(i) The most striking difference between the two analyses lies in the way information on ACEI/ARB treatment was obtained. In the study of Opelz et al., a questionnaire was sent out, with a return rate of 107 out of 299 participating centres. Their publication does not provide information on how completely the data was collected within those 107 centres. By contrast, we used data bases from the general public Austrian Sickness Funds and direct entry from patient charts.

(ii) Furthermore, we included the confounding variables in a time-varying manner. Different strategies to identify confounding variables yielded virtually the same results. Finally, we did not explicitly recommend ACEI/ARB use, we rather encouraged the scientific community to test a potentially causal relationship between ACEI/ARB use and increased survival in a randomized controlled clinical trial.

Conflict of interest statement. None declared.

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Effective treatment of four consecutive idiopathic membranous nephropathy patients

Sir,

Idiopathic membranous nephropathy (IMN) is a common cause of nephrotic syndrome in adults. The course of this disorder is often benign; however, the disease progresses to end-stage renal failure at 10 years, in approximately one-third of untreated patients [1]. Although several therapeutic regimens, including corticosteroids and other immunosuppressive drugs, have been studied, their efficacy is highly debated. Thus, new drugs or regimens with a higher efficacy and fewer side effects are urgently required for treating high-risk IMN patients [2], such as those with persistent high-grade proteinuria. We previously reported the effects of treatment with mizoribine followed by low-dose prednisone in four IMN and nephrotic syndrome patients [3]. Mizoribine inhibits purine nucleoside synthesis [4], and it is administered to patients after kidney transplantation in Japan, because of its fewer side effects.
### Table 1. Baseline data and reduction in urinary protein excretion

<table>
<thead>
<tr>
<th>Patient</th>
<th>Gender</th>
<th>Age (year)</th>
<th>Glomerular stage</th>
<th>Selectivity index**</th>
<th>Serum creatinine (mg/dl)</th>
<th>Protein-to-creatinine ratio (g/g)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mizoribine Prednisone</td>
</tr>
<tr>
<td>1</td>
<td>M</td>
<td>78</td>
<td>3</td>
<td>0.13</td>
<td>0.81</td>
<td>10.1–6.1 6.1–0.1 0.1</td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>74</td>
<td>2–3</td>
<td>0.15</td>
<td>0.86</td>
<td>4.6–5.4 5.0–3.9 2.0</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>43</td>
<td>2</td>
<td>0.10</td>
<td>0.61</td>
<td>3.2–4.1 4.0–2.2 0.8</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>65</td>
<td>1</td>
<td>0.09</td>
<td>0.82</td>
<td>3.3–8.0 7.6–4.2 2.0</td>
</tr>
</tbody>
</table>

*Glomerular stages were classified according to the system of Ehrenreich and Churg.
**Selectivity index was determined as a clearance ratio of IgG to transferrin.

Unfortunately, this regimen has not been popular, and additional reports have not been published. To draw attention to the true efficacy of our regimen, we report here four consecutive patients with newly diagnosed IMN and nephrotic syndrome.

From 2004 to 2005, four patients visited our Nephrology Department with lower extremity oedema. Each patient exhibited nephrotic syndrome without elevated creatinine concentrations; renal biopsy revealed IMN. These patients neither had any systemic illness nor had they received any immunosuppressive therapy. Hypertension was treated with a calcium channel blocker and/or an angiotensin receptor blocker, and furosemide was administered to control the oedema. After 2 months of observation without any other treatment, their serum albumin levels were 2.8–3.0 mg/dl and the urinary protein-to-creatinine ratio (P/C), which is closely correlated to daily protein excretion [5], ranged from 4.1 to 8.0 g/g. Mizoribine was started at a dose of 150 mg/day. After 2 months of mizoribine monotherapy, urinary protein excretion did not decrease in any patient. Therefore, 20 mg/day prednisone was combined with 150 mg/day mizoribine. The P/C ratio in each patient dropped dramatically within 1 month and decreased to ≤0.4 g/g within 1 year of this combination therapy (Table 1); during this period, both the agents were tapered gradually. Hypoaalbuminemia was also restored to normal levels (>4.0 mg/dl) at 2–8 months after the combination therapy. We would like to emphasize that in IMN treatment, low-dose prednisone can have a beneficial effect after an initial isolated mizoribine treatment, which may form the base for prednisone therapy. The benefit of this combination therapy appear to outweigh the risks of immunotherapy.

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Pentoxifylline as treatment for uraemic pruritus—an addition to the weak armentarium for a common clinical symptom?

Sir,

Uraemic pruritus (UP) remains one of the most bothersome symptoms in patients with renal failure and on dialysis [1]. To date, neither has its pathophysiology been clarified, nor are there any effective treatment strategies available. There is evidence that the proinflammatory state present in many patients on dialysis might play a role in the pathogenesis of UP [2]. Pentoxifylline (PTX), a phosphodiesterase inhibitor mainly used in patients with vascular diseases, has been shown to be an immunomodulating agent suppressing e.g. the production of tumour necrosis factor-α (TNF-α), interferon-γ and interleukin-10 [3]. In a study by McDougall [4], it was found that PTX may be able to partially suppress inflammation in uraemia and lead to a better response to erythropoietin in Epo-resistant cases. Since the drug has a benign side effect profile, we tested the hypothesis that administration of PTX may also help to reduce UP.

After giving informed consent, seven patients on chronic haemodialysis (HD) suffering from UP and pre-treated without success with other potentially effective modalities, received PTX as an experimental drug approach.

They were asked to rate the severity of pruritus once daily, using a visual analogue scale (VAS) ranging from 0 to 10, 7 days prior, during the treatment phase and at least 2 weeks thereafter. PTX 600 mg (Trental™) was administered intravenously using the venous blood line during the last hour of each dialysis session, over a period of 4 weeks. One patient stopped the treatment because of insomnia, two others because of nausea occurring within 20–30 min after the start of the first infusion, and in one patient jaundice