Elite Learning Podcast

Unraveling Lupus

From butterfly rashes to nephritis-buckle up for the shape-shifter disease that demands precision! 🦋✨

⏱️ **Listen time: ~60 minutes** • 👥 **Audience: Nursing educators, students, RNs, APRNs, nurse leaders** • 🎧 **Listen now:** elitelearning.com/ce-podcasts

Featured Voices

Host: Dr. Candace Pierce, DNP, RN, CNE, COI Faculty with Elite Learning by Colibri Healthcare, nurse educator, and advocate passionate about transforming nursing education	**Guest: Abby Schmidt, MSN-Ed, RN** Nurse educator **with expertise in autoimmune conditions and patient-centered care**

What You'll Learn

- How lupus differs from look-alikes: cutaneous, drug-induced, fibromyalgia, RA
- Why lupus is the ultimate 'shape-shifter'—different for every patient
- The organs under attack: skin, kidneys, heart, lungs, brain, blood
- Who's most at risk: women 20-40, especially Black, Hispanic, Asian, and American Indian populations
- What the ANA really tells you (and what it doesn't)
- The 2019 EULAR/ACR criteria clinicians actually use
- Why hydroxychloroquine (HCQ) is the gold standard—and how to use it
- Nurse-led interventions that prevent organ damage and save lives

Key Takeaways

• SLE is a chronic autoimmune disorder where your immune system attacks your own cells—it's not contagious, not curable, but manageable.

• The 'butterfly rash' (malar rash) is the hallmark—spreads across cheeks and nose bridge. Fun fact: 'lupus' means wolf in Latin because it looked like a wolf bite in the Middle Ages.

• Lupus is a roller coaster, not a slope—patients cycle through flares and remission, making diagnosis tricky.

• Time kills kidneys: Average diagnosis takes years—long enough for preventable organ damage to accumulate.

• ANA is a screening tool, not a diagnosis—95% of lupus patients test positive, but so do 1/3 of healthy Americans.

• 45% of adults with SLE develop lupus nephritis—look for proteinuria, hematuria, and rising creatinine.

• HCQ (hydroxychloroquine) reduces flares by 50%, lowers steroid dependence, and is recommended for ALL lupus patients—even in remission.

• Patience required: HCQ takes 3-6 months to reach full effect. Don't let patients stop early!

• Disjointed care = diagnostic delays. When patients see dermatology, rheumatology, and nephrology separately without coordination, the full picture never emerges.

• Nurse case managers are the unsung heroes—they connect the dots, share the notes, and keep patients from falling through the cracks.

Fast Facts That'll Make You Think

• 9 out of 10 adults with lupus are women—most diagnosed between ages 20-40

• Women aged 20-40 are 10x more likely to develop lupus than men in the same age range

• Even in childhood and elderly populations, women are 2-3x more affected

• African American, Hispanic, Asian, and American Indian women face higher prevalence and severity

• 45% of SLE patients develop lupus nephritis—the #1 cause of morbidity in lupus

• 95% of lupus patients have positive ANA, but ~33% of the general U.S. population also tests positive

• Early onset = worse outcomes—children who develop lupus face higher risk of organ failure

• UV exposure triggers flares—photosensitivity is a major red flag

• HCQ reduces flares by 50% and is safe for lifelong use—originally an anti-malarial drug!

Do This Next

☐ Add 3 lupus screening questions to your assessment workflow (kidney, neuro, immune)

☐ Look for patterns: photosensitive rash + migratory joint pain + cyclical symptoms

☐ Order a UA on patients with vague multi-system complaints

☐ Teach patients about HCQ: 'It takes 3-6 months to work—stick with it!'

☐ Connect the care: advocate for shared notes and care coordination across specialists

☐ Reinforce sun safety: SPF 30+, protective clothing, avoid 10am-4pm sun exposure

Clinical Spotlight

Systemic Lups Erythematosus (SLE): Chronic autoimmune disorder with multi-organ involvement. Follows flare-and-remission pattern. Immune system attacks nucleus of dying cells (apoptosis gone wrong).'

Butterfly Rash (Malar Rash): Hallmark presentation—spreads across nose bridge and cheeks, spares nasolabial folds. Photosensitive (worsens with UV exposure). Not all patients have it, but it's highly specific.

ANA (Anti-Nuclear Antibody): Screening test—NOT diagnostic. 95% of lupus patients positive, but also 1/3 of healthy population. Measured as titer (1:80+). Must be combined with clinical criteria.

Lupus Nephritis: Kidney inflammation affecting 45% of SLE patients. Early signs: proteinuria, hematuria, rising creatinine, peripheral edema. Requires urgent nephrology referral and aggressive treatment.

Hydroxychloroquine (HCQ): Gold standard first-line therapy for ALL lupus patients. Reduces flares 50%, lowers steroid need, safe for life. Takes 3-6 months to work. Requires annual eye exams (retinal toxicity risk).

2019 EULAR/ACR Criteria: Entry: positive ANA required. Then: weighted score across clinical domains (rash, joints, kidneys, neuro, blood) + immunological markers (anti-dsDNA, anti-Sm, low C3/C4).

Apoptosis & ANAs: When cells die (apoptosis), lupus patients don't clear cell debris—nucleus left behind. Immune system sees it as threat → creates anti-nuclear antibodies (ANAs) → autoimmune cascade.

❓ 3 Quick Lupus Screening Questions

Use these in any patient with vague, multi-system symptoms:

1. **Kidney function:** 'Have you noticed any changes in your urine—blood, dark color, thick consistency? Any swelling in your ankles or legs?'
2. **Neurological:** 'Any unexplained fatigue, confusion, seizures, or memory problems? Headaches that won't quit?'
3. **Immune patterns:** 'Do you get fevers that come and go? Joint pain in multiple spots? Rashes that get worse in the sun?'

🚨 Red Flags for Same-Day Escalation

- Seizure activity or acute neurological changes (confusion, severe headache)
- Severe chest pain or shortness of breath (pericarditis, pleuritis, possible effusion)
- Sudden peripheral edema or facial swelling (nephritis alert)
- Unexplained cytopenia—low WBC, RBC, or platelets (autoimmune attack on blood cells)
- Hypertensive crisis or hypotension unresponsive to treatment (kidney involvement)

💬 Conversation Starter

'If you could eliminate one barrier to earlier lupus diagnosis, what would it be—and how would you do it?'

🔗 Resources & Links

EULAR/ACR 2019 Classification Criteria: https://www.rheumatology.org/Practice-Quality/Clinical-Support/Classification-Criteria

Johns Hopkins Lupus Center: https://www.hopkinslupus.org/

Lupus Foundation of America: https://www.lupus.org/

Episode page: https://elitelearning.com/ce-podcasts

CE courses: https://EliteLearning.com

Colibri Healthcare

🎧 **Subscribe & Share**

Apple Podcasts • Spotify • YouTube • EliteLearning.com

📧 **Contact:** EliteLearning.com | Social: @ColibriHealthcare