

OXALATE NEPHROPATHY WITH AIN DUE TO VITAMIN C INTAKE.

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We report a case of Acute interstitial nephritis and acute kidney injury due to intake of Vitamin C in a patient with chronic pancreatitis. Enhanced absorption of oxalate with a deranged enterohepatic circulation can cause nephropathy. A 55-year-old African American man with a history of chronic pancreatitis CKD, and malabsorption syndrome presented to the renal clinic with dizziness, nausea, abdominal pain and weakness of 1 week's duration, and elevation of creatinine from 1.8mg/dl-10.7mg/dl over a 2-month interval. Two weeks before his presentation he had begun taking vitamin C tablets along with his multivitamin replacement, as well as furosemide 40mg daily. He denied any intake of alcohol, nor antifreeze.

Examination showed a blood pressure of 70/30mmHg, pulse of 112 beats/min, and oral temperature of 35° C. There was abdominal tenderness in the lower quadrants bilaterally. He had poor skin turgor, but no rash. Serum chemistry values were as follows: sodium 122mEq/L potassium 5.9meq/L chloride 105mEq/L bicarbonate 7.1mEq/L, (BUN) 83mg/dL, calcium 8.7mg/dl ; creatinine 10.7mg/dl ; Urinalysis showed specific gravity of 1.010, 1+ protein, + leukocyte esterase, but negative nitrite, 10-15 red blood cells/ hpf, and too numerous to count white blood cells/hpf. Urine eosinophils were absent. Because of persistent ARF, a kidney biopsy was done. The biopsy showed interstitial infiltration with eosinophils and extensive oxalate deposition. A diagnosis of oxalate nephropathy due to Vitamin C intake, with enteric hyperoxaluria was made. The patient has continued to require outpatient dialysis, on a low oxalate diet, and avoid taking vitamin C. This case illustrates that oxalate nephropathy should be considered in the differential diagnosis of unexplained AKI in patients with diarrhea and malabsorption states.