Response to comments by Ruiz-Irastorza et al. on the British Society for Rheumatology guideline for the management of systemic lupus erythematosus in adults

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Sir,

We are grateful to Guillermo Ruiz-Irastorza and colleagues for their very positive comments (1) about the British Society for Rheumatology guideline for the management of systemic lupus erythematosus in adults(2). Regarding their comments suggesting that we might have been more radical regarding the dose and duration of corticosteroids we would like to emphasise that we did state in the main text of the executive summary(3) and in the full guideline(2), as well as in our table in both documents suggesting dosing regimens for active disease and maintenance therapy, that the lowest effective dose should be used at all times.

We are well aware of the toxicity of high dose corticosteroids and that many patients will respond to doses well below 1mg/kg/day for severe flares. However there is considerable variation in dosing required in different patients with various lupus manifestations, particularly if they are already on corticosteroids. If intravenous pulses are not being used for any reason, oral doses of prednisolone or equivalent in the range of up to 0.75-1 mg/kg/day may be required for life-threatening conditions unresponsive to the lower dose such as up to 0.5mg/kg/day as suggested first in the table. We specifically recommend in the main guideline section on severe lupus therapy with corticosteroids(2) that the lower dose oral and intravenous regimens should be used rather than the higher doses that have been used in the past. We never suggested that prednisolone doses greater than 30mg/day were required for any specific indication.

We did not quote the paper by Ruiz-Arruza et al.(4) as it was published in early June 2015, just after we ran our last literature search for corticosteroids and we can only apologise that we did not pick this up later and for any other omissions. However this paper and other reports of corticosteroid regimens used in lupus nephritis mentioned by Ruiz-Irastorza et al.(1) do not address or exclude the need for patients with very severe lung, cardiac, gastro-intestinal, haematological and neuro-psychiatric lupus requiring higher dose corticosteroid regimens, particularly as the entry criteria for the study reported by Riuz-Arruza et al.(4) was a SLEDAI score of only 6 or more.

We did not provide any specific recommendations for tapering corticosteroids in non-renal lupus as there was little evidence for a reliable strategy for all lupus patients when we defined the topics for our literature review. This is certainly a topic worthy of further discussion in

the light of new evidence in a future revision of the guideline and we did emphasise reduction to a safer target dose of $\leq$7.5 mg/kg/day to avoid complications of corticosteroid therapy so we would not expect patients to be exposed to high doses for long periods of time. In the section on key standards of care at the end of the main guideline we discuss again the importance of using the least amount of corticosteroids possible and the importance of adjusting therapy if treatment is not producing the desired effect within the expected time frame to reduce the risk of accumulation of chronic damage.

REFERENCES

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