B) BRIEF PAPER ON RESEARCH AND CLINICAL EXPERIMENTS

The importance of early diagnosis to the prognosis of immune-complex tubulointerstitial nephritis

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Dear Editor:

Immune-complex tubulointerstitial nephritis (immune-complex TIN) is a frequent disease, causing 20-40% of all cases of chronic kidney disease (CKD) and from 10 to 25% of acute renal failure (ARF).[1]

In most cases, immune-complex TIN is caused by drugs, with antibiotics being the most frequent agents.[1] Allopurinol causes this type of nephritis in 1.2% of all cases.[2] Treatment consists of discontinuing the medication causing the condition[3] and prescribing steroids; this last step is widely debated.[4] We present the case of a woman aged 79 years with chronic arterial hypertension being treated with ARBs who received treatment with allopurinol. Two weeks after beginning this treatment, she was brought to the emergency room due to fever, general malaise and oligoanuria that had been evolving over a week, together with a diffused rash that had appeared in the previous 24 hours. Upon admission, her blood pressure was 100/50mmHg and she had foveal oedema up to the proximal ends of extremities. The analysis that was carried out showed normocytic and normochromic anaemia, eosinophilia of 767 x 10^3 eosinophils/ml, plasma creatinine of 8.13mg/dl, plasma urea of 203mg/dl, normal ionogram, no proteinuria and the presence of microhaematuria and eosinophilia in urine elements and sediment. Viral serology and immunology tests were negative. The abdominal Doppler ultrasound did not show pathological findings. Given a clinical profile of acute renal failure with a rash, fever and eosinophilia, together with the history of treatment with allopurinol two weeks before, the clinical diagnosis of immune-complex TIN was established; allopurinol was discontinued and steroid treatment begun (1mg/kg/day). The patient required a haemodialysis session. Subsequently, renal function underwent progressive improvement, for which reason a biopsy was not taken. The patient was discharged 10 days later with normal renal function.

Immune-complex TIN is frequent in clinical practice, accounting for 20-40% of cases of CKD and 10-25% of cases of acute renal failure.[1] In most cases, immune-complex TIN is caused by medications.[1] Its classic triad of a rash, fever and eosinophilia is only present in 10% of all cases.[5] Its sure diagnosis is histological,[1,5] but it was not performed in our case due to the patient's rapid improvement. The prognosis is good if the medication is discontinued early.[2] Debate exists regarding treatment with steroids,[4] although numerous studies attest to the role they play in this pathology.[3]

In conclusion, we stress the importance of carrying out an exhaustive clinical history so as to be able to make the clinical diagnosis of immune-complex TIN, discontinue the medication in question at an early stage and begin steroid treatment as soon as possible, which seems to improve the patients' renal prognosis.

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C) BRIEF CASE REPORTS

Atheroembolism in transplanted kidney

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Dear Editor:

We would like to present the clinical case of a male patient 64 years of age with a transplanted kidney. He was admitted for study of asymptomatic deterioration of the transplanted organ's function.

Patient history: arterial hypertension, type-2 diabetes mellitus, dyslipidaemia, severe peripheral vasculopathy, ischaemic cardiopathy.

Advanced chronic kidney disease secondary to cholesterol atheroembolism following a carotid endarterectomy in a periodical haemodialysis programme (PHD). First transplant failed due to intraoperative renal venous thrombosis. Recipient of second kidney transplant (baseline creatinine 1.8mg/dl). Donor: female 59 years of age with no associated Cardiovascular Risk Factors (CRFs).

Recent history: 15 months after the transplant, a decrease in renal function was detected in a routine check-up. There were no changes to the diuresis rhythm, nor was there any consumption of nephrotoxins or any recent invasive diagnostic procedures.