

Letters to the Editor

Sensorineural hearing loss in Wegener's granulomatosis—cytotoxic chemotherapy

Dear Sir,

We believe the article by Clements *et al.* in the May issue of the JLO to be misleading, in suggesting that the improvement in sensorineural hearing loss in Wegener's granulomatosis treated with combined cytotoxic-immunosuppressive therapy is an unusual finding. In the discussion they state there has been only one similar report (Peiterson and Carlsen, 1965). However, we should like to draw attention to two publications indicating that improvement is found in the majority of patients. McCaffrey *et al.* (1980) report nine patients with sensorineural hearing loss of which five had complete or partial recovery with combined treatment. Illum and Thorling (1982), who were primarily interested in conductive loss, also record improvement in 'nearly all' in the series of thirteen patients of whom 'most had major sensory hearing loss'. Improvement in sensorineural hearing loss is therefore to be expected with combined cytotoxic-immunosuppressive therapy.

Yours faithfully,

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References

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Peitersen E. and Carlsen B. H. (1965) Hearing impairment as the initial sign of polyarteritis nodosa. *Acta Otolaryngologica* **61**: 189–195.

Dear Sir,

Murty and Birchall draw our attention to the papers of McCaffrey *et al.* (1980) and Illum and Thorling (1982) describing improvement in sensorineural deafness in patients with Wegener's granulomatosis following treatment. In both of these articles the claim is supported by relatively scanty audiometric data.

The fact remains that the occurrence of sensorineural hearing loss in Wegener's granulomatosis and its amenability to cytotoxic/immunosuppressive therapy is not well recognized (Brook's and Booth, 1987). In a recent article in the British Medical Journal entitled 'Ear, Nose and Throat Symptoms in Subacute Wegener's Granulomatosis' the authors do not mention sensorineural deafness. (D'Cruz *et al.* 1989). We felt it important to

point out that it does occur and to emphasise that for treatment to be effective it may have to be maintained for many months.

More important, however, is the realization that disorders thought to have a basis in a disturbance of the immune system can involve the inner ear. When sensorineural deafness occurs as part of a recognizable systemic syndrome, diagnosis presents few problems; if it is the sole manifestation of a primary autoimmune disorder, appreciation of the cause may not be easy. The works of McCabe, and of Veldmann, however, make it clear that such processes do occur. We need to identify both clinically and preferably by means of an assayable marker in the bloodstream, the minority of patients from the population of idiopathic sensorineural deafness for whom such a therapeutic regimen is justifiable.

Yours faithfully,

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(on behalf of authors)

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References

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D'Cruz D. P., Baguley E., Asherson R. A., Hughes G. R. V. (1989) Ear, Nose and Throat Symptoms in Subacute Wegener's Granulomatosis. *British Medical Journal* **229**: 419–422.

Antineutrophil cytoplasm assay test in Wegener's granuloma

Dear Sir,

The antineutrophil cytoplasm assay test is more than a 'solid phase radioimmunoassay' (Mains 1989). Confirmation of specificity requires indirect immunofluorescence on normal human neutrophils, which was regarded as the standard technique at the first international ANCA workshop (Rasmussen *et al.*, 1988). Used alone the radioimmunoassay has an appreciable false positive rate (Savage *et al.*, 1987). ANCA have been reported in limited forms of vasculitis since the early report by Gross *et al.* (1986) quoted by Mains (1989) (Gans *et al.*, 1989; Hoare and Rhys Evans 1988).

It is unfortunate that a distinguished journal such as yours should give such prominence to an isolated case report based on misunderstood incomplete and outdated information (Mains 1989).

When properly performed and correctly interpreted the ANCA test is a useful diagnostic aid in a confusing and often confused field and it should not be discredited in the way your journal has done.

I enclose a paper concerning cases which posed con-

siderable diagnostic difficulty which was clarified when ANCA were found in their sera. The information, discussion and references concerning ANCA are complete and up to date. I urge you to publish this soon to repair the damage you have done without justification to the reputation of this very useful test about which more should be known by Otorhinolaryngologists.

Yours faithfully

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(for and on behalf of the authors)

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(Paper published on page 1187 of this issue)

Dear Sir,

The case under discussion is that of a 22-year-old man who presented with acute sinusitis and a nasal septal perforation. He was extensively investigated revealing no other clinical features, apart from a positive ANCA test, suggesting a diagnosis of Wegener's granulomatosis.

The ANCA test was performed on 3 occasions by

radioimmunoassay, and confirmed by indirect immunofluorescence. On each occasion the result was positive (personal communication, David Jayne).

As clinicians we were reluctant to commence a mode of therapy, one of the side effects of which would be sterility in a 22-year-old man. As it was, satisfactory control of his nasal symptoms was achieved with antihistamines.

If we accept that the test has no false positives, and hence is diagnostic for Wegener's granulomatosis, this presumably implicates the neutrophil in the pathogenesis of the disease—I strongly disagree with both these concepts.

The case report was presented in what I consider to be a balanced manner emphasising that the test, 'whilst useful should be interpreted in the context of other diagnostic criteria'.

The underlying principle must be that we treat patients and not results.

Yours faithfully,

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