Table 1. Cases of ATIN associated with the selective COX-2 inhibitors

<table>
<thead>
<tr>
<th>Drug</th>
<th>Author</th>
<th>Peak SCr</th>
<th>Treatment</th>
<th>Final SCr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Celecoxib</td>
<td>Alper [3]</td>
<td>186 μmol/l</td>
<td>Steroids</td>
<td>97 μmol/l</td>
</tr>
<tr>
<td>Celecoxib</td>
<td>Brewster*</td>
<td>522 μmol/l</td>
<td>Steroids</td>
<td>106 μmol/l</td>
</tr>
<tr>
<td>Celecoxib</td>
<td>Rocha [5]</td>
<td>769 μmol/l</td>
<td>Haemodialysis, steroids</td>
<td>124 μmol/l</td>
</tr>
<tr>
<td>Rofecoxib</td>
<td>Alim [6]</td>
<td>1202 μmol/l</td>
<td>Haemodialysis</td>
<td>115 μmol/l</td>
</tr>
</tbody>
</table>

SCr, serum creatinine concentration.

*Current case.


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Enzyme replacement in the treatment of Fabry’s disease. Is there a point-of-no-return?

Sir,

We read with interest the recently published article by De Schoenmakere et al. [1] on enzyme replacement therapy in Fabry’s disease and the Editorial Comment by Breunig and Wanner [2] in the same issue of *NDT*. In both papers the question raised is whether there is or not a point-of-no-return beyond which organ damage cannot be reversed in spite of correct enzyme replacement treatment. Our experience with a patient may help to answer to this question.

A young man, 29 years old, presented in our outpatient clinic with ankle oedema and was diagnosed with nephrotic syndrome with microhaematuria. The serum creatinine at that time was 1.1 mg/dl. The clinical exam discovered angioarterialomas in pelvic localization. He had suffered acroparaesthesias, hypohidrosis and dizziness for years. Kidney and skin biopsies suggested Fabry’s disease. Very low levels of alpha-galactosidase were demonstrated in the patient and in his mother. He received treatment with carbamazepine and phenytoin for 30 months. The clinical symptoms did not change very much and the renal function declined progressively.

During the month of June 2001 it became possible to start enzyme replacement treatment with agalsidase beta 1 mg/kg every 15 days by i.v. route. At that time the serum creatinine was 4.06 mg/dl and the calculated GFR 20 ml/min.

Three months later the patient began renal replacement treatment with haemodialysis. An echocardiography carried out at that time showed left ventricular hypertrophy. He developed arterial hypertension and was treated with amlodipine and irbesartan. Agalsidase beta treatment was continued at the same dose and was administered during the dialysis session every 14 days.

The clinical symptoms did not change significantly. In July 2002 the patient suffered from a cerebrovascular event diagnosed as ischaemic after a normal cranial CT. The arterial pressure was very difficult to control and he died 48 h later. The necropsy found that cerebral haemorrhage was the cause of death. Cardiac hypertrophy persisted and there were multiple deposits of globotriaosylceramide particularly in endothelial cells (Figure 1).

Enzyme replacement therapy was unable to stop the progression of Fabry’s disease in our patient. This treatment was initiated when the renal function was very low and probably the organ damage was very advanced. We think that in our patient the kidney fibrosis and the damage in other organs like heart, vascular endothelium, etc., had reached a point beyond which the treatment was not useful. The conclusion is that enzyme replacement therapy in Fabry’s disease patients must be initiated as soon as possible to avoid reaching that point-of-no-return.

Conflict of interest statement. None declared.

Sir,

Erythropoietin (EPO) requirements vary in haemodialysis patients. The most commonly recognized causes of EPO resistance are iron deficiency and chronic inflammation. We have previously noted a correlation between serum albumin and extracellular fluid volume (Vecf) in HD patients [1]. If serum albumin is lower in subjects with an increased Vecf, then haemoglobin may be too. However, unlike albumin,