

# Systemic Lupus Erythematosus

## 2026 Clinical Guidelines

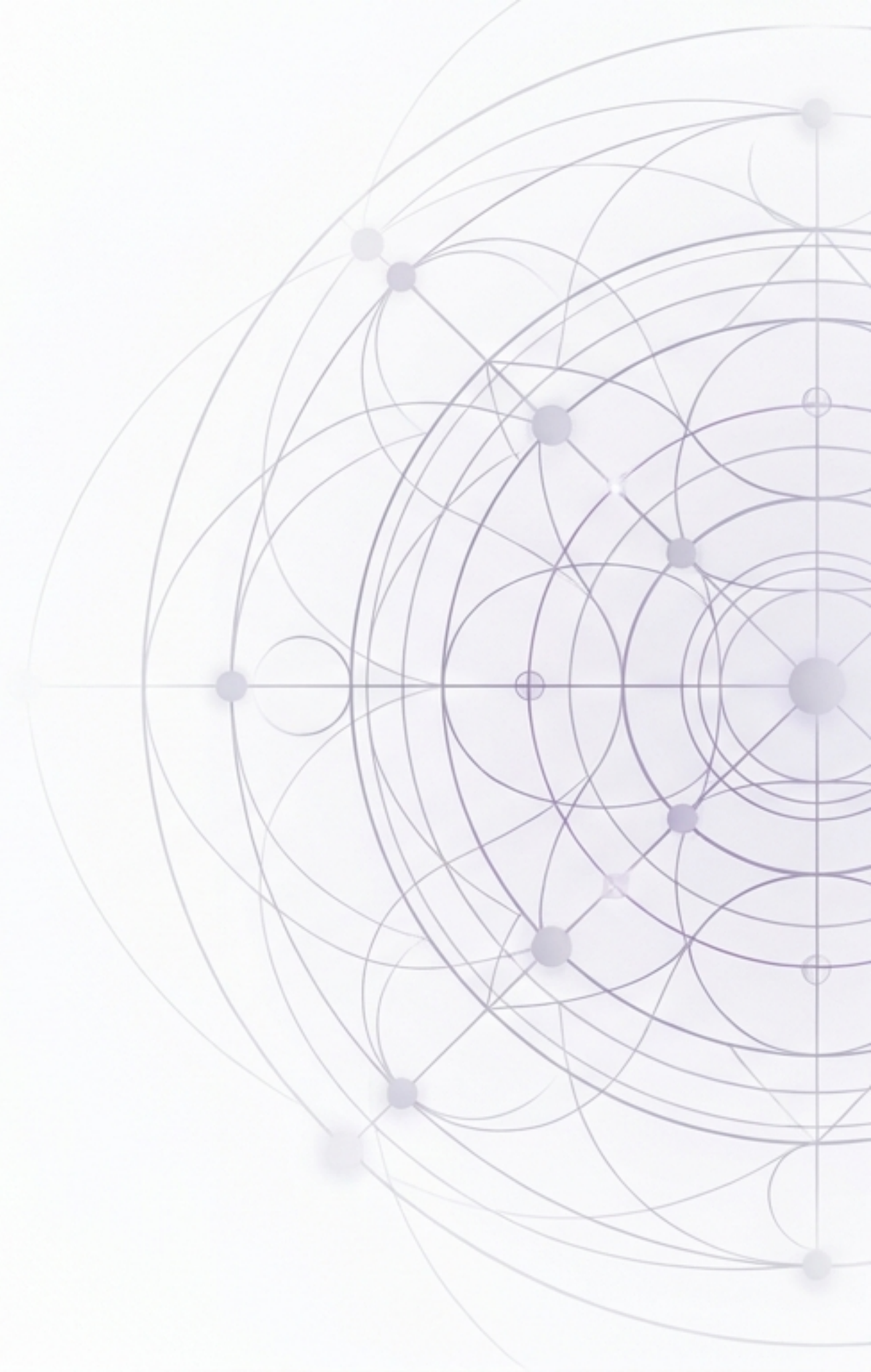
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Imposing order on the great imitator:  
A visual dashboard for phenotyping,  
targeted organ defense, and integrated  
care.

Evidence-Based Reference

EULAR/ACR Aligned

Reading Deck



# The Core Paradigm

Four pillars of modern SLE management.



## Diagnosis & Phenotyping

**Entry criteria:** 2019 EULAR/ACR (ANA titre  $\geq 1:80$ ).

**Action:** Profiling specific autoantibodies dictates the threat level and organ targets.



## The Organ Threats

**Lupus Nephritis (LN)** occurs in ~50% of patients. Biopsy-driven therapy is critical.

**Cutaneous lupus** affects >80%.



## The Pharmacological Arsenal

**Hydroxychloroquine (HCQ)** is the universal foundation.

Targeted escalations: MMF, Cyclophosphamide, Belimumab, Anifrolumab.



## Lifelong Protection

Accelerated cardiovascular disease is a primary late-mortality driver.

Aggressive BP and lipid management is mandatory.

# Epidemiology & The Equity Gap

## General Australian Epidemiology



**45–100 per 100,000**

Estimated Prevalence



Female-to-Male ratio of 9:1.  
Disproportionately affects non-European ancestry.

## Severe burden on Aboriginal and Torres Strait Islander (ATSI) populations



**Incidence:** Significantly higher rates of disease.



**Onset:** Occurs at a noticeably younger age.



**Severity:** More frequent, aggressive organ involvement (Lupus Nephritis progresses more rapidly).



**Mortality:** Increased mortality rates compared to non-Indigenous cohorts.

# ATSI Care Considerations: Navigating Structural Barriers



# The Diagnostic Blueprint: Serology Matrix

**i** Note: ANA  $\geq$ 1:80 is the EULAR/ACR entry criterion, but specific profiling is required to determine the clinical phenotype.

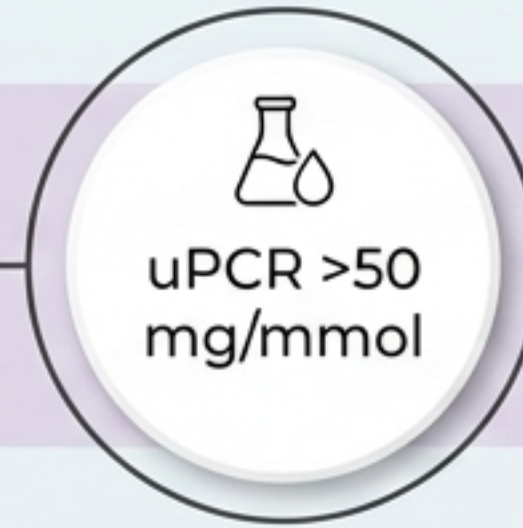
Antibody	Prevalence	Specificity	Clinical Danger Zone
Anti-dsDNA	60–70%	Highly Specific	Titres correlate with active Lupus Nephritis.
Anti-Smith (Sm)	20–30%	Most Specific (>99%)	Confirms diagnosis.
Anti-Ro / Anti-La	30–40% / 10–15%	ANA-neg SLE possible	Neonatal lupus, congenital heart block, photosensitivity.
Anti-RNP	25–40%	MCTD Overlap	Raynaud's, myositis.
Anti-ribosomal P	10–20%	CNS specific	Lupus psychosis, depression.
Antiphospholipid (aPL)	30–40%	Thrombosis risk	Arterial/venous clots, obstetric morbidity.

# Lupus Nephritis: The Silent Threat

Initial Screening Protocol  
(Trigger Biopsy if Abnormal):



Urine  
microscopy



uPCR >50  
mg/mmol



Serum  
creatinine /  
eGFR

## Lupus Nephritis Class Action

### Class I & II (Minimal/Mesangial)

Treat systemic symptoms; no specific nephritis therapy needed.

### Class III (Focal Proliferative) & Class IV (Diffuse Proliferative)

Most severe. Requires immediate, intensive induction immunosuppression.

### Class V (Membranous)

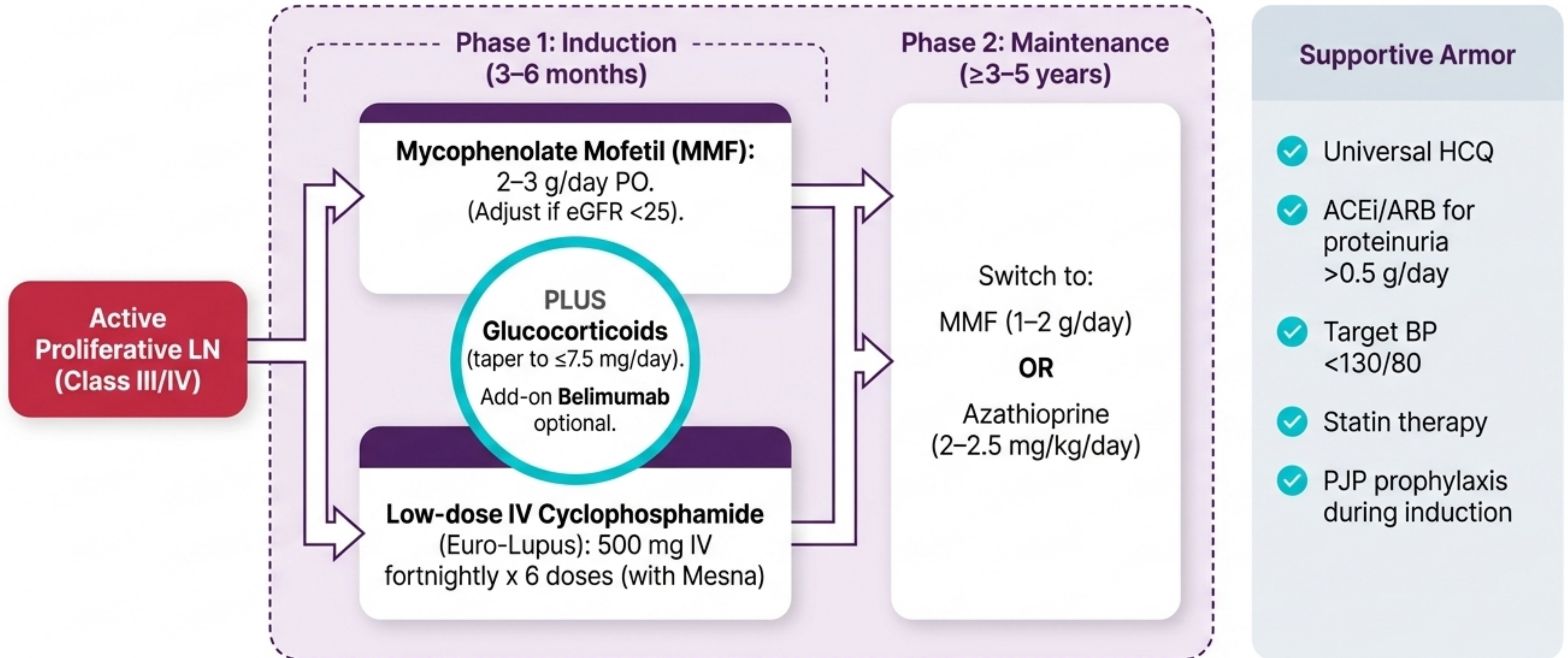
Often combined with III/IV. Treat if nephrotic-range proteinuria.

### Class VI (Advanced Sclerosing)

Immunosuppression usually futile. Supportive care for ESKD.

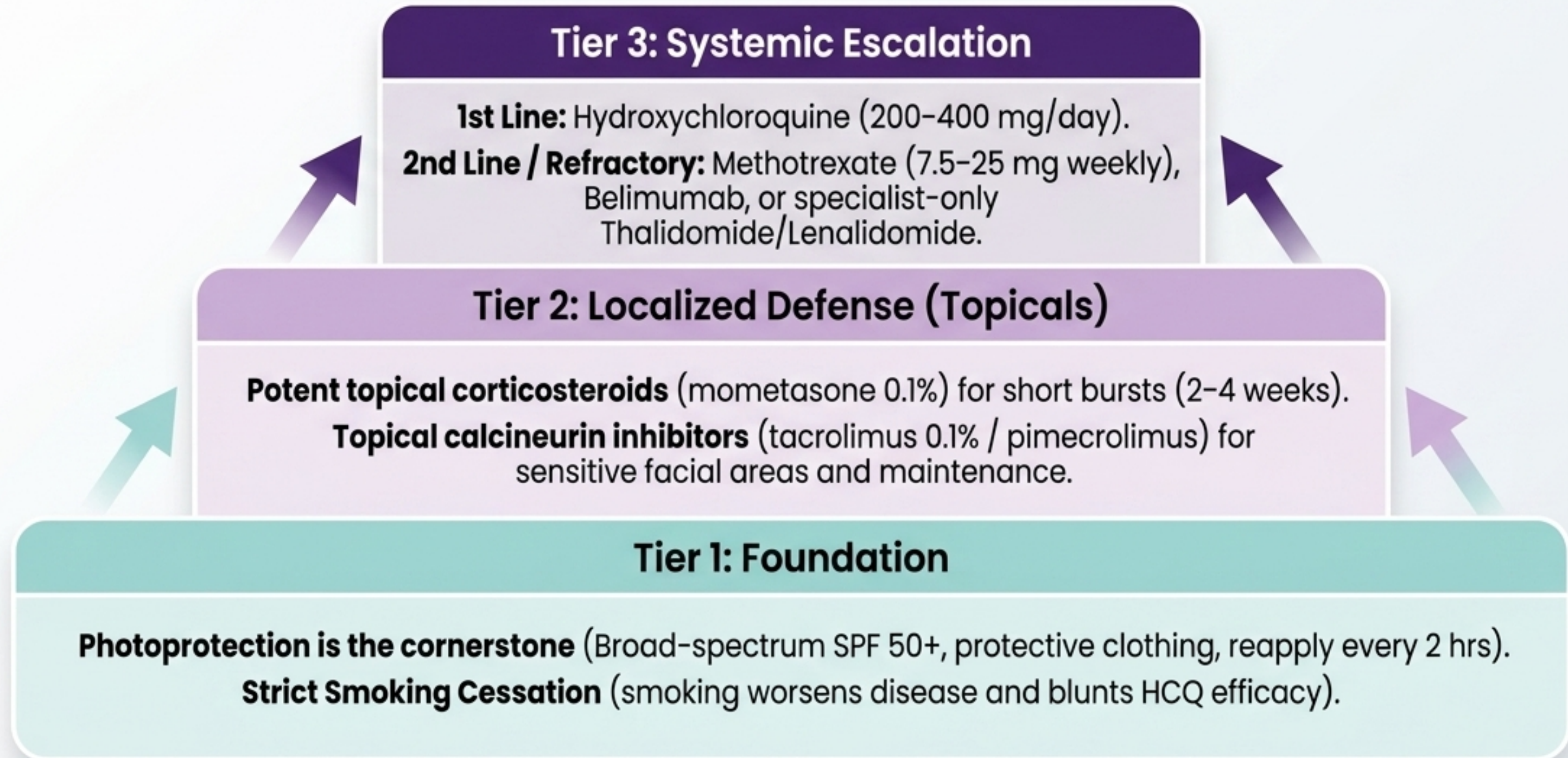
# Lupus Nephritis: Clinical Pathway

Management protocol for Class III/IV Proliferative LN.



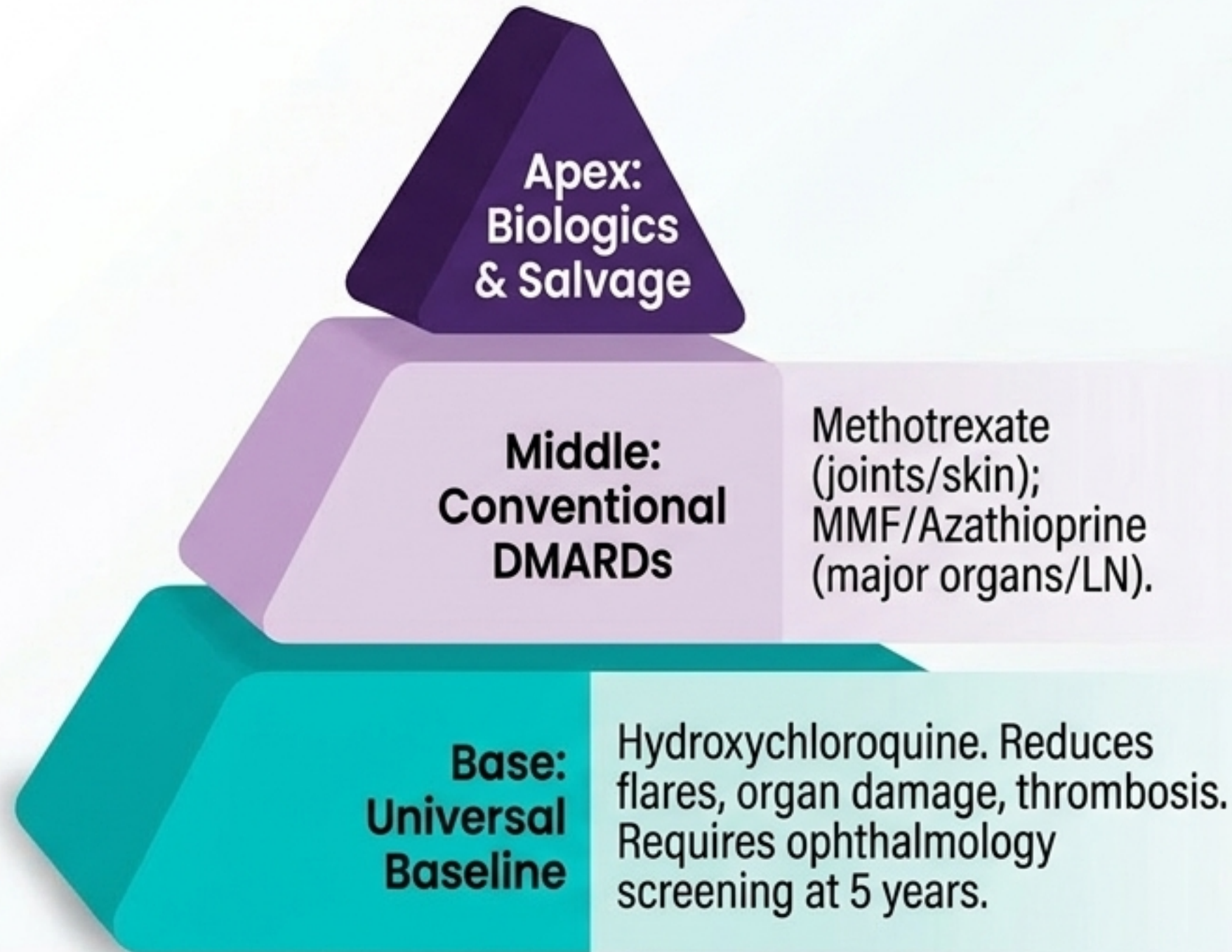
# Cutaneous Lupus: Tiered Treatment Approach

Affecting >80% of SLE patients: acute, subacute, and chronic manifestations.



# The Pharmacological Arsenal

## The Therapy Pyramid



## The Biologics Breakdown

### Belimumab (Anti-BLyS)

**Format:** IV/SC

**Indication:** Active autoantibody-positive SLE; add-on for active Lupus Nephritis.

### Anifrolumab (Anti-IFNAR)

**Format:** IV

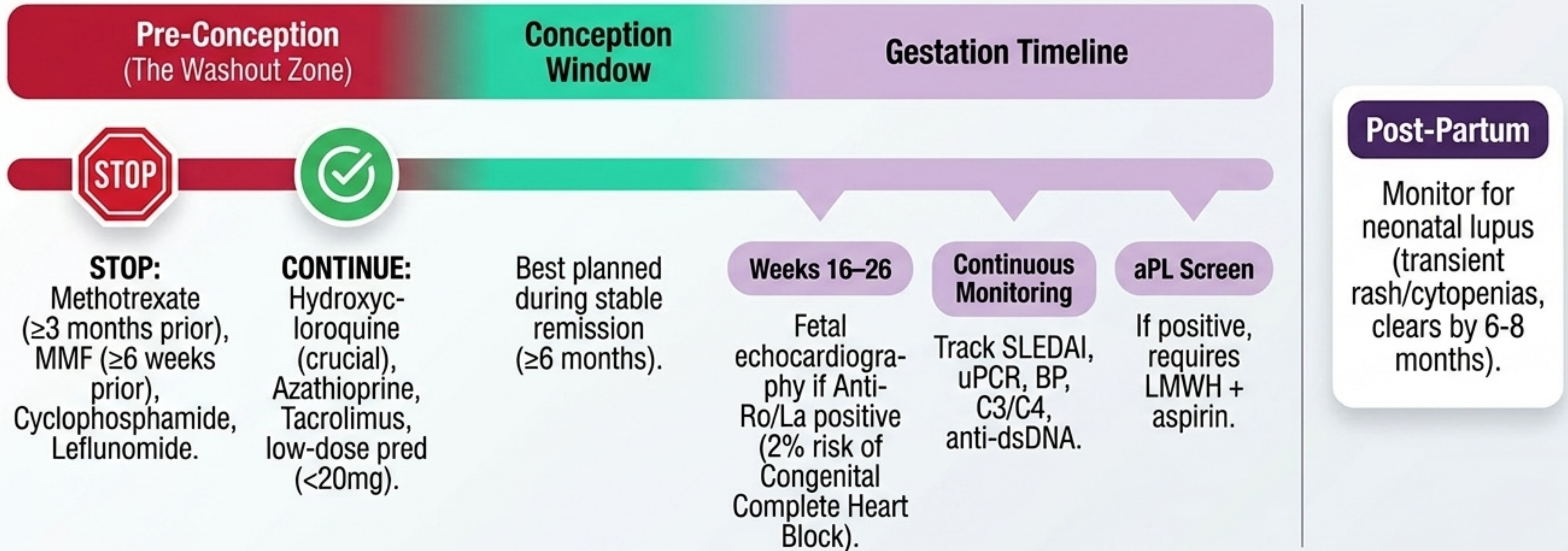
**Indication:** Moderate-severe non-renal lupus.

### Rituximab (Anti-CD20)

**Format:** IV

**Indication:** Off-label salvage for refractory severe LN, neuropsychiatric lupus, or cytopenias.

# Pregnancy & Neonatal Lupus: Safe-Harbor Timeline



# Cardiovascular Risk: The Dual-Threat Model

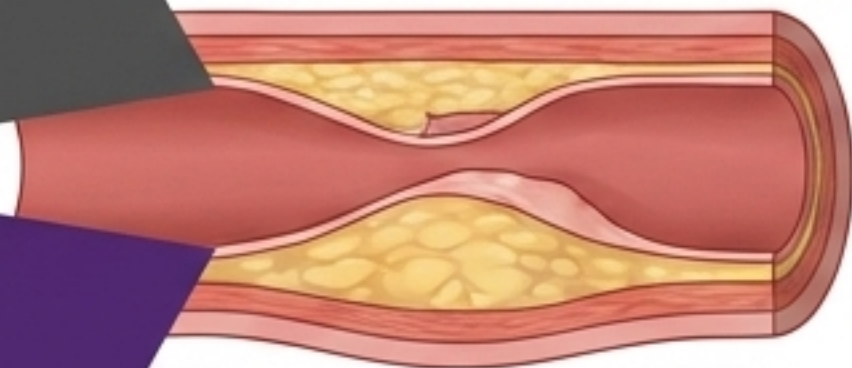
Accelerated atherosclerosis is a primary driver of late mortality.

## Traditional Risks

Hypertension, dyslipidaemia, diabetes, smoking, obesity

Chronic inflammation, cumulative glucocorticoid toxicity, Lupus Nephritis, aPL antibodies

## SLE-Specific Risks



## Actionable Defense Panel

### Lipids:

Target LDL <2.0 mmol/L for high-risk patients. Consider statins regardless of baseline.

### Blood Pressure:

Target <130/80 mmHg (ACEi/ARB first line).

### Steroid Sparing:

Force prednisolone down to  $\leq 7.5$  mg/day.

### Coagulation:

Low-dose aspirin for aPL positive; full anticoagulation (INR 2-3) for defined APS.

# Integrated Patient Care Ecosystem

SLE management is an overlapping, lifelong protective shield.

