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). We agree with the comment by Gabriel Figueroa-Parra et al concerning the lack of mention of hydroxychloroquine as major treatment in SLE.

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. Ruiz-Irastorza et al confirmed these results in 232 patients with SLE. 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 associated with a reduced risk of developing new damage in multivariate analysis. The Canadian Hydroxychloroquine Study Group realised a double-blinded, placebo-controlled study that included patients with SLE to compare HCQ with placebo. 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%. 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.

Moreover, patients with lower blood HCQ concentrations have greater SLE disease activity and have a greater risk of disease flare.

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

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

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