Learning Objectives
- Describe antimalarial muscle toxicity in skeletal and cardiac muscle
- Discuss the possible association between antimalarial treatment and QTc prolongation and its possible consequences
- Describe antimalarial deposition in cardiac muscle and its consequences
- Differentiate the role of cardiac biomarkers in the early detection of antimalarial induced cardiomyopathy

REFERENCES


LOW DOSE ASPIRIN IN APL-POSITIVE PATIENTS: ARE WE TREATING THE PATIENT OR THE DOCTOR?

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Patients with antiphospholipid antibodies (aPL) are at increased risk for arterial or venous thrombosis. There is, however, significant heterogeneity among patients according to clinical and laboratory features. Therefore, two therapeutic modalities can be discussed for primary prevention of thrombosis in patients: (1) primary prophylaxis in all aPL patients or (2) only in selected high-risk patients. Because aPL are often diagnosed in patients with systemic lupus erythematosus before occurrence of a first thrombosis, primary prophylaxis should be specifically discussed in this setting.

Risk for thrombosis in lupus patients may be increased by additional clinical risk factors, in particular hypertension. Laboratory profile is also important: lupus anticoagulant, double (any combination of lupus anticoagulant, antiphospholipid antibodies or anti-b2 glycoprotein I antibodies) or triple (all three subtypes) aPL positivity, as well as the presence of persistently high aPL titres indicate high risk patients. Specific risk scores may be helpful such as the global antiphospholipid syndrome score (GAPSS).

Observational data indicate that low dose aspirin reduces the risk of first thrombosis in aPL patients, particularly in those with lupus (by 50%) with a low bleeding risk. To improve the risk:benefit ratio, prescribe aspirin in patients with high-risk profiles and low bleeding risk.

Treatment failure may be due to aspirin resistance (insufficient dosage, poor absorption or drug interaction) or poor treatment adherence (long term prophylactic treatment in young patients) of which the attending physician must be aware.

In summary, prophylactic low dose aspirin in aPL positive lupus patients should be considered taking into account thrombotic and bleeding risks. Because of its long-term objectives, this treatment should be carefully explained and discussed with the patient before taking a shared decision.

Learning Objectives
- Explain when primary prophylaxis should be used for APL
- Describe the risk factors for thrombosis in patients with lupus
- Discuss optimal treatment options for thrombosis risk reduction in patients with aPL

SESSION 2: THE ROLE OF INTERFERONS IN SLE

Type I interferons (IFNs), including IFN-α, IFN-β, IFN-ω and IFN-κ, represent an essential host defense mechanism stimulated by virus infection.1-4 In that setting, type I IFN is tightly regulated with duration of expression limited to several days. When its production is sustained, its protean effects on immune cell function can be damaging. Activation of the type I IFN pathway, typically defined by elevated expression of type I IFN-inducible gene transcripts or their protein products, is a feature of nearly all children diagnosed with systemic lupus erythematosus (SLE), as well as the majority of adult lupus patients. Taken together with insights from murine models, studies of lupus patients have supported the conclusion that type I IFNs comprise a family of pathogenic mediators that contribute to autoimmunity, inflammation and ultimately tissue damage in patients with SLE and some other systemic autoimmune diseases, particularly primary Sjogren’s syndrome and dermatomyositis.

Coordinated expression of type I IFN-stimulated genes is a feature of most patients with SLE, but the relationship of the IFN signature to disease activity has been debated. In addition, the inducers of IFN and the molecular pathways and signaling molecules that result in IFN production have not been well defined. Endogenous nucleic acids have been identified as the relevant drivers of type I IFN production, but the specific features of those nucleic acids have not been well characterized. It is not apparent whether the endosomal toll-like receptors or cytosolic nucleic acid sensors are most relevant to IFN expression in individual patients. Finally, the mechanisms that regulate activation of the IFN pathway – or fail to regulate that pathway in some lupus patients – have not been well defined. To gain insight into these issues, we collected extensive longitudinal clinical, serologic, proteomic and gene expression data to assess the correlates of IFN pathway activation, and to establish new hypotheses regarding the relationship of autoantibody specificity and environmental exposures to production of IFN and induction of IFN-stimulated genes.

Analysis of proteomic and gene expression data collected for up to 4 years on individual patients was analyzed to
understand temporal patterns among relevant autoantibodies and the IFN signature in relation to disease flares. Our data suggest a potential role for microbial triggers in driving the immune system activation that leads to disease flares and support activation of the type I IFN as highly associated with disease flare in many patients.

Learning Objectives
- Describe potential mechanisms of type I IFN induction in SL
- Describe individual temporal patterns in immune system activation based on longitudinal patient data
- Explain possible interpretations of longitudinal patient data with regard to triggers of lupus flare

REFERENCES

06 INTERFERON INHIBITION AND THE FUTURE MANAGEMENT OF SLE

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Type I interferon (IFN) is the term for a family of cytokines acting through a common receptor, known as IFNAR. Though functions are diverse, broadly speaking IFNs act in the innate immune system, providing rapid early host response to viral infection. Viruses activate IFN production largely through activating nucleic acid sensors including toll-like receptors (TLRs) 7–9 as well as other intracellular pathways, which have evolved to detect the presence of nucleic acids in the cytoplasm. Ligation of IFNAR leads to a cascade of inflammatory responses and enhances activation of the adaptive immune system.

It is now understood that these pathways of response to nucleic acid can be activated in diseases ranging from hereditary interferonopathies to acquired autoimmune interferonopathies, of which SLE is the archetype. Evidence of activation of the IFN system through increased expression of sets of IFN-regulated genes, known as the IFN signature, was first detected in SLE over 20 years ago. Other evidence for the role of IFN in SLE includes exacerbation of animal models of lupus by IFN treatment and induction of lupus-like clinical phenotypes in humans treated with IFN for other diseases.

Early clinical trials of IFN-blocking therapies had limited success, associated with incomplete suppression of the expression of IFN signatures. More recently, a monoclonal antibody to IFNAR, anifrolumab, demonstrated efficacy in a Phase 3 trial, after prior success in Phase 2 and positive results against all but the primary endpoint in another Phase 3 study. 1–3 Broadly, anifrolumab treatment resulted in reduced disease activity, improved skin, joint and flare outcomes, and increased rates of glucocorticoid tapering, with acceptable safety notwithstanding included increased rates of herpes zoster reactivation. 4

The potential applications of IFN blocking treatments in the management of systemic lupus erythematosus (SLE) driven by this evidence base will be explored.

Learning Objectives
- Describe the biology of type I IFN in autoimmune disease
- Discuss the evidence for the role of type I IFN in the pathogenesis of SLE
- Explain early clinical trial data supporting the role of type I IFN in SLE
- Describe the efficacy and safety of anifrolumab in the treatment of SLE
- Discuss future directions in IFN inhibition in SLE

REFERENCES