



Positive ANA: a guide for referring clinicians

When an ANA matters, what to check next, and when referral usually isn't needed

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32%

of healthy people are ANA-positive at 1:40

13%

are positive at 1:80

5%

are positive at 1:160 (Tan et al., 1997)

A positive ANA on its own does not diagnose any disease. It is the most common reason for referrals that don't need a rheumatology visit. The clinical picture, not the ANA, decides what happens next.

Step 1. Why was it ordered?

A test ordered for specific features (rash, arthritis, Raynaud's with puffy fingers, cytopenias, proteinuria) means more than one ordered as a screen for fatigue or widespread pain.

Step 2. Look for features of connective tissue disease

- Photosensitive or malar rash, discoid lesions
- Mouth or nose ulcers, non-scarring hair loss
- Inflammatory arthritis (swelling, morning stiffness over 30–60 minutes)
- Pleurisy or pericarditis
- Raynaud's with puffy fingers, ulcers or skin thickening
- Proximal muscle weakness
- Dry eyes and mouth with gland swelling
- Unexplained cytopenias, proteinuria or hematuria

Step 3. Check the basics

CBC with differential, metabolic panel, and urinalysis with microscopy. At a titer of 1:160 or higher, or with symptoms, add an ENA panel (Sm, RNP, SSA/Ro, SSB/La, Scl-70, centromere), anti-dsDNA and C3/C4. Avoid ordering the ENA panel when the ANA is negative and suspicion is low.

Step 4. Decide

USUALLY NO REFERRAL

- Low titer (1:40–1:80) with no symptoms and normal basic tests
- Isolated dense fine speckled (DFS70) pattern without symptoms
- Non-specific symptoms only (fatigue, widespread pain) with negative follow-up tests

Reassure, document, and review if new symptoms develop. Don't repeat the ANA; the titer doesn't track disease activity.

REFER

- Any disease-specific antibody (anti-dsDNA, Sm, RNP, Scl-70, centromere, RNA polymerase III; SSA/Ro in pregnancy)
- Symptoms that fit lupus, systemic sclerosis, myositis, Sjögren's disease or MCTD
- Unexplained cytopenias, proteinuria or hematuria
- Kidney, lung, brain or severe blood involvement: call the same day

Other causes of a positive ANA

Autoimmune thyroid and liver disease, drugs (hydralazine, procainamide, minocycline, TNF inhibitors), infections, malignancy, older age, and relatives of people with autoimmune disease.

In children

A positive ANA is common in healthy children and does not, on its own, diagnose JIA or lupus. In a child with confirmed JIA, a positive ANA raises uveitis risk and changes the eye-screening schedule.

What to send with a referral

Why the ANA was ordered, the titer and pattern, symptoms (with photos of any rash), CBC, metabolic panel, urinalysis, and any ENA, anti-dsDNA and complement results.

Sources

1. Tan et al., Arthritis Rheum 1997 (ANA in healthy people). <https://doi.org/10.1002/art.1780400909>
2. Abeles & Abeles, Am J Med 2013 (positive ANA). <https://pubmed.ncbi.nlm.nih.gov/23395534/>
3. ACR 2025 SLE guideline. <https://pubmed.ncbi.nlm.nih.gov/41182321/>
4. ACR classification criteria. <https://rheumatology.org/criteria>
5. ACR 2026 JIA guidelines. <https://rheumatology.org/juvenile-idiopathic-arthritis-guideline>