



July 2000

What's New At RiskTutor

Long Term Care Tutor™ will be released in September 2000. It will feature a new screening tool called **Insurability Tutor™**. With decline rates on formal applications for LTC coverage approaching 35%, **Insurability Tutor™** provides producers with a much needed **5 minute screening system that will identify 98% of clients who should not apply for LTC coverage**. Like RiskTutor, **Long Term Care Tutor™** also will have unlimited online coaching by industry experts in LTC underwriting. Look for more information in August on RiskTutor's home page.

Underwriting Topic Of The Month

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Systemic Lupus Erythematosus (SLE)

"Lupus" (SLE) is an autoimmune disease where the body loses its ability to tell the difference between foreign substances called "antigens" and its own cells and tissues. The immune system instead attacks its own cells and tissue through "immune complexes" that build up in the tissues and cause inflammation, injury and pain. SLE is notable for unpredictable exacerbations and remissions and usually involves the joints, skin, kidney, lungs, heart and GI tract.

- Women and minorities have the highest incidence of SLE
- Women of child bearing age are at the highest risk
- SLE is three times more common in African American blacks than American caucasians.
- **Newer information puts the prevalence in the United States as high as 2,000,000**



IMPORTANT NOTE:

There are three (3) types of lupus:

1. **Discoid**–This always limited to the skin and presents as a rash on the face, neck and scalp. Discoid lupus does not generally involve the body's internal organs. 10% of patients with discoid lupus will go on to have the systemic form of lupus (SLE).
2. **Systemic (SLE)**–More severe than discoid lupus and can affect almost any organ or system in the body.

3. **Drug-induced**—This occurs after the use of certain medications (i.e. hydralazine to treat high blood pressure and procainamide to treat an irregular heart rhythm). The symptoms usually go away when the causing drug is discontinued.

Lab Studies Used In Diagnosis & Monitoring

Diagnosis of SLE

A diagnosis of SLE is based on a careful assessment of the patient's entire medical history in conjunction with certain laboratory findings.

Although SLE can affect any part of the body, most people demonstrate involvement in a number of the following areas:

<i>Area Affected</i>	<i>Percent Affected</i>
Achy Joints	95
Fever (>100 F)	90
Arthritis (swollen joints)	90
Prolonged or extreme fatigue	81
Skin Rashes	74
Anemia	71
Kidney Involvement	50
Pleurisy (pain with breathing)	45
Butterfly-shaped rash	42
Photosensitivity	30
Hair loss	27
Seizures	15



IMPORTANT NOTE:

Any patient who has involvement of four (4) or more "affected areas" is suspect for having SLE.

Commonly used laboratory tests used in the diagnosis of SLE are:

1. Anti-nuclear antibody test (ANA) which tests to determine if autoantibodies to the nucleus of the patient's own cells are present in the blood.
2. Anti-DNA antibody test which tests if the patient has antibodies to the genetic material in their own cells.
3. Anti-Sm antibody test which tests if the patient has antibodies to Sm of their own

- cells (Sm is a protein found in the nucleus of a cell).
4. Tests to detect the presence of immune complexes in the blood.



IMPORTANT NOTE:

A common mistake is to view the ANA as a diagnostic test for SLE. It is not. 25-40% of healthy adult females may be ANA positive and never develop SLE or other connective tissue disease.

In individuals with a suspected medical history of SLE and a positive ANA test additional tests are usually undertaken (i.e. anti-DNA, anti-Sm, etc.) to better establish the diagnosis.

Treatment

Treatment of SLE

Medications are a very important aspect in the management of SLE. Drug treatment has two primary goals:

1. Reduce the inflammation within the affected tissues.
2. Suppress the abnormalities of the immune system that are causing the inflammation.

Anti-Inflammatory Medications

These medications relieve the symptoms by reducing the inflammation responsible for the pain and discomfort of the disease. Anti-inflammatory medications fall into two categories: non-steroidal agents and corticosteroids.

Common non-steroidal agents include [aspirin](#) and [ibuprofen](#) based agents like [Motrin](#) and [Advil](#). Stronger non-steroidal agents are available by prescription (i.e. [Celebrex](#), [Daypro](#), [Lodine](#), etc.).

Corticosteroids (i.e. [prednisone](#)) are drugs with very potent anti-inflammatory properties. They can be used in SLE as creams (i.e. for skin rashes), pills or injections. Most signs of SLE respond rapidly to corticosteroid treatment.

There are many complications associated with corticosteroid treatment. Most of these complications are increased with high doses and prolonged use of these medications.

Anti-Malarial Medications

Drugs used for the treatment of malaria are widely used in the management of SLE symptoms. [Plaquenil \(hydroxychloroquine\)](#) and [Aralen \(chloroquine\)](#) is the most commonly used of the anti-malarial agents.

Immunomodulating Medications

Cytotoxic or immunosuppressive drugs similar to those used to treat cancer patients are used to "suppress" the immune system in SLE. The two most commonly used drugs are

Imuran and Cytoxan. The medications are reserved for the serious expression of SLE (kidney or neurological problems) where corticosteroids have failed.

Anticoagulant Medications

These drugs are used to "thin the blood" to prevent the blood from clotting rapidly. These medications include aspirin and Coumadin.

Underwriting Comment

Underwriting Comment

The idea that SLE is generally fatal is dated misconception. With current therapy options deaths from SLE are uncommon and 80-90% of people with SLE live more than 10 years after the diagnosis. This means that many clients with SLE will be insurable. However, standard offers will be uncommon. It is important to obtain the following information when screening your SLE cases:

1) When was the client diagnosed with SLE?

Clients can be postponed up to two years from the date of their diagnosis depending on their clinical stability. It is important to establish the exact date of the diagnosis.

2) Does the client have any "organ threatening" complications from SLE?

The heart and the kidneys are common sites of "organ threatening" complications from SLE. You need to document the presence of any "organ threatening" complication (i.e. what organ system does it involve) and how long has it been present.

3) What medications is the client taking to treat their SLE?

The "medication profile" of a SLE patient will tell your underwriter a lot about the severity of the disease. It is important to carefully document which medications the client is taking to manage SLE.

(See the [Systemic Lupus Erythematosus \(SLE\) questionnaire](#) to screen your cases)

Coming in the August 2000 RiskTutor Online Newsletter: **Coronary Artery Bypass Surgery**