Correspondence on "Update on the diagnosis and management of systemic lupus erythematosus" by Fanouriakis *et al*

This review¹ provided a comprehensive update on recent developments in systemic lupus erythematosus (SLE) and proposed several new viewpoints. In terms of diagnosis, the authors were the first to put forward two types of clinical SLE, in addition to classified SLE. Particularly, in the European League Against Rheumatism (EULAR)/American College of Rheumatology score <10 category in figure 4, the authors suggested that an immunological score of ≥ 2 together with a clinical score of ≥ 6 could be regarded as clinical SLE. Therefore, a patient with any joint involvement (six points) and positive antiphospholipid antibodies (two points) could be considered as having clinical SLE. However, in clinical practice, this patient could also be diagnosed with antiphospholipid syndrome. In addition, in the negative antinuclear antibody category, a patient with positive antiphospholipid antibodies and with joint (six points) and haematologic (four points) involvement could be diagnosed with clinical SLE under their proposed diagnostic approach. Clinically, a patient with lymphoma could also have these characteristics and the use of these diagnostic criteria might lead to misdiagnosis as SLE. Hence, we suggest that the criteria for clinical SLE, as defined in this review, require more careful consideration.

In terms of treatment, cyclophosphamide is also widely used in moderate activity SLE, especially in lupus nephritis (LN). This was not mentioned in figure 5 of this review. Furthermore, EULAR/European Renal Association-European Dialysis and Transplant Association guidelines suggest that the treatment of LN should be based on kidney biopsy results,² which should be emphasised in the Lupus nephritis section of this review. In addition, rituximab could be an alternative treatment in refractory cases of LN.

Zhuochao Zhou, Yijun You, Fan Wang, Yue Sun, Jialin Teng , Honglei Liu, Xiaobing Cheng, Yutong Su , Hui Shi , Chengde Yang , Junna Ye

Department of Rheumatology and Immunology, Ruijin Hospital, Shanghai Jiao Tong University School of Medicine, Shanghai, China

Correspondence to Dr Junna Ye and Dr Chengde Yang, Department of Rheumatology and Immunology, Ruijin Hospital, Shanghai Jiao Tong University School of Medicine, Shanghai, China; yjn0912@qq.com, yangchengde@sina.com

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Contributors Study conception and manuscript writing: JY, CY, ZZ and YY. Manuscript revisions: JT, HL, XC, YS, HS and FW.

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ORCID iDs

Jialin Teng <http://orcid.org/0000-0003-1016-9064>

Yutong Su <http://orcid.org/0000-0003-0488-2939>

Hui Shi <http://orcid.org/0000-0002-3574-8807>

Chengde Yang <http://orcid.org/0000-0002-3720-634X>

Junna Ye <http://orcid.org/0000-0002-2823-4349>

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