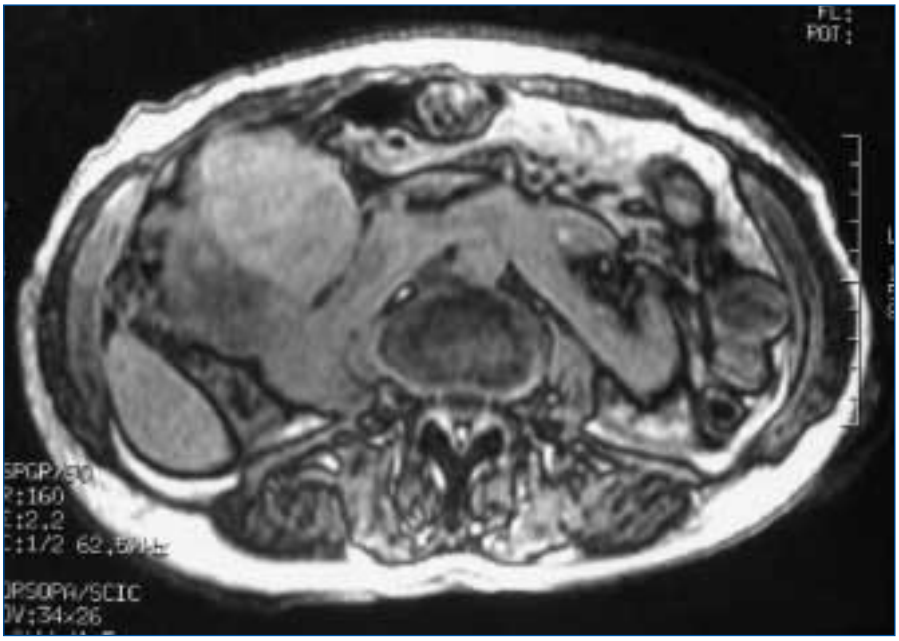

Figure 1. Magnetic resonance image, that shows a hypernephroma.

ration, that was sclerosed with adrenalin. A clinical picture of high fever with pancytopenia developed and Streptococcus was isolated in the blood culture. The patient presented bleeding from a sacral ulceration and the surgical wound and died in a few hours.

The horseshoe kidney is a frequent fusion anomaly. The kidney is irrigated by one renal artery in one third of the cases. In the remaining cases, duplicated or even triplicated renal arteries can be found.[1] Although the association with tumors is rare[2,3] some cases of hypernephroma have been reported, as well as of transitional cell carcinomas, squamous cell carcinoma, Wilms tumors, lymphomas, carcinoid tumors and sarcomas.[4,5]

10%-40% of the patients with hypernephroma presents a paraneoplasic syndrome, with unspecific symptoms (fever, asthenia, weight loss) or biochemical and metabolic alterations (hypercalcemia, hepatic dysfunction, hypertension or, like the reported case, amyloidosis).[6-10] The presence of a paraneoplasic syndrome does not mean that there is metastatic disease and, according to some authors, it does not mean a worse prognosis,[6] although that was not the case in our patient.

The treatment of the renal cell carcinoma is always surgical, and consists in partial or total nephrectomy.[11] It is important to be aware of the manifestations of the paraneoplasic syndrome, as they can constitute the clinical picture at presentation or in case of recurrence.[6]

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Emphysematous cystitis in a patient with renal transplant

Nefrología 2008; 28 **(1)** 110-111

Summary

We describe a renal transplant patient who developed an abdominal pain in the hypogastrium area and a urinary tract infection. An abdominal RX, and later, a computerized tomography showed an air collection in the bladder wall. Emphysematous cystitis is a rare complication of the urinary tract infection, more frequently in patients with diabetes mellitus. It is important to treat it since the beginning, so we can avoid several complications.

Resumen

Describimos el caso de una paciente trasplantada renal que desarrolla un dolor abdominal hipogástrico y una infección urinaria. Tras realizarse una radiografía abdominal y, posteriormente, una tomografía axial computerizada, se observó una colección de aire en la pared vesical. La cistitis enfisematosa es una rara complicación de la infección urinaria, más prevalente en pacientes con diabetes mellitus. Es importante tratarlo a tiempo para evitar posibles complicaciones.

To the editor: We present a 69 year-old woman who had a renal transplant and with 11- year- history of type 2 diabetes mellitus and visceral involvement (retinopathy and nephropathy). She also had high blood pressure and chronic renal insufficiency secondary to

diabetic nephropathy. The early course after renal transplantation was without complications. The graft achieved good renal function 7 days after the procedure and serum creatinine was 1.4 mg/mL.

In the follow-up the patient referred non-specific abdominal pain, mainly hypogastric two months after the transplantation. A computerized tomography (CT) scan was performed that revealed air collection in the inner wall of the bladder,[1] with no alterations in of the graft (fig. 1). The patient referred no other symptoms, except urinary tract infection that was treated with ertapenem for two weeks. Twenty days later a new CT scan was performed that showed a normal bladder with no evidence of air collection. The patient had an indwelling urinary catheter for two weeks, which was removed once the radiological image was normal.

DISCUSSION

Emphysematous cystitis is a rare complication of urinary tract infection, characterized by the spontaneous appearance of gas within the bladder wall or in the bladder. Fifty percent of the patients have diabetes and 62.2% are women. Other risk factors are neurogenic bladder and recurrent urinary tract infections.[3] The mechanism for the gas formation is unknown, but several hypothesis have been postulated, one of them being glucose fermentation in the urine. Symptoms present only in 53.3% of the cases. The most frequent ones are abdominal pain (65%) and hematuria (82%). Other less frequent complaints are fever, chills, nausea and vomiting. In patients with renal transplantation emphysematous cystitis is not very usual although there is a great percentage of patients with diabetes who undergo this procedure. *E. Coli* and *Klebsiella pneumoniae,* both capable of producing gas, are the commonest etiological agents. The prognosis is usually good with antibiotics and glycemic control,[2] except in those patients who present systemic organic dysfunction. Treatment duration depends on the clinical response, but antibiotics are necessary during a mean of 10 days.[4]

A high index of suspicion should be maintained, especially in patients with diabetes that present urinary tract infection, in order to treat the infection as soon as possible to avoid systemic involvement, for example bacteriemia, that develops in 54% of the patients. A plane abdomen X-ray film and/or an abdominal CT scan[5] are enough to rule out this condition.

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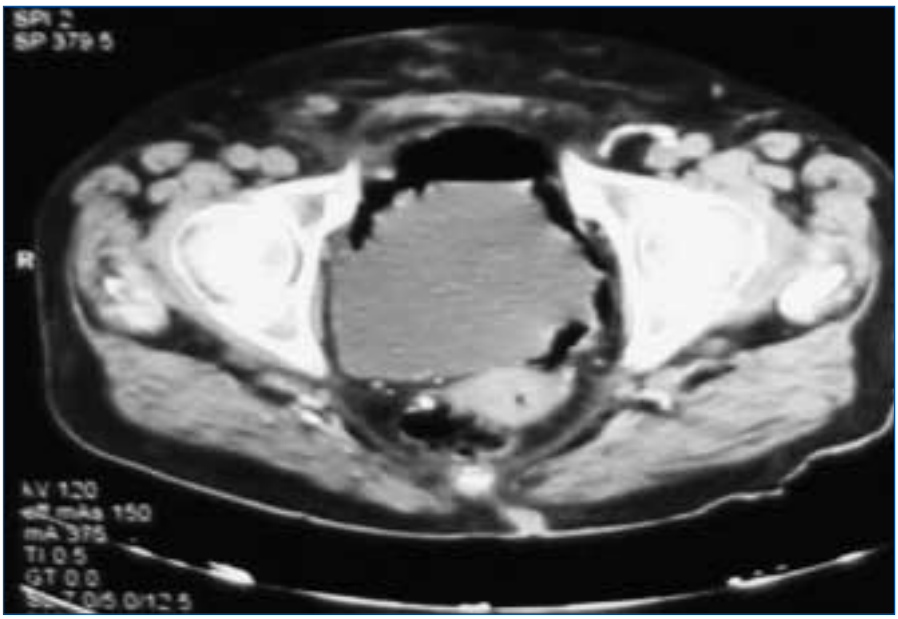

Figure 1.

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Effect of macrobiotic diet on the progression of diabetic nephropathy: a propos of a case

Nefrología 2008; 28 **(1)** 111-112

To the Editor: There are some reports in the literature pointing out that the progression of the diabetic nephropathy (DN) is slower in patients who take low protein diets.[1,2] Macrobiotic diet is an extreme form of vegetarianism that had showed to be useful in the prevention and in the treatment of some tumors. To date it has not been reported that this diet can slow down the progression of the DN.

We present a 58 year-old Caucasian male, with a history of high blood pressure since 1990 regularly controlled with antihypertensives drugs, and of type 2 diabetes mellitus since 1998, treated with insulin and with good metabolic control. He was referred to the Nephrology Department in 2000 because of stage 2 chronic renal failure (CRF) and microalbuminuria secondary to DN. He was being treated with irbesartan 300 mg/day, hydrochlorotiazide 12,5 mg/day, nifedipine 60 mg/day and salicylic acid 100 mg/day. During the follow up the renal function worsened lightly and he had normo-albuminuria. In December of 2005 the following measurements were made: blood