



Peripheral neuropathy in systemic lupus erythematosus: what can neuromuscular ultrasonography (NMUS) tell us? A cross-sectional study

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ABSTRACT

Objective To evaluate peripheral nerve involvement in patients with SLE with neuromuscular ultrasonography (NMUS) and understand its role in investigating SLE-related peripheral neuropathy.

Methods This is an observational cross-sectional study on patients with SLE and healthy controls. Five nerves in each patient were examined bilaterally with NMUS, and the cross-sectional area (CSA) of each nerve at certain sites was estimated. The mean CSA at each site, for each nerve, in each group was statistically analysed and compared between groups.

Results 370 nerves were evaluated in 37 patients. By nerve conduction study (NCS), 36 patients had polyneuropathy (80.6% mixed type, 19.4% sensory). Significant mean CSA enlargement was present among the ulnar nerve at the Guyon's canal and mid-humerus (both $p=0.001$); tibial nerve at the distal leg and proximal to the tarsal tunnel ($p=0.003$ and $p=0.001$, respectively); and peroneal nerve at the popliteal fossa ($p=0.042$). The mean CSA showed high specificity compared with NCS.

Conclusion Our study shows that CSA could be a complementary tool to NCS for studying peripheral neuropathy in SLE. Furthermore, NMUS provides data on the different pathophysiological aspects of nerve involvement in SLE. Future studies using more than one sonographic parameter in combination with NCS and nerve histopathology are recommended to further investigate SLE-related neuropathy.

Trial registration number NCT04527172.

INTRODUCTION

SLE is a chronic autoimmune connective tissue disease with multisystem involvement, including the central and peripheral nervous systems.¹ Its worldwide prevalence ranges from 0.3 to 23 per 100 000 persons per year.²

Peripheral neuropathy (PN) is not uncommon in SLE and includes mononeuropathy, mononeuritis multiplex, polyneuropathy and/or cranial neuropathy.^{3,4}

Key messages

What is already known about this subject?

- ▶ Polyneuropathy is the most frequent subtype of peripheral nerve involvement in SLE.
- ▶ Nerve conduction study (NCS) and neuromuscular ultrasonography (NMUS) detect functional and morphological changes of nerves, respectively.

What does this study add?

- ▶ Ultrasound measurement of the cross-sectional area of the peripheral nerves in SLE has high specificity and is repeatable, low cost and risk-free and more patient-friendly than NCS.

How might this impact on clinical practice or future developments?

- ▶ The combination of NCS and NMUS provides a more detailed idea of the nerve changes in SLE.
- ▶ NMUS could become an excellent screening test for evaluation of peripheral neuropathy in SLE.

In the last decades, the use of the neuromuscular ultrasonography (NMUS) to evaluate the different types of neuropathies has gained much attention.^{5–10} It is a dynamic, non-invasive, bedside tool with low interobserver reliability when used in multiple centres. When compared with MRI, NMUS was found to be a more sensitive, equally specific and less expensive tool in identifying multifocal nerve lesions.¹¹ Accordingly, NMUS might become a helpful tool in diagnosing PN especially when combined with electrodiagnosis (EDX). Many studies were performed on different types of PN using NMUS, including chronic inflammatory demyelinating polyneuropathy, Guillain-Barré syndrome, axonal neuropathies, vasculitis, diabetes and sarcoidosis.^{8–13}

Most of the authors concluded that NMUS facilitated the assessment of the nerves by



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evaluating certain parameters, including the nerve size (using nerve cross-sectional area, CSA), echogenicity, mobility and vascularity. It facilitates recognition of the underlying local cause in entrapment neuropathies.¹²⁻¹⁴ Nevertheless, it helps in the discrimination between demyelinating and axonal neuropathy, especially when clinical diagnosis and EDX are inconclusive.¹⁴

According to our knowledge, no previous study has investigated the morphological features of PN related to SLE. Thus, our work aimed to evaluate peripheral nerve involvement in patients with SLE using NMUS and to find out what can NMUS add to traditional electrophysiological studies in investigating SLE-related PN.

METHODS

Subjects

Forty-one patients with SLE fulfilling the Systemic Lupus International Collaborating Clinics classification criteria⁴ were collected from the outpatient clinic of the Department of Rheumatology and Rehabilitation, Assiut University Hospitals, and enrolled in this observational cross-sectional study. Twenty age-matched and sex-matched healthy subjects were included in the study as healthy controls. Patients were excluded from the study if an obvious cause of PN was found as degenerative, diabetic, traumatic, infectious, toxic or drug-induced PN.

Written informed consent was obtained from every subject included in the study.

Basic demographic data and clinical history were collected from patients' medical files.

All patients underwent clinical evaluation by expert rheumatologists, including full systemic and neurological examinations at the time of presentation. Laboratory work included complete blood count, erythrocyte sedimentation rate, liver and kidney function tests, serum electrolytes, urine analysis, 24-hour urine protein, creatinine clearance, and lipid profile. Serum autoantibodies such as ANA, anti-dsDNA, C3 and C4 were measured in all patients with SLE.

Two further investigations were applied to the subjects on the same day: electroneurophysiological study and peripheral nerve ultrasonography.

Electrodiagnosis

Using an electroneurophysiological device (NIHON KOHDEN Neuropack M1, MEB-9200 electromyography unit, four channels), nerve conduction study (NCS) was carried out on the median, ulnar, tibial, common peroneal and sural nerves bilaterally. The F-wave study was done for the median, ulnar and tibial nerves. Surface stimulating and recording electrodes were used. According to the results of EDX, the examined nerves were grouped into nerves with normal EDX and those with abnormal EDX, which was further subdivided into axonal and demyelinated PN (according to reference values in the literature).¹⁵

Neuromuscular ultrasonography

Peripheral nerves ultrasonography examination was carried out using a high-end machine (MyLab Seven eHD; Esaote, Italy) with linear array (6–13 MHz/11–18 MHz) transducers on the same nerves examined by EDX. The suitable machine presets for superficial and deep nerves were used. Ultrasonography scan was done at standardised anatomical points as follows: *median nerve*: proximally (at the axilla), mid-humerus (midpoint between the greater tuberosity and the antecubital fossa), distally at the mid-forearm (midpoint between the ulnar styloid process and the medial epicondyle of the humerus) and the carpal tunnel inlet (at the level of the pisiform bone); *ulnar nerve*: proximally (at the axilla), mid-humerus, at the mid-forearm (distal) and Guyon's canal; *tibial nerve*: proximally (within popliteal space), distally (5 cm above the medial malleolus) and at the tarsal tunnel; *common peroneal nerve*: proximally (within the popliteal space) and at the fibular neck; deep peroneal nerve at the ankle; and finally *sural nerve*: 14 cm proximal to the lateral malleolus.

Subjects were examined in a resting supine position with the arm supinated, abducted and supported at the body level. Lower limbs were examined in both supine and prone positions (to scan the popliteal fossa and the sural nerve). The probe was applied without pressure (only the weight of the probe) and was kept perpendicular to the nerve to obtain an optimum image of the nerve. The nerves were scanned in axial planes, and the CSA of each nerve was measured just inside the hyperechoic rim of the epineurium at the same anatomical points on both sides (figures 1 and 2).

Abnormal CSA was considered if it exceeded the mean CSA +2SD of healthy controls at the same point.

The ultrasonographic examination was performed and reported by an expert rheumatologist, and the images were then further evaluated (offline) by another expert rheumatologist who was blinded to both clinical and electrophysiological data of the patients. Any conflict in reporting was referred to a third expert rheumatologist to provide the final decision.

Statistics

IBM SPSS Statistics V.20 was used for statistical analysis. Mean±SD were used to describe most of the quantitative data, while for summarising the qualitative data frequency and per cent were used.

All quantitative data have been tested for normal distribution. Accordingly, Student's t-test and one-way analysis of variance were used; Mann-Whitney and Kruskal-Wallis tests were also applied when appropriate. For categorical data, χ^2 test was used to compare the significance between different proportions. $P < 0.05$ was considered statistically significant.

Receiver operating characteristic (ROC) curve and cross-tabulation were also used to find the benefit of using NMUS instead of EDX in detecting PN affection in patients with SLE.

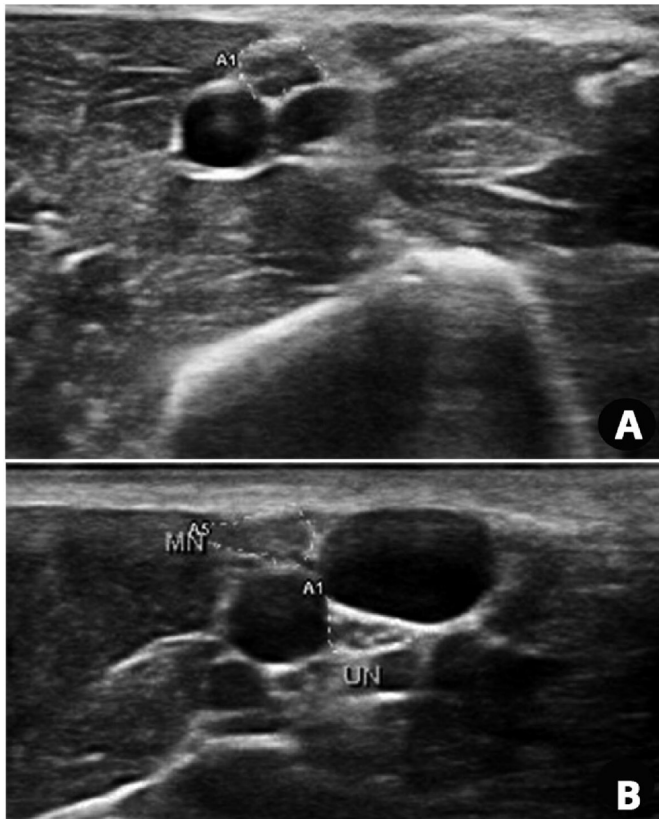


Figure 1 Neuromuscular ultrasonography showing axial views and cross-sectional area of the examined nerves: (A) median nerve at the mid-humerus measuring 10 mm²; and (B) median and ulnar nerves at the axilla measuring 11 mm² and 7 mm², respectively.

Patient and public involvement

It was not possible to involve the patients or the public in the design, or conduct, or reporting or dissemination plans of our research.

RESULTS

Forty-one patients with SLE were found to be eligible for the study, of whom four were excluded (two died and two refused to perform the NCS). Moreover, two healthy subjects refused the NCS examination.

The baseline characteristics of both groups are shown in [table 1](#). There was no statistically significant difference in the mean values of age, height, weight, body mass index or gender between the two groups ($p > 0.05$). Fourteen patients (37.8%) had clinical peripheral polyneuropathy manifestations (paresthesia, allodynia or hyperalgesia, numbness, burning and tingling). Thirty-six patients had asymmetrical polyneuropathy (according to NCS). Of them, 29 (80.6%) had mixed polyneuropathy, 7 (19.4%) had sensory polyneuropathy while only 1 (2.7%) showed electrical changes of mononeuritis multiplex. The number of individual nerve affection based on patients' clinical examination is also listed in [table 1](#).

On electrophysiological study, Student's t-test revealed the presence of a statistically significant difference

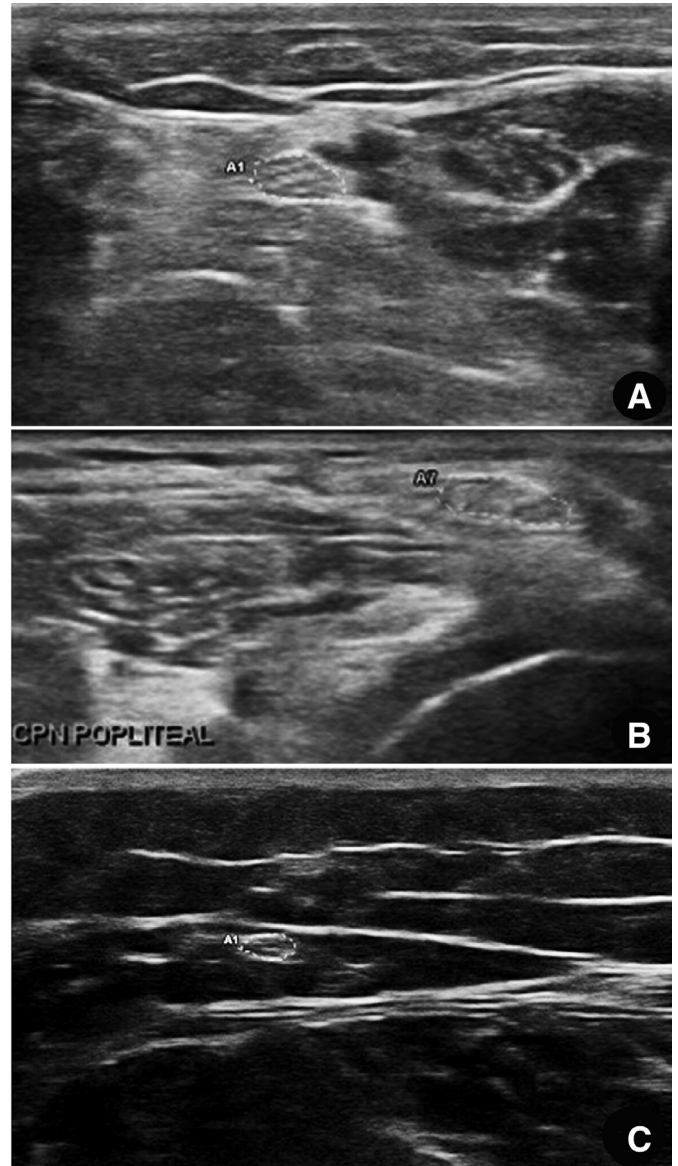


Figure 2 Neuromuscular ultrasonography showing axial views and cross-sectional area of the examined nerves: (A) tibial nerve at the distal leg measuring 8 mm²; (B) common peroneal nerve at the popliteal space measuring 12 mm²; and (C) sural nerve 14 cm proximal to the lateral malleolus level measuring 3 mm².

between patients with SLE and healthy controls regarding all the NCS parameters, except the compound muscle action potential (CMAP) amplitude of the ulnar and popliteal nerves, F-wave latency of the tibial nerve, and motor conduction velocity of the popliteal nerve when stimulated at the ankle ($p = 0.144$, $p = 0.219$, $p = 0.600$ and $p = 0.970$, respectively) ([table 2](#)).

Both axonal and demyelinating nerve affections were observed. According to electrophysiological studies, the upper limb nerves were the most affected (median and ulnar, respectively), while the lower limb nerves were less commonly affected (sural, tibial and peroneal in order). Besides, axonal neuropathy was more prevalent in the upper limbs, and demyelinating neuropathy in the lower

Table 1 Demographic and clinical data of the studied groups

	Patients with SLE n=37	Healthy subjects n=18	P value
Age in years, mean±SD	32.38±8.40	28.56±5.87	0.057
Gender			0.545
Female, n (%)	33 (89.2)	15 (83.3)	
Male, n (%)	4 (10.8)	3 (16.7)	
Height in cm, mean±SD	159.08±6.69	159.72±7.30	0.748
Weight in kg, mean±SD	63.68±13.62	64.72±12.84	0.786
BMI, mean±SD	25.17±5.32	25.35±4.67	0.901
Disease duration in years, mean±SD	7±3.98	NA	
SLEDAI	8.5±7.6	NA	
ACR Damage Index	2.2±1.1	NA	
Peripheral neuropathy (clinical)	14 (37.8%)	NA	
Peripheral polyneuropathy (by NCS)	36 (97.3%)	NA	
Individual nerve affection in patients with SLE (clinical-based)			
Nerve	Number of nerves		
Median	18		
Ulnar	12		
Tibial	6		
Peroneal	8		
Sural	6		

Student's t-test and χ^2 were applied when appropriate.

BMI, body mass index; n, number of subjects; NA, not applicable; NCS, nerve conduction study; ACR NPSLE, American College of Rheumatology; SLEDAI, Systemic Lupus Erythematosus Disease Activity Index.

limbs (table 3). The studied nerves were then divided into two groups: group A, which included the examined nerves in patients with SLE; and group B, which included the examined nerves of 18 healthy subjects. Depending on the results of NCS, group A nerves were further divided into group A1, which included nerves with normal NCS; and group A2, which included nerves with abnormal NCS. We examined a total of 1650 sites (1110 in 37 patients and 30 sites in 18 healthy subjects), and the mean CSA of each nerve at different sites was recorded in the studied groups (table 3). Significant CSA enlargement was found in group B as compared with the other two groups at the ulnar nerve at two sites, at Guyon's canal ($p=0.001$) and at the mid-humerus ($p=0.001$), in addition to the tibial nerve at the distal leg ($p=0.003$) and at the tarsal tunnel ($p=0.001$), and finally in group A1 peroneal nerve at the popliteal fossa ($p=0.042$) as compared with the other two groups. Furthermore, significant CSA enlargement was only described at the popliteal fossa in the tibial axonal and peroneal demyelinating neuropathies ($p=0.020$ and $p=0.026$, respectively) (table 3).

Using the mean CSA +2SD of healthy subjects as a cut-off value and the NCS as a gold standard, the sensitivity and specificity of the NMUS measured CSA were estimated (ROC curve and cross-tabulation) and showed low sensitivity in all examined sites, in contrast to high

specificity, although with low AUC (area under the ROC curve) and insignificant p value (table 4).

DISCUSSION

Our data show that the sonographically measured CSA of the peripheral nerves might be a helpful supplementary test to NCS in diagnosing PN in patients with SLE.

SLE-related peripheral nervous system (PNS) involvement is challenging for both rheumatologists and neurologists. In the last decade, many studies^{16–19} have focused on estimating the prevalence of PNS affection among patients with SLE, aiming to answer the question of whether it is caused by the disease or not. In our study, by clinical examination, PN was diagnosed in 37.8% of patients compared with 97.3% when diagnosed by NCS. This discrepancy may be attributed to the well-known high sensitivity, reliability and detective power of EDX versus clinical diagnosis.²⁰

Recent advances in the field of NMUS have inspired us to use it in studying the peripheral nerve affection in patients with SLE and to find out if NMUS can be used as an alternative or at least complementary diagnostic tool to EDX, which is yet considered the gold standard in the detection of PN.

Variation in size of the involved nerves is one of the commonly encountered sonographic features in different

Table 2 Results of nerve conduction study in the studied groups

Examined nerve	NCS item	Studied nerves in the SLE		P value
		group n=74 (mean±SD)	Healthy subjects n=36 (mean±SD)	
Median	MDL	3.43±0.42	3.21±0.26	0.006
	MAmp	11.40±4.37	13.38±3.52	0.020
	MNCV	60.93±7.90	70.83±5.96	0.000
	SDL	2.94±0.47	2.30±0.21	0.000
	SAmp	19.99±13.44	36.43±18.93	0.000
	SNCV	48.94±7.92	61.16±5.99	0.000
	F-wave latency	25.21±1.93	23.68±1.54	0.000
Ulnar	MDL	2.76±0.38	2.56±0.30	0.004
	MAmp	9.51±2.46	8.76±2.58	0.144
	MNCV	64.11±7.80	77.06±7.20	0.000
	SDL	2.59±0.41	2.04±0.21	0.000
	SAmp	15.20±9.50	30.56±14.31	0.000
	SNCV	55.72±8.84	68.82±6.86	0.000
	F-wave latency	26.03±2.04	24.94±1.64	0.026
Tibial	MDL	4.91±1.13	3.52±0.59	0.000
	MAmp	11.41±5.37	14.86±5.72	0.003
	MNCV	41.44±7.66	48.76±4.54	0.000
	F-wave latency	46.99±7.12	45.38±2.66	0.600
Peroneal	MDL	3.98±0.82	3.53±0.58	0.005
	MAmp	4.75±2.93	5.43±2.68	0.219
	MNCV1	47.51±6.30	53.93±6.37	0.000
	MNCV2	62.33±19.64	61.28±13.16	0.970
Sural	DL	3.45±1.28	3.10±0.45	0.003
	Amp	10.43±8.73	19.13±11.03	0.000
	NCV	39.58±16.70	46.70±6.68	0.000

Student's t-test was applied.

Amp, amplitude; DL, distal latency; MAmp, motor amplitude; MDL, motor distal latency; MNCV1, common peroneal nerve motor nerve conduction velocity stimulation at the ankle; MNCV2, common peroneal nerve conduction velocity stimulation at the fibular neck head; MNCV, motor nerve conduction velocity; n, number of each nerve examined; NCS, nerve conduction studies; NCV, nerve conduction velocity; SAmp, sensory amplitude; SDL, sensory distal latency; SNCV, sensory nerve conduction velocity.

types of nerve affection (hereditary or acquired polyneuropathy, entrapment neuropathy, nerve tumours, etc), based on the anatomical fact that the size of extremity nerves gets smaller along their course from proximal to distal.^{7 12 13 21 22} Currently, CSA is considered a suitable and reliable quantitative parameter for evaluating changes in such nerves' sizes.^{23 24}

Almost all our patients (97.3%) had polyneuropathy as diagnosed by NCS. This agrees with many studies that described the peripheral polyneuropathy as the most frequent subtype of PN.^{16 17 19 25} On the other hand, Oomatia and colleagues¹⁸ found 'small fiber neuropathy' to be the most prevalent type and drew the attention to some conditions not included in the American College of Rheumatology neuropsychiatric systemic lupus erythematosus (ACR NPSLE) case definition.¹⁵ Some papers suggested the revision of ACR NPSLE 1999 case definition

to consider some overlooked PN types like small fibre neuropathy.^{14-19 25}

Despite considering axonal neuropathy as the predominant polyneuropathy subtype in patients with SLE,^{16-19 25} our results revealed a dominance of axonal involvement in upper limbs' nerves and a dominance of demyelinating neuropathy among lower limbs' nerves, which could be explained by the different pathogeneses in different types of SLE-related polyneuropathy.^{14 16} The limited number of patients included in this study could be another cause.

We were expecting that the axonal degeneration of the median and ulnar nerves was preceded by initial demyelination due to the prescribed lupus-induced entrapment caused by nearby arthritis and/or tenosynovitis, lupus nephritis, or idiopathic PNS lupus-related pathogenesis.^{16 19 25} However, our data did not show any clinical or electrical findings suggestive of entrapment neuropathy.

Table 3 Nerve CSA in the study population

Examined nerve	Measuring site	Group A1 nerves (CSA mean±SD), mm ²	Group A2 nerves (CSA mean±SD), mm ²	Group B nerves (CSA mean±SD), mm ²	P1 value	Group A2 nerves		P2 value
						Axonal (CSA mean±SD), mm ²	Demyelinating (CSA mean±SD), mm ²	
Median		n=13	n=61	n=36		n=50	n=11	
	CT	8.0±2.1	9.2±3.1	9.0±1.6	0.167	9.3±3.1	8.9±3.4	0.664
	MF	5.9±1.8	6.6±1.8	6.4±2.0	0.346	6.5±1.8	7.1±1.6	0.247
	MH	8.1±3.0	8.0±2.1	8.5±1.7	0.491	8.1±2.1	7.7±2.3	0.691
Ulnar	AX	11±3.5	9.2±3.3	9.9±2.1	0.112	9.3±3.5	8.7±2.4	0.895
		n=14	n=60	n=36		n=51	n=9	
	GY	4.7±1.1	5.1±1.3	6.0±1.1	0.001*	5.1±1.3	5.0±1.5	0.677
	MF	6.3±1.8	6.6±2.0	6.8±1.5	0.557	6.6±2.0	6.6±2.1	0.833
Tibial	MH	6.3±1.7	7.2±2.2	8.0±2.0	0.001*	7.2±2.0	7.8±3.0	0.833
	AX	5.4±1.9	6.9±2.3	7.0±1.8	0.070	6.9±2.0	6.9±3.8	0.900
		n=35	n=39	n=36		n=10	n=29	
	POP	19±4.9	21±6.3	21±6.0	0.593	24±4.8	20±6.4	0.020*
Peroneal	DL	8.4±2.7	9.4±3.6	11±2.3	0.009*	11±3.7	8.9±3.6	0.144
	TT	8.6±2.8	9.2±3.3	11±2.8	0.0001*	10±3.5	8.9±3.2	0.382
		n=48	n=26	n=36		n=6	n=20	
	POP	15±4.3	14±4.8	14±4.4	0.042*	11±2.1	15±5.1	0.026*
Sural	FN	16±6.2	16±6.0	15±4.7	0.737	14±3.1	16±6.7	0.464
	DPN	2.4±0.010	2.2±1.0	2.3±1.0	0.554	2.2±0.98	2.2±0.67	0.742
		n=24	n=50	n=36		n=21	n=29	
		3.5±1.2	3.5±1.1	3.4±1.1	0.750	3.7±1.2	3.5±1.1	0.547

Group A1: nerves with normal NCS in patients with SLE; group A2: SLE nerves with abnormal NCS in patients with SLE; group B: nerves of healthy subjects (with normal NCS).

P1: one-way analysis of variance test was used; P2: Student's t-test was used.

*P<0.05 is significant.

AX, axilla; CSA, cross-sectional area; CT, carpal tunnel inlet; DL, distal leg (5 cm above medial malleolus); DPN, deep peroneal nerve at anterior aspect of the ankle; FN, fibular neck; GY, Guyon's canal; MF, mid-forearm; MH, mid-humerus; n, number of nerves; NCS, nerve conduction study; POP, popliteal fossa; TT, tarsal tunnel.

On NMUS examination of each nerve at certain sites between the studied groups, the following were noted:

- ▶ The mean CSA of the tibial nerve at the distal leg in the patient group was significantly smaller than the CSA in normal subjects, which may be supported by the 'dying back' theory of long-standing immune-mediated nerve injury occurring in lupus that eventually leads to axon loss.^{11 12 25}
- ▶ Among patients with SLE who have abnormal NCS, the mean CSA was significantly large in axonal tibial neuropathy and demyelinating peroneal neuropathy (both at the popliteal fossa). Grimm *et al*^{13 14} suggested that axonal neuropathy causes non-significant enlargement when compared with demyelinating.
- ▶ The mean CSA of the median nerve distally at the carpal tunnel was larger than its proximal segment in the mid-forearm among all groups, especially both nerves of healthy subjects and those with normal NCS in patients with SLE. This was also found in both

the ulnar (at Guyon's canal) and tibial (at the tarsal tunnel) nerves, but with the CSA in the healthy group significantly larger than both in the patient group. In concordance with this finding, Zaidman *et al*²¹ assumed that even normal nerves at the entrapment area are likely to be larger in size than its proximal segment.

The differences in nerves' CSA between the studied groups and along the course of the same nerve were statistically non-significant. Many authors found no correlation between CSA, electrophysiological and clinical findings, and functional disabilities.^{12 13 25}

The ROC curve analyses showed that of all the CSA measuring points, the median nerve at the mid-forearm has the best diagnostic power, where AUC was 0.579 and specificity was 95.9%, followed by ulnar nerve at the axilla and the fibular nerve at the fibular neck, with AUC of 0.545 and 0.544, respectively.

Table 4 Sensitivity and specificity of the nerve cross-sectional area in relation to the nerve conduction study results in all studied nerves

Nerves	Measuring site	Sensitivity (%)	Specificity (%)	Positive predictive value (%)	Negative predictive value (%)	Area under the curve	P value
Median	CT	18.0	95.9	84.6	48.5	0.514	0.796
	MF	3.3	95.9	50.0	44.3	0.579	0.157
	MH	3.3	95.9	50.0	44.3	0.451	0.378
	AX	11.5	93.9	70.0	46.0	0.385	0.038
Ulnar	GY	1.7	100.0	100.0	45.9	0.375	0.025
	MF	6.7	96.0	66.7	46.2	0.471	0.606
	MA	3.3	96.0	50.0	45.3	0.466	0.536
	AX	5	98	75	46.2	0.544	0.433
Tibial	POP	7.7	98.0	75.0	66.0	0.536	0.532
	DL	10.3	98.6	80.0	66.7	0.454	0.429
	TT	2.6	97.2	33.3	64.5	0.412	0.129
Peroneal	POP	7.7	91.7	22.2	76.2	0.439	0.349
	FNB	11.5	95.2	42.9	77.7	0.545	0.493
	DPN	0.0	97.6	0.0	75.9	0.443	0.383
Sural		4.0	96.7	50.0	54.7	0.530	0.585

AX, axial; CT, carpal tunnel inlet; DPN, deep peroneal nerve; FNB, fibular neck bone; GY, Guyon's canal; MA, mid arm; MF, mid-forearm; MH, mid-humerus; POP, popliteal; TT, tarsal tunnel.

Interestingly, all the examined sites of the 370 studied nerves showed low sensitivity values (<50%). On the other hand, the specificity values were remarkably high and reached up to 98.6% in some examination points.

The strength point of this study is being the first study carried out to evaluate SLE-related neuropathy using NMUS. Some of the strict methodology outlines could be considered as points of strength, for instance, the application of extensive exclusion criteria to sort out coincidental causes of neuropathy other than SLE and subsequently overcome any possible interference with the outcomes. Additionally, the use of healthy age-matched and sex-matched control subjects of the same ethnicity was to reduce any probable divergence in NCS or in NMUS value that might affect our analysis. Another strength point is the performance of both NCS and NMUS examinations on the same day for a more accurate analysis of the results.

Furthermore, the NMUS images were evaluated by three different expert rheumatologists who were blinded to clinical and electrophysiological results to guarantee agreement and an unbiased decision on the findings.

Although the sample size seems to be relatively small, we examined 1164 sites in both the patients and in healthy subjects, which gave relatively large data used in statistics.

Moreover, one of the strengths was the absence of clinical and electrophysiological evidence of entrapment neuropathy, which highly suggested the possible presence of different mechanisms of SLE-related neuropathy in comparison with other types of neuropathies.

Our study has some limitations, including being a single-centre study with a relatively small sample size (the minimum possible according to the sample size calculation software), which resulted in the inability to apply patient randomisation. We recommend future multi-centre study to develop a nation-based reference values of the CSA of different nerves. Another recommendation is to study other nerve parameters such as echogenicity, mobility and vascularity, in addition to CSA, while examining the peripheral nerves using NMUS.

CONCLUSION

To our knowledge, this is the first study that used NMUS in investigating peripheral nerve involvement in patients with SLE. Although the changes in nerve size were not pronounced, the CSA of individual nerves might provide informative data on possible different pathophysiological aspects of nerve disease in patients with SLE. Further validation in larger cohorts of patients is recommended.

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