Response to: ‘Treatment of systemic lupus erythematosus: don’t forget hydroxychloroquine’ by Michaud et al

We thank Michaud et al for their comment and thorough overview of the multiple benefits of hydroxychloroquine (HCQ) in systemic lupus erythematosus (SLE).1 We fully agree with the authors’ punchline that ‘HCQ is still in 2019 the cornerstone of the treatment of SLE’; a detailed description of its beneficial actions can be found in the Supplementary Table 2 of the recommendations’ manuscript.4 In addition to the ones mentioned by the authors, HCQ has also been shown in observational studies to decrease the risk for infections, development of metabolic syndrome/diabetes and dyslipidaemia,5,6 as well as the risk for evolution to chronic kidney disease in lupus nephritis.6 Importantly, given the recent debate regarding optimal HCQ dose in lupus, it is worth saying that the vast majority of these studies did not examine associations between HCQ dose and effect; rather, HCQ was typically tested as a binary variable, where patients were simply asked if they were taking the drug or not. The present comment by Michaud et al gives us the opportunity to emphasise that the main concern of treating physicians should be to optimise patient compliance, since the latter has been consistently shown to be suboptimal, with complete non-adherence rates (ie, undetectable blood levels of HCQ) ranging from 7% to 29% in different studies.7 8 The actual prescribed dose may ‘fluctuate’ between 200 and 400 mg/day depending on patient weight, disease status and periodic eye examination, as recommended.

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