The Sjögren’s Syndrome Foundation (SSF) has developed the first U.S. Rheumatology Clinical Practice Guidelines for Sjögren’s to ensure quality and consistency of care for the assessment and management of patients by offering recommendations to clinicians for systemic disease management.

Previously, treatment guidelines for serious organ involvement from Sjögren’s were borrowed from those used to treat Systemic Lupus Erythematosus (SLE) and Rheumatoid Arthritis (RA). Among the recommendations, the guidelines address the treatment of inflammatory, musculoskeletal pain in systemic Sjögren’s, use of biologic agents and management of fatigue.

SSF Rheumatology Guidelines Summary and Recommendations

For the development of the SSF Rheumatology Guidelines, a highly rigorous and transparent process was employed with important guidance from the American College of Rheumatology and the Institute of Medicine. An extensive, systematic literature review by Topic Review Groups (TRG) was followed by data extraction and drafting of recommendations to be considered by separate consensus expert panels (CEP) consisting of academic and community practice clinicians, registered nurses and patients. Using a modified Delphi-type consensus process, the CEP reached consensus on eighteen recommendations with consensus set at a minimum of 75% agreement.

DMARDs for Musculoskeletal Pain

Recommendations regarding the use of disease-modifying anti-rheumatic drugs (DMARDs) to treat musculoskeletal (MSK) pain were presented as a decision tree with use of hydroxychloroquine (HCQ) as the first-line therapeutic approach. Although HCQ treatment failed to reach the primary endpoint for pain in a recent, randomized control trial, other studies have shown that following HCQ treatment, Sjögren’s patients demonstrated improvement in inflammatory markers and MSK pain. The favorable safety profile of HCQ contributed to the 92% positive agreement of the Rheumatology Working Group. Thus, the recommendation for the use of HCQ received a moderate strength rating and is considered a best clinical practice first-line therapy.

Biological Medications

Biological therapies such as rituximab will become increasingly important in the management of Sjögren’s patients and are best used in Sjögren’s patients with serious organ manifestations who fail more conservative treatments. There was strong consensus that TNF-α inhibitors not be used to treat sicca symptoms in patients with Sjögren’s. This recommendation was qualified by the consideration that clinicians should not withhold TNF-α inhibitor treatment if a patient also suffers from another condition for which such treatment would be indicated.

Fatigue

Fatigue is most effectively managed with self-care measures and exercise. Exercise provides similar benefit to reduce fatigue in Sjögren’s patients as was seen for those with RA, SLE or Multiple Sclerosis.
**Table 1 – Recommendations for Systemic Disease Management in Sjögren’s**

### Biological Therapies*

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>TNF-α Inhibitors</th>
<th>Strength of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation #1</strong> – TNF-α Inhibitors</td>
<td><strong>Strong</strong></td>
<td></td>
</tr>
<tr>
<td>TNF-α inhibitors SHOULD NOT BE USED to treat sicca symptoms in patients with primary Sjögren’s.*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Note: this recommendation should not be considered disuse of TNF-α inhibitors in situations where there is evidence of Sjögren’s with rheumatoid arthritis (RA) or other conditions where TNF-α inhibition is indicated for the treatment of inflammatory arthritis.</td>
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### DMARDs for Inflammatory MSK Pain

**Recommendations are provided with the following caveat and then listed in a step-by-step process:**

*The physician should consider an individual patient's response when weighing risks and benefits of each therapy.***

- Insufficient evidence exists on the effectiveness of DMARDs in the treatment of inflammatory musculoskeletal pain in primary Sjögren’s. However, recommendations will be formulated based on expert opinion as guided by the consensus process.
- The following recommendations are listed in order of the Inflammatory Musculoskeletal Topic Review Group's preference for care in the treatment of inflammatory musculoskeletal pain in primary Sjögren’s. If one therapy is insufficient in effectiveness, the physician is advised to try the next recommendation in sequence and so on.**

**Recommendation #1 – Hydroxychloroquine (HQC)**

A first line of treatment for inflammatory musculoskeletal pain in primary Sjögren’s should be hydroxychloroquine.

**Recommendation #2 – Methotrexate (MTX)**

If hydroxychloroquine is not effective in the treatment of inflammatory musculoskeletal pain in primary Sjögren’s, methotrexate may be considered.

**Recommendation #3 – Hydroxychloroquine plus MTX**

If hydroxychloroquine plus methotrexate is not effective, the treatment of inflammatory musculoskeletal pain in primary Sjögren’s, short-term (1 month or less) corticosteroid therapy is insufficient in effectiveness, the physician is advised to try the next recommendation in sequence and so on.**

**Recommendation #4 – Leflunomide**

*Note: These patients should have had a suboptimal response to standard oral DMARD agents and/or have experienced unacceptable toxicity from these agents or corticosteroids or are incapable of tapering and discontinuing corticosteroids.**

**Recommendation #5 – Methotrexate Cautions**

- Hepatitis B reactivation
- Hepatic failure
- Severe pulmonary toxicity – especially nonmalignant

- *Note: These patients should have had a suboptimal response to standard oral DMARD agents and/or have experienced unacceptable toxicity from these agents or corticosteroids or are incapable of tapering and discontinuing corticosteroids.**

**Recommendation #6 – Hydroxychloroquine Cautions**

- Isychorexia
- Hepatitis
- Lymphomas
- Mycoses
- Oral leukoplakia

**Recommendation #7 – TNF-α Inhibitors**

*Note: These patients should have had a suboptimal response to standard oral DMARD agents and/or have experienced unacceptable toxicity from these agents or corticosteroids or are incapable of tapering and discontinuing corticosteroids.**

**Recommendation #8 – Cyclosporine**

*Note: These patients should have had a suboptimal response to standard oral DMARD agents and/or have experienced unacceptable toxicity from these agents or corticosteroids or are incapable of tapering and discontinuing corticosteroids.**

*Patients and physicians should refer to the FDA label for additional information.*