Response to: 'Renal biopsies should be performed whenever treatment strategies depend on renal involvement' by Chemouny *et al*

We thank Chemouny *et al* for their letter and concur with their conclusions.[1] As we state[2]: "A positive biopsy for ANCA associated vasculitis (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.[3–5] 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 granulomatosis with polyangiitis (GPA) with renal involvement can be as high as 91.5% from renal biopsy.[6] As Chemouny *et al* 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 because the cause for acute kidney injury may be due to another cause other than AAV.[7]

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