Heart Benefits of Antimalarials in SLE Posited

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SNOWMASS, COLO. — Antimalarials may not only treat active lupus, but also benefit the heart, W. Joseph McCune, M.D., said at a symposium sponsored by the American College of Rheumatology.

Lupus patients have an elevated risk of heart disease, and antimalarials have been shown to have a number of cardioprotective properties, said Dr. McCune, professor of internal medicine at the University of Michigan, Ann Arbor.

Such benefits may help offset the deleterious effects of prednisone, which has been shown to increase cholesterol levels. Each 10-mg titration in prednisone dosage is estimated to increase serum cholesterol by 7.5 mg/dL.

Several studies have shown that antimalarials are associated with lipid profile improvements in lupus patients. Each of those studies has treated patients somewhat differently and has shown slightly different results. "But the body of the studies clearly show that when a benefit is looked for, it is found mostly in lowering LDL cholesterol," Dr. McCune said.

In one study involving lupus patients not on corticosteroids, antimalarial therapy was associated with a 4% drop in total cholesterol at 3 months and a 1% drop at 6 months, compared with baseline levels. In patients on a corticosteroid, antimalarial therapy was associated with an 11% drop in total cholesterol at 3 months and a 9% drop at 6 months (J. Rheumatol. 1999;26:325-30).

Among diabetes patients, antimalarials have been shown to lower glucose levels in non–insulin-dependent patients. They also reduce insulin requirements in insulin-dependent patients. The dosages used have tended to be much higher than those typically used in rheumatology. However, even at the lower dosages used for treating lupus, it's believed that there is some positive effect on glucose tolerance, Dr. McCune said.

Dehydroepiandrosterone, which can be steroid sparing when it is added to lupus treatment, may produce increases in bone density that could offset steroid-induced osteopenia. But this has not been shown in patients with lupus, and the evidence is not definitive.

Statins clearly have immunomodulatory effects and have been shown to help prevent transplant rejection and to improve rheumatoid arthritis symptoms. However, at present there are no trials of statins used in patients with lupus, Dr. McCune said. ■

Biologic Doesn't Boost Remission Of Wegener's

Etanercept does not impact maintenance of remission in patients with Wegener's granulomatosis, according to results from a multicenter, randomized, placebo-controlled trial.

"Our results underscore three points," according to John H. Stone, M.D., of the Johns Hopkins Vasculitis Center, Baltimore. "Standard therapy fails to induce durable remissions in the majority of patients, etanercept does not enhance the effects of standard therapy, and even with the shorter courses of cyclophosphamide, now regarded as the standard of care, adverse events are common and frequently severe, with or without the addition of a specific tumor necrosis factor–α blockade."

Dr. Stone and other members of the Wegener's Granulomatosis Etanercept Trial Research Group evaluated etanercept for maintenance of remission in 180 patients with Wegener's granulomatosis (N. Engl. J. Med. 2005;352:351-61). Of the total, 89 received 25 mg etanercept twice a week via subcutaneous injection, and 91 received placebo. Each patient received standard therapy that consisted of glucocorticoids plus cyclophosphamide or methotrexate.

During the mean 27-month follow-up period, there were no differences between the etanercept group and the controls in terms of sustained remission (70% vs. 75%, respectively), sustained periods of low-level disease activity (87% vs. 91%, respectively), or the time required to achieve those measures.

In addition, 118 flares occurred in the etanercept group, compared with 134 in the control group, a difference that was not statistically significant.

—Doug Brunk

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