Journal of Renal Transplantation Science
JRTS, 3(S1): 04
www.scitcentral.com

ISSN: 2640-0847

Abstract: Open Access

When Children Rheumatoid Purpura Complicated by Nephropathy? What Therapies?

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Published October 06, 2021

ABSTRACT

Introduction: Nephritis is observed in about 30% of children with Henoch-Schönleinpurpura (HSP). Renal damage eventually leads to chronic kidney disease in up to 20% of children with HSP nephritis in tertiary care centers, but in less than 5% of unselected patients with HSP, by 20 years after diagnosis. Corticosteroid in combination with immunosuppressive agents is the commonly used treatment option and plasmapheresis could be an adjuvant therapy. This observation reports the diagnostic aspects and the difficulties in the management of rheumatoid purpura nephropathy in a three-year-old girl.

Material and Methods: She is a three-year-old girl who was admitted for the management of rheumatoid purpura with edematous syndrome in the face and lower limbs. The clinical examination found a puffy child with edema of the lower limbs, a purpura of vascular appearance made of raised petechial elements. The urinary strip found no blood or proteins. During the evolution and on day six 6 of his hospitalization, the child developed moderate abdominal pain with these times a hematuria with two crosses and a proteinuria with three crosses. diuresis was preserved a renal assessment was carried out with Urea = 0.26 g / l creat = 05. The blood pressure profile remained normal. The albumin level was 38g / l. The 24 h proteinuria assay found a rate of 3,111.36 mg / 24 h, or 190 mg / kg, and the Spot urine protein-creatinine ratio (UPCR)at 2,031.98 mg / mmol, which is very high, greater than 200 mg / mmol. We therefore decided to perform a renal biopsy puncture in order to classify this nephroapthia that this reveals a mesomericglomerulo nephritis with focal and segmental non-necrotizing crescent interesting 01 glomerulus / 10 including 00 PAC, very good conservation of the interstitium and the tubes apart from 02 very moderate infiltrates of mononuclear inflammatory cells, one under the capsular and the other cortico-median. The arteriolar and arterial vascular network is normal. Immunofluorescence objectified a granular mesangial positivity with IgA and .C3 and negativity of Glomeruli with IgG IgM and C1q and fibrinogen, this nephropathy was classified stage III according to ISKDC histologic classification of HSP nephritis. The child received three boluses of methyl prednisolone over three days with maintenance of corticosteroid therapy in decreasing doses. The disappearance of proteinuria was noted from the third month, and the hematuria had persisted macroscopically until the 13th month then microspique; and was negated at the end of the 16th month. The antihypertensive treatment was maintained at weak dose for 13 months then stopped. We have a two-year follow-up in our patient, who is doing well, presents no clinical or biological relapse, his growth is normal.

Conclusion: HSP children who have the risk factors for renal involvement, especially severe kidney disease, should be closely observed. There is a need for large, well-designed clinical studies to determine the best regimens for the treatment of HSP nephritis in children.

Keywords: Lymphatic fistula, Vein glue, Lymphatic fistula

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Citation: Aggoune S, Djermane A, Laloui Y & Maouche H. (2021) When Children Rheumatoid Purpura Complicated by Nephropathy? What Therapies? J Renal Transplant Sci, 3(S1): 04.