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Keys to Early Intervention for SLE: Strategies to Improve Patient Outcomes

**Announcer:**
You're listening to *Living Rheum* on ReachMD. This episode is sponsored by GSK. Here's your host, Dr. Jennifer Caudle.

**Dr. Caudle:**
Welcome to *Living Rheum* on ReachMD. I'm your host Dr. Jennifer Caudle, and joining me today to share early intervention strategies for systemic lupus erythematosus, or SLE for short, is Dr. David Batt. Not only is Dr. Batt board-certified in internal medicine and rheumatology, but he's also an Assistant Professor of Clinical Medicine at the Indiana University School of Medicine. He's also a Rheumatology Specialist at Indiana University Health Physicians. Dr. Batt, welcome to the program.

**Dr. Batt:**
Thanks so much for having me today.

**Dr. Caudle:**
Well, we're delighted that you're here. So let's begin by discussing some of the variable factors that can lead to diagnostic delays. Let's start with symptoms, Dr. Batt. What can the clinical manifestations of SLE look like?

**Dr. Batt:**
Well, the manifestations are myriad with almost every organ system that you can think of. Patients will present with skin rashes. Patients will present with joint pain and sometimes swelling. They can have headaches. They can have seizures. They can have hair loss. They can have mouth ulcers, nasal ulcerations, chest pain, shortness of breath, fatigue, weakness. And so it can be many of these symptoms or just a few of these symptoms, which sometimes becomes a diagnostic pitfall for physicians trying to make a diagnosis as early as possible with this condition.

**Dr. Caudle:**
And how about the age of onset? What can you tell us about that?

**Dr. Batt:**
So lupus can occur anywhere from the pediatric age group through the geriatric group. But in general, it tends to be younger people between the ages of 20 and 40. It also tends to affect women a lot more than men. And it also tends to affect the African American population a little more than some of the other ethnic groups. But remember, lupus can occur in anybody at any age, and these are just kind of general guidelines.

**Dr. Caudle:**
So with those variables in mind Dr. Batt, how can we get better at recognizing SLE early on and help close the diagnostic gap?

**Dr. Batt:**
So there are basically two ways that patients often will present with lupus. In those that are very, very ill who present to a hospital emergency room and then get admitted to the ICU with multi-organ failure; could be brain, CNS, heart, lung, renal, etc., those physicians almost always check an ANA and make a diagnosis quite promptly and we institute life-saving treatment. But it's a little more subtle in patients that present say, to a primary care physician because as I mentioned before, there are many of these presentations that they can have. So I think that when someone has multiple organs, even subtle, so for instance, a few swollen or painful joints, or a rash that occurs when patients go out in the sun, and they may complain of a little bit of hair loss and maybe a little bit of fatigue, and on laboratory tests, there may be a little bit of anemia, which has no other apparent reason, and maybe a little protein, I think it's like doing detective work. One needs to take all of these clues and put together and say to yourself, is this someone who may have systemic lupus

erythematosus? And if they are one of those potential patients, then I think it behooves the physician to check appropriate laboratory tests which includes not just routine tests, CBC, chem profile, urinalysis, etc., but also checking the hallmark test, which is the antinuclear antibody, or ANA, which is basically present in 98 to 90% of patients that have lupus. Remembering in mind that there are false positive ANAs and so many patients with some of these symptoms can have other diseases and having a low titer ANA, one should not focus on it being lupus, but maybe consider that it might be another situation, another disease that might be mimicking lupus.

**Dr. Caudle:**
For those of you who are just tuning in, you're listening to *Living Rheum* on ReachMD. I'm Dr. Jennifer Caudle and I'm speaking with Dr. David Batt about early intervention strategies for systemic lupus erythematosus, or SLE.

**Dr. Caudle:**
So switching gears to treatment, Dr. Batt, can you tell us about the role of targeted therapies for patients with SLE? And what are some of the downstream impacts of beginning targeted treatment early in the patient journey?

**Dr. Batt:**
So I think we have to begin with what our basic treatment is for lupus and basically all folks should receive hydroxychloroquine and use sunblock to avoid sun exposure. And obviously many of those patients will not do well with that alone. So we often employ low dose steroids, we employ immunosuppressive drugs such as methotrexate, such as azathioprine and mycophenolate. But in many of those patients, despite those drugs, there's active disease or the patients require too high a dose of prednisone, which in and of itself can lead to progressive organ damage. There are also studies that have shown that within five years of lupus, up to 50% of patients have some permanent organ damage. So our targeted therapies have been useful and these have come out in the last few years and they target, for instance, b cells, they target podocyte stability in the kidneys, they target interferon, which has a role in the activity of lupus. And these drugs have been very, very crucial to our treatment of our patients with lupus.

**Dr. Caudle:**
With that being said, what strategies can we use to help tighten the therapeutic window for our SLE patients?

**Dr. Batt:**
So I think there's three things that are important. Number one, making the diagnosis early. That's of utmost importance so that we can get patients on the road to treatment. The second thing is instituting what we like to consider standard of therapy and do that quickly. The use of again, hydroxychloroquine, the use of some of these immunosuppressives. And then when those medications are not working, rather than just sitting back and watching and waiting and allowing more organ disease to progress, I think it's important that we think about getting these targeted therapies started relatively earlier in the course of our treatment with patients, our treatment of our lupus patients because I think too many people have sat back and just kept people on steroids for long periods of time, which is not in the best interest of our patients.

**Dr. Caudle:**
Before we close Dr. Batt, do you have any final thoughts you'd like to leave with our audience?

**Dr. Batt:**
Yes. I think that a lot of people have always thought that when a diagnosis of lupus has been made that patients are going to do poorly regardless of what we do and have morbidity and having increased mortality. And certainly that is true of a very, very, very small subset of patients with lupus, but with today's treatment of immunosuppression and targeted therapies that we now use, I really think the future right now is very optimistic for our patients with lupus and most of them really can have fully enriched lives with minimal side effects from the medicines and minimal toxicity from them and improvement in the course of their disease so they do not end up with some of the bad pitfalls and problems that we've seen in past treatment of this disease. So I'm very, very optimistic for the future of my lupus patients.

**Dr. Caudle:**
Well with those final thoughts in mind, I'd like to thank my guest Dr. David Batt for sharing his perspective on early intervention for systemic lupus erythematosus. Dr. Batt, it was great speaking with you today.

**Dr. Batt:**
Thank you very much. My pleasure.

**Announcer:**
This episode of *Living Rheum* was sponsored by GSK. To access this and other episodes in this series, visit ReachMD.com/Living Rheum, where you can Be Part of the Knowledge. Thanks for listening!