disease symptoms. Withdrawal of hydroxychloroquine results in increased numbers of disease flares. Hydroxychloroquine prolongs survival and reduces accrual of tissue damage, including renal damage. Some experts recommend a hydroxychloroquine blood level of ≥750 ng/mL to optimize responses in active SLE; after achieving response, doses should be reduced. Because of potential retinal toxicity (occurring in 6% of patients after cumulative doses of 1000 g, ~5 years of continuing therapy), patients receiving antimalarials should undergo ophthalmologic examinations annually. One clinical trial showed that administration of dehydroepiandrosterone reduced activity of mild disease. If quality of life is inadequate despite these conservative measures, treatment with low doses of systemic glucocorticoids may be necessary. Belimumab (anti-Baff) and anifrolumab (anti-IFN type 1 receptor) are biologics that are each effective for patients with persistent disease activity and fatigue despite standard therapies; SLE patients most likely to respond to belimumab have robust clinical activity (SLEDAI-2K score of ≥10), positive anti-DNA, and low serum complement. See above under "Management of Systemic Lupus Erythematosus" for more details regarding SLEDAI-2K. Lupus dermatitis should be managed with topical sunscreens, anti-malarials, topical glucocorticoids, and/or tacrolimus and, if severe or unresponsive, systemic glucocorticoids with or without mycophenolate mofetil, azathioprine, methotrexate, or belimumab. Anifrolumab has been highly effective in patients with lupus dermatitis.

■ LIFE-THREATENING SLE: PROLIFERATIVE FORMS OF LUPUS NEPHRITIS

Guidelines for management of lupus nephritis have been published: see Tables 356-3 and 356-6 and Figure 356-2. The mainstay of treatment for any inflammatory life-threatening or organ-threatening manifestations of SLE is systemic glucocorticoids (0.5–1 mg/kg per day PO or 500–1000 mg of methylprednisolone sodium succinate IV daily for 3 days followed by 0.5–1 mg/kg of daily prednisone or equivalent). Evidence that glucocorticoid therapy is life-saving comes from retrospective studies from the predialysis era; survival was significantly better in people with DPGN treated with high-dose daily