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High-dose intravenous immunoglobulins: an option in the treatment of systemic lupus erythematosus.

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Despite encouraging reports on the efficacy of intravenous immunoglobulin (IVIG) therapy in systemic lupus erythematosus (SLE), the clinical value of this treatment is not well established, and most of the data are based on case reports and small series of patients. IVIG has been used successfully to treat SLE patients with a broad spectrum of clinical manifestations, such as refractory thrombocytopenia, pancytopenia, central nervous system (CNS) involvement, secondary antiphospholipid syndrome, and lupus nephritis. The beneficial effects of IVIG on overall disease activity are usually prompt, with marked improvement within a few days, but they are often of limited duration. Improvement lasts for several weeks after the last infusion, although clinical response could be maintained by continuous monthly IVIG infusions. IVIG therapy immunomodulates autoimmune diseases by interacting with various Fcγ receptors in such a way that it downregulates activating FcγRIIA and FcγRIIC and/or upregulates inhibitory FcγRIIB. However, in SLE, additional mechanisms include inhibition of complement-mediated damage, modulation of production of cytokines and cytokine antagonists, modulation of T- and B-lymphocyte function, induction of apoptosis in lymphocytes and monocytes, downregulation of autoantibody production, manipulation of the idiotypic network, and neutralization of pathogenic autoantibodies. At present, IVIG in SLE is indicated either in severe cases that are nonresponsive to other therapeutic modalities, or when SLE can be controlled only with high-dose steroids; in such patients, IVIG thus becomes a useful steroid-sparing agent. However, this needs to be confirmed in double-blind, placebo-controlled studies.

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