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A) COMMENTS ON PUBLISHED ARTICLES

Comment on "Acute renal failure after intake of mushrooms"

Nefrología 2009;29**(6)**:608.

Dear Editor,

After carefully reading the article by Rojas et al (*Nefrología* 2008;28[5]:559-560),[1] we would like to make a series of observations which we believe should be taken into account. The article describes the case of a child who, after consuming wild mushrooms, had symptoms of vomiting without the presence of diarrhoea, followed by anuric renal failure, anaemia and mild hepatic cytolysis, and needed haemodialysis for 8 days with satisfactory progress.

While discussing the case, the article mentions hepatotoxic mushrooms carrying amatoxins as the cause of the illness. However, in our opinion, the absence of diarrhoea, present in 100% of such poisoning,[2] together with the mild hepatic cytolysis and the normal prothrombin time, render the involvement of a hepatotoxic mushroom such as *Amanita verna* highly unlikely.

The erroneous use of the references is surprising. Five of the six articles mention poisoning from mushrooms of the *Cortinarius* genus, the symptoms of which greatly differ from those described here. The digestive symptoms indicate a latency of 3 days in appearance and renal failure of 4 to 15 days, leading to chronic kidney disease (CKD) in 34% of the cases without hepatic affectation in all the cases shown.[3]

However, the case described by Rojas et al is of particular interest because it corresponded to many of the data attributed to an accelerated nephrotoxic syndrome caused by mushrooms, which is described as being caused in the USA[4] by the *Amanita smithiana*, in Japan by the *Amanita pseudoporphyria* and in France,[5,6] Italy and Spain[7] by the *Amanita proxima*. The latter, that is, *Amanita proxima* (Dumée, 1916), is a mushroom with a creamy white colour similar to *Amanita ponderosa* or *Amanita ovoidea*, with which it is usually confused. It has an orange volva that is characteristically different from the rest of the white-coloured fungi, and it is predominantly found in the Mediterranean area.[5,6] De Haro et al,[5] with the greatest amount of cases (53 patients), report that between 2 and 48 hours following post-ingestion all patients showed signs of gastroenteritis, with a high number of vomiting (85%) and a lesser amount of diarrhoea (26%). Leray et al,[6] in a smaller amount of cases, report no diarrhoea. Acute renal failure occurred between days one and four following ingestion, always accompanied by mild cytolysis that was quickly reversible with a prevalence of LDH and GPT/ALT, the latter never surpassing 15 times the maximum normal limit. Renal affectation is histopathologically characterised by acute tubulointerstitial nephritis with an always-favourable progress.[6] The toxin responsible has yet to be isolated; however, suggestions have been made of non-protein amino acids, thermo-stable and similar to those found in other nephrotoxic fungi, for example, allenic norleucine isolated in the *Amanita smithiana*.[4]

1. Rojas P, González JD, Canalejo D, Sánchez A, Cabrera R, Martín J. Insuficiencia renal aguda tras consumo de setas. Nefrología 2008;28(5):559-60.
2. Piqueras J. Hepatotoxic mushroom poisoning: diagnosis and management. Mycopathologia 1989;105:99-110.
3. Saviuc P, Garon D, Danel V, Richard JM. Intoxications par les cortinaires. Analyse des cas de la littérature. Nephrologie 2001;22(4):167-73.
4. Warden CR, Benjamín DR. Acute renal failure associated with suspected Amanita smithiana ingestions: A case series. Acad Emerg Med 1998;5:808-12.
5. De Haro L, Jouglard J, Arditti J, David JM. Insuffisance rénale aiguë lor d'intoxication par Amanita proxima: expérience du Centre anti-poisons de Marseille. Nephrologie 1998;19(1):21-4.
6. Leray H, Canaud B, Andary C, Klouche K, Béraud JJ, Mion C. Intoxication par Amanita proxima: une nouvelle cause d'insuffisance rénale aiguë. Nephrologie 1994;15(3):197-9.
7. Martínez J, Losada P, Morey A, Alarcón A, Munar MA, Marco J. Fracaso renal agudo secundario a intoxicación por setas. Nefrología 1999;19(6):560-3.

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B) BRIEF PAPERS ABOUT RESEARCH AND CLINICAL EXPERIENCES

Continuous extrarenal treatment without anticoagulation therapy

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Dear Editor,

Critically ill patients often develop acute renal failure and, on many occasions, need continuous extrarenal treatment. One of the main disadvantages of the technique is the coagulation of the filters, which reduces the effectiveness of the therapy, increases costs and prolongs the patient's recovery. The continuous nature of the technique, therefore,