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LETTER TO THE EDITOR

Splenic infarction, warm autoimmune hemolytic anemia and antiphospholipid antibodies associated with systemic lupus erythematosus

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Dear Editor

The article entitled "Splenic infarction, warm autoimmune hemolytic anemia and antiphospholipid antibodies in a patient with infectious mononucleosis" written by Cull et al. [1] and published in one of the recent issues of your journal was quite interesting. We would like to emphasize a number of points with regard to this phenomenon.

Regular, vigilant testing for systemic lupus erythematosus (SLE) is required in patients initially diagnosed with autoimmune hemolytic anemia (AIHA). In patients with SLE and concomitant Coombs-positive AIHA, anticardiolipin antibodies (aCL) are found more frequently and at higher titers than in SLE patients without AIHA [2, 3].

Laboratory and imaging findings suggested a diagnosis of antiphospholipid syndrome (APS), an autoimmune disorder characterized by recurrent venous thrombosis or arterial occlusive events and fetal losses associated with elevated levels of aCL. APS may occur in association with SLE in childhood, as well as in adults. Coombs-positive AIHA is also associated with APS [4]. Splenic infarct may be seen in SLE [4].

False-positive findings of heterophile antibodies are more common among persons with connective tissue disease (such as SLE, Sjögren's syndrome), lymphoma, viral hepatitis, and malaria [5].

The most diagnostically important autoantibodies are antinuclear antibodies (ANA), as these test positive in >95 % of SLE patients, usually at the onset of symptoms. A few patients develop ANA within 1 year of symptom onset; repeated testing may thus be useful [3, 4].

In conclusion, we suggest that it is important to evaluate for both SLE and ANA in female patients presenting with aCL positivity and AIHA.

Conflict of interest We did not receive any financial support. This study has not been published in any journal. We have no conflict of interest.

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