Abstract: P2240

Title: AVATROMBOPAG IN IMMUNE THROMBOCYTOPENIA (PTI). A REAL-WORLD STUDY OF THE SPANISH ITP GROUP (GEPTI).

Abstract Type: e-Poster Presentation

Topic: Platelet disorders

Background:

Thrombopoietin receptor analogues (TPO-RAs) are recommended as second-line treatment for immune thrombocytopenia (ITP). Avatrombopag (AVA) is an oral TPO-RA for which there are little real-world data available.

Aims:

The Spanish ITP Group (GEPTI) of the Spanish Society of Hematology and Hemotherapy (SEHH) recruited a cohort of ITP patients to assess:

● the efficacy/safety of AVA, especially in patients with severe ITP but also in those with moderate/mild disease.

● the ability of AVA to succeed in patients where other TPO-RAs had failed.

● the ability of AVA to reduce concomitantly used immunosuppressant treatments.

● if the efficacy/safety of AVA in newly diagnosed/persistent ITP patients is similar to chronic ITP ones.

Methods:

AVESPA was a nation-wide, multicenter, retrospective study. Patients who attended hospital between July 2022 and November 2023 with a diagnosis of ITP or who were diagnosed with ITP for the first time and started AVA treatment were recruited. Rates and time to response (R) (^{3}50x109/L) and complete response (CR) (^{3}100x109/L), duration of response (DOR), loss of response (LOR), adverse events (AEs) and treatment withdrawal before follow-up end were assessed. Calculations were performed on the entire cohort and on patients presenting initially with either severe (<50x109/L), moderate (50-<100x109/L) or mild (^{3}100x109/L) ITP.

Results:

Two-hundred and forty patients were recruited in 26 Spanish hospitals and followed for a median (interquartile range) of 30.3 (16.0, 38.9) months (Table 1). Median age was 59.3 years, and 57.6% patients were female. ITP was primary in 86.9% of cases. When AVA treatment started, 176, 38 and 26 patients presented with severe, moderate or mild ITP, respectively. In the group of severe ITP, CR and either R or CR was achieved in 137/176 (77.8%) and 158/176 (89.8%) patients, respectively. Median time to response was 13 days for R and 14 for CR. By the end of follow-up [31.6 (16.5, 39.1) months], response was maintained in 70.2% patients [DOR ^{3}29.7 (10.1, 35.0) months]. Age and sex did not influence response but the number of previous treatments did: R/CR was achieved in 112/118 (94.9%) and 44/56 (78.6%) patients with £3 or >3 previous failed treatments, respectively, P=0.002). CR and R or CR was achieved in 54/76 (71.0%) and 65/76 (85.5%) patients who had been unsuccessfully treated with eltrombopag and/or romiplostim. The dose of steroids/other immunosuppressants that were concomitantly administered in 35 patients was reduced or discontinued in 25 (71.4%) of them. LOR and rescue treatments were reported in 29.7% and 28.9% patients, respectively. Six (3.4%) patients had grade 2-4 bleeding episodes. Forty-two (23.9%) patients had ^{3}1 AE, which were mostly mild and transient. Five (2.8%) patients had a thromboembolic episode (TEE). AVA was suspended in 17 (9.7%) patients with counts >400x109/L. Altogether, 61 (34.7%) patients discontinued AVA by follow-up end. The efficacy/safety of AVA was comparable between newly diagnosed/persistent severe ITP and chronic severe ITP

patients (CR: 83.0% vs. 75.2%; CR or R: 95.7% vs. 87.2%; LOR: 35.6% vs. 28.4%; TEE: 0% vs. 4%; thrombocytosis: 8.5% vs. 12.0%, respectively). Finally, CR was achieved by 31/38 (81.6%) moderate ITP patients, and maintained in 24/26 (92.3%) mild ITP patients, with LORs of 17.1% and 11.5% respectively. In the last group, thrombocytosis-caused withdrawal rose to 30.8%.

Summary/Conclusion: In this large real-world study, trial findings are confirmed. AVA can be safely used to treat chronic ITP even where other TPO-RAs have failed. AVA seems to be suitable to treat newly diagnosed and persistent ITP.

Table 1. Main variables at baseline and throughout the study

Reported variables	Whole cohort, n=240	Basal counts <50x10^9, n=176
Age at AVA start, years	59.3 (42.2, 73.4)	59.3 (45.5, 71.5)
Sex, female, n (%)	136 (57.6)	94 (54.6)
ITP type, primary, n (%)	206 (86.9)	148 (85.5)
Time since ITP diagnosis		
Newly diagnosed (<3 mo), n (%)	23 (9.7)	19 (11.0)
Persistent (3-12 mo), n (%)	32 (13.5)	28 (16.3)
Chronic (>12 mo), n (%)	182 (76.8)	125 (72.7)
N° of previous treatments	2 (1, 4)	2 (1, 4)
≥1 TPO-RA before AVA, n (%)	143 (59.6)	95 (54.0)
Reason of switching to AVA		
Easier posology, n (%)	37 (16.2)	8 (4.8)
LOR/low efficacy, n (%)	149 (65.3)	125 (74.8)
AEs, n (%)	12 (5.3)	7 (4.2)
Other/several/n.a., n (%)	30 (13.2)	27(16.2)
Current (maintenance) AVA dose		
20 mg, n (%)	35 (14.9)	28 (16.2)
40 mg, n (%)	44 (18.7)	35 (20.2)
Other, n (%)	124 (52.8)	86 (49.7)
n.a. (AVA withdrawn)	32 (13.6)	24 (13.9)
Follow-up since AVA start (mo)	30.3 (16.0, 38.9)	31.6 (16.5, 39.1)
Best response achieved		
CR, n (%)	192 (80.0)	137 (77.8)
Days to CR	n.a.	14 (9, 33)
R, n (%)	27 (11.2)	21 (11.9)
Days to R	n.a.	17 (11, 28)
NR, n (%)	21 (8.7)	18 (10.2)
Response maintained by follow-up end, n (%)*	160 (75.1)	111 (70.2)
Duration of response (weeks)†	≥28.0 (10.3, 35.4)	≥29.7 (10.1, 35.0)
CMT dose lowered after AVA start, n/N (%)	37/69 (53.6)	31/58 (53.4)
LOR, n (%)‡	56 (25.6)	47 (29.7)
Rescue required after R/CR§	52 (25.2)	43 (28.9)
Bleeding grade 2-4 while on AVA, n (%)	8 (3.4)	6 (3.6)
≥1 AE while on AVA, n (%)	70 (30.6)	42 (25.4)
Thromboembolic event, n (%)	6 (2.6)	5 (3.0)
AVA withdrawn bc of counts >400x10^9, n (%)	32 (13.3)	17 (9.7)
AVA withdrawn bc of other AEs, n (%)	14 (5.8)	9 (5.1)
AVA withdrawn bc of no response, n (%)	32 (13.3)	28 (15.9)

Results are median (IQR), except otherwise indicated. *Those who achieved no response are not considered to calculate percentages. †In those patients who did not have LOR nor required AVA withdrawal, the time between the end of follow-up and the date when response was either achieved (if basal counts were <50x10^9/L) or maintained (if basal counts were 50-100x10^9/L or ≥100x10^9/L) was calculated. ‡Percentages calculated considering only those patients who achieved response (if basal counts were <50x10^9/L) or maintained response (if basal counts were 50-100x10^9/L or ≥100x10^9/L). §Rescue due to bleeding or thrombocytopenia. AEs, adverse events; AVA, avatrombopag; Bc, because; CMT, concomitant medical treatment; CR, complete response; CTC, corticosteroids; IQR, interquartile range; mo, months; n.a., not applicable; NR, no response; LOR, loss of response; R, response; TPO-RA, thrombopoietin receptor agonist.

Keywords: Autoimmune disease, ITP, Thrombocytopenia