MINI SIMPOZIJUM
SAVREMENI MULTIDISCIPLINARNI PRISTUP LUPUSU: IZAZOVI I REŠENJA IZVAN OKVIRA PREPORUKA I VODIČA

Padua University Hospital, Department of Medicine DIMED, Division of Rheumatology, Padua, Italy

IS REMISSION POSSIBLE IN SYSTEMIC LUPUS ERYTHEMATOSUS?

Margherita Zen

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Treat-to-target (T2T) in systemic lupus erythematosus (SLE) prioritizes remission and, when unattainable, low disease activity (LDA). Definitions converge on absent clinical activity by cSLEDAI/SLE-DAS or BILAG, physician global assessment near zero, and constrained or absent glucocorticoids. Across cohorts and trials, achieving remission or LDA is consistently associated with slower accrual of organ damage, fewer flares, lower mortality, better quality of life, and better discrimination of active therapy versus placebo. Where remission cannot be reached, maintaining LLDAS offers meaningful protection against damage and flares. Is sustained remission feasible? Evidence from cohorts and a systematic review shows that many patients reach remission for at least one year, roughly a fifth to two thirds sustain it for five years, and about a tenth maintain it for a decade, although estimates vary by definition and population. An Italian multicenter analysis and the Padua Lupus Cohort show a meaningful minority off glucocorticoids or on very low doses long term.

Determinants span three domains. First, definition-related factors: the dichotomous nature of SLEDAI-2K, inclusion of serology, thresholds for prednisone and concomitant immunosuppression, duration requirements, and limits of physician global assessment. Second, disease-related factors: earlier disease, lower baseline activity, and absence of renal, hematologic, vasculitic, or serologically active disease favor remission; high activity, nephritis, cytopenias, vasculitis, anti-dsDNA positivity and hypocomplementemia predict failure. Third, population and system factors: genetics/ethnicity, socioeconomic status, geography, reference-center care, and drug-pricing and coverage policies shape access, adherence, and outcomes.

Therapeutically, biologics contribute: belimumab increases the odds of remission versus placebo in pooled phase III analyses and real-world data; anifrolumab roughly doubles time spent in remission versus placebo in pooled TULIP analyses, with supportive compassionate-use data in refractory disease.

In sum, durable remission is attainable for a substantial subset, particularly within accessible, high-quality systems with timely specialist care and advanced therapies in practice.

Keywords: SLE, treat-to-target, low disease activity, remission

Univerzitet u Beogradu, Medicinski fakultet
Kliničko bolnički Centar "Zvezdara", Kliničko odeljenje za nefrologiju i poremećaje metabolizma sa dijalizom "Prof. dr Vasilije Jovanović", Beograd

IMA LI NOVINA U LEČENJU LUPUS NEFRITISA?

Aleksandar Janković

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Lupus nefritis (LN) predstavlja bubrežnu manifestaciju sistemskog eritemskog lupusa (SEL) i javlja se kod 20% do 60% obolelih od SEL. Pojava LN povezana je sa većim mortalitetom bolesnika sa SEL, pogotovo kada LN dovede do terminalne bubrežne slabosti. Lečenje LN ima za cilj očuvanje bubrežne funkcije i smanjenje morbiditeta i mortaliteta povezanih sa hroničnom bubrežnom slabošću, uz što manju toksičnost lekova korišćenih u lečenju.

Dijagnoza LN se postavlja biopsijom bubrega, a nakon otkrivanja patološkog sedmineta urina (proteinurija, eritrociturija, leukociturija) i/ili uočenog pada procenjene jačine glomerulske filtracije.

Način lečenja LN zavisi od patohistološke forme bolesti, te dobijenim podacima o aktivnosti i hronicitetu promena u glomerulima i tubulima bubrega. Prema najnovijim preporukama KDIGO (*Kidney Disease: Improving Global Outcomes*) iz 2024.g., bolesnici sa LN tip III i IV bi trebali biti lečeni indukcionom kombinovanom imunosupresivnom terapijom koja uključuje kortikosteroide i jednu od sledećih lekova ili kombinacija lekova (analozi mikofenolične kiseline/niska doza ciklofosfamida/belimumab i analog mikofenolične kiseline ili niska doza ciklofosfamida/analog mikofenolične kiseline i kalcineurinski inhibitor(CNI)). Kod ovih bolesnika kao terapija održavanja preporučena je upotreba niske doze kortikosteroida uz analoge mikofenolične kiseline ili azatioprin ili CNI. Lečenje LN tip V je nešto drugačije i podrazumeva uz kortikosteroidnu terapiju, upotrebu još jednog agensa (analog mikofenolične kiseline, ciklofosfamid, CNI, rituksimab ili azatioprin). Imunosupresivna terapija nije preporučena u lečenju bolesnika sa LN tip I i II.

I pored značajnog napretka u lečenju LN i uvođenju različitih imunosupresivnih agenasa, ispitivanje novih je uvek aktuelno, pogotovo za refraktarne oblike bolesti. Trenutno je u svetu 14 aktivnih studija Faze III koje regrutuju bolesnike sa LN, a najveće među njima uključuju ispitivanje Ianalumaba (monoklonsko At koje utiče na depleciju B ćelija preko ADCC i BAFF receptora), anifrolumaba (monoklonsko At na tip I receptor za interferon) i obinutuzumaba (anti-CD20 monoklonsko At).

Ključne reči: SLE, lupus nefritis, analozi mikofenolične kiseline, kalcineurinski inhibitori, belimumab