Relapse-free survival was significantly longer for patients who positivity for 122 (79.2%) and PR3-ANCA for 102 (66.2%) of them. 67.5% patients suffered 154 clinical relapses associated with cANCA-90/115 (78.3%). After a median follow-up of 70 months, 85/126 became undetectable by IF for 70/115 (60.9%) patients and ELISA for and 3 at relapse. Remission was obtained in 112 (88%) patients. ANCA lung (69%), kidney (45.2%), with median BVAS/WG of 7 at diagnosis vasculitis organ-involvement distribution at inclusion was ENT (82.5%),

**Discussion.**– We have evidenced that most relapses were associated with IF-positive ANCA and for 60% of the GPA patients, clinical outcome and ANCA-titer changes were tightly correlated. However, they were completely discordant for about 25% of them. Conclusion.– ANCA alone cannot be considered a reliable marker of GPA remission.

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**Introduction.**– ANCA have been fundamental for recent advances in primary small-vessel vasculitides, and are a valuable diagnostic tool. However, their standardisation has been difficult and other conditions can present with positive results. Our aim was to know the diagnostic usefulness of ANCA in a nationwide respiratory referral centre.

**Methods.**– All patients with suspicion of AASV were prospectively and consecutively included. Sample size calculation was done according to Flahault et al. [1]. Intrinsic properties of the tests were evaluated, and results of IIF (cutoff ≥ 1:20) and direct ELISA (≥ 20 U/mL, as per manufacturer’s cutoff) were compared by estimation of areas under the curve (AUC). Diagnosis of an AASV was established by clinical and histopathological data. Serology was performed in duplicate without knowledge of clinical data by lab personnel according to manufacturer (Euroimmun).

**Results.**– Ninety-eight patients, 23 AASV (14 GPA, eight MPA, one EGPA), 75 disease controls. Test properties are shown in the table (table I), according to diagnostic categories. Regarding AUC of IIF and ELISA, there were no differences between P-ANCA vs MPO-ANCA or C-ANCA vs PR3-ANCA overall, nor when specific diseases were compared, except for MPA, in which the AUC for MO-ANCA was higher than IIF (90% vs 82%, \(P = 0.05\)).

**Discussion.**– Considering interpretation of IIF done by expert personnel, automated tests feasibility and characteristics of centres in where ANCA are ordered and performed, from our results, we can advise for either test to be used diagnostically in a referral centre where patients have respiratory symptoms in a high percentage. For MPA, ELISA may be better to use initially.

**Conclusion.**– Our results can lead to test optimisation and recommendations in referral units in our country. Both assays performed equally in

**References**


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**P3**

**Are anti-proteinase-3 ANCA a useful marker of granulomatosis with polyangiitis relapses? Results of a longitudinal study on 126 patients**

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**Introduction.**– Predicting granulomatosis with polyangiitis (GPA) relapses by measuring of ANCA titers remains a source of debate. Our objective was to evaluate the relevance of monitoring PR3-ANCA titers for GPA management.

**Methods.**– This retrospective study included 126 patients recruited from Cochin Hospital, all fulfilling the 1990 ACR criteria for GPA and PR3-ANCA-positive at the time of diagnosis. GPA activity was assessed with the Birmingham Vasculitis Activity Score for Wegener granulomatosis (BWAS/WG). cANCA were detected in an immuno-fluorescence assay and their PR3-ANCA specificity was determined in an ELISA. Risk factors of relapse were assessed using a conditional Andersen–Gill model. Hazard ratios (HR) [95% confidence interval (CI)] are given.

**Results.**– For the 126 patients (51.6% male, mean age 49 yr), the vasculitis organ-involvement distribution at inclusion was ENT (82.5%), lung (69%), kidney (45.2%), with median BWAS/WG of 7 at diagnosis and 3 at relapse. Remission was obtained in 112 (88%) patients. ANCA became undetectable by IF for 70/115 (60.9%) patients and ELISA for 90/115 (78.3%). After a median follow-up of 70 months, 85/126 (67.5%) patients suffered 154 clinical relapses associated with cANCA-positivity for 122 (79.2%) and PR3-ANCA for 102 (66.2%) of them. Relapse-free survival was significantly longer for patients who remained cANCA-negative (HR0.67 [95% CI 0.47–0.98], \(P = 0.037\) and PR3-ANCA–negative (HR 0.60 [95% CI 0.39–0.92], \(P = 0.02\). When we studied evolution in ANCA titers course and clinical outcome for each patient, a tight parallelism was observed for 60% of them, ie each relapse was associated with ANCA-positivity and relapse-free survival with persistent ANCA-negativity.

**Conclusion.**– It seems that it is high time to supplement the internationally recognized ANCA terminology and procedures for their diagnosis [4,5] to be effective not only in the diagnosis of vasculitis, but also other neutrophil mediated inflammatory diseases.

**References**


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**P4**

**Results of ANCA standardisation and their diagnostic usefulness in ANCA-associated vasculitides (AASV) in a respiratory referral centre in Mexico**

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**Introduction.**– ANCA have been fundamental for recent advances in primary small-vessel vasculitides, and are a valuable diagnostic tool. However, their standardisation has been difficult and other conditions can present with positive results. Our aim was to know the diagnostic usefulness of ANCA in a nationwide respiratory referral centre.

**Methods.**– All patients with suspicion of AASV were prospectively and consecutively included. Sample size calculation was done according to Flahault et al. [1]. Intrinsic properties of the tests were evaluated, and results of IIF (cutoff ≥ 1:20) and direct ELISA (≥ 20 U/mL, as per manufacturer’s cutoff) were compared by estimation of areas under the curve (AUC). Diagnosis of an AASV was established by clinical and histopathological data. Serology was performed in duplicate without knowledge of clinical data by lab personnel according to manufacturer (Euroimmun).

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**Discussion.**– Considering interpretation of IIF done by expert personnel, automated tests feasibility and characteristics of centres in where ANCA are ordered and performed, from our results, we can advise for either test to be used diagnostically in a referral centre where patients have respiratory symptoms in a high percentage. For MPA, ELISA may be better to use initially.

**Conclusion.**– Our results can lead to test optimisation and recommendations in referral units in our country. Both assays performed equally in