brane and renal infiltration with lymphocytes or plasmacytoid cells.[3] Despite this, renal failure is infrequent.

We present a 74 year-old male who was admitted to the Nephrology Department with a diagnosis of exacerbated chronic renal failure that required emergency hemodialysis. He went to the Hospital because of malaise, asthenia, diarrhea and nausea in the last five months. He had been evaluated at the Gastroenterology Department for 3 months and the creatinine value was 2 mg/dL. On physical exam he was pale, had cardiac arrhythmia, basal pulmonary hypoventilation, jugular ingurgitation, hepatomegaly, and edemas in both legs. In blood analysis anemia, thrombocytopenia, nitrogen retention (Creatinine 13 mg/dL) and metabolic acidosis were detected. ESR, IgM gammaglobulin and Kappa chains values were also elevated. A «rouleaux» phenomenon was seen. In urine there was no excretion of light chains. Bone marrow aspirate and biopsy disclosed infiltration of lymphocytes with plasmacytoid differentiation. The immunological study by means of flow cytometry was compatible with lymphoplasmocytic lymphoma. Renal biopsy showed: 22 histologically normal glomeruli and 3 sclerosed glomeruli. There was infiltration of the interstitium with small size atypical lymphocytes, plasmacytoid lymphocytes and plasma cells, which markedly widened the renal interstitium (fig. 1). By immunohistochemistry malignant cells were found to be positive for anti-CD20 and anti-CD3 anti-sera.

The etiology of WM is unknown but somatic mutations and chromosomal abnormalities of malignant B cell are present. Surface antigens expressed in atypical lymphocyte are mainly CD19, CD20, CD24 and light chain kappa.[4] The clinical picture is similar to other malignant conditions with general syndrome, night sweating, fever, together with symptoms derived from organ involvement due to tumoral infiltration, IgM or amyloid protein deposition or hyperviscosity syndrome.[1,3,5] The following renal manifestations have been described: glomerulonephritis, due to IgM or cryoglobulins depositions and nephrotic syndrome, commonly secondary to amyloidosis or to IgM thrombi within the glomerular capillaries.[6-9]

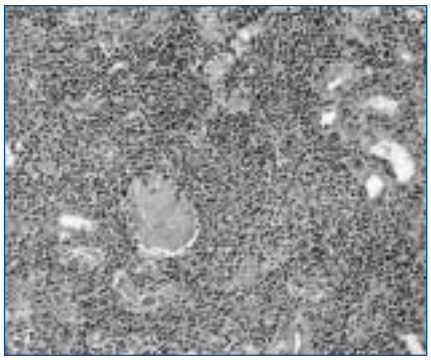

Figure 1.

In the reported case, the patient presented with general and digestive symptoms, and renal failure without proteinuria, which prompted the decision to perform a renal biopsy. The pathological examination of the sample revealed interstitial renal infiltration with lymphoplasmocytic lymphoma with no IgM depositions.

We consider that this case is interesting because of the presence of renal failure, which is infrequent in this condition, and also because of the lack of proteinuria, probably due to lymphocytic infiltration of the interstitium that did not affect the glomeruli.

The patient initiated chemotherapy with chlorambucil and prednisone and he was maintained in on chronic hemodialysis until he died nine months after the diagnosis.

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E. Jiménez Víbora, A. I. Martínez Puerto, J. A. Milán Martín and J. R. Armas Padrón

Nephrology Department. Pathology Department. Virgen Macarena University Hospital of Seville.

Correspondence: *Elena Jiménez Víbora ejvibora@hotmail.com. Centro de Diálisis Sierra Este. Avda. de la Innovación, 2. Edificio Sierra Este. 41020 Sevilla.*

Intoxication with Averrhoa carambola in a patient on chronic dialysis

Nefrología 2008; 28 **(1)** 117-118

To the editor: Patientsfrequently believed that natural products are harmless and that they have many curative and regenerative functions. The star fruit (scientific name *Averrhoa carambola;* See figure) is a widespread fruit in several regions of Central America, South America and above all, in Asia, where it is thought that the star fruit comes from. For some years the fruit is also in the markets of Europe and the United States, where it is considered an exotic fruit. Renal insufficiency is an increasingly prevalent medical condition. In patients with renal insufficiency star fruit intake has been causally related with severe neurotoxicity, that was the cause of death in a few patients. We present a case seen at our center.

Figure 1.

A 67 year-old male came to the Emergency Room of a hospital in Cali, Colombia, because of hiccups for 2 days. He had a history of type 2 diabetes mellitus with secondary renal failure and was on hemodialysis three times per week for 19 months. Twelve hours before his first visit, he had taken star fruit juice in a quantity equivalent to 4 pieces of fruit. In the Emergency Room no apparent cause for the hiccups was found and the patient was referred to our center for the scheduled hemodialysis, after which the hiccups disappeared. He went home and drank a similar quantity of juice. Almost immediately the hiccups recurred followed by vomiting and the patient was admitted to the hospital. During the two following days the patient presented progressive neurological deterioration leading to stupor.

The patient was again referred to our center. On admission he was stuporous, with no neurological focalization and irregular respiratory pattern. The physical exam was otherwise unremarkable. Laboratory investigations showed mild anemia, glycemia 315 mg/dL (17.5 mmol/L), and creatinine 3.93 mg/dL (347.4 mmol/L). Cranial images were normal. The association between the clinical picture and the star fruit intake was evident. The patient remained for the following six days at the intensive care unit, and daily hemodialysis with 4 hours sessions was performed. The symptoms disappeared progressively with no consequences, except for a complete amnesia of the facts that happened around the intoxication episode. Since then he hasd never again taken the fruit. At the Emergency Room, a presentation with hiccups should arise the suspicion of this potentially fatal intoxication in patients with chronic renal disease.

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L. Marín-Restrepo and D. Rosselli

Nephrology Department. Nuestra Señora de los Remedios Clinic. National Academy of Medicine. Colombia.

Correspondence: *Leonardo Marín Restrepo leomarin@hotmail.com. Clínica Nuestra Señora de los Remedios. Calle 35, 6 A Bis 36. Cali. 12345 Valle del Cauca. Colombia.*

Penis necrosis as an unusual manifestation of calciphylaxis in uremia

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To the editor: Penile necrosis is a rare entity and only a few cases have been described in patients on dialysis.[1,2] In these patients it can be associated to diabetes mellitus (DM), cholesterol emboli and seldom to calciphylaxis.[1,3,4] The diagnosis relies on clinical picture, history, physical exam and on other investigations like skin biopsy.[1] We present a case of calciphylaxis in an infrequent location in a patient on hemodialysis.

A 43 year-old male was on periodic hemodialysis because of chronic glomerulonephritis. In the next three years the Ca/P product was persistently higher than 70 mg2/dL2, he had hyperphosphatemia and severe hyperparathyroidism (iPTH 1200 pg/mL). No control could be achieved either with calcitriol or with subtotal parathyroidectomy, which was performed in January of 2005. Since the intervention the PTH level was 200 pg/mL, and calcium and phosphorus levels were 8.5 mg/dL and 4 mg/dL, respectively. In September of 2005 he was admitted because of general deterioration and progressive appearance of petechiae on the penis, which evolved to necrosis (fig. 1).

Laboratory findings were the following: 9,100 leucocytes/mm3, Hb 9.8 g/dL, proteins 4.4 g/dL, P 4.32 mg/dL, and PTH 248 pg/mL. Coagulation parameters were normal and HIV serology was negative. A plain X-ray film of the abdomen showed calcifications within the iliofemoral vessels. Doppler ultrasound of the penis and the iliac vessels revealed a complete lack of flow in the penis and minimal flow in the iliac and femoral arteries, as well as calcifications within the penis vessels.

A decision to perform a partial penectomy was made. The pathological study disclosed hyperplasia of the intimal layer, calcifications in the media with necrotic areas and bleeding within the penis. The postsurgical evolution was acceptable.

Calciphylaxis is a disorder of unknown etiopathogenesis. It is associated to hypercalcemia and/or hyperphosphatemia due to secondary hyperparathyroidism or to intake of calcium preparations and calcitriol.[5] It appears in 1%-4% of the patients on hemodialysis. It was also described in patients on peritoneal dialysis, and very rarely in patients with renal transplantation or in those with end stage CRF, stages III and IV.[6-8]

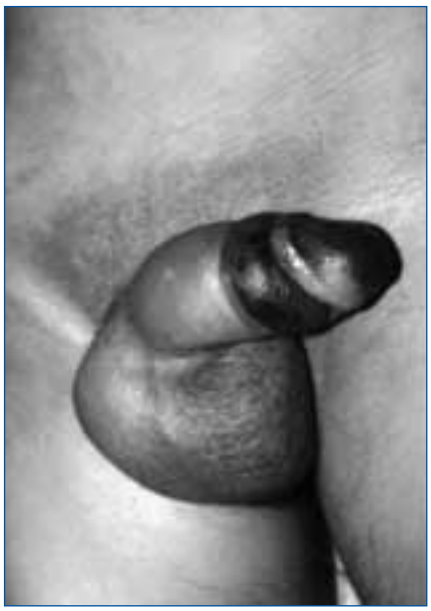

Figure 1. Lesion of the glans penis with a necrotic appearance.