026





Attention :

- MACE comprend mortalité toute cause
- Raison de la prescription (MTX ou TCZ) : époque ? terrain patient ?

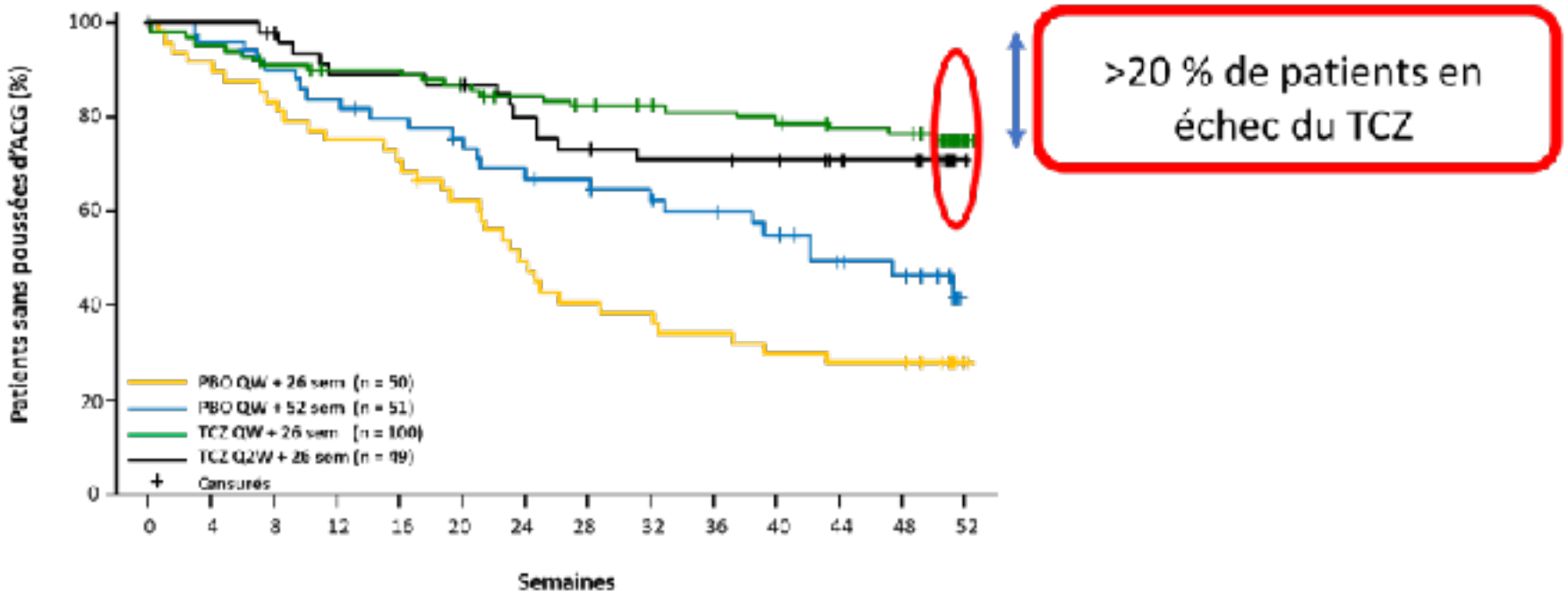
Signal sur les **evt coronariens convaincant**

Sur la mortalité, résultat peut être *trop* ***« optimiste ?*** ».

Quelles limites avec le tocilizumab ?

- **Quel(s) biomarqueur(s) utiliser pour monitorer l'activité de l'ACG ?**
- **Contre indiqué chez certains patients**
- **Stoppé/interrompu chez 21 % des patients (neutropénie +++ ; infection)**

- **Rechute / persistance d'une dépendance aux CS chez ≈ 20% des patients**

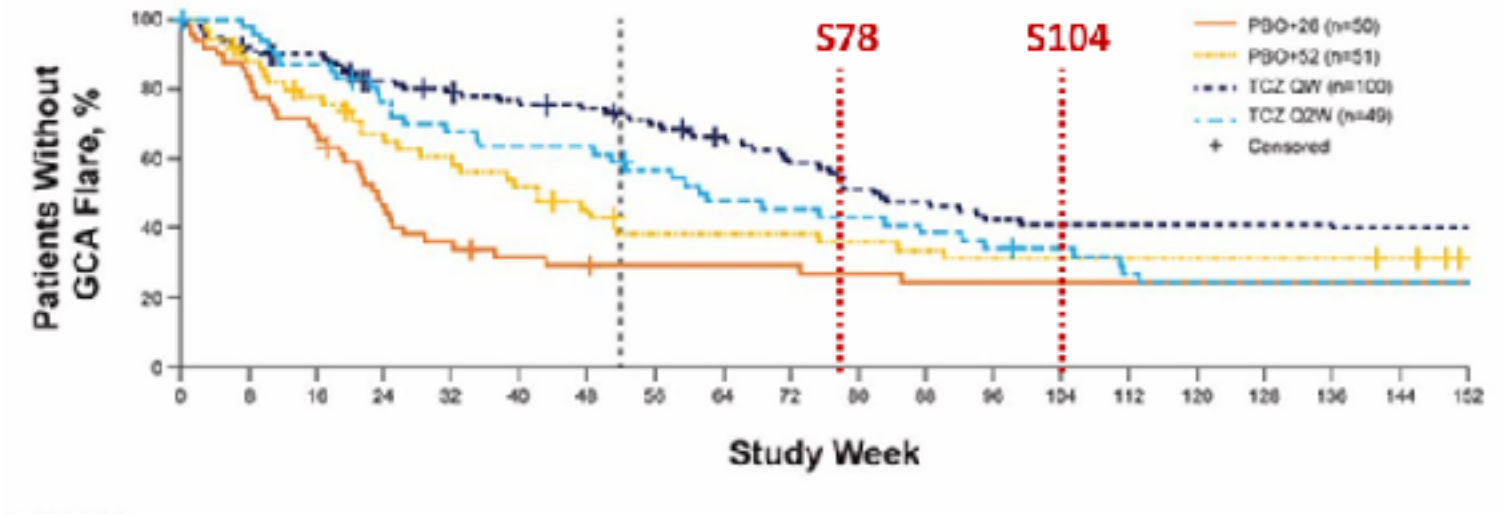


Stone JH et al. NEJM 2017

Rechutes après l'arrêt du tocilizumab

- **40 à 50%** des patients rechutent dans un délai de 12 mois après l'arrêt du TCZ [1-3]

Figure 1. Kaplan-Meier plot of time to first flare over 3 years (double-blind and part 2 periods; censored for open-label TCZ; ITT population).

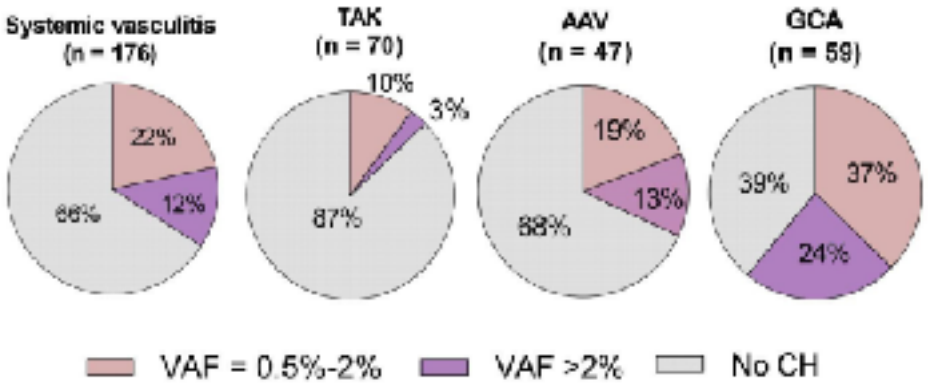


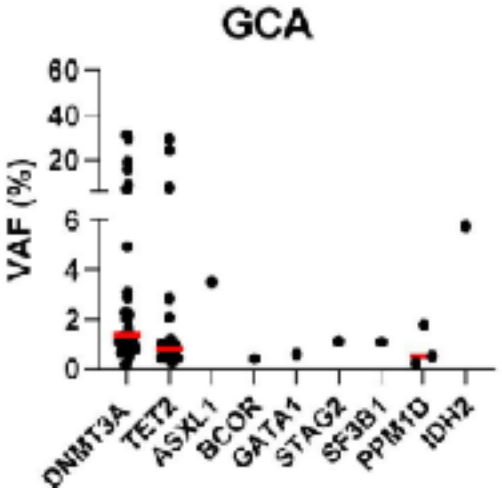
1 - Stone J et al. Lancet Rheumatology 2021
2 - Quick V et al. Rheumatology 2023
3 - Samson M et al. ACR 2025
4 - Nielsen MK et al. Sem Arth Rheum 2024

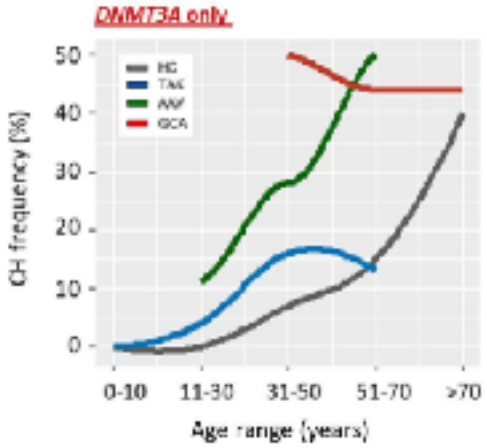
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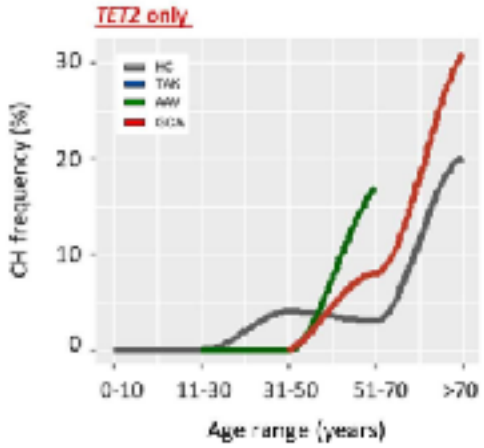
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- **Rechutes plus précoces si** [3, 5, 6]
  - « Rechute » sous TCZ
  - « ACG active » à l'arrêt du TCZ
  - **Sexe féminin, atteinte des gros vaisseaux**
  - **CHIP**







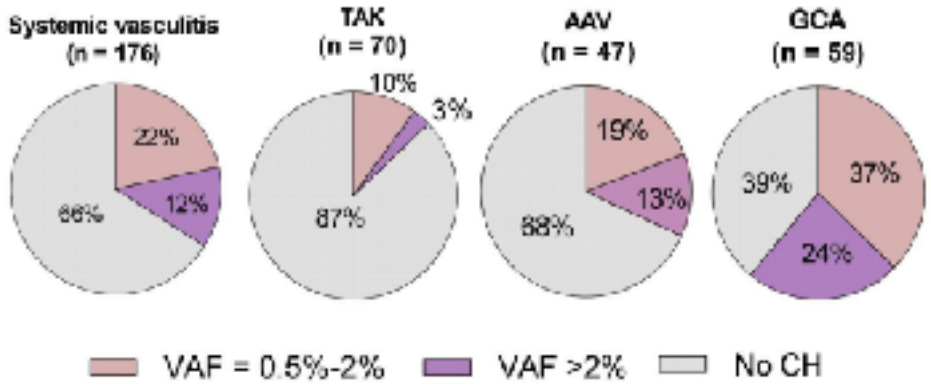


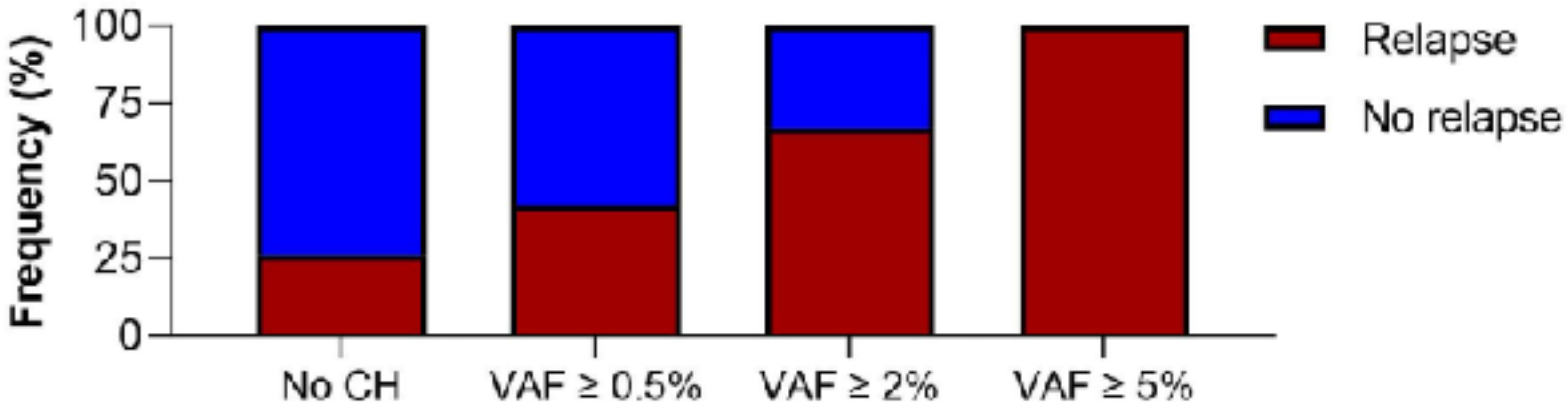
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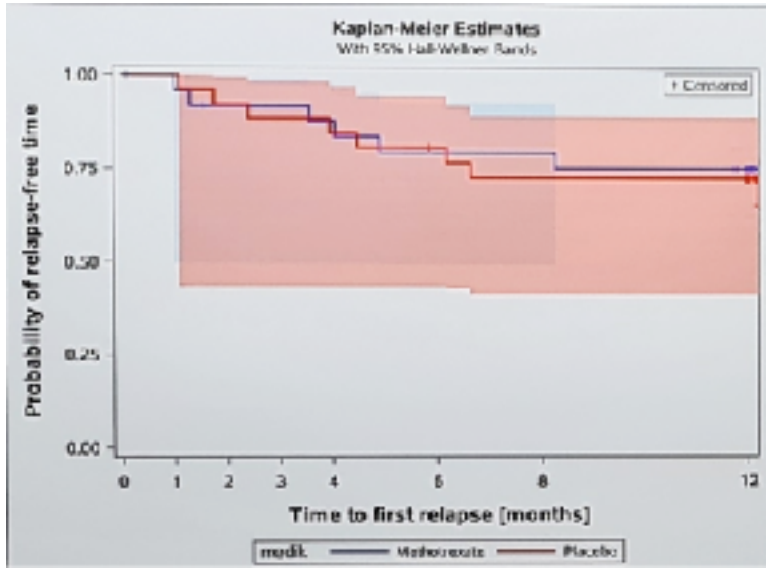
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  - **CHIP**

- **Pas d'effet de la prise de MTX à l'arrêt du TCZ**

  ➔ Essai METEORITICS (EULAR 2026)

  (Kreis L et al. EULAR 2026)

  MTX (17,5 mg/s sc) vs PLA



1 - Stone J et al. Lancet Rheumatology 2021
2 - Quick V et al. Rheumatology 2023
3 - Samson M et al. ACR 2025
4 - Nielsen MK et al. Sem Arth Rheum 2024
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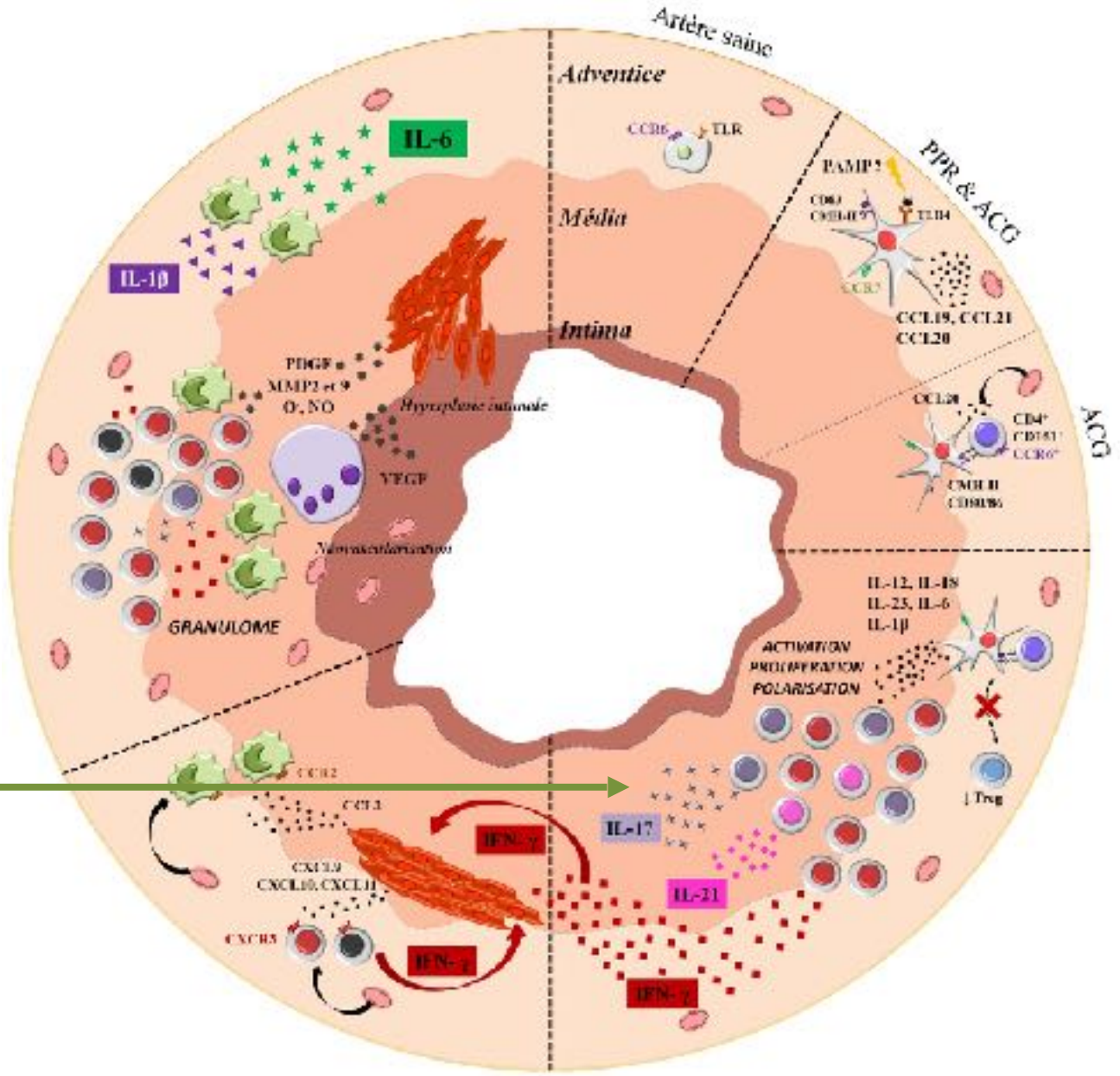
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- **Pas d'effet de la prise de MTX à l'arrêt du TCZ**
  - ➔ Essai METEORITICS (EULAR 2026)

- **Faut il privilégier un sevrage progressif ?** [4]
  - ➔ Essai MAGiCA (PHRC-N)

1 - Stone J et al. Lancet Rheumatology 2021
2 - Quick V et al. Rheumatology 2023
3 - Samson M et al. ACR 2025
4 - Nielsen MK et al. Sem Arth Rheum 2024
5 - Gutierrez-Rodrigues et al. ARD 2024
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Quelles sont les autres cibles thérapeutiques ?

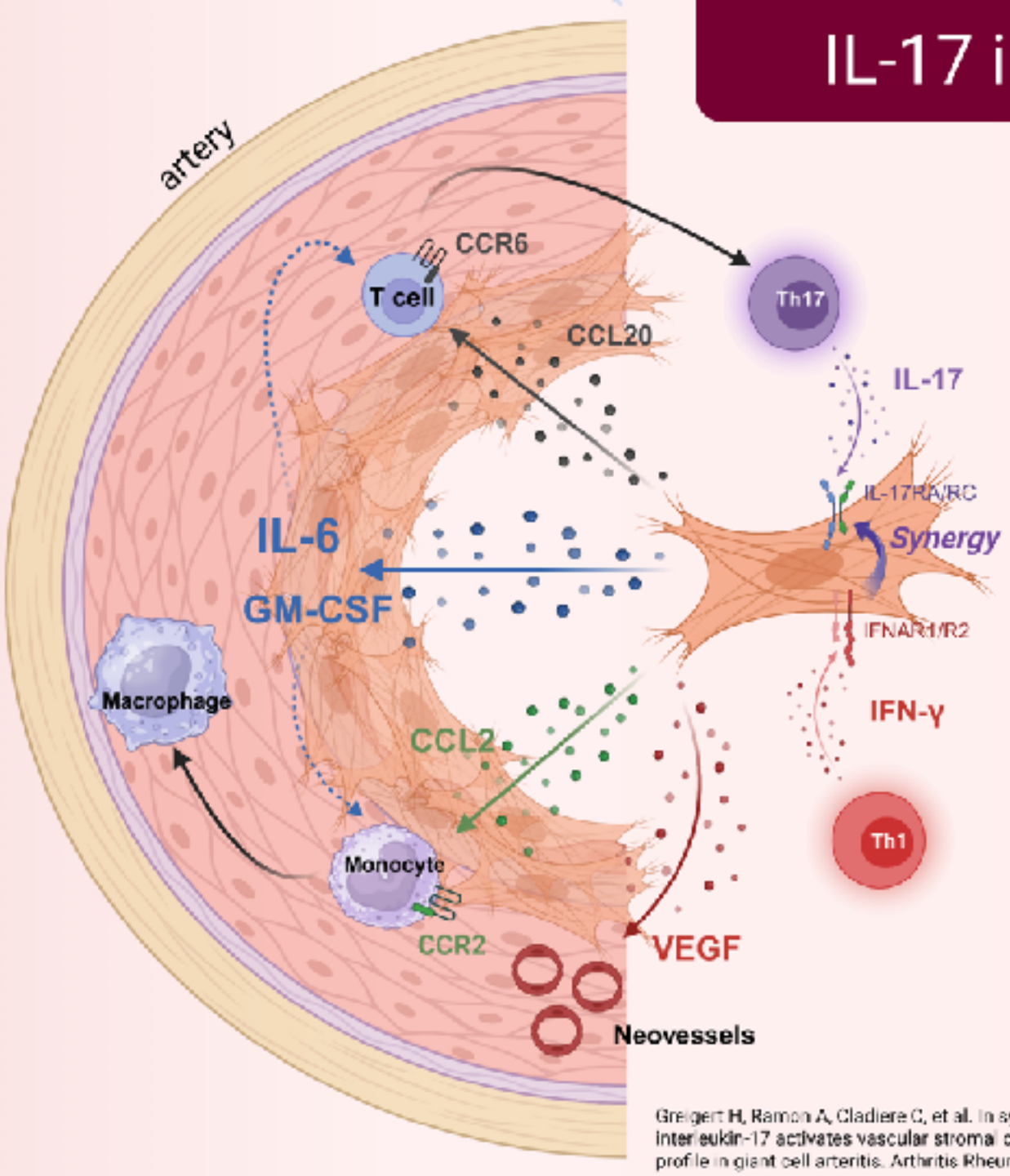


Anti IL-17
(*secukinumab*)

TiTAiN
GCAPTAIN

Samson M et al. 2019 Bulletin de l'Académie Nationale de Médecine. Volume 204, Issue 1, January 2020, Pages 18-28

IL-17 in Giant Cell Arteritis



Study Design



Used an ex vivo culture model of temporal artery biopsies to analyze the effect of IL-17 or its blockade in GCA

Key Findings

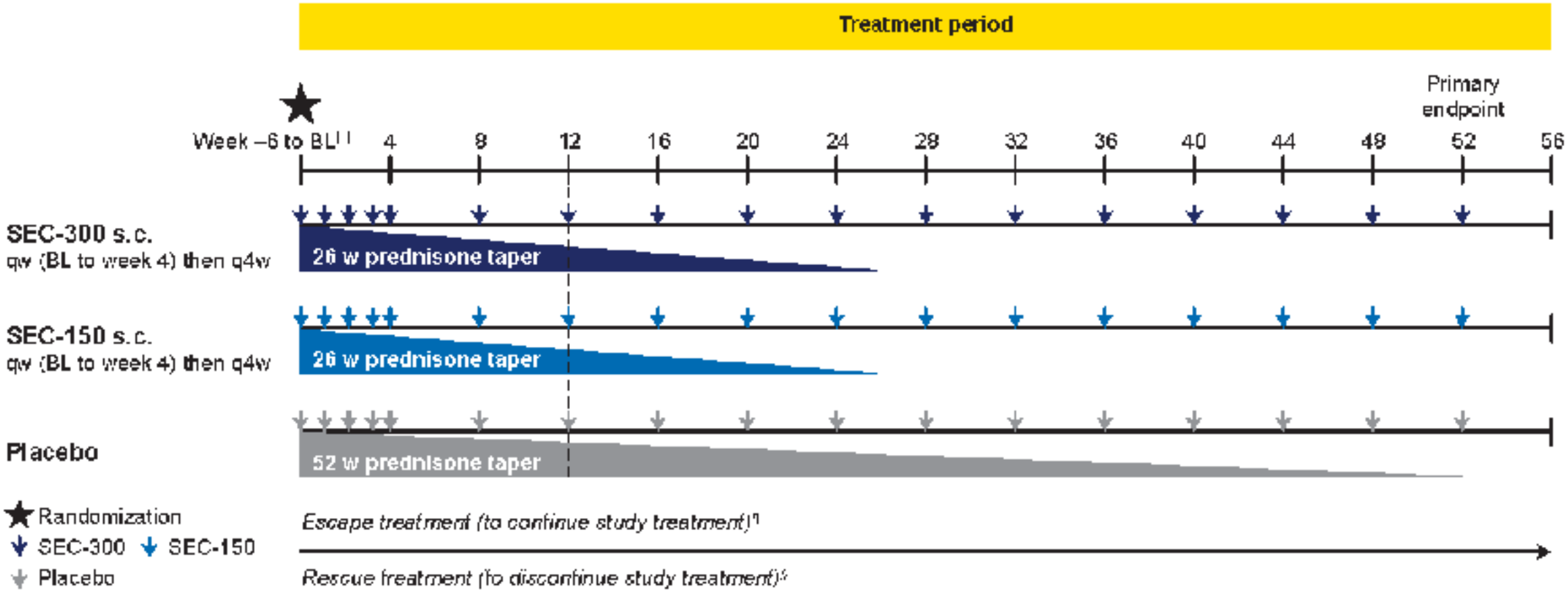
1. IL-17 induces proinflammatory cytokines and chemokines (IL-6, GM-CSF, CCL20) in ex vivo temporal artery cultures
2. Blocking IL-17 signaling, reducing inflammatory mediator production.
3. Myofibroblasts, mainly in the neointima of GCA arteries, express IL-17RA and IL-17RC.
4. IL-17 stimulates myofibroblasts to produce proinflammatory cytokines and chemokines; synergy with IFN-γ amplifies this response by upregulating IL-17RA and IL-17RC.
5. IL-17 does not directly affect myofibroblast proliferation or migration.

Greigert H, Ramon A, Cladiere C, et al. In synergy with interferon-gamma, interleukin-17 activates vascular stromal cells towards a proinflammatory profile in giant cell arteritis. Arthritis Rheumatol 2025.

Arthritis & Rheumatology
American College of Rheumatology

GCAptAIN trial

Randomized, parallel-group, double-blind, placebo-controlled, multicenter, Phase 3 study
Active GCA (new onset or relapsing)



Stone J et al. 2026, *NEJM Evidence 2026*

GCAptAIN trial

Objective	Endpoint
To demonstrate that secukinumab 300 mg + 26-week GC taper is superior to placebo + 52-week GC taper for sustained remission at week 52 in patients with GCA	**Sustained remission at week 52** Sustained remission was defined as meeting all the following criteria: • Remission achieved by week 12* and sustained from week 12 to week 52, with no: (a) recurrence of GCA signs or symptoms requiring an increase in glucocorticoid (GC) dose or rescue therapy; (b) increase in ESR to ≥30 mm/hr attributable to GCA and requiring an increase in GC dose or rescue therapy; (c) CRP elevation to ≥10 mg/L at two consecutive scheduled visits; or (d) non-adherence to the prednisone taper

*Remission at week 12 defined as meeting all of the following at week 12 and having had no recurrence of the following if reached remission prior to week 12: No signs or symptoms attributable to GCA that require an increase in prednisone dose compared with the pre-specified taper or rescue treatment; no elevation of ESR to ≥30 mm/hr attributable to GCA that requires an increase in prednisone dose compared with the pre-specified taper or rescue treatment; no elevation of CRP (≥10 mg/L) at two consecutive scheduled visits; no non-adherence to the pre-specified prednisone taper by an increase in the dose for GCA.
GC, glucocorticoid; GCA, giant cell arteritis.

Stone J et al. 2026, *NEJM Evidence 2026*

GCAptAIN trial

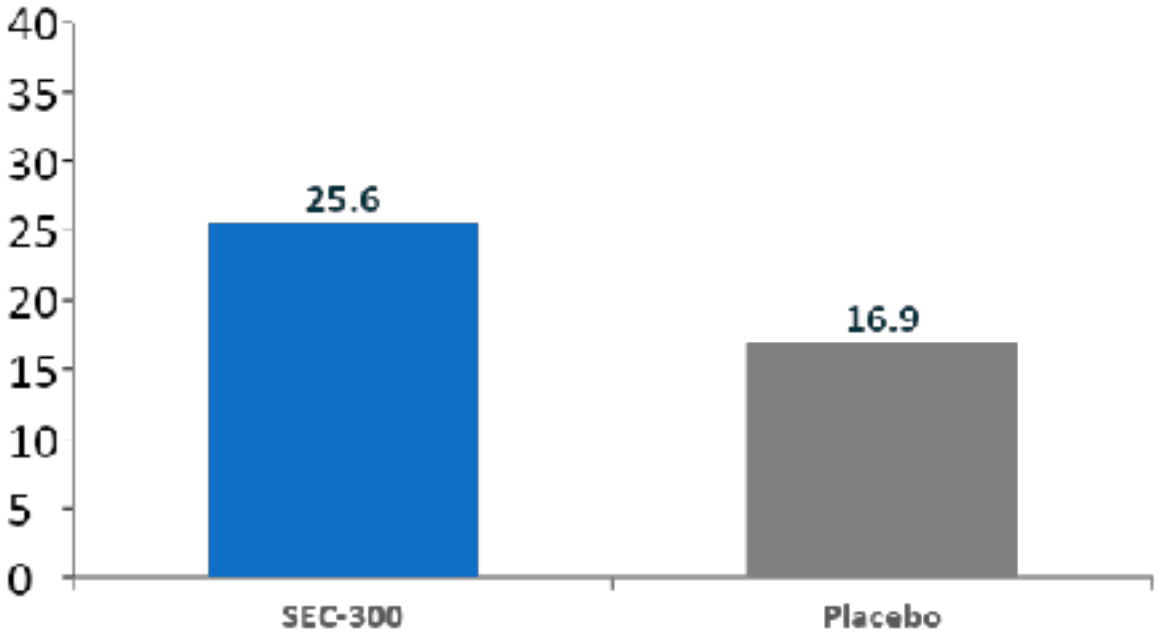
Table 1. Demographics and Baseline Clinical Characteristics.*

Characteristic	Secukinumab 300 mg (N=140)	Secukinumab 150 mg (N=98)	All Placebo (N=116)†	Subset of placebo group after protocol change adding secukinumab 150 mg group (N=97)†
Age (years) — mean (SD)	72.2 (7.34)	72.3 (7.37)	71.4 (7.46)	72.2 (7.38)
Non-Hispanic or Latino	120 (85.7)	87 (88.8)	103 (88.8)	86 (88.7)
Female sex — n (%)	101 (72.1)	66 (67.3)	65 (56.0)	57 (58.8)
	68.9 (14.3)	70.5 (18.6)	71.8 (16.0)	71.7 (16.2)
Signs and symptoms of GCA at baseline — n (%)‖				
Cranial signs and symptoms	36 (25.7)	37 (37.8)	35 (30.2)	29 (29.9)
Ischemia-related visual symptoms	8 (5.7)	11 (11.2)	11 (9.5)	9 (9.3)
PMR signs and symptoms	17 (12.1)	13 (13.3)	9 (7.8)	8 (8.2)
Signs and symptoms of limb ischemia	5 (3.6)	1 (1.0)	4 (3.4)	2 (2.1)
Time since first diagnosis of GCA (weeks, for relapsing patients) — mean (SD)¶	n=49 123.0 (150.3)	n=32 132.8 (109.1)	n=38 128.0 (181.3)	n=32 124.0 (186.1)
Signs and symptoms of GCA at baseline — n (%)‖				
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Assigned prednisone dose at baseline (mg/day) — mean (SD)	n=140 35.7 (12.0)	n=98 36.7 (13.6)	n=115 35.0 (12.1)	n=96 34.9 (12.6)
Prednisone dose at baseline — n (%)				
>30 mg/day	77 (55.0)	54 (55.1)	63 (54.3)	52 (53.6)
ESR at baseline — n (%)				
≥30 mm/h	33 (23.6)	17 (17.3)	22 (19.0)	18 (18.6)
CRP at baseline — n (%)				
≥10 mg/l	16 (11.4)	13 (13.3)	17 (14.7)	15 (15.5)
Methotrexate use at baseline — n (%)	7 (5.0)	5 (5.1)	6 (5.2)	—

Stone J et al. 2026, *NEJM Evidence 2026*

GCAptAIN trial

Sustained remission at W52 (%)



Δ +8,7 points [−1,3 ; 18,8]
P = 0,09

SEC-150 vs placebo
19,4% vs 17,7% (Δ +1,6; NS)

Mais des signaux favorables en faveur du SEC 300 :

Dose cumulée CS à S52

−783 mg

3158 vs 3941 mg
(SEC-300 vs PLA)

GTI-AIS à S52

23 vs 73

(SEC-300 vs PLA)

Stone J et al. 2026, *NEJM Evidence 2026*

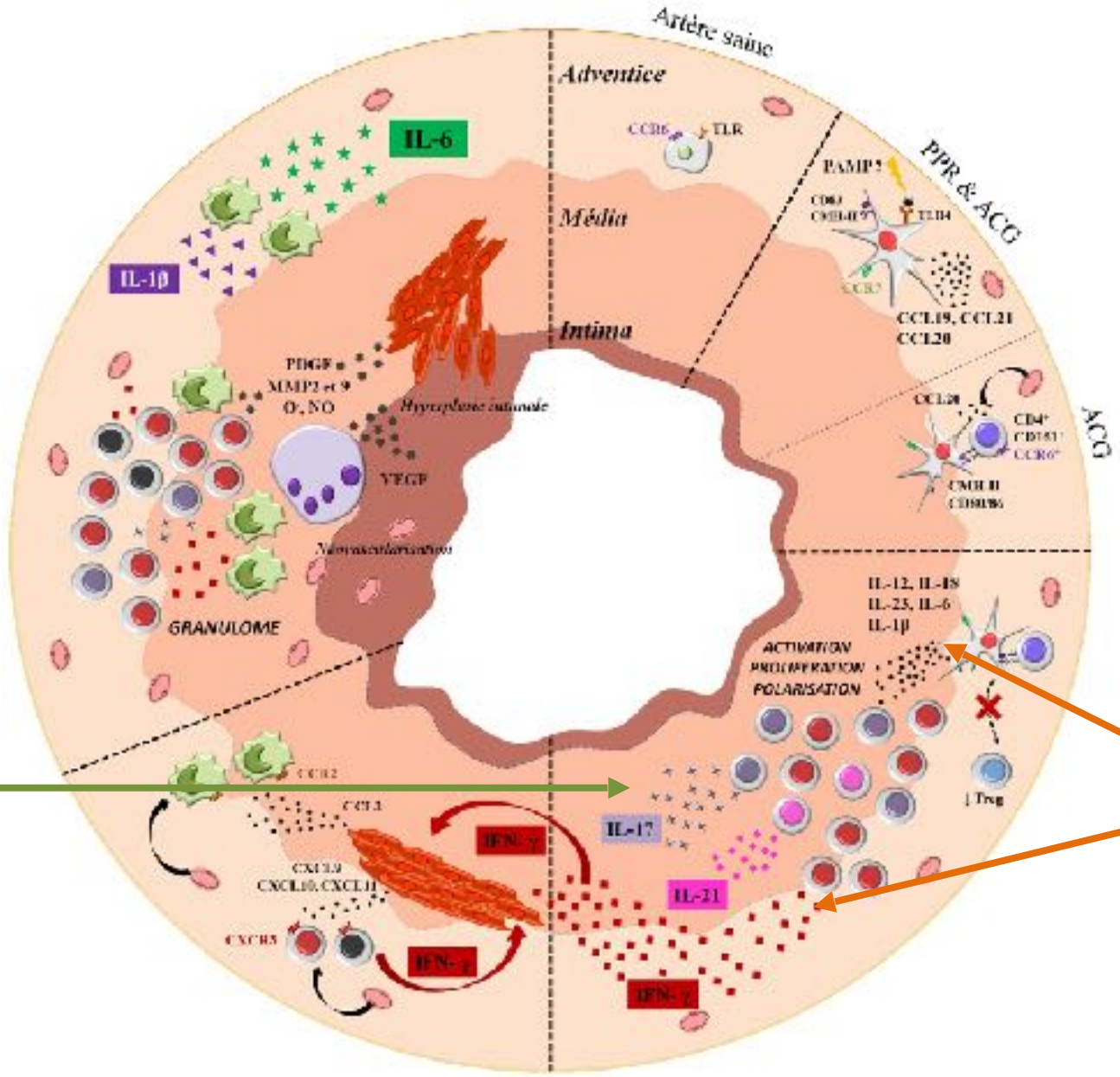
GCAptAIN trial

Analyse dans le sous groupe des femmes (post-hoc)

Endpoint	Secukinumab 300 mg N=101	Placebo N=64
Sustained remission at week 52, n/m (%)*	**24 (23.8%)**	**4 (6.2%)**
Estimated response proportion (95% CI)	**23.8 (15.5, 32.0)**	**6.3 (0.3, 12.2)**
Comparison vs placebo, marginal difference, 95% CI	**17.5 (7.3, 27.7)**	
Sustained clinical remission (excluding CRP) at week 52, n (%)*	39 (38.6)	14 (21.9)
Estimated response proportion (95% CI)	38.7 (29.4, 48.0)	21.8 (11.8, 31.8)
Comparison vs placebo, marginal difference (95% CI)	**16.9 (3.3, 30.5)**	

Stone J et al. 2026, *NEJM Evidence 2026*

Quelles sont les autres cibles thérapeutiques ?



Anti IL-17
(*secukinumab*)

TiTAiN
GCAPTAIN

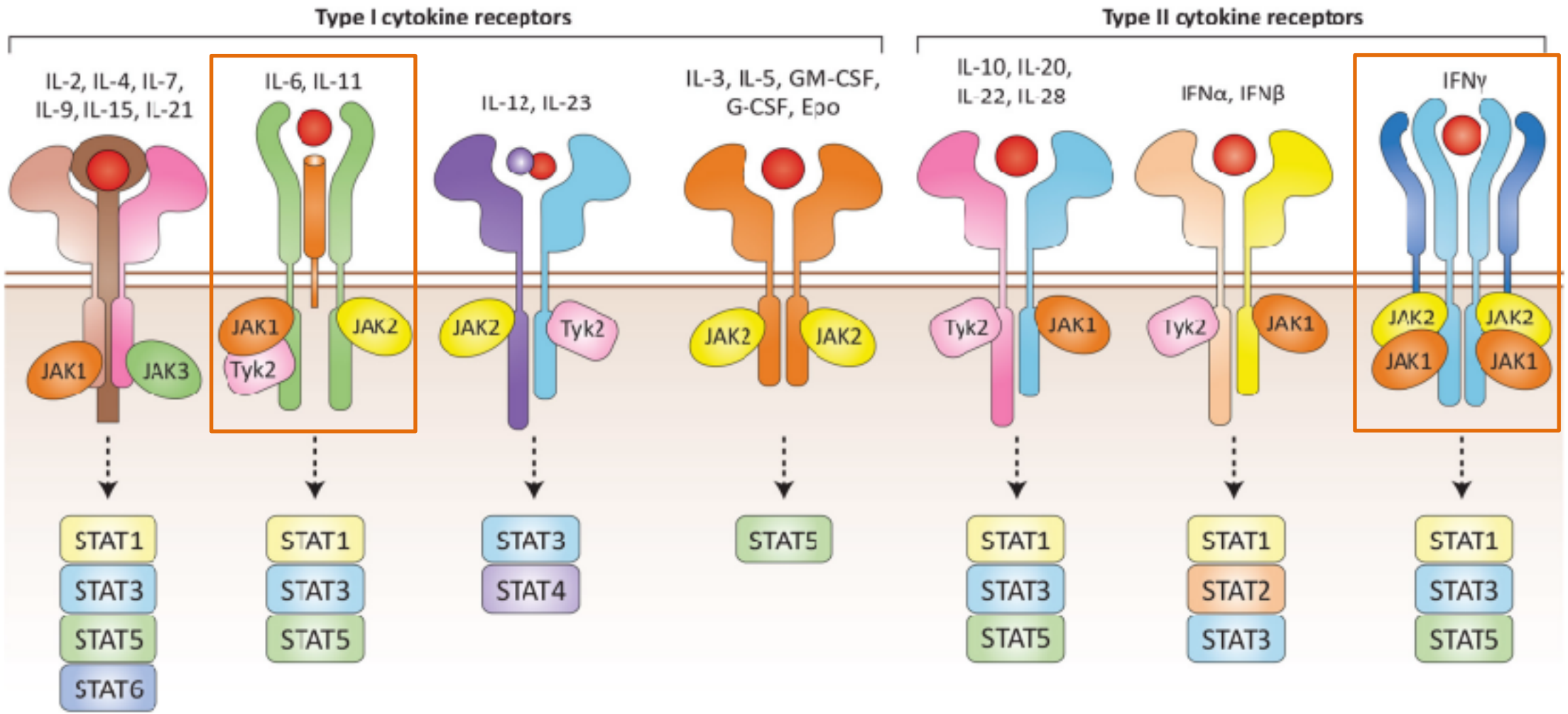
JAKi

SELECT-GCA

Samson M et al. 2019 Bulletin de l'Académie Nationale de Médecine. Volume 204, Issue 1, January 2020, Pages 18-28

Inhibiteurs de JAK

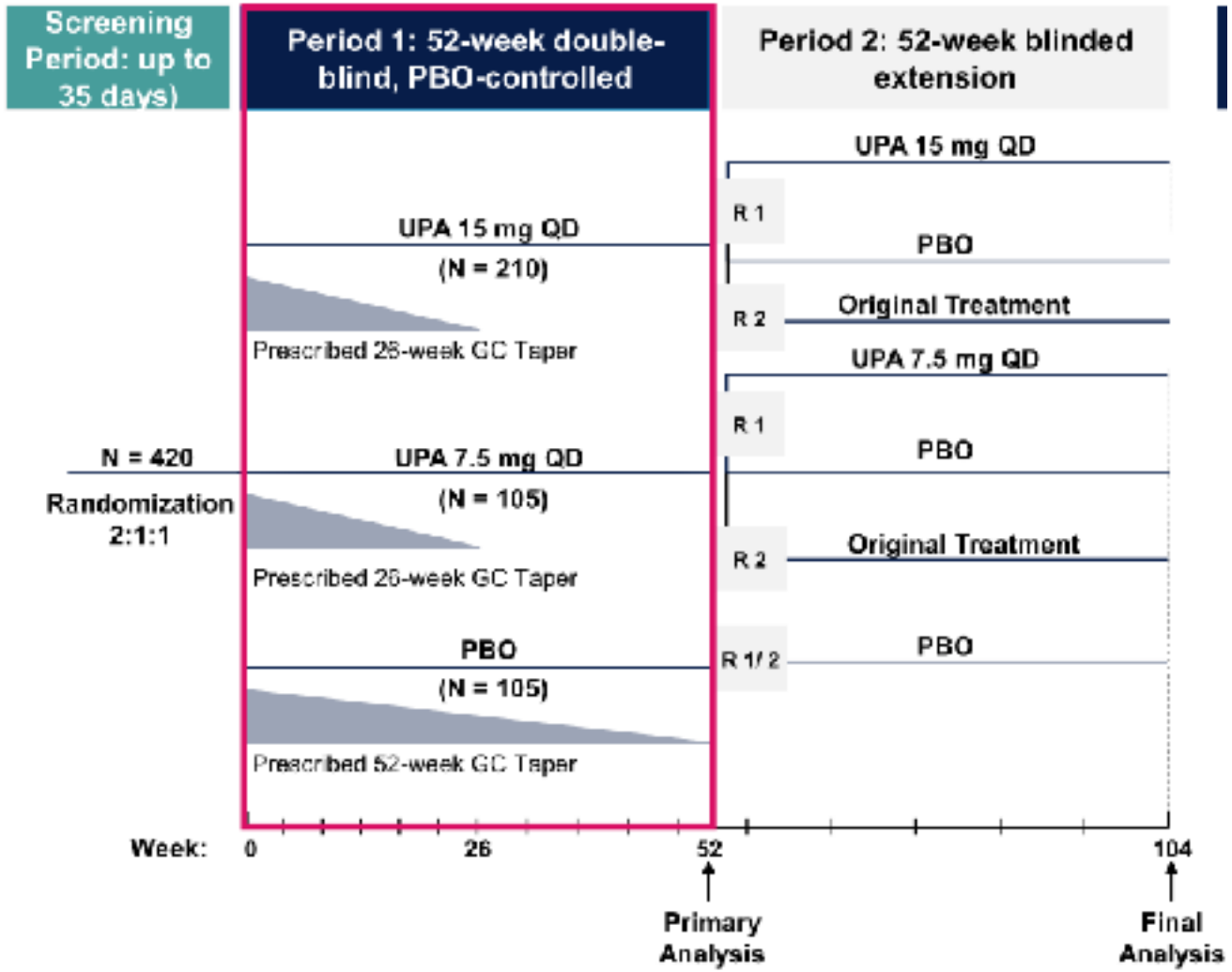
Upadacitinib (SELECT-GCA) → IL-6 et IFN-γ



Bonelli M et al. ARD 2023

Essai SELECT-GCA

Efficacité et tolérance de l'upadacinitib chez les patients atteints d'ACG



RCT double aveugle, phase 3

24 pays

428 patients avec ACG active

70% nouveaux dg, **30%** rechute

recevant ≥20 mg/j de prednisone à l'inclusion

Critère de jugement principal : rémission soutenue

- Absence de signes cliniques d'ACG de S12 à S52
- **ET** adhérence à la décroissance des corticoïdes

Blockmans D, *et al. NEJM 2025*

Essai SELECT-GCA

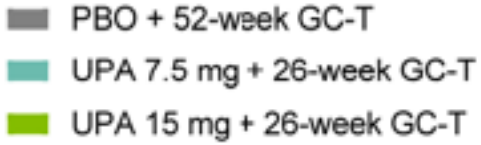
Efficacité et tolérance de l'upadacinitib chez les patients atteints d'ACG

Rémission soutenue à S52 **Dose cumulée de CS à S52**

AMM obtenue le 8 avril 2025

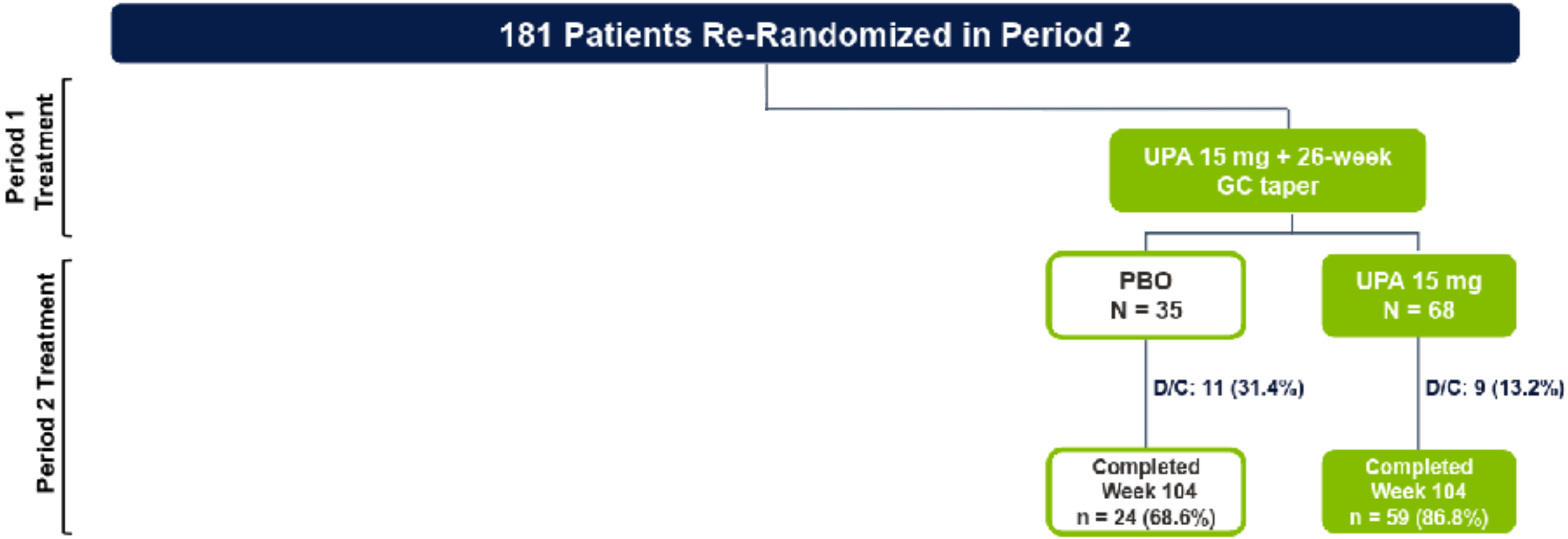
Avis de la CT favorable dans le « traitement de l'ACG en association à une corticothérapie dégressive chez les patients adultes nécessitant une épargne cortisonique, en l'absence d'alternative thérapeutique appropriée dont le tocilizumab, dans les situations suivantes :

- en cas de cortico-dépendance à une dose ≥ 7,5 mg/jour de prednisone entrainant des rechutes itératives,
- lorsqu'une décroissance rapide et précoce de la corticothérapie est rendue nécessaire par une intolérance aux corticoïdes ou des comorbidités sévères (diabète compliqué déséquilibré, troubles thymiques et psychotiques sévères, ostéoporose fracturaire sévère, hypertension artérielle sévère non contrôlée...). »



Blockmans D, *et al. NEJM 2025*

Disposition of Patients Entering Period 2[a]



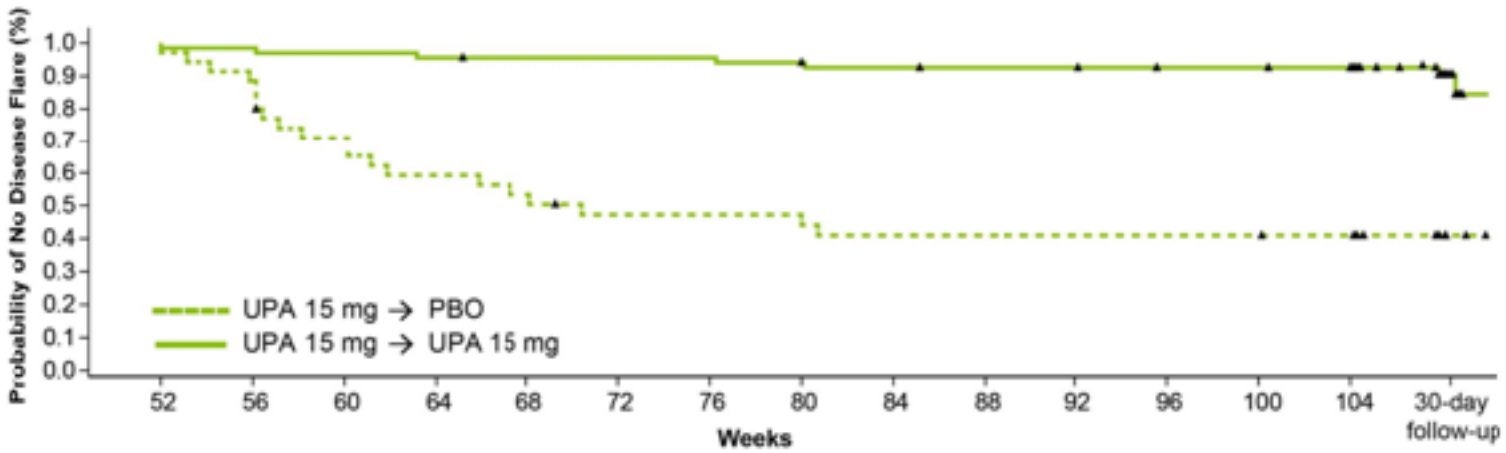
- Most patients (91%) entering period 2 completed the study, with 82% (149/181) remaining on study drug
- No patients who remained on UPA 7.5 mg or UPA 15 mg in period 2 discontinued due to lack of efficacy

GC, glucocorticoid; PBO, placebo; UPA, upadacitinib.
[a]Includes patients who achieved ≥ 24 weeks of consecutive remission before the week 52 visit.

Schmidt W et al. ACR 2025

Disposition of Patients Entering Period 2[a]

181 Patients Re-Randomized in Period 2



UPA 15 mg + 26-week GC taper

PBO N = 35	UPA 15 mg N = 68
D/C: 11 (31.4%)	D/C: 9 (13.2%)
Completed Week 104 n = 24 (68.6%)	Completed Week 104 n = 59 (86.8%)

- Most patients (91%) entering period 2 completed the study, with 82% (149/181) remaining on study drug
- No patients who remained on UPA 7.5 mg or UPA 15 mg in period 2 discontinued due to lack of efficacy

GC, glucocorticoid; PBO, placebo; UPA, upadacitinib.
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Schmidt W et al. ACR 2025

Rates of Treatment-Emergent Adverse Events of Special Interest Through 2 Years in SELECT-GCA[a,b] (1/2)

	Suivi à 2 ans	
	UPA-PCB	UPA-UPA
EIG	36,6 %	31,1 %
Décès	1,5 %	0,7 %
Infection sévère	10,5 %	5,9 %
HSV	3 %	5,9 %
Cancer	1,5 %	1,9 %
ECV	1,5 %	0 %
MTEV	3 %	3 %

Schmidt W et al. ACR 2025

Rates of Treatment-Emergent Adverse Events of Special Interest Through 2 Years in SELECT-GCA[a,b] (1/2)

Events/100 Patient-Years (95% CI) [No. of Events]	Through Week 52		Through 2 Years	
	PBO + 52-week GC-T (N = 112) (PY = 94.3)	UPA 15 mg + 26-week GC-T (N = 209) (PYS = 178.1)	PBO + 52-week GC-T (N = 112) (PYS =133.9)	UPA 15 mg 26-week GC-T (N =209) (PYS = 270.3)
Herpes zoster	4.2 (1.2, 10.9) [4]	7.3 (3.9, 12.5) [13]	3.0 (0.8, 7.6) [4]	5.9 (3.4, 9.6) [16]
CPK elevation	0	3.4 (1.2, 7.3) [6]	0	3.3 (1.5, 6.3) [9]

Schmidt W et al. ACR 2025

PBO, placebo; TEAE, treatment-emergent adverse event; UPA, upadacitinib.
[a]Safety analysis includes all patients enrolled in SELECT-GCA who received ≥ 1 dose of study drug. [b]Safety outcomes were also evaluated and found to be similar in patients originally randomized to PBO, UPA 7.5 mg, or UPA 15 mg and who received continuous treatment with the same drug and dose thereafter in period 2 (data not shown). [c]Excludes herpes zoster. [d]Reported as exposure-adjusted incidence (n/100 PY). [e]Defined as cardiovascular death, non-fatal myocardial infarction, and non-fatal stroke. [f]Includes pulmonary embolism and deep vein thrombosis.

Données de tolérance de l'upadacitinib

16 RCT de phase 3 (PR, Pso, SPA, DA, MC, RCH)

8632 patients
27164 PA

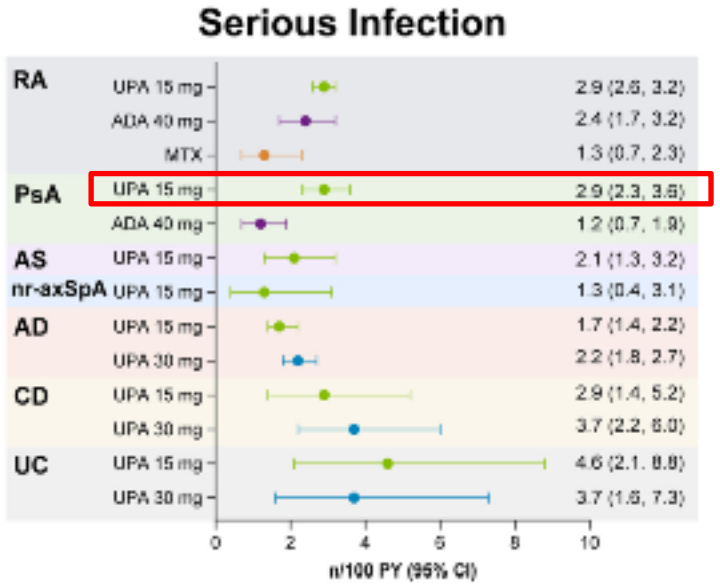
Dosages : 15 mg (PR, DA, MC, RCH), 30 ou 45 mg (DA, MICI)

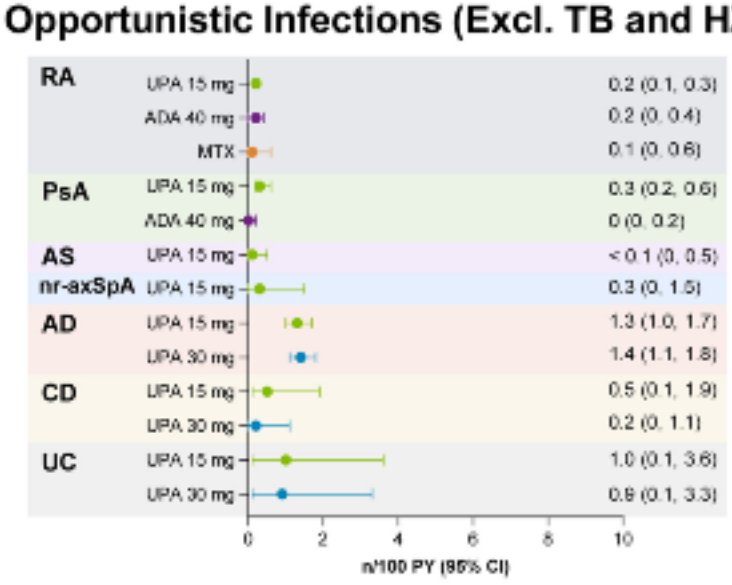
Comparateurs :
- ADA (PR, Pso)
- MTX (PR)

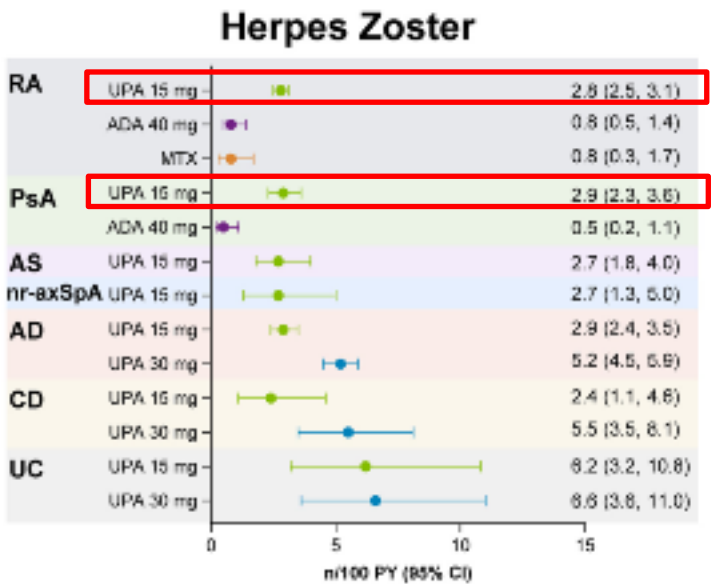
La plupart des patients avaient > 1 FdR CV

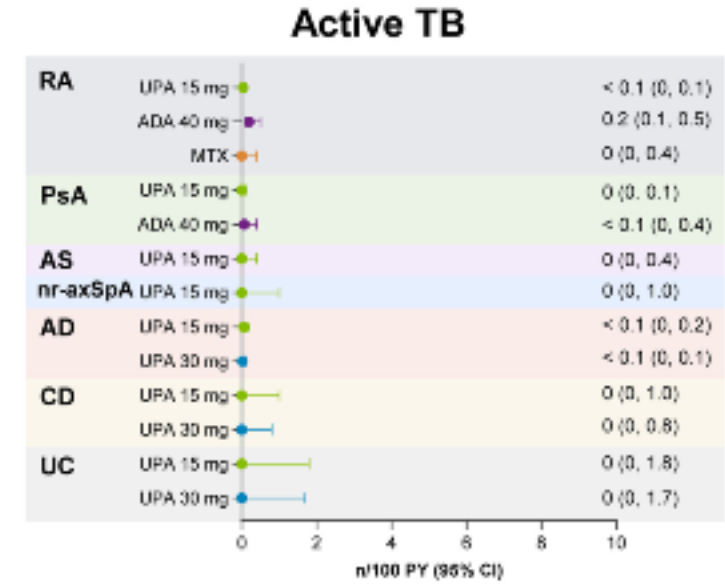
Exposition médiane à UPA = 4 ans (max = 8,5 ans)

Burmester G et al. Adv Ther 2025









Données de tolérance de l'upadacitinib

16 RCT de phase 3 (PR, Pso, SPA, DA, MC, RCH)

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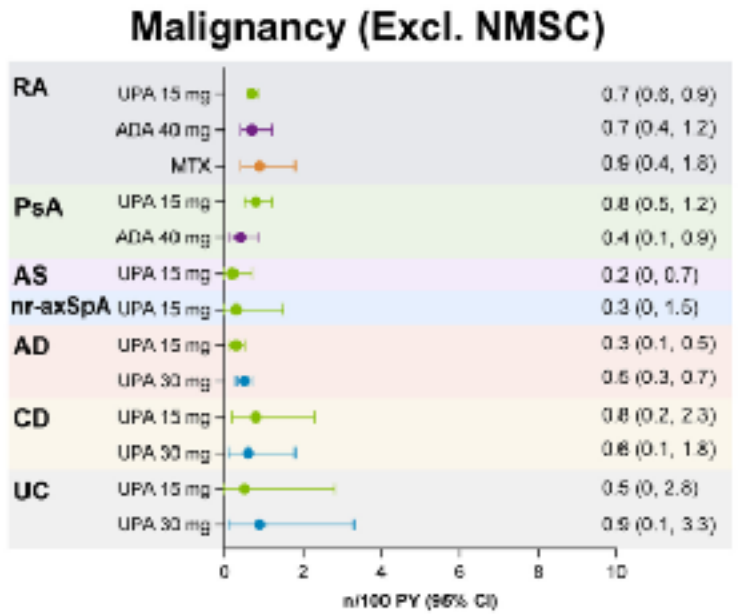
Dosages : 15 mg (PR, DA, MC, RCH), 30 ou 45 mg (DA, MICI)

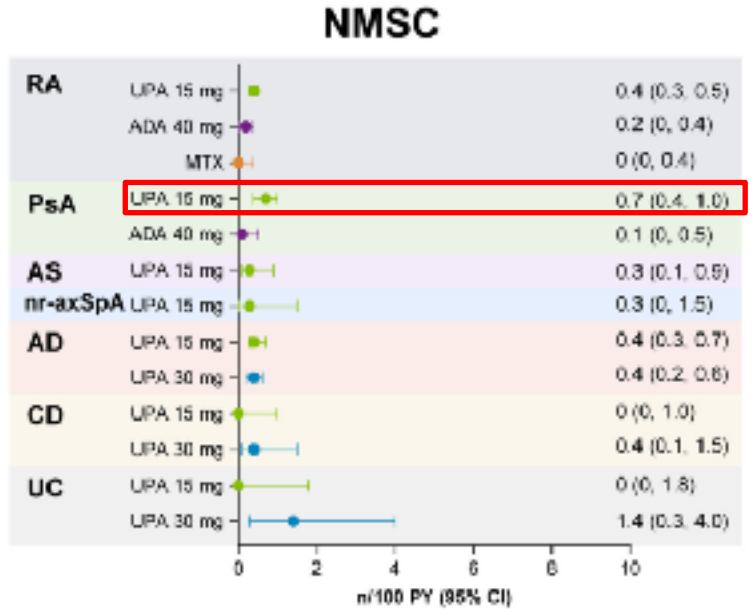
Comparateurs :
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- MTX (PR)

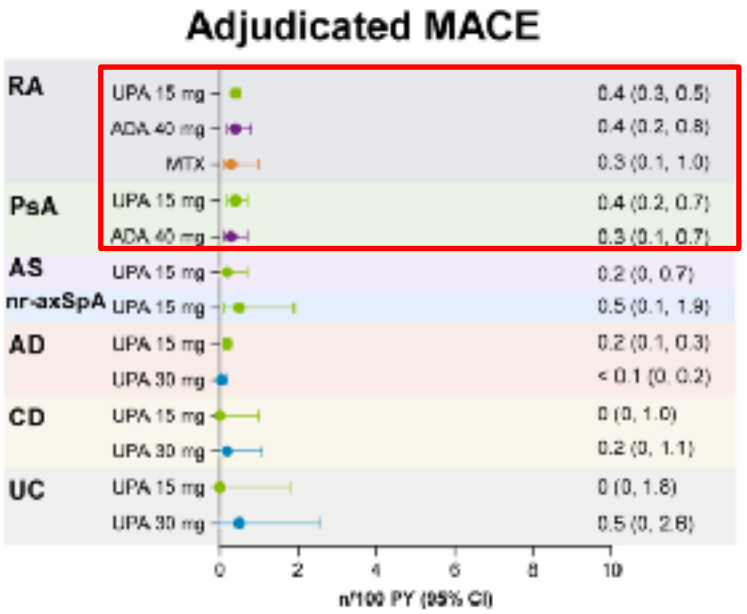
La plupart des patients avaient > 1 FdR CV

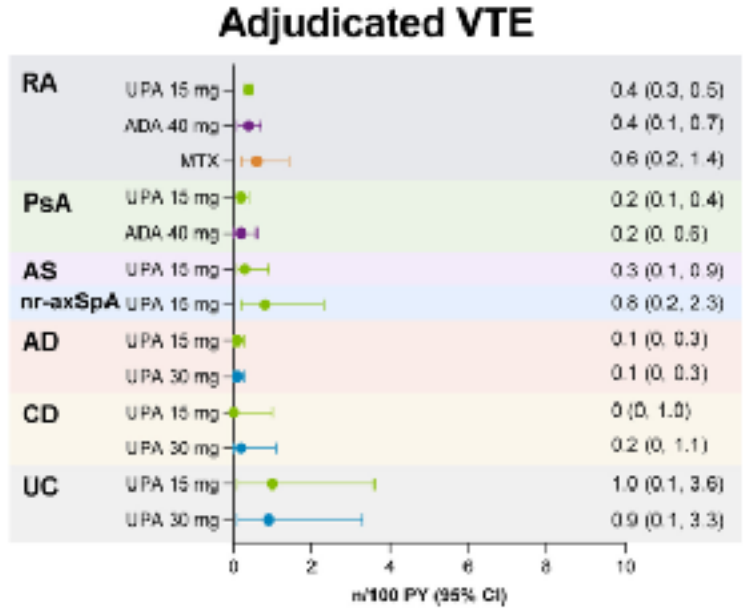
Exposition médiane à UPA = 4 ans (max = 8,5 ans)

Burmester G et al. Adv Ther 2025









Toci ou Upa ?

TOCILIZUMAB

Injectable

Pas de biomarqueur fiable

Pas d'effet sur la **voie Th1**

Suspensif …

UPADACITINIB

Tolérance ?

Moins de recul vs TCZ

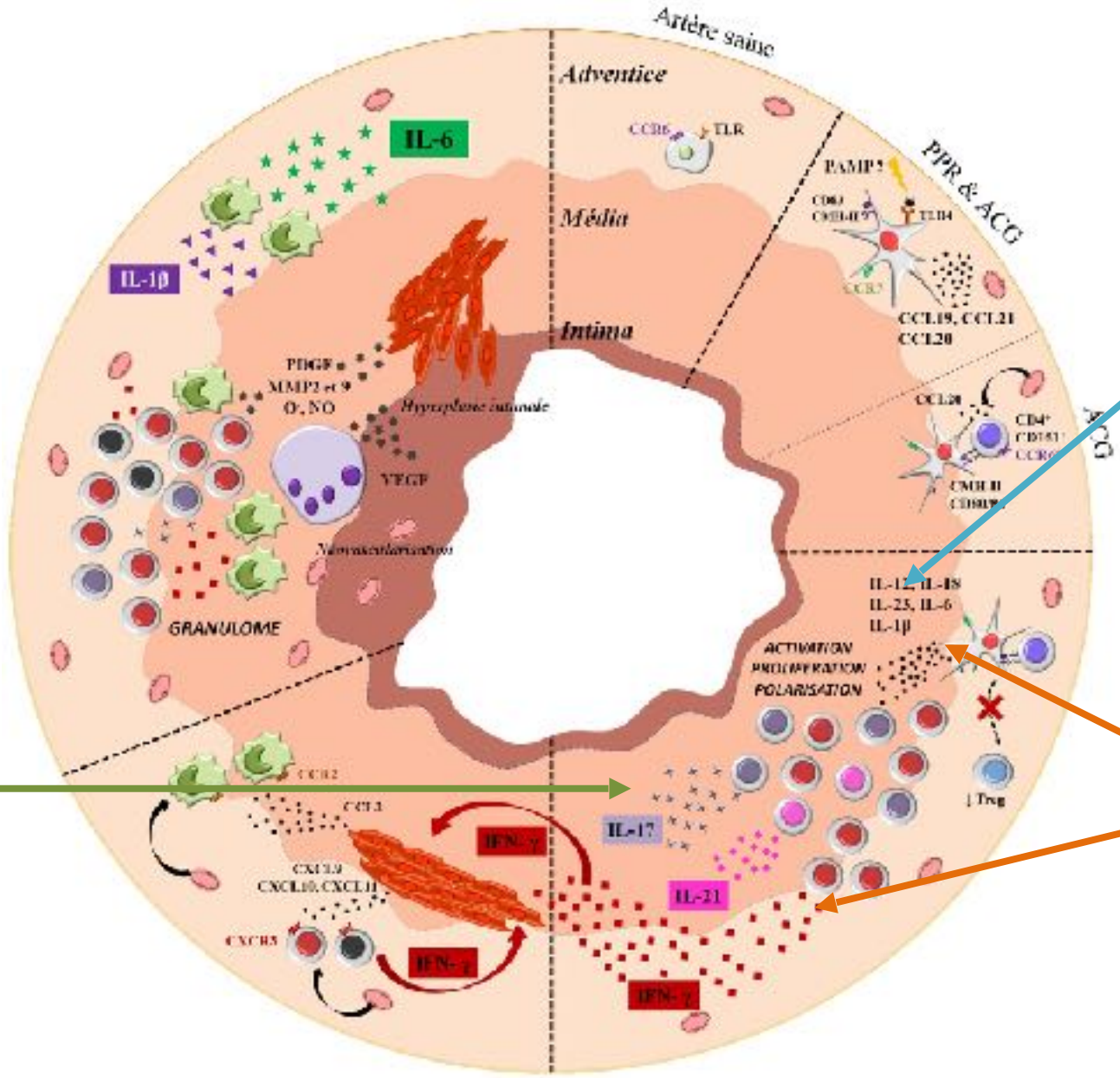
Suspensif …

ART-GCA

TCZ vs UPA en association à la prednisone (26 semaines) pour le traitement de l'ACG.

Projet accepté au PHRC-N 2026

Quelles sont les autres cibles thérapeutiques ?



Anti p19
(*guselkumab*)

THEIA study
Makhzoum JP et al. ARD 2026

Anti IL-17
(*secukinumab*)

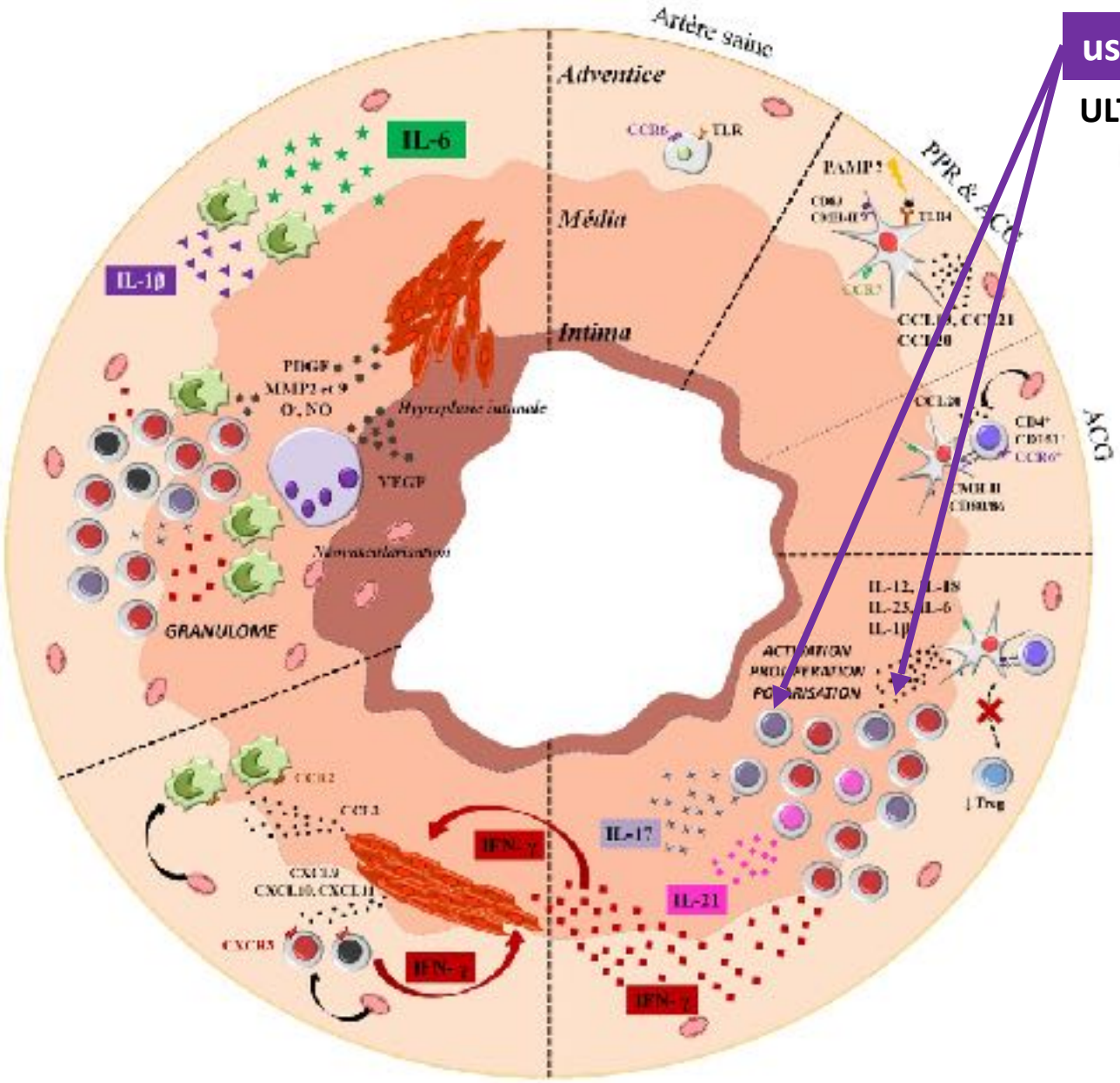
TiTAiN
GCAPTAIN

JAKi

SELECT-GCA

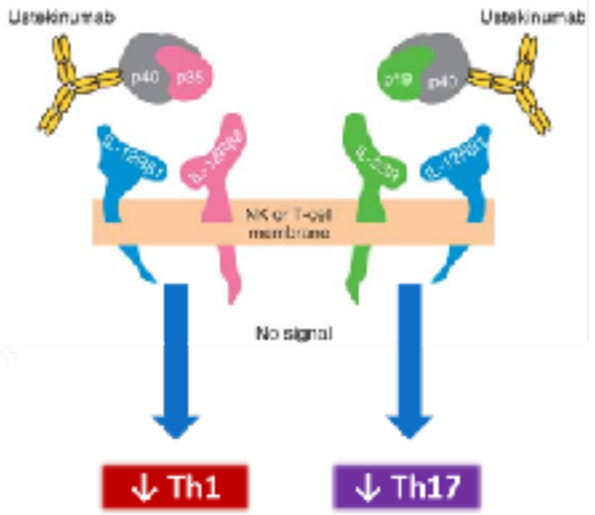
Samson M et al. 2019 Bulletin de l'Académie Nationale de Médecine. Volume 204, Issue 1, January 2020, Pages 18-28

Quelles sont les autres cibles thérapeutiques ?



ustekinumab

ULTRA



Benssen et al Nat Biotech 2011

Samson M et al. 2019 Bulletin de l'Académie Nationale de Médecine. Volume 204, Issue 1, January 2020, Pages 18-28

ULTRA: study design

Multicenter, randomized, open-label phase II superiority trial

Key inclusion criteria

- **GCA** confirmed by TAB and/or LVV imaging
- **Relapse** on prednisone ≤ 20 mg/d, after ≥ 12 weeks of treatment
- **CRP > 10 mg/L within 6 weeks**
- Relapse treated < 4 weeks before W0
- MTX stopped at W0

R

1:1, stratified on centre

Ustekinumab 90 mg SC
W0, W4, W16, W28 + prednisone

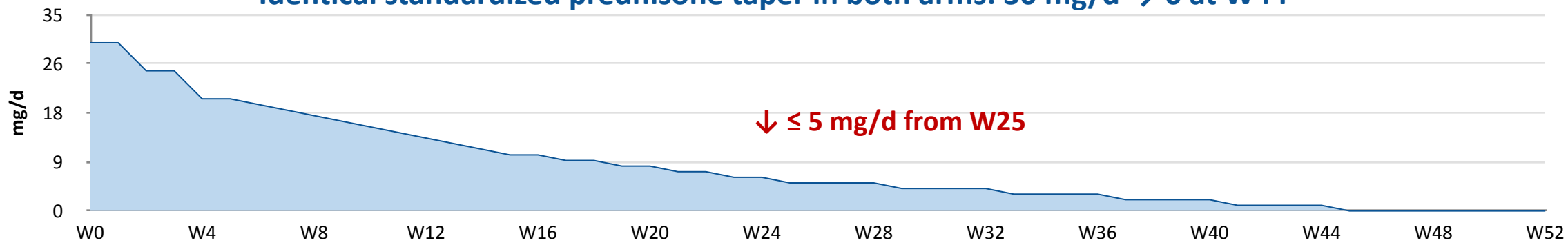
n = 20

Prednisone alone

n = 18

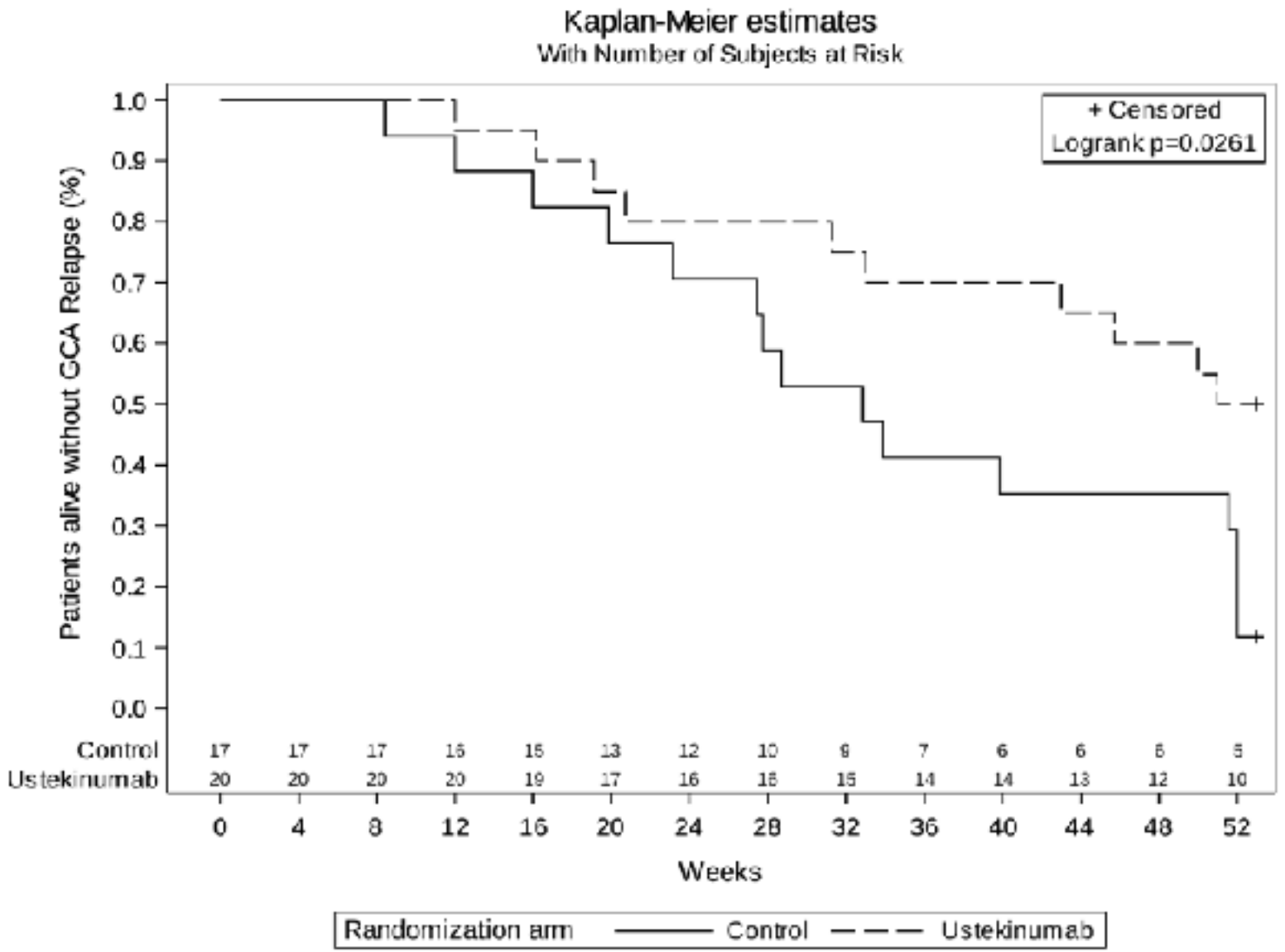
Primary endpoint
W52

Identical standardized prednisone taper in both arms: 30 mg/d → 0 at W44



Samson M et al. ACR 2026

Relapse-free survival: a delayed effect



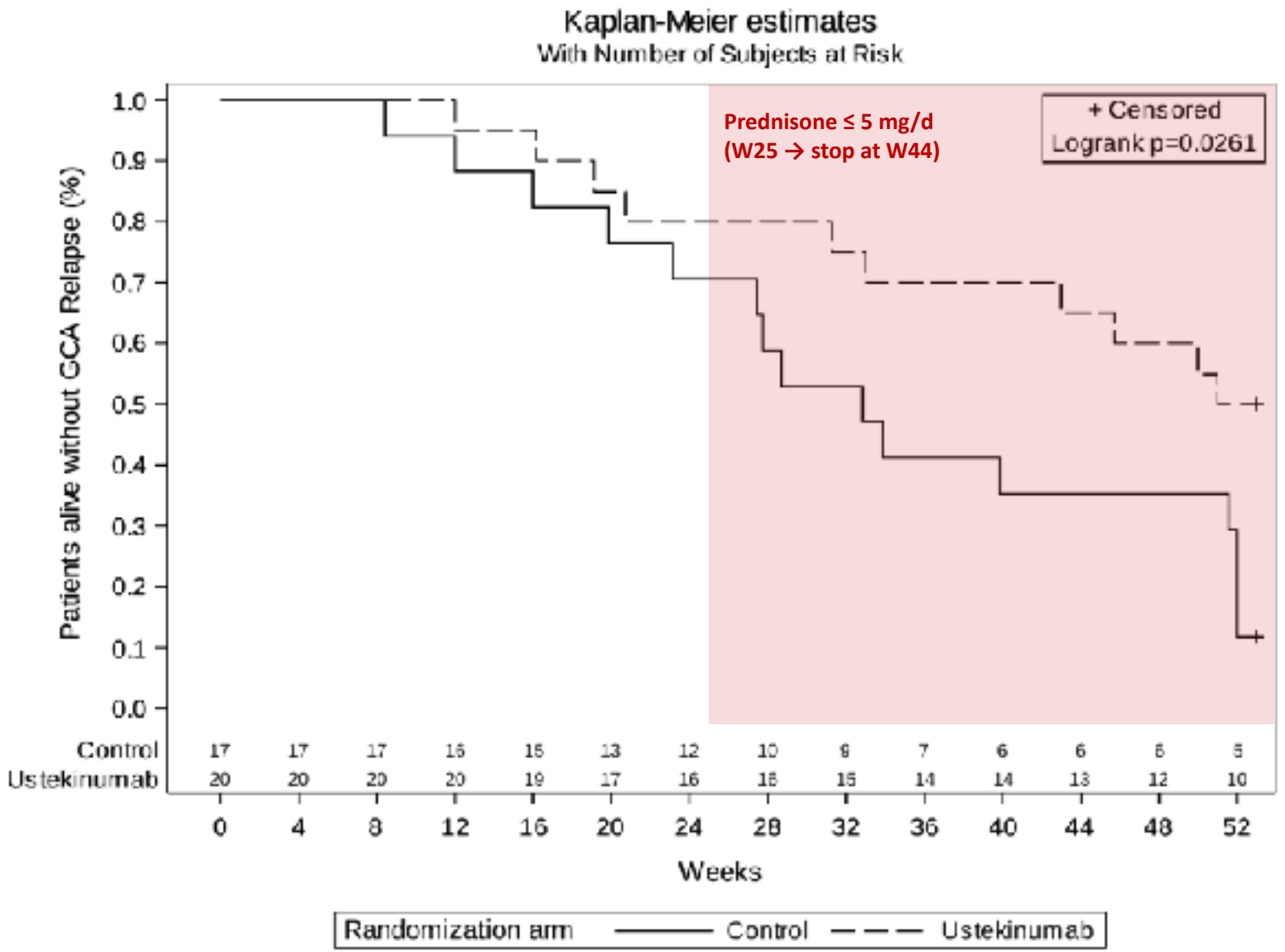
HR 0.42

95% CI 0.18 – 0.92

log-rank **p = 0.026**

Samson M et al. ACR 2026

Relapse-free survival: a delayed effect



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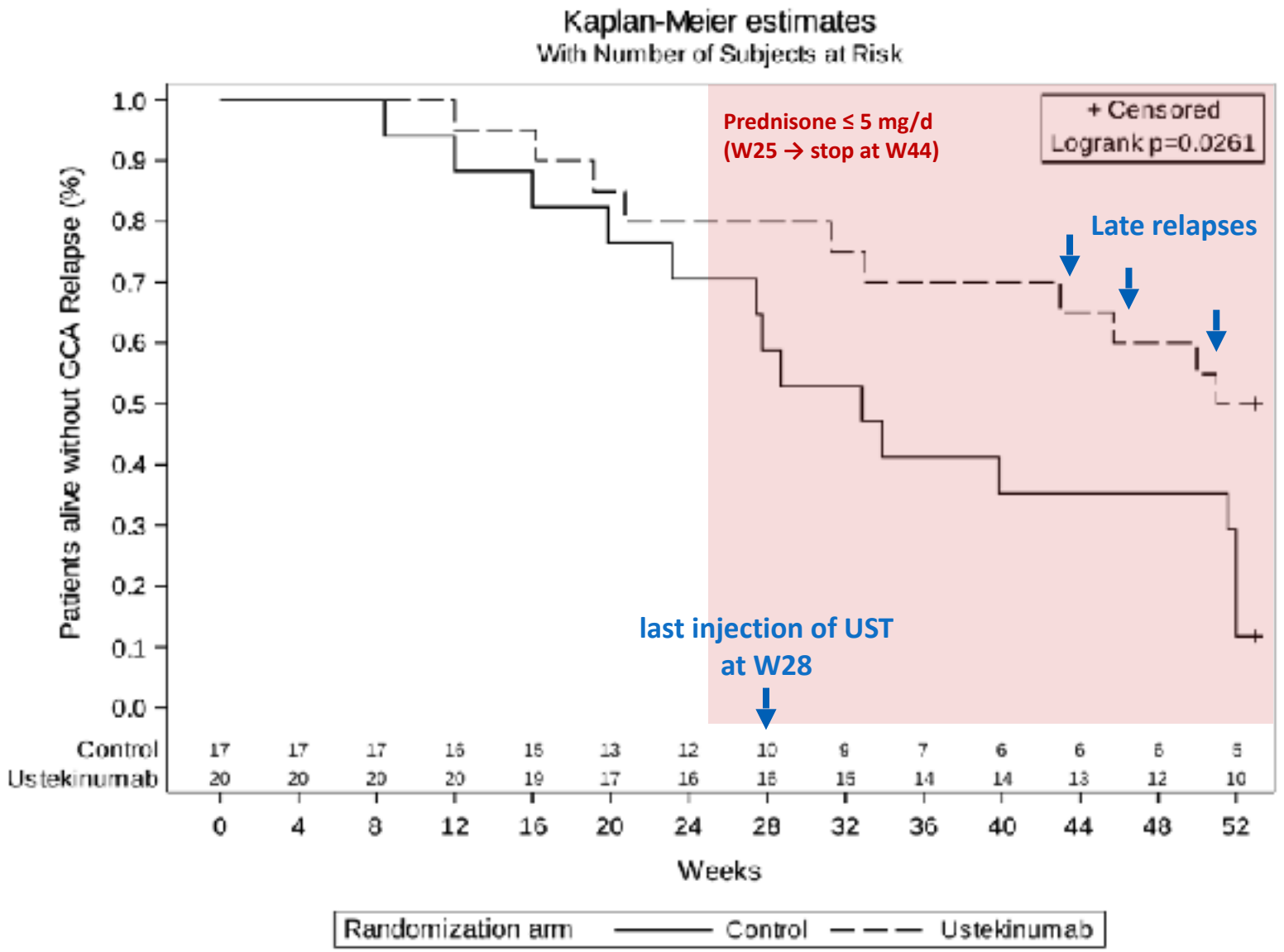
log-rank **p = 0.026**

Curves close until ≈ W24

They diverge once prednisone falls ≤ 5 mg/day ➔ **ustekinumab works… but slowly**

Samson M et al. ACR 2026

Relapse-free survival: a delayed effect



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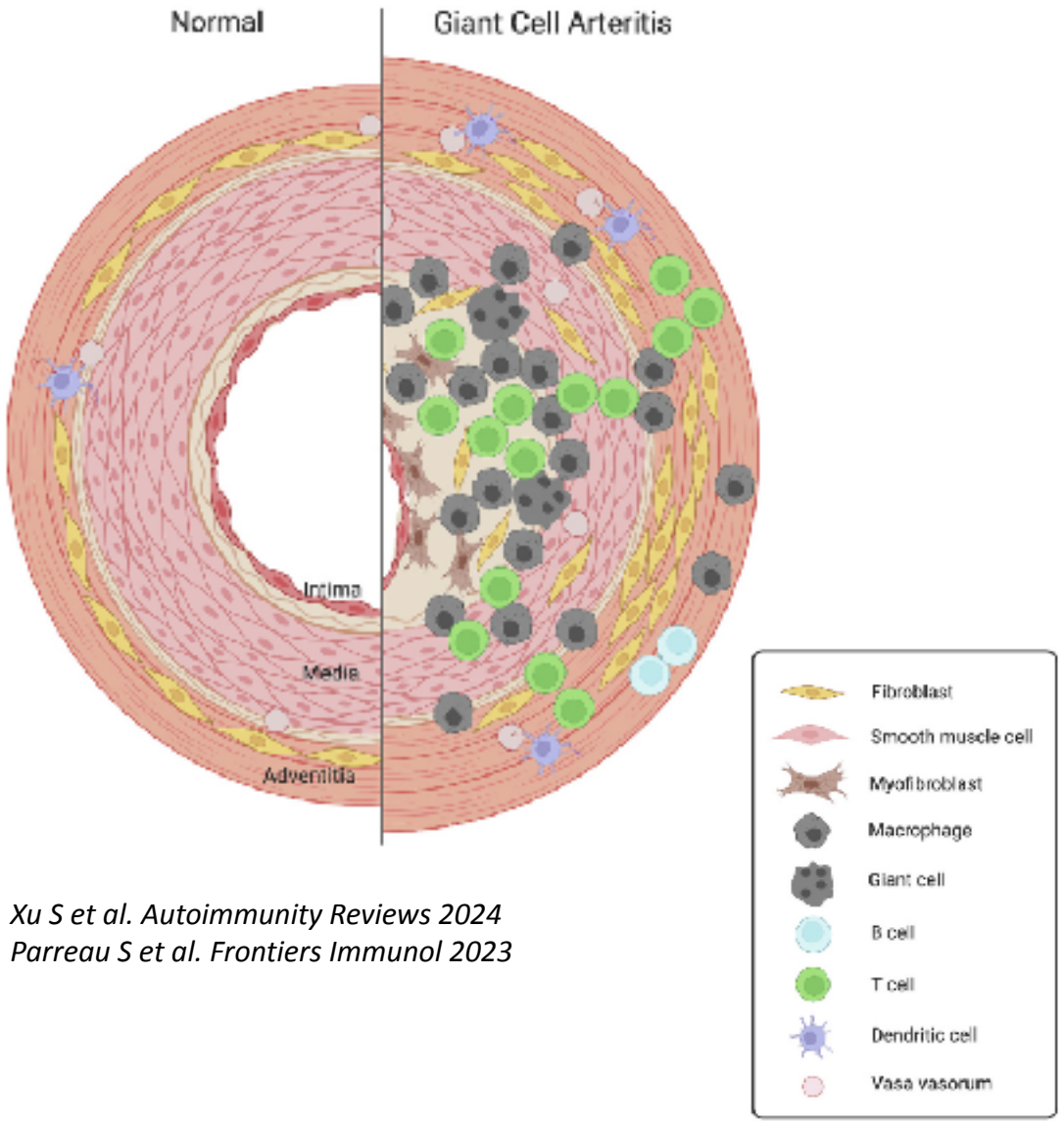
They diverge once prednisone falls ≤ 5 mg/day ➔ **ustekinumab works… but slowly**

Late relapses (W44–52) in the UST arm = **last injection at W28**

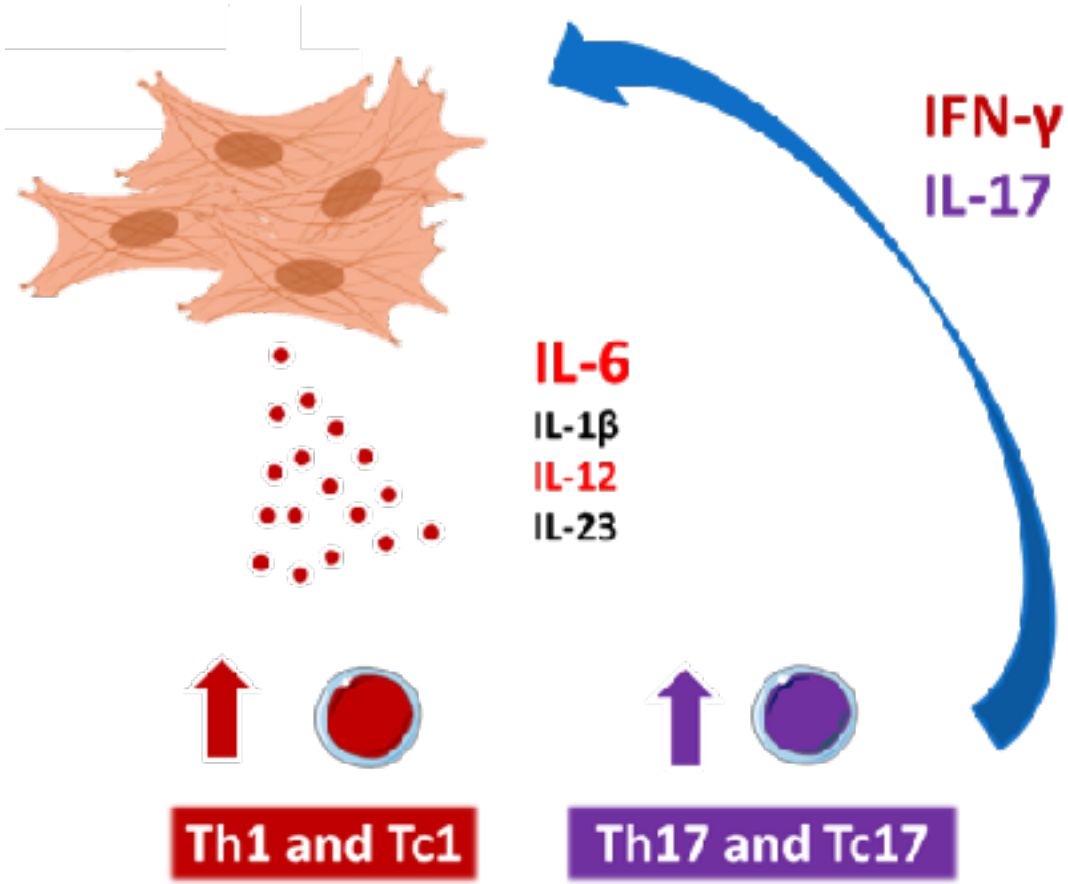
Samson M et al. ACR 2026

ACG « difficile à traiter »

Implication des cellules résidentes



Xu S et al. Autoimmunity Reviews 2024
Parreau S et al. Frontiers Immunol 2023

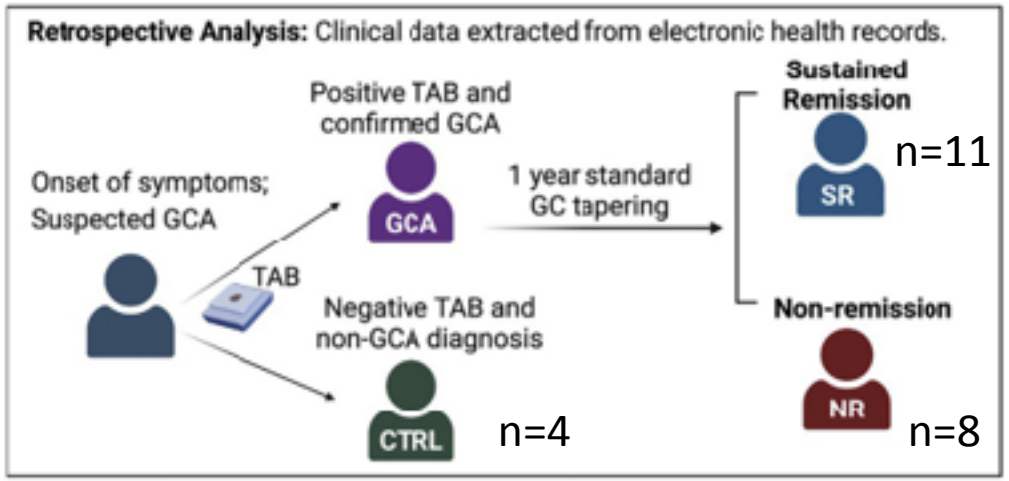


Greigert H et al. J of Autoimm 2023
Greigert H et al. Arthritis Rheum 2026

Spatial profiling of giant cell arteritis tissues reveals immune heterogeneity and potential predictors of glucocorticoid response

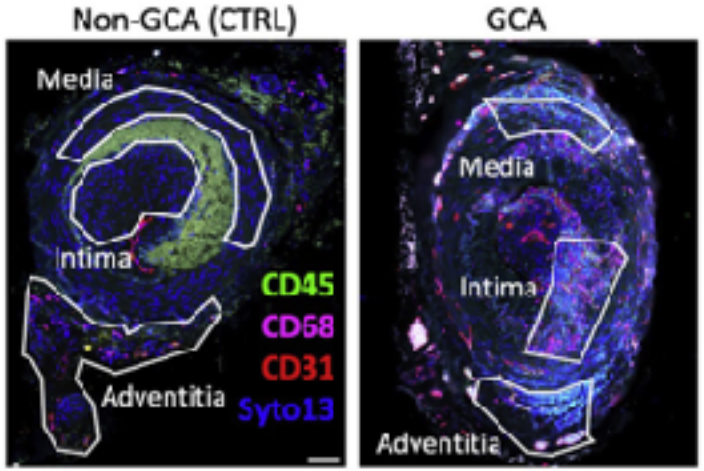
ARD 2025

Cecilia Ansalone[1,5], Samuel McAllister[1], Ethan S. Pickerill[2], Lin Zhang[2], David C. Gemperline[2], Annie Peacock[1], Ishita Gupta[1], Dominic Mcgovern[3], Victoria Kellior[1], Evelyn Qian[1], Aysin Tulunay Virlan[1], Maria Laura Vieri[1], Holly Leslie[4], Yoana Doncheva[4], Claire Kennedy Dietrich[4], Sylvia Wright[3], Paul Cauchi[3], Timothy Beckman[3], Lisa Hutton[3], John Cole[1], Nigel B. Jamieson[4], Isabella H. Wulur[2], Ajay Nirula[2], Iain E. McInnes[1], Robert J. Benschop[2], Carl S. Goodyear[1], Neil Basu[1,*]





GeoMx



Répondeurs = profil de réponse plasmocytaire IgG avec réponse T présente mais peu complexe

Non répondeurs = profil complexe :

- Activation des **cellules résidentes** (fibro, MF)
- Synthèse de **protéines de la matrice**
- **Réponse Th1 / IL-12**
- **LT mémoires**
- Pas/peu de réponse B

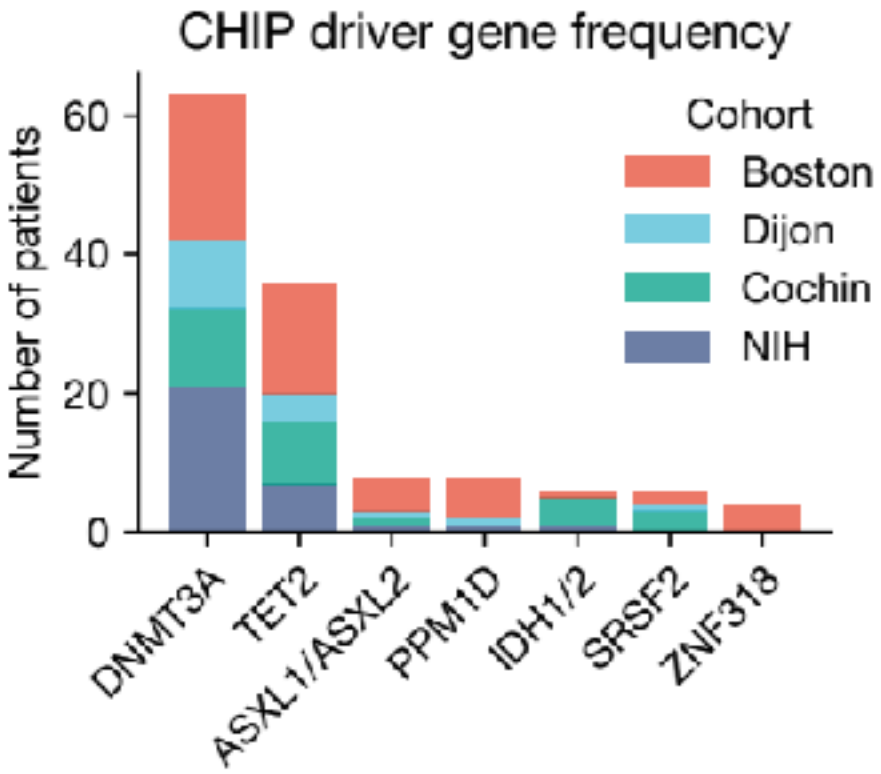
CHIP et ACG

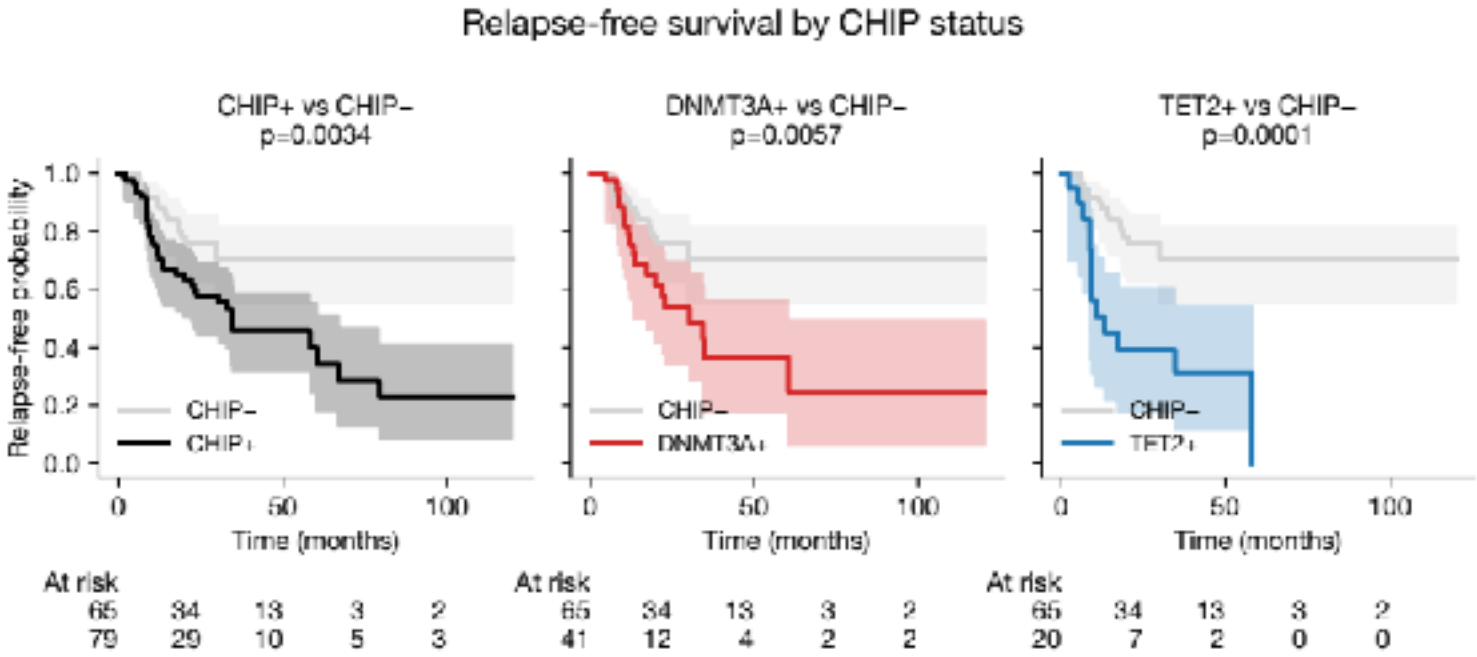
Métanalyse des cohortes génotypées dans l'ACG

Cohort	Original study	Size (n)	Age
Boston	Robinette et al., 2024	114	72
Cochin	This study	46	77
Dijon	This study	41	72
NIH	Gutierrez-Rodrigues et al., 2024	59	71
PSL	Cellier et al., 2026	40	73

Yatim N et al. ACR 2026

CHIP et ACG

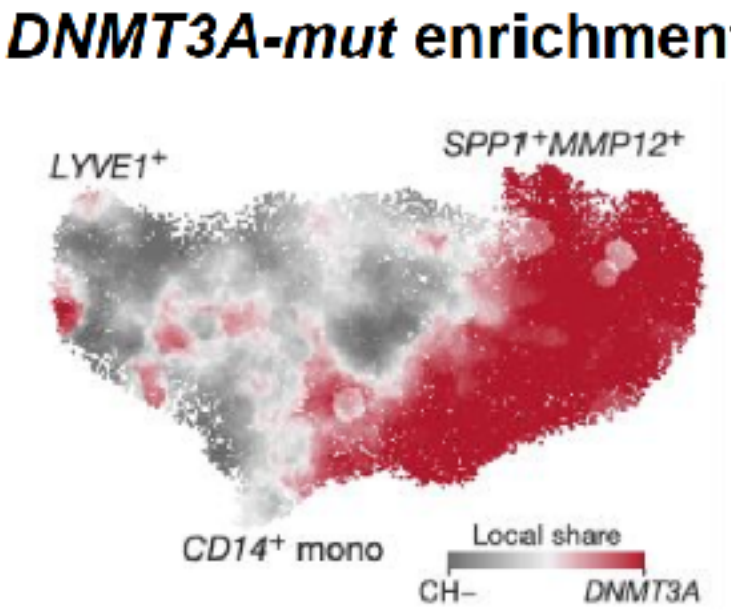




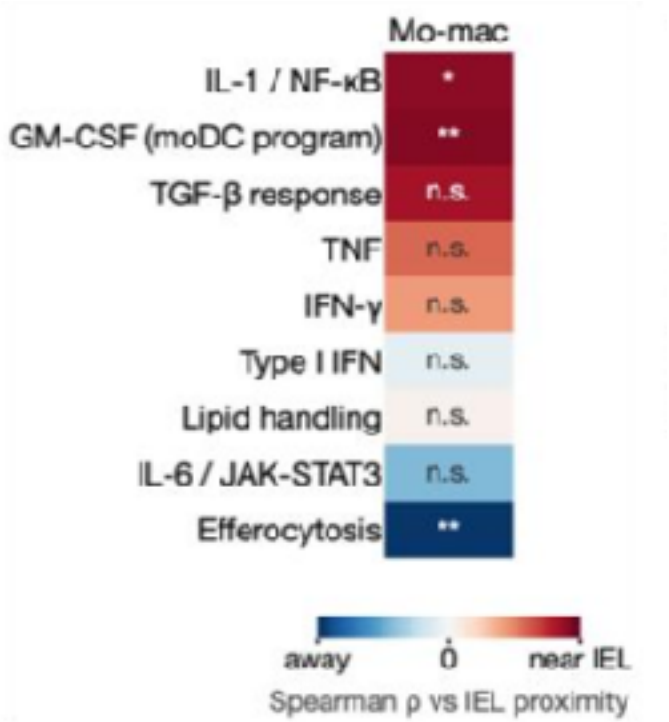
Yatim N et al. ACR 2026

CHIP et ACG

Transcriptomique spatiale de BAT+ CHIP+ vs CHIP-



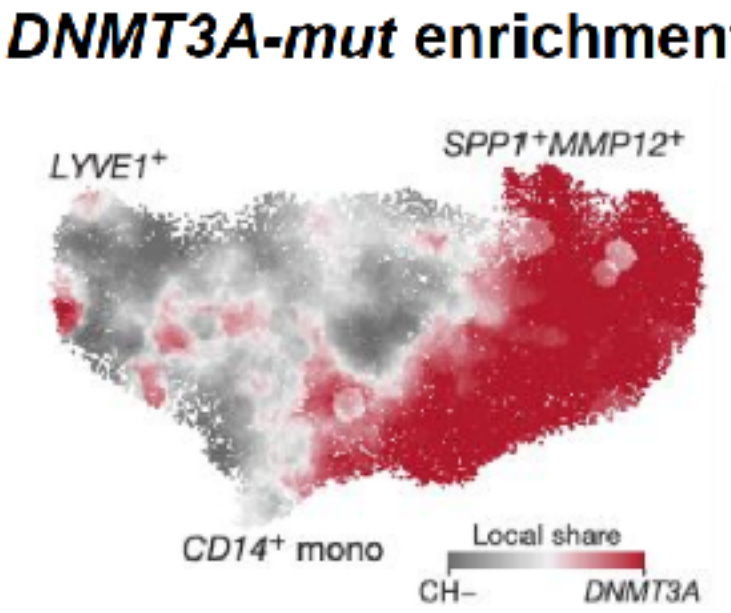
Programme enrichi au sein des Macro SPP1+ MMP12+



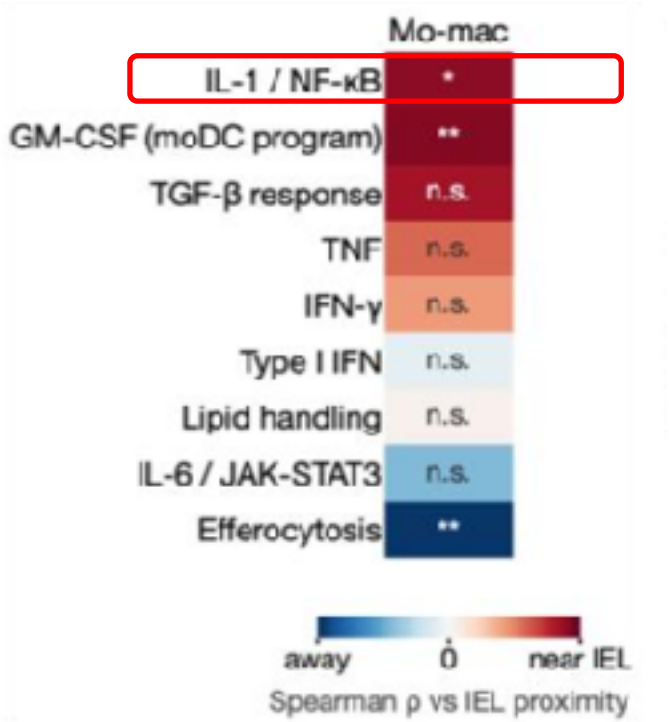
Yatim N et al. ACR 2026

CHIP et ACG

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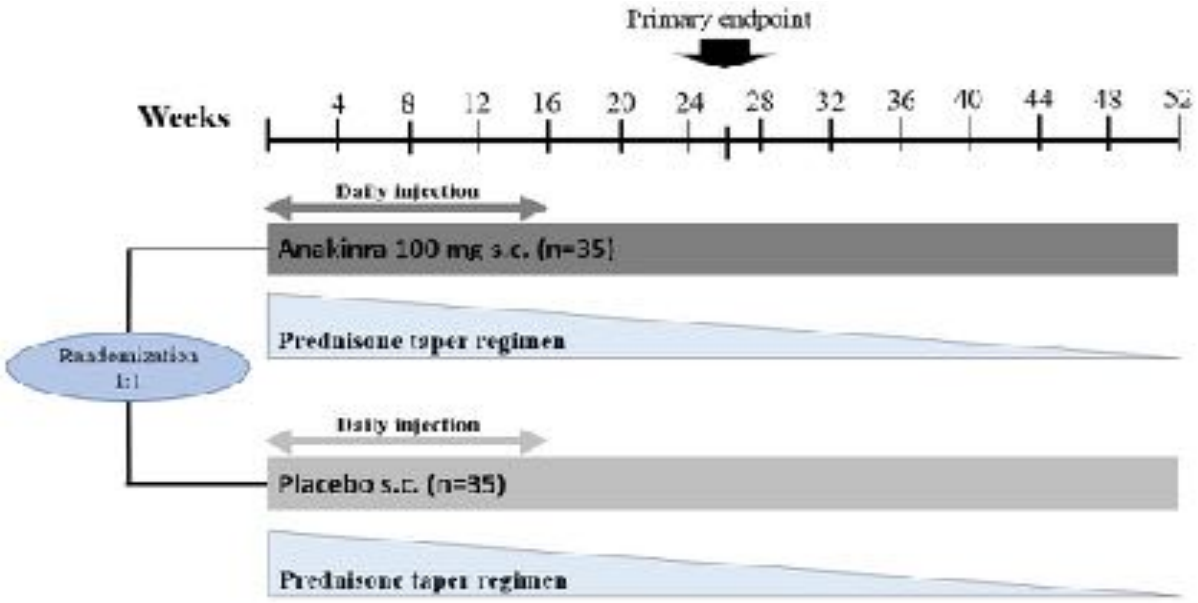
Yatim N et al. ACR 2026

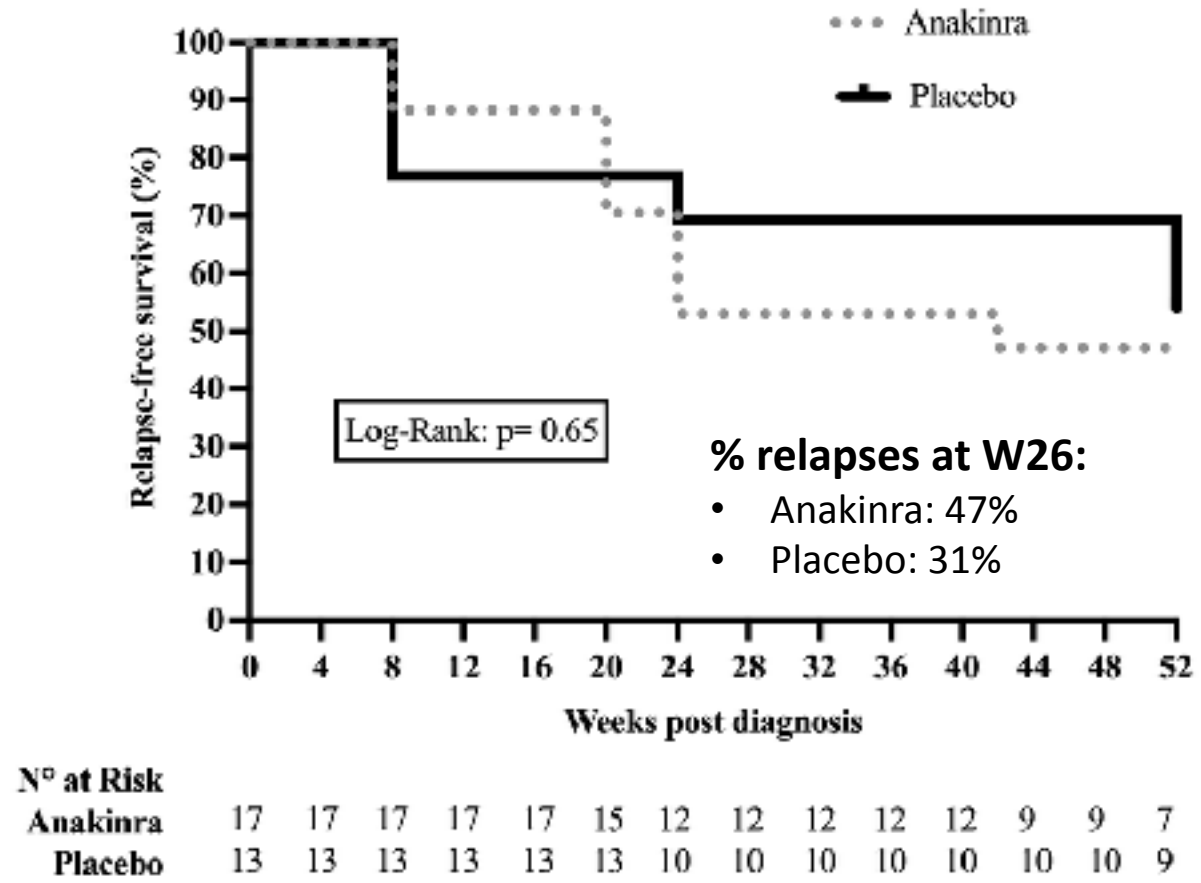
Etude GiANT

Pas d'effet significatif de l'anakinra sur le taux de rechute et l'épargne en corticoïdes

30 patients randomisés parmi les 70 prévus :

- Anakinra (n=17)
- Placebo (n=13)





% relapses at W26:

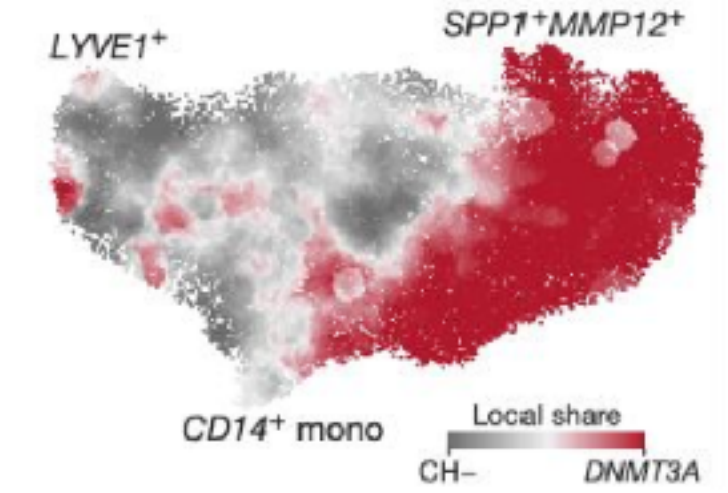
- Anakinra: 47%
- Placebo: 31%

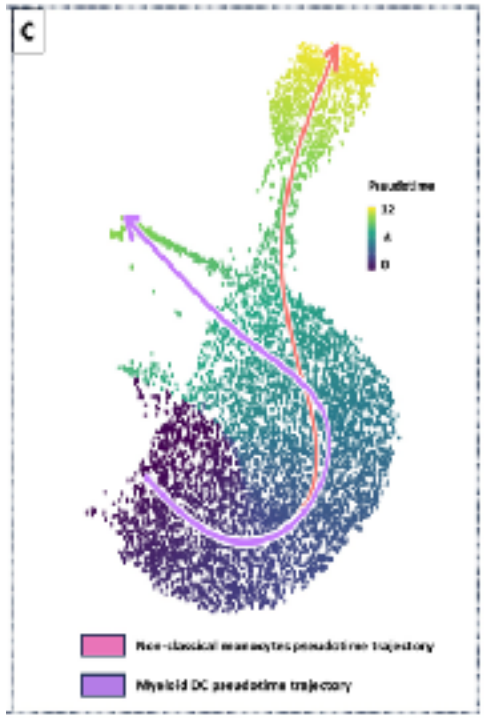
De Boysson H et al. ACR 2024

CHIP et ACG

Transcriptomique spatiale de BAT+ CHIP+ vs CHIP-

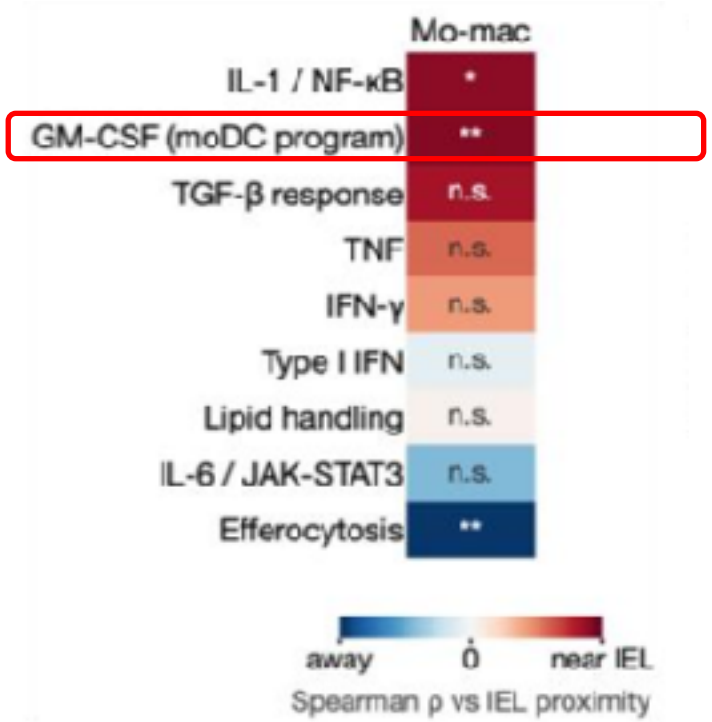
DNMT3A-mut enrichment





Ramon A et al. Sci Rep 2026

Programme enrichi au sein des Macro SPP1+ MMP12+

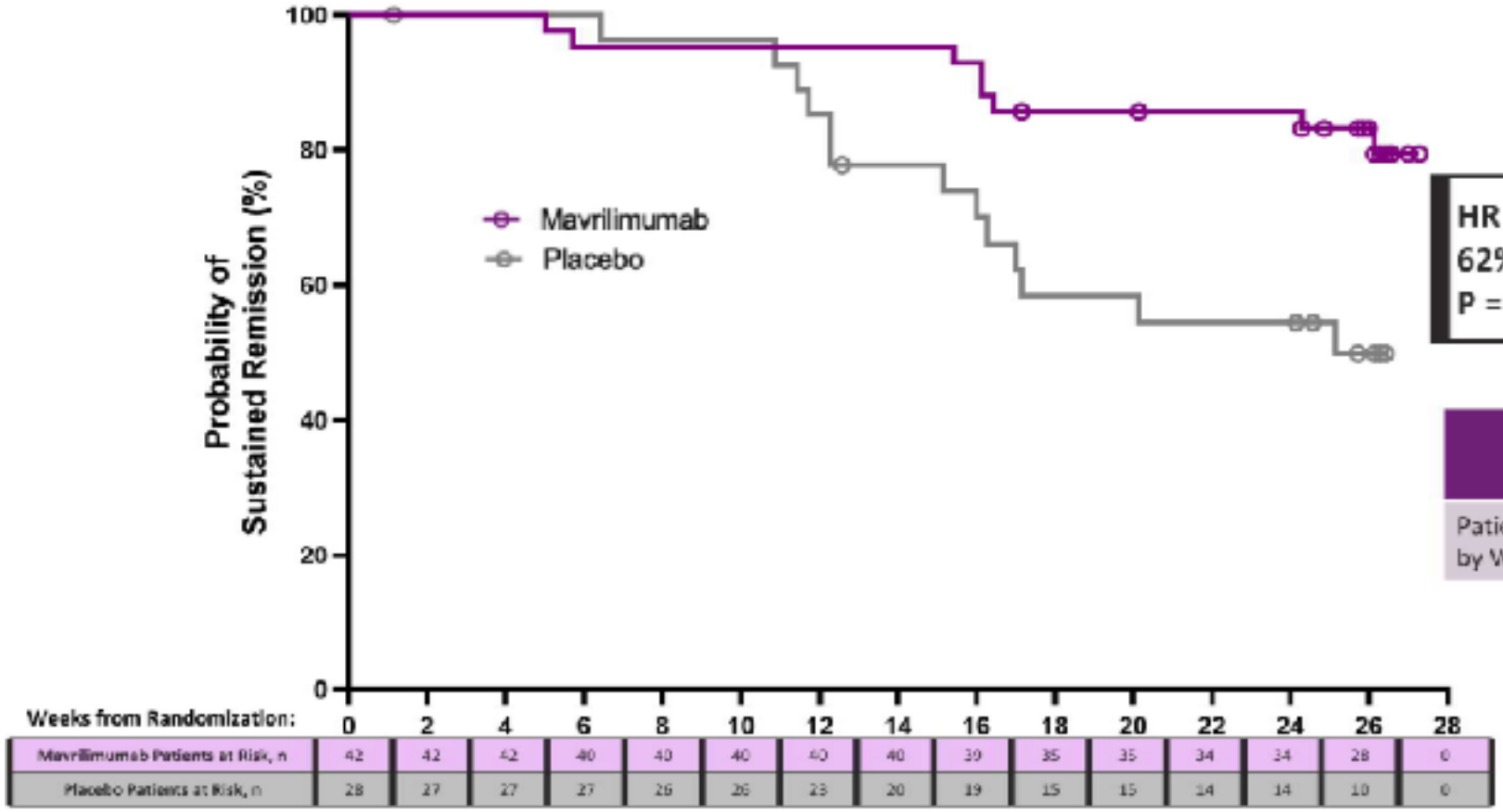


Yatim N et al. ACR 2026

Mavrilimumab au cours de l'ACG

Randomisé, contrôlé, double aveugle
70 patients (50% de rechutes)
Prednisone + placebo **26 semaines**
Prednisone + mavrilimumab 150 mg/2sem **26 semaines**

CRP, VS et imagerie **= pas d'aveugle**
Comité d'adjudication en aveugle
Rechute = signes cliniques ET CRP>10 mg/L



	Mavrilimumab (N=42)	Placebo (N=28)
Patients with Flare by Week 26, n (%)	8 (19)	13 (46.4)

Cid MC et al. ARD 2022

Conclusion : ACG en 2026-2027

Le PNDS se fait vieux (2024) et sera mis à jour en 2027

Une place plus large pour l'aspirine ?

Une place grandissante pour l'épargne en CS

TCZ et UPA = traitements d'épargne de référence

Quelle biothérapie pour quel patient ?



Quelle biothérapie pour quel patient ?

Majorité des patients

Traitements d'épargne :

TCZ **UPA**

ART-GCA

TCZ vs UPA (PHRC-N 2026) : lequel en première intention ?

MAGiCA

Comment arrêter ? Quels critères d'échec ?

Mais traitements suspensifs :
40 à 50 % de rechutes dans l'année suivant l'arrêt du TCZ

ACG « D2T »

≈ 10 %

(53/546, cohorte Dijon-Caen)

3 critères requis

- ≥ 2 rechutes
- CS > 5 mg/j à M24
- IS non sevrable à M24

Facteurs associés

- Sexe féminin
- Atteinte des gros vaisseaux
- Dose de CS à M6

Dhrif O et al. EULAR 2026

1 Traiter longtemps, sans corticoïdes

*Traitement suspensif prolongé : **prime à la tolérance***

TCZ	Pas de signal de surrisque CV au long cours (SNDS)	✓
UPA	Tolérance au long cours chez le sujet âgé à confirmer (JAKi)	?
UST / SEC ?	Moins efficace, effet retardé, mais bien toléré (ULTRA; G-CAPTAIN)	✓

2 Cibler ce qui entretient l'inflammation

Cellules résidentes	Fibroblastes, CML, **myofibroblastes**
CHIP	**DNMT3A**, **TET2** : rechutes, signature GM-CSF dans la paroi

Mavrilimumab ? **Anti-IL-1β ?**





Merci pour votre attention



