MICROSCOPIC POLYANGIITIS ANCA-ASSOCIATED
POLIANGEÍTIS MICROSCÓPICA ASOCIADA A ANCA

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Dear Editor:

We read with interest the case study by Andrade Rada J, et al. of a 44-year-old female presenting weight loss, muscular weakness, paresthesia and myalgias in both extremities.[1] Her father had pulmonary tuberculosis more than three decades ago, and she was treated for peritoneal tuberculosis with 29 years of age. Moreover, she was for a long time utilizing inhaled steroids to control pulmonary fibrosis; and, although asymptomatic, she reacted positively to COVID-19test five months ago.[1] Laboratory evaluation showed anemia, hypergammaglobulinemia, proteinuria (1gr/ 24h) positive rheumatoid factor and cytoplasmic ANCA, and altered kidney function AKIN I. Renal biopsy revealed extra capillary proliferative glomerulonephritis, and vasculitis of medium arterial vessels presenting with a consistent pattern of microscopic polyangiitis.[1] The authors stressed the successful use of methylprednisolone, prednisone and rituximab, in addition to the early diagnosis and prompt institution of immunomodulatory therapy.[1] As the vasculitis associated with ANCA are rare entities with high risk of complications and high mortality rate, even treated; and may pose challenging differential diagnosis with pulmonary tuberculosis, it seems opportune to comment on two Brazilian cases.[2,3]

Amaral BC, et al. reported a 62-year-old hypertensive male with microscopic polyangiitis causing fever of undetermined origin, who had pulmonary fibrosis with "tree-in-bud" images, a strong reactive skin test for tuberculosis, and negative blood cultures.[2] He had malaria and contact with a tuberculosis carrier in the infancy; cutaneous leishmaniasis at his 35 years; and with 59 years a strong skin test for tuberculosis. Complementary tests showed hematuria, microalbuminuria, erythrocyte sedimentation rate: 106 mm/h, C-reactive protein: 24.6 mg/dL, and pANCA (antimyeloperoxidase).[2] Lung biopsy ruled out tuberculosis and showed a pattern of microscopic polyangiitis, that was treated by immunosuppressive doses of cyclophosphamide and methylprednisolone. The authors emphasized the good outcome of a vasculitis with lung changes mimicking an infection, but is not included among the causes of fever with undetermined etiology.[2] Santos VM, et al. described the case of a 76-year-old hypertensive female with longstanding sinonasal disease, and had a recent rapidly progressive glomerulonephritis.[3] The imaging evaluations of her pleural and pulmonary fields were found unremarkable. She had proteinuria: 455 mg/24 h, creatinine clearance: 58 mL/min/1.73 m2, and pANCA 1:20; renal biopsy study revealed glomerular hyper-cellularity, segmental capillary retractions and sclerosis, debris and synechiae, surrounded by fibro cellular crescents.[3] She underwent prednisone and cyclophosphamide schedule with a rapid improvement; the authors highlighted the successful therapeutic approach due a prompt treatment, and ideal management by internists, nephrologists, otolaryngologists, and rheumatologists. They commented on the hypothesis of this entity related to chronic sinonasal disorders.[3]

Key words: ANCA, Glomerulonephritis, Microscopic polyangiitis, Tuberculosis
Palabras clave: ANCA, Glomerulonefritis, Poliangeítis microscópica, Tuberculosis

The authors are in accordance about the possible occurrence of underdiagnosis, misdiagnosis and underreported diagnoses of this uncommon condition. The clinical hypothesis of ANCA associated microscopic polyangiitis is usually a challenging task due to the nonspecific manifestations, in special sinonasal disturbances or glomerulonephritis, which are not infrequent among individuals of both genders and diverse age groups. Additional concerns may be due to reported casual relationships with tuberculous close contacts, antecedent and/or lung images compatible with pulmonary tuberculosis sequels.

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