

How is lupus treated?

(The following are excerpts from an article entitled Medications in Systemic Lupus Erythematosus written by Angela M. Stupi, M.D.)

“Systemic lupus erythematosus (SLE) is a chronic autoimmune disease that often has a relapsing course. The primary therapeutic approach, therefore, is to achieve and maintain adequate suppression of the disease without causing unacceptable drug side effects.

In general, the approach to patients with SLE involves evaluation of specific symptoms and clinical findings to establish the type and extent of organ involvement and overall disease activity, aided by laboratory tests to contribute to the overall therapeutic plan. Table 1 groups disease manifestations into three broad categories based on primary treatment modality used for initial management.

Fever, joint pain (arthralgias), arthritis, and serositis (pleurisy or pericarditis) can often be managed effectively by non-steroidal anti-inflammatory drugs (NSAIDs) alone. Many different NSAIDs are available, ranging from aspirin to non-acetylated aspirin derivatives (Trilisate, Disalcid, Salsalate), which have lesser GI or kidney side effects, and do not affect bleeding as can be seen with regular dosing of aspirin. There are also a variety of non aspirin anti-inflammatory drugs such as Ibuprofen, Naproxen, Diclofenac, Sulindac, etc., which can provide similar anti-inflammatory benefit with less frequent dosing and side effects.

COMMONLY USED NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

- **Acetylated Salicylic Acids**
 - Plain Aspirin
 - Buffered Aspirin
 - Bufferin
 - Ascriptin
 - Enteric Coated Aspirin
 - Easprin
 - Ecotrin

- **Non-Acetylated Salicylic Acids**

- Disalcid - Salsalte
- Trilisate - Choline Magnesium
- Trisalicylate
- Salflex - Salsalate

- **NON-STEROIDAL ANTI-INFLAMMATORY AGENTS**

- Ansaid - Flurbiprofen
- Clinoril - Sulindac
- Dolobid- Diflunisal
- Feldene - Piroxicam
- Indocin - Indomethacin
- Lodine - Etodolac
- Meclomen- Meclofenamate
- Daypro - Oxaprozin
- Motrin - Ibuprofen
- Nalfon - Fenoprofen
- Naprosyn- Naproxen
- Oruvail - Ketoprofen
- Relafen - Nabumetone
- Tolectin- Tolmetin
- Voltaren- Diclofenac

Experience with the specific drug, adverse reactions, patient tolerance and compliance in dosage and cost, are all relevant for the choice of NSAID. In general, in the absence of side effects, an NSAID should be continued at least 2-4 weeks at maximum dosage before switching to a second agent due to lack of benefit.

Although NSAIDs are usually well-tolerated, they are associated with a range of potential side effects or toxicities. Gastrointestinal complaints are the most common and potentiation of peptic ulcer is of concern. Special effort should be made to administer these drugs after eating, and medications helpful in protecting the stomach can be administered in patients susceptible to this risk.

— “Anti-malarial drugs (hydroxychloroquine, chloroquine, and quinacrine) are most effective for the management of cutaneous features of lupus. With proper ophthalmologic follow-up and careful attention to dosage recommendations based on ideal body weight, anti-malarials are among the safest oral medications available for treatment.”

— “Corticosteroid given orally or intravenously (bolus therapy) are often necessary for more serious organ involvement. Topical preparations are appropriate treatment for dermatologic manifestations and Prednisone is the most commonly used oral corticosteroid. Intravenous methylprednisolone pulse therapy (high-dose) has come into widespread use in the last decade for lupus nephritis and other serious non-renal manifestations, such as hemolytic anemia, central nervous system inflammation (cerebritis), life-threatening low-platelet counts, and severe pleuropericarditis when oral steroids are not effective. The IV approach may enable a more rapid, more sustained response, with fewer or only transient side effects (elevated blood sugar, hypertension, potassium abnormalities, etc.). Side effects of chronic Prednisone administration such as moon faces, truncal fat redistribution and skin and capillary fragility are not encountered. Susceptibility to infection is always a concern in chronic steroid use.”

— “Immunosuppressive drugs used in treatment of SLE include azathioprine (Imuran), alkylating agents (nitrogen mustard, cyclophosphamide, and chlorambucil). Methotrexate has been used sparingly, but recent studies suggest it may have a role given orally weekly. It is beneficial especially in the setting of multi-joint inflammation and for reduced high-dose Prednisone administration.”

Indications for use of immunosuppressive drugs include

- life-threatening disease unresponsive to high-dose Prednisone and IV bolus therapy;
- active major organ involvement resistant to high-dose Prednisone for 4-6 weeks;
- active major organ involvement which recurs with reduction of corticosteroid dosage or requires unacceptably high steroid maintenance dose;
- intolerable corticosteroid toxicity (glucose intolerance requiring insulin, recurrent infections, significant hypertension, osteoporosis with vertebral compression fractures, etc.);
- active major organ involvement in a patient who already has contraindications to high-dose steroids; and
- certain active organ manifestations that respond better to combination treatment with steroid and immunosuppressives.”