Media fact sheet

Facts about lupus treatment

The current goal of lupus treatment is to manage patients’ symptoms by suppressing the overactive immune system and reducing inflammation.1 2 However, management can be a challenge as existing therapies can have serious side effects, and use of drugs that have not been approved is common.3

At present, the five main groups of systemic drugs that are typically used to control lupus are:1 3 4

- Non-steroidal anti-inflammatory drugs (NSAIDs) such as aspirin and ibuprofen. NSAIDs reduce inflammation and can relieve pain, fever, and arthritis associated with lupus. NSAIDs can cause gastric bleeding and cannot be tolerated by some patients.

- Antimalarials such as hydroxyquino-lone and hydroxychloroquine. These drugs are useful in controlling arthritis-like symptoms such as joint pain and swelling.

- Corticosteroids such as prednisolone. Steroids are powerful anti-inflammatory drugs that can suppress the immune system and are the drugs of choice when treating serious complications, such as those affecting the heart, lung and brain. However, steroids are associated with side effects such as swollen face, weight gain, increased risk of infections, osteoporosis, high blood pressure and diabetes.

- Immunosuppressants such as azathioprine and methotrexate. These drugs are used to suppress the immune system and are often only used in serious complications where steroids are inadequate. Use of immunosuppressants must be monitored, as it can lead to increased susceptibility to infections.

- Cytotoxic chemotherapies such as cyclophosphamide. These drugs are only used when a patient’s lupus cannot be controlled by other drugs. They are considered immunosuppressive because they can prevent cell proliferation (including the proliferation of immune cells) and weaken the immune system. These drugs also suppress bone marrow activity and can lead to low white blood cell counts and susceptibility to infections.

Recent drug approvals

March 2011 saw the US Food and Drug Administration (FDA) approve belimumab for the treatment of adult patients with active, autoantibody-positive systemic lupus erythematosus (SLE) who are receiving standard therapy.5

The US label includes the following limitations of use: The efficacy of belimumab has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus, and has not been studied in combination with other biologics or intravenous cyclophosphamide. Use of belimumab is therefore not recommended in these situations.6

Are any new treatments under development?

Although current treatments can induce remission in the majority of patients by depressing the overactive immune system, they are not a cure. Many patients will experience periodic worsening of symptoms (‘flares’) despite treatment.7 8 In particular, flares can cause cumulative damage to the kidneys, causing problems that can be compounded by the use of immunosuppressive medications for flare control.7 Improvements in healthcare have improved survival in SLE patients, but at present there are few effective options. However, thanks to recent advances in the understanding of SLE, a number of promising new treatments are in development.3 9 10 These target immune system components such as B-cells and T-cells.3 10
**What is the prognosis?**

In the middle of the last century, only 50% of SLE patients could expect to live for 5 years after diagnosis; today, 90% of SLE patients survive for more than 5 years. This improvement can be attributed to earlier detection and diagnosis, improved education of physicians and patients, general advancements in healthcare — such as better management of hypertension and infections — and better specialized care for lupus patients. Importantly, mortality due to SLE itself is highest in the first few years after the onset of symptoms; in patients with long-standing SLE, mortality is more commonly due to infections resulting from the use of immunosuppressive drugs.

**For more information visit www.ucb.com**

**References**