nized into 2 groups. Researchers carried out a prospective, cluster-randomized trial. The intervention group was exposed to music during sessions and the control group received their regular therapy.

Studies show that anxiety and depression are psychological reactions that manifest in chronic kidney disease patients during hemodialysis treatment.[2–7]

Patients requiring dialysis may present with complications resulting from their use, as well as diet restrictions and limitations in their daily activities. This leads to a certain degree of stress. For this reason, we believe that the authors should have considered anxiety and depression among their descriptive variables and used psychological tests, such as the State-Trait Anxiety Inventory (STAI) and the BECK Anxiety Inventory (BAI),[8] as guides.

Anxiety and depression are the most frequent mental disorders in patients with chronic kidney disease requiring hemodialysis.[2,4,6] We would also like to emphasize that physicians do not evaluate patients for anxiety disorders[3] although these are associated with an increased risk of hospitalization and mortality.[7] In addition, healthcare professionals experience the same depressive symptoms as their patient.[5]

## Conflict of interest

The authors declare that they have no conflict of interest.

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# Tolvaptan-related toxicoderma

## Toxicodermia relacionada con el uso de tolvaptán

*Dear Editor,*

Tolvaptan (Jinarc®) is a vasopressin V2 receptor antagonist whose action leads to a decrease in intracellular cAMP levels.[1]

This drug is indicated for patients aged 18–60 years diagnosed with autosomal dominant polycystic kidney disease (ADPKD)[2–4] in cases of rapid progression and CKD stages 1–4.[5,6]

It first became available on the European market in 2015 following the promising results of the TEMPO 3:4 clinical trial.[7] Dosage is divided into two daily intakes, starting at 45 + 15 mg, with progressive increase up to the full dose of 90 + 30 mg,[1] maintaining the highest dose tolerated by the patient and monitoring the main side effects: hepatotoxicity and polyuria.[8]

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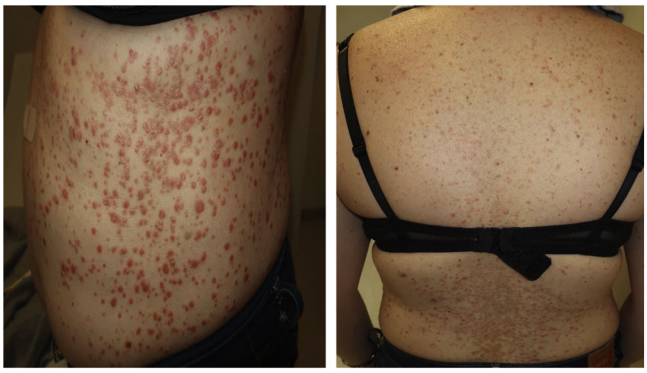

**Figure 1 – Erythematous papules with mild hyperkeratosis on the trunk.**

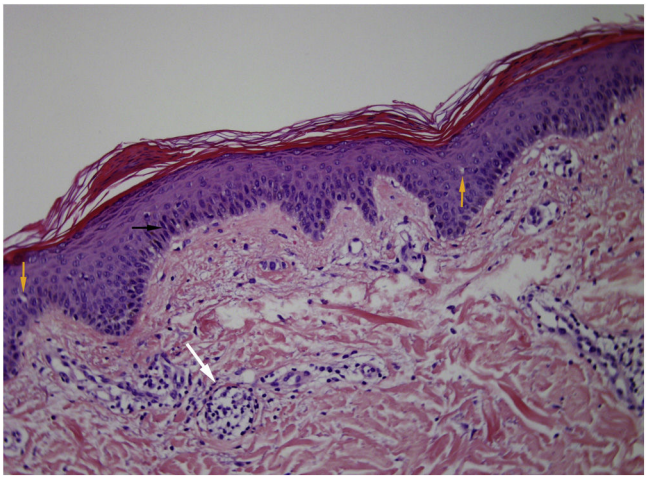

**Figure 2 – A) Black arrow: parakeratosis. B) Orange arrow: spongiosis. C) White arrow: focal lymphocytic exocytosis on the dermis with superficial perivascular lymphocytic infiltrate.**

There are no published cases in the literature identifying toxicoderma as an adverse effect.

We present the case of a 45-year-old woman being followed up for ADPKD since 1992. Her previous personal history included being a former smoker, with no other unhealthy habits, and no known drug allergies. Regarding previous illnesses, she had high blood pressure on dietary treatment and dyslipidaemia being treated with statins.

Her family history included her mother being diagnosed with ADPKD and starting renal replacement therapy (RRT) at the age of 48, and a sister also affected by the disease who had been on peritoneal dialysis since the age of 49.

Magnetic resonance imaging[9] was performed in April 2018, fulfilling the criteria for Mayo Clinic class 1E rapid progression[5]. Therefore, in June 2018, treatment was started with tolvaptan at a dose of 45–15 mg every 12 h, with normal liver function tests prior to starting the drug, with a glomerular filtration rate (GFR) on starting the drug of 53 ml/min/1.73 $m^2$.

In September 2018, the dose was increased to 60–30 mg every 12 h, and in November 2018, the full dose of 90–30 mg was initiated, with no clinical or analytical adverse effects of the drug having been reported so far.

In December 2018, the patient presented with a skin rash accompanied by palpitations, without associated respiratory distress, so it was decided to discontinue the drug.

The lesions consisted of pruritic erythematous papules, some with mild hyperkeratosis, on the trunk, upper extremities and face. A skin biopsy was performed as indicated by dermatology and treatment was started with Adventan® emulsion (Fig. 1).

Skin biopsy showed mounds of parakeratosis, mild spongiosis, minimal very focal lymphocytic exocytosis on a dermis with a mild superficial perivascular lymphocytic infiltrate (Fig. 2).

She was assessed by allergology and the condition was attributed to a possible allergy to tolvaptan, with disappearance of the lesions in May 2019. The manufacturing pharmaceutical company was notified of the pharmacological alert.

At the patient's request, with the consensus of a multidisciplinary session and taking into account the benefit of the drug in disease progression, it was decided to reintroduce the drug at low doses (45–15 mg), with close monitoring by the different medical specialties. In August 2019, lesions reappeared on the patient's forehead and cheeks, so the dose was reduced to 30–15 mg.

Low doses of the drug are currently being maintained, with control of skin lesions and stable renal function (creatinine 1.06 mg/dl and urea 37 mg/dl, GFR 61 ml/min).

Skin reaction is an extremely rare adverse effect in patients treated with tolvaptan, and no similar case has been reported in the literature to date.

In our opinion, in addition to the exceptional rarity of the case, two essential points should be highlighted: 1) the importance of a multidisciplinary approach in this type of patient (joint assessment by dermatology, allergology and nephrology, with the participation of the hepatology and gastroenterology departments also being common) to properly assess the risk/benefit ratio of using the drug; and 2) it should also be emphasised that, even in unusual situations such as this, treatment can be administered at lower doses than those established to maintain the beneficial effect of the drug.

We believe that being able to continue with tolvaptan preserves the principle of patient autonomy and will result in a better prognosis of long-term renal function.

In conclusion, the drug has been maintained at a low dose, with good tolerance and sporadic appearance of minimal skin lesions (one or two), with close dermatological follow-up.

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## Conflicts of interest

There are no conflicts of interest.

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# IgA nephropathy after long-term treatment with infliximab for Crohn's disease Crohn's disease, a review of two cases

## Nefropatía IgA tras tratamiento prolongado con infliximab por enfermedad de Crohn, a propósito de dos casos

*Dear Editor,*

Tumor necrosis factor-α inhibitors (TNF-α inhibitors) are potent immunomodulators and have been associated with the development of autoimmunity, such as glomerulonephritis.[1,2] Recently, investigators described a case of IgA nephropathy in patients with inflammatory bowel disease on a prolonged treatment with TNF-α inhibitors in sustained clinical remission of their intestinal disease, and with improvement after discontinuation of the drug, making the case less likely to be an extraintestinal manifestation.[3,4]

In this regard we e present two clinical cases from our hospital:

**Case 1.** The first case is a 20-year-old male, with Crohn's disease (CD) since 2013, who started treatment with infliximab and azathioprine, went into complete remission, and continued in monotherapy with infliximab since 2016. After seven years on treatment with infliximab (in April 2020), the patient suffered acute deterioration of renal function (Cr 1.8 mg/dL CKDEPI 51 mL/min /1.73 $m^2$), nephrotic proteinuria (8 g/24 h) and microhematuria. A renal biopsy was performed with the finding of IgA nephropathy, M1 E0 S1 T0 in the Oxford classification (Fig. 1). Complete sustained remission of his CD was confirmed, infliximab was discontinued, and an angiotensin-II receptor antagonist was started at maximum tolerated doses and corticosteroids (prednisone 1 mg/kg/day for one month followed by a tapering regimen and discontinuation after six months). After 14 months, his CD relapsed, with no associated deterioration of renal function, and ustekinumab was started,

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