diagnostic sensitivity of IEF [6], but lacked power to detect significant excess compared with controls. However, the combined prevalence of MG/OG was increased, particularly in those with more severe clinical disease. None of our eight RA patients with MG experienced malignant transformation during follow-up, compared with 7/23 reported by Kelly et al. [7]. This probably reflects important differences in prognostic variables, including baseline serum paraprotein concentrations [8], which may also explain the poor outcome in our MGUS controls. Serum oligoclonal bands often indicate systemic inflammation, but prevalence data are lacking. In RA, they are probably synthesized intrasynovially by a few B-cell clones [9], responding to excessive antigenic stimulation, and perhaps mirroring disease activity. Their antigenic specificity in RA is unknown although Cruz et al. [10] reported oligoclonal antibodies directed against measles intracellular proteins in 9/10 RA patients. Whether OG might disappear during effective therapy of RA in unclear, but MG can obviously diminish or become undetectable on prolonged follow-up.

In conclusion, MG/OG does seem more prevalent in RA, and may indicate more severe disease. The risk of malignant progression in RA patients with MG is most likely determined by baseline paraprotein concentrations, as in the general population.

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The initial work-up revealed creatinine 160 μmol/l and p-ANCA antimeylperoxidase (anti-MPO) positive (72.66 U/ml) and erythrocyturia. A chest X-ray showed diffuse interstitial thickening. An RB showed a pauci-immune crescentic GN. The patient was diagnosed with microscopic polyangiitis (MPA) with renal, lung, eye, skin and musculoskeletal involvement. Treatment with CS and CYC led to remission, creatinine decreased to 112 μmol/l.

This patient’s sister (56 yr old) had suffered from polyarthralgia, fever and anorexia for 2 months prior to admission in October 2004. Her erythrocyturia persisted after antibiotic treatment. The initial work-up revealed creatinine 160 μmol/l and p-ANCA anti-MPO positive (41.72 U/ml). Chest X-ray was negative. An RB confirmed the diagnosis of MPA. Induction therapy with CS and CYC led to remission, creatinine dropped to 81 μmol/l.

This observation illustrates the diversity of the AAV determined by the sites and the activity/chronicity of organ involvement. Generalized ‘flu-like’ manifestation, ENT or respiratory symptoms lead mostly to antibiotic treatment. The detection of erythrocyturia often prompts another course of antibiotics and/or urological work-up. A temporary spontaneous remission of the symptoms further delays the diagnosis. As the disease persists, it may start to resemble a malignancy. Nevertheless, an erroneous diagnosis of carcinoma in the setting of a histological diagnosis of cutaneous vasculitis is a grave mistake. However varied the AAV may be, their clinical presentation in the two families described was in some aspects very similar. Both the father and daughter had WG, c-ANCA and a history of ENT involvement that preceded dialysis-requiring renal failure with some corresponding features in renal histology. The two sisters both had MPA, p-ANCA, non-specific constitutional symptoms and histological and laboratory evidence of a rather slower decline in the renal function. We were unable to obtain objective data on their father. Nevertheless, the daughters described a suggestive picture of a pulmonary involvement in AAV. The difference in the presentation in the two families shows that PR3-ANCA and MPO-ANCA are markers of different diseases within the spectrum of AAV with a more acute presentation of patients with PR3-ANCA [1–3]. Last, but not least, the presented case reports raise the question of a familial presentation of patients with PR3-ANCA [1–3]. Last, but not least, the presented case reports raise the question of a familial presentation of patients with PR3-ANCA [1–3]. Last, but not least, the presented case reports raise the question of a familial presentation of patients with PR3-ANCA [1–3].