

New European recommendations (European League Against Rheumatism 2008) for the management of lupus erythematosus: American perspective

Daniel J. Wallace

David Geffen School of Medicine at the University of California, Los Angeles, CA, USA

The European League Against Rheumatism (EULAR) recently completed the formulation of recommendations for managing lupus [1]. This consisted of an eminence based group of 19 respected lupologists who utilized an evidence based approach of the peer-reviewed literature and proposed with 12 recommendations relating to the prognosis, diagnosis, monitoring, and treatment of systematic lupus erythematosus (SLE). As an outsider from the opposite side of the Atlantic who was invited to critique and comment upon this effort, I posed several questions which are answered below.

1. Is there a need for new practice guidelines for lupus?

Yes. None have been issued this century, and those previously used antedated the availability of biologics, recent clinical insights, newer imaging techniques and laboratory/serologic tools.

2. Are there any factual errors in the EULAR guidelines?

Yes. The workup of neuropsychiatric lupus mandates a lumbar puncture. There is considerable evidence-based documentation that elevated protein, white count, IgG synthesis rate, oligoclonal bands, immunoglobulins, antineuronal antibodies, or LE cells in cerebrospinal fluid is associated with central nervous system vasculitis. Performing blood testing, neuropsychological testing and brain imaging alone rarely confirms a diagnosis of neurovasculitis. Lumbar puncture is not mentioned anywhere in the article.

3. Are there any omissions in the guidelines?

Yes. The 12 areas of inquiry were narrowly answered with generalizations. Patient education, coexisting fibromyalgia, stress reduction, and many organspecific complications and aspects of SLE are ignored (e.g., autoimmune hemolytic anemia, screening for pulmonary hypertension).

4. Who is to carry out the recommendations?

The guidelines rightfully acknowledge the influence of hypertension, dyslipidemia, smoking, diabetes, screening for osteoporosis, and hormonal therapies in the prognosis of lupus. Nevertheless, these worthwhile observations will be buried since rheumatologists are rarely the practitioners who are primary care providers for the lupus patient. I would have preferred to see a proposed mechanism for assuring that lupus specialists can coordinate and interdigitate with primary care physicians to see that all lupus patients in Europe receive comprehensive screening and implementation of preventive measures enumerated by the committee.

5. Will the EULAR guidelines change the way lupus specialists treat lupus?

There is no specific recommendation that alters what lupologists have been practicing for years. The narrative goes from being very specific (e.g., comorbidities) to very general (e.g., using steroids and immune suppressives), while excluding many aspects of the disease (e.g., scant discussion of treating cutaneous lupus), and being more detailed on others (e.g., nephritis, pregnancy). Hopefully, the EULAR effort is a work in progress.

A constructive criticism

Lupus is either organthreatening (e.g., cardiopulmonary, renal, hepatic, central nervous system vasculitis, hemolysis, thrombocytopenia) or nonorgan threatening (e.g., cutaneous, musculoskeletal, serositis, constitutional). Twenty percent with the latter evolve organthreatening disease within five years of diagnosis. I would have organized the treatment

Correspondence to:

Daniel J. Wallace, MD, Clinical Professor of Medicine, David Geffen School of Medicine at the University of California, Los Angeles, CA 90048, USA, phone: 001-310-652-09-20, fax: 001-310-360-48-12, e-mail: dwallace@ucla.edu

Received: May 12, 2008. Accepted: June 6, 2008.

Conflict of interest: none declared.

Pol Arch Med Wewn. 2008; 118 (7-8): 402-403

Copyright by Medycyna Praktyczna, Kraków 2008

section as delineating the approach for organthreatening (e.g., moderate to high dose corticosteroids, immune suppressives, biologics) followed by nonorgan threatening manifestations (e.g., non-steroidal anti-inflammatory drugs [NSAID], anti-malarials, low dose corticosteroids, selected immune suppressants such as methotrexate). The wording in the recommendations for NSAID, for example, is confusing and could be simplified by endorsing its use for headache, serositis, arthritis, and fevers but discouraging its use in organ threatening circumstances.

REFERENCES

1. Bertsias GK, Ioannidis JPA, Boletis J, et al. EULAR recommendations for the management of systemic lupus erythematosus. Report of a Task Force of the EULAR Standing Committee for International Clinical Studies Including Therapeutics (ESCISIT). *Ann Rheum Dis*. 2008; 67: 195-205.