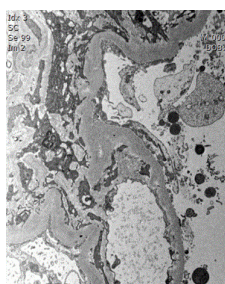


An adult minimal change disease presented with nephrotic syndrome and devastating renal function

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Background: Minimal change disease (MCD) is less prevalent among adults than among children and adolescents. It is known that renal function is usually preserved in MCD. AKI and its rapid aggravation in MCD is unusual. In this paper, we report MCD combined with acute kidney injury (AKI) aggravated rapidly within several days. **Case presentation:** A 79-year-old man experienced edema, weight gain, decreased urine output, and aggravated dyspnea, which started 2 weeks before he first visit. Recently he had taken NSAIDs (Non-steroidal anti-inflammatory drugs) because of lumbar spinal stenosis. The patient had poor oral intake and diarrhea persisted for 3 weeks. He was severely dehydrated. On admission, his blood pressure was high (188/92 mmHg). Serum Creatinine (Cr) was 1.84 mg/dL, serum albumin was 2.4 g/dL, random urine albumin was 3+, and 24-hour urine protein excretion was 8416 mg/d. Kidney biopsy was done on the 2nd day of hospitalization. Before the biopsy results, his Cr had rapidly increased for 4 days. The patient was initially diagnosed as rapidly progressive glomerulonephritis (RPGN) combined with prerenal AKI. After ruling out malignancy, the patient took steroid pulse therapy for 3 days. Cyclophosphamide pulse was considered if steroid pulse would not be effective. The patient started hemodialysis on the 6th day of hospitalization because of acute kidney injury and hypervolemia. Specific features were not found on the kidney specimen by light microscopy and immunofluorescence, and diffuse effacement of foot processes was revealed on an electronic microscopy. Based on these findings, the patient was diagnosed with MCD. Therefore we continued steroid therapy. The patient obtained complete remission from nephrotic syndrome 3 weeks after the treatment. Two weeks after remission, steroid dose was tapered. **Conclusion:** If the adult patient shows nephrotic syndrome with AKI aggravated rapidly, not only RPGN but also MCD needs to be considered.



E.anophelis as a cause of bacteremia, skin necrosis and renal embolic infarction in a Korean patient

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Background: Elizabethkingia anophelis bacteremia mainly occurs in neonates or adults with underlying medical illnesses, and was associated with pneumonia and neonatal meningitis. However, cases of severe septicemia, skin necrosis and embolic renal infarction caused by E. anophelis in a patient have not been reported in Korea. **Case presentation:** A 68-years-old female patient who were performed aneurysmal clipping due to aneurysmal rupture in 1994 was admitted to the emergency room with oliguria. Blood pressure was 80/50 mmHg. We assessed the patient as sepsis and performed blood culture in peripheral blood vessels and central catheter. She was given intensive care unit care and continuous renal replacement therapy because hypotension and oliguria were not resolved. We also performed thoracic and abdominal computed tomography (CT) for infection focus evaluation. Abdominal CT was noted multifocal embolic infarctions in the left kidney (Fig. 1a). On hospital day 3, she had severe skin necrosis on left lower leg (Fig 1b). Cultures of peripheral and catheter site blood have grown E. anophelis. Finally, E. anophelis was confirmed by 16S ribosomal ribonucleic acid gene sequencing (GenBank accession number: CP015066.2). We used tigecycline for more than 2 weeks according to the sensitivity of blood culture test, but the patient died without recovering from sepsis. **Conclusions:** E. anophelis bacteremia should be considered clinically in patients with severe underlying diseases. Although high mortality rate is shown in bacteremia, adequate antibiotic treatments should be administered. **Keywords:** Elizabethkingia anophelis, bacteremia, renal infarction

