Lupus Dx Increases Risk for Certain Cancers

BY HEIDI SPLETE

FROM THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF RHEUMATOLOGY

ATLANTA – Lupus patients were more than 2.5 times as likely as the general population to develop blood cancers, based on data from 13,492 adults with lupus.

The risk for hematologic cancers was significantly elevated among patients with lupus. Specifically, lupus patients were more than three times as likely as the general population to develop any type of lymphoma, and more than three times as likely to develop non-Hodgkin's lymphoma. In addition, lupus patients were 1.15 times more likely than the general population to develop any cancer, said Dr. Sasha R. Bernatsky of the divisions of clinical epidemiology and rheumatology at McGill University in Montreal.

Previous studies have shown an association between systemic lupus erythematosus (SLE) and cancer, due largely to the increased risk for lymphoma. In this study, Dr. Bernatsky and her colleagues aimed for a more precise estimate of cancer rates in lupus patients, as well as stratification by age. This global effort included researchers from the Systemic Lupus International Collaborating Clinics, the Canadian Network for Improved Outcomes in SLE, and other sites around the world.

Dr. Bernatsky and her colleagues reviewed data on patients from 24 centers worldwide for an average follow-up period of 9 years, and a total of 118,359 patient-years. They identified 632 cancers during the study period.

The researchers also found a significantly increased risk of lung cancer, vulvovaginal cancer, and hepatic cancer in lupus patients, compared with the general population.

However, there was a significant decrease in the risk of hormone-sensitive cancers, including breast cancer, endometrial cancer, and ovarian cancer.

Altered clearance of viruses such as human papillomavirus might be behind the increased risk for cervical and vulvovaginal cancers in lupus patients, suggested Dr. Bernatsky. Changes in estrogen metabolism might be behind the decreased risk for hormone-sensitive cancers, although more research is needed to study these possible associations.

HEIDI SPLETE/ELSEVIER GLOBAL MEDICAL NEWS

Lupus patients have significantly higher risks for blood, lung, vulvovaginal, and hepatic cancer, said Dr. Sasha R. Bernatsky.

When the results were stratified by age, patients in the youngest age group (younger than 40 years) were significantly (1.7 times) more likely to develop any cancer compared with the general population.

Despite the increase in risk, blood cancers remain rare in lupus patients, Dr. Bernatsky noted. But the study results highlight the overall risk of cancer in lupus patients. The findings remind clinicians to counsel smoking cessation to reduce the risk of lung cancer.

The decreased risk of certain cancers such as breast cancer is good news for women with SLE "and will be an area of keen research interest in the future," Dr. Bernatsky said.

She disclosed that she has received funding from the National Institutes of Health and research grants from the Arthritis Society of Canada. ■

CLE Patients Who Stop Smoking Respond Better to Antimalarials

BY SALLY KOCH KUBETIN

EXPERT ANALYSIS FROM A RHEUMATOLOGY SEMINAR

SANTA MONICA, CALIF. – Quitting smoking is the most important thing patients with cutaneous lupus erythematosus can do to increase their response to antimalarials, according to Dr. Jeffrey P. Callen.

Smokers are already at risk of having more severe disease than their nonsmoking CLE counterparts, he noted at the meeting sponsored by Skin Disease Education Foundation (SDEF) and the University of Louisville.

Antimalarial drugs are the basis of therapy for cutaneous lupus erythematosus. The need for maximizing treatment response has recently become clearer. In the past, certain patients with CLE were considered to be at low risk for progression to systemic LE. These included patients with fixed lesions with a potential for atrophy. However, data from a population-based study of inhabitants of Rochester, Minn. now show that these patients are as likely as others with CLE to progress to SLE.

The researchers found that the incidence of CLE and SLE were equal. But of the 156 patients with CLE, 12% (19 patients) progressed to SLE within a mean of 8.2 years from the time of their CLE diagnosis, said Dr. Callen, professor of medicine (dermatology) and chief of the division of dermatology at the University of Louisville (Ky). Of particular interest was the subtype of SLE that the researchers found in the 19 patients who progressed to SLE – there were 9 cases of the localized discoid subtype of CLE, 4 cases of the generalized discoid CLE subtype, 2 with the panniculitis CLE subtype, and 4 with the psoriasiform subtype of CLE (Arch. Dermatol. 2009;145:249-53).

Aggressive use of antimalarials, including smoking cessation, is warranted to stop progression of CLE to SLE.

DR. CALLEN

These findings "give us reason to treat these patients more aggressively than we might have done," said Dr. Callen, and part of that more aggressive treatment is to get patients who smoke to stop.

Another tool is to get patients to use sunblock. "This is a photosensitive disease. It's photodistributed. It's photoexacerbated. We can reproduce it with phototesting. So sunscreens are important, but even more so is photoprotection. Patients need to change their behavior and wear photoprotective clothing. Whenever we do that, patients are going to have vitamin D deficiency. Data have come out recently that lupus patients in general have vitamin D deficiency. So we need to address that and [ensure that they] get adequate vitamin D. No one has done a study to see if [supplementation with vitamin D] makes a difference," Dr. Callen noted.

First-line therapy is the antimalarial hydroxychloroquine or chloroquine. "To me, systemic corticosteroid therapy is not a therapy for cutaneous lupus," Dr. Callen said.

Data from one study suggest that giving patients hydroxychloroquine delays the time from onset of CLE to progression to SLE (Lupus 2007;16:401-9). "To me, that means we need to be treating patients with antimalarials earlier than we do," he said.

SDEF and this news organization are owned by Elsevier. Dr. Callen reported no relevant financial relationships. ■

Cutaneous LE Linked To Increased Cancer Risk

BY BRUCE JANCIN

FROM THE ANNUAL CONGRESS OF THE EUROPEAN ACADEMY OF DERMATOLOGY AND VENEREOLOGY

GOTHENBURG, SWEDEN – Patients with cutaneous lupus erythematosus appear to have an elevated overall risk of cancer, especially nonmelanoma skin cancer, lung cancer, and non-Hodgkin's lymphoma.

That's the preliminary conclusion from a Swedish national cohort study involving 3,788 Swedes with cutaneous LE (CLE), each matched to three controls and followed for an average of 4.1 years, said Dr. Carina M. Grönhagen.

The take-home message from this first-ever look at the cancer risk associated with CLE is that patients with this skin disease need to be followed regularly for the emergence of malignancy. And they need a strong antismoking message.

"Many of these cancers are connected to smoking, and patients with CLE are known to be smokers to a higher degree than in a normal population," observed Dr. Grönhagen, a dermatology resident at Danderyd Hospital and doctoral candidate in medical epidemiology at the Karolinska Institute, Stockholm.

She looked at cancer rates in patients with CLE because CLE is an autoimmune disease, and epidemiologic studies indicate other autoimmune diseases are associated with increased cancer risk.

The overall number of cases of cancer documented in the CLE group during the study period was 188, compared with an expected 112. This 67% increased incidence rate ratio remained significant after adjustment for comorbid SLE, which dropped the ratio only to 60%.

The greatest increase in cancer risk seen in the CLE cohort was for nonmelanoma skin cancer, with a 4.3-fold relative risk, compared with controls. The other strongest risk increases were the 2.9-fold increase in lung cancer, the 2.7-fold increase in non-Hodgkin's lymphoma, and the 2.7-fold rise in buccal cancer.

Asked if she thinks the observed increase in cancer in association with CLE is caused by the skin disease itself, or instead perhaps the immunosuppressive therapies employed in its treatment, Dr. Grönhagen replied that the well-established high rate of smoking among CLE patients is probably a significant contributor. But the immunologic derangement inherent in CLE is also likely to play a role, especially with regard to the increase in nonmelanoma skin cancer.

She declared having no relevant financial relationships. ■