Dear Sir,

We have recently had the opportunity of diagnosing acute tubulointerstitial nephritis and uveitis (TINU syndrome) and of proceeding with its follow-up for 2 years. The singularity of this syndrome, its relapsing capacity of the renal as well as ocular disease and the differential diagnosis with entities of great similarity have led us to present this report.

A 61-year-old woman was referred to us by the Ophthalmology Service because of bilateral anterior uveitis. Familiar and personal antecedents were without interest. There was no previous ingestion of drugs. No oral and/or genital repeating ulcers were present. Previously feeling good, she experienced asthenia, anorexia and weight loss (15 kg in 3 months). In the last 4 weeks, she also showed polyuria and abdominal pain. In the last 2 weeks bilateral blurred vision appeared and that is the reason why she went to the opthalmologist. On clinical examination, no abnormalities were found.

Laboratory studies yielded the following results: hemoglobin 10.4 g/dl, MCV 89 fl, WBC count 6,700/mm3 (66.9% polymorphonuclear cells and 4% eosinophils). Erythrocyte sedimentation rate was 112 mm/h. Serum creatinine was 2.6 mg/dl, uric acid 2.6 mg/dl, serum sodium 140 MEq/l, serum potassium 4.3 mEq/l, and glucose, calcium, phosphorus, alkaline phosphatase, GOT, GPT and cholesterol were normal. The serologic test (paratyphia, brucella, toxoplasma, cytomega-lovirus and Lyme disease) were negative. ANA, anti-DNA, anti-SSA, anti-SSB were negative. C4/C8 = 2.2, HLA B5 and HLA B27 were negative. Serum total protein was 8.1 g/dl, albumin 43%, γ-globulin 26.9% (poly-clonal). Urinalysis: density 1,009, pH 8, pro-teinuria (70 mg/dl) and glucosuria (50 mg/dl). Urine cultures remained sterile. Urinary calcium level was 39 mg in 24 h. Angiotensin-converting enzyme was normal. Tuberculin test was negative. Chest films and pulmonary galium 67 scintigraphy were normal.

The renal biopsy revealed an interstitial inflammatory infiltration composed of lymphocytes, plasma cells and polymorphonuclear leukocytes.
covering cells. No intense fibrosis was present and the glomeruli appeared normal, immunofluorescence studies were negative for immunoglobulins, fibrinogen and complement components. The TINU syndrome has been described as ‘New Syndrome’ by Dobrin [1] in 1975. The author’s attention was drawn by the presence in 2 patients with anterior uveitis of a systemic failure characterized by malaise, anorexia, weight loss, flank pain, high erythrocyte sedimentation rate and an acute interstitial nephritis not due to drugs, infection or diseases related to autoimmunity; together with these findings, bone marrow and lymph node granulomas were detected [1]. Later, over 30 cases have been studied, with a great incidence among children and adolescents and with similar characteristics to those described by Dobrin [1], thus, the systemic manifestations usually precede the localized manifestations of the process such as uveitis and nephritis [2]. Uveitis can be the presentation of the clinical picture, and in the reported cases, it has a clear relapsing effect but with an excellent prognosis both for the uveitis and the nephritis, whether by a spontaneous healing or by steroid treatment [3].

Many etiologies of this syndrome have been put in the balance, involving viruses [4], chlamydiae [5] and disorders in the cellular immunity [6]. With regard to the differential diagnosis, it has to refer to entities associated with uveitis and interstitial nephritis, such as sarcoidosis, Sjögren’s syndrome, Behçet’s disease, Wegener’s granulomatosis, polyangiitis, tuberculosis, syphilis, toxoplasmosis and Lyme disease, all these easily rejectable by serologic tests and other clinical characteristics; the same does not happen with sarcoidosis which shows a great similarity that makes us resort to a whole series of tests such as the pulmonary galium 67 scintigraphy, ECA levels, presence of hypercalciuria, and what is most important, it makes us follow the evolution of nephropathy, which in sarcoidosis has a slight reversibility capacity [7]. In a recent report [8], attention is drawn to the similarity between the TINU syndrome and Sjögren’s syndrome and it states the possibility of being in presence of the same entity, suggesting as a routine for these patients the realization of a biopsy of the minor salivary glands. Our patient during these 2 years has had 2 relapses of her process, both preceded by ocular manifestations, and during both she had renal disorder; in the same way, the response was always spectacular with a low dose of steroids. We think that in view of the clinical characteristics of this entity, its evolution, its excellent response to steroids it is worth being considered as an entity with its own personality, and it should be separated from the entities such as Sjögren’s syndrome and sarcoidosis with very torpid courses in a great number of cases.

References
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