Minimal change nephrotic syndrome associated with systemic lupus erythematosus

Sir,

In patients with nephrotic syndrome associated with systemic lupus erythematosus (SLE), the most common histological findings on renal biopsy are diffuse proliferative lupus nephritis (WHO class IV) and membranous lupus nephritis (WHO class V). We report a case of SLE with nephrotic proteinuria due to minimal change nephrotic syndrome (MCNS).

In 1995, SLE was diagnosed in a 29-year-old Japanese woman because of photosensitivity, arthralgia, positive antinuclear antibodies and lymphopenia. The nephrotic syndrome had occurred three times, in 1986, and 1995, with complete remissions following a short-term treatment with 30–40 mg of prednisolone daily. Renal biopsy was not performed. Neither non-steroidal nor immunosuppressive agents were used for SLE. She was followed in the outpatient clinic and was admitted to our hospital in March 1998 because of oedema and severe proteinuria. Her blood pressure was 116/62 mmHg, white blood cells were 5000/mm³ and lymphocytes 1600/mm³ (885/mm³ in March 1998 because of oedema and severe proteinuria). Her platelet count was 388 000/mm³. Urinalysis revealed proteinuria (3.5 g/day). Total serum protein, albumin and total cholesterol were 4.7 g/dl, 2.2 g/dl and 409 mg/dl, respectively, and blood urea nitrogen and creatinine were 13 and 0.56 mg/dl, respectively. C3, C4 and CH50 were within the normal range. Anti-double-stranded DNA antibody titre was 3 U/ml (normal range: <20). Antinuclear antibody was 1280 (× (<40×)). IgG, IgA and IgM were 574, 239 and 387 mg/dl, respectively. Creatinine clearance was 111.2 ml/min, and the selectivity index was 0.105. A renal biopsy was performed, which revealed normal glomeruli with only granular traces of mesangial IgM in immunofluorescence staining, with mild effacement of foot processes in electron microscopy, compatible with MCNS. The patient was treated with 60 mg of prednisolone daily, followed by improvement of proteinuria and oedema. To date, there has been no relapse of the nephrotic syndrome.

Although lupus nephritis is usually preceded by an active immune disorder, detected by a high titre of anti-DNA antibody and low titres of complement [1], immunological exacerbation was not observed in the present case, despite the onset of proteinuria. MCNS was diagnosed because of the acute onset of nephrotic syndrome, its frequent relapses without impairment of renal function, complete remission following steroid therapy and the finding of normal glomeruli in the renal biopsy [2]. The renal biopsy disclosed in the present case only granular traces of mesangial IgM by immunofluorescence staining, which was compatible with the diagnosis of MCNS [3]. Furthermore, the low titre of IgG and the hyperselectivity of urinary protein excretion demonstrated by the selectivity index supported the diagnosis [4]. As only 21 cases of MCNS in SLE have been previously reported in the literature [5,6], the occurrence of a non-lupus nephritis in patients with SLE is a rare event. Although the pathogenesis of lupus nephritis and MCNS still remains unclear, altered T-lymphocyte function has been postulated to play a pathogenetic role in both disorders [7,8], thus representing a possible clue as to their association.

Conflict of interest statement. None declared.

Department of Endocrinology Taro Horino
Metabolism and Nephrology Toshihiro Takao
Kochi Medical School Tatsuhito Morita
Kohasu Hiroyuki Ito
Okoh-cho Kozo Hashimoto
Nankoku
Kochi 783-8505
Japan
Email: horinot@med.kochi-u.ac.jp


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Transplantation of kidney with retrocaval ureter: what are the pitfalls?

Sir,

In India, nearly 80 000 new cases of end-stage kidney disease are diagnosed each year [1]. Therefore, donors with various types of anatomical anomalies are being accepted for transplantation. At present, there are no existing guidelines regarding acceptability of such donors although larger centres tend to be more liberal. We report our experience in one such case where a kidney from a live related donor with a retrocaval ureter was transplanted.

A 40-year-old male with end-stage kidney disease secondary to chronic glomerulonephritis was awaiting renal