Acute Renal Failure as the First Extrapulmonary Presentation of Sarcoidosis

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To the Editor We read with interest the article by Samuraki et al in a recent issue of the Journal (1). Their interesting case report showed diagnostic problems in a patient with no typical sarcoidosis symptom presentation. We agree that in similar situations organ biopsy should be considered as an effective diagnostic tool when sarcoidosis is suspected.

We report a patient with an extrapulmonary presentation of sarcoidosis with acute renal failure as the first sign of the illness. A 63-year-old woman had a 3-month history of fatigue, weight loss (5 kg/3months) and moderate proximal muscle weakness. Her laboratory data showed only a creatinine level 6.7 mg/dL and mild anemia with a normal iron level. Past medical history was unremarkable. X rays of the chest and ultrasonography of abdomen showed no abnormalities. Pre-renal and post-renal acute renal failure were excluded. A percutaneous biopsy of the kidney showed interstitial nephritis; a pathologist did not rule out glomerulopathy in the course of connective tissue disease. The patient was treated with 3 pulses of methylprednisolone (1 g/24h) and therapy with prednisolone in decreasing doses was continued. The patient stayed in a good condition for the subsequent few months with creatine level of 1.2 mg/mL so the corticosteroid therapy was discontinued. Six months later her laboratory findings showed a serum calcium level of 13.9 mg/dL (Ca++ 1.917 mmol/dL) with PTH in the normal range and creatinine level of 2.3 mg/dL. Ultrasonography of the abdomen showed no abnormalities, but CT scans disclosed hepatosplenomegaly and lymph node enlargement. The CT of the chest was normal. Histopathological examination of the inguinal lymph node revealed lymphadenitis, granulomatosa and gigantocellular granuloma. Therapy with prednisolone was restarted and continued for the following four years. Repeated X rays and CT of the chest were normal. Four years after the first symptoms, CT of the chest disclosed bilateral hilar adenopathy with parenchymal infiltration and the diagnosis of sarcoidosis was confirmed.

Renal complications of sarcoidosis are rare but they can be the first sign of illness and may lead to renal failure (2). It is noteworthy- that in many cases of renal sarcoidosis kidney biopsy does not reveal granulomatous interstitial nephritis. A diagnosis of interstitial nephritis should be analyzed in context of granulomatous disease too, especially in cases when other features of multisytem disorder are present.

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References