Background: The mortality figures for lupus have decreased from 50% 4-year survival (1950s) to 85% survival now. However it causes a host of morbidities. Using the BILAG activity categories this talk focuses on the key consequences of non-fatal lupus.

Discussion: In the constitutional system fatigue remains a major problem affecting > 80% of patients. Its cause is complex invariably a combination of disease activity, anaemia (several possible causes), depression, hypothyroidism and fibromyalgia. Although some of these factors are correctable, fatigue remains challenging. Dermatologically alopecia is found in 25-40% of patients with scarring a major concern in 10-15% of patients who develop it. Alopecia reflects disease activity and is often improved by more aggressive treatment but scarring is permanent. In the central nervous system, psychosis is devastating causing gross impairment in reality and disordered thinking. It is often accompanied by other aspects of active lupus. It occurs in 2% of patients, usually within the first two years of disease onset. The keys to successful management are immnosuppression, anti-psychotic drugs and time - this does not get better quickly. In the musculoskeletal systemic erosive arthritis (RIJUPUS) is present in 5%. Some patients move from SLE to rheumatoid arthritis and treating with methotrexate and, rarely, TNF alpha-blocking drugs can be very helpful but the latter have a predisposition to induce DNA antibodies; not necessarily the best thing to happen in a lupus patient. In the cardiovascular system, pulmonary hypertension has a prevalence of approximately 15% (using > 30mm Hg as a cut-off for right ventricular systolic pressure). The diagnosis is best made by Doppler echocardiography. Ventilation perfusion scans are important to exclude multiple pulmonary emboli. Once considered a fatal condition, its treatment has been revolutionised by the advent of continuous intravenous prostanlyclin and its analogues; if severe anticoagulation is recommended. Gastrointestinal manifestations in lupus are common and abdominal pain is divided into acute and common - the former much more likely to be associated with active lupus elsewhere and the latter with many non-lupus related problems. In the kidneys renal failure is genetically more likely to occur in black compared to Caucasian or South Asian patients but in any ethnicity, poor adherence remains a considerable influence upon its development. Effective dialysis and transplantation have hugely benefited this group. Haematologically thrombocytopenia may be acute and dramatic (often associated with anti-platelet antibodies) or chronic persistent (linked to antiphospholipid antibodies). For the more acute patients, rituximab and eltrombopag have proven effective. Ophthalmologically retinal vasculitis leading to blindness is recognised but mercifully rare. Finally other more classic long-term complications of lupus including osteoporosis, premature atherosclerosis and a slight increase in the risk of non-Hodgkin's lymphoma are other important factors to be considered.

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