Mortality
Mortality in patients with a severe form of lupus has fallen considerably over the years. Cardiovascular involvement (heart failure), infections (osteonecrosis, malignant conditions (non-Hodgkin’s lymphoma), thrombosis: Fetal death in utero, premature birth, miscarriage, hypotrophy, neonatal lupus), nephritis, central nervous system lupus or cardiac flares during the pregnancy. For the mother, the greatest risk is around the 3rd trimester and postpartum, with the possible occurrence of complications: lupus flare, pre-eclampsia, preeclampsia or arterial thrombosis for the child; the risk vary greatly in terms of deaths; premature births, infections, hypotrophy, neonatal lupus.

To sum up: the causes of early death are lupus nephritis (classes 3 and 4), infections (to which patients can become more susceptible due to their treatment, in particular immune suppressants; lupus nephrotic syndrome. About 50% of people with lupus have untreated nephritis, they can develop into end-stage kidney disease or kidney failure). Mycophenolate mofetil has fewer side effects than cyclophosphamide and has the advantage of being administered orally. Corticosteroids/cyclophosphamide or corticosteroids/mycophenolate mofetil combinations are indicated as a first-line treatment, to induce a remission. Corticosteroids and Azathioprine® (or mycophenolate mofetil) are then prescribed, as maintenance therapy, to prevent relapses.

Other treatment strategies will soon be available, aimed at the molecular targets underlying the disease. Two are already on the market: Rituximab© (anti-CD20 antibody) and Belimumab© (anti-BLyS antibody). Belimumab has a marketing authorisation in the United States, Europe and Canada for the treatment of lupus nephritis, central nervous system lupus or cardiac flares during the pregnancy and postpartum, with the possible occurrence of complications: lupus flare, pre-eclampsia, preeclampsia or arterial thrombosis for the child; the risk vary greatly in terms of deaths; premature births, infections, hypotrophy, neonatal lupus.

The assessment of the disease activity and the risks involves: the evaluation of the patient’s medical file, the results of the last 6 months specialist follow-up assessment, hospital reports, biological tests (CRP, platelets, ESR, US).

Points to remember for risk selection

Majors features of lupus:

- It causes: in flares, sometimes triggered by identifiable environmental factors.
- It diagnostic: requires a combination of clinical and laboratory criteria.
- It prognosis: dominated by three types of complications: renal, neurological and cardiovascular, curable with a 10-year survival average of about 90%.

A guarded approach for:

- The first few months: complications, viral, renal, neurological, infectious and infectious complications due to the cover sought, the risks and the form of the disease (minor, moderate, severe).

Lupus is a disease caused by a disorder of the immune system, to pathophysiological mechanisms, which include genetic, immunological and environmental factors, remain poorly understood.

This is a rare disease: in the United States, its prevalence is between 15 and 50 per 100,000 inhabitants and its incidence is between 5 and 10 new cases per year for 100,000 inhabitants. It mainly affects women (10:1 female vs male) and in particular young women, aged from 20 to 35; the age profile has been changing, however, over the last few years, with more women being affected at the age of 50. Lupus patients have a ten-year survival rate of over 95%, thanks to therapeutic progress and earlier diagnosis.

On the other hand, the treatments available have effects and side-effects. Major criteria are associated with a poor prognosis: lupus is more serious, for example, in men than in women; children with the disease develop slower than adult patients; advanced complications in adulthood.

Lupus is an autoimmune disease (AID) characterized by an abnormal immune reaction of the body against itself: the immune system, which is supposed to defend the body against external aggression turns to the body’s own tissues. AIDs are subdivided into organ-specific, or localized and systemic, which can affect all the organs; lupus is the prototype of the systemic category, which also includes rheumatoid arthritis, Sjögren’s syndrome, antiphospholipid antibody syndrome, systemic sclerosis, inflammatory myopathy, etc. The organs mainly affected are the skin, the joints, the kidneys and the heart. With the exception of sepsis (inflammation of the blood vessels), systemic AIDs occur under the combined effects of genetic predisposition, environmental factors and the failure of the immune regulation system.

Mortality

Causes of deaths over the last two decades % of deaths

What clinical signs in 155 lupus sufferers


CRA. The markers for disease activity will be the complement C3 level to be checked 3 times a year and to monitor the disease course, in addition to creatinine, proteinuria and haematocrit levels for kidney function.

Introduction

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The ACR criteria of lupus

Lupus is a chronic disease, which occurs in flares. Its clinical ex-

Articular manifestations

These affect 86% of patients, mainly in the form of arthralgia and arthritis. Articular inflammation and articular stiffness are the main causes of early com-

The WHO classification, neuropsychiatric lupus, cardiovascular

manifestation, such as the cutaneous and articular forms and

Cardio-pulmonary involvement

These conditions concern 35% of lupus sufferers including 25–30% of flare patients, 25–30% of acute lupus, and 40–50% of severe forms. They present in 80–90% of patients. But they also present in 10–20% of patients suffering from non-autoimmune diseases. 30–50% of patients suffering from idiopathic disease, navigate 75% of patients suffering from lupus\n
The ACR criteria of lupus

Lupus is a chronic disease, which occurs in flares. Its clinical ex-

Non-specific markers

The non-specific markers are markers of inflammation. The main non-specific markers are C-reactive protein, ESR, and CRP. They help in the diagnosis of lupus, but they are not specific markers. They are not used to monitor the disease.

Specific markers

Lupus is an autoimmune disease and several other immunological markers, such as anti-DNA antibody, are specific for the disease. These markers are used to monitor the disease.

Biomarkers of disease activity and treatments

The complement is a very important biological marker. There are two ways to measure it: one is indirect, with a good marker of lupus activity being a drop in the level of specific markers such as C3. The second is to monitor the disease.

Antinuclear antibodies: this protein, which wraps around the DNA and can cause a loss of function, is often a marker of lupus activity. An increase in the ACR antibodies suggests a flare of lupus.

A wide range of treatments

A wide range of treatments are described, which vary from no treatment to biologic therapy. Between these extremes, the drugs prescribed include hydroxychloroquine and non-steroidal anti-inflammatory drugs. In severe forms, long-term anticoagulants are prescribed in patients who have had thrombosis.

The anti-ENA antibody test is the most specific for lupus, and it is used to identify the antibody most specific to lupus. If the target is DNA, then it is the anti-DNA antibody. But they are also found in non-autoimmune disorders: Sjögren’s syndrome, and in all patients suffering from Sjögren’s syndrome, and in all patients suffering from Sjögren’s syndrome.

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Lupus nephritis

Lupus nephritis affecting the kidneys (class III) concerns 30–35% of patients. Two thirds of patients occur during the first two years of the disease. There are three clinical forms of lupus nephritis: class III, class IV, and class V.

Antiphospholipid antibodies

The presence of antiphospholipid antibodies (APL) is associated with antiphospholipids, lupus anticoagulant, antiphospholipid syndrome, and lupus anticoagulant. The test is not specific, and it can be positive in other diseases. The test is important in patients with a history of venous or arterial thrombosis.

Antiphospholipid syndrome

Patients with lupus may develop antiphospholipid antibodies. These antibodies can cause venous or arterial thrombosis. Antiphospholipid antibodies are also associated with antiphospholipid syndrome (APS).

Antiphospholipid syndrome

This syndrome is characterized by the presence of clinical signs (mucocutaneous lesions, pregnancy morbidity) and biological markers (antiphospholipid antibodies). Antiphospholipid antibodies are associated with antiphospholipid syndrome (APS), lupus anticoagulant, antiphospholipid syndrome, and lupus anticoagulant. The test is not specific, and it can be positive in other diseases. The test is important in patients with a history of venous or arterial thrombosis.

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Lupus is a chronic disease, which occurs in flares. Its clinical expression takes many forms and it may begin with any of the signs or symptoms.

The disease has benign and serious forms. The minor manifestations, such as the rash and arthritis-like forms and mononucleosis, are more common and may be caused by early.everything, although they are not seen in all of them. Such 'minor' manifestations are usually benign and resolve spontaneously. The most severe forms of lupus, however, are characterized by widespread, serious, and persistent organ involvement. The lupus nephritis, the central nervous system involvement, and the hematological complications are the most severe forms and they require regular monitoring of renal function.

The ACR (American College of Rheumatology) has defined eleven criteria of lupus, which are used throughout the world to diagnose the disease. Among the clinical criteria, there are seven clinical manifestations, which demonstrate the disease activity (skin, membranes; it will flare then clear without leaving any marks, or nasopharyngeal ulcers). The last four are biological.

Benoign forms of lupus

Cutaneous forms

The term lupus comes from the Latin word for wolf, as the disease has a cyclical nature. The various forms of lupus are divided into three different forms: acute, subacute (30 to 60 days of onset) and chronic forms (over 60 days of onset). The chronic forms are more severe. The disease is common in the skin, but can also affect other organs.

Articular manifestations

These affect 85% of patients, mainly in the form of enthesitis and articular inflammation of the hands, wrists, ankles, knees and feet, usually with arthralgias, but without joint deformity or destruction. When the joints are affected, the issue is whether or not it is linked to the disease in a lupus flare. The cutaneous and articular forms and manifestations (rash, arthritis, myositis, pleurisy, pericarditis, etc.) are the most severe.

Antiphospholipid syndromes

Lupus patients may develop antiphospholipid antibodies, which is one of the most common extensions of lupus. These antibodies: antiphospholipid antibody, lupus anticoagulant, antiphospholipid syndrome (APS), are polymorphisms. Other antiphospholipid markers include: hypergammaglobulinemia, anemia (autoimmune hemolytic anemia, aplastic anemia), prothrombin < 45%, fibrinogen, prothrombin, PTT (prothrombin time) normal.

All these signs are common in the disease and are markers of activity.

Specific markers

Lupus is an autoimmune disease and several other manifestations, specific markers, are used among the criteria for the disease. Antinuclear antibodies are directed against nuclear antigens, present in the cell nucleus. Antinuclear antibodies are tested for in almost all the autoimmune diseases. They are present in 90 to 95% of patients. But they also present in 40% of patients suffering from rheumatoid arthritis, 50% of patients suffering from SLE and in all patients suffering from lupus. These antibodies are almost always anti-nuclear antibodies, but they are also found in other autoimmune diseases. The last three of these antibodies are all directed against DNA.

Cardiovascular involvement

These conditions concern 35% of lupus patients, including hypertension, 75% of patients (50-80), AHT 14%, valvulopathy 3%, and cerebrovascular diseases. 35% of patients with lupus suffer from a stroke, usually in the first 30 years of the disease. These patients are especially susceptible to thrombosis. The hydroxychloroquine/NSAID/corticosteroid combination is a very important biological marker. There are specific blood tests (Methylprednisolone or MPA) that can determine the disease activity.

Methotrexate® to control the articular disease. Hydroxychloroquine is always of first line treatment in lupus, as it affects the skin and the joints and helps to prevent the disease, but it can also affect the liver function, platelet aggregations, which are useful in patients susceptible to thrombosis.

In severe lupus, the aim is to reduce mortality and morbidity, prevent flares and avoid side effects. In serious cases of lupus nephritis (class III or IV), corticosteroids and infusions supprin- sant cytokines (infliximab or napogenibulin) are used. The aim is to reduce mortality and morbidity, but a high level of disease activity, as it avoids both for diagnosis and to monitor the disease. Anti-nucleosome antibodies: this protein, which wraps around the DNA is a good marker of lupus a drop in its level is quite specific to a high level of disease activity, as it avoids both for diagnosis and anti-nucleosome antibodies: this protein, which wraps around the DNA is a good marker of lupus a drop in its level is quite specific to a high level of disease activity, as it avoids both for diagnosis and to monitor the disease. Anti-nucleosome antibodies: this protein, which wraps around the DNA is a good marker of lupus a drop in its level is quite specific to a high level of disease activity, as it avoids both for diagnosis and to monitor the disease. Anti-nucleosome antibodies: this protein, which wraps around the DNA is a good marker of lupus a drop in its level is quite specific to a high level of disease activity, as it avoids both for diagnosis and to monitor the disease.
Lupus is a chronic disease, which affects immune cells, causing the immune system to attack normal body tissues. Symptoms may range from minor to severe and can involve any organ system in the body. Common symptoms include fatigue, joint pain, rash (often on the face and upper chest), and swelling of multiple joints. Lupus can cause features that resemble those of other diseases, such as rheumatoid arthritis or lymphoma. Lupus is a autoimmune disease, and it is more common in women of childbearing age. It can be triggered by environmental factors, such as infections, drugs, and some hormones. Lupus is classified into different types based on the organs involved and the severity of symptoms. It can lead to complications such as kidney problems, heart issues, and blood clots. Despite advances in treatment, lupus remains a challenge for patients and healthcare providers. There is no cure for lupus, but treatments can help manage symptoms and slow disease progression.

The different forms of lupus and related symptoms

**Cause early death, include lupus nephritis (classes III, IV and VI in moderate forms of the disease). The more serious forms, which cause early death, include lupus nephritis (classes III, IV and VI in moderate forms of the disease).**

**The more minor range of symptoms.**

**Lupus is a chronic disease, which occurs in flares. Its clinical ex-**

**lesions (on the face, trunk and limbs) can be bluish or purple. When lupus is purely cutaneous, it can take up then clear without leaving any marks,**

**Finally, discoid or chronic lupus (15%) is similar to other systemic manifestations (myocarditis for example), thromboembolic phenomena and intracranial complications (infarction, coarctation, tendinites).**

**Most common complications are common: depressive syndrome, anxiety, encephalopathy, lymphocytopenia, aseptic osteonecrosis, tendinitis.**

**Cardiovascular involvement**

These conditions concern 35% of lupus sufferers including pericarditis, 35% (the worst form of the disease) and it is more common in the disease and are markers of activity.

**Specific markers**

Lupus is an autoimmune disease and several substrances, specific markers, stand among the criteria for the disease.

**Anti-nuclear antibodies are directed against nuclear antigens, present in the cell nucleus. Anti-nuclear antibodies are tested for in almost all the autoimmune diseases. They are present in 90 to 95% of patients. But they are also present in 45% of patients suffering from rheumatoid arthritis, 50% of patients suffering from Sjögren's syndrome, and in all patients suffering from Sjögren's syndrome. The test is very sensitive; when there is an ANA, there is almost always an auto-antibody.**

**Cardiovascular involvement**

**The non-specific markers are markers of inflammation. The**

**main ones are ESR (sedimentation rate), fibrinogen, haemolytic, (sedimentation rate), fibrinogen, haemolytic, leukopenia (<4000/µL), CRP (C-reactive protein).**

**After detecting the presence of antinuclear antibodies, it is necessary to determine their antigen specificity, in other words to identify the target of the antibodies. There are different ways to do this, but with a different clinical approach (histo-**

**Non-specific markers**

The non-specific markers are markers of inflammation. The main ones are ESR (sedimentation rate), fibrinogen, haemolysis, platelet aggregation effect, which can be useful in patients suffering from arthritis.

**Autoimmune markers**

All these signs are common in the disease and are markers of activity. It is often useful to start treating patients with antinuclear antibodies, to prevent flares and avoid side effects. In serious cases of lupus, the aim is to reduce mortality and morbidity, so it is necessary to determine their antigen specificity.

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Points to remember for risk selection

Average 10-year survival is now more than 90% and SLE survival has reached approximately 80%.

Lupus is a polyphagous disease, a distinction should be made between the various forms such as nephritis, nephrotic syndrome, lupus erythematosus, central nervous system lupus or cardiac flares during the pregnancy. The prognosis, however, is much better in early lupus or pre-existing lupus, with the possible complication of complications: lupus nephritis, pre-eclampsia, venous or arterial thrombosis, for the child, the risk of serious death in cases, premature births, miscarriage, hypertension, renal failure, pregnancy must therefore be planned and appropriate treatments given.

The assessment of the disease activity and the risks involves analysing different elements in the patient's medical file (a file for the last 6 months) specific to the assessment, hospital reports, biological tests (CRP, platelets, ESR, ANA, Dna).

The less serious cutaneous, arthritis, and visceral forms in the first few years are not as serious, despite a high mortality risk, perhaps because lupus patients are often considered to be of severe forms of the disease lupus nephritis, skin involvement, renal involvement and infections to which patients can become susceptible due to their treatment, in particular infections, vasculitis, nephritis, however, is no longer a major cause of death; it has fallen considerably over the years. Cardiovascular involvement in lupus has been found to be a worse cause of death, largely after the age of 40.

Class II to IV lupus nephritis are the most serious forms; if untreated, five-year mortality is stage and stage disease or nephritis. About 50% of lupus patients have classic cardiovascular risk factors such as obesity, diabetes, hypertension, dyslipidemia, tobacco consumption, and physical inactivity. Combined, these risk factors are added and when combined, the risk of death is even greater than in lupus. Cardiovascular involvement in lupus nephritis patients is serious and can be fatal, particularly when it affects the heart.

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Class II to IV lupus nephritis are the most serious forms; if untreated, five-year mortality is stage and stage disease or nephritis. About 50% of lupus patients have classic cardiovascular risk factors such as obesity, diabetes, hypertension, dyslipidemia, tobacco consumption, and physical inactivity. Combined, these risk factors are added and when combined, the risk of death is even greater than in lupus. Cardiovascular involvement in lupus nephritis patients is serious and can be fatal, particularly when it affects the heart.
and 15-year survival has reached approximately 80%. In the future, in particular an anti-CD40 antibody and Abatacept© for cutaneous and articular lupus; Rituximab does not have a market: Rituximab© (anti-CD20 antibody) and Belimumab© for kidney disease. Two are already on the market. Azathioprine© (or mycophenolate mofetil) are then prescribed, to induce a remission. Corticosteroids and non-steroidal anti-inflammatory drugs (NSAIDs) are used for pain and fever. Mortality in patients with a severe form of lupus has fallen considerably over the years. Cardiovascular involvement and cancer are later complications of lupus. It is estimated that 20% of lupus patients will develop cardiovascular disease within 10 years. Lupus patients have a ten year survival rate of over 90%, thanks to therapeutic progress and earlier diagnosis. The less serious cutaneous, articular and visceral forms in the males do not have any implications on the death risk. However, lupus nephritis, a glomerulonephritis that affects the kidneys, is a tough condition. In lupus nephritis, the kidneys progressively fail and infections to which patients can become more susceptible due to their treatment, in particular immune suppressions, cause nephrotic syndrome. About 50% of people with lupus have nephrotic syndrome. About 50% of people with lupus have nephrotic syndrome. Those who are nephrotic and have proteinuria (more than 3 g/day) have a 30% risk of developing end-stage kidney disease or kidney transplantation within the next 10 years. Nephrotic syndrome is characterised by an increased amount of protein in the urine. Nephrotic syndrome is often associated with hypertension, anaemia, oedema (swelling), and weakness. Nephrotic syndrome is a medical emergency and requires prompt medical attention. The assessment of the disease activity and the risks involves different elements in the patients’ medical file: a wide range of laboratory tests (C3, C4, PCR, CRP), urinalysis, ACE, ANA, antibodies to native DNA as well as creatinemia, proteinuria and haematuria for kidney function.

Major features of Lupus:
- It is a systemic autoimmune disease characterised by an abnormal immune reaction of the body against itself: the immune system, instead of protecting the body, starts attacking its own tissues.
- It affects all the organs; lupus is the prototype of systemic autoimmune disease.
- It is associated with a high prevalence of cardiovascular disease and is often associated with other autoimmune diseases such as rheumatoid arthritis, Sjögren’s syndrome, anti-phospholipid syndrome and SLE.
- Lupus is an autoimmune disease (AID) characterised by an abnormal immune reaction of the body against itself.

- Prognosis: dominated by three types of complications: renal, rheumatological and cardiovascular. Lupus patients have a 10-year survival rate of over 90%, thanks to therapeutic progress and earlier diagnosis.

A guarded approach for:
- The first few years: complications can be numerous: hypertension, dyslipidemia, atherosclerosis, accelerated oxidation of LDL molecules.

- The less serious cutaneous, articular and visceral forms in the males do not have any implications on the death risk. However, lupus nephritis, a glomerulonephritis that affects the kidneys, is a tough condition.
- In lupus nephritis, the kidneys progressively fail and infections to which patients can become more susceptible due to their treatment, in particular immune suppressions, cause nephrotic syndrome. About 50% of people with lupus have nephrotic syndrome. Those who are nephrotic and have proteinuria (more than 3 g/day) have a 30% risk of developing end-stage kidney disease or kidney transplantation within the next 10 years.

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