

TARGET AUDIENCE	Healthcare professionals in Primary and secondary care
PATIENT GROUP	Adult patients

Clinical Guidelines Summary

This guideline provides information on what immunology testing is indicated if a patient has a suspected underlying rheumatological condition

Antibody testing should not be undertaken without a high clinical index of suspicion for the underlying condition

No Diagnosis should be made based upon antibody testing alone

Guideline Body

Antibody testing should not be used as a screening test for rheumatological disorders. A good history will guide the tests undertaken. These conditions are managed by various specialities and symptoms/signs will also direct referral.

Who to refer:

- Only patients who have symptoms suggestive of an autoimmune inflammatory disorder (see table below)
- Diagnosis is based on the presence of typical symptoms and supported by the presence of a relevant auto-antibody

Who not to refer:

- A patient with a positive autoantibody testing without symptoms or non-specific symptoms should **NOT** be referred to Rheumatology
 - Non-specific symptoms including fatigue; widespread, non-localising pain; and/or transient rashes; combined with positive antibodies; have a low pre-test probability, and are unlikely to lead to a specific diagnosis/treatment
- Patients with suggestive symptoms and negative ANA are unlikely to have SLE / Sjogrens / CTD etc – alternative causes should be considered

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How to refer:

- Sci
- If patient is systemically unwell with suspected lupus, myositis, vasculitis please discuss with the Rheumatology on call team

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Symptoms	Tests to consider	Likely condition	Comment
New persistent joint inflammation > 4 weeks MCP/MTP joint involvement Raised ESR/CRP Early morning stiffness > 30 mins	RF (CCP hospital only test)	Early inflammatory arthritis (RA if RF positive)	Refer urgently and will be vetted to early inflammatory arthritis slot
Dry eyes/mouth	ANA, ENA, RF Positive Ro/La, RF	Sjogren's syndrome	Routine referral
Sclerodactyly Triphasic Raynauds Telangiectasia Gastro-oesophageal reflux Dyspnoea	ANA Positive SCL70, centromere antibody	Systemic sclerosis	
Arthralgia Photosensitivity Raised Malar rash Discoid rash Pleurisy Cytopenias Dipstick proteinuria Neurological involvement	ANA, dsDNA, C3/4 Positive ANA homogenous +/- dsDNA (ELISA & immunofluorescence) Ro, La, Sm or RNP Low C3/4	SLE	ANA at lower titres of up to 1/320, present in up to 30% of normal population, in the absence of any symptoms suggestive of SLE, are often of no clinical significance
Systemically unwell Dyspnoea, haemoptysis Nasal stuffiness, epistaxis Scleritis Peripheral nerve symptoms Dipstick proteinuria	ANCA MPO or PR3 positive	ANCA vasculitis	Refer urgently as OP Those with haemoptysis and other features of AAV require urgent hospital admission due to risk of pulmonary haemorrhage
Recurrent miscarriages Recurrent venous or arterial thrombosis	Antiphospholipid antibody Lupus anticoagulant (Check both twice 8 weeks apart)	Antiphospholipid antibody syndrome	Refer to haematology

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Progressive proximal muscle weakness Raised CK >500 (not on statins) May have skin changes or progressive dyspnoea	ANA (Myositis antibody screen hospital only)	Inflammatory myopathy	Refer urgently
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References/Evidence

Any content in your guideline that is either quoted, paraphrased and/or borrowed from an external source must be attributed to the original.

For published papers, Harvard referencing style is preferable

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4. Abeles, A.M. and Abeles, M. (2013). The Clinical Utility of a Positive Antinuclear Antibody Test Result. *The American Journal of Medicine*, 126(4), pp.342–348. doi:<https://doi.org/10.1016/j.amjmed.2012.09.014>.
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6. Kim E J, Wierzbicki A S. Investigating raised creatine kinase *BMJ* 2021; 373 :n1486 doi:10.1136/bmj.n1486
7. Knight J S, Branch D W, Ortel T L. Antiphospholipid syndrome: advances in diagnosis, pathogenesis, and management *BMJ* 2023; 380 :e069717 doi:10.1136/bmj-2021-069717

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Appendices

1. Governance information for Guidance document

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Endorsing Body:	Rheumatology Consultants, Primary Care
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CONSULTATION AND DISTRIBUTION RECORD	
Contributing Author / Authors	
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Distribution	Applicable to all health care professionals in primary and secondary care
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CHANGE RECORD

Date	Lead Author	Change	Version No.
29/7/25	Dr Karen Donaldson	<i>e.g. Review, revise and update of policy in line with contemporary professional structures and practice</i>	1
			2
			3
			4
			5

2.You can include additional appendices with complimentary information that doesn't fit into the main text of your guideline, but is crucial and supports its understanding.

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e.g. supporting documents for implementation of guideline, patient information, specific monitoring requirements for secondary and primary care clinicians, dosing regimen/considerations according to weight and/or creatinine clearance

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