One-Page Summary: Lupus and the Data Behind Plaquenil. Dr. Michelle Petri

SLE skin: When did the rash occur in conjunction with sun exposure (usually not within a day from sun exposure but later unlike other rashes). How long does it last (in SLE rash lasts from days to weeks). Is it raised? (should be for SLE).

Lupus alopecia: hair thinner/more fragile than normal. Alopecia areata is not a SLE manifestation. Hair fall is a subjective symptom.

Jaccoud’s arthropathy is reducible. May happen in feet too. Due to tendon/ligament laxity from tenosynovitis at initial stages of disease.

Prednisone is poison! Even doses of 0-6mg/day have a HR of 1.16 (6-12mg/day: HR 1.5; 12-18mg/day: HR 1.64; >18mg/day, HR: 2.51) for increase in organ damage (model adjusted for confounding by indication due to SLE disease activity). Prednisone increases the risk of CV events. Mild-moderate lupus flares: triamcinolone IM 100mg; however, this is not sufficient for major organ involvement.

HCQ should be background tx in all SLE patients: reduction in flares by 50%, reduces organ damage, lipids, thrombosis, triples MMF response in LN, improves survival. Can induce retinopathy (“flying saucer” sign on SD OCT). If hepatic or renal impairment or elderly, consider reducing the dose. Prefers HCQ blood level approach: dose based on whether HCQ blood levels are in therapeutic range. If levels high in blood (not plasma): higher risk for retinopathy. Adjust dose. Check multiple times, also when pt flaring (?non-compliance).

MMF is superior to CTX in LN in AA. Also works for serositis and cutaneous SLE. Not great for joints. Pt should sign REMS. For arthritis: MTX or leflunomide. AZA ok in pregnancy. RTX: LUNAR for LN and EXPLORE for non-renal SLE did not show benefit over MMF and standard-of-care respectively; EXPLORER included lots of prednisone use. When to use RTX: Acutely: thrombocytopenia, hemolytic anemia, lupus pneumonitis, CAPS; Chronic: lupus arthritis when other meds do not work. Anti-TNF can induce aPLs and anti-dsDNA (do not use in SLE). Belimumab: subgroup with both high anti dsDNA and low complement are more likely to respond. Anifrolumab for non-renal SLE (anti-INFa receptor blocker)-especially for skin. Awaiting FDA decision.

LN: tacrolimus can be added to MMF with acceptable safety and improved efficacy (multi target tx). In clinical trials: Voclosporin (next generation calcineurin inhibitor): AURORA. Belimumab (BLISS-LN). Obinutuzumab: better B cell depleter than RTX (NOBILITY).

SLE pts die from CV disease and infection. Atherosclerosis cannot be explained by traditional risk factors only. Assess and tx traditional CV risk factors (BP above 120 should be controlled). Statin did not reduce CV risk of SLE in 2 clinical trials. MMF slows progression (but only when indicated for SLE tx). Independent risk factors for CV events: SLEDAI, hx of +LA, low mean C3. Control disease activity

Chronic fatigue does not correlate with SLE disease activity. Exercise is very helpful.

Q&A pearls

For PJP prophylaxis prefers dapsone (need to check G6PD first) over Bactrim. 100mg MWF and quick prednisone taper.

RTX for LN: only 50% on MMF respond by 1 year. More likely to add tacrolimus rather than RTX but RTX may still be useful. Will have better tx in the future.

Sunscreen: Brand to block both UVA/UVB. Go to as high SPF as possible.

Chronic low dose prednisone: Attempt 5 to 4mg for 3 months (to allow recovery from adrenal insufficiency).