key points

SELECTED BY
Dr Peter Saul
GP, Wrexham and associate GP Dean for North Wales

The prevalence of systemic lupus erythematosus (SLE) is 28 per 100,000 suggesting that approximately 1 person in 3,500 will have lupus, but this is subject to ethnic variation. The disease is most common in people of Caribbean or Asian descent. SLE mainly affects adults and is common in women between the ages of 20 and 40 years, with a female to male ratio of 9:1.

The pathogenesis of SLE is multifactorial and encompasses multiple immunological, vascular and inflammatory processes, which are triggered by a combination of environment (sunlight), genetics, infection and hormonal milieu.

Diagnosing SLE can be challenging because of the myriad of clinical features and substantial variability between patients. Cutaneous involvement is present in about 60% of cases and typically manifests as a malar or butterfly rash. Joint involvement is inflammatory in nature with arthralgia, arthritis and/or tendinitis and occurs in about 90% of patients with SLE. Mucosal ulceration is another common feature, occurring in up to half of all patients with SLE. Patients may develop diffuse alopecia when the disease is active but this is usually reversible. Cardiorespiratory symptoms are common with chest pain on inspiration due to lupus-induced pleurisy or pericarditis, which may be associated with effusions.

Lupus glomerulonephritis is one of the most important systemic complications, occurring in about 30% of patients with SLE in the UK. Careful screening tests for renal disease need to be undertaken as it is asymptomatic. Neuropsychiatric manifestations of lupus are well recognised but uncommon and include epileptic seizures, psychosis, aseptic meningitis, stroke and transverse myelitis.

The diagnosis of SLE is traditionally based on a combination of clinical features and laboratory findings and any patient with suspected clinical features of lupus should be investigated for the presence of autoantibodies.

Treatment often includes corticosteroids, by various routes, at different points in disease management. In addition, some experts advocate the use of hydroxychloroquine, an antimalarial, as a principal drug in all SLE patients. It is beneficial in the management of mucocutaneous, musculoskeletal, serosal and constitutional symptoms. Patients must be fully informed about the importance of sun avoidance and/or protection with clothing and high factor sunscreen. In severe and/or refractory cases, systemic steroids are used.

As longevity of patients with lupus increases they are at risk of increasing co-morbidities, either due to the disease and/or its treatment. These include premature atherosclerosis, hypertension, dyslipidaemias, diabetes, osteoporosis, avascular necrosis, infection and malignancies.