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.² In addition to the ones mentioned by the authors, HCQ has also been shown in observational studies to decrease the risk for infections,³ development of metabolic syndrome/diabetes and dyslipidaemia,^{4,5} 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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