Date: September 23rd, 2025

To:
Compassionate Allowances Program Office
Social Security Administration

From:
Joel Wallskog, MD
Co-Chairman, React19
Email: joel.wallskog@react19.org
Cell: 262-893-6077

Proposed Condition Name

Thrombotic Antiphospholipid Syndrome (APS)

Alternate Names

- Antiphospholipid Antibody Syndrome
- Hughes Syndrome
- Lupus Anticoagulant Syndrome
- Secondary Antiphospholipid Syndrome (when associated with systemic lupus erythematosus)
- Primary Antiphospholipid Syndrome

Summary

Thrombotic Antiphospholipid Syndrome (APS) is a systemic autoimmune disorder characterized by recurrent venous and/or arterial thrombosis and/or pregnancy morbidity in the presence of persistently elevated antiphospholipid antibodies (aPL) [1,2]. These antibodies—including lupus anticoagulant (LA), anticardiolipin (aCL), and anti–β2-glycoprotein I (aβ2GPI)—activate endothelial cells, platelets, and complement, resulting in a hypercoagulable state [3].

APS can be primary or secondary to another autoimmune disease (most commonly systemic lupus erythematosus). Repeat thrombosis can occur despite adequate anticoagulation, and patients can also experience concurrent thrombosis with thrombocytopenia, requiring a crucial balance of these risks by a multidisciplinary team. In severe cases, **catastrophic APS (CAPS)** occurs, causing multiorgan thromboses over days to weeks and carrying high mortality [4].

Description of Condition

Pathogenic APL antibodies promote clot formation through immune-mediated activation of clotting pathways, platelet aggregation, and endothelial dysfunction. The hypercoagulability is independent of traditional thrombotic risk factors and can affect vessels of any size and location. Typical thrombotic events include:

- **Venous:** deep vein thrombosis (DVT), pulmonary embolism (PE)
- **Arterial:** ischemic stroke, transient ischemic attack (TIA), myocardial infarction
- **Microvascular:** skin livedo reticularis, renal microthrombi

Pregnancy morbidity is a hallmark, including recurrent miscarriage, intrauterine growth restriction, and preeclampsia.

Diagnostic Testing

Laboratory Criteria (Sydney APS Classification Criteria):

- Lupus anticoagulant detected on ≥2 occasions at least 12 weeks apart
- Moderate/high titers of anticardiolipin antibodies (IgG or IgM) on ≥2 occasions at least 12 weeks apart
- Moderate/high titers of anti–β2-glycoprotein I antibodies (IgG or IgM) on ≥2 occasions at least 12 weeks apart

Imaging Studies:

- Doppler ultrasound for DVT
- CT/MR angiography for arterial thrombosis
- CT pulmonary angiography for PE
- Brain MRI for ischemic stroke

Physical Findings

- Limb swelling, pain, erythema (DVT)
- Cutaneous thrombotic lesions and digital ischemia
- Dyspnea, pleuritic chest pain (PE)
- Focal neurological deficits (stroke/TIA)
- Livedo reticularis (net-like purplish skin discoloration)

- Pregnancy loss or complications

ICD-10 Codes

- **D68.61** — Antiphospholipid syndrome
- **I82.90** — Embolism and thrombosis of unspecified vein
- **I26.9** — Pulmonary embolism, unspecified
- **I63.9** — Cerebral infarction, unspecified

Onset

APS may develop at any age but is most common in women of childbearing age. Onset is often marked by the first thrombotic event or pregnancy loss. Secondary APS develops in patients with preexisting autoimmune conditions.

Course / Progression

Without anticoagulation, recurrent thrombosis is common and can be disabling or fatal. CAPS is a rare, fulminant form with rapid multi-organ thrombosis and high mortality despite treatment [4]. Even with therapy, APS is a chronic condition with lifelong risk for clot recurrence.

Treatment

Standard Therapy:

- Lifelong anticoagulation (typically warfarin with INR target 2–3, or higher for recurrent events)
- Low-dose aspirin in some cases for arterial events
- Heparin during pregnancy in combination with low-dose aspirin to prevent fetal loss

For treatment-resistant APS:

- Vitamin D
- Hydroxychloroquine

- Complement inhibition
- Aggressive anticoagulation
- immunomodulation similar to CAPS (below)

For APS-associated cutaneous lesions and digital ischemia:

- Vascular interventions
- Vasodilators
- Epidermal grafting
- Digital sympathectomy
- Hyperbaric oxygen therapy (HBOT).

For Catastrophic APS (CAPS):

- High-dose corticosteroids
- Plasma exchange
- Intravenous immune globulin (IVIG)
- Aggressive anticoagulation
- Immunosuppressive therapy in refractory cases

Rationale for Compassionate Allowance

- High morbidity and mortality from recurrent thrombosis
- Potential for sudden, severe disability from stroke, myocardial infarction, or CAPS
- Lifelong anticoagulation required with significant bleeding risk
- Documented objective diagnostic criteria and laboratory confirmation
- Chronic, incurable autoimmune process with no definitive cure

---

Submitted by:
Joel Wallskog, MD
Co-Chairman, React19
Email: joel.wallskog@react19.org
Cell: 262-893-6077

Heather Hudson

National Vaccine Injury Advocate

_____

Brianne Dressen

Co-Chairman, React19

_____

References

1. Miyakis S, Lockshin MD, Atsumi T, et al. International consensus statement on an update of the classification criteria for definite antiphospholipid syndrome (APS). *J Thromb Haemost*. 2006;4(2):295–306.
2. Cervera R, Piette JC, Font J, et al. Antiphospholipid syndrome: clinical and immunologic manifestations and patterns of disease expression in a cohort of 1,000 patients. *Arthritis Rheum*. 2002;46(4):1019–1027.
3. Giannakopoulos B, Krilis SA. The pathogenesis of the antiphospholipid syndrome. *N Engl J Med*. 2013;368(11):1033–1044.
4. Bucciarelli S, Espinosa G, Cervera R, et al. Mortality in the catastrophic antiphospholipid syndrome: causes of death and prognostic factors. *Autoimmun Rev*. 2006;6(2):72–75.
5. Magdaleno-Tapial J, Valenzuela-Oñate C, et al. Purpura fulminans-like lesions in antiphospholipid syndrome with endothelial C3 deposition. JAAD Case Rep. 2018 Oct 12;4(9):956-958.