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Enfermedades Autoinmunes Sistémicas

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Antiphospholipid antibodies and thrombotic events in covid-19 patients hospitalized in medicine ward

- 104 patients (57.7% males, 71 years)
- 11 (10.6%) patients had a thrombotic event (9 acute pulmonary embolisms, 1 deep vein thrombosis and 1 aortic thrombus).
- History of venous thrombosis, increased C- reactive protein and D-Dimer levels versus patients without thrombotic events.
- Overall, 49/104 (47.1%) patients had a least one positive aPL marker while double was found in 11.1% and triple positivity in 1.9%
- The presence of at least two positive aPL (>30 U/ml) was associated with thrombosis (27.3% vs 1.1%, p =0.003].

LeJoncou A et al. (Paris, France)

Determination of Homogenous Subgroups of Antiphospholipid Syndrome: A Cluster Analysis Based on 509 Cases

- Cluster 1 (n=181): patients with venous thrombosis (78%) and premature births due to placenta insufficiency (14%), without associated auto-immune disease
- Cluster 2 (n=130): older patients (mean 45.8 years), mostly men,with arterial events history (89%). Valvular involvement (21%), migraine (21%), livedo (35%), arterial hypertension (49%), and cardiovascular risk factors were relatively frequent.
- Cluster 3 (n=102): younger patients, frequently women, with associated SLE (76%) or other autoimmune diseases (30%). They frequently had history of venous thrombosis (74%) and of pregnancy morbidity (36%). Thrombocytopenia (48%), haemolytic anaemia (14%), and lupus anticoagulant (84%) were frequent.
- Cluster 4 (n=96): patients with a history of CAPS (77%) and/or APS-associated nephropathy (93%), and pregnancy morbidity (36%). Renal hypertension (61%), livedo (36%), seizures (14%), valvular involvement (44%) and triple positivity (66%) were relatively frequent.

Yann Nguyen et al. (Paris, France)

Rituximab for Refractory Manifestations of the Antiphospholipid Syndrome: A Multicenter Israeli Experience

- Manifestations of APS including diffuse alveolar hemorrhage, recurrent thrombosis, thrombocytopenia, neurological and skin manifestations.
- 40 patients treated with RTX for refractory APS [31 PAPS (78%)]
- 32 patients (80%) responded with complete response in 22 (55%).
- A RTX regimen of 375mg/m2 X 4 was more effective than a regimen of 1000 mgx2 (100% vs. 65%; p=0.01).
- Complete response was associated with a decrease in aPL titers 4-6 months post treatment. No significant change in aPL titers was observed in patients with partial or no response.

Management of APS: Scientific session

- Antiphospholipd antibodies:
  - aPS/PT no van a ser incluidos en los nuevos criterios
  - No sustituyen a la determiacion del AL
- Tratamiento de APS:
  - Los DOAC no estan indicados en APS trombótico
  - Mejor tratamiento para thrombosis arteriales: Sintrom INR 2.0- 3.0 + AAS
- Futuros tratamientos:
  - Ir a los mecanismos patogenicos

Delineation of a Proinflammatory Cytokine Profile Targeted by Janus Kinase 1/2 Inhibition Using Baricitinib in a Phase 2 SLE Trial

- Baricitinib 4 mg treatment was associated with statistically significant decrease of serum IL-12/23p40 and IL-6 at Week 12 which continued through Week 24. Serum IFN-α or IFN-γ were not reduced with baricitinib treatment.
- Baricitinib 4 mg simultaneously impacted multiple pro-inflammatory cytokines implicated in the pathogenesis of SLE.

Doner T et al (Berlin, Germany)

Herpes Zoster Events with Anifrolumab in Patients with Active SLE: An Integrated Analysis of Phase 2 and Phase 3 Trials

- In pooled data from MUSE, TULIP-1 and TULIP-2 trials
- HZ occurred in 5.4% (n=5), 6.1% (n=28), and 8.6% (n=9) of pts in the anifrolumab 150-mg, 300-mg, and 1000-mg groups
- Duration and severity, were comparable between treatment groups, and most HZ events were mild to moderate, cutaneous, and resolved without discontinuation of study drug.

Merrill J. (Oklahoma, US)

Gradual Glucocorticoid Withdrawal Is Safe in Clinically Quiescent Systemic Lupus Erythematosus

- 156 maintained low dose prednisone and 114 discontinued gradually (62 within 12 months and 52 in 12-24 months)
- Analysis of the slow (within 12-24 months) and fast (within 12 months) withdrawal patients demonstrated that the former group achieved better outcomes both for clinical flares and damage accrual
- Gradual glucocorticoid withdrawal was associated with significantly less clinical flares at 24 months. Damage accrual was significantly less in the withdrawal patients. Immunosuppressive therapy at baseline was protective against new flares.
- Gradual glucocorticoid withdrawal is safe in clinically quiescent SLE.

Tselios K et al. (Toronto, Canada)