Abstracts

Cardiovascular disease burden in SLE: risk assessment and management
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Background: Cardiovascular disease (CVD) is a leading cause of morbidity and mortality in systemic lupus erythematosus (SLE). Patients with SLE have a 2- to 10-fold higher risk of ischemic heart disease and stroke compared with the general population. An interrelationship between immunological, disease-related, and traditional cardiovascular risk factors contributes to CVD pathogenesis.

CVD Risk Assessment: Early recognition and management of CVD risk factors is important for the prevention of CVD events. For the assessment of CVD risk, generic clinical prediction scores have been used. Evidence has shown that Framingham score underestimates CVD risk in SLE, while limited data are available about the performance of the Systematic Coronary Risk Evaluation (SCORE). The modified Framingham, and the modified SCORE, multiplied by 2 and 1.5, respectively, have been developed, and the most recent version of the QRISK prediction score (QRISK3) included weights for SLE. The SLE Cardiovascular Risk Equation was recently developed including both traditional and disease-related CVD risk factors (SLEDAI, lupus anti-coagulant, C3) and was found to have higher estimated risks than the ACS/AHA risk equation.

Several vascular imaging markers (e.g., intima-media thickness, carotid and femoral atherosclerotic plaques) and circulating biomarkers have been evaluated for CVD risk stratification. Vascular ultrasound studies showed a 2- to 3-fold increased risk for asymptomatic plaque presence in patients with SLE compared to healthy controls, and a comparable risk to other high-cardiovascular risk disorders such as rheumatoid arthritis and diabetes mellitus. Markers of arterial stiffness or endothelial dysfunction such as the pulse wave velocity and flow-mediated dilation, respectively, have been also more impaired in SLE than in the general population in some studies.

CVD Risk Management: According to the recent ‘EULAR recommendations for cardiovascular risk management in Rheumatic and Musculoskeletal Diseases including Systemic Lupus Erythematosus and Antiphospholipid Syndrome’, a blood pressure target of <130/80 mm Hg should be considered in patients with SLE. Use of ACE inhibitors or angiotensin receptor blockers is recommended for patients with lupus nephritis with urine protein-to-creatinine ratio >50 mg/g or arterial hypertension. Patients with SLE may be candidates for preventative strategies as in the general population, including low-dose aspirin, based on their individual cardiovascular risk profile. Regarding lipid control, recommendations used in the general population should be followed.

Evidence from several observational studies has shown a lower risk of CVD events in patients treated with hydroxychloroquine versus those not treated. EULAR recommendations stated that treatment with hydroxychloroquine (which is recommended for all SLE patients) should be considered to also reduce the risk of cardiovascular events. Accordingly, the lowest possible glucocorticoid dose is recommended to minimise any potential cardiovascular harm. No specific immunosuppressives can be recommended for lowering the risk of cardiovascular events.

In conclusion, CVD burden in SLE is high. Increasing awareness of CVD risk in patients with SLE, regular screening and control of modifiable CVD risk factors, as well as patient education and lifestyle modifications, are crucial for CVD prevention and management in these patients.

References

Learning Objectives
- Describe the need for regular screening and control of modifiable cardiovascular risk factors in patients with SLE
- Explain the importance of increasing awareness of cardiovascular risk in patients with SLE, for improving patient outcomes
- Discuss the potential impact of patient education and lifestyle modifications for the prevention of CVD in patients with SLE

Fatigue in SLE
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Fatigue is one of the most common symptoms in those with systemic lupus erythematosus (SLE), and may impair daily activities, decrease health-related quality of life and lead to employment disability. In SLE, significant fatigue is reported by two-third of patients and rated as severe by one-third. Due to the highly multifactorial nature of fatigue, its assessment and treatment remains a major challenge in SLE. A careful assessment of its determinants is therefore key for an efficient and individualised management in SLE. First, common causes of fatigue unrelated to SLE such as sidereopenic anaemia, sleep apnea or adrenal failure should be ruled out based on a thorough medical history as well as targeted clinical and laboratory examinations. Then, disease activity and organ damage due to SLE should be assessed. The relationship between fatigue and disease activity remains very controversial in SLE. In those with active disease, remission is the most appropriate therapeutic target and may improve fatigue. Significant damage such as renal or cardiac failure is also associated with high levels of fatigue in SLE, and symptomatic treatment may also improve fatigue levels. In patients with inactive disease and no significant damage, anxiety and depression are common and