LETTER TO EDITOR

ANTIPHOSPHOLIPID SYNDROME IN CHILDHOOD ONSET SYSTEMIC LUPUS ERYTHEMATOSUS

Sir,
The occurrence of antiphospholipid syndrome in childhood onset SLE has been reported variably.1,2 We compared retrospectively, the occurrence of antiphospholipid syndrome in both childhood and adult onset SLE seen in our unit over one year period. Of the 76 patients, 18 (24%) were of childhood onset variety. This is comparable to that available in literature.3 Antiphospholipid syndrome was present in 55.5% of childhood onset and 13.7% of adult onset SLE patients (P=0.025).

There was a slightly high male prevalence and longer disease duration in the childhood onset SLE as compared to the adult onset SLE. Fever was the main presentation in childhood onset SLE in contrast to polyarthralgia or arthritis in the adult onset subset. The major events included deep vein thrombosis of leg,1 arterial occlusion and gangrene of toes,1 myelopathy2 in childhood onset SLE and mitral regurgitation,3 bortion,4 thalamic infarct5 and pulmonary embolism2 in adults.

Lupus headache, which is thought to be a manifestation of presence of antiphospholipid antibodies, was present in five and seven patients respectively in childhood and adult onset lupus patients. Incidence of renal lupus in our patients was comparable in both groups, although literature shows a higher incidence of renal lupus in pediatric SLE.4 A larger study with renal biopsy may show the real picture in our population. Focal neurological deficits, lupus headaches, myelopathy, cardiac valvular lesions have all been attributed to APS.3,5 Although neurological and vasculitic complications appeared higher in childhood onset SLE, this difference did not reach statistical significance. Reports claim that majority of CNS lupus features are due to APS, rather than vasculitis or other autoantibodies.7 In adults, history of abortion was the main presentation of APS, going by the conventional criteria. However major morbidity events like pulmonary embolism and death were also seen only in the adult onset subset.

Since significantly higher number of childhood onset lupus patients had APS features in this study, it may be an important determinant of morbidity and outcome in childhood onset SLE, especially in relation to neurological involvement. Our prevalence could be low because of the retrospective nature of our study and also because antiphospholipid antibodies were not tested in all patients, unless it was strongly suspected.

In conclusion, childhood onset SLE seems to be having a higher prevalence of APS. A prospective study involving a larger number of Indian patients may be needed to predict outcome and decide on anti coagulation therapy.

REFERENCES


