A 40-year-old woman presented with lassitude, malaise, abdominal dyscomfort and fever of several weeks' duration. Three days earlier, she noticed jaundice of the skin. Her medical history included Sjogren syndrome treated with prednisolone and azathioprine. She had no history of renal insufficiency. At admission, she was overweight, had icteric sclera and skin, blood pressure of 160/80 mmHg and a regular pulse of 92. Her liver and spleen were enlarged. No lymph nodes were palpable. There was an increase in serum creatinine (417 μmol/l), urea nitrogen (44 mmol/l), bilirubin (520 μmol/l) and total alkaline phosphatase (1158 U/l), and a reduction in white blood cell count (3.0 G/L), haemoglobin (9.3 g/dl) and platelets (148 G/L). Computed tomography of the abdomen and thorax showed hepatomegaly, splenomegaly and abdominal, retroperitoneal and mediastinal lymphadenopathy. A biopsy of the liver and bone marrow showed classical Hodgkin lymphoma infiltrates in both tissues. A kidney biopsy showed biliary casts in the tubules (Figure 1). Acute renal failure was due to tubular necrosis. There was no evidence of renal lymphoma. The patient received chemotherapy and recovered liver and kidney function.

In obstructive liver diseases, urinary excretion of bile salts is markedly enhanced [1,2]. Biliary casts in the tubule have been described in hepatic cirrhosis [3] and in subacute hepatic failure [4], but are rarely seen in acute renal failure.

Conflict of interest statement. None declared.

References