Response to: 'Anti-Ku antibodies: important points to consider' by Mahler *et al*

We thank the authors¹ for their interest in our paper² and are grateful for the opportunity to respond to the points raised. We agree with the opinion of Mahler *et al* that 'SLE frequently express many autoantibodies and sera accompanied by mixed HEp-2 IIF pattern were very common'. We adopted the same methods for anti-Ku screening that Spielmann *et al*³ used in their study to avoid missing multiple autoantibody-positive cases. The Spielmann group included ANA-positive sera showing several ANA patterns (ICAP nomenclature: AC-1, AC-4 or AC-5) for ELISA analysis.

Although Mahler *et al* noted that 'In our experience, anti-Ku antibodies are frequently found in SLE patients potentially associated with overlap features of a myopathy', of the four anti-Ku antibody-positive myositis patients in their referenced study, only two patients had systemic lupus erythematosus (SLE) overlapping with myositis.³ Given that 33 anti-Ku-positive SLE patients in their study⁴ did not have myositis, it seems that SLE and myositis are less likely to overlap. We need to be careful in discussing the frequency of anti-Ku-associated clinical phenotypes.

We detected anti-dsDNA and anti-ssDNA antibodies by using two commercial ELISA kits (MBL, Nagoya, Japan). These kits are commonly used in Japan and are covered by health insurance for clinical laboratory tests. As Mahler *et al* noted that there is variability between anti-dsDNA assays,¹ we need to use immunofluorescence tests with *Crithidia luciliae* as a substrate for confirmation.

Mariko Ogawa-Momohara,¹ Yoshinao Muro ,² Masashi Akiyama²

¹Nagoya Daigaku Daigakuin Igakukei Kenkyuka Igakubu, Nagoya, Japan

²Dermatology, Nagoya University, Nagoya, Japan

Correspondence to Dr Yoshinao Muro, Dermatology, Nagoya University, Nagoya, Japan; ymuro@med.nagoya-u.ac.jp

Handling editor Josef S Smolen

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Commissioned; internally peer reviewed.

© Author(s) (or their employer(s)) 2019. No commercial re-use. See rights and permissions. Published by BMJ.

To cite Ogawa-Momohara M, Muro Y, Akiyama M. *Ann Rheum Dis* Epub ahead of print: [please include Day Month Year]. doi:10.1136/annrheumdis-2019-216595

Received 8 November 2019

Revised 8 November 2019

Accepted 11 November 2019

► <http://dx.doi.org/10.1136/annrheumdis-2019-216535>

Ann Rheum Dis 2019;**0**:1. doi:10.1136/annrheumdis-2019-216595

ORCID iD

Yoshinao Muro <http://orcid.org/0000-0003-2329-8375>

REFERENCES

- 1 Mahler M, Satoh M, Fritzler MJ, *et al*. Anti-Ku antibodies: important points to consider. *Ann Rheum Dis* 2019. doi:10.1136/annrheumdis-2019-216535.
- 2 Ogawa-Momohara M, Muro Y, Akiyama M. Overlap of systemic lupus erythematosus and myositis is rare in anti-Ku antibody-positive patients. *Ann Rheum Dis* 2019. doi:10.1136/annrheumdis-2019-216375. [Epub ahead of print: 11 Oct 2019].
- 3 Spielmann L, Nespola B, Séverac F, *et al*. Anti-Ku syndrome with elevated CK and anti-Ku syndrome with anti-dsDNA are two distinct entities with different outcomes. *Ann Rheum Dis* 2019;78:1101–6.
- 4 Mahler M, Swart A, Wu J, *et al*. Clinical and serological associations of autoantibodies to the Ku70/Ku80 heterodimer determined by a novel chemiluminescent immunoassay. *Lupus* 2016;25:889–96.