Anti-DFS70 Antibodies: A Useful Biomarker in a Pediatric Case With Suspected Autoimmune Disease

**AUTHORS:** Martina Fabris, MD,† Silvia Zago, MD,‡ Raffaello Tosolini, MD,§ Paola Melli, MD,¶ Nicola Bizzaro, MD,¶ and Elio Tonutti, MD¶

†Institute of Clinical Pathology, ‡Pediatric Clinic, and ¶Laboratory of Immunopathology and Allergy, University Hospital S. Maria Misericordia, Udine, Italy; §Institute of Clinical Pathology, DSMB, University of Udine, Udine, Italy; and ¶Laboratory of Clinical Pathology, San Antonio Hospital, Tolmezzo, Italy

**KEY WORDS**
anti-DFS70 antibodies, anti-nuclear antibodies, systemic autoimmune disease, differential diagnosis

**ABBREVIATIONS**
ANA—antinuclear antibody
anti-DFS70—antidense fine speckles 70
IIF—indirect immunofluorescence
SARD—systemic autoimmune rheumatic disease

Dr Fabris did a fundamental contribution to conception of the study and acquisition, analysis, and interpretation of laboratory data; she made the first draft of the article and collected all the co-authors’ revisions to make the final version, then re-sent it to co-authors for their final approval before submission; Dr Zago did a substantial contribution to acquisition of laboratory data and to draft the first version of the article (introduction and laboratory data); Dr Tosolini did a substantial contribution to acquisition and interpretation of clinical data and to draft the first version of the article (clinical case description); Dr Melli, as clinical supervisor of Dr Tosolini, helped him during the period of hospitalization of the patient and revised clinical data to draft the case description; Dr Bizzaro did a substantial contribution to acquisition of laboratory data (anti-DFS70 IgG antibody detection by the QUANTA Flash DFS70 method) and critically revised the first draft thanks to his important knowledge in the field of autoimmunity and, in particular, in DFS70 analysis and interpretation; Dr Tonutti did a fundamental contribution to conception of the study and acquisition, analysis, and interpretation of data; he revised the draft critically for important intellectual content. All authors approved the final version to be published and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

www.pediatrics.org/cgi/doi/10.1542/peds.2013-3914
doi:10.1542/peds.2013-3914
Accepted for publication Jun 17, 2014
Address correspondence to Martina Fabris, MD, Institute of Clinical Pathology, University Hospital “S. Maria Misericordia”, piazzale S. Maria Misericordia 1, 33100 Udine, Italy. E-mail: fabris.martina@aoud.sanita.fvg.it

(Continued on last page)
Detection of antinuclear antibodies (ANAs) by indirect immunofluorescence (IIF) assay on HEp-2 cells is the test of choice when suspecting a systemic autoimmune rheumatic disease (SARD). Antidense fine speckles 70 (anti-DFS70) antibodies were initially identified as an ANA IIF pattern from a patient with interstitial cystitis, but were later associated with a variety of chronic inflammatory conditions and in healthy individuals. Anti-DFS70 antibodies were found to be frequently associated with anti-p80 coilin antibodies in patients with allergic diseases but rarely in patients with SARD. These findings suggested that the presence of isolated anti-DFS70 antibodies (ie, the unique antigenic specificity responsible for ANA-positive results) could be taken as strong evidence against a diagnosis of SARD, such as systemic lupus erythematosus, making it a possible key biomarker to discriminate SARD from other clinical conditions in ANA-positive individuals.

The typical DFS70 IIF staining pattern appears as a particular combination of a dense fine speckles fluorescence uniformly distributed throughout the interphase nucleus and a characteristic staining of the chromatin area in mitotic cells. According to this peculiar IIF pattern, the antigen was initially termed DFS70, due to the apparent molecular weight in immunoblot assays. Later, the main target autoantigen was first identified as the lens epithelium-derived growth factor, and more recently, as the DNA-binding transcription coactivator p75.

**CASE PRESENTATION**

An 8-year-old girl was referred to the emergency department with a 5-day history of progressive periorbital and lower limb edema, ascites, and increased weight. She complained of respiratory distress in the preceding 2 days. On physical examination, the child presented generalized edema, hypertension (140/100 mm Hg), and hepatomegaly. Parents noted a history of pharyngitis 3 weeks earlier. Blood analysis revealed white blood cells 9300 × 10⁶/L, with 55% neutrophils and 31% lymphocytes, hemoglobin 9.6 g/dL, platelet count 229 × 10⁹/L, total protein 60.8 g/L, albumin 33.5 g/L, complement C3 6 mg/dL and C4 19 mg/dL, serum urea nitrogen 35 mg/dL, creatinine 0.72 mg/dL, and electrolytes were in the normal range. Urine analysis revealed microhematuria and proteinuria. After a few hours of observation, the girl developed progressive dyspnea and a chest radiograph confirmed pulmonary edema. An echocardiogram revealed normal cardiac function. She was treated with a continuous infusion of furosemide and nifedipine with prompt recovery. No extrarenal symptoms or signs potentially associated to systemic lupus erythematosus were noted, and the clinical presentation appeared characteristic of poststreptococcal glomerulonephritis. Accordingly, the antistreptolysin O test presented an elevated titer (1110 UI/mL, range, 0–200), the measure of total proteins renal excretion in a 24-hour urine collection test revealed a significant proteinuria (1236 mg/24 hours), urinary casts and numerous red blood cells, and the throat swab demonstrated the presence of a *Streptococcus pyogenes* infection. Antibiotic therapy was administered; proteinuria and hematuria resolved completely within a few days with loss of weight and normal values of blood pressure without any further therapy.

In the meantime, to exclude the presence of an occult SARD, a large panel of autoantibodies was ordered. Anti-dsDNA antibodies, antielectroantigenic nuclear antigens, and antineutrophil cytoplasmic antibodies were negative, while ANA by IIF on HEp-2000 (ImmunoConcepts, Sacramento, CA) were detected at high titer (1:640) and were characterized by a dense fine speckles pattern distributed also in the chromatin region of metaphase nuclei. According to these observations, anti-DFS70 antibodies (143.3 U; reference interval <20 U) were measured by the QUANTA Flash DFS70 method (INOVA Diagnostics, San Diego, CA) that uses a partial length human recombinant DFS70/lens epithelium-derived growth factor protein. The assay was performed on the fully automated random access BIOFLASH chemiluminescence analyzer (Biokit SA, Barcelona, Spain). The sample resulted positive at high titer for anti-DFS70 antibodies (143.3 U; reference interval <20 U).

**FIGURE 1**

A, A typical anti-DFS70 IIF ANA pattern on HEp-2000 (400 ×); B, The ANA pattern observed in the reported case: dense fine speckles distributed also in metaphase nuclei plus 1–2 highly fluorescent large grains per cell (200 ×).
CONCLUSIONS

In clinical practice, ANA assays, often with subsequent automatic cascade profile tests, are often inappropriately ordered. This case represents such a frequent scenario, where the typical clinical and laboratory findings of acute glomerulonephritis might be misinterpreted in favor of an autoimmune pathogenesis, due to the occurrence of a significantly positive ANA test. Anti-DFS70 antibodies are rarely observed in autoimmune diseases and whenever observed, additional autoantibodies related to systemic autoimmune diseases are frequently present as well.

Therefore, the finding of an ANA-positive test caused by anti-DFS70 antibodies as the sole antibody specificity represents a useful tool to exclude an autoimmune disorder and thus avoids further unnecessary autoantibody cascade testing, which may be misleading and lead to an incorrect diagnosis and possible treatment with immunosuppressive therapeutic agents. However, due to the subjectivity of interpretation and differences in substrate performance, a DFS70-like ANA pattern identified by IIF is not sufficient to indicate the presence of this autoantibody, but it should always be confirmed by a specific immunoassay for the identification of DFS70 specificity.

ACKNOWLEDGMENT

We thank Dr Desrè Ethel Fontana for English revision of the manuscript.

REFERENCES

Anti-DFS70 Antibodies: A Useful Biomarker in a Pediatric Case With Suspected Autoimmune Disease
Martina Fabris, Silvia Zago, Raffaello Tosolini, Paola Melli, Nicola Bizzaro and Elio Tonutti
Pediatrics; originally published online November 10, 2014;
DOI: 10.1542/peds.2013-3914

Updated Information & Services
including high resolution figures, can be found at:
/content/early/2014/11/05/peds.2013-3914

Citations
This article has been cited by 1 HighWire-hosted articles:
/content/early/2014/11/05/peds.2013-3914#related-urls

Permissions & Licensing
Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
/site/misc/Permissions.xhtml

Reprints
Information about ordering reprints can be found online:
/site/misc/reprints.xhtml

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2014 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.
Anti-DFS70 Antibodies: A Useful Biomarker in a Pediatric Case With Suspected Autoimmune Disease
Martina Fabris, Silvia Zago, Raffaello Tosolini, Paola Melli, Nicola Bizzaro and Elio Tonutti

Pediatrics; originally published online November 10, 2014;
DOI: 10.1542/peds.2013-3914

The online version of this article, along with updated information and services, is located on the World Wide Web at:
/content/early/2014/11/05/peds.2013-3914