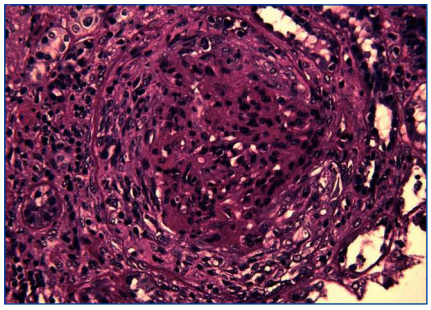

Figure 2. PAS stain shows a fibrocellular crescent in the urinary space that compresses the residual glomerulus and its tuft (PAS, x 400).

nephropathy, except in those cases associated with systemic lupus. The immunopathogenesis of this unusual transformation is unclear. It is well recognized that patients with a crescentic glomerulonephritis have severe and often rapidly deteriorating failure. Unlike membranous nephropathy, which often has an insidious course progressing to renal failure over a period of years, patients with superimposed crescentic glomerulonephritis appear to have a more aggressive clinical course. The importance of recognizing this group of patients with membranous nephropathy and crescentic glomerulonephritis is that immunosuppressive therapy may ameliorate the progression of renal damage and in some cases early treatment was associated with useful recovery of renal function.[4] In our case, the discontinuation of prednisone and azathioprine therapy may have facilitated the rapid progression of kidney disease.

Conflict of interest

The authors declare that there is no conflict of interest associated with this manuscript.

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Response:

Response to "Comment on 'Membranous glomerulonephritis associated with mieloperoxidase antineutrophil cytoplasmic antibody associated glomerulonephritis'"

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To the Editor:

We were very interested by the comment submitted by Dr. Gioacchino Li Cavoli and his collaborators, regarding their similar experience of a membranous glomerulonephritis with crescentic overlap. First of all, we would like to thank them for their input.

They reported a case of membranous glomerulonephritis (MGN) with crescentic transformation in a ANCA-negative vasculitis which revealed no evidence of systemic lupus erythematosus (SLE), anti-glomerular basement membrane (GBM) glomerulonephritis, infection, malignancy and showed no improvement after immunosuppressive treatments. The case they presented was similar to the patient that Kwan JT et al. described previously.[1] Although several authors have demonstrated the concomitance of MGN and ANCA-associated glomerulonephritis,[2-6] MGN accompanied by ANCA-negative crescentic glomerulonephritis has been rarely encountered.

The light microscopic visualization of renal tissue in their case showed the formation of 11 crescents (3 cellular crescents, 1 fibrocellular crescent and 7 fibrotic crescents) and 11 out of 17 glomeruli were globally sclerotic. These histopathological changes indicate the patient has reached to an advanced stage of crescentic glomerulonephritis and the renal disease has progressed to the sclerotic phase at the time of renal biopsy. Nasr SH et al. reported that the percentage of globally sclerotic glomeruli correlated with nonresponse to immunosuppressive agents.[5] This is why the patient showed no improvement after treated with steroid plus cyclophosphamide and started chronic haemodialysis treatment eventually. By contrast, our case showed 2 sclerosed glomeruli out of 19 glomeruli, the formation of 9 crescents including 4 cellular crescents and 5 fibrocellular crescents, as well as the fibrinoid necrosis lesions upon light microscopy. This indicates our patient might be at the relatively early stage of crescentic glomerulonephritis and the renal biopsy findings may interpret the better response to immunosuppressive treatments in our case.

Concerning the prognosis of this group of patients, Nasr SH et al. reported that 50% of patients had reached endpoints of end-stage renal stage (ESRD) or death whether or not treated with immunosuppressive agents and the only independent predictor of progression to

ESRD was serum creatinine at biopsy.[5] However, the different outcomes of the two cases we and Dr. Gioacchino Li Cavoli exhibited reveal that the histological finding is more reliable to predict the prognosis. As Dr. Gioacchino Li Cavoli mentioned in the comment, the importance of recognizing the patients with membranous nephropathy and crescentic glomerulonephritis at early stage of the disease is that early immunosuppressive treatment may ameliorate the progression of renal damage and may contribute to the useful recovery of renal function.

Watanabe S et al. demonstrated that the patient had MPO-ANCA-associated glomerulonephritis superimposed on idiopathic membranous nephropathy in the coexistence of MGN and ANCA-associated glomerulonephritis.[6] It is well recognized that ANCA-positive patient may develop ANCA-related crescentic glomerulonephritis; however, the immunopathogenesis of crescentic transformation in ANCA-negative patients with primary membranous nephropathy seemed to be more difficult to elucidate. Whether there are some other undetected autoantibodies involved in the pathogenesis of MGN accompanied by ANCA-negative crescentic glomerulonephritis remains unclear. Therefore, further research is required to clarify the pathogenesis of this rare concomitance and investigate the optimum treatment regimes for it.

Conflict of interest

The authors declare that there is no conflict of interest associated with this manuscript.

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B) BRIEF PAPERS ON RESEACH AND CLINICAL EXPERIMENTS

Laparoscopy as an effective technique for peritoneal catheter placement

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To the Editor:

Peritoneal dialysis (PD) is one of the treatment options available for replacing renal function in patients with chronic renal failure.

The success of PD as a dialysis technique depends heavily on correct catheter placement into the peritoneal cavity. Several different methods are available for this purpose: laparoscopy, the percutaneous approach using the Seldinger technique or trocars, and surgical.[1] No evidence exists regarding which technique provides the best results, although each technique obviously involves certain advantages and disadvantages. Purely surgical approaches require the availability of surgeons, operating rooms, and anaesthesia. Percutaneous techniques can be performed by nephrologists and/or radiologists in a properly equipped room, which obviates the need for waiting lists.[2] Recent results were published regarding the safety of laparoscopy as compared to open surgery and regarding radiologist-assisted percutaneous techniques.[3,4] Despite these advances, surgical techniques continue to be the most commonly used.

We enjoy a tight collaboration with the general surgery department at our hospital, which has led to our use of laparoscopy as the technique of choice. Here, we present our experience in the placement of peritoneal catheters.