Retinal disease in patients with systemic lupus erythematosus

Osamu Ushiyama, Keiko Ushiyama, Syuichi Koarada, Yoshifumi Tada, Noriaki Suzuki, Akihide Ohta, Shinji Oono, Kohei Nagasawa

Abstract

Objective—To investigate the incidence of retinopathy in systemic lupus erythematosus (SLE) and to clarify its significance in relation to other clinical manifestations.

Methods—A cross sectional study on lupus retinopathy was made in 69 patients with SLE. One expert ophthalmologist examined the ocular fundi of the lupus patients without any information of their disease state. Clinical and laboratory findings in the patients with retinopathy and those without were compared.

Results—Retinopathy was found in 7/69 (10%) patients. The findings included haemorrhages, vasculitis, cotton wool spots, and hard exudates, all of which were considered to reflect vascular damage. Retinopathy was found to be associated with the presence of antiphospholipid antibody (p<0.05) and with central nervous system lupus (p<0.01). The patients with retinopathy had higher levels of serum creatinine than the patients without retinopathy (p<0.01). The disease activity of lupus, as assessed by the maximum SLE disease activity index (SLEDAI) score of the patients, was also significantly higher in the patients with retinopathy (p<0.03).

Conclusion—Incidence of retinopathy in SLE was similar to that in previous reports and it may reflect tissue microangiopathy, particularly associated with vasculitis or antiphospholipid antibodies, or both.


It is known that patients with systemic lupus erythematosus (SLE) sometimes have ocular manifestations. It is generally understood that the causes of ocular manifestations of SLE include active lupus, antiphospholipid antibody syndrome (APS), and drugs used to treat SLE.1 The most common pattern of retinopathy is thought to be microangiopathy.2 However, it is not well understood whether retinopathy correlates with antiphospholipid antibodies (aPL) or central nervous system (CNS) disease. aPL represent a heterogeneous group of antibodies against phospholipid binding proteins or their complexes with anionic phospholipids.3 As the presence of aPL often provokes arterial and venous thrombosis, intrauterine fetal loss, and thrombocytopenia,4 many organs may be affected by these antibodies.5 6 On the other hand, CNS disease is known as a severe manifestation of SLE. CNS lupus is thought to be mainly associated with vasculopathy7 and it is characterised by a wide variety of clinical features, from mild psychotic symptoms to severe convulsion or disturbance of consciousness. An association of aPL with CNS lupus has also been described.8 9 This prompted us to make a cross sectional study of lupus retinopathy with special reference to aPL and CNS disease in patients with SLE.

Patients and methods

PATIENTS
Sixty nine consecutive patients with SLE (four male, 65 female) who fulfilled the American College of Rheumatology criteria for SLE10 were enrolled; three were inpatients and 66 outpatients. The mean ages at the onset of SLE and at the ophthalmological examinations were 32.1 and 40.7 years, respectively. Fifty three patients were receiving corticosteroids and 16 patients had never received them; no patients had discontinued corticosteroid treatment. The mean duration of steroid treatment was 5.8 years. The average daily dose of steroids at the ophthalmological examination was 7.8 mg (as prednisolone). Seven patients had taken immunosuppressant drugs, including cyclophosphamide and azathioprine.

METHODS
One expert ophthalmologist (KU) carried out all the ophthalmological examinations without knowledge of the general condition of each patient or of laboratory findings. Retinopathy was defined as the presence of any of the following lesions: haemorrhages, vasculitis (sheathing of retinal arterioles and/or venules or vascular tortuosity), cotton wool spots, papilloedema, optic atrophy, or retinal detachment according to the report of Stafford-Brady et al.2 In addition to these findings, we also included hard exudates unless the patients had essential hypertension or diabetes mellitus, because they were considered to be the result of deposition of exuded lipids or proteins from the degenerated ocular nerves or from vessels with hyperpermeability. Retinal lesions considered to be caused by hypertension (that is, not caused by SLE), arteriosclerosis, or diabetes mellitus, were excluded. We divided the patients into two groups according to the presence or absence of retinopathy, and clinical and laboratory findings were compared between the groups. The maximum disease activity through the entire history of SLE in each patient was scored according to SLE disease severity.
Renal disease was defined according to 1982 ACR criteria: persistent proteinuria (>0.5 g/day or >3+) or cellular casts, or both. In addition, a raised serum creatinine level (normal >84 µmol/l) was also included in the index. Measurement of anticardiolipin antibodies was performed with a commercially available anticardiolipin enzyme linked immunosorbent assay (ELISA) kit (Yamasa Shoyu Co, Ltd, Chiba, Japan). If the titre was over 3.2 U/ml, the result was defined as positive.

**STATISTICS**

The data were analysed with Student’s $t$ test, $\chi^2$ test, and Fisher’s $\times \times$ test.

**Results**

**INCIDENCE AND FEATURE OF RETINOPATHY**

Retinopathy was found in 7/69 (10%) patients—all female. The mean age at onset of SLE in the patients with and without retinopathy was 34.2 and 31.9 years, respectively. The mean age at the ophthalmological examination of each group was 42.3 and 40.4 years, respectively. The dose of steroids and the incidence of immunosuppressant treatment in both groups were similar (table 1).

Table 2 summarises the retinal findings of the patients with lupus retinopathy. Five of the seven patients had microhaemorrhages; this was the most common finding. Vasculitic lesions, cotton wool spots, and hard exudates were each found in two patients. As none of the patients had essential hypertension or diabetes mellitus, these findings were attributed to lupus retinopathy.

**CLINICAL FEATURES OF THE PATIENTS WITH LUPUS RETINOPATHY**

Table 3 shows clinical features of the seven patients with retinopathy. Patient 1 was a new case of SLE. She had severe chorea and mild proteinuria. Other patients were all outpatients and their disease was inactive when examined. CNS disease was found in 5/7 (71%) patients, being significantly higher than in those without retinopathy (8/62 (13%), $p<0.01$). As shown, the CNS manifestations varied, including chorea, convulsion, manic state, epilepsy, and visual hallucination. Four of seven patients with retinopathy had proteinuria or a raised serum creatinine level, or both. Figure 1 shows that the serum creatinine concentration was higher in the patients with retinopathy than in those without (84.0 µmol/l v 56.6 µmol/l, $p<0.01$). Moreover, proteinuria was more commonly found in the patients with retinopathy than in those without (4/7 (57%) v 8/62 (13%), $p<0.02$) (data not shown). These results indicate that retinopathy may have a tendency to develop in patients with CNS or renal disease, or both.

<table>
<thead>
<tr>
<th>Patient No*</th>
<th>Age†</th>
<th>SLE** duration (months)</th>
<th>Steroid dose at the exam. (mg/day)‡</th>
<th>CNS** disease</th>
<th>Renal disease¶</th>
<th>IgG aCL**</th>
<th>Thrombotic events</th>
<th>Other events</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>48</td>
<td>1</td>
<td>0</td>
<td>Severe chorea</td>
<td>(+)</td>
<td>(+)</td>
<td>(−)</td>
<td>(−)</td>
</tr>
<tr>
<td>2</td>
<td>23</td>
<td>16</td>
<td>11.25</td>
<td>Convulsion</td>
<td>(+)</td>
<td>(+)</td>
<td>(−)</td>
<td>(−)</td>
</tr>
<tr>
<td>3</td>
<td>49</td>
<td>141</td>
<td>8.75</td>
<td>Manic state</td>
<td>(+)</td>
<td>(+)</td>
<td>(−)</td>
<td>(−)</td>
</tr>
<tr>
<td>4</td>
<td>52</td>
<td>48</td>
<td>5</td>
<td>Epilepsy</td>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
</tr>
<tr>
<td>5</td>
<td>53</td>
<td>66</td>
<td>12.5</td>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
</tr>
<tr>
<td>6</td>
<td>49</td>
<td>75</td>
<td>0</td>
<td>Visual hallucination</td>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
</tr>
<tr>
<td>7</td>
<td>37</td>
<td>108</td>
<td>7.5</td>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
<td>(−)</td>
</tr>
</tbody>
</table>

*Each patient number corresponds to the number in table 1.
†At the ophthalmological examination.
‡As prednisolone.
§Continuous proteinuria and/or cellular casts and/or increase of serum creatinine concentration at the time of the investigation.
**SLE = systemic lupus erythematosus; CNS = central nervous system; aCL = anticardiolipin antibodies.
ASSOCIATION WITH ANTICARDIOLIPIN ANTIBODIES

IgG anticardiolipin antibodies (IgG aCL) were detected in 26 of 61 patients tested (43%). A significant difference in the prevalence of aCL between the two groups was found (table 4). Although IgG aCL were found in only 20/54 (37%) patients without retinopathy, 6/7 (86%) with retinopathy had IgG aCL (p<0.05). Two of the seven patients had evidence of aCL related events (infarctions and recurrent abortions) (table 3).

Discussion

Retinopathy is one of the important, if not major, manifestation of SLE, which develops with an incidence of 7%–26%. In our study retinopathy was found in 10% of the patients with SLE, comparable with previous studies. All the findings of retinopathy were considered to reflect vascular damage, such as vasculitis and thromboembolism. For instance, haemorrhages, which were seen in five patients, might have been caused by vasculitis, thromboembolism, or hypertension. In this study we included hard exudates in lupus retinopathy unless the patient had uncontrolled essential hypertension or diabetes mellitus. The hard exudates consist of proteinaceous and lipid material derived from exudation of serum components from vessels, or from an accumulation of lipid products from degenerating neural elements within the retina. Pathological examination of cotton wool spots discloses disciform thickening of the retinal nerve fibre layer. Vasculitis or microembolism of the retinal arterioles which supply blood to the retinal neurones may cause destruction of the vessel walls or neural fibres, or both, resulting in the formation of cotton wool spots and hard exudates.

An important finding characteristic of lupus retinopathy is thought to be vasculitis of the retinal capillaries associated with local microinfarction. Charles describes the diagnosis of retinal vasculitis with perivascular exudates and patches of fluorescein leakage along vessels. Histological evidence of immune mediated vasculitis has also been reported in lupus retinopathy. On the other hand, ocular fundus is the only part of the human body where we can directly observe small vessels without injuring the tissue. This suggests that lupus retinopathy reflects systemic vascular damage and that ocular fundus examination should be carried out more often.

In conclusion, lupus retinopathy may reflect systemic, particularly CNS, vascular damage, which may develop in association with vasculitis or aCL, or both. In addition, the presence of retinopathy is suggestive of high disease activity during the history of SLE.

We thank Motoko Fujisaki for her assistance in the preparation of this manuscript.

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doi: 10.1136/ard.59.9.705