Title:

Response to: "Renal biopsies should be performed whenever treatment strategies depend on renal involvement"

Yates M[1&2], Mukhtyar C[2] and Jayne DR[3]

[1]Norwich Medical School, Bob Champion Research and Education Building, Colney Lane, Norwich, UK.

[2]Department of Rheumatology, Norfolk and Norwich University Hospital, Norwich, UK.

[3]Addenbrooke's Hospital, Lupus and Vasculitis Unit, Cambridge, UK.

Corresponding author:

Dr Max Yates: Clinical Research Fellow, Norwich Medical School; m.yates@uea.ac.uk on behalf of co-authors EULAR/ERA-EDTA recommendations for the management of ANCA-associated vasculitis.
Ann Rheum Dis doi:10.1136/annrheumdis-2016-209133

We thank Chemouny et al for their letter and concur with their conclusions. As we state (1): “A positive biopsy for AAV is helpful when considering an initial diagnosis or recurrent disease.” In our view, renal biopsy is important to establish diagnosis and may also provide an indication of prognostic trajectory and although existing classification systems need further validation, changes like glomerular sclerosis have obvious adverse prognostic value for patients with AAV (2-4). The Delphi process, for the scope of the current recommendations, identified the role of biopsy at both diagnosis and follow-up as an important item for update. Histopathological evidence of vasculitis, such as pauci-immune glomerulonephritis or necrotising vasculitis in any organ, remains the gold standard for diagnostic purposes. The likely diagnostic yield varies and is dependent on the organ targeted and in patients with GPA with renal involvement can be as high as 91.5% from renal biopsy (5). As Chemouny and colleagues have demonstrated, a renal biopsy was definitive in determining their management decisions. However during follow-up when relapses occur, it may be prudent to consider judicious use of further kidney biopsy during suspected renal relapse since the cause for acute kidney injury may be due to another cause other than AAV (6).

Kind regards,

M Yates, C Mukhtyar and DR Jayne on behalf of co-authors.

Footnotes

Contributors The authors wrote the response to the eLetter.

Competing interests None declared.

Provenance and peer review Commissioned; internally peer reviewed.

References

1. Yates M, Watts RA, Bajema IM, Cid MC, Crestani B, Hauser T, et al. EULAR/ERA-EDTA recommendations for the management of ANCA-associated vasculitis. Annals of the Rheumatic Diseases. 2016;75(9):1583-94.
2. Berden AE, Ferrario F, Hagen EC, Jayne DR, Jennette JC, Joh K, et al. Histopathologic classification of ANCA-associated glomerulonephritis. Journal of the American Society of Nephrology : JASN. 2010;21(10):1628-36.
3. Chang DY, Wu LH, Liu G, Chen M, Kallenberg CG, Zhao MH. Re-evaluation of the histopathologic classification of ANCA-associated glomerulonephritis: a study of 121 patients in a single center. Nephrology, dialysis, transplantation : official publication of the European Dialysis and Transplant Association - European Renal Association. 2012;27(6):2343-9.
4. Noone DG, Twilt M, Hayes WN, Thorner PS, Benseler S, Laxer RM, et al. The new histopathologic classification of ANCA-associated GN and its association with renal outcomes in childhood. Clinical journal of the American Society of Nephrology : CJASN. 2014;9(10):1684-91.
5. Aasarød K, Bostad L, Hammerstrøm J, Jørstad S, Iversen BM. Renal histopathology and clinical course in 94 patients with Wegener's granulomatosis. Nephrology Dialysis Transplantation. 2001;16(5):953-60.
6. Choudhry WM, Nori US, Nadasdy T, Satoskar AA. An unexpected cause of acute kidney injury in a patient with ANCA associated vasculitis. Clin Nephrol. 2016;85(5):289-95.