Concerns about the operational definition of remission in 2019 update of the EULAR recommendations for the management of systemic lupus erythematosus

We have read the recently published update of the EULAR recommendations for the management of systemic lupus erythematosus (SLE) recommendations[1] with great interest. While we greatly appreciate the effort made by the panel of experts, we would like to add our own comments with regards treatment objectives and the definition of remission.

Remission as suggested in figure 1[1] would be defined as systemic lupus erythematosus disease activity index (SLEDAI)=0 with no use of corticosteroids at all. However, although we are aware of the lack a universal definition for remission for SLE,[2] we believe this view of remission is too stringent, given that it should include remission of both a clinical and serological nature. Working within of this definition poses doubts as to the amount of effort that would have to be made in order to achieve remission in our SLE patients. For example, in the scenario of patients with no active clinical lupus but with hypocomplementemia of positive native DNA (serologically active, SLEDAI=4), a common occurrence in daily clinical practice, should we even use belimumab, to get a 'complete remission' as defined in the 2009 update of EULAR expert's panel recommendations?

Several groups have proposed a diverse set of remission criteria for SLE and the creation of an international task force has led to the DORIS group proposal,[3] in which for two levels of remission, namely, clinical remission on-therapy and remission off-therapy, no treatment other than antimalarial agents should be permitted. Given the international consensus that no changes in the treatment should be implemented for patients who present only serological activity without clinical activity, we believe that it would be more realistic to define remission as 'clinical' SLEDAI-2K=0. Perhaps, a dose of prednisone no more than 5 mg/day for patients with/without stable immunosuppressants and antimalarials. According to data from several authors, this subgroup of patients does not accrue damage during follow-up.[4 5] Furthermore, in a study from the Hopkins Lupus Cohort has shown that corticosteroid doses of under 7.5 mg/day are also associated with a very low degree of damage progression, as measured by Systemic Lupus International Collaborating Clinics/American College of Rheumatology (SLICC/ACR) damage index.[6]

In summary, we suggest that in order to avoid confusion, the definition 'SLEDAI=0' in figure 1 of the document should be changed for 'clinical SLEDAI=0'.

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