PRESS RELEASE

52nd Congress of the Spanish Association of Dermatology and Venereology

Symposium

Cutaneous lupus erythematosus: the future is (practically) now

The second edition of the Autoinflammatory Diseases in Dermatology symposium was coordinated by María Elena de las Heras (Alcalá University, Madrid) and Ignasi Figueras (Barcelona University). The speakers for this session were Marta Feito (La Paz University Hospital, Madrid), Alina Lucica Boteanu (Ramón y Cajal University Hospital, Madrid), Ignasi Figueras **and Branka Marinovic president of the European Academy of Dermatology and Venereology (EADV)**. The aim of the session was to identify and offer answers to the most relevant challenges in the field of autoinflammatory conditions both in adult and paediatric patients. With current therapeutic algorithm to treat cutaneous lupus erythematosus (CLE) as the topic of Marinovic's dissertation, it was clear a combination of guidelines, experience and collaboration with fellow specialists will allow to reach a promising, close future for patients and clinicians.

It started with an overview of the disease itself, an inflammatory autoimmune condition with high heterogeneity, variable clinical course and significant impact on patients' quality of life due to its disfiguring symptoms. She noted that skin is one of the major organs affected by LE and, in fact, 20-25% of SLE are found to show initial skin lesions, with 70-80% of SLE showing skin lesions at any disease stages.

Cooperation with rheumatologist is crucial for the benefit of the patients when it comes com management of SLE.

The European guidelines were followed by similar documents by German and British medical societies for CLS (cutaneous lupus erythematosus). [1]

An overview of these guidelines in 2023 exposed the scarcity of conventional systemic therapeutic approaches of FDA or EMA-approved agents. The most recent guidelines for the treatment of non-renal SLE[2] recommend prevention measures such as photoprotection (including clothing), vitamin D supplementation, smoking cessation, assessment of drug-induced CLE (history of drug use and stopping culprit drug) and avoidance of isomorphic trigger factors.

In the topical treatment landscape corcosteroids (effective in all subtypes of CLE but limited to some weeks), calcineurin inhibitors (0.03% and 0.1% tacrolimus ointment, 1% pimecrolimus cream), retinoids (0.05% tazarotene gel, 0.025% tretinoin gel and 0.015% tretinoin cream, tocoretinate) are the options in the latest overview of the guidelines.

Regarding systemic treatments, antimalarials such as hydroxychloroquine diphosphate (HCQ), chloroquinesulfate (CQ) and quinacrine were mentioned, clarifying that CQ is not available in all European countries. Antimalarials are the first-line and long-term systemic treatment in all CLE patients with severe or widespread skin lesions, in particular in patients whose risk of scarring and developing systemic disease is high. “However, there is an ongoing debate about dosing adjusted by either ideal of actual body weight”, she said.

There is no consensus on ophthalmological evaluations, recommended for all CLE patients during the first year of treatment with antimalarials and once a year after five years of treatment, unless advised otherwise based on patients’ visual status or risk factors.

Hydroxychloroquine has raised interest recently, partially due to the covid-19 pandemic. Use is “strongly correlated” with a reduction in interferon alpha levels. It has been linked to multiple metabolic benefits, including improved lipid profiles and lower blood glucose levels. Due to its pharmacologic properties, the drug reaches steady-state concentration at approximately 6 months of treatment.

Systemic corticosteroids are an add-on first-line treatment in severe or widespread active CLE lesions, but long-term therapy with these agents is not recommended due to their well-known, serious side effects.

Thalidomide for refractory SCLE and DLE lesions, at a dosage of 100mg/day is also recommended. However, peripheral neuropathy has been found to occur in 17-27% of patients. Electrophysiological examination of the peripheral nerves prior to use and during treatment according to symptoms are necessary, Marinovic emphasised.

Other therapeutic options are the synthetic thalidomide analog lenalidomide, efficient and well tolerated (in small case series), even after thalidomide failure, and with fewer side effects, and iberdomide. Iberdomide has shown good results in phase II studies and can be a promising candidate in CLE, pending additional evidence.

Methotrexate can be used in some patients as second-line treatment, mycophenolate mofetil as third-line (preferably as add-on to antimalarials). Retinoids and dapsone can be used “as some specific cases”, but Marinovic expressed her caution about these two drugs not having a wide experience with them.

Novel therapies, which she sees as “quite promising” are anifrolumab, litifilimab and daxdilimab, ducravacitinib, enpatoran and edecesertib. “When preparing this conference, I was pleased to find, and read with great interest, the work of Valencia researchers assessing anifrolumab, with very positive results, in our clinical experience they can be impressive”[3], she added.

Even JAK inhibitors may play a role, but the speaker warned against thinking of these as a 'magic-bullet'.

In her opinion, a good future for the patients can be foreseen in light of intense research activity. A focus on guidelines, experience and team work will take clinicians and their patients further in that direction.

These and other relevant issues will be addressed in the EADV's upcoming symposium in Prague and its annual meeting in Paris from September 17th to 20th 2025, "where I look forward to seeing you all".

The meeting had started with a speech on the challenges of managing paediatric patients with autoinflammatory diseases by **Marta Feito**, who emphasised the "chameleonic" nature of these conditions and the regrettably frequent delay of diagnosis, which can take years. It was not by chance that Feito decided to use a study with the world 'riddle' in its title.[4]

Among key challenges, she backed efforts to make the best of those "windows of opportunity" between flare-ups where permanent damage can be avoided.

Boteanu presented data about pansclerotic morphea (PSM) in an attempt to determine whether it is an autoimmune or an autoinflammatory condition based on a case diagnosed and followed by her service at Ramón y Cajal University Hospital in Madrid. PSM is a rare but severe disease, considered autoimmune "until recently", with growing evidence about its autoinflammatory nature.

Both speakers commented on the novel approach based on JAK inhibitors, which play an increasingly important role in the treatment of numerous skin conditions.

The latest advances in autoinflammatory conditions were discussed by **Ignasi Figueras**, from general considerations (such as when genetic testing can be of use), advances in known conditions and findings in terms of new pathologies. When discussing newer therapeutic agents in development stages, Figueras noted that "practically all of them" target the inflammasome.

REFERENCES

1-Kuhn A, et al. S2k guideline for treatment of cutaneous lupus erythematosus - guided by the European Dermatology Forum (EDF) in cooperation with the European Academy of Dermatology and Venereology (EADV). J Eur Acad Dermatolo Venerol 2017; 31(3):389-404.

2-Fanouriakis A, et al. EULAR recommendations for the management of systemic lupus erythematosus. Ann Rheum Dis 2023.

3-Martín-Torregrosa D, et al. Use of Anifrolumab in Systemic Lupus Erythematosus, Cutaneous Lupus Erythematosus, and Other Autoimmune Dermatoses. Act DermoSifiliol 2025;116(1):t55-t67.

4-Meertens B, et al. The riddle of recurrent fever: a clinical approach to pediatric autoinflammatory diseases. Front Pediatri 2024 ;12:1448176. ESTA ES DE FEITO