Sir,

Recurrent urticaria with cutaneous vasculitis is a systemic immune disorder of unknown origin [1]. A striking feature of the syndrome is the response to indomethacin (IND) of cutaneous lesions poorly controlled with steroids [2-6]. Information relative to the response of the renal damage to therapy is scarce. We present a patient with urticarial vasculitis, in whom IND improved the renal damage and prevented the recurrent episodes.

A 5-year-old girl was admitted to our hospital in January 1985 for rash, fever and macroscopic hematuria. Physical examination was remarkable for normal blood pressure, fever and a generalized, erythematous, maculopapular rash.

Complementary data: hemoglobin 11 g/dl, leucocytes 30,000/mm3 with 90% neutrophils; ESR 70-107; serum IgE 900 IU/ml; CH50, C3, C4, IgG, IgA and IgM were within the normal range; cryoglobulins, HBsAg and ANA were negative; proteinuria 140 mg/m2/h.

Four days after admittance, oliguric renal failure developed with a creatinine peak of 4 mg/dl. A renal biopsy contained 40 glomeruli with intracapillary proliferation and exudation of neutrophils. Crescents were present in 55% of the glomeruli (fig. 1). The vessels and interstitium were normal. Immunofluorescence showed granular deposits of C3 in the mesangium, glomerular capillary wall and Bowman’s capsule (fig. 1). IgG, IgA and IgM were absent. Electron microscopy revealed a normal glomerular basement membrane, without electron-dense deposits. A biopsy of involved skin showed perivascular infiltrates of neutrophils and monocytes. After treatment with

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Fig. 1. Renal biopsy, a Glomerulus showing extracapillary proliferation. Methenamine silver, b Immunofluorescence showing granular fixation of anti-C3 antibody in the mesangium and glomerular capillary wall.

intravenous 6 M prednisolone (10 mg/kg/day) for 5 days, the renal function improved and the fever and rash disappeared, but severe proteinuria persisted. In the next 2 years, several recurrent episodes responded to high-dose corticosteroids, but neither these nor cyclophosphamide prevented them (fig. 2). IND was found to prevent new episodes. A flare-up closely followed IND dose reduction. At the time of this study,
Renal disease is present in 10-30% of the patients with urticarial vasculitis, and is usually mild [2,3] but, as in this patient, it may be severe [6, 8]. Renal biopsy usually shows diffuse proliferative or membranoproliferative glomerulonephritis [1,3,6-10]. Hypocomplementemia is not always present.

Therapy of urticarial vasculitis may be problematic. No single drug has been effective in all cases. Corticosteroids, dapsone, immunosuppressive drugs and colchicine have been useful in certain patients. IND has successfully controlled the cutaneous manifestations [2-4], even in steroid-resistant cases [2], but the effect on renal injury was not detailed [2‡].

The mechanisms of the beneficial effect of IND in this patient are not clear. IND may modulate both the inflammatory [11] and the immune response [12] through the inhibition of arachidonate cyclo-oxygenase and, at high doses, of phospholipase A₂. Arachidonate derivatives have recently been shown to influence the production and mode of action of several cytokines [13,14] that may mediate the vascular damage in vasculitis [15].

References


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Urticaria-Associated Glomerulonephritis and IND