The antinuclear antibody (ANA) test is commonly used to detect autoantibodies that react against nucleus components of the body’s cells. However, the ANA test can be positive for other reasons, such as infections and other autoimmune diseases. Other blood tests that are more specific for autoantibody types and people with lupus include anti-DNA, anti-Sm, anti-RNP, anti-Ro (SSA) and anti-La (SSB).

Biopsies are sometimes necessary and can be helpful in making a diagnosis. The examination of a small sliver of tissue under a microscope can identify the amount of inflammation and damage that has occurred. The most common sites to biopsy are the kidney and skin.

Many other disorders may mimic SLE and therefore are included in the differential diagnosis. These include rheumatic diseases, fibromyalgia and multiple sclerosis (Table 3).

### Treatment

There is no cure for SLE, but patients can manage symptoms with several treatments and strategies. Patients should avoid strong sunlight and general sun exposure, since they can cause photosensitivity and symptom exacerbation. Patients should use sunscreens with a sun protector factor of at least 15 and wear sun protective clothing.

A modest amount of exercise can be helpful in maintaining cardiopulmonary fitness, avoiding obesity and improving mood. Sufficient calcium and vitamin D are needed, due to the increased incidence of osteoporosis in patients with SLE.

Influenza vaccines should be administered annually, along with a pneumococcal vaccine since patients with lupus typically have splenic dysfunction. Prophylactic antibiotics should be prescribed when patients are undergoing dental, genitourinary or other invasive procedures due to an increased risk for endocarditis.

Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen can be helpful for managing joint pain, fevers and serositis. Careful monitoring for NSAID toxicity is warranted due to potential effects on the kidneys. These drugs can exacerbate hypertension, edema and renal insufficiency in patients with SLE.

Hydroxychloroquine (Plaquenil) can be helpful in the management of musculoskeletal, cutaneous, cognitive and serosal aspects of the disease. Corticosteroids (prednisone) are used for patients with more serious SLE or those who do not respond to Plaquenil. If major organ involvement occurs (pericarditis, thrombocytopenia, autoimmune hemolytic anemia, nephritis, central nervous system SLE), higher-dose corticosteroid therapy (40 mg to 60 mg/day or rapid intravenous therapy of 1 g methylprednisolone every day for 3 days) is needed.

Once the active disease is under control, immunosuppressive agents can be used to control the disease and allow for tapering of corticosteroids. The choice of immunosuppressive agent depends on the organ involved.

For renal involvement, intravenous cyclophosphamide and prednisone have produced better renal outcomes. The use of mycophenolate mofetil (CellCept) has demonstrated short-term effectiveness in lupus nephritis. The use of methotrexate and leflunomide (Arava) can be helpful for patients with severe arthritis.

If kidney involvement has occurred and toxic chemicals begin building up in the kidneys, dialysis is necessary to keep the patient stable. Kidney transplant may be necessary. SLE patients who have received transplants do very well.

### Putting It Into Practice

Nurse practitioners play an instrumental role in the recognition and diagnosis of SLE. Nurse practitioners who are well...