

Pruritus in Lupus Patients

Juan Jiménez-Alonso MD PhD

Past Director of Internal Medicine Division at University “Virgen de las Nieves” Hospital, Granada, Spain. University of Granada, Spain

Dear Editor,

I have read with interest the article by Yahya and Gideon (Characterizing Pruritus in Autoimmune Connective Tissue Diseases. *J Drugs Dermatol.* 2019;18:995-998) on pruritus in patients with autoimmune connective tissue diseases.¹ In this study, the authors did a chart review of all patients seen in the Rheumatology-Dermatology clinic at Massachusetts General Hospital, and itch was present in 61% of systemic lupus erythematosus patients (SLE), paralleled the course of inflammatory skin manifestations in 45% of them. However, as the authors comment, pruritus itself is just a symptom, and understanding the pattern of pruritus in each disease may help to identify different etiologies and give different treatments. Therefore, I think is relevant to consider the possibility that the treatment received by the autoimmune patients could induce itching, but the authors do not refer to the pruritus caused by antimalarial drugs (AD). AD are a widely used drug, either in patients with SLE or other autoimmune connective tissue diseases, to improve the cutaneous, musculoskeletal, and mild constitutional symptoms of the patients. We described several years ago, an aquagenic type of pruritus in six of 104 lupus patients, treated with hydroxychloroquine or chloroquine.² We studied 105 patients with at least four of the criteria of the American Rheumatism Association classification for the diagnosis of SLE and 31 with CLE. Of the 136 patients, 104 were given AD treatment, of which 29 received chloroquine at a usual dose of 250 mg/day, eighteen were treated with hydroxychloroquine, 200 mg/day, and fifty and seven both, but never in combination. One of the six patients with pruritus had CLE and five had SLE. The patients had an aquagenic or post wetness type of generalized pruritus, which started approximately between 1 and 3 weeks after initiating AD therapy and developed mainly after a hot shower, appearing within minutes after water contact, lasting at a high intensity for approximately 10 minutes, and remaining at a low intensity for several hours, without visible skin changes. It was necessary to stop definitively AD therapy in 2 patients and temporarily in another two.

Because of the great importance of AD in patients with lupus, both for the control of various clinical manifestations, and to avoid greater accumulated damage during the evolution,³ I think it is very important to know this possible adverse effect.

DISCLOSURES

The author has no conflicts of interest to declare.

REFERENCES

1. Yahya A, Gideon P. S. Characterizing Pruritus in Autoimmune Connective Tissue Diseases. *J Drugs Dermatol.* 2019;18:995-998.
2. Jiménez-Alonso J, Tercedor J, Jáimez L, et al. Antimalarial drug-induced aquagenic-type pruritus in patients with lupus. *Arthritis Rheum.* 1998;41:744-5
3. Hughes G. Hydroxychloroquine: an update. *Lupus.* 2018;27:1402-1403.

AUTHOR CORRESPONDENCE

Juan Jiménez-Alonso MD PhD

E-mail: jjimenezalonso@gmail.com