Recurrent Bloody Dialysate during Upper Respiratory Tract Infection in Mesangial IgA Glomerulonephritis

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Bloody dialysate is a known complication of CAPD, e.g. secondary to endometriosis, rupture of Graaf's follicle, trauma, tumor, etc. Recently we had the opportunity to examine a patient with mesangial IgA glomerulonephritis (IgA-GN) who was on CAPD and presented with recurrent bloody dialysate in temporal relationship to upper respiratory tract infections.

37-year-old patient; since 1975, known microhematuria and proteinuria, serum creatinine 2.5 mg/dl. Renal biopsy at that stage showed mesangial IgA-GN. Biopsy of uninvolved skin showed no IgA deposits suggestive of vasculitis.

The patient was admitted to our unit and put on CAPD in October 1983. In the following 2 years he complained of 6 bouts of bloody dialysate (erythrocytes 500,000/ml) without evidence of peritonitis (leukocytes 10,000/ml; negative bacterial cultures). The bouts lasted for 3–5 days and were not associated with abdominal symptoms. Bleeding time and coagulation tests (Quick, PTT, factor VIII) were repeatedly normal. Abdominal CAT scan was unremarkable.

Scintigraphy with ^{99m}Tc-Nano-Coll® showed no localized source of bleeding. Gastrointestinal X-rays were repeatedly normal. In every single instance, intraperitoneal bleeding was preceded by an upper respiratory tract infection several days prior to onset of bloody dialysate. The episodes were afebrile but associated with headache, rhinitis and on some occasions with painful swallowing.

Upon intensive questioning and check-up because of the episodes, the patient volunteered that in 1966 he had a bout of non-

bloody gastroenteritis accompanied by arthralgia and a fine macular and possibly petechial rash on the lower and upper extremities compatible with the diagnosis of Schönlein-Henoch's purpura (SHP).

After 5 episodes, tonsillectomy was performed in January 1985, after which only one minor episode occurred to date. The proportion of B cells expressing IgA versus IgG in the tonsils was within the normal range.

The observation documents asymptomatic bleeding into the peritoneal space as another clinical manifestation of IgA-GN/SHP. The case adds another differential diagnosis for bloody dialysate on CAPD. The observation also illustrates that the peritoneum is a potential target organ for the IgA-GN/SHP complex. A fortuitous association is unlikely in view of the occurrence of the

bloody dialysate in temporal association with respiratory tract infections and virtual disappearance after tonsillectomy.