

Clinically Quiescent Lupus Does Not Progress

BY KATE JOHNSON

MONTREAL — Patients with systemic lupus erythematosus that is serologically active but clinically quiescent do not require treatment with steroids or immunosuppressive agents until the disease flares, according to a study presented at the annual meeting of the Canadian Rheumatology Association.

Until now, patients with such discordant findings have presented a clinical dilemma, said Dr. Amanda Steiman, who presented the study's findings.

"Many physicians have wondered whether or not treatment is warranted in light of just the serological activity in the absence of any clinical disease," she said in an interview. "Does lupus progress subclinically during a quiescent period?"

Her study followed 55 patients with serologically active, clinically quiescent (SACQ) systemic lupus erythematosus over a 10-year period, and compared their outcomes to those of 110 controls with classic SLE who were matched for age, sex, disease duration, and decade of clinic entry.

Patients and controls were also matched for baseline damage according to the SDI (Systemic Lupus International Collaborating Clinics/American College of Rheumatology Damage Index), incidence of renal damage, and incidence of coronary artery disease.

SACQ was defined as a minimum of 2 years without clinical activity and persistent serologic activity as defined by elevated anti-double stranded DNA and/or hypocomplementemia. Antimalarials were permissible during an SACQ period, but steroids or immunosuppressives were not.

The study found that, compared with controls, SACQ patients showed very little subclinical progression. At 3 years after the start of the study, SDI damage in the SACQ patients was 0.7 vs. 1.13 in controls; this pattern persisted at 5 years (0.89 vs. 1.36), 7 years (0.94 vs. 1.71), and 10 years (1.26 vs. 2.26).

Similarly, whereas 3.6% of the SACQ patients vs. 6.4% of controls had coronary artery disease at baseline, new cases of CAD (myocardial infarction, angina, or sudden cardiac death) occurred in 1.8% of SACQ patients vs. 7.3% of controls over the 10-year study.

One (1.8%) SACQ patient vs. 15.5% of controls had renal damage at 5 years, and at 10 years these numbers rose to 3.6% of SACQ patients and 23.6% of controls.

Both disease and treatment can result in lupus-related damage, said Dr. Steiman, who is a rheumatology fellow at the University of Toronto.

"The SDI differentiates between damage which is definitely corticosteroid related (specifically ocular and musculoskeletal damage) vs. possibly corticosteroid related (such as cardiovascular, peripheral vascular, neuropsychiatric, and diabetic damage) vs. damage that occurs independent of corticosteroid use (specifically renal, pulmonary, dermatologic, and gonadal damage), as well

as malignancy," she said.

"Especially later in the course of lupus—these patients were 11 years plus into their lupus course—a lot of the damage is related to treatment morbidity," she said in an interview. "If we can avoid that for a good number of years, then we are going to spare the people the morbidity associated with the treatment." This subset of patients has less progressive disease-related damage, she

added. Findings from a previous study by Dr. Steiman's associates showed that patients with SACQ represent about 6% of the SLE population. Approximately 60% of them flare and require treatment after a median of 3 years.

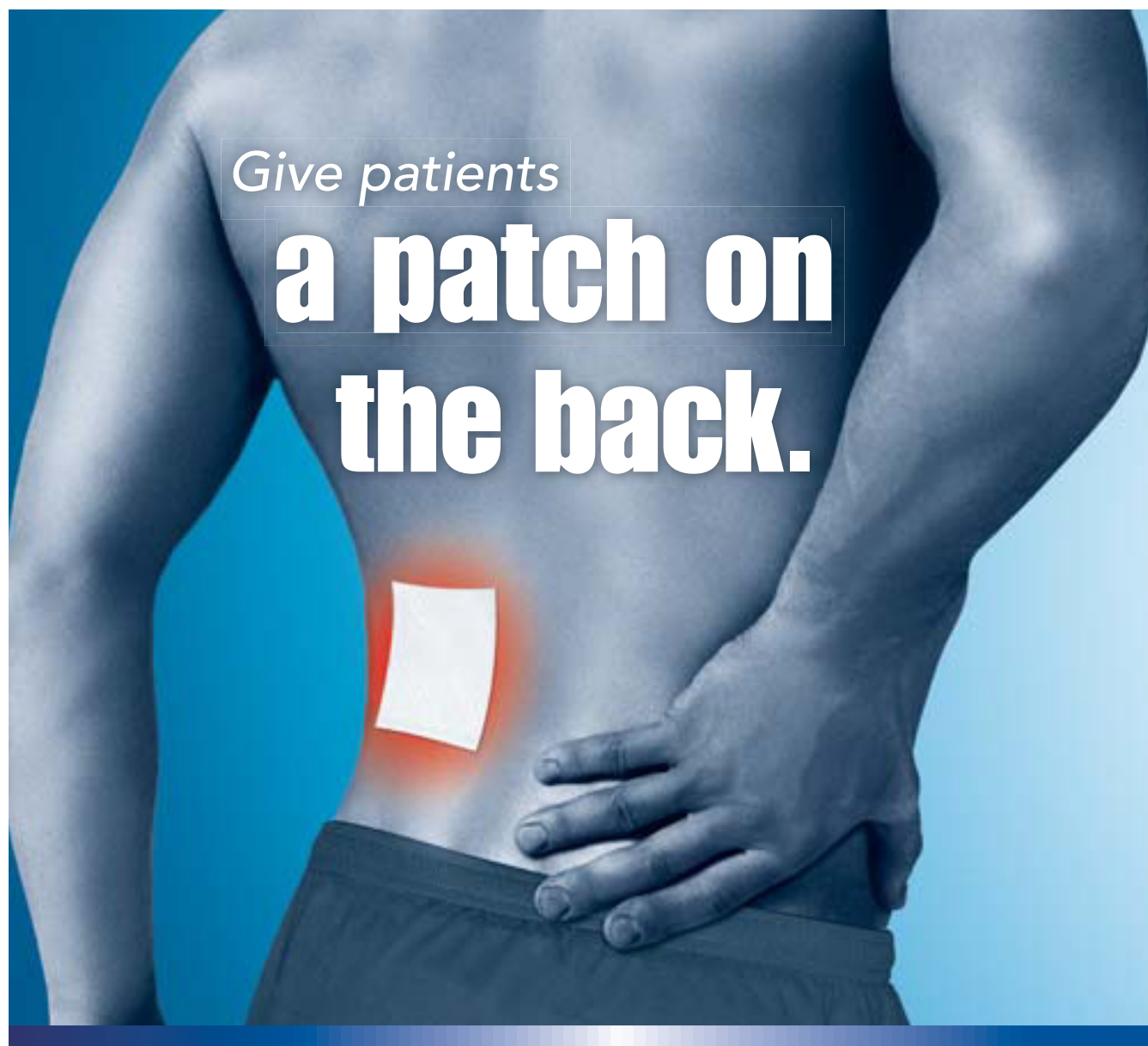
Findings from the present study show that SACQ patients used antimalarials, corticosteroids, and immunosuppressives at rates of 60%, 18%, and 5%, respectively, during the study period, compared

with 77%, 76%, and 44% in controls.

"The SACQ period can be a very prolonged period without a flare, and at our center we have not been treating these patients.

"Our study supports the practice of active surveillance without treatment, so that's reassuring."

Disclosures: Dr. Steiman stated that she had no conflicts to disclose.



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