Audit Tool – Systemic Lupus Erythematosus

The following specific topics may be audited. The purpose of this audit tool is to ensure that the Management of SLE guidelines are being followed. The audit should be undertaken on a sample of lupus patients attending clinic.

1. Baseline diagnosis and assessment
   a) The diagnosis requires a combination of relevant clinical features and the presence of at least one lupus related immunological abnormality.
   b) Baseline tests for serological markers including ANA, anti-dsDNA, anti-Ro/La, anti-Sm, anti-RNP antibodies and low complement (C3 +/- C4).
   c) Baseline tests for antiphospholipid antibodies (at least lupus anticoagulant and IgG and IgM anti-cardiolipin antibodies) with positives confirmed at least 12 weeks apart.
   d) Assessment of disease activity including thorough history and review of systems, full clinical examination and monitoring of BP, urinalysis and renal function, and other laboratory tests, imaging and biopsies including renal and other areas if indicated.
   e) Assessment of disease activity and categorisation into mild, moderate and severe.
   f) Measurement of disease activity and damage using standardised SLE assessment tools.
   g) Assessment of health status and quality of life

2. Monitoring of lupus patients on a regular basis for disease manifestations, drug toxicity and comorbidities.
   a) Patients with active disease to be reviewed at least every 1-3 months (including blood pressure, urinalysis, renal function, full blood count, liver function tests, complement levels, anti-dsDNA antibodies and ESR/CRP and other assessments below intermittently as for stable disease).
   b) Patients with stable low disease activity or in remission to be monitored less frequently e.g. 6 to 12 monthly with assessments above and those below.
   c) Measurement of disease activity and damage using standardised SLE assessment tools
   d) Assessment of health status and quality of life
   e) Re-evaluation of aPL prior to pregnancy or surgery and in the presence of a new severe manifestation or a vascular event.
   f) Anti-Ro and La antibody status to be assessed prior to pregnancy.
   g) Assessment of co-morbidities, such as atherosclerotic disease, osteoporosis, avascular necrosis, malignancy and infection with annual review of modifiable risk factors (i.e. hypertension, dyslipidaemia, diabetes, high body mass index and smoking).

3. Management of mild SLE
   a) Use of hydroxychloroquine and/or methotrexate
   b) Only short courses (not long term maintenance therapy) with non-steroidal anti-inflammatory drugs for patients with mild lupus (and non-organ threatening manifestations).
   c) Prednisolone treatment at a low dose of 7.5mg/day or less for maintenance therapy.
   d) Recommendation of high factor UV-A and UV-B sunscreen to patients with cutaneous manifestations.
4. Management of moderate SLE
   a) Treatment with higher doses of prednisolone (up to 0.5 mg/kg/day) an/or IA, IM or IV pulses of methyl prednisolone for flare.
   b) Treatment with methotrexate, azathioprine, mycophenolate mofetil, ciclosporin or tacrolimus depending on clinical situation in those refractory to/intolerant of hydroxychloroquine.
   c) For cases refractory to at least 2 immunosuppressives to assess whether patients have been considered for rituximab according to NHS England policy.

5. Management of severe SLE
   a) Immunosuppressive regimens for severe SLE including IV methylprednisolone or high dose oral prednisolone (up to 1 mg/kg/day) (either on their own or more often as part of a treatment protocol with an immunosuppressive drug).
   b) MMF or cyclophosphamide or azathioprine used in the management of lupus nephritis and for refractory severe non-renal disease (unless contra-indication).
   c) Biologic therapies considered in patients who have failed other immunosuppressive drugs due to inefficacy or intolerance.
   d) Intravenous immunoglobulin and plasmapheresis considered for patients with refractory cytopenias, thrombotic thrombocytopenic purpura, rapidly deteriorating acute confusional state and catastrophic APS.