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Optimizing Outcomes in Lupus Nephritis: Early Detection and Treatment Strategies

Announcer:
You're listening to *Living Rheum* on ReachMD, and this episode is sponsored by Aurinia Pharmaceuticals. Here's your host, Dr. Brian McDonough.

Dr. McDonough:
This is *Living Rheum* on ReachMD, and I'm Dr. Brian McDonough. Joining me to discuss the importance of effective monitoring and a treat-to-target approach in lupus nephritis care is Dr. Robin Dore. Not only is she a board-certified rheumatologist in private practice in Tustin, California, but she's also a Clinical Professor of Medicine at the David Geffen School of Medicine at UCLA. Dr. Dore, thanks for joining us today.

Dr. Dore:
Thank you very much for having me.

Dr. McDonough:
Diving right in, Dr. Dore, what do the latest screening guidelines recommend, and how are we doing in terms of screening our patients for lupus nephritis?

Dr. Dore:
Well first, talking about screening guidelines and the prevalence of lupus nephritis, about 50 percent of lupus patients will develop lupus nephritis. And I will tell you that I think it's something that's not top of mind for a lot of rheumatologists, and it really needs to be because what we see happen is that by the end of 10 years, about 5 to 20 percent of patients with lupus will have end-stage renal disease. So it's really important that we screen these people. Typically, the patients will go for a long period of time unless they present with lupus nephritis, and then all of a sudden, they can end up with proteinuria that we'll talk about. Or if they have more severe disease, they can have blood pressure changes and edema, things that we should look for each time that we screen the patients.

But so the screening guidelines recommend a urine protein/creatinine ratio at 3 to 6 months. And my preference would be 3 months because once the patients develop lupus nephritis, their prognosis changes, and they can develop severe disease. But the guidelines recommend someplace between 3 and 6 months, and then every 6 months, a double-stranded DNA, C3 and C4 complement, and a creatinine in addition to measuring the blood pressure.

There was a study that was performed here in California that answered your question about how we are doing in screening patients, and we are not doing very well. So this looked at 25 different clinical centers, and of 148 patients without lupus nephritis, only 38 percent of them had active lupus serologies, so that C3, C4, and double-stranded DNA. And only 42 percent had the screening labs for the lupus nephritis, so the creatinine and the urine protein/creatinine ratio. But 81 percent of them did have the minimum of having their blood pressure checked. It was interesting in the data that they found that men had the screening procedures performed less often. And it's unfortunate because men with lupus tend to get the worst lupus nephritis. And not surprisingly, the academic centers were much better than the community clinics in screening the lupus patients for lupus nephritis.

Dr. McDonough:
What barriers might be causing this gap in screening?

Dr. Dore:

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Well, when you look at their data, what they found, and not surprising, was the fact that public insurance patients didn't have as much screening. As I mentioned, the men don't get screened as often. Transportation to the rheumatology office can be a problem. Whether the insurance covers medications, sometimes in the back of their mind, the physician might think, “Well, the patient's insurance doesn't cover this medicine, so there's no reason to do this.” And a lot of it is really a lack of patient education and a health literacy problem that they don't understand that they can feel okay while their kidneys are getting worse. So it's not like they feel joint pain and can talk to us about this. This is silent, and so that's why we need to be screening so often.

Dr. McDonough:
With that in mind, let's zero in on how we can optimize our approach to diagnosing and monitoring proteinuria and lupus nephritis. Dr. Dore, can you walk us through the EULAR guidelines?

Dr. Dore:
The EULAR guidelines for treatment target a proteinuria of 25 percent or more reduction at 3 months, and at 6 months, greater than a 50-percent reduction to less than 3 grams a day. And by 12 to 24 months, the urine protein should be someplace between 0.5 and 0.7 grams per day. So again, when we're doing our screening, it's important that if we see that patient who has more than 500 milligrams of protein that they're spilling a day or if a 24-hour urine protein is done and the dipstick is 3-plus protein or more that we send them off to the nephrologist for kidney biopsy.

When we talk about treatment, the new treatment guidelines don't differentiate different medicines for different kidney biopsies, but it helps us with prognosis and maybe determine how we should follow their treatment and reassess something every 3 months. So that means these patients need to be seen every 3 months, and again, sometimes that's a transportation problem. Sometimes it's a problem that the doctor doesn't have that time in their schedule. So this is something that really we need to be on top of.

Dr. McDonough:
As a family doctor, I know that getting people to come in is often difficult. I'm glad you recognized the importance of this. I also want to ask you about the latest guidelines from KDIGO. What do they recommend?

Dr. Dore:
Well, let me just get back to talk about the glucocorticoids because both EULAR and KDIGO talk about steroids, but in the rheumatology community, there's this big push now to use the lowest dose of steroids for the shortest period of time. So there was some discussion in the EULAR guidelines actually to not even start with a pulse of methylprednisolone for 1 to 3 days. If the patients had, let's say, mild lupus nephritis, maybe just starting them on oral prednisone, but the renal guidelines still talk about using that pulse of steroids for 1 to 3 days and then very gradually tapering down that dose with not using more than—while it seems like a huge dose to me—80 milligrams per day. So the EULAR guidelines talk about if that pulse of steroids is used, to use a much lower dose of oral steroids, 0.3 to 0.5 milligrams per kilogram per day, again, depending on the severity of the lupus nephritis on the biopsy, and then rapidly tapering down to 5 milligrams of prednisone a day. And the goal really is getting off prednisone, and the KDIGO guidelines never mention getting off of prednisone. They don't talk about using prednisone as a bridging therapy. And it's really been the rheumatology lupus nephritis experts in the US concentrating on trying to get that patient at least 5 milligrams a day or less. Now, the 2019 guidelines talked about 7.5 milligrams of prednisone a day or less. But the problem is that the prednisone is associated, of course, with an increased risk of diabetes and increased cardiovascular disease. So the EULAR guidelines really emphasize trying the lowest dose of prednisone, definitely no more than 5 milligrams, and trying to get the patients off steroids completely.

Dr. McDonough:
For those just tuning in, you're listening to *Living Rheum* on ReachMD. I'm Dr. Brian McDonough, and I'm speaking with Dr. Robin Dore about how we can achieve optimal outcomes for our patients with lupus nephritis.

So, Dr. Dore, we've talked a lot about the importance of effective monitoring, but what if we focus on treatment now? Can you share the essential elements of a treat-to-target approach?

Dr. Dore:
Well, as most of the literature suggests, a treat-to-target approach is very difficult because all the patients have a different presentation. Their access to expensive medicines can certainly be different. They might have a lack of access to infusion centers, or maybe they want pills instead of an infusion. And then transportation to and from the doctor’s office to monitor for medication side effects or to receive those treatments. We have to keep all of that in mind because if we recommend something for the patient that’s not practical for them, it’s not going to happen. They’re not going to come back, and their lupus nephritis can definitely worsen.

The EULAR guidelines—so this was the 2023 EULAR guidelines for systemic lupus, so they weren’t specifically for lupus nephritis—said because we have two new medications, one specifically for lupus nephritis, voclosporin, and one for systemic lupus, including lupus

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nephritis, belimumab, that they really felt that the guidelines needed to be rewritten and actually talking as we do in rheumatoid arthritis, looking at combination therapy. So rather than using the initial therapy and then using a maintenance, actually considering starting these patients on combination therapy, and then if they respond by the criteria that I've already mentioned, continuing that treatment out to 3 years.

Now the problem with that is we're immunocompromising those patients, and so like everything we do in medicine, we have to balance risk versus benefit, and is the risk of that double immunosuppression, and maybe triple if they're on the steroids, is that risk worth the benefit? And that's where talking to the patient, what their situation is, what their other comorbid conditions are, and what their renal biopsy showed will all play a role in us approaching their treatment. So it's not cookbook, and it's not one treatment fits all.

Dr. McDonough:
Before we close, Dr. Dore, what other treatment strategies or lifestyle modifications can help our patients with lupus nephritis?

Dr. Dore:
Lots of different things. Obviously with the lupus patient, they need to practice sun protection, definitely stop smoking, and control their blood pressure because that should help prevent nephrosclerosis, which is another problem with the kidney in addition to the lupus nephritis. A healthy diet, which again, depending on the population can be unaffordable or difficult for them to do, and exercise. And sometimes these patients live in an area where it's really not healthy and safe for them to go out for a walk. The other thing is because lupus increases the risk of coronary heart disease and the steroids that we're trying to get the patients off of increase the risk of coronary heart disease and diabetes, we need to constantly be monitoring these patients for their risk of developing coronary heart disease and diabetes.

The EULAR recommends a multidisciplinary approach. And I think it's important that the team—and again, I'm in private practice, and so the team is in a different part of the city in a different office building—it's very important that we work together and have a plan. When the patient first is diagnosed with lupus nephritis, we need to have that conversation. So everybody has their own responsibility, and that's really what we need to do because there are so many aspects of lupus that affect the patient.

Dr. McDonough:
And with those strategies in mind, I want to thank my guest, Dr. Robin Dore, for joining me to discuss best practices in lupus nephritis care. Dr. Dore, it was great having you on the program.

Dr. Dore:
Thank you very much for inviting me, and I hope the attendees find it helpful.

Announcer:
You've been listening to *Living Rheum*, and this episode was sponsored by Aurinia Pharmaceuticals. To access this and other episodes in our series, visit *Living Rheum* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!

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