in the body, even if it is not manifest. An induration reaction is indirect evidence of an active tuberculous lesion.

Conflict of interest statement. None declared.

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Ulcereative tuberculin skin test in a dialysis patient

Sir,

A 53-year-old lady, hypertensive since 2003, was diagnosed with end-stage renal disease (ESRD) in January 2006 and initiated on continuous ambulatory peritoneal dialysis (CAPD). She has been on three exchanges per day with 2.5% dextrose solution. She used to achieve 1.5L of ultrafiltration per day. Prior to this presentation, she had never suffered any mechanical or metabolic complications. Her peritoneal equilibration test revealed her to be a high average transporter. She presented with complaints of breathlessness, cough with no expectoration and anorexia. She had no peripheral oedema and fever. Her blood pressure was under control and echocardiography was normal. A chest radiograph revealed distention of pulmonary veins. Suspecting congestive heart failure, she was initiated on continuous cyclic peritoneal dialysis. There was an improvement in the breathlessness and cough, but her anorexia and fatigue had worsened. A tuberculin skin test (TST), was done with 5TU which ulcerated within 24h, suggesting an infection due to Mycobacterium tuberculosis (Figure 1). She improved within a week of initiation of isoniazid (5 mg/kg), rifampin (15 mg/kg) and pyrazinamide (10 mg/kg), aimed at treating latent tuberculosis. A retrospective search for tuberculous infection was negative. She had a scar of BCG vaccination on her deltoid, administered in her infancy.

False negative reactions to TST are reported in HIV infection, severe tuberculosis disease, chronic renal failure, diabetes mellitus, old age and newborn infants. The prevalence of anergy to TST was significantly higher in the ESRD population (44% vs 16%, P < 0.0001) [1]. An ulcerative TST reaction is indirect evidence of an active tuberculous lesion in the body, even if it is not manifest. An induration >10 mm is considered positive in persons with a medical condition that increases the risk of tuberculosis, which includes ESRD patients [2]. Three regimes, isoniazid only, rifampin only, or rifampin plus pyrazinamide, are recommended for the treatment of latent tuberculosis. We used a three-drug regime as this is the practice at our institute. Two consecutive TSTs combined with a chest radiograph should be performed at the start of dialysis, to detect those patients with latent Mycobacterium tuberculosis infection [3].

Conflict of interest statement. None declared.

Sir,

In light chain deposition disease (LCDD), monoclonal immunoglobulin (Ig) light chain deposition usually involves the kidney [1]. End stage renal failure (ESRF) occurs in 70% of patients [2]. Outcomes of kidney transplantation are poor, due to recurrent allograft disease or progression of the underlying plasma cell dyscrasia [1,3]. Thus, renal transplant strategies must address the underlying disease. We describe the first reported case of LCDD treated with sequential autologous peripheral blood stem cell transplantation and kidney transplantation.

A 58-year-old male presented with mild anaemia and renal impairment (serum creatinine 2.8 mg/dl). Urinary protein excretion was 0.71 g/day. Serum protein electrophoresis revealed an IgG kappa paraprotein level of 1000 mg/dl, with depressed IgA and IgM. Bone marrow examination showed 5–6% plasma cells. Renal biopsy showed granular tubular protein deposits, thickening of the tubular basement membrane and peri-tubular sclerosis, in keeping with LCDD. Kappa light chain immunoperoxidase stain was positive (Figure 1). The patient was treated with chemotherapy,