Evening Medical Update: Keeping up with Kidneys
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Multisystem disorders – when to think of vasculitis – Professor David Jayne

Is there a relationship between stress and vasculitis?
No for ANCA vasculitis, as far as has been studied. But clear associations with infection and malignancy.

Do you monitor for haematuria resolution (beside creatinine, and UPCR) after starting treatment for ANCA vasculitis?
A hot topic. Persistent hematuria implies incomplete disease control and predicts a higher risk of relapse. We have too few repeat biopsy studies to be sure but the majority of repeat biopsies in this setting have activity. Right now we are not targeting loss of hematuria in our protocols but this may change.

Is vasculitis always a progressive disease or can it be at "waxing/waning type" or can it stop after a period of activity?
There are very few good examples of full blown ANCA vasculitis resolving without therapy, unless it is secondary to a drug or other disease process. However, we have good evidence that fluctuations in disease activity occur prior to diagnosis. My guess is that it is a building storm which once it crosses a critical threshold progresses remorselessly.

What are the cardiac sequelae that you are searching for on an echocardiography?
Several. Global, predominantly LV dysfunction reflecting myocarditis is the most worrying. PR3-ANCA vasculitis is associated with aortic root and aortic valve disease. A pericardial effusion can be seen during active disease.

If a patient has a weak positive ANCA, with a normal PR3 and MPO – what further tests could be done to find out if it is clinically relevant? Should you repeat it and if so for how long?
The European groups issued a statement in 2017 that the fluorescence ANCA test should no longer be the first line test, it should be PR3-ANCA and MPO-ANCA because the specificity of the old test is so low. In practice we receive lots of referrals with this pattern and very few turn out to have vasculitis.