#### Table I

**Immunopathology of active vs. remitting GPA**

<table>
<thead>
<tr>
<th>Active GPA</th>
<th>Remitting GPA</th>
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<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>CD3</td>
<td>CD152 (CD3+, CD4+ &amp; CD8+)</td>
</tr>
<tr>
<td>CD3+CD25</td>
<td>CD9+CD25</td>
</tr>
<tr>
<td>CD4+CD25+FOX3</td>
<td>CD4+CD25+FOX3</td>
</tr>
<tr>
<td>FOX3 gene expression</td>
<td>FOX3 gene expression</td>
</tr>
<tr>
<td>ROR-γt</td>
<td>ROR-γt</td>
</tr>
<tr>
<td>c-IL-17A &amp; s-IL-17A</td>
<td>c-IL-17A, s-IL-17A</td>
</tr>
<tr>
<td>c-TNF-α, IL-6 &amp; IL-10</td>
<td>c-TNF-α, IL-6 &amp; IL-10</td>
</tr>
</tbody>
</table>

* a-culture supernatants after PR3 stimulation.
* b-serum.

memory cells and they should be targeted and eliminated, to prevent relapse. Also modulating CD152 molecule in Tregs can also prevent relapse.

**Conclusion.** To achieve relapse free remission, there is need to give:
- anti-IL-17;
- by eliminating PR3 specific effector memory cells;
- by modulating CD152.

**Further readings**


http://dx.doi.org/10.1016/j.jlrp.2013.02.147

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**P78**

**Wegener or Churg Strauss**

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**Introduction.** Systemic vasculitis is a rare autoimmune disease that causes the blood vessels to become inflamed. There are many types. We present a case of a 38-year-old woman who developed multiple symptoms of systemic necrotizing vasculitis.

**Methods.** Patient A., 38-year-old, was hospitalized many times from February 2012 for dyspnea, wheezing and dry cough considered as an asthma triggered by chronic rhinosinusitis with nasosinusal polyposis with favorable evolution under corticotherapy. Renal function was normal. In November, patient presents aggravation of dyspnea with apparition of lower limb edema, polyarthritis, chest pain on inspiration, diarrhea and epistaxis. Creatinine: 639 μmol/L; proteinuria: 8 g/24 h; hematuria: 880/mm³. Inflammatory syndrome; and hypereosinophilia 4500 (41%).

Immunologic exams finds P-ANCA anti-MPO and the renal biopsy mark lesions of angiitis:
- fibrinoid necrosis;
- extracapillary proliferation of pseudo-crescents;
- massive infiltration by polynuclear neutrophils, plasmocytes and macrophages. NO eosinophils;
- neutrophil granulomas.

Chest scan: mediastinal nodules and pulmonary parenchymal granulomas. Pericardial effusion.

We started a treatment by extrarenal epuration three times weekly, therapeutic plasma exchange and three bolus of solumedrol 1 g each and then, then changed to oral corticotherapy. Two courses of cyclophosphamide was complicated by sepsis. No recovery of renal function.

**Results.** We are faced with interesting case of necrotizing vasculitis with P-ANCA anti-MPO+ with multiple organ damage including kidney. Clinical elements can evoke syndrome Wegener syndrome. Our findings confirmed that TBS are unusual GPA manifestations.

**Conclusion.** Push further investigations in the case of adult-onset asthma may reveal unexpected pathology. A clear differentiation between Churg Strauss and Wegener syndromes is not clear in some cases. Wishing that you add this case to your database through reference centers.

http://dx.doi.org/10.1016/j.lpm.2013.02.149