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Review Article

A BRIEF REVIEW ON WEGENER'S GRANULOMATOSIS AND ITS TREATMENT

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Abstract:

Wegener's Granulomatosis (WG) which is otherwise called as Granulomatosis with polyangiitis (GPA) is an uncommon multi system autoimmune diseases, which is exceptionally connected with Anti-Neutrophil Cytoplasmic Antibodies (ANCA). Wegner's Granulomatosis is a complex multisystem vasculitic disease characterized by necrotizing small arteries and veins of unknown reason. In WG remission can be accomplished by regular immunosuppressive treatment. The causes of WG includes infectious and environmental triggers, drug induced ANCA-associated vasculitis (AAV) and also genetic factors. Staphylococcus aureus is a common micro-organism implicated in the pathogenesis of WG and the repeating, relapsing nature of the disease might be connected to steady colonization of nasal sections with this organism. Staphylococcus aureus creates super antigens which activate B and T Cells, and through a procedure of sub-atomic mimicry Staphylococcus aureus can likewise actuate AAV. The symptoms of WG include fevers, conjunctivitis, rhinitis, cough, myalgia, and necrosis. The diagnostic tests include ANCA testing, chest radiography, CT scanning, abnormal kidney function tests etc. Wegener's granulomatosis affects various organs such as heart, eye, kidneys and lungs. Treatment of WG is considered to have two stages: induction, where active infection is put into remission; and support, where remission is managed. The backbone of treatment for WG is a mix of corticosteroids and cytotoxic agents.

Keywords: *Wegener's granulomatosis, vasculitis, Anti-Neutrophil Cytoplasmic Antibodies, cyclophosphamide.*

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INTRODUCTION:

Wegener's Granulomatosis (WG) which is otherwise called Granulomatosis with polyangitis (GPA) is an uncommon multisystem immune system sickness which is exceptionally connected with Anti-Neutrophil Cytoplasmic Antibodies (ANCA). Its clinical highlights incorporate Necrotizing Granulomatosis Inflammation, Pauci-resistant Vasculitis in little and medium sized blood vessels. Wegener's Granulomatosis is a complex multisystem vasculitic disease of unknown reason. Although once quickly dynamic and frequently lethal, WG is presently a reasonable condition in which remission can be accomplished by regular immunosuppressive treatment. It was previously known by the eponymous name, Wegener's Granulomatosis, after Friedrich Wegner who portrayed the clinical group of three related with this sickness in 1963. The utilization of ailment enlightening, etiology based terminology is currently prescribed and desirable over the utilization of eponymous names, along these lines since 2011 Wegener's Granulomatosis has been known as Granulomatosis with Polyangitis. This was suggested by the American school of rheumatology. European alliance against ailment and American culture of nephrology and is the name which ought to be utilized as a part of clinical practice and restorative writing for the ANCA – related vasculitis previously known as Wegener's Granulomatosis [1]. Figure 1 and 2 shows the clinical presentation of WG in a patient.



Fig 1: Necrotic, purpuric and blistering plaque on the wrist in patient with WG



Fig 2: Several necrotic, purpuric and blistering papules and plaques on the hands in a patient with WG

Classification

The American college of Rheumatology (ACR) classification criteria for Granulomatosis with Polyangitis (Formerly, Wegener's Granulomatosis) [2]. This is shown in the following Table 1.

Table 1: ACR's classification criteria for Wegener's Granulomatosis.

TYPE	DESCRIPTION
Nasal or oral inflammation	Painful or painless oral ulcers or purulent or bloody Nasal discharge
Abnormal chest radiograph	Pulmonary nodules, fixed pulmonary infiltrates or Pulmonary cavities
Abnormal urinary sediment	Microscopic haematuria with or without red cell casts
Granulomatosis inflammation	Biopsy of an artery or perivascular area shows granulomatosis inflammation

For the reasons for order, a patient is said to have GPA if no less than 2 of these 4 are available. The nearness of any at least 2 criteria yields an affectability of 88.2% and a specificity of 92%.

Epidemiology

The yearly rate of WG is 5-10 cases for every million populace with measure up to recurrence in guys and females. WG is exceptionally uncommon in adolescence and young grown-ups. The announced pinnacle rate of WG is in the seventh decade of life between the ages of 65 and 70 years [3]. The distributed point pervasiveness of WG goes in the vicinity of 24 and 157 cases for every million with a particularly higher predominance of WG among Caucasians, especially those from northern Europe, contrasted with Asian, African, Afro-Caribbean and African-American populations [4].

Aetiology

Irresistible triggers

Irresistible triggers incorporate bacterial, mycobacterial, contagious (or) viral diseases of the ears, nose and respiratory tract. *Staphylococcus aureus* nasal carriage is a typical trigger of WG flares.

Natural triggers

Natural triggers which may add to the beginning of GPA are contamination, smoking, breathed in poisons,

breathed in chemicals and introduction to metals, for example, mercury or lead.

Medication induced ANCA-related vasculitis

Cases of medication known to trigger medication prompted ANCA vasculitis are antibiotics: cefotaxime, minocycline hostile to thyroid medications: benzylthiouracil, carbimazole, methimazole, propylthiouracil against TNF alpha agents: adalimumab, infliximab; psychoactive drugs: clozapine; other drugs: cocaine, d-penicillamine and phenytoin [5].

Hereditary qualities

There is an expansion susceptibility to Proteinase 3 ANCA related vasculitis with certain hereditary variants. Single nucleotide polymorphisms (SNPs) in specific qualities may incline to WG. A SNP in SERPINA1 a quality α -antitrypsin, which is a neural serine protease inhibitor of the Proteinase 3 compound, is connected to GPA and a SNP in PRTN3, a quality which encodes Proteinase 3 is additionally connected with WG. CTLA-4 quality polymorphism is connected to the improvement of WG in light of the fact that the activity of T lymphocytes is restrained because of faulty authoritative of CTLA-4, communicated for the most part on CD4+ T lymphocytes, to CD80 and CD86 on antigen presenting cells (APCs) [6].

Pathophysiology

The immuno pathogenesis of WG is unpredictable. At present the immuno pathogenesis of WG is thought to originate from ecological (or) infectious triggers in a hereditarily predisposed person who needs resistance to ANCA self-antigens. The harmful triggers prompt a inflammation reaction with secretion of pro-inflammatory cytokines and ANCA generation in hereditarily pre-disposed individuals. Staphylococcus aureus is a common micro-organism implicated in the pathogenesis of WG and the repeating, relapsing nature of the disease might be responsible for nasal secretions. Staphylococcus aureus creates super antigens which activate B and T Cells, and through a procedure of sub-atomic mimicry which, in turn activate AAV.

Patients with WG by and large have increased B lymphocytes stimulator factor, for example, B cell activation factor and relative abundance of T follicular assistant cells contrast with healthy individuals [7, 8]. These self-responsive B lymphocytes may develop into long - lived plasma cells which emit ANCA, the pathogenic neutralizer related with WG, which ties to Proteinase 3 on neutrophil and monocyte surfaces. In the presence of ANCA, neutrophils and monocytes create and discharge reactive oxygen species, proteases, cytokines and neutrophil extracellular trap

products (NET-inferred items) are generated. Dendrite cells can be enacted by NET-determine item through Toll-like receptor (TLR) and the arrival of interferon alpha (IFN- α) disables T regulatory cell function. Activation of the complement supplement pathway, brings about the arrangement of film attack complex (C5b6789 MAC) which advance ANCA related neutrophil initiation, irritation and tissue damage. These pro-inflammatory pathways prompt the advancement of necrotizing foundational vasculitis, necrotizing glomerulo nephritis and granulomatosis irritation predominantly of the aviation routes, which are signs of WG.

Clinical manifestations

Signs and symptoms

- Fevers, night sweats
- Fatigue
- Loss of hunger
- Weight loss

Ophthalmic appearances

- Conjunctivitis
- Optic nerve vasculitis
- Retinal artery occlusion

Ear, nose and throat appearances [9, 10]

- Chronic sinusitis is the most widely recognized starting grumbling in GPA
- Rhinitis
- Epistaxis
- Collapse of nasal support, bringing about seat nose disfigurement
- Serous otitis media and hearing loss

Pulmonary

- Pulmonary invades
- Cough
- Hemoptysis
- Chest distress

Musculoskeletal indications

- Myalgia
- Arthralgia
- Arthritis

Renal signs

- Crescentic necrotizing glomerulonephritis portrayed by urinary residue with more than 5 RBCs for every HPF or erythrocyte casts
- Renal disease is available in 17% of patients at initials finding and is typically asymptomatic [11]

Nervous system indications

Periphery sensory system (PNS) contribution may happen in upwards of 67% of patients, commonly later in the illness course, and incorporates the accompanying:

- Mononeuritis multiplex
- Sensorimotor polyneuropathy
- Cranial nerve paralyses

CNS signs incorporate vasculitis of little to medium sized blood vessels of the brain or spinal cord and granulomatosis masses that include the orbit, optic nerve, meninges, or brain [12].

Cutaneous signs

- Palpable purpura or skin ulcers, ulcerations may look like pyoderma gangrenosum.
- Petechiae, vesicles, pustules, hemorrhagic bullae, livedo reticularis, digital necrosis and genital ulcers looking like squamous cell carcinoma have been accounted.

Extra findings

- Cardiac: Pericardial rub, myocardial localized necrosis or sudden death.
- Gastrointestinal: Abdominal torment might be available with splanchnic vasculitis.

Diagnosis

- Antineutrophil Cytoplasmic immune response (ANCA) testing
- Chest radiography and CT examining
- Blood tests
- Urine analysis
- Tissue biopsy
- Others
- Sinus CT scanning
- Pulmonary testing
- Bronchoscopy

Wegener's granulomatosis affects the following organs

Wegener's granulomatosis with heart involvement

Heart association of Wegener's granulomatosis was first announced by Wegener in 1936 [13]. Classical or summed up WG is portrayed by necrotizing Granulomatosis vasculitis of the upper and lower respiratory tract together with glomerulonephritis. Widespread scattered vasculitis including both little courses and veins strikes a more prominent or lesser degree as the illness progresses. A restricted type of WG constrained essentially to the upper and a lower respiratory tract has been described. Despite histopathological determination of WG, with auto antibodies against to circulatory neutrophilic cytoplasmic antigens, we can analyze WG effectively

and early. WG must be remembered as the differential finding of expanded cardiomyopathy, particularly in the presence of pneumonic and renal pathologies. The clinical introduction of WG can be diverse to the point that the rundown of differential conclusions is huge, extending from infections (fungal, bacterial and mycobacterial) to different vasculitis, including Henoch-Schonlein purpura, sarcoidosis, Behcet disorder, and malignancies.

Despite that including the heart is very much portrayed noteworthy cardiovascular confusions happening throughout the illness are rare. Pericarditis is the most well-known cardiovascular appearance representing around half of cardiovascular sicknesses in WG, which is asymptomatic in the majority of the cases, or might be showed by chest torment and dyspnea. The general death rate of Wegener's Granulomatosis with cardiovascular contribution has been accounted for to be between 15 & 45%. Cardiac indications are exhibited in Table 2.

Table 2: Cardiac Manifestations in Wegener's Granulomatosis

Pericarditis	Conduction abnormalities
Coronary arteries	Myocarditis
Myocardial ischaemia	Noninfectious endocarditis
Valvular regurgitation-stenosis	Heart failure

Wegener's granulomatosis stimulates pulmonary adenocarcinoma

WG is an uncommon fundamental granulomatous inflammatory process. The exemplary triad of WG comprises of upper respiratory tract, bring down respiratory tract and kidney involvement. The crest rate of WG is in the fourth to sixth decades of life [14]. In addition to particular indications, nonspecific sacred side effects, for example, fever, fatigue, weight reduction, and poor craving are additionally every now and again noted. C-ANCA, which demonstrates a positive response in 90% of patients with WG is a vital analytic test. Chest radiography regularly indicates bilateral pulmonary nodules with or without cavitation. Histology demonstrates necrotizing granulomatosis aggravation with geographical necrosis and related vasculitis however may just show noncaseous Granuloma. A blend of Clinical appearances, C-ANCA, and histological discoveries are critical in making a right diagnosis. If untreated, 90% of the patients with WG pass on inside 1 year. Immunosuppressive treatment with Cyclophosphamide and prednisone brings about 85-90% reduction rate and up to 75% of patients accomplish finish remission [15]. As an outcome,

early determination and treatment are important to prevent morbidity and mortality. The exact determination of vasculitis can be difficult. Approximately half of patients with vasculitis sufficiently extreme to warrant admission to the emergency unit undiscovered [16]. The exemplary group of three of manifestations is found in just 21% of patients [17].

Pulmonary-constrained Wegener's granulomatosis has been reported [18]. Besides, despite the fact that multinucleated monster cells and epithelioid histiocytes are thought about generally more particular on cytology, intense aggravation and rot are the most widely recognized cytopathological discoveries in Wegener's granulomatosis [19]. In patients with Wegener's granulomatosis, the sputum cytology discoveries reenacted adenocarcinoma. Two patients with Wegener's granulomatosis was initially analyzed as adenocarcinoma, one case through fine needle goal and the other by sputum cytology. They accepted that bronchial epithelial cells are regularly atypical in patients with Wegener's granulomatosis. The cells may have amplified erratic and somewhat hyper chromatic cores with noticeable nucleoli, looking like a very much separated adenocarcinoma. They reasoned that receptive alveolar cells seen on fine needle suctions of the lung may prompt a false positive outcome or bogus doubt of adenocarcinoma. Wegener's granulomatosis imitating squamous cell carcinoma on cytology has additionally been seen [20, 21]. They proposed the highlights, for example, atomic edge anomalies, huge nucleoli, and loss of cell extremity in the suction may have been over-translated as danger in perspective of the clinico-radiological foundation which recommended a threatening process. As an outcome, the cytological highlights were suggestive, yet not indicative, of harm. In patients with suspected threat, a biopsy sample should dependably be taken to affirm the diagnosis. They additionally recommended that the C-ANCA titer ought to be checked in patients with various aspiratory injuries, even without other clinical side effects and signs. In determination, Wegener's granulomatosis is a fundamental vasculitis which is a huge demonstrative test for clinicians and pathologists. The aftereffects of sputum cytology and fine needle goal are questionable and may additionally deceive pathologists to a conclusion of malignancy. The C-ANCA titer is checked in patients with respective pneumonic sores, particularly those with unexpected or new-beginning multifocal pneumonic lesions.

Wegener's granulomatosis in visual infection

An exceptionally constrained type of the ailment, with clinical contribution of a solitary organ, for example, the eye, has likewise been portrayed with any visual

structure being affected [22]. WG is a complex and possibly deadly infection with high death rate if left untreated. Signs incorporate vision misfortune or aggregate visual impairment might be found in 8-37% of patients, particularly if there has been a postponement in determination, or if the infection has been insufficiently treated [23].

Treatment of WG

Treatment of WG is considered to have two stages: induction, where active infection is put into remission; and support, where remission is managed. Cyclophosphamides saving methodologies have been created to utilize this powerful specialist ideally for the treatment of serious illness while constraining Cyclophosphamide introduction to diminish the danger of lethality [24].

Remission induction

Cyclophosphamide

Generalized or severe disease generally requires aggressive therapy. Since introduced by Fauci et al in the 1970s, oral cyclophosphamide in combination with high-dose glucocorticoids (Prednisone 1mg/kg/day) has been the criterion standard for induction of remission in AAV.

Mechanism: Cyclophosphamide is alkylating specialists of the nitrogen mustard compose. An enacted type of cyclophosphamide, phosphoramide mustard, alkylates, or ties, to DNA. Its cytotoxic impact is for the most part because of cross-connecting of strands of DNA and RNA and to hindrance of protein synthesis.

Adverse Effects: Extreme hemorrhagic cystitis, dysuria, hematuria.

Rituximab

Rituximab combined with high-dose glucocorticoids represents an alternative to cyclophosphamide.

Mechanism: Rituximab is a chimeric monoclonal antibody against CD20 IgG1 counter acting agent that prompts apoptosis of B cells, except for plasma cells and pre-B cells.

Adverse Effects: Infusion reactions, mucocutaneous responses, expanded danger of contaminations (to incorporate entrepreneurial diseases, for example, dynamic multifocal leukoencephalopathy), cytopenias, and malignancy.

Corticosteroids

Verifiably, glucocorticoid monotherapy delayed middle survival in WG by just 7.5 months. There have

been no clinical trials assessing the part or dosing of glucocorticoids in AAV, however every clinical trial has utilized glucocorticoids in combination with different immunosuppressant.

Mechanism: Steroid hormone enters the cells of target organ and binds to particular receptor in cytoplasm that is steroid receptor. This steroid receptor complex becomes activated and enters the nucleus binds to specific site on DNA regulates protein synthesis response.

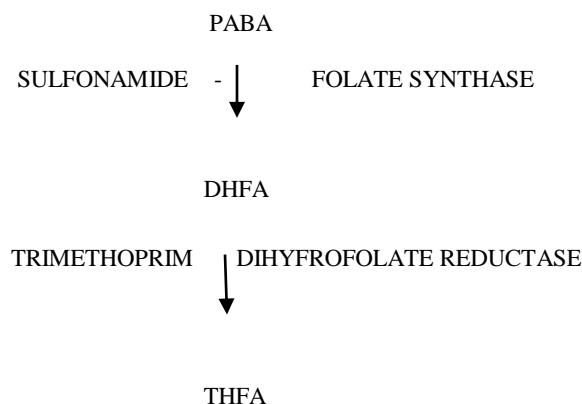
Adverse effects: Metabolic impacts: hyperglycemia, Cushing's habitus.

Gastro intestinal tract: Peptic ulceration, once in a while with hemorrhage or perforation.

Salt and water retention, Muscle weakness and fatigue, Osteoporosis Glaucoma and cataract, Behavioral disturbances, Hypothalamic – pituitary – adrenal (HPA) get to detachment, Immunosuppression.

Trimethoprim-Sulphamethoxazole

Mechanism: The combination of trimethoprim and sulphamethoxazole is called cotrimoxazole. Trimethoprim is a diaminopyrimidine which specifically inhibits bacterial dihydrofolate reductase and sulphamethoxazole inhibits Folate synthase.



Adverse Effects: All adverse effects seen with sulphonamides can be produced by cotrimoxazole. Nausea, vomiting, stomatitis, headache and rashes, Megaloblastic anemia and blood dyscrasias.

Plasma exchange

Plasma exchange might be considered in patients with quickly dynamic renal disease keeping in mind the end goal to save renal function [25]. Moreover plasma exchange, along with immunotherapy might be useful in WG [26].

Mechanism: AAV incorporates expulsion of pathologic circulating components (eg. ANCA, initiated lymphocytes), evacuation of excess physiologic factors (eg. complement, coagulation factors, and cytokines/chemokines), substitution of inadequate plasma factors and other less well-defined mechanisms.

Adverse Effects: electrolyte disturbances, hypersensitivity, hemorrhage and transfusion-related lung damage.

Methotrexate

A mix of methotrexate (oral or subcutaneous) and glucocorticoids can be considered as a less-lethal contrasting option to cyclophosphamide for the induction of remission of non-organ-undermining or no dangerous WG.

Mechanism: Folic corrosive is required for the all over again union of the nucleoside thymidine, required for DNA synthesis. Additionally, folate is fundamental for purine and pyrimidine base biosynthesis, so synthesis will be hindered. Methotrexate, in this manner, inhibits the synthesis of DNA, RNA, thymidylates and proteins.

Adverse Effects: Nausea, vomiting, mucosal ulcers, hepatotoxicity.

Remission maintenance

Once induction of remission has occurred, maintenance of remission should be continued for at least 18 months, often longer. Agents that can be used in remission maintenance include azathioprine, methotrexate, rituximab, and leflunomide [27]. Long-term oral cyclophosphamide has been used for remission maintenance but results in significant toxicity, making it unattractive.

Azathioprine

Azathioprine (2 mg/kg/day) is more secure than and as powerful as cyclophosphamide in maintaining remission.

Mechanism: Azathioprine damages leukocyte expansion by repressing purine synthesis.

Adverse Effects: Bone marrow suppression, hepatotoxicity, alopecia and gastrointestinal symptoms.

Methotrexate

Methotrexate (20-25 mg week by week, oral or subcutaneous) has been utilized for the upkeep of remission if the serum creatinine level is under 1.5

mg/dl. Methotrexate has been appeared to be like azathioprine as far as adverse effects, adequacy in maintaining remission, and rates of relapse.

Leflunomide

Leflunomide (20-30 mg/day) is as viable as methotrexate, yet it is related with more adverse effects.

Mechanism: Leflunomide targets T cells by inhibiting the mitochondrial compound dihydroorotate dehydrogenase and subsequently confines pyrimidine synthesis.

Adverse Effects: Pain or burning during urination, pale skin, bruising or bleeding, stomach pain, loss of hunger, tingling, dark urine, mud hued stools, jaundice, sore throat and headache.

Rituximab

Rituximab is a chimeric monoclonal antibody actively binds with CD20 protein which is present on the B lymphocytes. Then this antibody kills the B cells. It is therefore used to treat diseases which have excessive, dysfunctional or overactive B cells. This includes leukemia, lymphomas and auto-immune diseases such as Wegener's diseases.

Other therapies

The glucocorticoid dose ought to be decreased to prednisone 10 mg/day (or less) during remission. The dosage can be decreased continuously following 6-year and a half, contingent upon the patient's response. The expansion of Trimethoprim-Sulfamethaxazole (800/160 mg twice every day) to standard support treatment may lessen the rate of relapse in WG [28].

Alternative or promising therapies

Intravenous immunoglobulin

Intravenous immunoglobulin (IVIG) might be powerful by meddling with ANCAs and in this way repressing ANCA-interceded neutrophil activation [29]. Good outcomes were accounted for in an investigation of 22 patients with AAV given IVIG as an assistant to immunosuppressant as well as glucocorticoids.

Mycophenolate mofetil

Mycophenolate mofetil (MMF) (2 g/day) is a derivative of the fungus *Penicillium stoloniferum*, like azathioprine it limits purine synthesis. MMF is fundamentally utilized for immunosuppression in transplant patients and stifles B and T cells. On account of its ideal reaction profile and clinical power, MMF is by and large progressively utilized as a part of

the administration of foundational connective-tissue issue and is regularly utilized as a part of mix with prednisone.

Etanercept

Etanercept is a dimeric, recombinant human combination protein with 2 soluble p75 tumor rot factor - alpha (TNF- α) receptors connected to the Fc region of human IgG1. The underlying pilot thinks about demonstrated great reaction when etanercept was added to standard treatment [30].

Infliximab

Infliximab is a chimeric monoclonal antibody to TNF- α which comprises of murine antigen recognition sites bound to human Fc regions. The outcomes in different potential case reports have been blended, so it isn't presently conceivable to remark on the viability of infliximab [31, 32]. The security of infliximab treatment in patients with WG, like the outcomes in trials with etanercept, is by all accounts the restricting component, as there were expanded genuine contaminations in the infliximab group [33].

15-Deoxyspergualin

The medication 15-deoxyspergualin (0.5 mg/kg/day subcutaneous or intravenous) is a synthetic derivative of spergualin, a protein from *Bacillus laterosporus* that is capable for preventing T-cell and B-cell development. The medicine is authorized in Japan for intermittent kidney transplant rejection. What's more, 15-desoxyspergualin has been utilized with some accomplishment in unmanageable WG cases and in patients with contraindications to cytotoxic treatment [34-36]. It might offer a more secure alternative to cyclophosphamide for induction treatment however isn't yet bolstered for routine clinical use.

Antithymocyte globulins

Antithymocyte globulins are polyclonal antibodies focused against T-lymphocyte antigens. Implantation of antithymocyte globulin causes a profound quick consumption of T-lymphocytes. It has been explored for use in extreme obstinate WG [37]. However extreme unfriendly impacts including, demise may happen. In this way, antithymocyte globulin's utilization isn't clinically supported [38, 39].

Alemtuzumab

Hostile to CD52 treatment (alemtuzumab) is an adapted monoclonal immune response to CD52 that specifically exhausts lymphocyte and macrophage populaces. Its utilization in GPA is thought about experimental [40].

Abatacept

Abatacept is a dissolvable, cytotoxic T-lymphocyte Ag-4 immunoglobulin that binds CD28, in that way inhibiting T-cell activation. Abatacept has been utilized with some accomplishment to forestall illness movement in a creature model of crescentic glomerulonephritis [41].

Stem cell transplantation

Hematopoietic stem cell transplant in the treatment of WG is limited.

Monitoring and toxicity prevention

Checking for sickness movement and medication toxicity is among the most critical parts of care in a patient with WG. Observing blood checks to anticipate neutropenia and keep up the total neutrophil tally over 1500/mm³ decreases the danger of disease related morbidity and mortality that can happen from bacterial and viral pathogens. For patients who don't have blood in their urine, self- urine dipstick testing can help identify new hematuria as an early indicator of renal disease. For patients with pneumonic sickness, perform chest imaging one month after the start of induction treatment to affirm change, at the time of progress to upkeep treatment, and each three to a half year from there on. For patients who don't have respiratory sickness, perform imaging each six to a year or for new manifestations.

CONCLUSION:

The management of Wegener's Granulomatosis requires a multidisciplinary approach, aiming not only to treat the symptoms of diseases and prevent relapse, but also to manage long term complications like cardiovascular risk, kidney damage, respiratory complications and side effects of therapy. Drugs such as cyclophosphamide, corticosteroids, cotrimoxazole, rituximab and few more monoclonal antibodies are used in the treatment of WG. Even though many drugs are available, the backbone of treatment for WG is a mix of cyclophosphamide with prednisolone.

REFERENCES:

- Falk RJ, Gross WL, Guillevin L, Hoffman G, Jayne DR, Jennette JC, et al. Granulomatosis with polyangiitis (Wegener's): an alternative name for Wegener's granulomatosis. Ann Rheum Dis, 2011; 70(4):704.
- Scott DG, Watts RA. Systemic vasculitis: epidemiology, classification and environmental factors. Ann Rheum Dis, 2000; 59(3):161-3.
- Lane SE, Watts R, Scott DG. Epidemiology of systemic vasculitis. Curr Rheumatol Rep, 2005; 7(4):270-5.
- Cartin-Ceba R, Peikert T, Specks U. Pathogenesis of ANCA-associated vasculitis. Curr Rheumatol Rep, 2012; 14(6):481-93.
- Zhao Y, Odell E, Choong LM, Barone F, Fields P, Wilkins B, et al. Granulomatosis with polyangiitis involves sustained mucosal inflammation that is rich in B-cell survival factors and autoantigen. Rheumatol (Oxford), 2012; 51(9):1580-6.
- Abdulahad WH, Lepse N, Stegeman CA, Huitema MG, Doornbos-van der Meer B, Tadema H, et al. Increased frequency of circulating IL-21 producing T-cells in patients with granulomatosis with polyangiitis. Arthritis Res Ther, 2013; 15(3):R70.
- Gao Y, Zhao MH. Review article: drug-induced anti-neutrophil cytoplasmic antibody-associated vasculitis. Nephrol (Carlton), 2009; 14(1):33-41.
- Lyons PA, Rayner TF, Trivedi S, Holle JU, Watts RA, Jayne DR, et al. Genetically distinct subsets within ANCA-associated vasculitis. N Engl J Med 2012; 367(3):214-23.
- Hoffman GS, Kerr GS, Leavitt RY, Hallahan CW, Lebowitz RS, Travis WD, et al. Wegener granulomatosis: An analysis of 158 patients. Ann Intern Med, 1992; 116:488-98.
- Merkel PA, Lo GH, Holbrook JT, Tibbs AK, Allen NB, Davis JC Jr, et al. High incidence of venous thrombotic events among patients with Wegener granulomatosis: The Wegener's Clinical Occurrence of Thrombosis Study. Ann Intern Med, 2005; 142: 620-6.
- Bosch X, Guilbert A, Font J. Antineutrophil cytoplasmic antibodies. Lancet, 2006; 368: 404-18.
- Finkelstein JD, Merkel PA, Schroeder D, Hoffman GS, Spiera R, St Clair EW, et al. Antiproteinase 3 antineutrophil cytoplasmic antibodies and disease activity in Wegener granulomatosis. Ann Intern Med, 2007; 147:611-9.
- Safak O, Gursul E, Polat M. Wegener's Granulomatosis with cardiac involvement. International journal of the cardiovascular Academy. 2016; 2: 93-5.
- Leavitt RY, Fauci AS. Wegener's granulomatosis. Curr Opin Rheumatol, 1991; 3:8-14.
- Abdou NI, Kullman GJ, Hoffman GS, Sharp GC, Specks U, Mc Donald T, et al. Wegener's granulomatosis: survey of 701 patients in North America: changes in outcome in the 1990s. J Rheumatol, 2002; 29:309-16.
- Fauci AS, Haynes BF, Katz P, Wolff SM. Wegener's granulomatosis: prospective clinical and therapeutic experience with 85 patients for 21 years. Ann Intern Med, 1983; 98:76-85.
- Semple D, Keogh J, Forni L, Venn R. Clinical review: vasculitis on the intensive care unit. Crit Care, 2005; 9:92-7.

- 18.DeRemee RA. ANCA-associated diseases: a pulmonologist's perspective. Am J Kidney Dis, 1991; 28:180-5.
- 19.Blenner-Hassett JB, Borrie J, Lichter I, Taylor AJ. Localized pulmonary Wegener's granuloma simulating lung cancer: report of four cases. Thorax, 1976; 31:576-84.
- 20.Michael CW, Flint A. The cytological features of Wegener's granulomatosis. Am J Clin Pathol, 1998; 110:10-5.
- 21.Uppal S, Saravanappa N, Davis JP, Farmer CK, Goldsmith DJ. Pulmonary Wegener's granulomatosis misdiagnosed as malignancy. BMJ, 2001; 322:89-90.
- 22.Awasthi A, Malhotra P, Gupta N, Gupta D, Rajwanshi A. Pitfalls in the diagnosis of Wegener's granulomatosis on fine needle aspiration cytology. Cytopathology, 2007; 18:8-12.
- 23.Williamson JD, Murphree SS, Wills-Frank L. Atypical squamous cells as a diagnostic pitfall in pulmonary Wegener's granulomatosis. A case report. Acta Cytol, 2002; 6:571-6.
- 24.Ahmed M, Niffenegger JH, Jakobiee FA, Ben-Arie-Weintrob Y, Andreudi S, Folber R, et al. Diagnosis of limited ophthalmic Wegener's granulomatosis: distinctive features with ANCA test confirmation. Int Ophthalmol, 2008; 28(1): 35-46.
- 25.Spalton DJ, Graham EM, Page NG, Sanders MD. Ocular changes in limited forms of Wegener's granulomatosis. Br J Ophthalmol, 1981; 65:553-63.
- 26.Talar-Williams C, Hijazi YM, Walther MM, Linehan WM, Hallahan CW, Lubensky I, et al. Cyclophosphamide-induced cystitis and bladder cancer in patients with Wegener granulomatosis. Ann Intern Med, 1996; 124: 477-84.
- 27.Mukhtyar C, Guillemin L, Cid MC, Dasgupta DB, De Groot K, Gross W, et al. EULAR recommendations for the management of primary small and medium vessel vasculitis. Ann Rheum Dis, 2009; 68:310-17.
- 28.Klemmer PJ, Chalermskulrat W, Reif MS, Hogan SL, Henke DC, Falk RJ. Plasmapheresis therapy for diffuse alveolar hemorrhage in patients with small vessel vasculitis. Am J Kidney Dis, 2003; 42(6):1149-53.
- 29.Casian A, Jayne D. Plasma exchange in the treatment of Wegener's granulomatosis, microscopic polyangiitis, Churg-Strauss syndrome and renal limited vasculitis. Curr Opin Rheumatol, 2011; 23(1):12-7.
- 30.Jayne D, Rasmussen N, Andrassey K, Bacon P, Tervaert WC, Dadoniene J, et al. A randomized trial of maintenance therapy for vasculitis associated with antineutrophil cytoplasmic antibodies. N Engl J Med, 2003; 349(1):36-44.
- 31.Pagnoux C, Mahr A, Hamidou MA, Boffa JJ, Ruivard M, Ducroix JP, et al. Azathioprine or methotrexate maintenance for ANCA-associated vasculitis. N Engl J Med, 2008; 359:2790-803.
- 32.Metzler C, Miehle N, Manger K, Iking-Konert C, de Groot K, Hellmich B et al. Elevated relapse rate under oral methotrexate versus leflunomide for maintenance of remission in Wegener's granulomatosis. Rheumatology (Oxford), 2007; 46(7):1087-91.
- 33.Jones RB, Ferraro AJ, Chaudhry AN, Brogan P, Salama AD, Smith KG et al. A multicenter survey of rituximab therapy for refractory antineutrophil cytoplasmic antibody-associated vasculitis. Arthritis Rheum, 2009; 60(7):2156-68.
- 34.Rhee EP, Laliberte KA, Niles JL. Rituximab as maintenance therapy for anti-neutrophil cytoplasmic antibody-associated vasculitis. Clin J Am Soc Nephrol, 2010; 5(8):1394-400.
- 35.Hinze CH, Colbert RA. B-cell depletion in Wegener's Granulomatosis. Clin Rev Allergy Immunol, 2008; 34:372-79.
- 36.Schmitt WH, Birck R, Heinzel PA, et al. Prolonged treatment of refractory Wegener's granulomatosis with 15-deoxyspergualin: an open study in seven patients. Nephrol Dial Transplant, 2005; 20(6):1083-92.
- 37.Birck R, Warnatz K, Lorenz HM, Choi M, Haubitz M, Grünke M, et al. 15-Deoxyspergualin in patients with refractory ANCA-associated systemic vasculitis: a six-month open-label trial to evaluate safety and efficacy. J Am Soc Nephrol, 2003; 14(2):440-7.
- 38.Booth A, Harper L, Hammad T, Bacon P, Griffith M, Levy J, et al. Prospective study of TNF alpha blockade with infliximab in anti-neutrophil cytoplasmic antibody-associated systemic vasculitis. J Am Soc Nephrol, 2004; 15 (3):717-21.
- 39.Lee RW, Cruz DP. Novel therapies for anti-neutrophil cytoplasmic antibody-associated vasculitis. Drugs, 2008; 68:747-70.
- 40.Sangle SR, Hughes GR, Cruz DP. Infliximab in patients with systemic vasculitis that is difficult to treat: poor outcome and significant adverse effects. Ann Rheum Dis, 2007; 66(4):564-5.
- 41.Hinze CH, Colbert RA. B-cell depletion in Wegener's Granulomatosis. Clin Rev Allergy Immunol, 2008; 34:372-9.