

SPONTANEOUS REGRESSION OF RENAL FAILURE IN A PATIENT WITH HEMOLYTIC UREMIC SYNDROME: A CAUTIONARY TALE

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The constellation of intraglomerular hemorrhage, fibrin deposition and acute renal failure usually connotes a diagnosis of thrombotic microangiopathy, from which recovery is usually rare. We recently treated a 75 year old male patient with severe azotemia and Ecoli urosepsis. The patient presented with abdominal pain, dysuria, and oliguria. Urinalysis showed heavy proteinuria, 800 RBC, s, 500 WBC, s and many WBC clumps. Blood and urine cultures grew Ecoli.

Table 1. Laboratory data during the hospital course.

	Day1	Day3	Day5	Day7	Day9	Day11
BUN mg/dL	74	82	58	33	30	22
Creatinine	6.1	6.4	5.3	3.4	3.1	2.9
Urine Protein	20	10	4	1	0.8	0.3
Platelets	57	78	330	420	475	512
WBC	24	18	15	10	8.8	8.1

A renal biopsy showed intraglomerular congestion and hemorrhage, with crescents in some of the glomeruli. Immunofluorescence showed extensive fibrin deposition. The patient responded to treatment with IV fluids and antibiotics. The recovery of renal function occurred in the absence of treatment with dialysis or plasmapheresis.

The frequency with which urinary isolates of EColi producing shiga toxin is unknown. Very few cases have been reported and all had a bad course requiring RRT or plasma exchange. Death or ESRD occurs in about 12% of patients with Ecoli associated HUS. This intriguing case report emphasizes several important points - nondiarrheal HUS is rare in elderly, the possibility of an atypical clinical course and the management of HUS in adults. HUS should be considered as a possible diagnosis in the setting of ARF and Ecoli sepsis.