

Longterm Followup After Tapering Mycophenolate Mofetil During Maintenance Treatment for Proliferative Lupus Nephritis

To the Editor:

In their retrospective study¹, Laskari and colleagues describe their experience of tapering mycophenolate mofetil (MMF) maintenance treatment in patients in renal remission after proliferative lupus nephritis. They compare the relapse rates of patients according to the timing of reduction of MMF. Among 18 patients with reduction of MMF therapy, 10 (56%) experienced a relapse, while only 6 of 26 patients (23%) with stable MMF dosage (2–3 g/day) relapsed. MMF was withdrawn in only 2 patients. Patients in whom MMF was reduced before 18 months were more prone to relapsing, while a reduction after 18 months was as safe as the continuation of full-dose treatment. The authors conclude that tapering of maintenance therapy with MMF may be safe after 18 months in patients who are stable and in renal remission. They call for prospective studies to address this issue.

We believe important information is missing in this study: how many patients in each group were taking hydroxychloroquine (HCQ)? Indeed, in addition to the usual use of HCQ for cutaneous and articular manifestations of systemic lupus erythematosus, the data from the LUMINA cohort and retrospective studies have raised its possible benefit in the prevention or attenuation of renal flares. Consequently, tapering immunosuppressive therapy for maintenance in lupus nephritis could be safer in a patient receiving concurrent treatment with HCQ. In this context, the French Cooperative Group on Lupus Nephritis is currently conducting a prospective study — WIN-Lupus (Weaning of Immunosuppression in Nephritis of Lupus) to evaluate the safety of the withdrawal of immunosuppression after 2 years of maintenance therapy with MMF or azathioprine in patients in remission and under therapy with HCQ. Two hundred patients with proliferative lupus nephritis will be randomized into 2 groups: continuation of

immunosuppression for 2 more years, or tapering and withdrawal in 3 months. All patients will be receiving HCQ, and corticosteroids if needed. They will be followed for 2 years and more; the primary endpoint will be the rate of relapses at 2 years.

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