DE NOVO MINIMAL CHANGE DISEASE (MCD) FOLLOWING KIDNEY TRANSPLANTATION.

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Post transplant de novo MCD is a rare cause of nephrotic syndrome (NS) in kidney transplant recipients. It is important to know the etiology of ESRD in native kidneys, as recurrent FSGS may also present similarly. There is some evidence that living donor (LD) transplantation is a risk factor for de novo MCD. Native MCD has a higher rate of remission in pediatric patients compared to adults following steroid therapy. There is scarce evidence in the transplant literature about treatment of MCD. Also, in patients with unknown etiology of their native kidney disease, onset of MCD may herald recurrence of FSGS. Whether to start steroids or go to plasmapheresis presents an interesting dilemma. Case: A 41 year old female with ESRD from 'post-streptococcal glomerulonephritis' as a child & a failed LD transplant after 18 years from chronic allograft nephropathy, presented with new onset NS 6 months post LD transplant, with 8 gm proteinuria / 24 hours, & Scr of 0.9 mg/dl. Biopsy revealed epithelial foot process effacement only, consistent with the diagnosis of MCD. Prednisone was started at 1mg/kg, and slowly tapered over 6 months, along with ACEI and ARB. 24 hour proteinuria dropped to 4 gm, 2.3 gm and eventually 1.7 gm at 1, 2 & 4 months respectively with stable kidney function. Serum albumin has slowly risen back to normal. She continues on MMF, Tacrolimus & prednisone at present.

This patient represents a good response to steroid therapy in post-transplant MCD. There is evidence to suggest that early NS (< 7 days post-transplant) is more likely to be FSGS. Knowledge of the native disease process is crucial to evaluating the cause and treatment of NS post-transplant, and all efforts made to determine the etiology. Physicians should bear in mind that de novo MCD is a rare but possible cause of NS in the early post transplant period and should recognize it as being a potentially reversible cause of proteinuria with good graft outcomes.