Autoantibody prevalence in active tuberculosis: reactive or pathognomonic?

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ABSTRACT

Objectives: To evaluate the autoantibody in patients without corresponding symptoms, whether these autoantibodies are pathognomonic or not. We hypothesised that autoantibody may be reactive to chronic infection, such as tuberculosis (TB).

Design: Randomised, case–control cohort study.

Setting: A tertiary centre in Taiwan.

Participants: We randomly chose 100 patients out of the bank data of patients with TB in a tertiary medical centre. All patients completed the sera sampling. We chose 100 patients according to autoantibody prevalence in previous literature. We also chose 100 medical staff as control group.

Interventions: We tested anti-SSA, anti-SSB, anti-Sm, anti ribonucleoprotein, anti-Scl 70, anticentromere, anti-double-stranded DNA, antcardioli pin IgG and IgM in all patient and control groups. The clinical symptoms and the underlying disease were all recorded.

Primary and secondary outcome measures: The result of sera antibody titre was recorded. For those with specific positive serology results, following examination was carried out after a 3-month anti-TB medication.

Results: Anticardiolipin IgG titre was significantly higher in patients with TB than in control group. We compared the result with previous population study and found that anti-Scl70 is also significantly higher in patients with TB. The following up data in anti-Scl70 revealed decreased titre after treatment. No correlation between sera titre and clinical conditions was observed.

Conclusions: In TB endemic areas, a significant proportion (32%) of patients with TB have elevated autoantibody titres, especially anticardiolipin IgG and anti-Scl-70. Mycobacterial studies should be performed in patients with positive serum autoantibody titres but without the typical or multiple manifestations of autoimmune diseases.

Trial registration: The study was approved by the Institutional Review Board of the hospital (NTUH REC: 9561707008) after informed consent had been obtained from the patients.

INTRODUCTION

Tuberculosis (TB) has become one of the most important diseases in the past two decades. It leads to organ dysfunction, mortality and various clinical manifestations. Previous studies have shown that sera from patients with active TB may contain autoantibodies that are unique in autoimmune diseases. The reported autoantibodies include rheumatoid factor (RF), antinuclear antibody (ANA), antcardioli pin antibody (ACA; IgM isotype predominant), antineutrophil cytoplasmic antibodies (ANCA) and anticyclic citrullinated peptide. Some of these are hallmarks of certain autoimmune diseases like rheumatoid arthritis, systemic lupus erythematosus (SLE) and ANCA-associated vasculitis. Some are even disease-specific, such as anticyclic citrullinated peptide in rheumatoid arthritis. However, most studies are cross-sectional with limited case numbers and without definite correlations between
serology and clinical manifestations. Little is known on the clinical significance (ie, pathognomonic, reactive or incidental) of autoantibodies in TB and the necessity of corticosteroid therapy.

Since patients with TB present with non-specific symptoms like fever, malaise and weight loss, clinicians may simultaneously order mycobacterial studies (acid-fast smear and mycobacterial culture) and autoimmune serology. Results of the latter usually become available earlier than results of the former. Thus, some patients with TB are put on systemic corticosteroids rather than anti-TB treatment, rendering the further dissemination of Mycobacterium tuberculosis bacilli. In this prospective cohort study, the prevalence of autoantibodies in patients with active TB was evaluated and compared with those of healthy controls. Dynamic changes in the autoantibodies were also monitored to investigate their clinical significance in patients with TB.

PATIENTS AND METHODS
Patients and the study protocol
The Institutional Review Board of the National Taiwan University Hospital (NTUH) approved this study (NTUH REC: 9561707008). To have a power of 0.8 and an α error of 0.05 in a two-sided test where the prevalence of ANA in patients with TB and the general population was 33% and 20%, respectively, the calculated sample size was 83 for each. Therefore, from the 933 new cases of culture-confirmed TB, diagnosed at the NTUH between January 2007 and December 2009, 100 were enrolled. All of the study participants provided written informed consent.

Among the 100 patients with TB, 96 had pure pulmonary TB, two had concomitant pulmonary and extra-pulmonary TB (peritonitis in one and meningitis in another) and two had extrapulmonary TB only (neck lymphadenopathy in one and cutaneous TB in another). The first serum samples were collected before the start of anti-TB treatment. Blood was examined for autoantibodies to the Ro antigen, La antigen, centromere protein, dsDNA, Scl-70, Smith protein, RNP, histone protein and Jo1. Serum samples were collected 3 months after anti-TB treatment and ELISA was performed accordingly to the manufacturer’s instructions.

A commercially available kit QUANTA Lite ACA IgM III was used to test antinuclear IgM. Sera were prepared at 1:21 dilution and ELISA was performed according to the manufacturer’s instructions.

Detection of autoantibodies
A commercial test system AtheNA Multi-Lyte ANA-II Plus Test System was used to test IgG class antiextractable nuclear antigens, including autoantibodies to the Ro antigen, La antigen, centromere protein, dsDNA, Scl-70, Smith protein, RNP, histone protein and Jo1. Serum samples were prepared at 1:21 dilution and ELISA was performed according to the manufacturer’s instructions.

Statistical analysis
Intergroup difference was calculated using independent-samples t test for continuous variables and χ² test or Fisher’s exact test for categorical variables, as appropriate. Statistical significance was set at p<0.05. All analyses were performed using the SPSS software V.12.0 for Windows.

RESULTS
The clinical characteristics of the 100 patients with TB were summarised in table 1. The median age was 63 years (range, 19–92 years), with a male-to-female ratio of 2.03. Forty-one patients with TB had underlying diseases such as malignancy (n=17), diabetes mellitus (n=14), end-stage renal disease (n=9) and one each with SLE, ankylosing spondylitis and rheumatoid arthritis.
Among the 17 patients with TB with malignancies, 6 had lung cancer, 3 had haematological malignancies, 4 had airway and lung malignancies, 2 had prostate cancer, 1 had breast cancer and 1 had pancreatic cancer.

The SLE patient was a middle-aged woman who presented as polyarthritis, malar rash and positive anti-dsDNA and antinuclear antibodies. She received disease-modifying antirheumatic drugs (DMARDs) and corticosteroids. The patient with ankylosing spondylitis was a young woman diagnosed by clinical symptoms and positive HLA-B27. She received non-steroidal anti-inflammatory drugs (NSAIDs). The patient with rheumatoid arthritis was a young woman with symmetric polyarthritis with positive RF. She received DMARDs and NSAIDs. Before the diagnosis of pulmonary TB, results of autoantibody tests were all negative in these three patients.

Thirty-two patients with TB had elevated serum autoantibody levels, including nine with more than one autoantibody (table 1). The clinical manifestations and radiographic findings of the autoantibody-positive and antibody-negative groups were similar. Cough and sputum production were the most common respiratory symptoms, while fever and weight loss were the most common constitutional symptoms. Thirty-one patients were sputum smear positive for acid-fast bacilli.

Detailed results of the autoantibody tests were shown in table 2. The most prevalent autoantibodies in patients with TB were anti-Scl-70, antihistone and anticardiolipin IgG. A significantly higher proportion of patients with TB had elevated serum anticardiolipin IgG titres than the healthy controls (p<0.001). Among the anti-Scl-70-positive and anti-Scl-70-negative groups, 16% and 9%, respectively, had pulmonary cavitation (p=0.441) and 33% and 16%, respectively, had pleural effusion (p=0.245).

The median age of the healthy controls was 30 years, with a male-to-female ratio of 0.33. None had underlying diseases. Though not statistically significant, the control group had a higher prevalence of anticardiolipin IgM than the TB group (table 2). Of the 10 healthy controls positive for anticardiolipin IgM, 8 had borderline titres that just passed the cut-off value. Among them, one was positive for anti-RNP and another for anti-histone antibodies. Of the six patients with TB positive for anticardiolipin IgM, four had borderline titres and one was positive for antihistone antibody.

Within 3 months of anti-TB treatment, 61 patients had 148 adverse events (table 3). The most common were rheumatological events, followed by gastrointestinal events. There was no significant difference in adverse events between patients with autoantibody-positive and autoantibody-negative TB.

For the 11 patients with elevated anticardiolipin IgG and 6 patients with elevated anti-Scl-70 at baseline, serum titres were followed up after 3 months of anti-TB treatment (table 4). None of the patients received immunosuppressants and DMARDs. Follow-up serum titres of anticardiolipin IgG and anti-Scl-70 returned to normal limits in seven and four patients, respectively. Among the five patients with persistently elevated anticardiolipin IgG or anti-Scl-70 autoantibodies, none had rheumatological symptoms at the end of the 6-month anti-TB treatment.
DISCUSSION
The present study has three important findings. First, one-third of patients with active TB had elevated serum autoantibodies. The prevalences of their autoantibodies, especially anticardiolipin IgG and anti-Scl-70, were significantly higher than those of the general population. Second, consistent with previous studies, the presence of autoantibodies neither altered the clinical manifestations and radiographic findings of active TB nor changed the risk of developing adverse events during anti-TB treatment. Third, the elevated autoantibody levels returned to normal limits simply by anti-TB treatment and not by immunosuppressive therapy. These findings suggest that increased serum autoantibodies during active TB may not be diagnostic of autoimmune diseases. Clinical correlation and follow-up are still necessary.

Autoantibodies come from a break in self-tolerance whereby fragments of mixed self-antigens and pathogen antigens may induce immune response, as in a mode of epitope spread and autoantibody production. Epitope spread occurs when there is chronic inflammation, causing the immune system to produce a variety of antibodies against pathogens of chronic infections. Active TB is one of the most common infectious diseases causing long-term inflammation and tissue destruction. Thus, it is reasonable that autoantibodies are more common in patients with TB.

Clinically detectable autoantibodies are often characteristic of certain autoimmune diseases. However, like in other clinical examinations, all autoantibodies should be tested based on the corresponding clinical symptoms and signs. Most autoantibodies are pathognomonic of certain conditions, such as anti-dsDNA in SLE, anticyclic citrullinated peptide antibody in rheumatoid arthritis, anti-Scl-70 in systemic sclerosis and anti-Jo-1 in polymyositis. However, autoantibodies may also be present in conditions other than autoimmune diseases, especially when there are no corresponding clinical symptoms, such as RF in infective endocarditis and antiphospholipid syndrome secondary to infection or malignancy.

The high prevalence of serum autoantibodies in active patients with TB has rarely been investigated and thus, remains unclear. If the autoantibodies are

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**Table 2** Prevalences of autoantibodies in patient with tuberculosis (TB), healthy controls and the general population

| Autoantibody        | ELISA-pos | Percentage of pos | Patients with TB (n=100) | Healthy control (n=100) | p Value | TB vs normal | TB vs control |
|---------------------|-----------|------------------|-------------------------|-------------------------|--------|--------------|--------------|
| Anti-Ro             | 58        | 2.7              | 2                       | 2                       | 0.855  | 1            | 1            |
| Anti-La             | 5         | 0.2              | 0                       | 0                       | 0.795  | 1            | 1            |
| Anti-RNP            | 11        | 0.5              | 2                       | 1                       | 0.138  | 0.108        | 1            |
| Anti-Sm             | 0         | 0                | 0                       | 0                       |        | 1            | 1            |
| Anti-Scl-70         | 0         | 0                | 6                       | 3                       | <0.001 | <0.001       | 0.498        |
| Anti-Jo1            | 0         | 0                | 1                       | 1                       | <0.001 | 0.044        | 1            |
| Anti-dsDNA          | 10        | 0.5              | 1                       | 0                       | 0.579  | 0.39         | 1            |
| Anticentromere      | 30        | 1.4              | 5                       | 2                       | 0.101  | 0.059        | 0.683        |
| Antithemione        | NA        |                  | 11                      | 7                       |        | 0.323        |              |
| Anticardiolipin IgM | NA        |                  | 6                       | 10                      |        |              | 0.297        |
| Anticardiolipin IgG | NA        |                  | 11                      | 0                       |        |              | 0.001        |

**Table 3** Adverse events during anti-tuberculosis (TB) treatment in patients with autoantibody-positive and antibody-negative TB

| Autoantibody-positive (n=32) | Autoantibody-negative (n=68) | p Value |
|-----------------------------|-------------------------------|---------|
| Rheumatological events      | 10 (31)                      | 28 (41) | 0.340   |
| Gastrointestinal events     | 9 (28)                       | 22 (32) | 0.670   |
| Neurological events         | 8 (25)                       | 16 (24) | 0.872   |
| Renal events                | 7 (22)                       | 19 (28) | 0.519   |
| Constitutional events       | 4 (13)                       | 19 (28) | 0.087   |
| Respiratory events          | 2 (6)                        | 3 (4)   | 0.654   |
| Haematological events       | 1 (3)                        | 0       | 0.320   |

Total number of events 41 107

Data are number (%). TB, tuberculosis.
activity, such as anti-dsDNA in lupus nephritis. Titres of autoantibodies often change along with disease. Phosphatidylserine and annexin V may be the epitopes of antiphospholipid antibodies. Vesicles released from activated neutrophils that express phosphatidylserine and annexin V may activate neutrophils and release containers of lipids which may activate neutrophils and release containers of lipids. Inactive TB, mycobacterial phenolic glycolipids may activate neutrophils and release containers of lipids. 4-glycoprotein 1-dependent. In active TB, mycobacterial phenolic glycolipids may activate neutrophils and release containers of lipids. 

- **Table 4** Serum autoantibody titres in patients with TB before and after anti-TB treatment

| Patient No. | Anti-Scl-70 Initial | Follow-up | Patient No. | ACA-IgG Initial | Follow-up |
|------------|---------------------|-----------|-------------|-----------------|-----------|
| 8          | 137                 | 155       | 18          | 18.1            | 9.3       |
| 18         | 156                 | 35        | 19          | 33.2            | 2.6       |
| 51         | 125                 | 28        | 36          | 12.3            | 4.1       |
| 64         | 152                 | 55        | 48          | 14.1            | 6.7       |
| 65         | 154                 | 79        | 55          | 10.8            | 13.4      |
| 91         | 153                 | 68        | 60          | 23.8            | 2.6       |
| 72         | 18.9                | 30.9      |
| 81         | 14.6                | 23.5      |
| 92         | 21.2                | 21.1      |
| 94         | 12.8                | 5.1       |

Normal reference values for anti-Scl-70 and ACA-IgG are <100 U/mL and <10 GPL, respectively.

ACA, anti-cardiolipin antibody; TB, tuberculosis.

...pathognomonic, there should be corresponding rheumatological symptoms and signs, especially in those with specific antiextractable nuclear antigen antibodies. Since the presence of autoantibodies does not alter the clinical manifestations and radiographic presentations of active TB, it is unlikely that autoantibodies have a pathognomonic role. In autoimmune diseases, serology titres of autoantibodies often change along with disease activity, such as anti-dsDNA in lupus nephritis. However, the finding that autoantibody titres return to normal limits after anti-TB treatment in more than two-thirds of patients with TB suggests the opposite—that the increase in autoantibodies is a reactive change during the disease course of active TB. This is a very important reminder.

If a patient has elevated autoantibody levels but no typical or multiple rheumatological symptoms, other possible aetiologies should be considered. For a patient in TB endemic areas, sputum samples for acid-fast smear and mycobacterial culture should be performed. If TB is missed and patients are diagnosed as having autoimmune diseases and treated with systemic corticosteroids, disseminated TB and TB-related mortality may occur.

The association of active TB and anticardiolipin IgG and antitopoisomerase I has not been previously reported. ACA is one of the hallmark autoantibodies in systemic sclerosis. Such antibody may be triggered by an infectious process that is non-β2-glycoprotein I-dependent. In active TB, mycobacterial phenolic glycolipids may activate neutrophils and release containers of ectosomes. Vesicles released from activated neutrophils that express phosphatidylserine and annexin V may be the epitopes of antiphospholipid antibodies. This may explain the high prevalence of anticardiolipin IgG in patients with TB. In general, the transient positivity of antiphospholipid antibody is not considered pathognomonic and does not meet the diagnostic criteria of antiphospholipid syndrome.

However, some studies have different findings and show that patients with TB with diffuse alveolar haemorrhage have transient anticardiolipin IgG positivity. Moreover, in the present study, anticardiolipin IgG remained elevated in 4 of 11 patients even after 3 months of anti-TB treatment. Although anticardiolipin IgG is not diagnostic, a high index of suspicion should be maintained regarding their clinical manifestations, including thrombosis, haemorrhage, haemolytic anaemia and thrombocytopenia in patients with TB with elevated anticardiolipin IgG.

Anti-Scl-70 is the first known prevalent autoantibody in patients with progressive systemic sclerosis. The autoantibody targets an antigen that is a 70 kDa protein. Later studies reveal that Scl-70 should be the nuclear DNA topoisomerase I. Topoisomerase I is an enzyme that relaxes the strain on DNA by nicking and ligating it. One of the notorious manifestations of systemic sclerosis is interstitial lung disease, characterised by lung fibrosis. Although there is no significant difference, patients with TB in this study have elevated anti-Scl 70 and higher risk of pulmonary cavitation and pleural effusion. The underlying mechanisms involved are unclear since antigenic topoisomerase I is not a component of leukocyte ectosome. Moreover, it is not released from the TB bacilli because the structure of mycobacterial topoisomerase I is different from those of humans.

In the present study, anti-Scl-70 titres returned to normal range after anti-TB treatment in all except one patient. The anti-Scl-70 antibody in active TB is probably secondary to pulmonary inflammation and destruction, which is uncovered by the nuclear topoisomerase I, thereby triggering the production of autoimmunity. The titre decreases once pulmonary injury is alleviated.

This study has some limitations. First, because the control group was composed of medical staff members, their baseline characteristics were very different from those of the TB group. This might lead to uncertainty in the prevalence of autoantibody in non-TB groups. Nonetheless, the autoantibody prevalence was still higher...
in patients with TB than in the general population reported in a previous publication.\textsuperscript{10} Second, follow-up samples were only obtained in those with elevated serum levels of autoantibodies before anti-TB treatment. Dynamic changes in autoantibodies might have been missed. TB has a kaleidoscope of presentations that constantly challenge physicians. In TB endemic areas, a significant proportion (32\%) of patients with TB has elevated autoantibody titres, especially antiproteinase III antibodies. Dynamic samples were only obtained in those with elevated serum titres of autoantibodies before anti-TB treatment. Mycobacterial anti-Scl-70. This phenomenon is likely to be reactive due to the lack of clinical correlations, as well as the spontaneous regression after TB treatment. Mycobacterial studies should be performed in patients with elevated autoantibody titres but without the typical or multiple manifestations of autoimmune diseases.

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Competing interests None.

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REFERENCES

1. Eikayam O, Caspi D, Lidgi M, et al. Auto-antibody profiles in patients with active pulmonary tuberculosis. Int J Tuberc Lung Dis 2007;11:306–10.
2. Adeabajo AO, Charles P, Maini RN, et al. Autoantibodies in malaria, tuberculosis and hepatitis B in a west African population. Clin Exp Immunol 1993;92:73–6.
3. Ganesh R, Ramalingam V, Esvarra Raju T, et al. Antinuclear antibodies in Mycobacterium tuberculosis infection. Indian J Pediatr 2008;75:1188.
4. Kasikovic-Lecic S, Kerenji A, Pavlovic S, et al. Autoantibodies in patients treated for active pulmonary tuberculosis. Med Pregl 2008;61:333–42.
5. Aleta da D, Neogi T, Silman AJ, et al. 2010 rheumatoid arthritis classification criteria: an American College of Rheumatology/European League Against Rheumatism collaborative initiative. Ann Rheum Dis 2010;69:1580–8.
6. Rantapaa-Dahlqvist S, de Jong BA, Berglin E, et al. Antibodies against cyclic citrullinated peptide and IgA rheumatoid factor predict the development of rheumatoid arthritis. Arthritis Rheum 2003;48:2741–9.
7. Lu K-T, eds. Taiwan guidelines for TB diagnosis and treatment. Taipei, Taiwan: Centers for Disease Control, R.O.C. (Taiwan), 2011.
8. Laniado-Laborin R, Cabrales-Vargas N. Tuberculosis in healthcare workers at a general hospital in Mexico. Infect Control Hosp Epidemiol 2006;27:449–52.
9. Wang JY, Shu CC, Lee CH, et al. Interferon-gamma release assay and Rifampin treatment for household contacts of tuberculosis. J Infect 2012;64:291–8.
10. Hayashi N, Kobashi M, Nishimura K, et al. Prevalence of disease-specific antinuclear antibodies in general population: estimates from annual physical examinations of residents of a small town over a 5-year period. Mod Rheumatol 2008;18:153–60.
11. Siegel RM, Lipsky PE. Autoimmunity. In: Firestein MSG, Budd RC, Harris ED Jr, McInnes IB, Ruddy S, Seranti JS, MD. eds. Kelley’s textbook of rheumatology. Philadelphia: Elsevier, 2009:270.
12. Powell AM, Black JM. Anticardiolipin: protection from pathogens, but propagation of autoimmune? Clin Exp Dermatol 2001;26:427–33.
13. Peng SL, Craft JE. Antinuclear antibodies. In: Firestein MSG, Budd RC, Harris ED Jr, McInnes IB, Ruddy S, Seranti JS, MD. eds. Kelley’s textbook of rheumatology. Philadelphia: Elsevier, 2009:1963.
14. Tassilius IQ, Boumpas DT. Clinical features and treatment of systemic lupus erythematosus. In: Firestein MSG, Budd RC, Harris ED Jr, McInnes IB, Ruddy S, Seranti JS, MD. eds. Kelley’s textbook of rheumatology. Philadelphia: Elsevier, 2009:1273.
15. Kuhn KA, Kulik L, Tomoka B, et al. Antibodies against citrullinated proteins enhance tissue injury in experimental autoimmune arthritis. J Clin Invest 2006;116:961–73.
16. Varga J, Denton CP. Systemic sclerosis and the scleroderma-spectrum disorders. In: Firestein MSG, Budd RC, Harris ED Jr, McInnes IB, Ruddy S, Seranti JS, MD. eds. Kelley’s textbook of rheumatology. Philadelphia: Elsevier, 2009:1323.
17. Nagaraju K, Lundberg IE. Inflammatory disease of muscle and other myopathies. In: Firestein MSG, Budd RC, Harris ED Jr, McInnes IB, Ruddy S, Seranti JS, MD. eds. Kelley’s textbook of rheumatology. Philadelphia: Elsevier, 2009:1356.
18. Li JS, Sexton DJ, Mick N, et al. Proposed modifications to the Duke criteria for the diagnosis of fibrosing encapsulating mesothelioma. Clin Infect Dis 2000;30:633–8.
19. Miyakis S, Lockshin MD, Atsumi T, et al. International consensus statement on an update of the classification criteria for definite antiphospholipid syndrome (APS). J Thromb Haemost 2006;4:295–306.
20. Faldt J, Dahlgren C, Karlsson A, et al. Activation of human neutrophils by mycobacterial phenolic glycolipids. Clin Exp Immunol 1999;118:253–60.
21. Gasser O, Hess C, Miot S, et al. Characterisation and properties of ectosomes released by human polymorphonuclear neutrophils. Exp Cell Res 2003;285:243–57.
22. Lopez LR, Dier KJ, Lopez D, et al. Anti-beta-2-glycoprotein I and antiphosphatidylserine antibodies are predictors of arterial thrombosis in patients with antiphospholipid syndrome. Am J Clin Pathol 2004;121:142–9.
23. Galli M, Comfuruius P, Maassen C, et al. Anti-beta 2-glycoprotein I and antiphosphatidylserine antibodies are predictors of arterial thrombosis in patients with antiphospholipid syndrome. Am J Clin Pathol 2004;121:142–9.
24. Deane KD, West SG. Antiphospholipid antibodies as a cause of pulmonary capillaritis and diffuse alveolar hemorrhage: a case series and literature review. Semin Arthritis Rheum 2005;35:154–65.
25. Almerico Marruchella AC, Tommasi C, Lauria FN, et al. A case of pulmonary tuberculosis presenting as diffuse alveolar haemorrhage: is there a role for antiphospholipid antibodies? BMC Infect Dis 2010;10:33.
26. Erkan D, Lockshin MD. Non-criteria manifestations of mixed connective tissue disease. Lupus 2005;14:881–8.
27. Guldner HH, Szoesteki C, Vosberg HP, et al. Scl 70 autoantibodies from scleroderma patients recognize a 95 kDa protein identified as DNA topoisomerase I. Clin Exp Immunol 1992;92:73–6.
28. Rantapaa-Dahlqvist S, de Jong BA, Berglin E, et al. Antibodies against cyclic citrullinated peptide and IgA rheumatoid factor predict the development of rheumatoid arthritis. Arthritis Rheum 2003;48:2741–9.
29. Lu K-T, eds. Taiwan guidelines for TB diagnosis and treatment. Taipei, Taiwan: Centers for Disease Control, R.O.C. (Taiwan), 2011.