Co-morbidity in SLE

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One of the characteristics of systemic lupus erythematosus (SLE) is its great heterogenicity. Another striking trait is the commonly occurring overlap with other autoimmune conditions such as Sjögren´s syndrome, antiphospholipid syndrome (APS), Systemic sclerosis (SSc) and myositis to mention a few. APS is present in approximately 18% of SLE patients in our cohort and Sjögren´s syndrome is seen in 25%. Several other autoimmune conditions can thus be regarded as co-morbidities to SLE, defined as the presence of additional conditions with the initially diagnosed illness (=SLE). However it is possible that further knowledge of the underlying pathogenesis of autoimmune diseases will lead to new disease definitions based on common ethiopathogenesis as suggested by clinical symptoms, genetic susceptibility and autoantibody profile, all of which cross the diagnostic entities used today. Vascular disease and osteoporosis are other types of co-morbidities, which often become apparent many years after disease onset. They can be regarded as complications to chronic inflammatory disease and often lead to substantial impairment in the patients quality of life. Though life expectancy in systemic lupus erythematosus (SLE) has improved a recent report demonstrate that SLE patients still have an increased mortality rate (SMR 2,4). Fewer deaths are nowadays attributed to renal disease and infections. On the contrary mortality due to circulatory diseases, a late co-morbidity, had slightly increased since the 1970´s. Enhanced cardiovascular morbidity and mortality is seen both for cardiovascular and cerebrovascular disease, each affecting approximately 10 % of Swedish SLE patients. We recently demonstrated that risk profile differ for these two types of circulatory diseases. Antiphospholipid antibodies (aPL) and hereditary factors are major risk factors for stroke while traditional cardiovascular risk factors seem to be more important for ischemic heart disease. Venous thrombembolism (VTE) is another co-morbidity, which is associated with aPL. VTE affected 16 % of Swedish SLE patients. In a recent Swedish study osteoporosis was present in 20 % and osteopenia in 38% of SLE women with a mean age of 47 years. Of note is that 29 % of these women had radiological compression fractures but only 10 % of these fractures were diagnosed clinically. In addition to high age and low weight, markers of systemic inflammation, impaired kidney function and a high disease damage score were risk factors of low bone mineral density. Use of corticosteroids was not associated, but results are conflicting, as other studies have found an association.