SLE Linked to Comorbidities, Higher Mortality

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GOTHENBURG, SWEDEN – Sweden has systemic lupus erythematosus tend to die at a younger age rate than does the general population. During 13 years of prospective follow-up, 20.8% of 208 Swedish SLE patients died at a quite young mean age of 60 years. That translates into an age-adjusted 3.3-fold increased rate of all-cause mortality. Dr. Elisabet Svenningen reported the at the congress.

Cardiovascular disease accounted for 52% of the deaths, a proportion similar to findings from the general population. The difference is that cardiovascular death in the SLE cohort occurred predominantly in women at a substantially younger age than is common in women without SLE, observed Dr. Svenningen, a rheumatologist at Karolinska University Hospital in Stockholm. In addition to cardiovascular disease, patients with SLE have a number of other comorbidities, including osteoporosis, lupus heart disease, and autoimmune thyroid disease, she reported.

Vascular disease is one of the most common of the many comorbidities associated with SLE. She said. In a cross-sectional study of 597 patients in the Swedish SLE Network, 11% had ischemic heart disease, 10% had ischemic cerebrovascular disease, and 16% had a history of venous thromboembolism. The conventional Framingham risk factors don’t account for the cardiovascular disease that is present in patients with SLE. In a prospective cohort study involving 182 SLE patients with a mean age of 44 years, all of whom were free of known cardiovascular disease at baseline, Dr. Svenningen and coworkers found that the incidence of a first cardiovascular event was 13% during a mean 8.3 years of follow-up. In an age-adjusted, Cox multivariate regression analysis, the only conventional risk factors independently associated with a first cardiovascular event were smoking and age.

‘Lupus is an imitator. It’s difficult to say what is comorbidity and what is really a manifestation,’” Dr. Svenningen said in her keynote presentation to the meeting of the European Society of Cutaneous Lupus Erythematosus, which was held in conjunction with EADV congress.

The other independent predictors of a first cardiovascular event were the presence of any positive antiphospholipid antibody test, which conferred a 4.23-fold increased risk; elevated von Willebrand factor level, associated with a 1.97-fold risk; and the presence of thrombocytosis, which was a protective factor associated with a 65% reduction in risk of a cardiovascular event, Dr. Svenningen said. In her keynote lecture at the meeting of the European Society of Cutaneous Lupus Erythematosus, which was held in conjunction with EADV congress. She said that it has been established that one or more antiphospholipid antibodies are present in 30-50% of SLE patients. Among a cohort of 320 SLE patients who were being followed by Dr. Svenningen and her associates, 18% fulfilled strict 2006 criteria for antiphospholipid syndrome. SLE patients with antiphospholipid syndrome have a high rate of thrombotic events that don’t track with SLE disease activity.

“They just hit here and there; you never really know when,” the rheumatologist observed.

Turning to osteoporosis and SLE, Dr. Svenningen cited a new cross-sectional study by rheumatologists at the University of Gothenburg, who obtained x-rays of the thoracic and lumbar spine in 150 women with SLE who had a median age of 47 years and disease duration of 11 years. Although 29% of the SLE patients had at least one radiologic vertebral compression fracture, only 4% had been diagnosed with an osteoporosis diagnosis.

‘You have here for the first time a subclinical history of vertebral fractures. That we don’t detect most of these fractures may be one reason why patients...’

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Idiopathic Pulmonary Fibrosis: Two New Trials

Idiopathic pulmonary fibrosis is a progressive fibrosing lung disorder that affects over 120,000 Americans. To date, no FDA-approved drugs have been shown to reverse or halt the progression of this disease, which is often deadly.

To address this problem, the National Institutes of Health established the IPF Clinical Research Network (IPFnet), which includes more than 20 centers across the United States charged with designing and conducting clinical trials in IPF. Recently, the network finished a clinical trial testing the use of sildenafil, a vasodilator, in patients with advanced IPF; the trial was published this year (N. Engl. J. Med. 2010;363:620).

The IPFnet is now engaged in two new clinical trials testing drugs that block pathways considered key for the development of tissue fibrosis. The first trial, termed PANTHER, will evaluate the effectiveness of antioxidants. An earlier study suggested a promising role for antioxidants in IPF, but too few patients were evaluated. PANTHER will also examine the role of steroids and related drugs.

“Many patients are treated with these types of drugs, yet we still don’t know whether steroids and antioxidants are effective. PANTHER will answer these questions once and for all, but only if patients enroll in this trial,” said Dr. Jesse Roman, professor and chair of the department of medicine at the University of Louisville and chair of the IPFnet Education Committee.

The second trial being conducted by the IPFnet is called ACE. The ACE trial will explore the effectiveness of anticoagulants in treating IPF based on published data suggesting a role for coagulation in lung fibrogenesis. ACE was designed to test the benefits of this intervention. “Well-designed clinical trials are being conducted in search of safe and effective treatments for IPF, but patient involvement in these trials is crucial for their success,” said Dr. Imre Noth, of the University of Chicago.

The new trials, PANTHER and ACE, are currently enrolling patients. To enroll patients or learn more, visit the IPFnet Web site (www.IPFnet.org) or contact the IPFnet site closest to your geographic location.

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with SLE often complain about pain,” according to Dr. Svennungsson.

In the Gothenburg study, advanced age was an independent risk factor for one or more vertebral fractures at any site, whereas low bone mineral density in the total hip was associated with vertebral fracture in the lumbar spine. Interestingly, cumulative glucocorticoid dose wasn’t predictive of vertebral fracture risk (Arthritis Res. Ther. 2010 Aug. 2 [doi:10.1186/ar3104]).

A number of autoimmune diseases commonly overlap with SLE. Among them is autoimmune thyroid disease, which was present in 17% of 331 SLE patients being followed by Dr. Svennungsson and her associates at Karolinska, compared with 8% of matched controls. Hypothyroidism was far more common than hyperthyroid disease in the Karolinska cohort, as has been reported in other SLE studies.

Another autoimmune disease commonly overlapping with SLE is Sjögren’s syndrome. In the Karolinska cohort, 25% of SLE patients met strict diagnostic criteria for Sjögren’s syndrome. Dry mouth was reported by 40% of patients, compared with 7% of matched controls. Dry eyes were reported by 32% of SLE patients vs. 7% of controls.

In addition to cardiovascular disease, osteoporosis, Sjögren’s syndrome, antiphospholipid syndrome, and autoimmune thyroid disease, other conditions that occur at an increased rate in patients with SLE include malignancies, rheumatoid arthritis, systemic sclerosis, myositis, and vasculitis.

“Lupus is an imitator. It’s difficult to say what is comorbidity and what is really a manifestation of lupus,” Dr. Svennungsson concluded.

She declared that she has no relevant financial interests.