Predictors of incident proteinuria among patients with SLE

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ABSTRACT

Objective: To identify fixed and time-varying predictors of incident proteinuria.

Methods: This analysis was based on patients who did not have a history of diabetes and who did not have a prior episode of renal involvement. We defined an incident case of proteinuria as two or more measures of urine protein to creatinine ratio (or 24-hour protein measure) greater than 0.5 in two visits separated by more than 30 days and less than 180 days. We estimated rates of incident proteinuria in subgroups of patients with lupus defined by time-invariant and time-varying predictors.

Results: Among 895 patients included in the analysis, 840 (94%) were female, and 518 (58%) were Caucasian, 304 (34%) African-American, with mean age of 42 years at the start of follow-up. We observed 57 incident cases of proteinuria over a span of 4669 person-years of cohort follow-up. The rate of incident proteinuria was 12.2 per 1000 person-years. The rate was significantly lower among those of older age, and higher among those who were not Caucasian. In those with a very low C3 measure in a previous cohort visit, the rate was increased by a factor of 16.1 and in those with a very low C4 by 16.3. The rate among those prescribed hydroxychloroquine or ACE inhibitors/ARB was similar to those not on them.

Conclusions: Older patients with SLE are at low risk for developing proteinuria. There was not strong evidence that hydroxychloroquine or angiotensin-converting-enzyme (ACE) inhibitor reduced the risk of proteinuria. The highest rates of incident proteinuria were among those with recent low complement.

INTRODUCTION

Lupus nephritis is a common manifestation of SLE, occurring in 22%–41% of Caucasians,1 2 up to 70% of African-Americans,1 3 20%–60% of Hispanics and 24%–67% of Asian-Americans.3 4 Sociodemographic, clinical, histopathological, immunological and genetic features have all been associated with the occurrence of lupus nephritis.5 6 7 African-Americans, Hispanics, those with greater disease activity and those with anti-dsDNA and anti-ribonuclear protein (RNP) were more likely to develop lupus nephritis in one study.5

Despite advances in immunosuppressive therapy, dialysis and transplantation, the morbidity and mortality of lupus nephritis remain high. Based on studies using the US Renal Data System the incidence of end-stage renal disease (ESRD) has been stable, however in some groups—African-Americans and patients younger than 40 years—the incidence has increased.8–10 From the economic standpoint, the 4-year cumulative direct costs of lupus nephritis were reported to be close to $100 000 per patient.11 Therefore, it is of vital importance to find factors that predict lupus nephritis and, if modifiable, target them to prevent lupus nephritis or delay ESRD.

Most previous studies of predictors have studied the factors that predict the development of ESRD.12 13 Proteinuria is the clinical expression of lupus nephritis; few studies of incident proteinuria in SLE are prospective or incorporate time-varying predictors. Previously a study by Bastian et al14 reported predictive factors of new or worsening proteinuria using the dipstick method which has several limitations compared with newer methods like protein to creatinine ratio.

The Hopkins Lupus Cohort prospective database has the advantage of systematic follow-up quarterly, inclusion of both Caucasian and African-American patients, and a large number of patients with proteinuria measured by protein to creatinine ratio. We leveraged this large clinical cohort to identify fixed and time-varying predictors of incident proteinuria.

PATIENTS AND METHODS

Hopkins Lupus Cohort

This study was based on patients in the Hopkins Lupus Cohort from 2006, when urine protein to creatinine ratio started to be measured routinely, through 2015. The Hopkins Lupus Cohort was approved by the Johns Hopkins University School of Medicine Institutional Review Board (IRB# NC_00039294) on a yearly basis. All patients gave written informed consent. Patient inclusion in the cohort was based on the clinical
diagnosis of SLE by one rheumatologist (MP). Ninety-five per cent of the patients fulfilled at least four of the 1982 American College of Rheumatology revised criteria for the classification of SLE. At cohort entry, a detailed clinical history of each patient was collected. Thereafter, patients in the cohort were seen quarterly, or more frequently if medically indicated. At each patient visit, a complete history, physical examination and routine laboratory testing were performed in a systematic and prospective fashion by protocol. The Safety of Estrogens in Lupus Erythematosus National Assessment (SELENA) revision of the SLE Disease Activity Index and Physicians Global Assessment on a 0–3 visual analogue scale were calculated at each visit.

Cohort members not included in this analysis

This analysis was based on cohort follow-up that occurred after 1 January 2006 when the cohort began to measure urine protein to creatinine ratio routinely at every cohort visit. Only patients with three or more measures of urine protein were included. Patients with diabetes mellitus were excluded from the study. We also excluded patients with a history of renal disease prior to 2006. This was defined as a history of high urine protein (500 mg over 24 hours), renal insufficiency (serum creatinine >1.5 mg/dL or 75% decline in kidney function) or a clinical diagnosis of ESRD.

Definition of incident proteinuria

Patients were defined as having incident proteinuria if they had two or more measures of elevated urine protein (either a protein to creatinine ratio of >0.5 or a 24-hour urine collection of >500 mg) at least 30 days apart and within 180 days. Once an episode of incident proteinuria was established based on the above definition, we defined that episode as the start date of the proteinuria.

Statistical analyses

For each month of follow-up for each patient, we determined the patient’s current and past clinical history up until that month, and also whether the patient developed incident proteinuria that month. Based on this information we calculated rates of proteinuria per person-month given various patient characteristics and clinical histories. Pooled logistic regression was then applied to the person-month data to estimate rate ratios and to adjust for confounding.

RESULTS

There were 1306 unique patients in the cohort database as in May 2015 who had at least three proteinuria assessments after 1 January 2006. Two hundred and thirty-five were excluded because they had a history of significant proteinuria (>500 mg over 24 hours) or a history of nephritis or ESRD. In addition, 86 were excluded because they had high urine protein at their first assessment (protein to creatinine ration of >0.5), and 90 more were excluded due to having diabetes.

Included in this study were 895 patients with SLE, of whom 840 (94%) were women. The mean age was 42 years at the start of follow-up. Ethnic make-up was 518 (58%) Caucasian, 304 (34%) African-American and 68 (7.6%) others. There was a total of 4669 person-years of cohort follow-up (mean=5.2 years per patient) in which 57 cases met the definition of incident proteinuria. The overall rate of incident proteinuria was 12.2 per 1000 person-years.

The relationship between demographic variables and the incident proteinuria is shown in table 1. The incidence rate was significantly higher in patients younger than 40 years compared with those 40–49 years (RR=0.4, p≤0.01), 50–59 years (RR=0.2, p≤0.01) and those 60 years or older (RR=0.01, p≤0.01).

The incidence rate was significantly higher in African-Americans (RR 2.9, p≤0.01) and other non-Caucasian patients had higher rates than Caucasians (RR=3.7, p≤0.01). There was no difference in the incidence of proteinuria between men and women.

Table 2 summarises the associations of incident proteinuria with autoantibodies and complement. History of low complement for both C3 and C4, anti-dsDNA, anti-Sm, anti-RNP and anti-Ro were associated with incident proteinuria. Lupus anticoagulant, anti-La and antiprotein antibodies were not associated with incident proteinuria.

Some of the risk factors explored were highly correlated, so observed associations between incident proteinuria and one risk factor could be confounded by associations with other factors. To tease out the independent risk factors we fit multivariable models.

Table 4 shows the results of a single multivariable model including C3, C4, anti-dsDNA, age and race.

Although C3, C4 and anti-dsDNA are highly correlated with each other, a low C3 in the previous visit below 69 (RR=3.1, p<0.01), C4 below 9 (RR=4.3, p<0.01) and anti-dsDNA (RR4.2, RR p<0.01) provided independent predictive information for the development of proteinuria.

DISCUSSION

In this project we attempted to find the fixed and time-varying predictors of incident proteinuria in the Hopkins Lupus Cohort. Within the variables explored,
we found that non-Caucasian ethnicity, young age, a low C3 and low C4 at the previous visit as well as an elevated anti-dsDNA were risks factors for developing proteinuria. There was no evidence that the use of ACE inhibitors or the use of hydroxychloroquine reduced the risk of proteinuria. Among the strengths of our study were the use of urine protein to creatinine ratio, frequent visits every 3 months by protocol, predictors measured every 3 months, and inclusion of both Caucasian and African-American ethnicities.

African-American and other non-Caucasian ethnicities were found to have higher rates of incident proteinuria. In a previous report in the Lupus in Minorities: Nature versus Nurture (LUMINA) cohort, African-Americans were at higher risk of developing lupus nephritis, but in the same cohort, African-American ethnicity was not a risk factor for development of proteinuria in their multivariable model. Ethnicity can be taken as a surrogate marker for environmental factors such as socioeconomic status and access to healthcare. A recent epidemiological

| Subgroup       | Observed number of new cases of proteinuria | Person-years of follow-up | Rate of events per 1000 person-years | Rate ratios | p Value |
|----------------|---------------------------------------------|---------------------------|-------------------------------------|-------------|---------|
| Everyone       | 57                                          | 4669                      | 12.2                                |             |         |
| Age (years)    |                                             |                           |                                     |             |         |
| 18–39          | 38                                          | 1515                      | 25.1                                | 1.0 (Ref)   |         |
| 40–49          | 11                                          | 1171                      | 9.4                                 | 0.4 (0.2 to 0.7) | 0.0041 |
| 50–59          | 5                                           | 1183                      | 4.2                                 | 0.2 (0.1 to 0.4) | 0.0002 |
| 60+            | 2                                           | 780                       | 2.5                                 | 0.1 (0.0 to 0.4) | 0.0015 |
| Sex            |                                             |                           |                                     |             |         |
| Female         | 53                                          | 4376                      | 12.1                                | 1.0 (Ref)   |         |
| Male           | 4                                           | 293                       | 13.7                                | 1.1 (0.4 to 3.1) | 0.81   |
| Ethnicity      |                                             |                           |                                     |             |         |
| White          | 19                                          | 2802                      | 6.8                                 | 1.0 (Ref)   |         |
| Black          | 30                                          | 1548                      | 19.4                                | 2.9 (1.6 to 5.1) | 0.0003 |
| Other          | 8                                           | 319                       | 25.1                                | 3.7 (1.6 to 8.5) | 0.0019 |
| Calendar year  |                                             |                           |                                     |             |         |
| 2006–2009      | 26                                          | 1842                      | 14.1                                | 1.0 (Ref)   |         |
| 2010–2013      | 19                                          | 1716                      | 11.1                                | 0.8 (0.4 to 1.4) | 0.42   |
| 2013–2015      | 1110                                         | 10.8                      | 0.8 (0.4 to 1.5) | 0.44         |
| Mean past systolic blood pressure (mm Hg) |                                             |                           |                                     |             |         |
| <120           | 20                                          | 1660                      | 12.0                                | 1.0 (Ref)   |         |
| 120–129        | 13                                          | 1205                      | 10.8                                | 0.9 (0.4 to 1.8) | 0.76   |
| 130–139        | 8                                           | 793                       | 10.1                                | 0.8 (0.4 to 1.9) | 0.67   |
| 140+           | 7                                           | 413                       | 16.9                                | 1.4 (0.6 to 3.3) | 0.44   |
| Most recent systolic BP (mm Hg) |                                             |                           |                                     |             |         |
| <120           | 20                                          | 2065                      | 9.7                                 | 1.0 (Ref)   |         |
| 120–129        | 10                                          | 945                       | 10.6                                | 1.1 (0.5 to 2.3) | 0.82   |
| 130–139        | 12                                          | 745                       | 16.1                                | 1.7 (0.8 to 3.4) | 0.16   |
| 140+           | 15                                          | 726                       | 20.7                                | 2.1 (1.1 to 4.2) | 0.026  |
| Mean past diastolic BP (mm Hg) |                                             |                           |                                     |             |         |
| <70            | 18                                          | 1873                      | 9.6                                 | 1.0 (Ref)   |         |
| 70–79          | 20                                          | 1510                      | 13.2                                | 1.4 (0.7 to 2.6) | 0.32   |
| 80+            | 10                                          | 588                       | 14.5                                | 1.5 (0.7 to 3.3) | 0.29   |
| Most recent diastolic BP (mm Hg) |                                             |                           |                                     |             |         |
| <70            | 21                                          | 2127                      | 9.9                                 | 1.0 (Ref)   |         |
| 70–79          | 18                                          | 1448                      | 12.4                                | 1.3 (0.7 to 2.4) | 0.47   |
| 80+            | 18                                          | 905                       | 19.9                                | 2.0 (1.1 to 3.8) | 0.029  |
| Mean past total cholesterol* |                                             |                           |                                     |             |         |
| <150           | 12                                          | 782                       | 15.3                                | 1.0 (Ref)   |         |
| 150–199        | 24                                          | 2228                      | 10.8                                | 0.7 (0.4 to 1.4) | 0.32   |
| 200+           | 9                                           | 927                       | 9.7                                 | 0.6 (0.3 to 1.5) | 0.30   |
| Body mass index |                                             |                           |                                     |             |         |
| <20            | 7                                           | 347                       | 20.2                                | 1.0 (Ref)   |         |
| 20–25          | 17                                          | 1467                      | 11.6                                | 0.6 (0.2 to 1.4) | 0.22   |
| 25–30          | 14                                          | 1212                      | 11.6                                | 0.6 (0.2 to 1.4) | 0.23   |
| 30+            | 19                                          | 1435                      | 13.2                                | 0.7 (0.3 to 1.6) | 0.34   |
study in the US Medicaid population (high poverty group) showed a higher incidence and prevalence of lupus nephritis in African-Americans. \textsuperscript{19}

In the Hopkins Lupus Cohort, having an elevated anti-dsDNA, and low C3 and C4, were found to be predictors of incident proteinuria, both in the univariable and multivariable analyses. Bastian \textit{et al.} \textsuperscript{31 4} described anti ds-DNA as a predictor of lupus nephritis and incident proteinuria, and our observations confirm this association.

Previous studies identified that a decrease in complement levels occurred in some patients with SLE having a flare. \textsuperscript{20 21} Previous reports based on the Hopkins Lupus Cohort showed that the decrease in complement levels was predominantly associated with renal and haematological flares. \textsuperscript{22} Although reductions in complement are a recognised risk factor for renal flares, our data show that while having low complement is predictive, the degree to which the complement is low has a major impact.

### Table 2

Rates of incident proteinuria by complement and autoantibodies

| Subgroup | Observed number of new cases of proteinuria | Person-years of follow-up | Rate of events per 1000 person-years | Rate ratios | p Value |
|----------|--------------------------------------------|---------------------------|--------------------------------------|------------|---------|
| **C3 (mg/dL) at previous cohort visit** | | | | | |
| 117+ 10 | 1996 | 5.0 | 1.0 (Ref) |
| 79–116 14 | 2007 | 7.0 | 1.5 (0.7 to 3.5) | 0.34 |
| 70–78 5 | 268 | 18.7 | 3.5 (1.2 to 10.4) | 0.026 |
| ≤69 27 | 277 | 97.4 | 16.1 (7.5 to 34.6) | <0.0001 |
| Ever low C3 during cohort | | | | | |
| No 13 | 2763 | 4.7 | 1.0 (Ref) |
| Yes 44 | 1906 | 23.1 | 5.6 (2.9 to 10.6) | <0.0001 |
| **C4 (mg/dL) at previous cohort visit** | | | | | |
| 22+ 11 | 2024 | 5.4 | 1.0 (Ref) |
| 12–21 14 | 2038 | 6.9 | 1.4 (0.6 to 3.1) | 0.46 |
| 10–11 8 | 223 | 35.8 | 5.9 (2.3 to 15.1) | 0.0002 |
| ≤9 23 | 261 | 88.0 | 16.3 (7.7 to 34.6) | <0.0001 |
| Ever low C4 during cohort | | | | | |
| No 18 | 3086 | 5.8 | 1.0 (Ref) |
| Yes 39 | 1583 | 24.6 | 4.8 (2.7 to 8.5) | <0.0001 |
| **Anti-dsDNA (titer) at previous visit** | | | | | |
| 0 17 | 3707 | 4.6 | 1.0 (Ref) |
| 1–80 13 | 476 | 27.3 | 4.9 (2.4 to 10.2) | <0.0001 |
| ≤81 26 | 363 | 71.6 | 10.8 (5.7 to 20.3) | <0.0001 |
| Ever positive for anti-dsDNA | | | | | |
| No 7 | 1034 | 6.8 | 1.0 (Ref) |
| Yes 50 | 3635 | 13.8 | 2.8 (1.2 to 6.1) | 0.013 |
| **Previous lupus anticoagulant** | | | | | |
| No 41 | 3337 | 12.3 | 1.0 (Ref) |
| Yes 16 | 1332 | 12.0 | 1.0 (0.5 to 1.7) | 0.94 |
| **Recent lupus anticoagulant (RVVT<45)** | | | | | |
| No 6 | 398 | 15.1 | 1.0 (Ref) |
| Yes 51 | 4271 | 11.9 | 0.8 (0.3 to 1.8) | 0.59 |
| **Anti-Sm** | | | | | |
| No 35 | 3846 | 9.1 | 1.0 (Ref) |
| Yes 22 | 806 | 27.3 | 3.0 (1.8 to 5.1) | <0.0001 |
| **Anti-Ro** | | | | | |
| No 29 | 3188 | 9.1 | 1.0 (Ref) |
| Yes 27 | 1466 | 18.4 | 2.0 (1.2 to 3.4) | 0.0083 |
| **Anti-La** | | | | | |
| No 43 | 3983 | 10.8 | 1.0 (Ref) |
| Yes 13 | 669 | 19.4 | 1.8 (1.0 to 3.4) | 0.063 |
| **Anti-RNP** | | | | | |
| No 34 | 3580 | 9.5 | 1.0 (Ref) |
| Yes 22 | 1079 | 20.4 | 2.2 (1.3 to 3.7) | 0.0052 |
| **Anticardiolipin** | | | | | |
| No 17 | 1756 | 9.7 | 1.0 (Ref) |
| Yes 40 | 2910 | 13.7 | 1.45 (0.8 to 2.6) | 0.22 |

RVVT, Russell viper venom time.
C3, C4 and anti-dsDNA are highly correlated with each other, and previously they have been reported to have the strongest serological association with renal involvement. Our multivariable model showed that each of these markers (low C3, C4 and elevated anti-dsDNA) provide independent predictive information. For example, if a patient has a C3 below 9, C4 below 4 and an anti-dsDNA higher than 80, their risk of proteinuria at the next visit is increased by an estimated factor of 60 (3.1×4.4×4.2); these observations can have direct clinical applicability.

Hydroxychloroquine generally is used to treat constitutional and cutaneous manifestations of SLE, along with arthritis and pleurisy, but it now has a major role as a protective agent. The use of hydroxychloroquine is associated with improved survival, decreased frequency of lupus flares, reduced risk of damage accrual, increased probability of remission if used in patients with membranous lupus nephritis treated with mycophenolate mofetil, and decreased probability of renal failure if used prior to the onset of lupus nephritis. In the univariate model having used hydroxychloroquine in the past but not currently was a risk factor for the development of incident proteinuria. It is possible that quitting hydroxychloroquine results in a risk for incident proteinuria. This could be an interpretation given previous data that showed the benefits of hydroxychloroquine as a protective medication.

We did not observe a lower incident proteinuria among those using ACE inhibitors/ARB treatment, even when we confined the analysis to those taking some medications for hypertension. This finding must be viewed cautiously, however, because those with higher risk for nephritis, or those who had low level proteinuria might have been more likely to be prescribed ACE inhibitors/ARB creating confounding by indication. Our results contrast with those reported by Durán-Barragán et al who reported a 73% reduction in incident renal involvement among users of ACE inhibitors. However,

| Predictor | Rate ratio (95% CI) | p Value |
|-----------|---------------------|---------|
| Age (per 5-year increase) | 0.8 (0.7 to 0.9) | <0.0001 |
| Non-Caucasian (vs Caucasian) | 2.4 (1.3 to 4.3) | 0.0035 |
| C3 (mg/dL) at previous cohort visit | | |
| 79+ | 1.0 (Ref. Group) |
| 70–78 | 1.3 (0.5 to 3.6) | 0.65 |
| ≤69 | 3.1 (1.4 to 6.7) | 0.0053 |
| C4 (mg/dL) at previous cohort visit | | |
| 12+ | 1.0 (Ref. Group) |
| 10–11 | 2.2 (0.9 to 5.4) | 0.090 |
| ≤9 | 4.3 (2.0 to 9.3) | 0.0002 |
| Anti-dsDNA (titer) at previous visit | | |
| 0 | 1.0 (Ref. Group) |
| 1–80 | 3.6 (1.6 to 7.9) | 0.0017 |
| 81+ | 4.2 (2.0 to 8.6) | <0.0001 |

Table 3: Rates of incident proteinuria by past and current medications

| Subgroup | Observed number of new cases of proteinuria | Person-years of follow-up | Rate of events per 1000 person-years | Rate ratios | p Value |
|----------|---------------------------------------------|---------------------------|--------------------------------------|-------------|---------|
| Currently on Plaquenil | | | | | |
| No | 11 | 699 | 15.7 | 1.0 (Ref) |
| Yes | 46 | 3783 | 12.2 | 0.8 (0.4 to 1.5) | 0.44 |
| Plaquenil, current and past | | | | | |
| Never | 2 | 328 | 6.1 | 1.0 (Ref) |
| Past, but not current | 9 | 309 | 29.1 | 4.8 (1.0 to 22.2) | 0.045 |
| Current, <6 months | 14 | 476 | 29.4 | 4.8 (1.1 to 21.3) | 0.037 |
| Current 6+ consecutive months | 32 | 3236 | 9.9 | 1.6 (0.4 to 6.8) | 0.51 |
| Proportion of cohort follow-up on plaqunil | | | | | |
| <20% | 8 | 413 | 19.4 | 1.0 (Ref) |
| 20–79% | 5 | 374 | 13.4 | 0.7 (0.2 to 2.1) | 0.51 |
| 80%+ | 35 | 3119 | 6.1 | 0.6 (0.3 to 1.2) | 0.16 |
| Currently on ACE inhibitors/ARB* | | | | | |
| No | 10 | 628 | 15.9 | 1.0 (Ref) |
| Yes | 24 | 1592 | 15.1 | 0.9 (0.5 to 2.0) | 0.89 |
| Proportion of cohort follow-up on ACE inhibitors/ARB* | | | | | |
| <20% | 10 | 509 | 19.7 | 1.0 (Ref) |
| 20–79% | 5 | 485 | 10.3 | 0.5 (0.2 to 1.5) | 0.24 |
| 80%+ | 13 | 956 | 13.6 | 0.7 (0.3 to 1.6) | 0.38 |

*These analyses only include patients on antihypertension medications to control for hypertension.

Table 4: Estimated association between incident proteinuria and low complement and anti-dsDNA controlling each other as well as race and sex, based on a multivariable model

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we believe that estimate is biased towards a protective effect due to the way that they defined ACE inhibitor use. They defined ACE inhibitors as any use during the follow-up period. Since the follow-up period ends at the time of renal involvement, those who do not develop renal involvement are followed for a longer period. This makes it more likely that they will use ACE inhibitors at some point, inducing a possible false negative association between ACE inhibitors and renal involvement.

One limitation of this work is that we relied on a random urine protein to creatinine ratio to identify incident cases of proteinuria rather than a more accurate measure of proteinuria such as a 24-hour quantitative measure of urine protein. However, spot urine protein to creatinine ratio reliably predicts 24-hour total protein equivalents.

Another limitation is that proteinuria can develop slowly and it is difficult to define the exact time of incident proteinuria. This difficulty could affect our results with respect to variables that might be altered (such as medication use) during the slow development of proteinuria. As noted above, this could result in confounding by indication in our effort to assess the association between ACE inhibitors/ARB use and incident proteinuria in SLE.

Finally, due to the small number of incident events (57), the statistical power was limited to conclusively show evidence for clinically important but moderate associations between predictors and incident proteinuria.

CONCLUSIONS

In summary, we found that a number of immunological markers and demographic factors were strongly predictive of future renal involvement. Anti-dsDNA, low C3 and low C4 were independent predictive markers. Our data do not indicate that ACE inhibitors/ARB or hydroxychloroquine reduced the risk of proteinuria.

Contributors AD-G, EB, LSM and MP contributed to the conception or design of the work, the acquisition, analysis, or interpretation of data for the work and drafting or revising the work critically for intellectual content.

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REFERENCES

1. Petri M, Perez-Guthmann S, Longenecker JC, et al. Morbidity of systemic lupus erythematosus: role of race and socioeconomic status. Am J Med 1991;91:345–53.

2. Pistorius M, Wallace DJ, Nessim S, et al. Lupus erythematosus in the 1980s: a survey of 570 patients. Semin Arthritis Rheum 1991;21:55–64.

3. Bastian HM, Roseman JM, McGwin G Jr, et al. Systemic lupus erythematosus in three ethnic groups. XII. Risk factors for lupus nephritis after diagnosis. Lupus 2002;11:152–60.

4. Seligman VA, Lum RF, Olson JL, et al. Demographic differences in the development of lupus nephritis: a retrospective analysis. Am J Med 2002;112:726–9.

5. Freedman BI, Spray BJ, Heise ER, et al. A race-controlled human leukocyte antigen frequency analysis in lupus nephritis. The South-Eastern Organ Procurement Foundation. Am J Kidney Dis 1993;21:378–82.

6. Reveille JD, Moulds JM, Ahr C, et al. Systemic lupus erythematosus in three ethnic groups: I. The effects of HLA class II, C4, and CR1 alleles, socioeconomic factors, and ethnicity at disease onset. LUMINA Study Group. Lupus in minority populations, nature versus nurture. Arthritis Rheum 1998;41:1161–72.

7. Salmon JE, Millennials, Schachter LA, et al. Fc gamma RIIA alleles are heritable risk factors for lupus nephritis in African Americans. J Clin Invest 1996;97:1348–54.

8. Kostenbader KH, Desai A, Alarcón GS, et al. Trends in the incidence, demographics, and outcomes of end-stage renal disease due to lupus nephritis in the US from 1995 to 2006. Arthritis Rheum 2011;63:1681–8.

9. Ward MM. Changes in the incidence of end-stage renal disease due to lupus nephritis, 1982–1995. Arch Intern Med 2000;160:3136–40.

10. Ward MM. Changes in the incidence of end-stage renal disease due to lupus nephritis in the United States, 1996–2004. J Rheumatol 2009;36:63–7.

11. Clarke AE, Panopalis P, Petri M, et al. SLE patients with renal damage incur higher health care costs. Rheumatology (Oxford) 2008;47:329–33.

12. Essaei JM, Abrahamowicz M, MacKenzie T, et al. The time-dependence of long-term prediction in lupus nephritis. Arthritis Rheum 1994;37:359–68.

13. Goulet JR, MacKenzie T, Levinton C, et al. The long-term prognosis of lupus nephritis: the impact of disease activity. J Rheumatol 1993;20:59–65.

14. Bastian HM, Alarcón GS, Roseman JM, et al. Systemic lupus erythematosus in a multiethnic US cohort (LUMINA) XI: factors predictive of new or worsening proteinuria. Rheumatology (Oxford) 2007;46:683–9.

15. Hochberg MC. Updating the American College of Rheumatology revised criteria for the classification of systemic lupus erythematosus. Arthritis Rheum 1997;40:1725.

16. Abe EM, Cohen AS, Fries JF, et al. The 1982 revised criteria for the classification of systemic lupus erythematosus. Arthritis Rheum 1982:25:1271–7.

17. Petri M, Kim MY, Kalunian KC, et al. Combined oral contraceptives in women with systemic lupus erythematosus. N Engl J Med 2005;353:2550–6.

18. Petri M, Hellmann D, Hochberg M. Validity and reliability of lupus activity measures in the routine clinic setting. J Rheumatol 1992:19:53–9.

19. Feldman CH, Hirakul LT, Liu J, et al. Epidemiology and sociodemographics of systemic lupus erythematosus and lupus nephritis among US adults with Medicaid coverage, 2000–2004. Arthritis Rheum 2013;65:753–63.

20. Swoak AJ, Groenwold J, Bronsveld W. Predictive value of complement profiles and anti-dsDNA in systemic lupus erythematosus. J Rheumatol 1998;45:359–66.

21. ter Borg EJ, Horst G, Hummel EJ, et al. Measurement of increases in anti-double-stranded DNA antibody levels as a predictor of disease exacerbation in systemic lupus erythematosus. A long-term, prospective study. Arthritis Rheum 1993;35:8344–3.

22. Ho A, Magder LS, Barr SG, et al. Decreases in anti-double-stranded DNA levels are associated with concurrent flares in patients with systemic lupus erythematosus. Arthritis Rheum 2001;44:2342–9.

23. Oral AM, Truedsson L, Sturfelt G, et al. Anti-C1q antibodies in systemic lupus erythematosus. Lupus 2015;24:42–9.

24. Alarcón GS, McGwin G, Bertoli AM, et al. Effect of hydroxychloroquine on the survival of patients with systemic lupus erythematosus: data from LUMINA, a multiethnic US cohort (LUMINA I). Ann Rheum Dis 2007;66:1168–72.

25. Ruiz-Irastorza G, Egurbide MV, Pijoan JI, et al. Effect of antimalarials on thrombosis and survival in patients with systemic lupus erythematosus. Lupus 2006;15:577–83.
26. A randomized study of the effect of withdrawing hydroxychloroquine sulfate in systemic lupus erythematosus. The Canadian Hydroxychloroquine Study Group. *N Engl J Med* 1991;324:150–4.

27. Fessler BJ, Alarcón GS, McGwin G Jr, et al. Systemic lupus erythematosus in three ethnic groups: XVI. Association of hydroxychloroquine use with reduced risk of damage accrual. *Arthritis Rheum* 2005;52:1473–80.

28. Kasitanon N, Fine DM, Haas M, *et al*. Hydroxychloroquine use predicts complete renal remission within 12 months among patients treated with mycophenolate mofetil therapy for membranous lupus nephritis. *Lupus* 2006;15:366–70.

29. Sisó A, Ramos-Casals M, Bové A, *et al*. Previous antimalarial therapy in patients diagnosed with lupus nephritis: influence on outcomes and survival. *Lupus* 2008;17:281–8.

30. Pons-Estel GJ, Alarcón GS, Hachuel L, *et al*. Anti-malarials exert a protective effect while Mestizo patients are at increased risk of developing SLE renal disease: data from a Latin-American cohort. *Rheumatology (Oxford)* 2012;51:1293–8.

31. Durán-Barragán S, McGwin G Jr, Vilà LM, *et al*. LUMINA (LIX): a multiethnic US cohort. Angiotensin-converting enzyme inhibitors delay the occurrence of renal involvement and are associated with a decreased risk of disease activity in patients with systemic lupus erythematosus—results from LUMINA (LIX): a multiethnic US cohort. *Rheumatology (Oxford)* 2008;47:1093–6.

32. Leung YY, Szeto CC, Tam LS, *et al*. Urine protein-to-creatine ratio in an untimed urine collection is a reliable measure of proteinuria in lupus nephritis. *Rheumatology (Oxford)* 2007;46:649–52.