Treatment of systemic lupus erythematosus: don't forget hydroxychloroquine

We read with interest the last 2019 update of the European League Against Rheumatism recommendations for the management of systemic lupus erythematosus (SLE).¹ We agree with the comment by Gabriel Figueroa-Parra *et al* concerning the lack of mention of chloroquine as major treatment in SLE.²

Concerning survival, the LUMINA study group also showed that use of hydroxychloroquine (HCQ) was associated with a greater survival rate in 608 patients with SLE.³ Ruiz-Irastorza *et al* confirmed these results in 232 patients with SLE.⁴ The 15-year survival rate was 0.95 for patients using HCQ versus 0.68 for patients without antimalarial therapy. Finally, use of HCQ was also independently associated with a greater survival in a population of patients with SLE with nephritis.⁵

The LUPus in MInorities, NAture versus nurture (LUMINA) study group also showed that patients without HCQ had higher damage scores and were more likely to have renal disease or central nervous system disease and use of HCQ was associated with a reduced risk of developing new damage in multivariate analysis.³ The Canadian Hydroxychloroquine Study Group realised a double-blinded, placebo-controlled study that included patients with SLE to compare HCQ with placebo.⁶ The risk of SLE flares (including major flares) increased by 2.5 at the end of the 6-months follow-up period in the placebo group compared with the HCQ group. During the additional 3 years follow-up study, use of HCQ reduced major flares by 57%.⁷ Meinao *et al* published another double-blind placebo-controlled trial with chloroquine diphosphate steroid requirements and SLE Disease Activity Index score were higher in the placebo group and the flare risk was 4.6 times greater in the placebo group.⁸

Moreover, patients with lower blood HCQ concentrations have greater SLE disease activity and have a greater risk of disease flare.^{9 10}

During pregnancy, HCQ use is essential. It reduces risks of pre-eclampsia, cutaneous neonatal lupus erythematosus, fetal growth restriction and prematurity.^{11–13}

In conclusion, HCQ is still in 2019, the cornerstone of the treatment of SLE.

Martin Michaud,* Florian Catros, Sophie Ancellin, Francis Gaches

Department of Internal Medicine, Hôpital Joseph Ducuing, Toulouse, France

Correspondence to Dr Martin Michaud, Department of Internal Medicine, Joseph Ducuing Hospital, 31076 Toulouse, France; mmichaud@hjd.asso.fr

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