The Importance of Thrombosis in Patients with Lupus Erythematosus

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Much progress has been made during the last two decades in the knowledge of factors involved in the prognosis of patients with lupus erythematosus (LE). After 5 years of evolution, morbidity and mortality in patients with LE are essentially related to side effects of treatments, infections and thrombosis [1]. Infections and treatment-related side effects are well-known to most clinicians, but the importance of thrombotic complications is often underestimated. Thrombosis, whether in the context of lupus anticoagulant and/or antiphospholipid antibodies or not, is an important factor that should not be neglected. Both arterial and venous thrombosis may occur, and LE itself is a significant risk factor for ischemic heart disease and atheromatosis [2–4]. Many clinical signs indicative of thrombosis are skin findings that can occur simultaneously, after or before the onset of serious, sometimes life-threatening, thrombotic events. Thus, the recognition of cutaneous signs indicative of thrombosis in patients with LE is of major importance. Yet, though those signs are well known, their importance is not stressed in the current classification of cutaneous findings in patients with LE [5–7].

Clinical signs indicative of thrombosis in patients with LE are illustrated in table 1. The clinical significance of some of these signs is unequivocal as for example the white, ivory-colored, atrophic papules with peripheral tel-

Table 1. Cutaneous signs found in patients with LE indicative of – or possibly related to – thrombosis

Degos-like disease
Atrophie-blanche-like lesions
Cutaneous necrosis
Splinter hemorrhage
Livedo, especially racemosa-like
Telangiectasis
Purpura, especially noninfiltrated, stellar purpura
Anetoderma
Thrombophlebitis
Ulcerations

angiectasis called ‘Degos disease-like lesions’ which always indicate thrombosis [8]. Histopathologically, a cone-shaped cutaneous infarct is found, and these lesions can therefore be interpreted as the clinical consequence of an arteriolar cutaneous infarct. The interpretation of some other signs is more ambiguous, but their presence should raise suspicion of ongoing thrombosis, unless another mechanism can be proven. Purpuric macules and periungual telangiectasis are examples of such findings.

The presence of these lesions involves the search for thrombosis in other sites, the search for cardiac valvular disease as well as the search of known thrombotic predis-

posing factors, especially those with a therapeutic consequence such as hyperhomocystinemia or the presence of antiphospholipid antibodies. Patients should stop cigarette smoking, especially as cigarette smoking is also associated with cutaneous LE [9–11]. Women in child-bearing age should use adequate contraception, avoiding highly dosed oral contraceptives. Lipid levels should be

closely monitored and lowered if necessary. Indeed, these cutaneous lesions raise, merely by their presence, the question if an anti-platelet-aggregating treatment should be started, as they are direct evidence of thrombosis. It is therefore important in clinical practice to identify these signs because of their diagnostic, prognostic and therapeutic consequences.

References

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