to administer pegylated epoetin beta at the 50μg dose, but divided into two injections (25μg) for the first three doses.

At present, and after eight fortnightly intravenous doses of pegylated epoetin beta, we can state that the patient is tolerating this treatment, maintaining sustained haemoglobin and haematocrit levels within the recommended range for stage 5 CKD on haemodialysis. In this instance, the intravenous administration of pegylated epoetin beta did not result in the appearance of any cross-reactions arising from the patient's intolerance to epoetin beta and darbepoetin alpha. Therefore, we suggest that pegylated epoetin beta may be a good alternative for treating chronic anaemia in patients with CKD and intolerance to epoetin beta and darbepoetin alpha.

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Decrease in renal function due to myomatous uterus

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Dear Editor,

Acute renal failure (ARF) is a clinical syndrome characterized by a sudden decrease in the glomerular filtration rate and increased serum concentration of nitrogen products.[1,2] Obstructive ARF accounts for 10% of total ARF.[2] It is more common in elderly patients and especially in males.[2] Imaging tests, especially renal ultrasonography,[3] are essential for its diagnosis, in which dilation of the urinary tract is often seen as well as, at times, the cause of obstruction.

We present the case of a female patient, 41 years of age, with no significant past medical history, who was sent from the emergency department due to deterioration of renal function with serum creatinine (SCr) of 6.5mg/dl, in the setting of vaginal bleeding requiring transfusions. At that time, she was diagnosed with uterine fibroids by the gynaecology service. She was admitted for further work-up and a renal ultrasound was performed, showing grade IV bilateral hydronephrosis, with poor corticomedullary differentiation, but without visible ureters, for which a CT scan was performed. The CT showed grade IV bilateral ureterohydronephrosis secondary to extrinsic compression by the myomatous uterus, which measured 13 x 9cm (Figures 1 and 2). The urology service was notified, which placed a double "J" catheter in the right ureter, but was unable to place one in the left ureter. Evaluation by the gynaecology service was requested, which postponed a simple hysterectomy to the following week. Following the completion of the hysterectomy, the patient had a favourable clinical progression, but not biochemically, with SCr remaining at 4.5mg/dl 15 days after surgery. Another renal ultrasound was performed, which showed grade II hydronephrosis and poor corticomedullary differentiation, therefore a percutaneous renal biopsy was not performed. The patient was discharged with the diagnosis of grade IV chronic kidney disease, secondary to probable interstitial nephritis, with follow-up in the pre-dialysis clinic.

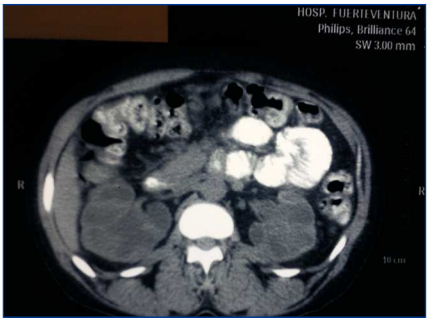

Figure 1. CT cut where bilateral hydronephrosis can be seen.

In cases of obstructive ARF, prompt resolution of the obstruction leads to complete resolution of ARF. In our case, from the time that the imaging tests were obtained, the chronicity of the process could be seen. Therefore, early diagnosis and treatment is important, since they ensure renal viability.

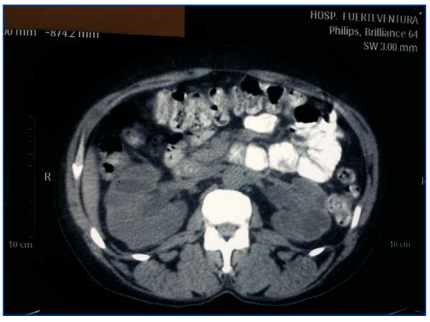

Figure 2. Lower CT cut where bilateral ureteral dilatation can be seen.

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Henoch-Schönlein nephritis triggered by *Salmonella enteritidis* infection

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Dear Editor,
Henoch-Schönlein purpura (HSP) is a common type of vasculitis in children. Renal involvement is frequent and not always benign. Prognostic factors have been recently reviewed by García et al. on your Journal, older age and relapses being related to a poorer renal prognosis.[1]

We present a case of 5-years old boy who was admitted to our hospital with a history of fever-chills, vomiting, abdominal cramping and diarrhoea. He received IV and subsequent oral rehydration and his conditions improved in three days. A stool culture yielded *Salmonella enteritidis*. After an interval of one week by the onset of gastrointestinal symptoms he developed symmetrical purpuric papules and plaques at the lower extremities and arthralgia of the tibio-tarsal joints. Two days later appeared frank hematuria lasting one day only and followed by microhematuria with mild proteinuria. Blood pressure was always normal. Among laboratory investigations creatinine was 77 µmol/l, platelet count, C3 and C4 levels were normal, antinuclear antibody and rheumatoid factor were absent, serum IgA levels were increased for his age (232 mg/dl). Characteristic skin manifestations, joint involvement and hematuria led us to the diagnosis of HSP nephritis (HSPN). Purpura and arthritis resolved in three weeks. Nephritis had a benign evolution. After six months the boy was normotensive without residual microhematuria nor proteinuria and his renal function was normal.

Pathogenesis of HSPN has very recently reviewed.[2] High levels of galactose-deficient IgA1 (Gd-IgA1) has been found in children with HSPN, but not in HSP affected patients without nephritis. Gd-IgA1 seems to have a pivotal role both in HSPN and IgA nephritis. Gd-IgA1 is recognised by anti-glycan antibodies and form large molecular immune complexes. Their deposit in renal mesangium is thought to initiate glomerular inflammation.

Many factors may activate IgA1 overproduction and subsequent disease: a list that includes various infective agents and medications has been published in a review by Rai et al., but it does not contain *Salmonella enteritidis*.[3] Afterwards a case of HSP nephritis in a 50-year-old woman with *Salmonella typhi* septicaemia has been described.[4] At our knowledge our case of HSP nephritis induced by *Salmonella enteritidis* is the first described in literature. This pathogen, very common in children, should be included in the number of infectious agent that can trigger HSPN.

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Acute rejection of pancreatic grafts

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Dear Editor,
Simultaneous renal and pancreatic transplantation is the best treatment option for young patients (< 45 years) who have type 1 diabetes mellitus (DM) and advanced stages of diabetic nephropathy, in the absence of other cardiovascular risk factors, as long as the transplantation waiting time is not unreasonably prolonged.[1]

Due to the characteristics of this type of donors and recipients, patient and graft survival is similar to living donor transplant cases.[2] The pancreatic graft in this case has a survival rate of around 70% five years after transplantation.

We report a case of a 47-year-old man who underwent simultaneous pancreas and kidney transplantation and came in for follow-up; he was asymptomatic except for mild discomfort in the area