a higher prevalence of anti-Sm and a lower prevalence of anti-dsDNA, considerably shorter disease duration and more damage in Sudanese patients with SLE. Just as authors described in this paper, their findings ‘will hopefully add to the general understanding of SLE in Sudan and demonstrate the importance of investigating this heterogeneous disease in larger cohorts and longitudinal designs from different parts of Africa’. We would like, however, to state that there are two confusions in this study that need to be explained more comprehensively.

Firstly, some laboratory data including proteinuria, anemia, leukopenia, lymphopenia, thrombocytopenia, LE cell, anti-DNA, anti-Sm and ANA are required for diagnosis of SLE according to the 1982 revised ACR classification criteria [2]. It is obvious that the data for two cohorts of this study were obtained from different laboratories. How to ensure the comparability of the data between laboratories? If the comparability of laboratory data is uncertain, the comparability of SLE diagnosis may be questionable between the two cohorts, which can influence and even bias the results and conclusions to some extent. As a matter of fact, when evaluating the SLEDAI, to obtain the comparable data, authors modified SLEDAI by excluding DNA binding and complement components and urinary items. As such, the study results are more accurate and objective. Therefore, authors could know that it is also very important to ensure the comparability of data associated with SLE diagnosis between the two cohorts.

Secondly, what is the purpose of setting up 106 and 318 age- and sex-matched controls from Sudan and Sweden, respectively? Because the study results did not show data about the controls, and furthermore, there was no comparability between the two controls (healthy individuals for Sudanese controls and non-SLE individuals for Swedish controls), we feel that there may be no need to set up the controls.

Funding: No specific funding was received from any funding bodies in the public, commercial or not-for-profit sectors to carry out the work described in this manuscript.

Disclosure statement: The authors have declared no conflicts of interest.

Zaixing Yang and Yan Liang

1 Department of Laboratory Medicine, Huayang Hospital of Wenzhou Medical University, Taizhou First People’s Hospital, Zhejiang and 2 Department of Laboratory Diagnostics, Changzheng Hospital, Second Military Medical University, Shanghai, China

Accepted 13 September 2019

Correspondence to: Zaixing Yang, Department of Laboratory Medicine, Taizhou First People’s Hospital, 218 Hengjie Road, Huangyan District, Taizhou, Zhejiang, China.

E-mail: yangzaixingdiyi@163.com

References

1 Elbagir S, Elshafie AI, Elagib EM et al. Sudanese and Swedish patients with systemic lupus erythematosus: immunological and clinical comparisons. Rheumatology 2020;59:968–78.

2 Tan EM, Cohen AS, Fries JF et al. The 1982 revised criteria for the classification of systemic lupus erythematosus. Arthritis Rheum 1982;25:1271–7.
papers on rheumatoid arthritis in Sudan [5, 6] and Malaysia [7] have shown that such national alignment of reference values and ‘cutoffs’ increases the value of auto-antibody analyses.

Funding: No specific funding was received from any funding bodies in the public, commercial or not-for-profit sectors to carry out the work described in this manuscript.

Disclosure statement: The authors have declared no conflicts of interest.

Sahwa Elbagir 1, Iva Gunnarsson 2 and Johan Rönnelid 1
1 Department of Immunology, Genetics and Pathology, Uppsala University, Uppsala and 2 Division of Rheumatology, Department of Medicine Solna, Karolinska Institutet, Karolinska University Hospital, Stockholm, Sweden
Correspondence to: Sahwa Elbagir, Department of Immunology, Genetics and Pathology, Uppsala University, Uppsala and E-mail: sahwa.elbagir@igp.uu.se

Funding: Travel expenses for Sahwa Elbagir for the congress (American College of Rheumatology, Chicago, USA) 2020 and laboratory analyses.

References

1. Yang Z, Liang Y. Comment on: Sudanese and Swedish patients with systemic lupus erythematosus: immunological and clinical comparisons. Rheumatology 2020;59:1453–4.

2. Elbagir S, Elshafie AI, Elagib EM et al. Sudanese and Swedish patients with systemic lupus erythematosus: immunological and clinical comparisons. Rheumatology 2020;59:968–78.

3. Tan EM, Cohen AS, Fries JF et al. The 1982 revised criteria for the classification of systemic lupus erythematosus. Arthritis Rheum 1982;25:1271–7.

4. Aringer M, Costenbader K, Daikh D et al. 2019 European League Against Rheumatism/American College of Rheumatology classification criteria for systemic lupus erythematosus. Ann Rheum Dis 2019;78:1151–9.

5. Elshafie AI, Elhalifa AD, Elbagir S et al. Active rheumatoid arthritis in central Africa: a comparative study between Sudan and Sweden. J Rheumatol 2016;43:1777–86.

6. Elshafie AI, Elbagir S, Aledrissy MIE et al. Occurrence of anti-CCP2 and RF isotypes and their relation to age and disease severity among Sudanese patients with rheumatoid arthritis. Clin Rheumatol 2019;38:1545–53.

7. Too CL, Rönnelid J, Mat Yusoff Y et al. Increased IgG rheumatoid factor-positivity in the Asian rheumatoid arthritis patients irrespective of ethnicity. Open J Rheumatol Autoimmun Dis 2014;04:43–51.

Letters to the Editor

Dear Sir, We read with interest the article by Pacini et al. [1], which highlights a higher prevalence and severity of urinary incontinence (UI) in SSc patients than in healthy matched controls. We congratulate the authors for their findings, suggesting that SSc can represent an independent predictor for UI.

UI has a substantial negative impact on health-related quality of life and it is well known that urinary tract involvement is frequently associated with other unrelated diseases. Patients affected by pulmonary diseases are at risk for UI because of chronic cough [2, 3]. During cough, the intra-abdominal pressure increases and leads to involuntary urinary loss in two-thirds of women with chronic cough [4]. Even in SSc, cough is very common: in the Sclerodema Lung Study it was observed in 73% of patients [5].

UI predictors in SSc are not well defined. Sex and BMI seem to play a role in UI occurrence, but it is controversial which antibody profile is associated with UI. While Pacini et al. identified anti-Scl70, another multicentre study points to the anti-centromere [6]. This discrepancy may derive from a bias.

We undertook the same study as Pacini et al., adding the quantification of cough using the Leicester Cough Questionnaire (LCQ) [7]. The Incontinence Questionnaire (ICIQ) has previously been used to assess UI presence and severity. Demographic, clinical and laboratory data were collected for consecutive SSc patients (according to ACR/EULAR classification criteria [8]), admitted to the Day Hospital of Rheumatology. Spearman rank test assessed the correlation between ICIQ and LCQ. The parameters associated with UI presence and severity were assessed respectively with logistic and linear regression tests. P < 0.05 was considered statistically significant.

We enrolled 49 patients: female prevalence was 94% and median age was 68 years (95% CI 56, 71). The median disease duration was 7 years (95% CI 5, 14). ICIQ has a mild strength of correlation with LCQ (rho = −0.37; P = 0.009). Both logistic and multilinear regression tests showed a correlation between LCQ and ICIQ presence (odds ratio 0.95; 95% CI 0.92, 0.99; P = 0.01) and severity (β coefficient = 0.09; R² = 25% P = 0.0009). If LCQ is not considered in the multiple linear regression, BMI emerge as associated with ICIQ (β coefficient = 0.29; R² = 12, 7%; P = 0.02).

These results should be interpreted carefully as the study is observational and on a limited number of SSc patients. Moreover, the extremely high female prevalence could have excluded sex from UI predictors. However, cough appears to play, even in SSc, a relevant role in UI onset. As the authors aim to better understand this issue in future studies, we suggest taking cough into account.

Rheumatology 2020:59:1455-1456
doi:10.1093/rheumatology/kez678
Advance Access publication 13 January 2020

Comment on: Lower urinary tract symptoms in systemic sclerosis: a detailed investigation