TABLE 79-5 REVISED CLASSIFICATION CRITERIA OF ANTIPHOSPHOLIPID SYNDROME

CLASSIFICATION CRITERIA*	DEFINITION
CLINICAL CRITERIA	
1. Vascular thrombosis	One or more clinical episodes of arterial, venous, or small vessel thrombosis in any tissue or organ. Thrombosis must be confirmed by objective validated criteria (i.e., unequivocal findings of appropriate imaging studies or histopathology). For histopathologic confirmation, thrombosis should be present without significant evidence of inflammation in the vessel wall.
2. Pregnancy morbidity	a. One or more unexplained deaths of a morphologically normal fetus at or beyond 10 weeks' gestation, with normal fetal morphology documented by ultrasound or by direct examination of the fetus *or* b. One or more premature births of a morphologically normal neonate before 34 weeks' gestation because of (i) eclampsia or severe pre-eclampsia or (ii) recognized features of placental insufficiency *or* c. Three or more unexplained consecutive spontaneous abortions before 10 weeks' gestation, with maternal anatomic or hormonal abnormalities and paternal and maternal chromosomal causes excluded
LABORATORY CRITERIA	
1. Lupus anticoagulant	LAC detected in plasma on two or more occasions at least 12 wk apart
2. Anticardiolipin antibody	The ACA antibody of IgG and/or IgM isotype in serum or plasma in medium or high titer (i.e., >40 GPL units, or >the 99th percentile) on two or more occasions at least 12 weeks apart, measured by a standardized ELISA
3. Anti-β_2 glycoprotein I antibody	B2GPI antibody of IgG and/or IgM isotype in serum or plasma (in titer >the 99th percentile), detected on two or more occasions at least 12 weeks apart, measured by a standardized ELISA

Modified from Miyakis S, Lockshin MD, Atsumi T, et al: International consensus statement on an update of the classification criteria for definite antiphospholipid syndrome (APS), J Thromb Haemost 4:295–306, 2006.

ACA, Anticardiolipin antibody; ELISA, enzyme-linked immunosorbent assay; B2GPI, anti-β_2 glycoprotein I antibody; Ig, immunoglobulin; LAC, lupus anticoagulant.

*Antiphospholipid antibody syndrome is diagnosed if at least one clinical criterion and one laboratory criterion are met.

enlargement is a common manifestation of SLE, physicians must consider malignancy if the lymphadenopathy does not resolve with SLE treatment, is nontender or nonmobile, or if it occurs without other lupus symptoms.

PROGNOSIS

In 1955, patients with SLE had a 5-year survival rate of only 50%. Advances in early diagnosis and treatment of lupus patients have led to the current 5- and 10-year survival rates of more than 90% and approximately 90%, respectively, in developed countries.

A bimodal pattern of mortality is seen in SLE. Early deaths (<5 years from diagnosis) are attributed to active SLE disease and infections, whereas later deaths (>5 years from diagnosis) result from chronic SLE complications and medications, atherosclerotic CVD, and infections. Data suggest that malignancy-associated morbidity and mortality are lifelong risks, but rates are the greatest early in the disease. With recent and ongoing improvements in the treatment of SLE and increasing survival rates of patients with SLE, we need to pay additional attention to comorbid conditions associated with SLE and its treatment, specifically premature atherosclerotic heart disease, malignancy, bone health, and psychosocial well-being.

SUGGESTED READINGS

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