Dear Sir,

In the December issue, Tabata et al. [1] report a new case of acute renal failure in McArdle’s disease which is considered to be the 15th appearing in the literature. We assume they were considering only English publications as non-English journals are scarcely included in the reference lists, perhaps because of little diffusion, lack of knowledge of the language or other difficulties. As a result of these considerations and the rarity of McArdle’s disease we report below the summary of another previously published case [2].

A 24-year-old male patient was admitted to the Hospital because of anuria. Two days before his admission, following exercise, he suddenly lost his strength in the limbs and fell down. Thereafter, discomfort in his back and thighs, nausea, vomiting, emission of dark urine and progressive oliguria developed. He had a history of easy fatigability and exercise intolerance since he was 12 and his father and one brother also complained of similar symptoms. Between the studies performed, the ischemic exercise test was positive, there were no changes in the blood concentration of lactate and the muscular biopsy showed PAS-positive deposits in the muscular sarcolemma, increased content of muscle glycogen and unde-tectable phosphorilase activity. Thus, a diagnosis of McArdle’s disease was made.

The evolution of acute renal failure is shown in fig. 1. Creatine phosphokinase and LDH were 9,000 and 10,000 a CPK, IU/1 x 10 Δ LDH, IU/1 10 SGPT, IU/1

& A

10

a Creatinine, mg/100 ml Δ Urea, mg/100 ml x 10

10 12 14 16 18 20 22 24 30 4
days months

Fig. 1. Clinical course of the patient (reproduced with permission of Nefrología, official journal of the Spanish Society of Nephrology). CPK = Creatine phosphokinase; PD = peritoneal dialysis.

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IU/1, respectively, and serum myoglobin reached 6,000 ng/ml (normal 8–80 ng/ml) on the 4th day. There was an important dissociation between the increments of urea and creatinine and the uric acid showed higher values (15 mg/dl) than acute renal failure of other etiologies (11.8 ± 1.6...
mg/dl). This has been attributed to an increase in production from the muscle purines [3]. The oliguria lasted 8 days and two peritoneal dialysis were necessary. A decrease in enzymatic activities and myoglobin level preceded the beginning of diuresis. As in the case referred to we found neither hypocalcemia in the oliguric phase nor hypercalcemia in the polyuric phase, which were present in other studies [4–6]. The evolution was good and the renal function was normal after 24 days.

References


Announcements
IVth International Workshop on Transplant Aspiration Cytology
This workshop will take place October 7–9, 1987, at the Princesa Sofia Hotel, Barcelona, Spain. It will be devoted to recent advances in cytology and histology of transplanted organs as well as in immunology.

For further information please contact: Servei de Nefrologia, Hospital G.M.D. L’Esperança, St. Josep de la Muntanya, 12, E-08024 Barcelona (Spain).

3rd International Symposium on Organ Procurement
This symposium will be held in Barcelona, Spain, December 2–4, 1987, at the Princesa Sofia Hotel. It will be devoted to recent advances in preservation and sharing of organs for transplantation (kidney, liver, heart, lung, pancreas), new trends in organization, and legal and ethical aspects.

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Nephrologisches Seminar – Seminar für Nieren- und Hochdruck-krankheiten
Heidelberg
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