

TABLE 1 Demographics of good and poor responders

	Good responders, N = 114	Poor responders, N = 112
Age, mean (s.d.), years	55 (10)	52 (12)
% male	111 (98)	111 (98)
BMI, mean (s.d.), kg/m ²	31.1 (5.0)	33.1 (5.9)
European, n (%)	89 (78.1)	86 (76.8)
Days on febuxostat prior to day 0, mean (s.d.)	46 (119)	32 (52)
Serum urate at day 0, mean (s.d.), mg/dl	4.1 (0.64)	6.3 (1.12)
ABCG2 rs2231142 allele count (freq.) GG/GT/TT	65 (0.57)/37 (0.32)/12 (0.11)	57 (0.51)/46(0.41)/9 (0.08)

ABCG2: ATP-binding cassette transporter G2.

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Nasal carriage of *Staphylococcus pseudintermedius* in patients with granulomatosis with polyangiitis

Rheumatology key message

- Patients with granulomatosis with polyangiitis can be colonized by *Staphylococcus pseudintermedius*, with unclear contribution to disease pathogenesis.

SIR, granulomatosis with polyangiitis (GPA, formerly Wegener's granulomatosis) is characterized by necrotizing granulomatous inflammation usually involving the upper and lower respiratory tract, and necrotizing vasculitis affecting predominantly small to medium vessels, frequently leading to glomerulonephritis [1]. Disease etiopathogenesis is complex but includes a genetic background, epigenetic modifications and environmental factors. There are several lines of evidence indicating an association of nasal colonization with *Staphylococcus aureus* and GPA. *S. aureus* is an independent risk factor for relapse of GPA in carriers, and therapeutic administration of trimethoprim-sulfamethoxazole has been shown to reduce relapse rates during a treatment period of 2 years [2]. Little is known about other bacterial species that colonize the noses of GPA patients.

We undertook a study to investigate the bacterial species carried by 69 patients with a diagnosis of GPA and ENT involvement. This work was approved by the National Research Ethics Service (NRES) Committee East of England – Cambridge Central (REC reference: 08/H0308/176). Informed consent was obtained before sample collection. Nasal swabs (1–3 swabs per patient) were inoculated into high-salt (7.5%) nutrient broths and incubated statically at 37°C overnight; from this culture, 100 µl was inoculated onto Brilliance Staph 24 Agar (all

although a study that investigated the presence of *Staphylococcus* spp. in 119 dogs and their 107 owners found only one dog–owner pair that both carried *S. pseudintermedius* [8]. Neither patient in the present study had a history of contact with dogs, and thus it remains unclear which factors determine colonization with *S. pseudintermedius*.

To the best of our knowledge, this is the first evidence of persistent nasal carriage of *S. pseudintermedius* in humans. The detection of two distinct lineages demonstrates that colonization is not limited to a specific clone. Transmission and factors leading to persistent carriage are not known, but local damage relating to vasculitis and pharmacological immune suppression may make GPA patients more prone to colonization. It remains unclear whether *S. pseudintermedius* has any impact on relapse risk or is directly involved in the etiopathogenesis of GPA.

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Supplementary data

Supplementary data are available at *Rheumatology online*.

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Coexistence of systemic lupus erythematosus with Kikuchi-Fujimoto disease involving the salivary gland, initially disguised as lymphoma

Rheumatology key message

- Kikuchi-Fujimoto disease associated with lupus can mimic lymphoma due to nodal and extra-nodal involvement.

SIR, Kikuchi-Fujimoto disease (KFD) is a histiocytic necrotizing lymphadenitis, which predominantly affects woman of Japanese or other Asiatic descent aged ≤ 40 years [1]. The aetiology of KFD is not well established, but it is suspected to be triggered by a virus or a hyper-autoimmune response [2, 3]. It is a rare benign disease, characterized by localized lymphadenopathy with fever and night sweats. KFD is an important differential diagnosis for malignant lymphoma and other infectious conditions because it mimics their clinical presentation and laboratory findings. Herein, we present the case of a male patient with KFD showing salivary gland involvement, coexisting with lupus, where lymphoproliferative disease was initially suspected.

A 42-year-old otherwise healthy male presented to our clinic with complaints of fever up to 38°C for 3 weeks, weight loss and night sweats. His medical history was